



Bankettb



# **Complications in Endoscopy**

**CONVIVERE NEL QUOTIDIANO**

**SIED Udine 2019**

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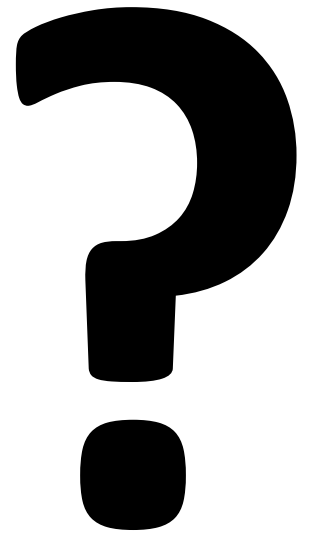
Hannover, Germany

# **What is a complication?**

- cerebral ischemia after cessation of warfarine before sphincterotomy**
- hypoxia during colonoscopy, managed by supportive care**
- acute bleeding after polypectomy, managed by clipping**
- depressive patient with suicidal obsessions after Propofol**
- 55-year old man having colonic carcinoma and liver metastases 5 years after uneventful screening colonoscopy**

# **Is a complication**

- an unavoidable problem**
- „part of the game“**
- bad luck**



# DEFINITIONS

**/ something went wrong**

**. > *adverse event***

**/ something was done wrong**

**. > *negligence***

**/ something went wrong while nothing  
was done wrong**

**. > *complication***





# **ADVERSE EVENT**

**/ The neutral term**

**/ Doesn't tell you anything about the  
cause of the event**



# **NEGLIGENCE**

- / The doctor has worked below the required level of care**
- / The problem could, and should, have been avoided**
- / The doctor and/or hospital are/is liable for damages**

# **COMPLICATION**

**/ A problem which could not have been avoided**

**/ “All in the game”**

**/ “Bad luck”**

**/ No legal consequences, unless there is a lack of informed consent**

# **DUTY TO INFORM**

- / Information about relevant complications to be expected (and about alternative ways of treatment) before receiving informed consent from the patient**
- / The occurrence of a complication can have legal consequences if the doctor has failed to inform properly**

# **Why do patients sue their physicians?**

- severe handicap of working ability, family and social life**
- unsensible or incomplete communication after the event**

