PROSTATE CANCER UK

‘TO ERR IS HUMAN’- BUILDING A SAFER HEALTH SYSTEM.

The problem is not bad people in health care, but good people working in bad systems that need to be made safer.

MY STORY – PROSTATE CANCER FOLLOW UP

58 years old.

‘Low risk’ asymptomatic white man.

Prostatitis 2008.

2009 PSA **1.4** ng/ml	had opted in to screening – 54yrs.
2013 PSA **3.86** ng/ml	advised 3/12 repeat (? Rate, cyclist)
2013 PSA **4.92** ng/ml	refer urology

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COLLEAGUES VS REALITY

‘ Don’t’ have a PSA test

Don’t get it repeated – what will you do then?

Rectal biopsy is a pain in the ass.

Treatment that you don’t need.

Dry ejaculates.

Erectile dysfunction.

Incontinent.

mp MRI

Transperineal biopsies

Gleason 3+4, focus 4+5

Discussion re options

Robotic prostatectomy

T2N0M0

Good news, all clear margins.

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FOLLOW UP PSA RESULTS / SOURCE OF TEST/ ACTION

PSA ng/ml	Date	Source	Action
	Postop – 'undetectable' at 3/12 – April 2014		
0.01	3/08/15	GP	letter to me and urologist
0.01	22/04/16	urologist/GP	'all well'.
0.05	27/04/18	GP	letter to me advising normal
0.10	11/04/19	dermatology/GP	no feedback
0.12	25/11/20	dermatology/GP	letter to dermatology ? result
0.22	22/04/22	GP	letter to me –normal (diff GP)
	after speaking to a friend , asked GP to give me the actual PSA levels		
0.27	11/04/23	GP	refer back urologist / oncology

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RECURRENCE NOTED

PSMA PET scan / MRI

33 doses 66 Gy prostate bed + 52.8 Gy pelvic nodes over 6.5 weeks

Bicalutamide 150mgs / day 2 years

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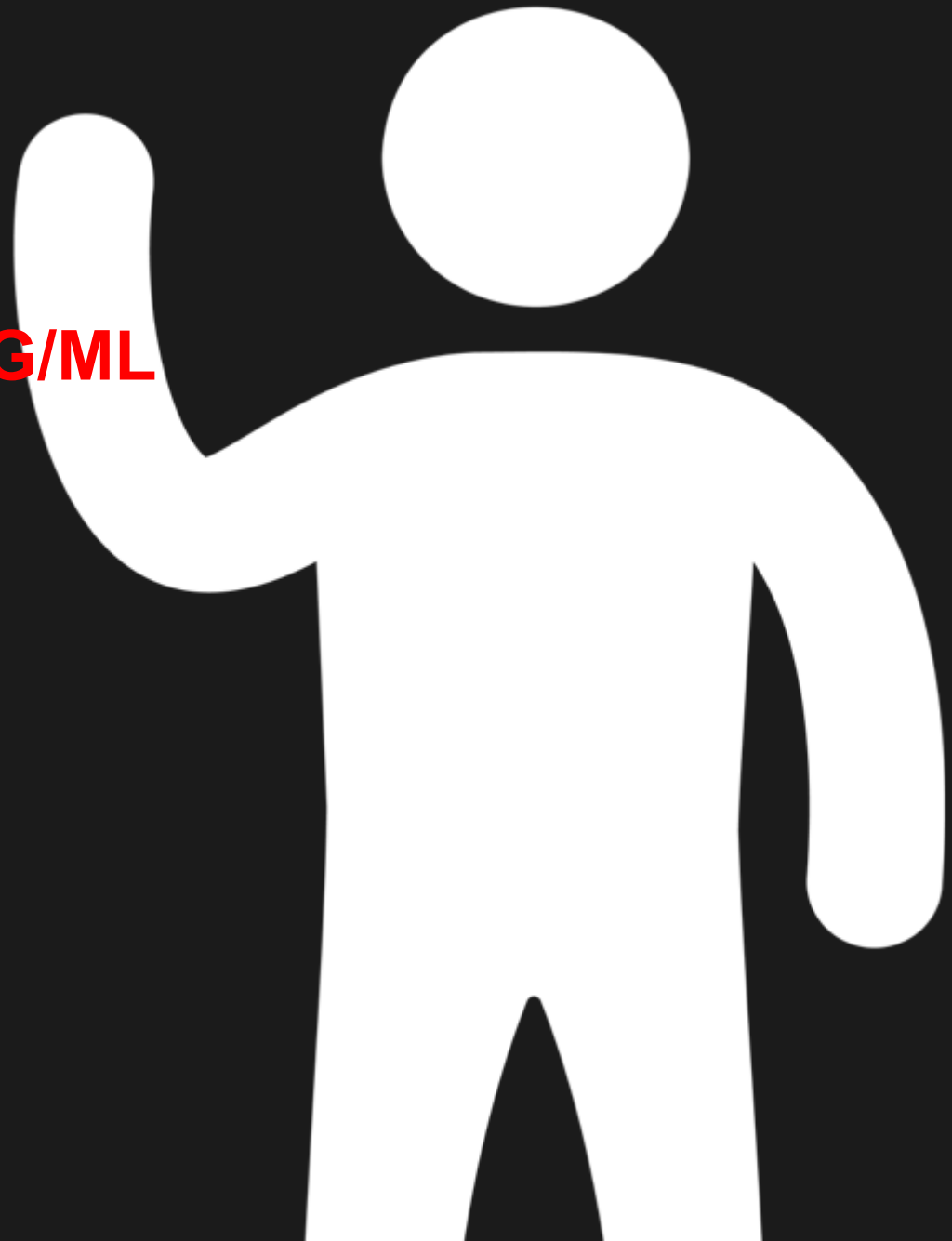
TWO CONSECUTIVE RISES > 0.1NG/ML OR THREE CONSECUTIVE RISES

