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Professor A [deleted] F[deleted]

Chief Resident

 Lausanne, 18-Jun-2015

Discharge faxmed

 Admission number: ------------

The above mentioned patient was admitted to our unit from 22-May-2015 to 18-Jun-2015, date on which he returned home.

Main diagnosis:

Wet gangrene 04 right side

**Active comorbidities:**

 Severe sepsis starting at the gallbladder (atypical cholecystitis): necrosis of the fourth toe on the right side with bacteraemia with *Citrobacter freundii* and *koseri* on 01-May-2015 with:

* Acute hepatitis

Ischemic and valvular heart disease with:

* Severe aortic stenosis
* Severe mitral stenosis
* Previous non-ST-segment elevation myocardial infarction in Jan-2015
* Jan-2015: left ventricular ejection fraction at 45% in Jan-2015
* 02-May-2015: left ventricular ejection fraction at 25%, compressed aortic stenosis and severe myocardial infarction, biventricular dysfunction, especially on the left side, pulmonary artery pressure at 80. No pericardial effusion detected. Echocardiography on 02-May: severe aortic stenosis with 0.73 cm2, gradient 32/1 mmHg. Severe mitral stenosis with ventricular ejection fraction at 35%
* Prior non-ST-segment elevation myocardial infarction due to two-sided heart disease, treated conservatively (medial left anterior descending artery, circumflex coronary artery)
* Infarction of the type non-ST-segment elevation myocardial infarction due to disease of the medial left anterior descending artery, followed by a subocclusive stenosis at the distal left anterior descending artery with double heart valve disease, respectively an aortic stenosis and a mitral stenosis, both of which were severe and with a significant left ventricular dysfunction with an ejection fraction of less than 35% currently

Peripheral obliterating arteriopathy of the lower extremities with:

* Right lower extremities:

§ 21-Feb-2007: Femoral to femoral bypass and popliteal to tibioperoneal trunk bypass

§ 07-Mar-2007: Arterioplasty to enlarge the common femoral and superficial artery

§ 08-Jul-2011: Angioplasties of stenoses in the anterior tibial artery

§ 21-Feb-2013: Angioplasties of stenoses at the anastomosis proximal to the femoral to femoral bypass

§ 10-Apr-2013: Significant stenosis of 80% of the distal popliteal artery

§ 30-Apr-2015: Angioplasty – stenting of the femoral bifurcation and angioplasty of the popliteal to tibioperoneal trunk bypass with a coated balloon

* Left lower extremities:

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§ 31-May-2006: femoral to popliteal bypass

§ 07-Mar-2007: Enlargement by grafting of the left femoral junction with endarterectomy from the beginning of the deep femoral artery.

* Status post Thiersch graft at the right heel due to an ulcer on 23-May-2006:
* Status post amputation of the first left toe due to diabetic foot ulcer
* Insulin-dependent diabetes type II
* Terminal renal insufficiency due to diabetes, hemodialysis 3x/week since 2001:
* Vascular approach:

§ 09-Aug-2013: Extension of the prosthetic brachio-axiliary arteriovenous fistula to the left subclavian vein by placement of a polytetrafluoroethylene prosthesis with resection of the first rib

§ 20-Jun-2013: Excision of an aneurismal brachiocephalic fistula of the left upper extremity, creation of a prosthetic brachio-axiliary fistula with placement of a Flixene graft at the left upper extremity

§ 14-Jun-2013: Significant intra-stent restenosis at the cephalo-subclavian siphon and in the brachiocephalic vein, compressed stenosis at the brachiocephalic arteriovenous anastomosis, subocclusive thrombus of the aneurysm distal to the cephalic vein with dislodgement of debris

§ 21-Feb-2013: Angioplasties due to recurrence of intra-stent restenoses of the left cephalic vein

§ 24-Jul-2012: Angioplasties of intra-stent of restenoses with a drug-eluting stents

§ 06-Oct-2011: Angioplasties of intra-stent restenoses of the cephalic-subclavian junction

§ 07-Jun-2011: Angioplasty/stent of the cephalic-subclavian junction

§ 17-May-2011: Angioplasty of the cephalic-subclavian junction

§ 04-Apr-2011: Excision of the cutaneous necrosis of the left arm with resection of the parietal necrosis and direct suture of the fistula.

§ 28-Jan-2011: Angioplasty of the cephalic-subclavian junction and angioplasty/stent of the cephalic vein at the middle of the arm

§ status after several other percutaneous angioplasties

§ 18-Dec-2001: Creation of a brachiocephalic fistula in the upper left extremity

**Passive comorbidities:**

* Acute ischemic colitis of the left colon: resection of the colon transversum and the colon descendens, creation of a split ileosigmoidostomy on the left side on 04-Jun-2013; closure of the split ileosigmoidostomy on 02-Jul-2013
* Severe retinopathy and ischemic uveitis of the left eye and blindness of the right eye
* Autonomous polyneuropathy and neuropathy of the lower extremities
* Cholangitis due to choledocolithiasis in Apr-2008, sepsis with Escherichia Coli and Klebsiella pneumonia
* Endoscopic Retrograde Cholangio-Pancreotography and sphincterectomy on 16-Apr-2008
* Blindness of the right eye
* Uveitis and ocular ischemic syndrome of the left eye

**Complications:**

Severe sepsis on 10-Jun-2015 due to bacteraemia with *Citrobacter freundii* with origin at the peripherally inserted central catheter.

