Diagnostic Difficulties; Diagnostic Delays

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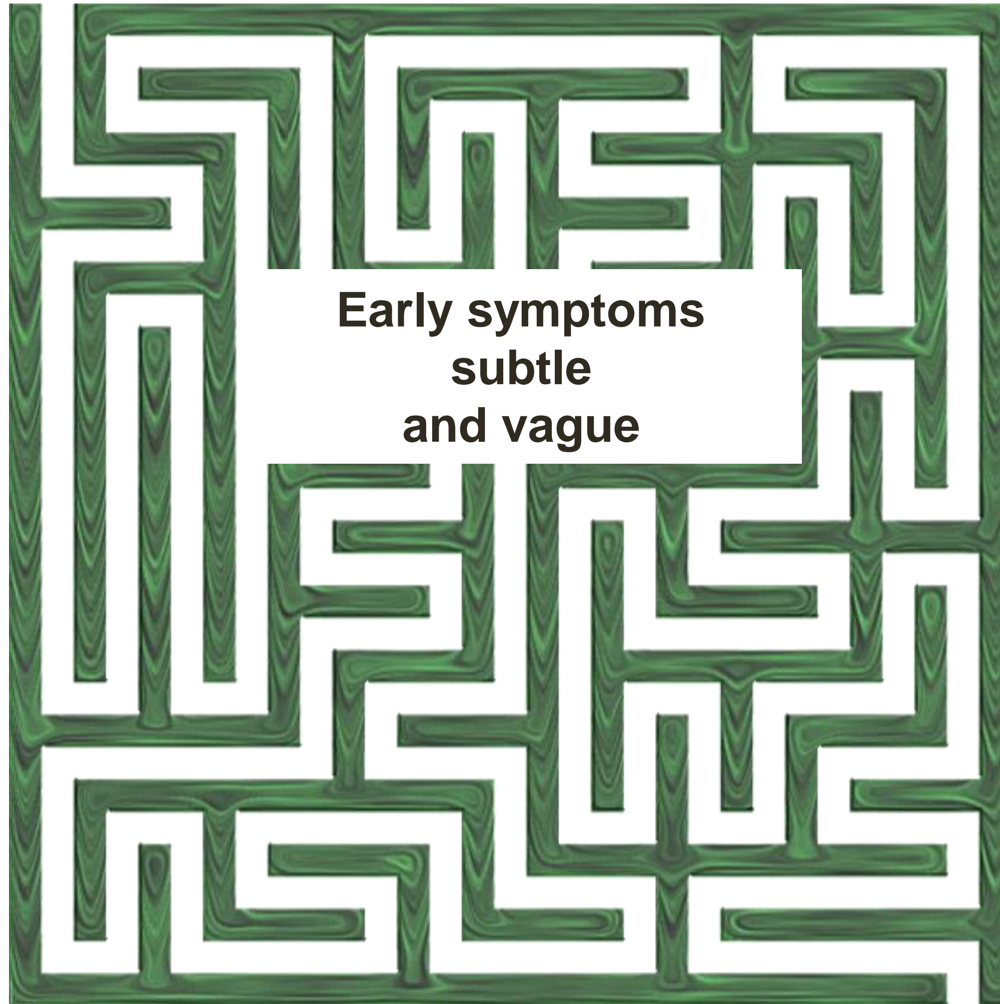
Spike Milligan's epitaph

Early diagnosis not easy



Time of presentation

(Whitaker et al, 2015)

- Sociodemographic differences in responses to cancer symptoms; socioeconomic inequalities in cancer survival (eliminating sociodemographic Inequalities estimated 5600 fewer advanced stage cancer diagnosis)
- Lower socioeconomic status, male, older age associated with lower health literacy
- ‘Common’ within social network leads to normalisation of symptoms…disadvantaging older populations
- COVID-19

Timely Diagnosis

Cancer staging at diagnosis; strong predictor of survival

MSCC; Ability to walk

CES; Ability to pass urine

Diagnostic delays investigated, Root cause analysis, Significant Event Audit

UK'S Health secretary Rank GPs according to prompt referral to specialist

(Lyratzopoulos et al, BMJ 2014)

Late Diagnosis

(Routes to diagnosis for cancer – determining the patient journey using multiple routine data set. Ellis-Brookes, 2012)

- Cancer survival in the UK falls below Europe
- Lower survival rate in the first year after diagnosis due to late diagnosis
- 1/3rd cancer diagnosis made in A&E in over 70s
- In all ages ¼ are diagnoses through A&E
- Emergency route to diagnosis is predictive of 1 year survival

Complexity

- Initial presentation low positive predictive value
- 20% with unknown cancer visit GPs 3 or more times before onward referral
- Seen by policy makes as avoidable delay???
- Ease of diagnosis can be site specific (Breast cancer, melanoma)

