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# Unexpected Events in Practical Medicine or Ways to Provide Safety during Surgical Procedures

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***Abstract---*** *Clinical observations on unexpected events in practical medicine are rarely published in official scientific journals. However, this issue should be addressed seriously, because certain tendencies and rational ideas can be revealed. Modern medicine relies on principles of standardization and clinical protocols of diagnostics and treatment that tend to exclude any untypical or unexpected events, which may ignore individual peculiarities of patients and methods of treatment. This provides a rationale for the present review. The presented information can be useful in practical medicine because in nonstandard or untypical situations, surgeons can make mistakes that lead to unpredictable consequences and threaten the patients' safety.*

*The aim of the study was to collect nonstandard events occurred in practical medicine and to systemize them. Individual recommendations on handing such critical situations were provided. In surgical practice, surgeons face unexpected cases that not only surprise them but also require their concentration and attention in handling such situations. Unfortunately, sometimes, critical situations cannot be successfully handled and resolved. It may seem that causal events lie outside the scope of our understanding and cannot be explained rationally. However, everything can be explained rationally after certain considerations. The analysis of clinical observations allowed the authors to focus on the conflict situations "circumstances-patient-doctor-mistake".*

*Materials and Methods. The review is based on 18 clinical observations.*

*Results. Based on the clinical materials that contained information on untypical situations and events, the authors tried to systemize them by the cause. The authors provided recommendations on clinical medicine safety. Untypical situations were considered from the perspective of a patient's safety. The authors discussed unprofessional approaches of doctors in such situations, issues of safety in clinical medicine and possible ways to handle such situations, legal issues in conflict situations and ways to improve the safety in clinical medicine.*

***Keywords---*** *Surgical Procedures, Patient's Safety, Clinical Medicine.*

## I. DEEP HYSTERIA

32-year-old patient applied to the hospital with complaints on periodic dry cough and general fatigue. The anamnesis said that the patient experiences periodic short-term empty's is that resolved without treatment. By the patient's observations, this event coincided with the periods of nervous excitement. The patients underwent general

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examination, but no objective symptoms of any diseases were revealed. X-ray imaging did not show any pathology in the chest. A day prior to the discharge from the hospital, the patients had a pulmonary hemorrhage. The nurse reported that clots of blood were coming out of the patient's nose and mouth. The doctors took emergency measures and stopped the bleeding.

Effective hemotransfusion and hemostatic therapy were performed. Erythrocyte count was naturally low after a pulmonary hemorrhage. When the patient's condition improved, he was examined by a thoracic surgeon and phthisiologist. The doctors did not reveal any pathological changes. The same clinical picture repeated and resolved several times.

After the therapy, the patient was discharged in a satisfactory condition, but the diagnosis remained unclear. After a while, the patient returned to the hospital to see the doctors and to tell that his symptoms resolved and never relapsed. He said that he got married the nurse that was taking care after him in hospital.

In psychiatric practice, there is a symptom called *deep hysteria*. Patients with this syndrome have all the mucosal lining of organs bleeding, including blood tears, etc. This symptom resolves after *positive changes in the patient's life*. Probably, due to a happy marriage, the pathology resolved.

***Internet***

Hysteria is one of the forms of general neurosis that is manifested by different functional locomotor, sensory, vegetative and affective disorders. Patients with hysteria have perceptive psychic and tend to attract attention by any means. Different exogenous and endogenous factors play a leading role in the genesis of this disorder. Hysterical neurosis is based on the peculiarities of the development of a personality and behavior that are associated with an increased perceptibility and emotionality. The primary role in the development of hysteria is played by the presence of psychic infantilism and hysterical traits of character, which is often determined by the genetic background.

(hnb.com.ua Tags: diseases, doctor, conditions dictionary)

## II. PREVENTION OF THROMBOEMBOLISM

A very rare observation was made during a surgery when a tumor embolus (a bit bigger than a match head) was found in the lumen of the renal vein.

64-year-old woman was diagnosed with left kidney cancer T2N1M. A planned left nephrectomy was performed.

After the pre-operational preparation, the patient was taken to an operating room. The surgery was going as planned. The revision of the kidney showed that the tumor was located in the middle segment and was 3-4 cm in diameter. The kidney with the tumor was mobilized without complications. Vascular pedicle (art. etvenarenalis) was separated along the entire length. There was a free-floating white tissue on a thin pedicle was found in the lumen of the renal vein. It was going in and out of the renal hilum and occupied ¼ of the vessel lumen. It was seen more clearly when the vein was slightly pressed. Further manipulations moved the "neoplasm" along the venous blood stream towards inferior vena cava. Timely, renal vein was clamped and ligated and the magistral renal artery was secured. Nephrectomy and lymph node dissection were performed. The post-operative period was without peculiarities and complications.

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Gross specimen: small size neoplasm in the kidney (Figure 1). The tumor is located in the middle segment of the organ. Histological study revealed renal cell carcinoma, G3. On the proximal section of the renal vein, a formed soft tumor embolus was identified. The embolus was 0.5 cm in diameter with a thin pedicle that got separated from the main tumor mass (Figure 2). Histopathologic test result – cancerous cells.

