The above mentioned was admitted on 29th Oct 2013 after falling from height whilst at work.

上述提到的，在2013年10月29日，本人在工作中被落下的重物砸到身体

The mechanism and circumstances surrouding the fall were not clear at the time of arrival.

在伤者送到医院时，伤者的机制还不是很清楚

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At the Emergency Department(ED),it was noted that he was bleeding from a scalp laceration and was complaining of abdominal pain.

在急诊部(ED)，我们医生注意到他肚皮正在出血，并抱怨腹痛。

His vital signs were stable and within normal range during his time in the ED resuscitation bay.Investigations revealed free fluid within the abdominal cavity.he was brought to the operating theatre immediately as there was evidence of active intra-abdominal bleeding.

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He underwent an emergency exploratory laparotomy within 30mins of arrival in hospital.Intra-operative findings were as follows:

1. Complex pancreatico-duodenal injury complete transaction of pancreatic head,duodenal transaction and perforation
2. Perforation of the transverse colon and multiple serosal tears of the transverse colon
3. Grade 3 lacerations of the liver
4. Scalp laceration

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He underwent damage control surgery where the bowel perforations were either primarily repaired or transected between staples,bleeding points were suture ligated and the liver lacerations were packed.His abdomen was temporarily closed,with the intent for a re-look laparotomy,in 24hrs.

This was to allow further resuscitationto take place after controlling the life threatening injuries.

He underwent a re-look laparotomy on 30th Oct 2013 where his injuries were reassessed.

It was noted that he had a complete transaction of the pancreatic head which was not suitable for primary repair.

The duodenal injury was severe and the 1st part of the duodenum had to be resected.

The transverse colon repairs were still healthy.

Haemostasis was also well secured.

The decision was then made to complete the transection of the pancreas that was caused by the trauma and over-sew the pancreatic stump.

A gastro-jejunostomy was also performed.

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During his 3rd relook laparotomy,it was noted that the previously healthy transverse colon repairs were not as healthy as before due to the pancreatic leak from the pancreatic stump.

A right hemi-colecomy was subse quently performed.Due to the pancreatic leak,the duodenal repairs were alse being auto-digested by the pancreatic enzymes.

The decision was then made to control the pancreatic and duodenal leak with drains placed.

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His post-operative recovery was complex and stormy.His post operative issues were as follows:

1. Pancreatic and duodenal stump leaks,with control of the leaks via drains
2. Hepatic artery bleed secondary to surrounding sepsis requiring laparotomy and angio-embolisation of the left hepatic artery.
3. An open abdomen as his condition did not allow for us to close his abdomen definitively
4. Entero-cutaneous fistula due to the complex nature of his injuries and repairs
5. Nutritional challenge requiring long periods of total parenteral nutrition and naso-jejunal tube feeding because of the entero-cutaneous fistula.

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In View of the complex nature of his injury and associated known post operative complication,definitive surgery to address the duodenal stump leak,pancreatic stump leak,entero-cutaneous fistula and open abdomen had to be delayed until his nutritional status improved.

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He underwent definitive closure of his abdomen was performed on 30th September 2014.A bio-prosthetic mesh was used to closed his open abdomen.

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Unfortunately,during his post-operative,he developed a small bowel entro –cutaneous fistula inferior to the mesh repair of the abdominal wall.

This resulted in a large amount of fluid loss.Thus he required long term term total parenteral nutrition.

He was planned for a definitive closure of the small bowel entero-cutaneous fistula one year later.

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During the 1 year wait,he was on total parenteral nutrition.He had to be read mitted a few times for electrolyte imbalance and dehydration.

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He underwent a take down and closure of the small bowel entro-cutaneous fistula on 14th June 2016.

A function end to end anastomosis was performed using GIA linear staples

He tolerated the produre well.

The duodenal stump fistula was also noted to have decreasing output post-op.

Unfortunately,prior to discharge,he was noted to have a leak from the entero-custaneous fistula repair site.He had to be put on TPN again with scheduled surgery in 6 months.

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He underwent a take down and close his entero-cutaneous fistula on 7th Nov 2016.

A handsewn end to end anastomosis was performed.

Post-operatively he was noted to be well and was able to tolerate normal diet.

As he was improving well,the percutaneously inserted biliary drain was also removed with no signs of a leak intra-abdominally.

His wounds continued to heal and he was discharged after 3 weeks in hospital.

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His last follow-up with me was on 29th March 2017,He was noted to be increasing in body mass and taking well orally.His wounds were clean with no evidence of further entero-cutaneous fistulas.

He will require life-long pancreatic exocrine and endocrime function support.