Letters and comments

Surgical safety

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In June 2008 the World Health Organization's Surgical Safety Checklist was released globally as part of the Safe Surgery Saves Lives initiative.¹ The original pilot study demonstrated that with the use of a checklist, surgical complications were reduced by more than a third.¹

Over the last year, the local trust has been implementing a trial using an alternative suture company. It was soon noted that the change in suture was not being altered on the operation note and, at times, that it was not known to the operating surgeon. Examples included the transfer of Vicryl® (an absorbable suture produced by Ethicon Inc) to Polysorb™ (an alternative suture with similar properties manufactured by Covidien). Over a period of 4 weeks we looked at 48 day case and inpatient operations in a single centre. An observation of the requested and used suture was compared with the suture documented on the operation note.

Of the 28 cases of deep tissue closure, 19 were documented incorrectly, 6 were documented accurately and 3 not at all. Of the 45 cases of skin closure, 32 were documented inaccurately, 12 documented accurately and 1 not at all. The overall accuracy of documenting the suture was 28%.

The results were fed back to the surgical consultants at our trust audit meeting. They were then offered six sutures (Monosyn®, Monocryl®, Polysorb™, Vicryl®, Prolene® and Surgipro® II) and asked if they could tell the difference between the matching pairs. Around 50% were able to tell the difference accurately.

This observational study highlighted a couple of important points. First, *Good Surgical Practice* states that we should give details of our closure techniques, which should include the name of the suture.² Second, were we to have any problems with our sutures, would there be any litigation if the operation notes are not documented accurately? Shouldn't each suture pack come with a sticker for the notes?

References

1. National Patient Safety Agency. *WHO Surgical Safety Checklist*. London: NPSA; 2009.
2. Royal College of Surgeons of England. *Good Surgical Practice*. London: RCS; 2008.

Intraoperative red blood cell salvage and autologous transfusion during open radical retropubic prostatectomy

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COMMENT ON

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We read with interest the work of Ubee *et al* and commend the authors for addressing the important issue of minimising perioperative homologous blood transfusions. We have used cell salvage in our department for all major urology cases and have regularly audited our results since 1996.¹ We agree with the authors' conclusions that cell salvage is safe and cost-effective. Furthermore, we feel that several important points should be emphasised.

First, in addition to acknowledged transfusion risks, homologous blood products are a precious diminishing resource. All methods to conserve blood should be actively employed. Knowledge and implementation of the threshold transfusion level of 7g/dl is essential in asymptomatic patients without comorbidity.

Second, although there is evidence to support the statement that the use of cell salvage does not affect oncological outcome, it is impossible to deduce this from the current series due to the fact that the time period and the duration of follow-up is not documented. Similarly, the reason for the shorter hospital stay is likely to be multifactorial in this consecutive series rather than due to cell salvage alone.

Third, with improved anatomical knowledge and the minimally invasive techniques of laparoscopic and robotic surgery becoming more prevalent, blood loss during radical prostatectomy has decreased considerably.² Although the ultimate surgical goal may be bloodless intervention, we are not there yet. The advantage of cell salvage is that there is a 'suck and save' option, where not all the consumables need to be opened unless a significant level of blood is lost intraoperatively. In our centre the cost of this is £25, thereby making cell salvage both cost-effective and a vital adjunct in major urology cases. Our current mean blood loss at open radical retropubic prostatectomy is 325ml and we find