BREAST CANCER TREATMENT DELAYED 15 MONTHS BY MISHANDLED RADIOLOGY REPORT

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DESCRIPTION

A 53-year-old patient experienced a 15-month delay in the treatment of cancer after breast biopsy.

KEY LESSONS

- A fragmented medical record can lead to delays in care.
- Lack of a closed-loop system for tracking orders and results exposes critical diagnostic information to being lost.

CLINICAL SEQUENCE

A 53-year-old woman presented to the internal medicine (IM) clinic for follow up after being evaluated in the Emergency Department for complaints of shortness of breath and atypical chest pain. Her medical history was significant for smoking, substance use disorder, and a prior breast lumpectomy (benign). At this time, she had a chief complaint of fatigue for several months.

The patient was evaluated by an IM resident. Blood work, a stress test, colonoscopy, and a mammogram were ordered under the resident's name, with no attending physician noted. When the blood work results returned, the IM resident called the patient to advise follow up on abnormal chemistries, but that follow up, the stress test, and the colonoscopy were never completed.

The patient was scheduled for a mammogram, and this imaging revealed fine calcifications in the patient's left breast and a suspicious, irregular mass in her right breast. The radiologist advised breast biopsy, and this was done in Interventional Radiology (IVR) within two days. The initial biopsy report noted pathology results to be pending.

In the hospital where the biopsy was performed, the anatomic pathology reporting system was manual, and not linked to the EHR. Even so, IVR was appropriately notified, and the results of the pathology report were integrated into the final IVR report two weeks later, confirming malignancy in the patient's right breast.

The radiologist sent the final report to the IM resident via electronic mail, and a hard copy via interoffice mail. The email was seen by the IM resident, but not acted upon, as the resident forgot to follow up with the patient. The attending IM physician remained unaware of this patient. At the completion of residency program 15 months later, the IM resident found the hard copy of the breast biopsy and pathology report while cleaning out his mailbox and notified the patient's attending IM physician.

The patient had surgery within a month, the breast mass having tripled in size. Surgical pathology from mastectomy diagnosed invasive ductal carcinoma and sentinel node involvement. By the time this case closed, the patient had undergone four cycles of chemotherapy, and endocrine therapy was being planned. Her chance of five-year survival was 93 percent.

ALLEGATION

The patient asserted a case against the resident and attending physician for failure to diagnose breast cancer

DISPOSITION

The case settled in excess of $1.5M.

DISCUSSION POINTS

Systems failure in managing imaging orders and results

In this case, the provider lost track of a critical pathology report, abnormal liver function tests, and orders for a stress test and colonoscopy.

Interventions to decrease systems error in managing test orders and results:

- Engage practice staff in rigorous process improvement: include all staff closest to the work.
- Facilitate patient engagement in the process of managing orders and results (e.g., consistent closed-loop communication; patient instructions and education aligned with level of health literacy)
- Optimize technology (e.g., EHR reminder systems; computerized physician order entry rules; patient portal technology)

Patient Safety Improvements

In follow up to this case, the organization adopted a policy requiring contact information for an attending physician be included in all orders for diagnostic studies. In addition, the chief resident's standard work now includes monthly

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monitoring of the residents' administrative mailboxes, and the organization's new EHR system was set to flag outstanding orders and critical results.

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