Complexity

- More difficult, Multiple Myeloma, Pancreatic, lung, stomach cancer (back pain, abdominal pain)
- Constellation of reasons for delay including patient, timing of presentation, clinician, health service delivery etc

Significant Event Audit

- Document process of event
- Reflect on what happened and why
- Identify good and bad learning points
- Consider changes to be made and actions to be taken

(Mitchell et al, 2012)

Delays

- Complexity of presentation
- Patient mediated factors
- Reassurance provided by investigations

Lessons learned

- Vigilance in relation to Red Flags
- Usefulness and limitations of diagnostic tools
- Good communication between Primary and Secondary care
- Inform patients of Red Flags to look out for

Key Messages

- Atypical cancer presentations are not uncommon
- It is difficult to differentiate new potentially malignant symptoms
- Initial normal investigations can be falsely reassuring
- Monitor/watchful wait? Refer on /investigate again
- Continuity of GP is preferred

Key Messages

- An infrequent attender who consults may be significant in itself
- Awareness of family history and smoking history is important
- Ensure that patients with existing risk factors are aware of Red Flags
- Clinicians must be vigilant and suspicious of patterns that do not fit
- Instinct, clinical skill and experience are important
- Mitchell et al, 2012

Date

Red Flags

Clinical Presentation Mapping

WHAT HAPPENED?

Reflection

Clinical Presentation Mapping

Date Document known dates and profession of clinician e.g. G.p., FCP

Red Flags

Document known red flags and significant clinical findings at each consultation

Reflection

Populate following completion of two sections above, including Red Herrings

Clinical Presentation Mapping

Date	27/08/ GP No 1	29/08/ GP NO 2	In-Patient until 11/09/08
Red Flags	•New onset left sided low back pain •Thought to be gallstones •New pain not previously • suffered •Age 52 years	•LBP severe, •Sent to A&E •Admitted	•Lumbar spine x-ray •Abdominal ultrasound •Abdominal x-ray •IVU **ALL REPORTED AS NORMAL**
Reflection			**CAUTION; Do not be reassured by previous investigations being reported as normal. Were they investigating the correct aspect or area?**

Clinical Presentation Mapping

Date	15/09/ GP No 3	26/09/ GP No 4	Physio appointment and GP No 5 09/10/ →
Red Flags	•'No Red Flags' specifically documented in GP notes •Thought to be musculoskeletal	•LBP severe, •Referred to Physiotherapy •No Red Flags again documented	•Patient had started to walk with a stick as legs felt weaker **but reported feeling some improvement** •Weight loss •Stopped work and describes feeling depressed →
Reflection			**CAUTION; Serious pathology appears to respond to physiotherapy in the early stages**

Clinical Presentation Mapping

Date	23/10/ Physio review	27/10/ Gp No 5	03/ 11// GP NO 6
Red Flags	•Feeling some improvement •Gait re-education •Discussed paced exs approach •Goal to wean off walking aid and return to work	•No red Flags Documented •Medication adjusted	•Patient reported feeling hot with increased frequency •Gp suspected UTI
Reflection	**Good knowledge of Red Flags essential**		

Clinical Presentation Mapping

Date	10/11/ Gp No 4 home visit	13/11/ DNA Physio appointment	14/ 11// Gp No 4 & 6
Red Flags	•Home visit requested due to pain		•Patient reported severe abdominal pain and PV bleeding 2/52 cancer pathway to gyaenocology
Reflection			•Seen by general surgeons •MRI lumbar spine organised •Discharged back to Gp for Ortho referral

Clinical Presentation Mapping

Date	16/12/ Gp No 6	2/01/ CATS AOP
Red Flags	•Oromorph prescribed and Orthopaedic referral carried out	•Documented significant weight loss •Non segmental neurology •Band like pain •Severe restriction of lumbar flexion •Poor balance and mobility •Saddle anaesthesia and retention •“Drunken feeling” Fuzzy feeling in legs •“Legs not my own” “Dragging leg
Reflection		•MRI lumbar spine expedited and changed to ***Whole spine***

Clinical Presentation Mapping

Date	6/01/09	9/01/09 RBH
Red Flags	•Multiple spinal metastases	Primary Breast Cancer
Reflection		**•7 Gp's** **•1 physio** **•1 AOP** **•Approx 5 month patient journey**

