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INTEGRATING THE
1st Emergency Medicine Annual Scientific (EMAS) Meeting

“A Multidisciplinary Approach in Strengthening the Chain of Survival”

19th to 21st August 2016
SHANGRI-LA HOTEL
KUALA LUMPUR, MALAYSIA
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Drug of abuse remain a significant burden to both the medical system and the society. Many drug abusers present themselves to emergency department for toxicity and complication of the drug abused. Hence, knowing the presentation and treatment of various abuse drugs are crucial to save life and improve outcome.

Despite new abusive drugs emerge every few years, all abusive drugs, old or emerging, can be classified according to its major effects on our central nervous system as stimulants (cocaine and amphetamines), depressants (narcotics and benzodiazepine) and hallucinogens (ketamine and Cannabis).

For the ED management of drug abuse patients, supportive is the mainstay of treatment. For stimulant drugs of abuse, we need to control the violence and agitation by early and liberal use of benzodiazepine with physical restraint. For depressants, support of ventilation with the use of antidote is sometimes needed. For hallucinogens, use of sedative agent may help the patient the sleep over the confusion state. In all situations, staff safety is important in the initial contact with the confused patients. Referral to proper drug rehabilitation program would help to take care of the long term outcome.
In this talk, the overview of the bradyarrhythmic algorithm is first discussed. Evidences for the management of bradyarrhythmias are relatively scanty and the classes of recommendation by the American Heart Association range from Class Ila to Class III. Atropine, a parasympatholytic drug, exerts its chronotropic positive effect by increasing sinus nodal and atrioventricular nodal automaticity as well as having a direct vagolytic action. Approximately half of unstable bradyarrhythmic patients show some response to atropine. Transcutaneous pacing may be helpful and is reasonable to be initiated for unstable bradyarrhythmic patients who are unresponsive to atropine. A recent systematic review on the use of transcutaneous pacing shows no evidence to support its use in prehospital setting. There are no major updates on the management of bradyarrhythmias in the 2015 resuscitation guidelines.
Hooking Up with Mechanical Ventilators – How To Do It?

Ramzuzaman Ismail
Hospital Raja Permaisuri Bainun, Ipoh, Perak, Malaysia

Mechanical ventilation in a critically ill patient is one of the skills that need to be mastered by healthcare provider in Emergency Department. At the very least, we have to care for them during the initial phase and initiate the mechanical ventilation. The ventilator parameters have to be set accordingly in order to achieve the desired clinical goals. At the same time, patient-ventilator interactions have to be managed carefully to ensure patient comfort and safety.
Emergency Tracheal Intubation (ETI) is a common lifesaving intervention in the practice of Emergency Medicine. All intubated patients will require mechanical ventilation. The ventilation strategy chosen will be dependent upon patient physiological factor and disease factor. Ventilation strategy require understanding of normal lung mechanics to achieve the goal of restoring normal or near normal physiology in disease lungs. Occasionally that goal cannot be achieved and some abnormal physiology are acceptable. Differentiation between complication of inappropriate ventilation strategy and acceptable abnormal physiology must be understood and identified to avoid further lung injury.
The abdomen is a ‘pandora box’ as it contains multiple vital organs. Emergency ultrasound of the abdomen practically involves almost all organs in the abdomen. Nevertheless, point-of-care ultrasound (POCUS) may be focused on organs or parts of organs that matters in making clinical decisions. Abdominal emergency POCUS among others include assessment and diagnoses of aortic aneurysm or dissection, acute pancreatitis, cholelithiasis, cholecystitis, nephrolithiasis, hydronephrosis, perforated gastric ulcer, intestinal obstruction, bowel ischemia, perforated viscus and acute appendicitis. In emergency ultrasound, the ability to ‘see the pathology’ makes a lot of difference. Ultrasound to a certain extent helps in ruling in and ruling out certain abdominal pathology. This presentation shall dwell into a system of covering all the above via a ‘Lasso’ technique. The presenter shall also propose the ‘Question Mark Maze’ method in simplifying bedside basic emergency ultrasound screening to answer clinical questions of acute abdomen.
Trauma related thoracic bleeding may results from simple intercostal vessel bleed to complex cardiac and great vessel injuries. With improvements in organized emergency medical transport system, those who sustained significant injury may reach the emergency department with signs of life. However many of them died after reaching the hospital and this only can be prevented with prompt diagnosis and treatment. The aim of treatment should follow the damage control resuscitation/surgery principal, which may include the goal-directed hemostasis, tube thoracostomy, thoracotomy, thoracoscopy and even with interventional radiological approach.
INTRODUCTION
Dengue is difficult. The disease is evolving and elusive. Many had succumbed despite being identified and treated early with close monitoring.

DISCUSSION
Point of care ultrasound (PoCUS) has recently been incorporated into the state of art of dengue management. This presentation will depict how PoCUS can be utilised in every step of dengue management including predicting the disease severity, determining the phases and monitoring the haemodynamic changes throughout the course of the illness. It will also highlight that fluid is not the only answer for dengue resuscitation as inotropy determines the fluid responsiveness and tolerance. PoCUS is also able to differentiate many types of shock that can concomitantly occur with dengue shock syndrome.

CONCLUSION
PoCUS should be incorporated into the management strategy for optimal dengue care.

KEYWORDS
Point of Care Ultrasound, Dengue Shock Syndrome
In this lecture we will review some of the 2015 International Liaison Committee on Resuscitation (ILCOR) guidelines and changes compared to 2010. In particular, we will focus on how these impact prehospital emergency care (PEC) and performance measurements.

We will share ideas on how to improve PEC, especially with regard to survival for out of hospital cardiac arrest (OHCA). These include specific recommendation on how to improve Emergency Medical Service (EMS) systems from the Global Resuscitation Alliance (GRA).
Advanced Care Provider definition in prehospital care varies among systems. The similar theme among systems that defines what is advanced care intervention are ability to perform definitive airway and ability to provide pharmacological intervention using parenteral access.

Malaysia has the capacity to provide advanced care interventions in prehospital environment using Assistant Medical Officers (AMO). They are trained to perform endotracheal intubation in Crash Airway situations, manual defibrillation and cardioversion in arrhythmias, obtain intravenous access and administer parenteral medications.

While we have the capacity to use all these interventions, which one of them matter most in the prehospital arena? How do we as Emergency Physicians decide on what AMO should perform in the field?

We shall discuss on the current recommendations on selected advanced care interventions in prehospital environment.
The APLS was established in UK 18 yrs ago and is now in more 38 countries including many European countries, Australasia, the Caribbean, the Middle East, South Africa, and, in the Far East, in Cambodia and Vietnam. In all of them content is similar with some modifications in resource poor areas. The APLS was first started in Malaysia in October 2011 and involve 12 initial providers who went on to be instructors after attending a GIC (generic instructor course). The regulations set up by the ALSG was strictly adhered to. Malaysia now has conducted more than 46 APLS courses and train about 1100 providers. We have also started the PLS for nurses and has conducted 100 such courses training 2400 nurses, paramedics and junior doctors. The Generic Instructor course is part of the programme to train instructors chosen from among the pool of providers. So far 12 GIC have been carried out training a total of 144 instructors. Instructors after passing the GIC need to be supervised as candidate instructors before being full fledged instructors.

Despite the numbers trained, instructors are lost due to resignation or work pressure.

With the new ILCOR guideline 2015, a few changes were made to the running of simulations with more emphasis on teamwork and debriefing.
Trauma is a preventable and a treatable disease. Crucial hours subjects to immediate response and intervention provided at scene or hospital. Airway obstruction, tension pneumothorax and exsanguinating hemorrhage are preventable life threatening injuries that can be overcome with precise recognition and early intervention. Debate continues in regards to endotracheal intubation at prehospital care. Managing exsanguinating hemorrhage is a demanding task. Control of hemorrhage, restoration of blood volume and prevention of coagulopathy are the cornerstone in management of massive hemorrhage. Accurate triaging, Improved communication between EMS (emergency Medical Service) providers and hospital surgeons, upgraded trauma system and dynamic trauma team improves outcome of a wounded victim.
Vascular trauma is a serious condition which carries high morbidity and mortality. It is often associated with injury to other organs and neurological structures. As it is thankfully rare, it is difficult to develop cumulative experience in management of vascular trauma. It can occur as a result of blunt and penetrating as well as iatrogenic injury. This presentation provides an overview of clinical features of vascular injury and examines effects of new developments in management of vascular injury such as endovascular treatments and use of vascular shunts in managing vascular injury. The evidence obtained from the new conflicts in the Middle East and Afghanistan is also discussed.
Difficult Airway is a clinical scenario requires knowledge and skills to manage in Emergency Medicine practice. The difficult airway can be anticipated or unanticipated. Obese and maxillofacial injuries are 2 group of patients almost always considered as difficult airway. Combination of anatomical and physiological alteration in the hand of unskilful or inadequate knowledge of airway management will pose potential of failed airway that can lead to hypoxia and eventually death. It is essential for the attending physician to have backup airway plan with the goal to maintain optimum oxygenation and ventilation.
Critical care or intensive care is a specialized care of patients whose conditions are life-threatening and who require comprehensive care and constant monitoring. This level of care should be started as soon as critically ill patients arrive in the emergency room (ER). A hypertensive emergency is an example of critical condition that requires immediate therapy to decrease blood pressure within minutes to hours. It is commonly seen in the ER and acute stroke is often the inciting etiology of a hypertensive emergency.

Blood pressure (BP) is elevated in 75% or more of patients with acute stroke and is associated with poor outcomes. Whether to modulate BP in acute stroke has long been debated. With the loss of normal cerebral autoregulation, theoretical concerns are twofold: high BP can lead to cerebral oedema, haematoma expansion or haemorrhagic transformation; and low BP can lead to increased cerebral infarction or perihaematomatic ischaemia.

Published evidence from multiple large, high-quality, randomised trials are increasing our understanding of this challenging area. The CATIS randomized clinical trial evaluated whether immediate blood pressure reduction has benefitted patient with acute ischemic stroke whereas INTERACT and ATTACH trial evaluated the effect of BP lowering in intracerebral hemorrhage patients. The talk will review of the evidences for BP modulation, discuss about the issues raised, applicability in the ER and look to on-going and future research in acute stroke for the betterment of our critically ill patients.
There used to have wide variations of clinical practice of gut decontamination of ingested poisoning in different parts of the world. To help to standardize the treatment, position statements were prepared by American Academy of Clinical Toxicology (NACCT) and European Association of Poisons Centres and Clinical Toxicologists (EAPCCT) and endorsed by major toxicology bodies.

The position statements were updated every few years only to find there is less and less good research on the choice of the various methods in treating severe poisoning.

The position statements advocate use of activated charcoal for most recent poisoning and replacing gastric lavage in most situations. And conclude that there is no evidence to support gastric lavage should be used routinely in the management of poisonings.

However, gastric lavage is still the standard practice in many Asian countries including China. While the evidence to support gastric lavage for mild to moderate poisoning is slim. With some 3% risk of major complication, it is reasonable to be replaced with activated charcoal in these situations. However, no evidence to support usefulness does not mean evidence to support no use. It is because the literature search for formulating the position statements are mainly in the English language and most the studies did not include enough life-threatening poisonings.

Furthermore, the external validity of study conducted in the developed countries cannot be extrapolated to developing countries where there is neither lack of common antidotes nor enough ICU facility.
Acute heart failure can be life threatening and requires urgent therapy and hospitalization. About 15% of acute heart failure occurs de novo but the majority of patients hospitalized have worsening of pre-existing chronic heart failure. Precipitants for decompensation should be sought and treated if possible.

Current therapies improve hemodynamics and symptoms. Diuretics are given for volume overload and vasodilators and inotropes are given to improve cardiac output.

Many randomized controlled trials have been negative. Promising therapies include serelaxin, and mechanical circulatory support.
How Doctors Think, and What Can Go Wrong – Teaching Heuristics

In the busy clinics, many experienced senior specialists would seem (to their junior colleagues) to be able to make accurate spot diagnosis, arriving at a patient care plan rapidly, and making sense out of the muddle of information, after sieving out from the chaff and background noise.

While this approach may seem the epitome of clinical acumen, and one that junior doctors aspire too, senior physicians will know that it is a clinical sense (or gestalt) borne out of many years of training and exposure. Many of them will know the pitfalls of such an approach, and will know to test their hypothesis and re-examine their assumptions if their first differentials do not stand up to scrutiny. Even worse, if there are anchoring biases that cloud their judgement, mistakes can occur.

The speaker shares his experience in when it is safe and appropriate to make rapid spot diagnosis, and when to correct the mistaken first assumptions. He will also examine some of the current theories in the field of medical literature on how clinicians think and formulate their diagnosis.
Resuscitation a patient in the pre hospital environment is very different from the hospital environment. In the Emergency Room the patient is relatively stationary because the structure and process makes the equipment, person and skills are brought to the patient. Only when the equipment and intervention requires specialized environment, that the patient is moved to another area in the hospital.

The opposite occurs in the pre hospital environment. The patient must be moved to the hospital environment in order to receive the appropriate intervention. Such movement must be timely especially when faced time dependent situations such as cardiac care, trauma care and stroke care. The more critically ill a patient is, the faster the patient needs to be transported to a hospital.

We will discuss and show examples of how training and education of Medical Assistant in pre hospital environment has evolved in Malaysia from static stations to dynamic simulation stations.
Neonatal emergencies, that is in those who are below 28 days of age, can be challenging as the neonates present to the emergency department (ED) with non-specific symptoms and signs. The signs and symptoms in a ill neonate are usually poor feeding, lethargy progressing to limpness and apnoea. The mnemonic “T.H.E M.I.S.F.I.T.S” can be helpful to the ED doctor as a guide to recall the most likely neonatal emergencies – trauma, heart, endocrine or metabolic disease, inborn errors of metabolism, sepsis, formula mishaps, intestinal catastrophes, toxins and seizures.

The onus is on the ED physician to recognize which life-saving interventions are appropriate depending on the likely diagnosis. The airway should be secured immediately and respiratory support given if necessary. Arriving at the most likely diagnosis requires a quick and efficient history taking including mother’s antenatal and patient’s newborn history, looking for relevant physical signs and sending for the more useful investigations.

The presentation will discuss the differentiation and stabilisation of the more common neonatal emergencies arising from “T.H.E M.I.S.F.I.T.S”.
Inborn errors of metabolism (IEM) are genetic enzyme defects that cause abnormal function of biochemical pathways. When an enzyme activity is reduced, the substrate accumulates, causing secondary toxic metabolic effects and deficiency of an essential product of a metabolic pathway, leading to “acute metabolic crisis”. The birth prevalence of IEM is 1 in 3000 in the general population. An acute metabolic crisis may resemble sepsis, encephalopathy and/or cardiorespiratory failure where the patient deteriorates suddenly and progresses rapidly with severe permanent brain damage. Early recognition of the presentation and its ‘triggers’ is essential as treatment is effective if started early. The earlier return of metabolic stability correlates well with long term prognosis and prevent learning handicap.
Interdisciplinary integrated services for the management of stroke has been associated with significant reductions in mortality and morbidity. This involves the development of regional structures in order to streamline the delivery of appropriate investigations and interventions such as thrombolysis and carotid endarterectomy in a timely manner and with low complications. Thrombolysis is an effective modality for the treatment of acute ischaemic strokes the debate continues its use. This presentation discusses the development of integrated and virtual integrated stroke services and how they can benefit patient care. It also reviews the most recent evidence for thrombolysis and prompt carotid endarterectomy for management of acute stroke patients.
Intracerebral hemorrhage (ICH) is the second most common cause of stroke, following ischemic stroke. Mortality and morbidity is high. Initial goals of treatment include preventing hemorrhage extension, as well as the prevention and management of elevated intracranial pressure along with other neurologic and medical complications.

Current guidelines suggest consideration of intensive or critical care during the first 24 hours after ICH onset due to dynamic nature of the ICH and postponement of new do not resuscitate (DNR) orders during that time. Ideally, acute neurosurgical care should be available at the hospital in which patients are cared for. Other management for ICH is discontinuation of all anticoagulant and antiplatelet drugs. Maintenance of normothermia and treat the source of fever. Normal saline should be used for maintenance and replacement fluids. Hyperglycemia should be treated with insulin and hypoglycemia should be avoided.

Other initial management of elevated ICP includes elevating the head of the bed and use of adequate analgesia and sedation. Invasive monitoring and treatment of ICP should be considered for patients with GCS <8, those with clinical evidence of transtentorial herniation or those with significant IVH or hydrocephalus. Treatment of high blood pressure is important to prevent continued force for bleeding. Appropriate intravenous antiepileptic treatment should be used to quickly control seizures for patients with ICH and clinical seizures.

Prevention is still the best. Treating hypertension is the most important step to reduce the risk of ICH. Stopping smoking and heavy alcohol use are also recommended.
This talk focuses on the pearls and pitfalls in the management of hyperkalemia. Diagnosis of hyperkalemia can be challenging if one is to rely on electrocardiographic (ECG) findings alone. In a retrospective review, ECG changes were seen in only about half of the patients with hyperkalemia. Patients with severe hyperkalemia may even present with normal ECG. Giving dextrose alone without insulin is not recommended and may in fact, paradoxically, exacerbates hyperkalemia due to its osmolality effect. Calcium, in its preferred preparation, calcium gluconate, exerts its effect within 1-3 minutes after administration but its effect lasts only for approximately 30 – 60 minutes. Nebulized salbutamol is an effective adjunct treatment but one should be aware that the dose needed is about four times the usual dose for bronchodilation therapy. As such, one should be aware of its sympathetic side effects. Hyper- and hypomagnesemia can be associated with cardiac arrhythmias. Disturbances in sodium level are unlikely to be the primary cause of severe cardiovascular instability and calcium abnormality as an etiology of cardiac arrest is rare.
The speaker will provide an overview of mass disaster triage algorithms that have been used, their international adaptability and inter-observer reliability. Examples will include Triage Sieve, Triage Sort, Jumpstart, SALT, etc.

Mention will also be made of triage algorithms for HAZMAT, radiation and smoke inhalation scenarios. Some examples of triage tags used internationally will be shown too.
LIFE THREATENING BITES AND STINGS – A SIMPLE GUIDE

Ahmad Khaldun Ismail

Department of Emergency Medicine, Universiti Kebangsaan Malaysia Medical Centre, Cheras, Kuala Lumpur, Malaysia

This lecture will bring the attention of the audience to the current issues pertaining to Clinical Toxinology and the management guidelines of animal bites and stings with particular emphasis on snakebite envenoming in Malaysia.
Rapid diagnostic testing (RDT) in infectious diseases has rapidly expanded in recent years. Increasing scope for tests include HIV, TB, RSV, Hepatitis B, Hepatitis C, Group A streptococcus, syphilis, malaria, dengue, influenza, hospital-acquired infections (MRSA, C difficile) and severe sepsis. RDT could minimize time-to-treatment initiation and expedites results for patient management decisions. To discuss the diverse RDT product profiles, users and settings, sensitivity, specificity, negative and positive predictive values, challenges for use and scale-up, costs, staff and technical training, quality assurance, reliability and reproducibility. New technologies would allow less expensive, more user-friendly RDT to complement standard microbiology laboratory testing.
Trauma care in Malaysia is still in its infancy. The gaps in a developing country are an opportunity rather than weakness. It gave us the chances to learn and improve our own system by adapting other trauma systems to suit our local settings and capabilities. The gap analysis of trauma care in Malaysia and recommendations for improvements will be presented and discussed.
In this lecture we will review some of the new therapies reviewed in the 2015 International Liaison Committee on Resuscitation (ILCOR) guidelines and the evidence for their effectiveness. In particular, we will focus on that have a higher likelihood of being implemented in our Emergency Medical Service (EMS) systems.

We will share ideas on how to improve PEC, especially with regard to survival for out of hospital cardiac arrest (OHCA). These include experiences from the Pan Asian Resuscitation Outcomes Study (PAROS).
FP 1.1 Prospective Review On Pattern And Distribution Of Acute Poisoning Cases In Hospital Kuala Lumpur (HKL), Malaysia
Mohd Ramly M F, Sabudin Z S, C H Sheng, Abd Wahab M, Shafie H
Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

FP 1.2 “Tempting Mushroom With Deadly Bites – Dinner That Almost Kill My Family” – Case Series Of Chlorophyllum Molybdites Mushroom Poisoning
Baran Palanimuthu¹, Alzamani Idrose¹, Vikineswary Sabaratnam²
¹Emergency Department, Kuala Lumpur General Hospital, Kuala Lumpur, Malaysia
²Mushroom Research Centre, University of Malaya, Kuala Lumpur, Malaysia

FP 1.3 A Prospective Observational Study On The Impact Of A Protocol-Driven Management Of St Elevation Myocardial Infarction (STEMI) On Event Timings In A Newly-Established STEMI Network
Mahathar Abd Wahab¹, Rosli B Mohd Ali², Rossman Hawari¹,
Alzamani Idrose¹, Rahal Yusoff³, Al Fazir B Omar³,
Intan Safarina Sabian², Farina Mat Salleh³, Robaayah Zambahari²
¹Emergency Department, Hospital Kuala Lumpur, Malaysia
²Emergency Department, Institut Jantung Negara, Kuala Lumpur, Malaysia
³Cardiology Department, Hospital Kuala Lumpur, Malaysia

FP 1.4 Are All Event Medical Coverage Services Equal? A Case Series From A Friendly Game Of Rugby
Phee-Kheng Cheah¹, Eng-Han Ong¹, Xiang-Yun Yang², Earnest Yeoh³
¹Emergency and Trauma Department, Sabah Women and Children’s Hospital, Kota Kinabalu, Sabah, Malaysia
²Emergency and Trauma Department, Kapit Hospital, Kapit, Sarawak, Malaysia
³Emergency Department, MAHSA University, Kuala Lumpur, Malaysia

FP 1.5 Psychomotor Skill And Knowledge Among Prehospital Care (PHC) Providers On Performing High Quality Cardiopulmonary Resuscitation (HQCPR) At A Tertiary Hospital: A Cross Sectional Study
Norhayati Mohamad Amin¹, Mahathar Abd Wahab¹,
Shamsuriani Md Jamal²
¹Hospital Kuala Lumpur, Kuala Lumpur, Malaysia
²Pusat Perubatan UKM, Kuala Lumpur, Malaysia
INTRODUCTION
Acute poisoning is one of the common presentations in Emergency and Trauma Department requiring specific management approach based upon patient’s characteristics. Patients outcome based on various factors which includes types of poisons, amounts of poisons, level of toxicity and patient’s pre-morbid status. Emergency and Trauma Department (ETD) toxicology cases compilation started from 1st October 2013 as databases for the purpose of management audit in poisoning cases.

OBJECTIVE
The objective is to evaluate the patterns of acute poisoning cases in relation to their epidemiological data, types of poisons, types of venoms and patient’s outcomes. This review also used to further understand the demographic data of acute poisoning cases in Kuala Lumpur.

METHODS
A prospective study was conducted on poisoning cases attended ETD of Hospital Kuala Lumpur from 1st October 2013 until 31st March 2016. All cases suspected or alleged ingesting poison or drugs is included in this review. Descriptive analysis is carried out looking at the types of poisoning, route of administration and patient outcome.

RESULTS
A total of 708 cases labeled as poisoning which comprise of 64.4%(456) cases due to toxic agents and 35.6%(252) due to venoms. For subgroup venomology; 19.8% (50) patients aged less than 18 years old with 2.3%(6) of cases were less than 2 years old, 3.9%(10) of cases more than 60 years old. 73.4%(177) involved was Malay, 17.8%(43) Indian and 8.7%(21) Chinese. 72.6%(183) is male patients and 27.3%(69) female. Types of venoms includes bite cases 54.3%(137) and 45.6%(115) due to sting. For sting category; 43.6%(110) were due bee sting, others were benign insect bite. 11.9%(30) snake bite reported. No mortality reported in this subgroup.

For subgroup toxicology; 78.4%(357) patients aged between 18 to 60 years old, 9%(41) age between 5 to 18 years old. 45.4%(184) cases were Indians, and 38.5%(156) Malays. 61.8%(282) were female patients. 93.2%(425) of cases used oral as their route of administration followed by inhalation, which comprises of 6.3%(29). Toxic agents used were Paracetamol 17.5%(80) cases, Chlorox 13.8%(63) and cyanide inhalation, 22 cases. Accident ingestion was the most common cause of toxicology with 35%(160) cases, deliberate self-harm 25.4%(116) cases and suicidal with 23.9%(109) cases. N-Acetyl-Cyteine was the most commonly used antidote 47.7%(21) cases followed by Atropine 15.9%(7) cases and Orphanedrine 9%(4) cases. 5 reported deaths in this subgroup.
DISCUSSIONS

Venomology
Patients mostly are within the productive age 18 years to 60 years old, corresponds to studies from Chew et al (2011) and Cesaretli Y el (2010).1,2 According to Malaysia statistic department, this is the largest population group. Most of them presented to the hospital at afternoon shift, 38.4%, which corresponding to the norm of workload in emergency department. Jamaiah et al (2006) also reported highest snake bite incidence during afternoon shift too (2pm to 9pm). This happen most likely because people are still at work and being out in the working field. Majority cases are Bee sting (43.6%), insect bite (39.2 %). In 2014, American Association of Poison Control (AAPCC) centers reported 3968 case for bee, wasp, or hornet sting, while other insect bites stand at 6049 cases. These 2 category remain the top 2 cases among envenomation in Malaysia and America.

Toxicology
Most of the distributions according to the age group shifted to the categories 18 to 60 years old, comprising 78.4%(357). Database from the American Medical Association (AMA) 2006 also reported the similar findings, 91.9% were aged 18 to 54 years old and majored by male gender with 67.1% among the unintentional pharmaceutical overdose fatalities. Regarding the route of administration, data recorded the most common route of administration is via oral comprise about 93.2%(425) followed by inhalational with 6.3%(29). The data from the “2014 Annual Report of the AAPCC” also recorded that ingestion is the highest cases reported with 83.7% followed by dermal (7.0%) and inhalation (6.1%). The top substance reported in this review is Paracetamol 17.5% (80).

CONCLUSION
This review showed the disease burden of acute poisoning cases in Kuala Lumpur City Centre and contributes to understand the demographic data, hence providing invaluable input to our preparedness in managing such cases.
“TEMPING MUSHROOM WITH DEADLY BITES -DINNER THAT ALMOST KILL MY FAMILY” – CASE SERIES OF CHLOROPHYLLUM MOLYBDITES MUSHROOM POISONING

Baran Palanimuthu¹, Alzamani Idrose¹, Vikineswary Sabaratnam²
¹Emergency Department, Kuala Lumpur General Hospital, Kuala Lumpur, Malaysia
²Mushroom Research Centre, University of Malaya, Kuala Lumpur, Malaysia

INTRODUCTION
We describe a case series of a family (4 people) presented to us with Chlorophyllum Molybdites Mushroom poisoning which has been picked up by roadside as mistaken for edible “Cendawan Busut”.

CASE DESCRIPTION
Mushroom poisoning is a rare case encountered by any healthcare providers. We often diagnose patient as Infective Acute Gastroenteritis (AGE) which caused by dirty environment and method of food handling. Meanwhile we forgot content of food product itself might be poisonous and harmful to us which even cause death.

CASE 1 (HUSBAND)
32 years old gentleman presented to us, with Vomiting and Diarrhoea (> 10x) after took half plate of wild mushrooms for dinner together with other family members. Patient also complaint of throat discomfort hence sent to Red Zone to anticipate possibilities for anaphylactic reaction (Laryngioedema). Patient was treated as Anaphylatic reaction secondary to mushroom poisoning. IM Adrenalin/IV Hydrocortisone/IV Piriton/Activated Charcol given to this patient. Continuous fluid replacement done under ultrasound guide until vital signs normalised and warded under Medical team.

CASE 2 (WIFE)
29 years old lady, G3P2 @ 20/52 POA accompanied husband (above). Also took mushrooms for dinner about (Quarter Plate). Initially did not have any AGE symptoms, however developed Vomiting multiple times and Diarrhoea in ED. However patient does not develop any anaplylatic reaction. Continuous hydration given under ultrasound guide and warded under O&G team.

CASE 3 (CHILD)
4 years old boy was brought to our emergency department together with parents (above) as complaint vomiting x5 at home after ingest small piece of mushroom for dinner. Otherwise, hydration status still good and vitals signs are normal. Child was warded under Pediatric team.

CASE 4 (MOTHER IN LAW)
64 years old lady, presented with vomiting multiple times at home after took mushroom for dinner together with other family member (above). However, vital signs were still normal and hydration status was fair. Patient was warded under medical team for observation with continuous hydration.
Mushroom was brought to Mushroom Research Centre in University Malaya for expert identification and subsequently was identified as Chlorophyllum Molybdites which can cause GI Disturbance.

All patients discharged well after 3 days as symptoms improved and blood investigation failed to releave any organ disfunction/ residual toxicity.

DISCUSSION/CONCLUSION
Mushroom poisoning should be included as one of differential diagnosis on any event of mushroom ingestion presenting with AGE symptoms. Early mushroom identification will be helpful in predicting patient outcome including management plan. Early anticipation in form of fluid resuscitation are compulsory to prevent dehydration and further deterioration of patient condition.

We presenting case series of a family with mushroom poisoning. We are first in world to present such case which patient ingest same type mushroom with different outcome- proportionate to quantity ingested.

We are also first in world to report same type of mushroom poisoning with outcome (Quantity based) from different age group/population (Adult/Pregnant Lady/Pediatric/Geriatric) group.
A PROSPECTIVE OBSERVATIONAL STUDY ON THE IMPACT OF A PROTOCOL-DRIVEN MANAGEMENT OF ST ELEVATION MYOCARDIAL INFARCTION (STEMI) ON EVENT TIMINGS IN A NEWLY-ESTABLISHED STEMI NETWORK

Mahathar Abd Wahab¹, Rosli B Mohd Ali², Rossman Hawari¹, Alzamani Idrose¹, Rahal Yusoff³, Al Fazir B Omar³, Intan Safarinaz Sabian², Farina Mat Salleh², Robaayah Zambahari²

¹Emergency Department, Hospital Kuala Lumpur, Malaysia
²Cardiology Department, Institut Jantung Negara, Kuala Lumpur, Malaysia
³Cardiology Department, Hospital Kuala Lumpur, Malaysia

INTRODUCTION

The network was a collaboration between an Emergency Department of a Non capable Percutaneous Coronary Intervention (PCI) center and a PCI-able center to enable access for ST elevation Myocardial Infarction (STEMI) patients for PPCI. The aim of the study is to determine if a protocol-driven management of STEMI patient will improve the first medical contact (FMC) to balloon time with this network.

METHODS

All STEMI patients had a focused history, examination and ECG performed. A standardized form was filled and the patients were managed as per local guidelines. Symptom onset to ED, Door-in-door-out time (DIDO), PCI center door-to-balloon time (D2B), First-medical-contact (FMC) to balloon and total ischemic time were collated. In-hospital and 30-day mortality rate at 30 days were also reported. For our analysis, the data derived are divided into two phases. This is to evaluate temporal improvements as the network matures.

RESULTS

150 patients were enrolled in the 13 month period (n=46 for phase A, and n=104 for phase B). The DIDO for the first cohort was 44 minutes, IQR (30-72), and this timing reduced significantly in the second cohort (30 minutes, IQR (24.5-50), p=0.043). The median FMC to balloon times also reduced significantly between the 2 phases (phase A, 111.5 minutes, IQR (95.75-132.75) and phase B 88 minutes IQR (75-108), p<0.001). There was no difference between in-hospital deaths reported between the phases (8.7% vs 2.9%, p=0.202). Thirty-day mortality differences were also not significant (2.4% vs 2.0%, p=0.971).

