

10. ULUSAL ACIL TIP KONGRESİ 1st INTERCONTINENTAL EMERGENCY MEDICINE CONGRESS

15 - 18 Mayıs 2014

Gloria Golf Resort Hotel,
Belek-Antalya



BİLDİRİ ÖZETLERİ

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SÖZLÜ BİLDİRİLER
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SÖZLÜ BİLDİRİLER

SS-001 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

If Not Now Then When ?

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Objective: Stroke is one of the most important disease which result in high morbidity and mortality. Incidence of ischemic stroke has been increasing with age and strokes are classified as young stroke that is under the age of 45. The causes of stroke among young adults are more diverse than in the elderly and require a thorough diagnostic workup

Case: In our case, 26 year old male patient with no medical history previously. He presented with a complains of vomiting. On his physical examination he was sweating and his skin color was pale also exhausted. He was not aphasic, on his motor examination he had no loss of strength on both upper and lower extremities. On initial arrival of the patient his blood pressure was documented as 135/78 mmHg, pulse rate 85 b/m, respiratory rate 14 p/m, temperature 36.4 C, sPO2 % 100 and a score of 15 on the Glasgow coma scale. No significant abnormality was identified on routine tests such as full blood count, renal and liver functions and troponin. His ECG showed sinus rhythm. He had loss of consciousness and loss of strength on motor examination therefore cranial MRI and CT scan were performed. There was no abnormality on CT scan. Magnetic resonance imaging of the brain demonstrated left sided acute infarcts in the middle cerebral artery and posterior cerebellar artery territories.

Neurology consultation was performed and the stated that the large infarct area had a risk of evaluation of an edema and herniation and loss of patient therefore brain surgery consultation was performed but both the consultant doctors approved the need of intensive care unit. On the fourth day of the patient in intensive care unit, the patient was considered as exitus

Conclusion: National Institute Of Neurological Disorders and Stroke does not impose an exclusion criteria for intravenous tPA usement in ischemic stroke that has an obliteration of sulci in more than 1/3 of middle cerebral artery territory on CT scan of the brain. However in National Institute of Neurological Disorders and Stroke, American Heart Association guidelines, tPA treatment is contraindicated in wide MCA infarct.

In patients with malignant MCA infarction, decompressive surgery reduces mortality and increases the number of patients with a favourable functional outcome. We wanted to highlight, what we would gain or loose in our patients condition in case of performing decompressive surgery of starting on thrombolytic treatment?

Keywords: Thrombolytic, Young Patient, Wide Infarct

SS-002 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

The analysis of Escherichia Coli in urine culture and antibiograms requested from Emergency Department

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Objective: Urinary system infection is existence of bacteria in kidneys, collecting duct system and/or urinary bladder together with pyuria and clinical symptoms. It is evaluated as a wide range from asymptomatic bacteriuria to pyelonephritis. Escherichia coli (E. Coli) is isolated in 50-90% of urinary system infections. In this study various antibiotic resistance of infectious or non-infectious E. Coli species was investigated to increase the success of empirical antibiotic treatment in urinary system infections.

Materials-Methods: The antibiotic susceptibility of 464 E. Coli strains which was isolated from urine samples of patients who visited Derince Training and Research Hospital Emergency Service between dates of 1 January-31 December 2012, was evaluated from records retrospectively. The antibiogram results were classified as susceptible, moderately susceptible and resistant. Moderately susceptible strains were assumed as resistant.

Results: There was 563 (28.1%) bacterial proliferation among 1998 urine cultures. 112 cultures could not be evaluated because of contamination and there was no proliferation in 1323 cultures. E. coli strains were isolated in 464 (82.4%) of cultures which proliferation was seen. 367 (79%) of patients were female, 97 (21%) of patients were male, mean age of all patients was 41.1 ± 24.1 (min:1, max:90). When antibiograms of E. Coli strains were investigated, the lowest resistance was in meropenem (0%), the highest resistance was in ampicilline-sulbactam (36.8%).

Conclusion: It is important to evaluate local antibiotic resistance intermittently for success of treatment of urinary system infections. In our study we investigate the antibiotic resistance among E. Coli strains isolated from urine cultures in our region, studies similar to this can be done later to help success of treatment.

Keywords: culture, emergency, e.coli

SS-003 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A syndrome should be remembered that does not response to the treatment in patients with asthma bronchiale: Churg-Strauss

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Objective: Churg-Strauss syndrome (CSS) is a rare systemic disease characterized by necrotizing vasculitis and peripheral eosinophilia. Although the overall prognosis is good, clinical studies suggest that cardiac involvement is associated with an adverse prognosis. The diagnosis of CSS is based on the American College of Rheumatology Criteria for CSS. We herein report the case of a 42 year-old woman who presented with high fever and widespread eruption on skin with the diagnosis of Churg-Strauss syndrome.

Case: A- 42 year-old female admitted to our emergency department with high fever, short breathing, and purple skin eruption on hands and feet. Her complaints continues in spite of orderly treatment. On admission time she had short breathing. Fever was 38.5°C, arterial pressure 160/110 mmHg, pulse 97 beat/min, breathing 20/min, and SO2 was %86. In physical examination: Widespread rales and ronchus was determined at both thorax. Multiple bullous and petechial eruptions on both helms, wrist and elbow and sculp; and oral aphtha was determined. The laboratory findings were: Eritrosits sedimentation rate 26mm/h (1-20), eosinophilia 46.8% (0-6), CRP 91mg/l (0-5), D-dimer 6.3µg/mL (0-0.5), and WBC was 20.9x10³/uL. C-ANCA was obtained as positive. Nodular infiltration and iced glass density on right lung apex and inferior lobe of left lung was observed by thorax computed tomography. Other laboratory results were normal.

In her history she was diagnosed asthma bronchiale and was given appropriate drugs; and she suited the treatment orderly. In spite of orderly treatment she did not benefit from drugs, and short breathing, resistant high fever and pruritis purple colored eruption at right hand developed. Weakness, weight loss developed. Eruption lesions on both hands, elbow and wrist of hands and feet, sculp increased within one week. Specially, painful white lesion that made difficult eating developed in mouth.

Conclusion: Among the criteria in the traditional classification, the present patient demonstrated asthma, eosinophilia, non-fixed pulmonary infiltrates on lung. Although she failed to meet the other three criteria. The patient was diagnosed as Churg-Strauss syndrome and was initiated pan-prednisolone. She was hospitalized to rheumatology service. On 10th days of admission she was ordered corticosteroid orally and was discharged with recovery.

Keywords: Churg-Strauss syndrome, eruption asthma, treatment

SS-004 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Necrotizing Fasciitis due to simple wounds: Two cases

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Objective: In present study two cases of Necrotizing Fasciitis that created due to simple intervention were discussed.

Case: Case1

A-33 year old male admitted to ED with swelling and pain on the left hand. His complaint created by sinking of a simple light bulb to the left hand two days before. Dressing and d tetanose prophylaxis was performed. He admitted to our ED because of the increasing of pain and swelling on the left hand. On admission he was conscious. Blood pressure, pulse and fever were measure as 110/60 mmHg, 92 beat/min and 37.2°C respectively. Widespread edema, enduration, subcutaneous emphysema and crepitation (began from left hand spreaded until left hemithorax) was detected. Pulses on the left hand were palpable. Widespread subcutaneous emphysema was fixed on Posterior-anterior (PA) lung and direct left hand-wrist graphy. The arterio-venous doppler of upper extremitee was normal. Laboratory findings were: WBC 20.9x10³/uL, Neutrophilia %83.5 (41-73), CRP 5.2mg/l (0-5). Other results were normal. The patient was diagnosed Necrotizing Fasciitis and parenteral antibiotherapy medication was initiated. (Siprofloxacin and metranidasole). He was discharged on the third days of hospitalization. The control examination of ten days later was normal.



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Case 2

A- 82 year-old female with hypertension, diabetes mellitus and chronic renal failure admitted to ED with enduration and pain on the left gluteal area. Blood pressure, pulse and fever were measured as 140/70 mmHg, 18 beath/min and 37° C respectively. Diclofenac Na was performed intramuscularly to the left gluteal due to lumbalgia seven days before. Sfe admitted because of the increasing of enduration and pain. On admission ecchymoses, enduration and crepitation were spreaded from left gluteal to the perine part. Common air ecogenity and heterogean area were detected with superficial USG inspection. Muscular thicken, increased phatological signal, and also at t1 and t2 sceans hypodens areas were seen on MRI examination.

Laboratuary examination: Wbc was 28700/μL, Neutrophilia 84.5%, Glukoz 270mg/dL, urea 89 mg/dL, Cr 0.14 mg/dL, albumin 2,9 g/dl CK 591 U/L, and CRP was 209 mg/l.

The patient was diagnosed Necrotizing Fasciitis and antibiotherapy was initiated. (Meropenem, Daptomisin). The devitlized tissues were debrided. While hospitalization sepsis developed and she was followed at intense care unite. She was discharged 90 days after admission.

Conclusion: Rapidly progression of Necrotizing fasciitis in second case is associated conditions of diabetes mellitus, and chronic renal failure. But we don't know the undelying risk of second case.

Keywords: Necrotizing Fasciitis, simple wounds, debridation

SS-005 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

The Analysis of Patient Who Are Using Warfarin And Applied To The Emergency Department

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Objective: In this study we aimed to detect the causes of warfarin use in emergency department patients, whether it is used in desired levels or not, the frequency of complications, whether there any need for treatment for complications and the need for hospitalization.

Materials-Methods: A total of 152 patients who are using warfarin and applied to the emergency department of Antalya Education and Research Hospital for treatment, were included. Of the patients included in the study, name and surname, age, gender, concomitant diseases, causes of admission to hospital, causes of warfarin use, duration of warfarin use, other medicine used along with warfarin, complications developed due to warfarin use, and INR, AST, ALT levels obtained from patients' blood samples, treatment to the patients, whether patients were hospitalized or not, were recorded through a form.

Results: 80(52.6%) of these patients were male and 72(47.4%) were female. The average age of patients was found 62.23 ±13.1 (min:20 max:85). 64.5% of these patients did not know what drugs are used. INR level was in therapeutic range only in 44 patients(28.9%). There was significant correlation between the age of patients and their INR levels (p:0.001). INR levels did not differ between the sexes (p:0.470). In 53 (34.8%) of patients complications were observed. Between the development of complications and age and gender no significant differences were found. (p:0.926, 0.528). No statistically significant differences between the development of complications and the INR level were found. (p:0.407). In 42 (27.6%) of patients who developed complications bleeding occurred, in 11 (7.2%) of them embolism was observed. While duration of warfarin use in patients who developed no complications and patients suffered from bleeding is 36 months on average, and was 60 months in patients with embolism. The difference was statistically significant (p:0.043).

Conclusion: patients using warfarin must be aware of the drugs and its side-effects by the medical practitioners and that practitioners should take the development of embolism along with the risk of bleeding into consideration as a sign of complication.

Keywords: Warfarin, complication, INR level, bleeding, emboli

SS-006 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Chickenpox in the elderly

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Objective: Chickenpox is a result of the varicella zoster virus infection which is a herpes virus. Itchy widespread and vesicular exanthema with ambiguous systemic symptoms are the typical signs. Chickenpox cases occur in late winter and early spring. Chickenpox incidence has been decreased at the region monitored by the vaccination programs dramatically. It is highly contagious in prodromal and vesicular period. Chickenpox usually occurs in children under the age of 10. It is extremely rare in adults and even the elderly. Severe infections may be associated with serious complications especially in immunocompromised and elderly patients. In this paper, we will draw attention to chickenpox which is rare in the elderly patients.

Case: A 65 year old male patient was referred to our hospital with fever, fatigue and itchy skin lesions. He had no disease in his medical history, he had no chickenpox before. A week ago fever, anorexia and discomfort complaints started. Then, itchy lesions was occurred especially on his face and body. His arterial blood pressure was 130/85 mmHg, SpO2 was 93%, heart rate was 100 bpm, fever was 38.5 OC. In his neurological examination he was conscious, cooperative-oriented, Glasgow Coma Scale score was 15. There were no signs of meningeal irritation. He had papular, vesicular and crusted exanthema on his face and body at different phases. There were no pathologic examination sign on his respiratory system. He was hospitalized with the diagnosis of chickenpox.

Conclusion: Even though chickenpox is rare in adults, its mortality rate and incidence of severe complications are higher than pediatric group's. Emergency physicians should keep in mind adult patients present with fever and exanthema for the diagnosis of chickenpox.

Keywords: chickenpox, geriatric, emergency

SS-007 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Modified early warning score (MEWS) and VitalPAC early warning score (VIEWS) in geriatric patients admitted to the emergency department

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Objective: Emergency risk scoring systems have been defined in order to identify the health status of the patients on admission to the emergency department. Modified early warning score (MEWS) and VitalPAC early warning score (VIEWS) are two of those risk scoring systems. In this prospective study, we aimed to investigate the efficiency of MEWS and VIEWS in terms of predicting hospitalization and in-hospital mortality in geriatric patients admitted to the emergency department.

Materials-Methods: This study was conducted in a university hospital between 15 January and 30 January 2014. All medical and surgical patients, 65 years old and older, admitted to the emergency department were enrolled the study. Demographic data, vital signs, peripheral oxygen saturation and central nervous system status of patients were recorded on admission. The admission of the patient to ward/intensive care unit (ICU) and in-hospital mortality were used as the primary outcomes. The differences between the groups for MEWS and VIEWS were compared.

Results: A total of 284 patients were included in the study. The median age of patients was 75(69-80) and 165(58.1%) of 284 patients were male. 145(51.1%) of patients were discharged from the emergency department, 75(26.4%) of them were admitted to any ward, 61(21.5%) of them were admitted to ICU, and 3(1.1%) of them died in emergency department. The median MEWS values of the patients admitted to any ward was significantly different from the median MEWS values of the patients discharged from the emergency department (1(1-3) vs. 1(0-2), p<0.001). The median MEWS values of non-survivors was significantly higher than the median MEWS values of survivors (4(3-6) vs. 1(1-2), p<0.001). The median VIEWS values of the patients admitted to any ward was significantly higher than the median VIEWS values of the patients discharged from the emergency department (5(2-8) vs. 2(1-4), p<0.001). The median VIEWS values of non-survivors was significantly higher than the median VIEWS values of survivors (10(8-13) vs. 3(1-6), p<0.001). The areas under the ROC curves of MEWS and VIEWS in predicting hospitalization were 0.716(95%CI 0.656-0.775, p<0.001) and 0.754(95%CI 0.698-0.811, p<0.001), respectively. The areas under the ROC curves of MEWS and VIEWS in predicting in-hospital mortality were 0.851(95%CI 0.759-0.944, p<0.001) and 0.897(95%CI 0.837-0.956, p<0.001), respectively.

Conclusion: MEWS and VIEWS can be considered as useful and simple tools in predicting admission to a ward, admission to ICU, and in-hospital mortality in elderly patients admitted to the emergency department.

Keywords: geriatrics, hospitalization, risk scores

SS-008 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Rapid emergency medicine score (REMS) and HOTEL score in geriatric patients admitted to the emergency department

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SÖZLÜ BİLDİRİLER

Objective: Rapid emergency medicine score (REMS) and HOTEL score are used to identify the seriousness of the acute illness in emergency department patients. In this prospective study, we aimed to investigate the efficiency of REMS and HOTEL score in terms of predicting hospitalization and in-hospital mortality in geriatric patients admitted to the emergency department.

Materials-Methods: This study was conducted in a university hospital between 15 January and 30 January 2014. All medical and surgical patients, 65 years old and older, admitted to the emergency department were enrolled the study. Demographic data, vital signs, peripheral oxygen saturation, central nervous system status, electrocardiogram findings, ability to walk of patients were recorded on admission. The admission of the patient to ward/intensive care unit (ICU) and in-hospital mortality were used as the primary outcomes. The differences between the groups for REMS and HOTEL score were compared.

Results: A total of 284 patients were included in the study. The median age of patients was 75(69-80) and 165(58.1%) of 284 patients were male. 145(51.1%) of patients were discharged from the emergency department, 75(26.4%) of them were admitted to any ward, 61(21.5%) of them were admitted to ICU, and 3(1.1%) of them died in emergency department. The median REMS values of the patients admitted to any ward was significantly higher than the median REMS values of the patients discharged from the emergency department (7(6-9) vs. 6(5-7), $p=0.004$). The median REMS values of non-survivors was significantly higher than the median REMS values of survivors (10(8-13) vs. 7(5-8), $p<0.001$). The median HOTEL values of the patients admitted to any ward was significantly higher than the median HOTEL values of the patients discharged from the emergency department (1(0-2) vs. 0(0-1), $p<0.001$). The median HOTEL values of non-survivors was significantly higher than the median HOTEL values of survivors (2(2-3) vs. 1(0-1), $p<0.001$). The areas under the ROC curves of REMS and HOTEL in predicting hospitalization were 0.705 (95%CI 0.644-0.766, $p<0.001$) and 0.791 (95%CI 0.737-0.844, $p<0.001$), respectively. The areas under the ROC curves of REMS and HOTEL in predicting in-hospital mortality were 0.844 (95%CI 0.766-0.923, $p<0.001$) and 0.836 (95%CI 0.752-0.920, $p<0.001$), respectively.

Conclusion: REMS and HOTEL can be used as simple triage tools for predicting admission to a ward, admission to ICU, and in-hospital mortality in elderly patients admitted to the emergency department.

Keywords: geriatrics, hospitalization, risk scores

SS-009 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

The association between saharan dust and emergency department admissions, hospitalization, and mortality in Gaziantep, Turkey

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Objective: In the last two decades there is a strong scientific interest regarding the role of aerosols for the Earth's climate and associated changes. Aerosol particles are very important to the Earth-atmosphere climate system playing a crucial role in cloud and precipitation processes, air quality and climate. Here, we evaluated the association between saharan dust and emergency department admission, hospitalization, and mortality.

Material-Method: The records of admission to emergency department of Gaziantep University and the dust storms of 31 months were studied. Patients admitted to ED at dust storm with chronic obstructive lung disease (COLD), asthma bronchiale (AB), cerebrovascular events (SVE), acute myocardial infarction (AMI), stable and unstable angina pectoris (SAAP andUSAP); and the days with and without dust storms were included. The study was realized from March 2010 to October 2012. The admission of three days before storm (group 1), during storm days (group 2) and three days after storm (group 3) were determined. The mean level of dust PM10 particulate was calculated, and the results were compared.

Results: 6864 patients with chronic obstructive lung disease, asthma bronchiale, cerebrovascular events, acute myocardial infarction, stable and unstable angina pectoris admitted during the days with and without dust storms. 28 dust storms occurred during 31 months. The total of storms continued 78 days. Of admissions, 35.5% (n=2075) were in group1, 29.8% (n=1746) in group 2, and 34.8% (n=2043) were in group 3. The mean of PM10 for groups (group 1, 2 and 3) were 78.53 mg/m3 (range 19–276) particulate, 108.7 mg/m3 (range 34–631) particulate, and 60.9 mg/m3 (range 17–160) particulate respectively. The mean admission per a day for groups were 24.86, 22.55, and 24.50 respectively. The mortality was 12 in group 1, 12 in group 2, and 17 in group 3. The hospitalization ratio for groups were 0.24, 0.27, and 0.27 respectively.

Conclusion: However, the mean level of PM10 particulate for groups 2 (in dust storm days) is significantly higher ($p=0.001$) than the days before (group 1) and after (group 3) dust storms, the mean admissions/day, hospitalization and mortality related to diseases (COLD, AB, SVE, AMI, SAAP andUSA) for group 2 is lower than the group 1 and group 3.

Keywords: PM10 particulate, dust storm, admissions, mortality, emergency department

SS-010 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Comparison of two methods of basic life support (BLS) training given to middle school and high school students

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Objective: Basic life support education (BLS) in our country is not sufficient. The purpose of this study is to investigate the effects of classical training and video training on the levels of learning of middle school and high school students.

Materials-Methods: Middle school and high school students in a private school were divided into two groups. The first group was given a 20-minute classical BLS training. The second group was shown a 20-minute BLS training video pre-prepared by researchers.

Results: The 80 (46.5%) students were given the classical education and named as group 1. The 92 (53.5%) students watched the video tutorial and named as group 2. There was no statistically significant difference between the mean ages of the two groups (Group 1= 15.4±1.3 years, Group 2= 14.1±0.9 years, $p=0.332$). Also, there was no statistically significant difference between sex of the two groups ($p=0.457$). After training, there was a statistically significant difference between group 1 and group 2, the classical training group was more successful than the other group ($p=0.001$). In all study group, there was no statistically significant difference between the success of male and female students ($p=0.497$).

Conclusion: Educators should prefer classical education in BLS training given in schools even though some disadvantages such as the cost and time.

Keywords: Basic life support, Student, Training, Video

SS-011 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Vertebral artery dissection occurring with Nausea and Vomiting

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Objective: Vertebral artery dissection, occurs with rending of subintimal or subadventisyal tissue layers in the vessel wall and with the entry of blood in the tissue range as a result of this blood flow in the vessel lumen is disrupted. At 2% of ischemic stroke, vertebral artery dissection (VAD) has been observed. If the patient who has dissection doesn't have a known trauma story, it is called spontaneous artery dissection. It is usually seen in parts of the extra cranial arteries internal cerebral, and it is rarely seen in vertebral artery. Vertebral artery dissection is an important cause of stroke in the young. The most common symptoms are dizziness and drowsiness.

Case: An 32 years old male patient with dizziness, nausea and vomiting came to our emergency clinic. At the examination there is no neurological deficit. No pathological findings in ECG, his vitals were stable. The patient said his complaints began after sudden neck movements. Patients' symptoms were not improved with symptomatic treatment. Lessons to explain the clinical situation of the event were not determined at the cranial and spinal radiography and computer tomography. Brain diffusion-weighted MR was asked for the patient. At the brain diffusion-weighted MR of the patient at the right cerebellar region diffusion restriction was detected which is coherent with ischemia. At the cervical MR angiography of the patient an aspect is viewed coherent with dissection in the right extracranial vertebral artery. The patient was hospitalized and antithrombotic drug therapy started.

Conclusion: Vertebral artery dissection may follow manipulation of the neck or a trauma but it can also occur spontaneously. The patient had declared that his complaints began after a non-severe neck movement.

Keywords: vertebral artery dissection, vertigo, neck manipulation



ORAL PRESENTATIONS

SS-012 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Novel Factor In Stroke: Tp-e/QT

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Objective: In recent studies, repolarization parameters like QT interval and QT dispersion were shown to be lengthened in stroke. We also aimed to investigate whether novel transmural repolarization parameters such as Tpeak-Tend (Tp-e) and Tp-e/QT change in stroke and their associations.

Materials-Methods: Study was planned in Konya Training and Research Hospital. Individuals over 18 and admitted to our hospital within first 6 h after exposure to stroke were included. Those under 18 with history of cardiac disorders or on use of antiarrhythmic drugs and with electrolyte abnormality were excluded. Vital findings, demographic features, Glasgow coma scores (GCS) and laboratory findings were recorded. Electrocardiographies (ECG) were performed on admission and at hour 24. The rhythms, ST-T changes and Tp-e and Tp-e/QT scores were calculated and recorded. All patients were followed-up as to in-hospital and 6-month mortality rates.

Results: Totally 106 patients were enrolled into the study. Median (interquartile range-IQR) for age was 74 (16), 44.3% (47) of patients were men. Systolic and diastolic blood pressures, and GCS were 150 (30)mmHg, 80 (18.5) mmHg and GCS 15 (5.5), respectively. Of patients, 82.1% (87) were with infarction, and 17.9% (19) were with hemorrhagic stroke. On admission, Tp-e and Tp-e/QT scores of V2 derivation were Tp-e 91(22)msec and Tp-e/QT 0.26 (0.07); at hour 24, Tp-e and Tp-e/QT scores of V2 derivation were Tp-e 80 (22) msec and Tp-e/QT 0.23 (0.06). Tp-e and Tp-e/QT scores of V5 derivation were Tp-e 95 (25) msec and Tp-e/QT 0.26 (0.06) on admission; at hour 24, Tp-e and Tp-e/QT scores of V5 derivation were Tp-e 80 (27) msec and Tp-e/QT 0.23 (0.07), and the measurements on admission and at hour 24 were significantly different ($p < 0.001$). In ischemic and hemorrhagic strokes, no difference was seen between ECG parameters. In-hospital and 6-month mortality rates were found as 35.8% (38) and 42.5% (45). In cox regression analysis, systolic and diastolic blood pressures, GCS and Tp-e/QT were independent indicators of both in-hospital and 6-month mortalities. Cut-off value, Tp-e/QT value, obtained using ROC curve for mortality was 0.26 (sensitivity: 66.7%, specificity: 61.4%, AUC: 0.64, 95% CI: 0.53-0.73 and $p=0.02$). According to this cut-off, survival rates calculated with Kaplan-Meier curve were significantly lower for in-hospital and 6-month mortality rates (Log Rank:7.2, $p=0.007$ and Log Rank:7.43, $p=0.006$).

Conclusion: In stroke, transmural repolarization parameters described on admission are lengthened at hour 24. Of these parameters, V5 Tp-e/QT is the independent marker of both in-hospital and 6-month mortality rates.

Keywords: Stroke, Tp-e, Tp-e/QT

SS-013 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Stroke differentiation by heparin binding protein and troponin-I

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N.E.U. Meram Faculty of Medicine

Objective: We evaluate the serum levels for heparin binding protein (HBP) and troponin I (TR-I) of patients presented with acute stroke to differentiate hemorrhagic (HS) and ischemic stroke (IS)

Materials-Methods: 124 patients presented to the emergency department of Necmettin Erbakan University Meram Faculty of Medicine, between April 2013 and November 2013 were prospectively studied. 4 patients were excluded from the study due to stroke mimics. Computerized tomography and magnetic resonance scanning were used for diagnosis. According to the final diagnosis patients were divided into 2 groups; ischemic stroke (IS) and hemorrhagic stroke (HS) group. Groups were evaluated and compared statistically for serum levels of HBP and TR-I.

Results: HS was found 25 of patients (20.8%) while 95 of the patients (79.2%) were accepted as IS. Transient ischemic attack patients ($n=11$, 9.166%) were included in the IS group. Mean HBP value was 0.1500 ng/ml for HS group with a minimum level of 0.05 ng/ml and a maximum level of 58.00 ng/ml. Mean TR-I value was 57.69 pg/ml for this group with a minimum level of 8.65 pg/ml and a maximum level of 2400 pg/ml. Mean HBP value was 0.1800 ng/ml for IS group with a minimum level of 0.05 ng/ml and a maximum level of 63.50 ng/ml. Mean TR-I value was 35.92 pg/ml for this group with a minimum level of 2.52 pg/ml and a maximum level of 2400 pg/ml.

Conclusion: There was no statistically significant difference between HS and IS groups in terms of serum HBP levels. ($p=0.361$). HS group had a higher value for TR-I. There was a statistically significant difference between in HS and IS groups in terms of serum TR-I levels. ($p=0.018$) Troponin I may be used for differential diagnosis of hemorrhagic and ischemic stroke but needs much more studies for cost effectiveness comparing with cranial imaging methods.

Keywords: troponin-I, heparin binding protein, stroke

SS-014 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Availability of glial fibrillary acidic protein in differentiation of stroke

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N.E.U. Meram Faculty of Medicine

Objective: We evaluated the serum levels of glial fibrillary acidic protein (GFAP) for differentiation of hemorrhagic and ischemic stroke.

Materials-Methods: 124 patients presented to the emergency department of Necmettin Erbakan University Meram Faculty of Medicine, between April 2013 and November 2013 were prospectively studied. 4 patients were excluded from the study due to stroke mimics. Computerized tomography and magnetic resonance scanning were used for final diagnosis. According to the final diagnosis patients were divided into 2 groups; ischemic stroke (IS) and hemorrhagic stroke (HS) group. Groups were evaluated and compared statistically for serum levels of GFAP. Double antibody sandwich enzyme linked immunosorbent assay method was used for studying GFAP in serum specimens.

Results: Hemorrhagic stroke was detected in 25(20.8%) whereas ischemic stroke was 95 (79.2%) of all. Transient ischemic attack patients ($n=11$) were included in the IS group. GFAP mean level among patients was 31.8061ng/ml with a minimum level of 0.02ng/ml and maximum level of 516.50ng/ml. GFAP mean level in HS group was 0.3300 ng/ml with a minimum level of 0.02ng/ml and a maximum level of 460.90ng/ml. IS group had a 0.2600 ng/ml mean level of GFAP. Minimum level of GFAP was detected as 0.02ng/ml and maximum level of GFAP was 516.50 ng/ml.

Conclusion: There were no statistically significant difference between HS and IS groups in terms of serum GFAP levels. ($p=0.084$) Computerized tomography and magnetic resonance imaging are still considered to be gold standard for differentiation of cerebrovascular diseases.

Keywords: Stroke, glial fibrillary acidic protein, emergency department

SS-015 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Demographic Characteristics Of Patients With Hemorrhagic And Ischemic Stroke

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N.E.U. Meram Faculty of Medicine

Objective: We aimed to compare demographic characteristics of the patients, presented to the emergency department whom were diagnosed as hemorrhagic or ischemic stroke.

Materials-Methods: This protective study includes 124 patients, presented to the emergency department of Necmettin Erbakan University Meram Faculty of Medicine, between April 2013 and November 2013. 4 patients were excluded from the study due to stroke mimics. According to the final diagnosis patients were divided into 2 groups; ischemic stroke (IS) group and hemorrhagic stroke (HS) group. Groups were evaluated and compared statistically by age, gender, background information as well as contact time, initial Glasgow Coma Scale (GCS), systolic and diastolic blood pressure.

Results: Ischemic stroke was detected in 95 patients (79.2%) whereas hemorrhagic stroke was detected in 25 (20.8%) of all. Transient ischemic attack patients (11 patient) were included to the IS group. Mean age was 64 years between ISK group and 69 between IS group. There was a statistically significant difference between two groups for age ($P = 0.016$). In terms of gender patient numbers were equal. ($n=60$) There was no statistically significant difference between two groups for gender. Mean time between symptoms and arrival at hospital was 7.25 ± 5.00 hours. There were no statistically significant difference between HS and IS groups about timing. History for coronary artery disease was detected as a risk factor for stroke, and there was a statistically significant difference between in HS and IS groups ($P=0.027$). Patient's mean initial GCS score was $13, 47 \pm 2, 870$. In HS group median score was $11, 96 \pm 3.90$ and $13, 86 \pm 2, 404$ in IS group. There was a statistically significant difference between HS and IS groups in terms of patient's initial GCS score ($p=0.020$). There were no statistically significant difference for diastolic and systolic blood pressures between HS and IS groups.

Conclusion: Comparing patients presented to emergency department whom were diagnosed as ischemic or hemorrhagic stroke, patients with ischemic stroke were found to be older and more



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like to have a history of coronary artery disease. GCS scores of hemoragic stroke group were detected lesser.

Keywords: Demographic characteristics, stroke, emergency department

SS-016 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Examination of oxidative stress parameters and signal peptide-cub-egf domain-containing protein 1 (scube1) in an experimental model of ischemic stroke

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Objective: Early diagnosis and treatment of patients presenting to the emergency department with stroke is very important in terms of preventing complications. This study was intended to determine the diagnostic value of plasma SCUBE1 levels in patients with acute ischemic stroke in the emergency department.

Materials-Methods: Once approval had been obtained from the ethical committee, ischemia was induced experimentally in rats with a mean weight of 250 g. Rats were divided into four groups of six members each. Blood and tissue specimens were collected after 1 h, 2 h and 6 h in the groups with induced ischemia and following the procedure in the control group. SCUBE1, IMA, tissue MDA and serum MDA levels were investigated in the serum specimens. The brain tissues collected were examined histopathologically. Correlation analysis was performed between the values.

Results: Median SCUBE1 values were 1.75 (1.64-1.87) ng/ml in the control group, 3.80 (3.54-4.29) ng/ml in the 1 h after ischemia group, 3.71 (3.21-5.08) in the 2 h after ischemia group and 4.19 (2.18-5.80) ng/ml in the 6 h after ischemia group. A statistically significant difference was determined between the control group values and those for 1, 2 and 6 h after ischemia ($p = 0.004$, $p = 0.004$ and $p = 0.004$, respectively). A significant and weak positive correlation was determined between SCUBE1 and IMA levels ($r = 0.495$ $p = 0.014$). A significant and powerful correlation was determined between SCUBE1 levels and percentage of atrophic neurons ($r = 0.744$ $p = 0.000$).

Conclusion: Plasma SCUBE1 levels in acute ischemic stroke patients rose from the 1st hour. The greatest increase compared to the control group was in the 6th hour. If this can be confirmed by other experimental and clinical studies, SCUBE1 is a potentially significant biochemical marker in the early diagnosis of acute ischemic stroke patients.

Keywords: Emergency, Acute ischemic stroke, SCUBE1, IMA

SS-017 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Lactate and thrombocyte counts and its role in the prognosis of sepsis

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NECMEETTİN ERBAKAN ÜNİVERSİTESİ MERAM TIP FAKÜLTESİ

Objective: With each passing day advances in understanding the pathogenesis of sepsis is provided, new diagnostic and follow-up parameters are determined. Despite all these innovations expected decline in mortality of the syndrome has not been achieved. one of the reasons for this situation is insufficiency of effective and easily repeatable follow up parameters which can be used for prediction of prognosis. in this study we aimed to point the value of lactate levels and thrombocyte counts in predicting the prognosis of sepsis.

Materials-Methods: This research was done prospectively in Necmettin Erbakan University Meram Medical Faculty Emergency Medicine Department Critical Care Unit in between the dates of October 1st 2012 and December 31st 2013. Patients were registered with APACHE II, SOFA scores, platelet (PLT) and lactate levels and the mortality rates and demographic data. The parameters were compared with 30-day mortality data of the patients.

Results: 136 patients were included to our study. 46 of the 136 patients were diagnosed with sepsis, 35 were diagnosed with severe sepsis and 55 were diagnosed with septic shock. There was a statistically significant difference ($p < 0.001$) in the following parameters; SOFA, APACHE II, Platelet values and Lactat values between the mortality group and non-mortality group.

Conclusion: by finding and using cheap and easily repeatable parameters in prediction of prognosis of sepsis, remarkable improvements in morbidity and mortality rates can be achieved. Lactate levels and thrombocyte counts were found valuable in prediction of prognosis of sepsis by our study in which we aimed to find a cheap and easily accessible marker that can identify the dynamic process from SIRS to sepsis in the early phase.

Keywords: Lactate, sepsis, thrombocytes

SS-018 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Neutrophil / lymphocyte ratio in patients with sepsis parameter identification is a new?

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NECMEETTİN ERBAKAN ÜNİVERSİTESİ MERAM TIP FAKÜLTESİ

Objective: The unspecific findings in the initial term of sepsis can cause unnecessary or late antibiotic usage. For this reason, there is a need of reliable and quick resulting and also easy repeatable and cheap laboratory tests that can support the diagnosis. This research was designed to show the value of N/L ratio in diagnosis of patients with sepsis

Materials-Methods: The research was planned prospectively, in a case control type in Necmettin Erbakan University Meram Medical Faculty Emergency Medicine Department Critical Care Unit in between the dates of October 1st 2012 and December 31st 2013. Patients APACHE II and SOFA scores, neutrophil / lymphocyte ratio (N / L) parameters and demografik data were registered from the diagnosis with 3 daily average values.

Results: 248 patients were involved to our study. 121 patients who were included to our study did not develop sepsis(these formed our control group), 46 of them were diagnosed with sepsis, 35 were diagnosed with severe sepsis and 55 were diagnosed with septic shock and all of them were followed with their diagnosis. The mean values of SOFA, APACHE II, N/L parameters that analyzed in our study, a statistically significant rise was observed in between the patients in control and study groups. ($p < 0.001$).the mean value of the parameters which is followed in control and study groups are as follow SOFA ($3.87 \pm 2.587 / 7.68 \pm 4.089$), APACHE II ($14.86 \pm 6.701 / 23.17 \pm 8.739$), N / L ($7.01 \pm 7.052 / 14.1 \pm 11.176$).

Conclusion: If the clinic picture can be noticed in the reversible term by early diagnosis in patients with sepsis, with targeted therapy approaches, distinct progress in mortality and morbidity rates among these patients can be maintained. N/L rates was found valuable in the process of diagnosis by our study that we planned to find a cheap and easily accessible marker that can identify the dynamic process from SIRS to sepsis in the early phase.

Keywords: Neutrophil, lymphocyte, sepsis

SS-019 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Comparison of efficacy dimenhydrinate and metoclopramide in the treatment of nausea due to vertigo

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Objective: Vertigo complaint is one of the common cause of patients who applied to emergency services. Patients who have applied to emergency services with vertigo complaint mostly have nausea as an additionally symptom to this complaint and anti-emetic agents can be used in their treatments very often. Our purpose is to investigate the advantages of dimenhydrinate and metoclopramide to each other in the treatment of vertigo and the vertigo accompanied by nausea.

Materials-Methods: A prospective, randomized, double-blind research we have designed, after approval by the ethics committee; was performed with in the six-month period between 01. Nov. 2012 and 01. May. 2013 in the Pamukkale University Faculty of Medicine, Department of Emergency Medicine. In our study, a total of 200 patients admitted to emergency department with the complaints of vertigo accompanied by nausea were divided into 2 groups. To the first group DMT and to the second group MTP are rapidly infused intravenously in 15 minutes. As a rating scale VAS scale was used for grading the symptoms of vertigo and nausea.

Results: Between DMT and MTP groups, about the terms of scores of vertigo VAS ($p = 0.53$), and nausea VAS ($p = 0.1$), statistically no significant differences were detected. In the 15. minute of treatment, the average VAS score of nausea was decreased from 7.62 ± 1.48 to 3.89 ± 2.29 in the DMT group and 7.45 ± 1.27 to 3.93 ± 2.33 in the MTP group. And also average vertigo VAS



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score was decreased from 7.57 ± 1.42 to 3.81 ± 2.18 in the DMT group and 7.27 ± 1.40 to 3.82 ± 1.93 in the MTP group. By comparing the groups in terms of side effects; in the DMT group 15 (15%) patients sedation, 6 (6%) patients hypotension was observed. In the MTP group; 18 (18%) patients sedation, 8 (8%) patients hypotension was observed. Between the two groups, no significant difference was detected about the side effects which are sedation ($p=0.56$) and hypotension ($p=0.57$).

Conclusion: In our study, DMT and MTP activity was found to be equal to each other in the treatment of vertigo and the vertigo accompanied by nausea. Contrary to what is MTP medical practice in the treatment of vertigo was found to be an option at least as effective as DMT.

Keywords: metoclopramide, dimenhydrinate, vertigo, nausea, emergency medicine

SS-020 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Fever, Ataxia, Ophthalmoplegia, and Areflexia: What Would You Think?

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Objective: Miller Fisher syndrome (MFS), a variant of the Guillain-Barré syndrome (GBS), is characterized by ophthalmoplegia, ataxia, and areflexia. The annual incidence is around one patient per one million population. The antiganglioside anti-GQ1b IgG antibody has a role in the pathogenesis of the syndrome, especially of ophthalmoplegia. The presence of this antibody in the serum can be identified in over 80% of the patients, peaking in the first week, whereas albuminocytological dissociation in the cerebrospinal fluid (CSF) appears later. The outcome of MFS is usually good with case fatality of < 5%.

Case: A thirty-four-year-old man, who was previously fit and well, presented to Accident and Emergency with a three-day history of fever, and an acute onset of ophthalmoplegia, dysarthria and difficulty in swallowing. Basic blood tests showed no major abnormality and cranial CT was normal. The patient was consulted to neurologist and nerve conduction studies were performed, they showed a motor neuropathy in keeping with the clinical picture of an MFS. Antiganglioside antibodies were negative. A lumbar puncture showed no major abnormality. The patient was underdosed immunosuppressive and immunoglobulin therapy later.

Conclusion: Miller Fisher Syndrome is a rare variant of Guillain Barre Syndrome and should be taken in opinion in patients presenting with acute onset of central nervous system neuropathy.

Keywords: Ataxia, Ophthalmoplegia, Guillain Barre Syndrome, Miller Fisher Syndrome

SS-021 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Foreign bodies ingestion; mentally retarded patient

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Objective: The majority of the foreign bodies in the body occur by swallowing. 80% of them were ingested by the pediatric population. In adults, foreign body ingestion can be occur especially in people with intellectual disabilities, in alcoholic individuals and in toothless individuals, but also can result from accidentally swallowing.

Case: A 24-year-old mentally retarded male patient was brought to the emergency room by her mother. In the patient's history it was learned that there was abdominal pain over the last weekend occasional vomiting of blood. The patient claimed that he swallowed nails about 1 month ago. The patient's reliability of history was low. In the physical examination of the patient, cardiovascular and respiratory systems were normal and there was no tenderness, defense or rebound in the abdominal examination. An intensive radiopaque image belongs to the swallowed nails was found in the plain abdominal radiography. The patient was admitted to a general surgical ward for operating purposes. Within the same day of the operation, the nails and screws parts around 1000 gram was removed from the small intestine of the patient.

Conclusion: Although ingestion of foreign bodies often seen in children, it may also occur in adults. In spite of the low reliability of the stories of the cases, any medical histories taken from the patients should be taken into account. More detailed physical examination should be performed and the threshold in the use of imaging techniques is kept low in these patients.

Keywords: Foreign bodies, gastrointestinal tract, radiography

SS-022 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Mesenteric panniculitis

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Objective: Mesenteric panniculitis (MP) is a rare and benign disease, involving the bowel mesentery and characterized by chronic inflammation fat necrosis and fibrosis. Although its etiology is not fully known, this disease is thought to be associated with especially malignancies and autoimmune diseases, inflammatory diseases, trauma and previous surgical operations. The incidence is two fold higher in males than in females and it is usually seen in the fifth and sixth decades of life. MP is often incidentally detected, but it may accompany especially lymphoma, genitourinary and gastrointestinal adenocarcinomas.

Case: A 63 years old female patient presented to our hospital because of abdominal pain lasting for a long time. There was found lumbar disc hernia on her medical history since few years ago. No significant pathological finding was found in her physical examination and laboratory analyses. On the complete abdominal ultrasound (US) ordered for the patient; an omental structure condensation of 10x9 cm in size which was forming mass formation in the heterogeneous-echogenic structure and this appearance was interpreted as compatible with MP. On the subsequent contrast enhanced computed tomography; a well-contoured, slightly hyperdense mesenteric mass lesion was detected, beginning from the origin of superior mesenteric artery and reaching up to the level of jejunal loops connections through perivascular distribution, arching the adjacent bowel loops. A remarkably thin and higher-density capsule was detected around the mass (Image 1). The mass was interpreted as quite characteristic for MP with these features. Necessary tests have been recommended in terms of the possible accompanying malignancy, but no any malignancy findings were found on these examinations. The patient was discharged with symptomatic medical therapy and recommended a close follow-up.

Conclusion: In conclusion, although MP is a rare and usually incidentally found asymptomatic disease, it may cause chronic abdominal pain and accompany to malignancy or inflammatory disorders. Radiological methods are quite crucial in terms of the correct diagnosis, treatment and follow-up of MP since they are usually warning for an easy diagnosis and in terms of possible accompanying pathologies.

Keywords: emergency service, fat necrosis, mesenteric panniculitis

SS-023 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

The accidents while sacrificing in a Feast of the Sacrifice

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Objective: The accidents while sacrificing that admitted to emergency department of an university hospital were evaluated in present study.

Materials-Methods: The injured patients while sacrificing older than 16 years old who admitted to Emergency Department of Gaziantep University within first day of Feast of the Sacrifice were included in present study. The patients were not investigated if they were professional butcher or not.

Results: All cases admitted within 24 hours. Of patients, 25.5 % (n=12) were female, and 74.5% (n=35) were male. The mean age was 38 years (20-70). Of patients, 43 admitted to ED between 08.00-17.00, and 4 admitted between 17.00-24.00. Whereas, 41 patients had just cutaneous and subcutaneous injury, six patients (all were male and were operated by plastic surgery) had extensor tendon incision. Six patients were professional butcher. The majority (n=24) of injuries occurred on fingers of hand in both male and female. The big toe was the most common (n=7) injured issue. Six patients had lower extremities incision. Of patients, 43 injured themselves, four were injured by another one. Motor deficit and sense defect were observed in three patients and one patient respectively three months later in their controlling.

Conclusion: Sacrifice injuries mostly occur in male and in fingers. The majority of accidents while sacrificing happen through the unprofessional person. Most of the victim incision themselves.

Keywords: Feast of the Sacrifice, accidents, emergency department



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SS-024 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Closed Pantalar Dislocation; a case report

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Objective: Pantalar dislocation of the talus from its three articulations (tibiotalar, talonavicular, and subtalar) is an exceedingly rare injury. The incidence of fracture of the talus ranges from 0.1% to 0.85% of all fractures, and 6% of injuries affect the ankle and foot. The management of this injury is controversial. Treatment options include reimplantation of the talus; talectomy; talectomy with subsequent salvage procedure (i.e. tibiocalcaneal fusion). Major complications following this injury include avascular necrosis of the talus or post-traumatic arthritis (OA) of the talar articulations. We present a case of closed pantalar dislocation that was successfully treated with closed reduction in the emergency department.

Case: A forty year old man was admitted in emergency department after falling down from stairs. She was complaining with pain swelling and deformity of her right ankle. There was tenderness and pain with palpation at foot and capillary refill was normal. X-ray showed that the talus was found completely dislocated from the ankle and subtalar and talonavicular joints and computed tomography showed that multiple small fractures line lie to talo-calcaneal surface. The reduction required a longitudinal traction of the forefoot with digital pressure on the talar head in a posterolateral direction combined with hindfoot inversion. The patient followed up three day with splint for circulation. Than patient discharged with splint.

Conclusion: Closed reduction of pantalar dislocation in the emergency department should be attempted immediately if the injury is closed. And patients should followed up for vascular injuries and circulation.

Keywords: dislocation, pantalar, foot

SS-025 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Neutrophil-lymphocyte ratio and prognosis of upper gastrointestinal bleeding

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Objective: Neutrophil-lymphocyte ratio (NLR) is a systemic inflammatory marker that has prognostic value in patients with cardiovascular diseases, cancers, cirrhosis, and renal insufficiency. The aim of this study is to investigate the prognostic value of the NLR in patients with upper gastrointestinal bleeding in terms of erythrocyte suspension requirement, length of stay in hospital, and mortality.

Materials-Methods: All patients (18 years of age and older) admitted to the emergency department of a university hospital with upper gastrointestinal hemorrhage in 2013 were enrolled in this retrospective study. Patients with pregnancy, hematological disease, hypersplenism and cancer were excluded from the study. Patients' admission complaints, complete blood count results on admission, erythrocyte suspension requirement, endoscopic evaluation results, length of stay in intensive care unit, length of stay in hospital, and outcomes were recorded. The NLR of patients were calculated. The patients were divided into groups according to the amount of transfused erythrocyte suspension, length of stay in hospital, and survival. The differences between the groups for parameters were compared. The receiver-operating characteristic (ROC) analyses were used to detect the cut-off values of NLR.

Results: A total of 151 patients were enrolled in the study. The median age of patients was 69.0 (21.0) years and 100 (66.2%) of the patients were male. Overall in-hospital mortality rate was 7.9%. Patients required ≥ 5 units of erythrocyte suspension transfusion had significantly higher NLR compared to patients required no transfusion and 1-4 units of erythrocyte suspension transfusion (6.50 (5.72), 3.05 (3.27), and 4.23 (3.25) respectively; for ≥ 5 U ES/no ES $p < 0.001$ and for ≥ 5 U ES/1-4U ES $p = 0.011$). Patients with ≥ 7 days of length of stay in hospital has significantly higher NLR compared to patients with < 7 days of length of stay in hospital (5.70 (6.19) vs. 3.56 (4.01), $p < 0.001$). Non-survivors had higher NLR than survivors (6.50 (14.09) vs. 4.28 (4.67), $p = 0.019$). Area under the ROC curve of NLR in predicting ≥ 5 units of erythrocyte suspension transfusion was 0.677 (95% CI 0.586-0.768, $p < 0.001$), and in predicting mortality was 0.704 (95% CI 0.551-0.858, $p = 0.019$).

Conclusion: Complete blood count is a cheap and fast resulting laboratory evaluation can be performed on admission to the emergency department. In upper gastrointestinal bleeding setting, CBC is generally performed to evaluate the hemoglobin levels of patients. According to our results, neutrophil and lymphocyte counts, and NLR should also be considered as prognostic factors in upper gastrointestinal bleeding.

Keywords: neutrophil-lymphocyte ratio, gastrointestinal bleeding, prognosis

SS-026 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acute appendicitis? Think again

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Objective: In ER, in patients admitted with abdominal pain cause is very important to exclude. Surgical reasons often refers to the differences by age. For example, right lower quadrant pain in a young patient who presented with acute appendicitis, it was believed, the ileocecal or colonic pathology should be considered in elderly patients. In particular, the frequency of the pathology of vascular origin is increasing with age. Acute colonic ischemia in the elderly is a major cause of mortality. Necrosis of cecum is also rare variety of acute colonic ischemia and also cause pain in the right lower quadrant may be confused with acute appendicitis is. Even radiologically is similar to acute appendicitis. Therefore, the diagnosis is usually on perioperative. Treatment is the partial resection or right hemicolectomy. Emergency Services which mimics clinical acute appendicitis, right lower quadrant pain that comes with the cecum and perioperative necrosis diagnosed patients will share.

Case: Seventy-two years old male patient to the emergency department were admitted with complaints of sudden onset of right lower quadrant. During admission the patient's blood pressure 150/90 mmHg, pulse 100 beats/min, body temperature 38 degrees Celsius, oxygen saturation %96, respectively. In good general condition, clear consciousness, orientation and cooperasyo was the exact. In physical examination, all other systems examinations except the right lower quadrant tenderness in the abdomen detected, defense and rebound, were normal. In his history of hypertension and diabetes patient's medical history was unremarkable. Patients with symptomatic treatment of fluid infusion was started. Laboratory investigations leukocytes: $23100 \times 10^3/\mu L$, urea: 48 mg/dL, creatinine: 1.64 mg/dL, and sodium: 122 mmol/L are otherwise normal. In the ECG and chest X-ray was not seen any pathology. The patient abdominal ultrasound was performed, but due to suboptimal assessment of any pathology was detected. Then, a contrast computed tomography of the abdomen was taken. Fourteen mm periapendicular, pericececal, mesentery inflammation, free fluid was seen between intestinal loops. Then the patient was hospitalized, cecal necrosis were detected in patients. Right hemicolectomy was performed. Afterwards the patient was discharged.

Conclusion: Necrosis of the cecum is a rare variation of ischemic kolik and will require emergency surgery. Generally large and small artery occlusion or by reason of obstruction in venous return occurs. Right lower quadrant tenderness, rebound tenderness, especially in elderly patients with acute appendicitis, diverticulitis, perforation, necrosis of the cecum and colon malignancies should be considered.

Keywords: abdominal pain, appendicitis, necrosis of the cecum

SS-027 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Left upper quadrant pain: Splenic infarcts

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Objective: Common etiologic factors, thromboembolic and hematologic diseases. They are more rare splenic vascular causes, anatomical abnormalities and connective tissue diseases are followed. Patients usually left upper abdominal pain, nausea, vomiting, fever and constipation refers to the emergency department with complaints. Treatment of the disease varies according to the symptoms and complications. In some patients, supportive therapy is sufficient, due to some complications, splenectomy is indicated. To emergency department admitted with left upper quadrant pain diagnosed as splenic infarction patients we offer.

Case: Sixty-four years old female patient in the emergency department three days left standing abdominal pain, left side pain, constipation, and shortness of breath was admitted with complaints. Patient's blood pressure 160/90 mmHg, the body temperature is 36.3 degrees Celsius, oxygen saturation 78%, respectively. General condition good, clear consciousness, orientation and cooperation was complete. On physical examination, inspection of the western umbilicus above and below the scar was present. In the left upper quadrant tenderness to palpation and there was no rebound. There was prolonged expiratory lung auscultation bilaterally. Other system examinations were normal. Resumes hypertension, coronary artery disease, chronic obstructive lung disease, congestive heart failure, diabetes mellitus, atrial fibrillation had. We also had a history of cholecystectomy thirty years ago. For atrial fibrillation, warfarin, digoxin



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for congestive heart failure, diabetes mellitus were using oral antidiabetic. Patients with nasal oxygen inhalation, bronchodilator therapy and symptomatic treatment with normal saline was started. The patient's laboratory values glucose 384 mg/dl, potassium 5.7 mmol/L and leukocytes $15,000 \times 10^3/\mu\text{L}$, except that the normal. ECG atrial fibrillation was present. Chest radiograph was normal. CT abdomen of the patient was taken for further evaluation. CT captured in the splenic artery calcification and infarcts in the spleen were determined compatible with the view. The patient was hospitalized for general surgery was consulted. Then, after five days of medical and surgical treatment patients were discharged uneventfully.

Conclusion: Admitted to the emergency department because of left upper quadrant pain patients must be considered in the differential diagnosis of many diseases. Among these rare splenic infarction predisposing factors you should keep in mind if you have the.

Keywords: abdominal pain, Splenic infarct, emergency department

SS-028 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acute Adrenal Hemorrhage in An Elderly Patient

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Konya Eğitim Araştırma Hastanesi Konya/Meram

Adrenal hemorrhage is a relatively rare condition which is caused by trauma, stress, sepsis, adrenal tumors, anticoagulation, hemorrhagic disorders and pregnancy (1). It is important to determine the etiology for appropriate treatment. However in acute adrenal hemorrhage prompt diagnosis and treatment may be lifesaving since acute adrenal hemorrhage may result in acute adrenalin insufficiency and fluid-electrolyte imbalance (2). A 74 years old male was admitted to the emergency room with right shoulder and chest pain lasting for about 8 hours. He had hypertension in his medical history and was taking only ACE inhibitor + thiazide diuretic combination without any anticoagulants. At admission his body temperature was 37.1°C, his blood pressure was 240/140 mm Hg, and his pulse was regular at 80/min. Electrocardiography and blood cardiac markers including creatinine kinase (CK)-MB, myoglobin and Troponin I were normal. His tension was controlled with iv glyceril trinitrate infusion. Since his symptoms did not resolve with the control of blood pressure and im analgesic administration thoracic and upper abdominal computed tomography (CT) was ordered. Thoracic CT did not reveal any abnormality but abdominal CT demonstrated a 6.0 cm lesion in the right adrenal gland. There was also a high-density fluid accumulation on the vicinity of this lesion compatible with an acute hemorrhage. Venography showed a partial defect in blood flow of inferior vena cava proximal to the right renal vein attuned as the pressure effect of the hematoma. Selective angiography of the right renal artery revealed an extravasation in right surrenal artery which was originating from the superior branch of right renal artery and this artery was embolised with a particular embolising agent. Acute adrenal hemorrhage is quite rare and an accurate diagnosis of this condition is also extremely difficult. In differential diagnosis, some imaging modalities are shown to be useful, and if there is a clinical suspicion of an adrenal hemorrhage, advanced imaging techniques including CT should be ordered immediately. Clinicians should be aware of this rare condition and its management in order to accomplish treatment promptly.

Keywords: Acute, Adrenal, Hemorrhage

SS-029 Pediatric Emergencies

A rare foreign body aspiration:safety pin

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Objective: Tracheobronchial foreign body aspiration is a common cause of respiratory distress in 6 months-3 years age of children. A history of drowning is very important clue for foreign body aspiration. However, in many cases, there is no adequate history for suggestive of foreign body aspiration. Due to most of the foreign bodies are non-opaque, X-ray diagnosis of foreign body aspiration is difficult. Cough, stridor, fever, wheezing, persistent asthma-like symptoms and respiratory diseases such as bronchiolitis, laryngitis, pharyngitis and croup can be considered among the causes of delayed diagnosis of foreign body aspiration. We want to present this case for purposing to emphasize the importance of foreign body aspiration in infants and to share our experiences

Case: In our case, 7 month old baby was brought to the emergency department by his mother with suspected foreign body aspiration. His general condition was good, and his consciousness was clear. There was no evidence of cyanosis or respiratory difficulty. Mouth and throat examination were normal. There was no bleeding. In the emergency department, baby looked comfortable during the examination. But, suspected foreign body aspiration cannot be fully excluded, x-ray of chest was obtained. Safety pin was detected in x-ray. Baby was consulted with ENT surgery and he was hospitalized for removal of foreign body by bronchoscopy.

Conclusion: Foreign body aspiration, forming a nearly complete occlusion of the trachea, leads to fatal acute respiratory failure. In contrast, foreign bodies in the distal tracheobronchial tree cause deterioration of ventilation and respiratory tract infections. Foreign body aspiration, particularly in infancy and childhood in developing countries are among the major causes of death. In the early period, foreign body aspiration may causes the symptoms such as coughing, dyspnea and hoarseness; in the late period, it may causes the complications such as obstructive emphysema, atelectasis, lung abscess, empyema, bronchiectasis, and pneumothorax that may lead to recurrent infections, hemoptysis and bronchial asthma-like symptoms. In our case, there was no these signs and symptoms depending on the nature of the foreign body. Complaints cannot be fully expressed, especially in infants so x-ray must be applied for atypical detection of foreign bodies.

Keywords: aspiration, child, foreign body, safety pin

SS-030 Toxicology

Three families, one dinner; Endosulfan poisoning

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Objective: Cases of poisoning have been started to be seen following widely use of pesticides. One of the agents most commonly associated with pesticide poisoning is Endosulfan.

Materials-Methods: Data were obtained for 8 out of 12 patients who initially admitted to county state hospital with gastrointestinal symptoms after having dinner on 14 November 2013 and were referred to 3 hospitals in Kayseri.

Results: Twelve people who had dinner together presented to the county state hospital with nausea and vomiting 5 patients (71.4%) had tonic-clonic seizures in the emergency room. Three of these patients had agitation before seizure and all of them were intubated due to a Glasgow Coma Scale (GCS) score of 6 after seizure.

The analysis report which arrived four days after the incident confirmed that the cause of poisoning was endosulfan pesticide.

Conclusion: Endosulfan is an organochlorine pesticide and cases of non-fatal endosulfan poisoning are encountered frequently. Poisoning cases are seen more frequently in developing countries such as Turkey.

Endosulfan toxicity usually occurs in agricultural farmers after crop spraying and rarely by food contamination. In our patients, toxicity developed as a result of accidentally mixing of endosulfan to the meal and one of them (the patient who prepared the dinner) died.

Keywords: poisoning, endosulfan, tonic-clonic seizures without epilepsy

SS-031 Toxicology

Red Blood Cell Distribution (RDW) is An Independent Predictor indicator Of in Patients with Carbon Monoxide Poisoning

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Objective: Carbonmonoxide (CO) is a colorless, odorless, tasteless gas which is a product of incomplete combustion of carbon-based fuels. In our study we investigated CO's effect on RDW and value of this effect in clinical practice.

Materials-Methods: Study was performed on 324 patients who were diagnosed as CO intoxication in our Emergency Department. Parameters of the research were age, gender, clinical condition, CO and RDW levels, symptoms and recovery state.

Data were assessed by using SPSS (Statistical Package for Social Sciences) Windows v.19.0. Kolmogorov-Smirnov, Chi-square, Mann Whitney U and Kruskal Wallis tests were used to analyze the data. P<0.05 level at %95 confidence interval was considered as significantly significant.



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Results: In our study mean age was 41.7 with STD of 16.65. 65.7% of the samples were female. Mean CO level of patients was 26.8 ± 9.8 and mean RDW value was 14.11 ± 1.4 tür. Most common symptom was headache (76.5%) followed by nausea (65.1%). No statistically significant correlation between RDW value and COHb levels ($p > 0.05$).

Relationship between RDW value, gender and patients recovery state was not statistically relevant ($p > 0.05$). Relationship between general clinical condition of the patients and RDW value was statistically noteworthy ($p < 0.05$). There was a connection between COHb level and patients administration and mortality rates ($p < 0.05$).

Conclusion: As a result although there is no correlation with COHb and RDW levels, there is a affiliation between RDW levels and patients clinical status.

Keywords: Carbon monoxide poisoning, Red blood cell distribution, emergency

SS-032 Toxicology

Comparison of alveolar-arterial oxygen gradients calculated by age and by blood gas values in patients with diagnosed carbon monoxide poisoning

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Objective: Carbonmonoxide poisoning should be considered as a life threatening situation among all the poisonings. In prediagnosed carbonmonoxide intoxicated patients; we aimed to find out a significant difference between alveolar-arterial oxygen gradient related to age and alveolar-arterial oxygen gradient calculated from blood gas analysis and it's relationship with measured carboxyhemoglobin value.

Materials-Methods: A prospective case matched control study was conducted. In this study, 30 patients with prediagnosed as carbonmonoxide poisoning and 30 patients with other complaints as control group were included. Blood gas samples were taken from both poisoning and control group patients and carboxyhemoglobin, arterial carbondioxide pressure, arterial oxygen pressure and alveolar-arterial oxygen gradient were measured. The gradient should be based on age was calculated and comparative analysis were performed.

Results: While the mean of COHb levels was 20.9 ± 10.6 in poisoning group, but it was 1.9 ± 1.6 in control group (Mann Whitney U, $p < 0.001$). A statistically significant increase in measurement of alveolar-arterial oxygen gradient was found in poisoning group compared to control group ($p < 0.001$). Alveolar-arterial oxygen gradient was calculated in cases of determine to carbonmonoxide poisoning in ROC analysis the sensitivity of 76.7, specificity of %70 and cut off point was at 11.84 recorded. In determine of cut off value (≥ 11.84) in carbonmonoxide intoxication had a sensitivity of % 76.7, specificity of %70, true positivity (PPV) of %71.9, false negativity of (NPV) %75.0 was calculated.

Conclusion: As a result, alveolar-arterial oxygen gradient increased in patients who had acute carbonmonoxide intoxication. While measured values were compared, the alveolar-arterial oxygen gradient measurement calculated of blood gas, was significantly higher from alveolar-arterial oxygen gradient that should based on age measurement.

Keywords: carbonmonoxide, carboxyhemoglobin, intoxication, gradient, oxygen

SS-033 Toxicology

Rhabdomyolysis Associated With Opiate Abuse: A Case Report

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RHABDOMYOLYSIS ASSOCIATED WITH OPIATE ABUSE: A CASE REPORT

A 21-year-old man was presented with unconsciousness to the emergency department. He was a night watchman and he was found by his friends in the morning at work lying on the ground. On clinical examination, clinical examination revealed a tachycardia of 124 bpm, and a blood pressure of 90/60mmHg. Initially in his complete blood count white blood cell count was $24.9 \times 10^9 /L$, hemoglobin was 14.3 g/dl and arterial blood gas analysis revealed a mixed metabolic and respiratory acidosis ($pH = 7.23$, $PCO_2 = 50$ mmHg, $HCO_3 = 20.1$ mm). His biochemical data are summarized in table 1. The multi-drug test performed for toxicology was positive for opiate. In a few hours of treatment in emergency department, he became awake and his physical examination revealed nothing abnormal except a slight power loss on left leg. Brain CT and diffusion MRI performed to determine the cause of unconsciousness were all normal. Owing to power loss noted in his left leg in neurological examination, vertebral CT and pelvic and left femur direct graphs were performed which were also normal. In soft tissue ultrasound examination of left femur, minimal fluid accumulation compatible with a hematoma was observed and this was followed up by orthopedists without any treatment. Although his electrocardiography was normal, his cardiac markers (Troponin I, CK, CK-MB) were high at admission and follow up. He was diagnosed with rhabdomyolysis and crush fluid was started to him. On the 6th day of his follow-up, he was transferred to nephrology ward with the diagnosis of rhabdomyolysis and accompanying focal segmental glomerulosclerosis. Rhabdomyolysis is a known but rare complication of intravenous opiate abuse (2). Dehydration, vascular insufficiency, muscle compression, vasoconstriction, shock, trauma, seizure, acidosis, and a direct toxic effect may be the causes of opiate associated rhabdomyolysis (3). Since rhabdomyolysis may be life-threatening and prompt diagnosis and treatment is essential, physicians should be aware of this complication among opioid addicts.

Keywords: Rhabdomyolysis, Opiate, Abuse

SS-034 Toxicology

Honey Sweet Poison: Mad Honey

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Introduction: Mad honey intoxication is seen after ingestion of the honey containing granayatoxin produced from Rhododendron flowers. Consumption of this honey leads to dose related symptoms such as mild gastrointestinal system irritation findings, life-threatening bradyarrhythmias and hypotension.

Case: In this case series reports, 6 cases of mad honey consumption who presented to our emergency medicine service with symptoms of fatigue, nausea and dizziness. Diagnosis was made according to history, physical examination and electrocardiogram (ECG) on which bradycardia was present.

All of these cases showed up with a consumption of honey from a variety of regions, before six hours of the entrance. Of these 6 patients, three were male, three were female. Male patients had no specific medical history. At the first assessment, complete blood test, biochemical analysis were asked and the vital findings examined. Bradycardia and hypotension were found in all of the patients. All of the blood tests were between the normal ranges. Patients were monitored. Five of the six patients received treatment with sympathomimetic agents. 10 minutes after the treatment, blood pressure and pulse rate increased immediately.

After the 12 hours of observation time, all of the patients were discharged from the emergency medicine service.

Result: Every patient who present to emergency services with symptoms of fatigue, nausea and dizziness and has bradycardia on ECG must be questioned about mad honey consumption.

Keywords: Bradycardia, grayanotoxin, mad honey poisoning

SS-035 Toxicology

Mad Honey Intoxication: With special emphasis on its effects on vital signs; a study on 13 patients

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Objective: This study was designed to analyze the characteristics of adult patients with mad honey intoxication, with special emphasis on its effects on vital signs.

Materials-Methods: Patients admitted to the Emergency Department of urban hospital in the Black Sea region of Turkey over the 2 months study period due to mad honey intoxication were included. Patients' demographic and clinical characteristics, including age, sex, systolic and diastolic blood pressure, rhythm at electrocardiogram, heart rate, blood glucose levels and clinical outcomes were recorded and analyzed.

Results: Thirteen patients with a presumptive diagnosis of mad honey intoxication were recruited. Mean age was 54.07. Systolic blood pressure (SBP) was low in 12 patients (92%) and normal in one (8%). Diastolic blood pressure (DBP) was low in 11 cases (84.6%) and normal in four (15.4%). Blood glucose level was normal in 8 cases (61.5%) and low in 5 (38.5%). The number of pulse rate per minute was low in (< 60 beats/min) 12 patients (92%) and normal in one (8%). The most common symptom were nausea, vomiting and dizziness.

Conclusion: Mad honey was found hypotension, bradycardia and related clinical consequences are commonly encountered in patients diagnosed with mad honey or grayanotoxin poisoning.

Keywords: Poisoning, grayanotoxin, mad honey



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SS-036 Toxicology

Comparison of Carbon Monoxide Poisonings Originated from Coal Stove and Natural Gas and the effect of Neutrophil/Lymphocyte Ratio on Prognosis in Carbon Monoxide Poisonings

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Objective: Carbon monoxide (CO) poisoning is the most commonly met poisoning type in daily life and is located in front row of the poisonings among the suicide attempt and accidental poisonings ended with mortality. The aim of our study is to present the epidemiologic, clinical, laboratory and prognosis differences between the coal stove origin poisoning which is the most common cause of CO poisoning in our country and natural gas leakages. We also aimed to investigate relationship between the severity of clinical picture, prognosis, complications develop in CO poisoning with neutrophil/lymphocyte ratio (NLO) at the initial admission.

Materials-Methods: All the acute carbon monoxide cases who applied to Ankara Training and Research Hospital Emergency Medicine Clinic between October 2009 and April 2010 were included to this prospective study. CO poisoning diagnosis was made by the history of CO poisoning with carboxyl hemoglobin (COHb) concentration is over 10%. 100 patients were included to our study.

Results: 36 patients were males (36%) and 64 were females (64%). Mean age was detected as 33.94 ± 14.07 years. Only 1 (1%) patient was poisoned for suicide except accidental causes. While 55 patients (55%) were poisoned with coal stove, 45 patients (45%) were poisoned with natural gas origin. While 77 patients (77%) were treated with normobaric oxygen (NO), 23 patients (23%) had the indication of hyperbaric oxygen (HBO) treatment. 4 patients (4%) had the need of intubation and mechanic ventilation. 1 (1%) patient has died. There wasn't any difference between the groups that poisoned from coal stove and natural gas for age and gender ($p=0.491$, $p=0.738$). While 17 patients (73.9%) had the need of HBO treatment in the group of natural gas poisoning, in coal stove poisoning group only 6 patients (26.1%) had the need of HBO treatment. The need of HBO treatment was significantly higher in the natural gas poisoning group than the coal stove poisoning group ($p=0.001$). While the mean COHb level of the group poisoned from natural gas was 31.7%, it is 26.1% in the group poisoned from coal stove and it is significantly higher in natural gas group ($p=0.01$). There isn't a significant relationship between NLO with COHb ratio, Glaskow coma score, troponin and CK-MB levels statistically (respectively; $p=0.87$, $p=0.89$, $p=0.47$, $p=0.53$).

Conclusion: Natural gas originated poisoning can be more toxic than the coal stove poisoning. There isn't any relationship between the severity of clinical picture, prognosis and complications in CO poisoning with the NLO during admission.

Keywords: Carbon Monoxide Poisonings, Coal Stove, Natural Gas, Neutrophil/lymphocyte ratio

SS-037 Toxicology

Poly (ADP-ribose) polymerase inhibition Against the Paraquat Induced Lung Injury in Rats

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Objective: Paraquat (PQ) is a herbicide agent used to kill weeds worldwide, and exposure to PQ at toxic doses may cause fatal acute lung injury. It has been shown that inhibition of poly (ADP-ribose) polymerase (PARP) enzyme alleviates inflammation and necrosis in various pathologies. In this study, we aimed to evaluate effects of PARP inhibition on PQ-induced lung damage in an experimental rat model

Materials-Methods: Sprague-Dawley rats ($n=24$) were involved in three groups: sham, PQ and PQ+3-aminobenzamide (3-AB) groups. 15 mg/kg PQ was administered intraperitoneally in PQ and PQ+3-AB groups to induce experimental lung injury. One hour after PQ treatment, PQ+3-AB group was administered a single dose of 3-AB (20 mg/kg/day) by intraperitoneal route for four consecutive days. The animals were sacrificed at 5th day after PQ administration. For histological and biochemical parameters, lung tissue and blood samples were collected and stored until analysis.

Results: Serum lactate dehydrogenase (LDH) and neopterin levels, tissue oxidative stress parameters, TGF-beta levels and histological injury scores in PQ+3-AB group were significantly detected as lower than PQ group ($P<0.05$, PQ vs. PQ+3-AB). Total antioxidant capacity in PQ+3-AB group was significantly higher than PQ group ($P<0.05$, PQ+3-AB vs. PQ).

Conclusion: Findings obtained from this study suggest that use of PARP inhibitors in PQ toxicity may be useful for prevention of mortal lung injury.

Keywords: Paraquat toxicity, Lung injury, PARP inhibition, Neopterin, Oxidative stress

SS-038 Toxicology

The diagnostic value of serum copeptin levels in carbon monoxide poisoning

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Objective: Carbon monoxide (CO) is a colorless, odorless, tasteless and nonirritating gas produced by incomplete consumption of organic substances. CO toxicity can cause cerebral, cardiac and general ischemia. Diagnosis is done according to blood carboxyhemoglobin (COHb) levels. To determine the clinical results of toxicity previously, biochemical markers except COHb are studied on.

Copeptin is secreted simultaneously with vasopressin from posterior hypophysis and reflects the vasopressin level at circulation. Copeptin is more stable at plasma and serum than vasopressin. Our aim at this study is to search copeptin levels at diagnosis and treatment of patients presented with carbon monoxide toxicity.

Materials-Methods: It is a prospective and controlled study done at Kecioren Training and Research Hospital between November 2012 and April 2013. 51 patients; admitted to emergency department and diagnosed as carbon monoxide toxicity, included to study group. Control group formed by 48 healthy volunteers at similar ages and gender.

For copeptin levels; blood samples taken at patient application and at 4th hour of follow up, and after centrifuge they preserved at -80 degree Celsius. At the end of research blood samples studied with copeptin kits and manual Elisa immunoassay method. Results analyzed by using SPSS 15.0. $p<0.05$ considered as significant.

Results: 51 patients included to study and 23 of them were male (%45.1) and their average age was 41.41±17.69. for carbon monoxide toxicity most important source was natural gas (%39.2). Most common reasons for admission were headache ($n:41$) and nausea ($n:32$). Average COHb levels at application and 4th hour were 30.11±6.71 and 7.46±3.22 respectively. 43 of cases take normobaric, 8 of them take hyperbaric oxygen treatment.

Average copeptin level of study group at 0th hour was 0.85±0.86 and with treatment 4th hour copeptin level average was 0.45±0.218. Decrease at copeptin levels between 0th and 4th hour was statistically significant ($p<0.001$). Average copeptin level of control group was 0.33±0.14 and it was statistically significantly lower when compared to 0th hour level of study group ($p<0.001$).

Cutoff value of copeptin is determined as 0.375 at the study. According to ROC curve drawn, AUC value was 0.148. Sensitivity, specificity, positive predictive value and negative predictive value, calculated for copeptin levels of patients admitted to emergency department and diagnosed carbon monoxide toxicity; determined as %78.4, %60.4, %67.8, %72.5 respectively.

Conclusion: In our study, it seem that compared to control group, blood copeptin levels significantly increased at patients admitted to emergency department with carbon monoxide

Keywords: carbon monoxide, copeptin, emergency department, poisoning

SÖZLÜ BİLDİRİLER

SS-039 Toxicology

Melena Associated With The Ganoderma Lucidum: A Case Report

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Konya Eğitim Araştırma Hastanesi Konya/Meram

Melena is a life-threatening complaint of patients admitting emergency department. The most common cause of the melena is the peptic ulcer which is followed by anticoagulant drug overdose, tumors of upper gastrointestinal system, esophageal varices and Mallory-Weiss syndrome (1). Herein we will present a Ganoderma Lucidum induced melena in a young man who did not have any symptoms of gastrointestinal disease before. A 33-year-old man admitted to the emergency department with a complaint of melena. He had complained of upper abdominal pain usually lasting for several minutes for 2 days. He did not have dyspepsia, stomach ache or melena before. In his history, any systemic diseases was not present and he was a non-smoker. However, he was obese and taking an herbal drug (Ganoexcel-Ganoderma Lucidum-Reishi) for 3 weeks in order to lose weight. Other than this drug, he was not taking any medications. His vital signs were stable upon admission: blood pressure was 110/80 mmHg with a heart rate of 98 beats/min.. The patient was transfused two units of blood, and he underwent endoscopy of the upper gastrointestinal tract. In upper gastrointestinal endoscopic evaluation there were 2 ulcers of 1 cm in diameter on hyperemic bulbus. Active bleeding was not present on those ulcers. Ganoderma is a family of mushrooms that grow on wood in tropical regions and they are used for a variety of beneficial therapeutic effects including anticancer effects, immunoregulatory effects, antioxidant activities, antibacterial effects and reducing blood cholesterol (2,3). Although that mushroom has been suggested to cause platelet inhibition and to have other antithrombotic and fibrinolytic activity; in a prospective, randomized study it was shown not to cause any impairment of hemostatic function in healthy volunteers (4). Some toxic effects of G. lucidum has been reported before (5) but to the best of our knowledge this is the first case report of an upper gastrointestinal bleeding associated with G. lucidum

Keywords: Melena, Ganoderma Lucidum, Reishi

SS-040 Toxicology

Retrospective analysis of cases with high paracetamol levels

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Objective: Paracetamol is one of the drugs used as analgesic and antipyretic all over the world. Although it is a safe drug when used at appropriate dose, toxicity signs may be seen in case of overdose. We retrospectively evaluated the cases whose blood paracetamol levels were measured high during a period of 24-months in the emergency department. Our aim was to investigate the difference between the patients who ingested paracetamol as single drug or concomitantly with other drugs according to laboratory parameters and clinical outcomes.

Materials-Methods: We included 471 patients over 15-year year of age whose paracetamol blood levels were obtained in emergency department in a 24-months period between January 1, 2011 and December 31, 2013. These 471 cases, who admitted as drug intoxication, were divided into 3 groups according to Modified Rumack-Matthew nomogram and single and multiple drug ingestion. The alanine aminotransferase (ALT), aspartate aminotransferase (AST), platelet, INR values of all patients at admission and at 12 hours later were retrospectively obtained. The groups were compared on the basis of discharge and hospitalization rate and mortality.

Results: 57% of cases was male (n = 273) and remaining 43% was female (n = 198), and it was statistically different when groups was compared for gender. Blood paracetamol level was toxic in 82 patients (Group 1). It was detected that there was a total of 264 patients who ingested paracetamol but not toxic (Group 2). The number of patients whose blood paracetamol level was not toxic and who ingested additional drug with paracetamol was 125 (Group 3). When the blood assays on admission and 12. hour were compared, significant differences was observed among patients in Group 1. Blood levels of ALT, AST, Platelet and INR were not significantly different in other groups.

Conclusion: Measurement of drug blood level in patients with suspicion of paracetamol intoxication is paramount in rapid confirmation of the diagnosis as well as determining ingested dose of drug and guiding therapy. This decreases length of stay in hospital, unnecessary N-acetyl-cysteine administration and costs.

Keywords: acetaminophen, intoxication, overdose, paracetamol

SS-041 Toxicology

Suicide attempt with methylphenidate

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Objective: Acting as a central nervous system stimulant, methylphenidate(MPH) is the most commonly used drug to treat attention deficit hyperactivity disorder(ADHD). As the use of MPH for the treatment of ADHD in children and adolescents is increasing, the risk of unintentional overdoses and intentional overdoses caused by abuse, misuse or suicide attempts increases as well. However, evidence about the frequency, risks, reasons, and outcomes of MPH overdoses is limited. In USA it is shown that in children, single exposures up to 80-mg MPH are well tolerated. Information about the effects of extremely high doses of MPH in humans is scarce. In this case we present a 17-year-old girl who had a suicide attempt with the ingestion of 30 tablets of 36-mg methylphenidate(Concerta®), 20 tablets of 20-mg fluoxetine(Prozac®) and 10 tablets of 50-mg Sertraline(Lustral®).

Case: A 17-year-old girl was presented to our emergency department about 5h after suicide attempt. Her history revealed that two months ago these drugs was given because of ADHD, but she took them only for ten days, than she gave up. After admission to the hospital, vital signs showed a tachycardia of 120/m, blood pressure 130/80 mmHg, slightly elevated body temperature and oxygen saturation 98%. Her physical and neurologic examination was normal except focal neurologic seizures on right hand. Gastric lavage was made with the use of 2000 cc 0.9% NaCl and after than, 50 gr charcoal was given via nasogastric way. For focal neurologic seizure, benzodiazepine used. Psychiatric consultation revealed depressed mood and normal insight. We called intoxication center to inform them about the patient. They informed us about the side effects and didn't recommend intensive care at that time. Laboratory results showed normal values for blood cells, hepatic renal and coagulation parameters, and reduced PCO2 in blood gas analysis. Six hours after the ingestion of the tablets, first blood sample for MPH was taken to the EDTA tube and kept at +4 °C over night in the refrigerator. Second blood sample was taken at 17th hour. The serum concentrations of MPH were 65.84ng/ml and 8.73ng/ml respectively. She followed up 36h and discharged from emergency department without any complication.

Conclusion: Despite toxic exposure, our patient resulted with a good clinical outcome and full recovery. Careful observation of possible complications and administration of charcoal were the only treatment. This case suggests that patients intoxicated with high-dose, long-acting MPH can recover without sequelae when managed properly.

Keywords: Methylphenidate, suicide, attention deficit hyperactivity disorder

SS-042 Cardiovascular Emergencies

Association between clinical symptoms and coronary vessels involvement in patients presenting with acute coronary syndrome

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Objective: It is estimated that more than 16 million Americans have coronary artery disease and 8 million have had a myocardial infarction. On the basis of experiences of the cardiologist there can be an association between chief complaints and type of involvement in the coronary vessels. We aimed to evaluate if there is an association between clinical manifestations and type of involvement in the coronary vessels

Material-Methods: In an analyzed descriptive cross sectional study, we studied 720 patients who were admitted with acute coronary syndrome diagnosis and had gone under treatment in Shahid Madani hospital of Tabriz city in Iran between August 2011 and March 2012. Statistical analysis was performed by SPSS software package version 16.0 for windows. P value less than 0.05 was statistically considered significant in all steps.

Results: After diagnosis by coronary angiography, patients were categorized in 4 groups on the basis of the involvement. 289(40.1%) were diagnosed with Single Vessel Disease (SVD)



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while this rate was 201(27.9%) for Two Vessel Disease (TVD), 227(31.5%) for Three Vessel Disease (ThVD) and 18(2.5%) for LM. LAD was involved in 416 (57.8%) patients, while rate of involvement for LCX, RCA, D1, D2, OM1, OM2 and PDA was 142(19.7%), 208(28.9%), 60(8.3%), 8(1.1%), 73(10.1%), 17(2.4%) and 21(2.9%), respectively.

Conclusion: Within symptomatic findings, LAD is the most involved vessel that is presented with different manifestations. Pain progression to tooth was seen only in RCA involvement but it is not reliable finding in our study due to limited cases of patients with pain in tooth and need a survey with more cases.

Within pathology findings, Retro-sternal pain was the most prevalent symptom in all of the involvements and the absence symptom in common with all involvements was tooth pain.

Keywords: Artery, Coronary Artery Disease, Angiography

SS-043 Cardiovascular Emergencies

Impact of genetic polymorphisms and haematological factors on acetylsalicylic acid and clopidogrel response variability in patients presenting with acute coronary syndrome

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Objectives: We sought to investigate whether genetic polymorphisms and haematological factors influence acetylsalicylic acid and clopidogrel response variability in patients presenting with acute coronary syndrome (UAP, NSTEMI, STEMI).

Methods: We analyzed the data of 166 patients presenting with acute coronary syndrome who had undergone coronary angioplasty. Acetylsalicylic acid resistance was measured with VerifyNow Aspirin Test assay and clopidogrel resistance was measured with VerifyNow PRU Test assay after dual administration of 300 mg of acetylsalicylic acid and 300 - 600 mg of clopidogrel loading dose within the last 24 hours. VerifyNow Aspirin Test results were expressed in Aspirin Reaction Units (ARU) and PRU Test results were expressed in P2Y12 Reaction Units (PRU). ARU $\geq$ 550 and PRU $\geq$ 230 were defined as cut-off levels in determining acetylsalicylic acid or clopidogrel resistance, respectively. Clinical data included assessments of genetic polymorphisms (angiotensin converting enzyme - ACE, Factor II, Factor V and methylenetetrahydrofolate reductase) and haematological factors (thrombin activatable fibrinolysis inhibitor - TAFI, von Willebrand Factor antigen - vWF:Ag, Factor VIII, protein S, protein C and antithrombin 3 - AT 3).

Results: A total of 166 patients constituted the study population (126 men, 75.9% and mean age was 64 ± 13 years). Of them, 42 (25.3%) were acetylsalicylic acid resistant and 49 (29.5%) were clopidogrel resistant. In multivariate regression analysis, ACE D/D polymorphism ($\beta = 0.141$, $p = 0.044$), TAFI levels ($\beta = 0.343$, $p < 0.001$) and vWF:Ag levels ($\beta = 0.216$, $p = 0.002$) were found as independent variables, which had statistically significant effects on clopidogrel resistance, and these effects were more pronounced in STEMI patients. In ROC curve analysis of STEMI patients, TAFI level ≥ 136 iu/dL measured had a 78% sensitivity and 95% specificity (area under curve, 0.876; 95% confidence interval, 0.766-0.987; $p < 0.001$), vWF:Ag level ≥ 122.5 iu/dL measured had a 65% sensitivity and 95% specificity (area under curve, 0.829; 95% confidence interval 0.704 - 0.954; $P < 0.001$) in predicting clopidogrel resistance.

Conclusions: Angiotensin converting enzyme gene D/D polymorphism was associated with clopidogrel resistance in acute coronary syndrome patients undergoing angioplasty. Despite normal values, vWF:Ag and TAFI plasma levels were significantly higher in clopidogrel resistant patients. These results add evidences for possible associations between ACE D/D polymorphism, TAFI levels, vWF:Ag levels and clopidogrel resistance. Therefore ACE D/D polymorphism, TAFI and vWF:Ag levels may be useful markers in predicting high loading dose clopidogrel resistance in acute coronary syndromes, particularly in STEMI patients.

Keywords: genetic, haematological factors, acetylsalicylic acid and clopidogrel response, acute coronary syndrome

SS-044 Cardiovascular Emergencies

An alternative medical application for phlebotomy: Bloodletting by cupping

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Objective: In present study Bloodletting by cupping was discussed as an alternative medical application for phlebotomy.

Case: A-32 year-old female admitted to our ED with palpitation, weakness, shorth breathing and chest pain. On admission blood pressure was 130/70 mmHg, respiration rate 17 beath/min, oxygen saturation %95, and pulse was 170/min. In physical examination she was tachypnea. Smooth bordered scar lesions was detected at bilateral of thoracic vertebra. Rectal examination was normal. She had 3/6 degree systolic ejection blowing. Chest pain was as widespread and was felled as pressure. The pain did not spread to arms and shoulder. In her history, she had weakness that increased with physical activities. She was followed due to multiple sclerosis for four years. The patient admitted to ED due to increased weakness and palpitation and shorth breathing that occurred new. When we asked the history deeply, she did the bloodletting by cupping per a month for two years. She had no cardiac diseases history. Melana and hematemesis were not noticed. A supraventricular tachycardia (170 /min) was detected in electrocardiography (ECG). The laboratory Results: Hg 5.7 g/dL, Hct %19.7, MCV 59.9 fL, RDW 22.4 fL, AST 75 U/L, ALT 42 U/L. Other parameters were normal. Anemia was thought to be become due to bloodletting by cupping. The patient was given two unite erythrocyte suspension. Control Hb was Hb 9 g/dL. Normal sinus rithm was obtained in ECG after erythrocyte transfusion. The patient was warned to avoid a new bloodletting by cupping and was discharged.

Conclusion: Bloodletting by cupping is not an innocent alternative medical application for phlebotomy if it is applied for a long time and applied by inexperienced person.

Keywords: Bloodletting by cupping, alternative medical application, phlebotomy

SS-045 Cardiovascular Emergencies

Evaluation of the current prognostic role of mean platelet volume in the history of patients with syncope

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Objective: Syncope is 1-2% of emergency department incomes and 6% of hospitalizations. Despite the fact that all examinations are done, still 40% of syncope's etiology is unclear. In our study, our aim was to investigate the relationship between the mean platelet volume and the diagnosis of syncope to clarify the approach of syncope in the future.

Materials-Methods: The survey has been conducted and the data were collected retrospectively between October 1, 2011 and June 30, 2012 within the 591 syncope patients and 523 trauma patients as control group. In addition to the base study, age, gender, requested examinations, consultations and hospitalization or outcoming of patients were included. Data were analysed in SPSS 19.0 version.

Results: When syncope and control groups were compared, mean platelet volume values were significantly higher in syncope group ($p < 0.05$). Platelet values were not significantly changing according to hematocrit values between the patients and control group ($p > 0.05$).

The hospitalized patients' MPV values have not significant differences ($p < 0.05$)

Older patients have more hospitalization indications. The patients' hematocrit values who were hospitalized in the Department of Internal Diseases, were lower. Syncope could be seen in any age groups and there is no differences of prevalence between genders.

Conclusion: As a result, MPV is a parameter for the diagnosis of syncope

Keywords: Syncope, mean platelet volume, emergency



SÖZLÜ BİLDİRİLER

SS-046 Cardiovascular Emergencies

Cerebro vascular disease patients who were followed as a result of the femoral embolism cases presenting to the emergency department, interesting cases

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Objective: cerebrovascular disease, side findings in patients with sudden onset of leg pain acute arterial embolism to be due to a rare condition, wherein us to the emergency room leg pain of a patient examinations and tests as a result of acute arterial embolism diagnosis to receive the share found it appropriate to

Case: 74 year old female patient to the emergency department with sudden onset of leg pain was admitted with complaints CVA and left hemiparesis due to patients who were followed to the emergency department were admitted with motor loss in the left leg. clear awareness of the overall situation in the middle of the examination arrhythmic pulse, there was loss of sensation in the left leg. hayip engine 4/5, respectively. pulse on the left side of the pulse examination was being taken. resume operations in the same vein from the leg had previously learned that the patient was taken to the emergency arterial doppler ultrasonography. From the femoral artery doppler ultrasound on acute thrombus iela not compatible with vascular surgery was consulted. in terms of arrhythmic pulse echo cardiology patients who were consulted were taken. echo left ventricular thrombus was present. DSA peripheral vascular surgery at the retreat was hospitalized for surgery done. Followed by cerebrovascular disease in patients with evidence of side stream slowdowns in patients with intravascular thrombus formation should be kept in mind that

Conclusion: In 25-50% of patients with PAD Cerebrovascular disease are accompanied. Coronary artery disease or cerebrovascular disease with PAH are in 40% of patients. Cerebral vascular disease, diagnosis - treatment and care Finn opposed to the principle of progress in the major health problem occurs as is. Particularly hypertension, diabetes mellitus, hypercholesterolemia, heart diseases, especially Located in the atherosclerotic disease process and cardioembolic reasons, cerebrovascular diseases is responsible for the formation of large portions. brain the more rare causes of vascular disease between arterial dissection, fibromuscular dysplasia, vasculitis, migrainous infarcts, Moyamoya paraneoplastic include disease and stroke.

Keywords: embolism, emergency department, cerebrovascular disease

SS-047 Cardiovascular Emergencies

Embolism and Aortic Dissection After Falling

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Objective: Aortic syndrome Located between the aortic dissection happens by forcing intima, entering the medial layer of blood adventitial and separating the intimal layers. As there may be ischemic organ findings depending on aortic dissection and at most of the events physical examine findings are normal it is getting harder to diagnosis. Anamnesis, physical examination and inspection can direct the doctor to diagnosis. In high-energy traumas major vascular injury and fat embolism may occur. The actual incidence of aortic injury connected to blunt trauma is not known. Posttraumatic fat embolism may usually occur as a result of long bone fractures. Also in thoracic trauma without rib fractures, fat embolisms have been reported.

Case: A 43 years old male patient who fell on his face from a height about 3 meters was brought by the 112 to the emergency department. He was conscious, oriented and cooperated. Blood pressure and pulse were respectively 120/80 mmHg and 86/minute. Hgb: 13.7 gr/dl, hct: 40.9%, AST: 46.9 U/L, ALT: 45.9 U/L, erythrocyte was 145/HPF in urine. The patient had no motor or sensory deficits but from X-Ray and maxillofacial tomography we saw fractures on nasal bone, orbitolateral right wall of the frontal bone, sphenoid bone and maxillae. The abdominal of the patient was good, there was no defense and rebound but there was ecchymosis on the umbilicus. On the contrast-enhanced computed tomography compatible with Stanford type B aortic dissection, undescending aorta proximal part there was a segmental intimal flap which is 2 cm tall. After 48 hours follow, in control thorax tomography embolism was detected in the patient's left main pulmonary artery. The patient was referred to another hospital for surgery.

Conclusion: Despite the developments in the medical and surgical techniques of aortic dissection, the risk of mortality still remains important. Detection of vascular injury may occur after trauma, will reduce the rate of mortality connected with aortic dissection. In high-energy traumas without long bone fractures in patients typically within 24-72 hours should be remembered possibility of development of fat embolism. During the initial assessment of trauma patients in the emergency department physicians should be skeptical in terms of aortic dissection. Early diagnosis ensures success in the surgical treatment of patients.

Keywords: trauma, aortic dissection, pulmonary emboli

SS-048 Cardiovascular Emergencies

Aortic dissection presenting with neurological deficit

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Objective: Aortic dissection is an emergency which has the high risk in death. It requires emergent detection and treatment. It occurs with different symptoms according to dissected aortic segment. A complete anamnesis and a physical examiner have to direct it towards the exact detection. Here it was presented an aortic dissection case consulted for the ailment in left leg which cannot stand.

Case: 59-year-old patient is presenting with the ailments of chest pain, backache, incapability in left leg. There is an obstructive lung disease in the story. In physical search lesions, left femoral pulse and distal could not be pulped. There was 3/5 motor impulse in patient's left lower extremity. Blood pressure was 110/70 mmHg in right arm and 70/50 mmHg in left arm. In the imaging on the predetection in aortic dissection, type 1 dissection was detected. The patient was transferred to the cardiovascular surgery clinic.

Conclusion: As a presenting manifestation of aortic dissection, neurologic complications such as neurological deficit are rare. However in patients with neurological deficits be kept in mind of aortic dissection can be lifesaving.

Keywords: Aortic dissection, neurological deficit, chest pain

SS-049 Cardiovascular Emergencies

Brugada type ECG pattern induced by electrolyte disorder: a transient horrifying sign

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Objective: Brugada syndrome (BS) is an important cause of sudden cardiac death (SCD) in young adults and has well defined ST elevation patterns on right precordial leads. Observation of these patterns without distinct clinical findings is called Brugada type ECG pattern (BTEP). Herein we report a case with electrolyte disorder demonstrating a transient BTEP.

Case: A 61 year old male patient admitted to our emergency department with complaints of lethargy and altered level of consciousness. His Glasgow Coma Scale (GCS) was 13. In physical examination there were no remarkable findings apart from an obvious distended bladder. The patient and his family did not define any history of previous heart/cerebrovascular disease, seizures, syncopal episodes or family history of SCD. He had an history of prostate laser surgery because of benign prostate hyperplasia 1 week ago. On his initial ECG, rhythm was sinus with a 1st degree AV block (PR interval: 230 ms). In V1, a coved type ST elevation of Brugada Type I pattern with a 6 mm J point elevation from baseline was observed. In V2, there was a typical saddleback type ST elevation of Brugada Type 2 pattern with a J point elevation of 5 mm. His initial blood tests was as follows: Blood Urea Nitrogen: 88 mg/dl, Creatinine: 7.7 mg/dl, K: 7.1 mmol/L, Na: 124 mmol/L, Glucose: 240 mg/dl, pH: 7.4. His urine analyses was negative for ketone. Urinary Foley catheter was applied and a urine output of 4800 ml was seen in 6 hours. Troponin values were stable. No diffusion restriction was detected on cranial magnetic resonance imaging.

Acute post renal failure was diagnosed and dextrose/insulin (1/5) infusion was started together with inhaled salbutamol and IV fluid (0.9% normal saline) infusion. After Na and K values were normalized in 6 hours, previously observed BTEPs completely resolved to an incomplete right bundle branch block pattern, PR interval normalized to 180 ms and his GCS developed to 15. No ventricular/atrial arrhythmias were observed in the follow-up.

Conclusion: Electrolyte disturbances are one of the factors causing BTEP on ECG because of a transient functional impairment on Na and K channels taking part in the phase I of action potential. This important phenomenon should always be kept in mind in the management of patients with BTEP and should carefully be ruled out before making a diagnosis of BS in order to prevent patients from further inappropriate tests and treatments.

Keywords: Acute renal failure, Brugada type ECG pattern, Brugada Syndrome, Hyperkalemia, Hyponatremia



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SS-050 Trauma Emergencies

Survivorship & outcome of patients with intertrochantric fracture of femur –A prospective study with six month follow up

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Objective: Intertrochantric fracture of femur is one of the common injuries in the geriatric population. Despite improvements in management of these patients, mortality rate is more than expected rate and the patients recovery and regaining the previous level of function fall short of expectation. In this prospective study, we tried to evaluate the mortality rate, locomotion of patients with intertrochantric fracture and the relation between the mortality rate and treatment outcome with various factors

Materials-Methods: During five years period study from September 2004, 964 patients with intertrochantric fracture who met the including criteria, had undergone surgery & internal fixation. 124 patients were lost of follow up and finally 840 patients were evaluated.

Results: Among 840 the case study patients with the average age 69 years, 153 out of 840 died within the first six months after surgery (18.1percent). Among 688 patients who were alive at the end of six-month period, only 420 patients (61 percent) could regain the prefracture ability to walk. Among independent Variables there were significant relationships among age, smoking, ASA score, and transfusion during surgery and duration of hospitalization with mortality rate of patient during six months after surgery. As well, age, sex, prefracture ability to walk, time interval between fracture and admission to hospital and transfusion during surgery were significantly associated with the ability to walk after six-month period.

Conclusion: Despite improvements in management of Intertrochantric fractures, mortality rate of these patients is higher than normal population and most of them do not regain the prefracture walking ability. Different factors can affect mortality and outcome of these patients which needs more investigations.

Keywords: Intertrochantric fracture of femur, Survivorship, Outcome, Locomotion

SS-051 Trauma Emergencies

Assessment of Supracondylar humeral fractures in elderly patients with double tension bond wiring method

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Introduction: One of the causes of limitation in range of motion of the elbow joint in old patients is supracondylar humeral fractures. There are some methods for its treatment like ORIF with double plating, ORIF with locking plate and ORIF with pinning & plating, but there is no a standard method in all cases. Due to the rising incidence of osteoporotic fractures from low-energy falls in the elderly, we decided to assay the efficacy of double tension bond wiring in distal humeral fractures.

Methods-Materials: 18 patients over 65 years of age with distal humeral fracture type A2 and C1 (On the basis of OTA classification); treated by double tension bond wiring method had been studied and followed in Shohada hospital since 2008. 12 cases were A2 type and 4 cases were C1 type, also 14 cases were closed fracture and 2 cases were open Fracture Gastilo type 1. Operation with medial & lateral approach is performed; the mean time of operation was 55 minutes. The motion of the joint started after some days after operation, but it was not possible to follow two patients up. In C1 type fracture, Intra articular parts of fracture were fixed by screw. 4 patients were done coronary artery bypass, 4 patients were Diabetic and a patient was diagnosed Chronic Renal Failure.

Results: All of the patients had the radiological union marks after three months. There was not any non union or mal union case. The range of motion after treatment was 100°. All of the patients were able to put their hands on top of their heads. The mean limitation of extension was 30°. Mild bursitis in pins tracts was seen in 5 cases that limited by taking the pins off. There was not any evidence for deeper infections and osteomyelitis. After six months, all of the pins were taken off by local anesthesia. Except one patient, all of the patients were satisfied by the result of the operation.

Conclusion: Although this plan isn't gold standard treatment for distal humeral fracture but, because of short operation time, without special instrumentation, fixation and treatment of it with double tension bond wiring method in old, osteoporotic patients with co- morbidities can be a good treatment method.

Keywords: , Supracondylar fractures, double tension bond wiring, fixation

SS-052 Resuscitation

Evaluation of the cardiopulmonary resuscitation training of sixth year medical students and investigation of its effects on their anxiety levels

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Objective: The aim of this study is to determine the level of knowledge of sixth year medical students on cardiopulmonary resuscitation and to examine its relation with the students' anxiety levels and to evaluate their metacognitive awareness.

Materials-Methods: The students took a four-hour long CPR training, which consisted of a three-hour theoretical class about BLS, ACLS and further airway management, followed by one hour practice, all based on the 2010 AHA/ESC guidelines. Before and after the training they were given a 20 multiple-choice questionnaire to evaluate their level of knowledge about CPR. Therewithal, before and after the training process the students' anxiety levels were scored according to the state and trait anxiety inventory. In addition, the metacognition scale was applied to the participants to be able to evaluate their metacognitive awareness.

The results were saved within the SPSS 15.0 for Windows package programme and statistically analysed.

Results: Having completed the training, a statistically significant increase was determined at the participants' CPR knowledge level test scores ($p < 0.05$). Following the training a significant rise was witnessed among the trait anxiety levels of the students. While the students' CPR test scores show no meaningful differences according to their gender ($p > 0.05$); the level of anxiety was found significantly high in female students ($p < 0.05$). A positive correlation was determined between the students' metacognitive scores and their state anxiety scores together with their trait anxiety scores before and after the training programme ($p < 0.05$). While the students' total metacognition scores exhibit no meaningful differences according to their gender ($p > 0.05$), however, the female students' need to control their thoughts was found significantly higher ($p < 0.05$) than those of the male students.

Conclusion: CPR training should be one of the priorities of the educational programme in the curriculum of medical faculties. We are in the belief that this training ought to be started in the first year and be updated according to the international standards and kept alive by frequent theoretical and practical repetitions. While preparing the training programme it should always be kept in mind that the female students' anxiety level is higher than that of the male students.

Keywords: Cardiopulmonary resuscitation, anxiety level, metacognition

SS-053 Resuscitation

The Importance Of Simulation In Medical Education And Improving The Emergency Team Performance On Cardiopulmonary Resuscitation By Using Simulation Based Education

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Aim: In this study, the importance of simulation in medical education, the simulation based training is able to enhance the team performance on cardiopulmonary resuscitation or not, and the needs to improve the quality of medical education were investigated.

Material-Method: This study was performed between September 2013 and November 2013 in Emergency Department of Gaziantep University Medical Faculty. One hundred and twenty participants from the third class of Medical Faculty were divided into 4 groups and Basic Life Support training was given. Traditional training, simulation based training on simple manikin, simulation based training on high fidelity manikin and self training methods were applied. The check lists were used to evaluate the team performance. Applications were recorded by audio-



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visual camera system. Independent-Samples T test, One-Way Anova, Tukey and Games-Howell for Post Hoc analysis, Paired-Samples T test, Repeated Anova, Mc-Nemar test Monte Carlo simulation technique, and Pearson Chi-Square tests were used. $P < 0.05$ was considered statistically significant.

Findings: There were no significant differences between the groups in age and sex ($p = 0.311$, $p = 0.217$). Knowledge was increased after trainings but no significant differences were detected between groups. This increase in knowledge was not compatible with the increase in the levels of team performance. Simulation based trained groups had significantly better team performances and skill levels than the other groups ($p < 0.001$). There were no significant differences between simple manikin and high fidelity manikin groups on the team performance ($p = 1$). There were no significant differences between traditional training and self training groups on team performance ($p = 1$), but there was a significant difference in skill levels of these groups; the self training group was better than traditional training group ($p = 0.018$). According to the results of the questionnaires self confidence of the participants were elevated after the trainings ($p < 0.001$). The check lists used in team performance evaluations were showing excellent correlation between each other.

Conclusion: Simulation based training improves the team performances, skill levels and the self confidences of the students. Therefore it should be integrated into medical education.

KEY WORDS: Simulation, resuscitation, team performance.

Keywords: Simulation, resuscitation, team performance

SS-054 Resuscitation

Analysis of the consequences of cardiopulmonary resuscitation in an emergency department

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Objective: Cardiopulmonary arrest (CPA), due to any reason, is the event of the sudden and unexpected halt of breathing and / or circulation. The Applications involving the effort to revive a person who his/her life was interrupted in any way is called cardiopulmonary resuscitation (CPR).

To obtain the first epidemiological data of CPA victims in our department in Kayseri Training and Research Hospital and in light this data, to review our current situation and compare our results with generally accepted statistical data.

Materials-Methods: 18 years-old and older CPA victims who were admitted to Kayseri Training and Research Hospital, Department of Emergency Medicine during January 1, 2012 – January, 1, 2013 were included in the study. Patient ages and gender distribution, possible reasons for arrest, the first arrest rhythms, resuscitation results, discharge rates and after 1 year survival rates were retrospectively analyzed and recorded.

Results: A total of 254 CPR because of CPA were included in the study. The mean age of arrest patients enrolled in the study was 66.2 ± 13.9 . In our study, there was no significant difference between genders in terms of CPR results. 1-year survival rates in patients who had CPA were better. The outcome of first rhythms ventricular fibrillation (VF) / pulseless ventricular tachycardia (pVT) for return of spontaneous circulation (ROSC) are significantly better than the other initial rhythms. The discharge rate in patients with the first arrest rhythm of VF was significantly higher compared to other rhythm.

Conclusion: The most common initial arrest rhythm was asystole. The best results in terms of ROSC were belonged to the VF / pVT rhythms. 1-year survival rates in patients who had cardiac arrest were better.

Keywords: Cardiopulmonary Arrest, Cardiopulmonary Resuscitation, Emergency Department, Survival

SS-055 Trauma Emergencies

Significant Relationship Between Blood Alcohol Level and Trauma Mortality and Severity of Traffic Accident Patients

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Aim: we researched significant relationship between blood alcohol level and trauma mortality and severity of road traffic accident patients

Materials-Methods: This study was performed on 720 patients who applied to our ER department from 1 June 2012 to 1 June 2013. Our variables were age, gender, Trauma time, Trauma mechanism, blood pressure, respiratory rate, heart rate, Trauma localization and severity, Glasgow coma scale, Trauma scales and patient recovery process, and blood alcohol levels. We performed study on 360 intoxicated and alcohol free patients at similar characteristics. Data was analysed with SPSS (Statistical Package for Social Sciences) Windows v.19.0 performing Kolmogorov Smirnov, Chi-square, Mann Whitney U test and Kruskal Wallis test. $p < 0.05$ was defined as statistically significant.

Results: In our study our patients mean age was 35.19 ± 13.14 . 80.1% were male and 19.9 were female. No statistically significant data was collected between gender age and alcohol levels ($p > 0.05$). Traumas mostly occur at weekends and at 16:00 o'clock. Intoxicated patients usually met between 00:00-04:00 ($p < 0.05$). In all patient group road traffic accidents were most common Trauma mechanism that intoxicated patients statistically are more prone to ($p < 0.05$). Intoxicated patients are significantly higher to have a Trauma to face and neck region but lower to have to abdomen ($p < 0.05$). but none correlation was exposed between alcohol levels and thorax, skin and extremity Trauma ($p > 0.05$). No statistically relevant data were shown between vital parameters, GCS and RTS between intoxicated and non-intoxicated patients but ISS and TRISS levels were statistically relevant ($p < 0.05$). Administration rates, mortality and hospital stays were not effected ($p < 0.05$).

Conclusion: Ethanol levels affects the Trauma severity on intoxicated road traffic accident victims that was brought to ER. This knowledge may help ER physicians to have clinical decisions.

Keywords: traffic accident, alcohol, mortality

SS-056 Resuscitation

Are YouTube videos accurate and reliable on basic life support and cardiopulmonary resuscitation?

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Objective: The objective of this study is to investigate reliability and accuracy of the information on YouTube videos related to CPR and BLS in accord with 2010 CPR guidelines.

Methods: YouTube was queried using four search terms 'CPR', 'cardiopulmonary resuscitation', 'BLS' and 'basic life support' between 2011-13. Sources which uploaded the videos, the record time, the number of viewers in the study period, inclusion of human or manikins were recorded. The videos were rated if they displayed the correct order of resuscitative efforts in full accord with 2010 CPR guidelines or not.

Results: 209 videos meeting the inclusion criteria after the search in YouTube with four search terms ('CPR', 'cardiopulmonary resuscitation', 'BLS' and 'basic life support') comprised the study sample subjected to the analysis. Mean scores of the videos were 4.65 ± 1.51 . 53.6% ($n = 112$) of the videos were compatible with 2010 guidelines. Videos uploaded by "Guideline bodies" (GB) had a significantly higher compatibility with 2010 CPR guidelines when compared to others ($p = 0.001$). Sources of the videos and date of upload (year) were not shown to have any significant effect on the scores received ($p = 0.622$ and 0.072 , respectively). The videos' number of downloads were significantly higher in the videos compatible with the guidelines ($p = 0.031$).

Conclusion: YouTube videos appear to be reliable on teaching basic life support and cardiopulmonary resuscitation and therefore can be useful in public education.

Keywords: CPR, internet, YouTube, education, BLS

SS-057 Trauma Emergencies

Barotraumatic Orbital Subcutaneous Emphysema After Nose Blowing

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Objective: Orbital subcutaneous emphysema is defined as the abnormal presence of air within the periorbital soft tissue. It occurs generally as a result of blunt or penetrating facial trauma. There are a few spontaneous orbital emphysema cases reported in the literature. Here we are reporting a rare case of barotraumatic orbital subcutaneous emphysema, occurring after forceful



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nose blowing managed conservatively without any complications.

Case: A 33-year-old man presented to the emergency department with a history of progressive right-upper eyelid swelling after nose blowing. He denied any physical trauma to the face or head. Past medical history revealed nothing special and he had no previous facial surgical operations. He was complaining of flu-like symptoms for a few days. On physical examination, the vital signs were normal. There was minimal tenderness localised at the right side of the periorbital region, and at the upper-eyelid. There was ptosis at the effected eyelid. Upper-eyelid palpation revealed fine crepitations. There was minimal bleeding through the right-nostril which had stopped spontaneously during the examination. The left nostril was clear. On ophthalmological examination both the left and right visual acuity were normal. Extraocular movements were also normal bilaterally. Computed tomography scan showed air over the right orbita. There was obvious fracture at the orbital walls. The orbitopalpebral subcutaneous emphysema diagnosed without blunt or penetrating facial trauma. The patient was treated with a 7-day broad-spectrum prophylactic antibiotic, nasal decongestant and non-steroidal anti-inflammatory drug. Icepack application, avoiding of nose blowing or sneezing was also advised. On head and neck surgery follow up visits the patient remained asymptomatic and no complications were observed.

Conclusion: Orbital emphysema is frequent after blunt or penetrating facial and orbital traumas. But rarely as in our case the intraorbital barotrauma can be the sole mechanism. The intraorbital pressure rise can be observed during nose blowing, sneezing, coughing, vomiting, diving or travelling by plane. In our case nose blowing especially by blocking of one nostril probably results in intranasal pressure elevation, and the pressure reflected directly to the orbital wall. Subcutaneous orbital emphysema is a relatively benign condition, that generally results in cosmetic concern in patients for a few days. Conservative treatment is usually the choice of treatment. Emergency physicians must be suspicious about the diagnosis of spontaneous fracture of orbital walls when evaluating the patients with ptosis and upper eyelid swelling without trauma. And ophthalmologic examination and close follow-up of the patients is important to prevent irreversible visual loss.

Keywords: Barotrauma, emphysema, nose blowing

SS-058 Trauma Emergencies

Fracture in Emergency Service Patients

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Objective: In this study we aimed to analyze epidemiological characteristic of patients who was presented to the emergency department (ED) with trauma and fracture.

Materials-Methods: This study was performed with examination the files of patients who admitted to emergency trauma department retrospectively, in a 45-days period between 01.10.2013-14.11.2013 dates. Patients was evaluated according to age, sex, decade, broken bones, anatomic location of the fracture, mechanism of the fracture development and severity. Bone fracture severity was determined by New Turkish Penal Code Bone Fractures Calculation Guide. Body bone fractures were classified as, Mild(1), Moderate(2-3) and Heavy(4-5-6) according to fracture severity. Data were analyzed using the SPSS 16 for Windows in computer programs. All data were expressed as the mean±standard deviation. Comparisons between groups were made using the Chi-square test. Statistical significance was defined as p<0.05.

Results: During the study period, a total of 39,479 patients were admitted to the ED, 9433(23.89%) of them were admitted to the trauma section and 670(7.10%) of the patients had a fracture. 488(72.84%) of the patients were males, 182(27.16%) patients were females and the mean age was 38±2 (min1-max:95). Considering the decade, more fractures 139(%20,74) were seen in the second decade, at least fractures 4(%0,59) were seen in tenth decade and of these results were found to be significantly higher (p<0,05). Considering the mechanisms of fracture, we determined 311(%46,41) of them were caused by fall flat on the ground, and this result was found to be significantly higher (p<0,05). Considering the distribution of broken bones, distal radius fractures were found in 117(17,46%) patients, more fractures 365(54,47%) were localized in upper extremity and these were significantly higher (p<0,05). Considering the degree of fracture, mild degree fractures 334(49,85%) were significantly higher than others (p<0,05).

Conclusion: Trauma patients holds an important place in the ED patients. Nevertheless fractures are common in trauma patients. As showed in this study; fractures are more common in males, and second decade, most of fractures are caused by fall flat on the ground. Most common fractures are distal radius fractures and more localizes in upper extremity. Mild degree fractures are more common type of fractures.

Keywords: Fracture, Emergency, Severity

SS-059 Resuscitation

Complications of Cardiopulmonary Resuscitation in Non-Traumatic Cases and Factors Affecting Complications

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Objective: In this study, bodily injuries which occurred related to chest compression were examined in non-traumatic arrest cases that had been autopsied. This study aimed to evaluate factors that can affect these injuries and whether the injuries which occurred have life-threatening effects.

Material-Method: Study data were collected retrospectively from patient records and autopsy reports of 203 non-traumatic cases within the previous 10 years in our Institution, Injuries related to chest compression during CPR were determined.

Results: The most frequently seen injuries were a single fracture in the left ribs (19.7%) and the least seen were liver and left ventricle injuries (1.0%). As a result of logistic regression analysis, only the duration of CPR was determined to be associated with injuries within the factors of age, gender, forward airway method, duration and place of CPR. Odds ratios were calculated as 2.953 (CI:1.283-6.796) at 30-60 minutes of CPR and 6.117 (GA: 2.270-16.486) at >=60 minutes of CPR compared to <30 mins. The injuries which occurred associated with CPR were such as to be life-threatening in 19.2% (n=39) of cases.

Conclusion: According to the autopsy results of non-traumatic cases, CPR application before hospital and forward airway usage did not increase the risk of injury. These injuries were determined to be life threatening in 19.2% of cases and also age, sex and CPR duration were determined to have an effect on the increase of risk of injury that could be life-threatening.

Keywords: CPR, cardiac massage, compression, complication, injury

SS-060 Trauma Emergencies

Demographic Features Of Civilians Injured By Explosion Of Explosive Materials In Southeastern Anatolia Region

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Introduction-Objective: Explosions are a rare and poorly studied mechanism of injury in peace time. In our country, clinical scoring and triage techniques are generally not used for various work accidents, injuries that resulted from the use of domestic appliances and terrorist attacks. Moreover, uncontrolled and illegal use of explosive materials increases injury and death rates.

Materials-Methods: The aim of our study was to retrospectively analyze the demographic characteristics of 117 injured civilians admitted to Dicle University, Faculty of Medicine, Department of Emergency Medicine, between January 2005 and September 2013 in the Southeastern Anatolia Region of Republic of Turkey. Patients were examined in the Emergency Department. Patients were resuscitated under the guidance of Advanced Trauma Life Support (ATLS) criteria and treated according to the available protocols.

Results: This study included a total of 117 patients (100 males (85.50%) and 17 females (14.50%). In this study, types of explosions responsible for injuries were bombs (29.06%), mines (20.51%), squibs (14.53%), 7.69 dynamite, and other explosive materials (28.31%). Injuries mostly occurred in summer and usually affected young persons and males.

Conclusion: In conclusion, appropriate triage, prompt treatment and a multidisciplinary approach play a key role in the adequate management of explosion-induced personal injuries. Furthermore, they will help to reduce the loss of workforce. More comprehensive studies are needed in this field to guide clinicians in the management of such injuries.

Keywords: Explosion-induced injury, preventive measures, explosive materials, demographic factors



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SS-061 Trauma Emergencies

Bilateral Traumatic Olecranon Fracture After Stab Attack

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Objective: Although olecranon fracture is frequent condition, bilateral olecranon fracture is rare in patients who don't have underlying disease. In this case we mentioned a 18 years old patient who did not have any underlying disease and had bilateral olecranon fracture after a stab attack.

Case: 18 years old man applied to emergency room because of bilateral incision in his elbows after a stab attack. His general condition was good. He was conscious, cooperated and oriented. He had 6 cm incision in his right elbow and 4 cm incision in his left elbow. There was no other injury in his body. We learned from his history that he was attacked with a big sharp object and injured while he was trying to protect his face. There was no chronic disease or drug use in his medical history. In physical examination; his vital signs were in the normal range. In his right elbow there was a 6 cm transverse incision. In the examination of incision area fracture line was palpated. There was no neurological deficit and peripheric pulses were palpable. Motion of right elbow joint was limited and painful. In his left elbow there was a 4 cm transverse incision. There was no neurological deficit and peripheric pulses were palpable. The motion of left elbow joint was limited and painful. The evaluation of other systems was normal. The x-ray of bilateral elbows were seen. There was bilateral olecranon fracture in the x-ray. The patient consulted orthopedics and plastic surgery. He was operated by orthopedics. Bilateral open reduction and internal fixation with tension band was used by the orthopedics in treatment.

Conclusion: Unilateral olecranon fracture after trauma is not a rare condition. Bilateral olecranon fracture may be seen in elderly patients and patients who have underlying disease which effects bone metabolism. Direct or indirect trauma can cause olecranon fracture. Most frequent indirect trauma mechanism for olecranon fracture is falling down while elbow is in extension and hands are open. Muscles, tendons and vessels are frequently injured in the stab attack to extremities. Bones are rarely injured in stab attack according to severity of trauma.

Keywords: stab attack, olecranon fracture, bilateral

SS-062 Cardiovascular Emergencies

Acute pancreatitis mimicking acute coronary syndrome

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Objective: Acute pancreatitis (AP) is an acute inflammatory process of the pancreas associated with variable involvement of pancreatic/peripancreatic tissue and one or more organ systems in varying degrees. Approximately 50% of patients with AP demonstrate ECG changes, most commonly T-wave flattening, ST-segment depression, tachy-brady arrhythmias and rarely ST segment elevations. AP patients may also have elevated cardiac markers, irrespective of the severity of the disease. Here we report a patient with AP and initial ECG changes giving a dubious impression of acute coronary syndrome (ACS).

Case: A 38-year-old male patient admitted to emergency room because of severe epigastric pain of 18 hours duration with nausea and vomiting. On admission his vital findings were normal and he was afebrile. Abdominal examination showed slight tenderness in the epigastrium. Cardiovascular examination revealed no murmurs or gallops. He denied the use of illicit drugs, alcohol or smoking. Past medical history and family history was insignificant. ECG revealed sinus rhythm with 1.5 mm of ST-segment depression and T wave inversion in leads DI, aVL and V2-V6. Blood biochemistry was normal including kidney function tests and liver enzymes however amylase was 666 U/L (25-125) and lipase was 4336 U/L (8-78) together with a slight leucocytosis (WBC:11.000/ μ L). Initial cardiac markers were in the normal range apart from the troponin-I levels which was detected at the upper limit of normal (Trop-I: 0.025 ng/mL, [0-0.030]). Because of the suspected ACS, sublingual nitroglycerin, oral acetylsalicylic acid and beta-blockers were administered but failed to ameliorate his symptoms. Chest X-ray was also normal and transthoracic echocardiogram showed no wall motion abnormalities. Control ECG on the 2nd hour of admission revealed complete resolution of the suspicious changes in his first ECG. Control troponin-I level was also negative failing to meet the criteria of the 3rd Universal Definition of Myocardial Infarction. Abdominal contrast enhanced computed tomography showed diffuse pancreatic edema which was consistent with AP. He was transferred to the intensive care unit and appropriate treatment for AP was started promptly.

Conclusion: Most of the ECG and cardiac marker abnormalities in AP are reversible. Some suggested mechanisms with normal coronaries are metabolic disturbances, direct cardiotoxic effect of proteolytic enzymes, coagulopathy and coronary vasospasms. It is crucial to rule out the non-ischemic reasons of ST-segment deviations especially in the low cardiac risk groups in order to prevent lethal hemorrhagic complications in AP cases by administration of thrombolytics and anticoagulants with a misdiagnosis of ACS.

Keywords: acute coronary syndrome, acute pancreatitis, ECG, ST segment depression

SS-063 Cardiovascular Emergencies

Diagnosis of non-compaction cardiomyopathy in a young subject presented with dyspnea and Brugada type ECG to the emergency department

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Objective: Non-compaction cardiomyopathy (NCCM) is a primary genetic disorder of myocardium. Its prevalence is increasing due to exact description of its diagnostic criteria and increasing case reports. Vague signs (e.g. ECG abnormalities and symptoms e.g. dyspnea) on rest or exercise may precede the overt heart failure even at younger ages. Although incidence of NCCM in general population is estimated at 0.05-0.25% per year still it is little known among physicians. In this study we reported a NCCM case that was admitted to emergency department (ED) with progressive dyspnea and Brugada type ECG changes.

Case: A 20-year old male presented to ED with progressive dyspnea on exercise and chest pain. He had vital signs within normal limits and normal physical examination. He denied syncope and any medication. RSR pattern with ST segment elevation on V1 and V2 derivations was observed on ECG. Chest radiogram was normal. Complete blood count, serum parameters and cardiac enzymes were in normal ranges. On point-of-care echocardiography performed by experienced emergency physician, hyper-trabeculation of left ventricle with normal diameters and ejection fraction was remarkable. The patient was consulted to cardiology clinic with pre-diagnosis of Brugada Syndrome and NCCM. Brugada syndrome was excluded with ajmaline test and electrophysiologic study with programmed stimulation. Then subject was diagnosed as non-compaction cardiomyopathy by cardiac MR and discharged with oral medication.

Conclusion: Diagnosis of NCCM should be reminded by emergency physicians who had the capability of echocardiography at emergency services. High-suspicion of index may shorten the duration to definite diagnosis by cardiac MRI and also to the exact therapy. Initial vague signs and symptoms may precede the overt heart failure with dilated left ventricle. Emergency physicians should enhance point-of-care echocardiography capabilities and they should be aware of NCCM in order to manage patient optimally.

Keywords: Isolated Noncompaction of the Ventricular Myocardium, Point-of-Care Systems, Emergency Medicine

SS-064 Cardiovascular Emergencies

The value of higher intercostal leads in unmasking Brugada Type 1 pattern: a case report

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Objective: Brugada syndrome (BS) is a distinct clinical entity associated with high risk for sudden cardiac death in young adults due to ventricular fibrillation without structural abnormality in the heart. Diagnostic ST elevation pattern in BS is Type 1 and it may fluctuate/disappear over time necessitating some pharmacological techniques to unmask it in suspected cases. ECG recordings at the upper intercostal lead positions of the right precordial leads have been claimed to have a high sensitivity of diagnostic accuracy for BS. Here we report a BS case whose diagnostic pattern was demonstrated by carrying the V1 and V2 leads to higher intercostal space.

Case: A 32 year old male patient admitted to our emergency room with syncope and palpitations. At the time of the admission, he was conscious, his vital findings/physical examination were completely normal and he was afebrile. He lived a witnessed syncope about 45 minutes ago while sitting in his shop with his friends and he regained his consciousness with full spontaneous recovery in about 30 seconds. He was complaining about frequent palpitations and presyncopal episodes since his childhood however he was admitting to live a syncope for the first time. His past medical history was unremarkable. However, his father died suddenly in his sleep at the age of 39 without any previous known disease. His initial ECG revealed a sinus rhythm with a



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rate of 68/min without any significant ischemic/arrhythmic changes. Cardiac markers and their 3rd hour controls were also normal. However, in the ECG, there was a 1.5 mm J point elevation with a slowly descending ST segment in V1 and V2 consistent with Type 2 Brugada pattern. Seeing this, we decided to carry the V1 and V2 leads to higher parasternal 2nd intercostal space and this maneuver nicely demonstrated the diagnostic coved type/Type 1 Brugada pattern with a J point elevation of 3 mm in V1 and V2. The echocardiography, blood chemistry and chest X ray were all in the normal limits. Thus, the patient was diagnosed with the BS and he was planned for an intracardiac defibrillator implantation.

Conclusion: Because of the fluctuating nature of diagnostic ECG signs in patients with diagnosed or suspected BS, various recording or provocation procedures have been proposed to identify diagnosis. Recording V1 and V2 leads from 2nd intercostal space might be tried in the suspected BS cases as an easy, harmless and cheap unmasking technique.

Keywords: Brugada Syndrome, ECG, higher intercostal space, ICD, syncope

SS-065 Cardiovascular Emergencies

The Sociodemographic - Clinical Characteristics of Patients With Diagnosis of Pulmonary Embolism in the Emergency Department

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Objective: Sociodemographic characteristics of patients diagnosed with pulmonary embolism in the emergency department and their effect on mortality were analysed.

Materials-Methods: The study group consisted of patients diagnosed with pulmonary embolism between years 2006-2013. Their detailed medical history, physical examination, laboratory results and mortality rate were reported.

Results: The study group consisted of 441 patients who met the criteria. The mean age was 61.5±13.1 years (min: 24; max: 90), 54.8% (n=242) was male. According to pulmonary embolism classification 92 (20.9%) patients were massive, 245 (55.5%) submassive, 104 (23.6%) non-massive pulmonary embolism. 28.1% (n=124) patients were discharged while 67.2% (296) patients were hospitalized. The 90 days mortality rate was 8.8% (n=39). The age, cancer and deep vein thrombosis were positively correlated with mortality (respectively p=0.021, p=0.041, p=0.001). Examining the relationship between first vital sign and mortality revealed significant correlation only with systolic blood pressure and saturation variables (respectively p=0.019, p=0.001). There was a significant difference on mortality rate among groups with and without changes in consciousness [56.7% (n=21) Vs 4.4% (n=18), p=0.001].

Conclusion: Age, changes in consciousness, hypoxia and hypotension are positively correlated with mortality in patients diagnosed with pulmonary embolism in the emergency department.

Keywords: Pulmonary embolism, mortality, emergency department

SS-066 Cardiovascular Emergencies

Plasma IMA levels may reflect coronary atherosclerotic burden in early phase of acute coronary syndrome

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Objective: Ischemia modified albumin (IMA), a novel biochemical marker, is known to reflect ischemia in early phases of acute coronary syndrome (ACS). In the present study we evaluated the role of IMA on prediction of atherosclerotic plaque burden in patients with ACS.

Materials-Methods: Fifty-four consecutive ACS patients presented within the first three hours of symptom onset were prospectively enrolled in the present study. Early blood samples were collected in the first thirty minutes of admission for IMA measurement. IMA was measured by a colorimetric assay based on measurement of unbound cobalt after incubation with patient serum. Coronary atherosclerotic burden was assessed by using angiographic Gensini score.

Results: The median Gensini score of the study population was 65. Patients were dichotomized into two groups according to median Gensini score as follows; Group 1 and 2 with Gensini ≥ 65 and <65 , respectively. Mean IMA was higher in Group 1 as compared to Group 2 (0.84 ± 0.18 vs. 0.70 ± 0.12 absorbance unit (ABSU), $p = 0.002$). The Gensini score was positively correlated with IMA and the number of the diseased ($\geq 70\%$ stenotic) vessels ($r = 0.415$, $p = 0.02$ and $r = 0.482$, $p < 0.001$; respectively).

Conclusion: IMA measurement in early phases of ACS may give predictive information on the coronary atherosclerotic burden. IMA measurement may aid risk stratification of patients presented with ACS.

Keywords: Ischemia modified albumin (IMA), acute coronary syndrome (ACS), atherosclerotic burden

SS-067 Cardiovascular Emergencies

Transient various conduction disturbances observed in a patient with ST segment elevation myocardial infarction

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Objective: The incidence of bradyarrhythmias in patients with acute coronary syndrome is 0.3% to 18%. It is caused by sinus node dysfunction (SND), high-degree atrioventricular (AV) block, or bundle branch blocks. Here we report a STEMI case demonstrating numerous conduction patterns in a relatively short time.

Case: A 55 year old male patient without any previously known disease admitted to our emergency clinics with a severe chest pain, nausea, presyncopal episodes and hypotension. His blood pressure was 80/60, apex beat was 40/min, respiratory rate was: 28/min. In his initial ECG diffuse 5-7 mm of ST segment elevation on V2-V6 and reciprocal depressions on DII-DIII and aVF were observed together with a complete 3rd degree AV block and ventricular rate of 40/min. His cardiac examination revealed a 2/6 early systolic murmur on the left parasternal side, S4 and summation galo. Pulmonary auscultation revealed no rales or wheezing. He kept monitored, was applied a transcutaneous pacemaker and IV atropin was applied together with IV fluid resuscitation. As he was conscious, he received p.o aspirin, clopidogrel, IV heparin and was referred for emergent coronary catheterization. After the application of atropin (2 mg) his rhythm changed into atrial flutter with variable block and ventricular rate was 50/min. However, in a few minutes his rhythm changed again into atypical wenkebach and there was a new complete left bundle branch block with a rate of 64/min. This rhythm turned into 2nd degree 2:1 AV block in a few minutes and remained so while being sent to the percutaneous coronary intervention centre. A proximal right coronary artery lesion was detected and successfully stented in the primary PCI centre. His rhythm disturbances and high grade AV blocks completely resolved in the first week of recovery. His final ECG was sinus with an incomplete right bundle branch block. His final EF was 50% with a slight inferoposterior left ventricular wall motion abnormality.

Conclusion: First- or second-degree AV blocks are seen very frequently within 24 h of the beginning of ACS; these arrhythmias are frequently transient and usually disappear after the third day. Third-degree AV blocks are also frequently transient in patients with infero-posterior myocardial infarction and generally permanent in anterior MI patients because of septal necrosis. In patients with bradyarrhythmia, intravenous (IV) atropine (1-3 mg) is helpful in 70% to 80% of ACS patients.

Keywords: AV block, acute coronary syndrome, right coronary artery, STEMI



SÖZLÜ BİLDİRİLER

SS-068 Other

Assessing the Therapeutic efficacy of augmentative plate fixation in femur bone nonunion subsequent to intramedullary nailing

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Objective: Femur is the tallest and one of the firmest bones of the body that is damaged in high energy traumas. Gold standard method for treatment of sub-trochanteric and shaft fractures of femur is interlocking Intra Medullary nailing Rod (IMR). New method for reinforcement of stability of these fractures is augmentative plate fixation in addition to IMR. In this study, we aimed to evaluate the results of treatment with this new method in femur bone nonunion for the first time world widely.

Material-Methods: In a case series study, we studied 28 females and 17 males with age distribution of 19-76 years of old referring to Shohada Hospital of Tabriz that were treated by IMR due to femur fracture and were diagnosed as nonunion fracture. Statistical analysis was performed by SPSS software package version 16.0 for windows. P value less than 0.05 was statistically considered significant in this study.

Results: There were union signs in 41 patients (91.1%) in radiologic findings after 6 months follow up, who were referred with femur fracture non-union that were treated by IMR previously and went under augmentative plate fixation in addition to IMR Non-union was more prevalent in females, patients with previous history of disease, smokers and patients with oligotrophic type of non-union.

Conclusion: Augmentative plate fixation can be used as appropriate treatment method in femur fractures non-union in patients treated by interlocking intramedullary nailing rod to avoid instability and rotation. It is advised due to short recovery time, faster weight bearing and no need for special instruments.

Keywords: Femur, Non-union, Fixation

SS-069 Other

Contribution of Turkish articles about emergency medicine to the international literature

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Objective: The aim of this study was to present characteristics of internationally published articles about emergency medicine originating from Turkey between 2002-2012 years.

Materials-Methods: For our evaluation all articles about emergency medicine published in SCI and SCI Expanded between 2002-2012 years were included. The articles were categorized according to subjects, hospitals, departments, years. The ISI Web of Knowledge was searched for all articles.

Results: A total of 1812 articles were included. Of all articles %64,3 (n=1165) were published in the last five years. Publications in the last five years were detected to increase at a rate of %4,6 per year. %78,1 (n=1416) of the articles were published in non-EM (non-Emergency Medicine) journals. Türkiye Klinikleri Dergisi in the non-EM group, with 46 articles, and the Turkish Journal of Trauma and Emergency Surgery in the EM (Emergency Medicine) group, with 134 articles, were the preferred journals. The most popular subjects were trauma, at %14,7 (n=266), followed by emergency medicine and management, at %14 (n=253).

Conclusion: Significant publication growth was detected related with the development of EM in Turkey. The preference of non-EM journals, trauma as the most popular subject and the effect of university hospitals were the interesting results of this study. The low number of multicenter trials and of published articles in high impact factor journals have led us to consider the importance of publication quality, which requires additional effort.

Keywords: Emergency medicine, journal article, Turkey

SS-070 Other

The comparison of MEWS and SOFA scoring systems in evaluation of patients at critical care units

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The comparison of MEWS and SOFA scoring systems in evaluation of patients at critical care units

Mehmet Ergin, Mustafa Gülpembe, Fatih Emin Visneci, Z.Defne Dündar, Sadık Girişgin, Sedat Kocak, Mehmet Gül, Basar Cander

Background: The patients admitted to critical care unit (CCU) are in trouble due to severe illness, intoxication, trauma or operation. Since all patients have their own specific problems, the comparison of these patient in case of mortality, morbidity and prognosis is important but difficult. Many scoring systems are used to compare and estimate prognosis. Scoring systems are including the type of illness, its severity, physiologic reserve of patients, the response to treatment, type and time duration of treatment to make estimation about mortality and prognosis. The scoring systems provide us to have knowledge about relation between treatment and results.

Purpose: To compare efficiency of Modified Early Warning Score (MEWS) and Sequential Organ Failure Assessment (SOFA) in estimating prognosis of patients admitted to CCU.

Method: The prospective observational study was performed at Critical Care Unit of Necmettin Erbakan University Meram Medicine School Emergency Department. The study protocol included patients older than 18 years and excluded patients who were younger than 18 year, admitted at CCU for less than 48 hours and refused to be in. there were 980 patients admitted to CCU and 139 patients included.

Results: Table 1 showed mean values of MEWS, SOFA at 24.hour, SOFA at 48 hour in Group 1 (discharged from CCU) and Group 2 (exitus at CCU). There was a statistically important difference between Group 1 (survival) and Group 2 (exitus) for all scoring type. Table 2 showed the distribution of scoring results in terms of mortality at 30th day Group 1 (survival) and Group 2 (exitus). There was a statistically important difference between groups for all scoring type. Table 3 showed the positive correlation that was statistically important between all scoring systems.

Conclusion: 1. Scoring systems shows development in estimating prognosis of patients admitted to CCU. 2. The physicians should understand that the negative results of scoring systems force them to find more effective treatment. 3. We found that the power of MEWS in estimating mortality at CCU and 30th day correlates with SOFA at high/medium degree so that it seems suitable in performing at CCU.

Keywords: MEWS, SOFA, scoring, systems



ORAL PRESENTATIONS

SS-071 Other

The comparison of APACHE II and SOFA scoring systems in evaluation of patients at critical care units

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The comparison of APACHE II and SOFA scoring systems in evaluation of patients at critical care units

Mustafa Gülpembe, Mehmet Ergin, Fatih Altunay, Z. Defne Dündar, Sadık Girişgin, Sedat Koçak, Mehmet Gül, Başar Cander

Background: The patients admitted to critical care unit (CCU) are in trouble due to severe illness, intoxication, trauma or operation. Since all patients have their own specific problems, the comparison of these patient in case of mortality, morbidity and prognosis is important but difficult. Many scoring systems are used to compare and estimate prognosis. Scoring systems are including the type of illness, its severity, physiologic reserve of patients, the response to treatment, type and time duration of treatment to make estimation about mortality and prognosis. The scoring systems provide us to have knowledge about relation between treatment and results.

Purpose: To compare efficiency of APACHE II and Sequential Organ Failure Assessment (SOFA) in estimating prognosis of patients admitted to CCU.

Method: The prospective observational study was performed at Critical Care Unit of Necmettin Erbakan University Meram Medicine School Emergency Department. The study protocol included patients older than 18 years and excluded patients who were younger than 18 year, admitted at CCU for less than 48 hours and refused to be in. there were 980 patients admitted to CCU and 139 patients included.

Results: Tablo 1 showed mean values of APACHE II, SOFA at 24.hour, SOFA at 48 hour in Group 1(discharged from CCU) and Group 2 (exitus at CCU). There was a statistically important difference between Group 1 and Group 2 for all scoring type. Table 2 showed the distribution of scoring results in terms of mortality at 30th day between Group 1 (survival) and Group 2 (exitus). There was a statistically important difference between groups for all scoring type. Table 3 showed the positive correlation that was statistically important between all scoring systems.

Conclusion: 1. Scoring systems shows development in estimating prognosis of patients admitted to CCU. 2. The physicians should understand that the negative results of scoring systems force them to find more effective treatment. 3. We found that the power of SOFA in estimating mortality at CCU and 30th day correlates with APACHE II at high/medium degree.

Keywords: APACHE II, SOFA, Scoring, Systems

SS-072 Other

The comparison of MEWS and APACHE II scoring systems in evaluation of patients at critical care units

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The comparison of MEWS and APACHE II scoring systems in evaluation of patients at critical care units

Mustafa Gülpembe, Mehmet Ergin, Z. Defne Dündar, Sadık Girişgin, Sedat Koçak, Mehmet Gül, Başar Cander

Background: The patients admitted to critical care unit (CCU) are in trouble due to severe illness, intoxication, trauma or operation. Since all patients have their own specific problems, the comparison of these patient in case of mortality, morbidity and prognosis is important but difficult. Many scoring systems are used to compare and estimate prognosis. Scoring systems are including the type of illness, its severity, physiologic reserve of patients, the response to treatment, type and time duration of treatment to make estimation about mortality and prognosis. The scoring systems provide us to have knowledge about relation between treatment and results.

Purpose: To compare efficiency of Modified Early Warning Score (MEWS) and APACHE II in estimating prognosis of patients admitted to CCU.

Method: The prospective observational study was performed at Critical Care Unit of Necmettin Erbakan University Meram Medicine School Emergency Department. The study protocol included patients older than 18 years and excluded patients who were younger than 18 year, admitted at CCU for less than 48 hours and refused to be in. there were 980 patients admitted to CCU and 139 patients included.

Results: Tablo 1 showed mean values of MEWS and APACHE II in Group 1(discharged from CCU) and Group 2 (exitus at CCU). There was a statistically important difference between Group 1 (survival) and Group 2 (exitus)for all scoring type. Table 2 showed the distribution of scoring results in terms of mortality at 30th day Group 1 (survival) and Group 2 (exitus). There was a statistically important difference between groups for all scoring type. Table 3 showed the positive correlation that was statistically important between all scoring systems.

Conclusion: 1. Scoring systems shows development in estimating prognosis of patients admitted to CCU. 2. The physicians should understand that the negative results of scoring systems force them to find more effective treatment. Although the scoring systems were found to be more effective than physicians' perception about mortality, they are not enough alone to decide about beginning or stopping of treatment. 3. We found that the power of MEWS in estimating mortality at CCU and 30th day correlates with APACHE II at high/medium degree so that MEWS seems suitable in performing at CCU.

Keywords: MEWS, APACHE II, Scoring, Systems

SS-073 Other

Drops outlays for measuring a blood level of acetaminophen therapy costs?

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Objective: Acetaminophen is an effective and safe analgesic and antipyretic which has been used since 1950. By acute ingestion single dose 7,5 gr or more than 150 mg/kg is accepted as toxic for adults. By Rumack-Matthew nomogram at 4 hours after ingestion giving N-Acetylcysteine therapy over 150 µg/ml line is recommended.

Materials-Methods: 6 months long were studied hospital database and files of patients which have been coming to Kayseri Training and Research Hospital with prediagnosis of acetaminophen intoxication. Patients' therapy costs were calculated according to calculation results after patient's statement with toxic level and patients with toxic measured blood acetaminophen level. The therapy costs of the two groups were compared.

Results: 6 months long total 558 drug overdose were diagnosed. 55 patients were evaluated as acetaminophen overdose. Level of acetaminophen which 19 patients gotten according to their statements were calculated as toxic. According to measured acetaminophen level, only 5 patients' blood acetaminophen levels were calculated as toxic. Upon measurement patients' therapy cost were clearly lower than patients' therapy cost upon calculation.

Conclusion: Measuring blood acetaminophen level means that reduce total therapy cost. Like the countries which their health system is advanced, measuring a blood acetaminophen level will be both from the point of therapy plan truer and from the point of cost more favorable also in developing countries.

Keywords: Acetaminophen intoxication, N-Acetylcysteine therapy, cost efficiency, emergency department

SS-074 Imaging in Emergency Units

A Case Report of Patient With Isolated Dysarthria: Fahr's Syndrome

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Objective: Fahr's syndrome is a rare clinical condition that is symmetrical calcification of the basal ganglia along with neuropsychiatric, extrapyramidal and cerebellar symptoms. It was first described in 1930 (1). Although the etiology is not known yet, changes in calcium metabolism is most accused cases. However, the disease, as a result of genetic damage, has been identified (2). Fahr's syndrome is mostly presented with cerebellar, movement and cognitive disorders (3). We just want to present a case of fahr's syndrome that is presenting with only dysarthria.

Case: 75 year old female patient was admitted to our clinic with complaints of slurred speech beginning 2 hours ago. She had a history of hypertension, diabetes, and asthma. In neurological examination, there was no pathological findings except dysarthria. Other systems examinations were normal. In biochemical parameters(pathologically) serum calcium levels were low (6.3 mg /dL). Brain CT scan was obtained with an initial diagnosis of cerebrovascular diseases. Computed tomography showed that bilaterally symmetrical basal ganglia, thalamus and cerebellum calcifications. There was no acute ischemic changes in the diffusion-weighted MRI. Bilateral calcifications were thought to be consistent with Fahr's syndrome. There was no close family member with a known history of Fahr's syndrome.



SÖZLÜ BİLDİRİLER

Conclusion: Fahr's syndrome is a rare degenerative neurological disorder characterized by calcifications within the white matter of brain especially in basal ganglia. Although Fahr's syndrome appears most commonly with motor deficits such as chorea, tremor, dystonia; headache, seizures, dysarthria and primarily cognitive disorders such as psychosis, dementia can also be occur. Fahr's disease can also include extrapyramidal symptoms such as tremors, muscle rigidity, a mask-like facial appearance. Sometimes pyramidal signs, balance disorders, psychosis, mental retardation, emotional lability, sensory defects, pain, irritability, cataract and papilledema were seen. In our case, the clinical onset, dysarthria, was helpful in the diagnostic process because it led to obtaining the head CT scan for initial diagnosis of cerebrovascular events, which revealed symmetrical calcifications in basal ganglia, thalamus and cerebellum. In the diagnosis of Fahr's syndrome computed tomography is the most important examination method. Intracranial calcifications are often seen in the globus pallidus putamen, caudate nucleus, internal capsule, thalamus and cerebellum. The symptomatic patients with Fahr's syndrome can be treated so rapid detection is vital for the patient. Fahr's syndrome should be kept in mind in the differential diagnosis in the presence of an unidentified neurological symptoms and especially underlying disorders of calcium metabolism.

Keywords: basal ganglia, calcification, dysarthria, Fahr's syndrome

SS-075 Imaging in Emergency Units

The Accuracy of Ultrasound Evaluation in Foot and Ankle Trauma

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Objective: Foot and ankle injuries that result in sprains or fractures are commonly encountered at the emergency department. The purpose of the present study is to find out the accuracy of ultrasound (US) scanning in injuries in the aforementioned areas

Materials-Methods: This study was a prospective evaluation of a diagnostic test (US) vs a reference standard examination (radiography). Our work was approved by the local university institutional review board and was enrolled from May 2011 to June 2012, at the Ankara University School of Medicine, Emergency Department. Ottawa Ankle Rules positive patients older than 16 years who presented to the emergency department with foot or ankle injuries were eligible. For all patients, US evaluation of the whole foot and ankle was performed by an emergency physician before radiographic imaging. The clinician who performed the US did not see the x-rays and x-ray interpretation. At the end of the study, all the radiographic images were interpreted by an orthopedic specialist in terms of fracture, and these were added to the records. All radiographic images were evaluated by an orthopedic specialist and compared with the interpretations of the US.

Results: One hundred thirty-one patients were included in the study. Radiographic evaluation enabled the determination of fractures in 20 patients, and all of these were identified with US imaging. Moreover, US evaluation radiographically detected a silent ankle fracture in 1 patient. The sensitivity of US scanning in detecting fractures was 100% (95% confidence interval [CI], 83.8-100), the specificity was 99.1% (95% CI, 95-99.8), the positive predictive value was 95.2% (95% CI, 89.6-98), and the negative predictive value was 100% (95% CI, 96.4-100), respectively. The most common fractures were detected at the lateral malleolus and at the basis of the fifth metatarsal.

Conclusion: In light of our findings during our study, we determined that US scanning is an effective method that can be applied in the emergency department to adult age groups to diagnose foot or ankle fractures. Because US imaging permits the evaluation of bone and because it is irradiation-free, we notice a high rate of satisfaction in patients. In addition, US evaluation can safely be applied in pregnant women and pediatric age groups.

Keywords: ankle injuries, foot injuries, musculoskeletal radiology, musculoskeletal ultrasound, ultrasound scanning

SS-076 Imaging in Emergency Units

A strategy to optimize CT use in children with mild blunt head trauma utilizing clinical risk stratification; Could we improve CT use in children with mild head injury?

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Objective: The purpose of our study was to investigate the impact of clinical risk classification on optimization of the rationale of CT scanning in children with mild blunt head trauma. Exposed effective radiation dose values of CT scanning were also evaluated.

Methods: Children with isolated pediatric mild head trauma admitted in a single center over a 5-year period (n=3102, >2 years and <16 years of age) were retrospectively reviewed. The study group comprised 806 patients with a mean age of 7.4 ± 2.1 years (range, 2–15 years). The patients were categorized into low and high risk groups with regard to presence of predefined signs and symptoms. Effective radiation dose values were calculated.

Results: Incidences of the pathologic CT findings related to trauma were significantly different between low (n = 10) 1.9% and high (n = 90) 29.8% risk groups. Certain predefined signs and symptoms (e.g., vomiting, suspected skull fracture and loss of consciousness) were related significantly with pathologic CT findings attributed to trauma. Estimated mean effective dose values were 3.91 ± 0.38 mSv for 2-6 year old (n = 557), and 3.33 ± 0.12 mSv for 7-16 year old patients (n = 349).

Conclusion: The pediatric victims of mild head trauma patients within high risk group and those with vomiting, suspected skull fracture and loss of consciousness should undergo head CT scanning. The manufacturer settings on the CT scanners for children should be revised to alleviate untoward radiation exposure.

Keywords: Computed tomography, head trauma, pediatric, radiation dosage

SS-077 Imaging in Emergency Units

Addition of Bedside Ultrasonography for Differential Diagnosis for Patients Suffer from Dyspnea in Emergency Department

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Objective: Acute dyspnea is one of the most common symptoms in emergency department. Among the patients presenting to emergency department %9 admitted with the complaint of dyspnea. Dyspnea may be associated with pulmonary, cardiac, neurologic causes. Management of dyspneic patients is difficult because of this large spectrum. For differential diagnosis there are limited tests. Lung ultrasonography is a new technique employed in this field that is bedside applicable, cheap and does not require waiting for the results.

Materials-Methods: 124 patients who were admitted to Hacettepe University Department of Emergency Medicine for Adults with the complaint of dyspnea within April 2013-October 2013 have been included to the prospective, cross-sectional, descriptive study. Exclusion criteria were as follows: Patients younger than 18 years old, dyspnea caused by traumatic injury, upper airway obstruction and if the ultrasonography wouldn't be done within the first 24 hours. During the first 24 hours, to patients, whose evaluations of lung ultrasonography is suitable, Bedside Lung Ultrasound in Emergency (BLUE) protocol is done. Ultrasonographic findings, according to BLUE Protocol, were compared with the clinical diagnosis of the patients to see whether they represent the diagnosis.

Results: It is determined that 35.5% (n=43) of patients is A profile, 12.1% (n=15) of patients is B profile, 24.2% (n=30) of patients is C profile, 39.5% (n=47) of patients is A/posterior-lateral alveolar-pleural syndrome (PLAPS), 16.9% (n=21) of patients is A/B profile and 63.7% (n=79) is PLAPS. By using the test of Pearson's chi-squared for the statistical analyses of lung ultrasonography (p<0.05), diagnoses and profiles are compared. Significant relationship is found between the B profile and congestive heart failure when p=0.002, between the A profile and chronic obstructive pulmonary disease (COPD) when p=0.003, between being PLAPS (+) and COPD Acute Exacerbation when p=0.003, between A profile and pneumonia when p=0.017, between C profile and pneumonia when p=0.014.

Conclusion: Lung ultrasonography can be used for evaluation of dyspneic patient in the emergency department. When commencing treatment towards diagnosis, it would be useful to assess patient with ultrasonography besides clinical condition.

Keywords: Acute Dyspnea, Lung Ultrasonography, Management of Dyspneic Patient, BLUE Protocol



ORAL PRESENTATIONS

SS-078 Imaging in Emergency Units

Foreign body in the esophagus: A case report

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Objective: Esophageal foreign bodies may lead to significant morbidity and mortality and constitute among 28-68 % of all gastrointestinal foreign body cases. Ingestion of foreign bodies is encountered most often between the ages of 6 months and 6 years, whereas the morbidity and mortality risk is greater in ingestion of foreign bodies in older age groups. In this article we present a case of esophageal foreign body, in a patient who admitted to the emergency department because of difficulty in swallowing.

Case: A sixty- nine year old male patient admitted to the emergency room with dysphagia and excessive secretion of saliva. The patient told that his complaints began about 2-3 hours ago, after he had eaten boneless meat. In physical examination the patient's arterial blood pressure: 140/85, pulse 90 beats / minute, fever: 36.4 °C, and the saturation was 99%. Indirect hypopharyngoscopy examination and other physical examination findings were normal. In the lateral cervical radiograph hypodense areas in the esophagus (foreign bodies) at the level of C6 corpus were observed (Figure 1). The patient was consulted with gastroenterology clinic and endoscopy was planned. But, just before endoscopy, the patient told that he swallowed the meat. On the control radiograph the shadow of the foreign body was disappeared.

Conclusion: It should be kept in mind that the complications of esophageal foreign bodies can be quite serious and even mortal, and proper treatment options should be planned.

Keywords: esophagus, foreign body, radiograph

SS-079 Imaging in Emergency Units

Validity of Chest X-Ray in Defining Pathologies Due to Blunt Trauma

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Objective: Chest radiography and chest computed tomography is the most common imaging in blunt trauma evaluation. Although they infrequently lead to management changing diagnoses, chest x-rays (CXR) are the most commonly ordered imaging study in blunt trauma evaluation

Materials-Methods: All consecutive patients admitted to the ED within the five-year study period (2009-2013) due to blunt thoracic trauma were retrospectively reviewed. Excluded from the study were those with hemodynamical instability and multiple trauma.

Results: The mean age was 39.5-19.2 (range: 9 and 87) in the study group (n=447). The most frequent mechanism of injury was motor vehicle accident (MVA) (passenger) (n=158, 35.3%) followed by pedestrians involved in MVA (n=92, 20.6%) and falls from height (n=76, 17.0%). Findings identified in CT in the study group were (in decreasing order): rib fractures (33.6%, n=150), pneumothorax (26.4%, n=118), contusion (18.3% n=82), hemothorax (14.1%, n=63), clavicle fracture (10.3%, n=46), pneumomediastinum (3.8%, n=17) and scapular fracture (2%, n=9).

Sensitivity and specificity of CXR interpretations regarding pneumothorax, hemothorax, contusion, rib fracture, clavicle fracture, scapula fracture and pneumomediastinum were demonstrated in Table 2. CXR was found to have the highest sensitivity for clavicle fractures [sensitivity (95% CI)=78.3 (63.6 to 89)] while the lowest figure was for pneumomediastinum [sensitivity (95% CI)=11.8 (1.5 to 36.4)]. Of note, the specificity of CXR was close to 100% in detecting a wide array of entities

Conclusion: According to the findings of this study, CXR has low sensitivity for all the pathologies in thorax occurred due to the trauma. However, the specificity is 100% percent for all of them. This means that if a pathology is seen in CXR it is absolutely true. However, the absence of a finding in X-ray can not strongly exclude the existence of a pathology.

Keywords: Trauma, chest, x-rays, computed tomography, emergency department

SS-080 Imaging in Emergency Units

Spontaneous Aortic Dissection In Pregnancy

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Objective: Aortic dissection is a disease characterized by tear of aortic intima, hematoma formation and separation of the arterial wall. In etiology, hypertension ranks first. In young woman aortic dissection is rare. However, in female cases with age of less than forty, half of the dissections are seen during pregnancy, particularly in the 3rd trimester and puerperal period.

Case: A 26-year-old pregnant patient at 28weeks of gestation was referred to ER on ambulance. She was unconscious, with cardiopulmonary arrest and total collapse.

The patient previously attempted family doctor with palpitation and breath shortness feelings, during waiting for the examination she collapsed and was brought to our ER. The patient immediately underwent rapid sequence orotracheal intubation and cardiopulmonary resuscitation. A bedside ultrasound examination showed an aortic dissection findings. Neither the patient nor the baby could be resuscitated.

Conclusion: Pregnant patients with syncope warrant immediate evaluation for possible life-threatening events. This case report of a pregnant patient with no risk factors for aortic dissection emphasizes the importance of maintaining a broad differential diagnosis and utilizing the necessary clinical tools to further direct patient care and necessary interventions.

Keywords: aortic diseases, pregnancy, bed-side ecocardiography

SS-081 Cerrahi Aciller (Genel Cerrahi, Ortopedi, Beyin Cerrahisi, Kalp Damar, Anestezi vb.)

Rektal Yabancı Cisimler

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Amaç: Hastanemiz acil servisine başvuran rektumda yabancı cisim saptanan ve hastanemizde müdahale edilen 18 vaka ile ilgili deneyimimizi paylaşmayı amaçlamaktadır.

Gereç-Yöntem: Haziran 2008 ile Şubat 2014 yılları arasında Bakırköy Eğitim ve Araştırma Hastanesi Acil Servisine çeşitli şikayetler ile başvuran ve sonucunda rektal yabancı cisim tanısı konan 18 vaka sunulmuştur. Veriler retrospektif taranmış olup yaş,cinsiyet,başvuru tarihi, şikayeti,fizik muayene bulguları, x-ray bulguları,tuşe bulguları,endoskopik ve ameliyat bulguları, çıkarılan materyaller, hastanede kalış süreleri,mental durumları ve antibiyoterapi durumları kayıt altına alınmıştır

Bulgular: Toplam 18 vaka kaydedildi. Mental durumu normal 32 yaşındaki erkek rektal tuşede ele sert metal cisim gelen hastaya ameliyat önerildi ancak hastaneyi izinsiz terk ettiğinden gerekli işlem yapılamamıştır.Hastaların ortalama yaşı 38,5 (15-78) idi. 3' ü kadın (%16,7) olup 15' i erkek (% 83,3). 12 hasta 20-50 yaş arasında idi (% 66,6). 16 tanesinin mental durumu normal(% 88,8) olup 2 tanesi mental retarde idi(% 11,1). Başvuru şikayetleri olarak 13 tanesi makatta ağrı(% 72,2), 3 tanesi karın ağrısı(% 16,6), 1 tanesi makatta kanama, 1 tanesi de makatta ağrı ve ateş ile başvurdu. Fizik muayenede 14 tanesinin (%77,7) normal, 2 tanesinde ileus (% 11,1), 1 tanesinde anal kanama ve 1 tanesinde de batin hassasiyeti mevcuttu. Tedavide 9 tanesine elle halas uygulandı. Bunlardan çıkan materyaller 2 adet kolonya kapağı, tahta parçaları(mental retarde hastada), plastik çubuk(mental retarde hastada), parfüm şişesi, ispirotolu kalem, musluk vanası, plastik materyel ve salatalık idi. 3 tanesine endoskopik girişim uygulandı. Bunlardan çıkan materyaller ise RİA, sosis ve kolonya şişesi idi. 6 hastaya anestezi uygulanmıştır. Anestezi altında 1 tane plastik kapak, 1 tane turp, 1 tane parfüm şişesi çıkarılmıştır. Spinal anestezi uygulanan birisinde plastik kalem çıkarılmıştır. Maske anestezi ile 1 tane şampuan kapağı çıkarılmıştır. Bir hasta ameliyata alınmış olup RİA çıkarılmıştır.

Hastanede en kısa kalış süresi 1 saat, en uzun kalış süresi 6 gündür. En çok takip süresi 1 gün olarak ortaya çıkmıştır(% 50). 3 hastaya yatırılarak antibiyoterapi uygulanmıştır(% 16,6). Hiçbir hastada işleme bağlı komplikasyon gelişmedi.

Sonuç: Rektal yabancı cisimlerin çoğunluğu elle halas ile çıkarılabilesine rağmen endoskopik ya da cerrahi girişim gerekebilir.

Anahtar Kelimeler: Emergency, Rectal, Foreign bodies



SÖZLÜ BİLDİRİLER

SS-082 Cerrahi Aciller (Genel Cerrahi, Ortopedi, Beyin Cerrahisi, Kalp Damar, Anestezi vb.)

Akut Divertikülit Tedavisinde Nonoperatif Yaklaşım

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Amaç: Akut divertikülit artan bir insidans ile birlikte özellikle ileri yaştaki hastalarda önemli sorun olmaya devam etmektedir.

Gelişmekte olan tanı yöntemleri ve yeni tedavi yaklaşımları, geleneksel akut divertikülit algoritmalarını da değiştirmeye zorlamaktadır

Biz bu çalışmada hastanemiz acil servisine karın ağrısı nedeniyle başvuran ve akut divertikülit tanısı konularak tedavi edilen olgularımıza ait sonuçlarımızı sunmak ve non operatif yaklaşımın önemini vurgulamak istedik.

Gereç-Yöntem: Ocak 2008 –Ocak 2013 tarihleri arasında kliniğimize akut batın tablosu ile başvuran ve divertikülit teşhisi konularak tedavi edilen 65 olgunun kayıtları retrospektif olarak incelendi. Demografik özellikleri, Radyolojik bulguları, Cerrahi ve nonoperatif tedavi sonuçları, Hastanede kalış süreleri, Morbidite ve mortalite oranları değerlendirildi.

Bulgular: Olgularımızın yaş ortalaması 58 olup (30-80), 41'i erkekti. Ortalama hastanede kalış süresi 4.7 (1-18) gündü.

Klinik ve BT bulgularına göre hastalardan yedisinin Hinchey 1, 39'unun Hinchey 2, sekizi Hinchey 3, 11'inin Hinchey 4 olduğu görüldü.

Rektosigmoid bölge en sık tutulan bölgeydi. Olguların 48'ine(%74) medikal tedavi başarıyla uygulandı. Bu hastalara ikili antibiyoterapi (3.kuşak sefalosporin +metronidazol) başlandı.

10 hastaya Hartman, 3 hastaya segmenter sigmoid rezeksiyon, 3 hastaya anterior rezeksiyon, 1 hastaya sol hemikolektomi yapıldı.

Perkütan drenaj yanıt alınamayıp opere edilen 1 hastada mortalite gelişti.

Sonuç: Akut komplike olmayan divertikülit hastalarında medikal tedavi başarıyla uygulanabilir. Bu hastalar cerrahiden ve buna bağlı muhtemel komplikasyonlardan korunabilir. Bununla birlikte rekürren ataklar geçiren, yaşlı(>50) ve majör komorbiditesi olan hastalarda cerrahi tedavi birçok cerrah tarafından uygulanırken literatürde son zamanlarda nonoperatif yaklaşımın daha geniş bir hasta grubunda uygulanması işaret edilmektedir.

Anahtar Kelimeler: Acil, divertikülit, nonoperatif, akut

SS-083 Cerrahi Aciller (Genel Cerrahi, Ortopedi, Beyin Cerrahisi, Kalp Damar, Anestezi vb.)

Acil Servise Akut Pelvik Ağrı İle Başvuran Hastaların Retrospektif Değerlendirilmesi

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Amaç: Ege Üniversitesi Tıp Fakültesi Acil Servisi'ne akut alt abdomenopelvik ağrı (APA) ile başvuran hastaların epidemiyolojik, demografik ve klinik özelliklerinin tanımlanmasıdır.

Gereç-Yöntem: Geriye dönük tanımlayıcı nitelikteki çalışmamızda bir yıllık dönemde başvuran akut alt abdomenopelvik ağrısı olan 18 yaş üstü hastalar geriye dönük incelendi. Gebeler, postoperatif ağrı nedeniyle başvuran hastalar, malignite tanısı olanlar, verileri kullanılamayacak oranda eksik olan dosyalar çalışmaya alınmadı. 8350 hasta dosyasının 1952'si çalışma kriterlerine uygun bulundu.

Bulgular: Çalışmamızda 1952 hasta değerlendirmeye alındı. Hastaların %64'ü (n=1249) kadındı. Genel yaş ortalaması 37,61 ±18 (18-97) (n=1952) idi. Bilateral kasık ağrısının kadınlarda daha fazla görüldüğü ve acil servisten 4 saate kadar taburcu olmakla birlikte, ağrısı sağ tarafa lokalize olduğunda bu sürenin arttığı görüldü. NSKA'nın erkeklerde daha fazla görüldüğü yönünde istatistiksel olarak anlamlı fark saptandı (p<0,0001). Hastaların sadece %4'ünün (n=77) dış merkezlerden ön tanı ile sevk edildiği görüldü. 1952 hastanın %38'ine (n=734) konsültasyon istendiği saptandı. En çok %46 (n=334) ile genel cerrahi konsültasyonu istendiği görüldü. Tüm hastalarda sırasıyla en çok konulan tanı %37,7 (n=735) idrar yolu enfeksiyonu, %14,3 (n=280) apandisit, %13,4 (n=262) nonspesifik karın ağrısı (NSKA), %7,9 (n=154) primer dismenore ve %7,8 (n=152) over kisti idi. Hastaların yaşı 25 yaş grubuna doğru yaklaştıkça jinekolojik tanı alma oranı yükselmekteydi. Jinekolojik tanıları konsültasyon isteme sayısı artmaktaydı. Acil serviste kalış süresi ile cerrahi tanı alma arasında istatistiksel olarak anlamlı fark izlendi (p<0,0001). Cerrahi tanı grubu ile kabızlık semptomu, rebound ve defans varlığı arasında istatistiksel olarak anlamlı fark vardı (p<0,0001). Ultrasonografi (USG) ile cerrahi patoloji oranının düşük olduğu, bilgisayarlı tomografi (BT) görüntüleme yöntemi ile yüksek olduğu saptandı. Apandisit tanı alma oranı ile bulantı, sağ kasıkta ağrı ve reboundun pozitif bulgusu arasında istatistiksel olarak anlamlı fark izlendi (p<0,0001). Ürolojik tanı grubunda bulantı, kusma, ateş, kostovertebral açısı hassasiyeti (KVAH) varlığı ile ürolojik tanı ayırımında sol kasıkta ve bilateral ağrı lokalizasyonu, tam idrar tahlilinin (TİT) anlamlı olduğu saptandı. Lökositoz ve C-Reaktif protein (CRP) tetkiklerinin cerrahi tanı ile ürolojik tanıyı desteklediği, fakat ayırımı yapamadığı görüldü. USG bulgusunun normal olması halinde taburculuğun arttığı yönünde istatistiksel olarak anlamlı fark saptandı (P<0,0001). Hastaların BT ile sonuçlanımı arasında BT bulgusunun patolojik olması halinde hastane yatışının arttığı yönünde istatistiksel olarak anlamlı fark görüldü (P<0,0001). BT'si normal olan hastaların %54'ü NSKA teşhisi koyulduğu görüldü.

Sonuç: APA'LI hastalarda muayene bulgularından ateş, KVAH, rebound, defans tanıda yardımcıdır. APA en sık nedeni idrar yolu enfeksiyonu, apandisit ve NSKA'dır. Acil servisteki kalış süresine etkileyen en önemli parametre ağrının sağ alt kadrana lokalize olmasıdır. USG taburculukta, BT ise hastanın yatırılmasında en önemli tetkiktir.

Anahtar Kelimeler: alt pelvik ağrı, acil servis, nonspesifik karın ağrısı

SS-084 Cerrahi Aciller (Genel Cerrahi, Ortopedi, Beyin Cerrahisi, Kalp Damar, Anestezi vb.)

Üst gastrointestinal sistem kanamalarında Forrest sınıflamasının değeri: 265 hastanın 3 yıllık takip sonuçları

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Amaç: Üst gastrointestinal sistem kanamalarında ilk 24 saat içerisinde endoskopik inceleme yapılması yönünde çalışmalar mevcuttur. Endoskopik incelemede ise amaç mevcut olan kanamayı durdurmak ve hastanın yeniden kanama ihtimalini öngörmektir. Biz kliniğimizde endoskopi yapılarak Forrest sınıflaması ile takip edilen 265 hastanın 3 yıllık takip sonuçları ile inceledik

Gereç-Yöntem: Ocak 2009 ile Haziran 2011 tarihleri arasında acil cerrahi kliniğine başvuran hastalar retrospektif olarak incelendi. Hastaların ilk başvuru anında demografik özellikleri, endoskopik incelemedeki forrest skorları not edildi. Hastalar 3 yıl boyunca yeniden kanama ve mortalite gelişimi yönünden takip edildi.

Bulgular: 265 hasta çalışmaya dahil edildi. 28 hastaya çeşitli nedenlerle (direk ameliyat, rockall skorunun 0 olması) endoskopi yapılmadı. Endoskopi yapılan hastalardan 93'ü forrest 3 geldi. Yeniden kanama ve mortalite oranları gruplar arasında benzerdi.

Sonuç: 3 yıllık gözlem sonucunda forrest sınıflamasının yeniden kanama ve mortaliteyi ön görmede uzun dönemde yeterli olmadığı ortaya konmuştur.

Anahtar Kelimeler: forrest sınıflaması, üst gıç kanama, endoskopi

SS-085 Cerrahi Aciller (Genel Cerrahi, Ortopedi, Beyin Cerrahisi, Kalp Damar, Anestezi vb.)

Pediyatrik Yaş Grubunda Risperidon Kullanımına Bağlı Gelişen Akut Distoni: Nadir Bir Olgu Sunumu

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Amaç: Bu çalışmada acil kliniğine travma sonrası ortaya çıkan kasılmalar şikayeti ile gelen ve takibinde risperidon kullanımına bağlı Akut Tardif distoni tespit edilen pediyatrik olguyu sunmayı amaçladık.

Olgu: 7 yaşında kız olgu, acil kliniğimize okulda oyun oynarken düşme sonrası boyunda ve vücudunun sol tarafında kasılma şikayeti ile getirildi. Fizik muayenesinde vucut ısı 36.6 C, kan basıncı 110/70 mmHg, nabız 117/dk, solunum sayısı 24/dk idi. Nörolojik muayenesinde bilinci açık, koopere, oryante, pupiller izokorik, IR +/- olup dipatrisi mevcut idi. Olgunun yapılan muayenesinde başında, boyunda, sol üst ve alt ekstremitelerde ritmik kasılmaları mevcuttu. Diğer sistem muayeneleri normaldi. Laboratuvar incelemesinde tam kan sayımı, elektrolit değerleri normaldi. Olgunun özgeçmişinde dikkat eksikliği ve hiper aktivite hastalığı nedeni ile 2 yıldır metilfenidat hidroklorür ve 4 aydır risperidon kullandığı öğrenildi.

Mevcut bulgular ve öykü ile hastada risperidon kullanımına bağlı akut tardif distoni geliştiği düşünüldü. Hasta pediyatrik nöroloji kliniğine yönlendirildi. Hastanın risperidon tedavisi kesildi. Hastaya intravenöz sıvı(1/3 izomix 500ml) başlandı ve biperiden HCL (Akineton® ampül) intramüsküler yoldan yapıldı. Hastanın klinik takibinde erken dönemde aynı gün kasılmaları geriledi.

Sonuç: Atipik antipsikotik kullanımı ile ilgili çalışmalarda atipik antipsikotiklerin tardif distoni gelişiminde düşük risk taşıdığı belirtilmiştir. Bu ilaçların ekstrapiramidal yan etkilerinin az olmasında bu ajanların yaptığı serotonerjik blokajın rol oynadığı düşünülmektedir. Atipik antipsikotikler tardif distoni riskini oldukça azaltmış olmalarına rağmen hen sunduğumuz bu olguda ve



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hem de son yıllarda literatürde olgulara rastlanmaktadır. Akut distonik reaksiyonlu hastalar ensefalit, hipokalsemi, nöbet, konversiyon, böcek ısırması ve tetanoz gibi farklı tanıları alabileceği bildirilmiştir. Bu gibi yanlış tanıları bir taraftan zaman kaybına, diğer taraftan ise gereksiz ilaçlarla tedaviye neden olabilmektedir.

Bu olguda görüldüğü gibi atipik antipsikotik ilaçların da tardif distoniye neden olabileceği literatürde bildirilmiştir. Mevcut tedavi yaklaşımları ne yazık ki yüz güldürücü değildir.

Bu durum göz önünde bulundurularak, acil serviste distonik kasılmalar ile başvuran olgularda, primer başvuru şikayeti ne olursa olsun (travma v.s.), acil servis hekimi ayırıcı tanıda mutlaka atipikantipsikotik ilaçlar gibi ilaç kullanımının anemnezde sorgulanması kanaatindeyiz.

Anahtar Kelimeler: Risperidon, tardif distoni, pediatri

SS-086 Cerrahi Aciller (Genel Cerrahi, Ortopedi, Beyin Cerrahisi, Kalp Damar, Anestezi vb.)

Subaraknoid Kanama Ayırıcı Tanısında Nadir Karşılaşılan Bir İdiopatik İntrakraniyel Pakimemenjit Olgusu

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Amaç: Bu olgumuzda acil servise baş ağrısı şikayeti ile gelen ve çekilen bilgisayarlı tomografi tetkikinde hiperdens görüntü tespit edilerek subaraknoid kanama teşhisi konan ancak yapılan ileri görüntüleme tetkiklerle vasküler patolojinin ekarte edildiği idiyopatik intrakraniyel pakimemenjit olgusunu sunmayı amaçladık.

Olgu: 65 yaşında erkek hasta acil servise şiddetli baş ağrısı şikayeti ile başvurdu. Baş ağrısının ara sıra olan ancak başvuru esnasında şimdiki kadar hiç olmadığı kadar şiddetli tarzda olduğunu belirtti. Yapılan nörolojik muayenede bilinci açık, koopere-oryante idi, ense sertliği ve lateralizan bulgusu yoktu. Tansiyon arteriyel 140/90 mm/hg olarak tespit edildi. Çekilen bilgisayarlı tomografi (BT)'de tentorial bölgede ve interhemisferik alanda hiperdens subaraknoid kanama ile uyumlu görüntü izlendi. Hipertansif subaraknoid kanama ön tanısı ile vasküler patoloji açısından değerlendirmek için dijital substraksiyon anjiyografi (DSA) yapıldı. Yapılan DSA'da vasküler patoloji izlenmedi. Hasta anevrizma (-) SAK tanısı ile servisimizde vital bulguların takibi ve medikal tedavisine devam edildi. Glasgow Koma Skalası 15 puan ve vital bulguları stabil olarak taburcu edildi. Hasta bir ay sonra acil servise tekrar şiddetli baş ağrısı şikayeti ile başvurdu. Acil serviste çekilen BT'sinde daha önce tespit edilen hiperdens görüntünün devam ettiği görüldü. Nörolojik muayenesinde ense sertliği ve lateralizan bulgu yoktu. Hasta klinik takip ve gözlem amacıyla servise yatırıldı. Ayırıcı tanı için Kraniyel Manyetik Rezonans Görüntüleme çekildi. Tentorial kalınlaşma ve idiyopatik hipertrofik pakimemenjit (IHP) olarak raporlanan hastaya streoid tedavisi başlanılarak takibe alındı.

Sonuç: Klinik belirtiler olarak ani başlayan baş ağrısı, bulantı, kusma, boyun ağrısı, baş dönmesi şikayetleri ile acil servise başvuran hastalarda öncelikli olarak SAK tanısı düşünülür. Vasküler patolojiler açısından daha ileri anjiyografik tetkiklere gereksinim duyulur. IHP her yaşta görülmekle birlikte, en yüksek insidans altıncı dekadadır. Hemen hemen her olguda bildirilen kardinal semptomlar baş ağrısı ve kranyal sinir felçleridir. Dural biyopsi her ne kadar tanıda esas olsa da kraniyel MRG ile tanı büyük ölçüde konulmaktadır. Tedavide streoid kullanılmakta olup, streoid tedavisi altındaki hastalarda remisyonlar ve ataklar görülebilmektedir.

Olgumuzda olduğu gibi BT'de hiperdens görüntünün bulunması hastada öncelikle SAK tanısını düşündürür. Ancak tekrarlayan baş ağrısı ile acil servise gelen hastalarda bilgisayarlı tomografide non spesifik değişikliklerin görülebileceği, İHS gibi streoid tedavisinin ve uzun süreli takibin gerekliliği olan hastalıklar uygun tanı ve tedavi açısından ayırıcı tanıda akılda tutulmalıdır.

Anahtar Kelimeler: Subaraknoid kanama, idiyopatik hipertrofik intrakraniyel pakimemenjit, manyetik rezonans görüntüleme

SS-087 Cerrahi Aciller (Genel Cerrahi, Ortopedi, Beyin Cerrahisi, Kalp Damar, Anestezi vb.)

Nadir Bir Olgu Sunumu: Pantopaque Droplets

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Amaç: Acil servise travma ile başvuran hastada çekilen rutin görüntüleme tetkiklerinde lomber bölgede spinal kanal içerisinde ve intrakraniyal bölgede çok sayıda hiperdens görünümün tespit edildiği, multipl pantopaque damlacıkları olgusunu sunmayı amaçladık.

Olgu: 64 yaşında erkek olgu acil servise 2 metre yüksekten düşme şikayeti ile başvurdu. Olgu Glasgow koma skalası 15 puanda, bilinci acık koopere oryante pupiller izokorik ışık refleksi +/-, olgunun 4 ekstremitesi tam ve eşit hareketli motor defisit yoktu. Olgunun sağ parietalde 1x2 cm lik sefal hematoma ve lomber bölgede hassasiyeti mevcuttu. Olguya yapılan bilgisayarlı tomografi tetkiklerinde lomber bölgede spinal kanal içinde ve beyinde multipl intrakraniyal en büyüğü 0,7x0,5 mm çaplarında olan hiperdens görünüm saptandı. Olgunun mevcut görünümünün ayırıcı tanısı açısından radyolojik tetkik ve rutin laboratuvar testleri istendi. Olgunun anemnezinde ateşli silah yaralanması öyküsünün, geçirilmiş tesbit edilen bir enfeksiyonunun, Fahr hastalığı gibi tesbit edilmiş bir hastalığının, Tbc öyküsünün, sarkoidoz gibi granülatöz hastalık öyküsünün olmadığı fakat 1980 yılında lomber disk hernisi tanısı konulması amacıyla lomber bölgeden myelografi yapıldığı tesbit edildi. Olguda mevcut anamnez radyolojik ve serolojik testler sonucunda mevcut atipik lezyonların kalsifikasyon olmadığı, 1980'li yıllarda kullanılan myolid isimli radyoopak maddeye bağlı olduğu, bu maddenin tamamen absorbe olmayıp hem beyinde hem de spinal kordda rezidü kalıntıları oluşturduğu, bu rezidü opaklar görüntülemeye bizim olgumuzda olduğu gibi multipl kalsifiye lezyon şeklinde görüldüğü tesbit edildi. Herhangi bir nörolojik defisiti olmayan olgunun mevcut lezyonların insidental olduğu düşünülerek klinik takibe alındı.

Sonuç: Serebral ve spinal kanal içindeki multipl kalsifikasyonlar rutin açıl pratiğinde karşılaşılabilen olgular olup, ayırıcı tanıda ateşli silah yaralanması öyküsünün, geçirilmiş enfeksiyon, fahr hastalığı, tbc, sarkoidoz gibi granülatöz hastalık göz önünde bulundurulmalıdır. Ancak sunduğumuz bu olguda görüldüğü gibi, özellikle 1980 yılından önce myelografide kullanılan myolid isimli opak madde ile karşılaşma öyküsü sorgulanmasının gözden kaçırılmaması kanaatindeyiz.

Anahtar Kelimeler: Pantopaque Droplets, intrakraniyal kalsifikasyonlar, bilgisayarlı tomografi

SS-088 Cerrahi Aciller (Genel Cerrahi, Ortopedi, Beyin Cerrahisi, Kalp Damar, Anestezi vb.)

Üst Ekstremitenin Postherpetik Ani Gelişen Segmental Parezi: Olgu Sunumu

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Amaç: Bu çalışmada kliniğimize önce boyun ve sağ kol ağrısı ve sonrasında sağ kolda motor defisit ile gelen ve takibinde herpes zoster enfeksiyonu tespit edilen olguyu sunmayı amaçladık.

Olgu: Daha önceden herhangi bir şikayeti ve travma öyküsü olmayan, 73 yaşında erkek hasta acil servise 2 gündür olan şiddetli sağ kol ve boyun ağrısı şikayeti ile başvurdu. Yapılan nörolojik muayenesinde, üst ekstremitesinde motor muayenesi normal, reflexler normoaktif ve üst ekstremitede nabazanları alınıyordu. Sağ kolda hareketle şiddetli ağrı tarifliyordu. Olgunun radiküler bir ağrı tariflediği düşünülerek beyin cerrahisi kliniğine yönlendirildi. Hasta 2 gün sonra sağ kolda ani gelişen kuvvetsizlik şikayeti ile tekrar kliniğimize başvurdu. Olgunun muayenesinde kol abduksiyonunda, önkol fleksiyon ve ekstansiyonda, el bileği ekstansiyonda, kol fleksiyon ve ekstansiyonunda 1+/5 kas gücü mevcuttu. Çekilen servikal vertebra manyetik rezonans görüntülemeye mevcut motor defisiti açıklayacak patoloji izlenmedi. Olgunun herhangi bir ilaç kullanımı veya malignite hikayesi yoktu. Hemogram, ve biyokimya tetkiklerinde bir özellik yoktu. Olguya analjezik tedavisi başlandı ve nöroşirürji kliniğine hospitalize edildi. Olgunun takibinde 1 gün sonra sağ kolda ağrı ile uyumlu bölgede tüm kola yayılan veziküler lezyonlar tesbit edildi. Yapılan serolojik tanı ve klinik bulgularla herpes zoster enfeksiyonunun sekonder motor nöron tutulumu olduğu tesbit edildi. Antiviral tedavi başlandı. Post herpetik nevraljisi için medikal tedavi başlandı. Veziküller takipte geriledi ve ek sistemik komplikasyon gelişmedi. Olgunun kısmen post nevraljik ağrısı devam etmektedir. Fizik tedavi rehabilitasyon alan olgunun rehabilitasyon tedavi süreci devam etmektedir.

Sonuç: Acil servise bel boyun ve ekstremitelerde şiddetli ağrı nedeni ile başvurular sık olmaktadır. Takibinde ani motor defisitlerin olduğu olgular çok sık değildir. Herpes zoster enfeksiyonlarında motor parezi, dermatomal veziküler tutulumdan sonra, sıklıkla da 2 hafta sonra, ortaya çıkar, fakat bu süreç olgumuzda olduğu gibi, miyotomal tutulumun dermatomal tutulumla öncelik ettiği de bildirilmiştir. Miyotomal tutulumun öncelik ettiği olgularda da tanı, veziküler dokuntu ortaya çıkıncaya kadar zorluk arz etmektedir.

Bu tip olgularda hekimlerin herpes zoster motor komplikasyonlarına dair bilincin olmaları, motor tutulumun etiolojisinde herpes zoster enfeksiyonunun göz önünde bulundurulması kanaatindeyiz.

Anahtar Kelimeler: herpes zoster, segmental parezi, postherpetik nevralji



SÖZLÜ BİLDİRİLER

SS-089 Other

Presentation of emergency medicine nursing master program at The Institute of Health Sciences of Near East University

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Background: The educational, administrative and legal infrastructure in the health care system should be prepared and evaluated rigorously in terms of emergency care with multidisciplinary approach. Emergency professionals who may be faced with acute health problems related with one or multiple organ systems at any moment should have education and ability at the highest level to perform life saving interventions. There is a need for emergency specialist nurses who are indispensable part of emergency team to upgrade the quality of emergency care and emergency system. We are presenting Emergency Medicine Nursing Graduate Program at The Institute of Health Sciences of Near East University that is scheduled to open and preparations have been completed. It will be first program on its own field in North Cyprus.

Discussion: Emergency Medicine Nursing Graduate Program have purpose to graduate emergency specialist nurses who understand the basis of evidence-based medicine, have up-to-date data about acute illnesses and acute care, qualification to perform scientific research, aim to increase quality of emergency care in Turkish Republic of North Cyprus and all over the world, know the theoretic basis of emergency service management. Master's degree program include at least seven courses with a minimum of 21 credits, a seminar, a thesis and other educational activities. The un-credit seminar and thesis are evaluated as successful or non-successful. The faculty members of Nursing School and Emergency Medicine Department of Medicine School give the lectures. The language of program is Turkish.

Conclusion: Emergency specialist nurses provide increment in quality of emergency care and patient satisfaction and make emergency team more powerful.

Keywords: Emergency, Nursing, Master Program

SS-090 Other

A case of self-mutilation: The man who eats himself

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Objective: Self-mutilation is a general term for a variety of forms of intentional self-harm without the wish to die. The self-mutilating patient is an unusual psychiatric presentation in the emergency department. Cutting one's skin with razors or knives is the most common pattern of self-mutilation, followed by genital and ocular self-mutilation. Despite many patients have been reported to have self-mutilation injuries, literature search does not yield any data on self-eating after self-mutilation. Here, a patient with self-eating following self-mutilation is reported.

Case: A male patient in his 34 was brought in the emergency department from the prison due to a laceration on the right leg. Physical examination revealed stable vital signs and a well-demarcated rectangular 7x11 cm (7 mm thick) soft tissue defect on his right anterior femoral area. Although calm in appearance, he did not respond to physicians' questions. The prison authorities told that the prisoner had cut his thigh with a knife and had eaten the flesh in around one hour. They also added the prisoner had done the same thing in his left arm a year ago. After administration of tetanus vaccine and 1 gr cefazoline sodium, the wound was repaired under local anesthesia, leaving the defect open for secondary healing. Psychiatric evaluation was also done in the emergency department. The patient lacked a regular psychiatric follow up despite several occasions of self-harm behavior. Diagnosed with psychotic disorder, the patient was transferred to a closed psychiatric ward.

Conclusion: Self-mutilating injuries are encountered predominantly in male patients in the emergency department. This pattern of behavior is seen prevalently in patients with personality disorders, acute and chronic psychotic disorders, major affective disorder, and gender disorders. Self-harm behavior is mostly encountered in patients with personality disorders, especially in borderline personality disorder.

The present case has unique difficulties hampering a thorough evaluation leading to psychiatric formulation: presenting in an emergency setting, imprisonment and thus retrieval of history and other relevant data from prison officers and poor collaboration of the patient.

Self-harm behavior is seen prevalently in patients with borderline and antisocial personality disorders, major affective disorder, substance abuse disorder and gender disorders.

Imprisonment status of the patient, secondary gain such as getting away from prison for admission to hospital due to "illness", probable decrements in the penalty to be received from the court warrants further investigation in terms of simulation, personality disorders and substance abuse.

Keywords: self-mutilation, self-harm behavior, emergency department

SS-091 Other

Rate Of 112 Staff's Exposure To Violence in Denizli City

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Objective: In the last decade, news about violence of the 112 emergency service staff frequently revealed in printed and mass media in our country. In this study, incidents of violence against 112 emergency service staff characteristics, to what extent these events have been reported by staff and work satisfaction of staff were investigated.

Methods: Face-to-face interviews with all staff on duty across the city, the data were obtained. Staff involved in the study suffered verbal and physical violence in the last year and within the period at work were investigated. Staff who didn't wish to participate in the study, who served in the 112 emergency service for less than one year and who were on annual leave or leave without pay during the study were excluded.

Results: 141 eligible staff for the study participated in the study. 73% (n=103) of the study group consisted EMT (Emergency Medical Technicians) and paramedics. The average years of work in the 112 emergency medical services was 4.9±2.8 (min: 1 max: 23). Staff 's exposure to verbal and physical violence over the last year were % 51,8 (n=73) and % 8,5 (n=12), respectively. Rates increased by % 77,3 (n=109) and % 24,8 (n=35) respectively, when investigation without time limitation. 85.1% (n = 120) of participants were found not to report the attacks formally. Large percentage (%95,2) of reported incidents were contained physical violence. Finally, the participants' levels of satisfaction with working in the 112 emergency service was high (90.8% n=128).

Conclusion: Violence against the 112 emergency service staff is greater than estimated, because there were not to reported sufficiently. Training must be organized for staff, about how to protect and to cope with violence, before working in the hospital.

Keywords: Prehospital, ambulance, workplace, violence



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SS-092 Other

Is it possible to increase the diagnosis rates of the psychological diseases-attention deficit and hyperactivity disorder, depression, anxiety and sleep disorders using scales?

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Objective: Psychological diseases are common in general population and it tends to be more common in hospitalized patients or who visit emergency services. It's an important issue of public health that these diseases are diagnosed and treated properly. Although it has been known that anxiety and depression are common in patients who visit the Emergency rooms, the rates of sleep disorders and attention deficit and hyperactivity disorder (ADHD) remain unknown. We evaluated the effect of self assessment surveys on the diagnosis rates of depression, anxiety, sleep disorders and attention deficit and hyperactivity disorder.

Materials-Methods: During a three month period on random days patients to whom the triage was applied were randomly chosen and included in the study were asked to answer the Hospital Anxiety and Depression Scale (HADS), Adult Attention Deficit and Hyperactivity Self Report Scale (ASRS), Pittsburg Sleep Quality Index (PSQI), Emergency Room Patient Satisfaction Survey (ERPSS). Hospital records were compared with the survey intersection points.

Results: According to survey intersection points out of 223 patients in 99 patients depression, in 72 patients sleep disorder, in 21 patients anxiety and in 11 patients attention deficit and hyperactivity disorder were suspected. It was shown that the scales used in this study could detect %0 of depression and sleep disorders, anxiety and ADHD rates 49%, 35.6%, 25.2%, 5.4% respectively.

Conclusion: Self assessment surveys are helpful for increasing the diagnosis and treatment rates of psychological diseases in emergency rooms. Increase in these rates could be beneficial both for the individual and the public.

Keywords: Psychiatry Disorders, Psychiatric Rating Scales, Recognition

SS-093 Other

Mean Platelet Volume in terms of Emergency Medicine

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Objective: In the last times, studies on the Mean Platelet Volume (MPV) are increasing. In this study, we aimed to analysis of studies about MPV and to evaluating of MPV in terms of Emergency Medicine.

Materials-Methods: This study was made in a period between 01.01.2009-31.12.2013 dates. In this period a total of 633 publications were obtained about MPV. These studies were examined according to dates, countries, clinics, and subjects. <http://www.ncbi.nlm.nih.gov/pubmed> address was used for this purpose. Publications that made by Türkiye, were also examined in terms of hospitals that published studies. Data were analyzed using the SPSS 16 for Windows in computer programs. All data were expressed as the mean ± standard deviation. Comparisons between groups were made using the Chi-square test. Statistical significance was defined as p<0.05.

Results: These studies were published from 42 different countries and most of them were made in 2013 year(290 %45,81). In terms of the number of publications, most of these studies were made by Türkiye (350, %55,29) and number of studies from Türkiye were significantly higher than the other countries (p<0,05). Published studies were made by 47 different clinics and most of studies were made by Cardiology Clinics in Türkiye (176 %50,28) and in the World (229 %36,17). In this period only 5 (%1,42) studies were published by Turkish Emergency Medicine Clinics. In terms of subject heading, Coronary Artery Diseases were significantly higher studied topics in Türkiye (69 %19,71) and in the World (p<0,05). Most of studies were published by University Hospitals in Türkiye.

Conclusion: In the world, most of studies about MPV were published by Türkiye and most of them were made by Cardiology Clinics, whereas Emergency Medicine Clinics did not show enough interest to subject. Mean Platelet Volume is a laboratory parameters that can be studied in the Emergency Department and Emergency Medicine physicians must show enough interest to MPV.

Keywords: Emergency, Mean Platelet Volume, Türkiye

SS-094 Other

Neutrophil Lymphocyte Ratio in terms of Emergency Medicine

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Objective: In the last times, studies on the Neutrophil Lymphocyte Ratio (NLO) are increasing. In this study, we aimed to analysis of studies about NLO and to evaluating of NLO in terms of Emergency Medicine.

Materials-Methods: This study was made in a period between 01.01.2009-31.12.2013 dates. In this period a total of 609 publications were obtained about NLO. These studies were examined according to dates, countries, clinics, and subjects. <http://www.ncbi.nlm.nih.gov/pubmed> address was used for this purpose. Publications that made by Türkiye, were also examined in terms of hospitals that published studies. Data were analyzed using the SPSS 16 for Windows in computer programs. All data were expressed as the mean ± standard deviation. Comparisons between groups were made using the Chi-square test. Statistical significance was defined as p<0.05.

Results: These studies were published from 50 different countries and most of them were made in 2013 year (299 %40,09). In terms of the number of publications, most of these studies were made by Türkiye (143, %23,48) and number of studies from Türkiye were significantly higher than the other countries (p<0,05). Published studies were made by 44 different clinics and most of studies were made by Cardiology Clinics in Türkiye (86 %60,13) and Internal Medicine Clinics in the World (159 %26,10). In this period only 2 studies were published by Turkish Emergency Medicine Clinics. In terms of subject heading, Coronary Artery Diseases were significantly higher studied topics in Türkiye (69 %48,25) (p<0,05). Most of studies were published by University Hospitals in Türkiye.

Conclusion: In the world, most of studies about NLO were published by Türkiye and most of them were made by Cardiology Clinics, whereas Emergency Medicine Clinics did not show enough interest to subject. Neutrophil Lymphocyte Ratio is a laboratory parameters can be studied in the emergency department and Emergency Medicine physicians must show enough interest to MPV.

Keywords: Emergency, Neutrophil Lymphocyte Ratio, Türkiye

SS-095 Other

Anxiety Levels Among Emergency Nurses Compared With Nurses in Other Inpatient Specialties

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Objective: For the urban people Emergency Department is the most chaotic and stressful place. In the new millennium life expectancy is extremely high and this situation makes the person obligatory to take entire life time under control. Therefore under catastrophic circumstances modern human being is becoming more agitated. Shift system and the desynchronisations of the circadian rhythm is one of the greatest contributors of the occupational stress. Shift working nurses reported significantly higher somatization, obsessive compulsive disorders and anxiety than day time nurses. In this study we have objected to determine whether emergency nurses are more anxiotic than the nurses in other inpatient services.

Materials-Methods: In this cross sectional observational study, 58 nurses working in emergency department and 51 nurses working in the other inpatient services were evaluated with Beck Anxiety Inventory for assessing anxiety levels. All participants personally visited and survey forms have filled in by the observers.

Results: A total of 109 candidates were included in this study. 58 of them were working in the emergency department and 51 of them were working in the other services. Of the emergency group 16 were male and 42 were female and in the service group 7 were male and 44 were female. Of the emergency group average Beck Anxiety Level was 31 (19 -55) and the service group it was 22(6-22). Nurses in other inpatient services revealed low to moderate anxiety levels while emergency nurses revealed moderate to high anxiety levels. (Up to Beck Anxiety Inventory'



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scores; below 8 means no anxiety, 8-15 low level, 16 to 25 moderate and 26 to 63 high level of anxiety). Also there were statistically significant relation between age and anxiety. Younger people shown significantly higher levels of anxiety.

Conclusion:

Emergency nurses are under higher risk of general anxiety disorder. Urgent intervention should be performed to improve the environmental conditions, shift patterns, salaries and social rights of the emergency nurses.

Keywords: Anxiety, Beck, Emergency, Nurse

SS-096 Other

Effect of montelukast on acute lung injury induced by intestinal ischemia and reperfusion in rats

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Objective: Lungs are the most affected remote organ after intestinal ischemia/reperfusion. To investigate the effects of montelukast on intestinal ischemia/reperfusion-induced acute pulmonary injury, mast cells, and apoptosis.

Materials-Methods: Wistar Albino rats were used in the study. Control, intestinal ischemia/reperfusion (IIR), and IIR+montelukast groups, each comprising six rats, were constructed. Ischemia was induced by ligating the superior mesenteric artery for 60 min, followed by 60 min of reperfusion. Montelukast at a dose of 7 mg/kg was administered intraperitoneally 10 min before reperfusion. Lung tissues were fixed in neutral formalin. Paraffin sections were stained with hematoxylin-eosin and toluidine blue to assess mast cells. Pulmonary damage was graded, and mast cells were counted. Apoptotic cells were examined by terminal deoxynucleotidyl transferase dUTP nick-end labeling (TUNEL) staining.

Results: Thickening of the inter-alveolar wall, capillary congestion, hemorrhage, edema, and accumulation of numerous inflammatory cells around the vessels were observed in the lung specimens of the IIR group. Wall thickness, edema, hemorrhage, and inflammatory cell infiltration were less severe in the montelukast-treated group. The number of mast cells and apoptotic cells with positive TUNEL staining was found to be increased in the IIR group and decreased in the montelukast-treated group.

Conclusion: Montelukast alleviated tissue damage and reduced the number of mast cells and apoptotic epithelial cells caused by IIR-induced acute pulmonary injury. These results suggest a new approach for the prevention or treatment of secondary lung injury.

Keywords: Intestinal ischemia/reperfusion, lung, montelukast

SS-097 Other

Parental Anxiety And Affecting Factors In Acute Pediatric Blunt Head Injury

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Objective: This study is designed to investigate the factors affecting parental anxiety in children with head injury in the emergency department (ED).

Materials-Methods: This prospective observational study enrolled all consecutive pediatric patients admitted to the university-based ED with the presenting chief complaint of pediatric blunt head injury (PBHI). The parents were asked to respond the 10-item questionnaire upon both presentation and discharge. Anxiety and persuasion scores of the parents were calculated and magnitudes of the decreases in anxiety and persuasion scores were analyzed with respect to sociodemographic and clinical variables.

