IMPROPER MANAGEMENT AND LACK OF COMMUNICATION CAUSES SIGNIFICANT POST-SURGERY COMPLICATIONS

DESCRIPTION

A 60-year-old female suffered long-term injury from the mismanaged complications of a cholecystectomy.

KEY LESSONS

- Communicate critical information (e.g., unresolved complaints) promptly and accurately to appropriate providers through calls, secured electronic communication, or set up alerts or flag systems in EHR
- Utilize available tools such as standardized data collection sheets for proper documentation of phone call, this can be integrated into the electronic health record (EHR) system
- Verification systems should be placed at the critical stages in surgery such as during identification of anatomy

CLINICAL EVENTS

A 60-year-old female presented to a general surgeon for laparoscopic cholecystectomy. The surgeon identified the gallbladder, removed adhesions, found the cystic duct/artery, and placed clips to create a ductotomy. The surgeon read the cholangiogram as normal. The intra- and extra-hepatic bile ducts, and duodenum, were checked. The operating surgeon noted no filling defect. The gall bladder and proximal cystic duct were dissected free. Surgery was completed without any noted intraoperative complications. The patient was transferred to the PACU for recovery and discharged later that day.

Post-op Day 1

The patient called the surgeon's office complaining about abdominal pain. The nurse told her that some pain is normal after surgery and encouraged her to walk and to take ibuprofen/Percocet to alleviate her pain. The surgeon was not informed about the patient's call.

Day 4

The patient called the office with complaint of left shoulder pain, nausea, and feeling of fullness. She reported that Percocet was not helping the symptoms and was advised by the nurse to continue a bland diet and call back if she had no relief. The surgeon was not updated on the patient's condition.

Day 12

The patient called the office complaining about vomiting bile and reported a hard spot in her right upper quadrant, fatigue, and inability to eat/drink without reflux. She was advised by the nurse to go to the Emergency Department (ED). The surgeon was not updated on the patient's condition. In the ED, an endoscopic retrograde cholangiopancreatography (ERCP) demonstrated a complete blockage of the bile duct.

Day 18

The patient underwent corrective surgery by a different general surgeon who noted injuries to the biliary tree bile duct. This surgeon's notes referenced the intraoperative images from the previous surgery and suggested a bile duct injury was visible on that study.

Day 25

The patient was transferred to higher level care with drains attached. The liver transplant team was consulted.

Over the next month, the patient continued with drains and underwent complex biliary reconstruction by another surgeon. She suffered from complications of hepatosplenomegaly, incisional hernias, and cholangitis. She required follow-up liver enzymes and would likely need additional procedures for scarring/stenosis.

The general surgeon apologized for the lack of communication of the messages by the office.

ALLEGATION

The patient alleged that the mishandling of the post-operative calls, and lack of follow up by the surgeon's office, caused her post-operative complications.

DISPOSITION

The case was settled in excess of $1M on behalf the surgeons group practice, but not the surgeon (due to the complexity of the case and adherence to the procedure/protocols during the surgery such as performing cholangiogram for verification, and possibility of an abnormal anatomy).

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ANALYSIS

1. *Communication failure: the patient's concerns were not escalated to the surgeon*

Action: Implement a triage system for patient calls, including a guidance for escalation if there are multiple calls with unresolved symptoms.

2. *Lack of post-op follow up*

Action: A timely follow-up outpatient visit should be scheduled post-op to evaluate the course and recovery following a surgery.

3. *Misreading of the cholangiogram*

Action: Increase educational efforts around anatomy identification and intra-operative imaging as needed

4. *Misidentification of the common bile duct as the cystic duct*

Action: Consider time-outs for cases where the surgeon is facing difficulty in identification of anatomy. Taking a break can help in reorientation and clear judgement of the situation. Simulation training for laparoscopic procedure can be incorporated to enhance performance in the operative setting.

ADDITIONAL RESOURCES

Analysis of Surgical Errors Associated with Anatomical Variations Clinically Relevant in General Surgery. Review of the Literature

Cause and Prevention of Laparoscopic Bile Duct Injuries

Failures in Communication Contribute to Medical Malpractice

Professional Communication and Team Collaboration

Re-Engineered Discharge (RED) Toolkit

Transferability of Simulation-Based Training in Laparoscopic Surgeries: A Systemic Review