CORESS
Confidential reporting system in surgery

CORESS Feedback

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This edition of CORESS Feedback includes a lesson (Ref. 35) learnt by every generation of surgeons. It reminds us that although learning from others can alter behaviour, errors tend to return and lessons must be repeated. Originality is not a necessary condition for reports and CORESS is grateful to surgeons who give us the opportunity to repeat these important lessons. Many surgeons are, understandably, pre-occupied with the current disarray in the NHS, and may be reluctant to send reports to CORESS at this time. CORESS needs your input for a high-quality output. If you value this Feedback, please remember that the CORESS on-line reporting form is at <www.coress.org.uk>. *It does not take long to let other surgeons learn from your experience.*

Try, try, try again? (Ref. 31)

My SHO recently took a man to theatre with a clinical diagnosis of peri-anal abscess. When no abscess could be found with a 'white' needle, I was called and, despite agreeing with the clinical diagnosis, could neither aspirate any pus nor identify an abscess on laying open the superficial layers of the wound. However, an MRI clearly showed a large perirectal abscess so the patient was returned to theatre. Again, it proved impossible to aspirate pus at which point the SpR suggested that I might be using a 'filter' needle. On changing the needle to a different type, pus drained immediately and open drainage was achieved.

Reporter's comments

The prepared packs for incision and drainage of anorectal sepsis contained a filter needle as they were mainly used for elective work which required the drawing up of local anaesthetic. This has been addressed, but it is easy to see how it happened.

CORESS Expert's comments

The Advisory Committee was most grateful for this timely warning. Filter needles are used to avoid aspirating organisms and foreign material when drawing up fluids from glass vials. They are particularly used for intrathecal injections. Although not in wide-spread use in operating theatres, the potential for misuse is clearly present. Aspiration is an acceptable diagnostic measure and/or treatment for anorectal sepsis but the correct equipment must be used!

Back to basics (Ref. 32)

An elderly man, with a past history of abdominal aortic aneurysm repair, was referred to the gastroenterologists for investigation of dyspepsia. Investigation showed him to have iron-deficiency anaemia but OGD and colonoscopy were normal. A year later, he was admitted as an emergency with haematemesis and melaena and was given a blood transfusion. Once more, he was investigated by the gastroenterologists with OGD and colonoscopy without finding a source of the bleeding. A further year later, he was admitted with a further melaena and I was asked to see him. Investigation showed an aorto-enteric fistula which was repaired successfully.

Reporter's comments

I believe that this patient should have been referred to a vascular surgeon much sooner. It is always necessary to exclude aorto-enteric fistula in an anaemic patient with previous abdominal aortic aneurysm repair and delay in treatment leads to a very high mortality.

CORESS Expert's comments

The Committee very much agreed with the Reporter's comments. This story is all too common and certainly not confined to the realm of gastroenterology. Management must include a

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thorough history and physical examination and all surgical scars should be accounted for. Substantial or occult blood loss in a patient who has undergone an abdominal aortic aneurism repair is always due to an aorto-enteric fistula until proved otherwise.

Constipation – or perforation? (Ref. 33)

A fit, elderly man was admitted as an emergency with a short history of obstructive symptoms from a small carcinoma of the sigmoid colon. He had appropriate pre-operative preparation, but without mechanical bowel cleansing. On the following day, he underwent sigmoid colectomy with standard antibiotic prophylaxis and, postoperatively, was transferred to ITU. On the third postoperative day, he had not yet opened his bowels and was prescribed a regular laxative by the ITU SHO. This was not noticed by the surgical team over the weekend and was given for 3 days, until stopped by the consultant on Monday morning. On Monday afternoon, he deteriorated and CT scan confirmed anastomotic leakage. At laparotomy, the anastomosis had completely dehisced. He had a Hartmann's procedure and made a very protracted recovery.

Reporter's comments

I do not think that laxatives should be used immediately following bowel anastomosis without consultant approval. The surgical team should check drug charts daily.