Results: The study sample included 341 patients admitted to the ED. Mothers' and fathers' anxiety and persuasion scores were not significantly different from each other on presentation while the extent of decrease in anxiety scores of mothers were significantly smaller than that of the fathers ($p=0.003$). The parents' education levels had significant impact on anxiety and persuasion scores recorded on presentation. The anxiety and persuasion scores were inversely related to education levels of the parents on presentation ($p=0.002$ and $p=0.000$, respectively). In addition, lower education levels were found to be associated with a greater decrease in anxiety and persuasion scores. Neurosurgical consultation also affected the magnitude of the decrease in anxiety and persuasion scores of the parents. The changes in the scores were affected negatively by the parents' age.

Conclusion: Radiological investigations had no significant impact on the decrease in anxiety and persuasion scores of the parents by themselves, while neurosurgical consultation had significant impact on them. Emergency physicians should tailor their strategy to institute effective communication with the parents of children to cut down unnecessary investigations in PBHI.

Keywords: Parental anxiety, pediatric head injury, blunt head injury, emergency department

SS-098 Other

Intravenous Paracetamol vs Dextetopropfen in Acute Migraine Attack in Emergency Department: A Randomized Clinical Trial

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Objective: Migraine is a common form of headache that causes burden of patients and to seek emergent care. The goal of this study is to compare the effectiveness of intravenous dextetopropfen and paracetamol in the treatment of the acute migraine attack.

Materials-Methods: This prospective randomized double-blind controlled study was conducted tertiary care emergency unit. Study patients were randomized into two groups, 50 mg dextetopropfen trometamol and 1000 mg paracetamol administered by an intravenous rapid infusion in 150 ml normal saline. Pain reduction was measured at baseline, 15th and 30th minutes by using visual analogue scale.

Results: Two hundred patients were included into the final analysis. The study subjects had a mean age of 30.1 ± 11 and 81% ($n=162$) of them were female. The median reduction in VAS score at 30th minutes was 56 (IQR: 30-78.5) for paracetamol group and 55 (IQR: 34-75) in dextetopropfen group with a difference of 1 mm (95% CI: -7 to 10) between two groups.

Conclusion: IV paracetamol and IV dextetopropfen are both effective in ceasing migraine pain in emergency department. But none of these drugs are superior to each other.

Keywords: Paracetamol, migraine attack, treatment, adult, emergency department

SS-099 Other

Practice and Knowledge Level of Health Professionals on Prevention of Tetanus

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Antalya Eğitim Araştırma Hastanesi

Objective: In this study, it was aimed to evaluate the level of knowledge of health care professionals, who will assess tetanus immunization status of patients and implement the vaccine program, and non-health care professionals about tetanus.

Materials-Methods: This study is a descriptive survey. Interviews were conducted face to face with Antalya Training and Research Hospital staff. The questionnaire consists of three sections and 13 questions. In the first section demographic data, in the second section tetanus immunization of participants, in the third section participants' level of knowledge about tetanus were evaluated.

Results: 300 staff participated in our study. Participants were divided into three groups as physicians, nurses and non-health care professionals and 100 participants were included in each group. 73.7% of participants had vaccine in childhood, while 65% had the vaccine after the age of fifteen. 45.7% of all participants had been vaccinated in the last 10 years and 32.1% of those people were immunized during pregnancy and 45.2% after injury, and only 21.6% had followed vaccination program. 38% of physicians and 51% of nurses had tetanus vaccination within the past 10 years. 93% of physicians and 91% of nurses knew that tetanus could be a deadly disease. ($p=0.002$) Need for the booster dose after completion of primary vaccination program was known highly in all groups. ($p=0.158$) 50% of the physicians, 31% of nurses and 34% of non-health care professionals knew that these boosters should be done every 10 years. ($p=0.114$) 73% of physicians, 64% of nurses and 44% of non-health care professionals knew the indication of tetanus immunoglobulin application. Statistically significant difference was



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observed between the groups. ($p = 0.001$) 61% of physicians, 80% of nurses and 64% of non-health care professionals think that a single dose prophylaxis should be applied regardless of previous vaccination with an open dirty wound. No significant difference was observed between the groups ($p = 0.152$).

Conclusion: In this study, it was found that the general level of knowledge of health care professionals, who will apply immunization, about tetanus is adequate, but they do not have sufficient knowledge about vaccination program and the correct application of tetanus

Keywords: knowledge, tetanus, vaccination

SS-100 Other

Difficult diagnosis in foreign body aspiration: a mentally retarded patient

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Presentations associated with foreign body aspirations are some of the most common causes of admission to emergency departments. Foreign bodies in the gastrointestinal system are associated with high morbidity and mortality. Early and appropriate intervention will reduce potential complications. A 30-year-old mentally retarded male presented to the emergency department with inability to swallow saliva, coughing and cyanosis in the lips. He had been discharged from health institutions to which he had previously presented with these symptoms, and no pathology had been determined. No foreign body was encountered at x-ray, but computerized tomography of the thorax was compatible with a bone-density foreign body proximal to the esophagus. This case report discusses the difficulty of determining the presence of a foreign body in a mentally retarded patient presenting to the emergency department with dysphagia, respiratory difficulty and cyanosis.

Keywords: Foreign body, Stridor, Aglutition, Mentally retarded patient

SS-101 Other

Geriatric Patient Density in the Emergency Service

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Introduction: In parallel with the aging population, the number of geriatric patients presented in the ER has grown significantly. Most geriatric patients have non-specific indications such as loss of appetite, nausea and asthenia, which suggest that the approach towards them should be integrated.

Material-Method: In this study, we retrospectively analysed the clinical and demographic features of 1000 patients over 65 (median age 75.8) who were presented in the ER with non-traumatic complaints. We classified the diagnoses of those patients into inspiratory, cardiac, neurologic, musculoskeletal, gis+endocrine and the others.

Findings:

The proportion of the patients with inspiratory diagnosis was 24%, of those 5% were hospitalised;

the proportion of the patients with cardiac diagnosis was 17%, of those 4% were hospitalised;

the proportion of the patients with neurologic diagnosis was 10%, of those 3.5% were hospitalised;

the proportion of the patients with gis+endocrine diagnosis was 12.5%, of those 4.5% were hospitalised;

the proportion of the patients with musculoskeletal diagnosis was 6%, of those only 1 person was hospitalised and 7 deceased.

Results: As a result, geriatric patients are mostly presented in the ER with inspiratory and cardiac complaints. Nevertheless, the proportion of the other disorders is also substantial. Therefore, it is crucial to have an integrated approach for those patients in the ER.

Keywords: geriatric patient, emergency, hospitalization

SS-102 Dahiliye Acilleri (Nöroloji, Enfeksiyon, Göğüs, Dahiliye)

Acil servise non-travmatik bilinç değişikliği ile başvuran 65 yaş altı ile 65 yaş ve üzeri hastaların etiyolojik nedene yönelik karşılaştırılması

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Amaç: Çalışmamızın amacı bilinç bozukluğu ile acil servise başvuran travmaya maruz kalmamış hastalarda bilinç bozukluğu nedenlerinin yaşlanmayla birlikte meydana gelen fizyolojik değişikliklerle ilişkisini değerlendirmek ve 65 yaş altı ile 65 yaş ve üzeri hastalardaki tanı farklılıklarını karşılaştırmaktır.

Gereç-Yöntem: Bu çalışma Uludağ Üniversitesi Tıp Fakültesi (UÜTF) Hastanesi Acil Servis'inde Aralık 2012- Kasım 2013 tarihlerini kapsayan 1 yıllık sürede prospektif olarak yürütüldü. Çalışmaya UÜTF Hastanesi Acil Servis'ine travma ile ilişkili olmayan bilinç bozukluğu nedeniyle başvuran 18 yaş ve üstü hastalar dahil edildi. Travmaya maruz kalan ve 18 yaş altındaki hastalar çalışma dışı bırakıldı.

Bulgular: Çalışmaya 646 hasta alındı. Hastaların yaş grupları ile cinsiyet, mevsimsel olarak başvuru zamanları, vital bulguları, bilinç durumu, GKS skoru, istenen konsültasyonlar, aldığı tanımlar ve sonlanma şekilleri karşılaştırıldı. Çalışmaya alınan hastaların ortalama yaşı 64.9 ± 16.4 yıl (min:18, max:103) idi. Başvuran hastalardan 312'si kadın, 334'ü erkek idi. Bilinç bozukluğu şikayeti ile en çok başvurunun yaz mevsiminde ($n=200$, %31) olduğu görüldü. 65 yaş ve üzeri hasta grubunda sistolik kan basıncı ortalama değerinde istatistiksel olarak anlamlı yükseklik saptandı ($p<0.05$). Yaş grupları ile bilinç durumu ($p>0.05$) ve GKS skoru ($p>0.05$) karşılaştırılmasında istatistiksel olarak anlamlı farklılık saptanmadı. Çalışmamızda hastaların 262'si nörolojik nedeni tanı alırken, 384'ünün de nörolojik nedeni olmayan tanı aldığı görüldü. 65 yaş ve üzeri hasta grubunda nörolojik nedeni tanılarıda serebrovasküler olayların ($p<0.05$), 65 yaş altı hasta grubunda da intrakranial kitle/metastaz ve nöbet/status olgularının ($p<0.001$) daha çok görüldüğü istatistiksel olarak anlamlı bulundu. Nörolojik nedeni olmayan tanılarıda ise renal nedenlerin ($p<0.05$) 65 yaş ve üzeri hasta grubunda, toksik nedenlerin de ($p<0.001$) 65 yaş altı hasta grubunda fazla görülmesi istatistiksel olarak anlamlı saptandı. Nörolojik nedeni tanılarıda sistolik ve diastolik kan basıncı değerleri daha yüksek bulunurken, nörolojik nedeni olmayan tanılarıda ise nabız dakika sayısı, solunum dakika sayısı ve vücut sıcaklığı değerleri daha yüksek olduğu görüldü ve istatistiksel olarak anlamlı farklılık saptandı ($p<0.05$). 65 yaş ve üzeri hasta grubunda daha fazla konsültasyon istendiği ($p>0.05$) ve hastaneye daha çok yatışı ($p>0.05$) olduğu görüldü ancak istatistiksel olarak anlamlı farklılık saptanmadı. 65 yaş altı hasta grubunda ise taburculuğun daha fazla olduğu görüldü ve istatistiksel olarak anlamlı farklılık saptandı ($p<0.05$).

Sonuç: Bilinç bozukluğu ile gelen hastalarda bilinç bozukluğunun nedenini saptarken, yaşlı hastalardaki fizyolojik değişikliklerin iyi bilinmesi gerekmektedir. Yaşlı hastaların vital bulguları ve başvuru anındaki kan şekeri düzeyi tanıda yardımcı olabilir.

Anahtar Kelimeler: Acil servis, bilinç bozukluğu, yaşlı hasta

SS-103 Dahiliye Acilleri (Nöroloji, Enfeksiyon, Göğüs, Dahiliye)

Hipoglisemiyle Gelen Fahr Hastalığı

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Amaç: Fahr hastalığı; bazal ganglionlar, serebellar dentat nükleus ve sentrum semiovalede idiopatik kalsifikasyon görülmesi ile karakterizedir. Etiyolojisi kesin olarak bilinmemekle birlikte sıklıkla kalsiyum ve fosfor metabolizma bozukluklarına bağlı olarak meydana gelir. Biz bu olgumuzda bilinci konfüze, hipoglisemi ile gelen fahr hastalığı vakasını sizlere sunacağız.

Olgu: 44 yaşında bayan hasta, acil servisimize halsizlik, titreme ve bilinç değişikliği ile getirildi. Yakını bu şikayetlerinin birkaç saat içinde başladığını ifade etti. Başka bir yakınması olmamış. Hastanın ögeçmişinde 2 kez tiroid operasyonu geçirdiği ve sonrasında levotiroksin ve kalsiyum tedavisinin başlandığı söylendi. Son zamanlarda ilaçlarını düzenli kullanmadığı öğrenildi. Fizik muayenede hastanın bilinci konfüzeydi. Oryantasyonu ve kooperasyonu yoktu. Pupiller izokorik ve orta hattaydı. DIR +/-, IDIR +/-, Fasiyal asimetri yoktu. İstemsiz hareketleri olan hastanın tüm ekstremiteleri spontan hareketliydi. Diğer sistem muayeneleri doğaldı. Hastanın vital bulguları stabildi. Bakılan parmak ucu kan şekeri 50 mg/dl olarak ölçüldü. %50 Dlik dextroz solüsyonundan 50 ml bolus intravenöz (I.V.) puşe yapıldı ve %10 Dlik infüzyon başlandı. Dextroz tedavisine yanıt vermeyen bilinç değişikliği devam edince, kontrastsız bilgisayarlı tomografi çekildi. Beyin tomografi görüntülemesinde her iki bazal ganglionlarda, talamuslarda, periventriküler beyaz cevherde, sentrum semiovalede ve serebellumda çok sayıda kalsifiye simetrik hiperdens alanlar izlendi. Mevcut görüntü Fahr Hastalığı olarak değerlendirildi. Hastadan alınan rutin biyokimya tetkiklerinde total düzeltilmiş Ca:6,1 mg/dl çıkması üzerine, %10 Dlik Dextroz solüsyonunun içine 3 ampul kalsiyum glukonat (1 ampul:93 mg elementer Ca / 10 ml) I.V. 15 dakikada gidecek hızda infüzyon verildi. Hastanın bilincinin açılması ve oryantasyon ve kooperasyonunun tam olması üzerine mevcut oral kalsiyum, levotiroksin tedavisine D vitamini de eklenip dahiliye polikliniğine yönlendirilerek taburcu edildi.

Sonuç: Fahr hastalığı paratiroid bozuklukları gibi metabolizma bozuklukları ya da bölgesel iske mi, inflamasyon gibi lokal dolaşım bozuklukları sonucu Ca, Fe, Zn, Al, Mg gibi minerallerin, mukopolisakkaritlerin, glikoproteinlerin birikimine bağlı olarak ortaya çıkmaktadır. Klinik bulgular sıklıkla parkinsonizm, distoni, tremor, kore, ataksiye ek olarak demans ve duyu durum bozukluklarıdır. Tanıda en önemli inceleme metodu bilgisayarlı beyin tomografisidir. İntrakranial kalsifikasyonlar globus pallidus başta olmak üzere sıklıkla putamen, kaudat nükleus, internal kapsül, dentat nükleus, talamus ve serebellumda görülürler. Kalsifikasyonların en önemli özelliği simetrik olmasıdır.



SÖZLÜ BİLDİRİLER

Fahr Hastalığı bu vakamızda da olduğu gibi atipik prezentasyonlarla gelebilmekte, hatta insidental saptanabilmektedir. Acil tıp doktorlarının özellikle tiroid cerrahisi geçiren hastalarda akıldaki bulundurulması gereken tanılar arasında olacağı açıkça görülmektedir.

Anahtar Kelimeler: Fahr hastalığı, tiroidektomi, hipokalsemi

SS-104 Dahiliye Acilleri (Nöroloji, Enfeksiyon, Göğüs, Dahiliye)

Acil Servise Epileptik Nöbet İle Başvuran Hastaların 4 Yıllık Retrospektif İncelenmesi

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Amaç: Acil Servis'e epileptik nöbet şikayetiyle başvuran hastaların genel özelliklerinin tanımlanmasıdır.

Gereç-Yöntem: Geriye dönük çalışma Ege Üniversitesi Acil Servisine 01.01.2008-31.12.2011 tarihleri arasında başvuran epileptik ataklı, on sekiz yaş üstü hastalar incelendi.

Bulgular: 657 hasta değerlendirilmiştir. Hastaların yaş ortalaması 41 ±17(18-89)' dı. Hastaların, % 57.2'si (376) erkekti. Yaş ilerledikçe sekonder nöbeti olan hastaların oranının arttığı istatistiksel olarak anlamlı bulundu (p<0.05). Sekonder nöbetli hastaların acil serviste gözlem süresinin istatistiksel olarak daha fazla olduğu saptandı (p<0.05). Başvuru GKS skoru düşük saptanan, yeni nörolojik defisiti olan hastaların gözlemlenirken nöbet geçirme oranının daha fazla olduğu istatistiksel olarak anlamlı saptandı (p<0.05). Yeni nörolojik defisiti olan hastaların 8 saat üzerinde nöbet geçirme riski olmayanlara göre 3.9 kat fazla saptandı (p<0.05, OR:3.9). GKS skoru anormalliği olanların 8 saat üzerinde nöbet geçirme riski 2.9 kat fazla saptandı (p<0.05, OR:2.9). Yeni nörolojik defisiti olanların olmayanlara göre 8 saat içerisinde nöbet geçirme riski 5.7 kat fazla olarak hesaplandı (p<0.05, OR:5.7). Gözlemlenirken nöbet izlenmesiyle, hemogram ve biyokimyasal parametreler arasında istatistiksel olarak anlamlı bir ilişki bulunamadı (p>0.05). Acil Servis gözlem süresi, yeni nörolojik defisit gelişen hastalar ve başvuru GKS skoru düşük hastalarda istatistiksel olarak daha uzun saptandı (p<0.05). İlk kez nöbet geçirme şikayeti olan hastaların; GKS skorları bilinen nöbeti olanlara göre daha düşüktü ve yeni nörolojik defisit gelişimi istatistiksel olarak anlamlı şekilde daha fazlaydı (p<0.05). Yine ilk kez nöbet geçiren hastalarda yeni nörolojik defisiti olan hastaların olmayanlara göre 8 saat ve üzerinde nöbet geçirme riski 4 kat daha fazla saptandı (p<0.05, OR:4). Bu grupta GKS skorunda anormallik saptananlarda saptanmayanlara göre 8 saat ve üzerinde nöbet geçirme riski 2.9 kat fazla saptandı (p<0.05, OR:2.9). İlk kez nöbet geçiren hastaların 8 saat içerisinde nöbet geçirme riski yeni nörolojik defisiti olan hastalarda olmayanlara göre 5.6 kat daha fazla olarak bulundu (p<0.05, OR:5.6). İlk kez nöbet geçiren grupta daha önce nöbet hikayesi olan gruba göre hastaneye yatış oranı istatistiksel olarak anlamlı şekilde daha fazla saptandı (p<0.05). İlk kez epileptik nöbet geçiren 158 hastanın %56.3'ü primer nöbet, %43.7'sinde sekonder nöbetti.

Sonuç: Yeni nörolojik defisit saptanması ve düşük başvuru Glasgow koma skalası skoru ilk kez nöbet geçiren hastalarda daha sık görülür, bu hastalarda acil serviste ilk sekiz saatte nöbet riski fazladır, acil servisi gözleminde nöbet geçirme riskini artırmıştır ve aynı zamanda bu hastalar acil servislerde daha uzun izlenmektedir. İlk kez nöbet geçirenler daha çok hastaneye yatmaktadır. Yaş ilerledikçe sekonder nöbet riski ve bu hastaların acil servis izlemi artmaktadır.

Anahtar Kelimeler: nöbet, acil servis, primer nöbet, sekonder nöbet

SS-105 Dahiliye Acilleri (Nöroloji, Enfeksiyon, Göğüs, Dahiliye)

Migren Hastalarında Artmış Serum High Sensitivity CRP ve Galectin-3 Düzeyi

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Amaç: Nörojenik inflamasyon, kortikal yayılan depresyon, kranial damarlarda kontraksiyon disfonksiyonu migren patogenezinin sorumlu tutulan yaygın mekanizmalardır. Genel görüş olarak nörojenik inflamasyon migren ataklarının başlamasında önemli bir unsur olarak kabul edilen, steril bir inflamasyondur ve sensoryal sinir aktivasyonu sonucu oluşan inflammatuar bir olay olarak tanımlanır. Galectin-3 lektin bağlayıcı galaktosid olup çeşitli dokularda yaygın olarak ve çoğunlukla mast hücreleri, nötrofil ve eozinofillerden ekspres edilir. Akut ve kronik inflamasyon gibi patolojik durumlarda intrasellüler sinyal yollarının aktive edilmesinde rol alır. High sensitivity CRP (hsCRP) sistemik inflamasyonun bir belirleyicisidir. Çalışmamızda migren atak ve interictal dönemlerinde, serum hsCRP ve Galectin-3 düzeyi arasındaki ilişkiyi araştırmayı planladık.

Gereç-Yöntem: Çalışmaya 90 migren hastası ve 50 sağlıklı kontrol grubu alındı. Migren hastaları atak ve interictal dönem olmak üzere iki gruba ayrıldı. Bu gruplarda sonradan auralı ve aurasız atak olmak üzere ikiye ayrıldı. Atak sayısı ayda dört veya daha fazla olan vakalar sık, daha az olanlar ise nadir atak olarak sınıflandırıldı. Galectin-3 ve hsCRP düzeyleri enzim linked-immunosorbent assay (ELISA) yöntemiyle ölçüldü.

Bulgular: Migren grubunda 69 hasta (%76.67) bayan, ortalama yaşı 36.33±9.96/yıl, kontrol grubunda ise 35 hasta bayan, ortalama yaş 34.32±9.33/yıl olarak tespit edildi. Migren grubunda 60 vaka atak, 30 vaka ise interictal dönemde idi. Migren atak grubunun %31.7'si, interictal grubun ise %20'si sık atak geçiriyordu. Migren hastalarının ortalama hsCRP ve galectin-3 düzeyi kontrol grubuna göre anlamlı yüksekti (sırasıyla hsCRP 4.47±1.66, 3.05±1.24, p<0.05, galectin-3 3.48±1.69, 2.05±0.22, p<0.05). Migren atak grubundaki hsCRP ve galectin-3 düzeyi interictal grubuna göre daha yüksekti (sırasıyla hsCRP 4.77±1.71, 3.89±1.41, p<0.05, galectin-3 3.75±1.78, 2.95±1.37, p<0.05). Biyomarkerların migren sıklığı ile arasındaki ilişkiyi baktığımızda sık atak geçirenlerde hsCRP düzeyi daha yüksekti (p<0.05). hsCRP ve galectin-3 düzeyi ile auralı ve aurasız ataklar arasında anlamlı fark bulunmadı ve hastalığın süresi ile hsCRP ve galectin-3 arasında korelasyon izlenmedi.

Sonuç: Çalışmamızda inflamasyonun nonspesifik bir markeri olan hsCRP ile inflamasyonda önemli rol oynadığı bilinen galectin-3 serum düzeyinin migrenli hastalarda kontrol grubuna göre anlamlı yüksek bulundu.

Anahtar Kelimeler: Migren, hsCRP, Galectin 3

SS-106 Dahiliye Acilleri (Nöroloji, Enfeksiyon, Göğüs, Dahiliye)

Tekrarlayan Serebral İskemiye Bağlı Total Kortikal Körlük: Nadir Bir Olgu

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Amaç: Kardiyovasküler hastalıklar ve kanserden sonra en sık üçüncü ölüm nedeni olarak gösterilen serebrovasküler hastalıklar (SVH), acil servis başvurularında önemli bir yer tutmaktadır. İnme, kaynaklandığı damara göre arteriyel veya venöz olabilmektedir. Arteriyel inmeler ise iskemik ve hemorajik olmak üzere iki gruba ayrılır. İskemik tip inmede, serebral bir damarın tıkanmasından ya da hipoperfüzyonundan sonra kan akımının kesilmesini takip eden birkaç dakika içinde, infarktüs alanının merkezinde nöron hücreleri ölümü gerçekleşir. İnme hastalarının acil serviste değerlendirilmeleri sırasında radyolojik tetkikler açısından ilk olarak kontrastsız BT (bilgisayarlı tomografi) istenmekte ve BT ile iskemik ve hemorajik tip inmeler ayrılabilir. Kortikal körlük, kortikal vizüel merkezlerin ve genikulokalkarin vizüel yolların lezyonları sonucu meydana gelen körlüktür. Kortikal körlüğün pek çok nedeni vardır. Bunlar arasında oksipital enfarktüs ve kanama-lar, tümör, enfeksiyonlar, oksipital lob epilepsisi, travma, hava emboli-si, kardiyak arrest, metabolik hastalıklar ve ilaçlar sayılabilir. Geçirilmiş iskemik inme sonrası sağ oksipital kortekste ensefalomalazik değişikliği bulunan bir olgumuzda, sol oksipital kortekste yeni gelişen iskemik inmeyle total bir kortikal körlük geliştiği görülmüştür.

Olgu: 56 yaşında bayan hasta acil servisimize yeni gelişen tam görme kaybı şikayetiyle başvurdu. Hastanın öyküsünde bir yıl önce iskemik serebrovasküler hastalık geçirdiği öğrenildi. Fizik muayenesinde lateralizasyon bulgusu yoktu. Kan basıncı: 140/80 mm Hg ve nabızı: 86 idi. Çekilen EKG'sinde atrial fibrilasyonu mevcuttu. Hastanın görme muayenesinde tam görme kaybının olduğu ve göz dibi bakışının ise normal olduğu görüldü. Hastanın çekilen BT'sinde sağ oksipital lobda ensefalomalazi ve sol oksipital lobda akut enfarktüs düşündürülecek dansite azalması saptandı. Bunun üzerine çekilen difüzyon MR'ında ise sol oksipital lob medial kesiminde akut enfarktüs ile uyumlu difüzyon kısıtlanması görüldü.

Sonuç: Total kortikal körlük gelişmiş bir vakada, körlüğün nedeni oksipital lobları farklı zamanlarda etkileyen iskemik tip inme olarak değerlendirildi. Non travmatik olarak sadece oksipital lobların bilateral olarak farklı zamanlarda etkilenmiş olduğu iskemik inmeye bağlı oluşan kortikal körlük durumunun nadir görülmesi nedeniyle bu olguyu paylaşmayı uygun bulduk. Geçirilmiş iskemik inme hikayesi bulunan olguların, acil servis ve diğer poliklinik başvurularında anti-agregan veya anti-koagülan tedavileri her fırsatta kontrol edilmeli ve ilaçlarının düzenli olarak kullanımı sağlanmalıdır.

Anahtar Kelimeler: serebrovasküler hastalık, total kortikal körlük, anti-agregan, anti-koagülan



ORAL PRESENTATIONS

SS-107 Dahiliye Acilleri (Nöroloji, Enfeksiyon, Göğüs, Dahiliye)

Eritrosit dağılım genişliği (rdw) 'nın Sepsisli hastalardaki prognostik rolü

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NECMEETTİN ERBAKAN ÜNİVERSİTESİ MERAM TIP FAKÜLTESİ

Amaç: Biliyoruz ki anemi ortaya çıkmadan önce RDW düzeyinde anemiye bağlı yükseklik ortaya çıkmaktadır. Ciddi sepsis ve septik şoktaki hastalarda kemik iliği baskılanmasının RDW düzeyi takibi ile henüz anemi ortaya çıkmadan tanınabildiği gerçeğinden hareketle ciddi sepsis ve septik şokun önceden tahmin edilebileceği hipotezi ile çalışmamızı planladık. Böylelikle RDW değeri sepsisli hastaların prognozunu belirlemedeki önemini göstermeyi amaçladık.

Gereç-Yöntem: 1 Ekim 2012 – 31 Aralık 2013 tarihleri arasında Necmettin Erbakan Üniversitesi Meram Tıp Fakültesi Acil Tıp A.B.D. YBÜ'nde prospektif olarak yapılmıştır. APACHE II, SOFA skorları ve RDW'nin tanı anından itibaren 3 günlük ortalama değerleri, hastaların mortalite durumları ile demografik verileri kayıt altına alınmıştır. Söz konusu parametrelerin prognoz açısından değerleri araştırılmıştır.

Bulgular: 136 hasta çalışmamıza dahil edildi. Hastaların 46'sı sepsis tanısı ile, 35'i ciddi sepsis tanısı ile, 55'i septik şok tanısı ile takip edildi. SOFA, APACHE II skorlarının ortalama değerleri açısından mortalite olan ve olmayan hastalar arasında istatistiksel açıdan anlamlı farklılık vardı ($p < 0,001$). Ancak RDW değerleri açısından mortalite olan ve olmayan hastaların ortalama değerleri arasında istatistiksel açıdan anlamlı farklılık tespit edilmedi ($p: 0,045$, $p: 0,014$). Her bir parametre için mortalite olmayan/olan gruplarda ortalama değerler şöyle idi; SOFA (4,55±2,91/10,11±3,772), APACHE II (16,51±6,889/27,90±8,686), RDW (13,50±2,713/14,51±3,092).

Sonuç: Sepsisli hastalarda; ciddi sepsis ve septik şoka ilerleyen dinamik süreçte erken tanı konulabilirse yapılacak hedefe yönelik tedavi yaklaşımları ile hastaların morbidite veya mortalite oranlarında belirgin iyileşmeler elde edilebilecektir. SIRS'tan septik şoka ilerleyen dinamik süreçte bu döngüyü erken tanımlayabilecek ucuz ve kolay ulaşılabilir bir belirteç bulabilmek amacıyla planladığımız bu çalışmamız bu RDW düzeyinin prognoz açısından değeri gösterilememiştir.

Anahtar Kelimeler: RDW, sepsis, prognoz

SS-108 Toksikoloji

Akrep Sokmasına Bağlı Gelişen Akciğer Ödemi

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Amaç: Akrep sokmalarının pek çoğu zararsızdır ve birtakım basit klinik bulgularla seyreder. Ancak bazen ciddi ve hayatı tehdit edici komplikasyonlara neden olur. Akrep çeşitliliği açısından zengin olan ülkemizde akrep sokması hala ciddi sağlık problemlerine sebep olmaktadır. Akrep zehri lokal olarak şişme, ağrı ve hissiyatsızlık neden olur. Sistemik işaretleri de nörolojik (koma, tremor, solunum kaslarında paraliz, imme), kardiyak (hipertansiyon, aritmi, akut kalp yetmezliği, pulmoner ödem) ve pankreatik olabilir. Kardiyovasküler tutulum en önemli mortalite ve morbidite nedenidir. Vakamızda, akrep sokmasına sekonder kardiyak komplikasyonlar ve pulmoner ödem gelişmiş, 38 yaşında bir erkek hasta sunularak konuya dikkat çekmeyi amaçladık.

Olgu: Otuzsekiz yaşında erkek hasta acil kliniğimize sol el 3. falanx distalinden akrep sokması nedeniyle başvurdu. Ani gelişen soğuk terleme, nefes darlığı, göğüs ağrısı şikâyetleri olan hastanın öyküsünde şikâyetleri başladıktan sonra başvurduğu başka bir hastanede belirgin nefes darlığı olması üzerine larinx ödemi düşünülerek Subkutan adrenalin, İntravenöz (IV) anti-histaminik, IV steroid ve bronkodilatör tedavi yapıp hastanemize sevk edildiği öğrenildi. Daha önce bilinen bir kalp hastalığı olmayan, fizik muayenesinde genel durumu bozuk, bilinç ajite, tansiyon arteryel: 80/60 mm Hg, nabız: 120/dakika, solunum sayısı 24/dk, ateş: 38 °C olarak ölçülen ve belirgin takipnesi ve dinlemekle bilateral ralleri olan hastanın yapılan tetkiklerinde pH: 7,22 pCO2:30 pO2:50 O2 sat:70 civarında idi. Hasta entübe edildi. White Blood Cell: 29600/mm3, Hgb: 15,4g/dl Trombosit: 354000, CK: 2202 U/L, CK-MB: 10,97 ng/mL, Troponin-T: 912 pg/ml AST: 37 IU/L, ALT: 38 IU/L. Diğer biyokimyasal parametreleri normaldi. Elektrokardiyografi (EKG)'sinde hız: 120/dakika sinüzaldi, Posterior anterior akciğer grafisinde pulmoner ödemle uyumlu görünüm, bilateral alt zonlarda konsolidasyon artışı mevcuttu. Yapılan Ekokardiyografisinde; sol ventrikül sistolik ejeksiyon fraksiyonu (EF): % 30-35 olarak ölçüldü. Hastaya akrep sokmasına sekonder miyokardit tanısı konuldu. Akciğer ödemi tedavisi başlandı. Zehir danışma merkezi tarafından hastaya 2 saate bir antivenom önerilmesi üzerine alerjik reaksiyonlar için gerekli tedbirler alınarak serum anti-scorpione antivenomu uygulanıp yoğun bakıma yatırıldı.

Sonuç: Sonuç olarak akrep sokmaları ülkemizde sık rastlanmakta olup bu olgularda mortal seyredebilen miyokardit, akut kalp yetmezliği, pulmoner ödem gibi komplikasyonların gelişebileceği mutlaka akıld tutulmalı, hastalar bu açıdan da iyi değerlendirilmelidir.

Anahtar Kelimeler: Akrep Sokması, Acil Servis, Pulmoner Ödem

SS-109 Travma Acilleri

Kronik Böbrek Yetmezliği ve Patolojik Kırık

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Antalya Eğitim ve Araştırma Hastanesi, Antalya

Amaç: Patolojik kırık, hastalıklı veya anormal bir kemikte nispeten küçük bir travmaya maruz kalma sonucuyla oluşan kırıklara denir. Daha önceden var olan süreç kemiği zayıflatıp normal şartlarda korteksi bozmayacak güçlere duyarlı hale getirmiştir. Metastatik lezyonlara bağlı kırıklar, iyi huylu kemik kistine bağlı kırıklar, osteoporozla bağlı kompresyon kırıkları bu tür yarananmaya genel örneklerdir. Kronik steroid kullanımı da osteoporozla yol açıp patolojik kırık oluşturabilecek nedenler arasındadır. Bu olgumuzda acil servise kalça ağrısı ile gelen hastayı irdeleyeceğiz.

Olgu: 37 yaşında erkek hasta, bir gün önce başlayan sol kalçada ağrı şikâyeti ile acil servisimize başvurdu. Herhangi bir travma öyküsü yoktu. Gelişinde GKS:15, oryante, koopere, bilinç açıktı. Fizik muayenesinde sol bacadaki hareket kısıtlılığı ve dış rotasyon pozisyonu görülmüyordu. Hasta 1 hafta önce sağ femur boynunda patolojik fraktür nedeniyle ortopedi servisinde opere edilmiş ve hastaneden 1 gün önce taburcu olmuştu. Acil serviste çekilen AP pelvis grafisinde sağ femur başında internal fiksator ve sol femur boynunda nondepres fraktür görülmüyordu. Hasta bu bulgularla ortopedi servisine yatırıldı. Açık redüksiyon ve internal fiksasyon uygulanan hastaya patolojik fraktür teşhisi kondu.

Sonuç: Kronik böbrek yetmezliği olan hastalar ömür boyu steroid kullanımı ve hemodialize bağımlıdır. Bunun sonucunda osteoporoz ve kemiklerde amiloid birikimi kaçınılmazdır. Kronik böbrek yetmezliği olan hastalar eklem ağrısı ile geldiklerinde patolojik kırıklar akıld tutulması gereken ön tanılardan biri olmalıdır.

Anahtar Kelimeler: femur, kby, kırık

SS-110 Toksikoloji

Karbonmonoksit zehirlenmelerinde laktat ve baz eksisi korelasyonu ve prognoza etkisi

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meram eğitim araştırma hastanesi acil tıp kliniği konya türkiye

Amaç: Karbon monoksit (CO) zehirlenmesi dünyada ve ülkemizde ölümlü sonuçlanan zehirlenmelerin en önemli nedenlerinden biridir. Karbon monoksit renksiz, kokusuz, tatsız ve irritan olmayan bir gazdır. CO, karbon kaynaklı yakıtların iyi yanmaması sonucu ortaya çıkar, akut ve kronik zehirlenmelere neden olabilir. COHb düzeyleri ile klinik bulgular ve prognoz arasında direk bir ilişki olmadığı bilinmektedir. Saturasyon normal seviyelerde ölçülmesi nedeniyle doku hipoksisini yansıtmamaktadır. Laktik asidoz doku hipoksisini gösteren durumlardan biridir. Biz bu çalışmada karbonmonoksit zehirlenmelerinde laktik asidoz ve baz eksisi arasındaki korelasyonu ve prognoza etkisini araştırdık.

Gereç-Yöntem: Çalışma aralık 2013-mart 2014 tarihleri arasında meram eğitim araştırma hastanesine başvuran ve co zehirlenmesi teşhisi konulan hastalarda prospektif olarak yapıldı. Çalışmaya 18 yaş üstü 112 hasta dahil edildi. istatistiksel olarak mann whitney u testi student t testi ve independent sample testleri kullanıldı.

Bulgular: Hastaların % 51,3 ü (58) bayan, %48,7 si (54) erkekti. Yaş ortalamaları 35± 12,9, ortalama cohb düzeyleri 24±7,5, laktat 0.saat değerleri 2(1.35) laktat 4. saat değerleri 1.1(0.7), BE 0.saat -2.3±3.9 BE 4. saat -1.7±3.6 olarak tespit edildi. Hastaların % 52 (59) si YB a yatırıldı, 7 hasta HBO tedavisi aldı. YB a yatırılan ve gözlem odasında tedavi edilen gruplar arasında yapılan karşılaştırmada BE değerleri arasında anlamlı fark tespit edilmedi. HBO tedavisi alan olmayan gruplar karşılaştırıldığında yaş, GKS ve laktat değerleri arasında anlamlı fark tespit edilirken COHb ve BE düzeyleri farklı bulunmadı. BE ve laktat arasında korelasyon tespit edilmedi.

Sonuç: Karbonmonoksit zehirlenmelerinde ölümcül olması ve kalıcı sekellerinin olması nedeniyle acil servislerde dikkatli olunmalıdır. Gereken hastalara mutlaka HBO tedavisi başlanmalıdır. Biz laktat ve BE değerlerinin prognoza etkisini araştırdık. Laktat değerleri bilindiği gibi prognozda değerli bir marker olarak bulundu. BE ile korelasyon tespit edilmedi. Daha geniş kapsamlı çalışmaların yapılması önerilir.

Anahtar Kelimeler: acil servis, baz eksisi, karbonmonoksit zehirlenmesi, laktat, prognoz



SÖZLÜ BİLDİRİLER

SS-111 Diğer

Denizli İlinde Görevli 112 Personelinin Geçirdiği İş Kazaları

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Amaç: Ülkemizde, 112 acil kurtarma ambulanslarında görevli sağlık personelinin maruz kaldığı iş kazaları konusunda sağlıklı veriler yoktur. Diğer sağlık personeline göre daha fazla risk altında olduğunu düşündüğümüz bu çalışanlarda bir anket çalışması planladık. Maruz kaldıkları iş kazalarının tipleri, sıklığı ve sonuçlarını araştırdık.

Yöntem: Denizli il genelinde 112 acil kurtarma ambulanslarında aktif çalışan sağlık personeline yüz yüze görüşme ile anket çalışması yapıldı. Çalışmaya katılmak istemeyen ve çalışma süresince (2 ay) içinde olanlar çalışmadan dışlandı.

Bulgular: Toplam 198 sağlık personelinin 141'i (%71,2) çalışmaya katılmıştır. Grubun yaş ortalaması 30,3±9,2, cinsiyet dağılımı ise eşitti (71 kadın, 70 erkek). Çalışırken %41,8'inin (n=59) bir ya da birden fazla trafik kazası geçirdiği belirlendi. Bu kazalar sıklıkla (n=47, %44,8) ambulansın başka bir araçla çarpışması ile oluşmuştu. 86'sı (%61,0) görevde iken kendisine hiç iğne batmadığını bildirdi. Bu tür bir iş kazasına maruz kalanlarda (n=55) olay sıklıkla (%47,5) hareket halindeki ambulans IV girişim sırasında gerçekleşmişti. Çalışanların kan veya vücut sıvılarının göz ile teması şeklinde bir iş kazasına maruz kalıp kalmadığı sorgulandığında %71,6'sının (n=101) maruz kalmadığı belirlendi.

Çalışırken iş kazası (iğne batması, kesici delici alet yaralanması, kan veya vücut sıvıları ile göze teması vb) geçirdiğini bildirenlerde, bu kazaların %41,0'ı ambulans hareketi nedeniyle gerçekleşmişti.

iğne batması, kesici delici alet yaralanması, kan veya vücut sıvıları ile göze teması şeklinde iş kazalarından herhangi birini geçirenlere (n=91), bu kazaları rapor edip etmediği soruldu. Sadece %8,8'inin (n=8) olayı rapor ettiği belirlendi. Karşılaşabilecekleri iş kazalarına yönelik eğitim alıp almadıkları sorusuna 96'sı (%68,0) «evet» yanıtı verdi.

Sonuç: 112 acil kurtarma ambulanslarında görevli personelde iş kazalarının sıklıkla hareket halindeki ambulansta gerçekleştiği ve iş kazalarının çoğunun rapor edilmediği belirlenmiştir. 112 çalışanlarının maruz kalabilecekleri olası iş kazalarına yönelik eğitim alması sağlanmalıdır.

Anahtar Kelimeler: Ambulans, iş kazası, 112

SS-112 Kardiyovasküler Aciller

Akut Koroner Sendrom ve Netrin-1

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konya eğitim araştırma hastanesi

Amaç: Acil servise akut koroner sendrom nedeniyle başvuran hastalarda serum netrin 1 düzeylerinin tanı ve prognoz üzerine etkisi belirlenmeyi amaçladık.

Gereç-Yöntem: Halen kardiyovasküler hastalıklar sanayileşmiş ülkelerde önde gelen ölüm nedeni olup 2020 yılında da durumun değişmemesi beklenmektedir. Netrin-1, memeli netrin ailesinin üyesinden biridir. Netrin-1 endotel hücreleri ve vasküler düz kas hücrelerinde proliferasyon uyarıcı, migrasyonu indükleyici ve adezyonu teşvik edici olarak işlev görmektedir. Netrin-1 aynı zamanda vasküler endotelial growth faktör yanıtını güçlendirerek vasküler angiogenezi uyarır. Yapılan son bir çalışmada netrin-1 nitrik oksit üretimi (NO) indükleyerek aort endotel hücre migrasyonu ve proliferasyonu teşvik etmektedir. Patolojik şartlar altında Netrin-1 angiogenetik etkisi ile tedavi edici özelliği sağlayarak kan dolaşımına yardımcı olur. Örneğin iv vivo ortamda farelerde diabet sonrası oluşan reversibil nöropati ve vaskülopati sonrası nörovaskülarizasyonu hızlandırarak bacakta oluşan iskemiyi tersine çevirebilmiştir. Ayrıca Netrin-1 adenovirüs ilişkili gen transferi yapılan yetişkin fare beyinde neovaskülarizasyonu indüklediği gösterilmiştir. Netrin-1 proteini enfakte kalp dokusunda işlevsel kan damar yoğunluğunu arttırmaktadır. Yetişkin dokusunda netrin 1 böbrek ve kalpteki iske, reperfüzyon hasarını apoptozisi baskılayarak azaltır. Acil servisimizde akut koroner sendrom düşünülen hastalara ilk değerlendirme, fizik muayene ve EKG çekildikten sonra hastalar monitörize edilecek hastanın demografik özellikleri, öz geçmişi vital bulguları, labratuar bulguları, anjiyografi bulguları, EKO bulguları, hastanede yatış süresi, 28 günlük ve 6 aylık mortalite bilgileri kayıtlı edildi. Killip, TIMI ve GRACE risk skorlaması yapıldı. Hastalar STEMI VE NSTEMI olarak ikiye ayrıldı. Hastaların acil servise geliş ve anjiyografi yapıldıktan sonraki 6-8 saatlerde iki defa kan alındı. Bu kanlarla eş zamanlı olarak troponin netrin-1 çalışıldı.

Bulgular: Toplam 188 hasta ve 50 kontrol grubu alındı. Median yaş hasta grubunda 63(23), kontrol grubunda 33(21)'di. Çalışmaya alınanların %59,7 (142) erkek, %40,3 (96) di kadındı. Vaka ve kontrol grubu geliş netrin düzeyleri karşılaştırıldığında vaka grubunda anlamlı olarak yüksek bulundu (p<0,05). Geliş ve anjiyografi sonrası netrin düzeyleri de anlamlı olarak farklı bulundu (p<0,05). Geliş netrin düzeyleri; TIMI risk skoru, TIMI risk skoru sınıflaması ve GRACE ile korole tespit edildi. (sırasıyla r:0,25,r:0,26, r:0,16, p<0,05).

Sonuç: Netrin-1 düzeyleri AKS' da yükselir. Risk skorlamaları ile koreleler ve risk sınıflamasında kullanılabilir. Daha yüksek vaka sayıları ile yapılan çok merkezli çalışmalara ihtiyaç vardır.

Anahtar Kelimeler: akut koroner sendrom, netrin-1, timi

SS-113 Diğer

Acil Servise Karın Ağrısı Şikayeti ile Başvuran 45-64 Yaş ile 65 Yaş ve Üzeri Hastaların Karşılaştırılması ve Tanılarının Fizyolojik Değişikliklerle İlişkisinin Değerlendirilmesi

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Amaç: Çalışmamız, acil servise travmaya bağlı olmayan karın ağrısı ile başvuran 45 yaş ve üzeri hastalarda, karın ağrısı nedenlerinin yaşlanmayla meydana gelen fizyolojik değişikliklerle ilişkisini değerlendirmek ve orta yaşlı (45-64 yaş) ile ileri yaşlı (65 yaş ve üzeri) hastalardaki tanı farklılıklarını karşılaştırmak amacıyla yapılmıştır.

Gereç-Yöntem: Çalışmaya 1607 hasta alındı. Hastaların yaş grupları ile karın ağrısına eşlik eden şikayetler, vital bulgular, yandaş hastalıklar, konsültasyonlar, tanıları ve sonuçları karşılaştırıldı.

Bulgular: Her iki grupta karın ağrısına eşlik eden en sık şikayet bulantı-kusmadır (p<0,05). 65 yaş ve üzeri grupta vital bulgularındaki değişikliklerin 45-64 yaş grubuna göre daha fazla olduğu görüldü (p<0,001). 65 yaş ve üzeri grupta en sık görülen yandaş hastalık hipertansiyon iken 45-64 yaş grubunda malignitedir. 65 yaş ve üzeri gruba konsültasyon istemi daha fazladır (p<0,05). 65 yaş ve üzeri grupta en sık görülen karın ağrısı nedeni safra kesesi ve yollarına ait hastalıklardır. 45-64 yaş grubunda ise ayırıcı tanısı yapılamamış karın ağrısıdır. İleri yaşlı hastalarda cerrahi nedenli tanıları orta yaşlı hastalara göre daha fazlaydı. 65 yaş ve üzeri hasta grubunda karın ağrısıyla birlikte vücut ısısı veya nabız yüksekliğinin olması cerrahi nedenli olmayan tanıları daha fazla bulundu (p<0,05). Her iki yaş grubunda karın ağrısı ile birlikte gaz-gaita çıkarmama cerrahi nedenli tanıları daha fazlaydı (p<0,05). Yaşlı grup hastada hastaneye yatış daha fazlayken, 45-64 yaş grubunda taburculuk daha fazla görüldü (p<0,001).

Sonuç: Karın ağrısı ile gelen hastaları acil patolojik durumlardan ayırmak için hekimlerin yaşla birlikte olan fizyolojik değişiklikleri bilmesi gerektiğini düşünmekteyiz.

Anahtar Kelimeler: Acil servis, karın ağrısı, yaşlı, fizyolojik değişiklikler

SS-114 Diğer

Türkiye'de Üniversite Ve Eğitim Araştırma Hastaneleri'nde Çalışan Acil Tıp Uzman Ve Asistanlarının Akut Karın Ağrısında Ağrı Kesici Kullanım Yaygınlığı Ve Bunu Etkileyen Faktörler

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Amaç: Türkiye'de acil servislere çalışan Acil Tıp uzman, asistan ve öğretim üyelerinin akut karın ağrılı hastalarda analjezik kullanımı konusundaki tutumlarını, günlük pratik uygulamalarını ve analjezik kullanım kararını etkileyen faktörleri incelemektir.

Gereç-Yöntem: Kesitsel anket çalışması 15 Kasım 2013-25 Ocak 2014 tarihleri arasında acil servis asistan, uzman ve öğretim üyesi ile posta, e-posta ve internet yoluyla anket doldurularak yapıldı.

Bulgular: Türkiye'de 2014 yılı itibarıyla 51 Eğitim ve Araştırma Hastanesinde, 39 Üniversite 'de acil tıp uzmanlığı eğitimi verilmektedir. 15 acil tıp profesörü, 79 Acil tıp Doçent doktoru, 77 yardımcı doçenti, 708 acil tıp uzmanı, 1002 acil tıp asistanı hizmet vermektedir. Toplamda 1881 acil tıp uzmanı ve asistanı vardır. Çalışmamızda 803 anket dolduruldu (Katılım oranı %43). Katılımcıların %48,3'i (n=355) EAH, %40,5'i (n=298) üniversite, %11,2 'si (n=82) devlet hastanelerinde çalışmaktaydı. %59,3'si (n=470) Araştırma Görevlisi, %35,1 (n=278) Acil Tıp



ORAL PRESENTATIONS

Uzmanıydı.

Katılımcıların %34,5'si (n=276) 'sıklıkla', %6, 2' si (n=50) "her zaman", %32, 3' ü (n=259) "bazen", %27' si ise "nadiren" analjezik kullandıklarını belirttiler. Katılımcıların %50,7'si (n=393) 'Muayene ve Hastanın Planlaması Yapıldıktan Sonra', %14,5' u "cerrah gördükten sonra", %16,4'u (n=127) 'Tanı Sonrası' analjezik uyguladıklarını bildirdiler. Katılımcıların %49,5 (n=395) "Analjezik ilaç kullanımının fizik muayene bulgularını baskıladığını", %45,9' u (n=366) fizik muayene bulgularını etkilemediğini düşünmekteydiler. Katılımcılar hastalarının %47,9'i (n=383) 'her zaman', %41,6'si (n=333) 'sıklıkla' analjezik talepleri olduklarını bildirdiler. Katılımcıların %60,6'si (n=487) Genel Cerrah Hastayı Değerlendirmeden Analjezik Uyguladıklarını, %39,4'i (n=316) Uygulamadıklarını, yine %56,9' u (n=457) kesin tanı konmadan analjezik uyguladıklarını, %43,1'si (n=346) uygulamadıklarını belirtmişlerdir. Katılımcıların %60,8'i (n=488) fentanil, %32,8'i (n=263) spazmolitik kullandıklarını belirtmişlerdir. Katılımcıların %79,1'i (n=628) cerrahi bölümlerle oluşturulmuş ortak politikalarının olmadığını bildirmişlerdir. Katılımcıların %34,6'sı (n=272) cerrahi konsültan hekiminin nadiren analjezi uygulamasını önerdiğini, %28,7'si (n=225) hiçbir zaman önermediğini bildirmiştir.

Sonuç: 2010 yılında yayınlanan benzer bir anket çalışmasındaki analjezik kullanım oranlarına göre Türkiye'deki Acil hekimlerinin akut karın ağrılı hastalarda analjezik kullanım sıklığının arttığı görülmektedir. Bilimsel kanıt olmasına rağmen ve hastaların %90' ının analjezik talep etmesine rağmen yıllar içerisinde yavaş yavaş gelişen bir davranış değişikliği olduğu görülmektedir. Buna rağmen kullanım oranları sadece %50' lerde kalmıştır. Genel cerrahi görüşü ise yıllar içerisinde değişmemiş ve analjezik kullanılmaması yönünde kalmıştır. Analjezik kullanımını etkileyen en önemli faktör cerrahi konsültan hekimle olabilecek tartışmadan çekinmektir. Cerrahi konsültan hekim ile acil servis hekimleri arasında belirli bir protokol sağlanmalıdır. Akut karın ağrılı hastalarda analjezi kullanmama kararı hala bir tabudur. Akut karın ağrısında analjezik kullanımı yıllar içerisinde artmış olmasına rağmen istenen düzeyde değildir.

Anahtar Kelimeler: Akut karın ağrısı, analjezik, acil servis

SS-115 Diğer

Acil Servise Yapılan Hasta Ve Yakınlarına Ait Şikâyet Başvurularının Geriye Yönelik İncelenmesi; 11 yıllık deneyimimiz

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Amaç: Hasta memnuniyeti "hastanın değer ve beklentilerinin ne düzeyde karşılandığı konusunda bilgi veren ve bakımın kalitesini gösteren temel ölçüt" olarak tanımlanmaktadır. Ülkemizde acil servise (AS) hasta veya hasta yakınlarına ait şikâyet başvurularını inceleyen çalışma sayısı oldukça azdır. Bu çalışmanın amacı, 11 yıllık dönemi kapsayan sürede Ege Üniversitesi Tıp Fakültesi Hastanesi (EÜTFH) acil servisine yönelik yapılmış olan, hasta veya hasta yakınlarına ait şikâyet başvurularının incelenmesidir.

Gereç-Yöntem: 2001-2011 tarihleri arasında EÜTFH Hastanesi Halkla İlişkiler birimi, Disiplin ve Ceza İşleri birimi ve Hastane Yönetimi tarafından ön inceleme için acil servise gönderilmiş şahıs veya kurumlara ait şikâyet dilekçeleri olmak üzere toplam 474 adet başvuru incelendi.

Bulgular: 651 adet şikâyet başvuru formu incelendi. AS' e yıllara göre başvuran hasta sayısı ve bu yıllara göre şikâyet oranları incelendiğinde, aralarında kuvvetli korelasyon olduğu saptandı (r:0.979, p:0.009). AS'e başvuran hasta sayısı arttıkça şikâyet sayılarının da arttığı tespit edildi. Tüm yılların AS'e başvuran hasta sayısına göre şikâyet oranına bakıldığında bu oranın 2010 yılında en fazla olduğu görüldü.

651 şikâyet konusu incelendiğinde; işleyişle ilgili şikâyet başvurularının %72.8 (n=474), medikal hata iddiası ile ilgili başvuruların %20.9 (n=136), fiziksel yapı ile ilgili şikâyet başvurularının %6.3 (n=41) oranında olduğu saptandı. İşleyişle ilgili şikâyetler incelendiğinde; en fazla şikâyet edilen konunun %26.5 (n=248) oranında "personelin davranışlarındaki olumsuzluk" ve ikinci sıklıkta ise %25 (n=235) oranında "bekleme süresinin uzun olması" ile ilgili olduğu görüldü. "Bekleme süresinin uzun olması" ile ilgili şikâyetler incelendiğinde ise; %40.4 oranında "acilde herhangi bir kliniğe yatış için bekleme", %25.5 oranında ise "trajda bekletilme" olduğu saptandı. "Bekleme süresinin uzun olması" ile ilgili şikâyetlerin "trajda bekletilme" ile ilgili bölümünün acil servise ilgili olduğu, diğer bekletilme nedenlerinin acil servis dışı hastane organizasyonundaki sıkıntılardan kaynaklandığı görüldü.

Hakkında şikâyetle bulunan hekimlerin %33.8' nin acil tıp hekimli, diğerlerinin ise acil tıp dışından hekimler olduğu saptandı. Yıllar içerisinde AS' e yönelik şikâyetlerin genel olarak arttığı fakat bu şikâyetler içerisindeki medikal hata iddialarının, genel şikâyetler içerisindeki oranının 2006 yılından itibaren azaldığı tespit edildi. 2005 medikal hata iddiası yüzdesi %37.8 iken, 2006 yılında %28.5, 2011 yılında ise %13.8 ' e düştüğü görüldü. Medikal hata iddialarının; en sık konsültan hekimlere (%10.5), ikinci sıklıkta da rotasyonel asistanlara (%9) yapılmış olduğu tespit edildi.

Tüm şikâyetlerin sonuçlanma durumuna bakıldığında; %95.9' nun (n=624) sonuçlarına ulaşıldı ve yalnızca %16.3' nün (n=106) ileri soruşturulmasına gerek görüldüğü tespit edildi.

Sonuç: Acil servise yapılan şikâyet başvurularının en sık nedeni işleyişle ilgilidir. Acil servise yönelik şikâyetlerin büyük bir kısmı hastanenin işleyişle ilgilidir. Şikâyetlerin çok az bir kısmı sadece acil servise ilgilidir.

Anahtar Kelimeler: Acil servis, Şikâyet, Hasta memnuniyeti

SS-116 Acil Ünitelerinde Görüntüleme

Renal Kaliks Rüptürü

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Amaç: Acil serviste nadir görülen renal kaliks rüptürünün olgu eşliğinde tartışılması amaçlandı

Olgu: 38 yaşında erkek hasta acil servisimize 1 saat önce başlayan karın ağrısı, sol yan ağrısı şikâyeti ile başvurdu. Bulantı ve kusması yoktu. Hastanın özgeçmişinden Ürolityazisi olduğu öğrenildi. Fizik Muayenede; hastanın genel durumu iyi, kan basıncı 120/80 mmHg, nabız 86/dakika, solunum sayısı 14/ dakika, bilinci açık, oryante ve koopereydi. Batın muayenesinde karın distandü, barsak sesleri hipokaktif, sol tarafta kostovertebral açısı hassasiyeti vardı. Damar yolu açılarak hastaya 250 mL/saat'ten izotonik başlandı.

Tam kan sayımı (lökosit 15000/µL, diğer parametreler normal), tam idrar tahlili (her sahada 8 eritrosit), Direk üriner sistem grafisi (taş izlenmedi) çekildi. Hastaya hiyosin N-butilbromür 20 mg ampul ve deksketoprolfen 50 mg ampul intravenöz (iv) yapıldı. Hastanın ağrısının azalmaması üzerine 50 mg dolantin iv yapıldı. Hastanın idrar çıkışının olmaması ve ağrısının şiddetlenmesi üzerine Üriner sistem ultrasonografisi (USG) yapıldı (Her iki böbrekte en büyükleri sağda üst polde 8 mm ve sol böbrek orta kesimde 8 mm çapında olmak üzere multiple milimetrik kaplı taşlar izlendi). Sol perirenal bölgede en kalın yerinde 8 mm ölçülen sıvı dikkati çekti. Mesane optimal distandü olmakla birlikte değerlendirilebildiği kadarıyla lümen içinde taş izlenmedi). USG'de perirenal sıvı görülmesi üzerine Batın Bilgisayarlı Tomografisi (BT) çekildi. BT'de taş ve sol tarafta superior kaliksde rüptür (Resim 1,2,3) tespit edildi. Hasta Üroloji ile konsülte edilerek acil ameliyata alındı. Hasta ameliyat sonrası 5. günde taburcu edildi.

Sonuç: Acil hekimleri yan ağrısı ile gelen hastalarda renal kaliks rüptürü tanısını da göz önünde bulundurmalıdır.

Anahtar Kelimeler: acil, taş, rüptür

SS-117 Diğer

Deneyisel Temas Tipi Yanıklarda Hypericum perforatum (Sarı Kantaron) Tedavisi ile Alpina officinarum (Havlıcan) Tedavisinin Yara İyileşmesi Üzerine Etkilerinin Karşılaştırılması

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Amaç: H.Perforatum'un (kantaron) ve Alpina officinarum (havlıcan) deneyisel temas tipi yanıklarda yara iyileşmesi üzerine etkilerinin belirlenmesi ve birbirleriyle karşılaştırılması

Gereç-Yöntem: Çalışmada ağırlıkları 180-250 gr. arasında, sadece dişi eşeyden, 35 adet sağlıklı Wistar albino cinsi sıçan kullanıldı. Sıçanlar 5 gruba ayrıldı. Üç adet, aralarında sağlam cilt dokusu bırakacak şekilde 1x1"lik alanlar sabit 100°C sıcaklıkta tutulan 1x1 cm"lik kare şeklindeki bakır uçlu levha ile 10 saniye boyunca temas ettirilerek yanık oluşturuldu. Grup 1 'e herhangi bir işlem veya tedavi uygulanmadı. Grup 2 'ye yanık sonrası sadece 100cc SF ile 2 dakika irrigasyon sağlanıp ilaçsız pansuman ile kapatıldı, başka bir tedavi uygulanmadı. Grup 3'e yanık uygulaması sonrası havlıcan otundan hazırlanan jel uygulaması tek sefer yapıldı. Grup 4'e yanık uygulaması sonrası kantaron otundan yapılan jel tek sefer uygulandı. Grup 5'e ise yanıktan sonra tek sefer boş jel uygulandı.

Bulgular: Tüm gruplarda zaman içerisinde ödem miktarının azaldığı görüldü. Grupların birbirleri arasında yapılan karşılaştırmalar sonucunda; havlıcan ve kantaronun yanık kontrol grubu ile

SÖZLÜ BİLDİRİLER

değerlendirilmesi sonrası 4. saatte anlamlı değer ($p<0.05$) bulundu.

Kıl kökü hasarında grupların birbirleri arasında yapılan karşılaştırmaları sonrasında; kantaron-yanık kontrol ve kantaron-jel karşılaştırılmasında 24. saatte anlamlı farklılık ($p<0.05$) izlendi. Glandula sebacea hasarı grupların birbirleri arasında yapılan karşılaştırmalar sonucunda havlıcan – yanık kontrol, kantaron – yanık kontrol karşılaştırmalarında 24. saatte anlamlı sonuçlar ($p<0.05$) gösterdi.

Toplam kıl kökü sayısı yanık kontrol, havlıcan ve jel grubunda 4., 8., 24. saatlerde giderek düşerken kantaron grubunda korunmuş olarak izlendi ve istatistiksel olarak anlamlı ($p<0.05$) bulundu. Havlıcan kantaronla karşılaştırıldığında ilk 4 saat etkileri benzerken 8 ve 24 saatlerde kantaronun toplam kıl kökü sayısına etkilerinin ön plana çıktığı görüldü. Kantaron-yanık kontrol grubunun karşılaştırılmasında 4 ve 8. saatlerde anlamlı farklılık göstermezken ($p>0.05$), 24. saatte anlamlı değer ($p<0.05$) bulundu.

Dejenere kıl kökü sayısı, yanık kontrol grubunda giderek artış göstermektedir. Tedavi alan gruplarda dejenere kıl kökü sayısı yanık kontrol grubuna kıyasla anlamlı farklılık göstermektedir. Havlıcan ve kantaron dejenere kıl kökü sayısına etkileri açısından karşılaştırıldığında istatistiksel olarak anlamlı bir farklı değer elde edilmedi. Kendi süreci içinde istatistiksel olarak dejenere kıl kökü sayısında anlamlı farkı ($p<0.05$) olan sadece kantaron bulunmaktadır.

Damar sayısı, Kantaron ve havlıcanda 4. saatte benzer etkiler oluştururken, 8. ve 24. saatlerde kantaron yönünde anlamlı farklılık ($p<0.05$) gösterdi.

Epidermis kalınlığı, kantaronun gerek değerleriyle gerekse kendi süreci içinde karşılaştırıldığında epidermis kalınlığının korunmasındaki etkileri daha üstün bir şekilde sürekli ve progresif olarak değerlendirildi.

Sonuç: Akut temas tipi deneysel yanıklarda günde tek sefer uygulanan topikal H.perforatum tedavisinin yanık iyileşmesinde etkilidir. Topikal Alpina officinarum tedavisine göre yara iyileşmesine etkileri daha belirgindir. İnsan deneylerine ihtiyaç vardır.

Anahtar Kelimeler: Yanık, Hypericum Perforatum, Alpina officinarum

SS-118 Diğer

Sağlık Çalışanlarında Yaşam Doyumu Düzeyinin İncelenmesi

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Amaç: Yaşam doyumu, bireyin iş yaşamı dışındaki duygusal tepkisidir. Yani hayata karşı genel tutumdur. Yoğun sağlık hizmetinin verildiği, acil servis ve nöroşirürji (NRŞ) kliniğinde görev yapan sağlık çalışanlarının yaşam doyumunu etkileyen faktörlerin incelenerek, elde edilecek sonuçlarla verilen sağlık kalitesini artırmaya yönelik davranışlara yol gösterici olacağı düşünülmektedir.

Gereç-Yöntem: Araştırma NRŞ kliniğinde çalışan 41, acil serviste çalışan 66 sağlık çalışanı olmak üzere toplam 107 kişi ile yapılmıştır. Çalışmada katılımcıların sosyo-demografik özelliklerini tanımlayan toplam 14 soruluk anket formu ile) Deiner, Emmons, Larsen ve Griffin (1985) tarafından geliştirilen, Türkçe geçerlik güvenirliği Yetim (1993) 12 ve Köker (1991) 13 tarafından yapılan Yaşam Doyumu Ölçeği kullanılmıştır. SPSS 20. Paket programı ile tanımlayıcı ve ANOVA testi istatistiksel analizi ile veriler elde edilmiştir.

Bulgular: Çalışmaya katılanların % 71'i kadın, %43,9'u 25-31 yaş aralığında idi. Katılımcıların %47,7'si bekar, % 52,3'ü kirada oturuyordu. Katılımcı olan sağlık çalışanlarının % 75,7 ile çoğunluğu hemşire olup, tüm katılımcılarda %37'si 1 yıldan az süredir çalışıyordu. % 11,2 sağlık çalışanı psikiyatrik ilaç kullandığını ifade etti. Katılımcıların n=53'ünün yaşam doyumu puanı 20 puan altındaydı.

Katılımcıların yaşam doyumu puan ortalamaları 18,91±6,68 olarak bulunmuş ve en uzun süre yaşanan yer ile doyum puanı arasındaki ilişki anlamlı bulunmuş ($p=0,02$) ve bu ilişkinin anlamlılığı ileri analiz ile incelendiğinde uzun süreyle köy/kasabada yaşayanların puan ortalamalarının yüksek olması olarak bulunmuştur. Psikiyatrik ilaç kullananların yaşam doyumu puan ortalamaları 13,88±6,09 düşük olup, ilişki istatistiksel olarak anlamlı bulunmuştur ($p=0,05$).

Sonuç: Sonuç olarak, yaşamın bütününi kapsayan yaşam doyumu kişinin nasıl bir ruh sağlığı içerisinde olduğunu gösteren önemli bir göstergedir. Yaşamda meydana gelecek çeşitli engellenmeler, zorlanmalar, çatışmalar ve ani olumsuz değişimler yaşam doyum düzeyinin düşmesine neden olabilir. Araştırmada katılımcıların büyük çoğunluğunun çalışma yıllarının başında (0-3 yıl) olmalarına rağmen %53,9 yaşam doyum puanlarının düşük olması, sağlık çalışanının motivasyonu konusunda araştırmalar gerekliliğini göstermektedir. Bilgi ve beceri kazanımının yöntemleri konusunda değişimlere gidilmesi, eğitimin kalitesinin artırılması, iletişim, stresle başa çıkma ve yönetme becerileri açısından özel eğitim verilmesi, spor, düzenli egzersiz gibi etkinliklere olanak yaratılması kişinin kendini daha iyi hissetmesine yardımcı olacak ve yaşam doyumunu yüksek tutacaktır. Sağlık kurumlarındaki Çalışan sağlığı ve Güvenliği Biriminde, çalışanların sadece fiziksel hastalıkları ve iş kazası ile değil aynı zamanda yaşama bakış açılarını değiştirmeye yardımcı olacak liyezon biriminin de dâhil edilmesi düşünülmelidir. Acil servis ve NRŞ kliniğine benzer, hasta bakım ve tedavisinin zaman ile yarışıldığı birçok klinikte çalışanların yaşam doyumunu artırmak, hasta bakım kalitesinde ve tutum/davranış/yaklaşımlarda da farklılığı doğuracaktır diye düşünülmektedir.

Anahtar Kelimeler: yaşam doyumu, acil servis, Yaşam Doyumu Ölçeği

SS-119 Diğer

Acil servise başvuran psikiyatri hastalarının profilleri ve Değerlendirilme süreçleri

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Amaç: Acil servislere başvuran psikiyatrik hastaların yönetimi sürecinin değerlendirilmesi ve sonucunda daha iyi hizmet sunulabilmesi için hasta profilleri tanımlamaktır.

Gereç-Yöntem: 2014 yılı Nisan ayında, tanımlayıcı ve kesitsel olarak planlanan bu araştırmada, Ege Üniversitesi Tıp Fakültesi Hastanesi Acil Tıp A.D.'na başvuran psikiyatrik acil hastaları; sosyo-demografik özellikleri, başvuru şikâyetleri, tanıları ve yapılan müdahaleler açısından değerlendirilmiştir.

Bulgular: Araştırma sürecinde, 32 erkek, 33 kadın olmak üzere toplam başvuru sayısı 65'dir. Başvurular ağırlıklı olarak 25-34 yaş arası (%33,8), bekar (%58,5), lise ve dengi okul mezunu (%50,8), çalışmayan (%58,5) erkek (%50,8) hastalardır. Uykusuzluk (%21,5), suikid girişim/düşüncesi (%18,5), saldırganlık (%18,5) nedeni ile çoğunlukla Bipolar Bozukluk (%33,8) tanılı hastalar başvurmıştır. Başvurular anne/baba/eş/akraba (%43,1) tarafından yapılmıştır. Bu hastalarla ilk görüşme Acil Tıp asistanları (%81,5) tarafından yapılmış, hastaların (%60,0)'ı farklı alanda izlenmiştir. Acil servis hemşirelerinin yaklaşımı ise tedavi/izlem (%63,1), yatış/sevk/taburculuk işlemleri (%30,8) şeklinde olmuştur. Başvuran hastalar ile iletişim kurmaya çalışan acil servis hemşirelerinin oranına bakıldığında sadece (%6,2) olduğu görülmüştür. Psikiyatri konsültasyonu sonrası (%36,9) taburculuk ve (%29,2) sevk kararı alınmış ancak büyük oranda (%12,3) izinsiz terk vakaları ile de karşılaşılmıştır. Sevk kararı alınan hastalar Sağlık İl Müdürlüğü ambulansı ile (%18,5) nakledilmiş (%12,3) oranında sevk işlemleri sırasında sorun yaşanmıştır. Yaşanan en önemli sorunlar vasiyet olmaması hastaların bizzat onam almak (%4,6) ve sevk aracını sağlamak için yapılan uzun telefon görüşmeleri (%4,6) olmuştur. Diğer bir sorun ise hasta yakınının olmaması (%3,1) ve Sağlık İl Müdürlüğü ambulanslarının sadece mesai saatleri içinde çalışıyor olması nedeniyle hastaların uzun süre Acil servislere bekletilmesi ve dolayısıyla izinsiz terklerin yaşanmasıdır.

Sonuç: Acil servislerin artan hasta başvuruları, yatış beklenen hastaların uzun süreli acil servislere takibi, acil hemşiresinin psikiyatri hastalarına bakma sorumluluğunu yerine getirmesine fırsat vermemektedir ki çalışmamızda da acil hemşirelerinin psikiyatrik acil hastasına yaklaşımında iletişimden çok (%6,2) tedavi/izlem (%63,1), yatış/sevk/taburculuk işlemlerine (%30,8) zaman ayırdığı görülmektedir. Bu bulgular doğrultusunda acil psikiyatrik hastaların sevk işlemlerinin hemşire dışında bir sağlık çalışanına verilmesi ile hemşirenin asıl sorumluluklarına odaklanabileceği düşünülmektedir. Bu hastalar için sosyal hizmet uzmanlarının sürece dâhil edilmesi önerilmektedir.

Diğer bir sorun bu hastaların vasisi olmadığına yaşana sorunlardır gerek psikiyatri hastalarının haklarının korunması gerekse hekimlere yüklenen sorumluluk sebebiyle bu hastalarda zorla hastaneye yatırılma sürecinin kimler tarafından başlatılacağı, sürecin ne kadar süreceği, yasal temsilci olmaması halinde yahut yasal temsilcinin hasta yararına kararlar verememesi halinde prosedürün nasıl işlemesi gerektiği, psikiyatri hastalarının özzerklığı, hastanın tedaviyi red hakkını ve sınırlarını içeren hükümler içeren yasal düzenlemelerin yapılması gerekliliği tartışılmalıdır.

Bu hastaların mesai dışındaki psikiyatrik hastalara hizmet veren hastaneye sevgi sırasında yaşanan sorunların çözümü için, bu hizmetin sürekli ve kesintisiz sağlanması gereklidir.

Anahtar Kelimeler: psikiyatri hastaları, acil servis, acil hemşiresi



ORAL PRESENTATIONS

SS-120 Diğer

Fantom Ağrısı

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Amaç: Amputasyon sonrası olmayan ekstremitede oluşan ağrı fantom ağrısı olarak adlandırılır ve mekanizması henüz tam olarak anlaşılamamıştır. Fantom ağrısının, hem periferik hem santral sinir sisteminin rol oynadığı bilinmektedir. Fantom ağrısının hava değişimi veya güdükteki basınç değişikliği gibi fiziksel etkenlerle veya duygusal stres gibi psikolojik faktörler nedeniyle ortaya çıkabileceği söylenmektedir. Genelde Fantom ağrısı amputeekstremitenin özellikle distal kısmında hissedilmektedir. Alt ekstremitampütasyonu olan kişilerden fantom ağrısıgenellikle ayak bileği, ayağın üst kısmı, topuk ve parmaklarda hissedildiği bildirilmiştir. Burada sağ alt ekstremitesindeampütasyonu olan fantom ağrılı hasta sunuldu.

Olgu: Sağalt ekstremitesi 40 yıl önce yanık nedeniyle femur orta üst kısmındaampute edilmiş71 yaşında erkek hasta sağ dizinde ve ayaklarında ağrı şikayetiyle geldi. Hastanın anamnezinde- ağrısının ampute olan ekstremitede yaklaşık 4-5 saatir olduğu ve nonsteroidal ilaçlarla geçmediği anlaşıldı. Fizik muayenede vital bulguları stabil olan hastanın sağ ampute bacak üzerinde ısı artışı, soğukluk, solukluk olmadığı vefemoral nabızlarının palpabl olduğu tespit edildi. Tam kan biyokimya parametre değerleri normal olan hastaya hidrasyon ile beraber nonsteroid anti inflamatuvar analjezik (diclofenak sodyum 75 mg/kg) intravenöz (iv.) olarak verildi. Ağrısı geçmeyen hastaya 1 saat sonra parasetamol(1 gr) iv. verildi. 1 saat içerisinde ağrısı geçmeyen hastaya narkotik analjezik olan tramadol(100mg)100 cc mayi içinde verildi. Hastanın ağrıların azalması üzerine hasta taburcu edildi.

Sonuç: Ampütasyon yapılan hastalarda, yaşamı olumsuz etkileyen ve sık karşılaşılan problemlerden biri de fantom ağrısıdır. Çoğunlukla santral ve periferik sinir sistemine ait mekanizmalar ağrının kaynağı olarak bildirilse de ağrı fizyolojik faktörlerden de etkilenmektedir. Fantom ağrısının tedavisinde ağrıya neden olacak fizyolojik bir durum saptanmadığında nöropatik bir ağrı gibi davranılmalıdır.

Anahtar Kelimeler: fantom ağrısı, nöropatik ağrı, ampütasyon

SS-121 Diğer

Acil Servise Başvuran Hastaların Profiline İncelenmesi

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Amaç: Türkiye gibi gelişmekte olan ülkelerde acil servislerde aşırı kalabalıktan dolayı hasta memnuniyetinin az olduğu yerlerdir. Türkiye gelişmiş ülkelere göre kıyaslandığında, acil serviste bakılan hasta sayısı ülke nüfusuna göre 3-4 kat fazla olduğu görülmektedir. (K.Kabaroğlu). Bu amaçla bizde bir üniversite hastanesi acil servisinde yapılan bu çalışma ile, hasta memnuniyeti ve bunu etkileyen faktörleri araştırarak acil servis kalabalığının çözümüne bir katkısının olup olmayacağını araştırdık

Gereç-Yöntem: Bu çalışma "Acil Servise Başvuran Hastaların Profiline İncelenmesi" amacı ile 11.02.2014 tarihli, 14-HADEK-014 kayıt numaralı Gaziosmanpaşa Üniversitesi Tıp Fakültesi Dekanlığı Klinik Araştırmalar Etik Kurulunun onayı ile yapılmıştır. Çalışma halen devam etmektedir. Bu çalışma Türkiye'de bir üniversite hastanesinin acil servisine başvuran 128 hasta ile yürütüldü. Anket formu, daha önce literatürde yapılan benzer çalışmalardaki anket formları uzman görüşleri doğrultusunda gerekli düzeltmeler yapılarak çalışmada kullanıldı

Bulgular: Toplam 128 hastanın 74 kadın ve 54 erkekti. Hastaların yaş ortalaması 35,3 (min 14, max 76). Eğitim seviyesine göre okur yazar olamayanların oranı %4,1, ilköğretim mezunu %34,7, ortaöğretim mezunu %33,1, üniversite mezunu %26,4 bulundu. En sık başvuru şikayeti %46,1 ile üst solunum yolu enfeksiyonları saptandı. Bir yılda ortalama acil başvurusu 3 ve daha az olanların oranı %72,7 saptanmasına karşın 50 kez başvuran hasta olduğunda saptanmıştır. Hastaların %10,2 'isi kendisini acil değil, % 56,3 ü orta derece acil, % 25 i acil, % 7,8 i çok acil olarak tanımlarken, doktor değerlendirmesinde ise %81,3 ü acil değil, %14,1 i orta derece acil, % 4,7 si acil olarak saptandı. Hastaların % 93,8 inden konsültasyon ihtiyacı gerekmezken, hastaların %96,9 u taburcu edildi. Hastaların acil serviste kalma süreleri ortalama olarak 42,5 dakika saptandı. Hastaların %58,6 sı acil servisten çok memnun olduğunu belirtti, %2,3 memnun değil % 3,1 i ise az memnun olduğunu, %10,2 si orta düzeyde memnun iken % 25,8 i memnun olduğunu belirtti. Memnun olamama nedenleri olarak %37,5 çevresel faktörler (konum, düzen...), %31,2 si personel hizmetlerini, %18,75 i acil servis hekiminden, %6,25 i radyolojik hizmetlerini gösterdi. Hastalara acil servisimize tekrar tercih edersiniz sorusuna ise %87,5 u evet cevabını verdi

Sonuç: Acil servis hizmetlerinin değerlendirilmesinde en önemlilerinden birisi de hasta memnuniyetidir. Servislerde ki hasta yoğunluğunu etkileyen önemli faktörlerden biri de servise başvuran hastaların demografik özellikleridir. Elde edilen bulgulara göre acil servise başvuranların çoğunluğu kadın olduğu ve eğitim seviyesinin düşük olduğu söylenebilir. Buna göre eğitim seviyesi düştükçe acil servis başvuru sayılarının artmış olduğu söylenebilir. Elde edilen verilere göre hastaların çoğu kendini olduğundan daha acil değerlendirmektedir. Acil servise gelen hastaların demografik özelliklerinin analizi gelecekte planlanacak acil servislerin dizayn edilmesine katkıda bulunacaktır

Anahtar Kelimeler: Acil servis yönetimi, hasta memnuniyeti, acil servis kalabalığı

SS-122 Diğer

Acil Serviste Kendinizi Güvende Hissediyor musunuz?

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Amaç: Şiddet, insan üzerinde fiziksel ve ruhsal etkiler ortaya çıkaran her türlü fiziki zorlanma, güç kullanımı ya da tehdidin amaçlı olarak kullanılmasıdır. Bu çalışmada son yıllarda şiddete en fazla maruz kalan acil servis çalışanlarının düşünce, tutum ve davranışlarının incelenmesi amaçlandı.

Gereç-Yöntem: Çalışma Sakarya Üniversitesi Eğitim ve Araştırma Hastanesi Acil Tıp Anabilim Dalında hizmet veren 136 kişiden çalışmaya katılmayı kabul eden 110 kişi ile gerçekleştirildi. Bu amaçla önceden hazırlanmış ve toplam 18 sorudan oluşan anket formu kullanıldı.

Bulgular: Katılımcıların % 62,7'si erkek ve büyük çoğunluğunun 40 yaşından küçük (n: 95, % 86,4) olduğu belirlendi. Mesleki analizde Hemşire + Sağlık Memuru + ATT grubunun 44 (% 40) kişi ile ilk sırada yer aldığı saptandı. Son bir yıl içerisinde fiziksel saldırıya maruz kalanların 24 (%21,8) ve sözel saldırıya maruz kalanların ise 95 (%87,2) kişi olduğu tespit edildi. Her iki tür saldırıda da hem hastanın hem de hasta yakınının olaya katıldığı saptandı (sırası ile: fiziksel saldırı - n: 18, % 46,2; sözel saldırı - n: 47, % 53,4). Saldırı sonrası "beyaz kod" veren kişi sayısının yalnızca 6 (% 6,4) olduğu ve yasal işlem başlatılanların sayısının ise 21 (% 21,4) olduğu tespit edildi. Yasal işlem başlatmayan 40 (%51,9) kişinin gerekçesi "yasal işlem sonrası ceza verilmeyeceği ve boşuna uğraşmak istemedikleri" şeklinde idi. Katılımcılardan 105 (% 97,2) tanesi kanunların kendilerini korumadığını, yaşanan şiddet sonrası 53 (% 52,5) tanesinin çalıştığı birimi terk etmeyi düşündüğü ve 35 (% 34,7) tanesinin de istifa etmeyi düşündüğü tespit edildi. Katılımcılardan 88 (% 80) tanesinin kendisini güvende hissetmediği saptandı. Şiddetin önüne geçilmesine yönelik olarak sorulan soruda 31 (% 28,2) katılımcının tüm seçenekleri (Sağlık çalışanlarını koruyan kanunlar düzenlenmeli; Kurumda bulunan güvenlik görevlileri özel eğitim almalı ve sayıları artırılmalı; Çalışan personel sayısı artırılmalı; Topluma şiddetin önlenmesi ve azaltılmasıyla ilgili eğitimler düzenlenmeli; Medyada sağlık çalışanlarına yönelik şiddet haberleri yayınlanmamalı) işaretlediği saptandı.

Sonuç: Sağlık çalışanlarına yönelik şiddet hem fiziksel hem de özellikle sözel boyutta mevcuttur. Bu durum çalışanların kendilerini güvende hissetmemelerine neden olmakta ve hatta istifa etme noktasına kadar getirmektedir. Temel sorun olarak ta yasal düzenlemelerin bu konuda yetersiz olduğu kanısı hâkimdir.

Anahtar Kelimeler: şiddet, acil servis, sağlık çalışanı

SS-123 Acil Ünitelerinde Görüntüleme

Santral venöz basınç tahmini için kullanılan ultrason ölçüm yöntemlerinin karşılaştırılması

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Amaç: Hastaların völüm durumlarının tespiti acil ve kritik bakım hekimleri için önemlidir. İntravaz santral venöz basınç (CVP) ölçümü zaman alıcı bir işlemdir ve komplikasyonlara neden olabilmektedir. Bu nedenle özellikle son yıllarda ultrason ile CVP tahmin yöntemleri yaygın olarak kullanılmaktadır. Bu yöntemler genel olarak juguler ven (IJV) ve inferior vena cava (IVC) çap ölçümlerini temel almaktadır. Biz üzerinde sıkça çalışma yapılmış ultrason ile juguler venöz dolgunluk (CVPusg), IJV maksimum çap (IJVmax), IJV minimum çap (IJVmin), IJV alanı (IJVarea), IVC maksimum çap (IVCmax), IVC minimum çap (IVCmin), IVC kollapsibilite indeksi (IVCindex) yöntemlerini intravaz CVP değeri karşılaştırdık ve üstünlüklerini/eksikliklerini araştırdık.

Gereç-Yöntem: Çalışmaya toplam 73 hasta alındı. 36 hasta mekanik ventilatör desteği alırken 37 hastanın spontan solunumu mevcuttu. IJV ve IVC supin pozisyonunda respiratuar siklus

SÖZLÜ BİLDİRİLER

boyunca kaydedilerek ölçüm yapıldı. IJVarea ve IVCindex bu ölçülerden hesaplandı. CVPusg, hastalar 45 derece semirekümbent pozisyonundayken ultrason ile juguler vendeki kan sütunun incelme yaptığı yer bulundu ve cilt kalemle işaretlendi. Sonra bu noktanın izdüşümü sternal açığı üzerinden vertikal olarak cetvel ile ölçüldü ve bu değere 5 eklenerek CVPusg sonucu elde edildi. Volüm yüklenmesi için CVP>10 mmHg ve düşük volüm için ise CVP<6mmHg kesme noktası olarak seçildi.

Bulgular: CVPusg, IJVmax, IJVmin ile santral venöz basınç arasında anlamlı ve orta düzeyli bir korelasyon mevcuttu. ($R_2 = 0.66, 0.53, 0.54$ sırasıyla) IVCmax, IVCmin IVCindex ise anlamlı fakat zayıf bir korelasyon gösterdi. ($R_2 = 0.32, 29$ ve 0.27 , sırasıyla). CVPusg için 7 kesme değeri santral venöz basınç > 10 mm Hg için %90 sensitivite ve %60 spesifite ve santral venöz basınç < 6 mm Hg için %77 sensitivite ve %68 spesifite göstermiştir. IJVmax, IJVmin, IJVarea ve IVCmax volüm düşüklüğü olan hastalarda yüksek sensitivite (90.32, 83.87, 90.32 sırasıyla) fakat düşük spesifite (52.38, 59.52, 45.24 sırasıyla) göstermiştir. IVCindex genel performansı orta idi fakat volüm yüklenmesi için yüksek sensitivite (95.2%) ve negatif prediktif değer (NPV 95.5) göstermiştir.

Sonuç: CVPusg tüm test değerleri birlikte değerlendirildiğinde en yüksek performansı göstermiştir. IJVmax, IJVmin, IJVarea ve IVCmax düşük volüm durumlarının tesbiti için daha iyi sonuçlar vermiştir. VClindex tüm test değerlerinde CVPusg'ye en yakın diğer test olmakla birlikte özellikle volüm fazlalığı durumlarında daha iyi sonuçlar vermektedir. IVCmax ve IVCindex değerlerinin birlikte kullanılması volüm değerlerini tesbit etmede daha doğru sonuçlar verecektir. Juguler ven ölçümleri de en az inferior vena cava ölçümleri kadar etkindir.

Anahtar Kelimeler: juguler ven, inferior vena cava, ultrason, santral venöz basınç

SS-124 Acil Ünitelerinde Görüntüleme

Acil Ünitesinde Serebrovasküler Olay Şüphesi İle Gelen Hastalara Radyolojik Yaklaşım

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Amaç: Serebrovasküler olay (SVO) beyin damar hastalıkları içinde en sık görülen hastalık grubunu oluşturur. SVO şüphesinde görüntüleme yöntemleri kullanılarak tanının erken dönemde konularak etkili tedavinin başlanması sağlanmalıdır. Çalışmamızda acile inme şikayeti ile gelip SVO ön tanısı ile Bilgisayarlı Tomografi (BT) ve Manyetik Rezonans Grafi (MRG) tetkiki yapılan hastalarda yardımcı tanı yöntemlerinin duyarlılığını değerlendirmeyi amaçladık.

Gereç-Yöntem: Çalışmamızda hastanemiz acil kliniğine Ocak 2013 ve Aralık 2013 tarihleri arasında SVO ön tanısı ile BT ve MR çekilen hastaların dosya kayıtları retrospektif olarak incelendi. Görüntüleme için 64 kesitli (Toshiba Aquilion) BT ve 1.5 T MR (Siemens Somatom) cihazları kullanıldı.

Bulgular: Hastaların 34'ü erkek ve 37'si bayan idi, yaş ortalaması 62.54 ± 20.85 yıl olarak tespit edildi. (18-101 yıl). Acil muayene sonrası hastalar görüntüleme için radyoloji ünitesine sevk edildiler. Yetmişbir hastadan beşi sadece bir görüntüleme tetkiki ile (sadece BT veya MR) değerlendirildi. Altmışaltı hastadan 57 tanesine MR ve diffüzyon MR'dan önce BT tetkiki yapıldı. Geri kalan 9 hastaya BT den önce MR çekildi. MR 19 lezyondan 15'ini, BT 12'sini tespit ederken 7 lezyon tomografide saptanmadı. MR'da lezyonların dört tanesi iskemik A. Serebri Media (MCA) enfarktı, bir tanesi hemorajik MCA enfarktı, bir tanesi posterior dolaşım lezyonu ve bir tanesi de laküner enfarkt olarak tespit edildi. MR'da 4 lezyon atlandı. BT'de üç tanesi iskemik MCA enfarktı ve bir tanesi laküner enfarkt olarak belirlendi. Hastaların BT ve MR tetkiklerinin yapılması arasındaki süre 73.00 ± 64.43 dk olarak hesaplandı (uç değerler çıkarılmıştır).

Sonuç: Erken dönemde iskemik beyin lezyonları tespit etmede önceki çalışmalarda belirtildiği gibi MR, BT den daha sensitiftir. Acil servislerde enfarkt şüphesinde diffüzyon ağırlıklı görüntülerin de alındığı rutin MR tetkikinin ilk kullanılacak modalite olması uygundur.

Anahtar Kelimeler: serebrovasküler olay, görüntüleme yöntemleri, acil

POSTER BİLDİRİLER
POSTER PRESENTATIONS



POSTER BİLDİRİLER

P-0001 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Parathyroid Adenoma Presenting with a Fracture Due to Electrical Injury: a case report

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Objective: Electrical injuries have become a more common form of trauma with high morbidity and mortality. Severity of the injury depends on the type of current (AC/DC), how high the voltage is, how the current traveled through the body, exposure rate, surface of the contact, the person's overall health and how quickly the person is treated.

Electrical shocks are classified as High Voltage (>1000 V), Low Voltage (<1000 V). Lightning's interaction with the body and Arc-flash.

High Voltage electrical shock can cause tissue damages and may have a poor prognosis.

Electrical shock injury has been found to be related with orthopedic fractures, neurological, ophthalmological, gastrointestinal, endocrinologic problems, and muscle contractions caused by electrical shock may be so severe that the spasms can break bones.

Experimental studies show that the greatest resistance to electricity is bone tissue.

Bone fractures have rarely been observed due to low voltage and short duration of exposure to electricity without a history of trauma

In this report, we describe a patient who presents with humerus fracture secondary to a parathyroid adenoma.

Case: 55 years old male patient visited the emergency department because of electrical shock at home. Electrical Exposure was short-time and there was no trauma history.

General medical condition was good and stable, conscious, cooperated. Patient had ecchymotic areas on right hand 1-2-3. Phalanx, right and left shoulder on his physical examination.

He had restriction of left arm movements and the x-rays revealed left shoulder dislocation and proximal humerus fracture.

Serum Calcium Level was 14mg/dl therefore patient was hospitalized to Internal Medicine Department for further examination and treatment.

During Clinical follow ups showed us Ca:13.4mg/dl, phosphor:1.4mg/dl, Creatine Kinase: 1220U/L Parathormon level:238pg/ml besides these levels, all laboratory was completely normal.

There was no radiopathology by ultrasound examination.

Parathyroid Adenoma was detected in the upper left of thyroid gland of Parathyroid scintigraphy (Tc-99m MIBI) Bone densitometry demonstrated severe osteoporosis on the DXA

Result was compatible with osteoporosis. (L1-L4 T Score:-4.7)

A surgery was planned after medical treatment.

Conclusion: Bone fractures have rarely been observed inpatients due to low voltage and short duration of exposure to electricity if there is no additional Traumas.

In this case osteoporosis due to parathyroid adenoma caused fractures which developed as a result of exposure to electric shock.

In case of unexpected fractures, we must be more careful about primary hyperparathyroidism causing osteoporosis.

Keywords: parathyroid adenoma, fracture, electrical injury

P-0002 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A patient that diagnosed as superior vena cava syndrome in our emergency service

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Superior vena cava syndrome (SVCS), is progress with obstruction of superior vena cava. Obstruction of this vein, commonly caused by an intra-thoracic tumor. We present a patient that admitted to our emergency service with edema, venous collaterals, plethora, chest pain, dispnea and jugular venous distension and later diagnosed as SVCS.

Keywords: dispnea, edema, bronchogenic carcinomas

P-0003 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Danger Coming With Bonsai !!!

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Objective: Substance abuse has been increasing rapidly in the world also in our country. Drugs are easy to reach and also compared to other categories of drugs, synthetic drugs low cost has effected the increase of substance abuse especially in large cities. In recent years, the drug which is known as Bonsai has been used likely among young population. Cerebrovascular and neurological complications have been reported to occur in patients after the use of bonsai.

Case: We report a case of a young patient who developed cerebrovascular symptoms after the use of bonsai. 39 year old male patient referred to our emergency department with complaints of numbness and loss of strength in left arm and left leg. He stated that symptoms developed after the use of bonsai. He had no medical evaluation. On initial arrival of the patient, Blood pressure was documented as 115 / 75 mmhg pulse 100 beats per minute, respiration rate 23, oral temperature 36.5, SaO2 91. On her physical examination she was conscious, oriented, cooperated, and a score of 15 on the Glasgow coma scale. Neurological examination noted 2/5 strength on her left upper and lower extremities and paresthesia. On her ct scan there was no abnormality. An MRI scan of the brain reported to show diffusion restriction on multiple areas. No significant abnormality was identified on routine laboratory investigations including full blood count, liver, renal, biochemistry and troponin. His Ecg showed sinus rhythm. The patient started on anticoagulation therapy and she was admitted to neurology clinic. In the neurology clinic bilateral carotid, arterial and vertebral artery doppler ultrasonography also transthoracic ecocardiography was performed and no significant abnormality was reported. As a result bonzai was considered as the etiology and days after she had full recovery of muscle strength and paresthesia, he was discharged from the hospital.

Conclusion: In this report, especially young patients presenting to the emergency department with neurological signs and symptoms should be questioned about drug substance.

Keywords: Bonzai, ischemic cerebrovascular disease, young patient

P-0004 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Stroke In Young Patients With Carotid Artery Dissection

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Objective: Stroke is one of the most detected diagnose in the emergency department. Strokes under the age of 45 is classified as young stroke. Extracranial arter dissection keep an important place in young cerebrovascular diseases. In this report, carotid arter dissection detected in a patient who applied to our hospital with stroke would be mentioned.

Case: 43 year old male patient referred to emergency department with complaints of rapid onset of slurred speech, right arm, right leg loss of strength. In his past medical history he had no disease and prescribed medication. On initial physical examination his blood pressure documented as 125/75 mmhg, pulse 80, respiration rate 16, oral temperature 36.5 transcutaneous oxygen 100. On neurological examination he was orientated, cooperated, 15 on the Glasgow coma scale. Additionally, dysarthria, facial asymmetry, 1/5 strength on her right upper extremity, 3/5 strength in her right lower extremity were recorded. Left upper and lower extremities were 5/5 strength. On his Ct scan showed no abnormalities. An mri scan of the brain reported to show diffuse restriction on the area of the left middle cerebral artery distribution. All the routine laboratory investigations were in normal range including full blood count, liver, renal, biochemistry and troponin. His ecg showed sinus rhythm. The patient started on anticoagulation therapy and admitted to neurology service. In the neurology service fat suppressed cranial mri and mr angiography revealed a dissection of the left internal carotid artery. In one week, the patient had full recovery and discharged from the hospital.

Conclusion: Carotid artery dissection should be remembered as an etiology of stroke especially in young patients

Keywords: Carotid artery dissection, Stroke, Young patient



POSTER PRESENTATIONS

P-0005 Pediatric Emergencies

Flail chest associated with a simple fall and successful external tampon application in a pediatric case

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Objective: Pneumothorax and tension pneumothorax associated with simple falls should be considered in pediatric patients. We report a 10-year-old case of a flail chest due to a simple fall from chair while at breakfast. We present this pediatric case because of its rare occurrence with a successful external tampon application. In our case, blunt chest trauma-associated bilateral multiple rib fractures and a flail chest were present. Early stabilization with tube thoracostomy and external tampon was achieved in the emergency setting.

A flail chest is clinically diagnosed as paradoxical respiration or movement of a segment of the chest wall. The clinical presentation includes severe pain, dyspnea, and mechanical dysfunction of the lungs. Children usually respond to treatment very well. Early intervention is crucial in the management of a flail chest. In most cases, radiographs should not be waited to confirm the diagnosis.

Case: A 10-year-old boy was admitted to the trauma unit of the emergency department with dyspnea. The patient history revealed that he fell from the chair to the ceramic-tile ground while having breakfast. He was brought to the ED by his family due to a sudden onset of dyspnea. Tube thoracostomy was scheduled urgently. The patient was placed in the left lateral position (lesion present) to prevent paradoxical respiration and for possible mechanical ventilation support. Left-sided thoracocentesis was performed. Then, emergency tube thoracostomy was performed under local anesthesia following local cleaning with positive air aspiration. Due to a prominent progressing paradoxical respiration in the left lung, compression with external tampon on the rib cage was applied using braces and roller cotton bandages used to support an injured limb.

Conclusion: Thoracic injuries varies with a broad spectrum of injuries from simple rib fractures to intra-thoracic organ injuries. 2,3 Rib fractures account for 35 to 40% of all thoracic injuries. Nearly 10 to 15% of these injuries may result with a flail chest. The presence of more than two rib fractures indicates severe injury. Life-threatening physiopathological changes always affect the clinical condition. In a typical flail chest, the fractured segment moves inward during inhalation and outward during exhalation which is termed as paradoxical respiration. The chest wall and mediastinum stability are compromised, thereby leading to decreased cardiac venous return.

Chest stabilization is required to prevent paradoxical respiratory movement in these patients. Tampon can be applied using practical materials in the emergency departments.

Keywords: flail chest, pneumothorax, external tamponade

P-0006 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Gitelman's Syndrome and Hypocalcemia

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Objective: Gitelman syndrome, discovered in 1966 by Gitelman, Graham and Welt, and it is an autosomal recessive renal tubular disorder characterized by hypomagnesemia, hypocalciuria, hypokalemia and metabolic alkalosis. The majority of patients are asymptomatic, but some patients have seizures, muscle weakness and episodic tetany. Paresthesia, abdominal pain, vomiting and fever may also occur. In this case we talked about a patient with Gitelman syndrome who admitted to emergency room with symptoms of hypocalcemia.

Case: 42 years old female patient complained of spasms in the face and hands admitted to emergency room of our hospital. She also had nausea. The patient had a history of Gitelman syndrome. The patient has no history of any other disease, and drug use. Her vital signs revealed a temperature of 37°C, blood pressure of 104/64 mmHg, respiratory rate of 18/min, pulse rate of 98/min, and pulse oximetry reading of 96% on room air. Chvostek's and Trousseau's signs are positive on physical examination. Her blood glucose level was 102 mg/dL. The ECG was normal sinus rhythm. Then the patient's laboratory tests were planned. The patient's laboratory results was compatible with hypokalemia, hypomagnesemia and hypocalcemia. Ionized calcium level of the patient was 0.26 mmol/L, magnesium level was 0.7 mmol/L and potassium level was 3.1 mmol/L. The patient's renal function tests were normal. Parathyroid hormone level was normal (22.6pg/ml). The patient was treated with intravenous calcium and patient's complaints disappeared.

Conclusion: Gitelman syndrome is rare and can occur at various clinical conditions. Gitelman syndrome patients may refer to emergency room with symptoms of hypokalemia, hypomagnesemia, hypocalcemia. In tetany patient along with serum calcium measurement, serum magnesium, serum potassium, and arterial blood gases should be measured.

Keywords: Gitelman syndrome, tetany, hypocalcemia

P-0007 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Demographic and Clinical Evaluation of Patients with Dermatological Emergency

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Objective: The purpose of this study, to determine the frequency of adult patients presenting with skin lesions, which complaints they have and in which the diagnosis they received, systemic diseases which is present with dermatologic lesions and to investigate why dermatology outpatients prefer to apply to emergency service instead of dermatology poliklinik for non-urgent cases.

Materials-Methods: This study is a prospective study including 262 patients who applied to Ankara Training and Research Hospital Emergency Department with dermatological symptoms between the dates of 06.01.2011-01.01.2012.

Results: The first three most commonly diagnosed in the emergency department diagnosis of acute urticaria (41.6%), maculopapular drug eruptions (17.2%), pruritus (7.6%), respectively. 26 of all patients (9.9%) were consulted to dermatology. The emergency medicine physicians and dermatology clinic dermatologist were agreed with same diagnosis in 84.6% of dermatology consultations, and in 75.8% of dermatology clinic dermatologists' control. Patients presenting to emergency department with Dermatologic complaints were asked whether it really is urgent, 194 of two hundred sixty-two patients (74.0%) said that this was an emergency situation but Emergency Medicine Specialists assessed only 105 patients (40.0%) as real emergencies. In general, all patients were asked why they prefer the emergency service. Patients most frequently (20.6%) said they'd come to the emergency room due to severe itching and pain

Conclusion: Dermatological patients are often admitted to the emergency department with complaints which are not "real emergency" but, cosmetic, social, cultural and environmental factors increase the frequency of emergency visits. Nevertheless, dermatologic diseases with high mortality and morbidity are well known by the Emergency Medical Specialists.

Keywords: dermatology, emergency, skin lesions

P-0008 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Stay Alive with 190 mmol/L sodium level

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Objective: Hyponatremia is defined as presenting of serum sodium level above 145meq/L. Hyponatremia is seen in %0,3-3,5 of patients who are hospitalized. Hyponatremia is an electrolyte disorder which has high morbidity and mortality ratio (%40-70). Hyponatremia is generally observed in older and sicker patients, especially in elderly patients with mental situation disorders. The normal range for the Na⁺ ion concentration in the blood is about 135-145 units. Death usually takes place if this level drops below 110 units or rises over 170 units. But this can vary from patient to patient.

Case: 75 years old female patient with oral intake disorders was admitted to the emergency room due to change in consciousness between times. Her vital signs revealed a temperature of 36,3°C, blood pressure of 96/60 mmHg, respiratory rate of 18/min, pulse rate of 108/min, and pulse oximetry reading of 93% on room air. On physical examination of the patient she had decreased skin turgor and dry mucous membranes. Neurological examination was normal during the examination. Laboratory tests of the patient was planned. In the results her creatinine was 3,8 mg/dL, urea was 170 mg/dL, sodium level was 190 mmol/L, potassium level was 5,4 mmol/L and chloride level was 167 mmol/L. Her ECG showed sinus tachycardia. Patient's treatment was started and consulted for hospitalization. The patient was hospitalized for 36 days and discharged in a healthy way.

Conclusion: Hyponatremia, is an electrolyte disorder associated with high mortality rates especially in the elderly population. Hyponatremia mortality in younger patients is more common than elderly patients. Elderly patients are more resistant to dehydration and hyponatremia. For thirst sensation is impaired in the elderly, hyponatremia is advancing slowly. In our case an old patient with 190 mmol/L sodium level could be able to stay alive. She benefited from treatment.

Keywords: Hyponatremia, sodium level, electrolyte disorder



POSTER BİLDİRİLER

P-0009 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Is Panax The Criminal?

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Objective: Herbal products are sold as drugs in the markets without the approval of the Ministry of Health widely used as a treatment of various diseases among the population. The botanical/genus name Panax means "all-heal" in Greek, sharing the same origin as panacean the context of the product named Panax oat extract, panax ginseng extract, lemon balm, Tribulus is located. Although the approval of the Ministry of Agriculture found the Ministry of Health is not authorized. Among the population this drug is used in the treatment of atherosclerosis, hypertension and hyperlipidemia.

Case: Our case 57 year old male patient referred to our emergency department with aphasia and loss of strength on left upper and lower extremities. He had a medical history of essential hypertension and ischemic stroke. He was on no prescribed drugs. Last one month he had a history of panax drug use. On his initial arrival his blood pressure was recorded as 145 / 75 mmHg, pulse rate 81 p/m, respiratory rate 17 p/m, oral temperature 36 OC, SP02 % 99. His general condition was fair, he was oriented and cooperated and a score of 15 on Glasgow Coma Scale. Neurological examination noted 3/5 loss of strength on both upper and lower extremities. On inspection his tongue was deviated contralaterally. His full blood test, liver and renal functions, biochemistry and troponin were in normal range. There was no noted coagulopathy and thrombocytopeni. His ECG showed sinus rhythm. On CT scan of the brain reported to show a hemorrhage with hyperdense area in right putamen area. There was no indication for surgery therefore he was transferred to neurology clinic.

Conclusion: In this case, the etiology of the hemorrhage has not been found exactly. The time of admission in emergency department his arterial blood pressure platelet count, coagulation parameters, the vasculature of the brain revealed normal so panax drug was thought the etiology of the hemorrhage. Drugs that are not under medical supervision are required to take into consideration when patients apply to emergency department with a history herbal drug abuse.

Keywords: Panax, Cerebral Hemorrhage, Criminal

P-0010 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Valproic Acid-Induced Encephalopathy in Case

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Objective: Valproic acid, is broad spectrum, narrow therapeutic range, used in neurology and psychiatry, which may be well tolerated. Usage of valproic acid is rarely caused of hyperammonemia encephalopathy which can be fatal, and it is very valuable to recognize in early level – in particular in the emergency department – for ensuring the recycling of heavy table.

Case: 66 year old male patient, following the diagnosis of epilepsy with antiepileptic treatment, was brought to the emergency department because of lethargy and confusion. He has a medical history of epilepsy, and ischemic stroke. He was using sodium valproate tablets 2 times 250mg/day dose for antiepileptic therapy. In first neurological examination, the patient has confused consciousness and flexor response to painful stimuli in the lower and upper right extremities. He had 3/5 loss of strength in the left upper and lower extremities connected to previous stroke. Babinski sign was present in the left side and it was absent on the opposite side. Serum biochemistry and CBC results were unremarkable. In the Cranial MRI, the right parietal lobe has a larger design in cortical-subcortical and in the right centrum semiovale, chronic ischemic hypodense area was observed. Blood level of ammonia was 503 mg / dL (N: 45 to 80). Blood level of valproic acid was 348 mmol / L (N: 347 to 693). In Electroencephalography (EEG), triphasic waves and diffuse deceleration was found. Cause of Valproic acid-induced encephalopathy, the drug was discontinued, and support therapy was administered. With decreasing blood levels of ammonia, after 36 hours, the patient has recovered consciousness. Instead of valproic acid treatment, levetiracetam 250 mg tablets twice a day started and patients discharged with suggestions.

Conclusion: Within therapeutic dose and high serum levels, valproic acid can cause symptomatic hyperammonemia resulting in encephalopathy. All patients taking valproic acid presenting with encephalopathic symptoms must be monitored for the condition.

Keywords: adverse effects, encephalopathy, valproic acid

P-0011 Pediatric Emergencies

Tourniquet Syndrome

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Bezmialem Üniversitesi Tıp Fakültesi Acil Tıp Anabilim Dalı

Objective: Hair-Thread Tourniquet Syndrome is a syndrome that is caused by entanglement of a strand of hair or some other similar material around extremities. The syndrome causes impairment of drainage of the involved extremity and it can cause results from surface skin damage to necrosis in the extremity. Early awareness and control is the most important factor in treatment.

Case: 4 months old baby applied for a complaint of swelling and reddening in 2nd, 3rd and 4th toes. Baby's general condition was well but the uneasiness of the baby was noticed. The edematous reddening in toes, was seen in examination but blood circulation was well. After looking carefully, a tourniquet by hair was determined around the toe. The hair which caused a tourniquet was removed and no other intervention was made because there was no problem with blood circulation and there was no symptom of infection. There was a skin irritation under the toe, therefore around it was dressed with antibacterial pomade. Then, the patient was discharged after suggestion control.

Conclusion: In literature, Usually these kind of cases are occurred in the pediatric age group. In order to inhibit the disability, it is important that families who has a kid in this age group and medical personnels are careful.

Keywords: Tourniquet Syndrome, emergency service, hair

P-0012 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Recurrent Orgasm Episodes After Duloxetine Intake

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Objective: Duloxetine is a serotonin and noradrenaline reuptake inhibitor. The basis of the indication for duloxetine is major depression. It can cause many adverse effects. Male erectile dysfunction, delayed ejaculation and ejaculatory dysfunction are common. There is no proven effect on sexual function in women. Probability of male erectile dysfunction is no bigger than 4%. Ejaculatory dysfunction is below 3%. It may also cause insomnia, anxiety, agitation, and orgasmic dysfunction. In this case, contrary to common belief we talk about a female patient who had recurrent orgasm episodes after duloxetine intake.

Case: 39 years old female patient admitted to emergency department with complaint of having orgasm since six hours. The patient's vital signs and physical examination was normal. In patient's history she had major depression. For this reason, the patient had been started to use duloxetine two weeks ago. Other than that, the patient had no illness and drug use. Her complaint disappeared spontaneously in the emergency department. Her complaint was associated with duloxetine and psychiatric consultation was requested. The drugs were replaced by psychiatry and she was called to the psychiatry clinic three days later.

Conclusion: Although many of the adverse effects are seen with duloxetine, in this case we have emphasized sexual effects. In males, duloxetine causes erectile dysfunction and delayed ejaculation but there is no precise information in females. Duloxetine activates manic episodes in patients with bipolar disorder. If orgasm is classified as a manic symptom, maybe our patient was bipolar. Consequently, in our patient duloxetine induced orgasm appeared.

Keywords: duloxetine, orgasm, depression

P-0013 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Is 2,6 g/dL hemoglobin level compatible with life?

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Objective: Anemia is a medical condition in which the red blood cell count or hemoglobin is less than normal. A complete blood count (CBC) blood test is performed to determine the presence of anemia. CBC results include measurements of hemoglobin, hematocrit, and mean corpuscular volume. The normal value for hemoglobin varies by age and gender. For men anemia is typically defined as hemoglobin level of less than 13.5 g/dL and women as hemoglobin of less than 12.0 g/dL. The severity of anemia is categorized by the following hemoglobin concentration ranges. Mild anemia is considered when hemoglobin is between 9.5 - 13.0 g/dL. Moderate anemia is considered when hemoglobin is between 8.0 - 9.5 g/dL. Severe anemia is considered for hemoglobin concentrations below 8.0 g/dL. In this case we talk about a patient whose hemoglobin level was too low to be compatible with life.

Case: An 87 years old female patient was admitted with complaints of eating disorder, feeling weak or tired more often than usual. Two years ago patient was admitted to the same complaint.



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There was no history of chronic disease and drug use. Her vital signs revealed a temperature of 36°C, blood pressure of 90/58 mmHg, respiratory rate of 20/min, pulse rate of 108/min, and pulse oximetry reading of 95% on room air. Her ECG showed sinus tachycardia. At physical examination the patient was conscious and oriented. She was cachectic and had a pale skin color. CBC results showed that the hemoglobin level was 2.6 g/dL. Other results were normal. The first three units of erythrocyte replacement was performed to the patient in emergency department. After the erythrocyte replacement patients was hospitalized for detailed tests and treatment.

Conclusion: Treatments for anemia are also varied and which one is right for you depends on what is causing the anemia. Patients with mild or moderate anemia may not have any anemia-related symptoms or only a few signs of tiredness. when anemia becomes severe – generally when hemoglobin drops to or below 7-8 g/dL – transfusions are often used to quickly raise hemoglobin levels to a normal range and reduce symptoms like significant fatigue and dizziness. Because anemia in chronic processes, symptoms may be delayed. In this case, our patient stayed alive with 2.6 hemoglobin level.

Keywords: anemia, hemoglobin, transfusion

P-0014 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Temporal Abscess Presenting with Symptoms of Acute Otitis Media

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Objective: Abscess formation in the infratemporal and temporal fossae is rare. Abscesses in this space have been reported secondary to maxillary sinusitis, maxillary sinus fracture, temporomandibular arthroscopy and drug injection. More commonly, temporal space infections are associated with the extraction of infected and non-infected teeth. The signs and symptoms are not specific, and include pain, altered sensory/mental status, and meningitis. Their presentation emergency departments is unusual and consequently may cause problems with diagnosis. Once diagnosed, treatment should be aggressive with intravenous antibiotics and surgical drainage. In this report we present a case involving severe infection which developed into an abscess in to the temporal region.

Case: 54 years old male patient admitted emergency department with headache, nausea, vomiting, fever, left ear pain and discharge which was started 3 days ago. According to his medical records he had no dental injection or dental operation history but he had an operation history 10 years ago in neurosurgery because of temporal mass. His initial vital signs were; blood pressures 140/80, pulse rates was 96/min, temperature was 37,4 C, respiratory rate was 14 breaths/min, oxygen saturation %94. He was tender to palpation and not able to open eye. There was tenderness with jaw movements. There was no pathological finding on his physical examination except these findings. The laboratory tests were within the standard range except for elevated white blood cell. Because of severe headache we wanted to see head tomography. There was temporal abscess in the head CT image. The patient was consulted to neurosurgery and infectious diseases specialist. Neurosurgery specialist did not planned operation to the patient and infectious diseases specialist began intravenöz antibiotic. Patient hospitalized and intravenöz antibiotic was started to the patient.

Conclusion: Infratemporal and temporal fossa infection is not commonly seen and might be easily misdiagnosed. A careful medical and dental history is required, as well as oral, facial, and systemic examination. With this information, together with radiographic findings and knowledge of the anatomical structures involved, temporal fossa infection can be suspected and management begun by urgent referral to the oral and maxillofacial surgeons and infectious diseases specialists.

Keywords: Temporal Abscess, Acute Otitis Media, Headache

P-0015 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Atypical presentation of disseminated intravascular coagulation

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DIŞKAPI YILDIRIM BEYAZIT EĞİTİM VE ARAŞTIRMA HASTANESİ

Objective: Disseminated intravascular coagulation is a syndrome that is characterized unstable hemostatic balance. Sepsis, trauma, surgery and circulatory disorders are main causes of disseminated intravascular coagulation. Hemorrhage, shock, pulmonary, kidney and liver dysfunction may be seen in this disease. The prothrombin time and activated partial thromboplastin time increase and hemolytic anemia can be seen. Herein, we intend to report a patient that admitted to emergency department with bloody vomiting. After then she was diagnosed with disseminated intravascular coagulation. DIC may causes mortal complications.

Case: A 77-year-old woman admitted to emergency department with haematemesis about a week. The patient was oriented and there was ecchymoses in abdominal and thoracic areas. There was rales in auscultation of lungs. There was any pathology except for this.

The vital signs were as follow: blood pressure: 100/50 mmHg, fever: 36.7, So2: 90. In her history, she was on medication warfarin, klopidoğrel and low molecule weight heparine treatment due to pulmonary thromboembolism. In laboratory examinations, prothrombin time and activated partial thromboplastin time was high, fibrinogen: 411,093 and d-dimer was 3,024. Disseminated intravascular coagulation was diagnosed for the patient.

Conclusion: Emergency physicians should be careful about patients that admitted to with haematemesis.

Keywords: intravascular, coagulation, vomiting

P-0016 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Purple Urine Bag Syndrome

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Objective: Purple urine bag syndrome (PUBS) is a relatively rare but interesting phenomenon where the urinary bag is discoloured purple. We present a case of PUBS as a manifestation of urosepsis.

Case: A 82-year-old woman was admitted to ED with fever, dysuria, constipation and vomiting. On examination, she was unwell and severely dehydrated, with a blood pressure of 91/70 mm-Hg, pulse rates of 103 beats/min, and a temperature of 36.7°C. Physical examination revealed diffuse tenderness on palpation of the abdomen. She had Foley catheterization for one month because of the femur neck fracture. It was noted that her urinary bag and part of the urine catheter were discolored purple. Other examinations did not indicate any other noteworthy symptoms.

Laboratory workup showed total leukocyte count was at 17640/microliter (normal 4000–10000/microliter). Urine analysis showed specific gravity of 1.019, alkaline urine of pH 8, and large amount of leukocyte (3+) and nitrites negative. The Foley catheter was changed and she was started on prophylactic antibiotic therapy with intravenous ceftriaxone 2 g daily for urosepsis and subsequently admitted to the hospital. Two days later, her blood cultures isolated Coagulase-Negative Staphylococcus, which was sensitive to teicoplanin and, urine culture only isolated contaminants. The antibiotic therapy was changed to teicoplanin 400 mg intravenous injection every day. She died at 18th days of hospitalization despite intensive care.

Conclusion: The cause of this color change is still not completely known, but is thought to arise from a complex series of chemical interactions resulting from concurrent constipation and urinary tract infection. Constipation allows adequate time for gut flora to deaminate dietary tryptophan to indole. Indole then travels via the portal system to the liver, where it is conjugated to indoxyl sulfate. This is subsequently excreted into the urine, where bacterial indoxyl sulfatases catalyze it to indoxyl. This metabolite then oxidizes to both indigo (blue) and indirubin (red) in the presence of a high urinary pH. These pigments interact with the plastic of the catheter set to create a purple hue.

This case highlights that PUBS may not always be benign and should be approached on a case-by-case basis because it may signal the underlying UTI which might be very difficult to treat. Emergency physicians must be aware of this clinical syndrome. Failure of recognition of this peculiar color early could delay the appropriate intervention leading to fatal complication.

Keywords: urosepsis, awareness, mortality

P-0017 Pediatric Emergencies

Evaluation of Pediatric Forensic Cases in Emergency Department: A Retrospective Study

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Objective: Our aim in this study is to evaluate the properties of the pediatric forensic cases who were admitted to the Emergency Department and to discuss the precautions in order to prevent the occurrence of these forensic events in the light of the literature.

Materials-Methods: The patient files and forensic reports of pediatric forensic cases, who were applied to the Emergency Department of Abant İzzet Baysal University Medical Research and Practice Center between January 01, 2009 and December 31, 2011 were investigated retrospectively.

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Results: A total of 421 forensic pediatric cases with a median age of 9.9 ± 5.5 were included in the study. Of the cases, 61% (n=257) were male and 47.3% were in 5-14 age group. The type of the events were traffic accident (50.4%), fall (18.3), stab injuries (10.9%), intoxication (5.9%), pounding (5.0%) and other incidents (9.5%). Injuries of head, lower extremities and trunk were the most seen injury localizations in traffic accidents. There were nine suicide attempt (all of them were above 14-year-old) and four physical abuse (three of them were under 15-year-old) cases. The mean time period from injury to admittance to the hospital was 45.0 ± 17.3 minutes. After the observation period, 79.8% cases were discharged from the Emergency Department, whilst 20.2% cases were hospitalized in one of the clinics.

Conclusion: Because most of the cases were traffic accident, this situation show to us these injuries are preventable. Preventive and intervening politics of education must be developed in order to constitution of safe environment for children.

Keywords: Emergency department, Forensic case, Pediatric injury, Pediatrics

P-0018 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Rare Case of Cerebrovascular Disease: Broca's Aphasia

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Objective: Cerebrovascular diseases was an important clinical problem in elderly patient which may cause neurological sequelae, even life threatening situations. We wanted to share our experience about a patient with specific type of cerebrovascular disease: Broca's aphasia which is an expressive aphasia where other neurological functions are clinically normal.

Case: 80 year old patient was admitted to Emergency Department with aphasia which was realised after he woke up 5 hours before. His children say that he could not talk after he woke up and that understood what is talked. He uses digoxin, clopidogrel, furosemide, spirinolactone, metoprolol and acetylsalicylic acid for his coronary heart disease and heart failure. His initial physical examination showed no neurologic deficits in upper and lower extremities, motor and sensory, cerebellar examination was also normal. GCS:15. Blood pressure was 136/85, pulse:76, saturation:95%, body temperature:36.7. When we asked something to him, he could confirm us with his head that he understood but not by talking. His labortory results showed no abnormality. Cranial CT was performed and showed no abnormality also. There was no psychiatric history of patient. So we decided to perform diffusion MR imaging which showed us diffusion restrict in left frontal lobe in broadmann area 44, 45. Our diagnosis then was broca's aphasia. Patient was hospitalised after diagnosis was certain.

Conclusion: Broca's aphasia is an expressive pathology which patient can not talk and may be misdiagnosed as a psychiatric pathology. Our patient was 80 year old man, had sudden onset of symptoms and had no psychiatric history and uses drugs for heart failure, hypertensive and earlier coronary artery disease.. We could pre-diagnose Broca's aphasia but head ct scanning was normal. So that whenever we still have suspicion about cerebrovascular disease when cranial ct shows no pathology, we must think about MR imaging study which showed us diffusion restrict in broadmann areas 44 and 45.

Keywords: cerebrovascular disease, broca's aphasia, emergency department

P-0019 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Iatrogenic spinal abscess

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Objective: Spinal abscess is an infectious condition with high morbidity and mortality rates that can be seen in the elderly, with poor personal care, diabetic, and weak immune systems after traumas, injections, surgical procedures or spontaneously. Patients generally present with low back pain, back pain, fever following a surgical procedure or trauma, and with neurologic deficits depending on the localization in advanced cases. Here, we present our case who applied to our emergency room with spinal abscess that had developed after therapeutic radio frequency procedure on the facet joints because of local disc herniation.

Case: The 44-year old male applied to our emergency room with low back pain, fever, swelling in the low back area and numbness in the left leg. The medical history of the patient included lumbar disc herniation, ankylosing spondylitis and FMF. Intraspinal injection treatment had been administered to the patient in the brain surgery clinic one week before his application to our emergency room. Physical examination: vital signs: BP: 120/70; Body temp.: 38°C, pulse: 100/min, respiration rate:12/min4; oxygen saturation: 98. L2-In the area corresponding to S1 vertebral area, tenderness with palpation, redness and strain test in the left leg were positive. There was nothing notable in the other system examinations. Laboratory tests: WBC:10.44; PLT:264000; NE%79.9; HB:14.1; LY%13.2; ROUTINE URINALYSIS: NOTHING NOTABLE; SEDIMENTATION RATE: 66; CRP:113; RF:10; BRUCELLA:NEG; ROSE BENGAL: NEG. In the lumbar MRI performed, an area with regular contours within the soft tissue neighboring the spinous process in the L2-3 and L3-4 levels, 16*23 mm in the widest place, slightly hyperintense in T2A series, and limiting the diffusion (abscess). Diffuse bulging was observed in L3-4, L4-5 and L5-S1 levels that narrowed the neural foramens bilaterally. The brain surgery and infectious diseases departments were consulted to, and subsequently, patient was admitted in the infectious diseases clinic to be treated medically with the pre-diagnosis of iatrogenic spinal abscess. Clinical improvement was achieved in the anti-biotherapy administered in the infectious diseases clinic, and he was discharged with cure on day 7.

Conclusion: Trauma and surgical procedures must be questioned in patients that apply to emergency rooms with back pain, low back pain, fever and neurologic deficits keeping the spinal abscess in mind as a possibility

Keywords: Iatrogenic, Spinal Abscess, Surgical Procedures

P-0020 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

The Prognostic Importance Of Neutrophil / Lenfocyte Ratio In Acute Term Ischemic Cerebrovascular Disease Patients Who Admitted To Emergency Department

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Objective: We emphasize the importance of inflammation instead of stasis, genetic factors, acquired factors in occurrence and recanalization in cerebrovascular disease. In this study, an important indicator of inflammation, neutrophil/lenfocyte ratio in acute cerebrovascular disease was investigated.

Materials-Methods: Between the dates of 01.10.2013 and 30-12.2013, 150 patients were admitted to our emergency department with a diagnosis and treatment of cerebrovascular disease. Patients blood count parameters from their files was compared with 50 amount randomly selected control group were analyzed retrospectively.

Results: In early stage of middle cerebral artery vascularization area infarction, there was a significant increase in neutrophil/lenfocyte ratio and decrease in lenfocyte value compared to control group.

Conclusion: There is a relationship between the degree of inflammation and severity of the disease and this relationship can be determining in the treatment and prognosis of the disease.

Keywords: Ischemic Cerebrovascular Disease, MCA infarct, Neutrophil / Lenfocyte Ratio

P-0021 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Rare and Serious Etiology of Headache: Cerebral Venous Sinus Thrombosis

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Objective: Cerebral venous sinus thrombosis (CVST) is presented rarely and with variable clinical symptoms in emergency departments. It is much less seen than ischemic stroke and an important consideration because of potential morbidity and mortality. It generally effects young population. Risk factors of CVST includes sinusitis, trauma, surgery, hypercoagulable states, intracranial hypotension and medications such as oral contraceptives, corticosteroids etc. We want to share our experience about a patient with CVST and familial history of generalised thrombosis situation.

Case: 27 year old patient visited emergency department by walking with complaint of headache which started 2 days ago. He told that this pain could be off for 2-3 hours after using analgesics until headache emerged itself again and that he is scared because his mother had died 3 months ago because of generalised thrombosis and bleeding situation –which made us think disseminated intravascular coagulation-. He had no previous coagulation abnormality neither in his own or his family's medical history except his mother. His sensory, motor, cerebellar examination was normal, pupils were isochoric, pupillary light reflex was normal. GCS:15. Systematic physical examination including peripheral arterial pulses was normal also.



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Blood pressure: 144/76, pulse:95, saturation:93%, body temperature:36.9 C. Laboratory tests showed no pathology. Patient then underwent cranial ct imaging which showed hyperdensity in interhemispheric fissure and posterior of right occipital lobe. This was either thrombosis of venous sinus or bleeding. Then we decided to perform emergency MR venography to make differential diagnosis and found out transverse sinus, sigmoid sinus, superior sagittal sinus thrombosis which restrict blood flow partially. We initiated 60mg of enoxaparin sodium treatment, then early consulted to neurology department for hospitalisation.

Conclusion: Diagnosis of cerebral venous sinus thrombosis is challenging situation but important because of high morbidity and mortality if not treated. CVST in our patient could be misdiagnosed, discharged with analgesics due to his age and normal examination clinically. His mother's medical history –possibly DIC- concerned and made us perform further diagnostic imaging such as cranial ct and MR venography. We think that he had a familial hypercoagulable situation which needs further evaluation. Complete medical history, correct radiologic instruments can save life, even in absence of pathologic examination findings.

Keywords: venous sinus thrombosis, headache, emergency department

P-0022 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A vasculitis case in ED; Drug-induced leukocytoclastic vasculitis

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Objective: Leukocytoclastic vasculitis is an inflammatory disease of small vessels which emerges with joint and skin manifestations. Various causes play a role in its etiology such as medications, infections, malignancies and systemic inflammatory disorders.

Case: The patient presented to the ED with the pain for two days and purpuric petechial rash of 3 days following intake of Cefuroxime axetil. The patient who previously had gone to ED two times had been administered antihistaminic and recommended to continue to his drugs. His treatment was based on the presence and prevalence of symptoms and included a typical leukocytoclastic vasculitis table in which conservative approaches were recommended such as discontinuation of drugs used, bed rest, leg elevation and administration of antihistamines for itching and analgesics for pain.

Conclusion: In this report, a leukocytoclastic vasculitis in which primarily the drugs used were stopped and the treatment was introduced in Emergency Department.

Keywords: drugs, emergency service, leukocytoclastic vasculitis

P-0023 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

An Unusual Case: Thyroid Nodule Hemorrhage with Acute Renal Failure

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Objective: Thyroid nodules are generally without symptoms and incidentally found out by patient or during a routine physical examination or while performing radiologic procedure of the neck such as carotid ultrasonography, computed tomography (CT) or magnetic resonance imaging (MRI). However some patients may develop symptoms such as neck pain, hoarseness, difficulty of breathing, dysphagia. Hemorrhage of nodule can cause the first clinical symptoms which pushes patients to seek medical attention in emergency departments (ED). Acute renal failure (ARF) is also common cause of emergency department visits and grouped as pre-renal, renal or post-renal. Dehydration in elderly patients creates the major portion of ARF.

Case: 41 year old female patient approached to our ED with sudden onset of neck pain. The pain was not related to trauma or eating something. She had no previous medical illness history. She described her pain increasing with her neck movements and by touching her neck. Her vital signs were initially: blood pressure:130/75mm/Hg, pulse rate:85/min, saturation:95%, respiratory rate:13/min, body temperature:36.8 C. Physical examination of neck revealed tenderness on her left side, matching on thyroid gland, and there was a palpable solid tender mass which could be associated with thyroid gland. So we decided to perform ultrasonography which showed 12x10mm nodule with irregular border on right thyroid gland and approximately 3x4cm nodule with heterogeneous echogenicity and septation, which is described as hemorrhage in thyroid nodule. Laboratory results were in normal ranges except Creatinine: 4.28 mg/dL (N:0.66-1.2), BUN: 128 mg/dL (N:17-43), WBC: 20000 10³/μL, NE: 15600 10³/μL and TSH: 0.49 μIU/mL (N:0.34-5.6), fT3: 3.42 pg/mL (N:2.5-3.9), fT4: 1.35 ng/dL (N:0.61-1.12). Her urine output was normal, renal ultrasonography showed no pathological finding. Patient then was admitted to internal medicine clinic for further evaluation due to acute renal failure and thyroid nodule hemorrhage.

Conclusion: Acute hemorrhage in thyroid nodule is an uncommon etiology of neck pain. And as we said before, thyroid nodules are generally diagnosed incidentally without symptoms. Acute renal failure (ARF) may be a manifestation of hypothyroidism. But our patient didn't have hypothyroidism (TSH: 0.49 μIU/mL). We could not associate the ARF with thyroid nodule hemorrhage due to normal thyroid hormone status but what we can say is that detailed physical examination and laboratory evaluation could diagnose this unusual situation and that more case reports are needed to understand the association between ARF and laboratory normal thyroid nodule hemorrhage.

Keywords: thyroid nodule, acute renal failure, neck pain

P-0024 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Case of Massive Pulmonary Embolism at Subacute Phase

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Objective: Pulmonary embolism is a serious medical condition in which pulmonary arteries are occluded by emboli generally originating from deep venous thromboses of lower extremities. It may cause death even if it is treated appropriately. We want to present a case of massive pulmonary embolism because she survived without any treatment for approximately one week.

Case: A 69-year-old female patient presented to our emergency room due to complaints of cough, dyspnea, and weakness. It was learned that she had been having these symptoms for approximately one week. She had been seen by her family physician for the same symptoms when they were started, and took the diagnosis of viral upper respiratory tract infection. Symptomatic treatment was started but her symptoms gradually worsened. So she presented to our hospital. Her vital signs were as follows arterial blood pressure was 90 over 60 mmHg, pulse rate was 115 beats per minute, respiratory rate was 24 breaths per minute, sPO2 was 80%, body temperature was 37.3 °C. Inspiratory rates were present bilaterally. Her electrocardiogram was taken. We saw pathological S waves in Lead I, and pathological Q waves, and T wave inversion in Lead III. She was monitored. Blood samples for complete blood count, biochemistry tests, coagulation studies, cardiac markers, D-Dimer, and arterial blood gas analysis were taken. Oxygen inhalation at a rate of 2 litres per minute was started with a nasal cannula, and the patient was positioned upright. Arterial blood gas analysis parameters were as follows pH: 7.46, pCO2: 28.7 mmHg, pO2: 44.5 mmHg, sPO2: 79.9 %, HCO3: 22.5 mmol/L, and Lactate: 1.8 mmol/L so it showed that a respiratory alkalosis is present. D-Dimer level was calculated 4254 ng/mL. Therefore an intravenous contrast enhanced helical computed tomography scan of chest was performed and it showed a widespread thrombus material in right main pulmonary artery, and in parenchymal branches of both pulmonary arteries. Thus the patient had the diagnosis of pulmonary embolism. Anticoagulant treatment was started by giving 8.000 units of enoxaparin sodium subcutaneously, and she was hospitalised in the general intensive care unit.

Conclusion: Emergency physicians should know pulmonary embolism may present with any kind of symptoms, and most of the patients with massive pulmonary embolism will not be as lucky as that patient was. So it should be kept in mind that a patient takes the diagnosis of pulmonary embolism only if his physician suspects he has pulmonary embolism.

Keywords: Massive pulmonary embolism, viral upper respiratory tract infection, weakness

P-0025 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Spontaneous Pneumomediastinum: Case Report

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Introduction: Spontaneous pneumomediastinum, without any triggers cause is described as finding air in the mediastinum and this is a benign, uncommon and generally self limiting condition.

Case: Admitted to the emergency department the feeling of congestion in the throat and dyspnea complaints, which present a case with the diagnosis of spontaneous pneumomediastinum.

Conclusion: Careful physical examination and radiologic evaluation are very important in making the diagnosis of spontaneous pneumomediastinum. A close follow-up is needed to avoid from possible complications.

Keywords: Pneumomediastinum, Dyspnea, chest CT



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P-0026 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Emergency Presentation of Ophthalmic Zona: A Case Report

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Objective: Herpes Zoster Ophthalmicus (HZO), known as shingles, is a viral disease characterized by a painful skin rash in one or more dermatome distributions of the fifth cranial nerve, shared by the eye and orbit. We report a patient in whom orbital symptoms and signs preceded the onset of the zoster rash.

Case: 66 year old male patient was admitted to emergency department with the complains of edema over and around the left eye, fluid filled blisters and crust formation on the left forehead. He also had fever (37.1 °C), pain in this area and malaise. Physical and biomicroscope examination revealed diffuse periorbital edema of left eye, vesicular lesions and crusting on left periorbital area and forehead, hyperemia and chemosis of conjunctiva. He was given 7 day treatment of intravenous Acyclovir (Zovirax®) and with the regression of lesions and symptoms. He was prescribed Acyclovir pomade and Lomefloxacin eye drop. After 1 month follow up, complete recovery was observed.

Conclusion: Herpes Zoster Ophthalmicus should be kept in mind in the differential diagnosis of ophthalmic region lesions to treat on time and not to cause further complications.

Keywords: Herpes Zoster Ophthalmicus, Acyclovir, Emergency Department

P-0027 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Bilateral Occipital Infarcts Associated With Bilateral Vertebral Arter Pathologies And MTHFR Gene Mutation

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Objective: Stroke occurs due to interruption of blood flow to the brain and is divided into ischemic and haemorrhagic. Ischemic strokes can occur due to many factors. In the ischemic strokes, while the most commonly affected vessel is median cerebral artery (MCA), particularly bilateral affected posterior cerebral artery (PCA) is quite rare. In this study, a patient who presented with sudden loss of vision and bilateral occipital infarct associated with bilateral arterial pathology and MTHFR gene mutation.

Case: A 62-year-old man admitted with sudden loss of vision complaint starting 10 hours ago. The patient was oriented and cooperated. There were no comorbid diseases in patient. Vital signs of patient were stable except hypertension (170/90 mmHg). On neurological examination, there was complete loss of vision in the right eye and only respond to light in left eye. The other neurological examination was normal. There wasn't motor and sensorial deficit and fascial asymmetry. Standard blood tests and electrocardiogram were normal. On the brain computerized tomography, density reduction was observed in both the occipital lobe. On magnetic resonance imaging (MRI), the foci showing diffusion limitation cortico-subcortical areas of bilateral parieto-occipital region and in the cerebellar hemisphere was seen. The patient was admitted to the neurology clinic with the diagnosis of ischemic stroke. On the detailed examination at the clinic, MTHFR(a1298c) gene mutation was detected. In addition, on the MRI angiography, moderate to severe stenosis at the level output of internal cerebral artery and hypoplasia of the right vertebral artery were detected.

Conclusion: The most common three reasons of ischemic strokes that constituting 80-85% of acute stroke are atherothrombosis, embolism and hypoperfusion. Other etiological factors of thromboembolism include trauma, hypercoagulable states, vascular anomaly, malignancy and gene mutations. The MTHFR gene mutation is rare and thrombosis occurs especially in patient with homozygous mutations. While the most commonly affected vessel is MCA, particularly bilateral affected PCA is quite rare. In the PCA infarct, because of loss of motor function is very rare, the patients may not be aware their stroke and generally are presented with isolated visual field defect.

In conclusion, especially bilateral occipital infarction is a rare and diagnosis can be difficult because of its atypical symptoms. Occipital infarction should be suspected when one sign is isolated vision loss and patients with risk factor for thromboembolism in their history should be evaluated more carefully and detailed visual and neurological examination of patients should be performed.

Keywords: MTHFR, occipital infarctus, visual loss

P-0028 Resuscitation

Advanced airway in the emergency department; How much advanced ?

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Objective: A different preparation and practice is needed in difficult airway management in the patients who present to EDs with respiratory distress and require advanced airway intervention. Especially troubles encountered in unpredictable difficult airway management cause difficult moments for the ED team and even lost of the patients. Existence of tracheal stenosis is a risk factor in itself for the difficult airway management, while additional events causing sudden respiratory distress like foreign body aspiration make the preparation and practice of ED team more important.

Case: We learnt from the first medical history which we received from a relative of our 18 years old female patient who admitted to our ED with respiratory distress that she had developed shortness of breath immediately after drug intake. Heimlich maneuver was tried on the patient who was brought in a cyanotic condition and severe airway obstruction was obvious from her respiratory effort, but it failed. Rapid resuscitation was introduced in the patient whom consciousness begins to close respiratory effort to decrease, but the first intubation attempt failed. In the second intubation attempt, although it was ensured that the vocal cords were passed, endotracheal tube could not be advanced. Because the patient could not be ventilated, cricoid membrane was entered through 3wide IV branules and the patient was tried to be ventilated. Anesthetic consultation was ordered for a safe and permanent airway control in the patient in whom the oxygen saturations partially raised. On the repeat medical history received from the patient at that time, tracheal stenosis was learnt and consultation was carried out with the department of thoracic surgery. Repeat intubation was tried through smaller endotracheal tubes before the consultations and she was intubated. Saturations of the patient raised and the branules were removed. The patient was extubated on the onset of her spontaneous breathing and opening of consciousness, reacting against the tube. The swallowed foreign body excised from the edge of the tube during the extubation. As a result of consultation with thoracic surgery and anesthesia departments, it was decided that the tracheal stenosis to be dilated with plugs and the patient to be referred to an advanced center after the stabilization.

Conclusion: ED should be prepared in advance due to unpredictable difficulties. Possible scenarios should be prepared and sufficient trainings and practices should be received. In parallel, we recommend that rigid bronchoscope should be added to the advanced airway equipments and emergency medical assistant curriculum should include its use.

Keywords: difficult airway management, emergency service, rigid bronchoscope

P-0029 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Immunologic skin reaction and compartment syndrome due to snakebite

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Objective: Majority of snakebites occur in the extremities and compartment syndrome develops in a part of these events. There is no consensus in the literature about the treatment of compartment syndrome which develops due to snakebite and insect sting. In this case report, we presented a compartment syndrome case of a 37 years old patient who presented to our ED due to bite of his/her 3rd finger and treated with elevation and palliative therapy without a need for fasciotomy. Since delayed diagnosis of compartment syndrome would lead to ischemic contractures or amputations at various levels in the extremities, patients should be carefully followed-up.

Case: A 37 years old male patient presented to our ED with the complaints of pain, tenderness and swelling in the bite site due to snakebite which occurred when he was working in the field. Vital symptoms of the patient were normal. The patient was supported with proper antivenom, tetanus immunization was carried out and put on prophylactic antibiotic therapy. A bullous necrotic area developed in the internal part of the 3rd finger of the patient who was taken under observation in our ED. He was carefully monitored for compartment syndrome since there was a diffuse swelling at the same site. Extremity of the patient was elevated. Extremity of the patient improved without a need to fasciotomy.



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Conclusion: There are different opinions about the cut-off value of compartment syndrome for surgical treatment. Some studies reported that fasciotomy must be waited until the final stage and that fasciotomy could lead to quite much complications. Therefore, it has been recommended that medical therapies such as elevation and mannitol should be performed for waiting until the clinical findings are fully understood in compartment syndrome. In contrary other studies argued that bites in the extremities should be closely monitored for compartment syndrome and fasciotomy must be carried out in the case of clinical suspicion. Whereas, our patient was healed with the conservative therapy without the clinical findings were fully understood. Since delayed diagnosis of compartment syndrome would lead to ischemic contractures or amputations at various levels in the extremities, patients should be carefully followed-up. Patients presented to EDs should be kept under observation in the emergency departments even if no clinical signs of poisoning.

Keywords: compartment syndrome, emergency service, skin reaction

P-0030 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Anaphylaxis After Intravenous Infusion of Dexketoprofen Trometamol

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Objective: Dexketoprofen trometamol (DT), a highly water-soluble salt of the active enantiomer of rac-ketoprofen, is a nonsteroidal anti-inflammatory drug. It is licensed in number of countries. Parenteral DT is widely used in acute pain management in the emergency department (ED) settings. Although diarrhea, indigestion, nausea, stomach pain, and vomiting are described as common adverse drug reactions in the product information of DT, anaphylactic shock secondary to DT is very rare with an incidence <0.01%. In our case report, we present an instance of anaphylactic shock occurring after intravenous infusion of DT and to our knowledge this is the first case report of this association.

Case: A 43-year-old female patient with right flank pain was admitted to our ED. The patient had known urological stone disease, but she had not been taking any drugs regularly. She did not have any drug allergy history. In her physical examination, there was costovertebral angle tenderness on her right flank region. The rest of her physical examination was normal. She stated that this pain was identical to previous renal colic pain. Bedside renal ultrasonography showed dilatation in the right urinary structures but we did not see any urinary stone. We decided that the patient suffering from renal colic. The patient was taken to the observation unit and then DT 50 mg (Arvels® 50 mg/2 ml Ampul, UFSA ilaç) was administered 10-minute intravenous infusion for pain management. During infusion, she developed confusion, tachypnea, tachycardia (pulse rate: 150 beats per minute), hypotension (blood pressure: 70/30 mmHg), and uvular and mucous membrane edema, so she was diagnosed as having anaphylactic shock. Infusion was stopped. We administered adrenaline 0.5 mg intramuscularly and pheniramine maleate 45.5 mg (Avil® 45.5 mg/2 ml, Sandoz) intravenously. Additional intravenous line was established on the other upper extremity, and a saline solution was given through both of them. The patient's clinical condition improved and her symptoms declined in the following hours. She was given the information that she has an allergy to DT. Dermatology department was consulted. The dermatologist prescribed dual antihistaminic therapy and suggested observation of the patient. The patient was discharged after a 12-hour follow-up in the observation unit.

Conclusion: In conclusion, DT is commonly used intravenously in acute pain management in the ED. Anaphylactic shock may develop after intravenous use of the DT, although it is rarely seen. ED physicians should know that there is some risk of development of anaphylactic shock in patients treating DT intravenously.

Keywords: Dexketoprofen trometamol, intravenous infusion, anaphylactic shock

P-0031 Resuscitation

Cardiac arrest data of Ankara Training and Research Hospital Emergency Department between January 2013-December 2013

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Objective: Early cardiopulmonary resuscitation, affects survival in a significant manner. We survey cardiac arrest cases who applied into our emergency department, and this is a retrospective study over a period of one year. Our goal is to determine the demographic characteristics of all cases that has a cardiac arrest inside or outside of the emergency department.

Materials-Methods: Cardiac arrest patients, over the age of 18, whom applied into the Emergency Department of Ankara Training and Research Hospital between January the 1st of 2013 and December the 30th of 2013 were included in the study. The data collect from the automation system of the hospital, case forms of ambulance record system, and record system of emergency services. Parametres like patients' age, gender, possible reasons for cardiac arrest, arrival times, duration time of cardiac arrest, arrest rhythms at that moment, treatment applied by ambulance crews of 112 system, arrest rhythms during the emergency services, and discharge rates were retrospectively analyzed.

Results: 298 cardiac arrest patients who admitted to the emergency department were included in the study. 186 (62%) of the patients were male and 112 (38%) of them were female. The mean age was 65.7. 39 (13%) of the cardiopulmonary arrest occurred inside the emergency department, and 259 (87%) of them occurred outside the emergency department. The number of cardiac arrests after trauma were 29 (10%). The most common arrest rhythm occurred inside the emergency department was ventricular fibrillation (VF) (49%), while the most common arrest rhythm occurred outside the emergency department was asystole (61%). VF compared to asystole had a significant difference on the level of hospital discharge ($p < 0.05$). 71% of patients died in the emergency department, and 20% of them died in the ward. 3% of patients referral to the another health care facility and 6% of them were discharged. When we assessed in terms of discharge rate, among inside the hospital arrests compared to outside the hospital arrests; there is a significant difference in favor to inside-hospital cardiac arrests ($p < 0.05$) (18% and 4% in order).

Conclusion: Despite all the advances in emergency medicine system and resuscitation, only 6% of patients with cardiac arrest, discharged from hospital without neurological sequelae. We believed that, basic and advanced cardiopulmonary resuscitation trainings for health care providers should repeated frequently and each transactions that mentioned inside the survival chain should be done in a integrated way, might helpful to improve the success rate of cardiopulmonary resuscitation.

Keywords: cardiac arrest, emergency department, patient discharge

P-0032 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A case report of probable pulmonary embolism

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Objective: Pulmonary embolism is a vascular emergency developed mostly as a result of blockage of pulmonary artery and/or its branches by pieces coming off thrombosis occurred in deep veins of legs. There are three types of pulmonary embolism: i.e. massive, submassive and non-massive. As a result of massive embolism in which more than 50% of vein deposit is suddenly blocked, pulmonary artery pressure (PAP) rapidly increase, thereby resulting in acute right ventricular dilatation, systolic dysfunction and cardiovascular collapse. Therefore, early diagnosis and treatment is crucial. However, it can be missed since the clinical table does not always show specific findings.

Case: A seventy years old male patient applied to emergency department with hemoptysis complaint for a month. The general status of the patient with no past disease history was good, and he was conscious, oriented and cooperated. Blood pressure was 130/80 mmHg, pulse rate was 95/min. Although the lung sounds were slightly coarse, ral and ronchus were not present. WBC was 6.08; Hb was 11.2 g/dl; INR was 0.95 and PLT was 259. In blood gas, pH was 7.44, PO₂ was 65 mmHg, PCO₂ was 35 mmHg and SO₂ was 93.8%. In pulmonary computed tomography angiography of the patient, embolus was detected in the middle lobe of right pulmonary artery. The patient was consulted with department of chest diseases and interned for thrombolytic treatment.

Conclusion: Pulmonary embolism is one of vital vascular emergencies and had fatal prognosis if it goes unnoticed. Deep vein thrombosis, previous embolism history, hypoxia, hypocarbia might help in early diagnosis. Isolated hemoptysis along with other important diagnoses as in the present case should also point to pulmonary embolism.

Keywords: Pulmonary embolism, hemoptysis, thrombosis, emergency

P-0033 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Paradoxical Renal Infarction secondary to Pulmonary Embolism

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Objective: Pulmonary embolism is a serious and fatal complication of thrombus formation within the deep venous circulation. Indeed, no single symptom or sign or combination of clinical findings is specific to PE. Some findings are fairly sensitive: dyspnea and pain on inspiration occur in 75–85% and 65–75% of patients, respectively. Tachypnea is the only sign reliably found in more than half of patients. The ECG is abnormal in 70% of patients with PE. However, the most common abnormalities are sinus tachycardia and nonspecific ST and T wave changes, each seen in approximately 40% of patients. Arterial blood gases usually reveal acute respiratory alkalosis due to hyperventilation. Pulmonary embolism is suspected due to recent clinical prediction rules.



POSTER BİLDİRİLER

Paradoxical embolism is an uncommon but increasingly reported cause of arterial embolic events. Renal infarctions are rare in paradoxical embolisms.

Case: 71 years old male was admitted to ED for abdominal pain and vomiting. Patients vital signs revealed a blood pressure of 200/100 mmHg, heart rate of 130/min and respiratory rate of 18/min. Physical examination revealed epigastric localised tenderness and haematochezia. ECG was nondiagnostic. Arterial blood gases revealed pH 7.45, pO₂ 45.5, pCO₂ 24.5, SO₂ 83.1. D-dimer level was 11000. Whole blood count revealed leukocytosis. Ultrasound scan revealed right paracolic free fluid, perisplenic free fluid and left jejunal bowel wall edema possibly due to mesenteric ischemia. Pulmonary computerized tomography(CT) angiography revealed bilateral pulmonary embolism in main pulmonary arteries. Abdominal CT revealed a right renal infarction. Patient underwent surgical intervention for mesenteric ischemia.

Conclusion: Paradoxical embolism may complicate pulmonary embolism. Although paradoxical embolism is rare, it may be diagnosed in patients with deep venous thromboembolism.

Keywords: Paradoxical embolism, pulmonary embolism, renal infarction

P-0034 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Elevated amylase levels due to parotitis may complicate abdominal pain management

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Objective: Amylase is a protein enzyme which catalyses the hydrolysis of starch into sugar. Amylase elevation can be seen in acute pancreatitis, chronic pancreatitis, any abdominal inflammation, parotitis, intestinal obstruction, drugs (such as aspirin, corticosteroids, narcotics, OCP), severe diabetic coma, scorpions sting and biliary tract diseases. Abdominal pain is most common symptom. Nausea, vomiting and intestinal abnormality are other symptoms.

Case: 69 years old male patient with sudden onset of abdominal pain was admitted to ED. Patient had previous gastritis. Initial physical examination was non-diagnostic. WBC was 13000, amylase was 1643, lipase was 110. Ultrasound and abdominal tomography was non-diagnostic. Normal saline 1000 ml and pantoprazole 80 mg was administered and patient was observed in the emergency observation unit. During observation patient complained of left sided facial pain. In the physical examination, his right parotis has swelling and tender with palpation. Other systems are normal. With the diagnosis of parotitis, patient was discharged with antibiotherapy.

Conclusion: Patients with non-specific complaints can have detectable amylase elevation. Physical examination findings are sufficient to diagnose without further investigations in parotitis. All possible diseases that elevate amylase should be considered prior to diagnostic tests.

Keywords: amylase, pancreatitis, parotitis

P-0035 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

The Case of Renal Infarction

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Objective: Renal infarction is a very rare reason of emergency applies which is about %0.007 of all cases. absence of special symptoms of renal infarction, the diseases like urinary track stones, lumbago and the other intraabdominal pathologies which are more common and have similar symptoms make the diagnosis harder. Because of that, the reasons of not thinking renal infarction in first place is its incidence rate.

Case: 68 years old male patient applied to the hospital with a two days history of nausea, vomiting and right flank pain. In his history, there was an operation because of stomach cancer and chemotherapy. The patient was in a good condition, blood pressure was 150/90 mmHg, and vitally stable. Tenderness of right costovertebral angle and optional defense of right lower quadrant, in hemogram tests: except leukocytosis (12,500 10³/μL) everything was normal. In urine examination, there was 10 erythrocyte. In biochemical blood tests, BUN was 30 mg/dl, creatinine was 1.1 mg/dl, Na: 135mmol/L K 4.1 mmol/L, ultrasound showed no pathology. The routine medication was given initially renal colic diagnosis: nausea and vomiting complaints regressed. But the pain did not. Contrasted abdominal computed tomography (CT) was performed. Abdomen CT: hipodens filling defect, at the middle posterolateral and medial renal region shaped of wedge which was not contrasted and coherent with infarction in the right kidney. After the consultations, enoxaparin sodium medications was given and after that, orally warfarin and polyclinic controls were suggested and the patient discharged.

Conclusion: The patient has risk factors for thromboembolic incident; if there is a triad of persistent flank pain, increased LDH levels in the 24 hour from beginning of the pain and haematuria; must be examined with CT and differential diagnosis of renal infarction or the other intraabdominal lesions must be done.

Keywords: computed tomography, emergency medicine, infarction, renal

P-0036 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Posterior Reversible Encephalopathy Syndrome in a Hypertensive Chronic Renal Failure Patient: Case Report

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Posterior reversible encephalopathy syndrome is a cliniconoradiologic syndrome characterized by symmetric high-signal intensity lesions in the bilateral parietooccipital lobes on T2-weighted magnetic resonance imaging. In this case presentation we discussed a 36 year old female patient with hypertensive chronic renal failure treated by peritoneal dialysis admitted to our emergency department with the complaint of visual loss. Emergency physicians should be aware of end organ damage in patient having neurological symptoms related to hypertension and this should be carried out especially in chronic renal failure and hypertensive patients.

Keywords: Posterior Reversible Encephalopathy Syndrome, Chronic Renal Failure, Hypertension

P-0037 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Pulmonary Hydatid Cyst Rupture

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Objective: Echinococcosis or hydatid disease is caused by larvae of the tapeworm Echinococcus. Four species are recognised and the vast majority of infestations in humans are caused by E. granulosus. E. granulosus causes cystic echinococcosis. In cystic echinococcosis, humans are an accidental host and are usually infected by handling an infected dog. The liver and lungs are the most frequently involved organs. Pulmonary disease appears to be more common in younger individuals. Although most patients are asymptomatic, some may occasionally expectorate the contents of the cyst or develop symptoms related to compression of the surrounding structures. Other symptoms of hydatid disease can result from the release of antigenic material and secondary immunological reactions that develop from cyst rupture. Occasionally, an unruptured cyst results in cough, haemoptysis or chest pain. The cyst may rupture spontaneously or as a result of trauma or secondary infection. Rupture may be associated with the sudden onset of cough and fever. Direct rupture into the pleura may follow by pneumothorax, empyema and pyopneumothorax

Case: 34 year old otherwise healthy male patient admitted to ED for 2-hour history of shortness of breath. There was no history of trauma, fever, cough, chest pain, or hemoptysis. On physical examination, he was reasonably well. There were decreased respiratory sound on the left lung; otherwise, the rest of the exam was normal. Chest radiography showed pneumothorax on the left. CT scanning of the lung showed on the left lung, at least 5 cm. pneumothorax and a thin-walled circular translucent area with air/fluid level in it. The intercostal chest tube was placed and started to medical treatment with albendazole. After 21 days he underwent surgery for the ruptured cyst, and histopathology confirmed hydatid cyst. His post surgery recovery was uneventful, and he has had no long term complications.

Conclusion: Pulmonary hydatid cyst most commonly appears in the lower lobe of the right lung, and is usually solitary. These cysts may initially be asymptomatic, and may be diagnosed incidentally during a radiological evaluation for other reasons. On the other hand, a hydatid cyst may present with symptoms, such as chest pain, hemoptysis, dyspnea, fever, asphyxia, anaphylactic shock, acute respiratory failure, massive hemoptysis, and circulatory collapse. Ruptured pulmonary hydatid cyst is often difficult to diagnose because after rupture into a bronchial lumen, radiographic appearance can be widely varied. It may be misdiagnosed as pneumonia, tuberculosis, lung abscess, tumor, or pneumothorax.

Keywords: Hydatid cyst, rupture, pleura



POSTER PRESENTATIONS

P-0038 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Paraspinal Abscess secondary to Brucellosis

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Objective: Osteomyelitis and paraspinal abscesses of the spine is a rare condition, reported as 1 in 100,000 – 250,000 of the general population in developing countries. The general population is lacking as the condition is infrequently reported in adults. Paraspinal abscesses mostly occur in the setting of invasive procedures. This includes transcutaneous infection of deep tissue by needles or catheters, bone surgery, blunt trauma, and hematogenous spread from distant sites. Hematogenous osteomyelitis and subsequent paraspinal abscess formation is most commonly caused by gram-positive organisms. While gram-negative organisms may also inflict similar symptoms, Staphylococcus aureus remains the most common cause. Back pain, pyrexia (50% of patients), and muscular weakness are the most common presenting symptoms of paraspinal abscess.

Case: 64 year old female patient with 4-month history of back pain presents with muscle weakness on both lower extremities in last one day. An X-ray of the thoracic spine was conducted and showed normal spinal column free of any acute bony thoracic spine abnormality. However, an impressive opacity superimposed over the lower thoracic spine was noted. A non-contrast and contrast MRI of the thoracic spine found this opacity to be a paraspinal abscess at T9 and T10 vertebrae. The patient was referred for decompression and abscess drainage, which isolated brucella, followed by broad spectrum antibiotic therapy (streptomisin+tygecyclin+rifampisin), and a full recovery was evidenced shortly thereafter.

Conclusion: Spontaneous paraspinal abscesses are rare and are thought to happen more often in immunocompromised patients and those with chronic debilitating disease, especially diabetes mellitus. The diagnosis is frequently not suspected until magnetic resonance imaging (MRI) is performed. In addition, computed tomography (CT) scan may be needed to rule out osteomyelitis

Keywords: brucellosis, spine, abscess

P-0039 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Extrinsic Pulmonary Artery Compression due to Non-Hodgkin's Lymphoma

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Objective: Acquired pulmonary stenosis in adults is rare and is usually caused by extrinsic pulmonary artery or right ventricular outflow tract compression by tumour. Extrinsic pulmonary stenosis is even rarer and predominantly caused by external thoracic masses creating non-dynamic obstruction of the right ventricular outflow tract. Several malignant masses may cause compression of the pulmonary artery, including nonmicrocytic lung carcinoma, non-Hodgkin's lymphoma, thymoma, teratoma, and malignancies of the pericardium or of unknown origin. The most common complaints associated with malignant extrinsic pulmonary compression include chest pain and dyspnea. Weight loss, fatigue, cough, and palpitations may also be seen. On physical examination, a systolic ejection murmur is the most frequent physical finding, and less frequently, a precordial lift or palpable thrill may be noted. On electrocardiography, normal sinus rhythm as well as a right axis deviation or right ventricular hypertrophy may be present. Finally, the most common appearance on the chest radiogram is enlargement of the mediastinum, followed by a normal chest radiograph and cardiomegaly.

Case: 60 year old male patient admitted to emergency room for 6-month history of progressive dyspnea. His physical examination revealed mild roncus and crepitant rales on basal lungs with mild hypoxia. The rest of the examination was unremarkable. The resting 12-lead ECG was normal and on his chest radiogram he has enlargement of mediastinum and left basal opasite (figure 1). Transthoracic echocardiography (TTE) revealed a mildly dilated main pulmonary artery, with turbulent flow at the level of the bifurcation. A subsequent CT thorax confirmed an extensive soft tissue mass encasing the great vessels with compression of the left pulmonary artery consistent with a malignant neoplasm (figure 2). A biopsy confirmed a high-grade non-Hodgkin's lymphoma (NHL).

Conclusion: Acquired pulmonary stenosis in adults is rare and is usually caused by extrinsic pulmonary artery or right ventricular outflow tract compression by tumour. Mediastinal lymphoma can compress vascular structures TTE as a useful non-invasive method for the diagnosis of extrinsic compression of the pulmonary arteries. Further evaluation requires other imaging modalities and tissue diagnosis. NHL was responsible for only 9% of cases of extrinsic pulmonary artery compression by tumour. The prognostic significance of acquired pulmonary stenosis in this setting is unknown.

Keywords: compression, pulmonary artery, lymphoma

P-0040 Resuscitation

Chest compressions applied to an out-of-hospital cardio-pulmonary arrest case by an untrained saviour

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Objective: In present case we discussed a cardiopulmonary arrested patient to whom cardiopulmonary resuscitation was applied by an untrained savior.

Case: A 85 year-old female patient who became bedridden after a lumbar hernia operation about 75 days ago was found unconscious in the morning by her caregiver. She was followed for hypertension and COPD for 30 years. The caregiver who realized that the patient was not breathing and had no pulse, turned her supine position, prevent the tongue escape back and began to chest compressions. She directed a second person to call 112 emergency medical services (EMS); and pressed as quickly as possible and deeply with the palm of both hands after placing the mid-point of the sternum. Caregiver did not check the pulse during compressions. About ten minutes after the chest compressions patient started breathing. At this time patient's radial artery pulse was able to be taken clearly. 112 EMS came to the scene and took over the patient. The caregiver has learned chest compression by watching a doctor who performed CPR previously just once. During the entrance to the emergency room the patient's O2 saturation was 83%, blood pressure was 80/40 mmHg, electrocardiogram (ECG) sinus bradycardia (36 beats / min). Laboratory examination WBC $14 \times 10^3 / \mu$, Pro-BNP 192.3 pg / mL, Troponin: 0103 ng / mL Urea: 115 mg / dL, D-dimer 33.6 microg / mL; arterial blood gas pH 7.425, PCO2, 29 were identified. The airway of patients were controlled and cardiac monitoring was provided. Left ventricular ejection fraction was 55, second degree tricuspid valve insufficiency was detected in echocardiography. The right ventricular cavity was in normal limits. Thrombus in both main pulmonary artery and its branches were observed by thoracic CT angiography. Brain CT showed no pathology. Patient was admitted to the coronary care unit with the diagnosis of pulmonary embolism, and syncope. Due to the recent operation history, thrombolytic therapy could not initiated. Patient was followed by heparin infusion. The overall situation improved and the patient was discharged four days later.

Conclusion: Recognizing arrest victim, starting early chest compressions, activating the emergency medical services and knowing the steps of Basic Life Support especially the chest compression for bystanders who witness the sudden collapse of an adult will have positive effects on the mortality of out-of-hospital cardio-pulmonary arrest cases

Keywords: Cardiopulmonary resuscitation, untrained, savior, out-of-hospital

P-0041 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Bilateral Facial Petechiae secondary to Sneezing

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Objective: Superficial hemorrhages in skin and mucous membranes often emerge in many different ways. 3mm small, fading with pressure and point shaped bleeding is called petechiae and lesions greater than 3 mm is called purpura.

Case: 19 year old female patient was admitted to ED with influenza symptoms for two days, and complaints of fatigue, nausea and eruption on her face. She told that she had hold back her sneeze and then facial eruptions had occurred. Patient's vital signs were in normal ranges. Her physical examination showed eruption of the face. As a result of the evaluation, no eruptive disease was detected in the patient. Whereupon, it was thought that the high pressure which occurs while sneezing can cause trauma of the capillaries of the skin and as a result of this trauma petechial hemorrhages can occur in mucous membranes in the face. The patient was consulted to dermatologist. It was diagnosed as a petechial eruption on patient's face which was due to subcutaneous bleeding that occurs with the increase in pressure

Conclusion: Upper respiratory tract infections are among the most common reasons for hospital admissions in our country and around the world. Sneezing is one of the most common symptom of upper respiratory tract infections. It is known that intracranial and intrathoracic pressure increase while holding back a sneeze. Medical problems that could be caused by increased pressure while sneezing should be predicted and the patients who come with symptoms of upper respiratory tract infections should be reminded that they shouldn't hold back their sneeze. In this case, it is shown that petechial hemorrhages in the skin and mucous membranes can occur after a simple sneezing apart from fever, infectious diseases, blood coagulation disorders and drug interactions.

Keywords: sneezing, petechia, face



POSTER BİLDİRİLER

P-0042 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Hypokalemic Periodik Paralysis

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Objective: Hypokalemic periodik paralysis is characterized by intermittent episodes of muscle weakness or paralysis. The attacks may occur everyday or one a year and may last for a few hours to several days. The serum potassium level is low during the attack. However, the serum potassium levels are normal between two attacks. Hypokalemic periodik paralysis occurs depending on primary and secondary etiologies.

Case: A 40 year old male patient weakness in the arms and legs, and came to the emergency department with complaints of inability to walk. The story all over the body, the patient wakes up in the morning and in the weakness and inactivity in the last week that had upper respiratory tract infection was learned that. Resumes unremarkable. On examination, blood pressure was 120/80 mmHg, pulse 67 beats/minute, fever of 36.6 degrees. Neurological examination glasgow coma score of 15, light reflex + / +, orientation and full cooperation, muscle strength tetraparesis asymmetric (right 3/5, left 2/5), hypoaactive deep tendon reflexes, cranial nerve examination was normal. Breath sounds, and abdominal examination was normal. Received on his arrival at the emergency department blood gas pH 7.374, pCO₂:41.6, pO₂: 54.9, pO₂: 91.5, potassium 2.4, lactate 3.2, HCO₃: 23.7, respectively. ECG was normal sinus rhythm. Computerized tomography was no haemorrhage and infarction in diffusion MRI did not. Potassium replacement after the improvement in the patient's neurological symptoms were observed. Had low blood levels of potassium in lab experiments. Other blood values were normal. Deepening anamnesis of the patient had similar complaints before. With the treatment in centers where applicants within the same day it was learned that heal. For that reason Improvement of paralysis after potassium supplementation and similar complaints previously was thought to be hypokalemic periodic paralysis. Neurology was consulted on. The patient was informed about hypokalemic periodic paralysis. Moses in the follow-up the patient was discharged completely recovered.

Conclusion: In patients presenting with paralysis hypokalemic periodic paralysis should be kept in mind. Especially during paralysis with hypokalemia detection and replacement should be considered in patients with remitted. The story is similar attacks confirms the diagnosis.

Keywords: hypokalemia, paralysis, weakness

P-0043 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Pneumoni With Pulmonary Embolism and Pericardial Effusion

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Objective: Pulmonary embolism is a common and potentially lethal disease that recurs frequently and is associated with long-term impairment and suffering. Patients with pulmonary embolism are at risk of death, recurrence of embolism, or chronic morbidity. Appropriate therapy can reduce the incidence of all. Pulmonary embolism is the most commonly overlooked disorder in patients with pleural effusion

Case: A 81 year old female patient came to the emergency department with shortness of breath was. In the story had been hospitalized due to pneumonia.

Today complaints were discharged on the decline. After entering dialysis patients complaining of shortness of breath resumed. Self history of diabetes mellitus, hypertension and chronic renal failure had. Examination of the patient had a glasgow coma score of 15, blood pressure 100/60mmhg, pulse 117 beats / min, blood glucose 202 mg / dL, fever, 35.9 degrees, oxygen saturation 87, diminished breath sounds, crackles, no rhonchi, no western casual, peripheral pulses open, pretibial edema +/.

Received on his arrival at the emergency department blood gas acidosis, hypoxia and hypocarbia had. ECG showed sinus tachycardia and had S1Q3T3. Was monitored, 2-4 l / min oxygen inhalation was performed. Right pericardial infiltration in lung X-ray. Cardiology consultation was requested. Echocardiography revealed pulmonary hypertension, ejection fraction of 40% and pericardial effusion. Due to current clinical pulmonary embolism in mind a contrast tomography was requested.

Contrast-enhanced CT perikardyal effusion, pneumonia and pulmonary embolism had. Intensive care and pulmonary consultation was requested. The patient was referred to the intensive care unit outside the center.

Conclusion: Pulmonary embolism is probably responsible for a significant percentage of undiagnosed exudative pleural effusions. Spiral CTPA is the best way to evaluate the possibility of pulmonary embolism in a patient with a pleural effusion. The treatment protocol of the patient with pleural effusion secondary to pulmonary embolism is the same as that for any patient with pulmonary embolism.

Keywords: pulmonary embolism, pericardial effusion, pneumonia

P-0044 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A case of pulmonary embolism developed related to the hemodialysis catheter

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Objective: Pulmonary Embolism develops with the breakage of the proximal portion of a venous clot to travel within the veins, passing through the right ventricle and then being stuck within a precapillary pulmonary artery. It is largely related to the deep venous thrombosis of the deep veins of the lower extremities. We are presenting our case with pulmonary embolism related to the thrombus that had developed around a hemodialysis catheter.

Case: The fifty-year old patient under follow-up for chronic renal failure in a routine dialysis program with a dialysis catheter in the right subclavian vein presented in the emergency room with shortness of breath with a sudden onset in the day before and gradually became more severe. In the physical examination, the general medical condition of the patient was medium, conscious was open, GCS was 15; and in auscultation, the patient was breathing heavily with forced expirium bilaterally and crepitations were heard in the bases during the inspiration. BP was 130/80 mmHg, pulse was 78/min, body temperature was 36.4 C, and sPO₂ was 93%; other system findings were natural. In the laboratory tests, it was found that D-dimer was 3.592 mg/L (REFERENCE RANGE: 0-0.55 mg/L) and the thoracic CT with contrast was reported as: "hypodense filling defect consistent with pulmonary embolism in the lower lobe segmental branch of the right main pulmonary artery and a hypodense thrombosis around the catheter ending in vena cava superior". The patient was hospitalized by the Thoracic Disorders Clinic and treatment consisting of low molecular weight heparin and varfarine was ordered. Symptoms of the patient receded, and the patient was discharged subsequently.

Conclusion: The pulmonary embolism, which can present with different clinical pictures, is a disease that can easily be missed in patients with weak clinical findings. It must be kept in mind that this disease, which is frequently seen together with deep venous thrombosis, can accompany the picture in patients with subclavian dialysis catheter accompanied by thrombosis.

Keywords: Pulmonary embolism, hemodialysis, catheter

P-0045 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Investigation of Chronic Drug Use Due To Chronic Diseases In Patients Admitted To Emergency Department

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Objective: In present study we aimed to investigate the chronic drug use due to chronic diseases in patients admitted to emergency department.

Materials-Methods: 144 patients who applied to emergency department (ED) of medicine school of Gaziantep University between June 2013 and September 2013 with chronic diseases and use chronic drugs were included. Information about drugs used by patients were recorded.

Results: Of patients, half were male, half were female, and the mean age was 58 years. The first three common diseases were diabetes mellitus, hypertension and coronary artery diseases. Of patients, 79.2 knew their illness. Fifty patients began to use drug within three months, 36 patient began to use within the last one year. While 42 patients brought all of their drugs with themselves, 17 patients brought along a portion of drugs. While three patients stopped their medication completely, 125 patients received medication on a regular basis. Fifty-two patient described the drugs with names, 13 patients described with their colors, 3 patients described by grammes, 45 patients described with the size of the tablet and 13 patients could not describe the drugs. Ninety-two patients explained which kind of drugs were used for each diseases, 17 patient explained partly, and 35 patients had no idea. Hundred patients received medication by themselves, 44 patients medications were giving by their relatives and med carers. Of medications, 140 were written by doctors directly, three medication were given by pharmacist; and one patient bought the drug by himself. For 11 patients the drugs were not harmonious to their diseases. Fifty-one patients admitted to the ED two times within last week, and 73 admitted two times within last month.



POSTER PRESENTATIONS

Conclusion: The majority of patients with chronic diseases and use chronic drugs know their diseases and use the drugs in order, but do not have enough information about their medication.
Keywords: Chronic disease, drug use, emergency department

P-0046 Resuscitation

An unusual complication of cardiopulmonary resuscitation: stomach perforation

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Objective: Stomach perforation is a rare complication of cardiopulmonary resuscitation (CPR). Stomach perforation may develop as a complication of chest compressions in a patient with stomach distention, which is caused either by long periods of bag-valve mask ventilation or esophageal intubation in an emergency setting. In this report, we aimed to emphasize that early diagnosis and surgical treatment may be lifesaving in a patient with stomach perforation developing as a complication of CPR

Case: Cardiac arrest developed in an 84-year-old female patient while she was taken to our hospital due to respiratory distress secondary to pneumonia, and CPR was started by ambulance staff. Endotracheal intubation was attempted, but the tube was taken back because of esophageal intubation; the patient was ventilated by bag-valve mask till she reaches our emergency department. The patient was evaluated in the emergency department. She was diagnosed as having cardiopulmonary arrest, so CPR was started and endotracheal intubation was performed. An abdominal distention was developed during CPR, and a nasogastric tube was inserted to provide decompression. Return of spontaneous circulation was seen after 20 minutes of CPR. Computed tomographic scan of the chest and abdomen was performed due to persisting abdominal distention after the patient was stabilized. Computed tomography showed a wide free air and stomach perforation (Fig. A-C). Laboratory parameters were as follows: leukocyte count, 13 300/mm³; hemoglobin level, 11 g/dL; hematocrit, 40.9%; platelet count, 406 000/mm³; alanine aminotransferase, 25 U/L; troponin I, 0.012 ng/mL; and creatinine, 0.6 mg/dL. Arterial blood gas analysis parameters were as follows: pH, 7.2; pO₂, 42mmHg; and pCO₂, 92 mm Hg. The patient was transferred to the general surgery department due to gastrointestinal perforation, and she underwent operation. When the abdominal cavity was open, a large amount of air leakage was seen. A 5-cm linear perforation defect was seen in the anterior region of stomach corpus. The defect was repaired by primary closure. The patient was taken to intensive care unit, and antibiotic therapy was started after the operation. She was discharged after 15 days of hospital stay without any prominent neurologic sequelae

Conclusion: Emergency physicians should remember that stomach perforation due to chest compressions after stomach distention may develop in patients undergoing cardiac arrest, especially in the management of whom difficulties in endotracheal intubation are encountered and/or false esophageal intubation is performed, and a long period of bag-valve mask ventilation is needed.

Keywords: Cardiopulmonary resuscitation, stomach distention, perforation

P-0047 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

The Diagnosis Of Migraine Was Placed Skipped Occipital Epilepsy

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Objective: The occipital lobe is the maincenter of the visual system. Occipital lobe epilepsy accounts for about %5-10 of all epilepsy syndromes. Occipital seizures usually begin with visual hallucinations like flickering or colored lights, rapid blinking or other symptoms related to the eyes and vision. They may occur spontaneously but can often be triggered by particular visual stimuli, such as seeing flashing lights or a repeating pattern. Occipital seizures are often mistaken for migraine headache because they share similar symptoms including visual disturbances, partial blindness, nausea and vomiting and headache.

Case: 51 year old male patient to the emergency department with complaints of headache and visual disturbances came. Resume feature is not available in. In the story had a headache for 5 days. From yesterday, the right eye had intermittent light scattering. Visual impairment occurred when coming to the light scattering. On examination, blood pressure 130/80mmHg, pulse 76 beats / min, body temperature 36.4, GCS, 15, co-operation and orientation of natural, no signs of meningeal irritation, natural cranial nerve examination, muscle strength, natural, natural cerebellar examination, respiratory and abdominal examinations were normal. Diklofenal sodium was administered with a preliminary diagnosis of migraine. The patient's headaches and intermittent light scattering on the continuation of the brain CT scans were obtained. Brain CT hypodense areas in the occipital region was observed. Diffusion-weighted MR hyperintensity was observed in the same area. Neurology was consulted. Neurology clinic of this would be the occipital seizures and contrast brain MRI for the diagnosis of the lesion suggested. Contrast-enhanced brain MRI results revealed a brain abscess. Brain surgery was consulted. Neurosurgery service was hospitalized.

Conclusion: In patients presenting with headache and visual symptoms should be kept in mind occipital seizures. Otherwise it is likely to be skipped after having been diagnosed migraine.

Keywords: migraine, occipital epilepsy, headache, light scattering of

P-0048 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Rare Cause Of Abdominal Pain; Hemolytic Uremic Syndrome

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Objective: Hemolytic uremic syndrome (HUS) is a disease of nonimmune (Coombs negative) hemolytic anemia, low platelet count, and renal impairment. Anemia is severe and microangiopathic in nature, with fragmented red blood cells (schistocytes) in the peripheral smear, high serum lactate dehydrogenase (LDH), circulating free hemoglobin and reticulocytes. Platelet count is <60,000/mm³ in most cases. In ethiopathogenesis infections, drugs and systemic diseases are as many different reasons. Excellent supportive care is necessary to reduce the mortality and morbidity due to HUS.

Case: 39 year old female patient in the emergency department were admitted with abdominal pain and fever. In his history of deep vein thrombosis, hepatitis B and had a diagnosis of epilepsy. Drugs used by the patient; Vastarel, tegretol and coumadin. In the story there were two days of continuous dull pain. Today we have started the fire. Went to the hospital and there is blood in the lab experiments in tests of AST, ALT, bilirubin, urea and creatinine values were high. Ultrasound of the abdomen; acalculous cholecystitis and nephrolithiasis were observed. In the lower abdominal CT also jejunal loops; minimal dilation and increased motility was monitored. From there, patient was referred to our hospital. On examination, blood pressure was 110/70, pulse 75 beats / min, body temperature 36.7, GCS 15, neurological examination and respiratory examination natural, abdominal tenderness, murphy positive in the right upper quadrant, increased bowel sounds and forme rectal examination stool was observed. From there, our patient was referred to our hospital. Oral feeding was stopping.

Hydration and symptomatic treatment was given. Ultrasound and abdominal CT scans were repeated. Acalculous and nephrolithiasis was observed again. There was no hydronephrosis. Urology and general surgery consultation was requested. Medical treatment was recommended by consultants. Due to poor general condition of the patient in the emergency department were going to follow. Patient controlled lab experiments taken from the patient's blood levels of urea, creatinine rise in the value, a decrease in hemoglobin values and platelets was observed fall in the value. These laboratory results due to hemolytic uremic syndrome in nephrology was consulted in mind. Patients with a diagnosis of hemolytic uremic syndrome was admitted to the nephrology service.

Conclusion: Hemolytic uremic syndrome is a rare disorder in adults. If hemolytic uremic syndrome diagnosis, it is likely to be skipped. Therefore especially with abdominal pain and diarrhea in the lab; acute renal failure, thrombocytopenia and decreased hemoglobin which should be kept in mind in patients.

Keywords: Hemolytic uremic syndrome, abdominal pain, acute renal failure

P-0049 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Aortic Dissection in An Ischemic Stroke Case Presented with Syncope

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Objective: Aortic dissections (AD) commonly present with abrupt and severe pain in the chest that radiates to an area between the scapulae. Neurological finding and symptoms such as syncope, hemiparesis and indefinite complaints such as low back pain, side pain are also seen. AD should be kept in mind as a reason for ischemic stroke and syncope. Here we presented



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an aortic dissection in a stroke case with a finding of left homonymous hemianopia after syncope.

Case: 52-year-old female patient presented with syncope, headache and confusion. She had no other medical history. In her vital signs BP: 130/80 mm/Hg, there was no difference in right and left arm, body temperature: 37.6, she had no pulse deficit in radial arteries or femoral arteries and pulse rate was 88 bpm. ECG findings were normal. Left homonymous hemianopia was found in the neurological examination. There was no bleeding sign in cranial CT. In diffusion weighted MRI findings, hyper-intense zones in DWI series and hypo-intense zones in ADC zones marked bilaterally hemispheric side which is in accordance with atypical acute ischemic stroke. Cardiology consultation and echocardiography were ordered because of the atypically placed infarcts in several different arterial brain zones. Echocardiography was normal. AD was evaluated as pre-diagnosis as patient had a history of syncope. Toraco-abdominal CT angiography showed aortic dissection. Sudden cardiac arrest developed after CT angiography. The patient was resuscitated in the emergency department and the patient was urgently taken to operation room by the cardiovascular surgeons after return of the spontaneous circulation.

Conclusion: Ischemic stroke can be seen in 5-10 % of the AD cases. Syncope is associated with high mortality within the hospital and it could occur due to serious complications such as stroke, cardiac tamponade. In our case the patient presented to emergency department with syncope and was diagnosed ischemic stroke. Afterwards underlying AD was found. Consequently, AD should be considered as differential diagnosis in the patients who present to emergency department with both syncope and ischemic stroke.

Keywords: Emergency, Aortic Dissection, Ischemic Stroke, Syncope

P-0050 Pediatric Emergencies

Femur Fracture Due To Convulsion

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Objective: Seizures increase fracture risk, occurring in the whole of the skeleton even without trauma. This risks mainly reported in epileptic seizures because of repeated occurrence of attacks and osteopenia due to the use of anti-epileptic drugs. We wanted to present a case with mental retardation and has a fracture of the femur during a seizure.

Case: 9 years old male patient admitted to emergency room with discomfort in his movements. In his medical history, he has epilepsy disease till born and mental retardation. His mother told that he had an epileptic seizure about two hours ago. In examination, he was conscious but not orientated as always before and he had a deformity on his left leg above knee. In x-ray a displaced fracture was seen in distal femur. His other skeletal graphics were normal. He was consulted to orthopedic and he was applied a splint. Our case's right femur was also fractured a week ago during a seizure and he was investigated for a bone disease.

Conclusion: Also vertebral and other skeletal pathologies can be seen after epileptic seizures so an emergency physicians should be careful while examining and be aware of fractures can be seen in any part of the body. When we are evaluating a mentally retarded patient it may be difficult to get a healthy and accurate anamnesis. Therefore we should be more skeptical and if necessary we should keep our imaging and laboratory tests wider.

Keywords: Epilepsy, fracture, seizure

P-0051 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Fahr's Syndrome Presented With Ataxia

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Objective: Fahr's syndrome is a rare clinical entity consisting of calcifications in the basal ganglia. Though sporadic and familial cases have been reported. Fahr's syndrome may be sporadic or familial as well as secondary to anoxia, irradiation, systemic disorders, toxins, disorders of calcium metabolism, hypoparathyroidism, pseudohypoparathyroidism and sometimes hyperthyroidism and encephalitis. Clinically it may present frequently with neuropsychiatric, extrapyramidal or cerebellar symptoms. In addition, seizures, dementia or speech disorders can be seen in Fahr's syndrome. In our case Fahr's syndrome is related to hypoparathyroidism. Herein, we want to present a Fahr's syndrome with cerebellar involvement.

Case: 87 female patient was brought to the emergency department by ambulance due to deterioration in walking, speech and oral intake. According to information from the vicinity of the patient; she was ambulatory until 2 days ago. She could walk by herself, speak and she was able to meet her needs. In her medical history, there was nothing remarkable except a thyroidectomy which was performed ten years ago. In her neurological examination; she was conscious, GKS: 10 (E4V2M4), her direct and indirect pupil reflexes were normal and no pathological reflexes and she was ataxic. Her vital signs were normal. There was no fever and meningeal irritation sign. Brain computerized tomography (CT) was performed. In her CT there was calcifications in cerebellum and around putamen bilaterally. Diffusion magnetic resonance imaging was performed but there was no diffusion limitation. In her laboratory findings, her alb:2.87, Ca:4.16, p:3.17, Na:149, Mg:1.62 were seen. There was no pathological value in her other laboratory findings. In this case, calcifications were compatible with Fahr's syndrome. She was given IV Ca gluconate and she was better when she was discharged for neurology and endocrine polyclinic control.

Conclusion: We see many patients with ataxia and impairment of consciousness in emergency department. In our case cerebellar involvement in Fahr's syndrome caused ataxia. So we should be aware of Fahr's syndrome with cerebellar involvement beside cerebrovascular diseases and other pathologies.

Keywords: Fahr's syndrome, ataxia, hypoparathyroidism

P-0052 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Platypnea-Orthodeoxia Syndrome Seen With Pneumomediastinum

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Introduction: Pneumomediastinum, presence of air in the mediastinum, may be with mediastinal injury or spontaneous. The most common symptoms are chest pain, dysphagia and dyspnea. Platypnea-orthodeoxia syndrome is a rare condition characterized by dyspnea and hypoxia when the patient changes from supine to an upright position. It may be due to pulmonary defect, hepatopulmonary syndrome or an anatomical cardiovascular defect increasing positional right to left shunting. Herein, we presented a case of platypnea-orthodeoxia syndrome in a patient with pneumomediastinum. To our knowledge, this is the first case described in the literature.

Case: A 33-year-old male patient was admitted to our intensive care unit with urinary system and decubitus ulcer infection. He was taken over from another clinic on his tenth day of admission. Patient's history revealed brain tumor and spinal metastasis. He had chemotherapy and radiotherapy treatment in the previous year and was bedridden for 10 months.

The physical examination on admission revealed arterial blood pressure of 130/70mmHg, heart rate of 130/min, respiratory rate of 22/min, and body temperature of 37.8°C. Glasgow coma scale was 9 and he was having epileptic seizures. Laboratory results were as followed; hemoglobin 10.91 gr/dL, white blood cell 12700/mm3, platelets 249000/mm3, creatinine 0.37 mg/dL, erythrocyte sedimentation rate 115 mm/saat, alanine aminotransferase 101 U/mL, aspartate aminotransferase 43 U/mL, C-reactive protein 25.54 mg/dL, arterial pH 7.535, HCO3 30.8 mmol/L, pCO2 35 mm/Hg, pO2 179 mm/Hg. Intravenous antibiotherapy and epilepsy treatment was started. On the 18th day of his admission, he began to go into septic shock, became desaturated and intubated. At follow up, he developed severe platypnea orthodeoxia. Computer tomography of thorax reported as pneumomediastinum. Echocardiogram didn't reveal any pathology. Patient's platypnea-orthodeoxia was related to pneumomediastinum in the basis of these results. Ten days later he was lost due to respiratory and cardiac arrest.

Conclusion: In our case, pneumomediastinum, in a patient with malignancy who had chemotherapy and radiotherapy treatment, was probably secondary to mechanical ventilation. Platypnea, an uncommon symptom in clinical practice, is mostly seen with cardiac or pulmonary pathologies. Most commonly recognized pulmonary pathologies are pneumonectomy, recurrent pulmonary emboli or chronic lung disease. None of them were present in our case so pneumomediastinum was the only entity that could explain platypnea-orthodeoxia syndrome. As a result, when platypnea orthodeoxia develops in a patient in the intensive care unit, especially in patients with malignancy, ventilator related pneumomediastinum should be kept in mind.

Keywords: Pneumomediastinum, Platypnea, orthodeoxia



POSTER PRESENTATIONS

P-0053 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Bilateral Thalamic Infarct

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Objective: Bilateral thalamic infarct is rarely seen in strokes. Neurologic, cardiac and hematologic pathologies may cause this case. Here we present a case of a patient who was referred to our clinic with sudden mental confusion.

Case: 89 year old female was admitted to our clinic with unconsciousness which started two hours previous to her presentation. She had the history of coronary artery disease and atrial fibrillation. On admission, her vital signs were normal. In her neurological examination, GCS was 8, and bilateral babinsky was positive. Her laboratory results were unremarkable. Afterwards, we applied neuro-imaging protocol for stroke, including computerized brain CT and MR imaging. On brain CT, bilateral hypodensity in the areas corresponding to centrum semiovale was observed. The MRI, also showed diffusion restricted areas in bilateral thalamic regions. The patient was diagnosed with bilateral thalamic infarct, and she was hospitalised in the neurology clinic.

Conclusion: Bilateral thalamic infarct is a rarely seen case in emergency medicine. It may occur as the results of occlusion of basilar artery and both posterior cerebral arteries. Early diagnosis and treatment is important because dramatically reduces morbidity and mortality. We should be cautious about the patients presenting to the emergency clinics with deep stupor because it may be the only symptom for bilateral thalamic infarct.

Keywords: Bilateral thalamic infarct, mental confusion, emergency medicine

P-0054 Resuscitation

Education program about cardiopulmonary resuscitation (CPR) at Nursing Department of Near East University Health Sciences Faculty

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Background: The studies conducted that the most of mistakes made during CPR are due to preventable human errors even in developed countries. So that theoretical and practical training about CPR is important. After taking theoretical course, students should practice on models until the correct application is performed, which reinforces knowledge about CPR. Training with models in simulator laboratories is accepted to be one of the important educational technics. In this way, we have goal to give data about CPR education at Nursing Department of Near East University Health Sciences Faculty.

Discussion: There is a 2-hour theoretic lecture about 'Adult CPR' in the context of Disaster Nursing and First Aid Courses for 3rd-year students at Nursing Department. Practical training is performed with CPR models (Life Format ®) at the simulator laboratory during 8-hour lecture. Instructors firstly shows Basic Life Support (BLS) application sheet with 20-steps on model. The application sheet is based on 2010 CPR Guideline of International Liaison Committee on Resuscitation (ILCOR). Then, all students perform CPR under supervision of the instructors. Each student repeats steps till every step is correct and complete. The students evaluate victim, perform CPR and finish case according to the scenario that the instructors tell. The scenarios create a case in which students can feel severity of the condition and provide them to understand importance of time - even seconds - while performing BLS. The students are divided into smaller groups and can watch other students' performance, which makes training more efficient and memorable.

Conclusion: According to the feedbacks that were taken from our students about CPR training, we can say that our CPR training model is useful. So that we suggest our model to instructors, health sciences schools and other institutions.

Keywords: education, resuscitation, simulation

P-0055 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Are New Regulations Necessary For Over The Counter (OTC) Drug Sales?

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Objective: Many OTC drugs are being sold currently in our country. We are presenting a patient who developed hematuria as a result of taking warfarin without any prescription.

Case: A 70 year old male was admitted to our emergency department with a complaint of painless bloody urine. It was started 6 hours ago. His past medical history revealed nothing special. As a part of the routine anamnesis, he was asked about any recent medication. It was learned that he had consumed 4 packs of warfarin 0.5 mg which he took once a day. When he was questioned about the reason of the drug prescription, he expressed that, one of his friends recommended him to use the drug for the spasms in the groin. He also added that he bought the drug from pharmacy without any prescription. His vital signs were within normal limits. The physical examination was unremarkable except a small ecchymosis over the suprapubic area. Routine blood tests were all normal. However the coagulation studies revealed that the INR value was immeasurably high. A 10 mg of vitamin K diluted in 100 cc of isotonic infusion with a 15 minute drip and 1500 IU human prothrombin complex was administered. The patient had an INR value of 1.22 during the control coagulation parameters. No changes were detected in the patient's control blood tests. He was discharged with recommendations.

Conclusion: Warfarin is a high-risk drug which should be used under physician supervision. Uncontrolled consumption may result in serious complications as in our case. It is in the category of drugs that can be sold over the counter in our country. It is obvious that new regulations are necessary for high-risk drug sales.

Keywords: warfarin, over the counter drugs, emergency room

P-0056 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Tetanus infection in old cases

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Objective: Tetanus is an acute toxemic infection caused by neurotoxin that is secretated by ClostridiumTetani and characterized with tonic contractions. We discussed three tetanus cases that were caused by simple wounds in present study.

Case: Case 1: A-67 year-old male admitted to ED with fever and contractions. Trismus and risus sardonius was detected in physical examination. She was diagnosed tetanos and was hospitalized. She fall down ten days ago and a simple wound accured on the right hand. Tetanus vaccination and wound care were applied. Then, her complaints increased she diagnosed as serebrovascular event and mandibular dislocation and followed by a neurology and an ear-nose-throat physicians. Because development of no recovery she was presented to our ED. She was hospitalized to intensive care unite and was died due to hospital infection eight months later.

Case 2: A-69 year-old male admitted to our ED due to speech defect and mandibular interlocked. Trismus and risus sardonius was detected in physical examination. In his history, he had a deep wound with a small piece of iron on left foot 12 days ago. Tetanus vaccination and wound care were applied. On the fourth day of event a swallow difficulty occurred, so he admitted to ED. He was diagnosed as tetanus and was hospitalized. She was discharged on the third days of hospitalization.

Case 3: A-55 year-old male admitted to our ED due to biting of tongue and contraction on his face. Trismus and risus sardonius was detected in physical examination. He had a sinking of a piece board to hand 20 days ago. He has not received health-care and no vaccination history. On the fourth months of hospitalization he was discharged with recovery.

Conclusion: The person who has insufficient or out of order vaccination application history and old male and female whose antioxidant activity reduced in progressed tim are under risk of tetanus. The health staff should be alert for these kind of patients.

Keywords: insufficient vaccination, antioxidant activity, tetanus, old person

P-0057 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Does The Diagnosis Of Conversion Disorder Or Hypokalemic Periodic Paralysis

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Objective: Hypokalemic periodic paralysis is a rare disorder characterized by attacks of muscle weakness due to hypokalemia. Although it is transmitted autosomal dominantly it can also be seen sporadically. Hypokalemic periodic paralysis is characterized by attacks, can be misdiagnosed as a conversion disorder because the patients could be neurologically normal.

Case: 31 year old female patient in the emergency department were admitted with complaints of loss of consciousness and convulsions. In her history such episodes have been occurred few times per year. Each episode has been started with dizziness and nausea. Low blood potassium levels has been noted during attacks.

This episode was started by loss of consciousness and convulsions. On her physical examination; blood pressure 90/60 mmHg, pulse 67 beats / min, body temperature 36.7 °C, blood sugar

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124 mmol/l, GCS 15 was observed. Other physical examination was normal. At arrival to the emergency department ECG showed QT prolongation and T flattening. On blood gas analysis pH 7.57, pCO₂ 39 mmHg, HCO₃ 38 mmol/l, and potassium 1.8 mmol / l were observed.. Radiological imaging was normal. Potassium replacement was performed. After potassium supplementation clinically improved. Normal sinus rhythm was observed on her posttreatment ECG. Patient was informed about the hypokalemic periodic paralysis. The patient was discharged from the emergency department.

In conclusion we could find organic causes while a patient seems having a conversive disorder.

Keywords: Conversion Disorder, Hypokalemic Periodic, convulsions

P-0058 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Cause of sudden visual loss:pseudotumor cerebri

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Objective: Pseudotumor cerebri (PTS) or idiopathic intracranial hypertension is a clinical syndrome characterized with the intracranial pressure increase with normal cerebrospinal fluid, without any mass lesions and normal neuroradiological evaluation. Papilla edema is the main clinical finding. We here present our case that had applied to our Emergency Room with visual loss and diagnosed with pseudotumor cerebri.

Case: The thirty-one year-old patient applied to the emergency room with visual loss. It was understood that blurred vision started about 8-9 hours ago, and she lost her vision fully within the last 2 hours. Trauma was not present in the history. She had flu that lasted for the last 7 days. She had past meningitis during childhood in her personal medical history. Her general medical condition was good in the physical examination, and vital signs were: BP: 110/80, SO₂: 97, Pulse: 80/min. Head and neck: Light reflex is absent bilaterally, no eyelash movements with touching with a piece of cotton, no eye avoidance, no reflex and no neck stiffness, and no cornea reflex. There were no pathologic findings in the examination of other systems. There was nothing notable in the laboratory tests. No emergent pathologies were found in the cranial tomography and angiography. Ophthalmology and neurology clinics were consulted for the patient, and papilla edema and surrounding dense hemorrhage were found in both eyes in fundus examination. The patient was hospitalized in the neurology clinic with the pre-diagnosis of "pseudotumor cerebri". The CSF pressure was found high in the lumbar puncture (LP) performed in the neurology clinic, and 20 cc CSF was discharged. An additional 20 cc CSF was discharged from the patient that the pressure was too high in the control LP and the patient was referred to the neurosurgery clinic for shunt operation.

Conclusion: The pseudotumor cerebri syndrome characterized with intracranial pressure increase must be considered in differential diagnosis who apply to emergency rooms with non-traumatic sudden visual loss that no neuroradiologic pathologic findings can be found.

Keywords: Pseudotumor cerebri, Emergency room, Sudden visual loss, Intracranial hypertension

P-0059 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Cause of post-infectious neurological deficit:Acute disseminated encephalomyelitis introduction

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Objective: Acute disseminated encephalomyelitis (ADEM) is an uncommon, but treatable demyelinating disease that involves subcortical white matter in the first place. ADEM is generally evaluated as a post-infectious condition or a parainfectious disease. It gives findings covering a large neurological spectrum, conscious can be in the range from normal to coma. Particularly, they present with a clinical encephalomyelitis picture with nonspecific cerebrospinal fluid (CSF) findings. The best diagnostic tool is magnetic resonance (MR) imaging. The lesions in the white matter that are in the same age, bilateral with asymmetric distribution of signal increases are the most important characteristics. It is best shown in 'T2' or 'FLAIR' slices. We here present our case who had applied to our Emergency Room and was diagnosed with ADEM after the examinations and tests.

