

SPSO decision report



Case: 202510882, Tayside NHS Board
Sector: Health
Subject: Clinical treatment
Decision: upheld, recommendations

Summary

C complained about care and treatment provided by the board for an anal abscess. C underwent three procedures over two admissions for treatment of the abscess, including the placement of a temporary stoma (a surgically created opening connecting the bowel to the surface of the body to safely divert waste out of the body).

We took independent advice from a Consultant Colorectal Surgeon. We found that, on first presentation, there was a failure to recognise during or after surgery that C presented with an uncommon horseshoe abscess (a complex type of anal fistula where the infected tunnel encircles the anal canal forming a U-shape or horseshoe-like configuration) with sepsis, that there was a failure to review C's blood results before discharge, and that it was unreasonable to delegate identification of antibiotic sensitivities to primary care.

On second admission, we found that, given C was re-presenting with the same symptoms following previous surgery, it would have been reasonable to consider carrying out an MRI prior to further treatment. We found that there was a failure to carry out adequate exploration during C's surgery, given that they had presented with large amounts of pus draining from the previous abscess site.

We also found that it was unreasonable to suggest that C should have an MRI as an outpatient, that there was no evidence on scans or surgery of connection to the bowel and that a stoma was not necessary, and finally that there was a failure to discuss the surgical options (whether or not a stoma was required) with C.

We recognised that this was a complex case and we noted that on first surgery it may have been understandable that there was a failure to appreciate the significance of the findings. However, this failure was repeated throughout C's two admissions, resulting in an extended period of illness and the placement of a stoma that we found was not necessary. We therefore upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to provide reasonable care and treatment for an abscess. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/meaningful-apologies.

What we said should change to put things right in future:

- The Board should carry out a review and identify learning and improvements including:
- Senior team members should review surgery done by trainees to ensure correct treatment.
- Teams should be aware of the signs of horseshoe abscess
- The requestor of tests performed within hospital should assume responsibility for follow up rather than delegation to primary care

- Where patients are readmitted soon after surgery, it should be recognised that this is commonly due to less-than-optimal treatment on the first occasion and surgical teams should ensure they carry out a critical review of the case
- Imaging should be considered where a patient re-presents with similar symptoms following previous treatment to drain an abscess
- Teams should be aware that use of stoma for treatment of horseshoe abscess is not a standard approach
- When there are options for treatment this need to be discussed with the patient.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.