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CORESS Feedback

CONFIDENTIAL REPORTING SYSTEM IN SURGERY

This edition of CORESS Feedback highlights problems that can arise due to failure of a patient to attend follow-up clinics. The fact that patient doesn't attend follow up, for whatever reason, does not necessarily absolve the surgeon from the clinical duty of appropriate care. Surgeons should make themselves aware of their Trust's policy with respect to follow-up for patients who fail to attend a booked appointment.

The case of anaphylaxis in association with injection of blue dye thankfully appears to be a rare occurrence. However, surgeons should be aware of this risk and should ensure that they remain familiar with resuscitation principles and of the availability of appropriate equipment in their working environment.

CORESS is grateful, yet again, to the surgeons who are prepared to support the programme by sending reports. The on-line reporting form is on our website www.coress.org.uk which also includes all previous Feedback Reports.

DID NOT ATTEND (1)

(Ref: 55)

A patient was referred to me for surgery for a pituitary tumour. He underwent successful surgery and was discharged on a safe dose of replacement steroid with written instructions on the take home medications, which were prescribed for two weeks. He was also given clear advice, in the form of patient information notes, on what he should be taking. He missed his six week multidisciplinary review clinic. In fact, he attended on the wrong day drunk and abusive, was briefly seen by my clinic nurse specialist and a subsequent appointment booked. He was then lost to follow up as he had moved away, but two years later was referred by his original GP, who had established contact with him again. By this time he had put on a huge amount of weight and was Cushingoid as a result of a temporary GP prescribing double the correct dose of hydrocortisone. He sued the Trust for loss of earnings because of back pain caused by obesity, although it was established by the Trust solicitors that he had not worked for a number of years prior to these events because of a bad back. However, the Trust agreed a small payment because they did not have a clear policy for tracking patients who did not attend (DNA) outpatients.

Reporter's Comments:

I am aware that difficult, substance-abusing, patients with considerable reason to be grateful can still be awkward and litigious.

Unfortunately, in this case, I failed to fully appreciate the importance of chasing up DNAs.

CORESS Comments:

Prescribing in general practice is the responsibility of the GP. However, if a patient has an out-patient appointment - even if unfulfilled - the surgeon still has a responsibility for care which may involve more than simply informing the GP. Although this may not accord with the policy of the local PCT, the CORESS Advisory Committee believes that the surgeon should be able to demonstrate due diligence in handing over care of the patient to the GP.

The importance of follow-up should be explained to the patient before his discharge and recorded in the patient's notes. Since procedures following non-attendance at outpatients have been a source of litigation, surgeons should be aware of their Trust's individual DNA policy.

DID NOT ATTEND (2)

(Ref: 56)

A paediatric patient had an uneventful Nissen fundoplication for severe gastro-oesophageal reflux. Five years after the operation he attended a joint spinal and neurology clinic for advice on his kyphoscoliosis. A spinal X-ray demonstrated loops of small intestine in a large hiatus hernia. This was reported by the radiologist but he had no gastro-intestinal symptoms and was not referred back to me - his original surgeon. Two years later, he presented as an emergency with a small bowel obstruction. On chest X-ray, the left hemithorax was almost filled with dilated loops of bowel. At operation, I could only reduce the small bowel into the abdomen with difficulty and a resection was required for an ischaemic strictured segment. Fortunately, he made an uneventful recovery and was discharged home ten days later.

Reporter's Comments:

There was lack of communication between paediatric neurologist, spinal surgeon and radiologist with the surgeon who had performed the fundoplication. Post-operative hiatus herniae all require a prompt surgical review. Those containing loops of small bowel require surgical repair before symptoms of obstruction occur. Waiting until there are ischaemic changes to the bowel must increase the morbidity and mortality of this recognised complication.

CORESS Comments:

The Advisory Committee agreed with the above and, in addition, questioned the role of the supervising Consultant Paediatrician in this case. It was recognised, however, that non-specialists may not necessarily interpret the significance of unusual radiological findings with which they may not be familiar. Don't avoid obtaining a specialist opinion if something appears odd! When a patient requires multidisciplinary care, good communication between specialists forms the basis of sound medical management.

