PP 22
RECURRENT PNEUMOTHORAX IN RESPIRATORY FAILURE TYPE II– TO ASPIRATE OR NOT TO ASPIRATE

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INTRODUCTION

In elderly with poor premorbid, advance management decision is complex and difficult.

CASE REPORT

An elderly gentleman with underlying history of chronic obstructive pulmonary disease presented gasping with respiratory failure type II. He had minimal mobility at home for the past five months. He could only walk from his bed to the toilet. However he was ventilated two months ago and discharged well. On examination, the lungs were fairly clear. The CXR revealed a significant pneumothorax on the right side. He had presented two months ago, with pneumothorax also, and chest tube was inserted then. As the chest tube was bubbling persistently, a CT thorax was done. No bronchopleural fistula was found. Subsequently talc pleurodesis was performed and patient discharged on a pneumostat. The pneumostat was found leaking a month ago, and was removed.

DISCUSSION

Should we intubate this patient? If we did were to intubate this patient, would the ventilation cause the pneumothorax to worsen? Is needle aspiration indicated as a life saving procedure, as the patient was in type II respiratory failure? The patient was connected to a BiPAP NIV, while discussion were underway as to the right choice of management in an elderly with seemingly poor premorbid. A decision was made not to insert the chest tube, but to intubate the patient. Half an hour post intubation, as the patient was about to be pushed to the CT scan room, the BP blood pressure(BP) dropped. He was given intravenous fluid, and subsequently started on high dose of triple inotropes to maintain his BP. He was stable enough to go for the CT thorax, where initially a CT guided pigtail insertion was requested.

CONCLUSION

He returned to ED, post CT scan, where BP was stable, with no pigtail. Subsequent decision on whether to insert a CT guided pigtail, was made. What would your decision be?

PP 23
HELP DOCTOR, I CAN'T MOVE MY RIGHT LEG POST LSCS

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INTRODUCTION

Our worst nightmare is post procedural complication.

CASE REPORT

A 30 year old lady, Para 1, had a LSCS in another hospital. Then, she presented to us 32 days post partum, very early one morning to the green zone, with right leg weakness since the caesarean section, which was done under spinal anaesthesia. Her husband said that the patient was admitted for prolonged stay post surgery in another hospital. A MRI of the lumbar sacral spine was already performed and it was reported to be normal. The patient was

alert, conscious and seated on a wheel chair. The power on the right leg was 2/5. Babinski was up going. Patient was not transferred to the examination couch as it was difficult for her to move.

DISCUSSION

Not really knowing what to do, a quick consultation was made to the other specialties but unfortunately no conclusive results were made. Patient was then referred to the neuromedical consultant who agreed to see the patient in his clinic on the very same day, even though his clinic was fully booked. Examination in the neuromedical clinic revealed a sensory level much higher than the spinal insertion site. A MRI was ordered.

CONCLUSION

In what appeared to be a surprise diagnosis, the patient was subsequently referred to the neurosurgical department in HKL for surgery.

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DON'T MISS IT!!!

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INTRODUCTION

Heterotopic pregnancy, the coexistance of intraueterine and extrauterine gestation, is very rare in natural conception and reported to be 1:30000 pregnancies. We report a case presented with haemoperitoneum from ruptured tubal pregnancy with no life of intrauterine gestation. This give a challenges to the managing team especially in detecting the sources of bleeding especially if they miss the extrauterine pregnancy.

CASE REPORT

A 33 years old lady 6 weeks of amenorrhea presented with clinical features of shock. Urine pregnancy test was positive. Transabdominal ultrasound revealed free fluid in the abdomen. Left extrauterine sac seen with fetal heart present. Intrauterine sac was seen without fetal heart.

Provisional diagnosis of a heterotopic pregnancy with ruptured left ectopic gestation was suggested. The patient underwent emergency exploratory laparotomy salphingectomy.There was ruptured left sided tubal pregnancy with haemoperitoneum.

DISCUSSION AND CONCLUSION

A heterotopic pregnancy is difficult to diagnose clinically because the clinical symptoms is lacking. It can be life threatening condition and can be easily missed. Usually sign of extrauterine pregnancy predominates. Sign and symptoms may include abdominal pain, adnexal mass, peritoneal irritation, enlarged uterus and vaginal bleeding. Vaginal bleeding may be retrograde from the ectopic pregnancy due to intact endometrium of the intrauterine pregnancy. Challenges in the emergency setting lie in the identifying of ectopic pregnancy with the presence of the large heamoperitoneum. Haemodynamic instability in ruptured ectopic pregnancy need to be addressed appropriately by the managing team and intervention is life saving. This requires high index of suspicion from the emergency personnel to identify this condition.