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Association of Turkey



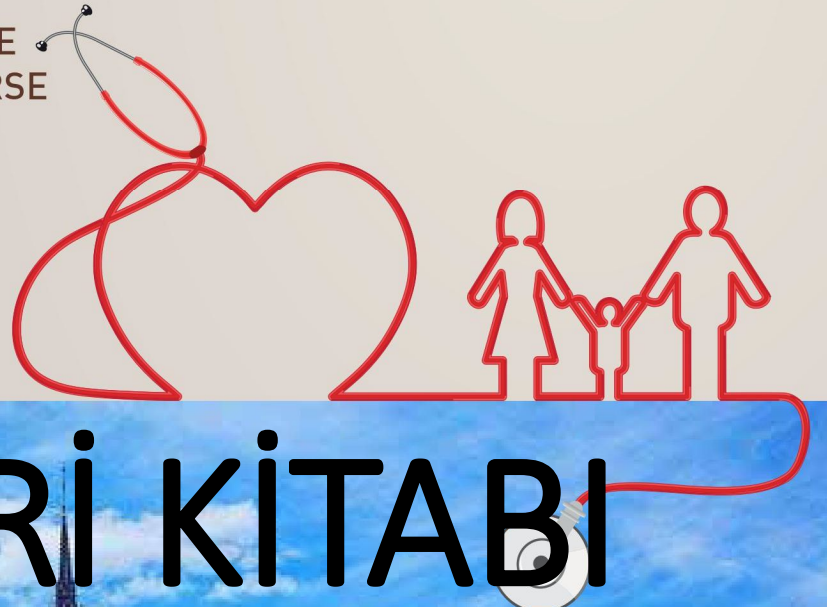
TRAHED
TRABZON ASSOCIATION OF FAMILY PHYSICIANS

4th INTERNATIONAL EMERGENCY AND FAMILY MEDICINE SYMPOSIUM

- BACK PAIN COURSE
- CARDIAC EMERGENCY COURSE
- PEDIATRIC EMERGENCY COURSE

March 21 - 24, 2019
Novotel City
Budapest / Hungary

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BİLDİRİ KİTABI

İÇİNDEKİLER

GENEL BİLGİLER	3
BİLİMSEL PROGRAM	5
POSTER BİLDİRİLER	11
SÖZEL BİLDİRİLER	19
KONUŞMA ÖZETLERİ	63

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BİLİMSEL PROGRAM

21 MARCH 2019 – MAIN HALL

Time	Subject and Speakers
14.00 - 16.00	Check-Into Hotel
16.00 - 18.00	<p>Hungary – Turkey Emergency and Family Medicine Panel</p> <p>Prof. Dr. Başar CANDER Chairman, President of Emergency Physician Association of Turkey</p> <p>Prof. Dr. Sándor BALOGH Chairman, President of Hungarian First Step Health Care Society</p> <p>Prof. László Kalabay, MD Semmelweis University, Faculty of Medicine</p> <p>Abdo KHOURY MD., MPH, MSc DM Vice president, European Society for Emergency Medicine (EuSEM) Vice president, International PanArab Critical Care Medicine Society (IPACCMS)</p> <p>Hakan UZUN, MD General Secretary, President of Trabzon Family Medicine Association</p>
19.00 - 24.00	Dinner

22 MARCH 2019 MAIN HALL

09.00 - 10.30	<p>Opening Speeches</p> <p>Prof. Dr. Başar CANDER Chairman, Emergency Medicine Physician Association of Turkey</p> <p>Prof. Dr. Ferenc HAJNAL Chairman, President Elect of the Hungarian Scientific Association of General Practitioners</p> <p>Dr. Renata PAPP President of the Hungarian Scientific Association of General Practitioners</p> <p>Hakan UZUN, MD</p>
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		General Secretary, President of Trabzon Family Medicine Association
10.30 - 11.00	Coffee Break	
11.00 - 12.30	Prof. Netijzhenko Vasyl ZAHAROVYCH	<p>Basic Life Support Course (Theoric)</p> <p>Prof. Dr. Başar CANDER Chairman, Emergency Medicine Physician Association of Turkey</p> <p>Advanced Life Support Course (Theoric)</p> <p>Prof. Dr. Mehmet GÜL Necmettin Erbakan University, Medical School</p>
12.30 - 13.30	Lunch	
13.30 - 15.00	Assoc. Prof Sophiko TSKVITINIDZE, PHD Assoc. Prof. Yahya Kemal GÜNAYDIN	<p>Surgical Emergencies Session</p> <p>Acute Abdomen</p> <p>Assoc. Prof. Şükrü GÜRBÜZ İnönü University, Medical School</p> <p>Erzsébet Horváth, MD Cardiologist in Budapest</p> <p>General Approach to Trauma</p> <p>Prof. Dr. Yunsur ÇEVİK R.T. Ministry of Health Keçiören Education and Research Hospital Emergency Medicine Clinic</p> <p>Therapeutic Injections in Emergency Service</p> <p>Assoc. Prof. Yahya Kemal GÜNAYDIN R.T. Ministry of Health Keçiören Education and Research Hospital Emergency Medicine Clinic</p> <p>Kos Csekeő, MD Head of Guildford Clinic</p> <p>Katalin Lónyai, MD Hungarian Physician of Physical Therapy</p>
15.00 - 15.30	Coffee Break	
15.30 - 17.00	Prof. Dr. Behçet AL	<p>Critical Care Session</p> <p>High Risk ECG Samples</p> <p>Assoc. Prof. Mehmet OKUMUS Ankara Education Research Hospital</p>

		<p>Curiosities In Cardiovascular Emergencies Case Study</p> <p>Dr. István KARÓCZKAI Jahn Ferenc South-Pest Hospital and Clinic</p> <p>Geriatric Patient Assesment</p> <p>Prof. Dr. Behçet AL Gaziantep University, Medical School</p> <p>Sepsis – From Family Doctor To The Hospital</p> <p>Dr. Katalin GASKÓ Jahn Ferenc South-Pest Hospital and Clinic</p> <p>Diabetic Emergencies</p> <p>Assoc. Prof. Mehmet KOŞARGELİR Haydarpaşa Education Research Hospital</p> <p>Andrea Ludányi, MD Travel Clinic, General Practice</p> <p>Ákos Csekeő, MD Guildford Clinic</p> <p>Pharmacovigilance In Family Practice</p> <p>Dr. Ádám ZAJZON Hungarian Scientific Society of General Practitioners</p>
17.00 - 17.15	Break	
17.15 - 18.00		<p>Rational Use of Medication</p> <p>Prof. Dr. Başar CANDER Chairman, Emergency Medicine Physician Association of Turkey</p>
19.00 - 22.00	Dinner	

22 MARCH 2019 SECOND HALL

Time	Moderator	Subject and Speakers
10.00 - 12.30	İMUNEKS FARMA OTURUMU	
12.30 - 13.30	Lunch	
13.00 - 14.00	İMUNEKS FARMA OTURUMU	

17.15 - 18.00	Assoc. Prof. Şükrü GÜRBÜZ	Oral Presentations
19.00 - 22.00	Dinner	

23 MARCH 2019 MAIN HALL

Time	Moderator	Subject and Speakers
09.00 - 10.30	Prof. Dr. Hakan OĞUZTÜRK Szabolcs Molnár, MD	<p>Pain Session</p> <p>Approach to Patient with Neuropathic Pain in Emergency Service</p> <p>Assoc. Prof. Özlem BİLİR RTE University, Medical School</p> <p>Andrea Ludányi, MD Travel Clinic, General Practice</p> <p>Myofascial Pain Syndrome</p> <p>Assoc. Prof. Şükrü GÜRBÜZ İnönü University, Medical School</p> <p>Ervin Bács, MD Abdominal And Vascular Consultant/Surgeon, Budapest</p> <p>Pain Sensation – Influencing Factors</p> <p>Ágnes PORZSOLT Jahn Ferenc South-Pest Hospital and Clinic</p> <p>Wound Care and General Suture Techniques</p> <p>Assoc. Prof. Ayhan AKÖZ Adnan Menderes University, Medical School</p>
10.30 - 11.00	Coffee Break	
11.00 - 12.30	Prof. Dr. Zeynep ÇAKIR Katalin Lónyai, MD Ferenc Németh, MD	<p>Neurologic Emergencies Session</p> <p>Hemoragic and Ischemic Strokes</p> <p>Prof. Dr. Hakan OĞUZTÜRK İnönü University, Medical School</p> <p>Akos K. Santha, MD Medical Director for Adult Health Care Services</p> <p>Curiosities In Neurology – Case Study</p> <p>Dr. Péter KOLBACH Jahn Ferenc South-Pest Hospital and Clinic</p>

		<p>Syncope</p> <p>Assoc. Prof. Yahya Kemal GÜNAYDIN R.T. Ministry of Health Keçiören Education and Research Hospital Emergency Medicine Clinic</p> <p>Andrea Ludányi, MD Travel Clinic, General Practice</p> <p>Headache</p> <p>Asst. Prof. Abdullah Osman KOÇAK Erzurum Atatürk University, Medical School</p> <p>Zoltán Gyulai, MD General Practitioner State Military Hospital, Budapest</p>
12.30 - 13.30	Lunch	
13.30 - 15.00	Prof. Dr. Yunsur ÇEVİK Krisztina Szele, MD	<p>Multiple Organ Failure</p> <p>Assoc. Prof. Özlem BİLİR RTE University, Medical School</p> <p>Ocute Respiratory Distress Syndrome</p> <p>Assoc. Ayhan AKÖZ Adnan Menderes University, Medical School</p> <p>Gábor Györi, MD Medical doctor, Semmelweis University of Medicine, Budapest</p>
19.00 - 22.00	Dinner	

23 MARCH 2019 SECOND HALL

10.30 - 12.30	Prof. Dr. Başar CANDER Prof. Dr. Mehmet GÜL	<p>Bacis Life Support Course Advanced Life Support Course</p>
12.30 - 13.30	Lunch	
13.30 - 17.00		<p>Low Back Pain Diagnosis And Management Course With Cases</p> <p>Prof. Dr. İlknur AKTAŞ Ministry of Health FSM Teaching and Research Hospital Head of Physical Therapy and Rehabilitation Clinic</p>

19.00 - 22.00	Dinner	

24 MARCH 2019 MAIL HALL

Time	Moderator	Subject and Speakers
08.30 - 11.30	Muhsin Ertuğrul ŞEN, MD Halil İbrahim KÜÇÜK, MD	Legal Problems with Solutions in Emergency and Family Medicine Hakan UZUN, MD General Secretary, President of Trabzon Family Medicine Association
11.30 - 12.00		Symposium Closing Speeches

POSTER BİLDİRİLER

POSTER 1

Preseptal cellulitis

Ayça Çalbay, Emergency Medicine Specialist

Health Science University Erzurum Regional Education and Research Hospital

Introduction: Preseptal selülitis is the infection of the soft tissues from anterior orbital septum to posterior to it. Some clinicians use the term "periorbital cellulitis" rather than "preseptal cellulitis. Preseptal cellulitis is more common in children than in adults, and preseptal cellulitis is much more common than orbital cellulitis. The main source of infection in orbital cellulitis is paranasal sinuses and in many cases of preseptal cellulitis become from external sources. Preseptal cellulitis may be seen after local trauma from the face and eyelids, insect bites, animal bites , or foreign bodies. Bacteremic seeding of the preseptal space is not common. It is intermitently seen in infants with bacteremia due to *Streptococcus pneumoniae*, *Streptococcus pyogenes*, or *Haemophilus influenzae*. In immunocompromised patients bacteremia due to *Pseudomonas aeruginosa* has been rarely associated with preseptal cellulitis.

Case: A 65 year old woman patient admitted to emergency department with the complaint of swelling and pain on her both eyes. She had been evaluated as angioneuretic edema after drug use last night. On her physical examination she had swelling, edema and pain in her both eyes but more on the left side. There were swelling, redness and herpetic rash on the dorsal side of the nose (Picture 1). Oropharynx hyperemic, bilateral tonsillar hypertrophic and bilateral cervical lap had been showned. After detailed examination and history of the patient, orbital tomography was performed for imaging. In these scans edema was showned on the anterior orbital area (Picture 2) and she had been consulted to the ophthalmology and dermatology clinics for periorbital cellulitis. She had not neurologic deficit and she was discharged on the basis of polyclinic control recommendations.

Result: A local allergic reaction can also have a similar clinic presentation with preseptal cellulitis but can usually be differentiated by the clinic history. Periorbital swelling from environmental allergies or angioedema is commanly seen on bilaterally (In contrast to preseptal cellulitis, which is usually unilateral.In our case swelling was bilaterally.). A history of recent sinusitis, insect bite, or local face and/or eyelid trauma is supportive of the diagnosis. In indefinite cases, computed tomography (CT) scanning of the orbits and sinuses is used to differantiate preseptal cellulitis from orbital cellulitis. Treatment is almost always empiric and based upon knowledge of the common infecting organisms (*Staphylococcus aureus*, *Streptococcus pneumoniae*, other streptococci and anaerobes) and their usual susceptibility patterns. Topical antibiotics have no place in the treatment of this infection.



Picture 1



Picture 2

POSTER 2

DOMESTIC VIOLENCE

Eren Sert^a, Melis Dörter^a, Ramazan Ünal^a, Ramazan Güven^a, Başar Cander^a

Kanuni Sultan Süleyman Education and Research Hospital University of Health Science,
Department of Emergency Medicine, Istanbul, Turkey

Introduction: Domestic violence affects mostly women and children worldwide, and men can become victims of domestic violence sometimes.

Case presentation: 45 years old male patient. He applied to hospital with the statement of that he was subjected of violence by his wife. In the physical examination; an iron trivet which used for small LPG tubes was found been stuck in the right zygomatic and occipital area of the head. The lesions were at the skin and subcutaneous level and the foreign body had not harmed the deep tissues and osseous structures. Tetanus prophylaxis and antibiotherapy were applied. After removal of the foreign body, the lesions were sutured properly and dressed.

Discussion: It has come into question the violence against women and children through the efforts of women's movements in the world in the 1960s and in Turkey in the 1980s and it has been recognized as one of the most important human right violations.

According to the study of domestic violence against women in Turkey in 2008; across the country 39% of women suffer from physical, 15% of women suffer from sexual violence and 42% of

women suffer from one of both physical or sexual violence. In other words, sexual violence was almost always with physical violence (1).

The same study was repeated in 2014, with a rate of 36% for physical violence, 12% for sexual violence and 38% for one of both physical or sexual violence (2).

These ratios are globally 30% for physical, 7% for sexual and 35% for one of both physical or sexual violence (3). These rates are higher in South Asia, the Middle East and Africa; It is lower in Europe, North America, and Australia (3).

Conclusion: When the literature is examined, it is noteworthy that there are few studies on domestic violence against men in the emergency departments. This may be due to the fact that these cases are rare or not declared as all cases of domestic violence.

References:

1. Türkiye’de kadına yönelik aile içi şiddet, Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü, 2009
2. Türkiye’de kadına yönelik aile içi şiddet, Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü, 2015
3. World Health Organisation, Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, 2013



POSTER 3

Ethanol and Mushroom Intoxication

Introduction: Life-threatening mushroom and ethanol intoxication can be seen together. We confront a patient who apply to emergency with the history of drinking vodka and eating mushrooms.

Case presentation: 40 years old female patient. She applied to the hospital with the complaint of nausea, and vomiting. She was referred to our clinic with the statement that she had drunk vodka and eaten fungus 4 days before the hospital appliance. She had decreased liver and kidney function. There were no significant examination in the system examinations. TA 130/90 mmHg, pulse 87 /min, SAT 98%.

Laboratory findings are urea 90,0 mg/dl, kreatinin 1,28 mg/dl, AST 126 U/l, ALT 60 U/l, GGT 63 U/l, ALP 146 U/l, LDH 365 U/l, amilaz 115 U/l, lipaz 26,9, total bilirubin 0,84 mg/dl, direct bilirubin 0,34 mg/dl, indirect bilirubin 0,5 mg/dl, serum protein 88,95 g/l, albümin 49,4 g/l, Ca 8,1mg/l, Na 131 mmol/l, K 4,3 mmol/l, CRP 39,03 mg/l.

Ethanol <10 mg/dl(0,1 promil).

Blood gas analyze; pH 7,48, pCO₂ 48,7 mmHg, pO₂ 33,7 mmHg, HCO₃ 35,9 mmol/l, SO₂ 48,6, BE 12,4 mmol/l, lactat 1,61 mmol/l.

Hemogram; WBC 11460 /mcl, Hgb15,1 g/dl, Hct 42,2%, Plt 222000 /mcl

aPTT 25,3 sn, PT 10,5 sn, INR 0,89.

Hypertrophic appearance and a uniformly limited echogenic formation with a diameter of 1 cm (hemangioma?) in the left lobe of the liver has been detected in the abdominal USG. Both kidney parenchymal echoes has increased to grade 1-2.

The patient was consulted to the internal medicine department and after 6 hours of hydration with 2000 cc isotonic laboratory:

Glukoz 95 mg/dl, üre 62,0 mg/dl, kreatinin 0,91 mg/dl, AST 107 U/l, ALT 56 U/l, GGT 53 U/l, ALP 123 U/l, LDH 298 U/l, amilaz 87 U/l, lipaz 37,5, total bilirubin 0,71 mg/dl, direct bilirubin 0,30 mg/dl, indirect bilirubin 0,41 mg/dl, serum protein 76,79 g/l, albumin 44,1 g/l, Ca 7,8 mg/l, Na 133 mmol/l, K 3,1 mmol/l, CK 2268 U/l, Troponin T 0,006 ng/ml.

Blood gas analyze; pH 7,45, pCO₂ 39,2 mmHg, pO₂ 71,3 mmHg, HCO₃ 26,8 mmol/l, SO₂ 93,1, BE 2,8 mmol/l, lactat 3,27 mmol/l.

Hemogram; WBC 11840 /mcl, Hgb 13,6 g/dl, Hct 38,8,2%, Plt 191000 /mcl

Anti HIV (-), Anti HCV (-), HBsAg (-), Anti HBs(-), Anti HAV IgM (-) Anti Hav IgG (+)

She was discharged with recommendations.

Discussion Alcohols are hidrocarbons which include an hidroxy (-OH) group. Most intoxications of these clear, colorless fluids are caused by isopropanol, methanol, ethilen glicol. These intoxications apply to emergency services mostly the clinic of respiratory depression, aspiration, hypotension, cardiovascular collabs, central nervous system depression, visual problems, vomiting, stomache, headache, confussion, coma, even death. Most important laboratory finding is metabolic acidosis with elaveted base deficit. The antidots of methanol and ethilen glicol are ethanol and fomepizol.

