



Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

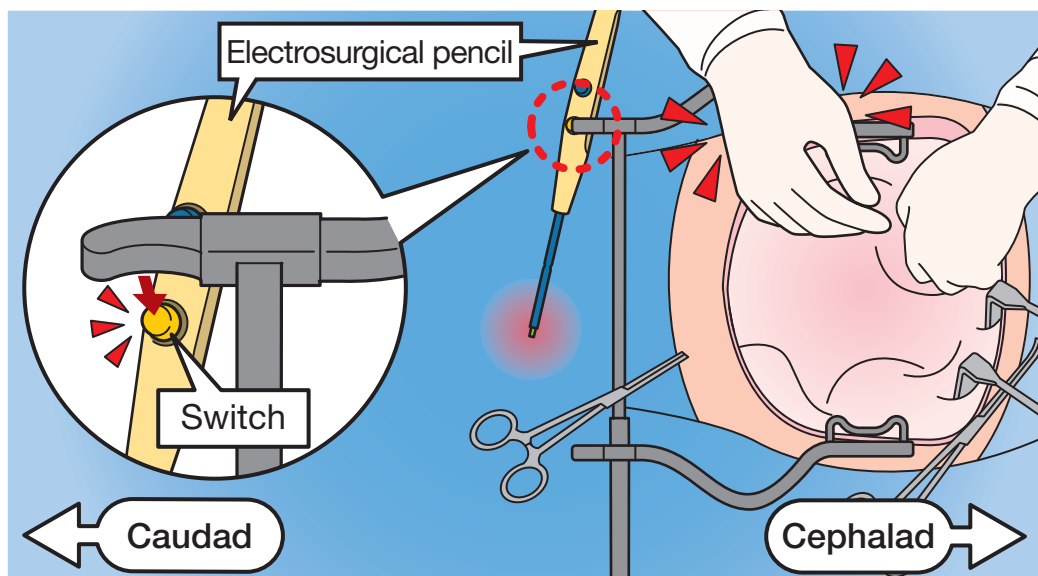
No.59, October 2011

Burns Due to Incorrect Handling of an Electrosurgical Pencil

Nine cases related to burns due to an electrosurgical pencil not properly being stored in the holder during use, have been reported (information collection period: from January 1, 2007 to August 31, 2011; the information is partly included in “Medical Adverse Event Information to be Shared” (p.127) in the 14th Quarterly Report).

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Image of Case 1



Burns Due to Incorrect Handling of an Electrosurgical Pencil

Case 1

The physician used an electrosurgical pencil to stop bleeding when implementing bowel preparation for sigmoid colon. Although space was limited because the patient's body was in the lithotomy position, the electrosurgical pencil was not stored in the holder. The electrosurgical pencil was placed close to the wound retractor, the end of the wound retractor touched the electrosurgical unit switch and activated the pencil. Sound from the activated pencil was noticed and the condition was checked. The covering cloth material had a hole in it and burn was observed on the patient's thigh.

Case 2

The physician was holding an electrosurgical pencil (although not in use) with one hand, and pointed the tip towards the patient. The switch of the electrosurgical pencil was inadvertently pushed, and the pencil was activated during incision of the fascia for an operation intraperitoneal cavity. Skin on the right side of the abdomen was damaged.

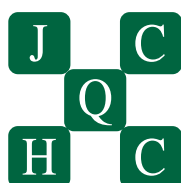
Preventive measures taken at the medical institutions in which the events occurred.

- **Organize the environment around the surgical area, and do not put the electrosurgical pencil on the surgical area and operation table.**
- **Store the electrosurgical pencil in the holder when not in use.**

* 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 "Comprehensive Evaluation Panel" to prevent occurrence and recurrence of medical adverse events. See quarterly reports and annual reports posted on the Japan Council for Quality Health Care website for details of the Project.
<http://www.med-safe.jp/>

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

* This information is neither for limiting the discretion of healthcare providers nor for imposing certain obligations or responsibilities on them.



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