CONCLUSION

A protocol-driven management of STEMI patients could improve system timings like the DIDO and the FMC to balloon times as the network ‘matures’ with time. There were no significant differences observed in the in-hospital death and 30-day mortality rate. Further study is required to evaluate the long term impact over of this strategy.
ARE ALL EVENT MEDICAL COVERAGE SERVICES EQUAL? A CASE SERIES FROM A FRIENDLY GAME OF RUGBY

Phee-Kheng Cheah\textsuperscript{1}, Eng-Han Ong\textsuperscript{1}, Xiang-Yun Yang\textsuperscript{2}, Earnest Yeoh\textsuperscript{3}

\textsuperscript{1}Emergency and Trauma Department, Sabah Women and Children’s Hospital, Kota Kinabalu, Sabah, Malaysia
\textsuperscript{2}Emergency and Trauma Department, Kapit Hospital, Kapit, Sarawak, Malaysia
\textsuperscript{3}Emergency Department, MAHSA University, Kuala Lumpur, Malaysia

INTRODUCTION
Event medical coverage is an integral part of pre-hospital care medicine and is increasingly used by event organisers to mitigate risk of high risk events such as contact sports and mass gatherings. Rugby is a collision sport played by amateurs and professionals. The game is physically demanding and results in a high incidence of injury, reportedly up to 497.6 events per 1000 playing hours.

CASE SERIES
We report on an event medical coverage for a rugby tournament which pitted 13 teams against each other with a total of 192 players, 46 team staff and 15 referees. During the 2-day event, there were a total of 26 players requiring medical attention. 2 required hospital referrals. The overall incidence of injury was 302.94 per 1000 playing hours. Two players who were originally discharged by the medical team subsequently presented to the hospital with deterioration of their condition.

Patient 1 was a 15-year-old girl who sustained a fall and landed on her left temporal region after being tackled by 3 opponents. She presented to the Emergency Department (ED) with multiple seizures. She was diagnosed to have a subdural hematoma and was subsequently discharged well without any surgery performed.

Patient 2, 16-year-old girl who sustained a fall after being pushed by her opponent while she was in the locks position. She landed on her buttocks with her legs extended. She also presented to the medical team who discharged her after a through examination. However, the patient presented to ED 3 days later with worsening lower back pain. She was diagnosed to have a compression fracture of L1 with extension to the right pedicle needing surgery.

DISCUSSION AND CONCLUSION
The incidence of injury is comparable to international tournaments and medical standby teams should be deployed to these events to mitigate risk of injuries.

KEY WORDS
Event medical coverage, rugby, pre-hospital care
PSYCHOMOTOR SKILL AND KNOWLEDGE AMONG PREHOSPITAL CARE (PHC) PROVIDERS ON PERFORMING HIGH QUALITY CARDIOPULMONARY RESUSCITATION (HQCPR) AT A TERTIARY HOSPITAL: A CROSS SECTIONAL STUDY

Norhayati Mohamad Amin¹, Mahathar Abd Wahab¹, Shamsuriani Md Jamal²

¹Hospital Kuala Lumpur, Kuala Lumpur, Malaysia
²Pusat Perubatan UKM, Kuala Lumpur, Malaysia

INTRODUCTION

International guidelines for CPR focused on methods of high quality cardiopulmonary resuscitation (HQCPR) in ensuring return of spontaneous circulation. Currently there is a large gap between knowledge and practical implementation. Environmental factors such as static and moving environment contribute in influencing level of competency in performing HQCPR. This study aimed to assess and compare the knowledge and psychomotor skill of pre hospital care (PHC) provider in performing HQCPR in controlled environment and uncontrolled environment at 2 minutes.

MATERIAL AND METHODS

This is an experimental study conducted in Emergency Department Hospital Kuala Lumpur on July 2014 until May 2015. Forty PHC providers enrolled into the study. The first part involved knowledge assessment using multiple choice questions. The second part involved objective and subjective assessment of psychomotor component in CPR within 2 minutes on a manikin in a controlled (static) and uncontrolled environment (moving ambulance and trolley). The objective assessment was measured with percentage of accurate compression and ventilation using a software program. The subjective assessment was conducted by two independent assessors following a modified standardised checklist.

RESULTS

In the knowledge assessment 30% scored satisfactory. The objective assessment showed accuracy of HQCPR was significantly effective in controlled environment (p ≤ 0.01). The subjective assessment revealed most participants were able to perform satisfactorily in a controlled environment. Assistant medical officer were more competent in delivering a HQCPR compared to staff nurse (p≤ 0.01). There were significant association between knowledge and competency on performing HQCPR among the PHC providers (p≤ 0.01)

DISCUSSION

There were minimal interruptions of chest compression in the controlled environment. The instability factor along with small closed compartment and variability of speed of the ambulance may affect the performance of HQCPR. Another contributing factor is lack of knowledge update among providers. Standardised training and frequent evaluation of knowledge and skill is needed to maintain performance.
FP 2.1 Average Time To Dispatch Cardiopulmonary Instructions Provision By Dispatchers In Medical Emergency Coordination Centre Malaysia
Sarah S A Karim¹, Kwanhathai Darin Wong², Rozita Ajis³, Anjelai Devi Muniandee², Kee Gaik Hoon³, Chia Kan Ooi¹, Chia Boon Yang⁴
¹Hospital Sungai Buloh, Selangor, Malaysia
²Hospital Pulau Pinang, Pulau Pinang, Penang, Malaysia
³Hospital Kuala Lumpur, Kuala Lumpur, Malaysia
⁴Hospital Miri, Sarawak, Malaysia

FP 2.2 Simulating A Hospital In Disaster, Planning The Lesson
Sarah S A Karim¹, Amir A Azman¹, Tong Ming W¹, Rosidah Ibrahim², Khairi Kassim³
¹Hospital Sungai Buloh, Selangor, Malaysia
²Hospital Serdang, Selangor, Malaysia
³Hospital Shah Alam, Selangor, Malaysia

FP 2.3 Flexible Intubation Video Endoscope In ED Hospital Serdang
KhengSoo Ng
Emergency and Trauma Department, Hospital Serdang, Selangor, Malaysia

FP 2.4 The Dramatic Shoshin Beriberi
Shafie H, Abd Wahab M
Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

FP 2.5 Study On Usage Of Bedside Ultrasonography In Detecting Plasma Leakage Among Dengue Patients In Emergency Department
Lailajan Mohamed Kassim, Mahathar Abd Wahab, Hidayah Shafie
Emergency and Trauma Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

FP 2.6 Genetic Variants That Are Associated With Neuropsychiatric Systemic Lupus Erythematosus: A Meta-Analysis
Roger Ho
Department of Psychological Medicine, Yong Loo Lin School of Medicine National University of Singapore, Singapore
INTRODUCTION
Dispatch Assisted Cardiopulmonary Resuscitation (DA-CPR) is a recognized method to improve not only rate of bystander CPR. It enhances the first two chain of survival which is early recognition and early bystander CPR. In Malaysia, medical dispatch is handled by Medical Emergency Coordination Centre (MECC) using the Medical Priority Dispatch System (MPDS) protocols. The objectives of our study is to identify the average time taken for dispatchers to recognize a suspected arrest situation and provide instructions for CPR.

MATERIALS AND METHODS
This is a prospective study conducted between April 2014 till May 2015. The study is part of the second Pan Asia Resuscitation Outcome Study (PAROS 2) that focuses DA-CPR performance. A total of 5 MECC in Malaysia participated in the study. The inclusion criteria are all calls received by MECC resulting in CPR performed or death identified by responders. The exclusion criteria are calls that were made for assistance to confirm death and also third party callers. Call recordings are reviewed for recognition of suspected arrest, provision of DA-CPR instructions and time taken from call to CPR instructions.

RESULTS
A total of 1380 calls were retrieved by our team. A total of 448 calls were then excluded based on exclusion criteria. Recognition of the need for CPR by our EMDs is 81%, while the rate of DA-CPR instruction provision is about 57%. The mean time taken for dispatcher in MECC to recognize the need for CPR is 28.7 seconds (SD±17.7 seconds). The mean time taken for DA-CPR instructions to be given is 2.32 minutes (SD±1.1 minutes).

DISCUSSION
Our study showed that using the AMPDS, our EMDs are able to recognize OHCA situations within 30 seconds of a call. However, there is a lag time of 2.32 minutes before DA-CPR instructions are given to caller. This may be due to lack of awareness on DA-CPR among population in Malaysia.
SIMULATING A HOSPITAL IN DISASTER, PLANNING THE LESSON.
Sarah S A Karim¹, Amir A Azman¹, Tong Ming W¹, Rosidah Ibrahim²,
Khairi Kassim³
¹Hospital Sungai Buloh, Selangor, Malaysia
²Hospital Serdang, Selangor, Malaysia
³Hospital Shah Alam, Selangor, Malaysia

INTRODUCTION
Disaster Management Plan is a requirement for all hospitals in Malaysia based on the Malaysian Hospital Accreditation Standards. Majority of hospitals based their disaster management plan on fire hazards. However, it is a known fact that hospitals are exposed to many other type of hazards either internally or externally.

CASE REPORT
We present a case of in-hospital disaster simulation with multiple hazards internal such as fire and chemical spillage combined with external hazardous material brought in by ambulance services. The simulation was done in Hospital Sungai Buloh beginning with fire outbreak coinciding with multiple patients with an unknown exposure to hazardous material, progressing to explosions that forced full building evacuation and declaration of hospital closure. The simulation exercise was done in collaboration with Fire and Rescue Services (BOMBA) for the Zone Shah Alam. The aim of the simulation was to test the resilience of the hospital disaster plan in face of multiple hazardous incidents and the capability of BOMBA to manage such incidents in a widespread area.

DISCUSSION AND CONCLUSION
It is a rare occasion to have hospitals to simulate disaster exercise of multiple hazards. The primary objectives of our team was to allow hospital personnel to be comfortable in execution of response plan but at the same time identify deficits in their preparation. The secondary objectives were to get the active involvement of State Health Department and Centre of Crisis Preparedness and Response of Ministry of Health. The Exercise Management Team paid special attention to planning of scenario, organization of various awareness program, and conduct Just in Time training programs. In such exercise it is easy to plan a simulation that lead to failure of the system and response than to create conducive learning environment allowing execution of a plan. Our experience will be helpful to other hospitals in simulating a hospital disaster exercise.
FLEXIBLE INTUBATION VIDEO ENDOSCOPE IN ED HOSPITAL SERDANG
Kheng Soo Ng
Emergency and Trauma Department, Hospital Serdang, Selangor, Malaysia

KEYWORDS
Flexible endoscopy, difficult airway, awake intubation.

Endotracheal intubation is the gold standard for maintaining airway patency and protection in critically ill patients. Conventional direct laryngoscopy is commonly performed but has many potential complications especially in patients with difficult or failed airways. These complications can significantly increase morbidity and mortality and should be avoided.

Recognizing a difficult airway is a vital component in the intubation process. Proper preparation of equipments and strategies should be planned in such cases. One such strategy is the usage of flexible endoscopy for endotracheal intubation in both anticipated and unanticipated difficult airways.

We report a total of eight cases which were intubated using flexible endoscopic awake intubation in Emergency Department (ED) of Hospital Serdang. All eight cases were predicted to have difficult airways to intubate, and consist of both medical and trauma patients. All of the endotracheal intubations were performed successfully in this cohort of patients with no complications.

Flexible endoscopic intubation of the awake patient is a safe and effective method to be used in the Emergency Department. It is the method of choice for intubating the anticipated difficult airway group of patients. Awake intubation can considerably reduce the risk of hypoxia. It allows the procedure in the conscious, spontaneously breathing patient to remain oxygenated using topical anaesthesia and mild sedation only until the endotracheal tube is place.
INTRODUCTION
Between December 2015 and March 2016, hospitals in the Klang Valley, Malaysia received a number of patients with similar extreme presentation followed by dramatic recovery. Ten cases from three institutions were studied and their diseases progress were analyzed. It revealed an almost forgotten disease, which requires high index of suspicion to diagnose yet, cheap but highly effective medicine to treat.

CASE REPORT
Ten Burmese males whose age ranging from 22 to 41 years old presented with worsening shortness of breath associated with abdominal pain and vomiting. Eight patients had been under detention for seven to ten months for being illegal immigrants. Eighty percent of patients were in shock and respiratory distress with severe metabolic acidosis, requiring intubation and haemodynamic support. Majority of them also had acute kidney and liver injuries. Point of care echocardiography revealed severe dilatation of the right heart with pericardial effusion. Diagnosis of Shoshin Beriberi was subsequently made and all patients were treated with high dose of intravenous thiamine. Dramatic recoveries were observed in 90.0 percent of patients with reversal of the heart, kidneys and liver injuries.

DISCUSSION
Shoshin Beriberi is a forgotten disease in some part of the world. It is due to thiamine deficiency that affects cells metabolism leading into low output cardiac failure. The diagnosis relies on high index of suspicion based on the history and clinical presentation as well as the dramatic improvement after thiamine administration. Difficult access to thiamine-enriched meals for more than three months increases the risk of the disease. Burmese male has the risk of developing the disease possibly due to their habits and lifestyle.

CONCLUSION
Thiamine has an important role in cardiac dysfunction of unknown origin. Awareness must be instilled among detention centres and prisons as prevention of Shoshin Beriberi is better and cheaper than the cure.

KEYWORDS
Shoshin Beriberi, Thiamine Deficiency, Low Output Cardiac Failure, Right Ventricle Dysfunction
INTRODUCTION
Dengue provides a diagnostic challenge to health care providers, especially in ensuring rapid diagnosis to reduce the morbidity. One of the most important parameters depicting dengue severity is evidence of plasma leakage, hence prediction of plasma leakage in dengue is vital. Bedside ultrasonography is an attractive tool that can be used to detect evidence of plasma leakage, detecting free fluid in potential space and evidence of gall bladder wall thickening, hence providing another armamentarium towards establishing dengue diagnosis and severity.

OBJECTIVE
This study is aiming to address accuracy of diagnosis and dengue severity categorization via ultrasonography without depending on laboratory index.

METHODOLOGY
A prospective studies carried out from September 2015 to March 2016. All adult patient age between 18- 65years with history of fever and ns1+ve /serology IG G or IGM was recruited in the study. All patient underwent protocolized bedside ultrasonography conducted by certified providers which include sonographic assessment of gall bladder wall, pleural cavity, peritoneal cavity and pericardial space. Bedside ultrasound was done upon patient arrival, and the assessment is repeated after 60 minutes if the first assessment was negative. The sensitivity (Sn), specificity (Sp), positive predictive value (PPV) and negative predictive value (NPV) of ultrasonography in detecting plasma leakage was analyzed. Result was tabulated in SPSS VERSION 24

RESULT
A total of 364 patient recruited and 228 had positive ultrasonography findings. 172  out of 228 (75.4%)  was subsequently diagnosed as severe dengue with findings such as ascites/pleural effusion and/or gallbladder (GB) wall thickening. 56 out of 228 (24.6%) who was initially diagnosed as non severe dengue were found to have positive ultrasonography findings, 28 (50%) them progressed to severe dengue. Patient whom came with dengue fever with warning sign 122 out of 228 (53%) has positive ultrasonography findings, 94 (77.0%) patients progressed into severe dengue.  Fifty severe dengue patient whom came with no clinical sign or symptom suggestive of plasma leakage found to have positive ultrasound findings. Sensitivity and specificity gallbladder wall edema was more pronounced in severe than in non-severe dengue patients and often preceded ascites/pleural effusion as the p value showed >0.001. The negative predictive value (NPV) of plasma leakage at Morrison’s pouch his 85.5%, NPV at splenorenal is 84.6%. and NPV at rectovesicle is 82.4%. As for sensitivity (Sn) and specificity (Sp), fluid collection at retrovesicle pouch has a Sp of 89% and Sn 4.9%. This showed high specificity but very poor
sensitivity. Meanwhile GB thickening showed specificity of 74.9% and NPV 86.3% which is highest among all other plasma leakage site. Pleural effusion also showed high specificity 79.8% and NPV 84%, but pericardial effusion showed high sensitivity 96.6% and low specificity with 83.7% negative predictive value. Gall bladder thickening noted more pronounce on the day 3-6 of illness in 93 patient, the diameter varied from 4.00mm-4.95mm. The GB wall diameter is >5.0mm in patient whom presented with combination (multiple sites) of plasma leakage such as gall bladder thickening and/or ascites and/or pleural effusion). When combining bedside ultrasonography with lactate showed to have p value of 0.00. Gall bladder thickening with raised hematocrit have p = 0.001.

CONCLUSIONS
Ultrasound is reliable prognostic and diagnostic tools in identifying plasma leakage, hence predicting the severity of diseases and progression of the diseases. Its also shown that when bedside ultrasound findings is combined with POCT result, the sensitivity and predictive values of diagnosing and classifying dengue severity is further enhanced. This is in contrast to using existing laboratory markers in isolation. Henceforth, such patients with evidence of plasma leakage should be managed as severe dengue and merits for intensive care monitoring to minimize the complication.
GENETIC VARIANTS THAT ARE ASSOCIATED WITH NEUROPSYCHIATRIC SYSTEMIC LUPUS ERYTHEMATOSUS: A META-ANALYSIS

Roger Ho
Department of Psychological Medicine, Yong Loo Lin School of Medicine National University of Singapore, Singapore

OBJECTIVE
While genetic risks have been implicated in systemic lupus erythematosus (SLE), the roles of various genotypes in neuropsychiatric SLE remain uncertain. The present meta-analysis aimed to combine data from different studies and evaluate the association between each genotype and the risk of developing NPSLE.

METHODS
Studies were searched and retrieved from online databases (PubMed, EMBASE, BIOSIS and Science Direct). Case-control studies containing available genotype frequencies of the gamma Fc region (FCγR) receptors II-A, III-A, and III-B; tumour necrosis factor–alpha (TNF-α); mannan-binding lectin (MBL); integrin alpha M (ITGAM); interleukin–1 (IL-1), IL-1β, and IL-6; IL-10 promoter; and vitamin D genes were chosen. The odds ratio (OR) with a 95% confidence interval (CI) was used to assess the strength of this association between NPSLE and SLE patients.

RESULTS
A total of 33 studies were considered in this meta-analysis. The results suggest that the homozygous FCγRIIIa 158 FF genotype (OR=1.89, p=0.03 for FF vs VV=FV), heterozygous FCγRIIIb NA1/2 genotype (OR=2.14, p=0.03 for NA1/2 vs NA 1/1; OR=1.81, p=0.04), and homozygous ITGAM rs1143679 HH genotype (OR=3.39, p=0.04 for HH vs RH; OR=3.11, p=0.048, for HH vs RR+RH) demonstrated a significant association with NPSLE. Polymorphisms of the TNF-α, MBL2, IL-1, IL-1β, IL-6, IL-10 promoter and vitamin D receptor genes did not show a statistically significant association with the risk of developing NPSLE (p>0.05).

DISCUSSION
This meta-analysis indicates that polymorphisms in the pathways of immune complex clearance, such as the FCγRIIIa, FCγRIIIb and ITGAM genotypes, are potential susceptibility genes for NPSLE.
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INTRODUCTION

Datura was traditionally used as treatment of asthma in some ancient cultures. With rise of public interest in so called alternative medicine some of the traditional treatment which has been abandoned is being used again, some with almost deadly consequence. We are presenting a case of middle aged man who developed anticholinergic toxidromes following datura ingestion following attempted treatment for asthma.

CASE REPORT

A 46 year old male presented with agitation, restlessness, tachypneic, hyperthermic, dry flush skin and tachycardia. History given by family members that he has taken some seeds of fruits mixed with coffee 1 hour earlier and woke up tachypneic and restlessness. The fruits were later identified Datura stramonium. Patient was having bronchospasm due his underlying hyperactive airway disease for which he has been experimenting with traditional. He was treated with activated charcoal and intravenous crystalloids for datura poisoning as well as given nebulized salbutamol for bronchospasm. The patient was treated symptomatically. Patient recovered from anticholinergic toxidromes few hours later but requires further treatment for bronchospasm which was treated as chronic obstructive airway disease. Further history from him later reveals later he has experimenting with datura both in form inhalation and ingestion as a form of treatment for what he thinks is asthma. He was discharged well the following day.

DISCUSSION

Datura is hallucinogenic and therefore has been used as drugs of abuse. It is also part of traditional treatment of asthma in various culture and tradition. It has been studied as treatment for hyperactive airway disease, especially by smoking in cigarette. It is found to be as potent as salbutamol in treating asthma in some studies. In the case presented here patient developed anticholinergic symptoms without being relieved of bronchospasm. It is risky to use datura outside medical supervision because likely to result in anticholinergic toxicity.
CASE STUDY: IMPORTANCE OF EARLY DIAGNOSIS OF TUBERCULOUS MENINGITIS USING GENEXPERT MTB/RIF OF CSF SAMPLES

G Kughan¹, G B Eow², C F Cheah²

¹Department of Medicine, Penang General Hospital, Penang, Malaysia
²Department of Neurology, Penang General Hospital, Penang, Malaysia

INTRODUCTION

Tuberculous meningitis is the most devastating consequence of infection with Mycobacterium tuberculosis (TB). Approximately a third of patients die soon after presenting to hospital, and many of those surviving are left with severe neurological sequelae. However, many patients are diagnosed late because initial signs are not specific, and rapid and sensitive diagnostic tests are lacking.

CASE REPORT

A 27 year old Burmese gentleman presented with fever, loss of appetite and headache with diplopia for one month. He had vomiting for ten days and altered behavior (increased agitation) for three days. On examination, patient had neck stiffness with positive meningeal signs and 6th nerve palsy bilaterally. He was treated as meningoencephalitis and commenced on intravenous Ceftriaxone and Acyclovir on arrival. CT Brain with contrast done showed diffuse leptomeningeal enhancement with communicating hydrocephalus. We proceeded with lumbar puncture, which showed a very high opening pressure (above 50 mmHg). Cerebrospinal fluid (CSF) showed elevated protein (1.310) and significantly reduced glucose level. However, CSF cell count was nil with no acid fast bacteria detected on Ziehl-Neelsen smear. CSF GeneXpert MTB/RIF showed MTB detection at low level with no rifampicin resistance. Patient was commenced on anti-TB medications (Isoniazid, Rifampicin, Streptomycin and Pyrazinamide). A ventriculo-peritoneal shunt was inserted by Neurosurgery Team, which improved patient’s level of consciousness. He completed intensive phase of anti-TB treatment for two months and is under maintenance phase for next ten months. His CSF Culture done in Mycobacterial Growth Indicator Tube (Bactec), which took about two weeks to be processed showed no growth.

DISCUSSION AND CONCLUSION

This case illustrates that early diagnosis of TB Meningitis is pivotal for early initiation of treatment and surgical interventions, if needed to prevent severe neurological sequelae. This case also reiterates the role of GeneXpert MTB/RIF as the most sensitive method in diagnosing TB Meningitis compared to other available diagnostic tests.
CASE STUDY: HYPERTROPHIC MENINGITIS WITH MULTISYSTEM INVOLVEMENT AS INITIAL PRESENTATION OF BEHÇET’S DISEASE

G Kughan¹, G B Eow², C F Cheah²

¹Department of Medicine, Penang General Hospital, Penang, Malaysia
²Department of Neurology, Penang General Hospital, Penang, Malaysia

INTRODUCTION

Behçet’s disease (BD) is a multisystem recurrent vasculitic disorder of unknown origin, which manifests as recurrent oral and genital ulcers, skin and eye alterations. Hypertrophic pachymeningitis is a rare disease characterized by localized or diffuse thickening of the dura mater of brain associated with infections, systemic autoimmune/vasculitic disorders, malignancy and meningioma.

CASE REPORT

A 35-year-old gentleman presented with two-year history of bilateral trismus and jaw pain which did not resolve, despite oral surgery was done. He also had fever, headache, blurring of vision with restricted left eye movement for three months. CT Brain and Orbit with contrast showed extensive pachymeningeal enhancement, bilateral retrobulbar mass and right infratemporal fossa lesion. MRI of Brain and Orbit showed diffuse pachymeningeal enhancement and inflammation of left recti muscles, right infratemporal and masticator spaces. Patient was empirically covered with antibiotics for meninigitis. Subsequently, he was started on anti-tuberculous treatment (anti-TB) due to high ESR and unresponsiveness to antibiotics. CSF results (cell count, biochemistry, C+S, acid-fast bacteria, MTB PCR, viral screening, GeneXpert) were not suggestive of infection. Despite being on anti-TB for eight months, fever did not resolve. Therefore, he was given trial of oral steroids (Tab Prednisalone) and his general condition improved. Due to worsening restriction of extraocular movement of left eye, left orbitotomy and retroorbital mass incisional biopsy were done. Left periorbital and orbital fat sent for histopathological examination showed neutrophilic vasculitis suggestive of Behcet’s disease. Currently, patient is started on Tab Azathioprine and being followed-up as outpatient.

DISCUSSION AND CONCLUSION

There should be high degree of suspicion about Behcet’s disease in patients with hypertrophic pachymeningitis with multisystem involvement although certain typical features such as recurrent oral and genital ulcerations are absent. Such atypical isolated cases has been reported worldwide. Early treatment with steroids are essential to halt progression of the disease and prevent serious complications.
Primary tension hemopneumothorax is a life threatening condition rarely encountered nowadays. This entity is defined as the accumulation of more than 400 mL of blood in pleural cavity associated with spontaneous pneumothorax in a previously healthy patient with no underlying lung disease. We described a case report of a young gentleman presenting with progressive worsening of breathlessness and chest pain associated with tachycardia and tachypnea to Emergency & Trauma Department, Hospital Sultanah Aminah Johor Bahru, Johor. Initial hemodynamic status was stable. Initial diagnosis of right spontaneous tension pneumothorax suggested by clinical findings and confirmed by radiographic findings was soon revealed to be a right spontaneous tension hemopneumothorax due to persistent hemoserous drainage after tube thoracostomy. He was then subject for right thoracotomy due to persistent bleeding and torn vascularized bullae was found to be the source of the bleeding intraoperatively. He was discharged without any complication after 9 days of hospital admission. We also performed electronic searches on PubMed, Medline and a general web search using Google scholar to review any literatures in relation to this rare clinical situation and their clinical presentations, possible causes and effective treatment modalities.

**KEYWORDS**
Primary tension hemopnuemothorax, emergency department/unit
BOERHAAVE SYNDROME: NOT THAT RARE?

J Ding, R Rahmat, N A Roslan
Hospital Sultan Ismail, Johor Bahru, Johor, Malaysia

KEYWORDS
Boerhaave Syndrome, Esophageal perforation

INTRODUCTION
Boerhaave Syndrome, the spontaneous rupture of the esophagus is a rare condition which carries a high mortality rate. Definitive treatment is surgical repair. Mortality is usually caused by mediastinitis, pericarditis, pneumonitis and empyema leading to sepsis and shock

CASE REPORT
A 38 year old man presented with complaints of vomiting coffee ground vomitus, epigastric pain and dyspnea. On examination he was pale, ill and tachycardic but blood pressure remained stable. There were reduced breath sounds over the left side and abdomen was tender and tense. Sepsis was clearly evident by leukocytosis, high BUN and metabolic acidosis; low hemoglobin signified considerable blood loss. Chest X-ray noted a hydropneumothorax over the left side. Nasogastric and thoracostomy tube drained coffee ground contents. The diagnosis of Boerhaave syndrome was confirmed with an OGDS revealing a perforation just above the cardioesophageal junction. Despite aggressively resuscitated with fluids, transfusion of blood products, started on broad spectrum antibiotic and admitted to ICU, He was clearly moribund within hours and a plan for surgical intervention failed to materialize due to his deteriorating condition. He succumbed after 2 days

DISCUSSION
Boerhaave syndrome is a spontaneous transmural perforation of the esophagus commonly involving the left side of the lower esophagus just above the diaphragm. The diagnosis of this condition is often challenging. In this patient although Mackler’s triad was absent, the diagnosis was established by a history of forceful emesis with signs clearly demonstrating communication between the esophagus and the pleural cavity. His condition was critical and prognosis guarded on presentation as he was in severe sepsis compounded by significant blood loss. Even with prompt treatment and surgery i.e. thoracotomy, lavage and repair of esophagus, patient outcome would have been poor.

CONCLUSION
Boerhaave syndrome is invariably fatal without intervention. It should be promptly diagnose and aggressively treated to prevent mortality.

REFERENCES
AIRBAGS RECALLED: A SIBU EXPERIENCE

C M Lau, D C Chai
Sibu Hospital, Sibu, Sarawak, Malaysia

KEYWORDS
Airbag recall, Perimortem Caesarean, Trauma

INTRODUCTION
This case describes the management of a pregnant women whom involved in a faulty airbag-related lethal road traffic accident. Perimortem Caesarean-section was performed in the emergency department as the women was unsalvageable. Massive consequences followed after this incident, led to international recall of thousands of vehicle and international lawsuit. This case is analyzed to seek for rooms of improvement in resuscitation.

CASE REPORT
A 43 year old female car driver at 37 weeks of pregnancy was brought in by the ambulance with no signs of life. She sustained bleeding from the neck and was unconscious after the car accident. Her husband described it as a “bump” on the car instead of a head-on collision. A deep laceration wound was noted which cut through her anterior neck and trachea. Endotracheal tube inserted directly into the trachea. Bedside scan revealed no maternal cardiac activity but fetal bradycardia was noted. Cardiorespiratory resuscitation was continued to maintain fetal perfusion. Obstetric team attended the patient and performed a perimortem Caesarean-section at the emergency department. Resuscitation stopped after the procedure as the patient showed signs of inevitable death. Baby was resuscitated immediately by attending paediatric team. Post-mortem revealed a metal shrapnel inside of her neck which was believed to be originated from the vehicle’s airbag.

DISCUSSION & CONCLUSION
Communication between pre-hospital care team and the attending team in the hospital needs to be improved. Trauma team including obstetric and pediatric team should be activated as soon as possible. Swift decision making for the procedure is also needed as to minimize delays. Seamless cooperation of pre-hospital care, trauma, obstetric and pediatric teams is crucial to ensure good outcome of both mother and fetus.
“NOT EVERY YOUNG MEN HAS A STRONG HEART” – EVALUATE CARDIAC FUNCTION IN YOUNG SEPTIC PATIENT

Chai Dek Chiun, Kevin Wong Chuang Shen
Sibu Hospital, Sibu, Sarawak, Malaysia

INTRODUCTION

Prevalence of sepsis is 20–30% in Malaysia with mortality of 16%. Despite having guidelines and new definition, management of sepsis is still challenging especially when complicated by other underlying conditions which might be overlooked. This is a patient with atypical sepsis that we encounter in our center.

CASE REPORT

18 year-old gentleman presented with 1 month of abdominal pain and jaundice. In district hospital patient was intubated for respiratory distress, started on IV noradrenaline infusion for persistent hypotension despite given crystalloid infusion. Full blood count shows white cell count 16.1x103/µL, haemoglobin 16.4g/dL, platelet 521x103/µL. ECG shows sinus tachycardia with right axis deviation and chest X-ray shows cardiomegaly. Patient was treated as septic shock secondary to acute hepatitis and was sent to us. In emergency department blood pressure crashed despite high dose IV noradrenaline. Bedside scan noted dilated and non-collapsible IVC, a hypokinetic heart with grossly dilated right ventricle and right atrium. Blood pressure picked up after starting IV dobutamine infusion. Further history from patient’s schoolmate noted that patient has history of substance abuse. While waiting in ward for ICU bed, patient entered into pulseless electrical activity (PEA) and succumbs despite performing CPR.

DISCUSSION & CONCLUSION

This patient has septic shock complicated by right heart failure with underlying recreational drug-induced dilated cardiomyopathy, which is atypical and easily missed. In a young adult with right heart failure, more history and workup is required to look for the cause. Methamphetamine (also known as ‘ice’) and amphetamine are the common substance abuse in Malaysia. These drugs expose the heart to excessive catecholamine concentration, leading to dilated cardiomyopathy. Refractory shock prompts us to look for other coexisting problem contributing to shock. Ultrasound is a helpful adjunct in shock management to access fluid status and cardiac function.

KEYWORDS

Sepsis, cardiomyopathy, substance abuse, Sibu.
“MOM, I PEE OUT STONES!” – PAEDIATRIC UROLITHIASIS

Chai Dek Chiun, Kevin Wong Chuing Shen
Sibu Hospital, Sibu, Sarawak, Malaysia

INTRODUCTION
Paediatric urolithiasis is rare (14.5 per 100,000) and usually presented with vague symptoms like abdominal pain which are easily attributed to other more common conditions. Correct diagnosis is often delayed and complicated with end stage renal failure.

