Failure to follow up CT reports

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Case histories are based on actual medical negligence claims or medicolegal referrals, however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

A failure to follow up test results is a common underlying cause of medical negligence claims and complaints involving general practitioners. This article examines a case in which an incidental finding of an aneurysm on cerebral computerised tomography scan was not followed up with disastrous consequences for the patient.

Case history

Mrs Salmon, 56 years of age, was admitted to a local hospital under the care of her general practitioner, Dr Baxter, complaining of headaches, dizziness and hearing loss. The patient's husband had died recently and the GP thought she was suffering from depression. As part of the investigation of her symptoms, the GP ordered a cerebral computerised tomography (CT) scan. The scan was performed 1 November 2002 and revealed an 8 mm aneurysm in the region of the anterior communicating artery, with no evidence of bleeding. Dr Baxter thought the aneurysm was an incidental finding. He discussed the results of the CT scan briefly with the patient and arranged to review her in his rooms after her discharge from hospital. On 18 November 2002, Dr Baxter reviewed Mrs Salmon at the surgery. He advised her that the aneurysm was like a 'balloon' in a blood vessel in the brain and if it ruptured it could have serious effects on her health. He told the patient that she should be reviewed by a neurologist. The GP did not record the CT results in the health summary or the medical records but simply made a notation 'Ref neurologist' in the medical records. A copy of the CT report was not included in the GP's records and only appeared in the hospital notes.

Over the ensuing couple of years, Mrs Salmon was seen by a number of the GPs in the practice with various complaints. On 18 July 2004, Dr Baxter saw Mrs Salmon and noted: 'recurrence of vertigo, CT scan at time of husband's death NAD, did not see neurologist at that time. For neurologist appointment'.

On 5 December 2004, the patient was seen by another GP in the practice concerning the patient's request for a CT scan: '...when having a cup of tea, electricity went through her brain'. A diagnosis of '? Migraine ?Anxiety' was made at this time.

On 16 January 2005, the patient was seen by Dr Baxter. The GP noted: '...continues to experience bizarre head pains and shooting or stabbing sensations'.

The GP recommended a trial of a low dose antidepressant medication.

On 17 May 2005, Mrs Salmon collapsed at home. She was transferred to a tertiary hospital where a diagnosis of subarachnoid haemorrhage secondary to rupture of a large left anterior communicating artery aneurysm was made. Surgical clipping of the aneurysm was performed but the patient was left with significant neurological impairment.

In July 2006, the patient commenced legal proceedings against Dr Baxter alleging a failure to follow up the CT scan results in November 2002 and failure to follow up the referral to the neurologist.

Expert evidence served on behalf of the patient concluded that the care provided by her GP was well below the standard of care expected of a reasonable GP. The GP expert was critical of Dr Baxter's failure to record the results of the CT scan in the medical records and health summary. The expert also noted that the GP should have followed up the issue of referral to the neurologist in 2002 and also in 2004–2005 when the patient was experiencing further symptoms.

An expert report was obtained from a neurologist on behalf of the defendant, Dr Baxter. The neurologist confirmed that the aneurysm that ruptured was the same aneurysm that had been identified on the initial CT scan performed in November 2002. The expert stated that if the patient had attended a neurologist in 2002, she would have been referred to a neurosurgeon for advice regarding surgical treatment of the aneurysm. The likely scenario would have included a full discussion of the risks

of treating the asymptomatic aneurysm either by open surgical repair or by interventional radiological coil. The annual cumulative risk of rupture of an 8 mm aneurysm was of the order of 2% per year, with a 20–30 % risk of death in the event of rupture. The risks of an elective repair of an unruptured aneurysm at this site included a 10% risk of significant neurological morbidity. The neurologist concluded that, on the balance of probabilities, it was likely that operative treatment of the aneurysm as an elective procedure would have significantly reduced the risks of a subsequent subarachnoid haemorrhage and neurological damage.

An expert report was also obtained from a GP. The expert stated that the patient was a difficult patient to evaluate with many illnesses and complaints, including neurological symptoms not due to the cerebral aneurysm. The GP opined that the reasonable obligation of a GP with a patient identified as suffering from a cerebral artery aneurysm as an incidental finding, would be to arrange referral of that patient to a neurologist or neurosurgeon and to explain the importance of the referral to the patient. The expert stated that she would have informed the patient that there was a significant risk that the aneurysm could rupture and that the risk of rupture accumulated over time. Even with immediate treatment, rupture of the aneurysm carried a mortality and morbidity rate of about 50%.

Based on the expert reports and the likelihood that a Court would find that Dr Baxter's management was below standard of care, the patient's claim was settled before trial. Settlement was in excess of $1 000 000 which included a large sum for the patient's future care costs.

Discussion and risk management strategies

In this case, there was a failure of the GP to follow up his referral of the patient to the neurologist. There were a number of factors that contributed to the outcome in this case but probably the most significant was the failure of the GP to record the finding of the cerebral aneurysm in the health summary or the medical records. In particular, when the patient re-presented with vertigo and headaches in 2004–2005, Dr Baxter and his colleagues were not alerted to the results of the cerebral CT scan performed in 2002 because the report was not included in the records and there was no notation about the aneurysm in the health summary, or in the body of the medical records. If this had been done, it would have alerted the GP and his colleagues to the importance of following up the results of the cerebral CT scan. While it was not apparent why the patient had not attended the neurologist, the GP had not recorded his reasons for the referral and there was no copy of the letter of referral in the records. The GP could not specifically recall what advice he had given to the patient about the need for the referral to the neurologist and, indeed, when the patient re-presented to him in 2004, he had forgotten that the CT scan in 2002 had revealed an incidental finding of a cerebral aneurysm.

This case serves as a reminder of the importance of good medical record keeping.

Conflict of interest: none.

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