CORESS Feedback

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AN APPENDIX TOO FAR

(Ref: 112)

An 18 year old male, with right iliac fossa pain, was diagnosed with acute appendicitis and underwent a lengthy laparoscopic appendicectomy. The operation was undertaken by a trainee, with his consultant supervising but unscrubbed. Post-operatively the patient failed to improve clinically and developed fluctuating pyrexia. Ultrasound suggested the presence of a pelvic abscess, and the patient was taken back to theatre for laparoscopic drainage. At laparoscopy, a mass was found in the right iliac fossa which proved very difficult to dissect. The procedure was converted to a midline laparotomy. The operative findings were surprising; there was an indurated mass and inflamed ileocaecal thickening, with a tubular structure, at the junction which could only have been the appendix. On this occasion appendicectomy was undertaken successfully!

Subsequent pathological examination of the previously resected "appendix" revealed a piece of mesenteric fat which had been mistaken for the appendix by the trainee and his mentor.

Reporter's Comments:
The operation was complicated by a difficult dissection and obvious failure to identify the appendix correctly. Early conversion would have been appropriate. From his unscrubbed position, the supervisor failed to recognise the trainee's mistake in tissue identification.

CORESS Comments:
In a difficult laparoscopic appendicectomy, early conversion should be considered by the surgeon, inexperienced or otherwise. The unscrubbed supervisor has responsibility for the procedure, and should either have scrubbed for the procedure or supervised the trainee more closely. The CORESS Advisory Board suggested that an escalating series of steps should occur in this situation:

Step One: Supervisor scrubs in (increases his/her situational, tactile and perceptual awareness).

Step Two: Supervisor takes control of procedure.

Step Three: Conversion to open procedure as necessary.

INADEQUATE HANDOVER AND WEEKEND COVER

(Ref: 125)

Our NHS Trust, a medium-sized one, is based across two hospital sites approximately 12 miles apart. One of these sites has an elective operating facility, used mostly by Orthopaedics, located away from the main hospital. This is a self-contained unit, with the capacity to deal with all stages of a patient's journey, from pre-admission to post-operative rehabilitation. This unit is fully staffed and functional during the working-week, but is run by ward nurses only at the weekend.

A 72 year old lady, with medical co-morbidities, underwent a total knee replacement on a Friday. Soon after surgery, it was noted that she had excessive bleeding from the wound, requiring blood transfusion. There was no routine weekend ward round by the on-call Orthopaedic team, and at no point was an orthopaedic surgeon called to attend the patient. The surgeon who performed the operation, a locum consultant with some experience and seniority, was not contacted either.

The patient was eventually attended by a cardiologist because she had chest pains, and it was then noted that she had sustained a myocardial infarction. She was transferred to the CCU, where she spent several days. She was eventually discharged from hospital. On follow-up with Orthopaedics, it was noted that she had a stiff knee due to the lack of physiotherapy input during the time she was away from an Orthopaedic ward. This had to be addressed with a manipulation under anaesthetic. A few weeks later, she presented to another NHS Trust with chest pain and died on arrival in A&E.

Reporter's Comments:
This significant operative procedure was performed on a Friday afternoon by a locum consultant, who had no nominated junior staff to cover his patients. No weekend ward rounds were undertaken at the elective facility, and there was a lack of on-call surgical input because of a communication breakdown. No handover was undertaken and neither the locum consultant, nor any of the on-call team, made enquiries about the well-being of the patients at the elective centre. Issues were raised concerning nursing communication, especially with the on-call doctors.

CORESS Comments:
The operating surgeon or consultant in charge of the patient has a professional duty to ensure continued and sustained care for his or her patients, and any in-patient undergoing surgery should be reviewed on the following day. This is facilitated by modern team-working practices. Adequate medical handovers should be conducted when there are shift changes, particularly at night and weekends.

If there is downgrading of medical or surgical cover at weekends, then perhaps scheduling of major surgical cases on a Friday may be inappropriate.

MISTAKEN ANATOMY 1

(Ref: 115)

A 69 year-old male underwent resection of an advanced squamous cell carcinoma of the right mandibular alveolus. Temporary tracheostomy, selective neck dissection, segmental mandibulectomy, dental extractions, reconstruction with a right fibula free flap and insertion of an open gastrostomy tube were planned.