Clinic of mushroom intoxication includes a widely spectrum of symptoms like nausea, vomiting, diarrhea, renal and hepatic failures and even death. Two clinic presentations are seen: Early toxicity is seen in first 2 hours with a benign clinic. But late toxicity is more catastrophic and mortal.

Conclusion: With this case report we aimed to draw attention to the fact that more than one intoxication can be seen together.

References:

1. Acil Tıp Temel Başvuru Kitabı, Başar Cander.

POSTER 4

A Neurological Emergency Because Of A Rare Cause: Intracranial Hemorrhage Due To Multiple Cavernoma

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Introduction:

Stroke is the third leading cause of death in all over the world. 80% of the stroke cases are ischemic in nature and the rest is hemorrhagic. Considering its high incidence, stroke must be managed in emergency department on a daily basis.

Case:

29 year-old male patient presented to emergency room with difficulty of speaking and walking for a week and had a seizure 3 days ago. His vital signs were all stable however orientation and cooperation was limited. Neither he was able to speak fluently nor was able to understand verbal statements. Muscle power examination showed 3/5 in left extremities and 4/5 in right extremities according to MRC. He had horizontal gaze paralysis in the right side. He was on sodium valproate medication for 20 years for epilepsy and once he was admitted to neurology clinic because of status epilepticus in relation with the information gathered from his medical records. Former cranial computed tomography (CCT) reports revealed multiple cavernoma in brain. He had no other chronic disease or medication/addiction. Immediately CCT performed and hemorrhage observed in most of the cavernomas in both hemispheres. He was admitted to neurology clinic.

Conclusion:

Although most of the cerebrovascular accidents occur due to ischemia, it is crucial to differentiate hemorrhagic ones from ischemic ones because of the totally different treatment modalities. Even though nowadays CCT is available in many of the medical centers, history of the patient has utmost importance in diagnosis process.

Keywords: Stroke, Intracranial Hemorrhage, Emergency medicine

POSTER 5

ESOPHAGEAL PERFORATION AFTER COUGH

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Introduction:

Esophageal perforation is a rare disease. The frequency is increasing due to invasive interventions. The most common symptoms and signs are; pain, fever, difficulty in swallowing, shortness of breath and subcutaneous emphysema. At least one of the pneumothorax, pleural fluid or mediastinal emphysema is seen. The definitive diagnosis is made by the endoscopic evaluation of the perforation. The most common cause is iatrogenic. Other reasons are foreign body, spontaneous, trauma, caustic injury, malignancy and barotrauma. In the case of oral food intake after perforation, in the case of oral food intake, sepsis findings such as general condition deterioration, fever, tachypnea and hypotension occur.

Case:

A 60-year-old female presented to the emergency service with the complaint of abdominal pain after coughing. The patient's general condition was moderate, conscious, oriented-cooperative, GCS: 15, blood pressure arterial: 100/60 mmHg, pulse 97 pulse / min, pulse oxygen saturation was 82%. It was learned that the patient did not have a chronic disease. In her physical examination, the lung sounds decreased in bilateral lower zones, there were no rebound defenses in the abdominal examination. There was crepitations extending from the neck to the trunk. Oxygen therapy was started and ECG was performed. Blood tests, PAAC radiography, cervical graphy, thorax and abdominal CT imaging tests were requested. Blood tests were performed with WBC: 14.03, glucose: 319, blood gas, pH: 7.3, lac: 3, pO₂: 52.9, sO₂: 81. Perforation of the esophagus was detected according to the results of imaging studies. The patient was consulted to the thoracic surgery clinic and was hospitalized by the same clinic. The operation of the chest surgery clinic was performed by the patient and it was learned that the patient was ex exed in the intensive care unit after four days.

Discussion:

Since esophageal perforation causes mediastinal, pleural inflammation and sepsis development, morbidity and mortality rate is high. In esophageal perforation, the intervention to be performed before mediastinitis is life-saving.

Keywords: Esophageal Perforation, Emergency Service, Subcutaneous Emphysema

POSTER 6

Acute Respiratory Failure Due To Conium Maculatum

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ABSTRACT

Conium maculatum is a toxic plant for animals and humans. Conium maculatum contains nicotine alkaloids. It activates the nicotinic receptors and then blocks them. Conium maculatum poisoning causes

nausea, vomiting, hypotension or hypertension, tachycardia and bradycardia, muscular fasciculations, seizures, paresthesias, high of salivation bronchospasm. Treatment is symptomatic, there is no antidote.

There are interest in healing herb in our country. Also; poisoning with healing herb is increasing. In this article, a person who had taken from the market and eaten *Conium maculatum* thinks that he/she had eaten *Chenopodium album*. Then, acute respiratory failure has occurred in the patient. In this article, the case is presented and discussed.

CASE

A family of three cooked cow parsley, 15 minutes after eating, started from the feet and spread to the body with a complaint of weakness applied to our emergency service.. Vitals were stable, the patients were cooperative, oriented and Glasgow Coma Scores (GCS) is 14-15. All the patients had ptosis. Some tests that are venous blood gas, detailed biochemistry, hemogram and coagulation have been done to patients. Intravenous (IV) fluid therapy was started in patients. After two hours, acute respiratory failure was observed in male patient (59 year old). Endotracheal intubation was done for respiratory system of the patient. 114-National Poison Advisory Centre called. Gastric lavage and activated charcoal were applied. The emergency service was asked to bring the herb that he ate from patient's relative. It is clear that the patient ate *Conium maculatum*. It was understood that male patient (59 year old) ate more *Conium maculatum* than the other patients. Patient transferred to intensive care unit. 2 days later, he was discharged from the hospital healthily. And after ten days, the patient had no complaints under control.



patient's eating herb



Anthriscus Sylvestris (Cow Parsley)



Conium Maculatum
(Hemlock)

DISCUSSION

Poisoning of *Conium maculatum* is one of the alkaloid poisoning of piperidine. There are many names of known to the public of *Conium maculatum* such as dizzy herb, umbrella herb, snake herb, smell herb. It is called spotted *Conium maculatum* because of there are red spots on it. In 399 B.C., the King poisoned the Socrates with *Conium maculatum* to kill. It grows from West of Europe to Asia and East Turkestan, But in Turkey, it grows more. Also it grows wild in North America. *Conium maculatum* contains derivatives of piperidine alkaloids, coniine, conisine and canhydrin. The most poisonous *Conium maculatum* is coniine (2-propiperidine- C₈ H₁₇N). Coniine is a liquid that smells similar to a cat or Mouse urine, colorless, volatile and soluble in chloroform. Coniine is a peripheral neurotoxin and produces nicotinic effects on autonomic ganglions; similar to curvature in neuromuscular junction. In early period, central nervous stimulation, headache and ataxia may occur due to nicotinic activation. Tachycardia, salivation, mydriasis, sweating may increase effects similar to nicotine in autonomic ganglions. In severe

cases, nicotinic receptors are excessively stimulated, resulting cholinergic blockage occurs. Clinical; what we intend to say is that vary of bradycardia from stimulation phase, motor paralysis from Asen, central nervous system depression and respiratory depression from depressive phase. There is no antidote. For people, the lethal dose is 0.15 g(4). 6-8 g of conium maculatum contains 0.10-0.30 g coniin. In the treatment, respiratory support, IV guidance, digestive system decontamination (gastric lavage, active coal application) is required . If you have convulsions benzodiazepine or barbiturate, IV liquid support, rabdomyolysis, urinary alkalization, careful use of antiemetics (may reduce convulsions threshold), potassium level monitoring is required(5,6).

In pursuit of treatment and support airway, IV route, providing digestive decontamination (gastric lavage, activated charcoal administration), benzodiazepine or barbiturate has convulsion, if the use of IV fluid support, if you have the localization of rhabdomyolysis urine, the careful use of antiemetics (may lower the convulsion threshold), close monitoring of potassium levels take place(5,6).

As a result of poisoning of conium maculatum; respiratory depression was improved and respiratory safety was ensured and ventilation support, digestive system decontamination, IV crystalloid fluid application was performed. The patient was followed up and transferred to intensive care for the continuation of the follow-up.

RESULT

Eating conium maculatum is a life-threatening intoxication. In addition, mortality and morbidity can be avoided with aggressive treatment and close follow-up.

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SÖZEL BİLDİRİLER

SÖZEL 1

Hypertriglyceridemia-induced acute pancreatitis in pregnancy

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Introduction

There are many difficulties in evaluating abdominal pain during pregnancy in which accurate diagnosis of even the most common pathologies may be challenging. In pregnant patients presenting with epigastric pain, acute pancreatitis should always be considered since timely diagnosis and treatment of these patients is life-saving. In this article, we present a 35-week pregnant woman who presented with epigastric pain due to hypertriglyceridemia-induced acute pancreatitis and had a fatal outcome.

Case

A 37-year-old, 35-week pregnant woman presented to the emergency department with epigastric pain, nausea, and vomiting for 2 days. The patient had a history of family hyperlipidemia and gestational diabetes. In laboratory analysis serum amylase level was 522 mg/dl, lipase 519 mg/dl, hematocrit 48%, calcium 6.5 mg/dl, and triglyceride was 7620 mg/dl. Initial diagnosis of acute pancreatitis was confirmed after ultrasonography analysis which was also consistent with acute pancreatitis. During treatment and at the 14th hour of her admission, emergency cesarean section was performed because of fetal distress and placental detachment. In the first 24 hours postoperatively, lipid apheresis was initiated and the treatment was continued under intensive care conditions. Abdominal tomography showed progression to necrotizing pancreatitis and at the 30th day of the treatment, the patient died due to sepsis and multi-organ failure.

Conclusion

Although acute pancreatitis is rare in pregnancy, early diagnosis and treatment are of great importance. Patients with a history of familial hyperlipidemia and gestational diabetes are at risk for hypertriglyceridemia-induced acute pancreatitis which is commonly seen in the third trimester. The multidisciplinary approach is particularly important for the prevention of premature delivery. Acute pancreatitis should be considered in the differential diagnosis of all pregnant women admitted to the emergency department with abdominal pain.

Keywords

Acute pancreatitis, hypertriglyceridemia, pregnancy

SÖZEL 2

Coexistence of Platypnea, Right Atrial Myxoma and Pulmonary Embolism

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Abstract

Myxomas are the most common primary heart tumor and 80-90% of them are found in the left atrium. These tumors have a wide spectrum of symptoms including dyspnea, unexplained syncope, congestive heart failure, stroke and sudden cardiac death. Platypnea is a rare but clinically important type of dyspnea, which is characterized by worsening of dyspnea while standing yet relieving in the supine position. A 45-year-old female patient with no history of chronic disease admitted to our emergency department for platypnea, in whom were detected a right atrial myxoma and consequent bilateral pulmonary thromboembolism. The presenting complaints of patients admitted to the emergency department should be thoroughly evaluated and rare conditions should always be kept in mind considering the diversity of the differential diagnosis.

Keywords: Myxoma; Dyspnea; Thromboembolism

Introduction

Myxomas are the most common type of primary cardiac tumor. They are considered to be a benign and slowly proliferating neoplasm of endocardial origin. Myxoma prevalence rates were reported to range from 0.0017% to 0.03% in different autopsy series. These tumors are more prevalent after 40 years old and among women (1). About 80-90% of myxomas are located in the left atrium. Rare right atrial myxomas have a more solid structure than the left and they show a relatively wide base. They may remain asymptomatic until diagnosed or may present with unexplained syncope or sudden cardiac death. The thrombotic material overlying the tumor is the main source of its detrimental consequences. Therefore, thromboembolism is observed in about 30% of the patients with right atrial myxoma (2). Diagnosis is often made by transthoracic two-dimensional echocardiography. Platypnea is a rare type of dyspnea which is indicative of important clinical outcomes. Although it has been defined for half a century, its mechanism has not been fully clarified yet. It is defined as shortness of breath which occurs while standing or during effort and relieves in the supine position (3). Here we present a case with platypnea as the presenting symptom, in whom were detected a right atrial myxoma and pulmonary thromboembolism. We aim to emphasize that such rare conditions may sometimes be encountered in emergency departments and that cardiac tumors must be kept in mind in patients with similar symptoms.

Case

A 45-year-old female patient with no previously known chronic illness admitted to the emergency department of Malatya State Hospital for the recent exacerbation of her shortness of breath, which had been present for one month. She stated that her dyspnea was worsening while standing and relieving in the supine position, thus describing platypnea. Peripheral oxyg

en saturation (SpO₂) measured in supine position was 87% and it decreased to 65% after standing for 3 minutes. The patient could not keep her upright position any further, due to severe dyspnea. On physical examination, her body temperature was 36.7°C, heart rate was 103 bpm, blood pressure was 130/80 mmHg and respiratory rate was 22 times per minute. On chest auscultation, long expirium, rhonchi at rare areas and basilar crackles were heard. Laboratory results were as follows: hemoglobin 9.9 gr/dl; WBC 9600/ml; platelet count 290,000/ml; sedimentation rate 50 mm/h; glucose 121 mg/dl; urea 43mg/dl; creatinine 0,6 mg/dl; CRP 1.7 mg/l; pCO₂ 29mmHg; SaO₂ 85%; PaO₂ 65; d-dimer 2200 mg/dl. ECG examination in the emergency department revealed a sinus tachycardia; while PA chest graph and bilateral lower limb venous and arterial Doppler studies were normal. Thorax CT scan demonstrated bilateral thrombus in the bilateral main pulmonary artery and a mass within the right atrium. A right atrial 8x6x4cm mass located in the right atrial side of the interatrial septum and right ventricular dilatation were detected in echocardiography. The mass was non-homogenous, motile and lobulated, and it had a regular margin (Figure). For a proper management of the patient, an interdisciplinary approach including a cardiologist, a pulmonologist and a cardiovascular surgeon was adopted. An anticoagulation treatment regimen with unfractionated heparin was commenced. On the next day, she was transferred to the cardiovascular surgery ward for a surgical removal of the mass as its being motile and relatively large. A right atrial mass resection and bilateral pulmonary trunk embolectomy were performed. She was discharged home on the 12th day of hospitalization.

Discussion

The benign intracardiac tumors, myxomas, are the most common of the extremely rarely encountered primary tumors of the heart, and they generally occur in the left atrium. Myxomas, as being slow-growing tumors, may reach large sizes without causing any symptoms. About 4% of the total myxoma cases are estimated to remain asymptomatic. It has been reported that there is a close relationship between the diameter and structure of myxoma and symptoms of patients. The presenting symptoms may be dyspnea, palpitation or syncope, as well as sudden death (4). Due to the nature of myxomas, they may cause thromboembolic events in various organ systems. However, cases of right atrial myxoma that is complicated by pulmonary embolism are quite rare (5). Echocardiography revealed an 8x6x4cm mass that was consistent with myxoma and was completely filling the right atrial cavity, along with a thrombus in the left main pulmonary artery. As their having the same echogenicity with the normal cardiac tissue, myxomas may be missed in CT examinations, which is a commonly performed imaging method in clinical practice. A lack of symptoms to indicate any cardiac pathology, even though her tumor has reached an extensive size within the heart, resulted in a late diagnosis in our patient.

Conclusion

Herein was presented a case of right atrial myxoma complicated by pulmonary embolism, diagnosed upon her admission for platypnea, a rare type of dyspnea. We would like to underscore the importance of a proper evaluation of the presenting complaints of the patients and of making a complete evaluation in terms of the diversity of differential diagnosis. The possibility of a cardiac mass and associated life-threatening conditions should always be kept in mind in patients with platypnea.

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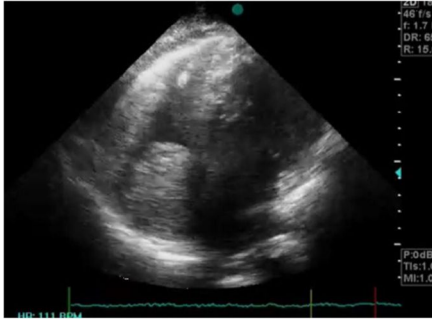


Figure: Right atrial myxoma

SÖZEL 3

A rare cause of acute ST elevation myocardial infarction

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Introduction

Acute ST elevation myocardial infarction (STEMI) which usually results from an occlusive coronary thrombus at the site of a ruptured plaque is one of the most frequent cardiac emergencies. Since timely intervention and reperfusion of the relevant artery is critical, patients are rushed to the cath laboratory if available or undergo thrombolytic therapy. However, there are some rare cases where occlusion and subsequent ST elevation may result from mechanical obstruction of the coronary ostium due to aortic dissection. In this case, we present a patient who had acute inferior myocardial infarction secondary to type A aortic dissection.

Case

A 55-year-old male patient who had no prior disease presented to the emergency department with severe chest pain and syncope. In his physical examination, he was fully alert, oriented and showed no signs of neurological deficit. However, his blood pressure was 80/60 mmHg in both arms and the patient was diaphoretic. ECG revealed a sinus rhythm and 2 mm ST-segment elevation in the inferior leads along with reciprocal changes. Therefore, the patient was rushed to the catheterization laboratory due to possible impending cardiac shock and inferior myocardial infarction. During his coronary angiogram, the left coronary system was unremarkable, however, the operator could not find the right coronary artery. Aortogram revealed a 6 cm ascending aortic aneurysm and with an apparent dissection flap. The procedure was halted and an immediate bedside echocardiogram which was

followed by computed tomography also revealed a type A aortic dissection, extending into the iliac arteries. The patient underwent surgery immediately.

Conclusion

Myocardial infarction secondary to aortic dissection occurs in approximately 3% of cases. The right coronary artery is mostly involved due to the anatomic localization of its ostium. Prompt recognition of aortic dissection is critical in order to avoid administration of antiplatelet and anticoagulant therapy. Differential diagnosis of STEMI from aortic dissection is challenging because of the need to minimize door-to-balloon time. Nevertheless, emergency physicians should always consider aortic dissection despite an apparent STEMI particularly in patients with a history of an aortic disease or other signs of dissection.

