coress Feedback

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This edition of *CORESS* Feedback includes a lesson (35) learnt by every generation of surgeons. It reminds us that although learning from others can alter behaviour, errors tend to return and lessons must be repeated. Originality is not a necessary condition for reports and *CORESS* is grateful to surgeons who give us the opportunity to repeat these important lessons. Many surgeons are understandably preoccupied with the current disarray in the NHS, and may be reluctant to send reports to *CORESS* at this time. *CORESS* needs your input for a high quality output. If you value this Feedback, please remember that the *CORESS* on-line reporting form is at **www.coress.org.uk** It does not take long to let other surgeons learn from your experience.

TRY, TRY, TRY AGAIN?

(Ref: 31)

My SHO recently took a man to theatre with a clinical diagnosis of peri-anal abscess. When no abscess could be found with a "white" needle, I was called and, despite agreeing with the clinical diagnosis, could neither aspirate any pus nor identify an abscess on laying open the superficial layers of the wound. However, an MRI clearly showed a large peri-rectal abscess so the patient was returned to theatre. Again it proved impossible to aspirate pus at which point the SPR suggested that I might be using a "filter" needle. On changing the needle to a different type, pus drained immediately and open drainage was achieved.

Reporter's Comments:
The prepared packs for incision and drainage of ano-rectal sepsis contained a filter needle as they were mainly used for elective work which required the drawing up of local anaesthetic. This has been addressed but it is easy to see how it happened.

CORESS Expert's Comments:
The Advisory Committee were most grateful for this timely warning. Filter needles are used to avoid aspirating organisms and foreign material when drawing up fluids from glass vials. They are particularly used for intrathecal injections. Although not in widespread use in operating theatres, the potential for misuse is clearly present. Aspiration is an acceptable diagnostic measure and/or treatment for ano-rectal sepsis but the correct equipment must be used!

BACK TO BASICS

(Ref: 32)

An elderly man, with a past history of abdominal aortic aneurysm repair, was referred to the gastroenterologists for investigation of dyspepsia. Investigation showed him to have iron deficiency anaemia but OGD and colonoscopy were normal. A year later he was admitted as an emergency with haematemesis and melaena and was given a blood transfusion. Once more he was investigated by the gastroenterologists with OGD and colonoscopy without finding a source of the bleeding. A further year later he was admitted with a further melaena and I was asked to see him. Investigation showed an aorto-enteric fistula which was repaired successfully.

Reporter's Comments:
I believe that this patient should have been referred to a vascular surgeon much sooner. It is always necessary to exclude aorto-enteric fistula in an anaemic patient with previous abdominal aortic aneurysm repair and delay in treatment leads to a very high mortality.

CORESS Expert's Comments:
The Committee very much agree with reporter's comments. This story is all too common and certainly not confined to the realm of gastroenterology. Management must include a thorough history and physical examination and all surgical scars should be accounted for. Substantial or occult blood loss in a patient who has undergone an abdominal aortic aneurism repair is always due to an aorto-enteric fistula until proved otherwise.

CONFIDENTIAL REPORTING SYSTEM IN SURGERY

CONSTIPATION...OR PERFORATION?

(Ref: 33)

A fit elderly man was admitted as an emergency with a short history of obstructive symptoms from a small carcinoma of the sigmoid colon. He had appropriate pre-operative preparation, but without mechanical bowel cleansing. On the following day he underwent sigmoid colectomy with standard antibiotic prophylaxis and post-operatively was transferred to ITU. On the 3rd post operative day he had not yet opened his bowels and was prescribed a regular laxative by the ITU SHO. This was not noticed by the surgical team over the weekend and was given for 3 days, until stopped by the consultant on Monday morning. On Monday afternoon he deteriorated and CT scan confirmed anastomotic leakage. At laparotomy the anastomosis had completely dehisced. He had a Hartmann's procedure and made a very protracted recovery.

Reporter's Comments:
I do not think that laxatives should be used immediately following bowel anastomosis without Consultant approval. The surgical team should check drug charts daily.

CORESS Expert's Comments:
The Advisory Committee agreed with the reporter that there appeared to have been a failure of senior supervision in the ITU. Evidence of anastomotic leakage in the early post-operative period may be very subtle and not apparent to a relatively inexperienced trainee. Drugs were written up by the ITU doctors without reference to the surgical team who do not seem to have checked the drug chart or electronic record on a regular basis. Surgeons do, of course, rely heavily on the expertise of colleagues but responsibility for the post-operative patient remains with the surgical team, even in the most difficult circumstances.

The BNF states that parasympathomimetic laxatives should not be used after bowel anastomosis. Although there is no objective evidence that laxatives cause leaks, their use can certainly complicate diagnosis. The Advisory Committee agreed with the reporter that laxatives should be avoided in these circumstances except after careful consideration by an experienced clinician.

MINUTES COUNT!

(Ref: 34)

A young man came to our A&E with an hour's history of acute pain in his single descended testis. The surgical registrar made a clinical diagnosis of acute testicular torsion and asked the anaesthetic SHO to see the patient in A&E with a view to immediate surgery. The anaesthetist could not come immediately and the patient was, therefore, transferred to the ward. The original anaesthetist had by then gone off duty and there was further delay for handover to another trainee anaesthetist who was concerned that the patient was not fully starved. I was then contacted, spoke to the duty anaesthetic consultant, after which the patient was immediately taken to theatre. At operation the single testis was untwisted but was only partly viable.

