

CORESS Feedback

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This issue of CORESS Feedback once more illustrates the potential for disaster when communication is compromised, either within the surgical team or between units in the hospital. Two reports deal with problems in the operating theatre and remind us that it is nearly always easier to consider potential difficulties and how we might overcome them – before starting the operation! As always, CORESS is most grateful to those who sent us these very valuable reports. The on-line reporting form is at <www.coress.org.uk> which also includes all previous Feedback Reports.

The NPSA has recently issued a Rapid Response Report arising from a death due to haemorrhage in a facility without the necessary equipment and transfusion service to deal with this recognised complication. This important report may be seen at <<http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/rapidrr/emergency/>>.

MISSING LINK?

(Ref. 46)

An elderly man was taken to theatre at 8 am for complex thoracic surgery on the morning list. On arrival in the anaesthetic room, but fortunately prior to induction, the theatre nurse reported that the implant required was not available in the hospital. The surgeon had not yet arrived so, as the anaesthetist concerned, I tried to contact the secretary who was to order it but she did not start work until 9 am. Subsequent investigation revealed that she had arranged for the implant to be available for the afternoon list. The operation was delayed until the implant was available.

Reporter's comments

The responsibility for seeing that the implant was available should not have been left to a medical secretary who may not be aware of the significance of operating list timings. The theatre nurse checked

and stopped the patient being anaesthetised but the lack of proper communication caused delay and consequent cancellation of other patients on the list.

CORESS comments

Although the surgeon is ultimately responsible for the availability of any implant or prosthesis prior to surgery, it is good practice to include details on the booking sheet and subsequent operating list. Good communication between all members of a dedicated specialist operating theatre team is important and certainly no patient should be anaesthetised until all necessary equipment (of the correct size!) is present in the operating theatre. The Advisory Committee felt that every hospital should have a protocol governing the availability of prostheses and specialised equipment at the time of surgery.

A SMALL, BUT URGENT, PROBLEM

(Ref. 47)

A male infant of 2 months, who had been born a month prematurely, was admitted at night with an irreducible left inguinal hernia. A surgical registrar reduced the bulk of the hernia but shortly afterwards I was informed that the infant had a tender distended abdomen and there was concern that the reduction was incomplete. An abdominal X-ray was taken and the infant reviewed by the consultant an hour after admission. The spermatic cord was thickened and palpable in the groin but was considered to be oedematous. There were dilated loops of gas-filled intestine on the X-ray. A

decision was made to re-assess the infant early in the morning as there was no convincing evidence of an irreducible hernia. However, as the position remained unchanged, a decision was made to explore the left groin on the emergency operating list. There was then a 10-h delay due to more urgent cases; when I explored the child's groin, a loop of gangrenous ileum was found in the hernial sac. This was resected and herniotomy performed. The child required 24 h on a ventilator in the intensive care ward but made a good recovery. Six months later, the left testis was smaller than the right.

A SMALL, BUT URGENT, PROBLEM (*continued*)

(Ref. 47)

Reporter's comments

With hindsight, the left groin should have been explored shortly after admission but even experienced paediatric surgeons may have difficulty assessing the completeness of reduction of the contents of an inguinal hernia. In most hospitals after midnight, an operating theatre is only available if delay would risk mortality or loss of limb. I consider that a premature infant of this age should have been given priority and taken promptly to theatre. This child had gangrene of a

segment of ileum and later evidence of testicular atrophy.

CORESS comments

The Advisory Committee agrees with the reporter that there was a failure to recognise the relevance of this infant's age and prematurity to the need for urgent surgery. Also, if there is evidence of spermatic cord compression, it suggests that the viability of the testis is at risk. Exploration is particularly urgent in these circumstances.

IT WENT TOO FAR

(Ref. 48)

A fit, middle-aged man was admitted for laparoscopic appendicectomy. Pneumoperitoneum was induced with a Verress needle and, shortly after insertion of the bladed trocar, the anaesthetist reported haemodynamic instability. Laparoscopic examination revealed retroperitoneal bleeding. There was immediate conversion to a mid-line laparotomy and involvement of the vascular surgeons. A transfixion injury to the IVC had occurred, the repair of which required two vascular consultants. Despite an unrecordable blood pressure for 15 min, he made an uneventful recovery after a week on ITU.