Keywords

Aortic dissection, myocardial infarction, chest pain

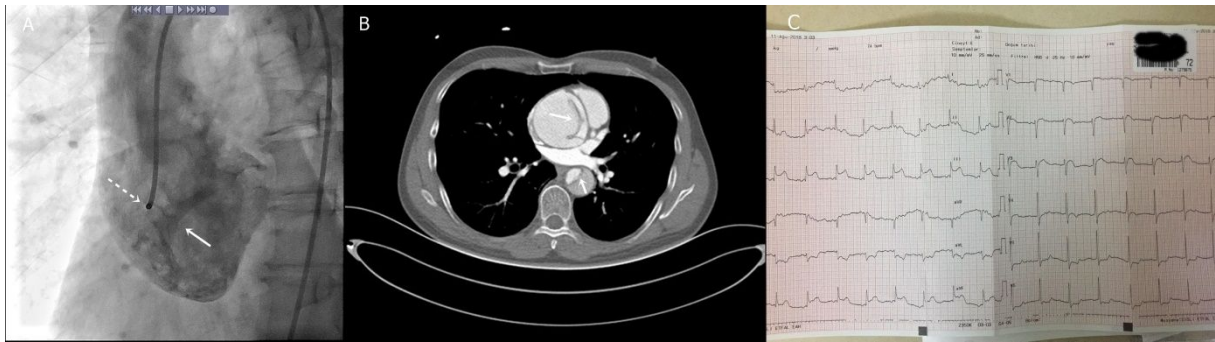


Figure 1a: Aortogram showing enlarged ascending aorta and dissection flap. White arrow indicates dissection plane. Dotted white arrow points the catheter tip

Figure 1b: Axial computed tomography image. White arrows show dissection flap both in the ascending and the descending aorta

Figure 1c: Electrocardiogram consistent with myocardial infarction

SÖZEL 4

FOURNIER'S GANGRENE: A CASE REPORT

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Introduction: Fournier's gangrene is a real and very important surgical emergency that progresses with the necrotizing infection of perineal and genital organs. Its mortality rate is about 20% on average, but rates up to 75% were also reported.

Case: The 32-year-old male patient visited the emergency service with complaints of pain, swelling, redness and discharge in the testes. As a result of the physical examination of the patient, while there were edema and redness in both testes, there were redness and increased temperature in the perineal region and discharge below the right testis in the part closer to the anal region (Figure-1). He said that these complaints started 3-4 days after he rubbed stinging nettle on the region. In the scrotal USG of the patient, in both the scrotal sacs and the inguinal region, cutaneous-subcutaneous tissue thickness was noticeably increased, there was a heterogenous and edematous appearance, and multiple multi echogenic regions that were linearly extended under the skin were observed, which corresponded to gas that reflected shading on the posterior (Fournier's Gangrene?). Urology, general surgery and infectious diseases consultations were requested for the patient. The patient was taken in surgery by the departments of urology and general surgery.

Discussion: Fournier's is accepted as a real and very critical emergency. It has very high rates of mortality. The most frequently encountered cause in FG patients is perianal infections. In our case, the patient who had pilonidal sinus infected the region in question by rubbing stinging nettle on it, which resulted in Fournier's gangrene formation. In FG, it is recommended to start wide-spectrum antibiotic treatment with double or triple combinations, and according to the result of culture-antibiogram, continue the same treatment or change the antibiotics if needed. One of the most important factors in treatment is performing debridement effectively until reaching the border of healthy tissues and not neglecting blood sugar management alongside debridement.

Conclusion: Consequently, Fournier's gangrene is one of the emergency cases that are very critical and have high mortality rates. Especially in patients who visit emergency services with redness, increased temperature and edema in the scrotum and the perineal region, Fournier's gangrene, whose mortality rate increases every second that patient cannot be diagnosed, should be considered among differential diagnoses.



Figure-1: Edematous, reddish testes, redness in the perineal region, discharge below the right testis in the part towards the anal region

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SÖZEL 5

INCIDENTAL CAVERNOUS ANGIOMA

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Introduction: Besides developmental venous anomaly (DVA), arteriovenous malformation (AVM) and capillary telangiectasia, cavernomas are one of the vascular malformations of the central nervous system. In this case report, we present a case diagnosed with cavernous angioma in the left posterior frontal region, who presented to our emergency department with the complaint of numbness in her left hand.

Case: A 38-year-old male patient was admitted to the emergency department with complaints of numbness in his left hand in the last few days. Brain CT examination showed a left sided hyperdensity at the level of vertex, which was suspected of hemorrhage. Afterwards, unenhanced and contrast-enhanced MRI scans of the brain revealed an image, which was considered primarily as hemorrhagic cavernous angioma, showed minimally heterogeneous intravenous contrast enhancement, hyperintense on T1-weighted images and heterogeneously hyperintense on T2-weighted images, and measured approximately 11 mm in size in the left posterior frontal region at high ventricular level. The patient was consulted to neurology and neurosurgery departments, and was hospitalized in the neurosurgery service.

Discussion: Cavernomas are the third most common vascular malformations after developmental venous anomaly and capillary telangiectasias, accounting for 5-13% of all cerebral vascular malformations. Cavernous angiomas can be seen in any area of the central nervous system (CNS), mostly in cerebral hemispheres (80%). They are most commonly located in the subcortical region and frontal-temporal lobes in the cerebral parenchyma. The most common clinical symptoms include epileptic seizures,

intracerebral hemorrhage, focal neurological symptoms and headache. Magnetic resonance imaging is the most sensitive radiological diagnostic method for cavernous angiomas. Asymptomatic cases of cavernous angiomas are followed by periodic MRI studies, surgical resection of the lesions is recommended because recurrent hemorrhages may cause permanent neurological deficits in symptomatic patients.

Conclusion: In conclusion, patients with cavernoma present with atypical complaints to the emergency department and can be diagnosed incidentally. Cavernomas are lesions of vascular origin, which tends to be located more frequently in the frontotemporal lobes and subcortical areas, is often accompanied by developmental venous anomalies, and has a radiological appearance that varies according to the extent of hemorrhage.



Figure 1: Brain CT examination showed a left sided hyperdensity at the level of vertex, which was suspected of hemorrhage

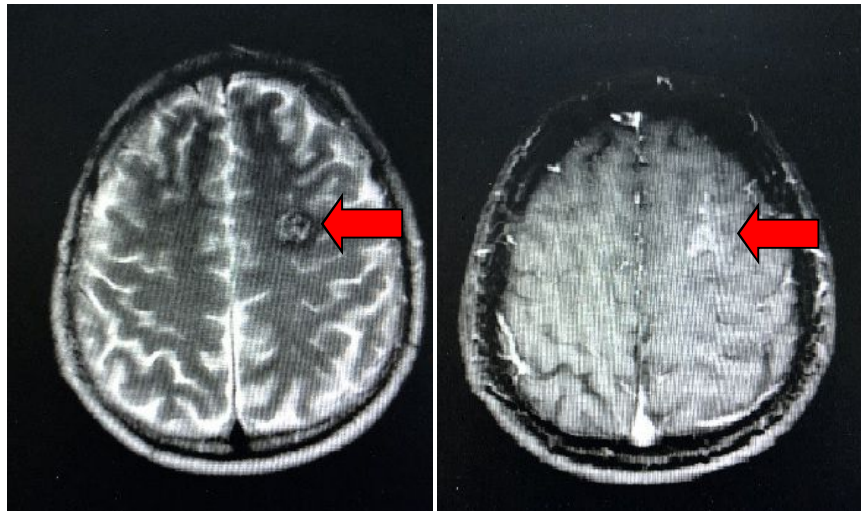


Figure 2: MRI scans of the brain revealing an image, which was considered primarily as hemorrhagic cavernous angioma, showed minimally heterogeneous intravenous contrast enhancement, hyperintense on T1-weighted images and heterogeneously hyperintense on T2-weighted images, and measured approximately 11 mm in size in the left posterior frontal region at high ventricular level

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SÖZEL 6

Prognosis predicted in acute coronary syndrome: MCHC, MPV, Procalcitonin

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Objective: The aim of this study was to evaluate the effects of serum procalcitonin (PCT), MCHC (Mean Corpuscular Hemoglobin Concentration) and MPV (Mean Platelet Volume) on myocardial infarction (MI), post-MI complications, three-vessel coronary artery disease (TVCAD) and mortality.

Materials and Methods: In this cross-sectional cohort study, 200 patients with acute coronary syndromes (ACS) admitted to our hospital emergency department room for chest pain between January 2014-December 2016 and admitted to Cardiology Clinic were included. Patients were divided into four groups according to their diagnosis. We compared PCT, MCHC, MPV, age, gender, blood sugar, left ventricular ejection fraction, cardiac troponin I (cTnI), TVCAD and mortality rates.

Results: Postoperative complications between ACS and subgroups, there was a significant difference between TVCAD and mortality. PCT and MCHC levels were higher in the inferior subgroup of ACS groups and mortality and complications were found to be higher than the other groups. In the group with high PCT and MPV, mortality and TVCAD were found more. In the anterior subgroup, ischemic heart failure was higher than other groups. Myocardial infarction in inferiors, anterior and non-ST elevation myocardial infarction (NSTEMI) groups 0, 6, 12. the time cTn I values were compared to the unstable angina group as well as the anterior group 12. the time cTnI value was significantly higher than the NSTEMI group.

Conclusions: High PCT, MCHC and MPV levels in ACS may be predictive value in terms of post-MI complications, TVCAD, and mortality.

Key Words: Acute coronary syndrome; emergency department; mortality; procalcitonin, MCHC, MPV.

SÖZEL 7

Outcomes Of Our Urological Emergency Experience on Circumcision Cases Performed By Unlicenced Local Traditional Health Providers In Southeastern Turkey

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Objective: Circumcision is a surgical procedure which is performed mostly for cultural/religious reasons and sometimes for obstructive urological pathologies like phimosis or urological emergencies like paraphimosis. The procedure can be described as the surgical removal of the foreskin of the penis and according to various guidelines on pediatric surgery and urology it is recommended that the procedure is done by a competent surgeon by using appropriate anaesthesia in a safe child-friendly environment. In this study we aimed to evaluate the clinical data on our emergency records due to complications after circumcision procedure performed by unlicensed local traditional health providers.

Method: Data of 64 patients who applied to emergency department due to complications after circumcision performed by unlicensed local traditional health providers in a 18 months period were evaluated. The evaluation criteria were method of circumcision, surgical equipment, coagulation technique, age, lesion type and localisation and the method of treatment.

Findings: Mean age of the 64 patients was 7.54 ± 1.81 (42 days-14) years. Affected area was glans penis in 19, penile skin in 18, frenulum in 13, urethra in 10, corpus cavernosum in 2 and scrotum in 2. Glanular lesions were partial injury in 12, bleeding in 5 and necrosis in 2. Penile skin lesions revealed bleeding in 12, infection in 4 and necrosis in 2, while frenulum lesions were detected as bleeding in 11 and necrosis in 2. It was observed that urethra lesions were partial injury in 6, obstruction in 2 and infection in 2 of the patients. Corpus cavernosum lesions revealed bleeding in 1 and necrosis in 1, while lesions of the scrotum were observed as 1 partial injury and 1 skin necrosis. All patients were diagnosed with physical examination and history taking. By cases with bleeding, hemogram and coagulation tests were performed. The most common surgical tool used for the removal of the skin was non-sterile razor blade and the most common coagulation technique applied was observed as dressings with hot ash. By 29 of the bleeding cases, abnormal coagulation test results were found in 4 and they were referred to pediatric hematology clinics after stabilisation of the acute bleeding. All complications were treated according to the medical condition where 9 of the patients were referred to other clinics for multidisciplinary treatment after required intervention for their urological emergency status.

Result: Circumcision is a surgical procedure which is undergone by the majority of the Turkish male population. Complications after procedure may lead to serious urological health problems, therefore the procedure should be performed by licensed surgeons in order to minimize the number of the complications and in case of complication, urgent intervention should be performed in order to prevent any severe urological disorders and any possible organ loss.

SÖZEL 8

An unusual combination: Idiopathic Pulmonary Artery Aneurysm, Bovine Aortic Arch and Bronchial Compression.

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Introduction

The left common carotid artery which originates from the brachiocephalic trunk (BT) is called as the bovine aortic arch (BAA). Although it is the third most-common normal variant found 9% in human, the origin of this term remains unclear. Idiopathic pulmonary artery aneurysm (IPAA) is a rare condition, mostly arising from main pulmonary artery. Even though specific prevalence of PAA is unknown, it has been reported in 1 out of every 14,000 autopsies. Until now, no association of BAA with IPAA and bronchial compression has been reported in the literature. In this paper, we present a case with BAA and IPAA associated with bronchial compression, which is incidentally detected by a chest radiograph.

Case report

A 56-year-old Caucasian female admitted to the cardiology clinic with complaint of chest pain, which was located retrosternal, not induced with exercise. She had history of hypertension and diabetes mellitus. Physical examination was unremarkable. Her blood pressure on admission was 140/95 mm Hg. All routine biochemical tests were normal. An electrocardiogram (ECG) revealed sinus rhythm with normal axis. A chest radiograph done upon admission demonstrated a widened mediastinum and prominent pulmonary conus (Fig. 1A). The treadmill exercise stress test, which was done to determine myocardial ischemia, was normal. A subsequent transthoracic echocardiography (TTE) revealed left ventricular hypertrophy, left atrial dilatation, mild mitral and tricuspid valve insufficiency, dilatation of main pulmonary artery (parasternal short-axis view diameter: 33 mm), no significant trans-pulmonary valve pressure gradient and normal left ventricular systolic function (Fig. 1B). There were no echocardiographic features of right cardiac failure. A computed tomographic scan of thorax revealed bovine aortic arch associated with a massively dilated main pulmonary artery (MPA) as well as dilated right (RPA) and left pulmonary (LPA) arteries. The main pulmonary artery, RPA and LPA were dilated to 53, 33 and 45 mm in diameter, respectively. Additionally, the left main bronchus was compressed by LPA (Figs. 1C). Then, the patient was consulted by cardiovascular surgeon. Since our patient did not have an aneurysm 60mm or greater in diameter, transpulmonary valve pressure gradient, and typical symptoms, it was decided to follow up at the clinic to re-assess her clinical status as well as the trans-pulmonary valve pressure gradient as an index of stability.

Discussion

Pulmonary artery aneurysm(PAA) is a rare condition,mostly arising from main pulmonary artery. The cause of PAA may be idiopathic; however, other causes include congenital shunt disease, infection (tuberculosis, syphilis, osteomyelitis, pneumonia), systemic vasculitides (Hughes–Stovin's disease, Behcet's disease), collagen vascular diseases, connective tissue disorders, (Marfan's syndrome, Ehlers–Danlos syndrome), trauma (direct or blunt chest injury), mucoid vasculopathic changes, valvular pulmonary stenosis, and pulmonary hypertension. Greene et al. described idiopathic PAA as one that satisfies the following criteria: a) enlargement of the pulmonary artery with or without involvement of the adjacent arterial trunk, b) absence of abnormal extracardiac or intracardiac shunts; c) absence of chronic pulmonary or cardiac disease, and d) more than minimal atheromatosis or pulmonary vascular tree arteriosclerosis or absence of arterial disease. For the patient reported here, the degree of dilatation was marked and both right and left pulmonary arteries were involved. Since other causes of PAA were unavailable in her family and medical history, it was considered as idiopathic PAA. Diagnosis of idiopathic PAA is generally established with echocardiography to confirm a dilated main pulmonary artery and its branches, along with the presence or absence of valvular regurgitation. Pathologically, the artery shows fragmentation of the media with degeneration and with less smooth muscle cells, which lead to progressive dilatation of the artery. These aneurysms are generally considered to be benign and less lethal, and there are no clear guidelines for the management of these aneurysms. Treatment ranges from simple follow-up with periodic echocardiographic assessments to surgical intervention. Surgical intervention has been recommended for those with an aneurysm that has a diameter of 60 mm or greater. It was showed that long-term follow-up for several decades is possible in different studies. One congenital variation of human aortic arch (AA) branching pattern in which the left common carotid

artery (LCCA) originates from the BT is called as BAA. Although both BAA and idiopathic PAA have been reported separately in literature, no case has been reported as having both BAA and PAA.

Conclusion

We report the case of a patient with BAA associated with idiopathic PAA and bronchial compression, which was diagnosed by a simple chest radiograph. Since idiopathic PAA is a possible cause of rupture or dissection of pulmonary artery, and cardiac sudden death, it is considered to be in asymptomatic patients as well and needs a multidisciplinary approach for diagnosis and treatment.

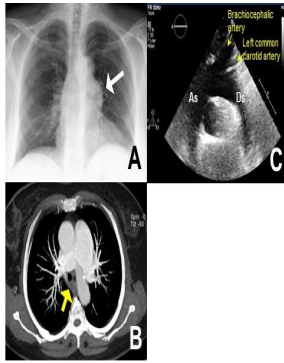


Figure1 (A) Posteroanterior chest radiography view demonstrated massive enlargement of the left pulmonary artery (arrow). (B) Axial contrast-enhanced computed tomography imaging revealed dilation of the main pulmonary artery and its branches. (C) Suprasternal view of echocardiography demonstrates bovine aortic arch. As=Ascending aorta; Ds=Descending aorta.

SÖZEL 9

THE RETROSPECTIVE INVESTIGATION OF TRAUMA CASES UNDER THE 16 YEARS OLD WHO APPLIED TO EMERGENCY DEPARTMENT OF INONU UNIVERSITY MEDICAL FACULTY

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Aims: Traumas are among the leading causes of death among the ages of 1-44 (1). Injuries leading to death in children are responsible for approximately 50% of all childhood deaths (2). Mechanisms and types of accidents, proportional with their age, vary depending on their anatomical structures, their environment and interests (3). Post-traumatic stress disorder, depression and unhappiness can also be seen in the child and family for months after the accident (4). The purpose of this retrospective study is to determine demographic information such as age, gender, time, place of trauma, mechanism of pediatrics traumas, consultation required department in emergency rooms and also to determine whether there is any relation between these data.

Materials and Methods: In this study, we retrospectively reviewed pediatric trauma cases of 0-16 years old pediatric group who applied to Emergency Medicine Department of Medical School, Inonu University between January 1, 2013 and December 31, 2013 from the files of the computer registry system. A total of 573 patients were scrutinized. In addition to the demographic characteristics such as age and sex of the patients, the number of patients apply according to the month, the trauma mechanism, the place where the trauma, the desired consultations, the services where the patients are followed, traumatized body region, radiological and laboratory findings and treatments were examined. The relationship between laboratory findings [Hemoglobin (Hgb), hematocrit (Hct), mean corpuscular volume (MCV), platelets (PLT), white blood cell counts (WBC), red blood cell distribution (RDW), creatine (Cr), blood urea nitrogen (BUN), aspartate aminotransferase (AST), alanine aminotransferase (ALT), glucose, activated partial thromboplastin time (aPTT), international normalized ratio (INR), erythrocyte and leukocyte in urine], age and injured body regions were investigated.

Results: It was determined that the number of male pediatric patients who applied with trauma was more than the number of female children patients who applied with trauma in this study. The mortality rate in pediatric trauma was found to be 0.87%. The number of pediatric traumas was found to be higher in July, August, September and October than in the other months. Falling and crashing is the most common mechanism of trauma etiology. Head and neck injuries were detected in the first place when the traumatized body region was examined. The most frequent consulted department is the department of orthopedics and traumatology, the second most frequent consulted department is the department of neurosurgery was detected. It has been determined that a large part of the patients who have been hospitalized and followed up have been monitored by emergency room. Head and neck injuries were found to increase more significantly when the age decreased. Patients with head and neck injuries were found to have significantly lower Hgb, Hct values than patients without head and neck injuries. The BUN value and the RDW value were detected to be significantly higher in patients with head and neck injuries. According to with the patience with head and neck injuries, the MCV value is higher than patients without head and neck injuries. As age decrease, patients have more abdominal trauma was detected. According to with the patience with abdominal injuries, the Hgb value and the Hct value are higher than patients without abdominal injuries. The AST and the ALT values of the patients with abdominal trauma were significantly higher than the AST and the ALT values of the patients without abdominal trauma. As age increased, injuries of extremity significantly increased.

