MINUTES OF THE MORTALITY MEETING
HELD ON 05TH SEPTEMBER 2014 AT 2.00P.M.

Total No. Attended : Faculty 26, P.Gs 46 TOTAL: 72

Chairpersons: 1. Dr. (Col.) V.M. Venugopalan
2. Dr. Gopal Reddy

Case No. 1:

T. Lachaiah, Age 50 years/Male, IP No.201420947, Orthopaedics Unit-I admitted to hospital on 19-07-2014 with H/O of injuries sustained in RTA on the same day. No H/O of loss of consciousness, seizures, GCS-E3 M6V4. Pupils normal bilateral. Pulse 90/mt., BP 140/90mmHg, RR-14/mt, SPO2 -96% .Wound parieto temporal region. Lacerated wound Lt.Leg and angulation of right leg mid shaft. Heart & Lump – NAD.

Investigations:

Hb. 11.2 ,G% ,TLC -11500/cmm, BT & CT Normal, RFT- Normal, **HIV –Positive**, HBSAg – Negative, X-Ray Rt.leg - fracture both bones and mid shaft , CT-Brain: Fractures nasal bones and right frontal and roof of both orbitis . SAH left frontal and right parietal region. X-Ray chest - Normal, ECG- T inversion V3, otherwise normal. Treated by EMD -- Inj. Mannitol 20G IV stat, Inj. Phenytoin 800mg ,in 100ml normal saline. Neurosurgeon opinion --No surgical intervention required. Continue treatment ,added Inj. Diclofenac 50mg. IM BD and Lubrex eye drops. GCS-E4 M5V4 on 21-07-2014

CT Brain showed SAH resolved . Treatment continued and patient shifted to ortho ward. Patient stable and treatment continued. On 26-07-2014 patient started getting hicuups. Tablet Bclofen 25mg BD and Inj. Ondasetran 4mg IV BD as per the advise of Physician .

In spite of treatment the intractable hicuups did not subside and on 28-07-2014 patient started having shortness of breath for which oxygen inhalation started. GCS –E4M5V4. Case seen by neurosurgeon on 30-07-2014 and CT Brain

did not show any intracranial bleed. The hicuups persisted and on 02-08-2014 the condition of patient started deteriorating with respiratory distress and falling GCS . Intubation and mechanical ventilation was decided at 8.00pm, but the patient's relatives delayed in giving consent. Patient had cardiac arrest at 9.25p.m. and inspite of all resuscitative measures could not be revived and declared dead at 9.59pm,

Cause of Death: Immediate : SAH with cerebral oedema leading to increased ICT . Antecedent cause – SAH
Secondary cause- Compound fracture tibia & fibula RT.

QUESTIONS AND ANSWERS

Dr. B. Srinivas Prof. of General .Surgery

Q1. When was the case treated by Neurosurgeon and when the case was transferred to Orthopaedis and EMD ?

A1. by **PG.** Patient was first seen by Neurosurgeon on 20-07-2014 and transferred to ortho dept., on 26-07-2014 and EMD on 01-08-2014.

Q2. What factors trigger AIDS in HIV positive cases ?

A2. by **P.G** Polytrauma and stress of surgery can trigger.

Q3. What are the causes of hicuup ?

A3. by **P.G.** Central and peripheral causes are there.

Comments by Dr.B.Srinivas

Dr.Shravan, PG in surgery, posted to neurosurgery department should have been more proactive in the follow up of this case and communication with Neurosurgeon.

Dr.Edwin Luther Prof. &HOD Orthopaedics Dept.,

Comments : There can be early and late manifestation of head injury.Patient had fracture nasal bones and frontal bones. Was there any lesion caused by trauma in brain stem that caused intractable hicuups In addition

to CT Scan MRI brain should have been done.

Dr.Gopal Reddy Asso. Prof. of Anaesthesialogy

Q1. Why there was delay in intubation ?

A1. by **P.G.** Patient's attendants took time to give consent.

Comments by Dr. Gopal Reddy

For emergency intubation there is no need for consent. While resuscitation only 3 cycles of CPR was done. All PG's and interns should be conversant with AHA guidelines 2010 FOR B LS

Dr.C.R. Patnaik , Prof. Of Anaesthesiology

Comments: Intractable hicupps and vomting are early indication of increased ICT .

