

This edition of CORESS Feedback contains descriptions of a variety of adverse incidents. Poor communication is a common theme underlying many near misses and is a contributing factor in several of these cases. Problems associated with absence of appropriate equipment are perennial, and the importance of training when adopting new techniques is emphasized. In an era where data protection and patient privacy have become paramount, a series of reports, (Case reference 244), highlights the need for professional discretion and maintenance of patient confidentiality.

We are grateful to those who have provided the material for these reports. The on-line reporting form is on our website www.coress.org.uk which also includes 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.

Professor Frank CT Smith
On behalf of the CORESS Advisory Board

Unsupported trainee

(Case ref: 238)

A teenage male was seen on a night shift in the Emergency Department (ED), with upper abdominal pain of short duration. He had no history of recent travel or trauma and was otherwise fit and well, although he had been fatigued and had flu-like symptoms during the previous fortnight. His girlfriend had recently been diagnosed with glandular fever.

On arrival in the ED he was taken to the resuscitation rooms, hypotensive, tachycardic and pale. Blood gases indicated acidosis (pH 7.2), and Hb was 110 g/L. U&Es testing suggested an acute kidney injury. On examination he was pale, sweaty and peripherally cool with a soft but tender abdomen, particularly in the left upper quadrant. A CT scan revealed intra-abdominal free fluid in the upper abdomen.

I contacted the on-call consultant to relay my concerns that this might be a splenic rupture related to possible Epstein Barr virus infection, but was advised to resuscitate with fluids and informed that this was an unlikely diagnosis, given the haemoglobin result and renal injury.

I remained concerned about the patient, whose blood pressure improved with fluid administration, but who continued to look unwell, and whose Hb dropped further after fluid resuscitation. After two further phone calls in which I stressed my concerns about this patient needing to go to theatre, the consultant on-call agreed to come in and review the patient in Emergency Department. On review of the patient the decision was made to proceed straight to laparotomy, at which the findings were of a ruptured spleen with over 2L of intra-abdominal blood. The patient required ITU support post-operatively and remained an inpatient for several weeks before being discharged home.

CORESS comments:

The trainee made a good diagnosis in this case, but irrespective of diagnosis, the patient had clinical signs consistent with a critical illness. Where there is any concern about a patient's well-being or the facts are in doubt, a consultant responsible for a patient has a clear responsibility to be: contactable; approachable; and to attend the patient if requested. Failure to respond to a trainee's request for assistance is neglect of duty.

The ASiT trainee representative on the Advisory Board also highlighted the element of two-way communication and advised that trainees develop good communication skills so that when they contact a senior for advice: they have seen the patient; they impart a concise and accurate summary of the clinical situation; and that they attempt to prioritise the most important clinical details. This enhances the professional relationship between trainee and consultant, and results in "flattening of the hierarchy", to the patient's benefit.



An old twist on a familiar tale

(Case Ref: 239)

The case was repair of an orbital floor on a patient with mechanical restriction of up-gaze following a blow-out fracture caused by an alleged assault. The pre-formed orbital implant fitted nicely and it was held in place with a single screw on the inferior orbital rim.

In recovery the patient coughed and started to develop proptosis. The subcuticular skin suture was removed from the mid-tarsal incision, some haematoma evacuated and the patient returned to theatre. In theatre, the blood was seen to be coming from below the orbital implant, but when removal of the screw was attempted, no screwdriver fitting the screw could be found. Other sets from the same manufacturer, proprietary 'universal' screw removing kit, and similar screwdrivers from other kits were tried, but none fitted. Eventually the screw was knocked out with a small hammer, the bleeding arrested, the implant replaced, and secured with a screw from one of the many opened kits, which were now available to me.

Reporter's Comments:

Whenever any 'new' plating kit is supplied, the standard package should include two separately wrapped screw drivers, one to use in a case like this, and another labelled and kept separately to extract the screw if subsequently necessary.

This double screwdriver rule should increase to four screwdrivers when the screws are trans-mucosal (Intermaxillary Fixation Screws, Screw-Fixed Arch Bars) and the patient may attend the outpatient clinic for them to be removed.

The manufacturer had 4 different cross head screws in decreasing size, and the one I used had was the smallest and was the only one of this type in the hospital. The screwdriver originally used from the set was no longer sterile and could not be sterilised on site.

CORESS Comments:

This was a systems failure. All kit necessary for a procedure should be checked for availability (and functionality), prior to an operation being undertaken. NATSSiPs emphasise this point. Surgeons would be well advised to have a backup "Plan B" in case a procedure does not proceed as intended.

Histopathology misdiagnosis in renal transplant

(Case Ref: 240)

A female patient with renal failure due to diabetes, nephrocalcinosis and glomerulonephritis was transplanted with a donor kidney. At the time of transplantation peri-hilar tissue from the donor kidney was sent for histological examination. The transplant recipient made a satisfactory recovery from surgery.