Reporter's comments

This patient was very slim, which increases the risk of vascular damage with the blind entry technique. The open dissection technique may well have been preferable in this particular patient. The surgical Royal Colleges no longer recommend the use of the Verress needle but it continues to be used by some gynaecologists. Damage by a bladed trocar is regularly reported. The significant risks of

haemorrhage and death with this method should be routinely discussed with the patient and clearly documented in the notes. This patient would have almost certainly died if there had been no experienced vascular surgeon available immediately. This raises the question of how the potential need for immediate vascular intervention should be organised.

CORESS comments

The Advisory Committee was grateful for this report which illustrates a situation well recognised by most vascular surgeons. Although opinions may differ about the safest way of achieving pneumoperitoneum there is no doubt that, after such injuries, deaths can occur due to insufficient early recognition and failure to control the bleeding. Vascular surgeons are not always immediately available. As in this case, the laparoscopic team must be able to stabilise the situation until the vascular surgeon arrived. This report is also a reminder of the importance of informed consent!

MALIGNANT CELL IMPLANTATION

(Ref. 49)

An elderly man underwent rigid sigmoidoscopy of the prepared bowel, under general anaesthesia, prior to haemorrhoidectomy. This showed an unexpected neoplasm, clinically a flat villous adenoma, within the rectum. Biopsies were taken and, after debate, it was decided to proceed with

formal haemorrhoidectomy, as the patient was expecting this procedure and the neoplasm seemed clinically benign. Unfortunately, later histology showed that the neoplasm was an invasive cancer. A resection of the lower sigmoid colon and upper rectum was undertaken 6 weeks later,

MALIGNANT CELL IMPLANTATION (*continued*)

(Ref. 49)

at a time when the haemorrhoidectomy wounds were only partly healed. The bowel was washed out below the tumour at the time of the operation with povidone iodine solution. The lesion was a Dukes' A cancer. Three years later, the patient presented with an adenocarcinoma deep to the scar of the right posterior haemorrhoid. Morphology of this tumour was indistinguishable from the original cancer. An abdominoperineal resection of the rectum was necessary.

Reporter's comments

The presence of large, prolapsing and bleeding piles does not necessarily account for a history of rectal bleeding and endoscopy, at the time of haemorrhoidectomy, is thus mandatory. After

biopsy of any neoplasm – even if clinically benign – further contemporaneous surgery on the distal bowel should be avoided. Luminal implantation of malignant cells is a definite possibility and can lead to catastrophe.

CORESS comments

The Advisory Committee agrees that all patients should undergo at least rigid sigmoidoscopy, and preferably a flexible sigmoidoscopy, before haemorrhoidectomy. As the Reporter notes, there have been other reports of implantation in these circumstances. As it is not possible to exclude malignancy without appropriate histological examination, it is unwise to proceed with elective haemorrhoidectomy until such histology is available.

TOO LATE

(Ref. 50)

A consultant whose list had over-run in the morning asked me to add a case to the afternoon operating list that I was already doing. She had a clinic to attend and, as there was space on my list, I agreed. She gave me a clear account of the patient who had been admitted the previous evening with an incarcerated inguinal hernia. I accepted her diagnosis but, at operation, the inguinal hernia turned out to be an area of necrotic tumour in the femoral nodes. A review of her clinical notes showed no evidence of a rectal examination but I was able to palpate a tumour low in the rectum. Biopsy of the groin lump subsequently confirmed the diagnosis of a secondary from an adenocarcinoma.

Reporter's comments

I was unwise to trust a colleague to supply all relevant information and I failed to note the lack of

a rectal examination. Always examine a patient upon whom you are going to operate. Always examine the rectum in a patient with a lump in the groin.

CORESS comments

The Advisory Committee considers that this situation is always potentially hazardous and very careful attention to handover procedures is advisable (*see also Case 37, September 2007*). It is unrealistic not to accept a colleague's diagnosis in these circumstances, but the operating surgeon is accepting responsibility for the patient and should always go as far as possible to confirm the diagnosis – in the anaesthetic room if necessary. Finally, the Committee strongly agrees with the Reporter that rectal examination (which, regrettably, is increasingly avoided) is essential in all patients with groin swellings.

FINALLY

Unrayliable

Stray radiation from linear accelerators may corrupt the memory chips in infusion pumps used in their vicinity. If a pump cannot be removed from a patient during therapeutic radiation sessions, it should be shielded and its ability to function correctly tested after the treatment.

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