CORESS
Confidential reporting system in surgery

CORESS Feedback

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This edition of CORESS Feedback includes two cases (43,44) relating to erroneous identification procedures in the operating theatre. Although not recent, the cases are included to remind readers that such disasters can and do occur if proper procedures are not followed.

CORESS would welcome more reports from the surgical specialties. If you can pass on a useful lesson, in confidence, to your colleagues they will certainly appreciate it! The on-line reporting form is on our website <www.coress.org.uk> which also includes all previous Feedback Reports. In case of difficulty, the Programme Director can be reached on coress@btinternet.com.

Finally, the MRHA and The Royal College of Surgeons of England have been working together to produce an education module on diathermy. This can be found at <http://www.mhra.gov.uk/LearningCentre/Electrosurgery/player.html> *and can be accessed by typing in the user name 'traininguser' and the password of 'MdTrain912$'.*

MINOR SURGERY? (Ref. 41)

An elderly woman underwent a wire-guided wide excision for an invasive breast cancer. She was discharged with no problems but, several days later, became very unwell at home and, after some delay, was re-admitted with septicaemia. The breast wound looked quite normal and initially it was thought that the source of her sepsis was gallstones. However, as she did not improve, the breast wound was explored and debrided. Despite this, her condition deteriorated rapidly and she developed multi-organ failure. Blood cultures indicated that the organism concerned was *Staphylococcus aureus* – not MRSA. She remains on haemodialysis.

Reporter's comments

With the benefit of hindsight, two things might have lessened the consequences of this catastrophic complication. First, the patient was not given prophylactic antibiotics. This is acceptable practice – but some units do give routine antibiotics to patients having a localising wire put into their breast. Second, the patient was seriously ill at home for several days before being re-admitted. Earlier re-admission and aggressive treatment may have made a difference.

CORESS comments

The Advisory Committee was grateful for this report which illustrates the very small, but occasionally unavoidable, risk of overwhelming sepsis (not necessarily MRSA) even after relatively minor surgery. Patients should be made aware of this risk, particularly prior to non-essential surgery. Although there remains some uncertainty, the Advisory Committee felt that the evidence base was now moving towards prophylactic antibiotics in these circumstances (<www.sign.org.uk>). There is good evidence that timely and aggressive treatment of septicaemia is essential and the Committee felt that, particularly for short-stay surgery, patient access to the surgical team should be facilitated and there should be a low threshold for re-admission.

A BIG PROBLEM (Ref. 42)

A morbidly obese diabetic man was recently admitted to our medical admissions unit just before evening handover with breathlessness and abdominal pain when coughing. Further assessment showed him to be pyrexial, tachycardic and hypotensive. There were fine crepitations in both lungs and vague right upper abdominal tenderness. A presumed diagnosis of pneumonia was made and he was treated with Frusemide and nebulised Salbutamol. After the evening handover, the patient's chest X-ray was seen and mistakenly considered to be normal by the incoming SpR (who had not seen the patient). In fact, it showed features consistent with ARDS. On account of a past history of gall stones, a serum amylase was requested and this was 1029. The diagnosis was changed to acute pancreatitis and he was referred for a non-urgent surgical

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A BIG PROBLEM *(continued)* (Ref. 42)

review. The next day, he was considerably worse, with generalised abdominal pain, continued pyrexia, tachycardia, hypotension and anuria. The surgical registrar requested admission to ITU but this was delayed by the evening handover after which he was seen by the ITU registrar and admission to ITU agreed. An abdominal CT was requested and this showed gas under the right diaphragm. After intensive resuscitation, he was taken to theatre and a perforated duodenal ulcer oversewn. Despite appropriate postoperative care in ITU, he arrested and died the following day.

Reporter's comments

There was a failure of the admitting team to recognise the severity of his illness. Early recognition of patients with severe sepsis is essential and a senior medical review must be requested at an early stage. There was also inadequate handover. The incoming medical SpR did not see the patient making it difficult to convey the severity of the patient's condition to the surgical team. There was further significant delay in getting him seen by and admitted to the ITU. Ideally, referral between specialties should be made by the doctor who last saw the patient but this may be impractical with the new style of working. There was an over-reliance on the serum amylase test. Serum amylase may be elevated in other acute abdominal conditions and should not always be regarded as diagnostic of acute pancreatitis until the exclusion of all other considerations.