**Today's opponent is your yesterday's patient !**

**...what about the incidence of  
endoscopic complications?**

**There are lies,**

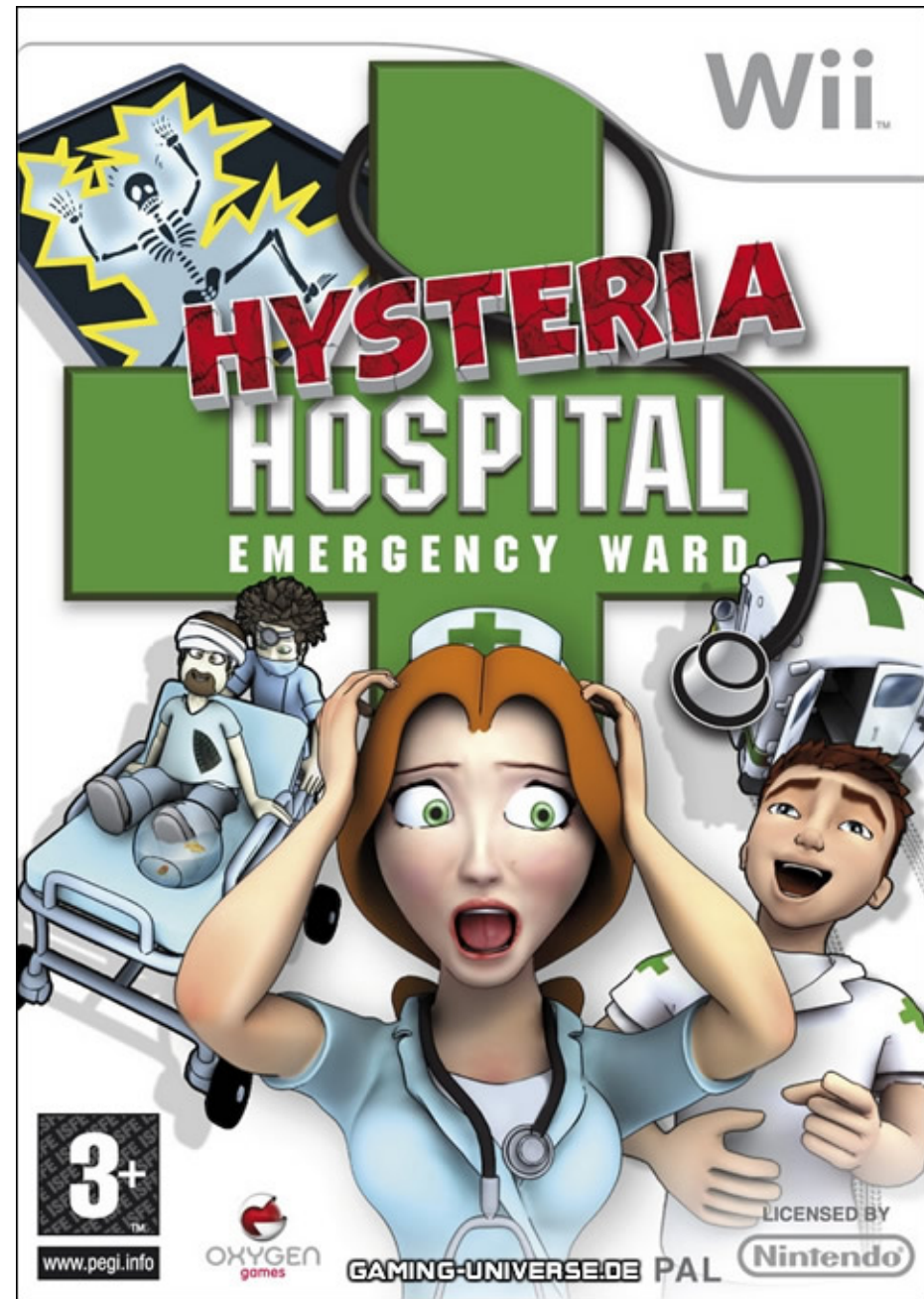
**there are bad lies**

**and there is statistics**



# Complications have to be

- anticipated
