

# cores

## Feedback

This issue of Feedback describes two cases, in which failure to make a correct diagnosis resulted in a delay in appropriate treatment for patients with acute surgical emergencies. Problems arising from inexperience when cross-covering other specialties are also highlighted. All efforts should be made by Trusts to ensure that, when necessary due to staffing considerations, those undertaking cross-cover across specialties are adequately trained, competent to do so, and are appropriately supervised.

We are grateful to those who have provided the material for these reports. The online reporting form is on our website, [www.cores.org.uk](http://www.cores.org.uk), which also includes all previous **Feedback Reports**. Published cases will be acknowledged by a **Certificate of Contribution**, which may be included in the contributor's record of continuing professional development.

**Frank C T Smith**  
**Programme Director, on behalf of the CORESS Advisory Board**

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### THINGS CAN GO WRONG WHEN A PATIENT SAYS 'YES' (Ref: 172)

During an ophthalmology outpatient laser clinic, another patient came to my clinic room instead of the patient I had actually called. I think she must have misheard the name that I called out. We discussed the scheduled treatment (laser iridotomy), she signed a consent form with the other patient's sticker at the top, and I performed YAG laser iridotomies on her. Unfortunately, the patient I treated had been listed for selective laser trabeculoplasty, and so she ended up having the wrong laser procedure.

I did not check her date of birth, and the patient had answered "Yes" when I asked her if she was Mrs X. Soon afterwards, I realised what I had done - I immediately told the patient what had happened and notified this event to my Trust as a Serious Untoward Incident. Thankfully, no harm was done.

#### **CORESS Comments:**

This case illustrates the dangers of 'passive' identification of patients. It is easy for a patient to mishear a question and then inadvertently agree with the clinician. This problem would not have occurred if the clinician had actively followed the principles of the WHO pre-operative checklist. The patient should be asked 'please tell me your name', with similar open questions asking them to state their date of birth, address, planned procedure and side to be treated.

This principle applies to many other situations in medicine and surgery. Positive identification of patient, procedure, and side to be operated on is also vital in many other situations, including ordering and interpretation of tests.

## “BEAR TRAP” BITES BACK

(Ref: 182)

A young woman was admitted electively for endoscopy and fitting of an 'over the scope' clip (OTSC) to manage a leaking percutaneous gastrostomy site, under the care of a gastroenterology team. An experienced registrar performed the procedure and the clip was deployed under direct vision. However, upon trying to remove the endoscope it became stuck, seemingly at the upper oesophagus. The endoscope was advanced into the stomach again and it was noted that the clip had deployed onto the scope rather than in a forward direction onto the PEG site as intended. A consultant took over the procedure but was unable to dislodge the clip from the endoscope or to remove the endoscope. A second endoscope was passed and the complication was confirmed. The general surgeon on-call was summoned and performed an upper midline laparotomy to remove the clip. The endoscope could only be removed by cutting the end off with a hacksaw and cutters. The ENT surgeon on-call attended to assess the oesophagus and found a deep laceration in the cricopharyngeus muscle. The oesophageal laceration was managed conservatively and the patient recovered after an extended hospital stay.

### **Reporter's Comments:**

This was an equipment malfunction. None

of the team had previously encountered this complication before. In using OTSCs for the management of enterocutaneous fistulae, the complication of deployment onto the endoscope can occur.

### **CORESS Comments:**

The OTSC is a clip made of shape-memory nitinol alloy, used to close fistulae, perforations, anastomotic leaks, and to seal bleeding GI tract vessels [1, 2]. The clip is mounted onto a silicone cap (similar to a band ligation device), placed onto the tip of an endoscope, and applied by stretching a wire by means of a hand-wheel installed on the entrance of the endoscopic working channel. When the clip is released from the applicator, it closes because of the “shape-memory” effect and the high elasticity of the nitinol alloy, occluding the defect. This is similar to a “bear-trap” closure mechanism and applies a permanent force to the tissues. During introduction of the scope, migration (retraction) of the hood can occur [1]. The operator should ensure that appropriate deployment and visualisation of the clip has taken place before the endoscope is withdrawn.

[1] Diagnostic and Therapeutic Endoscopy Volume 2013 (2013), Article ID 381873 <http://dx.doi.org/10.1155/2013/381873>

[2] Gut 2013;62:A145 doi:10.1136/gutjnl-2013-304907.326

## MISSED URETERIC OBSTRUCTION

(Ref: 155)

A 25 year old man was admitted with right iliac fossa pain, associated fever and vomiting. He had a family history of renal calculi. On examination, he was tender in the right iliac fossa and right loin. Urinalysis was strongly positive for microscopic haematuria. CRP was normal but there was a leucocytosis on full blood count and the serum creatinine was 111  $\mu\text{mol/L}$ . No stones were visible on X-ray KUB. Ultrasound of abdomen and pelvis was performed on day three "to exclude appendicitis or renal pathology". Kidneys were of normal size and appearance bilaterally, with no comment about the ureters. Free fluid was seen in the pelvis. The patient was listed for an appendicectomy on day four as his fever and pain persisted. Prior to surgery, however, the anaesthetist raised concerns that the creatinine was now 140  $\mu\text{mol/L}$  despite appropriate fluid administration, and that a CT KUB had not been performed. Surgery was postponed and a CT KUB was undertaken which showed a 5.5mm calculus in the proximal right ureter, causing

obstruction and hydronephrosis. The patient was transferred urgently to the local urology services for stenting. He was discharged the following day with improved renal function.

### **Reporter's Comments:**

A strong history and findings suggestive of renal tract pathology were not acted upon and timely appropriate investigations were not performed. The ultrasound report did not comment on the ureters despite mention of haematuria on the request form.

### **CORESS Comments:**

This case describes a failure to diagnose ureteric obstruction. The diagnosis of appendicitis was flawed. The patient exhibited a number of symptoms that should have prompted clinicians to carry out a CT KUB, the “gold standard” investigation for renal tract stones, within 24 hours of admission. Patients with haematuria and abdominal pain should be appropriately investigated for renal stones. Worsening renal function despite adequate fluid intake should increase suspicion of underlying renal tract pathology.