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Case Report

Abdomen-still a pandora's box

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ABSTRACT

An interesting case of young lady who had undergone obstetric hysterectomy during delivery with left ovary *in situ*. She was taken up for laparoscopic oopherectomy at a later date for a large ovarian mass on left side which was removed. She presented to us with recurrence of pelvic mass. Preoperatively we were reminded of the adage and popular saying." Abdomen-still a pandora's box." This article attempts to present the importance of truthful case notes in failed surgeries and effective communication to the patient to prevent clinical and surgical misadventures and dilemmas.

Keywords: Laparatomy, Laparoscopy, Pelvic mass, Medical records, Medical negligence

INTRODUCTION

Truthful history and diligent per op note writing is the cornerstone of all surgeries. All surgeons have encountered cases with unexpected findings beyond their capabilities and expertise, wherein they had to close the abdomen. Some cases are deemed inoperable, some if operated will invariably die on table and on many occasions surgeons rush in with immense confidence to be humbled. In all such cases it is the moral obligation of the operating surgeon to ensure effective and truthful communication to the patient and if intervention is deemed imperative and lifesaving; refer to a higher centre with detailed notes, diagrams, intraoperative difficulties and images.[1] This should be done to prevent a future catastrophic therapeutic misadventure, based on clinical findings and imaging alone which may be misleading. All surgeons are taught to hold the scalpel with confidence, but not overconfidence; with trepidation and reverence; a silent prayer and a humble demeanor; and yet be lion hearted; for the patient has placed her life unto your hands. Here we present such a case where improper documentation by the previous operating surgeon proved to be a challenge.

CASE REPORT

The 32 years old lady who underwent caesarean hysterectomy for obstetric PPH after twin operative delivery on 13.11.2014, presented with left adnexal mass as a diagnosed case of recurrent left ovarian cystadenoma. She underwent laparoscopic left ovarian cystectomy with right salpingectomy for on 11.01.2021 for left ovarian cystadenoma ~ 10×7 cm, right ovary measuring ~ 4.5×3.1 cm on MRI dated 21.12.2020 (Figure 1 and 2) as per available clinical notes. HPE dated 12.01.2021 revealed ovarian size of 5×3×1 cm and fallopian tube size of 4×5×1 cm, suggestive of accidental removal of right tube and ovary with falsification of documents. Patient persisted with pain and reported to this centre with USG report of right ovarian cystadenoma ~ 7×6 cm dated 25.06.2023. CECT was performed at this centre on 10.08.2023 revealing a left adnexal mass likely ovarian. Right ovary appeared to be *in situ* (Figure 3 and 4).

She was planned for staging laparatomy with a remote possibility of malignancy due to recurrence with a surgical consultation as the mass could also be mesenteric in origin. Perusal of old documents and comparison of radioimaging however raised the suspicion of error by the operating surgeon. She was planned for staging laparatomy with well-informed written consent on 25.08.2023.

Abdominal incision was midline vertical as per existing guidelines in standard textbooks and intraoperative findings were as shown in Figure 5. Large ~ 12×10 cm left adnexal mass adherent to RectoSigmoid colon was dissected and mobilised, clamped ligated and cut at origin from lateral pelvic wall along with right oopherectomy, appendicectomy and infracolic omentectomy. Specimens were identified, labelled and sent to medical college pathology dept for review and HPE.

Haemostasis was ensured. Intra-abdominal and Subcutaneous drain were inserted. Abdomen closed in layers. She was transfused with two units of whole blood postoperatively along with preantral antibiotics, analgesia and supportive measures. She was ambulated on first postoperative day and oral fluids were administered. Parenteral antibiotics, analgesia and fluids were stopped after 48 hours and oral soft diet was given to the patient. Catheter was removed after 48 hrs and subcutaneous drain was removed after 72 hrs. Intraabdominal drain was removed on 5th postoperative day. She had an uneventful recovery and sutures were removed on 14th postoperative day. HPE (25.09.2023) revealed serous cystadenoma-left ovary, haemorrhagic corpus luteum and cortical cysts-right ovary, lymphoid hyperplasia-appendix, normal left fallopian tube and omentum.

