

**Standard Operating Procedure (SOP)**

SOP Title	<b>Gynaecology/Obstetrics and General Surgery – Risk of Bowel Injury</b>		
SOP Number	040		
Care Group	Women and Children's		
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Approved by	Gynaecological Governance Group/Maternity Governance Group		
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May 2016	Mr Andrew Tapp and Mr J McCloud	Draft	Discussed and ratified at Gynae Governance
22.8.16	Mr Andrew Tapp and Mr J McCloud	Archived	
31.01.17	Mr Andrew Tapp and Mr J McCloud	Live	Minor changes to 3.1, L Atkin (07/02/17 very minor changes made in Gynae Governance (O&G consultant) and re-loaded to intranet 07/02/17)
20.09.22			'HRCR' replaced with 'Internal Review' as per Ockenden action. (Louise Weaver)
15 <sup>th</sup> December 2023	Mr Matthew Wood and Miss Kirsten McArdle	Full Review	Changes due to service re-configuration

SOP Objectives	To provide guidance for the process to be followed when an increased risk of a bowel injury is identified during the pre-operative phase, or bowel injury occurs during surgery
Scope	There is a recognised risk of a bowel injury for the group of patients undergoing Obstetric and Gynaecological surgery.
Performance Measures	Datix incident reporting system (and further reviews as appropriate), Complaints system

No.	Brief	Responsibility
1	<p><b>Selection of patients for planning of surgery with Colorectal Surgeons:</b>            Patients with the following should be discussed with a Consultant Colorectal surgeon before theatre planning:</p> <ul style="list-style-type: none"> <li>▪ Stoma</li> <li>▪ Significant abdominal wall incisional hernia that will involve the site of proposed incision (For this group of patients the discussion may be with a Consultant General Surgeon – either Upper GI or Colorectal)</li> <li>▪ Previous ileal pouch surgery</li> <li>▪ Previous pelvic mesh rectopexy</li> <li>▪ Complicated diverticular disease (previous abscess/fistula formation)</li> </ul>	Referring Consultant
1.1	<p>For patients requiring elective surgery relating to any of the clinical situations listed above, best practice is for the Consultant Colorectal Surgeon to review the patient in an outpatient clinic to discuss management including risks and benefits of intervention.</p> <p>For patients with large abdominal wall hernias, the Complex Abdominal Wall Reconstruction service should be involved to consider surgical approaches in this complex scenario. To contact dictate a letter to the complex abdominal wall MDT. For urgent advice individuals members of the team can be contacted (Mark Cheetham, Joe McCloud, Umesh Parampalli and Saurav Chakravarty).</p>	Referring Consultant
1.2	<p>The colorectal service has a departmental theatre planning meeting each week after the colorectal MDT meeting on Monday afternoons. For those patients where a Consultant Colorectal Surgeon will be needed to attend this can be arranged through this meeting. Referrals should be made to the Operational team on: <a href="mailto:louise.bolton2@nhs.net">louise.bolton2@nhs.net</a>. Please also copy in Emma Hamilton, clinical coordinator for the planning meeting on <a href="mailto:emma.hamilton19@nhs.net">emma.hamilton19@nhs.net</a>.</p>	Referring Consultant
2	<p><b>Intra-operative reasons for contact:</b></p> <ul style="list-style-type: none"> <li>▪ The finding of unexpected bowel pathology</li> <li>▪ Complex abdominal entry</li> <li>▪ Intra-abdominal adhesions predicted to require extensive dissection to gain access to the pelvis</li> <li>▪ Full thickness bowel injury</li> </ul>	Surgeon undertaking surgical intervention
2.1	<p>If the operating surgeon is non-consultant grade doctor then it is expected that the first point of contact will be the Consultant Obstetrician or Gynaecologist before the General Surgical team is contacted. Contact will be to the General Surgery Middle Grade on call for PRH in the first instance. They can then discuss with the Consultant General Surgeon on call as required.</p>	Surgeon undertaking surgical intervention
2.2	<p>There is no resident Consultant General Surgeon on call at PRH at any time. The department provides a Middle Grade Non-Resident on call rota to cover PRH referrals to General Surgery who then liaise directly with the Consultant General Surgeon on call who is based at RSH. The Middle Grade surgeon will attend PRH if required out of hours and the Consultant General Surgeon will travel to PRH when requested for emergency management when contacted.</p>	Referring Consultant
3	<p><b>Other intraoperative injury:</b></p>	
3.1	<p><b>Serosal injury:</b> if the operating surgeon is a non-consultant grade the Consultant Obstetrician or Gynaecologist should attend. Most serosal bowel injuries can be repaired by the operating surgeon, but this will be the judgement of the attending Consultant:</p> <p>Serosal bowel injury would be repaired with seromuscular sutures using:</p> <ul style="list-style-type: none"> <li>▪ 3/0 PDS on a round bodied needle.</li> <li>▪ Sutures are placed at or around 3-4 mm apart with visible evidence of serosal closure. Place sutures at 90 degrees to the lumen to avoid narrowing.</li> </ul>	Surgeon undertaking surgical intervention