Clinical Presentation Mapping

Date	27/08/08 GP No 1	15/09/08 GP No 2	09/10/08 Physio
Red Flags	•New pain not previously • suffered •Age 52 years	•New pain not previously suffered •Age 52 years •Band-like pain	•New pain not previously suffered •Age 52 years •Band-like pain •Weight loss •Sudden change in Mobility (began walking with a stick)
Red Herrings		•Negative investigations for abdo pain as in patient •Normal bloods and lumbar x-ray report •2/52 inpatient stay	•Back pain improving •Sleep ok, no night pain •CRP & Myeloma tests negative •Possible emergence of yellow flags

Clinical Presentation Mapping

Date	03/11/ GP		02/01/ CATS AOP
Red Flags	•New pain not previously suffered •Age 52 years •Band-like pain •Weight loss •Sudden change in •Mobility (began walking with a stick) •Fever & chills	•New pain not •previously suffered •Age 52 years •Band-like pain •Weight loss •Sudden change in •Mobility (began •walking with a stick) •Fever & chills	•Non segmental neurology •Severe restriction of lumbar flexion •Poor balance and mobility •Saddle anaesthesia and retention •"Drunken feeling" Fuzzy feeling in legs •"Legs not my own" "Dragging leg

‘Leeds man who 'begged' for MRI scan dies from cancer’

- ‘13 visits in four weeks a scan on 26 May revealed a tumor in his pelvis and 30 small tumors on his lungs’.
- suffering leg pain ………….sent away with a course of antibiotics.

Delay to diagnosis

- Working with uncertainty; Early symptoms subtle and vague, no objective manifestation of disease
- Human Factors; Surgery on wrong site
- System failure; Poor pathway, lack of robust referral systems, bottle necks e.g. MRI

Human Factors in Healthcare

https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf

A patient was given an unnecessary knee operation;

- Two patients with the same name had different medical conditions that required hospital appointments in different departments, however, they both just happened to have knee pain at the same time.
- The wrong patient arrived and had the procedure intended for the other.

How did this happen?

- Four different hospital numbers were recorded in the patient's medical notes, along with more than one GP and several different addresses.

- The hospital used patient identifier labels so one mistaken patient detail could be replicated many times.

- An independent translator wasn't always available when either patient turned up for the treatment of their different conditions.

- Neither the consent form nor the pre-operation assessment form were properly completed

Work with patients as partners

- Safety Net
- Watchful wait
- Avoid defensive medicine
- Relay on sound clinical reasoning

Safety Netting

WORKING WITH PATIENTS AS PARTNERS

Advice for patients	
	What Red Flag symptoms do they need to be aware of
	What to do if these Red Flag symptoms develop. Verbal and written advice where possible
	Clear timescale for when they need to act
	When to come back if symptoms not resolved
	The reason for tests or referrals
	How test results will be obtained
	Likely time scale of current symptoms
Action for clinicians	Check patient understood safety netting advice
	Communicate test results to patient and GP. Follow up as necessary . Document test findings clearly
	Consider accuracy of diagnostic tests (nb. False negatives)
	Consider referral after repeat consultation for new symptoms(e.g. Three strikes and you are in)
	Have system that can highlight repeat consultations for unexplained recurrent signs and symptoms
	Document safety netting advice carefully
	Debrief/reflect on all serious pathology cases

Three strikes and you are in

Good Housekeeping; look after yourself!

