CORESS
Confidential reporting system in surgery

CORESS Feedback

doi 10.1308/003588406X117061

The two cases in this issue of CORESS Feedback demonstrate the importance of reliable communication in the management of trauma. As always, we are most grateful to the reporters who have taken the trouble to pass on the lessons learned through the CORESS service.

Our website <www.coress.org.uk> now includes all previous Feedback published in the ASGBI Newsletter *as well as the on-line Reporting Form and the facility to download a form if you prefer this. If you have found the CORESS Feedback useful, why not contribute a case (or two?) yourself?*

If you would like the Association's CORESS programme director, or one of his team, to make a presentation at your local surgical society meeting or M&M, we would be delighted to help if at all possible. Please ring the CORESS administrator on 020 7973 0302.

A minor disaster (Ref. 020)

A group of cyclists were struck by a car that had skidded on a wet road while travelling at approximately 40 mph. A pre-alert call to the hospital from ambulance control stated that they were bringing in two of the cyclists but, as it was thought that they had been walking at the scene, it was concluded that any injuries were probably minor. For this reason a trauma call was not put out and I (the accident and emergency consultant) was not contacted.

When the first patient arrived, he was properly assessed by a reduced and relatively inexperienced trauma team and primary survey showed no serious injury. In particular, full trauma series radiographs were interpreted as normal. During the secondary survey, the patient became hypotensive and, on reviewing the radiographs, there was evidence of retroperitoneal haematoma associated with a fractured pelvis. The second patient arrived shortly afterwards. He was haemodynamically stable and appeared uninjured apart from a deep scalp wound from broken glass. The next day he was unable to pass urine and a CT pelvis showed fractures of both pubic rami.

Reporter's comments

First, the mechanism of injury should take precedence over unsubstantiated histories and pre-alert information. This was a high-speed road traffic accident and the full hospital trauma team should have been activated including the accident and emergency consultant.

Also, errors are more likely in emergency departments out of working hours when nursing numbers are reduced to the minimum and the number of senior doctors in the department may be less.

CORESS expert's comments

I very much agree with the reporter that the vital lesson here is the need to put out a trauma call according to clear criteria – in this case, the mechanism of injury. I suspect that had this been done and senior medical staff attended then neither injury would have been missed.

Clearly, the small and inexperienced team also played a part in the delayed diagnosis, especially in the second case but, currently, perhaps we have to make the best of those who are available. Might there be a training lesson here? For instance, new appointees, in particular, may be unaware of the local trauma call criteria. Most surgeons worry about errors occurring in their absence for which they will (usually unfairly) be held responsible and time spent in establishing clear protocols is seldom wasted.

Department syndrome (Ref. 014)

A man was admitted to our emergency department having been knocked down in the road in the absence of any reliable witnesses. A primary ATLS survey was done by the trauma team and the patient was found to be haemodynamically unstable with a tender abdomen. A CT scan indicated a substantial intraperitoneal bleed from a ruptured spleen so the patient was taken directly to theatre and I

CORESS
Confidential reporting system in surgery

Department syndrome – *continued* (Ref. 014)

assisted the registrar with an unavoidable splenectomy. Before leaving the operating theatre, I looked at the clinical record and noted that no secondary survey had been done to identify other injuries. I therefore asked that this be done and went home to bed.

The patient was transferred to ITU from theatre and 3 days after surgery was sufficiently alert to complain of pain in the left groin. Imaging revealed an impacted fracture of the left femoral neck and, on reviewing the records, it was clear that no postoperative secondary survey had been done. Fortunately, the patient suffered no long-term harm due to delayed diagnosis and, after appropriate explanation and apology, expressed his gratitude to the surgical team.

Reporter's comments

I think that this case shows the importance of a secondary survey, along ATLS guidelines, as quite serious injury can otherwise be missed. We have had recent problems with handover in our hospital and this case is an example of this. Also, I now regret that I did not check that the secondary survey had been done, even though the patient was in ITU and being managed by another consultant.

CORESS expert's comments

I was impressed with this honest report and the lessons learned from circumstances that are increasingly familiar to many of us. Clearly, ATLS guidelines exist to maximise the outcome after severe injury and they should have been followed in the emergency department. As in the previous case, I wonder whether there was a training issue here.

Rapid transfer from one department to another greatly increases the risk of error unless not only handover but also documentation is of a high standard. I agree with the reporter that this fracture would not have been missed if this had been the case. I would suggest that a regular review of local handover arrangements is increasingly important – particularly when trainees rotate to different teams twice a year.

Nevertheless, as the reporter frankly admits, the fundamental responsibility for this patient's care remained with the admitting surgeon. Few of us have not given a last minute instruction as we leave theatre to return wearily to bed. After all, we have to work the next day! But perhaps we would be wise to write it down – and check the next morning?