

## Bowel Surgery Audit in a small County/District Hospital

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### Background

The need of Clinical audit has been increased in the last two decades, as it is required for the accreditation process in every healthcare system. Data collection and analysis are excessively time-consuming in everyday practice. The primary aim of our study was to evaluate the colorectal work at small hospital with out ICU facilities, monitoring of our clinical practice and outcome in difficult circumstances and to evaluate the outcome of colorectal surgeries in a small hospital. The second purpose was to observed mortality rates in this small unit to compare with international standards.

### Methods Need to

Data were evaluated from 49 consecutive colo-rectal operations undergoing elective and emergency surgery over a 4-year period (September 2005–May 2009).

### Results

The observed mortality rate was 2% and morbidity 14% which was significantly in line with the values published in literature.

### Discussion

Our results show that bowel surgery and primary anastomosis is associated with substantial morbidity and mortality. Those patients who have underlying vascular aetiology had a particularly poor outcome. we had 2% of mortality who underwent bowel surgery in small hospital, even when the operation was delayed till the morning list rather doing in the middle of the night. We had conservative management for some patients with adhesion ob-

struction and it seems justified. We operated as emergency when there were clear signs of strangulation. The majority cases who got complications were general rather than specific to the bowel surgery. There was only one patient who had an anastomotic leak. The low incidence of complications suggests that bowel surgery remains a good training operation in a County/District hospital.

### Conclusion

The study confirms the usefulness of a dedicated database in a surgical audit activity. The overall bowel surgery operations performed in a small hospital with a low 30-day mortality and low in complications in our experience. Total 47 cases (7 complications 14%) [1-10].

Mortality	
One Mortality	2%
Morbidity	14%
One bleeding post right hemi	2%
One air leak	2%
One Prolapse of stoma	2%
One anastomotic leak	2%
3 Wound infection	6%
Procedures	Complications
Reversal of Hartman's Procedure	None
Laparotomy for Adhesions	None
Bleeding DU repair	None
Laparotomy Small Bowel anastomosis	None
Laparotomy division of bowel adhesions	None

Division of bowel adhesions	Wound infection
Laparotomy bowel resection	None
Anterior resection	None
Right hemicolectomy	None
Colostomy	None
Resection of bowel and stoma	None
Laparotomy and aortic L/N biopsy	None
Perforated DU laparotomy	None
Right hemicolectomy	
Hematoma evacuation post right hemicolectomy	Bleeding Hematoma formation
Laparotomy for bowel obstruction	None
Right hemicolectomy	None
Anterior Resection	None
Diagnostic Laparotomy for bowel obstruction	None
Laparotomy Small Bowel Resection	None
Laparotomy resection of bowel	None
Sigmoid colectomy	None
Loop colostomy due to air leak	Anastomotic air leak
Laparotomy and omental biopsy	None
Laparotomy reversal of stoma	None
Anterior resection	Wound infection
Reversal of stoma	None
Laparotomy for perforation DU	None
Right hemicolectomy	None
Stoma, loop ileostomy for bowel obstruction	None
Laparotomy right hemi-colectomy	None
Laparotomy for obstruction incision hernia	None
loop colostomy for bowel obstruction	None
Anterior resection	None
Laparotomy bowel resection	None
Colostomy for bowel obstruction	None
Refashion of for stoma due to prolapsed	Stoma prolapsed
Right hemicolectomy	None

Laparotomy and bowel resection, perforation	None
Laparotomy via RIF wound. Stoma --- complication	Wound infection
Right hemicolectomy and formation of ileostomy	Transferred to tertiary hospital and died
Right hemicolectomy	None
Right hemicolectomy	None
Laparotomy and Small Bowel resection	None
Laparotomy for appendicular abscess	None
Laparotomy bowel resection loop ileostomy	None
Laparotomy live L/N biopsies	None

Table 1

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