The Late Complications of Endoscopic Surgery: Unrecognized Bowel And Urinary Injuries, Causes and Management

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MODERATOR
Richard M. Soderstrom, MD

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Surgical Tutorial 8:
The Late Complications of Endoscopic Surgery:
Unrecognized Bowel and Urinary Injuries, Causes and Management

Faculty: Michel Canis and Marshall L. Smith
Moderator: Richard M. Soderstrom

Course Description

This course will provide an overview of the types of complications and the presentations that can signal that a vulnerable structure has been damaged. This includes intraoperative, postoperative and radiologic evaluation. It is important to not overlook ominous signs and symptoms after laparoscopy as they can mimic common benign findings after open surgery. These complications can be catastrophic because of subtle presentation and lack of timely recognition. An improved awareness of these complications provided by this course will aid in recognition, diagnosis and may prevent adverse outcomes and prevent litigation.

Learning Objectives

At the conclusion of this course, the participant will be able to: 1) Describe the techniques used to identify vulnerable structures to prevent complications; 2) describe the techniques used for the early diagnosis of complications; 3) describe clinical, ultrasound and CT scan signs observed in early postoperative complications; and 4) describe the surgical management of the most common early postoperative complications.
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Michel Canis
Grants/Research Support: Karl Storz Europe
Marshall (Mark) L. Smith
Other: Johnson & Johnson -owned stock in company that produced an orthopedic simulator
Richard M. Soderstrom*
Asterisk (*) denotes no financial relationships to disclose.
The Late Complications of Endoscopic Surgery

Unrecognized Bowel and Urinary injuries
Causes and Management

M Canis, B Rabischong, G Mage
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Disclosure Slide
• I have no financial relationships to disclose.

Objective
• Prevention of unrecognized complication
• Understand surgeon's quality required to prevent complications
• Stress the importance of installation and of the knowledge of anatomy
• Present a technique of reoperation within the first 10 post operative days with minimal risks
• Discuss clinical, biological and radiological signs of complication used to allow an early diagnosis and management

The surgeon should have
• Extensive knowledge
• Skilled hands

But The surgeon should be
• Humble
• Honest
• Rigorous

A fit and dedicated surgical team

Carl Levinson
• Former AAGL president in 1979 once in Europe did a presentation entitled:
  • “Why expert surgeons do mistakes ?”
He basically said: Surgeons are human beings!
- Lost a lot of money on stock exchange
- Family problems
- One of the child was sick last night
- ........
- Intense training for the marathon last evening
- ........

A team!
- Everyone may do a mistake
- Everyone may identify a mistake
  - A resident, a nurse, a medical student or an anesthetist should be able and feel free to tell you that he thinks that what you did one minute ago was a mistake
  - He is often wrong, but he or she may be right so you should check

Teach your team to tell you!
- During an hysterectomy, I found an abnormal adhesion on the right side, while I was dissecting it,
  - several people in the room thought: “he is going to open the bladder…”
  - However they also thought: “no he is very skilled so I am probably wrong” and they all remained silent
  - At the end, I entered the bladder and had to repair it!

A team!
- Explain what you need
- Explain what you want to do
  - Assistant and all members of the team will be much more effective if they know what you want to do and what is the exact goal of the procedure
- Explain what you do, where you are, explain the anatomy
  - Assistant and all members of the team will be much more effective if they understand what you do

Prevention
- 1 – Adequate installation
- 2 - Adequate trocar sites
- 3 – Ergonomy
- 4 – Perfect vision
- 5 – Knowledge of the instruments used
- 6 – Knowledge of normal and abnormal anatomy
### Procedures in which Injuries Occurred

<table>
<thead>
<tr>
<th>Procedure</th>
<th>United States</th>
<th>Non-United States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>68</td>
<td>50</td>
</tr>
<tr>
<td>Diagnostic lap.</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Sterilisation</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Endo/AD</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Appendectomy</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Oophorectomy</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

Endo/Ad = endometriosis/adhesions

---

### Intestinal injury in gynecologic surgery: a ten year experience


<table>
<thead>
<tr>
<th>Type of surg</th>
<th>Total N</th>
<th>Total bowel inj</th>
<th>Entry-related injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laparotomy</td>
<td>5700</td>
<td>93</td>
<td>48</td>
</tr>
<tr>
<td>Vaginal</td>
<td>965</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Laparoscopic</td>
<td>3710</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>D&amp;C</td>
<td>7575</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>

