

Medicolegal Misadventures in Colorectal Cancer: Misdiagnosis and Missed Diagnosis

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context Colorectal cancer is the third most common cancer in the United States and the second leading cause of cancer deaths. Physicians will diagnose around 146,000 cases this year, 57,000 of which will result in death. The incidence of colorectal cancer is increasing and the mortality is decreasing,¹ but this disease continues to pose a significant malpractice risk for surgeons. □

Payouts for malpractice claims arising from colorectal cancer have averaged \$286,000, the Physician Insurers Association America (PIAA) Data Sharing Project reported. The most frequent cause of litigation, missed or delayed diagnosis, accounted for 47% of cases.²

An analysis of these claims showed that a delayed diagnosis of 6 months is usually indefensible.³ In 151 claims, the average delay in diagnosis was 10 months. Delays were attributed to failure to perform an examination or respond to presenting symptoms, or incorrect reading of barium enema examinations.⁴ The following cases typify these medicolegal misadventures.

CASE 1 | A 70-year-old black male reported a 7-month history of rectal pain, constipation and bleeding. On 4 separate occasions he was seen at a hospital and diagnosed with hemorrhoids.

The symptoms continued, so the patient obtained a second opinion. Physical examination

revealed a large rectal mass extending to the anal verge. Computed tomography (CT) showed a large mass filling the pelvis, and biopsy revealed poorly differentiated adenocarcinoma.

The patient received neoadjuvant chemoradiation followed by an abdomino-perineal resection. The patient ruled out litigation, but sent a letter to Risk Management at the first hospital asking why he was treated for hemorrhoids and why his diagnosis was delayed.

CASE 2 | A 75-year-old white male had minor surgery for matted nodes in the right groin. Biopsy revealed squamous cell carcinoma. Panendoscopy of the upper aerodigestive system and proctoscopy discovered a squamous cell carcinoma of the anal canal.

The medical record showed the patient saw a physician 21 times in the previous 5 years, but never had a colorectal cancer screening. The patient had 3 rectal examinations, with only one guaiac. The last rectal exam 3 years before diagnosis revealed a small mass 2–3 cm from the anus. The patient received no follow-up, although he saw a doctor 13 times since and had 2 preoperative histories and physicals.

Chemoradiation led to a complete response. Like the first patient, he decided against litigation but wanted to know why the diagnosis was delayed.

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EDITOR'S COMMENT | Neither physician met the standard of care, the first a "mis"-diagnosis, the second a "missed" diagnosis. Thus, their acts are indefensible.

Colorectal Cancer Screening

Surgery can cure most colorectal cancers, especially when detected as a polyp (precursor lesion) or at an early stage. Fecal occult blood testing (FOBT) can help in detecting early stage colorectal cancer.⁵ Screening colonoscopy programs have shown that polypectomy can dramatically reduce colorectal cancers in the screened population.⁶

People age 50 and older have 90% of all colorectal cancers.⁷ The American Cancer Society recommends that this group have annual FOBT and either a flexible sigmoidoscopy every 3–5 years, a double-contrast barium enema every 5–10 years, or colonoscopy every 10 years.¹ Recent guidelines recommend an initial colonoscopy with repeat colonoscopy every 5 years.

Higher risk patients have inflammatory bowel disease, or a history of colorectal cancer or polyps, and hereditary colorectal symptoms.⁷ They should have screening earlier and more frequently.

Compliance with the guidelines is poor. Only 30%–40% of those at risk for colorectal cancer in the United States have been screened.⁸ Only 30% of a study cohort 50 and older reported having had FOBT in the previous 2 years, and only 20% had a screening endoscopy in the previous 2–3 years.⁹ In most cases, the rectal examination was "deferred." In our experience, preoperative physical examinations rarely documented a rectal examination or FOBT.

PREVENTIVE MEDICINE | Colonoscopy is the gold standard in screening for colorectal cancers, but it is neither 100% sensitive nor 100% specific.¹⁰ The procedure carries risks, which should be discussed with the patient beforehand. A large Mayo Clinic study showed an 0.19% incidence of colon perforation and a 0.019% risk of death following colonoscopy.¹¹

Document a thorough informed consent for the screening, and perform and document a rectal exam and FOBT to complete the physical. If a patient refuses, documentation will help to defend against a "failure to screen" claim. Emphasize that no screening will detect every cancer or polyp, but that any screening is better than none.

Screening for colorectal cancer remains an

Eight Steps to Manage Risks In Colorectal Screening¹²

1. Screen patients for colorectal cancer using authoritative and established guidelines.
2. Perform a thorough history including hereditary and personal risk factors for colorectal cancer.
3. Recommend patients contact relatives at higher risk for colon cancer.
4. Perform a careful physical examination with a rectal exam and fecal occult blood test (FOBT).
5. Perform and document informed consent, including risks, benefits, options, and complications, before any procedure.
6. If bowel prep is inadequate, document and repeat.
7. Document small bowel and/or cecal intubation with landmarks (ie, appendiceal orifice, confluence of the tenia) and use careful withdrawal techniques.
8. Recommend and document follow-up per established guidelines and implement a reminder system.

important part of general surgery. Proper counseling and documentation with the patient before, during and after the procedure will protect the surgeon and patient. Colorectal cancer should not be a misdiagnosis, nor should it be a missed diagnosis.

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