INTRODUCTION

Behçet's disease (BD) is a multisystem recurrent vasculitic disorder of unknown origin, which manifests as recurrent oral and genital ulcers, skin and eye alterations. Hypertrophic pachymeningitis is a rare disease characterized by localized or diffuse thickening of the dura mater of brain associated with infections, systemic autoimmune/vasculitic disorders, malignancy and meningioma.

CASE REPORT

A 35-year-old gentleman presented with two-year history of bilateral trismus and jaw pain which did not resolve, despite oral surgery was done. He also had fever, headache, blurring of vision with restricted left eye movement for three months. CT Brain and Orbit with contrast showed extensive pachymeningeal enhancement, bilateral retrobulbar mass and right infratemporal fossa lesion. MRI of Brain and Orbit showed diffuse pachymeningeal enhancement and inflammation of left recti muscles, right infratemporal and masticator spaces. Patient was empirically covered with antibiotics for meninigitis. Subsequently, he was started on anti-tuberculous treatment (anti-TB) due to high ESR and unresponsiveness to antibiotics. CSF results (cell count, biochemistry,C+S, acid-fast bacteria, MTB PCR, viral screening, GeneXpert) were not suggestive of infection. Despite being on anti-TB for eight months, fever did not resolve. Therefore, he was given trial of oral steroids (Tab Prednisalone) and his general condition improved. Due to worsening restriction of extraocular movement of left eye, left orbitotomy and retrorbital mass incisional biopsy were done. Left periorbital and orbital fat sent for histopathological examination showed neutrophilic vasculitis suggestive of Behcet's disease. Currently, patient is started on Tab Azathioprine and being followed-up as outpatient.

DISCUSSION AND CONCLUSION

There should be high degree of suspicion about Behcet's disease in patients with hypertrophic pachymeningitis with multisystem involvement although certain typical features such as recurrent oral and genital ulcerations are absent. Such atypical isolated cases has been reported worldwide. Early treatment with steroids are essential to halt progression of the disease and prevent serious complications.

PP 4
PRIMARY SPONTANEOUS TENSION HEMOPNEUMOTHORAX: CASE REPORT AND LITERATURE REVIEW

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Primary tension hemopneumothorax is a life threatening condition rarely encountered nowadays. This entity is defined as the accumulation of more than 400 mL of blood in pleural cavity associated with spontaneous pneumothorax in a previously healthy patient with no underlying lung disease. We described a case report of a young gentleman presenting with progressive worsening of breathlessness and chest pain associated with tachycardia and

tachypnea to Emergency & Trauma Department, Hospital Sultanah Aminah Johor Bahru, Johor. Initial hemodynamic status was stable. Initial diagnosis of right spontaneous tension pneumothorax suggested by clinical findings and confirmed by radiographic findings was soon revealed to be a right spontaneous tension hemopneumothorax due to persistent hemoserous drainage after tube thoracostomy.

He was then subject for right thoracotomy due to persistent bleeding and torn vascularized bullae was found to be the source of the bleeding intraoperatively. He was discharged without any complication after 9 days of hospital admission. We also performed electronic searches on PubMed, Medline and a general web search using Google scholar to review any literatures in relation to this rare clinical situation and their clinical presentations, possible causes and effective treatment modalities.

PP 5
BOERHAAVE SYNDROME: NOT THAT RARE?

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INTRODUCTION

Boerhaave Syndrome, the spontaneous rupture of the esophagus is a rare condition which carries a high mortality rate. Definitive treatment is surgical repair. Mortality is usually caused by mediastinitis, pericarditis, pneumonitis and empyema leading to sepsis and shock

CASE REPORT

A 38 year old man presented with complaints of vomiting coffee ground vomitus, epigastric pain and dyspnea. On examination he was pale, ill and tachycardic but blood pressure remained stable. There were reduced breath sounds over the left side and abdomen was tender and tense. Sepsis was clearly evident by leukocytosis, high BUN and metabolic acidosis; low hemoglobin signified considerable blood loss. Chest X-ray noted a hydropneumothorax over the left side.

Nasogastric and thoracostomy tube drained coffee ground contents. The diagnosis of Boerhaave syndrome was confirmed with an OGDS revealing a perforation just above the cardioesophageal junction. Despite aggressively resuscitated with fluids, transfusion of blood products, started on broad spectrum antibiotic and admitted to ICU, He was clearly moribund within hours and a plan for surgical intervention failed to materialize due to his deteriorating condition. He succumbed after 2 days.

DISCUSSION

Boerhaave sydrome is a spontaneous transmural perforation of the esophagus commonly involving the left side of the lower esophagus just above the diaphragm. The diagnosis of this condition is often challenging. In this patient although Mackler's triad was absent, the diagnosis was established by a history of forceful emesis with signs clearly demonstrating communication between the esophagus and the pleural cavity. His condition was critical and prognosis was guarded on presentation as he was in severe sepsis compounded by significant blood loss. Even with prompt treatment and surgery i.e. thoracotomy, lavage and