BLUE DYED - NOT QUITE

(Ref: 57)

A lady who denied any allergies was to undergo breast cancer surgery (mastectomy + axillary node sampling with blue dye). After I injected Patent Blue Dye in the subareolar and peritumoral plane, she developed extensive peripheral oedema, rash, and blue staining on her face, hypovolaemic shock and bradycardic arrest. Surgery was postponed and she was transferred to ITU where she was treated with adrenaline infusion and renal filtration. She remained in ITU for 3 days before discharge from hospital at day 5, on reducing doses of prednisolone. She is currently well and awaiting her breast cancer surgery.

Reporter's Comments:
Blue dye anaphylaxis is a recognised complication in sentinel node surgery. The incidence is generally considered to be 1% but there are some reports of up to 2.5 %. Despite this low incidence, it is difficult to defend routine usage when events like this happen. There is some published usage of routine prophylactic hydrocortisone and piriton. We are looking into such prophylactic protocol. Has anyone encountered such problems with other dyes in these circumstances?

CORESS Comments:
The Advisory Committee considered that the use of radioactive isotope in combination with Blue Dye gives the best results but neither is entirely reliable. The technique is widely regarded as safe and increasingly used despite the occasional allergic reaction. Adverse reactions to blue dyes may be dose-related. Patients should be asked about previous reactions to blue dyes, or other episodes of anaphylaxis and use of dye avoided in these cases. Technique is important - especially avoidance of inadvertent IV injection. Reactions may be biphasic and dye should only be given when the anaesthetist has good venous access and control of airway. Surgeons should be well-versed in resuscitation techniques. The figures given above seem high and the Committee would be interested to hear the experience of other surgeons who might have seen this complication. (Unpublished data from an anecdotal survey of members of the Association of Breast Surgeons at BASO, undertaken by the Advisory Committee, suggests an incidence of 3 in 2987 cases, from 9 pooled series - Ed).

UNSOUND?

(Ref: 58)

A middle aged man was admitted as an emergency complaining of epigastric, flank and chest pain. He was hypotensive and very unwell but an ECG was not diagnostic. An ultrasound scan was undertaken by an A&E staff grade doctor who was confident that an abdominal aortic aneurysm was present. He was then seen without delay by the duty surgical Registrar who felt that he could have leaked from the AAA. I was in theatre at the time finishing an elective case and gave instructions for the patient to be brought straight up to the vacant emergency theatre. When I examined him on the table he was hypotensive and it was difficult to either confirm or exclude a ruptured AAA. We decided to proceed and after a crash induction performed a midline incision. He did not have a ruptured AAA. The ultrasound appearance was due to a congested left lobe of the liver from cardiogenic shock caused by an inferior myocardial infarct.

Reporter's Comments:
There are issues around non-radiological staff doing ultrasound scans and their training. Doctors doing ultrasounds in departments such as A&E do need to be trained and monitored and know where to go for immediate advice. In this case, there was no written report and no retained pictures. A more experienced sonographer might have realised that the aorta was normal. If I had examined him in the A&E dept I could have questioned the doctor who did the ultrasound. Also, we did not report this as an incident immediately using the Trusts reporting system and, as a result, when later enquiries were made, the Trust management knew nothing about it. Always report these events immediately - it can save a lot of embarrassment!

CORESS Comments:
The Advisory Committee assumed that no ECG changes were apparent on induction and in these circumstances agreed that, even without diagnostic ultrasound, immediate laparotomy was appropriate management. Indeed, a patient with a ruptured aneurysm may often have an altered ECG. CT is a more reliable diagnostic method, but should only be used for a stable patient and when the investigation can be undertaken rapidly. Certainly, 'casual' ultrasound is unacceptable. A report should be written in the notes and, if there is doubt of confidence in the diagnosis, then the surgeon should be made aware of it. The Reporter raises an important issue with respect to training. When a surgeon or physician employs a diagnostic technique, it is essential that he/she has received appropriate training in performance of the technique and in data interpretation.

FINALLY...

MRHA have received a report of povidone iodine staining intra ocular lens material causing it to become opaque. This solution should not be used on an open wound following intra ocular lens implantation.

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