

appears to be an entity of cardiac failure known as "broken heart syndrome".

CASE HISTORY

A 25 year old Myanmar lady presented initially to our ED and treated as hyperventilation syndrome following an emotionally stressful event, and ECG at that time was sinus rhythm. On her second visit to our ED she was complaining of chest discomfort and shortness of breath. During her second visit her ECG changed from initial RBBB to ST elevation in leads I, AvL, V2 to V5 few hours later. Trop T was positive. Her echo initially shows showed right ventricular and atrial dilation but later developed akinetic mid and apical segment with normal right ventricular function and ejection fraction of 15%. In the intervening period she developed recurrent paroxysmal ventricular tachycardia with shock. PCI reveals pristine coronary vessels. She was ventilated in the coronary unit and died 24 hours later. All her septic work up was negative. Postmortem finding revealed infarcted left ventricular wall. She was treated as cardiogenic shock secondary to acute myocardial infarct.

DISCUSSION

While the preceding history is not clear it is likely that the hyperventilation syndrome was due to acute emotional stress which later leads her to develop TCM with cardiogenic shock and eventual death. Whether the changes in echo finding first done in ED and later by cardiologist as well serial changes in ECG suggest different phase myocardium in TCM need to be studied further. It is opinion of author in view of patent coronary vessels this could be Takotsubo cardiomyopathy.

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LITTLE THINGS THAT MATTER: PAEDIATRIC TRAUMA INJURIES

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INTRODUCTION

Traumatic injuries and death are considered a major health issue with a quarter of the deaths occurred in children younger than 15years. Majority of the cases happen after school hours. We describe a case of predicted poor outcome with conservative treatment and successful discharge home.

CASE REPORT

A 7 year old girl was hit by car and thrown forward. She was brought in unconscious with multiple petechial over the head, neck cutaneous emphysema, unequal chest rise and deformed left shoulder. FAST showed free fluid in Morrison Pouch. Child was asystole and CPR was performed for 5mins then revived. Injury Severity Score (ISS) 33; Revised Trauma Score (RTS) 4.3; Paediatric Trauma Score (PTS) 3 CT scan showed left temporal bone, left clavicle, multiple left ribs fracture, bilateral lungs contusions with large hemopneumothorax, extensive neck emphysema and parapharyngeal region with minimal pneumomediastinum, free fluid in pelvis. Child was admitted to ICU and treated conservatively, discharged home after 19days without neurological deficits.

DISCUSSION AND CONCLUSION

Children whose PTS is between 0 and 8 had an increasing mortality related to their decreasing PTS, and those below 0 has 100% mortality. Hence there is a direct linear

relationship between PTS and injury severity. For children with low PTS and high ISS, if treated conservatively may reduce the risks of blood transfusion and decrease the length of hospital stay compared with a surgical approach. In addition, a careful and close follow-up is essential in these injured patients with good collaboration with other teams.

The goals of managing severe paediatric trauma are the same as adult. The scoring systems enable us to identify and predict the severity and outcome. The core success within a trauma team is rapidly identifying the severity, resuscitation within the 'golden hour' and good co-management with the other teams.

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BERI BERI... A DISEASE OF TEXTBOOK?

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INTRODUCTION

Thiamine deficiency, also known as beri-beri has two major clinical manifestations, dry beriberi characterized by neurologic manifestation that includes peripheral neuropathy and acute encephalopathy, and wet beri-beri with cardiovascular manifestation including high output heart failure which we discovered in this case.

CASE REPORT

A 34 years old Burmese gentleman presented to us with complaint of difficulty in breathing and unwell for the past 1 week. Upon arrival to emergency department, patient was drowsy and tachypnoeic, blood pressure 89/50, heart rate 135, lungs were clear with bilateral pedal oedema.

Patient was intubated for impending collapse. Arterial blood gas post intubation showed severe metabolic acidosis with pH 6.91, lactate 20 and bicarbonate 5.3. There was no problem with his oxygenation and his blood glucose was 5.6. Other blood investigation was normal. Bedside echocardiography showed dilated right ventricle and inferior vena cava with undervolume left ventricle. Based on the presentation and patient's demography, we decided to give high dose thiamine (200mg stat and QID) to the patient with fluid hydration. Patient subsequently improved with the therapy and was discharged well.

DISCUSSION AND CONCLUSION

We report a case series of presumed fulminant wet beri-beri in critically ill patient. Since thiamine is not routinely administered to them, these observation emphasize the necessity of maintaining a high index of suspicion for this life-threatening but reversible diagnosis especially among patients with high output cardiac failure, unexplained severe metabolic acidosis and chronic vitamin B1 deficiency usually observed in foreign workers in Malaysia who are on high carbohydrate but low protein diet.

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KEEP BENDING KEEP KEEP BENDING

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INTRODUCTION

Hypocalcemia symptoms may vary from asymptomatic to life threatening. The following case demonstrates difficult intubation for a patient who suffered tetany and need to be intubated for respiratory distress.