- recognized
- reacted on
- communicated
- documented
- analysed



# Recognize



**Cystic duct insufficiency**

# **Recognize**

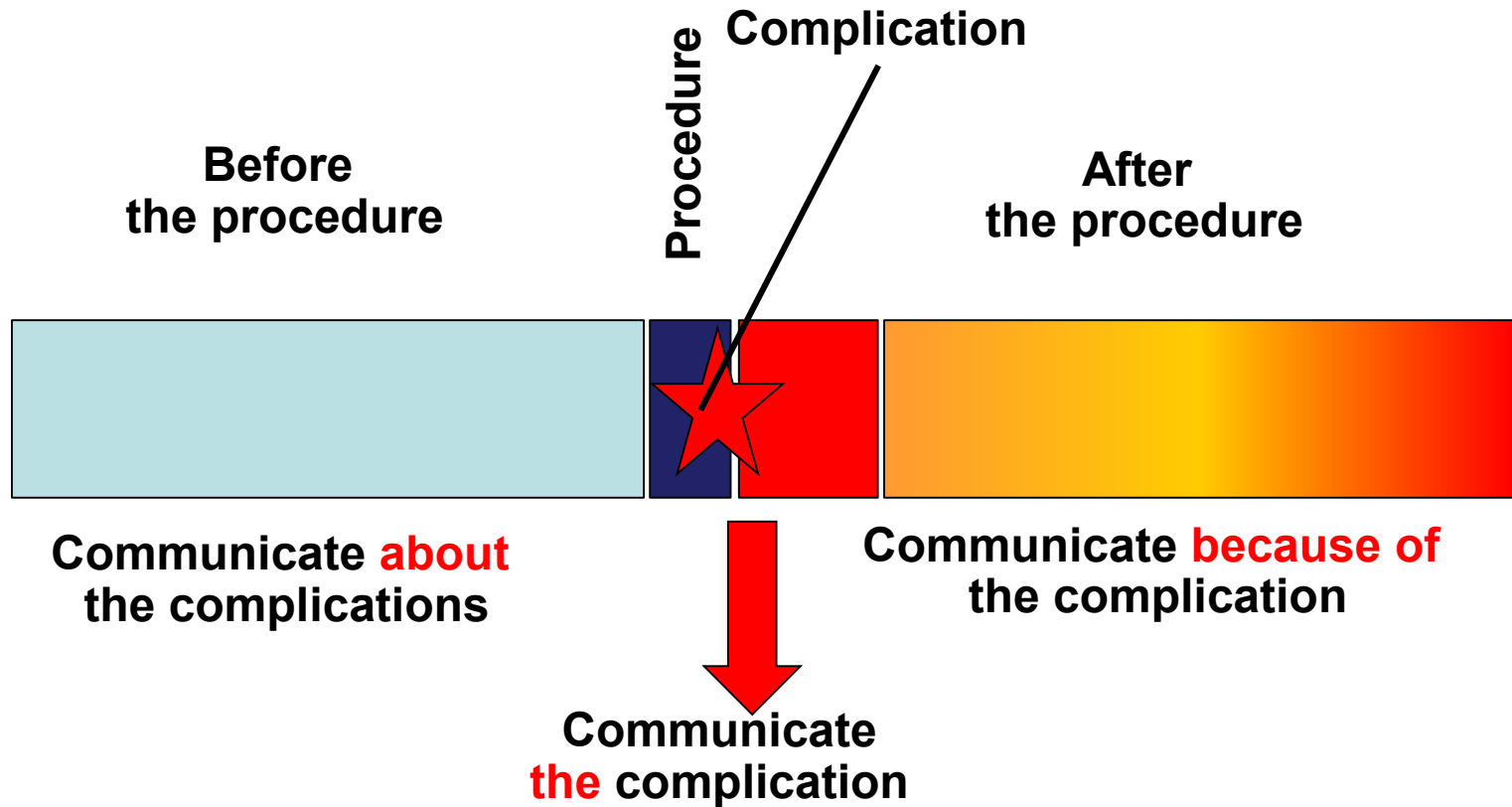
## **Looking for typical complications**

