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Critical incident in operation theatre: Surgical table remote might be the cause.

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Surgical tables are an important part of operation theatre and can be quite helpful in good patient outcome too. A good surgical table helps in proper positioning in less time, provides an easy access to the surgeon and reduces the duration of surgery as well as anaesthesia. As a part of modern day surgical practice a number of tables with a multitude of functions are readily available in the market. Due to continuing demand for reliable surgical tables that can be used for a variety of surgeries the manufacturing companies are introducing new modalities to the surgical tables so that they become more user friendly in terms of height modifications, handling generous weight and become multipurpose. Nowadays tables are too versatile that they can be used for different categories of surgeries such as cardiovascular, pediatric, gynecology, abdominal, gall bladder, plastic surgeries and more.[1]

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Previously operating tables were stationary units with lesser attachments. But in the era of modern Green operation theatres, multiple specialized attachments have been incorporated alongwith movements for various surgical positions as well as table top slide via remote control. Such surgical tables are called mobile unit modern operating tables.[2]

Although such tables are very handy to use and reduce operation theatre time for majority of the patient but rare incidence can occur when they become difficult to control and can result in fatal injuries such as skin abrasions, fracture spine, head injury or peripheral nerve injuries out of which brachial plexus injury is noteworthy. We report one such case where we successfully managed the patient when the table went out of control. A 26 year female patient was taken for dilatation and curettage under ASA-I. After following surgical safety list protocol of our hospital the patient was given general anaesthesia with Midazolam 1 milligram (mg) intravenous (iv), fentanyl 100 mg iv and propofol 50 mg iv. Patient was maintained on bag and mask ventilation alongwith a oxygen:nitrous oxide:sevoflurane mixture and small aliquots of propofol. Patient was placed in lithotomy position with all pressure points padded. After cleaning and draping, surgeon started the surgery and demanded for slight trelendeburg position. As soon as the button on the remote was pressed the surgical table went into steep trelendeburg position and the remote control stopped working. Urgently the patient's lithotomy poles were removed with the help of technicians and the patient was shifted to a trolley and placed in supine position. The surgical table remained working to multiple positions automatically even after shifting the patient. The biomedical person was called for help who looked into the matter. The likely cause for the incident was a hypothesis of short circuit of the remote machinery converting it to continuous auto mode that was probably due to percolation of betadine at some point of time. Patient did not suffer any injury and the surgery was done successfully on spare surgical table. The incident form was duly filled and a copy of it was handed over to biomedical engineer as well as the desired authorities.

Such rare incidents can happen with anyone and can lead to catastrophe. So, we conclude some tips to be kept in mind while positioning patient on operating table and what to do in case of any critical incident.

1) Strict surgical safety check list should be followed. The position of the patient should be discussed with the surgeon.
2) Co-operation is always needed between the anaesthetist, surgeon and operating theatre staff during positioning of the patient.
3) Patient's height, weight, body mass index and vital parameters are critical and can change the decision regarding patient's positioning.
4) All pressure points and eyes should be properly padded.
5) Surgical tables, remote control and table's detachments should be checked time to

time between the cases. Tables should be locked and grounded.

6) Remote of the table should always be kept on head end. We also suggest keeping the remote in chained moisture proof cover. They should be cleaned between two cases to prevent development of any moisture.
7) Spare trolley and atleast one emergency surgical table should be readily available in case of any such catastrophe.
8) All tables should get checked on their due dates of servicing and labels should be applied depicting “ok” sign and the date of service.
9) Such incidents should always be documented and reported in written as critical episode in the operation theatres incident form.

To conclude, it can be said that although modern day surgical tables are handy and flexible to be used in multiple types of surgeries, but rare incidences that can lead to critical incidents can occur. So we should always be well versed with the manual mode of the table and spare table/trolley should always be readily available. Critical incident reporting of such cases should be done at the earliest so that surveillance can be done time to time to prevent as well as handle such incidents efficiently for a better quality and outcome.

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