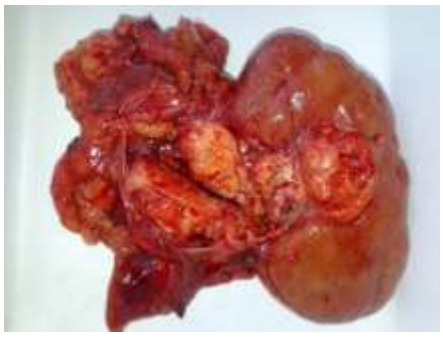

Figure 1. The dissected tumor

Figure 2. Tumor embolus in the lumen of the renal vein

Based on the presented case of clinical observation, the authors believe that the mobilization of kidney tumor can lead to an unexpected clot detachment. Each surgeon must be aware of such possibility during traumatic mobilization of a kidney.

***Munchausen Syndrome***

45-year-old woman applied to a hospital with complaints on numerous "lumps" all over the body. Locally, on the anterior abdomen wall, several tumor-like neoplasms 3-5 cm in diameter were identified. When palpated, the lumps felt painful and some of them fluctuated. The patient said that these lumps appeared already before, which was proved by numerous post-operative scars on the anterior side of the thighs.

The surgeons diagnosed "festered atheromas", although this was not confirmed by the examination. The lumps were dissected in the course of treatment. The patient visits to the hospital were often until one doctor noticed that these purulent formations were not observed on the posterior side of the body. Indeed, all those formations were located only on the anterior side of the body.

Finally, it was revealed that the patient simulated a purulent disease, i.e. she used to make infectious injections subcutaneously. That is why there were no lumps on the back; she simply could not reach there. The specialists say that this is a psychiatric disorder.

***Paired Event Probability***

It is a known fact that surgeons are superstitious. If something unusual happened in surgical practice, a similar event is expected to happen soon. Such a coincidence of two similar events was called "paired event probability".

25-year-old man was delivered to a hospital with acute appendicitis. Clinical manifestations were clear and the patient was operated. The surgery was performed without technical difficulties, the appendix had phlegmonous alterations. On the next day, during a morning doctor's round, the surgeon noticed that the condition of the patients worsened overnight, the pains in the abdomen intensified, fatigue and dizziness developed. The pulse rate was quick. In the right iliac region, Blumberg's sign observed.

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The patient underwent relaparotomy because of the suspected intra-abdominal bleeding. Indeed, the laparotomy showed a significant amount of blood clots in the ileocecal corner. By this time, the bleeding stopped and the leaking vessel was not found. After the sanitation and suturing of the suspicious parts of mesenterium of the appendix and draining of the abdominal cavity, the wound was closed. Post-operative recovery was normal and without complications. The patient was discharged from the hospital after the recovery.

In 2-3 month, a younger brother of this patient aged 20 was delivered to the hospital with the symptoms of acute appendicitis.

The surgeons remembered that his elder brother had surgery in that hospital and that he had post-operative intraabdominal bleeding, so they paid special attention to the quality of hemostasis. The appendix had phlegmonous alterations. The surgery was performed without technical difficulties. The quality of hemostasis was checked and confirmed. Next morning, the condition of the patient worsened, abdominal pains intensified, skin and mucosa were pale, and the pulse rate was quick. Percussion revealed dullness in the right iliac region and abdominal bleeding was suspected.

The patient was re-operated. The laparotomy showed a significant amount of blood clots in the ileocecal corner, but the source of bleeding was not found. Sanitation and draining of the abdominal cavity were performed and the wound was closed. The patient recovered and was discharged from the hospital.

The paired events – acute phlegmonous appendicitis and postoperative complication in the form of abdominal bleeding could not be explained rationally. The question is why the mechanism of paired even probability was initiated.

***Bilateral Endophthalmitis Associated with Septic Embolism of the Retina***

In ophthalmological practice, there were two cases with bilateral metastatic endophthalmitis. Taking into account the *severity* and *rarity* of these complications, the clinicians found it worthwhile to describe them.

1. 22-year-old woman applied to the Republican ophthalmologic clinic with a bilateral metastatic endophthalmitis. The patient had a sudden onset of the disease. When she had the temperature rose to 39°C, she had an acute reduction of eyesight in both eyes. She explained her disease with an illegal interruption of 6-month pregnancy. For 20 days, the patient received treatment in the maternity hospital with a diagnosis: sepsis, phlebitis of pelvic veins, and bilateral metastatic endophthalmitis. When the patient's condition improved, she was transferred to the ophthalmologic clinic.

The examination of the right eye revealed that the acuity of vision was 0 (zero). The location of the right eye bulb was normal and its movement was not restrained. The palpebral and eye bulb conjunctiva was moderately infected. The cornea was transparent, the chamber was less deep than average, the fluid was slightly opalescent (Tyndall's effect +). The corneal pattern was unclear with circular posterior synechia. Anterior and posterior lens capsule opacity was observed. Reflex from the fundus was yellowish green. Intraocular pressure was 16 mmHg. Left eye: acuity of vision = color perception with inadequate light projection. Objective picture of the left eye is similar the right one. Intraocular pressure was 15 mmHg.

