Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/Adverse Event Information

Medical Safety Information

No.152, July 2019

Gauze Remaining After Surgery (1) —Gauze Count—

Fifty-seven cases have been reported in which gauze was left in the body after surgery, even though a gauze count was performed before closing the incision (information collection period: from January 1, 2016 to March 31, 2019). This information was compiled on the basis of the content featured in “Recurrence of Events and Occurrence of Similar Events” in the 54th Quarterly Reports.

57 cases have been reported in which gauze was left in the body, despite a gauze count being performed before closing the incision. The gauze count matched in 48 of those cases.

Gauze Count Before Closing	Number of Cases
Matched	48
Did Not Match	9

Main Background Factors in Closure Despite Discrepancy in Count

- Physician thought the gauze sponge was outside the operative field, so did not search the operative field
- Physician thought that no gauze sponges remained, because the operative field was small
- Searched the operative field and operating room, but did not find the gauze sponge

Main Background Factors in Matching Count Despite Gauze Remaining

- The nurse counted rolled up gauze sponges by eye
- The nurse counted blood clots as well as gauze sponges when using a machine to count gauze sponges
- The nurse counted a gauze sponge without radiocontrast agent, which should have been excluded from the count
- The surgeon used gauze sponges cut in half
- A gauze sponge entered the body while the surgeon was closing, after the count

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Case 1

The physician performed a cesarean section. When counting the gauze sponges before closing the uterus and the abdomen, the nurse counted the rolled-up gauze sponges by eye and confirmed that the number matched. The physician noticed that the X-ray image taken at the end of the operation showed that there was gauze remaining in the abdominal cavity, so they reopened the abdomen and removed the gauze. When the number of counted gauze sponges was checked again, there was one fewer than previously counted.

Case 2

The physician performed an open right hemicolectomy. The nurse discarded outside the operative field a gauze sponge not containing radiocontrast agent (which should have been excluded from the count) that had been used to bundle the surgical instruments together, but it was counted along with the gauze sponges that did contain radiocontrast agent. The gauze count matched, so the physician closed the abdomen and ended the operation. The physician subsequently realized that gauze remained in the abdominal cavity.

Preventive measures taken at the medical institutions in which the events occurred

- **When counting gauze sponges, spread out each individual sponge to check it.**
- **Do not use gauze sponges excluded from the count during the operation.**
- **Count the gauze sponges again after the operation ends.**

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the "Comprehensive Evaluation Panel" to prevent the occurrence and recurrence of medical adverse events. See the Project website for details.
http://www.med-safe.jp/

* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.

* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

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