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### CONCLUSION:

**Probably no needle-trocar system can guarantee avoidance of injury during laparoscopic entry, especially when the trajectory of insertion puts great vessels at risk.**

**Bowel injuries occur during open as well as closed techniques of insertion, and with optical trocar systems as well.**

**Vascular injury is usually obvious, but delayed recognition of loss of bowel integrity is related to increased mortality, especially in patients over 60 years of age.**

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### Timing of injury recognition

- An early management of any complication is essential
  - An early management of complications is essential
  - Therefore an early diagnosis is mandatory
  - A close and careful follow up of each patient is required
  - The simplest procedure may induce a drama
  - No simple case ...

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**J Am Assoc Gynecol Laparosc. 2001 Aug;8(3):335-6.**

Survey of laparoscopic entry injuries provoking litigation.

Corson SL, Chandler JG, Way LW.

Department of Obstetrics and Gynecology, Thomas Jefferson University, Philadelphia PA 19107, USA.

**J Am Assoc Gynecol Laparosc. 2001 Aug;8(3):335-6.**

Survey of laparoscopic entry injuries provoking litigation.

Chapron, Human Reprod 1998
Main results

The review included 28 randomised controlled trials with 4860 individuals undergoing laparoscopy and evaluated 14 comparisons. Overall there was no evidence of advantage using any single technique in terms of preventing major vascular or visceral complications. Using an open-entry technique compared to a Veress Needle demonstrated a reduction in the incidence of failed entry, (Peto OR 0.12 (95% CI 0.02 to 0.92). There were three advantages with direct-trocar entry when compared to Veress Needle entry, in terms of lower rates of failed entry (Peto OR 0.21, 95% CI 0.14 to 0.31), extraperitoneal insufflation (Peto OR 0.18, 95% CI 0.13 to 0.26), and omental injury (Peto OR 0.18, 95% CI 0.14 to 0.55). There was also an advantage with radially expanding access system (STEP) trocar entry when compared with standard trocar entry, in terms of trocar site bleeding (Peto OR 0.31, 95% CI 0.15 to 0.62). Finally, there was an advantage of not lifting the abdominal wall before Veress Needle insertion when compared to lifting in terms of failed entry, without an increase in the complication rate (Peto OR 4.44, 95% CI 2.16 to 9.13). However, studies were limited to small numbers, excluding many patients with previous abdominal surgery and women with a raised body mass index who may have unusually high complication rates.

Authors’ conclusions

On the basis of evidence investigated in this review, there appears to be no evidence of benefit in terms of safety of one technique over another. However, the included studies are small and cannot be used to confirm safety of any particular technique.
Pivotal moment
Le moment de forces

Initial steps are much more important for advanced and extensive procedures, inadequate installation for a Tubal sterilisation is an incident, inadequate installation for a colon resection may be a cause of conversion to laparotomy or of major complications.

Pivotal moment
Trocars placement

• Trocars placement leads to the success of the procedure!

Trocars placement

• The surgeon’s right hand should not be lower than the left, so the central trocar should never be lower than the lateral
• Intra-abdominal length of the instruments should be equal at the external:
  Precision and force perception

Advice
Keep the right position for the surgeon:
Two elbows along the body.

Trocars placement is the most important part of the surgery

Ancillary trocars

Ancillary trocars

Ergonomy
Inadequate trocar site consequences

• Too much strength on the instruments
• Many unskilled movements
• Tired surgeons
• Blind movements .........

Complications

During the procedure

• Check the anatomy

During the procedure

• Never be blind
  – Careful hemostasis
  – Adequate exposure
  – Panoramic view when bringing in a new instrument
  – .............

Identification of the anatomy

• Adequate dissection and identification of vulnerable structure
• In the following example, the hypogastric nerve was identified and preserved while excising a nodule of the left utero sacral ligament.
Short videos of anatomy will be presented
Complications related to the disease

- Deep endometriosis may involve the bowel and the urinary tract

- Management of post operative complications should be planned,
  - if the gynecologist is not able to manage each possible post operative complication
  - he will call a specialist to help him and the specialist should be informed before the procedure

Information is essential for a good collaboration

- To ask for help is not a shame!

