Intraoperative cardiac arrest is rare enough in modern anesthesia that it should almost always be assessed in peer review or a root-cause analysis.  

In the case presented, the anesthetic depth at the time of trocar insertion appropriate?  

Was there anything unusual about the technology or the surgical approach? For example, variation in the site of initial trocar placement?  

Was the right treatment given in a timely fashion?  

Were there any secondary complications observed such as intravenous line failure or loss of monitoring during CPR?  

Were communications, both in the room and externally, appropriate for the situation?  

Following recovery, was the event appropriately disclosed to the patient and family?  

Was there consideration of the wellness of the surgical and anesthesia team, or were they sent back to work?  

In a similar case reported years ago, root cause analysis of a laparoscopic trocar injury to the aorta identified a change in equipment vendor occurring that same day, with a new trocar that was both longer and sharper. Further discussion revealed that the OR manager responsible for communicating this change was on vacation at the critical moment and did not send out the usual announcement, the resident handling the trocar was new to the service and did not have a basis for recognizing the change, and the scrub nurse – who did notice the difference – did not feel empowered to mention it. Even simple adverse events can have complicated causes!  

As quality improvement professionals, which all of us are by nature, it is the introspection after an event that is most likely to lead to mitigating strategies to reduce the chance of a recurrence. “Now what?” is often the most important question to ask when assessing a perioperative adverse event.