CASE REPORT
8 year-old girl presented with dysuria and lower abdominal pain for 10 months. All the while she was treated as recurrent urinary tract infection in polyclinic. Subsequently patient getting more lethargic, more pale, and puffy. Further history noted patient was passing stones in urine intermittently for 4 months with largest stone of 1cm, with consanguineous parents and two out of five of her siblings passed away at young age due to renal disorder. Full blood count shows microcytic hypochromic anaemia (haemoglobin 5.3g/dL), renal profile shows urea 42.6mmol/L, potassium 5.6mmol/L, creatinine 1,510µmol/L. Electrolytes shows hypocalcemia 1.14mmol/L, hyperphosphataemia 2.6mmol/L. Serum uric acid 523µmol/L. ALP 336U/L. Blood gases shows severe metabolic acidosis with bicarbonate 9.7mmol/L. Random urine calcium/creatinine ratio is 0.13 (normal <0.09 in 7-8 year-old girl). Abdominal X-ray and ultrasound show right staghorn calculi with left renal calculi. Patient was referred to Sarawak General Hospital for haemodialysis, extracorporeal shock wave lithotripsy and further workup for inherited disorders.

DISCUSSION & CONCLUSION
Hypocalcemia with hypercalciuria is suggestive of familial idiopathic hypercalciuria (4 per hundred) and hypoparathyroidism (7.2 per million). Extensive pedigree with further investigations is needed. Patient with multiple visits with similar presentation warrants for further investigations. High index of suspicion of inherited disease is required; early onset of disease, positive family history and consanguineous parents are the red flags to prompt for further investigation. “Horses” are more common, but we should not forget the “zebras”.

KEYWORDS
Paediatric, urolithiasis, Sibu, Malaysia.
THE FAT THAT RAN AWAY
Loke Kien Yip, Syed Shahrul Naz, Datin Ranjini

INTRODUCTION
Fat embolism syndrome (FES) usually results from trauma and typically presents between 30 minutes and 48 hours post injury. The following case demonstrates the similarity of fat embolism to the commoner pulmonary embolism where both presented with a syndromic interpretation of acute respiratory distress.

CASE REPORT
A 12-year-old boy was brought to Red Zone on 31st January 2016; presented with dyspnoeic since morning. He had a history of left femur fracture put on implant twice in May and August last year. He also had a trauma to the left ankle a day before presentation.

On arrival, he is alert but noted to be tachypneic and tachycardia. His blood pressure was normal. Lungs auscultation and other systemic examination were unremarkable except for swelling and tenderness over left ankle region. Noted also petechial rashes over the body. Saturation was 100% on high flow mask oxygenation.

Bedside echo found an enlarged right ventricles with a plethoric inferior vena cava. Electrocardiogram showed sinus tachycardia with an S1Q3T3 presentation. Arterial blood gas showed metabolic acidosis, lactate of 14 and pO2 of 239. His full blood count was normal except total white cell of 23.5/uL. D-dimer recorded 6498ng/mL. Also sustained closed fracture distal third tibia.

The patient was brought into ICU and intubated. Then was decided for thrombolysis based on ECHO findings and D-dimer. However, CTPA done post metalyse showed likely to be pulmonary fat embolism with no evidence of pulmonary artery thromboembolism as no filling defect seen.

DISCUSSION
There is no gold standard test for diagnosing FES; it is a clinical diagnosis.

The Classical triad of respiratory symptoms, neurological abnormalities, and petechial rashes may not be all present. Gurd & Wilson criteria requiring 1 of 3 major criteria and four minor criteria (see table). A chest x-ray is usually normal initially but may reveal increasing diffuse bilateral pulmonary infiltrates. ECG of S1Q3T3 does not confirm pulmonary embolism but rather acute pressure and volume overload of the right ventricle. The presence of fat globules, either in sputum, urine, wedged pulmonary catheter or even bronchoscopy to diagnose FES lack specificity and sensitivity.

CONCLUSION
In the patient presenting with a syndromic interpretation of acute respiratory distress, a high index of suspicion of fat embolism should be entertained especially if there was a recent trauma to the skeletal system. However, a non-traumatic situation like acute pancreatitis and sickle cell crisis may also cause fat embolism syndrome.
Clinical reasoning describes cognitive process involved in medical decision-making. This process requires effective cognitive skill to arrive to a final diagnosis through a series of inferences derived from medical histories, physical examination findings as well as laboratory data. Effective decision making is very important in emergency department which is loaded with the highest decision densities as well as diagnostic uncertainty among all other medical fields. Emergency physicians not only facing the physical challenges of doing long hour, demanding shift work but also mental challenges of high cognitive load. Various clinical decision making strategies have been reported by literatures but no research has yet to define the prevalence of any of them. Using a real case scenario of a 34 years old Sarawakian lady presented with respiratory distress to Emergency & Trauma Department of Hospital Sultanah Aminah Johor Bahru who eventually succumbed to endotracheal intubation with a final diagnosis of advanced retroviral disease with pneumocystis pneumonia (PCP), various types of clinical decision making strategies are being discussed in different clinical phases before arriving to the final diagnosis. The advantages and disadvantages of each method are also being highlighted. In conclusion, there should be increase emphasize on learning and teaching decision making strategies and it’s underlying cognitive phenomena to help emergency physicians’ clinical decision process become more effective and less error prone.

**KEY WORDS**
clinical decision making, cognitive reasoning, emergency department/unit, emergency physicians
A CASE OF TRAUMATIC CARDIAC TAMPONADE – TEMPORIZED BY ULTRASOUND GUIDED PERICARDIOCENTESIS

Suresh N, Pratab G, Zarina N
Hospital Seberang Jaya, Penang, Malaysia

Cardiac tamponade, pericardiocentesis, open heart surgery

INTRODUCTION
Cardiac tamponade is a life threatening injury following trauma where life can be saved with appropriate and timely intervention. Several studies have been published about management of cardiac tamponade comparing pericardiocentesis vs open surgery. In absence of cardiothoracic surgeon, pericardiocentesis remains the only option for treatment for cardiac tamponade. We present here a successful case of cardiac tamponade managed solely by pericardiocentesis under echo guidance.

CASE REPORT
A 37 year old man involved in motor vehicular accident was brought to emergency services by local EMS services. On presentation he was restless and agitated, tachypneic with vital sign in extremis. Bedside ultrasound shows no free fluid in abdomen and positive sliding sign in lungs however echo shows pericardial fluid collection with diastolic ventricular collapse. Pericardiocentesis were performed successfully under ultrasound guidance and catheter was anchored for future aspiration. Vital improved following pericardiocentesis, but patient required intubation due to type 1 respiratory failure due to lung contusion. He was subsequently transferred to centre with cardiothoracic unit. Patient was subsequently discharged well on day 15.

DISCUSSION
While studies have shown superiority of open heart surgery compared to pericardiocentesis, but in centers without cardiothoracic surgery, option to surgery is not available. As such pericardiocentesis might be the only option available, and sometimes may be the only treatment needed without proceeding to surgical repair as seen in this case. Medical literature is scarce regarding comparison of pericardiocentesis as sole management for cardiac tamponade vs open heart surgery in trauma. More study needed to compare between this two methods to find out if pericardiocentesis alone could be successful in managing traumatic cardiac tamponade.
A SPONTANEOUS CORONARY ARTERY DISSECTION: ACUTE MYOCARDIAL INFARCTION IN FEMALE WITH NO CARDIOVASCULAR RISK FACTORS

Victor Au¹, Cheng Ho Ang²

¹Emergency Department, RIPAS Hospital, Brunei Darussalam
²Cardiac unit, Gleneagles Jerudong Park Medical Center, Brunei Darussalam

INTRODUCTION
Spontaneous Coronary Artery Dissection (SCAD) is a rare cardiac emergency condition that occur due to spontaneous separation of the coronary arterial walls with or without intramural hematoma, causing acute coronary syndrome.

CASE STUDY
A 42 year-old Malay female who just delivered her fourth baby 6 weeks ago, with no risk factors of cardiovascular disease presented to emergency department with acute onset of central chest pain. Vital signs and physical examination was otherwise unremarkable. An electrocardiography showed dynamic ischemic changes in antero-lateral lead. Cardiac marker showed raise troponin t level. She was treated as NSTEMI. Angiography and intravascular ultrasound confirmed the present of spontaneous dissection + intramural haematoma in the mid left anterior descending coronary artery causing 90% coronary stenosis. Drug eluting stent was placed successfully at the lesion with no residual stenosis.

DISCUSSION
The prevalence of SCAD has been reported to be as high as 1% to 4% of ACS overall 3 and up to 80% of the cases happened in female4. SCAD patients are typically in young women who do not have risk factors for atherosclerosis. Although the pathophysiology of SCAD is not clearly understood, few related conditions has been identified such as pregnancy and postpartum period, fibromuscular dysplasia, extreme physical exertion or emotional stress, coronary vasospasm, hypertensive crisis, connective tissue disorders, and cocaine used4.

CONCLUSION
Acute myocardial infarction is not solely due to ruptured atherosclerosis plaque. Consider SCAD in young female who presented with angina without cardiovascular risk factors.

KEY WORDS
Spontaneous coronary artery dissection, acute coronary syndrome, non-ST elevated myocardial infarction (NSTEMI), angina.
The number of drugs which adversely affect the respiratory system continues to increase and their effects pose a great challenge to all physicians. The range of reactions is wide, from familial simple pharmacological effects through less well understood reactions to the infective complications of immunosuppressants.

A 28-years old male with no significant medical history presented to ED with acute respiratory distress. He was intubated and placed on broad spectrum spectrum antibiotics. Initial blood gas investigation was suggestive of Type 2 Respiratory Failure. He was then diagnosed with ARDS (PaO2:F_iO2<200 and bilateral lung infiltrates present on chest X-ray) related to substance abuse, which was confirmed through subsequent further history and a positive urine toxicology screen (positive for metamphetamine). The diagnosis was made after further exclusion of other etiological factors. Patient was admitted to ICU and empiric antibiotics, diuretics was continued there. Echocardiogram showed normal findings, CT Thorax reported as extensive consolidations and ground glass changes in both lungs. Patient’s ventilation was weaned down and subsequently extubated on the second day of ICU admission. Repeated chest X-ray after 48 hours of presentation showed lesser infiltrates on bilateral lung in comparison with the previous X-ray. Patient recovered within 6 days of ICU admission and was discharged then with subsequent follow up given.

Drug induced ARDS is a diagnosis of exclusion. There is the need to rule out other disease before making the diagnosis of drug induced ARDS. Drug Induced ARDS can be suspected if a patient is exposed to the drug develops new signs and symptoms and has a remittance of these symptoms once the drug is withheld. Similarly, the rapid improvement with no serious overall sequelae is unique and may be related to the underlying cause of ARDS in this patient.
A RARE CASE OF CHRONIC ECTOPIC PREGNANCY

J Ding, R Rahmat, S A Cha
Hospital Sultan Ismail, Johor Bahru, Johor, Malaysia

KEYWORDS
Chronic Ectopic Pregnancy, Urine Pregnancy Test

INTRODUCTION
Chronic Ectopic pregnancy is an enigma which accounts for 6% of all ectopic pregnancies. The diagnosis is confounded by stable hemodynamics, chronic symptoms and high incidence of false negative pregnancy test; and often diagnosed on surgical exploration. Characteristic findings include chronic inflammatory mass and degenerated trophoblastic tissue.

CASE REPORT
A 44 year old multiparous widow presented with 2 days of fever, abdominal pain, diarrhea and vomiting. She was unable to recall her LMP and denied PV bleeding. Treated as acute gastroenteritis, she was discharged but returned hours later in severe sepsis. Right iliac fossa was tender and guarded. UPT was negative. Although having a normal full blood count, acute renal failure and severe metabolic acidosis had set in. A provisional diagnosis of intraabdominal sepsis was made and was referred to surgical team. She was resuscitated and started on IV antibiotics, but deteriorated rapidly in the ward, was intubated and admitted to ICU. A CT abdomen noted bilateral pleural effusion, free fluid in the peritoneal cavity and features of ileitis. The decision was therefore made to continue medical therapy. Unfortunately she succumbed 2 days later. A post mortem revealed a right ovarian inflammatory mass. Histopathology showed gestational trophoblastic tissue, establishing a diagnosis of an undetected chronic ectopic ovarian pregnancy

DISCUSSION
Unlike ‘acute’ ectopic pregnancy which clinicians are more acquainted to, chronic ectopic pregnancy is a diagnostic challenge due to high incidence of negative pregnancy tests as a consequence of the very small amount of live villi, subtle symptoms and poor specificity on sonography. It may mimic other surgical or medical conditons. A CT or TVS with Doppler may be helpful but often than not is found during surgery. The treatment involves either conservative surgery or methotrexate therapy.

CONCLUSION
Diagnosis of chronic ectopic pregnancy requires high index of suspicion. Although rare its importance should never be understated.
INTRODUCTION
Acute pulmonary embolism is a disease which is fatal and often easily missed as it may mimic cardiac diseases.

CASE REPORT
We report two cases of acute PE presenting with ACS. The first case was a 64-year-old female with underlying diabetes mellitus and hypertension. She presented with sudden onset of shortness of breath associated with left sided chest pain, diaphoresis, nausea and vomiting. On examination, she was tachycardic and tachypneic with low oxygen saturation. Chest X-ray revealed blunting of costophrenic angle bilaterally. ECG showed ST-elevation at inferior leads with reciprocal changes. Bedside ECHO was normal. In view of a recent major gynaecological surgery, D-dimer was done and tested positive. CTPA revealed PE. The second case involved an 81-year-old female with underlying hypertension and history of right hip fracture 3 years ago. She presented with sudden onset of shortness of breath with chest discomfort. Clinically, patient was tachypneic with low oxygen saturation. Respiratory examinations were unremarkable. ECG showed T-inversion in inferior and anterior leads. Cardiac enzymes were not raised. Bedside ECHO revealed dilated right ventricle with hypokinesia. CTPA showed an extensive PE with right lung infarction.

DISCUSSION
Several ECG changes in PE have been reported with sinus tachycardia being the most common. Even the ‘classic’ S1Q3T3 pattern is found in 20% of patients only. This finding is not specific nor sensitive. We would like to highlight other ECG changes suggestive of myocardial ischemia mimicking PE. ST elevation in inferior leads in PE have been reported but is extremely rare. Furthermore, simultaneous T-wave inversions in anterior and inferior leads are also found in only 4 – 11% cases of PE.

CONCLUSION
A high index of suspicion of PE should always be raised in patients with ECG changes suggestive of a myocardial ischemia whom the clinical presentation does not tally with a possible cardiac event.

KEYWORDS
Pulmonary embolism, acute coronary syndrome, electrocardiogram in pulmonary embolism, ST-segment elevation, echocardiogram

REFERENCES
INTRODUCTION
Cardiomyopathy can go undetected with grave consequences, especially in young active adults. Non-compacted ventricular myocardium (NVM) is a unique disease where there is incomplete compaction of the ventricular wall during intrauterine life. As a result, the heart becomes sponge like, thickened, with poor reserve. Complications include arrhythmia, heart failure and systemic embolic event.

CASE REPORT
21 years old, collapsed after playing futsal. There was no bystander CPR. He was brought to nearby private hospital and was resuscitated for 50 minutes, during which he had persistent VF. ROSC achieved. He was then transferred to our facility 2 hours later. He had a history of syncope one week prior after playing futsal, but did not seek medical attention.

On arrival to our centre, the patient was ventilated, supported with double inotropes. There was a severe acidosis, with pH 6.4, pCO2 104, HCO3 11.6, lactate 7. He arrested shortly after arrival and had 4 cardiac arrest events. Bedside echo showed thickened ventricles bilaterally with trabeculation, poor contractility and enlarged right ventricle. He succumbed 2 hours later despite maximum resuscitation.

Post mortem findings showed myocardial infarction secondary to noncompacted biventricular cardiomyopathy.

DISCUSSION & CONCLUSION
Syncope in young patients should warrant further investigation to rule out several important diagnosis such as aortic insufficiency and cardiomyopathies. Therefore, we recommend bedside echocardiography by emergency physician.

The management of collapsed patient with NVM is even more challenging. The non compaction of the heart, coupled with thickened ventricular wall leads to ineffective contraction with reduce potential energy. The numerous trabeculation can lead to both abnormal relaxation and restrictive filling, hence diastolic dysfunction. This patient most likely has both systolic and diastolic dysfunction. Fluid, inotropic and vasopressor management is difficult. Physician requires multidisciplinary input as well as other adjuncts including bedside echo and cardiac output monitoring.
INTRODUCTION
Heat stroke is a life threatening illness characterized by hyperthermia and altered mental status after exposure to the hot weather. The global heat wave caused by El Nino phenomenon recently affected Malaysia with many suffering health consequences. We report the case of the first victim, a 23-year-old young trainee policeman who died of heatstroke after exposed to the hot environment during his training.

CASE REPORT
A 23 years old Malay man, who just enrolled in police training program, has been brought to Emergency & Trauma Department (ETD) Hospital Segamat after fainted during his training session. He was initially brought to nearby public health clinic. Unfortunately, it took nearly two hours for patient to arrive in ETD Hospital Segamat. His GCS upon arrival was 9/15 with the temperature of 40.2°C. Without delay, patient was intubated to secure the airway. With the working diagnosis of heat stroke at that moment, aggressive cooling therapies were started in the ETD. After three hours of resuscitation in emergency department, he was admitted to ICU for definitive care. His condition was further complicated by disseminated intravascular coagulation (DIVC) and refractory hypotension. He died on day two of admission with the cause of death of heat stroke complicated with DIVC and severe lactic acidosis.

DISCUSSION & CONCLUSION
This unfortunate case demonstrates the fundamental importance of early recognition and prompt treatment of heat stroke. In this case, failure to recognize with the delay of first aid and cooling, lead to poor outcome. With the relatively uncommon El Nino phenomenon, several preventive measures should be taken, these involve identification of vulnerable individuals like police and military trainee, dissemination of information about dangerous heat waves may help to prevent life-threatening heat stroke.
ERYTHRODERMIC PSORIASIS – A POTENTIALLY LIFE-THREATENING DERMATOSIS: A CASE REPORT

Thai Lun Tan, Wai Mun Chung, Ihsan Ismail
Department of Emergency, Hospital Taiping, Perak, Malaysia

KEYWORDS
Erythroderma, Erythrodermic Psoriasis, Acute Skin Failure

INTRODUCTION
Erythroderma is a dermatological emergency defined as erythema and scaling occurring in a generalized distribution involving more than 90% of the total body surface area. Widespread alterations of the skin functions could result in a number of complications which are known collectively as acute skin failure.

CASE REPORT
We report a case of erythrodermic psoriasis in a 37 year old Malay male prisoner with underlying Hepatitis C Virus infection and unstable plaque psoriasis. He presented with rapid worsening of his psoriatic lesions which eventually affecting his entire body surface area associated with pruritus and erythema within one week duration. Patient was admitted for medical stabilization. He was eventually discharged well at day 13 of admission and PASI was reduced from 72.0 to 2.7. (PASI: Psoriatic Area Severity Index)

DISCUSSION & CONCLUSION
Erythroderma can be life-threatening, primarily because of it’s metabolic burden and complications. Hence, it is mandatory to establish it’s etiopathology in order to facilitate precise management. This disorder may be the morphologic presentation of a variety of cutaneous and systemic diseases, and a thorough workup is essential. A pre-existing dermatosis is the single most common cause of adult erythroderma. Pathogenesis of acute skin failure involves failure of the skin to perform its multiple functions which would result in the potentially fatal syndrome of acute skin failure. This case report underscores the importance of understanding the etiopathogenesis of various systemic complications of acute skin failure which require prompt treatment. Speculative mechanisms for complications of acute skin failure and the implications for clinical practice are discussed.
INTRODUCTION
Posterior circulation infarct is a debilitating disease and often easily missed as it may mimic any peripheral causes of vertigo.

REPORT
A 61 years old lady with underlying diabetes mellitus and hypertension presented with symptom of vertigo for nearly two hours before she decided to come to the Emergency Department. It was associated with nausea and vomiting and she could not walk due to it. On examination, the Dix-Hallpike test was positive on the right side. Cerebellar signs were not elicited and there was no focal neurological deficit. Blood investigations were reported to be normal. Her symptom of vertigo improved after administering intravenous prochlorperazine and she was subsequently discharged with a scheduled follow up. However, fourteen hours later, she returned with worsening of vertigo and a deteriorating GCS requiring airway protection.

DISCUSSION
There exists a dilemma when differentiating a central or peripheral cause of vertigo. When a stroke which is one of the central causes of vertigo is missed, the consequences can be profound. Therefore, a non-invasive 3 steps bedside clinical examination like HINTS test (Head Impulse-Nystagmus-Test of Skew) should be practiced in every patient that presents with vertigo. As reported by one study, it is 100% sensitive and 96% specific for detecting posterior circulation stroke.

CONCLUSION
A high index of suspicion of posterior circulation infarct should always be raised in patients with persistent, unresolved vertigo. The HINTS test is capable to distinguish between stroke and other peripheral causes of vertigo as it has a high sensitivity and specificity.
INTRODUCTION

About 12% of Malaysian aged between 18 and 60 has mental health issues. Between one and two suicides were reported daily in Malaysia. We present a case that we had encountered in our hospital whereby uncontrolled psychiatry symptoms leads to multiple attempts of suicide and hospital admissions.

CASE REPORT

This is a 46 years old gentleman underlying schizophrenia and depression on follow-up. He is a poorly controlled psychiatry case with history of multiple suicidal attempts. His last attempt was a week ago before current admission. He presented to emergency department at 3.45pm with alleged poison ingestion and had vomiting and diarrhea. Physical examination was unremarkable. Blood gas shows metabolic acidosis. Medical and psychiatry referral was made. Prior to admission, he was stable and calm. He arrived to the ward at 7.00pm and was reviewed by the medical officer at 8.30pm. He attempted to commit suicide by jumping off from the second floor of the hospital building at 3.00am the following day and sustained life threatening injuries: intracranial hemorrhage and multiple pelvic and spine fractures. He was intubated and required intensive care.

DISCUSSION & CONCLUSION

There were multiple pitfalls identified in this case. There was lack of close monitoring and suicidal precaution for this patient in the ward. Patient has resistant psychotic symptoms and main stressor (erectile dysfunction) was not managed adequately. Poor security in the hospital leads to failure in preventing untoward incident from happening. In conclusion, recurrent admissions with no previous adverse incident lead to hospital staff taking this patient with high suicidal risk lightly. Unfortunately, the patient was not seen as a whole, thus leads to this catastrophic incident. We seek to improve on those aspects to prevent such incident from happening again in the near future.

KEYWORDS

Suicide, psychiatry, Sibu, Malaysia.
INTRODUCTION
This is the case of a pediatric patient with diabetic ketoacidosis whom symptoms were undetected on her initial visit to ED.

CASE REPORT
A 2 year old previously healthy girl first presented to ED with vomiting for 2 days. The vomiting was non projectile with no blood or bile, no diarrhea, without preceding trauma or fever. She was diagnosed as acute gastroenteritis and discharged home. 12 hours later, she presented again with lethargy and rapid breathing. On further questioning, she had increase in fluid consumption and polyuria since the course of the illness. Initial assessment revealed drowsiness, lethargy, pale, Kussmaul’s breathing, moderate dehydration with estimated fluid deficit of 7.5%. She was normotensive with BP 110/60 mmHg (MAP 70), tachycardic (HR 150/minute), SpO₂ 96% and normothermic (temperature 37.2°C). Her blood glucose level was 37 mmol/L with severe acidosis (venous pH 6.8, HCO₃ too low, lactate 2.6, BE -28) and serum ketone 4.7. Full blood count shows leukocytosis with white cell counts of 17.3 (lymphocytes 50%, neutrophils 43%), platelets of 590 and hemoglobin of 12.9 g/dL. Blood urea was high (6.6), however liver enzymes and electrolytes were all within normal limit. Initial saline bolus of 100 ml over the first hour was started, followed by 7.5% correction using 16 ml/hour of saline over 48 hours and maintenance using half saline mixed with 1g KCL at a rate of 40ml/hour. Insulin infusion was started at a rate of 0.1 unit/kg/hour and was transferred to PICU.

DISCUSSION & CONCLUSION
Diagnosing DKA in pediatric patient can be challenging, especially when the staff is unfamiliar with such case as they usually present with vague symptoms without known history of diabetes. This unfortunate case demonstrates the importance of high level of suspicion and considering glucose as the sixth vital sign in sick child.
INTRODUCTION
Pneumopericardium is defined as collection of air or gas in the pericardial cavity. It is a rare complication of tuberculosis and HIV. Pneumopericardium most commonly results from trauma, approximately 60%, other causes can be due to iatrogenic and noniatrogenic. Development of spontaneous pneumopericardium is a very rare complication of tuberculosis with coexisting HIV infection.

CASE REPORT
22 year old, male, no known medical illness, not obese. Presented to Emergency Department due to on and off pleuritic chest pain for the past 2 weeks, associated with mild dyspnea. Pain is relieved by rest and leaning forward. On examination patient alert, pink, not tachypneic. Vital signs was stable, Lungs clear, equal air entry, no hyperresonance, CVS no murmurs and no pericardial rub, per abdomen soft non tender. Chest xray erect done showed lucencies around the right and left heart border suggestive of pneumopericardium, no pneumothorax or mediastinal mass. ECG, sinus rhythm with no acute ischaemic changes. Patient remained stable and was admitted to ward for further investigation.

DISCUSSION AND CONCLUSION
Spontaneous pneumopericardium is a very case. Cases that have been reported usually are related to tuberculosis and immunocompromised patients, which is not in this case. The pathogenesis of pneumopericardium is increase in intra-alveolar pressure with alveolar overdistention that results in rupture of alveolar walls, allowing air to travel through the pulmonary interstitium along perivascular sheaths to the lung hilum and mediastinum and to the pericardial reflection. Pericardial connective tissue is discontinuous at the reflection of parietal onto visceral pericardium near the ostia of the pulmonary veins so that there is a site of potential weakness where a microscopic dissection of air into the pericardial sac is possible. It is potential that in this case it is related to vasalva maneuver with forced expiration against a closed glottis in exertional activity.
Almost all causes of scalp abscess is due to direct introduction of microbes into the subgaleal space after disruption of skin barrier (laceration, or puncture wounds). Infected scalp hematoma without interruption of skin barrier is rarely reported. Mr S, 35-year-old IVDU was brought by the prison officer with a complaint of worsening right sided scalp expanding hematoma for more than a month. He was assaulted with a blunt object prior to that and did not seek any medical treatment up until the current visit. He denied of any external wound or bleeding from the site during the attack. Other than the pain over the scalp he did not have fever, loss of appetite or change in behavior. Computer tomographic scan showed right subgaleal collection with extradural extension and right temporal bone fracture. He was referred to neurosurgery team and subsequently a craniectomy, exploration and evacuation of abscess was done. Intraoperatively, the temporalis muscle was unhealthy with sloughy dura. He was started on antibiotic and discharged home well.

The diagnosis and treatment of subgaleal abscess are often not complicated. Nevertheless, this condition is usually affiliated with extended morbidities such as seizure or sepsis and diagnosis might be missed initially. High level of suspicion of an abscess is especially suspected in the immunocompromised with non resolving and expanding hematoma. Identification of this condition is usually made with history of prolonged swelling, increased inflammatory markers and a computer tomography scan that showed subgaleal collection. The recommended treatment for this is surgical incision and careful debridement followed by appropriate systemic antimicrobial therapy for a week with continuation of oral therapy for another week.
RECURRENT PNEUMOTHORAX IN RESPIRATORY FAILURE TYPE II
– TO ASPIRATE OR NOT TO ASPIRATE

Cecilia Anthonysamy, Ng Keng So, Rosidah Ibrahim
Serdang Hospital, Selangor, Malaysia

INTRODUCTION
In elderly with poor premorbid, advance management decision is complex and difficult.

CASE REPORT
An elderly gentlemen with underlying history of COPD, presented gasping with respiratory failure type II. He had minimal mobility at home for the past five months. He could only walk from his bed to the toilet. However he was ventilated two months ago and discharged well. On examination, the lungs were fairly clear. The CXR revealed a significant pneumothorax on the right side. He had presented two months ago, with pneumothorax also, and chest tube was inserted then. As the chest tube was bubbling persistently, a CT thorax was done. No bronchopleural fistula was found. Subsequently talc pleurodesis was performed and patient discharged on a pneumostat. The pneumostat was found leaking a month ago, and removed.

DISCUSSION
Should we intubate this patient? If we did intubate this patient, would ventilation cause the pneumothorax to worsen? Is needle aspiration indicated as a life saving procedure, as the patient was in type II respiratory failure? The patient was connected to a BiPAP NIV, while discussion were underway as to the right choice of management in an elderly with seemingly poor premorbid. A decision was made not to insert the chest tube, but to intubate the patient. Half an hour post intubation, as the patient was about to be pushed to the CT scan room, the BP dropped. He was given intravenous fluid, and subsequently started on high dose of triple inotropes to maintain his BP. He was stable enough to go for the CT thorax, where initially a CT guided pigtail insertion was requested.

CONCLUSION
He returned to ED, post CT scan, where BP was stable, with no pigtail. Subsequent decision on whether to insert a CT guided pigtail, was made. What would your decision be?
HELP DOCTOR, I CAN’T MOVE MY RIGHT LEG POST LSCS!
Cecilia Anthongsamy, Muhammad Hafizi Suhaimi Fauzi, Lim Poh Hin, Rosidah Ibrahim
Serdang Hospital, Selangor, Malaysia

INTRODUCTION
Our worst nightmare is post procedural complication.

CASE REPORT
A 30 year old lady, Para 1, had a LSCS in another hospital. Then, she presented to us 32 days post partum, very early one morning to the green zone, with right leg weakness since the caesarean section, which was done under spinal anaesthesia. Her husband said that the patient was admitted for prolonged stay post surgery in the other hospital and treated with no improvement in that hospital. A MRI of the lumbar sacral spine was already performed and it was reported to be normal. Examination revealed a very irritated, unhappy couple who was seeking a second opinion in the emergency department. The patient was alert, conscious and seated on a wheel chair. The power on the right leg was 2/5. Babinski was up going. Patient was not transferred to the examination couch as it was difficult for her to move.

DISCUSSION
Not really knowing what to do, a quick consultation was made with anaesthetist on call, who could not provide any answers. The orthopaedic medical officer on call agreed to see her. However the husband refused to be referred to the orthopaedics department, as he said all and every test was already performed by them. Patient was then referred to the neuromedical consultant. Fearing medicolegal issues, the consultant immediately agreed to see the patient in his clinic on the very same day, even though his clinic was fully booked. Examination in the neuromedical clinic revealed a sensory level much higher than the spinal insertion site. A MRI was ordered.

CONCLUSION
In what appeared to be a surprise diagnosis, the patient was subsequently referred to neurosurgical department in HKL for surgery
INTRODUCTION
Heterotopic pregnancy, the coexistence of intrauterine and extrauterine gestation, is very rare in natural conception and reported to be 1:30000 pregnancy\(^1\). We report a case presented with haemoperitoneum from ruptured tubal pregnancy with no life of intrauterine gestation. This gives challenges to the managing team especially in detecting the sources of bleeding especially if they miss the extrauterine pregnancy.

KEYWORDS
Natural conception, heterotopic pregnancy, challenges in diagnosis

CASE REPORT
A 33 years old lady 6 weeks of amenorrhea presented with clinical features of shock. Urine pregnancy test was positive. Transabdominal ultrasound reveal free fluid in the abdomen. Left extrauterine sac seen with fetal heart present. Intrauterine sac seen without fetal heart. Provisional diagnosis of a heterotopic pregnancy with ruptured left ectopic gestation was suggested. The patient underwent emergency exploratory laparotomy salpingectomy. There was ruptured left sided tubal pregnancy with haemoperitoneum.

DISCUSSION AND CONCLUSION
A heterotopic pregnancy is difficult to diagnose clinically because the clinical symptoms is lacking\(^2\). It can be life threatening condition and can be easily missed. Usually sign of extrauterine pregnancy predominate\(^3\).

Sign and symptoms may include abdominal pain, adnexal mass, peritoneal irritation, enlarge uterus and vaginal bleeding. Vaginal bleeding may be retrograde from the ectopic pregnancy due to intact endometrium of the intrauterine pregnancy\(^4\).

Challenges in the emergency setting lies in the identifying of ectopic pregnancy with the presence of big haemoperitoneum\(^5,6\).