RISE OF >2 NG/ML ABOVE NADIR AFTER RADIOTHERAPY

Accuracy of PSA test at very low levels?



LABORATORY REPORT

Clinical details – prostatectomy

On my report the values eg 0.27 ng/ml were then followed by the normal range (0 - 4.5 ng/ml), despite clinical details being clear.

Two consecutive rises > 0.1ng/ml ?
Three consecutive rises ?
Rise of >2 ng/ml above nadir after radiotherapy ?

Should this be written on report?

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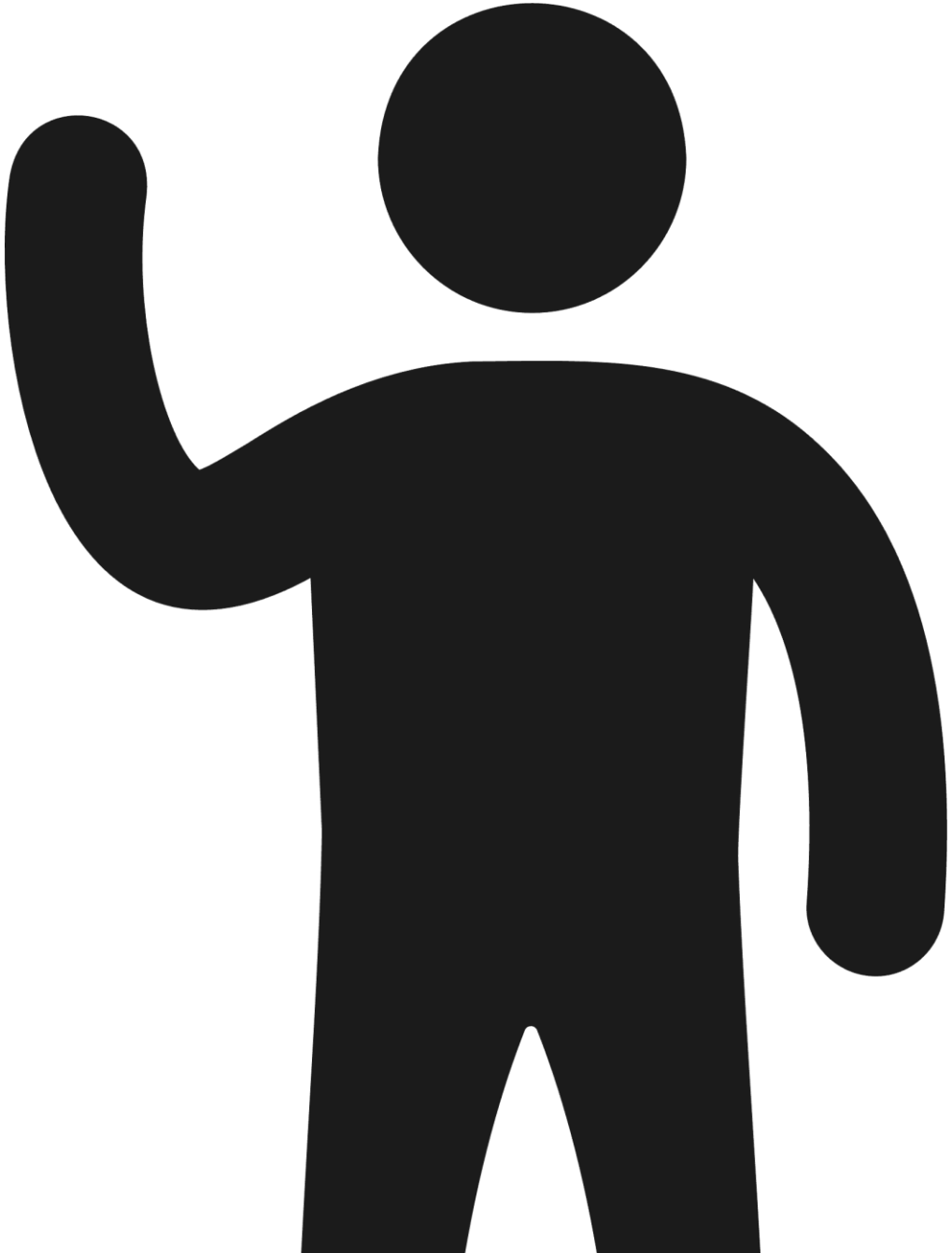
SADLY, ‘YOU’RE NOT THE ONLY ONE WITH THIS STORY’



There will be men totally unaware that they have a recurrence that requires treatment, with the disease metastasizing.

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LABORATORY RESPONSE

'Based on available data, the results were sent out in accordance with our reporting procedure, and there is no indication of any laboratory, clerical, or operational error. The reference ranges we give on the report are in line with NICE guidelines and other UK trusts. We very rarely get sufficient clinical data on the request forms to be able to provide bespoke reference intervals and unlikely have the IT capability to do so. The expectation is that the person making the request is responsible for the clinical interpretation and decision making on what is a normal result for their patient.'

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DATIX INCIDENT RESPONSE

‘ I recognise that the conclusion that has been derived, after careful consideration, will fall short of your expectations. The review team having considered potential adaptions, have regrettably concluded, based on current circumstances, that they don’t believe reasonable adaptions can be effectively implemented and applied within the constraints of their existing working environment, processes and procedures.’

Is this an acceptable response?

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WHAT CAN BE DONE?

1. Does the laboratory have a legal and professional duty to provide the appropriate reference ranges for results? Should this be part of the lab. accreditation process?
2. Should laboratory reporting be contextualized from the clinical details; why are clinical details requested ? Maybe no details, no result?
3. AI must be developed to demonstrate trend analysis and trigger points for concern.
4. Encourage patients to ‘own’ their reports, and understand the importance of tracking PSA levels.

