

## Supplemental Electronic Media-Postoperative Course in 10 Patients who Died

- 1 Significant hemorrhage (2100 mL) in OR requiring transfusion. Developed hypoxia/hypotension on POD 4. CT chest, abdomen, pelvis negative for PE but shows free fluid and intraperitoneal air. Returned to OR POD 4. Has pancreatic fistula. Pancreatic anastomosis repaired. Develops sepsis, MSOF. Died POD 5.
- 2 Developed abdominal distension POD 7. CT shows localized fluid collection near pancreaticojejunostomy. Percutaneous drain POD 9 consistent with pancreatic fistula and abscess. POD 10 develops hemorrhage (hematemesis) and cardiac arrest. Emergently returned to OR and had several liters of blood in the abdomen. The patient could not be resuscitated and died in OR.
- 3 NG reinserted POD 2. POD 3 abdomen distended, reintubated for respiratory decompensation thought likely secondary to an aspiration event. CT shows intraperitoneal fluid. POD 7, percutaneous drain placed and amylase is 7042. POD 12 drain fluid Cx positive for *Klebsiella*. By POD 14, 3 percutaneous drains placed for pancreatic fistula/abscess. Repeat CT shows fluid controlled and right side pneumonia confirmed. Develops ARDS, UGI bleed (multiple EGDs confirmed ulcer at GE junction as source), transfusion exacerbates ARDS, develops MSOF. Dies POD 19.
- 4 Laparoscopic PD for ampullary cancer. Initial postoperative course complicated by fever on POD 3, staphylococcal bacteremia, and DGE requiring NGT. Discharged home on POD 10 with PICC line for vancomycin. Returns POD 24 in hemorrhagic shock. Returned to OR emergently rather than IR. Hemorrhage from hepatic artery (not GDA stump). Packed abdomen and closed. Developed abdominal compartment syndrome in ICU and abdomen opened at bedside. Died in ICU POD 24.
- 5 Worsening abdominal pain on POD 1, eventually peritonitis and hypotension. Returned to OR POD1 and drained serosanguinous fluid. Outer layer of PJ had pulled apart but duct-to-mucosa sutures intact. Sutures placed at anastomosis. Drain amylase next day is 72. Drain amylase 9 days later POD 11 is >4000. POD 8 reintubated for MRSA pneumonia. Also developed MRSA bacteremia, septic shock, and renal failure. POD 29, covered stent placed in common hepatic artery. PTC drain placed for bile leak on POD 45. Subsequent CTs showed increasing abdominal fluid. Died POD 54.
- 6 PD with resection of PV (R1 resection). Uneventful postoperative course except for *C. difficile* colitis and mild gastroparesis. D/C home POD 14. Returns POD 39 with abdominal pain. CT POD 49 shows recurrence and PV/SMV thrombus. Patient sent home with hospice. Hospice nurse informed patient found dead on POD 59, likely died of cancer related cardiopulmonary event.

- 7 POD 6 distended abdomen and emesis. CT shows 4 x 5 cm fluid collection and percutaneous drain placed. Peritoneal fluid cultures positive for *E. coli* and *Candida* and amylase was 157 (not diagnostic for a pancreatic fistula). Developed septic shock and was returned to OR on POD 13. Findings consistent with pancreatic leak (saponification). Developed pneumonia, UTI, UGI bleed from gastric ulcer, *C. diff* colitis, leak from G-tube site, sepsis, and renal failure. Died on POD 75.
- 8 POD 10 abdominal distension. CT shows dilated stomach and loops of bowel (3.5 cm) with collapsed bowel distally concerning for SBO. Minimal amount of fluid in GB fossa. NGT placed. Next day POD 11, WBC became elevated. Returned to OR POD 11. No SBO just large amount, at least 1 L, of fluid in SQ and abdomen with high amylase concentration. Abdominal fluid cultures initially negative but later grew *Enterococcus*, resistant *Pseudomonas*, and *Candida*. Developed encephalopathy, pneumonia, UTI (*Candida*), line sepsis (*Candida*), ARF (dialysis withheld). Died POD 79.
- 9 LS converted to open PD **with drain**. Confused on POD 2. POD 3 became hypotensive. POD 4, respiratory failure and NGT blood tinged. EGD showed clot in stomach. Blood cultures positive. CT showed questionable filling defect in PA. Lower extremity US positive for DVT. Anticoagulated. Drain amylase indicated fistula, and changed to purulent by POD 4. Developed wound dehiscence and evisceration. Returned to the OR POD 13 for abdominal closure with vicryl mesh. D/C'd to rehab facility on POD 26 but returned the next day with hypotension. CT angiogram showed no fluid, aneurysm, or active bleed and patient responded to fluid/blood. On POD 33 Hg dropped again and repeat CT angiogram again negative. Sent for contrast study via drain on POD 35. Coffee ground emesis in radiology and study confirmed fistula. Abdomen distended and patient coded and died in radiology on POD 35.
- 10 PD **with drain**. Postoperative course complicated by a combined biliary and pancreatic fistula controlled with the operatively placed drain. Also had mild gastroparesis and skin dehiscence. CT on POD 7 showed a large amount of mesenteric fat stranding and multiple small foci of free air. D/C home on POD 8. Decided to leave drain in place at 4 weeks postoperative office visit. At 7 week postoperative visit, the drain was pulled back 2 inches and resutured. Never recovered well from surgery, unable to eat, required readmission POD 50. CT showed multiple new hepatic metastases and ascites. WBC was 45. Liver Bx confirmed adenocarcinoma. Developed septic shock and MSOF. Transferred to hospice and died POD 64.