Haemodynamic instability will be life threatening condition in ruptured ectopic pregnancy need to be addressed appropriately by the managing team and on time surgical intervention may save the life. This need high index suspicion from the emergency personnel to identify this condition and get the obstetric and gynaecology team to deal with the situation.

FOOTNOTE
source of support: nil
conflict of interest: nil
REFERENCES
INTRODUCTION
Cardiac involvement such as functional myocardial impairment, arrhythmia and myocarditis is not uncommon in dengue infections but it may have been frequently under-reported because it usually manifests as a mild and self-limiting condition. Dengue perimyocarditis is rare with only few cases reported worldwide. Nevertheless, more cases of dengue with cardiac involvement, which progress to acute heart failure, cardiogenic shock and death have been increasingly described.

CASE REPORT
A 16 years old boy, diagnosed dengue in defervescence phase with compensated shock, was transferred to emergency department (ED) from a primary care clinic. Upon arrival to ED, he had just completed 10ml/kg/hour normal saline infusion. In ED, patient was still in shock and blood gas analysis showed metabolic acidosis. Hence, 20ml/kg/hour gelafusine infusion was initiated. 12 lead ECG was performed upon noticing ST elevation in lead II on cardiac monitor and revealed saddle shape ST elevation in lead I, II, aVL, V2-V6. Bedside echocardiography showed poor cardiac contractility and presence of pericardial effusion. Patient had a cardiac arrest an hour after arrival in ED. Initial CPR (for 8 minutes) was successful but second cardiac arrest began 20 minutes later. Prior to second cardiac arrest, triple inotropes support was commenced. During second CPR, blood transfusion was started and intravenous dexamethasone was given. Despite the resuscitation efforts, patient was pronounced dead after two hours upon arrival in ED.

DISCUSSION AND CONCLUSION
In addition to circulatory shock due to plasma leakage and occult bleeding, the persistent shock in the above patient can be attributable to cardiogenic shock caused by myocarditis or pericarditis. Therefore, care should be taken not to cause iatrogenic fluid overload. Using echocardiography in dengue patient with features of heart failure and ECG changes, may help clinician to guide fluid resuscitation, identify patients at risk of fluid overload and allow early use of inotropes or use of other alternative therapies.
HEART STOPPER!
J Ding, R Rahmat, S A Cha
Hospital Sultan Ismail, Johor Bahru, Johor, Malaysia

KEYWORDS
Sudden cardiac death, Acute Coronary Syndrome, Brugada Syndrome

INTRODUCTION
Brugada syndrome is a cardiac sodium channelopathy associated with one of several ECG patterns characterized by incomplete right bundle-branch block and ST elevations in the anterior precordial leads. Autosomal dominant inheritance is found in 50% of cases. It affects young males with structurally normal hearts who are prone to develop ventricular tachyarrhythmias leading to syncope, cardiac arrest, or sudden cardiac death.

CASE REPORT
An apparently healthy 35 year-old man suddenly collapses after complaining of dyspnoea. There was no prior history of chest pain, palpitations or syncope. He arrived in the emergency department with asystole. He was resuscitated as per ALS guidelines, ventilated, started on chest compressions and boluses of IV adrenaline. He then develop ventricular fibrillation, was defibrillated multiple times and given IV amiodarone. A return of spontaneous circulation was achieved after 40 mins. An ECG done showed ST elevation in aVR and widespread ST depression and the cause of his cardiac arrest was attributed to acute coronary syndrome. However an ECG done 2 hours later revealed a coved ST elevation V1-V2 followed by negative T wave, rearing the ugly head of Brugada syndrome. Further episodes of ventricular tachyarrhythmias and hemodynamic instability precluded transfer to a tertiary center. He succumbed the following day.

DISCUSSION
Brugada syndrome is diagnosed by both ECG and clinical criteria. There are 3 types of ECG abnormality but only type I (Brugada sign) is potentially diagnostic as in this case. One clinical criterion must also be fulfilled: Documented VF or VT, Family history of sudden cardiac death at <45 years old, Coved-type ECGs in family members, Inducibility of VT with programmed electrical stimulation, syncope or nocturnal agonal respiration. The only proven therapy is an implantable cardioverter-defibrillator. Quinidine is a possible alternative

CONCLUSION
Diagnosis and early intervention of Brugada syndrome is key to preventing sudden death in affected young adults.
INTRODUCTION
Allergic reaction/anaphylaxis is a common presentation in emergency department with wide variety of symptoms. But an allergy presenting with chest pain and ischaemic changes on the electrocardiogram (ECG) should ignite any clinicians to ask - Is the patient having 2 different entities, that is myocardial infarction (MI) in concurrence with an allergy, or is this MI resulting from the allergy, also known as Kounis syndrome.

CASE PRESENTATION
A 52 year-old gentleman with hypertension and coronary artery disease (CAD) presented to ED with generalized body rash post crab ingestion. He is known to be allergic to crab. He also complained of giddiness and chest pain.

He was alert, had generalized urticaria and vital signs were stable. Other physical examinations were unremarkable. ECG showed ST-elevation at leads V1-V4 suggesting acute MI. Troponin T was not raised. Treatment for anaphylaxis and acute coronary syndrome (ACS) were given immediately. He was not thrombolysed. Subsequent ECG after 30 minutes showed resolution. He was admitted for observation.

DISCUSSION
Kounis syndrome also known as allergic angina/allergic MI is the occurrence of ACS resulting from allergic/anaphylaxis insult. This is caused by the inflammatory mediators, e.g. histamine, neutral protease released during the allergic insult which actually promote plaque disruptions and coronary vasospasm in patients with preexisting CAD and even in normal coronary arteries.

Though it is not a nosologic entity, it is actually not uncommon rather underdiagnosed. Hence, clinicians should begin to be aware of this clinical variation “Kounis syndrome” as there have been increasing cases reported over recent years.

The mainstem of treatment is to stop the allergic process. Classical medical therapy for ACS can be initiated. Do consider thrombolysis when there is acute MI with elevated cardiac enzymes.

LESSON LEARNT
A good understanding of this rarely diagnosed syndrome in a common disease is life-saving and rather interesting.

KEYWORDS
Allergic, Angina, Myocardial Infarction, Kounis
THE MISTIFYING DISAPPEARANCE OF MYOCARDIAL INFARCTION

Ruzaini R, Ng S G
Emergency and Trauma Department, Sarakei Hospital, Sarawak, Malaysia

INTRODUCTION
Transient ST elevation myocardial infarction (TSTEMI) is not classified in the universal definition of MI. Its existence is not well known hence we illustrated a case to share our experience, whereby we were mistified by the sudden disappearance of myocardial infarction.

CASE
A 40 year old gentleman, known case of hypertension, active smoker, presented with a sharp right sided chest pain. Physical examination: unremarkable. Initial ECG showed ST elevation in inferior leads, reciprocal changes in lead AVL, first degree heart block with no right sided heart involvement. Ten minutes later, there was no ST elevation seen in lead II on the cardiac monitor. A repeated ECG showed complete resolution of ST elevation. Troponin I: 11.38(raised). He received aspirin, clopidogrel and S/C clexane without thrombolysis. He remained clinically stable throughout admission. He was discharged well and an angiogram appointment was given.

DISCUSSION
Transient ST segment elevation is not a nosologic entity but rather a clinical sign that can be attributed by various conditions such as coronary thrombosis, vasospasm or tako-tsubo syndrome.

In this case, this gentleman was diagnosed as TSTEMI based on the significant risk factors, history, ECG changes and raised troponin.

Spontaneous reperfusion was achieved rapidly due to endogenous fibrinolysis and the presence of recruitable collateral vessels.

Regarding the management, should this gentleman receive thrombolysis? The definitive treatment for TSTEMI remains unclear. However, according to a previous study by Meisel et all, data suggest immediate medical therapy with an early angiogram is an appropriate approach. Thrombolysis is not indicated as there is complete resolution of ST elevation.

CONCLUSION
Albeit there is no evidence of ongoing ischemia, patients with TSTEMI are at high risk of re-occlusion. Hospital admission with continuous ECG monitoring is required. Intense medical therapy must be initiated if there is unavailability of a PCI centre.

KEY WORDS
Transient ST elevation, Myocardial Infarction
OCCASIONALLY, I SWELL – A CASE REPORT OF DELAYED-ONSET ACE INHIBITORS-ASSOCIATED ANGIOEDEMA

Q S Tan, S G Ng, W J Kang
Hospital Sarikei, Kuala Lumpur, Malaysia

INTRODUCTION
Angiotensin Converting Enzyme (ACE) inhibitors-associated angioedema is a non-allergic, drug-induced complication related to bradykinin accumulation. It usually affects the lips, tongue, face and can lead to death due to airway obstruction. Urticaria is absent. The incidence is rare between 0.1%- 0.2%, but the widespread use of ACE inhibitors mandates a special awareness by all clinicians.

CASE REPORT
62 year-old lady with no known allergy history, presented with progressive tongue and lips swelling throughout the day. Further history, few self-limiting milder episodes developed 4 months after perindopril was prescribed. Clinically, there was no urticaria, her airway was still patent. Standard treatment for anaphylaxis was initiated but progress of resolution was poor. Fortunately, symptoms resolved eventually and Perindopril was withheld. Patient has been symptom free until perindopril was restarted back 3 months after discharge due to uncontrolled hypertension. She was readmitted for another attack of angioedema.

DISCUSSION
This patient was on ACE inhibitor, developed episodic, non-urticarial angioedema over the lips and tongue. Symptoms free after discontinuation of perindopril confirmed the diagnosis of ACE inhibitors-associated angioedema. This complication usually begins as mild self-resolved episodic attacks even without discontinuation of ACE inhibitors. But the crescendo nature of severity will ultimately lead to life-threatening airway obstruction. The onset of angioedema in this patient was 4 months after initiation of perindopril. Although ACE inhibitors-associated angioedema typically occurs within 2 weeks of treatment but delayed-onset of angioedema up till years had been reported. Unlike allergic angioedema, ACE inhibitors-associated angioedema poorly responds to conventional allergy treatment, discontinuation of ACE inhibitor is the key of resolution.

CONCLUSION
A justifiable working diagnosis on the basis of comprehensive medical history and adequate awareness of adverse drug reaction are the keys to put a halt to this potentially life-threatening yet preventable complication.
CASE REPORT

Introduction: Hospital Serdang is the coordinating hospital for airport disaster in KLIA. Exercise is often held to prepare hospital and state response to any event.

The call came through to MECC to announce KLIA RED ALERT, KLIA RED ALERT, KLIA RED ALERT. The emergency physicians present in the emergency department responded by first choosing a clinical commander and a Medical Incident Cordinator (MIC). An Emergency Department Cordinating Centre (EDOC) was opened. A staff of 4 persons consisting of an ED assistant medical officer supervisor, the hospital sister on call and 2 clerks assisted the Medical Incident Cordinator (MIC). Reports were made to Air Disaster Unit(ADU) and Hospital Operations Room (HOR) that EDOC was opened. Then, coordination of ambulance response from all hospitals in the state was done, together with coordinating request for more ambulance back up from ADU. Almost as soon as this ambulance response was being coordinated, real patients were reported. By this time a Hospital Red Alert was announced, and coordination was also underway to prepare the ED for surge in patient load. Request for more staff, equipment, food was forwarded to Operations Room. Reports of casualties was collected from ADU and forwarded to operations room together with the destinations of dispatched ambulances. Cases coming to Serdang Hospital was communicated to Clinical Cordinator. With 4 walkie talkies and 4 phone lines (with 2 phone lines down), communication was abuzz. All communications was documented by the 2 clerks. Finally final data was tallied from ADU of cases, diagnosis and disposition and forwarded to Operation Room.

DISCUSSION AND CONCLUSION

EDOC is the nerve of activity during a disaster. The personnel involved must know their job well, be patient, have good communication and coordination skills. Team work is key to a successful disaster exercise.
INTRODUCTION
Takotsubo cardiomyopathy (TCM) may mimic acute myocardial infarct by virtue of ECG changes and raised cardiac enzyme but with negative cardiac angiogram finding as well as left ventricular apical ballooning on echocardiogram. I am presenting a case of lady presented with what appears to be an entity of cardiac failure known as “broken heart syndrome”.

CASE HISTORY
A 25 year old Myanmarese lady presented initially to our ED and treated as hyperventilation syndrome following an emotionally stressful event, and ECG at that time was sinus rhythm. On her second visit to our ED she was complaining of chest discomfort and shortness of breath. During her second visit her ECG undergoes changes from initial RBBB to STE in leads I, Avl, v2 to v5 few hours later. Trop T was positive. Her echo initially shows right ventricular and atrial dilation but later developed akinetik mid and apical segment with normal right ventricular function and ejection fraction of 15%. In the intervening period she developed recurrent paroxysmal ventricular tachycardia with shock. PCI reveals pristine coronary vessels. She was ventilated in coronary unit and died 24 hours later. All her septic work up was negative. Postmortem finding reveals infarcted left ventricular wall. She was treated as cardiogenic shock secondary to acute myocardial infarct.

DISCUSSION
While the preceding history is not clear it is likely that the hyperventilation syndrome was due to acute emotional stress which later leads her to develop TCM with cardiogenic shock and eventual death. Weather the changes in echo finding first done in ED and later by cardiologist as well serial changes in ECG suggest different phase myocardium in TCM need to be studied further. It is opinion of author in view of patent coronary vessels this could be Takotsubo cardiomyopathy.
INTRODUCTION
Traumatic injuries and death are considered a major health issue with a quarter of the deaths occurred in children younger than 15 years. Paediatric trauma in Malaysia comprised of 7%. Majority of the cases happen after school hours. We describe a case of predicted poor outcome with conservative treatment and successful discharge home.

CASE REPORT
A 7-year-old girl was hit by car and thrown forward. Brought in unconscious with multiple petechial over the head, neck cutaneous emphysema, unequal chest rise and deformed left shoulder. FAST showed free fluid in Morrison Pouch. Child was asystole and CPR was performed for 5 mins then revived.

Injury Severity Score (ISS) 33; Revised Trauma Score (RTS) 4.3; Paediatric Trauma Score (PTS) 3

CT scan showed left temporal bone, left clavicle, multiple left ribs fracture, bilateral lungs contusion with large hemopneumothorax, extensive neck emphysema and parapharyngeal region with minimal pneumomediastinum, free fluid in pelvis.

Child was admitted to ICU and treated conservatively, discharged home after 19 days without neurological deficits.

DISCUSSION AND CONCLUSION
Children whose PTS is between 0 and 8 had an increasing mortality related to their decreasing PTS, and those below 0 has 100% mortality. Hence there is a direct linear relationship between PTS and injury severity. For children with low PTS and high ISS, if treated conservatively may reduce the risks of blood transfusion and decrease the length of hospital stay compared with a surgical approach. In addition, a careful and close follow-up is essential in these injured patient with good collaboration with other teams.

The goals of managing severe paediatric trauma are the same as adult. The scoring systems enable us to identify and predict the severity and outcome. The core success within a trauma team is rapidly identify the severity, resuscitation within the ‘golden hour’ and good co-management with others.
INTRODUCTION
Thiamine deficiency, also known as beri-beri has two major clinical manifestations, dry beri-beri characterized by neurologic manifestation that includes peripheral neuropathy and acute encephalopathy, and wet beri-beri with cardiovascular manifestation including high output heart failure which we discovered in this case.

CASE REPORT
A 34 years old Burmese gentleman presented to us with complaint of difficulty in breathing and unwell for the past 1 week. Upon arrival to emergency department, patient was drowsy and tachypnoeic, blood pressure 89/50, heart rate 135, lungs were clear with bilateral pedal oedema. Patient was intubated for impending collapse. Arterial blood gas post intubation showed severe metabolic acidosis with pH 6.91, lactate 20 and bicarbonate 5.3. There was no problem with his oxygenation and his blood glucose was 5.6. Other blood investigation was normal. Bedside Echocardiography showed dilated right ventricle and inferior vena cava with undervolume left ventricle. Based on the presentation and patient’s demography, we decided to give high dose thiamine (200mg stat and QID) to the patient with fluid hydration. Patient subsequently improved with the therapy and was discharged well.

DISCUSSION AND CONCLUSION
We report a case series of presumed fulminant wet beri-beri in critically ill patient. Since thiamine is not routinely administered to them, these observation emphasize the necessity of maintaining a high index of suspicion for this life-threatening but reversible diagnosis especially among patients with high output cardiac failure, unexplained severe metabolic acidosis and chronic vitamin B1 deficiency usually observed in foreign workers in Malaysia who are on high carbohydrate but low protein diet.
**INTRODUCTION**

Hypocalcemia symptoms may vary from asymptomatic to life threatening. The following case demonstrates difficult intubation for a patient who suffered tetany and need to be intubated for respiratory distress.

**CASE REPORT**

A 60-year-old lady with underlying hypertension and end stage renal failure was brought to Red Zone on 16th February 2016; presented with sudden onset of dyspnea.

On arrival, she is drowsy, tachypneic and hypersalivating. Her blood pressure was normal. Lungs auscultation noted generalised crepitation till upper zone. Saturation was 100% on high flow mask oxygenation. However noted patient suffering severe muscle spasm over the neck and back with bilateral upper limb in flexed position. She was in a bent forward position and also having lock jaw.

In view of severe metabolic acidosis (ph 7.0, HCO₃ of 7.0, pCO₂ 18, pO₂ 259) and patient was tachypneic, she was planned for intubation. Patient was given few bolus of intravenous valium for muscle relaxation to lie her flat but failed. Anaesthesiologist was called in for difficult airway and surgical airway equipment is prepared in case of failed airway.

Patients was successfully intubated in operation theatre by anaesthesiologist. Noted corrected calcium is 0.71mmol/L and potassium level of 6.8mmol/L. Calcium gluconate; sodium bicarbonate; and lytic cocktail for hyperkalaemia was given before patient went for urgent hemodialysis. Patient also had one episode of unstable AF where patient was synchronised cardioverted. Prolonged QT interval was also noted on ECG.

**DISCUSSION**

In the neuromuscular system, ionized calcium facilitates nerve conduction, muscle contraction and relaxation. Since calcium blocks sodium channels and inhibits depolarization of nerve and muscle fibers, diminished calcium will lowers the threshold for depolarization. As result, carpopedal and generalized tetany might be observed.

Alkalemia induces tetany due to a decrease in ionized calcium, whereas acidemia is protective. This is important in patients with renal failure who have hypocalcemia because rapid correction of acidemia or development of alkalemia may trigger or worsen tetany.

**CONCLUSION**

Most hypocalcemic emergencies are mild and require only supportive treatment. However rapid correction must be done in severe hypocalcemia in those with seizures, tetany, refractory hypotension, or arrhythmias.
INTRODUCTION

Early identification of infectious disease depends on high index of suspicion, local epidemiology data and heuristic experience of the attending physician.

CASE REPORT

33-year old gentleman with Type I Diabetes was seen for Left flank pain and fever for 3 days. There was no diarrhoea, vomiting or dysuria. No significant travelling history elicited. He was tachycardic and feverish but was neither hypotensive nor tachypnoeic. Apart from positive renal punch other examinations were normal. The patient is hyperglycaemic with a slightly elevated lactate. Other investigations were normal. Initial managing team treated him as renal colic with uncontrolled Diabetes in observation ward.

Reassessment 2 hours later showed a persistent flank pain with minimal skin erythema. Further probing discovered a suspicious travel history of multiple exposures to soil from his work as a palm oil estate supervisor. A working diagnosis of severe sepsis due to splenic abscess secondary to melioidosis was made. IV Unasyn and adequate fluid resuscitation was given. Formal ultrasound showed Serratus Anterior abscess. Burkholderia Pseudomallei was isolated. Patient was discharged weeks later after appropriate antibiotic course.

DISCUSSION AND CONCLUSION

Melioidosis is an infectious disease caused by a gram-negative bacterium, Burkholderia pseudomallei, found in soil and water. It is of public health importance in endemic areas, particularly in Southern Thailand, Malaysia and Northern Australia.

Patient with diabetes is particularly susceptible with grave outcome1. Since the organism is able to withstand a harsh environment, it is very resistant to antibiotic and can lie dormant in the body for years. Therefore antibiotic choice should be organism specific with a prolong course up to 6 month. A 10-years sample from IMR discovered Augmentin, Bactrim, Cefotaxim and Imipenem has the highest sensitivity compared to Ciprofloxacin and Tazosin. From this study it is suggested to give a combination of antibiotic is necessary for total eradication2.
"MY CHILD HEART BEAT AS FAST AS FERRARI" – A CASE OF SVT IN 4 MONTHS OLD INFANT REVERTED USING ICE BUCKET CHALLENGE

Baran Palanimuthu, Alzamani Idrose
Emergency and Trauma Department, Kuala Lumpur General Hospital, Kuala Lumpur, Malaysia

INTRODUCTION
We describe a case of 4 month old Infant came to our Emergency department with Supraventricular Tachycardia

CASE DESCRIPTION
Supraventricular tachycardia is a life threatening condition where heart beat exceed 150bpm with abnormal rhythm arise from improper electrical activity of heart. It is a rapid heart rhythm originated from or above atiroventricular node.

We presenting such a case SVT in 4 Month old Baby Boy with not known medical illness who presented to us with rapid breathing and fever. Child had high grade fever with Core body temperature 40 degree celcius and Pulse Rate 240bpm, BP:99/47, Tachypnoiec with Respiratory rate 58 x/min otherwise Hydration fair, child was crying with tears with moist mucus membrane, lungs: clear, equal air entry, Per abdomen: Soft nontender. Child was promptly triaged to Red Zone and cardiac monitoring done. Infant cardiac rhythm analysed and noted to have Supraventricular Tachycardia.

Steps taken to revert SVT to Sinus rhythm using IV Adenosine x3 via axillary venous access however failed to revert cardiac rhythm. At the same time infant was given bolus NS to improve hydration status and suppository antipyretic (Given by mother at home prior to presentation to hospital), however infant condition remain same. Tepid sponging done with ice water with close monitoring to prevent hypothermia. Surprisingly despite IV Adenosine x 3, child cardiac rhythm reverted to sinus rhythm after tepid sponging with iced water.

Child was managed together with Peadiatric team subsequently transferred to Paediatric ward and was treated as SVT secondary to Presumed Sepsis. Follow up in ward yeilded: TSH and T4 level/ Electrolytes/ CKMB/ LDH normal. Hb level: 10.2

Echo by Paediatric team: Small PFO. Child was discharged well after 3 days of hospitalisation.

LESSON LEARNT
Supraventricular Tachycardia in 4 months old infant is a rare and life threatening condition. As child presented with high grade fever and rapid heart beat, it is necessary to reduce the core body temperature of child as one of the measurement to revert to sinus rhythm. Tepid sponging with ice water more accesible compared to conventional IV adenosine/ propanolol/ lignocaine. Message for doctors who serve in distant district areas, it will be more convinient to manage patient with “Ice Bucket challenge” with close core temperature monitoring while trasferring them to tertiary centres.

This will be our second case of supraventricular tachycardia in Peadiatric population which cardiac rhythm been reverted to sinus rhythm using ice water- Ice Bucket Challenge” method.
“ALL OF SUDDEN I CAN’T FEEL MY BOTH FEET” – A CASE OF BILATERAL ACUTE LIMB ISCHEMIA

Thiviya Muthusamy, BaranPalanimuthu, AlzamaniIdrose
Emergency And Trauma Department, Kuala Lumpur General Hospital, Kuala Lumpur, Malaysia

INTRODUCTION
We present a case of 52 years old man with past medical history of IHD (2 vessel disease and stented 6 times) and dilated cardiomyopathy presented to us with Acute Limb Ischemia.

CASE DESCRIPTION
A 52 years old man with medical history of IHD and dilated cardiomyopathy presented to us with acute onset of bilateral lower limb pain subsequently numbness.

The initial vital signs included 124/75, PR: 71, RR: 18, SPO2: 99% under room air and temperature of 37 degree celcious. The cardiopulmonary/abdominal examination was unremarkable. On the extremity examination, both limbs appeared dusky, cold clammy on touch, numbness over bilateral lower limb, CRT less than 4 seconds, SPO2 ranging 70-75% all toes. On vascular examination, DPA and PTA not palpable, popliteal and femoral pulsation absent as well as confirmed with doppler. Bedside ultrasound shows 2point compression test test shows compressible but with absence of popliteal artery pulsation. On neurologic examination, the power was 2/5 over the bilateral lower limb, sensation was still intact with subjective complaint of numbness and tingling on his bilateral lower limb.

Working diagnosis of Acute Limb Ischemia of bilateral lower limb was made. Emergent phone referral was made with a vascular surgeon and interventional radiologist were initiated. A computed tomography angiogram (CTA) of the abdomen and lower limb was performed and demonstrated an aorta-iliac occlusive disease involving the infrarenal abdominal aorta.

DISCUSSION
Acute limb ischemia in high risk patients are common however involving bilateral lower limb is a rare condition. In our case, prompt action taken right after clinical diagnosis as patient already presented with cold clammy feet and absents of DPA/PTA pulsation. Immediate CTA done and was noted patient to have occlusion high up at common Iliac artery. Early referral to vascular surgeon and interventional radiologist are crucial to establish diagnosis and early intervention to salvage affected limb. However in these case, Patient was treated conservatively as patient having poor cardiac function.

CONCLUSIONS
Acute Limb ischemia are common in especially in high risk patients, however rare involving both lower limbs. Do consider higher level occlusion if patients presented with such symptoms despite working on differential diagnosis such as Hypokaleamia periodic paralysis or Gullen Barre Syndrome. Early diagnosis and intervention might salvage the affected limb.
POST TRAUMA MASSIVE PULMONARY EMBOLISM IN PREGNANCY
Kalaivanan M K, Kheng Soo Ng, Kalai Amuthan G, Losheni P
Emergency and Trauma Department, Hospital Serdang, Selangor, Malaysia

KEYWORDS
Trauma, massive pulmonary embolism, pregnancy

INTRODUCTION
Pulmonary embolism (PE) is among the most common causes of maternal death during pregnancy and postpartum worldwide. The clinical diagnosis of PE in normal population is usually difficult, but it is more complicated in pregnant patients, because physiologic changes of pregnancy can mask signs and symptoms of pulmonary embolism.

CASE REPORT
In this case study, a Nigerian lady developed Massive Pulmonary Embolism after sustaining closed left lateral malleolus fracture. She underwent plating of left lateral malleolus. After discharge from the ward she developed shortness of breath, palpitation and chest pain. Patient was brought in by ambulance team and noted SPO2 on arrival was 85% on room air, tachycardic 150 beats per minute. ECG: Sinus tachycardia with S1Q3T3. CT angiogram findings: Bilateral pulmonary artery thromboembolisms.

She was then given IV Heparin in Emergency Department. Patient was then admitted in CCU and was given IV Streptokinase. Patient underwent thrombolectomy as well. Inevitably, patient passed away the next day after the operation.

DISCUSSION & CONCLUSION
Pulmonary embolism in pregnancy is not uncommon and causes significant morbidity and mortality amongst pregnant women. Diagnosing PE can be challenging and involves the usage of echocardiography, laboratory, and clinical findings. Rapid and accurate diagnosis is vital because treatment must be initiated early before deterioration. However the treatment itself has potential complications. Most patients with DVT and/or PE can be safely and successfully treated with unfractionated or low-molecular-weight heparin for the duration of the pregnancy. But, in massive PE, thrombolytic or thrombolectomy must be decided fast to achieve a good outcome.
“DON’T STREP ME!” – MYOCARDIAL ISCHAEMIA IN SEPTIC SHOCK
Chai Dek Chiun, Chan Pei Fong, Kevin Wong Chuing Shen, Tan Ai Ling, Chong Chun Yip
Sibu Hospital, Sibu, Sarawak, Malaysia

INTRODUCTION
ECG findings in septic shock include loss of QRS amplitude, prolonged QTc interval, bundle branch blocks, Osborn waves. However ST segment elevation in septic shock is rare.

CASE REPORT
29 year-old gentleman presented with fever for 5 days, vomiting and diarrhea for 3 days. Patient was alert but blood pressure on arrival was 71/39mmHg, pulse rate was 114bpm. Patient has cold peripheries and right hypochondrial tenderness. Blood investigation showed leukocytosis $12.0 \times 10^3/\mu L$, thrombocytopenia $104 \times 10^3/\mu L$. ECG showed sinus tachycardia. Dengue rapid test was negative. In view of history jungle trekking 2 weeks ago, patient was treated as leptospirosis with septic shock. Diagnosis was confirmed with positive leptospirosis rapid test. While commencing IV fluid resuscitation and IV noradrenaline infusion, noted there was ST elevation on cardiac monitor, blood pressure 101/59mmHg. Repeated ECG showed ST elevation in inferior and posterior leads, with reciprocal changes in antero-septal and right sided leads. Patient has no chest pain. Patient was treated as type 2 myocardial infarction (MI) and didn’t proceed for thrombolysis. When the volume restored and vasopressor was weaned off, repeated ECG on the following day showed normalization of ST segment to baseline.

DISCUSSION
Type 2 MI, also known as supply/demand MI consisted of 3.5% of all MIs. In hypotension, reduced perfusion to coronary circulation can leads to imbalance between myocardial oxygen supply and demand, causing type 2 MI. In this case normalization of ST segment suggests a transient myocardial ischaemia. Adequate fluid resuscitation and judicious use of vasopressor will correct the supply/demand imbalance. Thrombolysis will not be helpful as the ischaemia is not due to coronary artery thrombosis. We need to treat the cause, not the ECG. Elevation of cardiac biomarkers can be due to septic shock itself, but elevated cardiac troponin directly related to mortality.

KEYWORDS
Type 2 MI, ST elevation, sepsis.
INTRODUCTION
Ketamine is often be used for sedation and analgesic purpose. It has side effects but mainly not serious. The following case demonstrated patient who had paralytic ileus post ketamine administration.

CASE REPORT
A 2-year-old girl with no known comorbid was involved in a motorvehicle accident where she was a pillion rider without helmet; hitted by a car. On arrival, primary survey was normal. Only noted her GCS was E4V4M6, pupils 3mm reactive bilateral with some abrasion wound over left side of face. Blood pressure 79/50mmHg with pulse rate 154bpm. At same time noted clotted blood at external genitalia. Otherwise abdomen was soft and non tender at this time.

Patient was given iv ketamine 10mg on titrated dose each time with total of 100mg over 45mins for gynaecological examination. Gynaecology team review noted there is right labia minora haematoma but not expanding. Three and half hour later, the mom noted that the patient abdomen becoming more distended. Serial FAST scan noted no free fluid. Chest xray was normal but abdominal xray noted dilated bowel.

Patient regained full consciousness later and was admitted for cerebral concussion. She was put on nasogastric tube, kept nil by mouth with intravenous drip. Abdomen distension resolved by itself throughout hospital stay. Child was discharged well on day 3 post trauma.

DISCUSSION
Ketamine is preferred drugs for analgesia as it is considered relatively safe. Beside analgesic properties, it create trance-like state and provides sedation with amnesia, while preserving upper airway and spontaneous breathing. Opioid drugs when used for analgesic cause likelihood of respiratory depression than ketamine.

Ketamine is NMDA receptor antagonist, but also acts on opioid receptors and monoamine transporters. μ-opioid receptor have constipating effects by increasing the tone of intestinal smooth muscle, and reducing propulsion and the strength on contraction.

Common complications of ketamine will be emergence reaction, hypersalivation and nausea and vomiting. Rarely paralytic ileus occur post ketamine administration.

CONCLUSION
Use of ketamine in children for analgesic is very common hence we must be able to look for potential complications. Beside ketamine, other drugs that might induce paralytic ileus is muscarinic antagonist and tricyclic antidepressant drugs.
“BEHIND THE SCAR”; THE UNUSUAL COMPLICATION OF POST ECTOPIC SURGERY

I Fadzillah, M M Amin, C T Chow, M M Saed
Emergency & Trauma Department, Hospital Sultanah Aminah, Johor, Malaysia

INTRODUCTION
Internal herniation is a rare complication and has low incidence of less than 1%. We present a case of intestinal obstruction due to small bowel entrapment in preperitoneal space secondary to previous laparotomy for ruptured left tubal pregnancy.

