

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.