The tissue taken from the donated kidney was processed in histopathology. Initial microscopy showed no abnormal features, although ectopic adrenal tissue was evident in the sample. Therefore further immunochemical stains were performed. These suggested that the adrenal tissue was benign, but abnormal uptake of the markers in lymph nodes in the tissue suggested the presence of diffuse nodal carcinoma.

At a histopathology MDT, the consensus was that there was a malignant infiltrate in the lymph nodes, the source of which could not be determined. The kidney recipient was contacted and the situation was explained to her in detail. Options, including conservative management and surveillance, with or without cessation of immunosuppression, or immediate renal explantation, were outlined. The patient opted for nephrectomy of the donated kidney, which was carried out uneventfully with patch reconstruction of the external iliac artery.

Subsequently, the histopathology was sent to two other academic institutes for further opinions. The possibility that the cells within the lymph node were benign mesothelial cells was suggested. More tests supported this hypothesis. This occurrence is extremely rare but has been described in case reports^{1,2}.

The situation was discussed in depth with the patient, and it was explained that her functioning transplant had been removed on the basis of an erroneous histological diagnosis.

It was noted that the original kidney donor had suffered from end-stage liver failure prior to a successful liver transplant, which might have allowed abnormal circulation of mesothelial cells to the retroperitoneum.

Reporter's Comments:

Benign hyperplastic mesothelial cells can mimic a malignant process. Full ascertainment of the histological discrepancy and a definitive diagnosis should have been established, before suggesting nephrectomy of the transplanted kidney to the patient.

CORESS Comments:

This is an exceptionally rare situation. In deceased donor transplantation, very uncommonly a sample from the donor kidney may be sent for histology if there is an area, which has an abnormal appearance. If there is clearly significant suspicion of malignancy then the kidney would not be transplanted, irrespective of histology. However, if there is a low index of suspicion, especially as the recipient may have been waiting for some time for this offer, it would be reasonable to implant the organ and await subsequent histology results. Typically, frozen section is not used, for two reasons: firstly, this may not be available out of hours; secondly, it may not be accurate enough for diagnosis of certain lesions.

The CORESS transplantation expert had experienced two similar cases in which histology reports later came back positive for tumour. In the case described in this report, the correct approach was taken, with discussion with the recipient about whether the organ should be explanted. It was perfectly reasonable to proceed to nephrectomy based on a histopathology report, which suggested malignancy. If the subsequent histological opinions were based on the original biopsy rather than study of the full kidney, then it would have been appropriate to suggest waiting for this opinion before proceeding to nephrectomy. However, the patient herself might not have wished for this, and might have opted for nephrectomy irrespectively in this scenario.

In summary, accurate histological diagnosis is vital for any lesion biopsied at the time of transplantation, and early opinions from specialist histological centres are useful.

References

1. Argani P, Rosai J. Hyperplastic mesothelial cells in lymph nodes: report of 6 cases of a benign process that can stimulate metastatic involvement by mesothelioma or carcinoma. *Hum Pathol* 1998; Apr 29 (4):339-46
2. Peng L, Shen Q, Liu X et al. Diffuse hyperplastic mesothelial cells in multiple lymph nodes: case report with a review of the literature. *Int J Clin Exp Pathol* 2013; Apr 15; 6(5); 926-31





Ureteric stent misplacement

(Case Ref: 241)

A 62 year-old man underwent a difficult anterior resection for a carcinoma of the low sigmoid colon. During mobilisation of the colon it was noted that the left ureter had suffered a partial thermal injury due to diathermy. The on-call urologist was called to inspect the ureter and, at the request of the consultant colorectal surgeon, agreed to place a ureteric stent into the injured ureter at the end of the procedure. On completion of a protracted procedure, the urologist was called back, but a handover had taken place and although correctly briefed, a new on-call urologist attended. Unfortunately, the stent was placed into the right ureter.

A week later the patient returned to theatre for drainage of a pelvic abscess, at which time it was noted that the stent was in the wrong ureter. The right ureteric stent was removed and a further stent was correctly positioned in the left ureter. The patient subsequently made an uneventful recovery.

Reporter's Comments:

Stent placement was undertaken as an emergency, and the usual safety precautions of radiology review and marking of the correct side did not take place. No "Stop" period was undertaken before stent placement. There appears to have been miscommunication between the colorectal and urological teams and the first stent was placed into the right ureter on the understanding by the urologists that this was the injured structure. The colorectal team had un-scrubbed and despite observing the procedure did not comment on the stent placement. The remaining scrub team also failed to alert the surgeons to the side discrepancy.

CORESS Comments:

This case is a "Never Event" and raises several issues. It is well recognized that poor communication may cause problems when teams change over. Scrupulous handover and communication of important information is vital. Where one senior surgeon, initially responsible for the case, is present throughout, that surgeon (the colorectal consultant) should have overseen all aspects of the case and takes responsibility for the wrong-sided intervention, even if the stent placement was not within the realm of their specialty. A team pause, and joint confirmation that the stent was to be placed appropriately, might have prevented this incident. Team briefings should empower other members of the team to speak up if an incorrect manoeuvre is recognized, and the sign-out check was a further potential opportunity to remedy the situation.