Case: The twenty-eight year-old male applied to the emergency room with weakness in feet and inability to walk at 00:40 hours. It was found out in his history that he has been medically treated because of flu for about 15 days. In the physical examination carried out, his general medical condition was medium, and vital signs were as follows; PB: 110/70, sO₂: 98, Pulse: 100/min, SS: 18 and body temperature: 37.2 C. The head and neck examination showed that the right nasolabial sulcus has become indistinct slightly, conjunctivas were pale and he had postnasal discharge. Examination findings of the respiratory system, gastrointestinal system and cardiovascular system were natural. In the neuromuscular system examination, the motor and sensory findings of the upper extremities were natural, Babinski was positive in the lower extremity and motor strength was 4/5, the deep tendon reflexes in the lower right extremity were increased. The laboratory test results of the patient were as follows: Hgb 7.6, Htc: 25.7, MCV: 70 and other laboratory results were normal. Brain MR ordered later displayed early sub-acute infarct areas in DAG and ADC in the vertex level in bilateral centrum semiovale together with the dilated appearance of the temporal portion of the right lateral ventricle and the trigon. Neurology and infectious diseases departments were consulted for the patient, and he was hospitalized in neurology clinic with the pre-diagnosis of acute disseminated encephalomyelitis (ADEM ?).

Conclusion: The diagnosis of acute disseminated encephalomyelitis must be kept in mind for patients in pediatric or adolescent age groups who apply to the emergency room with neurological deficits in post-infectious period or after parainfection periods.

Keywords: Post-infectious, Neurological deficit, Acute disseminated encephalomyelitis

P-0060 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Effects of Drug Use on the development of Diabetic Ketoacidosis and Patients' Clinics in Patients Presented to Emergency Departments

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Objective: In this study, we aimed to investigate the effects of drug use on the development of DKA and patients' clinic in patients presented to Emergency Department with the diagnosis of diabetic ketoacidosis.

Materials-Methods: This study was retrospectively conducted in Şişli Etfal Training and Research Hospital between 01/10/2011 and 31/03/2013. Age, gender, complaints, history of drug use, cause of DKA, pH, HCO₃ levels, time spent in the ED, treatment outcomes and hospitalization durations were assessed in patients presented due to DKA. Statistical analysis was carried out using SPSS for Windows v.18 software. Distribution of the variables was evaluated with Kolmogorov Smirnov test. Independent samples t-test was used in analysis of quantitative data. Qualitative data were analyzed using Chi-square test.

Results: Mean age of the patients was 42.6±18.6, while 58% of them were females. Of the patients, 20.3% were found to be drug free. Mild acidosis clinic was observed in 80% of the patients. Of the patients; 73% were followed up in the wards, 17.5% in ED and 9.5% in ICU. Mean duration of stay in the ED was found as 15 hours, and mean hospitalization time as 10 days. Mortality rate was found as 3%. When effects of the drug use on diabetic ketoacidosis were examined; no statistically different was found between the patients in terms of acidosis condition, mortality, clinic of hospitalization and the durations of follow-up and treatment (p>0.05). The most important factor causing ketoacidosis was found as infections (40.5%), while the most common symptom was nausea / vomiting (51.4%).

Conclusion: Newly diagnosed drug free patients and those using drugs may develop Diabetic Ketoacidosis. Following the development of diabetic ketoacidosis, drug use was seen to be insignificant in terms of follow-up, treatment and mortality.

Keywords: diabetic ketoacidosis, hyperglycemia, infections, emergency department

P-0061 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Ruptured Hydatid Cyst Associated Syncope: Case Report

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Objective: Cyst Hydatid is an infestation of echinococcus granulosus. Liver involvement creates the highest number of cyst hydatid cases, on the other hand, the other organs –especially lungs- can be effected by this parasite. Symptoms of illness vary due to effected organ. Cyst hydatid is diagnosed incidentally and it may be clinically asymptomatic unless it is ruptured.



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Radiologic exams are the best instruments for diagnosis. In this case report, we wanted to share our experience about a patient with ruptured hydatid cyst and the first symptom is syncope. **Case:** 32 year old female patient applied to our emergency department (ED) with history of fainting a couple of times followed by abdominal pain after the last fainting at the day she applied to ED. Vital signs were: blood pressure 110/70 mm/hg bilaterally, pulse 85/m, saturation 96%, body temperature 37.2 C. Initial physical examination showed no pathology except moderate tenderness in both lower quadrants. She was cooperating, mental status was open, rectal examination showed normal gaita. GCS was 15. ECG was normal sinus rhythm. Cranial CT was also normal. Laboratory Results: Hgb: 16 g/dl, hct: 48.2%, other results (b-hcg, carboxyhemoglobin) were in normal ranges. Patient was accepted for follow-up in ED, after 4 hours, hypotension developed (Systolic BP: 90mm/Hg). Control hemoglobin value was 13.1 g/dl, hct: 45.3%. Patient was underwent abdominal ultrasound examination which showed subhepatic and pelvic free fluid. So we decided to perform abdomen CT. CT revealed the 27 mm of cystic lesion in liver bordered with gastric antrum and intraabdominal free fluid. So patient was taken to surgery room, 10x5cm of ruptured hydatid cyst was removed, abdominal free spaces was cleared. There was no pathology detected in other organs.

Conclusion: Association between ruptured cyst hydatid and syncope is really rare in literature. Abdominal tenderness in physical examination and decreased value of hemoglobin made us think that the etiology of syncope is inside of the abdomen. So that computed tomography and the surgery revealed the reason of syncope: ruptured cyst hydatid. Etiology of syncope vary and ruptured hydatid cyst is nearly not one of these etiologies like how we faced in our case. We still must keep in mind the intraabdominal pathologies in patients applying with syncope.

Keywords: Syncope, Ruptured Hydatid Cyst, Emergency Department

P-0062 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Are the hematological examinations effective in case of acute migraine attack?

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Objective: Migraine is the most frequent of vascular headaches and it also leads to the biggest labor force loss. Inadequate treatment causes not only more frequent migraine attacks but also leads to the loss of labour force. As far as patients suffering from headache are concerned, hematological parameters have not been much studied.

In this study, by evaluating patients admitting to the emergency with acute migraine attack diagnosed, we made research whether there is a relation between this disease and hematological markers conducted at the emergency.

Materials-Methods: 100 migraine patients and 65 control cases were enrolled in the study. Migraine diagnosis was settled according to the International Classification of Headache Disorders-II diagnostic criteria. Migraine patients were evaluated according to the headache characteristics including severity, frequency and duration of the attack, or the duration of the disease. Routine hematological analysis was applied for migraine patients in our laboratory.

Results: We found that 74% of cases were women, the average age was 33.67, 53% of migraine cases were reported as without aura. In 23% of cases patients did not use any drugs against migraine, in 31% of cases patients used analgesic and in 46% migraine-specific drugs. In 51% of cases patients suffered from an attack once a month, in 31% of cases they stated that attacks used to happen once a week. When analyzed in terms of the pain character, 35% of one-sided, 25% of throbbing and 20% of patients localised in the midline. In patients with aura, 36% of cases vision loss, numbness in 25.53% cases and 17.2% cases were detected as described in the flicker of light. Having compared a group with attacks with the control group, the essential change from the statistical point of view was found only between WBC and Hb. As far as other parameters are concerned, no essential change was reported.

Having divided iron values and ferritin of cases into 2 groups – group of values below normal and group of normal values, whereas a statistically significant relation between RDW, Htc, MCV and ferritin was found. Having divided ferritin values of cases into 2 groups, whereas a statistically significant relation between RDW, Plt, MPV, Htc, MCV, MCH and Fe was found, a statistically significant relation between Hb and WBC was not found.

Conclusion: To sum up, in our research we did not report statistically significant RDW increase at patients with migraines and iron deficiency and/or anemia.

Keywords: emergency, migraine, RDW, MCV, Fe

P-0063 Resuscitation

Liver laceration related to cardiopulmonary resuscitation

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Objective: In recent years, cardiac and / or respiration stops cardiopulmonary resuscitation in patients is very important. However, when CPR should be careful not to cause complication. Rib and sternal fractures, which occur due to the blunt trauma afflicting the chest, and liver, lung and heart injuries developing due to them together with tracheal injury, gastric rupture and pneumoperitoneum, which develop due to intubation and ventilation, can be classified as complications of cardiopulmonary resuscitation (CPR). In these case presentations, by analysing the autopsies performed by the forensic medicine institute in Mugla province, we wanted to emphasise that perhaps the resuscitation could be the reason of death.

Cases: CASE 1: A 26 year old female patient with pain in her heart, palpitations and sudden collapse was brought to the Emergency and as she did not respond to the resuscitation, she was recognized as exsitus. In the autopsy performed because of the suspicious death nothing that could be compatible with trauma was found. Thorax examination revealed bilateral fractures of the 2nd, 3rd, 4th and 5th rib and abdominal examination of the patient revealed 0.5 cm deep and 7 cm long blunt laceration on the external surface of right lobe of liver. Next to this laceration from the diaphragm 3x4 cm subcapsular hematoma was found. On the left part of external surface of right liver lobe 1.5x1 cm hemangioma was found.

CASE 2: A 65 year old male truck driver who collapsed in the vehicle was resuscitated at the scene by the 112 resuscitation team but as he did not respond to the resuscitation, he was recognized as exsitus. In the autopsy performed because of the suspicious death, at the midclavicular line, on the left and right part of the 4th, 5th and 6th rib fractures were found. Moreover, the ecchymose was observed around fractured places. These injuries were thought to be connected with the resuscitation. Furthermore, a 3.5 cm long laceration with an ecchymotic around, which matched to the projection of the xiphoid process was found in the liver and 1 litre of aspirated blood was observed in the abdomen.

Conclusion: Both cases show that the patient did not suffer from trauma, they indicate the connection between rib fractures and liver laceration with the resuscitation and prove once more how important are the qualifications of a person performing resuscitation.

Keywords: resuscitation, autopsy, liver laceration, emergency

P-0064 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A case acute cholecystitis with asymptomatic massive pulmonary embolism

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Objective: The clinical manifestations of pulmonary thromboembolism are non-specific, which makes this condition difficult to diagnose. The aim of this manuscript is to present a case of acute cholecystitis with asymptomatic massive pulmonary embolism which is an unusual presentation of pulmonary embolism.

Case: A 55 year-old man applied to the emergency department for constipation and abdominal pain with diaphoresis, nausea and vomiting. Constipation and abdominal pain had started 5 days ago and he had referred to gastroenterology department. Medical treatment didn't relieve his symptoms. He had no complaints of dyspnea, fever, cough and chest pain. Blood pressure was 90/60 mmHg, pulse rate was 90/min, pulse oximeter was 94% on room air, respiration rate 18/ min, axillary temperature was 36 °C. The patient was pale, anxious and sweaty. Abdominal examination revealed epigastric and right upper abdominal tenderness. There was rale at left lung base and it was considered to have congestive heart disease in his history. Systemic examination of the patient revealed no additional abnormality. Left bundle branch block was seen in his EKG. Laboratory studies showed WBC 10.900 with 86% neutrophils, AST 4202 U/L, ALT 942 U/L, ALP 112 U/L, GGT 74 U/L, amylase 52 U/L, total bilirubin 2.3 mg/dL, direct bilirubin 1.2 mg/dL, troponin I 0.05 ng/dL. His abdominal ultrasound indicated that the thickness of the gallbladder was 4.8 mm and there were some stones smaller than 5 mm in it. After ultrasonography the patient got worsened and complained of paraesthesia at his perioral region and arms with an increasing pain. Pulses of four extremities were nonpalpable and extremities were cool. Our pre-diagnosis was aortic dissection, therefore the patient underwent CT angiogram of chest and abdomen which revealed massive pulmonary embolism in left and right main pulmonary arteries. Patient admitted to intensive care unit and died a few hours later.

Conclusion: We didn't initially think pulmonary embolism in this case because there was not any symptom which was related to pulmonary embolism. We found pulmonary emboli by chance. One should be aware of pulmonary embolism may present without any obvious symptom.

Keywords: abdominal pain, acute cholecystitis, pulmonary embolism



POSTER BİLDİRİLER

P-0065 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Rare Cause of Amnesia: Intracranial Mass

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Objective: Amnesic disorders are general admission symptoms of a group disease which markedly increased incidence especially after the 4th decade. Neurological diseases characterized by dementia (Alzheimer's most often), intoxications, infections and vitamin deficiencies (B1-B12 most often) are the internal causes of amnesia. Head trauma and posttraumatic amnesia, intracranial hemorrhage, intracranial mass lesions (rarely) are the surgical causes of amnesia. In this paper, we will draw attention to intracranial mass case admitted with amnesia complaints.

Case: 46 year old male patient was referred to our hospital with amnesia complaint for 3 days. His arterial blood pressure was 145/89 mmHg, SpO2 was 95%, heart rate was 92 bpm, fever was 36,90C, gluco test was 124 mg/dL. In his medical history he has no disease and he has no drug use. In his neurological examination he was conscious, cooperative-oriented, GCS 15, pupillary was isochoric, light reflex was bilaterally normal, sensory and motor examination was normal and bilateral Babinski was flexor. There was no abnormal findings in cerebellar tests. He has no balance disorder and speech disorders. Cranial computed tomography was taken to the patient. There was a mass view and localized edema in the left cerebellar hemisphere. Hospitalization of the patient was planned for further evaluation and treatment.

Conclusion: Everyday dozens of patients refer to emergency room with neurological symptoms. Even though patients present with only complaints of amnesia detailed neurological examination signs are normal, additional studies on suspicion of intracranial disease should be considered. Emergency physicians should keep in mind that intracranial mass which is a rare cause of amnesia.

Keywords: Amnesia, intracranial mass, emergency

P-0066 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

An Important Cause of Masses in The Neck: Cervical Tuberculous Lymphadenitis

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Objective: Extrapulmonary tuberculosis (TB) incidence has been increasing in recent years. In this paper; we present a 53-year-old woman who followed because of a mass in the neck, diagnosed with cervical TB lymphadenitis the microbiological and histopathological.

Case: A 53-year-old woman was admitted to polyclinic of General Surgery with complaints mass in the neck, fatigue, night sweats. Bilateral thyroid glands was nodular and palpable on physical examination. A mass which on the right side of neck, on the 1/3 in the upper part of sternocleidomastoid muscle, under the muscle located, approximately in size 3x2 cm, painless, consistency of tire, immobile, clear boundaries indistinct, do not make change of color and temperature on skin was palpated. Oropharyngeal and lung examination was normal. There were no any pathological findings on examination of other systems. Laboratory analysis; WBC 8.43x103/mm3 (neutrophil 62%), erythrocyte sedimentation rate 25 mm/h, C-reactive protein 3 mg/L (N= 0-5 mg/L), other routine test results were within normal limits. Isoechoic multiple nodules in both thyroid lobes and the largest in size 25x22 mm hypoechoic lymph node on right cervical region detected by neck ultrasonography. We have diagnosed 'bilateral multinodular goitre + mass in the neck' with these findings in patient and the bilateral total thyroidectomy + neck mass excision were performed by surgeons. Histopathological analysis of the tissue revealed "caseous granulomatous lymphadenitis". Tuberculin skin test done to patient with an initial diagnosis of TB lymphadenitis, its result was measured as 16 mm. Anti-HIV test was negative result. We showed a few of bacilli in Ehrlich-Ziehl-Nielsen staining in the microbiological examination of tissue smears taken from mass in the neck. With the diagnosis of cervical tuberculous lymphadenitis, isoniazid (INH), rifampicin (RIF), ethambutol, pyrazinamide were orally administered. This diagnosis was confirmed with reporting mycobacteria culture positivity in tissue received from the mass after 45 days. Treatment was completed 6 months "first 2 months quartet, second 4 months for 2 (INH+RIF)". We are following still the patient.

Conclusion: The definite diagnosis of cervical TB lymphadenitis may not be diagnosed by clinical examination and radiological tests. It can be confused with other tables forming mass in the neck. The definite diagnosis is made with positive for acid-fast bacilli from biopsy material, grown in culture of Mycobacterium tuberculosis or the detection of caseous granulomatous inflammation in histopathological examination. Cervical tuberculous lymphadenitis may be kept in mind for the differential diagnosis of patients presenting with neck mass.

Keywords: Tuberculosis, neck mass, lymphadenitis

P-0067 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Ischemic stroke with dehydration: Incidence of disease at summer in geriatric population

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Objective: Despite advances in the treatment of acute ischemic cerebrovascular accident (CVA), stroke is still 3rd most cause of death in many countries. Disability related to stroke leads to huge economic losses. Determination of stroke risk factors by epidemiological studies and prevention of the disease is important. To understand the problems associated with old age period; it is necessary to understand the normal physiological aging process. Although many studies on this subject are available as yet unknown. In this study, acute prerenal failure rates were searched in patients over the age of 65 with diagnosis of ischemic cerebrovascular disease in summer.

Materials-Methods: In this study, between 01.06.2013 and 31.08.2013, patients admitted to Okmeydanı Research and Training Hospital with a diagnosis of ischemic stroke over age of 65 were included in the study. Patients with chronic renal failure were excluded from the study. Patients' age, sex, blood urea nitrogen (BUN) levels and blood creatinine levels were analysed.

Results: The study included 45 men (54%), 39 women (46%) of 84 patients of total. The mean age of these patients was 74.8 ± 6.56. The mean BUN value was 27.59 mg/dl, mean serum creatinine level was 1.21 mg/dl. 49 patients' BUN/creatinine ratio was determined over 20 (15%).

Conclusion: Prerenal failure rates were analyzed in patients with lack of oral intake and tendencies to dehydration. With improvement of living conditions and presence of new treatments have prolonged the life expectancy and the elderly population is rapidly increasing with each passing year. As elderly population increase; the number of emergency department visits with ischemic stroke are also increasing. However, the incidence of acute renal failure in the elderly is also increasing. In addition, these patients conditions was considered to be compared with the winter months.

Keywords: dehydration, geriatric, prerenal, cerebrovascular accident, stroke

P-0068 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Single Center Experience on Causes of Cancer Patients Visiting the Emergency Department in Southwest Turkey

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Objective: Emergency departments are visited by cancer patients for palliation of cancer-related symptoms, management of treatment-related side effects, oncologic emergencies, comorbidities, and/or end of life care. In this study, we aimed to identify the characteristics of cancer patients admitted to an emergency medicine department in Southwest Turkey.

Materials-Methods: In this retrospective descriptive study, a total of 304 emergency department admissions of 102 patients with cancer due to medical conditions were evaluated. Descriptive statistical methods, statistical analysis for correlation, Student's t-test, chi-square tests and logistic regression test were used.

Results: The majority of patients visiting to emergency departments were male (n=66, 65%) and over 65 years of age (53, 52%). Some 30% (n=31) had a lung cancer diagnosis, 32% (n=33) presentation with dyspnea, 53% (n=55) with metastasis, 30% (n=16) with multiple metastatic lesions in lung, and 68% (n=70) had a poor ECOG performance status (score 3 to 4).

Conclusion: Emergency departments have valuable roles in managing and caring for patients with malignancies.

Keywords: Emergency Department, Southwest Turkey, Cancer Patients



POSTER PRESENTATIONS

P-0069 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Hypoxia-induced hepatic failure

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Objective: Ischemic hepatitis is a clinical entity resulting from acute circulatory failure of liver. Hypotension and hypoxia or both are the predisposing factors. Classically alanine and aspartate aminotransferases abruptly increase 20 folds and then return to normal in clinically compatible patients. Diagnosis is based on exclusion of other etiologies. Here we report a case of ischemic hepatitis induced by hypoxia due to compression of brain stem by a mass.

Case: A 58-year-old, diabetic and hypertensive female was referred to the emergency department with complaint of dyspnea that has been lasting since 2 months. Her dyspnea gradually increased in severity since last 3 days. Her vitals were: blood pressure, 90/60 mmHg; heart rate, 100 bpm; respiratory rate, 17/minutes; and oxygen saturation, 83.9%. Her physical examination revealed subicteric scleras, right central facial paralysis, multiple palpable thyroid nodules, bilateral crepitant rales up to middle zones, and hepatomegaly. Electrocardiogram was in sinus rhythm. Arterial blood gas analysis: pH, 7.35; pCO₂, 61 mmHg; pO₂, 49 mmHg; sO₂, 84.9%; and HCO₃, 32.8. Other laboratory findings were: ALT, 1059 U/L; AST, 816 U/L; GGT, 164 U/L; LDH, 935 U/L; CPK, 197 U/L; CK-MB, 8.12 ng/ml; Troponin I, 1.858 ng/ml, and hepatic viral markers were negative. Echocardiography revealed left ventricular ejection fraction of 69%, PAB of 45 mmHg and biatrial dilatation. Abdominal ultrasonography detected hepatomegaly with vertical length measuring 16.5 cm. she had facial paralysis for one week. With the suspicion of intracranial space occupying lesion, a cranial magnetic resonance imaging was ordered that showed contrast-enhanced mass lesion in cerebellopontobulbar confluence that makes mass effect. It was thought that this lesion makes respiratory depression resulting in hypercapnia and hypoxia. The cause of elevated liver enzymes was ischemic hepatitis induced by respiratory depression. The patient was admitted to the intensive care unit for monitorization and therapy.

Conclusion: The underlying mechanisms of hepatocellular necrosis in the setting of hepatic ischemia are decreased blood supply, passive venous congestion and arterial hypoxia. Especially intrahepatic microcirculatory disturbances can cause parenchymal cell deaths. Emergency physicians should be aware of this clinical entity, because early recognition and treatment of underlying cause of ischemic hepatitis carries a prognostic importance.

Keywords: Hepatitis, hepatotoxicity, hypoxia, ischemia, liver transaminases

P-0070 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Importance of medical history in stroke cases

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Objective: Careful and accurate history and physical examination are essential for diagnosis of stroke. In stroke clinical presentation can occur severe (facial droop, monoparesis in arm, speech abnormalities) or mild (weakness, dizziness, sensory deficits). Compared to men, women notice 62% non-typical symptoms and less than 33% typical symptoms.

Case: A 59-year-old male patient due to the presence of aggressive behavior at home was taken by ambulance to the emergency room. His medical history was notable for coronary artery disease. He was told no type of behavior disorders before and that night he woke up shouting at his wife and attacked her. Patient's blood pressure was 130/70 mmHg, pulse 90 beats/minute, body temperature: 36.20C, Glasgow coma scale was 15. In patient's physical examination no neck stiffness was revealed, there was no motor or sensory deficits. Speech was clear and fluent. Patient could understand well but could not name certain objects. The patient's laboratory parameters were within normal limits. He was checked with a brain tomography with preliminary -cerebrovascular disease diagnosis and it was normal. In patient's magnetic resonance diffusion, diffusion limitation was observed in his left temporal region.

Conclusion: To receive history before the inspection takes a great role in the diagnosis of patients. A neat history can elucidate the etiology of stroke, but it's a long -unnecessarily detailed story should not delay treatment. Particularly for patients considered as cerebro vascular disease, suffering from only aphasia without lateralization should be kept in mind.

Keywords: Stroke, cerebral infarct, aphasia

P-0071 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Septic shock due to lung abscess

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Objective: Lung abscess is a localized suppurative lesion occurred as a result of tissue necrosis and cavity formation by pyogenic microorganisms in the lung parenchyma. Patients complain about progressive fever, cough, shoulder pain and weakness and usually there is a 1-3 week-old pneumonia history. More than one third of lung abscess are accompanied by empyema.

Case: 39-year-old male patient with respiratory distress was taken by ambulance to the emergency department. In his medical history, nothing was worthy except alcohol use. According to caregiver's information; for about two weeks cough, sputum, fever was present. Antibiotic therapy was started a week ago in another hospital, but the patient continued to suffer and shortness of breath started today. The patient's blood pressure was 70/40, SaO₂ was 90, fever was 39.5 and respiratory rate was 40 per minute. Physical examination of the Glasgow Coma Scale was 15 and during auscultation breath sounds had decreased. Rales were present in the basal portions of the right lung. In chest X-ray; in the right lung a 5 cm solitary mass was viewed showing an air fluid to level the round and also right sinus cavity was blunt. Thoracotomy was performed for empyema. Fluid replacement and positive inotropic agents were not answered and he was diagnosed as septic shock. Afterwards, patient was intubated because of superficial breathing and decreasing in saturation. After cardiac arrest, patient who did not respond to resuscitation was admitted exitus.

Conclusion: As a reason of unconsciousness-alcohol use and other disfiguring diseases facilitate aspiration of oropharyngeal flora by suppression of gag reflex and become more important as a risk factor. Patients with chronic alcohol abuse can be presenting with nonspecific symptoms in the respiratory system and should be investigated more carefully. Early diagnosis of lung abscess is significantly reduced mortality and morbidity.

Keywords: respiratory distress, sepsis, empyema

P-0072 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A rare cause of abdominal pain: Splenic infarction

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Objective: The splenic infarction is rarely encountered in the emergency room and it is a rarely suspected cause of abdominal pain. The splenic infarction generally occurs with hematological, vascular and thromboembolic disorders. The diagnosis is based on clinical examination and imaging methods. The current report presents spontaneous splenic infarction that occurred in a patient with coronary artery disease.

Case: A 54-year-old male patient presented to the emergency room with progressively worsening abdominal pain that continued for the last 4-5 days. The patient denied nausea, vomiting, diarrhea, constipation, dysuria, and radiating pain. The patient had a history of coronary artery disease for which he did not regularly use medications. The vital findings were: BP:140/80 mmHg, PR: 84 bpm, RR:16/min, T: 36.7°C. On physical examination, GCS was 15, general condition was good, and there was tenderness on palpation in the left upper quadrant of the abdomen and in the projection of left ureteral tract, but there was no rebound tenderness or guarding. Electrocardiography showed normal sinus rhythm and there was no evidence of acute ischemic changes. The patient was placed on intravenous fluid therapy containing hyoscine-N-butylbromide and ranitidine, and urine and blood samples were obtained for analysis. The results were as the following: WBC: 17200/μL, total/direct bilirubin: 4.89/4.37 mg/dl, GGT: 179 U/L, CRP: 21.35 mg/dl, and +1 bilirubin in the urine. The patient then underwent computerized tomography of the abdomen that revealed hepatosplenomegaly, widespread hypodense areas in the spleen, and there was not pathological findings in the gallbladder, choledoch, and intrahepatic bile ducts and there was no evidence for intra-abdominal free fluid (Figure 1). A consultation with a general surgeon was performed, and the patient was hospitalized for further



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follow-up and treatment. During the hospitalization period of 8 days, the patient received conservative therapy and surgery was avoided.

Conclusion: The splenic infarction occurs as a result of parenchymal ischemia and tissue necrosis caused by the occlusion of the splenic vascular supply. The clinical picture in patients with splenic infarction considerably varies from non-specific abdominal pain to hemorrhagic shock associated with massive subcapsular hemorrhage. There is no diagnostic laboratory test specific to this condition. CT with contrast enhancement is the best method and the first choice in the diagnosis of splenic infarction. By considering underlying pathologies and risk factors in an individual patient, splenic infarction must be considered in differential diagnosis of patients that present to the emergency room with abdominal pain.

Keywords: abdominal pain, emergency department, splenic infarction

P-0073 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Emphysematous Pyelonephritis: A Case Report

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Introduction: Emphysematous pyelonephritis is a rare, fatal suppurative infection of the kidneys which is characterized by intraparenchymal or perirenal gas formation. In this report, findings of a patient who was diagnosed with emphysematous pyelonephritis at our emergency department are presented and discussed in accordance with the literature.

Case: A 47 year- old, diabetic female who had a left renal double -J stent was admitted to the emergency department with the complaints of fever, left -sided flank pain and fatigue. The patient who had an increased white blood cell count and an urine sample that is positive for leukocytes was hospitalized with the suspicion of a diagnosis of an emphysematous pyelonephritis and an antibiotherapy was started.

Result: For the patients who have the findings of fever and flank pain and have a history of a recent renal intervention, an early diagnosis using all necessary diagnostic methods to reduce mortality rates is crucial. This is especially true for the patients with a known history of diabetes.

Keywords: Emphysematous pyelonephritis, diabetes mellitus, flank pain emergency department

P-0074 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Primary adrenal insufficiency in a patient with gastrointestinal tuberculosis in emergency department

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Objective: Primary adrenal insufficiency (PAI) is the consequence of the bilateral destruction or impaired function of the adrenal cortex. In the past, Tuberculosis(TBC) was the most common cause of primary adrenal insufficiency. Currently, the most common cause of PAI is autoimmune adrenalitis.

Case: 54 Years old male patient admitted to emergency department with hypoglycemia, fatigue, confusion, abdominal pain and hiccup. In patient's medical history; he has gastrointestinal tuberculosis and he is on therapy of tuberculosis for two months. On physical examination; arterial blood pressure was 80/40 mm/Hg, pulse rate was 85/dk, body temperature was 36,7 C0, blood glucose level 30 mg/dl(with strip test). Before he had admitted emergency medicine he had hypoglycemic attacks at home and ambulance paramedics gave %5 dextrose to patient. On laboratory tests, sodium level was 110mg/dl, potassium was 5,8 mg/dl and other parameters were in normal range. IV %30 bolus dextrose and dextrose infusion had started. After dextrose infusion his cognitive functions improved. His symptoms and laboratory results were compatible with adrenal insufficiency or sepsis. We gave corticosteroids and IV %0.9 saline infusion and 2gr ceftriaxone intravenously. The tenth hour after he admitted to emergency he was conscious and his vital parameters were normal. He had hospitalized to Endocrinology Service. Adrenal MRI was performed and adrenal involvement of tuberculosis was shown.

Conclusion: PAI should be considered in the differential diagnosis of patients who has a history of TBC and complaints of fatigue, hypoglycemia and electrolyte disturbance.

Keywords: adrenal insufficiency, hypoglycemic attacks, tuberculosis

P-0075 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A rare cause of motor dysfunction and cognitive impairment; Metachromatic Leukodystrophy

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Introduction: Metachromatic Leukodystrophy (MLD) is a rare lysosomal storage disorder characterized by arylsulphatase A enzyme deficiency. Enzyme deficiency results in demyelination and storage of sulphatide in peripheral and central nervous system. There are three major clinical types of disease according to age of onset: infantile, juvenile and adult forms. Within 2 years after the onset of symptoms; quadriplegia, blindness, decerebrate posture and gait disturbances may be seen. MRI shows demyelinating areas in centrum semiovale and periventricular white matter sparing subcortical arcuate U-fibers.

Case: 18 years old man referred to our emergency department with upper extremity weakness. It was learned from his history that he had been using narcotics for about 3 years and 2 days before admission he had used marijuana and synthetic cannabinoids. No other specific feature was detected in his past medical history. After the last drug intake, his communication with parents disordered and he had difficulty in walking. In his physical examination, upper left extremity muscle power was 3/5, he was lethargic, bradykinetic and ataxic in walking. Non-contrast brain CT scan showed subacute infarct in both cerebellar hemisphere and diffuse atrophy incompatible with his age. Non-contrast brain/diffusion MRI showed symmetric demyelinating areas in periventricular and cerebellar white matter. Other laboratory test showed no pathological findings. He was consulted to neuropsychiatrist and radiologist. He was admitted to neurology clinic with pre-diagnosis of cerebellar infarction and metachromatic leukodystrophy. Aryl sulphatase levels were studied and diagnosis was confirmed as leukodystrophy. Antiaggregant and anticoagulant therapy were organized and he was referred to psychiatric follow-up for drug abuse.

Conclusion: By this case, we aimed to remind that findings of systemic and metabolic diseases may be masked and new neurological deficits may be missed in patients whom have history of substance abuse and refer to emergency department with confusion. These patients should be taken under close observation and neurological examination should be carefully repeated after the complete ending of substance effect.

Keywords: cerebellar infarction, demyelination, metachromatic leukodystrophy

P-0076 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Rare Cause of Chest Pain: Mitral Valve Rupture

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Objective: Mitral valve rupture is a rarely seen pathologic condition. Suddenly developing severe mitral insufficiency may lead to heart failure, and death if it is not treated surgically. We presented a case who admitted to emergency room due to chest pain with typical features of angina pectoris, and was thought to have myocardial infarction but took the diagnosis of mitral valve rupture finally.

Case: A 73-year-old female patient presented to emergency room with a suddenly developing squeezing chest pain which radiates to her left arm, and neck. Her arterial blood pressure was 80/40 mmHg, pulse rate was 100 beats per minute. Blood glucose level measured with strip test was 124 mg per dL. She was oriented and cooperative. Her Glasgow Coma Score was 15. While her electrocardiogram (ECG) was taken cardiopulmonary arrest developed. Cardiopulmonary resuscitation was started, and endotracheal intubation was performed. Spontaneous circulation returned after 5 minutes of resuscitation. Arterial blood pressure was 100/60 mmHg, pulse rate was 110 beats per minute. Her ECG showed ST segment elevation in leads V1, V2, V3, and V4, and ST segment depression in leads II, III, and aVF. She was taken to coronary angiography unit with possible diagnosis of acute myocardial infarction after consultation with cardiology department. Her coronary arteries were totally normal. Then echocardiography was performed, and a complete mitral valve rupture was detected.

Conclusion: Lots of patients with chest pain present to emergency room every day. Mitral valve rupture which is quite rarely seen should not be missed out by performing a detailed physical examination, and echocardiography in these patients.

Keywords: chest pain, diagnosis, Mitral valve rupture



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P-0077 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Acute Pancreatitis: Normoamylasemia and Normolipasemia

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Objective: Acute pancreatitis (AP), can progress vary clinical presentation from mild and self-limiting clinical table to severe fluid loss, metabolic imbalances, hypotension, sepsis and death. AP can usually be diagnosed based on clinical symptoms, such as abdominal pain, vomiting and laboratory testing, mostly high - at least 3 times - serum amylase or lipase levels. In 20% of cases amylase levels, in %2,4 of cases lipase levels are normal. We aimed to present two cases that patients have normal amylase and lipase levels, and diagnosed AP during clinical follow-up and after abdominal CT scanning.

Case 1: Thirty-four-year-old woman was admitted to emergency department with nausea, vomiting and abdominal pain complaints which started early morning in that day. There was tenderness in the right upper quadrant of the abdomen. In routine laboratory tests; WBC was 21500 103/µl, glucose was 279 mg/dl, Na was 127 mmol/L, Ca was 7.1 mg/dL while the detection of serum amylase and lipase levels were normal. During follow up abdominal examination, guarding was present in the right upper quadrant. Patient undergo abdominal CT scan; its found that pancreatic size increased, the boundaries are blurred. Fluid collection areas seen in peripancreatic, on the left pararenal, and in the posterior of third part of duodenal neighborhood areas, and also significant heterogeneity was seen in the mesenteric fat plans. Free fluid was found in the intestinal loops of right lower quadrant of abdomen, in Douglas and in both surgical adnexa and measured 25mm free fluid in the deepest place. Findings were compatible with acute pancreatitis.

Case 2: Twenty-six year old male patient who was admitted to emergency department with abdominal pain and nausea complaints which started 2 days ago. Guarding was present in the right upper quadrant of abdomen. Laboratory tests were normal. In hepatobiliary ultrasonography, a slight increase of thickness and heterogeneity was observed in the pancreatic head level. In abdominal CT scan, its found that thickness increase in the pancreatic head sections and slightly heterogeneous pancreatic parenchyma. Findings were compatible with acute pancreatitis.

Conclusion: AP is a potentially mortal disease. Due to different clinical characteristics and variability of AP, early detection of clinical severity may provide effective treatment approach. Abdominal CT scan can help to early diagnosis and detection, decision of intensive care unit admission, determination of the treatment strategy, determination of prognosis; unless diagnosis acute pancreatitis with clinical presentation, laboratory tests and abdominal ultrasonography could helpful.

Keywords: Acute pancreatitis, amylase, lipase

P-0078 Pediatric Emergencies

A case of pediatric skin burn associated with coin cell battery ingestion

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Objective: Foreign body ingestion in children is a common problem. While coins are still the most common foreign bodies swallowed in children, ingestion of batteries became more frequent in recent years among children, due to the increasing accessibility to electronic toys and devices by children (1). Generally, batteries pass easily through the upper gastrointestinal tract and are eliminated in the stools in a few days. Swallowing of batteries poses a more dangerous and serious challenge than swallowing of coins or other inert objects, due to their electrochemical composition and large potential for local damage. By the dissolving of batteries within the upper aerodigestive tract, a strong exothermal reaction occurs within the tissue, causing severe mucosal injuries which resemble skin burn (2). Here we report a case of foreign body aspiration who referred with dermal chemical burn in anal region that resulted from accidentally swallowing coin cell battery.

Case: A 2-year-old girl was presented to emergency department by her parents with complaint of dermal wound in anal region. It was learnt that 10 days ago she had swallowed a coin battery accidentally and 3 days later it was found in her diaper. First there was a simple erythema but it became a necrotic wound during a week. The child was well-appeared. Her systemic examination was almost unremarkable except that a necrotic wound, measuring 3 x 2 cm, 1 cm on the left side of anal region (figure 1). This was thought to be a chemical burn associated with coin battery. She was consulted with pediatric surgeon. Ten days later the wound was totally healed

Conclusion: Coin cell battery ingestions may result in catastrophic complications such as esophageal or aortic perforation, tracheo-esophageal fistula, severe esophageal bleeding, bilateral vocal cord paralysis and heavy metal (lithium) intoxication as well as skin burns as reported in our case (3-6). Increased public and health personnel awareness is necessary to diminish the incidence of battery ingestion and its related sequelae. Physicians who treat battery ingestion injuries in children should be aware of the possible serious and fatal adverse outcomes, and home safety education instructions for new parents may help prevent these tragic complications.

Keywords: Battery injury, coin cell battery, foreign body, skin burn

P-0079 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Renal artery embolism in the differential diagnosis of abdominal pain

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Objective: Thromboembolic renal artery occlusion is a rare clinical entity usually diagnosed after irreversible renal infarction. Trauma and cardiac dysrhythmias such as atrial fibrillation are the most common predisposing factors in etiology. Here we report a case of renal artery embolism in a patient with a history of atrial fibrillation

Case: A 58-year-old female was presented to emergency department by relatives with complaint of abdominal pain. Her pain started at midline and then localized to right upper and flank regions. Pain started 24 hours ago and was accompanied with fever, nausea and vomiting. Vital signs were: blood pressure, 110/70 mmHg; heart rate, 85 bpm and irregular; respiratory rate, 14/minutes; and body temperature, 36.4 °C. Her heart sounds were normal and she had crepitant rales at lower zones. Her bowel sounds were normokinetic and there was tenderness at right upper quadrant. Her electrocardiogram revealed atrial fibrillation. Laboratory tests were: WBC, 7940; hemoglobin, 13.2 mg/dL; platelet, 345; urea, 41; creatinine, 1.30; CK, 358 U/L. Urinalysis revealed hematuria and proteinuria. Abdominal ultrasonography did not reveal any pathologic finding. With the suspicion of mesenteric artery embolism CT angiography was ordered that revealed right renal infarction compatible with renal artery embolism. She was referred to another hospital for interventional radiology.

Conclusion: Renal artery embolism should be considered in the differential diagnosis of abdominal pain in patients with risk factors

Keywords: Emergency department, renal artery embolism, renal infarction

P-0080 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

The reliability of blood gas electrolytes

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Objective: Reliable blood gas results increase treatment success in critically ill patients. Emergency physicians frequently use venous and arterial blood gas measurements. This study evaluated the reliability of blood gas test electrolyte results by comparing with biochemistry results.

Materials-Methods: 722 patients with blood gas (BG) and biochemistry results, admitted to our emergency department in May 2013 were evaluated retrospectively. Patients were grouped as acidosis group, normal PH group and alkalosis group. Data was analyzed with SPSS ver 16.0. Categorical data were compared with paired Sample T- test.

Results: There was statistical difference between BG and biochemistry potassium results in normal PH ($p<0.01$). There was no statistical difference between BG and biochemistry potassium results in acidosis and alkalosis groups. There was statistical difference between BG and biochemistry chlorine results in all PH's ($p<0.01$). There was no statistical difference between BG and biochemistry sodium results in all PH's.

Conclusion: BG potassium results were not reliable in normal PH. BG chlorine results were not reliable in all PHs. We must use the initial treatment of critically ill patients blood gas and electrolyte values in an emergency. However we need to know that the results are not reliable while using blood gas electrolytes. These results has to be confirmed with routine biochemistry electrolyte, EKG and physical examination results.

Keywords: blood gas, reliability, emergency



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P-0081 Resuscitation

Foreign body aspiration in a child

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Objective: The aspiration of foreign bodies into airways can be a very serious event, sometimes resulting in morbidity and mortality outcomes. In the majority of cases, the problem of the aspiration of a foreign body into the respiratory system affects children of 1-3 years old and it is less common in new-born babies and school children. The common site of foreign body in patients is often right bronchus but sometimes two bronchi are affected. Most commonly sunflowers, seeds and shell, nutshell, pins, plastic material, pen caps are aspirated. Here we report a case of bean aspiration in a child who presented in cardiac arrest and survived after successful cardiopulmonary resuscitation

Case: A 2-year old male child was presented to emergency department in cardiac arrest. He was unresponsive and cyanotic. There was no pulse and respiration, pupils were fixed dilated with no light reaction. Immediately cardiopulmonary resuscitation was started with chest compressions and intubation. His parents stated that he aspirated a bean and then became unresponsive. Adrenalin 0.1 mg/kg was given intravenously at every 3 minutes with ongoing chest compressions. At 7th minute cardiac activity with pulse returned. He was consulted with pediatric surgeon for bronchoscopy. After removal of foreign body (bean) in operation room he was transferred to intensive care unit. He was discharged with speech and gait disturbances 2 weeks later. On follow-up his gait disturbances disappeared but speech disturbance was progressive.

Conclusion: Tracheobronchial foreign body aspiration is common in children during transition to solid feeding and playing toys. If early intervention delays it is highly morbid and mortal. Parents should be aware of this and instructed

Keywords: Cardiac arrest, children, foreign body aspiration

P-0082 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Vertebral Collapse of C2 Spine and Quadriplegia Due to Multiple Myeloma

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Objective: Osteolytic bone disease is the most common complication of multiple myeloma, resulting in skeletal complications that cause significant morbidity and mortality. Pathological fractures, spinal cord compression or uncontrolled pain can be seen in such patients. Herein we report vertebral collapse of C2 spine and quadriplegia due to multiple myeloma.

Case: 77-year old man with the history of multiple myeloma, treated with chemotherapy and radiation to the cervical spine, was admitted to our emergency after sudden onset quadriplegia history. On physical examination he was conscious, alert and except slight hypotension (95/60 mmHg) he had no physical examination abnormality. On follow up quadriplegia was developed as the patient's previous history. Computed tomography images showed progression of the disease with pathologic fracture and subluxation at C2 and substantial kyphosis [Figure 1,2]. Cervical collar was placed to the patient, emergent neurosurgical consultation was done and magnetic resonance imaging (MRI) was performed. In MRI, acute cord compression was detected and then the patient was hospitalized for nonsurgical close follow up to neurosurgery ward. The patient was discharged after 10 days at the end of radiation therapy.

Conclusion: Consideration should be given to vertebral metastasis and acute cord injury in the patients with multiple myeloma and these mass lesions in the cervical region can cause quadriplegia.

Keywords: multiple myeloma, vertebral metastasis, vertebral collapse, quadriplegia

P-0083 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Splenic and Portal Vein Thrombosis in a Congenital Coagulopathy

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Objective: Splenic and portal vein thrombosis (PVT) is a rare disorder that is associated with a variety of underlying condition of which liver cirrhosis, malignancy and myeloproliferative disorders are the most common. Rarely congenital or acquired coagulopathy can be the reason of such thrombosis. Herein we presented a case of splenic and portal vein thrombosis in a congenital coagulopathy.

Case: We present an unusual case of a 44-year-old man who was in his normal state of health until one week before her emergency department visit, when he began to have generalized abdominal pain that got acutely worse over two days. On examination he had epigastric pain and tenderness and the other physical examination is normal. On laboratory, he had white blood cell 22500 k/uL (4000-11000 k/uL, normal reference range), hemoglobin 16.2 g/dl (13.5-18 g/dl, normal reference range), thrombocytes 184000 k/uL (150000-450000 k/uL normal reference range), CRP 45.5 mg/dL (0-0.8 normal reference range), sedimentation 50 mm, APTT 37.7 sn (22-38 normal reference range), PT 16.7 (8.8-13.9 normal reference range), Antifosfolipid IgG 1.588 U8mL (0-10 u/mL normal reference range), Antifosfolipid IgM 0.318 U/mL (0-10 u/mL normal reference range), Protein C activity 56% (70-140% normal reference range), Protein C antigen 67 % (72-160% normal reference range), protein S activity 130 % (55-160% normal reference range), protein S antigen 104 % (60-150% normal reference range), antithrombin 3 83% (70-125% normal reference range), active protein C resistance (APC-R) 272 second (120-300 second, normal reference range), factor II 95% (50-150 % normal reference range), factor V 13 % (50-150 normal reference range). Genetic examination revealed factor V Leiden mutation. Other laboratory parameters including procalcitonin, liver and kidney function tests, urinalysis, serum electrolytes, hepatitis markers were all in normal reference range.

Computed tomography (CT) scan revealed total thrombosis of splenic vein, partial thrombosis of main portal vein and total thrombosis of right portal vein.

He was admitted to the surgery department and followed by low molecular weight heparin and warfarin for thrombosis. He was discharged home after 10 days of hospitalization with no complication.

Conclusion: Portal and Splenic vein thrombosis can be seen in the patients with congenital coagulopathy. Physicians must keep in mind such vascular problems in coagulopathic patients

Keywords: splenic vein thrombosis, portal vein thrombosis, coagulopathy, congenital coagulopathy

P-0084 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Small But Mortal; Pontine hemorrhage

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Objective: Pontine hemorrhage is characterized by a medial hematoma that extends into the base of the pons. These often lead to deep coma over the first few minutes following the hemorrhage. The motor examination is marked by total paralysis. In this study we aimed to present a pontine hemorrhage patient who presented to emergency service with complaints of headache.

Case: A 55 years old woman was admitted to our hospital because of headache. Her headache was ongoing for three days and it was severe, spread from the nape to forward and not accompanied by nausea and vomiting. On admission she had a paresis, paralysis and motor deficits. Pupils were isochoric. At brain CT there was bleeding in prepontine cistern, reaching a thickness of 8.5 mm at the widest portion, the lower end at the cervical level continuing to the anterior epidural space (epidural bleeding?). Patients was consulted with brain surgery and neurology and followed at emergency department. After 7 day follow up patients discharged from hospital with full neurological examination.

Conclusion: At pontine hemorrhage deep coma and neurological deficit were usually occurs and this clinic can result with mortality. Emergency physicians should be kept in mind this important and rare clinical status and investigate careful of neurological imagings.

Keywords: Pontine hemorrhage, headache, neurology

P-0085 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Epilepsia partialis continua following ischemic stroke

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Objective: Epilepsia partialis continua (EPC) is characterized by a simple partial motor seizure, restricted to one part of the body with repetitive regular or irregular clonic jerks without loss of consciousness. EPC is considered as a type of seizure rather than a form of epilepsy and is categorized under focal status epilepticus. Clonic activity persists for days or weeks either



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continuously or intermittently and remains localized to a single muscle group or may even progress to secondary generalized convulsive status. Here we present a male patient who suffered progressive focal seizures during 7 days under antiepileptic medication following ischemic stroke.

Case: A 58-year-old male patient was referred to emergency department with involuntary repetitive muscle contractions at face and left arm since two hours. He was conscious during this time period. He had hypertension in medical history. At arrival he was conscious and vital signs were: blood pressure, 155/95 mmHg; heart rate, 88 bpm; respiratory rate, 16/minutes; body temperature, 36.7 °C. His clonic jerks on left arm and face were going on. Systemic examination was unremarkable. His laboratory tests and cranial compute tomography scan were almost normal. His diffusion weighted magnetic resonance imaging revealed diffusion retraction measuring 0.77 x 0.67 cm at right caudate nucleus. Firstly 10 mg intravenous diazepam was given. As contractions continued 18 mg/kg phenytoin sodium was loaded and the patient was hospitalized. As his seizures permanently continued intravenous 2 x 1000 mg levetiracetam, 5 mg/hour midazolam infusion and 2 x 500 mg intravenous sodium valproate were added to his therapy. His spasms were partially slowing during sleep but never stopped. On electroencephalogram yielded frequently repeated high amplitude sharp and slow wave paroxysm. He was transferred to another hospital at fourth day.

Conclusion: EPC is a rare type of focal motor status epilepticus. Although its prevalence is as low as one in million, it may arise at any age. The prognosis depends on the underlying cause and early treatment. The identification of underlying cause is of paramount importance. It can be the initial manifestation of an ischemic stroke as in our case.

Keywords: Epilepsia partialis continua, ischemic stroke, status epilepticus

P-0086 Pediatric Emergencies

A case of imperforate hymen presenting as abdominal pain

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Objective: Imperforate hymen is a rare congenital malformation and seen 1 in 1000 females. Patients are often asymptomatic until puberty and present in early adolescence with cyclic abdominal pain. Most of the cases are found on physical examination incidentally. It is an easily treatable entity and not associated with significant morbidity or mortality. Here we present a 12-year-old girl with acute abdominal pain diagnosed as imperforate hymen.

Case: A 12-year-old girl presented to the emergency department with complaint of abdominal pain. Her pain has started suddenly two days ago and gradually increased in intensity. She was otherwise healthy but she has not any menstrual cycle before. Her vitals were as following: blood pressure, 100/65mmHg; pulse rate, 88 bpm; respiratory rate, 18/minute, and body temperature, 37.1 °C. On examination, her abdomen was soft and moderately tender in the lower quadrants. Other systemic examinations were unremarkable. Laboratory results revealed WBC of 17.4 K/uL, hematocrit of % 36.7, platelet count of 260 K/uL, and CRP of 2.26 mg/dL. Her blood glucose, kidney and liver enzymes, electrolytes, coagulation parameters and urinalysis were almost normal. Bedside ultrasonography revealed free fluid in the pelvic regions and hemometocolpos in the uterin cavity. Then, patient was referred to pediatric surgeon and diagnosed as imperforate hymen. She was operated successfully and discharged after second day of admission.

Conclusion: Hematocolpometra is a rare condition and is a result of retrograd mensruation due to imperforate hymen. Diagnosis is based on history, physical examination, and ultrasonographic findings. Common initial symptoms of patients are abdominal pain, urinary retention, low back pain, tenesmus, and swelling and edema on the lower extremities. Mass effect of the enlarged uterus and vaginal cavity on the surrounding structures cause these symptoms. The key question of the history is asking if the patient have menstrual bleeding or not. On physical examination, most commonly detected pathologies are the low abdominal mass and tenderness. Sonography of the lower abdomen reveals the characteristic appearance of the large cystic mass containing echogenic fluid in the uterin cavity and vagina. Free fluid is also seen in pelvic region. Complications include hematosalphinx, endometriosis, pyocolpos, and nephritis. Imperforate hymen should be considered in the differential diagnosis of abdominal pain in virgin patients at pubertal age and after querying menstrual cycle, gynecologic examination should also be performed because it has an important role in the diagnosis.

Keywords: Amenorrhea, hemometocolpos, imperforate hymen

P-0087 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Psychogenic polydipsia and hyponatremia occurred after head injury

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Objective: Psychogenic polydipsia, which is a condition usually associated with psycatric disorders. Although it is often asymptomatic, rarely it can cause electrolyte disturbances which can be mortal. Although in the literature the most frequent cause of hyponatremia which occurs after head trauma is syndrome of inappropriate ADH, in our case, not previously reported in the literature, psychogenic polydipsia occurred after head trauma is available and than hyponatremia occurred.

Case: 42 year old female refers the emergency department, due to epileptic seizures, confusion and dysarthria complaint. The patient history revealed, head trauma before 10 day. And she followed up for 4 days. Cranium tomography presented resorption. Low-dose steroids and antiepileptic drugs applied for treatment. After she was discharged, the patient has excessive water drinking and urination. The blood sodium level of patient in the internal medicine service 105(first day) mmol/L, urine sodium 12. 3% NaCl 150cc 6X1 treatment was started when the patient admitted the hospital. Then the treatment continued 4X1. Oral water intake was limited to 1 liter. Patient's blood level of sodium 133 (10th day) mmol/L and urine sodium 112 mmol/L (10th day).

Head trauma, cranial tumors and their surgical treatment, intracranial infections take place among the main cause of hyponatremia which occur neurosurgical clinics. Water intoxication is hyponatremic encephalopathy case which is characterized with excessive water intake and low serum sodium level and low serum osmolality about 80% of the psychiatric patients who were showed compulsive water drinking behavior is schizophrenic. As well as this conditions described other psychotic conditions, personality disorders, autism, mental retardation and also in case of dementia. The case presented here has not a distinct psychiatric disorders previously, she has a psychogenic polydipsia after head trauma.

Conclusion: Psychogenic polydipsia means to consume more water due to any psychiatric causes. Water intoxication can occur when too excessive water intake to renal excretions. Water intoxication can lead to serious neurological complication that carries the risk of mortality.

Keywords: Psychogenic polydipsia, hyponatremi, subdural hematoma

P-0088 Resuscitation

What does ultrasonography during resuscitation give us?

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Objective: Emergency medicine became the leading discipline that placed ultrasonography into their practice. Ultrasonography during resuscitation has been studied by many researchers. It is especially important for identification of underlying cause predisposing to cardiac arrest. An acute pulmonary embolism is a cardiovascular emergency with high morbidity and mortality. The mortality of acute pulmonary embolism is closely related to initial hemodynamic status and right ventricular dysfunction. Right ventricle to left ventricle ratio (RV/LV) is an important index, because a RV enlargement resulting in a RV/LV >1, can be indicative of a hemodynamically significant pulmonary embolism. Here we report a case of massive pulmonary embolism diagnosed by ultrasonography during cardiopulmonary resuscitation (CPR).

Case: A 70-year-old female, with a history of hypertension and atrial fibrillation, was transferred to emergency department by 112 emergency staff in cardiac arrest. They were performing CPR during 15 minutes. She was taken into resuscitation room with ongoing CPR. There was no palpable pulse nor arterial tension. Emergency physician performed immediate goal-directed ultrasonography that revealed dilated right heart chambers with agonal cardiac contractions. She was monitored and the rhythm was ventricular fibrillation. After defibrillation we continued chest compressions and intubated her. Arterial blood gas analysis revealed pH:6.9, pCO2: 72 mmHg, pO2: 47 mmHg. After about 10 minutes of CPR spontaneous circulation returned. We repeated ultrasonography. Right heart chambers were dilated and there were free hyperechogenic particles in all chambers indicating coagulated blood. Her blood pressure and heart rate were 80/40 mmHg and 110 bpm, respectively. After exclusion of intracranial pathology with cranial computed tomography (CT), a thorax CT with contrast was ordered with strong suspicion of pulmonary embolism. There was embolism in left main pulmonary artery and branches of both pulmonary arteries. She was transferred to intensive care unit with the diagnosis of massive



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pulmonary embolism. Immediate thrombolytic therapy with reteplase was started. At the end of fourth day the patient was extubated with spontaneous circulation and respiration but the patient did not become conscious at 14th day. Her control cranial CT did not show any hemorrhage or ischemic change and pulmonary arteries were open at thorax CT with massive pleural effusion at left hemithorax. She was excepted as hypoxic brain and died at 21th day.

Conclusion: Ultrasonography during cardiac arrest help us to early diagnose underlying cause.

Keywords: Cardiac arrest, echocardiography, pulmonary embolism, resuscitation, ultrasonography

P-0089 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Bilateral Anterior Fracture Dislocation of Shoulder After Epileptic Seizures

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Objective: Bilateral simultaneous dislocations of the glenohumeral joints in all planes are rare injuries. Most cases are posterior and due to seizures associated with generalized convulsion or after severe electric shock. On the other hand, bilateral anterior dislocations have also been reported in patients who have epileptic seizures. This paper presents a case of bilateral simultaneous anterior dislocation of glenohumeral joints caused by epileptic seizures.

Case: A 25 years old female presented in emergency with pain, swelling and deformity of bilateral shoulder joints after epileptic seizures. There was history of seizure disorder. She did not use regularly drug. The physical examination shown obvious bilateral anterior glenohumeral dislocation with no peripheral motor or vascular deficit. Computerized tomography scan was done for confirmation of extent and pattern of fracture of left and right glenohumeral joint (Figure 1) Emergency surgery under general anesthesia was suggested to patient and she transferred to orthopedic clinic.

Conclusion: It is not known why some dislocations occur anteriorly during seizure activity. Probably, Cause of this may be due to the position of the shoulders during the seizure. Extremity pathologies in epileptic patients must be kept in mind.

Keywords: Dislocation, Epileptic seizures, emergency department

P-0090 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Rare Cause of Hypoglycemia: Short Bowel Syndrome

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Objective: Hypoglycemia occurs due to diabetes mellitus (most often), ethanol intoxication and sepsis in the emergency room. Hypoglycemia is diagnosed by the presence of hypoglycemia symptoms, low blood glucose (<60 mg/dL) and improving the signs of hypoglycemia after treatment. Short bowel syndrome (SBS) is a clinical condition characterized by malabsorption (post extensive intestinal resection) and subsequent malnutrition. Enteral functions are disrupted by the resection of small intestine (75% or more) and the short remaining bowel length (70-100 cm). Mesenteric infarction, Crohn's disease, trauma, radiation enteritis, intestinal atresia and necrotizing enterocolitis are among the common causes of short bowel syndrome. Diarrhea, fluid and electrolyte imbalance, malnutrition, sepsis and hypoglycemia are the frequent complications in short bowel syndrome. In this paper, we will draw attention to short bowel syndrome admitted with hypoglycemia complaints.

Case: 48 year old male patient was referred to our hospital with change in consciousness and low glucotest (15 mg/dL) at home. In his medical history he has no diabetes mellitus. He was operated for gastrointestinal stromal tumor one month ago. Jejunostomy was performed in consequence of distal jejunum and ileum resection. His glucotest was 50 mg/dL. His arterial blood pressure was 125/75 mmHg, SpO2 was 96%, heart rate was 97 bpm, fever was 36,5 oC. In his neurological examination he was conscious, cooperative-oriented, Glasgow Coma Scale score was 15, pupillary was isochoric, light reflex was bilaterally normal, sensory and motor examination was normal and bilateral Babinski was flexor. Electrocardiograph was normal sinus rhythm, 92 bpm. 125 cc 20% dextrose IV bolus was performed. He was hospitalized after emergency treatment in consequence of resistant hypoglycemia.

Conclusion: Hypoglycemia is a clinical condition easy diagnosed and it includes rapid clinical improvement after right treatment. Emergency physicians should be well-informed to diagnose and manage hypoglycemia, they should research the etiology of disease and plan the long-term treatment of patients.

Keywords: Hypoglycemia, etiology, bowel

P-0091 Resuscitation

Tongue angioedema caused by black tea

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Objective: Tea is commonly produced and used all over the world. Contact dermatitis while harvesting the plant is not unusual, however only a few cases of anaphylactic reaction to types of tea described in literature. We present a tongue angioedema after taking black tea in this case.

Case: A 37 year old male patient presented to our emergency department with edema in his tongue after taking black tea. There was no itching, urticaria, uvula edema, dyspnea or another finding. There were no allergic reactions in his past history. His vital findings were stable. There were not any allergic reactions in his past history and family history. His symptoms regressed after treatment with intravenous feniramin maleat 45.5 mg and methylprednisolone 80 mg. The patient was observed in the ER for 4 hours and discharged

Conclusion: Tea is an aromatic beverage commonly prepared by pouring hot or boiling water over cured leaves of the tea plant, Camellia sinensis. Tea originated in China as a medicinal drink. In our country tea is produced in the Eastern Black Sea Region and used worldwide. It is used as a medical remedy against stomach ache, irritable bowel syndrome and sleeping aid. All teas from the camellia tea plant are rich in polyphenols, which are a type of antioxidant. A 2001 Boston University study concluded that short and long-term black tea consumption reverses endothelial vasomotor dysfunction in patients with coronary artery disease. Although it has much more benefits there are some allergens in this plant. But the allergens responsible for type I camomile allergy have not yet been completely characterized. Reider et al identified some of this molecules and cross-reactivities to some other herbs. However anaphylactic reactions caused by camomile are very rare, with only a few well documented reports.

In this case, tongue edema developing after tea consumption emerge as an example of type-1 hypersensitivity reactions. The case also shows this quite commonly consumed beverage should not be ignored that the risk of allergy. Furthermore patients sensitized to black tea should be investigated about other herbs.

Keywords: black tea, camellia sinensis, angioedema

P-0092 Pediatric Emergencies

The Hair-Thread Tourniquet Syndrome

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Objective: Hair-thread tourniquet syndrome is described as appendages strangulated by hair fibers especially in infants. There are cases about roundly thread wrapping fingers, toes, penis, clitoris and neck. Early diagnosis and treatment should be necessary to rescue the region involved.

In this case we present hair-thread tourniquet syndrome affecting multiple toes of an infant

Case: A three-month year old boy presented to our Emergency Department after three days of restlessness, erythema and swelling on his left third and fourth toes detected by his mother while changing diaper. There were no similar symptoms in his history. In physical examination there was hyperemia, edema and tenderness with strangulation ring at the proximal part of third and fourth toes and skin of fourth toe was cut. On examination using magnification, several tightly eight-shaped entangled hair fiber was found. The hair fiber was removed gently. Hyperemia and edema were regressed at 2 hours observation. The patient discharged home with topical antibiotic treatment.

Conclusion: Hair-thread tourniquet syndrome is a rare but dangerous disorder if early treatment is not possible. It is frequently described fingers, toes, external genitalia in 6-36 week-year old babies. Toe tourniquet syndrome was determined by Quinn. Edema caused by constriction blocks arterial and venous circulation. If treatment delays tissue necrosis and auto amputation can develop at the affected area. Although the mechanism of thread wrapping is not clearly defined, it is thought to be accidental or the combination of babies' plantar flexion behavior and overall clothing. Treatment is simply incision and removal of the hair fiber. If the hair fiber cuts the skin and becomes invisible surgical exploration should be necessary. In conclusion; hair-thread tourniquet syndrome should not be ignored in babies whose parents describe restlessness and all of the appendages should be examined carefully.

Keywords: emergency medicine, tourniquet syndrome, toe



POSTER PRESENTATIONS

P-0093 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Cerebellar Symptoms at Young Adult; Vertebral Artery Dissection

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Objective: Vertebral artery dissection has two major types of presentation; the hemorrhagic type which presents with subarachnoid hemorrhage (SAH) caused by rupture of an intradural VA dissecting aneurysm, and ischemic type which presents with vertebrobasilar insufficiency or posterior circulation infarction attributable to arterial narrowing and thromboembolism (ver dis1- 18). Dissection of the extracranial vertebral artery (ECVA) usually involves the distal portion of the ECVA as it winds around the upper cervical vertebrae. Sometimes dissections involve the proximal ECVA between the origin of the artery and its entry into the vertebral column, usually at C5 or C6. Ischemic symptoms due to ECVA dissection are most often vestibulocerebellar and include dizziness, vertigo, veering to one side, and loss of balance. In this case we aimed to present a ECVA dissection patient who presented to emergency service with vestibulocerebellar symptoms.

Case: A 31 years old woman was admitted to the emergency department complaining of dizziness, nausea and vomiting, veering to one side, and loss of balance. Complaints have begun suddenly about four hour ago. She had any disease or no risk factors. On admission she had normal muscle strength at lower and upper extremity. She had vertical nystagmus while she was looking to right side and upwards. She had dysmetria. At cranial diffusion MR there was acute infarct at right cerebellum. At MR angiogram right V4 was thin and left PCA P1 was occlusive. Anticoagulant therapy started and DSA planed for patient. At DSA left VA was normal. Right VA V1, V3, V4 was normal and there was %40 obstruction at V2 and intimal flap after this obstruction. This sign was compatible with dissection. Anticoagulant therapy continued and after findings resolved patient discharged with warfarin therapy.

Conclusion: In young patients with signs of posterior circulation emergency physicians should be kept in mind vertebral artery dissection and patients should be investigated carefully.

Keywords: dissection, vertebral artery, cerebellar symptoms

P-0094 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Creaking Neck; PNEUMOMEDIASTINUM

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Objective: Pneumomediastinum is defined as free air or gas contained within the mediastinum, which almost invariably originates from the alveolar space or the conducting airways. In this case we aim to present a pneumomediastinum young male patient who had no etiologic factor for pneumomediastinum.

Case: A 21-year-old male patient presented to emergency department complaining of chest pain and creaking in the neck. He had sudden onset of chest pain two hour ago and after the chest pain crackling in the neck was occurred. He had no trauma, cough or other etiological factors. His vital signs were stable. On his physical examination there was subcutaneous emphysema over the neck and other physical examination was normal. X-ray showed that there was suspected mediastinal air and subcutaneous air in the neck extending upwardly from clavicle to thyroid cartilage. The thoracic computed tomography (CT) showed air in mediastinum and widespread emphysema in cervical tissue. Patient diagnosed pneumomediastinum and hospitalized. In the following days, pneumomediastinum resolved spontaneously with supportive therapy and patient discharged.

Conclusion: Subcutaneous emphysema is the most common sign of pneumomediastinum and careful physical examination and radiologic evaluation in suspected cases are very important in making the diagnosis of spontaneous pneumomediastinum.

Keywords: Pneumomediastinum, subcutaneous emphysema, chest pain

P-0095 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Effect of the Existence and Size of Infarction Area on the Plasma B-Type Natriuretic Peptide Levels in a Group of Ischemic Stroke Patients

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Objective: Stroke is the third leading cause of death in Western societies and the leading cause of long-lasting severe disability. The aim of this study was to determine the effect of the size of infarction area on the plasma B-type Natriuretic Peptide (BNP) levels in a group of ischemic stroke patients.

Materials-Methods: Sequential patients showing stroke symptomatology, having a series of exclusion criteria, and admitting to Istanbul Goztepe Training and Research Hospital Clinic Emergency Department were included into the study. Seventy nine patients were included in the final analysis. The patients were categorized according their diffusion MR findings. In regarding to the existence (3 groups) and the size of the infarction we created groups. (SPSS was used for the analysis of the data. Means and frequencies were calculated as usual. The differences among means were tested by non parametric tests.

Results: %38 of the participants were men and %62 were women. The age distribution of patients are, grup 1 (no infarct) 58,6 (± 19,84), grup2 (infarkt group) 72,53 (± 12,72), grup3 (control group) 61,05 (± 9,05). Mean age and BNP levels of the participants were 67,8 (16,7) and 146,5 (156,4). In regarding to the existence and the size of the infarction, Group 1 (no infarct) consisted of 20 (25,3%); Group 2-a (small infarct), 16 (20,4%); Group 2-b (midsize infarct), 10 (12,6%); and Group 2-c (big size infarct), 13 (16,4%) Group 3 (kontrol grubu) 20 (%25,3) participants. When BNP levels compared for groups, Grup1 (no infarct), 22,6 (1,5), Grup2 (infarkt group), 111,5 (147,8) ve Grup3 (control group) 8,3 (2,9) were identified. (overall p<0,001). The level of BNP changed according to the existence and the size of the infarction; the mean level of BNP in Group 1 (no infarct) was 22,6 (1,5); Group 2-a (small infarct), 90,2 (6,2); Group 2-b (midsize infarct), 171,3 (27,3); and Group 2-c (big size infarct) 387,3 (37,8), Group 3 (control group), 8,3 (2,9) (overall p<0,001). Post hoc analyses showed statistical differences among each group.

Conclusion: BNP levels are increased in the presence of an acute infarct. BNP levels are correlated with the height size of the infarct. Plasma BNP may be helpful for the prediction of the existence and size of the infarct in acute ischemic stroke.

Keywords: Ischemic Stroke, Plasma B-Type Natriuretic Peptide, Size of Infarction Area

P-0096 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Factors triggering seizures in patients presenting with epileptic seizures to the Emergency Department and the frequency of seizure recurrence during 1-week period of follow-up

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Objective: It was aimed to investigate that factors triggering seizures and status of seizure recurrence after discharge from a 1-week period in patients admitted to the ED with complaining of epileptic seizures.

Materials-Methods: The study was a prospective clinical study between January 2013 and July 2013 conducted in the adult ED of urban tertiary care training and research hospital. Ninety patients were included in the study. All patients were enrolled into the study on admission. Patients were contacted by phone 1 week after discharge so that the frequency of seizures and drug use data were recorded. Statistical analysis was conducted via SPSS for Windows 18.0 (SPSS Inc., Chicago, USA) program. In all analysis, p<0.05 was considered statistically significant.

Results: When patients were evaluated in terms of factors that increase the frequency of seizures there was no significant difference in age, gender, alcohol intake in the last 24 hours before seizure, antiepileptic drug group that was used or skipping doses of the antiepileptic drug. There was a statistically significant reduction in seizure frequency in patients taking antiepileptic drugs regularly (p <0.05). Whereas there were statistically significant increase in seizure frequency in patients who have a sleepless night last 24 hours before the seizure (p=0,026), and are experiencing a stressful situation (p=0,48). Also, there was a statistically significant increase in seizure frequency in patients who were single (p=0,001).

Conclusion: Among the factors that affect the seizure frequency in patients admitted to the ED with complaining of epileptic seizure regular antiepileptic drug use, marital status, and depri-



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vation of sleep or the presence of a stressful situation in last 24 hours were statistically significant.

Keywords: antiepileptic drugs, epilepsy, seizure

P-0097 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A case of cerebral venous sinus thrombosis at the emergency department

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The diagnosis of cerebral venous thrombosis is difficult due to the variety of its clinical symptoms. Most often, superior sagittal sinus is affected. Reasons include etiological causes, systematic inflammatory diseases, genetic and environmental coagulation pathologies and oral contraceptive usage in women. The clinical spectrum ranges from headache, focal deficit, to seizure and coma. MRI and venography are the most important diagnostic tools. Our case is a young woman who applied to the hospital three times in a week. We tried to place a cerebral venous sinus thrombosis diagnosis using detailed historical and physical examination.

Keywords: cerebral venous sinus thrombosis, headache, emergency department

P-0098 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A patient with arteriovenous malformation who applied with epileptic attack

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Arteriovenous malformation (AVM) are anomalies in intracranial vascular structures. They can expand over time. Bleeding, hemiparesis, sensorial deficit, demans, sight area defects, seizures and headache attacks may be clinical symptoms. About half of the patients apply the emergency department upon bleeding, while 27% of them apply as a result of epileptic attacks.

Our case is a 47 year old male with a first epileptic attack. In the performed tests were diagnosed with arteriovenous malformation

Keywords: epileptic attack, arteriovenous malformation, emergency department

P-0099 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Cause of Intermittent Headache, FAHR Syndrome: Case Report

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Objective: Collection of calcium and different minerals in cerebellum, centrum semiovale bilaterally and symmetrically causes FAHR syndrome. Etiology varies; hypoparathyroidism, pseudohypoparathyroidism, hyperparathyroidism, radiation, systemic diseases and some toxins creates etiologies.

Case: 54 year old woman applies emergency department (ED) with complaint of intermittent headache which she had in the last 1 year. Her physical examination revealed no pathology. Her medical history had only hypertension. Laboratory results were normal except Total Calcium: 7.9, AST:20, ALT:18, Creatinin:0.95, BUN:33, PTH:71.8, fT4:1, TSH:4.33, 25OH Vitamin D:5.17. So we decided to perform brain ct which showed us calcification in basal ganglia bilateral and symmetric. We decided the diagnosis as: FAHR syndrome and started active vitamin D treatment. Patient was hospitalised, calcium level and symptoms improved normally during follow-up.

Conclusion: The element responsible for FAHR syndrome is Calcium. Cranial CT is the right choice to reveal out the calcium collection. As a result, neurologic symptoms vary and we must keep in mind FAHR syndrome when we detect calcium collection in basal ganglia, deep cortical structures and cerebellum.

Keywords: FAHR syndrome, headache, calcification

P-0100 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Aortic Dissection Presenting With Plegia

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Introduction-Objective: Aortic dissection is entry of blood into the medial layer of aorta through a tear in the intimal layer. As a result, two separate lumens are formed. The intimal tear is the starting point of dissection; dissection either reenters true lumen distally or remains as a blind pouch. The incidence of the disease is 5-6 patients/million/year. Males are affected three times more common than females. Affected patients may present with severe pain, stroke, syncope, paraplegia, oliguria, anuria, sudden death, tamponed, acute aortic insufficiency, and congestive heart failure. A third of patients with aortic dissection die before the disease is diagnosed. In this paper, a patient diagnosed with aortic dissection after presenting with lower extremity plegia was presented.

Case: A 74-year-old man presented to our emergency department with numbness and weakness in his right leg. His general status was moderate and he was conscious. His blood pressure was 100/60 mmHg in his right upper extremity and 130/80 mmHg in left upper extremity. His pulse rate was 84 bpm and body temperature was 36.8°C. Muscle strength was 3/5 in right lower extremity and 5/5 in the remaining extremities. A brain tomography showed hypodense lesions consistent with chronic ischemic lesions in periventricular white matter. The patient was consulted with the neurology department. Later in the course, the patient developed back pain. He also had a history of hypertension and coronary artery disease, and thus a thoraco-abdomino-pelvic tomography with contrast revealed a type B dissecting aortic aneurysm with a partially thrombosed pseudo lumen, which began in the proximal part of the descending aorta and extended down to the abdominal aorta. A consultation was obtained from the thoracic surgery department and the patient was operated. He was discharged on 9th day after the admission without complications.

Conclusion: Aortic dissection is a rare condition carrying a high mortality risk that necessitates prompt recognition and treatment. We aimed to emphasize that patients may present with varying clinical pictures, although majority have common signs and symptoms. The patients should be thoroughly questioned about the presence of subtle neurologic signs and symptoms including paraplegia and plegia, which may be present in up to 25% of type B aortic dissection victims.

Keywords: acute aortic insufficiency, plegia, aortic dissection

P-0101 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Mesenteric Cyst As A Rare Cause Of Intraabdominal Tumors: A Case Report

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Introduction-Objective: Mesenteric cysts are rare intraabdominal tumors that are encountered in only one of every 27000 to 250000 hospital admissions. They are usually located in intestinal mesentery; however, their origin is not clear. These cysts are usually of benign character, with less than 3% of cases being malignant. They are usually asymptomatic and hard to diagnose owing to lack of typical clinical and radiological signs. They usually manifest themselves with abdominal bloating, pain, or mass.

Case: A 17-year-old female patient with no history of any disease presented to our emergency department with abdominal pain for three days. On physical examination, her general status was well and she was conscious. The right lower abdominal quadrant was tender and there was a palpable mass in the right lower quadrant and at the midline. Hemogram, biochemistry, and B-HCG were all normal. An abdominopelvic USG revealed a cyst (mesenteric cyst?) with a size of 20X10 cm originating from the level of umbilicus at the midline and extending to pelvis. An oral-IV lower and upper abdominal CT with contrast was reported as follows: there is a hypodense lesion of cystic density measuring 205X144 cm and extending from the right middle quadrant to the lower quadrant of abdomen. The cystic wall is thin. This appearance was considered to be of a mesenteric cyst.

Conclusion: There are no specific tests for definitive diagnosis of mesenteric cysts. Imaging modalities such as USG and CT are quite helpful for diagnosis. A detailed patient history should be obtained and a thorough physical examination be performed in patients presenting to emergency department with the complaint of abdominal pain. The appropriate imaging examinations should be ordered thereafter. Although the patient anamnesis and physical examination were nonspecific in our patient, the imaging tests were very helpful to make the definitive diagnosis.

Keywords: mesenteric cysts, intraabdominal tumors, hypodense lesion



POSTER PRESENTATIONS

P-0102 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Acetabular fracture and iliac vein injury due to convulsion

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Objective: Soft tissue injuries, joint dislocations, fractures, dental injuries, head trauma, road traffic accidents, burns and drowning are the most frequently reported accidents due to seizures in patients with epilepsy. Risk of skeletal fracture and dislocation which occur during epileptic seizures 2 times more than normal population. Mostly hand, radius, ulna, tibia, fibula and ankle fractures are seen. Hip and femur fractures are rare. In this paper, a rare case of fracture of the acetabulum and the iliac vein injury occurred due to epileptic seizure was presented.

Case: An 63 year-old female patient was brought to emergency department with complaints of weakness in her left leg occurred after generalized tonic-clonic convulsions during sleep in early morning. The patient was consciousness, oriented and cooperative. Vital signs were stable. There was tenderness and limitation of motion in the left leg. Acetabular fracture was detected on pelvis x-ray radiograph of the patient. A great hematoma compressing the bladder close to the left acetabulum fracture was detected on pelvic CT angiography. The contours and density of the left iliac vein were observed to disappear in the area of hematoma. Patient was hospitalized with a diagnosis of a fracture of the acetabulum and hematoma due to the iliac vein damage.

Conclusion: Possible injuries due to epileptic seizures should also be considered and investigated after seizures of the patients.

Keywords: epilepsy, fracture, convulsion

P-0103 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Hyperpotassemia with non-specific symptoms which diagnosed with ECG

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Objective: When we notice rhythm disorders with the routine ECG that we take almost all patients in the ER department; we should be aware of electrolyte imbalance. We aimed to mention the ECG signs of a patient that admitted our emergency medicine with non-specific symptoms and hyperpotassemia.

Case: A 74 year-old female admitted to emergency department suddenly feel sick and become worse. In the patient's history we noticed that the patient has liver cirrhosis due to hepatitis C virus. We couldn't learned the medications that she has been taken but we supposed that she might be taken aldactone. In her physical examination her vital signs was normal, detailed system examination was usual. We took a routine ECG and we had an ECG that the rate of approximately 70/dk at extremity leads, first degree AV block and the rate of approximately 40/min chest leads first degree AV block was detected again. And we planned long rhythm ECG. Then we took a long rhythm ECG and we noticed the average rate of approximately 60/min in normal sinus rhythm and a prolonged PR interval and peaked T waves. The blood test analyses showed that the patient's potassium was 8 mEq/L and the control value in blood gas analyse was 8.06 mEq/L. We immediately started medication for high potassium and the patient sent to the dialysis unit after the nephrology consultation. After dialyses the patient discharged. The after dialyses ECG of the patient was normal sinus rhythm.

Conclusion: The expected ECG signs of hyperpotassemia is prolonged PR interval, peaked T waves short QT interval, flattened P waves, widening of the QRS complex and the QRS complex disorder in sinusoidal pattern. We aimed that the ECG signs of hyperpotassemia can be very different configurations and we have to be aware.

Keywords: hyperpotassemia, long rhythm ECG, non-specific symptoms

P-0104 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Ovarian Hyperstimulation Syndrome In The Emergency Department: A Report Of Three Cases

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Introduction-Objective: Ovarian hyperstimulation syndrome (OHSS) is a serious clinical picture with potentially life-threatening consequences, which is either an iatrogenic condition that develops as a result of ovulation induction or controlled ovarian hyperstimulation, or a spontaneous occurrence. In this syndrome with a quite wide clinical spectrum, ovarian size and the number of follicles characteristically increase. In mild cases, there may exist minimal abdominal free fluid, while more severe cases may present with widespread free fluid in all third spaces including pleural and peritoneal cavities. The symptoms at admission reflect these pathologies. Ultrasonography (USG) is a good imaging modality for diagnosis of OHSS.

Case reports: Case-1: A 30-year-old woman who received treatment for infertility presented to the emergency department with abdominal pain, bloating, and dyspnea. She had abdominal distention and diffuse tenderness. BP: 90/60 mmHg, PR: 90 bpm, RR: 16 bpm. Beta HCG: 183.7 mIU/ml. An abdominal USG revealed prominently increased size (9X7cm) of both ovaries with a lot of cysts within. There was a marked amount of ascites in the abdominal cavity.

Case-2: A 28-year-old female patient presented to our emergency department with abdominal pain and bloating for one week. Her abdomen was diffusely tender and breath sounds were diminished over the basal portion of the right lung. BP: 100/70 mmHg, PR: 82 bpm, RR: 14 bpm. Beta HCG: 200.3 mIU/ml. An abdominopelvic USG demonstrated multiple cysts in both ovaries, with the biggest measuring 10 cc. There was also free fluid of moderate amount in all abdominal quadrants. A 2-cm pleural effusion was present in right pleural cavity.

Case-3: A 28-year-old female patient presented to our emergency department with abdominal pain and dyspnea. She had diffuse tenderness in abdomen. BP: 100/70 mmHg, PR: 82 bpm, RR: 14 bpm. Beta HCG: 635.9 mIU/ml. An USG revealed an ovarian size of 6X4 cm on the right side and 8X7 cm on the left side, which were both enlarged. There were a number of cysts in the left ovary. There was a free fluid accumulation of moderate amount in all abdominal quadrants.

Conclusion: OHSS is a complication with varying clinical properties, which is increasingly encountered as the in vitro fertilization (IVF) procedures become widespread. Therefore, emergency physicians should remember this syndrome that has a steadily increasing incidence.

Keywords: ovarian hyperstimulation, Ultrasonography, Emergency Department

P-0105 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Acute Pancreatitis and Polypharmacy

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Objective: Acute pancreatitis is an acute inflammatory process of the pancreas that may involve surrounding tissue and remote organ systems. The disease can range from mild inflammation to severe extensive pancreatic necrosis and multi-organ failure with mortality rates of 20% to 30% or higher. Alcohol and gallstones diseases are the most common etiologic factors in the acute pancreatitis. One of the rare causes of acute pancreatitis associated with the drugs. Many drugs are reported to be associated with acute pancreatitis, but they account for only 1.4% to 2.0% of all cases. In our case, one of rare cause of acute pancreatitis, polypharmacy will examine.

Case: A 69 year old female patient; with 11 days ongoing diarrhea, increasing fatigue in recent days, mild abdominal pain and vomiting; was admitted to the emergency service. She use thioctic acid, esomeprazole, insulin aspart, atorvastatin, olmesartan, nifedipine, vitamin B12, pregabalin, metoprolol, metformin, acetylsalicylic acid, alverine citrate, simethicone and venlafaxine treatment for hypertension, diabetes mellitus, coronary artery disease, depression, neuropathy, peptic ulcer, hyperlipidemia. In addition the last 10 days the patient, because of gastroenteritis, use ciprofloxacin, metronidazole and paracetamol. On physical examination of the patient, there were any pathology except hyperactive bowel sounds. In laboratory tests amylase:1390 was determined and patient was evaluated for acute pancreatitis. There were any other pathology to explain acute pancreatitis; and patient hospitalized diagnose of acute pancreatitis depend on polypharmacy.

Conclusion: Acute gastroenteritis are frequently encountered in emergency service. Careful history taking and laboratory support can be found with other underlying diseases. Also in the investigation of the etiology of acute pancreatitis, which is one of the rare causes with polypharmacy may also be kept in mind.

Keywords: Acute Pancreatitis, polypharmacy, emergency medicine



POSTER BİLDİRİLER

P-0106 Pediatric Emergencies

Live Leech Enfestation Due to Oral Intake: A case report

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Dumlupınar Üniversitesi, Kütahya Evliya Çelebi Eğitim Araştırma Hastanesi

Objective: Leeches usually live in spring waters, dirty pools and rivers. Human enfestations usually spreads by drinking or swimming in these water. The most common type is cutaneous enfestations. Internal enfestations are mucosal enfestations. It can involve any area of the upper respiratory tract mucosa. There are nose, nasopharynx, oral cavity and gastrointestinal system settlements reported in the literature. Leech enfestations are rare in the larynx.

Case: A 10 year old girl referred to emergency service with deglutition of a foreign body. In her anamnesis, it is reported that patient drank water from plastic bottle by mistake which had 4 leeches on it and after drinking it is noticed that there was 2 leeches left.

Patient was in fine medical condition, conscious, and had vital signs within normal range and there was no signs of foreign bodies in her ear, nose and throat examination. After taking blood samples for routine tests, patient was consulted to pediatric surgery department. At her oropharynx examination and indirect laryngoscopy, there was no foreign bodies neither at oropharynx nor larynx. Patient was then taken to endoscopy. At her broncho-esophagoscopy there were no signs of a foreign body and it is thought that suspected foreign body (leech) went right into the stomach after the deglutition process. Patient got internalised to follow conditions like acute abdomen and other possible systemic conditions. No problems occurred within 48 hours of follow-up. There were no complaints of stomach ache, fever, nausea, respiratory distress, or hoarseness. It is thought that the enfestation material (leech) that the patient swallowed would possibly be denaturated due to stomach acid. The patient who had no complaints 15 days later was deducted from follow-up.

Conclusion: Follow-up is important in patients who refer to emergency service with leech enfestation. Great caution should be taken while remove the leeches if they are seen. Leeches can be removed under general or local anaesthesia with the help of laryngoscopy. Leeches' saliva contain some enzymes (antielastase, antipain, antitrypsin and esterase) as well as well known anticoagulant substances (hirudin, thrombin, factor Ix and plasminogen activating factor). Leeches settled in nasal cavity or nasopharynx causes epistaxis, nasal obstruction. The ones in oral cavity causes haemoptysis, and ones within larynx causes breathing difficulties, hoarseness and hemoptysis; in delayed cases, deep anemia and death by asphyxia can be seen. In these cases, detailed oropharynx examination and indirect laryngoscopy should be made to visualise the leeches and endoscopy should be planned if its necessary. It is appropriate to follow these cases a few days if its not possible to visualise the leeches.

Keywords: Leeches, Internal enfestations, Leech enfestations, rare, emergency medicine

P-0107 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Rare Diagnosis of Sudden Vision Loss: Posterior Reversible Encephalopathy Syndrome(PRES)

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Dumlupınar Üniversitesi, Kütahya Evliya Çelebi Eğitim Araştırma Hastanesi

Objective: Posterior reversible encephalopathy syndrome(PRES) is characterised by posterior circulatory impairment of brain in which nausea, vomiting, changes in consciousness, headache, visual impairment due to sudden raise of sudden blood pressure can be seen.

Case: A 64 year-old woman referred to emergency service with the history of a sudden vision loss which started an hour ago. Patient had no known history of eye or visual problems. Patient was receiving dialysis treatment 3 times a week due to chronic kidney failure and was receiving hypertension treatment. Patient's last dialysis treatment was 2 days ago and it was planned to undergo dialysis the next day. At her neurological examination, bilateral light reflexes were natural, pupils were isochoric; extremity motor and sensory examination were normal. Physical examination had no significant findings. Initial blood pressure was 240/120 mmHg. There were no significant findings in her brain tomography and diffusion magnetic resonance imaging. Patient was then consulted to neurology department. The patient in whom posterior reversible encephalopathy syndrome(PRES) was suspected received perlinganit(Nitroglycerin) and undergone dialysis after nephrology consultation. After the dialysis procedure, patient's visual problems improved dramatically. Patient was discharged from the hospital due to having no neurological problems at her 36 hours of follow-up.

Conclusion: PRES is an acutely developed and mostly temporary neurological picture. Early diagnosis and rapid treatment is of great importance to prevent sequela. We tried to introduce this case in order to notify that PRES can be the cause in patients with sudden vision loss and neurological symptoms can be ameliorated with proper symptomatic treatment.

Keywords: Posterior Reversible Encephalopathy Syndrome, headache, blood pressure

P-0108 Pediatric Emergencies

A foreign body ingestion that needs attention: Sea-monkey

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Dumlupınar Üniversitesi, Kütahya Evliya Çelebi Eğitim Araştırma Hastanesi

Objective: Sea-monkey is an object named Cristagel which is non-living. It can become inflated through absorbing water up to 400 times of its mass. Its ingestion needs close follow-up.

Case: A 9 year old girl referred to emergency service after drinking the glass of water by mistake in which her older brother was growing sea-monkeys. Patient with no respiratory complaints and stomach aches, was internalised to the Pediatric Surgery Department after the consultation. Since there was no stomach ache history during her 48 hours of follow-up and had normal defecation, patient was discharged with suggestions of referring outpatient clinic 2 days later.

Conclusion: It is known that gel balls which are sold as a toy and known as 'sea-monkey' is posing a risk against child health and security. It is known that the ingestion of products which are known to be sold at groceries, supermarkets, stationeries, school canteens with the names of 'sea monkey', 'enlarging water balls', 'bio-gel' and which are reputed to be toys by children, can be lethal. Aspiration or ingestion of these products which are known to enlarge up to 400 times upon contact with water, can be life-threatening and its follow-up is a must.

Keywords: sea-monkey, enlarging water balls, bio-gel, children

P-0109 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Transformation process from atypical pneumonia to lobar pneumonia of a patient with mental retardation: Case report

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Objective: In lobar pneumonia, microorganism that reaches periferic alveoli damages alveoli epithelium and causes hemorrhagic oedema. Following that, rapid proliferation of that microorganism and accumulation of polymorphonuclear leukocytes occur. Infection which is segmenter spreads via bronchioli and pores of Kohn and involves whole lobe. The most common lobar pneumonia agent is S. Pneumonia which is accounted for 50-75% of the cases. Other causes are K. Pneumonia and other Gr(-) bacilli, H. Influenzae, M. Pneumonia and C. Pneumonia. Radiologically, lobar pneumonia causes opacifications which held air bronchograms within. Whole lobar involvement is rare due to early antibiotherapy usage. It can be seen 'round' pneumonia which imitates masses in some cases.

Case: A 40 year old male patient referred to emergency service with sore throat, cough and expectorating complaints. Patient with fine general medical condition and intermediate self care found out to have 65 IQ. Patient's blood pressure was 110/70 mmHg, pulse: 95/min, respiratory rate: 14/min, SpO2:99 and temperature: 36.7 °C. In his examination its noted that oropharynx was hiperemic and undergone chest x-ray due to coarsening of respiratory sounds at left middle area. Patient neither had gross pathology on his x-rays nor dyspnea and got discharged with oral gemifloksasin 320 mg/7 tablets therapy and referred to chest diseases department outpatient clinic. While waiting on the queue at outpatient clinic 42 hours later, patient referred to emergency service with fever, deterioration in his general condition, cough and dyspnea. In his physical examination, significant rale and minimal rhoncus was noted at left lung. Patient with 100/50 mm Hg blood pressure, 120/min pulse, 21/min respiratory rate, 95 SpO2 and 39.4 °C temperature got internalised for routine blood tests and 5lt/min oxygen therapy started. It is learnt that the patient did not take his medicine. Patient undergone control chest x-ray. In his control graphy, left middle lobe pneumonia which was absent before was spotted and patient got consulted to chest diseases department. Department of chest diseases internalised the patient with lobar pneumonia.

Conclusion: It is important to internalise patients with mental retardation whether they will use therapy is unknown.

Keywords: lobar pneumonia, Pneumonia, Radiological, mental retardation



POSTER PRESENTATIONS

P-0110 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Evaluation of patients admitted to the emergency department with headache

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Objective: Headache is an important symptom which consist %3-5 of all emergency department admissions. Life threatening conditions, such as subarachnoid bleeding, meningitis, and brain tumor, are diagnosed in approximately 1% of all patients with headache. Even if the incidence of the life threatening conditions seems to be rare, these diagnosis should be ruled out in every patient with headache. In this study we aimed to evaluate the demographic characteristics of the patients admitted to the emergency department with headache and compare the final diagnosis of patients and performed diagnostic tests.

Materials-Methods: Patients, 18 years old and older, admitted to the emergency department with headache between January 1 and February 28, 2014 were enrolled the study. Pediatric and trauma patients were excluded from the study. Data about patients' age, gender, and place of residency were recorded. Accompanying symptoms, physical examination findings, imaging test results, lumbar puncture findings and final diagnosis were also recorded. Results are expressed as mean $\pm$ SD and n(%).

Results: A total of 153 patients were enrolled the study. The mean age of patients was 43.5 $\pm$ 15.1 years and 42(27.5%) of them were male. 118(77.1%) of patients were living in city center and 35(22.9%) in rural area. 57 (37.3%) of patients had nausea and vomiting, 31(20.3%) of them had photophobia, and 10(6.5%) diplopia in addition to headache. 36(23.5%) of patients had high blood pressure, 11(7.2%) of them had high fever, and 3 (2.0%) had neurological deficit. Brain computed tomography was performed in 22(14.4%) of patients, and diffusion MRI was performed in 1(0.7%) of them. 37(24.2%) of patients diagnosed as migraine attack, 28(18.3%) of them diagnosed as hypertensive attack. Only 3(2.0%) of them had central nervous system pathology. 143(93.5%) of patients were discharged from hospital and 10 (6.5%) of them were hospitalized with different diagnosis.

Conclusion: Headache is an important clinical manifestation for emergency physicians because it may be the first sign of life threatening conditions. In our study, 2% of all patients had a diagnosis of central nervous system pathology. Our findings were in accordance with current literature. For every patient admitted to the emergency department with headache, an attentive medical history should be taken, physical examination should be performed and life threatening conditions should be ruled out.

Keywords: headache, emergency, demographics

P-0111 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Successful resuscitation with thrombolysis of a masif pulmonary embolism during cardiac arrest

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Objective: pulmonary thromboembolism (PTE) is a disease with high mortality rate and it is known declared to comprise more than 15% of hospital deaths. Approximately 40% of acute PTE patients have cardiac arrest and these patients are treated with thrombolytic during resuscitation. In this paper, we present a case of a successful resuscitation of an acute PTE patient accompanied by cardiac arrest with thrombolytic treatment.

Case: A 39 years old female patient was admitted to the emergency department with dyspnea. The patient reported that her symptoms started approximately an hour ago and she did not use any medication. During triage, patient's initial assessment values were found to be following: blood pressure 117/74mmHg, heart rate 62/min, respiration rate 18/min, fever 36C, oxygen saturation (sO₂):%91. Physical exam did not show any additional symptom except agitation of patient. In ECG, there were an incomplete Right Bundle Branch Blok and in leads V1-V4 inverted T wave (T negativity in chest derivation V1-4). Laboratory results demonstrate hypoxemia (pO₂:46.9) and hypocapnia (pCO₂:26.1) in blood gas analysis.

Thorax CT angiography displayed bilateral thrombus in pulmonary arteries. Immediately after CT, patient had cardiac arrest. Cardiopulmonary resuscitation (CPR) was initiated and appropriate protocols were practiced. During CPR, 15 mg tissue plasminogen activator (TPA) was administered to the patient and approximately three minutes later patient spontaneous circulation was reinitiated. Then, 85 mg t-PA IV infusion was administered and patient started to breathe spontaneously.

Conclusion: Following results were obtained by transthoracic echocardiography: right atrium and ventricular were extremely wide, pulmonary artery pressures were 60 mmHg and there was no intra cardiac thrombus. Patient was transferred to the intensive care (ICU) unit. During ICU controls, there was not any observed bleeding related to TPA. The patient died in the second day of her ICU stay.

Keywords: pulmonary thromboembolism, cardiopulmonary resuscitation, thrombolytic therapy

P-0112 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Demographic Characteristics of Patients with Pulmonary Thromboembolism

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Objective: Pulmonary thromboembolism (PTE) is a common disease with high mortality and difficult diagnosis. The incidence in our country can not be calculated because there is no adequate and regular data. In our study, we aimed to investigate the demographic characteristics, risk factors, incidence, Wells and Geneva scores diagnostic and treatment methods of the patients in our emergency department with a diagnosis of PTE.

Materials-Methods: Files of the 112 patients who were admitted to Erciyes University Medical Faculty Emergency Department between January 2010 - February 2012 were analyzed retrospectively. Patients' demographic characteristics, risk factors, Wells and Geneva scores, diagnosis, and treatment methods were collected from patient files and recorded to the study form. Data were analyzed with SPSS 17.0 statistical software.

Results: The mean age of patients was 65.02 $\pm$ 16.23. Forty-one (36.6%) of the patients were male and 71 (63.4%) were female. The most common complaint of patients was shortness of breath (81.3%), respectively. Immobilization(35.7%) and history of previous surgery (19.6%) were among the risk factors of the patients. From the electrocardiograms of patients the most frequently sinus tachycardia (69.6%) and S1Q3T3 pattern (43.8%) were detected. Hypoxemia (%80.4), hypocapnia(%72.3) and alkalosis (%27.7) were detected from arterial blood gas analysis. Average troponin levels of the patients was 0.13 $\pm$ 0.48 ng/L and average d-dimer levels was 12,698.12 $\pm$ 8,779.92 μ g/L. Geneva scores of the patients were: 4 patients (3.6%) low score, 88 patients (78.6%) medium score and 20 patients (17.9%) high score. Wells Clinical Probability scores of the patients were; 1 patient (0.9%) low probability, 74 patients (66.1%) intermediate probability and 37 patients (33%) high probability. Spiral computerized tomography results of the patients were revealed; 57 patients the main pulmonary artery embolism, 50 patients segmental pulmonary embolism and 44 patients subsegmental pulmonary embolism. In the treatment of patients; heparin infusion (42.9%), enoxaparine sodium (52.7%), varfarin (26.8%) and TPA (3.6%) were used.

Conclusion: In spite of improvements in diagnosis and treatment methods, pulmonary embolism diagnosis is still a problem. The first step to diagnosis in patients with risk factors begin to suspect. We think that; PTE must be emphasized in the educative procedures of Emergency Department (ED), and selected scoring systems should be used in practice.

Keywords: pulmonary embolism, diagnosis, treatment, demographic characteristics

P-0113 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Name of ghost stroke

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Objective: Reaching a diagnosis of Todd's paralysis (post epileptic paralyses) can be crucial because the symptoms may closely resemble those of a stroke. A stroke involves an injury to a person's brain due to oxygen deprivation after bleeding or the blockage of a person's artery. The two diagnoses are quite different, making a clear diagnosis very important. In literature there has been cases misdiagnosed by stroke and given thrombolytic. We present a patient had seizure and diagnosed by Todd paralysis.

Case: A 38-year-old female patient with the history of epilepsy, who suffered from epileptic seizure for 3 times, was admitted to the emergency room. Her medical examination revealed that she had mild paralysis at left side of her body. The tone was normal and the reflexes were slow. She had minimal sensory deficit and noticeable numbness. Other system examinations were normal. There were no abnormal hematologic and biochemical findings. Brain CT and Brain MR Scans showed no abnormality. Patient was referred to the neurology consultation and diagnosed with Todd paralysis. After 24 hours follows patients discharged to the emergency service without any neurologic deficit.

Conclusion: Todd's paralysis is a form of neurological condition people with epilepsy experience after having a seizure. It involves a brief period of paralysis that can be partial or complete, but commonly happens on just one side of their body. The paralysis may last from an hour and a half to thirty-six hours. The average period of time for Todd's paralysis is fifteen hours – after which it resolves entirely. In general, Todd's paralysis can be easily diagnosed when it happens after a person has a documented seizure. Quick resolution of the symptoms of Todd's paralysis is another means of distinguishing between it and a stroke. When a diagnosis remains unclear tests can be run, to include an EEG, test that records information about the person's brain electrical activity. There is no particular treatment needed for Todd's paralysis itself. The persons should rest as comfortably as they possibly can until the symptoms of paralysis disappear. All patients who comes emergency room with have paralysis is not only stroke. Don't forget Todd's paralysis.

Keywords: Todd's paralysis, Stroke, Emergency medicine



POSTER BİLDİRİLER

P-0114 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Computer tomography image of bilateral humpton hump in pulmonary thromboembolism

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Objective: Pulmonary thromboembolism (PE) is usually a complication of deep venous thrombosis. It should be considered as a differential diagnosis for patients who are immobilized, patients with recent surgery and cancer patients with dyspnea and tachypnea. Humpton's hump is a radiologic sign which consists of a shallow wedge-shaped opacity in the periphery of the lung with its base against the pleural surface. Though it is rarely seen, it is a classical finding of pulmonary infarction. The gold standard in the diagnosis of PE is pulmonary angiography.

Case: A 75 year old patient was admitted to the emergency department with complaints of dyspnea. He had a history of hypertension and has been bedridden for two years after a cerebrovascular accident. He has been complaining of dyspnea and swelling on his left leg for the past one week. His vital signs were: blood pressure 100/70 mmHg, pulse: 125/min, SpO₂: 87% breathing 40/min. Arterial blood gases were pH: 7.39, pO₂: 45, pCO₂: 23, SO₂: 85, HCO₃: 23, Lac: 3.

The patient's Wells score was 9, therefore he was considered as high risk for PE and a contrast based CT-pulmonary angiography was ordered. There were mass filling defects in the distal section of the right and the left main pulmonary arteries. There was also Humpton's hump sign visible in a few sections. The patient was diagnosed as PE, heparin treatment started and he was admitted to the chest disease department.

Conclusion: The clinical and physical examination findings of PE are not specific. Among the radiological signs are: pleural effusion, atelectasis, Humpton's hump, Westmark sign, dilated right ventricle and dilated pulmonary arteries. Although Humpton's hump is a definitive sign of PE, it is very rarely seen. Humpton's hump can be visualized in the x-ray as well as in the tomography.

Keywords: Computer tomography, humpton hump, pulmonary thromboembolism

P-0115 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A case of subdural haematoma with asymptomatic shift

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Objective: Acute subdural hematomas generally occur via rupturing of bridge veins linking brain superficial veins to dural sinuses. As a result, blood leaks into the space between dura mater and arachnoid mater. Venous bleedings generally stop due to intracranial pressure increase or pressure coming from the clot formed. Arterial bleedings may also result in subdural hematomas. Studies have shown that about 20-30% of subdural hematomas are of arterial origin. Subdural hematomas pose significant risks for morbidity and mortality. They are more common in old patients, alcoholics, patients with brain atrophy, trauma and intracranial aneurysm. Depending on the time of occurrence, they can be classified as acute, subacute and chronic. The ones lasting more than two weeks are called chronic subdural hematomas. Chronic subdural hematomas have insidious and slowly developing processes. Delays in diagnosis and treatment may result in bad prognosis, and subsequent deformities not only affect the patients and their families, but they also make a heavy burden on economies.

Case: Sixty seven years old female patient applied to emergency department with the complaints of mild headache and nausea. She had a head injury due to falling. She was conscious, oriented, cooperative and had a Glasgow coma score of 15. The patient had Type II Diabetes mellitus and liver cirrhosis secondary to hepatitis C. Based on physical examination, Grade 3 acid was evident in abdomen. Laboratory test values were as follows: WBC: 2.58/mm³; Hb: 11g/dl and INR: 1.58. Examinations carried out showed that she had another falling 20 days earlier, but she did not apply to any health institution since she did not have any complaints. In brain computed tomography of the patient, there was a subdural hematoma of 20 mm size at its largest locale, situated along the right frontoparietal line and a 6 mm shift secondary to it. Consultation was carried out with brain surgery and the patient was hospitalized at neurosurgery intensive care department for operation.

Conclusion: Subdural hematomas are common especially in old people after trauma, and sometimes they do not show any indication as in our case. Complaints of the patient may overlap with comorbid conditions and may make the diagnosis erroneous. Since the symptoms may be weak especially in older patients, trauma history of the patients should be questioned, and brain tomography should be ordered in suspected situations.

Keywords: subdural hematoma, shift, computed tomography

P-0116 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A rare cause of nausea-vomiting: methotrexate toxicity

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Objective: Chemoreceptor trigger zone (area postrema) is located in the base of the fourth ventricle and is one of the places where blood-brain barrier does not exist. Chemoreceptor trigger zone consists of many receptors such as dopamine receptor, opioid receptors and acetyl choline receptors. Activation of these receptors through different pathways and reasons might trigger nausea and vomiting. Events such as chemotherapy, radiation, distension or acute infections cause irritations of gastrointestinal system. Through the stimulation of enteric nerve system and vagal nerve, chemoreceptor trigger zone might cause nausea and vomiting through stimulation of serotonin receptors (5-HT₃).

Methotrexate is an antineoplastic drug, and it is an antimetabolite of folic acid. It is generally used orally and well-tolerated. It can also be used in intramuscular and intravenous ways. Neoplastic conditions are indicated in psoriasis and rheumatoid arthritis. Among the side effects are stomatitis, leukopenia, nausea and other gastrointestinal tract problems, feeling bad, fatigue-tiredness, feeling cold-trembling, fever and head swimming. Oral dose in rheumatoid arthritis is 7.5 mg once a week. Continuous administration of methotrexate is not appropriate. It needs to be monitored for its side effects. In case of excess dose, Folic acid/Leucovorin is used as antidote.

Case: Seventy one years old male patient applied to emergency department with the complaints of nausea, weakness and fatigue. No feature was evident in viral tests, physical examination and routine laboratory tests of the patient who had chronic obstructive pulmonary disease and rheumatoid arthritis in the past. Neurological and ear-nose examinations were normal. An in-depth questioning of the patient's history indicated that he had been having the weekly oral dose of methotrexate daily. He was taken under emergency medical observation, methotrexate was stopped and 1 mg/kg leucovorin was administered intravenously once every six hours. The patient was hydrated, and urine alkalization was performed. Complaints were relieved 48 hours later and the patient was discharged after an adjustment of the drug.

Conclusion: Although nausea-vomiting, tiredness and fatigue are non-specific symptoms, finding the etiology is important rather than starting symptomatic treatment for the patients applying to emergency departments with these complaints.

Keywords: methotrexate, Toxicity, nausea, vomiting

P-0117 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Hookah Poisoning

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Objective: Carbon monoxide (CO) is an odorless, tasteless, colorless, nonirritating gas formed by hydrocarbon combustion. CO binds to hemoglobin with much greater affinity than oxygen, forming carboxyhemoglobin (COHb) and resulting in impaired oxygen transport and utilization. CO can also precipitate an inflammatory cascade that results in CNS lipid peroxidation and delayed neurologic sequelae. Smoke inhalation is responsible for most inadvertent cases of CO poisoning. Other potential sources of CO include poorly functioning heating systems, improperly vented fuel-burning devices (eg, kerosene heaters, charcoal grills, gasoline-powered electrical generators, camping stoves, and motor vehicles operating in poorly ventilated areas (eg, ice rinks, warehouses, parking garages).

Case: A 30-year-old male patient was admitted to the emergency department with nasal trauma. His friends mentioned that he lost his consciousness after smoking a hookah. His vital signs were: body temperature 36.1°C; blood pressure 128/73 mmHg; and heart rate 71 beats per minute. There was one centimeter laceration over the nasal septum. General examination was within normal limits. Her blood gas analysis showed, acidosis (pH: 7.309) and high level of COHb (%29,3). Urea, creatinine, plasma glucose, liver function, urine test, troponin I were within normal limits. Electrocardiography was also normal. High flow oxygen was administered immediately and then he was transferred to hyperbaric oxygen treatment center.

Conclusion: A carboxyhemoglobin level greater than 3% in nonsmokers or greater than 10% in smokers confirms exposure to carbon monoxide. But the level does not correlate with the presence or absence of initial symptoms or with later outcomes, which may be more attributable to inflammatory aspects of poisoning than to hypoxia. Health care providers in the emergency department should consider using hyperbaric oxygen for treating poisoned patients. Hyperbaric-oxygen therapy (HBO) is defined as the breathing of 100% oxygen by patients within



POSTER PRESENTATIONS

hyperbaric chambers compressed to greater than 1.4 atm of absolute pressure. HBO may be beneficial in preventing the late neurocognitive deficits associated with severe CO intoxication. If HBO is used, the available literature suggests that benefit is greatest if treatment begins as early as possible, ideally within six hours. We suggest treatment with HBO if CO level >25 percent, CO level >20 percent in pregnant patient, loss of consciousness, severe metabolic acidosis (pH <7.1), evidence of end-organ ischemia (eg, ECG changes, chest pain, altered mental status). Our patient was treated with HBO because of syncope. Hookah smoking should be kept in mind among the causative reasons of CO poisoning.

Keywords: Carbon monoxide, Carboxyhemoglobin, Hookah Poisoning

P-0118 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

An extraordinary carbonmonoxide intoxication case

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Objective: The most causes of the CO intoxication are the uncompleted burn of the carbon-based substances such as exhaust gases, coal, and natural gas, in which contains higher amounts of carbonmonoxide. The toxicity level depends on the degree of concentration and exposure. Carbonmonoxide may lead to an insidious intoxication due to its colourless, flavorless and non-irritant properties. Therefore, patient history is very crucial to prevent delay in diagnosis. Clinical findings of CO intoxication reveals a wide range from headache and nausea-vomiting to coma. Carbonmonoxide combines with hemoglobin, that results in carboxyhemoglobin(COHB) formation. Higher levels of COHB lead to tissue hypoxia, in which can cause acute neurological damage, cardiac injury, and death. Higher concentration of oxygen administration and hyperbaric oxygen treatment when required are the life-saving treatment modalities.

Case: A 70 years-old woman was admitted to the Emergency department with a focally located chest pain with no spread. The pain showed a central localization with a pressure feeling, and no spread. The patient had a history of hypertension and coronary artery disease. After monitoring, the blood pressure was measured as 160/90 mmHg; heart rate, 80/min; respiratory rate, 18/min; and body temperature, 36.1 °C. In electrocardiogram, ST depression was detected between V3 and V6. The lab values showed that WBC was 11130; Hb, 8.3 gr/dl; Platelet count, 161.000/mm³; sedimentation, 42; C-RP, 23 mg/dl; Troponin-T, 18 pg/ml; and CK-MB, 1.68 ng/ml. While the patient was taken to the ward for cardiac enzyme follow-up with the diagnosis of acute coronary syndrome, the husband of the patient was admitted to the emergency department with a complaint of headache and dizziness. The blood gas analysis of the patient's husband in which revealed a higher carboxyhemoglobin level suggested that the CO intoxication could be a diagnosis of the first patient. The blood gas analysis of the first patient showed that pH, 7.38 mmHg; pCO₂ 34.8 mmHg; pO₂ 25.7 mmHg; HCO₃ 20.3 mmol/L; COHB, 17.9 %. Higher concentration of oxygen was administered to the patient. After oxygen therapy, the chest pain of the patient was recovered and carboxyhemoglobin levels were dropped to 7.5% and 2.8%, respectively. The Troponin-T levels revealed no significant increase. The patient was discharged with full recovery.

Conclusion: Patients with carbonmonoxide intoxication may admit to the emergency departments with various complaints and symptoms. A fully detailed history can be very important for the patient and the emergency team to prevent a delay in the diagnosis of intoxications.

Keywords: Carbonmonoxide, intoxication, carboxyhemoglobin

P-0119 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Isolated oculomotor paralysis in a young patient

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Objective: Extreme falling of upper eyelid is termed ptosis. Based on the etiology, ptosis can be classified as myogenic, neurogenic, aponeurotic, mechanic, traumatic and pseudoptosis. The levator palpebrae superioris muscle, the main muscle lifting the eyelid, is stimulated by the third cranial nerve, while much less effective Müller's muscle is stimulated by sympathetic system. Consequently, ptosis as a result of paralysis of the third cranial nerve is termed real ptosis, and can generally be seen as accompanied with exotropia and horizontal diplopia symptoms. In pseudoptosis in which Müller's muscle is not functional, on the other hand, ptosis can be accompanied by miosis, enophthalmia and anhidrosis symptoms that belong to Horner's syndrome due to sympathetic nerve system dysfunction. In miosis due to the third cranial nerve, any condition that can prevent the communication in the area from nuclear complex in mesencephalon part of brain stem to muscular levator palpebra superior muscle might lead to ptosis. It can develop due to various reasons such as aneurism, trauma, tumors, multiple sclerosis, hypertension, diabetes, carotico cavernous fistulas and cavernous sinus thrombosis

Case: Thirty six years old female patient with the complaints of ptosis in right eye and headache applied to emergency department. She was conscious, oriented and cooperated (GCS= 15). She had no known disease history. In physical examination, no nuchal rigidity was determined. Blood pressure was 110/70 mmHg; WBC was 6.02; HGB was 13.55 g/dl. Light reflex was present in both eyes and eyesight was full. Ptosis was apparent in right eyelid and right pupil was mid-dilated. There was no trauma history. In brain tomography, a mass lesion of 25x23 mm major part of which was hypodense was detected in front of the mesencephalon which eroded dorsum sellae. After contrast hypophysis MRI examination, this mass was considered to be a hypophysis adenoma. The patient was consulted to brain surgery and interned to be operated.

Conclusion: Though rare, isolated the oculomotor nerve palsy is an important symptom for detection of intracranial tumors. Just like its potential as an indicator in central nervous system tumors, and helped in the diagnosis of hypophysis adenoma in the present case.

Keywords: oculomotor nerve palsy, ptosis, hypophysis adenoma

P-0120 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Rectus sheath hematoma mimicking acute abdomen

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Objective: Stomachache constitute a significant part of emergency room admissions. Rectus sheath hematoma is a condition that needs to be evaluated within this group. Rectus sheath hematoma is a non-common cause of acute abdominal pains. It occurs spontaneously or after a trauma. Rectus sheath is a large, aponeurosis-like sheath surrounding rectus abdominis and pyramidal muscles. It is made up of aponeuroses of oblique external abdominis, internal abdominis and transversus abdominis muscles. Below Linea arcuata at the back side is only fasci transversalis. Rectus abdominis muscle along with inferior and superior epigastric veins and terminal parts of last six intercostal nerves are within rectus sheath. Rectus sheath hematoma occurs via rupturing of abdominal muscle or superior and inferior epigastric veins located at the posterior boundary of rectus muscle sheath (Henzel JH). Possible risk factors are trauma, fast and sudden position changes, conditions resulting in intra-abdominal pressure increase, anticoagulant treatment, recent intra-abdominal surgical operations, chronic obstructive pulmonary disease exacerbations, coughing attacks, injections and pregnancies.

Case: Seventy four years old female patient applied to our emergency department with stomachache which started on the same day after coughing. Her pain was a continuous type along the upper and lower right quadrants. She had a previous abdominal surgery story. In abdominal examination, she had defense and rebound in upper and lower right quadrants. Laboratory test values at the admission were as follows: Hb: 12.4 g/dl; Plt: 197100; Cr: 0.9 mg/dl; INR: 0.97; Total Bilirubin: 0.7; Direct Bilirubin: 0.2. Abdominal x-ray: no ileus was observed. Patient's control Hb was 11.06 g/dl. Abdominal computed tomography (CT) was performed for etiology. Based on CT findings, a high density appearance was observed on the right side within rectus abdominis in abdominal anterior wall starting from epigastric level to symphysis pubis level in inferior. It was 9.5 by 4.5 cm dimension and was in umbilicus level in its largest place. It was interpreted to be hematoma. The patient was hospitalized after consultation with general surgery.

Conclusion: Rectus sheath hematomas could be responsible for acutely starting stomach aches. Considering the findings of the studies that two-thirds of them are women and two-thirds of them are anti-coagulant-using patients, rectus sheath hematoma should be kept in mind in patients coming to emergency departments with stomachache complaints. Inaccurate diagnoses might lead to morbidity and mortality along with unnecessary laparotomies. Appropriate clinical evaluation in emergency department is crucial and prevents unnecessary laparotomies.

Keywords: rectus sheath hematoma, mimicking, abdomen



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P-0121 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Pneumobilia: Benign Or Life-Threatening

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Objective: Pneumobilia, also known as aerobilia, is accumulation of air in the biliary tree. It is important to distinguish pneumobilia from portal venous gas, the other type of branching hepatic gas. There are many causes of pneumobilia and clinical context is often important to distinguish between these. Also both entities can be due to benign or life-threatening conditions, but the list of potential causes is different for each. Mesenteric ischemia accounts for approximately % 50 of cases of portal venous air, but is not associated with pneumobilia. Portal venous air is a late and ominous finding of mesenteric ischemia, distinguishing air in the portal venous system from pneumobilia may alert the emergency physician to the diagnosis of mesenteric ischemia.

Case: A 87-year-old man presented to the Emergency Department (ED) with dyspnea and cough after dinner. He was living in nursing home. His friends mentioned that decreased urine output in two days. The patient had a history of Type II diabetes, Alzheimer's disease, hypertension, congestive heart failure. Her vital signs were: body temperature 36,3°C; blood pressure 96/52 mmHg; respiratory rate 40 per minute and heart rate 133 beats per minute. General examination was within normal limits.. Her laboratory results showed, anaemia (10,1 g/dL; normal range [NR]: 12-18), leukocytosis (23400 K/uL; NR: 4800-10800), normal thrombocyt (K/uL; NR: 130-400) and a high level of urea, creatinine (2,55 mg/dL and 50,3 mg/dL) in blood serum. CT scan of the thorax and abdomen was obtained and revealed pneumonia and pneumobilia. There was no sign of emphysematous cholecystitis. Patient was transferred ICU.

Conclusion: The first distinction that must be made is between biliary air and portal venous air when air in liver was showed. Pneumobilia is typically seen as linear branching air within the liver most prominent in central large calibre ducts as flow of bile pushes gas toward the hilum. Air bubbles are typically less than 2 mm in width. Portal venous air may extend to within 2 cm of the liver capsule, whereas pneumobilia usually does not. Emphysematous cholecystitis is distinguished from other causes of pneumobilia based on the appearance of gas in the gall bladder lumen, wall and pericholecystic soft tissue. Emphysematous cholecystitis is an uncommon variant of acute cholecystitis with a higher mortality rate. The incidence is higher in men and diabetics. The other most common causes of pneumobilia are biliary-enteric fistulae, biliary-enteric surgical anastomosis and ERCP with sphincterotomy.

Keywords: aerobilia, biliary air, pneumobilia

P-0122 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Isn't it meningitis?

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Objective: Cerebral vein thrombosis (CVT) is a type of stroke which is less common than other types of stroke but can be more challenging to diagnose. The most frequent predisposing factors are prothrombotic conditions, oral contraceptives, malignancy, infection, pregnancy and the puerperium. Although headache is the most frequent symptom of CVT patients may have highly variable clinical presentations.

Case: A 23-year-old female patient was admitted to the emergency department with complains of altered mentation and fever. Her parents mentioned that colonoscopy and biopsy has been performed 20 days ago because of anemia (4.7 g/dL) and diarrhea. Colonoscopy reported pancolitis. Four units of packed red blood cells were transfused three weeks ago. Her vital signs were: body temperature 38.1°C; blood pressure 130/70 mmHg; and heart rate 91 beats per minute. General examination was within normal limits. There was neck stiffness on neurological examination. Other systemic examination was within normal limits. Her laboratory results showed, anaemia (7,5 g/dL; normal range [NR]: 12-18), leukocytosis (16100 K/uL; NR: 4800-10800), thrombocytosis (493 K/uL; NR: 130-400), negative beta-hCG (<=1,2 mIU/mL) and a high level of C-reactive protein 5,36 mg/dL (NR: 0-0,5) in blood serum. Urea, creatinine, plasma glucose, liver function tests, urine tests were within normal limit. Cranial computed tomography (CT) scan revealed irregular hyperdense lesions in interhemispheric fissure, occipital region, and right tentorium. The cerebral paranchyme was mildly edematous. Therefore, we strongly suspected a case of cerebral venous sinus thrombosis and MR venography was performed. MR venography showed thrombus in the left sigmoid sinus. She was admitted and treated conservatively without neurological sequela.

Conclusion: While high-quality epidemiologic studies of CVT are lacking, the available data suggest that CVT is a very rare entity. CVT is more common in women than men, with a female to male ratio of 3:1. Also women with CVT are generally younger than men (mean age 34 years for women and 42 years for men). Cranial CT is normal in %30 of CVT cases, and most of the findings are nonspecific. MR venography is useful for demonstrating absence of flow in cerebral venous sinuses. Disturbances of consciousness and cognitive dysfunction, such as delirium, apathy or seizures, can be present in severe cases of CVT. Emergency physician should remember CVT as a possible diagnosis in patients presented with altered mental status.

Keywords: Cerebral vein thrombosis, meningitis, MR venography

P-0123 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Leptospirosis

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Objective: Leptospirosis caused by leptospira interrogans is an acute, febrile, zoonotic disease of worldwide distribution. Humans become infected by direct or indirect contact with infected animals. Outbreaks of leptospirosis have occurred many times following flood events in different part of the world especially in India, Latin America and South-East Asia.

Case: 56 year old male patient to the emergency room was admitted with fever and diffuse joint pain. In the story the patient's work on the ship and go on a journey 10 months ago was understood. He has visited Ukraine, Guinea, France, Libya, Israel, the Netherlands and Croatia. Patients have stayed in Guinea two months. The patient had joint pain and fatigue since two months. Patient was clean mouse droppings on board with bare hands before 10 day. During this period, the patient had a cut on her leg. He had bleeding in the leg section. Patient had been fever, nausea and weakness since 6 day. Physical examination, blood pressure 120/60, pulse 96/dk, fever 38.9, GCS 15 was observed. The patient was conscious and cooperative, oriented, patients had no evidence of meningeal irritation. patient was icteric sclera and skin. Patient had conjunctival hemorrhage. Abdominal examination was normal. On examination, the patient had not lymphadenopathy and splenomegaly. There are hepatomegaly, traube open, no acid in percussion examination, normoaktif bowel sounds. At the posterior left tibia had an inch linear scar. Other physical examination was normal. examinations of patients in lab experiments: leukocytosis, thrombocytopenia, urea 129mg/dl, creatinine 3.85mg/dl, ALT 90 U / L, AST 111 U / L, creatine kinase 1328 U / L, amylase 589 U / L, lipase 411 U / L, total bilirubin 10.66 mg / dl, sodium 128meq / l, CRP 15.7 were absorbed. Department of Infectious consultation was requested. USG revealed hepatic steatosis. The patient was admitted to the department of infectious with a preliminary diagnosis of leptospirosis. Due to contact with mouse droppings thought leptospirosis patients. The patient was started ampicillin. During follow-up clinic remitted patients were discharged with ampicillin. A week later, the patient polyclinic control have been proposed.

Conclusion: Leptospirosis is a water-borne disease and can often be overlooked, it should be kept in mind especially for patients presenting with fever and multi-organ involvement.

Keywords: Leptospirosis, febrile, zoonotic

P-0124 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Pulmonary Embolism Due to Isotretinoin: A Case Report

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Objective: Isotretinoin is a powerful drug derived from vitamin A and is often used for the treatment of inflammatory and nodulocystic acne lesions (6). As well as serious side effects, such as, teratogenic effects, hepatitis, intracranial pressure, hypertriglyceridemia, arthralgia, myalgia, hyperostosis and night blindness, as well as occasionally life threatening side effects such as pulmonary embolism may occur. In this report we present a case of pulmonary embolism which we thought to be due to the use of isotretinoin in a young patient.

Case: A twenty-six year old male patient admitted to the emergency department with complaints of shortness of breath, cough, and chest pain on the right side. The patient told that these complaints were lasting for the last 3 days and exacerbated before he admitted to the emergency department. In physical examination the patient's arterial blood pressure: 110/70 mm / Hg, pulse 110 beats / minute, fever: 36.1 °C, the saturation was 98%. Lung sounds were decreased on both sides and there were significant difference in diameter between left and right legs. Other physical examination findings were normal. In patient's history, he had no pathologies and he had been using isotretinoin for 15 days. In doppler ultrasonography examination intraluminal hypoechoic thrombi in proximal of the popliteal vein in VSM under the knee level and intraluminal isoechoic thrombi in VSP were detected. In contrast enhanced computed tomography pulmonary embolism in the right lung was observed and the patient was hospitalized in chest diseases clinic.

Conclusion: It should be kept in mind that pulmonary embolism is a rare but life threatening complication among several complications in patients using isotretinoin.

Keywords: Isotretinoin, Deep vein thrombosis, Shortness of breath, Pulmonary embolism



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P-0125 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A rare pneumonia in adults: round pneumonia

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Objective: Round pneumonia, mostly in the form of consolidation on chest radiography, round pneumonia occurring in children. Is rarely seen in adults. S. pneumoniae is the pathogenic microorganism commonly, other bacteria or viruses may also play a role. Generally, responding well to antibiotic treatment, sometimes also heals spontaneously. Importance of clinical and radiological lung cancer is caused by mixing with. Determined in an adult patient treated by antibiotics and round the pneumonia cases, we offer.

Case: Sixty-five years old male patient to the emergency room, coughing, fatigue, chills and with chest pain was admitted. On admission, blood pressure 140/100 mmHg, heart rate 105 beats/min, body temperature 38.60C, oxygen saturation 93% was that. Well general condition, clear consciousness, orientation and cooperation was complete. On physical examination, bilateral basal lung crackles heard in crepitan otherwise normal. There was in a week of the patient's current complaints. Similar complaints have been two months ago and have received oral antibiotic treatment. If complaints recovered, said it was not necessary to come. In his history of hypertension, congestive heart failure and had a history of coronary artery bypass grafting. Patients complete blood count, biochemistry and cardiac enzymes were measured, as well as chest x-ray with electrocardiography (ECG) were taken. There was nonspecific ST-T changes on ECG. In patients taking under observation, analgesic, antipyretic and diuretic were performed. Chest X-ray, right in the middle zone circumscribed round opacities were detected. Laboratory values of leukocytes 12,500 x10³/µL, urea 50 mg/dL, creatinine 1.6 mg/dl otherwise normal. For further evaluation in patients with thoracic computed tomography was taken. Tomography, peripheral masses in the middle lobe of the right lung was found, which accordance with the appearance. The patient was consulted with chest disease. Recommendations to the patients with chest disease, ampicillin sulbactam was prescribed. Coming to biopsy after a week by saying he was discharged. A week later, the patients admitted for biopsy of lesions had completely disappeared. It was learned that the remains of any complaints. The patient was considered as round pneumonia.

Conclusion: Round pneumonia patients to the emergency room, fever, chest pain, cough and shortness of breath usually present with complaints. Some patients may have no clinical symptoms. These complaints of patients admitted with chest x-ray in detecting opacity round, as a priority, round pneumonia should be considered. Further investigation and unnecessary invasive procedures will prevent.

Keywords: adult, round pneumonia, emergency department

P-0126 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Co-occurrence of acute coronary syndrome and stroke: Trousseau's syndrome

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Objective: In 1865, Trousseau remarked that there was a possibility for an unforeseen or mobile thrombophlebitis to be a sign of an occult visceral malignancy. Trousseau's syndrome is often a comorbidity of mucin-positive carcinomas in patients who have cancer and it includes chronic disseminated intravascular coagulopathy associated with microangiopathy, verrucous endocarditis and arterial emboli.

Case: 86 year old male patient came to our emergency room with a complaint of weakness in the right arm and difficulty of speaking. His general condition was good and his consciousness was clear, cooperative and oriented. There were in his history DM and CVD. His physical examination revealed 2/5 muscle power in the right arm, 5/5 muscle power in the left arm and difficulty of speech. The patient's complaints had started 8 hours ago. His systemic examination showed that his fever was 37.2, his pulse was 98 and his blood pressure was 120/80. His 12 derivation ECG showed normal sinus rhythm and ST depression at D2 D3 aVF. His laboratory results were as follows: wbc: 6.43, hb: 12.7, platelet 160, BUN: 28.60, creatinin: 1 and INR: 1.31. His computerized tomography did not show any specifications. His MR diffusion showed linear diffusion limitations on the left postcentral gyrus area and lacunar diffusion limitations on the right+left posterior cerebral artery area with lacuna large scale diffusion limitation on the left cerebral area. The patient's ECG showed ischemia, thus his cardiac markers were checked. The results were as follows: CK:148, CKMB:30, Troponin I: 11,537. Other laboratory and genetic datas were normal. Neurology department recommended 300 mg acetylsalicylic acid and the cardiology department recommended clopidogrel hydrogen sulfate, ramipril, tirmetadizine hydrochloride, isosorbide mononitrate, metoprolol and enoxaparin sodium treatment. His ECO showed that his EF was 55%, his septum basal was hypokinetic, his valves were degenerative and right cavities were dilated. The patient who was hospitalized in the neurology service was discharged on the ninth day.

Conclusion: 1. Since patients who have malignancy history have a higher possibility of developing acute thrombus, these patients should be checked with more frequent intervals.

2. Physicians should be alert for secondary ischemia in cancer patients presenting ischemic manifestations such as acute MI or acute stroke.

3. Patients who have malignancy should have their systemic examination in the emergency services after their detailed history is taken and it should be taken into consideration that the patient's clinic can get worse at the follow-up.

Keywords: emergency service, malignancy, trousseau's syndrome

P-0127 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A case of pulmonary embolism after ophthalmic surgery

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Objective: Pulmonary embolism is one of the emergency cases that require early diagnosis and treatment. Risk factors include malignancy, major operations and immobilization. We wanted to draw attention to a case of pulmonary embolism observed following phacoemulsification surgery that is considered as a minor operation and that may be a cause of immobilization in elderly patients due to recession of visual capacity.

Case: 83-year old female patient suffered dyspnea and chest pain followed by loss of consciousness. Patient was hospitalized by 112 to the emergency department in an arrested state. She responded to CPR applied for 5 minutes. Subsequent to CPR; blood pressure:80/50mmHg, heart rate:110/min, fever: 35.8°C. ECG showed no abnormality other than the right branch block. ECHO was applied. Left ventricular mobility was reported as normal and 2nd degree tricuspid regurgitation was reported as PAB:45mmHg. The anamnesis of the patient revealed no particularities other than HT. When the medical records were considered further, it was revealed that the patient had undergone cataract surgery 5 days prior. Thoracic and cerebral BT of the patient were taken. Observation was concordant with embolism in the left main pulmonary artery. Thrombolytic treatment of the patient was started. Patient who had repetitive arrests during follow-ups, failed to respond to the final CPR and was considered as exitus.

Conclusion: We should not undermine the risk of embolism at eye surgeries that are considered as minor operations. We should suggest prophylaxis for such patients prone to early mobilization and thrombus.

Keywords: Pulmonary embolism, ophthalmic surgery, minor operations

P-0128 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Women have headache more frequently

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Objective: The prevalence of headache in society reaches 90%. Together with many other diseases or alone (primary), headache constitutes a significant part of emergency service applications. The International Headache Association has classified the headache into 14 main divisions and numerous sub-divisions. By diagnosing the life-threatening headaches in emergency services, other headaches are approached from symptomatic aspect.

Materials-Methods: The epidemiologic changes in patients who applied to emergency service for headache have been investigated. They have been split into 2 groups as Ambulatory (green) and Observation-required (yellow) groups, and the difference between the groups has been examined. This retrospective study involves the patients having headache complaint who applied to Emergency Service of Taksim GOP Education and Training Hospital between 01.01.2014 and 03.31.2014. The demographic characteristics and the application zones in emergency service were examined.

Results: 1809 patients who applied with headache to emergency service were involved in this study. Of the cases, 1228 (68%) were female and 581 (32%) were male. 1247 (69%) patients have applied to green zone and 562 (31%) patients have applied to yellow zone. Of the patients who applied to emergency service in same dates, 42154 (54%) were female and 36235 (46%) were male.



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were male.

Conclusion: In our study, we found that the rate of women applying to emergency service with headache complaint is higher, in harmony with the literature. Also, the majority of the headache of these patients were not requiring emergency treatment, and they were examined in green zone.

Keywords: Emergency medicine, headache, Epidemiology

P-0129 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Does Allergic Reactions Are Common In Women Than Men?

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Objective: Allergic reactions are encountered frequently in emergency department (ED) will also cause life threatening diseases takes place within. In this study; Gazi Osman Paşa Taksim Training and Research Hospital Emergency Department of patients admitted with a diagnosis of an allergic reaction to epidemiological analysis is intended.

Materials-Methods: The study is a retrospective study; we have analyzed the patients admitted between 01.01.2014-04.04.2014. Patients' age, sex, the time of admission to the ED were investigated.

Results: In the study 392 cases were included; 55.8%(219 cases) of them were female and 44.2%(173 cases) were found to be male. The mean age of the patients was 39. While men mean age of case was 41 and the average age of the women was 37. Patients admitted to the ED from 08:00 to 16:00 were 36.73%(144 cases); between the hours of 16:00-00:00 were 40.30%(158 cases) and between the hours 00:00 to 08:00 were 22.95%(90 cases)

Conclusion: ED patients presenting with allergy should be considered in patients constitute a group. Our study examined 392; women constitute the majority of cases. However, clinical studies is that there is not a relationship between gender and allergic reactions. Female patients admitted to the ED of the multitude of reasons stems from the sheer number of female patients. Allergic reactions of the patients coming to the ED at hospital arrival times; arrival times of the patients coming to the ED with were similar. Male-female difference in age between the patients with allergic reactions were not significant.

Keywords: emergency medicine, Allergic Reaction, gender

P-0130 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Demographic Review Of Cases Presenting To The ED With An Overdose Of Alcohol Intake

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Objective: This descriptive study; affected by alcohol intake by determining the demographic and clinical characteristics of the patients, and to compare it with similar studies aimed to contribute to measures to be taken.

Materials-Methods: GOP Taksim Training and Research Hospital emergency department between 10/26/2013 and 04/04/2014 44 patients admitted for alcohol intake were examined retrospectively.

Results: Of the patients 37 (81.4%) were male, seven percent (15.9%) were female and the mean age of the group was found to be 34.93. Of all cases 50% of the weekday and weekend to be admitted to the emergency department revealed that equal distribution. 24 of the cases (54.54%) percent from 24 hours before midnight, while 20 (45.45%) have 24 hours' skin was then admitted to the emergency. 3 patients (6.81%) percent of the sale of alcohol is prohibited under the age of 18 groups. 112 emergency ambulance to the emergency room with acceptance rate of 45.45%, while 54.54% of the patients admitted outpatients' roll. 2 of the patients admitted to the emergency department (4.54%) patients who were referred to another health care provider, and again 2(4.54%) patients in our hospital ICU what was hospitalized. The remaining 90.9% were discharged from the ED parts.

Conclusion: Acute alcohol intoxication due to high amounts of alcohol intake is a life-threatening condition. In this case, the patient behavioral, cardiac, gastrointestinal, pulmonary, neurologic and metabolic disorders cause. Acute alcohol intoxication primary aim of the treatment is to stabilize the patient's clinical condition and to accelerate the elimination of alcohol. In cases of patients required admission to the intensive care unit should be considered. Under the age of 18 pediatric patients presenting with alcohol consumption physician should be consulted. All cases of alcohol treatment centers to redirect after discharge is required.

Keywords: Emergency Medicine, over dose, alcohol

P-0131 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Left Flank Pain Caused by Lung Hydatid Cyst

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Objective: Hydatid cyst is an infestation which caused by echinococcus. It is frequent health problem in endemic areas dealing with livestock. It is mostly seen in liver and lung is the second most frequently organ with %30 percent. Signs and symptoms depends localization of cyst. Small and unruptured cysts are mostly asymptomatic. In lung hydatid cyst cough is the most frequent symptom. Abdominal pain may be seen in some case which cyst has contiguity with diaphragma. In this case we discussed a patient who has lung hydatid cyst and left flank pain with no other symptom.

Case: 47 years old female patient applied to emergency room with left flank pain. She had flank pain for three days and she didn't have any other complaint. Her pain was blunt and severity of pain did not change with time. In the first evaluation her general condition was good, she was conscious, cooperated and oriented. In physical examination; her vital signs were in the normal range, abdominal examination was normal, there was no tenderness, rebound and defense. In respiratory system examination, respiratory sounds were decreased in lower part of left side. Other system examinations were normal. Urine test, CBC, cardiac markers, liver function tests, kidney function tests, EKG, lung x-ray and urinary system USG were applied for diagnosis. In her lung x-ray a smooth-edged, round opacity was seen in the left lower lobe of the lung. Other tests were normal other than little elevation in liver enzymes. Thorax CT was applied for diagnosis. In thorax CT smooth edged, liquid density lesion with hyperdense wall was seen. In lower section of thorax CT and in hepatobiliary USG cysts in liver were also detected. The patient hospitalized by thorax surgery for operation with diagnosis of lung hydatid cyst.

Conclusion: Hydatid cyst is frequent in Turkey especially areas which livestock is a common deal. It is mostly seen in liver. It may be seen in lung with less frequency. Symptoms of lung hydatid cyst depends localization. Dry cough is the most frequent symptom. The big cyst can cause pressure signs and centrally localized cyst can cause bloody sputum. Peripheral localized cyst can cause pleuritic chest pain and dyspnea. Abdominal pain may be seen if the cyst has a contact with diaphragma. In this case we think left flank pain of patient was caused by cyst which has contiguity with diaphragma. Lung pathologies must be considered in the evaluation of flank pain and lung x-ray must be applied for patients who have flank pain.

Keywords: hydatid cyst, flank pain, lung

P-0132 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Rare Case of Headache: SUNCT Syndrome

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Objective: SUNCT (Short-lasting Unilateral Neuralgiform headache attacks with Conjunctival injection and Tearing) was first described by Sjaastad in 1978 and included by Headache Classification Subcommittee of the International Headache Society in the primary headaches, among cluster headaches and other trigeminal autonomic headaches group. Accordingly, the diagnostic criteria are as follows:

- "A. At least 20 attacks fulfilling criteria B-D
- B. Attacks of unilateral orbital, supraorbital or temporal stabbing or pulsating pain lasting 5-240 seconds
- C. Pain is accompanied by ipsilateral conjunctival injection and lacrimation
- D. Attacks occur with a frequency from 3 to 200 per day
- E. Not attributed to another disorder"

We herein report this rare headache etiology.

Case: A patient admitted to our emergency department with headache for 1 year. The headache occurred at night and had a pulsatile character. It lasted 3 minutes and repeated 200 times a day. It was localized to the left facial side. The patient additionally had lacrimation in left eye, nasal discharge, and sweating. The pain was resistant to painkillers. The patient experienced



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fascial paralysis 3 years ago. On physical examination the patient had a pulse rate of 84 bpm, a blood pressure of 120/80 mmHg, an edematous left eyelid, a hyperemic left eye and left cheek. The patient had a visual pain score of 7-8. Other systems were normal on physical examination. Cranial brain tomography and angiography were normal. Laboratory results were also normal. The patient was considered to have SUNCT syndrome and was treated with gabapentin and lamotrigine.

Conclusion: SUNCT syndrome should be considered and appropriate therapy should be begun in patients with pulsatile pain along the trigeminal nerve tract, lacrimation, and at least 20 painful attacks.

Keywords: headache, lacrimation, pulsatile pain, SUNCT syndrome

P-0133 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Anaphylactic Reaction due to Cefuroxim Axetil: A Case Report

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Objective: Anaphylaxis is a rapid-onset systemic hypersensitivity reaction caused by mediators that are released from mast cells and basophils as a result of IgE-mediated immunological reaction. The same clinical scenario is called "anaphylactoid reaction" when it occurs by non IgE-related mechanisms. In addition to drugs and agents used in diagnostic tests, food and bee sting are the most common causes of anaphylaxis. In two of three largest series in the literature food and drugs ranked top as a cause of anaphylactic reactions. Among drugs, antibiotics and nonsteroidal anti-inflammatory drugs are the most common agents responsible from anaphylaxis while nut and shellfish rank top among food.

Case: A 42-year-old woman presented with difficulty breathing and altered mental status after being injected Cefuroxim Axetil 750 from intramuscular route at an outside healthcare facility. As an emergency treatment, she was administered epinephrine 1 ml(1/1000) I.V, diphenhydramine 50 mg I.V, and methyl prednisolone 100 mg I.V. She was unresponsive to treatment. She was intubated and sent to our institution for further workup and treatment. She had no history of disease or drug allergy. On physical examination she was intubated, unconscious. Her blood pressure was 70/55 mmHg, pulse rate was 52 bpm, GCS was 3. Her pupils were bilaterally dilated. Her laboratory parameters were as follows: Hb: 17.8 gr/dL, Hct: 58%, Leucocyte count: 31.6 K/uL, thrombocyte count: 112 K/uL, glucose: 67 mg/dL, urea: 51 mg/dL, creatinine: 2.31 mg/dL, Na: 142 mg/dL, K: 5.7 mg/dL, Ca: 7.7 mg/dL, Albumin: 2.4 gr/dL, ALT: 1159 U/L, AST: 2131 U/L, LDH: 1995 U/L, APTT: 155.7 sec, PT: 95.8 sec, INR: 7.49, Fibrinogen: 179 mg/dL. Arterial blood gas analysis revealed the following Results: pH: 7.2, PO2: 94.4, PCO2: 32.8, HCO3: 13.6, SO2: 94.4%. The patient was admitted to intensive care unit and connected to mechanical ventilator. She had metabolic acidosis and hypotension. Bicarbonate and dopamin infusion were begun. She died on second day of admission.

Conclusion: Patients should be questioned about drug allergy before prescribing drugs with a potential to cause anaphylaxis. The first dose of such drugs should be administered at healthcare facilities that are capable of intervening should an anaphylactic reaction occur. The most important point for the management of anaphylaxis is recognition of the life-saving role of epinephrine administered at an adequate dose via an appropriate route.

Keywords: Anaphylaxis, cefuroxim axetil, drug reaction

P-0134 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Report Of A Rare Case: Thrombotic Thrombocytopenic Purpura Presenting To Emergency Department With Acute Myocardial Infarction

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Objective: Thrombotic thrombocytopenic purpura (TTP) is rare disease characterized with fever, thrombocytopenia, microangiopathic hemolytic anemia, renal failure, and fluctuating neurologic impairment. TTP can develop secondary to bacterial or viral infections, autoimmune disorders, malignancy, stem cell trans-plantation, or drugs. In this report we present a male patient who admitted to emergency department with acute myocardial infarction (AMI) and was diagnosed with TTP.

Case: A 47-year-old man admitted to emergency department with severe abdominal pain starting from epigastric area and radiating to back, fatigue, and nausea for 4 hours added on top of severe headache and ecchymotic lesions on entire body for around 3 days. On physical examination his general condition was moderate and he was conscious and cooperating. His blood pressure was 90/55 mmHg, pulse rate 58 bpm, and body temperature 38.3 C. Laboratory examinations were as follows: Hb: 9.6 gr/dL, Hct: 29%, Leucocyte count: 6.4 K/uL, thrombocyte count: 29.7 K/uL, glucose: 90 mg/dL, urea: 67 mg/dL, creatinine: 2.1 mg/dL, Na: 136 mg/dL, K: 4.1 mg/dL, Ca: 9.1 mg/dL, Albumin: 3.5 gr/dL, ALT: 45 U/L, AST: 79 U/L, ALP: 48 U/L, GGT: 26 U/L, Total Bilirubin: 2.5(0.2-1) mg/dL, Indirect Bilirubin: 1.7(0.2-0.7), LDH: 1259 U/L, Direct Coombs: negative, sedim: 26mm/h, CRP: 4.5 mg/dL, APTT: 24.9 sec, PT: 12.5 sec, INR: 1.1, Fibrinogen: 179 mg/dL, Troponin I: 0.16(0-0.04), CK-MB: 1.9(0.6-6.3). An ECG revealed ST elevation in inferior leads. The patient was admitted to coronary care unit with inferior AMI. Additionally, TTP was also considered in the patient owing to thrombocytopenia, elevated LDH level, fragmented erythrocytes on peripheral smear, renal dysfunction, and severe headache as neurological sign. Plasmapheresis was carried out for treatment of TTP. After a total 10 courses of plasmapheresis the patient exhibited improvement in overall condition, a rise in thrombocyte count, a fall in LDH level, and improved renal function tests.

Conclusion: TTP is a serious, life-threatening condition characterized by thrombotic complications, which should be considered in the differential diagnosis of all diseases with thrombosis including AMI.

Keywords: Thrombotic thrombocytopenic purpura, thrombocytopenia, myocardial infarction

P-0135 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Case Report: Neuroleptic Malignant Syndrome Due to Quetiapine

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Objective: Neuroleptic malignant syndrome (NMS) is a catatonic-like condition that is usually characterized by extrapyramidal signs, blood pressure alterations, altered consciousness, and hyperreflexia. In this paper we present a male patient who presented to our emergency department with fever and altered consciousness and was diagnosed with NMS.

Case: A 37-year-old man who was under follow-up for schizophrenia and had been using Quetiapine for 2 years presented to emergency department with fever, altered consciousness, and stiffening of his body for a couple of days. His general status was moderate and he was confused. His blood pressure was 100/75 mmHg, pulse rate 118 bpm, and body temperature 39.7 °C. All extremities were rigid. Laboratory results were as follows: Hb: 13.0 gr/dL, Hct: 38.2%, leucocyte count: 14470 k/μL, Glucose: 90 mg/dL, urea: 18 mg/dL, creatinine: 0.88 mg/dL, Na: 136 mg/dL, K: 4.1 mg/dL, Ca: 9.1 mg/dL, Cl: 102 mg/dL, Mg: 1.2 mg/dL, Albumin: 3.5 gr/dL, CPK: 4267 mg/dL, ALT: 45 mg/dL, AST: 79 mg/dL, ALP: 48 mg/dL, GGT: 26 mg/dL, T-bil: 0.8 mg/dL, and LDH: 680 mg/dL, sedim: 16mm/h, CRP: 1.02 mg/dL. His urinalysis was normal, hepatitis markers were negative, and arterial blood gas analysis was free of any abnormality. One of the most commonly used diagnostic criteria sets is DSM-IV (the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition). According to DSM-IV, NMS diagnosis is made by both of the major criteria (muscle rigidity and fever) or at least two of the minor criteria of sweating, dysphagia, shivering, incontinence, altered mental status, mutism, tachycardia, high or variable blood pressure, leukocytosis, and laboratory findings indicative of muscle injury such as CPK elevation. Our patient had a history of Quetiapine use and two major criteria (muscle rigidity, fever) and four minor criteria (altered mental status, tachycardia, leucocytosis, CPK elevation). We therefore made the diagnosis of NMS. The patient was begun on bromocriptine 20 mg/day (Parlodel 4x5 mg) and hydration. On follow-up his general condition improved and vital signs were stabilized. He was discharged on 9th day of admission.

Conclusion: NMS is an important clinical condition that develops as a result of antipsychotic therapy. Past history and use of certain drugs should be thoroughly questioned for its diagnosis. NMS should be remembered in patients who take antipsychotic drugs and present with fever, altered mental status, muscle rigidity, and CPK elevation.

Keywords: altered mental status, neuroleptic malignant syndrome, quetiapine

P-0136 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Emergency Department Visits of Critically Ill Patients and Evaluation of Intensive Care Unit Admissions

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Objective: The number of critically ill, elderly patients with multiple comorbidities and oncological problems who present to Emergency department (ED) are growing and also, increased frequency and duration of critically ill patients cause deadlock for ED crowding. The aim of this study was to determine priority of critically ill patients and the appropriate critical care area to admit for these patients.

Materials-Methods: The study was a prospective, observational study conducted at Hacettepe University Emergency Department, from 15th April to 14th September 2013. Over 18 years old patients who presented to the ED and consultation for intensive care unit (ICU) were eligible for inclusion in this study.

All the patients were divided four priority group by The Society of Critical Care Medicine criteria. Priority 1 group include unstable patients and most benefit from ICU, priority 2 group patients require intensive monitoring and may need intervention, priority 3 group include unstable patients with reduce likelihood of recovery because of their chronic illness. Priority 4 patients are



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not appropriate for ICU that means "too well or sick for ICU".

Results: 400 patients (2.86% of ED visits) were consulted for ICU admission from ED. Inappropriate consultations for ICU admissions were 8% for priority model. Admissions of critically ill patients were 269 (67.3%) to ICU, 48 (12%) to palliative service, and 22 (5.4%) to acute care services. Also, inappropriate admissions for ICU were 11.9% for priority model. 61 patients (15.3%) had to be treated in the ED because admissions to other departments were not possible. Patients who were treated in the ED had higher scores compared to the patients who were admitted to ICUs, for ages (mean 67 (28 – 97) v 60 (18 – 94)), priority model 3 (82% v 11.9%), sepsis (49.2% v 5.9%), diagnosis of pulmonary system diseases (50.8% v 14.5%), diagnosis of gastrointestinal system diseases (13.2% v 3.7%), malignancies (60.7% v 21.2%) and mortalities (75.4% v 20.4%). Mortality of patients, who were admitted to ICUs in 24-72 hours, was 2.4 times higher than the mortality of patients who were admitted in 24 hours.

Conclusion: ED physicians should be careful about critically ill patients triage and manage those patients properly for required critical care areas (ICU, acute care, palliative care unit). Hospital managements should develop policies for growing population of critically ill patients who present to EDs. Developing palliative care for homes and health centers, may help reduce ED visits and crowdings.

Keywords: Critically ill patients, emergency department crowding, intensive care unit admissions, priority model, palliative care

P-0137 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Pleural Fluid Penetration of Moxifloxacin: An Experimental Study

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Emergency department (ED) presentations of pleural-based diseases including complicated parapneumonic pleural effusion (CPPE), empyema, hemothorax and pneumothorax are common, with severity ranging from mild to life threatening. These diseases should also be considered in the differential diagnosis of all patients treated in ED for dyspnoea and chest pain that require an immediate diagnosis given the need to apply urgent and specific treatment [1,2]. The new quinolones which are derivatives of nalidixic acid and exhibit favourable-pharmacokinetic properties such as moxifloxacin show promise for empirical therapy that needs to be initiated as soon as possible. Also distribution of the antibiotics in the body as important as its specificity for disease-causing microorganisms is a critical factor in determining its therapeutic efficacy. Treatment depends on the adequate concentrations within infection sites where microorganisms reside [3]. Thus, we aim to investigate the penetration of moxifloxacin (POM) into pleural fluid (PF) using a rabbit model of empyema.

An empyema was induced via intrapleural injection of turpentine (1 mL), followed 24 h later by instillation of 5 mL *Klebsiella Pneumoniae* (ATCC 33495), *Fusobacterium Nucleatum* (ATCC 25586) and *Streptococcus Pneumoniae* (ATCC 6305) into the pleural space. After an empyema was corroborated, Moxifloxacin (25 mg/kg-1) was administered intraperitoneally. In order to determine the levels of antibiotic measured by High Performance Liquid Chromatography in pleural and blood samples were obtained serially at 8, 24, 48 and 72th hour.

POM into the PF was very good. Penetration rate of moxifloxacin (area under the curve (AUC) for PF/blood (AUCPF/AUCblood) ratio) was 0.78. Equalization time between the PF and blood concentration of moxifloxacin was slower than other antibiotics in the literature. Peak PF concentration of moxifloxacin was 0,81 µg/mL-1 and occurred 8 h after infusion and then gradually decreased. Blood concentrations were similar to pleura. Differences were found in penetration of blood and pleura. Moxifloxacin had convenient penetration to achieve therapeutic levels in the PF.

CPPE and empyema is an increasing serious problem around the world with significant morbidity and mortality. Mortalities are ranging from 10% to 20%. Despite appropriate antibiotic therapy, nearly one-third of patients necessitating subsequent surgical drainage [4]. Rapid recognition, accurate diagnosis, and definitive treatment were made by emergency physicians as first physicians who examined the patients appear to reduce morbidity and mortality as well as health care costs. Moxifloxacin is a good option for the treatment of pleural effusion such as CPPE and empyema in the emergency departments.

Keywords: Emergency, Chromatography, Moxifloxacin, Empyema, Turpentine

P-0138 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Angioedema due to Angiotensin-converting enzyme inhibitor: A Case Report and Review of The Literature

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Objective: Angiotensin-converting enzyme inhibitors (ACE-I) inhibit the action of ACE, which is the primary enzyme responsible for the conversion of angiotensin I to angiotensin II, and the degradation of bradykinin. The benefits of ACE-Is are remarkable and include the control of hypertension and positive effects on the progression of coronary artery disease, kidney injury, peripheral vascular disease, diabetes, and stroke. The first member of ACE-I, captopril was discovered in 1981. The most common adverse effects of ACE-Is are a dry non-productive cough and angioedema (respectively occurring in 15–30% and 0.1–2.2% of patients). Angioedema (AE) is defined as the deep tissue swelling under the skin and mucous membranes. It is often characterized by asymmetric non-pitting and non-pruritic swelling where mostly occurs in the perioral area, periorbital area, tongue, genital area, and extremities. It may arise immediately after the start of treatment, even after years of use. AE is a life-threatening adverse effect and usually manifests itself with the involvement of the face, tongue and lips especially middle aged woman and black race. Even though several theories have been proposed about its pathophysiology exact mechanism is still unknown.

Due to the most preferred drugs that prescribed for the treatment of hypertension and heart failure with high benefits; leads to increasing rates of AE. Herein, we aim to describe the patients with AE secondary to ACE-I use.

Case: A 56-year-old woman with diabetes mellitus was admitted to our emergency department with chest and stomach pain. She was treated with oral antidiabetic for 5 years. At presentation her vital signs were: Heart rate 80 beats/min, blood pressure 181/102 mm Hg, respiratory rate 16 breaths/min, room air oxygen saturation 97%, and temperature 36.50C. Captopril 25 mg was given sublingually. After 5 minutes she was complaint of a swelling under her tongue without involvement of the lips, soft palate, or pharynx. She was given 60 mg methylprednisolone, 45.5 mg feniramin maleat, and 40 mg famotidine i.v. Her tongue swelling stopped and her symptoms were improved during 4 h of observation. She was discharged home on same day later after resolution of the symptoms with instruction to avoid using ACE-I.

Conclusion: There is no consensus on current treatment ACE-I induced angioedema. Treatment should be aggressively because of their life-threatening and fatal cases that have been reported in the literature. No matter what the reason in the use of captopril angioedema should be noted.

Keywords: Angioedema, Angiotensin-converting enzyme inhibitor, Captopril, Emergency

P-0139 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Protamine use in dialysis patients

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Objective: Catheter occlusion and prophylaxis in the prevention of embolic events is also being treated by heparin on hemodialysis's Patients. Bleeding is the most common complication of heparin. Protamine sulfate is used in the treatment of bleeding complications. In this article we are presented efficiency protamine sulfate to bleeding in the form of leakage from the catheter

Case: 68 year old woman while receiving dialysis 3 times a week due to fistula problems, right subclavian hemodialysis catheter enters. Dialysis catheter in place after the completion of the last session in the style of the leak started bleeding and was brought to the emergency room on the bleeding does not stop. Examination of the patient on the right subclavian catheter was seen bleeding from the leak style. The patient's PT, PTT, INR tests are normal, bleeding time was long. This result was attributed to the patient to undergo hemodialysis heparin. First, the buffer was applied to leak. Despite the implementation enough buffer minimal bleeding did not stop. Slow infusion to the patient was given 5000 units IV protamine sulfate. Bleeding was controlled in a dramatic way. Being observed in the emergency department for a while, in the remaining patient was discharged on the absence of any complications

Conclusion: Bleeding complications in hemodialysis patients admitted to the emergency room and that will be the antidote of bleeding with heparin with protamine sulphate should be noted that stopped.

Keywords: heparin, protamine sulphate, bleeding



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P-0140 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A rare cause of speech disorder

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Objective: Presenting to emergency department with complaint of speech disorder is rare. Etiology includes electrolyte disturbances, cerebrovascular events such as ischemia and hemorrhage. We wanted to present a patient who had a rare cause of speech disorder.

Case: A 50-year-old male patient was admitted to the emergency room with complaints of speech disorder and cry continuing for 3-4 days. There was no history of any disease, and of drug use. The patient said that he had arrived to the neurology department with the same complaints on that day's morning. In neurology department, Diffusion MRI revealed diffusion restriction, compatible with ischemia, at left temporal region. Neurological examination and speech were observed in normal ranges in neurology department. The patient had been discharged with acetylsalicylic acid treatment and recommendations. In emergency department, his all vital signs were normal. The patient had sensory aphasia in the neurologic examination. Hemogram and biochemical analyzes were in normal ranges except hyperglycemia (876 mg / dL). There was no pathology on the control computed brain tomography and there was also no new pathology on the diffusion MRI. Undulant speech disorders was thought to be due to hyperglycemia. The patient was hospitalized to the internal medicine department with the diagnosis of new onset diabetes mellitus. Then, HbA1c was detected 13.6%. After the patient's glycaemia had been regulated, the patient's speech was improved. The patient was discharged five days later.

Conclusion: Hyperglycemia has various systemic symptoms. However, it should be kept in mind that hyperglycemic patients may also arrive to emergency department with neurologic symptoms.

Keywords: speech disorder, hyperglycemia, aphasia

P-0141 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Occult diagnosis of headache: transverse sinus thrombosis

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Objective: Headache is one of the most common complaints of patients who admitted to emergency departments. One of rarest cases among these admissions is cerebral venous thrombosis. Early diagnosis and treatment of venous thrombosis reduce mortality and morbidity.

Case: A 40-year-old male patient was admitted to emergency department suffered from headache, nausea and vomiting. These complaints were continuing for 3 days and persistent to drugs. On his past medical history, revealed asthma, diabetes mellitus and hypertension. On physical examination, his general condition was well, he was oriented and cooperated. On examination, vital signs were normal. His physical examination was normal and his biochemical blood tests were in normal ranges. Hiperatenuation on the bilateral transverse sinus was observed on computed brain tomography. On posterior of superior sagittal sinus, bilateral transverse sinus and proximal of bilateral sigmoid sinus, hypo intense appearance was detected allowing weak stream and compatible with presence of thrombus, with cerebral MR venography.

The patient was hospitalized to the neurology department. Initially, the patient was given bolus heparin, then he was treated with heparin infusion. After that, he was followed by LMWH. His symptoms' decreased and the INR level was regulated. The patient was discharged after 14 days.

Conclusion: Headache, nausea and vomiting can be observed in many different diseases. Transverse sinus thrombosis is a rare disease among these group of diseases. High clinical suspicion is the first step for the diagnoses. For the patients having headache especially long-termed and refractory to analgesia, this diagnosis should be kept in mind.

Keywords: Headache, thrombosis, sinus transversus

P-0142 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Syncope due to gabapentin: a case report

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Objective: Syncope is one of the most common reasons of presenting to emergency department. Syncope is mainly classified as cardiac and neurological syncope.

Case: A 54-year-old female patient was admitted to the emergency room with complaints of sudden onset chills, dizziness and then fainting. Patient had a history of migraine, osteoporosis and gastritis. It was reported that, her complaints had begun after receiving first dosage of Gabapentin 800 mg tablets. The patient's general condition was good in the first examination. She was conscious, oriented and cooperative. At the time of arrival her vital signs: blood pressure; 110/80 mmHg, pulse rate; 90 beats/min, body temperature; 36.1oC, sPO2; 99%. On physical examination, no pathology was detected. No significant pathology was detected in the laboratory examination and computerized brain tomography. Electrocardiography was in normal sinus rhythm. The patient was evaluated by neurology and cardiology departments. Both of these departments did not detect any pathology. It was considered that syncope was due to Gabapentin.

Conclusion: Gabapentin is especially used for neuropathic pain and fibromyalgia. Gabapentin is not tolerate easily when it is started particularly in high doses. Also the patients suffer from its neurological side effects. In the patients admitted to the emergency department with a syncope, the patients' history should be assessed in detail and the physicians should be alert about drug's side effects.

Keywords: gabapentin, syncope, side effect

P-0143 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Human Bites Can Cause Complications: Cellulite

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Objective: Human bites can cause complications ranging from slight injuries to serious infections. Approximately 10%-15% of human bite wounds become infected because of multiple factors. The bacterial inoculum of human bite wounds is rich in oral flora, containing as many as 100 million organisms per milliliter that represent as many as 190 different species. Many of these are anaerobes that flourish in the low redox environment of tartar that lies between human teeth or in areas of gingivitis. Compared with animal bites, human bites have a higher risk of infection development. These infections are often far advanced by the time they receive appropriate care. Patients often wait until infection is well established before seeking medical treatment. Wounds that are reevaluated are frequently more extensive than estimated on initial examination by the inexperienced observer and are frequently managed inadequately.

Case: A 35-years old man presented to emergency department for headache and fever 48 hours after he ran into goalkeeper during football match.

Mans teeth penetrated his scalp on frontal region of his head. His temperature was 38,5. He had got 2 cm laceration sutured with stapler and seropurulent fluid. The frontal, periorbital, periauricular part of the head were painful, swollen, red, warm and include fluctuation. No organisms were present on direct examination of a gram stain of the fluid. But marker of inflammation, C-reactive protein was 9,9 mg/dl and WBC was 16800/.

He transferred to the plastic surgery unit for wound debridement and yielded seropurulent fluid. Intravenous treatment with amoxicillin/clavulanic acid, metranidazol and gentamycin was initiated. The clinical signs of inflammation also disappeared within 48 hours. He was discharged 72 hours later with oral antibiotherapy (ko-amoksilav and metranidazol).

Conclusion: As a result, human bites remain a major health problem. These bites can cause serious infections and complications. Serious complications can be prevented by detailed assessment, proper cleansing of the wound on time and prophylactic approaches.

Keywords: human bites, cellulite, complication

P-0144 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Predicting febrile neutropenic patients at high risk in the emergency, is it possible?

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POSTER BİLDİRİLER

Objective: Febrile neutropenia is a life-threatening treatment related condition that requires urgent management in the emergency department. Recent progress in the treatment of neutropenic fever have underscored the importance of risk stratification and recommended to evaluate the predictive factors for outcomes. In this study we aimed to determine independent factors for prediction of outcomes in patients with febrile neutropenia.

Materials-Methods: From 2011 to 2013 all adult chemotherapy induced febrile neutropenic patients visited the Emergency Medicine Department were included in this study. 200 chemotherapy induced febrile neutropenic patients older than 18 years were evaluated retrospectively. Clinical data were assessed from medical records from the electronic patient record system. Upon arrival at the Emergency Department all febrile neutropenic patients gender, age, vital signs, underlying systemic diseases, laboratory tests including assessment of complete blood count, blood chemistry with differential, liver and renal function tests, blood glucose, electrolytes, protein, estimated GFR, blood cultures, C reactive protein (CRP) concentration, and radiologic examinations including a chest radiograph were evaluated. The MASCC risk index score was calculated for all patients. Outcomes were categorized as good if the patient could be discharged without any serious complications. Outcomes were categorized as poor if serious complications during hospitalization including death have occurred.

Results: Of the 200 patients, 105 (52.5%) had medical complications including 58 (29%) deaths. Five parameters emerged as independent factors for the prediction of neutropenic fever with complications in the multivariate regression analysis: platelet count $<50,000$ cells/mm³ (OR 3.933, 95% CI 1.416-10.920), serum C-reactive protein >50 mg/dl (OR 3.798, 95% CI 1.675-8.611), hypoproteinemia (OR 7.812, 95% CI 3.433-17.777), Glomerular filtration rate <90 mL/min/1.73 m² (OR 3.058, 95% CI 1.133-8.255) and MASCC risk-index score <21 (OR 3.450, 95% CI 1.528-7.789).

Conclusion: Therefore, we tried to identify simple independent factors that can predict patients who develop subsequent complications after chemotherapy induced neutropenic fever. The platelet count, CRP, protein level and GFR were shown to have a significant association with outcome. The clear advantage of these significant variables is that there is no observer variability and they can be very readily assessed on presentation. Early classification of patients into low or high risk groups, with timely and tailored empiric antimicrobial therapy can improve the prognosis in patients with febrile neutropenia.

Keywords: febrile neutropenia, chemotherapy, emergency

P-0145 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Cerebral Venous Thrombosis Following Parturition: A Case Report

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Objective: Cerebral venous thrombosis (CVT) is a rare diagnosis characterized by headache, nausea, vomiting, focal deficits, and epileptic seizures. It is associated with the use of oral contraceptives, pregnancy and the puerperium, obesity, and other diseases. Without an adequate therapy, CVT can lead to a fatal outcome and it increases importance of determination in emergency department (ED). It is aimed to emphasize CVT with this case.

Case: A 41 year old woman admitted to ED with headache that lasted three days. It is learned that she was previously healthy. Before two weeks she gave birth and it was performed epidural analgesia for labor and delivery. Her vital signs were; T/A: 120/80, PB: 67, RR: 20, Temp: 36.5. There was no pathological signs on her physical examination include neurological exam. Her laboratory tests were normal. The brain computed tomography was performed and it was seen hyperdensity on left sigmoidal sinus area. Brain MRI was showed thrombosis of superior sagittal, transverse, sigmoid sinuses and left jugular vein (Figure 1). The patient was transferred to neurology department.

Conclusion: CVT is an uncommon disease that may present as serious headache resulting from thrombosis of the cerebral sinuses and veins. Particularly, women in pregnancy or peripartum period with headache, emergency doctors should be doubtful of CVT.

Keywords: Cerebral Venous Thrombosis, headache, parturition

P-0146 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Severe metabolic alkalosis in Emergency Department, Case Report

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Objective: Chemotherapy induced nausea and vomiting (CINV) is the most common side effect of many chemotherapeutic agents. Persistent vomiting can result in serious metabolic disturbances such as metabolic alkalosis. Metabolic alkalosis has been associated with a high risk of mortality of up to 45% with a pH of 7.55 and 80% when pH is greater than 7.65. We presented a case with an "extreme" metabolic alkalosis due to persistent chemotherapy induced nausea and vomiting.

Case: A 63-year-old female woman presented to our emergency department with complaints of nausea & vomiting (N&V), decreased appetite, difficulty in eating and weakness. On admission her hemodynamic parameters were normal and had a history of over carcinoma. She received chemotherapy and her complaints (N&V) became much more severe in addition to intermittent diarrhea.

On physical examination, she was dehydrated and had increased bowel sounds. ECG revealed prolonged QT interval (QTc >470) and U-wave. Patients was accept at observation room and monitored

On admission, blood parameters were as following: CBC: Hb= 9.9, WBC=2600, platelet=309000.

Blood biochemical analysis: K=2.4, Cl=54 and ionized calcium and magnesium levels and, urine Chlorine level were decreased. Blood gas analysis were as following: pH=7.69, pCO₂=57, HCO₃=68, Cl=54, SpO₂=88%.

Our initial diagnosis was hypokalemic hypochloremic metabolic alkalosis due to prolonged persistent vomiting, which resulted in massive loss of gastric acid (HCl), and treatment of this patient was initiated with gradual replacement of Cl⁻ and K⁺ by intravenous infusion of 0.9% NaCl solution including KCl. Additionally, 5% dextrose solution infusion, ondansetron 2x8mg and metoclopramide 3x10mg intravenously were started to prevent nausea & vomiting. Calcium and magnesium were also replaced. Allopurinol was added to therapy in order to decrease uric acid level. Gradual and controlled supplementation of potassium, chloride, magnesium and calcium led to improvement of serum electrolyte levels and normalization of blood pH, consequently normalization of QTc and disappearance of U-waves in ECG over time in 5 days. Patient was discharged on sixth day of hospitalization from our ED without any complaints.

Conclusion: Prognosis of severe metabolic alkalosis (pH >7.65) is very poor and has a high mortality rate. Management of these patient need early diagnosis and comprehensive treatment in the emergency department. Severe alkalosis should keep in mind in patients with persistent N&V in emergency department.

Keywords: emergency, severe alkalosis, chemotherapy

P-0147 Resuscitation

The Platelet-Lymphocyte Ratio In Out-hospital Cardiac Arrest

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Objective: Platelets and lymphocytes are among subtypes of WBC, affected during inflammation. While megacaryopoiesis is inhibited in acute infections, thrombocytosis occurs in chronic infections. Also, number of lymphocytes decreases in acute stresses. Studies showed that platelet-lymphocyte ratio (PLR) is an independent sign of mortality in patients with cancer and non-ST myocardial infarctions. We also aimed to investigate the effect of PLR on postcardiac arrest syndromes.

Materials-Methods: The study was performed in Konya Training and Research Hospital. Patients admitted with out-of-hospital cardiac arrest and returning into spontaneous circulation were retrospectively scanned within the last one year. Demographic data, pulse rate on admission and the reasons for arrest were recorded. Twenty four-h and 14-day mortalities were followed. Statistical analyses were performed with SPSS for Windows 15.0 package. Categorical data were evaluated with the chi-square and the Fisher's exact tests, and numerical data were compared with the Mann Whitney U test due to abnormal distributions

Results: To study, total 91 patients were included. Median (interquartile range-IQR) for age was 73 (19), 48.4% (44) of patients were men. Of patients, 57.1% (52) with asystolia, 11% (10) with VF, and 31.9% (29) were admitted with pulseless electrical activity; 40.6% (37) with cardiac results and 59.4% (54) with noncardiac results were detected to become arrested. On admission, Hb, neutrophil, lymphocytes and platelets rates were determined as 12.7 (3.65) gr/dl, 8.6 (8.3), 2.8 (5.2), 208 (128) and PLR 60 (178), respectively. As to 24-h mortality, while no difference was present between demographic data and laboratory findings, PLR was found to be significantly lower (p=0.04). Additionally, cardiac-induced arrests were also found to be significantly lower, compared to the results of noncardiac arrests (39(135) and 83(243) respectively). No significant difference was seen in 14-day mortality.

Conclusion: A great number of patients returning into spontaneous circulation among out-of-hospital arrests are lost in the period of post resuscitation care after out-of-hospital cardiac arrest. New therapeutic principles targeting to decrease poor outcomes in post-cardiac arrest syndrome have been defined by medical scientific community. Especially coronary reperfusion is recommended for cardiac-induced arrests under 90 min. PLR may be a marker that can be used, especially in cardiac-induced arrests, and prospective studies performed with larger populations are needed.

Keywords: Platelet lymphocyte ratio, resuscitation, post-cardiac arrest syndrome



POSTER PRESENTATIONS

P-0148 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

The Effect Of Shock Index On Short- And Long-Term Consequences In Critical Patients

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Objective: The shock index is a non-invasive parameter, especially used in the determination of hemorrhagic shocks. In recent years, the shock index has also been showed to be related to prognosis in acute coronary syndromes and pneumonias. We also aimed to investigate the effect of shock index on the mortality of critical patients except for hemorrhagic shocks.

Materials-Methods: The study was prospectively designed to be performed in medically critical patients admitted to the emergency unit of Konya Training and Research Hospital. Traumatic patients and those with gastrointestinal bleeding and admitted to the hospital due to other reasons leading to bleeding like ruptures of ectopic pregnancy and aortic aneurisms were excluded out of the study. On admission, vital findings, demographic features and laboratory findings of all patients were recorded. The scores of shock index, APACHE II and SOFA were calculated. The patients were followed-up as to in-hospital and 6-month mortality rates.

Results: Totally 373 patients were included into the study. Of all patients, 54.4% (203) were men, and 45.6% (170) were women. Median (interquartile range-IQR) for age was 74 (19); APACHE-II score was 20.7 ± 10.1 ; and, SOFA score was 4.9 ± 2.2 . The shock indexes were grouped into four quartils as <0.62 , $0.62-0.75$, $0.76-1$ and >1.01 . No significant difference was detected among the four groups as to age, gender and demographic features, and SOFA scores ($p > 0.05$). However, APACHE II and Glasgow coma scores (GCS) were significantly different. In cox regression analysis performed, shock indexes, APACHE II and GCS were determined to be the independent marker of in-hospital and 6-month mortality (HR: 1.73, 95% CI: 1.07-2.80, and $p=0.02$; HR: 1.05, 95% CI: 1.02-1.08 and $p<0.001$; and, HR: 0.87, 95% CI: 0.82-0.92 and $p<0.001$, respectively). According to the quartils of shock index, survival rates calculated with Kaplan-Meier curve were significantly lower in quartil 4 as to in-hospital and 6-month mortality rates (Log Rank:30.8, $p<0.001$ and Log Rank:30.8, $p<0.001$).

Conclusion: Easily and fast available, the shock index is an independent marker of short- and long-term mortality. We consider that the shock index may be helpful not only for those in hemorrhagic shock, but also for critical patients and especially for the interventions to be performed in a few hours.

Keywords: Critical Patients, Hemorrhagic shocks, Shock Index

P-0149 Resuscitation

Prognostic Value of Neutrophil-Lymphocyte Ratio in Critically Ill Patients Underwent Cardiopulmonary Resuscitation

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Objective: The majority of patients who underwent cardiopulmonary arrest (CPR) outside the hospital and returned to spontaneous circulation die during post resuscitation period. In the current study a month mortality rate are ranging from 58% to 86%. Prognostic factors after CPR are still unknown. In the literature, Neutrophil-Lymphocyte Ratio (NLR) has been found to be higher in critically ill patients with acute coronary syndromes and pulmonary embolism. In this retrospective study, we aimed to investigate the prognostic values of neutrophil, lymphocyte and NLR measured in the complete blood count within the first 24 hours in the patients undergoing CPR in the emergency department (ED) in terms of 24 hours and 14-day mortality.

Materials-Methods: The study was performed in Konya Education and Research Hospital. In the last year patients who underwent cardiopulmonary arrest outside the hospital and returned to spontaneous circulation were reviewed retrospectively. The demographic characteristics of the patients, rhythm at the time of admission to the hospital and cause of arrest were recorded. Neutrophil and lymphocyte values were also recorded and neutrophil-lymphocyte ratios were calculated. 24-hour and 14-day mortality was documented.

Results: 91 patients who underwent CPR in the last year included and mean age(IQR) was 73(19). Of the patients, 44 (48.4%) were male. The patients were rated according to the data recorded within the first 24 hours and on the 14th day. Patients were admitted to emergency department with %57,1(52) asystoly, %11(10) ventricular fibrillation, %31,9 (29) pulseless electrical activity. haemoglobin $12.7(3.65)$ g / dL, lymphocytes 2.8 (5.2), NLR 2.9(9.3) were identified on the admission. There was no statistically significant difference between demographic characteristics and laboratory tests of the patients for 24 hour death. Survival rates in 24 hours and 14 days mortality, calculated with Kaplan-Meier curve, were almost significantly lower according to NLR median (LogRank:5.06, $p=0.04$ ve Log Rank:4.09, $p=0.04$) Receiver operating curve (ROC) analysis showed that a NLR cut-off value for mortality of 1.5 had a sensitivity of 52.0% and a specificity of 80.8%. (area under the curve 0.68, 95% confidence interval 0.56-0.78 $p=0.002$).

Conclusion: WBC and subtypes are playing a pivotal role in systemic inflammatory response. Zahorec demonstrated that NLR were reflecting the intensity of stress and the reliable parameter of monitoring and evaluation of the systemic inflammatory response. In recent studies shown that NLR was prognostic factor for cardiovascular disease. According to the results of our study NLR is an indicator of mortality in critically ill patients who underwent CPR.

Keywords: Marker, NLR, Resuscitation

P-0150 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

The patients who are receiving of treatment blood and blood products in the emergency room

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Objective: Ankara Atatürk Training and Research Hospital Emergency Medicine Clinical blood and blood products treated with patient's demographic characteristics, transfusion indications, use of blood products and with the amount of complications to identify prospective basis is made.

Materials-Methods: In this preliminary study, 01.01.2013-01.01. 2014, between blood and blood products in the emergency treatment of 214 patients included in the study area. Patient age, sex, current diseases, transfusion indications, blood products and the amount of complications, hemoglobin levels, transfusion before and after the vital signs of the patient with recent case studies forms of emergency medicine physicians were recorded.

Results: In 9 patients with transfusion related acute transfusion complications developed. These complications in 4 patients fever, hypotension 3 patients, 2 patients were found to have allergic reactions. Made transfusion of patients discharged from the emergency department 142 percent has been hospitalized 58 patients and 12 patients who were referred to another hospital, while two cases had been exitus. Majority of cases hemoglobin values of 8 mg / dL, respectively. While giving most of the erythrocyte suspension due to anemia, bleeding control with indication was given fresh frozen plasma

Conclusion: The majority of our cases of anemia and red blood cell suspension had received indications. Blood and blood products to treat the life-threatening complications in the emergency measures should be taken against and indications should be reconsidered.

Keywords: transfusion, complication, emergency services

P-0151 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Status epilepticus related to hypocalcemia

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Objective: Electrolyte disorders have often been come up in the emergency service. The patients who have electrolyte disorder may apply to a hospital with a wide range of symptoms, with the inclusion of central nervous system. Metabolic tests have to be checked on the patients who have unconsciousness disorder. Here, it has been asked to put emphasis on the importance of testing electrolyte evaluation about a patient presenting with amnesia and status epilepticus.

Case: A 50-year-old female patient was taken to the hospital with the ailments of not remembering the incidents and the names, by the patient's relatives. In the story, it was found out that she did not have any disease. Generalized tonic clonic attack started during the physical examination. The patient who was taken to the resuscitation room was monitored and started to be given oxygen and the laboratory tests were sent. 5 mg diazepam was applied to the patient, and it was repeated, as the attack continued. The patient whose attack continued was regarded as status and 20 mg/kg phenytoin was applied. The patient whose attack was stopped was continued to be monitored. In the laboratory tests, the kidney function tests were normal, serum albumin and total protein were normal. Electrolyte measurements were Na 138 mmol/L, K 3.6 mmol/L, Cl 101 mmol/L, Ca 3.9 mg/dl, Mg 1.6 mg/dl, phosphor 5.4 mg/dl. During monitoring, the patient who was given calcium for the treatment had the conscious and the amnesia was healed. In the computerized tomography bilateral hyperdense zones were scanned. The patient whose control calcium tests were recovered and whose monitoring had no problem, was directed to the clinic with the aim of upcoming investigation diagnosis by planning hormone tests.

Conclusion: In the emergency service, especially for the incidents which require emergent treatment, the imbalance in electrolyte has to be born in mind and electrolytes such as calcium and magnesium have not to be ignored. Just as such patients have to be informed, they have to be directed to an available clinic, precisely.

Keywords: Status epilepticus, hypocalcemia, electrolyte disorders



POSTER BİLDİRİLER

P-0152 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A drug reaction: Toxic Epidermal Necrolysis

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Objective: Skin reactions are common adverse drug reactions and may include angioedema, erythroderma, Stevens-Johnson syndrome, and toxic epidermal necrolysis (TEN). TEN often induced by drugs is a rare skin reaction that results in full thickness denudation of the skin, involving the cutaneous and mucosal surfaces. It involves more than 30% of the total body surface area. Mortality rate of TEN is approximately 25% to 30%. Therefore, TEN constitutes a therapeutic emergency at diagnosis. Clinically, a painful macular exanthem appears in a symmetrical distribution on the face and trunk, spreading to the extremities and nikolsky sign is usually positive. After emergency intervention, patients with TEN should be treated in a burn intensive care unit where vital organ function is supported admitted to intensive care. We presented a case of TEN rarely encountered in emergency departments (ED).

Case: A 40-year-old man admitted to ED with widespread skin eruption. He gave a past history that amoxycillin-clavulanic acid and deksketoprofen trometamol treatment had been started by general surgeon because of soft tissue infection two days ago, and six hours after taking these drugs, skin lesions had been occurred in the whole body along with extremities.

On arrival to the ED, the patient was alert and his pulse and blood pressure were within normal limits. He had oral erosions, maculapapular eruptions and epidermal peeling together with bullae on his body surface area. The Nikolsky's sign was positive.

Amoxycillin-clavulanic acid and deksketoprofen trometamol treatment was discontinued. In first treatment, intravenous methylprednisolone/125 mg, antihistamine, fluid resuscitation with normal saline was administered in ED. Patient was consulted with clinic of dermatology and was hospitalized in the intensive care unit.

Conclusion: Drug eruptions are one of the most dermatological challenges presenting to an ED. The manifestations range from maculapapular rash to severe systemic symptoms like renal and cardiovascular failure. Skin reactions such as angioedema, TEN may lead to mortality and morbidity. Therefore, early diagnosis and treatment is important in patients applied to ED with drug eruptions.

Keywords: Drug eruptions, skin, toxic epidermal necrolysis, ED

P-0153 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Can Carotid Doppler Ultrasound Test Cause Stroke?

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Objective: Cerebral infarction following a carotid doppler ultrasound is theoretically possible although only one case has been reported in the literature.

In a carotid ultrasound doppler test, the technician presses probe against the neck area and moves it along the neck to pick up the signal. The carotid artery is very close to the neck surface, such a test can cause the unstable plaque to erupt. In our case we have aimed to emphasise the stroke risk during the performance of carotid doppler ultrasound in elderly patients with risk factors such as hypertension, atherosclerosis, hyperlipidemia, diabetes mellitus, etc.

Case: Seventy-seven year old male presented with left arm weakness that occurred during carotid doppler ultrasound procedure. Physical examination in the emergency department was normal, except left upper limb hemiparesis. Past medical history included hypertension and coroner arterial disease. Blood cell count and serum biochemical analysis was normal. ECG was normal sinus rhythm.

The non contrast brain CT revealed no haemorrhage or mass lesion. Ischemic stroke was diagnosed, immediate antiaggregant and antithrombotic treatment was administered.

Diffusion-weighted MR imaging showed multiple diffusion restricted areas on right cerebral frontal and parietal lobes. He has been admitted to the neurology clinic with the diagnosis of acute ischaemic stroke.

Conclusion: Ultrasonographic findings of atherosclerotic plaques are subclinical markers of early atherosclerosis and are associated with subsequent risk of new or recurrent stroke. Male sex and aging are strongly associated with carotid atherosclerosis. The study by Kitamura et al, showed a positive association between carotid intima-media thickness (IMT), a measure of carotid and generalized atherosclerosis, and the incidence of stroke in Japanese male residents aged 60 to 74 years. Maximum IMT of the common carotid arteries and plaque in the internal carotid artery are strong predictors for risk of stroke.

Our patient was under the high risk of atherosclerotic plaque and related subsequent stroke. For such patients other diagnostic modalities as carotid and vertebral MRI angiogram could be a safer option.

Keywords: carotid doppler ultrasound, stroke, elderly patient

P-0154 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Physician and patient can both be mistaken: cephalic tetanus

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The emergency physician may encounter tetanus in insufficiently immunized individuals, with acute and generally atypical pictures. In advanced cases it appears with generalized muscular rigidity, severe muscular contractions and findings of increased sympathetic activity. It may also cause such different clinical findings as dysphagia, ptosis, trismus and cranial nerve palsy. A patient who suffered a superficial graze after being hit on the head by a piece of wood but who did not initially attend hospital since the resulting trauma was minimal, eventually presented with ptosis, restricted mouth opening and dysphagia. The patient was diagnosed with cephalic tetanus and discharged after 15-day monitoring in intensive care. This case report describes cephalic tetanus that may appear with different clinical findings with a discussion of the literature.

Keywords: Tetanus, cephalic tetanus, ptosis, facial paralysis

P-0155 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Soft tissue infection in the emergency department can be fatal: toxic shock syndrome

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Streptococcal toxic shock syndrome (TSS) is a clinical picture that frequently develops as a result of necrotizing soft tissue infections and that requires emergency intervention. Mortality levels are high unless diagnosed and treated early. A 47-year-old man presented with sudden pain from the right knee down. Within a few hours, ecchymosis developed rapidly on the anterior surface of the leg, followed by hemorrhage. His general condition deteriorated rapidly and vital findings were compromised. Swelling, widespread erythema and extensive tissue necrosis developed. The patient died on the day of admission to the emergency department.

Keywords: Toxic shock syndrome, necrotizing fasciitis, A group beta hemolytic streptococcus

P-0156 Pediatric Emergencies

Death Resulted Child Abuse

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Objective: Any actions that affect child growth and development adversely can be defined as child abuse, they are found in every culture of human history. Can be seen as Physical abuse, sexual abuse, emotional abuse and neglect. although it is Common and significant health problem, in diagnosis and cooperation with the related specialties are often faced with failure. The lack of evidence, incorrect information, cultural and traditional values can lead to ignorance of abuse. Only child abuse is considered when the trauma is very serious. when the minor findings of child abuse is omitted or not reported, the consequences may be fatal.

Case: 15 year old girl was brought to our emergency room after been assaulted by her brother. patients general condition was bad, she was intubated. There were bruises in different parts of the body. BP: 80/40mmhg pulse: 98/dk no spontaneous respiration and pupillary were dilated, Light reflex was not taken. In CT scan of the patient presented serious subdural hemorrhage that causing shift. she was operated immediately by neurosurgeons. After 16 days following the operation stayed in the intensive care unit patient have died



POSTER PRESENTATIONS

Conclusion: The lack of evidence, incorrect information, cultural and traditional values can lead to ignorance of abuse. Only child abuse is considered when the trauma is very serious. When the minor findings of child abuse are omitted or not reported, the consequences may be fatal. Therefore, in the diagnosis and treatment of child abuse, the ethical, moral and legal obligations are on the members of the medical team so they need to know the signs and symptoms of child abuse. As demonstrated in our case of child abuse resulting in mortality. Therefore, in children come with trauma as an emergency physician child abuse must always come to mind.

Keywords: Death Resulted Child Abuse, assault, subdural hemorrhage

P-0157 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Periorbital Cellulitis Secondary to Herpes Zoster

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Objective: Periorbital cellulitis is infection of the soft tissue of the eyelids and periocular region anterior to the orbital septum. Periorbital cellulitis is characterized by an erythematous, tender, indurated, swollen eyelid and periorbital area.

After a primary varicella-zoster virus (VZV) infection (termed "varicella" or "chickenpox"), the virus establishes latency in dorsal root and cranial nerve ganglia. Herpes zoster (HZ), also known as "shingles," results from reactivation of VZV and its spread from a single ganglion to the neural tissue of the affected segment and the corresponding cutaneous dermatome. HZ is a localized, generally painful cutaneous eruption that occurs most frequently among older adults and immunocompromised persons. Most commonly, herpes zoster affects the chest and face, but it can affect any dermatomal level.

Local skin infections commonly causing periorbital cellulitis are impetigo, herpes simplex, herpes zoster, erysipelas, and cellulitis of the face in infancy.

We describe a case of herpes-zoster infection with periorbital cellulitis.

Case: A 58-year-old previously healthy man presented with three day history of vesicular eruption, erythema, swelling on the left side of his upper forehead and scalp with left sided periorbital cellulitis (figure 1). No relevant medical, dental and family history was reported by the patient. The skin was appearing swollen shiny and involved areas were very tender on palpation. Any systemic pathology was not found on physical examination. Upon correlating with the history and clinical findings the final diagnosis of periorbital cellulitis secondary to herpes zoster was given. Antiviral therapy was started with acyclovir 800 mg tablets 5 times per day for 10 days and antibacterial therapy was started with amoxicillin clavulanate 1000 mg tablets PO twice a day for 1 week.

Conclusion: In majority of the patients herpes zoster is a self-limiting condition and healing is usually complete. Early diagnosis and prompt treatment of the disease in the prodromal phase by the use of antiviral agents should be the mainstay of its management. Antiviral therapy has been shown to be very much beneficial in decreasing the duration of viral shedding, new lesion formation, severity of pain and accelerating the events of cutaneous healing. A thorough knowledge of this disease will help in early diagnosis and prevents delayed treatment for the patient thus reducing the complications.

Keywords: herpes, cellulitis, shingles

P-0158 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Does acute ischemic stroke treat Parkinson?

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Objective: Stroke is a common medical condition in community and has high mortality and morbidity. Being the most common reason of disability in the world, stroke is also a very important socioeconomic health problem because of high treatment cost. Acute stroke is a rapid-approach-requiring urgent neurologic condition. In recent years many important developments about ischemic stroke were happened. By new imaging Technologies acute stroke started to be more easily diagnosed. Parkinsonism is a syndrome characterised by tremor, bradykinesia, akinesia and postural abnormalities. Parkinson's disease is the most common variant of parkinsonism syndrome and divided by its unique pathological findings, clinical manifestations and dopaminergic-treatment response.

Case: A 70- years old female patient was brought to the emergency department with sudden disappearing of the tremor on her right hand. She was diagnosed and treated for parkinson's disease for 4 years. She had no other complaints. Her general condition was good, she was conscious, blood pressure was 130/80 mmhg, heart rate: 92/bpm, and neurological examination was normal. In diffusion MRI, acute decreased diffusion was shown in basal ganglias. Then she hospitalised in neurology department.

Conclusion: Parkinson's disease is a long-lasting and slowly progressing disease, so patients, patients' family and doctors must cooperate for treatment for long years. This Cooperation will both control the disturbing clinical manifestations and upgrade the patient's life quality. Today, the absolute cure for dopaminergic cell injury is not found, existing medications replace the decreased dopamine in basal ganglias or simulate dopamine's effect. Some of them prevent dopamine from chemical fragmentation. Despite the best therapy, disappeared symptoms may occur again or new symptoms may be added because of the disease's progressing nature. In our case, with the acute ischemic stroke in basal ganglias, parkinsonism symptoms had regression. There is no other similar case in literature.

Keywords: stroke, parkinsonism, treatment

P-0159 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Complication of Pneumonia: Lung Abscess

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Objective: Pneumonia is an acute inflammation of the lower respiratory tract. Lower respiratory tract infection is a major cause of mortality worldwide. In adults, tobacco smoking is the single most important preventable risk factor. Complications of pneumonia include pleural effusion, empyema and lung abscess.

Lung abscess is necrosis of the pulmonary tissue and formation of cavities containing necrotic debris or fluid caused by microbial infection. It can affect anyone at any age In the beginning. The symptoms of lung abscess are moderate fever, chills, chest pain, and general weakness. The immediate cause of most lung abscesses is infection caused by bacteria. Medical management will successfully treat most of lung abscesses.

Case: A 40-year-old woman, previously healthy, presented with an intermittent nonproductive cough, pleuritic chest pain, and a 3-day history of fever (> 38 °C). He denied dyspnea, contact with any illness, recent travel, exposure to animals. Her medical history was unremarkable, except for being a smoker for 15 years, 2 packet/day. Physical examination revealed an acutely ill appearing individual, with a respiratory rate of 23 breaths/min, heart rate of 110 beats/min, blood pressure of 90/65 mm Hg, temperature of 38.3°C, and oxygen saturation of 96% in ambient air and tenderness with palpation on the right lateral-anterior chest wall. A complete blood count revealed a substantial increase in the white-blood-cell count (15,100 cells/mL), with a left shift (86.2% neutrophils) and CRP was significantly elevated (188 mg/L). Chest x-ray showed an area of dense consolidation with an air-fluid level inside of a thick-walled cavitary lesion. Computed tomography scan of the chest was performed, which showed an air-fluid level inside of cavitary mass with thick enhancing wall in the right lower lobe (figure 1). The patient admitted to Respiratory Medicine and started on broad-spectrum antibiotics, pending the outcome of cultures. Blood, urine, and sputum samples were collected for aerobic and anaerobic cultures. IV antibiotherapy was started according to the culture results. The chest radiograph was repeated 5 days later and showed decreased pulmonary infiltrates with no air-fluid level (figure 2). The patient's condition improved dramatically, and he was discharged on the eight day of hospitalization.

Conclusion: Patients diagnosed with new lung abscess in the ED should be admitted to the hospital for further evaluation and treatment. IV antibiotics should be initiated in the ED based on the patient's demographic factors, immunocompetence, potential for health care-associated infection, and antibiotic allergies.

Keywords: abscess, lung, pneumonia

P-0160 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Spontaneous Pneumomediastinum

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Objective: Pneumomediastinum is defined as the presence of free air in mediastinum and divided into three main types: spontaneous, iatrogenic and traumatic. Spontaneous pneumomediastinum (SPM) is firstly described by Hannan in 1939. SPM occurs due to increased intra-alveolar pressure which can be caused by valsalva maneuver, hard coughing, forced physical activity and vomiting. Alon Yellin et al found the incident of SPM 1/12850 in four years period and Jougon et al found 1/25000. As seen in these rates, SPM is a very rare medical condition. SPM reported in cases with hypnosedative/narcotic drug use. Some authors presented that SPM can happen even after Yoga practices.

Case: Our case is a 22 year-old female patient, presented to an external emergency service with cough ongoing for 5 days. She was treated for atypical pneumonia. She presented to our clinic with her



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current symptoms worsening. Her general condition was good, mental status was normal, she had tachypnea (30 breaths per minute), blood pressure: 120/90 mm Hg, body temperature: 36.5. On physical examination there was subcutaneous crepitation at the anterior part of the neck and there was no history of trauma recently. In X-ray imaging emphysematous changes were shown in mediastinum and serval zones. Pneumomediastinum was observed in thorax CT. The patient as hospitalised in thoracic surgery clinic. In clinical follow-up, pneumomediastinum had complete regression in fourth day.

Conclusion: This case report is presented because SPM can be a life-threatening medical condition and rarely seen without any accompanying problems.

Keywords: pneumomediastinum, spontaneous pneumomediastinum, mediastinum

P-0161 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Retrospective analyses of contrast induced nephropathy and allergic reaction in patients admitted to emergency department who received intravenous contrast agent during computed tomography scan

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Objective: The aim of this study is to investigate the development of contrast induced nephropathy and allergic reaction after an IV contrast-enhanced computed tomography scan between 1 January 2012 and 31 December 2012 in İzmir Katip Çelebi University Atatürk Training and Research Hospital Emergency Department.

Materials-Methods: Patients admitted to emergency department between 1 January 2012 and 31 December 2012 who received IV contrast agent during computed tomography scan were identified. Patients aged 16 and older who received IV contrast during computed tomography scan were included in the study. Patients with contrast induced nephropathy and patients with allergy were evaluated separately. Exclusion criteria were constituted for both groups.

Results: 1463 patients were scanned by IV contrast-enhanced computed tomography at our emergency department. Contrast induced nephropathy was detected in 37 (9.39%) of 394 patients included in the study. In our study, compatible with literature, development rate of contrast induced nephropathy decreased with increasing glomerular filtration rate. It is established that contrast induced nephropathy develops more frequently in patients with a high intake of NSAIDs, diuretics, metformin and ACEI. Highly increased risk of contrast induced nephropathy was determined in patients with multiple organ failure, sepsis, congestive heart failure, myocardial infarction, major abdominal surgery and trauma. 2 (5.4%) of 37 patients with contrast induced nephropathy also developed chronic renal failure which didn't necessitate hemodialysis and 2 (5.4%) of them were taken into dialysis. None of the patients with contrast induced nephropathy needed permanent hemodialysis.

After administration of the contrast agent, 13 (0.88%) of 1463 patients manifested an allergic reaction. Allergic symptoms comprised skin findings (itching, rash, angioedema, redness) in 12 (92.3%), respiratory system findings in 2 (15.4%) and gastrointestinal system findings in 2 (15.4%) patients; no cardiovascular system findings were recorded and some patients showed more than one symptom at a time. No deaths were reported during the course of our study.

Conclusion: For prevention and early diagnosis of contrast induced nephropathy we believe it is beneficial to determine the risk factors of patients who are to be administered an intravenous contrast agent.

