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Case 1

25.3.2024 MUDr. E. Štefela Horváthová

19.3.2024

- ♀, 73 yo
- S: worsening condition, - 5kg, fecal incontinence, anorectal pain
- O: exofytic mass d=5 cm at the anal region, thorough inspection or DRE not possible
- PMH: Alzheimers dementia, anxiety, hemmorhoids, dyslipidemia

Assessment

- Labs: norm incl. NS parameters, CRP 16
- OM: CEA 12

- **Diff. Dg?**
- **Workup?**

Workup plan

- Routine preoperative assesment

- Derivation procedure – LSK axial sigmoideostomy, PE and biopsy

- Chest CT
- CT/MRI of the abdomen and pelvis

Anal cancer TNM staging AJCC UICC 8th edition

Primary tumor (T)	
T category	**T criteria**
TX	Primary tumor not assessed
T0	No evidence of primary tumor
Tis	High-grade squamous intraepithelial lesion (previously termed carcinoma *in situ*, Bowen disease, anal intraepithelial neoplasia II-III, high-grade anal intraepithelial neoplasia)
T2	Tumor >2 cm but ≤5 cm
T3	Tumor >5 cm

Regional lymph nodes (N)	
N category	**N criteria**
NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	Metastasis in inguinal, mesorectal, internal iliac, or external iliac nodes
N1a	Metastasis in inguinal, mesorectal, or internal iliac lymph nodes
N1b	Metastasis in external iliac lymph nodes
N1c	Metastasis in external iliac with any N1a nodes

Distant metastasis (M)	
M category	**M criteria**
M0	No distant metastasis
M1	Distant metastasis

Prognostic stage groups			
When T is...	**And N is...**	**And M is...**	**Then the stage group is...**
Tis	N0	M0	0
T1	N0	M0	I
T2	N0	M0	IIA
T2	N1	M0	IIIA
T3	N0	M0	IIB
T3	N1	M0	IIIC
T4	N0	M0	IIIB
T4	N1	M0	IIIC
Any T	Any N	M1	IV

TNM: tumor, node, metastasis; AJCC: American Joint Committee on Cancer; UICC: Union for International Cancer Control.

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21.3.2024 - surgery

- standard preoperative preparation – Ampicilin/Sulbactam, Metronidazol
- LSK axial sigmoideostomy, tumour biopsy
- Postoperatively standard monitoring at the ICU

22.3.2024 – 1.POD

- Postoperative monitoring at the ICU **uneventful**
- transfer to the ward

- **collapse during PT** – no trauma, not unconscious

- **Transfer back to ICU**

What would you do?

What we have done – 1. POD

- Patient cardiopulmonary stable at the ICU
- Labs: WBC 3,87 (8,78) the only abnormality
- Abdominal US: increased gastric filling, artefacts after LSK
- NGT – deriving gastric stagnational secretion
- evening labs show further **decrease in WBC count** to 1.97, increasing renal parameters

Night 22.-23.3.2024

- **hemodynamic instability, NRA**
- S: w/o complaints
- O: no patholigical finding at the abdominal examination