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There was no positive dynamics after the performed anti-inflammatory, immune correcting and resolving treatment. During the control examination in 2 years, absolute bilateral blindness and preatrophic eye bulbs were registered.

This case demonstrates severe consequences that women face after illegal abortions outside specialized clinics and in late pregnancy.

2. 34-year-old man was delivered to an ophthalmologic clinic of the National Hospital with bilateral endophthalmitis. The disease onset was sudden after the intravenous injection of opium mixed with other illegal drugs. The patient was shivering, the temperature rose, the eyes were red, and the eyesight reduced sharply. The patient was diagnosed with sepsis and hospitalized to a surgical department. When the septic condition resolved, the patient was transferred to an ophthalmologic clinic.

The examination showed that the patient's condition was satisfactory. The acuity in both eyes was 0 (zero). The eye bulbs were moderately irritated, the anterior chamber contained exudate, the pupils were moderately dilated, posterior synechias and anterior and posterior lens capsule opacity were observed. Reflex from the fundus was yellowish green.

Due to an expressed pain syndrome, the right eye was dissected. To cope with the inflammation in the left eye, antibiotics were indicated (the patient refused the intravitreal injection of antibiotics), mydriatics, diuretics, and immune modulators. The performed treatment did not bring positive results. The patient was discharged from the hospital and indicated an outpatient course of treatment. This observation shows that drug addiction not only influences on a person's mind and will, but can lead to an eyesight loss.

Information from the internet**:** Septic embolism can develop after a massive invasion of microorganisms into a bloodstream. This provokes different local disorders of microcirculation in organs and the development of focal infections.

***Do not harm…***

In gynecological practice, doctors often fail to perform manipulations properly, which, unfortunately, leads to additional suffering of patients. There are some examples of such cases below.

37-year-old woman (a doctor by profession) was delivered to an oncologic urology department with a diagnosis of bladder cancer T2N0M0. The patients complained about unpleasant sensations at the bottom of the abdomen, in particular, in the bladder, sometimes, she had blood in the urine and, periodically, she suffered from dysuria.

From medical history: the patient considered herself sick for the past 6-7 years. A single case of hematuria was 5 months ago. Lately, she complained about urethralgia at the end of the urination and unpleasant sensations in the bladder. The examination at the local hospital showed the symptoms of bladder tumor and the patient was sent to the Institute of Oncology.

Gynecologic anamnesis: menarche at 14 years old, sexual life since 23 years old, 5 pregnancies, 2 childbirths, 3 medical abortions. IUD was installed 8 years ago in the municipal clinical hospital.

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Objective observations: general condition was satisfactory, the constitution was normosthenic, regional lymphatic nodes were not altered and not painful at palpation. No pathologies of organs and systems were revealed.

Excretory urography showed that kidneys functions were not disturbed, the contrast fills all the sections of the upper urinary tract, renal ducts are visualized all the way long.

UI scanning of the bladder showed that there was a mass up to 11 mm in the base of the bladder. Cystoscopically: there was a formation on the left wall of the bladder that had fibrinous pellicle encrusted with salt crystals on the surface.

Surgery was planned. During the surgery, an exophytic formation (that was taken for neoplasm) was found to be a foreign body – IUD with a tube case 0.5 cm in diameter and 5 cm long that was going out the uterus (Figure 3).


Figure 3: Intrauterine device with a tube case

The tube case contained an intrauterine device that never reached its target location. The surface of the formation was encrusted with salts. The tube was removed and the defects of the bladder were corrected. Post-operative period was without complications. After the surgery, the discomfort and the pains in the bladder resolved. The patient stopped taking pain relievers that she used to take for 8 years. The patient was discharged from the hospital in a satisfactory condition.

## III. Non-invasive Removal of a Gauze Swab from the Bladder

50-year-old woman was delivered to an oncologic urology department with complaints on incomplete emptying of the bladder, urethralgia, blood in the urine, and feeling of fullness in the bladder

.A year ago, the patient had surgery in the small pelvis in a local hospital; she had a dissection of a uterine myomatous nodule. Supravaginal uterectomy was performed. After the surgery, all the mentioned symptoms developed. The patient received therapy but the condition did not improve. After the CT scanning, the doctors suspected a tumor of the bladder and the patient was directed to an oncologic urology department of the National Center of Oncology. The size of the formation was 3x4 cm in diameter.

Unfortunately, there was no record in the medical history on the damage of the bladder during the surgery (Figure 4).

