

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 feets 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 safe 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 masks 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.

DISCUSSION & CONCLUSION

Pulmonary embolism in pregnancy is not uncommon and causes significant morbidity and mortality amongst pregnant women. Diagnosing PE can be challenging and involves the usage of echocardiography, laboratory, and clinical findings. Rapid and accurate diagnosis is vital because treatment must be initiated early before deterioration. However the treatment itself has potential complications. Most patients with DVT and/or PE can be safely and successfully treated with unfractionated or low-molecular-weight heparin for the duration of the pregnancy. But, in massive PE, thrombolytic or thrombolectomy must be decided fast to achieve a good outcome.

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“DON'T STREP ME!” – MYOCARDIAL ISCHAEMIA IN SEPTIC SHOCK

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INTRODUCTION

ECG findings in septic shock include loss of QRS amplitude, prolonged QTc interval, bundle branch blocks, Osborn waves. However ST segment elevation in septic shock is rare.

CASE REPORT

29 year-old gentleman presented with fever for 5 days, vomiting and diarrhea for 3 days. Patient was alert but blood pressure on arrival was 71/39mmHg, pulse rate was 114bpm. Patient has His peripheries were cold with right hypochondrial tenderness. Blood investigation showed leucocytosis 12.0x10³/μL,

thrombocytopenia 104x10³/μL. ECG showed sinus tachycardia.

Dengue rapid test was negative. In view of history jungle trekking 2 weeks ago, patient was treated as leptospirosis with septic shock. Diagnosis was confirmed with positive leptospirosis rapid test. While commencing IV fluid resuscitation and IV noradrenaline infusion, noted there was ST elevation on cardiac monitor, blood pressure 101/59mmHg. Repeated ECG showed ST elevation in inferior and posterior leads, with reciprocal changes in antero-septal and right sided leads. Patient has no chest pain. Patient was treated as type 2 myocardial infarction (MI) and didn't proceed for thrombolysis. When the volume restored and vasopressor was weaned off, repeated ECG on the following day showed normalization of ST segment to baseline.

DISCUSSION

Type 2 MI, also known as supply/demand MI consisted of 3.5% of all MIs. In hypotension, reduced perfusion to coronary circulation can lead to imbalance between myocardial oxygen supply and demand, causing type 2 MI. In this case normalization of ST segment suggests a transient myocardial ischaemia. Adequate fluid resuscitation and judicious use of vasopressor will correct the supply/demand imbalance. Thrombolysis will not be helpful as the ischaemia is not due to coronary artery thrombosis. We need to treat the cause, not the ECG. Elevation of cardiac biomarkers can be due to septic shock itself, but elevated cardiac troponin directly related to mortality.