CORESS
CONFIDENTIAL REPORTING SYSTEM IN SURGERY

CORESS FEEDBACK

You will notice that the editor has given CORESS its own double-page spread, so we are either doing something right or he his distancing himself!

CORESS needs your r eports
This month's feedback has some interesting reports that may strike a cord with readers. Now that the system is becoming established, it is fervently hoped that colleagues will feel confident and motivated enough to come forward with more material. The paucity of laparoscopic reports is noticeable, for example, considering the volume of this type of surgery that is being carried out. Any member of the team can report and remember that it must be in hardcopy – however hurriedly scribbled – and provide contact information to enable the CORESS editor to check details and show the reporter the completed feedback before publication. The richest source of reports has got to be the regular M & M meetings held in surgical departments throughout the land. Medico-legal cases similarly. Where necessary, the original reports are disassembled and made unidentifiable by the time that the feedback has been constructed. Nothing will be published unless it is agreed by the reporter. Why not make writing a report for CORESS an action point at the end of the discussion at your M & M meeting? That way we will all learn. No reports = no CORESS, it is as simple as that!

A CORESS Reporting Form, which includes the "Freepost" address to which it can be returned, is enclosed with this edition of the Newsletter. The Form can also be downloaded from the CORESS section of the Association's website at: www.asgbi.org.uk

Fancy being a CORESS Editor?
It is clear that we will need to expand the team at CORESS. We have started discussions with our sister specialties and the Colleges with a view to taking the programme forward across surgery, rather than confining it to General Surgery. It makes sense in that many of the incidents and near misses contain lessons that are pertinent to surgery in general. Furthermore, by pooling our administrative resources, each of the specialties can capitalise on a common system for receiving, processing and disseminating their own feedback reports to their individual memberships. The advert will be placed shortly.

ANOTHER WRONG-SITE NEAR MISS…

A day case paediatric list was in progress. The list comprised mostly what is commonly known as 'paediatric groinery'. That is to say, infant hernias, circumcisions and orchidopexies. The consultant operator (Consultant 1) had made arrangements for Consultant 2 to take over the list half way through the morning, in order that he could attend a meeting. Consultant 1 completed the preceding case and, having checked by telephone that his colleague was 'en route', left the operating suite. The departing colleague had briefed Consultant 2 on the next case, which was a right inguinal herniotomy in an 8-year old boy. Consultant 2 was delayed slightly and did not arrive in the operating theatre until the anaesthetised child was on the operating table undergoing skin cleansing and draping by the scrub nurse. Disposable drapes of the type that contained a single aperture measuring approximately 8 x 6 cms. were in use. The surgeon took up her place at the operating table and prepared to make a groin incision at which point the scrub nurse stopped her and pointed out that this was listed as a circumcision and not an inguinal herniotomy. The order of the list had been changed to expedite the child undergoing circumcision, who had become very distressed while waiting.

Reporter Comment
This was a close shave and kept me awake that night. I broke the cardinal rule that one must always check the notes and patient before proceeding to surgery. In fairness, the list change didn't help matters and, as usual, I was under time pressure, which made me late. I assumed that the mark had been covered up by the drape – as is not infrequently the case – and the fact that the hole in the drapes exposes the whole pudenda and groins of these children, provides no clue as to the site of operation in these small bodies. We used not to be in the habit of marking circumcisions as this is a mid-line structure, but I think that this would be a good idea, and would have been an added safeguard.

I bought the scrub nurse a bottle of wine. The meeting that my colleague had dashed off to attend? You've guessed; it was the Risk Management Working Party…….!

CORESS Expert writes:
This is the second wrong site report that CORESS has published in its short life, so there must be a message there in itself. We agree with the reporter that the nub of the matter is the failure of the operating surgeon to check the details of the notes, the patient and the operating list. There were, however, other factors that degraded the safety of the whole system. A change of surgeon during a list is undesirable, but if it has to take place in the context of the team working to which we all aspire, greater than normal care must be taken. Changes of order of an operating list are frequent occurrences and should be expected. Paediatric lists and other specialty lists that comprise multiple cases of a similar type seem to be at particular risk of this sort of mishap and it would be good practice to mark every case, regardless of whether the operation is a mid-line or 'sided' structure.

