Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

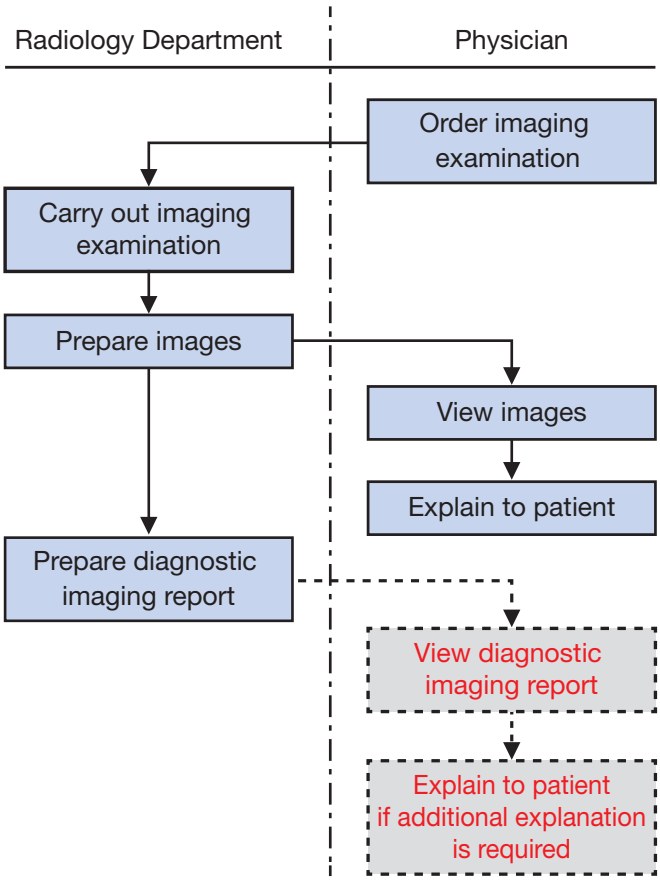
No.138, May 2018

Inadequate Checks Concerning Diagnostic Imaging Reports (1st Follow-up Report)

Information about inadequate checks concerning diagnostic imaging reports was provided in Medical Safety Information No.63 (February 2012). As 37 similar events have been reported since then, information about this issue is provided here again (information collection period: from January 1, 2015 to March 31, 2018). The information is compiled based on “Recurrence of Events and Occurrence of Similar Events” in the 51st Quarterly Report.

Cases have been reported in which treatment was delayed because the physician failed to check the diagnostic imaging report after checking the images, and therefore failed to notice findings other than those associated with the purpose of the examination.

Example of the imaging examination process



Main Factors Behind the Failure to Check the Diagnostic Imaging Report

- When the physician looked at the site that was the focus of the examination on the image and explained it to the patient, the diagnostic imaging report had not yet been prepared and the physician forgot to look at it later
- The physician was not in the habit of viewing diagnostic imaging reports
- CT and MRI examinations were carried out around the same time and the physician was able to confirm the diagnosis from the results of the MRI examination, so did not look at the diagnostic imaging report for the CT examination
- The physician did not view diagnostic imaging reports because they were confident in their ability to interpret images in their field of specialism
- The physician mistook a diagnostic imaging report dated the same month of the previous year for that day’s report

◆ 36 of the 37 cases involved CT examinations.

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Case 1

A CT examination was carried out on the day of the outpatient consultation as a follow-up after surgery for intrahepatic cholangiocarcinoma. After the CT examination, the physician viewed the images and explained them to the patient, but forgot to check the diagnostic imaging report later on. Another CT examination was carried out five months later. When the radiologist went to compare the images with the previous CT images, they noticed that the diagnostic imaging report from five months earlier had not been read and contained a finding of suspected lung cancer, so the radiologist contacted the physician.

Case 2

A contrast CT examination was carried out on the day of an outpatient consultation as a thorough examination for renal cancer. The physician viewed the images during the outpatient consultation and explained them to the patient, but forgot to check the diagnostic imaging report later on. When the patient was admitted for renal cancer surgery, the physician noticed that the diagnostic imaging report from the contrast CT examination performed three months earlier stated that a thorough examination should be carried out, due to suspected liver metastasis of a malignant tumor.

Preventive measures taken at the medical institutions in which the events occurred

- **Physicians will explain the results to patients after checking the diagnostic imaging report.**
- **A mechanism will be established to ensure that any unread diagnostic imaging reports are noticed.**

Complementary comment by the Comprehensive Evaluation Panel

- **Put together an operational process that summarizes the processes from carrying out an imaging examination through to checking the diagnostic imaging report and explaining it to the patient.**

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the "Comprehensive Evaluation Panel" to prevent the occurrence and recurrence of medical adverse events. See the Project website for details.
http://www.med-safe.jp/
* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.
* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

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