Timings for the procedure proved difficult. The first provisional date for surgery was declined by the patient. The operation date was, therefore, brought forward by one week and preceded by pre-operative assessment. There were no beds available on the day prior to surgery, so the patient was advised to attend at 09.30 on the morning of the procedure. An ITU bed had to be secured. The planned start time of the operation was 10.45, but knife to skin occurred at 12.30. The procedure was complicated and took until 19.00. Due to staff shortages and lack of availability of gastrointestinal surgeons, the planned gastrostomy was deferred and an NG tube placed in-situ. Post-operative X-rays demonstrated that the NG tube was incorrectly positioned and three further (futile) attempts were made to re-site this.

The following morning, the patient was placed on the emergency list for gastrostomy which was postponed, due to other cases, until the early evening when he was taken back to theatre and a gastrostomy tube inserted by the on-call surgical registrar, in a lengthy open procedure. Early feeding via the gastrostomy was commenced, but the patient failed to improve, developing a pyrexia and gradually increasing CRP over the next three days. When he developed diarrhoea and epigastric pain on the fourth post-operative day, an abdominal CT scan was undertaken, with contrast introduced down the gastrostomy. This revealed the gastrostomy to be sited in the mid-transverse colon with some extravasation of contrast. At further laparotomy the feeding tube was removed from the colon and, because of some local contamination, a tranverse loop colostomy was undertaken and the gastrostomy re-sited appropriately.

Subsequently, the patient made an uneventful recovery, in-hospital stay prolonged while he learned to manage his stoma, which was successfully reversed three months later.

Reporter's Comments:

These problems started with late admission of the patient on the morning of major procedure and were compounded by a string of other problems: no ITU bed was available initially; there was a late start with a late finish and no availability of other surgeons. The gastrostomy was, therefore, subsequently undertaken inappropriately as an elective procedure on an emergency list and delegated to the on-call trainee who didn't request help when they ran into difficulties.

CORESS Comments:

Complex cases require meticulous pre-operative planning. Day of surgery admissions are feasible and save hospital resources, provided protocols are adhered to. In a case such as this, some surgeons may have considered pre-emptive use of a percutaneous gastrostomy (PEG). If the trainee experienced problems during the latter procedure help should have been sought at an early stage.

FORGOTTEN TOURNIQUET

(Ref: 132)

A 64 year old man sustained injuries to the pulps of his non-dominant middle and ring fingers on a hedge trimmer. He was taken to theatre and his fingers were washed, debrided, and sutured under local anaesthetic ring blocks. During the procedure, the fingers of surgical gloves were rolled down to act as ring tourniquets on each finger, to provide a bloodless operative field. An artery clip was used to secure the tourniquet at the base of the middle finger, and this was removed on completion of surgery, after which dressings were applied to the hand. The patient was subsequently discharged with the hand dressed, with simple analgesia and oral antibiotics. In the ensuing post-operative period, he suffered significant discomfort, so much so that he presented to his GP and local NHS walk-in centre for review on three occasions. Unfortunately, his dressings were not taken down on any of these occasions and he was sent home with stronger analgesia each time. He finally had his dressings taken down on review in the dressing clinic when the tourniquet was discovered, still in-situ on his ring finger. This was removed. Remarkably, the ring finger was congested but viable, although a reduction in sensation distal to the site of the tourniquet was noted. On further review, five days later, the congestion in the finger had resolved but sensory loss persisted.

Reporter's Comments:

This case occurred because there was non-adherence to Trust policy of not using glove fingers as ring tourniquets. Only one artery clip was used on one of the ring tourniquets. This ensured that this tourniquet was taken off at the end of the operation to facilitate dressing, at which time the other tourniquet was missed. The use of tourniquets was not recorded on the theatre whiteboard, failing to prompt removal on completion of the procedure. Failure to take down the patient's dressings to examine the hand for a source of persisting pain, by both GP and NHS walk-in centre staff, compounded the error.

CORESS Comments:

Glove fingers should not be used as ring tourniquets under any circumstances. Instead, brightly coloured tourniquets, which are easily apparent, should be employed. The whole theatre team should have been involved to ensure that the tourniquet was not forgotten at the end of the procedure, and the outcome should have been avoided if WHO checks had been carried out. Use of a tourniquet should have been recorded on the theatre whiteboard. Day case patients should have recourse to an emergency contact number on discharge. There is an onus on the reviewing clinician and triage nursing staff to undertake a full and appropriate examination to determine a source of pain.