- X-ray control (with contrast) after dilatation?**
- abdominal finding/palpation post colonoscopy?**
- Emphysema during ESD or Dilatation?**
- ERCP: free air post procedure?**

# Communication



# The time line of communication about complications





**What?**

**The Truth !**



# **When the complication is recognized...**



## **/ When to communicate?**

- . Immediately**

## **/ By whom**

- . Personal involved**
- . Direct information**

## **/ To whom?**

- . The patient himself**
- . The family**
- . The family doctor/ referring physician**
- . The surgeon/ radiologist**

# **Bad News...**

- Chosing the right surroundings**
- Chosing the right language**
- Clear speach, time for questions**
- Enough time for answers**
- Summarizing the event and further steps**

# **Document**

**/ Clear detailed and „true“ honest report**

**/ Immediate documentation – stepwise**

- Detailed physicals with date and time**
- Documentation of consultations and decisions**
- Visual (picture, video, file) documentation if possible**

**/ Complication summary for medical record**

# **Act!**

**Induce appropriate  
interventional actions to**

- minimize**
- reverse**
- avoid**

**further deterioration of the  
complication**



# **A quick reaction results in a better outcome**

## **Surgical treatment of oesophageal perforations**

	% Deaths	
	Treatment < 24h	Treatment > 24h
<b>Bladergroen et al. 1986</b>	<b>15</b>	<b>33</b>
<b>Nesbitt et al. 1987</b>	<b>11</b>	<b>26</b>
<b>Sandasagra et al. 1978</b>	<b>20</b>	<b>35</b>
<b>Ajalat et al. 1984</b>	<b>0</b>	<b>33</b>
<b>Michel et al. 1981</b>	<b>11</b>	<b>29</b>
<b>Moghissi et al. 1988</b>	<b>30</b>	<b>56</b>
<b>Larsen et al. 1983</b>	<b>13</b>	<b>33</b>

# **New Tools?**

- YES!**
- via EMR/ ESD/ NOTES**

# **New Tools for**

- Hemorrhage**
- Perforation**
- Infection**
- Drainage**
- (sedation)**

# Hemorrhage

- **pharmacologic Tx**
- **injection**
- **thermal Tx**
- **mechanical Tx**
- **hemospray**

