KAMINENI INSTITUTE OF MEDICAL SCIENCES

Sreepuram, Narketpally, Nalgonda (Dist.) 508 254

MINUTES

SUMMARY OF THE MORTALITY MEETING (28-03-2014)

Chairperson : Dr. (Col.) Mathi Edwin Luther Professor & HOD of Orthopaedics

Total No. Present : 49 (Including Staff & P.G's)

Case 1 : B. Maremma 72 /F IP No. 201406635 General Surgery – II

1. Mortality Meeting was held on 28-03-2014 from 2 – 3 p.m.

   One case was presented & discussed from Department of Surgery.

2. Brief Description of the Case

   a) 72 / F, was admitted to hospital as a case of blunt trauma abdomen.She was haemodynamically stable & was taken up for emergency laparotomy the same day.

      Laparatomy revealed haemoperitonium with mysenteric tear & 15cm of gangrenous bowel. The haemoperitoneum was evacuated the mysentery repaired and ileostomy was performed .

   b) Subsequently patient recovered well & was discharged. Month later she was admitted for Vomtings, Hicough, abdominal distention, also found to have electrolyte disturbance and cardiac problem with ectopics / Patient was resuscitated and taken up for drainage of the intra abdominal absess, closure of ileostomy and gut resection and anastomosis (over next four weeks) after optimisation of general condition.

c) She developed features for sepsis with multiple organ failure & expired on the 5th post of op day.

DISCUSSION :

Q1. By Chairperson :- Why end to end anastamosis was not performed? Instead of ileostomy.

A1. By Surgery Resident :- Answer was not convincing. He was not clear when to do ileostomy ; or resection anastamosis.

Q2. By Chairperson :- What was the clinical diagnosis at second admission ?

A2. By Surgery Resident :- Post-OP Obstruction (intestinal), electrolyte inbalance', sepsis

Q3. By Chairperson :- What was the indication for the exploration.

A3. By Surgery Resident :- To drain abscess ; close the entero cutaneous fistula & do an end to end anastamosis for gangrenous gut.

Q4. By Chairperson :- Will we do an anastamosis when pt. is moribund and had oedamatous gut.

A4. By Surgery Resident :- Answer was not correct . Indication for exploration / closure of antero cutaneous fistula was discussed by Prof. of surgery.

Q5. Professor of Surgery :- What are the stages of Septic Shock.

A5. By Surgery Resident :- Given Correctly .

Q6. Professor of Surgery :- What is high out put failure ? What is the presentation of dyselectrolytemia.

A6. By Surgery Resident :- Not clearly stated. Prof. of Surgery explained in detail.

LESSONS LEARNT :

1. Initial surgery should have been peritoneal toilet; repair of mysentary & end to end anastamosis, after gut resection & not ileostomy.

2. Repeat Surgery should have aimed at drainage of abscess ; peritoneal toilet rather than closure of ileostmy & end to end anastamosis .

3. Aggressive supportive care with I.V. Fluids, ianotropic support,. Antibiotics, ventilatory support . Nutrition (parenteral) could have saved the patient, possibly.

Dr. (Col.) Mathi Edwin Luther
Professor & HOD of Orthopaedics