

Manitoba Health, Healthy Living & Seniors (MHHLS) supports reporting and learning from patient safety events. The focus of a patient safety review is to look closely at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

***Post Endoscopy Complications
To Reduce Gastric Volvulus***

A patient with possible para-esophageal hernia/query volvulus was admitted to hospital and initially treated conservatively with nothing by mouth, gastric decompression, and IV therapy.

Following this, the patient underwent endoscopy to reduce a gastric volvulus.

A stomach perforation and subsequent needle decompression resulted in a lacerated liver, difficulty in controlling post procedure bleeding and ultimately, a delay in surgery. The outcome for the client was severe hypovolemic shock and multi-organ failure.

Given the patients' prognosis, the decision to discontinue treatment was made and the patient died shortly afterward.

Keywords: organ failure, volvulus, shock, post-op bleed

Device Name (if applicable):

Drug/Name/Fluid Name: (if applicable):

Type of Analysis: single event

Topic: Surgery

Findings of the Review:

- Following an endoscopy to reduce the gastric volvulus, the patient developed severe abdominal distention, decreased oxygen saturation and elevated lactate levels
- There was a delay in treating the complications arising from the endoscopic attempt to reduce the gastric volvulus.
- There was a risk that the patient could develop abdominal compartment syndrome due to the volume of carbon dioxide used during the endoscopy procedure. Emergency treatment of this complication may have resulted in a laceration to the liver.
- Earlier surgical intervention may have resulted in an improved outcome for the patient.
- There was not an established formal process for medical/surgical call coverage and handover report between care providers.

System Learning:

- Develop and implement a standardized formal process for the transfer of clinical information between surgeons to enhance patient safety.
- Review the escalation procedures used by nurses to inform physicians of changes in patient condition to ensure that they are implemented appropriately.
- Develop policy and procedure related to the use of carbon dioxide during endoscopy and include parameters for use that reflect best practice standards.

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