- To do inadequate procedures because of ignorance is not acceptable

- To ask for help after an inadequate management is a shame!
The specialist should be informed of the first procedure

- He may come and see the procedure
- He may give an opinion on the intraoperative management
- He will understand, that this surgery is difficult and may induce complications
- He will understand the importance of preserving pelvic organs in young patients
- His attitude in the management of complication will be different

Final check list

- Bleeding
- Ureters
- Sigmoid: be aware that shaving is possible only on the rectum not on the sigmoid
- Rectum: Michelin test, the pelvis is filled with ringer lactate, air is injected in the rectum while the rectum is clamped above the traumatized area
- ..........

Is it useful?

Anastomotic Leak Testing After Colorectal Resection: What Are the Data?

From: Anastomotic Leak Testing After Colorectal Resection: What Are the Data?

Postoperative clinical leaks in all anastomoses (A) and circular stapled anastomoses (B) that were either airtight, confirmed to have an air leak, or untested. Significance established at χ² testing. Bars indicate standard deviation.

Figure Legend:
- Postoperative clinical leaks in all anastomoses (A) and circular stapled anastomoses (B) that were either airtight, confirmed to have an air leak, or untested. Significance established at χ² testing. Bars indicate standard deviation.

To diagnose complications

- Post operative pain management should be optimal and almost always the same

- So that when the patient is painful despite this management, you know that something is probably wrong
Post operative pain management

- The surgeon and the anesthesiologist had to follow a precisely defined post operative analgesia protocol.
  - A trocar site infiltration (5 ml/orifice) and intra peritoneal instillation (20 ml): ropivacaine 40 ml 4.75 mg/ml (mix of 20 ml of ropivacaine 2 mg/ml with 20 ml 7.5 mg/ml) was performed at the beginning of the surgical procedure.
  - Reduction in pneumoperitoneal pressure (between 8 and 12 mm Hg) was recommended.
  - Paracetamol 1 g and ketoprofen 50 mg in slow intravenous infusion were injected at the vaginal incision.
  - At the end of the procedure, a manual exsufflation of the pneumoperitoneum was routinely achieved.

Post operative pain management

- The patient returned to her room with an intravenous catheter, ready for use if a complication occurred, but without any intravenous infusion.
- Oral analgesia was used exclusively, associating: paracetamol 1 g every 6 hours, ketoprofen 150 mg 1 tablet every 12 hours.
- If the pain persisted an oral morphine rescue supplementation was administered, with morphine sulphate 10 mg for 4 hours.
- Patients could drink when back in their room and could eat something light two hours after, if they wished.

With this protocol pain scores were always < 4 when everything was normal

2012 study

Aim of the study:
- Evaluate the post operative consequences of a lower intraperitoneal pressure during laparoscopic hysterectomy.

Patients:
- 40 consecutive patients who had a laparoscopic hysterectomy
- Senior surgeons
- Two groups:
  - low pressure (8 mm Hg)
  - normal pressure (12 mm Hg)

Exclusion criteria:
- Age: <35 ans or >70 ans
- Extensive Adhésiolysis, lymphadenectomy or T.V.T-O during the same procedure
- Patients operated for chronic pelvic pain or endometriosis de douleurs chroniques
- Cancer
- Uterine Morcellation at 15 mmHg during more than 15 minutes
### Results

<table>
<thead>
<tr>
<th></th>
<th>Pression 8 mmHg</th>
<th>Pression 12 mmHg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>48.2</td>
<td>48.6</td>
</tr>
<tr>
<td>BMI</td>
<td>25</td>
<td>24.1</td>
</tr>
<tr>
<td>Duration of surgery</td>
<td>115</td>
<td>130</td>
</tr>
<tr>
<td>Sufentanil (total dose)</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>Bowel activity</td>
<td>16.3</td>
<td>20.1</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>7.8</td>
<td>7.9</td>
</tr>
<tr>
<td>Hospital stay</td>
<td>2.2</td>
<td>2.5</td>
</tr>
</tbody>
</table>

- Earlier bowel activity after a procedure achieved with an 8 mmHg pressure.
- Lower pain after 8 mmHg but the difference was not statistically significant.
- Post operative pain was very low in both groups.

