病歷紀錄IV
對手術病人之安全評估及術後照顧

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2024.04.19.

- Preoperative evaluation
- Postoperative status—functional change
- Postoperative care.
- Adequate communication.
- Adequate recording..

PREOPERATIVE EVALUATION

- 1. Operation是否必要
- Resectability in patients with cancer (自我重要的評估)
- (誠實的評估)(可信賴的評估)
- True diagnosis 確切嗎? 一定列出確診的證據.
- 要不要再等看看? 要不要立即就手術?
- 2. 手術本身是安全的嗎
- “肝癌手術成功” 病人卻因肝昏迷死亡
- 3. 手術之前向家屬說明清楚:成功率有多少,手術後又怎麼樣
- 4.有沒有其他的選擇

1. OPERATION是否必要:
(自我重要的評估-我可以做得到)
(誠實的評估)(可信賴的評估)

- How to Determine Unresectability in Hilar Cholangiocarcinoma. Pratt CG, Whitrock JN, Shah SA, Fong ZV.Surg Clin North Am. 2024 Feb;104(1):197-214. doi: 10.1016/j.suc.2023.09.001. Epub 2023 Sep 27.PMID: 37953036 Review.
- (Cincinnati Research in Outcomes and Safety in Surgery (CROSS) Research Group, Department of Surgery, University of Cincinnati College of Medicine)
- Hilar cholangiocarcinoma is considered a biologically aggressive disease for which surgical resection remains the only curative treatment. **Preoperative evaluation** for resectability is challenging given tumor proximity to the porta hepatis,but-----

術前評估、術中評估和手術切除的關鍵步驟，以及不可切除腫瘤的治療方案.開刀前就把意見清楚的敘述出來

•Margin negative (R0) resection is the strongest predictor for survival.
••Preoperative evaluation for resectability is challenging given the tumors
proximity and possible invasion into to the *porta hepatis*.--Over one-half to two-thirds of cases are deemed surgically unresectable at presentation.
••No clinical staging system readily predicts resectability.
••A multidisciplinary, holistic, and individualized approach gives the

- Treatment options in the event of unresectability
- When a patient with hCCA is not a candidate for resection, other treatment modalities can be considered in the context of a multidisciplinary team approach. The most common first-line treatment of patients with unresectable hCCA is systemic chemotherapy, typically with gemcitabine and cisplatin. This combination was first demonstrated to increase survival in the Advanced Biliary Cancer (ABC)-01 trial followed by the ABC-02 trial.[48]

告訴病人即使不能開刀,也還能夠做化療
化療還有相當的效果

Gemcitabine alone or in combination with cisplatin in patients with advanced or metastatic cholangiocarcinomas or other biliary tract tumours: a multicentre randomised phase II study - The UK ABC-01 Study

J W Valle[1], H Wasan, P Johnson, et al (Department of Medical Oncology, The Christie NHS Foundation Trust, Wilmslow Road,, UK.)

Patients, aged > or =18 years, with pathologically confirmed ABC, Karnofsky performance (KP) > or =60, and adequate haematological, hepatic and renal function were randomised to G 1000 mg m(-2) on D1, 8, 15 q28d (Arm A) or C 25 mg m(-2) followed by G 1000 mg m(-2) D1, 8 q21d (Arm B) for up to 6 months or disease progression.

Responses (WHO criteria, % of evaluable patients: A n=31 vs B n=36): no CRs; PR 22.6 vs 27.8%; SD 35.5 vs 47.1% for a tumour control rate (CR+PR+SD) of 58.0 vs 75.0%. The median TTP and 6-month progression-free survival (PFS) (the primary end point) were greater in the C/G arm (4.0 vs 8.0 months and 45.5 vs 57.1% in arms A and B, respectively).

結論: Both regimens seem active in ABC. C/G is associated with an improved tumour control rate, TTP and 6-month PFS.

Affiliations

PREOPERATIVE PREDICTORS FOR NON-RESECTABILITY IN PERIHILAR CCC.

Preoperative predictors for non-resectability in perihilar cholangiocarcinoma

Carlos Constantin Otto et al (Germany)

World J Sug Oncology 2024 Feb 7;22(1):

1. monocentric cohort comprised 318 patients with 209 (65.7%) being surgically resected.
2. Statistically significant ($p < 0.05$) risk factors for non-resectability were

   age above 70 years (HR = 3.76, p = 0.003),

   portal vein embolization (PVE, HR = 5.73, p = 0.007), and

   arterial infiltration > 180° (HR = 8.05 p < 0.001)

   elevated CA 19-9 (HR = 3.2, p = 0.009) for oncological/liver-functional non-resectability.
3. Preoperative assessment of those factors is crucial for better therapeutical pathways. Diagnostic laparoscopy, especially in high-risk situations, should be used to reduce the amount of explorative laparotomies without subsequent liver resection. Preoperative assessment of those factors is crucial for better therapeutical pathways.

