Delay in Diagnosis of Colorectal Cancer Results in Advanced Metastatic Disease and Ultimate Death of the Patient

The Case

This case involves a patient who had been under the care of the same physician for 9 years. During this time he complained intermittently of back problems and fatigue. He was prescribed B12 injections, multivitamins, iron and folic acid over the ensuing years. In 1999 at the age of 43, the patient presented with complaints of rectal bleeding and had a hemoglobin of 14.6. His physician ordered a barium enema and found diverticular disease. At a follow up office visit two weeks later, the patient again reported rectal bleeding. A high fiber diet and Cipro were recommended. No rectal exam is recorded at either of these office visits.

In 2001, nearly 22 months later, the patient returned to the physician. Now at age 45 his follow up CBC revealed a hemoglobin of 10.7, although he reported having had no rectal bleeding for a year. At this visit his documented problems included chronic back pain, fatigue, diverticulosis and iron deficiency. The physician again prescribed vitamins and iron. At his deposition, the physician recalled that he had also recommended a colonoscopy. However, neither a referral nor documentation of that plan was noted in his office chart.

Several months later the patient returned to the office. Anemia was again confirmed at 12.6 grams. The patient was prescribed a more potent iron preparation. Again, no rectal exam was recorded. The next visit is 7 months later, now
about 18 months after anemia was first confirmed, and 3 ½ years after the initial complaint of rectal bleeding. The patient was now 46 with continued complaints of bleeding. A rectal exam was done this time, confirming blood and the presence of “an internal hemorrhoid”. The colonoscopy performed four weeks later revealed a “lobulated, ulcerated mass at 2-5 cms from the anal verge.” A small polyp was removed 20 cms from the anus. Biopsies of the smaller polyp were non-diagnostic at pathologic exam, but Pathology confirmed the rectal mass to be adenocarcinoma.

Referral was made to a colorectal surgeon who ordered an abdominal and pelvic CT scan. The CT scan was negative for evidence of metastatic disease. The chest x-ray was normal. The surgeon recommended neoadjuvant chemoradiation which the patient completed without incident. Five months later the surgeon performed a recto-lower sigmoid resection and sigmoid colostomy. The resected specimen revealed adenocarcinoma extending into the perirectal tissues with two nodes revealing malignancy. Following the surgery, adjuvant 5FU was prescribed and given for approximately four months.

Five months after completion of the adjuvant chemotherapy, and now one year after surgical resection, a pulmonary nodule showed on PET scan and was biopsied. The biopsy report was positive for malignancy. Although there is some debate about tissue type, an outside expert confirmed the tissue was most consistent with metastatic disease from the primary rectal carcinoma. Also at this time the patient developed cardiomyopathy with rather severe congestive heart failure and atrial fibrillation.

The patient died approximately 1 ½ years following his eventual diagnosis.

The lawsuit subsequently filed alleged delay in the diagnosis of rectal cancer by the primary care physician. Several primary care physicians and gastroenterologists reviewed the case for MagMutual. None of the reviewers could support the care rendered by the primary care physician. After months of negotiation, MagMutual settled the case for a large amount.

**Clinical Risk Management Commentary**

This patient had no positive family history for colorectal cancer, no co-risk factors, and was young for the usual presentation of colorectal cancer.

The major concerns in this case revolve around the failure to perform digital rectal exams when the patient complained of rectal bleeding, and the treatment with iron and vitamins. A documented anemia in a male should have prompted immediate referral for endoscopic examination.

In this particular case, office anoscopy would very likely have discovered the lesion, as well as ridged proctoscopy. Flexible sigmoidoscopy and/or colonoscopy would have also have provided a diagnosis.

The failure on the part of the primary care physician to refer the patient, particularly when anemia developed, did not meet the accepted standard of care.

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