Delayed diagnosis of perforated bowel and peritonitis (02HDC09815, 12 November 2003)

Colorectal surgeon ~ Bowel surgery ~ Postoperative care ~ Standard of care ~ Handover of care ~ Record-keeping ~ Right 4(1)

A 46-year-old woman complained that following elective surgery to release abdominal adhesions there was a delay in diagnosing her perforated bowel and consequent peritonitis. Furthermore, a second colorectal surgeon did not respond to the diagnosis or to her deteriorating condition.

The surgery was performed in a private hospital. The day after surgery, the woman complained of pain in the abdomen and shoulder tip. She had not passed urine or flatus and had a distended abdomen. The surgeon arranged a baseline X-ray, inserted a urinary catheter, and prescribed pethidine for pain relief. The following morning, because he was travelling overseas, he arranged for a colleague to take over care of the woman and recommended that a further X-ray of the abdomen be taken if the pain persisted. Although the handover took place at 4am, the first surgeon telephoned his colleague later that morning to discuss the case at length. A diagnosis of protracted postoperative ileus was suggested, but the surgeon said he would have "a low threshold to look further for an occult perforation".

The woman's condition did not improve over the next two days, and she became confused. On the third postoperative day the second surgeon spoke with the operating surgeon about the woman's lack of improvement. Consequently, the second surgeon ordered a CT scan to exclude bowel perforation. He found the results "inconclusive" and said that, while he suggested conducting a laparotomy, the woman refused further surgery. The woman denied this, and concerns were raised as to her fitness to make such a decision at that time.

Expert advice was that the results of the CT scan demonstrated strong evidence of bowel perforation and would be difficult to explain on the basis of a diagnosis of postoperative ileus. Moreover, by this time the woman had a number of symptoms of bowel perforation (constant, generalised abdominal pain, vomiting and failure to pass flatus) and signs of perforation (tachycardia, fever, dehydration reflected in low urinary output, abdominal distension, abdominal tenderness and absence of bowel sounds). Her confusion could also have been a result of well-established peritonitis.

Surgery was not scheduled, however, and the surgeon elected to continue with conservative management with a view to transferring the woman to a public hospital if her condition had not improved by the following morning.

By morning, the woman's condition had deteriorated further, and she was transferred to the public hospital. The hospital noted that she presented with "a distended abdomen, abdominal pain and evidence of multiorgan failure, with impaired renal function, disordered liver function tests and was confused". Further surgery revealed a jejunal perforation with gross intraperitoneal sepsis. The woman was transferred to intensive care, and eventually discharged from hospital.

The first surgeon was found to have managed the woman's care and handover of her care appropriately. However, the second surgeon was found to have breached Right 4(1) in failing to diagnose the perforation and resultant peritonitis in the light of signs and symptoms of peritonitis, the woman's higher risk of occult perforation, and the first surgeon's warning to be on the look-out for signs of occult perforation. His

record-keeping was also found to be inadequate. The private hospital was not held vicariously liable for the surgeon’s failures.