Keywords: Contrast induced nephropathy, allergic reaction, emergency department

P-0162 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Ischemic cerebral infarction at a patient with pulmonary thromboembolism and intracranial hemorrhage as a complication of thrombolytic therapy

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Objective: Pulmonary thromboembolism (PTE) is a disease with high mortality rate and despite it's seen very commonly there are many difficulties about diagnosis and treatment(1). massive PTE is said to comprise 5-10% of all PTE. As shown in prospective cohort studies, mortality rate of acute PTE is about 7-11(2). Thrombolytic therapy is the most effective therapy for moderate and high-risk PTE if there is no absolute contraindication(3). Undesired results, including death, are reported at about 15-20% of cases treated with thrombolytic therapy(4). In this study, we planned to present intracranial hemorrhage at a patient who had thrombolytic therapy after diagnosed as PTE and cerebral infarction.

Case: 71 years-old male patient, who had colon adenocarcinoma, applied to the emergency service with dyspnea which was on going for two days and worsening with effort. He was normotensive and had no tachycardia, ECG was normal. In echocardiography right ventricle and atrial were enlarged. In Pulmonary CT angiography embolism was imaged at both main pulmonary arteries. After then patient had hemiplegia and dysarthria, so diffusion MRI and cranial MRI was imaged and decreased diffusion was shown at watershed area supplied by middle cerebral artery. The patient was consulted to the neurology and cardiology department. Thrombolytic therapy used in two hours at cardiology intensive care unit and after heparin infusion was started. In clinical follow-up, the patient got confused and intracranial hemorrhage was shown in cranial CT imaging. While having an operation by neurological surgeons, the patient died due to cardiac arrest.

Conclusion: Our case was diagnosed as PTE despite being in low-risk group and thrombolytic therapy is used for cerebral infarction which occurred in clinical follow up. This case report is presented because there are very rare similar cases in literature. As it is shown in our study, intracranial hemorrhage can be a complication of thrombolytic therapy at patients with PTE.

Keywords: Pulmonary thromboembolism, thrombolytic therapy, cerebral infarction

P-0163 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A rare cause of dyspnea: mixed type laryngocele

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Objective: As having numerous masses due to containing endocrine and neurovascular structures, Neck is a delicate part of the body. Masses in the neck region having dense lymphatic network usually lead to specific symptoms such as dyspnea, hoarseness. Advanced research is required for neck masses above 1 cm in size.

Case: A 74-year-old female suffering from shortness of breath, swelling and pain under the jaw, and hoarseness was admitted to emergency department. Medical history was otherwise noncontributory. Over the last week, she had been suffering from dyspnea and swelling in the neck growing gradually and hoarseness. Physical examination revealed solid, tender, immobile and remarkable mass about 8x5 cm in size over the right side of the neck. Laryngoscopy revealed a supraglottic mass covered with normal mucosa, extending into airways from the right wall of hypopharynx. CT revealed a mixed type (internal plus external) laryngocele completely filled with air. She referred to ENT clinic for surgery.

Conclusion: Laryngocele, an abnormal cystic dilatation of the laryngeal saccule, usually develops in pediatric patients originating from ventricular appendix. Laryngocele may extend internally into the airway or externally through the thyrohyoid membrane, so they may present as internal, external or combined mixed internal and external laryngocele. While external type is the most frequent type, mixed type is quite seldom. Laryngocele requires Computed Tomography and laryngoscopy for diagnosis. Patients with severe dyspnea may require removal of the pouches immediately. In our opinion, this case is of particular interest since she was affected by a large laryngocele unrelated to her profession.

Keywords: Laryngocele, Mixed type, Dyspnea, Computed Tomography, Laryngoscopy

P-0164 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A rare cause of rhabdomyolysis: Choreoathetosis

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Objective: Rhabdomyolysis is a potentially life-threatening condition caused by muscle necrosis and extravasation of intracellular muscle contents into the circulation. The release of creatine kinase, potassium, uric acid, myoglobin, calcium and phosphate can result in a spectrum of conditions. CPK values should be more than 3000 unit to diagnose rhabdomyolysis. Rhabdomyolysis may result from a wide variety of disorders including trauma, infections, intoxications, malignant neuroleptic syndrome, and hereditary metabolic and connective tissue disorders. We report a 77-year-old woman with parkinson's disease who developed severe choreoathetosis with rhabdomyolysis after lack of medication.



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Case: A 77-year-old female patient with severe choreoathetosis, oromandibular dystonia, and hypotension was admitted to the emergency department of our hospital. The medical history revealed that she had Parkinson's disease and was under levodopa+karbidopa+entakapon combination and levodopa+benserazide combination therapy. On the other hand she has not taken her stable medication since ten days. Her temperature was 36.3 °C, blood pressure was 80/50 mmHg, pulse rate was 74/min, respiratory rate was 18/min, oxygen saturation was 98% with pulse oxymeter. Patient was conscious, cooperating, orientated and hypophonic. She had bilateral rigidity especially on the left extremities, voluntary neck stiffness and was bradimimic also glabellar reflex was positive. The rest of the examination was normal. Electrocardiogram had normal. Laboratory findings at presentation were as follows: Complete blood count: 12,100 leukocytes, hemoglobin 13.1 g/dL, platelets 174000/mm, glucose 93 mg/dL, creatinine 1.6 mg/dL; blood urea nitrogen: 65 mg/dl, AST 72 IU/L, ALT 7 IU/L, creatinin phosphokinase(CPK) 3614 mg/Dl, mass CK-MB 24.8 IU/L, troponin-I 0.329, sodium 142 mEq/L, potassium 6.2 mEq/L and calcium 9.6 mg/dl. No alterations were observed in the urine except dark urine. No other abnormal laboratory findings were found.

Conclusion: The severity can range from an asymptomatic elevation in skeletal muscle enzymes to life threatening conditions such as acute renal failure secondary to myoglobinuria or cardiac arrest resulting from hyperkalaemia. Management of rhabdomyolysis begins with removing the cause, if possible.

In conclusion, all of the reasons of rhabdomyolysis are not traumatic. Emphasize the importance of the anamnesis for diagnosis and treatment for suspecting rhabdomyolysis.

Keywords: Rhabdomyolysis, choreoathetosis, emergency department

P-0165 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Numbness in the left arm: is it due to cardiac or neurological disorder?

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Objective: Multiple sclerosis (MS) is an immune-mediated inflammatory disease characterized by destroying of the myelin and the axon in variable degrees in the central nervous system (CNS). The cause of MS is not known, but it likely involves a combination of genetic susceptibility and a presumed non-genetic triggers. MS is usually diagnosed in persons aged 15-45 years; however, it can occur in persons of any age. Symptoms of MS vary and may include numbness or weakness in one or more limbs, visual disturbances, tingling or pain in parts of your body, tremor, lack of coordination or unsteady gait, slurred speech, fatigue and dizziness. The diagnosis of MS is difficult after only a single symptomatic episode, as diagnosis required the occurrence of repeat clinical attacks suggesting the appearance of lesions separated in time and space. Therefore, misdiagnosis is common.

We aimed to present a case of MS misdiagnosed in the emergency department (ED) with numbness in left arm.

Case: A 54-year-old male patient was admitted with complaint of numbness in the left arm to the ED. On admission, his blood pressure was 128/75 mmHg, pulse rate was 77/min, and temperature was 37.7 °C. Numbness had been lasting for three days radiating from the neck to the left arm. There was not chest pain and electrocardiography revealed normal sinus rhythm. On the neurological examination, there was no significant sensory or motor deficit. Other system examination was unremarkable. Laboratory results were in normal range including troponin level. As his symptom persists, follow-up was recommended, but the patient left against medical advice. On subsequent follow-up of patient in the outpatient neurology clinic, cranial MRI was taken (Figure 1A-B) and he was hospitalized to neurology ward with diagnosis of MS.

Conclusion: Patients with left arm symptoms without neurological finding usually tend to be evaluated as having cardiac or orthopedic disorders. However, neurological disorders such as MS may present with atypical and insignificant symptoms and should be kept in mind in patients like our case.

Keywords: Numbness, left arm, cardiac, multiple sclerosis

P-0166 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Blastocystis Hominis Gastroenteritis in Emergency Department: Should be Cured?

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Objective: Stomachache and diarrhea have an important place in emergency department admissions. Fluid resuscitation is enough in patients having normal microscopic examinations with normal oral intake and unaffected renal functions. It's in controversial if there is a need of cure and the role of blastocystis hominis parasites as a normal flora member in generating gastroenteritis syndromes.

Case: 18 year-old female patient admitted to emergency department with the complaints of severe stomachache starting in the morning, nausea and vomiting and numerous aqueous defecations. Vital signs of the patient had no specific personnel history were 36.7 °C fever, blood pressure as 110/60 mmHg, 76 beats per minute and 97% SatO₂. There was no significant physical examination findings except tenderness in all abdominal quadrants in patient having hyperactive bowel sounds. Blastocystis hominis cysts were seen in patient's microscopic examination of stool without any leukocyte or erythrocyte. In biochemical parameters there was no abnormal value except white blood cell count as 15400. The patient having oral intake was discharged with hydration suggestion and prescription of seven days of trimethoprim/sulfamethoxazole tablets. Control microscopic examination of stool was suggested.

Conclusion: Blastocystis hominis being a normal flora member may cause gastroenteritis outbreaks effecting all age groups especially kids. Blastocystis hominis cysts being cause of enteritis especially in developing countries infect with fecal oral way. In cases admitting emergency departments with enteritis table having no symptoms before, when blastocystis hominis is determined, trimethoprim/ sulfamethoxazole cure is recommended even if in controversial.

Keywords: Blastocystis Hominis, Gastroenteritis, Emergency Department

P-0167 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Patient with severe anxiety

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Objective: When applying to the emergency department patients with anxiety sometimes causes anxiety among doctors as well. The real problem may completely psikolojik serious metabolic disorders. We offer article further developed metabolic alkalosis, PCO₂ 10.8 mmHg, or declined to have talked about a case

Case: 22 year old male patient anxiety, worry, was brought with complaints of respiratory distress. Extreme tachypnea initial examination, there was severe anxiety. Learned that the disease is not known in advance in cases of tachycardia was present. Breath sounds were normal arterial blood gas analysis examined PH: 7.692, PCO₂: 10.7 mmHg, PO₂ 127, HCO₃: 12.7 mmol / l were identified as. Patient and diazepam 10 mg IV was administered as a slow infusion. After 4 hours, the patient's arterial blood gas analysis when looking statements totally recovered, was seen as clinically healed.

Conclusion: Generalized anxiety disorder in the emergency department sometimes can be serious enough to metabolic disorders. In the literature were reported as the lowest value of PCO₂: 12 mm Hg. However, in our case, this information will change 10.7 mmHg value was so low. Anxiolytics should be applied early in the emergency department after diagnosis, and the patient should be reevaluated after calming down.

Keywords: anxiety, diazepam, metabolic disorder

P-0168 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A Rare Cause of Intermittent Hypoglycemia: Solitary Fibrous Tissue Tumor

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Objective: Hypoglycemia is usually seen in diabetic patients and a clinical condition develops because of misuse of drugs. If hypoglycemia occurs recurrently episodic, it may be based on malignancies as seen in insulinoma. We aimed to inform emergency physicians about a rare cause of hypoglycemia with a case Solitary Fibrous Tissue Tumor with intermittent hypoglycemia.

Case: A 63-year-old male patient admitted to ED with dizziness and cold sweating. Patient had hypoglycemia attacks for two months but got no treatment. In medical history, he had hypertension and a solitary fibrous tumor with lung and liver metastasis. Vital Signs were fever: 36.7 °C, blood pressure: 164/92 mmHg, pulse: 115 beat/min. Capillary glycaemia was detected 38 mg/dL. After bolus infusion of 50 cc dextrose patient's general condition had improved and infusion of %5 dextrose had started. Hypoglycemic attacks assessed as extra pulmonary



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complication of solitary fibrous tissue tumor and the patient hospitalized.

Conclusion: Solitary fibrous tissue tumors are usually benign tumors. When its size exceeds 7 cm, it may cause symptoms such as cough, chest pain, and dyspnea. Though it's rare, in some patients intermittent episodes of hypoglycemia may be seen. This condition does not change the management of hypoglycemia but as an advanced treatment surgery may reduce the symptoms.

Keywords: Hypoglycemia, Solitary Fibrous Tissue Tumor, Emergency Department

P-0169 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Giant hydatid cyst of lung case

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Objective: Hydatid disease is a parasitic infection caused by Echinococcus granulosus, characterized by cystic lesions in the liver, lungs, and, rarely, in other parts of the body. The large cysts in the lung are a special clinical entity called giant hydatid cysts. We talk about a patient who admitted to the emergency department with shortness of breath, chest pain and nausea, vomiting and he has a 10cm diameter hydatid cyst on his lung.

Case: 23 years old male patient who admitted to emergency medicine green room with shortness of breath, chest pain, vomiting and nausea. Sometimes he also has out of breath attack and vomiting before admit to hospital. Patient's Glasgow Coma Scale (GCS): 15/15, TA: 110/60 mmHg, Fever 38.5°C, Oxygen saturation 92. On patient's direct posterior-anterior chest x-ray there was air fluid level in the left lower lobe of lung and the lesion that was a demarcated (Figure-1) On CT there was a lesion which opened to bronchial and approximately 100mm in diameter at the lower lobe of the left lung and has germinative membrane lesion which also has minimal fluid and more than air component. (Resim 2). Patient hosted on observation room and dispatched to Yedikule Chest Medicine and Chest Surgery Hospital. We received reports from the hospital and we learned the patient was operated and discharged.

Conclusion: Shortness of breath, chest pain, vomiting and nausea often seen on patients who admitted to emergency departments. We aim to attract attention to giant hydatid cysts on young patients who admitted with shortness of breath, chest pain, vomiting and nausea.

Keywords: Shortness of breath, Chest pain, vomiting, nausea, Giant hydatid cyst

P-0170 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Demographic Properties and Clinical Outcomes of Pregnancy-Associated Acute Pancreatitis: Our Experience with 33 Patients

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Objective: In this study we aimed to examine the clinical, demographic properties, and outcomes of pregnancy-associated acute pancreatitis.

Materials-Method: Our study included 33 patients with pregnancy-associated acute pancreatitis (PAP) who were followed at the departments of Obstetrics and Gynecology and Internal Diseases at Dicle University Faculty of Medicine between January 2004 and June 2013. Patient information were accessed from the hospital records and age, gestational age, etiology, complications, laboratory results, diagnostic tests, treatment modalities, mode of delivery (normal vaginal delivery or cesarean section), duration of hospital stay, and maternal mortality and morbidity rates were assessed.

Hypertriglyceridemia was recorded as the etiological factor when triglyceride level was more than 11.3 mmol/L (1000 mg/dl) and biliary pathology was recorded when there were biliary stones or bile mud. Patients who did not have a history of alcohol abuse or any condition responsible from pancreatitis were classified as idiopathic pancreatitis and grouped accordingly.

Results: This study included a total of 33 patients with PAP among a total of 85542 deliveries. Mean age of the study population was 34.8±7.15 (23-46) years and mean gestational age was 25.75±7.49 weeks. The etiology of acute pancreatitis was a biliary pathology in 18 (54.5%) patients, hypertriglyceridemia in 11 (33.3%), and idiopathic PAP in 4 (12.2%). Four (12.1%) maternal deaths occurred. Sixteen (48.5%) patients suffered from a maternal complication while 10 (33.3%) experienced a fetal complication. Twenty-nine patients were discharged with cure. All maternal deaths and 50% of maternal complications occurred in second trimester.

Conclusion: In our study PAP was most commonly observed in second trimester and it had a more complicated and fatal course during this period. Biliary pathologies were the most fatal etiological group.

Keywords: acute pancreatitis, demographic properties, pregnancy

P-0171 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

A cause of misdiagnosis of abdominal pain in ED: portal vein thrombosis

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Objective: Portal vein thrombosis is a condition that should be diagnosed and treated accurately on account of its serious complications. It is a rare cause of abdominal pain in the emergency department. Therefore, the disease can be diagnosed if it comes to mind. Malignancies, hypercoagulation status, liver cirrhosis and some infections may play a role in etiology. Patients complain with non-specific symptoms such as abdominal pain, distention, diarrhea, nausea, vomiting and bleeding resulting in misdiagnosis. In this case, we aimed to draw attention to portal vein thrombosis, a rare cause of abdominal pain in the emergency department.

Case: A 27-year old male admitted to our emergency department with epigastric pain. He stated that he had abdominal pain for a long time and endoscopy performed five days ago revealed antral gastritis, enterohepatic bile reflux and sliding hernia. On physical examination, his vital signs were normal. There were epigastric tenderness and guarding sign in right upper quadrant. Other systemic examination was unremarkable. The laboratory results were in normal range. Abdominal and chest x-ray were unremarkable. Abdominal pain was thought to be due to gastritis and symptomatic treatment was initiated. Because of the symptoms persisted, ultrasonography was done and it showed no pathology of gallbladder, but increased lumen diameter in confluence of the portal vein and superior mesenteric vein with hypoechoic appearance of lumen were observed. Abdominal computed tomography showed scattered perfusion defects of the liver (figure). The patient was consulted to gastroenterology clinic and hospitalized with diagnosis of portal vein thrombosis for further evaluation.

Conclusion: Abdominal pain is a common cause of emergency admissions and need detailed evaluation. Rare causes such as portal vein thrombosis should be kept in mind in patients with non-specific signs and resistant to symptomatic treatment.

Keywords: abdominal pain, emergency, portal vein, thrombosis

P-0172 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Crohn's Disease Presenting As Chronic Diarrhea

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Objective: Crohn's disease, also known as Crohn syndrome and regional enteritis, is a type of inflammatory bowel disease (IBD) that may affect any part of the gastrointestinal tract from mouth to anus, causing a wide variety of symptoms. It primarily causes abdominal pain, diarrhea (which may be bloody if inflammation is severe), vomiting, or weight loss, but may also cause complications outside the gastrointestinal tract such as anemia, skin rashes, arthritis, inflammation of the eye, tiredness, and lack of concentration. Crohn's disease tends to present initially in the teens and twenties, with another peak incidence in the fifties to seventies, although the disease can occur at any age. The diarrhea may or may not be bloody. The nature of the diarrhea in Crohn's disease depends on the part of the small intestine or colon involved.

Case: A 43 year male patient with had diarrhea lasted for 2 months, rare abdominal pain complaints and vomit was accepted in Emergency department. We were informed that he had had a surgical operation because of fistul and cases of emergency for a week. He had had two appendectomy operation at last two months. His vitals were stables and he had an extensive diarrhea. Abdominal exam revealed normal breath sounds and no tenderness, guarding, or rebound. In the laboratory tests making for blood and urine degrees, parameters were at normal level and there were no parasites at his gaita microscopy.

The abdominal ultrasonography of him were at normal. The patient was sent to Gastroenterology for inflammatory diagnosis. In his endoscopy, there were duodenal colossus ulcer and linear gastric ulcers. Abdomen CT was taken and it is identified that thickening in the rectum, ileum and cecum wall thickening, mesenteric tissue inflammation in the right lower quadrant was interpreted as.

For a further diagnosis, colonoscopy was planned. In his colonoscopy, terminal ileum was in edema, eritem and they were partly as ulcer appearance. Also, it was seen that there were ulcerations and deep ulcers on the colon. The biopsy was sent to the laboratory and the result confirmed the Crohn's.



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Conclusion: Crohn's disease, like many other chronic, inflammatory diseases, can cause a variety of systemic symptoms. It is for the long-term ongoing etiology elucidated abdominal complaints or findings that patients with inflammatory bowel disease in the differential diagnosis should be considered and early endoscopy and / or colonoscopy as diagnostic tests need to be done.

Keywords: crohn, diarrhea, disease

P-0173 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Mucormycosis: Two Cases, Two Different Going-ons

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Objective: Mucormycosis is a rare but emerging fungal infection with a high mortality rate. The most important conditions predisposing to mucormycosis are malignant hematological disease, severe neutropenia, poorly controlled diabetes mellitus, iron overload, major trauma, prolonged use of corticosteroids, illicit intravenous drug use, neonatal prematurity. Rhinocerebral mucormycosis is of particular interest to emergency physicians because its presentation can be confused with sinusitis, orbital cellulitis and viral syndromes. We report two different cases of mucormycosis admitted to the emergency department. We aimed to establish the most important conditions predisposing to mucormycosis that may be useful in predicting the diagnosis of this infection.

Case: Case1: A 64-year old diabetic male patient presented to the emergency department with fever and weakness. The patient's right eye was noted to be red and chemotic. The primary focus was considered to be orbital and mucormycosis was considered. Surgical debridement was performed and intravenous antibiotics was given. Patient was discharged few weeks later. Case 2: The patient was a 63-year-old man who presented to the E.D with left facial pain and anesthesia. He had a medical history of ITP and steroid induced diabetes mellitus. The physical examination was significant for left ptosis and exophthalmus with a dilated and unreactive left pupil. Mucormycosis was considered, and antibiotherapy (intravenous amphotericin) was started. Approximately 2 months after admission, patient died of sepsis.

Conclusion: Physicians should consider mucor when there are predisposing background illnesses such as diabetes, malignancy, or immunocompromised conditions accompanied by clinical evidence of orbital cellulitis, and radiographic findings. The key features of management of mucor are prompt diagnosis with the use of CT and early treatment with antimicrobial therapy. Early diagnosis, with timely and specifically tailored treatment, will improve the prognosis and survival.

Keywords: diabetes, emergency medicine, mucormycosis, orbital cellulitis

P-0174 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Spontaneous intracranial epidural hematoma originating from dural metastasis of multiple myeloma

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Objective: Intracranial epidural hematoma (EDH) is usually a consequence of head injury. But spontaneous intracranial EDHs can occur rarely; in patients with paracranial infections, coagulation disorders, vascular malformation and neoplastic condition. We report a patient of multiple myeloma with having low platelet count who presented with spontaneous acute EDH. The case is important as the condition reported is very rare. In our patient possible mechanisms for epidural hemorrhage is tumor related epidural inflammation and fragility of epidural venous plexuses.

Case: The patient was a 63-year-old woman who had acute episode of unconsciousness with headache, dizziness and fatigue. She was already diagnosed with multiple myeloma since 2008. She had received chemotherapy (velcade and cyclophosphamide) two weeks ago in our hematology clinic. In her medical history; she was operated for intracranial hemorrhage four years ago in another hospital. The patient and her relatives had questioned but neither of them had no knowledge or document about this operation. She had no history of recent head trauma. Initial vital signs were all in normal ranges. On physical examination, she was disoriented and drowsy. Neurological examination revealed no focal neurological deficits. She had a burr-hole defect on the right side of her occipital bone. Blood investigations revealed anemia with hemoglobin 5,9gr/dl, also platelet count of 23,000/ mm3 with prolonged prothrombin time: 16.7 second but aPTT was normal. Computerized tomography of the head had showed 12mm right occipital epidural hematoma with burr-hole defect and 15mm left cerebellar epidural hematoma. In emergency room the patient had been started 2 two units of erythrocytes transfusion after that consulted neurosurgery. Close observation and serial brain imaging was suggested for her management. Then she hospitalized in hematology department for 6 days. She had given platelet transfusion. Accompanied by clinical findings and control cranial CT intervention was not considered by neurosurgery. She was discharged by her own request.

Conclusion: Multiple myeloma is a B-cell malignancy characterized by accumulation of monoclonal plasma cells. Typically, the disease involves the bone marrow and breaks through the cortex, invading the surrounding tissue. It is possible that such changes may cause vascular damage and bleeding. Spontaneous intracranial epidural hematoma due to multiple myeloma is very rare. Follow-up is suggested in asymptomatic cases. However surgery may be indicated if the patient has midline shifts, elevated intracranial pressure, and progressive clinical deterioration. As a rare cause of spontaneous EDH, dural metastasis from malignancy should be considered by emergency physician.

Keywords: spontaneous, cranial epidural hematoma, multiple myeloma

P-0175 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Pleural Aspergillosis: A Rare Presentation of Fungal Infection

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Objective: Aspergillus species is one of the commonest causes of fungal infections. The aspergillus empyema is a rare clinical entity. Pleural aspergillosis is not characteristically associated with pulmonary aspergillosis in either its allergic, bronchopneumonic, or intracavitary forms. Empyemas are rare presentations of fungal infection. We report a case of aspergillus empyema thoracis with pneumothorax in an immunosuppressed patient.

Case: A 63-year-old female presented with complaints of progressive breathlessness and right-sided chest pain. She was being followed hypothyroidism, sarcoidosis, primary hyperparathyroidism and hypopituitarism due to granulomatous hypophysitis. She had been used corticosteroids for two months. CT scan of the chest showed pneumonic consolidation in the right middle lobe. She was treated for a short course of antibiotics empirically including imipenem. There was aspergillus spp. cultured sputum and voriconazole treatment was given her symptoms dyspnoea and chest wall pain improved after a 2-week antibiotic treatment. Control CT scan showed right hydropneumothorax that was treated with intercostal drainage. Purulent fluid drainage and massive air leak were seen. Aspergillus spp were seen in pleural fluid culture. Pleural fluid showed hyphae of Aspergillosis. 25. day of treatment there was no pleural drainage, the air leak was stopped and chest tube removed. Antibiotherapy continued with oral voriconazole. Patients who have Aspergillosis infection usually are immunocompromized. The predisposing factors are diabetes, prior tuberculosis infection, chronic lung disease, receiving chemotherapy, and post-transplantation state. Fungal infection is a rare cause of empyema thoracis. Management of Aspergillosis empyema is very difficult. Antifungal medications, including intravenous Voriconazole or Amphotericin, should be considered in invasive fungal infection.

Conclusion: Empyemas of fungal origin are associated with high mortality rates but early administration of anti-fungal agents and pleural drainage might be helpful in improving the outcome.

Keywords: aspergillus, empyema, fungal infections

P-0176 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Incidence of CA-MRSA In A Major Dubai Teaching Hospital

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Objective: Although numerous studies established incidence of CA-MRSA pertinent to their region, data for the Middle East was still lacking giving rise to our study. We explored CA-MRSA in adults with SSTIs presenting to Rashid Hospital Trauma Centre ED in Dubai, UAE.

Our secondary objectives were to identify variables helping predict the likelihood of a SSTI being MRSA positive.



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Materials-Methods: Prospective observational study conducted in a single centre treating 150,000 patients per annum, over 18 months. Participants meeting our inclusion criteria underwent a structured interview. Cultures were obtained and MRSA isolates confirmed by PCR. Patient characteristics were summarized using descriptive statistics and MRSA prevalence and 95% confidence intervals were estimated using standard equations. Backward stepwise multivariate logistic regression models determined predictor variables independently associated with MRSA infection.

Results: Of 100 patients enrolled, 44% had Staphylococcus Aureus & 18% had MRSA. 39% were of 20-29 years age group. 40% presented within a week of onset of symptoms of which 23% presented within the first 3 days.

Hypertension was a risk factor for CA-MRSA with 5 of 18 patients presenting with CA-MRSA (p-value <0.001)

Incarceration also increased the incidence of CA-MRSA (p-value <0.001)

Interestingly, recent skin infection appeared to reduce CA-MRSA (p-value <0.001), possibly because patients seek medical attention early. Of the SSTI's, skin abscesses appeared to increase the probability of developing CA-MRSA (p-value 0.008) while cellulitis surrounding a SSTI was also predictive (p-value 0.001).

Conclusion: CA-MRSA is of significant prevalence and should be considered when initiating empiric antibiotic therapy, particularly in patients who are hypertensive, prisoners and those presenting with an abscess or a SSTI involving an area of cellulitis.

Keywords: CA-MRSA, Dubai, infection

P-0177 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Coagulopathy Due To Akbaşı Herb

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Background: Bleeding tendency or known bleeding tendencies are not receiving adequate treatment of hemoragic stress in a patient with unexpected bleeding is referred to as incompatible with my blood. Akbaşı herb yarrow *Achillea millefolium* is known as the other. Drinking akbaşı tea to determine the effect of the coagulopathy.

Case: 45 year old female patient to the emergency room in the stool blackening with the complaint was admitted examination and vital 130/90 mmHg, pulse 78/dak, fever of 36 degrees, saturation of 99 physical examination, digital rectal examination in the melena. Patient attached to the nasogastric tube non active hemorrhage. Patients tests aPTT: 65 INR: 4.5 PTR: 14.4 biochemistry is normal. The patient's history of drug use drinking akbaşı tea within the last week.

Conclusion: We investigate coagulopathy in the patient for vitamin K deficiency, liver disease, or warfarin and heparin, FX, V, prothrombin or fibrinogen deficiency or inhibitor. However, patients with fresh frozen plasma therapy after and Akbaşı herb tea after discontinuation of patient examinations and clinical is normal. Depending on the patient coagulopathy revealed that akbaşı herb. Drinking tea for getting thin side effects are not known so must be careful.

Keywords: akbaşı herb, coagulopathy, tea

P-0178 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

THE ASSOCIATION of MCV with MORTALITY in STROKE

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Objective: In recent studies some hematological parameters including Red blood cell distribution width (RDW), mean platelet volume (MPV) and neutrophil lymphocyte ratio have been reported to be associated with mortality in some diseases such as stroke, myocardial infarction and pulmonary embolism. We aimed to study the association of mean corpuscular volume (MCV) with mortality in stroke.

Materials-Methods: This is a retrospective study. The stroke cases admitted to the Konya Education and Research Hospital in between January 2013- January 2014 were included in the study. The patients who were under the age of 18 years old, with any hematological diseases, who took chemotherapy or get any transfusions in last 3 months, with vitamin B12 or folic acid deficiencies were excluded. Demographic features, NIHSS scores and in-hospital mortalities of patients were recorded. Descriptive analysis were defined as median and interquartile range (IQR).

Results: Totally 237 patients were included in the study. Among cases the median (IQR) age was 71(18), and %51.1(121) of the cases were male. In %84.8 (201) of the cases, the diagnosis was ischemic stroke while in %15.2(36) of them it was hemorrhagic stroke. The median (IQR) NIHSS score of the patients was 10(14), while the hospitalization days was 6(5) and the mean MCV levels was 86.5±6.0. Among cases, %25.3(60) were expired. There was a significant difference in regards to the age and NIHSS scores between alive and expired patients, however there was not a significant difference in regards to MCV levels (p>0.05). There was not a correlation between MCV and age, NIHSS scores or hospitalization period

Conclusion: Many hematological parameters show some changes in situations such as inflammation or acute stress. This condition affects the prognosis of many diseases. According to our results, we could not determine an association between MCV levels and mortality in stroke.

Keywords: MCV, Mortality, Stroke

P-0179 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Systematic Evaluation of Alzheimer Disease in Emergency Department

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Objective: The autopsy results of a patient followed in an outpatient clinic with behavioral changes and progressive defects in mental functions for 5 years were compatible with Alzheimer Disease (AD). In microscopical evaluation of brain tissue, neurofibrillary tangle and senile plaques are the specific pathological markers in diagnosis of this disease.

Materials-Methods: This retrospective study was performed in Konya Education and Research Hospital, and last 1 year was screened for Alzheimer Disease. The demographical features, history, blood pressure, pulse rate and body temperature, laboratory findings and diagnosis of patients at admission were all recorded. SPSS for Windows 15.0 program was used for the statistical analysis. Descriptive analysis were defined as median and interquartile range (IQR). Categorical data were compared with chi-square and fisher exact tests while numerical data were analyzed with Mann-Whitney U test.

Results: The median (IQR) age of 21 patients admitted to the Emergency Department with the diagnosis of AD was 79 (11) years, and 57.1% of those patients were male. When the vital signs at admission were evaluated; median (IQR) of body temperature was 36.8 (1.4), pulse rate was 96(29), systolic blood pressure was 110 (50), and diastolic blood pressure was 79 (20). Hypertension was accompanying AD with a ratio of 57.1%. Hematological and biochemical data revealed that Hemoglobin: 13.20 (4), Hematocrit: 40 (13.5), White blood cell count: 11.6 (16), Urea: 69 (77), Creatinine: 1.2 (1.6). When the reasons of admission were evaluated; the most common reason was infection with a ratio of 61.9%. 47.6% of the patients were expired. There was a statistically significant difference in regards to the systolic blood pressure levels between alive and expired patients. There was not a significant difference in regards to other vital signs, laboratory parameters and age.

Conclusion: Although the knowledge about the physiological and neurological structure of nervous system and the diagnostic methods are increasing, still unknowns about the AD are abundant. With the fact that the mean life expectancy is getting longer, an increase is predicted in admission of patients with AD. Many studies reported that diseases disturbing vascular system escalations the development of AD. Systolic blood pressure may be a sign of mortality. It takes attention that, the most common reasons of admission were infection and acute renal failure due to dehydration. In that aspect, informing and education of the patients' relatives about the home-care is mandatory.

Keywords: Alzheimer Disease, Emergency Department, infection, blood pressure

P-0180 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Cadasıl Sendrom

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Objective: CADASIL (cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy) is a hereditary disease with high penetrance in which occlusion of small arteries in the brain of adults results in small deep brain infarcts and progressive accumulation of demyelination areas in the brain. Its manifestations are diverse and in most individuals include recurrent headache of migraine pattern, focal deficits secondary to brain infarction and, in later stages, progressive neuropsychiatric disorders including dementia

Case: A 45 year old female patient accepted to the AD with diplopia started one day ago. There was no any other complaint except diplopia. There was only hypertension in medical history and restricted medial movement of right eyes in physical examination. All laboratory tests were normal. In MRIs of both cerebral hemispheres, at the level of periventricular white matter and centrum semiovale reported pathological changes hypointense on T1 weighted and hyperintense on T2 weighted in signal intensity as multiple confluent areas. in white matter of both



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hemispheres of cerebellum, more likely located in subcortical area, bulbus, upper cervical spinal cord and pons reported diffuse micro-hemorrhage remarkable on GRE sequence

Conclusion: CADASIL is an autosomal dominant disease resulting from mutations of the gene encoding the transmembrane receptor Notch 3, located on chromosome 19. CADASIL may be one of the most common inherited neurological conditions. Its manifestations are virtually restricted to the central nervous system, especially the brain, and are caused by the progressive development of disseminated white matter lesions in association with small infarcts - lacunes - in subcortical areas. Migraine with aura and focal neurologic deficits caused by these lacunar infarctions are characteristic forms of presentation in young or middle age. Over the years, mood disorders, diverse neurological deficits and cognitive disturbances add up.

The diagnosis of CADASIL should be particularly suspected in the presence of:

-Typical clinical picture: one or more subcortical infarcts, especially early or with familial history, migraine, usually with aura; progressive cognitive changes or subcortical-type dementia;

-Typical neuroradiological findings on (MRI)

-Positive familial history: autosomal dominant pattern for one or more of the typical clinical features. The disease is probably underdiagnosed. The diagnosis should be considered not only in patients with recurrent small subcortical infarcts leading to dementia, but also in the patients with transient ischemic attacks, migraine with aura and mood disturbances and focal neurological symptoms whenever MRI reveals prominent signal abnormalities in the subcortical white matter and basal ganglia.

Keywords: Cadasil, Diplopia, MRI

P-0181 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

serebro vascular stroke due to systemic lupus erythematosus: a case report

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Systemic lupus erythematosus (SLE) is a complex multisystem disease that may

involve the central and peripheral nervous systems. The incidence of stroke as a neurological involvement in patients with SLE is between 3-20%. Possible reasons for the development of stroke are suggested as hypercoagulability and thrombosis due to antiphospholipid antibodies, cerebral vasculitis, cerebral embolus due to Libman Sacks endocarditis and hypertension due to the disease itself or long term corticosteroid use. In this study, we presented 33 years clinical acute stroke and stroke of after the diagnosis of SLE, clinical, laboratory and radiological imaging are presented in emergency room.

In this study, we presented clinical, laboratory and radiological imaging of a 33 year patient who admitted to emergency room with clinical acute stroke and diagnosed of SLE after this stroke.

Keywords: lupus, strok, emergency

P-0182 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Anaphylaxis with hypertension. Is this a real anaphylaxis?

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Objective: Anaphylaxis typically emerges due to release of bioactive mediators from mast cells and basophils by the Ig E - mediated immunological mechanism. It's an early type and life threatening hypersensitivity reaction. The diagnosis of anaphylaxis is based generally on physical findings and history. Adrenaline is generally advocated as the initial treatment of choice for anaphylaxis regardless of the underlying cause. Although hypotension is a cardiovascular system finding which is mostly seen and used as a criterion of diagnosis, hypertension may present rarely in anaphylactic patients too.

Case: A 37 year old female suffering from low back pain was admitted to the emergency department. On detailed questioning, stating that she was suffering low back pain for two years which relieves by analgesics, her present pain emerged after jerk and did not relieve despite oral analgesic. Her past history included Meniere disease. On admission, her blood pressure was 113/74 mmHg, pulse 90 beats per minute, body temperature 36.7°C and oxygen saturation 98%. After she was considered as experiencing lumbago she was administered Meperidine 50mg intravenously under monitoring. At the 15th minute of the treatment, she had experienced hot flush, hypertension (180/100 mmHg), shortness of breath and tachycardia (200 beats per minute). Standard anaphylaxis treatment except adrenaline was applied in addition she was administered naloxone. She was discharged after 24 hours monitoring without any complaint.

Conclusion: Diagnosis of anaphylaxis is based usually on physical findings and history. Hypotension is a rare initial manifestation especially in children and infants with anaphylaxis. However, incidence of hypotension in adults is common. In anaphylaxis, internal compensatory vasopressor responses such as secretion of catecholamine, activation of angiotensin system, production of potent vasoconstrictor peptide endothelin-1 can produce variable result and peripheral resistance can elevate abnormally with anaphylactic episodes in some patients. Moreover it's known that reversal of endorphin effects with high dose naloxone may improve hemodynamic function. As in our case, compensatory vasopressor response can be very dominant and this can cause anaphylactic reactions emerge with hypertensive attacks.

Keywords: Anaphylaxis, Hypertension, Meperidine, Naloxone

P-0183 Other

A Rare Cause Of Epistaxis Due To Leech Infestation: A Case Report

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Objective: Leeches are rare blood-sucking endoparasites and live in unfiltered water or contaminated water but they can cause potentially fatal complications. Land leeches have powerful jaws that grip the skin and attack the outer surface of the body. Aquatic (wetlands) leeches are common on the world but they have weak and feeble jaws, and they need to be a soft tissue for feeding. Leeches are usually taken into the human body while bathing or drinking unfiltered water or while swimming in contaminated water. They remain for days and weeks. The most prominent symptom is continuous bleeding from the mouth and nose in patients that have leech infestations and the other symptoms are headache, fatigue and discomfort. Limnatis nilotica is the most common leech that has been reported in our country. In this case report we present a patient who is mental retardation and has a leech infestation in the nasopharynx that caused symptoms of epistaxis and obstruction of upper respiratory system.

Case: A 19-year old man lived in a rural area presented to emergency department with complaints of intermittently epistaxis, nasal obstruction, sore throat and dispne about for two weeks. In his medical history of the patient who has mental retardation, previously he was evaluated for these complaint in another medical center, where a routine blood test, a chest X-ray, and a physical examination revealed no reason for this pathologic condition. And then upper respiratory tract infection was diagnosed and discharged on prescription. The patient was admitted to the emergency department with complaints of non-regression. On physical examination, a moving gray green foreign body was seen in the oropharynx. A single foreign body that extended to nasopharynx was observed on the coronal and axial tomography sections. The patient was consulted by an otolaryngologist. The foreign body was removed with the help of forceps and understood to be a leech which measured about 5.5 cm in length. The patient was discharged from the emergency department after a few hours having no complications.

Conclusion: Especially, leech infestation should be considered in some cases such as a patient who does not fully able to express due to mental retardation, lives in a rural area, uses unfiltered water and in unknown causes of patient's complaints like epistaxis, nasal congestion, sore throat and dispne

Keywords: epistaxis, mental retardation, leech infestation

P-0184 Trauma Emergencies

Oil Pressure Injection Injury: A Case Report

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Objective: High-pressure injection injuries of the hand are rare. The incidence is becoming more common with increasing industrialization. Generally, the entry hole is small, but emergency surgical intervention may be necessary as a result. Foreign substances easily navigate through the soft tissue due to the high pressure of the impact and ultimately lead to serious complications. The case of accidental hydraulic oil injection into the hand of a 36-year-old male that came to the emergency department (ED) is presented. The patient was followed up with for approximately three months. Post treatment, full recovery was observed. This case report aims to emphasize the necessity of close monitoring and treatment of patients suffering from



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high-pressure injection trauma in the ED. We want to emphasize that the injection trauma patients need to be evaluated immediately in ED and followed up in ED if necessary.

Case: 36-year-old male patient came to the emergency department (ED). He was working as a ready-mixed concrete pump operator. He said oil was leaking from the hydraulic pump, so he wore gloves and tried to block with his hands the leakage, but suddenly oil was injected into his right hand due to the high pressure. The hand was slightly swollen. There were no necrosis or ischemic areas. The patient's radiographs were normal. No fractures were found. The patient was consulted by orthopedics. Patient was monitored to see whether there was compartment syndrome progression. As his hand was elevated, hand washing, dressing, and tiny incision at the impact point were performed. Patient's hand was massaged to extract the hydraulic oil out through the impact point. Five hours later, edema and swelling were observed in the injured hand but more so in the dorsal. Cyanosis was present on the fourth right finger. Fasciotomy was performed by orthopedics on the first day. Patient was followed up with for two days in the hospital and was discharged after. The Patient was followed later on the seventh and fifteenth days of the accident in the emergency room. Necrosis developed on the distal part of the fourth right finger.

Conclusion: High pressure injection traumas rarely occur in our region, but as industrialization increases, we expect to see more similar cases in our ED. The amputation rates increase due to the patients' negligence or delays in coming to the ED. Patient's hospitalization, early surgical interventions, and close monitoring reduce the risk of morbidity and mortality.

Keywords: Injection Trauma, High Pressure Trauma, Oil Injection

P-0185 Trauma Emergencies

Our Successful Experience in Hemostating The Broad Scalp Laceration With Chitosan

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Objective: A 20 year old male patient was taken by ambulance service to our Emergency Department due to head injury. There was a whole layer scalp cut about 15 cm in size and seemed like a crescent beginning from the left posterior parietal region to the right occipitotemporal region. Although pressured compress was applied in the ambulance the bleeding couldn't be stopped. We prepared to share our experience in this case that bleeding control was hard and was stopped by the help of chitosan.

Case Report: A 20-year-old Iranian male patient was brought to the emergency department with a knife wound to the head following an assault. Physical examination revealed the presence of a crescent (half-moon) shaped full-thickness scalp laceration extending 15 cm from the posterior aspect of the left parietal bone to the right occipito-temporal area. The wound had straight margins on a horizontal plain, with 7 identified sources of massive arterial bleeding. Chitosan was quickly applied over the wound, completely covering both edges. This was preceded by cleaning and drying of the wound with a sterile sponge, since chitosan powder is readily soluble in water/blood. Tight dressing was then applied to the wound for 30 minutes to allow time for hemostasis. Continuing bleeding was observed after removal of the tight dressing, albeit only oozing. The chitosan was carefully removed and the wound washed with saline. A tetanus booster and prophylactic antibiotics were administered. A subsequent computerized tomography of the head did not reveal any parenchymal or bone defect. No significant drop in hematocrit was observed on a complete blood count and the patient was discharged from the emergency department.

Results: Chitosan is generally marketed as a powder mixed with an organic acid such as succinic or lactic acid. As a hemostatic agent, it transfers a negative charge to the cell membranes of erythrocytes which accelerates thrombus formation and facilitates clot adherence. Chitosan is more absorbent when mixed with calcium alginate. The use of chitosan in the emergency department has increased in recent years due to its hemostatic efficacy in large surface wounds. It has also been proven to be a useful surgical adjuvant for skin wounds that require surgical intervention. It may be used as a hemostatic agent for scalp lacerations and large surface wounds that required surgical intervention, and could prove particularly helpful in trauma cases where control of bleeding is challenging.

Keywords: Chitosan, bleeding, scalp laceration

P-0186 Trauma Emergencies

Bilateral pneumothorax case: Spontaneous or Iatrogenic?

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Objective: Pneumothorax is the collection of air in the pleural space. It is classified in two main groups; spontaneous and traumatic. Depending on the extension and the etiology of the pneumothorax, management usually consists of tube thoracostomy and underwater seal drainage

Case: Sixty three years old female patient had first injection on dorsal region during the physical rehabilitation due to muscle pain. She begun to experience dyspnea and cough just after the injection. On detecting reduced breath sounds at the right in auscultation, chest x-ray and computed tomography were performed. Radiological investigation revealed bilateral pneumothorax and the patient referred to our hospital. Because of the extensive pneumothorax (>30%) on the right tube thoracostomy and underwater seal drainage were performed, pneumothorax on the left was minimal (<10%). Right lung was expanded after tube thoracostomy, and aeration on the left was increased after the oxygen therapy. Pneumatic infiltration area was observed on the right lung in computed tomography. There was no any clinical or laboratory finding of infection. We found leucocyte count: 14.27 10⁹/L, sedimentation rate: 6mm/h and CRP: 3.5mg/L.

Conclusion: On the basis of these findings, it is controversial to classify this case whether spontaneous pneumothorax, iatrogenic pneumothorax or pneumothorax secondary to pneumonia. Considering that it is bilateral, the timing of symptoms and the absence of signs of infection it is highly suspected to be iatrogenic pneumothorax. For this reason we decide present this interesting case.

Keywords: Pneumothorax, iatrogenic, emergency medicine

P-0187 Trauma Emergencies

Due to The Physical and Psychological Trauma of War

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We want to share both the psychological and physical condition of 32 years old female patient having 4 children who lost her two children because of explosion in city centre in Syria and had multisystem injuries as well as had glass pieces inside thorax and eye and had 3 operations after this injury.

Keywords: Foreign Body in Eye, Hemothorax, Major Depression

P-0188 Other

Use of Mean Platelet Volume Levels In Thrombosis Patients As A Diagnostic Criteria

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Objective: In this study, we aimed to investigate the usability of mean platelet volume (MPV) levels of thrombosis patients as a diagnostic criteria.

Materials-Methods: In our study, 01 January 2008 - 31 December 2012 between the dates of Süleyman Demirel University, Faculty of Medicine Hospital presented all of the confirmed cases of thrombosis were evaluated. The patient had a definitive diagnosis in 2052. The demographic values were determined. Patients' complaints, audits required MPV admission, complete blood count, hemoglobin, platelets, neutrophils, lymphocytes, WBC and other blood tests troponin, homocysteine, hs-CRP, CRP, D -dimer, CT imaging tests, Doppler examinations were determined by scanning archives.

Results: First admission time MPV levels of the patients were higher than the last MPV levels and statistically significant (p=0,00). First MPV levels were positively correlated with the diagnosis (p=0,032,r=0,012).

Conclusion: MPV may be used as a diagnostic criteria especially in acute myocardial infarction, stroke, deep venous thrombosis and pulmonary embolism.

Keywords: Thrombosis, Mean platelet volume, diagnostic criteria

P-0189 Trauma Emergencies

Traumatic Rupture of The Urinary Bladder after Alcohol Intake

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Objective: Urinary bladder rupture in blunt abdominal trauma is rare. Urinary bladder rupture is seen in 10% of distended bladder patients. Iatrogenic and spontaneous causes of bladder rupture include pelvic surgery, suprapubic or foley catheter placement, bladder biopsy, ureteral stent manipulations, radiation therapy and infection. In this case, we talked about bladder rupture after alcohol intake and blunt abdominal trauma. The most common symptoms of major bladder injury are gross hematuria (82%) and abdominal tenderness (62%).

Case: 35 year old male patient after alcohol intake and getting kicked in the abdomen was admitted to the emergency department with complaints. The patient's inability to urinate and had abdominal pain. At physical examination, abdominal tenderness was found. His vital signs revealed a temperature of 36.5°C, blood pressure of 100/59 mmHg, respiratory rate of 24/min, pulse rate of 108/min, and pulse oximetry reading of 94% on room air. Foley catheter inserted into the patient and haematuria was observed. Laboratory tests of the patient and ultrasound was performed. In USG, free fluid was seen common in the pelvic region, within containing millimeter of internal echoes. We suspected bladder rupture and consulted in urology. Bladder rupture was diagnosed by retrograde cystography. Finally, patients were operated on by urology.

Conclusion: After alcohol intake in patients with bladder distention is expected. Therefore, these patients become prone to bladder rupture after blunt trauma. Trauma admitted to the emergency department with abdominal pain should also be considered in patients with bladder rupture. Penetrating or blunt injury rarely causes until empty bladder rupture. However, if the bladder is full, the risk of rupture increases.

Keywords: blunt trauma, bladder rupture, abdominal pain

P-0190 Trauma Emergencies

Traumatic Hip Dislocation

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Objective: Hip dislocations can be classified as anterior, posterior, and central, and are typically due to high-energy trauma. Posterior dislocations constitute approximately 90% of hip dislocations. They are caused by force applied to a flexed knee, directed posteriorly, most commonly in high-speed motor vehicle crashes. Concomitant life-threatening injuries must be excluded. Studies of motor vehicle accident have shown hip dislocations are commonly associated with knee injuries such as fractures, dislocations and ligamentous damage.

Case: Our case study is a 26 year old man, who transported by ambulance to the emergency department for motor vehicle accident. Patient was agitated and vital signs were stable. Glasgow coma score (GCS) was E4 V4 M5: 13. His face was multiple lacerated and on examination, the extremity was shortened, internally rotated, and adducted. Other system sing was normal. The patient radiologic imaging shown bilateral maxilla anterior wall fracture, mandibula fracture, right lung contusion and left posterior hip dislocation. The patient's posterior hip dislocation was made closed reduction under procedural sedation (fentanyl + midazolam). After the hip reduction control CT shown there was no complication and was successfully redislocated. There was not any neurological deficit, after the procedure. The patient was consulted to concerned departments and admitted to intensive care unit.

Conclusion: The reduction of traumatic hip dislocation should be attempted as expeditiously as possible, as prolonged time (> 6 hour) to hip reduction is associated with more severe avascular necrosis and nerves injuries. Closed reduction should be attempted under conscious sedation, general anesthesia, or spinal anesthesia immediately after the injury. Emergency medicine physician be careful to diagnose hip dislocation and should treat the patient as soon as possible.

Keywords: Emergency Department, Posterior Hip Dislocation, Procedural Sedation

P-0191 Trauma Emergencies

Pectoralis Major Rupture in Bedridden Patient

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Objective: The pectoralis major muscle is in front of the chest wall. It is a large muscle and larger of pectoralis muscles. Its tendon is attached to the humerus. Rupture of the pectoralis major is a rare injury that was first described by Patissier in 1822 in Paris. Pectoralis major ruptures are uncommon injuries that occur almost exclusively in men between the ages of 20 to 50. Rupture usually occurs after challenging activities. In this case we talk about a bedridden patient whose relatives caused pectoralis major rupture.

Case: 73 years old bedridden patient admitted to the emergency department complaining of swelling and bruising in front of the chest. He had a pain at the same region. His vital signs revealed a temperature of 36.7°C, blood pressure of 130/72 mmHg, respiratory rate of 18/min, pulse rate of 88/min, and pulse oximetry reading of 95% on room air. On physical examination of the patient in the left pectoral and axillary regions on an area of 15 x 20 cm, edema and hematoma was present. There was tenderness in the same area. The patient had a history of ischemic cerebrovascular disease. He had right hemiparesis since this event. It was learned that, the relatives of the patient always support from the left axillary region to remove the patient. Radiographs taken of patients are in the normal bone structure. Ultrasound was planned in the area of the patient's complaint. Pectoralis major rupture was seen on ultrasound. Then orthopedic consultation was requested.

Conclusion: Pectoralis major injuries generally occur during forceful activities. Almost half of all pectoralis major ruptures occur during weightlifting. Patients who has a pectoralis major rupture feel sudden pain, and often a tearing sensation in their chest. Also steroid use can weaken the tendon, and this is thought to be a contributing factor in many pectoralis major muscle ruptures. As in this case, it can also occur as a result of wrong management of the elderly and bedridden patients. Pectoralis major rupture should be considered for this patients.

Keywords: pectoralis major, rupture, bedridden

P-0192 Other

Cardiopulmonary Arrest following inadvertent IV administration of hydrotalcite

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Objective: Intravenous administration of drugs is a complex and demanding task that involves a drug preparation process prior to injection of the medication. So far, mortality and morbidity following medication errors have been reported, including administering a wrong drug, dose, or diluent, or causing contamination of one medication with another during injection. In the present case we report a patient who developed cardiopulmonary arrest following inadvertent IV administration of 10 cc hydrotalcite solution intended by the patient's nurse to be given via oral route.

Case: A 50-year-old woman presented to emergency department with epigastric pain of burning character for a few days. Her vital signs on admission were as follows: Blood pressure: 140/80 mmHg, pulse rate: 98 bpm, SaO₂: 98%, body temperature: 36.5°C. Electrocardiogram was normal. In physical examination her general condition was well and she was conscious with full cooperation, orientation. Abdominal examination revealed epigastric tenderness without rebound or guarding. Her laboratory examinations were all within normal limits. An IV route was established and it was intended to administer ranitidin 50 mg and hydrotalcite (talcid) for epigastric pain. A solution containing 10 cc hydrotalcite prepared in an injector for oral administration was inadvertently injected through IV line by the patient's daughter who was a nurse. The patient's general condition quickly deteriorated immediately following injection of 3 cc drug and thus she was promptly taken to the resuscitation room. She rapidly developed cardiopulmonary arrest and was urgently intubated followed by cardiopulmonary resuscitation (CPR). Two ampoules of adrenaline and 80 mg prednol IV were administered. She was converted to sinus rhythm 5 minutes later. Her blood pressure was 90/50 mmHg, pulse rate 110 bpm, and SO₂ 90%. She was admitted to intensive care unit. A thoracoabdominal CT with contrast was performed. Thoracic CT revealed no pulmonary embolism. Abdominal CT revealed signs of cholecystitis. Intravenous antibiotics were begun. She was extubated 8 days after admission and taken to regular ward. She was followed at the ward for 8 days and discharged without sequel thereafter.

Conclusion: To prevent medication errors it is essential to provide the system with qualified nurses, adequate man power and proper definitions of roles and responsibilities of nursing staff, pass legal regulations, provide continuous education, use of information technologies, enhance registry systems, eliminate inadequacies about physical ultrastructure, implement teamwork to working environments, develop efficient communication, develop quality assurance and standards of care, develop adequate treatment protocols, and raise personal/public awareness

Keywords: intravenous hydrotalcite, medication error, cardiac arrest



POSTER BİLDİRİLER

P-0193 Trauma Emergencies

Myocardial Contusion After Punching

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Objective: Blunt chest trauma can lead to cardiac contusion in 5 to 50% of patients. Unfortunately, there is no gold standard for making this diagnosis. Several factors are used in conjunction to make this diagnosis, including a history of trauma, physical examination, ECG, echocardiography and serum cardiac markers. The ECG may be entirely normal or show nonspecific changes, such as dysrhythmias and the most common is sinus tachycardia. Echocardiographic findings may reveal a pericardial effusion or regional wall motion abnormalities. The sensitivity and specificity for CK-MB in the detection of cardiac injury is low in the setting of trauma, but troponin levels are more specific for detecting myocardial injury.

Case: We evaluated an 65-year-old woman admitted to the emergency department following punch to her chest wall. She did not recall the events leading up to the punch and could not remember if this pain was present before the punch. She had coronary artery disease history, on initial examination, she was tachycardic and had tenderness on lower sternum. Her initial vital signs were; blood pressure was 130/74, pulse rate was 112/min, temperature was 36.8 C, respiratory rate was 14 breaths/min. An ECG was obtained which revealed normal sinus rhythm at a rate of 112, with left bundle block (LBBB). Laboratory findings showed creatine kinase (CK) 143, CK-MB 37, and troponin I of 0.129. The patient was transferred to the intensive care unit for cardiac monitoring and follow-up serial cardiac enzymes.

After four hours CK-MB level increased to 55 and a troponin to 0.644. Serial ECG monitoring was also obtained, and in the third ECG a normal sinus rhythm with left bundle block was seen. She was consulted to the cardiologist. In echocardiogram there was left ventricular segmental wall motion abnormalities and left atrial enlargement. Coronary angiography was planned for the patient. In the coronary angiography there were no significant pathology. After evaluating all of the ancillary tests, the patient was diagnosed with cardiac contusion related with punching.

Conclusion: Blunt cardiac injury is a significant risk factor for cardiac dysrhythmia and myocardial injury. The clinical presentation of the patients with blunt cardiac trauma varies widely. Cardiac enzyme determination has a useful role in the evaluation of patients with suspected myocardial contusion. Serial ECG and cardiac enzyme monitoring should be obtained from all of the patients presenting with blunt chest trauma.

Keywords: Punching, Blunt chest trauma, Myocardial contusion

P-0194 Trauma Emergencies

Analysis of 4 Cases with Tracheobronchial Injury

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Introduction: Tracheobronchial injury may emerge depending on such blunt and penetrant thoracic trauma as vehicle accidents and sharp object injuries. Usually, symptoms are dyspnoea, subcutaneous emphysema and pneumothorax. Tracheobronchial injuries have 30% mortality. More than half of mortalities occur at the first hour of injury. In this article, we would like to present 4 cases including 2 bronchial rupture, 2 isolated cervical tracheal laceration and rupture.

Material-Method: Our cases consist of 4 male patients, who were taken to emergency department. Ages of patients were between 5 and 33 and average age of them was 15.4. One patient had isolated cervical tracheal injury (Figure 1-3) following sharp object injury. One patient had bronchial rupture of right upper lobe, after the patient trapped under tractor. And one patient had isolated cervical tracheal rupture, after extravehicular traffic accident. Four patients underwent operation. While 2 patients died due to multiple organ failure, 2 patients were discharged from hospital healthfully.

Result: In patients who had respiratory distress after thoracic trauma, massive air is released from chest tube. And in postoperative observations and in chest x-ray, lung did not expand. This facts should be suggestive of bronchial rupture. In the event of common subcutaneous emphysema, pneumomediastinum, especially trachea and/or bronchial rupture should be suspected. The patients, for whom such injuries are suspected, should have bronchoscopy. In interventions, the primary aim is to ensure ventilation of patient. Tracheobronchial injuries are life-threatening injuries which require immediate treatment.

Keywords: bronchial rupture, Trachea injury, trauma

P-0195 Trauma Emergencies

Asymptomatic Epidural Hematoma after Baseball Stick Injury

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Objective: Blood collection between dura mater and skull is called epidural hematoma. Epidural hematoma is caused by disruption of middle meningeal artery after blunt trauma to temporal or temporoparietal region. On the other hand, epidural hematoma is also associated with trauma to the parieto-occipital regions which can cause tears of the venous sinuses.

Case: 26 year old man arrived to emergency department by walking after a blunt trauma -with a baseball stick- to his left temporal region. He had no symptoms, even no headache. His vitals were stable, glasgow coma scale was 15, and initial physical examination showed no pathologic findings, except 3 cm of laceration on left temporal region scalp. No new pathologic clinical findings and no symptoms has occurred after a 3 hours of follow-up. We performed a head CT scanning and saw 21 mm of epidural hematoma of left temporal area without skull fracture. He has been admitted to neurosurgery intensive care unit. After 3 days of follow-up, epidural hematoma showed regression to 17 mm and he has been discharged without symptoms.

Conclusion: Blunt trauma to temporal bone with sticks -like baseball- carry higher risk for epidural hematoma. Classical pattern of epidural hematoma includes loss of consciousness, altered mental status, lucid period, subsequent rapid neurologic demise. But only a minority of patients show this classical pattern. High pressure bleeding can cause herniation within hours and early surgical intervention can save patients life but in our case, there were no symptoms, no pathologic clinical findings and only head ct scan showed the pathology. Patient didn't need surgical intervention so could be discharged safely after 3 days of follow-up. Even there were no need of surgery, emergency medicine physicians must be aware of epidural hematomas for prognosis, after high energy blunt trauma to temporal bone like how we faced in our case.

Keywords: head trauma, epidural hematoma, baseball stick

P-0196 Trauma Emergencies

Acromioclavicular Joint Dislocation after Punching

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Objective: Acromioclavicular joint injuries usually occurs by a direct falling onto shoulder. Mechanism of acromioclavicular joint dislocation is that scapula is pushed downwards, so clavicle becomes prominent after ligament injury which supports acromioclavicular joint. This mechanism is uncommon after punching.

Case: 79 year old man has been carried to emergency medicine service with head and shoulder trauma after a fight. He had left shoulder pain and headache. His initial clinical finding showed no crepitation on left shoulder, 2 lacerations of scalp on occipital and frontal region and there were no neurologic deficits due to head trauma. His vitals were stable and glasgow coma scale was 15. Head ct scan showed no pathological finding. Left shoulder x-ray was performed and we saw dislocation between acromion and clavicle without fracture. Clavicle's position was in its neutral area. No surgical intervention was needed so that velpeau bandage was performed to patient and discharged with painkillers.

Conclusion: Acromioclavicular joint dislocation is common but due to mechanism of injury it is uncommon after punching. Our patient was 79 year old man, he possibly had weak acromioclavicular joint ligaments so that only punching to his shoulder caused this dislocation. Grade 1, 2, 3 acromioclavicular joint dislocations don't need surgical intervention, but grade 4, 5, 6 need surgery. Our case was not grade 4, 5 or 6 because of neutral position of clavicle so velpeau bandage was enough. Elderly patients have weaker supportive ligaments of joints so dislocations could happen after even low energy trauma.

Keywords: Acromioclavicular joint dislocation, trauma, elderly

P-0197 Other

Dasatinib is A Rare Cause of Pleural Effusion

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Objective: Dasatinib is a tyrosine kinase inhibitor (BCR-ABL) which is used for the treatment of patients with chronic myeloid leukemia (CML) resistant or intolerant to imatinib. Dasatinib can cause fluid retention in some patients, leading to peripheral edema and pleural effusion. Pleural effusion was reported in 14% to 30% of patients. We report a patient with CML under medication of dasatinib and admitted to emergency service because of dyspnea.

Case: 37 year old female patient admitted to the emergency department with dyspnea and cough. The patient's complaints began 2 weeks ago. She was diagnosed CML and she was using



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dasatinib. There was no other disease except CML in the patient's medical history. Her initial vital signs were; blood pressures 126/68, pulse rates was 126/min, temperature was 37.9 C, respiratory rate was 22 breaths/min. On patient lung auscultation there was bilateral rales. Complete blood count, d - dimer levels, arterial blood gases were studied for differential diagnosis of pneumonia, pulmonary embolism, heart failure. Complete blood count was with normal values. There was hypoxia and hypocarbia on arterial blood gases and there was high D-dimer levels in patients blood results. There were bilateral pleural effusion on chest radiograph. The patient was consulted to cardiologist to exclude pulmonary thromboembolism. Patient was evaluated with echocardiography and no pathological findings were found in patient's echocardiography and no emergent cardiac disease was considered by cardiologist. Then she was consulted to infectious diseases specialist because of high fever and cough to exclude pneumonia. Infectious diseases specialist started oral moxifloxacin therapy and she was discharged from hospital. Patient was called back after 3 days. The patient's pleural effusion increased on control chest radiograph and there was an increase in patient complaints. In this patient, pleural effusion was considered related to treatment with dasatinib. We started oral diuretic therapy. Patients were called back after 5 days. The patient's pleural effusion decreased on control chest radiograph and the patient's complaints reduced.

Conclusion: A detailed history should be obtained from all patients admitted to the emergency department. Drugs used by the patient must be learned. When the patients who are taking dasatinib admitted to the emergency department with dyspnea and cough, the cause might be drug-related pleural effusion. Recognition of these symptoms as a potential complication of dasatinib will help prevent unnecessary investigations and facilitate adequate management.

Keywords: Dasatinib, Pleural Effusion, Dyspnea

P-0198 Trauma Emergencies

Isolated Peroneal Nerve Injury After Stabbing

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Objective: The peroneal nerve is a branch of the sciatic nerve, which supplies movement and sensation to the lower leg, foot and toes. Separated from the sciatic nerve in the popliteal fossa, the peroneal nerve crosses the gastrocnemius muscle lateral head in the outer part of the popliteal fossa. Peroneal nerve palsy is a common form of lower extremity peripheral nerve damage and is usually caused by trauma, surgery or postural compression of the nerve. Symptoms of peroneal nerve injury may include inability to point toes toward the body (dorsi flexion), pain, weakness, numbness (on the shin or top of the foot, loss of function of foot, high-stepping walk (called steppage gait or footdrop gait)). We report a patient presented to the emergency department with isolated peroneal nerve injury after stabbing

Case: A 22-year-old male presented to the emergency department stabbing at left leg. Emergency hospitalization was undertaken. According to his medical records he has no disease history. Her initial vital signs were; blood pressures 110/54, pulse rates was 88/min, temperature was 36.6 C, respiratory rate was 13 breaths/min, oxygen saturation %97. The first assessment there was 3 cm incision in the left leg thigh laterally. In the extremity physical examination he had no signs of vessel injury and no motor deficits in the proximal left lower extremity but his left foot dorsiflexion was 0/5 and his left toe dorsiflexion was 2/5. Also he had hypoesthesia on peroneal nerve region. Other physical examination findings was normal. The laboratory tests were within the standard range. He was diagnosed with peroneal nerve injury following clinical examination and EMG. He was discharged home with close follow-up after a period of observation and was given instructions to return immediately for swelling, numbness, increasing pain, pus, redness, or weakness.

Conclusion: Penetrating trauma of the extremities like stabbing is considered a difficult injury to manage because artery and nerve injuries can be serious and may significantly impair outcome of the patient. At the peroneal nerve injury diagnosis will include a comprehensive clinical exam, complete medical history, electrical testing, imaging studies, such as X-rays or high-resolution 3-T MRI (magnetic resonance imaging). Despite possible (long-term) complications, overall survival is very high. Because of high morbidity of penetrating trauma of the extremities, detailed physical examination should be performed all the patients admitted to the emergency department with penetrating trauma.

Keywords: Penetrating Trauma of The Extremities, Peroneal Nerve Injury, Stabbing

P-0199 Trauma Emergencies

An interesting work accident: the invasive screw in ethmoid bone from medial orbital wall

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Objective: 17 year old female patient was admitted to our emergency department with a work accident. Foreign body on the edge of the eye was detected in the examination. Orbital CT was requested. Foreign body were found to be an invasive screw from medial orbital wall to ethmoid bone. The patient was consulted with plastic surgery. She was admitted to the hospital for the operation.

Reviewing the literature, intracranial foreign bodies are generally can be seen the orbital, frontal sinus and nasal area. (1,2) Determining and correct identification number and location of the intraocular foreign body is important for treatment and prevention of complications. Those patients with maxillo-facial or orbital trauma to a preliminary diagnosis of intraocular foreign body (IOFB) presence should be investigated carefully. Computed tomography (CT), is the first imaging modality in orbital trauma. (3)

Case: 17 year old female patient was admitted to the emergency room complaining of pain and stinging in the eye after the accident at work. After the events, the patient was admitted to examination of the family doctor, he said it was normal and she was discharged by giving a prescription. The patient was admitted to our hospital after pain worsened. Right in the eye examination were found to be increased in the medial orbital epicanthal fold, sclerotized redness and tears. In addition, when one looks carefully, foreign bodies were seen stuck to the edge of the medial epicanthal area in the eye and it was shining. On closer inspection it was found that the foreign body is a screw. Orbital CT was asked to in order to determine the exact location of the foreign body in the patient. Tomography has been detected an invasive screw, it was been passing through medial orbital wall into the ethmoid bone. The patient was consulted plastic surgery for the removal of the foreign body and she was hospitalized.

Conclusion: The important things are for the success surgical extraction, not omitted of foreign body and its correct identification of the placement in the eye. Accidents at work are important in the etiology such as motor vehicle accidents. Emergency physicians must be vigilant about the patients with maxillofacial or orbital trauma for undetected intraocular foreign bodies even when low intensity of trauma. CT imaging is to be applied primarily to defining of intraocular foreign body presence and location.

Keywords: foreign body, orbita, screw

P-0200 Other

Esophagus Obstruction Due to Ingestion of Multiple Foreign Bodies: A Case Report

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Objective: Foreign body (FB) ingestion is an important health problem for children. However Aspiration or ingestion of a FB has frequently been reported in the adult population who is of elderly, psychiatric, alcoholic or mentally retarded illnesses. Most foreign bodies usually pass through the gastrointestinal tract without causing any damage. Management based on the size and nature of the foreign body and whether it is smooth or sharp. Here we report a case of multiple FBs being ingested over a period of seven days and in which there was surgical intervention after attempted endoscopic approaches had failed.

Case: A 22 year-old man was admitted to the emergency department complaining of abdominal pain after swallowing FBs. On the admission, the patient was general status was moderate. His blood pressure was 110/80 mm Hg, heart rate was 85 beats/min, oxygen saturation was 95%, and his body temperature was 36.5 °C. Upon physical examination nonspecific abdominal tenderness and chest discomfort was found. The laboratory parameters were within the normal range. Conventional radiography of the chest and abdomen revealed multiple FBs (Figure 1). The patient said that he had swallowed a few screws and a wrist watch. On esophagoscopy performed by a gastroenterologist a toy car, and small teddy bear were removed. However, since the body of the wristwatch could not be extracted a thoracotomy performed to remove it. As a result of these two interventions, all the FBs were removed (Figure 2). The postoperative period of patient was good and 6 days after the intervention he was transferred to the psychiatry clinic.

Conclusion: To our knowledge, this is an interesting case in terms of the nature and number of FBs in an adult patient. In this case surgical intervention was required following the failed endoscopic procedures. It is important that the medical practitioner considers the size, number, shape, structure and the anatomical location of swallowed objects before deciding on the appropriate treatment and follow up regime.

Keywords: foreign body, esophagoscopy, emergency department

POSTER BİLDİRİLER

P-0201 Other

Knowledge Levels Regarding Crimean Congo Hemorrhagic Fever among Emergency Health Care Workers in an Endemic Region

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Objective: In this study, we aimed to determine knowledge levels regarding Crimean Congo Hemorrhagic Fever (CCHF) among emergency healthcare workers (HCWs) in an endemic region. **Materials-Methods:** A questionnaire form consisted of questions about CCHF was applied to the participants.

Results: The mean age was 29.6±6.5 years (range 19- 45). Fifty-four (49.5%) participants were physicians, 39 (35.8%) were nurses, and 16 (14.7%) were paramedics. All of the participants were aware of CCHF, and 48 (44%) of them had previously followed CCHF patients. Rates of the use of protective equipment (masks and gloves) during interventions for patients who were admitted to the emergency service with active hemorrhage were 100% among paramedics, 76.9% among nurses, and 61.1% among physicians (p=0.003). Among 86 (78.9%) HCWs who believed that their knowledge regarding CCHF was adequate, 62 (56.9%) declared that they would prefer not to care for patients with CCHF (p=0.608).

Conclusion: The use of techniques to prevent transmission of this disease, including gloves, face masks, face visors and box coats, should be explained to emergency room HCWs, and encouragement should be provided for using these techniques.

Keywords: Crimean-Congo Hemorrhagic Fever, emergency, health care worker

P-0202 Other

Spontaneous pneumothorax caused by density altitude and temperature alteration: A case

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Objective: Density altitude is an expression of atmospheric density in terms of altitude compared to international standard atmospheric conditions. Density of atmosphere is the amount of the air molecules in a given volume. Temperature changes, pressure and air humidity directly affect the air density. Rapid temperature changes and altitude differences are among the factors, which appear in spontaneous pneumothorax etiology.

Case: A 56 year- old male truck driver drove his truck for 40 days along the European E-40 road. He spent the last 15 days driving from Kazakistan Pavlodar to Bolu (altitude:732-725m) via the Ural (altitude:1890m) and Geyikli (altitude:1500-2500m) mountains. He was admitted to our emergency service with complaints of right chest pain and shortness of the breath just after leaving his truck. Spontaneous pneumothorax was developed due to the temperature changes from -52degree to +10degree during his journey. No significant findings were observed in the patient history other than previous pulmonary disease in his left lung. Closed tube drainage treatment was applied to the patient examined in the emergency room due to the right spontaneous pneumothorax. The patient was discharged three days later, fully recovered after drainage was applied and his lung extended.

Conclusion: Spontaneous pneumothorax is usually seen widely in the populations of young, thin, male smokers and people with long breast structure. When these cases are investigated, the most underlying cause is the spontaneous rupture of the subpleural blebs or bullae located in apex of lung. The most likely rise factors are density altitude and temperature changes since our case doesn't have these characteristics. Sudden temperature changes and significant altitude changes should be remembered questioned in the history of the patients admitted to the emergency service with chest pain and shortness of the breath.

Keywords: Pneumothorax, Altitude, Temperature changes

P-0203 Trauma Emergencies

Quadriplegia Case Development Related To Post-Syncope Cervical Trauma

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Objective: Type of cervical spine injuries are different than young people and C1-2 fractures in elders are more frequent. If an elder person who had a trauma in the past is suffering from neck pain, the ER Physician needs to be cautious and ensure the stabilization of the patient's neck as if there is cervical spine injury until the cervical spine is fully diagnosed.

Case: Relatives brought 81 years old male patient by ambulance, stating that he woke up at night to have some water and then passed out. From his anamnesis, it's learned that he's diagnosed with hyper high blood pressure and diabetes, and he's receiving treatment for these. In the physical examination performed, he was conscious, co-operative, oriented, blood pressure 100/70 mmHg, peak heart rate 56/min., sPo2 94, blood sugar fingertip measurement was 95 mg/dl, quadriplegic, sub C6 hypoesthetic respiratory sounds were bilaterally equal to listen, no properties in cardiac examination. Laboratory observations were normal. EKG normal sinus rhythm speed was 56/min. Cranial thoracic was not detected in imaging and no pathology was detected in lumbar BT, on BT there is C6 anterior dislocation and totally closed the spinal canal.

Conclusion: Cervical injuries between C3-C7 are usually seen in traffic accidents or entertainment activities. Knowing cervical spinal trauma, which can be an important morbidity and mortality reason and various treatment options have vital importance. Sub-axial cervical injuries are observed in a wide range from basic ligament strain or spinous process fracture to full fracture and dislocation ending up with serious spinal cord injuries. Emergency approach to such injuries should be as correct anamnesis, careful physical examination, systematic radiographic evaluation.

Keywords: quadriplegia, cervical trauma, post syncope

P-0204 Trauma Emergencies

An interesting gunshot injury: An eye perforation by a bullet, passing through the temporal bone and orbita

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Objective: The perforative and incisive wounds of orbita include injuries with metallic substances like bullet and shrapnel pieces, tiny glass pieces, and stone or wood pieces. Particularly the wounds localized inside the orbita can lead to serious clinical consequences, even the removal of the eye. 24-year-old male patient was presented in this article. He had got perforation of the right eye as a result of gunshot injury. In this article, a case with an eye perforation by a bullet, passing through the temporal bone and orbita was presented.

Case: 24-year-old man with gunshot injuries was brought to the emergency department by 112. When the patient comes to the emergency department, his GCS was 15 and his vital parameters were normal. (blood pressure, pulse, sato2 etc.) and it was understood that by the patient's speech and the smell of the breath, he was an alcoholic. He said that he committed a suicide attack but the story was doubtful. On the examination of the patient, there was a bullet injury about 1x1 cm in size with burn marks and gunpowder residue in the right temporal area of the head. There was a crush injury in the right eye sclera. Right eye had total hyphema and its globe integrity was impaired. Other system examinations were normal. In the spiral CT of the orbita and brain it was seen that the right eye was found to be perforated by the bullet that was firstly entered into the right orbita then exited from there after entering from the right temporal bone and passing through the right temporal bone and right zygomatic arch. Also, there was common hematoma in the retro-orbital region and fragmented burst fractures of the lateral wall of ethmoid bone. There was an unseparated linear fracture in the frontal bone. There was no bleeding or contusion in the brain parenchyma. He was consulted to plastic, eye and brain surgeries and he was hospitalized.

Conclusion: Gunshot injuries can cause very dramatic consequences due to availability of the excess of energy. Especially the mortality and morbidity of cranial gunshot wounds are very high and these injuries are growing a social problem in the community. Indeed, many patients with gunshot injuries have been dying without any assessment by a specialist brain surgery due to lack of time. Mortality rate in patients with a history of suicide were found to be increase in the previous studies. A good neurological examination and appropriate radiologic examinations plays a key role for the correct and effective treatment.

Keywords: eye, gunshot injury, perforation



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P-0205 Trauma Emergencies

A rare cause of abdominal pain: Strangulated herniation developing following blunt abdominal trauma

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Objective: About 7-10% of the patients applying to trauma centers are those with abdominal trauma. Abdominal traumas are classified as blunt or penetrating traumas based on mechanism of occurrence. Deaths related to blunt traumas are more frequent because of the difficulties of diagnosis and delays seen in treatment. The mechanism of the traumatic injury most frequently operates with pressure effect, and less commonly, with squeezing and tearing effect. Although rare, fascia defects can develop in the abdomen following blunt trauma, and organs can be herniated through such defects. Here, we are presenting our case who applied to our emergency room with blunt abdominal trauma and diagnosed with strangulated hernia after the examinations made.

Case: The 15-year old male was brought to our emergency room with inguinal pain. The history of the patient involved a hit with knee in his inguinal region during a fight about 24 hours ago. Although the inguinal pain was mild at first, he was brought to the emergency room by his family upon the pain and swelling became more severe later and onset of nausea and vomiting. Vital signs were stable in the physical examination, the right inguinal area was tender with palpation and a mass 39*4 cm in size was palpable. Other system findings were natural. Laboratory tests: WBC:14.50; Hb:15.6; Hct:43.9; Amilase:78; AST:18; and ALT:21. In the abdominal USG, a hematoma was found in the right inguinal area, about 40*37 mm in size, including septa and hypoechoic areas in places surrounded with a minimal fluid area. In the abdominal tomogram with contrast substance taken later, herniation of the intestinal structure through the defect about 1.7cm in size located in the lower right quadrant of the abdomen together with some mesenteric fatty tissue into the inguinal canal (strangulated herniation?). Pediatric surgery was consulted for the patient and he was admitted with the diagnosis of strangulated herniation. The patient was operated and discharged on day 4 with cure.

Conclusion: It must be kept in mind that herniation and strangulation, which, although rare, can have a mortal course if diagnosis is delayed, can develop in relation with fascial defects in blunt abdominal traumas as well as solid organ and retroperitoneal organ injuries. Emergency room doctors must be careful in this issue.

Keywords: Strangulated Herniation, Blunt Abdominal Trauma, Abdominal Pain

P-0206 Trauma Emergencies

An Interesting Judicial Trauma Case in Emergency Department

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Objective: Trauma cases frequently admit to emergency departments with traumas in different ways and localizations. We wanted to share a trauma case admitted with a trauma occurred in an extraordinary way.

Case: A 16 year-old -boy case admitted to emergency department complaining knife wound in the neck. In his history, his neck was cut while his mother was swinging a plastic bag which a knife was in. She was sitting close to the patient and did not know the knife was in the bag. His vital signs were stable. In physical examination, there was a 2 cm horizontal incision in m. trapezius, laying from posterior to anterior, regular sided was on the right neck back. Incision was sutured with 4/0 prolene primarily and closed with dressing.

Conclusion: Emergency physician must be aware of judicial cases in especially trauma patients. Although it is a simple case, the history and the story make the case a forensic case. So questioning the patient is an essential issue for the emergency doctor.

Keywords: Judicial, trauma, forensic

P-0207 Other

A Rare Cause of Dysphagia in Emergency Department: Forestier Disease (Diffuse Idiopathic Skeletal Hyperostosis)

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Objective: Forestier Disease or Diffuse Idiopathic Skeletal Hyperostosis (DISH) is a disease of unknown etiology and diagnosed primarily on the basis of radiological criteria. The disease is rarely symptomatic and the symptoms may not be localized accurately. We wanted to share a case who admitted to emergency department with complaint of dysphagia.

Case: A 74 year old male patient presented to emergency department with an increasing dysphagia for 2 days. His vital signs, respiratory system examination and inspection of oropharynx were within normal range. A bony overgrowing was detected at anterior of C 4-5 vertebrae on lateral neck x-ray. We recognized that the cause of dysphagia was physical impingement of that bony overgrowth. The patient diagnosed as Forestier's disease and referred to ENT. Further diagnostic imaging (CT & Osophagography) was planned. After further imaging (neck CT and osophagography) the passage was determined adequate and no further surgical intervention was necessary. A Follow-up was planned.

Conclusion: Patients presented to emergency department with difficulty in swallowing should be also considered for Forestier's Disease which is one of the rare causes of dysphagia that can be diagnosed with a simple imaging.

Keywords: DISH, Dysphagia, Forestier Disease

P-0208 Other

A Case of anjiomyolipoma: a rare cause of hematuria

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Hematuria is one of the symptoms causing emergency service admittance. The common reasons of this complaint may involve urinary tract infections, renal and urethral stones, trauma, benign prostatic hypertrophy, nephropathy, iatrogenic circumstances, and urinary tract malignancies including prostate cancer, bladder cancer and renal cancers. However, angiomyolipoma is a rare cause of this complaint. In this study, we present a 24-years old female patient admitted to our emergency service for hematuria ongoing five hours. She reported that she had tuberous sclerosis and had given birth a baby three months ago. After urology consultation, she was diagnosed as having renal angiomyolipoma rupture, and she was hospitalized in urology clinic. Erythrocyte suspension infusion was commenced. She was evaluated by the radiology department, and they performed transarterial embolization at same day. After this procedure, her hematuria decreased and hemoglobine counts was stabilized. She was discharged with cure after five days hospitalization in urology clinic. In conclusion, we suggest that it will be helpful for emergency physician to keep in mind that angiomyolipoma ruptures may be a cause of hematuria.

Keywords: Angiomyolipoma, emergency medicine, hematuria

P-0209 Trauma Emergencies

Isolated First Rib Fracture: Case Report

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Objective: Rib fractures are common in emergency departments, but isolated first rib fracture is rare. Once we detect first rib fracture, there could be another pathology of visceral organs even though it is only one rib broken.

Case: 35 year old woman was admitted to our emergency department after a low energy motor vehicle collision with symptoms of pain on her left clavicle site and headache. She was sitting on passenger seat of the car and she had her child sitting in the middle of back seats. Once she realised that a collision was about to happen, she opened her left arm (abduction of arm) to stop her child move horizontally, but during collision, she had trauma on her left clavicle site and head. Initial physical examination showed tenderness upper of clavicle, there was no crepitation or deformity on her clavicle, and there was a little dermabrasion on her forehead. Vital signs were stable, GCS:15. After performing chest x-ray, we detected first rib fracture. Patient underwent non-contrast thorax ct which first left rib fracture and 14 mm of pneumothorax, contusio in apex of lung were detected. There was no other radiologically or laboratorily pathological finding. Patient was hospitalised for 3 days until seeing the regression of pneumothorax followed by discharging from hospital safely.

Conclusion: Isolated first rib fracture can have concomittant pathology such as pneumothorax, contusio like we had in our case. Fractured first rib could be with other fractured bones due to it is anatomically in a more secured position than other ribs or clavicle. Once we detect first rib fracture, we must presume the trauma as high energy after which comprehensive evaluation of patient should be performed.

Keywords: isolated first rib fracture, pneumothorax, trauma



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P-0210 Trauma Emergencies

C1 Fracture Caused by Animal Kick: Case Report

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Objective: C1 and C2 cervical vertebrae are more mobile than other cervical vertebrae. C1 is associated with flexion and extension of head and hyperextension or hyperflexion of this articulation can result as fracture of the vertebrae.

Case: 68 year old farmer woman came to our emergency department by walking with a history of being kicked by an animal (bullock) from her back 1 day before. She had pain on her right wrist, neck and back. Her vital signs were in normal ranges. First survey of patient revealed tenderness on her posterior cervical and T1-2 region, deformity and crepitation on her right wrist. There was not another clinically abnormal findings such as neurological deficits. So we performed x-ray to see bone abnormality for clinically tender sites. Cervical and thoracic x-ray was not clearly evaluated due to osteoporosis, wrist x-ray showed distal radial fracture. She underwent cervical and thoracic vertebrae CT scanning because there was still clinically suspicion of possible cervical or thoracic vertebrae fracture. Finally, anterior arch fracture of C1, odontoid process fracture of T2 were detected. Patient was then admitted to neurosurgery clinic for further evaluation and stabilisation.

Conclusion: Abnormal movements of head may result as C1 or C2 vertebrae fractures even though there is no direct trauma on bone. Our patient's hyperextension of head after being kicked from her back caused this fracture of C1 vertebrae's anterior arch. She was neurologically normal and spine injury does not seem to exist but we must be aware of neurological deficits due to possible injury of cervical spine.

Keywords: C1 fracture, trauma, animal kick

P-0211 Trauma Emergencies

Bilateral Transverse Process Fracture

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Objective: A transverse process is shaped like a wing. They extend from both the left and right sides of the vertebral body. A fracture of a transverse process is a break of a part of one of the bones in the spine. Many of these injuries occur in the thoracic and lumbar spine. Patients with transverse process fractures have severe pain even if the actual break is small or limited and there is no injury to nearby bones, organs, or the spinal cord.

Case: A 42 years old male patient applied to the emergency room because of back and chest pain after joked with his friend. During joking his friend had squeezed him with his arms and shook him. He did not have any disease and drug use in his medical history. His vital signs revealed a temperature of 36°C, blood pressure of 135/69 mmHg, respiratory rate of 20/min, pulse rate of 88/min, and pulse oximetry reading of 97% on room air. Physical examination revealed no abnormality other than tenderness in his back. Chest x-ray, lumbar and dorsal vertebral x-ray and thoracic and lumbar vertebral ct was applied. Bilateral fracture of transverse process of first lumbar vertebra was determined in ct. There was no other pathology in his tests. He consulted to orthopedy and brain surgery. They recommended analgesia and corset to the patient. The patient was discharged and polyclinic control suggested.

Conclusion: Vehicle accidents, recreational activities, industrial, agricultural and aviation accidents, gunshot wounds and direct blows to the back, parachuting incidents may cause transvers process fracture. Although rare, as in our case, bilateral transvers process fracture may occur by squeezing and shaking. So after such a trauma, if patient have a pain in the dorsal and lumbar regions, transvers process fracture should be considered. And these patients should be examined in terms of accompanying injuries.

Keywords: transverse process, fracture, squeezing

P-0212 Trauma Emergencies

Isolated Ileal Perforation After Blunt Abdominal Trauma

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Objective: Blunt abdominal trauma are often seen in the emergency department. As a result of blunt abdominal trauma, small bowel is third most frequently injured organ but isolated perforation of the ileum, following blunt ab-dominal trauma is extremely rare. These injuries are difficult to diagnose because initial clinical signs are frequently nonspecific and a delay in treatment increases mortality and morbidity of the patients.. Conventional ra-diograms are often inadequate for diagnosing this sub-set of trauma. Here, we report on an isolated ileal perforation caused by a blunt abdominal trauma in setting of a industrial accident.

Case: 21 year old male patient jammed between the walls and machines was brought to the emergency department. Emergency hospitalization was undertaken. According to his medical records he has no disease history. Her initial vital signs were; blood pressures 105/64, pulse rates was 94/min, temperature was 36,2 C, respiratory rate was 14 breaths/min, oxygen saturation %94. The first assessment, superficial laceration was available in the area around the navel. In the physical examination he had mild abdominal pain. In the patient's abdominal examination there was common defense and rebound in all quadrants. The laboratory tests were within the standard range. Free fluid in the abdomen between bowel loops were seen in ultrasound examination and free air in abdomen was seen in lateral decubitus x-ray. The patient was consulted to general surgery and general surgery planned emergency operation. Isolated ileum injury(10 cm laceration in ileum) was seen in operation. The patient was discharged from hospital 5 days after operation.

Conclusion: Isolated perforation of the ileum, following blunt abdominal trauma is extremely rare. Conventional radiograms are often inadequate for diagnosing. Especially in the case of an isolated injury where diagnostic investigations have failed, it may result in delayed therapy and a prolonged clinical course. For an accurate and timely diagnosis, the possibility of bowel perforation and the need for repeated examinations should be kept in mind.

Keywords: Blunt Abdominal Trauma, Ileal Perforation, Conventional radiograms

P-0213 Other

Spontaneous Haematoma of the Iliopsoas Muscle

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Objective: Motor strength loss in the lower extremity has more than one reason. For the patient presented emergency department with complaint of motor strength loss in the lower extremity, primarily lumbar disk herniation, lumbar spinal stenosis, cerebrovascular diseases and many neurological disorders are to be thought. In this case we report a patient with femoral neuropathy caused by an iliopsoas haematoma

Case: A 48 years old man presented emergency department with increase of weakness and hypokinesia of right leg for recent week. In the medical history of patient he has heart valve replacement only and taking warfarin 5 mg everyday. The weakness of quadriceps femoris muscle with rate of 3/5 and paresis on the anterior thigh were determined during neurological examination. On abdominal examination, palpable mass was identified on the lower right quadrant with palpation. The outcome assessment of the lumbar spinal MR taken at another clinic three days ago and lumbar disk herniation was not detected. No abnormal results were detected other than HGB: 11.2, HCT: 34, INR: 8.3 by blood analysis. The right iliopsoas muscle hematoma within the limits compatible with 12 * 8-cm mass was reported in abdomen computed tomography. Upon completion of the examination depending on warfarin overdose, weakness was detected as a result of nerve compression induced by iliopsoas muscle hematoma. The patient consulted to general surgery and hospitalized. He had been treated conservatively and was entirely asymptomatic thereafter.

Conclusion: When causes of motor strength loss in the lower extremities are questioned lumbar disc herniation and neurological diseases come to mind primarily. However, the medical history and the drugs used should be questioned in detail for patients with such complaints and suspiciously abnormal findings on physical examination are identified easily and tests can be directed in this manner. Factors rarely lead to loss of motor strength in the lower extremities should not be ignored.

Keywords: iliopsoas hematoma, warfarin overdose, femoral neuropathy, emergency department

P-0214 Trauma Emergencies

Pneumoperitoneum and Pneumomediastinum After Fall From Height

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Objective: Pneumomediastinum and pneumoperitoneum occur frequently in critically ill patients in association with blunt or penetrating trauma, soft-tissue infections or any condition that creates a gradient between intra-alveolar and perivascular interstitial pressures. A continuum of fascia planes connects cervical soft tissues with the mediastinum and retroperitoneum, permitting aberrant air arising in any one of these areas to spread elsewhere. While the presence of air in retroperitoneum or mediastinal tissue is not dangerous in itself, prompt recognition



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of the underlying cause is essential. We report a case detected pneumomediastinum and pneumoperitoneum with computed tomography after a blunt trauma.

Case: A 28 years old female patient brought to the emergency department by jumping from a building 5 meters height after psychosocial stressor inhabited with self-injurious behavior. Her Glasgow coma scale was 15 points. Pulse rate and blood pressure were normal, and oxygen saturation on room air was 97%. She was conscious, oriented, cooperative and had no subcutaneous emphysema. She had pain on back and left foot. The patient described no abdominal pain or shortness of breath. Her respiratory sounds were normal and bilaterally equal. A computerized tomography (CT) scans of the chest, abdomen was performed with contrast and pneumomediastinum at anterior mediastinum and multiple intraperitoneal and retroperitoneal free air values were observed. Esophagography administered with radiopaque agent and esophageal injury was not detected. She consulted to general surgery, thoracic surgery and psychiatry. She hospitalized by general surgery and they followed up her for 5 days with conservative approach and she discharged with no surgery.

Conclusion: There are different mechanisms whereby extra luminal air may reach the different body compartments. Air may travel along the fascia planes from mediastinum. Air in the peritoneal cavity which may occur either as a direct rupture of the bowels or a result of decompression of retroperitoneal air. Air may pass through small diaphragmatic fenestrations and enter the pleural space by means of a pressure gradient. It is important to be aware that profound clinical and radiological signs in the emergency department such as in our patient

Keywords: pneumomediastinum, pneumoperitoneum, blunt trauma, emergency department

P-0215 Other

Prothrombin Complex Concentrate for Anticoagulation Reversal in Patient with Gastrointestinal Hemorrhage

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Objective: Prothrombin complex concentrates (PCCs) have emerged as an important therapeutic option for the rapid reversal of vitamin K antagonists (VKA) -related bleeding. This case report is of a 38-year-old male receiving coumarin for peripheral arterial occlusive disease in whom prothrombin complex concentrate (PCC, Co-factor) was used for immediate correction of his international normalized ratio (INR) before undergoing endoscopic intervention.

Case: A 38-year-old patient receiving coumarin for peripheral arterial occlusive disease, Addison's disease, chronic kidney disease was admitted to our hospital because of rectal bleeding. He had no other gastrointestinal symptoms prior to the bleed. On arrival at the emergency department, our patient had hemodynamic stability. His hemoglobin (Hb) level dropped to 6.4 g/dl over a 24-hour period. Initial laboratory findings were as follows: blood glucose level 67 mg/dl, blood urea nitrogen: 36 mg/dl, creatinine: 4.77 mg/dl, sodium: 137 mEq/L, potassium: 3.9 mEq/L, chloride: 108 mEq/L. Under long-term oral anticoagulation with coumarin an actual INR of 2.08 was determined. As he was becoming more symptomatic (blood pressure: 70/40 mmHg), normal saline and 2 total units of red blood cells with consideration for 10 mg of vitamin K and prothrombin complex concentrate (PCC) at a dose of 50 IU per kg body weight consistent with current guideline recommendations for management of severe warfarin-induced bleeding were administered. Blood tests subsequently showed an INR of 1.5, at which point the patient underwent for endoscopic intervention. Upper gastrointestinal endoscopy was reported to show gastric angiodysplasia. Profuse rectal bleeding continued despite tamponade and, following a brief response to the transfusions, the hemoglobin level decreased to 6 g/dl again. Another unit of packed red blood cells was given. Colonoscopy was performed and revealed a rectal cavity full of fresh blood and clots, without a visible bleeding source. He had further episodes of bleeding and received nine more units of red blood cells during these periods. Due to increasing frequency of these hemorrhagic episodes, our patient underwent emergency computed tomography mesenteric angiography. There was no obvious source of bleeding. The patient was transported to general surgery department because of ongoing bleeding. The patient underwent total gastrectomy.

Conclusion: The case described highlights that PCC are an important therapeutic option when urgent reversal of anticoagulation is required. Indeed, PCC not only correct clotting factor deficiencies more rapidly and completely than plasma, but are also associated with a lower incidence of volume overload and carry minimal risk of viral transmission

Keywords: Oral anticoagulants, Prothrombin complex concentrates, bleeding, gastrointestinal hemorrhage

P-0216 Other

Prothrombin Complex Concentrates for Rapid Correction of Haemostatic Defects in Patient with Liver Failure

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Objective: Patients with liver damage requiring an urgent invasive intervention need rapid correction of their haemostatic defect. Here we describe the case of a patient presenting with hepatic encephalopathy and underwent successful femoral venous catheterization for emergency hemodialysis treatment after his INR had been corrected with prothrombin complex concentrate (PCC, Co-factor) that was administered according to current guideline recommendations.

Case: A 65-year-old man with a history of liver failure, was brought to the emergency department for acutely altered mental status. The patient was known to have a history of recurrent episodes of hepatic encephalopathy was in the prior 1 month. On examination showed a male in no acute distress with a Glasgow Coma Scale of 13. His pupils were equally round and reactive to light. Cardiopulmonary examination was unremarkable. A massive amount of ascites was present in the abdomen. Because he was not following commands, the neurologic examination was limited. Fingertick glucose level was 96 mg/dl. Noncontrast head tomography revealed no acute pathologic lesion. Laboratory tests were as follows: blood glucose level: 100 mg/dl, blood urea nitrogen: 71 mg/dl, creatinine: 5.08 mg/dl, sodium: 124 mEq/L, potassium: 4.7 mEq/L, chloride: 89 mEq/L, total bilirubin: 31.70 mg/dl, aspartate aminotransferase: 261 U/L, alanine aminotransferase: 84 U/L, albumin: 2.1 g/dL, prothrombin time: 32.2 seconds, INR: 2.78, and ammonia: 33 umol/L. Blood gases: Ph: 7.465, HCO3: 20.4 mmol/L, PCO2: 28.9 mmHg. Following therapy with a presumed diagnosis of hepatic encephalopathy, the laboratory investigations showed a worsening renal function. The patient consulted a nephrologist. An emergency dialysis was planned for the patient on the impaired renal function. Because rapid correction of INR was required before femoral vascular access, 10 mg of vitamin K and PCC at a dose of 50 IU per kg body weight were administered intravenously. After intravenous administration of PCC the INR was 1.7. Emergency femoral venous catheterization was performed. Hemodialysis treatment was performed without complication. The patient was transferred to intensive care unit for further management.

Conclusion: The patient presented here had an increased perioperative bleeding risk, including minor invasive interventions. Fluid restriction is mandatory for our patient because of expanded plasma volume and renal insufficiency. In this case in which there is a risk for volume overload with the use of fresh frozen plasma (FFP), the use PCC was considered. This case demonstrates that PCC therapy is an effective treatment in patients with liver failure. It is also a well-tolerated approach to correct haemostatic defects in these patients when given prior to minor invasive interventions

Keywords: prothrombin complex concentrates, liver failure, hepatic encephalopathy, bleeding

P-0217 Trauma Emergencies

Mandible Fractures and Maxillofacial Trauma

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Objective: Mandible fractures are the second most common facial fracture after nasal fractures. Mortality of patients admitted for maxillofacial trauma with isolated mandibular fractures is fairly low (1.6%), when combined with fractures of other areas of the face, the mortality is substantially higher (25%). Studies have reported that the incidence of C-spine injuries in patients presenting with facial fractures ranges from 2 to 10%. Up to 44% of patients with severe maxillofacial trauma require endotracheal intubation due to mechanical disruption or massive hemorrhage into the airway.

Case: 32 years old man patient presents to emergency department with severe head trauma.

First evaluation of the patient there was no breath and circulation. CPR was applied. Before the intubation there was bleeding in his mouth and fracture in his mandible. After five minutes pulses was seen. After the resuscitation patient blood pressure was 90/50 mmHg and GCS was 3. CT scan showed bilateral presymphyseal mandibular fracture, right mandibular condyle fracture and lateral wall of maxillary sinus fracture. The patient admitted to the intensive care unit and died after 7 days. If there was resuscitation after the accident patient would be in the life.

Conclusion: During the primary survey of facial trauma patients, the airway must be protected from hemorrhage and mechanical obstruction. Significant hemorrhage into the airway can result from mandible and midfacial fractures. Loss of mechanical support resulting in airway obstruction can occur with bilateral posterior mandible fractures. Reposition the airway as needed with a jaw thrust, or head tilt and chin lift after cervical spine clearance.

Keywords: Emergency Department, Resuscitation, Mandible Fractures



POSTER BİLDİRİLER

P-0218 Trauma Emergencies

Skull Fracture With Cow Horn Trauma

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Objective: Fractures of the skull can be classified as linear or depressed. Linear fractures are either vault fractures or skull base. Linear fracture result from low-energy blunt trauma over a wide surface area of the skull. When the linear fracture is runs through a vascular channel, venous sinus groove, or a suture, it may cause epidural hematoma, venous sinus thrombosis and occulsion, and sutural diastasis, respectively.

Case: 56 years old man patient presents to emergency department with head trauma by cow horn. His first evaluation GCS was E3 V3 M4:10, agitated and vital signs were stabil. His right parietal side of head was having abrasion. E-FAST ultrasound evaluation showed there was no free fluid in his abdomen and pneumothorax in his chest. Under sedation of the brain CT scan revealed a linear skull fracture on his right parietal bone and contusion in the parietal region of the brain. The patient was followed in the intensive care unit for several days and discharge without neurologic deficit.

Conclusion: Although skull fractures carry a significant potential risk of cranial nerve and vascular injuries and direct brain injury, most skull fractures are linear vault fractures are not associated with epidural hematoma. Most skull fractures, including depressed skull fractures, do not require surgery. Hence, all of the potential complications listed are associated with a graver prognosis if the fracture is missed during the diagnostic workup.

Keywords: Emergency Department, Skull Fracture, Cow Horn Trauma

P-0219 Trauma Emergencies

Old, Antithrombotic, Head Trauma, Can You Trust the First CT Result?: Case Report

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Objective: Intracranial hemorrhage (ICH) may occur within brain parenchyma or within the meningeal spaces; epidural, subdural, subarachnoid. There are many symptoms associated with ICH including headache, nausea, vomiting, alteration in level of consciousness, seizure. Trauma associated intracranial hemorrhage is common in emergency departments. Life threatening ICH without symptom is really rare and may be a serious cause of ED visit days later after trauma.

Case: 66 year old patient -with a history of head trauma 1 week ago- was referred to our ED with nausea, vomiting and altered level of consciousness. It's learnt that his symptoms started a couple of hours ago, before arriving to our ED. He had a history of coronary bypass operation 3 months ago and minor head trauma caused by falling 1 week ago. His children said that he applied to ED 1 week ago after falling and head CT scan was said to be normal. And it was also learnt that he had used warfarin sodium (coumadin) after coronary bypass surgery. His initial vital signs were: blood pressure:185/95mm/Hg, pulse:122, saturation:85%, body temperature:37.1C, respiration rate:18/min. GCS was 9 (E:2, V3, M4). Physical examination showed bilateral mydriatic pupil, bilateral positive babinski reflex. We performed cranial CT which revealed the 6cm of parenchymal hemorrhage in frontal lobe, 8.5 mm of subdural hematoma in temporal, blood in lateral ventricles associated with 12 mm of cranial shifting. Laboratory results were in normal range, except WBC:17000 and INR:4.83. Patient then was hospitalised in neurosurgical intensive care unit for further evaluation and treatment.

Conclusion: Patient had minor head trauma 1 week ago followed by normal vital signs, normal clinical findings and normal head CT scanning. He had used coumadin, resulting 4.83 of INR level. We associate the patient's clinical situation with the coumadin usage, minor head trauma and the age of patient. As a result; elderly patients are more vulnerable to ICH after minor head trauma, so we had to evaluate carefully patients over 60 year old with antithrombotic agent usage, even patient is clinically normal.

Keywords: head trauma, antithrombotic, intracranial hemorrhage

P-0220 Trauma Emergencies

The value of Serum BNP for diagnosis of intracranial injury in minor head trauma

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Objective: Head injury is the main cause of death among individuals younger than 45 years old. Cranial Computerized tomography (CT) is commonly used for diagnosis of head injury. Brain Natriuretic Peptide (BNP) is a peptide originally isolated from brain ventricles. The main aim of this study is to investigate BNP as an indicator of head injury among patients presenting to emergency department (ED) with minor head trauma.

Methods: This was a prospective study conducted at the emergency department of the Numune Training and Research Hospital. A total of 162 patients who presented to the ED with minor head injury were enrolled. The patients were categorized into 2 groups as the cranial CT-negative and positive groups. The normality of the data was tested using One Sample Kolmogorov Smirnov test. Mann-Whitney U test was used to compare 2 independent groups while the Kruskal-Wallis test was utilized for comparison of more than 2 groups. A p-value of <0.05 was considered to be significant.

Results: Ninety-six (59.3%) patients were male and 66 (40.7%) were female. The cranial CT-negative group had a median BNP level of 14.5 pg/ml while the cranial CT-positive group had a median BNP level of 13 pg/ml. There was no statistically significant difference between these two groups for serum BNP levels (p > 0.05).

Conclusion: This study suggested that serum BNP level wasn't used in defined of intracranial injury

Keywords: emergency, head trauma, bnp

P-0221 Other

Intravesical foreign body: silicone

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Objective: We aim to this study presented an unusual intravesical foreign body.

Case: Forty-two year old male patient was admitted to the emergency room with complaints of inability to urinate for one day. According to the anamnesis of the patient we have learned that; he inserted a silicone foreign objects into the urethra for sexual satisfaction one night ago and he could not remove it. On physical examination, no foreign body was palpable in penile urethra. AP pelvis radiograph was performed. Foreign body within the boundaries of the bladder was observed. Tubular foreign body in the bladder was detected on ultrasonography. About 30 cm long and 20 French thick silicone foreign body was removed from the bladder by cystoscopy. After the procedure, the patient was discharged with recommendation of antibiotics and NSAIDs.

Conclusion: Intravesical foreign bodies are rarely seen. Treatment is usually removal of the foreign body with endoscopic procedures

Keywords: emergency, silicone, bladder



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P-0222 Other

Uvula Haematoma; A Very Rarely Seen Clinical Finding

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Objective: Uvula Haematoma is local collection of blood in uvular tissue. It is rarely seen. It may occur spontaneously due to minor trauma while patient eating something but it rather develops as a complication of thrombolytic therapy, endotracheal intubation or other invasive procedures of oropharyngeal region. If it is large enough it may lead to upper airway obstruction and may be life-threatening. We presented a case of uvula haematoma secondary to intense coughing in a patient with upper respiratory infection.

Case: A 57-year-old female patient presented to our emergency room due to small reddish blue lesions which appeared in the last 24 hours on her soft palate. There was no history of coagulation, and/or bleeding disorder or any chronic disease. She had had an upper respiratory tract infection for the last 3 days and she complaint of primarily intense coughing. She had not used any drugs for this infection. Her vital signs were normal. We saw lots of petechiae approximately 1 mm in diameter on both sides of her soft palate, and a uvular haematoma on the left posterolateral side of uvula. Its dimensions were approximately 2X3X4 mm. Blood samples were taken for complete blood count, biochemistry tests and coagulation studies. They were all within normal range. Thus it was understood that uvula hematoma developed due to intense coughing as petechiae on soft palate did. Because her hematoma was small and unlikely to cause any upper airway compromise we started oral treatment for her upper respiratory tract infection, and exchanged her recommending Ear Nose Throat outpatient clinic follow up.

Conclusion: If a patient complaints of a foreign body sensation on back of his throat although he did not take a foreign body in his mouth, and needs repeated gagging or swallowing physician should be careful about a uvula haematoma. Because uvula haematoma may threaten upper airway it is an important clinical finding but its dimensions are important. If it is large enough to threaten air passage through the upper airway early endotracheal intubation to secure airway, and surgical management of haematoma may be considered.

Keywords: Uvula haematoma, upper respiratory infection, cough

P-0223 Other

An unusual manner is up to allopurinol: DRESS syndrome

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Objective: Allergic reactions consist of big part of requests to emergency service. They can come in front of us with from bare symptom to life threatening manner in changeable clinic.

Case: Because of itchy rash especially on her face and body, a 60 years old female patient was admitted to emergency department. It was learnt from the history of the patient that the administration of allopurinol was started as a result of high uric acid levels shown in the routine examinations 15 days before. Vital signs were stable at physical examination. Conjunctivas were hyperemic. There were erosion and hemorrhagic crusts on lips, maculopapular lesions which got pale after pressing and with common erythema on oral mucosa face, body and back. Glucose 136 mg/dl, aspartate aminotransferase (AST) 109 U/L, alanine aminotransferase (ALT) 171 U/L, alkaline phosphatase (ALP) 423 U/L, gamma-glutamyl transferase (GGT) 299 U/L, lactate dehydrogenase (LDH) 312 U/L, amylase 283 U/L were detected on examination which were asked. Dermatology consultation was asked for the patient with preliminary diagnosis of DRESS syndrome. Later previous treatment of the hospitalized patient were stopped and antihistaminic and systemic steroid treatment were applied. The patient was discharged with recovery.

Conclusion: For patients who are admitted to emergency department with the history of using allopurinol, having skin lesions and increase in liver function tests showing involvement internal organs, DRESS syndrome should be considered.

Keywords: DRESS syndrome, allopurinol, allergic reaction

P-0224 Trauma Emergencies

A rare cause of amputation; High pressure injection injuries

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Objective: When the liquids like paint and thinner injected with high pressure, with a high speed and acceleration they split from the liquid gun, drill the skin, pass the fat and subcutaneous tissue and spread especially in the course of vessels and nerves. So it causes cutaneous and subcutaneous necrosis and extremity losses. In this case, we aimed to present the high pressure injection trauma which can cause amputation by reviewing the literature.

Case: 48 years old male patient revealed to emergency suffering thinner injection to his hand 8 hours ago with a high pressure liquid gun. In physical examination, it seemed that there was edema and lack of circulation in left hand second finger distal and median phalanks. Finger movements are limited because of pain and edema. Sensual examination was normal. The patient consulted to plastic and reconstructive surgery (PRS). Decompressive treatment performed in emergency conditions. For follow up, the patient hospitalized in PRS service. During the follow up in service, the necrosis was too fast because of the contribution of smoking habit of the patient and the finger amputated from the middle of the medial phalanks.

Conclusion: Injection traumas caused by paint and paint solvents go acute and severe and generally end with amputation. Early appeal to hospital, early decompression and debridement in high pressure traumas result satisfactorily well. But as in our case, appeals after 6 hours usually result with amputation. Small lesions and insignificant symptoms should not mislead us.

Keywords: amputation, high pressure liquid gun, trauma

P-0225 Trauma Emergencies

Bilateral Posterior Shoulder Dislocations With Fractures Following Seizure

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Objective: Posterior dislocation of the shoulder is a rare clinical entity. Posterior dislocation of the shoulder should be kept in mind in patients presenting with shoulder pains related to epileptic seizures, electric shock, or hypoglycemic comas, irrespective of whether a history trauma exists. This case report is of a 52-year-old male with bilateral posterior fracture-dislocation of the shoulder, caused by convulsive seizure without any trauma.

Case: A 52-year-old man was taken to our emergency department (ED) after an acute generalize tonic-clonic episode. On arrival at the ED, he was post-ictal and unable to offer either a complaint or a history of present illness. The neurologic examination findings of patient were; cooperation and orientation was limited. The patient's mental status improved as his post-ictal state resolved. He complained that his shoulders hurt and that he could not move them. Physical examination revealed pain in both shoulders, which were fixed in adduction and internal rotation. The results of neurovascular examinations of both upper extremities were normal. The anteroposterior (AP) radiographs of both shoulders revealed bilateral posterior dislocation of the shoulders. The mechanism of posterior shoulder dislocation is believed to be unbalanced muscle contraction. Attempts to carry out closed reduction of both shoulders were unsuccessful. He also underwent a CT scan, which confirmed a bilateral posterior dislocation of the shoulder with displaced fractures. The patient was transferred to orthopedic surgery for open reduction of both sides.

Conclusion: Posterior shoulder dislocations occur rarely but are often missed on initial presentation. Posterior shoulder dislocations should be considered in post-ictal patients with shoulder pain or an abnormally appearing shoulder. ED physicians may attempt to reduce the dislocation if there is no concomitant fracture, but early consultation with orthopedic surgery is often advisable.

Keywords: Convulsive seizure, posterior fracture-dislocation, shoulder

P-0226 Trauma Emergencies

A Case of Grade 4 Renal Laceration in a Child: Can We Treat with Conservative Management or Not?

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Objective: GU injuries are uncommon in children. In the literatures, there are many studies to guide us for renal trauma in adults, but the literatures for renal trauma in children are limited. Here, we presented blunt renal injury and its management options in a child. In general, about 90% of these injuries are the result of blunt trauma, but only 2% require surgical intervention. Our patient was managed medically despite his high grade of injury.

Case: A 9-year-old boy fell from a height of about 1 meter onto the his bicycle. He complained of mild, right lower abdominal pain, but her parents did not seek medical advice immediately. At



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the evening, about 4 hours after the accident, he vomited once and he had gross hematuria, at which point her parents brought him to the emergency department. On physical examination, his vital signs were stable. His heart rate was 100 beats per minute; blood pressure was 110/55 mm Hg; and respiratory rate was 25 breaths per minute. He was in no acute distress. His abdomen was soft and there is a little tenderness to palpation. He had mild, right costovertebral-angle tenderness. No bruising were noted. His urine was light red. Laboratory examination indicated that the serum hematocrit was 36% and the serum creatinine level was 0,8 mg/dL. Urinalysis showed 1552 red blood cells and 109 white blood cells per high-power field. To accurately stage the renal injury and to identify associated injuries to other organs, a CT scan of the abdomen with intravenous contrast was performed. It revealed a large, grade 4 right renal laceration and a large perirenal hematoma. The decision was made to follow the patient conservatively. He was admitted to the hospital and placed on bed rest, with R2 diet and intravenous hydration. Whole abdominal ultrasound were checked serially. His Hematuria resolved within several days His urine remained clear. He was discharged on day 7 of his hospital stay. Follow-up CT scans were recommended at approximately 2-month later to document the resolution of the hematoma and function of the kidney.

Conclusion: Children presenting with high grade (grade 4 or 5) renal lacerations who are hemodynamically stable can be followed safely nonoperatively. No long-term complications from conservative management have been noted.

Keywords: Kidney, Child, Hematuria, Computed tomography

P-0227 Other

Orbital emphysema after nose blowing

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Objective: Orbital emphysema is usually associated with the fractures of paranasal sinuses and orbital bones. The clinical spectrum may range from simple periorbital emphysema to loss of vision. The treatment involves medical follow-up, corticosteroids and surgical decompression.

Case: A 40-year-old woman presented to our emergency department with the complaints of progressive pain and swelling around her left eye after nose blowing 2 hours ago. Her physical examination was unremarkable except left crepitant eyelid swelling and periorbital edema (Figure 1). Her direct and indirect light reflexes were normal responsive. Her eye movements could not be evaluated because of edema and swelling. Her vital signs were as following: Blood pressure, 120/70 mmHg; heart rate, 76 bpm; respiratory rate, 17/minute; and body temperature, 36.4 C. Her cranial tomography revealed periorbital swelling of the soft tissues and areas of emphysema in the orbit, but there was no accompanying bone fracture (Figure 2). She was consulted with Ophthalmology and no other imaging study was required. She was started prophylactic antibiotherapy and discharged for outpatient follow-up. Three days later her complaints were resolved. She was informed about the activities that increase the intranasal pressure.

Conclusion: Orbital emphysema associated with maxillofacial trauma is a self-limited condition. But when there is valve effect at fracture line, emphysema becomes progressive. Ischemic optic neuropathies may occur following these orbital emphysemas with high pressure. Surgical decompression may be the choice of treatment in such cases to prevent loss of visual function. Our case recovered without sequela with no additional intervention

Keywords: Conservative treatment, Orbital emphysema, Non-traumatic

P-0228 Other

The Public's View of Increasing Violence towards Healthcare Staff of Emergency Department

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Objective: We investigated the public's view of increasing violence in the healthcare sector, their position on violence, the underlying causes of violence and possible ways of preventing violence.

Materials-Methods: This study was conducted between November 2012 and February 2013 in central Gaziantep, Turkey, by the Emergency Department of Medicine Faculty, Gaziantep University. We administered a face-to-face survey, consisting of 33 questions, to 1600 respondents who closely resembled the general structure of the population. We analyzed the results using the Chi-square and Yates correction Chi-square tests.

Results: Of the respondents, 38.5% had used violence on at least one previous occasion, and 2% had done so more than five times throughout their lifetime. The most common causes underlying violent behavior were the failure of the healthcare staff to perform their tasks properly (15.9%), the prolonged waiting times at hospitals (15%), media coverage encouraging violence (13.6%), and politicians' remarks criticizing healthcare staff (9.7%). A total of 20.3% considered violence as a method of securing rights. The issue that disturbed the respondents most (28%) was being unable to find someone who would listen to them, while 13.3% believed that the doctors should be beaten or killed when patients died, and 14.3% stated that they felt happy if they heard that a member of healthcare staff had been beaten or killed. The majority of the respondents who used violence, or were more inclined to do so, were men aged 24-30 years who had been poorly-educated.

Conclusion: This study found that half of the respondents primarily engaged in verbal abuse directed toward healthcare staff, mainly in emergency departments and in public hospitals. It is remarkable that one in 10 respondents believed that they should claim their rights themselves when they have been mistreated. One in five respondents believed that violence is a method of claiming rights, while half of the respondents were not sufficiently informed with regard to the penalties they could face as a consequence of violent behavior. The most disturbing issues were being unable to find someone who would listen to them and being insufficiently informed about the patient who they were. Approximately one in four respondents wanted the doctor to be beaten or killed if a patient died, or felt happy if they heard that this had happened.

Keywords: Healthcare staff, violence, the public's view, media, politician

P-0229 Trauma Emergencies

Pathogenomonic Symptom Associated With Lightning Strike: Lichtenberg Figure

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Objective: Lightning strikes occur especially during spring and summer months in the afternoons when there is heavy rain. In deaths resulting from lightning strike, there may either be no evidence on the dead person's clothes or body, or there may be burnt or torn places on their clothes and lichtenberg figures specific to lightning strikes on their bodies. In these cases that also have a comorbid of cognitive dysfunction, since there is generally amnesia, having these figures during the physical examination has a valuable place in early diagnosis and starting treatment early. This paper presents a case of lightning strike that was found to have lichtenberg figures on the back and right leg after secondary examination.

Case: 32 year old patient, who was found in an unconscious state by his friend, was brought to our hospital. His physical examination revealed that his physical general condition was moderate, his conscious was blurry and he responded to painful stimulus. His glasgow coma score was 14 and he had burnt lesions on his back and right leg. His vital findings were as follows; blood pressure: 100/55 mmHg, pulse: 115 beat/minute, respiratory rate: 16. His laboratory examinations were as follows: ALT: 57, AST: 60, CK:1952, CKMB: 42, Troponin I: 0,612. The patient was taken to red line, he was monitored and broad lumen vascular access was established. When the patient was undressed for secondary examination, 3 Lichtenberg figures on his back and 1 Lichtenberg figure on the lateral of his right leg were observed; thus, hydration was started (picture 1 and 2). His ECG was taken and bladder catheter was inserted. His ECG showed normal sinus rhythm. After anesthetic consultation, his conscious became clear on the second day of his hospitalization. His anamnesis revealed that suddenly rain had started while he was tending animals with his friend and he could not remember what happened afterwards. His general condition was stable and on the third day of his hospitalization, he was discharged with recommendations.

Conclusion: When the geography of our country and the socioeconomic levels and educational levels of our people are taken into consideration, the number of injuries or deaths resulting from lightning strikes may be more than the estimated number. Thus, early diagnosis of injuries resulting from lightning strikes and starting treatment early is important.

Keywords: emergency medicine, lichtenberg figure, lightning strike

P-0230 Trauma Emergencies

Patellar Dislocation

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Objective: Patella dislocation is an injury of the knee, typically caused by a direct blow to the medial side of patella or a strong abduction of the tibia by rotating to the lateral due to falling or



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during sportive activities. The medial capsule of knee tears or dislocation results by the avulsion of small bone fragments from the medial side of patella.

Case: The patient presented to emergency department suffering from a discharging feel, sliding and intense pain resulting from a pressure on the left knee while standing up from a chair. On the arrival, the left knee was fully extended. On physical examination, he had tenderness on the left knee, pain during active and passive knee movements and an outward dislocation. The left patellar x-ray was normal however A-P x-ray showed that the left knee was dislocated to left lateral side. No fracture was detected. Compared to the right knee, the dislocation on the left knee was clear. The history the patient didn't reveal any medical problem and patella dislocation beforehand. After patellar reduction and splinting of the leg the patient was interned to orthopedic department.

Conclusion: Knee is a joint which have function such as carrying the body weight, standing and walking in daily life or sportive activities. Knee consists of femur, tibia and patella bones, and also articulations and ligaments which hold together these bones. Patella dislocations result from extensor mechanism disorders including patella-femoral joint, supportive muscle, tendon and ligament pathologies and disorders in the knee mechanism. The patella generally dislocates laterally and femoral side of patella rotates to the outside of the lateral condyle of femur. Medial, vertical and superior dislocations are rarely seen. Our case involves lateral dislocation. Patients have feeling of sliding and discharging in their knees. Hemarthrosis occurs in acute injuries. There is tenderness on medial side of patella and lateral condyle of femur. There is a clear deformity and patellar bump is seen lateral side of the knee. It is likely that there is a fracture in lateral condyle of femur or medial patellar facet. Knee dislocations might accompany with patella dislocations. In this case nerve and most importantly vascular injuries should be considered. In our case knee was hyperextended and patella was laterally dislocated and there was no fracture, vascular or nerve injury. In conclusion patella dislocations can be successfully treated in the emergency departments after excluding the accompanying injuries.

Keywords: Emergency, dislocation, patella

P-0231 Trauma Emergencies

Luxatio Erecta Humeri: Hands up Dislocation

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Objective: The glenohumeral joint is the most frequently dislocated joint treated in the emergency departments (EDs). Inferior shoulder dislocation also known as luxatio erecta humeri or hands up dislocation is extremely rare form of glenohumeral dislocation, with an overall reported incidence in the general population of 0.5%. Patients with luxatio erecta present typically with hyperabduction of the affected arm, flexion at the elbow, and forearm above their head. Only a few sporadic cases with respect to this type of shoulder dislocation have been reported in the literature. Here, we report an original case of an unusual luxatio erecta humeri resulted from a motorcycle crash and associated with greater tuberosity fracture.

Case: A 24-year-old man sustained motorcycle accident and was referred to the emergency department (ED) of our hospital. The patient presented with his lower right arm abducted over his head and the elbow in flexion. Physical examination revealed that the patient was conscious, cooperative, and complaining of severe pain to the right shoulder with inability to move his forearm from its elevated position. The right arm was abducted to 120° with swelling in the right axilla. The right humeral head was palpable in the axilla. Clinical examination of right upper extremity revealed no neurovascular disruption. The right shoulder x-ray demonstrated inferior displacement of the humeral head with respect to the glenoid fossa, consistent with luxatio erecta humeri—an inferior dislocation of the shoulder. The humeral head was dislocated anteriorly and inferiorly associated with greater tuberosity fracture. Radiographs of the cervical spine, chest, and pelvis were normal. Closed reduction, under conscious sedation (pethidine 50 mg and midazolam 2 mg intravenously), was achieved by using the traction and countertraction technique in the ED. Subsequently, anterior-posterior chest radiograph confirmed anatomic reduction of the right shoulder. The brachial, radial, and ulnar pulses were palpable and no motor or sensory deficits were detected after conservative treatment with closed reduction. The patient's right shoulder was placed into a shoulder immobilizer and orthopedic consultation was obtained for follow-up care in 1 week postinjury.

Conclusion: Luxatio erecta humeri is an unusual and often missed as a subglenoid anterior dislocation of the humerus. This rare type of shoulder dislocation can be differentiated by clinical examination of the affected arm hyperabducted and locked above the head and by radiographic observation of the dislocated humeral head inferiorly, as it was in this case.

Keywords: inferior glenohumeral dislocation, shoulder dislocation, luxatio erecta, motorcycle crash

P-0232 Trauma Emergencies

Bilateral posterior shoulder dislocation due to trauma

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Objective: Double-sided shoulder dislocations are rare and often occur due to convulsions, spasms of withdrawal crisis, heavy lifting, diving into the water or traction injury. In this paper, 17-year-old male case admitted with bilateral posterior shoulder dislocation which occurred due to joking with his friend was presented.

Case: A 17 year old male patient were brought to the emergency department by ambulance with complaints of inability in lifting his both arms. We learned that his friend has hold and pulled his both arms to himself behind his back for joking, and after that event he could not have lifted up his arms and pain has occurred. His both arms were in mild abduction and external rotation in examination. Shoulders have lost their normal rounded contour and typical depressions were formed under the acromion. Shoulder movements were very limited and painful. There was no neurovascular injury. Only 2 x 4 cm size hyperemia and abrasion were observed on the skin under the right clavicle. Bilateral posterior shoulder dislocation was detected on X-ray. The patient stated that it was the first dislocation. Dislocations in both shoulders were reduced under sedation and anesthesia. After that both shoulders were made bandage in Velpeau position.

Conclusion: Usually bilateral posterior shoulder dislocations occur due to neurological disorders, and bilateral anterior shoulder dislocations occur due to traumatic causes. As in our patient, posterior shoulder dislocation could be rarely seen due to trauma.

Keywords: shoulder dislocation, trauma, orthopedics

P-0233 Other

Results of Black Grape Intoxication: Acute renal failure and Hyperkalemia

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Objective: The most frequently encountered in the emergency department hyperkalemia causes; hemolysis, renal failure and rhabdomyolysis. Excessive consumption of potassium-containing substances are not known, but a cause of hyperkalemia is common. Disorders of plasma potassium levels are especially important effects on cardiac function. Is able to make a serious rhythm disorders. Excessive consumption of foods rich in potassium in renal function is impaired, and sometimes urgent dialysis is required.

Case: 82 year old male patient to the emergency room, the feeling of evil and faintness came with the complaint. Resumes had a history of hypertension and coronary artery. In the story; In the evening fatigue, weakness, and after it was learned that evil feeling. Patients today have made the bus ride. Before coming to the emergency room was in the swoon. On examination, blood pressure was 120/80, pulse 38 beats / min, body temperature 36.7, GCS 15, blood sugar of 125, respiratory rate 24 / min, until the apex of bilateral breath sounds crackles, neurological examination and abdominal examination natural observed. The ECG on arrival in the emergency department; nodal rhythm was observed. In the case of blood gas pH: 7.27 mmHg, P CO 2: 41.3, p O2: 84, potassium: 7.6 mEq / L, lactate 1.5meq / l, HCO3: 17.5meq / l was observed. Patient calcium gluconate, 25 units of insulin and 500 cc of 20% dextrose was administered intravenously. When patients deepen the history of the patient all day, ate boiled black grapes resin was understood. Although the patient to continue treatment of hyperkalemia and acute renal failure developed, nephrology consultation was requested. Patient was hospitalized nephrology service. Double-lumen catheter was inserted and hemodialysis were included. After dialysis, the patient improved clinically.

Conclusion: In reference to the emergency department in patients with hyperkalemia detected excessive consumption of foods rich in potassium, should be kept in mind as etiological factors

Keywords: potassium, hyperkalemia, acute renal failure



POSTER BİLDİRİLER

P-0234 Other

Acute Kidney Failure Related to Anaphylactic Shock due to the Diclofenac Sodium

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Objective: Diclofenac sodium is widely used in pain treatment. Diclofenac induced anaphylactic shock is a rarely seen entity. However, renal function impairment is a well-known side effect. Intervening dehydration may make patients prone to renal failure. In cases of severe dehydration, prostaglandins are effective in maintaining GFR. Severe dehydration occurring in the presence of chronic diseases and inhibitory effect of diclofenac sodium on the beneficial effects of prostaglandins can lead to rapid onset of renal injury.

Case: A 57-year old male patient referred to ophthalmology clinic with headache. Intramuscular diclofenac sodium (Voltaren® 75 mg/3 ml Ampule, Novartis) is administered to relieve pain. He lost consciousness five minutes after the injection and brought to the emergency department. Physical examination revealed unconsciousness, tachypnea, tachycardia (120 beats/min), hypotension (60/40 mmHg), and edema of the uvula and mucosa. He also had widespread rashes all over his body. Other body systems were unremarkable. His medical history included type-2 diabetes mellitus for 5 years. Medications taken included metformin HCL 1000 mg PO twice daily (Glifor® 1000 mg, Bilim) and glimepiride 2 mg PO once daily (Amaryl® 3 mg, Sanofi Aventis). There was no history of drug allergy. Laboratory findings on admission were within normal range (Table 1). The case was accepted as an anaphylactic shock and 0.5mg intramuscular epinephrine was administered. Intravenous 45.5 mg pheniramine maleate was applied in 100 mL saline (Avil® 45.5 mg / 2 mL, Sandoz). 1000 ml of saline was given within 20 minutes. During the follow up, mental status and blood pressure (100/60 mmHg) improvement was seen. Improvement in mucosal edema was also observed. Patient was admitted to the emergency observation unit for follow-up. Biochemical tests were repeated because of oliguria during the fourth hour of follow-up. Control laboratory results were; BUN: 30 mg/dL, creatinine: 1.74 mg/dL. Patient was accepted as acute renal failure and was admitted to internal medicine service after consultation. At the end of the first day, elevated creatinine levels (1.89 mg/dl) were seen. On the fourth day of follow-up creatinine was 1.45 mg/dl and clinical improvement was observed. Nephrology polyclinic follow-up was recommended and patient was discharged.

Conclusion: In those with underlying chronic disease such as diabetes mellitus, it should be kept in mind that acute renal failure might develop due to serious dehydrated conditions such as anaphylactic shock following the single-dose DS.

Keywords: Diclofenac sodium, diabetes mellitus, acute renal failure

P-0235 Other

Is anaphylactic shock a distributive or obstructive shock?

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Introduction and Objective: Anaphylaxis is known to cause shock due to vasodilatation. Vasodilatation means distributive impairment, a relative but significant volume loss that results a reduction in cardiac filling volume. Here we present a case admitted with hypotension and epigastric pain, whose pericardial effusion was detected during RUSH protocol and who was later diagnosed as anaphylaxis. We aim to discuss reason of shock in this patient.

Case: A-54-year old factory worker male was transported with ambulance to our university based emergency clinic. He was prescribed intramuscular antibiotic (a cephalosporin, 2.generation) for pneumonia, and had received 6. dose 30 minutes before initiating of complaints. He was suffering from epigastric pain and suspected to have acute myocardial infarction. His vitals were as follows: BP: 70/30 mm/Hg; pulse rate: 140/min; Resp.rate: 20/min; O2 sat: 98%. His physical examination revealed tachycardia without murmurs, tachypnea without rales or ronchi, epigastric tenderness, pallor and anxiety. He was started normal saline bolus. Due to antibiotic injection and hypotension, anaphylactic shock was thought to be diagnose and he was given 120 mg methylprednisolone, 50 mg ranitidine and 100 mg diphenhydramine. Adrenaline was delayed till diagnostic confirmation. ECG was obtained and there was no ST-T changes. We performed RUSH exam to exclude reasons of shock. His cardiac sonography revealed massive pericardial effusion but cardiac contractions were visible. He had leucocytosis. His biochemical blood tests except cardiac markers were in normal ranges. He had elevated CK-MB and CK with negative troponine. Serial cardiac marker follow-up revealed return to normal ranges of CK and CK-MB of which elevation was speculated to be due to intramuscular injections. After a total of 2 L saline infusion, his blood pressure was elevated and tachycardia was resolved. He was hospitalized to monitor pericardial effusion. His vitals were in normal ranges and his pericardial effusion was resolved in the next day.

Conclusion: Vasodilatation of pericardial vessels might have caused pericardial effusion. Aggressive fluid infusion and medical treatment of anaphylaxis ameliorated both hypotension and vascular dilatation. We offer to perform cardiac sonography to all hypotensive patients to exclude other possible causes of shock. Moreover, pericardial effusion might be the cause of hypotension besides peripheral vasodilatation. We speculate that anaphylactic shock may be the result of both distributive and obstructive by pericardial effusion.

Keywords: anaphylaxis, shock, pericardial effusion

P-0236 Other

THE EFFECT OF FIRST NEUTROPHIL/LYMPHOCYTE RATIO IN MORTALITY OF PATIENT WHO ADMITTED EMERGENCY DEPARTMENT WITH SPONTAN SUBARACHNOID HAEMORRHAGE

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Objective: Pathological view which occurs in bleeding into the subarakhnoid distance of brain, cerebellum and spinal cord is called subarakhnoid hemorrhage (SAH). There are a lot of studies searching parameters and markers which are effective on prognosis and mortality in subarakhnoid hemorrhage. But there aren't any studies about the effectiveness of neutrofil lenfosit rate (NLR) on mortality.

Materials-Methods: In our study, former informations of one hundred and thirty one patients who applying for varied complaints to our emergency service between January 2010 and April 2013 and diagnosed subarakhnoid hemorrhage was analysed back and worked on study. All patients was evaluated and diagnosed in emergency service, and then they were hospitalised in intensive care, department of neurology and brain surgery. Patients' demographic features, hemogram, computed tomography scans of the brain and neurologic conditions were examined in the course of applying.

Results: The average of our patient's ages was 52.88 ± 14.79. The most frequent designated complaint was headache (% 51.1). Anterior comminican artery anevrism was the most seen (% 28.2) and the most mortal (%38.8) developed anevrism in subarakhnoid hemorrhage. The conditions of patients who were unconscious in the course of applying developed more mortal. Neutrofil lenfosit rate was found 7.71 ± 6.59 among survivor patients; 16.23 ± 12.68 among dead patients. Neutrofil lenfosit rate was found considerably high among dead patients compared to survivor patients. (p<0.001).

Conclusion: In consequence, compared to other parameters Neutrofil lenfosit rate can be used as a simple, easy, and cheap parameter to guess short term prognosis and mortality. Doing more comprehensive and more studies will guide for the reason of high rates in NLR and the treatment of it.

Keywords: Subarakhnoid hemorrhage, Neutrofil Lenfosit Rate, Mortality



POSTER PRESENTATIONS

P-0237 Trauma Emergencies

Diploic Haemorrhagia

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Objective: Diploic distance, are located between the inner and outer tabula in the cranial bones and has a spongy structure. Breschet's diploic veins are seen in this distance. Haemorrhagia in diploic distance is rare. Especially in pediatric age group it may occur due to head trauma. In this case, we report a 1 year old boy admitted to the emergency room due to head trauma and diagnosed haemorrhagia in the diploic distance.

Case: 1 year old male patient was brought by relatives to the emergency room because of falling from bed. After falling the patient vomited in style gush once. On physical examination the patient was crying but active, and had a tubercle on right parietal bone. Other system examination was normal. Cranial computed tomography revealed thickening in diploic distance at the apex of the right parietal and internal tabula of the parietal bone fracture is observed (figure1-2). The patient was consulted to the neurosurgery and was hospitalised in the neurosurgery clinic. Control cranial computed tomography was the same one day later. Patient was discharged from neuro surgery clinic 3 days later without any surgical intervention.

Conclusion: Diploic hemorrhagia should be followed as it may progress in to subdural hemorrhagia. Especially in pediatric age group diploic hemorrhagia caused by trauma should not be overlooked.

Keywords: Diploic distance, haemorrhagia, tomography

P-0238 Trauma Emergencies

Popliteal Artery Injury

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Objective: Popliteal artery injuries are an important cause of amputation and morbidity. Existence of concomitant bone or other different pathologies and prolonged time of transport to the hospital leads to increased mortality. On the other hand, early surgical intervention, prevention of hypovolemic shock, and fasciotomy in proper cases decrease morbidity and mortality

Case: A 27 year old male was brought to the emergency department with 112 ambulance. The patient was found lying on the floor in a toilet of a restaurant. No one knew for howlong he has been in this state. His right knee was wrapped by the 112 team and cardiopulmonary resuscitation was performed. In the emergency room the patient was intubated and CPR continued. After 5 minutes the patient responded to CPR. His vital signs were blood pressure:80/40 mm/hg, heart rate: 155 per minute. With fluid resuscitation, 2 unites 0 RH (-) blood was transfused. On physical examination he had a deep bleedin wound behind the right knee. Other system examinations were normal. Laboratuvarı results were hb:6,7 g/dL (N:13-17 g/dL), hct:18,9 (N:% 40-50). Abdominal and thoracal computed tomography with contrast media were normal but anjiography for extremities could't be performed because the patient had cardiac arrest again while undergoing computed tomography. The patient was returned to the emergency room again and cardiovascular surgery consultation was requested. The patient was taken to the operation room due to popliteal artery injury. He had cardiac arrest fort he third time while undergoing surgery and he did not respond to CPR.

Conclusion: In patients with popliteal artery injuries, late intervention, blunt trauma, extensive soft tissue defect and bone fractures have significantly increased mortality and the amputation rate. Early intervention, replacement of blood volume, usage of systemic anticoagulation, decreasing the severity of ischemia by fasciotomy, preoperative and postoperative aggressive deb-ridement of necrotic tissues would decrease the morbidity and mortality rates.

Keywords: Popliteal artery, injury, cardiopulmonary resuscitation

P-0239 Other

Violence Related Cases Overtaking Motor Vehicle Accidents In Forensic Emergency Medicine

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Objective: In all the studies done previously on forensic emergency cases, motor vehicle accidents (MVA) have been shown to be the largest single group in forensic cases. In this study, we aimed to proof that human violence (assaults, suicide attempts, gunshots and stabbings) causes more burden on the emergency physicians when compared to MVA cases.

Materials-Methods: This is a retrospective study involving 3.838 forensic cases and was conducted between January and December 2011 in a tertiary hospital in Istanbul. We then analyzed forensic cases into two groups as MVA and Violence. Inclusion criteria were all forensic cases. The data were collected from official hospital police sheets. Also seven more studies on emergency forensic cases involving over 54 thousand cases that were conducted in different regions of the country by different institutions were analyzed and used to support our argument.

Results: A total of 3.838 medical-legal cases were examined, 70.3% were male 29.7% were female. Mean age was found as 32.5 ± 15.52 (min 0, max 94). The majority of the patients were of young age; the largest group being 20-29 age group. Violence with 45.6% [assault 29.1%, stabbing 7.4%, drug intoxications 8.1%, and gunshot 1.0%, sexual assault 0.1%] accounted for the largest group of forensic cases followed by MVA, 37.9%.

Conclusion: Violence and the resulting morbidity and mortality can be prevented or reduced to minimal level through, small-scale individual and community efforts to national policy and legislative initiatives.

Keywords: Forensic medicine, emergency medicine, motor vehicle accidents, violence, suicide

P-0240 Other

Idiopathic sudden sensorineural hearing loss

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Objective: Idiopathic sudden sensorineural hearing loss (ISSNHL), defined as a greater than 30 dB sensorineural hearing loss occurring in at least three contiguous audiometric frequencies over 72 hours or less is a disease with unknown etiology.

Case: 39-year-old man presented emergency department with a sudden unilateral hearing loss. He suddenly lost his left hearing, tinnitus, vomiting and buzzing in the ears. He had no history of either otitis media or any ototoxic medication. His blood pressure was 145/85 mmHg. Ear examination was unremarkable. Patient was consulted otolaryngology department. Weber testing with a 512 Hz tuning fork showed no hearing response by the patient in right ears. He was diagnosed as unilateral ISSNHL. The audiogram revealed right profound sensorineural hearing loss with a threshold of 120 dB. A high dose of steroids (prednisolone, 60 mg/day) was administered in emergency department.

Magnetic resonance imaging of the brain and the cerebropontine angle was unremarkable. Complete blood count found no leukocytosis and no anemia. Fasting blood sugar was 95 mg/dL. The patient was hospitalized and a high dose of oral steroid treatment (prednisolone, 60 mg/day) was administered 3 days after the onset of the hearing loss. Audiogram was repeated after a week of standard treatment. The audiogram revealed right profound sensorineural hearing loss with a threshold of 86 dB. Administration of systemic steroids was then discontinued. Intratympanic membrane steroids (methylprednisolone, 40 mg/mL) were administered in the right ear 3 times within a week (at day 5, 7, 10 after the onset). The hearing level after the third dose showed minimal improvement. The air conductive thresholds and The bone conductive threshold were 82 dB and 72 dB for the right ears, respectively.

Hyperbaric oxygen therapy (HBOT) program was scheduled for 10 sessions according to the US Navy treatment table (2 ATA 90 minutes). We used a 6-seat multi place chamber for the HBOT (Figs. 2), which was started at day 36 after the hearing loss onset. After the twenty session of HBOT, important hearing returned, with minimal tinnitus in both ears. The following audiogram revealed right threshold of 52 dB. The patient was sent for the 4th (day 41) and the 5th sessions (day 42) as scheduled. The following audiogram 3 months after the entire treatment showed hearing level with a right threshold of 42 dB.

Conclusion: Outcomes of ISSNHL are significantly improved in the combined therapy of HBOT with conventional treatment modalities

Keywords: sudden sensorineural hearing loss, Hyperbaric oxygen therapy, Intratympanic corticosteroid injection



POSTER BİLDİRİLER

P-0241 Other

Does the lunar cycle affect suicide attempts?

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Objective: Suicide attempt is the intentional act of a person to end his/her life. Nowadays, this becomes a universal problem. Elimination of the causes of suicide attempts (SA) is crucial. Objective of this study was to determine whether there was a correlation between the lunar cycle (LC) and suicide attempts.

Materials-Methods: This multicenter study was conducted using retrospective file screening method between 01/01/2012 and 31/12/2012. Recordings of the patients presented to the emergency departments of 9 hospitals due to suicide attempt in various regions of our country were retrospectively investigated. Lunar cycle phases of the days of presentation were examined.

Results: When the days of the patients' presentation were examined according to lunar cycle days; 25.58% of the patients presented in the first quarter, 25.71% in the full moon, 25.03% in the last quarter and 23.68% in the new moon. Whereas, according to the lunar cycle phases; 26.56% of the patients presented in the first quarter phase, 25.71% in the full moon phase, 25.52% in the last quarter phase and 22.21% in the new moon phase. No significant difference was found between the patients presented due to SA in terms of the days and phases of lunar cycle ($p < 0.05$).

Conclusion: Similar to the results from studies conducted about the lunar cycle in the literature, our study also demonstrated that, no correlation was found between the lunar cycle and suicide attempts.

Keywords: Lunar cycle, suicide, emergency department

P-0242 Trauma Emergencies

Trumatic Aortic Dissection and Bilateral Pneumothoraks

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Objective: Thoracic traumas account for a significant number of traumas presented to emergency services in terms of both quantity and mortality. Simultaneous pneumothorax is defined as the occurrence of pneumothorax in both hemithorax at the same time. It is a rarely seen clinical picture (3 %) and generally occurs due to traumas. Aortic dissection is a serious condition in which there is a separation of the aorta walls. Aortic dissections resulting from acute traumas are associated high rate of mortality. Here we presented a case of the combination of two clinical pictures rarely seen and with high rate of mortality.

Case: 40 year-old female presented to emergency department suffering from motor vehicle traffic accident. She was in poor general condition, unconscious, Glasgow Coma Scale was (GCS): 4-5, spontaneously breathing, blood pressure (BP): 140/80 mm/Hg, pulse rate: 108 bpm, pulse oximeter O2 saturation: 78 pupils are isochoric and pupillary reflex was poor. Her breathing sounds had diminished bilaterally and abdominal examination was normal. She was intubated. As cranial and thoracic trauma was prediagnosed, cranial and intravenous contrasted thorax CT was ordered. Cranial CT was normal. Thorax CT showed rupture in thoracic aorta and approximately 30 % bilateral pneumothorax. Bilateral chest tube was inserted. Cardiovascular surgeon and thoracic surgeon were consulted. The patient was referred to intensive care unit.

Conclusion: An aortic dissection is a serious condition in which a tear develops in the inner layer of the aorta. Blood surges through this tear into the middle layer of the aorta, causing the inner and middle layers to separate (dissect). Aortic dissections resulting from acute trauma are associated with high rate of mortality. Pneumothorax is seen 15-20 % of the patients exposed to blunt trauma while the rate of bilateral pneumothorax due to thoracic trauma is only 3%. Simultaneous bilateral pneumothorax is a rarely seen clinical picture. Although there are several factors in its etiology, it is often associated with malignancies. When bilateral pneumothorax occurs due to trauma, emergency physicians should be careful about combined other organ and systemic pathologies just as the aortic dissection in our case. In conclusion, other organ and systemic traumas in addition to thoracic organs should be studied carefully in patients with bilateral pneumothorax.

Keywords: Emergency, Aortic Dissection, Pneumothorax, Trauma

P-0243 Trauma Emergencies

Handlebar trauma causing small bowel hernia with jejunal perforation

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Objective: Abdominal wall hernia and related visceral organ injuries should be considered following blunt abdominal trauma. Failure to diagnose promptly may lead to delay in appropriate treatment and increase the morbidity and mortality. We report a case of eleven year-old boy with handlebar trauma which caused a rare type of abdominal wall hernia and jejunal perforation.

Case: An eleven year-old boy was admitted to emergency room with abdominal pain, bilious vomiting and rectal bleeding one day after falling from bicycle. He stated that he landed directly onto the handlebar through his left lower quadrant of the abdomen. Physical examination revealed a soft tissue bulge, tenderness and defense in the left lower quadrant without any head or skeletal injury. His abdomen was soft with no evidence of peritoneal irritation. Ultrasonography demonstrated intraabdominal fluid and herniation of a small bowel loop through the abdominal wall at left lower quadrant. Computed tomography of the abdomen revealed the herniation of jejunal loop through a defect in the left lower abdominal wall just lateral to the rectus muscle, segmental ileus due to the herniated bowel segment, intraperitoneal fluid and pneumoperitoneum. Based on these findings, the patient was referred to pediatric surgery service with the diagnosis of intestinal perforation and abdominal wall hernia. Surgical exploration of the injured area demonstrated the disruption of all layers of the abdominal wall, and perforation of the jejunum at 110 cm distal to Trietz ligament. The postoperative period was uneventful.

Conclusion: In our case, high velocity impact by handlebar was able to disrupt abdominal muscle and fascia. In most handlebar hernias, the defect is in the lower abdominal wall and can be associated with intra-abdominal injury. Injuries to the small bowel may occur secondary to high impact blunt trauma in a variety of deceleration mechanisms such as high-speed motor vehicle crashes, handlebar injuries, and falls. Diagnosis is often delayed because there is usually no associated major blood loss. The small intestine is the most common site of perforation, and peritoneal irritation may not be evident initially. Plain radiograph is also unreliable in diagnosis. CT is useful to differentiate hernia and its content, to define the anatomy of disrupted abdominal wall layers, and to detect associated injuries accurately and surgery is the eventual management of these patients.

Keywords: abdominal wall hernia, handlebar, perforation, computed tomography



POSTER PRESENTATIONS

P-0244 Other

Spontaneous Rib Fracture After Coughing

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Objective: Spontaneous rib fracture without any underlying cause is a rare situation. 62 year old male patient admitted to our emergency department (ED) with complaint of chest pain. He has an unremarkable past medical history except chronic bronchitis. Rib fracture has been diagnosed as a reason for chest pain with the aid of physical examination and Posterior Anterior Chest X-RAY. Here we present the case in which spontaneous rib fracture developed as a result of severe coughing.

Keywords: rib fracture, cough complication

Case: 65- year- old male patient admitted to the ED with severe chest pain. it has been learnt that he had chest pain for one week and consulted to cardiology clinic multiple times with this complaint. His pain was on the left side of his chest with a stabbing character that spreads to his back. No change in the severity of the pain has occurred after one week.

The chest pain of the patient was continuous and worsening with breathing. Physical examination has revealed that TA: 110/60 mmHg pulse: 98/min breath count: 115/min O2 sat/92. There was a very loud click sound in every focus of cardiac auscultation.

The same click sound was audible both in inspiration and expiration during the chest auscultation. Abdominal examination and electrocardiography were not unremarkable.

Thorax CT without contrast was ordered and a displaced fracture on left costo-sternal angle and luxation on costo-sternal joints were diagnosed in fifth costa.

Patient has been hospitalized at the emergency observation unit for rest and pain medication. On the 2nd day of his hospitalization, he was discharged with the thoracic surgery outpatient follow-up

Conclusion: As a conclusion, cough-related stress fracture is a rarely seen complication. A high degree of suspicion after coughing, in cases of acute onset of chest pain may prevent delay in the diagnosis of stress fractures.

Keywords: rib fracture, cough, complication

P-0245 Trauma Emergencies

A Rare Case: Isolated Subcutaneous Emphysema in Upper Extremity

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Objective: Isolated subcutaneous emphysema in upper extremity is a very rare case. Although it generally develops secondary to local infections; various extremity trauma, replacement of the instrumentations used for fracture fixation, wound irrigation performed with hydrogen peroxide and injuries with pneumatic gun are the other causes. In this case we aimed to present the subcutaneous emphysema case that tried to stop the bleeding occurred with the insertion of foreign body to hand by using air compressor.

Case: 40 years old male patient has admitted to our emergency service with pain in left arm and hand. The patient has reported that a piece of wire entered to the dorsal side of his left hand at workplace and after removing this wire piece by himself, on bleeding at his hand he sprayed high pressure air on bleeding site with an air compressor at the workplace. He stated that his bleeding stopped however there has been pain and swelling in his left arm after half an hour. The vital signs of the patient were stable and there wasn't any disease and medication use history of the patient. Left hand movements were natural but painful in the physical examination. There was widespread subcutaneous crepitus at palpation from left wrist to the top of elbow. Pulses were clear and sonorous. Neurologic examination was normal. Direct graph was performed with the preliminary diagnosis of subcutaneous emphysema. There were widespread air densities in the direct graph beginning from left wrist up to left elbow. Long arm resting splint was performed to the left arm of the patient and followed in emergency service for compartment syndrome for 6 hours. The patient whose pain was relieved after analgesic and compartment syndrome didn't develop was discharged by informing about the symptoms of compartment syndrome, initiating antibiotic therapy and recommendation of daily polyclinic control. As the results of controls, subcutaneous emphysema was observed recovered completely and there wasn't any complication developed.

Conclusion: Wide spectrum antibiotherapy and wound debridement is recommended if the isolated extremity subcutaneous emphysema developed secondary to infection. If it is due to non-infectious causes like in our case, it is recommended to take the extremity resting and follow for compartment syndrome.

Keywords: Subcutaneous emphysema, Upper extremity, Pneumatic gun

P-0246 Other

Tinnitus and suicide: A case report

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Objective: Tinnitus is one of the most common seen complaint in otolaryngology practice. Tinnitus as will be mere complain, may be seen with hearing loss and vertigo. Tinnitus may impair the quality of life in advanced degrees. In very rare cases may cause suisit.

Case: In this article was presented, 61 year old female patient who attempted suicide due to tinnitus. Patient has suffered from constant tinnitus in both ear since she had serous otitis media in two months ago. The patient said, despite medical treatment, tinnitus did not healed and lately, she suffered from severe insomnia. Due to severe tinnitus and insomnia, patient drank hydrochloric acid. Then patient was came to our emergency department by her family. On physical examination, the patient's vital signs were stable and floor of the mouth mucosa, gingiva, hard and soft palate had widely ulcerated areas. Severe laryngeal edema and ulceration was observed on laryngoscopic examination. and eardrum was myringosclerotic on otoscopic examination. Patient were followed closely for respiratory distress. Tracheostomy was no required.

Conclusion: Emergency department patients presenting with symptoms of tinnitus as simple as good if not treated may predispose to suicide attempts. Therefore, a good mental status of patients in an emergency meeting to assess needs.

Keywords: tinnitus, suicid, emergency medicine

P-0247 Other

Is an Emergency or not?: Hemifacial Spasm

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Objective: We will present two cases with hemifacial spasm visually.

Case: Hemifacial spasm is a neuromuscular sendrom that characterized with irregular contractions and eyelid closure one side of face (1,2). Our cases were two women at ages 40 and 60. After confirming diagnose of cases has been treated with botulinum toxin (3). After the treatment, the patients were discharged. Neurology control was recommended after 2 weeks.

Conclusion: In patients who admitted emergency services with cheek contractions like tics and eyelid closures we must keep in mind hemifacial spasm. For the differential diagnosis EMG can be done and MRI can show of facial nerve compression. Alternative to Botulinum toxin injection surgical seperation of facial nerve can be done (4). Hemifacial paralysis is not an emergency situation, but miscible with facial paralysis and must be in the minds of doctors working in the emergency department.

Keywords: fasial, spasm, emergency, services

P-0248 Trauma Emergencies

Seat Belts Save Lives

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Objective: Seat belt, is the mechanism that stops the seat and the passanger from being thrown out, prevents sensitive and most important organs including the head and spinal cord and preserves the human body. The seat belt not used effectively in our country. It is important increase the awareness and introduce traffic penalties to reduce the morbidity and mortality in motor vehicle accidents.

Case: A 18 year old male patient, was brought by ambulance to the emergency department after a car accident with his 17 year old girl friend. It was learned that the vehicle rolled over during



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the traffic accident, female patient had her seat belt fastened and was sitting near the driver, male patient who was the driver did not use the seat belt and was ejected out of the vehicle. There wasn't a significant finding in the examination of female patient. In examination of male patient, there were edema and abrasions in the right frontal and left occipital area and tenderness in the right hemithorax. The radiological investigations (cranial, cervical, thoracic and abdominal computed tomography and radiography) of the male patient, revealed fractures of the right 8-9 rib, contusion in the lower lobe of the right lung, acute subdural hematoma from anterior to posterior in the left cerebral hemisphere, acute subdural hematoma in the right frontal region, about 5 mm shift in the midline structures to the right, minimal blood in occipital horn of the lateral ventricles (figure1-2). There were no pathological findings in the female patient and she was discharged from emergency service after 12 hours. Emergency brain surgery consultation was done and he underwent emergency surgery. He was admitted to the intensive care after surgery. In intensive care the patient was evaluated by thoracic surgery and general surgery and they recommended follow-up. His control cranial computed tomographies revealed diffuse brain edema. On the 10th day of hospitalization, the patient developed cardiac arrest and died in the intensive care unit. In both patients, the severity of trauma, exposure to trauma type, and age group were similar, but because of not using the seat belt the male patient was exposed to a larger trauma and hence the resulting morbidity and mortality was inevitable.

Conclusion: In motor vehicle accident, the seat belt is one of the most significant predictors of morbidity and mortality.

Keywords: Motor vehicle accident, seat belt, mortality

P-0249 Trauma Emergencies

Traumatic Pneumothorax Due To Nail Gun: A Case Report

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Objective: Nail guns have been used on wooden surfaces since the 1950s. They have a ballistic potential being capable of firing projectiles at speeds of 100–150 m/s and distances of up to 500 m. The nail guns are potential dangerous tools. Failure of training and use of tools with contact triggers are known risk factors for acute nail gun injuries. Although extremity injuries are most common, life-threatening injuries to the head, neck, chest, or abdomen and pelvis may occur. Nail gun injuries may cause serious injury or death. Here, We presented that a case injured and developing pneumothorax by nail gun

Case: A 17 year-old man was admitted to the emergency department after being shot in the chest accidentally by a nail gun. On the admission, the patient was anxious. His blood pressure was 110/70 mm Hg, and his heart rate was 90 beats/min. His oxygen saturation was 97%. The entry point of the nail was apparent on the right 5. intercostal space, anterior-mid axillary line area of the patient's thorax. The nail was not palpable. Auscultation of the lungs revealed to decreased breath sound in left lung. Chest radiography and computed tomography showed pneumothorax in right lung (Fig 1). Then tube thoracostomy was performed.

Conclusion: This case indicates that the nail guns are potential dangerous tools for especially inexperienced workers. Rapid diagnosis and treatment are quite important in penetrating nail guns. Worker training and education also are important for prevention mechanics of nail gun injuries.

Keywords: Pneumothorax, Nail Gun, Emergency

P-0250 Other

Retained Foreign body in the Gastrointestinal system for twelve years: A case report

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Objective: Foreign body ingestion is an important health problem for children but it can also occur in all age groups. Most foreign bodies pass through the gastrointestinal tract without causing any damage. Prompt recognition and early intervention are necessary to avoid morbidity and mortality. Management based on the size and nature of the foreign body and whether it is smooth or sharp. These are observed clinically and, if radio-opaque, by serial radiographic examination. It is said that waiting for up to a week usually will solve the problem. In this case report, we present a case who has abdominal pain and incidentally are learned needle was swallowed approximately 12 years ago.

Case: A 31 year-old man was admitted to the emergency department with complaints abdominal pain. On the admission, the patient was general status was good. His blood pressure was 120/80 mm Hg, and his heart rate was 70 beats/min. His oxygen saturation was 99%, and body temperature was 36.5 °C. There was nonspecific abdominal tenderness on physical examination. Laboratory parameters were normal range. Conventional radiography of the abdomen revealed foreign body (Figure 1). Symptomatic treatment is given to nonspecific complaints. He said that the needle swallowed and no treatment approximately 12 years ago. Computed tomography of the abdomen was normal except that hyperdense appearance of foreign bodies (Figure 2). Surgical or endoscopic intervention was not recommended by general surgeons and gastroenterologists.

Conclusion: In some cases endoscopy and surgery may need while majority of foreign bodies pass harmlessly through the GI tract. However, We report a patient with FB persistent without complication for a long time in gastrointestinal system

Keywords: Foreign body, Emergency department, Gastrointestinal system

P-0251 Trauma Emergencies

Injury pattern of falls from Walnut tree

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Objective: To analyse the injuries caused by falls from walnut tree and assess their mortality and morbidity risk.

Materials-Methods: This is a retrospective hospital-based study of patients presenting to emergency department (ED) of Ahi Evran University between september and october 2012. Patients were studied in detail with regard to patient profile, description and location of the injury, associated injuries, delay in referral, vital signs, laboratory parameters, treatment and survey. Results were expressed as mean-standard deviation (S.D.) or percentage. Statistical comparisons were carried out with Chi-Square test for categorical data and non-parametric spearman correlation tests were used to test the association between variables. A p value less than 0.05 was considered to be statistically significant.

Results: Fifty-four patients admitted to our emergency department with fall from walnut tree. Of these, 52 were adult and 2 were in pediatric age group. Fifty (92.6%) patients were male. Spinal region (44.4%) and particularly lumbar area (25.9%) sustained the most of the injuries among all body parts. Wedge compression fractures ranked first among all spinal injuries. Extremities were the second most common (41.7%) injury. Abdominal trauma was not observed in any patient. Thirteen (24%) patients had injuries to more than one anatomical region. Forty-four (81.5%) cases had minor injuries (ISS = 1-9). The correlation between ISS and duration of hospital stay was strongly positive, linear, and statistically significant (rs= 0.818, p<0.05). The duration of hospital stay was prolonged as ISS increased. No mortality was seen. Morbidity rate was highest with thoracolumbar injuries (40%) and with burst fractures (40%).

Conclusion: Falls from walnut trees are a significant health problem owing to being an important source of morbidity and disability from spinal injury, and also a substantial social and economic burden due to labor force loss. Traditional outdated methods employed in our region for harvesting walnut trees lead to a higher rate of falls from these trees. Preventive measures including education of farmers and agricultural workers and using mechanized methods for harvesting walnut will lead to a dramatic decrease in mortality and morbidity caused by falls from walnut trees.

Keywords: Walnutt tree, falls, spinal injury



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P-0252 Other

Hiccup Treatment Options in Emergency Department: Grape Vinegar

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Objective: Hiccups happen as a result of involuntary, intermittent and spasmodic contractions of the diaphragm. Although hiccups may arise from organic, psychogenic or idiopathic factors, the pathogenesis of its has been poorly understood. Transient hiccup is a common problem, usually resolves spontaneously and no clinical significance. When persistent (>2 days), hiccups may associated with considerable discomfort. Deep anesthesia, neuromuscular blockers, local anesthetic application to vagal nerve, pharmacologic approaches such as methylphenidate, ketamine chlorpromazine, metoclopramide, haloperidol, amitriptyline, carbamazepine, diphenhydantoin, and valproic acid, nasogastric tube application are recommended as treatment options for hiccup. We present two cases who is recovered with grape vinegar and beginning two or three days previously

Case: A 55 year-old man and 43 year old man were admitted to the emergency department with persistent hiccup. On the admission vital signs and all of the system examination including psychiatric and neurologic examinations signs were normal. There were not pathological features in laboratory parameters, electrocardiography and chest radiography. Before on admission to the our hospital, chlorpromazine and metoclopramide had been performed to cases. In our emergency department, We gave as peroral a cup of grape vinegar. We observed resolve of hiccup.

Conclusion: The patients with persistent hiccup sometimes may be resistant against medical drugs. Grape vinegar as alternative treatment method should be used in treatment of hiccup.

Keywords: Grape Vinegar, hiccup, emergency department

P-0253 Trauma Emergencies

How Many Hours Do Patients With Mild Head Trauma Observe?

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Objective: Trauma, especially head trauma, is an expanding major public health problem and the leading cause of death of the world's population. Trauma patients with head trauma(HT) have a 10-fold higher mortality than in those without HT. Traumatic intracerebellar hematoma account for 0.6-0.82 % of the total HT. Patients with HT are evaluated in different groups according to their Glasgow Coma Scale (GCS) score. GCS of 13-15 indicates mild HT, 9-12 moderate and 3-8 severe. Here we report a case of delayed traumatic intracerebellar hematoma that has mild HT

Case: Twenty-five year-old male fell down while he played a football match. He had headache and vertigo. Upon admission to the hospital, his arterial blood pressure was 130/80 mm Hg, his respiratory rate was 20/min, his temperature was 36°C and his O2 saturation level was 98%. His heart rate was 82/min during auscultation. His Glasgow Coma Scale score was 15 (E-4, V-5, M-6). His pupils were isochoric and his light reflex was bilateral positive during his physical examination. No focal finding, meningeal irritation evidence or pathologic reflex was noted. The other system examinations returned normal results except from right otorrhagia. On admission, An initial computed brain tomography (CT) scan was normal (Figure 1). He was observed about 12 hours in emergency department and discharged from the hospital with normal neurological examination signs and without complaints. But, On the 26 hours after the HT event, he again admitted to our hospital with complaints of nausea, vomit and headache. CT again was obtained and traumatic intracerebellar hematoma was determined. He was transferred to neurosurgery clinic.

Conclusion: The mechanism responsible for delayed intraparenchymal hematoma is still controversial. Delayed traumatic intracerebral hematoma is a clinical entity demonstrated by computed tomography. This situation may be fatal. Fortunately, our case is full recovery.

Keywords: Mild Head Trauma, Emergency Department, Delayed traumatic intracerebral hematoma

P-0254 Trauma Emergencies

Referral after diagnosis of tension pneumothorax!

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Objective: Tension pneumothorax occurs when a one-way valve is created between the lung and the pleura. Air accumulates in the pleural cavity during the respiratory cycle and the consequent increase in intrapleural pressure interferes with the effective expansion of the lung on the side of pneumothorax. Increasing pressure in the pleura cavity aggravates the ipsilateral lung collapse and pushes the heart and mediastinal structures toward the other side of the chest. The vena cava and right heart become compressed, venous return is compromised, and diastolic filling and cardiac output are decreased. Dyspnea, tachycardia, hypotension, tracheal deviation and loss of unilateral respiratory sounds are the most common symptoms and signs. The most common reasons are barotrauma due to mechanical ventilation with positive end-expiratory pressure, blunt thoracic trauma, catheterization of internal jugular and subclavian veins. Tension pneumothorax is a clinical diagnosis and radiological confirmation is not obligatory. Treatment includes emergent decompression.

Case: A 54-year-old man who suffered car accident was transferred to our tertiary care emergency department from a second degree state hospital. He was conscious, partially cooperated and oriented. Vital signs were: blood pressure, 80/60 mmHg; heart rate, 136 bpm; respiratory rate, 24/minutes; and oxygen saturation, 94%. He had a sutured laceration on left temporal region and right leg was in short leg cast. He had jugular venous distension and his trachea was deviated to left, breath sounds were lost on right hemithorax. The clinical picture was compatible with tension pneumothorax. Immediately, right tube thoracostomy was performed from fifth intercostal space at midaxillary line by emergency physician. 400 cc blood was drained and the respiratory distress of patient was partially resolved. The patient had been evaluated by general surgeon and orthopedist in the first hospital. On his first chest X/R and thorax computed tomography he had multiple displaced rib fractures, hemothorax and pneumothorax. He also had right bimalleolar fracture. The patient was transferred to our hospital for neurosurgeon and thoracic surgeon. A diagnostic peritoneal lavage was performed by general surgeons which revealed hemoperitoneum. The patient was transferred to operation room. Splenectomy was performed due to rupture. He was discharged at day 16.

Conclusion: Tension pneumothorax is a medical emergent condition. By needle thoracostomy from second intercostal space on affected side at midclavicular line, it can be converted to simple pneumothorax. Then tube thoracostomy is the choice of treatment. Every patient may not be as lucky as this patient.

Keywords: Needle thoracostomy, tension pneumothorax, trauma, tube thoracostomy

P-0255 Trauma Emergencies

Posterior urethral injury secondary to blunt abdominal trauma

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Objective: Male urethra is divided into anterior and posterior portions by urogenital diaphragm. Posterior urethra consists of prostatic and membranous urethra. Motor vehicle injuries, crush injuries and falls from a height may cause pelvic fractures resulting in posterior urethral injuries. Blunt trauma is the leading cause of urethral injury (90%). 3.5-19% of pelvic fractures are associated with posterior urethral injury. The gold standard of diagnosing urethral injury is retrograde urethrography. The treatment modality includes secondary healing or urethroplasty following suprapubic catheter in partial injuries and delayed primary urethroplasty in total urethral rupture.

Case: A 40-year-old male was presented to the emergency department with a blunt trauma that resulted from fall of 20 doors of wardrobe on him an hour ago. He was conscious and well oriented. Her thoracic and abdominal examinations were almost normal. He had meatal blood with tenderness on left side of pelvis and range of motion on left hip joint was restricted. His vital signs were: blood pressure, 120/70 mmHg; heart rate, 84 bpm; and respiratory rate, 10/minutes. On antero-posterior pelvic radiography there was fracture line at superior and inferior pubic



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rami. An urethral catheter was not placed due to suspected urogenital injury. After intravenous contrast, a contrast-enhanced abdominopelvic computed tomography scan was obtained that demonstrated that contrast fills bladder with an intact bladder wall but there was no flow distal to urethra and the contrast leaks into the pelvis. Retrograde urethrography revealed rupture of posterior urethra. A suprapubic catheter was placed and the patient was hospitalized in urology service for urethroplasty.

Conclusion: Stable fractures associated with anterior portion of pubic ring, sacroiliac joint, ileum or sacrum may cause posterior urethral injury. The bony fractures may cause tears of urethra or more commonly twisting of bony pelvis may cause displacement of urethra. In this rare trauma with suspicion of urethral injury, necessary diagnostic tests were ordered adequately and early diagnosis and prevention of complications became possible.

Keywords: Blunt trauma, diagnosis, pelvic fractures, urethra, urethral injury

P-0256 Trauma Emergencies

Minor trauma and thoracic vertebra fracture

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Objective: Thoracic vertebra injuries are encountered more rarely than the other vertebra regions. Usually they occur with high energy trauma. Our aim is to present T5 fracture that occurred with minor trauma.

Case: A 18 years old male patient was admitted to the emergency department with backward somersault fall. The patient was conscious and his GCS was 15. There was tenderness on T4-T5 with palpation. He had no neurological deficit. Other systemic examinations were normal. His laboratory results were normal too. His thoracic tomography revealed T5 burst fracture. The patient was consulted to and admitted to the neurosurgery service for operation.

Conclusion: Vertebra fractures are very important as they may result in neurological deficits. Patients with minor trauma who may come to the emergency department walking, should also be examined in detail.

Keywords: Minor trauma, thoracic vertebra, fracture

P-0257 Other

The Bullet Don't Ask Address: A Case Report

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Objective: Many process such as tattoo, piercing and handmade various accessories have used to express thought and diversity of individual from past to present. Performance of procedures such as production of accessories, tattoo, piercing by untrained people who do not specialize in the subject area may lead to some complications. These complications occasionally may be life-threatening. In this case report, we present a case because of explosion of bullet while doing bullet necklace.

Case: A 15 year-old man was admitted to the emergency department after being shot in the chest accidentally by a bullet while doing bullet necklace (Figure 1).

On the admission, the patient was anxious. His blood pressure was 100/70 mm Hg, and his heart rate was 80 beats/min. His oxygen saturation was 98%. The entry point of the bullet was apparent on the right 2. intercostal space, sterno-clavicular line area of the patient's anterior thorax. The bullet was not palpable. System examination findings were normal. Chest radiography and computed tomography showed foreign body between subcutaneous soft tissue planes and free air on the paratracheal, superior mediastinum, precardiac areas (Figure 2). It was reached to foreign body with the blunt dissection. FB was removed. Hemostasis was achieved. The incision was sutured. Antibiotherapy was performed.

Conclusion: Traumatic events during the production of accessories as well as allergic reactions due to materials used and infectious diseases (hepatitis B, hepatitis C, tuberculosis, tetanus, HIV) may occur in processes such as tattoo, piercing. Increased public awareness in this regard will reduce unwanted complications.

Keywords: bullet necklace, injury, emergency

P-0258 Trauma Emergencies

A 10 Days Old Baby with Immobility of Upper Extremity After Shoulder Subluxation

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Objective: Upper extremity motor deficit of newborn is associated with presence of prolonged labor history, obstetric brachial plexus palsy and clavicle fractures. Dislocation or subluxation due to shoulder joint distortion is quite rare. When physicians encounter a baby with arm immobility they usually consider it because of obstetric brachial plexus palsy and/or clavicle fractures. Dislocation and/or subluxation which are quite rare seldom find place in differential diagnosis. Those with upper extremity motor deficit due to dislocation and/or subluxation usually remain undiagnosed and immobile for a long time and it may result with upper extremity complications. Delayed treatment usually requires surgical operation and long-lasting rehabilitation programs. In this paper it has been aimed to share pre and post reduction clinical data of a 10 day old baby with undiagnosed shoulder joint subluxation.

Case: 10 days old baby born with normal spontaneous vaginal delivery weighed 3150 grams with normal Apgar score in the state hospital. After delivery it was noticed the baby can't move her right upper extremity. Post birth X-ray had showed no fracture, then patient was referred to our hospital with pre-diagnosis of obstetric brachial plexus palsy.

The patient was brought by her parents after ten days of birth. Since examination performed by both emergency and pediatric neurology find no pathology patients was consulted to our clinic. We performed X-ray and it showed subluxation towards to superolateral of right shoulder joint when compared to the left one. MRI scan under sedation showed slight effusion in joint, general edema in bone marrow and humerus head has a superior allocation with respect to glenoid (Figure 1)

Closed joint reduction has been performed under general anesthesia, during manipulation phase click sound was heard and full joint reduction was seen in control scopy graphy. Post-operative patient was performed 20-30degree velpau bandage after it was seen joint has full mobility.

Control x-ray showed joint reduction is full (Figure 2). After ten days long velpau bandaging, it was seen joint mobility was full and stability so bandaging was stopped and then patient referred to rehabilitation.

Comparative graphy performed after four month showed that humeral head and sphericity are equal (Figure 3).

Conclusion: Since subluxation and/or dislocation of shoulder in newborns is quite rare we aimed to address that it should be clearly differentiated from other postnatal complications and treated at the very early stage.

Keywords: newborn, immobility shoulder, subluxation, obstetric brachial plexus palsy, clavicle fractures

P-0259 Other

The role of oxidative stress in benign positional paroxysmal vertigo pathophysiology

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Objective: The number of patients admit to emergency departments with vertigo clinics is quite a lot. Vertigo is a case that negatively affects the quality of social life. Benign Paroxysmal Positional Vertigo (BPPV) is the most frequent vertigo reason. In this study, we aimed to measure the oxidative stress parameters of patients, who admitted emergency departments with vertigo clinics and who are diagnosed with BPPV, and also we aimed to research the impact of oxidative stress index on BPPV etiology.

Material-Method: Our study was completed between 1st of July, 2013 and 31st of December 2013 at the Emergency Department of Ankara Atatürk Training and Research Hospital. 64 patients, who admitted to the emergency department between these dates and who were diagnosed with BPPV, and 47 healthy volunteers were included in the study scope. Blood samples were taken from the patients and control groups in order to study the oxidative stress parameters. Total antioxidant status (TAS) and total oxidative status (TOS) values were studied on the basis



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of these blood samples. Also, their proportion to each other and oxidative stress indexes (OSI) were calculated. The data was analyzed via SPSS 15.0 software by using Mann Whitney-U test. **Results:** 47 (42.3%) of samples were from the control group, while 64 (57.7%) of them were from the patient group. 18 (28.6%) of workgroup were male, while 46 (71.4%) of them were female. The average value of the control group's OSI level was 1.312, while the patient group's OSI level was 2.154. We have observed that this difference was statistically significant ($Z = -3.515$, $p < 0.05$). While, for TOS value, the control group's average value was 2.32, it was 4.07 in the patient group. Accordingly, the TOS level of the control group was significantly below the patient group's TOS level ($Z = -3.515$, $p < 0.05$). The average value of the control group for TAS value was 2.02, while the average of the patient group was 1.95. We have observed that this difference was not significant statistically ($t = 1.232$, $p > 0.05$).

Conclusion: On the basis of these findings, we can assert that there are significant changes to the oxidative stress tests in BPPV pathogenesis. We are of the opinion that this must be supported with further studies.

Keywords: oxidative stress, vertigo, BPPV

P-0260 Other

Oxidative stress and ischemia modified albumin levels in subarachnoid hemorrhage patients

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Objective: This study was planned in order to research the relation between the oxidative stress level and the clinical and radiological findings of patients that are diagnosed with subarachnoid hemorrhage (SAH) at the emergency service.

Materials-Methods: 41 patients that had been diagnosed with SAH and 47 healthy adults were enrolled in the study. Blood samples were taken at the time of application for the purpose studying the oxidative stress parameters. Serum total oxidant status (TOS), total antioxidant status (TAS), and ischemia modified albumin (IMA) levels were measured and oxidative stress index (OSI) was calculated as the indicator of degree of oxidative stress.

Results: The TOS, OSI, and IMA levels of SAH patient group were found significantly higher than the control group. There was no difference between the two groups in terms of TAS levels. In patients with trauma, TAS level was determined lower in comparison with the patients without trauma. A significant correlation between including loss of consciousness and have bad results according to Glasgow outcome scale, TOS and TAS levels of all patients have been observed. Moreover, there was a meaningful correlation between Glasgow Coma Scale (GCS) TOS levels and Fisher Scale TAS levels of patients. Hospitalization length was correlated with OSI. In the patients with headache and neck stiffness, IMA levels were found lower than those of the other patients.

Conclusion: According to the results of this clinical study, we are of the opinion that oxidative stress important in SAH pathogenesis and oxidative stress parameters may be valuable in the assessment of clinical severity and in predicting outcome.

Keywords: Subarachnoid hemorrhage, oxidative stress, ischemia modified albumin

P-0261 Other

The relationship between weather condition and forensic case admission

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Objective: In our country an important portion of forensic patients are initially admitted to the emergency departments. In this study our aim was to determine the distribution of forensic patient admissions to the emergency room over months and seasons and whether there is a relation between weather conditions and forensic patient admissions to the emergency room.

Materials-Methods: Data was obtained from a retrospective review of 3626 forensic cases that admitted to our emergency room between July 2012-June 2013. We took the weather data from www.accuweather.com web site. We used IBM SPSS Statistics 21 programme for analysis. In this study, forensic case load of our hospital and its distribution among case types has been determined.

Results: In our study 74.1% of the applicants were male, 25.9% were women. Our study showed that the most common reason for presentation is traffic accidents which are followed by work accidents. The forensic case presentations were more common in May, June and July and least common in February. When evaluated on seasonal level it is found that more patients present during summer months. When forensic applications are analyzed according to the time of arrival the busiest times were between 4:00 pm and midnight. When we looked at the weather conditions at the time of arrival, we found that 85% of the time it was open skies, 3.2% cloudy and 11.8% it was rainy or snowy. When looked at the relationship between weather conditions at the time of admission and the reason for emergency room hospitalization we found that traffic accidents are more common in rain or snowfall or with clear skies. The most common cause of patient admission during cloudy weather is work accidents. In our study when we looked at the relationship between weather conditions and admission cause, a statistically significant relationship is found between admission cause and temperature, and humidity. In our sample treatments of 8.7% of the patients are completed in the emergency room, 2.5% are admitted as in patients and 88.8% of the patients are discharged.

Conclusion: In this study we found that forensic patient admissions were commonly male and younger so it may be helpful to take precaution (education, wearing helmet etc.) for this patients. Forensic cases were most seen in summer and 4:00 p.m. to 11:59 pm, so it is important to plan emergency service personal and supplies in this time period.

Keywords: forensic medicine, weather condition, season

P-0262 Other

Contact Dermatitis Observed after Hair Dying

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Objective: Cosmetic products are products without treatment effects used on the body, especially on skin, hairs, and teeth, mucosa membranes in order to protect, clean-up and embellish the outlook. These products have been developed to color, to create fashion, to improve mood and to emit odor. Permanent hair dyes may lead to violent reactions more pronounced in face and ears more than in skull. In our study, we have presented the case of a patient who applied to the emergency unit with a severe allergic reaction after hair dye which is an important cosmetic product.

Case: A 22 year-old female patient applied to the emergency unit with edema especially around her eyes and with an allergic eruption at the hair roots, and it has been determined that she had her hair dyed 3-4 hours ago. The vital observations at arrival were TA:120/80 mmHg, Pulse:72/min, breath rate:12/min, temperature: 36.5 0C and SaO2: 95%. In the physical examination, edema has been observed in periorbital, frontal and temporal regions. Erythematous eruptions were present in post auricular and occipital hairy skin. No other pathology has been detected in the other system examinations. The patient has been followed-up using conservative medical methods; no aggressive treatment has been applied. The patient has been discharged without any problem in the follow-up.

Conclusion: A good patient interrogation is mostly helpful for the diagnosis. The hobbies, the job, the clothes, the previous and actual treatments of the patient may be directive for the diagnosis and the treatment. The most differentiating diagnosis of the disease is irritant contact dermatitis. The potential antigen may be determined with questions about the lesion localization. The basic principle of the treatment is to improve the dermatitis and to detect the allergen. Knowing the allergen is important to avoid the recurrence of the disease. The patient shall be informed about the chemical product that led to dermatitis and a list of products containing these chemicals shall be given to the patient.

Keywords: contact dermatitis, allergic reaction, hair dying



POSTER BİLDİRİLER

P-0263 Other

Warfarin over doz; Hard palate hematoma

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Objective: Thrombotic agents are standard for the treatment of both arterial and venous thromboembolic situations. These agents present life-threatening complications in addition to the treatment action and the protective effects from occlusive venous events. Warfarin which is an oral anticoagulant drug is widely used for treatment in thromboembolic events but is also used to prevent thromboemboly. Warfarin shows its effects by blocking the vitamin K-related coagulation factors (II, VII, IX, X) and the vitamin K-dependent coagulation inhibitors (protein C and S). The warfarin dose shall be arranged such as the prothrombin time normalized according to the International Normalized Ratio (INR) level of 2-3 to obtain an efficient treatment. The most frequent and important complication of the treatment is hemorrhage. In this study, the rare case of hard plate hematoma associated to warfarin over dose has been presented.

Case: A 61 year-old male patient using oral anticoagulant applied to the emergency unit for a hemorrhage that started approximately 1 hour ago. In the history of the patient, there was no disceptic complaint, peptic ulcer, anterior gastrointestinal system bleeding or trauma. The general situation of the patient was fine, the vital observation was stable, and examination results were normal except for the exudate-like hemorrhage in the hard palate (Figure 1). The patient history has shown coronary artery disease, hypertension, cardiac insufficiency, diabetes mellitus disease; and the utilization of Coumadin, Coraspin, Plavix drugs. In laboratory analyses; the results were as follow; hemoglobin: 11.2 gr/dl, hematocrit: 34.1%, thrombocytes count: 155.000 /mm3, leucocyte count: 3.730 mm3/dl, prothrombin time: 18.9 seconds (normal: 10.70-13.60), INR: 1.53 (normal: 0.90-1.10). The liver and kidney function tests were found to be normal. The patient has been discharged by adjusting the Coumadin dose.

Conclusion: The anticoagulant effect changes in a dose-dependent manner. Moreover, oral anticoagulant drugs enter into reaction with some drugs and some decrease while some decrease the anticoagulant efficiency. The dose shall be titrated accurately and the follow-up shall be made precisely because the safety index of the drugs is limited an even a slight increase of the dose may lead to hemorrhage.

Keywords: warfarin, over dose, hard palate hematoma

P-0264 Other

A Case with Groove Pancreatitis

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Objective: Groove pancreatitis, rare form of chronic pancreatitis, is characterized by fibrous scars in the anatomic space between the head of the pancreas, the duodenum and the common bile duct. The patients usually present with postprandial abdominal pain, impaired motility and stenosis of the duodenum and postprandial vomiting. It is frequently misdiagnosed as pancreatic malignancy or autoimmune pancreatitis because of its pseudotumor formation. Most patients with groove pancreatitis are males aged 40-50 years with a history of alcohol using. The clinical symptoms are weight loss, upper abdominal pain, postprandial vomiting, and nausea due to duodenal stenosis. The pathogenesis of groove pancreatitis is believed to be anatomical or functional obstruction of the minor papilla.

Case: We are offering a patient who is admitted emergency department with abdominal pain. A 40-year-old male smoker who consumed excessive amounts of alcohol presented with epigastric pain radiating to the back for nearly two months. 3-D CT of the abdomen showed swelling of the pancreatic head with inflammatory changes, cleavage a hypodense mass of pancreaticoduodenal cleavage. Upper gastrointestinal endoscopy revealed an edematous, shiny, reddish raised mucosa having a polypoid appearance with narrowing of the second portion of the duodenum. Histological examination of the duodenal biopsy specimens showed preservation of the crypt-villus ratio, and the signs which consistent with active gastritis. Laboratory data showed slightly elevated serum levels of lipase (77 U/l). These findings appeared consistent with the diagnosis of groove pancreatitis. Presently, the patient is on conservative medical management with analgesics, proton pump inhibitors and a pancreatic enzyme supplement.

Conclusion: Groove pancreatitis is a rare, benign disease, and if diagnosed correctly, unnecessary surgery can be refrained. The differential diagnosis varies from anatomic variants to malignancies. Groove pancreatitis and pancreatic head cancer treatment procedure is completely different so the correct diagnosis is very important. If the duodenal wall is thickened and cysts are present in the groove region in a middle-aged male patient with chronic alcohol consumption, groove pancreatitis should be considered. It is often misdiagnosed as pancreatic malignancy or autoimmune pancreatitis because of its pseudotumor formation. Groove pancreatitis must thought when patients admitted with pancreatitis clinic and abdominal pain.

Keywords: Groove pancreatitis, pancreatitis, chronic pancreatitis, pancreatic malignancy, alcohol

P-0265 Other

Thyroid hormones and suicide attempts: A prospective case-control and follow up study

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Objective: Suicide is a complex issue involving a number of psychological, social, cultural and biological factors. Suicide is an important public issue, as well as one of the leading causes of death. The aim of this study was to assess hormones in the hypothalamic-pituitary-thyroid (HPT) axis, namely TSH, fT3, fT4 and fT3/fT4 ratio in euthyroid suicide attempters and euthyroid healthy controls.

Materials-Methods: A total of 358 patients (115 suicide attempters) who admitted to the ED and 243 healthy controls who admitted to endocrinology polyclinic of our hospital for checkup in the last weeks of the months between November 2009 and December 2013 were included. Using database of the Republic of Turkey Social Security Institution via ICD diagnostic codes related to suicide, the data of future suicide attempts were collected. Average follow-up period was 874.2 days (64-1582 days).

Results: Of the suicide attempters, 110 participants attempted suicide only by self-poisoning with drugs, 5 used violent attempts such as firearms, cutting a vein, jumping off a high place. Two out of these 5 people had taken drugs at the same time. There was no in-hospital mortality. Female suicide attempters and controls differed with regard to fT4, TSH and fT3/fT4 levels. Male suicide attempters and controls differed with regard to fT4, fT3/fT4. TSH levels was near to significance. A logistic regression model indicated that suicide attempters were 32.7 times more likely to have higher fT4 levels (OR: 32.7; 95%CI: 5.3-202.9; P<0.0001), 1.7 times more likely to have higher TSH levels (OR: 1.7; 95%CI: 1.2-2.3; P=0.002) and 2.5 times more likely to have lower fT3/fT4 levels (OR: 1.7; 95%CI: 1.2-2.3; P=0.002) than controls. Diagnostic validity of fT4 was found to be good in differentiating patients with suicide attempters and healthy subjects (Area Under the Curve = 0.821; 95%CI: 0.77-0.87; P<0.0001). The cutoff point for fT4 of 1.15 µg/dl gave a high sensitivity (85%) and high specificity (70%). This point can be used as discriminative cutoffs between suicide attempters and healthy subjects. Health insurance data of our country showed that 13 of the suicide attempters (10 female, 3 male) reattempted during follow-up. None of the thyroid hormones indicated future suicide attempts.

Conclusion: Our results suggest that suicide attempt is independently associated with higher fT4, TSH and lower fT3/fT4 levels in females and higher fT4 and lower fT3/fT4 levels in males. fT4 may be a useful marker to predict current suicide attempt.

Keywords: HPT axis, suicide, thyroid hormones, T4

P-0266 Other

Rib Fracture Due to Cough: A Case Report

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Objective: Violent or sustained coughing may result in rib fracture. A stress fracture of the ribs is caused by an internal force, rather than by an external force. The term "stress fracture" mentions that the cause of the fracture is muscular strain. Terms such as rebound rib, fatigue fracture, golfer's fracture, and cough fracture only reflect the preceding or predisposing physical activity associated with the muscular strain that induces the fracture. Cough fracture is known that the most commonly reported type of stress fracture. A case of single, unilateral rib fractures sustained by an adult man during a paroxysm of coughing is presented.

Case: A 45-year-old man was admitted to the emergency department. He complained of severe, stabbing pain in the lateral aspect of the right side of his chest that had begun during a paroxysm of coughing two-three hours before. His medical history was unremarkable. But he has treated with cefuroxime and NAC for acute bronchitis about ten days. And his condition did not improve. There was no recent history of trauma. On the admission to the hospital, his arterial blood pressure was 110/80 mm Hg, his respiratory rate was 16/min, his temperature



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was 36°C and his O₂ saturation level was 96%. General status was good. There was moderate tenderness and crepitation detected with palpation on the lateral aspect of the right side of patient's chest. No sign of trauma was evident. His laboratory parameters were normal. Chest radiography showed fracture on the right eighth rib (Figure 1). He transferred to department of pulmoner diseases

Conclusion: Cough-induced rib fractures occur primarily in woman with chronic cough due to reduced bone density. However, As in our case, some complications such as rib fractures may show in adult men after coughing.

Keywords: Rib Fracture, Cough, emergency

P-0267 Other

A man in his seventies with syncope

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Objective: Abdominal aortic aneurysm (AAA) has a population prevalence of 2-5% and mortality in case of rupture of 80%. The most frightening and potentially life threatening complication is rupture of AAA. Patients present with atypical symptoms such as abdominal or flank pain, gastrointestinal hemorrhage or shock.

Case: A 76-year-old man presented to our emergency department with syncope after severe back pain. He had diabetes, kidney failure and hypertension. On physical examination, GCS 15/15, BP: 90/60 mmHg, HR: 76 bpm, BG: 147mg/dl, isochoric pupillary. ECG and brain CT was normal. While the patient was under observation, he got cold sweats and presyncope, then thoracic-abdominal contrast-enhanced CT angiography was planned. At the Infrarenal abdominal aorta, approximately 60-mm segment wall calcification at the widest point 61 mm measured aneurysmal dilatation and adjacent retroperitoneal from the left psoas muscle, anterior adjacent aneurysm due to rupture hemorrhage suggestive of heterogeneous fluid accumulation were observed. (Picture-1) (Picture-2). He was admitted to the intensive care unit of cardiac and vascular surgery for endovascular aortic aneurysm repair (EVAR).

Conclusion: Emergency physicians should keep in mind that AAA and its rupture can present with a wide range of symptoms such as back pain and syncope that appear to be simple.

Keywords: Back pain, syncope, AAA

P-0268 Trauma Emergencies

Traumatic inferior hip dislocation

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Objective: Inferior hip dislocation (luxatio erecta femoris) is the least common form of hip dislocation. It often occurs in children. This condition very rarely occurs in adults, and there has been only 10 case reports in the literature. This case report presents a patient with this rare condition.

Case: A 55-year-old male patient was brought to the emergency room after his left side of the body being remained under compression. On admission, GCS was 15, general condition was good. BP: 140/70 mmHg, PR:100 bpm, RR:16/min, sPO₂: 100% On physical examination, hip joint was rotated and flexed at around 100 degrees, and knee joint was flexed. The patient did not have motor and sensorial deficits, distal pulses were bilaterally palpable and equal on both lower extremities. Anteroposterior hip x-ray revealed inferior dislocation of the femoral head and the joint was flexed (Figure 1). After achieving sedation and analgesia in the emergency room by intravenous administration of fentanyl and midazolam, closed reduction was performed using Allis maneuver. There was no neurovascular deficits after the reduction. Control radiographs confirmed femoral head location (Figure 2). The patient was then admitted to the regular ward of the department of orthopedics and traumatology for follow-up treatment.

Conclusion: It must be kept in mind that inferior hip dislocation, despite its very rare occurrence in adult patients, is not a specific condition for children and it can also occur in adult patients. The patient's position and radiographic appearance have typical patterns, and closed reduction can be performed with sedation analgesia or under general anesthesia.

Keywords: hip dislocation, luxatio erecta femoris, trauma

P-0269 Trauma Emergencies

Two cases of injuries with porcupine quill

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Objective: The aim of these cases were to give information about injuries of the quill, which was rarely seen in the emergency department.

Case 1: 17 year old male patient was admitted to our emergency department after a quill was pricked on his foot when wandering around the land. A quill was found approximately in the 3 cm depth at the dorsum of foot in the physical examination. Quill was removed, dressing and tetanus vaccine was performed and then discharged by giving antibiotics. No complication was occurred in the follow-up.

Case 2: 5 year old female patient was brought to our emergency department after falling prostrate on a quill. In the physical examination, the quill penetrated into the abdomen in approximately 2 cm on the left side to the umbilicus was seen. In abdominal computed tomography examination, quill was observed to enter through the front wall and exit from the rear wall of the stomach, and to cause a capsula injury in the segment 2 of the liver. Emergency operation was performed and she was discharged with healing 5 days later after operation.

Conclusion: Quill can rarely cause serious injuries. Therefore, patients admitted to the emergency department with this complaint should carefully be evaluated. Tetanus vaccine should not be forgotten, and antibiotics should start for infections which may occur in follow-up.

Keywords: porcupine, quill, emergency, hedgehog

P-0270 Other

Angioedema due to pomegranate:

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Objective: In this case presentation, we aim to presentation angioedema due to pomegranate.

Case: A 35-year-old female patient presented to our emergency department with redness on the cheeks and edema in her mouth, lips and eyelids It was learned from the history that her symptoms were begun 15 minutes after eating a pomegranate.

In her medical history there was no any illness and drug use. On physical examination, she was alert. She has a regular heart rate of 78 bpm, her blood pressure was 120/75 mmHg and respiration rate was 12 breathes per minute. Redness was present her cheeks. Edema was present around her mouth and eyelids (Fig. 1).

The patient was placed on a cardiac monitor, an intravenous line was established and 6 lt/min oxygen was started. 40 mg methylprednisolone and 50 mg diphenhydramine were administered intravenously. The patient was placed in our observation unit for 8 hours and was discharged without any further problems

Keywords: emergency, angioedema, pomegranate



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P-0271 Trauma Emergencies

Post traumatic pulmonary pseudocyst

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Objective: Blunt thoracic traumatic injuries of the lung parenchyma often results in contusion or hematoma. Cavitary lesions or formation of pseudocyst rarely occur as a result of lung trauma. Traumatic pseudocysts mostly do not require specific surgical intervention and can be treated with supportive therapy. The current report presents a young adult patient who sustained traffic accident.

Case: A 18-year-old male patient was brought to the emergency room after sustaining a motor vehicle crash. On admission, the patient was intubated and was being ventilated by bag-valve-mask device. BP: 100/60 mmHg, PR: 115 bpm, sPO2: 84%. On physical examination, GCS was 8 (E2M5V1), there was diffuse tenderness on palpation of both hemithorax, respiratory sounds were decreased in the left side, and bilateral crackles were heard that were more prominent on the right side. Other system findings were normal with the exception of abrasions on the scalp and left femur. Computerized tomography (CT) revealed bilateral pneumothorax that was more prominent on the left side, lung contusion, and bilateral cavitary lesion more prominently in the right side (Figure 1). A consultation with a thoracic surgeon was performed. Bilateral tube thoracostomy was installed. The cavitary lesions observed on CT scans were considered to be traumatic pulmonary pseudocysts (TPP) due to the fact that multiple pseudocysts were observed and they were determined after the trauma. The patient did not have additional pathologies that would require urgent intervention, and the patient was therefore admitted to the intensive care unit for follow-up and treatment by thoracic surgeons. The patient did not undergo additional surgeries during the follow-up period, and he was discharged from the hospital after being hospitalized for 13 days in the intensive care unit and 8 days in the regular ward. Control CT obtained prior to discharge confirmed the recovery of pseudocysts (Figure 2).

Conclusion: TPPs are rare complications occurring usually after blunt traumas to the thorax. Although the majority of TPPs resolve with supportive care, some patients may show enlargement of the pseudocysts, lung abscess or massive hemoptysis that may be life-threatening or require surgical intervention in rare circumstances. These lesions may not be noticed on chest x-rays. Computerized tomography is superior to chest radiography in diagnosing such lesions, and this diagnostic tool must be considered in patients presenting to the emergency room with blunt thoracic trauma.

Keywords: chest trauma, lung, pseudocyst

P-0272 Other

The analysis of elderly patients admitted to the emergency department of a university hospital

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Objective: Senescence is an irreversible process. The elderly patient population in Turkey, as well as in the world, is rapidly growing. Elderly patients are considered to pose an additional burden on the emergency services due to the altered pattern of disease presentation and pharmacodynamics, decreased functional capacity, social issues, and physiologic changes due to aging. From this point of view, the present study evaluated the demographic features and the outcomes in elderly patients

Materials-Methods: The medical records of the patients aged at or above 65 years and who were admitted to the emergency department (ED) were retrieved from the hospital's database and retrospectively reviewed for criteria including age, gender, admission data, length of stay in the ED, diagnosis, triage category, billing data, and outcomes.

