Complicated Post-Operative Colectomy in a High Risk Patient

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Abstract	Introduction All patients scheduled to undergo noncardiac surgery should be thoroughly assessed for their risk of cardiovascular event. Patients with multiple comorbidities are at high risk for multiple complications such as ACS, respiratory failure, bleeding, VTE, etc. There are multiple different modalities and scoring systems that allow healthcare providers to access the patient preoperatively. The Revised Cardiac Risk Index (RCRI) and the National Surgical Quality Improvement Program (NSQIP) are two widely used risk stratification tools that have been validated in medicine. All patients should be assessed and medically optimized prior to any procedure. Case Report A 75 year old Caucasian male with a significant past medical history of coronary artery disease, prostate cancer in remission, hypertension, and hyperlipidemia presents to the hospital with a chief complaint of "left sided stomach pain." -Symptoms: fevers, chills, night sweats, abdominal distention & cramping, nausea, vomiting, & diarrhea -After imaging (Figure 1), colonoscopy was performed which showed cancerous area in proximal sigmoid colon -General surgery consulted for open colectomy, immediately after surgery patient begin to have chest pain -EKG showed lateral STEMI, Cath lab for PCI (Figures 2 and 3) -POD#1 patient experienced severe hemoptysis and melena from ostomy -Consensus to continue DAPT by cardiology and general surgery -POD#4 severe abdominal distention (Figure 4) dehiscence of anastomosis -Pathology resulted in adenocarcinoma with metastasis (T3N1bM1b) Discussion In the event of acute GI bleed, the decision to discontinue aspirin, P2Y12 receptor blockers, or other antithrombotic therapy is made upon an individual patient basis, balancing the likelihood and consequences for either a thrombotic or a hemorrhagic event. In this case, the decision to continue dual antiplatelet therapy was heavily deliberated between medicine, cardiology, and general surgery. It was concluded to continue dual antiplatelet therapy as the patient was at an extremely high risk of in-stent thrombosis if dual antiplatelet therapy was discontinued. The patient required a total of two units of pRBCs after initial GI bleed. The patient experienced no further cardiovascular events throughout the hospital course. Conclusion After having a PET scan (Figure 6 & 7), an extensive discussion was held with the patient and family about long term goals of care. The patient was informed of the grim prognosis and ultimately declined treatment. The patient decided to be discharged on home hospice.
Learning Objectives	1. Discuss the indications for dual antiplatelet therapy in the setting of an acute GI bleed. 2. Discuss the preoperative risk stratification tools
References and Resources	References 1. Mangano DT, Goldman L. Preoperative assessment of patients with known or suspected coronary disease. N Engl J Med 1995; 333:1750. 2. Lindenauer PK, Pekow P, Wang K, et al. Perioperative beta-blocker therapy and mortality after major noncardiac surgery. N Engl J Med 2005; 353:349. Smilowitz NR, Gupta N, Ramakrishna H, et al.

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Disclosures

All authors and coauthors have no relevant financial relationships to disclose.
The author does not intend to discuss an off-label/investigative use of a commercial product/device.