Conclusion: It has been determined that there are different etiological reasons for the incidence of pediatric traumas and incidence frequency has been determined to change seasonally. The duration of apply to the emergency room is different according to the types of trauma, and it has been found that the injured body region is usually the head and neck region.

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PATIENT WHO SPONTANEOUS PNEUMOTHORAX IN THE EMERGENCY SERVICE

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Introduction: Pneumothorax is defined as the presence of air in the pleural area between the lungs and the thoracic wall. Primary pneumothorax is seen in healthy people who do not have an underlying lung disease. Secondary pneumothorax develops as a result of a pulmonary disease. Regardless of its etiology, emergency response is dependent on the magnitude of the cardiorespiratory disorder, severity of the symptoms and the size of the pneumothorax.

Case: A 79-year-old female patient was admitted to the emergency service with the complaint of shortness of breath. The physical examination of the patient had normal systemic results while her bilateral respiratory sounds were rough. For radiological imaging, thoracic CT was requested for the patient, and there was no significant difference in the right lung (Figure-1). At this point, d-dimer test was requested for the patient with the pre-diagnosis of pulmonary embolism, and the d-dimer result of the patient came back as high as 7.79 ugFEU/m (normal interval: 0-0.5). Thoracic CT-angiography was carried out on the patient after this, and no pulmonary embolism was observed. However, in the CT-angiography, an appearance compatible with pneumothorax that was not found in the first thoracic CT was observed (Figure-2). Consultation was requested for the patient from thoracic surgery, and the patient was hospitalized at the intensive care unit of the thoracic surgery department.

Discussion: The most frequent cause of primary spontaneous pneumothorax (PSP) is the tear of the apical subpleural blebs. Secondary SP occurs as a result of an underlying pulmonary disease such as chronic obstructive pulmonary disease (COPD), tuberculosis, AIDS, sarcoidosis, pneumonia or cystic fibrosis. Additionally, with the increase in invasive practices, iatrogenic pneumothorax cases were encountered as the most frequently observed type of pneumothorax cases that are seen in research and training hospitals that are seen after traumatic pneumothorax cases. Thoracic interventions such as placement of central venous catheters, percutaneous subclavian venous pace makers, transthoracic needle biopsies, thoracenteses, transbronchial thoracic biopsies, bronchoscopy and tracheostomy may be a cause of iatrogenic pneumothorax. The classical treatment that is applied for pneumothorax is conventional underwater drainage (8). Especially in iatrogenic pneumothorax, 99% of success has been reported in tube thoracostomy. The disadvantage of this method was reported as the negative effects on patient comfort (10).

Conclusion: In addition to problems in people who visit the emergency services with complaints of shortness of breath including asthma, COPD, pulmonary embolism, congestive heart failure, we could include among our pre-diagnoses pneumothorax that requires hospitalization at the time of diagnosis but may be fatal when missed even without the history of trauma in patients.

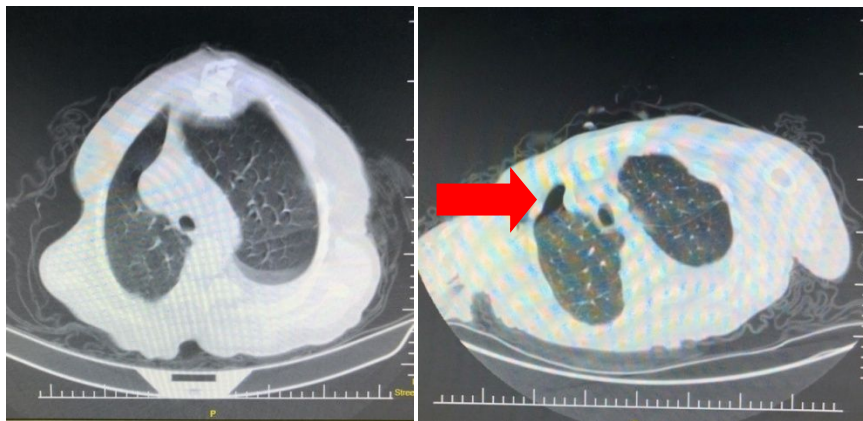


Figure-1: Non-Pnx thoracic CT

Figure-2: Pnx thoracic CT

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SÖZEL 11

Analysis of Patients Receiving High Dose Drugs Applying to the Emergency Department of a University Hospital

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Objective

The aim of this descriptive study was to determine the demographic data, vital signs and agents of patients receiving high doses of suicidal drugs in the emergency department of our hospital.

Method

We retrospectively reviewed the files of the patients who received high dose medication for suicide between 01.01.2016 and 31.12.2017. Incomplete or incorrectly filled patient files were excluded from the study.

Findings

168 patients were included in our study. The mean age of the patients ranged from 18 to 63 years, with a mean of 26.6 ± 9.22 years. 71.4% (n = 120) of the patients were female. The vital signs of the patients are shown in Table-1. The duration of admission to the hospital after drug intake varied between 0-12 hours and the mean admission time after drug intake was 2.29 ± 2.59 . 120 patients were admitted to the hospital within the first hour. According to the drugs taken by the patients, 53 patients

are receiving multiple drugs. This included 39 patients with NSAID only, 23 patients with only SSRI, 19 patients with only antibiotics, 18 patients with paracetamol (7 patients > 7 g), 9 patients with mites only and 7 patients with TCA alone.

Table-1 Vital findings of patients

	Minimum	Maximum	Mean	Std. Deviation
Systolic Blood Pressure	85	195	124,16	16,135
Diastolic Blood Pressure	35	115	75,26	12,341
pulse	43	160	85,49	18,220
Respiratory Rate	12	27	17,37	2,990
Body Temperature	36,0	37,6	36,53	,3658
Pulse Oximeter(%)	83	100	95,09	2,944

Result

The majority of patients who received high doses of suicidal drugs in the emergency department received multiple drugs. Generally, NSAIDs were found to be the most commonly used agents for suicide use.

Keywords: poisoning, suicid, emergency medicine

SÖZEL 12

Type A Aortic Dissection Presenting with Anterior ST-Elevation Myocardial Infarction

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Introduction

Acute aortic dissection (AAD) is a relatively rare cause of acute chest pain in emergency services and one of the most challenging life threatening medical emergencies. When it presents with acute coronary syndrome (ACS), early accurate diagnosis and appropriate interventions are necessary for the survival. Differential diagnosis with AAD from ACS is a common and challenging because they can have the similar clinic presentation but contradictory management. Here we report a case of type A aortic dissection with ST elevation myocardial infarction (STEMI) that was initially misdiagnosed as acute anterior wall myocardial infarction.

Case

A 74-year-old man had initially presented to the emergency room with sudden onset of retrosternal compressive chest pain and dyspnea. The patient had a severe deafness and anamnesis is taken patient relatives. He had a history of uncontrolled hypertension, diabetes mellitus with controlled oral anti-diabetics. He had a history of coronary angiography and diagnosed non-critically coronary artery disease two years ago. He had tachypnea, bradycardia and cold sweating. The electrocardiogram showed ST elevation and biphasic T waves in the anterior leads (Figure 1). Hypotension was noted and

dual anti-platelet agents were prescribed immediately. He transferred catheter laboratory for primary percutaneous coronary intervention with acute STEMI of the anterior wall. Coronary angiography revealed a lesion causing 30-40 % stenosis in the mid and distal left anterior descending artery and 50 % stenosis in the mid left circumflex (Figure 2A and 2B). Attempt to engage right coronary artery was unsuccessful and aortography revealed an aortic flap (Figure 3). Thoracic and abdominal angio with computerized tomography scan confirmed type A aortic dissection extending to abdominal aorta (Figure 4). The patient was transferred for emergency surgery and underwent emergent surgical repair with preservation of the aortic valve. The patient survived the acute stage and did well with good recovery of the heart. Two weeks later he had sudden onset dyspnea and then hypotension. Acute pericardial effusion was diagnosed with echocardiogram. He was transferred for emergency surgery, but he could not be weaned and died in the operating room.

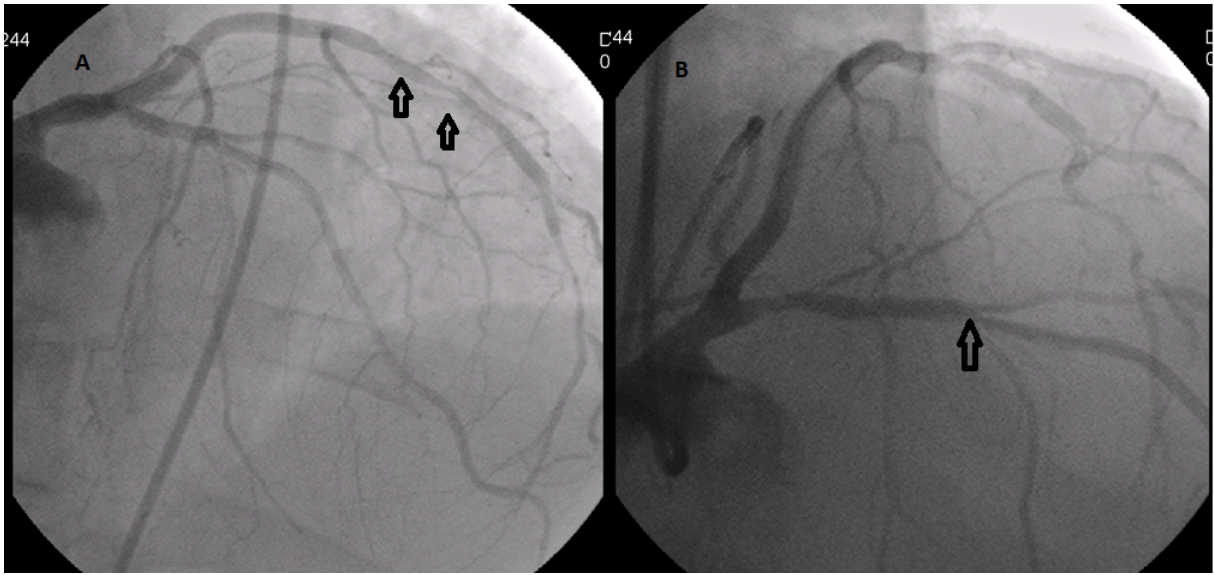
Discussion

Acute type A aortic dissection can be difficult to diagnose and can mimic STEMI which is occurring in approximately 3% patients with aortic dissection. Although the right coronary artery is involved in most patients, aortic dissection has to be considered when difficulty is present in selective catheterization of either ostia. Differentiating acute type A aortic dissection with acute myocardial infarction is challenging for emergency physicians and cardiologists, and misdiagnosis is common in patients with ST segment elevation on initial ECGs. Inappropriate treatment with antiplatelet, antithrombin, and thrombolytic agents can cause catastrophic bleeding.

Figure 1. Admission ECG in the emergency service

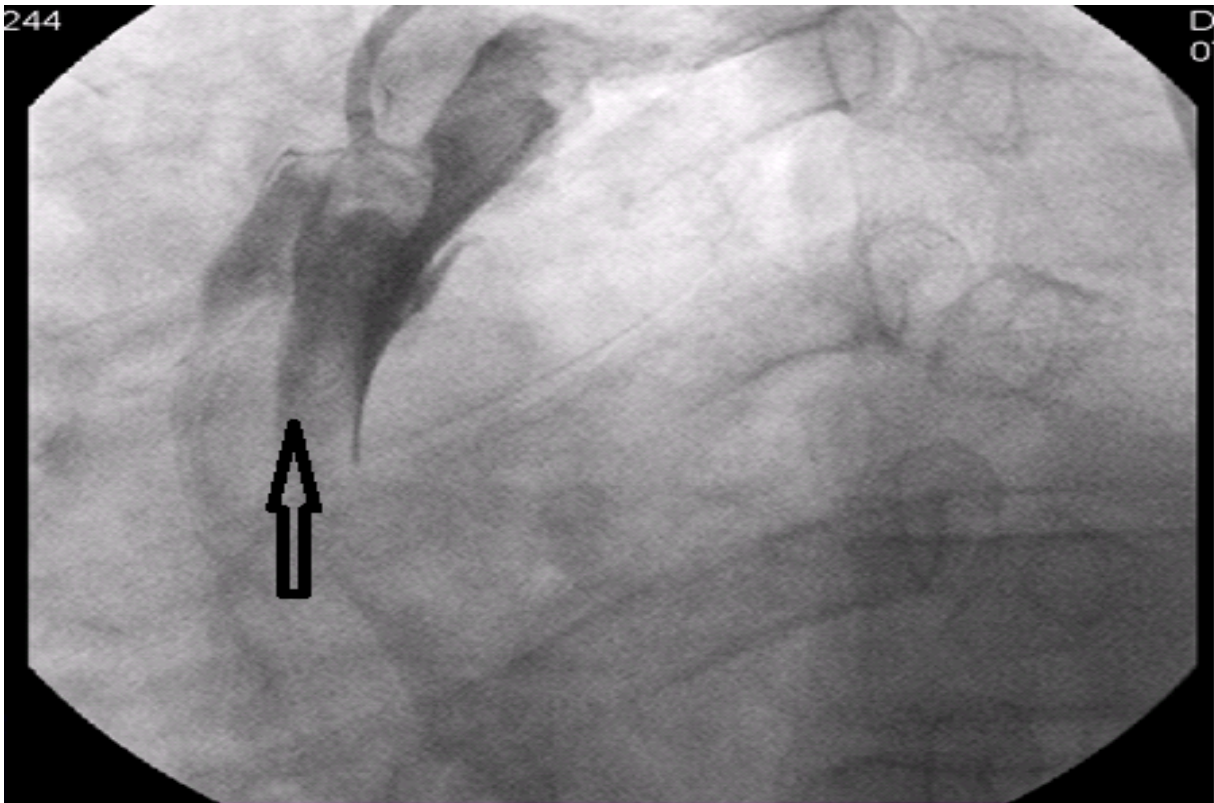


Figure 2. Coronary angiography images



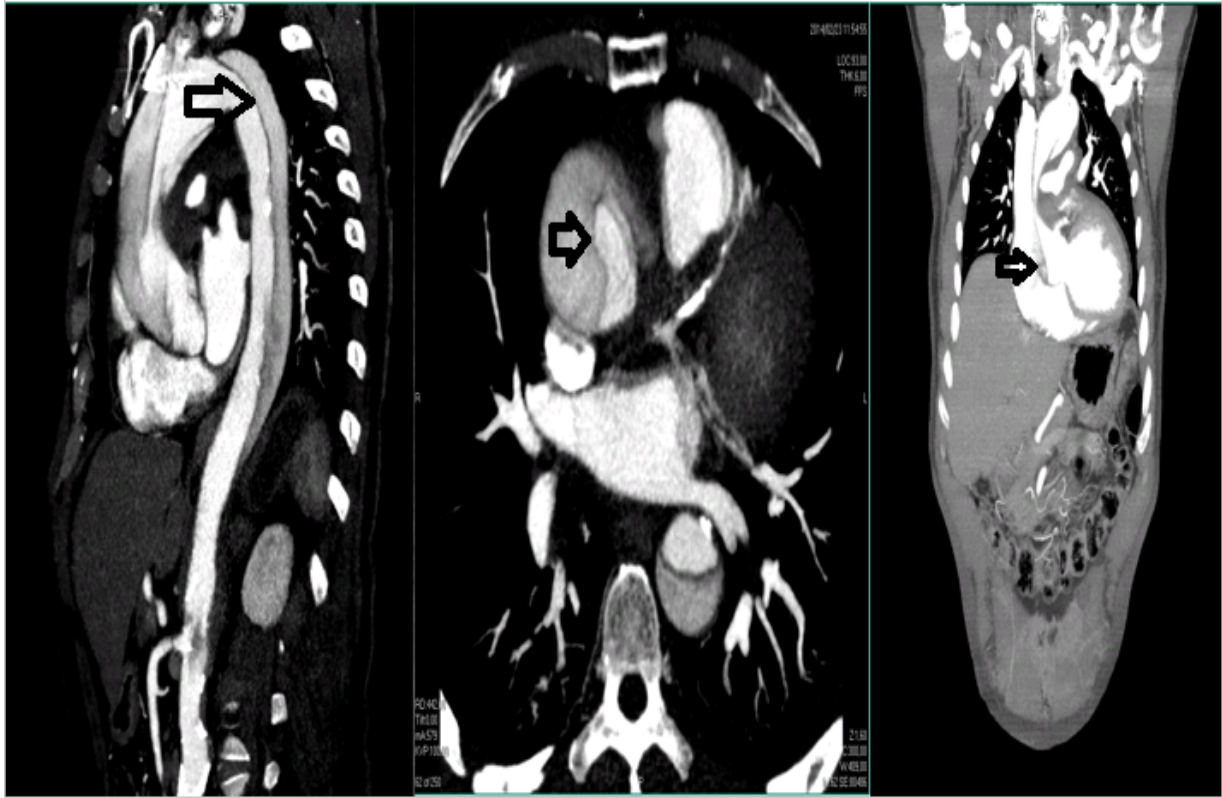
A shows the lesions of left anterior descending artery. B shows the lesion of left circumflex artery

Figure 3. Aortography image



The marker shows the flap of aortic dissection

Figure 4. Computerized tomography images



The markers show the flap of dissection

SÖZEL 13

Diagnosis of Lung Cancer Associated with Superior Vena Cava Syndrome

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Abstract

Introduction

Superior vena cava syndrome (SVCS) is obstruction of blood flow through the superior vena cava (SVC). It is a medical emergency and most often manifests in patients with a malignant disease process within the thorax. Lung cancer is now the underlying process in approximately 70% of patients with SVCS. However, as many as 40% of cases are attributable to nonmalignant causes . A patient with SVCS requires immediate diagnostic evaluation and therapy.

Early in the clinical course of superior vena cava syndrome (SVCS), partial obstruction of the superior vena cava (SVC) may be asymptomatic, but more often, minor symptoms and signs are overlooked.

As the syndrome advances toward total SVC obstruction, the classic symptoms and signs become more obvious. Dyspnea is the most common symptom, observed in 63% of patients with SVCS. Other symptoms include facial swelling, head fullness, cough, arm swelling, chest pain, dysphagia, orthopnea, distorted vision, hoarseness, stridor, headache, nasal stuffiness, nausea, pleural effusions, and light-headedness.