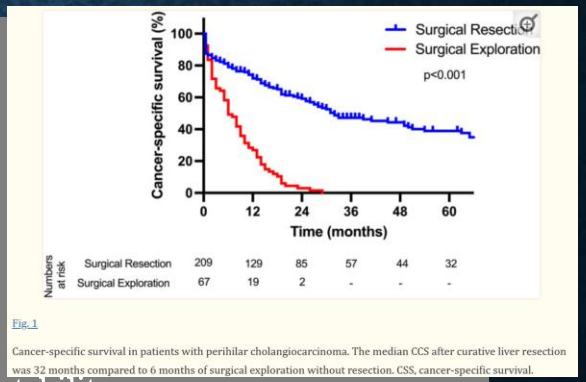

Fig. 1

Cancer-specific survival in patients with perihilar cholangiocarcinoma. The median CCS after curative liver resection was 32 months compared to 6 months of surgical exploration without resection. CSS, cancer-specific survival.

Diagnostic laparoscopy, especially in high-risk situations, should be used to reduce the amount of explorative laparotomies without subsequent liver resection.

2.手術本身是安全的嗎?
更多的專業評估-我們需要多專科專業人(MDT)員的評估

- 1. Heart and lung condition
- 2. Under Anesthesia
- 3. Postoperative functional status– esp in patients with liver disease.
- Compensated or decompensated ?
- 4. Experience in postoperative care.

創建高性能手術安全檢查表： high-performance surgical safety checklist (重振檢查表的多模式評估計劃)

1.世衛組織手術安全檢查表是一種溝通工具，旨在改進手術安全流程並加強團隊合作。自十多年前推出以來，它已被廣泛採用。隨著手術安全需求的發展，組織應定期審查和更新其檢查表。

2.多學科團隊制定並實施了一個由三部分組成的評估計劃。評估包括評估 1.通過審查手術安全事件來提高護理品質;2. 通過經過驗證的調查和非正式反饋進行安全文化;和 3.通過直接觀察和員工調查來檢查績效。

Rachel Moyal-Smith et al J. Evaluation in Clinical Practice 29:341-350, March 2023,

3.手術成功率有多少,可能有些什麼合併症(後果),事先要說清楚

- 手術之前向家屬說明清楚:成功率有多少,手術後又怎麼樣
- 有沒有其他的選擇

切忌用恐嚇的手段像病人威脅一定要手術,否則 ------

Get informed consent

整形外科醫師會被起訴嗎？
當病人做了美容手術不滿意時

- Do Plastic Surgery Residents Get Sued? An Analysis of Malpractice Lawsuits.Gibstein AR, Jabori SK, Watane A, Slavin BR, Elabd R, Singh D.Plast
- 1Division of Plastic & Reconstructive Surgery, University of Miami, Miami, Fla.
- [2]Department of Ophthalmology, Yale University, New Haven, Conn.
- [3]Division of Plastic and Reconstructive Surgery, McGill University, Montreal, Quebec, Canada
- Reconstr Surg Glob Open. 2023 Jan 13;11(1):e4721

在32年的時間里，確定了21起涉及整形外科實習生的訴訟。其中，14宗（66.67%）涉及受訓者被直接列為被告的申索。18例（85.7%）病例由程序相關不良結局引起，3例（14.3%）病例與臨床或診斷相關不良結局相關。在與手術有關的病例中，有5例（27.8%）發生在受訓者擔任主刀醫生時。**指控包括缺乏對手術併發症的知情同意（11人，52.4%）**、程序錯誤（11人，52.4%）、未能監督受訓者（11人，52.4%）、受訓者缺乏經驗（8人，38.1%）、不正確的 診斷或治療（5人，23.8%）、評估延遲（3人，14.3%）、缺乏居民參與意識（3人，14.3%）、缺乏隨訪（3人，14.3%）和手術時間延長（1人，4.8%）。從受傷到訴訟解決的中位時間為3.8年[四分位距），3-5年]。在8起案件（38.1%）和6起案件（28.6%）中，判決對原告有利。7宗（33.3%）案件達成和解。原告勝訴案件的賠付中位數為 5,100,000 美元（IQR，1,530,000 美元至 17,500,000 美元）;結算金額中位數為 2,500,000 美元（IQR，262,500 美元至 4,410,000 美元）

