Breast Cancer Delay Claims: Proving Causation

Breast cancer delay claims are rarely won or lost on the existence of cancer alone. The decisive issue is usually causation: whether the delay made a material difference to the claimant's outcome. In practical terms, the question is not simply whether something went wrong, but whether earlier referral, imaging, diagnosis or treatment would probably have led to a better clinical position.

This ebook is based on a webinar delivered by Dr Vasileios Angelis, Consultant Medical Oncologist at St Bartholomew's Hospital, as part of INNEG's oncology webinar series. The session focused on how delay in breast cancer diagnosis translates into breach, causation and damages, and how solicitors can approach these claims with stronger evidence, clearer expert instructions and a better understanding of oncological outcomes.

This eBook has been produced by INNEG and is based on key clinical insights shared during our webinar, Breast Cancer Delay Claims: Proving Causation, presented by Dr Vasileios Angelis, Consultant Medical Oncologist.

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Why Breast Cancer Delay Claims Matter

Breast cancer is not a niche area of litigation. Around 55,000 people are diagnosed with breast cancer in the UK each year, and it remains one of the most commonly litigated cancers. One reason for this is that the diagnostic pathway involves several stages and multiple clinicians. A patient may move from GP assessment to radiology, histopathology, surgery and oncology. Each handover creates a potential failure point.

The failures seen in breast cancer negligence claims are often not rare or technically obscure. They are usually ordinary pathway failures: a symptomatic patient not referred under the correct pathway, an abnormal mammogram not reported, a biopsy incorrectly interpreted as benign, a result not communicated, or a patient lost to follow-up. These errors matter because they often occur when the tumour is still potentially curable.

Breach Is Often the Easier Argument

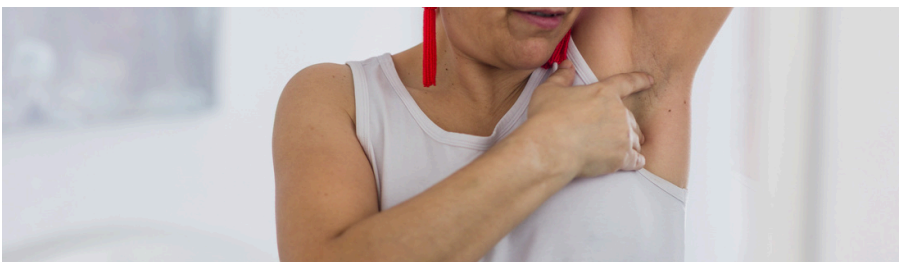
In many cases, breach is the easier part of the claim. A GP referral threshold may be set out in NICE guidance. A mammogram abnormality may be visible on retrospective review. A pathology slide may clearly show malignant cells. Once the records, images or slides are reviewed by the right expert, breach may become relatively straightforward.

However, breach alone does not prove the claim. A solicitor still has to show that the breach made a material difference to the claimant's outcome. That is where many cases become more difficult.

The Central Causation Question

Causation requires the parties to reconstruct a world that never happened. The core question is: but for the delay, what would the claimant's cancer stage, treatment and prognosis probably have been?

That requires careful evidence, expert analysis and a disciplined timeline. It is not enough to say that diagnosis was delayed. The solicitor has to show what probably changed during the period of delay.



A Practical Causation Framework

A useful causation framework starts with identifying the breach. The precise date matters because it becomes the anchor point for the counterfactual analysis. The solicitor must establish what should have happened at that moment, whether that was referral, recall, further imaging, biopsy, MDT discussion or treatment.

The next step is reconstructing the counterfactual. This means asking what a competent clinician would have found and done if the negligent act had not occurred. A breast radiologist may need to review the original mammogram or MRI. A breast histopathologist may need to review the original biopsy slides. The oncologist then uses that evidence to assess likely stage, treatment and prognosis.

The third step is determining the tumour stage at the point of breach. This is often where defendants focus their arguments. They may argue that the cancer was already more advanced than the claimant alleges, or that metastatic spread had already occurred before the negligent delay. The claimant's expert must address this directly using imaging, pathology, tumour biology, growth rate evidence and clinical presentation.

The fourth step is comparing prognosis. The expert must consider the likely prognosis at the but-for stage and compare it with the actual prognosis at eventual diagnosis. This may include the likelihood of recurrence, survival outcomes and the impact of nodal involvement or metastatic disease.

The fifth step is assessing treatment burden. A claim does not fail simply because survival cannot be shown to have changed materially. Delay may still cause avoidable treatment, including mastectomy, chemotherapy, radiotherapy, axillary clearance, prolonged endocrine therapy or newer systemic drugs. These interventions may carry physical, psychological and quality-of-life consequences.

Why Tumour Biology Matters

Breast cancer subtype is critical. Not all breast cancers behave in the same way. Hormone receptor-positive, HER2-negative cancers are often slower growing, particularly luminal A tumours. These are common and may have better outcomes, although delay can still matter.

