

hydration status and suppository antipyretic (which was also given by the mother at home prior to presentation to the hospital). However, the infant condition remained same. Tepid sponging was done with ice water with close monitoring to prevent hypothermia. Surprisingly despite IV adenosine x 3, child cardiac rhythm was only reverted to sinus rhythm after tepid sponging with iced water. Child was managed together with the paediatric team and subsequently transferred to paediatric ward and was treated as SVT secondary to presumed sepsis. In the ward other blood investigations revealed TSH and T4 level, electrolytes, CKMB and LDH were all normal. The hemoglobin level was 10.2g/dL. The echocardiography by the paediatric team revealed a small PFO patent foramen ovale. Child was discharged well after 3 days of hospitalisation.

LESSON LEARNT

Supraventricular tachycardia in a 4 months old infant is a rare and life threatening condition. As the child presented with high grade fever and rapid heart beat, it is necessary to reduce the core body temperature of child as one of the measurements to revert to sinus rhythm. Tepid sponging with ice water was a more accessible compared to conventional IV adenosine/ propranolol/ lignocaine. Message for doctors in distant district areas, it will be more convenient to manage patient with "Ice Bucket challenge" with close core temperature monitoring while transferring them to tertiary centres. This will be our second case of supraventricular tachycardia in paediatric population which cardiac rhythm been reverted to sinus rhythm using ice water- Ice Bucket Challenge" method.

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"ALL OF SUDDEN I CAN'T FEEL MY BOTH FEET" – A CASE OF BILATERAL ACUTE LIMB ISCHEMIA

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INTRODUCTION

We present a case of 52 years old man with past medical history of IHD (2 vessel disease and stented 6 times) and dilated cardiomyopathy presented to us with Acute Limb Ischemia.

CASE DESCRIPTION

A 52 years old man with medical history of IHD and dilated cardiomyopathy presented to us with acute onset of bilateral lower limb pain subsequently numbness. The initial vital signs included BP=124/75, PR=71/min, RR=18/min, SPO2 =99 % under room air and temperature of 37 degree celcius. The cardiopulmonary and abdominal examination was were unremarkable. On the extremity examination, both limbs appeared dusky, cold clammy on to touch, numbness reduced sensation over bilateral lower limb, poor capillary refill time crt less than 4 seconds, and SPO2 ranging 70-75% all toes. On vascular examination, femoral, dorsalis pedis and popliteal arteries were DPA and PTA not palapable, popliteal and femoral pulsation absent as well as and were confirmed with by doppler. Bedside ultrasound shows 2point compression test test shows compressible but with absence of popliteal artery pulsation. On neurologic examination, The power of

both lower limbs were 2/5 over the bilateral lower limb, with intact sensation was still intact with subjective complaint of numbness and tingling on his bilateral lower limb. Working diagnosis of Acute Limb Ischemia of bilateral lower limb was made. Emergent phone referral was made with to a vascular surgeon and an interventional radiologist were initiated. A computed tomography angiogram (CTA) of the abdomen and lower limb was performed and demonstrated showed an aorta-iliac occlusive disease involving the infrarenal abdominal aorta.

DISCUSSION

Acute limb ischemia in high risk patients are common, however involving bilateral lower limb is a rare condition. In our case, prompt action was taken right after clinical diagnosis as patient has already presented with cold clammy feet and absents of DPA/PTA arterial pulsation. Immediate CTA was done and was noted patient to have occlusion high up at common iliac artery. Early referral to vascular surgeon and interventional radiologist are crucial to establish diagnosis and early intervention to salvage affected limb. However in this case, Patient was treated conservatively as patient having poor cardiac function.

CONCLUSIONS

Acute Limb ischemia is common in high risk patients. However it is rare to involve both lower limbs. It is wise to consider a higher level of occlusion in patients presented with such symptoms despite working on differential diagnosis such as hypokaleamia periodic paralysis or Guillain-barré syndrome. Early diagnosis and intervention might save the affected limb.

PP 37 POST TRAUMA MASSIVE PULMONARY EMBOLISM IN PREGNANCY

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INTRODUCTION

Pulmonary embolism (PE) is among the most common causes of maternal death during pregnancy and postpartum worldwide. The clinical diagnosis of PE in normal population is usually difficult, but it is more complicated in pregnant patients, because physiologic changes of pregnancy can mask signs and symptoms of pulmonary embolism.

CASE REPORT

In this case study, a Nigerian lady developed massive pulmonary embolism after sustaining closed left lateral malleolus fracture. She underwent plating of left lateral malleolus. After discharged from the ward she developed shortness of breath, palpitation and chest pain. Patient was brought in by ambulance team and noted SPO2 on arrival was 85% on room air, tachycardic 150 beats per minute. ECG: Sinus tachycardia with S1Q3T3. CT angiogram findings were bilateral pulmonary artery thromboembolisms. She was then given IVI Heparin in Emergency Department. Patient was then admitted in CCU and was given IV Streptokinase. Patient underwent thrombolectomy as well. Inevitably, patient passed away the next day after the operation.