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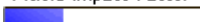
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Tagging surgical sponges means patients don't go home with unwanted extras

Devices/Technology

Published: Tuesday, 18-Jul-2006



It appears in as many as 1 in every 10,000 operations in the U.S. involving an open cavity, something inadvertently gets left behind after the patient had been closed up.

This is more common in emergency operations and accounts for a total of 1,500 operations each year.

As a rule 60% of the objects mislaid are sponges which can remain undetected for many years until something such as a serious infection develops which can be fatal.

No matter how rigorous medical staff are at accounting for equipment used, bits still go missing.

Now a new type of tagged surgical sponge has been invented which should go a long way to rectify the potentially lethal problem.

The device uses radio-frequency identification (RFID) and when medical staff wave a wand over the patient, the wand detects

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any sponges that are left inside.

When Dr. Alex Macario and a team at Stanford University, California, USA, conducted a small study using the device it proved to be effective for 100% of the time.

For the study at [Stanford University Medical Center](#), tagged and un-tagged sponges were 'hidden' inside 8 patients who underwent abdominal or pelvic surgery by one surgeon, who then asked another surgeon to find them.

According to the researchers the battery-operated wand, a type of detector easily found the tagged sponges but not the others.

In less than 3 seconds the device detected all sponges correctly, and there were no mistakes.

RFID devices are commonly used in stores and for tagging pets and recently, some drug companies have been considering the technology for use in the fight to eliminate drug counterfeiting.

Using this technology for surgical sponges was the idea of a nurse who has patented it.

Dr. Macario says the technological part of the problem was initially a concern but the device worked 100 percent of the time.

However how the device is incorporated into the workflow of the operating room will be a challenge.

Regardless of which system is used a fail-safe one is needed so patients do not leave the operating room with a retained foreign body says Macario.

Macario says a review of malpractice claims related to retained foreign bodies found that sponge counts had been falsely correct in 76 percent of non-gynecologic surgeries.

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While surgeons and nurses reported that the device was easy to use, a smaller wand device was preferred and many believe that retained objects will persist unless the system was made fail-safe.

The study was funded by the [National Institutes of Health](#) and [ClearCount Medical Solutions Inc.](#) the makers of the device and is published in the [Archives of Surgery](#).

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