HER2-positive and triple-negative breast cancers are generally more aggressive. They may grow faster, become node-positive earlier and carry a greater risk of recurrence or metastatic spread.

In these cases, even a relatively short delay may have a significant impact on prognosis and treatment burden.

This means solicitors should not treat “breast cancer” as one uniform disease. The tumour’s subtype, grade, receptor status, size, nodal status and imaging history all matter. A delay in a slow-growing, low-risk tumour may produce a different causation argument from the same delay in a high-grade HER2-positive or triple-negative tumour.

Stage Progression and Prognosis

Staging is central to causation. Stage one, two and three breast cancers are usually treated with curative intent, although treatment intensity increases as the stage rises. Stage four disease means metastatic disease and is generally incurable, although modern systemic therapy may control disease for significant periods.

A key distinction is between cancer in the local lymph nodes and true metastatic disease. Cancer found in axillary lymph nodes may be described as metastatic in a pathology sense, but that does not necessarily mean the patient has stage four metastatic breast cancer. Stage four disease means spread beyond the breast and regional lymph nodes, for example to the liver, lungs, bones or brain.

This distinction matters because a defendant may argue that metastatic disease was already present at the time of breach. In those cases, the evidence needs to address whether distant disease was probably present but occult, or whether it probably developed during the period of negligent delay.

The Role of Imaging Evidence

Imaging evidence is often crucial. Mammography is commonly involved in missed diagnosis claims, particularly where a density, asymmetry or suspicious lesion was visible but not reported. Ultrasound may be important, especially in younger patients or those with dense breasts. MRI may be relevant in particular tumour types, including lobular breast cancer, or where mammography is less reliable.

Cross-sectional imaging, such as CT, bone scan or PET scan, may be needed to assess whether metastatic disease was present. However, tumour markers should be treated with caution. They are not usually sensitive or specific enough to prove metastatic disease on their own, although they may be used in monitoring established disease.

The Role of Pathology Evidence

Pathology evidence can be decisive. If a biopsy was wrongly reported as benign, the whole clinical pathway may stop. The patient may be reassured, discharged and left without follow-up while the tumour continues to grow.

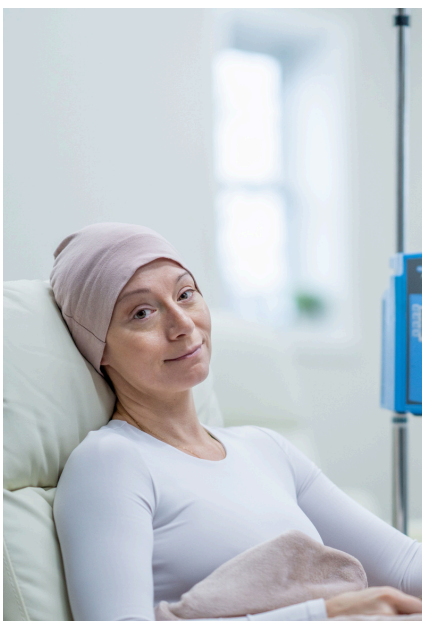
In this scenario, the original slides are essential. A report alone is not enough. A breast histopathologist needs to review the primary material and determine whether malignant cells were visible and should have been identified at the time.

Case One: Missed Screening Abnormality

The first case study considered a 52-year-old woman undergoing routine NHS screening. In 2021, a spiculated density was visible on the screening films but was not reported. The patient was not recalled. By the time she was eventually diagnosed, the tumour had grown significantly and had progressed from a likely stage one cancer to a stage two cancer.

In that kind of case, breach may be established by a breast radiologist reviewing the original screening films and confirming that the abnormality was visible and reportable. Causation may then be addressed by oncology evidence comparing the likely earlier stage with the actual later stage.

The damage in such a case may include avoidable mastectomy, avoidable chemotherapy and a worse prognosis. Even where survival remains good, the difference between breast-conserving surgery and mastectomy can be substantial. The treatment burden itself may form a significant part of the claim.



Case Two: Misreported Biopsy & Metastatic Disease

The second case study was more complex. A 47-year-old woman presented with a two-centimetre breast mass. Ultrasound showed a suspicious lesion and a core biopsy was performed. The biopsy was wrongly reported as benign fibrocystic change. The patient was reassured and discharged.

Seven months later, she returned with a larger mass, skin changes and a diagnosis of grade three ductal carcinoma, ER-negative and HER2-positive. CT imaging showed liver lesions consistent with metastases. The key causation issue was whether the liver metastases were already present at the time of the original biopsy, or whether they developed during the seven-month delay.

If the liver metastases developed during the delay, the negligence may have transformed a potentially curable presentation into incurable metastatic disease. That is a powerful causation argument. If, however, the disease was already metastatic in occult form at the time of the biopsy, the survival argument becomes harder, although treatment burden, earlier access to systemic therapy and quality-of-life issues may still remain relevant.

