Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.63, February 2012

Inadequate Checks Concerning Diagnostic Imaging Reports

Three cases have been reported involving a situation in which, although the diagnostic imaging report had been delivered after having conducted imaging examinations, the content was not checked and the physician failed to notice a diagnosis that s/he had not anticipated, thereby giving rise to the possibility that treatment was delayed (information collection period: from January 1, 2008 to December 31, 2011; the information is partly included in “Individual Theme Review” (p.131) in the 26th Quarterly Report).

Cases in which, after having conducted imaging examinations, the physician failed to check the content of the diagnostic imaging report and did not notice a diagnosis that s/he had not anticipated, thereby giving rise to the possibility that treatment was delayed, have been reported.

Objective of the Imaging Examination	Content Not Checked
Thorough examination for the purpose of a catheter ablation	Suspected pulmonary adenocarcinoma
Follow-up after a synthetic blood vessel graft replacement	Suspected primary lung tumor
Follow-up for an internal iliac artery aneurysm	Suspected lung cancer

◆ All three reported cases involved a failure to check the diagnostic imaging report following a CT examination.

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Case

The patient had undergone synthetic blood vessel graft replacement due to an aortic arch aneurysm. Having had a CT examination carried out, the outpatient physician looked at the images the same day and confirmed that there was no aortic aneurysm in the anastomotic site, so s/he judged that there were no abnormalities. Subsequently, the comment "primary lung tumor suspected" was written on the diagnostic imaging report, but the outpatient physician did not notice this finding. About a year later, when the patient underwent a thorough examination due to suffering from a cough and pleural effusion, a primary lung cancer was diagnosed.

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

- **After checking the diagnostic imaging report from the radiology specialist, the physician will explain the results of the imaging examination to the patient.**
- **In the event that a serious finding is made while interpreting the image, relating to something other than the main objective of the examination, the radiology specialist will warn the physician who requested the examination.**

Complementary comment by the Comprehensive Evaluation Panel

- **A mechanism shall be constructed within the medical institution to enable diagnostic imaging reports to be checked, irrespective of whether the patient is an inpatient (particularly if it is immediately before his/her discharge) or outpatient.**

* 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 quarterly reports and annual reports posted on the Japan Council for Quality Health Care website for details of the Project.
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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