

## 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 dissection<sup>1</sup>. 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 involvement<sup>2</sup>. Diagnosis of aortic presentation in these cases can be difficult and delayed. Patients with typical features were diagnosed sooner than those without<sup>3</sup>.

## 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 runway. 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 caused 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

to a cool environment and encouraged to increase the consumption of fluids. However one of them required admission and another three was sent to the nearest hospital for further observation and management.

## DISCUSSION

Preparedness for a drill is not solely pertaining to the scenario injuries but also by expecting and anticipating possible real injuries or emergencies as well. Several factors need to be considered at all time such as the weather changes, environment safety and players' health conditions. Thus, it is important to ensure preparedness for real emergencies during a disaster drill.

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#### LOW GCS: TO INTUBATE OR NOT TO INTUBATE

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## INTRODUCTION

Altered level consciousness is a common presentation in emergency setting. Misconception of equating a low Glasgow Coma Scale (GCS) with indication of intubation is not uncommonly seen. The act of juvenile decision to intubate prior to detailed assessment, has lead to unnecessary intubation and raise intubation-associated complications.

## CASE REPORT

33 year-old female presented to emergency department with sudden onset of quadriplegia and aphasia, shortly after having quarrel with her husband. On arrival to Emergency department, noted patient GCS was E4V1M1. Patient was normoglycemic with normal cardiac rhythm on immediate assessment. She was able to

respond to some questions by blinking her eyes. No prior history of fever, substance abuse, alcohol intake, recent medications or any previous illness. On examination, pupils were reactive, spontaneous breathing effort, absent gag reflex, power all 4 limbs 0/5 however tone and reflex normal. Further blood investigations, urine toxicology, CT brain were unremarkable. Intubation was not performed, as patient was able to maintain airway spontaneously with no respiratory distress and no features of traumatic brain injury. Case referred to medical team, who subsequently treated the patient as meningoencephalitis and started on empirical antibiotic. Miraculously, on 3rd day of admission, patient suddenly recovered completely and was treated as pseudocoma.

## DISCUSSION

The concept of GCS in deciding need of intubation is revisited. It should be emphasized that interpretation of GCS score of patients should be individualized case-by-case basis. In the end, good history taking with thorough clinical examinations will gives limitless amount of benefits in deciding treatment plans.

## CONCLUSION

As a primary responder, we have to shift our thinking process in managing patients with altered level of consciousness. The role of GCS should be kept as a first line guide rather than sole indication of intubation.