CASE
A 38-year-old Chinese lady presented to Emergency Department (ED) at day 9 post laparotomy for ruptured left tubal pregnancy. First presentation, she complained of mild abdominal pain without vomiting. She was discharged with analgesia without doing abdominal X-ray. She returned to ED five days later with persistent abdominal pain and symptom of intestinal obstruction. An abdominal X-ray revealed dilated stomach and small bowel. Patient was admitted and underwent laparotomy. Intraoperatively, the stomach and small bowel were distended and tense with segment of small bowel 30 cm from terminal ileum entrapped in potential space at preperitoneal region secondary to previous surgery. Post operatively, patient was admitted to ICU for ventilatory support and extubated at day 5 post operation. She developed severe gastropharesis and required total parenteral nutrition.

DISCUSSION
CT scan is a better imaging modality for evaluation of abdominal pain, but the patient was not subjected for one because her condition deteriorated and proceeded for laparotomy. Intraoperatively, there was internal herniation leading to mechanical obstruction and required decompression by performing enterotomy at mid jejunum. This complication is very rare and less than 1 % incidence. Post operation, patient developed severe gastropharesis that resolved after resting the bowel by keeping nil by mouth and total parenteral nutrition.

CONCLUSION
Numerous studies have demonstrated low sensitivity for plain abdominal radiography in the evaluation of acute abdominal pain, but it is still the method of choice in ED for cases of suspected obstruction, perforation or foreign body especially in post operation patient.
POINT OF CARE ULTRASOUND IS USEFUL IN DIAGNOSING SOFT TISSUE TUMOUR

J Md Noor¹, MIK Mohamad¹, M A M Mokhtar¹, S S Hamzah², N F Yasin³

¹Universiti Teknologi MARA, Malaysia
²Hospital Sg Buloh, Sungai Buloh, Selangor, Malaysia
³Universiti Malaya, Malaysia

INTRODUCTION
Differential diagnosis of a large soft tissue swelling is multiple, but perhaps the most feared diagnosis is a soft tissue sarcoma. Inappropriate aspiration may cause seeding of the cancer cells and complicates future management of the soft tissue sarcoma.

CASE REPORT
This is a case of a 44 year old male, with a one month history of left thigh swelling. There was no fever, pain, discharge and no trauma. On examination, there was a large swelling over antero medial aspect of the thigh. A junior doctor suspected underlying abscess and attempted needle aspiration but it was a dry aspirate. Bedside ultrasound showed a well encapsulated dense lesion, rather homogenous in appearance. The diagnosis of possible benign soft tissue tumour was made. But because of it’s significant size, soft tissue sarcoma has to be ruled out, hence the patient was referred to orthopaedic oncology unit. MRI scan confirms this finding of homogenous lesion suggestive of intramuscular lipoma.

DISCUSSION & CONCLUSION
Point of care ultrasound is a useful adjunct to narrow down differential diagnosis of a swelling and fast track patient to the appropriate unit.
INTRODUCTION
Dengue is a mosquito borne viral that are endemic in South East Asia and Pacific region. The incidence is increasing and so is the severity and mortality. According to WHO guidelines, severe dengue is characterized by severe plasma leakage, severe haemorrhage and severe organ impairment.

Plasma leakage can be difficult to detect clinically in the initial stage. Myocardial depression, a sign of end organ impairment is also difficult to assess. Early detection of these signs can direct the patient to be placed under closer monitoring. It also results in a more judicious fluid therapy, which is the mainstay of dengue treatment.

CASE REPORT
We present five cases of dengue fever with ultrasound evidence of severe dengue. These patients have plasma leakages either in pleural or peritoneal cavity. One patient had myocardial depression. All five patients had gallbladder oedema with reticular pattern, a findings consistent with severe dengue, but not specified in the WHO guidelines. 3 of these patients were admitted to intensive care unit. All 5 patients survived.

DISCUSSION & CONCLUSION
Based on this, we suggest the ultrasound approach to identify some of the signs of severe dengue. Clinicians should look for: Effusions (pleural, peritoneal, pericardial), Cardiomyopathy, Gallbladder oedema, or E-C-G. Any positive findings will add value to the management of the patient in terms of monitoring and volume of fluid. Whether these findings has direct effect on mortality and morbidity requires a proper clinical study.
**CAN ULTRASOUND ASSIST IN ASSESSMENT OF STRIDOR?**

*J Md Noor¹, N Abd Karim¹, I Ismail¹, A D Mohd Kamal²*

¹Universiti Teknologi MARA (UiTM, Malaysia)  
²Hospital Sg Buloh, Selangor, Malaysia

**INTRODUCTION**

Stridor is a potential airway nightmare. Preparation for impending respiratory collapse has to be made emergently. Cricothyroidotomy, which is hailed as the airway rescue in can’t intubate, can’t oxygenate (CICO), can have devastating outcome in certain patient. This case highlight ultrasound as a potential tool in assisting with airway management.

**CASE REPORT**

A 56 years old gentleman presented to ED with 3 days history of shortness of breath. He has been having coryzal symptoms for last 4 days and had noisy breathing since that morning. This patient had a history of wound debridement 7 months prior for which he underwent general anaesthesia. Since then he has said that his voice has become hoarse.

On examination, his vitals signs were as follow: HR 118/min, BP 139/126mmHg, SpO₂ 100% under room air. He was tachypnoeic with audible inspiratory stridor. There was no neck swelling, no mass, trachea was central. Provisional diagnosis of vocal cord palsy was made. ENT assessment with flexo nasopharyngolaryngoscope (FNPLS) showed fungating mass involving false vocal cord region extending to subglottic region, irregular mucosa at right vocal cord region. Ultrasound revealed heterogenous mass within the larynx extending from above to below cricoid cartilage. Tracheostomy was performed the next day, followed by CT scan and operation for laryngeal ca.

**DISCUSSION & CONCLUSION**

Clinicians could add ultrasound as an adjunct to assessment of stridor. Physical examination alone has its limitation. This patient was fortunate as he did not deteriorate further. Should he desat, and physicians found a CICO situation, cricothyroidotomy could potentially be disastrous.
SCREAMING AIR UNDER THE SKIN
Kalai Amuthan G, Kheng Soo Ng, Kalaivanan M K
Emergency and Trauma Department, Hospital Serdang, Selangor, Malaysia

KEYWORDS
Subcutaneous emphysema, prolong intense shouting, intrathoracic pressure

INTRODUCTION
Subcutaneous emphysema is commonly related to trauma, surgery, any various respiratory and non respiratory causes. It can occur at any part of human body. This is a case study regarding a simple non traumatic activity resulting in subcutaneous emphysema. It was due to excessive straining during shouting leading to possible airway injury subsequently causing air leak. This leads to pneumothorax and pneumomediastinum with subcutaneous emphysema.

CASE REPORT
In this study, a teenager developed subcutaneous emphysema after a football match, denying any trauma or physical contact. The symptom appeared after prolong intense shouting during the game whereby he developed neck pain and gradually developed swelling over the neck which extended to the chest. He was hemodynamically stable and the subcutaneous emphysema did not progress. He was treated conservatively and was discharged well after few days of observation.

DISCUSSION & CONCLUSION
Subcutaneous emphysema with pneumothorax and pneumomediastinum can be caused by extreme prolong intense shouting which may cause sudden raise in intrathoracic pressure. This leads to rupture of alveoli and air leaking to mediastinum and pleural space and subsequently travel subcutaneously.
THE ROLE OF REGIONAL BLOCKS IN FACILITATING THE ACUTE MANAGEMENT OF LIMB TRAUMA IN THE EMERGENCY DEPARTMENT

Shah Jahan Mohd Yussof¹, Sabariah Faizah Jamaludin², Abu Hassan Asaari¹

¹Hospital Kuala Lumpur, Kuala Lumpur, Malaysia  
²Hospital Sg Buloh, Sg Buloh, Selangor, Malaysia

INTRODUCTION
The role of regional blocks has been globally established as an effective modality of providing surgical anesthesia as well as an effective option of postoperative pain management. The anesthetist often performs such procedures in the pre or post-operative phases. This mode of anesthesia has many advantages including, avoiding the potential morbidities of general anesthesia as well as a safer effective alternative for providing surgical anesthesia. In the recent years, the practice of regional blocks has made its way into facilitating procedures in the Emergency Departments (ED). Nevertheless, such intervention has still not been well established in Malaysia and the South East Asian region.

CASE REPORT
This report presents to you a case series of 6 limb related trauma patients receiving regional blocks in the Emergency Department. The ED team led by the Emergency Physician provided the regional blocks. The procedures for each of the 6 patients differed in the indications as well as the type of blocks provided. All the patients in this case series were acute trauma cases whom were treated in Hospital Sungai Buloh, Selangor Malaysia.

DISCUSSION & CONCLUSION
The case series will demonstrate the burst of benefits in providing regional blocks in the Emergency Department. All the patients had a drastic reduction in their pain scores and underwent vital emergency acute care procedures comfortably and successfully in the Emergency Department. Some of the procedures, which would otherwise require procedural sedation and pre-procedural fasting, were successfully avoided, hence reducing the rare but potentially fatal risk associated with it.

We would like to promote the utility of regional blocks in facilitating the management of acute limb trauma in the ED. In order to achieve this aim, we would suggest emergency department doctors to undergo training and practice in performing safe and effective limb related regional anesthesia.
AORTIC DISSECTION: A LETHAL MIMICKER

N H Ahmad¹, TL Tan²

¹Universiti Teknologi MARA, Sungai Buloh, Selangor
²Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia

INTRODUCTION

Diagnosis of aortic dissection remains elusive despite advances in its diagnostic imaging and treatment, mainly contributed by its diverse clinical presentation. Aortic dissection as a cause of neurological symptoms is often overlooked. Unusual combination of symptoms and signs should raise suspicion of an underlying vascular pathology such as aortic dissection¹.

CASE REPORT

We report a case of a previously well 44 year old man presented with sudden onset of right lower limb weakness. However, examination noted no pulse over right leg from level of femoral artery down to dorsalis pedis and feeble left radial pulse. He was admitted for acute limb ischemia and underwent emergency embolectomy. Embolectomy improved flow of the femoral artery but popliteal artery was still unpalpable. He then underwent CT thorax which revealed extensive Stanford Type A aortic dissection involving aortic root until the abdominal aortic bifurcation with superior extension to all aortic arch branches, compression of superior vena cava and left brachiocephalic vein by the dilated aortic root and right renal ischemia from a thrombus at true lumen. Patient succumbed after operative aortic dissection repair.

DISCUSSION

The occurrence of painless dissection ranges between 5-15%. Neurological symptoms without any pain are observed in 1/3 of patients with Type A aortic dissection¹. It is caused by dissection or occlusion of aortic side branches supplying the brain, spinal cord or peripheral nerves. Lower extremity pulse deficit in the absence of peripheral vascular disease are associated with malperfusion syndrome of aortic dissection and found in approximately half of patients with thoraco-abdominal or aortic arch involvement². Diagnosis of aortic presentation in these cases can be difficult and delayed. Patients with typical features were diagnoses sooner than those without³.

CONCLUSION

Aortic dissection presented with neurological symptoms is rare. Physician must have high level of suspicion especially in cases with unusual presentation.

REFERENCE

THE PURPLE TAGS
Surekha Kaneson, Cecilia Anthonysamy, Rosidah Ismail
Hospital Serdang, Selangor, Malaysia

KEYWORD
Preparedness, purple tags, heat exhaustion

INTRODUCTION
Like any disaster, an air craft accident may require actions that do not fall into a predictable pattern. Thus a regular drill exercises are done to minimize the risk to victims and the rescue personnel. In conjunction to that, Aerodrome Emergency exercise (AEX) was held recently, involving 265 players. 23 purple tagged patients were encountered, where players presented as real patients with wide spectrum of heat exhaustion.

CASE REPORT
AEX was held, with a scenario of an airplane crashed onto the runway. The event took place in the middle of noon. 74 of the players was tagged green, 43 as yellow, 56 as red and remaining 69 as white. All players which were recruited into this drill are clinically fit and age ranging from 20-30 years old. We had 23 real emergency cases of heat exhaustion (purple tagged). Long exposure to extreme heat and too much activity under a hot sun causes excessive perspiration, which lead to heat exhaustion. They presented with headache and feeling weakness and dizziness accompanied by nausea and vomiting, muscle cramps and pre-syncope. All 23 patients was given first aid from the site medical camp and transferred to medical base at Air Disaster Unit (ADU). They were moved to a cool environment and encouraged to increase the consumption of fluids. However one of them required admission and another three was sent to the nearest hospital for further observation and management.

DISCUSSION
Preparedness for a drill is not solely pertaining to the scenario injuries but also by expecting and anticipating possible real injuries or emergencies as well. Several factors need to be considered at all time such as the weather changes, environment safety and players’ health conditions. Thus, it is important to ensure preparedness for real emergencies during a disaster drill.
LOW GCS: TO INTUBATE OR NOT TO INTUBATE
S A K M Saleem
Hospital Bintulu, Bintul, Sarawak, Malaysia

INTRODUCTION
Altered level consciousness is a common presentation in emergency setting. Misconception of equating a low Glasgow Coma Scale (GCS) with indication of intubation is not uncommonly seen. The act of juvenile decision to intubate prior to detailed assessment, has lead to unnecessary intubation and raise intubation-associated complications.

CASE REPORT
33 year-old female presented to emergency department with sudden onset of quadriplegia and aphasia, shortly after having quarrel with her husband. On arrival to Emergency department, noted patient GCS was E4V1M1. Patient was normoglycemic with normal cardiac rhythm on immediate assessment. She was able to respond to some questions by blinking her eyes. No prior history of fever, substance abuse, alcohol intake, recent medications or any previous illness. On examination, pupils were reactive, spontaneous breathing effort, absent gag reflex, power all 4 limbs 0/5 however tone and reflex normal. Further blood investigations, urine toxicology, CT brain were unremarkable. Intubation was not performed, as patient was able to maintain airway spontaneously with no respiratory distress and no features of traumatic brain injury. Case referred to medical team, who subsequently treated the patient as meningoencephalitis and started on empirical antibiotic. Miraculously, on 3rd day of admission, patient suddenly recovered completely and was treated as pseudocoma.

DISCUSSION
The concept of GCS in deciding need of intubation is revisited. It should be emphasized that interpretation of GCS score of patients should be individualized case-by-case basis. In the end, good history taking with thorough clinical examinations will gives limitless amount of benefits in deciding treatment plans.

CONCLUSION
As a primary responder, we have to shift our thinking process in managing patients with altered level of consciousness. The role of GCS should be kept as a first line guide rather than sole indication of intubation.
A BEE-ZY COMPARTMENT SYNDROME

Mohd Rizwan M¹, Nur A K²
¹Hospital Sungai Buloh, Sungai Buloh, Selangor, Malaysia
²Faculty of Medicine, UiTM Sungai Buloh, Selangor, Malaysia

INTRODUCTION
Bee stings by the genus *Apidae* give rise to a variety of life threatening conditions due to the systemic effects of amines, peptides and toxins released by the sting. Rarely, local reactions result in compartment syndrome, a dreadful limb threatening complication. We describe a case of left middle finger compartment syndrome after a bee sting; requiring emergency fasciotomy.

CASE REPORT
A 21-year-old man was stung by a honeybee over the palmar surface of his left middle finger 19 hours prior to presentation. He complained of worsening pain and swelling over the bite site. He had a short history of fever following the sting but subsided after antipyretics. Upon examination, his vital signs as well as systemic examinations were unremarkable. Local examination of his left middle finger revealed a grossly swollen, sausage-like, erythematous and tender finger. There was no punctum and the bite site was obscured. Flexion and extension over the interphalangeal joints were severely restricted and the passive stretch test was positive. Peripheral sensation was also affected. X-rays of the finger were normal. Considering the positive clinical findings and time since insult, this patient underwent a fasciotomy to release the compartment pressure. Secondary suturing was done 2 weeks later and he achieved full function in 1 month.

DISCUSSION
Most clinicians’ worry about the systemic effects of a bee sting but the wide variety of toxins present in a bee sting may just as well cause dangerous local reactions. The inflammatory reaction triggered by these amines and peptides in an enclosed area such as the finger raise inter-compartmental pressures and jeopardize neurovascular integrity and should not be confused with secondary bacterial infection.

CONCLUSION
Compartment Syndrome is a real and present complication of a bee sting that should be considered especially when bitten over the limbs.
INTRODUCTION
Calcium-channel blocker toxicities are rare but account for about 40% of deaths in cardiovascular drug overdoses. Patients commonly present early and urgently with features of hemodynamic instability. We describe a case of a dihydropiridine toxicity that presented late and was in profound cardiac failure; assumed to be due to an acute coronary event.

CASE REPORT
A 29-year-old man presented to the ED with headache, vomiting and breathlessness 3 days after ingesting 300mg of Amlodipine besylate, in a para-suicidal attempt. He had gone to a GP the day before and received intravenous fluids presumably due to a low blood pressure. The history of deliberate ingestion was not known in the early stages. On arrival, he was tachycardic and mildly tachypnoeic but not hypotensive. Subtle clinical findings of congestive cardiac failure were compounded by a B-profile on lung ultrasound and a raised pro-BNP level. ECG showed sinus tachycardia with evidence of lateral wall ischemia; the glucometer was 7.1mmol/L and remained normal throughout. His condition worsened with time and he eventually required non-invasive ventilation. Following supportive therapy he was discharged well 10 days later.

DISCUSSION
Amlodipine preferentially block the L-type calcium channels of the vasculature and have minimal effects on cardiac contractility- with consequent hypotension and bradycardia. As the degree of toxicity was moderate (300mg), this selectivity was not lost and this patient presented with congestive cardiac failure likely due to being left untreated. The presence of ischaemic ECG changes was a red herring in the diagnosis.

CONCLUSION
Overdosage of any type of cardiac drugs require further investigation and monitoring to ensure delayed and subtle complications like this are not missed.
INTRODUCTION
Massive pulmonary embolism is defined as acute pulmonary embolism with sustained hypotension, pulselessness or bradycardia. The combination of history taking, clinical findings, prediction probability test and bedside echocardiography is of value in diagnosing and treating unstable pulmonary embolism patient.

CASE REPORT
48 year old Chinese male, underlying Lung Carcinoma ongoing chemotherapy. Presented to Emergency Department with sudden onset shortness of breath started the morning of arrival. Patient had been having cough with minimal sputum, denies fever, no hemoptysis, no chest pain and no failure symptoms. On examination patient hemodynamically unstable with moderate respiratory distress, other systemic physical examination is unremarkable. Bedside echocardiography showed right ventricle hypertrophied and dilated with paradoxical septal movement, low end diastolic left ventricle volume and plethoric inferior vena cava. Well’s criteria calculated with a score of 3 which is high possibility of pulmonary embolism. In view of patient unstable for transfer for CT-PA, combination of history given and other clinical findings suggested patient was having massive pulmonary embolism. Hence, patient was thrombolysed with IV Tenecteplase 50mg and subsequently admitted to ICU. Patient showed overall marked improvement. CT-PA done later showed right pulmonary artery embolism.

DISCUSSION AND CONCLUSION
The above case was a classic presentation of massive pulmonary embolism which is marked with persistent hypotension. CT-PA is the gold standard for diagnosing pulmonary embolism but in unstable massive pulmonary embolism it is not possible to be done. In the latest guidelines by European Heart Journal and American College of Physician recommended the use of prediction probability test to proceed with the treatment. In cases of uncertainty and many differential diagnosis it is important to combine history taking, clinical findings and other modalities such as prediction probability test and bedside echocardiography to determine diagnosis and management.
ARISE FROM THE DEAD, CASE REPORT
A H Mohd Mustamam, M F Mohd Abdul Kader Jailani, N Z’aba, S L Balakrishnan, N Mohd Ali
Hospital Tengku Ampuan Rahimah, Klang, Selangor, Malaysia

INTRODUCTION
Lazarus phenomenon is a rare clinical condition, first reported by Linko et al. in 1982. The pathophysiology is not well understood. Hyperinflation, myocardial stunning, hyperkalaemia, delayed action of drugs, countershock asystole, and unobserved minimal vital signs amongst others have been considered to be the most common mechanisms.

CASE REPORT
40 year old Indian male, presented to emergency department with sudden onset of typical chest pain. Patient developed ventricular fibrillation en route to PCI center. CPR commenced immediately and resuscitation per ACLS guidelines was done. In view of refactory VF, resuscitation continued with IV Vasopressin 40, IV methylprednisolone 40mg and IV esmolol 30mg, despite the additional medications and CPR for 45 minutes, there was no ROSC and cardiac monitor deteriorated to asystole and resuscitative effort discontinued. Patient was extubated and explained to family members regarding poor prognosis. Death was not pronounced to family members in view of the presence of agonal breathing. After 30 minutes cessation of CPR noted patient had good spontaneous respiratory effort and started moving his upper limb and localizing pain, cardiac monitor showed sinus rhythm. Airway was than secured. Patient was than thrombolysed and admitted to ICU.

DISCUSSION AND CONCLUSION
The decision to stop CPR is a challenging clinical task. In general, CPR should continue as long as shockable rhythm or the other reversible cause for cardiac arrest persists. It is widely accepted that asystole for more than 20 minutes without reversible factors is a reasonable cause. The decision to stop is based on resuscitation team judgement, time before initiation of CPR, primary rhythm, comorbidity, and duration of resuscitation.
INTRODUCTION
Organophosphate is a commonly used pesticide and poisoning of its substance is not uncommon. It is widely used in any oil palm plantation worldwide. The detrimental effects of its substance may range from a well-known “SLUDGE” symptoms to neurology manifestation, and cardiorespiratory compromise. Prompt and accurate diagnosis is needed to initiate early treatment.

CASE REPORT
This is a case of an 18 years old gentleman with no known medical illness presented to our emergency department on 20th May 2016 with complaint of abdominal pain, and giddiness for 1 day. On examination, he was lethargic, dehydrated and having generalized muscle twitching. Diagnosis tetanus was top of the list but there is no external wound noted and no history of trauma. Upon further questioning, patient also has vomiting and diarrhea since yesterday. History obtained from colleagues revealed that class II pesticides was splashed onto his pants whilst working the day before. He was then treated as organophosphate poisoning and given IV atropine and IV Pralidoxime. However patient developed VT with pulse and bronchorrhea hence intubated for airway protection. Patient subsequently admitted to ICU and discharged well after 7 days.

DISCUSSION & CONCLUSION
Organophosphate compounds are the organic derivatives of Phosphorus containing acids and they act at neuron synapses by inhibiting acetyl-cholinesterase. The clinical manifestation after exposure of this pesticide depends on amount of organophosphate consumed and lag time. After the exposure to organophosphate, the clinical manifestation divided into three phases which are acute cholinergic crisis, the intermediate syndrome and delayed polyneuropathy. In this case, despite having the typical “SLUDGE” symptoms, patient demonstrate generalized muscle fasciculation due to his late presentation. Good history and clinical examinations are mandatory to detect the uncommon presentation of any poisoning as the patient may present with atypical symptoms.
“ATTRACTIVE PENIS TURNED INTO TRAGEDY” – A WRONG MOVE IN PENILE ENHANCEMENT THERAPY – CASE REPORT OF PENILE SILICONOMA

Baran Palanimuthu, Alzamani Idrose

Emergency Department, Kuala Lumpur General Hospital, Kuala Lumpur, Malaysia

INTRODUCTION

We describe a case report of Penile Siliconoma where patient injected liquid silicon into penile tissues to enhance penile girth, subsequrntly makes it more attractive.

CASE DESCRIPTION

Penile siliconoma is a rare condition where patient injected liquid silicon to make penis appear attractive for opposite sex. We presenting such a case, a 43 years old gentleman with not known medical illness injected liquid silicon for sexual cosmetic purpose.

Patient had 3 course of injection within 6 months time. Initially claimed penis became bigger in size and patient did not encounter any abnormalities. However, after subsequent 2 months (8 months from first Silicon injection), patient noticed penis start to become granulomatous and harden. Patient also experienced skin changes surrounding penile area with on and off difficulty in urination (Hesistancy) and retention.

Upon examinations. Vital signs were in normal parameters, patient did not possessed any urinary retention symptoms. Genital examination shows, harden shaft of penis, with thickening of surrounding skin.

Patient was taken over by urology team and planned for operation-Skin Degloving and grafting

DISCUSSION/CONCLUSION

Penile enhancement theraphy especially for cosmetic reason are uncommon in daily practise especially in Malaysia. Patient tend to make wrong decision to get treatment from unrecognise practitioner which often result unwanted outcome.

For medical practitioners, do consider obstructive uropathy symptoms which in these case hesistancy and on and off urinary retention as emergency condition. Early referral to urology unit will ensure better outcome.
A CASE OF ELECTRONIC CIGARETTE INDUCED ANAPHYLAXIS

Iskasyimar Ismail\textsuperscript{1}, Boon Hui Kua\textsuperscript{2}, Mohd Amin Mohd Mokhtar\textsuperscript{3}

\textsuperscript{1}Universiti Putra Malaysia, Serdang, Selangor, Malaysia
\textsuperscript{2}Hospital Serdang, Serdang, Selangor, Malaysia
\textsuperscript{3}Universiti Teknologi MARA, Shah Alam, Malaysia

INTRODUCTION

“Vaping”, the use of electronic cigarettes (e-cigarettes), has gained popularity especially among the younger population, worldwide. The vapor generated by e-cigarettes contains variable levels of nicotine and potentially harmful toxins, possibly triggering a life threatening anaphylaxis episode. Here we describe a case of anaphylaxis after using an e-cigarette.

CASE DESCRIPTION

A 22 year old male presented to the emergency department with complaints of acute periorbital swelling, shortness of breath, chest tightness, and a foreign body sensation in his throat. He has underlying bronchial asthma and allergies to soy and peanuts. He had been using e-cigarettes with strawberry flavor for the past 1 year as a smoking substitute. However, he changed to a nut containing flavor the day prior to becoming unwell. Upon examination, he had bilateral periorbital oedema but no other significant mucosal swelling. He was not tachypnoeic and apart from reduced air entry bilaterally, his chest examination was unremarkable and his oxygen saturation on room air was 99 percent. His heart rate on presentation was 114 beats per minute but was normotensive. Chest x-ray was unremarkable. He was treated with intramuscular adrenaline plus intravenous corticosteroid and anti-histamine. Post treatment, his symptoms improved almost immediately and his heart rate dropped to 84 beats per minute. He was observed overnight in the ward and discharged well the next day.

DISCUSSION

Most e-cigarette liquids (e-liquids) consists of various combinations of nicotine, propylene glycol, glycerine, tobacco extracts, flavorants and/or adulterants which vaporizes to an aerosol/vapor. A study has shown that long term exposure to propylene glycol has been found to exacerbate and/or induce multiple allergic symptoms in children. However, we have not been able to identify any other articles detailing a specific allergic or anaphylactic reaction secondary to ingredients in e-cigarette liquids. Further research is needed to characterize the potential adverse effects of exposure to e-liquids.
“THE TOY STORY” – DILDO IN RECTUM
Baran Palanimuthu, Alzamani Idrose
Emergency Department, Kuala Lumpur General Hospital, Kuala Lumpur, Malaysia

INTRODUCTION
Intra-abdominal foreign body is uncommon to be encountered in emergency setting especially usage of sex toys. We present such a case where patient presented with Dildo stuck in rectum.

CASE DESCRIPTION
27 years old Iranian man who is RVD positive not on any HAART therapy. Presented to our emergency department complaining sex toy (Dildo) stuck in anus since a night before presentation to emergency department. Patient was under recreational drug abuse upon the incident. Patient also complained abdominal pain and unable to pass out flatus.

Upon examination, Vital signs were normal, Abdominal examination: Abdomen not distended, Bowel sound present. Digital rectal examination: Foreign body felt.

Case was referred to surgical team for Examination under anestesia - rigid sigmoidoscopy and removal done. Intraoperative findings: FB removed with no difficulty, Rigid sigmoidoscopy done, no obvious mucosal injury/perforation noted.

Patient was discharged well after 2 days hospitalisation

DISCUSSION/CONCLUSION
Sex toy abuse is uncommon in daily practise especially in emergency department. However, patient who is in high risk group (RVD Positive) in these case and able to provide clear history, Sex toy abuse should be considered.

A systematic package of management, including calm the patient, pharmaco therapy (PPI once NBM), radioimaging (Abdominal x-ray) and counselling should be given to prepare patient before removal of foreign body.

We should be careful and precaution steps and proper systematic management needed to prevent patient from become more agitated which will harm himself (possibilities for perforated viscus)

Early referral to primary team (Surgical) will ensure FB to be removed as eary as possible to prevent any obstructive symptoms.

Upon discharge patient should be referred to psychology department for counselling to prevent recurrence in future.
There is always been a myth that airbag has been always the saviour of life. Airbags are not cribs or babysitters. They are in fact a hidden killer that can cause injuries and death to human beings during accidents. Due to high impact of the air bag inflation, it can cause traumatic brain injury among paediatric population. A typical case that was managed by emergency department was a traumatic brain injury that was caused by inflated air bag in a 3 year old child. The details of this case is presented below.

Case description: A 3 year old child was brought in to our emergency department as intubated from a private hospital for traumatic brain injury. A 3 year old child had alleged MVA (car versus car) from the opposite direction in a high velocity. Informed that child was wearing seatbelt on the passenger seat. After the collision, the air bag from passenger seat inflated in high impact manner but child was still remain seated on the passenger seat. The child’s GCS upon arrival to private hospital was 3/15 and therefore intubated for airway protection and referred case to ED HKL for further management. Upon review at ED HKL, child was intubated, but not sedated, pupil 4mm fixed on right had side and noted hypheme on the left side of the eye, and there was ongoing ENT bleed. Primary survey was cleared and extended fast scan was done and no free fluid was seen. Child was attempted for ct brain however was not stable enough for transportation due to his unstable vital signs. Noted that the child was experiencing hypotension and tachycardia and was started on Noradrenalin. Patient was then transferred to Peads ICU and currently the child is still at peads ICU HKL.

Lesson Leant and Conclusion: Air bag is designed to prevent extensive high impact injury over facial, neck and chest. However these air bags are mostly designed for adult population where similar amount of pressure that is applied towards paediatric population might be harmful. In this case as presented above, seat belt was applied and child was remained seated at passenger seat. Based on further analysis of the case, traumatic brain injury might have happened due to high impact of the accelerations and decelerations of the airbag. However the bleeding from the ears and nose has not been concluded. There is high possibility for basal skull fracture could have been caused due to the high inflation velocity of the air bag directed to the child’s face.

Intubation is necessary if child is presented with low GCS which is below 8/15 as airway protection measurement. Early referral to primary team is crucial for early interventions. There is limited study or literature has been conducted towards the air bag impact on children. Therefore proudly presenting this case for further evaluation of all the automobile companies for child safety.
Acute pancreatitis is not only an inflammatory condition of pancreas but may lead to fatal state. Even with great advances in critical care medicine over the past 20 years, the mortality rate due to acute pancreatitis remained at approximately 10%. Diagnosis of pancreatic problems is often difficult and management is often delayed as the pancreas is an organ which is relatively inaccessible especially in pregnant women. It is often difficult to diagnose an acute pancreatitis in a patient with gravid uterus, even inconvenient in a patient with underlying gastritis presenting with sudden pain at epigastric region sometimes extending to the back. The common causes of acute pancreatitis in pregnancy is often alcohol abuse or gall bladder or bile duct disease. It is thought with the weight and hormonal changes induced by pregnancy, gallstones are more likely to form and thus travel down the common bile duct to obstruct the pancreas duct outflow.

A 31 year old, Malay female G3P0+2 at 26 weeks 5 days who was previously well presented to us in the emergency department with the chief complaint of sudden onset of epigastric pain radiating to the back, on and off sharp in nature with a pain score of 8/10, relieved by leaning forward associated with vomiting of multiple episodes for one day containing water and food particles due to which she was unable to tolerate orally. Patient had no history of eating outside or skipping meals. Vital signs upon arrival was noted within normal range. Patient looked lethargic with epigastric tenderness with a pain score of 8/10. Urine dipstick showed albumin:2+, ketone: 1+, leucocyte:1+. FBC noted WCC:30.9, Hb: 12.2, Plt:384, Hct: 35, RP and LFT noted within normal range.