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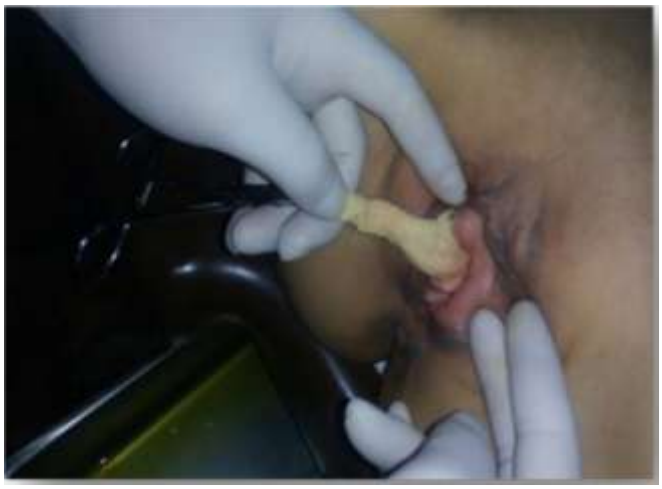

Figure 4. Removal of a gauze swab via the urethra with biopsy forceps.

Cystoscopy revealed a hyperemic region on the posterior side of the bladder. By means of biopsy forceps, single fibers of a swab were separated. The region was dilated with forceps. After further manipulations, the urologists removed a gauze swab that was left there during the previous surgery in the small pelvis. The swab was removed without any difficulties and complications. The control examination did not reveal any pathology.

Due to the knowledge and experience of the urologists, the foreign body was removed without invasive manipulations.

***Risky Actions of a Surgeon***

Being a real surgeon requires profound knowledge in the sphere and a surge for helping patients. A true surgeon often takes risks for the sake of a patient and acts in an untypical way. There are cases, when a surgeon fails to cope with a life-threating situation. In such extreme conditions, the efficiency of the performance and a strong character play a crucial role. The performance is dictated by the risk. Below, such a case is presented.

The patient had surgery for the right kidney cancer. Due to the localization of the tumor, the dissection of the diseased kidney with metastasis at the renal hilum was technically extremely complicated. After the surgery, the patient was moved to an intensive care unit. After a while, the signs of intensive arterial bleeding from the bed of the removed organ appeared. In seconds, around 500-700 ml of fresh blood came out of the drainage tubes.

The failure of the sutured renal magistral vessels was diagnosed. The attending doctor was called in urgently. The BP was falling sharply, the peripheral pulse rate was hardly traced. To take the patient to the operation room required some time, which the doctors did not have.

A young surgeon made a decision to act against the protocol. He put on a sterile glove and very quickly removed the sutures on the wound. The source of bleeding was a failed ligature on the renal vessels. The surgeon pressed the bleeding vessel with his fist against the patient's spine. The purpose was achieved and the patient was taken to the operation room.

Another factor that helped the situation was the intubation tube that remained in the respiratory tract. The patient

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was given general anesthesia and, in minutes, the surgeons were ready for the operation. The bleeding vessels were found and the life-threatening bleeding was stopped. The surgery finished successfully.

***Treasure in the Stomach***

**Internet:** (http://imgl.lienternet.ru/images/attach/c/9/112/423/112423803_large_neobuychnuyy_klad_foto_2.jpg.):

63-year-old man was delivered to one of the hospitals in Deli with complaints on pains in the stomach and vomit. The surgeons were surprised to find real treasure in the patient's stomach – 12 bank gold bars (400 g in total).

The patient turned out to be a crooked businessman who did not want to pay the customs fee on the imported to India gold and decided to smuggle it in his stomach. After the surgery, the doctors called in the police and customs officers that confiscated the removed gold (Figure 5).

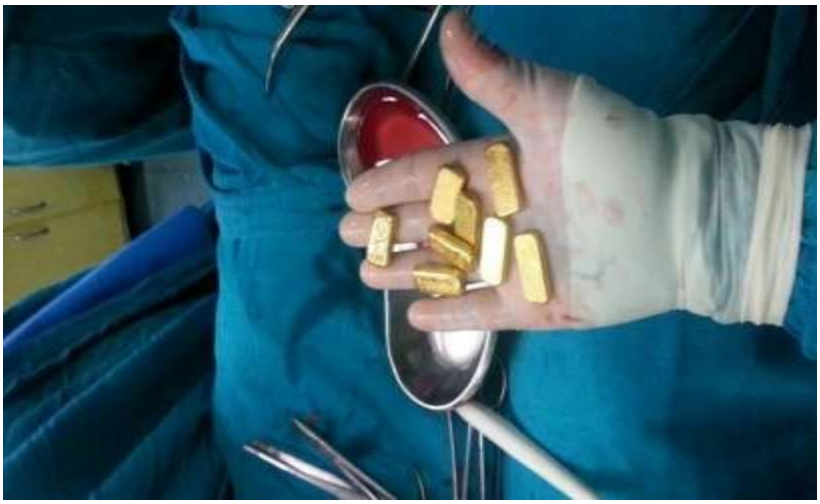

Figure 5: The gold bars removed from the stomach.

***Foreign Matters in the Gastrointestinal Tract***

The history of the treatment of patients with foreign matters in the gastrointestinal tract is closely associated with the history of the development of abdominal surgery. It should be mentioned that first gastrostomies and enterotomies were performed for foreign matters removal.