**Performed interventions**

22-May-2015: **Right transmetatarsal amputation.**

**Anamnesis**

The patient was transferred from the vascular surgery unit for patient care due to wet gangrene of the 4th right toe.

**State at the time of discharge**

Following the surgery, there were no complications and the patient was afebrile. Replacement of the first dressing 4 days after the surgery, then gradual rehabilitation to full-load walking depending on the pain and with the protection of a Kassel shoe.

The antibiotherapy started by our colleagues from the vascular surgery unit consisting of Piperacillin-tazobactam 2.25 g 3x/day was continued and then discontinued on 28-May-2015, taking into consideration the positive local evolution and that the surgical procedure was far from the possible origin of the infection.

The intraoperative bacteriological samples revealed only human microbiota (*C.amycolatum* and *S. capnae).*

On 10-Jun-2015, the patient vomited gall 3 times and presented with a fever of 39 degrees and a hemodynamic instability requiring the administration of noradrenalin and a transfer to the ongoing care unit for monitoring. Clinically, on the abdominal level, the patient presented with tenderness at the right hypochondrium, the Murphy test was subject to doubt, but without signs of peritonism. At the foot, the scar was healing well and the foot was tumid, but without signs of infection. Lastly, a redness was noticed at the needle-puncture site of the peripherally inserted central catheter placed on 22-May-2015. According to the lab tests that day, the patient did not present with an inflammatory syndrome, but the following day, the C-reactive protein was at 127 mg/l and the leucocytes at 19.3 G/l. The patient presented as well with a thrombopenia at 65 G/l which was thought to be due to the state of infection. An antibiotherapy with Meronem and Vancomycin intravenous at a low dose was started with discontinuation of the Meronem and initiation of a treatment with Pipercillin-tazobactam 2.25 g 3x/day on 11-Jun-2015. The peripherally inserted central catheter was removed the same day and sent to the lab for cultures. The bacteriological results would turn out to be negative: the hemocultures would test positive for *Citrobacter freundii.* An abdominal ultrasound revealed lithiases of over a centimeter in size in the bladder and a thick wall, however probably in connection with a significant right cardiac insufficiency and thus, an abdominal infection is excluded. In order to complete the evaluation, a Positron emission tomography-computed tomography was performed on 17-Jun-2015 which excluded the arteriovenous fistula as the origin of infection.

The evolution is thereafter rapidly favorable and allows for the discontinuation of the noradrenalin and a return of the patient to his room. The patient’s blood work for discharge showed a C-reactive protein of 23 mg/l, leucocytes at 4 G/l and platelets at 85 G/l. In regard to the thrombopenia, we recommend remote monitoring. At the time of discharge, the antibiotherapy was replaced by Ciproxin 250 mg 2x/day per os for 2 weeks after the removal of the peripherally inserted central catheter.

In regard to the vascular aspect, an angiological follow-up assessment one month after the surgery showed a lower right extremity with permeable stents and bypass at the lower right extremity and stable transcutaneous oxygen pressure values at 56 mmHg at the level of the instep. The treatment is continued as indicated by our colleagues from the vascular surgery unit in the discharge letter.

In regard to the cardio-vascular aspect, the situation of the patient has been discussed again at a multidisciplinary colloquium in cardiology (Dr. M[deleted], Dr. F[deleted], Dr. J[deleted]) and the decision for a conservative treatment was made for the time being, considering that the patient is asymptomatic with regular ambulatory follow-ups. The patient will thus be called up for a follow up with Dr. M[deleted] for the continuation of the treatment.

In regard to the nephrological aspect, the patient undergoes dialysis 3x/week without complications.

**Treatment at discharge**

Ciproxin 250 mg 2x/day to be continued until 24-Jun-2015

Atorvastatin 40mg 1x/day

R Lexotanil 1.5mg 1x/day

Pantozol 40mg 1x/day

Aspirine Cardio 100mg

Plavix 75mg 1x/day until 30-Jul-2015 included

Rocatrol 0.5mg 1x/day

Calcium acetate 400mg 2x/day

Hyaluronic acid drops 1x/day

Sorbisterit 20 cc 1x/2 days

Dexafree UD eyewash 0.1% 1 drop 3 times/day left eye

Floxal eyewash 0.1% 1 drop 3x/day left eye

Optava 1 drop 8x/day left eye

Autologous serum 1 drop 6x/day left eye

Insulatard 10 IU 1x/day

**Follow-ups**

The next follow-up at the consultation with Dr. B[deleted] in 10 days

The next follow-up at the consultation with Prof. C[deleted] 2 weeks after the discharge

The next follow-up in angiology to be planned for August 2015

The next follow-up at the consultation with Dr. M[deleted] on convocation

 Dr. T[deleted] D[deleted”S[delted]

 Assistant physician

*The presence of the names of the signatories confirms the electronic validation of the document by them*