【第 1 回翻訳チャレンジ】
以下の英文を和訳してください。
細部の添削はしませんが、注意が必要な部分についてはコメントします。
（ある患者が当院を受診しました。受診に至るまでの経緯を記述した文書です。）

A 67-year-old man was admitted to this hospital with hypoxemia.

Six years before the current presentation, the patient was evaluated because of melena and anemia. Esophagogastroduodenoscopy revealed duodenal ulcers; biopsy of one of the ulcers revealed changes consistent with moderately differentiated adenocarcinoma. Computed tomography (CT) of the abdomen showed a locally invasive mass in the head of the pancreas. A diagnosis of pancreatic adenocarcinoma with metastasis to the duodenum was made, and treatment included chemotherapy, chemoradiation, and pancreaticoduodenectomy. Two months after the surgery, surveillance CT of the chest showed segmental pulmonary embolism in the right lower lobe. Treatment with low-molecular-weight heparin was recommended, but the patient declined.

During the next 5 years, surveillance CT of the chest, abdomen, and pelvis was performed every 6 months. Six months before the current presentation, CT of the abdomen showed a new mass in the sigmoid colon with associated nodularity and lymphadenopathy. Colonoscopy revealed two fungating, nonobstructing, medium-sized masses, one at the ileocecal valve and the other in the sigmoid colon. Biopsy was performed, and a diagnosis of mantle-cell lymphoma was established. The patient was evaluated in the oncology clinic of this hospital, and plans were made for treatment with chemotherapy. Five months before the current presentation, pain in the right leg developed after a long car trip. Ultrasonography of the right leg revealed distal deep-vein thrombosis, and treatment with apixaban was initiated.

Nine weeks before the current presentation, cycle 1 of rituximab, dexamethasone, high-dose cytarabine, and cisplatin (R-DHAP) chemotherapy was administered, along with filgrastim. In addition, the administration of acyclovir and trimethoprim-sulfamethoxazole was started for prophylaxis; however, rash developed on the trunk after 1 week, and trimethoprim-sulfamethoxazole was replaced with atovaquone for prophylaxis against Pneumocystis jirovecii pneumonia. Six weeks before the current presentation, cycle 2 of R-DHAP chemotherapy was administered. Two days later, melena, fatigue, and dyspnea on exertion developed. Laboratory testing revealed anemia (hematocrit, 26.8%; normal range, 41.0 to 53.0). The patient received 2 units of packed red cells, and fatigue and dyspnea resolved. Treatment with omeprazole was initiated. Four weeks before the current presentation, the administration of atovaquone was stopped because of the cost of the medication, and dapsone was started for

prophylaxis against P. jirovecii pneumonia.

Three weeks before the current presentation, cycle 3 of R-DHAP chemotherapy was administered. Ultrasonography of the right leg revealed resolution of the distal deep-vein thrombosis, and treatment with apixaban was stopped. Two weeks before the current presentation, fatigue and dyspnea on exertion recurred, but melena did not. Laboratory testing again revealed anemia (hematocrit, 28.7%), and the patient received 1 unit of packed red cells; fatigue resolved, but dyspnea did not.

On the day of presentation, the patient was evaluated before the administration of cycle 4 of R-DHAP chemotherapy. He reported ongoing dyspnea on exertion but no cough, fever, chills, chest pain, or orthopnea. He had been having loose stools since the pancreaticoduodenectomy. Other medical history included hypertension and hereditary spherocytosis, which had been treated with splenectomy. Medications included acyclovir, dapsone, lisinopril, and omeprazole. Trimethoprim-sulfamethoxazole had caused a rash; there were no other known drug allergies. The patient drank alcohol rarely; he had smoked tobacco for 2 years but had quit 20 years before this presentation. He was divorced, lived alone in a suburb of Boston, and worked as a lawyer. His mother had had breast cancer.

On examination, the temporal temperature was 36.6° C, the blood pressure 134/82 mm Hg, the pulse 90 beats per minute, and the respiratory rate 22 breaths per minute. The oxygen saturation was 92% while the patient was at rest and breathing ambient air, 88 to 90% while he was walking and breathing ambient air, and 93% while he was at rest and receiving supplemental oxygen through a nasal cannula at a rate of 6 liters per minute. The body-mass index (the weight in kilograms divided by the square of the height in meters) was 25.4. The patient had tachypnea but no increased work of breathing. The lung sounds were normal, and the jugular venous pulse was not elevated. The legs had no edema.

The blood levels of glucose and electrolytes were normal, as were the results of coagulation, kidney-function, and liver-function tests. Other laboratory test results are shown in Table 1. Testing of a nasopharyngeal swab for severe acute respiratory syndrome coronavirus 2 RNA was negative, as was a respiratory viral panel. An electrocardiogram showed normal sinus rhythm.

参考表(和訳不要)

Table 1. Laboratory Data.

Variable	Reference Range, Adults*	On Presentation
Hematocrit (%)	41.0–53.0	25.2
Hemoglobin (g/dl)	13.5–17.5	7.9
White-cell count (per μl)	4500–11,000	21,560
Differential count (per μl)		
Neutrophils	1800–7700	14,380
Lymphocytes	1000–4800	750
Monocytes	200–1200	5280
Eosinophils	0–900	0
Basophils	0–300	190
Metamyelocytes	0	900
Platelet count (per μl)	150,000–400,000	596,000
Mean corpuscular volume (fl)	80.0–100.0	107.7
Lactate dehydrogenase (U/liter)	110–210	382

* Reference values are affected by many variables, including the patient population and the laboratory methods used. The ranges used at Massachusetts General Hospital are for adults who are not pregnant and do not have medical conditions that could affect the results. They may therefore not be appropriate for all patients.