Gastrostomy was first performed for the removal of a foreign matter from the stomach in 1635. It was a knife that the patient accidentally swallowed when tried to provoke vomit with its handle.

Enterotomy was first performed in 1811 by Whits who successfully removed a teaspoon from the ileum. In 1848, Reali removed a foreign matter from the large intestine.

From 1896, when X-ray imaging was implemented in clinical practice, a new era in the diagnostics and removal of foreign matters from the gastrointestinal tract began. And recently, the method of US scanning started to be used, although it is less informative than the X-ray imaging.

In scientific literature, there different classifications of foreign matters types. The authors believe that the

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classification of Yakhnich I.M. (1963) is the most appropriate. According to this classification, there two types of foreign matters:

1. Foreign matters that penetrated the body via natural ostia.
2. Foreign matters that penetrated the gastrointestinal tract via the damaged tissues.

Foreign matters get into the gastrointestinal tract after accidental or intentional swallowing or via the rectum.

It should be mentioned that there are people that regularly swallow different objects.

Thus, Avanesyan (1949) described one circus performer that after long-term training became capable of drinking 5-6 L of water in 1.5 minutes and return it back, swallow up to 10 cups of kerosene and return it as a "fire fountain". Besides, the mentioned performer could swallow several fishes, a water lizard, and a frog and return them alive. He could also swallow eggs, women's watches and other objects and return them back.

The movement of foreign matters along the gastro-intestinal tract is performed due to the peristalsis. The objects enter the body via natural ostium or get stuck in a certain section of the tract depending on the size, shape, weight, number as well as on anatomic and physiologic condition of the organs in the abdominal cavity.

In 1902, Exner published experimental data on the so-called "needle" reflex, wherein he explained the mechanism of a self-induced evacuation of sharp foreign matters. He suggested that sharp objects that got in touch with the mucosa cause its retraction due to the contraction of muscle fibers of the submucosal layer and peristaltic movements of the intestine. As a result, a sharp foreign matter (needle) turns ahead with its blunt end along the direction of peristaltic movement.

However, other authors claim that foreign matters that get into the gastrointestinal tract get excreted in a natural way in 28-96% of observations (Bairov et al) depending on their shape and size.

The clinical picture of the presence of foreign matters in the gastrointestinal tract can be different, varying from lack of any symptoms to different complications. The complications include perforation, peritonitis, bleeding, intestinal obstruction, ulcers, infiltrates, etc.

The diagnostics of the presence of foreign matters in the gastrointestinal tract is based on the anamnesis, clinical examination, X-ray imaging, and US scanning.

The present report contains the results of the treatment of 27 patients with foreign matters in the gastrointestinal tract that received inpatient treatment in the clinics of departmental surgery (15 women and 12 men aged 18 to 45).

Accidental penetration of foreign matters into the gastrointestinal tract was observed in 19 patients that were delivered to the clinic. The rest 8 patients intentionally swallowed different objects to commit suicide. The range of foreign matters that got into the gastrointestinal tract was diverse: needles, blades, nails, fish bones, balance weights for clocks, tampons, rubber tubes, wire, etc.

Foreign matters remained in the body from several days to several months (9 months). They were localized in the esophagus (1 patient), stomach (7 patients), and intestine (19 patients).

Out of 27 patients that received treatment in the departmental surgery, 14 patients had the foreign matters

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excreted in a natural way and 13 patients underwent surgeries for different complications.

The treatment of patients with foreign matters in the gastrointestinal tract is widely observed in the published literature. However, there are no unified treatment techniques for such patients.

The indications for the conventional treatment:

1. No expressed pain syndrome.
2. The passage of foreign matters along the gastrointestinal tract in the X-ray image.
3. Foreign matters that does not exceed 15 cm in size.
4. No pathological alterations in the abdominal cavity.

There are some data in the scientific literature on the self-induced excretion of foreign matters, such as needles, from the body. There are two such cases described below.

1. 48-year-old woman was delivered to the surgical department with complaints on dull pains in the abdomen. The anamnesis showed that two days before she swallowed several packs of sewing needles to commit suicide.

When the patient was admitted to the hospital, her condition was satisfactory, the pulse rate was 78 bpm, BP was 100/70 mmHg. The tongue was clear and moist, the stomach was soft but the palpation was painful along the large colon and, especially, in the left iliac region. The symptoms of peritoneum irritation were not revealed. The X-ray image of the organs of the abdominal cavity showed that there were numerous needles in different parts of the intestine. The doctors decided to continue the monitoring of the patients since there were no complications revealed. 21 hours after her admission to the hospital, 31 needles were excreted with the feces. The control X-ray imaging showed that there were still numerous needles left in the colon. The patient was indicated hardly digestible food and the doctors continued her monitoring. In 3 hours, 87 more needles were excreted. The controlled X-ray imagining did not show any foreign matters left in the colon.

