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Abstract	<p>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 assess 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.</p> <p>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."</p> <p>-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 began 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)</p> <p>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.</p> <p>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.</p>
Learning Objectives	<ol style="list-style-type: none"> 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	<p>References</p> <ol style="list-style-type: none"> 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.

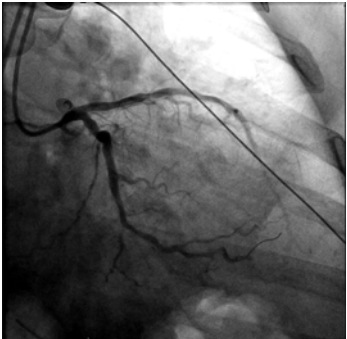
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Disclosures All authors and coauthors have no relevant financial relationships to disclose.
The author does not intend to discuss an off-label/investigative use of a commercial product/device.



BIOMARKER HIGHLIGHTS (SEE PAGE 2 AND APPENDIX FOR MORE DETAILS)					
Linkage Biomarker Biomarkers			Linkage Biomarker Biomarkers (Cont.)		
MSI	NGS	Stable	PIK3CA	NGS	Mutation Not Detected
Mismatch Repair Status*		Proficient	ERBB2 (Her2/neu)	NGS	Amplification Not Detected
MLH1	IHC	Positive (1+, 55%)	PTEN	IHC	Positive (1+, 100%)
MSH2	IHC	Positive (2+, 95%)	Other Notable Biomarker Results		
MSH4	IHC	Positive (1+, 60%)	PD-L1	SP142	Negative (0, 100%)
PMS2	IHC	Positive (1+, 35%)	APC	NGS	Mutated, Pathogenic Exon 10 (p.T1438S)
Tumor Mutational Burden		Intermediate (8 Mutations/Mb)	TP53	NGS	Mutated, Pathogenic Exon 8 (p.L286K)
KRAS	NGS	Mutation Not Detected			
NRAS	NGS	Mutation Not Detected			
BRAF	NGS	Mutation Not Detected			

*Mismatch repair status is determined by the presence or absence of the repair proteins MLH1, MSH2, MSH4 and PMS2 by IHC. If any of these IHCs are negative, mismatch repair status is considered deficient.

The therapies listed below are FDA approved on NCCN Compendium® for the tested lineage or deemed relevant for this lineage by a panel of internal and external oncology experts. Complete therapy association information and OFF NCCN Compendium therapies are listed on page 18-19.

THERAPY (S) WITH POTENTIAL BENEFIT		THERAPY (S) WITH UNCERTAIN BENEFIT	
cetuximab*, panitumumab*	BRAF, KRAS, NRAS, PIK3CA, PTEN	capecitabine	ATM, BRCA1, BRCA2

* Drug/biomarker associations supported by the highest level of clinical evidence.

Drugs are placed in the Uncertain benefit category when a study suggests only a decreased likelihood of response (vs. little to no likelihood of response) or if there is insufficient evidence to associate the drug with either benefit or lack of benefit.

