

coress feedback

This edition of CORESS Feedback contains a number of cases that emphasise the need for good communication between surgeons themselves and with their patients. Attention is drawn to some common problems (needlestick injuries and providing advice on driving to patients with surgical conditions) for which there is sometimes confusion over correct management.

We are grateful to those who have provided the material for these reports. The online reporting form is on our website (www.coress.org.uk), which also includes all previous Feedback reports. Published cases will be acknowledged by a 'Certificate of Contribution', which may be included in the contributor's record of continuing professional development.

Explosive gastrostomy (Ref 206)

I was called by the gynaecologist, who had taken a patient back to theatre with a burst abdomen five days after a Caesarean section. The patient had been doing well up to that point. On the day of the burst abdomen, she had eaten a large meal at midday. The abdomen had become distended and painful following this, and about five hours later, the abdominal wound had burst.

The gynaecologist was worried as he was not sure what the cause of the distension was. I found that the middle section of the small bowel was moderately distended but with no obvious cause of obstruction. I extended the incision superiorly and found the stomach to be massively distended despite the presence of an 18G nasogastric tube. I asked for the tube to be aspirated without success. I requested the tube to be replaced with a larger one. No larger nasogastric tubes were available so a further 18G tube was inserted. Again, it was not possible to aspirate the tube. The tube was removed and found to be blocked by grains of rice. I therefore decided to decompress the stomach via a gastrostomy.

I placed a purse string suture on the antrum of the stomach and opened the stomach using diathermy. I usually use diathermy to open the small bowel and stomach (unless bowel obstruction is present) to minimise bleeding. On gaining access to the stomach lumen, there was a loud explosion, and the operative field and staff were covered with grains of rice. The distal half of the stomach had a large anterior rent and the rest of the wall was severely contused with a number of shorter, full-thickness lacerations. I proceeded to perform a partial gastrectomy with a Billroth I reconstruction. Thankfully, the patient has made a good recovery from her surgery.

Reporter's comments

A combination of rice and gastric acid led to fermentation. As a trainee, I had been taught not to use diathermy to

open dilated bowel because of the risk of gaseous explosion but I had never encountered this previously. I performed the gastrostomy with diathermy, without relating the gross gastric dilation to the risk of production of explosive gases. Explosive gases are produced in the stomach and can occur even without bowel obstruction.

CORESS comments

CORESS is grateful for this reporter's interesting and honest contribution, and includes the reporter's further comments below:

'I would like to use this event to help my colleagues and me to develop a more open and educational system for reporting and learning from adverse events. I am Head of Surgery at a major government hospital in a developing country. I have previously worked in the UK. Currently, we do not have a system for reporting or educating staff in preventing or dealing with adverse events and near misses. Most adverse events are not reported. I see this case as an opportunity to show staff that being open and discussing problems can lead to improvements in care and that they can be dealt with in a blame free manner.'

Second appendicectomy? (Ref 207)

A 52-year-old male patient with right iliac fossa pain was admitted with suspected appendicitis. He had a history of a similar presentation ten years earlier, when he had undergone a diagnostic laparoscopy. He was kept under observation. Blood tests and abdominal ultrasonography were normal. (The appendix was not visualised.) The pain persisted unchanged and remained severe.

On the third day of admission, the patient was listed for a diagnostic laparoscopy by the responsible consultant. However, the consultant was not available to supervise the on-call registrar, who was not able to perform the laparoscopic procedure independently. The on-call consultant did not agree with the plan and was not happy to support any operation. The responsible consultant then requested the operation to be changed to an open appendicectomy, which could be undertaken by the on-call registrar.

Open surgery revealed that the patient had, in fact, undergone a laparoscopic appendicectomy at his previous admission and that the history concerning a previous simple diagnostic laparoscopy was incorrect. No cause for the pain was found. The patient made an uncomplicated recovery from an unnecessary operation.

Reporter's comments

Patients often forget procedural details and may provide incorrect information unintentionally. In this case, simply referring to his GP summary of past medical problems would almost certainly have avoided this unnecessary operation.

CORESS comments

The operation was delegated to a trainee and a compromise was made in terms of the procedure performed, which was not in the patient's best interests. There does not appear to have been any direct communication between the responsible consultant and the on-call consultant, and there was no collegiate approach to patient management. Formal consultant-to-consultant handover and good communication are vital components of a modern, safe surgical service.