2. 46-year-old woman was delivered to the surgical department with complaints on dull pains in the abdomen and nausea. The patient said that a day before she swallowed 4 needles and a blade to commit suicide. The condition of the patient was satisfactory, the pulse rate was 74 bpm, the tongue was coated and moist, the abdomen was soft, and the palpation was painful in the right iliac region. The symptoms of peritoneum irritation were not revealed. The X-ray imaging showed the shadows of foreign bodies in the left part of the abdomen. The patient was indicated diet therapy and the doctors decided to monitor her.

In 4 days, the control X-ray imaging showed that the shadows of the foreign matters did not move since her admission.

4 days later, the control X-ray imaging did not show any foreign matters. The patient was discharged from the hospital with a favorable outcome.

The majority of surgeons claim that the indication for surgery are expressed pain syndrome, foreign matter larger than 15 cm, complications (perforation, peritonitis, infiltrate, phlegmon, etc.).

Below, there are two records from the medical histories.

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56-year-old man was delivered to the surgical department with complaints on intensive pain (cramps) in the abdomen, dry mouth, constipation and vomit. The anamnesis revealed that a week before, the patient (who was on the sentence in prison) swallowed a wire. Two days before, the pain in the abdomen developed and his general condition worsened. A day before, he was hospitalized to one of the municipal clinics of Bishkek. The X-ray imaging showed that there was a foreign matter in the intestine. The patient was indicated a cleansing enema and discharged from the hospital, but the pain intensified and he was delivered to the clinic of departmental surgery.

The patient was delivered to the clinic in a critical condition. The pulse rate was 120 bpm, the tongue was dry, the abdomen was distended, the palpation revealed the tension of the anterior abdominal wall. The peritoneum was irritated, percussion was dull and auscultation did not reveal intestinal murmur. The X-ray imaging of the abdomen showed a foreign body (folded wire) 20 cm long in the long intestine. The patient was diagnosed with a foreign body in the gastrointestinal tract complicated with perforation and generalized peritonitis. Urgent surgery was indicated. During the operation, a generalized septic fibrinous peritonitis was revealed, which was caused by perforation of a Meckel diverticulum with a wire, as well as a perforation of the opposite intestinal wall with the other end of the wire. The perforation was sutured. Meckel diverticulum was dissected. The abdominal cavity was drained and the micro-irrigator was left in the cavity for the introduction of antibiotics. Postoperative period was complicated. The peritonitis resolved but the wound got infected. The patient was discharged from the hospital in a satisfactory condition. This case worth attention because the patient was not indicated X-ray imaging after the cleansing enema, was discharged from the hospital and, a day after, he was delivered to the clinic with complications.

2. 59-year-old man was delivered to the surgical department with complaints on cramp-like pains in the abdomen and constipation. The anamnesis revealed that 16 years before he had surgery for acute appendicitis. Since then, the patient suffered from constipation that he tried to cure by insertion of a one-kilo weight for clocks into his rectum. The last time, the patient inserted the weight 4 days before. He tried to remove it himself unsuccessfully.

The patient was delivered to the surgical department in critical condition. The pulse rate was 100 bpm, the abdomen was distended, the palpation revealed the tension in the anterior left iliac region and dense infiltrate. The examination of the rectum showed that the rectal ampulla was empty and it was impossible to reach the weight with a finger. The X-ray imaging showed gas accumulation in the large intestine loops. The small pelvis contained a 8x3 cm foreign matter. During the rectoromanoscopy, the rectal tube could be inserted only 16-17 cm deep. Its further insertion was impossible because of the pains and outflow of purulent masses. The surgeons made a decision to perform a laparotomy for the intestinal obstruction (foreign matter in the sigmoid colon).

The patient was given endotracheal anesthesia and underwent laparotomy. During the laparotomy, unclear excaudate appeared. Sigmoid colon was adhered to the anterior abdominal wall and infiltrated. After its separation, purulent discharge came out and a perforation was revealed. The foreign matter was removed via this perforation and a sigmostoma was made. The post-operative recovery was without complications and the patient was discharged from the hospital.

The presented cases showed that patients with foreign matters in the gastrointestinal tract should not be discharged from the hospital even if there are no indications for surgery yet. Such patients need to be monitored

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until a complete excretion of foreign matters. It is difficult to foresee the outcome of this condition and a surgeon has to perform a surgery as soon as the symptoms for its indication appear. The hospitalization is also necessary when the pain syndrome develops, even if there no symptoms that indicate the complications.

***Retained Foreign Objects in the Abdominal Cavity***

Nearly any surgery in the abdominal cavity or abdominal wall is associated with the temporary or permanent presence of foreign matters in the organs and tissues. Intentionally left absorbable and non-absorbable foreign objects in the abdominal cavity include surgical suture material, steel staples, tissue grafts and different types of drainages. This is inevitable in modern surgical practice, but sometimes it provokes different complications. At the same time, any unintentionally retained objects during surgery, regardless of the complications, is traditionally seen in surgery as an emergency situation. Most often, surgeons find swabs that were left behind after previous gynecological surgeries.