CORESS Expert's comments

The Advisory Committee agreed with the reporter that there appeared to have been a failure of senior supervision in the ITU. Evidence of anastomotic leakage in the early postoperative period may be very subtle and not apparent to a relatively inexperienced trainee. Drugs were written up by the ITU doctors without reference to the surgical team who do not seem to have checked the drug chart or electronic record on a regular basis. Surgeons do, of course, rely heavily on the expertise of colleagues, but responsibility for the postoperative patient remains with the surgical team, even in the most difficult circumstances.

The BNF states that parasympathomimetic laxatives should not be used after bowel anastomosis. Although there is no objective evidence that laxatives cause leaks, their use can certainly complicate diagnosis. The Advisory Committee agreed with the reporter that laxatives should be avoided in these circumstances except after careful consideration by an experienced clinician.

Communicate, communicate (Ref. 34)

An elderly man was admitted to a medical ward with pneumonia and a CT scan showed multiple nodules throughout both lung fields. He then suddenly developed lower abdominal pain and a provisional diagnosis of appendicitis was made. An ultrasound scan showed multiple gall stones but the radiologist noted the marked tenderness and advised a CT scan which was said to show an appendix abscess. He was then seen by the duty consultant surgeon who wrote in the notes that a perforated viscus, possibly a colonic primary, was the most likely diagnosis and despite his co-morbidity, he needed an urgent laparotomy which he asked his registrar to arrange. However, due to a change of shifts, a different registrar explored the abdomen through a Lanz incision and found what appeared to be a gangrenous appendix. The registrar had difficulty closing the appendix stump and, postoperatively, the patient developed a faecal

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fistula. Three weeks later, a CT scan and colonoscopy showed a perforated hepatic flexure carcinoma associated with an abscess cavity draining through the fistula. In due course this was successfully resected.

Reporter's comments

There appear to be several things to learn, none of which of course are in any way new. First, there were communication problems at several levels especially between the duty consultant and registrar and in the registrar handover. Second, when the clinical picture does not fit the X-rays, treat patients not x-rays. Third, we should have gone back to the beginning and re-thought the diagnosis rather than pursuing the original diagnosis long after it ceased being very likely.

CORESS Expert's comments

The Advisory Committee agreed with Reporter's comments. It is also difficult to understand why the operating registrar failed to inform the duty consultant when, after an inappropriate incision, difficulty was experienced in theatre, particularly when the consultant's diagnosis was not confirmed. Handover between the registrars appears to have been inadequate – a feature of previous CORESS reports – and this subject has recently been addressed by the publication of guidance by The Royal College of Surgeons of England (*Safe Handover: Guidance from the Working Time Directive Working Party*, March 2007 <http://www.rcseng.ac.uk/publications/docs/publication.(2007-05-14.3777986999/view?searchterm=SAFE%20HANDOVERS>). Meanwhile, handover arrangements remain a consultant responsibility – often difficult to fulfil.

Minutes count! (Ref. 35)

A young man came to our A&E with an hour's history of acute pain in his single descended testis. The surgical registrar made a clinical diagnosis of acute testicular torsion and asked the anaesthetic SHO to see the patient in A&E with a view to immediate surgery. The anaesthetist could not come immediately and the patient was therefore transferred to the ward. The original anaesthetist had by then gone off duty and there was further delay for handover to another trainee anaesthetist who was concerned that the patient was not fully starved. I was then contacted, spoke to the duty anaesthetic consultant, after which the patient was immediately taken to theatre. At operation the single testis was untwisted but was only partly viable.

Reporter's comments

Acute testicular torsion is an acute emergency and needs urgent surgery. Delays are not acceptable and a consultant anaesthetist may be required if anaesthetic problems are anticipated.

CORESS Expert's comments

The Committee strongly endorsed the Reporter's comments. The admitting doctor should either assert his/her authority or contact the appropriate consultant immediately. Minutes count. Both the MDU and the MPS are aware of this recurring problem and have referred to it in their publications. Sadly, further reminders are clearly needed.

Finally – Failed to click

Investigations into loss of output during diathermy have revealed the use of diathermy electrodes that are incompatible with the generator. It is important to be aware that electrosurgical instruments from one manufacturer are not always compatible with the generator of a different manufacturer.

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