DISCUSSION & CONCLUSION

Retropharyngeal abscess is rare in adults. Have high index of suspicion for patients developing stridor after an invasive procedure. Early presentation to hospital and administration of antibiotics could have saved the patient's life.

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"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. He 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.

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"AIR IN MY EYE": ORBITAL EMPHYSEMA

Muhamad Syis Zulkipli[1], Alzamani Idrose[2]
[1]UKM Medical Centre, Kuala Lumpur, Malaysia
[2]Hospital 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 his face hitting the road while riding a motorcycle motor without a helmet. He

had loss of consciousness with no ENT bleed. Upon arrival his vitals were all normal and triaged to the yellow zone. On examination, his GCS was 15. There was a swelling at glabella area with facial crepitus 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.

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'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 usual case in which a needle used to poke the sisha alumunium 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. Xrays 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.