Delay in diagnosis of cancer
17 March 2024

This case relates to the care provided to a woman by Health New Zealand|Te Whatu Ora Southern (Health NZ Southern). The woman presented to primary and secondary services with urinary symptoms multiple times over a five-month period. The urinary symptoms were attributed to a urinary tract infection. In the fourth month of the woman's presentation, she was diagnosed with a rare type of cancer, known as primary mucinous adenocarcinoma of the vagina, extending to the urethra and bladder. This case considers whether the woman's diagnosis of cancer occurred within a reasonable timeframe.

The investigation found that delays in the woman's cancer diagnosis originated from the initial care she received after an outpatient clinic consultation. During the outpatient visit, a junior registrar detected a lump in the woman's vaginal wall as part of a physical examination. This was escalated to the gynaecology team, who advised the registrar to refer the woman for a transvaginal pelvic ultrasound scan and follow-up with the gynaecology service after the scan had been completed. As the woman's general practitioner had already completed a referral for a transabdominal ultrasound scan, the registrar did not update or change this referral to a transvaginal ultrasound scan. In addition, the paper referral had been lost, and Health NZ Southern did not follow up with the gynaecology service. This led to a four-month delay in receiving gynaecology input.

Health NZ Southern acknowledged that losing the referral was a departure from accepted standards. It also acknowledged that there was a delay in diagnosing the woman's cancer. However, Health NZ Southern attributed part of these delays to the rarity of her cancer.

The investigation also found that there were shortfalls in other aspects of the woman's care. First, a differential diagnosis of physical obstruction was not considered by Health NZ Southern clinicians when she presented with urinary symptoms. Secondly, the woman's MRI scan had been terminated partway through the scanning process due to the absence of a specialist radiologist who could report on gynaecology-related MRIs. Finally, the investigation noted resourcing constraints within Health NZ Southern's oncology services, which was linked to the broader issues within Health NZ Southern's clinical governance systems, as found previously by the Commissioner-Initiated Investigation into Health NZ Southern in 2023.[1]

Since these events, Health NZ Southern has increased the resourcing within its oncology services and developed an electronic referrals system internally. Health NZ also made many improvements to its governance systems following the findings of the Commissioner-Initiated Investigation.

[1] https://www.hdc.org.nz/news-resources/news/commissioner-initiated-investigation-into-delays-in-provision-of-non-surgical-cancer-services/

Findings

The Commissioner found that Health NZ Southern breached Right 4(1) due to the absence of a robust referrals system. In addition, the Commissioner criticised Health NZ Southern's lack of follow-up of the gynaecology referral and made educational comment in relation to termination of the MRI scan.

The Commissioner criticised the junior registrar's lack of documentation and failure to update the pelvic ultrasound referral.

Recommendations

The Commissioner recommended that Health NZ Southern apologise to the woman for its breaches of the Code. In addition, the Commissioner recommended that Health NZ Southern remind its clinicians of the importance of updating any radiology referrals when new relevant clinical information has been found and provide an update on whether external referrals could be completed electronically.

The Commissioner recommended that the urology registrar review their practice in light of the deficiencies identified and report back to HDC on their learning.