CORESS
Confidential reporting system in surgery

CORESS Feedback

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The two cases in this edition of CORESS Feedback illustrate the continued need for an accurate and detailed history, even in less than ideal circumstances. As always, we are grateful to the surgeons who have taken the trouble to tell us about the cases and the lessons they have learnt from them. We do hope that readers who find this Feedback useful will feel able to contribute a case. The on-line reporting form is on our website <www.coress.org.uk> which also includes all previous Feedback Reports.

After the last Feedback on trauma management, a correspondent suggested that, because consultant general surgeons on call are part of the trauma team, they should all have recent ATLS training. The Programme Director is always interested to hear from readers and will include comments in the CORESS Feedback if they are educationally important.

Finally, the CORESS programme has received generous donations from the Association of Breast Surgery at BASO and the British Orthopaedic Association for which we are most grateful.

Nobody told me (Ref. 023)

A man underwent major abdominal surgery after which he was referred for chemotherapy and completed treatment 6 months later. Three years later, he came to my clinic on a particularly busy day when I had to leave early for a meeting with management. My registrar found a large abdominal incisional hernia and arranged admission for mesh repair. He was admitted on the day of surgery having been pre-clerked by a nurse consultant. At operation, I repaired the hernia with mesh as agreed; when I examined him on the ward the next day, I was surprised to see a very large haematoma. On further enquiry, I learnt that he had had coronary artery surgery shortly after his abdominal surgery. This had not been noted pre-operatively and the aspirin prescribed after his coronary artery surgery had not been stopped. The wound broke down completely and subsequently healed very slowly over the next 9 months. He was not pleased but, after an apology, has accepted that his complication was managed with due diligence.

Reporter's comments

I cannot assume that patients will always admit to treatment elsewhere. Sometimes they forget or, if not directly asked, will think it unimportant! A careful past history should be taken even if the patient is well known to the unit and I have since reviewed the protocol used by the nurses doing the pre-clerking. In this case, the fact that the patient was on aspirin had been noted at pre-clerking but was not brought to my attention and I did not specifically check. In my view, aspirin and certainly the new more powerful antiplatelet agents should be stopped before hernia repair if at all possible – especially if mesh is inserted.

CORESS expert's comments

The CORESS Advisory Committee felt that this case raised a number of interesting issues. First, it illustrates how individual minor errors or omissions can sometimes coincide and lead to adverse outcome. If just one of the several opportunities to elicit this patient's past history had been taken, and even more importantly acted upon, then the outcome might have been different. 'Rapid transit' through the modern healthcare system and the delegation of tasks across members of a team comprising highly variable levels of expertise can make it difficult for a consultant to fulfil his responsibility for the overall care of an individual patient. The Committee agreed with the reporter that detailed protocols, regularly reviewed, are the best safeguard in this respect. The Committee did not entirely accept the view that the aspirin had necessarily caused the haematoma, nor that aspirin should invariably be discontinued before hernia repair; it is usually a balance of risks. Surgeons should be particularly circumspect when contemplating surgery on a patient taking the newer antiplatelet agents such as clopidogrel. Alone, or in combination with aspirin, this agent provides formidable anticoagulation that can lead to serious intra-operative haemorrhage and more than one vascular surgeon has found himself in major difficulties under such circumstances. Surgeons might wish to review the literature and their practice in the latter respect and it is certainly an issue that should be discussed with a patient when obtaining consent.

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I assumed … (Ref. 025)

A private patient came to my consulting rooms with an inguinal hernia. My full history and examination indicated no other co-morbidity. He admitted to smoking heavily but was only a 'social' drinker. Investigation of his respiratory system showed no significant abnormality but it was agreed that a mesh repair should be carried out under local anaesthesia and this was done. Although haemostasis was apparently complete on closure of the wound, I found a large haematoma when I examined him the next day. He had not received prophylactic heparin but investigation now showed abnormal liver function and haemostasis. It then emerged that the patients idea of 'social' drinking consisted of a minimum of a bottle of claret a day and often more! The wound broke down and the mesh became infected. Eventually, it appeared to have healed but 2 years later I removed the mesh on account of continued intermittent sepsis.

Reporter's comments

A small omission in the history can have serious, long-term consequences and I should have insisted on more detail about his drinking habits. I also think I should have removed the mesh earlier. This is the only mesh I have had to remove from the groin and assumed that the longer the operation could be postponed the better.

CORESS expert's comments

This very honest report demonstrates the potential vulnerability of a patient to the error of a single individual practising in the independent sector. The pre-operative assessment of this patient was limited and a potentially serious omission was not corrected prior to operation. If we very properly insist on detailed and up-to-date protocols in an NHS setting, perhaps we might be wise to keep copies in the private consulting room for our own use!

As in the previous case, the CORESS Advisory Committee felt that the haematoma might have occurred anyway and noted that sepsis is, in any case, more common in heavy smokers. There is a considerable literature on the place of prophylactic antibiotics in hernia surgery which should be reflected in appropriate protocols. Finally, the Committee agrees with the reporter's conclusion that drainage and, if it is infected, early removal of the mesh, is the correct management in these circumstances.

BEWARE!

Trouble a foot!

Various manufacturers of diathermy equipment use the same type of footswitch connector but wire these differently. This may result in delivery of 'cut' wave forms when the 'coagulate' footswitch is depressed, or vice versa, if the footswitch that is intended for one type of generator is used with the other.

Lights inaction!

Operating lights are designed to work correctly with bulbs supplied by the original manufacturer. Other brands may fit and be cheaper but the performance of the light may be compromised due to the position of the filament inside the bulb.

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