# Closed Claim Study

## Retained Mitomycin-C Sponge During Combined Trabeculectomy and Cataract Surgery

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### ALLEGATION

Retained foreign body. Failure to remove Mitomycin-C soaked sponge following surgery.

### DISPOSITION

Settled for $35,000.

### Case Summary

An OMIC insured performed an uncomplicated combined trabeculectomy and cataract removal with lens implantation on the patient's right eye. On postoperative day one, the patient complained to the insured of pain and blurry vision. During the week one postoperative visit, she informed the insured that she had been using the prescribed medications and the right eye was no longer painful but it itched. One month postoperatively, the patient reported that the eye was okay but complained of blurry vision and problems driving. Approximately two months postoperatively, she reported that vision in the right eye was still blurry. At the three month postoperative examination, the patient complained of soreness in the right eye not helped by artificial tears; the insured diagnosed a tear film insufficiency. The patient was then seen by the insured six times during postoperative months four and five. At the first of these examinations, the patient complained that the right eye felt worse and she could not sleep due to severe pain. The insured diagnosed episcleritis. At the next examination, the insured questioned the etiology of the patient's severe pain and considered a secondary inflammation for which the patient was advised to continue taking Cosopt. Seven days later the patient reported feeling much better. Two weeks later the patient again reported feeling much better during an examination with the insured. Nodular scleritis was diagnosed. The patient did not show up for her next scheduled examination but at her last visit with the insured she complained that the right eye pain was gradually getting worse. The patient then self-referred to another ophthalmologist, who diagnosed scleritis due to a Mitomycin-C sponge left in the right eye during the insured's surgery. The second ophthalmologist removed the sponge from the patient's right eye and also had to perform an additional graft surgery due to sclera that was thinned by the Mitomycin.

### Analysis

The ophthalmologist who the patient self-referred to was of the opinion that the foreign body was the cause of the patient's problems. OMIC was able to retain an expert who opined that there was no evidence that what this treating ophthalmologist found was a sponge since a sponge left in the eye would have caused corneal melting. This expert believed that what was removed was inflammatory debris or human granuloma tissue. OMIC's defense counsel retained an ocular pathologist to examine three specimens that the second ophthalmologist took from the patient's eye during the subsequent surgery: specimen A was white tissue, specimen B was sclera, and specimen C was conjunctiva. Unfortunately, the ocular pathologist reported that specimen A was not "native to the eye" and was likely a retained piece of sponge used in the surgery by our insured. Since our expert confirmed that the object in question was indeed a piece of sponge, the decision was made to settle the case. Fortunately, the patient did not lose any visual acuity as a result of the retained foreign body and the matter was settled for $35,000.

### Risk Management Principles

Accurately accounting for sponges throughout a surgical procedure should be a priority of the surgical team to minimize the risk of a retained sponge. OMIC Director Steven V. L. Brown, MD, suggests this may be accomplished by monitoring the number of sponges placed during surgery and standardizing the size of the sponges. Counting and timing of sponge placement should be noted by both the surgeon and surgical nurse to ensure that all surgical team members are aware of the number of sponges and duration of exposure. Additionally, labeling and laying out the sponges on a tray prior to surgery and then placing them back on the tray after removal will make it extremely obvious that all sponges have indeed been removed. Consider using an 8-0 vicryl suture or Micropatties (manufactured by Pearsalls in the UK) with a tail string in order to provide easy retrieval and visibility of the sponges. For further suggestions on how to reduce the risk of retained surgical instruments, please see the article "Recommended Practices for Sponge, Sharp, and Instrument Counts" in the 2009 issue of *Perioperative Standards and Recommended Practices*.