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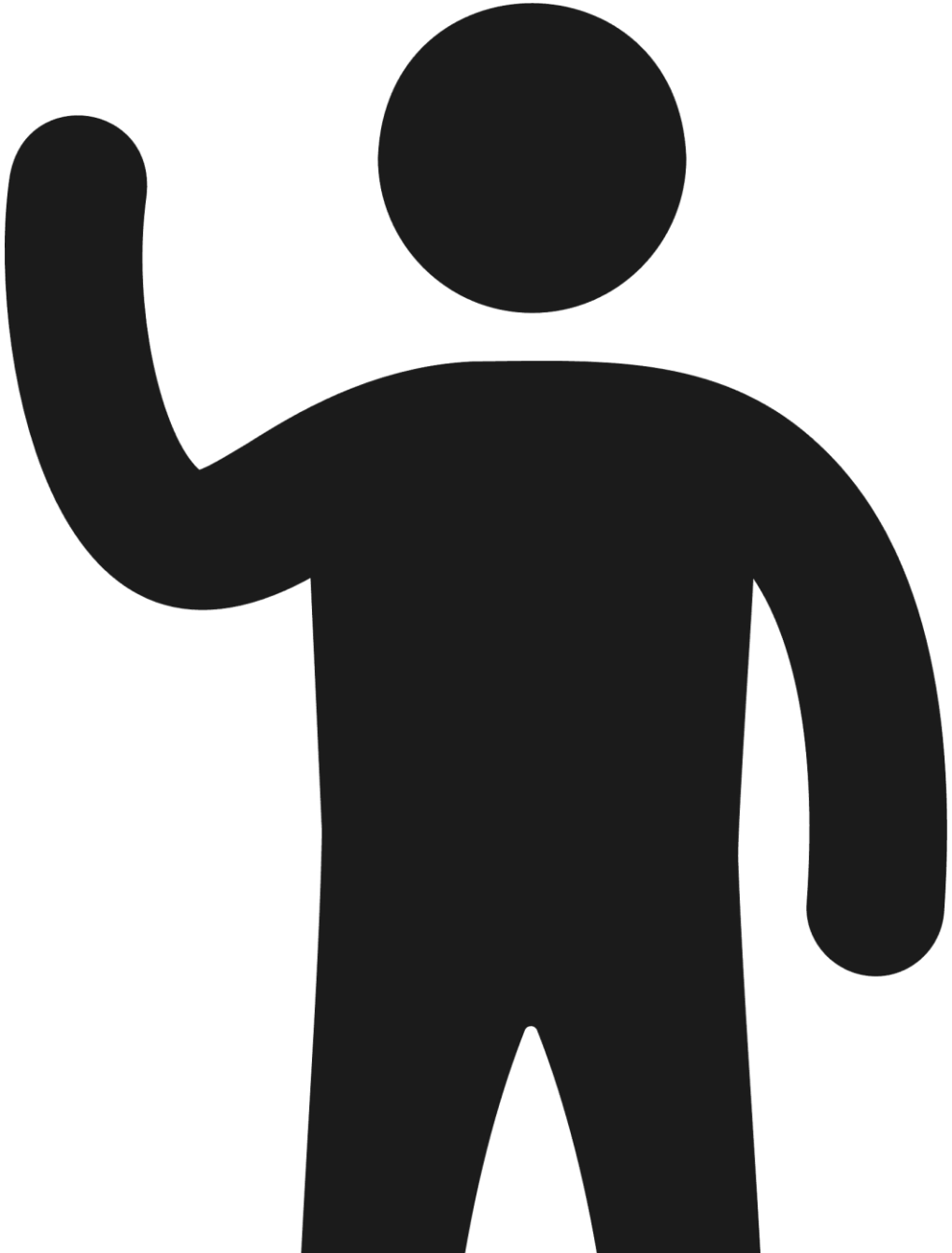
PROSTATE SCREENING MAYBE CONTROVERSIAL FOR SOME MEN, BUT ITS VALUE FOR FOLLOW UP AFTER TREATMENT IS NOT.

This value must not be diminished by communication errors.



