



**Department of Veterans Affairs
Office of Inspector General**

Healthcare Inspection

**Alleged Delay in Colorectal Cancer
Diagnosis and Treatment
Kansas City VA Medical Center
Kansas City, Missouri**

**To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The purpose of the review was to determine the validity of allegations made by a complainant, the son of a patient. The complainant alleged that the medical center delayed diagnosis and treatment of his father's colorectal cancer. The complainant made several specific allegations regarding delays in diagnosis concerning rectal bleeding, right shoulder pain, an abnormal chest x-ray, and a diagnostic biopsy.

We found that medical center clinicians provided screening for colorectal cancer and offered definitive diagnostic testing. Providers screened for occult rectal bleeding on a routine basis. On multiple occasions, providers asked the patient if he had blood in his stools, and the answer was negative. The complainant alleged that the patient suffered pain in his right shoulder for several months prior to his shoulder fracture in April 2005. The patient did not report pain or any other problems in his right shoulder until the time of this fracture. The complainant alleged a chest x-ray performed in November 2004 showed an area of lucency, a concern for cancer, in the right shoulder and should have been evaluated further. We asked a consultant radiologist to read this x-ray and his report confirmed no abnormalities of the right shoulder. The complainant alleged that there was a procedural error in a diagnostic bone biopsy and a second biopsy was never done. We determined a procedural error did not occur. Little tissue was available from the biopsy site which prevented a sufficient sample for diagnosis. The oncologist scheduled a repeat biopsy but when he contacted the patient with the appointment time, the patient declined further testing.

The complainant also alleged the medical center did not provide proactive treatment for a month following his father's diagnosis of cancer. Physicians diagnosed cancer of the colon and the rectum during a hospital admission in April 2005. The medical center discharged the patient on April 15, 2005, with follow-up appointments scheduled in primary care, oncology, surgery, and orthopedics. The patient did not keep his oncology and orthopedic appointments and left before the physicians saw him at his surgery appointment. The medical staff was in the process of planning surgical intervention when the patient began treatment in the private sector. We did not substantiate a delay in diagnosis or treatment of colorectal cancer.

Because we did not substantiate the allegations, we made no recommendations.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network (10N15)

SUBJECT: Healthcare Inspection – Alleged Delay in Colorectal Cancer Diagnosis and Treatment, Kansas City VA Medical Center, Kansas City, MO

1. Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations regarding delays in diagnosis and treatment of colorectal cancer for a patient at the VA Medical Center (the medical center), Kansas City, Missouri.

2. Background

The medical center provides primary and secondary medical, surgical, neurological, psychiatric, and rehabilitative care for veterans in Kansas City and surrounding areas. It is a specialty referral center for Veterans Integrated Service Network (VISN) 15 and is affiliated with the University of Kansas School of Medicine.

On March 21, 2006, the OIG Hotline Division received allegations from a complainant, the son of a patient, that the medical center delayed diagnosis and treatment of his father's colorectal cancer. The complainant made several specific allegations regarding delays in diagnosis concerning:

- Rectal bleeding.
- Right shoulder pain.
- Abnormal chest x-ray.
- Diagnostic biopsy.

He further alleged that physicians should have provided treatment within 30 days of the date of diagnosis and that the delay in treatment changed the outcome for the patient.

3. Scope and Methodology

We conducted a site visit at the medical center on April 27, 2006, and interviewed clinicians and medical center management as needed to investigate the allegations. We reviewed policies, procedures, directives, medical records, referral criteria, and cancer care guidelines. We consulted with a radiologist from another VA medical center to verify radiographic images. We also interviewed the complainant and the patient's significant other by telephone to obtain clarification of the allegations.

We conducted the review in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

4. Inspection Results

Case Review

The patient was an 86-year-old male with a history of hypertension, diabetes, atrial fibrillation, diverticulosis, anemia, degenerative joint disease, lumbar strain, hearing impairment, and varicose veins. The patient had a partial colon resection in the early 1970's due to diverticulosis, which remained stable. The patient had no prior or family history of cancer. The same primary care provider had seen the patient at the medical center for approximately 9 years and stabilized the patient's health with medications, diet, and ongoing monitoring. Because of his atrial fibrillation, the patient was taking an anticoagulant. Clinical pharmacists monitored his anticoagulant status every 7–10 days from June 2004 until his last medical center admission in April 2005. The patient was reportedly compliant with his diet and medications, aware of his health problems, and involved in decisions related to his health care.

His significant other reported that he diagnosed himself as having hemorrhoids and was treating this condition with over-the-counter medications until November 2004 when he reported hemorrhoid problems to his primary care provider for the first time. The patient did not complain of rectal bleeding, but rather "hemorrhoids," and the primary care provider prescribed a topical ointment.

