INCOMPLETE PATIENT UNDERSTANDING OF RISKS COMPLICATES SURGERY

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DESCRIPTION

A patient undergoing elective surgery suffered severe anoxic brain injury due to complications from a pre-existing condition.

KEY LESSONS

- Elective surgery should not proceed when the team does not have a thorough understanding of the patient's medical history.
- A patient memory and understanding of complex clinical facts is not a substitute for reviewing the medical record or consulting with clinical colleagues.

CLINICAL SEQUENCE

A 56-year-old female met with the anesthesia resident 10 days before she was scheduled for an elective vaginal hysterectomy due to uterine prolapse. The resident examined the patient and they discussed her (five-year) history of polychondritis—a rare and chronic rheumatic disease which can affect a patient's cartilage, trachea, and mucus membranes. The patient indicated that she never had a problem with breathing. Since the resident had not heard of polychondritis, she checked with the attending anesthesiologist, did some research regarding the condition, and found nothing contraindicating general anesthesia. The patient was cleared for surgery. She was felt to be ASA II (her illness should not affect receiving anesthesia).

On the day of the surgery, the attending anesthesiologist evaluated the patient and asked if she had any problems with her respiratory status; she denied any problems. The plan was to use general anesthesia with a possible stress dose of steroids. The patient was induced by an anesthesia resident for general anesthesia, but the endotracheal tube could not be passed beyond the glottis. The attending then attempted the intubation and switched to a laryngeal mask airway. The ventilation with this was only adequate.

A decision was made to cancel the case, awaken the patient, and obtain an ENT consult as an outpatient regarding the apparent sub-glottic stenosis. However, as the patient was awakening, she developed progressive shortness of breath and stridor. An emergency tracheotomy (performed by an otolaryngologist) was unsuccessful due to narrowing of the trachea. The patient then developed flash pulmonary edema. A thoracic surgeon performed a successful sternotomy, but significant anoxia had occurred over approximately 10 minutes.

After surgery, the patient suffered continuous seizures. An EEG confirmed severe anoxic brain injury. After two months in a vegetative state, the patient died. An autopsy revealed evidence of polychondritis in the upper airway and nasal passages. An investigation revealed a history of spiral CT scans of the trachea (at an outside facility) which, initially, demonstrated scarring of the patient's trachea, then showed that the scarring was resolving. This information had not been communicated to either the gynecologist or to the anesthesia team. The patient's family was similarly unaware that her polychondritis had been symptomatic.

ALLEGATION

The patient's family sued the Anesthesia attending, resident, and CRNA alleging that they failed to recognize that the patient's polychondritis put her at increased risk for complication under general anesthesia..

DISPOSITION

The case was settled for more than $1 million against the attending anesthesiologist.

ANALYSIS

An inadequate history hindered clinical decisions.

Without a commitment to patient safety as an ongoing process, clinicians run the risk that time pressures will influence their ability to take a proper history, to document that history in the medical record, and to review and reflect on that history. Since no operation will ever have zero percent risk, each deserves a preparation involving all of the required steps.

Lacking the complete set of medical records, the anesthesiologists relied on the interview with the patient—who did not give them the complete information.

For patients with a known (rare) condition, they might have used a time out to clarify the disease and

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ANALYSIS

appreciate the fact that there could be airway involvement. This was an elective procedure and time was on their side.

Under no real pressure to rush ahead, the anesthesiologist proceeded without speaking with a rheumatologist or an otolaryngologist.

Physicians should not hesitate to consult a colleague in determining diagnosis, prognosis or treatment modality. The defense of care that is brought into question is, generally, supported by (documented) consults with other physicians.