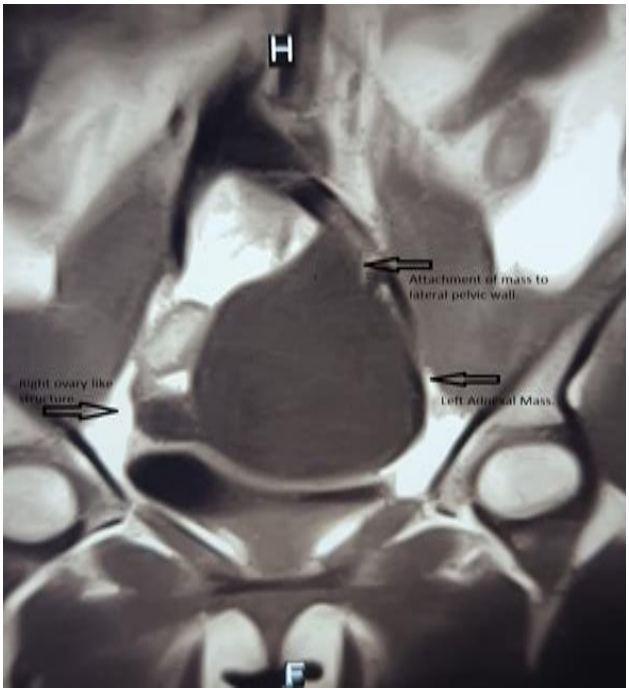

Figure 1: MRI of pelvis preoperatively showing large left ovarian cystadenoma.

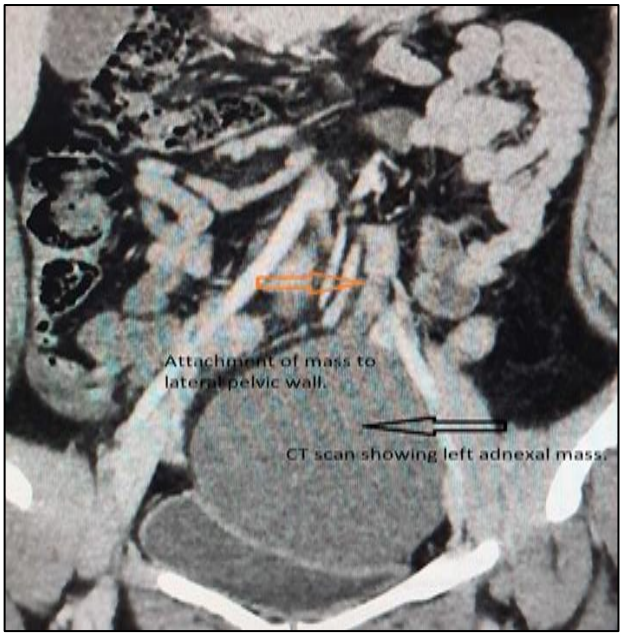

Figure 2: CT scan at our centre after first laparoscopic surgery wherein right ovary and fallopian tube was documented as removed with histopathology report from the centre, confirming removal. CT scan demonstrates ovary like structure in right adnexa, with large left adnexal mass, likely ovary, transverse section.