Results: During the course of the study, 4,619 out of 6,295 patients, for whom complete medical records were available, were evaluated. The mean age of the patients was 73.7 ± 6.1 (65-97) years; 2,676 (57.9%) were aged between 65 and 74 years, 1,710 (37.1%) were aged between 75 and 84 years, and 233 (5.0%) were aged above 85 years. When the patients were grouped according to age and triage category, the degree of emergency condition was found to be more severe with the increasing age (p<0.05). The number of admissions was the highest on Sundays, and mean length of stay in the ED was 251.5 ± 206.6 minutes. Of the admitted patients, 31.5% were hospitalized, and the department of cardiology received the highest number of patients from the ED. The mean invoice amount was 142 Turkish Lira (TL), and the invoice amount increased with the increasing patient age (p<0.05).

Conclusion: The geriatric patient population in the ED is increasingly growing with each day. The severity of the emergency condition, length of stay, hospitalization rates, and treatment costs are also increasing with the increasing age. The hospitals and EDs must perform the required arrangements to provide better service to the geriatric patient population, and ED staff should maintain their knowledge base at high level about geriatric conditions.

Keywords: data, demographic, geriatric, emergency department

P-0273 Trauma Emergencies

Zone 2 Gunshot Injury

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Objective: cervical penetrating trauma has a high mortality and morbidity due to injury of vital organs. However, zone II trauma has lower mortality and morbidity than other types.

Case: 46 years old male patient was admitted to emergency department for penetrating cervical trauma due to gunshot wound. entry and exit wound were localized on both sides of the neck about C4 level (Zone II). Patients vital signs revealed: Glasgow coma scale of 15, blood pressure 130/80 mmHg and heart rate of 56/min. Neck CT revealed only C4 and C5 corpus fracture without injury to medulla spinalis, esophagus, trachea and major vessels. Endoscopic evaluation of esophagus was non-diagnostic. There was no deficit and abnormality in the follow up. Patient was discharged from the hospital with cervical callor.

Conclusion: Penetrating neck trauma, in particular stab wounds to zone II in asymptomatic patients, is associated with low morbidity and mortality. A selective management protocol with investigations directed by symptoms is the most appropriate approach for the patient population and resource base in this setting.

Keywords: zone 2, neck, penetrating injury

P-0274 Other

Are we neglecting physical examination?

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Objective: With routine usage of high technology radiologic diagnostic procedures, detailed medical history and systemic physical examination are losing their priority for patient evaluation. Even we, clinicians, assert the contrary, generally we use patient density as an excuse, do not take proper medical history, mostly don't touch the patient and use laboratory and radiological procedures and consult to a specialist. In our case we start out this situation, and present a patient that admitted with fatigue and weakness then diagnosed plastron appendicitis with detailed medical history and physical examination.

Case: 24 year old male patient admitted with fatigue and weakness for about 1 week, cough for 3 days. We thought about upper respiratory tract infection but there was no evidence of infection on respiratory tract, on detailed systemic examination there is only a palpable solid mass for about 4 cm in the right lower quadrant of abdomen without defecation and rebound. After questioning patients medical history, visiting emergency clinic for a month ago with abdominal pain on right lower quadrant then after CBC results, extension with antibiography was learned. In patients blood tests WBC was 18000/mm³ ure was 106mg/dl creatinine was 1.8mg/dl. Plastron appendicitis was detected with unenhanced tomography taken because of high creatinine levels. Urgent operation decision was made after consulting surgery, and appendectomy was performed. Patient extened postoperative 3rd day without any problems.



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Conclusion: In these days that being a physician becomes distant of being an art, confusing following technological progress with being a physician that avoids talking or touching the patients, and educating medical students in this circumstances are the painful truths that awaits our younger colleagues.

Keywords: emergency, physical examination, plastron appendicitis

P-0275 Other

Hearing loss due to sea pebbles

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Objective: Ear plugs, acute otitis externa or otitis media are usually diagnosed in cases admitting to emergency departments with complaints of ear pain and usually complaints are seen in acute phase. We wanted to share a case whose ear pain occurred very long after the event and the pain was complication of a foreign body unexpectedly.

Case: A 30-year-old female case admitted to emergency department with complaints of pain and hum in the ear and hearing loss. In her anamnesis, it was learned that her complaints had continued for two days, she had a throbbing pain and no complaints of fever or otorrhea. It was seen a foreign body had a 0.4x0.3 centimeters diameter attached to the eardrum in physical examination. The foreign body was removed with the help of otoscope. When questioned about the case story, it was learned that the sea pebbles had escaped her ear about 4 months ago and she had had an earache, she had used an eardrop containing gentamicin reduced her earache. The case was discharged with the prescription of an analgesic eardrop.

Conclusion: The earaches may not always point out acute events at the admission to the emergency services and a foreign body, which may be unnoticed if a serious anamnesis hadn't taken, must be thought in the possible diagnosis.

Keywords: sea pebbles, earache, hearing loss

P-0276 Trauma Emergencies

Wild boar attack in suburb Antalya: a case report

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Objective: The wild boar (*Sus scrofa*) is an animal widely found in forests and maquis areas in Turkey. Agricultural land, pathways, and animal pastures near such areas are locations in which humans encounter wild boars and may be subject to attack. Attacks on humans by wild boar are occasionally reported in rural areas of Turkey. While fatalities are rare, individuals may sustain significant soft tissue trauma.

Case: A 43-year-old male patient presented to the emergency department following a wild boar attack sustained at 14:00 pm in 10th of March 2014 while he was working in semiforest-maquis area in Döşemealtı (suburb of Antalya) for chopping woods. The injured party had engaged in no behavior thought to have provoked the boar. The patient had a 10-cm skin and subcutaneous tissue laceration on the lateral of the left knee. This wound was irrigated using pulse lavage, and tetanus toxoid and antibiotic prophylaxis were administered. Rabies vaccine and toxoid also has given. The wound was subsequently sutured and the patient discharged. No complications developed.

Conclusion: Injuries resulting from wild boar attacks generally occur in the lower extremities and lower-abdomen region. This pattern is related to the height of the animal. Following the initial assault the animal generally turns and attacks repeatedly. This results in victims frequently having more than one injury site.

Wound cleaning, debridement, and tetanus prophylaxis are recommended after wild animal attacks. Most wild mammals can become infected with rabies. So, every suspected wild mammalian bite patient should be considered for rabies vaccination. Antimicrobial treatment should be administered for all bite wounds, with the exception of wounds in those patients who present 72 hours or more after injury with no clinical signs of infection.

In conclusion, although wild boars are known to be animals that do not generally pose a threat to human beings, people working on agricultural land bordering forests and in our case suburb areas in regions known to be inhabited by wild boar herds need to be made aware of the possibility of wild boar attacks.

Keywords: Wild boar, wild animal attack, suburb

P-0277 Other

Acute Urinary Retention Causing Urethral Calculus; Case Report

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Objective: Urethral calculi represent less than 2% of all urinary stone disease. Primary urethral stone is a rare condition. It usually develops secondary to congenital urethral diverticulum. The majority of urethral calculi are migrant from the upper urinary system or bladder. Treatment is contingent on the size and location of the stones and condition of the urethra. We present the urethral stone which stays in the external meatus of the urethra in this report.

Case: A 65-year-old female patient applied to our emergency department with the complaint of being unable to void for 13 hours. She had neither history of urinary system complaints and passing a kidney stone in her background, nor her family had such a stone disease history. The patient's vital signs were measured as BP: 120/70 mm/Hg, pulse 88/min, respiratory rate 20/min, pulse oximetry: 98%. After detecting globus vesical during the physical examination, it was planned that the patient should be inserted with a urinary catheter. However, during the urinary system examination, a hard bulk was observed to block the external meatus of the urethra (Picture 1). This 2 x 1.5cm-sized stone was removed kindly by using a forceps without leading to any injury. The patient was able to urinate without resorting to any other procedure. Since her renal function tests were observed to be within normal range (Creatinin: 0.9 mg/dl, BUN: 11 mg/dl), the patient was discharged from the emergency department with some suggestions.

Conclusion: As a result, calculus in urethra is a rare phenomenon for women. Especially primary calculus in urethra may give off symptoms late and reach to a critical point. The stones reaching external meatus can be removed with the help of forceps in the emergency department, which reduces both the hospitalization duration and the cost of treatment.

Keywords: Urethral calculi, urolithiasis, external meatus, emergency department

P-0278 Trauma Emergencies

Traumatic pneumothorax and pneumomediastinum accompanied by myocardial infarction

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Introduction: Coexistence of traumatic pneumothorax, pneumomediastinum and myocardial infarction is a rare condition and may result in death. Many studies have been made about cardiac damage that may develop in blunt chest trauma. However, a small number of cases have been reported about thoracic trauma accompanied by myocardial infarction.

Case: A 62-year-old man, with history of chronic obstructive pulmonary disease, referred to our emergency department with symptoms of severe chest pain and shortness of breath. In his detailed history, it is learned that he fell from a chair and crashed his right chest to a table approximately 1 hour before admission. Traumatic pneumothorax and pneumomediastinum were detected in CT exam. During his follow-up, patient was diagnosed as myocardial infarction due to troponin elevation.

Conclusion: In each new reference with chest pain or shortness of breath in chronic lung disease patients, differential diagnosis should be made for other reasons, physical examination findings should be evaluated carefully and reliability of patient history should be questioned. In patients with traumatic pneumothorax, detection of accompanying cardiac injury is absolutely necessary for prevention of morbidity and mortality.

Keywords: Myocardial infarction, Trauma, Pneumothorax, Pneumomediastinum



POSTER BİLDİRİLER

P-0279 Other

An important cause of dyspnea; foreign body “nail” aspiration

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Introduction: Bronchial aspiration is infrequently seen in healthy adults. The aspiration of a foreign body is usually combined with acute clinical symptoms requiring immediate medical intervention. It can mimic primary airway diseases and diagnosis may be delayed. Late-diagnosed bronchial foreign bodies can lead to irreversible changes in the bronchi and the lungs. Rigid or flexible bronchoscopy, and rarely thoracotomy may be required to remove the foreign body.

Case: A 33-year-old man referred to our emergency department with bronchial aspiration of a foreign body and sudden onset of dyspnea. He aspirated a nail that was in his mouth while he was driving nails and talking with friends at the same time. Past medical history revealed former smoking. Physical examination revealed unilateral wheezing meanwhile vital signs including body temperature, blood pressure, heart rate and peripheral oxygen saturation were normal. A chest x-ray was eventually performed and it showed a foreign body “nail” in the inferior lobe of right lung.

Conclusion: A careful and detailed medical history and exact physical examination should be performed to all patients referring emergency department with suspicion of foreign body aspiration. In order to making localization accurately, non-contrast computerized tomography should be added to posteroanterior chest x-ray. In all cases with suspicion of foreign body aspiration, bronchoscopy should be done at the earliest possible time with both diagnostic and therapeutic purposes. Thoracotomy should be done in complicated or late admitted patients.

Keywords: dyspnea, foreign body aspiration, nail

P-0280 Trauma Emergencies

Isolated scapular fracture related with comorbidities

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Objective: Scapular fractures are usually caused by major blunt trauma. Fracture of the scapula due to minor traumas is an uncommon injury. In the review of literature, it is reported in a few cases. In this study we aimed to present isolated scapular fracture due to a fall while walking.

Case: 93 years old male patient was admitted to emergency department due to simple fall. Patient had chronic kidney disease. The vital signs of the patient were normal, and the patient was alert and conscious. In his physical examination, he had an obvious tenderness on his left shoulder with palpation and occipital abrasions and pain. Radiologically; there was a scapular fracture in the left scapula. Patient was hospitalized for 5 days and discharged.

Conclusion: Fracture of the scapula is an uncommon injury, with an incidence of 0.4% to 1% of all fractures. Scapular fractures may be classified by their anatomic location: body, glenoid neck, intraarticular glenoid, spine, coracoid, and acromion. The most common area of the scapula to be fractured is the body and glenoid neck. Significant force is required to fracture the scapula; thus, the presence of scapular fractures is believed to be associated with high rates of other injuries and accompanying morbidities. Associated injury has been reported in 35% to 98% of patients with scapular fractures. On the other hand, isolated scapular fracture is rare. Additional comorbidities may increase risk of isolated scapular fractures.

Keywords: scapula, fracture, comorbidity

P-0281 Other

Weever fish sting: an unusual problem

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Weever fish are among the most venomous fish present in the temperate zone. They are found in coastal waters of West Africa and Europe including Mediterranean Sea. The lesser weever fish inhabits shallow inshore waters where the bottom is flat or sandy and muddy. The greater weever fish lives in deeper, offshore waters and is the species usually responsible for the stings suffered by fishermen and divers. The fish possess approximately six venom containing spines in the front dorsal fin and a single spine on each main gill cover (Figure 1).

The venom, an ichthyocanthotoxin which causes pain, contains several thermolabile proteins, including 5-hydroxytryptamine, a kinin or kinin-like substance, adrenaline, noradrenaline, histamine, possibly serotonin as well as several enzymes. The venom causes wheal and flare reactions in subcutaneous injections and is lethal to some animals.

In summer, the fish prefers shallow water where it buries itself in the mud or sand with eyes, mouth and dorsal fin protruding above the surface. The most common injury is to the lower extremities and a small puncture wound with surrounding, spreading erythema is evident; oedema appears within a few hours. Inflammation of the wound may continue for up to 14 days and movement of the limb can be greatly restricted. The victim may be agitated, clammy, pale, anxious. Headache, nausea, vomiting, sweating and syncope may occur rarely. Systemic symptoms are unusual. Death is extremely rare and is thought to be due to respiratory failure.

Principles of treatment are to alleviate the pain with simple analgesics, opiate analgesia, intravenous calcium gluconate or injection of local anaesthetic (infiltration or regional nerve block). Immersing the affected limb or wound promptly in hot water (approximately 40°C) for about 30-90 minutes, applying hot wet compresses to combat the effects of the venom and to prevent the secondary infection. Cold application worsens the pain. Local wound toilet, debridement and tetanus prophylaxis are provided as necessary. There is no antivenom serum available. Infection is rare but antibiotics will be necessary if local infection develops, and can be considered for prophylaxis in the immunocompromised patient. The patient given a course of tetanus toxoid if not already immunised. Antihistamines may relieve the local inflammatory response. Usually no dressing is required. Prevention is primarily by avoidance, wearing sufficient protective footwear and never handling weever fish.

In summer the mediterranean coast of Turkey rarely encountered such cases. Patients we have encountered, responded to symptomatic treatment.

Keywords: weever fish, poisonous fish, venom

P-0282 Trauma Emergencies

Stab wound at christmas is bad or good luck

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Objective: The entrance hole size can not provide information about the extent of internal damage with penetrating injuries. In particular, at thorax, abdomen or lumbar region penetrating injuries may seem like a small incision and innocent from outside, can cause life-threatening injuries.

Case: A 21 year old male patient applied to the emergency service due to sharp penetrating object injury at the back. Physical examination of the patient revealed approximately 1 cm long transvers laceration at the point where the 9th vertebral place and right subscapular area intersect. Patient had a good general condition and he was oriented cooperative. BP:120/65 mmHg, HR:94/min, BR:14/min, satO2: 95% was determined. Equal bilateral breath sounds are received, where the blade enters crepitus on palpation is available, patients have complained of stinging while breathing. Significant pneumothorax and hemothorax wasn't observed in the posterior-anterior lung radiography of the patient. Thoraco abdominal CT scan at the level of T9 vertebral bodies beneath the skin to the pleural cavity foreign bodies monitoring the course of about 9 cm, was found in the neighborhood pneumothorax view and batin was found clear. The patient was operated by chest surgery and detected penetrating thoracic injuries with damage lung tissue minimal. He was discharged after follow up without problem.

Conclusion: The entrance hole can not provide information about the severity of internal organ damage at sharp penetrating object injury of stab injuries. Small incisions should be taken seriously and the patient's life may be lost should be remembered that could cause serious injuries by minor trauma in such patients must be treated very carefully.

Keywords: chest, trauma, sharp penetrating object injury

P-0283 Trauma Emergencies

Non Traumatic Rib Fracture Related with Cough in a Pregnant

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Objective: Osteoporosis associated with pregnancy is a very unusual situation when bones break suddenly or severe pain occurs during or soon after pregnancy in otherwise apparently healthy women. Bone density decreases in the later part of routine pregnancies but returns to normal in the months following birth. Although the growing baby requires calcium from its mother, a woman's body has its own way of regulating itself so that her own skeleton still gets sufficient calcium. Therefore, especially during the last trimester of pregnancy, spontaneous bone fractures may occur. We report A 32 year old woman in week 31 of her pregnancy presented with the chief complaint of acute onset of left upper quadrant pain after coughing and stretching



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Case: A 32 year-old women in the last weeks of pregnancy admitted the emergency room a sudden sharp pain in the left lower side of chest after coughing and stretching. On physical examination acutely tender area was found in the midaxillary line overlying the eight rib. The pain was aggravated by inspiration. Other physical examination findings were normal. Her initial vital signs were; blood pressures 126/68, pulse rates was 89/min, temperature was 36.9 C, respiratory rate was 22 breaths/min. Ultrasonography was performed to the patient and non-displaced fracture were found in eight rib. Patient were consulted to breast surgery. She was followed by breast surgery and hospitalized for 24 hours. No complications occurred and the patient was discharged with recommendations after 24 hours.

Conclusion: In cases decreased bone density such as pregnancy, spontaneous bone fractures can be seen. So a complete history should be taken from pregnant patient and a complete physical examination should be performed to avoid misdiagnosis.

Keywords: Rib Fracture, Non Traumatic, Pregnant

P-0284 Other

Evaluation of patients admitted to emergency dental clinic of a secondary care public hospital

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Objective: Emergency visits due to various dental conditions are frequent. Dental complaints are problematic for emergency physicians (EP) and only 67% of them are managed appropriately according to current literature. Few emergency departments (ED) have dentists and EPs are faced to evaluate these patients. In this study we aimed to evaluate the emergency visits due to dental problems.

Materials-Methods: This is a retrospective analysis of emergency visits of a secondary care public hospital's emergency dental clinic. The data of patients admitted to dentist in ED between 01.01.2012-31.12.2013 were collected from medical records. The study form included the demographic features of patients, final diagnosis, the tooth number causing problem and applied treatments in ED.

Results: A total of 36.875 patients were presented to ED during the study period and 1477 (4.01 %) of them were dentist visit. 331 (22%) of patients were female and the study subject had a mean age of 24.59±11.07 (min-max: 2-76). 531 (36%) patients were between 20-25 years old. The most common diagnosis was acute apical abscess (n=647, 43.8%) and the most common therapy was prescription antibiotics and/or analgesics (n=897, 60.7%). Only 8 patients were traumatic and only 3 patients were consulted other clinics for any reason. First molars constituted the largest group [16 (n=107, 7.2%); 26 (102, 6.9%); 36 (n=154, 10.4%); 46 (n=147, 10.0%)] of causative teeth.

Conclusion: Non-traumatic dental complaints seem more frequent than expected in ED. In view of many EDs have not dental clinic, EPs should be aware of most frequent causes, simple treatment and follow up modalities of dental emergencies.

Keywords: Dental emergencies, emergency medicine, dentistry

P-0285 Trauma Emergencies

Two child and two blind lead

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Objective: Gunshot-related injuries are a leading cause of death and non-fatal injury among children and adolescents in the United States. 1 Gunshot injuries rank second only to motor vehicle crashes as a cause of death for children ages 15 to 19 years. 1 From 2001 through 2010, 29 331 children age 0 to 19 years died of gunshot-related injuries. We represent two nonfatal accidentally gunshot wound to the chest and neck.

Case: A 9-year-old male was admitted to the emergency department with pain and bleeding on his neck. At the admission he had no idea about what happened. He said that while he was playing on the street he had pain on his neck and then realized bleeding. At physical examination there was a single gunshot wound, hyperemia around the bullet entry hole at the medial of left scapula at the level of T2-3 vertebra (Picture 1). Vital signs were stable. Chest X-Ray was taken and bullet was seen near the tracheal air column at the T1 vertebra. Then thorax CT were performed and there was subcutaneous air at posterior cervical area and foreign bodies in the neighborhood of the T1 vertebra left posterior (picture 2).

Case 2: A 8-year-old male was admitted to the emergency department with pain and bleeding on his thorax. At examination there was gunshot wound at the 4-5 cm right side of T 4 vertebra and crepitus. At thorax CT there was foreign hyperdense body in the neighborhood of the rib 7 and there was subcutaneous air rib 4 to rib 7. Child was admitted to the hospital and foreign body was removed then patient discharged after 3 days.

Conclusion: Accidentally gunshot injuries in the developing countries can be much more than developed countries. For the prevention of these injuries to develop social awareness is necessary.

Keywords: Gunshot, blind lead, children

P-0286 Trauma Emergencies

Posttraumatic Vertigo

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Objective: Vertigo and dizziness are common symptoms occurring after minor head trauma. Although they resolve within few days following trauma, may sometimes progress. Here we report two cases suffering physical activity restriction due to vertigo for 6 months after minor head trauma without any organic pathology.

Case: A 64-year-old male was referred to emergency department for motor vehicle accident. He was conscious with a GCS score of 15. He had a 2 x 1 cm abrasion on left frontoparietal region. Other systemic examination and vital signs were almost normal. His laboratory and imaging studies including cranial computed tomography did not show any pathology. During monitorization in emergency department he developed resistant vertigo. Another male patient who was 47-year-old was transferred to our emergency department after motor vehicle accident. He was also conscious with GCS score of 15 and stable vital signs. He had 2x2 cm ecchymosis on left temporoparietal region, 2 cm laceration over left knee, and ecchymosis on right fourth finger. His laboratory and imaging studies were almost normal except fracture of distal phalanx of fourth finger. During follow-up he developed vertigo and could not be mobilized. Both patients did not respond to symptomatic and supportive treatment. They were hospitalized. Control cranial tomographies, magnetic resonance imaging studies did not show any audiometric or nervous system pathology. They were discharged with medication. When they returned to work or daily physical activity they experienced increase in severity of vertigo. They admitted several times to emergency department and polyclinics. During 6 months period only severity of vertigo decreased but never passed totally.

Conclusion: Concussion of labyrinth, unilateral vestibular nerve injury, injury of utricle and saccule, perilymphatic fistula or traumatic hydrops of endolymphatic sac commonly play a role in posttraumatic vertigo. Structural or microstructural traumas of central nervous system or posttraumatic stress disorder may also be causative agent. Patients may experience difficulty in returning to work or performing daily activities. Emergency physicians should be aware of these conditions for rapid diagnosis and treatment and inform patients suffering head trauma.

Keywords: Dizziness, trauma, vertigo



POSTER BİLDİRİLER

P-0287 Trauma Emergencies

Mesenteric Hematoma due to motor vehicle accident

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Objective: Mesenteric injury from blunt abdominal trauma is rare and can be difficult to diagnose. Usually small bowel and colon injuries accompany mesenteric injury. Mesenteric injury without hollow viscus injury is not common and may not cause clinical manifestations. Delayed diagnosis can be cause of significant morbidity and prolongation of the hospital stay. We present a case of isolated mesenteric injury after motor vehicle accident.

Case: A 41-year-old female patient was referred to the emergency department after motor vehicle accident. The car struck her left side and she suffered pain at her left shoulder, left flank, and umbilical regions. Her vitals were: blood pressure, 135/85 mmHg; heart rate, 98 bpm and regular; respiratory rate, 18/minutes; and oxygen saturation, 98% at room air. Physical examination revealed left scapular crepitation, left flank and umbilical tenderness. On the FAST exam there was no free fluid in the abdominal cavity. Then, thorax and abdominal computed tomography was performed that revealed left comminuted scapular fracture, hematoma at inner surface of the left iliac bone and in the mesentery of umbilical region. There were no intra-abdominal pathology in other organs. She was admitted to the hospital and no complication was observed. After ten days of admission she was discharged without any complication and surgical treatment.

Conclusion: Mesenteric injuries are not commonly seen after blunt abdominal trauma. If the clinical signs do not develop at the early stage of trauma, the diagnosis can be overlooked. Clinical signs may develop between 1-2 hours to 5-8 weeks period. In early periods irritation due to hemorrhage may be seen. Between 12 hours-5 week period, intestinal ischemia may develop secondary to vascular injury. Intestinal stenosis and adhesion formation may be seen between 5-8 weeks following trauma. Injuries of pancreas, diaphragm, small intestine, colon and mesentery are usually overlooked as their early specific signs are subtle. In case of high energy traumas, these uncommon injuries should be in concern and patients should be hospitalized for close follow-up.

Keywords: Blunt abdominal trauma, mesenteric hematoma, mesenteric injury, motor vehicle accident

P-0288 Other

A Huge serous cyst adenoma: A case report

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Objective: Ovarian neoplasms may be divided by origin cell type into three main groups: epithelial, stromal and germ cell. The single most common type benign ovarian neoplasm is the benign cystic teratoma; however, according to some studies it is serous cyst adenoma.

Ovarian epithelial tumors comprise about half of all ovarian tumors, accounting for about 40% of benign tumors and 86% of malignant tumors. Benign serous tumors include cyst adenomas, adenofibromas, cyst adenofibromas and surface papillomas. These tumors are common, accounting for about 25% of all benign ovarian neoplasms and 58% of all ovarian serous tumors.

Case: A 18-year-old nonmarried, virgin woman presented with abdominal distension, left flank, abdomen pain and amenorrhea and hipermenorrhea. Social and economic status of her family is low.

As learned from her family, she was increasing weight but she had no complaints. Physical examination revealed a severely distended abdomen a painless mass, occupying a vast portion of the abdominal cavity, lying between the xiphoid process and the pubic symphysis. Her medical history was normal. She had no serious illness or operation before. On abdominal ultrasound, a giant cyst was found which encompassed the whole abdomen. However grade 4 dilatation was shown on the pelvicalyceal system of right kidney. Computerized tomography revealed a cystic mass lying between the symphysis and the xiphoid process, probably originating from the right ovary (Figure 1). Her laboratory results were as follows: Creatinine:1.44, hemoglobin:11.7 g/dl, Hematocrit:% 34.3. Double J catheter was performed to the right kidney. Cyst was removed as laparoscopic.

Conclusion: During the reproductive years, the most common ovarian masses are benign. As in our case, these patients may admit to the emergency department various symptoms and signs such as urologic symptoms, disorders of menstruation, massive abdominal mass, abdominal pain and discomfort. Also, Follow-up loss of the patient (due to low socioeconomic level) may contribute to over-growth of the mass.

Keywords: ovarian mass, emergency department, surgery

P-0289 Trauma Emergencies

Retrospective Evaluation of Electricity Injuries

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Objective: Electricity injuries (EI) are one of the most important injuries affecting human life. It can be seen in different layers of society and all age groups. Metabolic, cardiac, septic and surgical complications in acute phase and psychological, social and aesthetic problems are in forefront. In this study we aimed to present the EI cases brought to our emergency service in terms of both epidemiologic and the clinical picture and complications.

Materials-Methods: This is a retrospective study performed in the light of the information obtained by screening the patient files. We included all the patients who were brought to our emergency service in 2011, 2012 and 2013 and followed at least twenty four hours to the study.

Results: Total 147 patients have admitted to our emergency service with EI complaint within this time period. 72 of them have followed at least twenty four hours. The results that were obtained by screening of 35 of these 72 patients have been presented as pilot study. 28 of them were males (80%), 7 of them were females (20%) and the mean age was determined as 29.45 ± 11.06 years. While the 17 of the cases were occurred at home (48.6%), 18 cases were occurred at workplaces (51.4%). 23 cases (65.7%) were exposed to low voltage electricity current and 12 cases (34.3%) were exposed to high voltage electricity current. Various traumatic injuries secondary to EI have been developed in 7 patients (20%) and varying degrees and sizes of burns have been developed in 9 patients (25.7%). ECG changes have been seen in 8 patients (22.9%) and troponin increase has been seen in 6 patients (17.1%). However there wasn't any permanent cardiac pathology observed at the end of 24 hours. Acidosis in 3 patients (8.6%), rhabdomyolysis in 5 patients (14.3%) and acute renal failure picture has developed in 1 patient (2.9%). Only 2 patients (5.7%) had the need of intubation and mechanic ventilation. While 29 patients (82.9%) discharged from our clinic with cure, 2 patients (5.7%) were discharged by surgery clinic after the operation. 4 patients (11.4%) were transferred to burn unit.

Conclusion: EI can lead traumatic and metabolic complications. Also it can lead severe burns. However, the cardiac changes that EI cause generally do not lead a permanent pathology.

Keywords: Electricity Injuries, Cardiac changes, Traumatic and metabolic complications

P-0290 Trauma Emergencies

Human Bite:Case Report

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Objective: Human bites are common injuries especially contact sports like boxing and fighting. They can cause ranging from slight injuries to serious infections. Human bites have higher risk of infection development compared with animal bites. Bites of human origin are mostly occur in males between the ages of 20-30, and especially seen on the arms, fingers and head-neck regions. Although hand, face and genital region bites are rare they have higher risk for complication as infection. In this case we present an ear injury caused by a human bite leading to partial amputation.

Case: A 40-year-old male patient presented to our Emergency Department with a human bite on his left ear. Lateral portion of his auricula was amputated. He was stabilized, local wound treatment and tetanus prophylaxis was performed. He was consulted to Plastic Surgery Department. The defect of left auricular helix repaired with composite graft after debridement. Then antibiotherapy was added. During control physical examinations graft's perfusion inspected. The patient discharged five days later.

Conclusion: Human bites often seen in hands, arms, head region. Human bites are a common cause of injury in pediatric age groups especially daycare centers in the USA, although in some series the proportion of human bites is highest among adolescents. In adolescents, fist-to-mouth (tooth) injuries are associated with fights. In adults this injuries are rare. Tetanus prophylaxis should not disregard for human and animal bites. The surgical treatment of amputated portion can be performed with primary repair or secondary reconstructive procedures. Human bites are an increasingly common presentation that healthcare professionals should be aware of. The ear in particular is a notoriously difficult structure to reconstruct but yields positive psychological benefits.

Keywords: Human bite, ear, emergency medicine



POSTER PRESENTATIONS

P-0291 Other

Contact Dermatitis Caused by Walnut-Shell Juice

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Objective: Walnuts are edible single-seeded fruits of the walnut tree of the genus *Juglans*. While China is the world's largest producer of walnut seeds Turkey is in fourth place. Walnuts are nutrient-dense food and contain proteins, fat, carbohydrates, vitamins-especially vitamin A-, and dietary fiber. Also it is rich in omega 3 and 6. Walnut is a kind of alternative medicine promoted for its effect on health but there is no available scientific evidence to support this theory. The allergy to this seeds is often seen by digestion. But there are also contact dermatitis reactions usages of cosmetics that contain walnut extract.

In this case we present a contact dermatitis caused by walnut-shell juice in treatment acne vulgaris.

Case: A 23 year old female patient presented to our Emergency Department with hyperemia and pruritus on her eyebrow region. In her history there was local usage of boiled walnut-shell juice for acne vulgaris treatment. There were not any systemic symptoms and vital findings were stable. There was no allergic reaction in her past and family history. After the treatment with intravenous feniramin maleat 45,5 mg and corticosteroid methylprednisolone 60 mg, her pruritic symptoms and hyperemia regressed. The patient was observed in the ER for 4 hours and discharged to control with topical steroid. When she represented after three days her symptoms were significantly reduced.

Conclusion: Allergic contact dermatitis is a kind of delayed type hypersensitivity reaction (Type IV) to exogenous agents.. Acute phase is characterized by erythematous, scaly plaques. Vesiculation and bullae in exposed areas are very characteristic in severe cases. A diagnosis of contact dermatitis requires consideration of patient history, physical examination and patch testing. The most common region for contact dermatitis is hands. At the periorbital region the commonly responsible agent is cosmetics. In the treatment of contact dermatitis topical cream-based steroids should be used⁷. The topical products contains antihistamine do not recommended because of sensitizing feature. There are nearly 3000 allergens cause contact dermatitis. There is no case like ours in the literature; therefore it is needed further researches for determining the etiologic agent. Furthermore these nut seeds used as food as usual, in the young women population cosmetic agents contains these seed extracts and traditional treatments should not be ignored.

Keywords: contact dermatitis, emergency medicine, walnut

P-0292 Other

Hailey-Hailey: A Different Diagnosis

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Objective: Familial benign chronic pemphigus (Hailey-Hailey disease) is an autosomal dominant disorder with recurrent eruption of vesicles and bullae involving predominantly the neck, groin and axillary regions. The Hailey brothers first described in 1939. In this poster we presented a case that rarely seen in emergency medicine.

Case: A 38 years old male patient admitted to our emergency department at with complaints of painfull erosive rash and blisters to his inguinal area. On examination, the lesions were hyper-pigmented with irregular well-demarcated border especially at the genital region. Other sistem examinations was normal. He was a history of multiple sclerosis past two years. Patient was referred to dermatology consultation and diagnosed by hailey hailey disease.

Conclusion: Hailey-Hailey is a genetic skin disease included in the group of autosomal dominant calcium ATP ase disorders. Disease is caused by mutation in gene ATP2C1. Clinical findings usually start in these condition third decade. Lesions are mostly located on axilla, inguinal folds, lateral sides of the neck and perianal regions. Lesions are usually erythematous patches with erosion and maseration. Rarely intact vesicles or vegetative lesions can be observed. Lesions are most commonly complicated by secondary infections. Disease affects life quality by its chronic course, itching and pain caused by the lesions. Treatment usually often by topical steroids. Drugs such as antibiotics, antifungals, corticosteroids, dapsone, methotrexate, thalidomide, etretinate, cyclosporine may be helpfull by treatment. All patients who comes emergency medicine by chronic eruption need to think second time for hailey disease

Keywords: Hailey-Hailey, Emergency medicine, Pemphigus

P-0293 Trauma Emergencies

Axillary Block and Radius-Ulna Fracture Reduction

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Objective: In orthopaedic emergencies, the most frequently seen type of fracture is the forearm fracture. In the reduction procedure of these fractures which do not require surgery, local block procedures can be applied as procedural sedation for pain control in the Emergency Department. The case is here presented of an elderly patient with a forearm radius-ulna shaft fracture to whom reduction was applied with ultrasound-guided axillary block.

Case: A 75-year old female presented at the Emergency Department with complaints of pain and deformed shape of the left forearm following a fall. A fracture of the radius and ulna shaft was determined in the left arm. It was decided to apply axillary block for the reduction procedure and pain control. The axillary block was applied with a 20ml Prilocaine HCl (1%) injection under ultrasound. After achieving sufficient anaesthesia, the fracture was successfully reduced. The patient was referred to the orthopaedic clinic after the procedure.

Conclusion: Pain control in the treatment of forearm fractures and dislocations in the Emergency Department is an important procedure for both the patient and the physician. The medications used in procedural sedation can have significant side-effects, particularly in elderly patients with systemic disorders and who are using various medications. The application of local blocks and particularly axillary blocks in forearm fractures, provide both pain control and prevent complications which may develop associated with procedural sedation. In addition, a shorter time can be spent in the Emergency Department by these patients with the application of local blocks. These applications can be made with the aid of ultrasound easily and safely in the Emergency Department.

Keywords: Axillary Block, Radius-Ulna Fracture Reduction, Emergency Medicine

P-0294 Trauma Emergencies

A Case of Isolated Posterior Malleolus Fracture

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Objective: The ankle is the most commonly injured joint in sport-related injuries. While sprains are the most common reason for ankle injury, fractures can occur frequently. Some sports such as high jump, basketball, football, volleyball, athletics or skiing take place in the high risk factors. Ankle fractures usually include lateral malleolus, medial malleolus, bimalleolar, and trimalleolar fractures. On the other hand, isolated posterior malleolus fracture is a fairly rare injury. Because of the low incidence, isolated posterior malleolus fractures can be a diagnostic challenge. In this case we will focus on detection of the fracture, that may not be so obvious at first sight.

Case: A 20-year-old male military personnel was admitted to emergency trauma section after falling from height (in a hard landing, parachuting) with complaints of pain and swelling in his right ankle. On initial evaluation, the patient's vital signs were stable. On physical examination, there was moderate edema that surrounds the ankle. There was no tenderness at the lateral and medial malleoli. The proximal part of fibula was also evaluated, for Maisonneuve fracture but there was no tenderness. All other system examinations were normal. Ottawa Ankle Rules were negative; however, he was tender to palpation just anterior to the achilles tendon. And so, we ordered a two view (Anteroposterior and lateral views) ankle radiograph series for the suspicion of posterior malleolar fracture. A/P radiograph of the ankle was evaluated as normal but lateral ankle radiograph revealed vertical fracture at the posterior malleolus (Figure 1). An orthopedic surgeon was immediately consulted for further evaluation and treatment of a posterior malleolus fracture. For assessment of severity and extent of posterior malleolar fractures, a Computed Tomography (CT) was ordered, which confirmed a non-displaced isolated posterior malleolar fracture (Figure-2). Immobilization of ankle was made by short-leg posterior splint. And then the patient was admitted to the orthopedic ward.

Conclusion: Isolated posterior malleolus fractures of the ankle are very uncommon and so its diagnosis is more difficult than the other types of ankle fractures. Although the findings of the OAR could not indicate that a fracture was likely, plain radiographs could be obtained due to the injury mechanism and physical examination (significant edema and location of tenderness). If a fracture is suspected at the posterior malleolus, visualization of a fracture may not be evident on the A/P and also lateral view of a radiograph, so a CT scan is needed and of greater value for diagnosis of this fracture.

Keywords: Posterior malleolus fracture, isolated, plain radiography, computed tomography



POSTER BİLDİRİLER

P-0295 Other

The evaluation of emergency levels of patients who presented to the emergency department with 112 emergency ambulance and the treatments during the transportation

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Objective: This research was carried out to evaluate the emergent levels of patients who presented to the emergency department by 112 Emergency Ambulance service, the necessity of using ambulance service, and the 112 Emergency Ambulance crew's first treatment during transportation.

Materials-Methods: This research was carried out prospectively on 3000 cases who arrived at Ankara Training and Research Hospital, Department of Emergency Medicine by ambulance between 01th March- 31th July 2012.

Results: In this research, it was detected that, 26.4% of the cases are age of 65 and over and, 56.7% of the applications are internal complaints. 88.9% of those patients defined themselves as emergent. 55% of them by emergency department doctors and, 57.6% of them by ambulance crew, were defined as being emergent. 78.5% of those patients who were transported by an ambulance, evaluated in the yellow area at emergency department. The medical treatment applied by ambulance crew is intravascular access mostly. The most common etiologies of the transported trauma patients are falls and traffic accidents.

Conclusion: Because of the increasing elderly population and additional chronic diseases, it is foreseen that usage of ambulance services will increase. It is thought that; by education programmes at schools, by the way of media raising awareness of public about basic first medical aid and, practising triages by specialists working at 112 call centers, will contribute to decrease unnecessary ambulance usage.

Keywords: Emergency, Unnecessary Use of Ambulances, 112

P-0296 Trauma Emergencies

Pneumomediastinum

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Objective: Pneumomediastinum is the case that the air localized in the mediastinum due to the perforation of respiratory or digestive system organs. It is divided into spontaneous or traumatic. Spontaneous pneumomediastinum is usually seen in healthy young men. The traumatic pneumomediastinum may be developed due to head, neck, chest traumas and inner mouth injuries. In this paper, a pneumomediastinum case developed after stab wounds was presented.

Case: A 23-year-old male patient who had psychiatric problems and opiate drug usage history was brought to the emergency department with complaint of self-mutilation with penetrating instrument by his relatives. The patient was conscious, orientated, cooperative, his pulse rate was 89/min and blood pressure: 140/80 mmHg, blood glucose: 103 mg/dl, oxygen saturation: 98%. The patient had multiple stab wounds (1 cm skin incision in midclavicular line below the left breast, 1 cm skin incision in upper side the manubrium sternum, 2-3 cm of superficial skin incisions in his both flexor surface of wrists). Although common subcutaneous emphysema, patient had no respiratory distress. Other system examinations were normal. FAST ultrasound was performed, and any free fluid was not detected in pericardial and intra-abdominal regions. Minimal pneumothorax, pneumomediastinum and mediastinal subcutaneous emphysema were detected in Thoracic CT. But there was not any major vascular injury. Patient's echo was assessed as normal. Patient was hospitalised to the intensive care unit of thoracic and cardiovascular surgery department for the purposes of follow-up and treatment. Patient was followed for 2 days. During the follow-up, regression of subcutaneous emphysema, pneumothorax and pneumomediastinum was observed, and he was discharged with recommendations.

Conclusion: Thoracic CT is the most sensitive method for the diagnosis of pneumomediastinum. Air bubbles seen with mediastinal enlargement will confirm the diagnosis. Diagnosis should be fast, and if it is necessary surgical intervention should be implemented quickly. If the patient has severe shortness of breath, 100% oxygen therapy should be given, and antibiotic therapy should be done if complications of mediastinitis has developed. Follow-up of these patients must be at least 24 to 36 hours. Pneumomediastinum usually regress spontaneously within 48 hours.

Keywords: Pneumomediastinum, trauma, mediastinitis

P-0297 Trauma Emergencies

Evaluating the use of cranial computed tomography in minor head trauma cases under two years of age

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Objective: In this study, we investigated in which patients with minor head trauma (MHT) less than two years of age should cranial computed tomography (CT) scan be used. The aim was to determine those parameters which might shed light in the decision-making stages.

Materials-Methods: This study was retrospectively performed using those patients under two years of age who visited the Emergency Department (ED) with MHT, and who received a CT scan between 1 April and 30 September 2013. Age, sex, time of applying to ED, time of trauma, type of trauma, Glasgow Coma Scale (GCS) value at the time of applying to ED (14 or 15), symptoms (crying/unrest, vomiting, innutrition, drowsiness, loss of consciousness) and findings (hyperemia/ecchymosis, abrasion, skin laceration, cephal hematoma, fontanel bulging) were all recorded for the patients included in the study.

Results: In total, 312 patients (32%) who underwent cranial CT scan out of 972 patients meeting isolated MHT criteria were included in the study. 50.6% were male and 49.4% were female, and the average age was 10.4 months. In 8.3% of cases, clinically significant cranial CT findings were detected; however, surgical intervention was not needed for any of them.

Conclusion: In this study, statistically significant relevance between hyperemia/ecchymosis, cephal hematoma and vomiting + drowsiness and positive cranial CT results was detected. (p<0.05) Also, fear of skip an important intracranial pathology causes the unnecessary use of cranial CT, which leads to increases in health expenditures and higher exposure to radiation.

Keywords: Computed tomography, head trauma, pediatric

P-0298 Trauma Emergencies

Prognostic effect of soluble cd40 ligand in traumatic lung contusion

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Objective: Pulmonary contusion is a common type of injury resulting from thoracic trauma and found in 17-70% of patients with multiple trauma. It is known that sCD40 Ligand levels increase in endothelial injury and CD40L expression by the activated thrombocytes increases following vascular trauma. In our study, we aimed to investigate the relationship between traumatic pulmonary contusion and sCD40L

Materials-Methods: This study was conducted at the Emergency Department of Recep Tayyip Erdoğan University Research and Training Hospital between January 2012 to January 2013. All patients who were diagnosed to have traumatic pulmonary contusion were included in the study. Blood samples obtained from these patients were studied by ELISA and sCD40L values were measured, and then compared with the control group. Our study was approved by the ethics committee of Karadeniz Technical University.

Results: Of the 26 patients, 57.7% (n=15) have pulmonary contusion in single hemithorax, whereas, 42.39% (n=11) have pulmonary contusion in both hemithoraces. 26.9% (n=7) of the patients were female and 73.1% (n=19) were male. The mean sCD40L values of the patients and the control group were found to be 4.38±3.71 and 2.10±0.92 (p değeri?), respectively. 7.7% (n=2) of the patients were followed as outpatient whereas 65.4% (n=17) was followed at the wards and 26.9% (n=7) was followed at the intensive care unit. 46.2% (n=12) of the contusions resulted from falls from height, 34.6% (n=9) from passenger injuries in motor vehicle accidents, 11.5% (n=3) from pedestrian accidents, and 7.7% (n=2) from other reasons. 19.2% (n=5) of the patients were complicated by pneumonia and ARDS during follow-up. 15.4% (n=4) of the patients died during follow-up.

Conclusion: sCD40L values were increased in patients with pulmonary contusion. As the mortality rate was higher in patients suffering blunt thoracic trauma with bilateral pulmonary con-



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tusion, increased number of rib fracture, and head trauma, these should be followed-up in intensive care unit.

Keywords: sCD40L, pulmonary contusion, thoracic trauma

P-0299 Trauma Emergencies

Vagina and bladder ruptures due to the penetrating trauma of pen

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Objective: Bladder or vagina injuries usually occur according to blunt or penetrating traumas such as high-velocity gunshots, sharp stab wounds or perforation by bone fragments. Rarely, iatrogenic or spontaneous bladder rupture can be seen. In this paper, a rarely seen case who admitted to the emergency department with abdominal pain and diagnosed as the vagina and bladder ruptures occurred due to penetrating trauma of pen was presented.

Case: A 21 year old single female patient was admitted to our emergency department with complaint of abdominal pain. The patient was conscious, orientated, cooperative, her blood pressure: 110/60 mmHg, pulse rate: 82 / minute, respiratory rate 15 / min and Galaskow coma scale score: 15. Physical examination revealed tenderness in the pelvic region. Five cm in length of linear echogenicity and free fluid was detected in the neighborhood of right lateral bladder by FAST ultrasonography performed in the emergency department. In urinalysis, 1454 leukocytes and 273 erythrocytes were determined. Patient was consulted to obstetrics and urology departments. Linear foreign body with thickness of 8 mm and length of 80 mm was detected in the bladder on pelvic CT. Penetrating foreign body in the bladder (pen) was removed via endoscopic method, and damaged areas were repaired by urology department. The patient was followed up for 1 month with the urinary catheter. During follow-up, urine extravasation was not observed, and patient was discharged with recommendations.

Conclusion: If there is a suprapubic abdominal tenderness, inability to void, bruises over the suprapubic and pelvic region on physical examination of the patients admitted with abdominal pain, bladder injury should be considered. Vaginal and rectal examinations should be done in all trauma patients suspected of bladder injury. Excellent outcomes can be achieved with early clinical suspicion, appropriate and reliable radiologic diagnostic tests such as urinalysis, FAST ultrasonography, contrast enhanced abdominal CT and appropriate medical and surgical treatments.

Keywords: bladder injury, penetrating trauma, abdominal pain

P-0300 Trauma Emergencies

Effect of Zofenopril and comparison with methylprednisolone in experimental spinal cord trauma

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Objective: Spinal cord injuries (SCI) have an increasing incidence and represent an emergency condition with a high risk of mortality and morbidity. The mechanism of the traumatic SCI has been identified as having primary and secondary causes. The usage of high-dose methylprednisolone (MP) to prevent secondary damage in the treatment of emergent conditions is debatable due to its side effects and thus alternative methods of treatment have been evaluated. Zofenopril, is an antioxidant agent which has been shown to have beneficial effects in hypertension and heart failure. The aim of this study we compared the biochemical and histopathological efficacies of zofenopril and MP in rats with traumatic SCI.

Methods: This study was conducted in six groups including three controls (C, L, T) and three treatment (MP, Z, ZMP) with eight rats in each group. In the group MP, 30 mg/kg methylprednisolone (MP) was administered as a bolus intraperitoneally (IP), and a standard treatment in a dose of 5.4 mg/kg was applied for 24 h. In the fifth group (group Z), only 15 mg/kg Zofenopril was administered through gavage. Group ZMP got both MP and Zofenopril. A modified Allen weight-drop model was used to create SCI. The development of paraplegia was observed. At the 24th hours, the rats were sacrificed. The extracted samples were sent for histopathological and biochemical evaluations (Antioxidant: Superoxide dismutase (SOD), Glutathione Peroxidase (GPX) Oxidant: Protein carbonyl (PC), Malondialdehyde (MDA)).

Results: The SOD level of group MP was lower than the other groups. When groups Z and MP were compared to groups T and L for the PC levels, the decrease in the level of PC were found to be statistically significant. We found similar results for the levels of SOD and GPX in groups Z, ZMP and MP in their own. When group T and Z were compared, significant differences were identified in some histopathological parameters such as necrosis, PNL infiltration, histiocyte accumulation in favor of group Z (p<0.01). There were statistically significant differences between groups T and ZMP for almost all parameters in favor of group ZMP (p<0.05).

Conclusion: According to biochemical results, treatment with zofenopril decreased secondary damage in SCI and got similar results with MP and combine treatment. But according to histopathological results, combine treatment was observed as more superior than singly Zofenopril or singly MP.

Keywords: Zofenopril, Spinal Cord Injury, experimental

P-0301 Other

Hijama burns

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Hijama is a five thousand year old tradition. Its dictionary meaning is to 'suck'. It is known to have been performed in Ancient China, Egypt and Mesopotamia. Since the beginning of Islam, it has been used commonly. There are two types of Hijama; with or without blood. The bloodless version is also known as 'bottle closing'. The blood version is typically used with scalpel or razor blade.

A 73 year old male patient applied the emergency department with a complaint of fatigue, cough and back pain. In his physical examination, burns were spotted and crepitant rales were spotted in his lung basals at the auscultation. The patient had been using Hijama for the past 4-5 days..

Keywords: emergency department, Hijama, burn, traditional medicine

P-0302 Other

Spontaneous isolated Staphyloedema

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Staphyloedema is a life-threatening rare case which develops due to infections, trauma, allergies and physical causes. Isolated staphyloedema is known as Quincke edema. Allergy, NSAID and ACE inhibitors, some inhaling agents, plants used for treatment (such as sour melons), infections such as epiglottitis, endoscopic and broncoscopic operations and some surgical operations are the main causes of staphyloedema.

Our case is a 25 year old male, who woke up with swallowing difficulties and applied to the emergency department.

Patients who apply the emergency department with a neck pain and swallowing complaint should be inspected carefully. It should be remembered that staphyloedema is a life-threatening condition.

Keywords: Emergency department, staphyloedema, Quincke edema



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P-0303 Trauma Emergencies

Closed reduction of subtalar dislocation under sedoanalgesia in emergency department

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Objective: Subtalar dislocations are rarely occur as a result of high energy traumas such as falls from high, sports injuries and motor vehicle accidents. Dislocations are named according to the position of the foot with the talus, and in order of frequency it could be medial, lateral, anterior or posterior dislocation. In this article, we presented a rare case of medial subtalar dislocation which was treated with closed reduction under sedoanalgesia in emergency department.

Case: A 17 year old male patient was brought to the emergency department by ambulance due to sprain his left foot during basketball practice. It was learned that his ankle had been twisted during training after jumping into the air and fell on his ankle in an uncontrolled manner. On physical examination, the ankle was in a deformed appearance. There was no cut on the skin, but generalized edema and ecchymosis were present in the dorsal foot. Neurovascular examination was normal. The foot rest out of the talus was dislocated medially on anteroposterior X-ray radiograph. Patient was monitored. Vascular access was opened. Intravenous fluid replacement was started. Closed reduction was performed under sedo-analgesia including midazolam and fentanyl by making traction to the foot and pushing talus in the opposite direction of the deformity. After this, a short leg splint was applied within the neutral position of ankle. Reduction was confirmed in computed tomography, and there was no accompanying osteochondral fractures. Movements of the ankle joint was started after 3 weeks, and the patient was advised to press on his leg in a controlled manner.

Conclusion: Making appropriate reduction of dislocations without any delay in the emergency department under sedoanalgesia could help the patient's pain relief and increase the chance of success in closed reduction. By this way, the need of general anesthesia and open reduction could be reduced, patients could be mobilized in a shorter period.

Keywords: dislocation, closed reduction, sedoanalgesia

P-0304 Trauma Emergencies

Arc Burn

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Objective: Electricity causes electrothermal damage to the body. The damage caused by exposure to the heat of a high current rather than direct contact with the electrical current, is known as an arc burn. The case is presented here of a high voltage arc burn.

Case: A 62-year old male who had been exposed to high voltage (34000 volts) electricity was brought to the Emergency Department. There were 3rd degree burns associated with electric arc burn injuries on 60% of the body; the head and neck, both upper and lower extremities and the left side of the trunk. Peripheral and central venous routes were opened to start fluid therapy for the patient. Normal sinus rhythm was determined on ECG. The patient had respiratory problems so rapid series intubation was applied. The results of the laboratory tests applied to determine any organ damage were normal. FAST-E and radiological imaging were applied for trauma evaluation. The patient was attached to a mechanical ventilator and transferred to the burns unit.

Conclusion: An arc burn, which is caused by a high voltage electric current, is an indirect electricity injury. The heat of the arc may be as high as 2500 degrees and this heat causes very deep thermal damage to the body. There may also be burns from flames when clothes have caught fire. The electrothermal damage from high voltage affects muscles, blood vessels and nerves. In these cases, there is no entrance and exit area of the electricity and rather than end organ damage there are burns on the body caused by the heat. Early intubation must be applied for airway management, especially if there are inhalation burns or burns in the head and neck area. FAST-E must be applied to evaluate trauma and it should be known that there may be spinal and extremity injuries.

Keywords: Arc Burn, electrothermal damage, emergency department

P-0305 Trauma Emergencies

Patient Tells More Than Radiology: An Orbital Foreign Body Case

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Objective: Foreign bodies are important causes of ocular trauma and ocular emergencies. Removal of foreign body can be performed at emergency department setting or at ophthalmology clinic. At all conditions it is important to assess the corneal and global penetration possibility and decide in a timely manner in order to prevent prolonged pain and complications such as infection and ocular necrosis. Our study represents a case of spiral notebook wire stuck into the upper eyelid mucosa.

Case: A-12-year old boy admitted to our emergency department with a complaint of foreign body at right orbital cavity. The patient was in a daze and holding his spiral notebook carefully. However a wire extended between his right eye and his notebook summarized the case. It was learned that a piece of wire went into his right orbital cavity accidentally and stuck into the upper eyelid 15 minutes before admission. He described that the tip of the foreign body was hook-shaped curved. At initial examination, his vital signs were stable. Eye movements were not restricted and any sign of orbital penetration was not observed. His visual acuity and field of vision were also normal. After initial examination, we cut the wire with pliers in order to prevent the foreign body's damage possibility to the eye. Patient consulted to the ophthalmologist within minutes and he primarily ruled out the possibility of corneal abrasion or penetration by slit lamp examination. Next, upper eyelid was everted gently, the tip of foreign body was inspected and it was removed with gently maneuver. At last step influenced eye was closed with medical dressing and patient discharged with prescription of eye drops including antibiotic and NSAID. In 7-day follow up any complication was observed.

Conclusion: Radiologic imaging has pivotal assistance at diagnosis of an orbital foreign body case. A detailed radiologic assessment including plain radiography, CT or MRI scans of eye should give us information about nature and severity of the injury. But patient's description of foreign body and injury nature may give us more accurate information about removal procedure. Similarly in our case patient's description informed us no need to radiologic assessment of foreign body and its position. At the same time, patient's description indicated to ophthalmologist consultation and removal of the foreign body after slit lamp examination of eye.

Keywords: Orbital foreign body, upper eyelid penetration, emergency department

P-0306 Trauma Emergencies

Rare Intracranial Hemorrhage; Hemorrhage in septum pellucidum: case report

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Objective: Almost half of the posttraumatic deaths are head traumas. Of these, ethiological factor of more than 60% are vehicle accidents. Posttraumatic septum pellucidum hemorrhages are one of the uncommon intracranial bleeding causes in the literature.

Case: A 61 year old male patient was brought to emergency service after vehicle accident. Patient got monitored. Blood pressure was 110/70 mmHg, pulse: 105/min, respiratory rate: 14/min, and SpO2 was 98. At his physical examination, there was nothing significant except a 2x3 cm superficial dermabrasion at frontal area. Patient was cooperative, there was nothing suspicious at neurological examination and his GCS was 15, but since the patient had posttraumatic amnesia and wasn't remembering how did the accident happen, patient had a servical and brain tomography scan. Patient with no significant finding on his tomography scans, was followed at emergency service for 6 hours. Patient was discharged with head trauma suggestions since there was no deterioration at his general status and his vital signs were stable. Discharged patient was then brought back to emergency service after 5 hours with syncope complaint. After re-assessment, patient with stable vital signs and GCS score of 15, had a control tomography scan. According to tomography scan, patient was then referred to neurosurgery department with haematoma at septum pellucidum (interhemispheric fissure) which was absent on his first tomography scan. Patient was hospitalised at intensive care unit for close follow-up. After the follow-up period, patient was discharged due to spontaneous regression of the haematoma with suggestions.



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Conclusion: One of present day's most important health care problems, head traumas, hold a very important place amongst trauma cases because of its mortality and morbidity. Traumas are on the first place when we take a look at death causes of 0-40 years people in developed countries. In the literature, trauma patients consist 3-20% of emergency service referrals in our country. When we look at death by trauma, vehicle accidents are in first and occupational accidents are in second place. Although deterioration of the general medical condition is expected in trauma patients with bleeding, it has to be kept in mind that a patient with high GCS score and normal vital signs may have bleeding and traumatic intraventricular bleeding may not only accompany to other haematomas and brain oedema.

Keywords: Intracranial Hemorrhage, Hemorrhage in septum pellucidum, head traumas, haematomas

P-0307 Other

Shock index and lactate as prognostic factors in critically ill patients

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Objective: Critical care is an art of interventions that save the patient's life. Being able to predict the prognosis of critically ill patient on admission to intensive care unit (ICU) is a desirable component of the critical care. In this study, we aimed to evaluate the prognostic value of shock index and lactate levels on admission in critically ill patients.

Materials-Methods: In this study, critically ill patients admitted to the ICU of emergency department of a university hospital, and followed up in this emergency department ICU till the end of their hospitalization between September 2013-March 2014 were enrolled. The data about patients were recorded, including age, gender, pulse rate, temperature, arterial blood pressure, and arterial blood gas results on admission. The shock index of each patient on admission was calculated. In-hospital mortality was considered as primary outcome. The differences between survivors and non-survivors were compared in terms of parameters.

Results: A total of 48 patients were enrolled in the study. The mean age of patients was 71.7 ± 16.7 years and 32 (66.7%) of the patients were male. The patients' mean length of stay in ICU was 6.0 ± 7.2 days and 29 (60.4%) of them died. There was no significant difference between survivors and non-survivors in terms of systolic blood pressure, pulse rate, PO₂, PCO₂, and length of stay in ICU (for all, $p > 0.05$). The mean arterial pH and bicarbonate levels of non-survivors were significantly lower than the levels of survivors (7.25 ± 0.23 vs. 7.42 ± 0.08 , $p = 0.001$; 16.6 ± 5.4 vs. 23.3 ± 4.7 mmol/L, $p < 0.001$; respectively). The mean lactate levels of non-survivors was significantly higher than the levels of survivors (5.49 ± 5.64 vs. 2.08 ± 1.76 mmol/L, $p = 0.006$). The mean shock index of non-survivors was significantly higher than the levels of survivors (1.21 ± 0.54 vs. 0.83 ± 0.28 , $p = 0.005$). There was no correlation between the length of stay in ICU and the other parameters. There was a significant negative correlation between shock index and pH ($r = -0.442$, $p = 0.003$). There was a significant positive correlation between shock index and lactate levels ($r = 0.390$, $p = 0.012$).

Conclusion: Shock index and lactate levels are seemed to be valuable prognostic predictors for all critically ill patients.

Keywords: critical care, prognosis, shock index

P-0308 Trauma Emergencies

Odontoid fracture due to Minor trauma

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Objective: Odontoid fracture is the most widely encountered upper servical vertebra fracture. It usually occurs a result of combined flexion, axial loading or extension and rotational forces. We present a case of odontoid process fracture as a result of falling from the same ground level.

Case: A 78 year old male patient applied to the emergency department with neck pain after falling down on the same level. He claimed to have tripped over while walking and knocked his head. He kept on walking but when he found that his pain did not decrease he decided to seek medical help. In his physical examination there was abrasion on his frontal region. The sistamic and neurological examinations were intact. His servical X-ray was reported as normal. He claimed that his servical pain increased with neck movements. A computed tomography of the servical region was performed and C2 odontoid fracture was revealed. He was consulted to neurosurgery department and admitted. The patient was discharged on the fifth day with servical color and pain killers.

Conclusion: A thorough examination of the servical vertebra should be done in minor trauma patients who complain of neck pain. In case of suspicion even if the servical x-ray is normal, it is mandatory to order a servical tomography for correct diagnosis.

Keywords: Odontoid, fracture, minor trauma, tomography

P-0309 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

The cause of dyspnea: Hiatal hernia

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Objective: Although dyspnea is one of the most common complaints of the patients with hiatal hernia, the diagnosis is often missed or not suspected at all. The current case report presents a patient who was admitted to the emergency room with shortness of breath.

Case: A 70-year-old male patient presented to the emergency room with shortness of breath which already existed before but worsened in the last three weeks. The patient denied cough, sputum or orthopnea. The patient had a past history of coronary artery disease, but he did not have a history of respiratory or gastrointestinal disorders. BP: 150/70 mmHg, PR: 84 bpm, RR: 16/min, T: 36.4°C, sPO₂: 94%. On physical examination, GCS was 15, general condition was good, and there was epigastric tenderness on abdominal examination. The cardiac and respiratory examinations revealed normal findings. Electrocardiography did not show dysrhythmia or acute ischemic changes. The patient was placed on therapy with intravenous (IV) lansoprazole and 4 lt/min oxygen inhalation. Hemogram, biochemical test results, and cardiac enzymes were within normal ranges. Posteroanterior chest x-ray revealed air-fluid level behind the heart shadow (Figure 1). Echocardiography did not show any findings that would explain for the shortness of breath. The patient underwent computerized tomography (CT) of the abdomen with IV contrast injection. CT revealed displacement of the entire stomach into the mediastinum suggesting hiatal hernia (Figure 2). A consultation with a general surgery was performed. The patient was then hospitalized for laparoscopic repair of the hernia.

Conclusion: In patients presenting to the emergency room with shortness of breath, rare causes must also kept in mind and not overlooked after ruling out life-threatening conditions at the initial step.

Keywords: computerized tomography, dyspnea, hiatal hernia

P-0310 Other

Nutritional Situation Assessment of 65 Years Old Patient Who Applicate To Trakya University Medical School Emergency Department

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In this study, we want to purpose that nutritinos and socio-demographic situations who over 65 years old patients come in one of the most important 3rd degree hospital emergency department.

We practice MNA test descriptive and forward-looking on 93 women and 111 men totally 204 patients between 15.03.2014-30.03.2014 who came emergency department.

In these group % 68.61 Of patient was between 65-79 years old; % 31.39 of was patient over 80 years old. After MNA test results patient of % 60.8 in Group 1; % 18.6 in Group 2; % 20.6 in Group 3.

However in Goup1 and 2 there was no important difference between gender ($p = 0.196$, $p = 0.216$); in Group 3 male gender was meaningful more than female ($p = 0.024$). In Group 1 and Group 2 65-79 years old patient group was meaningful more than 80 years ol patient group ($p = 0.02$, $p = 0.017$). In Group 3 there was no difference between in these groups ($p = 0.109$). In this study groups there was meaningful difference between age and weight ($p < 0.001$), there was no diffience for height ($p = 0.722$). In Group 2 avarege of arm circumference and calf circumference



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higher than Group 3 ($p=0.010$, $p=0.016$).

In this study patients who hospitalized in intensive care unit after this treatment in emergency department meaningful more than Group 1 and 2 ($p=0.038$).

Early diagnosis of malnutrition in elderly patient who comes emergency department is important for treatment.

Keywords: Elderly, Nutrition, Mini Nutritional Assessment, Emergency department

P-0311 Trauma Emergencies

Pneumoscrotum due to traumatic pneumothorax

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Objective: Pneumoscrotum is a term used for the definition of the presence of gas within the scrotum, or subcutaneous emphysema of the scrotum. The differential diagnosis of the subcutaneous emphysema is important, because urgent medical or surgical intervention may necessitate. Free subcutaneous or retroperitoneal air enters the scrotum through the dartosling of the scrotal wall. Pneumoscrotum due to traumatic pneumothorax is a rare medical situation and only a few cases are reported in the literature.

Case: A 19-year-old male patient was admitted to our Emergency Department (ED) by ambulance with the complaints of blunt injury of the thorax and abdomen. He was hit by a car while riding a bike on the road. On arrival, he was alert (GCS: 15) but had signs of mild respiratory distress (SpO_2 : 93% on room air, RR: 22/min). He was hemodynamically stable (BP: 98/55 mmHg, HR: 96/min). During the initial assessment, subcutaneous emphysema extending from the ear to the anterior abdominal wall was palpable. Past medical history revealed an abdominal perforation which was placed after meningitis when he was 15. Central vein access was gained, and blood tests (complete blood count, complete blood chemistry, blood type) were obtained. Bed side sonography revealed bilateral pneumothorax. Free intra-abdominal fluid was not observed. Right chest tube was inserted immediately. Computed tomography (CT) showed bilateral pneumothorax, right hemothorax, common lung contusion, laceration of the liver, subcutaneous air over chest and abdominal wall, pneumoscrotum. Left chest tube was inserted. After 4 hours of observation in ED, he suddenly lost his consciousness and became desaturated. Intubation was performed and patient was transferred ICU. He was managed conservatively. At day 7, he was transferred to the thoracic surgery clinic and discharged home after 4 days. There wasn't any intervention applied specifically for the pneumoscrotum.

Conclusion: Isolated pneumoscrotum due to genital injuries is nearly impossible. Therefore, emergency physicians should be suspicious about a life threatening condition which is most likely a pneumothorax or a retroperitoneal perforation. The most important thing is to define the origin of the free air. It is generally enough to treat the underlying pathology in order to manage with the pneumoscrotum.

Keywords: Pneumoscrotum, trauma, pneumothorax

P-0312 Trauma Emergencies

Splenic injury

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Objective: The most common mechanism of blunt abdominal trauma in the U.S. is a motor vehicle crash. The spleen is one of the most commonly injured intra-abdominal organs. A history of trauma to the left-upper quadrant, left flank or left rib cage should increase the suspicion for splenic injury. Splenic injuries usually produce symptoms and signs due to blood loss. The focused assessment with sonography for trauma (FAST) examination is a bedside screening tool in identifying free intraperitoneal or intrathoracic fluid. Computed tomography (CT) scanning is the gold standard for the diagnosis of abdominal injury.

Case: A 30-year-old male patient was admitted to our Emergency Department (ED) ambulance after sustaining a blunt injury of the abdomen. Mechanism of the injury was a hit by car while riding motorcycle. On arrival, he had signs of mild respiratory distress (SpO_2 : 97% on room air, RR: 20/min), and he was hemodynamically stable (BP: 110/70 mmHg, HR: 80/min) and alert (GCS: 15). During the initial assessment, deformity of the left upper arm and left upper quadrant abdominal tenderness was observed. FAST revealed intraperitoneal free fluid around the spleen. Two peripheral vein accesses were gained, and blood tests (complete blood count, complete blood chemistry, blood type) were obtained. The patient received whole body CT scan and X ray. CT showed splenic laceration and free fluid around the spleen (Grade III). X ray showed displaced humeral shaft fracture. A coaptation splint and sling were applied after closed reduction was performed. He was transferred to the general surgery clinic for observational management. But at day 3, splenectomy was performed because of hemodynamic deterioration.

Conclusion: The spleen is the most commonly injured visceral organ in blunt trauma. Abdominal tenderness and peritoneal signs are the most common findings indicative of intra-abdominal injury; however, these are not sensitive or specific for splenic injury. Some patients develop tenderness early with hemoperitoneum; others may remain asymptomatic for many hours or days. Splenic injury can be initially managed with observation, angiographic embolization, or surgery depending upon the hemodynamic status of the patient, grade of splenic injury, and presence of other injuries and medical comorbidities. Hemodynamically stable patients with low-grade (I to III) blunt or penetrating splenic injuries may be initially observed. But if they have any evidence for other intra-abdominal injuries, active contrast extravasation, or a blush on CT, it requires emergent abdominal exploration.

Keywords: Focused assessment with sonography for trauma, Splenic injury, Splenectomy

P-0313 Other

Development of knowledge and skills in cardiopulmonary resuscitation for medical students and research assistants

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Objective: Aimed to assess the level of knowledge and skills of medical students attending medical school from different classes and resident physicians about CPR training before and after training course.

Materials-Methods: Theoretical and practical training and education on basic life support, advanced cardiac life support, airway management, airway obstruction due to foreign body, cervical collar and spine board application were given. Education program during course was didactic and interactive. Pre-test was applied before theoretical education program and post-test was applied after theoretical education. Practical training was applied after theoretical education was applied.

Results: Before CPR course program, average scores of pre-test of participants from class 1, 2, 3, 4, 5 and 6 were 40.5±9.6; 46.1±9.7; 53.8±16.4; 39.9±18.5; 56.6±14.1; 52.5±11.7, respectively. For resident physicians, average score of pre-test was 72.3±11.6. Average scores of post-test for participants from medical students and resident physicians were 58.2±11.4; 62.2±9.2; 79.3±7.5; 73.3±15.6; 94.3±6.2, 80.6±9.1 and 94.2±7.1, respectively.

Conclusion: Training program about CPR improved level knowledge and skill with theoretical and practical education, and CPR should be implemented to faculty curriculum of medical schools for graduate and post-graduate trainees. Standardization and assessment measures of curriculum was adapted to international standard can be suggested.

Keywords: Basic Life Support, Knowledge Level, Advanced Cardiac Life Support

P-0314 Trauma Emergencies

Pathognomonic symptom associated with lightning strike: lichtenberg figure

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Objective: Lightning strikes occur especially during spring and summer months in the afternoons when there is heavy rain. In deaths resulting from lightning strike, there may either be no evidence on the dead person's clothes or body, or there may be burnt or torn places on their clothes and lichtenberg figures specific to lightning strikes on their bodies. In these cases that also have a comorbid of cognitive dysfunction, since there is generally amnesia, having these figures during the physical examination has a valuable place in early diagnosis and starting treatment early.

Case: 32 year old patient, who was found in an unconscious state by his friend, was brought to our hospital. His physical examination revealed that his physical general condition was moderate, his conscious was blurry and he responded to painful stimulus. His glasgow coma score was 14 and he had burnt lesions on his back and right leg. His vital findings were as follows; blood pressure: 100/55 mmHg, pulse: 115 beat/minute, respiratory rate: 16. His laboratory examinations were as follows: ALT: 57, AST: 60, CK: 1952, CKMB: 42, Troponin I: 0.612. The patient was taken to red line, he was monitored and broad lumen vascular access was established. When the patient was undressed for secondary examination, 3 Lichtenberg figures on his back and 1 Lichtenberg figure on the lateral of his right leg were observed; thus, hydration was started. His ECG was taken and bladder catheter was inserted. His ECG showed normal sinus rhythm. After anesthetic consultation, his conscious became clear on the second day of his hospitalization. His anamnesis revealed that suddenly rain had started while he was tending animals with



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his friend and he could not remember what happened afterwards. His general condition was stable and on the third day of his hospitalization, he was discharged with recommendations.

Conclusion: When the geography of our country and the socioeconomic levels and educational levels of our people are taken into consideration, the number of injuries or deaths resulting from lightning strikes may be more than the estimated number. Thus, early diagnosis of injuries resulting from lightning strikes and starting treatment early is important. Since the first anamnesis is not generally taken from the patient, most of the time, there are some delays in making a diagnosis. Thus, in patients whose anamnesis is not fully taken, secondary examination should be certainly made and the cases should be reviewed in detailed physical examination.

Keywords: emergency service, lichtenberg figure, lightning strike

P-0315 Other

Rebound Rib: Cough-induced rib fractures

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Objective: In the emergency department, we encountered rib fracture secondary to trauma frequently consists. However, sometimes due to stress fracture of the rib fractures may occur. The most common causes, physical activity, and cough. According to the causes of stress fractures: muscle fatigue or golfer is defined as a fracture or fracture cough. Stress fractures are fractures most frequently reported cough with lung disease seen in any. Our emergency room, a left chest pain and bruising as well come with complaints of cough and offer the patient rebound rib. Admitted to the ED with complaint of left chest pain and bruising and depends on rebound rib, we offer.

Case: Eighty-five years old male patient to the emergency department two days ago evolving left chest pain after coughing and noticed bruising one day before that came with the complaint. Patient's acceptance blood pressure was 130/90 mmHg, body temperature 37.6 degrees Celsius and oxygen saturation 88%, respectively. Well general condition, clear consciousness, orientation and cooperation was complete. On examination, inspection, irregular region in the left thoracolumbar is limited by widespread ecchymotic area. There was tenderness to palpation in that area. Auscultation detected with other system examinations were normal except for the expiration of the extension. In his history of chronic obstructive pulmonary disease, coronary heart disease and gastritis in patients who did not use an anticoagulant drug. History of pain and severe coughing after any traumatic experience that was learned. In laboratory tests, blood urea nitrogen 26 mg/dL, creatinine 1.65 mg/dL and creatine kinase 245 U/L, except that it was normal. A posteroanterior chest radiograph no pathology was detected. Thereupon, chest computed tomography was taken. In the 11th and 12th ribs, non-displaced fractures were observed. Patients without any complication due to fractures, thoracic surgery were discharged also taking suggestions.

Conclusion: Stress fractures, although without external force, a force trauma with internal consist. Therefore, just as in other trauma cases fractured ribs can be easily consisting. In our case, as in such a case clinically mimicking trauma with a good story if there is any underlying disease is also easily recognizable cough fracture.

Keywords: Rebound rib, rib fractures, stress fracture, emergency medicine

P-0316 Other

Shoulder reduction was going to do, but: Hypertonicity of ketamine

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Objective: Sedoanalgesia many initiatives in the emergency department and is used for manipulation. Therefore, emergency physicians in sedoanalgesia indication and side effect profiles of the drugs used have to know very well. Non-barbiturate derivative ketamine, dissociation providing anesthesia, is an agent which may be administered intravenously or intramuscularly. Short anesthetic is required especially in orthopedic procedures, pediatric patients, and are often preferred for patients with bronchospasm. Also cardiac depressive effect is limited, it is also preferable hypotensive patients. The most common side effects are urgent reaction. These recurring nightmares from mild agitation and may vary up to hollinations. Due to the use of ketamine in the emergency department because of the rarity of cases developing in hypertonicity offer.

Case: Fifty years old male patient, as a result of tripping of feet to the left shoulder pain and limited movement was admitted to the emergency department with a complaint. More like this once before, and that out of his shoulder, he said. Resumes and patients without a family history of any property in the shoulder epaulettes sign in inspection examination, there was tenderness to palpation and passive movement limitation. Captured with anterior shoulder dislocation shoulder radiograph was detected. Any fracture was observed. The patient was planned closed reduction by sedoanalgesia accompanied. After making pulmonary and cardiac monitoring, a total of ninety mcg fentanyl, ninety mg ketamine was made by titrating. After providing sedation and analgesia to experiment with the reduction maneuver slowly the patient's neck, arms and legs contractions started. The reduction process could not be performed because of these contractions. Contractions spontaneously in about fifteen minutes slowly improved. Waking up from a full realization process was attempted again and successful reduction was achieved. The patient after fully waking up were fixed by bandages vello shoulder and control radiography. Successful reduction was confirmed by X-ray. Patients with orthopedic clinic control recommendations were discharged from the emergency department.

Conclusion: Sedoanalgesia as one of the most important application of the emergency department by emergency physicians must be very well known. For this purpose, effect and side effect profiles of agents used should be known well. It also should be prepared for complications. Depending on ketamine hypertonicity is rare and self-terminates. Ketamine practitioners to carry this in mind, be needed.

Keywords: Shoulder reduction, Ketamine, Hypertonicity

P-0317 Trauma Emergencies

Vertebral compression fracture caused by body massage

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Objective: Back pain is frequent in elderly patients and there are many reasons for these pains. In this case we present an unusual case of T6 fracture.

Case: 59 year old male patient admitted to the emergency service with backpain. He stated that the pain was present for a month. He told that he went to Turkish bath one month ago and had a massage by bath's masseur. He had no chronic disease and didn't use any medication. On physical examination, there was tenderness on dorsal spine line and there was no motor weakness. His ECG was normal. On the chest X-ray there was suspicious T6 vertebral corpus fracture so we took non-contrast thorax CT. T6 vertebral body height reduced (compression fracture) was detected on thorax CT. The patient was consulted with neurosurgery department. He was fitted with korset, recommended policlinic control and discharged.

Conclusion: Body massage can be beneficial for musculoskeletal system but hard massage can cause bad results. A case of vertebral peduncle fracture due to body massage had been published by Guo and colleagues in 2012. But in the literature, vertebral body fracture cases due to the same mechanism aren't exist. It is important to keep in mind that serious bone fractures may occur with minor traumas like body massage. Careful physical examination is the key point in such cases.

Keywords: Body massage, minor trauma, vertebral fracture

P-0318 Other

The Epidemiologic Examination Of The Patients Who Applied To Emergency Service For Anxiety Disorder

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Objective: In this study, it was aimed to perform the epidemiologic analysis of the cases who applied to Gaziosmanpaşa Taksim Education and Training Hospital for anxiety disorder.

Materials-Methods: In this retrospective study, the cases were chosen from the patients who applied to our Emergency Service Clinic between 01.11.2013 and 03.31.2014. The ages, genders and the application dates were examined

Results: 197 patients who applied to Emergency Medicine Clinic of Gaziosmanpaşa Taksim Education and Training Hospital were involved in this study. Of these patients, 28.9% (57 patients) were male, while 71.1% (140 patients) were female. The mean age of all of the patients was 36.3. The mean age of male patients was 37.3, while the mean age of female patients was 36.2. The application hours of patients were 08:00-16:00 for 48 patients (24.3%), 16:00-00:00 for 106 patients (53.8%), and 00:00-08:00 for 43 patients (21.9%).

Conclusion: Anxiety disorder is the general reaction against situations affecting the functionality of individuals negatively such as fear and anxiety. As a result, in our study on patients who applied to our service, most of patients applying with anxiety disorder are female. The percentages stated in American National Comorbidity Study database are 30.5% for females and 19.2% for males. Considering the prevalence in the entire world, the proportion of women to men is 2/1. The results of our study show similarities. Also, most of the patients have applied in late hours, and it is in harmony with literature too.

Keywords: emergency medicine, anxiety, Epidemiology



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P-0319 Other

Crowdedness Of Emergency Services And Triage

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Objective: The patients applying to emergency services are examined in green, yellow, and red zones according to their triage characteristics. This study aims to perform numeric analysis of patients who applied to our emergency service, and who were examined in green, yellow and red zones.

Materials-Methods: In this retrospectively performed study, the patients who applied to our emergency service between 01.01.2014 and 03.31.2014 were involved. The number of patients and the departments where they applied were evaluated.

Results: 57,960 patients were involved in this study. Of these patients, 47.8 % (27,725 patients) were examined in green zone, 52.1% (30,201 patients) were examined in yellow zone, and 0.1% (34 patients) was examined in red zone.

Conclusion: The number of patients applying at emergency services, especially ones examined in green zone, is an actual matter of debate, the new regulation in this topic is topical. In our study, it has been observed that green zone applications form the half of total emergency service applications. In fact, most of those patients are polyclinic patients, and this situation causes crowdedness in emergency services. Besides it, although the number of red zone patient was more than it seems, they were labeled as yellow incorrectly in triage. In hospitals where the patient application rate is high, triage prevents polyclinic patients to cut in front of real emergency service patients to some extent.

Keywords: emergency medicine, triage, crowdedness

P-0320 Other

The Features Of Forensic Cases Treated In The Emergency Department Of Ondokuz Mayıs University Medical School Hospital

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Objective: To determine the epidemiological features of forensic cases treated in the Emergency Department of Ondokuz Mayıs University Medical School Hospital

Materials-Methods: Medical documents and forensic reports of the patients, who had presented to the emergency department at Emergency Department of Ondokuz Mayıs University Medical School Hospital between 01.01.2012-1.01.2013 were analyzed retrospectively

Results: Of the 1046 forensic cases, 64 % were male (665) and 36 % were female (381). The distribution of the cases according to the age was as follows; 253 cases (24,2 %) were between 25-34 years old, 240 cases (22,9 %) were between 18-24 years old and 178 cases (17 %) were between 35-44 years old, respectively. The distribution of the forensic cases according to case forms was as follows; 306 (29,3%) of cases suffering from traffic accidents were in the first place, 248 (23,7 %) of cases suffering from poisoning and 202 (19,3 %) of cases suffering from falls were following respectively. Forensic patients most commonly attended the emergency room in August(20,6%) and October(19%), on Tuesday(15,7 %), and between the hours 16:00 and 17:59 (25,9%). 675(64,5 %) of the cases were treated at Emergency Department, 371 (35,5 %) of the cases were hospitalized at associated departments.

Conclusion: Data presented in this article provide preliminary results on the pattern of epidemiological features of forensic cases treated in the emergency department of Ondokuz Mayıs University medical school hospital in Samsun. It is important to determine the forensic cases characteristics of each region to undertake preventive measures and educate the public and health staff

Keywords: Forensic cases, Emergency Department, Accident

P-0321 Other

Evaluation Of Intoxication Cases Admitted to Emergency Department of a Ondokuz Mayıs University Hospital

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Objective: In this study we aim to evaluate the clinical and demographical properties of poisoning cases at the emergency department of the Ondokuz Mayıs University Hospital

Materials-Methods: Human with the diagnosis of poisoning admitted to the emergency department of the Ondokuz Mayıs University Hospital in Samsun, between December 31 2013 and July 1 2013, were evaluated retrospectively. The age, sex, the admission time, the admission duration, the way of intoxication, symptoms, the items which caused intoxication, the aim of taking the item and the hospital stay of the cases were evaluated.

Results: Of the 231 intoxication cases, 61 % were male and 39 % were female. The distribution of the cases according to the age was as follows; 79 cases (34,2 %) were between 18-24 years old, 61 cases (26,4 %) were between 25-34 years old and 38 cases (16,5 %) were between 35-44 years old, respectively. Most frequent reason for intoxication was drugs (40,3%), central nervous system drugs were the most common class of drug used (35,5%). 25,1% of the patients presented with intoxication to the hospital between 24.00 and 03.59. While 43,6% of all the intoxication cases were because of taking the item accidentally, 57,8% of the patients were diagnosed as intoxication via gastrointestinal system. %36,4 of all patients were discharged from emergency department, %53,2 were hospitalized to emergency department, %10,4 were hospitalized to services. It was determined that 19,5% of the poisoning cases occurred at home. The rate of conscious patients was 87,9 %, subconscious patients was 3,5%. The rate of the unconscious when they arrived at the hospital was 5,2 %

Conclusion: Drugs were the most frequent poisoning agents in our region. Data presented in this article provided preliminary results on the pattern of symptomatic poisonings in Samsun. In intoxication managements, the most effective methods is prevention of poisonings.. It is important to determine the poisoning characteristics of each region to undertake preventive measures and educate the public and health staff.

Keywords: Emergency services, Forensic cases, Intoxication

P-0322 Trauma Emergencies

A Very Rare Orthopedic Emergency: Fractures With Dislocation on Shoulder and Hip of the Same Patient

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Objective: Traumatic hip dislocation is an injury occurring as a result of high-energy trauma and can cause long-term morbidity. The motor-vehicle accidents constitute main cause or traumatic hip dislocation in several countries. Although fractures with dislocation in acetabulum related to femoral neck fractures are described, acetabular fracture with dislocation together with perthrocanteric subthrocanteric process is rare. Likewise, the inferior shoulder dislocation (luxatio erecta), which makes 0.5% of all shoulder dislocations is rather rare. Proximal fractures of humerus with shoulder dislocation are important injuries as regards the neurovascular injury risk and high complication rates in long term. Our case was first in the literature, and he had inferior hip dislocation with acetabular and perthrocanteric femoral fracture with inferior shoulder dislocation and proximal fracture of humerus after a traffic accident.

Case: The seventy-two year-old male was brought in the emergency after an accident. Physical examination in emergency revealed pathologic appearance of right hip and left shoulder. There were neurologic deficits in radial, ulnar and median nerves in neurovascular examination of upper left extremity, and distal pulses were patent. The plain x-rays and CTs revealed fracture/dislocation of right hip and fracture/dislocation of left shoulder. He was taken to operation. Open reduction and fixation with proximal femoral screw was performed on right hip, and open reduction was performed on left shoulder followed by osteosynthesis with plate. When distal pulses could not be felt in postoperative day 1 examination, Cardiovascular Surgery (CVS) consultation was requested and emergent Doppler US was performed. Upon finding thrombus in axillary artery, patient was taken to operation by CVS, and embolectomy was performed. The patient was followed-up in postoperative period under treatment with enoxaparin sodium, acetylsalicylic acid 100 mg and pentoxifylline. Patient's neuropraxia is going on postoperative follow-ups; however, distal pulses are patent.

Conclusion: Simultaneous inferior dislocation of shoulder and hip (luxatio erecta) with rather rare respective fractures hasn't been described on the same patient before. Both cases are



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seen after high-energy traumas, they are orthopedic emergency cases with high complication rates, and rate of additional injuries is high. Postoperative complications can be seen despite emergent surgical treatment. Thrombus developed in our case is also related to intimal injury in axillary artery despite emergent surgery. Therefore, these patients must be treated emergently and postoperative follow-up must be performed attentively.

Keywords: Glenohumeral, hip, inferior fracture and dislocation

P-0323 Other

Skin Lesion After Centipede Bite

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Objective: A variety of animal bite and sting cases are generally presented to the emergency service such as spider, snakes, centipede and bee stings and bites. A very small part of these bites and stings of arthropods causes serious injuries in our country. However, the feeling of anxiety and panic of the people is quite disturbing in these injuries. In the summer-time, an increase in these injuries occurs. We have presented a case of the centipede bite and developed skin necrosis near the injured area.

Case: A 20-year-old female patient admitted to the emergency department with symptoms of bruising and pain in the first toe. She had no systemic disease in her past medical history and when she came home after the picnic in day-time; bruising, itching and pain had developed in her first toe. On physical examination, vital signs were stable. Physical examination revealed an ulcerative lesion that was 2-3 mm in size with sharp boundaries and erythema around the medial part of her right first toe. Finger was painful on palpation and sensory loss was present in this region. When the patient questioned about any insect contact, it was learned that she had a contact with the centipede. Blood analysis were normal. The patient was treated symptomatically and was discharged suggesting to admit the dermatology for out-patient follow-up..

Conclusion: Arthropods are important for several reasons in clinical practice. The bites and stings of the arthropods can induce allergic reactions ranging from local irritations to life-threatening events. Many of the side-products of arthropods can trigger allergic reactions in immunologically sensitized persons. In recent years, bites and stings have become even more important in terms of disease transmission and have raised concerns in practice. The most common type of hypersensitivity reaction against the bites, stings, and products of arthropods is papular urticaria. Generally, the diagnosis of arthropod bites and stings are largely based on suspicion and physicians should consider the arthropods as an etiology not only for their habitual areas and also for the areas where the patients had made trips. In conclusion, centipede bites should also be remembered while assessing the ulcerative skin lesions.

Keywords: Centipede Bite, ulcerative skin lesion, ER

P-0324 Trauma Emergencies

Pneumomediastinum And Hand Amputation After Explosion Of A Home-made Bomb: A Case Report

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Objective: Bomb explosions result in multiple injuries and occur generally in populated centers. Victims of bomb explosions may suffer a combination of blast, penetrating, and thermal injuries. When the injuries in explosion victims are compared with gunshot victims, they are professedly complicated as their special nature that combines both an explosion effect and shrapnel-causing penetrating trauma. Explosion injuries to the upper extremity differ from injuries due to other mechanisms because they have specific clinical characteristics. The rate of amputation of the upper extremity has been linked to the load of the explosion. we reported a patient who had multitrauma after an explosion of a home-made bomb.

Case: A 26-year-old man was brought to our emergency department with multitrauma after explosion of a home-made bomb. On physical examination, he had a temperature of 37°C, a heart rate of 104 beats per minute(bpm), a respiratory rate of 16 breaths/min, and a right upper extremity manual blood pressure of 130/80 mmHg in the supine position. He had burns involving the face, trunk, and extremities; a puncture wound (4 cm in length) in the anterior aspect of the left shoulder with some tissue destruction and no active bleeding; and multiple smaller penetrating wounds. His left hand had been amputated. He moved all extremities and had no gross focal neurologic deficits. On admission, he had dyspnoea, and physical examination demonstrated an evident decrease in breath sounds over the bilateral hemithorax. A chest radiograph and tomography demonstrates the presence of a pneumomediastinum and lung contusion. He was admitted to hospital after consulted by orthopedist, neurosurgeon, thoracic surgeon and cardiovascular surgeon. He was observed in the department of thoracic surgery. When he became clinically asymptomatic, he was discharged from the hospital on the 15th day after admission.

Conclusion: Because an explosion of bomb has blastic, penetrating, and thermal features, we must evaluate patients carefully and treat with appropriate methods.

Keywords: bomb, explosion, multitrauma

P-0325 Other

Study of the Proliferative and Apoptotic Effect of Ankaferd in Chondrocyte Cell Culture

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Introduction: Limitation of movement, arthralgia, articular cartilage destruction associated to chronic deformative diseases are important health problems that may decrease the quality of life.

Aim: This study has been performed in order to determine if this agent may be used as an alternative treatment for diseases associated to articular cartilage destruction by studying the potential proliferative and apoptotic effect that may be associated to the use of Ankaferd in chondrocyte and chondrosarcoma cell culture.

Materials-Methods: The cytotoxic effects of increasing doses of Ankaferd on normal and cancer cartilage cells have been determined using MTT cell proliferation test. Cell deaths triggered by Ankaferd have been measured using the changes on caspase-3 enzyme activity.

Observations: The caspase 3 activity of chondrosarcoma cells has been observed to increase 1.4 and 2.7 times for 5 µg/ml and 10 µg/ml Ankaferd respectively. For chondrocyte cells: when 5 µg/ml and 10 µg/ml Ankaferd have been administered, the caspase 3 activity has been observed to increase 1.2 and 2.5 times respectively. No statistically significant difference has been observed for MTT results in control group and chondrocytes and chondrosarcoma cells exposed to 5 µg/ml and 10 µg/ml Ankaferd.

Conclusion: In our study, the reactions of the two cell series with different genetic history used in our study to ankaferd, have been found to be similar for MTT, and Caspase-3 levels within the cell and apoptotic cell staining. When 5 µg/ml ankaferd has been used, proliferation has been observed in both cell series, and it has been observed that all cells died in both series in following dose increases, especially for doses over 10 µg/mL dose. Thus, considering the use of ankaferd for degenerative diseases, safe dose interval shall be considered; when considering the use of ankaferd for cancer treatment, it shall be known that this agent is not selective for cancer cells but that it may affect normal tissue at specific doses.

Keywords: Chondrocyte cell culture, Ankaferd, proliferative and apoptotic effect

P-0326 Trauma Emergencies

Long linear fracture on the head

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Objective: Head trauma is the most common cause of death and disability in the early years of life. It affects people between the ages of 15-30 and affects men 2-4 times more than women. Because of there is a head trauma in every 15 seconds and a death by head trauma in every 12 minutes, emergency doctors are facing with such patients every day. 50% of all injury death is accompanied with head trauma

Case: 22 year old male patient fell from the 2nd floor of the construction and brought to the emergency department by ambulance. The patient was conscious. GCS was 15, there were a 7x15-cm flap form incision at the frontoparietal area. There were tenderness at 6-7-8th ribs and limitation of movement in the left hip. Patient's arterial blood pressure was 120/90 mmHg, pulse rate was 88 beat/min, oxygen saturation was 98%. There were fronto-parietal fracture extending to the orbita upper wall in the brain CT, partial pneumothorax at the right side at the



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torax CT and a fracture in left acetabulum, a fracture in left pubic arm. Patient was hospitalized in the thoracic surgery intensive care unit

Conclusion: Among patients admitted to the emergency department, head trauma takes an important place. Head trauma can be mortal, may leave disability afterward, needs long term treatment and care, statistically is the fourth cause of death in all cases. The intracranial damages determination at head trauma patients depends on the quick determination of risk factors that can cause intracranial damages.

Keywords: scalp, lineer, fraktür

P-0327 Trauma Emergencies

Hand Injury

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Objective: Hand injuries are the often encountered cases at emergency departments. Traumatic hand injuries often happen at work places as work accidents. Besides, this house and traffic accident can cause traumatic hand injuries. 10% of the emergency cases contain hand injuries. In the series of 1000 patients came to emergency department with hand injuries, 42% of cases was lacerations, 27% was contusion, 17% was fracture and the 5% was found to be an infection. 2/3 of the cases were male and 1/3 of the cases were under the age of 18. 1/3 of the injuries were house accident and the most common type of injury is blunt trauma

Case: A 7-years-old male patient brought to the emergency department by ambulance with hand trauma caused by a school accident. While patient was joking with the friends a desk fell on his hand and screws on the bottom steeped in the hand. Patients general condition was good, vital signs were stable. On physical examination, the screw was lodged in to the thumb nail through the desk. The hand x-rays of patient was taken with the portable x-ray device, we could not be able to get a quality image because of the desk. Tetanus vaccines and antibiotic injections were done and orthopedic consultation was requested. The evaluation by the orthopedics was made at the emergency service trauma department and the screw removed from the patient under local anesthesia. There were fracture presented at the distal phalanx of the thumb on control x-ray. After revision of the nail, finger was sutured and finger splint was applied.

Conclusion: Hand injuries that may occur in the form like cutting crush or fragmentation. Injuries can be seen along with many trauma types. Hand injuries can be present as a cut or a crush although fractures, vessel and nerve cuts, loss of tissue or a limb can be occur. The good results in the trauma treatment are depends on a good initial evaluation and accuracy of the treatment. No matter in what way trauma is occurred, primary purpose of the treatment is to provide patient full recovery of the hand functions.

Keywords: hand, injury, trauma

P-0328 Trauma Emergencies

Open Supracondylar humerus fractures

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Objective: Supracondylar humerus fractures are common in children. Supracondylar humerus fractures is second after forearm fractures in childhood in terms of frequency, it constitute 5 to 10% of all pediatric fractures and 50 to 70% Of children elbow fractures. Type 3 open humeral suprakondylar fracture incidence is 1% this case having been presented because of its rarity

Case: 17 years old male patient was brought to emergency department by ambulans as a result of falling. The general condition of patient was moderately good bp: 120/80 mmHg, heart rate: 90 / min GCS was 15. There were type 3 supracondylar humerus compound fracture. Neurovascular examination was normal. There was pain and tenderness in his right wrist. There were type 3 supracondylar humerus open fractures and distal radius fractures on right wrist presented on x-ray films. Patients open fractures washed with 4000 cc sf and full arm was splinted, the patient was operated immediately by orthopedics.

Conclusion: In case of inadequate or unsuccessful treatment of supracondylar humerus fractures in children very serious complication like compartment syndrome, Volkmann's ischemic contracture, vascular-nerve injuries, cubitus varus / valgus deformities, myositis ossificans, limitation of movement may occur as the result so immediate stabilization and early surgical intervention in emergency department is extremely important.

Keywords: open, Supracondylar, humerus, fractures

P-0329 Trauma Emergencies

Clavicle Fracture: Physical Examination or Radiology?

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Objective: In the clinical approach to the clavicle fractures, the physical examination and imaging methods are the basis of the diagnostic approach. However, clavicle fracture can not be diagnosed by plain radiograph sometimes because of different properties of fracture. At this stage, computed tomography may be required in the final diagnosis. In this case report, we aimed to point out insufficient plain radiography in the diagnosis of a clavicle fracture.

Case: Fifty one years old male patient was brought to our hospital by ambulance with complaint of fall on the shoulder followed by alcohol intake. At admission, the patient was conscious, cooperative and oriented. There was not any abnormality in vital signs. Detailed physical examination performed and pain was present on the central 1/3 part of right clavicle. Other systemic examinations were normal. There was not any abnormal finding on x ray. (Figure 1). However, based on clinical experience required in computerized tomography an undifferentiated clavicle fracture was detected in the (Figure 2, 3). After clavicle bandage application, the patient was discharged with recommendations.

Conclusion: Clinical approach is as important as imaging studies in the diagnosis of clavicle fractures.

Keywords: clavicle, fracture, emergency

P-0330 Other

Pulmonary thromboembolism due to paliperidone: report of two cases

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Objective: Venous thromboembolism is serious medical condition, which might be caused by psychotropic medications. Previously, antipsychotic induced venous thromboembolism due to olanzapine, risperidone, clozapine and amisulpride were reported. In this report, we present two cases of paliperidone induced venous thromboembolism.

Case 1: A 28 year old man, engineer, single, was admitted to hospital due to first episode psychotic disorder. Treatment with paliperidone (3mg/day) was started, and the dose was gradually increased to 9mg/day. After 8 weeks of treatment, the patient applied to emergency service with complaints of respiratory pain and hemoptysis. Clinical examination did not show auscultator findings, dyspnea, tachypnea, fever. Spiral computed tomography showed a pulmonary embolism in the left lower lobe. Standard anticoagulant treatment was started, and the patient recovered immediately.

Case 2: A 40 year old man, medical doctor, married, got a son. He had been treated with 8mg/day risperidone for 3 years with a diagnosis of psychotic disorder. 6 months ago his treatment was changed to paliperidone 6 mg/day due to complaints of drowsiness. He was seen in emergency service with fever, irritability and mild dyspnea during the last four days. The patient was referred to the department of chest diseases urgently. Computed Tomographic Pulmonary Angiography (CTPA) revealed left lobar pulmonary artery thrombosis, regional consolidation, and atelectasis with infection in the left lower lobe, and a small pleural effusion. Based on the history and the above results, the diagnosis of pulmonary embolism was established. Standard anticoagulant treatment was started, and the patient recovered.

Conclusion: This case report suggests that clinicians should consider antipsychotic drugs as a potential risk factor of VTE. Controlled studies are needed in order to further elucidate this adverse effect, and to determine the possible predisposing factors and the biological mechanisms involved.

Keywords: Pulmonary thromboembolism, paliperidone, antipsychotic drug, emergency department



POSTER PRESENTATIONS

P-0331 Trauma Emergencies

Amazing Injury

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Objective: hand is the most active upper extremity section and it is our most needed organ in our daily life. for this reason it is also the most frequently injured body part. today hand injuries constitute %20 of the all injury admissions to the emergency department.

Hand injury cases increased in direct proportion to the industrial development, in our study agricultural tools (drills) are presented as a case with hand injury.

Case: Sixty-year-old male patient came to our emergency trauma department with occupational accidents in the right hand (became hooked on mipsper). On physical examination of the patient there were a 10-cm incision in the palm of the right hand, and the deep and superficial flexor digitorum profundus tendon of the third finger severed with a small amount of muscle tissue. there were 2 cm incision at the 2. metacarpophalangeal finger joint inner face and 2 cm incision at the 4. metacarpophalangeal joint of the right hand. ulnar and radial pulses were palpable. hypoaesthesia at the 3. finger. patient's wound was cleaned and dressed. prophylactic antibiotics and tetanus vaccine was done. Preoperative blood tests were required. Analgesia and fluid therapy provided patient's hands two-way hand radiography, two-way radius ulna radiography and chest x ray was taken. after consulted with orthopedics He was hospitalized to orthopedic service for further treatment.

Conclusion: Hand injuries are common and important causes for permanent loss of work abilities. These injuries may involve skin, tendons, nerves, blood vessels and bone tissues. . Injuries most commonly seen in young men and dominant hand. injuries that occurred in industrial area are dirty and infected injuries. in general, hand injuries are not life-threatening but with the significant functional loss, loss of work and the high cost of treatment modalities, may be a lifelong disability result the importance of the hand injuries can be pointed out. in emergency conditions, surgical repair should be done with the specialized team and tools. he results of treatment of these injuries dependence on several factors. Among these factors pre-hospital first aid and delivery time for the emergency surgery center and the time elapsed before the operation, treatment plan before the surgery according to the findings and evaluations, identify damaged structures in surgery and make the appropriate repair order, for the surgeon the necessary technical equipments accessibility and postoperative follow-up and rehabilitation programs can be count.

Keywords: Hand, injury, tendon, amazing

P-0332 Trauma Emergencies

Keep away from children

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Objective: Intraorbital foreign bodies are usually traumatic and generally seen among children. foreign bodies both can be inorganic materials such as metal, glass, plastic and organic materials such as wood. Although the entrance wound is small and superficial, serious injuries in deep parts of orbita, brain parenchyma, vascular structures and cranial nerves may happen. In our case, a whip antenna of the remote control of a toy car was stuck in the left eye of the patient.

Case: A three-year-old male patient was brought to the emergency department by his parents with a whip antenna stuck in to his left eye, which happened while he was playing with a toy car. In physical examination the whip antenna was stuck in to the palpebral conjunctiva of the left inferior eyelid. Prophylactic antibiotic therapy, analgesic therapy and head x ray imaging was done and after preoperative blood tests were analysed in case an urgent operation might be planned. The patient was consulted to the ophthalmology department and hospitalized in ophthalmology service. The foreign body was removed from the patient's eye by an urgent operation.

Conclusion: Penetrating traumas of orbita are commonly seen among children and usually traumatic. Sometimes, the trauma cannot be noticed, and manifested with complications. Brain parenchyma, and the structures in the base of skull can be effected by the injury. It must be diagnosed as soon as possible by imaging techniques. Cerebrospinal fluid leaking fistulas may cause secondary complications such as infections. foreign body must be removed to prevent from intracranial and intraorbital complications. Our case is a child, which is seen in literature in such eye traumas but we did not see any case injured by a whip antenna of a toy car in literature. This case report is presented because of the unusual way of the trauma.

Keywords: orbital, trauma, whip antenna of a toy car

P-0333 Trauma Emergencies

Attention in The Workplace

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Objective: Isolated head traumas are the cases that can lead patient to morbidity mortality. This case was chosen from admissions to our emergency service because this is a rare case of trauma due to accidents. We didn't see any case like this.

Case: A twenty-four year old male patient came to our emergency trauma department with isolated head trauma from the work-related accidents. When patients working in the footwear industry while bending over to pick something off the ground, the pneumatic tacker in shoe making machine threw punches out and it have been hit on the head. In physical examination of the patient staples were found in the left parietooccipital area. Other physical examination findings were normal. patient's wound was cleaned and dressed. prophylactic antibiotics and tetanus vaccine was done. in the analgesia treated patients two-way head x-ray the punches was found to be penetrating the bone. traumatic brain tomography imaging was ordered for SAH. Patients was consulted with brain surgery department. after their treatment The patient was discharged with recommendations.

Conclusion: with the isolated head trauma although it may seem to be a simple case but the penetration to the skull supplying the importance of the case approach. in addition there are not many similar cases in literature to compare. so this case was reported as a rare case in terms of case approach, diagnosis and treatment.

Keywords: Head, stapler, attention

P-0334 Trauma Emergencies

Hard Reduction

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Objective: Hip joint dislocation is a very rare injury which caused from high energy traumas. While examining a patient with such dislocation, a careful assessment must be done to not skip concomitant traumas. Today, motor vehicle injuries cause more than two-thirds of hip dislocations. Hip dislocations consist %2-5 of all joint dislocations and are divided in three main types; anterior, posterior and central. The most common type is the posterior one. Anterior dislocation is very rare and consists %11 of all hip joint dislocations.

Case: 29 year old male patient was brought to the emergency department for a motor vehicle injury which happened while he was driving the vehicle. In physical examination the patient seen medobesity, there was an ecchymosis on the left side of the neck; tenderness at the lower abdominal quadrants, shoulders and right femur head. Necessary x-rays were imaged, the patient was vaccinated for tetanus, antibiotherapy was given. In abdominal ultrasound minimal free fluid seen perihepatic zone and severe free fluid seen in pelvis. X ray images showed fracture at the distal part of the left clavicle and dislocation of right femur head. Computerized tomography was planned but couldn't performed because of the patient's obesity. The patient was consulted to the general surgery department for the free fluid in abdomen and to the orthopedic surgery department for the femur dislocation. Under sedo analgesia, orthopedic surgeon tried to the reduction but they couldn't succeed because of the patient's morbid obesity. Reduction was made in operation room with in the operating conditions and facilities. After reduction the patient was observed at intensive care unit for a day and then transferred to the orthopedic surgery service.

Conclusion: Not only because of its anatomic structure, Hip joint is also very stable with strong muscles and ligaments surrounding. For this reason traumas causing hip joint dislocation are very high-energy traumas and physicians must be careful for any concomitant traumas. In our case patient's obesity made reduction harder. Early diagnosis and expeditious reduction reduces the complications of hip joint dislocations.

Keywords: obesity, hard reduction, hip joint, femur, dislocation

P-0335 Other

Subclavian Steal Syndrome

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Objective: Chest and left arm pain consist an important part of the emergency department applications. Determination of highly mortal situations in patients with these complaints, is very important for emergency department physicians. When any abnormality couldn't found in laboratory tests of patients with chest and left arm pain, subclavian steal syndrome, which is a very rare disease, must be thought as a differential diagnosis. Our case is a patient who applied to the emergency department with chest and left arm pain, and diagnosed as subclavian



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steal syndrome.

Case: 20 year-old female patient applied to the emergency department with chest pain changing with position and breathing. At physical examination blood pressure was taken 110/70 mm hg at right arm. At left arm, blood pressure couldn't taken. also Left radial and brachial pulses were weak. In patient's background there was no history of any disease, CBC, biochemical testes and cardiac markers were analysed and no abnormality was found. ECG was normal. Posteroanterior lung x-ray was imaged. Computerised tomography was made to show if there was dissection of aorta. CT showed stenosis at left subclavian artery, so left subclavian artery was imaged with doppler ultrasound. The patient was consulted to the cardiology and cardiovascular surgery department, both of them suggested polyclinic control so the patient discharged from hospital.

Conclusion: Coronary artery disease is the firstly considered diagnose for patients who applied to the emergency department with left arm and chest pain. It must be remembered that subclavian steal syndrome may seen together with coronary artery disease. In most cases, subclavian artery stenosis happens due to atherosclerosis. Subclavian steal syndrome is a rarely seen disease but diagnosed more often nowadays with the new imaging Technologies. It is seen more likely in male and average sixty ages. Takayasu arteritis consists %90 of the etiologic factors in Patients under thirties. our case is a female and 20 year old, so the first one in literature. In such patients, peripheral pulses and blood pressures of upper extremities must be assessed carefully. Carotid artery and vertebral artery must be imaged with doppler ultrasound. endarterectomy is an effective therapy in selected cases with subclavian steal syndrome. Percutaneous transluminary angiography and stent implantation are the new alternatives to the surgical therapy. Surgical therapy is not recommended for the patients who diagnosed incidentally.

Keywords: subclavian arter, pulse, stenoz

P-0336 Trauma Emergencies

Renal injuries

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Objective: Kidneys are protected by perinephric fat tissue, gerote fascia, muscles, abdominal organs and peritoneum in retroperitoneal cavity. The incidence of renal injury is 4.9 / 100000. Kidney injuries are classified as blunt (80 - 90%) and penetrating (10%) renal injuries. Blunt renal injuries usually occur due to sudden bumps (deceleration) or sudden acceleration according to road traffic accidents, falls from heights, also they may be occur due to sports injuries, industrial accidents, household accidents, assaults by direct impingement of external bodies to the lumbar spines or abdomen. Renal traumas was divided into 5 degrees by American Association for the Surgery of Trauma (Grade 1: renal contusion or unexpanded subcapsular hematoma; Grade 2: <1 cm laceration, or unexpanded perirenal hematoma; Grade 3: > 1 cm cortical laceration without Grade 4-5; Grade 4: parenchymal lacerations which is involving cortico-medullary region and reaching the collecting system, or segmental renal artery or vein injury containing hematoma; Grade 5: shattered kidney, renal pedicle injury or avulsion). In the early stages of kidney injuries, complications such as hemorrhage, infection, perinephric abscess, sepsis, urinary fistula, hypertension, urinary extravasation and urinoma can occur. In this paper, a patient with blunt renal injury was presented for the aim of drawing attention to this issue.

Case: An 29 year old male patient was admitted to the emergency department with complaints of low back and left flank pain after falling on his waist. The patient was conscious, oriented, cooperative and his blood pressure: 120/80 mmHg, pulse rate: 75/ minute, respiratory rate: 24 / minute. The urinary catheter was implanted to the patient, and gross hematuria was observed. The left kidney laceration, left perirenal hematoma, fractures of transverse and spinous processes in L5 vertebra were detected on CT. Patient was stable, his hematocrit value was 37.2%, platelet: 231 x 103/ul, INR: 1.02. Patient was hospitalised to the intensive care unit for follow-up on behalf of Urology.

Conclusion: Patients who has hemodynamic instability due to renal gross hematuria, growing or pulsatile perirenal hematoma or Grade 4-5 renal injuries are absolute indications for surgery. Other patients (98%) can be followed by applying conservative treatment with bed rest, hydration, analgesia and prophylactic antibiotics. Conservative treatment with supportive care in stable patients with renal injury is the preferred initial approach with low nephrectomy rate, low failure rate (5%) and not increased short-and long-term morbidity.

Keywords: renal injury, renal laceration, renal hematoma, surgery

P-0337 Trauma Emergencies

Isolated Calcaneus Fracture: A Rare Result of Foot Injuries

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Objective: Isolated fracture of calcaneus is uncommon injuries of foot. It is reported that the annual prevalence of calcaneal fracture is 11.5 per 100,000 persons and the most common (71.5%) etiology has been a fall from a height. An intra-articular calcaneal fracture due to fall from height was presented in this case.

Case: A 27 year old man admitted to emergency department with pain and swelling on his right ankle due to fall from nearly 1 meter height. He was consciousness and his vital signs were in normal ranges. On his physical examination, there was swelling and pain with moving on his right ankle. X-Ray was performed and showed calcaneus fracture (Figure 1). Additionally, computed tomography of knee was showed and seen intra-articular, fragmented and displaced fracture line of calcaneus (Figure 2). He was taken to emergent surgery by orthopedists.

Conclusion: The intra-articular fracture of calcaneus is rare and can be misdiagnosed. Early determination is important for prevent serious complications as compartment syndrome.

Keywords: calcaneus, fracture, compartment

P-0338 Trauma Emergencies

An Incidental Diagnosis of Chronic Subdural Hematoma

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Objective: Chronic subdural hematoma (CSDH) is a very common condition seen usually in the later stages of life. It tends to occur with a history of mild head injury a few months prior to the onset of symptoms. The clinical features of headache, hemiparesis, signs of increased intracranial pressure, and alterations in consciousness were all reported for CSDH. Symptoms usually occur quite late in the clinical course and it may cause incidental diagnosis of CSDH as our case report.

Case: A 85 year old man admitted to emergency department with heading bump to corner of the kitchen cabinet. There was hematoma on his left eye. He had loss of vision impairment on that eye. Additionally, he said that he had headache for one months but he had no history of trauma before. In his medical history, there was coronary artery disease and hipertension. His Glasgow Coma Score was 15 and neurological examination was normal. In his brain computed tomography, CSDH was determined (Figure 1). Also, there was corneal perforation on left eye. The patient was gone to emergency surgery for corneal perforation. Neurosurgery decided to follow up the patient after surgery.

Conclusion: In elderly patients, CSDH may occur with non-traumatic conditions. The symptoms as headache, vertigo and alterations in consciousness should be evaluated for CSDH in emergency departments.

Keywords: Chronic subdural, hematoma, elderly age

P-0339 Trauma Emergencies

Lomber Disc Herniation Due to Falling Height

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Objective: Lomber disc herniation is a common situation especially in advanced age. There are many interactive factors at play as mechanical, nutritional, genetic and traumatic. The traumatic factors are seen rarely compared with others. It is aimed to present a case with disc herniation without fracture or dislocation due to falling height.

Case: A 20 year old woman admitted to emergency department with falling from stairs complaint. She said that she crushed her back to the corner of the stairs. On her physical examination, there was tenderness on her back through lumbar vertebral plane and also, there was loss of power on her right lower limb (4/5). Lumbar X-Ray and computed tomography were performed and there was no pathological finding. MRI was performed and it was showed that there was loss of signal on L4-5 intervertebral disc and on this line, it was determined diffuse bulging (Figure 1). The patient was transferred to neurosurgery department.

Conclusion: It should be kept to mind that the lumbar disc herniation without fracture or dislocation can be seen after injuries. Although the X-Ray and computed tomography is normal, the patients with neurological deficit should be evaluated with MRI.

Keywords: lumbar disc, herniation, injury



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P-0340 Trauma Emergencies

A Case Of Pneumothorax Due To Injury At The Level Of Thoracic Vertebrae

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Objective: Pneumothorax, pulmonary parenchymal injury in penetrating thoracic trauma is the most common findings. Depending on the visceral and parietal pleura lacerations negative intrapleural pressure which develops due to loss of balance. Observed in respiratory distress is connected to the lung collapse. In this case, at the level of thoracic vertebrae were examined in cases of pneumothorax after injury

Case: A 18 year old male patient, posterior midline T3-T4 vertebra at the level penetrating and cutting instruments injuries as a result of shortness of breath and back pain to emergency department patients admitted Physical examination of the left lung and respiratory sounds could not be taken, other physical examination findings, natural, vital signs were stable. Laboratory tests were within normal limits. Partial pneumothorax on chest X-ray revealed the left lung. The patient in ED tube thoracostomy was performed. General Surgery Department nine days which is followed by chest tube in a patient's chest tube was removed upon loss of the the air outlet was discharged.

Discussion: In our country, the average age of adult thoracic trauma suffered varies between 38 and 43. More common in patients with thoracic trauma is known that men in our country. Penetrating thoracic injuries is rare than blunt thoracic trauma. Thoracic trauma is the leading cause of mortality and morbidity. In our country, the incidence of blunt thoracic trauma of 58.7-75.8%, 24.1-41.3% in the incidence of penetrating thoracic trauma varies. Motor vehicle accidents is the major cause of blunt thoracic trauma, while The major cause of penetrating thoracic trauma, stab injuries. Altunkaya and colleagues in the study performed tube thoracostomy at 100% of penetrating chest trauma while only 62% of blunt chest trauma was performed tube thoracostomy. Urgent tube thoracostomy should be drained of air. Although chest tube the progress of subcutaneous emphysema and failure of lung expansion in the event, surgical indications are provided.

Conclusion: The chest trauma patients admitted to the ED are mostly men and exposed to blunt chest trauma. In penetrating trauma, stab injuries constitute the majority. The way to reduce it to obey the traffic rules, to raise public awareness about the compliance and goes through to keep away society from violent images.

Keywords: chest, trauma, pneumothorax, tube thoracostomy

P-0341 Trauma Emergencies

Bilateral traumatic subdural hematoma

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Objective: Subdural hematoma secondary to mild traumas in elderly is not a rare case. However, bilateral subdural hematoma due to minor or overlooked head traumas which occur different times may also be seen.

Case: A 55 year old female patient admitted to emergency department with complaint of weakness of legs. In the patient's history, she had pancytopenia. The patient's relatives gave the information that she had fallen down and hit her head in bathroom, 3 days ago. The vital signs were stable. In physical examination of the lower extremity, motor strength was 2/5 in the left lower extremity and 4/5 in the left upper extremity. In sensory examination no significant sensory deficit was observed. Other examinations were normal. In the CT scanning of the brain, subacute subdural hematoma, approximately 1cm in length, leading to midline shift on the right side and acute subdural hematoma in the left side were observed. In the complete blood count PLT was 27000. The patient was taken to surgery and was admitted to the neurosurgery department.

Conclusion: Traumatic subdural hematomas are common, but bilateral acute subdural hematomas are not so common in the literature. Bilateral acute subdural hematomas are likely to be seen more frequently in elderly patients, who have pathologies such as thrombocytopenia, platelet dysfunction, and coagulation disorders. Mild head traumas are usually overlooked by the elderly and their relatives, and they usually do not admit to emergency department, due to lack of any significant clinical symptoms. As in our patient, in patients presenting with complaints such as impairment of consciousness, headache, dizziness, nausea, vomiting, limb weakness anamnesis should be conducted carefully and any recent trauma should be questioned as well as acute traumas and the threshold should be kept lower in terms of imaging.

Keywords: Subdural hematoma, bilateral, mild trauma

P-0342 Other

A case of tailgut cyst presenting to the emergency department due to urinary retention

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Tailgut cysts are infrequent tumors in the presacral area. Although most presacral tumors in the literature are single-case, these tumors constitute 1/40,000 of applications to hospital. A 27-year-old male presented to the emergency department with urinary and fecal retention. Abdominal pain and swelling had persisted for 1 week. At physical examination the abdomen was swollen and distended. Rectal examination revealed a mass exerting external pressure on the inferior wall of the anal canal. Computed tomography of the abdomen revealed a cystic lesion in the pelvis, 13x12x9 cm in size, containing thin septa and displacing the bladder to the anterior and the rectum to the right. This case report describes a case of tailgut cyst in the presacral area and creating urination difficulty.

Keywords: Dysuria, pelvic mass, tailgut cyst, abdominal pain

P-0343 Other

Selective immunoglobulin A deficiency: A Case Report

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Objective: Selective immunoglobulin A deficiency (sIgAD) is defined as a serum Ig A level of less than 5 mg/dl. This disease is the most common among all primary immunodeficiency diseases but the pathogenesis is not exactly understood(1).

It firstly described in serum in 1953. The worldwide prevalence of IgAD differs due to different countries 1:143 in the Arabian peninsula, 1:163 in Spain, 1:252 in Nigeria, 1:875 in England and 1:965 in Brazil(2). Most people with IgAD are asymptomatic. However, some people may present with recurrent infections of the respiratory and gastrointestinal tracts, allergic disorders and autoimmune manifestations (2). Herein we report a case with IgAD who has suffer from pruritus, dental caries and chronic sinopulmonary infections.

Case: Twenty-six years old female, admitted to our polyclinic with itching. She had this complaint for 15 years. In the past she had been diagnosed with acute gingivitis, pneumonia, with a seasonal allergic rhinitis and had been prescribed corticosteroids, antihistamines, analgesics and antibiotics. However, her itching proved to be persistent and her other symptoms recurred and she had several dental cavities. The patient's family history, history of allergy, weight loss, occupation and hobbies were questioned. She had no prior illnesses. She had stable vital parameters. Physical examination was unremarkable except several scratch marks throughout her limbs due to itching.

A pulmonary function test was performed. FEV1 was measured as %85 and FEV1/ FVC was measured as %84. The laboratory parameters are presented in table 1. Blood IgA levels was measured 2,5 mg/dl, IgG ve IgM were normal. A preliminary diagnosis of IgA deficiency was made.

Conclusion: in patients with long term pruritus, tooth decay and sinopulmonary infections, in addition to the normal physical examination, oral examination should be performed at regular intervals. In patients with recurrent dental caries, IgA deficiency should be kept in mind and an early diagnose should be made.

Keywords: Itching, Selective immunoglobulin A deficiency, recurrent sinopulmonary infections



POSTER BİLDİRİLER

P-0344 Trauma Emergencies

Isolated Hyoid Bone Fracture Due To Blunt Trauma: A Case Report

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Objective: To present a case with an isolated hyoid bone fracture due to blunt trauma.

Case: A 30 years old, construction worker, male patient was admitted to our emergency department after falling down from 2 m height. He had complaints of pain in the neck and left flank after a blunt trauma. He was alert and Glasgow Coma Scale score was 15/15. The patient's blood pressure was 120/80 mmHg, his heart rate was 70 bpm, his temperature was 36,8°C, his respiratory rate was 20 and his room air saturation was 96%. He had a tenderness and crepitation at the anterior of neck in his physical examination. Complete blood count, electrolytes were normal at admission. After physical examination, servical computed tomography (CT) was performed. Servical CT showed an anterior fracture in hyoid bone. The patient was consulted to ear-nose and throat specialist. He was followed-up about 24 hours in emergency observation unit. The patient was discharged with recommendation of outpatient control.

Conclusion: Diagnosis of hyoid bone fracture is difficult and usually can be made only with a strong degree of suspicion. Emergency physician should be aware of the possibility of hyoid fractures in blunt traumas to neck.

Keywords: hyoid bone, trauma, emergency

P-0345 Trauma Emergencies

Retrospective Analysis of Pregnant Trauma Patients Admitted to Emergency Department

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Objective: The pregnant trauma patient presents a unique challenge for emergency clinician because care must be provided for two patients (the mother and the fetus). Anatomic and physiologic changes in pregnancy can cause a difficulty in diagnosis of trauma-related problems. We investigated the pregnant trauma patients admitted to our emergency department retrospectively.

Materials-Methods: A retrospective cohort study was conducted of pregnant trauma patients admitted to Emergency department (ED) of Ondokuz Mayıs University Faculty Hospital between dates of 1/1/2012-1/1/2013. Patient data abstracted included mechanism of injury, physiologic parameters on admission, Revised Trauma Score (RTS), gestational age, diagnostic and surgical procedures performed, complications, and maternal and fetal mortality.

Results: Twenty-eight patients between 17-37 year-old are involved in this study and mean age of all patients was 26,2±5,8 years. Only one patient (%3,5) was in the first trimester, 16 patients (%57,1) were in the second trimester and 11 patients (%39,4) were in the third trimester. All the patients were nullipara. All of them presented to ED due to blunt trauma (motor-vehicle accident, domestic violence etc). The most common complaints were abdominal pain (%10,7) and vaginal bleeding (%7,2) respectively. Transfusion was required in five patients (%12,8). In only one patient (%3,5), cardiocardiography was abnormal. Ten patients (%35,7) was follow-up about 8 hours in ED. Ten patients (%35,7) was hospitalized in only one day in ED observation unit. Eight patients (%28,6) were hospitalized about one more day (2-30 days). There was no maternal mortality and only one fetal mortality (%3,5) was seen in this study. Specific complications related to pregnancy after trauma were placental bleeding (n=1; %3,5), placental decollement(n=2; %7), preterm deliery (n=2; %7) in this study population.

Conclusion: The assessment and resuscitation of the injured pregnant patient must take into account the specific needs of both the mother and the foetus. Management of pregnant trauma patients with severe injuries often requires a multidisciplinary approach. A prospective study is required to determine the effects of trauma during pregnancy because this retrospective study was a single-institution experience and may reflect local patient characteristics.

Keywords: Pregnancy, Trauma, Emergency

P-0346 Trauma Emergencies

Retrospective Analysis of Legal Cases in Geriatric Patient-Group Admitted to Emergency Department

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Objective: The proportion of people over 60 years of age is growing faster than any other age group, as a result of longer life expectancy and declining birth rates. As a result, more elderly individuals are presenting to emergency departments. The aim of this study is to analyze the legal cases of geriatric population admitted to our emergency department (ED).

Materials-Methods: A retrospective cohort study was conducted of geriatric patients (>65) admitted to ED of Ondokuz Mayıs University Faculty Hospital between dates of 1/7/2012-1/1/2013. Patient data included demographic characteristics, mechanism of incident, time of incident, scene of accident, Glasgow Coma Scale Score (GCS) on admission, complications and mortality. Data of all patients were obtained from legal case forms filled by clinicians.

Results: Fifty-two patients were included to this study. The range of age was 65-86 years (average age 74,63±5,93). Thirty-four patients were male. In 22 patients, the first admission was in our ED and 30 patients were referred to our ED from another public hospital. Types of accident included as the following: carbon monoxide poisoning (n=1), motor vehicle accident (n=9), pedestrian-motor vehicle collision (n=4), falls (n=30), penetrating stab wounds (n=5), trauma with blunt object (n=3). The time of incident was between 18.00-23.59 in 5 cases, 24.00-05.59 in 4 cases, 06.00-11.59 in 4 cases and 12.00-17.59 in 19 cases. The scenes of accident were in home of 20 patients, street of 10 patients, bus of 1 patient, nursing home of 1, garden of 3 patients. Glasgow Coma Scale Score on admission was 13/15 in 2 patients and 15/15 in 50 patients. Forty-nine patients were cooperated but 3 of them had no cooperation. Four patients had head trauma (isolated eye trauma [n=1], maxillofacial trauma [n=1], isolated intracranial hemorrhage [n=1] and intracranial hemorrhage and maxillofacial trauma [n=1]). Four patients had thoracic trauma (rib fracture [n=3] and rib fracture and hemothorax [n=1]). Twelve patients had fractures of extremities (n=12). One patient had abdominal trauma (spleen laceration). Five patients had lumbal vertebrae fracture. Sixteen patients had lacerations (head-neck [n=13], extremities [n=3]). Thirty patients were hospitalized and 19 patients were discharged from ED after treatment. Only one patient was died at ED.

Conclusion: Geriatric trauma patients have greater morbidity and mortality for virtually all traumatic injuries and mechanisms. This retrospective study was a single-institution experience and may reflect local patient characteristics. This situation shows a need to a prospective study.

Keywords: Geriatric, Trauma, Emergency

P-0347 Trauma Emergencies

Enucleation of the eye due to industrial accident

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Eye traumas result in serious social and economic losses. Although the eyeball is supported by fat and connective tissue and well protected anatomically and physiologically in the socket, injuries are still common. This case report discusses a rare case of avulsion of the eye associated with an occupational accident. A 23-year-old male patient was brought to the emergency department after falling from a height. Left bulbous oculi and the bony structure comprising the orbit, including the surrounding soft tissue was avulsed and the left globe was brought to the emergency department in a plastic bag by relatives. Eye traumas in manual laborers generally occur due to preventable causes. Increasing the precautions on the subject or workplace safety, activities aimed at increasing employees' attention in the workplace and the use of protective equipment such as goggles can reduce the number of accidents.

Keywords: Eye traumas, enucleation, workplace safety

P-0348 Trauma Emergencies

Head liner in a head

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Objective: Home and recreation-related injuries affect people of all ages, from infants to older adults, and account for about a third of all injury-related emergency department visits (1) especially pediatric household injuries are one of the most worrisome concerns in houses with children, when sharp objects and corners of the furnitures are the deal. Specifically head injury in children accounts for a large number of emergency department visits and hospital admissions each year and remains a major cause of death and disability in children over 1 year of age. Falls are the most common type of injury, followed by motor-vehicle-related accidents. (2) Penetrating head injuries constitute only a small part of the total number of traumatic head injuries but belong to the class of most severe traumatic brain injuries. In these cases, communication arises between the intracranial cavity and surrounding environment. Gunshot head wounds are the most frequent and are encountered with increasing frequency. Bihemispheric is the most common injury pattern in these cases. (3) Less frequent are injuries from knife, nails, pencils, chopsticks and scissors (4,5) In our case, we present a 3 years old male children whose fronto-temporal segment of cranium was surprisingly penetrated with a pencil (photo 1)



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Case: A 3 years old male children admitted to our ER with a pencil which penetrated to his temporal part of his head (photo 2). Patient's AVPU scale was 'alert', there were no active bleeding through the lesion and the vitals were stable (Table 1) Patient was administered intravenously of 1,5 mg/kg (25 mg) for sedation, 18 mg/kg of phosphophenytoin for seizure prophylaxis and 1 gr of ampicide for antibiotherapy. Then the patient sent for cranial imaging with CT scan. After CT scan, as the lesion was seen through the imaging(photo 3), patient was consulted with neurosurgery department and operated.

Conclusion: In conclusion, injuries at home and at play are not accidents. They can be prevented. A wide variety of damage can be seen in penetrating head injuries and our aim is to prevent these injuries and possible permanent sequelae and to ensure that all people have safe and healthy homes and places to play.

Keywords: Head injury, penetrating trauma, trauma

P-0349 Trauma Emergencies

Carotid Cavernous Fistula After Traumatic Brain Injury: In Patients With Basilar Artery Aneurysm

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Introduction: Carotico-cavernous fistula (CCF) is an abnormal communication between the venous cavernous sinus and the carotid artery. It may occur spontaneously but is usually caused by a significant head trauma. Timing of presentation after the injury can vary from one day to 2 years according to the literature. We present a case of direct CCF after head trauma in a patient with basilar artery aneurysm.

Case: A 72 year-old female patient presented to Pamukkale University Department of Emergency Medicine with cephalgia, oedema and ecchymosis around her left eye. Her vital signs were in normal range of values. Physical examination revealed left periorbital oedema and ecchymosis, orbital pulsatile exophthalmos, chemosis, enlarged episcleral veins, optic disc obliteration, orbital movement was restricted and there was bruit on orbital auscultation. On visual acuity test; right eye 0,5 and left eye can only see pen light. We learned that the patient had a head trauma four days ago and there was no other finding except a minor laceration of the scalp and a hematoma on her physical examination that time. There was also no acute pathology on the patient's laboratory tests and CT scan. Eye examination findings emerged 48 hours after the trauma.

Patient's fluctuant clinical and physical examination findings were assessed and CCF was suspected. The patient was diagnosed as carotico-cavernous fistula after CT angiography.

Cerebral angiography confirmed the presence of a high flow fistulous connection between the internal carotid artery and the cavernous sinus by demonstrating rapid filling of the cavernous sinus following internal carotid arterial injection. Our patient's high-flow CCF is closed with appropriate endovascular embolization treatment. A month later vision examination was repeated; right eye 0,5 and left eye with a total vision loss.

Conclusion: Direct CCF which is encountered rarely in daily emergency service practice, should be kept in mind in cases with rubor at one eye, tinnitus, proptosis, orbital bruit, diplopia, vision loss, as well as head trauma. CCF is a disease which is hard to be diagnosed and can be ameliorated with early diagnosis and therapy

Keywords: carotico-cavernous fistula, trauma, orbital bruit and pulsation, emergency service

P-0350 Trauma Emergencies

Pediatric suicide:would you do for your love?

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Objective: Suicid is one of the most important causes of mortality incidence in adolescents. The incidence of suicide among adolescents is increasing at a significant rate. In Turkey, 20% of all suicide attempts are seen among young high school students. In all psychiatric disorders major depressive disorder (MDD) are closely related to suicide and considered as a pioneer of suicide attempts.

Case: 12 years old male patient after been told by his girlfriend in the play ground that he should hang himself if he loves her, he hanged himself with the rope tied to the goalposts on the playground in front of his girlfriend. Patient was taken to the epicenter with Poor general condition and loss of consciousness. After 30 minutes of cardiopulmonary resuscitation (CPR) patients spontaneous circulation returned and he was brought to our emergency department. At the Arrival his general condition was bad, GCS 3, intubated, there were common rales at bilateral breath sounds. With the radiographic imaging patient was diagnosed with acute respiratory distress syndrome and he was hospitalized in the intensive care unit and connected to a mechanical ventilator.

Conclusion: The increase of suicide attempts in children and adolescents, makes it important to identify the risk factors. There are studies reporting risk factors of Suicide attempt in adolescents like family problems, school problems, such as separation of parents. In our case beyond pediatric age group suicide attempts this suicide enter to the literature as a love suicide case.

Keywords: suicide, death, hang

P-0351 Other

Drug Eruption

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Objective: As a result of the increasing use of drug adverse drug reactions has become a major medical problem. Hypersensitivity reactions to a drug or any biological agents can be defined as a revers immunological reactions to drug itself or its metabolites. Although reactions may occur on any organ, the skin reactions are more noteworthy because of its frequency and easy noticeability

Case: 85 year old female patient came to emergency department with rash all over her body for 5 days. Patients treated with antihistaminic at the external center. Patient has no allergic history and she has been taking NSAID before the rash. At the first assessment patient's general condition was good, conscious, blood pressure: 130/80 mmHg, heart rate: 78/min. There were desquamous rashes all over her body. There was no mucosal involvement. Patient was consulted with dermatology, because of the remission of the rashes patient was discharged with clinic control advice. In the patient's subsequent outpatient follow-up the rashes were all regressed.

Conclusion: Drug reactions is an important and common complication in medical treatments. 6%-30% of normal population may develop drug reaction and 1-8% may develop cutaneous drug reaction. Cutaneous drug reaction constitutes 30% of all the drug reactions. Cutaneous drug reactions are seen more frequently in women than in men, children then adults. Drug eruptions like urticaria and maculopapular lesions appear in 30 min to 3 weeks. Others like Steven Johnson's syndrome appear in a time line of few hours to few weeks. As a result, patients with a history of drug allergy should be properly informed about the drugs should be avoided, combined drug use should be avoided as much as possible in the elderly population in which secondary disease rate is rising.

Keywords: drug eruption, urticaria, anaphylaxis

P-0352 Trauma Emergencies

Management of An Extensive Flame Burn

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Objective: Burn injuries represent a significant public health concern in developed and developing countries, due to the increased length of stay in both intensive care units and general wards. A large percentage of burns occur accidentally. The management of burns remains a challenge in developing countries. Burn injuries require a multidisciplinary approach. Prevention is the vital factor that will have an impact on decreasing the morbidity and mortality associated with burns. Emergency Department has an important role in the treatment of burns.

Case: A 24-year-old man was brought to the emergency department by the 112 emergency medical team with extensive flame burn. On the day of admission, he had used intravenous heroin. He had a history of heroin use. He was exposed to flame burns caused by spontaneous combustion of house before being brought to the emergency room. A part of his body was charred through the skin. The burned surface represented 86% of the body surface (figure 1). The patient was aware, but because of the pain response was agitated state. He was monitored closely. Shortly after becoming hemodynamically unstable the patient had low blood pressure and sinus tachycardia. He was administered analgesia and intubated with narcotics and sedatives. A central venous line was inserted and administered IV fluids with the Parkland formula. Chest and limbs escharotomy were performed in the mean time. Nasogastric tube and urinary drainage catheter inserted. Arterial blood gas analysis, carboxyhemoglobin level and routine laboratory tests were obtained. Judicial report was prepared. The patient was transferred to the burn



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center treatment.

Conclusion: Burn wounds and injuries are often devastating. They can have severe long-term consequences for the victims and they continue to be a major problem affecting communities worldwide. The majority outpatients. The incidence of inpatient admissions has decreased over time owing to improvements in outpatient care both in the Emergency Department and in the Burn Unit.

Keywords: burn, flame, management

P-0353 Trauma Emergencies

Lucky case of maxillofacial firearm injury

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Objective: head and neck are the body parts which contains many vital and important anatomical structures. head and neck injuries constitutes 30% of the all fire arm injuries. statistics show that this kind of injuries are more common in man and black race and it has a high death rate among young people.

Case: 46 year old male patient was brought to the emergency department. at first assesment patients general condition was bad, he was unconscious and there were some serious maxillofacial trauma. his ventilation was not affective so he was intubated through rapid intubation protocole. after intubation a wound exploration was made to rule out any major vessel injury. then patient was transferred to the reanimation intense care unit. he was operated by plastic surgery and discharged from hospital with a very good condition.

Conclusion: The large high-flow blood vessels, larynx, trachea and initial section of the spinal cord which have vital role in regulating many vital functions of the body are under the threat against many traumatic factors. for this reason compared to the other body parts in head and neck fire arm injury more life-threatening situation arises. In such cases, and the degree of severity of injury occurring during the impact depends on the ballistic properties of the bullet. In our case, it was described as lucky. major vascular and neuronal injury has not occurred on our patient. he had just some mandible and soft tissue injuries. in the emergency department this case was presented as an example of the approach in head and neck trauma.

Keywords: Lucky case, maxillofacial firearm injury, firearm

P-0354 Trauma Emergencies

Farm injury: bilateral traumatic lower extremity amputation

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Objective: Extremity amputations are constituted as human's severe health problems due to the wars, natural disasters and social rules of law throughout human history. The etiology of amputations, are examined under three main headings: vascular (arterial occlusive diseases), systemic (diabetes mellitus) and as traumatic. Some of them may be mortal. Lower extremity amputations constitute %80-85 of all amputation cases.

Case: A 54 years of male patient applied to the emergency department with a farm machine injury. He was using a digging machine in his own garden. At first assesment in emergency department his general condition was bad, he was intubated, heart rate: 152/bpm, blood pressure: 80/60 mmHg, and seemed pale. At Left lower extremity, skin integrity was impaired from hip to the distal part of the foot, with open bone fractures. Left leg was deformed and turned around its own vertical axis. There was no active bleeding. At right lower extremity skin integrity was impaired from knee to the foot, with open bone fractures. There was no active bleeding, popliteal, posterior tibial and dorsal pedal pulses couldn't be taken with manuel doppler. Left lower extremity femoral pulse could be taken triphasic. At emergency department rapid fluid resuscitation and blood transfusion was made. While the patient was getting prepared for urgent operation, cardiac arrest happened. Patient did not response to the cardiopulmonary resuscitation.

Conclusion: Rising number and variety of farm machines, brings about farmyard injuries. Job security is a sistematic study to prevent employees from harmful conditions and dangerous situations which can be caused by working conditions. Extremity traumas are very serious medical conditions which may be mortal, patients with extremity trauma should be assessed carefully and necessary precautions must be taken.

Keywords: amputation, traumatic, soft tissue traumas, farm injury, lower extremity

P-0355 Trauma Emergencies

Which Imaging Study Would Be Appropriate for Rib Fractures?

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Objective: Rib fractures are the most common bony injuries in chest trauma and are diagnosed in approximately 50% of patients admitted to the hospital. Rib fractures are painful injuries and closely associated with mortality and morbidity.

Up to 50% of rib fractures (especially those involving the anterior and lateral portions of the first five ribs) are not be apparent on conventional radiography, particularly in the first few days after injury. AP supine chest radiographs often fail to demonstrate rib detail. With improvements in the resolution of CT scanners, the thoracic spine can be examined for fractures by using chest CT images. CT scans obtained for trauma evaluation should be viewed using a bone window. CT scans can be reformatted into 2-mm-thick scan sections with a bone technique, which will demonstrate nearly all rib fractures.

Case: A 28-year-old man presented in our ED with an alleged history of fall from an approximately 4 meters onto a wooden roof, landing his left shoulder and back first. He was hemodynamically stable (Pulse 79 beats/min, blood pressure 18/72 mm Hg, respiratory rate 17 breaths/min and oxygen saturation 98 percent), awake and alert. He was complaining of chest pain mainly located over first rib and left clavicle. On examination, the patient had left first rib and left clavicle tenderness without dyspnea. A complete blood count was normal. Focused abdominal sonography of trauma (FAST) was performed, which showed no intraabdominal bleeding. Chest x-ray revealed fracture of left clavicle without any rib fractures (figure 1). Thoracic CT was performed because of confirming high-energy trauma. Thoracic CT cuts confirmed fracture of clavicle, minimal pulmonary contusion, posterior fractures of ribs 1th and 2th ribs with no evidence hemothorax and pneumothorax (figure 2). The patient admitted to Thoracic Surgery service.

Conclusion: Rib fractures can be markers of potential internal injury; fractures of the first three ribs indicate high-energy trauma, and lower rib fractures raise suspicion of a possible intra-abdominal injury. Chest radiographs frequently underestimate the severity and extent of chest trauma and may fail to detect the injury, and up to 50% of blunt chest trauma. With improvements in the resolution of CT scanners, the thoracic spine can be examined for fractures by using chest CT images

Keywords: appropriate, fractures, rib

P-0356 Trauma Emergencies

A workplace accident: Subtotal digit amputation

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Occupational injuries at the workplace are important because they necessitate emergency healthcare and have legal consequences (1). Each year, 270 million OI occur around the world, causing 1.1 million deaths (2). Avoidable OI greatly impact productivity and the economy, in addition to causing great suffering (3). In Turkey, an average of 70,000 to 80,000 workers per year visit health facilities due to OIs (4). Most of these injuries result in presentation to Emergency Departments (ED) (2). More than 9,000 workers are treated in EDs each day, and approximately 200 of these workers are hospitalised. In 2006, workers' compensation costs for employers totalled \$88 billion in the USA (5). A woodworker has too many injuries most of them are serious. We present a case report of patient who developed subtotal digit amputation due to injury of woodworking machine.

Case: A 54-year-old man were admitted to the emergency department with subtotal digit amputation by woodworking machine. He has been working for many years with woodworking machine. Bu it was his first such a serious workplace accident. He has been sleepless and tired because of family circumstances for a few days. his hand caught at the wood working machine after loosing his attention for a moment. It took more than 30 minutes that she was taken to hospital with severe injuries to two fingers. His 3th and 4th mid phalanx of right hand were fractured. Furthermore, tendon of extensor digitorum dorsal, tendon of extensor indices dorsal and interosseus muscles of right hand were lacerated. The patient admitted to emergency surgery service.

Conclusion: An occupational injury is any physical injury condition sustained on a worker in connection with the performance of his or her work in the industry. Employed people in industries spend at least one third of a day at work which have a strong effect on their health and safety due to work and work-related injuries. These occupational injuries pose a major public health and developmental problems which result in a serious health, social, and economic consequences on workers and their employers.

For the industrial workers who are exposed to injury of working machine as part of their work practice, precautions should be taken to eliminate or reduce exposure as much as possible. And also local governments enforce health and safety law in workplaces allocated to them.

Keywords: accident, amputation, workplace



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P-0357 Trauma Emergencies

Characteristics of Patients with Minor Head Traumas Referring to Emergency Ward and Analysis of Brain Tomography Indications

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Objective: Head traumas are healthcare problems which can be seen at all ages and causing significant economic losses. Despite severe head traumas cause higher mortality and morbidity, minor traumas have a larger percentage of referral. From patients referring to emergency services with mild head traumas, it is the physician's duty to identify intracranial pathologies that can be life-threatening or cause high mortality results. In our study, we aimed to examine the abnormal BCT prevalence at patients diagnosed as minor head trauma and tried to identify the clinical variables that can introduce the need for BCT. Moreover, we tried to contribute to our country's epidemiological data about minor head traumas and investigated the parameters that increase these patient's length of stay.

Materials-Methods: We retrospectively reviewed patients that referred to Emergency Service and had a brain CT (BCT) scan. We recorded the data about patient characteristics (age, gender), mechanism of trauma, amnesia, loss of consciousness, headaches, vomiting, otorrhagia, alcohol usage, usage of anticoagulant drugs, coagulopathies and neurosurgical history, GCS, vertigo, findings at neurological examination like orientation disorder and nystagmus, findings of head examination, additional system trauma, skull x-rays and results, BCT results, length of stay, consultations to neurosurgery, results of consultations, length of follow-ups, hospitalisation-discharges.

Results: Of 703 patients included to study, 428 was male and 275 was female. It is designated that mild head traumas were usually seen at children and adolescent-adult ages and most common causes were landfalls and collisions. The abnormal BCT prevalence was 10.7% and surgical intervention rate was 0.9% at patients with minor head trauma. Of the clinical variables there was significant relationship between abnormal BCT scans and causes of trauma, headache, vomiting, GCS, otorrhagia, dizziness, nystagmus and orientation disorder. Causes that increased the length of stay were loss of consciousness, PTA, alcohol, usage of anticoagulant drugs, coagulopathy history and orientation disorder.

Conclusion: From patients that referred to hospital with minor head traumas, patients with GCS score of 15, having no focal neurological deficit, without penetrating head injury or gunshot wound history, younger than 65, that don't have amnesia, headache, dizziness after trauma, having no orientation disorder, vomiting, otorrhagia and having no nystagmus at neurological examination are in the lowest risk group. For these patients, proper approach can be giving the patient an outpatient appointment after keeping the patient under observation for a while and informing the patient and his/her relative about the conditions that they have to be aware of.

Keywords: Mild head trauma, Computerised Tomography, Glasgow Coma Scale

P-0358 Other

Abdominal ultrasonography performed in emergency department

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Objective: Large portion of the emergency department patients presented with abdominal pain. Nonspecific abdominal pain is diagnosed in 35% of patients with abdominal pain. Whether abdominal pain is acute or chronic, it leads us to a wide range of diagnosis. To diagnose correctly, we need a good physical examination, patient history, laboratory tests. As well as we need a easily accessible, inexpensive diagnostic tool which can also be use in pregnant women and children which exposure to radiation is undesirable, can be used in emergency acute abdomen. For these reasons, ultrasonography is very important for the diagnosis guiding in abdominal pain.

Materials-Methods: In this study, patients admitted with complaints of abdominal pain to a tertiary care university hospital between the date of January 1-April 1, 2014 were included. Patients' gender, age, final diagnosis, ultrasonography findings were investigated and recorded to data charts. Data were expressed as n(%) and mean $\pm$ SD.

Results: A total of 389 patients admitted to emergency department with abdominal pain were included in the study. 161 (41.3%) of them were male, and 228 (58.7%) of them were female. The mean age of patients was 40.4. The youngest patient was 1-year-old, and the eldest patient was 87-years-old. The diagnoses of patients were as follows: 222 (57%) of them were other diagnoses than abdominal pathologies, 36 (9.2%) of them were renal colic, 7 (1.7%) of them were acute cholecystitis, 51 (13.1%) of them were ovarian diseases, 16 (4.1%) of them were acute pancreatitis, 5 (1.2%) of them were acute appendicitis, 51 (13.1%) of them were trauma, 1 (0.2%) of them mesenteric ischemia and 1 (0.2%) of them also diagnosed with the criteria ileus.

Conclusion: The ultrasonography in the emergency departments with its quickly and easily accessible advantage still continues its popularity. In this study done by reviewing 3 months data retrospectively, 222 (57%) patients had a diagnosis other than abdominal pathologies. Diagnoses like acute appendicitis, acute cholecystitis, mesenteric ischemia, were taking the lower percentages of all diagnoses. As is clear from this study, emergency department diagnosis of abdominal pain has a wide range of features for each patient.

Keywords: Abdominal pain, emergency department, ultrasonography

P-0359 Trauma Emergencies

Acceleration-Deceleration Injuries Due to Multi-Cervical Spine Fractures

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Objective: Road traffic accidents in our country are still a major public health problem due to having high mortality and morbidity. Intervention within the golden hour period in accidents developed injuries may be required for patients who may cover all age groups and permanent disability probabilities may vary according to location of injuries. Physical examination creates the basis of diagnosis in traffic accidents which are considered as high energy trauma.

Case: A 36 year old male driver involved in a collision suffering from head and neck pain was admitted to the emergency department. He was maintained in a supine position with rigid collar immobilization. History revealed that vehicle speed was high, he was wearing seat belts and had no complaints other than the head and neck pain. Physical examination revealed an abrasion of frontal region, tenderness in processes of cervical spine and Glasgow Coma Scale with a score of 15 points. On admission, his blood pressure was 111/78 mmHg, pulse 68 beats per minute, respiration rate was 14 per minute and temperature was 36.7°C. Brain and cervical tomography was planned for the patient due to tenderness of cervical spines and collision with high speed. Cervical tomography revealed multiple contiguous fractures in C3, C4, C5 and C6 vertebrae. He was referred to neurosurgery.

Conclusion: Cervical fractures may develop in patients fastened seat belt due to acceleration and deceleration of the head after a traffic collision. Fractures of vulnerable areas of the body such as neck causing severe neurological deficits such as paraplegia are of major importance. Treatment of patients should start yet with cervical immobilization on the scene and should continue until fracture has excluded.

Keywords: Acceleration-Deceleration Injuries, Cervical Spine Fractures, High Speed Collision

P-0360 Trauma Emergencies

Fracture of lateral tibial plateau; Are radiographs capable always for diagnosis?

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Objective: Trauma has become the most frequent reason for admittance to emergency service. Apart from high-energy trauma, trauma often from falls from the same level, and also sport injuries, is frequently handled in emergency service. Knee injuries are usually evaluated via radiographs and advanced imaging is rarely required, irrespective of severity and mechanism of trauma.

Case: A 55 year old female suffering from knee pain was admitted to the emergency department. History revealed that she fell down after stumbling on stone while walking on the road. Medical history was otherwise noncontributory. Physical examination revealed an abrasion about 20x2cm in size over the patella and diminished range of motion of the knee joint. A comparative knee radiograph revealed no significant pathology. Having severe knee pain and inability to ambulate and bear weight, she had undergone Computed Tomography (CT). CT revealed fracture of lateral tibial plateau. She referred to orthopedics for surgery.



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Conclusion: Fracture of lateral tibial plateau are encountered more frequently. The medial plateau fractures as a result of high energy trauma are seen comminuted as different from lateral tibial plateau. Tibial plateau fractures usually are accompanied by cruciate ligament injury, meniscal tears and peroneal nerve lesions. CT is the best imaging modality in patients with incompatibility of clinical manifestation.

Keywords: Fracture, Lateral Tibial plateau, Radiograph, Computed Tomography

P-0361 Trauma Emergencies

Bilateral Colles Fracture Due To Parachute Accident

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Objective: Parachuting events, one of the most dangerous aviation sports are also applications involving large risks. During landing on the ground after performing successful jumping, ground impact exposes parachute staff to high energy trauma. This trauma can cause fractures rarely.

Case: A 28 year old male exposed to ground impact suffering from bilateral forearm pain was admitted to the emergency department. On detailed questioning, he reported that he had landed on his both hands due to failure of keeping balance during landing. On the admission, vital signs of the staff were within normal range. Visual inspection of the both forearms revealed significant tenderness and deformity distally. Radiographs confirmed the presence of Colles' fracture in the forearm. After providing adequate sedoanalgesia, circular cast is applied after reducing a forearm fracture.

Conclusion: Fractures of the distal radius comprise of 16% of all types of fractures and 75% of all forearm fractures admitted to emergency department. As the majority of Colles fractures are unilateral, only a handful of case reports regarding bilateral Colles fractures exist. However it can be seen as a result of an unusual mechanism and different etiologic factors. Consideration should be given to excluding additional pathologies for those with bilateral Colles fracture that might be exposed to a high-energy trauma.

Keywords: Parachute Accidents, Bilateral Colles' fracture, High Energy Trauma

P-0362 Trauma Emergencies

Late Epidural Hematoma

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Objective: Epidural hematomas are one of the most common complicated closed-head injuries. The diagnosis of epidural hematoma is made in most patients within 24 hours of injury' but presentation may be delayed until the second or third week. Traumatic delayed epidural hematomas are hematomas that are not present in the first neuroradiological examination made after trauma, but appear in sequential neuroradiological examinations. We report a case of a 15 year-old boy with late epidural hematoma.

Case: A 15 year-old male patient referred to the emergency department with head trauma. His vital parameters were normal. He was conscious with good orientation and cooperation. Physical and neurological examination was normal. Cranial computed tomography was planned due to his headache. There were no pathological findings in non-contrast cranial computed tomography. He was discharged with advice after 12 hours of follow-up in the emergency room as his headache was regressed. Two days later, he referred to the emergency department again with persistent headache. His vital parameters were normal, physical and neurological examination showed no abnormality. Cranial computed tomography was planned as he had suffered from unregressed headache. Late epidural hematoma was detected in cranial tomography and he was admitted to the neurosurgical service for further observation and treatment.

Conclusion: Traumatic head injury is a common cause of mortality and acquired neurological impairment in children. The origin of delayed epidural hematoma is thought to be venous bleeding. In childhood period, slow accumulation of blood through the epidural space may delay the diagnosis. Early diagnosis of the delayed traumatic epidural hematomas before the irreversible brain injury and rapid treatment will decrease the mortality.

Keywords: Epidural, Hematoma, Traumatic, Hematoma

P-0363 Other

Esophagealaryngeal Flap: A Rare Cause of Recurrent Foreign Body Aspirations

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Objective: Foreign body aspirations giving symptoms due to airway obstruction are emergencies usually seen in childhood. It is also seen in all age groups, it may give the symptoms needing urgent airway support. In recurrent foreign body aspirations in adult patients, structural abnormalities are in the foreground.

Case: A 68-year-old female patient admitted to emergency department with complaints of dyspnea, foreign body in throat after eating meat and sticking feeling. It was the third same admission of her who had twice surgery for larynx ca 12 years ago and had tracheostomy. In physical examination; oropharynx and respiration sounds were normal in case with stable vital signs. It was determined that vocal cords were immobile at bilateral paramedian line in fiber optic endoscopic laryngoscopy. In endoscopic examination, it was seen esophagealaryngeal flap and foreign body upper side of flap. Foreign body was removed with the help of endoscopy.

Conclusion: Previous surgeries with the cause of malignant conditions including neck region, applied radiotherapy and tracheostomies bring about contraction in esophagus. Esophagealaryngeal flaps occurred after the cure may cause obstructions of upper respiratory way. Esophagealaryngeal flaps must be thought in patients admitted to emergency department having the story of malignancy with the recurrent foreign body aspirations and advanced airway supports needed by these patients must be considered.

Keywords: Esophagealaryngeal Flap, Foreign Body, Aspiration

P-0364 Trauma Emergencies

Isolated scapular fracture: a case report

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Objective: The scapula is protected by its surrounding musculature complex and its ability to move along the wall of the thorax. Fractures to scapular structures typically require significant force. These factors explain the infrequent occurrence of scapular fractures. Scapular fractures occur infrequently and account for approximately 1% of all fractures and fewer than 5% of shoulder girdle injuries. Other major injuries often accompany scapular fractures, such as fractures in the shoulder, collarbone and ribs, or damage to the head, lungs, or spinal cord. We aimed to present a case with isolated scapular fracture, although this fracture is usually accompanied by other injuries.

Case: A 44-year-old male admitted to emergency department with right shoulder pain after a traffic accident. On physical examination, his vital signs were normal and there was 2x2 cm abrasion, pain and limitation of movement on the right shoulder. He complained of sharp pain on the right side of his thorax during breathing. Other system examination was unremarkable. X-ray imaging of shoulder revealed a scapular fracture (figure 1). Computed tomography of thorax showed scapular fracture without other thoracic pathology such as rib fracture, pneumothorax, hemothorax or pulmonary contusion (figure 2). The patient was consulted to orthopedic and discharged with conservative treatment.

Conclusion: Isolated scapular fractures are rare conditions. Scapular fractures usually accompanied by other major injuries and sometimes, may be misdiagnosed due to other life-threatening injuries.

Keywords: Scapular fractures, isolated, emergency department

P-0365 Other

Contact dermatitis after henna tattoo

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Objective: In recent times temporary tattoos are more popular among young people than permanent tattoos all over the world. Henna known as the source of natural paints. Allergic reaction to pure henna is rare. Allergic reactions mostly occurs due to the chemical paints which are added for shortening henna's absorption time from skin and for darken colour. Allergic reactions



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mostly occurs due to paraphenyldiamine (PPD). We will present two contact dermatitis case about temporary henna based tattoo.

Case: 34 year old female admitted to emergency service with erythema, itching and swelling after henna based tattoo to her both forearm one day before admission. During the admission patient's vitals were stable. There were bullous lesions both forearms. Patient had no history of allergic reaction. patient discharged with topical steroid and anti histamines and called for control examination. On her control examinations patient's lesions had regressed.

Conclusion: Although allergic reaction about pure henna is rare, adding pigments for colourizing henna can cause these situations. Temporary tattoos are quite popular among young people. Society should inform about results of these tattoos and should warn about their harmful effects.

Keywords: henna tattoo, contact dermatitis, emergency department

P-0366 Trauma Emergencies

Subconjunctival Hemorrhage Caused By Nasogastric Probe Applications: A Case Report

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Subconjunctival hemorrhage is a hemorrhage, which is within Tenon's capsule under the conjunctiva. This is usually self-limiting and easily identifiable symptom. There is hemorrhage under the transparent conjunctiva in the layer biomicroscopy and it heals within 1-2 weeks. Although it is an issue cosmetically, it has generally good prognosis clinically. If the completeness of globin is not degenerated, the visual function will not be affected. It usually doesn't give any symptoms besides mild ocular irritation. Hypertension, trauma, diabetes mellitus, anticoagulant therapy, blood dyscrasias, acute hemorrhagic conjunctivitis, etc.. are shown as the reasons of hemorrhage. The history which is taken during the physical examination is important in determining the etiology. A nasogastric tube is the most common devices which is placed in the gastrointestinal tract. The indications of the placing a nasogastric tube are; upper gastrointestinal bleeding, after suicide and accidents for gastric emptying and washing, in case of requiring immediate surgery for emptying gastric contents, ileus, patients who have weak oral intake for enteral nutrition, for avoiding aspiration in unconscious patients, giving medications and providing nutrition, for protecting the patient who follow up with mechanical ventilation against the gastric distension, preoperative and postoperative for decompression.

Although it may seem like a simple and reliable operation, misplacement of nasogastric tube can cause serious and fatal complications.

Case: A thirty years old man was admitted with abdominal pain, constipation and loss of appetite. A nasogastric tube was applied to the patient. He had no vomiting and no operation history. There are guarding rigidity and rebound tenderness in the right lower quadrant in the physical examination of the patient. He had subcutaneous and subconjunctival hemorrhages on the face especially around the nose with the form of petechia. The laboratory test results were WBC:17000/mm3, hgb:14, plt:350000/mm3, INR:0.82, pt:11.4sec, APTT:28.8sec, the other laboratory parameters were normal. In the patients abdominal ultrasonography there was a 10 mm noncompress intestinal loop which was compatible with acute appendicitis. The patient had subconjunctival hemorrhage which checked with the consultant eye disease doctor. He was discharged on the fifth post operative day. The subconjunctival hemorrhage was regressed on the fifteenth day after the operation.

Conclusion: During the application of nasogastric tube, performing excessive force with the Valsalva maneuver was considered as a result of this bleeding. Although nasogastric tube application process is a simple and reliable process, we have to keep in mind that there will be serious and fatal complications because of the misplacement of nasogastric tube.

Keywords: Subconjunctival hemorrhage, nasogastric, tube

P-0367 Trauma Emergencies

Case Report: Use of PCC in Patient with Traumatic Hemothorax

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Objective: Prothrombin complex concentrates (PCC) has been used for reversing oral anticoagulants (Vitamin K antagonists) effects in many clinical condition especially in severe hemorrhages such as intracranial bleeding and gastrointestinal hemorrhages. PCC provide rapid reversal of normal INR level. We present use of PCC in patients with traumatic hemothorax because of trauma due to high INR level.

Case: A 73 years old female patient admitted to our emergency department with a dyspnea. In her medical history, she fell down 15 days before and her dyspnea developed gradually in 15 days. She was under oral anticoagulant therapy because of cerebrovascular accident.

On admission, her vital signs were normal. On physical examination, decreased lung sounds detected in right lower hemithorax and tenderness on ribs. On chest X-ray, 1/3 of right hemithorax was filled by fluids (Figure 1). On laboratory test, Complete Blood Count and Biochemical test were in normal limit. INR level was 8.54. PCC (8 vials) therapy was given in dose of 50 IU/kg of body weight and 2nd hour INR level was 1.41. Patient was consulted by Thoracic Surgery Department and tube thoracostomy was performed. Patient was hospitalized in Thoracic Surgery Ward. Thorax tube was removed 7 days after admission and oral anticoagulant therapy was initiated. Patient was followed for new hemothorax for 7 days and discharged 14th day of hospitalization without any complaint.

Use of PCC was approved for mainly life threatening hemorrhages due to high INR levels because of oral anticoagulant therapy. There were limited data about use of PCC in trauma patients especially in life threatening conditions (mainly in brain injury). There were no informed data about the use of PCC in traumatic hemothorax with high INR levels in oral anticoagulated patient.

Conclusion: PCC can be significant option for reversing oral anticoagulant therapy in patients with traumatic hemothorax due to high INR level in emergency department.

Keywords: PCC, traumatic hemothorax, emergency medicine

P-0368 Other

Limitation of Shoulder Movement; Omovertebral Bone

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Objective: The omovertebral bone is found in ~35% (range 19-47%) of cases of Sprengel deformity. It runs from the superomedial border of the scapula to the spinous processes, transverse processes or laminae of C4 to C7. Occasionally it can be bilateral. The connection from the scapula to the vertebrae may be fibrous or osseous. The aim of this case is point to the omovertebral bone with 20 year-old patient.

Case: A 20-year-old male patient was admitted to our hospital with the complaint of left shoulder pain and limitation of movement. At his history there was no trauma. There have been complaints for a while. His vital signs were stable. At physical examination left shoulder abduction was restricted at 120 degree. Flexion and external rotation was almost normal. Right shoulder was normal and he was kyphotic. Two scapula was at same level. Radiography and tomography planned for patient. There were irregularities and vertebral fusion at cervical and thoracic vertebrae. There were 18 degree scoliosis at T3-4 and 34 degree kyphosis at inferior thoracic vertebrae. Tomography showed that spinal processes of cervical 5-6 vertebra extending toward the scapula and there was a joint with supero-medial of corpus scapulae. Analgesics started and the patients was invited for elective treatment.

Conclusion: Consequently we thought that the movement restriction was because of scapula and vertebral processes joint. Some congenital deformities could cause to limitation of motion and this deformities should be remembered by the emergency doctors.

Keywords: Omovertebral Bone, Shoulder, pain

P-0369 Trauma Emergencies

Isolated Scapular Body Fracture

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Objective: Fractures of the scapula body are relatively rare constituting 1% of all fractures and 5% of all fractures around shoulder. They are usually caused due to high energy vehicular trauma or fall of heavy object over scapula. We report a patient who had isolated fracture of scapula that was successfully managed by the emergency physician.

Case: A 35 year old male was admitted to emergency department following a motorbike accident. The patient was haemodynamically stable and had no other injuries. Physical examination revealed tenderness over posterior aspect of the right shoulder. There was no external wound. The movements of right shoulder were painfully restricted. X-ray was normal. In the Scapula Computerised Tomography there was a non-displaced body fracture in the right scapula. As a result of our clinical evaluation, we accepted this patient isolated right scapular body fracture. We performed Velpau bandage on the right shoulder. He was given analgesics and then discharged.

Conclusion: isolated scapular body fracture is extremely rare. Usually, high energy is required to fracture a scapula, hence scapular fractures are commonly associated with concomitant



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injuries. Scapular fractures are notoriously difficult to visualize radiographically. As a result, diagnosis and treatment of scapular injuries may be delayed or suboptimal. Finally, CT scan can be very helpful in the diagnosis of scapular fracture.

Keywords: Scapular fracture, accident, emergency medicine

P-0370 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Bilateral urethral stones causing anuria: Case report

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Objective: In this case report was aimed to present the patient that bilateral urethral stones causing anuria.

Case: An eighteen years old male patient was admitted to emergency department with the complaint of sudden inability to urinate. He did not mention any additional complaints except the complaint. At physical examination, we could not detect any pathological findings. In the patient's blood tests, potassium value was 6.4 mmol/L, creatinine value was 9.81 mg/dl. Later on, we found bilateral urethral stones on ultrasonography and non-contrast spiral computed tomography. Urology consultation was requested. The patient who was taken into emergency surgery by urology department had ureterorenoscopy and DJ stents was discharged with the patient's kidney function improvement and having urine output.

Conclusion: For the patients admitted with complaint of anuria, we should bear in mind that the patient could have bilateral urethral stones and therefore he or she may have acute kidney failure and later on it may require emergency surgery.

Keywords: Anuria, acute kidney failure, bilateral urethral stones

P-0371 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Comparing Serum Procalcitonin Level With Serum C-Reactive Protein Level At Early Diagnosis Of Acute Appendicitis

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Objective: The goal of this study is to determine the place of procalcitonin which is a new parameter for inflammation at the diagnosis of acute appendicitis and is to compare with c-reactive protein which is a inflammatory parameter.

Materials-Methods: This study include 50 patients who are older than 16 years old and diagnosed as acute appendicitis (group I), and 50 healthy persons, at same age (group II). Cases was choosen randomize.

Group I include patients who are macroscopically diagnosed as acute apandicitis during operation and guess as acute apandicitis with history, clinic and ultrasonography. Blood samples was taken for c-reactive protein and procalcitonin in emergency department and after operation.

Group II include persons who have not any inflammatory disease in history and during study. One blood sample was taken from group II.

Results: Procalcitonin and c-reactive protein levels were compared at emergency department; average serum c-reactive protein level of group I was statically singificant higher than average serum procalcitonin level of group II ($p<0,05$). For meaninful of the test at group I; statically significant difference was determined between procalcitonin and c-reactive protein ($p<0,05$). When look at average levels of procalcitonin and c-reactive protein, statically significant difference was determined between perforate appendicitis and non perforate appendicitis.

At diagnosis of acute appendicitis; sensitivity, specificity, positive predictive value and negative predictive value of procalcitonin were determined respectively %88, %90, %90 and %88. At diagnosis of acute appendicitis; sensitivity, specificity, positive predictive value, negative predictive value of c-reactive protein were determined respectively %40, %100, %100 and %62.5.

Serum procalcitonin level was high all of perforate appendicitis, that is to say sensitivity was determined %100. Serum c-reactive protein level was high 10 of all perforate appendicitis, that is to say sensitivity was determined %55.

Conclusion: Procalcitonin may be used for diagnosis of acute apendicitis and to diagnose acute apendicitis better parameter than c-reactive protein. Also, procalcitonin may be used as a significant parameter to show complication of acute apendicitis, and it increases with severity of inflammation.

Keywords: Acute appendicitis, c-reactive protein, diagnostic parameters, procalcitonin, prospective clinic study

P-0372 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Chylothorax Fact Due To Wounding By Firearms

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Chylothorax is a rare manifestation that can cause a serious metabolic and immunological defects with cumulation of lymphatic fluid in pleural space. Chylothorax can be seen congenitally as well as in deterioration of ductus thoracicus due to thorax trauma or as a result of iatrogenic, inflammatory and malign lymphatic obstruction. Diagnosis is confirmed by biochemical analysis and by macroscopic existence of white colour of pleural fluid. Biochemically the effusion is defined as chylothorax when the level of triglyceride is more than 110mg/dl and the ratio of cholesterol/triglyceride is less than 1. Traumatic chylothorax is a manifestation that can be rarely observed among thorax traumas but can be easily diagnosed. The treatment should be started from the moment of diagnosis. Surgical treatment should be planned in case of daily drainage is more than 500 cc with 10-14 days of conservative treatment. A delay in surgical treatment can cause serious complications. Complications such as respiratory insufficiency, malnutrition due to protein degradation and infection due to immunoglobulin and lymphocyte dilution can be seen.

Keywords: Chylothorax, Thoracic Trauma, Foreign Bodies

P-0373 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Evaluation of nontraumatic adult abdominal pain patients admitted to our emergency department during one year

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Objective: In this study, it was aimed to determine the frequency of the patients who came with the complaints of abdominal pain to our emergency service, the rate of those who hospitalized, distribution of disease which caused the abdominal pain, demographic characteristics, morbidity and mortality, to evaluate results which were received from the observations.

Materials-Methods: In our study, demographic characteristics, vital findings, physical examination findings, pain etymology, laboratory and imaging tests, final diagnoses, consultations and the general condition of 1080 patients were evaluated between 12 March 2012-11 March 2013.

Results: While looking over the ages, youngest and oldest patient were 18 and 97 years old respectively. The patients who admitted to emergency service were avaragely 41.9 years old and age pattern distribution observed homogeneous. While the patients classified from the perspective of gender, man are made up 39% (421 people), women are 61% (659 people). It has identified that the patients after the start of abdominal pain 12.9% first 6 hours, 42.4% between 6-12 hours, 44.7% after 12 hours were admitted to emergency service.

While analysing, the final diagnosis of patients who has abdominal pain in order of frequency of non-specific pain 27.2%, dysmenorrhea 10.6%, peptic ulcer 8.6% renal colic 6.6%, appendicitis 5.9%, and ileus 3.6% were identified. And also, most of patients, respectively, were 33% discharged in good condition with medical treatment, 18.4% discharged by ordering a control examination, 18.7% hospitalized into general surgery service, 9.4% hospitalized into internal medicine service.

Conclusion: As a result of this study, the importance of anamnesis and physical examination on the adult patients except trauma cases who admitted emergency service with the complaints of abdominal pain were stated. When anamnesis and physical examination are required to assist in case of needs of emergency physician, laboratory tests, imaging methods and consultations should be done quickly and put patient's final diagnose, take necessary actions, were expressed. Finally, it is seen that the patients who have abdominal pain were not consulted emergency service in early period were identified. Therefore, further comprehensive studies on this issue are needed.

Keywords: Emergency Service, Final Diagnosis, Abdominal Pain



POSTER PRESENTATIONS

P-0374 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Ileus caused by left-sided rupture of the diaphragm

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Objective: Diaphragm is anatomical structure between chest and abdominal cavities. Diaphragm injury may result from blunt and penetrating trauma. It is dome-shaped and consists of muscles and tendons. Traumatic left diaphragmatic rupture is 10 times higher than right traumatic right diaphragm rupture. Penetrating trauma has been reported to cause 12.3% to 20% of diaphragm injuries. In autopsy series the incidence of diaphragmatic rupture is reported to be from 5.2 to 17%. diagnostic peritoneal lavage, ultrasonography (USG), computed tomography (CT), diagnostic laparoscopy are used for diagnosis of diaphragmatic rupture.

Case: 33 year old male patient admitted to the emergency department with abdominal pain and dyspnea. It was learned that the patient had a history of stabbing on the left anterior axillary line three years ago. On physical examination of the patient, there was no breath sounds on the left lower thoracic segments and he had diffuse abdominal tenderness. His vital signs revealed a temperature of 37°C, blood pressure of 100/62 mmHg, respiratory rate of 24/min, pulse rate of 102/min, and pulse oximetry reading of 95% on room air. In the patient's ECG, there was sinus tachycardia. On the patient's chest radiograph, the left middle and lower lung zone opacity viewed. Patient was consulted to thoracic surgery and planned computed tomography. Patient's CT viewed the ileus in enterothorax caused by left-sided rupture of the diaphragm and the patient underwent laparotomy.

Conclusion: In the period of following Trauma, it may not be diagnosed in the absence of specific symptoms and radiologic findings. Therefore, over the years of traumatic diaphragmatic rupture may increase morbidity and mortality. All patients with thoracoabdominal trauma, diaphragmatic rupture should be suspected. We conclude that diaphragma ruptures may cause herniation of abdominal organs and intestinal obstruction. The optimal treatment of traumatic diaphragmatic rupture is repairing the defect in patients with early diagnosis.

Keywords: Diaphragma rupture, ileus, trauma

P-0375 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Celiac Artery Thrombosis Resulting in Infarction of the Liver and the spleen

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Objective: Acute aortic occlusion is rare but catastrophic pathology with very high morbidity and mortality. It may result from thrombus formation, saddle embolism, false lumen expansion in aortic dissection, aortic trauma, and other etiologies related to arteriosclerosis, low flow states or hypercoagulability. The clinical presentations include acute limb ischaemia, neurologic symptoms of the lower extremities, abdominal symptoms and acute hypertension. Postoperative mortality is high even with optimal surgical treatment. Death can be associated with major organ ischemia such as stroke, myocardial infarction, hepatic infarction, and mesenteric ischemia, as well as with severe respiratory failure, fatal arrhythmia or renal failure secondary to myonecrosis.

Case: Female patient, 42 years old, was admitted to Emergency Department with nausea, vomiting and abdominal pain complaints that developed a day ago. She has a medical history of angiography performed a year ago, but without any medication after procedure, that she said. Her general condition was good. Her vitals were; blood pressure: 100/50 mmHg, heart rate 92/min, fever 36.4 C, oxygen saturation is 93% with pulse oximeter. In her ECG; the rate is 92 bpm with bigeminy ventricular extra systoles. In physical examination; epigastric and left upper quadrant guarding was available in the abdomen, other systemic examination was unremarkable. While urinary analyses, CBC and serum biochemistry complete, during the follow up of the patient abdominal pain was increased and her general condition was getting worse. In the bedside ultrasonography, was not observed any pathological condition in the abdomen. Lower and upper abdominal CT scan with contrast main was taken. Filling defect viewed in the lumen of abdominal aortic celiac trunk and immediately distal to the anterior of the celiac trunk were completely obliterating with the presence of thrombus; cystourethrography passage through to liver and spleen was not observed; spleen size markedly increased and hypodense areas compared to the parenchyma, in the central part of spleen, is relatively primarily necrosis in favor were evaluated. Patient, who consulted to general surgery and cardiovascular surgery, underwent surgery for splenectomy was performed. Patient monitored in the intensive care unit of the Anesthesiology and Reanimation Department after the surgery, during the follow up signs of liver failure seen in the first day. During the follow up in the intensive care unit, on the third day, patient has died due to multiorgan failure.

Conclusion: Acute aortic occlusion is a rare, Early diagnosis and treatment is very important in order to prevent metabolic compromise.

Keywords: Abdominal pain, Acute aortic occlusion, Celiac Artery, Thrombosis

P-0376 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Young Patient, Headache, Spontaneous Intracerebral Hemorrhage

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Objective: Spontaneous intracerebral hemorrhage (ICH) causes 8% to 11% of all acute strokes and is twice as common as subarachnoid hemorrhage. Risk factors for ICH include long-standing hypertension, arteriovenous malformations, arterial aneurysm, anticoagulant therapy, use of sympathomimetic drugs (particularly cocaine and phenylpropanolamine), intracranial tumors, and amyloid angiopathy in the elderly. Current smoking and increased frequency of smoking also raises the risk of ICH, but the etiology of this increased risk has not been as well defined as in ischemic stroke.

Case: Our case study is a 20 year old woman, who admitted to emergency department having severe headache. In the story firstly she had a severe headache and vomiting and then syncope. Patient vital signs were stable. On examination she had a neck rigidity, motor weakness on the right extremities and babinski (+). Glasgow coma score (GCS) was E4 V4 M6: 14. The patient brain CT imaging shown intracerebral hematoma at the left side. The patient was consulted to neurosurgeon and took cerebral angiography. Cerebral angiography shown that there was a arteriovenous malformation at the occipito – parietal region. The patient was admitted to intensive care unit and died five days after to admission.

Conclusion: Cerebellar hemorrhage is commonly associated with dizziness, vomiting, marked truncal ataxia, gaze palsies, and depressed level of consciousness. Patients with ICH are more likely to have rapidly progressive symptoms and may require more aggressive intervention. Emergency medicine physician be careful to evaluate sudden onset neurological symptoms and take rapid decisions.

Keywords: Emergency Department, Headache, Intracerebral Hemorrhage

P-0377 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Fatal Spontaneous Rupture of A Giant Hydatid Cyst in an Elderly Patient

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Objective: Hydatid cyst (HC) disease, which is endemic in Turkey, is mainly located in the liver. Cyst rupture is the most common complication of HC. Ultrasonography (US) and computerized tomography (CT) are the main diagnostic modalities for HC disease. Presented herein is a case of an elderly female patient who died shortly after presenting to the emergency department with severe abdominal pain, which was attributed to non-traumatic HC rupture.

Case: A 79-year-old woman was brought to the emergency department with a three-day history of worsening abdominal pain and progressive clinical deterioration. The patient was responsive with a Glasgow coma score of 15, but disoriented and agitated. She also had tachypnea and tachycardia. The patient's abdomen was tender to light palpation, especially in the right upper quadrant. Guarding and rebound tenderness were also present.

An ultrasound performed for the acute abdomen revealed the presence of a large complicated cyst, 16 x 15.5 x 20 cm in size in the right lobe of the liver. The cyst had multiple septations and internal echoes with several smaller cystic formations within. Its posterior wall had calcifications with acoustic shadows.

The patient was hypotensive during follow-up in the emergency department, with persistence of hemodynamic instability despite intravenous fluid resuscitation. She was promptly transferred to the anesthesiology intensive care unit. Emergency surgery was performed on the same day during which a cystotomy was followed by cystectomy and closure of the remnant cavity. Post-operatively, the patient continued to require mechanical ventilation and was followed-up in the ICU. She died 12 days after admission.

Conclusion: HC should be considered in the differential diagnosis in a patient presenting to the emergency department with abdominal pain. Radiologic modalities such as US and BT are important diagnostic tools, with US particularly offering details regarding cyst morphology. On its own, US is a reliable and efficient method for making a diagnosis. Giant HC may easily rupture, and intraperitoneal rupture is a potentially fatal complication. Initial presentation of HC may be due to rupture following blunt trauma or a fall, and a ruptured HC should always be



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considered as a potential cause of acute abdomen. Such cases warrant initial follow-up in a resuscitation unit and admission for intensive care. Surgery should be not delayed in case of a ruptured HC due to the risk of developing anaphylactic shock.

Keywords: Primary hydatid cyst, hydatid cyst rupture, acute abdomen

P-0378 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Dolichosigmoid Volvulus

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Objective: Dolichocolon is an abnormally long large intestine. It should not be confused with an abnormally wide large intestine, which is called a megacolon. Dolichocolon may predispose to abnormal rotation interposition between the diaphragm and the liver. We aim to present a 60-year-old male patient who was admitted to our emergency service with dolichosigmoid volvulus.

Case: A 60-year-old male presented to the emergency department (ED) complaining of abdominal pain, vomiting and constipation for 2 days. He had presented many times to surgery clinics for 3-4 years for constipation and conservative treatments were administered. He did not have a history of chronic disease and surgery. In his physical examination, he had abdominal distension and tenderness and the rectum was empty. Nasogastric decompression was applied to the patient. White blood cell count of the patient was a bit high and other blood tests were normal. Plain abdominal x ray showed evidence of volvulus (Figure 1) and consulted with the general surgeon. The patient was pre-diagnosed with volvulus and he underwent emergency surgery. In the explorative laparotomy, the patient was diagnosed with dolichosigmoid volvulus. He had an 80 cm ischemic dolichosigmoid colon. Left hemicolectomy and Hartman colostomy were applied. The patient was hospitalized 7 days after surgery and then discharged.

Conclusion: Dolichosigmoid volvulus is a rare cause of emergency service admission. Emergency doctors should realize this rare cause of volvulus is usually present with abdominal pain and incidentally seen on radiological evaluation.

Keywords: Dolichocolon, abdominal pain, emergency service

P-0379 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Amyand's Hernia: Inguinal Hernia With Acute Appendicitis, Accompanied By Bilateral Undescended Testicle

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Objective: Presence of appendix vermiformis (non-inflamed or inflamed) in inguinal hernia is called Amyand's hernia. The incidence of Amyand hernia is approximately 1% of types inguinal hernia. We presented a nineteen years old patient with Amyand's hernia, who had acute inflamed appendix vermiformis in bilateral inguinal hernia sac, accompanied by bilateral undescended testicle.

Case: 19-year-old male patient was admitted to our emergency department with complaints approximately 6 hours of existing two-sided groin pain. On physical examination, sizes of testes is normal and palpable in the inguinal canal and the right testis was sensitive to palpation. On abdominal examination revealed no evidence of rebound and defense. Inguinoscrotal doppler ultrasonography of the patient, both testes are present in the inguinal canal, their blood supply are normal and bilateral hernia was reported. WBC was 11000/mm³ and other laboratory tests were normal. The patient was operated. Inflamed appendix was seen in the right inguinal hernia sac. After Appendectomy, inguinal hernia was repaired using polypropylene mesh by Lichtenstein method, and the two-sided orchidopexy was performed. The patient were discharged uneventfully after surgery 2 day.

Conclusion: Acute appendicitis within an Amyand hernia can be life threatening and the patients always require emergency surgery.

Keywords: Amyand's Hernia, Appendicitis, Undescending testes

P-0380 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Laparoscopic appendectomy for giant appendiceal mucocele in an elderly patient: A case report

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Objective: Mucocele of appendix is an obstructive dilatation of the appendiceal lumen by accumulation of mucus. It is a rare pathology of the appendix and the incidence is 0.2-0.7% in appendectomy cases. We presented a case of laparoscopic appendectomy for a giant appendiceal mucocele in an elderly patient.

Case: A sixty years old female patient admitted to our clinic with abdominal pain. There was not additional complaint of patient. On physical examination, vital signs were stable. There was tenderness in the right lower quadrant. Ultrasonography showed a cystic lesion is 7x4 cm in size, hyperechoic, avascular, complex in the right adnexal area. Magnetic resonans imaging revealed a cystic mass with thin septal is same dimensions, in anterior of the psoas muscle in the lower right quadrant. Diagnostic laparoscopy was operated to mass. Laparoscopic examination was detected an immobile mass in right paracolic area. The mass is hard, fixed to the retroperitoneal region, arising from the appendix, approximately 8x5 cm in size. The mass was excised. Histopathological examination showed a diagnosis of a mucinous cystadenoma.

Conclusion: As a result, the possibility of appendiceal tumors should be considered with chronic or acute abdominal pain in patients with advanced age and detailed review should be made for the preoperative diagnosis.

Keywords: Appendix, Laparoscopy, Mucinous cystadenoma, Mucocele

P-0381 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Fournier's Gangrene: Our Experiences For 5 Years And Analysis Of Factors Affecting Prognosis

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Objective: Fournier's gangrene is a rare, an acute, rapidly progressive, fatal polymicrobial necrotizing fasciitis affecting of genital, perianal and perineal areas. The incidence of mortality is still high and mortality increases with age. In this study we proposed to our experience in the treatment of Fournier's gangrene and to determine risk factors affecting prognosis.

Materials-Methods: Fifty one patients operated for Fournier's gangrene during 2009-2014 were investigated retrospectively. Patients were divided into to groups; surviving and exitus groups. Groups were compared by age, gender, demographic features, presence of diabetes mellitus, etiological factors, place of gangrene, time of symptom, number of debridements.

Results: Mean age was 56.8 years, and female/male rate was 19/32. Mortality was seen in five patients 9.8%. The most common comorbid disease was diabetes mellitus. The most common etiological factors was soft tissue infection (54.7%). The most common localization was perineal area (27.5%) and the least common was pelvic area (2%). There wasn't significant difference between groups in terms of gender, presence of diabetes mellitus, etiological factors, time of symptoms, the number of debridement. There was significant difference between groups in terms of localization of gangrene and operated fecal diversion (p<0.05).

Conclusion: Fournier's gangrene is a progressively, fulminant synergistic necrotizing fasciitis. Because of high mortality rate, patients should be evaluated in detail in an emergency. Otherwise, infections that simple and can be corrected with a little medical intervention can result in death.

Keywords: Fournier's gangrene, mortality, soft tissue infections



POSTER PRESENTATIONS

P-0382 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Foreign Body in Sigmoid Colon

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Objective: Rectal foreign bodies are a known phenomenon and are most mostly associated with eroticism. Various foreign bodies includes bottles, stics, spray cans, money, iron bars, and sex toys. We are presented that a case of foreign body in sigmoid colon.

Case: A 21-year-old male patient admitted to our emergency clinic with the complaint of a foreign body that he self-inserted into his rectum. On physical examination, the abdomen was soft and flat, and bowel sounds were normal. In the rectal examination, the foreign body was non-palpable. Thus, digital removal of the foreign body could not be performed. On direct abdominal radiograph, a foreign body was observed. The patient was operated under general anesthesia and foreign body was excised forwarding to rectum from splenic The foreign body was revealed to be a deodorants bottle.

Conclusion: Rectal foreign bodies are a known phenomenon. Foreign body's shape, size, place to place and time affects the treatment process. Most of rectal foreign body was excised by digital removing without surgery while a small portion is required surgical intervention.

Keywords: Foreign body, Rectum, Sexual behaviour

P-0383 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Hemorrhagic Ovarian Cyst Rupture in Inguinal Hernia Sac

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Objective: Incarcerated inguinal hernia is one of the most common emergency surgery. Many reasons such as tumors, abscesses, genitourinary pathologies should be considered in the differential diagnosis. We have presented a case that hemorrhagic ovarian cyst rupture in a patient that operated for incarcerated inguinal hernia.

Case: 42 year old female patient admitted to our emergency clinic due to swelling and pain in the left groin. On physical examination, there was mass in the left inguinal region which 3x4 cm. and irreducible. The patient was operated. Indirect incarcerated hernia was present in surgical exploration. Hernia sac was opened. In the pouch, ruptured hemorrhagic ovarian cyst along with inflamed fallopian tube and hematoma were present. Inflamed fallopian tube was excised, ovarian pathology was primary repaired and herni was repaired by use polypropylene mesh.

Conclusion: All incarcerated inguinal hernias should be detailed examination and all the differential diagnosis should be considered.

Keywords: incarcerated inguinal hernia, ovarian cysts, rupture

P-0384 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Appendix agenesis in a patient with acute abdominal picture

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Objective: Acute appendicitis is most frequently seen in adults as a result of the obstruction of the lumen of the appendix with fecalith, and constitutes a significant portion acute abdominal pictures that apply to the Emergency Rooms. Imaging methods and laboratory findings take an important place in the diagnosis together with the clinical history and physical examination. However, the accuracy of some imaging methods including ultrasound that depend on the individual can vary. We present here a case who applied to our Emergency Room with acute abdominal picture and diagnosed with acute appendicitis based on the history, physical examination, laboratory findings and emergency ultrasound study, and found out as the agenesis of the vermicular appendix during the surgical procedure.

Case: 47 year-old female applied to our Emergency Room with abdominal pain for about one day that started right over the umbilicus and then moved to the right lower quadrant. Upon questioning she reported that she had nausea without vomiting and she had no appetite. There were no past operations or known co-morbidities. Physical examination: Vital signs are normally. No scars related to past operations were observed in the abdominal examination. Intestinal sounds were positive in all the four quadrants of the abdomen, and tenderness and rebound tenderness was positive in the lower right quadrant with palpation. No muscular defense was positive. Laboratory tests: WBC:12.690 with prevalent neutrophilia. There were no pathologic findings in biochemical tests. Emergency whole abdominal ultrasound was performed on the patient with the pre-diagnosis of acute abdominal picture (acute appendicitis) and it was found that the surrounding mesenteric structures were edematous in the lower right quadrant, and a structure consistent with vermicular appendix terminating in a dead end that was measured as 13mm in the widest part. Upon completion of the tests, she was admitted in the General Surgery Clinic and was taken to surgery. No appendix tissue was observed in the intraoperative exploration. Exploration was continued, and it was observed that the right ovarian wall was irregular; since the patient did not allow sampling from her ovary, no surgical excision was performed. A specimen was collected and the operation was terminated. Then, she was taken to the General Surgery Clinic to take medical treatment.

Conclusion: Like in our case, diagnostic procedures in patients with operated with acute abdominal pictures can prevent surgical procedures to a significant level, particularly in adult females.

Keywords: Acute Abdomen, Appendix Agenesis, Acute Appendicitis

P-0385 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Condition that should be kept in mind in patients with distension: Chilaiditi Syndrome

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Objective: Chilaiditi Syndrome; defined as abnormal transposition of colonic tissue between right diaphragm and liver and it is a rare condition. If it is asymptomatic, this condition is known as Chilaiditi Sign. Distension, dyspnea, constipation can be seen. Acute abdomen can be seen if complications like volvulus or obstruction. It's prevalence increases with age. It is frequently seen in male patients (men/women ratio is 4/1). Story and the physical findings of patients are nonspecific. For diagnosis, first of all conditions which causes pneumoperitoneum must be ruled out. Colon is seen between right diaphragm and liver in direct graphic evaluation. But best imaging modality is abdominal tomography. Laboratory changes can be seen if complications occur. This condition can be treated conservatively or surgically. We are presenting a Chilaiditi Syndrome patient admitting to our Emergency Department with distension and dyspnea.

Case: 67 year old male, complaining with distension, abdominal pain and dyspnea for a week, administered to our Emergency Department. He has no operation or additional systemic pathology story. In physical examination; GKS:15, TA: 140/90 mmHg, Pulse rate:100, respiration rate: 28, saturation of oxygen: %85, Fever:36.4. Abdominal distension was seen and intestinal motility was diminished. In laboratory evaluation WBC was 10140. Electrolyte deficiency was not seen in biochemical evaluation. Colon was seen between liver and right diaphragm in direct graphic evaluation. Emergent abdominal tomographic evaluation was performed and bowel was full with gas and intestinal tissues was seen between right lobe of liver and the right diaphragm. After the diagnosis, the patient was hospitalized by General Surgery department. Rectal tube was used and patient was treated conservatively. Patient was discharged after elective colonoscopic evaluation was planned.

Conclusion: Colon can be placed abnormally and patients can administer to Emergency Department with distension, abdominal pain and dyspnea like our case.

Keywords: Chilaiditi Syndrome, Constipation, Distension, Dyspnea

P-0386 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

An acute cholecystitis case related to a giant gall stone

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Objective: Acute cholecystitis is generally caused by gall bladder stones and can present itself as an emergency. Although it is rather recognized as the disease of the younger females, the gall bladder stones can be seen also in males. These patients commonly apply to the Emergency Room with upper right quadrant pain, nausea and vomiting. Fever can also be seen based on severity of the condition. Laboratory tests and imaging studies are used for diagnosis in addition to the history and physical examination. These cases can be operated either electively after anti-



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biotherapy or under emergency conditions. Either laparoscopic or open cholecystectomy can also be performed. We present a patient with a giant gall stone applied with acute cholecystitis. **Case:** The 53-year old male applied to our Emergency Room with upper right quadrant pain accompanied by nausea and vomiting. He reported that he applied to hospitals with similar findings a few times in the past, operation was suggested but he had refused operation. He had no medical history of operation and co-morbidities. Physical examination Findings: GCS:15; BP:130/90 mmHg; Pulse rate:100/min; Respiration rate:22/min; Body temperature:36.2oC. No scars were observed in the abdominal examination. Intestinal sounds were positive in all quadrants. Tenderness and muscular defense were positive in the upper right quadrant. Murphy sign was positive. In the laboratory tests, WBC was reported as 18.0000. Liver function tests and indirect bilirubin values were mildly high. Emergency US was performed, and the gall bladder were hydropic with the dimensions 10x4x4 cm in the upper right quadrant. The wall thickness of the gall bladder was increased, and a gall stone settled on the gall bladder neck, was observed with a size of about 4x2 cm. No widening of the intrahepatic gall ducti was observed. After diagnosis was done, the patient was admitted by the General Surgery Clinic and emergent laparoscopic cholecystectomy was performed. In the exploration following the surgery, it was noted that the gall bladder stone causing the acute cholecystitis was 5x3 cm in size.

Conclusion: Like our case, the gall bladder stones are the most common causes of acute cholecystitis and can reach large dimensions. Treatment with laparoscopic surgery is possible, even if the gall bladder stones are large.

Keywords: Acute Cholecystitis, Gall Bladder Stone, Laparoscopic Surgery

P-0387 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Necrotizing fasciitis developing after muscular injection

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Objective: Necrotizing fasciitis (NF) is a disease characterized with necrosis rapidly spreading on the soft tissues and fascias and that can have a fulminating course if not treated properly. Infectious process in NF can start with minor injuries (scratches, cuts, insect bites, improper injections, etc.), or it can be seen following surgical procedures or blunt traumas. It is mostly seen in individuals with immunosuppression. Treatment consist of suitable anti-biotherapy and surgical debridement. Here, we present our necrotizing fasciitis case seen in our Emergency room that developed after muscular injection.

Case: 33-year old male applied to our emergency room with pain and swelling in his leg. The history of the patient included pain, swelling and stiffness that started in the hip area following the muscular injection administered in a hospital 3 days ago. There was nothing notable in the personal history of the patient. Vital signs were stable in the physical examination. Scleras were icteric, and crepitation was positive with palpation in the left flank area and left anterior of the thorax. The left leg was stiff, edematous, hyperemic from the left ankle to the hip, and crepitation was positive with palpation. The left hip of the patient was as stiff as wood. Laboratory Findings: WBC 38.77, INR: exceeded the upper detection limit, AST 1003, ALT 118, ÜRE 69, Creatine 3.42, Potassium 6.6, Calcium 7.8 In the superficial ultrasonogram, multiple millimetric hyperechoic (air) appearances were noted in a wide area in the left gluteal region involving the cutaneous /subcutaneous with edema and thickening of the fascias was noted (infectious process?). In the computerized tomography, air densities were noted in the cervical area between muscular tissues, and there were wide spread air densities with greater density in left flank region, posterior of the chest wall, subcutaneously in the area in the left anterolateral and supraclavicular area and in-between the fascias. The general medical status of the patient was poor, and after consultation with general surgery and plastic surgery, he was admitted to surgical intensive care unit with diagnoses of necrotizing fasciitis + sepsis +. The patient had cardiovascular arrest 3 hours later than admission, did not respond to cardiopulmonary resuscitation and died.

Conclusion: Like in our case, necrotizing fasciitis can develop, even rare, without facilitating factors (diabetes, HIV, substance abuse, radiotherapy, malnutrition etc.) with improper injection applications or poor hygiene.

Keywords: Necrotizing Fasciitis, Injection, Facilitating factors

P-0388 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Pneumothorax After Dry Needle Therapy

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Objective: Dry needle therapy is among the most popular of all complementary or alternative therapies. It is an invasive therapy and it is not free from risks for the patient. Recent systemic reviews of the adverse events associated with acupuncture concluded that minor adverse events may be considerable but serious events were rare. The most common adverse events were needle pain, tiredness, and bleeding. In this case we report a patient who developed pneumothorax after dry needle therapy.

Case: A 32 year old woman presented emergency department with complaining of shortness of breath and right chest pain. In her medical history, she had gone to dry needle therapy for back pain one hour before her complaints started. During the dry needle therapy which contains needle insertion to the right and left scapular region she said one of the needles caused sharp pain on insertion. The patient had no significant medical history. On physical examination, her vital signs were normal but examination of the chest suggested reduced air entry in the right apex but was otherwise normal. On her chest x-ray there was right side pneumothorax. Chest tube was applied to the patient and consulted to chest surgery and hospitalized. After seven days of follow-up she discharged from hospital.

Conclusion: Pneumothorax is a rare complication occurring only twice in nearly a quarter of a million treatments, it is estimated that a pneumothorax would be expected to occur once in every 41 years. The potential serious adverse events associated with dry needle therapy must be thought of in patients receiving such therapy.

Keywords: dry needle therapy, Pneumothorax, emergency

P-0389 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Aortic dissection

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Objective: Aortic dissection is defined as separation of the layers within the aortic wall. Although acute aortic dissection classically produces sudden onset of severe chest pain that often has a tearing or ripping quality, no one sign or symptom can positively identify acute aortic dissection. The clinical manifestations are diverse, making the diagnosis difficult and requiring a high index of suspicion. An estimated 38% of acute aortic dissections are missed on initial evaluation. There are no validated clinical decision rules to help identify acute aortic dissection. The diagnosis is best made when there is high clinical suspicion. Aortic dissection can be rapidly fatal, with many patients dying before presentation to the emergency department or before diagnosis is made in the ED.