Initially patient was referred to O&G team and then to Surgical and Gastroenterology team with a working diagnosis of Acute Gastritis and TRO Acute Pancreatitis. Subsequently serum amylase noted 1608 and ultrasound abdomen noted cholelithiasis with bulky and heterogenous pancreatitis with no peripancreatic fluid or collection and acute pancreatitis cannot be ruled out due to raised amylase level.

Patient was discharged once observed with closed monitoring at medical ward and discharged once noted serum amylase level was decreased with no more symptoms. Patient was given TCA for gastro and O&G prn while surgical to see in 6 weeks for reassessment and planned for gall bladder removal post pregnancy.

INTRODUCTION
Acute pancreatitis is a fatal condition where the pancreas becomes inflamed over a short period of time. The pancreas is a small organ located behind the stomach and below the ribcage. Most people with acute pancreatitis improve within a week and experience no further problems, but severe cases can have serious complications that may cause death depending on the cause.
the nature or nature of disease. Most cases of acute pancreatitis in pregnancy are caused by
gallstone disease. Apart from other reasons such as alcohol use, trauma to pancreas as well
as reactions to medications, it is thought with the weight and hormonal changes induced by
pregnancy, gallstones are more likely to form and therefore travel down the common bile duct
to obstruct the pancreas duct outflow. Another theory of mechanism for acute pancreatitis in
pregnancy is high fat levels in the blood called triglycerides. As noted, the hormonal changes of
pregnancy can be a predisposing factor in some women. When the triglyceride levels become
too high, oxygen cannot adequately travel to the pancreas via the blood stream, and pancreatitis
may occur.

Patient commonly develops sudden severe epigastric or right upper quadrant pain lasting from
hours to several days, fever, vomiting, loose stool, rapid pulse and generalised feeling unwell if
not sought treatment.

CASE REPORT
A 31 year old, Malay female, G3P0+2 @ 26 weeks 5 days with a medical history of bronchial
asthma on MDI ventolin prn basis, gastritis not on regular medication and maternal obesity
presented to us with acute onset of epigastric tenderness radiating to the back associated with
vomiting. She arrived at emergency department within 24 hours of onset of symptoms. She
denied any history of trauma or fall, eating outside food, skipping meals or fever and no recent
hospital admissions. All other assessment of systems were unremarkable except epigastric
tenderness.

PHYSICAL EXAMINATION
The patient appeared obese, lethargic and very uncomfortable due to epigastric tenderness. The
initial vital signs are within normal range, fair hydration. Vital signs noted BP: 114/68, PR: 95,
SPO2: 100% under room air and afebrile with temperature of 37 degree celcius., CRT less
than 2 seconds, good pulse volume, warm peripheries, not tachypneic. The cardiopulmonary
examination was unremarkable. Per abdomen was soft, tender at epigastric region, uterus at
28 weeks and thick abdominal wall. Patient was still able to ambulate as usual. Urine dipstick
showed albumin: 2+, ketone: 1+, leucocyte: 1+. FBC noted WCC: 30.9, Hb: 12.2, Plt: 384, Hct: 35,
RP and LFT noted within normal range, serum amylase: 1608. ECG noted sinus tachycardia with
no acute ischemic changes.

The patient was diagnosed as acute gastritis TRO pancreatitis. However, in view of patient obese
and gravid uterus, unable to confirm diagnosis through clinical examination. Subsequently, case
referred to O&G team for fetal well being as well as surgical and gastroenterology team in view
of acute gastritis TRO pancreatitis. TAS done noted fetal heart present, was shown to mother.
Biparietal diameter and fetal length according to date, unable to measure head circumference and
abdominal circumference. Initially, RANSON score : 1, APACHE score : 7, BISAP score : 0. Apart
from positive blood investigations supporting diagnosis, ultrasound abdomen urgent was done to
confirm cause of diagnosis. Ultrasound noted cholelithiasis where distended gall bladder calculus
measuring 1.2x1.3cm found and bulky and heterogenous pancreas with no peripancreatic fluid
or collection noted. In view of raised amylase, acute pancreatitis cannot be ruled out.

Final diagnosis made by primary team was acute pancreatitis with cholelithiasis. Surgical team planned for removal of gall bladder post pregnancy with TCA after 6 weeks. Medical team and O&G team respectively monitored patient in ward and upon discharge for TCA prn.

**DISCUSSION**

Our patient was a 31 year old, Malay female, G3P0+2 @26weeks 5days with medical history of bronchial asthma on MDI ventolin prn basis, gastritis not on regular medications with maternal obesity presented with acute onset of epigastric tenderness radiating to the back. After obtaining a confirmed diagnosis, we encountered the challenge of further managing the patient in view of pregnancy and effect to baby. Patient was admitted to general medical ward for close monitoring of symptoms as well as daily updated blood investigations. Patient was daily seen by all three teams consisting medical, surgical and O&G team to make sure no complications occur to both mother and baby and condition can lead to mortality. This case represented a classic case of epigastric tenderness radiating to the back associated with vomiting with a pain score of 8/10 for the past one day. Although symptoms were just one day, we should not jump the gun concluding just any diagnosis. We have to be aware and take all possible cases into consideration especially with different conditions of different patients.

Acute pancreatitis is confirmed by medical history, physical examination, and typically a blood test (amylase or lipase) for digestive enzymes of the pancreas where it increases 3 folds. The basic blood investigations that can be taken are full blood count, renal profile, liver function test, amylase, triglycerides in order to diagnose 90% of these cases. In some cases when the blood tests are not elevated and the diagnosis is still in question, abdominal imaging, such as a basic ultrasound is performed especially in pregnancy where it is the safest for both mother and baby. Ultrasound uses sound waves that bounce off the pancreas, gallbladder, liver, as well as other organs, and their echoes generate electrical impulses that create an image, called a sonogram on a video monitor. If gallstones are causing inflammation, the sound waves will also bounce off of them, showing their location. This method does not transmit any radiation that will cause harm to mother and baby.

Diagnosis and outcome is also determined by a certain scoring system in view of monitoring daily progress of the patient to avoid fatality.

**TREATMENT**

The treatment of acute pancreatitis in pregnancy is similar to that of non-pregnant patients with some exceptions. Resting the digestive tract by not eating, pain control and aggressive fluids given through an IV line are vital. Typically, if the reason is gallstone pancreatitis, removal of the gallbladder is postponed until after pregnancy. If need be, a stent placed into the bile duct temporarily prior to proceeding with operation. However, if waiting until the end of pregnancy is not possible, surgical resection can generally be performed safely. If the cause of acute pancreatitis is due to triglycerides, medications and dietary modifications can be used to help
prevent recurrent attacks. However, if the attack occurs late in the third trimester, delivery is usually the option, as this will cause an immediate decrease in the triglyceride level. Other causes of acute pancreatitis, such as traumatic ductal injury, need to be carefully assessed on an individual basis.

OUTCOME
Mortality is less than 1% for acute pancreatitis in pregnancy. The rate of pre-term delivery, however, is about 20%. Also in patients with non gallstone pancreatitis, the rate of pre-term delivery appears to be higher. It is very important, therefore that pregnant patients present as soon as possible to the emergency room for evaluation should they develop any abnormal abdominal pain symptoms.

CONCLUSION
While a rare event, acute pancreatitis does occur in pregnancy. Fortunately, if treated early, generally pre-term labor and mortality can be avoided and the incidence of recurrent attacks minimized. Therefore, it is important to rapidly detect and diagnose for appropriate and early management for optimal results for both mother and baby. Emergency physicians should consider establishing acute pancreatitis as a diagnosis when such cases are seen on set.
OPEN TIBIAL FRACTURE WITH ANTERIOR TIBIALIS ARTERY (ATA) INJURY FOLLOWING EXTERNAL FIXATOR StABILIZATION WITHIN THE SAFE ZONE OF PIN INSERTION

Mohd Ariff Sharifudin, Nur Akmal Ismail Mansor, Nazri Mohd Yusof, Ahmad Fadzli Sulong

Kulliyyah (Faculty) of Medicine, International Islamic University Malaysia, Kuantan, Pahang, Malaysia

INTRODUCTION
In the setting of severe trauma, placement of external fixator is an expedient and minimally invasive method of temporarily stabilizing fractures. Neurovascular structures are still at risk despite the establishment of anatomic safe zones for placement of external fixation pins. Although the pin causing the iatrogenic arterial injury was placed under direct visualization, the degree of soft tissue injury altered the appearance of the local anatomy.

CASE REPORT
A 17-year-old man sustained an open tibial fracture type IIIC. Intra-operative exploration revealed an injured PTA with a 3-cm substance loss at the level of fracture. The dorsalis pedis artery (DPA) remained palpable and the toes were pink. A unilateral external fixator was applied to stabilize the fracture. Pins were inserted within the anatomic safe zones for pin placements. However, immediately after surgery, the toes were noted to be pale and DPA was no longer detectable even with Doppler ultrasonography. The distal pin was removed and the wound was re-explored. An iatrogenic partial ATA cut was noted near the pin insertion site. The pin placement was subsequently revised and both ATA and PTA were reconstructed using contralateral saphenous venous graft. Perfusion was restored immediately.

DISCUSSION & CONCLUSION
Careful assessment of external fixator pin placement is crucial to avoiding iatrogenic injury. A thorough vascular examination prior to leaving the operating room is essential while the patient remains in a controlled setting. This case highlights among the hazardous outcome associated with the use of external fixator stabilization, particularly when the normal local anatomy is altered due to trauma.
RESULTS OF IMPLANTATION OF AUTOLOGOUS MONONUCLEAR STEM CELLS IN PATIENTS WITH BUERGER’S DISEASE

Vascular Unit, Department of Surgery, Faculty of Medicine, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

INTRODUCTION
Buerger’s Disease is a segmental inflammatory occlusive disorder of unknown aetiology affecting the upper limb and lower limb. It is also known as thromboangiitis obliterans. Studies have shown Bone Marrow Mononuclear cells may enhance neovascularization in ischaemic limbs secondary to Buerger’s disease. We are describing 2 cases of Buerger’s disease with history of multiple amputations of the toes, treated with stem cell therapy.

ABSTRACT
CASE 1
25 year old smoker presented with non healing painful foot ulcer for 2 months duration. On examination, there was an ulcer at right fifth toe. Digital Substraction angiography showed a single arterial supply to both lower limb and cork-screw appearance at the ankle region. Wound debridment was done. Autologous bone marrow Mononuclear cells (BM-MNC) obtained using the standard protocol and injected intramuscularly to the calf, plantar and lateral region of the right lower limb. Another cycle of autologous bone marrow mesenchymal stem cells (BM-MSC) injection was done on the subsequent month. There was no immediate or post-procedure complication. Digital substraction angiography 1 month after the therapy showed improvement of collaterals at the affected leg. His ulcer healed at 2 months follow-up.

CASE 2
35 year old man, a smoker presented with wet gangrene of the right fourth and fifth toe. He had history of ray amputation of the right first and third toe, with right femoral-popliteal bypass done 6 months prior to this presentation. Digital Substraction Angiography showed feature of Buerger’s Disease.

Right transmetatarsal amputation was done. The wound was noted to be slow healing. 2 cycles of autologous bone marrow injection was done at the calf muscles, plantar and wound. Digital substruction angiography post procedure shows increased collateralizations of the right lower limb and foot. After 2 months, the transmetatarsal amputation wound healed, patient was asymptomatic.

CONCLUSION
Our results shows the stem cell therapy can treat ischaemic limb secondary to Buerger’s disease.
POPLITEAL ARTERY ENTRAPMENT SYNDROME: AN UNCOMMON CAUSE OF LOWER LIMB ISCHAEMIA
E S Lim, K Izan M G, Lenny S, Krishna K, Azim I, H Harunarashid
Department of Surgery, Faculty of Medicine, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

INTRODUCTION
Popliteal Artery Entrapment Syndrome (PAES) is a rare vascular disease that usually affects the young adults and athletes. It is a consequence of an abnormal positioning of the popliteal artery in relation to its surrounding structures. Patient usually presented with intermittent claudication and in severe cases, patient may presented with acute vascular insufficiency.

ABSTRACT
We are report a 32 years old soldier presented with intermittent claudication of the right leg for 2 years. The pain worsens for 2 months as the claudication distance reduced to 100 metres. He has no other risk except for heavy smoker. Examination shows the right leg was cold, no skin changes, intact sensory and the distal pulses was not palpable. Ankle brachial systolic index was 0.7. Digital substraction angiography of the right lower limb shows short segment chronic total occlusion of the distal superficial femoral artery. However there were reconstitution of the popliteal artery, anterior tibial artery and posterior tibial artery. Ultrasonography of the right leg shows the medial head of gastrocnemius impinge over the right popliteal artery. Intraoperative findings revealed Type II Popliteal Artery Entrapment Syndrome. Right myomectomy and popliteal bypass with interposition of vein graft was done. At follow-up, he has a complete resolution of his symptoms.

CONCLUSION
Popliteal Artery Entrapment Syndrome should be considered when dealing with young patients with claudication.
HEART FAILURE AS A PRESENTATION OF ABDOMINAL AORTIC ANEURYSM CAUSED BY THE PRESENCE OF AORTOCAVAIAL FISTULA

Krishna K, K Izan M G, Lenny S, Azim I, H Harunarashid
Department of Surgery, Faculty of Medicine, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

INTRODUCTION
Aortocaval fistula is an uncommon complication of ruptured abdominal aorta aneurysm (AAA). It accounts for 3-6% of all ruptured cases. The AAA usually ruptures to the retroperitoneum space or peritoneal cavity; rarely do they rupture into the IVC forming an aortocaval fistula.

ABSTRACT
We report a case of aortocaval fistula that was found during an elective abdominal aortic aneurysm repair. A 60 years old gentleman presented with lethargy and worsening of shortness of breath for 3 days duration. No history of abdominal pain or back pain. Clinically he was hypotensive and there was a pulsatile central abdominal mass. Computed tomography of the abdomen shows 8.7 x10 x 12 cm infrarenal abdominal aortic aneurysm that extend to the bifurcation of aorta. There was an aortocaval fistula noted. There was no evidence of leak or dissection. Open Abdominal Aortic Aneurysm repair was done. The fistula was closed within the sac with a monofilament polypropylene sutures. Post operatively patient developed hospital acquired pneumonia and prolonged ileus. He was discharge well on post operative day 10.

CONCLUSION
Aortocaval fistula is an uncommon complication of AAA. However the diagnosis should be considered as it may lead to massive bleeding intraoperatively.
CONGENITAL ARTERIOVENOUS MALFORMATION PELVIS AND PERINEUM: A MULTIDISCIPLINARY APPROACH

Lenny S, K Izan MG, Krishna K, Azim I, H Harunarashid
Vascular Unit, Department of Surgery, Faculty of Medicine, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

INTRODUCTION
Arteriovenous malformation of the perineum is a rare condition. Although most patients are asymptomatic but it may cause potential sexual dysfunction due to size and position of the lesion. The management of this condition remains challenging because of their unpredictable behavior and high recurrence rate.

ABSTRACT
We report a 28 year old lady with a painless swelling at the vulva since birth which causes her disfigurement. In the past she had seek various treatment but was advice to be treated conservatively due to the extensiveness. She was referred by a gynaecologist to us as she is getting married. On examination, there was a labia swelling size 6x5 cm. There was a limb length discrepancy with varicosities. Computed tomography of the pelvis and lower limb revealed extensive vascular malformation with mixed arteriovenous component involving the perineum, pelvis and left lower limb. Angioembolization was done prior to the excision. Excision was performed using argon plasma and ligasure supplemented with tissue glue for haemostasis. The wound was primarily closed. Histopathology report is consistent with arteriovenous malformation. Unfortunately it was complicated with wound breaksown and bleeding. This was treated with multiple surgeries and haemostasis. The wound was leave open with vacuum dressing and subsequently healed.

CONCLUSION
Treating arteriovenous malformation is challenging especially dealing with the risk of infection and bleeding.
INTRODUCTION
The Nutcracker Syndrome (NS) is a constellation of symptoms that arise as a result of venous hypertension within the left renal vein (LRV) caused by compression between the superior mesenteric artery (SMA) and the aorta.

ABSTRACT
We report a 18 years old girl with chronic abdominal pain, diagnosed with NS which was treated by endovascular stenting (EVS) with a new adjunct technique of monitoring the SMA angle during the procedure. She presented with lower abdominal pain for 1 year. No symptoms suggestive of Nutcracker Syndrome. Examination was unremarkable. She was extensively investigated. Computed tomography of the abdomen revealed compression of the left renal vein by the superior mesenteric artery and the aorta with varicosities of its tributaries. The superior mesenteric angle calculated on computed tomography scan was 47 degrees. A subsequent selective venogram showed preferential contrast flow into the left lumbar plexus and the left gonadal vein. During the endovascular stenting, the catheter was angled into the superior mesenteric artery origin for angle monitoring. A 14x60 mm self expanding nitinol stent was deployed. Post stenting run showed good stent expansion, no reflux into the left renal vein and an increased superior mesenteric angle to 55 degrees.

Post procedure, she recovered well. Her symptom was relieved. 1 year post procedure she remains asymptomatic, no evidence of stent migration with patent non dilated left renal vein.

CONCLUSION
EVS plus SMA angle monitoring is an attractive inexpensive new technique which can be used but needs further evaluation due to the potential subsequent risk involved.
A RARE CASE OF METASTATIC DISEASE OF THE AORTA


Department of Surgery, Faculty of Medicine, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

INTRODUCTION
Carcinoma of unknown primary (CUP) is defined as metastatic lesion without identifiable primary origin despite complete clinical history, physical examination; laboratory tests, imaging techniques and extensive histopathological specimen examination have been done.

ABSTRACT
We report a case of a 28 year old lady presented with worsening abdominal pain for 2 weeks duration. Examination was unremarkable. Computed tomography of the abdomen and pelvis showed aortic mass with paraaortic lymph node in which ultrasound guided biopsy confirmed to be metastatic adenocarcinoma. Position emission tomography (PET) scan and colonoscopy failed to find the primary tumour. Exploratory laparotomy, en bloc excision of the aortic tumour with aortic reconstruction with Dacron graft. 28 cycles of radiotherapy was given to the abdomen. She developed graft infection thus the graft was removed and a bilateral axillofemoral bypass was done. Follow-up computed tomography of the abdomen revealed a new lesion at segment V of the liver. Chemotherapy was given. On follow-up, she developed new lesions at the left anterior abdominal wall, right thigh and worsening liver metastasis. She was sent for second line chemotherapy.

CONCLUSION
Metastatic adenocarcinoma in the aorta is rare and can be treated by enbloc resection and reconstruction.
INTRODUCTION

Inferior Vena Cava (IVC) leiomyosarcoma is a very rare vascular tumour. It is a slow growing tumour, a fact that frequently delays the diagnosis and keeps the patient to be asymptomatic.

ABSTRACT

CASE 1

50 year old gentleman was incidentally found to have a large mass in the abdomen via ultrasound while he was being investigated for anaemia. Computerised tomography (CT) scan revealed a retroperitoneal tumour which was arising from the inferior vena cava. The tumour was resected en bloc and the inferior vena cava was repaired with a vein patch. No notable post operative complication. Histopathology examination shows grade I leiomyosarcoma of the inferior vena cava. The margin was clear. Patient was sent for chemotherapy. During follow-up, there was no evidence of recurrence.

CASE 2

61 year old lady presented with right hypochondrium pain and bilateral lower limb swelling. Abdominal examination was unremarkable. Both lower limbs are oedematous. Ultrasonography of the abdomen shows multiple liver cyst with biliary duct dilatation. Subsequent Computerised tomography abdomen revealed long segment occlusive thrombosis of infrahepatic inferior vena cava. No other suspicious lesion in other organs. Gastroscopy and colonoscopy was normal. PET scan showed a metabolically active intraluminal mass within infrahepatic inferior vena cava. Tumour markers were within normal limit. She developed bilateral femoral vein complete occlusion with left long saphenous vein thrombosis. Inferior vena cava filter insertion was done. Laparotomy showed inferior vena cava mass 7x7x6 cm in size and thrombosed bilateral renal vein. Resection of the mass and graft reconstruction done for the Inferior vena cava and the bilateral renal veins. The histopathology examination shows leiomyosarcoma. She was sent for chemotherapy. Post operatively, she developed chyle leak, successfully managed conservatively.

CONCLUSION

Leiomyosarcomas are the most common malignancy involving the IVC. Although there are correlations between clinical manifestations and the location of the tumour within the IVC, most patients present with non specific symptoms. Aggressive surgical treatment is recommended due to the tumour’s slow growth pattern and low metastatic potential, though chemoradiotherapy may serve as an adjunct.
ANEURYSM OF THE VISCERAL VESSEL: A RARE CAUSE OF ABDOMINAL PAIN

Vascular Unit, Department of Surgery, Faculty of Medicine, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

INTRODUCTION
Hepatic artery aneurysm (HAA) is a rare occurrence, comprising of approximately 20% of splanchnic aneurysms. Rupture of HAA can lead to potentially disastrous complications like hemobilia, cholangitis and upper gastrointestinal bleeding.

ABSTRACT
We report a case of a 55-year-old lady who presented to us with intermittent upper abdominal pain and fever for the past one month. She lost 4 kg in a month. Physical examination revealed a pulsatile mass at the epigastrium. Blood investigation was unremarkable. Computed tomographic scan revealed a large saccular aneurysm of the common hepatic artery measuring 6.6x7.3x9.3cm with intramural thrombus seen within. The gastroduodenal artery is being displaced posterolaterally by the aneurysm and is small in caliber. The hepatic artery proper, the left hepatic artery and the right hepatic artery are normal. Normal pancreatic parenchyma was only seen at the uncinate process and head of the pancreas. The adrenals, liver, spleen and both kidneys are normal. She was offered surgery or endovascular coiling of the aneurysm but she refused.

CONCLUSION
HAA carries a high morbidity and mortality rate. CTA will help to aid into the diagnosis. It can be treated surgically or by endovascular.
RESULTS OF AUTOLOGOUS BONE MARROW MONONUCLEAR CELLS IN THE TREATMENT FOR ACUTE LIMB ISCHAEMIA IN A PATIENT WITH CROHN’S DISEASE

Chua SH, Krishna K, K Izan MG, Lenny S, Azim I, H Harunarashid
Department of Surgery, Faculty of Medicine, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

INTRODUCTION
Chron’s Disease is associated with extraintestinal manifestation including vasculitis. Managing this group of patients is challenging due to vasculitis and microthrombosis.

ABSTRACT
We reported a gentleman with Chron’s Disease that presented with acute limb ischaemia. Clinically he was in pain and the toes were gangrene. He was anticoagulated but compounded by upper gastrointestinal symptoms. In view that the symptoms were augmented, intravenous iloprost infusion was given for 5 days. Digital subtracation angiography shows thrombosis of the left superficial femoral artery, with small collaterals. There was long segment deep vein thrombosis from common femoral to popliteal vein. He went for a transmetatarsal amputation, however the healing was poor. He was given autologous bone marrow mononuclear cells (first injection) and autologous bone marrow mesenchymal stem cell (second injection). Follow-up shows good resolution.

CONCLUSION
Autologous bone marrow therapy is a good option after all the options have been exhausted in managing Chron’s Disease patients with limb ischaemia.
INTRODUCTION
Chylous Ascites is defined as a pathologic accumulation of chyle in the peritoneal cavity. The incidence of Chylous Ascites following inferior vena cava tumor resection is rare.

ABSTRACT
We reported a case of inferior vena cava leiomyosarcoma. She underwent resection of the tumor with reconstruction of the inferior vena cava and bilateral renal vein using a graft. Intraoperatively was uneventful. At postoperative day 10, patient was noted to have a large amount of milky discharge from the laparotomy wound. The diagnosis of chyle leak was confirmed by fluid analysis that showed to have high triglyceride content. Computed tomography of the abdomen showed perihepatic collection which was connected to subcutaneous. Aspiration under ultrasound guidance was done for both the perihepatic and subcutaneous collection. 60 ml of chyle aspirated. After that collection of the chyle was done by putting a stoma bag at the wound. The wound was dry 1 month post operation. Repeat ultrasonography of the abdomen showed minimal collection at the hepatic region.

CONCLUSION
Chylous Ascites following of Inferior Vena Cava tumor resection is rare. It is commonly due to traumatic disruption of lymphatic during the surgery. Most of the patients are successfully treated conservatively.
INTRODUCTION
Urinary Tract Infection (UTI) is a very common disease. It can present with cloudy urine, urine with sediment or even clear urine. What if the urine is purple in colour? Is it an alarming colour?

We would like to highlight our purple encounter - purple urine bag syndrome (PUBS).

CASE PRESENTATION
66 year-old female, bed bound presented to a district hospital with difficulty in passing urine. Her bladder was catheterised, noted hematuria thus irrigation was performed. Post bladder irrigation, her urine was clear for 3 days.

Her condition deteriorated and was referred to us for further management.

Upon arrival, she was tachypneic and dehydrated. Temperature = 37.5°C, pulse rate = 146 beats per minute, blood pressure = 123/66mmHg, SpO2 = 95%. Systemic review was unremarkable. Her urine bag was filled with purple-coloured urine. Urine analysis showed pH 9, Leukocytes=3+, Ketone=4+, erythrocytes=4+ and nitrate negative. Total white count = 26.7x10^9/uL.

Urosepsis was diagnosed and she was treated with intravenous cefuroxime and admitted for further care.

DISCUSSION
PUBS is a rare entity. It is characterised by a purple discolouration of the urine bag in patients with prolonged bladder catheterisation in occurrence of UTI. The pathogenesis of it is the metabolism of dietary tryptophan by intestinal bacterias. The metabolites are catalysed by bacteria producing sulfatase and phosphatase into indirubin (red) and indigo (blue) pigments in the presence of alkaline urine. These pigments interact with the plastic of the urine bag to create the purple colour.

It generally affects female with profound disabilities on long term bladder catheterisation. It can be thought that it requires the presence of all the above factors to develop PUBS. Therefore, it is an uncommon encounter.

CONCLUSION
The purple-coloured urine can be distracting but PUBS is generally benign. Treatment should be aimed at the underlying infection and catheterisation hygiene.

KEYWORDS
Purple urine bag syndrome
ADMINISTRATION OF ANTI-EPILEPTIC IN MANAGEMENT OF SEIZURES BY PREHOSPITAL CARE RESPONDERS IN SUNGAI BULOH

Sarah SA Karim, Muhammad AI Suhaimi, Vasanthan R Mogan, Hazlimi A Hazis, Khairul N Mohamad
Hospital Sungai Buloh, Sungai Buloh, Selangor, Malaysia

OBJECTIVE
The management of seizures by prehospital care (PHC) responders are prevention of airway complications and if indicated administration of an antiepileptic. The administration of an epileptic require responders not only be trained on the pharmacology of the drug but also managing the subsequent effects of the medication. 90% of the patients transported by ambulance to the Emergency Department of Hospital Sungai Buloh (HSgB) receive care from Medical Assistant either from Primary Health Clinics or Emergency Department (ED). In Sungai Buloh, we conduct simulation training on management of seizures.

MATERIALS AND METHODS
We conducted a cross sectional observational study of all calls received by the Medical Emergency Coordination Centre (MECC HSgB) managed using seizures protocol between January 2014 till December 2015. We excluded response that was not transported to ED HSgB and interfacility referrals. The data form included dispatch information obtained by MECC dispatchers and first hour interventions provided by the ED team. Our study is aimed at looking into the frequency of antiepileptics being administered in the PHC environment by responders.

RESULTS
A total of 310 PHC response were included into our analysis. 71% of the response were provided by HSgB responders. In 20% of the response, seizures were witnessed by PHC responders. 75% of the patients with seizures witnessed by PHC responders received antiepileptics. Midazolam was the drug of choice used by our PHC responders in treating witnessed seizures. Three patients had documentation of breathing complications after the administration of antiepileptics.

DISCUSSION
Medical Assistant in our PHC system are comfortable with the first dose administration of midazolam for witnessed seizure patient using our seizures management protocol. The rate of documented breathing complications after the administration of antiepileptics is low.
“I CAN’T RECALL EVER FALLING” SUBTLE PRESENTATION OF CHRONIC SUBDURAL HEMATOMA IN GERIATRIC PATIENT

Alzamani Idrose, Saiful Safuan Mohd Sani
Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
In geriatric population, intracranial hemorrhage may not present in typical manner. We present a case in which patient could not recall any history of trauma but ended up having such pathology following investigation.

CASE DESCRIPTION
A 67 years old active gentleman complaints intermittent mild headache for a month. He denied any recent history of trauma. Nevertheless, the wife noticed that recently he had intermittent history of short-term lapse of memory. Apart from that, he had no nausea, can walk normally and had no other problems. He was brought to our centre by his son who was also a physician at our centre. Upon arrival, his pupils were equal and reactive and he had a full GCS and no other remarkable examination finding. Nevertheless, it was noted intermittently he had short term amnesia. Her vitals were normal and he was afebrile. Decision was made to proceed with CT SCAN. CT SCAN showed large chronic subdural hematoma over left parietal area measuring 5X3 cm over 4 layers causing midline shift and obliterating left ventricle. Contusion was also noted over left cerebellum. Neurosurgical team was referred and patient subsequently underwent clot evacuation. Post surgical procedure, patient recalled that he had a fall about 4 weeks earlier during jogging for which he denied any loss of consciousness. He also had history of going on long flight post fall about 2 weeks earlier. Patient had full recovery following the procedure. Patient likely had chronic subdural hematoma post-trauma complicated by history of flying.

LESSONS LEARNT AND CONCLUSION
This case illustrates the subtlety of chronic subdural hematoma in an elderly patient. Amnesia is a feature and in this case patient completely could not recall history of fall. Flying post intracranial bleeding provides decompression environment and increase risk of rebleeding. Apply high index of suspicion in such case and lower threshold for CT SCAN procedure so as not to miss such patients.
WORMS IN MY URINE! : SHISTOSOMIASIS
Mohd Safwan Che Jamil, Alzamani Idrose
Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
Schistosomiasis is rare in Malaysia. It is of risk for patients who had history of having fresh water contact in the jungle. We present a case of which a middle-aged lady who presented with history of passing worm in the urine.

CASE REPORT
43 years old lady who was previously well presented to our centre with chief complaint of passing ‘worms’ in her urine. Apart from that she was well had no associated symptoms. She denied any recent history of traveling, jungle trekking or eating raw meat. Her vital signs were normal and no fever recorded. There was no abdomen distention or tenderness on examination. All other systems were normal on examination. She brought the worm which was small and red in colour. His full blood count was normal. Bedside ultrasound did not show any abnormalities in kidneys and bladder. She was subsequently referred to urology team. A working diagnosis of schistosomiasis was made. Patient was admitted by the urology team for urethroscope. Praziquantel was started for treatment. The urethroscope showed 3 more worms and they were removed. Patient was well with no more symptoms after that. She completed Praziquantel.Consultation with Parasitology department confirmed that the worm was ‘schistosoma’.

DISCUSSION & CONCLUSION
On top of being a rare presentation in Malaysia, this case is even more rare without history of exposure to fresh water. It is prudent to keep the sample of the worm for confirmation and praziquantel may be started to eradicate the parasite.
‘DEADLY STRIDOR’ RETROPHARYNGEAL ABSCESS IN AN ELDERLY PATIENT
Zarif Syazani Sabudin, Alzamani Idrose, Nurul Liana Roslan
Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
Retropharyngeal abscess is rare in adults. We present such case in an elderly gentleman presenting to our centre.

CASE DESCRIPTION
A 66 years old Chinese man with the background history of hypertension had a procedure under general anaesthesia for open biopsy of a granulomatous lesion on his right posterior lumbar area 2 weeks earlier. He presented to our centre with the chief complaint of hoarseness of voice for 2 weeks developing after the procedure associated with difficult and noisy breathing. There was also a productive cough with white sputum. Upon arrival, patient had stridor and triaged to the red zone. His vital signs showed BP 162/88, PR 124, T 37.9 and SPO2 100%. On examination, patient was alert, conscious, tachypnoeic and loud inspiratory stridor was heard. There was no salivation at all. Throat inspection was normal. Generalized ronchi with tight air entry heard over both lungs. Initially a working diagnosis of bronchospasm secondary to hospital acquired pneumonia was made. A differential of epiglottitis and anaphylaxis were thought for. Patient was put on high flow mask at 15 L/min. Nebulizer using salbutamol and adrenaline were given. IV dexamethasone 8mg was started. IV Rocephine 2g administered as antibiotics. Subsequently, lateral neck X-ray showed expanded diameter of C6 and C7 retropharyngeal space while the anterior neck X-ray showed the ‘steeple’ sign. A final diagnosis of retropharyngeal abscess complicated by laryngeal oedema and sepsis was made. Patient was referred immediately to the ENT team as well as the anasthesiology team. He was then sent to the general operation theatre for elective intubation upon which laryngeal oedema was confirmed and admitted to the ICU. Unfortunately, patient deteriorated in the ICU and succumbed to death after 5 days there.