A matter of consent (Ref 208)

A patient of mine, admitted as a day case for repair of a paraumbilical hernia, was taken to theatre and given a general anaesthetic before I had seen her preoperatively. It is my practice to see all my patients preoperatively, mark the surgical site appropriately, and sign and date confirmation of consent on the consent form. However, it is also normal practice at my institution for a senior ward nurse to undertake and document patient consent. In this case, the theatre staff noted that the consent form had been signed by the ward nurse and assumed that I had also seen the patient. The patient was therefore taken to theatre and given a general anaesthetic without me being informed. Luckily, the hernial defect was still palpable after anaesthesia so I repaired it. The patient had an uncomplicated recovery and was discharged home later that day.

Reporter's comments

This was a problem with a system that allowed consent to be undertaken by someone other than a member of the surgical team in order to increase speed and efficiency. In the event, it did not achieve the latter. There was failure of communication. All patients admitted for a procedure under general or regional anaesthesia should be seen by the operating surgeon preoperatively to ensure that the procedure is appropriate, the surgical site is marked correctly and informed consent has been obtained.

CORESS comments

The following documents set out principles of consent:

Royal College of Surgeons of England – *Good Surgical Practice* (2014)

3.5.1 Ensure that consent is obtained either by the person who is providing the treatment or by someone who is actively involved in the provision of treatment. The person obtaining consent should have clear knowledge of the procedure and the potential risks and complications.

General Medical Council – *Consent: Patients and Doctors Making Decisions Together* (2008)

26 If you are the doctor undertaking an investigation or providing treatment, it is your responsibility to discuss it with the patient. If this is not practical, you can delegate the responsibility to someone else, provided you make sure that the person you delegate to:

- (a) is suitably trained and qualified
- (b) has sufficient knowledge of the proposed investigation or treatment, and understands the risks involved
- (c) understands, and agrees to act in accordance with, the guidance in this booklet.

27 If you delegate, you are still responsible for making sure that the patient has been given enough time and information to make an informed decision, and has given their consent, before you start any investigation or treatment.

An observation from the CORESS Advisory Committee was that 'the road to litigation is paved by assumptions'.

Needlestick lesson (Ref 205)

I sustained a needlestick injury during closure of the abdomen. I was using a straight hand needle and was hurrying to complete closure so we could get the next case on table. I became momentarily distracted when the scrub nurse asked for a second swab count.

I should have been using a forceps to retrieve the needle after each bite but wasn't. I didn't know the needlestick protocol but I sought advice and do now!

Reporter's comments

Know the needlestick protocol. Stop operating immediately, de-scrub and wash the wound. Your blood should be tested and occupational health informed. Someone else should inform the patient and obtain consent for a blood sample for testing for HIV, hepatitis B and hepatitis C.

CORESS comments

Despite universal precautions and safe practice, needlestick injuries will occur. All surgeons should be aware of the procedures to be followed in the event of a needlestick injury and of the protocols in their own unit. Useful guidance can be found in *Section 2 – Managing Exposure* of the NHS *Needlestick Injury* document at:

<http://www.nhsemployers.org/~media/Employers/Documents/Retain%20and%20improve/Needlestick20injury.pdf>

The law says you should not be driving! (Ref 210)

A 75-year-old woman presented to the eye clinic 4 months after being referred by her own GP, following an incidental finding of left hemianopia at the opticians. By the time the patient arrived in clinic, her visual field loss has worsened and she admitted that she 'can't see a rabbit running across the road until it's too late'. She also said her car had been written off following an accident, in which she had

she collided with a stationary car at the side of the road because she had not seen it.

The patient lived in a village. She said that she still had good distance vision so she would be careful, drive slowly and only in the daylight. She was informed emphatically that the law was clear that she should not be driving. Her GP was informed and the patient was asked to contact the Driver and Vehicle Licensing Agency (DVLA) immediately.

Reporter's comments

This case highlights the fact that doctors, opticians and patients are often not aware of visual factors that limit the right to drive. The outcome was exacerbated by delay in the primary referral.

Although no harm was done (except to the parked car), this report raises a very important safety issue. The situation should have been dealt with much earlier and the patient asked to contact the DVLA. Awareness of visual driving standards should be raised among all involved parties,

including GPs, opticians and patients themselves. There is a misconception that if you can see well in the distance (car registration plate at 20m), you can drive. Double vision and visual field loss pose serious risks for driving.

CORESS comments

Although this is a case submitted by an ophthalmic specialist, there are a number of surgical conditions that place restrictions on driving. Examples include cardiac and vascular conditions such as aortic aneurysms and carotid stenosis with transient ischaemic attacks, hand surgery, and some malignancies. Surgeons need to understand their responsibilities and should familiarise themselves with the conditions common to their specialty so that they can provide patients with appropriate advice. DVLA advice with respect to specific surgical conditions can be found at:

<http://www.gov.uk/guidance/current-medical-guidelines-dvla-guidance-for-professionals>