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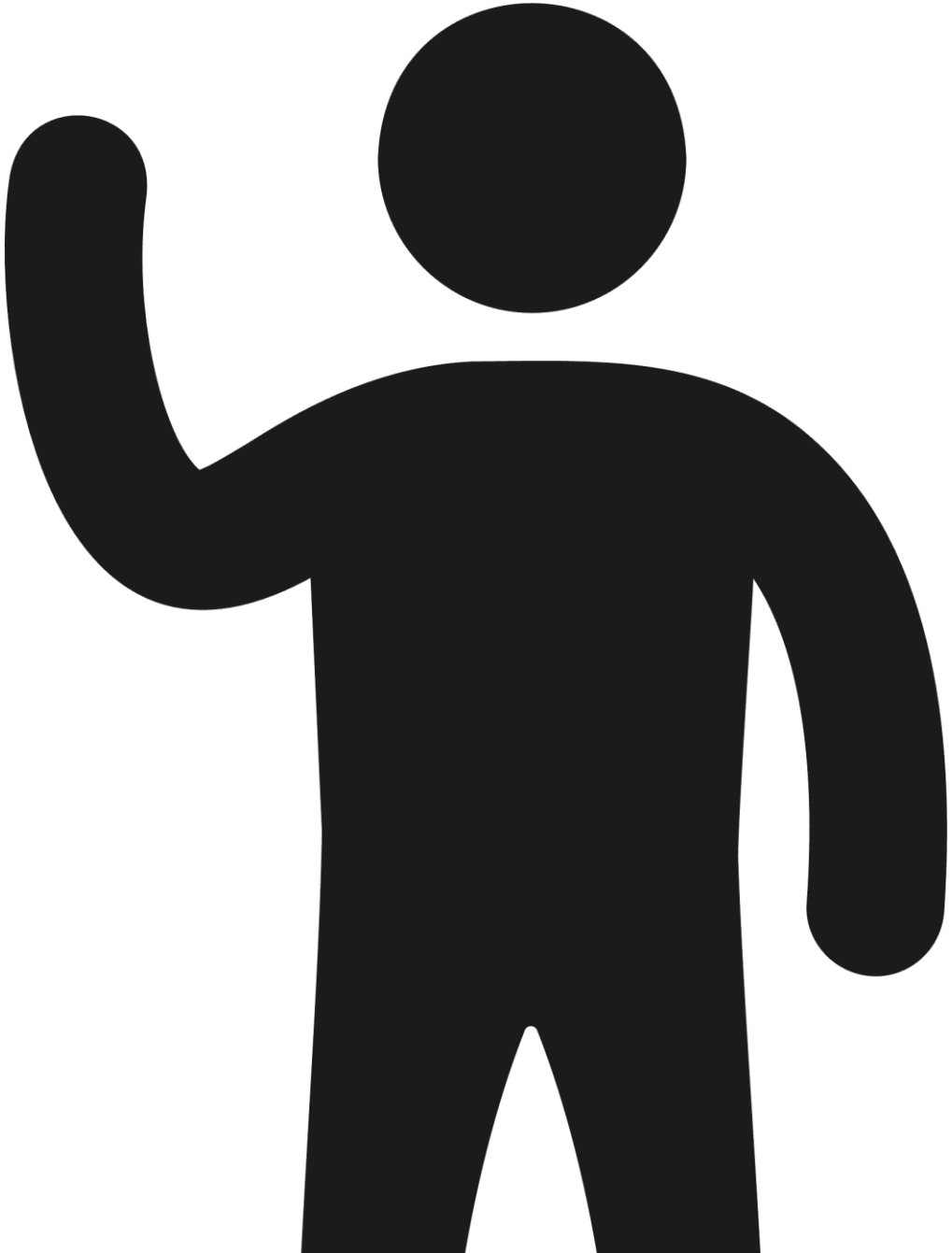
JUST DO IT.



To Err is Human ?

Let good people fix this bad system !