

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 $16.1 \times 10^3/\mu\text{L}$, haemoglobin 16.4g/dL , platelet $521 \times 10^3/\mu\text{L}$. 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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INTRODUCTION

Paediatric urolithiasis is rare (14.5 per 100,000) and usually presented with vague symptoms like abdominal pain which are easily attributed to other more common conditions. Correct diagnosis is often delayed and complicated with end stage renal failure.

CASE REPORT

An 8-year-old girl presented with dysuria and lower abdominal pain for 10 months. She has been treated for recurrent urinary tract infection in polyclinic. Subsequently she got more lethargic, paler and puffier. Further history noted patient was passing stones in urine intermittently for 4 months with largest stone was 1cm in size. She came from consanguineous parents and two out of five of her siblings passed away at young age due to renal disorder. Full blood count shows microcytic hypochromic anaemia (haemoglobin 5.3g/dL), renal profile shows urea 42.6mmol/L, potassium 5.6mmol/L, creatinine 1,510µmol/L. Electrolytes showed hypocalcemia 1.14mmol/L and hyperphosphataemia 2.6mmol/L. Serum uric acid 523µmol/L. ALP 336U/L. Blood gases shows severe metabolic acidosis with bicarbonate 9.7mmol/L. Random urine calcium/creatinine ratio is 0.13 (normal <0.09 in 7-8 year-old girl). Abdominal X-ray and ultrasound show right staghorn calculi with left renal calculi. Patient was referred to Sarawak General Hospital for haemodialysis, extracorporeal shock wave lithotripsy and further workup for inherited disorders.

DISCUSSION & CONCLUSION

Hypocalcemia with hypercalciuria is suggestive of familial idiopathic hypercalciuria (4 per

hundred) and hypoparathyroidism (7.2 per million). Extensive familial studies are needed. Patient with multiple visits with similar presentation warrants further investigations. High index of suspicion of inherited disease is required. An early onset of disease, positive family history and consanguineous parents are the red flags for prompt investigation. "Horses" are more common, but we should not forget the "zebras".

PP 8

THE FAT THAT RAN AWAY

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INTRODUCTION

Fat embolism syndrome (FES) usually results from trauma and typically presents between 30 minutes and 48 hours post injury. The following case demonstrates the similarity of fat embolism to the commoner pulmonary embolism where both present as acute respiratory distress.

CASE REPORT

A 12-year-old boy was brought to Red Zone on 31st January 2016; presented with dyspnoea since morning. He had a history of left femur fracture put on implant twice in May and August last year. He also had a trauma to the left ankle a day before presentation. On arrival, he is alert but noted to be tachypneic and tachycardia. His blood pressure was normal. Lungs auscultation and other systemic examination were unremarkable except for swelling and tenderness over left ankle region. Petechial rashes were