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.

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RESULTS OF AUTOLOGOUS BONE MARROW MONONUCLEAR CELLS IN THE TREATMENT FOR ACUTE LIMB ISCHAEMIA IN A PATIENT WITH CROHN'S DISEASE

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INTRODUCTION

Chron's Crohn'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 Crohn'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 substraction 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 transmetartasal 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 showsed 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.

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BEWARE OF THE MILKY FLUIDS POST ABDOMINAL SURGERY

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INTRODUCTION

Chylous ascites is defined as a pathologic accumulation of chyle in the peritoneal cavity. The incident of chylous ascites following inferior vena cava tumour resection is rare.

CASE REPORT

We reported a case of inferior vena cava leiomyosarcoma. She underwent resection of the tumour 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 a subcutaneous

collection. 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 tumour resection is rare. It is commonly due to traumatic disruption of lymphatic during the surgery. Most of the patients are successfully treated conservatively.

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PURPLE URINE BAG SYNDROME: A COCKTAIL OF RED AND BLUE

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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

A 66 year-old female bed bound woman 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 = 26.7x109/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.