As in our patient, the characteristic physical findings of SVCS include venous distention of the neck and chest wall, facial edema, upper-extremity edema, mental changes, plethora, cyanosis, papilledema, stupor, and even coma. Bending forward or lying down may aggravate the symptoms and signs.

Case

52-year-old patient was admitted to our hospital with the complaints of swelling in his right upper limb. He was admitted to the local hospital for cough, hoarseness and sputum complaints that had begun about 2 weeks ago. Antibiotic therapy was started. The patient did not improve her clinical symptoms despite using antibiotic therapy and onset swelling in his right arm, he was admitted to our hospital. There was no history of disease in the patient's medical history. When the patient applied, the blood pressure was 140/90mmHg in the right arm and 130/80mmHg in the left arm; saturation %97; fever 36.5 degrees celsius. Peripheral pulses were palpated. His right arm had a marked diameter increase. In the lung auscultation examination the right lung apex and middle zones were ral.

In upper extremity venous doppler usg examination for thrombosis in emergency conditions; total occlusal appearance of proximal and middle cervical levels of right internal jugular vein. In the right supraclavicular area, there are 2 heterogeneous, solid nodular formations of 24x19 mm in size. right subclavian, axillary and brachial veins are clearly observed. cephalic and basilic veins were normal. no evidence of thrombosis.

In the thorax CT imaging of the patient, there was a solid mass extending to the apex starting from the lower right lung. this solid mass was invading the right hemithorax wall. The mass in the lung showed prolongation and compression of the vena cava superior.

The patient was diagnosed with vena cava superior syndrome due to lung cancer. and the patient was consulted for chest diseases. The patient was hospitalized for etiology.

Conclusion

Lung malignancies are the most common causes of vena cava superior syndrome. In particular, the diagnosis of VCSS in patients with lung cancer comes to mind quickly. However, there are also cases in which some patients come up with VCSS symptoms and are diagnosed with lung malignancy.

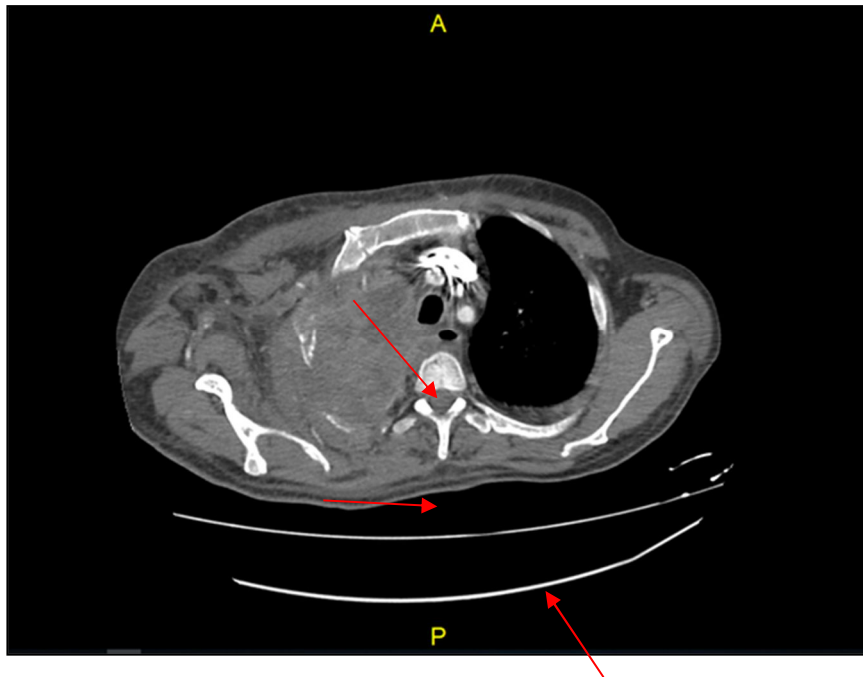


Figure: Mass in the right lung apex.

A RARE CAUSE OF ABDOMINAL AIN: RENAL ARTERY INFARCT**Introduction:**

Renal artery embolism is a rare condition, which causes parenchymal loss in the kidney. Its diagnosis is relatively difficult due to the non-specific symptoms and it can be even overlooked. It should be definitely considered in patients, who had flank pain concomitant with arrhythmia. Predisposition to the acquired or inherited thrombosis is one of the etiological factors. This group of patients should undergo contrast-enhanced computerized tomography. In this article, we presented a case with renal obstruction.

Case presentation:

A 79-year old female patient had applied to the emergency unit due to abdominal pain, flank pain on the right side and recurring vomiting, which had started two hours before the admission. Regarding the vital signs; fever was 37.1° C, blood pressure was 140/70 mmHg, heart rate was 105/minutes. There was no characteristic finding in the echocardiography. The physical examination of the patient, who did not have any known disease except for hypothyroidism, revealed diffuse abdominal tenderness and muscular defense in the left upper quadrant. In addition, costovertebral tenderness was observed in the left flank. The findings in the laboratory analysis were as follows: Urea=58 mg/dL, creatinine=1.5 mg/dL, LDH=265 IU/L, leukocyte=9.2 mm³. There was no special finding in the urinary analysis. Contrast-enhanced abdominal tomography was carried out due to the pre-diagnosis of acute abdomen. The CT examination showed thrombosis in the left renal artery and partially impaired blood perfusion in the renal parenchyma (Figure 1). Consultation was requested from the departments of urology and cardiovascular surgery. The patient was referred to the clinic of cardiovascular surgery following the diagnosis of thrombosis in the renal artery. Anticoagulant and thrombolytic treatments were initiated.

Conclusion:

If thrombosis, which may emerge due to various reasons, may cause an obstruction in the renal artery, renal artery ischemia may develop. The clinical findings are non-specific symptoms such as nausea, vomiting, abdominal pain, and flank pain. As the clinical picture is similar in acute cholecystitis, myocardial infarction, nephrolithiasis, and pyelonephritis, the diagnosis may be delayed and even overlooked. Furthermore, examination tools other than contrast-enhanced abdominal tomography, like unenhanced abdominal tomography, urinary and whole abdomen ultrasonography are not useful for diagnosis. The laboratory analysis does also not have diagnostic value. The most important biochemical parameter is LDH. The increased levels of LDH may be an indicator of the severity of the infarction and useful for the clinical follow-up. In order to increase the diagnostik value of the LDH level, disorders such as myocardial ischemia, mesenteric ischemia, and hemolysis should be excluded. The urinary analysis may display proteinuria and hematuria. Imaging methods should be used for diagnosis. The most specific diagnostic tool is the renal artery angiography along with the contrast-enhanced tomography.

The main goals in patients with renal artery ischemia is to diagnose as early as possible and initiate a treatment, which enables the recovery of the renal function. First an anticoagulant agent should be administered if no contraindication exists. The decision for medical treatment or nephrectomy depend on the functionality of the kidney. Surgery is not a preferred choice due to the high mortality rate and limited amount of functional renal tissue. While thrombectomy with open surgery is not recommended, percutaneous endovascular thrombectomy is the surgical alternative to be preferred.

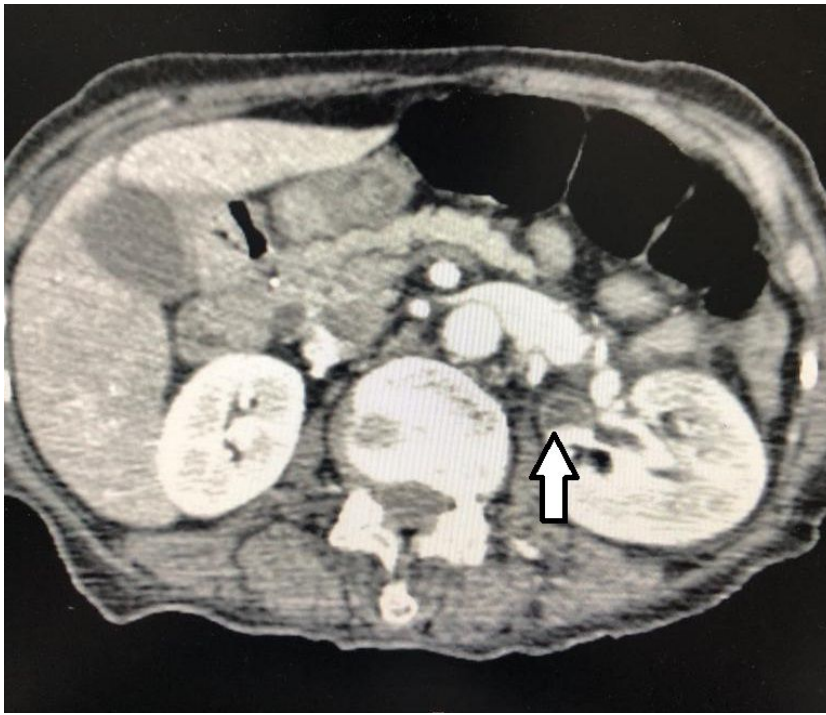


Figure 1: Left renal artery thrombosis and parenchymal partial contrast uptake in the contrast-enhanced upper abdomen tomography. Renal artery embolism is a rare but important condition that causes parenchymal loss in the kidney.

Key Words: kidney, injury, thrombosis

SÖZEL 15

Review of Diagnosis and Treatment of Patients with Urinary Tract Infection and Renal Colic from Emergency Department

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Objective: Infection in the urinary tract is related with the bacteria to adhere and colonize the renal interstitium, renal pelvicalyceal system, bladder, urethra and perineum. If the urine collected by suprapubic aspiration of the bladder is sterile and does not contain leukocytes. This practice represents the gold standard in the diagnosis of urinary tract infection (UTI). But not performed routinely in clinical use. Instead, urine samples are often collected after daily micturition; in this practice, some degree of anatomical contamination probability with normal urethral organisms must be accepted.

Renal and ureteral stones are a common admission reason in emergency practice. Patients may come with the classic symptoms of renal colic and hematuria. Others may be asymptomatic or have atypical symptoms such as vague abdominal pain, acute abdominal or flank pain, nausea, urinary urgency or frequency, difficulty urinating, penile pain, or testicular pain.

Both study groups's definition is very important for the management and treatment in emergency service and discharge.

Method: This is a retrospective descriptive study. The patients who were diagnosed with renal colic or/and urinary tract infection were evaluated retrospectively in the last 3-month period (in september, november, december 2018). Urine tests of these patients, and, if available, urinary system ultrasonography (USG), abdominal USG and non-contrast abdominal tomography were recorded.

SPSS 20 program was used for statistical analysis of patients's datas. Renal colic and urinary tract infection diagnoses were compared in patients who were evaluated with guidelines.

Results: We scanned 266 patients in totally. Of these, 180 (67.7%) were diagnosed as renal colic, and 86 (32.3%) were diagnosed with urinary tract infection. The F/M Ratio of the patients was 132/134. 49.6% female and 50.4% male. The mean-median-standard deviation, minimum and maximum values for the values of density, ketone, blood, protein, ph, nitrite, leukocyteterase, leukocyte, erythrocyte, bacterium, uric acid and calcium oxalate measured in urine tests are given in Table 1. According to the analysis, 247 of the 266 patients were diagnosed with UTD. For the patients with renal colic diagnosis, it was shown that 179 of the 266 patients should have this diagnosis. Nitrate, leukocyteterase positivity for UTD; > 5 bacteriuria (bacteria> 20 / hpf) and leukocyte> 10 were taken as valid diagnostic criteria.

Of the 180 patients diagnosed with renal colic, 179 had been shown to be truly renal. In our study, we used the USG and non-contrast abdominal CT images and urine blood positivity was used to confirm the diagnosis of the patients.

Conclusion: Imaging or urine culture cannot be performed on every patient who comes to the emergency department with complaints of dysuria, pollakuria or urine bleeding. The reason for this is the physical qualification of the emergency services or the treatment or examination payment of social insurance. These conditions should not prevent this group of patients from receiving inadequate or misdiagnosed diagnosis and treatment. The addition of protective drugs to the treatment of this special population should be kept in mind.

	Mean	Median	Std. Deviation	Minimum	Maximum
Density	1019,39	1020	8,018	1002	1040
Ketone	0,05	0	0,310	0	4
Blood	1,30	1	1,197	0	3
Protein	0,17	0	0,443	0	2
ph	5,50	5,25	0,668	5	7,5
Nitrite	0,08		0,289	0	2
Leukocyte esterase	0,78	0	1,071	0	3
Leukocyte	29,92	2,05	75,04	0	687,45
Erythrocyte	60,54	1,95	381,066	0	6060
Bacterium	29,53	19,42	35,467	0	310
Calcium oxalate dihydrate	0,14	0	1,09	0	15,9
Calcium oxalate monohydrate	0,11	0	0,692	0	7,95
Uric acid crystal	0,07	0	0,77	0	8,87

Table 1: The mean-median-standard deviation, minimum and maximum values for the values of density, ketone, blood, protein, ph, nitrite, leukocyteterase, leukocyte, erythrocyte, bacterium, uric acid and calcium oxalate

SÖZEL 16

OUR 8 YEARS OF EXPERIENCE IN CASES WITH FOURNIER'S GANGRENE

Ahmet Karakeçi, Tunç Ozan, İrfan Orhan

Fırat Üniversitesi Üroloji Anabilim Dalı Elazığ

Objective: Fournier's Gangrene (FG) is a type of necrotizing fasciitis caused by aerobic and anaerobic bacteria in the genital area. This is one of the very important urological emergencies which needs urgent intervention. Due to its high mortality rate, early diagnosis and efficient treatment is very important for prognosis. In this study we aimed to evaluate the clinical data on our emergency application records on Fournier's Gangrene.

Method: Data of sixteen patients who applied to urology clinic due to Fournier's Gangrene between April 2010 and April 2018 were evaluated. The evaluation criteria were age, co-morbidities, morbidity and mortality rates, microorganism species swab isolated by the infected area, complaint, duration of the complaints, diagnostic tool, the method of treatment and hospital stay.

Findings: All of our patients were male and their mean age was 59.5 (40-89) years. Mean duration of the complaints were recorded as 7.8 (3-30) days. Mean hospital stay was 10.6 (6-25) days. Most common comorbidity was recorded as diabetes mellitus (10 patients, 62.5 %) and coronary artery disease (4 patients, 25 %). While by 9 of the patients scrotal region was affected (56.25 %), affected area was detected as scrotal and inguinal in 5 (31.25 %) and scrotal and perineal in 2 (12.5 patients). Except physical examination, diagnosis was made by scrotal and superficial tissue ultrasound by 13 (81.25 %) and with lower abdomen magnetic resonance imaging in 3 (18.75 %) patients. Treatment was urgent surgical debridement and daily wound dressing by 14 and additional orchiectomy in 2 patients. Two of the patients died in the intensive care unit (12.5 %) and 14 (87.5 %) patients were discharged in good health after secondary suturisation.

Result: Fournier's Gangrene is a rapidly progressing urgent urological disease which can result in high morbidity and mortality in absence of early diagnosis. Standart treatment modality is urgent surgical debridement and medical treatment with broad spectrum antibiotics in order to prevent serious complications.

SÖZEL 17

Evaluation of The Relationship Between Gallbladder Wall Thickness and CRP / Albumin Ratio in Diagnosed With Biliary Colic and Acute Cholecystitis

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Abstract

Background

While the researches are in progress about the cure of acute cholecystitis by surgery and interventional methods, early diagnosis would be more beneficial for advanced treatment methods. Therefore, various predictive parameter studies are being studied. The aim of this study is to research the

worthiness of C-reactive protein (CRP) Albumin (Alb) ratio in the distinction of acute cholecystitis biliary colic.

Methods

The study included 129 patients diagnosed with biliary colic and acute cholecystitis which admitted to the emergency department with complaints of right upper quadrant pain, nausea and vomiting between the dates of 01.06.2018-30.12.2018. Data of the patients were analyzed retrospectively.

Results

The study was carried out with a total of 129 patients, %67,4 (n=87) of patients with biliary colic and %32,6 (n=42) of patients with acute cholecystitis. In this study, gender ratio of %41,9 (n=54) men, %58,1 (n=75) women. %25,6 (n=33) of them were complaining about nausea-vomiting, %74,4 (n=96) of them were complaining about right upper quadrant pain. %57,4 (n=74) of patients were observed with Murphy symptoms, and %57,4 (n=74) of them were observed with right upper quadrant pain. The CRP/ Albumin ratios of the patients who were gallbladder wall thickness were thicker than 3mm in computerized abdominal tomography were meaningfully higher than the patients who were gallbladder wall thickness were thinner than 3mm ($p=0,001$; $p<0,01$). No statistically significant disparity was observed between CRP/Alb ratios according to the ultrasound of the gallbladder wall thickness ($p=0,054$; $p>0,05$), however, the patients who were gallbladder wall thickness were thicker than 3mm have higher levels of CRP/Alb ratios which were a quite striking result.

Conclusion

We put forward that the CRP/Alb ratio is a useful parameter for acute cholecystitis diagnose for the patients who have complaints about right upper quadrant pain, nausea and vomiting due to acute cholecystitis or biliary colic.

keywords: Acute cholecystitis, albumin, biliary wall thickness, C-Reactive Protein

SÖZEL 18

Thrombolytic Therapy After Cardiopulmonary Resuscitation: 30 days follow up intensive care unit

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Pulmonary embolism (PE) is a life threatening emergency. PE is considered high risk when a suspected patient refers to a syncope or shock table. Thrombolytic therapy can be started in patient with high risk PE, according to the results of transthoracic echocardiography (TTE). An 80-year-old female patient was brought to the emergency room by her relatives as being unconscious. The patient could not get a pulse during the initial evaluation. Cardiopulmonary resuscitation (CPR) was started. Spontaneous circulation returned after (ROSC) 15 minutes of CPR. As a result of TTE, it was found that the right ventricle dilated and the left ventricle was mild pressure. There was no known risk factor for pulmonary embolism as a pre-diagnosis. Unstable patient was sent to computed tomography (CT) angiography with emergency medicine specialist. As a result of CT angiography, thrombolytic therapy was started in the patient because of embolism compatible appearance was detected in both pulmonary artery branches. The patient was then admitted to the emergency service intensive care unit. After 30 days of intensive care follow up, the patient was discharged. Thrombolytic therapy can be applied in

patients with high risk PE and after arrest in patients with a pulse. Also these situations have been seen as life saving.

