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

repair of esophagus, patient outcome would have been poor.

CONCLUSION

Boerhaave syndrome is invariably fatal without intervention. It should be promptly diagnose and aggressively treated to prevent mortality.

PP 6
"NOT EVERY YOUNG MEN HAS A STRONG HEART" – EVALUATING CARDIAC FUNCTION IN A YOUNG SEPTIC PATIENT

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INTRODUCTION

Prevalence of sepsis is 20-30% in Malaysia with mortality of 16%. Despite having guidelines and new definition, management of sepsis is still challenging especially when complicated by other underlying conditions which might be overlooked. This is a patient with atypical sepsis that we encounter in our center.

CASE REPORT

18 year-old gentleman presented with 1 month of abdominal pain and jaundice. In district hospital patient was intubated for respiratory distress, started on IV noradrenaline infusion for persistent hypotension despite given crystalloid infusion. Full blood count shows white cell count 16.1x103/μL, haemoglobin16.4g/dL, platelet 521x103/μL. ECG shows sinus tachycardia with right axis deviation and chest X-ray shows cardiomegaly. Patient was treated as septic shock secondary to acute hepatitis and was sent to us. In emergency department he remained hypotensive despite high dose IV noradrenaline. Bedside scan noted dilated and non-collapsible IVC, a hypokinetic heart with grossly dilated right ventricle and right atrium. Blood pressure picked up after starting IV dobutamine infusion. Further history from patient's schoolmate noted that patient has history of substance abuse. While waiting in ward for ICU bed, patient entered into pulseless electrical activity (PEA) and succumbs despite performing CPR.

DISCUSSION & CONCLUSION

This patient has right heart failure as a complication of septic shock with underlying recreational drug induced dilated cardiomyopathy. This presentation is easily missed. In a young adult with right heart failure, more history and workup is required to look for the cause. Methamphetamine (also known as 'ice') and amphetamine are the common substance abuse in Malaysia. These drugs exposed the heart to excessive catecholamine concentration, leading to dilated cardiomyopathy.

Refractory shock prompts us to look for other coexisting problem contributing to shock. Ultrasound is a helpful adjunct in shock management to access fluid status and cardiac function.

PP 7
"MOM, I PEE OUT STONES!" – PAEDIATRIC UROLITHIASIS

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