DISCUSSION & CONCLUSION
Retropharyngeal abscess is rare in adults. Have high index of suspicion for patients developing stridor after invasive procedure. Early presentation to hospital and administration of antibiotics could have saved patient’s life.
“I SWEAR I WASN’T TRYING TO Impress ANY WOMEN”: PRIAPISM SECONDARY TO HEMATOLOGICAL MALIGNANCY

Izzah Hazwani Dzulkifli, Alzamani Idrose, Yong
Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION

Priapism is more commonly thought as a result of sex-enhancing drugs abuse or in spinal injury. We present such case in an unsuspecting teenager which turns out to be an uncommon manifestation of underlying disease.

CASE DESCRIPTION

A 16 years old boy with no known medical illness presented to our centre with chief complaint of persistent erection. Patient initially went to Hospital Putrajaya (30 kilometres from our centre) and subsequently referred here. Patient had painful erection for a total period of almost 30 hours by the time we saw him.

He denied taking any medications, promiscuity or any recreational drugs abuse. He claimed to only have taken olive oil supplement for many years. Otherwise patient had no abdominal pain or fever and passed urine normally. No history of easy bruising or bleeding tendency or hematological disorder in family. Denied any trauma or spinal injury as well. His vital signs were stable. Upon examination, patient was pale and but had no jaundice. There was large splenomegaly extending to umbilical area. His penis was rigid, enlarged and tender on palpation. Both testes were palpable and normal. His full blood count showed: wbc 421, hb 7.4, hct 24, platelet 957. Patient was immediately referred to the urology team and sent straight to operation theatre for cavernosa aspiration. Diagnosis of Priapism secondary to Chronic Myeloid Leukaemia was made.

LESSONS LEARNT & CONCLUSION

Priapism can be part of manifestation of chronic myeloid leukaemia apart from pallor, aberrant blood counts and enlarged spleen. In this case priapism is most likely caused by venous obstruction from microemboli or thrombi as well as hyperviscosity caused by the increased number of circulating leukocytes in mature and immature forms. Pallor and sky-high white cell and platelet count should alert managing team to diagnosis of hematological malignancy.
“AIR IN MY EYE” : ORBITAL EMPHYSEMA

Muhamad Syis Zulkipli¹, Alzamani Idrose²

¹UKM Medical Centre, Kuala Lumpur, Malaysia
²Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
We report a case of left traumatic orbital emphysema following motor-vehicle accident.

CASE REPORT
A 15 years old boy presented with multiple facial bone fracture after alleged history of fall with face hitting the road while riding a motorcycle motor without a helmet. He had loss of consciousness but no ENT bleeding. Upon arrival his vitals were all normal and triaged to yellow zone. On examination, his GCS was 15. There was a swelling at glabella area with facial crepits and tender on palpation, increased intercanthal distance, depressed nasal bridge and mobile nasal bone. Mild chemosis with subconjunctival emphysema of left eye was noted. CT brain showed multiple facial bone fracture involving nasal bone, nasal septum, ethmoid and sphenoid fracture, anterior and medial wall of both maxillary sinus with air entrapment at left lateral rectus muscle and lateral orbital wall. Nasal bone fracture was treated conservatively by ENT team. Ophthalmology team treated patient symptomatically with close monitoring. He was admitted to neurosurgery unit for pneumocranium with base of skull fracture. In ward, he developed cerebrospinal fluid (CSF) rhinorrhea and was started on intravenous antibiotics. No clinical deterioration or visual impairment was reported during the duration of admission in neurosurgery ward.

DISCUSSION & CONCLUSION
Be aware of risks in a patient with orbital emphysema. Sunconjunctival emphysema sign should be recognized by clinician so as not to miss the diagnosis. Although most are benign, some may develop orbital compartment syndrome (OCS) leading to irreversible optic nerve neuropathy requiring surgery. In a not too severe case, conservative management with regular assessment can be considered.
‘NEEDLESS NEEDLE’: THE HAZARD OF SMOKING SHISHA
Syakeer Hilfie, Alzamani Idrose
Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
Shisha smokers sustain unhealthy risks associated with the heavy smoke inhaled into the lungs. We present an unusual case in which a needle used to poke the sisha aluminium foil was ingested into the alimentary tract.

CASE REPORT
A 36 years old Syrian who was previously well presented to our centre with the chief complaint of accidentally ingesting a needle. He came to our centre 3 hours after the ingestion. The needle was used to poke aluminium foil of the shisha and subsequently put in between his teeth. He was having fun with his friend and laughed and in the process ingested the needle. At our centre, his vital signs were all normal. He did not complain any pain or discomfort. X-Rays taken showed a 3 centimeters needle over the left gastric area. Surgical referral was made. Patient was observed for 6 hours. Subsequently, decision for surgery was made as the needle remained static.

DISCUSSION & CONCLUSION
Accidental needle ingestion is unusual. Needle does not travel within the gut easily and tend to get stuck. Surgical intervention is required to remove the foreign body.
“I AM TALL AND BREATHLESS FOR A REASON”: MARFAN’S SYNDROME WITH PNEUMOTHORAX

Muhammad Salahuddin Mohamed Ayoob, Shalini Krishna Kumar, Alzamani Idrose

Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
We present a case of Marfan’s syndrome presenting at our centre with chest pain and our approach of management.

CASE REPORT
A 17 years old young Indian gentleman who was well previously, presented with right sided chest pain for 4 days. Patient had chest pain and shortness of breath; worse during coughing. There was no sweating or nausea. Patient denied any history of recent trauma, exercise or sports injury. On arrival, he was hemodynamically stable but there was tachypnoea at the rate of 18 per minute while the oxygen saturation was 98% on air. Upon examination, the trachea was central. Slight increase in resonance was noted on percussion on the right lung. The lungs were clear on auscultation but reduced air entry noted over the right upper and middle zone. The chest X-Ray showed pneumothorax of the right lung (apex region) measuring 1cm. It was also noted that patient was thin and tall (178cm) and his arm span to height ratio was almost 1:1. His fingers were long and he had a high arch palate. Patient was given a high flow mask at 15L/min on top of nasal prong at 3L/min for 1hour, in the hope that there will be reabsorption of air. Nevertheless, the size increased to 2 cm on repeat X-Ray although patient felt a lot better with the oxygen delivery. A chest tube was inserted and patient was admitted to medical ward. Patient was diagnosed to have pneumothorax as well as Marfan’s syndrome. Patient stayed in ward for 3 days and discharged well.

DISCUSSION & CONCLUSION
This is a case of Marfan’s syndrome presenting with pneumothorax. It is a known fact that one of the features of Marfan’s syndrome is that patients may be prone to developing pneumothorax. Be alert in patients having features of Marfan’s syndrome and chest pain as this may indicate the development of pneumothorax.
“ONE IN AND ONE OUT”: A CASE OF HETEROTROPIC PREGNANCY

Fareena Zahari, Alzamani Idrose
Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
We share a case of in which a pregnant lady collapsed, resuscitated and revived with surgical intervention.

CASE REPORT
A 31 years old Chinese lady with Gravida 1 Para 0 at 8 weeks of pregnancy based on last menses was referred to our centre from private hospital with the chief complaint of abdominal pain and giddiness. Patient collapsed at the private hospital and CPR commenced for 20 minutes after which she regained return of spontaneous circulation. The full blood count (fbc) there showed a hemoglobin level of 7.4 and the urine pregnancy test was positive. No ultrasound was done. Patient was sent to our centre intubated after that with the diagnosis of ruptured ectopic pregnancy. Upon arrival, patient was intubated and sedated. The blood pressure was 80/54, and the heart rate was 120. Patient was pale and had poor pulse volume with cold peripheries. Ultrasound at the emergency department showed intrauterine growth sac. Free fluid was noted over the right Morrison pouch and at the pouch of douglas. Repeated fbc showed hemoglobin at 6.3. The arterial blood gas showed severe metabolic acidosis with pH 6.9 and Hco3 4.3. Patient was transfused with safe O blood. The obstetrics and gynaecology team was referred promptly and patient was pushed straight to the operation theatre. Intraoperatively patient had heterotrophic pregnancy (right ruptured tubal pregnancy + missed miscarriage intrauterine pregnancy). Tubal repair and dilation and curettage were performed. Post surgery, patient was placed in the intensive care unit (ICU). Patient recovered and discharged to normal ward after 4 days in the ICU. After another 3 days in normal ward, patient was discharged.

DISCUSSION & CONCLUSION
Heterotrophic pregnancy should be considered in patients with anaemic hemoglobin drop despite ultrasound finding of intrauterine growth sac. This is a rare condition and fast surgical intervention can save patient’s life.
INTRODUCTION
Acute coronary syndrome (ACS) typically presents with a chest pain. We present a case in which a patient with high blood pressure presented with only headache and cause diagnostic dilemma.

CASE REPORT
63 years old Malay lady doctor with underlying history of hypertension and left mastectomy for breast carcinoma presented with sudden onset of headache and lethargy in the morning. She was on tablet Amlodipine 10mg daily and took etoricoxib 90 mg but headache persisted. Upon arrival the blood pressure was 216/90 mmHg, heart rate 101 per minute and temperature 37.6 degrees Celcius while the pain score was 5/10. Patient was treated as hypertensive urgency and given captopril 25 mg and additional tramadol 50 mg in view of persisting headache and monitored in observation ward. There was no chest pain. 1 hour later, upon reassessment patient claimed worsening of headache. Fundoscopy showed no papiloedema. There was no obvious neurological deficit and ECG showed ST elevation with q wave in lead III and depression in leads I and AVL. Then, patient informed developing severe neck pain. CT Brain done ruled out subarachnoid haemorrhage. Patient was also uptriaged to resuscitation zone with troponin was taken. Repeat ECG showed evolving changes with Q wave at leads III, AVF and T inversion over II and AVF. Troponin level was raised at 0.256. The updated diagnosis were hypertensive emergency with NSTEMI. Patient was started IV infusion of GTN and was given T.aspirin 300 mg stat. Patient was further given enoxaparine and fondaparinox and admitted to the high dependency ward.

DISCUSSION & CONCLUSION
This is a case of hypertensive emergency affecting the myocardium but presenting atypically with high blood pressure and headache. Ensure ECG is always done especially for elderly patients despite no classic presentation of acute coronary syndrome. CT SCAN is essential to rule out intracranial event.
“THE FISTULA TWIST” CARDIAC ARREST DUE TO HYPERKALEMIA DESPITE COMPLIANCE TO DIALYSIS: A CASE OF DYSFUNCTIONAL FISTULA

Christopher Sheng, Alzamani Idrose
Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
A patient who is compliant to dialysis should not be having hyperkalemia. We describe a case at our centre who had cardiac arrest despite completing dialysis regularly.

CASE DESCRIPTION
A 45 years old Malay female lady collapsed at a dialysis centre and was brought in to the resuscitation zone by prehospital care crew with ongoing cardiopulmonary resuscitation (CPR). She had underlying end stage renal failure with good compliance to dialysis regime via a left fistula. She also had diabetes mellitus, hypertension and 3 vessel coronary disease. 2 weeks earlier, patient was treated for pneumonia. At the dialysis centre, patient collapsed after completion of dialysis. Patient was also defibrillated at the dialysis centre as she developed ventricular fibrillation. Patient was intubated and after 3 cycles of CPR at our centre, patient had restoration of spontaneous circulation. Patient was given 10% calcium gluconate 10ml, iv sodium bicarbonate 50 cc and iv insulin 6 unit per hour during resuscitation. The ECG showed complete heart block. Our impression was that patient developed the VF and subsequent asystole due to hyperkalemia. Dopamine was started upon recovery as the BP was lowish (90/60 mmHg). The Arterial Blood Gas showed mild metabolic acidosis. The wcc count was raised (22). Hyperkalemia was confirmed as the renal profile showed potassium of 8 mmol/L. One more lytic cocktail was administered and upon completion, the complete heart block was reverted to normal sinus rhythm. Patient’s fistula was reassessed found to be dysfunctional. Hence the cause of hyperkalemia despite compliance to dialysis.

LESSONS LEARNT & CONCLUSION
A patient may still get hyperkalemia despite being compliant to dialysis when the fistula is dysfunctional. Resuscitation of ESRF patients should include lytic cocktail as hyperkalemia is the most common cause of arrest.
‘IT CREEP UNDER MY SKIN’ SUBCUTANEOUS EMPHYSEMA FOLLOWING PENETRATING INJURY WITH DELAYED MEDICAL PRESENTATION

Cyrus Lai Sin Nan, Alzamani Idrose
Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
Penetrating injury should not be taken lightly and thorough investigation should be performed so as not to miss life-threatening conditions. We describe our patient who did not seek treatment immediately after having such injury.

CASE DESCRIPTION
13 years old boy with a history of alleged fall the day before in prone position while playing in the park came to our centre with the chief complaint of pain and wound over his abdomen. He claimed to have landed on a metal sharp object which pierced over the left abdomen. Patient earlier pulled out the object and went home, claiming only minimal bleeding. On examination, patient was comfortable with stable vital signs. There was a puncture wound over the left lumbar measuring 0.5 x 0.5cm, with subcutaneous emphysema extending up to the left hypochondriac region. Abdomen was soft and not tender. Lungs had equal air entry and no subcutaneous emphysema. No intraperitoneal free fluid on focused assessment with sonogram for trauma (FAST). CT Abdomen was done subsequently and showed skin and underlying muscle defect over the left side of abdomen resulting in subcutaneous emphysema. Nevertheless, there were no evidence of solid organ injury or perforated viscous. Patient was referred to the surgical team and wound debridement was done under general anaesthesia. Patient was well after operation and discharged 4 days later.

CONCLUSION & LESSONS LEARNT
Any penetrating injury should be investigated fully. CT SCAN is helpful in being certain of injuries sustained. Public awareness is required so that patients would come to the hospital for thorough assessment so as to avoid life-threatening condition.
ANGRY WOLF ON MY LEG: BULLOUS ERYSIPelas

Nishkah Jeyapalasingam, Alzamani Idrose

Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
We present a patient developing bullous erysipelas following trauma.

CASE DESCRIPTION
A 36 years old Indian gentleman presented to our emergency department with the chief complaint of reddish wound over the right shin and fever after history of abrasion wound following alleged history of fall from his motorcycle 1 week earlier. He came to our centre then whereupon wound irrigation and dressing was done with antitetanus given and discharged. For this current consultation, diagnosis of infected wound was made. Dressing was done and patient was discharged with paracetamol and cloxacillin 500mg tds as the skin did not look too bad. The fever resolved after 3 days. On Day 14 post-trauma, patient returned to our follow-up clinic after noticing that the wound became more extensive involving most of anterior shin. The area was erythematous and thickened with multiple bullae. In view of the worsening of the wound, referral was made to dermatology team. Patient was diagnosed as having bullous erysipelas. He was treated as out patient by the dermatology team with oral antibiotics and cream. He came back for given appointment after 7 days at the dermatology clinic and the wound was healing well. Discussion Bullous erysipelas, is a clinical diagnosis that indicates superficial cellulitis with lymphatic involvement; it is typically caused by group A β-hemolytic streptococci. It typically appears on the legs and face as sharply demarcated, tender erythema and edema, with an indurated border. Diagnosis involves the differential exclusion of cellulitis, allergic contact dermatitis, bullous pemphigoid, necrotizing fasciitis and varicella– zoster. Management of bullous erysipelas includes appropriate empiric antibiotic therapy, with consideration given to local rates of MRSA.

LESSONS LEARNT & CONCLUSION
Be aware that simple abrasion wound following trauma in some cases may develop bullous erysipelas as a complication. Late initiation of antibiotics may predispose this. A prolonged course of antibiotics is required for this condition because of risk of reinfection and the recovery takes longer time.
“BREAKING MY HEART, SHATTERING MY CHEST, CLOUDING MY BRAIN” : A CASE OF COMMOTIO CORDIS WITH STABLE VT FOLLOWING A POLYTRAUMA

Fatin Salwani Zaharuddin, Lailajan Mohamed Kassim, Alzamani Idrose
Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
We describe a case in which a patient without any past co-morbid present to our centre with cardiac dysrhythmia.

CASE DESCRIPTION
31 years old male pedestrian was hit by a car. Patient was seen having seizure at the scene of accident. Ambulance team responded and brought the patient back to our department. The seizure aborted spontaneously. Upon arrival, patient was unconscious. The GCS was 3/15. Pupils were unequal. BP 180/110 HR 69. Patient was immediately intubated. After 30 minutes, patient developed ventricular tachycardia (VT) but with pulse palpable. Synchronized cardioversion delivered at 150 & 200J, 200J. Rhythm reverted but recurred and another 200, 200 J delivered. Patient still had VT intersped with mixture of poly and monomorphic PVC. IV MgSO4 2.47gram was given in quick infusion over 15 minutes and no more recurrence noted. CT SCAN showed SAH and SDH with cerebral edema. Bilateral lung contusions were seen on CXR. Patient was treated conservatively in neurosurgery ICU. The VT was attributed to cardiac contusion (commotio cordis). The troponin level was high. Patient’s cardiac condition stabilized until he was admitted to neurosurgical intensive care unit. However, patient succumbed 3 days later due to severe traumatic head injury.

LESSONS LEARNT & CONCLUSION
This is a rare case in which patient developed persistent stable VT after having head injury following a motorvehicle accident. Magnesium sulphate was useful in reverting the rhythm to sinus rhythm in this case.
“SHORTENED AIRWAY” OPEN TRACHEAL INJURY FROM SLASHED WOUND

Nurul Liana Roslan, Alzamani Idrose, Ibrahim
Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
Slashed wound over neck may be deadly. We present a case in which a patient was lucky that the slash wound spared the carotid arteries but cut open the trachea.

CASE REPORT
A 34 years old gentleman was attacked by a gangster. His throat was slashed with a parang. The slash left his trachea open and he was breathing through it. Patient was brought to our centre with an ambulance. On arrival, patient was able to breathe through the open trachea. No active bleeding was noted. The slash missed injuring the carotid arteries, jugular veins, thyroid gland and esophagus. Patient was immediately given IV Morphine 5 mg and Metochllopromide 10mg. He was then sedated with IV Midazolam 5mg. Patient was paralyzed with IV Suxamethonium 75mg. Endotracheal tube of the size of 7.5 mm was used to insert the trachea and the process was easy. Patients BP was 165/90 mmHg, HR 110 bpm and SpO2 88%. Better sealing was made using gauze around the entry site of the tube and the SpO2 went to 100%. The ETT end was stabilized using the head immobilizer. ENT team was called in and patient was sent to the operation theatre(OT). Intraoperatively, patient had injured hypopharynx and larynx cartilages. Laryngeal nerve was injured. Emergency tracheostomy was performed in the OT. The next morning patient undergo repair and anastomoses procedure.

DISCUSSION & CONCLUSION
Airway is the most important component to be preserved in order to keep patient alive. Direct intubation using endotracheal tube may be performed in order to keep patient’s airway patent. Sealing is required since the normal cuff may not be adequate. Immediate attention by both the ENT and anaesthesiology team to preserve and repair the trachea in the operation theatre is essential to save patient’s life.
‘DISARMED’ AMPUTATED FOREARM AT THE ELBOW JOINT
Prasannah Selvarajah, Ahmad Ibrahim Kamal Batcha, Alzamani Idrose
Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
We present a rare trauma case in which the whole forearm was amputated from a motorvehicle accident but could be reattached with expedient emergency medical response by multiple teams.

CASE REPORT
A 32 years old gentleman had an alleged history of fall of his motorcycle. As he fell, his left elbow was cut through and through by a telephone cable by the roadside. The whole forearm was amputated. He was brought to the hospital via an ambulance and arrived along with the limb. On arrival, his GCS was full. The BP was 142/88, HR 101 bpm and SPO2 97% on air. No active bleeding was noted over his elbow stump. Fluid was started, antitetanus toxoid administered and analgesia in the form of morphine 5 mg was given. Pain was well controlled. Wound irrigation was performed on the stump. Wound irrigation was also performed using normal saline on the segregated forearm. It was then wrapped in a plastic and placed in plastic filled with ice and kept in an ice-box. The orthopaedics team was called in. Patient was sent to the operation theatre in the attempt of limb reattachment. Unfortunately, the procedure failed and stump refashioning was performed.

DISCUSSION & CONCLUSION
Preserve limbs with double layered iced plastic bag. Wound irrigation is essential to ensure contaminants are removed early to avoid infection post-surgery. With a bit of luck, amputated forearm may be reattached with patient surgical repair work. Unfortunately, this procedure failed. Pre-procedure counseling is essential to prepare patient’s mind.
INTRODUCTION
Brugada syndrome is deadly and caused by abnormal sodium channel. We present a case in which patient was treated for arrhythmia but incidentally found to have the syndrome.

CASE REPORT
34 years old gentleman with background history of Bronchial asthma on MDI Salbutamol and MDI Budesonide presented to our centre with fever, cough, shortness of breath, wheezing and palpitation for 2 days. On arrival, he had ronchi on auscultation and was sent to the asthma bay and given a Salbutamol nebulizer followed by another two using Combivent. It was noted patient had severe tachycardia with a heart rate of 170bpm. First ECG showed atrial fibrillation (AF) with rapid ventricular response with RBBB. On examination, he was alert, GCS 15/15, mild tachypneic, normal hydration and good perfusion. No signs of heart failure. Crepitation over the left lower lung with scattered rhonchi. BP 104/50, HR 176, Temp 37.4, Spo2 100% under room air. Cardiac monitor showed AF with rate of 160-180bpm. IVD NS 10ml/kg and IVI MgSO4 2.47g given, yet persistently fast AF. He was given 1 dose of IV Verapamil 5mg and this successfully reverted to Sinus rhythm. Repeated ECG showed sinus tachycardia, HR 100, Brugada Type 1 (Elevation of J-point, a coved type ST segment with inverted T wave over V1-V2). Patient is otherwise asymptomatic. On further history, patient had 3 episodes of unexplained syncope and never investigated. No family history of cardiac disease, nor sudden death. Patient was admitted at Coronary Care Unit. The final diagnosis was AF with rapid ventricular response secondary to Community acquired pneumonia with underlying Brugada syndrome Type 1.

DISCUSSION & CONCLUSION
The Brugada pattern is only recognized once patient’s fast AF was reverted to sinus rhythm. History suggested that patient survived multiple syncopal events. ECG recognition is pivotal so that implantable cardiac defibrillator can offered as that would save patient’s life.
INTRODUCTION
Carbon monoxide exposure is potentially deadly and has been used in suicidal attempt. We present a case in which such poisoning occurred accidentally in a faulty car exhaust system.

CASE DESCRIPTION
A 43-year-old gentleman was found unresponsive in his car around noon. Passers-by alerted the ambulance. On paramedic assessment, he was unconscious with GCS of 11/15 (E3V3M5) and appeared flushed. The BP and heart rate were normal. Pulse oxymetry showed 100% under room air. Nevertheless, he was put on a high flow mask oxygen at 15L/min. His GCS became full on arrival to hospital but still groggy. He complained of lethargy, sleepiness and giddy for the last 3 days. He drives a Kancil (a compact car produced locally between 1994 and 2009 which name means ‘mousedeer’) and for the preceding 3 days has been driving car more than usual. He admitted smelling exhaust fume within the cabin. He also napped in the car twice in those days for half an hour each time. At the emergency department, vital signs were stable and the SPO2 was 99% with random blood sugar level of 10.7mmol/L. The arterial blood gas showed carboxyhemoglobin level of 46.5% (normal value for non-smokers < 3%, for smokers < 10%). Patient was put on a non-rebreathable high flow mask and the level came down to 20.3% and 12% at 30 minutes and 60 minutes respectively. Patient was admitted for observation and after 2 hours, the level had normalized to less than 3%. He was discharged well the next day.

LESSONS LEARNT & CONCLUSION
Consider carbon monoxide poisoning in an unconscious person with high oxygen saturation and reddish skin. Accidental poisoning should be suspected in patients present being unconscious in old vehicle with presence of fume smell within the cabin or car that rattles.
INTRODUCTION
Tenecteplase is new generation of fibrin specific thrombolysis. It is perceived as higher superiority in terms of efficacy, complications and mortality as compared to streptokinase.

There is limited literature comparing tenecteplase and streptokinase.

MATERIALS & METHOD
This is prospective cross sectional study of convenient sampling in Hospital Umum Sarawak over a period of 6 months. Patient was diagnosed and treated as MI by attending physicians. The choice of thrombolysis is at discretion of the treating doctors. Outcome data was collected in ED or Cardiology centre, Sarawak. Criteria for successful reperfusion includes resolution of ST elevation of at least 50%, resolution of symptoms, and improvement of clinical pictures.

RESULTS
45 patients were enrolled in this study. Our patients were predominantly male (93.3%), Bumiputera in origin (64.4%) with a mean age of 59 years old. 62.3% were smokers and 64.6% has at least 1 premorbid condition. 22 patients were given tenecteplase, with 6 failed reperfusion. 23 patients received streptokinase, with 5 patients failed thrombolysis. 62.2% of the lesion arise from the left coronary artery. Rate of mild bleeding is similar between both group. There is no major bleeding in this cohort.

DISCUSSION
From our data, there’s no different in success rate or bleeding rate between tenecteplase and streptokinase regardless of demographic or type of coronary lesion. Larger prospective RCT study is needed to confirm our findings.
AN OPEN LABELED RANDOMIZED CONTROL TRIAL OF STEROFUNDIN COMPARED TO 0.9% NORMAL SALINE INFUSION FOR THE TREATMENT OF DIABETIC KETOACIDOSIS
Rossman Hawari¹, Nik Azlan Nik Muhammad¹, Mahathar Abd Wahab²
¹Emergency Department, Pusat Perubatan UKM, Kuala Lumpur, Malaysia
²Emergency Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

INTRODUCTION
The mainstay treatment for managing Diabetic Ketoacidosis (DKA) is rehydration but the ideal fluid for it is still controversial.

OBJECTIVES
The objectives of the study was to compare the rate of resolution of acidosis in DKA patients treated with 0.9 % NS and Sterofundin® over 12 hours and to compare the significant ion difference, the clearance of blood ketone over 12 hours, the electrolytes between the two groups.

METHODS
The study was a prospective open labeled randomized control trial. Sterofundin® was used for fluid replacement therapy compared to the standard therapy of 0.9% NS in DKA patients. The study was conducted over 6 months. The sample size was 18 patients with 9 patients in each arm. The mean changes of acidosis and electrolytes was measured over time and compared between the two group using student t test to measure statistical difference. The rate for renal replacement therapy and mortality rate was calculated.

RESULTS
The biggest pH improvement difference was in the first two hours. The SIDs and ketone clearance in both group is not significant between the two groups. The anion gap decrease with time in both group. The potassium level in the Sterofundin® group was not raise during the 12 hours of infusion. The morbidity and mortality is similar in both group.

CONCLUSIONS
Comparing the two groups, there is no significant statistical improvement in the biochemical changes during the treatment of DKA and it does not translate into significant clinical outcome.
INTRODUCTION
Age-related memory dysfunction is the main symptom of dementia-related disorders.

Current treatments for dementia are limited, and no therapies are known to halt the development of this neurodegenerative disease. In this study, we tested the hypothesis that electrical stimulation of the medial prefrontal cortex (mPFC) enhanced learning and memory-related behaviors in an aged animal model.

MATERIALS AND METHODS
Aged rats were stimulated in the mPFC and they were behaviorally tested for hippocampal-dependent memory and anxiety-related tests to evaluate possible side-effects. The molecular mechanisms in the hippocampus along with other brain regions were investigated using a combination of in vivo electrophysiological recording, immunohistological and biochemical approaches including DNA microarray-based genome-wide analyses with real-time quantitative PCR and western-blotting techniques.

RESULTS
Our data demonstrated that electrical stimulation targeting specifically the mPFC evoking powerful memory enhancement effects in aged animal model. Our results showed a remarkable increase of neural progenitors, surviving BrdU-positive cells, and dendritic arborization after chronic stimulation as compared to the control. Principle component analyses revealed differentially expressed genes in both the dorsal and ventral hippocampi. Pathway analysis showed a distinct pattern of biological signaling mechanisms after stimulation in particular the monoamine and synaptic neurotransmission, neuroplasticity-related functions, regulation of cyclic adenosine monophosphate metabolic and biosynthetic processes. In addition, the electrophysiological and histochemical data have also demonstrated that mPFC stimulation evoked a specific brain circuitry modulation of the serotonergic networks, which linked to the dorsal raphe nucleus in regulation of the mood and hippocampal-dependent memory behaviors.

DISCUSSION
Our findings suggested that electrical stimulation of the mPFC has the potential to be developed into a therapy to treat patients suffering from dementia. Importantly, the mechanisms by which stimulation improves memory functions are likely to be mediated by a complex hippocampal signaling pathways that underlie the process for memory acquisition, consolidation and retrieval.

KEYWORDS
Deep brain stimulation, aging, dementia, learning and memory, neuroplasticity
ELECTRICAL STIMULATION RESCUES DOPAMINERGIC DEGENERATION IN THE DORSAL RAPHE NUCLEUS AND ENHANCED HIPPOCAMPAL NEUROGENESIS OF VULNERABLE DEPRESSIVE-LIKE RATS

Sharafuddin Khairuddin\textsuperscript{1}, Wei Ling Lim\textsuperscript{2}, Yasin Temel\textsuperscript{3}, Lee Wei Lim\textsuperscript{1,2,3}

\textsuperscript{1}School of Biomedical Sciences, Li Ka Shing Faculty of Medicine, the University of Hong Kong, Hong Kong

\textsuperscript{2}Department of Biological Sciences, Sunway University, Selangor, Malaysia

\textsuperscript{3}Departments of Neuroscience and Neurosurgery, Maastricht University, the Netherlands

INTRODUCTION

Electrical stimulation has been proposed as a potential therapy for patients with treatment-resistant depression. In this study, we investigate the effects of high-frequency stimulation (HFS) in different brain regions on various depressive-like behaviors using the stress resilience and vulnerable rat depression models.

MATERIALS AND METHODS

Rats were exposed to chronic unpredictable stress procedures (CUS) for 3 weeks. Vulnerable and resilience animals were characterized based on their sucrose consumption levels during CUS procedures. CUS-treated rats received HFS in the lateral habenula (LHb), ventromedial prefrontal cortex (vmPFC), nucleus accumbens (NAc) and they were tested for depressive-like behavioral experiments. The morphological changes of dopaminergic neuron and hippocampal neuroplasticity were determined by immunohistochemical labeling methods.

RESULTS

CUS exposure for 3 weeks increased number of animals (51%) exhibiting reduced sucrose consumption, separating the resilience and vulnerable group of CUS-induced model. CUS vulnerable sham animals demonstrated anxiety-like behavior, decreased motivation and increased immobility compared to that of the resilience group, implicating high susceptibility of vulnerable individuals to the CUS procedure. Interestingly, vmPFC HFS significantly reduced anxiety response, increased hedonia and motivation levels for food intake in the vulnerable group compared to the resilience group, while HFS in other brain regions did not show difference. HFS in vmPFC and LHb also showed reduced behavioral despair in both CUS vulnerable and resilience group. In histochemistry, our results demonstrate that vmPFC HFS rescued the stress-induced dopamine neuron degeneration in the dorsal raphe nucleus, as well as increased hippocampal neurogenesis of stress vulnerable animals.