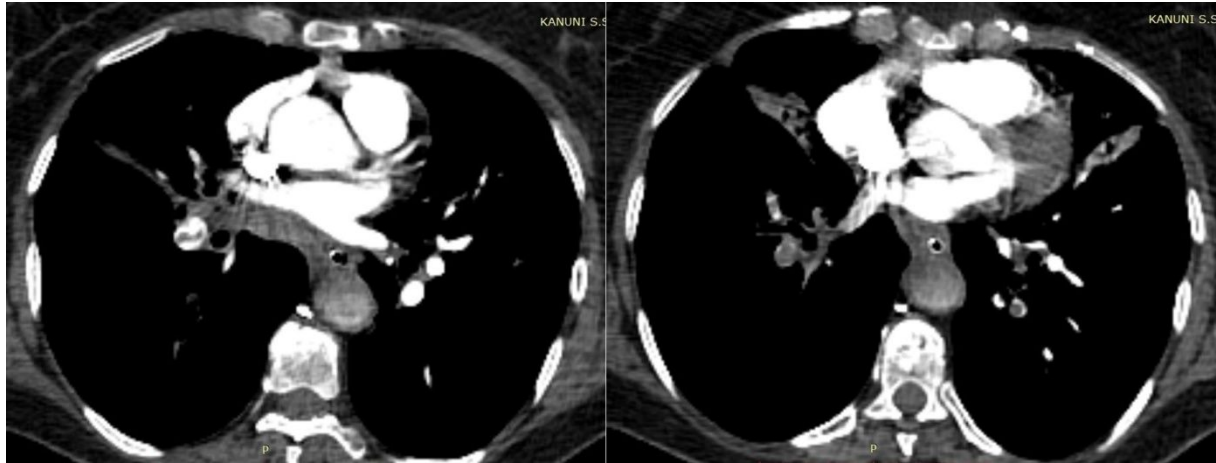


Figure 1. Thoracic CT Angiography (Pulmonary Embolism causing filling defects in bilateral pulmonary artery branches)

SÖZEL 19

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Acute Pyelonephritis in Adults: Retrospective Analysis of 39 Cases

Objective: Acute pyelonephritis is an infectious pathology affecting the kidney parenchyma and pelvis. *Escherichia coli*, *proteus* and *klebsiella* are common microorganisms. Infection agents usually reach the upper urinary tract ascending way. Hematogenous, lymphogen, or direct spread pyelonephritis are other preferred routes of microorganisms. Clinically, it can be seen in a wide spectrum ranging from renal colic, fever, weakness to ürosepsis. In this study, it was aimed to investigate the data of patients with acute pyelonephritis in the emergency clinic.

Method: The data of 39 patients with acute pyelonephritis diagnosed in the emergency clinic of the last 13 months were analyzed retrospectively. Patients who did not allow their data to be used in scientific publications and whose data could not be fully reached were not included in the study.

Findings: Sixteen (41.03%) of the patients were male and 23 (58.97%) were female. The mean age was 53.9 (18-91). The complicating factor was determined in 27 of 39 patients (69.23%). Diabetes mellitus (30.77%), urinary stone disease (23.07%) and neurogenic bladder (7.69%) were the most common complicating factors. On the other hand, perinephric area contamination (87.17%), hydronephrosis (20.51%), urinary system stone disease (15.8%) were the most frequently detected pathological findings in ultrasonography. Among the microorganisms in which growth was observed in urine culture, *escherichia coli* (69.23%) took the first place. Despite appropriate treatment and close follow-up, 3 (7.69%) patients died due to urosepsis.

Result: We conclude that multidisciplinary approach to emergency clinics is very important in patients with upper urinary tract symptoms such as side pain and fever.

Keywords: Acute, adults, pyelonephritis

In the case of approval by the jury, our choice is verbal presentation.

SÖZEL 20

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Sigmoid Colon Perforation: Case Report

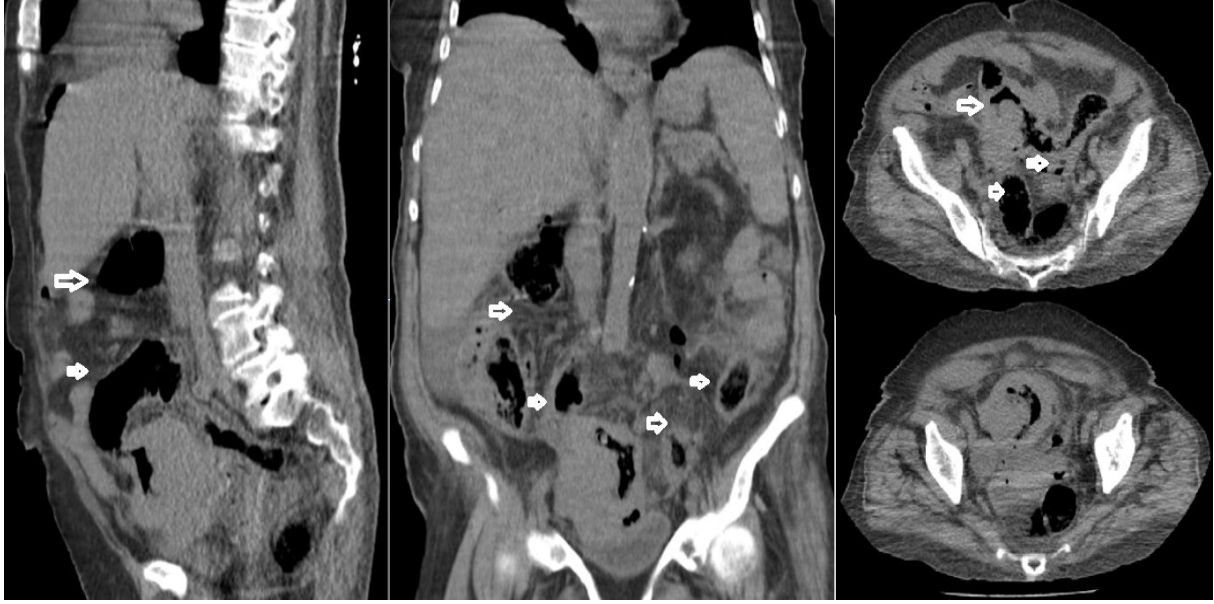
Objective: Spontaneous colon perforations due to colorectal cancer are rare pathologies in emergency clinics. The emergency surgical intervention is necessary due to the risk of peritonitis, sepsis and multiple organ failure after discharging of the fecal content into the abdomen by perforation. In this study, we aimed to present a patient with peritonitis due to spontaneous colorectal cancer perforation.

Case: The 87-year-old female patient was admitted to the emergency clinic with abdominal pain for 1 day. The patient's history revealed chronic constipation. Physical examination performed in the emergency room showed widespread tenderness, defense and rebound in the abdomen. Biochemical test results of Hgb: 11.9 g / dL, Wbc: 35000 / mm³, BUN: 63 mg / dl, creatinine: 2.1mg / dl, sodium 136 mEq / l, K: 5.1 mEq / l, AST: 19 U / L, ALT: 21 U / L. In the imaging, widespread air densities were observed in the portal and perisplenic areas adjacent to the anterior abdominal wall (Figure-1). The patient was gone under emergency operation with a pre diagnosis of hollow organ perforation. During the operation, purulent contents of the abdomen were observed in the abdomen, while the intestines were distended. The exploration revealed a mass in the sigmoid colon and a perforated area of 1.5 cm in diameter on the meso margin. It was planned to open Hartmann colostomy by tumor resection. Partial cystectomy was performed when the tumor was detected invasion of bladder during resection. Two ureteral stents were placed in the patient at the partial cystectomy. The tumor detected in the sigmoid colon was resected together with the bladder dome without damaging the ureters. After the procedure, ureteral stents were taken off and diagnostic ureteroscopy was performed to see that no damage to the ureters. The procedure was terminated by opening the Hartmann colostomy.

Conclusion: Sigmoid colon tumors can be confused with spontaneous colon perforation especially in elderly patients. Therefore, we think that it is very important to have gastrointestinal perforations among differential diagnosis in elderly patients who present to emergency clinics with abdominal pain.

Keywords: Sigmoid, colon, perforation

Figure-1: CT scan demonstrates widespread air densities in the portal and perisplenic areas (arrow).



In the case of approval by the jury, our choice is verbal presentation.

SÖZEL 21

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Scrotal Gunshot Injury: Case Report

Objective: Nowadays, gunshot injuries are increasing as a result of the increasing tendency of societies to obtain increasing arms. Genitourinary system injuries account for approximately 2% to 10% of all traumas. In this study, we aimed to present a patient with scrotal trauma as a result of gunshot injury.

Case: A 61-year-old male patient presented to the emergency department with pain and burning sensation in the right scrotal region. In the anamnesis, it was learned that they went hunting with their friends. The patient had a history of hypertension and type-2 diabetes mellitus. In the genitourinary system examination, a round and hard formation of 0.5x1 cm was detected in the right testicle. Blood pressure: 125/75 mmHg, pulse: 90 / min rhythmic, respiratory rate: 19 / min, fever: 37.2°C.

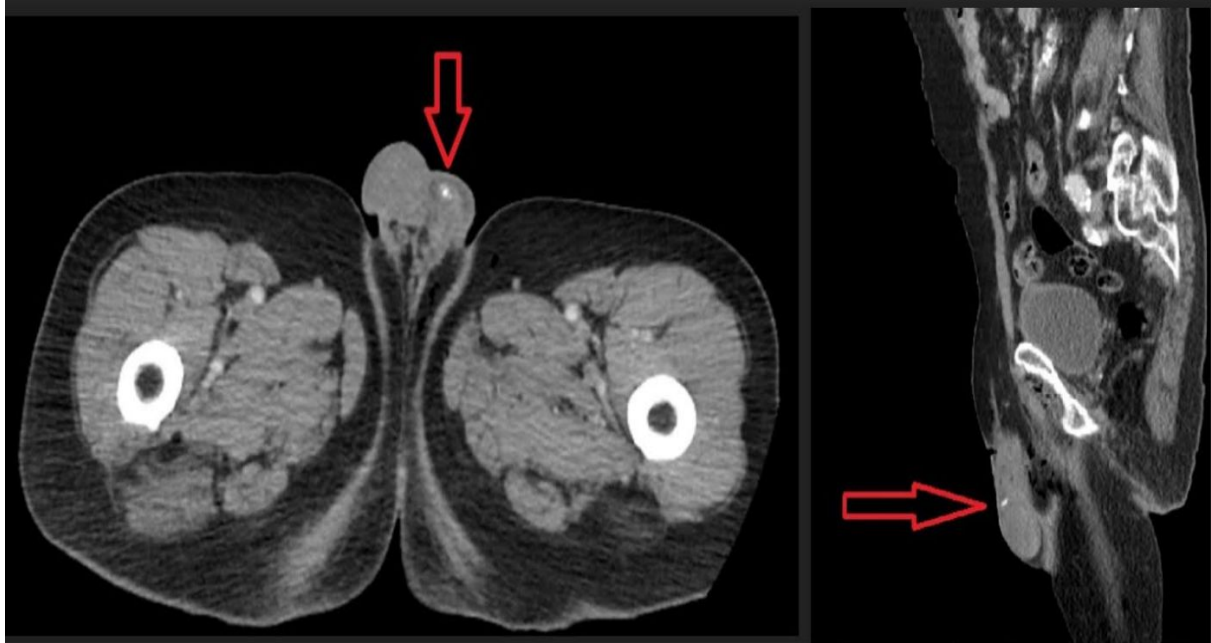
Ultrasonographic examination revealed an echogenicity of approximately 0.5x1 cm in the scrotal area and a foreign body which was associated with thickening of the surrounding tissues. All abdominal computed tomography revealed no solid organ pathology but radiopaque structure consistent with the small shot in the right scrotal region (Figure-1). In the scrotal exploration accompanied by these data, metal partikül which was subcutaneous and attached to the tissues was removed. No intra- and postoperative complications were observed. The patient was discharged from the hospital on the first postoperative day.

Conclusion: Since the scrotum is a moving organ, the injury rate is very low. However, untreated scrotal injuries; risk of infection, endocrine and sexual dysfunctions. We believe that it is very

important to consider the examination of the genital area as part of the systemic examination in patients admitted to the emergency clinic with gunshot wounds.

Keywords: Scrotal, gunshot, injury

Figure-1: CT scan demonstrates radiopaque structure consistent with the small shot in the right scrotal region (arrow).



In the case of approval by the jury, our choice is verbal presentation.

SÖZEL 22

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Paraphimosis: A Case Report

Objective: Paraphimosis is a urological emergency seen in uncircumcised men. It is characterized by the squeezing of the prepuce in just below the glans, forming a suffocating band. The incidence of paraphimosis in uncircumcised adolescent males is 0.7% and is mostly iatrogenic. The main goal of the treatment of paraphimosis, to provide of the blood circulation of glans penis. In this context, many different techniques are used such as manual reduction, reduction of edema with pharmacological treatments, puncture techniques and dorsal slit. In this case report, we aimed to present the patient who was diagnosed with paraphimosis in a pediatric emergency clinic.

Case: An 8-year-old, uncircumcised male patient was referred to our emergency clinic by a family physician with complaints of swelling and pain in his penis, which lasted for about 2 hours. In his genitourinary system examination, it was observed that the penis is edematous, the glans skin is bright and ischemic and a circular style fibrotic band in the proximal part of the glans penis (Figure 1). The patient was evaluated as paraphimosis and treatment with manual reduction and puncture technique was tried, but it was not successful. The patient was taken to emergency operation. Parafimosi was treated by dorsal slit method and circumcised. There was no intra and postoperative complication.

Conclusion: Paraphimosis is a very serious urologic emergency that deteriorates penile blood supply. If the cases are not treated timely and appropriately; paraphimosis end with penile necrosis and autoamputation. For this reason, it is very important that physicians who take part in pediatric emergency and family medicine clinics should adopt a multidisciplinary approach in the clinical management of paraphimosis cases.

Keywords: paraphimosis, penile, pain

Figure-1:



In the case of approval by the jury, our choice is verbal presentation.

SÖZEL 23

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Acute Urinary Retention Secondary to Constipation in a Seven-Year-Old Girl: A Case Report

Objective: Acute urinary retention is defined as the inability to perform urination although the bladder is full. This condition, considered as one of the urological emergencies and increases with age. It is rarely seen in female gender and childhood age group. Accurate and timely treatment of acute urinary retention is extremely important in preventing renal damage. In this study, we aimed to present a patient with acute urinary retention due to constipation.

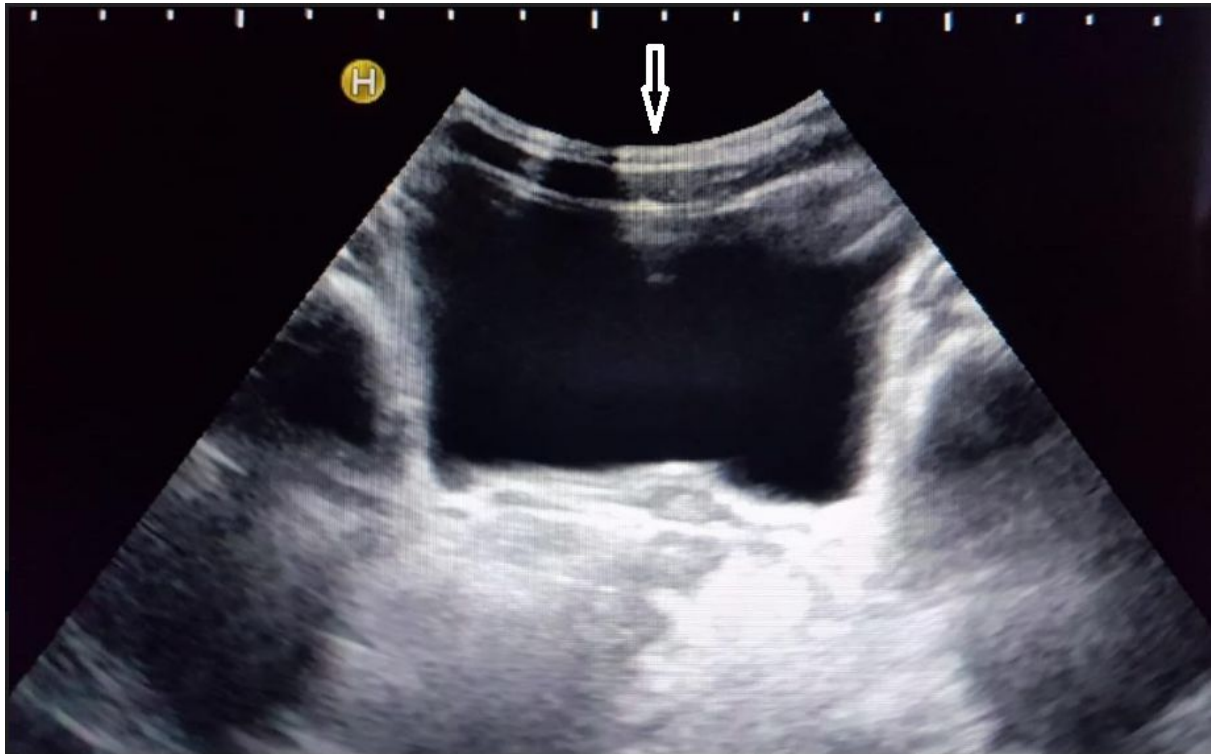
Case: 7-year-old girl was referred to our emergency clinic with a complaint of abdominal pain and inability to urinate for 12 hours. She had no systemic disease or previous history of surgery. It was learned in her detailed history that she had constipation for a long time but she did not receive any treatment. Physical examination revealed abdominal distention and lower intestinal sounds. No additional pathological physical examination finding was observed. Serum creatinine and urea values were 1.91 mg / dL and 55 mg / dL, respectively. In the ultrasonography performed in the emergency unit, 310 cc of urine was found in the bladder, and rectal compression to the bladder neck and to the proximal urethra was observed (Figure 1). In the direct abdominal X-ray, images of gas /gaita accumulated in the intestine were observed. 8F catheter was placed into the bladder and urine drainage was achieved. Drainage of solid stool was achieved by using rectal phosphate enema. After detailed evaluation, the patient was diagnosed as functional constipation according to Rome III criteria. In order to treat functional constipation, behavioral training was given and oral lactulose 2 ml / kg / day

was started. Lactulosis treatment was discontinued after 12 weeks. The patient's behavioral treatment and diet regimen continued and no pathology related to functional constipation was observed.

Conclusion: It should be considered that functional disorders of gastrointestinal system may be associated with lower urinary tract dysfunction in pediatric patients presenting with acute urinary retention.

Keywords: Acute, urinary retention, constipation

Figure-1: Ultrasonography demonstrates 310 cc of urine was found in the bladder, and rectal compression to the bladder neck and to the proximal urethra was observed (arrow).



In the case of approval by the jury, our choice is verbal presentation.

SÖZEL 24

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Retrospective Analysis of 31 Cases Diagnosed with Urolithiasis in Pediatric Emergency Clinic in 2017

Objective: In the century we live, there has been a dramatic increase in urinary system stone diseases with more sedentary life and changing eating habits. Recurrent urinary stones are an important cause of morbidity in children. Therefore, it is very important to determine the diagnosis of urinary stone disease in pediatric patients at an early stage and to establish a successful treatment plan by

determining the etiology. The aim of this study is to evaluate 31 child patients diagnosed with urinary stone disease.