CORESS comments

The Advisory Committee agrees with the Reporter's comments and would add that this case well illustrates the great difficulties of imaging and diagnosis in the morbidly obese. It is particularly important that a consultant sees such patients at an early stage and that diagnosis and decision making remains at a senior level.

WRONG SIDE (Ref. 43)

I was asked to do a biopsy excision of the left 12th rib for a patient with an isolated lesion suggestive of malignancy. While I was scrubbing up, the anaesthetist called out, 'Which side?' and I replied 'Left'. When I came into the operating theatre, the patient had been prepared and towelled up by the house-surgeon and theatre sister and was lying on the left side. I took out the right 12th rib before I realised my mistake. I then had the patient turned onto the right side and took out the left 12th rib which, on later histological examination, showed metastatic tumour.

Reporter's comments

I thought I would never operate on the wrong side but I did and I cannot blame anyone else for failing to realise that the patient had been placed on the wrong side.

WRONG PATIENT (Ref. 44)

I was a newly appointed consultant surgeon doing my first list at a hospital that I had worked at previously as a registrar. The anaesthetist was a locum. The registrar telephoned me the night before with an operating list of patients, all of whom I had seen as out-patients. He suggested starting with an inguinal hernia followed by an appendicectomy, *etc.* In order to assist the registrar with his first hernia, I suggested that I should first do the appendicectomy followed by the inguinal hernia so there would be no time pressure on him. He promised to change the list with the ward and theatre. I arrived (early) next morning to find the patient already anaesthetised

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WRONG PATIENT *(continued)* (Ref. 44)

and on the table. The skin had been prepared and towelled off. I was just about to make an incision when the registrar gasped, 'This is the hernia patient!' We repaired his hernia. It was extremely fortunate that the registrar had recognised the patient as the two patients were very similar in appearance.

Reporter's comments

As always, it is the surgeon's responsibility to follow the routines, especially if the circumstances are unusual. I was unused to finding the patient already on the table, prepared and draped. The anaesthetist should have checked the name band – but this does not excuse my final responsibility. The failure to alter the list in the ward the night before may have been due to the sudden illness of the nurse in charge. But for the miraculous recognition by the registrar, I would have opened the abdomen of a patient with an inguinal hernia.

CORESS comments

The Advisory Committee is most grateful for these two very honest reports. Although neither of the cases occurred recently, clear identification procedures existed at the time and, for various reasons, were not properly followed by either surgeon or anaesthetist. The NPSA and surgical Royal Colleges have published clear guidance on correct site surgery and it is recommended that surgeons review this (<www.npsa.nhs.uk/site/media/documents/883_CSS%20PSA06%20FINAL.pdf>).

WRONG PLACE (Ref. 45)

A patient underwent colonoscopy and was referred with a diagnosis of carcinoma of the splenic flexure. At laparoscopic left hemicolectomy, it was clear that there was no abnormality at the splenic flexure but there was a mass in the sigmoid colon which was also affected by diverticular disease. I assumed that the mass in the sigmoid was the carcinoma and that the report had overestimated the length of colon examined. Following resection, the specimen was opened and found to have sigmoid diverticular disease only. The right colon was then examined and an obvious caecal carcinoma found.

Reporter's comments

Do not trust colonoscopy. In this case, the report was misleading and because our initial port placement for left colectomy is a right lateral port, the right colon is not initially in view. If the mass is not where it should be, all the colon should be examined, though this may be difficult laparoscopically – particularly the flexures. We now encourage our colonoscopists to tattoo carcinomas if small or if they are uncertain of the position.

CORESS comments

The Advisory Committee agreed that it is unwise to trust colonoscopy for identification of the anatomical site of any lesion and all patients should have radiological corroboration of the site of a cancer before operation. There are differing views on the value of opening the specimen before closing the abdomen in such circumstances but it can be a sensible precaution if the tumour is difficult to identify at operation.

FINALLY

One Liner

A patient's hand was seriously injured while gripping the side of a lithotripter table as it was being repositioned. Patients' hands should be correctly positioned on the top surface of moving tables at all times.

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