SURGICAL SAFETY UPDATE

Cases from the Confidential Reporting System for Surgery (CORESS)

Missed anal carcinoma

A 62-year-old woman was referred to the colorectal team with a generic GP letter describing altered bowel habit, occasional rectal bleeding and "nasty piles". She was booked for fast-track flexible sigmoidoscopy before being seen, with a view to an outpatient appointment after the test.

A flexible sigmoidoscopy was performed by an experienced nurse practitioner and reported as normal. As a result, a routine outpatient appointment was made, which the patient attended 16 weeks after the test. At the outpatients it became evident that the "nasty piles" were an anal carcinoma.

Reporter's comments

This case demonstrates the potential danger of a fast-track policy in which the patient may not have been seen by a clinician with colorectal experience before the investigation. The description of "nasty piles" should have flagged up the possibility of anal or perianal pathology.

CORESS comments

This case begs the question of whether the patient was examined thoroughly prior to referral to the fast-track colorectal clinic. Anal examination should be undertaken before any colorectal endoscopy, but if the endoscopist is uncertain of the clinical implications of abnormal appearances, they should seek a second opinion.

Tunnelling device mishap

A 68-year-old man underwent an obturator bypass for critical limb ischaemia to avoid a groin scarred by chronic infection from previous surgery. This involved retroperitoneal exposure and placement of a tunnelled prosthetic graft from the iliac artery through the obturator foramen to the medial thigh, with distal anastomosis to the superficial femoral artery.

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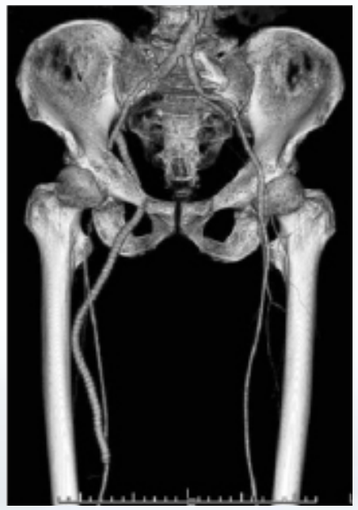
Below: CT angiogram right obturator bypass



A standard tunnelling device was used with a 'screw-in' blunt olive, matched to the Dacron graft 8mm diameter. As the tunneller was introduced through the obturator foramen of the pelvis, from the thigh, the olive tip of the tunnelling trocar became unscrewed and disconnected from the rod of the trocar, ending up lodged and inaccessible somewhere in the deep pelvic tissues.

After numerous attempts to retrieve the 1cm-long bullet-shaped olive, and despite on-table imaging to confirm its position, it was deemed too potentially disruptive to attempt to extract the tip. The operation was completed using a second tunneller and the metallic olive was left *in situ* when the incisions were closed.

Postoperatively, a full explanation with diagrams was provided to the patient by the operating surgeon. No complaint arose and at six months follow-up the graft was patent with no complications.

Reporter's comments

With this particular tunnelling device, the correctly sized olive had to be selected and screwed into the trocar rod. This was undertaken by the scrub nurse while the surgeons prepared the operative field. It is possible this was not done correctly or that the olive was mis-threaded. Nonetheless this should have been checked by the surgeon prior to use. In the event of the olive dislodgement, a team decision was eventually made to abandon attempts at retrieval because of the risk of causing injury. A full and honest explanation to the patient helped to defuse any potential complaint.

CORESS comments

Unfortunately, kit failures do occasionally occur across all surgical specialties and it is sometimes in the patient's interests to refrain from retrieving an inaccessible foreign object if it is deemed that the risk of leaving this in place is significantly less than further, potentially injurious, surgical exploration.

Key points related to this case are the importance of checking all surgical equipment before introducing this into the patient. In the event such an incident there is a duty of candour to provide a full and frank explanation to the patient. The patient should also be warned of implications of retained metallic objects with respect to potential future MRI scans.

Retained tip of vein hook

The 38-year-old wife of a local GP underwent bilateral radiofrequency ablation of incompetent varicose great saphenous veins, with concomitant phlebectomies, at a local private hospital.

We are grateful to those who have provided the material for these reports.

The online reporting form is on our website, coress.org.uk, which also includes previous Feedback Reports.

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The procedure was carried out under general anaesthesia at her request. Phlebectomies were undertaken via small stab incisions in skin creases using a size 1 (larger) Oesch-style vein hook.

During the phlebectomies on the second limb, while removing a large anterior thigh vein varicosity, the vein hook snapped at approximately 1cm from its tip, leaving the tip embedded in the thigh tissues. Attempts to locate the hook tip with a fine arterial clip were unsuccessful and despite undertaking image intensification, using crossed 21g hypodermic needles to triangulate the hook's position, it proved impossible to remove the hook tip without potentially significantly enlarging the incision. The decision was taken to complete the procedure without retrieving the hook tip. This was done without further incident.

An explanation was provided to the patient who made a good cosmetic recovery.

Reporter's comments

On completion of the operation, the set of vein hooks were inspected and it became apparent that all had been bent through usage and probably re-bent into shape, representing wear and tear of usage. The fracture of the hook tip had probably occurred as a result of metal fatigue rather than the use of inadvertent force.

CORESS comments

As in the previous case, a careful check of the equipment prior to use may have revealed a potential problem. Where kit is obviously worn it should be withdrawn from use and replaced as necessary.