DID YOU KNOW THAT…

A 67 year old gentleman developed a high enterocutaneous fistula following a right hemicolectomy for Crohn's disease. He was established on parenteral nutrition and long acting somatostatin 200ug tds was administered subcutaneously. Over the ensuing week the serum potassium gradually rose reaching levels above 6 mmol/litre on a number of occasions necessitating glucose insulin treatment. The patient was not acidotic and there was no evidence of renal dysfunction. There was no history of renal problems. The serum potassium level reverted to normal on stopping the drug.

Reporter's comments:
A rare but recognised complication of somatostatin analogues is selective hyperkalaemia. All patients receiving these preparations should have regular serum potassium measurements as well as serial ECGs.

CORESS expert writes:
I too was unaware of this occasional side effect of somatostatin analogues and will watch out for it. It is a genre of drugs that are proving useful in diverse situations and it is fair to say that the full range of indications for their use is still evolving.

Somatostatin is a growth hormone inhibitor, secreted largely by the pancreas and the gut. GI surgeons will be familiar with the drug, which is life saving in situations such as hepato-renal syndrome. It is also commonly used in the management of oesophageal varices and high output intestinal fistulas. Google gives access to some good websites.

A CHRISTMAS STORY

It was a Friday night during the Christmas week-end. The patient, an obese 60-year old male diabetic, was sent in to the surgical admissions unit complaining of pelvic and lower abdominal pain. The admitting PRHO noted that the patient had not passed urine for several hours and, in view of the degree of guarding in the lower abdomen, suspected acute retention of urine, with the body habitus preventing palpation of a distended bladder. The patient was catheterised and 400 mls. of clear urine were forthcoming with some relief of symptoms. The patient was admitted to the general surgical ward. During the night, the patient attempted to get out of bed and fell. The SHO who attended him found no new abnormality and felt that this was merely an accident. No further action was taken at the time. The patient was reviewed on the ward round on the following morning (Christmas Day), at which point it was noted that he had also developed a fever. After examining the patient the consultant felt that spinal cord compression was a possibility and contacted the local neurosurgical service. A CT scan was arranged, which showed a collection at the L4/5 level causing compression of the cauda equina. Transfer was arranged and emergency decompression of a spinal abscess was carried out that evening. By this time the patient had developed substantial weakness of the legs and only partial recovery of this and bladder function ensued. Subsequent review showed that in the nursing notes covering the night of admission was a sentence to the effect that the patient had complained of pins and needles in the right buttock shortly before the fall.

Reporter's comments:
When we discussed this case at the M & M, everyone appreciated that the signs of spinal cord compression included (painless) retention of urine and/or perineal sensory symptoms and/or motor signs in the legs. Although I did not see the patient on admission, as was the custom in those days, it was a pity that it did not click when the juniors ran the case past me on the 'phone. Even so, the diagnosis was not absolutely obvious to me the next morning and I still had a suspicion that we were likely to be dealing with a pelvic abscess. As I recall, there wasn't much weakness of the legs on testing and I thought that the sensory symptoms of which the patient was complaining when I saw him were probably due to the fall and contusion. It just goes to show how one has to be on the ball, particularly on Xmas day – thank goodness that I did call the neurosurgeons!

CORESS expert writes:
Our neurosurgical expert tells us that although most cases of spinal cord compression presenting in primary care are sent in correctly diagnosed, some do slip through the net into other emergency takes and then delayed or misdiagnosis is not unknown. Our expert made the point that it is rare for spinal compression to occur without back pain and, in his experience, what has sometimes been construed as abdominal pain, with hindsight was in fact back pain radiating through to the lower abdomen. Another important clue is the patient who complains of general weakness of the legs and/or 'goes off his/her legs'. Such symptoms must be given the utmost credence in this situation. Clearly, from this account, the patient was experiencing progressive paralysis during the night. It is worth emphasising that spinal cord compression frequently presents with retention of urine and this and/or any sensory or motor signs require immediate investigation and expert spinal input. Every hour counts. An MRI is now the investigation of choice.

There is also something about 'consultant based', rather than 'consultant led' working here, which the reporter has picked up. An interesting case and many thanks to the reporter for letting us have sight of it.