oolulliger metreu.

22-05-2018: Following puncturing the area of the left iliac fossa identified before, a 12F drainage catheter was inserted in this area because of the pus content. ERCP 24.05.2018 GA: A gap on esopahgo-gastric anastomosis line? Stent placement into the pancreatic canal.

\*Family History: There is no characteristic.

: The abdomen is distended. There is an extensive tenderness. Bowel sounds are hypoactive.

: 12.05.2018: WHOLE ABDOMEN CT On the evaluation made in comparison with CT examination dated 11.05.2018 :

The pleural effusion detected on left hemithorax was measured as 3 cm in the current scan and it presented an increase. Free air images extending to subdiaphragmatic area adjacent to anterior side of the liver on the right, on inferior side hemidiaphragm on the left at esophago-intestinal anastomosis level, were noted as additional findings. There is not any significant difference in the collection detected on pancreatic tail locus. A moderate increase was noted in the fluid collection on the spleen locus. Distention of gas is noted as additional finding on large intestine loops.

30.5.18: WHOLE ABDOMEN CT Liver is of normal size, and parenchymal density is homogeneous. No pre-post contrasted lesion is found. The gallbladder and bile ducts are observed with their normal anatomical characteristics. Postoperative changes associated with the Whipple operation and heterogenicity of the residual pancreatic tissue are noted. Spleen is operated. Adrenal glands are in normal dimensions and no pathologic lesion was

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detected. Dimensions, parenchymal thickness and contours of the both kidneys are normal. Perirenalfascias are intact, Adipose planes are patent. No pre-post contrasted lesion was detected. Both kidney functions are concurrent and normal. No obstructive pathology is observed in the bilateral pelvicalyceal system and ureters. Flatulence and dilation of the colonic segments and partial intestines are noted. There are drainage catheters localized in the intraabdominal iliac fossa and left diaphragm. There are intraabdominal perihepatic, periintestinal pelvic minimal free fluid collections. The bladder is empty and Catheter balloon is observed within urinary bladder. A few millimetric air bubbles were noted adjacent to anterior of the liver below the right diaphragm. Other tests are in the patient file.

: Distal pancreas cancer

: 26-05-2018: Anastomosis leakage, peritoneal debridement due to development of peritonitis, esophagojejunostomy (Roux en Y), nutritional jejunostomy. 30-05-2018: Abdominal sepsis, laparotomy due to vac procedure, abdominal debridement re-laparotomy-vac replacement 01-06-2018

: The patient was operated because of distal pancreatic tumor on 10.05.2018; distal pancreatectomy, splenectomy and proximal gastrectomy, esophagogastrostomy were performed because of invasion. The patient was operated again because of leakage from anastomosis and abdominal sepsis on 26.05.2016; the anastomosis was converted inti roux-n-y esophagojejunostomy. The stomach was closed as remnant and left. VAC procedure was performed to control abdominal sepsis of the patient during follow-up. Nutritional jejunostomy was used for nutrition. VAC change was performed 3 times and the abdomen was closed. However, bile-like leakage (probably from side of the nutrition tube), free air and bleeding appeared. General condition is moderate. Latest developments did not spoil the overall state of the patient. He is still fed parenterally. He has intraabdominal drainage tubes. Heart beat is about 110 and respiration count of 2224. There is no fever. The patient is immobile for a long time as he is in ICU and he has decubitus ulcers. Conscious. No organ failure. Renal functions are good. Blood glucose regulation disrupted occasionally. Parenteral antibiotic and other treatments continue. Re-exploration was considered. However, the patient relatives did not accept due to financial issues and they wanted to return to Iran. Therefore, a treatment rejection notice was signed and the patient was discharged.