# Perforation

**therapeutic principles:**

- adaptation**
- covering**
- drainage**

# Perforation

- **primary closure**
  - **clipp, suture**
- **stent**
- **drainage**

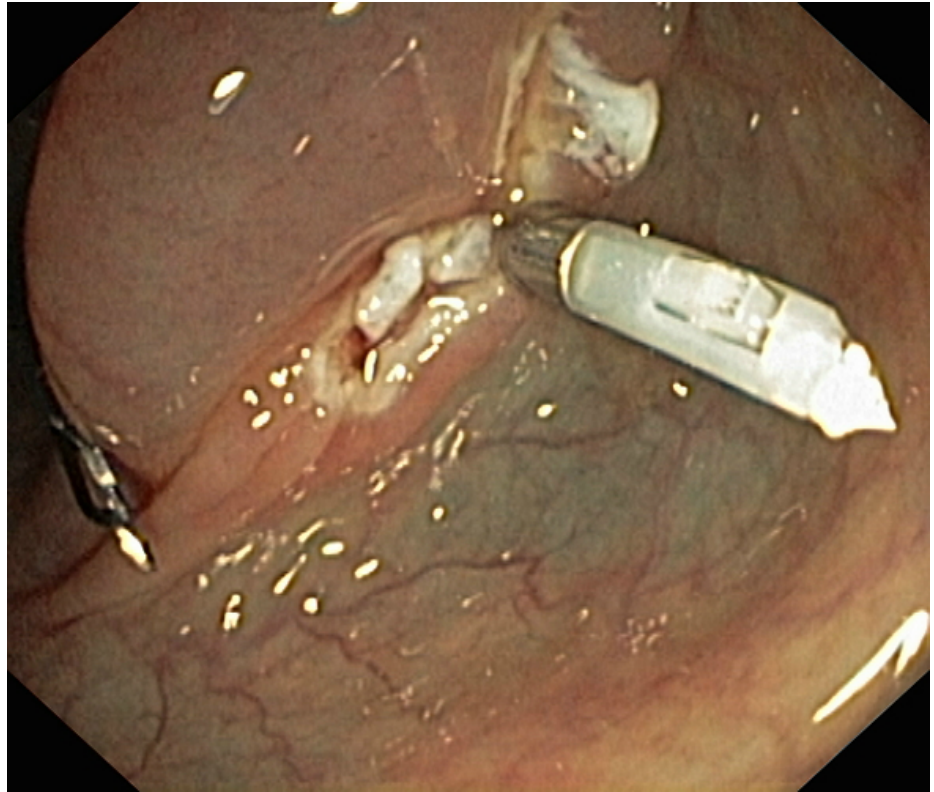
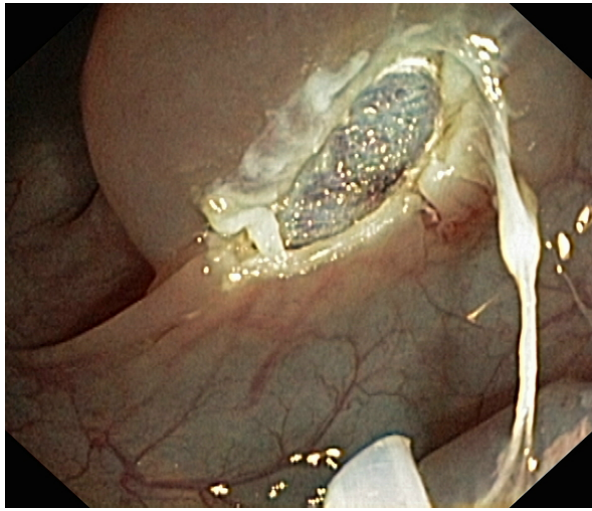
**Perforation: SEMS**