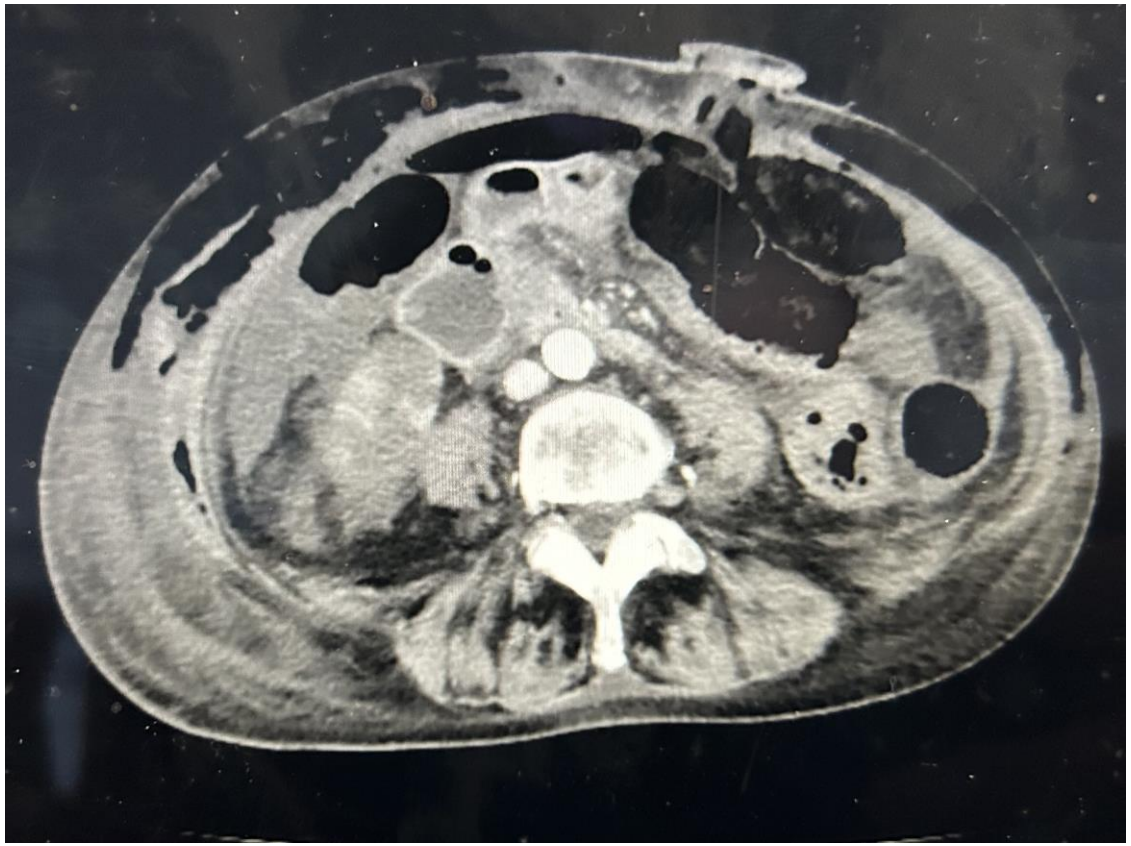
23.3. 2024 - POD 2

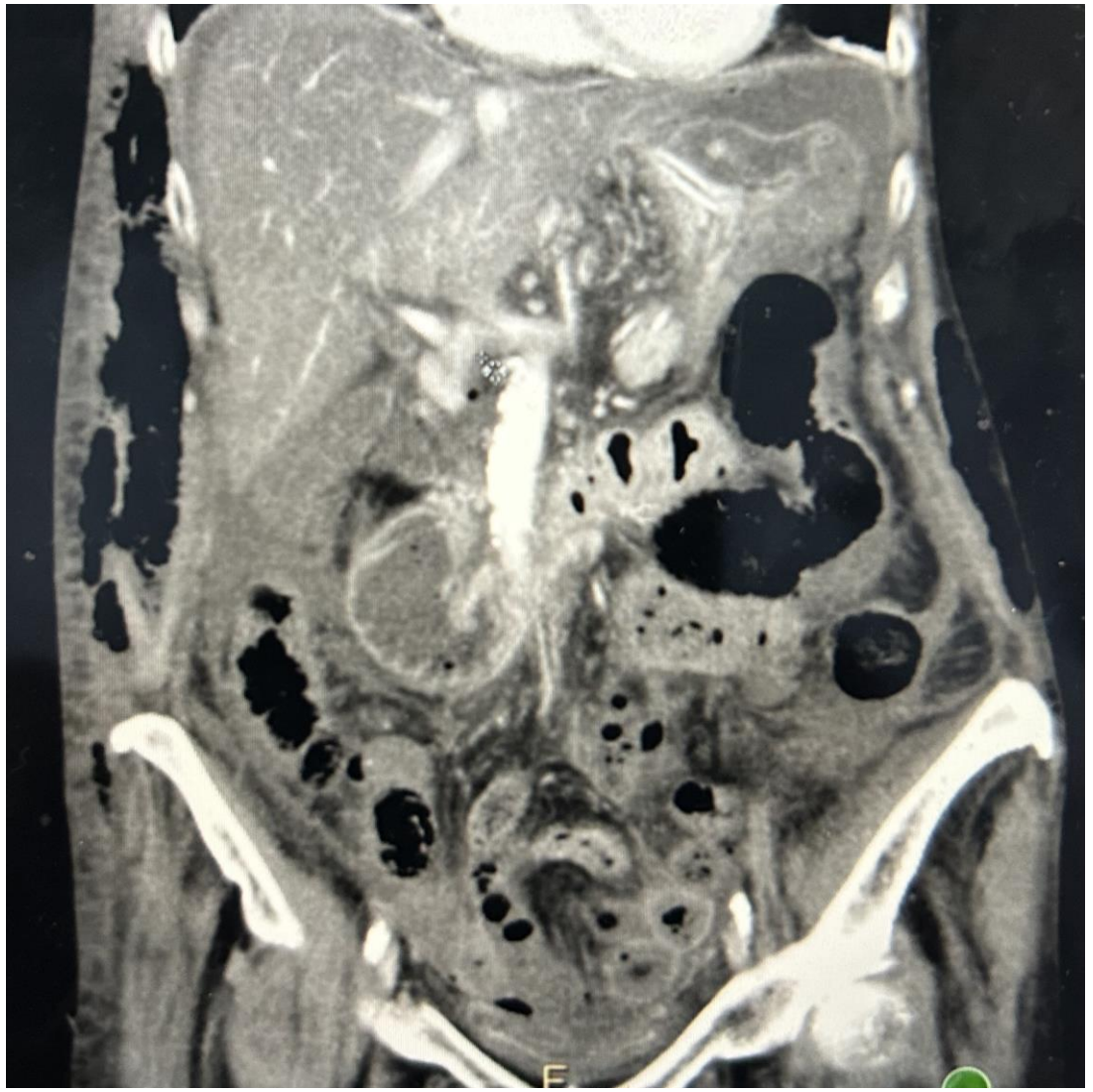
- worsening HD instability, growing need of circulatory support with catecholamins
- O: new finding – **crepitation of the abdominal wall**
- Lab: WBC 0,9, Lactate 8, CRP 260, Kreat. 162

What would you do? What might be happening?

23.3. - POD 2 : What we have done

Acute thoraco-abdominal CT scan





23.3. – 2. POD – Emergent LPT

- Evacuation of massive **stercoral sekretion** from the abdominal cavity and subcutaneous layers
- **Origin not found**
- Small punctual perforation of the gastric wall sutured
- Lavage, drainage, incision of the abdominal wall, laparostoma
- Further deepening of the HD instability – **existus letalis before returning to the ICU from OP theater**

What has happened?

- Microbiologist informs of suspicion of presence of ***Clostridia*** in the microscopic examination of the wound smear taken **before** the emergent procedure
- cultivation results of perioperatively taken samples – ***no C.perf.***

- ***Autopsy is yet to be carried out***

Learning points

- C.perfringens sepsis following abdominal surgery is rare
- Signs of imminent fulminant sepsis can be extremely subtle

What could/should have been done differently?

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Thank you for your attention