Introduction:
Surgical septic shock is associated with high morbidity & mortality especially when associated with organ dysfunction. The aim of this study was to study the incidence & predictors of organ failure & mortality in surgical septic shock on admission to the SICU after surgical source control.

Methods:
This prospective observational study was done in 220 (age > 18 yrs) septic shock pts on admission to the SICU after surgical source control between Oct 2014-Sep 2019. Pts with preadmission ARDS, ESRD, stroke&delirium were excluded. Study data included: pts demographic, comorbidities, ASA class, source of infection, time of first antibiotic, shock reversal & source control, used of NE or other vasopressor/inotrope,steroid,intraop resuscitation & complications. First 72 hr data included admission& average Hb, serum albumin& lactate; fluid/blood replacement & balanced; organ failure as stroke, delirium,ARDS & AKI (KEDIGO criteria), 7days& 28days mortality.

Results:
Among the study pts (age 67.9 ± 14.5 yrs), 82% was ASA III, admission SOFA score 2.9 ± 2.1, 82% were cancer. 66% had intraabdominal infection, 38%, 6%, 3%, 14 & 22% had AKI, ARDS,delirium,7 & 28 days mortality subsequently. Eight patients developed cardiac arrest during anesthesia induction. From multivariate analysis showed age > 75 yrs, smoker, GFR < 40 ml/min, inadequate preop/intraop fluid resuscitation & overused NE/inotrop, admitted Hb < 9gm% & serum albumin < 3mg/dL were significant predictor of AKI. Pts with 7 days mortality had higher incidence of low EF (< 40%)/heart failure, longer (> 6hr) time to start & inadequate source control, inadequate pre/intraop resuscitation & overused NE/inotrop, higher SOFA score, antibiotic resistance, later start RRT. Blood purification were used in 4 pts with good outcome.

Conclusion:
Pre/intraoperative resuscitation, faster & adequate source control were key component in surgical septic shock.