25-year-old woman was delivered to the hospital with complaints on pains in the right iliac region during her period and discomfort at the bottom of the abdomen. The anamnesis showed that the above-mentioned symptoms persisted for 3 months.

The patient applied for the US scanning that revealed the presence of an ovarian cyst and a formation in the small pelvis. The patient was sent to an oncologist. The patient said that a year before, she had a surgery for extrauterine pregnancy in the maternity clinic. The blood assay did not show any pathological alterations.

Irrigoscopy results were normal. US scanning of the organs of the small pelvis indicated the presence of cystoma of the right ovary and follicular cyst of the left ovary. Rightward and posterior to the uterus, encapsulated fluid mass 106x102 mm was located. Gynecological examination showed that sexual organs were in norm, the uterine cervix was cylindrical and epithelized. The uterus was not enlarged, inclined to the left, left adnexas were not enlarged. Parametrias were free. There were no infiltrates in the small pelvis.

Per rectum: lateral to the pelvic wall, a solid mass with sharp contours, which was relatively mobile and painful, was revealed. After the examination, the patient was indicated surgery for the mass formation in the right adnexa.

The laparotomy of the small pelvis revealed retained foreign objects which included a gauze swab and surgical suturing material. The post-operative period was without complications and the patient was discharged from the hospital in a satisfactory condition.

***Bad Bet***

19-year-old woman was delivered to the hospital with complaints on headache and the presence of a foreign object (nail) in her head. The anamnesis showed that she had a bet with her friends and hammered a 80 mm nail in her left parietal region. Objective observations: the patient was conscious and did not have any disturbances in the cranial nerves. In the projection of the left parietal bone closer to the sagittal seam, there was a nail head and traces of bleeding. The skin around the nail was pale and painful at palpation, no subcutaneous hematoma was observed. The X-ray image of the scull in two projections showed that the foreign object penetrated the skull to the upper border of the left eye orbit (Figure 6). The surgeons made a decision to remove the nail under general anesthesia

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because there was a risk to damage major blood vessels, in particular, sagittal sinus, and in case of intensive bleeding, a craniotomy would be needed.

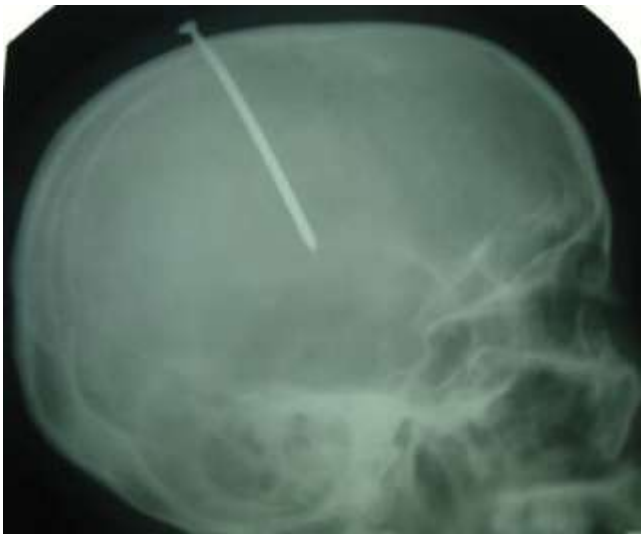

Figure 6: X-ray image: side projection. Foreign object penetrates the skull

In the course of the surgery, the foreign object (80 mm rusted nail) was removed. It was hard to remove the nail because of the lateral pressure of the cranial bones. After the removal, the bleeding started which was stopped by a swab saturated with the solutions of hydrogen peroxide and furacilin within 5 minutes. The bleeding stopped and 3x2 mm wound was covered with a semi-spirituous bandage. Wide spectrum antibiotics were indicated. Antitetanic serum was injected by the Bezredka method. The postoperative recovery was without complications.

During the treatment, the patient underwent numerous examinations by a neurologist who did not reveal any alterations in the cranial and cerebral nerves. There were no disturbances of the psychic either. On the $10^{th}$ day, the patient was discharged from the hospital in a satisfactory condition. For the following 5 years, she was monitored by the doctors. The recovery was complete. The patient got married and had children.

***Proper Medical Records are Crucial for the Indication of Adequate Treatment***

Often, the diagnosis during surgery can be wrong. Why that happens is a controversial issue. Sometimes, it is high ambitiousness and lack of professionalism in the personnel lead to the situations when surgeons face difficulties during reoperations. Naturally, medical history helps to give a correct diagnosis, but sometimes, in urgent situations or without the access to medical history, a surgeon has to act promptly.

Often, diagnostic mistakes can be life-threatening for a patient. There were cases when patients were delivered to a hospital in critical conditions because of diagnostic mistakes. Primarily, such patients underwent in clinics where doctors are not used to admitting their mistakes.

Internet: According to the report of the Medical Informational network on the study conducted in 1999 in the USA, annually, 100 thousand patients die because of medical errors. By the estimations of HealthGrades (Lakewood, Colorado), by 2004, this number increased to 195 thousand people.

