Experience of a Tertiary-Level Urology Center in the Clinical Urological Events of Rare and Very Rare Incidence. I. Surgical Never Events: 1. Urological Wrong-Surgery Catastrophes and Disabling Complications

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Abstract:

Introduction: Surgical never events are preventable harmful non-intentional human errors. Urology is a common surgical specialty for their occurrence. Patients and Methods: A retrospective search of our center's data was done during the period 2006-2016 for surgical never events. Each included case was studied for the primary diagnosis, procedure, and subspecialty, never event type and timing, needed extra-interventions, urologist/procedure proportioning, outcomes, and possible underlying causes of the event. Results: Of more than 55,000 different urological interventions, 61 patients were involved in never events. Wrong procedures represented 75% of the never events, and endourology and urolithiasis subspecialties were more often involved. The main detectable underlying factor was the disproportion between the levels of the procedure class and the qualification of the urologist (41%). Thirty-four cases had extra-procedures. The short-term harm effect represented the final outcome in 42% of all events. Death, permanent organ loss, and long-term harm represented 20, 15, and 23%, respectively. Conclusion: Urological surgical never events are rare, but their final outcomes could be catastrophic, even leading to death.

Keywords:

Never events; Surgical catastrophes; Urological complications

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