Reporter's Comments:
Acute testicular torsion is an acute emergency and needs urgent surgery. Delays are not acceptable and a consultant anaesthetist may be required if anaesthetic problems are anticipated.

CORESS Expert's Comments:
The Committee strongly endorsed the reporter's comments. The admitting doctor should either assert his/her authority or contact the appropriate consultant immediately.

Minutes count. Both the MDU and the MPS are aware of this recurring problem and have referred to it in their publications. Sadly, further reminders are clearly needed.

COMMUNICATE, COMMUNICATE,.....

(Ref: 35)

An elderly man was admitted to a medical ward with pneumonia and a CT scan showed multiple nodules throughout both lung fields. He then suddenly developed lower abdominal pain and a provisional diagnosis of appendicitis was made. An ultrasound scan showed multiple gall stones but the radiologist noted the marked tenderness and advised a CT scan which was said to show an appendix abscess. He was then seen by the duty Consultant Surgeon who wrote in the notes that a perforated viscus, possibly a colonic primary, was the most likely diagnosis and despite his co-morbidity, he needed an urgent laparotomy which he asked his Registrar to arrange. However, due to a change of shifts, a different registrar explored the abdomen through a Lanz incision and found what appeared to be a gangrenous appendix. The registrar had difficulty closing

the appendix stump and post-operatively the patient developed a faecal fistula. Three weeks later, a CT scan and colonoscopy showed a perforated hepatic flexure carcinoma associated with an abscess cavity draining through the fistula. In due course this was successfully resected.

Reporter's Comments:
There appear to be several things to learn, none of which, of course, are in any way new. Firstly, there were communication problems at several levels especially between the duty consultant and registrar and in the registrar's handover. Secondly, when the clinical picture does not fit the X-rays, treat patients not X-rays. Thirdly, we should have gone back to the beginning and re-thought the diagnosis rather than pursuing the original diagnosis long after it ceased being very likely.

CORESS Expert's Comments:
The Advisory Committee agreed with reporter's comments. It is also difficult to understand why the operating registrar failed to inform the duty consultant when, after an inappropriate incision, difficulty was experienced in theatre, particularly when the consultant's diagnosis was not confirmed. Handover between the registrars appears to have been inadequate - a feature of previous CORESS reports - and this subject has recently been addressed by the publication of guidance by the Royal College of Surgeons of England (*Safe handover: Guidance from the Working Time Directive Working Party; March 2007*) http://www.rcseng.ac.uk
Meanwhile, handover arrangements remain a consultant responsibility - often difficult to fulfil.

FINALLY...

Failed to Click

Investigations into loss of output during diathermy have revealed the use of diathermy electrodes that are incompatible with the generator. It is important to be aware that electro-surgical instruments from one manufacturer are not always compatible with the generator of a different manufacturer.

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SHOs: "THE LOST TRIBE" OR A LOST OPPORTUNITY?

The recent debacle of MTAS has served to highlight the ever-increasing disillusionment and deep unhappiness of the medical profession with Government micromanagement in a whole range of medical and health areas. Issues such as the GP and Consultant Contracts, Choose and Book, Connecting for Health (CfH), privatisation, lack of strategy for specialist services and an overwhelming, almost evangelical, desire for change at any cost have further fuelled this disenchantment. Despite these problems, the most pressing issue must be the future careers of our medical and surgical trainees.

The principles behind the drive for change in medical training are commendable and the development of the foundation years have, in general, been received well, although the evidence base for tangible benefit is, to date, absent. The concept of (what is effectively) a two-year internship is desirable, given the reduction in hours and the seemingly ever-increasing amount of non-clinical and clinical information that is pushed upon our students. The problem comes when a career choice in a speciality/General Practice has to be made. This problem is particularly acute in surgery and its specialities.

MTAS: Selection and short-listing
This was unquestionably a disaster. It was predicted by many but ignored by the few decision-makers who felt they knew better. Some people have recently suggested that because the candidates in round 2 have not been found to be as good as round 1, this vindicates MTAS. It would be truly staggering if the second round candidates in MTAS were as good as the first round. The point that many of us have made was that there were some excellent candidates that did not get short-listed when they should have been, not that the majority of candidates left out were worthy.

MTAS is inherently a flawed system in terms of selection, the IT system and process. Importantly, this point has been conceded by the DoH and Mrs Hewitt herself, rendering it vulnerable to successful legal challenge even by candidates who we would all generally agree are not up to the mark.

Using MRCS type questions on surgery/medicine is educationally unsound in those candidates who have already demonstrated competence by passing the MRCS (SpR2/3). This is true even if we subscribe to the notion that this exam has been 'dumbed-down' in recent years; (you are asking one or two selected questions on candidates who have previously passed in a far more exacting and rigorous competence examination system already).

Using aspirational statements on "why I want to be a surgeon" to shortlist candidates is ridiculous. The one certainty is that the candidate will not have written the statement. If they have, then he/she will likely run the risk of non-selection (very similar to ACAS selection of medical students!).

Participation in MTAS and appointing candidates for training under the new system means effectively that the deanery will be contractually obliged to provide seamless training for the candidate for six years. This is the case even though MMC, as it is currently planned,