This type of case requires early expert evidence. Waiting until late in the litigation to determine whether the metastatic disease was probably present at breach is a serious mistake. The solicitor needs the original pathology slides, the imaging, the staging scans and a clear oncological opinion before deciding how the case should be pleaded.

Choosing the Right Expert

Expert selection is one of the most common weaknesses in breast cancer delay claims. A general expert may not be enough. The right expert depends on the alleged breach and the causation question.

A breast radiologist is needed where the issue is whether an abnormality was visible on mammogram, ultrasound or MRI. A general radiologist may not be the strongest choice, particularly where breast imaging is the central issue. The expert should be experienced in the specific imaging modality involved.

A breast histopathologist is needed where the issue is whether biopsy slides were correctly interpreted. The solicitor should obtain the original slides, not simply the written pathology report. The expert must be able to say what a reasonably competent pathologist should have seen at the time.

A medical or clinical oncologist is needed for causation, prognosis and treatment burden. The oncologist considers tumour biology, stage progression, survival outcomes, treatment options and whether the claimant received more extensive treatment because of the delay.

In complex breast cancer claims, a specialist breast oncologist may be preferable. However, not every case requires an oncologist who treats only breast cancer. An experienced oncologist with relevant breast cancer expertise may be sufficient for straightforward cases. The more complex the tumour biology, treatment history or causation issue, the stronger the case for a highly specialised expert.

Asking the Wrong Question

The letter of instruction should not ask the wrong expert to answer the wrong question. A radiologist should not be asked to determine oncology prognosis. An oncologist should not be asked to decide whether a mammogram was negligently reported. A pathologist should not be asked to calculate treatment burden.

Each expert should be asked questions within their proper field. This sounds obvious, but it is a common source of weak evidence.

Building the Timeline

The solicitor should build the timeline early. This should include the first symptom, first presentation, referral date, imaging date, biopsy date, reporting date, MDT discussion, diagnosis date, treatment date and eventual staging.

The timeline is not administrative housekeeping. It is the structure on which breach, causation and damages depend. If the timeline is vague, the causation argument will usually be vague too.

Using NICE NG12 in Referral Failure Claims

NICE NG12 is often a useful anchor in referral failure cases. If the claimant presented with symptoms meeting a referral threshold, the guideline can help demonstrate what should have happened.

Courts may find this persuasive because it provides a contemporaneous clinical standard rather than a purely retrospective opinion.

Treatment Burden as a Head of Damage

Solicitors should think beyond survival. A narrow focus on life expectancy may undervalue the claim. Delay can increase surgical burden, systemic treatment, radiotherapy, endocrine therapy duration, surveillance, psychological distress and fear of recurrence.

Treatment burden is becoming more important because breast cancer treatment is evolving quickly. Newer systemic therapies, including CDK4/6 inhibitors for higher-risk hormone receptor-positive, HER2-negative disease, may be given for prolonged periods and require monitoring. These treatments can create additional side effects, appointments, blood tests and disruption to daily life.

The “Better Drugs” Defence

Defendants may argue that a later diagnosis gave the claimant access to newer or more advanced drugs. That argument is weak if framed as a benefit of delay.

The better analysis is that higher-risk patients receive additional treatment because they need it. A patient diagnosed earlier at lower risk would not have missed out; they may simply have avoided the need for that treatment altogether.

Earlier diagnosis remains associated with better outcomes. More drugs do not erase the consequences of later-stage disease. Modern treatment may improve outcomes for high-risk patients, but it does not make delayed diagnosis harmless.

Preserving the Primary Evidence

Evidence preservation is critical. The solicitor should obtain original imaging, PACS images, biopsy slides, pathology reports, MDT notes, oncology letters, treatment plans and follow-up records.

Relying on summaries is dangerous. The strongest opinions are based on primary evidence.

Practical Takeaways for Solicitors

Do not start with the allegation. Start with the timeline. Then secure the primary evidence. Then instruct the right experts. Then test whether the claimant can prove that the outcome would probably have been materially better but for the delay.

Breast cancer delay claims are emotionally powerful, but emotional force is not enough. The case must be built around stage, biology, prognosis and treatment burden. The strongest claims are those where the clinical story and legal argument align clearly.

For solicitors, the central task is to prove what the tumour probably looked like at the point when competent care should have occurred. Everything flows from that: breach, causation, treatment burden, prognosis and damages.

Conclusion

Causation in breast cancer delay claims is not a single question. It is a sequence of questions.

When did the negligence happen? What should have happened then? What stage was the cancer likely to be? What treatment would probably have followed? What actually happened? What changed because of the delay?

Answer those questions clearly, with the right evidence and the right experts, and the case becomes significantly stronger.

Stronger Cases Start with the Right Medical Expert

Oncology issues can sit at the centre of complex clinical negligence and personal injury claims, particularly where questions arise around diagnosis, treatment pathways, prognosis, causation or the long-term impact of cancer care.

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