PAG Clinical Governance Report – April 2018

In a six month period, September 2017 to April 2018, there were 48 reported Incidents where the Pancreas was mentioned as one of the Key words. This is almost identical to recent 6 monthly periods – it was 44 in the previous period, and 47 in the one before that

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, 9 Incidents were clearly related to the Pancreas, fewer than in the previous period, when there were 14. One incident was highlighted by the Governance team for inclusion in this report

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 3 in the previous period and 5 in the one before that.

The instances where damage prevented transplantation are illustrated. The first case was flagged specifically for this report. The pancreas was lost because all available vessels had been sent with the liver, and there was a late change pf acceptance from Islets to whole Pancreas

This has been investigated by the clinical lead for the abdominal NORS team and discussed with those involved. The retrieval surgeon reflected on the retrieval and explained that they were informed that the pancreas was being retrieved for islets. They were also aware that the liver recipient was a re transplant and longer vessels were requested to be able to perform the transplant. Both surgeons agreed and made the conscious decision to divide the portal vein very low because they were aware of how important a long portal vein was for the liver recipient. This decision was made in the knowledge that the pancreas was going for Islets therefore a long portal vein would not be required.

Following this, the retrieval surgeon was informed by the SNOD that the pancreas had been declined for islets and accepted as a whole organ. Unfortunately the pancreas had already been retrieved and would not be suitable for whole transplantation.

The importance of sharing this information with the retrieval surgeon was fed back to the SNOD at the time; however it is impossible to know if this had been known and the liver had a shorter portal vein whether this would have impacted upon the liver transplantation. It is acknowledged that the SNOD involved self reported and has reflected on this incident and apologised to those involved.

This was discussed with our clinical expert who agreed that although usually the pancreas is retrieved the same irrespective of whether the pancreas is being retrieved for islets or as a whole organ in this case the retrieval surgeons made a clinical decision based on the information available to them at the time, to benefit the liver recipient.

In another case, the issue was around length of the portal vein
It was reported that pancreas retrieved however the portal vein had been cut short and was cut right on the confluence of the splenic vein deep in the hilum of the pancreas. Decision not to transplant, fast tracked and declined - offered for research

The respective NORS Clinical Lead discussed the incident with the retrieving surgeon who appreciated that the vessel should have been left longer for the pancreas and has learnt from this. Additionally, they have apologised for not noting this on the HTA-A organ form. The retrieving surgeon has reflected on the event and realised that they should also have called the accepting surgeon to discuss. They have also apologised for this oversight.

Due to the loss of organ for transplant this incident was reported to the HTA as a Serious Adverse Event. Following NHSBT's investigation report the HTA have asked that the NORS centre share this learning wider in their governance forum which they have been requested them to do.

One organ was not used because of presumed contamination from an untied bile duct
It has been reported that bile duct was left untied and transport fluid was bile stained - organ not transplanted but accepted for research.

One organ was damaged but still useable
Damage to pancreas - Portal vein was cut very short (.5cm) requiring an extension graft
There was a haematoma in the head of the pancreas and the mesentry was stapled very close to the pancreas incorporating the side wall of the donor duodenum. The pancreas was transplanted.

There were two instances of problems, or potential problems with vessels. In one, the vessels intended for the pancreas were despatched with the liver, although the transplant went ahead. In another, vessels were sent with a pancreas already identified as for islet isolation

There was a single significant Incident involving a transplant centre, when after a pancreas was accepted for islets, the isolation could not proceed for logistic reasons

There were two problems from Donation. A donor was described as having a BMI of 25.5, but on arrival of the NORS team, this was re-calculated as 35, and the pancreas was very fatty. A recipient had been called in.

A potentially more serious Incident surrounded the mistaken identification of a donor:
It was reported that the SNOD was informed incorrectly that pancreas had been accepted for islets by the isolation laboratory.

This was due to there being two donors in the same region and when the RCPoC and SNOD discussed the donor, they did not clarify they were discussing the same donor, which they could have done if they had confirmed the donor by using 3 points of PID at the beginning of their conversation.

This has been investigated by the ODST Team Manager and has highlighted the importance of using 3 point of PID when discussing a donor.

For wider awareness of the importance of using 3 points of PID when discussing donors whether it is with Hub Ops staff, DRD staff, RCPoCs or other SNODs this incident will be highlighted in communication training to be rolled out in the new year.

John Dark
April 2018