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.

PP 78

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

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.

PP 79

"THE FISTULA TWIST" CARDIAC ARREST DUE TO HYPERKALEMIA DESPITE COMPLIANCE TO DIALYSIS : A CASE OF DYSFUNCTIONAL FISTULA

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INTRODUCTION

A patient who is compliant to dialysis should not be having hyperkalemia. We describe a case at our centre who had suffered a 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, the 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 milde 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 rthym. Patient's fistula was reassessed found to be dysfunctional. Hence the cause of was 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.

PP 80

'IT CREPT UNDER MY SKIN' SUBCUTANEOUS EMPHYSEMA FOLLOWING PENETRATING INJURY WITH DELAYED MEDICAL PRESENTATION

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INTRODUCTION

Penetrating injury should not be taken lightly and thorough investigation