Too many Cooks

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Would you have changed the management of this patient’s course to death?

General Surgery: Diagnosis delays, can they be eliminated?
History

• 76 y/o male patient presented with mechanical fall and a fracture dislocation of ulnar and radius at the wrist (reduced and plastered)
• Previously independent brought into Cas 13/6 by nephew after requiring walking aid for the past week
• Also had a fixed flexion deformity of R knee
• Subsequently admitted by orthopaedics with stable observations- for an MRI
Background

• Chronic renal impairment
• Atrial fibrillation (warfarin)
• CCF (Frusemide, Coversyl and Bisoprolol)
• Type II Diabetic
• Suffered Gout

Both medical and allied health were co-opted for care

No system review was recorded (ie GIT health) but admission was otherwise satisfactory
Progress

- **Day 3** – a “Pre” MET review for tachycardia occurred ‘sick sinus’ syndrome was diagnosed
- Pulse between 40-150 Bpm Telemetry
- **Day 4** – a MET call at 11:30 for low $O_2$ sats and tachycardia- bloods were taken
- Hb 117, WCC 15-3 INR 2.5 Creat 125
- IV fluids and pain relief administered
- O/E very tender w/ guarding and peritonism in R abdomen
- General surgeon was consulted
The Process of Diagnosis

Working Diagnosis
- Ischaemic bowel
- Perforated appendix
- Perforated R diverticulitis
- Cancer of colon

Tests
- CT Scan
- Blood gas and lactate

Management
- Resuscitation
- Operation
1st surgeon favoured a laparotomy, CT Scan showed R sided retroperitoneal paracolic collection. Surgeon 1 then discussed findings with surgeons 2 and 3 who recommended percutaneous drainage if stable “they did not examine the patient themselves”

At 17:00 an image guided pigtail drain retrieved small faecal fluid, patient deteriorated and was transferred to ICU
In ICU patient was anuric and commenced on inotropes and amiodarone. 11 Hrs post MET call surgeon 4 was consulted for a laparotomy. A perforated R hemicolon w/ frank peritonitis and mild colonic Ischaemia was observed due to a proximal transverse colon stenosing obstructing cancer (which was retrospectively visible on CT) R hemicolecotomy stapling both ends was performed w/ copious lavage. Returned to ICU for haemofiltration under surgeon 2’s care
A day later on the 18\textsuperscript{th} a re-look laparotomy was done by surgeon 5 with ileostomy and mucous fistula formation and lavage. The patient remained under surgeon 2’s bed card. Despite good ICU care the patient developed multiple organ failure and ischaemia of the stoma. At 11 am on the 20\textsuperscript{th}, post family discussion, a withdrawal of active care resulted in the patient succumbing rapidly. The coroner was advised.
Could this outcome have been prevented?

- Assessor 1 deemed the course inexorable once peritonitis was diagnosed and that Duty of care was undertaken w/o negligence
But there were areas of concern

**Concern 1** lack of awareness of abdominal symptoms until overt sepsis was evident. Assuming all cardiac abnormalities were ‘de novo’ from pre-existing heart disease

**Concern 2** CT scan was “underreported”. Knowing a cancer was present may have prompted immediate surgical intervention

**Concern 3** 1 orthopaedic surgeon and 4 general surgeons were involved in a 12 Hr period (and a 5th for the re-look). Surgeons 2 and 3 did not see the patient before offering advice which led to a late night laparotomy
2nd Line Assessment

This assessor felt that there was no pointer to perforation prior to the patients “crash”.
There is no annotation by the general surgeons in the notes, so the diagnostic approach is somewhat retrospective.
It was felt that the audited surgeon managed the case appropriately in view of the patient’s age, ASA 4 grading, comorbidities and cardiac history.

Summary: Peritonitis is decisive, however the timeframe to diagnosis was prolonged.