



## TEST RESULT SNAFU DELAYS CERVICAL CANCER DIAGNOSIS

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### DESCRIPTION

A 32-year-old patient did not receive abnormal test results nor associated need for follow up, leading to a delayed diagnosis of cervical cancer.

### KEY LESSONS

- Closing the loop on referrals ensures patients receive appropriate follow up.
- Electronic systems should support clinicians and provide alerts for follow up.
- Ensure clinicians understand electronic health system processes and potential gaps.

### CLINICAL SEQUENCE

A 32-year-old female with a history of genital herpes had a physical exam and Papanicolaou test (Pap) with her internal medicine (IM) provider. One month later, a message was sent to the patient stating that her Pap results were abnormal and a referral to Gynecology would be made. For unclear reasons, the Gynecology referral made by her IM provider through the electronic health system did not go through and the patient never saw a concurrent message sent to her through the online portal. This message did not have an associated email alert to the patient.

Over the next two years, the patient had several encounters with the same office, including treatment for asthma, refill of birth control pills, and evaluation for an axillary lump. During that time, no mention of the abnormal Pap test or Gynecology referral was documented. Two years after her abnormal Pap test, the patient returned for a routine physical and interest in attempting pregnancy. A Pap test done at this time was also abnormal. This time, the patient saw the message sent via the online portal and scheduled a Gynecology appointment.

Colposcopy and biopsy revealed squamous carcinoma. A loop electrosurgical excision procedure was done with negative margins, but question of lymph involvement. The patient underwent further testing, referral to Oncology, removal of several lymph nodes, and was ultimately diagnosed with 1A-1 cervical cancer. Following surgical treatment, the patient's

## PATIENT SAFETY RESOURCES

prognosis includes close follow up, egg donation, and the need to use a surrogate for any future pregnancy.

### ALLEGATION

The patient initiated a medical professional liability (MPL) lawsuit against the IM provider, alleging delay in diagnosis of cervical cancer.

### DISPOSITION

This case was settled in the mid-range (\$500,000–\$999,999). The defense experts opined that cervical cancer from human papillomavirus is slow growing and that the time delay did not alter the subsequent treatment plan. Fertility options would have been the same if follow up had occurred two years prior.

### ANALYSIS

#### **Electronic health system failure**

Investigation of this case revealed a series of errors and omissions occurred and follow-up systems failed to recognize that the Gynecology referral was never made.

### LEARNINGS

#### **Closing the loop**

[Ambulatory safety nets](#) are high-reliability, person-centered programs that provide a backup system for following up on abnormal test results or referrals when the standard follow-up process fails. They include:

- Registries for patients with abnormal results/outstanding referrals
- Communication workflows
- Patient navigators

Ambulatory safety nets are designed design to ensure closed-loop communication and follow up of abnormal test results to enhance proper referral management.

#### **Defendant support**

Emotional support for providers who are impacted by a malpractice case recognizes that their coping skills can significantly impact their day-to-day practice and how effective they are as a defendant. Institutions are encouraged to develop defendant support programs for all clinicians involved in MPL claims.