**fully covered**

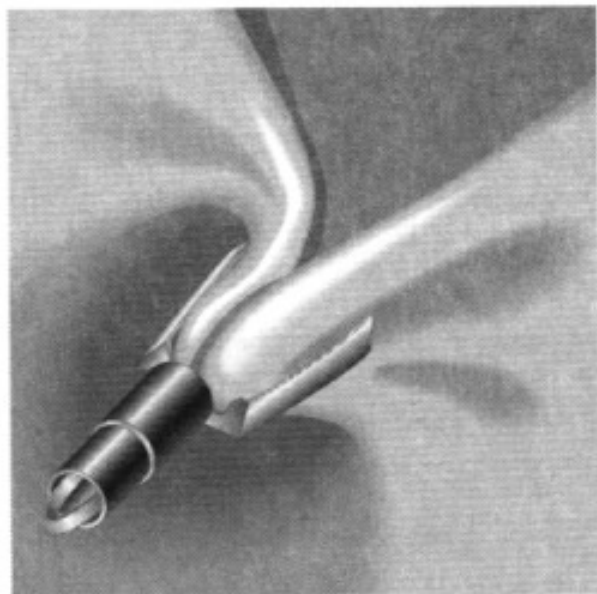
**duration 1-2 Monate**

**diameter 22m**

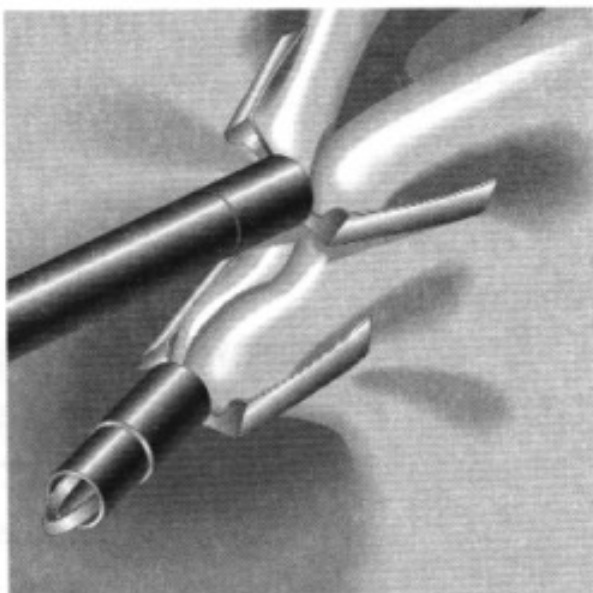
**change after 4 weeks**



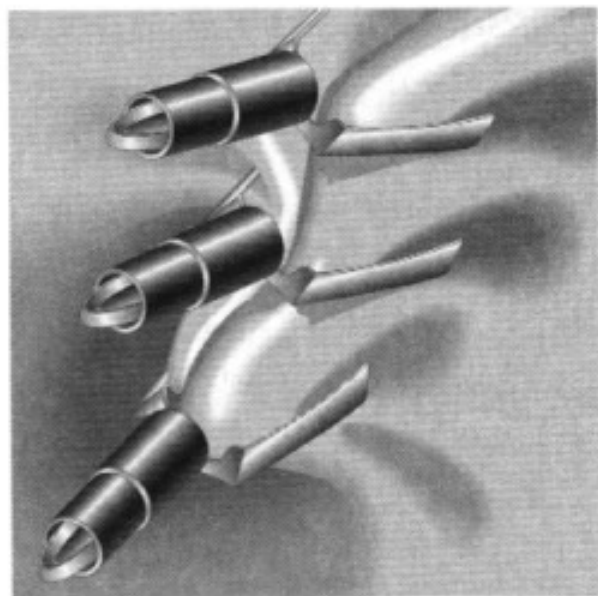




*a*



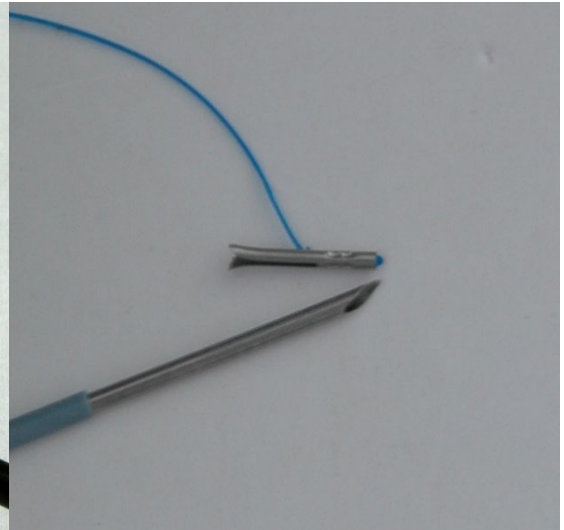
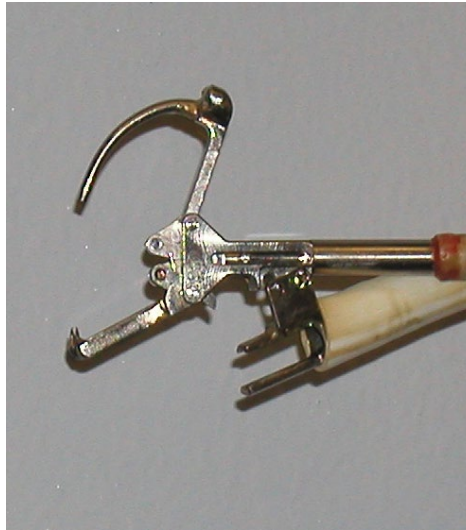
*b*



