Id_23

Admission Report:

A 68-year-old Caucasian man with a history of HTN, HF, and right hemicolectomy for colon carcinoma one year ago, was admitted to the emergency department with an insidious onset of asthenia, mild, progressive, and constant right lower back pain without precipitating factors, associated with dark stools over the past three days.

On physical examination, he presented with pale skin and right renal Murphy's sign. He complained of intense and progressive fatigue. He appeared pale. Right lower back pain was also notrd. He reported dark stools over the past three days.

He received two units of packed red blood cells.

Discharge Report:

A 68-year-old Caucasian male patient with a history of hypertension, heart failure, and right hemicolectomy for colon carcinoma one year ago, was admitted to the emergency department with a chief complaint of progressive asthenia, mild but increasing and constant right lower back pain without triggering factors, associated with melena over the past three days.

On examination, he presented with pale skin and a positive right renal Murphy’s sign. Hemoglobin was 6.6 g/dL (with microcytosis and hypochromia), platelets were 246000/uL, and CRP was 6.52 mg/dL. He received a transfusion of two units of packed red blood cells.

Endoscopy revealed greenish stools in the lumen, with no blood, and limited progression at the rectosigmoid junction due to angulation. Abdominal CT imaging suggested a small bowel neoplasm with right retroperitoneal invasion. The patient underwent a right nephrectomy with multiple segmental small bowel resections.

In the immediate postoperative period, he developed colonic suture dehiscence, requiring another surgical intervention and transfer to the ICU due to distributive shock and peritonitis caused by Enterococcus faecium, treated with vancomycin.

During hospitalization, he experienced two episodes of sepsis: one caused by *Klebsiella pneumoniae* and *Acinetobacter baumannii*, treated with colistin, and another caused by *Saccharomyces cerevisiae* (the laboratory was unable to differentiate between *S. cerevisiae* and *S. boulardii*), likely due to cross-contamination from compounded medication, treated with liposomal amphotericin B.

He developed progressive multiple organ dysfunction, requiring hemodialysis. Despite initial improvement with antifungal treatment, his condition deteriorated progressively, and he passed away after 18 days of treatment due to multiple organ failure.
Discharge status: Deceased.
Medications at discharge: None.
Recommendations: N/A.

Full Journey Report:

Admission Report

A 68-year-old Caucasian male patient with a history of hypertension, heart failure, and right hemicolectomy for colon carcinoma one year ago, was admitted to the emergency department complaining of insidious asthenia, mild, progressive, and constant right lower back pain without precipitating factors, associated with melena over the past three days. On physical examination, he presented with pale skin and a positive right renal Murphy's sign. He complained of intense and progressive fatigue. He appeared pale. Right lower back pain was noted. He reported dark stools over the past three days. He received two units of packed red blood cells.

Day 1-3 Report

Post-transfusion evolution was satisfactory. Hemoglobin increased to 8.2 g/dL. Lower back pain persisted despite analgesia. Upper gastrointestinal endoscopy revealed greenish stools in the lumen, with no active bleeding, and limited progression at the rectosigmoid junction due to angulation. Additional investigation was initiated.

Day 4 Report

Abdominal CT imaging suggested a small bowel neoplasm with right retroperitoneal invasion. The case was discussed in a multidisciplinary team, and a surgical approach was chosen.

Surgical Report

Right nephrectomy with multiple segmental small bowel resections was performed without significant intraoperative complications. Estimated blood loss was 500 mL. Abdominal cavity drainage was placed.

Day 5-7 Report

The postoperative course was complicated by colonic suture dehiscence, requiring another surgical intervention for repair. The patient was transferred to the ICU due to

distributive shock and peritonitis caused by *Enterococcus faecium*. Vancomycin was initiated.

Day 8-12 Report

Peritoneal fluid culture confirmed *Enterococcus faecium*. The patient initially responded to vancomycin but subsequently developed two successive episodes of sepsis: one caused by *Klebsiella pneumoniae* and *Acinetobacter baumannii*, treated with colistin, and another caused by *Saccharomyces cerevisiae* (the laboratory was unable to differentiate between *S. cerevisiae* and *S. boulardii*), likely due to cross-contamination from compounded medication, treated with liposomal amphotericin B.

Day 13-18 Report

Despite initial improvement with antifungal treatment, the patient experienced progressive deterioration of his general condition, requiring hemodialysis. He developed worsening multiple organ dysfunction, leading to death.

Discharge Report

A 68-year-old Caucasian male patient with a history of hypertension, heart failure, and right hemicolectomy for colon carcinoma one year ago was hospitalized for 18 days.

He was admitted to the emergency department with a chief complaint of progressive asthenia, mild but increasing and constant right lower back pain without triggering factors, associated with melena over the past three days. Hemoglobin was 6.6 g/dL (with microcytosis and hypochromia), platelets were 246000/uL, and CRP was 6.52 mg/dL. He received a transfusion of two units of packed red blood cells.

Endoscopy revealed greenish stools in the lumen, with no blood. Abdominal CT imaging suggested a small bowel neoplasm with right retroperitoneal invasion. The patient underwent right nephrectomy with multiple segmental small bowel resections.

In the immediate postoperative period, he developed colonic suture dehiscence, requiring another surgical intervention and transfer to the ICU due to distributive shock and peritonitis caused by *Enterococcus faecium*, treated with vancomycin. He experienced two episodes of sepsis: one caused by *Klebsiella pneumoniae* and *Acinetobacter baumannii*, treated with colistin, and another caused by *Saccharomyces cerevisiae* (the laboratory was unable to differentiate between *S. cerevisiae* and *S. boulardii*), likely due to cross-contamination, treated with liposomal amphotericin B.

The patient developed progressive multiple organ dysfunction, requiring hemodialysis. Despite initial improvement with antifungal treatment, his general condition deteriorated

progressively, and he passed away after 18 days of hospitalization due to multiple organ failure.

Discharge status: Deceased.

Medications at discharge: None.

Recommendations: N/A.