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"SHORTENED AIRWAY" OPEN
TRACHEAL INJURY FROM
SLASHED WOUND

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INTRODUCTION

Slashed wound over at the neck may be deadly. We present a case in which a patient was lucky that the slash wound spared the carotid arteries but cut open the trachea.

CASE REPORT

A 34 years old gentleman was attacked by a gangster. His throat was slashed with a parang. The slash left his trachea open and he was breathing through it. Patient was brought to our centre with an ambulance. On arrival, patient was able to breathe through the open trachea. No active bleeding was noted. The slash missed injuring the carotid arteries, jugular veins, thyroid gland and esophagus. Patient was immediately given IV Morphine 5 mg and Metochlopramide 10mg. He was then sedated with IV Midazolam 5mg. Patient was paralyzed with IV Suxamethonium 75mg. Endotracheal tube of the size of 7.5 mm was used to insert the trachea and the process was easy. Patients BP was 165/90 mmHg, HR 110 bpm and SpO2 88%. Better sealing was made using gauze around the entry site of the tube and the SpO2 went to 100%. The ETT end was stabilized using the head immobilizer. ENT team was called in and patient was sent to the operation theatre(OT). Intraoperatively, patient had injured hypopharynx and larynx cartilages. Laryngeal nerve was injured. Emergency tracheostomy was performed in the OT. The next morning

patient undergo underwent repair and anastomoses procedure.

DISCUSSION & CONCLUSION

Airway is the most important component to be preserved in order to keep patient alive. Direct intubation using endotracheal tube may be performed in order to keep patient's airway patent. Sealing is required since the normal cuff may not be adequate. Immediate attention by both the ENT and anaesthesiology team to preserve and repair the trachea in the operation theatre is essential to save patient's life.

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'DISARMED' AMPUTATED
FOREARM AT THE ELBOW JOINT

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INTRODUCTION

We present a rare trauma case in which the whole forearm was amputated from a motorvehicle accident but could be reattached with expedient emergency medical response by multiple teams.

CASE REPORT

A 32 years old gentleman had an alleged history of fall of his motorcycle. As he fell, his left elbow was cut through and through by a telephone cable by the roadside. The whole forearm was amputated. He was brought to the hospital via an ambulance and arrived along with the limb. On arrival, his GCS was full. The BP was 142/88, HR 101 bpm and SPO2 97% on air. No active bleeding was noted over his elbow stump. Fluid was started, antitetanus toxoid administered and analgesia in the form of morphine 5 mg was given. Pain was well

controlled. Wound irrigation was performed on the stump. Wound irrigation was also performed using normal saline on the segregated forearm. It was then wrapped in a plastic and placed in plastic filled with ice and kept in an ice-box. The orthopaedics team was called in. Patient was sent to the operation theatre in the attempt of limb reattachment. Unfortunately, the procedure failed and stump refashioning was performed.

DISCUSSION & CONCLUSION

Preserve limbs with double layered iced plastic bag. Wound irrigation is essential to ensure contaminants are removed early to avoid infection post-surgery. With a bit of luck, amputated forearm may be reattached with patient surgical repair work. Unfortunately, this procedure failed. Pre-procedure counseling is essential to prepare patient's mind.

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"I COULD HAVE DIED YOUNG AND NOT KNOW WHY" PAROXYSMAL FAST AF PRESENTING IN AN UNDIAGNOSED UNDERLYING BRUGADA SYNDROME

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INTRODUCTION

Brugada syndrome is deadly and caused by abnormal sodium channel. We present a case in which patient was treated for arrhythmia but incidentally found to have the syndrome.

CASE REPORT

34 years old gentleman with background history of Bronchial asthma on MDI Salbutamol and MDI

Budesonide presented to our centre with fever, cough, shortness of breath, wheezing and palpitation for 2 days. On arrival, he had ronchi on auscultation and was sent to the asthma bay and given a Salbutamol nebulizer followed by another two using Combivent. It was noted patient had severe tachycardia with a heart rate of 170bpm. First ECG showed atrial fibrillation (AF) with rapid ventricular response with RBBB. On examination, he was alert, GCS 15/15, mild tachypneic, normal hydration and good perfusion. No signs of heart failure. Crepitation over the left lower lung with scattered rhonchi. His vital signs were; BP 104/50, HR 176, Temp 37.4, Spo2 100% under room air. Cardiac monitor showed AF with rate of 160-180bpm. IV drip NS 10ml/kg and IVI MgSO4 2.47g given, yet persistently fast AF. He was given 1 dose of IV Verapamil 5mg and this successfully reverted to Sinus rhythm. Repeated ECG showed sinus tachycardia, HR 100, Brugada Type 1 (Elevation of J-point, a coved type ST segment with inverted T wave over V1-V2). Patient is otherwise asymptomatic. On further history, patient had 3 episodes of unexplained syncope and never investigated. No family history of cardiac disease, nor sudden death. Patient was admitted at Coronary Care Unit. The final diagnosis was AF with rapid ventricular response secondary to Community acquired pneumonia with underlying Brugada syndrome Type 1.

DISCUSSION & CONCLUSION

The Brugada pattern is only recognized once patient's fast AF was reverted to sinus rhythm. History suggested that patient survived multiple syncopal events. ECG recognition is pivotal so that implantable cardiac defibrillator can offer as that would save patient's life.