Rectus sheath catheter retention

(Case Ref: 242)

On the basis of literature suggesting a benefit in postoperative analgesia, bilateral rectus sheath catheters for post-operative local anaesthetic infusion were placed, prior to laparotomy closure, following abdominal surgery. At day-4 postoperatively, the left-sided catheter was removed without incident, but the right-sided catheter remained obstinately stuck. The patient had to return to theatre for re-exploration, whereupon the catheter was found, securely fixed, in the knot of the mass closure suture.

Reporter's Comments:

This was the first time this technique had been adopted, on the basis of a literature review. The surgeon, who was placing the catheter at the anaesthetist's behest, had received no training in the technique. There were no institutional protocols for catheter insertion. Retrospectively, trapping the catheter in the mass closure suture knot seems an obvious risk.

CORESS Comments:

Sound anatomical knowledge and grounding in physiological and pharmacological principles of postoperative pain relief are basic tools of a surgeon's trade. So undertaking this procedure seems to have been reasonable. Nonetheless, when undertaking any procedure for a first time it is advisable to plan appropriately, and where possible, to have received some formal training or experienced mentorship during the procedure. This is particularly apposite in an increasingly litigious culture.

A screw too few!

(Case Ref: 243)

When repairing a difficult fractured mandible, the surgeon placed a four-hole plate on one side, inserting two proximal screws and a single one distally, intending to return and place the last screw after plating the fracture on the other side. There was some discussion with a visiting consultant in theatre about the case, and some non-pertinent conversation as well. Time was running short in theatre, and concerns were expressed that the case might not finish on time. The specialty trainee was keen to do some of the operation. The consultant fixed the second plate with four screws. The trainee asked if he could close the wounds. The trainee was a little slow closing the first side and theatre staff asked the consultant to close the other side. The consultant did so, and the WHO checklist was completed. It was only during the next case that the consultant suddenly realised that the final screw had not been placed in the first plate. The surgeon and the trainee, during the swap-over of sides, forgot that the final screw had not been placed. The scrub nurse, who had mounted the final screw ready on a screwdriver did not alert the surgeon and the visiting consultant did not notice or comment.

Reporter's Comments:

When part of an operation is deliberately not completed, this should both be declared to the theatre staff formally (it was informally discussed in this case) and written on the 'board'. Leaving 'work to be done' always presents a risk.

When a visitor attends theatre, they should be incorporated into the team during the team brief, engaging them as a participant, rather than as an observer or "tourist".

CORESS Comments:

A variety of factors contributed to this adverse incident. Having a visitor in theatre can disrupt the team process and may have contributed to a loss of focus by the operating consultant. Other distractions included time pressures and the need to allow the trainee to participate. Lip service was paid to the "sign-out" of the WHO checklist, and the operation was recorded as repair of fractured mandible, but this did not trigger the scrub nurse or the surgeons to realise that the operation had not been completed.





Matters of Professionalism

(Case Ref: 244)

Three young doctors returning from an academic meeting on a crowded train loudly bemoaned the personal and professional characteristics of one of their supervising Consultants. One then went on to describe loudly, in detail, an operation in which he claimed that the anaesthetist slept through most of the procedure. Unknown to them, the wife of another Consultant Surgeon, who knew their supervisor, was sitting next to them...

...In a separate incident, in the queue at the hospital Costa Coffee, two trainee surgeons openly discussed the adverse incidents giving rise to the necessity for a post-mortem in one of their patients, surrounded by the public and patients' relatives...

...In a busy hospital trust, the surgical team undertaking the ward round visited an outlying patient on another floor, taking the lift en route. A member of the public subsequently sent a written complaint to the Chief Executive, providing evidence of a patient's name and clinical prognosis, which the surgical team had openly discussed in the public lift...

...An NHS Consultant was reported to his Trust when a member of the public was able to provide clinical details concerning patients whom the Consultant had been dictating letters about, in the quiet carriage on a train...

...The Patient Liaison Group was perturbed when their monthly meeting followed on from the endocrine cancer MDT in the boardroom, and sheets providing patient details and diagnoses were still sitting on the meeting room table...

...Following the ward night out, handover sheets from that morning's ward round at the local NHS Trust, containing details of patients' diagnoses and management, were found blowing around the city centre taxi rank...

CORESS comments:

Patient confidentiality is a cornerstone of medical practice. As a profession we are privileged to share patients' intimate personal, social, and health details. Practice evolution has resulted in diminishing professional spaces; loss of doctors' private rooms; open plan offices; and increasingly, facilities shared with patients and relatives. As such, we need to reflect on values of discretion and sensibilities...and where we are, when communicating privileged information. Inadvertent communication of patient details breaches data protection laws. An up-to-date adaption of the well-known wartime epithet might read: "Careless talk costs lives-careers"