

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.