thrombosis, vasospasm or tako-tsubo syndrome. In this case, this gentleman was diagnosed as TSTEMI based on the significant risk factors, history, ECG changes and raised troponin. Spontaneous reperfusion was achieved rapidly due to endogenous fibrinolysis and the presence of recruitable collateral vessels. Regarding the management, should this gentleman receive thrombolysis? The definitive treatment for TSTEMI remains unclear. However, according to a previous study by Meisel et all, data suggest immediate medical therapy with an early angiogram is an appropriate approach. Thrombolysis is not indicated as there is complete resolution of ST elevation.

CONCLUSION

Albeit there is no evidence of ongoing ischemia, patients with TSTEMI are at high risk of reocclusion. Hospital admission with continuous ECG monitoring is required. Intense medical therapy must be initiated if there is unavailability of a PCI centre.

KEY WORDS

Transient ST elevation, Myocardial Infarction

PP 28

OCCASIONALLY, I SWELL – A CASE REPORT OF DELAYED-ONSET ACE INHIBITORS-ASSOCIATED ANGIOEDEMA

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INTRODUCTION

Angiotensin Converting Enzyme (ACE) inhibitors-associated angioedema is a non-allergic, drug induced complication related to bradykinin accumulation. It usually affects the lips, tongue, face and can lead to death due to airway obstruction. Urticaria is absent. The incidence is rare between 0.1%- 0.2%, but the widespread use of ACE inhibitors mandates a special awareness by all clinicians.

CASE REPORT

62 year-old lady with no known allergy history, presented with progressive tongue and lips swelling throughout the day. Further history, few self-limiting milder episodes developed 4 months after perindopril was prescribed. Clinically, there was no urticaria, her airway was still patent. Standard treatment for anaphylaxis was initiated but progress of resolution was poor. Fortunately, symptoms resolved eventually and Perindopril was withheld. Patient has been symptom free until perindopril was restarted back 3 months after discharge due to uncontrolled hypertension. She was readmitted for another attack of angioedema.

DISCUSSION

This patient was on ACE inhibitor, developed episodic, non-urticarial angioedema over the lips and tongue. Symptoms free after discontinuation of perindopril confirmed the diagnosis of ACE inhibitors-associated angioedema. This complication usually begins as mild self-resolved episodic attacks even without discontinuation of ACE inhibitors. But the crescendo nature of severity will ultimately lead to life-threatening airway obstruction. The onset of angioedema in this patient was 4 months after initiation of perindopril. Although ACE inhibitors-associated angioedema typically occurs within 2 weeks of treatment but delayed-onset of angioedema up till to years had been reported. Unlike allergic angioedema, ACE inhibitors-associated angioedema

poorly responds to conventional allergy treatment, discontinuation of ACE inhibitor is the key of resolution.

CONCLUSION

A justifiable working diagnosis on the basis of comprehensive medical history and adequate awareness of adverse drug reaction are the keys to put a halt to this potentially life-threatening yet preventable complication.

PP 29

EDOC: THE NERVE IN A DISASTER EXERCISE

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INTRODUCTION:

Hospital Serdang is the coordinating hospital for airport disaster in KLIA. Exercise is often held to prepare hospital and state response to any event.

CASE REPORT

The call came through to MECC to announce KLIA RED ALERT, KLIA RED ALERT, KLIA RED ALERT. The emergency physicians present in the emergency department responded by first choosing a clinical commander and a Medical Incident Cordinator (MIC). An Emergency Department Cordinating Centre (EDOC) was opened. A staff of 4 persons consisting of an ED assistant medical officer supervisor, the hospital sister on call and 2 clerks assisted the Medical Incident Cordinator (MIC). Reports were made to Air Disaster Unit(ADU) and Hospital Operations Room (HOR) that EDOC was opened. Then, coordination of ambulance response from all hospitals in the state was done, together with coordinating request for more ambulance back up from ADU. Almost as soon as this ambulance response was being coordinated, real patients were reported. By this time a Hospital Red Alert was announced, and coordination was also underway to prepare the ED for surge in patient load. Request for more staff, equipment, food was forwarded to Operations Room. Reports of casualties was collected from ADU and forwarded to operations room together with the destinations of dispatched ambulances. Cases coming to Serdang

Hospital was communicated to Clinical Cordinator. With 4 walkie talkies and 4 phone lines (with 2 phone lines down), communication was abuzz. All communications was documented by the 2 clerks. Finally final data was tallied from ADU of cases, diagnosis and disposition and forwarded to Operation Room.

DISCUSSION AND CONCLUSION

EDOC is the nerve of activity during a disaster. The personnel involved must know their job well, be patient, and have good communication and coordination skills. Team work is the key to a successful disaster exercise.

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BROKEN HEART SYNDROME OR MYOCARDIAL INFARCT?

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INTRODUCTION

Takotsubo cardiomyopathy (TCM) may mimic acute myocardial infarct by virtue of ECG changes and raised cardiac enzyme but with negative cardiac angiogram finding as well as left ventricular apical ballooning on echocardiogram. I am presenting a case of lady presented with what