PP 11
A SPONTANEOUS CORONARY ARTERY DISSECTION: ACUTE MYOCARDIAL INFARCTION IN FEMALE WITH NO CARDIOVASCULAR RISK FACTORS

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INTRODUCTION

Spontaneous Coronary Artery Dissection (SCAD) is a rare cardiac emergency condition that occur due to spontaneous separation of the coronary arterial walls with or without intramural hematoma, causing acute coronary syndrome.

CASE STUDY

A 42 year-old Malay female who just delivered her fourth baby 6 weeks ago, with no risk factors of cardiovascular disease presented to emergency department with acute onset of central chest pain. Vital signs and physical examination was otherwise unremarkable. An electrocardiography showed dynamic ischemic changes in antero-lateral lead. Cardiac marker showed raise troponin T level. She was treated as NSTEMI. Angiography and intravascular ultrasound confirmed the present of spontaneous dissection + intramural haematoma in the mid left anterior descending coronary artery causing 90% coronary stenosis. Drug eluting stent was placed successfully at the lesion with no residual stenosis.

DISCUSSION

The prevalence of SCAD has been reported to be as high as 1% to 4% of ACS overall 3 and up to 80% of the cases happened in female4. SCAD patients are typically in young women who do not have risk factors for atherosclerosis. Although the pathophysiology of SCAD is not clearly understood, few related conditions has been identified such as pregnancy and postpartum period, fibromuscular dysplasia, extreme physical exertion or emotional stress, coronary vasospasm, hypertensive crisis, connective tissue disorders, and cocaine used.

CONCLUSION

Acute myocardial infarction is not solely due to ruptured atherosclerosis plaque. Consider SCAD in young female who presented with angina without cardiovascular risk factors.

PP 12
DRUG INDUCED ARDS

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The number of drugs which adversely affect the respiratory system continues to increase and their effects pose a great challenge to all physicians. The range of reactions is wide, from familial simple pharmacological effects through less well understood reactions to the infective complications of immunosuppressants.

A 28-years old male with no significant medical history presented to ED with acute respiratory distress. He was intubated and placed on broad

spectrum spectrum antibiotics. Initial blood gas investigation was suggestive of Type 2 Respiratory Failure. He was then diagnosed with ARDS (PaO2:FiO2<200 and bilateral lung infiltrates present on chest X-ray) related to substance abuse,which was confirmed through subsequent further history and a positive urine toxicology screen (positive for metamphetamine). The diagnosis was made after further exclusion of other etiological factors.Patient was admitted to ICU and empiric antibiotics,diuretics was continued there. Echocardiogram showed normal findings, CT Thorax reported as extensive consolidations and ground glass changes in both lungs. Patient's ventilation was weaned down and subsequently extubated on the second day of ICU admission.Repeated chest X-ray after 48 hours of presentation showed lesser infiltrates on bilateral lung in comparison with the previous X-ray. Patient recovered within 6 days of ICU admission and was discharged then with subsequent follow up given.

Drug induced ARDS is a diagnosis of exclusion. There is the need to rule out other disease before making the diagnosis of drug induced ARDS. Drug Induced ARDS can be suspected if a patient is exposed to the drug develops new signs and symptoms and has a remittance of these symptoms once the drug is withheld. Similarly, the rapid improvement with no serious overall sequelae is unique and may be related to the underlying cause of ARDS in this patient.

PP 13
A RARE CASE OF CHRONIC ECTOPIC PREGNANCY

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INTRODUCTION

Chronic Ectopic pregnancy is an enigma which accounts for 6% of all ectopic pregnancies. The diagnosis is confounded by stable hemodynamics, chronic symptoms and high incidence of false negative pregnancy test; and often diagnosed on surgical exploration. Characteristic findings include chronic inflammatory mass and degenerated trophoblastic tissue.

CASE REPORT

A 44 year old multiparous widow presented with 2 days of fever, abdominal pain, diarrhea and vomiting. She was unable to recall her LMP and denied PV bleeding. She was treated initially as acute gastroenteritis, discharged home but returned hours later with severe sepsis. The right iliac fossa was tender and guarded. UPT was negative. Although having a normal full blood count, acute renal failure and severe metabolic acidosis had set in. A provisional diagnosis of intraabdominal sepsis was made and was referred to surgical team. She was resuscitated and started on IV antibiotics,but deteriorated rapidly in the ward, was intubated and admitted to ICU. A CT abdomen noted bilateral pleural effusion, free fluid in the peritoneal cavity and features of ileitis. The decision was therefore made to continue medical therapy. Unfortunately she succumbed 2 days later. A post mortem revealed a right ovarian inflammatory mass.