

# Study: Tools left in 1,500 patients yearly

By Jeff Donn  
The Associated Press

BOSTON — Surgical teams accidentally leave clamps, sponges and other tools inside about 1,500 patients nationwide each year, according to the biggest study of the problem yet.

The mistakes largely result not from surgeon fatigue, but from the stress arising from emergencies or complications discovered on the operating table, the researchers reported.

It also happens more often to fat patients because there is more room inside them to lose equipment, according to the study.

Both the researchers and several other experts agreed that the number of such mistakes is small compared with the roughly 28 million operations a year in the United States. "But no one in any role would say it's acceptable," said Dr. Donald Berwick, president of the Boston-based nonprofit Institute for Healthcare Improvement.

The study was done by researchers at Brigham and Women's Hospital and Harvard School of Public Health, both in Boston. It was published in today's New England Journal of Medicine.

The researchers checked insurance records from about 800,000 operations in Massachusetts for 16 years ending in 2001. They counted 61 forgotten pieces of surgical equipment in 54 patients. From that, they calculated a national estimate of 1,500 cases yearly. A total of \$3 million was paid out in the Massachusetts cases, mostly in settlements.

Two-thirds of the mistakes happened even though the equipment was counted before and after the procedure, in keeping with the standard practice.

Most lost objects were sponges, but also included were metal clamps and electrodes. In two cases, 11-inch retractors — metal strips used to hold back tissue — were forgotten inside patients.

The lost objects often caused tears, obstructions or infections. One patient died of complications, but the researchers withheld details for reasons of privacy.

Most patients needed additional surgery to remove the object.

The study found that emergency operations are nine times more likely to lead to such mistakes, and that operating-room complications requiring a change in procedure are four times more likely. A rise of one point in the patient's body-mass index, a measure of weight relative to height, raises the chances of such a mistake by 10 percent.

The length of the operation or the hour of day does not appear to make a difference, suggesting that fatigue does not cause such mistakes.

"It tends to be in unpredictable situations," said lead author, Dr. Atul Gawande of Brigham and Women's Hospital.

Dr. Sidney Wolfe, health-research director of the public-interest lobby group Public Citizen, said the real number of lost instruments may be even higher, because hospitals are not required to report such mistakes to public agencies.

However, others said such mistakes are so rare — occurring about 50 times in 1 million operations — that figuring out how to prevent them could be difficult.

"I find it's going to be difficult to make much more improvement, because some of the risk factors are things that are hard to control," said Lori Bartholomew, research director at the Physician Insurers Association of America, which represents medical-malpractice insurers.

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## **Drugs and Doctors May be the Leading Cause of Death in U.S.**

By Joseph Mercola, D.O.

This finding is more of a speculation though, so below I have provided some other studies to support this assertion.

- In 1994, an estimated 2,216,000 (1,721,000 to 2,711,000) hospitalized patients had serious adverse drug reactions (ADRs) and 106,000 (76,000 to 137,000) had fatal ADRs, making these reactions between the fourth and sixth leading cause of death.
- Fatal ADRs accounted for 0.32 percent (95 percent confidence interval (CI), 0.23 percent to 0.41 percent) of hospitalized patients.

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