

coress feedback

CORESS feedback

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More perils of pooled lists: carotid confusion (Ref 211)

In order to meet guidelines with respect to urgent carotid surgery, I was asked by a colleague to undertake a right carotid endarterectomy on a 75-year-old woman. I met the patient on the morning of surgery. On review of the notes, there seemed to be some confusion as to which side her neurological symptoms had occurred. Notes written by different doctors variably documented left or right-sided symptoms and the overriding reason for listing for surgery had been documentation of 'free floating thrombus' in the right internal carotid artery, on computed tomography (CT) angiography. Conflicting ward-based duplex imaging, of only the right carotid artery, had been obtained, on which no thrombus was noted but plaque causing a '50–69% stenosis' was seen at the origin of the internal carotid artery.

The notes also documented concern by a junior doctor that the patient seemed too confused to provide informed consent. On eliciting a careful history from the patient, it emerged that she was fully lucid but had significant residual expressive dysphasia (interpreted by the junior doctor as confusion) from a previous left hemispheric cerebrovascular accident, which made obtaining an accurate history convoluted. On the morning of her supposed recent symptoms, her blind partner had thought that her speech was a little worse and had dutifully examined her, believing that on palpation she seemed to have a weakness on one side of her face. This had resulted in her referral to hospital and the prompt for CT angiography. The patient herself denied any new symptoms.

Rather than proceed to surgery, further duplex imaging of both carotid arteries was undertaken in the vascular laboratory, at which time both carotids were noted to be free of thrombus, with less than 50% internal carotid artery stenoses. The patient was relieved to be discharged from hospital without an unnecessary operation, on best medical therapy, with a routine follow-up outpatient appointment.

Reporter's comments

This case illustrates the risks of pooled lists. A series of factors contributed to inappropriate listing of the patient for

surgery. The history was not straightforward and was compounded by the patient's expressive dysphasia. Existence of clear symptomatology was not established and there were discrepancies between investigations. Weight was placed on the blind partner's assessment of the patient for facial weakness.

CORESS comments

When undertaking pooled operation lists or surgery on a patient previously unknown to the surgeon, it is the duty of the operating surgeon to ensure that he or she is satisfied that the patient will undergo the correct procedure. This involves obtaining an adequate history, examining the patient and reviewing relevant investigations. Good handover communication is essential. The operating surgeon remains responsible (and liable) for surgery and must reassure himself or herself that the appropriate procedure is performed for the correct indications.

Omental extrusion (Ref 212)

A 25-year-old patient underwent an emergency laparoscopic appendicectomy. During the procedure, it was noted that the appendix was perforated and there was purulent fluid in the pelvis. A 24Fr Robinson drain was inserted and placed through the suprapubic port into the right iliac fossa. The patient recovered well and two days postoperatively, the drain was removed on the ward.

When the drain was retrieved, a large part of the patient's omentum extruded from the wound with the drain. The patient was returned to theatre for omentectomy and relaparoscopy. On inspection, the omentum had been pulled out of the abdominal cavity because 4cm of omentum was stuck firmly in the distal drain lumen.

Following discharge from hospital, the patient was subsequently readmitted with hospital acquired pneumonia, requiring CT pulmonary angiography as well as CT of the abdomen and pelvis. Necessity for a second general anaesthetic may well have contributed to this further complication, readmission and radiation exposure.

Reporter's comments

A smaller drain might have prevented omentum becoming stuck in the lumen although this problem is recognised with all suction drains. When a drain is placed during laparoscopic surgery, if a clip is not applied to the end, the positive pressure pneumoperitoneum will vent out of the drain, potentially entraining omentum or even bowel into the drain lumen. Over a period of several days, this tissue becomes

oedematous and trapped in the lumen, complicating drain removal as above.

An appropriately sized drain should be selected for each case. When inserting a drain in the presence of a pneumoperitoneum, care must be taken to prevent entraining of intra-abdominal contents into the lumen, by clipping the end of the drain to prevent venting.