Method: The data of 31 patients with urinary stone disease diagnosed in our pediatric emergency clinic between January 2017 and December 2017 were analyzed retrospectively. Patients who did not give consent for the use of their knowledge in scientific studies and whose informations incomplete were excluded from the study.

Findings: The mean age of the patients was 8.9 ± 6.2 years (range 3 months-17 years). In the first evaluation in the emergency clinic, renal function tests (serum urea and creatinine values) were found above normal limits in 6 patients (19.35%). Stone was located in the right side of 12 patients (38.7%), in the left side of 9 patients (29%) and in both bilateral of 10 patients (32.3%). The distribution of stone localities is shown in detail in Table-1. The Renal colic (71%), restlessness (45.2%), abdominal pain (42%) and hematuria (29%) were the main clinical findings of the patients . A total of 9 patients (29%) had a history of stone in their first-degree relatives. Calcium oxalate stone (58.1%) was found most frequently in stone analysis.

Result: The stone diseases of the urinary system in children are the result of highly complex processes. It is an extremely important disease that can lead to chronic renal failure by progressive renal damage in this age group. Therefore, we believe that physicians who take part in pediatric emergency clinic should adopt a multidisciplinary approach in the clinical management of urinary stone diseases.

Keywords: Urolithiasis, pediatric, emergency

Table 1: Location of stone

Location	N (%)
Kidney	14 (%45.2)
Kidney+ureter	7 (%22.6)
Kidney+bladder	5 (%16.1)
Ureter+bladder	3 (%9.7)
Kidney+ureter+bladdet	2 (%6.4)

In the case of approval by the jury, our choice is verbal presentation.

SÖZEL 25

Evaluation of the Vital Signs of Patients Presenting to the Emergency Department in the Month of Ramadan

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Objective

The aim of this descriptive study was to analyze the vital signs of the patients admitted to our hospital emergency medicine clinic during the month of Ramadan.

Method

We retrospectively reviewed the files of the patients who applied to the emergency department of Atatürk University Medical Faculty between 28.05.2018 and 30.05.2018 (3 days). Incomplete or incorrectly filled patient files were excluded from the study.

Findings

1080 patients were included in our study. The ages of the patients ranged from 18 to 97 and the mean age was 43.95 ± 19.40 . Of the patients, 50.3% (n = 543) were female. The vital signs of the patients are shown in Table-1.

	Minimum	Maximum	Mean	Std. Deviation
Systolic Blood Pressure	79	211	124,95	15,701
Diastolic Blood Pressure	40	135	76,88	10,257
Pulse	45	148	84,31	12,740
Pulse Oximeter(%)	54	100	94,95	4,129
Body Temperature	36,0	40,0	36,594	,4663

Result

The vital signs of the patients admitted to our hospital emergency medicine clinic during the month of Ramadan were determined in the normal range. In the month of Ramadan fasting, there is no effect on vital signs.

SÖZEL 26

An Unusual Foreign Body Aspiration Management: Coca Cola Pet Cap

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Abstract

Laryngotracheal foreign body aspiration is one of the most common reasons for the presentation of especially pediatric patients to emergency departments. Delayed diagnosis and treatment increase morbidity and mortality significantly. Foreign bodies aspirated by children vary from coins to pen points. This paper presents the management of a 16-month old male patient admitted to the emergency department due to severe shortness of breath as he swallowed a Coca-Cola cap. On admission to the emergency department, he was cyanosed and had severe shortness of breath. After he was sedated, he was examined directly with the laryngoscope, which revealed that the foreign body settled on the vocal cords in the laryngeal region. A Coca-Cola cap was removed with curved tip forceps under the guidance of the laryngoscope. He was discharged without any complications after his control in the emergency department for 12 hours

Keywords: Foreign body



Figure 1

Aspirated Coca Cola pet cap

SÖZEL 27

Neuroleptic Malignant Syndrome After Use Single Dose Oral Quetiapine

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Abstract

Introduction

NMS, is a rare and life-threatening idiosyncratic reaction to antipsychotic drugs characterized by fever, altered mental status, muscle rigidity, and autonomic dysfunction NMS often occurs shortly after the initiation of neuroleptic treatment, or after dose increases.

In this article, we aimed to present a case of neuroleptic malignant syndrome with the first dose of oral quetiapine treatment.

Case

73-year-old female patient. She was admitted to the hospital who due to unconsciousness and muscle rigidity in the whole body. The patient was started on 50 mg quetiapine tablet for insomnia one day ago. The patient was asleep after taking 1 tablet and advanced contraction of the extremities. There is known hypertension, advanced tricuspid regurgitation, atrial fibrillation and depressive disorder. Vital

Signs: Blood Pressure: 150/70 mm/Hg, Heart rate: 112/min, Respiratory Rate: 19/min, Temperature: 36,7 °C, Spo2: %98. The patient's condition is bad. Glasgow Coma Score: 13 (G3M6V4), pupils isochoric, light reflex + / +, wide spread muscle rigidity, tonus increase present. Deep tendon reflexes brisk, breathing sounds were common, heart sounds: tricuspid focus pansystolic murmur. The patient had macroscopic hematuria.

Laboratory: Glucose: 75 mg/dL, Urea: 184 mg/dL, Creatinine: 1.86 mg/dL, Total Bilirubin: 1.29 mg/dL, Direct Bilirubin: 0.58 mg/dL, ALT: 15u/L, AST: 50u/L, LDH: 359, Creatine Kinase: 2013 U / L, CRP: 0.49 mg /dL, WBC:6,98 10³/uL, RBC:3.48 10/uL, PLT:190 10³/uL

She was hospitalized in the intensive care unit with the diagnosis of NMS due to quetiapine use.

Conclusion

In the USA, NMS has been variably reported as occurring in 0.07-2.2% of patients taking neuroleptics. The key to diagnosis is that NMS occurs only after exposure to an neuroleptic drug. Cardinal features are as follows: severe muscular rigidity, hyperthermia (temperature>38°C), autonomic instability, changes in the level of consciousness. The most widely accepted mechanism by which antipsychotics cause NMS is that of dopamine D2 receptor antagonism. Hypothalamic D2 receptor blockade results in an elevated temperature set point and impairment of heat-dissipating mechanisms, while nigrostriatal blockade results in muscular rigidity. Treatment of neuroleptic malignant syndrome is mainly supportive; it is directed toward controlling the rigidity and hyperthermia and preventing complications. Monitoring and management in an intensive care unit is recommended.

SÖZEL 28

Ovarian torsion in an adolescent girl: A case report

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Objective

Adnexal torsion in childhood and adolescence is a rare but well known clinical entity that can involve the fallopian tube, ovary, or both. Diagnosing adnexal torsion is still challenging despite advances in imaging methods. We present a adolescent with ovarian torsion complicated by delayed diagnosis.

Case Presentation

A 18-yr-old virgin was admitted to emergency department with a history of severe pain and tenderness on lower left abdominal region, nausea, and vomiting. She admitted to another hospital before and was diagnosed with cystitis and treated with analgesics and antibiotic. A day later, she developed severe pelvic pain and admitted to our hospital. Abdominal examination showed lower abdominal tenderness. Ultrasound examination revealed presence of a 95x90 mm, non-blooded, left ovarian cystic mass and free fluid in the abdominal cavity. As a result of the patient's symptoms, acute abdomen and primarily left ovarian torsion was assumed and emergency laparotomy was performed. Intraoperative findings confirmed a left ovarian torsion that was twisted around itself twice and looked significantly necrotic. Detorsion of ovary were performed but the necrotic appearance did not improve due to extented delay

before the operation. Surgical team decided to perform a left-sided salpingo-oophorectomy. Pathologic diagnosis was hemorajic cyts.

Discussion

Adnexal torsion was reported to constitute 2.7% of all cases with acute abdominal pain in children. Torsion is commonly associated with adnexal pathology such as benign cystic teratomas, tubal cysts, follicular cysts, and serous or mucinous cystadenomas. Although ultrasound can be a helpful diagnostic tool, it may be misleading, contributing to a subsequent delay in management. In patients with early diagnosis, conservative detorsion approach is a very effective method for preserve fertility but may result in retorsion or tubo ovarian abscess. So, especially in delayed cases, salpingo-oophorectomy can be first-line treatment.

Conclusion

Adnexal torsion must be one the first things that comes into mind in a child or adolescent who describes intermittent lower quadrant pain and show symptoms including nausea and vomiting, and an adnexal mass. Screening with radiographic modalities may be beneficial; however, suspicion is a key feature that the clinician must have.

Keywords: Adolescence, emergency, ovarian torsion

SÖZEL 29

Adolescent Pregnancy Trends: Tertiary center records

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Objective

Adolescent pregnancy term is used for pregnancies between 10 and 19 years of age. Adolescent pregnancy is a common public health problem worldwide. There is growing awareness that early child bearing has multiple consequences in terms of maternal health and child health in not only in developing countries but also in developed countries. The purpose of this study to research to trends in rates of adolescent pregnancy in University Hospital in Rize, Northeastern Turkey.

Material and Method

The number of women who had a gestational age exceeding 20 weeks of gestation, aged under 19, and who gave birth in Recep Tayyip Erdoğan University, Obstetrics and Gynecology clinic was investigated retrospectively from the hospital records. According to the annual birth rates between 2010-2018, adolescent pregnancy rates were calculated.

Results

Trends in rates of adolescent pregnancy between 2010 and 2018 are shown in figure 1. The mean age of pregnant was 18.4 years (min:15-max:19 years). The lowest rate was found 3.4% in 2011 and the highest rate was 8.41% in 2017.

Discussion

Pregnant women in adolescent period are not mature enough to meet the responsibilities of pregnancy, both physically and emotionally. The incomplete development of genital tract predicts adverse maternal

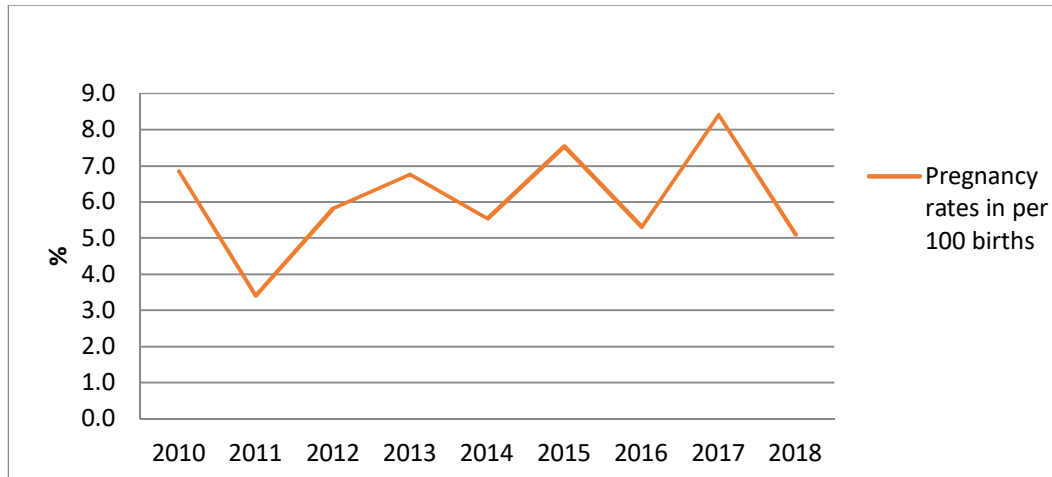
and neonatal outcomes, including low birth weight, stillbirth, preterm delivery, maternal anemia, postpartum depression, eclampsia, maternal death and newborns death.

In 2010 the birth rate in USA was 34.3 births per 1000 women aged 15-19. In Turkey, the rate of adolescent pregnancy in the 1990's was around 0.9% whereas in the age group of 15-19 today, it is reported that the rate of adolescent pregnancy is 6%.

In our study, we found the rates of pregnant aged between 15-19 in our region was similar to Turkey's average rates (6.08%, 6%, respectively). In 2017, trends in rates of pregnancy reached the highest value as 8.41% but in 2018, trend went down and returned to its former value. We think that this sudden increase in value in 2017 may be related to the settlement of Syrian settlers in our region.

In conclusion, when we look at the upward trend in rates, it is seen that society in Rize still confirms adolescent pregnancies. We should take step to decrease the incidence of teenage pregnancy by increasing public awareness, ensuring female education and enforcing marriage law. There is a need for sociological and field studies with broader participation in order to investigate the reason for community approval of marriages.

Figure 1 Trends in rates of pregnancy per 100 women aged 15-19, 2010-2018



SÖZEL 30

Atypical presentation of atypical carbonmonoxide poisoning: Facial Tic

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Introduction:

Carbonmonoxide is a colorless, odorless, tasteless gas which leads to poisoning in humans. It has more affinity to haemoglobin than oxygen therefore respiration on the basis of cell metabolism is deprived. Signs and symptoms of carbonmonoxide poisoning are variable. Nonspecific symptoms like headache, nausea, dizziness may be observed on the other hand patients may present with altered mental status and coma. While its half life in room pressure is approximately 90 minutes, 20 minutes in hyperbaric chamber.

Case:

32 years old female patient presented to emergency department with perioral tic. Her vital signs were all stable and had no chronic diseases and/or medications. She was a smoker for 6 years. Initial physical examination revealed orbicularis oris tic on the left side of the face. Remaining physical examination showed no significant clue. When the history of patient was digged deep, it was acknowledged that patient was smoking hookah when the tic occurred. Blood tests revealed 7,7% of carboxihaemoglobin level in serum. There was no other abnormality in the blood test. Patient was removed to observation room and 13 lt/min O2 administered via reservoir mask. Patients' complaint decreased gradually and disappear entirely on the 4th hour of oxygen therapy. After an overnight observation and repeating blood gas analysis patient was discharged.

Conclusion:

Patients with carbonmonoxyde poisoning presents with subtle and variable findings more than often. History is the key point of the diagnosis of carbonmonoxyde poisoning. A complete history may provide a better understanding of the clinic and permits to clinician take precautions for long term complications of poisoning by diagnosing it.

Keywords: Carbonmonoxyde Poisoning, Facial Tic, Emergency medicine

SÖZEL 31

3 MONTHS ANALYSIS OF AN EMERGENCY INTENSIVE CARE UNIT: RETROSPECTIVE EXPERIENCE

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ABSTRACT

Objectives: The aim of this study was to determine the demographic characteristics of the patients followed in the Emergency Intensive Care Unit (EICU) of Kanuni Sultan Süleyman Training and Research Hospital.

Methods: The data of the patients admitted to our emergency department between 24 November 2018 and 1 March 2019 and followed-up in the EICU with the indication of intensive care unit were evaluated retrospectively from the hospital records. Age, gender, nationality, emergency intensive care unit stay, hospitalization, discharge, consultation request, intubation, tracheostomy, inotropic application rates, non-invasive mechanical ventilation / invasive mechanical ventilation (NIMV / IMV) requirement, pressure ulcers development, culture results, antibiotic use, mortality and morbidity rates were taken into consideration. Descriptive statistics were used to analyze the study data. Mean \pm standard deviation for numerical variables and number and percentage frequency for categorical data were used in descriptive statistics.

EICU; is a 5-bed service and managed by an emergency doctor and 2 intensive care nurses for 24 hours. EICU works physically as a level 1 but functionally level 3. It is the first intensive care unit in Istanbul which is in the emergency department and managed by emergency specialists.

Findings: A total of 68 patients were included in the study. Of the patients 58.8% (n = 40) were male, 41.2% (n=28) were female and 17.6% (n=12) were foreign nationals. According to the diagnosis of

EICU admission, 25.0% (n=17) pneumonia, 17.6% (n=12) cerebrovascular diseases (CVH), 13.2% (n=9) acute renal failure (ARF), 11.8% (n=8) trauma 10.3% (n=7) multiple organ failure syndrome, 7.4% (n=5) malignancy, 5.9% (n=4) gastrointestinal bleeding, while 2.9% (n=2) were listed as other reasons. During the intensive care follow-up, 73.5% (n=50) had no complication, 25.0% (n=17) had infection, 1.5% (n=1) ARF developed. The mean day of stay of patients in intensive care unit was 5.9 days. Discharged from EICU was 35.3% (n=24) referral to another center, 26.5% (n=18) to service, 13.2% (n=9) with health discharge, 25.0% (n=17) patients died. 94.1% (n=64) consultation requests were made and 61.8% (n=42) were multiple departmental consultations. In the large-scale prevalence studies, 11.1% of the patients in intensive care unit developed pressure sores. In our EICU %97.1 (n=66) patients developed new pressure sores and %2.9 (n=2) patients did not develop pressure sores. While 41.2% (n=28) of the patients were followed as intubated, 58.8% (n=40) were followed as extubated. 73.5% (n=50) culture growth was not detected, 26.5% (n=18) culture growth was detected. According to the results of culture 11.8% (n=8) Candida, 8.8% (n=6) Coagulase negative Staphylococcus spp, 1.5% (n=1) Klebsiella, 1.5% (n=1) Pseudomonas and 1.5% (n=1) E.coli + Acinetobacter + Coagulase negative Staphylococcus spp. were identified. The low rate of cultural reproductive results can be attributed to the low rate of invasive mechanical ventilation with a rate of 42.6% (n=29).

Results: This three-month intensive care experience showed that the rate of complications and mortality was similar to the literature and the quality of patient management was similar to the third level intensive care services. EICU's can be considered as a solution where intensive care is needed.

Key Words: Intensive care, retrospective, analysis, complication, demographic feature

SÖZEL 32

WHICH ONE IS MORE IMPORTANT FOR THE DIAGNOSIS OF ACUTE PANCREATITIS? BLOOD TESTS OR IMAGING?

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Keywords: abdominal pain, pancreatitis, amylase, amylase

ABSTRACT:

Acute pancreatitis (AP); It is defined as a reversible inflammatory process in which the tissue of the pancreas is affected at various degrees, accompanied by local tissue or organ systems. It is characterized by a sudden onset of upper abdominal pain and associated vomiting, fever, tachycardia, leukocytosis, serum amylase or lipase increase of 3 times normal. Acute pancreatitis has a spectrum of varying severity of disease ranging from self-limiting mild disease that is present with abdominal pain to severe fluid loss, metabolic imbalances, hypotension, sepsis and severe disease that may lead to death. Mortality rate is 6-23% for acute pancreatitis in different article. We report the case with a diagnosis of acute pancreatitis, who have abdominal pain; but no serum amylase and lipase elevation. We diagnosed edematous pancreatitis image in the computed tomography (CT).

