Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.181, December 2021

Resected Organ/Tissue Remaining after Performing Laparoscopic Surgery

Thirteen cases have been reported in which, when performing laparoscopic surgery, the surgeon forgot to take the resected organ/tissue out of the body and had to perform surgery again (information collection period: from January 1, 2017 to October 31, 2021). This information was compiled on the basis of the content featured in the Analysis Themes section of the 63rd Quarterly Report.

Cases have been reported in which the surgeon forgot to take the resected organ/tissue out of the body when performing laparoscopic surgery.

Organ/Tissue Left Behind	Number of Cases	Main Background Factors
Gallbladder	3	• The surgeon checked the abdominal cavity before closing the incision, but did not notice that the resected organ had been left inside. • The surgeon did not check whether the resected organ had been removed. • The circulating nurse noticed that the organ due to be resected had not been removed from the patient's body, but interpreted this to mean that the surgeon had decided not to resect it due to the severity of the adhesions and failed to check with the surgeon. • The surgeon was supposed to remove the retrieval bag* containing the resected organ after removing the camera port, but forgot to remove it. • There was no rule about counting retrieval bags*.
Appendix	3	
Greater omentum	1	
Ovary and fallopian tube	1	
Excised segment after esophagojejunostomy	1	
Small intestine adhering to colon cancer	1	
One of several enucleated uterine fibroids	3	• The surgeon miscounted the number of uterine fibroids enucleated. • Information about the number of uterine fibroids enucleated was shared only between the surgeons, without being communicated to the nurses.

*Retrieval bags are used during laparoscopic surgery when retrieving the resected organ or tissue and removing it from the body.

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Case 1

Laparoscopic gastrectomy and cholecystectomy were performed on a patient with gastric cancer. The surgeon placed the resected gallbladder in a retrieval bag and told the nurse it would be removed before closing the incision, but forgot to remove it. When closing the incision, the surgeon and the nurse performed an instrument and gauze count, but retrieval bags were not included in the count. When surgery was complete, X-ray imaging was carried out, but the surgical team did not notice the retrieval bag had been left in the abdominal cavity because the bags are X-ray-transparent. The surgeon subsequently noticed that they had not removed the gallbladder when organizing the specimens.

Case 2

During laparoscopic enucleation of multiple uterine fibroids, 10 uterine fibroids measuring up to 10 cm were enucleated. On the fourth day after surgery, an ultrasound examination revealed an image of a 3 cm mass, which was judged to potentially be a hematoma. After consulting with the patient, the surgeon discharged her, having decided that she should undergo observation as an outpatient. When the attending surgeon subsequently reviewed a video of the surgery, they noticed that only nine uterine fibroids had been removed from the patient's body.

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

- **Surgeons and nurses will check the resected organ has been removed from the body before closing the incision.**
- **Include retrieval bags in the count.**
- **Bear in mind that any retrieval bags left in the abdominal cavity will not show up on an X-ray image as they are X-ray-transparent.**
- **When enucleating multiple uterine fibroids, surgeons will inform nurses of the number enucleated and the number removed, and nurses will record and share this information.**

The measures above are examples. Please consider initiatives suitable for your own facility.

* 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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