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"I AM TALL AND BREATHLESS FOR A REASON": MARFAN'S SYNDROME WITH PNEUMOTHORAX

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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 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 proned to developing pneumothorax. Be alert in patients having features of Marfan's syndrome and chest pain as this may indicate the development of pneumothorax.

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"ONE IN AND ONE OUT": A CASE OF HETEROTROPIC PREGNANCY

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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

Heterotropic 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.

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A HARD HEADACHE AND A HURT HEART: ATYPICAL PRESENTATION OF HYPERTENSIVE EMERGENCY WITH NSTEMI

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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 Amlodepine 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 was done to rule 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 was hypertensive emergency with NSTEMI. Patient was started IV infusion of GTN and was given T.aspirin 300 mg stat. Patient was further given