CASE REPORT

A 60-year-old lady with underlying hypertension and end stage renal failure was brought to Red Zone on 16th February 2016; presented with sudden onset of dyspnea. On arrival, she is was drowsy, tachypneic and hypersalivating. Her blood pressure was normal. Lungs auscultation noted generalised crepitation till up to upper zone. Saturation was 100% on highflow mask oxygenation. However it was noted that patient suffering she has severe muscle spasm over the neck and back with bilateral upper limb in flexed position. She was in a bent forward position and also having lock jaw. In view of severe metabolic acidosis (ph 7.0, HC03 of 7.0, pC02 18, p02 259) and patient was tachypneic, she was planned for intubation. Patient was given few bolus of intravenous valium for muscle relaxation to lie her flat but failed. Anaesthesiologist was called in for difficult airway and surgical airway equipment is prepared in case of failed airway. Patient was then successfully intubated in the operation theatre by anaesthesiologist. Noted The corrected calcium is was 0.71mmol/L and potassium level of was 6.8mmol/L. Calcium gluconate, sodium bicarbonate and lytic cocktail for hyperkalaemia was were given before patient went for urgent hemodialysis. Patient also had one episode of unstable AF where patient was synchronized cardioverted. Prolonged QT interval was also noted on ECG.

DISCUSSION

In the neuromuscular system, ionized calcium facilitates nerve conduction, muscle contraction and relaxation. Since calcium blocks sodium channels and inhibits depolarization of nerve and muscle fibers, diminished calcium will lowers the threshold for depolarization. As result, carpopedal and generalized tetany might be observed. Alkalemia induces tetany due to a decrease in ionized calcium, whereas acidemia is protective. This is important in patients with renal failure who have hypocalcemia because rapid correction of acidemia or development of alkalemia may trigger or worsen tetany.

CONCLUSION

Most hypocalcemic emergencies are mild and require only supportive treatment. However rapid correction must be done in severe hypocalcemia in those with seizures, tetany, refractory hypotension, or arrhythmias.

PP 34

SERRATUS ANTERIOR ABSCESS: RARE PRESENTATION OF MELIOIDOSIS

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INTRODUCTION

Early identification of infectious disease depends on high index of suspicion, local epidemiology data and heuristic experience of the attending physician.

CASE REPORT

33-year old gentleman with Type I Diabetes was seen for left flank pain and fever for 3 days. There was no diarrhoea, vomiting or dysuria. No significant travelling history elicited. He was tachycardic and feverish but was neither hypotensive nor tachypnoeic. Apart from positive renal punch other examinations were normal. The patient is hyperglycaemic with a slightly elevated lactate. Other investigations

were normal. Initial managing team treated him as renal colic with uncontrolled Diabetes in observation ward. Reassessment 2 hours later showed a persistent flank pain with minimal skin erythema. Further probing questioning revealed discovered a suspicious travel history of multiple exposures to soil from his work as a palm oil estate supervisor. A working diagnosis of severe sepsis due to splenic abscess secondary to melioidosis was made. IV Unasyn and adequate fluid resuscitation was given. Formal Ultrasound showed Serratus Anterior abscess. Burkholderia pseudomallei was isolated. Patient was discharged weeks later after appropriate antibiotic course.

DISCUSSION AND CONCLUSION

Melioidosis is an infectious disease caused by a gram-negative bacterium, Burkholderia pseudomallei, found in soil and water. It is of public health importance in endemic areas, particularly in Southern Thailand, Malaysia and Northern Australia. Patient with diabetes is particularly susceptible with grave outcome. Since the organism is able to withstand a harsh environment, it is very resistant to antibiotic and can lie dormant in the body for years. Therefore antibiotic choice should be organism specific with a prolong course up to 6 month. A 10-years sample from IMR discovered Augmentin, Bactrim, Cefotaxim and Imipenem has the highest sensitivity compared to Ciprofloxacin and Tazosin. From this study it is suggested to give a combination of antibiotic is necessary for total eradication.

PP 35

"MY CHILD HEART BEAT AS FAST AS FERRARI" – A CASE OF SVT IN A 4 MONTHS OLD INFANT REVERTED USING ICE BUCKET CHALLENGE

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INTRODUCTION

We described a case of 4 four month old infant came to our Emergency department with Supraventricular Tachycardia

CASE DESCRIPTION

Supraventricular tachycardia is a life threatening condition where the heart beat exceed 150/min with abnormal rhythm arise from improper electrical activity of the heart.It is a rapid heart rhythm originated from or above the atrioventricular node. This is a case of SVT in a 4 four month old baby boy with no medical illness who has presented to us with rapid breathing and fever. The infant has high grade fever with core body temperature of 40 degree celcius and pulse rate 240/min, BP:99/47, tachypnoiec with respiratory rate 58 /min. The otherwise hydration was fair, with tears formation upon crying and having moist mucus membrance, lungs were clear, equal air entry and the abdomen was soft and nontender. The infant was promptly triaged to Red Zone and cardiac monitoring was done. The cardiac rhythm was analysed and noted to have supraventricular tachycardia. Steps were taken to revert the SVT to sinus rhythm using IV adenosine x3 via axillary venous access however but failed to revert cardiac rhythm. At the same time the infant was given bolus NS to improve