CORESS
CONFIDENTIAL REPORTING SYSTEM IN SURGERY

CORESS FEEDBACK

A couple of interesting cases are offered this month, with thanks to the reporters as usual for taking the time and trouble to write in. We at CORESS are delighted to report the appointment of Adam Lewis as our first Programme Director. Adam will be known to many of you as a distinguished colleague who works as a general/colorectal surgeon based at the Royal Free. He has held the job of Medical Director there for some years and it is of note that he is also a keen amateur pilot. He was selected from a shortlist of four excellent contenders, each one of whom was clearly capable of doing the job. Our thanks to them all for applying and we hope to use their talents in due course.

The other important snippet is the development of the project. It is clear that there is a niche to fill in the way that we capitalise on mistakes and near-misses and that an informal feedback system such as CORESS, run for and by surgeons, can do the job. Thus encouraged, we have asked the other surgical associations and Royal Colleges to join the project and all so far approached have signed up to taking this forward as a group. It will take some time to develop and organise, but all the signs are that, providing colleagues send in regular reports, we can really make this part of the fabric of surgical practice. If any local M & M meetings would like one of the CORESS team to come and set out our stall with a local presentation, please get in touch with Emma Seekings, CORESS Administrator on 020 7973 0302. Meantime, M & M chairmen, you must have something interesting to report to after the last meeting … surely?

A CORESS Reporting Form, which includes the "Freepost" address to which it can be returned, can be downloaded from the CORESS section of the Association's website at: www.asgbi.org.uk

HE WAS SPEECHLESS…….

(Ref: 013)

Mr BS presented to my endocrine clinic with a six month history of enlargement in a long-standing goitre. He was a keen amateur singer in the local male voice choir and had noticed some changes in the quality of his voice. When I examined him, I found a multi-nodular goitre with a pronounced (dominant) nodule on the left hand side which was confirmed on ultrasound. TSH was 5.4 and cytology of the lesion showed branching follicular cells with scantly colloid, nuclear enlargement and vacuoles, classified as C4.

After due discussion, we agreed a left total thyroid lobectomy with frozen section, which in the event was consistent with a papillary carcinoma of the thyroid. Accordingly, we went on to perform a bilateral total thyroidectomy.

The procedure was uneventful with exposure of both recurrent laryngeal nerves and re-implantation of parathyroid tissue. I closed the wound leaving a small drain to the bed of the thyroid and completed the performance by infiltrating 20mls of Bupivacaine, as is my routine.

He was extubated in theatre while I wrote up the operation notes and all was well. We went off to have a cup of coffee, only to be called to the recovery area about 15 minutes later where the patient was in acute respiratory difficulty with audible stridor. An urgent fibre-optic laryngoscopy showed bilateral vocal cord palsy and he was re-intubated and admitted to HDU.

The next few hours were, of course, worrying although I was confident that I had left the recurrent laryngeal nerves intact. Fortunately, by 6 hours post-op on trial of extubation he was able to breath and speak normally.

When I saw him at follow-up he reported that his speaking voice was back to normal and his singing voice was 'almost there'. We suspect that some of the Bupivicaine solution must have entered the central compartment, either via the drain or by infiltration.

Reporter 's Comments:

I carry out a lot of thyroidectomies and this is the first time that I have encountered this particular complication. It had me worried that I had in some way produced a mechanical bilateral neuropraxia. I now make sure that the infiltration of local anaesthetic is confined to the skin flaps.

CORESS Expert' s Comments:

The reporter makes an important learning point by submitting this case, namely that Bupivacaine injected into a wound at the end of a procedure may enter any of the planes opened by the surgeon and if nerves have been exposed they may be blocked. If the nerves are the recurrent laryngeal nerves then the potentially life threatening outcome described here is a real possibility. If Bupivacaine is to be used in thyroid or parathyroid operations many find it safer, and just as effective, to infiltrate the wound site before the incision is made. If premixed bupivacaine/adrenaline is used it has the added advantage of limiting bleeding from the wound edges.

This problem is not confined to thyroidectomy. There are reports of femoral nerve palsies following inguinal hernia repair under LA. These can present with the leg giving way when the patient tries to stand for the first time postoperatively and can result in injury.