CORESS comments

Use of drains in abdominal surgery remains a matter for debate. Ensuring that all gas is vented adequately at the end of laparoscopic surgery should reduce the risk of forcible entrapment of peritoneal contents in a drain. The drain should be the smallest required to do the job effectively. Use of suction drains should be avoided in the abdomen.

Delayed healing due to retained GranuFoam™ in negative pressure wound therapy (Ref 213)

A 72-year-old diabetic man, with a body mass index of 39kg/m², underwent laparotomy and bowel resection for perforated diverticulitis. On the seventh postoperative day, the cephalic section of his abdominal wound started to discharge purulent fluid and a superficial wound infection was diagnosed. He was commenced on antibiotics but the wound broke down. A cavity of approximately 10cm developed and negative pressure wound therapy (NPWT) was employed to manage exudation, encourage granulation and expedite healing.

GranuFoam™ (KCI, San Antonio, TX, US) was used with the NPWT system and after several dressing changes, the patient was discharged home, for his wound to be managed with NPWT by the district nursing team. The wound responded with reduction in depth and development of granulation tissue. After six weeks, NPWT was discontinued, a surface dressing was applied to encourage epithelialisation and he was discharged to primary care.

The patient was referred back to the tissue viability nursing team nine months later with a chronic abdominal sinus. The surgeon responsible for the original procedure reviewed the patient and re-explored the wound. At reoperation, a 2cm piece of foam dressing was found incorporated in the granulation tissue, preventing the wound from fully healing.

Reporter's comments

It became apparent that it was not common practice to document the number of foam pieces packed into a cavity during dressing changes. It was also uncommon to count them out again. Dressing changes were rarely performed by the same clinician. In order to prevent this incident from occurring again, foam dressings that are cut to shape and do not dissolve should be documented in the clinical records, to prevent retention of a foreign object causing infection. This may require changes in routine practice. The patient's wound subsequently healed completely, nearly a year following the original emergency surgery.

CORESS comments

This case raises awareness that foreign objects can prevent wound healing. Foam dressings should be designed to function with the appropriate NPWT system and all foreign materials should be removed to aid healing in such circumstances. Wounds should be inspected carefully to ensure this has taken place.

Malignant pathology missed (Ref 214)

I was conducting a general surgery clinic in a peripheral hospital. My registrar saw a patient who had been referred with an axillary lymph node. On examination, it was clear that this was in fact a solitary group of firm lymph nodes. The registrar took a careful history, which included the fact that two years previously, the patient had undergone removal of a skin nodule from his back under local anaesthesia. This had been performed by a locum general practitioner (GP), at another practice, before the patient moved areas and changed GP practice. The scar on the patient's back had healed well but there was a little local induration.

My registrar phoned the laboratory for a copy of the histology report, which had not been included with the referral. The report suggested that the lump was malignant and was incompletely excised. The original report was not in the patient's GP records and could not be found. The original GP practice admitted liability. The locum GP had left the country and was not contactable.

Reporter's comments

This was a major system error. An appropriate outcome depended on one person seeing the report and taking action. There was no back-up system. The GP practice had provided the patient with a follow-up appointment, which he failed to attend because he had moved, but the practice did not follow up the report when there was no response from the patient. The patient assumed that all was well having not been contacted. There were no checks in the pathology department to ensure that someone was acting on the report of malignancy. Clinicians are under pressure to reduce outpatient follow-up appointments, at which important clinical data can be reviewed before a patient episode is formally closed.

CORESS comments

This is an increasing problem; individual responsibility for patient management and follow-up review has been eroded by the introduction of pooled clinics, multidisciplinary team meetings at which the primary clinician responsible for the patient may not be present and failure to develop red-flag systems, which ensure that important clinical results are acted on. A system should be in place to make sure that relevant pathology reports are reviewed by the responsible clinician and acted on appropriately.