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An Easy Acronym to Improve the Check-List: CALPE[☆]



Un acrónimo sencillo para mejorar el check-list: CALPE

Dear Editor:

According to the results of the article published in the journal entitled “Difficulties in implementing a surgical check list in operating theatres”, only 27.8% of surgery checklists were followed exactly.¹ I would like to contribute a practical, simple system that I have developed mainly for short surgeries with local or regional anesthesia.

My idea is to use an acronym that makes the surgery checklist easier for physicians and nursing staff. It is based on other acronyms, such as the ABCDE (Airway, Breathing, Circulation, Disability, Exposure)² that is used in trauma patients.

The system I propose is in Spanish and uses a Spanish word that is easy to remember—CALPE:

- C is for the informed *consent*, which, when correctly filled out, covers the legal and ethical aspects of the intervention.
- A is for patient drug *allergies* in order to avoid mistakes when administering medication that could cause problems for the patient.
- L is for the *location* of the lesion, including the side for the intervention if any bilateral organs or extremities are involved, including the arms, legs, eyes, lungs, kidneys, etc., in order to avoid human errors with devastating consequences.

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- P is for the surgical *procedure* to be done, double-checking which intervention has been scheduled and whether the patient is aware of the procedure type.
- Lastly, E is for the Spanish word *enfermedades* (diseases). It is important to take into account patient diseases, especially metabolic diseases such as diabetes, coagulopathies or cardiac, pulmonary or renal diseases that would compromise the results of the intervention or during the postoperative period.

I personally believe that this acronym can help increase the percentage of correctly completed checklists due to its simplicity and the fact that it covers the most important factors that could affect patient safety.

When surgeons perform a large number of surgeries under local or regional anesthesia in surgical or medical-surgical specialties like General Surgery, Vascular Surgery, Traumatology, Otorhinolaryngology, Maxillofacial Surgery, Ophthalmology or Dermatology, it is complicated to fill out the numerous items that appear on the surgical checklists at many hospitals. Furthermore, some items are not justified in short surgeries or those done under regional or local surgery.

My opinion is that it is better to have shorter checklists (with fewer items to check) that are correctly completed instead of complex lists that are done in a manner that is almost automatic.

This surgical verification acronym should be used to complement, not substitute, other more complex systems. It goes without saying, for instance, that it is essential to verify the patient's name and medical file number.

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Enterocutaneous Fistula Secondary to an Error in Placement of a Negative-Pressure Abdominal Dressing[☆]



Fístula enterocutánea secundaria a error en la colocación del sistema de presión negativa abdominal

Dear Editor:

We have read with interest the article published in your journal by Pérez et al.¹ about the use of open abdominal negative pressure systems as an alternative for the prevention of abdominal compartment syndrome (ACS). Recently, we had the opportunity to treat a complication secondary to the misuse of the system, and we would therefore like to comment on the basic steps of its placement, as well as the treatment of enterocutaneous fistulas related with incorrect placement.

Our patient is a 57-year-old male who had undergone urgent surgery for ruptured abdominal aortic aneurysm. An aorto-aortic bypass was performed, and the patient presented postoperative ACS. The abdomen was left open with a negative pressure system, although the sponge was incor-

rectly placed in direct contact with the intestinal loops. During the revision surgery for the system dressing change, it was observed that the foam had adhered to the intestinal loops; it was not removed, and the negative pressure therapy was suspended. Daily wound treatment achieved epithelialization of the area around the foam (Fig. 1). Six months later, the patient was discharged with follow-up, and subsequent adequate healing of the wound was observed with integration of the foam in the tissue.

Six months later, the patient presented purulent secretion through the foam, and a CT scan confirmed the diagnosis of enterocutaneous fistula. Initial treatment was conservative. Subsequent elective surgery involved resection of the neo-tissue/foam plate, which was able to be separated from the

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