

A central theme of checking patient details and performing appropriate procedural checks runs through this edition of Feedback. This is appropriate when the adoption of formal preoperative checks in the form of the WHO surgical checklist has been emphasised in a recent NPSA safety alert and published elsewhere in this Newsletter.

The CORESS Advisory Committee and Board of Directors have agreed that future contributions to the confidential reporting process will be acknowledged by a certificate which will be issued to the reporter if so wished. It is hoped that this certificate may be useful as a record of contribution to CPD and may be used in the contributor's portfolio for appraisal purposes. All details of the contribution will remain confidential. CORESS also wishes to encourage trainees to recognise the value of the reporting process as an example of reflective practise.

As ever, we are grateful to the clinicians who have provided the material for these reports. The on-line reporting form is on our website www.coress.org.uk which also includes all previous Feedback Reports.

INCORRECT RECORD OF PATHOLOGICAL DIAGNOSIS (Ref: 63)

A 65 year old patient underwent right upper lobectomy for a suspicious right lung mass. Histological diagnosis of a resected plasma cell granuloma was recorded in the notes and the patient was eventually discharged, with no further treatment planned. Two years later, the patient was re-admitted with a recurrent right lung mass. After assessing operability, right lower lobectomy was undertaken. Histological examination on this occasion suggested a plasmacytoma. Since plasmacytomas tend to be more aggressive than plasma cell granulomas, with low five-year survival rates, the original histology report was reviewed. In fact, this confirmed that the originally resected tumour had identical features to the (re)current tumour (plasmacytoma), but the report had been inaccurately copied into the patient's discharge summary, with consequent incorrect labelling of the disease process, a situation perpetuated in the subsequent notes.

Reporter's Comments:

The importance of concise and accurate note-taking and production of discharge summaries is evident. Incorrect transcription of important medical details may have significant detrimental impact on a patient's clinical management.

CORESS Comments:-

The Reporter's comments are fair. Correct and accurately recorded histological diagnoses are fundamental to appropriate treatment of soft tissue tumours. Changes in practice in recent years, characteristically, have led to discussion of such pathology at multidisciplinary team meetings (MDTs). However, this does not necessarily remove risk of transcriptional errors. Clinicians should clarify and check such diagnoses, particularly where there is known difficulty in differentiating between pathological conditions, which may impact on subsequent management.

DELAYED RECOVERY FROM LAPAROSCOPIC HERNIA REPAIR (Ref: 64)

A 60 year old male with a large symptomatic incarcerated incisional hernia, following previous sigmoid colectomy complicated by wound infection, was admitted for elective laparoscopic incisional hernia repair. Risks of surgery, including conversion to open surgery, infection, bleeding, and bowel perforation, were discussed in clinic but not documented in the notes. The patient was admitted on the day of his surgery and consented by the registrar who only recorded peri-operative risks of infection, bleeding and thromboembolism on the consent form.

Left upper quadrant access established by the Hassan technique was used for the first port site, revealing dense adhesions and a large hernial defect. Subsequent port sites were inserted under direct vision. Adhesiolysis, undertaken to free bowel from the hernial sac, was performed using a harmonic scalpel and the defect repaired by endo-tacking a large mesh over the defect. No intra-operative complications were noted.

On the first postoperative day the patient had an ileus. Chest x-ray revealed basal atelectasis. Free gas was evident under the right hemidiaphragm. An NG tube was inserted and large aspirates obtained. On the fifth postoperative day the patient developed an area of cellulitis over the central abdominal wall. Persistent gas below the right hemidiaphragm was seen on erect chest x-ray. The patient was treated with intravenous antibiotics for what was thought to be a possible mesh infection. On the seventh postoperative day his abdomen became tender to examination. CT scan revealed free intra-abdominal fluid. Laparotomy, undertaken on the same day, revealed a perforated segment of small bowel. This was brought out as a split stoma. Second-look laparotomy demonstrated a further perforation distal to the stoma, which was repaired. A laparostomy was performed and the patient spent the following two weeks in ICU where he required eventual tracheostomy. He was

discharged home four weeks later and subsequently had his stoma closed without complication.

Reporter's Comments:

Several aspects of management of this case warrant discussion. Discussion and documentation of operative risks should be undertaken by the operating surgeon where potential complex surgery is anticipated. Failure to progress after laparoscopic surgery should engender a high index of suspicion of visceral injury, further suggested here by persistent free gas in the abdominal cavity. Timely intervention in such cases is indicated.

CORESS Comments:

There appear to be two main issues here. Consent should be documented by a member of the team who is able to perform the operation, ideally the operating surgeon. Although visceral injury occurs rarely during incisional hernia repair, discussion concerning possibility of this important complication should be recorded. Additionally, possibility of conversion to an open operation, or need for further surgery, should be documented.

Secondly, post-operative management of laparoscopic surgery requires a high index of suspicion as clinical signs often remain subtle. Failure to progress within the expected time frame is always a matter of concern, particularly when related to delayed return of gut function. This should prompt suspicion of 'out of camera' visceral injury. In these circumstances early re-laparoscopy is usually the most helpful investigation.