Case: 60 years old female patient presents emergency department with severe abdominal pain. The patient's initial complaint at emergency was sudden onset of severe abdominal pain. In the patient's history there was a by-pass operation. GKS was E4 V5 M4 = 13 and vital signs were stable. Although there was no any tenderness and rebound in the abdomen examination, the patient's abdominal pain did not change. We administered opioid for pain management. ST depression seen in all derivations of the ECG. Contrast abdominal ct scan showed aortic false lumen. During the patient's follow hypotension was seen. Contrast thoracic ct scan to analyse the spread of the dissection in thoracic aorta. The ct showed the spread of the dissection starting from thoracic aorta to iliac artery at the same time pericardial effusion was observed. Cardiovascular surgeon made operation on the patient. Patient was needed to dialyse in third day at the intensive care unit and died fifth day after the operation.

Conclusion: Patients with acute aortic dissection typically present with the sudden onset of severe chest pain, although this description is not universal. In patients presumed to have acute coronary syndrome, the chest radiograph should be very carefully assessed for mediastinal widening or an abnormal aortic contour, because such findings raise the possibility of aortic dissection. A chest radiograph should be obtained before administering heparin or fibrinolytic agents for presumptive acute coronary syndrome or acute myocardial infarction.

Keywords: Abdominal Pain, Aortic Dissection, Emergency Department



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P-0390 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Incidental Giant Arachnoid Cyst As A Rare Cause Of Headaches

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Objective: Arachnoid cysts are cerebrospinal fluid-filled sacs that are located between the brain or spinal cord and the arachnoid membrane, one of the three membranes that cover the brain and spinal cord. Most individuals with arachnoid cysts develop symptoms before the age of 20, and especially during the first year of life, but some people with arachnoid cysts never have symptoms. Small arachnoid cysts are usually symptomless and may not require treatment. If arachnoid cysts grow significantly, they may cause symptoms, such as headache, weakness, fatigue, nausea, vomiting, seizures, hearing and visual disturbances, vertigo, and difficulties with balance and walking. Diagnosis usually involves a brain scan or spine scan using diffusion-weighted MRI (magnetic resonance imaging) and cranial computed tomography which helps distinguish fluid-filled arachnoid cysts from other types of cysts. We report a case of incidentally diagnosed giant arachnoid cyst who admitted to emergency department with severe headache.

Case: An 44-year-old man with a 4-week history of headaches was admitted because of nausea and severe headaches. His medical and family histories were unremarkable. He had no medical history of infection or cerebral trauma and no previous disease. There was a history of refractory headache. Her initial vital signs were; blood pressures 126/68, pulse rates was 84/min, temperature was 36.9 C, respiratory rate was 12 breaths/min. Neurological examination and other physical examination was normal. There was any focal neurological deficits. The Glasgow Coma Scale was normal, as were the deep tendon reflexes. Optic fundi were normal. Because of refractory headache, cranial computed tomography (CT) was taken. It revealed a giant hypodense image in deep temporal and frontal lobe, occupying lesion isodens with cerebrospinal fluid and it was suppressing the frontal, temporal, and parietal lobes. he was consulted to neurosurgery specialist. He was being followed by brain surgery for operation decision after MRI Scan.

Conclusion: Symptomatic arachnoid cysts remain rare in the elderly, which is probably due to their very slow development. Symptoms usually consist of headaches, with or without seizures or neuropsychological disturbances. Their management is still controversial; if surgical treatment is decided many techniques are possible with no consensual indication, probably because of the absence of long term follow-up. In serious cases, symptoms may become life threatening. Radiological imaging should be performed for the patients presenting to the emergency department with recurrent headaches.

Keywords: Arachnoid cyst, headache, radiological imaging

P-0391 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

One Week of Analgesic Resistant Headache: Spontaneous Subarachnoid Hemorrhage

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Objective: When there is a bleeding inside of the subarachnoid space, it is called subarachnoid hemorrhage and it accounts for a small portion of all emergency department visits and needs to be treated correctly and acutely to prevent life-threatening outcome of patient. Patients with subarachnoid hemorrhage generally define their pain like "thunderclap", "sudden onset", "it is maximum in minutes". But we present an interesting complaint of a 'neurologically normal' patient who defines his pain as "analgesic resistant for one week, it is not the worst ever but different than others", then found out that he had spontaneous subarachnoid hemorrhage.

Case: 60 year old male patient was admitted to our ED with headache which he described as analgesic resistant for one week and he said that he had headache before when his blood pressure was high, but this headache was in a different character. His medical history includes hypertension and diabetes, he uses gliclazide, metformin, valsartan w/ hydrochlorothiazide. His sensory, motor, cerebellar examination was normal, pupils were isochoric, pupillary light reflex was normal. GCS:15. Blood pressure:190/88 mm/Hg, body temperature:36.7C, pulse:77, saturation:95%, peripheral glucose level:244. We administered 500 mg of paracetamol followed by 70mg of tramadol, blood pressure was 170/75 after 1 hour of follow-up but there were still headache. His laboratory results were normal, there were neither acidosis nor ketosis which could have been complication of diabetes, so it didn't help us to diagnose to origin of his headache. So we concerned about an intracranial pathology and decided to perform head ct due to his headache was "in a different character than others". We revealed subarachnoid hemorrhage in left temporal and frontal lobe and in sylvian fissure. Patient then was admitted to neurosurgery department for further follow-up and operation.

Conclusion: Risk factors of subarachnoid hemorrhage includes hypertension, smoking, alcohol consumption, polycystic kidney disease, family history of intracranial bleeding, coarctation of the aorta, marfan and ehler-danlos syndrome type 4. There was only hypertension as risk factor. What makes our case interesting is that there wasn't any classical presentation of subarachnoid hemorrhage and there was no trauma history. Our patient was physically and laboratorily normal. The only symptom was "this headache has different quality and intensity". Usage of non-steroids might cause size of the hemorrhage. As emergency medicine clinicians, we have to concern about patient's new description of his pain.

Keywords: subarachnoid hemorrhage, headache, emergency department

P-0392 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Haemorrhage or Mass? Acute Interdural Hematoma

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Objective: Although intracranial hematomas are a common event following trauma or neurosurgical operation in adulthood, they are rarely present between two layers of dura mater. We present a case of interdural hematoma.

Case: A 73 year- old -male patient who had the sudden loss of power in the right arm and leg was brought to emergency service by 112. According to information received from relatives, he had a headache which was started before the arriving at the hospital about one hour ago and his consciousness became worsening. In the patient's history, he had hypertension, asthma and congestive heart failure. His vital signs were normal. (The blood pressure: 117/69, heart rate: 68, respiratory rate: 18, satO2: 93, fire: 36.4 C). His consciousness was lethargic. Light reflex was taken bilaterally and there was no anisocoria. There was a hemiplegia in the right upper and lower extremity and he had babinski sign at the right. There was no urine and fecal incontinence. Other system examinations were normal. Brain CT was requested with the initial diagnosis of cerebrovascular disease. In the CT; a hyperdense formation which was limited regularly and adjacent to brain parenchyma in the left edge of oksipitoparietal region was detected. Brain MRI and diffusion-weighted MRI was obtained to distinct whether this hyperdense formation was a mass or a bleeding. There was no limitations in the acute diffusion-weighted MRI. In the brain MRI, an approximately 45X26 mm in size, well-circumscribed hyperintense on T1, T2 hypointense space occupying formation in all sequences which is located extra-axially was observed at the level of the vertex adjacent to the central sulcus. This lesion was initially evaluated as mass. Brain surgery consultation was requested. The patient was admitted to neurosurgical intensive care unit for operation. A intracranial space occupying lesion, approximately 5.5X5X2 cm in size and compatible with hematoma which is coated with dura, was detected in the operation material. Bleeding had occurred between two layers of dura and so hematoma had formed.

Conclusion: Interdural hematoma is a rare entity in adulthood and commonly presents in the convexity of brain. It can originate in branches of meningeal vessels, such as the middle meningeal artery. Preoperative CT scan is not sufficient for precise diagnosis due to the similarity in appearance of interdural hematoma and epidural hematoma. MRI findings provide a correct diagnosis. Removing the hematoma and suturing the dura layers to each other is sufficient to manage the condition.

Keywords: haemorrhage, interdural hematoma, mass

P-0393 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Lateral Patella Dislocation Following a Domestic Accident: Case Report

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Objective: Dislocation of patella, the largest sesamoid bone of the body, is a case that is rarely encountered in emergency service. Dislocations can be successfully reduced in emergency departments and the patient can be discharged. The current study presents a case of patella dislocation following a domestic accident, which was reduced in the emergency department and discharged.

Case: A 43-year-old female patient was admitted to the emergency department with complaints of severe pain in the right knee and unable to step on her foot. The anamnesis revealed that her complaints first began after running into the refrigerator door. The physical examination showed that the patient's overall condition was good with stable vital signs. On inspection, edema and deformation were observed on the right knee (Figure 1). Lateral dislocation of the right patella was detected by palpation with the inability to perform active and passive movements. Other systemic examinations of the patient who had no motor, sensory, or vascular deficits, were normal. The patient's bilateral knee arthrography revealed a dislocated patella (Figure 2). Following intramuscular analgesic administration to the patient, the patella was reduced by medially applying force to the patella while the right leg was in extension. A long leg splint was applied. Analgesic and anti-inflammatory drugs were prescribed and the patient was then discharged with instructions to follow-up in an orthopedic clinic.



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Discussion: Traumatic dislocation of the patella occurs due to aligned or non-aligned extensor mechanisms. On the other hand, most patella dislocations are lateral and occur after sports injuries. Being acute, patellar dislocations can also recur, and if this is the case, the patellofemoral ligament is surgically repaired. It is important to diagnose patellar dislocation in the emergency department. Vascular injury in distal extremities should also be considered and knee arthrography should be taken both before and after reduction.

Conclusion: An accurate diagnosis is the first condition of proper treatment of patellofemoral diseases. Patellofemoral dislocations can be diagnosed in emergency departments and uncomplicated patients can be managed. The emergency physician should carefully monitor for any complications, considering that some of the cases could have fractures.

Keywords: Patella, Dislocation, Accident

P-0394 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Cause of Headache in Emergency Service: A Giant Arachnoid Cyst

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Objective: Although chronic headaches are a frequent cause of admission to emergency clinics, it should be kept in mind that they could present with fatal clinical diagnoses, which could be overlooked as chronic headaches are commonly seen in society, and they generally present as tension or migraine headaches. Effective examination of the patients medical histories and clinical evaluation without any prejudice are important to prevent this situation. We aim to present a case that was admitted to the emergency medicine clinic with complaints of headache and was diagnosed with a giant arachnoid cyst.

Case: A 49-year-old male was patient admitted to the emergency service with complaints of increasing headache. The physical examination revealed the following Results: Blood pressure: 135/90 mmHg, Pulse: 86/min, Temperature: 37 °C, Respiratory rate: 14/min and Glasgow coma scale: 15/15. He had no stiff neck and the neurological examination revealed no deficits. The computerized tomography (CT) that was performed to identify the etiology showed a mass of approximately 6x3 (5x8 cm at its largest) filling the left temporal lobe and a Sylvian fissure, extending into the centrum semiovale (Figure 1). The magnetic resonance imaging (MRI) that performed for the differential diagnosis found that the lesion was consistent with an arachnoid cyst (AC) (Figure 2). Symptomatic treatment was administered and the patient was discharged with instructions to follow-up at a neurosurgery clinic.

Discussion: AC, which are cystic lesions localized in the extracranial region between the dura and the brain, constitute approximately 1% of intracranial masses. Although AC have a congenital origin, they can develop due to inflammatory or traumatic causes. They are benign lesions, which are uniformly bound, demonstrating the same signal and density characteristics with CSF, not containing calcification and contrast enhancements at CT or MRI.

The symptoms typically begin at an early age. Symptom occurrences decrease with increased age and some giant arachnoid cysts even become completely asymptomatic, diagnosed accidentally during autopsy. Obscure symptoms and normal clinical examination of the current case seem to be the most important factors resulting in difficulty in diagnosis.

Conclusion: Complaints of headache are a common form of admission to emergency services. In addition to being a disease alone (migraine), headaches might be precursors of other diseases (e.g., bleeding or intracranial space-occupying masses). Therefore, it is very important for the emergency physician to make an accurate and effective differential diagnosis.

Keywords: Arachnoid Cyst, Headache, Emergency Service

P-0395 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

It Seems Like It is Panic Attack Again but This Time It is Brain Tumor

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Objective: Brain tumors may present with a large spectrum of signs and symptoms according to their size, type, and location. Complaints of some patients' may really resemble complaints of a panic attack patient. Herein we presented a case of a brain tumor in a patient with panic disorder history.

Case: A 40-year-old female patient presented to our emergency room with complaints of blurring of vision, headache, and numbness in tips of her fingers and toes of both hands and feet. She was a patient whom we know very well because she had panic disorder and come to our emergency room with different complaints so many times. We also learned that she went to an ophthalmologist due to her complaint of blurred vision in the same day, and she was prescribed eyeglasses but her vision did not get better, and a headache started after wearing eyeglasses. Her vital signs were normal. The only pathological finding we found in her physical examination was a hardly visible strabismus. When asked she said that she had never had strabismus till that day. So we sent her to the imaging unit with possible diagnoses of stroke and brain tumor for computed tomography scan of brain, and it showed a prominent cerebral edema in right temporoparietal region, and a mass lesion approximately 5 cm in diameter in the center of that edematous area. Then intravenous contrast enhanced magnetic resonance imaging (MRI) of brain was performed, and a 4 X 4.5 cm mass lesion with periperal contrast enhancement was detected. Edema of surrounding tissues was also prominent in MRI. Dexamethasone 16 mg was given i.v. and intravenous infusion of 300 cc of mannitol 20 % solution was started at a rate of 500 cc per hour for cerebral edema, and the patient was hospitalised in neurosurgery clinic.

Conclusion: Complaints of a patient should not be attributed to panic disorder or somatoform disorders unless a careful physical examination is performed even if he has a history of these psychiatric disorders because some symptoms which may be seen in these conditions may also be a clue of an important organic medical problem as it was in this case.

Keywords: Brain tumor, panic disorder, strabismus

P-0396 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Spleen Infarction in Congenital Afibrinogenemia: Case Report

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Objective: Congenital afibrinogenemia is a rare, autosomal recessive hemorrhagic disorder. Most often, patients with congenital fibrinogen disorders suffer from a bleeding diathesis but paradoxically may undergo severe thrombotic episodes.

Case: We describe a case who was a twenty-three-years-old man with a known case of congenital afibrinogenemia who presented abdominal pain and he was diagnosed as having spleen infarction. Fresh frozen plasma replacement was started in emergency department and patient was consulted with general surgery. He was admitted to the surgical ward for four days where he was given intravenous fluids with his oral intake restriction. Fresh frozen plasma and fibrinogen therapy were also ordered. His condition improved clinically within four days after admission. He was discharged immediately after improvement. No problem was observed during the follow-up period.

Conclusion: Because of various presentations of patients with congenital fibrinogen disorders, thrombotic events should be considered.

Keywords: Spleen infarction, Afibrinogenemia, Fresh frozen plasma

P-0397 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Hip Fracture In An Asymptomatic Osteoporotic Patient Diagnosed Alzheimer's Disease

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Objective: Fractures of proximal femur are common among elderly people. They are associated with considerable morbidity and mortality. Osteoporosis is commonly present in the heads of femurs. Insufficiency stress fractures of the femoral neck in the elderly are not uncommon, but unless suspected, the condition can be easily overlooked.

Case: A 82 years old female patient brought by relatives of patient to the emergency department with complaints of yelling with discomfort for two days. Her initial vital signs were normal. In her medical history we learned that she had Alzheimer's for 5 years and osteoporosis for 18 years and taking medication for those diseases. We couldn't learn medical history from the patient because of her agitation. When we asked whether she had pain we couldn't take any answer. In her physical examination we examined every bone with palpation and checked joints ROM's for a suspicious fracture. We couldn't find any evidence that suggest fracture and her relatives didn't mention any falling down. In her laboratory tests, her electrolytes, renal and liver functions were normal. She had an only 16.000 leukocytosis predominantly neutrophils but with no fever and no brudzinski sign. She was sedated with midazolam. Her computed tomography of brain was normal then we planned lumbar puncture and consulted to infectious diseases. Her cerebrospinal fluid findings were in normal range and ruled out meningitis. Even she had asymptomatic for fracture x-ray of pelvis and hips applied and subcapital fracture of collum femoris on the left detected. She consulted to orthopedics and they hospitalized her for



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surgery. After surgery and 8 days follow-up she discharged with medication.

Conclusion: The diagnosis of stress fractures in patients with rheumatic diseases may often be delayed or missed, and thus improperly treated. Increased awareness of this entity is of importance for prompt diagnosis and correct management. Even the patients are asymptomatic for fracture in osteoporotic Alzheimer's patients x-rays should be seen carefully.

Keywords: hip fracture, asymptomatic, alzheimer's, osteoporosis, subcapital fracture

P-0398 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Presentation to emergency department due to intraocular foreign body injuries

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Objective: Ocular traumas are yet among the most important causes of vision loss and low vision, decreasing the quality of life. Even the most minor injuries cause pain and discomfort, leading to labor loss and costs of treatment and care. Foreign bodies cause damage to the eye mainly through two ways. First, penetrating injuries and related complications which they cause and second, damages developing as a result of infection, toxicity and inflammatory reactions due to foreign body itself. Such ocular injuries usually lead to diffuse damage and poor visual prognosis. Young adults, especially males expose to industrial and agricultural accidents. However, anatomical and functional results can be satisfactory with proper surgical methods applied in the early period.

Case: A 41 years old male patient presented to the ED due to penetrating ocular injury in the left eye and intraocular foreign body (Image 1). Computed tomography of the patient was ordered (Image 2), ophthalmology department was consulted and he was referred to the Süleyman Demirel University, Medical Faculty, Ophthalmology Department. His right eye's vision was full and all the examination findings of this eye were normal. Whereas, left eye had the following Findings: vision 0.2, intraocular pressure hypotonia; and on biomicroscopy; cornea was hyaline, lens intact and there was a foreign body at the level of 2 o'clock from the peritemporal in about 7-8 mm away from the limbus. Haemorrhage was observed on the fundus examination. The patient was immediately taken to surgery, intraocular body was removed and primary perforation repair was carried out. The patient who had no any problem during the postop follow-ups was discharged with recommendations.

Conclusion: In conclusion, removal of intraocular foreign bodies requires a complicated surgery. The most appropriate surgical technique must be selected considering the location, size and nature of the foreign body. It is possible to achieve better anatomical and functional results in such patients through proper case selection, good surgical planning and use of the correct methods.

Keywords: emergency service, intraocular foreign body, ocular trauma

P-0399 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Rectus Sheath Hematoma: En Garde, If Not Touche

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Objective: Rectus sheath hematoma is a condition in which damage to the superior or inferior epigastric arteries or direct tear of the muscle itself leads to bleeding. Causes include external trauma, previous or recent surgery, rigorous contractions of the muscle due to excessive coughing, strenuous exercise or Valsalva maneuvers, and anticoagulation.

Case: Our case is 72 year old woman who presented to our emergency department with vertigo and oliguria. She was on anticoagulant therapy for 7 months and had a history of heart failure, atrial fibrillation, and goiter. Her vitals revealed; pulse rate: 120, arterial blood pressure: 100/60, oxygen saturation: 90, body temperature: 38 C. On physical examination, she had a palpable mass on the left lower quadrant of her abdomen. Urinary output was less than 10 ml/hour. Ultrasound was performed and a heterogeneous cystic supravescal mass in the left paramedian pelvic cavity was detected. MRI revealed a pelvic hematoma of 15x12x8 cm diameter in the rectus sheath compressing the left ureter and aorta. She was hospitalized for further follow-up and treatment to general surgery department. Anticoagulation was stopped, she was discharged after 8 days and general surgery and cardiology follow-ups were planned.

Conclusion: Rectus sheath hematomas can be large enough to deplete intravascular volume leading to hypovolemic shock and may lead to death if not diagnosed early. We want to remark that emergency medicine physicians should suspect rectus sheath hematoma in any patient who presents with abdominal mass /pain especially on anticoagulants or if he/she is a victim of trauma.

Keywords: Rectus sheath hematoma, anticoagulation, oliguria

P-0400 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Rapidly Fatal Necrotizing Fasciitis Presenting as Bilateral Breast Necrosis

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Objective: Necrotizing fasciitis (NF) is an uncommon but potentially fatal condition that can affect any part of the body. It was first described in a specific body region by Fournier in 1883 and as a more generalized condition by Meleney in 1924. The use of the term "necrotizing fasciitis" can be attributed to Wilson in 1952. NF is characterized by necrosis of the fascia and subcutaneous tissue with relative sparing of underlying muscle. The etiology is not fully understood but most patients have pre-existing conditions. Diagnosis is often delayed and still primarily a clinical one and a high index of suspicion is required. Management options include immediate resuscitation, early surgical debridement, and administration of broad spectrum intravenous antibiotics. We report a case of NF involving the breasts bilaterally, and had a fulminant course leading to death within 12 h of presentation.

Case: A 56-year-old obese female patient with a history of diabetes mellitus and hypertension was presented emergency department with the chief complaint of bilateral mastalgia, and erythema, bruising, and peeling of bilateral breasts for 7 days. On admission, she had a temperature of 38.7 °C, respiratory rate of 24 / min, pulse rate of 98 / min, and blood pressure of 80/50 mmHg. There was massive enlargement of both breasts with erythema and peeling of the overlying skin. The breasts were warm, tender, and edematous, with an intense anaerobic odor. Laboratory work up showed leukocytosis (48100 µL), hyperglycemia (532 mg/dl), acute renal failure (BUN: 236 mg/dl, and creatinine: 3.4 mg/dl), hyponatremia (123 mmol/L), and metabolic acidosis. The patient was diagnosed with severe sepsis. Management was initiated by rapid intravenous hydration and empirical antibiotic regimen comprising meropenem, and piperacillin-tazobactam. With worsening blood pressure, intravenous dopamine infusion was initiated. The patient was taken to the operating room. While the radical breast debridement was planning, the patient developed cardiac arrest. Despite cardiopulmonary resuscitation, the patient died.

Conclusion: In conclusion, we report a case of fulminant NF presenting as bilateral breast necrosis. Despite the rarity and unusual presentation, this case illustrates the significant mortality that can be associated with NF infections. Emergency physicians should not forget that a high index of suspicion is required to diagnose NF and an aggressive resuscitation, rapid surgical debridement, and broad-spectrum antibiotic therapy are cornerstone of the management.

Keywords: Necrotizing fasciitis, severe sepsis, soft tissue infection, emergency department

P-0401 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Bullet seen in urethra after gunshot injury

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Objective: Gunshot injuries are one of the most common cause of administration to the emergency department. Rectal and genitourinary injuries can be seen in pelvic region injuries. If there is an ureteral injury, blood in urine, urine extravasation from the injury tract or hematoma in injury tract can be seen. If we see these signs we have to be alert and we must not place an urinary catheter for avoiding from additional injuries. We are presenting urethral injury case, bullet was seen in urethra, with gunshot injury and bloody urine administrated to our emergency department.

Case: 65 year old man; administered to our emergency department with pelvic gunshot injury. He had no abdominal injury sign. He was suffering from bloody urine. In physical examination GCS:15, TA: 130/80 mmHg, Pulse rate:105, Ventilation rate: 22, Fever:36.5, Oxygen Saturation: %97. In pelvic evaluation gunshot wound was seen 2 cm posterolaterally away from anal verge. There was no pain in abdominal palpation. Rectal wall injury wasn't seen in rectal examination and rectal sphincter tone loss wasn't seen. In laboratory evaluations WBC:9650, Hb/Htc: 12.2/33.2, LDH:482, Ürea: 39, Creatinin:1.14. In plane graphy bullet was seen in the anterior of the symphysis pubis. Pelvic contrasted CT was performed to the patient with gunshot injury



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of pelvic region as preliminary diagnosis. In CT evaluation a hiperdens metallic subject was seen in the radix of penis. Patient was emergently operated by Urology Department. Cystoscopy was performed before the operation in the operating room and gunshot bullet was seen in the urethra of the penil radix. Incision was performed under scrotum. Urethra was injured partially from the posterior region and bullet was seen in the urethra. After taking the bullet from urethra, an urinary catheter was placed and posterior wall of the urethra was sutured. In follow up period there wasn't any problem seen and patient was discharged with urinary catheter.

Conclusion: Genitourinary system injuries must be kept in mind and uncontrolled urinary system catheterization mustn't be performed in pelvic injury patients.

Keywords: Gunshot wound, Pelvic injury, Urethral injury

P-0402 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

An ileus cause should be kept in mindin adults: ileoileal intussuception caused by extraluminal mass

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Objective: Intestinal intussusception or invagination is seen mainly in childhood but 5 percent of the cases is seen in adults. Patients are generally complaining with ileus symptoms (abdominal distension and pain, nausea and vomiting). Plane graphies can show ileus but contrasted CT evaluation is more helpful for the diagnosis. Underlying neoplastic lesions was the cause of %90 of the cases. We are presenting a jejunojejunal intussusception case administering to our emergency department with ileus symptoms.

Case: 48 years old woman was administered to our emergency department with abdominal pain, distension, nausea and vomiting. These symptoms were started two hours ago. She has no abdominal operation history. In physical examination TA:120/70, Fever:36.7oC, pulse rate:100, ventilation rate:18, oxygen saturation: %98. Distension was seen in inspection and general abdominal pain was seen palpation. In laboratory evaluation WBC:11.36, PLT:408000, NE%79, HB:11.1, HTC: 33.8. There wasn't any significant changes in the biochemical evaluation. In plane graphy air-fluid levels was seen. With ileus preeliminary diagnosis contrasted abdominal BT was performed. In the tomographic evaluation ileoileal intussusception signs (target sign of the ileal tissues) seen in the right low quadrant. After the diagnosis General Surgery Department operated the patient emergently. In the operation extraluminal mass which causes ileoileal intussusception was seen. This tissue was removed and end-end ileoileal anastomosis was performed. After follow up patient was discharged without any problem.

Conclusion: If there isn't any abdominal operation history, ileoileal intussusception can be a cause of ileus in patients administering to emergency department with ileus.

Keywords: Acute abdomen, Ileus, Intussusception

P-0403 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A rare complication of appendectomy: Stump appendicitis

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Objective: Appendectomy, which is the most frequent one among the emergency cases of general surgery and probably will be encountered by 7% of all the people, is possibly the first operation of many general surgeons. Complications including wound site infection, postoperative bridge ileus, intra-abdominal abscess or leakage from the appendectomy stump can be seen, even rare. An even rare complication from these is the appendectomy stump seen in cases that complete appendectomy had not been performed. The stump appendectomy that first described by Rose in 1945 is seen in 1 case out of 50,000 cases. The most serious dilemma is the history of appendectomy of the medical history of patients. Experience and suspicion of the clinician are the most important factors in the prevention of the potential complications.

Case: The twenty-six year-old male presented in the emergency room with abdominal pain started two days ago around the umbilicus and then settled in the lower right quadrant, nausea and vomiting. It was found out that he had undergone appendectomy when he was paying his military service. Vital signs were normal in the physical examination. Mc Burney incision scar was present. Tenderness, muscular defense and rebound defense were positive in the lower right quadrant. WBC was 15.800/mm³. Plain lung and abdominal x-rays were positive. In the abdominal ultrasonography (USG), an appearance consistent with non-compressed appendectomy appendicitis 5 cm in length and 9mm in diameter was seen together with edema of caecum. Appearance consistent with acute appendicitis 5 cm in length with retrocaecal subserous location was found in the abdominal computerized tomography (CT) (Figure 1). Appendicitis with retrocaecal location was present in the laparotomy made through the previous Mc Burney incision. Appendectomy was completed. The patient was discharged with cure in the postoperative day 2. Histological evaluation was reported as appendectomy stump.

Conclusion: Appendectomy stump is a rare complication of appendectomy. In general, 68% of the patient present with perforation. It can cause life-threatening complications in patients if not suspected. The appendectomy stump must be kept in mind in patients presenting with pain in the lower right quadrant and acute abdomen picture, even if the patient had undergone appendectomy previously.

Keywords: Morbidity, Mortality, Stump appendicitis

P-0404 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Is distortion areliable procedure in sigmoid volvulus? Introduction

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Objective: Volvulus can be defined as the rotation of an intestinal segment around its axis and causing complete or partial obstruction. The most frequent location of colonic volvulus is the sigmoid colon with 65%. We wished to share with you our approach to the patients who applied to our Emergency Room with colonic volvulus complaints.

Materials-Methods: Patients who applied to Emergency room with abdominal pain, distension and inability to pass gas or stool between January 2010 and December 2013 and treated and followed-up in the General Surgery Clinic for sigmoid volvulus (SV) were examined retrospectively. Total 58 patients were followed-up. Since the data of 6 of these patients were missing, and another 3 were referred to elsewhere, these were excluded from the study and the study was carried out on the remaining 49 patients.

Patients were seen in the emergency-room and were taken to follow-up. Patients without acute abdomen findings at the time of diagnosis were decompressed using rigid retroscope or flexible sigmoidoscope. Patients that peritoneal irritation signs developed, with progressive increases in WBC and/or decompression procedure was not successful or those with perforation were taken to surgery.

Results: Forty-one patients (83.6%) were males and 8 (16.4%) were females. The mean age of the patients was 72.6±18.4 years (range: 48 – 91). The mean WBC value of the patients was found as 11.320±2.750. Emergency surgery was performed on 7 patients presented with acute abdomen findings and that ischemia was suspected; sigmoid resection with primary anastomosis for 3 of these patients, and Hartman procedure was performed on 4.

Sigmoidoscopic distortion was attempted in 42 patients. Perforation developed in 2 out of five that distortion was unsuccessful. Resection and anastomosis was applied in one of these patients, and resection and Hartman procedure was applied in four. Three of the patients died that surgery was performed on (perforation occurred in one of these during distortion). Fifteen patients out of 37 (75.5%) that conservative treatment was successful accepted elective surgery. In the patients who refused elective surgery, recurrence was seen in 3 patients in the early period and in 8 patients in the late period.

Conclusion: We think that sigmoidoscopic distortion in SV is a reliable option that should attempted in the first place both for the diagnosis and as a chance for cure for the patients.

Keywords: Acute Abdomen, Sigmoidoscopic Distortion, Sigmoid Volvulus



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P-0405 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A rare acute abdomen reason: Gossypiboma

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Objective: Gossypiboma, in other words, forgetting non-absorbed materials that are used in surgical operations in the peritoneum cavity is a rare but preventable medical error. The most frequent reason is the buffers in gauze-bandage structure forgotten during the operation. Other than this; needles, small objects and all kinds of tools included in the surgical set can be potentially forgotten in the abdomen.

In this essay, we are presenting a 58-year old female patient who applied to hospital complaining from stomach ache and nausea which had been continuing for around 4 days and who was diagnosed with gossypiboma.

Case: The fifty eight year old female patient applied to emergency service with complaints of stomach ache, nausea and lack of appetite that have been continuing for four days. In her story; it was learned that she had undergone a hysterectomy operation six years ago and she had been suffering such complaints for around 4 years. Finally, she said that the stomach ache that started four days ago had gradually become stronger. In physical examination of the patient, the vital symptoms were: TA:140/80mmHg, Fever:38.4 °C, pulse:110, respiration number:18. In the physical examination, there were sensitivity and defense in left upper quadrant. Directly abdominal graphy was applied to the patient and then abdominal USG was made. In the abdominal USG, mesentery eco increase was observed in the left upper quadrant and increase in thickness was observed in the intestine peripheries. In this area, an edematous appearance and fluid collections, which were measured as 22x10mm at the widest point, were observed. Acute abdomen pre-diagnosis was made on the patient with the current clinical and radiological findings and urgent abdomen tomography was taken. In the tomography, foreign substance and secondary reactions depending on this were detected.

An operation was performed on the patient by the general surgery clinic. In the exploration that was performed by median incision at upper side of umbilicus; it was observed that small intestine had formed a gatto around the gauze-bandage buffer in 15-20 cm dimension in the left upper quadrant of the abdomen and that there was intestine perforation. Around 40 cm of the small intestine, which had been perforated and necrosed with the buffer, was resected. The patient was discharged from the hospital without problem on the 6th day postoperatively.

Conclusion: Gossypiboma, which is a rare complication of surgery, should be considered in differential diagnosis in cases with an operation history.

Keywords: Acute Abdomen, Abdominal Pain, Gossypiboma

P-0406 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

The diagnosis of aortic dissection in a poisoning case

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Objective: Aortic dissection occurs as a result of filling blood into the aortic wall due to the tearing of aortic intima and media layers. Its incidence is 5-10 cases / million / year. Males are affected three times more than females. Early diagnosis is a life saver in this disease, and mortality increases with every passing hour. Primarily, we should have doubts about the presence of this disease for early diagnosis. In this article, 56-year-old patient who was brought to the emergency department with complaints of poisoning and diagnosed aortic dissection was presented.

Case: A 56 years old male patient who has not any known disease was brought to the emergency department by ambulance with complaint of pesticide poisoning occurred during disposing of medications in the field. The patient had no complaints except respiratory distress. The patient was conscious, orientated, cooperative, arterial blood pressure: 100/60 mmHg, pulse rate: 82 / minute and SaO₂: 94% (without oxygen). Physical examination revealed no pathological findings. There is no difference between bilateral pulses. The electrocardiogram was normal. There was no toxicological findings. The mediastinum and aortic arch were wide in chest X-ray. Type 1 aortic dissection was detected in contrast thoracic CT, and patient underwent urgent surgical operation. The patient was discharged from the hospital with full recovery after 1 month.

Conclusion: The most important step in the diagnosis of aortic dissection is clinical suspicion.

Keywords: aortic dissection, emergency, diagnosis

P-0407 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A rare cause of acute abdomen: hematoma in the rectus sheath

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Objective: Only one-third of the case with acute abdominal pain, which constitute 5 to 10% of the applications to emergency rooms are related to pathologies included in surgical areas. A rare cause of non-surgical pathologies is the hematoma in the rectus sheath. Although it is located below the umbilicus generally, they can also be located in the upper quadrants of the abdomen. Hematomas under the semicircular line can cause irritation of the peritoneum and create a picture resembling the acute abdomen. Erroneous diagnosis can lead to unnecessary laparotomies accompanied by high levels of morbidity and mortality. The best way to prevent unnecessary laparotomy is a proper clinical evaluation in the emergency room. It must be kept in mind that patients particularly with abdominal traumas and operations, subcutaneous drug injections, anticoagulant therapy and hematological disorders are under risk.

Case: The fifty-four year old male presented in the emergency room with vomiting followed by abdominal pain with sudden onset after taking alcohol a few hours ago. The patient was diabetic and was using antidiabetic drugs. There are no anticoagulant drugs in his history. Physical examination revealed tenderness with palpation in the right lower quadrant and a mass that borders could not be felt clearly. Intestinal sounds were normo-active. He did not describe nausea and vomiting. Hemodynamic findings were stable, and laboratory findings were within normal limits. In the ultrasonogram taken with diagnostic purposes, a hematoma was seen along the right rectus abdominis muscle that reached 12x7 cm at the widest location (Figure). The patient was consulted (with the surgeons) in the emergency room, and surgical intervention was not considered. He was followed-up for any bleeding, and the serial hemotocrit follow-ups did not show any falls, the hemodynamic course was stable, and no enlargement of the hematoma was seen. The patient was discharged after a non-operative follow-up of 8 hours.

Conclusion: Hematoma of the rectus sheath is a pathology that is poorly-known, diagnosis can be possible only if suspected, not requiring surgical intervention and generally improves with conservative treatment; however, the differential diagnosis with the surgical acute abdominal masses and intraabdominal masses must be made by all means.

Keywords: acute abdomen, hematoma, rectus sheath

P-0408 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Intraabdominal closed perforation in a patient with high fever

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Objective: Perforation is defined as the opening/rupture of the gastrointestinal system into the abdominal cavity. It may present itself as typical physical examination and laboratory findings. But in the case of late presentation to the emergency department it may be fatal within minutes or hours. Here we present a case of perforation without signs of acute abdomen.

Case: A 64 years-old female presented to our emergency department with complaints of fever and malaise/weakness since 5 days. She was conscious, cooperated and oriented, and her general appearance was intermediate. Her vital signs were as following: Blood pressure, 100/70 mmHg; heart rate, 98/min; respiratory rate, 17/min; body temperature, 38.8 °C. Her neurological, respiratory and cardiac examination was normal as well as abdominal examination except an operation scar on the left knee. There was no abdominal tenderness. She has been operated 20 days ago for knee prosthesis. Three days after the operation, she has suffered an abdominal pain lasting 3 days. She was given antiinflammatory medication during hospitalization after



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the surgery. Although her physical examination did not give any clue for the focus of fever, her laboratory examination revealed following pathological Findings: Hemoglobin, 7.3; Htc, 20.9; leucocytes, 14.6; AST, 45 U/L; ALT, 65 U/L; ALP, 190 IU/L; CRP, 31 mg/dL; urinalysis, 1-2 leucocytes, 2-3 erythrocytes. Her plain radiographs of chest and abdomen were almost normal. Her abdominal ultrasound could not detect any pathological finding. Abdominal tomography with intravenous contrast revealed free air around liver, fluid loculations with air measuring 6X11X12 cm in right paracolic area, 3x4.5x6 cm in right perinephric area, and 2.5x3x3 cm in inferior of third part of duodenum. The patient was diagnosed as closed duodenal perforation and secondary intraabdominal abscess. The patient was operated by the general surgeon and discharged at the tenth day.

Conclusion: Intraabdominal abscess must be included in the differential diagnosis of fever. Clinical suspicion of closed perforation of the intraabdominal viscera should be in mind in patients with recent abdominal pain who are on antiinflammatory medication.

Keywords: Computed tomography, Duodenal perforation, Emergency Department, Intraabdominal abscess

P-0409 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Secondary Spontaneous Pneumothorax Due to Metastatic Lung Cancer

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Objective: Primary spontaneous pneumothorax (PSP) is defined as a pneumothorax with a normal lung x-ray, however the pneumothorax with an abnormal lung x-ray is called secondary spontaneous pneumothorax. The cause of the secondary spontaneous pneumothorax in 60% of the patients is chronic obstructive pulmonary disease. Besides, asthma, interstitial lung diseases, tuberculosis, lung cancer, lung infarcts and pneumonia cause pneumothorax. We presented a case of secondary spontaneous pneumothorax in a patient with metastatic lung cancer diagnosis.

Case: A 70 year old man suffering from nausea, vomiting, diarrhea and long term dyspnea presented to emergency department. He had a history of hypertension, diabetes and colon cancer with a lung metastasis. The patient had 4 cures of chemotherapy and the last cure was taken a week ago. After the last cure he was suffering from nausea, vomiting, stomachache, diarrhea and long term dyspnea. His blood pressure was 120/80, pulse rate was 88 bpm, respiratory rate was 16/min, 82% of pulse oximeter O2 saturation and body temperature was 36.6 C0. Auscultation of the lung he had deep breath sounds on right hemithorax while there was no breath sound on left hemithorax. On abdominal examination he had hyperactive bowel sounds but he had no tenderness. 6 lt/min O2 was given. Thorax tomography showed total pneumothorax on the left lung and mediastinal shift to the right. Needle decompression with 14 gauge IV catheter midclavicle line was introduced just above the rib at the second intercostals space and then chest tube was inserted. O2 saturation increased dramatically. His laboratory results showed that leucocytes was 500, neutrophils was 300 and c-reactive protein was 25. The case was consulted with chest surgeon, internal diseases specialist and infection diseases specialist. With a diagnosis of pneumonia and neutropenic fever treatment was began. The patient was interned to the intensive care unit.

Conclusion: For the first time in 1937, Barrin defined that secondary lung carcinoma was an unusual cause of pneumothorax. It is stated that tumors related to pneumothorax were Ewing sarcoma, Wilm's tumor, malign melanoma, cervix, pancreas and kidney carcinoma, leiomyosarcoma and osteogenic sarcoma in the literature. Contrary to the literature, in our case the lung metastasis resulted from the colon cancer. In conclusion, secondary spontaneous pneumothorax should be kept in mind when evaluating the respiratory system of the patients who present to the emergency department suffering from atypical symptoms and findings, especially with a history of metastatic lung cancer.

Keywords: Emergency, Lung Cancer, Pneumothorax

P-0410 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Cause of Syncope Celiac Aneurysm Rupture

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Objective: Celiac trunk aneurysms are rare and constitute approximately 4% of all splanchnic aneurysms. Celiac artery aneurysms typically sixth decades of life in the majority of patients are symptomatic. The most common symptom is abdominal pain. The most important complication is rupture into the abdominal cavity and in most cases will be correct. Rupture is difficult to predict and nearly all mortal.

Case: At the age of 57 male patient come to the emergency department with syncope. Story of the patients is pilot and in today's flights was learned that abdominal pain. Air field doctor during the examination write swoon was referred to our hospital by ambulance on. Resume feature is not available in. On examination, gks 15, co-operation and orientation, complete blood pressure of 110/60, pulse 90beats/minute, fever 36.7, oxygen saturation 95, blood sugar 134, S1-S2 rhythmic, no murmur, peripheral pulse deficits, neurological examination and breathing natural, epigastric and right upper quadrant tenderness in the abdomen, stool rectal examination was forme. EKGs taken on arrival in the emergency department was normal sinus rhythm and blood gas values were normal. There was no bleeding in the brain CT radiologic imaging and diffusion MRI, there was no infarction in. Blood tests had decreased hemoglobin and other blood values were normal. Check ECG was normal sinus rhythm. Monitoring and hydration were performed. Follow-up of 6 hours of continuing complaints and advanced imaging was performed on a drop in blood pressure. Contrast-enhanced abdominal subhepatic area of btd covering the right half of the abdomen, duodenal ans surrounding the lateral contour, surrounding the right flexure, flexure consistent with hemorrhage, obstruction of forming common liquid density values that were detected. Hemorrhage in the middle area of about 1 cm in diameter, showing intense contrast enhancement compatible with aneurysms and hemorrhagic fluid in the peritoneal vascular structures to draw attention paracolic for rear leaf area and also in mesenteric adipose tissue is observed in a scattered manner. Abdominal angiography btd celiac artery in the abdominal aorta at the level of about 90-95% lumen narrowing segment constitutes the very appearance sinotik revealed. Hydration was done but the blood pressure drop continued. Therefore, patients underwent two units of erythrocyte suspension. General surgery was consulted. Was admitted to a general surgical ward. Constructive in general surgery service was followed.

Conclusion: Celiac trunk aneurysms are rare. Although natural processes just disclosed, the high mortality associated with emergency requires aggressive approach. In patients with symptomatic or ruptured aneurysm surgical approach must be precise. He therefore came to the emergency department with syncope and in patients with abdominal pain should be deducted.

Keywords: Celiac trunk, aneurysm, syncope, rupture

P-0411 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A rare cause of abdominal pain: Superior mesenteric vein thrombosis

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Objective: Superior mesenteric vein thrombosis is included among the epidemiology of rare causes of extensive abdominal or epigastric pain frequently accompanied by hypercoagulability conditions and liver diseases. We are presenting a case with superior mesenteric vein thrombosis in a patient with liver insufficiency in his/her history.

Case: The sixty-eight year-old patient was brought to the patient with liver insufficiency and peptic ulcer in the history with abdominal pain that was mild within the last 10 days and gradually became more severe in the last one day together with nausea. In the physical examination, general medical status of the patient was medium and conscious was open; abdominal examination revealed extensive tenderness around the umbilicus without muscular defense or rebound tenderness. BP was 110/80 mmHg, Pulse: 60/minute, Body Temperature: 36 °C, and sPO2 was %97, and examination findings of other systems were natural. The laboratory results revealed that WBC was 10800/mm³, AST 36 U/L, ALT 16 U/L, GGT 81 U/L, and T. Bilirubin was 2.1 mg/dL. Abdominal US was reported as: "Severely increased intestinal wall thickness and edema in distal jejunal and ileal loops and extensive free fluid were observed. Proximal of SMA was patent. The abdominal CT taken with I.V. contrast was reported as: "In the distal portions of the superior mesenteric vein, thrombotic hypodense appearances were observed within the lumen that caused full occlusion in places up to the portal vein level, which were interpreted in favor of superior mesenteric vein thrombosis. The patient was admitted to the General Surgery Clinic, and oral intake was stopped, and treatment consisting of low molecular-weight heparin and antibiotics. Symptoms of the patient receded, and the patient was discharged about subsequently.

Conclusion: For patients applying to the emergency room with abdominal pain, which is involved in the differential diagnosis of a great number of diseases, it must be kept in mind that superior mesenteric vein thrombosis accompanied by hypercoagulation conditions and liver diseases can be involved.

Keywords: Abdominal pain, superior mesenteric vein, thrombosis



POSTER PRESENTATIONS

P-0412 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Iatrogenic pneumothorax due to liver biopsy

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Objective: Liver needle biopsy is still reported to be the most effective method for grading and staging of chronic viral hepatitis to made appropriate treatment and determining the prognosis of the patients. In this paper, a case of iatrogenic pneumothorax developed in a patient with chronic hepatitis B as a result of liver needle biopsy was presented.

Case: A 17 year old male patient was admitted to the emergency department with complaints of 4 hours of continuing right side pain and shortness of breath. There was no history of exposure to trauma before, but he had liver biopsy due to chronic hepatitis B one day ago. The patient was conscious, oriented, cooperative, and his Glasgow Coma Scale score was 15. The patient's pulse rate was 95 / minute, blood pressure: 100/70 mmHg, body temperature 36.7 °C and oxygen saturation was 97%. In physical examination, breath sounds in the right hemithorax were decreased. Heart sounds were rhythmic and tachycardic. ECG was in normal sinus rhythm. The pneumothorax was determined in the right hemithorax in PA chest X-ray. The patient underwent tube thoracostomy. On the fifth day of admission, patient's lung was expanded, tracheostomy tube was withdrawn, and patient was discharged from hospital.

Conclusion: Although liver biopsies are routine administrations with easy process in daily practice, it should be kept in mind that minor complications such as pain, vasovagal reaction, epigastric discomfort, nausea, hypotension and major complications such as hemorrhage, bile leak, biloma, fistula formation, septic shock, rash, needle tract to an extent could be seen.

Keywords: pneumothorax, liver biopsy, complication

P-0413 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

The Combination of Ovarian Renal Vein Thrombosis Mimicking Acute Appendicitis

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Objective: Ovarian vein thrombosis is a rare but severe complication at postpartum period which is seen in the pregnancies ranging from %0.05 to %0.18 and it is detected in the right ovary in %80 -%90 of the cases. We present a case of the combination ovarian and renal vein thrombosis admitted to emergency department with right lower abdominal quadrant pain clinically mimicking acute appendicitis which is detected at the postpartum period.

Case: A 26 year old woman suffering from right lower abdominal quadrant pain for 2 days presented to emergency department. She had a history of spontaneous vaginal delivery 7 days before and in her vital signs her body temperature was 37.8 CO. On physical examination, there was an apparent tenderness in the right lower abdominal quadrant and also an indeterminate rebound was found out. WBC was detected as 13400 in the complete blood count. With the suspicion of acute appendicitis, abdominal ultrasonography was asked but it couldn't be eliminated with USG so IV contrasted abdominal CT was ordered. A calibration increase throughout the right ovarian vein and a thrombosis in the pedicled lumen causing a filling defect in the inferior of the renal vein were seen. The patient was admitted to the hospital after the diagnoses of postpartum right ovarian and renal vein thrombosis and following the treatment of anticoagulant.

Conclusion: Ovarian vein thrombosis(OVT) is a rare clinical picture generally seen at the postpartum period and it is diagnosed with contrasted computerized tomography. Its pathophysiology is explained with Virchow's triad. As pregnancy is a hipercoagulopathic state, the venous stasis due to the pressure of uterus on the inferior vena cava and the endothelial injury caused from local inflammation or during the delivery result in ovarian vein thrombosis. Secondary to OVT, thrombosis in the renal vein, similar to our case, in the inferior vena cava and also in the pulmonary artery is reported. Regarding all these serious complications secondary to OVT, OVT is one of the important diagnoses to be kept in mind for the patients who admit to the emergency department suffering from acute abdominal pain in the postpartum period since OVT can mimic acute appendicitis.

Keywords: Acute Appendicitis, Ovarian Vein, Postpartum, Renal Vein, Thrombosis

P-0414 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Toothpaste Complication

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Introduction: In recent years, there is a significant increase in the percentage of foreign bodies which are placed in the rectum. Such cases are one of the significant emergency surgery problems due to the complications they caused. The rectal foreign bodies are mostly composed of the objects which are pushed into the rectum for various purposes. The patients are mostly composed of middle aged and homosexual males. The foreign body which is placed through anal channel with sexual purposes, is stuck in rectum and stayed there. Occasionally, the foreign bodies which are used for decreasing rectal itching, curing hemorrhoiditis or treating prolapsus, can be stuck in rectum.

Case: 22 years old male patient presented to the emergency service with the complaint of not being able to extract a toothpaste tube which was placed in his anus by himself. Patient had complaints of pain in anus and in lower abdominal.

Patient stated that he applied same kind of practices to his anus before, on the other contrary the object was stuck inside this time and he presented to the emergency service because he could not take it off. Patient had no chronic disease, no regular use of medication, no history of allergy and no past operation. He stated that he received psychiatric treatment following the military service.

The vital signs were normal. The patient had no tenderness in his abdomen, no sign of defence or rebound and no palpable mass. No foreign body was identified in anal examination. Anal tonus decrease was identified in rectal touché. Rest system examinations were normal.

General surgery consultation was requested for the patient. As the foreign body could not be extracted by rectal techniques, the patient was rushed into an urgent operation. After opening of the abdomen, the foreign body which was inside the colon was extracted from rectum by pushing. Following the operation, the patient was placed in the general surgery service.

Conclusion: As a result, in the rectal foreign body cases, extracting in the emergency service can be tried if the foreign body's characteristics are familiar. Consultation should not be delayed if extracting in the emergency service is not possible or hard to do.

Keywords: rectum, foreign body, emergency service

P-0415 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Cause of Acute Abdomen in Adults: Morgagni Hernia

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Objective: Morgagni hernia is a rare congenital diaphragmatic hernia which may not be symptomatic and can be diagnosed during testing for other pathologies. But the patient may also refer to ED with serious symptoms as chest pain, dyspnea and acute abdomen.

Case: 89-year-old woman was referred to our clinic with an epigastric pain and right upper quadrant pain, dyspnea and chest pain, which has continued for 4 days. The severity of symptoms increased day by day. On physical examination, vital signs were normal; patient had severe pain on epigastrium and right upper quadrant which spread to dorsum. The lungs sounds were normal. In laboratory tests, EKG was normal. There was no leukocytosis, and minimal lactate elevation was seen on arterial blood gas. Patient had pain which did not decrease with analgesics. On chest x-ray, there was an image of pleural effusion and a mass in the right lungs. During the diagnostic CT scans, a fatty tissue was detected at right parastellar area which was reaching towards the thorax. This scan image was interpreted as morgagni hernia and patient was referred to general surgery clinic.

Conclusion: Morgagni hernias are the rarest types of congenital diaphragmatic hernias and may not be present until adulthood. Many are asymptomatic, but can present with acute symptoms such as acute shortness of breath with chest pain, epigastric pain, right or left upper quadrant pain spreading to dorsum. With a high probability, it is located at the right antero-medial part. The diagnosis is usually confirmed by chest X-ray and CT scans and the treatment is surgical repair.

Keywords: Morgagni hernia, congenital, acute abdomen



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P-0416 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Gas In Gallstones: A Rare Radiological Sign

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Objective: On average 10% of adults have gallstones. Gallstones are twice as common in women as in men. Gallstones are divided into two groups: the dominant component in the structure of cholesterol stones and pigment stones. 80% of gallstones are predominantly cholesterol and 20% are pigment stones. The majority of patients with gallstones (70-80%) are asymptomatic in their lifetime. For silent gall stones in 1 to 2% of cases symptoms occur each year. About 10-20% of gallstones can be sufficiently calcified to be visible on abdominal films. "Mercedes Benz" sign is a triad of collection of nitrogen gas. The procedure of choice for gallstone diagnosis with 95% accuracy is ultrasound. CT is superior to ultrasound for demonstration of calcification and of fissures in gallstones. We report a 52 year old woman with gas in gallstones.

Case: 51 year old female was admitted to the emergency department with pain in the right upper quadrant. She had nausea but no vomiting. She had no history of pain, disease and any drug use. Her vital signs revealed blood pressure: 110/70 mmHg, axillary temperature: 36.7°C, heart rate: 84 per minute. On physical examination the patient had right upper quadrant tenderness. Other physical examination signs were normal. Laboratory tests results were WBC: 11700 (N: 4-10 10³/ML), ALT: 22 U/L (N: <42 U/L), AST: 21 U/L (N: <37 U/L). The other laboratory test results were within normal range. There was no pathological findings in abdominal ultrasonography. Abdominal computed tomography revealed multiple stones in gallbladder and air in gallstones (Figure: 1-2-3). Patient was consulted to the general surgery and after symptomatic improvement, discharged and recommended elective surgery.

Conclusion: In patients presenting with right upper quadrant pain it is important to conduct a thorough physical examination and imaging modalities. Some of gallstones aren't seen in ultrasonography thus the use of advanced imaging techniques is important.

Keywords: Gallstones, air, radiological sign

P-0417 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acute intestinal obstruction due to non-involutedly uterus after cesarean section

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Objective: Reasons of acute intestinal obstruction after C/S's are usually related to formation of adhesions. Although rare, acute pseudo-colonic obstruction (Ogilvie's syndrome) has also been reported after C/S's.

Case: A 41-year-old-female was referred for intestinal obstruction from an obstetric center on the first postpartum day after a successful delivery by cesarean section (C/S). This was the fourth live birth and the first C/S after 3 vaginal births. However indication for C/S was due to delay over one week in delivery after 40 weeks of pregnancy. Physical exam revealed abdominal distention with rebound tenderness. Her white blood cell count was 15000/mm³. Plain abdominal graphics showed dilated multiple small and large bowel segments. Abdominal computerized tomography pointed out a non-involutedly large uterus measuring approximately 20 cm in diameter accompanying dilated small and large bowel segment which had been thought as acute abdominal compartment syndrome requiring immediate decompression. Thus, the patient underwent an emergent abdominal laparotomy. During exploration, all small bowel segments and the colon was diffuse dilated from Treitz ligament to recto-sigmoid region. The recto-sigmoid colon was compressed between the uterus and sacral promontorium, which was the cause of the mechanic obstruction. A hole was performed at the transverse colon to relief distention by milking gas and bowel fluid. After intraoperative consultation to obstetric and gynecology department for hysterectomy, it was decided to left the uterus in its place because of legal reasons and fears that the patient may want further pregnancies in the future. Additionally intravenous oxytocin (Synpitan®, Deva Turkey, and metilergonovin-maleat (Metiler®, Adeka, Turkey) was applied for uterine involution. However, little response was observed. The hole in the transverse colon could be closed by primary repair, but a transverse loop colostomy was performed with primary attempt of damage control surgery while involution of the uterus takes time and compression of uterus on recto-sigmoid colon persists during this process. Postoperative course of the patient was uneventful and she was discharged on the sixth postoperative day with decision on colostomy closure 2 months later.

Conclusion: The primary mechanism of intestinal obstruction in the present case was compression of uterus on recto-sigmoid colon. After search the English Literature, this is the second reported case. Although uncommon, a non-involutedly uterus can lead in the early postoperative period to acute intestinal obstruction by compressing the recto-sigmoid colon.

Keywords: uterus, intestinal obstruction, colostomy

P-0418 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Valuableness of Tomography and CRP for Abdominal Pain

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Objective: We evaluated that the abdominal tomography is essential for admitting because of non traumatic abdominal pain to the emergency service and are CRP and tomography effect to patient management.

Materials-Methods: On retrospective study, we recorded demographic data, tomography diagnose, CRP and leucocyte values of 199 patient who are 18 years old and over and were admitted to emergency service because of abdominal pain and were scanned abdominal tomography. 104 patient are hospitalized and their CRP values, tomography diagnose, operation and following decision, end of operation diagnoses are recorded from patient files. The statistical analysis was performed using the Chi-square test and the diagnostic value was assessed through the logistic regression test.

Results: A statistically significant relationship was observed between the abnormal tomography findings of the 199 patients included in the study and high CRP and leukocyte values (p<0.05). The tomography and CRP were observed to influence the discharge and admittance ratios (p<0.05). When tomography finding and CRP value were combined, the operation decision was effected (p<0.05).

Conclusion: Based on our study; in the event of abdominal pain, CRP can predict abnormal tomography finding and it is more valuable than leucocyte. When tomography was used with CRP, it affects the operation decision.

Keywords: CRP, Abdominal tomography, Emergency Service, Abdominal Pain, Leucocyte

P-0419 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Traumatic avascular necrosis of capral scaphoid bone

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Objective: Scaphoid fractures are the commonest fracture of the carpal bones, comprising almost 90% of carpal fractures. Tenderness in the anatomical snuff box is the cardinal sign of a scaphoid fracture, but missing of scaphoid fractures are common. Avascular necrosis can occur in bone areas with terminal circulation when the blood supply is disrupted. Commonly involved bones include the femoral head, talus, and scaphoid. Avascular necrosis of the carpal scaphoid bone can occur after a fracture, repetitive trauma or accompany with a systemic disease and chronic steroid intake. In this case, we reported a 27 year old male with avascular necrosis of the carpal scaphoid bone after trauma.

Case: A 27 year old male admitted to emergency service with pain in right wrist. The complaint had begun after falling on the wrist two years ago. After falling his first wrist radiography was interpreted as normal. 2 years later he was admitted to the emergency department due to aggravation of pain and limitation of movement. On physical examination he had swelling, severe pain and limitation of joint movement on his right wrist. The wrist x ray showed radiopaque scaphoid bone (figure 1). The patient was consulted to orthopedics and traumatology. Avascular necrosis of scaphoid bone was considered. Magnetic resonance result showed scaphoid bone erosion and edema, findings consistent with avascular necrosis (figure 2). Biochemical parameters were normal and no metabolic disease was detected. The wrist was immobilized and oral indomethacin 100 mg / day was given. After this treatment his pain persisted and he was recommended scaphoid avascular necrosis operation by orthopedics and traumatology.

Conclusion: Avascular necrosis of the scaphoid bone can occur after trauma or idiopathic. Especially in wrist trauma, emergency physicians should do a thorough physical examination for scaphoid bone fracture and if there is suspicion, orthopedic consultation and advanced imaging methods should be done. In the emergency services scaphoid bone fractures can often be overlooked and this can cause permanent disability.

Keywords: Avascular necrosis, scaphoid bone, trauma



POSTER PRESENTATIONS

P-0420 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Traumatic Amputated Arm

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Objective: The traumatic amputation of upper extremity is a severe and clinical picture which causes the loss of life in addition to loss of extremity. Amputations fall into two groups called complete and incomplete. Since such traumas generally result from the use of tools such as saw, printing press, agricultural tools, rope and knife, they are seen frequently in the third, fourth and fifth decades. Here we presented a case of total amputation of left arm because of using an agricultural tool.

Case: 18 year-old male patient presented to emergency department after the rupture of his left arm by a haymaker (an agricultural machine). He was alert and cooperated. His vital signs were stable. On physical examination his left arm was totally amputated above the elbow. 4 hours after the amputation, the amputation zone on the left arm was covered with a tampon and there was minimal bleeding. Bilaterally intravenous line was produced. He was monitored and saline infusion was begun. The amputated left arm in the form of avulsion covered with a gauze bandage was brought in a closed box full of ice water with the patient. The patient was referred to another health center for replantation.

Conclusion: In the literature, the causes of amputation are stated as trauma, diabetic and neurovascular reasons, peripheral vascular diseases, gunshot traumas, chronic infections, tumors and congenital anomalies. In Turkey accidental traumas (traffic accident, occupational accidents etc.) take the first place in the causes of amputations. It is of high importance to select the right cases for replantation among those amputations. In our case as the patient was young enough and he presented to emergency department within the 4th hour of amputation, he was consulted to cardiovascular surgeon and orthopedics immediately. In conclusion, it is quite significant to preserve the amputated extremities appropriately, to transport the amputation cases to right health center as quickly as possible and to coordinate with the surgical departments for the successful replantation.

Keywords: Emergency, Amputation, Replantation, Trauma

P-0421 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Isolated Triquetrum Fracture After Trauma: A Case Report

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Triquetrum fracture is the second most common carpal bone fracture after scaphoid fracture. Clinically there are 2 kinds of triquetrum fracture; dorsal avulsion fracture and corpus fracture which is seen less frequently. In this case report we presented a 33 year old male patient admitted to the emergency department due to fall over his right wrist. His direct x ray had no pathological finding. His wrist tomography was planned due to clinical suspicion. A fracture line over his triquetrum was detected in this visual evaluation. Emergency physicians should be aware of physical examination of wrist bone even if the patient's direct x ray is in normal ranges.

Keywords: triquetrum fracture, carpal bone, emergency department

P-0422 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acute-on-Chronic Subdural Hematoma: A Case Report

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Subdural hemorrhage occurs mostly due to the rupture of the bridging dural vein, dural venous sinus wall, or small cerebral cortical vein caused by head trauma. A 90-year-old female patient was admitted to emergency department with complaints of falling on her head four days ago. A computed tomography of the head was performed and revealed an acute-on-chronic subdural hematoma (SDH) with 6 mm midline shift. Cranial nerves were intact with no focal neurological deficits. Acute-on-chronic subdural hematoma is not rare and repeated trauma may cause acute bleeding over the chronic SDH.

Keywords: Emergency Department, Subdural Hematoma, Trauma

P-0423 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A case of posttraumatic facial paralysis in the emergency room

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Objective: The most frequent cause of facial paralysis is trauma after the Bell's paralysis. It can cause devastating outcomes including difficulties of talking and eating, inability of expressing emotions through facial expressions or ocular complications. Medical and surgical treatments are used in facial paralysis. Diagnosis and treatment at the early stages give satisfactory outcomes. We here present our case that was brought to our Emergency Room with facial paralysis after trauma, and that recovery was provided in the facial paralysis with medical treatment started in the early period.

Case: The six-year old patient fell down from a chair when attempting to climb on it, and crashed the left side of his head on the concrete flooring. Later, he was brought to our Emergency Room his/her face became asymmetric. The patient's general medical condition was good in the physical examination, GCS was 15, vital signs: BP: 110/70, Pulse: 105/min and SO2 was 98. Pain around the left auricle and left-side facial asymmetry was found in the head and neck examination. There was nothing notable in the examination of the other systems. No pathologies were found in the laboratory tests. No emergency pathological findings were seen in the temporal and brain tomography taken. The ENT clinic was consulted for the patient, and s/he was hospitalized in the ENT clinic with the pre-diagnosis of "posttraumatic facial paralysis". Following the medical treatment in the clinic, regression was observed in the facial paralysis, and the patient was discharged with recommendations at day 5.

Conclusion: Careful physical examination must be carried out on patients brought to emergency rooms with head and neck trauma in search of traumatic facial paralysis. The recovery period of patients shortens and recovery rate increases with early diagnosis.

Keywords: posttraumatic, facial paralysis, emergency room

P-0424 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Paraplegia in Aorta Dissection

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Objective: Acute aortic dissection (AAA) is a life threatening event in emergency departments (ED). Although, we can see wide variety of symptoms in AAA, paraplegia is one of the rarest symptom among them.

A 42-year-old female patient with sudden strength and sensation loss in her legs without chest or back pain has been presented to our ED. Our aim in this case is to present a rare case of AAA with the symptom of paraplegia.

Case: A 42-year-old female patient admitted to our ED with sudden weakness and numbness in her both legs associated with urinary incontinence has been referred with diagnosis of Guillain Barre Syndrome. Patient was in a well seeing in appearance, oriented and cooperated. Her past medical history was unremarkable except hypertension and hyperlipidemia. Her physical examination showed normal findings except a decrease in motor strength which were 3/5 motor (0, no motion and 5, normal force) in both lower extremities. Sensory deficits were defined



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with a level of T11-L1 vertebra. Patella and Achilles reflexes could not be examined. Laboratory values were as follows: White blood cell count 10400 K/uL and the other values were normal limits. Her ECG and posteroanterior chest X-RAY were unremarkable. After neurological consultation, we have ordered thoracolumbar MRI with contrast medium. The patient was diagnosed as De Bakey Type 1 AAA in thoracoabdominal aorta, starting from supra valvular level and ending right renal artery outlet distal, AND paraplegia WAS related to spinal cord ischemia. She has been taken under an operation. Patient died in post-operative period in intensive care unit.

Conclusion: AAA with spinal cord damage can be identified with sudden paraplegia starting in 1-2 hours. Accompanying hypertension, chest, back and abdominal pain in varying degrees, shock syndrome with elevated (high) TA, hematuria, decreasing pulses in dorsalis pedis may be associated findings of AAA. Fast diagnosis and treatment of this catastrophic disease with spinal cord ischemia by emergency physicians is vital for mortality

Keywords: Acute aortic dissection, paraplegia, Guillain Barre Syndrome

P-0425 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Case: Esophagus Perforation

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Objective: Esophagus perforation is rarely seen but a highly mortal pathologic condition. It should be diagnosed and treated at early period. Generally develops during endoscopy, dilatation or sclerotherapy. The other causes are; swallowing foreign body, caustic substance ingestion, severe esophagitis, severe vomiting (Boerhaave syndrome) and cancer, direct penetrating or blunt trauma. In this case we aimed to present esophagus perforation developed following severe vomiting.

Case: 53 years old male patient has admitted to our emergency service with sudden onset of vomiting after meal and then severe chest pain that radiate to back and abdominal pain complaints. The patient was seen very agitated in the physical examination. For the vital findings; arterial blood pressure was 140/90 mmHg at right arm and 130/80 mmHg at left arm, pulse: 96/min, body temperature: 37 C, oxygen saturation was 98%. The patient was conscious, oriented and cooperated. Respiratory and cardiovascular system examinations were normal. There was widespread abdominal tenderness and there wasn't defense and rebound. Neurologic examination was normal. There wasn't any history of disease or medication. In the performed examinations; there was sinus tachycardia in the electrocardiogram. White blood cell count was 20000 K/uL and the other cardiac enzymes, d-dimer and biochemical tests were normal. Thoracic and abdominal tomography was performed with the preliminary diagnosis of aorta dissection and peptic ulcer. As the result of tomography; air densities compatible with pneumomediastinum visualized together with hiatal hernia which is evident at the para-aortic area were visualized. Esophagus lower end perforation was detected in esophagography performed with the suspicion of esophagus perforation. Upon this, the patient is consulted with thoracic surgery clinic and was taken to operation. The patient who was first followed in intensive care unit and then in the service was discharged from the hospital with cure at the end of the 7th day.

Conclusion: As in our case, abdominal pain, pneumothorax, hydropneumothorax and pneumomediastinum develop in lower end esophagus ruptures. The interventions performed before the development of mediastinitis in esophagus perforations are life-saving. For this reason, the patients should be consulted with thoracic surgeons as soon as possible and operation should be planned.

Keywords: Esophagus, Perforation, Vomiting

P-0426 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Nutcracker Syndrome

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Objective: Nutcracker Syndrome (NCS) is defined as the incarceration of left renal vein between superior mesenteric artery (SMA) with abdominal aorta and stenosis of the left renal vein and increase of pressure in the renal vein segment in front of this segment, due to external pressure at this level. Although there are limited numbers of case reports and case serials depending on personal experiences were defined, the true incidence of NCS is unknown. The most common symptoms are hematuria, proteinuria, and left side pain due to left renal venous hypertension. More rarely, left side tenderness of vagina, dyspareunia, dysuria, dysmenorrhea, scrotal varicose vein formation, gluteal and the formation of varicose veins in the lower extremities and abdominal pain and gastrointestinal symptoms due to venous congestion syndrome in a very few patient group. Left renal vein entrapment is accidentally detected in radiologic examinations in some asymptomatic patients. In this case, we aimed to present a NCS case which is rare and almost never seen in older patient.

Case: 83 years old female patient was brought to our emergency service with abdominal pain and constipation complaints. In the physical examination of the patient there wasn't orientation and cooperation due to cerebral infarct she had 14 years ago. Consciousness was blurred. Vital signs were stable. There was tenderness in abdomen with palpation. There wasn't defense and rebound. There were ronchi and coarse crackles at the lower lobes of both lungs with auscultation. There was arrhythmia in the cardiovascular system examination. Atrial fibrillation detected in electrocardiography. There was normal stool involvement in rectal touche. There wasn't any other pathology than anemia in the performed laboratory tests. Contrasted abdominal tomography was performed to clarify the abdominal pain. SMA was open in tomography and there wasn't thrombus or emboli detected. Left renal vein was narrowed between abdominal aorta and SMA and dilated at the distal part (Nutcracker phenomena). Cardiovascular surgery (CVS) consultation was requested upon this. CVS clinic didn't suggested surgical intervention and recommended polyclinic follow up.

Conclusion: The first and most important step in NCS diagnosis is clinical suspicion of NCS. However, this is difficult in clinic practice. One of the most important factors that the syndrome is defined very rare is its less recognition. Generally, the surgical indications are considered as massive hematuria that lead deep anemia and severe lateral pain, follow up and conservative treatment is recommended for the patients with NCS not at this level.

Keywords: Nutcracker Syndrome, Abdominal pain, Older patient

P-0427 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Valentino's Syndrome - Perforated Peptic Ulcer Presenting As Acute Appendicitis

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Objective: Valentino's syndrome is pain presenting in the right lower quadrant (RLQ) of the abdomen caused by a duodenal or gastric ulcer with perforation through the retroperitoneum. The pain is caused by gastric and duodenal fluids that tend to settle in the right paracolic gutter causing peritonitis and RLQ pain. Now we present a case of a 24-year-old male who presented with symptoms and signs suggestive of appendicitis accompanied by elevated inflammatory markers. That is Valentino's syndrome-unusual presentation of perforated peptic ulcer.

Case: A 24-year-old man visited our ED with the complaint of abdominal pain in the right lower quadrant for 8 hours. He had a history of gastric ulcer without any treatment. The pain was initially in the epigastric area and right flank for 6 hours and then shifted to the right lower quadrant in the following hours. The character of the pain was persistent but not cramping. There was nausea, vomiting, fever but no, diarrhea and constipation. He had no other systemic diseases, daily medication. On physical examination, the abdomen was soft, but there was tenderness and rebound tenderness in the RLQ area and epigastric area. The degree of tenderness in the RLQ was more severe than in the epigastric area. The obturator sign was present, but psoas and Rovsing's sign were absent.

Laboratory data revealed a white blood cell count of 9.2 $\times$ 10³ /uL with 77% neutrophils and 5% bands, hemoglobin level of 14.5 g/dL, and platelet count of 252 $\times$ 10³ /uL. After 3 hours of admission at control laboratory data revealed a white blood cell count of 14.6 $\times$ 10³ /uL with 84% neutrophil. In the emergency ultrasonography there was 5mm, minimal compressible tubular structure in right lower quadrant. There was free fluid monitored around the tubular structure. There was no free air in the patient's chest X-ray. With acute appendicitis suspected clinically by the surgeon, He underwent appendectomy via the McBurney incision. During the operation, turbid ascites approximately was aspirated, but unexpectedly, the appendix was minimally inflamed. After appendectomy there was still purulent discharge in the appendectomy area. The surgeon extended the incision and on further inspection, a perforated prepyloric ulcer was discovered and perforation repair was performed. He was discharged from the hospital 9 days after admission.

Conclusion: In summary, if a patient with peptic ulcer history suffers from RLQ pain, ultrasonography demonstrates pericecal and peritubular fluid accumulation without obvious blindended tubular structure, despite rarity, Valentino's syndrome should be taken into consideration.

Keywords: Perforated Peptic Ulcer, Valentino's syndrome, Acute Appendicitis



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P-0428 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Bilateral blindness caused by a single birdshot: case report

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Objective: The aim of this study was to analyze the effect of a surgical management protocol and clinically important features on the prognosis of patients who had penetrating orbito-cranial gunshot injuries. At the same time, in this study we aimed to emphasize that bilateral amaurosis can be seen as a result of penetrating head trauma due to firearm bullets.

Case: A 25-year-old female patient had a suicide attempt with a gunshot in her business office. On physical examination she was consciousness and bilateral totally amourotic, her general condition was moderate. An input hole on the lateral side of right orbita and an output hole on the lateral side of left orbita was detected.

Cranial Computed Tomography scan revealed increased diffuse reticular density, milimetric bone fragments and air values at bilateral retrobulbar area; displaced fractures in anterior and posterior walls of frontal sinus, bilateral orbital floor and medial orbital walls, lamina papricea, cribriform plate and lateral wall of right orbita; hemorrhagic contusion at the level of gyrus recti and right frontal subcortical white matter and pneumocephalus at the level of gyrus recti. The patient was taken into operating room and wound sites were irrigated by normal saline. Foreign tissues and bone fragments were cleaned from the entry-exit holes and the holes were sutured primarily. Patient was hospitalized 6 days in our department and followed up for rhinorrhea. No any complication was developed and she was discharged. Orbital penetran injuries are frequently seen in children and usually occur accidentally. These injuries may extend to brain parenchyma and skull base structures. Imaging studies should be the diagnostic methods. If fistulization of cerebrospinal fluid occurs complication rates due to infection are high. Prevention for orbital and intracranial complications bullet fragments should be removed.

Conclusion: The prognosis of the injury depends on the course of the bullet or shrapnel fragment and the interdisciplinary care. An extensive preoperative evaluation of penetrating orbital trauma and a combined ophthalmic and neurosurgical approach are recommended to minimize the morbidity of the patients. However, complete removal of the foreign material in a deep or ventricular localization is not mandatory because careful debridement and tight closure of dura provides desired outcome. Evaluation of trauma mechanism and injury characteristics according to the Ocular Trauma Classification System seems to predict accurately the visual outcomes in this series.

Keywords: blindness, gunshot injuries, penetrating head trauma

P-0429 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Laryngeal tumor or laryngospasm? a case presentation

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Objective: Patients suffering from laryngeal tumor are admitted to hospital for surgical diagnosis and treatment or tracheostomy in order to provide a safe airway. However, patients without diagnosis or whose treatment has been neglected and who suffer from progressive respiratory distress or cyanosis may attend the Emergency Department. Laryngospasm is a rare but frightening experience. When it happens, the vocal cords suddenly seize up, blocking the flow of air into the lungs. People with this condition may be awakened from a sound sleep and find themselves momentarily unable to speak or breathe. Though it can be scary while it is happening, laryngospasm typically goes away within a couple of minutes.

By submitting this case presentation we aimed at drawing attention to the issue by reminding larynx spasms acting as laryngeal tumor.

Case: A 71 year old male patient was admitted to the Emergency Department of our hospital with complaints of sudden and developing shortness of breath and respiratory distress. From the anamnesis given by the relatives of the patient it was found that the patient suffered from the larynx tumor but he had not accepted any kind of treatment. During a physical examination performed at the Emergency Department arterial blood pressure of the patient was recorded as 140/90 mmHg, saturation without oxygen as 60%, characteristic trachypneic stridor was noticed as well. IV steroid + inhalation therapy and oxygen therapy were prescribed to the patient and the tests were planned. CT of patient's larynx showed that the laryngeal passage at the glottis level has been almost completely closed. Moreover, it was observed that the obstruction extended on incisions to the subglottic area (Fig. 1-2). Having analysed patient's current situation together with the amnesia, because of the suspicion of larynx tumoral lesion, the patient was taken to the operating room in the Department of Laryngology in order to make emergency tracheostomy and laryngeal sampling. Due to the endoscopic examination performed during operation it was found that the tracheal passage was open in the hypopharynx, larynx and subglottic area and the tracheotomy was performed. The patient was discharged from the hospital with the diagnosis of acute exacerbation of COPD and laryngospasm and the treatment planned.

Conclusion: It should be kept in mind that progressive respiratory distress and cyanosis can occur together with laryngeal tumors, especially in case of patients whose treatment has been hindered, and that it might be confused with laryngospasm.

Keywords: emergency medicine, laryngospasm, laryngeal tumor, tracheostomy

P-0430 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Penetrating Neck Injury, A Case Presentation

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Objective: Head and neck parts are the places where a large number of life sustaining anatomical structures are located. High blood flow veins, larynx, trachea and the upper section of medulla spinalis, which plays a very important role in regulating many vital functions, are exposed to factors that can cause a traumatic influence on the neck. Therefore, in comparison to other anatomical parts, life-threatening clinical situations resulting from penetrating neck injuries occur more frequently.

In this case presentation our aim is to emphasize the importance of this body section by submitting the presentation of the penetrating neck injury.

Case: A 32 year old male patient has been referred to our hospital from another institution due to complaints of consciousness changes. Having received 3 points from Glasgow Coma Scale (GCS) at the admission to the Emergency Department, the patient underwent the intubation. According to the explanation made by patient's fellow workers, the patient was seen at the work place hit by the screw, which after leaping out from the working machine hit the wall and later on hit the patient. In the left part of the neck there was a lesion in size of 2x2cm that could possibly be the inlet through which the foreign body could enter into the body and come across the upper cervical section. The radiography and tomography performed indicated the foreign body artifact in the right part of the cervical section and the air density in cervical canal (Fig. 1, 2, 3). The patient requiring the consultation of the neurosurgeon was transferred from the Emergency Department to the Intensive Care Unit for the follow-up treatment.

Conclusion: Particularly in case of penetrating cervical injuries it should not be forgotten that the foreign body's route might pass through the cervical segment; the patient should be examined from this perspective as well.

Keywords: Neck Injury, emergency service, foreign body

P-0431 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A rare cause of abdominal pain: Acute renal infarct

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Objective: Acute renal infarct is a rare condition that can develop with renal colic-like pain, nausea, vomiting, fever and hematuria, and that can present with anuria if bilateral. Diagnosis requires a high level of suspicion. We are presenting our patient who applied to our Emergency Room with abdominal pain and was diagnosed with left renal acute infarct.

Case: The ninety-year old patient was brought to the emergency room with abdominal pain for the last 10 days that increased within the last 2 days, nausea and vomiting. Physical examination revealed that the general medical condition of the patient was medium, conscious was open, BP was 170/90 mmHg, pulse 110/min, body temperature 36.5 C, and sPO2 was 95%. The patient had extensive abdominal tenderness and muscular defense, and blood tests revealed that WBC was 8000/mm3, Hb 13.3 g/dl, Platelet 246.000/mm3, INR 1.19 mg/dl, urea: 41 mg/dl



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mg/dl, and creatinine was 1.57 mg/dl. In the abdominal CT taken with contrast, soft-weighted mixed plaque was observed in the orifice of the left renal artery, and filling and contrasting of the left renal artery. The patient was hospitalized in the General Surgery Clinic and taken under clinical follow-up and treatment with low molecular weight heparin was ordered. Symptoms of the patient receded, and the patient was discharged about 1 week later.

Conclusion: For the patients applying to the emergency room with abdominal pain, nausea and vomiting that is included in the differential diagnosis of a great number of diseases; it must be kept in mind that acute renal infarct that requires a high level of suspicion can be included in the etiology.

Keywords: Abdominal pain, acute renal infarct, emergency room

P-0432 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Co-occurrence of hemorrhagic infarct and venous sinus thrombosis

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Objective: While venous sinus thrombosis is a rare condition, it displays variable neurologic findings, and headache, vomiting and seizures are seen frequently. Diagnosis requires a high level of suspicion. We are presenting here our patient, who presented with headache and seizures and was diagnosed with transverse sinus thrombosis and hemorrhagic infarct.

Case: The twenty-seven year-old female, with nothing notable in her personal history except for intermittent headaches for about one month applied to our Emergency Room with headache that became more serious for the last two days, nausea and vomiting. Generalized tonic-clonic seizures developed in the patient twice in the emergency room. Her general medical condition was medium with a tendency for sleep, and BP was 120/80 mmHg, Pulse: 140/min, Body temperature 36°C, and sPO2 was 96%. In the blood tests, WBC was 13700/mm³ and PT INR was 1.3 mg/dl. In the brain CT taken for the patient who displayed no other characteristic findings was reported as: "Multiple hemorrhagic infarct areas were observed extending from the left temporo-occipital area to the sinus rectus, reaching 22x16mm in the widest area and causing graying and edema in the adjacent sulci. Appearance consistent with hyperdense thrombus in the confluence sinus and left transverse sinus was observed". The MR study was reported as: "Graying sulci in the left temporal area and hemorrhagic venous sub-acute infarct including slightly hyperintense areas in T2 FLAIR, slightly hyperintense areas in DAG, and hypointense areas in GE (bleeding) were observed. Hypointense filling defect was observed in the left transverse – sigmoid sinus." She was hospitalized in the Neurology clinic and her treatment was prescribed.

Conclusion: It must be kept in mind that hemorrhagic infarct found in patients presenting in the emergency room with headache, seizures and vomiting can be accompanied by venous sinus thrombosis, even rarely.

Keywords: Headache, Hemorrhagic Venous Infarct, Transverse sinus thrombosis

P-0433 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Mortal companionship; aortic dissection and pulmonary embolism

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Objective: Aortic dissection is defined as the dissection of the intimal layer of aorta and dissection of the media layer to cause blood fill in the aortic wall. It can develop spontaneously, or can be iatrogenic or traumatic. Pulmonary thromboembolism is a cardiovascular emergency with a mortal course. It develops with the clogging of the pulmonary arterial bed. We here submit a case that applied to our emergency room with the clinical picture of aortic dissection and diagnosed with pulmonary embolism together with the dissection.

Case: Eighty-seven year-old female was referred to our emergency service from elsewhere with abdominal pain, back pain, and numbness in feet. She reported that she had tingling feeling in both legs together with abdominal pain with sudden onset. Physical examination: GCS:15; BP: Right arm: 130/80 mmHg; Left arm: 130/70mmHg; Pulse:118, Respiratory rate: 20; Body temp.:36C, Oxygen saturation: 94. Pulses of the four extremities were felt equally. Her skin was cold and damp. She had widespread tenderness in the abdomen. Sphincter tonus was negative in the neurologic examination, and there was 1/5 motor strength and sensory loss in the lower extremities. Laboratory tests: WBC:10.91; LDH:553; CK-MB:231; CK:4914; Urea: 97; Creatinine:2.13; Troponin:5.09; and Potassium:6.5. Contrast CT angiogram was taken with the pre-diagnoses of aortic dissection? and cauda equina syndrome? CT Findings: dissection flap in the ascending and at the beginning level of the descending thoracic aorta, pericardial hematoma, linear hypodensity within the main right pulmonary artery (pulmonary embolism), infarct in the inferolateral and posterior mid section of the right kidney, full occlusion in the abdominal aorta starting right after the distal of the renal artery at the SMA level till the anterior common iliac arteries. The general health status of the patient was impaired and she was intubated in the ER and was taken to the intensive care unit. Arrest developed during the preparation for surgical intervention and the patient died despite all the efforts.

Conclusion: Pulmonary embolism can be rarely seen with mortal aortic dissection in elder patients like this case. Surgical intervention should be thought. Surgery was planned for our case also; however it was not applied since patient had died.

Keywords: Aortic Dissection, Mortal Companionship, Pulmonary Embolism

P-0434 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Abdominal hematoma as a result of clexane use

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Objective: Clexane is low molecular weight heparin. Elderly patients who use Clexane are at risk of hemorrhage because of delayed excretion even in therapeutic doses. In this case we aim to present abdominal hematoma in a patient who was on Clexane because of pulmonary embolism.

Case: A 80 years old female patient was admitted to the emergency department with a sudden, ripping pain from her abdomen to her left leg. Her Physical examination showed: BP:110/70 mmHg, no difference of blood pressure in left and right extremities, left lower abdominal sensitivity, increase of pain with left leg movement, peripheral pulses are palpable. The patient was using Clexane because of pulmonary embolism that was diagnosed a week earlier. Her laboratory results were: WBC:22000, HGB:13, HTC:39, PLT:210000, INR:1.02. Abdominal X-Ray was normal. Abdominal CT revealed: Hematoma of 100*60 mm in the left iliopsoas muscle. The patient was admitted to the general surgery for follow up.

Conclusion: Detailed physical examination is important for the patients that are admitted to the emergency department with abdominal pain. Special attention should be given to elderly patients who are on antithrombotic because of hemorrhage risk.

Keywords: Clexane, abdominal hematoma, tomography

P-0435 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Complication After Laparoscopic Cholecystectomy: Giant Biloma

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Objective: We report a case of a 27-year-old woman with a history of previous laparoscopic cholecystectomy (about 1 month ago) for cholecystitis with lithiasis. We wanted you to remind that a biloma which is seen very rarely and is a well-demarcated, encapsulated or not, intrahepatic or extrahepatic bile collection secondary to iatrogenic, traumatic or spontaneous injury of the biliary tree can be develop after surgery. And so this situation should be considered in the differential diagnosis.

Case: A 27-year-old woman was admitted to our emergency department with complaints of nausea, vomiting, abdominal pain and mild back pain started about 2 weeks ago and exacerbated during the last 2-3 days. In the patient's history, it was learned that laparoscopic cholecystectomy was performed 25 days ago due to cholecystitis with lithiasis. On physical examination (pathological), right upper quadrant and epigastric tenderness was present. Vital signs were stable except low-grade fever. Laboratory tests were detected (pathological) as follow: hemoglobin 10.2 g/dL, hematocrit 33%, WBC 14,520, platelets 488,000/mm³, AST 55 (0-41), ALT 95 (0-45) and GGT 273 (9-64), calcium 8.3 (8.4-10.6), sodium 132 (135-148), and direct bilirubin 0.6 (0-0.5). Pregnancy test was negative. Posteroanterior (P-A) chest radiograph was normal. Then, abdomen ultrasonography (USG) was performed for preliminary diagnosis of acute pancreatitis or biliary tract pathology. A cystic mass lesion compatible with biloma was detected (Figure 1). Contrast-enhanced abdomen Computed tomography (CT) was taken to clarify the



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localization and size of the lesion. Approximately 20x11x16 cm in size giant biloma was confirmed by abdomen CT (figure-2). The patient underwent urgent explorative surgical operation. According to operation note, the biloma was detected and 2 liters bile was drained. Open drainage was applied and the patient was transferred to service for follow up.

Conclusion: Possible complications such as infection, bleeding and damage to the biliary tract are rarely seen after laparoscopic cholecystectomy. One of the complications of laparoscopic cholecystectomy is biloma which is a well-demarcated, encapsulated or not, intrahepatic or extrahepatic bile collection secondary to iatrogenic, traumatic or spontaneous injury of the biliary tree. Laboratory findings of the biloma are nonspecific. The diagnosis is usually suspected on the basis of a typical history (right upper quadrant abdominal pain, fever and recent abdominal trauma or surgery) and is confirmed by detection of typical radiologic features.

Keywords: Postoperative complications, Biloma, Cholecystectomy, Laparoscopic

P-0436 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Hurthle cell carcinomas in the thyroid gland; two rare cases

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Objective: Thyroid cancer are relatively rare. Hurthle cell carcinoma is a rare form of thyroid carcinoma which is considered an oxyphilic variant of follicular carcinoma making up about 3% of all thyroid cancer cases. We presented two different cases who applied our hospital in a same month. Those two patients came to the emergency polyclinic with an ambiguous complaints such as swelling of the neck, breathless.

Case: One of those 46 year old male. Biochemical results presented hypothyroidi. About 45 mm diameter nodular lesion was seen in the left thyroid lobul with USG. Bilaterally total thyroidectomy was applied. After the operation histopathologically nodular lesion was seen. It was 5cm diameter. Hurthle cells were seen in the nodular lesion. Diffuse vascular and capsular invasion was observed. Diagnose was diffuse invasive hurthle cell carcinoma.

The other case was 65 year old female. Biochemical examination revealed othyroidi. Ultrasonography hypoechoic, 43 mm diameter lesion was seen in the left lobul of thyroid. Bilaterally total thyroidectomy was carried out. Histopathological diagnose was minimal invasive hurthle cell carcinoma.

Regularly control was recommended for both two patients.

Conclusion: Hurthle cell neoplasia in thyroid gland has a silent cytological and histomorphological carecteristic. We see a hurthle cells in this neoplasia which have a abundant granular cytoplasm and well-defined contour. Clear cut capsuler and /or blood vessel invasion are indicated carcinoma. Hurthle cell carcinomas are relatively rare neoplasia. Although different views are found for hurthle cell carcinoma in literature, those tumors can be associated with aggressive clinical course. We want to draw attention to hurthle cell carcinomas which are may be not rare as much as we think.

Keywords: Thyroid gland, Thyroid cancer, Hurthle cell carcinoma

P-0437 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Primary Lipoma of the Scrotum: Two Cases

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Objective: Testicular tumours are the most common neoplasias of the scrotum. Paratesticular tumours contain few of those neoplasias. 70% of paratesticular neoplasias are benign. Although lipoma is the most frequent type of the scrotal paratesticular tumours, scrotal lipoma is relatively rare neoplasia. We presented two scrotal lipoma cases.

Case: Case1: 51year old male patient applied to emergency polyclinic due to soft painless mass in the scrotum. Physical examination found scrotal tumoration. Ultrasonography and Xray film showed solid mass. Under the diagnosis of intrascrotal tumour the mass was removed. Macroscopically tumour measured 7X3X2 cm. It was solid, well circumscribed and encapsulated. Microscopically, it was composed of the mature adipocytes. Histopathological diagnosis was made of lipoma. No evidence of recurrence has been seen during the 6 month follow up.

Case2: 67 year old male presented with scrotal complaints. Physical examination revealed right scrotal mass. X ray film and ultrasonography exhibited well circumscribed scrotal lesion. Complete surgical resection was performed. Macroscopic examination revealed 6X6X4 cm, yellow coloured, encapsulated tumour. Histopathologically lesion presented mature adipocytes. Cellular atypia and necrosis weren't seen. Histopathology confirmed the diagnosis of lipoma. No evidence of recurrence has been seen during the 3 month follow up.

Conclusion: Scrotal lipoma is rarely seen. It originate from spermatic cord. It has unknown etiology. It frequently appears in the forth and fifth decades. Treatment is made with surgical excision. Because rarely liposarcoma is seen in the scrotal region, scrotal mass is detected and operated rapidly

Keywords: scrotum, lipoma, liposarcoma

P-0438 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Traumatic acromioclavicular joint seperation

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Objective: The acromioclavicular joint is a diarthroidal joint formed by medial part of acromion and distal part of clavicle. Acromioclavicular joint seperation is a rarely seen entity and typically occurs after a trauma to the superolateral part of the shoulder. Most of the cases result from falls during skiing, riding bicycle or playing football. When superolateral part of shoulder hits, acromion displaces inferiorly. According to the type of injury, treatment is conservative or surgical. Here we present and discuss a case of acromioclavicular joint seperation.

Case: A 24-year-old male referred to emergency department with complaint of right shoulder pain after fall on to shoulder during joking with his friends. On physical examination he had right shoulder deformity, his right humeral head was more inferiorly located and distal part of his right clavicle was superiorly displaced compared to the left but humeral head was in glenoid. Active shoulder abduction was restricted. Other examinations were unremarkable. On plain radiography there was no fracture but right acromioclavicular joint was seperated. He was consulted with orthopedic surgeon. It was accepted as Type III seperation with accompanying coracoclavicular ligament tear. Closed reduction was performed by elevating humerus upwards and compressing clavicle inferiorly and immobilized in Velpeau sling.

Conclusion: Treatment of type I and II injuries consists of rest, ice, analgesics, and immobilization, followed by early range-of-motion exercises. Although treatment of type III injuries is controversial, there is a trend of shifting to conservative treatment with sling immobilization as in our patient.

Keywords: Acromioclavicular joint, clavicle, dislocation, separation

P-0439 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Appendicitis With Atypical Location Owing to Malrotation

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Objective: Malrotation of the midgut (the mid-intestine) is an anomaly, which presents with an abnormal peritoneal fixation during its rotation around superior mesenteric artery. Left-sided appendicitis is an atypical presentation and has been reported rarely. The majority of these cases have been described to be associated with congenital midgut malrotation, situs inversus, or an extremely long appendix. Here, we report a rare case with acute appendicitis associated with intestinal malrotation.

Case: A 59 year old man with a history of hypertension and coroner artery disease, was brought to the emergency department because of severe permanent abdominal pain with fever, vomiting, nausea and diarrhea. His blood pressure was 110/75 mmHg, pulse rate was 79 bpm, body temperature was 37.6 C0. Abdominal examination revealed periumbilical pain but no rebound tenderness. Laboratory blood tests showed leukocytosis (white blood cell count:17.000) with 83% neutrophils. C- reactive protein was found 5 times higher than normal limits. Other tests,



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including glucose, kidney and liver function tests and electrolytes were all normal. Because of persistent pain abdominal computed tomography (CT) was performed 2 hours later. CT image showed a misplaced caecum located in the left-side of pelvis with the swelling of the appendix (0.8 cm caliber and located in the middle of pelvis). Based on these findings acute appendicitis was diagnosed and then emergency laparoscopic appendectomy was performed.

Conclusion: While appendicitis is the most common abdominal disease requiring surgical intervention seen in the emergency room setting its continues to be a condition at high risk for missed and delayed diagnosis. This case is presented to increase awareness among emergency physicians of this anatomical variant and atypical presentation of appendicitis.

Keywords: malrotation, left sided appendicitis, emergency room

P-0440 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Bilateral anterior shoulder dislocation associated with seizure

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Objective: Anterior shoulder dislocation is the most common form of shoulder dislocations. Bilateral shoulder dislocation is a very rare entity and is mostly posterior. Bilateral anterior shoulder dislocation may occur after violent trauma, electrocution, or seizures. We report a case of acute bilateral anterior glenohumeral dislocation secondary to a generalized tonic-clonic seizure.

Case: A 30-year-old male was transferred to our emergency department by 112 emergency staff with seizure. His seizure was ceased after administration of 10 mg intravenous diazepam. The patient was stuporous upon arrival. His blood glucose was 108 mg/dL. Vital signs were as following: Blood pressure, 105/60 mmHg; heart rate, 115 bpm; respiratory rate, 14/minutes; body temperature, 37.2 °C; and O2 saturation, 99%. His respiratory and cardiac examinations were normal. He did not have lateralizing sign. His pupils were normally reactive and Babinsky was bilaterally negative. His relatives said that he had a cranial surgery following head trauma (fall from height) at age of 4 but they did not give a history of epilepsy or epileptic medication. Her emergency cranial computed tomography (CT) revealed right craniectomy scar and cortical volume loss at right parietotemporal region secondary to surgery. Her laboratory findings revealed WBC of 14.9 K/uL, glucose of 148 mg/dL, CPK of 204 U/L, and other laboratory findings including electrolytes, CRP, urinalysis, and arterial blood gases were all unremarkable. As the patient awoken he suffered bilateral shoulder and neck pain. He had tenderness on both shoulders, movements were painful, and range of motion was restricted. No neurovascular deficit was present. He was obtained bilateral shoulder graphy that revealed bilateral anterior shoulder dislocation. He and his relatives denied use of any toxicologic medication. He was consulted with orthopedic surgeon and after conscious sedation and analgesia in emergency department closed reduction was successfully performed and immobilized in arm slings. Then he was consulted with neurologist. A cranial magnetic resonance imaging was performed that revealed hyperintense cortical lesion on FLAIR and T2 sequences compatible with trauma sequela. The patient was hospitalized by orthopedist. His electroencephalography was also normal. He was started antiepileptic drug. He did not have any other seizure and was discharged.

Conclusion: It is important to make a complete physical examination to exclude shoulder dislocation in patients with seizure. This is especially of concern, since the reported rate of late diagnosis is greater than 10%. Fractures, rotator cuff ruptures or neurovascular injuries may accompany such injury.

Keywords: Anterior, bilateral, emergency department, seizure, shoulder dislocation

P-0441 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Peptic ulcer perforation in the setting of inferior myocardial infarction

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Objective: Abdominal pain is a common complaint accounting for 6.7% of all emergency department (ED) visits. Although acute and severe pain is almost always a symptom of intraabdominal disease, a variety of systemic and extra-abdominal diseases can cause symptoms within the abdominal cavity such as acute coronary syndrome, pneumonia, pulmonary embolism, etc. Acute myocardial infarction presents with abdominal pain in 2% of patients. Here we present a case of peptic ulcer perforation in the setting of myocardial infarction.

Case: A 72-year-old male patient was suffering abdominal pain for four days that partially responded to analgesics. When he experienced a heavy-sharp pain and dyspnea, he admitted to an ED of a secondary care state hospital. When free air was seen under diaphragm, he was transferred to our tertiary care ED for operation with the diagnosis of peptic ulcer perforation. He does not have a remarkable medical history except being a heavy smoker. His vital signs were: Blood pressure, 90/60 mmHg; heart rate, 90 bpm; respiratory rate, 21/minutes, body temperature, 36.8 °C; O2 saturation, 94%. His breath sounds were hoarse and had bilateral rales. He had abdominal tenderness and rebound tenderness. The rest of the physical examination was almost normal. His chest radiogram was compatible with perforation. He was early consulted with general surgeon for operation. When the patient said that he had been suffering pain and dyspnea with exertion during a short time period we obtained an electrocardiogram that showed pathologic Q waves and 2 mm ST elevation in leads II, III, and aVF. His pathological laboratory findings were: WBC, 12.5 K/uL; Hemoglobin, 11.4 mg/dL; creatine, 1.83 mg/dL; LDH, 450 U/L, CKMB, 4.45 ng/dL; Troponin-I, 1.39 ng/dL. He was consulted with cardiologist. His ejection fraction was 35% with hypokinetic inferior wall. He was thought to have inferior subacute myocardial infarction. He was operated by general surgeon with high risk. After the fourth day of operation he was given to coronary care unit for angiography. The patient was truck driver. He stated that he must go working as soon as possible and did not obey angiography. He was discharged after arrangement of cardiac medical therapy.

Conclusion: Electrocardiogram is a key diagnostic tool in the emergency department patients and should be obtained in the evaluation of abdominal pain as well as chest pain.

Keywords: Emergency department, myocardial infarction, peptic ulcer, perforation

P-0442 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Giant hiatal hernia mimicking aortic dissection

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Objective: Approximately 60% of individuals aged 50 or older have a hiatal hernia (HH) (1). A giant HH is a hernia that includes at least 30% of the stomach in the chest, although a uniform definition does not exist; most commonly, a giant HH is a type III hernia with a sliding and paraesophageal component (2). Patients with a giant HH generally present with pain, heartburn or a history of heartburn, dysphagia, vomiting, and anemia. We present a case of giant HH presenting with burning upper abdominal and sternal pain radiating to the back.

Case: A 46-year-old man presented to our emergency department with the complaint of a burning upper abdominal and sternal pain radiating to the back. His medical history was unremarkable except that a history of urolithiasis. He had a blood pressure of 130/100 mmHg (left arm), heart rate of 110 bpm, respiratory rate of 22/minutes, and axillary temperature of 36.5 °C. He had tenderness on epigastrium and right lower quadrant. His electrocardiogram was normal. He was started symptomatic treatment with suspicion of gastritis. His plain abdominal radiogram was normal. His laboratory tests revealed leucocytosis of 10.9K/uL, hemoglobin of 8 g/dL. His liver and kidney function tests and urinalysis were all normal. On follow-up, he started to vomit and had a tearing chest pain radiating to his right shoulder. His control blood pressure was 100/60 mmHg on right and 130/100 mmHg on left arms. Emergency physician-performed bedside echocardiography revealed an aortic root of 3.7 cm and there was a suspicion of flap on ascending aorta. He was ordered a contrast-enhanced thorax and abdominal tomography with the suspicion of aortic dissection. Because of technical problems we could not get a good contrast-enhanced CT but there was a hiatal hernia and the wall thickness of stomach was increased. He was consulted with cardiologist and there was still a suspicion of flap in ascending aorta. As we could not exclude aortic dissection, the patient underwent an aortography and coronary angiography after the consultation with vascular surgeon. He had a normal aortography and angiography. His pain was resolved by narcotics and he was pain-free on the following day. He was consulted with gastroenterologist and discharged for out-patient follow-up for hiatal hernia.

Conclusion: Emergency physicians should be aware of HH and it should be in the differential diagnosis of chest pain even in patients without a previous history of heartburn or dysphagia.

Keywords: Aortic dissection, emergency department, hiatal hernia



POSTER PRESENTATIONS

P-0443 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A case of recurrent aortic occlusion

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Objective: Aortic occlusion is a rare entity with high morbidity and mortality. Thrombotic process is the mainstay in pathogenesis. It is not a sole disease of the aorta, because as a great artery of the human body, aorta perfuses many organs and extremities. As a result it may present with overlapping symptoms and signs of different organ systems resulting in diagnostic challenging in some cases. Hence, early diagnosis is an important factor in reducing morbidity and mortality.

Case: A 61-year-old female patient presented to our emergency department by relatives with the complaint of abrupt onset of abdominal pain. She was conscious, cooperated, and oriented. Her vital signs were as following: Blood pressure, 130/90 mmHg; heart rate, 103 bpm; respiratory rate, 17/minutes; and body temperature, 36.6 °C. Her abdominal physical examination revealed an abdominal operation scar and incisional hernia. Her right leg was amputated at the level of knee and left leg at the level of heel. Her extremities were warm and her left lower extremity pulses were non-palpable at femoral level. Her other systemic examination was unremarkable. Her abdominal hernia was manually reduced. Her relatives said that she had been operated for aortic occlusion and peripheral artery embolus one year ago. Her laboratory findings were almost normal. Abdominal computed tomography with contrast revealed thrombosed abdominal aorta at infrarenal level. Her renal and mesenteric arteries were open. Left kidney was atrophic. Left lower extremity arterial Doppler ultrasound revealed thrombosed left popliteal artery. She was consulted with cardiovascular surgeon for operation. The patient did not give consent for operation so she was given medical therapy.

Conclusion: Aortic occlusion is a rare entity presenting with mixed clinical signs and symptoms. Emergency physicians play an important role in the diagnosis and management of patients with aortic occlusion since they need to make a rapid differential diagnosis and perform a complete vascular examination on patients with abdominal pain and neurological deficit, if aortic occlusion is suspected.

Keywords: Aortic occlusion, computed tomography, emergency department

P-0444 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Aorta dissection in patient applying for dysarthria

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Objective: Aorta dissection generally manifests by sudden, severe, intense, violent and harmful chest pain developing between the two scapulas and associated with death fear. However, in some patients, some unexpected complaints such as hemiplegia, syncope, myocardial infarcts developed in addition to the regular symptoms. In the absence of regular symptoms, the diagnosis of the patient is delayed and this leads to the increase of mortality. In this case, we have presented the case of a patient with aorta dissection applying for atypical symptoms.

Case: A sixty-eight years old male patient applied to the emergency unit for speech disorder and swallowing impairment. The complaints of the patient started approximately 4-5 hours ago. The conscious was open, cooperate and oriented. The system examinations were normal except dysarthria speech, facial paralysis, and bilateral Babinski lesion. The arterial tension was 170/80 mmHg, the pulse was 91/min, and the temperature was 37.2°C. A computer-assisted brain tomography has been requested for the patient known to have undergone cerebrovascular disease and hypertension history. The result was normal except for chronic ischemic area. Cerebrovascular disease has been proposed for the patient transferred to neurology. PA lung graph has been performed on the patient who developed respiratory troubles and whom situation deteriorated. In the computer-assisted contrast tomography following the observation of abnormal aorta knob in lung graph, an aspect corresponding to aorta dissection has been observed. An emergency hospitalization in intensive care has been requested. Respiratory and cardiac arrest developed in the patient. Following a successful cardiopulmonary resuscitation, the patient has been submitted to mechanic ventilation. No surgical intervention has been planned for the patient upon consultation to vascular surgery. Hypotension and renal impairment developed in the patient followed-up for two weeks. In the fifteenth day of hospitalization of the patient who did not present any improvement, cardiopulmonary arrest developed and no answer has been obtained upon cardiopulmonary resuscitation.

Conclusion: Aorta dissection may manifest with clinic symptoms and observations different from the regular symptoms. It shall be remembered that a patient applying with neurologic-cardiologic complaints in addition to chest pain, back pain may present aorta dissection.

Keywords: dysarthria, cerebrovascular disease, aorta dissection

P-0445 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Catheter Malposition

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Objective: Central venous catheter (CVC) applications are an important application frequently used in complicated cases requiring long-term follow-up and large vascular access in emergency unit and intensive care units. Some complications associated to the catheter or to the process during or after CVC application may develop. The most frequently encountered complication is malposition, but pneumothorax, cardiac tamponade, vascular erosion, air emboli, arrhythmia and death may occur. The development of a resistance during the evolution of the guide fiber during the placement of the catheter, the failure of the catheter, the insufficient speed of blood transfers may let think about catheter malposition. In our study, we have presented the case of a catheter malposition during subclavian vein catheterization of an intensive care unit patient.

Case: The 83 year-old male patient has been taken to the emergency unit by his relatives due to his general situation. The consciousness of the patient was open and he presented limited cooperation and orientation. The tension was 85/55 mmHg, the pulse was 110/minute, the breath rate was 22/minute. In addition to the hemogram and the biochemical analyses of the patient, activated partial thromboplastin time (aPTT), prothrombin time (PT) have been requested to evaluate the diathesis of the hemorrhage. The analyses were normal except the hypernatremia. A central venous catheter has been planned from the right subclavian vein to provide vascular access and liquid administration. Malposition has been supposed due to the development of a resistance during the evolution of the guide fiber during the placement of the catheter. In the back-forward lung graph performed for control purpose after the procedure, it has been determined that the tip of the catheter was not at the normal position and that it bent towards the right inner jugular vein. The catheter that did not lead to any major complication has been removed. It has been placed again and localized by radiology for control.

Conclusion: Basic procedures shall be respected and the catheter shall be placed in the right position to avoid potential complications that may happen during and after the procedure of application of central venous catheter. It is important to remember that the complication caused by malposition may not display any clinic feature at the beginning. We believe that it is important to perform a lung graph after the procedure to detect a catheter malposition.

Keywords: central venous catheter, subclavian vein, malposition

P-0446 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Intracranial Lipome

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Objective: Intracranial lipomas are rare benign tumors that develop as a result of the differentiation of mesenchyme cells. There are mostly localized near the central line. They are usually asymptomatic, but in symptomatic cases, they are frequently associated with headache. Symptoms such as vertigo, seizure, and cerebellar ataxia, diplopia, hearing troubles or loss may be observed rarely. As the intracranial lipomas are asymptomatic, they are diagnosed incidentally. In computer-assisted tomography, lipomas present as hypodense masses with a homogenous structure. Their surgical treatment becomes difficult if they are stuck to the surrounding tissues and if they enclose veins and nerves. The surgical treatment is performed only in patients with persistent symptoms, important cranial nerve deficits or brainstem pressure in spite of the conservative treatment. In our study, we have presented a case presenting this rare lesion.

Case: The patient applying to another health institution for loss of consciousness and spasm has been transferred to our hospital with SVO pneumocephalus pre-diagnosis. The sixty-four year-old female patient explained her complaints were pursuing transiently for 6 hours. She presents morbid obesity and hypertension. In her neurologic examination; the features were normal except her conscious was drowsiness, and cooperation and orientation were limited. Her vital observations were stable, the laboratory analyses results were found to be normal except for hypernatremia (Na:154 mmol/L) and hypoxia (PaO2:65 mmHg). In CAT performed to discard intracranial pathology, an image of homogenous, hypodense structure conform to lipomas has been observed in the central line. No other congenital malformation has been observed. The patient, for whom surgical intervention has not been proposed, has been hospitalized in intensive care unit and medical treatment has been started. The symptoms of the patient have regressed, and she has been discharged in the 17th day of her hospitalization upon recovery.

Conclusion: Intracranial lipomas usually represent 0.1 % of all the intracranial tumors. Their detection has become easier with the use and the development of CAT among the diagnosis methods. Lipomas are asymptomatic and incidentally detected benign masses.

Keywords: intracranial lipome, seizure, emergency unit



POSTER BİLDİRİLER

P-0447 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Retropharyngeal Hematoma Developed after Obtuse Whiplash Injury

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Objective: Retropharyngeal injuries are usually observed with penetrant injuries. However, it may be observed rarely after obtuse whiplash injury or more rarely without cervical vertebral injuries. As the hematoma formed as a result of retropharyngeal injuries have light clinic features, diagnosis is difficult in emergency application. The most frequent clinic complaints are anterior neck pain and swelling, swallowing difficulties, cyanosis, difficulty in breathing, speech impairment. In our study, we presented the case of a retropharyngeal hematoma after swallowing difficulties and difficulty in breathing after obtuse trauma.

Case: A 79 year-old male patient taken to the emergency unit upon falling down the stairs presented throat ache and difficulty in breathing. His consciousness was open, cooperated-oriented and his vital observations were stable. His breath rate per minute was 18, SO₂: 98%. A large swelling, ecchymosis and rubor from the lower part of the chin to the upper part of the clavicle have been observed. Cervical collar has been put to the patient who had limited movements. No other lesion has been observed in the general body examination. An enlargement in prevertebral smooth tissue has been detected in cervical lateral graph (Figure 1). In the tomography performed on the neck region to better evaluate the retropharyngeal section, a structure compatible with an organized, 2.5x5x10 cm hematoma without hemorrhage, heterogeneous hypoechoic, with strict limits, in the left retropharyngeal- laryngeal of hypo pharynx and larynx. The main vascular structures are normal in USG. In the endoscopic examination, a structure in the back wall of the hypo pharynx associated to a potential hematoma has been observed but this structure did not block the way, and normal vocal cord movements have been detected. The patient has been hospitalized in emergency intensive care unit for medical treatment under precise clinic observation. The patient has been discharged on the 4th day upon the regression of the hematoma in Daily controls.

Conclusion: Obtuse whiplash injuries may lead to retropharyngeal hematoma even this event is rare. In this kind of cases, a precise intensive care follow-up may be used with airway manipulation in addition to aggressive early airway intervention.

Keywords: obtuse whiplash trauma, retropharyngeal hematoma, early aggressive airway intervention, close follow-up

P-0448 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

We Have Been Crushed But We Did Not Die

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Objective: Road accidents are at the first place for the patients applying to the emergency units for trauma. 1/3 of the deaths associated to accidents occur within few hours after the accident. In this time period, deaths are associated to epidural or subdural hemorrhages, hemopneumothorax, rupture of the spleen, liver laceration, pelvic fractures or other wounding types leading to significant hemorrhage. These are the patient groups that we can help. In this case, we will present a patient – a greyder of approximately 15-20 tones has ridden over him- taken to the emergency unit.

Case: A fifty-four male patient has been taken to the emergency unit of our hospital by the 112 for extravehicular road accident. Approximately one hour ago, a caterpillar has ridden over the chest and pelvic region of the patient during backwards maneuver on the worksite. The patient's conscious was open, cooperated and oriented. The vital observations of the patient with GKS:15 were normal except the tachycardia. The patient presented scrapes in the right cheek and ecchymosis around the left eye. The breath sounds were normal, ecchymosis were present on the anterior part of the chest, crepitation were present on the sternum. The abdomen was free and sensibilities were present on the pelvis. Pain and sensibility have been noticed in left shoulder and left wrist. Arterial blood gas values were as follow: pH:7.45, PCO₂:30, PO₂:83, HCO₃:23.4, SO₂:97. In the graphs of the patient, thorax sternomanubrial separation, rib fractures, pneumomediastinum, pneumothorax, hemothorax, smooth tissue emphysema, multiple rib fractures, right clavicle fracture, right wrist luxation, radius styloid fracture and sacrum fracture in left side of the pelvis associated with pubic separation and fracture in the anterior part of the left acetabulum. The right wrist of the patient taken to the surgery in the orthopedic department has been splinted, and left leg skeletal traction has been applied. The patient has been transferred to the intensive care unit of the emergency service. After a sternum surgery by the chest surgery department two days later, the patient has been transferred to the orthopedic department after one postoperative week of follow-up in the intensive care unit.

Conclusion: In accidents, almost half of the patients die within few minutes before reaching the health institutions. It is possible to save the patients and increase their quality of life with on-time and efficient intervention performed within what we call the gold-hour on the patients taken to the hospital.

Keywords: attention, efficient and on-time intervention, road accident

P-0449 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Prognostic Factors and Treatment of Penetrating Gunshot Wounds to the Head Presenting to Emergency Department

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Objective: In our study, we aim to evaluate the predictive factors of morbidity and mortality in patients presented to emergency department and hospitalized in neurology who suffered from gunshot wounds to the head. We reviewed 22 patients who admitted to Ankara Numune Training and Research Hospital between 2010 and 2014.

Materials-Methods: Of patients 18 were male and 4 were female. All of the patients were injured with bullet. On admission Glasgow Coma Scale (GCS) score of 9 patients was 15, GCS of 2 patients was 13, GCS of 3 cases was 12, 8 and 7 respectively, GCS of 3 patients was 5 and GCS of 4 patients was 3 points. Statistical analyses were performed with IBM SPSS statistics version 19.

Results: In our study 22 cases who had penetrated injury to dura were evaluated. Seven of patients had an injury to frontal bone, 5 of them to parietale and 3 of them to occipitale bone. Parenchymal injuries were accompanied with all bone injuries. Four cases had entrance and exit holes. Patients of whom GCS was 15 and had no neurological deficits and 9 patients of whom GCS 3 and had no survey expectation were followed up non-surgically and with close clinical monitoring. One patient of whom GCS was 13 with rhinorrhea had cranioplasty by transcranial intervention. The remaining 11 patients also had cranioplasty with foreign body resection. During follow up of 16 patients whom 4 were suffered from seizure and 1 had ventriculo-peritoneal shunt due to development of hydrocephalus. There were statistically significance between findings of physical examination and imaging studies on admission and mortality, the lower GCS scores on emergency admission the higher mortality ($p < 0.001$). Mortality rate was 36% and GCS on admission had significant correlation with mortality rates.

Conclusion: Low GCS scores at admission, unilateral dilated pupil or medium fixed pupil, transventricular or bihemispheric central type trajectory, and bilobar or multilobar wounds noted through CT scan are predictive factors of high morbidity and mortality in patients with gunshot wounds to the head, in our clinical experience. Also, surgical treatment is not recommended for patients with penetrating wounds and GCS score of 3 to 5 in the absence of hematoma causing a mass effect.

Keywords: gunshot wounds, Prognostic factors, emergency admission

P-0450 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Neurofibroma with atypical feature- A rare scrotal mass

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Objective: Neurofibromas arise from perineural and schwann cells and they occur throughout the body. Solitary neurofibroma is a benign tumour, which is not associated with neurofibromatosis type I. It's exact incidence is unknown because of the difficult in excluding neurofibromatosis, in some cases.

Solitary neurofibroma of the scrotum is an extremely rare. Also we didn't see any case 'neurofibroma with atypical feature' in the scrotum in the literature (pubmed). Here in we report a rare case 'neurofibroma with atypical feature'.



POSTER PRESENTATIONS

Case: A 34 year old man presented with a four month history of scrotal swelling. He came to emergency polyclinic, due to pain in scrotal region. Scrotal mass was defined with physical examination. Radiological examination revealed a well circumscribed mass. Clinical diagnoses was scrotal calcinosis. The patient underwent surgical excision. Grossly the mass was unencapsulated. Histopathological examination of the mass revealed interlacing bundles of elongated cells with wavy, dark-staining nuclei. Focal nuclear atypia was detected. Necrosis and increased mitosis was not seen.

Immunohistochemically, the lesion was diffusely positive for S100, vimentin and moderately positive for CD34. Also the mass was negative for SMA and desmin. Proliferative index for Ki 67 was about 15%. All of those histopathological and immunohistochemical results confirmed the diagnosis of a neurofibroma with atypical feature.

Conclusion: Differential diagnosis for this lesion is included leiomyomas, lipomas, fibromas, hemangiomas and epidermoid cysts and scrotal calcinosis as well.

Neurofibroma should be considered in the differential diagnosis this rare location. Malign transformation can be occur this rare tumor, rapid and correct diagnosis especially substantial for prevented patients morbidity and mortalities.

Keywords: Neurofibroma, atypical feature, scrotum

P-0451 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Detection of raised intracranial pressure in arrested hydrocephalus by optic disc ultrasonography

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Objective: Hydrocephalus is the abnormal accumulation of cerebrospinal fluid (CSF) in ventricular system leading to dilatation of ventricles and increase in intracranial pressure (ICP). But in some cases, CSF pressure, ventricular pressure, and parenchymal pressure remain equalized or stable and this continues for many years. In this case, typically ventricles are widened but there is no edema around them. This clinical entity is called 'stable' or 'arrested' hydrocephalus. There is no need for CSF shunt and it implies non-worsening condition. But these patients may experience an episode of hydrocephalus in any period of lifetime.

Case: A 37-year-old female presented to emergency department with complaint of headache and recurrent vomiting. She was diagnosed as arrested hydrocephalus 5 years ago and followed-up radiologically. As there was not any sign of increased ICP, a CSF shunt was not placed. A cranial computed tomography was obtained but there was not an abnormal ventricular dilatation compared to the previous ones. To detect if there was a raised ICP, optic nerve sheath diameter (ONSD) was measured by bedside ultrasonography that revealed 5.3 mm on right and 7.2 mm ONSD on left that was compatible with raised ICP. Then optic disc was evaluated with ophthalmoscope. There was papilledema and optic disc borders were obscured.

Conclusion: Measurement of ONSD with ultrasonography is a simple method to detect raised ICP. This method may be helpful to guide CSF shunt need or shunt function in patients with previously placed CSF shunts.

Keywords: Hydrocephalus, intracranial pressure, optic nerve sheath diameter, papilledema, ultrasonography

P-0452 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Left flank pain: Superior mesenteric vein thrombosis and left atrial thrombus

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Objective: Mesenteric vein thrombosis is the least common form of the mesenteric ischemias and it accounts for around 10% of all mesenteric ischemias. It is mostly hereditary and associated with hypercoagulopathy. The condition may be accompanied by acute myocardial infarction. The patients should also be assessed for the presence of life-threatening additional findings due to predisposition to thrombosis. This case report presents a patient with superior mesenteric vein (SMV) thrombosis accompanied by left atrial thrombus.

Case: A 66-year-old male patient presented to the emergency room with non-colic left flank pain for the last 3 days. The patient had nausea and denied diarrhea, constipation, and dysuria. The patient's past medical history was not remarkable; however, he was using metoprolol and acetylsalicylic acid. On physical examination, the patient's GCS was 15, general condition was good, and there was tenderness on the left upper quadrant on abdominal examination. Other system findings were normal. Electrocardiography revealed normal sinus rhythm. The patient was placed on intravenous fluid therapy containing hyoscine-N-butylbromide, ranitidine, and metoclopramide, and urine and blood samples were obtained for analysis. The laboratory findings did not provide evidence to explain the complaints. Due to persistence of the complaints, the patient underwent abdominal computerized tomography (CT) with contrast enhancement. CT revealed globally increased heart size. There were widespread calcifications in the mitral valve. There was hypodense filling defect in the left atrium suggesting thrombus formation. There was minimal fluid collection between the pleural sheets (Figure 1). A filling defect was observed suggesting thrombus formation in the SMV, but intestinal segments appeared normal (Figure 2). After cardiology consultation, the echocardiography revealed 7.5x4.2 cm immobile thrombus in the left atrium adhered to the atrial wall (Figure 3). The patient was consulted with cardiovascular surgeon, cardiologist, and general surgeon. Heparin therapy was initiated and the patient was admitted to the cardiology ward for further follow-up.

Conclusion: Although mesenteric vein thrombosis is a rare form of mesenteric ischemia, the possible presence of other life-threatening conditions must be kept in mind and the patients must be evaluated accordingly by the physicians in the emergency room

Keywords: atrial thrombus, mesenteric ischemia, mesenteric vein thrombosis

P-0453 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Giant calcified cerebral meningioma detected incidentally after trauma

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Objective: Meningiomas originate from meninges and constitutes 15% of brain tumors. They are usually seen between 40-60 years and more common in women. They may grow anywhere where meninges are found and are named according to site of growth. As they grow very slowly they may not form any clinical sign until they generate mass-effect in surrounding structures.

Case: A 78-year-old female was referred to emergency department with severe right hip pain after a simple fall at home. She has been suffering gait and posture disturbances and increase time of sleep since few months. She does not have headache. She had hemiparesis on left side and her right hip movements were painful. She was diagnosed to have osteoporosis a few years ago. On direct graphy there was a fracture on right femoral head. Her cranial computed tomography revealed a totally calcified mass, possibly originating from duramatter, commencing from olfactory bulb and filling the frontal fossa up to the right of midline, compatible with meningioma. Probably the tumor has been growing very slowly because it was totally calcified. At the end of this process, the clinical signs were thought to be resulted from the effect of the surrounding edema on motor cortex, that was just posteriorly located. Left hemiparesis is the cause of fall resulting in femur fracture.

Conclusion: To our knowledge, this was the largest calcified meningioma in the literature that was diagnosed incidentally.

Keywords: Calcification, femur fracture, hemiparesis, intracranial tumor, meningioma

P-0454 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Hepatic portal venous gas and pneumatosis intestinalis after cardiopulmonary bypass surgery

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Objective: The postoperative cardiac-origin morbidity and mortality rates for Coronary Artery Bypass Grafting (CABG) are quite low thanks to advances in technology. However, non-cardiac complications are still an important cause of mortality.

We present a case where the very rare complications of air in the portal venous system and pneumatosis intestinalis developed after CABG.

Case: A 60-year-old female presented to the emergency service with abdominal pain and inability to pass gas. The patient had undergone CABG surgery 6 days ago and been discharged from the hospital 1 day ago. Her symptoms included abdominal bloating, mild abdominal pain, and inability to pass gas one day before her discharge. Her physical examination revealed a confused patient in poor general condition with a GCS score of 13, BP 70/50 mmHg, heart rate 130/min, temperature 37.5 oC superficial and tachypneic respiration, and a distended abdomen



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with diffuse sensitivity and guarding. Laboratory results were BUN: 110 mg/dl, Kr: 2.4 mg/dl, AST: 506U/L, ALT: 313 U/L, myoglobin: 2169 mg/dl, LDH: 1334 U/L, and T. Bilirubin: 4.41 mg/dl. The clinical and laboratory findings of the patient were thought to be consistent with the multi organ dysfunction syndrome (MODS). Fluid resuscitation was started. The respiration became superficial and the patient was intubated after RSI. Abdominal ultrasonography showed 2 cm of free fluid in the abdomen. Contrast-enhanced abdominal CT scan revealed diffuse air densities in the intrahepatic portal veins, the main portal vein and superior mesenteric vein, and an increase in the calibration of the small bowel segments and diffuse air densities in the intestinal wall compatible with pneumatosis intestinalis. The patient was transferred to the surgical intensive care unit with a diagnosis of MODS due to pneumatosis intestinalis and portal venous air. There was no response to fluid replacement, vasopressor support and wide spectrum antibiotics and she died 1 day later.

Conclusion: GIS complications that can be fatal should be considered in patients who present to the emergency service after CABG so that the mortality rates can be possibly decreased with rapid diagnosis and intervention.

Keywords: pneumatosis intestinalis, portal venous gas, complications

P-0455 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Sigmoid diverticulitis mimicking acute appendicitis in right sided descending and sigmoid colon: A case report

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Objective: In this article we report on a sigmoid diverticulitis mimicking acute appendicitis on the right descending colon and sigmoid colon, detected by abdominal CT and resolved with medical treatment. This situation was confirmed by colonoscopy three months later.

Case: A 54-year-old man was admitted to the Emergency Department with presence of acute appendicitis symptoms and signs including right lower abdominal pain, nausea, vomiting and fever, for 2 days. Plain abdominal radiography showed that there was no air in the left side, whereas there was massive air in the right side. Abdominal ultrasonography reflected that the cecum, terminal ileum and surrounding mesenteric tissue were thickened and a 9 mm hyperechogenic image on the cecum lateral wall, right paracolic fossa, had free fluid. The CT showed that the cecum, ascending colon, and colon transversum had normal localization, but after the splenic flexure, the descending colon returned to the right side towards the midline and the sigmoid colon coursed on the right side. In addition to 1 cm diffuse wall thickening in a 10 cm segment of sigmoid colon, surrounding mesenteric tissue showed increased density, and the medial wall of the adjacent region of the sigmoid colon included millimetric air density. The patient was treated medically and diverticulosis was confirmed by colonoscopy.

Conclusion: In a patient with lower right abdominal pain, it is important to consider anatomical variations of the gut; if there is any clinical suspicion, appropriate imaging method should be used.

Keywords: Position anomalies of the colon, diverticulitis, acute appendicitis

P-0456 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Yaşlılarda akut safra taşı hastalıkları: Klinik Deneyimlerimiz

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Objective: The prevalence of gallstone disease increases with human longevity. Medical developments in the treatment of acute cholecystitis in elderly are controversial topics, we present our experiences with the treatment of acute biliary disease in elderly patients

Materials-Methods: This retrospective analysis used the records of 172 patients over age 65 were included in this study. Patients were assessed using demographic information, hospitalisation diagnosis, white blood cell count, ASA classification, treatment type, conversion rates, length of hospital stay, morbidity and mortality.

Statistical analyses were performed using the SPSS 20.0

Results: Our sample included 128 females (74.4%) and 44 males (25.6%); the male/female ratio was 1/3. Patients' diagnoses included acute cholecystitis (135, or 78.4 %) and acute pancreatitis (37, or 21.6%). Medical treatment was offered to 113 patients (65.7%) and an open cholecystectomy was performed in 17 patients (9.9%). Two patients (4.8%) were converted, while a laparoscopic cholecystectomy was performed successfully on 42 patients (24.4%). Those who underwent surgery were discharged as cured except for minimal surgical complications.

Conclusion: Treatment choice in acute biliary diseases in the elderly depends on the patient's general condition, severity of the disease, and ASA score. Careful preoperative assessment and patient selection, experienced surgeons and better postoperative care are necessary for successful treatment.

Keywords: Elderly, gallstone, surgery, medical therapy, acute diseases

P-0457 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

The bullet does not ask for an address

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Objective: Firearm injuries have increased in recent years due to the increase in terror incidents and individual arms possession. Penetrating abdominal gunshot wounds are a trauma group with relatively high morbidity and mortality rates where treatment difficulties are still encountered. The most commonly injured organs in this group are the small intestine, colon, liver and stomach.

We emphasize the importance of careful examination and investigation of the patient presenting to the emergency service with a gunshot wound with this case report.

Case: A 43-year-old male patient presented to the emergency service due to a gunshot wound. The patient's general condition was good and he was conscious, cooperating and orientated. BP was 120/69 mmHg, pulse: 105/min, and SaO₂ 93. There was a 1x0.5 cm lesion with irregular contours and a halo was present at the 7th intercostal distance and left midaxillary line, the probable entry point. An exit wound was searched in the whole body but could not be found. Lung sounds were normal. Upper abdominal quadrant tenderness was present with no rebound or guarding. FAST revealed no hemopneumothorax or pericardial effusion. Some fluid was present in Morrison's pouch in the abdomen. Whole blood count revealed Hb: 18.2 g/dL, Htc: % 54.1, Plt: 365,000/mm³. Thorax CT showed 5 mm pleural fluid at the left hemithorax and a nondisplaced fracture line in the anterior section of the left 7th rib. Subcutaneous millimetric air values were observed next to this level. IV contrast-enhanced abdominal CT revealed free air densities in the perigastric area at the left upper abdomen indicating stomach damage, extravasation at the level of the hepatogastric ligament indicating vascular injury and contusion-laceration at the liver right lobe posteroanterior section. In addition, some subhepatic and paracolic fluid and a metallic foreign body inside the abdominal sidewall soft tissue at the level of the L3 vertebra were found. The patient was immediately taken to surgery. Injuries of the liver, stomach and pancreas were found and primary repair was performed. The patient was discharged without problems 8 days later.

Conclusion: The patients should undergo a careful multisystem examination and investigation for gunshot wounds, not just according to the entry site.

Keywords: Firearm injuries, gunshot wounds, careful examination



POSTER PRESENTATIONS

P-0458 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Malignant Melanoma with aggressive behavior

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Objective: We present a malignant melanoma case, which is growing very fast and metastatic lesion have occurred during one year follow up.

Case: A 55 year old female patient had a haemorrhagic lesion about 2 cm diameter, below her left eye. Biopsy was taken after one year latter, the patient applied the emergency department due to excessive growth of the mass in recent times. Dressing was applied the lesion. The patient was evaluated routine blood and radiological aspects. Her history revealed she has a bilaterally loss of vision since 10 years old, and she was a dialysis patient since 25 year. Physical examination exhibited necrotic mass whose diameter was 20 cm. The mass was closed left eye and left ear. Atrophy of both kidneys presented with abdominal tomography, and metastatic mass in the left lung apical region presented with toracal tomography. Computed tomography revealed nodular mass in the left neck region. Numerous lymph node was viewed in both sides of the neck. She has a chronic kidney failure and she was dialysis patient. She didn't accept operation. Only chemotherapy and medical treatment could be performed.

Conclusion: Malignant melanoma originates from dark-melanocytes in the body. Although it generally occurs in the skin, it also occurs a variety region of the body. if treatment isn't performed quickly, the mass can reach greater extent in a very short time and metastasis can occur in a short time. Because it has the most mortality rate among all of the skin neoplasias, dark lesions on the body, crusting and hemoragic lesions should be resected as soon as possible and chemotherapy should be initiated as soon as possible.

Keywords: Malignant melanoma, skin tumour, aggressive behavior

P-0459 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Foreign Body in The Rectum: A Case Report

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Objective: The placement of foreign bodies into the rectum is an uncommon medical problem. Other than for sexual stimulation, foreign bodies have been placed into the rectum during sexual assaults, prostate massage, by accident, to seek attention, or to relieve constipation. It is important for emergency room physicians and general surgeons to be systematic in their approach and be familiar with a variety of extraction techniques and management of colorectal injuries resulting from the insertion or extraction of the foreign body.

Case: A case of a 68 year old man patient who presented to the emergency room for a bottle retained in the rectum, which had been placed there by sexual assault. Abdominal radiography revealed a well-delineated bottle in the rectum with no evidence of bowel perforation. An attempt to remove the bottle manually under sedation was unsuccessful. Surgery with a laparotomy was performed. The bottle was extracted by pushing downward toward the anus. The patient was discharged with full recovery on post-operative day 4.

Conclusion: Rectal foreign bodies are difficult problem because of the type of object, host anatomy, time from insertion, associated injuries and amount of local contamination may vary widely. Most common problem encountered in the management of rectal foreign bodies is the delay in presentation, as many patients are embarrassed and reluctant to seek medical care. The first aim of therapy is to extract the foreign body using the simplest method possible without harming the integrity of the intestine. With adequate sedation, most foreign bodies can be extracted transanally either in the emergency department under direct vision. When these techniques are not available or cannot extract the foreign body, surgery is required.

Keywords: Foreign body, Sexual assault, Rectum

P-0460 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acute abdomen due to a ruptured tubal pregnancy

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Objective: Ectopic pregnancy is one of the most common causes of maternal death. Even if early diagnosis and treatment methods develop in parallel with technological developments, the incidence is increasing with the increase in older age pregnancies and infertility treatments. It should certainly be kept in mind for patients who are β -hcg positive and when the intrauterine amniotic sac cannot be seen.

Case: A 32-year old female who had previously given birth 4 times presented at the Emergency Department of an external centre with complaints of abdominal pain extending to her back which had started 2 days previously. She gave a history of having had a miscarriage 3 weeks previously. In the tests, hemoglobin (Hgb) was determined as 12.9 g/dl, and leukocyte (WBC) as 8700/mm³. Abdominal computerised tomography (CT) was recommended but the patient did not accept this. The following day, the patient presented at the Emergency Department again with complaints of abdominal pain and she was transferred to our centre. Our evaluation determined the patient as tachycardic with arterial blood pressure of 60/40mmHg, Hgb 7g/dl and WBC 15500/mm³. CT was taken under sedation and widespread free fluid was determined in the abdomen. The patient was taken for emergency surgery. In the intraoperative evaluation, 3100cc haemorrhagic fluid and perforation in the left tube were observed. After aspiration of the fluid, a deceased purulent fetus 2x2cm of 12-week size was determined at the left tubal exclusion over the sigmoid colon. The tubal connections of the fetus were excised. On postoperative day 5, the patient was discharged with no complications.

Conclusion: For thousands of years throughout history, the primary method of patient evaluation in the art of medicine has been a detailed anamnesis and systemic examination. However, nowadays rather than talking to the patient and making a detailed examination, evaluation is based on laboratory and radiological test results. In a pregnant patient with a history of bleeding, by not considering that the patient may still be pregnant or the possibility of ectopic pregnancy, requesting a series of tests rather than just β -hcg, leads to delayed diagnosis in an event such as ectopic pregnancy and morbidity and even mortality. As physicians, all cases should be approached with doubt and the application of algorithms learned during training must not be forgotten.

Keywords: Ectopic pregnancy, maternal death, anamnesis, systemic examination

P-0461 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acute mesenteric ischemia occurring due to the idiopathic brid formation on mesenteric root

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Objective: The thrombus in bowel vein, the internal obstruction based on emboli or acute mesenteric ischemia (AMI), which is defined as a disruption in bowel nutrition based on external pressure are some of the non-traumatic emergency diseases that have the most mortality and morbidity based on delays in their diagnosis and treatment. Ileus is a multifactorial occurrence which can develop based on a lot of causes. While the adherence based on recent operations is the most frequent etiological factor, the electrolyte imbalance and space-occupying occlusive



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lesions are some of the frequent reasons. Based on etiological and predisposing factors, its treatment varies from conventional follow-up to massive resection.

Case: In the examination of a 30-year-old male patient who visited the emergency service because of acute abdominal pain and vomit but did not have any laparotomy history or comorbid factor, WBC:18100/mm³ biochemical examinations were natural and minimal air-liquid level was determined in abdomen graphy. 250 cc intestinal content was determined for the patient with naso-gastric catheter. In contrast abdomen tomography, minimal dilatation was observed in ileal ans. As a result of physical examination, the patient with rebound and defence positivity was taken into emergency operation by being regarded as acute abdomen. In exploration, mesenteric ischemia was determined based on 5 mm brid that surrounded meso stem of 100 cm ileum segment in the shape of a band and stopped the flow completely. The brid was opened but any flow could not be obtained. Segmenter intestinal resection and end side ileotransversostomy were practised. The patient was discharged from the hospital smoothly on postoperative 8th day.

Conclusion: In ileus, while malignancy is the most frequent etiological factor for geriatric patient population, brids are the most frequent ones for non-geriatric patient population based on recent operations. It should be kept in mind that, sometimes as in the presented case, spontaneous brids that can occlude the passage completely or stop the blood flow exactly may occur and loss of time may raise morbidity and mortality rates for even young patients who do not have any laparotomy and malignancy symptoms.

Keywords: acute mesenteric ischemia, ileus, laparotomy, idiopathic brid

P-0462 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Diagnostic Importance of Neutrophil/Lymphocyte Ratio in Patients with Acute Cholecystitis

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Objective: Acute cholecystitis is one of the major causes of abdominal pain in admission to the emergency department. Given that the number of neutrophils increase and the lymphocyte decrease as a result of physiological response of the circulating leukocytes to inflammation, the Neutrophil / lymphocyte ratio (NLR) is used as an inflammatory marker together with other inflammatory markers. In this study we investigated the diagnostic value of the NLR in the diagnosis of acute cholecystitis, in patients who admitted to the emergency department with complaint of right upper quadrant pain.

Materials-Methods: In this study, 318 adult patients who admitted to the emergency department with complaint of right upper quadrant pain, who evaluated with ultrasonography and other necessary medical records were available between July 1 and December 31 2013 were included. The patients were divided into three groups: acute cholecystitis, cholelithiasis and no pathology. Diagnosis of acute cholecystitis is made according to the criteria of Tokyo Guideline.

The patients with a history of infectious, autoimmune or neoplastic diseases, previous surgery or recent trauma, who were treated with immune suppressive or steroid drugs, and the patients with severe hepatic or renal failure were excluded from the study. The demographic characteristics ultrasonographic findings and a complete blood count parameters of the patients were recorded. After the patients were divided into groups the NLR scores were calculated from patients' blood parameters.

Results: A total of 382 patient files were examined and 318 patients were included in the study, 64 patients matching exclusion criteria were excluded from the study. 221 patients (69.5%) were female and 97 patients (30.5%) were male and the average age was 47.12 ± 17.30 . Fifty eight patients (18.2%) had acute cholecystitis, 70 patients (22%) had cholelithiasis and in 190 patients (59.8%) no pathology was detected. The mean age was 55.87 ± 18.48 in the acute cholecystitis group, 46.41 ± 16.27 in the cholelithiasis group, and 44.71 ± 16.52 in "no pathology" group. Average NLR scores were 8.78 ± 6.30 in acute cholecystitis group, 2.93 ± 1.69 in cholelithiasis group, and 3.72 ± 4.02 in "no pathology" group ($p < 0.001$)

Conclusion: NLR was significantly higher in patients diagnosed with acute cholecystitis when compared to the other two groups. NLR is a valuable data which can be used together with other markers of inflammation, in the diagnosis of acute cholecystitis.

Keywords: Neutrophil/Lymphocyte Ratio, Acute Cholecystitis, Emergency Medicine

P-0463 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Asymptomatic Giant Hydronephrosis

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Objective: Abdominal pain is one of the most common complaints of patients who admitted to the emergency department. Some of the patients admitted with abdominal pain might have serious pathologies such as peptic ulcer perforation or aortic aneurysm rupture and on the other hand many patients have more trivial pathologies such as dyspepsia. While medical history, physical examination, laboratory tests and ultrasonography helpful to differentiate diagnosis, Computed Tomography (CT) is used with increasing frequency. We aimed to present a case which; the patient who admitted to emergency department with abdominal and back pain, and also has resistant hypertension; incidentally detected bilateral giant hydronephrosis while screening of thoracoabdominal CT scan for differential diagnosis of dissecting aortic aneurysm.

Case: 77 years old female patient was transferred to the emergency department from another center due to high blood pressure, abdominal and back pain. In the medical history, she has hypertension. Right-arm blood pressure was 210/110mmHg and left arm blood pressure was 170/100 mmHg measured. In abdominal examination there was a mass palpated in the right upper zone. Routine laboratory tests; Blood Urea Nitrogen was 98mg/dl, Creatinine was 4.07 mg / dL detected. Thoracoabdominal CT scan, without contrast due to high creatinine level, was taken for differential diagnosis of dissecting aortic aneurysm. In thoracoabdominal CT; diameters of thoracic and abdominal aorta was normal, and the flap was not observed. However, urolithiasis; sized 15mm and 23 mm in the medium lower part of the right ureter, and 15mm size in the proximal left ureter; and grade 3 hydronephrosis detected in both kidneys. Patient undergo bilateral percutaneous nephrostomy catheter placement by urology department. 1300ml urine came out from the right catheter, 1000ml urine came out from left catheter.

Conclusion: Urinary tract obstruction has variable clinical presentations. Besides the asymptomatic hydronephrosis cases there are patients with presenting renal colic tables are available. Usually in asymptomatic patients, hydronephrosis could be developed for a long period of time. In these patients diagnosis of obstruction is more difficult and in most cases it is detected by chance. The presence of more than 1,000 ml of fluid in the collecting system and thinning of parenchymal tissue is defined as the giant hydronephrosis. In giant hydronephrosis mass palpated in abdomen and is associated with chronic renal failure when it is bilateral. As in our case, while addressing the masses, palpated in the abdomen examination; the giant hydronephrosis should be considered in the differential diagnosis.

Keywords: abdominal pain, emergency department, hydronephrosis

P-0464 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Rectus Sheath Hematoma Due to Taking the Shuttle

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Objective: Rectus sheath hematoma (RSH) is a relatively rare condition among the causes of acute abdomen. It occurs as a result of collection of blood in the rectus sheath due to rupture of the epigastric vessels in the anterior sheath of the rectus abdominis muscle or rupture of the rectus muscle fibers.

Considering this condition in the differential diagnosis may facilitate early diagnosis and may prevent unnecessary invasive procedures and diagnostic delay. In this report we present case of RSH which were conservatively treated.

Case: Thirty-three year old female patient admitted to the emergency room with complaints of abdominal pain, which began after sit-up exercise. The patient had no other symptoms accompanying abdominal pain. In the patients history she had no known disease or continuing treatment. She was conscious, cooperative, and oriented on admission to the emergency department. Vital signs were stable. On physical examination, tenderness was present in the bilateral lower abdominal quadrants and suprapubic area, increasing by leaning forward. Other system examinations were normal. In laboratory tests biochemical parameters were normal and WBC was 9000 μ /L, Hg: 13.8 g/dL, hematocrit: 42.5, Plt: 337,000 μ /L, INR: 1.08, PT: 12.9sec, and PTT: 31.2 second, respectively. In abdominal ultrasonography (USG) no intra-abdominal pathology was seen, but liquid reaching a thickness of 4 mm in the right and 3 mm in the left was viewed in the medial of bilateral rectus muscles (Figure 1-2). There was no intra-abdominal pathology. The patient was treated with fluid replacement and IV analgesics. Complete blood counts were followed and hemoglobin values did not decrease. In the follow up ultrasonography there was no increase in rectus muscle hematoma. After the patient was relieved with analgesics, she was discharged from the emergency department with suggestions.

Conclusion: Although RSH is a well-known clinical diagnosis often overlooked when investigating different reasons of acute abdominal pain in the emergency department and/or it may cause unnecessary surgical interventions, but it is a well documented clinical condition.

RSH differs from the other causes of acute abdomen in the emergency room in terms of treatment planning. Early diagnosis, avoids unnecessary tests and invasive procedures.

Keywords: Rectus Sheath Hematoma, Emergency Medicine, Abdominal Pain



POSTER PRESENTATIONS

P-0465 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

I felt air inside me

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Objective: Rectum is a small organ, 15-20 cm in length, which extends from sacral promontorium to anal verge. Rectal injury is caused frequently by gunshot wounds and more rarely stabbing, pressurized water and air pistols. Mortality rate of isolated rectal injury is % 4-22. The most common cause of mortality is iliac vascular injury. Preoperative treatment with antibiotics decreases the rate infection down to 7%. Diagnostic tools include radiography, sigmoidoscopy and computed tomography (CT).

Case: A 39 year old woman admitted to the emergency department with story of falling on the hose air compressor in the workplace. During the examination the patient told that she felt as if air filled into her. The general condition of the patient was well and vital signs were stable. In physical examination, tenderness in coccyx and abdomen was present. Rectal examination was normal. No pathology was detected in USG examination of the whole abdomen. In the follow-up, patient's abdominal tenderness increased and rebound and defense developed. In the IV contrast-enhanced abdominal CT scans, free air was observed in the rectosigmoid and perirectal areas extending to the right retroperitoneal space. Treatment with IV antibiotics was started and the patient was operated by general surgery department. In the operation perforation in the posteromedial rectosigmoid junction, about 4-5 cm in length was detected and primary repair was performed.

Conclusion: CT is more valuable than radiography and ultrasonography in the diagnosis of gastrointestinal tract perforation. Sigmoidoscopy and rectal examination are the most important methods of examination in rectal injuries. But additional injuries can not be diagnosed by these methods. Although radiography is the first test in the diagnosis of perforation it's sensitivity is between 50 - 70%. There are studies reporting possibility of overlooking the perforation in the USG examination, because of free air. CT is the most useful method for detecting presence and location of gastrointestinal perforation. The use of oral contrast is still controversial. As a result, CT is the most reliable diagnostic tool in patients with suspected gastrointestinal perforation, whereas other methods may not be confirmatory.

Keywords: compressor, rectal perforation, ultrasound

P-0466 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Meningioma presenting as seizure

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Objective: Meningiomas are generally located supratentorially (90%). The most common sites are parasagittal and falx localization. These tumors are usually benign in nature (90%); however, a small percentage are malignant. Many meningiomas are asymptomatic, producing no symptoms throughout a person's life, and require no treatment other than periodic observation. They are mainly diagnosed incidentally. Though very rare they may present as seizure.

Case: A 75 year old male patient was brought to the emergency department after having a generalized tonic clonic seizure that lasted about 3 minutes. He had history of hypertension but has never had seizure before. On arrival his vital signs were; blood pressure:160/90 mmHg, Pulse:89/min and temperature:37 degrees. He was drowsy but his systemic examination was normal. His laboratory results were also unremarkable. His cranial tomography revealed a meningioma 1.5-2 cm at the falx localization. After consultation the patient was admitted to the neurosurgery ward.

Conclusion: Meningiomas are mainly diagnosed incidentally. It may cause headache, nausea, vomiting, alteration in consciousness and also seizure. Emergency physicians should consider meningioma as differential diagnosis in patients presenting with seizure. The treatment is surgical resection.

Keywords: Meningioma, seizure, surgical resection

P-0467 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Complication of endoscopic thoracic sympathectomy

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Objective: Endoscopic thoracic sympathectomy (ETS) is a surgical procedure used in treatment of hyperhidrosis. The procedure is performed under general anesthesia. The operation is accomplished by penetrating the thoracic cavity through the axilla region and dissecting the nerve tissue of the main sympathetic chain. Apart from normally encountered surgical complications like bleeding and infection some rare complication like pneumothorax and subcutaneous amphysema may also be encountered. Here we present a patient who had pneumothorax, atelectasis and subcutaneous amphysema as a complication of ETS.

Case: A 19 year old male patient presented to the emergency department with dyspnea. In his history we learnt that he underwent ETS for treatment for hyperhidrosis 2 days ago. His vital signs were normal. His physical examination revealed a subcutaneous amphysema that extended through the cervical region, right hemithorax anterior side, right axilla and right sub-scapula area. The thoracic tomography showed right sided pleural effusion, right lung lower lobe subtotal atelectasis, pneumothorax in the apical region of the right lung, and extensive subcutaneous amphysema that involved the deep fascia of the pectoralis and the latissimus dorsi muscles. The patient was consulted to the surgery department and admitted.

Conclusion: Though it is rare, following an ETS procedure, post operative complications like pneumothorax, atelectasis and subcutaneous amphysema can be encountered. Emergency physicians must be aware of such a complication in patients who present with dyspnea after an ETS procedure and should evaluate such patients with thoracic tomography.

Keywords: ETS, hyperhidrosis, pneumothorax, subcutaneous amphysema

P-0468 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Gluteal penetrating injuries

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Objective: The aim of this study is to evaluate the epidemiologic features of gluteal penetrating injuries (GPIs) and the effect of anatomic localization and muscle tissue penetration in severe cases.

Materials-Methods: Forty-two patients admitted to our hospital emergency service between 2010 and 2012 for gluteal penetrating injuries were included in the study. Hospital records were evaluated retrospectively.

Results: Thirty-six (85.7%) patients were male, and six (14.3%) patients were female. The mean age was 32.55 ± 12.85. Seven (31.8%) of the lower GPI patients had soft tissue hematomas, seven (31.8%) had intramuscular hematomas, two (9%) had vascular injuries, one (4.5%) had a peritoneal injury, one (4.5%) had a bone fracture and one (4.5%) had nerve injury. None in this group had rectum injury. Three (13.6%) lower GPI patients had severe injury, and all had muscle penetration.

Eight (31.8%) of the upper GPI patients had soft tissue hematomas, 10 (50%) had intramuscular hematomas, three (15%) had intraperitoneal injuries, one (5%) had a rectum injury and one (5%) had vascular injury. None in this group had bone fracture or nerve injury. Five (25%) of the upper GPI patients had severe injuries.

Lower and upper GPI localizations were not related to the severity of the injury ($p > 0.05$). Severe injuries were more common in patients with muscle penetration ($p < 0.004$).

Conclusion: Gluteal penetrating injuries (GPIs) are rare. These injuries are usually superficial and can be treated with local wound care. Severe, life-threatening injuries might occur in GPIs, and our study showed that severe injuries can happen in upper and lower GPIs. Anatomic classification did not predict the severity of injury. We recommend wound exploration in the initial evaluation of all GPIs. Patients with evidence of muscle penetration should be evaluated with further diagnostic imaging.

Keywords: Gluteal injury, muscle, anatomy



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P-0469 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Oxidized Nail Aspiration in Left Bronchus and Retrieval of the Nail via Scopy

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Objective: Foreign body aspiration is a common emergency especially in childhood and constitutes major cause of mortality. It may be asymptomatic or occurs with serious complications and death. We present a 53 year old male building worker who aspirated an oxidized nail accidentally into his left bronchus while working and successfully retrieval of the nail via scopia.

Case: A 53 year old build worker male patients had aspirated oxidized nail 2 hours ago while working and he admitted to government hospital and he was sent to our emergency service. He was holding a nail between his lips and he said it was happened while trying to talk. He has coronary by-pass history and had been smoking 30 pacs/year. His vital signs were; TA:120/80mmHg, HR:86/min, BR:14/min, sPO2:92. His physical examination was normal including thorax auscultation. The radioopaque nail image was seen on his computed tomography. He received tetanus immunisation and prophylactic antibiotic at the government hospital's emergency unit. We consulted the patient with chest surgery and the patient underwent to surgical room for retrieval of the nail. After anaesthesia with propofenon (2mg/kg), 8.5 rigid bronchoscope was used to see the nail. The oxidized metal was seen at the basal subsegment of the left bronchus, then the optic part of the device was removed. We reached the metal nail via scopy imaging and retrieved it with forceps. No complications occurred after bronchoscopy and the patient was discharged after one hospitalisation day.

Conclusion: Emergency clinicians should always consider and handle acute foreign body aspirations an emergency and immediately consultate the patient with surgery clinic for immediate removal of the foreign body.

Keywords: Foreign body aspiration, nail, scopy, left bronchus

P-0470 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Spontaneous rupture of renal angiomyolipoma as a cause of acute retroperitoneal hemorrhage: case report

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Introduction: Angiomyolipoma is a rare mesenchymal tumor composed of the mixture of mature fat tissue, smooth muscle cell bundles and thick-walled blood vessels. Although often benign, some types are considered as malign. Two types were described: sporadic or associated with tuberousclerosis. We report a case who underwent emergency laparotomy due to massive retroperitoneal hemorrhage because of anjiomyolipoma rupture.

Case: A 35-year-old woman was admitted to emergency service because of left flank pain, nausea and vomiting. She was transferred to our emergency department from emergency room of other hospital for acute left flank pain interpreted as a renal colic and not responsive to medical therapy. She has no feature in her and family history. On clinical examination she was hemodynamically instable with rapid decrease in hemoglobin (Hb: 6.7mg/dL), with a persistent left flank pain and hypochondrium pain as in acute abdomen. Blood pressure:80/40 mmHg, heart rate:135/min. Physical examination revealed skin lesions on her face like adenoma sebaceum. Abdominal ultrasonografi showed hyperechoic lesions around the left kidney (the largest is 12cm diameter), suspected hematoma around the left kidney, hyperechoic lesions with the same characteristics like on the left kidney on the lower pole of the right kidney (the largest is 2cm diameter), abdominal free fluid. Subsequent computed tomography of the abdomen revealed areas with fat density at the lower pole of the right kidney (35mm) and exophytic renal mass lesions. The appearance which suggested bleeding was detected in the left kidney, which was more pronounced in the lateral segment and enlargement of the left psoas muscle was revealed. Free fluid viewed in the pelvic area and abdomen. The patient was consulted by general surgery and urology doctors. She underwent emergency laparotomy. Retroperitoneal hemorrhage due to renal angiomyolipoma rupture was observed. Left radical nephrectomy was done. The patient was stable in perioperative course. 4U of packed red cells transfused during the operation. She was transported to intensive care unit(ICU) after the operation. The postoperative period was uneventful. The patient discharged from ICU unit one day later and from hospital one week later. Pathology report declared angiomyolipoma. Tuberousclerosis was not detected in the genetic analysis.

Consequently, AML often accompany tuberousclerosis, but also available spontaneously. The most important complication is massive retroperitoneal hemorrhage. While choosing treatment methods, renal functions should be preserved maximally. In the emergency room with a diagnosis of renal colic patients are advised to check with the ultrasonography and computer tomography.

Keywords: angiomyolipoma, rupture, retroperitoneal hemorrhage

P-0471 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Gallstone ileus without bilioenteric fistula

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Introduction: Gallstone ileus, is a rare complication of cholelithiasis in the long term. Early diagnosis and treatment significantly reduces mortality. Gallstone ileus is a caused by the bilioenteric fistula of gallstones into the intestinal lumen. It is a rare disease and accounts for 1%-4% of all mechanical intestinal obstruction. It usually occur in the elderly with a female predominance. The morbidity and mortality rate of gallstone ileus remain very high because of difficult diagnosis, misdiagnosis and delayed diagnosis. Here, we report a case of gallstone ileus without bilioenteric fistula of gallstones into the intestinal lumen.

Case: A 79-year-old woman was brought to our emergency department because of 2 day history of dizziness, vomiting and abdominal pain. She had medical history of hypertension and end stage renal failure. She have been followed regular hemodialysis programe. She underwent cholecystectomy two years ago. Blood pressure was 90/60 mmHg and pulse rate was 90 beats/min. Her abdomen was slightly distended but soft with tenderness. Bowel sounds were weak but audible. Significant laboratory results were: white blood cell count 19300mm3, urea 127 mg/dL, creatinin: 5.99 mg/dL, hemoglobin. 11 mg/dL. Computed tomography of the abdomen revealed air-fluid levels that support the diagnosis of ileus. She underwent an emergency laparotomy. After laparotomy, a stone was palpated in the jejunum about 20 cm proximal of the ileocecal valve. When the jejunum was opened, the stone was observed. Enterolithotomy was performed. A histopathological examination revealed a gallbladder stone (3.5 cm x 2.5 cm x 2.2 cm). The patient was taken to intensive care unit with inotrop support and died 2 days after the surgery.

Conclusion: Gallstone ileus, is a cause intestinal obstruction especially in elderly and in patients who had biliary tract problems previously. The morbidity and mortality rate of gallstone ileus is very high so we want to emphasize early diagnosis of gallstone ileus. Early diagnosis and surgical intervention reduces morbidity and mortality. However, gallstone ileus without bilioenteric fistula like our case, is extremely rare.

Keywords: gallstone, ileus, enterolithotomy

P-0472 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Phytobezoar

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Objective: Bezoars are usually solid masses composed of vegetable fibers (phytobezoar) or ingestion of hair (trichobezoar) or other materials that accumulate in gastrointestinal system. Phytobezoars consist of fibers and seeds of indigestible plants and fruits in digestive system. Bezoars that are generally formed in stomach can cause small bowel obstruction and perforation which is very rare. Clinical symptoms and findings such as sense of fullness in epigastric region, abdominal pain, nausea, vomiting, loss of appetite imitate peptic ulcer and carcinoma.

Case: A 60 year-old female suffering almost one month of increasing sense of fullness in epigastric region and abdominal pain, loss of appetite, nausea and vomiting, applied to emergency service. Patient had no past medical history and medicine prescribed except for cholecystectomy. Vital signs of patient on admission were stable and physical examination revealed abdominal



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tenderness in epigastric region. There was no defense or rebound. Physical exam and laboratory tests revealed WBC 7.8, Hgb 9.4, Hct 28, Glucose 113, Urea 28, Creatinine 1.06, ALT 14, AST 18, Bilirubin Total/Direct 0.24/0.09, ALP 73, GGT 17, Amylase 56, Lipase 55. PAAC X-ray did not identify any (clinical) features. Although IV PPI and antiemetic were used, resistant epigastric pain continued. Hepatobiliary USG was done and abdominal scan without contrast was performed afterwards. The only finding was cholecystectomy. Due to resistant epigastric pain and nausea, an endoscopy was performed by general surgeon in which a phytobezoar was detected but could not be removed. In an operation performed by general surgeon phytobezoar in the stomach was removed.

Conclusion: Bezoars can be detected incidentally during other examinations although there are not any clinical symptoms. They can cause abdominal pain, nausea, vomiting, bleeding, ulceration, intestinal obstruction and perforation, as well. For this reason, bezoars should be taken into consideration in differential diagnosis.

Keywords: Phytobezoar, Epigastric pain, Emergency department

P-0473 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Uterine rupture in pregnancy

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Objective: Rudimentary horn of a unicornuate uterus is one of the uncommon anomaly of the female genital tract. It causes many obstetric and gynecologic complications. A pregnancy in a rudimentary horn is very rare. Uterine rupture risk in second trimester of pregnancy is very high because the muscle structure of the rudimentary horn is weak. If it is not diagnosed and treated approximately, the mortality risks are high for mother and fetus. For this reason, early diagnosis is significant.

Case: A 32 year-old female presented with pregnancy at 17 weeks according to the last menstrual period. This was the second pregnancy. The patient had in her history a c-section operation and a right unicornuate uterus with left rudimentary horn. Due to 10 days of increasing abdominal pain, the patient had been examined by two different obstetricians and she was told that it was not related to pregnancy. The patient was brought to emergency service (by 112) with abdominal pain that began an hour ago and she had near-syncope. She was observed to be in bad general condition but she was cooperative, lethargic. Her skin was cold, clammy and sweating. Blood pressure was 70/40 mmHg and pulse 138. On systemic examination, abdominal tenderness, defense and rebound were found. 2000cc IV bolus saline was initiated via bilateral antecubital vein. Laboratory values revealed Wbc 15.500 mm³, Hb 8.4g/dl, Htc %25, Plt 397.000 mm³ Glucose 148, Urea 21, Cr 0.65. The patient was evaluated as having hemorrhagic shock resulted from bleeding that depends on pathology secondary to the pregnancy. The patient was referred to an obstetrician for consultation urgently. Bedside USG that is performed by the obstetrician showed 17w fetal heart rate, positive CRL and intraabdominal fluid. General surgeon consultation was required. Despite IV fluid treatment, erythrocyte suspension was given to the patient with hemorrhagic shock. Obstetrics and Gynecology and General Surgery took the patient under operation urgently. It was understood that present condition was caused by uterine rupture. The patient was admitted to the postoperative intensive care unit immediately.

Conclusion: For patients with abdominal pain and shock in second and third trimester of pregnancy, uterine rupture should always be given priority in provisional diagnosis.

Keywords: Uterine rupture, pregnancy, shock

P-0474 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Patient with kidney stone pain: unilateral renal artery thrombosis

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Objective: Acute renovascular obstruction is difficult to diagnose, and only when there is a high clinical suspicion it can be investigated and determined. Acute renovascular obstruction should be considered, especially in the presence of acute flank pain in patients with valvular heart disease, atrial fibrillation, endocarditis and in patients with embolic attack history. Although acute renal infarction might be asymptomatic, a patient can apply (to ED) with complaints of sudden and severe onset abdominal and lumbar pain, nausea and vomiting. A patient with pain in lumbar region that was similar to severe left-sided renal colic presented to the clinic.

Case: A 41 year-old female who received medical treatment for pain in left lumbar region that began 24 hours ago applied because her pain did not go but sharpened and she had nausea. There was nothing significant in past medical history. On physical examination, the patient was in good general condition, conscious, cooperative and well-oriented. Vital signs of the patients were stable, lung sounds were normal, heart sound S1+, S2+. There were no arrhythmic sounds or bruits, abdominal tenderness in left lumbar region, defense or rebound except CVAT(+). Pulses were palpable and strong both in the upper and lower extremities. ECG revealed sinus arrhythmia. Laboratory values revealed complete blood count within normal range except leukocytosis (12.700) and the parameters measured in urinalysis were normal. Liver and kidney function tests were within normal limits. There was no significant pathology in renal ultrasound. The patient who continued to have pain in spite of medical treatment underwent IV contrast enhanced CT scan of abdomen. CT scan demonstrated non-enhancing wedge-shaped hypodense areas in left kidney. The patient with diagnosis of left renal artery partial thrombosis was admitted to the urology service.

Conclusion: Patients with complaints of pain in lumbar region that is similar to renal colic should be evaluated carefully because it should not be forgotten that acute renovascular can imitate renal colic symptoms and findings in pathologies.

Keywords: Renal colic, Lumbar pain, Renal artery thrombosis

P-0475 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Choledochocoele (Type III choledochol cyst - in intraduodenal portion of the bile duct)

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Objective: Choledochol cysts are less common in adults than in childhood, and it's congenital. Child patients mostly present with abdominal pain, jaundice and a palpable abdominal mass whereas adult patients present with right upper quadrant pain, jaundice, acute pancreatitis. Bile duct cysts can be diagnosed in cholangitis examinations. In cases of cholecystitis, cholangitis and pancreatitis findings of infections accompany the presentations. A patient with acute pancreatitis is presented. Patient also has abdominal pain, nausea and vomiting.

Case: A 18 year-old-female applied to emergency service with complaints of epigastric pain for the past few days, nausea and vomiting. The patient had no past medical history and medicine prescribed. Vital signs (of patient) on admission were stable and physical examination revealed abdominal tenderness in epigastric region. There was no defense or rebound. Physical exam and laboratory tests revealed WBC 13.7, Hgb 12.1, Hct 37.3, Glucose 82, Urea 28, Creatinine 0.67 ALT 13, AST 21, Bilirubin Total/Direct 0.84/0.31, ALP 86, GGT 5, Amylase 238, Lipase 597, HCG total < 2 and urinalysis revealed ketones of 1+. Hepatobiliary USG of patient detected a cystic formation of 13 mm in diameter in intraduodenal position of the distal common bile duct. Afterwards IV contrast enhanced CT scan of abdomen revealed cystic lesion of 10 mm in the second portion of the duodenum. The patient was kept under surgical observation and oral intake stopped. IV fluid replacement was provided. General surgical consultation was performed. The patient recovered after medical treatment, vital findings and physical examination were normal, WBC count and amylase/lipase levels fell. The patient had no problem in oral intake. Consequently the patient was discharged with general surgery polyclinic follow-up.

Conclusion: While the etiology of abdominal pain, jaundice and pancreatitis is investigated especially in young patients, anatomy of biliary tract should be checked carefully and a congenital choledochol cyst that might be a baseline in differential diagnosis should be taken into consideration.

Keywords: Choledochol cyst, Choledochocoele, Pancreatitis

P-0476 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Perforated sigmoid diverticulitis

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Objective: Diverticular disease over 60 years in the West, affects more than 50% of the population and is more common as the population ages. It is one of the complications of diverticular disease diverticulitis and colon perforation may result. Perforated (punctured) diverticular disease is not uncommon, despite the simultaneous colonic perforations in diverticulitis is rare.

Case: 41 year old male patient was admitted to emergency department with abdominal pain going on about three days. The patient's general condition is good conscious, oriented and cooperative. BP: 125/70 mmHg, HR: 94/min, RR: 14/min, fever: 37.4 was detected. On physical examination, there were more pronounced and rebound tenderness in the lower quadrant abdominal predominantly. In laboratory testes glucose: 98 mg / dL, kidney and liver function tests, lipase and amylase was normal, CRP: 147 mg/L, WBC: 17,470 mm³ and Neutrophils 14,470 mm³. There was no free air under the diaphragm at chest radiography. Abdominal ultrasonography was reported as suspected diverticulitis. Due to the patient's acute abdomen, oral-intravenous contrasted thoraco abdominal CT was taken, multiple diverticula at descending colon and rectosigmoid region in air density, which is and surrounding fatty tissue density increases with the free air was detected. Patients with a diagnosis of perforated diverticulitis was consulted to the general surgery and he was admitted to general surgery service for operation.

Conclusion: Only 2% of patients with diverticulitis are under 40 years of age. In recent years, the incidence of diverticulitis in younger patients with abdominal pain are increasing. With lower quadrant pain in the preliminary diagnosis of diverticulitis in younger patients and complications related to diverticulitis may also be kept in mind.

Keywords: Sigmoid diverticulitis, sigmoid perforation, emergency department



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P-0477 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Don't underestimate acute pancreatitis

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Objective: Hydatid cyst is a parasitic infection that is caused by Echinococcus granulosus. It is seen anywhere in the body but mostly at the liver and lung. Hydatid cysts may rupture should always be kept in mind. Spontaneous rupture, due to trauma or during surgery can take place and rupture into the biliary tract, blood vessels, bronchi or intraperitoneal may occur.

Case: 48 year old male patient was admitted to emergency department with abdominal pain, nausea and vomiting for two days. The patient's general condition is good conscious, oriented and cooperative. Any systemic disease or trauma history was available. Vital signs were found to be stable. On physical examination, there was rebound tenderness in the right superior quadrant abdominal predominantly and positive murphy sign. In laboratory testes glucose: 125 mg / dL, urea: 38mg/dL, Cr: 0.98mg/dL, AST: 399U/L, ALT: 463U/L, TB/DB: 2.14/1.63 mg/dL, GGT:624 U/L, LDH:370 U/L, amylase/lipase: 1391/2352 U/L, WBC: 20.950 mm3 and Neutrophils: 19.830. There was no sign at chest and abdomen radiography. Abdominal ultrasonography at liver segment 5 about 68 * 60 mm size Type 2 hydatid cysts, IHBD right lobe predominant dilatation of the common bile duct calibration increased, bile duct lumen within and gallbladder cyst contents belong to the view (hydatid cyst bile duct opening up to?). As the patient's acute abdomen state was surviving, contrast-enhanced whole abdominal CT scan was taken and at liver widest spot 75 * 64 mm in size hypodense appearance of cystic lesions and adjacent to the right being more pronounced IHBD the main bile duct and common bile duct dilated view (IHBD to hydatid cyst showing expansion stage 1) were detected. Hydatid cyst ruptured into the biliary tract was determined and he was admitted to general surgery service.

Conclusion: Spontaneous rupture of hepatic hydatid disease, although rare, especially those living in endemic areas or those with a history in endemic areas have to be considered in the differential diagnosis of acute abdomen.

Keywords: Hydatid cyst, acute abdomen, acute pancreatitis

P-0478 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A rare fracture in the emergency services: hamate fracture

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Objective: Wrist contains 8 carpal bones which are associated with a network of tightly interwoven ligamentous connections and located between the forearm and hand. In general, mechanisms that cause carpal fractures are injuries of moderately high energy. Hamate fracture, constitutes about 2% of carpal bone fractures.

Case: 40 year old male patient was admitted to the emergency service with complaints falling on his right hand. At the physical examination of patient tenderness were detected on his right hand and wrist with palpation and movement. The patient had no motor or sensory deficits. We detected hamate fracture in patient and he was held a consultation to the orthopedics. Short arm splint was applied to the patient, and he was discharged by prescription analgesic and anti-inflammatory treatment.

Conclusion: Patients who admitted to the emergency services with precision of wrist, especially common in fall and athletes, should be examine carefully with their radiographs and carpal bone fractures which are difficult to detect should be kept in mind.

Keywords: hamate, wrist, radiography

P-0479 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acute pancreatitis due to a hydatid cyst of the liver: A case report

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Objective: Primary liver hydatid disease is endemic in many countries, including those around the Mediterranean, Central Asia, the Far East and Latin America. There is no case of acute pancreatitis due to a hydatid cyst of the liver.

Case: A 64-year-old male patient with a persistent, severe epigastric pain radiating to the back, nausea and vomiting for two days referred to ER. He had no chronic disease. On abdominal examination, he had epigastric tenderness and right upper quadrant tenderness. Abdominal ultrasound revealed a multilocular semisolid lesion of 123x93 mm in size located in the right-posterior side of the liver. His white blood cell count was 12,9 x109/L (reference range: 4.0-10.0 x109/L), serum total bilirubin was 6,0 mg/dL (reference range: 0.3-1.2 mg/dL), serum direct bilirubin was 3,18 mg/dL (reference range: 0,0 – 0,2 mg/dL) serum aspartate aminotransferase (AST) was 162 U/L (reference range: 0-50 U/L), serum alanine aminotransferase (ALT) was 237 U/L (reference range: 0-50 U/L), serum amylase level was 1,897 U/L (reference range: 22 - 80 U/L), serum lipase level was 3946 U/L (reference range: 0,0 - 67 U/L) and serum gamma glutamyl transferase level was 458 U/L (reference range: 0,0 - 55 U/L). The patient was admitted to gastroenterology service. Oral intake was stopped and fluid and electrolyte replacement were begun parenterally. MRCP of the choledochus reported that the median lumen of choledochus was wider than normal and gives an "image" of the abnormal duct. ERCP was reported normal. The patient consulted to general surgery. Partial cystectomy and omentectomy were performed. Excised material was confirmed as a hydatid cyst in histopathological examination.

Conclusion: Hydatid disease, is a common condition worldwide and continues to be a high incidence societal problem in many countries on all continents. A hydatid cyst of the liver is a common condition but acute pancreatitis due to a hydatid cyst of the liver is an extremely rare condition. In fact there isn't any case report in literature. Radiological examinations and laboratory findings may help clinicians in diagnosing cystic masses in abdominal organs. The clinicians must be aware such this conditions in acute pancreatitis patients.

Keywords: hydatid cyst, pancreatitis, hydatid disease

P-0480 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare coexistence; scaphoid and triquetral fracture

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Objective: Injuries to the wrist are common in children, adolescents, and young adults. Carpal fractures account for 18 percent of hand fractures and 6 percent of all fractures. The scaphoid is the most commonly fractured carpal bone, accounting for approximately 68 percent of all carpal fractures. Triquetral fractures are the second most common carpal bone fracture and are usually ligamentous avulsion fractures. The purpose of this paper is to report the coexistence of scaphoid and triquetral fracture with an adult patient.

Case: A twenty one year old man was admitted to the emergency department after falling on an outstretched and. He was complaining about pain in his wrist. There was swelling and tenderness of the anatomic snuff box and ulnar aspect of wrist, decreased range of motion in flexion and extension. X-ray showed a fracture at scaphoid and triquetral bone. Computed tomography showed that proximal fracture of scaphoid and fracture at triquetral body. The scaphoid treated with closed reduction and internal fixation and the patient followed with short arm cast for six week.

Conclusion: Triquetral fractures are associated with carpal instability and there is risk of avascular necrosis for scaphoid fracture. Emergency physicians should be careful at wrist injuries because of accompanied unclear fractures.

Keywords: scaphoid, triquetral fracture, trauma

P-0481 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acute Myokardial Infarction Following Bupropion (Zyban)

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Objective: Smoking is one of the leading risk factors for preventable morbidity and mortality as a result of heart and lung diseases and various forms of cancers. For giving up smoking, people may use nicotine replacement therapies (patches, gums, lozenges, sublingual tablets, inhalers), medicines (bupropion, varenicline and cytisine) and psychological aid. Pharmacologic therapies have an important role for smoking cessation.

Bupropion (Zyban) was licenced by the UK Medicines Control Agency as an aid in smoking cessation in June 2000. Bupropion is also effective as an antidepressant therapy and is beneficial in the treatment of methamphetamine addiction, cocaine dependence, addictive behaviors such as pathological gambling, and attention deficit, hyperactivity disorder Subsequent reports of



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18 deaths during zyban therapy raised questions about their safety.

We reported a patient, who presented with acute myocardial infarction and whose symptoms of chest pain can be concerned with bupropion therapy.

Case: A 48-year-old retired man presented with chest pain which began 3 hours ago, before arriving in emergency room. Risk factors included a positive family history and cigarette smoking of 30 -years. His past medical history was unremarkable. He had started to bupropion therapy of 150 mg/day in an attempt to stop smoking ten days before. Until this therapy, he had not experienced chest pain. The dose was increased as per the suggested dosing regimen, and 7 days later, he stopped smoking. ECG in our emergency department revealed an inferior ST elevation MI. Laboratory values were normal except the following ones; Troponin I: 0,258 ng/mL CK-MB: 8,16 ng/mL. He was consulted with an attending cardiologist and patient underwent to coronary artery angioplasty. 99% stenosis in the circumflex coronary artery and minimal stenosis in diagonal coronary were seen in the angiography laboratory.

Conclusion: Bupropion has been used to be prescribed as an antidepressant. Although bupropion(zyban) has been reported of severe adverse reaction such as seizures and deaths in case reports and case control studies the literature contains only one prospective study in the treatment of depression for its safety. United States Public Health Service guidelines suggests that additional research into the relative efficacy and safety of this group of drugs is required. Although associations between fatalities and myocardial infarction with bupropion therapy may be coincidental, people on bupropion therapy must raise a suspicion in physicians mind while investigating the coronary artery risk factors of the patients.

Keywords: Acute Myocardial Infarction, Bupropion, Zyban

P-0482 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Spontaneous Rupture Of Inferior Vena Cava

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Objective: Spontaneous rupture of inferior vena cava (VCI) is an extremely rare and fatal diagnosis. It has been reported in the literature only secondary to an already existing aortocaval fistula. A rupture of an aortic dissection co-existing with a spontaneous rupture of inferior caval vein has never been reported before.

Case: 31-year-old male patient admitted to Emergency Room with right flank and epigastric abdominal pain which has started 6 hours ago and gradually worsened. Pain was stabbing and colic in nature. He had nonspecific urinary symptoms. He has taken nonsteroid analgesics for pain with no benefit. He had an operation for spontaneous duodenal ulcer perforation 3 years ago, and an operation for spontaneous caecum perforation 2 years ago. On clinical examination, the patient was pale and dehydrated. His pulse rate was 88 per minute, blood pressure was 130/70 mm / Hg. Abdominal palpation revealed tenderness on both inferior parts of the abdomen with generalised rigidity. He had a right flank tenderness. Rectal examination was nonspecific. Laboratory investigations documented a normochromic normocytic anemia with an Hb of 10.9 gm/dl. The clotting profile was normal. Biochemical analysis of blood were in normal limits. Urine analysis showed minimal erythrocytes and ECG was normal. Chest X-Ray revealed normal findings. Bedside FAST examination was normal. In the 4th hours after admission, patient abruptly become hypotensive and confused. After vital stabilisation, an IV Contrast computed tomography was ordered, and demonstrated the free flow of contrast in the abdomen, mainly in retroperitoneal area. An initial diagnosis of a dissected and ruptured abdominal aorta was sought.

A laparotomy made by the attending surgeon of Cardiothoracic Surgery. After initial incision patient underwent to cardiac arrest. Peroperative CPR performed for 90 minutes but patient was accepted as nonresponsive. Intraoperative findings showed free blood in the peritoneal cavity. The inferior vena cava was ruptured around inferior renal vein junction. The abdominal aorta had no aneurysms but dissected and also ruptured just before iliac bifurcation.

Conclusion: In a young patient, a spontaneous rupture of VCI and co-existence of aortic dissection bleeding are quite difficult to pinpoint as a diagnosis and quite fatal situations. In the emergency department, this type of presentations may be misdiagnosed as renal colic. Emergency department physicians should be suspicious of these diagnosis and should not avoid imaging procedures in order to exclude them.

Keywords: inferior Vena Cava, Spontaneous Rupture, Aortic Dissection

P-0483 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Cause Of Secondary Headache: Postcoital Subarachnoid Hemorrhage

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Objective: Aneurysmal subarachnoid hemorrhage (SAH) is a significant cause of death in young and middle-aged individuals and causes tremendous morbidity in affected patients. Despite the identification of various risk factors, the series of events leading to the formation, growth, and rupture of intracranial aneurysms is poorly understood. Cerebral aneurysm rupture has been associated with sexual intercourse and other forms of physical exercise. In fact, multiple case series reported that coitus was the immediate preceding activity in 3.8–14.5% of patients suffering from aneurysmal SAH. This may be related to the large elevations in mean arterial blood pressure that occur in both males and females during sexual intercourse. While coitus and physical exercise share important physiological similarities, each may differentially affect the probability that a preformed aneurysm will rupture.

Case: 46 year old female patient was admitted to the emergency department with complain of headache. In her history patient's headaches started two hours ago. It's the first time the patient had a severe headache. Her left arm was started weakness before coming to the emergency department. In the patient's history was unremarkable. On her physical examination; blood pressure 120/60 mmHg, pulse 87 beats / min, body temperature 36.7 °C, blood sugar 124 mmol/l, GCS 15 was observed. Other physical examination was normal. Radiological imaging was cerebral hemorrhage. Laboratory examinations were normal. When patients deepen the history of the patient headache had begun after sex. A neurologist was consulted. The patient was admitted to the neurology service. Follow-up of patients with aneurysms identified in the process.

Conclusion: Patients presenting with severe headaches, sexual intercourse should be questioned.

Keywords: Secondary Headache, Postcoital, Subarachnoid Hemorrhage

P-0484 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Childhood falls; Lateral condyle fractures

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Objective: Lateral condyle fractures are frequently seen second after supracondylar humerus fractures on elbow fractures in childhood. We aimed to present three cases who admitted to our hospital emergency department by domestic falling.

Case: 34 month ages male patient admitted to emergency department with motion limitation in his right arm due to fall. There is tenderness by palpation in the right lateral condyle on physical examination. Patient was called back after a week whose radiograph has no feature and his arm based on long arm splint. Bone fragments were identified on control radiographs when the patients relatives brought him 20 days after, and treated with open reduction and internal fixation of fracture was performed

Case 2: 5 years old female admitted to emergency department with right elbow pain on outer side due to a fall. On physical examination there was limitation of movement and tenderness to palpation on pain described region. Long arm splint was applied due to fracture line seen in radiograph on lateral humeral condyle. Bone depletion was not determined on controls.

Case 3: 7 years old male admitted to emergency department due to pain on left elbow region. When a detailed history received it was learned there was a history of fall 1 month ago. Severe movement limitation was detected on the left elbow on physical examination. There is a fragment on lateral humerus which is likely to be localized avascular displacement of fracture on control radiograph.

Conclusion: Lateral condyle fractures are important because of leading to complications like cubitus valgus due to difficulty in identification on direct graphy, easement to be skipped and not to be

Keywords: Lateral condyle, fractures, child, trauma



POSTER BİLDİRİLER

P-0485 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare coexistence; right scaphoid and left distal radius fracture

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Objective: Of all the joints in the upper extremities, the wrist joint is most susceptible to injury. Falls onto an outstretched arm or direct blows to the wrist cause a spectrum of injuries, including simple sprain, scaphoid fracture, perilunate dislocation, or distal radius fracture. Fractures of the distal radius are the most common fracture in children and adolescents, accounting for 35 to 47 percent. The scaphoid is the most commonly fractured carpal bone, accounting for approximately 3-4 percent of all fractures. Both fractures can be seen together on the same side but it is rare on the different sides. The purpose of this case is to report the right scaphoid and left distal radius fracture occur by falls onto an outstretched arm.

Case: A thirty two year old man was admitted to the emergency department after falling on an outstretched and while he was cleaning the stairs. He was complaining about pain in his bilateral wrist. There was swelling and tenderness of the right anatomic snuff box and left wrist. At radiography there was non-displaced scaphoid fracture at right wrist and left distal radius fracture which was associated with radio-carpal joint. The patient treated with bilateral long arm cast and followed for complications.

Conclusion: Wrist injuries are important because of avascular necrosis and limited joint mobility. At emergency department complaints of falls onto an outstretched arm patients should be investigated exhaustive.

Keywords: scaphoid, radius, fracture

P-0486 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Femur intertrochanteric fracture and unclear findings

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Objective: Injuries to the hip and femur are common, occurring most often in the elderly population. Major risk factors for hip fractures among elderly patients include osteoporosis and falls. It is estimated that approximately 30 to 60 percent of community-dwelling older adults fall each year. In USA femoral neck and intertrochanteric fractures occur with approximately the same frequency in patients between the ages of 65 and 99 years. Morbidity and mortality is substantial, with the majority being due to prolonged immobilization, deep venous thrombosis, and pulmonary embolus. We presented this case to draw attention and discuss this important fracture for elderly adults.

Case: A seventy-two years old woman was admitted to emergency department because of his right hip and lomber pain. We learned that he fall down at bathroom because of vertigo. At his physical examination he had pain with palpation on L2-5 vertebra and minimal pain at hip. At hip radiograph there was intertrochanteric fissure at right hip but this situation has been overlooked due to examination. Patient discharged with analgesic and rest. Five days after the first application the patient admitted to emergency service because of increased hip pain. At hip radiograph there was intertrochanteric fracture at right hip. Patient operated for femur intertrochanteric fracture and started LMWH for prophylaxis. After one week patient discharged with antiplatelet therapy.

Conclusion: Femur intertrochanteric fracture is most common in elderly patients and important because of complications. Emergency physicians should pay attention to unclear findings and should be made correct diagnose.

Keywords: femur, fracture, intertrochanteric

P-0487 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Wrist Pain; Kienbock Disease

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Objective: Kienbock disease is a condition of uncertain etiology that results in osteonecrosis of the carpal lunate. Kienbock disease usually affects the dominant wrist of men aged 20-40 years. Patients present with reports of activity-related dorsal wrist pain, decreased wrist motion in the flexion-extension arc, and poor grip strength. The symptoms tend to occur more often in the dominant hand. The primary methods of nonoperative treatment are immobilization and anti-inflammatory medications. In this case we aimed to present a man with osteonecrosis of lunate who presented to emergency service with non-traumatic wrist pain.

Case: A twenty one year old man was admitted to the emergency department complaining of wrist pain. He had no trauma history. His pain was deteriorated last two years. He was using concrete crushing machine at work for three years. There was tenderness at his left wrist. At radiography there was involution at lunate and there is no fracture. MRI planned and the patient treated with NSAID and followed for complications.

Conclusion: Avascular necrosis should be consist with repeated minor trauma and these patients can present to emergency department because of pain. These patient's graphy can be normal and should be examined in more detail.

Keywords: Kienbock disease, wrist pain, trauma

P-0488 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A patient with a right shoulder pain as a result of spontaneous liver hemangioma rupture

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Liver Hemangioma are most common benign tumors. It has two types; cavernous or capillary. Many are asymptomatic. The symptoms usually result from pressure to neighboring organs. In the natural behaviour of liver hemangioma, spontaneous or traumatic rupture, intratumoral bleeding, consumption coagulopathy and fast growth can be seen. It is estimated that there are less than 100 patients with spontaneous hemangioma rupture in the world.

Our case is a 39 year old male patient. He applied the emergency department with a complaint on right shoulder pain which increases with breath intake

Keywords: liver hemangioma, hemangioma spontaneous rupture, emergency department



POSTER PRESENTATIONS

P-0489 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Penetrable Periorbital Trauma Due to Nail Stinging

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Objective: An unbelievable accidental event that occurred during putting up a wall by a bricklayer (worker) that injured himself by nail. This is a interesting case by its formation mechanism so that we present a case report.

Case: A 36-years old male patient admitted to emergency department of Afyon State Hospital with a nail that plunged into his periorbital regional. The nail has knotted under its head by a thick rope fragment(Figure 1). It is learned that while the worker was putting up the wall he has hitted a nail into the wall and then stretched the rope that knotted to the nail. While stretching the rope the nail extracted from its place and plunge into his face.

The patients Glasgow coma score was 15. He was in a state of agitation. Vital signs were stable. Visual function tests applied and was normally detected that he could be able to count phycians fingers from one meter distance and eye moments were functional. The right lower orbital rim was intact. The conventional X-ray imagination(Figure 2) and computerized tomographic(CT) analysis showed that tip of the nail touched to the posterior wall of right maxiller sinus(Figure 3). The patient was taken to the theatre and performed right infraorbital nerve regional anesthesia by using local anetetic agent (2 cc lidocaine). The foreign material extracted by the help of pens. Some blood leaked out from the puncture.and the hemostasis was performed by pressure on the puncture. The nail 8 cm length was extracted and the emergent stuff were shocked at the length of the nail.

The control X ray and CT were taken. Soft tissue puncture and bone puncture left intact to heal secondary. Facial nerve function was intact. Hipoesthesia, parestesia, plegia were not detected in the early postoperative and late postoperative term after 3 days.

Conclusion: Periorbital penetrative foreign materials should be analyzed by CT to explore the relationshipness of the material by the intracranial structures, the orbital structures, facial bones and paranasal structures(1,2) The operative plan should be made according to the available data.(3)

Keywords: Periorbital Trauma, Foreign Material, Structure

P-0490 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Nicolau Syndrome Following Intramuscular Diclofenac Injection: A Case Report

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Objective: Nicolau Syndrome(NS) was first defined in 1920 by Freudenthal and Nicolau after using bismuth salt for treatment of syphilis. Up to date, NS cases have been reported in relation with using antiinflammatory drugs, local anesthetics, corticosteroids, antihistamines, vitamin B complexes, sulfonamides, penicillin, recombinant interferon alpha and beta, vaccines (varicella and diphtheria-tetanus-pertussis), and pyrazolone. Although its pathogenesis is not well understood, the pathophysiology of NS probably involves intra-arterial and/or para-arterial injection and arterial embolism of viscous suspensions of drugs meant for intramuscular, intravenous, or intra-articular injection, followed by acute vasospasm. Actually, diclofenac is a cyclooxygenase inhibitor and inhibitsynthesis of prostaglandin. This may lead to the vaso-constructive phenomenon(1,2).

Case: We report the case of a 67-year-old female patient who presented a painful necrotic tissue on the left buttock. A week ago, she had been given an intramuscular diclofenac injection, and livid discoloration appeared around the injected area. Over the following days, erythema, edema, and painful hemorrhagic blisters developed around the ecchymosis. On physical examination, well-defined 8 x4 cm necrotic tissue was observed on the left buttock(Figure 1,2). General patient status was good, her glasgow coma scale score was 15. Vital signs were stable. Surgical debridement at the operating room is performed. A small amount of viable tissue is sent to the microbiology lab for quantitative culture. to prove the presence of invasive microorganism and to determine antibiotic sensitivity. Vacuum-assisted closure devices have been used for decreasing the size of these soft tissue defect. The wound was constructed by fasciocutaneous flaps.

Conclusion: There is no specific therapy for NS. Treatment depends on the extent of the necrosis, and ranges from conservative topical therapy to agresive surgical therapy. This case is an example of surgical treatment(3).

Keywords: Intramuscular, Necrotic Tissue, Flap

P-0491 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Human Bite, Not An Animal Bite

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Introduction-Objective: Human bites are an uncommon type of injury. They may lead to severe clinical consequences. When a human bite reaches subcutaneous tissue or deeper, cellulitis develops in the region of bite and surrounding tissues. This lesion progresses to abscess formation that leads to widespread necrosis if left untreated. Mostly Staphylococcus Aureus and Echinococcus Corrodens proliferate in wound cultures. The aim of this paper was to report a patient presenting to our emergency department with an iatrogenic human bite.

Case report: A 35-year-old female patient was admitted to our emergency department after being bitten by her husband while trying to open his jaw during an epileptic seizure. She was on the fourth day of the bite when she was admitted to the emergency department. Her general status was moderate and she was conscious. Her blood pressure was 120/80 mmHg, her pulse rate was 80 bpm and body temperature was 36.1°C. There was swelling and ecchymosis in the middle finger of left hand and a 0.5 cm cut in its distal phalanx.

The laboratory results were normal except for an elevated white blood cell count (15000K/uL). A superficial USG of the left hand revealed a dense, hypo echoic region with a size of 21*15 mm (an abscess formation?) in the distal part of the metacarpal bone of the left hand's middle finger. There were also increased echogenicity and linear fluid loculations in the subcutaneous fat tissue of the dorsal aspect of left hand.

The patient was begun on empirical wide-spectrum antibiotic therapy (ceftriaxone IV 2*1 gr plus metronidazole 500 mg 2*2) and she was vaccinated against tetanus. No culture proliferation was observed during her hospital stay. She was operated by the plastic surgery department and the wound site was debrided. A flap from forearm was used to close the wound site.

Conclusion: Human bites should be managed with wide-spectrum antibiotics and wound cultures should be taken at an early time point after presentation since these patients often present at a delayed time after the index incident.

Keywords: abscess formation, antibiotic therapy, husband

P-0492 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Complication Of Trauma: Pott's Puffy Tumors

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Objective: Pott's puffy tumor is a condition that can occur after blunt trauma to the frontal bone and it is characterized with frontal bone osteomyelitis and subperiosteal abscess. In addition sinusitis, intranasal drug use and after sinus surgery cause the pott's puffy tumor. The extent of abscesses is through the venous system. Cortical vein thrombosis, epidural abscess and subdural abscess can be associated with Pott's puffy tumors.

Case: 17 years old male patient applied to the emergency department with complaints of nausea, vomiting and mental status changes. The patient's state of consciousness was confused. The frontal region has soft tissue swelling in size 4*2 cm, the frontal region of blunt trauma that occurred before 10 days. Left lower extremity muscle strength was revealed the 2/5 muscle strenght. The patient had no neck stiffness. The patient's vital signs; TA:120/60 mmHg, pulse: 120/min.,body temperature: 39 C.In addition the patient's hemogram had wbc:13200 (%93 neutrofil).The frontal bone in the neighborhood size 40*17 mm hypodense lesion and size 4 cm subdural empyema at the level of falks cerebri was viewed in cranial CT. He was underwent an operation to drain the abscess.After surgery operation; antibiotic therapy was started

Conclusion: First level of treatment in Pott's puffy tumor is drained to abscess and then antibiotic therapy about 6-8 weeks. We remember Pott's puffy tumor In patients with alterations in consciousness from frontal head trauma.

Keywords: Pott's puffy tumors, epidural abscess, head trauma



POSTER BİLDİRİLER

P-0493 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Pneumothorax following acupuncture

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Acupuncture is an important component of traditional Chinese medicine. It dates back to 8000 BC. Since 1965 in the literature, it has been reported that Acupuncture has life-threatening side effects. Bacterial and viral infections, tissue and organ wounds form the main side effects.

Pneumothorax is the accumulation of air in the pleural space. It is classified into spontaneous, traumatic and iatrogenic. Pneumothorax is the most common mechanical organ wound.

Our case is a 43 year old male, who had been visiting an acupuncture center due to his complaints on neck, back and shoulder pain. During the operation, he felt a breathing problem. Since his breathing problem continued for three days, he applied the emergency department.

As an alternative medicine type, acupuncture is becoming increasingly popular. This operation should be performed by experts and the public must be made aware of the side effects and potential complications.

Keywords: Acupuncture, emergency department, pneumothorax

P-0494 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Epidural Hematoma with a Fruit Knife

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Epidural hematoma is defined as the collection of blood between the skull and the duramater. The most common cause is trauma. Epidural hematoma, although seen rarely in infants and older people, is more common among children and adults. Typically, following temporoparietal linear fracture, it builds on bleeding in the middle meningeal artery and its vessels. Parietal bone fractures are the most common skull fractures. Temporal, occipital and frontal bones follow this. Linear fractures are the most common fractures. Contraction and basilar fractures are less common.

Our case is 26 year old woman who walked to the emergency department. She reported that her boyfriend hit her with a fruit knife and did not have any complaints other than a cut on his head.

A computerized brain tomography was taken. As a result, in her right parietal bone, a fracture was detected and under the fracture epidural hematoma with minimal level was detected

Keywords: Emergency department, epidural hematoma, skull fracture

P-0495 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Axillary Block and Elbow Dislocation

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Objective: Forearm fractures and dislocations are one of the most common reasons for presentation at the Emergency Department. Reduction of upper extremity dislocations which do not require surgery should be done in the Emergency Department. For pain control during the reduction process, local block procedures which are able to provide sedation can be applied. The case is here presented of a reduction procedure made with ultrasound-guided axillary block on a patient with elbow dislocation.

Case: A 35-year old male patient presented at the Emergency Department because of right elbow trauma and severe pain after a fall. On examination, vital signs were determined as TA: 150/95 mmHg, temperature: 36.5°C, pulse: 104/min, SpO2: 92% (room temp), respiratory count: 18/min and from the radiological examination, elbow dislocation and avulsion fracture of the ulna were determined. Ultrasound-guided axillary block procedure using a 20ml Prilocaine HCl (1%) injection was applied to the patient who was in severe pain. After providing sufficient anaesthesia, the elbow was reduced. Following the reduction procedure, a long-arm plaster cast was applied to the patient who was then referred to the orthopaedic polyclinic.

Conclusion: Upper extremity dislocations, which are frequent presentations in the Emergency Department, are orthopaedic emergencies. Pain control during the reduction procedure is very important. Ultrasound-guided local blocks in upper extremity dislocations and especially the application of axillary blocks have the benefit of providing both pain control and preventing complications which may develop associated with procedural sedation. Local blocks facilitate the application of the reduction procedure and make a significant contribution to reducing the time spent by the patient in the Emergency Department.

Keywords: Axillary block, Ultrasound-guided, Elbow dislocation

P-0496 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Giant Hydatid Cyst in the Parietal lobe of a Child: Case Report

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Objective: Hydatid cysts of the brain are an uncommon disease, accounting for 2–3.6% of all intracranial space-occupying lesions in endemic areas. Cerebral hydatid cysts are usually unilocular. They are most often supratentorially localized in the distribution of the terminal branches of the middle cerebral artery, usually temporo-parieto-occipital. The disease is frequently diagnosed several months after the onset of symptoms, which are usually headaches and vomiting. Here, a child with a massive hydatid cyst located in the parietal lobe is presented. The patient's symptoms gradually disappeared following total cyst extraction.

Case: A 6-year-old boy presented with a 4-month history of headache and vomiting. The headaches had worsened 4 times a month and were associated with vomiting during head movement. The results of a physical examination were normal. On neurological examination papilloedema, positive Babinski's sign and ataxia were all within normal limits. Routine blood analysis, plain cranial radiography and abdominal ultrasonography were all within normal limits. Cranial magnetic resonance imaging (MRI) showed a spheroid cystic lesion in the parietal lobe that was hypointense on T1- weighted sequences and hyperintense on T2- weighted sequences, non-enhancing with contrast. There was no evidence of calcification or surrounding oedema (Figure 1). The patient underwent right frontotemporoparietal craniotomy. A cyst approximately 5 cm in diameter was excised using Dowling's technique (Fig. 2). Histopathology confirmed that this was a hydatid cyst. The patient was treated with the antihelminthic agent, albendazole, in combination with antibiotics. The patient's symptoms improved post-operatively and he was discharged after 1 week.

