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

should be performed so as not to miss life-threatening conditions. We describe our patient who did not seek treatment immediately after having such injury.

CASE DESCRIPTION

A 13 years old boy with a history of alleged fall the day before in prone position while playing in the park came to our centre with the chief complaint of pain and wound over his abdomen. He claimed to have landed on a metal sharp object which pierced over the left abdomen. Patient earlier pulled out the object and went home, claiming only minimal bleeding. On examination, patient was comfortable with stable vital signs. There was a puncture wound over the left lumbar measuring 0.5 x 0.5cm, with subcutaneous emphysema extending up to the left hypochondriac region. Abdomen was soft and not tender. Lungs had equal air entry and no subcutaneous emphysema. No intraperitoneal free fluid on focused assessment with sonogram for trauma (FAST). CT Abdomen was done subsequently and showed skin and underlying muscle defect over the left side of abdomen resulting in subcutaneous emphysema. Nevertheless, there were no evidence of solid organ injury or perforated viscous. Patient was referred to the surgical team and wound debridement was done under general anaesthesia. Patient was well after operation and discharged 4 days later.

CONCLUSION & LESSONS LEARNT

Any penetrating injury should be investigated fully. CT SCAN is helpful in being certain of injuries sustained. Public awareness is required so that patients would come to the hospital for thorough assessment so as to avoid life-threatening condition.

PP 81

ANGRY WOLF ON MY LEG : BULLOUS ERYSIPELAS

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INTRODUCTION

We present a patient developing bullous erysipelas following trauma.

CASE DESCRIPTION

A 36 years old Indian gentleman presented to our emergency department with the chief complaint of reddish wound over the right shin and fever after history of abrasion wound following alleged history of fall from his motorcycle 1 week earlier. He came to our centre prior to this presentation then whereupon where antitetanus injection was given, wound irrigation and dressing was done, with and later discharged. For this current consultation, Hence, a diagnosis of infected wound was made. Dressing was done and patient was discharged with paracetamol and cloxacillin 500mg tds as the skin did not look too bad. The fever resolved after 3 days. On Day 14 post-trauma, patient returned to our follow-up clinic after noticing that the wound became more extensive involving most of anterior shin. The area was erythematous and thickened with multiple bullae. In view of the worsening of the wound, referral was made to dermatology team. Patient was diagnosed as having bullous erysipelas. He was treated as out patient by the dermatology team with oral antibiotics and cream. He came back for given appointment after 7 days at the dermatology clinic and the wound was healing well.