Relative risk

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doi 10.1308/003588411X572015

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We recently admitted an octogenarian Second World War veteran with a metastatic ileocaecal carcinoma who subsequently developed a small bowel obstruction. It was decided that a laparotomy would be required to adequately palliate his symptoms and prevent an unpleasant death. Fully understanding the high risks involved with surgery, the patient and his family were keen to proceed in order to alleviate his symptoms. A preoperative anaesthetic review concluded him to be very high risk with a predicted 50% chance of mortality. An initial opinion was expressed that the risk to the patient was too high for him to undergo surgery for symptom palliation despite the patient's own wishes.

'Risk' (the verb) is defined by the *Concise Oxford English Dictionary* as 'to expose to chance of injury or loss, venture on, accept the chance of'. To put this in perspective, 160,000 allied troops were involved in the first wave of the D-Day landings in Normandy on 6 June 1944. Winston Churchill feared that the casualties in the first wave of troops would be in the region of 50% and indeed some commanders predicted it could be as high as 90%.¹ This was clearly deemed an acceptable risk by the coalition war government. Our patient did in fact land with the first wave on D-Day and therefore faced a predicted 50% mortality risk as a teenager. It is ironic that as an octogenarian a similar 50% risk was deemed potentially too high by some healthcare professionals for palliative surgery.

This case draws specific attention to issues within the modern NHS that result in adverse patient care. First, we believe that 'percentage risk' should be used with caution and would emphasise the definition of risk: 'to accept the chance of'. If the patient understands and accepts the risk (as did our patient both in 1944 and in 2010), professionals may act in the patient's best interest. Second, this case emphasises the importance of the multidisciplinary decision making process. Despite the concern that a consultant spending a few minutes assessing an unfamiliar unwell patient might reverse the decision made by the surgical team and consultant who cared for the patient on a daily basis and had regular communication with the relatives, discussion between colleagues allowed a balanced decision.

Fortunately, there are two happy endings. Churchill and the Allied command were wrong and the D-Day casualties were far fewer than predicted. Our patient was operated on and was managed on the high dependency unit postoperatively after the successful relief of his small bowel obstruction.

Reference

1. Beevor A. *D-Day: The Battle for Normandy*. London: Viking; 2009.

General anaesthetics: why have two when one will do?

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doi 10.1308/003588411X572006

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COMMENT ON

Lynch M, Sriprasad S, Subramonian K, Thompson P

Postoperative haemorrhage following transurethral resection of the prostate (TURP) and photoselective vaporisation of the prostate (PVP). *Ann R Coll Surg Engl* 2010; **7**: 555–558
doi 10.1308/003588410X12699663903557

Tomorrow's consultants run the risk of having never managed a life-threatening post-transurethral resection of the prostate (TURP) bleed until their name is displayed above the patient's bed. We therefore read the article by Lynch *et al* with great interest.

Both the European Working Time Regulations and Modernising Medical Careers have lessened the opportunities for trainee urologists to gain the necessary experience to learn the technique of a safe TURP and be competent in the management of rare life-threatening haemorrhage.

Lynch *et al* acknowledge that the use of ribbon gauze to pack the bleeding prostatic cavity 'does, however, necessitate the need for a second exploration under general anaesthetic to remove the packs'. In an elderly man with less than perfect performance status, this may be not without risk.

One way to avoid the need for re-exploration is to pack the prostatic cavity with a bolster of an absorbable haemostat rather than ribbon gauze. Products such as Surgicel® (Ethicon Inc) are fully absorbable; therefore the risk of introducing a nidus for infection or calculus formation is minimal.

Furthermore, the use of gelatine matrix thrombin such as Floseal® (Baxter International Inc) in urology and general surgery for solid visceral haemorrhage is well established. However, little is known about whether these haemostatic matrices have a role in intractable post-TURP bleeding. Such a product could conceivably be utilised in addition to a bolster of absorbable haemostat, to reduce further the necessity for a second general anaesthetic.