Measurement of ICT would have helped. Close coordination between depts., is essential for management of cases.

CASE No.2

IP No. 201422779 Sathaiah 48years Male, of General surgery Unit –II Date of Admission:: 5-08-2014 at 9.00p.m. Admitted with H/O pain abdomen 3days , vomting, diarrhea, fever with chills 2 days. Had similar complaints one year ago. Past history of Pulm TB 15 years ago (treated) Pulse 114/mt. BP 90/60mmHg Resp. Rate 20/mt.

Temp. 101 F Mild dehydration present .

Abdomen : Distended. Diffuse tenderness, more in right iliac fossa

Prov. Diagnosis : Appendicular perforation with sepsis and paralytic ileus.

Investigations :

Hb. 14.5G% Platelet count 1.92 L/cmm TL C 4200 / Cmm DLC-- P 87% L10% E3%

RBS – 193mg%, Blood urea 60mg%, Serum creatinine 1.3mg% , Serum.electrolytes, Amylase and Lipase WNL.

LFT – Hypoalbuminaemia . USG Abdomen signs of appendicular perforation. X-Ray abdomen NAD

CT Abdomen & pelvis signs of appendicular perforation.

Exploratory Laparotomy under GA on 06-08-2014 at 6.00a.m. 100ml of white fluid in right iliac fossa. Appendix and other organs were normal,but for hyperaemic area over pancreas and a soft, lobulated,brownish mass near right kidney in the retroperitoneum . No biopsy was taken.

On 07-08-2014 at 7.00a.m. patient developed tachycandia (160/mt) Physician advised inj. Metoprolol 5mg. in 10ml saline over 10 minutes. ABG showed metabolic acidosis with compensatory respiratory alkalosis X-Ray chest showed pleural effusion.

In view of falling SPO2 patient was intubated and mechanically ventilated at 8.00am Ionotropic support started because of hypotension. Central vein cannulation of right subclavian was done. Inj. Soda bicar 25mg given.

On 07-08-2014 evening patient developed anuria which was treated conservatively .Patient did not show any improvement and at 12.45p.m. on 08-08-2014 had cardiac arrest . Patient could not be revived and declared dead at 1-17p.m. on 08-08-2014.

Immediate cause of death – Cardio pulmonary arrest with sepsis.with MODS

QUESTIONS & ANSWERS

Dr.Gopal Reddy Associate Prof. Anaesthesiology

Q1. Why adequate amount of fluids were not given to this patient preoperatively to correct dehydration. ?

Ans. by **PG** Two litres of normal saline was given preoperatively.

Q2. Patient had leukopenia . Was the patient in sepsis preoperatively

A2.by **PG** Patient was febrile but other signs of sepsis were not seen.

Q3. When there was renal failure why dialysis was not done ?

A3. **PG** Patient was having persistant hypotension and hence dialysis could not be done.

Comments by Dr.Gopal Reddy

Guidelines of AHA 2010should be followed and documented while resuscitating patients.

Dr.Edwin Luther , Prof.& HOD Orthopaedics

Q1. What was the incision given?

A 1. by**PG.** Since the suspicion of appendicular perforation and peritonitis was there, an extended para median incision was given

Q2. Was a biopsy of retroperitoneal mass was required, since appendix was normal?

A2. By **PG**. There was brownish discolouration of tumour and was soft and friable . Biopsy was not taken, not to complicate the issue if it was a vascular tumour.

Dr.B.Srinivas , Prof. Of General Surgery

Comments : Preoperiative diagnosis was perforated appendix . Intra operatively the appendix was found normal, but

there was a retroperitoneal lesion near upper pole of right kidney,. Patient was stable intra operatively. In the post operative period there was cardiopulmonary collapse and anuria. Post operative thrombo embolism and adrenal pathology have to be kept in mine in addition to sepsis as immediate course of death.

Dr. P.K. murthy. Prof. Of General Surgery

Explained the preoperative clinical condition of patient, the operative procedure done and why any active intervention was not done except drainage of pus and saline wash of peritonaeal cavity.

Appendix was normal. There were no sealed perforations or mesenteric vascular occlusion. Pancreas was hyperaemic

with fat necrosis , with normal values of serum amylase and lipase, which excluded pancreatitis.

Retro peritoneal cellulitis was there.

As there were no further questions or comments the session was declared closed.

Chairman
Mortality & Morbidity Meeting