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.

Histopathology showed gestational trophoblastic tissue, establishing a diagnosis of an undetected chronic ectopic ovarian pregnancy.

DISCUSSION

Unlike 'acute' ectopic pregnancy which clinicians are more acquainted to, chronic ectopic pregnancy is a diagnostic challenge due to high incidence of negative pregnancy tests as a consequence of the very small amount of live villi, subtle symptoms and poor specificity on sonography. It may mimic other surgical or medical conditons. A CT or TVS with Doppler may be helpful but often than not is found during surgery. The treatment involves either conservative surgery or methotrexate therapy.

CONCLUSION

Diagnosis of chronic ectopic pregnancy requires high index of suspicion. Although rare its importance should never be understated.

PP 14
PULMONARY EMBOLISM MIMICKING ACS

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INTRODUCTION

Acute pulmonary embolism is a disease which is fatal and often easily missed as it may mimic cardiac diseases.

CASE REPORT

We report two cases of acute PE presenting with ACS. The first case was a 64-year-old female with underlying diabetes mellitus and hypertension. She presented with sudden onset of shortness of breath associated with left sided chest pain, diaphoresis, nausea and vomiting. On examination, she was tachycardic and tachypneic with low oxygen saturation. Chest X-ray revealed blunting of costophremic angle bilaterally. ECG showed ST-elevation at inferior leads with reciprocal changes. Bedside ECHO was normal. In view of a recent major gynaecological surgery of this patient, D-dimer was done and tested positive. CTPA revealed PE. The second case involved an 81-year-old female with underlying hypertension and history of right hip fracture 3 years ago. She presented with sudden onset of shortness of breath with chest discomfort. Clinically, patient was tachypneic with low oxygen saturation. Respiratory examinations were unremarkable. ECG showed T-inversion in inferior and anterior leads. Cardiac enzymes were not raised. Bedside ECHO revealed dilated right ventricle with hypokinesia. CTPA showed an extensive PE with right lung infarction.

DISCUSSION

Several ECG changes in PE have been reported with sinus tachycardia being the most common. Even the 'classic' S1Q3T3 pattern is found in 20% of patients only. This finding is not specific and not sensitive. We would like to highlight other ECG changes suggestive of myocardial ischemia mimicking PE. ST elevation in the inferior leads are seen in PE have been reported but is extremely rare. Furthermore, simultaneous T-wave inversions in anterior and inferior leads are also found in only 4 – 11% cases of PE.