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"I CAN'T RECALL EVER FALLING" SUBTLE PRESENTATION OF CHRONIC SUBDURAL HEMATOMA IN GERIATRIC PATIENT

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INTRODUCTION

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

CASE DESCRIPTION

A 67 years old active gentleman complaints was complaining of 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 lapsed of memory. Apart from that, He had no nausea, can could 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 while jogging for which he denied any loss of consciousness. He also had history of going on long flights 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.

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WORMS IN MY URINE! : SHISTOSOMIASIS

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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 or 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 rarer 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.

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'DEADLY STRIDOR' RETROPHARYNGEAL ABSCESS IN AN ELDERLY PATIENT

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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.