### Pain scores

- Pain scores were very low even during physical activity of post operative day one.
- Pain scores should decrease with time!

### After the procedure

- The patient should get better and better!
- The patient did not became strange or “hysteric” after the procedure if she complains of pain something is probably wrong.
- The surgeon should listen and take care of patients complaints.
- Again an earlier and effective management likely decrease the consequences of the complication.

### If post operative pain is severe

- Check the quality of the analgesic protocol, is the standard protocol used as usual?
- If No, use it and check again pain scores 2 hours later.
- If Yes look for a potential complication ultrasound, blood tests and even CT Scan may be indicated.
After an intra umbilical trocar insertion

- An early reoperation is possible with minimal or even no risk related to the installation of the laparoscope.
- During the first 10 post operative days, the laparoscope can be inserted in the peritoneal cavity without pneumoperitoneum and without any sharp instrument.

- In high risk patients after an adequate 15 mmHg pneumoperitoneum you may use a vertical incision in the lower part of the umbilicus.

Re operation with no risk is possible !!

- Insufflation is connected to the trocar, the laparoscope is placed in the trocar the skin is opened then

- The laparoscope is placed in the incision and moved slowly toward the pelvis, using visual and tactile sensations it is almost always possible to place the trocar in the abdominal cavity in less than 1 minute.
Post operative course

• After two laparotomies, duration of recovery is 2 and even 4 time longer than after one laparotomy

• After two laparoscopies, duration recovery is similar to that observed after one laparoscopy if the complication has been adequately treated.

In other words: duration of hospital stay

Laparoscopic reoperation

• Low or no risk related to installation of the procedure

• Much less morbid than re operation was when laparotomy was the rule

C Reactive protein and post op complication

If a complication is suspected Do not wait too long! Just have a laparoscopic look
But you should exclude pneumonia and wound infection

Conclusion

Persisting CRP elevation and elevation of serum CRP above 140 mg/dl on PODs 3-4 are predictive of infectious postoperative complications and should prompt intense clinical search for an inflammatory process, especially for an anastomotic leak if pneumonia and wound infection are unlikely or excluded.

Safe and Early Discharge After Colorectal Surgery Due to C-Reactive Protein

A Diagnostic Meta-Analysis of 1832 Patients

Conclusions: This diagnostic meta-analysis of 1832 patients—the first in the literature—presents compelling evidence that C-reactive protein on postoperative day 4 has a high negative predictive value for infectious complications of 89%. Therefore, CRP measurement allows safe and early discharge of selected patients after colorectal surgery.
In case of abnormal clinical symptoms and or abnormal biological signs (elevated CRP or WBC) a CT scan should be performed.

Pelvic ultrasonographic examination is difficult.

CT is accurate in the diagnosis of pelvic abscesses, of anastomotic leak and of ureteral fistula.

CT is also useful in patients for whom a reoperation has been decided, indeed the intraoperative diagnosis of a complication may be difficult.

Reoperation may also induce post op complications.

Therefore it is helpful to have a good imaging evaluation of the pelvis before surgery so as to facilitate the surgical diagnosis and to minimize the risks related to the reoperation.

CT scan after surgery for deep endometriosis will be presented.

Our experience in post operative CT scan after surgery for deep endometriosis will be presented.

If the delay to obtain the CT scan is too long (several hours) and the indication for surgery is obvious.

Surgery should be performed without preoperative evaluation.

To allow a laparoscopic management of complications.

Complications should be diagnosed and managed early.

The surgical team should be trained to extensive laparoscopic procedure.