MURPHY'S LAW...

(Ref: 012)

We cared for an obese man on whom we undertook colectomy with ileocolic anastomosis for extensive angiodysplasia and life-threatening haemorrhage. All was well until the time came to carry out the stapled anastomosis. The device used was one that involved separation of the anvil and head; purse-stringing the ends of the ileum and upper rectum onto the head and anvil respectively; re-assemby of the two components and, after tightening, firing the gun. At this point it became clear that the gun had misfired and to my consternation could not be withdrawn from the patient. The reason then became apparent. Initially, we had planned to use a size X anastomotic gun but found that the head was too large to insert into the proximal bowel (ileum). The gun was, therefore, discarded but left on the scrub trolley and a smaller size brought into play. At this point it was realised that there had been a transposition of the components between the two guns. Having been fired, the incorrectly assembled gun could not be disassembled and the anastomosis had to be resected and a further one carried out - fortunately there was sufficient colon/rectum to complete this satisfactorily.

Subsequently, I am pleased to report that the patient made an uneventful recovery.

Reporter's Comments:

This could have been worse. If, for example, we had been carrying out a totally closed procedure, we would have had to open the abdomen. If there had been insufficient rectum left after the failed attempt we would have had little choice but to leave the patient with a stoma.

We now make it a rule that disposable devices are taken off the scrub trolley once they have been tried.

CORESS Expert's Comments:

The reporter quite rightly highlights the need for vigilance when using devices that have several components, and I agree with his/her analysis of the cause and remedy. Manufactures should be made aware of this incident and any other similar that occur (we have done – Ed). I would guess that this danger is something that other surgical specialties routinely using similar devices such as joints, will have encountered more than us in General Surgery. When I discussed this with my theatre sister she felt that the Reporter's solution was correct and we also went on to check and found that this could happen with several of the most commonly used brands of guns.

Again, as the Reporter states, if the one short segment of rectum/anal canal has been destroyed in this way there is little alternative to a stoma or a hand-sewn endo-anal anastomosis, now but rarely performed.

AND FINALLY...

Collectors of trivia will be intrigued to know that there really was a Captain Edward A Murphy. In Pilot 2004 he is described as an engineer working on Air Force Project MX981 in California during 1949. The project sought to discover the human body's tolerance to sudden deceleration, by means of rocket sled tests. One day after finding a transducer was wired incorrectly, Murphy roundly cursed the technician responsible saying "If there's a way to do it wrong, that guy'll find it". Hence Murphy's Law. Shortly afterwards, a USAF doctor rode a rocket sled during a 40g deceleration (!), and at a press conference afterwards said "The good safety record of the project is due to a firm belief in Murphy's Law, and in the necessity to try and circumvent it". So now you know!

A SURGICAL THREAD

I studied medicine for five long years
It was mostly fun, just a few tears.
I passed my finals and received my degree
My parents were pleased, it was plain to see.

They had scrimped and saved to help me achieve
My childhood ambition, for they'd always believed
I could make the journey from secondary school
Through the University's lecture hall.

Inspired by surgeons in my clinical years
I started my house jobs with almost no fears
That a surgical career would be there to be had
By a bright, reliable, hard working lad.

Now that my name is proudly in
The medical register, it seems a sin
That I'm having to go overseas to obtain
My post grad training- is that insane?

We are told the UK is short of physicians,
Surgeons, GP's and paediatricians,
So having trained many hundred more docs
I say to our leaders, 'pull up your socks'.

The nation has spent a small fortune on
My education, so what went wrong?
Was there no manpower planning to guarantee
Some seamless training for the likes of me?

I'm told it's all down to MMC
F one, F two and ST one, two, three.
Well all I can say is an Ass in a cellar
Could probably have organised things a bit better.

I'm young, enthusiastic and willing
To bend my surgical back for a shilling,
But sadly it's farewell to this frustrated scholar
I'm off to work for a Rand or a Dollar.

So should you find, in a year or two,
A few gaps appear in your surgical crew,
I'd need to be sure that if I returned
I wouldn't once more be used and then spurned.

I would love to return to your surgical team,
I still have a burning UK based dream.
Yet I cannot help but wonder aloud
Am I the thread of an NHS shroud?

Magnus King