Conclusion: Infection with Echinococcus granulosus should be included in the differential diagnosis for unspecific neurologic symptoms such as progressive headache, especially in pediatric patients from regions in which such parasitic diseases are endemic.

Keywords: Giant Hydatid Cyst, Hydatid cysts of the brain, headache

P-0497 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Cause Of Acute Abdomen; Intestinal Volvulus

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Objective: Small bowel volvulus is a condition in which there is a torsion of all or a segment of the small bowel and its mesentery. It is a well-recognized entity in neonates of midgut rotation. Although the condition is one of the more common surgical emergencies in the adult population in developed countries.



POSTER PRESENTATIONS

Case: 25 year old male patient was brought to the emergency department with severe abdominal pain. The story, the patient awakened from sleep with severe abdominal pain. Abdominal pain around the navel was started and gradually increased in intensity. Patient had no appetite. The patient did not vomit. In the patient's history, patients who have received tuberculosis treatment for 6 months in 2008 and patient was operated from appendicitis. On her physical examination; blood pressure 120/80 mmHg, pulse 72 beats / min, body temperature 36.7 °C was observed. Abdominal examination revealed tenderness around the navel. There was defense and rebounds. The patient's bowel sounds increased. Other physical examination was normal. There was leukocytosis in the results of lab experiments. Superficial tissue ultrasound examination; In the lower right quadrant, indicating residential moving in the right lateral cecum dilated intestinal loops are observed locally. This small amount of free fluid between intestinal structures are available. In view of the cecum is distended in the common falko material being monitored. Intestinal structure due to the layout of the cases were considered as intestinal volvulus. Contrast-enhanced abdominal computed tomography were evaluated in the intestinal volvulus. General surgeon was consulted. The patient was admitted to a general surgical ward.

Conclusion: With clinical features of acute abdomen in the young adult patients with small bowel volvulus should be considered.

Keywords: Volvulus, abdominal pain, bowel

P-0498 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Simultaneous Celiac Trunk and Mesenteric Artery Thrombosis: Two Case Reports

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Objective: Although superior mesenteric artery (SMA) obstruction is seen quite frequently in the emergency clinical practice, celiac trunk (CT) obstruction is unusual. Simultaneous SMA and CT obstruction is even rarer.

CASE 1: A 65-year-old female patient presented to the emergency clinic with abdominal pain that persisted for two days. Upon physical examination, diffuse distension, tenderness, and guarding were present. She had no systemic disease other than hypertension. The laboratory examinations revealed leukocytosis (19,000/mm³). Plain abdominal radiographs were evaluated as nonspecific; however, contrast enhanced abdominal computed tomography (CT) demonstrated no contrast filling in the Celiac T and SMA. The patient was taken to the operating room with a preliminary diagnosis of mesenteric ischemia. On exploration, the right and left lobes of the liver were seen to be ischemic, and the liver had patchy necrotic areas. The gallbladder, stomach, spleen, entire small bowel, and partial pancreas and duodenum were found to be necrotic. Arterial pulses could not be felt on the localizations of the celiac trunk, left gastric artery, hepatoduodenal ligament, and superior mesenteric artery. No further surgical intervention was planned with the present findings and the patient died at the 18th hour of intensive care follow-up.

CASE 2: A 75-year-old male patient presented to the emergency clinic with poor general condition. The patient was intubated with a preliminary diagnosis of cerebrovascular disease. The history of the patient revealed that the patient complained of abdominal pain for the previous three days, accompanied by bloody vomiting. Abdominal CT with intravenous contrast revealed thrombus in the superior mesenteric artery and celiac trunk. Upon exploration, the entire small bowel, liver and spleen were found to be ischemic, and the right colon and the right half of the transverse colon were found to be necrotic. Pulses were not felt on the celiac trunk and superior mesenteric artery. No further surgical intervention was planned. The patient died at the third postoperative hour of follow-up in the intensive care unit.

Conclusion: Celiac artery thrombosis is quite rare in the daily clinical practice. The patients commonly present with sudden onset abdominal pain. There is no specific laboratory finding for diagnosis. Although Doppler ultrasonography, abdominal CT, and CT angiography are helpful in the diagnosis, a definitive diagnosis is possible with angiography. Treatment options depend on the general clinical condition of the patient, the degree of Celiac T obstruction. The mortality is high in spite of early diagnosis and treatment.

Keywords: Mesenteric Artery Thrombosis, Celiac Trunk Thrombosis, Abdominal Pain

P-0499 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Simultaneous Meckel's Diverticulum and Carcinoid Tumor Of The Appendix

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Objective: Of the current study presents a case of simultaneous Meckel's diverticulum and carcinoid tumor of appendix, a rare case in the emergency clinical practice.

Case: A 36-year-old male patient presented to the hospital with abdominal pain, loss of appetite, nausea, and vomiting over the course of two days. He had no chronic diseases or previous abdominal surgery. There was tenderness, guarding, and rebound tenderness in both lower abdominal quadrants. Laboratory tests revealed a WBC of 14,000/mm³; other parameters were in the normal range. Intravenous contrast enhanced abdominal computed tomography demonstrated free peritoneal fluid in the pelvis. He was taken to the operating room with a preliminary diagnosis of acute abdomen syndrome. Upon exploration, Meckel's diverticulum was detected at 50 cm proximal to the ileocecal valve and wedge resection was performed. The appendix was found to be hard although it was not grossly inflamed and an appendectomy was performed. The postoperative period was uneventful and the patient was discharged on day 5. Histopathological examination revealed a carcinoid tumor in the appendix (localized at the tip of the appendix measuring 0.3 x 0.2 cm with no lymphovascular invasion) and the decision was made to follow-up on the patient.

Conclusion: Meckel's diverticulum is a pathological condition originating from the vestigial remnant of the omphalomesenteric duct that causes acute abdomen syndrome especially in children. Clinical findings may be mixed with acute appendicitis and intraoperative diagnosis is generally performed. On the other hand, carcinoid tumor is a tumor originating from the neural crest cells, which is most commonly located in the appendix in the gastrointestinal tract. Carcinoid tumors are incidentally encountered in 2% of the appendectomy materials. The risk of metastasis in the carcinoid tumors of the appendix depends on the localization of the tumor in the appendix, to the dimensions of the tumor and to the depth of invasion, and is almost never seen in tumors smaller than 1 cm in diameter. These two separate diseases are each rare cases; however, simultaneous presence of both in a patient is extremely rare. A whole abdominal exploration should be performed in patients who are being operated on for acute abdomen syndrome, even though detect a pathological condition that can already explain the clinical pathology.

Keywords: meckel, carcinoid tumor, appendix

P-0500 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Fournier Gangrene Developing In A Case With Transverse Myelitis

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Objective: Transverse myelitis is an acute- sub-acute clinical picture characterized by the dysfunction of the motor-sensorial-autonomic nerves and tracts of the medulla spinalis.

Case: A 40-year-old patient with no known systemic disease was diagnosed to have transverse myelitis two months prior. The bedridden patient presented with foul smelling perianal discharge. Upon physical exploration, an infected and necrotic field including the perianal region and anus extending to the left gluteal region and posterior thigh was detected. The patient had a fever of 37.90C with leukocytosis (10,500/mm³) and hyponatremia (2.1 gr/dl). Emergency debridement of the necrotic area was planned and the patient was taken to the operating room after bladder catheterization. No analgesia was needed due to the sensorial defect and the necrotic tissues were debrided with the patient in the right decubitus position. Additionally, fecal diversion was provided performing a sigmoid loop colostomy in the left upper quadrant of the abdomen. Extended spectrum antibiotics (meropenem and vancomycin) were initiated and pseudomonas aeruginosa was cultured from the wound. The patient was treated for 33 days in the hospital and surgical debridement was performed 20 times during the hospitalization. When no microorganisms were cultured in the wound samples, a reconstruction with a graft obtained from the right thigh was performed by plastic surgeons.

Conclusion: Although large necrotizing infections of the perianal region generally occur in the presence of systemic diseases such as diabetes mellitus, they can also develop in bedridden patients. Therefore, the required precautions should be taken in patients in the risk group for various reasons (aged and bedridden individuals) other than systemic diseases.

Keywords: transverse myelitis, fournier gangrene, necrotizing infections



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P-0501 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Port Site Hernia After Laparoscopic Cholecystectomy

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Objective: Laparoscopic cholecystectomy is one of the most frequently performed laparoscopic operations. Port site hernia is not a common complication after laparoscopic operations. Clinical findings vary from a palpable lump to intestinal obstruction depending on the intraabdominal contents of the hernia.

Case: The medical records of four patients who presented to the emergency service with complaints of abdominal pain accompanied by vomiting and were diagnosed to have port site hernia between March 2012 and March 2014 were retrospectively analyzed. All patients were female with a mean age of 31.1 years (range: 27-43). Previous laparoscopic operation in all patients was cholecystectomy and mean time from operation to presentation was three days (range: 2-4). Hernia developed through the subumbilical port site and emergency operations were planned in all patients. The herniated intestinal organ was found to be the small intestine in all patients and findings of no ischemia or necrosis were detected. Hernia reduction and herniorrhaphy was performed in all patients. Upon examination of the operation notes, it was found that the fascia of the port site was sutured in one out of three patients.

Conclusion: Port site hernia is an infrequently seen complication of laparoscopic operations. Appropriate closure of the fascia can decrease the rate of this complication.

Keywords: port site hernia, strangulation, ileus

P-0502 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Abdominal Trauma Due To Livestock

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Objective: Blunt trauma due to livestock is seen relatively frequently in populations of farming and agriculture. These types of trauma are usually mild and intraabdominal organ injury is rare. The current paper presents cases admitted to the emergency clinic due to blunt abdominal trauma secondary to livestock.

Case: The medical records of patients who presented to the emergency service in 2013 and 2014 after blunt abdominal trauma due to livestock were retrospectively evaluated. There were five male and four female patients with a mean age of 47.2 years (range: 31-54). Mean time from trauma to presentation was 17.3 hours (range: 4-48). Five patients (55.5%) underwent emergency surgery, while four patients (44.5%) were medically followed-up. Grade 3 splenic trauma was detected in three patients (60%), and rectum (20%) and sigmoid colon perforation (20%) were found in four patient. Splenectomy was performed in patients with splenic trauma. Primary repair was applied in the case with rectal injury, and colostomy was performed in the patient with sigmoid colon perforation. There was no mortality and only one (20%) minor morbidity (wound infection) was detected. Mean duration of hospitalization was three days (range: 2-5) in patients who had medical treatment.

Conclusion: Intraabdominal organ injury secondary to blunt trauma due to livestock should be taken into account although rare. Education of individuals who have the potential to be subject to this kind of trauma risk about the development of such intraabdominal trauma will result in early presentation to a health institution in such cases, thus, early diagnosis of a life threatening situation will be maintained.

Keywords: Animal trauma, Blunt abdominal trauma, Intraabdominal injury

P-0503 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

This is a case report about taking careful medical history, explaining the procedure properly and using proper language whilst talking to the patient referred to emergency service with rectal foreign body

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Objective: This is a case report about taking careful medical history, explaining the procedure properly and using proper language whilst talking to the patient referred to emergency service with rectal foreign body.

Case: A 40 year old male patient referred to our emergency service with defecation difficulties and rectal pain. Patient stated that he was naked while cooking at night and dropped the jar in his hand. After slipping, patient said that he fell onto the jar and noticed that the jar stuck inside. While taking detailed history, patient stated that he inserted foreign bodies into his rectum a few times and was able to pull them out. Today, patient stated that he inserted the jar with 7 cm diameter after lubrication and was not able to pull it out. Then patient tried to pull it out using drilling bit and referred to emergency service after being unsuccessful. Foreign body didn't spotted at rectal palpation. The jar was seen on abdominal x-rays. Then the patient was consulted to the department of general surgery. General surgery department assessed the patient and suggested service follow-up. In case, the body does not get out, general surgery department suggested operation. Patient accepted the procedure. Whilst preparations about service admission being handled, the patient left the emergency service unauthorized.

Conclusion: Rectal foreign bodies are usually seen by pushing a body into the rectum via anus. And we come across with anal bodies as they are usually used by mid-aged man as a sexual stimulant. The first way that should be considered at emergency service in these situations is giving the patient Sims or lithotomy position and taking the foreign body out after sedation. As patients usually try to conceal how the event occurred, medical history should be taken carefully and detailed information regarding the procedure should be given.

Keywords: Rectal, foreign bodies, emergency service

P-0504 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

An uncommon cause of abdominal pain: Endometriosis of rectus muscle

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Objective: Localisation of endometrial stroma and glands out of uterine cavity is called 'endometriosis'. Endometriosis which is localised within muscle rectus abdominis is very rare. Although extrapelvic endometriosis is rare, endometriosis can be seen almost at any organ. Endometriosis which is localised within muscle rectus abdominis is something which is very rarely seen. Patients refer with repetitive abdominal pain which occurs usually once a month and lasts a few days. There are very few reported cases in the literature.

Case: A 31 year old woman who has repetitive referral to general surgery outpatient clinic has abdominal pain and local distention complaints which happens nearly every month in 2 years and lasts a few days. In the patient's medical history, it's learnt that patient got diagnosed as ALL 15 years ago and got cured by therapy; had mastectomy and chemotherapy history for breast malignancy which was diagnosed 5 years ago, and had C/S 3 years ago. In the examination, palpable distention was spotted 5 cm above of the C/S incision. When patient with stable vital signs undergone abdominal ultrasonography, haematoma got visualised within rectus muscle. Patient then got consulted to the General Surgery Department. Tissue which was excised by laparotomy, was sent to pathological examination. Pathology report revealed endometriosis. Patient got discharged with suggestions and follow-up at outpatient clinic.

Conclusion: Rectus muscle haematoma must be kept in mind in patients with abdominal distention and pain. Rectus muscle endometriosis is an uncommon cause of abdominal pain in the literature. Female patients usually have the history of abdominal wall operations. Pain usually starts a few days after the onset of menstruation, increases gradually, and stops after a few days. Distention of the anterior abdomen usually accompanies. Diagnostic methods are abdominal ultrasound and abdominal tomography. Final diagnosis can be established with histopathological assessment. And the therapy is surgical excisement of the endometrial tissue.

Keywords: Rectus muscle haematoma, abdominal distention, pain, Rectus muscle endometriosis, menstruation

P-0505 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Patient who thought the ticks at anal area as hemorrhoids: Inspection is a must

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Objective: Ticks that live in rural areas can cause local and systemical diseases at people and animals that they use as a host. Microorganisms that pass onto people after tick bite can cause systemical infections as well as local skin and soft tissue infections due to microorganisms that reproduce at bite location. People may not refer to physicians as they can be thought as hemorrhoids.

Case: In our 65 year old female case, patient who referred to a private hospital's emergency service with anal itching and swelling was discharged without examination with hemorrhoid pre-



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diagnosis and was suggested to refer general surgery outpatient clinic. At general surgery department's assessment, patient was referred to emergency service as it was noticed that swellings at anal area are not hemorrhoids and might be ticks. At patient's anal area examination, 5 ticks, of these biggest was 2X2 cm and the smallest was 1X1 cm, were noticed and all intact ticks were removed. As the patient's blood counts were normal, patient was referred to infectious diseases outpatient clinic.

Conclusion: In patients referring to emergency service planning should be done after the examination based on physicians pre-diagnosis, not on patient's diagnosis. In some conditions, inspection alone can be enough. When patients refer with their hemorrhoid pre-diagnosis, at least inspection must be made and if thrombosed hemorrhoids are seen treatment and referrals should be made.

Keywords: Ticks, hemorrhoids, general surgery, swelling

P-0506 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Primary subcutaneous hydatid cyst of abdominal wall

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Objective: Hydatid disease, also known as echinococcosis or hydatidosis, is an infectious disease caused by the cestode *Echinococcus*. Hydatidosis is endemic in some region such as South America, the Middle East, Africa, Australia, and the Mediterranean, including our country. *Echinococcus granulosus* is a zoonotic disease mainly involving the liver and the disease can infiltrate neighboring organs and/or can do hematogenous spread to distant organs such as lung, spleen, and brain. We presented an unusual localization of hydatid cyst formation on incision scar of abdominal wall in an adult patient, which is the first in English literature.

Case: A 57-year-old female applied to our hospital with complaints of abdominal pain, gradually increasing right sided local abdominal swelling, smoothly outlined mass on the subcostal incision scar site in the right upper quadrant of abdomen, and intermittent nausea for eighteen months. There was an open abdominal operation history for cholecystectomy 9 years ago. Abdominal ultrasonography revealed a cystic lesion of a size of approximately 55x37 mm in the subcutaneous area of the right upper abdominal wall. On the abdominal computed tomography, there was a well-defined cystic lesion in the antero-lateral subcutaneous area right upper abdominal wall. All serologic tests were negative. For diagnostic and definitive treatment, a cystic mass in the subcutaneous area was excised totally. The postoperative period was uneventful and the patient was discharged on albendazole at a dose of 10 mg/kg/day.

Conclusion: Hydatid cyst is most frequently involved in the liver and lungs, and rarely in the bone, brain, eye, heart, kidney and spleen. Atypical localization of hydatid cyst may be challenged the diagnosis of hydatid disease especially on cases with negative serologic tests. Primer subcutaneous hydatid cysts have a nonspecific clinical course and symptoms depend on localization. Sometimes symptoms can mimic other acute abdominal disorders. Therefore, Primer subcutaneous hydatid cysts should be considered on differential diagnosis of soft tissue masses and abdominal disorders. Our case is different from other primary subcutaneous hydatid cysts on abdominal wall because it is localized on incision scar area.

Keywords: hydatid cyst, subcutaneous, incision scar

P-0507 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Intussusception is not only baby nightmare

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Objective: Having defined as a proximal intestinal segment interpenetrating an adjacent distal intestinal segment lumen in the gastrointestinal system intussusception or invagination, is the most common cause for acute abdomen in children following acute appendicitis. Contrary to childhood period intussusception is rarely encountered among adults. Etiology, clinical presentation and treatment methods are different in adults as well. In this poster spontaneous ileo-ileal intussusception was analysed and presented.

Case: A male patient at age 42 was admitted to our emergency service with complaints of paraumbilical abdominal pain, nausea and vomiting, this complaints was non reducing 2 days. His medical history revealed that he applied another emergency service more than 3 times at this complaints and all time diagnosed by constipation. No prior disease and operation history was detected in her background check. The physical examination revealed moderate dehydration, abdominal distention and sensitivity with deep palpation. There were no rebound and defenses. Intestinal peristaltic sounds were detected as lowered. The ampulla in rectal examination was empty. Other system examinations were assessed as normal. There were no abnormal hematologic and biochemical findings. No ileus compliant finding was detected in direct abdominal X ray, and abdominal ultrasound was normal. Patient was scanned in all contrast enhanced abdominal CT. CT was showed ileo-ileal intussusception. The case was taken into emergency operation with ileoileal intussusception diagnosis.

Conclusion: adult intussusceptions differ from childhood area intussusceptions in terms of having a different clinical presentation. While there is no known etiology of invagination in 95% of the pediatric cases, the etiology in adults is idiopathic in merely 20% of the cases. 65% of adult intussusceptions consist of benign or malignant neoplasms. The average age for adult intussusception cases is 45-51. In etiology of an adult intussusception mostly there are malignant, non-malignant and iatrogenic reasons. In rare cases the etiology is idiopathic or spontaneous. Diagnosis of an adult intussusception can be overlooked or delayed when it is rarely encountered and atypically presented. The classic triple symptoms vomiting, abdominal pain and blood-stool mainly encountered in children, is encountered in 15-20% of adult suffering from intussusception. The delays of detect and treatment of intussusception may cause, bowel necrosis, perforation, sepsis and mortality related complications. Treatment firstly using pneumatic and hydrostatic systems. Most of cases goes under surgery. So all cases with complaints constipation vomiting and abdominal pain need a second think for intussusception.

Keywords: adult, abdominal pain, intussusception, emergency medicine

P-0508 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Case report; recurrent patellar dislocation

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Objective: Patellar dislocations could be seen as acute (traumatic) or chronic (subluxation, recurrent or habitual). Recurrent patellar dislocations occurs less trauma by time and the patient usually reduces its own patella by itself. By analyzing the patoanatomy of patellofemoral instability we can observe the possible causes as; soft tissue abnormalities, malalignment of the lower limb or patellar/trochlear dysplasia. We can examine soft tissue anomalies of dynamic stabilizers as the vastus medialis muscle weakness or the medial patellofemoral ligament rupture/laxity.

Case: 33 year old male patient admitted to our emergency department because of the pain that occurred while sitting on his knees. There was deformity at the lateral part of knee. The patient has previously had a history of patellar dislocation thrice. In the examination of patient knee movement were restricted and painful. The patella was displaced to the lateral and it was palpable at the lateral part of knee. In the X-ray image right patella was displaced to the laterally. Patient was consulted in orthopedics & traumatology. After reducing the patella, a tight bandage was made to the knee. Patient was discharged to outpatient orthopedics.

Conclusion: Patellar dislocations must be reduced urgently. The history is diagnostic in the patients who refers to the emergency service with patellar dislocation to distinguish that the case is acute or chronic.

Keywords: Patellar dislocations, emergency, pain

P-0509 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Emphysematous cholecystitis

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Objective: Gallbladder is located in a place where rectus abdominis muscle intersects right arcus costalis. Except for conditions such as acute cholecystitis, it cannot be felt through physical examinations in healthy normal individuals. Emphysematous cholecystitis is a rare variant of acute cholecystitis caused by gas-producing microorganisms characterized by air in gallbladder or lumen. It is more common in diabetic and old patients. Although it is generally caused by gallbladder stones, about 30-50% of the patients do not have gallbladder stones. Prognosis



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may deteriorate rapidly in emphysematous cholecystitis. In case of gangrene or perforation development, mortality is high. The diagnosis of emphysematous cholecystitis can be made by abdominal graphy, USG and CT. BT has an especially high diagnostic value in that it shows the little amount of air in gallbladder wall or lumen

Case: An 83 years old women patient applied to emergency department with the complaints of stomachache and fatigue. She had had stomach ache in the last a few days and decided to apply emergency department after the pain became severe. Two days ago, nausea started and bilious vomiting occurred. The patient's history included diabetes and hypertension. TA was 120/70 mm/Hg, temperature was 37.6 °C and pulse rate was 117/min. Physical examination revealed tenderness, defense and rebound in upper right quadrant of abdomen. Murphy sign was positive. Palpable mass was evident in upper right quadrant of the abdomen. In laboratory tests, WBC was 23.2 K/ml and CRP was 204 mg/l. In abdominal CT, gallbladder was distended, thickened and had an edematous appearance. Inside the gallbladder, mud and stones of millimetric size were apparent. Millimetric gas appearances were also present in wall neighborhood and gallbladder lumen. Findings of CT imaging were in accordance with emphysematous cholecystitis. Consultation was made with general surgery department for emergency surgical operation.

Conclusion: In patients presenting with pain in upper right quadrant of abdomen, emphysematous cholecystitis should be considered. Given the high probability of gangrene and perforation development which increase mortality, a fast diagnosis should be made and the patient should be referred to emergency operation.

Keywords: gallbladder, cholecystitis, pain

P-0510 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

The impact of comorbiddisease to minor injury

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Objective: Both psychological and physical trauma for people refers to a demolition. Especially in a human trauma, a significant increase in morbidity and mortality could be seen if supplemenatary disease is present. One of the most important comorbid diseases is the renal failure. In this case, also called renal osteodystrophy; phosphate retention, hypocalcemia, vitamin D deficiency, secondary hyperparathyroidism and mineral metabolism disorder could seen and these features creates the deterioration of bone structure. Secondary osteoporotic changes depending on the disease in bone, following trauma easily may lead to breakage of bones. Often involving multiple fractures may occur.

Case: A 44 years old male patient referred with both of shoulders and left elbow pain after falling a three-legged ladder when hanging curtains. He has CRF. AV fistulas for dialysis in the left wrist of the patients. At the physical examination, there was crepitus in the shoulders and left elbow with painful movements. There was also pain in the mandible too. Blood tests was Hb 14.4 g / dl, WBC: 12280 BUN: 48.7 mg / dL, Cr: 9.3 mg / dL K: 5 and at the X-ray examination there was bilateral proximal humerus fracture, left humerus fracture of the lower end, the left distal radius fractures and mandible fracture was detected. Patient was admitted for operation after orthopedic and plastic surgery consultation.

Conclusion: It should be noted in individuals with comorbid disease, even in minor trauma injuries can be serious. That's why a detailed patient history and physical examination is our gold standard for diagnosis based.

Keywords: comorbiddisease, minor injury, pain

P-0511 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Portal vein thrombosis in a patient with stomach ache

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Objective: Portal vein is the one where the blood from pancreas, spleen and gastrointestinal system is drained. It is formed by merging of lienal vein and superior mesenteric vein behind the pancreas neck. It is separated into two branches, i.e. right and left, and dispersed in the liver. Portal vein brings about 70% of the blood coming to the liver, while hepatic artery brings about 30%. Portal vein pathologies are frequent in cirrhosis caused by alcohol and viral hepatitis. The most common causes of portal vein thrombosis are omphalitis in children, and cirrhosis, pancreatitis, appendicitis, acute dehydration, umbilical vein catheterization and malignity in adults.

Portal vein thrombosis (PVT) is a rare cause in patients with stomach ache. Since it has a quiet clinics, it can only be incidentally diagnosed. Patients with PVT may report stomach pain which developed suddenly or within a few days, fever and dyspeptic complaints. PVT that goes untreated may lead to life threatening conditions such as gastrointestinal bleeding or infarction. Crucial factor for the diagnosis of PVT is heavy clinical suspicion. USG is used as the primary diagnosis tool. A case of a patient applying to emergency department with stomach ache who eventually had PVT and cirrhosis diagnosis is being given here.

Case: Sixty two years old patient applied to emergency department with stomach ache complaint. His pain continuously increased in two-day follow-up period. He had diabetes mellitus, hypertension and chronic obstructive pulmonary disease in his history and was a hepatitis B carrier. In physical examination, tenderness was evident in upper right quadrant of the abdomen. Examinations of other systems were normal. Laboratory test results were as follows: WBC12,900 K/mm3; ALT123 U/l; AST292 U/l; GGT517 U/l; LDH553 IU/l. In USG examination, multiple hiperecogen nodular lesions were evident in all segments of the liver. There was thrombus in vena porta from portal confluence surface to right main branch and portal vein diameter increased. In abdomen CT, an appearance in accordance with thrombus and cavernous formation extending to right main branch in vena porta was found.

Conclusion: Although the first symptom of PVT is generally stomach ache, PVT is not generally considered in differential diagnosis of patients with stomach ache. PVT should be considered as an unusual cause in patients applying to emergency department with stomach ache, especially in the patients who had tenderness in upper right quadrant of abdomen.

Keywords: Portal vein, thrombosis, emergency

P-0512 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Spontaneous subdural hemorrhage

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Objective: Subdural hemorrhage generally occurs as a result of rupture in bridge veins linking brain superficial veins to dural sinuses. The blood seeps into subdural space as a result of rupture in these veins. Studies which have been conducted so far showed that about 25-30% of subdural hematomas can be of arterial origin. Subdural hematomas are more common in older patients, alcoholics, patients with brain atrophy, trauma patients and people with intracranial aneurism. Depending upon the time of occurrence, hematomas can be classified as acute, subacute and chronic. Hematomas lasting for more than two weeks are called chronic subdural hematoma

Case: Thirty five years old male patient applied to emergency department with a headache complaint lasting for a week. He had no history of trauma, chronic alcoholism or anticoagulant use. No feature was found in vital findings, but he had neck stiffness. No indication was observed in whole blood counting, INR and biochemical analyses. Because of enduring headache and suspicious neck stiffness, brain CT was ordered. CT imaging revealed subdural hematoma. The patient was consulted with brain surgery and after an operation discharged upon full recovery.

Conclusion: Headaches are among the leading causes for emergency departmentvisits. Although patient's history, vital findings and laboratory tests do not yield meaningful results as in the present case, positive physical examination findings shouldn't be disregarded, and causes of life threatening headache must absolutely be ruled out.

Keywords: Subdural hemorrhage, headache, computerize tomography



POSTER PRESENTATIONS

P-0513 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Vertebral fracture missed after a dog bite

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Objective: The injuries that goes unnoticed might pose serious risks for both the patient and the physician. Failure to get a detailed history of the patient, to conduct a systematic physical examination, to order the necessary imaging or bad quality imaging taken under emergency conditions may prevent the detection of the pathology and especially the pathologies in muscle-skeletal system. Risk for missing the fractures and dislocations are high in drug intoxications, confusion-causing situations such as alcohol use, multiple trauma cases and during the times when the emergency department is crowded by seasonal flu epidemics. In the present case, missed vertebral fracture is given in a trauma patient evaluated by more than one other hospital due to other prominent pathologies.

Case: Our case was a 64 years old woman who got bitten by a dog and subsequently fallen from the same height. She got bitten by the dog around the left elbow level. There was a deep cut in the form of a crescent which was about 8cm by 3cm, extending from left front arm proximal to elbow and forming a tissue defect. The patient had the complaint of a mild backache. She was evaluated in two other hospitals before coming to our service, and was referred to us because of lack of a plastic surgeon. TA was 90/60. In physical examination, she was conscious and the light reflex was +/+. Pupillary isochoric neurological examination was normal. There were no cervical and thoracic tenderness. She had lumbar vertebra tenderness. No power loss was evident in extremities. Breathing and heart sounds were natural. No abdomen tenderness was observed. No active bleeding was evident in wound area in left arm. Distal pulses were palpable and capillary filling was full. Motor movements in left arm was normal. Soft tissue loss was observed in wound area. In side thoracolumbar graphy, height loss was observed in L1 vertebra corpus. Lumbar CT was taken. In CT imaging, fracture was observed in L1 vertebrae anterior column. No invasion to spinal canal was determined. The patient was consulted with plastic and brain surgery departments.

Conclusion: Trauma patients should be systematically evaluated. Their full stories should be taken. A full inspection should be made after the clothes are taken off. The mechanism of the wounding should be learned, and pathologies of that type should be considered in advance. In patients with other distracting injuries, systemic examinations should be made for each patient in order to eliminate missing of other pathologies.

Keywords: Trauma, vertebral fracture, emergency

P-0514 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Lateral intraventricular epidermoid cyst rupture with hydrocephalus

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Objective: Lateral intraventricular tumors are not common tumors. Since these tumors grow linearly rather than exponentially, they grow gradually and thus do not cause mass effects and hydrocephalus. This study is the case report of a rare great volume left intraventricular epidermoid cyst rupture. The tumor was found to be associated with mass effect on neighboring structures and hydrocephalus.

Case: 43-year-old male patient was admitted with a complaint of moderate, gradually progressive headache and occasional episodes of vomiting that had been going on for 6 months. The patient's history did not suggest any neurological cause. Power in the right UL and LL were 4/5 and 3/5 respectively. No other neurological deficit other than this was found.

The patient's brain tomography showed lobulated contour image in the CSF density which formed a compression on the level of right lateral ventricular anterior horn of the left frontal region. The lesion had air-fluid levels on the lateral ventricles and air particles on subarachnoid spaces. The rupture was evaluated in favor of cystic mass. The ventricular system had a dilated appearance (Figure 1).

Pre-operative magnetic resonance imaging of the brain showed a lobulated, well-defined mass lesion in the anterior horn of the left lateral ventricle, which included hyperintense material hypointense on T1 (Figure 2) sequences and hypointense material hyperintense on T2 sequences (Figure 3). The lesion had a size of 30X50 mm, it had a lobulated contour and it was hyperintense. The lesion compressed the left lateral ventricle anterior horn and minimal periventricular ooze with obstructive hydrocephalus was observed on FLAIR sequences (Figure 4). The patient's lesion was completely removed with left frontal craniotomy, duraplasty and tisselean tissue adhesive. The tumor was avascular and pearly white and it covered the left lateral ventricle anterior horn.

Post-operative contrast negative computed tomography showed near-total excision of the lesion and resolution of hydrocephalus. The patient's post-operative recovery was normal. 6 months later, at his follow-up the patient was found to have improvement in his hemiparesis as well.

Conclusion: As a result, in patients who are thought to have cerebrovascular disease, especially those with a comorbid of ventricular hydrocephalus and spontaneous air presence, epidermoid cyst rupture should be considered.

Keywords: Epidermoid cyst, hydrocephalus, intraventricular

P-0515 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Descending necrotizing mediastinitis: a rare case presentation

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Objective: Descending necrotizing mediastinitis with a high mortality rate is a rare infectious disease. Especially as a complication secondary to oropharyngeal and odontogenic infections is composed. Early diagnosis, appropriate antibiotics and surgical treatment can be increased in a significant survival. To the emergency department with the complaint of pain in the throat and neck and descending necrotizing mediastinitis patients who died from the offer.

Case: Thirty years old female patient, emergency department fever, chills, pain in the jaw and neck, under the chin and neck redness, swelling, was admitted with complaints. During admission blood pressure 130/90 mmHg, the body temperature 38 degrees Celsius, oxygen saturation 94% was found to be. General status good, clear consciousness, orientation and full cooperation with the patient's current complaints a week before the start and after tooth pull himself and has continuously increased. Resume and any family history was unremarkable. On physical examination, a mass which erythematous progressing to the neck under the left chin, that rigid on palpation was detected. Oropharynx was hyperemic and hypertrophic tonsils. Purulent discharge under the tongue with tongue depressors were seen when pressed. Other system examinations were normal. May be developed after tooth extraction in patients with deep neck abscess and infection in mind, complete blood count, biochemistry, and chest X-ray was requested. Meanwhile, patients with ceftriaxone one gram of antibiotics and analgesic, antipyretic therapy was started. Neck and thorax tomography scan. The patient's laboratory values, WBC 20,000 x10³/µL, hemoglobin 11.2 g/dl were normal except that. Computed tomography of the neck and thorax, neck and chest from the right jaw abscess extending to the density consistent with appearance were available. By consulting with otorhinolaryngology patients were hospitalized. otorhinolaryngology and thoracic surgery patients treated by the medical and surgical treatment, thirty days later died.

Conclusion: Extremely rare and fast progress despite treatment descending necrotic mediastinitis is a disease that can be fatal. To avoid any delays in diagnosis and treatment of this rare but deadly emergency department physicians should be vigilant about the table that we think.

Keywords: mediastinitis, infectious disease, emergency medicine



POSTER BİLDİRİLER

P-0516 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Right colon perforation due to toothpick ingestion mimicking acute appendicitis

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Objective: Usually, ingested foreign bodies are seen in childhood but in adults occur frequently elderly, mental retarded and alcoholics individuals. Frequently, foreign bodies excreted with stool without any complications or morbidity but sharp or pointed foreign bodies like toothpick can lead to intestinal perforation and peritonitis. We report herein a case colon perforation caused by ingested toothpick unawares.

Case: A17-year-old man was admitted to the emergency department with complaints of abdominal pain and vomiting for 16 hours. Although of his past medical history has any illness but he explain that he works as a waiter in a restaurant. On physical examination, she was conscious and mild pyrexia. Abdominal examination revealed rebound tenderness on lower right quadrant. His white blood cell count is 15600/μL, another biochemical parameters are normal range. There is no abnormality was detected on abdominal X-ray, abdominal ultrasound revealed that a lineary, hyperechoic, 4 cm length object in bowel lumen lied to bowel wall and perforated it on the right abdominal region, there is minimally fluid collection surrounded tissue and space (Figure 1). Intravenous contrast enhanced abdominal computed tomography showed that a 4 cm length, hyperdensity foreign body perforated colon wall (Figure 2). We could not underwent laparoscopic intervention failure of technical support. At laparotomy, there is no abdominal or local fluid collection and a perforation caused by a protruding sharp pointed toothpick, 5 cm distal of the ileocecal valve in right colon, were noted (Figure 3). Wedge resection of colon wall were performed. He was discharged on the postoperative 6th day.

Conclusion: Acute appendicitis differential diagnosis on adult patient with lower right abdominal pain consider bowell perforation due to ingested non-opak foreign body perforation, careful patients history and imagination methods are important for preoperative accurate diagnosis.

Keywords: toothpick, right colon perforation, acute appendicitis

P-0517 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Peroneal nerve injury after artroskopik intervention to the knee

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Objective: To present a case with complaints of leg weakness, numbness and tingling on anterior-lateral side of the cruris after applied arthroscopic intervention to the right knee

Case: A 21 year old male patient who had undergone meniscectomy as arthroscopic with 350 mm hg pneumatic tourniquet pressure of left knee had complaints of the same leg of weakness, atrophy and numbness. Examination of force and sense were normal before operation. After than electromyographic examination of the patient was revealed peroneal nerve injury and pneumatic tourniquet applied during operation was connected to the reason. To help the patient comfortable walking ankle brace was built in neutral. Patient was followed up with brace.

Conclusion: Pneumatic tourniquet applied to the surgical procedures for lower extremity may occur the peroneal nerve injury. Therefore during the operation, we the need to pay attention to the pressure applied and tourniquet time.

Keywords: tourniquets, arthroscopy, peroneal nerve injury

P-0518 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

The Relationship Of Demographic Characteristics Of Patient Diagnosed For Acute Appendicitis With Blood Group

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Objective: It has been aimed to reveal the relationship between blood type and epidemiologic characteristics of patients who applied to GOP Taksim Training and Research Hospital and who were diagnosed for acute appendicitis, and hospitalized in general surgery department.

Materials-Methods: This is a retrospective study, and the patients who applied to emergency service of GOP Taksim Training and Research Hospital between 01.01.2014 and 03.31.2014, and who were diagnosed for acute appendicitis, were involved in this study. In this study, the patients' ages, genders, blood types and the hours of application at emergency service were investigated.

Results: 73 patients were involved in this study. Of these patients, 61.6% (45 patients) were male, and 38.4% (28 patients) were female. The mean age of patients was 31.6. The mean age of male patients was 30.8, while the mean age of female patients was 32.8. The hours of patient's application at emergency service were 08-16 for 24 patients (33%), 16-24 for 29 patients (40%), and 24-08 for 20 patients (27%). About the distribution of those patients in terms of blood type; 41% (30 cases) were O Rh+, 27% (20 cases) were A Rh+, 5% (4 cases) were A Rh-, 18% (13 cases) were B Rh+, and 9% (6 cases) were AB Rh+.

Conclusion: Acute appendicitis is the inflammation of appendicitis, and is one of the surgical emergencies. The prevalence of acute appendicitis in males is 1.5 fold of the prevalence in females. The rate found in our study is very close to this value. The patients applying to our institution were young, and there wasn't any significant age difference in terms of genders. In a study carried out in Red Crescent Blood Centre between 1995 and 2000 covering 82,292 individuals, it has been determined that the frequencies of blood types in Turkish nation are 29.8% for O Rh+, 37.8% for A Rh+, 14.2% for B Rh+. Comparing with those results, a significant relationship was find in our study between O Rh+ blood type and acute appendicitis (p<0.02). Under the light of these results, it is thought that this study should be repeated on larger groups.

Keywords: Acute Appendicitis, emergency medicine, Blood Group

P-0519 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Three Clinics Three Diagnosis

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Objective: Mortality rates in first 48 hours approaches to 50% with delays in the diagnosis and treatment of aortic dissections. These patients usually refer to ERs with the complaints of inter-scapular or sudden severe pain in anterior thoracic wall region. Besides, they can also be presented with unexpected complaints such as syncope, neurological symptoms like hemiparesis – hemiplegia, paraparesia - paraplegia, myocardial infarction, dysphagia and lower back pain. We aim to present three different cases in which aortic dissections were diagnosed to remind this mortal disease entity.

Case: The case was a 64-year-old male patients with a chest pain complaint. He was referred to our tertiary care emergency department with a diagnosis of acute coronary syndrome and stroke from another hospital. During the pre-hospital transport, bradycardia has developed and his consciousness was disoriented. On his physical examination, his GCS was E4M3V3. Vital signs were as follows; TA: 110/60mmHg pulse: 62/min SS: 22/min. In 4 extremities pulses were palpable and other system findings were regular in the patient. On neurologic examination, there were motor weakness in his left upper and lower extremities and repeating throwing up complaints. The patient's preliminary diagnosis was acute coronary disease. In Cranial computed tomography, there were no pathology and in diffusion weighted MRI, there was no restricted area. In bedside ultrasound, it has been revealed that aorta stem was 53 mm and there was a flap in abdominal aorta. In computed tomography of abdomen with contrast material, there were dilatation in the aorta and a dissection starting from aortic root and continuing to arcus aorta and abdominal aorta up to hilar level extending also to truncus brachiocephalicus. Patient has sent to the operation room. But in the post-operative 5th day patient died.

Conclusion: In ER, diagnosis of acute aortic dissection with the patients presented with chest pain and hemiplegia must be kept in mind. In case of clinical suspicion, physical examination should be done as soon as possible and it should also be kept in mind that the mortality would increase in case of late diagnosis.

Keywords: Aortic Dissection, Hemiplegia, Chest pain



POSTER PRESENTATIONS

P-0520 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Phalanx fracture observed after horse bite

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Objective: Even if it is rare, it is possible to encounter injuries related to animal bites in actual emergency medicine. Usually, animal bites occur in races such as dogs or wolves called predacious animals. But it is very rare to observe injuries related to horses which are domesticated and used in various works and actions in daily life. In our presentation, we have presented the case of a patient with a phalanx fracture due to horse bite.

Case: It has been learnt that the patient taken to our emergency clinic with finger bleeding and pain has been bitten by the horse he wanted to feed. The vital observations were stable, the general situation was good, the conscious was open, cooperated and oriented in the examination. There was a bleeding in skin in the distal part of the 2nd finger of right hand, an incision and painful articulation movements have been noticed (Figure 1). However, there was no movement defect. An oblique-type fracture line in the distal phalanx has been observed in the direct graph performed after the first care. The wounding of the patient has been fixed, the finger has been put insplint, tetanus prophylaxian and double antibiotherapy has been started and the patient has been discharged.

Conclusion: In literature screening, we have encountered ear, nose, penis amputations associated to horse bites. Our case can be considered as a slight case compared to these cases. However, even if we encounter animal injuries in predacious races, it is also possible to experience severe injuries with domesticated animals such as horses.

Keywords: horse bite, phalanx fracture, emergency medicine

P-0521 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Cause Of Flank Pain: Renal Infarct

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Objective: Renal infarction is a rare cause of acute flank pain. It is characterized clinically by a sudden-onset flank pain, hematuria, fever, and leukocytosis. It is commonly confused with renal colic or pyelonephritis. It is usually common in patients with cardiac disorders or a high thromboembolic risk. The most common causes of systemic atheroembolism are a damaged atheromatous plaque and senility. Risk factors for arteriosclerosis include advanced age, male gender, diabetes, hypertension, hypercholesterolemia, and smoking. In this study we aimed to report the clinical presentation of a case with renal infarction.

Case: A 72-year-old man presented to the emergency department with left flank pain for 5 days. His past history was notable for congestive heart failure, atrial fibrillation, hypertension, and right renal infarction 2 years ago. He had previously been on warfarin 5 mg/day. However, he stopped taking warfarin 1 week ago. On physical examination his blood pressure was 110/100 mmHg, pulse rate 130 bpm, body temperature 37°C. On electrocardiography there was atrial fibrillation with rapid ventricular response. The patient did not have macroscopic hematuria. Urinalysis revealed blood at a concentration of 250 mg/dl and a leucocyte count of 100/μL. Other laboratory parameters were within normal limits. A direct urinary graphy and urinary ultrasonography revealed no stones. Considering the risk factors, a renal angiography was taken. It showed subacute splenic infarction and acute renal infarction.

Conclusion: Renal infarction should be considered in differential diagnosis in patients presenting with flank pain, and advanced age, cardiac disease, and risk factors for atherosclerosis should be questioned.

Keywords: atheroembolism, flank pain, renal infarct

P-0522 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Chance To Be At The Scene Of An Emergency Medicine Specialist

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Objective: By chance, an Emergency Medicine Specialist located near the scene of the first intervention of a patient with multiple trauma and the development of events has been presented.

Case: I was called to the scene for a patient who felt from about 5 meters height on iron bars while he was cutting a long linden tree. I reached the scene by running approximately three hundred meters close to my house. He was a 47 year old male patient. His general condition was moderate and he was confused and pale. His pulse was over 120 per minute. His injury was on right upper quadrant of abdomen and there was active bleeding. There was also an open fracture of the right knee. I pressed on active bleeding area with my hands than with towels to control bleeding. Then I called an ambulance from 112 EMS and gave information about the patient. Shortly after I called my friends which are emergency physician and general surgeon on duty at the hospital and wanted them to get ready in the emergency room and operating room. The ambulance arrived twelve minutes later. Bolus crystalloid infusion started. After immobilization of spine and open leg fracture, the patient was transferred to hospital. The patient was taken to the resuscitation room and IV fluid and blood replacement was started. There was active bleeding from the injury on right anterior axillary line at the level of tenth costa. His vital signs were; BP:90/50 mmHg, HR: 124/min, and SaO2 94%. Bilateral hemothorax, liver parenchyma laceration, L5 vertebral body fracture and the right distal femur open fracture were detected with computed tomography. The patient underwent urgent surgical operation. There was active bleeding in the abdomen. Liver laceration and rupture were detected at the junction of inferior vena cava and right renal vein with exploration. Hemostasis was achieved by tying the renal vein. After repair of vena cava inferior laceration, bleeding was taken under control. Right nephrectomy was performed and diaphragma was repaired. Bilateral tube thoracostomy was performed and right distal femoral fracture was repaired. A total of twelve units of blood were transfused. After observation two days in intensive care unit patient were discharged on the tenth day.

Conclusion: Accordance with the appropriate intervention at the scene, then transferred to the hospital and fast/efficient treatment of multiple trauma patients with high mortality rate can be rotated to life.

Keywords: multipl trauma, hemorrhagic shock, emergency surgery

P-0523 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Appendix mucocoele case with acute cholelitis due to gall bladder stone

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Objective: Acute cholelitis, usually caused by gall bladder stones, is an emergent pathology. Occasionally different pathologic findings can be seen with this acute case. Appendiceal mucocoele can be rarely seen with acute cholelitis. Right upper quadrant pain and tenderness can be seen in physical examinations. History of gall bladder stone and physical examination findings are helpful for the diagnosis. Additional laboratory tests and imaging technics can be helpful for diagnosis. Appendiceal mucocoele is usually asymptomatic and can be found in additional evaluations due to different pathologies. Laparoscopic appendectomy can be performed with laparoscopic cholecistectomy. Open surgery is an alternative surgical intervention. We are presenting a appendiceal mucocoele case administered to our emergency department with acute cholelitis.

Case: 50 year old woman with right quadrant pain and nausea – vomiting for one day administered to our emergency department. In clinical history neither surgical intervention nor additional chronic pathologies were seen. In physical examination GCS:15, tension arterial: 120/90 mmHg, pulse rate:90, Ventilation rate: 24, fever:37.5 centigrade celcius. In abdominal palpation right quadrant tenderness and murphy sign were seen. In laboratory evaluation mild elevated WBC count was seen. In emergent US evaluation gall bladder was hydropic and wall thickness was increased. Multiple stones were seen in gall bladder, additionally appendiceal tissue diameter was measured 2 cm (Appendiceal Mucocoele). After evaluations patients was hospitalized by General surgery and emergent CT imagination was performed. In CT findings gall bladder was full with stones and in right lower quadrant appendiceal mucocoele with 2.15 cm diameter was seen. Emergent laparoscopic cholecistectomy and laparoscopic appendectomy was performed simultaneously. After clinical follow-up patient was discharged.

Conclusion: Additional pathologies like appendiceal mucocoele should be kept in mind in acute cholelitis cases.

Keywords: Acute Cholelitis, Gall Bladder Stones, Acute Abdomen, Appendiceal Mucocoele



POSTER BİLDİRİLER

P-0524 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

The case of Foreign body Who admitted with Apple in the rectum

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Objective: Various voluntary bodies in the rectum can be found for different reasons. Patients with different complaints coming, could prefer to hide their chief complaint. Careful history and physical examination in these patients is important.

Case: 35 year old male patient to the emergency department with foreign objects into the rectum by others to be forced onto admitted. Physical examination was normal, mild redness in the anal area, fissure -style scrapes and there was a slight decrease in sphincter tone. At high levels in digital rectal examination was palpable palpable hard bodies. Vital signs were within normal limits. ADBG obtained from the patient since there was no abnormal appearance. Then unenhanced abdominal CT in lower rectum 67x74 mm in size in the round well-circumscribed non- radiopaque foreign bodies were seen. General surgery than patients who consulted with rectal foreign body was removed in surgery room The foreign body was removed apples. The patient was hospitalized for postoperative follow-up.

Conclusion: Depending on the risk of rectal foreign body perforation is present with early diagnosis and treatment in the emergency room with the removal of foreign bodies most cases are discharged home.

Keywords: perforation, foreign body, surgery

P-0525 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Tracheostomy, is it really innocent?

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Objective: Tracheostomy one of the oldest surgical procedures has been practiced probably for thousands years, there was no routinely use up to the 19th century. Modern surgical procedures described by Chevalier Jackson have remained virtually unchanged until today. Even though its broad range of indications, tracheostomy is generally indicated for ventilator-dependent patients in order to facilitate readily weaning from the ventilator, allows convenient access for pulmonary toilet, reduce the need for sedatives, be more comfortable for the patient, reduce the risk of long-term squal of an endotracheal tube, and potentiate ICU discharge. Therefore, it is the most commonly performed surgical procedures in ICUs with appreciable morbidity and complications (8-45%). Its complications are ranging from intraoperative that can be rapidly life threatening to late or chronic postoperative that may become apparent much later such as tracheal stenosis and granulation. Clinically significant stenosis is very rare and occurs in approximately 1% of patients. We aimed to investigate the histopathological changes which lead to stenosis in tracheal epithelia after the conventional tracheostomy in rabbit model.

Materials-Methods: Twenty-four male New Zealand White rabbits were used for this study. They were randomly divided into three equal groups. Classic tracheostomy was carried out in sixteen subjects. Group 1 which was made any surgical procedure served as control for tracheal measurements. After tracheostomy, we applied sterile saline in Group 2, Mitomycin-C (0.8 mg/ml) (MMC) in Group 3 around tracheotomy for 5 minutes. At 3 weeks after surgery, tracheas were evaluated by morphometric and histopathological examination with the inclusion of tracheal lumen diameter, number of capillary vessels, subepithelial tissue thickness, fibroblasts and inflammatory cells.

Results: There were statistically significant differences between tracheostomy and control group for tracheal lumen diameter (P=0.35), number of capillary vessels (P=0.06), subepithelial tissue thickness, fibroblasts and number of lymphocyte (p < 0.001). Histopathological analysis showed the decreased fibrosis in the group treated with MMC.

Conclusion: Current treatment modalities of Tracheal stenosis one of the most difficult and devastating problems in airway surgery tend to fail due to the new scar formation and restenosis. We are believed to wound healing modulation may prevent scar formation and no need further surgery. Even if, there are undoubtedly many advantages of tracheostomy these must be balanced against the real risk of the procedure. As a result, tracheostomy is not an innocent procedure. In patients who underwent tracheostomy, scarring and granulation tissue formation should always be kept in mind.

Keywords: Tracheostomy, ICU, Mitomycin-C (MMC), Tracheal Epithelia

P-0526 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Internal fixation of Clavicle fractures with titanium clips (STRATOS™ System): A Case Report

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Objective: Clavicular fractures (CFs) are a common injury and most often occur in younger adults with the highest incidence in the second and third decades. After the age of 20, its prevalence has been reduced by every decade whereas sex ratios (female to male) are increasing. Anatomically, CFs can be divided into three as medial, mid-shaft and lateral. Mid-shaft fractures are most common type, constitute approximately 82% of all clavicle fractures. Customary, CFs have been treated conservatively, even if largely displaced. Because of high non-union rates, surgical treatment is gaining more acceptances. Plate/screw systems and intra-medullary devices that are most commonly used devices still continues to be problematic. We describe our experience with a case of traumatic CF who successfully treated with open reduction and internal fixation with rib clips, as miscellaneous usage.

Case: A 48-year-old man was admitted to our emergency department after fall from height. Radiological examination revealed a right midshaft CF, other bone fractures and organ injuries. Patient was operated on the 13th day after trauma. Standard surgical approach was made as an oblique incision on the fracture area of the clavicle. Subcutaneous and deep dissection was carefully carried out through sharp and blunt dissection. After periosteal elevation, clip was applied to the clavicle only in fracture area. Before replacement, clip was reshaped for corresponding to bone curved shape. Subsequently, clip legs were crimped on each side of the clavicle via using special tools. There was no pain, complication or instability after operation. Arm flexion and abduction was limited during the first 3 weeks. The postoperative course was uneventful, the patients discharged with immobile right arm in a sling two weeks after surgery. Outpatient physiotherapy was organized and instructions were given to execute pendular exercises within a painless range.

Conclusion: Despite the wide range of surgical options, because of the sigmoid shape of clavicle makes them difficult to use these devices for CFs. Compared to the other material; titanium is easily adaptable to the bone shape that wanted to be fixated. STRATOS™ system is titanium clips/rods mainly used for rib fractures and pectus excavatum surgery. According to our best knowledge it is the second report for using this system for clavicle fractures. Open reduction and internal fixation with rib clips in clavicle fractures is a good and safe alternative to conservative treatment. It makes procedure simple and cheap, reduces hospital stay and complications.

Keywords: Internal fixation, Clavicle fractures, titanium clips, STRATOS

P-0527 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Rib Fractures: Could we accelerate the healing?

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Objective: Mortality due to trauma rank third after cardiovascular diseases and cancers among the causes of adult death worldwide. Rib fractures (RFs) are a common injury affecting greater than 145,000 people each year in the United States, with at least one third of patients requiring hospital admission. It is clear that this number is higher, considering that 77% of patients with



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rib fractures are not applied to emergency departments.

Historically RF's treatment is symptomatic, based on pain control with analgesics including narcotics and non-steroidal anti-inflammatory drugs (NSAIDs), respiratory physiotherapy and specific treatment of associated complications. Approximately 31% of them will encounter complications including nosocomial pneumonia, prolonged respiratory failure, prolonged hospitalization, or death, due to coexisting injuries, age, and comorbidities. In spite of proper treatment, long-term disability and persistent chest wall pain frequently develop and may take several months to recovery; leads to high hospital, medicine, labor and social burden. We thought that "How fractures are improving more rapidly". For this purpose, we made an experimental model to investigate the effect of zinc supplementation on the development of new bone in young rabbits.

Materials-Methods: Twenty 6 weeks of age, male New Zealand white rabbits were evaluated in four groups, each including 5 subjects. To simulate the rib fractures; subperichondrial costal cartilage resections beginning from the third costal cartilage were carried out in the right hemithorax according to groups. Rabbits in group 1 and 2 underwent partial resection of the two ribs; rabbits in group 3 and 4 underwent total resection of those. Zinc was administered by intraperitoneal injection of 6 mg / kg / day for 4 weeks after the surgery for group 2 and 4. The animals were followed-up at the twenty-fourth week of their life.

Results: In every subgroup, we analysed histologic changes in the bone. There were statistically significant differences for osteoblasts and osteoclasts among all subgroups. Histologic consolidation was significantly increased by zinc supplementation. In accordance with the literature, in our study while zinc stimulates osteoblastic bone formation, suppresses osteoclastic bone resorption

Conclusion: Our findings indicate that zinc supplementation accelerates the consolidation of ribs. Zinc can be used to increase the bone maturation such as the site of new bone formation in rib fracture.

Keywords: Zinc Supplementation, rib fracture, rabbits

P-0528 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

The rektal perforation who has diffus abdominal pain after sigmoidoscopy: case report

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Objective: Emergency services are frequently conducted in the interventional procedures. Sigmoidoscopy is one of them, because of lower GI bleeding in a patient admitted after this process we have presented a case of developing rectal perforations.

Case: 76 year old female patient gastroenterology outpatient clinics during sigmoidoscopy after advancing approximately 10 cm from the entrance of abdominal pain and abdominal tenderness on the development was directed to the emergency room. Physical examination of the abdomen was giving common defense delicate and light. ADBG and PA chest X-ray taken immediately and the patient's values of free air seen on the general surgery departments were consulted with. The patients were evaluated by CT of the abdomen CT; Right subdiaphragmatic area in the West, perihepatic - subhepatic area, right lower quadrant paracolic area at the midline between the free air value intestinal segments were present. The patient was admitted to the surgical clinic based in an emergency operation.

Conclusion: Multiple complications can appear after interventional procedures. These complications advanced age, genetic structure, the transaction is variable depending on the location. Some of the complications that may be life threatening if early diagnosis reduces mortality.

Keywords: sigmoidoscopy, perforation, free air

P-0529 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Role of Low-Intensity Pulsed Ultrasound (LIPUS) on Growth Factors Expression during Rib Fracture Healing

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Objective: Mortality due to trauma rank third after cardiovascular diseases and cancers among the causes of adult death worldwide. Rib fractures (RFs) are common and responsible for a substantial portion of injury-related morbidity in USA. Despite appropriate therapy RFs that is considered to be healed in 6 to 8 weeks could be painful and potentially disabling. Low-intensity pulsed ultrasound (LIPUS) is a form of mechanical energy that is transmitted through and into biological tissues as an acoustic pressure wave and has been widely used in general medicine as diagnostic purposes and physical medicine as important therapeutic tools. Several studies have demonstrated that enhancing fracture consolidating, preventing complications and shorten returning time to his or her daily life after LIPUS treatment. Fracture healing is characterized by the recruitment and differentiation of osteoblastic and osteoclastic cell populations, whose cellular activities are coordinated and regulated by growth factors. In this study we investigated the effect of low-intensity pulsed ultrasound (LIPUS) on expression of growth factors and fracture healing in rat ribs.

Materials-Methods: 72 male Wistar-Albino rats were randomly distributed in 3 equal groups, each including 24 subjects. To simulate a fracture; left thoracotomy was performed under general anaesthesia and a 0.5 cm segment was removed from the ribs. After 24 hours of surgery LIPUS began to be implemented according to the groups. Group 1 served as control for the observation of normal bone healing. LIPUS was applied at a doses of %20 (2 msn pulse-8 msn pause) 100 mW/cm2 and %50 (5 msn pulse – 5 msn pause) 200 mW/cm2 respectively in group 2 and 3. Eight animals from each group were sacrificed at 2, 4 and 6 weeks for further assessment. We analysed histologic changes in the bone.

Results: Although no statistical difference was noted for osteoblasts, osteoclasts and new bone formation among all groups; there were significant differences in all growth factors including Vascular Endothelial Growth Factor (VEGF), Insulin-Like Growth Factors (IGF-I) and Platelet Derived Growth Factor (PDGF). Histologic consolidation was significantly increased by LIPUS. In our study LIPUS stimulates all growth factors.

Conclusion: In accordance with the literature, LIPUS either used in lower or higher doses stimulates the consolidation of rib fractures. The most prominent improvement was observed in 200 mW/cm2 group after long term follow-up. Accelerating the natural healing process in patients with rib fractures will be able to treat more effective, short and low cost treatment.

Keywords: Low-Intensity Pulsed Ultrasound (LIPUS), Growth Factors, Expression, Rib Fracture Healing

P-0530 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Spontaneous Non-traumatic Gas Gangrene

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Objective: Severe skin and soft tissue infections are often life-threatening emergencies that require a rapid diagnosis. Gas gangrene is one of the most fulminant types of soft tissue infections and is usually caused by Clostridium perfringens' contamination of an open wound. Although gas gangrene is usually associated with fecally contaminated wounds, "spontaneous" cases occur and are most commonly caused by Clostridium (C.) septicum. We report a case of spontaneous gas gangrene caused by C. septicum that only became manifest while the patient was being monitored in the emergency department. We also review the diagnosis and treatment aspects of this entity.

Case: An 60-year-old diabetic man was seen in the emergency department with a 2 day history of leg pain.. His medical history included coronary artery disease and diabetes mellitus. There was no prior history of a surgery or trauma. On initial examination the patient was in no distress and his vital signs were temperature 37.5°C, pulse 66 beats/ min, respiratory rate 16 breaths /min and blood pressure (BP) 129/63 mm Hg. The right leg had a normal range of motion but there was skin erythema. On the right leg palpation, he had diffuse subcutaneous emphysema. The white blood cell count (WBC) was 110 109/L, the hemoglobin was 15 g/dL and the serum creatinine was 1.9 mg/dL. His serum lactate was elevated at 4.2 mmol/L. On plain films, soft tissue had diffuse subcutaneous air image. In patients diagnosed we thought gas gangrene, necrotizing fasciitis. General surgery consultation was requested. Operation was planned by general surgery and the patients hospitalized and he was taken to the operating room. Incisions were made in the thigh and a foul smelling thin exudate was obtained. The underlying muscles were necrotic and a decision was made to perform a disarticulation of the right leg at the hip. Only the anaerobic culture was positive and grew Clostridium (C.) septicum. The patient was given a total of 12 days of combined cefazolin and clindamycin.

Conclusion: Gas gangrene is a well-recognized serious life and limb threatening emergency. In certain patients the source of this infection may be nontraumatic. Early recognition of nontraumatic gas gangrene is crucial to reduction of mortality and morbidity. Emergent therapy requires resuscitation, surgical consultation, pharmacological therapy, and consideration of hyperbaric oxygen therapy. Early institution of a multifactorial approach to treatment may significantly reduce the mortality and morbidity of this life threatening disease.

Keywords: Gas Gangrene, Non-traumatic, Clostridium septicum



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P-0531 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Is Sharp Object Injury Really More Frequent In Men?

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Objective: In this retrospective study, it has been to determine the demographical characteristics of cases applying with sharp object injury and firearm injury to emergency services, and to investigate the characteristics.

Materials-Methods: 41 sharp object injury and 17 firearm injury cases applying to Gaziosmanpaşa - Taksim Training and Research Hospital between 10.01.2013 and 04.01.2014 were retrospectively evaluated.

Results: The mean age of firearm injury cases was 36, and only 1 case was younger than 18 years-old. Of these 17 cases, only 2 (11.7%) cases were female and 15 (88.3%) were male. 5 (29.4%) of cases applied to emergency service after midnight.

The mean age of 41 sharp object injuries was 26, and all of the cases were male. 13 (31.7) of those cases were younger than 18 years-old. 8 cases (19) applied to emergency service after midnight.

Conclusion: Being surgical emergencies, the firearm and sharp object injuries are the cases requiring emergency surgery depending on localization. In this study, significant difference has been determined between applicant injury cases in terms of gender. The quantitative superiority of men in both of groups is remarkable, and this situation is in harmony with literature. But, almost 1/3 of sharp object injuries are younger than 18 years old. It causes the thought that the usage of sharp objects is more common in children and young people.

Keywords: Emergency medicine, Sharp Object, gun shoot

P-0532 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A rare stone form: rhinolithiasis

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Objective: Rhinolithiasis is a structure which originates from exogenous or endogenous nidus. As a result of mineralization of this niduses, a growing intranasal mass is formed. Rhinolithiasis may not lead to any symptoms or it can cause symptoms such as nasal obstruction, unilateral malodorous and mucopurulent nasal discharge.

Case: A 21-year-old male patient was admitted to the emergency room with complaint of prolonged unilateral mucopurulent nasal discharge and oral malodor. On physical examination, there was no sign of pathology in the oropharynx, teeth and gums. Abdominal examination was also normal and the patient did not suffer from dyspepsia. On anterior rhinoscopy examination with speculum, a white- yellow colored lesion covered with mucus was detected on the right nasal cavity. On maxillofacial CT, a calcific lesion was observed in the right nasal cavity. The patient was hospitalized to otorhinolaryngology department and operated under general anesthesia. At the end of the operation 3-4 rhinoliths, the largest of which was a diameter of 15 mm, was extracted.

Conclusion: Physicians suspect of foreign body in the nose, especially in young children with prolonged unilateral nasal obstruction, mucopurulent discharge and oral malodor complaints. However, physicians should keep rhinolithiasis in mind in adults with these complaints.

Keywords: Rhinolithiasis, foreign body, intranasal mass

P-0533 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Tibial tubercle fracture: A Case Report

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Objective: Avulsion fracture of the tibial tubercle generally occurs in adolescent males and is seen quite rare and is surgically treated. It usually occurs during exertion as a result of sudden and strong contraction of the quadriceps muscle, in situations such as high energy trauma during forced knee flexion, falling down on to the foot after jumping and blocked knee extension. Right tibial tubercle avulsion fracture which occurred during a football game while trying to shoot the ball, is discussed in this case report.

Case: 14-year-old male patient was brought to the emergency ward with pain and extension restriction at the right knee and in flexion posture. He told that he shot the ball during the football game and he felt burning, pain and movement restriction. His vital signs were stable. In the physical examination, his right knee was in flexion and could not be extended. There was pain and edema at the knee. The continuity of patellar tendon towards tibia was lost. Patella was dislocated from its normal anatomic position to proximal. Other system signs were normal. In the lateral knee X-ray, Ogden Type 3A tibia avulsion fracture was detected. Following the orthopedic consultation, the patient was hospitalized for operation. Open reduction and internal fixation was done to the patient. Following the operation, long leg splinting was applied for 3 weeks, then physical therapy was initiated. The patient started to walk unaidedly, and no sequel was detected.

Conclusion: Tibial tubercle fractures are seen rarely, and usually between ages 13 and 17. Since epiphyseal closure isn't completed yet, applying excessive extensor force in the adolescents who play sports, may lead to the avulsion of tibial epiphysis. Additional pathologies including patellar tendon rupture, medial and lateral ligament ruptures, and meniscal tears may also be seen based on the severity of the trauma. In some patients it may also be seen because of the underlying osteogenesis imperfecta and osgood schlatter. Tibial tubercle fractures are important to be diagnosed and treated properly since they are related with epiphysis and therefore they may lead to problems such as deformity and shortness. Thus, all physicians working in the Emergency Ward which is the first place to be applied about traumas, must have knowledge of the diagnosis and management of this rarely seen disease.

Keywords: tibial tubercle, avulsiyon fracture, adolescent

P-0534 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Why is the baby crying?-A Case Report

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Objective: Hair thread tourniquet syndrome is clinical presentation in which a hair or a thread encircles a part of the body and causes ischemia, and if it is not treated it can lead to necrosis. It is generally seen in infants. Surgical removal of the material that is causing ischemia may prevent irreversible damage and even necrosis. A 6-month-old baby who was brought to the emergency ward with ischemic digit caused by hair wrapping is discussed in this case report.

Case: 6-month-old baby girl was brought to the emergency ward with inconsolable crying by her parents. She presented with a good appearance, and sufficient breathing and circulation. She had no feature and developmental anomaly in her history. Physical examination revealed edema and incision line on the mid-phalanx of the 4th toe of the right foot. There was also a color change in the distal part of the mid-phalanx due to ischemia and circulatory impairment. Capillary refill was 4 seconds. There was no pathology in the bone in the X-ray. When the ischemic area was examined, it was detected that a bunch of hair encircled the toe and caused ischemia. The bunch which is causing ischemia was cut under sterile conditions. Skin and subcutaneous tissue cut was detected in the diseased toe, but there was no tendon injury. After the removal of the hair bunch, rapid perfusion in the distal part was seen. After seeing full circulation in the follow-up, she was discharged with outpatient control recommendation.

Conclusion: Hair thread tourniquet syndrome was first reported in 1971. It is usually presented with pain, swelling and redness in the digit. The constricting material, first leads to venous return impairment, and after swelling, the arterial flow gets obstructed too. If it is not treated it may lead to tissue necrosis and loss of the finger. Thus, the constricting material should be removed immediately. Since missing this clinical manifestation can cause digit loss, the swelling and color change in the digits must be examined more carefully by emergency physicians.

Keywords: Hair thread tourniquet syndrome, hair toe, ischemic finger

P-0535 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Rectal Perforation due to Accidental Anorectal Injury

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Objective: Anorectal impalement injuries and rectal foreign bodies are uncommon situations in emergency departments (ED). Particularly, etiology of foreign bodies is anal eroticism but it may be occurred by an accident as seen this report.



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Case: A 63 year old man admitted to ED with anorectal pain due to accidental impalement injury by piece of wood. He presented with anorectal pain, difficulty in walking and rectal bleeding. There is no pathological finding on his physical examination excluding anal exam. It was found that there was a laceration (nearly 3-4 cm long and 2 cm deep) extending towards to anus by digital rectal examination (figure 1). The laboratory results were in normal range (hgb: 14.9 g/dL plt: 165000 INR: 1.04 AST:40 U/L ALT:18 U/L BUN/Cr: 140/0.92). Abdominopelvic computed tomography was performed and showed edema next to posterior wall of rectum and there was extraluminal air bubbles in perirectal fatty tissues (figure 2). Patient has gone to surgery from ER with diagnosis of rectal perforation by surgeons.

Conclusion: Although traumatic rectal injuries are rare, they have increased morbidity and mortality. Early diagnosis and evaluating for surgery treatment is very important in ER.

Keywords: perforation, injury, rectum

P-0536 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Combined treatments at sedation analgesia: Ketamine midazolam

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Objective: Procedural sedation involves the use of short-acting analgesic and sedative medications to enable clinicians to perform procedures effectively, while monitoring the patient closely for potential adverse effects. Ketamine has been the single most popular agent to facilitate painful emergency department (ED) procedures in children but due to adverse effects, it is recommended for use with midazolam in adults. The aim of this case is point to the effectiveness and safety use of ketamine midazolam combination for adult reduction of elbow dislocation and radius fracture in the emergency service.

Case: A 32-year-old male arrived at emergency service with complaints of pain and limitation of movement to the right elbow. Patient was fell down while he was playing volleyball. His vital signs was stable and there were no additional injury. There was deformity, swelling and pain at elbow. Elbow movements were restricted. Neurovascular examination was normal. Radiography shows humero-ulnar dislocation and radius shaft fracture. Reduction was applied with sedation and analgesia. Ketamine 1.5 mg/kg and low dose midazolam (2 mg) was administered intravenously. Reduction was successful and recovery time was 25 minutes. There was no hypotension and hypoxia during the procedure. There were no adverse effects like emesis, recovery syndrome. Patient satisfaction was good. Long arm splint was applied and patient admitted to orthopedy for elective ligament repair.

Conclusion: Ketamine and low dose midazolam combination can be safely used for reduction of dislocations and fractures with lower risk for cardio pulmonary side effects.

Keywords: Ketamine, midazolam, sedation and analgesia

P-0537 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Cervical Abscess Due To Tracheoesophageal Fistula

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Objective: Vertebral canal infections are reported with a rate of 2.4/100000. Among those, infections of the lumbar vertebra are the most common ones which is followed by thoracic and cervical vertebra infections. Commonly hematogenous spread is the cause of these infections. Herein we will present a cervical abscess case that took place via the way of neighborhood.

Case: A 56 years old male patient was referred to our hospital with the complaint of bilateral power loss on his legs for 2 days, from a secondary hospital. It was learnt that he had larynx ca 9 years ago, he was operated and having tracheostomy from then on. In physical examination, his blood pressure was 130/70mmHg, pulse was 87/min and body temperature was 37.80C. His neurological examination revealed a muscle power of 5/5 on his upper extremities bilaterally but the muscle power was 1/5 on his bilateral lower extremities. There was not any abnormalities in his laboratory examinations other than a white blood cell count of 14,500, C-reactive protein level of 151 and pro calcitonin level of 0.1. The patient did not have a trauma history. In order to determine the cause of the paraplegia of the patient, cervical and thoracic vertebrae MRI was performed. The MRI revealed an abscess formation with a diameter of approximately 2,5x1 cm, showing peripheral contrasting, on the anterior subarachnoid area at the level of C6-C7, pressing on the spinal cord on the center and left half. The radiologists offered an upper gastrointestinal system endoscopy in order to diagnose the cause of this irregularity. Endoscopy revealed a tracheo-esophageal fistula. The patient was operated by neurochirurgie and ENT surgeons for the abscess and trachea-esophageal fistula at the level of C6-C7. The fistula was repaired and the abscess was drained and the drained material was sent for the culture. The culture revealed gram positive and negative bacteria compatible with the skin flora. His paraplegia did not ameliorate after the operation and the patient was referred to the physical therapy and rehabilitation department.

Conclusion: Vertebral infections most commonly take place due to the hematogenous spread. Other less frequent ways of infection are the direct inoculation and via neighborhood. In this case, tracheoesophageal fistula developed due to the tracheostomy which was inserted during the operation of larynx ca and cervical abscess was formed with the bacteria of skin flora

Keywords: ABSCESS, CERVICAL, TRACHEOESOPHAGEAL FISTULA

P-0538 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Rupture of cyst hydatid with diffuse urticarial rash after lifting heavy object

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Objective: Cyst hidatid is a parasitic disease which caused by *ecinococcus granulosus*. Generally it exists at liver. Major findings can be at a wide range from simple urticarial rash to anaphylactic shock. In some cases the only symptoms can be allergic reactions like erythema and itching. In our case we aimed to present rupture of cyst hydatid with sudden onset abdominal pain and diffuse urticarial rash after lifting a heavy fruit box

Case: 18 year old male with no history of known disease and allergic reaction admitted to county hospital emergency service with tearing type abdominal pain and itchy diffuse urticarial rash after lifting a heavy fruit box at work. In county hospital initial treatment was intravenous 1 ampule avile and 1 ampule decort. After initial treatment during his follow ups patient's rash and itching continued to grow up. Patient sent to our clinic with these complaints. In our clinic patient's vital signs were stable. on his physical examination there were diffuse urticarial plates at whole body which are erythematous sided and swollen from skin. His oropharynx was normal and there was no uvula edema. His respiratory examination was normal and there was no sign of roncus. on abdominal examination patient's abdomen was very sensitive but there were no sign of defence and rebound. At blood tests patient's wbc was 15260/mm3 and liver function tests were normal. Patient sent to ultrasonography room because of his abdominal sensitivity. USG revealed free abdominal fluid and cyst at liver. After usg patient sent to abdominal ct scan with contrast agent. ct scan revealed 120 x 104 mm type 1 cyst hidatid at liver, free abdominal fluid and also 70 x 35 mm perforated cyst hidatid close to the gall bladder. patient consulted to surgery. Surgery performed cystectomy and peritoneal lavage with 3% NaCl. after treatment patient's complaints improved and discharged with albendazol.

Conclusion: Cyst hidatid is a common disease in our country. Rupture of cyst hidatid should be considered at patients who are admitted to emergency service with urticarial rash. clinicians should not be content with symptomatic treatment and they should analyse about possible causes of rash.

Keywords: Hydatid cyst, rupture, urticaria, emergency department

P-0539 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Spontan Pnömotorax Complicated with Pneumohemothorax in Non-smoker Patient

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Objective: Spontaneous pneumohemothorax is a rare, but potentially fatal condition, complicating 0.5–12% of patients with spontaneous pneumothorax. It possess an abnormal accumulation of blood and air within the pleural spaces of the lungs resulting from rupture of subpleural blebs in the absence of trauma or medical disorders. Only a few sporadic cases regarding spontaneous haemopneumothorax have been reported in the literature Here, we report an unusual case of a large spontaneous pneumohemothorax treated by the tube thoracostomy combined with thoracic surgery.

Case: A 24 year-old male patient referred to our emergency department (ED) with the diagnosis of acute coronary syndrome. On arrival at the ED, the patient was conscious, cooperative, and complaining of pleuritic chest pain and shortness of breath for 2 hours. His vital signs were as follows: blood pressure 90/60 mmHg; pulse rate 112 beats per minute; respiratory rate 22 breaths and oxygen saturations 95% on room air. The patient denied using smokeless tobacco or illicit drugs. No other disorders such as pulmoner disease, bleeding diathesis, clotting disorder or trauma were noted. On physical examination, he was in mild respiratory distress with noted mild tracheal shift to the right. There were markedly decreased breath sounds on the left side with hyper-resonance on percussion. Laboratory data included platelets, electrolytes, kidney functions, prothrombin time and partial thromboplastin time were within normal



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range. Chest x-ray revealed a 60% pneumothorax on the left hemithorax with mild mediastinal shift to the right. Thoracic computed tomography confirmed the presence of a large left-sided pneumohemothorax, which caused the left lung compression with the middle and lower lobes atelectasis and an elevated diaphragm on the side of the collapse. A diagnosis of a spontaneous pneumohemothorax was made and a left-sided larger chest tube was inserted through the chest wall to drain the pneumohemothorax. After insertion of a pleural catheter, 2300 ml blood was drained and the patient underwent emergent thoracotomy by thoracic surgeons.

Conclusion: Spontan pnömoemotoraks should be considered in the differential diagnosis of patients presenting with sudden onset of dyspnea and chest pain. Although this condition is rare, it can very rapidly become a serious or life-threatening, if it is not recognised earlier and treated properly. Closed-tube thoracostomy is the first choice of treatment in the cases of spontaneous pnömoemotoraks. When the tube thoracostomy is not sufficient, an aggressive approach in management of spontan pnömoemotoraks with immediate thoracotomy may be required.

Keywords: spontaneous hemopneumothorax, thoracostomy, thoracic surgery

P-0540 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

An alternative IV way for drug abuse and bleeding with coumadin overdose: an interesting case

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Objective: Drug use is an increasing public health problem, and admissions to EDs due to drug abuse are increasing day by day. In this presentation, we wanted to share a patient who had found alternative IV access for drugs and faced unexpected results.

Case: A 27-year-old male patient admitted to ED with complaints of pain and swelling on his left leg for three days. In history, he was injecting heroin from his fistulas which are in the both femoral parts of the body. On his physical examination, his vital signs were in normal ranges, and skin fistulas and serous leak were observed on both two femoral regions. Pretibial edema on left side was 2+, medial of left thigh was ecchymotic, and left leg was lightly cyanotic. A poplitea and the distal parts were impalpable bilaterally. Left thigh and calf were wider than the right ones. Venous Doppler ultrasonography of lower extremities was performed and an echogenic thrombus was observed in the lumen of left popliteal vein, and compression was limited. In soft tissue ultrasonography, in proximal part of left femur, with femoral artery and vein neighborhood, 24x25 mm sized heterogenic echoic space with 6 mm neck that has an orifice to skin was observed. After cardiothoracic surgery department consultation, he was discharged with treatment of Coumadin, enoxaparin, antibiotics, nonsteroid anti-inflammatory drugs, foment and elevation.

The patient admitted to ED again 2 months later with complaint of bleeding in left thigh. In history, he injected heroin from left fistula with thick needle and bleeding didn't stop. On physical examination, he was conscious, cooperated, orientated, and Glasgow coma scale was 15. His vital signs were in normal ranges. Flushing bleeding was observed from the previously described left sided fistula, and we compressed with the hands immediately. Except being hemoglobin: 7.3g/dl and INR: 10.5, the biochemical tests were in normal ranges. 3 units of fresh frozen plasma and erythrocyte suspension were transfused with the diagnosis of Coumadin overdose, and he was hospitalized to the cardiothoracic surgery department with the prediagnosis of tear of femoral artery.

Conclusion: Due to legal concerns, drug users can look for alternative IV ways. Although they use Coumadin, they continue to use drugs. So it is vital to explain and teach the side effects and points to take into consideration of oral anticoagulants to the patients. Emergency physicians must be aware of these kind of insidious events and patients.

Keywords: drug abuse, coumadin overdose, femoral artery

P-0541 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Case of Gastrointestinal Bleeding Due To Giant Gastric Bezoar

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Objective: Gastric bezoars occur in the stomach as a result of foreign body accumulation with inability to pass through the pylorus. Patients have usually a history of previous gastric surgery. Phytobezoars are the most common type of bezoars. Major complications of bezoars include intestinal obstruction, gastric ulcer, gastric perforation, and bleeding. We present a case that had a gastrointestinal bleeding and was treated surgically due to a giant gastric bezoar.

Case: A 79 year-old man with complaints of abdominal pain, nausea, hematemesis and black stool was admitted to the emergency room. These symptoms appeared 15 hours before the admission. He had mentioned fullness in the stomach, a complaint lasting for about six months. Past medical history reported peptic ulcer disease with gastric ulcer perforation and surgical ulcer treatment with vagotomy about 20 years before the admission.

Physical examination revealed gastrointestinal bleeding indicating melena. Abdomen was not tight, but painful in the epigastrium. Blood analysis showed severe anemia with a hemoglobin concentration of 5.4 g/L. Upper GI endoscopy showed a giant foreign body (dimensions; 12x6x4 cm) positioned longitudinally in the stomach and a huge ulcer coated exuda formation.

Histological examination of biopsy specimens from ulcer and its adjacent area revealed a typical ulcer induced by pressure of bezoar. There were defects in the mucosal integrity. There were typical changes of superficial ischemic damage, likely due to prolonged bezoar compression. Helicobacter pylori and intestinal metaplasia were not seen.

The patient was consulted to a general surgeon for surgical treatment. Abdominal computerized tomography was administered. Abdominal CT showed a foreign body which had a contrast defect and a dimension of 12x6x4 cm. There was an open anastomosis of gastrojejunostomy in the inferior of corpus. Although gastric bezoar was filled into the stomach, there was no obstruction of outlet to distal from the stomach according to CT. The giant bezoar was removed by surgical treatment. After appropriate treatment, the patient who had a hemoglobin concentration of 11 g/L was discharged healthily at the seventh day after surgery.

Conclusion: Large bezoars may be a cause of gastric ulcer and chronic gastrointestinal bleeding. Large gastric bezoars resulting from gastric dysmotility related to previous surgery have commonly been described, but complications such as ulcer caused by pressure of foreign body and gastrointestinal bleeding are especially rare. Patients with previous gastric surgery should be warned about this preventable complication and dietary advice should be given for these patients.

Keywords: gastric, bleeding, phytobezoar

P-0542 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

The reason of abdominal pain; portal vein and superior mesenteric vein thrombosis

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Objective: Portal vein thrombosis (PVT) is characterized by formation of a thrombus in any segment of the portal vein. In contrast to arterial mesenteric pathologies, intestinal ischemia is extremely rare in venous pathologies. We aimed to present a patient admitted to emergency department (ED) with acute abdominal pain as a result of intestinal ischemia caused by portal and superior mesenteric vein (SMV) thrombosis.

Case: A 41 year-old man consulted our emergency department (ED) with abdominal pain, nausea and vomiting and hematemesis. Vital signs at the arrival were as follows: blood pressure: 110/70 mmHg, respiratory rate: 20, pulse rate: 100/min, body temperature: 36.7°C. On palpation he had abdominal defense and tenderness. Bowel sounds were positive, slightly distended. Lungs were symmetrically clear. Breathing was spontaneous; tachypneic with normal depth. On cardiac examination S1 and S2 sounded normal, without any murmur or gallop. The electrocardiogram showed normal sinus rhythm and normal axis with a rate of 96. His rectal examination was normal. Neurological findings were normal. During the follow-up, abdominal pain of the patient exacerbated gradually.

The contrast-enhanced CT scan showed generalized jejunum wall distention and edema, abdominal free fluid and dilation in the portal and superior mesenteric veins without blood flow. The scan also demonstrated partial obstruction of PV and near-total obstruction of SMV. Laboratory examinations revealed normal hepatic enzyme levels. The patient had leukocytosis (14700/µL), with normal hemogram (hemoglobin 16 g/dL). However, prothrombin time was 14.1 seconds and INR was 1.31. He received anticoagulant therapy in the intensive care unit; no surgical interventions were necessary.

Conclusion: PVT is an important condition because of its serious long-term complications. PVT may lead to extensive intestinal ischemia with a high mortality rate. Few reports of the clinical features and consequences of acute PVT have been published. The difficulty in clinical diagnosis arises from nonspecific nature of the symptoms and signs. Acute PVT is a difficult clinical diagnosis because of the wide variety of clinical presentations. In our case, acute abdomen was thought to originate from partial obstruction of portal vein and complete obstruction of SMV,



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which was documented by contrast-enhanced tomography scans. In any patient admitted to ED with unexplained acute abdominal symptoms, especially in those with signs of sepsis or acute abdomen, the possibility of acute portal vein thrombosis should be considered and investigated.

Keywords: abdominal pain, portal vein thrombosis, superior mesenteric vein thrombosis, emergency department

P-0543 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Tension Pneumocephalus

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Objective: Pneumocephalus defined as the presence of air in the cranial cavity. causes of pneumocephalus are spinal trauma, penetrating traumas, tumors, infections, lumbar puncture and iatrogenic causes as laparoscopic biopsy procedures. involuntary spinal durotomy during spinal surgery and cerebrospinal fluid leakage is a well known and frequently encountered complication. Pneumocephalus is a very rare complication of lumbar disk herniation surgery. pneumocephalus generally presents non specific symptoms like headache, nausea, dizziness, lethargy, impairment of consciousness and meningeal triad.

Case: A 56 year old male had a operation for cervical spinal cord abscess at external center. during the operation patient had some symptoms like headache and impairment of consciousness. his general condition was bad, lethargic and paraplegic. blood pressure: 120/80 heartbeat: 110/min body temperature: 39.5. There was pneumocephalus in patients cranial CT. CT image was interpreted as tension pneumocephalus by radiologists.

Conclusion: Pneumocephalus can be presented at intracranial cavity, epidural, subdural, subarachnoid, intraventricular cavities or intraparenchymal area. The most common cause is skull base fractures associated head trauma. other causes of cranial pneumocephalus are tumors, infections, cerebrospinal fluid fistula, nitrous oxide anesthesia and cranial surgeries. beside these spinal pneumocephalus causes are trauma, penetrating traumas, tumors, infections, lumbar puncture and laparoscopic biopsy procedures. there is just a few case report about pneumocephalus occur after a posterior spinal surgery and the case number of tension Pneumocephalus is more rare.

Keywords: Pneumocephalus, tension pneumocephalus, iatrogenic pneumocephalus

P-0544 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A colonic perforation case report resulting with pneumomediastinum

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Objective: Pneumomediastinum (PM) is defined as the presence of free air in the mediastinum. PM is a rarely reported sign of colonic perforation mainly associated with malignancies, diverticulitis, toxic megacolon and colonoscopy. PM is an uncommon clinical entity that occurs with the leakage of air from the lungs or any of the luminal organs, such as the bronchial tube, larynx, trachea, esophagus, and very rarely, the colon, with subsequent diffusion into the mediastinum. We aimed to present a patient manifested with PM caused by colonic perforation.

Case: An 86-year-old female patient was referred to our emergency department (ED) with speech impairment and consciousness. The patient's relatives stated that she had an oral intake disorder and decrease in urine output with diarrhea for a few days. She had abdominal defense on palpation and no signs of respiratory distress. The rest of her physical exam except of consciousness was unremarkable. Her vital signs were as follows: pulse 122/min, blood pressure 120/70 mmHg, stick blood glucose 132 mg/dl and temperature 37°C. In her medical history, she was taking NSAIDs for osteoarthritis. The initial total leukocyte count was 17.3 K/ul with neutrophilia, hemoglobin was 9.6 g/dl. She had fluid and electrolyte disorder explaining her consciousness associated with hyponatremia (120 mEq/L). Arterial blood gas analysis was as follows: pH: 7.39, pCO₂: 29 mmHg, pO₂: 91 mmHg and oxygen saturation: %98. Her vital signs and hemoglobin level remained stable during the follow-up in ED. Computed tomography scan demonstrated perforation of a colonic malignancy in conjunction with air. Thoracoabdominal tomography scan revealed mesenteric and mural thickenings of the sigmoid colon and minimal perihepatic, perisplenic accumulation of fluid with abdominal and mediastinal free air designated as PM. After the tomography, laparotomy was performed revealing a perforated colonic malignancy, fistulized into the retroperitoneal cavity.

Conclusion: PM is a very rare sign of colonic perforation; it's usually seen secondary to malignancies, diverticulitis, toxic megacolon in ulcerative colitis, colonoscopy, endoscopic polypectomy, and very rarely, spontaneously. In our case, it was supposed that the PM and pneumoretroperitoneum were due to the perforation of a colonic carcinoma, which later was proved by both tomography scans and abdominal exploration. To our knowledge, there are very rare reports in the literature about PM caused by colonic malignancies in ED. The best treatment for colonic perforation is controversial and depends on the patient's clinical presentation. Laparotomy and thoracotomy may be necessary.

Keywords: pneumomediastinum, colonic perforation, emergency department

P-0545 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Cause of Long Lasting Abdominal Pain: Intestinal Angina

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Objective: Abdominal pain holds an important place in the admission to Emergency Department. Intestinal angina, an unusual clinical entity causing abdominal pain, having high mortality and morbidity in terms of its results. History of the features such as beginning time of pain, relationship with nourishment and lasting time will help in diagnosing.

Case: A 76 year old male suffering from abdominal pain and diarrhea lasting for 4 days was admitted to the emergency department. His past history included hypertension and coronary artery disease. He had stated that his pain tended to increase after every food intake and decrease in hunger periods. Physical examination revealed diffuse tenderness in all quadrants and increased bowel movement frequency. Abdominal ultrasound revealed multiple gallstones and decreased intraluminal bowel movements. Aortic Color Doppler was otherwise noncontributory in terms of mesenteric ischemia due to patient incomppliance. Dynamic Computed Tomography revealed severe occluded superior mesenteric artery. He was considered to be intestinal angina and referred to surgery.

Conclusion: Intestinal angina is characterized by postprandial abdominal pain and anorexia accompanying weight loss. Symptoms of intestinal angina may occur in terms of insufficient blood supply of two or more involved major splanchnic vessels. Intestinal angina, sitophobia and weight loss are the leading clinical manifestations. Intestinal ischemia should be kept in mind in terms of long lasting abdominal pain remaining to have unintelligible causes.

Keywords: Intestinal Angina, Abdominal Pain, Weight Loss, Sitophobia, Dynamic Computed Tomography

P-0546 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Cause of Pseudo Acute Abdomen in Patients under Warfarin Treatment: Rectus Sheath Hematoma

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Objective: Rectus sheath hematoma, an accumulation of blood in the sheath of the rectus abdominis muscle, is caused by either rupture of epigastric arteries or muscular tear and usually located well demarcated and infraumbilically. With a wide spectrum, severity depends on its size, etiology, and the development of complications. It takes place in the differential diagnosis of abdominal pain however it's frequently troublesome to realize and diagnose. While trauma is the most common cause, especially anticoagulant treatment in elderly patients is major risk factor.

Case: A 82-year-old female, suffering from abdominal pain lasting for 8 hours localized in the left inferior quadrant of abdomen, was admitted to the emergency department. Her past history included hypertension and warfarin treatment due to mitral valvular insufficiency. On admission vital signs were within normal limits. Physical examination revealed diffuse tenderness in all quadrants and positive Carnett's sign. No other pathologic results of the physical examination such as rebound or defense were obtained. The results of routine laboratory blood work were nonspecific except INR (3.9). Ultrasonography had limited diagnostic merit. Computed tomography revealed rectus sheath hematoma about 504 cm in size localized in the left lower quadrant of abdomen. After consultation of General Surgery, she was discharged with the recommendation of adjusting warfarin dose with goal INR 2.0-3.0.



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Conclusion: Hematoma of rectus sheath is an uncommon as well as important entity in the differential diagnosis of abdominal pain. History such as warfarin use and physical examination such as positive Carnett's sign may provide valuable clues leading to the diagnosis. Moreover difficulties in diagnosis frequently result in delay in the treatment or unneeded surgery. CT-scan is the gold-standard. It will help avoiding complications and unneeded surgery when rectus sheath hematoma kept in mind during the evaluation of the patients under anticoagulant treatment masquerading symptoms of acute abdomen.

Keywords: Rectus Sheath Hematoma, Abdominal Pain, Warfarin, Computed Tomography

P-0547 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Prolonged mechanical stenosis: Mega ileus

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Objective: Intestinal obstruction can be treated by elimination of the underlying cause such as postsurgical adhesions, tumors, foreign bodies and hernias. While patients presenting symptoms of acute abdomen, air-fluid levels in radiographs and dilatation of small intestine at the level proximal to the obstruction are valuable clues leading to diagnosis. Dilatation sometimes may reach to unexpected size. During the management of the patients with ileus, mortality may be encountered unexpectedly.

Case: A 73 year old female suffering from abdominal pain, flatulence and constipation lasting for 7 days was admitted to the emergency department. Her past history included diabetes mellitus and congestive heart failure without history of abdominal surgery. On admission, her blood pressure was 175/90 mmHg, pulse 81 beats per minute, body temperature 36.8°C and oxygen saturation 85%. Inspection of abdomen revealed diffuse distension. Diffuse tenderness in all quadrants was present on physical examination. No other pathologic results of the physical examination were obtained. Radiographs showed wide air-fluid levels in abdomen. Dynamic Computed Tomography revealed the intestinal lumen about 1500x203 mm in size at the ileal level and no passage of the contrast agent distal to dilatation. During the conduction of colonoscopy, visualization was unable at the 50 cm level of the colon due to pollution. At the end of the procedure she had experienced cardiac arrest who subsequently underwent cardiopulmonary resuscitation and then finally back to life. She hospitalized in intensive care unit.

Conclusion: While investigation of the underlying etiological factor in case of mechanical bowel obstruction allowing for diagnosis, patients hemodynamically unstable with ileus are associated with increased risk of mortality and morbidity. Especially prolonged obstruction, enlarged bowel segments should be regarded as a harbinger of poor prognosis.

Keywords: Ileus, Abdominal Pain, Mortality, Computed Tomography

P-0548 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Cause of Left Sided Pain: Renal Artery Segmental Thrombosis and Left Renal Infarction

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Objective: Acute renal infarct holds an important place in the admission to the Emergency Department due to having high mortality and morbidity rates despite low annual incidence such as 0.007% of admissions. The frequency of renal infarction is probably higher than reported in literature due both to the rarity of the disease and its non-specific clinical presentation. Usually these patients are diagnosed after renal infarct developed.

Case: A 50 year old male suffering from left flank pain lasting for 16 hours was admitted to the emergency department. Stating that his pain was in colic style, his past history included right surrenectomy due to feocromocytoma. On admission, vital signs were within normal range. Left costovertebral angle tenderness was present on physical examination. No other pathologic results of the physical examination were obtained. Laboratory findings were within normal range. Abdominal ultrasound was otherwise noncontributory. Computed Tomography revealed occluded segmental artery supplying 1/3 of upper segment of kidney and hypodense area compatible with wide infarct located in 1/3 of upper segment of kidney. After Embolectomy performed by interventional radiology, he was hospitalized.

Conclusion: Renal infarction is oft-missed or delayed because patients present with abdominal or flank pain that mimic other, more common conditions, such as acute abdomen, urolithiasis, pyelonephritis and lumbago. Thus diagnosis is established in advanced stages of damage. Consideration should be given to lowering mortality and morbidity rates, in terms of unintelligible pain and noncontributory imaging tests.

Keywords: Renal infarct, Flank Pain, Computed Tomography

P-0549 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Atrial Fibrillation Gave Birth to Bilateral Renal Infarction

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Objective: Acute renal infarct holds an important place in the admission of patients with abdominal pain due to having high mortality and morbidity rates despite low annual incidence such as 0.007% of all admissions to the Emergency Department. Incidence of renal infarction is probably higher than reported in literature due both to the scarcity of the disease and its non-specific symptoms. Experiencing thromboembolic disease is the major risk factor for renal infarct.

Case: A 61 year old female suffering from abdominal pain and burning sensation of abdomen lasting for 6 days was admitted to the emergency department. Stating that his pain was radiating both sides of the flank region, her past history included hypertension, diabetes mellitus, atrial fibrillation and sleep apnea. On admission, her blood pressure was 98/58 mmHg, pulse 98 beats per minute, body temperature 37.3°C and oxygen saturation 90%. Physical examination revealed no pathologic sign but diffuse tenderness. Laboratory findings were within normal range. ECG showed atrial fibrillation pattern. In the light of history of atrial fibrillation, abdominal ultrasound was planned to rule out mesenteric ischemia. Ultrasound was noncontributory, whereupon she was underwent computed tomography which revealed left kidney including multifocal patch type hypodense area and right kidney including hypodense area medially located as a short segment. After she was considered as bilateral renal infarct in the light of tomography findings, she was hospitalized.

Conclusion: Renal infarction is oft-diagnosed in patients within 6. decade with atrial fibrillation. Baseline renal functions may deteriorate and laboratory findings consistently may reveal hematuria (54 to 100%) and an elevated serum LDH as a good indicator of infarct. In addition to laboratory findings, realizing renal infarction is essential for diagnosis.

Keywords: Bilateral Renal Infarct, Atrial Fibrillation, Abdominal Pain, Computed Tomography

P-0550 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Spontaneous subcapsular renal hematoma

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Objective: Spontaneous subcapsular renal hematoma is a rare condition in clinical practice. Most of the cases are due to renal tumors, renal cysts, trauma, arteritis and anticoagulation. We present an unusual case of spontaneous subcapsular renal hematoma because of renal cyst rupture.

Case: 68 year old woman presented to our emergency department with sudden abdominal and flank pain. In her history, she only had hypertension. Her physical examination revealed tenderness and rebound tenderness at right upper quadrant and she also had right costovertebral angle tenderness. She was hemodynamically stable, her vital signs were within normal limits on presentation. In her laboratory findings her complete blood count, coagulation panel and liver enzymes and renal function tests were within normal limits. In her urine sample test there were 3/HPF erythrocytes and no leukocyte. In her complete blood count wbc: 15.7 K/µL, Hgb: 10.4 g/dL, Ptt: 235 K/µL, Urea: 41 mg/dL, creatinine: 1.1 mg/dL, Inr: 0.9, Aptt: 28 sec. In her renal ultrasound there was a 66x33 mm sized heterogen hyperechoic mass lesion at right kidney area. Her contrasted abdomen computed tomography scan revealed a 48x38 mm



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heterogen cystic area (renal subcapsular hematoma) at right kidney upper middle section. Patient was consulted to urology clinic and admitted for observation.

Conclusion: Kidney related spontaneous retroperitoneal hematoma is rarely seen. Nontraumatic rupture of renal cysts is associated with elevation of intracystic pressure. It may mimic acute abdominal conditions like acute appendicitis or perforated viscus or dissecting aneurysm. Ultrasound is valuable for rapid identification of the condition. Sometimes, they might be misdiagnosed as renal tumor or abscess. The findings on ultrasonography have to be confirmed with computed tomography scan finding. Spontaneous subcapsular renal hematoma might arise from a variety of situations. Although earlier small renal cell carcinoma was thought to be the most common reason, the cause might not be evident in many cases. We propose that hypertension might be one of the causes. Rapid diagnosis with ultrasound in emergency room can save the kidney.

Keywords: renal, hematoma, ultrasound

P-0551 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Anterior dislocation of shoulder and humerus neck fracture due to epileptic seizure

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Objective: Patients can rarely have anterior dislocation of shoulder and humerus neck fracture following an epileptic seizure. Unilateral shoulder dislocation and humerus fracture is usually seen after trauma. In patients with epilepsy, the commonest type of shoulder dislocation following a seizure is the posterior type. In this case we report an epileptic patient who presented with anterior shoulder dislocation and humerus fracture after a seizure

Case: A 30-year-old patient known to suffer from epilepsy, presented to our emergency department with a painful left shoulder following a seizure. The patient's GCS score was 15. On physical examination of the affected shoulder there was a loss of deltoid bulge and fullness in the anterior chest wall inferior to the clavicle. Palpation revealed an empty glenoid and all shoulder movements were painful with associated muscle spasm. A restriction of adduction and internal rotation of the shoulder was noticed. There was no neurological deficit and the radial pulse was palpable. Radiographs revealed that patient has left anterior shoulder dislocation and humerus neck fracture. Patient was referred to orthopedics. Left shoulder joint was reduced with external rotation technique and immobilized with velpau sling. Patient was admitted to orthopedics ward for surgery.

Conclusion: We should be aware that shoulder dislocation and humerus fracture may develop after epileptic seizures. Patients should be evaluated for orthopedic injuries beside neurologic examination

Keywords: shoulder, dislocation, seizure

P-0552 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Orbital emphysema and pneumocephalus caused by compressed air pressure gun

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Objective: Orbital emphysema with pneumocephalus without fractures of cranium or orbital walls is a rare condition. There are only few cases associated with compressed air pressure by air guns or hoses. These injuries can occasionally cause severe visual loss. We report a case with unilateral orbital emphysema and pneumocephalus.

Case: 13 year old boy complaining of right eyelid swelling, pain and periorbital ecchymosis was admitted to our emergency department. He was injured when his friend accidentally pointed the air pressure gun to his right eye. Physical examination revealed mild crepitation on palpation of his right periorbital area. Ocular movements in all directions were normal in both eyes. Biomicroscopic evaluation showed subconjunctival emphysema. The cornea was clear and there was no epithelial defects. An emergency computed tomography scan of brain and orbita showed that there was free air in right periorbital area, right extra and intra optic canal area, and sella turcica. Patient was discharged from emergency department after neurosurgery and ophthalmology consultations. The patient was given systemic and topical antibiotics.

Conclusion: Here, we report a rare case of compressed air pressure gun injury to the eye. The patient not only had subconjunctival and orbital emphysema but also pneumocephalus. In cases like this we should be aware that air can also travel through optic canal to the subarachnoid space.

Keywords: orbita, pneumocephalus, pressure gun injury

P-0553 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Chronic subdural hematoma due to warfarin use without trauma

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Objective: The majority of patients who come to the ED with a headache do not have a life-threatening problem. The challenge is to identify the small but significant percent that do. The differential diagnosis of headache is huge. A subdural hematoma (SDH), a life-threatening cause of headache, is a collection of blood below the inner layer of the dura but external to the brain and arachnoid membrane. Causes of subdural hematoma include head trauma, coagulopathy or medical anticoagulation, arteriovenous malformation, tumors, and spontaneous bleeding or rarely unknown causes. We aimed to present a case with headache due to subdural hematoma caused by warfarin use without trauma.

Case: A 59-year old female using warfarin for heart valve replacement admitted to emergency room with headache lasting 5 days. Her vital signs were as follows; blood pressure: 135/85 mmHg, pulse rate: 80/min, temperature: 36.7 C and O2 Sat: %80 (room air). On her physical examination, there was not any neurological sign except headache. Other system examinations were unremarkable. Laboratory results were in normal range except INR which is 4.26. Because of severe headache computed tomography was performed and it revealed chronic subdural hematoma. The patient hospitalized to the brain surgery department.

Conclusion: Even if the examination findings are normal, the patients with headache using an anticoagulant drug may need further.

Keywords: Headache, subdural hematoma, anticoagulant drug

P-0554 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Pneumothorax In a Young Patient Associated With Cocaine Use

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Objective: Pneumothorax is defined as the presence of air or gas in the pleural cavity, which can impair oxygenation and ventilation. The clinical results are dependent on the degree of collapse of the lung on the affected side. No clinical signs or symptoms in primary spontaneous pneumothorax until a bleb ruptures and causes pneumothorax; typically, the result is acute onset of chest pain and shortness of breath.

Cocaine use causes various pulmonary complications which includes chest pain, pneumothorax, pneumomediastinum, emphysema. Spontaneous pneumothorax carries a high risk of recurrence, possibly higher if induced by continued cocaine-use

Case: We present a case of pneumothorax in a young patient, 18 year old a man was referred to emergency department mainly for chest pain in the right side of the chest. Blood pressure was 110/65 mm Hg, heart rate 120 beats per minute, respiratory rate 24 breaths per minute, oxygen saturation was 98 percent and temperature was 36.8°C. Physical examination revealed a well-nourished man. Pulmonary examination was notable for decreased breath sounds on the right side of the chest. He had smoked cocaine since the age of 16 and now smoked it daily. Chest radiograph showed an almost complete pneumothorax in the right lung. Chest tube was placed because of the continued dyspnea. The patient gradually improved and repeated chest radiograph revealed almost complete re-expansion of the right lung. Peripheral pulse oximetry indicated normal oxygen saturation with room air. As the clinical condition had stabilized, he was discharged from hospital on hospital day 3. He had also been referred to substance misuse services for support.

Conclusion: We describe a case of patient who suffered from pneumothorax after taking cocaine and emphasize the importance of always keeping in mind the possibility of illicit substance use in such cases, especially among young and healthy patients. The prevalence of drug abuse is an increasing problem in the younger population especially in the adolescent groups and measures have to be taken to target these groups as hard as possible to make them aware of all the complications secondary to drug abuse.

Keywords: Cocaine Use, Pneumothorax, Young Patient



POSTER BİLDİRİLER

P-0555 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Use Of Low Molecular Weight Heparin Induced Abdominal Rectus Sheath Hematoma; Case Report

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A rectus sheath hematoma is a rare symptom which may be mixed with acute abdomen. It occurs from the rupture of the epigastric vessels in the anterior rectus abdominis sheath or the blood collection in the rectus sheath because of tear of the rectus muscle fibers. It usually occurs from trauma, abdominal surgery, subcutaneous injections of drugs, anticoagulant therapy, etc. It can rarely occur spontaneously.

While it is often under the umbilicus, it can be formed in the upper abdomen. The hematomas which is under the Semicircular line can cause peritoneal irritation. This reveals a clinical symptom similar to acute abdomen. Taking history quickly, carefully physical examination and appropriate imaging studies help to find the correct diagnosis and prevent from unnecessary laparotomy. In this case, we wanted to remind you the rectus sheath hematoma will occur in the patient with abdominal pain who use subcutaneous low molecular weight heparin.

Case: A seventy three years old female patient was admitted to the emergency department with fatigue, dyspnea, abdominal pain and swelling in the abdomen. She had coronary artery disease, chronic atrial fibrillation and deep vein thrombosis. In her medical history, she used oral anticoagulant for 2 years. On physical examination the patient's general condition was moderate, she was conscious, her vital findings were; blood pressure: 90 / 60 mmHg, pulse: 104 /min, saturation % 92, temperature: 36.7 °C. In palpation there was an abdominal swelling and a mass like lesion in the left middle quadrant which's borders were not identified clearly. In auscultation, intestinal sounds were normal. There were rebound tenderness and guarding rigidity. Her laboratory findings were; WBC: 5700/uL, Hgb: 9.3, plt: 228000/uL, INR: 1.39, PT: 17.4 sec, APT: 21.8 sec and the other laboratory parameters were normal. The CT was admitted and there was free liquid in perihepatic, perisplenic areas and quadrants of the intestinal loops. There was a heterogeneous lesion in the left rectus muscle that started from the intercostal plane reached through the symphysis pubis. The patient was discharged with reduced complaints and non-bleeding without a surgical operation after 15 days.

Conclusion: You must suspected of the patients who use subcutaneous low molecular weight heparin treatment and admitted with the complaint of sudden abdominal pain, has abdominal mass and is anemic with old age. The computed tomography should be taken for the definite diagnosis. The conservative treatment should be chosen even if the hematoma is larger.

Keywords: A rectus sheath, hematoma, low molecular weight heparin

P-0556 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Injury: Medial Subtalar Dislocation

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Objective: Subtalar dislocation is a rare ankle injury accounting for approximately 1% of all dislocations. This injury occurs due to high-energy trauma. A subtalar dislocation occurs through the disruption of 2 separate bony articulations, the talonavicular and talocalcaneal joints. The subtalar joint is a synovial joint between the 'facies articularis calcanea posterior' of the talus and the 'facies articularis talaris posterior' of the calcaneus. The calcaneus does in- and eversion movements, of which the supination/pronation and abduction/adduction components are the most important ones in a closed chain. In supination, the posterior part of the calcaneus will slide laterally, in pronation it will slide to the medial side [3]. Subtalar dislocations these traumas are usually seen when a person suffered a high-energy trauma, when falling from a height (20%) or in case of motor accidents (48%)

Case: A 10 year old male patient with swollen condition, edema and pain was accepted in the emergency department. He fell down from 3 meter height on to hard floor. After his pain and swollen condition increased, he accepted in emergency department. In clinical examination the ankle was substantially swollen and ecchymotic, while the talonavicular and medial subtalar joints were very tender and painful to palpation. Additionally, there is an inversion and adduction mobility problem on his left foot. However, no neurovascular or tendon disturbances were identified. In other medical examinations, there was no positive findings. It was stated that a subtalar medial joint dislocation on patient's direct foot graphy (Figure 1). To clarify the patient's situation, he was examined by computer tomography (CT). According to CT results, it was confirmed that patient had a subtalar medial joint dislocation (Figure 2). After those findings, patient was sent to orthopedics department. Closed reduction under sedation was performed by longitudinal manual foot traction. Post-reduction radiographs revealed a congruent reduction of the subtalar and talonavicular joints

Conclusion: Subtalar dislocations are rare injuries. Additional radiologic examination may be of clear benefit in all the subtalar dislocations. Conservative treatment remains the optimal treatment choice for the all the dislocation types without concomitant displaced fractures. However, the long-term performance of the foot is unpredictable due to the risks of avascular necrosis of the talus and degenerative arthritis.

Keywords: dislocation, injury, subtalar

P-0557 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Intestinal perforation: a rare complication of ERCP

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Objective: Endoscopic retrograde cholangiopancreatography (ERCP) is a method which is used for imaging of bile and pancreatic duct and for treatment of obstruction of these structures. Although ERCP is an effective method of diagnosis and treatment, it may lead serious complications. The rates of morbidity up to 10% and mortality up to 1% have been reported in the literature. Although pancreatitis is the most common complication of ERCP, other complications such as bleeding, cholangitis, cholecystitis, perforation and cardiopulmonary complications may occur. The treatment option of perforation developed after ERCP is differs according to the patient's clinical condition. Patients with good clinical status may be followed by conservative treatment. Otherwise, patients with poor clinical status or poor response to medical therapy need surgery.

Case: A 22-year old female patient admitted to the emergency department with abdominal pain. ERCP was performed to the patient due to cholelithiasis and she was hospitalized about 16 hours ago in another hospital. Chest x-ray which is taken after worsening of her abdominal pain revealed perforation and she had transferred to our hospital. On admission, her vital signs were normal. Her abdominal examination revealed tenderness in all quadrants and crepitation in right lower quadrant. Chest and abdominal radiographies showed free air under diaphragm (figure 1). Her laboratory results were unremarkable except elevation of alanine aminotransferase and gamma-glutamyltransferase. Abdominal computed tomography showed intraperitoneal, retroperitoneal, intramuscular and subcutaneous free air (figure 2). The patient hospitalized to the clinic of general surgery and followed by medical treatment. She was discharged on 12th day of hospitalization with clinical healing and radiological regression (figure 3).

Conclusion: Although intestinal perforation is a rare complication in a patient with abdominal pain developing after ERCP, it should be kept in mind.

Keywords: Endoscopic retrograde cholangiopancreatography, Complication, Intestinal perforation

P-0558 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A rare cause of intestinal obstruction: the bottle in the rectum

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Objective: Foreign bodies in the rectum and anus are common in homosexuals, prisoners, psychiatric patients, rape cases, and rarely seen as usage of a storage place for smugglers. Rectal foreign bodies are reported to be more common removed from young and middle-aged men. In the literature, a tea cup, iron rods, shaped tree branch, stick, metal shaving kit handle, cucumbers, spray bottle, plastic caps, pens, drug packs, bottles, vacuum cleaner handle, vibrator, dildo, thermometer, eggplant, wishbones, toothbrush, egg-like rigid material, such as bull horn and a wide variety of knives have been reported as foreign bodies that have removed from the lower gastrointestinal tract. If the foreign body did not cause perforation and it is below the rectosigmoid junction and patient has admitted to the hospital in the early stage, transanal removal of the foreign body with the help of your fingers by applying mild sedation in the emergency department may be tried. In case of failing of the removal of foreign body with fingers, using tools such as endoscopic instruments, obstetric forceps, foley catheters and endotracheal tube can be tried out for the removal of the foreign body. It should be more cautious to avoid possible complications during the removal of foreign bodies made of glass. But in the event that these methods have failed, foreign objects should be removed by laparotomy under anesthesia. In this paper, a rare cause of intestinal obstruction case occurred due to rectal foreign body is presented.

Case: An 54 year old male patient was admitted to the emergency department with complaints of abdominal pain, lack of defecation and rectal bleeding for the last three days. On physical examination, the patient had abdominal tenderness, palpable foreign body and fresh blood was determined by rectal examination. Plain abdominal radiography revealed a foreign body in the pelvis. Diagnosis was confirmed by CT. It was learned that the patient had seated on soda bottle for the treatment of hemorrhoid, and the bottle had been fled into the anus by accident, after that he had tried to remove the bottle, but did not succeed. Sigmoidoscopy was not successful for the removal of the bottle. Then the surgical removal of foreign body was performed.



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Conclusion: In the differential diagnosis of patients admitted to the emergency department with complaints of abdominal pain and constipation, also rectal foreign bodies should be considered.

Keywords: rectal foreign body, constipation, abdominal pain, intestinal obstruction

P-0559 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A rare cause of acute abdomen in which broad-spectrum antibiotics should be given in the emergency department: typhlitis

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Objective: One of the diagnoses that must not be forgotten in neutropenic patients with abdominal pain in ED is typhlitis. There is no prominent physical examination sign. Diagnosis can be put by abdominal tomography with opaque. By the time prediagnosis is suspected in ED, wide spectrum antibiotics should be given to the patient.

Case: A 61-year-old woman with abdominal pain with a history of hodgkin lymphoma who took her first chemotherapy 5 days ago admitted to ED. Physical and laboratory examinations showed generalized abdominal tenderness and WBC:800 mm³/dl and neutrophil:300mm³/dl, respectively. Abdominal computed tomography demonstrated marked asymmetric wall thickening in the cecum and ascending colon with pericolic inflammatory stranding (figure 1A-B). The patient was hospitalized in medical oncology unit and tazobactam and metranidazol were given. One day later, the patient got worsen and died.

Conclusion: In neutropenic patients who take chemotherapy admit to ED with the complaint of abdominal pain, typhlitis is one of the most important prediagnoses that should be kept in mind.

Keywords: Neutropenic enterocolitis, typhlitis, necrotizing enterocolitis, ileocecal syndrome, acute abdomen

P-0560 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Hawkins III Talar Neck Fracture

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Objective: The talus is a small bone that sits between the heel bone (calcaneus) and the two bones of the lower leg (tibia and fibula). The bones of the lower leg "ride" on top and around the sides to form the ankle joint. Where the talus meets the bones of the foot, it forms the subtalar joint, which is important for walking on uneven ground. The talus is an important connector between the foot and the leg and body, helping to transfer weight and pressure forces across the ankle joint. Most injuries to the talus result from motor vehicle accidents, although falls from heights also can injure the talus. These injuries are often associated with injuries to the lower back. An increasing number of talar fractures result from snowboarding, which uses a soft boot that is not rigid enough to prevent ankle injuries.

Case: A 40 year old male patient with left foot trauma was accepted in the emergency department. He fall down from 3 meter height on his feet. In the patient's story, he stated that firstly he touch the floor by his right foot but later he used his left foot to strike his own balance. The clinical evidences of patient who was accepted with complaints about pain and swollen condition on his left foot. In his physical examination, we observed that he had edema, sensitiveness and mobility problem on his left foot. In other medical examinations, there was no positive findings. In anteroposterior and lateral direct graphies (Figure 1) there was no fracture on tibia, fibula and calcaneus but it was identified a talus neck fracture. After that, he has examined by computer tomography (CT). Hawkins classification of talar neck fractures in CT captured by the type 3 fractures had (Figure 2). According to our results, patient was sent to orthopedics department for surgery.

Conclusion: Talar neck fractures have been associated with a high incidence of complications, including osteonecrosis, infection, skin necrosis, malunion, non-union, and posttraumatic arthritis. The high-energy nature of the injury required to produce a displaced talar neck fracture also causes severe associated soft tissue damage, including damage to the precarious blood supply. Anatomic reduction and internal fixation of displaced neck fractures to restore and to maintain alignment has a key role in minimizing the complications rate. However, the sequelae of posttraumatic complications may be inevitable. Even in the absence of osteonecrosis following anatomic fracture reduction and fixation, patients frequently experience chronic pain and stiffness due to post-traumatic arthritis.

Keywords: fracture, hawkins, talus

P-0561 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Descending necrotizing mediastinitis

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Objective: Descending necrotizing mediastinitis (DNM) occurring after dental abscesses and deep neck infections is a rare disease with a rapid course and high mortality rate. Oral infection may rapidly descend into the mediastinum through the retropharyngeal and retrovisceral spaces or from fascial plans of the neck. Dysphagia, dyspnea, dysphonia and restriction of neck movements are significant symptoms in DNM. Alcohol and diabetes mellitus are predisposing factors. It can rapidly progress to sepsis and death.

Case: 72 year old woman patient was admitted to ED with neck rashes and wheezing. The patient described an allergy like redness on neck after amoxicillin antibiotherapy was started for an abscess of left lower molar teeth by a dentist 3 days ago. There were aortic and mitral valve replacement in history of the patient. Her physical exam revealed redness and swelling in the neck and bilateral diffuse ronchus in auscultation of the lungs. Auscultation of heart revealed mechanical valve sounds but no murmur. Her laboratory findings were: blood pH:7.31 pCO₂: 31 pO₂: 71, O₂Sat: %92, HCO₃: 15.6, BE: -9.5, Lactate: 2, Hb:10.8 gr/dl, WBC: 20.250/mm³, Neu:%92, Plt:144.000/mm³; BUN: 239 mg/dl, Cr:4.86 mg/dL, Na:131mmol/L, K:4.8 mmol/L, Ca:9.3, Alb:3.31, LDH:363, CRP:35.4 mg/dl, PCT:137 ng/ml. There was no significant air or fluid level and no sign of pneumonia on lung x-ray. In thorax CT, we detected subcutaneous emphysema in left side of the neck, anterior mediastinum and posterior of the trachea. The patient was consulted to infectious disease, ENT and cardiovascular surgery department with mediastinitis being the preliminary diagnosis. Imipenem 2x250 mg (iv) was started as medical therapy and the patient was hospitalized. In follow-up of the patient died after a respiratory arrest episode.

Conclusion: Mediastinitis is a rapidly progressive disease which may result in sepsis and death within hours. If DNM is suspected, cervical and thoracic CT are most valuable predictors. The main stones of therapy is aggressive surgical debridement of the deep cervical spaces and mediastinum, and intravenous broad spectrum antibiotic therapy is required.

If patients come to ED with shortness of breath and swelling on neck after dental procedures, the possibility of mediastinitis should be kept in mind and CT will be the most valuable method for diagnosis. Emergency physicians must act quickly and should take an administrator role in the management and early treatment of mediastinitis.

Keywords: mediastinitis, dental abscess, deep neck infection

P-0562 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Rarely cause of fever: Bilateral subdural hematoma

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Objective: A subdural hematoma is a collection of blood outside the brain bleeding occurs between the dura and the next layer, the arachnoid. Subdural hematomas are usually caused by severe head injuries such as from a fall, motor vehicle collision, or an assault when rapidly changing velocities within the skull may stretch and tear small bridging veins. Factors increasing the risk of a subdural hematoma include very young or very old age. Infants, too, have larger subdural spaces and are more predisposed to subdural bleeds than are young adults. Symptoms of subdural hematoma can include: headache, confusion, change in behavior, dizziness, nausea, vomiting, lethargy, weakness, apathy or seizures.

Case: A 81 year old male patient with fever and weakness lasted four days was accepted in emergency department. He reported having no history of coagulopathy, alcohol abuse, or use of antiplatelet or anticoagulant medication. He reported being otherwise healthy. The fever of patient's 38.1 °C and his vital findings were normal. His consciousness was open, orient and cooperate and there was no deficit in his neurological examination. In other medical examination, there was no positive findings. In the laboratory tests was made for fever etiology, blood (White blood cells:3700/ul, CRP<3.45 mg/dl) and urine (leukocyte esterase negatif, nitrite negatif) parameters were normal. In his lung graphy, there was no infiltration. Patients with lumbar puncture (LP) prior unenhanced computed tomography (CT) scan was taken. Computed tomographic scan of the head without contrast (figure 1) shows a bilateral subdural hematoma of mixed



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density. Patient was sent to brain surgery department for operation.

Conclusion: Elderly people are at higher risk for chronic subdural hematoma because brain shrinkage causes these tiny veins to be more stretched and more vulnerable to tearing. It is important that a person receive medical assessment, including a complete neurological examination for subdural hematoma. We observed that subdural hematoma is especially seen on the elderly with a lot different symptoms except for neurologic symptoms.

Keywords: bilateral, hematoma, subdural

P-0563 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A Rare Cause of Chest Pain in an Emergency Department: Elastofibroma Dorsi

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Objective: Elastofibroma dorsi (EFD) defined as accumulation of abnormal elastic fibers and often occur bilaterally. EFDs are slowly growing benign tumours of soft tissue origin. Even though most of them are located in the characteristic subscapular localization, EFD rarely has been reported in other part of the body. It usually represents in middle-aged women and older than 50 years patients. Its etiology and prevalence is still unknown. It was incidentally discovered in examinations for other causes up to 2% by CT imaging and in autopsies with higher prevalence, up to 24%. Despite common symptoms are swelling, back or shoulder pain and scapular snapping, most EFDs are asymptomatic or represent with moderate symptoms. Differential diagnosis was not challenging due to typical localization and imaging findings that have been expressly described in literature. It may not be noticed in emergency departments (EDs). Therefore, we discussed this case to draw attention to EFDs characteristics and diagnosis in EDs.

Case: A 59-year-old female patient admitted to our clinic with weakness, fatigue, back and chest pain that increasing with respiratory movements. Her medical history showed hypothyroidism, diabetes mellitus, operated malignant gallbladder tumour and secondary malignant neoplasm of the lung. On admission, laboratory analyses were normal and only positive finding on physical examination was bilateral chest wall mass. Thorax CT and MR image showing bilateral soft tissue mass deep to the muscles and adjacent to the chest wall.

The skin was incised over the lesions, parallel to the medial margin of the scapula, with the latissimus dorsi dissected parallel to the muscle fibres. First the right then the left mass has been reached. During surgery frozen section examination has been performed due to patients had metastatic disease. Because of non-encapsulated tumours were tightly adhered to the ribs periosteum and scapula muscles. They were removed together with adherent fatty tissue. After removal, Hemovac drain was placed to prevent seroma. Defect was closed primarily. She was discharged on the fourteenth postoperative day.

Conclusion: Although there are typical localization and imaging characteristics; EFDs can be easily overlooked because of the ambiguous symptoms due to the clinicians were focused on the other diseases. EFDs have received little attention in ED and as far as we know no cases have been described in emergency literature. Although EFDs are not as rare as that we formerly assumed it should be kept in mind within cause of chest pain in EDs.

Keywords: Elastofibroma dorsi, Chest Pain, Chest Wall Tumor

P-0564 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

An Urological Emergency: Penile Fracture

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Objective: Penile fracture results from rupture of the corpus cavernosum as a result of strain of an erect penis and/or exposure to a blunt trauma. Characteristic clinical presentation are as follows: sudden onset sharp pain with a cracking sound in the penis, rapid loss of erection, swelling, ecchymosis and deviation. Diagnosis can be made by a careful history and physical examination. In most cases, additional diagnostic methods are not needed. The gold standard for the treatment of penile fracture is considered as surgical repair. We have presented the penile fracture case who admitted to the emergency department.

Case: A 20-year-old male admitted to the emergency department with symptoms of sudden onset penile pain, swelling, discoloration, deformity and urethral bleeding while rolling over in bed in the morning. It happened two hours ago and the patient reported that he made effort to micturate a small amount of bloody urine during the time. On physical examination, dorsal penile hematoma, pain with palpation, ventral deviation of the penis and urethroragia were determined. Penile fracture was considered as the diagnosis. The patient underwent surgical repair after the informed consent was obtained.

Conclusion: Penile fracture is an urological emergency disease that was reported with increasing frequency. The most common causes are though sexual intercourse and penile manipulations. It is usually diagnosed clinically. In suspected cases various radiological techniques can be used. Recently, the recommended treatment of penile fracture is early surgical repair. The use of advanced diagnostic methods for diagnosis is not cost effective, they are not recommended for use except suspected cases and the presence of urethral rupture.

Keywords: Penil Fracture, Urological emergency, ER

P-0565 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

A rare case of acute abdomen: Appendagitis Epiploica

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Objective: Appendix epiploica are pedicled structures covered with serosa and rich in fat tissue in the colon wall. They are frequently located in the transverse and sigmoid colon. Appendagitis epiploica (AE) is the acute abdomen clinical picture that develops following inflammation of the appendix epiploica and the subserosal fatty tissue of the colon. We wanted to emphasize the need to consider the rare condition of AE in the differential diagnosis of acute abdomen.

Case: CASE 1: A 32-year-old male patient presented at the emergency service with symptoms of abdominal pain and nausea for the last 3 days. The blood pressure and temperature were normal. Physical examination revealed tenderness and rebound in the left lower abdominal quadrant. A hemogram revealed a leukocyte count of 11.300/mm³ and the biochemistry values were normal.

CASE 2: A 35-year-old male patient presented at the emergency service for abdominal discomfort in the last day. The temperature was 38,1°C and the patient had tenderness in the left lower abdominal quadrant. A hemogram revealed a leukocyte count of 13.500/mm³ and other test results were normal.

CASE 3: A 42-year-old male patient presented at the emergency service with abdominal pain that had started 8 hours ago. The vital signs were normal and there was left lower abdominal quadrant sensitivity and rebound. A hemogram revealed a leukocyte count of 12.000/mm³ and other test results were normal.

Conclusion: AE will be more commonly seen in the future with increased use of imaging methods such as CT. Considering AE in the differential diagnosis in patients presenting at the emergency service with acute abdomen will help make the right diagnosis and prevent unnecessary laparotomy.

Keywords: CT, abdominal pain, appendagitis epiploica

P-0566 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Unusual cause of small bowel obstruction: Phytobezoar detected by multidetector computed tomography: A case report

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Objective: Primary small bowel bezoars are rare and approximately 2-4 percent of small bowel obstructions (SBO) are caused by them. And only 1% of the patients are presented with features of acute surgical abdomen. In our case we report computed tomography (CT) findings of small bowel obstruction due to phytobezoars.

Case: A 50-year-old woman admitted to the emergency department with a 3-day history of colicky abdominal pain localized in left upper quadrant associated with repeated nausea and vomiting. She also had absolute constipation. On physical examination she had generalized tenderness and rebound especially localized in the left upper quadrant. Also her abdomen was



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distended. Laboratory data showed elevation of the white blood cell count to 12.3 K/uL and C-reactive protein of 7.2 mg/dL. Other chemistry and liver function tests were normal. An erect X-ray film of the abdomen showed multiple air-fluid levels. A non-contrast abdominal CT was arranged and it showed too much distended stomach and dilated duodenal and proximal jejunal segments with collapse of distal jejunal and ileal segments.

Conclusion: A bezoar is a concretion of indigestible material found in the gastrointestinal tract, which usually forms in the stomach and passes into the small bowel where it can cause SBO. It can be classified into four major types: trichobezoar, pharmacobezoar, lactobezoar and phytobezoar. Phytobezoar is the most common type which can cause SBO. CT is the best diagnostic imaging technique for detecting cause and level of intestinal obstruction. The presence of a focal ovoid or round shaped well-defined intraluminal mass located in the obstruction level with a mottled gas pattern and heterogeneous internal structure on emergency CT scan is suggestive of an intestinal phytobezoar.

Keywords: Multidetector computed tomography, phytobezoar, small bowel obstruction

P-0567 Imaging in Emergency Units

Screening of Abdominal aort aneurysm in patients admitted to the emergency department with over the age of 65

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Background: A significant number of applications to emergency services consists of elderly patients. Screening of these patients with bedside ultrasound will allow early detection of abdominal aort aneurysm (AAA) and contribute to the reduction of mortality. Therefore, we measured the diameter of the aorta in patients over the age of 65 and compared with the risk factors

Method: 150 patients, over 65 years old who admitted to the emergency department and not undergone abdominal ultrasound before, were included. The patients with trauma or with any complaints or findings vascular disease, have not been included in the study. Aortic diameters were measured from separation zone of the renal artery and the iliac bifurcation and the remaining areas of the aorta were evaluated with scanning. The data was evaluated with SPSS 20.0 statistical software and t-test, chi-square tests were applied.

Results: 3 of the patients, 2 women and a man, were identified AAA. Aortic diameters larger than in the smokers compared to nonsmokers. ($p < 0.01$) Aortic diameters compared with other risk factors, there were no statistically significant difference.

Conclusion: In our study, AAA has been found in 3 of 150 asymptomatic patients. Smoking and age were found to be the most important risk factor for AAA.

Keywords: abdominal aortic aneurysm, bedside ultrasound, scanning

P-0568 Cardiovascular Emergencies

Role of Inflammatory Mediators in the Prediction Angiographic Thrombus in Patients with Acute Coronary Syndrome

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Background: Inflammatory mechanisms had played a major role in the formation and prognosis of acute myocardial infarction. Inflammatory mediators was associated with negative consequences of acute myocardial infarction. This study tested the hypothesis that in the acute phase of acute coronary syndrome, leukocyte count, neutrophil count, neutrophil lymphocyteratio, and highsensitivity C reactive protein are predictive of angiographic thrombus formation in the infarct related artery.

Methods: This prospective study included 150 consecutive patients with acute coronary syndrome. Patients were assigned to a thrombus formation group (n=65) and a nonthrombus formation group (n=85). Blood samples for measurement of high-sensitivity C reactive protein and for routine blood laboratory studies were collected before to coronary angiography. Numerical data were expressed as mean $\pm$ Standard deviation. Nominal data were expressed as the number and percentage. Comparisons between groups, chi-square test was used for nominal variables. Comparisons between groups, t-test was used for numerical data. All statistical analyzes, $p < 0.05$ was considered significant.

Results: The levels of high sensitivity C reactive protein, total leukocyte counts, neutrophil counts, and neutrophil/ lymphocyte ratios were substantially higher in the thrombus formation group than in the nonthrombus formation group patients (for each, $P < 0.05$). T-test analyses identified highsensitivity C reactive protein, leukocyte count, neutrophil count, and neutrophil/ lymphocyte ratio as independent predictors of thrombus formation in the infarct-related artery (for each, $P < 0.05$).

Conclusion: In patients with acute coronary syndrome, higher leukocyte count, neutrophil count, neutrophil/ lymphocyte ratio and level of high sensitivity C reactive protein are predictors to indicate thrombus formation.

Keywords: acute coronary syndrome, thrombus formation, inflammatory mediators

P-0569 Cardiovascular Emergencies

Diagnosis of more lethal coincidental diseases in emergency departments

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Objective: Cardiac tumors can be primary tumors or a neighboring tumor spread or a distant metastasis of other tumors. Heart tumors can hold endocardium, epicardium, pericardium, or a combination of all of them. In this paper, a case of incidental diagnosed cardiac mass who admitted to the emergency department with clinic of lung infection was presented.

Case: An 62 year old male patient was admitted to the emergency department with complaints of continuous fever, cough, phlegm, shortness of breath and chest pain for 2 days. We learned that he had a coronary artery bypass graft six years ago, and do not come to follow-up and use recommended drugs after the operation. The patient was conscious, oriented, cooperative and Glasgow Coma Scale score was 15. His pulse rate was 115 / minute, blood pressure: 150/90 mmHg, body temperature: 38.7 °C and oxygen saturation was 85%. Bilateral diffuse rhonchi were determined in auscultation of the lungs. Breath sounds in the left lung could not get under the scapula. Heart sounds was rhythmic and tachycardic. ECG had showed sinus tachycardia. Oxygen, nebulised beta agonists, metilprednizolon, H2 receptor blocker and paracetamol were given to the patient. The patient's chest pain, shortness of breath had get better and fever fell down. Properly limited hyperdense lesion was determined in PA chest radiograph in adjacent to the heart in the left lower lobe of lung. Properly contoured, 7x5x4 cm in size, hyperdense and hypodense focal lesion areas in the leaves of the pericardium was determined in computed tomography of the thorax. Only apical aneurysm was detected in echocardiography. The patient was referred to the university hospital for the operation.

Conclusion: Careful physical examination and appropriate diagnostic tests could help correct diagnosis of more lethal coincidental diseases such as presented in this case.

Keywords: coincidental, diagnosis, cardiac mass

P-0570 Toxicology

Uvula Edema And Squirting Cucumber !

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Objective: Herbal medicine is use of plants for medical purposes. Plants have been the basis for medical treatments through much of human history however the unknown side effects of the plants can cause many harms and even end up in deaths. In this case, a woman who had uvula edema after the use of squirting cucumber would be discussed. Squirting cucumber also known as ecballium elaeaterium is a hairy perennial harbeaceous vine of the cucurbitariae family, endemic to Medeterranian region. It is frequently used in the treatment of sinusitis, urinary incontinence also in hemorrhoid a, in sinusitis it is used by nasal aspiration of undiluted vice of squirting cucumber

Case: 33-year-old woman was presented to the emergency department with shortness of breath, sense of swelling in oropharynx and dysphagia. In her past medical history, she had no known disease prescribed medicine and allergy. She stated that symptoms developed 4 hours previously she had aspirated intranasally undiluted fruit juice of squirting cucumber 5 drops per each nostril for the treatment of sinusitis. On initial physical examination his blood pressure was recorded as 100 / 60 mmhg, pulse rate 82 beats per minute, respiratory rate 15, oral temperature 36.5 °C, transcutaneous o2 saturation 98. She was cooperated and a score of 15 on the Glasgow coma scale. On her physical examination uvula edema was recorded and bron-



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hospasm was heard on auscultation of the lung. Examination of the remaining system was unremarkable

. She was given intravenously prednol 2mg /kg 50 mg ranitidine 50 mg difenhidramine and 2000 L serum physiological. Bronchodilator treatment was given. No significant abnormality was identified on routine laboratory tests including kidney, liver, biochemistry, troponin. Her Ecg showed sinus rhythm. Her posterioranterior chest x ray had no abnormalities. After the treatment she had full recovery of symptoms and discharged from the the hospital with recommendations

Conclusion: Paramedical products are widely used among the people therefore emergency room doctors should be aware of the complications of these products and examine it in the medical history of patients.

Keywords: Squirting cucumber, uvula edema, dispnea

P-0571 Toxicology

A local effect of phoxim-based insecticides

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Objective: We will present a case report of a patient who used phoxim based pesticide and lividness at her thumb.

Case: 55 year old woman admitted to emergency department with lividness at her thumb. In history there is no trauma and bleeding disorder. She has been sprayed her lice infested chickens with pesticides containing phoxim. After one hour she have noticed bruising on her thumb. Complete blood count, biochemical tests and PT, aPTT were performed. PT% value was 132 (Normal 70-120) and INR was 0.85. Local therapy and ice application applied for lividness. The day after lividness on her thumb has reduced. Control PT% value was 97.

Conclusion: Phoxim is an organophosphorus compound which is used in agriculture and veterinary as pesticide. Its adverse effects had shown in vitro. There is also case report as contact dermatitis. We keep in mind that organophosphorus compounds also local effects beside concerning the whole body.

Keywords: phoxim, local effect, pesticide, organophosphorus

P-0572 Toxicology

Outdoor Carbonmonoxide Intoxication by Narghile

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Objective: Carbon monoxide (CO) poisoning is one of the leading causes of death in both adults and children worldwide. CO intoxication can be notoriously nonspecific in its initial presentation to the emergency department (ED). Narghile smoking is a traditional method of tobacco use, and it has been practiced extensively for 400 years. Traditionally, narghile smoking is a matter of culture mainly in Middle East, Asia, and Africa. In recent years, its use as a social activity has increased worldwide, especially among young people. Narghile smoking is an unusual cause of carbon monoxide poisoning. Narghile smoking, compared to cigarette smoking, can result in more smoke exposure and greater levels of carbon monoxide.

Case: 19 year old male patient was brought to the emergency department with complaints of fainting after alcohol intake and smoking hookah outdoors. Of the patients' relatives was learned that the patient's nausea and vomiting. His vital signs revealed a temperature of 37°C, blood pressure of 110/70 mmHg, respiratory rate of 18/min, pulse rate of 114/min, and pulse oximetry reading of 94%. Blood glucose level was 92 mg/dL His EKG was rhythmic and tachycardic. In patient's neurological examination he was confused. The laboratory tests and kranial CT were planned for patient. There was no acute pathology on CT. Laboratory results was normal except for carboxyhemoglobin (COHb) level. His COHb level was 29.8%. The patient was started on oxygen therapy and hyperbaric medicine consultation was requested.

Conclusion: The ability to diagnose and thus treat CO poisoning is always based on an increased index of suspicion. Young patients presenting with unexplained confusion or nonspecific neurologic symptoms should be asked specifically about narghile smoking. As in this case, even outdoors narghile smoking can lead to carbon monoxide intoxication.

Keywords: narghile, carbon monoxide, intoxication

P-0573 Toxicology

Cardiac Conduction Abnormalities and Dysrhythmias in Liquid Detergent Poisoning

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Objective: Non-ionic, anionic and cationic detergents are found in a wide variety of household products, including body soaps, shampoos, dishwashing detergents, various household cleaners, etc. These products are gastrointestinal and ocular irritants with few to no systemic effects. Cationic detergents can cause systemic toxicity including CNS depression, coma, seizures, hypotension, muscular weakness and fasciculations, collapse, pulmonary edema, metabolic acidosis and rarely arrhythmias; the mechanism of these signs is not known.

Clinical signs consist of hypersalivation, vomiting, and diarrhea, and are generally mild and self limiting, although ingestion of large quantities may result in more severe vomiting.

Case: 27 years old man was admitted to emergency room because of drinking "moquette cleaner" which was a kind of household cleaner including anionic and cationic detergents. In the medical history of patient we learned that he drank this detergent approximately 200-300 cc for suicidal aim one hour ago before the hospital admission. The patient had no complaints except nausea. There was no disease in the patient's medical history. His initial vital signs was; blood pressures 122/75, pulse rates was 76/min, temperature was 36.2 C, respiratory rate was 12 breaths/min. There were no pathological findings on his physical examination. First electrocardiogram (ECG) finding was 1st degree AV block. PR interval was 276 milliseconds. He had been monitored and observed at emergency service. There was no indication decontaminate of the gastrointestinal tract. Parenteral fluid therapy and oxygen was administered for supportive treatment. After three hours second ECG was taken and detected mobitz type 1 block. Patient was consulted to cardiology physician. Cardiology physician suggested only supportive treatment and 12 hours observation. At the ninth hour of the observation patients heart rhythm reverted to the sinuzal rhythm. The patient who remained asymptomatic after 12 hours of observation did not require hospital admission for toxicologic reasons.

Conclusion: Cardiac conduction abnormalities and dysrhythmias are rare complication of patients admitted to emergency department due to detergent poisoning. Therefore emergency physicians must be aware of cardiac conduction abnormalities and dysrhythmias for those patients. All symptomatic patients require hospital admission to a monitored bed. Patients demonstrating signs of moderate to severe toxicity should be admitted to an intensive care unit. Hospitalized patients can be cleared medically after 24 hours of being asymptomatic, which includes having a normal or baseline ECG. Asymptomatic patients with sinus tachycardia, isolated PR interval prolongation, or first-degree atrioventricular block do not require specific pharmacologic therapy.

Keywords: detergent poisoning, Cardiac conduction abnormalities, dysrhythmias

P-0574 Imaging in Emergency Units

A Rare Reason of The Chest Pain: Spontaneous Pneumomediastinum A Case Report

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Objective: Pneumomediastinum (PM) is defined as the appearance of air within the mediastinum in the absence of an obvious precipitating factor. It is first described by Louis Hamman in 1939 and for this reason it is called Hamman's syndrome. It is mostly seen at young males. But it is mostly misdiagnosed condition. The differential diagnosis of PM is important because it can be caused by trauma, gas-producing organisms, and esophageal rupture, which are all potentially fatal.

In this case report we aimed to emphasize to show regard to the diagnosis of PM in a patient with chest pain.

Case: 21 year-old male presented to our emergency department with the complaint of chest pain ongoing for two days. Onset of the pain was following cough attacks sustaining for three days. Initial vital signs were completely normal. In medical history there was no specific diseases. Physical examination was normal except mild tenderness over sternum and crunching sound on cardiac auscultation. ECG was in normal sinus rhythm without any abnormalities. Chest x-ray showed mediastinal gas along left heart border. Presence of air in the mediastinum was evident on the non contrast thorax Computerized Tomography (CT). Esophagogram was performed to exclude esophagus perforation (Boerrhove Disease); revealed no pathology. The patient was hospitalized for three days and no consecutive complication occurred and discharged healthy.

Conclusion: Spontaneous PM is an uncommon condition that predominantly affects young males. It occurs usually due to vomiting or coughing and may be associated with structural lung diseases including emphysema, asthma and bronchiectasis. The most common associated symptoms in the literature are chest pain, dyspnea and neck pain. It can be detected radiologically on x-ray. In our case the cause of the suspicion was the gas among the left heart border on chest x-ray. CT scan detect small amounts that missed on x-ray. As was in the literature we have confirmed the diagnosis with thorax CT. According to some reports, patients with Spontaneous PM should be admitted to the hospital. Hospital admission is critical in those patients with PM in whom nonspontaneous PM cannot be ruled out and in which PM is caused by exacerbation of emphysema. Our patient was admitted to the hospital for the evaluation exact reason of the Spontaneous PM either. Spontaneous PM may rarely rapidly progress to tension PM, which may be fatal; therefore, patients showing an exacerbation of dyspnea should be carefully



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monitored.

Keywords: Hamman's syndrome, spontaneous pneumomediastinum, chest pain

P-0575 Cardiovascular Emergencies

Ventricular Fibrillation or Epileptic Seizure

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Objective: Epilepsy is the name of a brain disorder characterized predominantly by recurrent and unpredictable interruptions of normal brain function, called epileptic seizures. An epileptic seizure is "transient," demarcated in time, with a clear start and finish. Termination of an epileptic seizure often is less evident than is the onset, because symptoms of the postictal state can blur the end of the seizure. An epileptic seizure is a clinical event; therefore signs and symptoms must feature prominently in the definition.

Case: 58 years old male patient was brought to the emergency department with complaints of seizures by 112 team. Ambulance doctor noted that the patient had a seizure on the road three times and they used dizepam for that. Patient had a existing diagnosis of epilepsy for 8 years. His vital signs revealed a temperature of 36°C, blood pressure of 122/88 mmHg, respiratory rate of 20/min, pulse rate of 110/min, and pulse oximetry reading of 92% on room air. His ECG showed sinus tachycardia. The patient's laboratory tests were planned and monitored. During follow-up the patient began to spasm and bruising. Meanwhile, ventricular fibrillation viewed on the monitor. The patient was defibrillated immediately and he returned to sinus rhythm. In laboratory results, patient's cardiac enzymes were positive and patient was transferred to the coronary care unit with a diagnosis of non-ST MI.

Conclusion: Ventricular fibrillation is a fatal complication developed after myocardial infarction. Ventricular fibrillation clinic is very similar with generalized tonic-clonic seizures. Seizures in patients with epilepsy may be mimicking myocardial infarction should be kept in mind. ECG and cardiac enzymes should be planned for patients admitted with seizures. In addition, it should not be forgotten that seizures may trigger the myocardial infarction.

Keywords: Ventricular Fibrillation, Epilepsy, Seizure

P-0576 Toxicology

Fatal herb senna: case report

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Objective: Due to its laxative effects, Senna (Cassia angustifolia) has been used frequently in our country and the whole world. It is known that if consumed in a long period with large quantities, Senna has many adverse effects, one of which is especially hepatotoxicity. We aimed to present a case of toxic hepatitis, afterwards death because of drinking a large amount of senna tea.

Case: A sixty years old female patient admitted our emergency service with the complaints of weakness, abdominal pain and distension ongoing for about three days. She expressed that she had drunk a kind of tea made of Senna for the treatment of her chronic constipation a long time and especially last month mostly. According to anamnesis, physical examination and other investigation, we concluded our patient having toxic hepatitis in relation with consuming a large amount of Senna. We consulted the patient to gastroenterology and organ transplantation service. She was followed for multiple organ failure, but did not respond to the interventions and died before transplantation.

Conclusion: Finally it should be noted that Senna, which is known to have many benefits by people and easy to obtain, may cause toxic hepatitis and also death if consumed in an uncontrolled way.

Keywords: Senna, toxic hepatitis, death

P-0577 Imaging in Emergency Units

Chilaiditi Syndrome: A Rare Cause of Epigastric Pain

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Objective: Chilaiditi sign is defined as the interposition of bowels between the liver and right diaphragm. A radiologic finding of hemidiaphragmatic interposition of the colon is referred to as Chilaiditi sign, while a symptomatic case is known as Chilaiditi syndrome. This sign was first described in the medical literature in 1910 by the Greek radiologist Demetrius Chilaiditi. Chilaiditi syndrome is a rare condition occurring in 0.025% to 0.28% of the population.

Case: A 48-year-old male presented to the emergency department with a 24-hour history of nausea and worsening epigastric and right upper quadrant pain. The patient previously experienced a similar experience 6 years ago. In his past medical history he was diagnosed with peptic ulcer without an endoscopy and began pantoprazol. On original presentation, he was afebrile, with a blood pressure of 132/75 mmHg, pulse of 87 beats/min, respiratory rate of 17 beats/min and oxygen saturation of 96% on room air. On physical examination, the cardiovascular and respiratory exams were unremarkable. His abdomen was soft but exhibited tenderness to palpation in the epigastrium as well as the right upper quadrant. Murphy's sign was equivocal. There were no signs of rebound tenderness, guarding or ascites. Basic laboratory studies; hepatic panel was within normal limits, complete blood count demonstrated a normal WBC, platelet count and hemoglobin. His cardiac enzymes and urinalysis were unremarkable. Imaging studies showed a remarkable abdomen X-ray with a chilaiditi sign. Based on results of the diagnostic studies, a presumptive diagnosis of Chilaiditi syndrome was made because the patient continued to be symptomatic. The patient was managed conservatively with IV fluid hydration, nasogastric decompression and pain management. He was consulted and admitted to the surgical service with a diagnosis Chilaiditi Syndrome. During the course of his hospital stay, his abdominal pain resolved without surgical intervention. In the repeat images the chilaiditi sign disappeared.

Conclusion: Chilaiditi syndrome is extremely rare. The treatment of Chilaiditi syndrome conservative management that including intravenous fluids, nasogastric decompression, enemas should be attempted first. If repeat imaging shows failure of resolution or if ischemia is suspected, surgical treatment is indicated. Although a rare condition, Chilaiditi's syndrome may have important clinical outcomes.

Keywords: Chilaiditi syndrome, Chilaiditi sign, epigastric pain

P-0578 Imaging in Emergency Units

Bilateral spontaneous massive hemothorax in late postoperative period of pectus excavatum

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Objective: A 17-year-old man with a funnel chest who underwent the Nuss procedure at 15 years of age due to chest pain was referred to our hospital with a complaint of chest pain and dyspnea.

Case: Vital signs were TE: 60/40 mmHg, pulse: 88/dk-rhythmic T: 36.2 C, SaO₂: 98%. SF infusion was started.

On the clinical examination, we auscultated decreased breath sounds were decreased bilaterally. Other systemic examination was normal. Chest X-ray was planned. But the patient has undergone syncope, when he stood up. Chest radiograph revealed bilateral pleural effusion. There was no pneumothorax and a pectus bar. In addition, computed tomography revealed a massive hemothorax. (Picture B). Thoracic CT scan revealed bilateral pleural effusion. There was no additional pathology. Results of echocardiography were normal.

In the results of blood Wbc: 17:31, Hb: 10.2, Hct: 30.8, Plt: 251. The patient's blood and coagulation test was completely normal. Diagnostic thoracentesis was performed and was found to be hemorrhagic. Pleural effusion CBC Hb: 9.8, Hct: 30.5 on being spontaneous, was diagnosed with bilateral massive hemothorax. The patient was admitted to the thoracic surgery clinic.

Conclusion: Some reports show the Nuss procedure to have the potential for the development of complications of hemothorax. Complications associated with the Nuss procedure: analysis of risk factors and suggested measures for prevention of complications within the early and late postoperative period. Postoperative complication rate was 16.1% in total patients. Early complications are pneumothorax 6.9%, wound seroma 3.3%, bar displacement 2.4%. Late complications are pericarditis and pericardial effusion 1.5%, bar displacement 1.2%, hemothorax 0.9%. However, a case of massive hemothorax developing at a later stage is rare. We were unable to find a cause of the hemothorax, except for the pectus bar, in this case. Complication rate was reduced with accumulation of experience and advancement of surgical techniques.

The Nuss procedure can be performed at a low risk of complications with the current technique.

Must be considered in patients with hemorrhagic shock isolated. Bilateral hemothorax as the late complication of the Pectus Excavatum should be considered.

Keywords: Hemothorax, pectus excavatum, Nuss procedure



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P-0579 Cardiovascular Emergencies

Acute Pharyngitis, Coronary Syndrome or Hypothyroidism?

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Objective: It's a common approach to think an acute coronary syndrome due to elevated troponin in cases with history of cardiac problems or in cases with angina pectoris. But acute coronary syndrome might not be your certain diagnosis in cases with hypothyroidism. Hypothyroidism and its relationship to cardiac enzymes were showed in few studies, close relationship was related especially in cases had thyroxin and triiodothyronine autoantibodies with elevated cardiac enzymes. We wanted to share a case that isolated elevation of troponin with no myocardial injury and a history of toxic goiter.

Case: A 34 year-old female case admitted to emergency department with complaints of sore throat for ten days and pain in the left arm and neck for one day. It was learned that the case had no treatment for sore throat and arm pain started from left shoulder spreading on left arm and neck after, like a myalgia during one hour. The case was accustomed to smoking 20 cigarettes per a day, history of coronary angiography 5 months ago and after that placed a stent to LAD, had a migraine diagnosis and followed up for toxic goiter. She had no specific family history. Her medications were metoprolol 50 mg tablet 2x1, acetylsalicylic acid 100 mg tablet 1x1, ramipril 2.5 mg tablet 1x1, rosuvastatin 10 mg tablet 1x1 (for ten days), methimazole 5 mg tablet 3x1. General state was good, vital signs were stable and physical examination of all systems were normal. ECG was normal sinus rhythm. We determined troponin-I 0.738 ng/mL (normal range 0.02-0.06) at zeroth hour and 1.04 ng/mL at fourth hour so that the case was consulted to cardiology department. According to cardiology department's consultation there was no acute coronary syndrome. Myocardial perfusion scintigraphy with effort was reported as a normal range scintigraphic sings applied ten days after her admission to emergency department. Her anti-TPO antibody, fT4 and TSH were 61.5 IU/mL (normal range 28-60), 0.64 ng/dL (0.89-1.76), 6.36 microIU/mL (0.35-5.5) in written order.

Conclusion: In our case we mentioned that it should be considered hypothyroidism as an alternative diagnosis in cases studying cardiac enzymes due to admitting atypical symptoms like left arm ache and had a history of coronary artery disease. Sore throat may be a cardiac pathology and also may be a hypothyroidism case with a carefully taken anamnesis as in this case.

Keywords: Toxic goiter, troponin, sore throat

P-0580 Cardiovascular Emergencies

A Rare cause of Non-STEMI: Kounis Syndrome

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Objective: Allergic reactions may develop after drug use or exposure to environmental hypersensitivity reactions and may cause various clinical presentations such as angioedema, anaphylaxis etc. Coronary syndromes are triggered by the release of mast cells following an allergic insult. Non STEMI after a bee sting is presented in this paper and diagnosis and treatment of Kounis syndrome is discussed.

Case: A 27 year old male suffering from cold sweat and pain radiating from stomach to the chest and back after a bee sting 45 minutes ago was admitted to the emergency department. Medical history including drug use, risk factors and family history was otherwise non-contributory. On admission, his blood pressure was 90/60 mmHg, pulse 62 beats per minute, respiration rate was 14 per minute, heart was rhythmic and there was no additional sound or murmur. ECG revealed ST depression and T inversions located at inferior derivations. He was administered 300 mg of acetylsalicylic acid orally and parenteral 45.5 mg of pheniramine maleate and 80 mg of prednisolone. There was a significant elevation of cardiac enzymes on admission. Complaints were reduced and ST depressions were absent after 3 hours of treatment. Decline in cardiac enzymes was observed in sixth hour and cardiac enzymes were back to normal range in ninth hour. He was regarded as Kounis Syndrome hospitalized with the diagnosis of non-STEMI.

Conclusion: Kounis syndrome is a condition characterized by chest pain and associated ECG changes after exposure to an allergen. Although ST elevation is common, cases with non ST elevation are rarely encountered. Administration of antihistamines, steroids and adrenaline are usually sufficient for treatment and abolish symptoms. Suspecting from Kounis Syndrome in patients suffering from allergic reactions and chest pain will help in diagnosis and treatment.

Keywords: Kounis Syndrome, Allergic Reactions, Chest pain, ECG Changes

P-0581 Toxicology

Recurrent Sinus Bradycardia Due to Mad Honey Poisoning

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Objective: Grayanotoxins binding to specific sodium ion channels in cell membranes are a group of closely related toxins found in rhododendrons such as Rhododendron luteum and Rhododendron ponticum found in honey made from the nectars of abovementioned plants. Although initial symptoms are related with gastrointestinal system such as excessive salivation, abdominal pain, nausea and vomiting, symptoms regarding cardiovascular system may include bradycardia, hypotension, syncope and heart block also encountered frequently especially in higher doses when honey contaminated with Grayanotoxins is consumed. Medical intervention is not frequently needed but sometimes atropine therapy and other agents are used to mitigate symptoms.

Case: A 33 year old male suffering from dizziness, cold sweat, nausea and vomiting was admitted to the emergency department. Medical history was otherwise non-contributory. On detailed questioning he reported that he had eaten 4-5 spoons of honey. On admission, his blood pressure was 70/45 mmHg, pulse 38 beats per minute, oxygen saturation was %98. ECG revealed sinus bradycardia. He was monitored and administered 1 mg of atropine twice and saline infusion with rate of 150 cc per hour as soon as he was regarded as hemodynamically unstable. His cardiac enzymes were within normal range. Pulse rate was observed to be 72 beats per minute following administration of atropine. Administration of atropine was repeated when pulse rate was observed to be 43 beats per minute on the seventh hour of arrival. He was discharged when he remained hemodynamically stable throughout the 24-hour observation.

Conclusion: Grayanotoxins increases vagal tone by blocking sodium ion channels. Increased vagal tone creates cholinergic effects resulting in hypotension, bradycardia and respiratory depression. Decreased blood flow may cause coronary syndromes. Duration of action of the toxin varies depending on the amount of consumption. Patients with severe poisoning symptoms should be monitored 24 hours a day due to the possibility of recurrence of symptoms.

Keywords: Grayanotoxin, Mad Honey Poisoning, Sinus Bradycardia

P-0582 Toxicology

An Unusual Reason of Arrest, Transdermal Fentanyl Patch Intoxication

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Objective: Opioid intoxication is generally with respiratory and mental status depression, analgesia, bronchospasm, miotic pupils, decreased gastrointestinal motility, urinary retention. Coma and even respiratory arrest can happen after high doses of opioid use. Fentanyl is a synthetic opioid, intoxication from transdermal patches –which is generally used for chronic pain for patient with malignancy- is rare in literature. Our patient was given 4 transdermal patches to use for shoulder pain by her neighbour who uses these patches for malignancy.

Case: 62 year old woman patient was carried to our ED, presumed as stroke due to she had vomitted at home followed by decreased level of consciousness. Her GCS was 10 (E:3, V:2, M:5), blood pressure:105/67, respiratory rate:11, saturation:88%, body temperature:36.7 C, pulse:98 and peripheral blood glucose:177, ECG:Normal sinus rhythm. She had no prior history of chronic illness such as cardiovascular, neurologic diseases or diabetes. Initial physical examination showed shallow respiration, miotic pupils. Just after she arrived to our emergency department, she had respiratory arrest so that we intubated and resuscitated patient for 5 minutes successfully. There were no laboratory abnormality, bedside cardiac usg was normal, head ct scan showed no pathology. After 2 hours of follow up, her spontaneous respiration turned back, she could make eye contact, vital signs were stable. There wasn't any laboratory or radiologic findings to explain this situation. Spontaneous respiration and stable vitals continued 45 minutes until she had respiratory arrest again followed by second 5 minutes of resuscitation. Detailed



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analysis of patient's secondary survey was performed, patient was undressed completely and we realised 4 transdermal fentanyl patches (100 mcg/h each) on her back. We removed the patches suddenly and administered 2 mg of naloxone intravenously, patient responded to naloxone just after administration. She was admitted to intensive care unit, extubated 4 hours later and followed for 48 hours until she was discharged from hospital safely without any sequelae.

Conclusion: Arrest due to usage of transdermal fentanyl patches is really rare in literature. Our patient was 62 year old without a chronic illness history and priorly could not suggest opioid intoxication until we saw transdermal fentanyl patches on her back. Once diagnosis was clear, we used 2 mg of naloxone and patient was followed 48 hours, safely discharged in the end without sequelae. Patients with arrest must be undressed completely and should be asked for comprehensive history and we must be alert about any intoxication after completing stabilisation.

Keywords: fentanyl intoxication, respiratory arrest, opioid, naloxone

P-0583 Imaging in Emergency Units

Primary Spontaneous Pneumomediastinum

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Objective: Spontaneous pneumomediastinum (SPM) is a rarely seen clinical entity which is defined as existence of air in mediastinum and typically effects young adult men. SPM occurs when air leaks through small alveolar ruptures to the surrounding bronchovascular sheath. Less commonly, pneumomediastinum results from air escaping from the upper respiratory tract, intrathoracic airways, or gastrointestinal tract. Symptoms generally resolve without any specific treatment. We are presenting a patient with chest pain admitted to our emergency department.

Case: Eighteen years old young male came to our emergency room with chest pain. The pain started suddenly at rest. Past medical history revealed nothing specific. He denied any history of trauma, drug usage, and coughing, vomiting or sportive activity. Body temperature was 36.1 °C, respiratory rate was 12/min, O₂ saturation was 98% and blood pressure was 115/75 mmHg. On physical examination percutaneous emphysema was detected in the left supraclavicular area and lungs were clear on auscultation bilaterally. ECG was normal sinus rhythm and no pathological findings were detected. Blood tests were all normal. Posteroanterior chest X-ray was not descriptive. Thorax computerized tomography (CT) revealed free air in the mediastinum and left sided subcutaneous emphysema extending from apex to scapula and minimal pneumothorax. The patient was followed up conservatively with parenteral antibiotics, analgesics and oxygen. After 60 hours of admission his complaints resolved totally and he was discharged from hospital. On control CT, taken 10 days later at outpatient clinic showed that the emphysematous lesions were completely disappeared.

Conclusion: Uncomplicated SPM is managed conservatively with analgesia, rest, and avoidance of maneuvers that increase pulmonary pressure as in our case. Patients should be followed up for possible complications. This case is particularly presented to emphasize that; SPM should be kept in mind in the differential diagnosis of chest pain.

Keywords: primary spontaneous pneumomediastinum, chest pain, emergency room

P-0584 Cardiovascular Emergencies

Acute pericarditis cause of ST-segment elevation: Case report

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Objective: Chest pain is one of the common reasons for admission to the emergency department and an important symptom in terms of precursing mortal illnesses. In this respect, electrocardiogram (ECG) which is of critical importance in the evaluation of patients is a guide for us. However starting such treatments as thrombolytic therapy that is solely considered according to ECG may be a wrong decision. In this case presentation, we have aimed to present a patient admitted to our emergency department with chest pain and diagnosed with acute pericarditis.

Case: A nineteen year old male patient admitted to our emergency department with chest pain, having ST segment elevation of D2, D3 and aVF in ECG along with troponin elevation and diagnosed with acute pericarditis.

Conclusion: Acute pericarditis should be considered for the patients presented to the emergency department with the complaints of chest pain, having ST segment elevation in ECG along with troponin elevation. We should keep in mind that the contraindication for thrombolytic therapy in this situation.

Keywords: Pericarditis, ST segment elevation, troponin, thrombolytic

P-0585 Cardiovascular Emergencies

A rarely diagnosed clinical phenomena - Kounis syndrome

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Kounis syndrome is described as provocation of acute coronary syndrome (ACS) by the activation of mast cells resulting in allergy, hypersensitivity, anaphylaxis or anaphylactoid reactions. Drugs, food, environmental factors (insect bite, bee sting, pollens, latex contact) and intracoronary stent placement can be the reason which trigger the allergic reaction. In our case, after 30 minutes following ingestion of amoxicillin and clavulonic acid, development of kounis syndrome with retrosternal chest pain and atrial fibrillation is discussed. 28 year- old male patient with a diagnosis of acute pharyngitis presented to our emergency department with symptoms like shortness of breath, hypotension, flushing, intense retrosternal chest pain, difficulty of swallowing, nausea and vomiting 30 minutes after ingestion of amoxicillin and clavulonic acid. Physical exam revealed; no uvular edema, prevalent pulmonary bronchospasm and epigastric tenderness. Vitals revealed; arterial blood pressure: 92/60 mmHg, SpO₂:97, pulse rate: 150 bpm and rapidly responding atrial fibrillation on electrocardiogram (ECG) was detected. Kounis syndrome was diagnosed as the patient had no prior cardiac history and a new onset atrial fibrillation was discovered. He was given 80 mg Prednisolone, 50 mg ranitidine, 45.5 mg pheniramine maleate, 1000 cc saline solution for the allergic reaction. On his follow-up, 20 mg diltiazem was given intravenously for heart rate control followed by 25 mg diltiazem when no control was obtained. He was given 300 mg propafenone hydrochloride orally when no response to diltiazem was received. His ECG obtained after 90 minutes was normal sinus rhythm. On his follow-up, there was no rhythm disturbance and his complaints were regressed. Kounis syndrome should be kept in mind in cases which present allergic reactions along with chest pain following exposure to agents which may be allergic to the immune system.

Keywords: allergy, anaphylactoid reactions, Kounis syndrome

P-0586 Cardiovascular Emergencies

Reversion Of A Cardiac Arrest After 17 Times of Shock: Shock-Resistant Ventricular Fibrillation

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Objective: Ventricular fibrillation (VF) is a pathological cardiac rhythm which causes inadequate ventricular contraction due to unsynchronized reentrant pattern of excitation. It requires emergent defibrillation to provide effective cardiac pump function. If VF persists after 3 times of shock, it is then called: shock-resistant ventricular fibrillation. Amiodarone or lidocaine are choices of medical treatment. Myocardial infarction is one of the etiologies of VF. We could successfully reversed the shock-resistant VF in a patient who had acute MI.

Case: 53 year-old male presented to our emergency department (ED) without pulse with information that he had chest pain, vomited, then fainted 5 minutes later. He could arrive ED in 30 minutes. We initially started CPR procedure, checked the rhythm with defibrillator paddles while intubating and saw ventricular fibrillation, we defibrillated him with 360J monophasically and started cardiac compressions, administered 1mg of IV epinephrine followed by 1mg of epinephrine every 3 minutes. We checked the rhythm 2 minutes later, VF persisted, we defibrillated again with 360J monophasically, continued compressions, at 4th minute, checked the rhythm, VF persisted again, we defibrillated, continued compressions, at 6th minute, the rhythm was still VF so there was a shock-resistant VF which we were facing. 300mg of amiodarone was administered just after 4th defibrillation, we continued CPR and checked the rhythm in every 2-2.5 minutes—which counts for every 5 cycles of CPR-, VF persisted until 17th defibrillation. 17th defibrillation was performed at about 42nd minute of CPR, we compressed for 2 minutes more, checked the pulse, finally fibrillation could be reversed, pulse was back. The only rhythm during CPR was VF. MI was the first differential diagnosis due to history of chest pain. So patient was transported to percutaneous coronary intervention (PCI), LAD was seen to be 99% occluded, cardiac stent was applied. He then was admitted to coronary ICU with recurrent VFs until he died 10 days of ICU follow-up.

Conclusion: We associate shock-resistant VF to ongoing MI and late arrival of patient to ED. He possibly had syncope because of VF which was detected in ED admission also. Depending on our knowledge, there isn't any other sample of successful CPR after 17 times of defibrillation. Appropriate cardiac compressions and medication in CPR could perfuse cardiac tissue enough to reach PCI but prolonged VF and occlusion of LAD caused irreversibly damage to his heart tissue so patient died because of recurrent VF and ineffective cardiac function.

Keywords: shock-resistant ventricular fibrillation, defibrillation, myocardial infarction



POSTER BİLDİRİLER

P-0587 Cardiovascular Emergencies

Encysted pleural fluid mistaken for a mass; Phantom tumor

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Objective: Pleural fluid (effusion) is among the most common pathologies of pleura. Approximately 5-7 mL of pleural fluid is found in pleural space in healthy persons [1]. Fluid may accumulate in the pleural space due to various diseases. Encysted state of pleural effusion in the distance between fissures and its homogeneous internal structure having an appearance of smooth contoured mass might be mixed with a mass appearance on the chest radiograph. Encysted pleural fluids may develop also in heart failure. Computed thoracic tomography may be needed in order to make a definite diagnosis. Since this mass appearance disappears in a short time, this appearance was called as phantom tumor [2]. In this report, we presented a phantom tumor case with a PA AC X-ray graphy diagnosis mixed with mass.

Case: A 77 years old male patient presented to our ED with the complaints of shortness of breath and tightness in the chest. On his history; chronic obstructive pulmonary disease, heart failure and coronary artery disease were detected. His vital finding were found as BP: 140/80, pulse as 88 /min, fever as 36oC and peripheral oxygen saturation as 85. On his EKG ordered, there was left bundle branch block while his EF was found as 18% on his ECHO. Since PA AC x-Ray graphy of the patient yielded a mass image in the right lung, thoracic BT of the patient was ordered. On the thoracic BT ordered, phantom tumor pleural encysted effusion was found instead of the right lung mass.

Conclusion: It must be kept in mind that the structures appeared as a mass on the graphies ordered for patients who presented to ED with the complaints of shortness of breath and chest pain and has heart failure might be pleural effusions which are called as phantom tumors.

Keywords: Emergency service, Encysted pleural fluid, Phantom tumor

P-0588 Imaging in Emergency Units

An unusual cause of shoulder pain and need of MRI

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Objective: We report a case of subcutaneous shoulder abscess which developed in a diabetic patient with a week history of furuncle on his left shoulder. This case demonstrates that the management of soft tissue infections in the diabetic patient involves early diagnosis and treatment using bedside ultrasonography and Magnetic resonance imaging.

Case: A 40-year-old man with poorly controlled diabetes mellitus presented to emergency department with mild shoulder pain. He had a temperature of 38oC. There was no history of recent infection to the left arm or hand, trauma, insect bite animal exposure, or recent travel. He had no palpable lymphadenopathy. Range of motion of the left shoulder was restricted. Radiographs of the shoulder and lungs reported to be normal. Ultrasound scan of the left shoulder showed loculated collection lying under the skin. Drainage of the abscess was performed. Staphylococcus aureus was isolated from cultures of aspirated pus from his left shoulder. He was administered intravenous antibiotics, and was ordered MRI of the shoulder. Multiplanar magnetic resonance imaging (MRI) of the left shoulder, including T1-weighted and T2-weighted images demonstrated the loculated collection of size 9x3.5 cm (anterior-posterior, transverse) lying deep to the deltoid region and extending into the posterolateral area of the shoulder. There was neither effusion nor synovial contrast enhancement in the joint. He was managed with surgical drainage. The patient completed a 1-week course of parenteral antibiotic therapy with ampicillin sulbactam and was successfully discharged home with adequate oral antibiotic treatment.

Conclusion: The presented case highlights that the management of soft tissue infections in the diabetic patient involves early and prompt diagnosis and treatment. The appearance of the lesion is not always helpful in differentiating an abscess from other soft tissue infections or recognizing the extent of infection. The presence of edema and induration can make it difficult to palpate an underlying abscess. Physical examination can also be limited by pain, patient compliance, and other factors. Bedside ultrasonography and Magnetic resonance imaging help to confirm the diagnosis. The treatment strategy is directed according to microbiological results in addition to surgery.

Keywords: shoulder, infection, abscess, diabetes mellitus, skin

P-0589 Toxicology

Haemodialysis Therapy of Lactic Acidosis Caused by a Suicide Attempt with Metformin

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Objective: We present the case of a 73-year-old man, who attempted to commit suicide by ingesting metformin overdose associated with lactic acidosis, which we treated by performing haemodialysis.

Case: A 73-year-old male patient presented to emergency department of our hospital following ingestion of 10 metformin 1000 mg and 10 coraspin 100 mg tablets in a suicide attempt. The patient's caregiver reported that the patient had a depressive mood, and had attempted suicide by ingesting metformin tablets on the day of arrival. He had a history of type 2 diabetes mellitus for 20 years, which was controlled with metformin, 1000 mg once daily, and he was found to have diabetic nephropathy during the follow-up period. The initial evaluation of the patient upon referral to our hospital revealed a state of confusion. A nasogastric catheter was inserted and gastric lavage was performed, in addition to activated charcoal treatment. Following therapy, which included oxygen, other supportive therapy, the laboratory investigations showed a worsening renal function with serum creatinine 3.27 mg/dl and blood gases: Ph: 7.3 and lactate: 48 mmol/L. An emergency dialysis was planned for the patient on the impaired renal function. bicarbonate hemodialysis treatment was administered for 3 hours. Two days after admission and 3 h after the first session of haemodialysis the serum lactate level had increased to 20 mmol/L with a Ph of 7.334, serum bicarbonate of 13.6 mmol/L and a base excess of -10.9 mmol/L. Therefore a second haemodialysis was performed over 2 h which succeeded in lowering the serum lactate to 2.5 mmol/L. Lactate levels returned to normal values and no further dialysis treatment was required. Blood gases and glucose levels were monitored daily. Blood glucose levels were maintain within the reference range. Improvement in the vital and laboratory findings were observed in the follow-up visits. The patient was discharged from the emergency department 4 days after admission and transferred to the nephrology department for renal replacement therapy.

Conclusion: This case demonstrates that early diagnosis and treatment of metformin intoxication using hemodialysis, together with maintenance of blood glucose, provide the positive outcome. In conclusion, metformin toxicity is a serious clinical condition, and causes severe lactic acidosis. Hemodialysis is an efficient method to treat metformin intoxication and correct the metabolic abnormalities.

Keywords: metformin intoxication, lactic acidosis, suicide attempt

P-0590 Cardiovascular Emergencies

Catheter-Related Tricuspid Valve Infective Endocarditis

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Objective: We report a rare case of catheter-related infective endocarditis, which occurred unusually at a tricuspid valve. Since infective endocarditis can be a complication of central venous catheterization, early detection and appropriate treatment are obligatory for patients' prognosis.

Case: A 74-year-old woman was admitted to our hospital because of nausea and vomiting. Her condition gradually deteriorated, resulting in dyspnea. According to her relative, she began complaining of general malaise, weakness and nausea one month prior to admission. She was maintained on regular hemodialysis for 8 months through a permanent catheter in the right jugular vein. She first presented to our hospital in November 2013 with dyspnea. She was prescribed intravenous antibiotics for pneumonia. Two weeks later, the patient was transferred to the intensive care unit where she experienced hemodynamic instability and progressive respiratory failure requiring intubation and mechanical ventilation. The patient remained anuric, and dialysis was considered necessary for the uremic state. Since her condition was dramatically improved, she was extubated, and transferred to nephrology department for renal replacement therapy. Four days after admission, she had cough and fever. The lung auscultation revealed bilateral fine bubbling crackles. Chest X-ray revealed diffuse bilateral pulmonary infiltrate with airbronchogram. Blood cultures performed on peripheral blood and blood contained in the catheter. Partially nodular infiltrates with small cavernous fusions in both lungs were recognized in the thoracic computed tomography (CT), in the context of multiple septic emboli with pulmonary congestions symptoms. In addition, bilateral pleural effusions were demarcated in the interlobar fissures and dorsally. The initially prescribed and begun in-patient antibiotic therapy for a primary pulmonary infection (Piperacillin/Tazobactam, Clarithromycin) was changed according to the antibiogram following the blood culture verification of a Staphylococcus aureus. She persistently recorded high temperatures and was breathless even at rest. The permanent catheter was removed, antibiotic treatment based on vancomycin and meropenem. Dialysis sessions were maintained and carried out using a temporary femoral catheter placed one day after removal of the first permanent catheter. In view of the lack of clinical and biological improvement, an echocardiography was performed and showed a large tricuspid valve vegetation. Three days after the IE diagnosis, the patient died following respiratory failure most likely secondary to a massive septic pulmonary embolism.

Conclusion: Catheter-related blood-stream infections, especially infective endocarditis, are associated with high morbidity, mortality, and medical costs in HD patients. Strict preventive methods and early detection and appropriate treatment of these complications are necessary to improve patients' outcome.

Keywords: Pulmonary septic emboli, Tricuspid valve, endocarditis, Central venous catheterization



POSTER PRESENTATIONS

P-0591 Toxicology

You Can Throw Away Carbon Monoxide Through The Chimney But It Can Return Through The Window

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Objective: Carbon monoxide (CO) which is a tasteless, colourless and odorless gas may cause serious intoxications resulting in severe morbidity and even death. Herein, we presented a case of carbon monoxide poisoning because the way it happened was interesting.

Case: A 55-year-old female patient with a possible diagnosis of stroke due to change in consciousness was referred to our hospital from another hospital. It was learned that she entered bathroom to take a shower but did not get out although approximately 30 minutes passed. Her husband worried about her and saw her lying on the floor unconsciously when he opened the door. He activated emergency medical services. She was taken to another hospital, and referred to our hospital with a possible diagnosis of stroke. She was unoriented and uncooperative at admission to our emergency room but her neurological examination gave no additional information. Her vital signs were normal. Electrocardiogram (ECG), blood samples for complete blood count, biochemistry tests, cardiac markers and arterial blood gas analysis were taken. ECG was normal. She was sent to imaging unit for computed tomography scan and diffusion magnetic resonance imaging of brain. They were normal, too. Arterial blood gas analysis showed a carboxyhemoglobin saturation (COHb) of 34.3 % and the patient took the diagnosis of carbon monoxide poisoning. It was learned that they use an electric water heater in the bathroom when asked from her husband who had no signs and symptoms although he was at home while her wife suffered from CO, too. Then it was learned that they use a coal stove at their home, and the end of stovepipe opens to balcony to the which the bathroom has a ventilation window opening, too. Hence it was understood that CO coming out of stovepipe entered the bathroom through that window and accumulated there. So the patient was exchanged without any sequela after 2 days of high dose oxygen treatment at a rate of 10 liters per minute.

Conclusion: It could be remembered that CO can accumulate even in well-ventilated places and CO intoxication should be excluded in all patients with signs and/or symptoms of possible CO exposure even if there is no apparent source of CO.

Keywords: Carbon monoxide poisoning, stroke, electric water heater

P-0592 Toxicology

Epidemiological and Cost Analysis of Self-Poisoning Cases in Ankara: Capital City of Turkey

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Objective: This study was designed to investigate the epidemiological, clinical and economic aspects of deliberate self-poisoning patients admitted to Yenimahalle State Hospital Intensive Care Unit.

Materials-Methods: The study was retrospectively carried out in Ankara Yenimahalle State Hospital. We included all patients over 16 years of age presented in 2012. We included 71 patients, presented in 2012, who were admitted to the hospital's ICU due to self poisoning. Poisons involved in the exposure were classified into one of three categories: pharmaceuticals, pesticides, and alcohols. Cost account was based on the medical bills billed at patient discharge. Data were compared using Student T test and The chi-squared test. A p value less than 0.05 was accepted significant.

Results: The female/male ratio was 2.55. The mean age of 71 poisoned patients was 28.92±11.51 years. Most of the poisoning agents were pharmaceuticals (68 cases). Among the pharmaceuticals, antidepressants were involved most often, followed by analgesics. There was no statistically significant difference between pharmaceutical agents in terms of hospital cost (p>0.05). The mean length of hospital stay was 6.4±4.3 days. There was a statistically significant difference between the number of hospitalized days in terms of hospital cost (p<0.05).

Conclusion: The patient cost increases as the hospital stay lengthens due to the policy of bundle pricing.

Keywords: poisoning, cost, intensive care unit

P-0593 Toxicology

Retrospective Assessment of Patients over 15 Years of Age Presenting to Emergency Department with a Suicide Attempt

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Objective: In this study we aimed to assess sociodemographic characteristics of cases over 15 years of age who admitted to emergency department (ED) after a suicide attempt and determine the risk factors for suicide.

Materials-Methods: This study was conducted retrospectively between 01.01.2013 – 31.12.2013 at the Emergency Department of Keçiören Training and Research Hospital.

Age, sex, marital status, educational status, suicide cause and method, interventions applied in emergency department, self or family history of suicide attempts, self or family history of psychiatric diseases, time of suicide attempt, time from suicide attempt to emergency department admission, and waiting time at ED were examined. The relationship between the suicide method and patient age and sex was also evaluated.

Results: This study included data of 561 patients. The patients were most commonly 15 to 24 years old (46.3%) and 419 (74.7%) of them were female. Three hundred (53.5%) patients were single, 271 (48.3%) were primary school graduate, and 111 (19.8%) were active workers. The most common suicide cause was familial problems (49.9%). The most common suicide method was consuming medications in large amount (92.5%) and the most common intervention applied in emergency department was gastric lavage (26.6%). Twenty-seven (4.8%) patients had a history of suicide attempts, 371 (66.1%) patients had a previously diagnosed psychiatric illness. The highest number of attempts occurred in July (11.1%) and majority of them occurred between 18:00 and 24:00. The mean time from suicide attempt to ED admission was 2.5 hours. There was a significant relationship between the suicide method and age range (p<0.05), while the relationship of the former with sex was not significant (p>0.05).

Conclusion: Although it is probably not possible to completely eliminate all suicide attempts, it is well possible to decrease the number of suicide attempts by reducing the number of possible risk factors for suicide.

Keywords: Emergency, suicide, Psychiatry

P-0594 Cardiovascular Emergencies

Acute myocardial infarction after normal coronary angiography

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Objective: Coroner angiography (CAG) is a definitive diagnosis as well as treatment is an indispensable diagnostic and treatment methods. In patients who had normal CAG, next 6-12 months myocardial infarction is not expected in the neck.

Case: A 55 year old female patient admitted to emergency department with chest pain. The patient's general condition was good, she was conscious, Glasgow Coma Scale score: 15, pulse rate: 105 / minute, blood pressure: 140/90 mmHg, body temperature: 36.7 ° C, oxygen saturation: 95%. In physical examination, tachycardia and bilateral crepitan basilar rales in lungs. Inferior myocardial infarction with ST elevation was detected on ECG. According to the patient's laboratory investigations, Hb: 11,6 g / dL, hematocrit: 36.3%, platelets: 366x103/dl, WBC: 17.5 x103/dl, glucose: 288 mg / dL, BUN: 10 mg / dL, creatinine: 0.87, Na: 139 mmol / L, K: 4.14 mmol / L, ALT: 20 IU / L, AST: 41 IU / L, amylase: 41 IU / L, PTZ: 12.5 sec (N: 10.5 to 14.5 seconds), aPTT: 32.9 sec (N: 22-34 seconds) and INR was 0.94 (N: 0.8-1.2) troponine t: 87,56 (N:0-14) CK-MB: 7.46 (N:0-4). Patient's emergency coronary angiography was performed and revealed totally occluded RCA. In the three days prior to the patient's history of coronary angiography demonstrated normal coronary arteries.

Conclusion: can be seen acute myocardial infarction in patients with normal coronary arteries before three days ago. We have to take ECG for all patients with chest pain.

Keywords: myocardial infarction, coronary angiography, chest pain



POSTER BİLDİRİLER

P-0595 Imaging in Emergency Units

Spontaneous pneumothorax and seasonal relationship

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Objective: Pneumothorax, parietal and visceral pleural within the chest cavity between the leaves means that free air. Under normal conditions, there is negative pressure in the intrapleural space. If a subsidiary of the alveolar pleural interval defined range with more than intrapleural always due to intra-alveolar pressure would be developed pneumothorax as the passage of air into the pleural space. Spontaneous pneumothorax is usually seen in weak and tall young men who smoke.

Spontaneous pneumothorax determine the frequency according to seasonal changes and to determine the efficacy of diagnostic tests.

Materials-Methods: In our study, the Ministry of Health in Eskişehir Yunus Emre State Hospital between 01.01.2013 and 31.12.2013 all patients diagnosed with spontaneous pneumothorax were included. Year was divided into four seasons. Winter; December-January-February, spring; March-April-May, summer; June-July-August, autumn; September-October-November.

Results: A total of 57 patients in the study were included in the 12-month period. 54 male and 3 female patients. The average age of the patients was found to be 35. Looking at the distribution of patients with seasonal autumn and winter months when the most common of them were cases of spontaneous pneumothorax. All patients with posterior-anterior chest radiograph (P AC) and computed tomography (CT) was performed. PAAC pneumothorax was detected in 3 patients. BT was evident in all patients. In our study, right-or left-sided pneumothorax were no significant differences when looking at the distribution. A total of 57 patients were evaluated in our study. A majority of the patients were detected in the autumn and winter months. In these seasons due to upper respiratory tract infections and influenza infections in patients admitted because of symptoms such as shortness of breath diagnosis of pneumothorax can be skipped. On especially in autumn and winter months in patients admitted with complaints of shortness of breath, a good physical examination and x-rays must be taken.

Conclusion: In the autumn and winter of patients admitted with complaints of shortness of breath very well done physical examination and is recommended for the differential diagnosis of spontaneous pneumothorax.

Keywords: spontaneous pneumothorax, seasons, x-ray

P-0596 Toxicology

Case Report of Acute Amitraz Intoxication

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Objective: Amitraz, formamidine derivative insecticide and acaricide, is widely used in agriculture and veterinary medicine. Despite its widespread use, amitraz intoxication is extremely rare and of human intoxications in the medical literature, the majority of intoxications are in children. Intoxication can occur through the oral or dermal route or by inhalation. Amitraz stimulates α_2 adrenergic receptor sites in the central nervous system (CNS) and α_1 adrenergic and α_2 adrenergic receptor sites in the periphery. It also inhibits monoamine oxidase enzyme activity and prostaglandin E2 synthesis. Therefore, the frequent findings of amitraz intoxication in humans are CNS depression, respiratory depression, hypotension, bradycardia, hyperglycemia, myosis/mydriasis, and hypothermia. The available amitraz formulation in Turkey is called Kenaz (Kenaz®, 100 mL, Atabay Ilac, İstanbul, Turkey). Kenaz contains 12.5% amitraz and 57.5% xylene in water. Herein, we report a 30-year-old male patient who ingested a glass of Kenaz solution (about 100 mL) as a suicidal attempt and admitted to our emergency department (ED) with hypotension, vomiting, and bradycardia.

Case: A 30-year-old male was referred from a rural hospital to our ED, for evaluation and treatment of amitraz intoxication. He had ingested a glass of (estimated 100 mL) Kenaz solution. After 1 hour, he developed nausea and vomiting. His family immediately took him to a clinic nearby. At that clinic they did gastric lavage and referred him to our ED. While being transferred to our ED, he became progressively bradycardic, hypotensive and declining mental status. His medical history was unremarkable, with no medical conditions and no history of alcohol and drug abuse. The patient strongly denied consumption of any medication, including over-the-counter, natural and alternative drugs. On admission the patient appeared confused. Vital signs included a blood pressure of 70/40 mmHg with features of tissue hypoperfusion, bradycardia of 48 beats per min., and a respiratory rate of 11 breaths per minute. Pupils were equal, widened and reactive to light. The rest of the physical examination was unremarkable. Laboratory findings were unremarkable, including complete blood count, biochemistry panel, arterial blood gases, urinalysis, serum ethanol levels, and osmolar gap. The patient was admitted to the observation unit of our ED, and total dose of 2 mg atropin, and aggressive fluid infusion was initiated. This treatment resulted in a rapid regaining of consciousness and resolution of bradycardia and hypotension. The patient was discharged after 16 hours of follow-up without any sequelae.

Conclusion: In conclusion, there is no specific antidote for amitraz poisoning and the management should be supportive and symptomatic. Particular attention must be given to monitoring and evaluating of the respiratory, cardiac, and CNS.

Keywords: Amitraz, bradycardia, confusion, hypotension

P-0597 Cardiovascular Emergencies

Wellen's syndrome in the emergency room

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Objective: Wellen's syndrome is a clinical condition characterized with T-wave changes observed within painless periods in patients with intermittent chest pain. This finding indicates the presence of a critical narrowing in the proximal of left ascending artery (LAD) that can cause anterior myocardial infarction (MI) within a short time. Wellen's syndrome is divided into two based on the ECG pattern. Type A (75% of the patients) is characterized with reverse T-waves in V2 and V3. In type B (25% of the cases) biphasic T-waves are seen in V2 and V3. We present here the acute anterior MI case evaluated as Type B Wellen's Syndrome because of the presence of classical T-waves in the SCG of a 35-year old female without any known cardiac diseases.

Case: The thirty-five year-old female presented with chest pain that started 2 hours ago. In the physical examination, pulse was 120/min and arterial blood pressure was 120/70 mm-Hg. She had normal sinus rhythm according to ECG, and there were biphasic T-waves in the V2 and V3 derivations (illustration 1). The initial Troponine I value of the patient was 0.031 (reference range: 0.01-0.023) while the same after one hour was 0.093. In the echocardiogram taken, EF was 40%, and left ventricular systolic dysfunction, segmental wall motility impairment, slight mitral insufficiency and slight aortic insufficiency were found. In the coronary angiogram, diffuse obstruction of 80% in LAD extending to the immediate distal of the proximal B1 and 95% in the proximal of B2 (illustration 2) were found, and angiogram was completed with the decision of by-pass operation.

Conclusion: We believe that with the rapid diagnosis of similar cases in the emergency rooms based on the specific ECG findings to prevent through early revascularization any potential MI or Sudden Death cases and possible other complications is extremely important as regards the shortening of hospital stays and labor force losses.

Keywords: Wellen's syndrome, emergency room, myocardial infarction, sudden death

P-0598 Toxicology

Toxic hepatitis after use of escitalopram

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Objective: One of the major causes of hepatic dysfunction are toxic hepatitis developed after drug intake. Hepatic dysfunction has a wide clinical spectrum that ranging from mild hepatic impairment characterized by biochemical abnormalities to hepatic failure. Antidepressants are an important cause of drug-related toxic hepatitis. Escitalopram, selective serotonin reuptake inhibitor, has less hepatic toxicity compared to other group of antidepressants. We aimed to emphasize that escitalopram may have serious toxic effects on the liver with this case presentation.

Case: A 27-year-old female patient with nausea and abdominal pain was admitted to our emergency department (ED). The patient had known anxiety disorder and had been taking escitalopram (Cipralax®, 10 mg tablet, Lundbeck İlaç, İstanbul) 10 mg a day for 3 months. In her physical examination, there was minimal abdominal tenderness in all four quadrants. Vital signs, and the rest of her physical examination were normal. Laboratory evaluation was notable for severe hepatic dysfunction of liver enzymes [AST=2990 U/L (N:5-35), ALT=3140 U/L (N:5-35), GGT=108 U/L (N:5-38), total bilirubin= 1.57 mg/dl (N:0.3-1.2), and INR=1.4 (N:0.8-1.2)]. Other laboratory and radiological findings were unremarkable, including complete blood count, kidney function tests, arterial blood gases, urinalysis, serum ethanol levels, toxic screen, hepatitis markers, and abdominal ultrasonography. The patient was admitted to internal medicine service. The patient's escitalopram was discontinued. Other laboratory tests performed in the internal medicine service for differential diagnosis of toxic hepatitis were normal. The liver function tests decreased to normal values during follow-up. The patient was discharged on the 5th day of admission, and gastroenterology polyclinic control has been proposed.

Conclusion: Toxic hepatitis can be interfere with many diseases that clinically characterized by hepatic dysfunction. Asymptomatic moderate increase in serum aminotransferases was



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observed at a rate of 0.5-3.0 % due to use of antidepressant drugs. Hepatotoxicity caused by antidepressant drugs are usually seen in older patients and multiple drug users. Hepatotoxicity occurs unpredictably and independent of the dose of drug in many cases. Hepatotoxicity may be seen at any time interval from treatment initiation after a few days up to 6 months. It should be kept in mind that toxic hepatitis can develop due to use of escitalopram even this drug has less potential for hepatotoxicity compared to other antidepressants.

Keywords: Antidepressive agents, emergency department, toxic hepatitis, transferase

P-0599 Toxicology

A Foreigner in Aegean: Mad Honey Poisoning

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Objective: Mad honey poisoning is the cause of a rare food poisoning which has been known from ancient times in the Eastern Black Sea region of Turkey. It is a clinical entity that can occur with ingestion of honey made from the pollen and nectar of the plant family Ericaceae and Sapindaceae containing grayanotoxin for alternative therapeutic purposes. We want to emphasize that mad honey poisoning should be taken into consideration and questioned regardless of geographical difference.

Case: A 44-year-old male patient admitted to the emergency department with chest pain, dizziness, nausea and vomiting. The patient's arterial blood pressure was 80/50 mmHg and the 12-lead electrocardiogram (ECG) showed sinus bradycardia (42 beats/min). He had also flushing. Other systemic examination was normal. The patient was given 1 mg of atropine, and intravenous fluid replacement was started. When we deepened the history, we learned that he ate honey in the evening and his symptoms started about two hours after. The patient whose clinical signs resolved during the follow-up was admitted to the emergency observation unit, and he was discharged after a 12-hour follow-up.

Conclusion: When symptomatic bradyarrhythmias or hypotension is detected in the patients who admitted with dizziness, syncope, gastrointestinal symptoms or signs, without history of cardiovascular disease, mad honey poisoning possibility should be considered as the etiology and the history should be deepened as well.

Keywords: Mad Honey, Bradycardia, Hypotension

P-0600 Toxicology

Effects of Malathion in Fetal Kidney Tissues in Pregnant Rats: Teratogenic Effects Induced by Different Doses

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The aim of this study was to investigate the teratogenic effects of Malathion (ML) induced by different doses on fetal kidney tissues in pregnant rats. A total of 28 Sprague-Dawley pregnant rats were randomly divided into 4 groups of 7 rats each. Depending on ML dose, four groups were formed, including (I) control, (II) ML 2.5 (ML 2.5 mg/kg/day, orally), (III) ML 5 (5 mg/kg/day, orally), and (IV) ML 10 (10 mg/kg/day, orally). ML application started when the male and female were put together (when mating started). Daily ML application was continued until birth. It was determined that in parallel with dose of ML, ML resulted in toxic effects on serum enzymes (acetyl-cholinesterase (AChE), amylase and lipase) and kidney tissues of pregnant rats, and also -regardless of ML dose in fetal kidneys- it led to teratogenic effects in all the doses. Biochemical data was confirmed by histopathologic data. We concluded that ML leads to kidney damage in both pregnant and fetal rats as a result of its teratogenic and toxic effects.

Keywords: Fetus, Pregnant rat, Organophosphate, Prenatal exposure, Teratogenic effect

P-0601 Toxicology

Protective Effects of Intralipid and Caffeic Acid Phenethyl Ester (CAPE) on Hepatotoxicity and Pancreatic Injury Caused by Dichlorvos

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Aims: To investigate the protective effects of Caffeic Acid Phenethyl Ester (CAPE) and intralipid (IL) on the hepatic and pancreatic injuries in rats caused by the toxic effects of acute Dichlorvos(D).

Study design:Animal experimentation.

Methods: Forty-eight Wistar Albino rats were randomly divided into 7 groups. The groups included control, D, CAPE, intralipid, D+CAPE, D+IL, and D+CAPE+IL.

Results: Compared with the control group, D caused a decrease in total oxidant status (TOS) and a decrease in total antioxidant status (TAS). Also, compared to the D group, TAS was higher in D+CAPE, D+IL, and D+CAPE+IL groups. Biochemical results were confirmed by histopathologic examinations. The administration of CAPE following D decreased mitotic density and caused regenerative changes. In the D+IL group, relative decrease in the mitotic density and regenerative changes were observed. Immunohistochemical examinations revealed that D led to increased hepatic apoptosis and that the D+CAPE and D+IL groups had lower apoptosis compared to the D group. In histopathologic examination of pancreas, the D group revealed intralobular and interlobular lymphocytic infiltration and pancreatic parenchymal necrosis around the pancreatic parenchyma. In the CAPE+IL group, the pancreatic issues were almost normal and presented with benign congestion and edema formation.

Conclusion: The results of our study indicate that CAPE and IL can prevent the hepatic and pancreatic injuries caused by the D by means of their antioxidant effects. Therefore, it was determined that CAPE and IL can be used as supportive therapy or as facilitators for the therapeutic effect of the routine treatment in the patients presenting with acute pesticide poisoning.

Keywords: Dichlorvos, CAPE, hepatotoxicity, pancreatic injury, oxidative stress

P-0602 Toxicology

Protective Effects of Intralipid and Caffeic Acid Phenyl Ester (CAPE) on Hepatotoxicity Caused By Glyphosate isopropylamine

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Aims: To investigate the protective effects of Caffeic Acid Phenethyl Ester (CAPE) and intralipid (IL) on the hepatic injuries in rats caused by the toxic effects of acute Glyphosate isopropylamine (GI).

Study design:Animal experimentation.

Methods: Forty-eight Wistar Albino rats were randomly divided into 7 groups. The groups included control, GI, CAPE, IL, GI+CAPE, GI+IL, GI+CAPE+IL.

Results: Compared with the control group, GI caused a decrease in total oxidant status (TOS) and a decrease in total antioxidant status (TAS). Also, compared to the GI group, TAS was higher in GI+CAPE, GI+IL, and GI+CAPE+IL groups. Biochemical results were confirmed by histopathologic examinations.