Procedural error,、不當(improper)知情同意、不當的受訓監督和住院醫師缺乏經驗是最常見的指控。這些因素可能導致醫生職業生涯早期的經濟和心理負擔。

為什麼會發生針對外科TRAINEES的醫療事故訴訟，如何預防？

Medical Malpractice Lawsuits Involving Surgical Residents

- Cornelius A. Thiels, DO, MBA[1,2]; Asad J. Choudhry, MBBS[1]; Mohamed D. Ray-Zack, MBBS[1]; et alRachel A. Lindor, MD, JD[3]; John R. Bergquist, MS, MA, MD[1]; Elizabeth B. Habermann, PhD, MPH[2]; Martin D. Zielinski, MD[1]
- [1]Department of Surgery, Mayo Clinic, Rochester, Minnesota---

- *JAMA Surg.* 2018;153(1):8-13. doi:10.1001/jamasurg.2017.2979

A database review of malpractice cases involving surgical residents found that 70% of cases involved elective surgery and 69% named a junior resident, while **lack of direct supervision by attending physicians** was cited in 55% of cases.

1. Surgical residents are not immune from being involved in malpractice ligation.
2. Medical decision making errors are commonly cited in legal cases involving surgical trainees, particularly among junior residents.
3. faculty supervision and communication between residents and attending physicians in an effort to reduce the number of lawsuits involving trainees.