The general surgeon and the urologist should be experienced laparoscopist.
For an optimal management

- Reoperation is the most difficult situation
- Reoperation is the most difficult indication

Ask for help
- You are stressed
- You may be depressed ....
- You are hopefully less confident
- You are in the situation to do another mistake

In the management of post operative complication the most reliable symptoms is :

- Abnormal Pain
- Abnormal Pain in a patient who has adequate pain management
- Elevated WBC
- Increased C reactive protein
- Increased body temperature
- The difficulties encountered during the first procedure

References

The Late Complications of Endoscopic Surgery: Unrecognized Bowel and Urinary Injuries, Causes and Management

Marshall (Mark) Smith, MD, PhD

AAGL Global Congress 2012

Disclosure

Other: Johnson & Johnson - Owned stock in company that produced an orthopedic simulator

Learning Objectives

1. List techniques used to identify vulnerable structures to prevent complications.
2. List techniques used for the early diagnosis of complications.
3. Describe clinical, ultrasound and DT scan signs observed in early postoperative complications.
4. Describe the surgical management of the most common early postoperative complications.

How many lawsuits have you had filed against you for malpractice?

A. 0
B. 1 - 2
C. 3 - 4
D. > 4

Complications of Laparoscopy

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>635</td>
<td>Blood loss over 500 cc</td>
</tr>
<tr>
<td>254</td>
<td>Transfusions</td>
</tr>
<tr>
<td>238</td>
<td>Bowel injuries</td>
</tr>
<tr>
<td>152</td>
<td>Bladder injuries</td>
</tr>
<tr>
<td>53</td>
<td>Ureteral injuries</td>
</tr>
<tr>
<td>25</td>
<td>Nerve injuries</td>
</tr>
</tbody>
</table>

AAGL, 1993

How did the lawsuit affect you?

A. No big deal....
B. A real hassle...
C. Impacted me emotionally and/or professionally
D. Devastated me....
Complications of Laparoscopy

635 Blood loss over 500 cc
254 Transfusions
238 Bowel injuries
152 Bladder injuries
53 Ureteral injuries
25 Nerve injuries

AAGL, 1993

Complications of Laparoscopy

“delayed recognition of loss of bowel integrity is related to increased mortality, especially in patients over 60 years of age.”

Corson et al, JAAGL, 2001

Complications of Laparoscopy

“Most cases in the US involved biliary-gastrointestinal surgery rather than gynecologic procedures....Small bowel led the group of structures injured.”

Corson et al, JAAGL, 2001

Complications of Laparoscopy

First
Do
No Harm!

Error Rates

To Err Is Human:
Building a Safer Health System
Institute of Medicine
1999

Error Rates

45 % Are Surgical Errors!

JCAHO reveals most frequently reported sentinel events
Based on JCAHO’s annual report, which summarizes the sentinel events reported by healthcare facilities over the past year. The report includes 11 patient safety indicators and 5 individual events that are considered to be the most frequently reported by hospitals.

- Patient safety
- Wrong-site surgery
- Surgical complications
- Medication error
- Treatment delay
- Patient fall
"You cannot solve a problem with the same type of thinking that is creating it."

Einstein

Patterns of technical error among surgical malpractice claims
- 52% of claims were due to technical error
- 65% due to linked to manual error
- 9% linked to errors in judgment
- 26% due to both
- 49% caused permanent disability
- 16% resulted in death

Regenbogen et al, Ann of Surgery, 2007

Patterns of communication breakdowns resulting in injury to surgical patients.
- 60 cases identified that involved communication breakdown
  - 38% pre op
  - 30% intra op
  - 32% post op


Cause and Effect Analysis of Closed Claims in Obstetrics and Gynecology
- 78% had identifiable contributing or causative factors
- Clinical performance was a factor in 31% of cases
- Communication problems were a factor in 31% of cases

White et al, Obstet Gynec 2005

CONCLUSIONS: Most technical errors occur in routine operations with experienced surgeons (73%), under conditions of increased patient complexity or systems failure.

Regenbogen et al, Ann of Surgery, 2007

Patterns of communication breakdowns resulting in injury to surgical patients.
- The majority of breakdowns were verbal communications (92%)
- Attending surgeons were the most common team member involved!
Cause and Effect Analysis of Closed Claims in Obstetrics and Gynecology
- 78% had identifiable contributing or causative factors
- Clinical performance was a factor in 31% of cases
- Communication problems were a factor in 31% of cases

White et al, Obstet Gynecol 2005

Patterns of communication breakdowns resulting in injury to surgical patients.
- “CONCLUSIONS: Serious communication breakdowns occur across the continuum of care, and typically result from a failure in verbal communication between the surgical attending and another caregiver…”


Transfer of Surgical Skills

Complications of Laparoscopy
With a detailed knowledge of pelvic anatomy, familiarity with the many laparoscopic instruments, and attention to the details of good technique, many of the complications of laparoscopy described in this article can be avoided….

