OK to admin close
DH.
2/15/10

Administrative Closure
Delay in Diagnosis
Lexington VA Medical Center, Lexington, KY
MCI Number: 2010-00480-HI-0243

The VA Office of Inspector General (OIG), Hotline Division was contacted by a veteran diagnosed with lung cancer in the private sector in September 2009. The veteran alleged undergoing computerized tomography (CT) scans of the chest in January and April 2009, at the Lexington VA Medical Center (LVAMC) for respiratory symptoms.

Pulmonary nodules had been identified in two chest CT scan reports dated January 7, and April 7, at the LVAMC. The veteran had several appointments at the LVAMC in April including primary care and general surgery for evaluation of rectal symptoms. In early July, the veteran was assessed in the emergency room at LVAMC for bruising to the abdominal wall after falling during a coughing spell.

The veteran returned to LVAMC in mid July complaining of cough and again no chest x-ray was ordered or review of prior studies documented. The veteran received phone calls from LVAMC in July and August to report laboratory results without reference to the chest CT scans.

The veteran moved to Louisiana where he continued with respiratory symptoms and a diagnosis of metastatic lung cancer was made. Notes in the electronic medical record reveal discussions in September about initiating treatment. The veteran opted for treatment in Louisiana and a summary of the care received was scanned into the medical record.

The OIG Dallas Office of Healthcare Inspections contacted the Interim Chief of Staff (COS) to review the case and take appropriate action. The Interim COS reviewed the case and scheduled a meeting with the veteran and spouse on November 24, at the LVAMC. The veteran was aware that there was a delay in diagnosis and requested an explanation of the events.

Discussion of the adverse event was documented in the medical record with the advisement of the claims process and the right to file an Administrative TORT Claim. In addition, a peer review of the case had been conducted at the LVAMC on November 17. The veteran indicated he would request a copy of the disclosure and had not decided if a claim would be filed.

Based on our review of the LVAMC's response to the veteran's allegations, we concluded that leadership had addressed the veteran's concerns and taken appropriate action. Therefore, we made no recommendations and consider the issue closed.

Prepared by: Wilma I. Reyes, Healthcare Inspector, 54DA
Date: February 9, 2010

10-2