*c*

# suturing

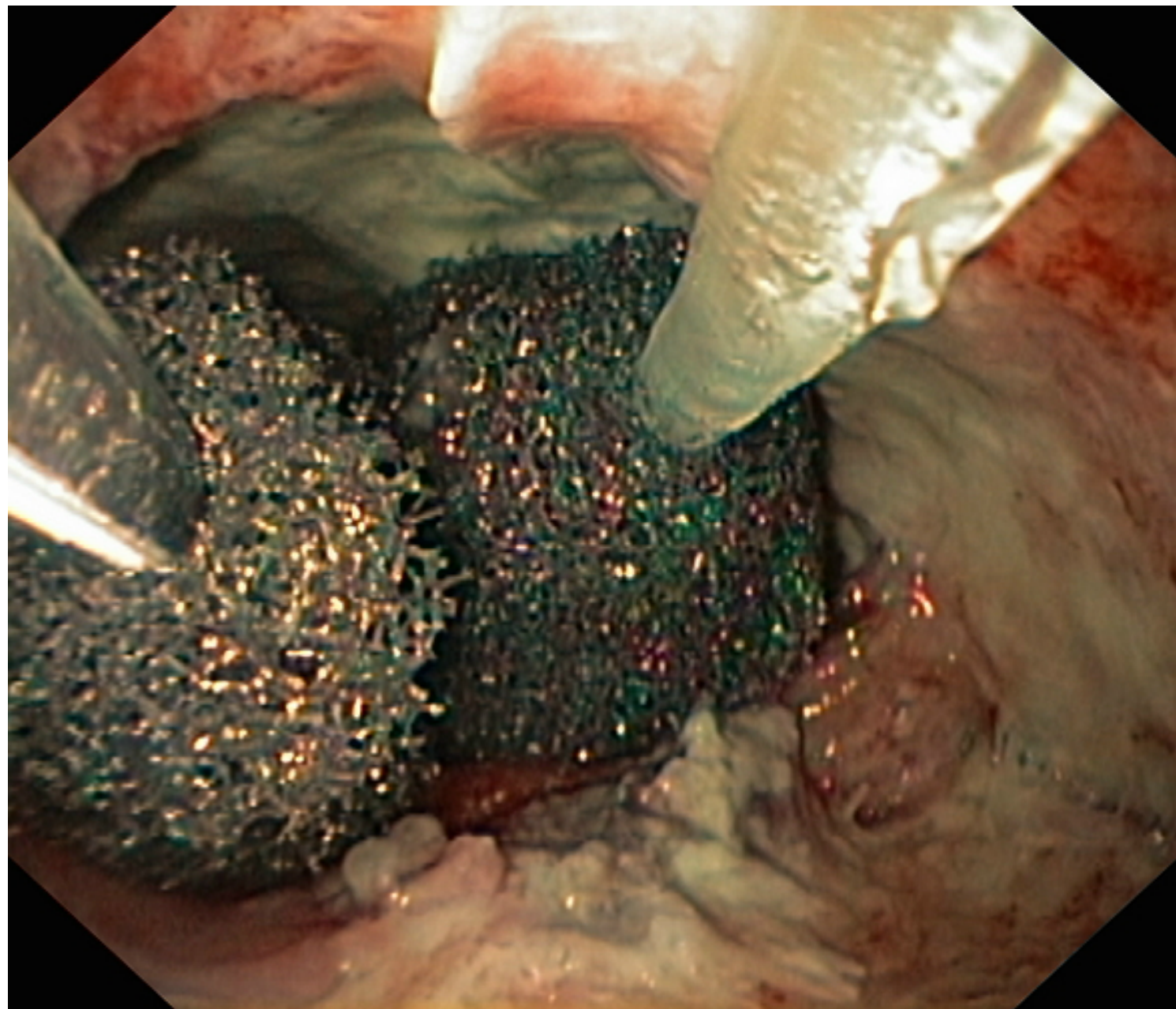
## still experimental



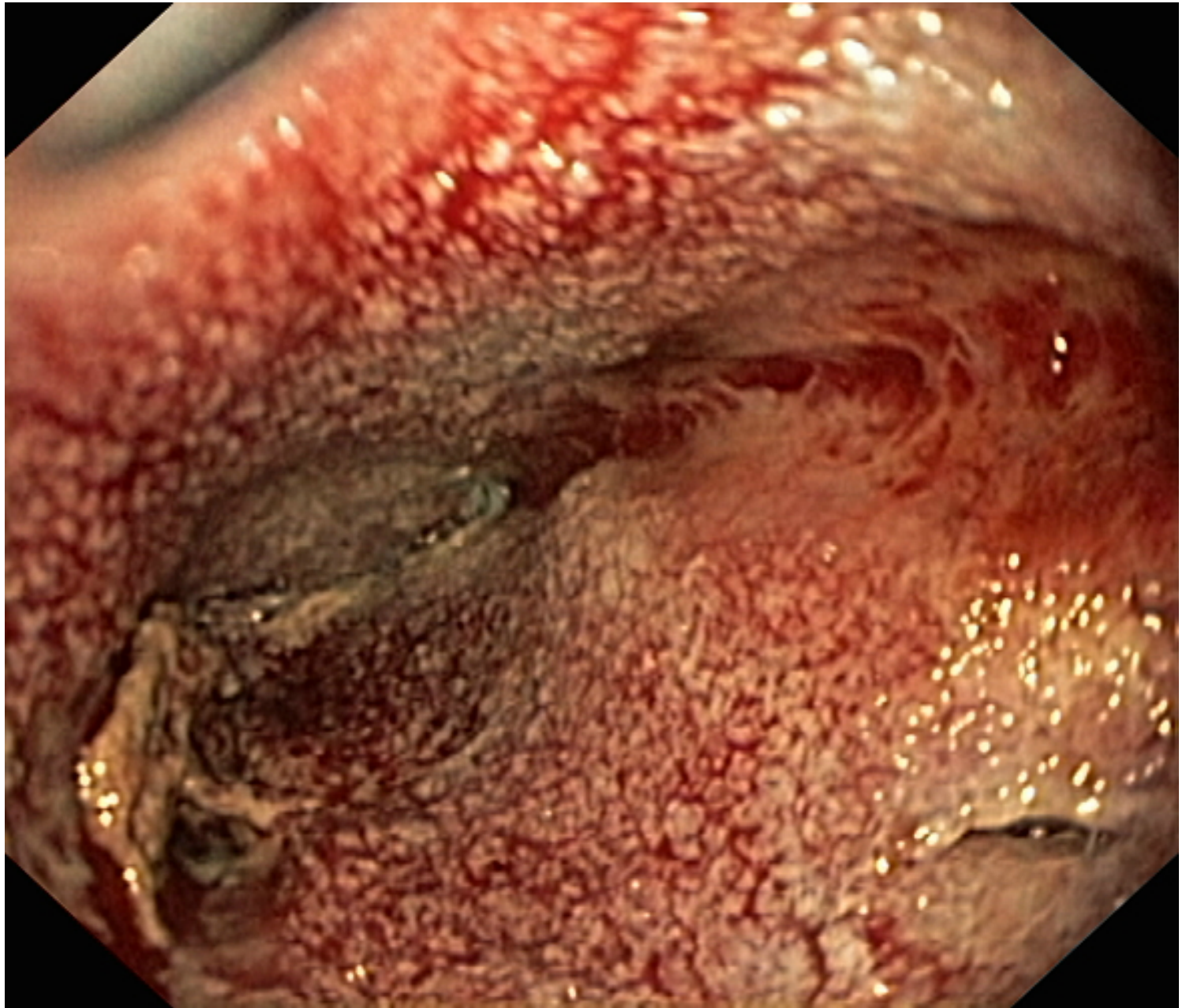


**sponge**

**= therapy of septic/ infected  
wounds**







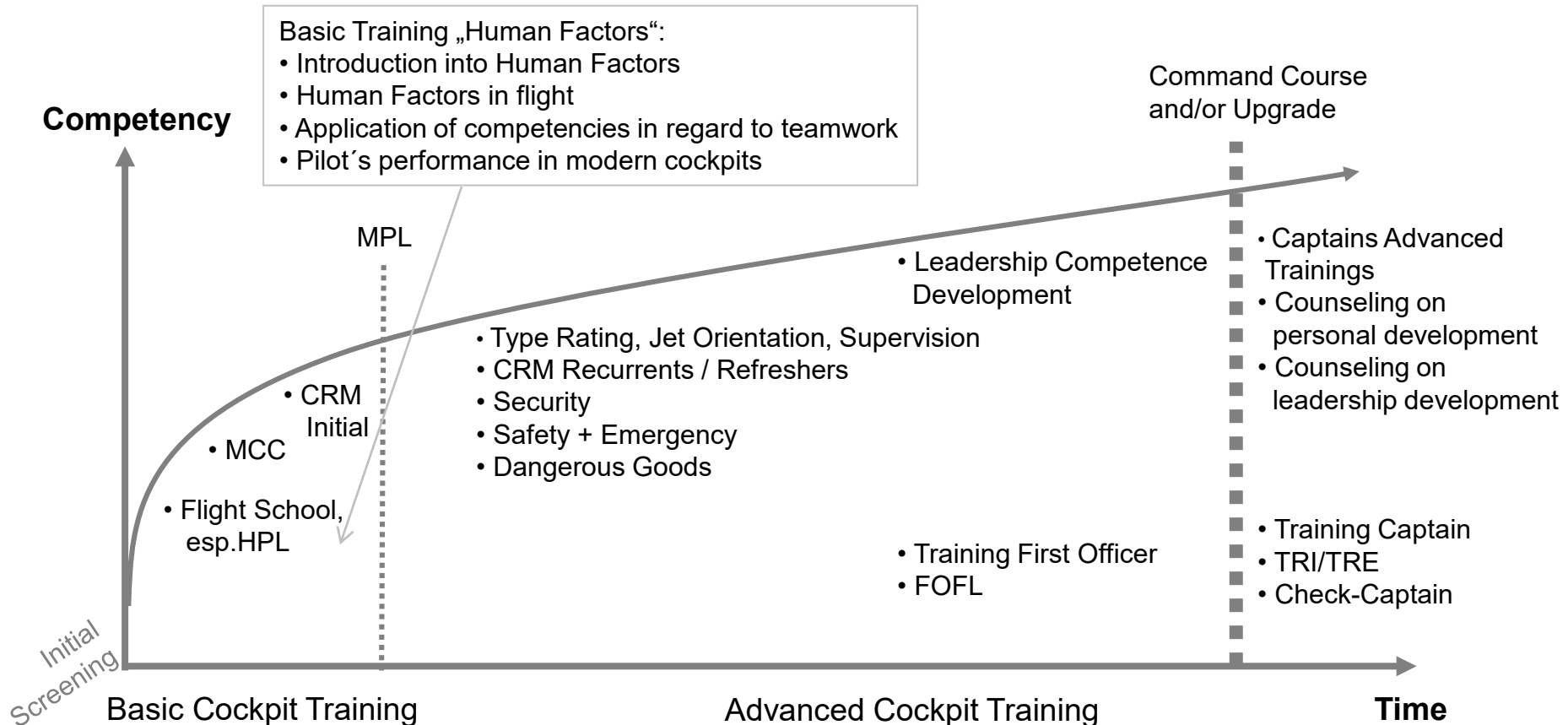
# **Strategies to improve patients care**

- Critical incidence report systems (CIRS)**
- registries**
- morbidity- mortality-conferences**
- definition of standards**
- Team-Time-Out**
- certifications**

**Team-Time-Out**



# Development of safety-related skills: Lifelong Learning!





**No absolutism  
in endoscopy !**



# Team conference



# Conclusions

- / Communicate a complication is always a painful time**
- / The better prepared and the more experienced physicians are, the less difficult the task will be**
- / Always orientate decisions on scientific evidences and seek multidisciplinary advice**
- / Frankness, humility, humanity are the keywords**

