Royal Australasian College of Surgeons

ANZASM Case of the Month
August 2025 Edition

(case selected by the ANZASM Committee for your information)

Death of an elderly patient after inadequate postoperative care

General Surgery

Case summary

An 80-year-old man was admitted to hospital following a dizzy spell at home. The patient lived with his family independently at home. He suffered with hypertension and epilepsy.

Investigations revealed anaemia (haemoglobin 8.1 g/L). A colonoscopy showed an almost obstructing lesion in the sigmoid colon. A CT (computed tomography) scan showed no evidence of metastatic disease.

The patient was readmitted a week later for an elective laparoscopy-assisted high anterior resection of the colon with stapled anastomosis (reinforced with sutures) and no stoma. The operation commenced at 9:00 am and took 3.5 hours. There were no intraoperative issues.

Postoperatively, the patient was transferred to the ward and placed on an ERAS (early recovery after surgery) protocol. Just after midnight on postoperative day 3, the patient was found unresponsive. He had vomited and aspirated, and despite CPR (cardiopulmonary resuscitation) was unable to be resuscitated.

Discussion

There were several issues with the care of this patient.

The preoperative risk was assessed as moderate by the treating surgeon (ASA grade III by the anaesthetist), so it is surprising that the patient was transferred to an ordinary ward rather than a high dependency unit where monitoring would have been more intensive.

It appears that the signs of ileus were misdiagnosed as nausea due to reflux. This, even when the patient began to vomit. Metoclopramide was administered on 3 occasions on the day prior to death, in addition to ondansetron 3 times and Gaviscon twice.

The notes show only one entry for a postoperative ward round, conducted on day 2 post-surgery. This entry was modified after the death of the patient. No physical examination was performed even though it was clear that ongoing nausea was an issue. The only other medical review seems to have

been conducted by the night resident medical officer, who noted that the patient had not voided for almost 24 hours following removal of an in-dwelling catheter. A subsequent bladder scan revealed only 13 ml of urine.

There were no contemporaneous nursing notes for the patient from day 2 post-surgery until the time of his death almost 48 hours later.

There was no fluid balance chart, despite this being a requirement of the ERAS regime. The patient had not been mobilised out of bed until late on day 2 post-surgery.

Clinical lessons

This patient's care was cursory at best. He was never properly examined. Signs were missed or misinterpreted and his issues were never properly addressed. Ileus is so common following bowel surgery as to be normal, but it was never considered in this case. It was certainly not adequately managed by making him nil by mouth and inserting a nasogastric tube.

The medical notes also appear to have been scanned at random, as though someone had shuffled them. Of the total 684 pages, most were largely unhelpful. More than 100 pages were devoted to a recurring narrative about whether the patient was wearing non-slip socks and could reach the call bell. Had more time been spent with the patient instead of completing swathes of useless documents, this man's ileus may have been diagnosed and treated earlier.