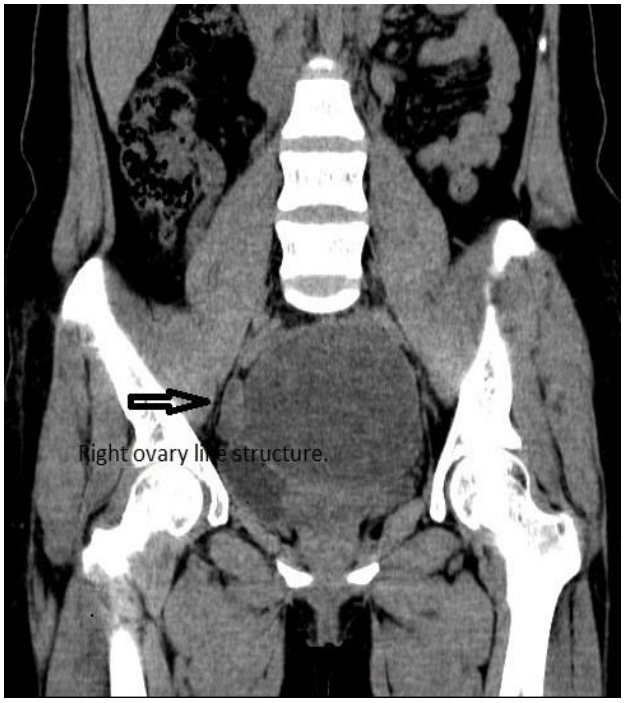

Figure 3: CT scan at our centre after first laparoscopic surgery wherein right ovary and fallopian tube was documented as removed with histopathology report from the centre, confirming removal. CT scan demonstrates ovary like structure in right adnexa, with large left adnexal mass, likely ovary, longitudinal section.

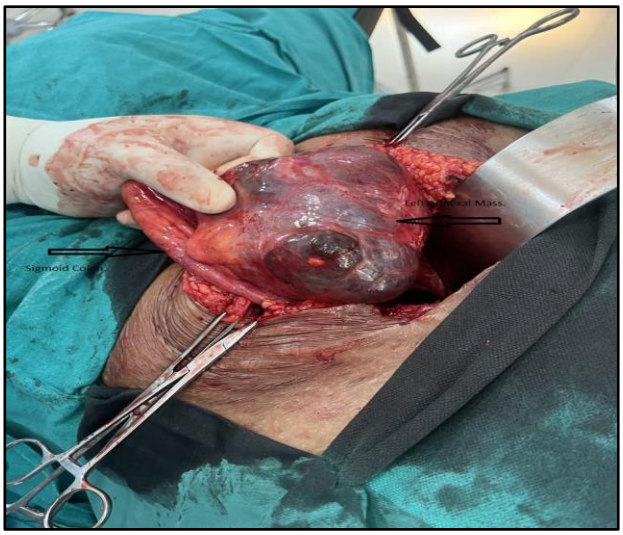

Figure 4: Intraoperative view of left adnexal mass with sigmoid colon and attachments to lateral pelvic wall with adhesions.