On April 5, 2005, the complainant took the patient to the emergency department with complaints of severe pain in his right shoulder. The pain began earlier in the day when he was rising up from a sitting position, felt a sudden sharp pain, and heard a cracking sound. The emergency room (ER) physician obtained x-rays of the shoulder and diagnosed a fracture of the right clavicle. The ER physician placed the patient in a sling, provided pain medication, and instructed the patient to return the next morning to see his

primary care provider. The ER physician determined the fracture was pathologic¹ with an unknown underlying cause. The patient's primary care provider admitted him the next day to determine the cause of the fracture. An orthopedist recommended continuing the sling and pain medication, and recommended computerized tomography (CT) scans of the abdomen, chest, and pelvis to rule out the possibility of cancer as the cause of the fracture. The CT scan of the abdomen and pelvis were completed on April 7 and showed an ill-defined mass in the left kidney and a questionable density in the liver. An oncologist saw the patient on April 8 and ordered a bone biopsy of the clavicle to determine if cancer metastasis was the cause of the fracture. On April 11, repeat CT scans of the abdomen and pelvis were negative for cancer in the kidney and liver.

Fecal occult blood (FOB) testing done during the admission assessment was positive, indicating blood in the patient's stool. Colonoscopy on April 12 revealed a 3 centimeter (cm) mass in the rectum, a 5 cm mass in the cecum, and several polyps. Physicians biopsied the masses and removed the polyps during the procedure. Pathology reports were positive for cancer.

A surgeon evaluated the patient on April 12 and recommended completion of the evaluation for possible metastasis prior to surgery. A CT scan of the chest showed no evidence of metastasis. A bone scan originally scheduled for April 12 was rescheduled for May 5 because of a camera failure. A radiologist performed a bone biopsy of the right clavicle on April 14 and the patient was discharged on April 15. The medical center gave the patient follow-up appointments within the next 2 weeks for primary care, oncology, and orthopedics.

The results from the bone biopsy were atypical cells (a possible indication of malignancy), but the sample size was too small to provide additional diagnostic information. An oncologist contacted the patient and explained that the procedure needed to be repeated to obtain additional tissue for a definitive diagnosis, and offered an outpatient appointment time. The patient refused to have the procedure repeated and cancelled all of his appointments, stating that he was being seen by a private physician. The patient continued with care in the private sector until his death in January 2006.

Issue 1: Delay in Diagnosis

Rectal Bleeding

We did not substantiate that physicians did not investigate rectal bleeding or perform appropriate screening tests for colorectal cancer. The complainant alleged that a digital rectal examination (DRE) would have detected the rectal mass earlier.

¹ A "pathologic" fracture is a break in a bone not associated with any trauma to which it could be attributed. Pathologic fractures are characteristic of metastatic cancer.

Veterans Health Administration (VHA) colorectal screening criteria require patients between 50–80 years old to receive FOB testing each year or colonoscopy every 10 years. The guidelines state that it is reasonable to discontinue screening when age limits life expectancy. The medical center follows VHA guidelines. A DRE is not recommended for colorectal cancer screening. Clinicians perform DRE as a routine screen for prostate cancer, but not for colorectal cancer. The Chief of Primary Care stated that an 86-year-old patient would normally only have FOB testing if clinical symptoms were present.

The patient completed two negative FOB screening assessments on March 29, 2000, and December 18, 2001. In addition, clinicians offered the patient FOB screening three other times, but he declined those tests. Physicians performed DREs on the patient as part of admission physical examinations in March 2000 and November 2004. During those DREs, physicians did not palpate any abnormalities but did obtain stool samples that were positive for FOB. Physicians scheduled colonoscopy examinations to follow up on both of the positive FOB tests, but the patient did not keep the appointments.

In October 2004, a progress note in the medical record stated the patient complained of “occasional hemorrhoid problems,” but does not mention symptoms of bleeding. His primary care provider prescribed a steroid cream and no further complaints were noted. Rectal bleeding was not a complaint for this patient until the November 2004 admission when he reported occasional bright red blood present on toilet tissue. Physicians scheduled an outpatient colonoscopy on January 12, 2005. This was one of the colonoscopies the patient cancelled. Nine entries in the medical record between 2000–2005 specifically state that there was no blood in stools, and no changes in bowel habits. In 2004, the patient began anticoagulation therapy (blood thinning medication) and was seen weekly in the Anticoagulation Clinic. Part of the weekly evaluation was to question the patient about signs and symptoms of bleeding. Each week the record notes that the patient denied bleeding.

On the April 2005 admission history and physical, a physician performed a DRE and recorded no mention of any mass.

We concluded that physicians did provide FOB screening for colorectal cancer and offered colonoscopy as warranted. When the patient was admitted to the medical center in 2000, 2004, and 2005, physicians did perform DREs that did not reveal any mass.

Right Shoulder Pain

We did not substantiate that the patient complained of intense pain in his right shoulder area since fall of 2004 that should have alerted medical center physicians for further evaluation.