The Association of Laparoscopic Surgeons of Great Britain and Ireland's guidelines on **Recognition, Management and Prevention of Abdominal Complications of Laparoscopic Surgery** can be found at:

<http://domain1686280.sites.fasthosts.com/uploads/ALS%20Complications%20Management.pdf>

SNAP (UN)HAPPY!

(Ref: 65)

During discussions at the Upper GI multidisciplinary team meeting, concerning a patient who had undergone OGD, a discrepancy was revealed. Composite endoscopic photographs taken during the patient's investigation, consisting of a single sheet of photographic paper with four exposures per sheet, demonstrated normal anatomy in three of the frames and the appearances of a carcinoma in the fourth frame. The endoscopist who had undertaken the OGD was present and recalled that the patient's investigation had been normal. It transpired that the printing process for endoscopic photographs had been set up to print consecutive photographs sequentially and that only three photographs had been taken for the patient concerned. The fourth photographic frame, illustrating the carcinoma,

belonged to the next patient who had undergone OGD, but had been incorrectly labelled as being part of the investigation of the patient in question.

Reporter's Comments:

Economic usage of photographic resources is laudable, but it is important that endoscopic photographs from individual patients are printed separately to avoid diagnostic errors.

CORESS Comments:

Clinicians should always check identification details, including patient's name, date of birth and hospital number, before acting on results of investigations. Individual photographs in this situation should have had the patient's details printed on them. Endoscopists should be familiar with the output of the printing devices that they use, to prevent this situation recurring.

POSTOPERATIVE MINOCYCLINE PIGMENTATION

(Ref: 66)

A woman aged 63 had bilateral saphenofemoral ligation and multiple phlebectomies for extensive symptomatic varicose veins. After the expected postoperative bruising had resolved, unsightly blue/brown discoloration persisted over all the areas where veins had been removed. She sought a second surgical opinion and was referred to a dermatologist who diagnosed minocycline-induced pigmentation. She gave a history of taking the tetracycline-derivative antibiotic minocycline (100mg daily) for rosacea for the year preceding her operation, and thereafter. The dermatologist also

noted slate-grey pigmentation of the nail beds and sclerae, which is an associated clinical feature. The minocycline was stopped and the pigmentation gradually resolved over the subsequent year.

Reporters Comments:

Postoperative minocycline pigmentation is uncommon and its precise cause is unknown. It can be avoided by stopping minocycline about one month before surgery. Pigmentation resulting from minocycline use resolves when the drug is stopped, but may take many months to do so.

UNWANTED INCLUSION 1

(Ref: 67)

A 72-year old man underwent an anterior resection for a low rectal carcinoma 5 cm from the anal verge. A double stapled technique was used. The consultant was assisted by the registrar, a new ST3 trainee. After mobilisation of the splenic flexure and descending colon, the lower sigmoid was cross stapled. Further dissection of the rectum was then performed with total meso-rectal excision. A Foley catheter was inserted in the rectum for washout. The balloon of the catheter is not usually insufflated, but the registrar was unfamiliar with this procedure and inflated the balloon. The catheter was left in the rectum after the washout. Due to the bulky tumour, the presence of the Foley catheter was overlooked and a

TA 45 stapler was applied to cross-staple the rectum. On division of the rectum, the transected catheter appeared in the staple line. The problem was rectified by insertion of a purse string suture around the end of the rectum and the transected end of the catheter was excised. End-to-end colorectal anastomosis was then performed with a circular stapler. A leak test confirmed secure anastomosis.

Reporter's comments:

This case highlights potential complications that can arise from failure to communicate. The consultant assumed the trainee was familiar with the procedure of rectal washout and neglected to check that the catheter had been removed.

UNWANTED INCLUSION 2

(Ref: 68)

A 62-year old female patient underwent distal gastrectomy for carcinoma of the gastric antrum. A TA90 cross stapler was used to close the stomach before transection and roux loop reconstruction. On the third post-operative day, when ward nurses were unable to remove it, it became apparent that the tip of the nasogastric tube was included in the staple line. The problem was rectified by endoscopic division of the tube close to the suture line, leaving a small portion of the tube in-situ, with no detriment to the patient.

CORESS comments:

Inclusion of catheters within suture lines is not an

infrequent problem. It may become more likely to occur as increasing numbers of operations are performed laparoscopically, when bowel cannot be palpated prior to application of the stapler.

The problem could be prevented by formal briefing of the team prior to any part of an operative procedure in which the technique employed is unfamiliar. A checklist used prior to application of any stapler should include making sure that: all tissue to be closed is within the staple line; no tissue from adjacent structures has been inadvertently included within the staple line; all intra-luminal catheters have been removed prior to firing of the device.

FINALLY... *Live Wires*

A number of reports have been received by the MHRA concerning electrical safety.

A hospital staff member received an electric shock when connecting a plug-in mains lead to an infusion pump. The insulation had been pulled back exposing copper connectors. Ensure that mains leads are

regularly checked and taken out of service if damaged.

Never swap plug-in mains leads between devices, as leads correctly sold with non-earthed equipment may have no earthed connection, increasing risk of shock.

Reprinted from 'One Liners' (Issue 63, January 2009) with the kind permission of the Medical and Healthcare Products Regulatory Agency.