

its significant size, soft tissue sarcoma has to be ruled out, hence the patient was referred to orthopaedic oncology unit. MRI scan confirms this finding of homogenous lesion suggestive of intramuscular lipoma.

DISCUSSION & CONCLUSION

Point of care ultrasound is a useful adjunct to narrow down differential diagnosis of a swelling and fast track patient to the appropriate unit.

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ULTRASOUND SIGNS OF SEVERE DENGUE – THE E-C-G APPROACH

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INTRODUCTION

Dengue is a mosquito borne viral that are endemic in South East Asia and Pacific region. The incidence is increasing and so is the severity and mortality. According to WHO guidelines, severe dengue is characterized by severe plasma leakage, severe haemorrhage and severe organ impairment. Plasma leakage can be difficult to detect clinically in the initial stage. Myocardial depression, a sign of end organ impairment is also difficult to assess. Early detection of these signs can direct the patient to be placed under closer monitoring. It also results in a more judicious fluid therapy, which is the mainstay of dengue treatment.

CASE REPORT

We present five cases of dengue fever with ultrasound evidence of severe dengue. These patients have plasma leakages either in pleural or

peritoneal cavity. One patient had myocardial depression. All five patients had gallbladder oedema with reticular pattern, a findings consistent with severe dengue, but not specified in the WHO guidelines. 3 of these patients were admitted to intensive care unit. All 5 patients survived.

DISCUSSION & CONCLUSION

Based on this, we suggest the ultrasound approach to identify some of the signs of severe dengue. Clinicians should look for effusions (pleural, peritoneal and pericardial), cardiomyopathy, gallbladder oedema, or E-C-G. Any positive findings will add value to the management of the patient in terms of monitoring and volume of fluid. Whether these findings have direct effect on mortality and morbidity requires a proper clinical study.

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CAN ULTRASOUND ASSIST IN ASSESMENT OF STRIDOR?

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INTRODUCTION

Stridor is a potential airway nightmare. Preparation for impending respiratory collapse has to be made emergently. Cricothyroidotomy, which is hailed as the airway rescue in "can't intubate, can't oxygenate (CICO)", can have devastating outcome in certain patient. This case highlight ultrasound as a potential tool in assisting with airway management.

CASE REPORT

A 56 years old gentleman presented to ED with 3 days history of shortness of breath. He has been

having coryzal symptoms for last 4 days and had noisy breathing since that morning. This patient had a history of wound debridement 7 months prior for which he underwent general anaesthesia. Since then he has said that his voice has become hoarse. On examination, his vitals signs were as follow: HR 118/min, BP 139/126mmHg, SpO2 100% under room air. He was tachypnoeic with audible inspiratory stridor. There was no neck swelling, no mass, trachea was central. Provisional diagnosis of vocal cord palsy was made. ENT assessment with flexo nasopharyngolaryngoscope (FNPLS) showed fungating mass involving false vocal cord region extending to subglottic region, irregular mucosa at right vocal cord region. Ultrasound revealed heterogenous mass within the larynx extending from above to below cricoid cartilage. Tracheostomy was performed the next day, followed by CT scan and operation for laryngeal ca.

DISCUSSION & CONCLUSION

Ultrasound can act as an adjunct to assessment of stridor. Physical examination alone has its limitation. This patient was fortunate as he did not deteriorate further. Should he desaturate, and physicians found a CICO situation, cricothyroidotomy could potentially be disastrous.

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SCREAMING AIR UNDER THE SKIN

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INTRODUCTION

Subcutaneous emphysema is commonly related to trauma, surgery,

or any various respiratory and non respiratory causes. It can occur at any part of human body. This is a case study regarding a simple non traumatic activity resulting in subcutaneous emphysema. It was due to excessive straining during shouting leading to possible airway injury subsequently causing air leak. This leads to pneumothorax and pneumomediastinum with subcutaneous emphysema.

CASE REPORT

In this study case report, a teenager developed subcutaneous emphysema after a football match. He denied denying any trauma or physical contact. The symptoms appeared after prolong intense shouting during the game. He developed neck pain and gradually developed swelling over the neck which extended to the chest. He was hemodynamically stable and the subcutaneous emphysema did not progress. He was treated conservatively and was discharged well after few days of observation.

DISCUSSION & CONCLUSION

Subcutaneous emphysema with pneumothorax and pneumomediastinum can be caused by extreme prolong intense shouting which may cause sudden raise in intrathoracic pressure. This leads to rupture of alveoli and air leaking to mediastinum and pleural space and subsequently travel subcutaneously.