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THE ROLE OF REGIONAL BLOCKS IN FACILITATING THE ACUTE MANAGEMENT OF LIMB TRAUMA IN THE EMERGENCY DEPARTMENT

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INTRODUCTION

The role of regional blocks has been globally established as an effective modality of providing surgical anesthesia as well as an effective option of postoperative pain management. The anesthetist often performs such procedures in the pre or post-operative phases. This mode of anesthesia has many advantages including, avoiding the potential morbidities of general anesthesia as well as a safer effective alternative for providing surgical anesthesia. In the recent years, the practice of regional blocks has made its way into facilitating procedures in the Emergency Departments (ED). Nevertheless, such intervention has still not been well established in Malaysia and the South East Asian region.

CASE REPORT

This report presents to you a case series of 6 limb related trauma patients receiving regional blocks in the Emergency Department. The ED team led by the Emergency Physician provided the regional blocks. The procedures for each of the 6 patients differed in the indications as well as the type of blocks provided. All the patients in this case series were acute trauma cases that were treated in Hospital Sungai Buloh, Selangor Malaysia.

DISCUSSION & CONCLUSION

The case series will demonstrate the burst of benefits in providing regional blocks in the Emergency Department. All the patients had a drastic reduction in their pain scores and underwent vital emergency acute care procedures comfortably and successfully in the Emergency Department. Some of the procedures, which would otherwise require procedural sedation and pre-procedural fasting, were successfully avoided, hence reducing the rare but potentially fatal risk associated with it. We would like to promote the utility of regional blocks in facilitating the management of acute limb trauma in the ED. In order to achieve this aim, we would suggest emergency department doctors to undergo training and practice in performing safe and effective limb related regional anesthesia.

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AORTIC DISSECTION: A LETHAL MIMICKER

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INTRODUCTION

Diagnosis of aortic dissection remains elusive despite advances in its diagnostic imaging and treatment, mainly contributed by its diverse clinical presentation. Aortic dissection as a cause of neurological symptoms is often overlooked. Unusual combination of symptoms and signs should raise suspicion of an underlying vascular pathology such as aortic dissection1.

CASE REPORT

We report a case of a previously well 44 year old man presented with sudden onset of right lower limb weakness. However, examination noted no pulse felt over the right leg from level of femoral artery down to dorsalis pedis and feeble left radial pulse. He was admitted for acute limb ischemia and underwent emergency embolectomy. Embolectomy improved flow of the femoral artery but popliteal artery was still unpalpable. He then underwent CT thorax which revealed extensive Stanford Type A aortic dissection involving aortic root until the abdominal aortic bifurcation with superior extension to all aortic arch branches, compression of superior vena cava and left brachiocephalic vein by the dilated aortic root and right renal ischemia from a thrombus at true lumen. Patient succumbed after operative aortic dissection repair.

DISCUSSION

The occurrence of painless dissection ranges between 5-15%. Neurological symptoms without any pain are observed in 1/3 of patients with Type A aortic dissection1. It is caused by dissection or occlusion of aortic side branches supplying the brain, spinal cord or peripheral nerves. Lower extremity pulse deficit in the absence of peripheral vascular disease are associated with malperfusion syndrome of aortic dissection and found in approximately half of patients with thoraco-abdominal or aortic arch involvement2. Diagnosis of aortic presentation in these cases can be difficult and delayed. Patients with typical features were diagnoses sooner than those without3.

CONCLUSION

Aortic dissection presented with neurological symptoms is rare. Physician must have high level of suspicion especially in cases with unusual presentation.

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THE PURPLE TAGS

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INTRODUCTION

Like any disaster, an air craft accident may require actions that do not fall into a predictable pattern. Thus a regular drill exercises are done to minimize the risk to victims and the rescue personnel. In conjunction to that, Aerodrome Emergency Exercise (AEX) was held recently, involving 265 players. 23 purple tagged patients were encountered, where players presented as real patients with wide spectrum of heat exhaustion.

CASE REPORT

The scenario at the AEX was of an airplane crashed onto the runaway. The event took place at noon. 74 of the players was tagged green, 43 as yellow, 56 as red and remaining 69 as white. All players which were recruited into this drill were clinically fit and age ranging from 20-30 years old. We had 23 "real" emergency cases of heat exhaustion (purple tagged). Long exposure to extreme heat and too much activity under a hot sun has causesd excessive perspiration, which lead to heat exhaustion. They presented with headache and feeling weakness and dizziness accompanied by nausea and vomiting, muscle cramps and pre-syncope. All 23 patients was were given first aid from the site medical camp and transferred to medical base at Air Disaster Unit (ADU). They were moved