PAG Clinical Governance Report – For November,2017

In a six month period, April to September 2017, there were 44 reported Incidents where the Pancreas was mentioned as one of the Key words. This is almost identical to recent 6 monthly periods – it was 47 in the previous period

Because of inclusion in multi-organ retrieval, the pancreas crops up in Incidents such as “difficult behavior of retrieval surgeon” or “retrieval team did not bring enough ice (or bags)”, but there is clearly no direct relevance to the organ. But on careful analysis, 14 Incidents were clearly related to the Pancreas, which is double the number in the previous period.

Most of the incidents are relatively trivial – minor HLA discrepancies, an issue with the ODR, or transcription error of unimportant results or donor date of birth.

Retrieval issues were most numerous but slightly fewer than in the past.

There were 3 organs not transplanted because of retrieval damage, compared with 5 in the previous period and two in the one before that.

Two of the instances where damage prevented transplantation are illustrated

In one case

The pancreas (part of SPK) assessed by transplanting centre have retrieval damage and therefore untransplantable despite it's healthy parenchyma.
1. Two sizeable serosal tears of the transplant duodenum (about 3cm and 5cm in length)
2) Dusky duodenum (not well perfused)
3) Widely open pyloric stump (failed staple line)

There were clearly significant donor factors and the HTA-A organ form recorded - "gangrene of ascending colon with hepatic fissure - adherent to head of pancreas with inflammation around it." NORS operation notes in the donor medical notes describe "ischemic gangrene of the ascending colon and hepatic fissure - ?due to cardiac arrest - moderately fatty liver and pancreas, rest of laparotomy normal."

The NORS centre also reported that with regards to the open pyloric stump which was as a result of a failed staple line, the retrieval surgeon should have checked the organ on the back table before bagging which would have identified the failed staple line. It has been stressed to the wider NORS team about the back table inspection and subsequent documentation. It has been highlighted to us that the incident will be discussed again in their NORS audit meeting to cascade the learning points to the team.

In another case

On inspection of the pancreas (SPK) the following were identified:
1) The SMV was stripped up to the pancreatic parenchyma, although the SMV was not used for portal perfusion
2) The arterial Y graft had severe atherosclerosis and multiple intramural haematomas (most likely because of donor disease); however it was not reported as unusable and no extra arteries were sent to facilitate transplantation of the pancreas.
Pancreas untransplantable

Reporter additionally informed CG that they would have transplanted the organ if the iliac vessels were usable and then spent more time on haemostasis. Accepting surgeon contacted

the retrieval surgeon to ask why the SMV was skeletonised, but there was no comment on the Y-graft.

Investigated with abdominal NORS centre for their comments.

The retrieving surgeon couldn't remember all the sequence but explained that they did prepare the infra-colic portion of the SMV for portal perfusion. However as soon as they realised that pancreas had been accepted for transplantation, the supra-pancreatic portal vein was cannulated as per abdominal perfusion policy. From their recall at no stage was the SMV damaged or dissected at the level of the pancreas. The retrieval surgeon observed the pancreas to be fatty and not of good quality. It was also highlighted that the donor was an arteriopath and all arteries were noted to have moderate to severe atherosclerosis. The retrieval surgeon did ask the SNOD to inform the accepting centre regarding the quality of the vessels, however I have been unable to establish through investigation if this happened.The retrieving surgeon accepts that they didn't communicate directly with the recipient surgeon or document the findings on the HTA form. The team believe that if appropriate documentation and communication was undertaken the concerns that were raised in this incident could have been avoided.

This has been fed back have fed this back to the retrieving surgeon and it was believed that their reflection on the incident was satisfactory. As part of their local NORS governance the team planned to discuss the learning points in their next audit meeting for the benefit of all team members.

Following an independent review of the all the facts of the incident it was determined that the event was reportable to the HTA as a Serious Adverse Event as it was felt that the Y graft should have been examined and a suitable replacement sent and it did not appear that this had been communicated directly between surgeons. It was felt that the skeletonisation of the SMV would not have impacted alone on the use of the organ.

There was another case where the pancreas was not lost, but there were protracted discussions about vessel allocation between a pancreas for SPK and a liver for splitting. The liver was delayed leaving theatre, with the result that the decision to split was reversed because of anticipated prolonged ischaemic time.

There have in the past been discussions at both PAG and LAG about pancreas donation when the liver is to be split, with accord reached on both sides. The anatomy seems to have been particularly complex in this case, but it highlights the need for good communication with the right people when there are complexities

There was one Incident related to change of CMV status of a multi-organ donordonor. The change was almost certainly related to testing of pre-transfusion and post-transfusion specimens at donor and recipient centres respectively. Most recipients, if CMV negative, were entered onto a surveillance program

There were some other, minor retrieval problems – absence, or inadequate labeling of spleen and lymph nodes, and in one case, the vehicle carrying the pancreas and two kidneys was forced off the road by another road user. There was no delay in delivery

The other non-retrieval Incidents were minor. One related to a positive transport fluid culture with a non-fungal organism which did not need to be

reported. Across the board, there is confusion about reporting positive cultures, and steps are being taken to clarify this issue

John Dark
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