



PATIENT SAFETY RESOURCES

A FORGOTTEN STENT

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DESCRIPTION

Patient suffers an infection when a biliary stent that should have been removed after three months is discovered still in place after 12 months.

KEY LESSONS

- Determination among providers regarding accountability for patient follow-up is essential to prevent gaps in care.
- The discharging provider must have systems in place to confirm that the subsequent provider received information needed to accurately care for the patient. Information transfer involves physicians, nurses, care managers, office personnel, and information technology staff.
- Unresolved complaints are not closed until all parties have resolution for outstanding issues.
- Any temporary implement or device intentionally left in a patient needs to be tracked until removal.

CLINICAL SEQUENCE

A 52-year-old male in relatively good health is admitted to the hospital for surgical removal of a large hemangioma on his liver by an oncology surgeon. Four days after an uneventful left hepatectomy, the patient is discharged home with a surgical drain in place.

One week post-op, the patient is seen in the emergency department (ED) with complaints of abdominal pain and increased drainage from his tube. From the ED, the patient is discharged home and told to follow up with his surgeon.

Three days later at the patient's follow-up appointment, his surgeon notes that the drainage is not alarming and removes the drain.

Two weeks later, imaging studies reveal a right upper quadrant fluid collection and the patient undergoes a drain placement in interventional radiology (IR).

Two months later, the patient has an MRI that reveals a stricture in the anterior segmental branches in the right hepatic lobe. He undergoes an endoscopic retrograde cholangio pancreatography (ERCP) to determine if there is a bile leak. Although no leak is found, the gastroenterologist places a biliary stent from the common bile duct into the small intestine to facilitate drainage.

The plan is for the patient to return in 6–8 weeks for removal of the stent. No follow-up appointment is made.

Two weeks later, the patient is seen by his oncology surgeon who expresses concern that drainage from the tube placed by IR is poor. They discuss a plan for the patient to have another surgical procedure to improve drainage from the fluid collection in his abdomen.

Four months after his initial surgery (hepatectomy), the patient undergoes a second surgery. During this surgery, a bile leak is identified and repaired, and a new drain is placed. Postoperatively, the patient continues to have drainage from his drain and loses 30 pounds.

One month later, the oncology surgeon decides to perform a hepaticojejunostomy. Drains from this surgery are removed two months later. The patient is seen in the surgeon's office one month later and reports he is doing well. He is advised to have laboratory blood work, but no mention is made of the indwelling stent placed during the ERCP five months prior.

Eight months later, the patient is admitted to the ED with fever and chills. A CT scan reveals the indwelling biliary stent placed during the ERCP 13 months prior is still in place in his common bile duct and is infected. The patient requires another surgery to remove the infected stent.

ALLEGATION

The patient files suit against his oncologist and the hospital, alleging that they mismanaged his post-operative recovery, leading to complications that required additional surgery.

DISPOSITION

Eight months after the defendants are notified of the lawsuit, and 26 months after initial surgery, this case is settled in the low range (<\$100,000).

ANALYSIS

Continued patient concerns and symptoms warrant further investigation.

A focused reevaluation of this patient's condition would have encouraged providers to think about other potential causes for the repeated issues. Failure to reassess clinical indicators and laboratory findings can contribute

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ANALYSIS

to a narrow diagnostic focus. Reassessment (at regular intervals) should include: a thorough review of the record, physical examination, incoming diagnostic test results, vital signs, and clinical status.

Coordination of care.

A system to schedule the return appointment for the stent removal would have prevented the loss of follow up and ultimate sepsis from the occluded stent. The plan was for the patient to return in 6-8 weeks for removal of the stent, however, no follow-up appointment was made. Clarifying the responsibility for the follow-up monitoring and treatment of patients “between” services lessens the potential that their care will suffer due to incorrect assumptions or lack of awareness.

A tracking system for implantable devices would have prevented the failure to remove the stent.

A registry for implanted stents placed for various therapeutic procedures can aid in preventing indwelling stents from being forgotten both by the patient as well as the physician. The registry should include a deadline for which the stents should be removed with a trigger system for the care team to alert the patient and physician.