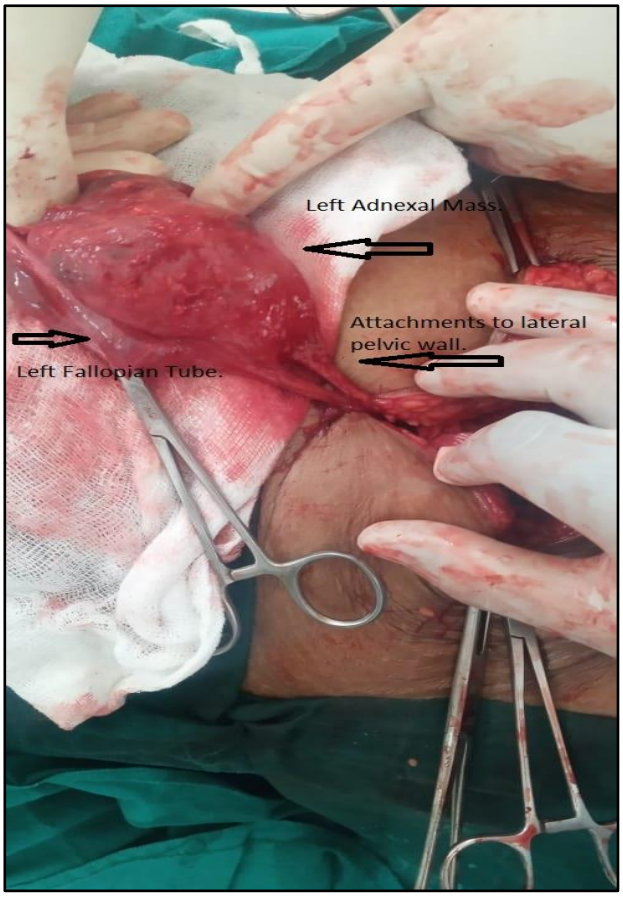

Figure 5: Intraoperative view of left adnexal mass with fallopian tube and attachments to lateral pelvic wall post dissection.

DISCUSSION

Res Ipsa Loquitur is a situation of gross negligence or rashness. The clinical findings are so apparent that they "speak for themselves". Usually there is no requirement of any proof of negligence in such cases.[2] Common examples include transfusing incompatible blood to patient without prior checking and confirmation, or operating on wrong side of the body, amputating the wrong limb or on wrong patient. It is imperative on the treating physician to diligently document the management of the patient under her care. Medical record keeping is the only defence of a doctor to prove that the treatment was as per existing standard guidelines to the best of his abilities and available resources. Absence of expert evidence has also been referred to as one of grounds of 'no-proof' of negligence. We have seen the material on record and find that while no expert evidence has been produced or examined by the appellant, we have to see this in 'ground reality' terms, that very rarely, if ever, any other doctor comes forward to give evidence in person or by way of evidence against other doctor. In this case, this gap was made good by producing literature on all the points at issue-national commission. "In the case of a medical man negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. This is a perfectly accurate statement, as long as it is remembered that there may be 1 or more perfectly proper standard; and if a medical man confirms to one of those proper standards, then he is not negligent. Counsel for the plaintiff was also right in my judgment in saying that mere personal belief that a particular technique is best is no defence, unless that belief is based on reasonable grounds. That again is unexceptionable. A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art." Justice Mc Nair in Bolam vs. Friern hospital management committee (1957) 2 All ER 118.[3]

The legal system relies mainly on documentary evidence where medical negligence is alleged by the patient or the relatives. In an accusation of negligence, this is the most important evidence deciding on the sentencing, quantum of punishment or acquittal of the physician. With increasing use of medical insurance for treatment, proper record keeping is essential to process the patient's claim for medical expenses. It is wise to remember that "Poor records mean poor defence, no records mean no defence". Medical records include patient's history, clinical findings, diagnostic test results, preoperative care, operation notes, post operative care, and daily notes of a patient's progress and medications.[2] An essential component is nurse's or Matron's records.

A well-informed written consent goes a long way in proving that the procedures were performed with the concurrence of the patient or next of kin. A crisp and clear operative note with supporting diagrams or images can defend a surgeon in case of alleged negligence due to operative complications. The treating physician is the nodal person who has to oversee this process and is primarily responsible for history, physical examination, treatment plans, operative records, consent forms, medications used, referral papers, discharge records, and

medical certificates. There should be truthful record of nursing care, Intake Output charts laboratory data, reports of diagnostic evaluations, pharmacy records, and billing processes. Hospital management, paramedical and nursing staff also should be trained in proper maintenance of such records. Anaesthesia and OT charts are invaluable defence in such cases. Certain records must be given to the patient as a matter of right. Discharge summary, referral notes, and death summary in case of natural death are important documents for the patient. These must be given free of cost to all patients who leave against medical advice too. Hospital bill clearance cannot be prerequisite to providing these sensitive documents that are necessary for continuing patient care. These documents cannot be legally refused even if hospital bills have not been settled.[4]

