DEPARTMENT OF SURGERY
Wisconsin Surgical Outcomes Research Program (WiSOR)
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

The Patient Preferences Project

Patient Story: Case 1-AB

A 38-year-old female, AB, with a past medical history of sickle cell trait, polycystic ovarian syndrome, and history of perforated appendicitis 7 weeks prior is brought in emergently to your hospital after serious complications during an appendectomy at the referring facility earlier that day. She takes no medications. She initially presented for an interval laparoscopic appendectomy at the referring facility. During the operation, there was concern for vascular and bowel injuries. The referring surgeon attempted a vascular repair prior to transferring her to your tertiary care hospital. On arrival, massive transfusion protocol was initiated given her existing blood loss, tachycardia, and hypotension.

8/1/21: She went emergently to the operating room for an exploratory laparotomy.

Findings: Enterotomies with compromised bowel
Stool spillage in abdomen
Right iliac artery injury

Procedure: Right iliac artery reconstruction
Resected 25cm of small bowel, left in discontinuity
Abthera (temporary abdomen closure system) placed

Dispo: to SICU postoperatively

8/2: A central line was placed for access. Hemodynamically stable, making adequate urine.

8/3: Resuscitation continued, lactate improving. Later in the day, they returned to the OR for washout and Abthera replacement. Creatinine increased to 1.6.

8/4: Patient saturating in the low 90s, FiO2 increased to 60% overnight. Bilateral pulmonary infiltrates seen on chest x-ray on rounds and she has increasing ventilator requirements with concern for delayed TRALI (Transfusion-Related Acute Lung Injury).

Pulmonology was consulted later in the day; no bronchoscopy was recommended.

8/5: Ventilatory settings weaned to 40%, PEEP decreased to 7.5. She follows commands.

8/6: No new events.

8/7: Returned to OR for Abthera exchange.

8/8: Total parenteral nutrition (TPN) started. Failed spontaneous breathing trial (SBT).

8/9: Planned return to the OR. The surgeons restored continuity and closed her fascia.

8/10: Continued resuscitation in the ICU. She was unable to pass SBT today. The ICU attending brings up discussions about a tracheostomy.

Later in the day, her acute kidney injury is worsening (Cr 2.2). Deep venous thromboses are noted on ultrasound of bilateral lower extremities.

8/11: No events. Unable to pass SBT today.

8/12: Nurse notes bleeding from the patient's nose, eyes, and around her IV sites. The thromboelastography (TEG or ROTEM) was concerning for disseminated intravascular coagulation (DIC).

A stroke code was called later in the day for anisocoria. A head CT was concerning for hemorrhagic stroke. Neurology and Neurosurgery were consulted. Neurosurgery did not recommend surgical intervention.

8/13: She was hypotensive and a cardiac echo was ordered. Her clinical picture is consistent with multi-system organ failure; she has elevated liver function tests, worsening acute kidney failure with concern for renal infarcts. Pressors were started.

8/14: Low urine output, unresponsive to IV Lasix.

8/15: Heart rate overnight was in the 140s. FiO2 increased to 100%, increasing plateau pressures. Worsening acidosis on labs. Family endorses continued life supporting procedures.

Stops producing urine. CRRT initiated. LFT's in 10,000's. Profound multi-system organ failure.

23:03 The patient, AB, is pronounced dead.