Lin PJ, Grow DR

Complications of Laparoscopy
- Know your anatomy!
- Know your instruments!
- Use good technique!

Complications of Laparoscopy
I don’t have complications, I have learning experiences!
Gastrointestinal Injuries

Trocar
- Most common at entry
- Avoid old scars
- Bowel prep of some type

Gastrointestinal Injuries - Prevention
- Lysis of adhesions with traction
- Understand your energy source
- Good visualization
- Hydrodissection

Gastrointestinal Injuries
- Visualization of serosal injury

Gastrointestinal Injuries
- Visualization of serosal injury
  - Visualization of lumen
Gastrointestinal Injuries

- Visualization of serosal injury
- Visualization of lumen
- Visualization of bowel burn or damage

Gastrointestinal Injuries

- Visualization of serosal injury
- Visualization of lumen
- Visualization of bowel burn or damage
- Smell or visualization of feces

Large Bowel - Sigmoid

- Fill pelvis with fluid
- Fill rectum with air with Asepto syringe

Gastrointestinal Injuries

- Nausea, vomiting
- Fever, chills
- Leukocytosis

Gastrointestinal Injuries

- Abdominal pain
- May not present for up to seven or more days
Gastrointestinal Injuries

- Suspect bowel injury in any patient whose post op pain does not improve after surgery.

Gastrointestinal Injuries

Direct Contact

Defect in Insulation

Capacitance Coupling

Gastrointestinal Injuries

Cutting or unmodulated electrical current

Complications of Laparoscopy

Instruments don’t have complications...

Surgeons do!
Gastrointestinal Injuries

- Make a mini-laparotomy incision and exteriorize bowel loop for repair
- Enlarge umbilical incision and exteriorize
- Check both sides of bowel for damage

Forty Percent (40%) Rule

Gastrointestinal Injuries

- Take extra time to ensure that bowel injury did not occur during surgery
- High ROI on your time (and stress level)

Urinary Tract Injuries

Bladder Injuries - Prevention

- Foley or catheterization
- Visualize bladder before inserting midline trocars
- Fill and drain bladder if question

Bladder Injuries

Postoperative Symptoms
- Peritonitis
- Leukocytosis
- Abdominal pain
- Fever
- Present 24-72 hours after laparoscopy
- Ascites
**Bladder Injuries**
- Extraperitoneal vs. intraperitoneal
- No repair for small lacerations
- Repair laparoscopically with double layer closure
- Leave catheter in place for seven days

**Ureteral Injuries**
One ureter was damaged, which case was it?
- Case # 1
- OR
- Case # 2

**Ureteral Injuries**
Most common Sites of Injury
- IP Ligament
- Crossing of uterine artery

**Best technique to avoid ureteral injury,**

**Dissect it out !**

**The best management of all complications!**

**AVOIDANCE**

**Complications of Laparoscopy**
The management of laparoscopic complications does NOT end when the patient reaches the post op recovery room!
Complications of Laparoscopy

• Discussion of events with patient’s family
• Later discussion of events with patient
• Continued close communication with patient and her family

The Late Complications of Endoscopic Surgery: Unrecognized Bowel and Urinary Injuries, Causes and Management
Mark.Smith@BannerHealth

Thank you!
CULTURAL AND LINGUISTIC COMPETENCY

Governor Arnold Schwarzenegger signed into law AB 1195 (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

California Business & Professions Code §2190.1(c)(3) requires a review and explanation of the laws identified above so as to fulfill AAGL’s obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at http://www.imq.org.

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 http://www.usdoj.gov/crt/cor/pubs.htm.

Executive Order 13166,”Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 http://www.usdoj.gov/crt/cor/13166.htm was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

If you add staff to assist with LEP patients, confirm their translation skills, not just their language skills. A 2007 Northern California study from Sutter Health confirmed that being bilingual does not guarantee competence as a medical interpreter. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538.