A 51-year-old male admitted to the emergency department with severe abdominal pain. He had diabetes mellitus (DM) in his medical history; but drugs used for DM could not be learned due to communicative reasons.

On his presentation to our emergency department (ED), he was conscious, oriented and cooperative. His vital signs were as follows: his blood pressure was 130/90 mm Hg, his pulse rate was 100 beats per min, his respiratory rate was 20 per min, his body temperature was 36.5°C, and his oxygen saturation was 100% while breathing room air. He has epigastric tenderness and abdominal guarding on palpation; but no rebound tenderness or rigidity was noted on palpation. No pathological findings were found in the respiratory system, cardiovascular system and neurological examination. The blood test measurements were WBC: 5.50 10^3 /uL, Hb:13.2 g/dl, Plt:160.000 10^3 /uL, Glucose: 444 mg/dl, urea:30.0 mg/dl, serum creatinine: 0.74 mg/dL, AST: 13U/L,,ALT: 15 U/L, GGT:33 U/L, ALP: 107 U/L, Amylase: 28: U/L, Lipase: 58.8 U/L, CRP: 104.05 mg/L, cardiac troponine: 0.006 ng/ml. . ECG is normal beat.

In abdominal ultrasonography of the patient; pancreas and midline structures could not be evaluated due to gas. No ultrasonographic pathology was detected in other intraabdominal organs and intraabdominal fluid was not seen in the abdominal ultrasonography. Contrast-enhanced CT of the abdomen was performed because of persistent, severe abdominal pain and it revealed peripancreatic diffuse inflammatory densities (edematous pancreatitis), shown in image 1. The patient was consulted with the internal medicine clinic. Internal Diseases Clinic suggested hydration with intravenous Serum Physiological and then re-consultation with blood tests. We detected that WBC: 5.75 10^3 /uL, Hb:13 g/dl, Plt:150.000 10^3 /uL, Glucose: 248 mg/dl, urea:18.0 mg/dl, serum creatinine: 0.6 mg/dL, AST: 12U/L,,ALT: 14 U/L, GGT:31 U/L, ALP: 96 U/L, Amylase: 20: U/L, Lipase: 38.1 U/L, CRP: 120.56 mg/L cardiac troponine: 0.006 ng/ml in blood test after hydration.

The patient was re-consulted with the internal medicine clinic. Internal Diseases Clinic suggested hospitalization with the diagnosis of edematous pancreatitis to him.

Patients with acute pancreatitis are admitted to the ED with abdominal pain, nausea and vomiting. Generally, the amylase and lipase elevation are seen in the blood tests and then abdominal CT is performed for further examination and follow-up.

When amylase and lipase are detected in normal values, pancreatitis is not thought; but two of the three criteria for acute pancreatitis must be determined. These criteria are abdominal pain, amylase-lipase elevation and view compatible with pancreatitis in imaging examinations. In this context, a rare diagnosis of pancreatitis can be made without amylase and lipase elevation. In our case, the patient was diagnosed with pancreatitis because of having abdominal pain and imaging consistent with pancreatitis without elevated amylase and lipase. As in this case, blood tests are not sufficient for diagnosis of pancreatitis and if there is clinical necessity, the emergency physician should consider imaging examinations for diagnosis of pancreatitis.

Image 1:



SÖZEL 33

DYSPNEA CAUSED BY POLYCYTHEMIA VERA

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Abstract:

Although dyspnea is a common symptom in patients admitted to the emergency department, dyspnea due to polycythemia vera is seen rarely. Here, we describe a rarely seen case of polycythemia vera, one atypical cause of shortness of breath, as a case report. A 62-year-old man was admitted to the emergency department (ED) with complaint of shortness of breath. He had polycythemia vera and phlebotomy due to this illness in his past medical history. On his presentation to our ED, he was conscious, oriented and cooperative. His vital signs were as follows: his blood pressure was 125/85 mm Hg, his pulse rate was 98 beats per min, his respiratory rate was 24 per min, his body temperature was 36.7°C, and his oxygen saturation was 82% while breathing room air. Widely ronki was heard by auscultation. There is no pretibial edema. ECG is normal beat. Laboratory results are normal except for hemoglobin level and hematocrit level in the hemogram and pO₂ in the blood gas (hb: 19,1 g/dl, hct 63,7 %, and pO₂: 64,2 mmHg). It is seen a mass that can be lymphadenopathy in the right hilar region in the X-Ray. The left ventricle segmental motion was defected and EF is calculated 35%.

Phlebotomy was planned for the patient who was consulted to Internal Medicine, Chest Diseases and Cardiology departments and after phlebotomy, the patient recovered from dyspnea. Polycythemia vera of a rare reason of dyspnea is should be kept in mind for the patients admitted to the emergency department especially who had no histories of heart and lung diseases.

Keywords: dyspnea, polycythemia vera

SÖZEL 34

Evaluation of Procalcitonin, CRP and Lactate Values with SOFA and APACHE II Scores in Critical Patients in Emergency Intensive Care Unit.

Critical Patient; is a term that refers to patients with a high morbidity and mortality rate that require advanced monitorization and treatment due to one or more organ or system failure. Various scores have been developed for early diagnosis of these patients and treatment planning of the patient due to the high morbidity and mortality occurring in these patients. APACHE II and SOFA are two of them. C-reactive protein (CRP), procalcitonin and lactate are laboratory parameters that are significantly increased in infection or inflammation. In many studies about sepsis, the high levels of procalcitonin, crp and lactate were determined. Changes occur in serum levels of serum inflammatory markers commonly used to demonstrate mortality such as CRP and procalcitonin caused by induced inflammation in critical patients. The role of CRP and procalcitonin in patient management can be explained by the seriousness of the inflammatory process in critical patients. In this study, we aimed to investigate the effects on mortality and clinical process of procalcitonin, CRP and lactate levels as biochemical markers by correlating with the SOFA and APACHE II Scores in Critical Patients in Emergency Intensive Care Unit. This study is carried out examining demographic feature and procalcitonin, CRP, lactate levels and APACHE II and SOFA scores in the intensive care patients hospitalized between 28.11.2018-28.02.2019 at the Emergency Intensive Care Unit of Kanuni Sultan Süleyman Training and Research Hospital, Istanbul Health Sciences University by retrospectively. In this study, patients who were under 18 years of age or having bone marrow metastasis with any other malignancy or having primary blood cell malignancies, such as leukemia and lymphoma, were excluded as exclusion criteria. As statistical analysis, It is performed to normality test for normal distribution to all variables so it is evaluated with parametric test criteria. Spearman rank correlation and parametric Pearson correlation types were used for correlations between non-parametric data. 53 patients are included in the study. Of these patients, 58.5% (n = 31) are male and 41.5% (n = 22) were female. The mean age is 73.0 (19; 91). The most common histories of the patients are 30.2% (n = 16) diabetes mellitus (DM), 22.7% (n = 12) malignancy and 15.1% (n = 8) hypertension, respectively. According to the diagnosis of ICU admission, the most frequent diagnoses are pneumonia-sepsis 54.7% (n = 29), acute renal failure (ARF) 9.4% (n = 5) and multiple trauma 7.5% (n = 4), respectively. The average hospitalization duration in the intensive care unit is 6.7 days. When the final results of the patients are evaluated; 37.7% (n = 20) with 112 referral to another center, 13.2% (n = 7) to the service, 13.2% (n = 7) was discharged by healthy, 24.5% (n = 13) was exitus. Correlation analysis is performed to determine whether there was a significant correlation between CRP, procalcitonin, lactate from laboratory parameters and APACHE II and SOFA (Table 1 and 2) score. According to this; APACHE II is found to be low significant associated with procalcitonin, positively. (r: 0.286 and p = 0.040) (Table 1). It is found that SOFA have an intermediate significant positive relationship with lactate and procalcitonin. (r:0.339 and p=0.013; r:0.447 and p=0.001, respectively) (Table 2). It is required to provide guidance in monitoring response to treatment, sensitive and specific scoring systems and laboratory tests for critical patients. In our study, prognostic predictive scores such as APACHE II and SOFA is compared with acute phase markers such as procalcitonin, CRP and lactate for clinical follow-up of critically ill patients and if there is a correlation between these scores and markers. As a result; There was no linearity between CRP and APACHE II and SOFA scores as positively or negatively. Procalcitonin was positively correlated with APACHE II and SOFA scores and it was thought that procalcitonin is an adjunctive laboratory parameter for follow-up and treatment during clinical course. It is thought that procalcitonin with variable data sets can shed light on other studies to determine prognosis.

Table 1:

	APACHE II Score (n=53)				Correlation
	<10, (n=3)	11-20, (n=21)	21-30, (n=19)	>31, (n=10)	P Value and (Correlation Coefficient, r)
CRP (mg/L), median	52.2	66.0	64.6	53.1	0.565 (0.081)
Prokalsitonin (ng/mL), median	0.19	0.39	0.99	1.2	0.040 (0.286)
Laktat (mmol/L), % (n)					
<2	11.1 (3)	52.4 (11)	42.1 (8)	50.0 (5)	0.130 (0.211)
2-4	0.0 (0)	33.3 (7)	47.4 (9)	0.0 (0)	
>4	0.0 (0)	14.3 (3)	10.5 (2)	50.0 (5)	

Table 2:

	SOFA			Correlation
	1 (n=13)	2-4 (n=21)	>5 (n=19)	P Value and (Correlation Coefficient, R)
CRP (mg/L), median	60.82	73.28	69.19	0.253 (0.160)
Prokalsitonin (ng/mL), median	0.19	0.68	1.98	0.001 (0.447)
Laktat (mmol/L), % (n)				0.013 (0.339)
<2	76.9 (10)	47.6 (10)	36.8 (7)	
2-4	15.4 (2)	42.9 (9)	26.3 (5)	
>4	7.7 (1)	9.5 (2)	36.8 (7)	

SÖZEL 35

RİB FRACTURE DETECTED BY ULTRASONOGRAPHY IN A PREGNANT PATİENT

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ABSTRACT

The imaging modalities to be preferred in pregnant women who applied to the emergency department are controversial. In these patients, it is stated that all radiological examinations can be made by considering the profit-loss ratio. USG are preferred because of easy application, portable, low cost

and non invasive. In this case report, we wanted to remind that is a safe method for pregnant women in whom X-ray is contraindicated by sharing the rib fracture we detected by a USG in a pregnant patient.

A 33 years old, 35 week pregnant patient was admitted to the emergency room with pain complaint on the left side after a severe cough. In physical examination , there is no significant finding except pain with palpation on the lateral edge of left side ribs. The ultrasound showed irregular cortex image which could be compatible with fracture in the left 9th rib location (Figure 1).The patient was discharged. Because there was only one rib fracture and no respiratory distress.

In terms of cost-effectiveness, USG is one of the radiological imaging modalities recommended to be used in pregnant. In the light of all this information, we think that USG usage should be widespread in the diagnosis of rib fracture.

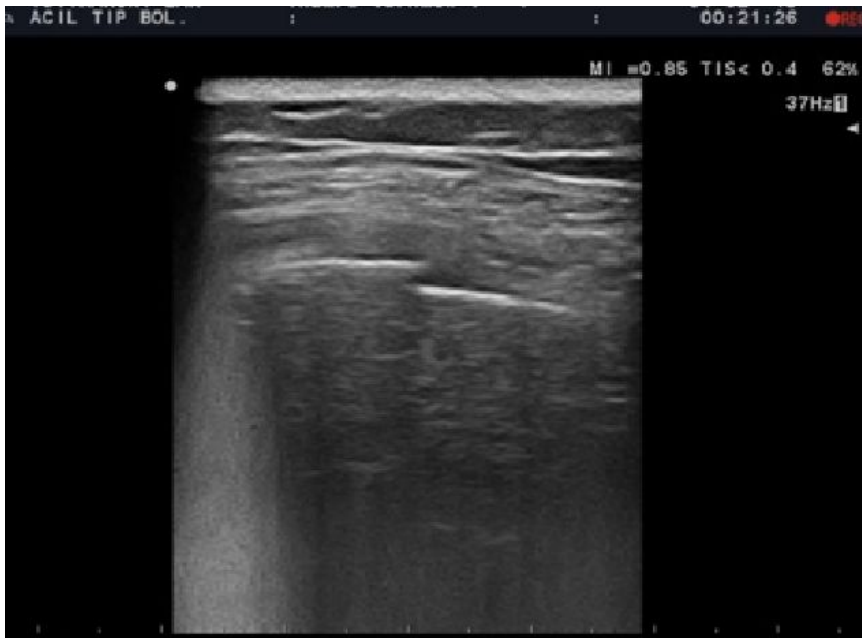


Figure 1: Rib fracture detected by USG

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KONUŞMA ÖZETLERİ

KONUŞMA ÖZETİ 1

Travmaya Genel Yaklaşım

Prof. Dr. Yunsur Çevik

Travma özellikle genç nüfusta önlenabilir ölümlerin başında gelir. Amerikan verilerine göre yıllık 150000 kişi travma nedeniyle hayatını kaybetmektedir. Kafa yaralanmaları, göğüs ve büyük damar yaralanmaları travmayla ilişkili ölümlerin en önde gelen nedenidir. Ölümlerin en azından %20'si iyi bir bakımla önlenabilir. Zira travmaya bağlı ölümlerin bir kısmı olay yerinde majör kafa veya damar yaralanması nedeniyle olmaktadır. Esasen kurtarılabılır kısım ilk 1 saatte müdahale ile hayatta kalıma katkı sağlanabilecek olan daha hafif kafa travmaları, göğüs ve karın yaralanmalarıyla ilişkilidir. Travmaya yaklaşımın temel basamakları aşağıda sıralanan şekilde olmalıdır;

Hazırlık, Primer Bakı, Resüsitasyon, Sekonder bakı, gerekli tedaviler ve yeniden değerlendirme, kesin tedavi ve sonuçlandırma şeklinde olmalıdır.

Hazırlık; hasta acil servise gelmeden önce ambulans ekibinin haber vermesiyle başlar. Travma ekibi lideri organizasyonu sağlar. Her türlü hava yolu, damar yolu ekipmanları, sıvı, oksijen, sabitleyici ekipmanlar, sondalar, cerrahi konsültanlar dahil, müdahale edilecek alan hazırlanır. Gerekli hazırlıklar sonrasında ilk basamak Primer bakı olarak adlandırılan ve tamamen yaşamı sıkıntıya sokabilecek her türlü yaralanmayı belirlemeye yöneliktir. ABCDE şeklinde sıralanan bu basamaklar, A (Hava yolu): hava yolu tıkanıklığına yol açabilecek bir durumun varlığını araştırmak ve gerekli ise hava yolu açma manevralarıyla bu engelleri ortadan kaldırma çabasıdır. Eş zamanlı olarak boyun stabilizasyonu da önemlidir. Bu nedenle bir kişi boynu sabitlerken diğer bir kişi hava yolunu kontrol etmelidir. Hava yolunun devamlılığını sağlamak ve ikincil beyin hasarını önlemek için komatöz hastalarda derhal endotrakeal entübasyon yapılır. Hava yolu açılması için gerekli ise supraglottik hava yolu ekipmanları veya cerrahi yöntemler de kullanılabilir. B (Solunum): solunumu sıkıntıya sokan ölümcül problemleri belirleme aşamasıdır. Trakeal deviasyon, emici göğüs yarası veya solunum seslerinin alınamaması gibi hayati bulgulara dikkat edilmelidir. Tansiyon pnomotoraks, açık pnomotoraks, massif hemotoraks, trakeobronşiyal yaralanma gibi durumlar saptanırsa derhal müdahale edilmesi gereklidir. Sonraki aşama C (Dolaşım) aşamasıdır. Bu aşamada hem kanamanın hem de perfüzyonun değerlendirilmesi yapılır. Perfüzyonu değerlendirmede; cilt rengi, bilinç durumu, periferik nabızlar, kalp hızı yol göstericidir. Dışa kanamalar varsa öncelikle bası veya gerekli ise turnike uygulanır. Durdurulamayan kanamalar için traneksamik asit veya lokal kanama durdurucu ajanlardan da faydalanılabilir. 2 adet geniş damar yolu açılır ve gerekli resüsitasyon sağlanır. Sonraki aşama D (Kısa nörolojik değerlendirme): Bu aşamada kısaca bilinç durumu, pupil çapı ve reaktivitesi değerlendirilir. Bilinç durumu değerlendirmesinde sıklıkla GKS skoru kullanılır. E (Tamamen soyma ve hipotermiyi önleme): hasta soyulup her tarafı gözden kaçması olası yaralanmalar açısından incelenir. Bu aşamaya kadar her basamakta saptanan olası ölümcül yaralanmalara derhal müdahale edilir.

Sekonder Bakı: Kabaca tepeden tırnağa inceleme olarak adlandırılabilir. Kişinin alerjileri, kullandığı ilaçlar, geçmiş tıbbi öyküleri, en son yediği yemek ve olayların derin hikayesine kadar bilgiler toplanır. Saçlı deriden başlayarak, göz kulak burun, yüz muayeneleri derinlemesine yapılır. Göğüste tek tek kotlar palpe edilir, solunum dinlenir, batında hassasiyet, barsak sesleri değerlendirilir. Pelvik muayenede stabilite bakılır, üretral yaralanma açısından perineal ekimoz, skrotal ekimoz veya meatal kan varlığına dikkat edilmelidir. Tüm üst ve alt ekstremiteler parmaklarına kadar hassasiyetle bakılır. Bu aşamada ekstremitelerdeki deformite, kas, tendon, yumuşak doku, damar yapıları tek tek incelenir. Sonra detaylı nörolojik muayene gerçekleştirilir. Bilinç durumundan, kas tonusu, duyu muayenesi ve reflekslerine kadar tek tek bakılır.

Resüsitatif sıvı seçiminde öncelik kristalloidlerdir. Ringer laktat veya izotonik sodyum klorür bu amaçla kullanılır. Kolloidler hem daha pahalı hem de ek avantaj sağlamamaktadır. 1 litre sıvı sonrası yeterli yanıt alınamadığında kan ve kan ürünleri planlaması yapılmalıdır. Durdurulamayan kanamalarda traneksamik asit de unutulmamalıdır.

Radyografik incelemeler ve Laboratuvar testleri; Hızlıca ameliyathaneye gitmesi gerekmeyen hastalar için, yatak başı ultrasonografi başta olmak üzere gerekli radyolojik tetkikler yapılmalıdır. Kan grubu, hemoglobin ve doğurganlık çağındaki kadınlarda gebelik testi mutlaka istenmesi gereken laboratuvar testleridir.

Travma hastaları sürekli değerlendirme ve gözlem gerektirir. Hemodinamisi bozuk olan veya sürekli kanayan hastalar derhal ameliyathaneye alınmalıdır. Diğer hastalara kliniğinin gerektirdiği tedavi yaklaşımları sağlanmalıdır.

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