DISCUSSION

These results suggest that vmPFC HFS effectively restores depressive-like behaviors by mechanisms of dorsal raphe dopaminergic neurons restoration and enhanced hippocampal neuroplasticity in the vulnerable CUS-induced model. Further studies are needed to understand the underlying mechanisms of HFS on the resilience and vulnerable group of CUS-induced depression models.
KEYWORDS
High-frequency stimulation, depressive-like behavior, resilience and vulnerable, dopamine, hippocampal neuroplasticity
TRAUMA SCORING SYSTEMS IN MALAYSIA: WHICH ONE?
Sabariah F Jamaluddin, Ikhwan H M N, Choy R X Y, Thyagarajan Ravi C, Yeo Y L
Hospital Sungai Buloh, Sungai Buloh, Selangor, Malaysia

INTRODUCTION
In Malaysia, trauma is the third most common cause of admission to government hospitals, and 6th principle cause of death. A good trauma score can be used to estimate the severity of the disease, assist in appropriate triaging of the patient, a benchmark tool to compare between centres and research utility for epidemiological databases. Trauma and Injury Severity Score (TRISS) commonly used to evaluate the severity and probability of survival is complicated and resource intensive. Our objective is to study whether simpler trauma scorings is comparable to TRISS in evaluating severity of trauma.

METHODS
A retrospective analysis of data from the National Trauma Database (NTrD), which included 8 secondary hospitals in Malaysia were done. Patients above the age of 16 who presented between 1/1/2006 to 31/12/2009 were sampled. Cases with missing variables were excluded from analysis. The trauma scores of TRISS, Kimura simplified TRISS (sTRISS), Revised Trauma Score (RTS), Kampala Trauma Score (KTS), KTS II, GAP, mGAP were calculated for each patient. Discrimination was assessed using the area under the receiver operating characteristic curve (AUROCC).

RESULTS
A total of 3322 patients were included after exclusion of missing variables. All scores performed equally well with AUROCC value of between 0.84-0.85; TRISS 0.85 (95% CI 0.84-0.86), RTS 0.84 (95% CI 0.82-0.85), KTS 0.84 (95% CI 0.83-0.85), KTS II 0.84 (95% CI 0.83-0.85), GAP 0.85 (95% CI 0.84-0.86); mGAP 0.84 (95% CI 0.83-0.86), Kimura sTRISS 0.85 (95% CI 0.84-0.86).

DISCUSSION
Malaysia a middle-income nation do not have the capacity for highly resource intensive trauma scoring system such as TRISS which are often complex and time consuming. Our study has shown that using simpler trauma scoring systems perform as well as internationally accepted TRISS and can be used for benchmarking and trauma quality audits.

KEYWORDS
Trauma, scoring, systems, deaths
THE APPLICATION OF SERUM BIOMARKERS TO DETECT PRE-MALIGNANT LESIONS IN GASTRIC CORPUS

H L Tan¹, C S Ngiu¹, N R Kosai², J Naidu¹, R Abdul Rani¹³, M H Elias⁴, N M Mokhtar⁴, NA Hamid⁵, R A Raja Ali¹

¹Unit of Gastroenterology and Hepatology, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia
²Upper Gastrointestinal and Bariatric Surgery, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia
³Faculty of Medicine, Universiti Teknologi Mara, .......................
⁴Department of Physiology, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia
⁵Faculty of Medicine and Health Science, University Sains Islam Malaysia, .......................

INTRODUCTION
Gastric adenocarcinoma is often diagnosed at advanced stage, leading to cancer death. Corpus-predominant atrophic gastritis increases the risk of gastric cancer. We aim to investigate the utility of serum biomarkers to diagnose chronic atrophic gastritis (CAG) and intestinal metaplasia (IM) and determine the sensitivity and specificity of serum pepsinogen I (PGI), pepsinogen II (PGII), ratio of PGI to PGII (PG I/II) and gastrin-17 (G-17) in detecting these lesions.

MATERIALS AND METHODS
We performed a cross sectional observational study involving patients who underwent gastroscopy for dyspepsia in our unit. Endoscopic CAG is graded based on Kimura-Takemoto classification and gastric biopsies were analyzed using updated Sydney system. Serum PGI, PGII, G-17 and H. pylori antibody levels were measured by enzyme-linked immunosorbent assay.

RESULTS
A total of 72 patients with mean age of 56.2 years (±16.2) were recruited. The median level of PGI, PGII, PG I/II ratio and G-17 for all subjects were 129.9µg/L, 10.3µg/L, 14.7 and 4.4pmol/L respectively. Subjects with corpus CAG/IM had significantly lower PG I/II ratio (7.2, p< 0.001) compared to the control group (PG I/II=15.7). There was no significant difference in serum G-17 level between antral CAG/IM group and non-CAG group. Histological CAG and IM correlated well with serum PG I/II ratio (r = -0.417, p< 0.001). The cut off value of PG I/II ratio of ≤ 10.0 exhibit high sensitivity (83.3%), specificity (77.9%) and area under the ROC curve (AUC) of 0.902 in detecting corpus CAG/IM. However, at PG I/II ratio of ≤ 3.0, the sensitivity was very low. Serum PG I, PGII and G-17 level have low sensitivity in detecting CAG/IM.

CONCLUSION
Serum PG I/II ratio could potentially be used as an outpatient and non-invasive method for detecting pre-malignant gastric lesions, in particular chronic atrophic gastritis and intestinal metaplasia in gastric corpus.

KEYWORDS
Gastritis, atrophic; metaplasia; pepsinogens; gastrin-17
INTRODUCTION
Hydrogen sulfide (H₂S) is a colorless gas with a distinctive rotten egg odor. It originates as by-product from organic matter breakdown under anaerobic condition. Well known as being extremely toxic, it may lead to immediate loss of consciousness and death upon exposure.

CASE SERIES
We report a case of hydrogen sulphide poisoning in a fishing vessel involving six fishermen who accidentally inhaled high concentrations of H₂S when they opened the storage containing a-week trip’s catch. The ship’s hold had a faulty cooling system leading to H₂S production from the decomposed fish.

Six victims were identified, of whom 2 died on site. Both EMS and HAZMAT teams were activated. 3 of the survivors were in respiratory distress and subsequently required intubation. Upon arrival to ED, Patient 1 had cardiac arrest and succumbed to death. The latter two, developed acute respiratory failure and electrolytes abnormalities. Patient 2 was given nitrite therapy but passed away on post trauma day 3 while Patient 3 was successfully extubated and discharged well with supportive treatment alone. Autopsy findings revealed that victims suffered massive pulmonary hemorrhage secondary to gas inhalation. The last victim, Patient 4, experienced mild respiratory symptoms and was discharged well after observation. HAZMAT team detected presence of 50 parts per million (ppm) of H₂S at site, 1-2 hours from EMS activation time. Diagnosis of multiple gas poisoning was made as high levels of ammonia was also detected in patients’ blood, apart from the on-scene detection of H₂S.

DISCUSSION AND CONCLUSION
Hydrogen sulfide poisoning has been a major concern in the petroleum, agricultural and fishing industry. Our review attempts to increase knowledge and awareness of this danger in fishing industry and explore treatment modalities including the proposed antidote and hyperbaric oxygen therapy (HBOT) as therapeutic adjunct. The optimum mainstay therapy however remains supportive.

KEYWORDS
Hydrogen sulfide; nitrite therapy; hyperbaric oxygen therapy; fishing industry
Traumatic brain injury is a leading cause of disability worldwide and most of them presenting to the hospital are those in the mild category. The current management of patients with mild traumatic brain injury varies amongst health centres across regions, due to lack of proper consensus and guidelines. In recognizing post traumatic amnesia duration as a predictor of the severity of mTBI, the Abbreviated Westmead Post Traumatic Amnesia Score (A-WPTAS) was created by Shores et al, 2008. The aim of this study was to validate the A-WPTAS to be used in the local setting and whether it can predict the optimal time of discharge of patients. This prospective cohort study was carried out in the Emergency Department of PPUKM for duration of 2 years beginning from 1st May 2013 which involved a total of 62 patients. Patients were observed and assessed using the A-WPTAS at hourly intervals for a minimum of 4 hours. All patients had a full A-WPTAS at 2 hours of observation. Patients who were fit for discharge were sent home and called back after 24 hours to determine whether they had any post concussive symptoms or not. Forty eight patients were discharged home well and did not report any post concussive symptoms after 24 hours. There were 7 (11.3%) patients who were admitted to the neurosurgery ward for abnormal CT scan results despite having a full A-WPTAS score. Two (3.2%) of them had intracranial bleeds. However none of the patients required any surgical intervention. Although the safety and reliability of the A-WPTAS in the current setting remains inconclusive because of study limitations, it does show promise as an aiding tool for physicians to decide on patient discharge.
EARLY COAGULOPATHY AND ITS RELATIONSHIP WITH SEVERITY OF TRAUMA (ECAST)

Roslanuddin M S¹, Sabariah F J¹, Julina M N²
¹Sungai Buloh Hospital, Sungai Buloh, Selangor, Malaysia
²Universiti Teknologi Malaysia, ..........................

Introduction
Coagulopathy occurs very early in trauma especially in more severe victims. Unlike Thromboelastography (TEG), conventional coagulation test (PT/APTT/INR) only measures about 4% of total coagulation process. Using TEG, our study aims to explore the relationship between Acute Coagulopathy in Trauma (ACoT) with severity of injury. (using ISS score).

Methodology
We conduct a prospective cross-sectional study over 6 month period where eligible, acute (less than 2 hour) polytrauma patient was selected. TEG readings performed upon arrival was compared with different ISS score.

Result
Thirty-six patients were included where 8.3% (3/36) have an ACoT, defined as APTT > 35 sec.

However there was a statistically significant drop of MA (maximal amplitude) in high ISS group (42.9 mm) compared to low ISS group (54.8 mm). Other TEG parameters showed no statistical significant.

Discussion
The prevalence of ACoT in our study is small (8.3%) compared to previous work. This may be due to small sample size or a different in the timeframe of the blood sampling of other studies, ranging from 12 hour to 72 hour from injury.

Patients with reduced clot strength (maximal amplitude < 50 mm) evaluated by TEG was associated with higher mortality in multiple studies conducted in emergency setting. For example, Nystrup et al showed means ISS of 27 in this subgroup of patients with a high mortality. Amy JP et al showed relationship between low MA and platelet dysfunction and ultimately, the need of transfusion.

Although statistically not significant, the trend of prolong R, more acute alpha angle and longer K values indicates more generalized coagulation dysfunction. Therefore, individualized transfusion strategy involving TEG-goal-directed approach appears promising.
INTRODUCTION
For some, population ageing is associated with increasing frailty. Existing frailty assessment scores exhibit poor predictive power for adverse events in the acute medical setting. We have published work validating a model based on frailty syndromes (cognitive impairment, falls, reduced mobility, pressure sores, functional dependence and anxiety/depression) on English administrative data (DOI: 10.1136/bmjopen-2015-008457). We aim to explore concurrent (comparison with frailty index) and predictive validity (30-Day mortality, emergency readmission and institutionalization) for this model in the acute medical setting.

MATERIALS & METHODS
A prospective observational study in the Acute Assessment Unit of Chelsea and Westminster Hospital with convenience sampling from May - Dec 2013 of adult acute medical patient admissions. Data was abstracted by a researcher from patient records up to 36 hours from admission. Outcomes were retrieved at one month after index admission. Statistical analysis includes descriptive statistics, logistic regression and Area Under the Receiver Operator Characteristics Curves (AUC) for predictive power derived from predicted probabilities. Missing data analysis followed by multiple imputation (by regression of dataset) where appropriate. Frailty Syndromes models were adjusted for age, gender and number of readmissions in previous 6 months. A Frailty Index was created from 31 criteria from previously described methodology (DOI: 10.1186/1471-2318-8-24).

RESULTS
Frailty syndromes were prevalent in those >65 years (N=482; cognitive impairment-27.8%, falls-42.1%, reduced mobility-5.2%, pressure sores-10.4% functional dependence-42.5% and anxiety/depression-31.3%). The frailty syndromes model had excellent concurrent validity with Frailty Index (AUC 0.83-0.85). The frailty syndromes model had moderate to good predictive power for adverse events at 30 days (inpatient mortality AUC 0.80-0.81, emergency readmission AUC 0.71-0.72, institutionalization AUC 0.63-0.65) in comparison to Frailty Index (inpatient mortality AUC 0.73-0.74, emergency readmission AUC 0.53-0.55, institutionalization AUC 0.52-0.58).

DISCUSSION
Frailty syndromes are a valid and useful for risk stratification in older persons requiring acute medical care.
INTRODUCTION
Dengue fever has become a main public concern in recent years. This study was conducted in University Malaya Medical Centre (UMMC) with the objective to ascertain the current level of knowledge, attitude and practices (KAP) regarding dengue management among the frontline doctors working in UMMC.

MATERIALS AND METHODS
The study design was a descriptive cross sectional study. All doctors working in the Emergency department (ED) and primary care department (PCD) were recruited in the survey. All 117 doctors were interviewed by using a structured questionnaire.

RESULTS
The study showed that more than two third of the doctors had 5-10 years of working experience and they were seeing 20-40 patients in a day; while near to one third of them did not have dengue training in the past two years. This study showed that 70.9% of the doctors failed to identify the correct tourniquet test and only about one quarter of the doctors routinely advised patients on dengue preventive measures. There was significant association found between the working experience and practice behavior (p=0.007), working department and practice behavior (p=0.003) as well as knowledge and attitude among the ED doctors (p=0.004).

DISCUSSION
This study indicates that doctors in longer years of service gained more experience from seeing patients. PCD doctors had better practice score compared to ED doctors because more time were spent on advising patients on dengue self care and preventive measures. ED doctors had both good knowledge and positive attitudes towards dengue management. The knowledge of the frontline doctors can be improved further although majority of them posed high level of knowledge, while most of them had moderate attitude and fair practice score. Therefore, regular dengue training is necessary for improvement of knowledge, attitude and practice behavior on dengue management among the frontline doctors.
THE MODE AND LOAD OF REFERRAL FOR THE “ISLAND” WITHIN AN ISLAND: A REVIEW

X Y Yang, K C Hii

1Emergency and Trauma Department, Kapit Hospital, Kapit, Sarawak, Malaysia
2Kapit Hospital, Kapit, Sarawak, Malaysia

INTRODUCTION
Kapit Hospital serves as the only hospital in the division of Kapit, Sarawak, covers three districts (Kapit, Song and Belaga) and two sub-districts (Nanga Merit and Sungai Asap). It is the only hospital that not connected by road to the nearest referral center. The main mode of referral is by boat and air MEDEVAC.

METHOD
This paper reviews the load and mode of cases referred to Sibu or Sarawak General Hospital. It is a retrospective study of data collected in year 2015.

REVIEW
The total cases referred were 1083 cases, with an average of 90.25 cases per month. The outpatient referral takes up 61.6% (667 cases), while in patient referral 38.4% (416 cases). Cases for imaging purposes 26.4% (286 cases), with the highest referral load is Ultrasonography 12.8% (139 cases), followed by Computed Tomography Imaging 10.7% (116 cases). The department with the highest referral load was Medical (38.4%, 416 cases), followed by Surgical (23.9%, 259 cases). The mode of transport using express boat is 1052 cases (97.1%), followed by the ambulance boat usage (1.8%, 20 cases), MEDEVAC (1.0%, 11 cases) and MAS fixed wings (0.6%, 7 cases).

DISCUSSION
Escorting referral cases is an integral part of Kapit Hospital staff’s duty as reflected by the total number of 824 cases (76.1%) requiring medical escorts. This put a heavy burden not only on the hospital’s manpower, but also the hospital expenditure. All the modes of transfer carry different advantages and disadvantages, wisely choosing the mode of transfer is a must to learn skill. Good patient packaging and preparation for long journey of transfer is essential to achieve quality transfer. It ensures better continuity of patient care and safety of the staff on escorting missions.
RULELING OUT PE: A NOVEL APPROACH USING END-TIDAL CO2 WITH COMPRESSION ULTRASONOGRAPHY AND TRANSTHORACIC ECHOCARDIOGRAPHY IN PULMONARY EMBOLISM DIAGNOSIS (CUEPED)

Cheong Chee Yen¹, Kiran Nesarajah¹, Rashidi Ahmad¹, Rishya Manikam¹, Muhaimin Noor Azhar¹, Aida Bustam¹, Tai Woon Ting¹, Muhammad Athar Sidiq²

¹Department of Emergency Medicine, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia
²Department of Cardiology, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

INTRODUCTION

Pulmonary embolism (PE) is a common illness with substantial morbidity and mortality. The aim of this study was to evaluate the diagnostic accuracy of CUEPED, a novel method of ruling out pulmonary embolism using a combination of end-tidal CO2 (ETCO2), Compression Ultrasonography (CUS) and Transthoracic Echocardiography (TTE).

MATERIALS AND METHODS

In this prospective study, patients who presented to Emergency Department at University Malaya Medical Centre with suspected acute pulmonary embolisms from December 2013 to October 2014 were assessed using CUEPED. CUEPED was considered positive if the measured ETCO2 was less than 35 mmHg, or if there was presence of venous incompressibility in lower limb ultrasonography or if tricuspid annular plane systolic excursion (TAPSE) in transthoracic echocardiography was less than 1.6cm. All patients were diagnosed using computed tomography pulmonary angiography (CTPA). Data obtained was analyzed to determine if a negative CUEPED would be able to conclusively rule out a pulmonary embolism. All patients received a CTPA for confirmation of diagnosis.

RESULTS

30 patients (mean age 48 years) were included with an equal distribution between genders. The incidence of PE was 56.7%. CUEPED had a sensitivity of 100% (95% CI 80.3% to 100%) for PE. Negative CUEPED ruled out PE (P=0.001) with a negative predictive value of 100% (95% CI, 58.9% to 100%). Positive CUEPED ruled in PE with a low specificity (53.8%, 95% CI 25.2% to 80.6%) and moderate positive predictive value (73.9%, 95% CI 51.5% to 89.7%).

DISCUSSION

This prospective diagnostic study showed conclusively that a negative CUEPED proved reliable in ruling out pulmonary embolism.
“TEMPTING MUSHROOM WITH DEADLY BITES-DINNER THAT ALMOST KILL MY FAMILY” – CASE SERIES OF CHLOROPHYLLUM MOLYBDITES MUSHROOM POISONING

Baran Palanimuthu¹, Alzamani Idrose¹, Vikineswary Sabaratnam²

¹Emergency Department, Kuala Lumpur General Hospital, Kuala Lumpur, Malaysia
²Mushroom Research Centre, University of Malay, Kuala Lumpur, Malaysia

INTRODUCTION

We describe a case series of a family (4 people) presented to us with Chlorophyllum Molybdites Mushroom poisoning which has been picked up by roadside as mistaken for edible “Cendawan Busut”.

CASE DESCRIPTION

Mushroom poisoning is a rare case encountered by any healthcare providers. We often diagnose patient as Infective Acute Gastroenteritis (AGE) which caused by dirty environment and method of food handling. Meanwhile we forgot content of food product itself might be poisonous and harmful to us which even cause death.

CASE 1 (HUSBAND)

32 years old gentleman presented to us, with Vomiting and Diarrhoea (> 10x) after took half plate of wild mushrooms for dinner together with other family members. Patient also complaint of throat discomfort hence sent to Red Zone to anticipate possibilities for anaphylactic reaction (Laryngioedema). Patient was treated as Anaphylatic reaction secondary to mushroom poisoning. IM Adrenalin/IV Hydrocortisone/IV Piriton/Activated Charcol given to this patient. Continuous fluid replacement done under ultrasound guide until vital signs normalised and warded under Medical team.

CASE 2 (WIFE)

29 years old lady, G3P2 @ 20/52 POA accompanied husband (above). Also took mushrooms for dinner about (Quarter Plate). Initially did not have any AGE symptoms, however developed Vomiting multiple times and Diarrhoea in ED. However patient does not develop any anaplylatic reaction. Continuous hydration given under ultrasound guide and warded under O&G team.

CASE 3 (CHILD)

4 years old boy was brought to our emergency department together with parents (above) as complaint vomiting x5 at home after ingest small piece of mushroom for dinner. Otherwise, hydration status still good and vitals signs are normal. Child was warded under Pediatric team.

CASE 4 (MOTHER IN LAW)

64 years old lady, presented with vomiting multiple times at home after took mushroom for dinner together with other family member(above). However, vital signs were still normal and hydration status was fair. Patient was warded under medical team for observation with continuous hydration.
Mushroom was brought to Mushroom Research Centre in University Malaya for expert identification and subsequently was identified as Chlorophyllum Molybdites which can cause GI Disturbance.

All patients discharged well after 3 days as symptoms improved and blood investigation failed to reeve any organ disfunction/ residual toxicity.

DISCUSSION/CONCLUSION
Mushroom poisoning should be included as one of differential diagnosis on any event of mushroom ingestion presenting with AGE symptoms. Early mushroom identification will be helpful in predicting patient outcome including management plan. Early anticipation in form of fluid resuscitation are compulsory to prevent dehydration and further deterioration of patient condition.

We presenting case series of a family with mushroom poisoning. We are first in world to present such case which patient ingest same type mushroom with different outcome- proportionate to quantity ingested.

We are also first in world to report same type of mushroom poisoning with outcome (Quantity based) from different age group/population (Adult/Pregnant Lady/Pediatric/Geriatric) group.
A PROSPECTIVE STUDY OF PAEDIATRIC FRACTURES IN AN EASTERN PENINSULAR MALAYSIA POPULATION REQUIRING IN-PATIENT MANAGEMENT TO A TERTIARY MEDICAL INSTITUTION

Mohd Shukrimi Awang, Mohd Ariff Sharifudin, Ardilla Hanim Abdul Razak, Mai Nurul Ashikin Taib

Kulliyyah (Faculty) of Medicine, International Islamic University Malaysia, Kuantan, Pahang, Malaysia

INTRODUCTION
The aim of this study was to identify fracture patterns in childhood requiring inpatient management at a tertiary hospital of Eastern Peninsular Malaysia. The focus was for patients aged below 12 years since they will be the only age group admitted in paediatric wards. With this surveillance, patterns of fractures and repeated injury can be identified and prevention strategies can be devised.

MATERIALS & METHODS
This is a prospective study on paediatric fractures that required admission from January 2009 until June 2010. Sociodemographic and clinical data of participants including aetiology and type of fracture, location and type of injury, diagnosis, and type of treatment, were recorded in a proforma.

RESULTS
108 patients were included in the study. Majority (69%) were boys with highest number of injuries occurred during school age (7-12 years). Most hospital admissions were in the month of October (during school holidays). Injury at playground and domestic injuries contribute to 39% and 29% of cases. 75% of patients sustained single bone fracture. 28.7% of patients were treated conservatively while 33.3% required surgical fixation of fracture either with K-wires or plates. 35.2% of patients required surgical intervention after failed conservative treatment. Supracondylar humeral fracture was the commonest fracture; surgical intervention rather than conservative treatment was the treatment of choice.

DISCUSSION
Fractures involving the upper limb were the commonest with most of the injuries involved climbing apparatus at playgrounds. These results may alert the respective authorities to improve the safety aspect during outdoors activities.
DEVELOPING A SYSTEMATIC SCORING FOR THE EVALUATION OF MUSLIM ORTHOPAEDIC AND TRAUMA PATIENTS’ ABILITY TO PERFORM RELIGIOUS PHYSICAL CLEANSING AND PRAYER

Mohd Ariff Sharifudin¹, Wan Rumaizi Wan Husin², Aminudin Che Ahmad¹, Nazri Mohd Yusof¹, Mohd Shukrimi Awang¹

¹Kulliyyah (Faculty) of Medicine, International Islamic University Malaysia, Kuantan, Pahang, Malaysia
²Kulliyyah (Faculty) of Islamic Revealed Knowledge and Human Sciences, International Islamic University Malaysia, Kuala Lumpur, Malaysia

INTRODUCTION
For Muslim patients, illness does not alleviate the obligation to perform religious duties such as prayer. The need for a systematic evaluation of patients’ ability to perform such duties should be highlighted and anticipated. This study aims to develop an objective evaluation scoring system to recognize disability levels of Muslim patients in performing religious physical cleansing and prayer during their illness and improve the deliverance of assistance they need.

MATERIALS & METHODS
Based on observation and critical survey among patients and health care personnel in orthopaedic wards of a tertiary hospital, we identified problems contributing towards patients’ inability to perform religious practices during hospitalization. They can be grouped into five main disabilities, which formed the basis of the scoring system: pain, mobility, extremity involvement, bandage/cast application, and toileting. The scale ranged from score of 1 (no disability) to 5 (worst ability to perform specific task). Panels of experts involved in face and content validations, as well as pilot testing of the scoring system.

RESULTS
100 patients participated in the study. We evaluated the inter- and intra-observer reliability using intraclass correlation coefficient and Spearman correlation coefficient, respectively. Our analysis provided good results for inter-observer agreement and reliability, and internal consistency for most disabilities. At the end of the study, two major outcomes produced; a disability score to categorize trauma patients according to their needs, and a coding system to assist health care personnel in scrutinizing the types of assistance required by patients.

CONCLUSION
The proposed system provides a new practical measure to evaluate disability among Muslim patients in performing their religious duties. It will provide a balance approach in trauma patients’ care and deliverance of assistance wherever required. It has potential of becoming a standard of practice in a holistic patient care in accordance to the much-anticipated ibadah-friendly hospital.
UTILISING FRAILTY SCORING IN THE ACUTE HOSPITAL SETTING TO IDENTIFY FRAIL AND VULNERABLE PATIENTS
Lotte Dinesen*, Alan J Poots1, Federico Ciardi1, John Soong1, Derek Bell1,2
1NIHR CLAHRC Northwest London, Imperial College London, London, United Kingdom
2Department of Acute Medicine, Chelsea and Westminster Hospital, Chelsea, London, United Kingdom

ABSTRACT CATEGORY
Research

TITLE
Utilising frailty scoring in the acute hospital setting to identify frail and vulnerable patients

AIM
Our objective is to operationalize a clinically usable tool, frailty early warning score (FEWS), which will identify frailty and help predict significant outcomes, including readmission, length of stay (LOS) transfer to higher level of care and mortality.

METHODS
FEWS is based on a frailty model described by Soong et al (2015) with four specific domains (physical, mental, social and environmental, as illustrated in figure 1).

Between 03 June 2015 and 27 August 2015, 700 acutely admitted patients over the age of 65 were reviewed. Data were collected from clinical notes taken routinely as part of the emergency admission process. No new data were collected. All data were collected electronically through bespoke software by Thinkshield and innate hospital programs. The national early warning scores (NEWS) were simultaneously collected for comparison.

FIGURE 1: FOUR DOMAINS OF FRAILTY

- To improve frailty model and produce a clinically meaningful score:
  - Physical
  - Psychological
  - Socio-Economic
  - Environmental

- Primary Care
- Social Care
- Secondary Care
- For Patient Usage
OUTCOMES/RESULTS

700 patients were included (52.6% female) with an average age of 81 years. 94% were medical admissions (including orthogeriatric patients). 30 day mortality was 3.0%, 30 day readmission rate was 16.1% and the average length of stay (LOS) was 12.3 days (Table 1). 280/700 (40.0%) patients aged > 80 had >3 frailty score, whereas ages 65-80; 96/700 (13.7%) had a frailty score of 0. Table 1 provides additional patient demographics. NEWS and FEWS were cross-tabulated: 246 admissions scored < 3 on NEWS (i.e. this would not trigger escalation), of which 206 scored ≥1 on the frailty tool. This could indicate a potential threshold for frailty escalation.

**TABLE 1: NUMBER OF PATIENTS, OUTCOMES AND AVERAGE NEWS SCORE FOR EACH FRAILTY SCORE BAND**

<table>
<thead>
<tr>
<th>Frailty Score (FEWS)</th>
<th>Score 0</th>
<th>Score 1-3</th>
<th>Score 4-6</th>
<th>Score 7-9</th>
<th>Score 10-12</th>
<th>Score 13-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>116</td>
<td>288</td>
<td>209</td>
<td>84</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Average Age</td>
<td>80.7</td>
<td>79.7</td>
<td>80.4</td>
<td>80.6</td>
<td>80.6</td>
<td>0</td>
</tr>
<tr>
<td>Number Female</td>
<td>66</td>
<td>140</td>
<td>115</td>
<td>46</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Number Male</td>
<td>50</td>
<td>148</td>
<td>94</td>
<td>38</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Marital status - married</td>
<td>46</td>
<td>114</td>
<td>69</td>
<td>31</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Marital status - divorced</td>
<td>20</td>
<td>41</td>
<td>25</td>
<td>9</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Marital status single &amp; widowed</td>
<td>50</td>
<td>133</td>
<td>114</td>
<td>44</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>NEWS (average)</td>
<td>2.3</td>
<td>2.2</td>
<td>2.1</td>
<td>2.1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>In hospital mortality</td>
<td>3</td>
<td>17</td>
<td>19</td>
<td>10</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7 day mortality</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>30 day mortality</td>
<td>1</td>
<td>10</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>90 day mortality</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>LOS (days)</td>
<td>7.5</td>
<td>8.6</td>
<td>12.3</td>
<td>12.4</td>
<td>12.5</td>
<td>0</td>
</tr>
<tr>
<td>readmission 7 days</td>
<td>7</td>
<td>28</td>
<td>25</td>
<td>12</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>readmission 30 days</td>
<td>18</td>
<td>52</td>
<td>31</td>
<td>12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>readmission 90 days</td>
<td>27</td>
<td>49</td>
<td>41</td>
<td>21</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Missed out pt appointments</td>
<td>10</td>
<td>33</td>
<td>31</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Down streamed to ward</td>
<td>44</td>
<td>143</td>
<td>131</td>
<td>50</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>transfer to higher care</td>
<td>19</td>
<td>31</td>
<td>34</td>
<td>14</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Discharged to higher social care settings</td>
<td>12</td>
<td>13</td>
<td>21</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>average number of medications</td>
<td>6.3</td>
<td>8.6</td>
<td>8.7</td>
<td>8.5</td>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>

The frequency of sub-domain responses to the FEWS questions are shown in fig 2.
CONCLUSION
This study describes FEWS as a novel way of predicting a frail individual’s outcomes. This score can be easily calculated at the point of care using routinely corrected data. It is fast and simple to use; it will not require additional clinical assessment. Further work is needed to determine the weight of each domain and sub-domain, as this will be needed to define the sensitivity of the final aggregate score.

ETHICS
This research is limited to secondary use of information previously collected in the course of normal care. The patients or service users were not identifiable to the research team carrying out the research.

DISCLAIMER
This abstract presents independent research commissioned by the National Institute for Health Research (NIHR) under the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) programme for North West London. The views expressed in this publication are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.
FACTORs INFLUENCING THE WILLINGNESS OF PARAMEDICS TO PERFORM SUPRAGLotic AIRWAY DEVICE (SAD) INSERTION IN PRE HOSPITAL CARE (PHC)

Shameera Navaratnam
Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia

BACKGROUND
The use of Supraglotic Airway Device (SAD) by Prehospital Care (PHC) paramedics is on the rise globally by paramedics, and evidence suggests that they are suitable alternatives to conventional endotracheal intubation, or during a difficult airway situation in PHC. However, the use of SAD in PHC by paramedics in Malaysia is very limited, and therefore a study was conducted to elucidate potential factors influencing paramedic willingness based on the Theory of Work Performance.

METHODS
This is a cross sectional study using a self-administered, validated questionnaires. The study population consists of 143 paramedics working at pre hospital care from 4 government-funded public hospitals. Universal sampling procedure was employed and the response rate was 90.5 %. The questionnaire consists of demographic information such as years of working experience and academic qualification, willingness and confidence in performing SAD insertion and availability of administrative policies.

RESULTS
The study showed 88% (n=127) were willing to use SAD in PHC with a statistical significant association between confidence and willingness (p<0.05). There was also a significant association between willingness to perform a SAD and having a Post Basic in Emergency Medicine in addition to Diploma, as compared to only having Diploma in Medical Assistance (p<0.05). Approximately 80% (n=114) of paramedics perceived that there are no clear policies available with regards to the use of SAD in PHC. A significant number 72.5% of paramedics had also shown a degree of concern over medical liability during work.

CONCLUSION
This study suggests that there are possible weaknesses in the current policies practiced in PHC services in regards to the use of SAD in Malaysia. Focus should be centred to further improve the policy environment that would promote this practice based on best practices at international levels.

KEYWORDS
Paramedic, Prehospital Care, Supraglotic Airway Device, Willingness, Confidence, Administrative Policies.