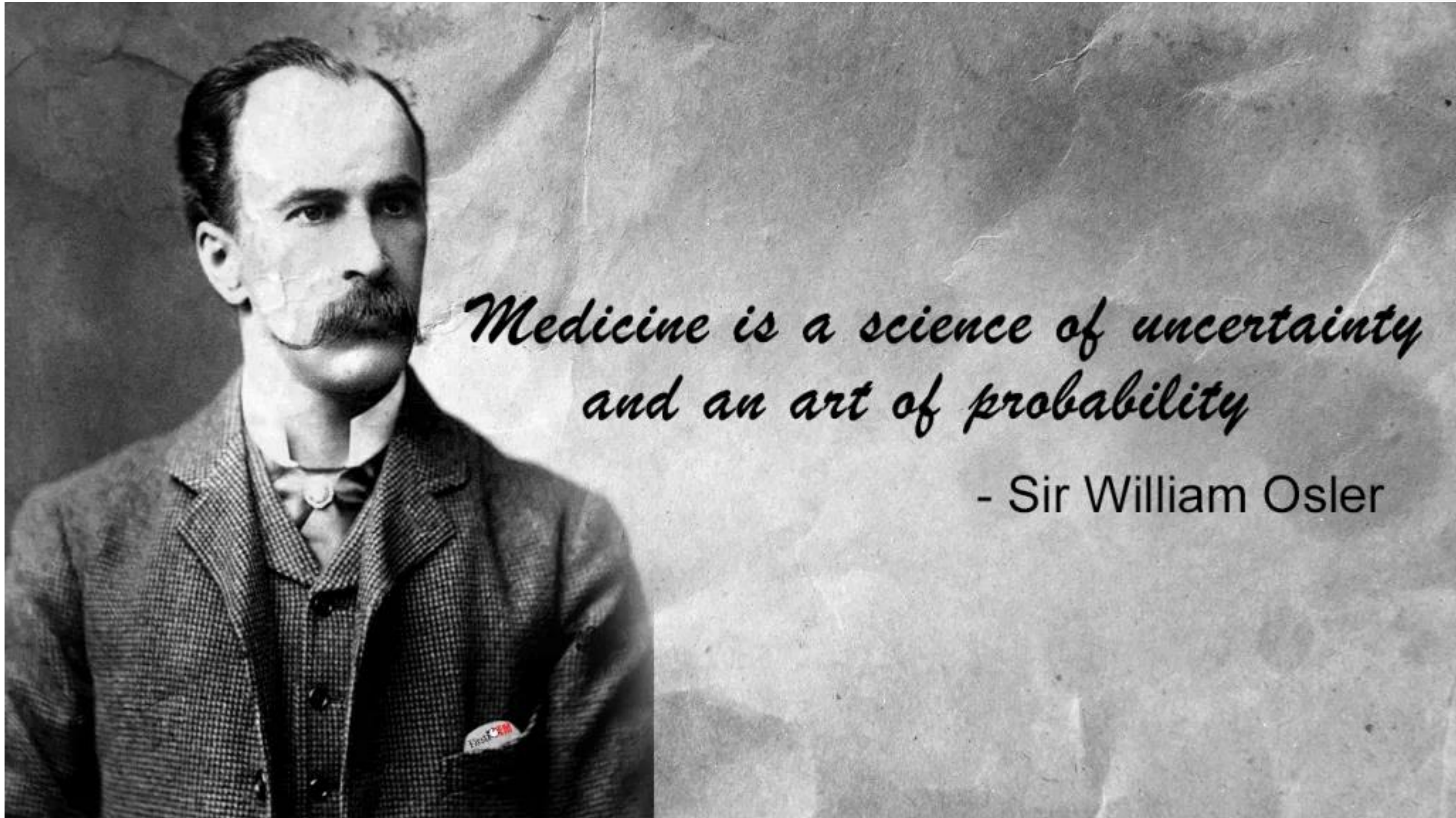
- Roger Neighbour
- Compassion Fatigue-

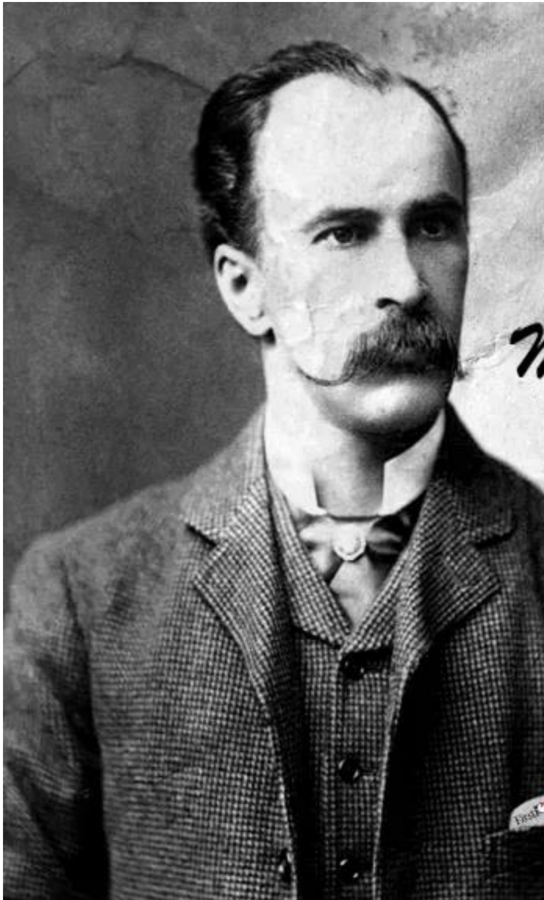
strain of exposure to working with those suffering from the consequence of traumatic events

- Burnout-

cumulative process marked by emotional exhaustion and withdrawal associated with increased workload and institutional stress

- 2 minute reflexion daily (Adam Kay wrote 2 books)
- Avoid isolation
- ‘have arrangements for debriefing clinicians who have been involved with the care of patients with confirmed CES’ (NBP-CN, 2019)


Medicine is a science of uncertainty
and an art of probability
- Sir William Osler



No risk would overload the health service

As low a risk as possible

Map serious cases

Awareness vigilance and suspicion

Clinical skill

Learn from patterns; conditions, systems

Work with patients as partners

Be kind to yourself

Thank you for listening

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