The complainant alleged the patient had severe pain in his right shoulder and no treatment or x-rays were done. The patient was seen five times in Primary Care during 2004 with no complaints of shoulder pain. Primary care physicians addressed a complaint of left shoulder pain resulting from a motor vehicle accident in March 2002. X-rays were normal at that time.

We found no other mention of shoulder pain in the medical record until the patient was admitted in 2005 for the fractured clavicle.

Abnormal Chest X-Rays

We did not substantiate that there was an abnormality on a chest x-ray in November 2004 that should have alerted physicians to possible cancer.

When the complainant brought his father to the ER for shoulder pain in April 2005, an ER physician ordered an x-ray of the clavicle. When reviewing those images, the physician reportedly compared them to a chest x-ray taken in November 2004. The complainant alleges that the ER physician noted a lucency of the bone in the right shoulder from the November 2004 x-ray. Based on that information, the complainant felt that physicians should have evaluated the patient for cancer at that time.

The OIG asked a consultant radiologist to read this x-ray. His report confirmed that there was no clavicle abnormality on any x-rays done in November 2004. The Chief of Radiology at the medical center reported multiple radiologists on staff had reviewed these same films and had come to the same conclusion. Attempts to interview the 2004 ER physician were unsuccessful, as the physician no longer works for the medical center.

We concluded that there was no abnormality on the November 2004 x-rays of the right clavicle.

Diagnostic Biopsy

We did not substantiate there was an error in carrying out the biopsy and that radiologists did not perform a second biopsy. The complainant alleged a procedural error occurred April 14, 2005, during a bone biopsy of the clavicle as part of the malignancy assessment.

Medical staff needed to determine if the fracture of the clavicle was related to the colon masses or if another primary cancer was the cause. The initial x-ray during the biopsy indicated an impaction of the site of the fracture, with little soft tissue available for biopsy. The impaction was healing bone and not soft tissue needed for biopsy. Radiologists obtained small amounts of tissue and sent them to pathology. The Chief of Radiology told us that the healing of the fracture prevented a sufficient sample for diagnosis. The oncologist called the patient after he was discharged to schedule a repeat

bone biopsy but the patient refused the procedure, stating he was being followed in the private sector.

We concluded that the lack of definitive diagnosis from the bone biopsy was not due to a procedural error. Rather, it was due to limited tissue available for sampling. The medical center attempted to perform a second biopsy but the patient refused.

Issue 2: Delay in Treatment

We did not substantiate the allegation that the medical center delayed treatment of cancer for this patient. The complainant alleged the patient received no treatment for a month following the diagnosis of cancer.

We reviewed the medical records for the care provided to this patient during and after the admission in April 2005. We found multiple actions to diagnose and stage this patient's cancer, and preliminary plans for surgical intervention. The patient was discharged April 15, 2005, and given follow up appointments within 2 weeks for primary care, oncology, orthopedics, and radiology for a bone scan. The patient did not keep the oncology and orthopedic appointments. The medical center scheduled a surgery clinic appointment for April 27, 2005. The patient arrived but left before seeing the physician.

The oncologists recommended surgical removal without further need for treatment. The staff was in the process of planning the surgery to remove these tumors when the patient cancelled his appointment. Because of this, surgery was never scheduled. The patient received care in the private sector until his death in January 2006.

5. Conclusion

We concluded that medical center staff provided appropriate care and followed VHA guidelines for colorectal cancer screening. Physicians evaluated the patient and were in the process of developing a treatment plan at the time he chose to pursue medical care with a private physician. Because we did not substantiate the allegations of delay in diagnosis or treatment, we are closing this case without recommendations.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 19, 2006

From: Director, Veterans Integrated Service Network (10N15)

Subject: **Alleged Delay in Colorectal Cancer Diagnosis and Treatment, Kansas City VA Medical Center, Kansas City, MO**

To: Office of Inspector General

I have reviewed and concur with the report findings that the Kansas City VAMC staff provided appropriate care and followed VHA guidelines for colorectal cancer screening. I have no further recommendations and agree that this case should be closed.

(original signed by:)

PETER L. ALMENOFF, M.D., FCCP

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 17, 2006

From: Director, Kansas City VA Medical Center (589/00)

Subject: **Alleged Delay in Colorectal Cancer Diagnosis and Treatment, Kansas City VA Medical Center, Kansas City, MO**

To: Director, VISN 15 (10N15)

I have reviewed the report findings and agree that our medical center staff provided appropriate care to this patient and followed the VHA guidelines for colorectal cancer screening. I have no further recommendations in this case.

(original signed by:)

KENT D. HILL

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections (816) 426-2023
Acknowledgments	Jennifer Kubiak Jerome Herbers, M.D. Dorothy Duncan Marilyn Stones

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