Medical records and legal experts spot medical record falsification in a board review. They are looking for incomplete, sparse, or unsubstantiated or haphazard information about the patient. Any discord or discrepancy between documentation, discharge summary and outcome are noted and correlated with verbal or written complaints of the patient. Forensic and medico legal experts compare progress notes with imaging and lab reports, OPD notes along with the pharmacy data. Inconsistencies with the documented record is reviewed by experts. A case in which a wrong limb or organ was treated, operated, amputated, or infected blood was given or qualification was wrongly written, the physician is entitled to engage the services of a lawyer. Discussion of the entire legal scope is beyond the scope of this clinical case report. To minimise adverse intraoperative, it is obligatory to maintain a surgical safety check list and record events as outlined by WHO and ClassIntra.[5]

The classification defines iAE as any deviation from the ideal intraoperative course occurring between skin incision and skin closure. Any surgery- and anaesthesia-related event during the index-surgery must be considered and should be rated directly after surgery. (Table 1).[4]

Table 1: ClassIntra® v1.0 classification of intraoperative adverse events (iAE).

Grade	Definition	Examples
Grade 0	No deviation from the ideal intraoperative course	
Grade I	Any deviation from the ideal intraoperative course: Without the need for any additional treatment or intervention Patient with no or mild symptoms	Bleeding: bleeding above average from small calibre vessel, self-limiting or definitively manageable without additional treatment than routine coagulation Injury: minimal serosal intestinal lesion, not requiring any additional treatment Cautery: small burn of the skin, no treatment necessary Arrhythmia: arrhythmia (e.g., extrasystoles) without relevance
Grade II	Any deviation from the ideal intraoperative course: With the need for any additional minor treatment or intervention Patient with moderate symptoms, not life threatening, and not leading to permanent disability	Bleeding: bleeding from medium calibre artery or vein, ligation; use of tranexamic acid Injury: non-transmural intestinal lesion requiring suture(s) Cautery: moderate burn requiring non-invasive wound care Arrhythmia: arrhythmia requiring administration of antiarrhythmic drug, no haemodynamic effect
Grade III	Any deviation from the ideal intraoperative course: With the need for any additional moderate treatment or intervention Patient with severe symptoms, potentially life threatening or potentially leading to permanent disability	Bleeding: bleeding from large calibre artery or vein with transient haemodynamic instability, ligation or suture; blood transfusion Injury: transmural intestinal lesion requiring segmental resection Cautery: severe burn requiring surgical debridement

Continued.

Grade	Definition	Examples
		Arrhythmia: arrhythmia requiring administration of antiarrhythmic drug, transient haemody namic effect
Grade IV	Any deviation from the ideal intraoperative course: With the need for any additional major and urgent treatment or intervention Patient with life threatening symptoms or leading to permanent disability	Bleeding: life threatening bleeding with splenectomy; massive blood transfusion; stay at intensive care unit Injury: injury of central artery or vein requiring extended intestinal resection Cautery: life threatening burn injury by cautery leading to fire requiring intensive care treatment Arrhythmia: arrhythmia requiring electro-conversion, defibrillation, or admission to intensive care
Grade V	Any deviation from the ideal intraoperative course with intraoperative death of the patient	

Class Intra version 1.0 classification of intraoperative adverse events. The classification defines intraoperative adverse events as any deviation from the ideal intraoperative course occurring between skin incision and skin closure. Any event related to surgery and anaesthesia during the index surgery must be considered and should be rated directly after surgery. A requirement is that the indication for surgery and the interventions conform to current guidelines. These events were not defined as intraoperative adverse events: sequelae, failures of cure, events related to the underlying disease, incorrect site or incorrect patient surgery, or errors in indication.

CONCLUSION

A patient consulting a doctor expects and is entitled to treatment and care with all the knowledge and skill, to the best of his abilities with all available resources that he possesses for a permanent cure or temporary relief with appropriate guidance. The relationship is a contract with the essential elements of tort. Any breach of contract gives a cause for a case of negligence against the doctor. Prior informed consent from the patient before carrying out diagnostic tests and therapeutic management is essential. The services of the doctors are covered under the provisions of the consumer protection act, 1986 and a patient can seek redressal of grievances from the consumer courts.

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