can be fatal. Even with great advances in critical care medicine over the past 20 years, the mortality rate due to acute pancreatitis remained at approximately 10%. Diagnosis of pancreatic related problem is often difficult and management is often difficult and is delayed as the pancreas is an organ which is relatively inaccessible especially in pregnant women. It is often difficult to diagnose acute pancreatitis in a pregnant patient even more so in a patient with underlying gastritis presenting with sudden pain at epigastric region sometimes extending to the back. The common cause of acute pancreatitis in pregnancy is often due to alcohol abuse or gall bladder. It is thought with the weight and hormonal changes induced by pregnancy, gallstones are more likely to form and thus travel down the common bile duct to obstruct the pancreas duct outflow.

CASE REPORT

A 31 year old, Malay female G3P0+2 at 26 weeks 5 days presented to the emergency department with the chief complaint of sudden onset of epigastric pain radiating to the back, on and off sharp in nature with a pain score of 8/10. The pain was relieved by leaning forward. This was associated with multiple episodes of vomiting for one day containing water and food particles. Patient had no history of eating outside food or skipping meals. The vital signs upon arrival were noted within normal range. Patient looked lethargic with epigastric tenderness with a pain score of 8/10. Urine dipstick showed albumin: 2+, ketone: 1+, leucocyte:1+. FBC noted WCC: 30.9, Hb: 12.2, Plt:384, Hct: 35, RP and LFT noted within normal range. Initially patient was referred to O&G team and then to Surgical and Gastroenterology team with a working diagnosis of Acute Gastritis and TRO Acute Pancreatitis. Subsequently serum amylase noted 1608 and ultrasound abdomen showed cholelithiasis with bulky and heterogenous pancreas with no peripancreatic fluid or collection and acute pancreatitis cannot be ruled out due to raised amylase level. Patient was discharged after close monitoring at the medical ward and the serum amylase level has decreased. A follow up with surgery in 6 weeks time was given for reassessment and planned for gall bladder removal post pregnancy.

CONCLUSION

While a rare event, acute pancreatitis does occur in pregnancy. Fortunately, if treated early, generally pre-term labor and mortality can be avoided and the incidence of recurrent attacks minimized. Therefore, it is important to rapidly detect and diagnose for appropriate and early management for optimal results for both mother and baby. Emergency physicians should consider establishing acute pancreatitis as a diagnosis when such cases are seen on set.

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RESULTS OF IMPLANTATION OF AUTOLOGOUS MONONUCLEAR STEM CELLS IN PATIENTS WITH BUERGER'S DISEASE

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INTRODUCTION

Buerger's Disease is a segmental inflammatory occlusive disorder of unknown aetiology affecting the upper

limb and lower limb. It is also known as throboangiitis obliterans. Studies have shown Bone Marrow Mononuclear cells may enhance neovascularization in ischaemic limbs secondary to Buerger's disease. We are describing 2 cases of Buerger's disease with history of multiple amputations of the toes, treated with stem cell therapy.

CASE 1

25 year old smoker presented with non healing painful foot ulcer for 2 months duration. On examination, there was an ulcer at right fifth toe. Digital Substraction angiography showed a single arterial supply to both lower limb and cork-screw appearance at the ankle region. Wound debridment was done. Autologous bone marrow Mononuclear cells (BM-MNC) obtained using the standard protocol and injected intramuscularly to the calf, plantar and lateral region of the right lower limb. Another cycle of autologous bone marrow mesenchymal stem cells (BM-MSC) injection was done on the subsequent month. There was no immediate or post-procedure complication. Digital substraction angiography 1 month after the therapy showed improvement of collaterals at the affected leg. His ulcer healed at 2 months follow-up.

CASE 2

35 year old man, a smoker presented with wet gangrene of the right fourth and fifth toe. He had history of ray amputation of the right first and third toe, with right femoral-popliteal bypass done 6 months prior to this presentation. Digital Substraction Angiography showed feature of Buerger's Disease. Right transmetatarsal amputation was done. The wound was noted to be slow healing. 2 cycles of autologous bone marrow injection was done at the calf muscles, plantar and wound. Digital substraction angiography post procedure shows increased collateralizations of the right lower limb and foot. After 2 months, the transmetartasal amputation wound healed, patient was asymptomatic.

CONCLUSION

Our result shows the stem cell therapy can treat ischaemic limb secondary to Buerger's disease.

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POPLITEAL ARTERY ENTRAPMENT SYNDROME: AN UNCOMMON CAUSE OF LOWER LIMB ISCHAEMIA

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INTRODUCTION

Popliteal Artery Entrapment Syndrome (PAES) is a rare vascular disease that usually affects the young adults and athletes. It is a consequence of an abnormal positioning of the popliteal artery in relation to its surrounding structures. Patient usually presented with intermittent claudication and in severe cases, patient may presented with acute vascular insufficiency.

ABSTRACT

We are report of a 32 years old soldier presented with intermittent claudication of the right leg for 2 years. The pain worsens for 2 months as the claudication distance reduced to 100 metres. He has no other risk except for heavy smoker. Examination shows the right leg was cold, no skin changes, intact sensory and the distal pulses was