C inica project summary

Generated: 11/10/2023 15:19

Project details

Title: **Complex Atypical Hyperplasia identified on histology**

Code: **GYNAE/SE/2020-21/08**

Date registered: **18/09/2020**

Speciality: **Gynaecology**

Other associated specialities: **N/A**

Business unit: **Women's Services**

Division: **Women's and Children's**

Is your project related to particular sites?: **No**

Is your project related to particular wards/areas?: **No**

Project information

Priority: **3**

Lead participant: [redacted]

Audit mentor: [redacted]

Audit facilitator: [redacted]

Forward plan/additional

Forward plan/additional activity: **Forward plan**

Rationale

An incident arose over the summer of 2019 involving a delay in identifying malignancy due to an administrative error. The patient was erroneously added to a routine list and removed from the 2 Week Wait tracking. A GA hysteroscopy found malignancy, but then there was a delay in results being reviewed. An audit was requested as part of the action plan from the investigation.

Guidance

No items have been selected

Criteria

No criteria has been added

Governance

Governance: **Incident**

Reference details: [redacted]

Project progress

Sign off date: **08/12/2020**

Presentations

No presentations have been selected

Results

All patients with a laboratory diagnosis of Complex Hyperplasia with Atypia were identified between January 1st 2018 and December 31st 2019. This included patients from NBT and across UHBW including the former Weston General Trust. A list of patients was generated by the pathology laboratory at NBT based on codings. ICE records were reviewed alongside all available documentation on the UHBW medway system which includes gynae-oncology Multidisciplinary Team Meeting discussions and outcomes, clinical notes and letters sent to patients.

The initial data collection included a number of patients who were represented several times, for example in supplementary published reports or in biopsy and hysterectomy specimens and therefore the total number of cases reviewed was less than anticipated. The sample contained biopsies sent from across UHBW (UHB and Weston) and also NBT and therefore the number of patients where we could assess timeliness of report viewing on ICE was small (this can only be viewed for samples requested at UHB).

Initial number of cases identified = 49

Number of patients represented = 33

Source of Diagnostic Biopsy: UHB = 7, WSM = 11, NBT = 15

- Average number of days between biopsy taken and report issued on ICE = 11
- Average nunber of days between report issued and viewed on ICE = 5
- Average number of days between viewing result and informing patient =16
- Average number of days between biopsy reporting and hysterectomy performed, when cases removed for acceptable delays - treating comorbidities, covid, patient choice = 70

- How was the patient informed of the biopsy results? (only assessable on small number of samples from UHB and WGH)

[redacted]

- Was hysterectomy completed?

Yes = 18, No = 15

- Was time between date patient informed of biopsy and date of hysterectomy less than 42 days (6 weeks)?

[redacted]

Of those that were greater than 6 weeks, all were cases discussed at the MDT. [redacted] were delayed due to patient choice, comorbidities or Covid. The other cases do not appear to have a clear reason for delay and may be considered to be related to availability on urgent surgical lists and prioritisation of cases. Of those, [redacted] were originally WSM patients who were then operated on at UHB.

There is no nationally recommended timeframe for hysterectomy to be performed. The average time between a diagnostic biopsy report and the date of surgery was 70 days (10 weeks) in this sample.

- Hysterectomy histology outcome (Total = 18)

[redacted]

- Reasons why patients did not undergo hysterectomy:

[redacted]

All cases where hysterectomy was not performed due to either comorbidities or desire for fertility had multiple subsequent endometrial biopsies in keeping with RCOG green top guideline 67, unless they were unable to due to being deemed too unwell for this due to other comorbidities. Biopsies were not always undertaken at the recommended 3 monthly intervals, however further review of decision for timing of biopsies would require additional information not readily available on ICE or medway. None had significant delays to biopsies (> 6 months) and all biopsies subsequently normalised on progesterone therapy.

Abnormal result identified and patient informed: 91% (30/33)

There were [redacted] where abnormal histology was not appropriately actioned. For each of these cases a Datix Form has been completed and a review of the case been initiated (see uploaded report).

Conclusions

Following a laboratory report of endometrial hyperplasia with atypia, [redacted] of cases [redacted] were not correctly identified and managed and the patient was not made aware of the result. All remaining cases were managed appropriately, regardless of whether they were discussed in the gynae-oncology MDT or not. If only cases where routine management was not appropriate were referred to the MDT, [redacted] of cases of endometrial hyperplasia with atypia would require MDT discussion.

- A further review of cases over a longer time period is recommended to identify any other missed or inappropriately managed cases. The number of cases obtained from NBT pathology for this report period appear to be lower than anticipated and further contact with the laboratory team at NBT is required to establish whether this truly represents all cases of endometrial hyperplasia with atypia.

  This data will be presented to the 2ww pathway review group on 02/10/2020. Staff that track 2ww results and are responsible for removing patients from this pathway will be made aware that biopsy results of hyperplasia with atypia must not be removed from the 2ww tracking process until discussed with a clinician. Results will be shared with 2ww leads at NBT and UHB to highlight to clinicians and those members of staff involved in the 2ww tracking process.

- Consideration should be given to a laboratory pathway that flags or highlights abnormal results of cancer or hyperplasia with atypia to reduce the incidence of missed diagnoses due to clinician error.

Assurance & risk

Assurance

Assurance not selected

Risk

Risk not selected

Action plan

	Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG	Progress
1	Disseminate results to staff	Feedback results to 2 week wait review group	[redacted]	19/10/2020	02/10/2020		Fully Complete

	Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG	Progress
2	Disseminate results to staff	Share results with members of 2ww tracking staff at UHB	[redacted]	19/10/2020	10/10/2020		Fully Complete
3	Disseminate results to staff	Disseminate results to NBT and Weston staff	[redacted]	19/10/2020	10/10/2020		Fully Complete
4	Disseminate results to staff	Present results to UHBW audit meeting including an educational update on endometrial pathology	[redacted]	19/10/2020	24/11/2020		Fully Complete

Re-audit

Would you like to schedule this audit to be conducted again?: **Yes**

Re-audit date: **28/02/2021**