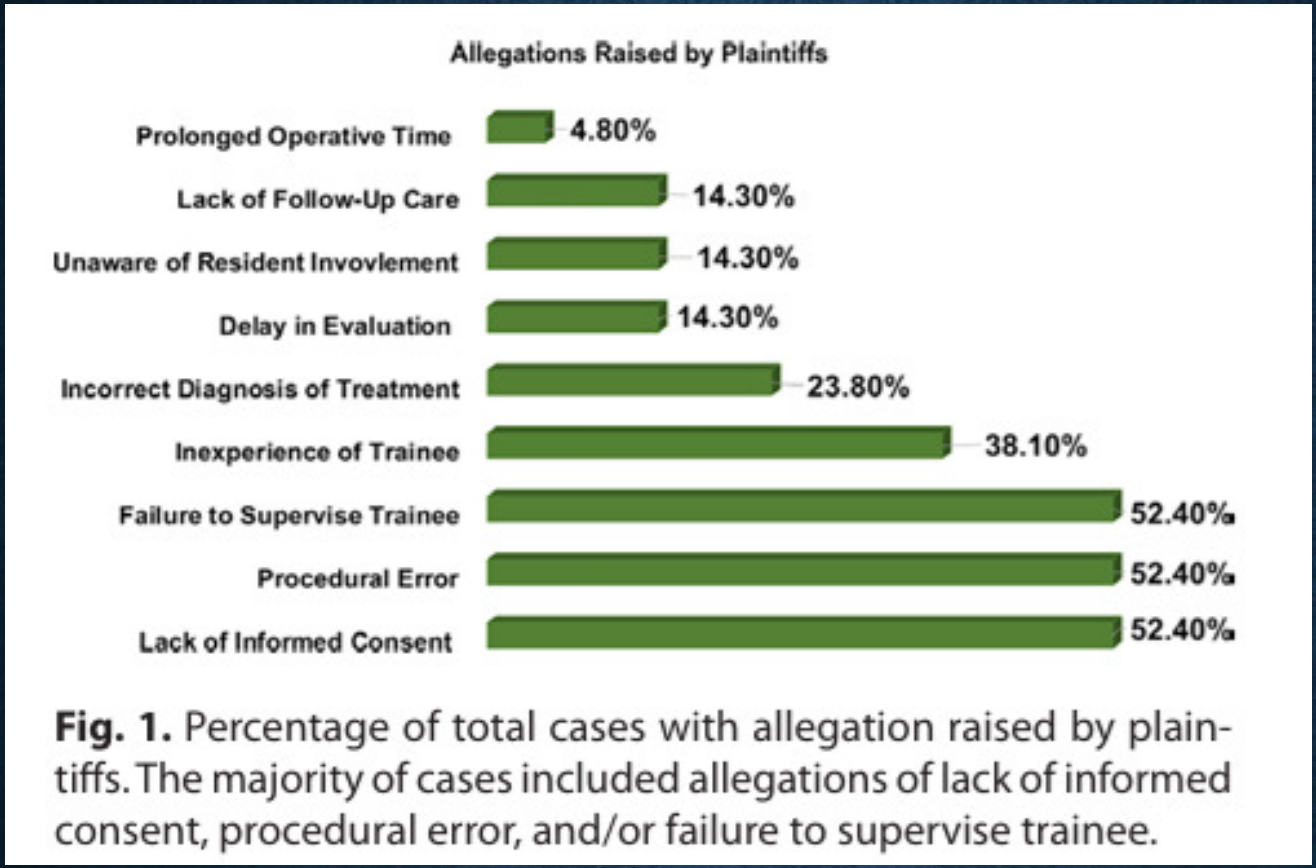

Fig. 1. Percentage of total cases with allegation raised by plaintiffs. The majority of cases included allegations of lack of informed consent, procedural error, and/or failure to supervise trainee.

Furthermore, a study from JAMA analyzing medical malpractice lawsuits among surgical residents in the United States showed that communication not only between physician and patient, but also between residents and attending physicians, as well as residents and staff, is key.

Do Plastic Surgery Residents Get Sued? An Analysis of Malpractice Lawsuits. Gibstein AR, et al :Reconstr Surg Glob Open. 2023 Jan 13;11(1):e4721.

一個最聳人聽聞的報告-沒有問,就說沒有-絕對不該有的毛病

- 某一次預評的經驗: history taking不重視而且還隨便回答.沒想到評鑑委員會見病人,一下子就知道醫師沒有問,很漏氣的.
- Oral cavity cancer 的病人---R3做報告
- Q: 請問病人的家人還有沒有同樣的病例? 嚼檳榔或得到口腔癌?
- A (R3):都沒有.
- _____
- 評鑑委員到病人床邊詢問,
- Q您的家人有沒有人跟你一樣嚼檳榔或得到口腔癌?
- A(Patient) : 我弟弟也嚼檳榔而且兩年前也得到口腔癌,也在你們醫院治療

術後照顧要用心

- 至少手術後3天內要經常到床邊去看病人的狀況每天寫醫療紀錄(寫病歷)
- 術后應該每天都去觀察病況.也要寫紀錄.
- 出院後第一次的門診, 一定要自己看過
- ---有問題也可以早點發現.不可以不當一回事,生手醫師特別要養成習慣
- Operator 對手術程序多很清楚,是否會發生問題也應該很有概念.
- 必須針對這一點密切觀察.不可以視而不見.大而化之 (粗枝大葉、馬馬虎虎.) (1.careless. 2.negligent)

最新的新聞事件是開錯了病人
-病人辨識問題是最簡單的事,現在還會出錯.太扯了.

2024.04.11 公視新聞
高雄民生醫院手術開錯患者 主刀醫師、院長遭免職
-市立醫院,可能衛生局局長.市長 都有連帶責任 ,要重罰

高雄市民生醫院**2024.04.04**日發生開錯刀事件，有工友協助推患者進手術房時推錯人，導致患者被開錯刀，過程中也完全沒人發現，直到護理師送藥才發現疏失，但手術已經做完

一錯再錯,一連串的錯誤.
交班之際,慌亂?

	2.6.5	應於手術前向病人充分說明，取得同意，並簽署同意書
	2.6.6	麻醉醫師於術前探視病人並確立麻醉計畫
	2.6.7	確實落實手術病人辨識程序，確保病人身分、手術項目與手術部位正確無誤
合	2.6.8	手術室以外之麻醉與鎮靜作業應適當執行
	2.6.9	詳實記載麻醉紀錄及手術紀錄
	2.6.10	訂定手術前後之護理照護常規及處置步驟，確實執行、製成護理紀錄及適時修正
	2.6.11	手術後恢復過程應適切管理，且明訂術後恢復室等之使用基準及步驟

沒看手圈

結論(2024.04.19)

- 1. 誠實問病人跟誠實作評估同樣的重要,內科系病人如此外科系也
- 是一樣.
- 2.評估病人的危險性應該有一套清單可以全面性去了解
- 3.細心照顧小心觀察,還是最重要的治病態度
- 4.發現問題要跟病人家屬細心說明並及時處理.
- 5. 醫療品質與病人安全是重點
- 6. 年輕醫師的教育訓練是主治醫師的職責要用心指導.
- 7. Informed consent一定要確實說明,最好有書面資料