Sourse: GZT.ru.

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***Know-how of a Casanova or how the Issues are Handled by Sexually overactive People***

Life is given once only, so some people claim that it has to be live to the full. It is normal when this principle keeps a person within adequate limits. But sometimes, *homo sapience* act quite irrationally and not smart.

One military retiree had often visits to his urologist. He had complaints on sexual frustration. The doctor said that it was an age-related inevitable issue and indicated the treatment, but gradual decline of physiological processes took over. However, the patient decided to prove that the doctor was wrong. In a while, the patient returned to the hospital with complaints bleeding during the urination and urethralgia. The urologist indicated general examination, including X-ray imaging of the bladder.

The X-ray image showed that the bladder contained a foreign object which looked like a 10 cm bent wire. It was a hairpin. For some reason or another, the patient decided to use a hairpin as an erector for his penis. Before the sexual intercourse, he inserted a hairpin into his urethra. Evidently, the intercourse did not last long. One problem caused the other and the patient had to apply for medical help. Surgery was indicated and a rusty metal hairpin was removed from the bladder.

## IV. OATH-BREAKER

34-year-old woman was delivered to the Republican center of Nephrology (Bishkek) in a critical condition complaining of 2-day anuria. The anamnesis said that she had a surgery 2 days before in the regional hospital.

The symptoms indicated cholelithiasis, however, there was no acute pain syndrome. An experienced local surgeon planned surgery and persuaded the relatives of the patient that the sooner the hepatolith were removed, the better would be the outcome. The revision of the gall bladder did not reveal any pathology.

Further examination showed a tumor-like formation in the kidney and the surgeon made a decision to perform a nephrectomy.

It turned out later that the patient that a congenital pathology and had only one kidney. The honored surgeon ignored the revision for the presence of the second kidney.

## V. CRIMINAL MISTAKES

**The other leg.** It is difficult to imagine that an experienced doctor can confuse left and right. But this actually happened in Tampa, Florida (USA). In 1995, the surgeon had to amputate the right leg of his 52-year old patients Willie King. When the patient recovered after the anesthesia, he found out that his sick leg remained and his left leg was missing. The doctors tried to persuade the patient that the amputated leg was also damaged and it had to be amputated later, but the patient applied to the court and won the case. He was compensated 900 thousand dollars by the clinics and 250 thousand dollars by the surgeon. Besides, the surgeon lost his license for half a year.

//www.malomo.ru/test/

***Desinfectant Instead of a Drug***

Drugs must be labeled properly. In one of the medical centers in Virginia, Mason, the personnel failed to do so. As a result, a 69-year old patient Mary Mac Clinton was injected a disinfectant instead of a drug. This caused the

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patient's death and the protocols on drugs handling in the medical center became stricter.

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## VI. DISCUSSION

Medical treatment always required great responsibility, and surgery, in particular, requires great attention, knowledge and courage. One surgeon operated himself in front of the mirror, another surgeon risked his life and removed an unexploded grenade from a soldier's wound. The article presents unusual interesting situations, wherein the surgeons reacted promptly and their knowledge and experience saved many patients. Unfortunately, perfection and a will for helping patients were not enough. Sometimes, the circumstances, ambitiousness, arrogance and lack of professionalism threaten the safety in clinical medicine.

Lately, there has been a tendency for the increase in the incidence of medical errors. According to the published data, medical errors are classified as a) honest mistakes, b) ignorant mistake and c) low qualification. Apart from medical errors, there are accidents. Still, regardless of the classification, patients suffer. The majority of the retained foreign objects in the abdominal cavity are left behind after the surgery due to the forgetfulness or lack of concentration in a surgeon. Retained cell phones or different steel objects, including rings, certainly harm a surgeon's reputation. There was a case when a steel clamp was "diagnosed" in an airport. Video surveillance can partially prevent this problem.

Ten successful operations are not worth a single failure that with cause a patient's death. The provided statistical data on the rate of lethality from medical errors is frightening considering the level of the development of modern medicine.

And how can doctors provide safety for patients who harm themselves? Such cases not only upset doctors but also cause economic damage to the country that spends money on medical care for such patients and compensates the time spent in a hospital.

## VII. CONCLUSION

1. In non-standard situations, surgeons sometimes made medical mistakes that lead to unpredictable consequences that can be life-threatening for patients. Adequate readiness for such situations can prevent negative effects.
2. Clinical protocols of diagnostics and treatment do not cover untypical and unusual situations. Still, they are inevitable. For this reason, it is necessary to expand the medical students' knowledge and practicing doctors with interesting clinical observations on this issue. It is useful to involve video presentations on the minimization of medical errors and safety of surgical manipulations. Legal competence of doctors should also be improved.

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3. The education plan of future surgeons should include such subjects as performance in non-standard situations, iatrogenic diseases in surgical practice, etc. A reference book written by surgeons, doctors, medical care authorities, psychologists and lawyers should be published. These are one of the options of handling the issue with the increased incidence rate of medical errors.

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