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.

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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.

DISCUSSION

Bullous erysipelas, is a clinical diagnosis that indicates superficial cellulitis with lymphatic involvement; it is typically caused by group A β-hemolytic streptococci. It typically appears on the legs and face as sharply demarcated, tender erythema and edema, with an indurated border. Diagnosis involves the differential exclusion of cellulitis, allergic contact dermatitis, bullous pemphigoid, necrotizing fasciitis and varicella–zoster. Management of bullous erysipelas includes appropriate empiric antibiotic therapy, with consideration given to local rates of MRSA.

LESSONS LEARNT & CONCLUSION

Be aware that simple abrasion wound following trauma in some cases may develop bullous erysipelas as a complication. Late initiation of antibiotics may predispose this. A prolonged course of antibiotics is required for this condition because of risk of re infection and the recovery takes longer time.

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"BREAKING MY HEART, SHATTERING MY CHEST, CLOUDING

My Brain": a case of commotio cordis with stable VT following a polytrauma

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INTRODUCTION

We describe a case in which a patient without any past co-morbid present to our centre with cardiac dysrhythmia.

CASE DESCRIPTION

31 years old male pedestrian was hit by a car. Patient was seen having seizure at the scene of accident. Ambulance team responded and brought the patient back to our department. The seizure aborted spontanouesly. Upon arrival, patient was unconscious. The GCS was 3/15. Pupils were unequal. BP 180/110 and HR 69. Patient was immediately intubated. After 30 minutes, patient developed ventricular tachycardia (VT) but with pulse palpable. Synchronized cardioversion delivered at 150 & 200J, 200J. Rhythm reverted but recurred and another 200, 200 J delivered. Patient still had VT intersped with mixture of poly and monomorphic PVC. IV MgSO4 2.47gram was given in quick infusion over 15 minutes and no more recurrence noted. CT SCAN showed SAH and SDH with cerebral edema. Bilateral lung contusions were seen on CXR. Patient was treated conservatively in neurosurgery ICU. The VT was attributed to cardiac contusion (commotio cordis). The troponin level was high. Patient's cardiac condition stabilized until he was admitted to neurosurgical intensice care unit. However, patient succumed 3 days later due to severe traumatic head injury.

LESSONS LEARNT & CONCLUSION

This is a rare case in which patient developed persistent stable VT after having head injury following a motorvehicle accident. Magnesium sulphate was useful in reverting the rhythm to sinus rhythm in this case.