Moderate toxicity was found in the hepatocytes in the GI group. (The cytoplasm was present with hyper eosinophilia or vacuolization, condensed pyknotic nuclei, loss of intercellular attach-



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ments, and inflammation or necrosis.) Toxicity was also moderate in the GI+CAPE group, and toxicity was significantly corrected in the GI+IL and GI+CAPE groups. Immuno histochemical results revealed that hepatic apoptosis increased in the GI group, and the apoptosis level was significantly lower in GI+IL, GI+CAPE, and GI+IL+CAPE groups compared to the GI group. It was found that CAPE and IL are capable of preventing the hepatic and pancreatic injuries caused by GI by means of their antioxidant effects. Therefore, it can be concluded that CAPE and IL can be used as supportive therapy or as facilitators for the therapeutic effect of the routine treatment in the patients presenting with pesticide poisoning.

Keywords: Glyphosate isopropylamine, CAPE, Intralipid, hepatotoxicity, oxidative stress

P-0603 Toxicology

Effects of Quercetin and Coenzyme Q10 on gentamicin-induced nephrotoxicity in rats

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Aim: We investigated the effects of Quercetin and Coenzyme Q10 antioxidant, on gentamicin-induced renal failure in rats.

Materials-Methods: The rats were given gentamicin (100 mg/kg/day, i.m., once a day), gentamicin (100 mg/kg/day, i.m., once a day) + Quercetin (15 mg/kg i.p. once a day) and gentamicin (100 mg/kg/day, i.m.) + Coenzyme Q10 (8 mg/kg i.m. once a day). The study was made in the year of 2008 and in the Çukurova University Medical Sciences Experimental Search and Application Center.

Results: In control the BUN value was 26.8 ± 0.8 (mg/100 mL); whereas, it was 117.3 ± 15.4 in gentamicin group ($p < 0.05$). Renal histopathologic examination confirmed acute tubular necrosis in this group. In rats treated with gentamicin + Quercetin and gentamicin + Coenzyme Q10, a partial improvement in biochemical and histologic parameters was observed. BUN values were 117.3 ± 15.4 , 44.0 ± 8.3 , 47.8 ± 13.8 in gentamicin, gentamicin plus Quercetin and gentamicin plus Coenzyme Q10 treated groups, respectively ($p < 0.05$). The gentamicin group produced three remarkable nephrotoxicity, characterized by a significantly decreased creatinine clearance and increased serum creatinine, blood urea nitrogen (BUN) when compared with controls. Creatinine values were 4.3 ± 0.6 , 0.8 ± 0.1 , 1.5 ± 0.4 in gentamicin, gentamicin plus Quercetin and gentamicin plus Coenzyme Q10 treated groups, respectively ($p < 0.05$).

Conclusion: These results suggest that the administration of Quercetin and Coenzyme Q10 may have a protective effect on gentamicin-induced nephrotoxicity in rats.

Keywords: Gentamicin, nephrotoxicity, Coenzyme Q10, Quercetin

P-0604 Toxicology

Assessment of patients who presented to the emergency department with mushroom poisoning

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Objective: We aimed at assessing the demographic characteristics, complaints at emergency department (ED), laboratory findings and latent phase periods of patients who presented to the ED due to mushroom poisoning and the efficacy of conventional and hemofiltration therapies.

Materials-Methods: The study was conducted on patients who presented to the ED with mushroom poisoning between 2010 and 2012. The demographic characteristics, complaints at ED, latent phases, laboratory findings and treatments of mushroom poisoning cases were evaluated.

Results: The mean age of patients was 38.03 ± 15.96 and 63.8% of them were female and 36.2% were male. The season in which visits occurred most frequently was fall (32.6%). The most frequently seen complaint when presenting to the ED was nausea-vomiting. The AST, ALT, INR and BUN values of those with a latent phase between 0 and 5 hours were significantly lower than the values of those with a latent phase between 6 and 24 hours. In our study, 62% of the patients ($n=36$) were administered stomach lavage and given activated charcoal. We found that 55.2% of the patients had been administered conventional therapy, 37.9% of them hemofiltration and all of them supportive treatment. The AST, ALT and INR values of those who were administered hemofiltration and conventional therapies were significantly higher than of those who received only supportive treatment ($p < 0.01$).

Conclusion: Hemofiltration in combination with conventional therapy seems to be an effective treatment for reducing mortality in cases thought to be mushroom poisoning involving late-acting toxins.

Keywords: Mushroom intoxication, emergency department, hemofiltration

P-0605 Imaging in Emergency Units

Is PA chest radiography safe to diagnosis pneumothorax?

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Objective: A-25 year-old male who developed spontaneous pneumothorax two times within four months was discussed in present study.

Case: A-25 year-old tall and thin male admitted to emergency department with chest pain that began suddenly and spreaded to the left side of neck. On admission without the decreasing sound on the left hemithorax there was no critical signs appearance. Blood pressure was 110/90 mmHg, oxygen saturation 92%; and the other laboratory tests were found normal. Electrocardiogram was detected as sinus rhythm. Posteroanterior (PA) chest radiograph was determined normal. Spontaneous pneumothorax was suspected and thoracic CT was obtained. Spontaneous pneumothorax was diagnosed. But the patient rejected tube thoracostomy

In his history he smoked 20 cigarette/day for seven years. He had a history of spontaneous pneumothorax four months ago either; tube thoracostomy was performed. He experiments body-building exercises and takes oral steroids and amino acid supplementation to develop his muscles.

Conclusion: However, posteroanterior chest radiograph is the first choice for diagnosing spontaneous pneumothorax; it is not possible to determine the real diagnosis every time. In such case thoracic CT should be obtained.

Keywords: Spontaneous pneumothorax, chest radiograph, computed tomography

P-0606 Cardiovascular Emergencies

Acute Coronary Syndrome Due to Sildenafil Citrate Ingestion

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Objective: Sildenafil is the first oral agent which is approved to treat erectile dysfunction. It acts by inhibiting cGMP specific phosphodiesterase type 5 (PDE-5), an enzyme that regulates blood flow in the penis. Myocardial infarction (MI) associated with sildenafil is rarely seen in patients without prior coronary artery disease. Here we presented a case of MI resulting from sildenafil ingestion in a patient without prior coronary artery disease.

Case: 66 year old male patient presented to emergency department with a history of chest pain and syncope. He had no medical history or drug use beforehand. In his vital signs, blood pressure: 110/80 mmHg, pulse rate: 70 bpm. Neurological examination, respiratory system and abdominal examinations were normal. In his ECG, ST elevation was identified in inferior (DII-DIII and aVF) derivations. Looking closely at his history it was found out that he ingested 100 mg sildenafil citrate 4 hours before. The patient was admitted to coronary intensive care unit with the diagnosis of acute coronary syndrome associated with sildenafil.

Conclusion: PDE-5 enzyme inhibited by sildenafil is in bowel smooth muscles, thrombocytes and chondrocytes apart from vein and corpus cavernosum smooth muscles. As side effects headache, flushing, gastrointestinal symptoms, nasal congestion, visual disorders and hypotension can be seen. Also acute MI, periarthritis and death were rarely reported. Taking into consideration the epidemiological features of coronary artery disease and erectile dysfunction, the incidence of known or unknown coronary artery disease in males with both diseases is quite high. So before suggesting sildenafil it should be determined whether the patient is coronary artery disease free. Also it should be researched whether the stress associated with sexual activity can be tolerated as nitrates are contraindicated.



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Keywords: Acute Myocardial Infarction, Chest Pain, Sildenafil

P-0607 Toxicology

Symptomatic bradycardia and hypotension secondary to topical testosterone

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Objective: Testosterone is responsible for occurrence of secondary sex characteristics in men and so many events such as the regulation of metabolic processes in the muscle, bone, bone marrow (erythropoiesis), the immune system and brain with anabolic effects. Besides these, it has also potent effects in libido and sexual desire. In this paper, symptomatic bradycardia occurred due to topically testosterone used for erectile dysfunction in young male patient with liver transplant was presented.

Case: A 35 year old male patient was admitted to the emergency department with one hour ongoing dizziness, fatigue, nausea and feeling of evil. Patient was conscious, oriented, and cooperative and his arterial blood pressure was 80/50 mmHg, pulse rate: 45 / minute, fever: 36.7 ° C, respiratory rate: 18 / min. The electrocardiogram (ECG) was present in sinus bradycardia. We learned that he had liver transplantation due to liver failure secondary to chronic hepatitis B six months ago. He was still receiving immunosuppressive therapy. Also he said that he has used a cream containing testosterone for erectile dysfunction for the first time, and after 10 minutes than using cream, dizziness, nausea, feeling of evil occurred. Patient was monitored and oxygen 4 L / min by nasal cannula was started. The patient was assessed as symptomatic sinus bradycardia and 1 mg of atropine was administered intravenously. Control of ECG were within normal limits, arterial blood pressure: 110/70 mmHg, pulse rate: 68 / min. The patient was discharged without further complication after followed up for 8 hours in the observation unit.

Conclusion: It is known that usage of topical testosterone with high doses and long-term cause fluid retention, hypertension, vasodilation, dyspnea and edema especially in patients with heart failure, chronic liver failure or chronic renal failure. However, rarely as in our case, bradycardia and hypotension could be occurred secondary to topical testosterone usage. Transdermal or topical medication should always be questioned in patients with symptomatic bradycardia and hypotension.

Keywords: topical testosterone, bradycardia, hypotension

P-0608 Imaging in Emergency Units

An interesting gunshot wound

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Objective: In both developed and developing countries, gunshot injuries are on a rise. Neck and head injuries can cause bad consequences. Rarely, there are some cases that no vital sutures are injured. We present a case of gunshot injury to the neck.

Case: A 39 years old patient was brought to the emergency room with gunshot wounds and be assaulted. The patient's general condition was moderate and conscious, oriented cooperative. GCS score was 13 and he has multiple depressed fracture of the cranium. Physical examination the patient has 1 cm ecchymotic skin defect under his left eye. Another finding of firearms or entry and exit holes could not be determined. The cranial and cervical CT side stepped the lead entering the bottom of the left eye in the front part of the C1 vertebra bone was observed adjacent to the stand. The bone structures and the spinal cord was normal. Compression was not available. The patient was admitted to the neurosurgical intervention for elevation of depressed fracture of the skull. C1 vertebra in front of the bullet did not intervene. Overall condition of the patients was recovering from neurosurgery wards after 1 week and discharged with a cervical collar.

Conclusion: If hemodynamically stable patients with gunshot wounds, a careful physical examination and further investigations should be carried out.

Keywords: gunshot, cervical, trauma

P-0609 Imaging in Emergency Units

Bilateral rectus sheath hematoma diagnosed with point-of-care ultrasonography in emergency department

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Objective: Rectus sheath hematoma (RSH) is a rare condition in emergency department (ED) and may mimic many important clinical conditions such as acute abdomen. Emergency bedside ultrasound can shorten length of hospital stay and lower patient management costs. In this study we reported a bilaterally RSH case diagnosed with emergency bedside ultrasound imaging.

Case: A 20-year old man was admitted to ED with acute abdominal pain after heavy exercise. He remarked neither chronic illness nor anticoagulant medications but recently he had heavy physical activities. His vital signs were BP: 120/70 mmHg, pulse rate: 96/bpm (regular), temperature: 36.7 °C, SaO₂: 98 % and respiratory rate: 12/per minute. In physical examination there was tenderness and rebound in lower quadrants bilaterally but any other abnormality could not have been detected. A hypo-echoic view was detected in bilateral insertion regions of rectus abdominis muscle by emergency physician with bedside ultrasound scanning. It was pre-diagnosed as bilaterally RSH and the diagnosis was confirmed by radiologist. Patient was proposed to rest and discharged with oral analgesic prescription after one hour from admission any other laboratory and/or imaging test was not needed.

Conclusion: Emergency physicians must evaluate abdominal pain attentively and consider a broad spectrum of clinical conditions. While conventional diagnostic procedures such as history and physical examination are essential, laboratory tests are indispensable, also. However, proper and timely assessment of imaging techniques -such as point of care ultrasonography in ED- may result in favorable decisions, vice versa.

Keywords: Rectus hematoma, emergency department, ultrasound

P-0610 Imaging in Emergency Units

Traumatic Longitudinal Clivus Fracture: A Case Report

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Introduction: Clivus fractures are highly uncommon and classified as longitudinal, transverse, and oblique. Longitudinal Clivus fractures have a special risk of causing entrapment of the basilar artery and thus ischemia of the brainstem, so mortality is higher. In this study, we aimed to present radiologic and clinical characteristics of a patient who was detected to have longitudinal clivus fracture.

Case: In this case report, we presented radiologic and clinical features of a 32 year old male patient who was detected to have longitudinal clivus fracture after severe head trauma.

Conclusion: Diagnosis of clivus fracture may be made easily and reliably with high-resolution bone window imaging.

Keywords: Clivus fracture, Head trauma, Computed tomography

P-0611 Toxicology

Dermal exposure of herbicide causing burn like lesions

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Introduction: Here we present a case with dermal erythema and bulla caused by spraying herbicides.

Case: A 42-year-old male farmer was admitted to emergency department with complaints of itchy dermal lesions. He had sprayed a herbicide named Atlantis WG(R) in a windy day. The



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chemical was spread to his shirt and this was followed by swelling of skin in abdominal, lumbar and back areas. He was conscious, cooperative, with normal vitals as follows: BP: 130/70 mm/Hg; pulse rate: 96/min; resp. rate: 16/min, O₂ saturation: 98%. Physical exam revealed diffuse erythema and bulla in the upper body regions including arms of which majority was in the trunk. There was no other pathology in systems examination. He had no cholinergic symptoms. His blood tests including biochemical parameters, serum pseudocholinesterase level, blood gas analyse and complete blood count were all normal. The patient was hospitalized and consulted with dermatology. He was started local wound care and discharged in the second day. **Conclusion:** Atlantis WG is a herbicide containing %3 Mesosulfuron-methyl and 0,6% Iodosulfuron methyl-sodium. There is no published data about overdose or exposure of this chemical to our knowledge. This herbicide may cause burn like lesions in the skin due to irritation.

Keywords: Herbicide, dermal exposure, skin lesions

P-0612 Cardiovascular Emergencies

Can We Use Red Cell Distribution as a Marker of Mortality in Acute Myocardial Infarctus?

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Objective: Red cell distribution width (RDW) is elevated in ischemic diseases and it is reported that this elevation is associated with mortality in this process. In this study, it is aimed to investigate the place of RDW in the diagnosis of myocardial infarction and short-term effect on mortality in the patients presenting with chest pain.

Materials-Methods: The study was performed retrospectively between 1 July 2013 - 31 December 2013. Age, gender, RDW level, the affected cardiac region, and cardiac mortality levels of the patients with chest pain who were included in the study were examined. Data were analyzed with SPSS version 18 for Windows. In the descriptive statistics of data; mean, standard deviation, and frequency ratio values were used. In the analysis of quantitative data, Mann-Whitney U test was used. Results were evaluated at 95% confidence interval, significance were evaluated at p < 0.05.

Results: The median age of patients with AMI was 69 (Range = 65) and 230 of whom (68.9%) were male) in the study. Red Cell Distribution Width was significantly higher in the group with diagnosis of AMI (p < 0.05) (Table 2). The most frequently seen myocardial infarctus type was anterior myocardial infarction (23.8%) whereas hypertension (HT) has been found to be accompanied. Red Cell Distribution Width was significantly higher in the patients who died with a diagnosis of AMI.

Conclusion: As a result, the RDW level, can be considered as statistically significant in patients with AMI and is a parameter that may be associated with mortality.

Keywords: Red cell distribution, emergency, Acute myocardial infarction

P-0613 Toxicology

A Rare Cause Of Severe Bradycardia And Third Degree Av Block: Mad Honey Poisoning

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Objective: Mad-honey intoxication is an unusual incidence due to ingestion of mad honey, made by bees using wild flowers of the rhododendrons and other plants of the Ericacea family. Mad honey poisoning which is caused by Grayanotoxin (Andromedotoxin), is also known to have adverse effects in the cardiovascular system causing various clinical results. In this article, we present a case of third degree av block. This case was referred to emergency room with complaints of nausea, vomiting, dizziness and chest pain which emerged about 30 minutes after consuming honey produced in the Black Sea Region.

Case: 45-year-old female patient presented to our clinic with complaints of syncope two minutes after consuming honey which came from Black Sea Region. She also had vomiting, nausea, dizziness and chest pain. Her blood pressure was 70/40 mm Hg, heart rate was 35/minute. She had no previous history of heart disease or drug use. The EKG showed third degree av block. Parenteral hydration with normal saline was provided. 3 mg of intravenous (IV) atropine was applied. After initial treatment, blood pressure and pulse rate returned to the normal range. The control ECG returned to normal sinus rhythm. Routine laboratory tests, including serum potassium and magnesium level, were normal; and cardiac enzymes were not elevated. Heart rate was 80 and blood pressure was 110/70 mmHg and there were no other specific symptoms left. Consequently, we discharged the patient after 24 hours observation.

Conclusion: The toxic effects of honey poisoning are rarely fatal and generally last for no more than 24 hours. Generally, it causes dizziness, weakness, excessive perspiration, nausea and vomiting, sweating, salivation, loss of consciousness, fainting, blurred vision, chills, circumoral and extremity paresthesia, cyanosis, and convulsions shortly after the toxic honey is ingested. Other symptoms that may occur are low blood pressure or shock, bradyarrhythmia, sinus bradycardia, nodal rhythm, Wolff-Parkinson-White syndrome and complete AVB. Mad honey intoxication must be kept in mind as a possible cause of sudden haemodynamic instability in patients consuming honey imported from endemic areas.

Keywords: Mad-honey, intoxication, third degree av block

P-0614 Cardiovascular Emergencies

Carvedilol Induced Bradycardia

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Objective: Carvedilol is a beta blocker used in hypertension, congestive heart failure, left ventricular failure following myocardial infarction. Carvedilol is contraindicated in severe bradycardia (<50atm/dk.). Elimination half-life is 6-10 hours. In this case, we report a 75 year old male patient admitted to the emergency department because of dizziness and heart rate 35 per minutes.

Case: 75 year old male admitted to the emergency department with dizziness for two days. He was taking acetylsalicylic acid 100 mg po, carvedilol 6,25 mg po and digoxin tb due to heart failure and coronary artery disease. His vital signs were blood pressure of 100/60 mmHg, heart rate of 35/minute. When admitted to emergency department, he was oriented and cooperative, GKS:15. His physical examination was normal, neurological examination and cerebellar tests were normal. He had atrial fibrillation in ekg and heart rate was 35/minute (figure:1-2). Routine laboratory tests were normal. He was consulted to cardiology. His echocardiography showed ejection fraction: %50 and mitral failure. He was evaluated as atrial fibrillation with low ventricular response, induced by the use of beta-blockers. Outpatient cardiology control was recommended. The patient was monitored for about 24 hours in emergency department. He was discharged with blood pressure:120/70 mmHg, heart rate:64 beats per minutes and recommended to stop using carvedilol.

Conclusion: In addition to detailed neurological examination, elderly patients with comorbid diseases and history of multiple drug use, should be questioned and examined with regard to cardiac pathology. For every patient admitted to the emergency department with dizziness, it is important to have electrocardiography done.

Keywords: Carvedilol, dizziness, bradikardia

P-0615 Toxicology

Syncope Related to Carbonmonoxide Poisoning after Narghile Smoking: Case Presentation

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Narghile has been used commonly by the elderly in the last 400 years and by younger population since 1980's. Carbonmonoxide poisoning in Narghile smokers is very rare. In this presentation we evaluated two female patients (20 and 21 years old) having carbonmonoxide poisoning after Narghile smoking and presented to the emergency department due to syncope. Their carboxyhemoglobin levels were 26.5 and 21.4 respectively. Narghile smoking became very popular especially in young population in the last decade. Carbonmonoxide poisoning rate with nonspecific symptoms also increased in proportion with this increase. In this presentation, we wanted to remind carbonmonoxide poisoning in young patients admitted to emergency department with nonspecific symptoms.

Keywords: Narghile smoking, poisoning, carbonmonoxide



POSTER PRESENTATIONS

P-0616 Toxicology

Toxic hepatitis caused by malva sylvestris

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Objective: A fulminant case caused by malva sylvestris was discussed in present study.

Case: A 40 year-old female admitted to our ED with unconscious. She had vomiting, nausea and stomach for last two days. In her history, she have eaten malva sylvestris two times per a day during four days. She Levotiroksin 50 µg 101 due to hypothyroiditis. An admission, she was unconscious, but could be awakened by giving pain (stupor). Blood pressure was 10/70 mmHg, pulse 106 beath/min, breathing rate 17/min, fever 38.2°C, and oxygen saturation was 95%. A tenderness was obtained at upper right quadrant, and crepitan rakes was obtained at bilateral hemithorax. Laboratory Results: WBC 16300/µ, AST 3076 U/L, ALT 1960 U/L, ALP 24 U/L, GGT 01 U/L LDH 920 U/L, Ammonia 220 ug/dl, Total Bilirubin 20 mg/dl (indirekt Bilirubin 15.4 mg/dl), Na:123 mmol/L, K+:2.9 mmol/L, Cl 81 mmol/L, and Ca 6.9 mg/dl, CRP 29 mg/l, and INR was 2.9. hepatitis marker were measured as normal. No abnormality was obtained in abdominal USG. The patient was diagnose toxic (fulminant) hepatitis that caused by malva sylvestris eating. She was hospitalized to intensive care unite and was reported as liver transplantation candidate. Liver transplantation was performed within four days. Three days after transplantation she was initiated eating.

Conclusion: It is important for emergency staff to investigate the beet consumption for patient coming from urban area with acute toxic hepatitis.

Keywords: Toxic hepatitis, malva sylvestris, liver transplantation

P-0617 Cardiovascular Emergencies

Kounis Syndrome Resulting From Anaphylaxis To Diclofenac Sodium

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Objective: "Kounis syndrome" refers to acute coronary syndromes of varying degree (myocardial ischaemia to infarction) induced by mast cell activation as a result of allergic and anaphylactic reactions. It is also known as "allergic angina syndrome" or "allergic myocardial infarction". We present a case of a patient who developed Kounis syndrome as a result of anaphylactic reaction to "Dicloron" Diclofenac sodium (DS) which is widely used in the emergency departments as intramuscular pain killer.

Case: A 54 year old man with severe back pain was admitted to our emergency department. The patient had history of coronary artery disease, and hypertension. He had no history of allergy to any drug. In his physical examination on arrival, the blood pressure was 140/90 mmHg, pulse:95/min., fever:37 degrees centigrade, breathing: 18/min, saturation:98%. Apart from tenderness in intrascapular region his physical examination was normal. The ECG and laboratory tests were also normal. The patient was diagnosed as myalgia and hence DS 75mg, (Voltaren 75 mg/3 mL Ampul; Novartis, Stein-AG, Swiss) was admitted intramuscularly for pain management. Immediately after the injection the patient collapsed. His blood pressure fell to 50/30 mmHg, pulse was 145/minute and he developed urticaria and mucous membrane edema. He was diagnosed as having anaphylactic shock. Adrenaline 0.3mg and pheniramine maleate 45.5mg (Avil 45.5 mg/2mL; sandoz, Kurtkoy, Istanbul Turkey) were administered intramuscularly. Intravenous fluid administration was started and vasopressor support was given. His laboratory results after the incident showed a seven fold increase in Troponin levels (from 0.02 ng/ml to 1.40 ng/ml) also an increase in CK-MB (from 15 ng/ml to 68 ng/ml) and AST levels (from 16 U/L to 44 U/L). There were no changes in his ECG findings. Cardiology consultation was sought immediately. His echocardiography showed an EF of 25% and global hypokinesia of the left ventricle. The patient was diagnosed as Kounis Syndrome resulting from anaphylaxis to DS. Emergency cardiovascular intervention was not found necessary and he was put on medical treatment. After 36 hours of hospitalisation the patient was discharged with normal vital signs.

Conclusion: DS which widely used in the ED as intramuscular pain killer has been known to cause anaphylaxis. Physicians should be aware of such a complication to make a prompt diagnosis and initiate an early treatment. We recommend that ECG and cardiac markers tests should be done in all patients developing hypersensitivity reactions.

Keywords: Diclofenac sodium, Kounis Syndrome, Anaphylactic shock, Myocardial ischemia

P-0618 Toxicology

A Case of Latrodectism Complicated With Acute Myocarditis

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Objective: Latrodectism is the syndrome caused by the bite of the black widow spider and related species. Severe pain, muscle rigidity, diaphoresis are the hallmarks of latrodectism. Myocarditis can be occurred following black widow envenomation. Chest pain, an abnormal electrocardiogram (ECG), and elevated serum troponin can be considered as the findings of myocarditis. Here, we describe a case of a 60-year-old male with severe chest and back pain result from spider bite complicated by myocarditis.

Case: A healthy 60-year-old man was brought to the emergency department (ED) by his relatives. He suddenly declared severe chest, back and abdominal pains that rapidly spread to the lower extremities accompanied by cramping myalgia and sweating. He was looking seriously ill. His vital signs were as follow: blood pressure, 170/90 mm Hg; pulse rate, 110/min; respiratory rate, 18/min and temperature, 37°C. Firstly, myocardial infarction with ST elevation or aorta abdominal dissection was considered in the differential diagnosis. The initial electrocardiography (ECG) was normal except sinus tachycardia. The Computed tomography (CT) of Thorax angiography was normal. There was no dissection. Shortly thereafter his relatives found a slightly crushed black spider (figure-1) in the patient's athlete in the CT room. His detailed physical examinations were normal except some red spots on his left back at the level of the sub-region of scapula (figure-2). This lesion was considered as target lesion. Symptomatic treatment was began for severe chest, back and leg pain. His initial laboratory findings were normal. Antivenom could not be given because it was not in our hospital. Morphine and diazepam were made for severe pain. Tetanus prophylaxis was performed. Initial laboratory findings were normal. His control ECG revealed augmentation in T-wave amplitude in precordial leads without reciprocal changes (figure-3) and cardiac biomarkers (CK, CK-MB and Troponin -I) were high after the twelfth hour of admission to the ED. Cardiology consultation was requested in terms of myocarditis. His echocardiographic examination result was normal and so coronary angiography was not performed. He was given supportive treatment, and throughout 72-hour stay in the ED, his symptoms subsided. During follow up, increase in T wave amplitude returned to normal. His cardiac biomarkers returned to normal limits, and he was discharged home without any complications.

Conclusion: More severe envenomations can result in agitation, nausea, hypertension, tachycardia, and muscle cramps. Myocarditis following black widow envenomation is very rare and can be fatal. And so, in addition to symptomatic treatments, we recommend serial ECG and cardiac biomarkers follow-up for every patient bitten by black widow spider for potential cardiac damage.

Keywords: Latrodectism, Black widow spider, myocarditis

P-0619 Toxicology

Retrospective analysis of suicide attempt with analgesic drugs

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Objective: Socio-demographic characteristics of patients who attempted suicide with analgesic intake and the types of the analgesics taken were examined retrospectively in this study.

Materials-Methods: Files of two hundred and one patients found out to apply to emergency rooms after taking analgesics in suicidal attempts between 2004 and 2011 were examined retrospectively. Demographic characteristics of patients, time of application, period till application, intervention in the emergency room, type of the analgesic taken, intake of multiple drugs, and whether or not multiple drugs were taken were recorded in the form prepared.

Results: It was found out that 201 patients had taken analgesic drugs during the study period. 71.1% of the patients were women; 49.3% were single, 48.8% were married, and 2% were separated. Majority of the married patients were females (53.1%). The frequency of suicidal attempts in the age range of 15-24 was greater (56.7%). It was found that 156 of the patients attempted suicide to draw attention. It was found that patients frequently applied to the emergency room after taking drugs between 21:00 and 00:00 hours (%18.9). It was also found that the most frequently taken analgesic types were paracetamol and NSAID derivative drugs. Number of suicidal attempts with multiple drugs was greater as compared to the number of attempts with a single drug (%57.7). Together with the intake of multiple drugs, it was found that intake of one type of analgesic was greater as compared to intake of multiple drugs (92.0%). While 103 of the patients were discharged after the intervention in the emergency room, 73 patients were hospitalized in several clinics. 190 patients were diagnosed with impulsive suicide after the psychiatric evaluation (94.5%).

Conclusion: Drug intake is the most frequent method used in suicidal attempts seen in emergency rooms. Frequency of taking analgesics is in the first place among drugs. Among the analgesics, particularly paracetamol and its derivatives including NSAID's appear in the first place in the drug group preferred for suicidal attempts because of their availability.

Keywords: Analgesic drug, retrospectively, suicide



POSTER BİLDİRİLER

P-0620 Cardiovascular Emergencies

From Abdominal Pain To Cardiac Thrombus

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Objective: Renal artery thromboembolism is a serious clinical condition which early diagnosis and treatment is needed. Heart is a source of systemic embolism at 94 % of all patients. In this case we presented 88 years old male with any medical history of chronic disease, admitted to emergency service with abdominal pain and diagnosed intracardiac and left renal artery thrombus.

Case: 88 years old male admitted to the emergency department with sudden abdominal pain since 2 days. His vital signs were as; GCS: 15, pulse rate: 115/min., blood pressure: 100/60 mmHg, body temperature: 37.1 °C, pulse oximetry: % 94. Physical examination revealed; tenderness at all abdomen, tachycardia and arrhythmia and bilateral crepitant basilar rales in lungs. Atrial fibrillation was detected on ECG. His laboratory investigations was: Hb: 13.2 g / dL, haematocrit: 39.7%, platelets: 208x103/dl, WBC: 16.9 x103/dl, glucose: 145 mg / dL, BUN: 26 mg / dL, creatinine: 1.32, Na: 132 mmol / L, K: 4.34 mmol / L, ALT: 41 IU / L, AST: 85 IU / L, amylase: 103 IU / L, PTZ: 13.0 sec (N: 10.5 to 14.5 seconds), aPTT: 27.9 sec (N: 22-34 seconds) and INR 1.19 (N: 0.8-1.2), CK-MB: 5.93 ng/ ml, Troponin T: 46.03 pg/ ml, D-Dimer was 2.39 mg/L. In his urine microscopy: 8-10 erythrocytes, leukocytes 3-5, 5-10 epithelial cells was detected. Abdomen computer tomography was performed due to initial diagnosis of mesenteric embolism. Superior mesenteric artery lumen was open; only a small plaque was seen. But, low attenuation plaque formation which were thought to belong to the left renal artery stenosis in the localization of output in the left kidney causing perfusion defects together with hypodense areas has been reported. Computer tomography of thorax was also performed due to initial diagnosis of pneumonia. This was reported as significant increased cardiothoracic index with left ventricular hypodense appearance that was thought primary thrombus and infiltration of lower lobe of the left lung. He was not receiving anticoagulant therapy and possible source of emboli was considered to be of cardiac origin. In his echocardiography all heart chambers was dilated, there were many thrombus in both atrial and ventricular chambers, aortic and mitral valves were and ejection fraction was %. Patients admitted to the coronary care unit and anticoagulant therapy was started. Conclusion: Admissions of old patients with abdominal pain to the emergency department in some times may be confusing. Clinician may diagnose so rare causes by detailed physical examination and radiological examinations

Keywords: atrial fibrillation, Cardiac Thrombus, renal artery Thrombus

P-0621 Cardiovascular Emergencies

Stroke or Aortic Dissection?

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Objective: Aortic dissection is an emergency clinical situation with high mortality if it has not been diagnosed on time. Patients may be presented with a wide clinical range of symptoms such as syncope, ripping like severe chest pain expanding to back, neurological disorders like hemiparesis, hemiplegia, acute myocardial infarction and acute renal failure. Our case indicates that the diagnosis of the acute aorta dissection (AAA) in patients admitted with neurological complaints without typical annoyances is not surprising.

Case: 55 -year- old male patient referred to our emergency department from a secondary care unit with a sudden paralysis on the right leg of cerebrovascular infarction diagnosis. Sudden severe pain in the right groin and paralysis in the right leg of the patient has begun three hours ago. The patient was half conscious, cooperative and oriented in physical examination but he looked agitated, pale and sweaty due to his pain. His vital findings were TA: 63/24 mmHg, pulse: 86/min, sO2: 97. His past medical history was unremarkable except CABG operation. His heart sounds were deeply audible. There were no pulse deficit in periphery. In his right low extremity, there were decrease in muscle strength, coldness and paleness. Other system examinations were in normal limits and immediately bed side ultrasonography was performed. Aortic root was measured as 40mm and there were pericardial fluid with tamponade findings. Thoracoabdominal Computerized Tomography with contrast enhancement was ordered for patient. In Computed Tomography with contrast, there was an aortic dissection starting from the aortic root and continuing to ascending aorta, arcus aorta and descending aorta and to iliac bifurcation. Besides, pericardial effusion and dense fluid accumulation in mediastinum that might be consistent with hemorrhage. Patient's full blood count, biochemistry and cardiac markers were in normal limits and ecg has revealed sinus tachycardia. Although, he was underwent to the operation immediately, perioperative cardiac arrest had been occurred and patient died.

Conclusion: Diagnosis of AAA in patients with neurological complaints is diagnostics challenge for emergency physicians who must carry a high clinical suspicion. Patients, diagnosed as stroke or myocardial infarction, are faced with both delays in surgical treatment and risk of thrombolytic treatment. In this group of patients, AAA must be hold in mind in the differential diagnosis of the patients. Emergency physicians should remember that the atypical presentations might be related to acute aortic dissection and should be given priorities in diagnosis.

Keywords: Acute Aortic Dissection, Stroke, Hemiplegia

P-0622 Toxicology

A Synthetic Cannabinoid Bonzai; Rarely Cause of Recurrent Convulsions

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Objective: Bonzai is a kind of a new generation of synthetic cannabinoids. Recently it is spreading rapidly in our country and around the world. Even if it is very dangerous and the risk of death at one time can create. All of the common side effects are the same as synthetic cannabinoids.

Clinical presentations following the use of synthetic cannabinoids have included agitation, anxiety, emesis, hallucinations, psychosis, tachycardia, and unresponsiveness. Convulsions due to synthetic cannabinoids are very rare.

Especially; after use of synthetic cannabinoid, recurrent convulsions have not been reported. We describe a patient who had witnessed recurrent generalized convulsions soon after smoking "bonzai"

Case: A 25-year-old male in his normal state of health had a witnessed generalized 1 to 2-min convulsion. He had a diagnosis of epilepsy but he had no history of convulsions for 8 years and he had no history of drug use. Initial vital signs were: pulse, 112 beats per minute; respirations, 22 cycles per minute; temperature, 36.8°C; and blood pressure 168/92 mmHg. After 10 minutes admitted to emergency department (ED), the patient vomited and soon afterward had a second generalized convulsion that was treated with midazolam. In laboratory tests complete blood count, chemistry values were normal. An electrocardiogram was normal including no QRS nor QT interval prolongation. A noncontrast computed tomography of the brain were normal. The blood ethanol concentration was 0 mg/dL. After 1 hour admitted to emergency department he had a third generalized convulsion. The patient was consulted neurology specialist and he was loaded phenytoin. The patient was under observation in the emergency department. After 8 hours observation, he regained consciousness and remained asymptomatic without any intervention. After the patient regained consciousness he admitted that bonzai use. Recurrent convulsions associated with the use of the bonzai and he was discharged after a 16 hour observation.

Conclusion: Recreational use of synthetic cannabinoids is a very recent phenomenon and there is a very limited literature detailing the associated complications including convulsions. As a summary recurrent convulsions have only rarely been associated with synthetic cannabinoids but the use of synthetic cannabinoids should not be forgotten among the reasons of recurrent convulsions.

Keywords: Synthetic Cannabinoid, Bonzai, Recurrent Convulsions



POSTER PRESENTATIONS

P-0623 Cardiovascular Emergencies

Pacemaker inserted of a digoxin poisoning cases: A case report

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Objective: Digoxin is a cardiac glycoside used for the treatment of heart failure and/or atrial fibrillation. Indirectly with the moderate parasympathetic activation and directly by influencing the atrioventricular node it causes a decrease in heart rate. The safe range of digoxin level in blood is narrow. Toxicity usually occurs due to the chronic use. In case of digoxin toxicity nausea, blurred vision, double vision, seeing objects in yellow and green colours, seeing a white halo (light) around objects, photophobia, diarrhoea, headache, uneasiness, fatigue, delirium, confusion, hallucinations, agitation, muscle weakness, bradycardia, blocks in varying degrees have been observed. Moreover, syncope, which might result from AV block and serious heart rate decrease, can lead to ventricular tachycardia and ventricular fibrillation and in this way cause death as well.

By submitting this case presentation we wanted to remind again that this disease should be kept in mind.

Case: A 82 year old female patient admitted to the Emergency with complaints of nausea, vomiting and fainting. According to the information received from the patient, who suffered from heart failure in advanced stage and arrhythmia, nausea, vomiting and diarrhoea started few days before and soon after standing up fainting occurred as well. When the patient admitted to the hospital, her arterial blood pressure value was recorded as 70/40 mmHg, heart rate as 40 beats/min; during medical interview patient's green-yellow vision was found. In the ECG performed of heart rate was evaluated as 40 beats/min and arterial fibrillation as QRS <100 ms and insert a pacemaker in order to maintain hemodynamic stability. When questioned about taken medications, the patient indicated digoxin and it appeared that she suffered from AF rhythm as well. Tests made due to the initial diagnosis of digoxin intoxication showed normal level of complete blood count and biochemical test and digoxin level of 3.2 ng/ml. Patient with a diagnosis of digital toxicity was admitted to the coronary care unit and as no other problem appeared, she was discharged from the hospital on the 5th day of hospitalization.

Conclusion: Despite the fact that it does not happen often, when diagnosed because of its typical symptoms it should not be neglected, otherwise it will obviously have fatal consequences. As long as digoxin usage is not ceased it does not require a treatment, however it should be kept in mind that it may be necessary to insert a pacemaker in order to maintain hemodynamic stability.

Keywords: Digoxin intoxication, emergency service, pacemaker

P-0624 Cardiovascular Emergencies

De Winter: A Vital Sign As ST Elevation

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Objective: ST segment elevation myocardial infarction (STEMI) is one of the well-known indications of urgent percutaneous transluminal coronary angioplasty (PTCA) and one of the most common reasons of non-traumatic deaths. The electrocardiography (ECG) of patients arriving emergency department (ED) with chest pain should be evaluated carefully and patients with PTCA indications should be identified. De Winter ECG, the signs of left main coronary artery (LMCA) occlusion, is a STEMI equivalent. These equivalent conditions require urgent diagnosis and treatment just like STEMI. In this case, we aimed to present a patient given to PTCA with De Winter signs.

Case: A 56 years old male patient was admitted to emergency department with an hour long pressure-like chest pain. The patient did not report any feature than hypertension about her medical history. Physical examination did not show any pathological signs. The patient's initial values were found to be following; blood pressure: 80/50mmHg, heart rate: 94/min, oxygen saturation: %91. Patient with resistant hypotension was suspected to have acute coronary syndrome (ACS), acute pulmonary thromboembolism and aortic dissection as preliminary diagnosis; however, since the patient was unstable, he was not transferred to computer tomography. In ECG, there were an incomplete Right Bundle Branch Block, upsloping ST segment depression with tall, positive, symmetrical T waves in inferior and chest derivations, also 1.5 mm ST elevation in aVR. With these signs, De Winter ECG was considered. Cardiology consultation was requested, bed side echocardiography was performed, but it was normal. The patient was given to PTCA with preliminary diagnosis of LMCA occlusion by almost entirely De Winter ECG. The patient had cardiac arrest in the angiography laboratory. Coronary angiography accompanied with cardiopulmonary resuscitation (CPR) showed that LMCA was totally occluded, balloon was performed and thrombolysis in myocardial infarction (TIMI) 1 flow was obtained. Patient was transferred to cardiovascular surgery for coronary artery bypass graft (CABG). After CABG, inotropic agent supplement was started and intraortic balloon pump was placed. Despite this, sufficient blood pressure was not obtained. Patient was connected extracorporeal membrane oxygenation (ECMO). Patient was observed in the intensive care unit (ICU) for two days and he died in the second day of ICU.

Conclusion: Early diagnosis of STEMI equivalents like De Winter, increases survival. Therefore, it is extremely important for ED doctors to develop their ECG knowledges and to be careful during ECG evaluations.

Keywords: De-Winter ECG, STEMI equivalents, urgent PTCA indications

P-0625 Cardiovascular Emergencies

Peripartum Cardiomyopathy: Case Report

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Objective: Pregnancy causes anatomical and physiological changes, resulting pulmonary and cardiovascular failures. As a result of these, peripartum cardiomyopathy (PPCMP), heart failure symptoms and left ventricular dysfunction are course of a rare cardiac failure. Below, two patients admitted to emergency service with symptomatic postpartum asphyxia after 7th and 10th days, are discussed.

Case 1: A 27-year-old female admitted to emergency service complaints of asphyxia, swollen legs and orthopnea. Her symptoms were started a week after C/S birth. Patient's condition was fair, tension 110/70mmHg, pulse 119/min and respiratory rate was 20/min. On the physical examination, heart was rhythmic but a 1/6 mitral systolic heart murmur was detected on cardiac auscultation. There were fine crackles in both lung bases. The clinical inspection and palpation revealed unilateral 3+ edema in her legs, Homans' negative.

Laboratory tests didn't indicate any pathologies. On patient's chest X ray, common congestions were presented at both middle and lower lung zones. In the echocardiography, systolic dysfunction and left ventricular dilatation, also global hypokinesia was detected. Left ventricular EF was 30%. Then, the patient was hospitalized for congestive heart failure (CHF). The patient responded well to treatment, and after three day, she was discharged to be followed up in outpatient clinic.

Case2: A 41-year-old female orthopedic patient was brought to emergency department with significant dyspnea, fear of death and anxiety. The patient had no known medical history but a C/S birth 10 days ago.

The patient was anxious and in serious condition, with the blood pressure 90/60 mmHg, pulse 124/min, respiratory rate 25/min and SaO₂ 90 %.

Pulmonary auscultation confirmed bilateral lung and coarse crackles on the middle zones. She had 3+ pretibial edema. Initial electrocardiogram showed sinus tachycardia. Left ventricular dilatation, septal hypokinesia and EF of 35% at rest was detected in echocardiography. CHF patient was discharged on postoperative 12th day.

Conclusion: PPCMP may also develop during pregnancy, prenatal or in the first 5 months of postpartum periods without previous cardiac pathology. Inflammatory processes are thought to be important in PPCMP pathogenesis. Signs and presentation play roles in diagnosis and treatment. Conventional treatment options are used effectively in CHF. Over half of the PPCMP patients respond well to medications although some may progress to dilated cardiomyopathy. Cardiac transplantation, supportive mechanic devices, immune-modulators and antiviral agents are some alternatives for treatment-resistant cardiomyopathy patients. Minding PPCMP is vital, for emergency department doctors for differential diagnosis of dyspneic post-partum patients.

Keywords: pregnancy, postpartum, peripartum cardiomyopathy



POSTER BİLDİRİLER

P-0626 Cardiovascular Emergencies

Recognition of arrest patients and application of basic life support by bystanders in the field

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Objective: Th Recognition of arrest patients and application of basic life support (BLS) by bystanders in the field and the activation of emergency serves were evaluated in present study.

Materials-Methods: The present study was carried out by Emergency Department of Medicine Faculty of Gaziantep University at 33 of Emergency Health center in Gaziantep between December 2012- April 2014 prospectively. Of 539 arrested patients, 171 patients were included in study.

Results: 118 (69%) male, and 53 31(%) female with a totlay of 171 patients were included in this study. Of patients, 32.2% had syncope and 24% had shorth breathing just befor being arrested. The majority of arrest cases had ocured at home (61.4%) and rural area (11.7%) respectively. Of asking help, %48.5 were constructed by family members. Of announcement, only 15.2% occurred within first minute of arrest. The BLS ratio that was applied by bystanders was 22.2%. Of bystanders, 47.4% had a course experience of BLS. The emergency serve had reached to the field with a mean of 8.43 min. Of cases, 55% (n=94) were evaluated as exitus firstly bu emergency staff. The most noticed rythim was asystol (73.1%). BLS and advanced life support (ALS) were applied to 98.8% and 60% respectively at the field. 10.5% (n=18) of cases were defibrilated, and 45 (26.3%) were intubated endotrecealy. The majority (48.5%) of staff who applied BLS and ALS at the fied were emergency medicine technicians. CPR was performed to 86.5% (n=148) cases in ambulance while they were transported. The mean arrival time to mergency department was 9.13 min. When the patients arrived to ED 15.2% needed defirilation. 91.2% (n =156) of patients resulted in exitus in ED. 15 (8.8%) patients were discharged (9 with recovery, six patients with damage).

Conclusion: The ratio of inntervention for arrest patients by bystanders is still low. To obtain a high percentage of survival, BLS training should be widened among the puplic especiallyamong the caregivers.

Keywords: arrest patients, basic life support, bystanders, field

P-0627 Toxicology

Cerebral Hypoxic Brain Damage Due To Carbon Monoxide Intoxication

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Objective: Carbonmonoxide (CO),the most common cause of accidental poisonings, is a colorless, odorless,tasteless and non-irritant gas produced by incomplete combustion of carbonaceous material.As a result of poisoning,various symptoms in the brain, heart,kidney, skeletal system, skin, peripheral nerves due to hypoxia may occur.In this case,we want to offer the patient with acute cerebrovascular disease resulting from CO poisoning.

Case: A female patient aged 71,was brought via ambulance to the emergency department with complaints of confusion and speech disorder.According to the information given by relatives,the patient was living alone at home and was found unconscious in the morning and also it was learned that there was the smell of smoke in the house and the stove had been used to heat.She had no history of neurological deficit or cerebrovascular disease.At the time of admission,blood pressure was 150/70,heart rate 73/min,fever 37.2 C,respiratory rate 22/min and oxygen pulse oximeter 80%,blood gas pH 7.45,PCO2 30mmHg,PO2 75 mmHg,HCO3 22.5mmol /L.Finger-measured blood glucose was 155 mg/dL.ECG was normal sinus rhythm. On physical examination,the patient was disoriented,non-cooperative,slurred. Glasgow Coma Scale was 11 points (E4M4V3) and there was plegia in the right upper extremity and also the patient had a loss of power 3/5 at the right lower extremity.Acute cerebrovascular disease resulting from CO poisoning was considered and carboxyhemoglobin level was found to be 23(normal range 0-5).Subacute infarct, in the region of left temporoparietal,was seen in the computed tomography(CT) imaging of brain.The patient was treated with 100% normobaric oxygen.An hour later,carboxyhemoglobin level was measured as 12.2.The patient could not be transferred to the center where is made of hyperbaric oxygen therapy because her relatives did not accept shipped out of the province.Acute diffusion limitation was detected in the left side of temporoparietal region and the basal ganglia in the diffusion-weighted MR.The patient was transferred to the neurology service.The patient who was treated with enoxaparin and acetylsalicylicacid in the service was discharged on the fifth day of hospitalization with policlinic control recommendations after informing the relatives of the patient.A month later,in the patient's neurological examination, there was no dysarthria and plegia in the right upper extremity and 3/5 power loss in the lower extremities recovered as 2/5 and 1/5,respectively.

Conclusion: CO intoxication should be considered in the differential diagnosis and should be ruled out in patients who were admitted to the emergency services with unconsciousness and neurological sequelae.

Keywords: Carbonmonoxide, Intoxication, Acute cerebrovascular disease

P-0628 Cardiovascular Emergencies

Electrocardiography Changes Due to Contrast Matter: A case report

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Objective: Administration of intravenous and oral contrast matter (CM) for the radiographic imaging is commonly used. Adverse reactions to CM are considered allergy-like, with cutaneous, cardiovascular, respiratory, and gastrointestinal system symptoms.. Many reports of allergic reactions to intravenous CM have been reported; however, there have We present a case of chest pain and common ST depression on the ECG (Electrocardiography) following intravenous contrast.

Case: A 52-year-old women admitted to the general surgery policlinic of another center with complaint of nonspecific abdominal pain in Jan 2014. Computerized abdominal tomography with contrast performed to her for diagnosis. In patient, presyncope, chest pain had developed after infusion of CM. Her tension arteriel (TA) were 80/50 mmHg. Laboratory parametres were normal. There was ST segment depression in D2, avF, V2-6 on her ECG.

On admission to our ED, her vital signs were tension arteriel (TA) of 80/50 mmHg; heart beat (HB) of 75 beats/min; body temperature of 36°C. On her ECG, his normal sinus rhythm was 75/min, and there was ST segment depression in D2, D3, avF, D1, aVL, V2-6 (Figure 1). Her coronary angiography which performed 6 months ago was normal. Her allergy history was unremarkable. Her general status was poor. Patient's Glasgow Coma Scale score (E3M5V2) was 15, her pupils were isochoric and her light reflex was bilateral positive. Other system examination findings were normal. Immediately, she was monitored. Intravenous access was achieved and started bolus isotonic fluid replacement, antihistamine (Feniramin maleat 45.5 mg), steroid (methyl prednisolone 1mg/kg) and histamine-2 receptor blockers (Ranitidine 50 mg) treatment. Patient's general status improved after an hours from her admission. Control TA was 110/70mmHg after 2000 ml fluid infusion. There was not ST depression on control ECG (Figure 2). Creatin cinaz-myocardial band and troponin I levels were normal.

Conclusion: Allergy-like reactions are usually unpredictable. To our knowledge, in the literature there is many case report on allergic drug reaction especially against penicillin group and metazolol. Allergic reactions due to CM may show many forms from urticarial lesions to cardiac arrest. Also, As in our case, this reactions may cause of ECG changes. Early diagnosis and treatment for survival is important.

Keywords: Electrocardiography, contrast matter, emergency department

P-0629 Imaging in Emergency Units

The Assessment Of Distances Of Intramuscular Injection Location From Some Landmarks In The Ssudents Of Muğla School Of Healt Sciences

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Objective: This subject is a confusing matter for intramuscular injection administration in clinical practice. The correct assessment of this situation is important for probable complications. There isn't any research in the literature that assesses the distances of the injection area to some landmarks. This study was carried out to determine these regions more accurately.

Materials-Methods: Intramuscular injection is a commonplace nursing procedure. Although considered a basic technique, it is far from innocuous. Gluteal region muscles are the most



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commonly used region in the practice and the necessary precautions must be taken. -A total of 216 male and female students, from University of Muğla School of Health Sciences, Nursing and Physiotherapy and Rehabilitation Departments were randomly selected and included to the study.

Results: In this study we found that intramuscular injection location in males is 1.87 ± 0.63 cm and in females 2.28 ± 1.01 cm from the upper point.

Conclusion: The research base for intramuscular injection site is limited. We think that these distances will be very valuable in clinical practice in the patient population consisting of 17-29 years of age and who have normal body mass index. This study will be a norm for patients who have a normal body mass index.

Keywords: anatomy, Injection, Emergency service

P-0630 Toxicology

Acute coronary syndrome associated with pine mushrooms

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Objective: Lactarius salmonicolor, lactarius deliciosus ve lactarius deterrimus which are in the Russulacea family are generally called as pine mushrooms in Turkey. They grow after the autumn rains. The mushrooms grow in shade areas are yellow-orange colour, but others which grow in sun-exposed areas are greenish-purplish color. The colour of them could be darker in places where pine trees present. These mushrooms consist of 90 to 95 percent of water, and some symptoms such as nausea, vomiting, diarrhea may occur after the ingestion of them. There are no rules to decide whether a mushroom is poisonous or not. But, the false ideas and beliefs about the mushrooms can lead to serious repeated health problems each year. In this paper, we presented a case developed acute coronary syndrome 24 hours after ingestion of pine mushrooms.

Case: A 36 year old male patient who has not any health problem before had been referred to our emergency department for the purpose of advanced diagnosis and treatment with complaints of sweating, nausea, vomiting and chest pain which started 24 hours after ingesting pine mushrooms collected from nature. The patient's arterial blood pressure was 90/60 mmHg, pulse rate: 90 / minute, respiratory rate: 15 / min, fever: 37.1 C and Glasgow Coma Scale score was 15. ECG showed sinus rhythm, and no pathological findings were detected. Laboratory tests including CK-MB (6.44 ng / dl) and Troponin T (204.3 pg / dL) were positive, and other tests were unremarkable. ECHO were normal and the EF was measured as 60%. The patient was hospitalized according to the cardiology consultation with the preliminary diagnosis of acute coronary syndrome. Coronary angiography was performed in the cardiology clinic in the same day, and no pathology was detected. Patient was followed-up for 4 days with symptomatic supportive therapy and discharged from the hospital with suggestions.

Conclusion: The complaints of the patient such as sweating, nausea and vomiting may probably be attributed to the cholinergic effects of the pin mushrooms. Also increase in cardiac enzymes and chest pain could be occurred according to the fluid deficit and cardiovascular collapse due to the cholinergic effects of these mushrooms.

Keywords: pine mushroom, acute coronary syndrome, mushroom poisoning

P-0631 Cardiovascular Emergencies

Anaphylaxis and Kounis Syndrome after using Amoxicillin and clavulanic acid: Case report

Gökhan Eyüpoğlu, Kerem Dost Bilmez, Mehmet Tatlı, Özlem Güneşel

DR. LÜTFİ KIRDAR KARTAL EĞİTİM VE ARAŞTIRMA HASTANESİ ACİL TIP KLİNİĞİ

Objective: Kounis syndrome is the coincidental occurrence of acute coronary syndrome comprising hypersensitivity reactions associated with allergic or hypersensitivity activation of inflammatory cells.

Case: An 84-year-old man referred to our emergency department with anaphylaxis symptoms after intake of a 1000mg Amoxicillin clavulanic acid tablet. In his history, he had diabetes mellitus, coronary artery disease and hypertension. During his observation, ECG changes and Troponin elevation were detected and he was diagnosed as Type 2 Kounis syndrome. After 24 hours follow-up, he was discharged without any complication.

Conclusion: This case is presented in order to remind a rare but remarkable condition of Anaphylaxis and Kounis syndrome after using a single dose of Amoxicillin and clavulanic acid.

Keywords: kounis syndrome, anaphylaxis, amoxicillin

P-0632 Toxicology

Propafenone intoxication: Cardiac arrest and full recovery

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Objective: Propafenone is a class IC antiarrhythmic drug which has B adrenergic blocking and calcium channel blocking activity, approved for use in patients with life-threatening ventricular and supraventricular tachycardia. In high doses of propafenone, serious complications and also death have been reported in the literature. In our study, we aimed to investigate a case of cardiopulmonary arrest due to propafenone intoxication which is completely healed after the emergency room and intensive care therapy.

Case: A 27-year-old woman ingested about 15 tablets of propafenone (per 150 mg; total 2250 mg) with suicidal intent. Within one hour after ingestion, she was brought to emergency department. On initial evaluation, her heart rate was regular with 72 beats/min and blood pressure was 74/53 mmHg. respiratory rate was 16/min, oxygen saturation was 74% and in the blood gas pH was 7.34. Glasgow coma score (GCS) was 12 (E3M5V4). Other systemic examinations were normal. There was first degree AV block with wide QRS (160 ms) at first electrocardiogram (ECG) and she had sinus rhythm. Rapid sequence intubation was performed due to her superficial breathing after generalized tonic-clonic seizure. Gastric lavage was performed and active charcoal was given. Sodium bicarbonate (NaHCO₃) was applied because of prolonged hypotension and increasing QRS duration. Positive inotropic agents were administered due to refractor hypotension. Ca gluconate and glucagon and also high dose of insulin were intravenously administered. Bradycardia (50/min) has evolved and so atropine and 3% hypertonic saline were applied. After the ninety minutes of aggressive fluid and drug resuscitation, pulseless electrical activity was seen in the patient and cardiopulmonary resuscitation (CPR) was initiated. After a successful resuscitation, at the end of the 30 minutes, the patient's control blood pressure was 92/54 mmHg, pulse was 92/min and she had a rhythm of ECG with the wide QRS complex. The patient was admitted to intensive care unit. During follow up, she was extubated on the fifth day after symptomatic treatment and discharged home on eighth day of hospitalization without any sequelae.

Conclusion: Propafenone has been a drug within easy reach of suicide attempts due to the increasing use in the treatment of supraventricular and ventricular arrhythmias. In the literature, although cardiopulmonary arrest development can be at higher doses, the case of cardiopulmonary arrest due to 2.25 g propafenone intake was significant. With early diagnosis, rapid support and aggressive resuscitation, treatment mortality rate can be reduced.

Keywords: Propafenone, intoxication, arrest, recovery

P-0633 Imaging in Emergency Units

Title. Anatomy of the Cubital Veins in the Antecubital Fossa and its Importance for Intravenous Access

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Objective: This study is conducted to investigate both the anatomic characteristics of cubital veins located in cubital fossa and find the distance of these veins used in intravenous applications to the central point and their angles

Materials-Methods: Peripheral intravenous access is commonly performed in the Emergency Department to collect blood specimens and to provide a route for intravenous medication and fluid administration. Although this procedure is usually performed by nurses, in cases difficult access emergency physicians are often called on to perform this task. -This study was carried out between April and July 2007. Patterns of superficial veins of the cubital fossa were studied in 80 students who male and female were randomly selected and included to the study in School of Health Sciences, Muğla University in Turkey.



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Results: A lot of types of variations arrangements of the cubital veins were found. The commonest type was that the median vein of the forearm divides in the cubital fossa into 2 veins, one of which joins the basilic vein, and the other the cephalic vein.

Conclusion: As a result, it was seen that knowledge and understanding of the variety of regional venous anatomy can be responsible for supporting an efficient intravenous access. Under these circumstances, we achieve an ideal procedure in which the person will not face any problems; otherwise failure would sooner or later be inevitable.

Keywords: Cubital vein, Intravenous access, emergency service

P-0634 Toxicology

Drug-induced acute pancreatitis

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Objective: One of the most common causes of acute pancreatitis are stones in the gall bladder. Drugs used for any purposes are responsible for the 0.3% to 1.4% percent of acute pancreatitis cases. Over 50 kinds of drugs have been reported to lead to acute pancreatitis until now. The exact pathogenesis of drug-induced pancreatitis is not known, but it may be occurred due to allergic reactions or direct toxicity. In this article, we presented a case with pancreatitis which occurred due to multiple drug intake for the aim of drawing attention to this issue.

Case: A 35 year old male patient was brought to our emergency department with complaints of abdominal pain and unconsciousness which developed after the intake of a large number of multiple drug ingestion including doxylamine succinate, paroxetine and clonazepam 10 hours ago. In initial physical examination, the patient was lethargic, his arterial blood pressure was 90/60 mmHg, pulse rate: 82 / minute, and he had abdominal general tenderness. Sinus tachycardia was detected on ECG. Amylase was 354 U / L, lipase: 442 U / L, and other laboratory tests were in normal levels. The patient was transferred to the gastroenterology department with the diagnosis of acute pancreatitis after the treatment for intoxication.

Conclusion: It is clinically impossible to distinguish drug-induced pancreatitis from other causes of pancreatitis, but the prognosis is quite good in drug-induced pancreatitis. Also careful assessment of drug usage history can help the diagnosis. The presence of findings such as; the absence of other causes that can lead to pancreatitis, regression of pancreatitis after accused drug is discontinued, and the presence of recurrent episodes of pancreatitis after drug re-use should be checked for the diagnosis of drug-induced pancreatitis.

Keywords: pancreatitis, side effect, intoxication

P-0635 Imaging in Emergency Units

Emergency physician-performed bedside compression ultrasonography for deep vein thrombosis

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Objective: Because the incidence of venous thromboembolism is so high and progression from deep vein thrombosis (DVT) to pulmonary embolism (PE) can lead to significant morbidity and mortality, the ability to rule in or rule out DVT in the emergency department is essential. Ultrasound is a sensitive and specific tool for the assessment of patients presenting with symptoms suggestive of lower extremity DVT. Focused ultrasound of the lower extremity can be performed quickly by emergency physicians using a simplified three-point compression technique that concentrates on the evaluation of those areas with highest turbulence and at greatest risk for developing thrombus: 1) the common femoral vein at the saphenous junction, 2) the proximal deep and superficial femoral veins, and 3) the popliteal vein. We present a case of DVT diagnosed by emergency physician-performed sonography that resulted in submassive PE.

Case: A 49-year-old male patient presented to our emergency medicine department with complaints of new onset of dyspnea and right lower extremity swelling and pain lasting for four days. He was conscious, oriented, and cooperated. His vital signs were: Blood pressure, 125/80 mmHg; heart rate, 85 bpm; respiratory rate, 14/minutes; body temperature, 37.4; and oxygen saturation, 98%. His cardiac and respiratory physical examinations were almost normal. Proximal and distal pulses were palpable in both lower extremities. Right leg was swollen compared to the left and Homan's sign was positive on right. Emergency physician-performed bedside ultrasonography revealed venous thrombosis in femoral and popliteal veins. Electrocardiography, arterial blood gas analysis, complete blood count and blood chemistry were almost normal. A thorax computed tomography with contrast to exclude pulmonary thromboembolism revealed contrast defect in subsegmental branches of bilateral pulmonary arteries but there was no thrombosis in main pulmonary arteries. Echocardiography performed by cardiologist revealed normal right and left cardiac functions. Cardiovascular surgery suggested limb elevation, tinzaparin sodium 0.9 mL 1x1(sc), warfarine 5 mg 1x1(1 day), 1x1/2 (2 days), triterpen 2x1. He was admitted to chest diseases clinic. Warfarine and enoxaparin sodium were started. After regulation of warfarine dose he was discharged for out-patient follow-up.

Conclusion: Ultrasound is a useful diagnostic tool in the evaluation of patients presenting with signs and symptoms suggestive of a DVT. Using ultrasound in the evaluation for DVT can decrease time to definitive care and length of stay in the emergency department.

Keywords: Bedside ultrasonography, deep vein thrombosis, emergency department, pulmonary embolism

P-0636 Imaging in Emergency Units

Emergency physician-performed bedside ultrasonography for cellulitis

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Objective: Cellulitis is a clinical diagnosis based on erythema, swelling and local tenderness of the skin and subcutaneous tissues accompanied by fever and malaise. Cellulitis of the lower limb shares several clinical characteristics with deep vein thrombosis (DVT) and both have variability of clinical signs. These factors may sometimes lead to diagnostic uncertainty.

Case: A 52 year-old female presented to our emergency department with the complaints of swelling, hyperemia and pain on his right lower extremity lasting for 2 days. Her vital signs were as following: Blood pressure, 90/50 mmHg; heart rate, 85bpm; respiratory rate, 12/minutes, body temperature, 38.3 °C; O2 saturation, 99%. She had chemotherapy for ovarian cancer before. She was conscious, alert, and cooperated. Her respiratory, cardiac, abdominal, and neurological examinations were unremarkable. She had a well-demarcated hyperemia extending from right heel to hip. Her right leg was swollen compared to left. Homan's test was negative. She was ordered antipyretic for fever. Her laboratory findings revealed WBC of 8.2 K/uL, CRP of 6.18 mg/dL, D-Dimer (quantitative) 999µg/L, and other laboratory findings were unremarkable. The clinical picture was compatible with both cellulitis and DVT. Official Doppler ultrasonography was not available at that time. Emergency physician performed bedside ultrasonography. There was diffuse thickening of the dermis, edema in the subcutaneous tissue, and typical cobblestone appearance compatible with cellulitis. Femoral and popliteal veins were compressible with Doppler ultrasonography and typical venous flow was observed. The patient was consulted with infectious diseases and hospitalized. She was started 1 gr of intramuscular Ampicillin-sulbactam. As the infection was restricted by antibiotherapy she was discharged 10 days later

Conclusion: Bedside ultrasonography is a useful adjunct to the physical examination in patients with suspected soft tissue infections such as cellulitis.

Keywords: Bedside ultrasonography, cellulitis, emergency department

P-0637 Toxicology

Nervous system and myocardial dysfunction induced by carbon monoxide exposure

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Objective: Carbon monoxide (CO) intoxication is one of the most common intoxications in Turkey. During intoxication, CO is bound to hemoglobin and decreases oxygen carrying capacity of blood. It affects many organ systems including brain, heart, kidneys, skeletal muscle, and peripheral nervous system. Here we present a case of CO intoxication in which myocardial and cerebral ischemia were seen together.

Case: A 85-year-old male was transferred to our emergency department by 112 emergency staff with chest pain and decreased level of consciousness after exposure to smog resulting from fire at his home. His general appearance was intermediate. He was stuporous, non-cooperated, non-oriented with a Glasgow coma scale score of 10. His vital signs were as following: Blood pressure, 155/80 mmHg; heart rate, 100 bpm; respiratory rate, 22/minutes; oxygen saturation, 85%. His hair, eyebrow and eyelashes were burned and had first degree burn at dorsum of both hands. His systemic examination was unremarkable except hoarse breath sounds. He was on medication for hypertension and Alzheimer disease. He was thought to have CO intoxication



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and was started 100% oxygen. As he also had chest pain, 300 mg acetyl salicylic acid was also given orally followed by intravenous nitroglycerin infusion. His carboxyhemoglobin level was 13%. Other pathological laboratory findings were: CK, 370 U/L; CK-MB, 30.98 ng/mL; Troponin-I, 35.157 ng/mL. Electrocardiogram did not show any ST-T wave abnormality. His cranial computed tomography (CT) showed only cortical atrophy without ischemic changes. Although his carboxyhemoglobin level decreased to 2%, his unconsciousness did not resolve. So a diffusion magnetic resonance imaging (MRI) was ordered that revealed acute ischemic infarct in subcortical white matter on parietal area. His clinical picture was thought to be resulting from CO intoxication and was admitted to coronary intensive care unit for coronary angiography. His relatives did not give consent for angiography and the patient was discharged with medical therapy at fourth day.

Conclusion: CO causes tissue hypoxia by destroying cellular respiration and oxygen supply to tissues. This results in myocardial dysfunction, hypotension, and demyelination, edema and focal necrosis in central nervous system. Although accurate diagnosis is based on detection of elevated carboxyhemoglobin level on arterial blood gas analysis, low levels does not exclude intoxication. ECG, cranial CT, MRG, urinalysis should be considered to show the effects of hypoxia at cellular level. Besides hemodynamic stabilization, the mainstay in treatment is 100% oxygen or hyperbaric oxygen treatment to eliminate CO.

Keywords: Carbon monoxide, intoxication, myocardial dysfunction, nervous system dysfunction

P-0638 Cardiovascular Emergencies

Patient Sinus Syndrome

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Objective: Patient sinus syndrome is a heterogeneous disease including abnormalities in the creation and transmission of supraventricular impulses associated to sinus node degeneration. This syndrome is characterized by different arrhythmia such as temporary sinus bradycardia, sinus discontinuation, supraventricular tachycardia. This arrhythmia may be observed in the same patient at different times. Many diseases such as cardiomyopathy, myocarditis, and surgical damage affecting the sinus node may be at the origin of sinus syndrome. Palpitation, chest pain, presyncope, syncope may be observed according to the heart rate. As arrhythmia episodes will not be observed in routine ECG, ECG monitoring from feet and electrophysiological studies are necessary for the diagnosis of patient sinus syndrome.

Case: The patient applying to another health institution for transient fainting complaints has been taken by his relatives to our emergency unit in the evening. The seventy-one year old male patient displayed complaint the day before for 8-10 fainting events of less than one minute each. He did not experience spasms or urine or stool incontinence, and the patient was immediately recovering after the fainting events. The conscious of the patient was open, cooperated and oriented. The values for the patient were: arterial tension: 125/80mmHg, pulse:81, temperature: 37.4, breath rate:14. In the physical examination, no pathologic observation has been made in hematologic and radiologic analyses. The patient who experienced a 10 second loss of consciousness in the emergency unit follow-up, has been transferred to the neurology department considering the patient with absence seizure. No pathology has been observed in the tomography and in the EEG. Cardiology department has been consulted for syncope etiology, and 50 mg metoprolol tablet and 100 mg acetylsalicylic acid tablet have been administered to the patient in the absence of pathology in ECG. The patient has been followed-up in the emergency unit by monitoring. Upon the observation of a short-term loss of consciousness in the evening, it has been determined, according to the ECG records, that the patient entered a sinus arrest. The patient has been transferred to the cardiology unit with patient sinus syndrome diagnosis.

Conclusion: As the course of disease is intermittent, it may not be determined early. It is important to remember that the patients with syncope and absence of symptoms in many cases and the heterogeneous nature of the symptoms may come up with a clinic presentation such as patient sinus syndrome.

Keywords: absence seizure, ECG monitoring, patient sinus syndrome

P-0639 Toxicology

Amlodipine Intoxication: A Poisoning Case Requiring Intensive Follow-Up

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Objective: Calcium channel blockers are drugs used in hypertension, arrhythmia and coronary heart diseases by blocking L type calcium channels. At high concentrations, calcium channels are blocked and calcium entry from L type channels is totally prevented. After intake at a toxic dose, the treatment may lead to metabolic acidosis, hyperglycemia, hypotension, atrioventricular block and high mortality. In our study, we aimed to present the changes and the treatment approaches for the hospitalization period of a patient who applied to the emergency unit following the intake of high dose of calcium channel blocker, until the discharge.

Case: The patient brought to the emergency unit of our hospital by the 112, applied to another medical institution for taking high dose of medication for suicide purpose. The thirty-eight year-old female patient took 30 pieces of 5 mg Norvasc (amlodipine) tablets at 6.30 pm for suicide purpose. Approximately at 8.00 pm, a nasogastric probe has been placed and stomach lavage have been performed on the patient taken to the emergency unit of the public hospital, then 1 mg/kg activated charcoal has been administered to the patient. In the physical examination of the patient; the consciousness was open and oriented. Blood pressure was 90/50 mm Hg, the pulse was 88 pulses/minute, the respiratory rate was 12/minute, the temperature was 37.2. A urinary catheter has been placed and 50 cc/hour serum physiologic infusions have been started. The patient was hospitalized in intensive care unit. 20mcg/kg/min dopamine, 20mcg/min noradrenalin administration have been started for the patient who developed deep hypotension. Upon the measure of 500mg/dL for blood glucose, insulin treatment has been started. Hemofiltration has been applied to the patient who did not have any urine output. In spite of the administration of 6L/min oxygen, the patient developed tachypnea and metabolic acidosis and hypoxia in arterial blood gas, and mechanic ventilation support has been started. On the fourth day of hospitalization, as the blood pressure was normotensive, dopamine and noradrenalin infusions have been stopped. The patient has been extubated, the mechanic ventilation has been stopped and the patient has been discharged with full recovery.

Conclusion: It shall be remembered that in intoxication with calcium channel blockers, the clinic situation of the patient may deteriorate, hypotension, lung edema and renal impairment may develop in association with the deterioration of organ perfusion. Thus, an accurate hemodynamic follow-up of the patient in intensive care conditions is important.

Keywords: drug intoxication, calcium channel blockers, accurate hemodynamic follow-up

P-0640 Imaging in Emergency Units

Diffuse Falx Calcification Related with Seizure

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Objective: Intracranial calcifications seen on computed tomography (CT) are the most common finding in the everyday practice. The intracranial calcifications may have no clinical importance or they may be critical findings in diagnosing the underlying pathology. Intracranial calcifications can be classified mainly into 6 groups based on their etiopathogenesis: age-related and physiologic, congenital, infectious, endocrine and metabolic, vascular, and neoplastic.

Case: 68 year old male patient presented with at least 5 min of seizure. There were any neurological abnormalities in his exam and any abnormalities in his laboratory findings except mild hypercalcemia (13.2 mEq/L). The CT shows any pathological signs but only diffuse falx cerebri and tentorial calcifications. The patient admitted for further examination. No new pathologies found in the patients follow-ups and therefore the seizure was attributed to idiopathic hypercalcemia.

Conclusion: The physiologic calcifications are very common and have been well-described in the past decades. They are associated with aging and can be seen in the basal ganglia, pineal gland, falx, tentorium, arachnoid granulations, choroid plexus and the cerebellum. Physiologic calcifications are almost never clinically significant.

Keywords: falx, calcification, seizure

P-0641 Imaging in Emergency Units

Suspect sinus vein thrombosis save patients life

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Objective: Sinus Vein Thrombosis (SVT) is usually described as "non infectious occlusion of brain venous structures due to hypercoagulability". The most frequent symptom is headache and occurs approximately 75-90% at initial presentation. Despite the gold standard diagnostic modality is cerebral angiography, Magnetic Resonance Venography is the best noninvasive study option. In this Cases we have objected to describe SVT patients presented to emergency service (ES) with epileptic seizure and headache.

Case 1: 56 y.o male presented with headache. Vital signs, physical and neurological examination were all normal. There was headache episodes which improving with non steroidal anti-



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inflammatory drugs on medical history.

Computed tomography (CT) revealed “cord” sign on the right occipital area (Figure1a). For the exact diagnosis 3D MR venography performed (3DMRV) that showed filling defects in the right transverse sinus. Anticoagulant and antiaggregant therapy had begun and admitted to the neurology department.

Case 2: 32 Years old female seizure admitted to ES with epileptic seizure. There was no seizure history. 12 days before she had a c-section labor. Baby was alive and healthy. She had story of gestational hypertension. Neurological examination revealed slight hemiparesis on right upper extremity physical examination was completely normal otherwise. She had three consequent seizure in the ES. MRV revealed SVT. Admitted to neurology department. Discharged healthy.

Case 3: 20 Years old male with first epileptic seizure has brought to ES. Physical and neurological examination were all normal. CT revealed “cord” sign on the right occipital area. 3DMRV showed filling defects in the right transverse sinus. Anticoagulant and antiaggregant therapy head begun and admitted to the neurology department.

Case 4: 25 Years old male with second epileptic seizure has brought to emergency service. 1 weak before he had had one epileptic seizure. Physical and neurological examination was normal. CT revealed “cord” sign on the right occipital area. 3DMRV Show filling defects in the right transverse sinus. Anticoagulant and antiaggregant therapy head begun and admitted to the neurology department.

Case 5: 56 Years old female presented with headache. Physical and neurological examination was normal. Headache was not relieved with painkillers for 4 days. CT scan was normal. 3DMRV show filling defects in the right transverse sinus. Anticoagulant and antiaggregant therapy head begun and admitted to the neurology department.

Conclusion: In Emergency Services SVT should be in the differential diagnosis of patients with headache, vomiting and epileptic seizure.

Keywords: epileptic seizure, headache, Sinus Vein Thrombosis

P-0642 Toxicology

Acute Myocardial Infarction Secondary to Carbon Monoxide Poisoning

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Objective: Carbon monoxide (CO) is a gas which is tasteless, odorless and colorless. CO poisoning is one of the frequently seen types of poisoning in the world. CO's binding affinity to hemoglobin is very high compared to oxygen. For this reason in organs like brain and heart, which needs high oxygen level and sensitive to hypoxia, clinical findings appear early.

In this article we wanted to present a case with myocardial infarction with ST elevation (STEMI) secondary to CO poisoning in a patient who has medical history of coronary artery disease (CAD).

Case: Fifty-five years old female patient brought to the emergency department with nausea, vomiting, weakness and shortness of breath complaints. In history it was learned that she was living in a home with stove and has hypertension and CAD. On physical examination, vital signs were normal, GCS was 15 and systemic examination was normal. In ECG; rhythm was sinus and in D2-D3-aVF derivations ST elevation, in aVL derivation ST depression, in V2-V6 derivations T negativity was present. (Figure 1-2) In the patient's laboratory, COHb level was 21.8% measured and hemogram, bio-serum parameters were normal. Oxygen therapy with high concentration non rebreathing mask with reservoir bag and anti-ischemic therapy was given to patient who has preliminary diagnosed CO poisoning and acute cardiac ischemia. Hyperbaric oxygen therapy was planned due to high cardiac markers levels. Thus the place for hyperbaric oxygen therapy could not be found, the patient was hospitalized into coronary intensive care unit with a diagnosis of acute inferior myocardial infarction. The patient underwent coronary angiography; stent located in the circumflex artery (Cx) was clear and at the distal of this stent was stenosis identified and medical follow-up was decided.

Conclusion: CO; due to its affinity to hemoglobin, causes tissue hypoxia in the heart and central nervous system. After CO exposure sinus tachycardia, QT prolongation, myocardial ischemia, ventricular arrhythmias may occur in ECG. In patients with history of CAD, CO poisoning is predisposing factor for MI. In patients presenting with CO poisoning ECG and cardiac enzymes should be monitored. In the treatment of these patients; 100% oxygen therapy, hyperbaric oxygen therapy should be given and in appropriate patients coronary angiography should be performed.

Keywords: Acute Myocardial Infarction, Carbon Monoxide Poisoning, Emergency Medicine

P-0643 Imaging in Emergency Units

A benign radiological finding; vacuum phenomenon

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Objective: The vacuum phenomenon is defined as presence of air in the intervertebral disc space. It may be an early radiological sign of disc degeneration. It rarely occurs after trauma. The reason for the accumulation of air in the intervertebral disc space is not clearly understood. In this study we presented two cases and a review of literature about vacuum phenomenon which is usually considered to be a benign radiological finding.

Case1: A 63 year old woman admitted to the emergency department because she had fallen down on her back while she was walking. In physical examination, the patient's general condition was well, and GCS was 15. Vital signs were stable. There was tenderness in the middle and lower thoracic vertebra. Other systemic examination was normal. In the patient's thorax radiography height loss was observed between 7th - 12th thoracic vertebrae. In the CT scanning of Thoracic vertebrae porous bone structure was evident, wedging and height loss between 7th - 12th vertebrae and vacuum phenomenon was observed in the intervertebral disc space. The patient was prescribed a NSAID. Policlinic control and resting were advised to the patient and she was discharged.

Case 2: A 66 years old female patient admitted to emergency department with complaint of pain in her waist. The patient told that the pain in her began after lifting a heavy material one week ago and the pain continued ever since. In patient's history she had hypertension and osteoporosis. In physical examination, there was tenderness in the lumbar vertebrae. There were no motor or sensory deficits. In the direct radiography of lumbar vertebrae free air density was seen between 2nd -3rd lumbar vertebrae. In the CT scanning of the lumbar vertebrae, degenerative changes were observed in all corners of the lumbar vertebral bodies and facet joints and vacuum phenomenon intervertebral space between L2-L3. Analgesia was administered to the patient and she was recommended to admit outpatient physical therapy for control.

Conclusion: Intervertebral vacuum phenomenon usually occurs due to osteoporotic vertebral collapse. Many cases of intervertebral vacuum phenomenon are related to benign causes. However, it may also develop due to causes such as spinal infections, multiple myeloma, and intervertebral disc pathologies.

Keywords: emergency department, radiological finding, vacuum phenomenon

P-0644 Cardiovascular Emergencies

Syncopal Mayday call in Aortic rupture

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Objective: Sub-diaphragmatic abdominal aortic aneurysm results from loss of normal structure and localized weakness in the vessel wall. It is manifested by abnormal dilatation with a vessel diameter greater than 1.5 times. Aortic aneurysm is a progressive vascular disease. Abdominal, flank and back pain, syncope, low blood pressure, pulsatile mass, lack of pulse in lower extremity are the main clinical signs of the disease. Elective surgery mortality rate is 1-5%. Emergency surgery mortality rate is 40-60%.

Case: 82 years old syncope patient was admitted to ED. Vital signs revealed a blood pressure of 90/50 mmHg, heart rate of 81/min, respiratory rate of 15/min. arterial blood gases revealed a pH of 7.05, lactate of 6 mmol/L. Whole blood count revealed hemoglobin of 11g/dL. Abdominal contrast ct revealed a 9 cm diameter abdominal aorta aneurysm from the renal artery to the end of left iliac artery. The aneurysm had leakage and there was free abdominal fluid. During stabilization, patient had cardiopulmonary arrest.

Conclusion: Abdominal aneurysms may present with syncope and this may be related with leakage from the rupture. As in this patient, there may be a short duration between syncope and arrest. ED physicians should be aware of the urgency of abdominal aortic aneurysm rupture. Syncope may be a Mayday call in aortic rupture.

Keywords: aorta, aneurysm, syncope

P-0645 Cardiovascular Emergencies

Brachial Artery Occlusion Due to Paroxysmal Atrial Fibrillation

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Objective: Upper limb acute arterial occlusions are uncommon, and against lower limb occlusions, there are few cases reported. Age, female sex, AF, hypertension, diabetes, myocardial infarction, heart failure and stroke are most common risk factors. Embolic ischemia can be diagnosed with the following criteria: sudden clinical presentation, an embolic source, absence of peripheral atherosclerosis, and removal of discrete “clot” on operation. The general symptoms include pain, pulselessness, pallor, paresthesia and paralysis. Herein we presented a patient



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with brachial artery occlusion due to paroxysmal atrial fibrillation.

Case: 73-year old man was admitted to our emergency with the complaints of pain and coldness in left forearm for 4 hours. Left radial artery pulslessness was observed while there was no paresthesia and paralysis in the examination of upper limb. He had a history of paroxysmal atrial fibrillation. On laboratory; he had white blood cell 8900 K/uL (4-11000 K/uL, normal reference range), Hemoglobin 17 g/dL (13.5-18 g/dL, normal reference range), platelets 180000 K/uL (150000-450000 K/uL, normal reference range). Other biochemical parameters were in normal reference range. 12-derivation electrocardiography (ECG) was normal at the admission. Through the follow up he had two times palpitation attacks and the repeated ECGs revealed the atrial fibrillation periods. The doppler USG of the left upper limb showed that increasing calibration on axillary and brachial arteries; and in color mode examination, doppler USG detected the occlusion with an embolism through the left brachial artery (figure). The patient had undergone an urgent operation. After 3 days of hospitalization period, the patient discharged home with no sequelae.

Conclusion: Majority of patients with arterial embolism are likely to have co-existing atrial fibrillation and even more likely to have associated ischaemic heart disease or recent myocardial infarction. Emergency medicine professionals should be actively take a decision-making role for identification and administration of acute brachial arter tromboembolism.

Keywords: Brachial Artery Occlusion, Paroxysmal Atrial Fibrillation, Atrial Fibrillation, Upper Extremity, Arterial embolism

P-0646 Toxicology

Vomiting and tachycardia: disulfiram-alcohol reaction

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Objective: Disulfiram shows its effect by blocking the enzyme acetaldehyde dehydrogenase. After alcohol intake under the influence of disulfiram, the concentration of acetaldehyde in the blood may be five to 10 times higher than that found during metabolism of the same amount of alcohol alone. As acetaldehyde is one of the major causes of the symptoms of a "hangover", this produces immediate and severe negative reaction to alcohol intake. Some five to 10 minutes after alcohol intake, the patient may experience the effects of a severe hangover for a period of 30 minutes up to several hours. Symptoms include flushing of the skin, accelerated heart rate, shortness of breath, nausea, vomiting, throbbing headache, visual disturbance, mental confusion, postural syncope, and circulatory collapse.

Case: 35-year-old patient was admitted to the emergency department with complaints of mental fog, nausea, hematemesis and tachycardia. In his history we learnt that the patient was addicted to alcohol for 4 years and that he has been taking antabus to give up alcohol for the last 3 months. He had taken 100 cl vodka and antabus before coming to the hospital. His physical examination on arrival showed a GCS: 9, TA: 90/50 mmHg, pulse: 190/minute, respiratory rate 25/ minute. ECG: Sinus tachycardia. His laboratory results showed ethyl alcohol level of 350 mg/dl. The blood gas results were: pH:7.34, PO2:80, PCO2:32, HCO3:30, Lactate:2.5, blood glucose: 65 mg/dl, sodium:135 mEq/l, potassium: 4 mEq/l, wbc:15.000, hemoglobin:16, hematokrit:40. The patient was monitored in trendelenburg's position. He was put on oxygen (6-8 L), 500 ml 5% dextroz, 3000 ml serum physiologic, 1gr of ascorbic acid (Vitabiol-c ® 500 mg/5 ml, I.E Ulugay) and 45.5 mg feniramin maleat (Avil ® 45.5 ml/ 2 mL, Sandoz). After 12- hours of close follow-up, the patient's vital findings and consciousness returned to the normal and was discharged from the hospital after consultation with psychiatry.

Conclusion: The consumption of disulfiram with alcohol causes serious side effects. For emergency physicians, the presence of nausea, vomiting and tachycardia in patients taking disulfiram, should alert them to question the patient about the use of alcohol and should take into account disulfiram-alcohol reaction as differential diagnosis.

Keywords: Nausea, vomiting, tachycardia, disulfiram, alcohol

P-0647 Cardiovascular Emergencies

Femoral Vein Thrombosis and Pulmonary Embolism Due to Femoral Venous Catheterization

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Objective: Acute renal failure require temporary central venous catheterization utilizing subclavian, internal jugular, or femoral veins. Central line insertion may cause some complications such as pneumothorax, thrombosis, central-line associated bloodstream infections, hemorrhage, and air embolism. Venous catheterization can cause thrombosis due to direct vascular injury. Pulmonary embolism, a potentially life-threatening complication of thrombosis, is caused by the detachment (embolization) of a clot that travels to the lungs.

Herein we presented a patient with femoral vein thrombosis and pulmonary embolism due to femoral venous catheterization

Case: 51-year old man with the history of acute renal failure who was under the treatment of dialysis through the femoral catheter was admitted to our emergency. He had a strong pain in the area of femoral catheter and dyspnea for two days. On physical examination he had swelling and tenderness on femoral catheter insertion area. He had also tachypnea, and slight hypertension (140/90 mmHg). On laboratory; he had hemoglobin 9.8 g/dL (13.5-18 g/dL, normal reference range), creatinine 2.75 mg/dL (0.7-1.2 mg/dL, normal reference range), urea 154 mg/dL (10-48.5 mg/dL, normal reference range), albumin 2.12 g/dL (3.5-5.2 g/dL, normal reference range), total protein 5.39 gr/dL (6.4-8.3 gr/dl, normal reference range) and D-dimer >10000 ng/mL (0-500 ng/mL, normal reference range). Other biochemical parameters were in normal reference range. Doppler ultrasonography revealed total occlusion of main femoral vein with deep and superficial branch. CT pulmonary angiography was performed and submassive pulmonary embolism was detected. Catheter was removed, low molecular weight heparin was started and the patient was hospitalized to internal medicine ward for non-surgical follow up. Two weeks later, the patient was discharged home with no complication.

Conclusion: Venous catheterization can cause thrombosis and then pulmonary embolism. Physicians should be alert for thrombosis in the use of long-term femoral catheter.

Keywords: catheterization, thrombosis, venous, complications, pulmonary embolism

P-0648 Cardiovascular Emergencies

Pericardial Hemorrhage and Cardiac Tamponade in The Use of Warfarin

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Objective: Warfarin is used for preventing and treating venous or arterial thrombosis and embolism. It is a potentially hazardous drug, causing major bleeding in 1.1%-8.1% of patients treated during each year of therapy. Bleedings into the body's potential cavities can be seen. Pericardial cavity is rarely included to such hemorrhages.

Signs of classical cardiac tamponade include three signs, known as Beck's triad. Hypotension occurs because of decreased stroke volume, jugular-venous distension due to impaired venous return to the heart, and muffled heart sounds due to fluid inside the pericardium.

Herein we presented a patient with pericardial hemorrhage and tamponade in the use of warfarin.

Case: 28-year old man with the history of mitral valve replacement and under the treatment of warfarin was admitted to our emergency. He had chest discomfort and shortness of breath for two days. On physical examination he had hypotension (90/60 mmHg), tachycardia (115/min), and shortness of breath with 20/min breath rate. The patient had also muffled heart sounds, jugular-venous distension. On laboratory; he had white blood cell 12800 K/uL (4-11000 K/uL, normal reference range), Hemoglobin 11.2 g/dL (13.5-18 g/dL, normal reference range), platelets 384000 K/uL (150000-450000 K/uL, normal reference range), PT >120 sec (8.8-13.9 sec, normal reference range) INR >10 (0.8-1.2, normal reference range). Other biochemical parameters were in normal reference range. Chest X-ray showed a large, globular heart. Echocardiography demonstrated an enlarged pericardium with 3 cm diameter fibrinous blood, collapsed right ventricle. The patient was hospitalized to cardiac surgery intensive care unit and emergency pericardial window was performed in the operation room.

Conclusion: Pericardial hemorrhage and cardiac tamponade can be seen in the patients who take warfarin. If the chest X-ray showed a large, globular heart, these patients need to investigate for cardiac tamponade. In some circumstance, tamponade fluid can be fibrinous, in these case emergency pericardial window can be performed.

Keywords: Pericardial hemorrhage, cardiac tamponade, warfarin, coagulopathy

P-0649 Cardiovascular Emergencies

Skin Burns After Implantable Cardioverter-Defibrillator (ICD) Shocks

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Objective: Implantable Cardioverter-Defibrillator (ICD) is programmed to detect cardiac arrhythmia and correct it by delivering a brief electrical impulse to the heart. In current variants, the ability to revert ventricular fibrillation has been extended to include both atrial and ventricular arrhythmias. Herein we report a case of skin burns after five times of ICD Shocks due to intractable atrial fibrillation

Case: 58-year old man with the history of intractable dysrhythmia, followed with ICD, was admitted to our emergency after 5 times of ICD Shocks. On physical examination he had three skin burns (two of them were second, one of them first degree) on right anterior chest wall. After consultation with cardiology and pace control, five times of ICD Shocks due to intractable atrial fibrillation were detected. Laboratory tests including liver and kidney function tests, electrolytes and three times of cardiac enzymes were in normal range. Defibrillator voltage adjustment



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and wound care was done. At the end of twenty four hour of follow up he was discharged home.

Conclusion: ICD have demonstrated clear life-saving benefits. Rarely electrical burns due to multiple defibrillations may occur. These burns can be followed by simple treatment approaches.

Keywords: ICD, burn, skin burn, implantable cardioverter-defibrillator, defibrillator shock

P-0650 Cardiovascular Emergencies

Superior Vena Cava Thrombosis in a Patient with Behcet's Disease

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Objective: Behcet disease is a multisystemic, genetically heterogeneous, T cell dependent inflammatory process including vascular system that has been considered to result from systemic vasculitis. Vasculitis of veins is mostly affected through 5-10% of the patients. However, superior vena cava (SVC) involvement is rare; it accounts for only 6-10 % of the cases. Herein we report a patient who had partial thrombosis in SVC and brachiocephalic vein in a patient with behcet's disease.

Case: 51-year old a man patient was admitted to emergency with complaints of chest pain and dyspnea. He has history of Behcet disease and Ankylosing spondylitis. On Physical examination, the patient had no pathological signs. On laboratory; he had white blood cell 3100 K/uL (4-11000 K/uL, normal reference range), platelets 85000 K/uL (150000-450000 K/uL, normal reference range) and D-dimer >10000 ng/mL (0-500 ng/mL, normal reference range). Other biochemical parameters were in normal reference range. X-ray of the patient was normal. Performed CT pulmonary angiography was explored a partial thrombosis in medial wall of the VCS and brachiocephalic vein (figure). We consulted the patient with cardiovascular surgery, cardiology and pulmonology department. Performed echocardiography revealed ejection fraction as 65%, pulmonary artery pressure as 30 mmHg, and dilated right ventricle and atrium together. Medical treatment with enoxaparin 2x60 mg SC was achieved and the patient hospitalized to cardiovascular surgery ward for non-surgical follow up. Two weeks later, the patient was discharged home with no complication.

Conclusion: Behcet disease is a chronic relapsing systemic vasculitis in which disease affects many systems and causes hypercoagulability. CT imaging and magnetic resonance venography are excellent diagnostic tools when SVC thrombosis is suspected. The patients who have any type of vasculitic process must be evaluated in the formation of thrombosis in large vein especially in VCS. CT scanning can be the research option.

Keywords: Superior vena cava thrombosis, Behcet's disease, vena cava thrombosis, thrombosis

P-0651 Toxicology

Alprazolam intoxication

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Objective: Alprazolam is a benzodiazepine derivatived drug used as anxiolytic and antidepressant. High doses of benzodiazepines can cause morbidity and mortality. We report a case, who take high doses of alprazolam with dideral, seroquel and diazepam; presented improvements in his symptoms with flumazenil.

Case: 18 year-old-man with diagnosis of depression was admitted to our emergency department with suicide attempt. He had taken alprazolam (10 tablets xanax), dideral (5 tablets), seroquel (5 tablets) and diazepam (5 tablets). The doses of drugs were unclear. His Glasgow Coma Scale score was E3M6V4 Physical examination revealed consciousness tend to fall asleep, closed eyes and normal-sized, normally reactive pupils. Blood pressure:124/79 mmHg, heart rate:73/min. Gastric lavage, activated charcoal, fluid resuscitation and oxygen by nasal cannula was applied. Simultaneously flumazenil, benzodiazepine antagonist, 0.3 mg IV was administered. Poison control center was called. After 5 minutes his Glasgow Coma Scale score was E4M6V5. Level of consciousness and vital signs remained stable. Laboratory findings were normal. The patient discharged from emergency department after 24 hours follow.

Discussion: Benzodiazepines can be used to treat anxiety, insomnia, muscle spasms and epilepsy. Severe intoxication occurs when used alone in high doses or combined with other drugs. Especially alprazolam has been reported to reduce the heart rate. In our case, this effect was potentiated with the use of dideral. To reduce this interaction and prevent drug potentialisation, flumazenil was applied.

Conclusion: In our case, there was controversy about the intake of benzodiazepines. By flumazenil application, we have confirmed the intake of benzodiazepine. If the patient's history is suspicious, we can go to diagnosis from treatment.

Case: Conclusion:

Keywords: alprazolam, intoxication, aneaxe

P-0652 Imaging in Emergency Units

Aspirated turban pin self-ejected by coughing: case report

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Introduction: Turban pin aspiration syndrome is a new clinical entity afflicting young Islamic girls wearing a turban (1,2). The turban pin aspirating history is frequently same in all cases. They hold the pin between teeth while dressing in a turban and aspirating the pin during laughing or talking (3). We report a case aspirated turban pin and self-ejected by coughing.

Case: A previously healthy 19 year old girl admitted to emergency department with turban pin aspiration. She aspirated a turban pin when she tried to talk with the pin in her mouth while fixing the headscarf. She was coughing on admission. Her physical examination revealed no significant abnormality. Radioopaque foreign material was visualized with posteroanterior and lateral chest x-rays (Figure 1). The turban pin was self-ejected by coughing. Repeat chest x-ray (Figure 2) appeared normal and the patient was discharged after 24 hours of observation. There was no complaint and complication during the follow-up.

Discussion: Turban pin aspiration is new syndrome in Islamic girls wearing turban (1,2).

To realize the ingestion of a turban pin is as important as aspirating a turban pin. After aspiration, turban pins can go trachea or esophagus. Often goes to the gastrointestinal tract, and exit from the gastrointestinal tract without causing problems (6,7,8). Exit must be followed up (7). Aspiration of turban pin, leads to complications according to the localization. Gastrointestinal perforation due to turban pin can cause appendicitis, intestinal perforation, intestinal obstruction(6), fistula (6,7), bleeding (6,7), peritonitis, abscess (7). Varies methods of treatment are: rigid bronchoscopy, flexible bronchoscopy, laryngoscopy, thoracotomy, treated by rigid bronchoscopy, fluoroscopy-assisted rigid bronchoscopy.

Conclusion: With the increasing use of Islamic headscarves in the country, especially in young girls the frequency of turban pin aspiration occurrence has increased. This case is the third patient in the literature who self-ejected the turban pin by coughing. People wearing turban must be informed and different ways to straighten the turban should be found. Clinicians should be aware of this new aspiration syndrome, its method of diagnosis and extraction techniques.

Keywords: turban pin, aspiration, self-rejected

P-0653 Toxicology

Successful treatment of metformin intoxication requiring dialysis

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Introduction: Metformin is one of the most common oral agents used to treat diabetes mellitus. Intoxication is associated with lactic acidosis and has significant clinical consequences. We report a case who ingested metformin for suicide attempt and subsequently developed severe lactic acidosis.

Case: A 27-year-old woman took 4000 mg metformin and 400 mg atorvastatin in a suicide attempt, admitted to our emergency department. On admission, Physical examination was normal. GKS was E4M6V5, Blood pressure: 100/60 mmHg, heart rate: 85/min, body temperature: 36.7°C, g. glucose: 90 mg/dL, creatinin: 0.91 mg/dL, Potasyum: 2.9 mmol/L, pH: 7.3, lactat: 65. She transferred to intensive care unit. Subsequently she developed acute renal failure. Laboratory findings were: Creatinin: 2.52 mg/dL, Potasyum: 3.9 mmol/L, pH: 7.2. She was consulted by nephrology and hemodialysis planed. She was successfully treated by daily hemodialysis for two days. After two days laboratory findings were: Creatinin: 0.75 mg/dL, potasyum:4.1 mmol/L,



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pH: 7.4, lactat: 1. She also consulted by psychiatry doctor. She was discharged from intensive care unit to internal service with offers after two days.

Conclusion: Lactic acidosis can be seen in patients who are receiving metformin even in therapeutic doses. The relationship between lactic acidosis and metformin intoxication is not known. Metformin toxicity is a serious clinical condition and causes severe lactic acidosis and significant mortality 30-50%. The mortality rate do not correlate with metformin or lactate levels. Only bicarbonate infusion can not correct the acid-base metabolism so hemodialysis or hemofiltration treatment is mandatory. In our case of metformin intoxication, early diagnosis and rapid correction of the metabolic acidosis using hemodialysis had been life saving.

Keywords: metformin, hemodialysis, lactic acidosis

P-0654 Cardiovascular Emergencies

All new LBBB is not myocard infarction

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Objective: Left bundle branch block (LBBB) usually indicates underlying coronary artery disease or myocardial disease. LBBB with normal coronar artery is infrequent phenomenon. We report the case of a patient with exertional dyspnea associated with left bundle branch block with normal coronary arteries.

Case: A 80- year old woman was referred to the emergency room with exertional dyspnea. She had no previous history of cardiovascular disease and diabetes mellitus. There are only known for its moderate hypertension. Clinical examination did not reveal any abnormalities. Blood pressure was 135/80 mmHg, heart rate of 75 bpm. The first ECG showed a sinus rate of 75 with LBBB. Her laboratory investigations including cardiac enzymes were unremarkable. Her echocardiogram showed normal. Patient hospitalized with a diagnosis of unstable angina pectoris (USAP) and elective coronary angiography (CAG) was performed. The CAG showed normal coronary arterial tree. Repeat ECG showed that the normal sinus rhythm which was confirmed on twenty-four hour cardiac monitoring.

Conclusion: LBBB associated with exertional dyspnea in the presence of normal coronary arteries is infrequent but a well known clinical entity. There is no consensus of opinion on why certain patients with LBBB get chest pain in the absence of myocardial ischaemia. LBBB with exercise develops either due to ischaemia of the left bundle (mainly the interventricular septum) or due to rate dependency (where the heart rate exceeds the refractory period of the bundle). We need to know all new LBBB is not a myocard infarction.

Keywords: Left bundle branch block, myocard infarction, unstable angina pectoris

P-0655 Cardiovascular Emergencies

Dipnea and massive pericardial effusion

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Objective: Though the pathophysiology of dipnea is diverse, two- thirds of the patients who visit emergency services with complaints of dipnea have an underlying pathology of cardiac or pulmonary origin. We present a case of dipnea resulting from massive pericardial effusion, that did not show full symptoms of cardiac tamponade.

Case: A 69 year old patient was brought to the emergency room with dipnea that has been progressing for the last ten days. In his history we learnt that he was using methotrexate for treatment of arthritis secondary to psoriasis. His complaints started ten days ago and 2 days prior to his visit, he was misdiagnosed as lung infection and was put on antibiotherapy. He denied having any fever or sputum. On auscultation there were no lung sounds on base of the lungs, especially on the right side, his heart sounds were distant and muffled but he did not have jugular venous distension and pretibial edema. His blood pressure was: 120/75mmHg, his abdominal and neurologic examinations were normal.

His laboratory results were as follows: arterial blood gases: pH:7.52, pCO₂: 25.2, pO₂:56, d-dimer:3143 ng/mL, BUN:15mg/dl, creatinin:0.77mg/dl, troponin I:0.0008ng/ml, amylase:27U/L, ALT:93U/L, AST:66U/L, Hgb:9.52g/dl, WBC:14500 U/L. His thorax tomography revealed; massive pericardial effusion and bilateral pleural effusion. There was no pulmonary embolism. He was consulted to the cardiology department and pericardiosynthesis was performed. He recovered without any complications.

Conclusion: In patients who come to the emergency department with complaints of dipnea, especially those with diseases like psoriasis or other immune system related diseases, the development of massive effusion due to pericardial or plural involvement should be a differential diagnosis that should be kept in mind.

Keywords: Dipnea, psoriasis, pericardial effusion, pleural effusion

P-0656 Imaging in Emergency Units

Hemorrhagic ovarian cyst diagnosed by bedside ultrasound in emergency department

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Objective: Abdominal pain is a frequent complaint in emergency department (ED) and especially for female patients it can be confusing for emergency physicians. Ovarian pathologies must be considered also and value of emergency ultrasound (US) is promising according to current literature. In this study we reported an ovarian hemorrhagic cyst case that was diagnosed by point-of-care US in ED.

Case: A 33-year-old woman presented to ED with an abdominal pain of acute onset. Pain was sharp, continuous, and radiated to groin. She denied any trauma and pregnancy. Her vital signs were BP: 110/80 mmHg, pulse rate: 88/bpm (regular), temperature: 36.5°C, SaO₂: 99 % and respiratory rate: 11/per minute. In abdominal examination rebound and tenderness was positive in bilaterally lower quadrants. Point-of-care US was performed by emergency physician to exclude intra-abdominal free fluid. In point-of-care US, a cystic lesion was observed in diameter of 28x29x33 mm and located in right ovary. Hemoglobin and hCG levels were in normal ranges. Patient was consulted radiologist for abdominal US examination and the lesion was reported as hemorrhagic ovarian cyst. Patient was consulted to Obstetrics and Gynecology clinic for further evaluation. Patient refused surgical intervention and followed by repetitive US scanning. The lesion regressed spontaneously and any complication was not observed.

Conclusion: Use of US in ED is especially directed to trauma patients but many studies suggest the use of US for non-trauma patients. While US is a cheap, harmless, repeatable and easy-to-use technique, it is operator-dependent. So, training and experience is crucial for US scanning and emergency physicians may enhance their capabilities and should consider the use of US for non-trauma patients also.

Keywords: Ovarian cyst, emergency medicine, ultrasound

P-0657 Cardiovascular Emergencies

Fatal Complication of Acute Myocardial Ischemia: Ventricular Septal Rupture

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Objective: Myocardial ischemia (MI) usually is a result of fixed atherosclerotic lesion in coronary arteries. Ventricular septal rupture (VSR), which can complicate an acute myocardial infarction, carries a high mortality rate. We present a VSR case due to myocardial infarction.

Case: A 84-year-old man was admitted to the Emergency Department Unit with right arm pain and dyspnea for the last three days. He had not any history of cardiac disease. His initial oxygen saturation was %84 and other vital signs were nearly within normal limits. Positive signs of his physical examination was diminished auscultation of lung in the basal and middle lobe and there was a new holosystolic murmur at the lower left sternal border. The initial electrocardiogram showed subacute MI (ST elevation in the D2, D3 and Avf lead) and acute posterior MI. Transthoracic echocardiography revealed an inferior VSR associated with a left-to-right shunt. Since his cardiac troponin level was increased 10-fold, he was hospitalized in Coronary Unit.

Conclusion: Ventricular Septal Rupture is a fatal complication of Acute Myocard Ischemia and its prognosis is ominous. Rapid and noninvasive examination with Transthoracic echocardiography gives high accuracy for diagnosis of acute coronary syndromes and its complications such as VSR. Its is important to make an ecocardiographic examination in patients who suffer from angina. In those cases, early diagnosis can be lifesaving.

Keywords: Ischemia, Myocardial, rupture, VSR



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P-0658 Imaging in Emergency Units

Atypical clinical presentation of subarachnoid haemorrhage

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Objective: Subarachnoid haemorrhage a neurological disease with potential cause of significant morbidity and mortality, more common in the mid ages and seen with the same frequency in men and women.

Most important cause of this disease is rupture of underlying brainstem's congenital aneurysm which has a mortality ratio as %30-45 in first two weeks from onset. The other causes are trauma, infections and arteriovenous malformations.

Classical presentation is with symptoms of sudden onset of a severe headache, nausea, vomiting, fluctuating and worsening consciousness. Review of the literature shows a number of case reports of atypical presentations for subarachnoid haemorrhage that may result with missed diagnosis. Our case is significant with patient's atypical clinical symptoms that don't remind subarachnoid haemorrhage

Case: 77 year old man admitted our emergency department because of weakness of lower limbs, loss of sense in lower part of body from abdomen. Patient told that these symptoms started with a syncope that occurred after back pain. He has diabetes mellitus disease in his history. On physical examination general situation was mid-well, vital signs were stabile. On neurological examination hypoesthesia was present from the level of nipples to lower limbs. Motor deficits were 1/5, no responsible for Babinski reflex (both positive or negative) and deep tendon reflexes was weak in both lower limbs. Biochemical parameters and blood count values were in normal ranges. There was not pathological view in unenhanced computed tomography. Unenhanced cranial and spinal magnetic resonance imaging obtained to identify demyelinating diseases, spinal cord injuries which are thought for differential diagnosis. Cranial magnetic resonance imaging revealed subarachnoid haemorrhage and patient transferred to neurosurgical intensive care unit.

Conclusion: Patients with subarachnoid haemorrhage symptoms initially admit to emergency departments and emergency departments are the unique places for diagnosing this highly mortal situation. In our case patient admitted with atypical symptoms and subarachnoid haemorrhage was diagnosed on cranial magnetic resonance imaging instead of cranial tomography that known as gold standard for showing haemorrhages. We point out atypical clinical presentation and atypical cranial imaging of subarachnoid haemorrhages may result with delayed diagnosis, and clinician must be aware about atypical symptoms of subarachnoid haemorrhage that was reported in many cases before in literature.

Keywords: subarachnoid haemorrhage, cranial magnetic resonance imaging, atypical clinical presentation

P-0659 Cardiovascular Emergencies

Thoracic aortic mural thrombus with atypical pain

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Objective: Pain is one of the most common admission causes of emergency services. Abdominal pain is also common and require further reevaluation and sometimes difficult to diagnose. Acute aortic syndrome is a term that includes classic aortic dissection, intramural hematoma, and symptomatic penetrating aortic ulcer. Intramural hematoma was described as an aortic wall hematoma without an intimal flap. The prevalence of intramural hematoma in acute aortic syndrome ranges from 6-30% and it may progress to frank rupture, true aortic dissection, aneurysm or pseudo aneurysm, or complete resolution. From a surgical and prognostic stand point, this syndrome can be divided into two groups depending on the aortic segment involved: proximal and distal acute aortic syndrome. In type A intramural hematoma, surgical management is advisable in most cases. In intramural hematoma confined to the descending thoracic aorta, survival with medical treatment was not different from surgical therapy.

Case: A 48 year old male patient was admitted to the emergency service with chills, fever and left side and abdominal pain. His vital signs: blood pressure: 150/90 mmHg pulse: 108/min. Fever: 38, 6 O2sat: %99. Four days before application, patient was controlled at another center because of malaise, fever and sudden severe chest pain; any pathology was detected and upper respiratory tract infections prescription. The patient's complaints regressive for 4 days; but current complaints started again today. Firstly a renal pathology has been considered in patient; but because of 4 days ago complaints the lab has been broad. D-dimer: 4, 43 was detected and thorax CT angiography was planned to diagnose embolism or aortic dissection. As a result of imaging in patient thoracic aortic mural thrombus has been identified and patient has been consulted to the cardiovascular clinic. Cardiovascular clinic followed patient by medical treatment, appropriate 10 days of rest and was discharged.

Conclusion: All abdominal pain in Emergency Services should be questioned with a detailed history. Patient's admitting complaints can be misleading the actual discomfort, if the results cannot explain existing conditions the examination and laboratory tests should be detailed.

Keywords: mural thrombus, abdominal pain, aortic dissection

P-0660 Cardiovascular Emergencies

Prognosis of patients who present with chest pain and diagnostic criteria of Wellens' Syndrome

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Objective: We aimed to find out 30 and 60 day morbidity and mortality of patients who presented to emergency department with chest pain and carry the clinical, electrocardiographic and laboratory features of Wellens' Syndrome.

Materials-Methods: All patients who presented to emergency department of Recep Tayyip Erdoğan University Research and Training Hospital with chest pain and carry the clinical, electrocardiographic and laboratory features of Wellens' Syndrome between 01.01.2011-31.12.2013 were retrospectively screened. Fifty patients were included in the study. All demographic data including risk factors for coronary artery disease were obtained. Results of routine laboratory tests and imaging studies that are used in the evaluation of patients with chest pain such as complete blood count, blood chemistry, cardiac enzymes (CK-MB, Troponin I), electrocardiogram, and chest radiogram were recorded. Coronary angiography results were obtained from archive of cardiology department. By reviewing hospital records or by telephone call with patient or first degree relatives, one month and two month mortality and morbidities were queried.

Results: Of these 50 patients, 20 (40%) were female and 30 (60%) were male. Mean age was 62.26±14.14. There was lesion in left anterior descending coronary artery (LAD) in all patients. There was >= 50% LAD lesion in patients with at least 2 of diabetes, hypertension, and hyperlipidemia. Also there was >= 50% LAD lesion in patients whose 6th hour troponin I levels were higher than 0th hour levels and this was statistically significant (p < 0,05). There was no death at the end of 30 and 60 days. Of the patients, 10% in the first 30 days and 4% in the second 30 days period readmitted to the emergency department with chest pain.

Conclusion: Early diagnosis and treatment of acute coronary syndromes which is the most common cause of death in all age groups, is very important for patient survival and to prevent complications. We suppose that morbidity and mortality of patients who have the clinical and electrocardiographic features of Wellens' Syndrome will decrease with early detection and treatment with coronary angiography.

Keywords: Acute coronary syndrome, electrocardiography, Wellens' Syndrome

P-0661 Imaging in Emergency Units

Movement artifact of the different 3D image

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Objective: In an emergency, you must often make quick interventions. Quick hematological and radiological examinations are carried out. But motion artifacts should be considered when performed imaging analysis with computed tomography which is one of the radiological examinations. After the images which have motion artifacts were reconstructed, different, mislead image can be obtained.



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Case: A 20 month –old girl has aspirated olive, while having breakfast. She fell from her chair to the ground during coughing. The help was requested immediately from the emergency room to the cyanotic patient. The first intervention was cardiopulmoner resuscitation for patient who has cardiopulmoner arrest. Immediately she was brought the nearest hospital by ambulance. After her situation was stabilized, the patient intubated and routine hematological and radiological investigations were performed for her. The patient was GKS 9 point.

The patient's cranial tomography was normal. Grade 3 spondylolisthesis was observed between L1-L2. She was referred to our hospital for intensive care.

The patient's respiratory distress has continued. Because of this condition the intervention was made. Pneumothorax was seen during intervention Chest tube was inserted due to pneumothorax. It was decided to transport the patient to top hospital for further examination. Before she was transported, cranial tomography and spinal column tomography was applied. In order to check the patients condition. Cranial computed tomography was normal again. Interestingly lumbar lysis was not seen. The normal alignment of the vertebrae was observed.

Conclusion: During tomography, when three- dimensional imaging was obtained, different reconstruction views may be occur due to patient's movement. Not common, but you need to keep in mind. Because it can lead to incorrect diagnosis and incorrect treatment.

Keywords: motion artefact, 3D image, Trauma

P-0662 Toxicology

Narghile: A Rare Cause of Carbonmonoxide Poisoning

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Objective: Carbon monoxide (CO) poisoning, is a disease that is difficult to diagnose, if you do not suspicious it has non-specific symptoms, such as headache, nausea, vomiting, syncope. In emergency department (ED), CO poisoning easily missed, the most important step to diagnose have to ask the right questions while patients' history taking. Narghile (water pipe, hookah, hubble bubble) use is rare but a reason for CO poisoning. Narghile smoking worth 100 cigarette smoking, so for the detection of intoxications should be asked narghile exposure. In these two cases we aim to present CO poisoning due to narghile use.

Case 1: 24 year-old male patient was brought to the ED due to falling after the seizure. He has been diagnosed with epilepsy for 6 years, but he did not take his medications for 1,5 years. He dropped after a generalized tonic-clonic seizure. Blood pressure 110/80 mmHg, pulse 80 beats/min, oxygen saturation by pulse oximetry 92%, his capillary blood glucose was 140 mg/dl. In neurological and other systems examination, there was no any pathology other than nasal crepitus and right zygoma abrasions. Brain computed tomography did not have any pathology except for nasal fracture. Valproic acid level with zero output which he has to use. Despite this, narghile use was questioned. He said that smoked narghile for hours before seizure. Blood gas analysis, which revealed CO-Hb of 25,1 % (normal 0–1.5%). The patient was initially treated with 100% oxygen via a nonrebreather mask with anti- epileptic treatment. Given that the patient had syncope, seizure and CO-Hb > 25%, a decision was made he hospitalized to treat the patient with hyperbaric oxygen. Following this treatment, he remained asymptomatic until his discharge the following day.

Case 2: 17 year-old female patient admitted to the ED with headache and nausea. This previously healthy patient smoked narghile for approximately 6 hours. Vital signs were normal: blood pressure 120/85 mmHg, pulse 78 beats/min, oxygen saturation by pulse oximetry 95%, his capillary blood glucose was 97 mg/dl. Physical examination, including neurological examination was normal. In laboratory workup blood gas analysis which revealed CO-Hb of 23,9%. The patient was initially treated with 100% oxygen and discharge with no symptoms.

Conclusion: For the diagnosis of carbon monoxide poisoning, questioning only common sources such as stove, water heater is not enough. Rare resources such as narghile should always be asked.

Keywords: Narghile, Carbonmonoxide, Poisoning

P-0663 Cardiovascular Emergencies

Sick Sinus Syndrome

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Objective: Disease in the sinus node may cause bradyarrhythmias or tachyarrhythmias. Bradyarrhythmias occur because of impaired automaticity (with or without sinus arrest) or because of sinus node exit block. Reentrant or automatic rhythms may produce tachyarrhythmias. Symptoms and signs of sick sinus syndrome include lightheadedness, palpitation, syncope and peripheral or cerebral emboli. After diagnosis by holter monitoring, symptomatic patients usually improve with placement of a permanent cardiac pacemaker.

Case: 25 years old male patient was admitted to the emergency department with chest pain. In his history such episodes have been occurred few times per year. Each episode has been started with chest pain. Patient have been fatigue and weakness when chest pain started. On her physical examination; blood pressure 120/75 mmHg, pulse 40 beats / min, body temperature 36,3 °C, GCS 15 was observed. Other physical examination was normal. At arrival to the emergency department ECG showed sinus bradycardia. Laboratory examinations were normal. Patients admitted to the emergency department with recurrent attacks were directed to the cardiology clinic Foreign central holter shooting; Pause briefly after the attacks identified nodal warning. Also bradycardic and tachycardia were observed. Sick sinus syndrome were evaluated.

Conclusion: Young patients presenting with chest pain were monitored for bradycardia and tachycardia attacks at emergency department. If sick sinus syndrome is not thought the diagnosis can be skip.

Keywords: Sick Sinus Syndrome, tachyarrhythmias, Bradyarrhythmias

P-0664 Toxicology

Hypercalcemia due to vitamin-D poisoning

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Objective: Vitamin-D deficiency is a common condition. This lead to bone diseases such as osteomalacia; although this poses a risk for many diseases such as cancers, infections, rheumatic diseases, autoimmune diseases, neuropsychiatric diseases, coronary heart disease and hypertension. Here we wanted to offer a patient who presented with clinical hypercalcemia as a result of vitamin-D therapy.

Case: A 20 year old female patient was admitted to the emergency department with anorexia and lethargy symptoms. She was 18 years old and receiving antiepileptic therapy with a diagnosis of Rett syndrome. Patient's relatives reported that she had been on treatment with cholecalciferol (300,000IU/day) ampoules for 20 days by oral route. In the last 10 days symptoms of lethargy and loss of appetite were noted. On physical examination, deterioration in cooperation, orientation and consciousness was found; Glasgow coma score was calculated as 13. In laboratory tests, blood count was normal; kidney, liver tests were found to be normal. In electrolytes such as sodium, potassium and chloride levels were normal. Blood calcium level was 16,5 mg/dl. Blood parathyroid hormone levels was 12,5 pg/ml (normal: 15–65 pg/ml). Vitamin D toxicity was considered as a cause of hypercalcemia and patient was admitted to the internal medicine service.

Conclusion: Vitamin D toxicity dependent hypercalcemia cases are reported in the literature, especially for pediatric patients. However, at least some adult cases have been reported. Hypercalcemia often depends on chronic use. In such cases, discontinuation of the drug, intravenous fluid and diuretic treatments are usually successful. These patients' history and especially drugs which are used are important. Drug incompatibility and misses of control examination, particularly in elderly patients may lead to undesirable results. However, also in young patients these details must be questioned carefully. Drugs which could be used chronically as vitamin D must be prescribed carefully and these patient's control time should be well planned.

Keywords: Vitamin D, toxicology, hypercalcemia

P-0665 Cardiovascular Emergencies

eleveatd red blood cell distribution width in patients with paroxysmal atrial fibrillation

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Objective: Red blood cell distribution width (RDW) has been reported to be a risk marker of morbidity and mortality for some cardiovascular and noncardiovascular diseases. The present study aimed to evaluate RDW in patients who admitted to the emergency department with a diagnosis of paroxysmal atrial fibrillation (PAF).

Materials-Methods: Forty patients with a diagnosis of PAF and 50 age- and gender-matched healthy subjects in sinus rhythm were included in the present study. PAF was defined as recurrent (two or more) episodes of AF that terminate spontaneously in less than 24 hours. Complete blood count and hs-CRP levels were analyzed in all study participants.

Results: The mean RDW values were higher in patients with PAF when compared to the controls (13,9 ± 1,2 versus 13,1 ± 0,8, p<0,0001). The mean leukocyte count and hs-CRP levels



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were also significantly greater in patients with PAF in comparison to the controls. (8440 ± 1.750 vs 7090 ± 1550 , $p < 0.0001$; 2.42 ± 0.53 mg/L vs 1.46 ± 0.52 mg/L, $p < 0.0001$, respectively). Significant correlations between RDW and hs-CRP was identified in patients with PAF ($r = 0.565$ and $p < 0.001$).

Conclusion: Elevated RDW is associated with PAF and may be a useful indicator of inflammatory activity in patients with PAF.

Keywords: Red blood cell distribution width, paroxysmal atrial fibrillation, high-sensitivity C-reactive protein, inflammation

P-0666 Cardiovascular Emergencies

A case of aort dissection with atypical complaint

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Aort dissection leads to high mortality if it is diagnosed late or not diagnosed. Aort dissection takes place due to a forcing of intimal layer and the blood penetrating to the media layer. The patients can visit the hospital with complaints on severe chest and back pain, acute myocardial infarction, syncope, neurological pathologies and acute kidney malfunction. Our case did not apply with such usual complaints; instead reported a pain in chest which increases with breathing. From physical examination, ECG changes and bedside USG data, we put a diagnosis of aort dissection.

Keywords: aort dissection, atypical complaints, emergency department

P-0667 Imaging in Emergency Units

Dress Syndrome In The Emergency Department

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Introduction-Objective: Also known as drug hypersensitivity syndrome, Dress syndrome (drug rash with eosinophilia and systemic symptoms) is a rare, acute drug reaction with life-threatening conditions, which is characterized by fever, skin rash, single or multiple organ involvement, and lymphadenopathy. Its exact prevalence and pathogenesis are unknown. The clinical signs and symptoms develop 1-8 weeks after drug use. The basic principles of treatment are rapid recognition, prompt discontinuation of the responsible agent, and supportive therapy. Systemic corticosteroids and IVIG therapy are still controversial. The mortality of the syndrome varies between 10% and 40%. The aim of this report was to remind clinicians dress syndrome in a patient with rash.

Case: A 57-year-old man presented to our emergency department with fever and rash. His general condition was moderate and he was conscious. His blood pressure was 110/70 mmHg, pulse rate 110 bpm, and body temperature 39.6°C. A maculopapular rash was noted on almost his entire face, anterior and posterior aspects of abdomen, and all his four extremities. There were bilateral cervical lymphadenopathies and diminished breath sounds in both basal lung portions. It was learned from the patient history that he used a second generation cephalosporin against an upper airway disease two weeks ago. Laboratory tests were as follows: white blood cell count: 17.6 K/uL; neutrophil count: 13.8 K/uL; eosinophil count: 2.38 K/uL; ALT: 110 U/L; AST 109 U/L; ALP 357 U/L; CK 254 U/L; GGT 274 U/L; Sedimentation rate: 43 ml/h; HBSAG: negative; ANTIHCV: negative; ANTIHIV: negative. An abdominopelvic ultrasonography revealed an enlarged spleen with a homogenous parenchyma, as well as an enlarged lymph node with a size of 15*7 mm at the periportal area. Transabdominal examination showed 2 cm thick effusion in both pleural spaces. The patient was diagnosed with Dress syndrome and begun on IV methylprednisolone 16 mg tb 2*2, an oral proton pump inhibitor 1*1, and IV phenyramine maleate 1*1. The general status of the patient improved and he was discharged on steroid therapy 32 mg in the morning and 16 mg in the evening, bed rest, and liberal oral fluid replacement.

Conclusion: Dress syndrome is an acute, potentially life-threatening, rare drug reaction. It should be considered in the differential diagnosis of patients presenting with fever, diffuse skin rash, and internal organ involvement and drug use should be questioned. Early recognition and medical therapy are vitally important in management of this rare entity.

Keywords: Dress syndrome, diffuse skin rash, maculopapular rash

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Pres Syndrome In The Emergency Department

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Introduction and Objective: Posterior reversible encephalopathy syndrome (PRES) is characterized by headache, mental disorders, epilepsy, and impaired vision. It usually develops as a result of abruptly increased and poorly compensated arterial pressure and is diagnosed clinically and radiologically.

Although the number of studies reporting that the disease recurrences in various patient populations has recently increased, the available data suggests that it is mostly seen in postpartum period in pregnant women. This case report presents a nulliparous pregnant woman diagnosed with reversible encephalopathy syndrome with the help of clinical and neuroradiological findings and discusses the case in light of the relevant literature.

Case Report: A 38-year-old woman complaining of headache beginning from nuchal area for 2-3 days was brought by her relatives to our emergency department after 2 episodes of convulsive seizure attacks the night before. Her relatives stated that the convulsions were one-sided and lasted for 10 minutes. The patient had no history of any chronic disorder or drug use. Her general status was moderate and she was confused. Her blood pressure was 170/110 mmHg, pulse rate 95 bpm, respiratory rate 22/min, and body temperature 37.5 C. The results of the laboratory tests were as follows: Glucose: 122 mg/dl; Albumin: 3.1 g/dL; WBC: 15.9 K/uL; HGB: 15.8 M/uL. An abdominal ultrasonography showed a 20-week pregnancy. A cranial tomography with abdominal shielding revealed edema typically located in subcortical white matter and symmetrically in cortex in occipital and parietal lobes. PRES was diagnosed with the available clinical and radiological information. The patient showed complete hemodynamic and neurological improvement and was discharged on third day after admission, with obstetrics and neurology outpatient appointments being arranged.

Conclusion: PRES is a condition of multifactorial origin with variable clinical signs that is diagnosed by radiological imaging methods. Early diagnosis allows resolution of symptoms without sequelae. This case report aimed to remind clinicians' necessary points for the etiology and differential diagnosis of PRES, a condition well known by neuroradiologists and neurologists, but not frequently encountered by emergency physicians.

Keywords: encephalopathy syndrome, neuroradiological findings, pregnant woman

P-0669 Cardiovascular Emergencies

The Dilemma of acute myocarditis and acute myocardial infarction

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Objective: The first diagnosis in patients with chest pain and ST segment elevation must be acute myocardial infarction. But acute myocardial infarction sometimes can be confused with other diseases such as myocarditis. The treatment and prognosis of those two diseases are completely different from each other because of that differential diagnosis and decision of coronary angiography lifesaving. Electrocardiography is very important in the differentiation of these diseases. Although ECG findings are different from each other in acute myocarditis and acute myocardial infarction; sometimes they can imitate each other.

Case: 20-year-old male patient was admitted to the emergency department with sudden chest pain onset 2 hours ago. The patient has been severe influenza infections two weeks ago. Minimal PR depression and concave ST elevation of 1 mm in first derivation, also 1 mm concave ST elevation in lead aVL was observed in 12-lead electrocardiography. In third derivation and in aVF 1 mm evident ST segment depression was observed. On admission troponin and d-dimer values were negative. Chest pain on precordium was pressured and spread to the patient's lower jaw, severity of pain was decreasing by leaning forward or changing the position. First of all intramuscular diclofenac sodium 75 mg / im was injected and acetylsalicylic acid 300 mg, metoprolol iv 25 mg, nitroglycerin 5 micrograms / min was added as a precaution for the possible acute lateral myocardial infarction or vasospastic angina. There was no response to nitrate, analgesic and anti-inflammatory agents. After 15 hours of admission, in ECG, ST elevation in leads of V5-V6 viewed which had not been in the first ECG. For this reason coronary angiography was performed on the patient and evaluated as normal.

Conclusion: Patients with chest pain are not always admitted with typical complaints. Patients with myopericarditis with atypical presentation can be confused with myocardial infarction. Unlike our traditional knowledge, reciprocal ST depression also may be observed in myopericarditis, physicians should have knowledge on this subject. There is not enough information in



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the literature on this subject. It should be made a wider research for the separation of these two entity which treatment and prognosis completely different to each other

Keywords: myocarditis, myocardial infarction, vasospastic angina

P-0670 Toxicology

Palpitation and Carbonmonoxide

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Objective: Carbonmonoxide intoxication cause hypoxia and ischemia in tissues. They are cardiovascular and central nerve system injuries that mostly influenced and life-threatening due to hypoxia. In this study, detection of carbonmonoxide intoxication as the reason of palpitation of a case who admitted to the emergency department with palpitation is shared.

Case: 58 years old female admitted to the emergency department with complaints of palpitation. Vital signs of the case who is conscious and has a good medical condition were measured as blood pressure: 90/60 mmHg, heart rate: 80 pulse/min, SpO₂: 94%. There was bigeminy extrasystole in the ECG of the case who has not have ever dysrhythmia diagnosis (Figure). Systemic examination was evaluated as normal. Carboxyhemoglobin (COHb) level was measured as 31.8 % in blood gas analysis. Other biochemical tests were normal. Normobaric therapy was performed. Hyperbaric oxygen therapy was not needed. Normobaric therapy was continued for the case who was kept under observation in Cardiology Department. Decreasing and disappearing of extrasystoles were observed during the therapy. Control COHb level was measured as 4.2 % six hours later. Case who was normal for control biochemical tests and echocardiography was discharged with full recovery.

Conclusion: CO exposure may cause ischemia and conduction abnormalities in cardiovascular system. Sinus tachycardia is most frequently detected among ECG findings. ST-T depression which is an evidence of ischemia is also frequent. Fatal rhythm abnormalities such ventricular tachycardia and ventricular fibrillation can also occurred. Even if there is not another complaint, CO intoxication should be considered in patients who are admitted to the emergency department with palpitation and in these cases, should be careful for rhythm abnormalities.

Keywords: Bigeminy extrasystole, palpitation, carbonmonoxide

P-0671 Toxicology

Managing The Patient Poured Down Cellulosic Paint At Emergency Department

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Objective: Cellulosic paints are industrial materials that widely used in a broad range of industries. Cellulosic paints contain varying amounts of multiple chemical components mainly acetone, cosolvent, butyl alcohol and toluene. Components of cellulosic paints have detrimental effects on human health. Besides these possible consequences, clinical effects are substantially depends on length of time, way and amount of chemical exposure. Unfortunately, in current literature, the management strategy of the exposures is not stated clearly. Our study represents a case of accidental cellulosic paint exposure by pouring down on head and our experiences about managing this patient and cleaning up the paint.

Case: A 20-year old man presented to our emergency department with a complaint of cellulosic paint exposure as an occupational accident. Exposure happened by pouring down on head 15 minutes before admission. At initial examination; his face, head, neck and upper extremities were covered by black cellulosic paint. The patient failed to see because the periorbital region and eyelids were covered by paint. His vital signs were BP:131/71 mmHg, pulse rate: 111/bpm (regular), temperature: 36 °C, SaO₂: 99 % and respiratory rate: 12/per minute. His state of conscious was assessed agitated (GCS:14). ECG was sinus tachycardia. After initial examination, cellulosic paint was primarily removed by washing with water and soap and the patient's hair cut. We had to wipe with thinner to remove residual paint remnants on patient's ears, eyebrows and nails. Eyes were washed with saline solution, and then eye drop including NSAID applied. Patient's whole blood count, blood urea, creatinin, sodium, potassium, SGOT, SGPT, PTZ, INR and arterial blood gases (pH:7.398) were all in normal ranges. Blood toxicological (GC-FID/HS) analysis detected toluene at blood sample. At follow-up patient had insomnia and eye irritation for 7 and 3 days, respectively.

Conclusion: In recent literature, majority of intoxications with toluene has been reported as intentional or accidental inhalation of fumes. Our case represents a different exposure way of toluene toxicity. We suggest that initial (tachycardia, agitation, eye irritation) and follow-up symptoms (insomnia, eye irritation) were caused by toluene intoxication. In case of exposure, cellulosic paint substantially should be removed by washing with soap and water as soon as possible. We recommend using low amounts of thinner to remove residual paint at nails, ears and eyebrows. Instead of cleaning with water or thinner, cutting the patient's painted site of the hair will be safer and practical.

Keywords: Cellulosic paint, toluene, insomnia

P-0672 Cardiovascular Emergencies

A case of st elevation myocardial infarction associated with 5-flourourasil: left main coronary artery trombus

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Objective: 5-Flourourasil (5-FU) has been used in the chemotherapeutic treatment of gastrointestinal malignancies for many years. However, in addition to its beneficial antitumor effects, 5-FU also possesses a number of important side effects.. Cardiotoxicity is a rare adverse effect of 5-FU, has a reported incidence of 1.2% to 18%. The pathogenesis of 5-FU cardiotoxicity is not clear and coronary vasospasm is the prevalent suggested hypothesis. However, several mechanisms have been also described that cause cardiotoxicity such as endothelial damage, thrombogenic effects, direct myocardial toxicity. 5-FU may lead to the development of thrombosis by inducing endothelial damage in patients with coronary artery disease.

Case: 67 year-old man was admitted to the general surgery clinic with vomiting, stomachache, weight loss one months ago. Gastric cancer (T1 N2 M1) had diagnosed after gastroscopy and biopsy evaluation. A subtotal gastrectomy + omentectomy had done 20 days ago. 5 flourourasil+ folinic asit chemotherapy administration was decided after operation. A severe chest pain was occurred after 20 hours later of 750 mg/m 5-FU and 30 mg folinic asit administration. Electrocardiography showed st elevation on anterior leads (V1-V6) and reciprocal depressions on inferior leads (II,III,avF).he had gone to catheter laboratory. A trombus and vasospasm was seen concomitantly distal segment of left main coronary artery that causes %70 stenosis on coronary angiography.

Conclusion: Previously st elevation myocardial infarction after 5 FU reports was mentioned only one contributory mechanism. it was generally vasospasm. St elevation MI due to thrombus was very rare. In our case vasospasm as well as thrombus formation was observed with both. In our knowledge there was no data about these two mechanisms involving simultaneously. This case supports the vasospastic and thrombogenic hypothesis of 5-FU cardiac toxicity and treatment of 5-FU cardiotoxicity all patients should have a careful evaluation for cardiovascular risk factors as well as any subclinical CAD or cardiomyopathies which may be exacerbated by 5-FU infusion

Keywords: 5-flourourasil, Cardiotoxicity, St elevation myocardial infarction

P-0673 Toxicology

Botulismus; A lucky botulinum exposure: case report

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Objective: Botulism is a neuropathic illness which is caused by exotoxins of clostridium botulinum, a gram positive anaerobic bacteria that's common at soil. It is well known that there are seven types of toxins, but only four of those (A, B, E, F) cause illnesses on humans. Poisoning usually occurs after ingesting the bacteria that's found in homemade canned foods. Botulinum toxin irreversible blokades the presynaptic and autonomic nerve cholinergic tip acetylcholine release at neuromuscular junction. There are four clinically identified types: 1. Foodborne botulism, 2. Wound botulism, 3. Infant botulism and 4. Unclassified botulism.

Case: A 32 year-old female cardiovascular surgeon came to home after her long shift and ate the spinach that her mother canned 10 days ago while its still hot. 5 hours later she referred to emergency service with botulinum exposure findings including numbness around her chin, trismus, dysphagia, nausea and diplopia. At her physical examination bilateral midriasis and hypoesthesia at nervus mandibularis, which is the 3rd brach of nervus trigeminus, was found. The gastric lavage was made and then patient was admitted to the intensive care unit for close



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follow-up and consulted to the infectious diseases, neurology and anesthesia departments. After neurological and infectious diseases department's assessment, Botulinum antitoxin was provided from Presidency of Refik Saydam Health Centre with botulism initial diagnosis. 12 hours after initial toxin intake, 500 mL Botulinum anti-toxin (Botulinum Antitoxin Behring®, against type A, B, E types, 250 mL) infusion was given within 5 hours. Complaint which regressed first was diplopia. Patient got discharged after 48 hours of close follow-up.

Conclusion: It is important to keep botulism in mind in patients with these complaints. Disease usually come up within 18-36 hours of initial intake, but in some cases this time period can shorten to 2 hours or can lengthen to 8 days. The disease affects ocular and orofaryngeal muscles first. Initial findings can be blurred vision, dysarthria and dysphagia and then spreads to extremity and respiratory muscles with increasing its severity.

Diagnosis is usually made with anamnesis and physical examination. Electrophysiological studies may not give tips at early stages. Other neurological diseases gets excluded with cranial displaying methods. The most important part of botulism therapy is close follow-up of respiratory function. The follow-up should be made within intensive care units as there can be a respiratory support need. Botulinum anti-toxin should be considered at the early stages of the therapy.

Keywords: Botulism, toxin, emergency

P-0674 Cardiovascular Emergencies

A rare cause of acute coronary syndrome: malignant right coronary artery

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Objective: In the absence of significant coronary artery diseases coronary artery anomalies can cause angina, acute myocardial infarction and sudden death. The incidence of coronary anomaly is %0,27-%1,2 in the literature. The anomaly of right coronary artery generally thought benign, but sometimes it can be dangerous. The right coronary artery (RCA) can undergo compression between the aorta and the pulmonary trunk, especially during exercise, and this carries the risk of sudden cardiac death. So it is called malignant right coronary artery.

Case: 60 year old man admitted to emergency department with chest pain for 1 hour. He has no previous coronary artery diseases. On admission electrocardiography revealed ST depression in the II, III, aVF leads (inferior leads) with sinus rhythm. His chest pain respond to nitroglycerin. Tension arterial was 130/70 mmHg, heart rate 76/min respectively. Physical examination was unremarkable. S1 S2 were normal, there was no S3 and murmur. Troponin was 0.02 mg/dl on admission (after 1 hour). Crp was 1,2 mg/dl otherwise normal. So firstly acute coronary syndrome was considered. He was taken to CCU for further examination. Left anterior descending artery, circumflex artery were normal and a poor image could be obtained on coronary angiography suggesting the RCA to be originated from the left sinus of valsalva. Multislice CT was performed because of suspicion of interarterial coursing the RCA. On 256 slice CT, the RCA was arising from the left sinus of valsalva. Proximal segment of the RCA was coursing and compressing between the aorta and the pulmonary artery. Surgical treatment was advised and medication including beta-blockers and acetylsalicylic acid was initiated. The patient refused surgery and has been asymptomatic at follow-up.

Conclusion: In this anomaly, the RCA generally courses between the aorta and the pulmonary artery. The findings described above are characteristic of a malignant RCA. It is called "malignant" because the RCA can undergo compression between the aorta and the pulmonary trunk, especially during exercise, and this carries the risk of sudden cardiac death. Multislice CT demonstrated superior imaging capability compared to conventional coronary angiography in demonstrating the origin, course and relationship with other vessels and chambers of anomalous coronary artery. The optimal treatment for this anomaly is controversial. Some authors propose surgical treatment such as translocation, ostioplasty or bypass grafting. However, it was reported that medical treatment with beta-blockers was also effective in resolving the symptoms. The acute coronary syndrome may be occurred coronary artery compression.

Keywords: malignant right coronary artery, multislice computerized tomography, acute coronary syndrome

P-0675 Cardiovascular Emergencies

Total abdominal aortic occlusion diagnosed in a patient entered emergency department by walking

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Objective: Thrombosis is the formation of a blood clot inside a blood vessel, obstructing the flow of blood through the circulatory system. The risk of thrombosis is increased in hypercoagulability. Hypercoagulability can be inherited or acquired. A patient with inherited hypercoagulability is usually under the risk of facing with venous thromboembolism. Here, we want to present a patient with inherited hypercoagulability who came in the emergency department by walking and was diagnosed as acute aortic thrombosis and acute renal artery thrombosis.

Case: A 48-year-old female patient presented to our emergency medicine department with a history of right flank pain for 30 minutes. The pain had started abruptly and was in continuous characteristic. She came in the emergency medicine department by walking. Also, she had dysuria and low back pain for a month. Her medical history revealed that she had hypertension, asthma, and mitral valve insufficiency. On her physical examination the vital signs were in normal range. There was no tenderness, guarding and rebound signs on abdominal examination. There was costovertebral angle tenderness on right flank examination. In her laboratory investigation, leukocyte count, and biochemistry results were in normal range. In her urinalysis, there were leukocytes and erythrocytes in urine. Her abdominal ultrasound was normal. Her abdominal pain did not relieve with hydration and antispasmodic medication. Then, contrast enhanced abdominal computed tomography was performed. Abdominal CT showed that there were right renal infarction, right artery occlusion, and abdominal aortic thrombus at the level of iliac bifurcation. Although there was no blood flow in both external iliac arteries, there was blood flow in both internal and femoral arteries by collaterals. Angiography was performed and the thrombus in abdominal aorta was aspirated. An aortic stent was implanted to abdominal aorta. Her genetic analysis revealed that she had MTHFR (A1298C) and PAI-1 (4G/5G) gene mutations. She was discharged from hospital without any complication after 11-days follow-up period.

Conclusion: Abdominal aortic thrombus is a relatively rare complication of hypercoagulability. Total occlusion of aorta is generally presented with pain, pallor, weakness and numbness of lower limbs. In our case, there was none of these signs due to the blood flow supplied by collaterals. It is a challenge to diagnose total aortic occlusion in patient that comes in emergency department by walking.

Keywords: thrombosis, abdominal aorta, renal artery

P-0676 Cardiovascular Emergencies

Thrombolytic therapy during cardiopulmonary resuscitation

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Objective: Pulmonary embolism is a life-threatening clinical condition, that the diagnosis is based on clinical suspicion. Thrombolytic therapy during cardiopulmonary resuscitation (CPR) is recommended in patients with cardiopulmonary arrest due to suspected pulmonary embolism in 2010 AHA Guidelines for CPR as Class IIb recommendation. Here, we want to present a young patient with massive pulmonary embolism, treated by thrombolytic therapy during CPR in the emergency department, and discharged from hospital by walking.

Case: A 38-year-old male patient presented to emergency medicine department with dyspnea and chest pain. His chest pain had begun suddenly with accompanying dyspnea, and increased by time. His medical history revealed that he had had chronic deep vein thrombosis of his right leg for 8 years. On his physical examination his general status was poor, his arterial blood pressure could be detected, his pulse rate was 145/min and he was cyanotic. Bed-side echocardiography was performed by emergency physicians, and revealed that there was a mobilized thrombus in the right atrium. Just one minute after echocardiography, cardiopulmonary arrest was developed. Then, the patient was resuscitated for 5 minutes. After ROSC was obtained, 100 mg alteplase was given as thrombolytic therapy. He was resuscitated twice during the thrombolytic therapy, and ROSC was again obtained. He was admitted to coronary intensive care unit. He was extubated on the same day. He was discharged from hospital at 6th day without additional complication. He was able to walk and talk at discharge.

Conclusion: Although the most feared complications of thrombolytic therapy given during CPR are intracerebral and pulmonary bleedings, we should not hesitate to treat the patient with thrombolytic therapy if we think the cardiopulmonary arrest is due to pulmonary embolism. Our case shows that early thrombolytic therapy, bed-side echocardiography performed by emergency physicians, and efficient CPR are very important issues of emergency management of patients with massive pulmonary embolism.

Keywords: cpr, pulmonary embolism, thrombolytic



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P-0677 Toxicology

Skipped Reality; Honey Production Centers Possibility Of Pentane Gas Intoxication

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Objective: Pentanes are components of some fuels and are employed as specialty solvents in the laboratory. Pentanes are relatively inexpensive and are the most volatile alkanes that are liquid at room temperature, so they are often used in the laboratory as solvents that can be conveniently evaporated. Pentane is used in production of honey. Pentane gas side effects: mixing air with high density makes dizziness and headache. Anesthetic (numbness) impact leads. Eyes and skin contact: Redness, irritation. Pentane gas is not likely to be hazardous if swallowed.

Case: 61 year old male patient to the emergency department with headache, dizziness and funny turn was brought with complaints. Patients with no history of the disease. The story is running in place before headach and dizziness. After it was learned that the patient had collapsed. On his physical examination; blood pressure 180/110 mmHg, pulse 64 beats / min, body temperature 36.7 °C, blood sugar 143 mmol/l, GCS 15 was observed. The patient had stasis dermatitis. Other physical examination was normal. At arrival to the emergency department ECG was normal. The patient had normal brain CT. Diffusion MR review; 3 at the level of the right middle part of the cingulate gyrus adjacent large 4 mm in diameter, in the middle part of the left centrum semiovale 3 mm in diameter limitation of diffusion lesions are observed. V4 segment of the right vertebral artery hypoplasia in appearance. Multiple bilateral periventricular white matter deep cerebral ischemic microangiopathic - gliotic foci are observed. Laboratory examinations were normal. When deepening the patient's history patients were working in the center of honey production and had been staying there. Patients due to business; exposed to some substance if inhaled. Where the patient stayed pentane gas had been used. Patients were consulted in neurology. Of the patient's clinical was said to be incompatible with the radiological images by neurology. Patients were followed up for 16 hours in the emergency department. Patient controlled lab experiments and radiological imaging was performed. Patients did not change the results. The patient's symptoms have passed. Patient clinic could not be explained by radiological imaging and lab experiments. The patient was thought to be the pentane gas intoxication. The patient was discharged with recommendations.

Conclusion: Beekeeping is prevalent in our country pentane gas is used in the production of honey. Dizziness, headache and funny turn should be considered in patients presenting with intoxication.

Keywords: Intoxication, pentane, headache

P-0678 Toxicology

Intravenous lipid therapy in beta-blocker intoxication

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Objective: intravenous lipid emulsions in the treatment of cardiovascular collapse due to local anesthetic agent is used for a long time. Especially in recent years, this treatment of local anesthetics as well as other lipophilic drugs that have been used in the treatment of cardiotoxicity. Especially calcium channel blockers, beta blockers, parasites, herbicides and various psychotropic medications with drugs developed has been successfully applied in over doses. With intravenous lipid emulsions treatment (IVLET), in the target tissue the amount of active drug is reduced and so is prevented toxicity. Successfully applied in the emergency room beta-blocker intoxication cases we offer.

Case: Thirty years old male patient, before admission to the emergency department, thirty minutes ago, due to taking twenty pills (BELOC ZOKR), was brought by relatives. During admission of patients with complaints of dizziness, blood pressure 90/60 mmHg, pulse 75 beats/min, body temperature 36.8 degrees Celsius and 95% oxygen saturation was measured. In good general condition, mentally awared, oriented cooperative was good. Any property in history and family history are not available. In the anamnesis, due to psychological distress in the specified drugs taken about thirty minutes before using any other medicine, he said. ECG was performed immediately. Complete blood count, biochemistry, coagulation tests were performed. Also seen on chest x-ray. ECG in sinus rhythm and heart rate seventy-three beats/min was measured. 2000 cc with tap water almost patient orogastric lavage was performed. Fifty grams of activated charcoal was applied orally. Starting with isotonic saline infusion were observed. Did not detect any abnormalities in laboratory values. In follow-up systolic blood pressure of 80-90 mm Hg and diastolic blood pressure of 40-60 mmHg range due to the continuation and persistence of dizziness intravenous lipid therapy was started. Post-treatment blood pressure was 110/70 mmHg, and regressed patients complaining of dizziness asymptomatic period of twenty-four hours after, he was discharged from the emergency department as well.

Conclusion: IVLET especially caused by lipophilic drug toxicity, in the emergency room and intensive care units have become an accepted treatment approach. Beta blocker caused by intoxication decontamination treatment, fluid treatment, includes treating vasopressin and glucagon. Especially in cases of intoxication IVLET, resistant to conventional treatment approaches, may be a safe and effective treatment.

Keywords: intravenous lipid, beta blocker, intoxication

P-0679 Toxicology

Piles Of Grass Induced Toxic Hepatitis Cases

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Objective: Recently, cases of toxic hepatitis due to herbal products, the incidence is increasing. Also known as piles or small celandine herb, also known as buttercup ranunculus Ficaria familia among the bushes that grow in the spring, is a small plant. Among the people is used for hemorrhoid. Boiling the plant root is formed into flakes, and then is applied locally on the hemorrhoids. Also, because of the influence of antimicrobial, are also used to clean wounds. Solely by reason of being a poisonous plant is used externally. Piles herb (ranunculus Ficaria) are known to be toxic in combination protoanemo and anemone derivatives are a very small amount. Furthermore, saponins and vitamin C contains. Due to the structure of these toxic substances in the liver was thought to be harmful, but no cases have been reported.

Here we describe, due to the use of piles of grass, a case of acute hepatitis.

Case: Thirty-six years old female patient, is a day with complaints of nausea and vomiting continued, was admitted to the emergency room. Without additional complaints of the patient's physical examination was normal. In her history was unremarkable. Laboratory examination ALT 468 U/L, AST 268 U/L, WBC 11600 x10³/μL, PTT 3.15 sec., INR 1.34 was determined to be. Other values were within normal limits. Hepatobiliary ultrasonography, was reported as normal except for hepatic steatosis grade 1. In a few weeks before, the patient's medical history was learned that hemorrhoids herb. Patients with disorders due to liver function tests after being consulted by the gastroenterology department for follow-up were being treated at the gastroenterology service. With medical therapy in patients who were followed for five days, additional tests may be explained in the liver function test disorder pathology and laboratory values regression was not found. Thereupon she was discharged with healing.

Conclusion: Lack of enough information about herbal treatments on this issue is caused by inadequacy of scientific works on. All active substances contained in plants is not known, and therefore their effects are not predictable. Adverse effects may occur months to years after, so follow-up is made difficult.

In our case, that cause acute hepatitis after exclusion of evolving hemorrhoids herb may cause hepatitis has been concluded.

This may occur after use of the plant's toxic hepatitis think we should keep in mind.

Keywords: Toxic hepatitis, Grass, Herbal products

P-0680 Imaging in Emergency Units

Alveolar consolidation in bedside ultrasonography, pneumonia

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Objective: Acute dyspnea is one of the most common reasons patients present to emergency departments (EDs). In most cases, the physical examination and bedside radiography are inconclusive, resulting in the need for more sophisticated diagnostics(1). These diagnostics may delay treatment or expose the patient to unnecessary radiation. We present a case of dyspnea due to pneumonia in a patient that was diagnosed using bedside thoracic ultrasound.

Case: An 57-year-old man was brought to our emergency department with complaints of fever, cough and dyspnea. The history obtained from his relatives revealed that his complaints have began five days ago. His temperature was 38.5 °C, blood pressure was 90/60 mm Hg, pulse rate was 128, respiratory rate was 28/min, oxygen saturation was 92 % with pulse oxymeter. On physical examination, he was found to be lethargic, crackles were heard on right sides of thorax, the rest of the examination was normal. His medical history was unremarkable. Initial investigations on admission confirmed leukocytosis(18,500/μL, 84% neutrophils). Arterial blood gas analysis revealed hypoxemia (pH:7.35, pO₂: 65 mm Hg, pCO₂: 30 mm Hg). Bedside thoracic ultrasound (TUS) performed. Right middle lobe consolidation and pleural effusion were seen by TUS (Fig. 1), computed thoracic tomography (CT) scan has revealed presence of



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lobular consolidations (Fig. 2). Patient's thorax X-ray graphy was as in fig 3.

Conclusion: Radiographs can diagnose many common diseases related to thoracic pathology, including pneumothorax, pleural effusion, alveolar consolidation and interstitial syndrome(1). The posterior lung areas can immediately indicate pleural effusion and 90% of acute alveolar consolidation (AAA) locations. Consolidation yields two characteristic patterns, which are called tissue-like signs and shred signs (2). The consolidated lung has a tissue-like pattern that is echogenic, with regular trabeculations reminiscent of a liver (Fig. 1). The lung border is observed as shredded with an uneven surface if it is in contact with the pleural surface. It has been shown that when the definition of the AAA includes both of these signs, the sensitivity of ultrasound is 90% and the specificity of CT, which is considered the gold standard, is 98%(3). In conclusion, TUS may be used for diagnosing pneumonia in the ED because it has high accuracy, low cost and no radiation exposure. Furthermore, it can be used bedside, and there is no need to transport an emergent patient to the radiology unit.

Keywords: bedside ultrasonography, pneumonia, emergency

P-0681 Imaging in Emergency Units

Sonographic bedside detection of sialolithiasis

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Objective: Sialolithiasis is the presence of stones or calculi in the salivary gland ducts and sialadenitis is defined as inflammation of the salivary gland (1). As a result of the superficial position and accessibility of the salivary glands, ultrasonography can be used as an inexpensive first-line imaging technique to evaluate undifferentiated neck swelling. Ultrasound has a reported 96% accuracy in the diagnosis of sialolithiasis (1). We report a case of a patient presenting with unilateral neck swelling where emergency physician performed bedside ultrasonography allowed rapid identification of sialolithiasis that was later confirmed by computed tomography (CT).

Case: A 46-year-old woman came to the emergency department with a chief complaint of neck swelling. The patient reported progressively worsening right-sided neck pain and swelling for 2 days after eating lemon. She had any additional complaint in the story. The patient's vital signs were stable. The physical examination was significant for right mandibular and submandibular swelling with tenderness to palpation. The mouth and oropharynx were unremarkable with normal-appearing dentition. The other system examinations were normal. Laboratory analysis was significant for a white blood cell count of 13.7 K/mL. A bedside ultrasound of the submandibular region was performed as well as CT imaging. Ultrasound showed a discrete hyperechoic structure surrounded by hypoechoic fluid and heterogeneous tissue. A submandibular salivary gland on the right with a dilated Wharton's duct. There were no evidences of cellulitis or abscess. Wharton's duct was followed from the right submandibular gland to the distal end. A small hyperechoic structure was detected within the lumen of the duct and had significant posterior shadowing. CT scan demonstrated asymmetric enhancement of the submandibular gland with dilation of the proximal portion of Wharton's duct with obstructive sialolithiasis. The patient was discharged with prescriptions for an antibiotic and pain medications and a plan for outpatient follow-up with the otorhinolaryngologist.

Conclusion: Sialolithiasis has an incidence of about 1% in the general population and is the main cause of overall salivary gland obstruction [2,3]. The submandibular gland is most commonly affected at around 92 % [4]. The sonographic bedside detection of size and location of salivary stones in acutely symptomatic patients with obstructive sialolithiasis could help the emergency physician guide management of these patients at the bedside[2-4]. This approach may also help limit patient exposure to additional imaging modalities using radiation, such as computed tomography, especially in the young patient population.

Keywords: bedside ultrasound, sialolithiasis, neck mass

P-0682 Imaging in Emergency Units

Bedside Ultrasound Aids Identification And Removal Of Cutaneous Foreign Bodies

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Objective: A variety of imaging modalities are available to the emergency physician in the evaluation of patients with cutaneous foreign bodies (FB). Plain radiography is quick and inexpensive, but does not reliably identify certain types of FB and gives no information about location relative to anatomic structures other than bone (1). In this setting, bedside ultrasound offers high-definition imaging, and is inexpensive, easy, and does not expose the patient to radiation(2).

Case: Twenty-five year old auto mechanic applied to emergency service with a ring-shaped scar on his right second metacarpopharyngeal joint caused by a piece of metal. The range of motion of that joint was total but painful. There was no neurovascular deficit. Plain radiography demonstrated a radiopaque FB within the soft tissue of the hand overlying the metacarpophalangeal joint (Figure 1). Bedside ultrasound performed by the emergency physician showed that the FB was superficial to the joint(Figure 2). Given this superficial location, the physician decided to remove the FB in the ED. After local infiltration with lidocaine, ultrasound was used to guide a needle towards the FB. A small incision and blunt dissection around the needle led to discovery and removal of the FB. This procedure was performed without complication. At a follow-up call 1 week later, he was doing well.

Conclusion: Traumatic soft tissue injury, including penetrating injuries and lacerations, are common reasons for ED visits. These injuries are often complicated by retained foreign bodies, most commonly wood, glass, metal, plastic, or gravel. Detection of foreign bodies can be difficult, because they may initially be asymptomatic, and some objects are radiolucent. Plain radiography is low cost and easy to obtain, and sensitivities are high for radiopaque foreign bodies such as metal and glass (100%,93 %) (1,2). For substances that are radiolucent, such as wood or certain types of plastic, standard radiographs are of limited use, with only 15% of wooden foreign bodies visualized (3,4). Ultrasound is able to detect almost all foreign bodies, regardless of composition. Sensitivity for detecting all foreign bodies has been reported to be as high as 94–98% (3,5,6). Both wood and plastic are better visualized by ultrasound than by plain radiography. Because ultrasound permits excellent visualization of surrounding anatomical structures including arteries, veins, nerves, and muscle bundles, it is a useful tool in making the informed decision to proceed with removal by the emergency physician in the ED.

Keywords: ultrasound, foreign body, imaging

P-0683 Toxicology

Bradycardia Due To Mad Honey Poisoning: A Case Report

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Objective: Mad honey poisoning is one of the common food intoxications that can occur after the eating of honey that contains grayanotoxin. Japan, Nepal, Brazil, parts of North America and Europe, and the eastern Black Sea region of Turkey. It causes a sharp burning sensation in the throat and thus is also referred to as "bitter honey". This form of poisoning has been known since 401 BC. Clinically, grayanotoxin in low doses is caused by dizziness, hypotension, and bradycardia; in high doses is caused by impaired consciousness, syncope, atrioventricular block, and asystole owing to vagal stimulation. Therefore, hypotension and bradycardia are the most frequent symptoms of the intoxication. This case report describes a case of honey poisoning related bradycardia and hypotension and the patient's response to atropine.

Case: A 65-year-old man was admitted to the emergency department with dizziness and syncope that arose after eating a few spoonfuls of honey. The patient had no cardiac problem other than congestive heart failure. On physical examination, the patient had a temperature of 37°C, a heart rate of 54 beats per minute(bpm), a respiratory rate of 12 breaths/min, and a right upper extremity manual blood pressure of 80/50 mmHg in the supine position. There was sinus bradycardia in his electrocardiogram. His routine hematological and biochemical parameters were normal. Parenteral fluid was administered, and atropine (0.5 mg) was given for symptomatic treatment of hypotension and bradycardia. Five minutes later his heart rate increased to 70 bpm and his blood pressure increased to 110/60 mmHg. He was observed in the emergency room. When the patient became clinically asymptomatic, he was discharged after eight hours.

Conclusion: When a patient is brought to emergency department with dizziness, bradycardia and syncope, we must think diagnosis of mad honey poisoning in this patient and it can be treated with intravenous fluids and atropine.

Keywords: atropine, bradycardia, mad honey



POSTER PRESENTATIONS

P-0684 Toxicology

An Important Clue: Barbiturate Bubbles

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Objective: The barbiturates which belong to the sedative-hypnotic drug group, are not preferred nowadays because they cause addiction and they present a narrow therapeutic efficiency interval and are used out of purpose. However, this drug is free in countries such as USA, Canada, and Japan. Clinical symptoms are dose-dependent. Central nervous system depression is the most important effect at high dose. Symptoms such as deep coma, hypotonicity and decrease in reflexes may be observed. In 6% of barbiturate poisoning cases, the mechanism is not well known but skin symptoms called barbiturate bubbles may be observed. In our presentation, we have described the case of deep coma and barbiturate bubbles associated to barbiturate toxicity.

Case: The general situation of a 67 year-old female patient taken to our hospital by an ambulance was bad and her point on Glasgow Coma Scale was 3. She has been intubated and put under mechanic ventilation. In her history, it has been determined that she and her husband had not been contacted for two days and then they have been found lying on the floor by the police who have been called by their relatives. Her husband has been taken to our hospital with a cardiopulmonary arrest, but he did not answer to the cardiopulmonary resuscitation and died. The values for the patient were as follow: Arterial tension: 90/65 mm hg, Pulse: 105/minute, finger tips sO₂: 94% intubated. In her electrocardiography, 105/minute sinus tachycardia has been observed. In the systemic physical examination, bullous skin lesions have been observed in ankle. In the urine toxicology, tricyclic antidepressant, and positivity has been observed in barbiturate parameters. A minimal edema has been detected in brain tomography and the patient has been hospitalized in intensive care unit and has been followed-up. At the 4th day of the follow-up, she has regained consciousness and the mechanic ventilation support has been stopped. The bullous lesions observed in feet have regressed. At the 6th day of the follow-up, the psychiatry clinic came into action.

Conclusion: Despite the limitations about the use of barbiturate all over the world, it is possible to encounter intoxication cases. We have wanted to remember the importance of bullous skin lesions associated to barbiturate intoxication for patient taken to the hospital being unconscious.

Keywords: barbiturates, bubbles, poisoning

P-0685 Imaging in Emergency Units

Pulmonary embolism developing after rib fracture

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Objective: Thorax trauma is supposed to be responsible for 25% of deaths. Mortality, morbidity, ventilator care or the hospitalization time increases in patients who present additional diseases such as heart disease, chronic lung diseases, diabetes, and obesity. Moreover, the risk of complication development has been declared to be more important for 3 or more rib fractures. However, in literature studies, we have not determined any association of rib fracture and acute pulmonary embolism. In this presentation, we aimed to expose a case of rib fracture and acute pulmonary embolism association.

Case: The general state of a 25-years male patient brought to our clinic after a traffic accident in a car is good, the vital results are as follow, arterial tension; 130/85 mmHg, heart rate; 110/ minute, fingertip saturation O₂; 94%. In the systemic physical examination, pain sensitivity was present between the 6th-10th ribs in the anterolateral region of the left hemithorax. No additional wounding due to the trauma has been observed in physical examination. The anamnesis has shown that the patient had no known disease, he does not use any drug, that he does not smoke, drink alcohol or any other noxious substance. Free fluid has not been detected in the abdomen in bedside ultrasonography. A suspicious fracture line has been observed in left 7th-8th ribs in the posterior anterior lung graphy. In arterial blood gas analysis, the results were pH; 7.45, pCO₂ mmHg30, pO₂; 50 mmHg, Saturation O₂: 94%. In spite of the 100% oxygen support provided to the patient, the fingertip oxygen level did not come up 95%. In the thorax angio-tomography performed for advanced examination purpose, acute thrombus has been observed in the upper section of the left pulmonary artery. Heparinization has been started for the patient who had not hemothorax and hospitalized in emergency intensive care unit. No pathology has been detected in the studied thrombophilia panel and in the methyl tetrahydrofolate reductase enzymes. The patient has been discharged from the hospital at the 14th day of the monitoring and treatment.

Conclusion: We wanted to show that acute pulmonary embolism may be observed as a complication in patients with traumatic rib fracture and to emphasize on the importance the early diagnosis examinations in suspicious cases.

Keywords: rib fracture, traffic accident, pulmonary embolism

P-0686 Toxicology

Hemodialysis in Theophylline Intoxication

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Objective: Theophylline is a methylxanthine derivatives used in the treatment of adults with chronic obstructive pulmonary disease (COPD) and asthma. Theophylline intoxication may present as nausea, vomiting, palpitations, difficulty in breathing, cardiac arrhythmias, status epilepticus, coma, and death. It have been shown that chronic theophylline intoxication are more deadly than acute intoxication. In this case, we presented a male patient with theophylline intoxication after taking theophylline for suicidal purpose

Case: A 44-years-old male patient was brought to our emergency department with chest pain and dizziness after taking 30 tablets of 200mg theophylline. Patient's general condition was normal and he was conscious. Patient was having nausea, vomiting, dry mouth, tachypnea. On physical examination, his arterial blood pressure was 100/60 mmHg, his heart rate was 140 beats/min, and his electrocardiogram revealed sinus tachycardia. Esmolol infusion was started. At the arrival, theophylline level was 37.4 µg/mL, his laboratory evaluation pH was 7.28, HCO₃act was 11.8 mmol/L, K was 3.5 meq/L, Na was 139 meq/L. He has received hemodialysis. After the follow-up period in emergency department critical care unit, patient was discharged from hospital without any complication.

Conclusion: Theophylline intoxication generally presents in regular users as chronic poisoning. Acute poisoning is rarely emerges. Therefore in any suspicious case, we should get a careful history, anybody who uses drug at home must be questioned. It is well known that hemoperfusion is superior than hemodialysis at eradication of various drugs. But while considering the cost, availability and the treatability, when patient is having acid-base and electrolyte disorder, hemodialysis should come to mind as a affective treatment option.

Keywords: Hemodialysis, Theophylline, Intoxication

P-0687 Toxicology

Myocardial Injury Due To Carbon Monoxide Poisoning: Case Report

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Objective: Carbon monoxide(CO) poisoning is important cause of toxicologic mortality and morbidity. Carbon Monoxide toxicity appears to result from a combination of tissue hypoxia and direct damage at the cellular level. Carbon monoxide poisoning can lead wide range of symptoms such as flue, headache, dizziness, weakness, nausea, and confusion. Although measured in CO levels are not always correlated with clinic, neurological symptoms may be present in lower CO levels and cardiac signs and symptoms may be occurs in high level of CO. Low levels of CO exposure is very rare cause of myocardial injury. We aimed to offer patient who have 20 % level of CO and high troponin level without cardiac signs and symptoms.

Case: A 26-year-old male who lives in house that is heated by stoves presented with headache nouse and vomiting. There was no disease and no smoking in his medical history. The patient's general condition is good, conscious, oriented, and cooperative. The patient's vital signs were as follows: body temperature of 36.7 C, blood pressure of 130/80 mmHg, heart rate of 82 beat/minute, respiratur rate of 14 breath/minute and his physical examination signs were all normal. The initial electrocardiogram showed ST-segment depression of 1 mm in II-III-aVF, ST-segment elevation in I- aVL. ST-segment elevation in the anterior chest leads was due to early repolarization. The patient's laboratory values indicated wbc count of 15,160/microL hemoglobin:12.1g/dL pH:7.33 pCO₂:44.8mmHg, FCOHb: 20.7%. The cardiac necrosis markers were as follows: troponin I, 1.5 ng/mL (cutoff value = 0.01); creatine kinase MB, 13.3 ng/mL; and myoglobin: 172.9 ng/mL in his blood results. High-flow(12-15 L/min) 100% oxygen was administered to the patient who are considered CO poisoning with a face mask. The first echocardiogram of patient demonstrated a global hypokinesia at the left ventricle. The patient was transferred to the primary PCI center. Although there is no wall motion abnormalities on second echocardiogram, the patient was qualified for coronary angiography due to marked elevation of cardiac necrosis markers. Coronary angiography was normal.

Conclusion: Carbon monoxide poisoning can lead to myocardial injury even in patients with normal coronary arteries. Myocardial injury in patients with CO poisoning can be identified difficultly, especially in asymptomatic patients. So that all patients who considered CO poisoning should be evaluated with electrocardiograms, cardiac necrosis marker measurements, and an echocardiogram for myocardial injury regardless of the level of CO and regardless of the absence of cardiac symptoms and signs.

Keywords: Carbon Monoxide Poisoning, Myocardial Injury, Emergency Department

POSTER BİLDİRİLER

P-0688 Imaging in Emergency Units

Asymptomatic Idiopathic Giant Bladder in Emergency Department: Case Report

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Objective: We present a case of asymptomatic idiopathic giant bladder from which 10500 ml urine was drained. This is the largest volume of bladder that we found in the literature.

Case: 66 year old male patient was admitted to the emergency department with complaints of abdominal pain and constipation continuing for three days. In his history the patient has diabetes mellitus and hypertension and using oral antidiabetic and antihypertensive drugs. His general condition was good, he was conscious, cooperative and oriented. His vital signs were; BP:140/90mmHg, HR: 86/min, temperature: 36.8oC, SaO2 98% and fingertip blood glucose: 314 mg / dl. On physical examination, widespread abdominal distension, decrease in bowel sounds and a mass extending to completely fill the abdomen to subxiphoid area were detected. Other systemic examination was normal. He had no urinary complaints. In laboratory tests WBC: 6.7 K/uL, Glucose: 309 g/dl, BUN: 59 mg/dL and creatinine: 1.8 mg/dl was measured. Other parameters were normal. Bedside ultrasound performed in the emergency department and a 24x15x28 cm fluid-filled cystic structure mass beginning from the epigastric region and filling whole abdomen was detected. Then the patient had abdominal computed tomography scan. A hydrops gallbladder, dilatation in collecting system and both kidneys (hydronephrosis) and an advanced degree distended bladder starting from transverse colon to rectum were detected (Figure 1-3). An urinary catheter was inserted for urinary outflow follow-up. After catheterization, 10.500 mL of urine was drained, and the abdominal distention disappeared. After Urology consultation the patient was discharged with recommendations.

Conclusion: Because of being the largest volume of asymptomatic bladder in the literature, the presented case is important in terms of emergency room admissions. Starting from this case we think that in the differential diagnosis of conditions associated with bladder should come to mind in the approach to patients with abdominal distension.

Keywords: giant bladder, urine, emergency

P-0689 Toxicology

acute liver toxicity caused by paracetamol use

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Objective: Paracetamol toxicity is one of the most common causes of suicide by drug overdose. Generally overdose and excessive use of paracetamol causes hepatotoxicity. In this case report, hepatotoxicity caused by low doses of paracetamol and an unknown drug is presented

Case: 25 year-old male patient applied to an external emergency service with altered mental status, abdominal pain and vomiting. He was said to be taken an unknown, purple coloured drug, paracetamol and amoxicillin-klavulanate for infection. He was transferred to our emergency service with prediagnosis of acute liver failure or toxic hepatitis as the liver enzymes were elevated. The patient's general status was good, mental status was normal, blood pressure was: 140/90 mmhg, heart rate: 88/BPM, saO2: %96. In physical examination there was scleral icterus and diffuse abdominal tenderness. Laboratory tests: AST: 719, ALT: 1594, amylase: 183 lipase: 84, INR: 3.22, hb: 13.2, Tbil: 21, Dbil: 11. In urine analysis tetrahydrocannabinol and paracetamol was positive. In external emergency service n-acetylcysteine therapy was started and it was continued in our service with fluid medication. The patient hospitalized in critical care unit with acute liver failure and toxic hepatitis. In abdominal ct: edema at periportal zone, liver sizes are at the upper limit, prominent gallbladder despite contraction (hepatitis?). Liver biopsy: chronic hepatitis, cholestasis signs. Patient stayed in critical care unit for three days and in gastroenterology service for 10 days. After 13 days, he was discharged from hospital with complete cure.

Conclusion: Acute liver toxicity comprise an important part of drug intoxications. In our case hepatotoxicity occurred despite the lower doses of paracetamol. For this reason, patients with drug intoxication must be carefully assessed and followed for accompanying drugs side effect even they are said to be not taken high doses of the drug.

Keywords: acute, hepatotoxicity, paracetamol

P-0690 Toxicology

Uvular edema due to Ecballium Elaterium: A Case Report

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Objective: Ecballium elaterium, belong to Cucurbitaceae family, takes place in alternative medicine because of cytotoxic, analgesic, purgative effects of the bioactive materials involved. The plant's juice is used as diluted nose drip for the treatment of rhinosinusitis in the community.

Uvula edema is a life-threatening condition occurs as a result of several reasons such as trauma, infection, allergic reactions.

In this paper, severe uvula edema case, after using E.Elaterium for sinusitis treatment is presented.

Case: 34 years old male patient referred to the emergency department with difficulty in swallowing and shortness of breath. Pulse rate: 88/min, respiratory rate: 14/min, oxygen saturation was 97%. In the physical examination, uvula was hyperemic and edematous. Chest examination was normal, there was no bronchospasm. Other systemic examination was normal. In detailed history, it is understood that he had chronic sinusitis, he put 5-6 drops of Ecballium elaterium plant's juice, which is known as squirting cucumber in community, in his nose for the treatment of sinusitis because of friend advice and the shortness of breath occurred after 30 minutes. The patient was monitored, IV line was obtained. In biochemical parameter, electrolytes, liver and kidney function tests were normal. 50 mg defenhydramin, 80 mg metilprednisolon and 40 mg pantaprozol was applied via intravenous (IV) route. The patient was consulted to otorhinolaryngologist because uvular edema was not regressed. 80 mg extra dose of metilprednisolon was applied to the patient with the advice of otorhinolaryngologist, who had no extra pathology. After 12 hours follow-up in the emergency room, uvular edema was regressed and patient was discharged with advises.

Conclusion: Patients referred to emergency department with shortness of breath and difficulty in swallowing should be carefully examined for the purpose of uvular edema. Detailed history should be received for local herbal agent usage with drugs that can lead to allergic reactions

Keywords: Ecballium elaterium, uvula edema, sinusitis

P-0691 Toxicology

paracetamol-induced acute liver failure

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Objective: Paracetamol toxicity is one of the most common causes of suicide by drug overdose. Generally overdose and excessive use of paracetamol causes hepatotoxicity. In this case report, hepatotoxicity caused by low doses of paracetamol and an unknown drug is presented

Case: 25 year-old male patient applied to an external emergency service with altered mental status, abdominal pain and vomiting. He was said to be taken an unknown, purple coloured drug, paracetamol and amoxicillin-klavulanate for infection. He was transferred to our emergency service with prediagnosis of acute liver failure or toxic hepatitis as the liver enzymes were elevated. The patient's general status was good, mental status was normal, blood pressure was: 140/90 mmhg, heart rate: 88/BPM, saO2: %96. In physical examination there was scleral icterus and diffuse abdominal tenderness. Laboratory tests: AST: 719U/L, ALT: 1594U/L, amylase: 183U/L, lipase: 84U/L, INR: 3.22INR, hb: 13.2MG/DL, Tbil: 21MG/DL, Dbil: 11MG/DL. In urine analysis tetrahydrocannabinol and paracetamol was positive. In external emergency service n-acetylcysteine therapy was started and it was continued in our service with fluid medication. The patient hospitalized in critical care unit with acute liver failure and toxic hepatitis. In abdominal ct: edema at periportal zone, liver sizes are at the upper limit, prominent gallbladder despite contraction (hepatitis?). Liver biopsy: chronic hepatitis, cholestasis signs. Patient stayed in critical care unit for three days and in gastroenterology service for 10 days. After 13 days, he was discharged from hospital with complete cure

Conclusion: Acute liver toxicity comprise an important part of drug intoxications. In our case hepatotoxicity occurred despite the lower doses of paracetamol. For this reason, patients with drug intoxication must be carefully assessed and followed for accompanying drugs side effect even they are said to be not taken high doses of the drug.

Keywords: paracetamol, liver, failure



POSTER PRESENTATIONS

P-0692 Cardiovascular Emergencies

Spontaneous haemopericardium and cardiac tamponade associated with warfarin

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Objective: Cardiac tamponade is characterized by rapid fluid accumulation in pericardial cavity. Pericardial fluid accumulation causes an increase of mechanical pressure on the heart. Hemopericardium may occur with traumatic and non-traumatic causes. Non-traumatic causes are quite rare. Malignancies, uremia and infectious diseases are often involved in non-traumatic causes. Treatment of pericardial tamponade is discharging the liquid quickly with pericardiocentesis. Non-traumatic hemopericardium and cardiac tamponade depended warfarin overdose is rare and accompanies to other system haemorrhages.

Case: 83 year-old female patient was treated and discharged 5 months ago with a diagnosis of pulmonary embolism with warfarin treatment and regularly followed up with INR monitoring. She was admitted to our hospital with progressive dyspnea for 3 days. International Normalized Ratio(INR) level was 8,66. An increased cardio-thoracic ratio revealed on PA chest X-ray. There was no former thrombus on thorax CT. However, 33 mm diameter pericardial effusion and minimal pleural effusion on left side were detected. The echocardiography was performed and pericardial tamponade was diagnosed because of compression on right ventricle. 300 ml hemorrhagic fluid was drained by percutaneous pericardiocentesis after vitamin K and fresh frozen plasma infusion. The patient's blood pressure, orthopnea and dyspnea improved dramatically. There was no another source of bleeding. The patient was followed in the coronary care unit. INR level came to the normal range at follow-up. There was not recurrence of pericardial fluid on control echocardiography and the patient was discharged.

Conclusion: Anticoagulation is the efficient and reliable treatment of PTE. Today warfarin sodium is the most commonly used agent for anticoagulant therapy. Coagulation time must be monitored closely because of drug interaction and food effects. While inadequate coagulation time can cause ineffective treatment, whereas overdose can cause bleeding. Bleeding gums, nosebleed, conjunctival hemorrhage, gastrointestinal bleeding, hemoptysis, hematuria, subcutaneous bleeding and intracranial bleedings are most common seen with warfarin overdose. The characteristic of our non-traumatic hemopericardium was that there was no another source of bleeding. Isolated non-traumatic hemopericardium seen rarely. This diagnosis should be kept in mind in patients presenting with shortness of breath

Keywords: Spontaneous haemopericardium, cardiac tamponade, pericardiocentesis

P-0693 Cardiovascular Emergencies

Stanford Type A Aortic Dissection Onset with Neurological Symptoms: A Rare Case Report and Review of The Literature

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Objective: Aortic dissection (AD) was first described in 1761, by Morgagni and occurs with the separation of the layers of the aortic wall. The intima and inner media are separated from the outer media and adventitia of the aorta to create a false lumen. AD whose incidence ranges from 5 to 30 cases per million people per year normally represents with acute thoracic or abdominal pain and concomitant cardiovascular symptoms. Even though pain and hypotension most frequently encountered clinical symptoms are wide and extremely variable. Neurological symptoms emerge due to hypotension, brain vessels occlusion and perfusion deficit.

For 250 years after being notified by Morgagni AD is still associated with high mortality. Here in; we report a rare case of Stanford Type A Aortic Dissection (STAAD) onset with neurological symptoms

Case Report: A 71-year-old male, who was transported to our emergency department by ambulance complaint of inability to recognize the environment, suddenly became non-verbal and had back pain. He was mild distress and confused at the admission. Physical examination was substantially unremarkable, with the exception of thready peripheral pulses and cold extremities. Initial computed tomography (CT) of the head showed no hemorrhage or areas of hypodensity. It was regarded as a normal by the attending radiologist. Acute stroke was determined in diffusion magnetic resonance imaging (MRI) but we thought that these complaints were not likely due to the stroke. The history and physical examination may strongly suggest AD that was suspected. Chest CT was performed and defined STAAD in the anterior arch of the aorta. He was taken immediately to operating room. Patient died because of ventricular fibrillation on second postoperative day.

Conclusions: AD occurs due to tearing in the inner wall of the aorta, which then causes blood to flow between layers of the muscular wall. Stroke occurs in one in twenty of patients with aortic dissection was associated with increased morbidity and in-hospital mortality, but not higher long-term mortality among survivors. Neurological symptoms at the onset of AD are not only frequent (17–40%), but often dramatic and may mask underlying conditions. Making the correct diagnosis could be difficult due to the rarity, wide range of symptoms and the similarity of other disease in emergency departments. Here, the essences of diagnosis are high level of suspicion in the patient with atypical signs and symptoms. Even though, relatively uncommon cause of stroke, AD should be kept in mind.

Keywords: Stroke, Aort Dissection, Neurological Symptoms

P-0694 Cardiovascular Emergencies

The relation between intensity and complexity of coronary artery lesion and oxidative stress in patients with acute coronary syndrome

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Objective: We aimed to determine relationship between oxidative stress indices and the complexity and intensity of coronary artery disease (CAD) in patients with acute coronary syndrome (ACS).

Materials-Methods: Sixty-seven patients with ACS included in the study. Syntax (SS) and Gensini scores (GS) were calculated based on angiographic findings. Blood levels of total oxidative status (TOS) and total antioxidant capacity (TAC) were determined by Erel method; oxidative stress index (OSI) was calculated.

Results: CAD complexity assessed by SS and patients were divided into two groups as low SS (< 22) and moderate to high SS (≥ 22). There was no significant difference between two groups. In order to determine intensity of CAD we calculated GS. According to median GS; patients were separated into less intensive CAD (GS < 64) and intensive CAD (GS ≥ 64) groups. Median TOS and OSI values were found significantly high in intensive CAD group (6.8 vs. 10.65, p = 0.005 and 0.52 vs. 0.68, p = 0.04, respectively). GS was positively correlated with TOS and OSI (p = 0.003 and p = 0.02; respectively).

Conclusion: Oxidative stress markers may be considered as supportive laboratory parameters related to CAD intensity; but not complexity in ACS patients.

Keywords: Acute coroner syndrome (ACS), oxidative stress (OS), coronary artery disease (CAD)

P-0695 Toxicology

The effectiveness of naloxone in morphine poisoning: case report

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Objective: Opioids do central nervous system depression, they have potent analgesic effects. Frauds in the community can be purchases in overdose. With respiratory depression in overdose mortality shows the cruise. Loss of consciousness, respiratory depression and myozis findings suggest that opioid toxicity. If the case presented in our unconsciousness and respiratory



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depression while in the foreground myozis findings were mild. With naloxone treatment had complete resolution

Case: 18 year old male patient at noon on having respiratory distress and impairment of consciousness was brought to the emergency room by relatives. Examination confused consciousness, pupil of myotikd. Tachycardia in vital signs, pulse light, TA; 90/60 mmHg, fever: 37.4 C, respiration was 24/dk. Fingertip the oxygen saturation was found to be 92. Preliminary diagnosis of vascular events in patients with brain stem brain CT scans were obtained. However, to be completely normal in patients on opioid poisoning can be applied with the idea of 2 mg naloxone IV. The patient's consciousness was opened. When speaking with patients receiving opioids said. However, the opioid joined by his friends that he might drink. About 6 hours emergency department patients observed was discharged after staying in the room

Conclusion: Patients presenting with opioid overdose treated with naloxone after 4-6 hours after symptom-free periods can be discharged from the emergency department

Keywords: opioid, naloxone, unconsciousness

P-0696 Cardiovascular Emergencies

Right Atrial Mass

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Objective: Echocardiographic detection of intracardiac masses situation is not uncommon during the evaluation. The most common thrombus, vegetation, myxoma and metastases of malignant tumors. Primary cardiac tumors are rare. Myxomas can mimic a lot of cardiovascular disease to early diagnosis should be suspected to do. This article is non-specific complaints, as a result of the tests performed right atrial mixoma we present a case to be determined.

Case: 75 year old female patient to the emergency room is 1 week cough and sputum was admitted with complaints such as fatigue, loss of appetite. They also noticed that the house fire. Because of pre-existing hypertension calcium channel blockers were in use. On physical examination, bilateral basal inspiratory crackles lung, lung sounds were coarser. Vital signs were normal. Dyspnea on exertion of the patient that results were available. Bilateral lower extremity edema was present in nonpitting. Patient 1 week ago, and abdominal pain and weight loss with complaints of another health center has applied, where the abdominal CT at Vena Cava inferiorly extending adrenal and renal tumors, liver metastases, which might be hypodense lesions identified. The patient's hb: 10.2 and, except for mild anemia laboratory values were normal. POAG the infiltrative appearance and there was an increase in the cardiac silhouette. Patients were primarily ECHO cardiography. ECO in the right atrium extending from the inferior Vena Cava and end-systolic and diastolic tricuspid inflow coming out of the mobile 7.0x3.5 cm in size in myocardial echogenicity mass density close to the viewed image. Patients with probable thoracic CT scans were obtained for the detection of lung pathologies. Have multiple solid nodules in the lung parenchyma (metastasis ?) Right atrium thrombus or mass separation suspicious filling defect can not be viewed.

Conclusion: The inferior and superior vena cava may be a transit route for intracardiac masses. Adrenal gland, liver and kidney malignancies can serve as the source into the heart thrombus propagation. Echocardiography and chest CT should be performed in patients. Along with a mass in the right atrium, especially in the case of superior vena cava, the possibility of malignancy should be remembered in the differential diagnosis of early detection and treatment should be directed to the respective clinics.

Keywords: Echocardiography, mixoma, malignancy

P-0697 Toxicology

Full recovery after excessive intake of lithium With proper treatment: a case report

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Objective: Lithium excessive intake frequently seen in the emergency department, although not one of the cases a full recovery is sufficient and appropriate treatment. In this article we use lithium irregular with a patient receiving treatment in intensive care that we provide a full recovery

Case: 60 year old male patient in the emergency department general disorder, tremor, somnolence with complaints such as fetching. In the story of the patient with schizophrenia lithium 1200 mg / day, largactil 100 mg, 5 mg of haloperidol learned that their treatment is taking. The patient was reported by his wife to take medication irregularly, could have received a large amount of drugs, he said. In the first examination of the patient is shivering, had difficulty communicating. That uses the patient's vital signs were normal lithium level of drug levels of 2.5 mmol / l were measured. Blood urea 68, cre: 1.94 was found to be. Later we given IV hydration state of consciousness worsened. Brain CT scans were obtained. Were normal. Respiratory worsening of the patient's Glasgow coma score of 6 was seen as connected to mechanical ventilation and intubation was performed. The patients in intensive care a little more for worsening renal function and normal levels of serum lithium levels is asked to come to the supportive treatment of hemodialysis was also performed at the first time. Patients in intensive care two days after the pop consciousness Extube was put into service. During the follow up patients with tremor as it was discharged.

Conclusion: Polypharmacy patients admitted to emergency services is a lot of space. Irregular use of these drugs after the visible signs of intoxication. In patients with poor state of consciousness to be a detailed history of drug use, can help in the diagnosis of intoxication. Looking drug levels and full recovery with proper treatment, patients may show.

Keywords: Polypharmacy, lithium, consciousness

P-0698 Imaging in Emergency Units

Atrial septal defect diagnosis guided chest X-ray graph

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Objective: Chest X-ray radiography is the most commonly used imaging method in the emergency departments. With the help of this graph, many pulmonary and cardiac pathology can be diagnosed. In this presentation, we wanted to share an ASD case which could not be diagnosed until the patient is 22 years old even though she admitted to hospital many times.

Case: A 22-year-old female patient admitted to the emergency department with the complaint of chest pain continuing for 24 hours. The chest pain was on the left lung apex and it was pleuritic type. There was no known medical history of any disease. At the time of arrival her vital signs: blood pressure; 113/70 mmHg, pulse rate; 86 beats/min, body temperature; 35.8oC, sPO2; 99%.

On physical examination lung sounds were normal. In order to exclude pneumothorax, only chest x-ray was taken. Left hilar fullness, increased mediastinal diameter and cardiothoracic index were detected on the chest x-ray. In heart auscultation; 2-3/6 systolic murmur was detected, but the patient had not suffered from cardiac symptoms until that day. Electrocardiography was in normal sinus rhythm. The bedside echocardiography revealed second degree of mitral failure and approximately 2 cm of ostium secundum ASD.

Conclusion: Due to overwork, physicians only focus on emergency diagnoses. However, it must also be kept in mind that chest x-rays for the diagnosis of serious chronic diseases may also be a guidance.

Keywords: ASD, ostium secundum, X-ray

P-0699 Toxicology

Prolonged headache for three days

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Objective: Headache is a common complaint in emergency departments. Although there are various causes of headache, particularly carbon monoxide poisoning should not be disregarded in emergency departments.

Case: A 41-year-old female patient was admitted to the emergency room with complaints of headache (the most serious in her life), chill, sweating, and numbness in the body. Headache had been continuing for three days. The patient reported that she had admitted to the neurology department with the same complaints on that day's morning. In neurology department no significant pathology had been detected in the laboratory examination and computerized brain tomography.

In emergency department, her all vital signs and neurologic examination were normal. But there was dysrhythmia in cardiac examination.

ECG showed atrial fibrillation. Then the carboxyhemoglobin value at blood gases analysis was found to be 22.6%.

Hemogram and biochemical markers including cardiac enzymes were normal. 100% O2 (15 l/min) was given for treatment. The patient was monitored. After four hours of monitoring, cardiac rhythm returned to sinus rhythm and carboxyhemoglobin value decreased to 0.6%.

The patient was consulted to cardiology department. There was no pathology in cardiac echocardiogram. Causes of atrial fibrillation was associated with carbon monoxide intoxication.



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Conclusion: Complaint of prolonged headache does not so much interest emergency department physicians. However, in prolonged headache cases, chronic carbon monoxide exposure should also be kept in mind, especially in countries like Turkey where carbon monoxide intoxication are common.

Keywords: carbon monoxide, headache, poisoning

P-0700 Toxicology

A rare incident: neuroleptic malignant syndrome precipitated by hypericum perforatum

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Objective: Neuroleptic malignant syndrome (NMS) is a rare but potentially lethal phenomenon. In this case report, we aim to draw attention to St. John's wort (*Hypericum perforatum*) as the cause of NMS. St. John's Wort is a weak monoamine oxidase inhibitor (MAOI) and serotonin agonist which has been associated with the precipitation of serotonin syndrome. However, in this case, we see that it can also precipitate NMS.

Case: Twenty-five years old male presented to the emergency department with fever and altered mental status. He was hypertensive, tachycardic and hyperthermic. Physical examination revealed a Glasgow Coma Scale of 4, with muscle rigidity, and erythema. The patient was intubated for the safety of airway. Medical history was significant for long term use of antidepressant and antipsychotic drugs (venlafaxine, sulpride, sertraline), with a new addition of St. John's Wort for the last few days. Laboratory tests revealed rhabdomyolysis and leucocytosis, in addition to renal failure and increased AST and ALT levels. However, no infectious pathology was detected in the tests, including lumbar puncture. Arterial blood gas revealed acidosis, and urinary output was insufficient. The patient was started on nitroglycerine and esmolol for hypertension, and hemodialysis was performed for renal failure. The patient was admitted to Anesthesiology ICU, with the differential diagnosis of neuroleptic malignant syndrome (NMS) or serotonin syndrome (SS).

Conclusion: There are two points we would like to discuss. The first point is that SS and NMS are rare, serious medication-induced disorders with certain overlapping features. SS can present with restlessness, agitation, hypertension, tachycardia, diarrhea, tremor, myoclonus, hyperreflexia, diaphoresis, hyperthermia, and tachypnea. Symptoms of patients presenting with NMS include: HTN, tachycardia, tachypnea, diaphoresis, stupor, hyperthermia, lead pipe rigidity, hyporeflexia, and decreased bowel sounds. The similarities in presentation can make diagnostic decisions problematic. Prompt recognition and discontinuation of the causative agents is imperative in preventing serious complications in both disorders. When considering treatment options, clinicians must be able to differentiate between the two syndromes since each condition is treated differently. Looking at the precipitating agents and laboratory findings may aid in making the correct diagnosis. The second point is that in literature, St. John's Wort is associated with SS. However, in our case, St. John's Wort precipitated NMS. This should prompt awareness among clinicians that sometimes an usual factor may precipitate NMS.

Keywords: St John's Wort, *Hypericum perforatum*, Neuroleptic malignant syndrome

P-0701 Imaging in Emergency Units

Clinical Suspect Is More Important Than Radiologic Report: Acute Mesenteric Ischemia

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Introduction: Acute mesenteric ischemia (AMI) is a life-threatening condition with mortality rates. Despite the progress in understanding the pathogenesis of mesenteric ischemia and the development of modern treatment modalities, AMI remains a diagnostic challenge for clinicians with high mortality rate. Computed tomography (CT) is a fast and widely available noninvasive modality with high accuracy rate for diagnosis of AMI.

Case: 72 years old female presented with acute abdominal pain and dyspnea. Her past medical history was significant for HT, CHF. Her vitals were as follows: BP: 109/62 mmHg, pulse: 112/min, respiratory rate: 24/min, SatO₂: %84. Physical examination revealed right upper quadrant pain with widespread severe abdominal tenderness, bilateral basal rales on inspiration and pretibial pitting edema. Her cardiac rhythm was AF with rapid response. Laboratory work-up showed no pathological findings except WBC: 21.860/μL, CRP: 2.86 mg/dL, BUN: 63 mg/dL, Cr: 1.3 mg/dL, K⁺: 5.3 mEq/L, Phosphor: 5.72 mg/dL, CKMB: 95 U/L, Myoglobin: 210.8 ng/mL, Troponin T: 0.069 ng/mL and LDH: 402 U/L. Abdominal USG showed a hydropic gallbladder with no stone and increased wall thickness. Diuretic and nitrate therapy was started for congestive hepatopathy. Her pain didn't resolved and lactic acidosis had occurred. Contrast enhanced CT was planned for differential diagnosis of AMI or viscus perforation. On the first CT scan report only a cholecystitis was indicated. We couldn't explain the clinical findings of the patient and warned the radiologist to control the images especially for mesenteric arteries. The report was corrected for a superior mesenteric artery (SMA) ischemia. The patient was transferred to operation room after general surgery consultation.

Discussion: The peak incidence of mesenteric infarction is in the sixth and seventh decades. Mortality from this condition still remains high despite medical advances, short time for diagnosis was shown as reducing mortality. We diagnosed both AMI and acute cholecystitis in our case. Patients with SMA embolism or thrombosis like our patient, have an acute onset of symptoms like severe and unrelenting abdominal pain, nausea, vomiting, which are very common for other abdominal pathologies. They may have a rapid deterioration like in our case with elevated lactate levels and metabolic acidosis. Leukocytosis and prerenal azothemia is other common findings. Elevated phosphate levels, found to be elevated only in %25 of the patients. Biphasic CT with mesenteric CT angiography is effective for diagnosis of AMI.

Conclusion: An emergency physician has to verify the measurable values and subjective comments about the diagnoses. Clinical findings and physical examination are more important than radiological results.

Keywords: acute mesenteric ischemia, clinical suspect, radiologic report

P-0702 Toxicology

Mad honey poisoning

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Objective: Mad honey is produced by the bees taking nourishment with the flowers of a plant from rhododendron family. In alternative medicine, an mad honey which is often used, thinking of being beneficial for stomach-ache, bellyache, high blood pressure, has to be consumed carefully because of including grayanotoxin. Here it was presented a patient who consulted about syncope after eating mad honey.

Case: A 53-year-old male patient consulted about the ailments of feeling bad and syncope. In the story, it was understood that he did not have any chronic disease or medications have been regularly used but he ate some honey. The patient's physical examination was natural. It was evaluated that blood pressure is 70/40 mmHg, heart rate is 45/min with sinus rhythm in ECG, temperature was normal, saturation in room air was normal. The patient was implemented 1 mg atropine and intravenous fluid therapy. Monitoring was followed and cardiac marker evaluation was done. In his surveillances vitals were completely healed. The patient who had normal cardiac markers was discharged by offers.

Conclusion: Although mad honey poisoning is common in Black Sea district, it could be seen in every region because of heterogeneous settlement and widespread tourism. Grayanotoxin causes neurological symptoms gastrointestinal, irritability and arrhythmia by influencing cell membrane. With the cases of unexplainable syncope and bradycardia, mad honey has to be taken into account in distinctive detection.

Keywords: Mad honey, syncope, grayanotoxin

P-0703 Toxicology

Pneumomediastinum and pneumorrhachis and spontaneous subcutaneous emphysema after cocaine use

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Objective: Cocaine-related spontaneous pneumomediastinum usually follows a benign course and is associated with subcutaneous emphysema. Cocaine is often used by younger people. Symptoms such as neck pain and shortness of breath occur a few hours after ingestion of the substance.

Case: 28 year old male patient was admitted to the emergency department with complaints of shortness of breath, chest pain, neck pain, facial swelling which developed four hours after cocaine intake. In patients history, he received treatment for cocaine addiction. On physical examination, palpable subcutaneous emphysema was seen around the neck, under the chin and upper chest area. Vital findings were: blood pressure 150/80 mmHg, pulse 150 beats / min, saturation on room air 96%, respectively, and fever was normal. Computerized tomography imaging revealed diffuse subcutaneous emphysema, pneumomediastinum and pneumorrhachis. Respiratory distress developed due to increased subcutaneous emphysema around the neck of the patient and it was drained by applying skin incision over the suprasternal notch. The patient was transferred to the thoracic surgery service for clinical follow-up.

Conclusion: Cocaine is often used in younger age groups. The most common cocaine-related side effects include subcutaneous emphysema and spontaneous pneumomediastinum. Pneumoperitoneum, pneumopericardium and pneumorrhachis (free air in the spinal canal) may also develop rarely. Clinically, these symptoms usually follow a benign course. As far as we



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know this is the first case of pneumorrhachis due to cocaine use, reported in English, in the literature.

Keywords: Cocaine, pneumomediastinum, pneumorrhachis, subcutaneous emphysema

P-0704 Toxicology

Atypical bleeding due to warfarin intoxication

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Objective: Warfarin, which is an anticoagulant agent which acts by inhibiting vitamin K-dependent coagulation factors, is commonly used in the treatment and prophylaxis of many diseases. The most common clinical presentations of bleeding symptoms due to warfarin use include hematuria, hematemesis and melena. We presented a case of peritonsillar bleeding due to use of anticoagulant which is a rare but life-threatening complication.

Case: A 80 year old female patient admitted to the emergency department with complaints of difficulty in breathing, choking sensation and bruising in the face. In the patient's history, she was using warfarin for atrial fibrillation. In physical examination the head and neck regions were cyanotic and stridor was present. In examination with video laryngoscope, there was a hematoma beginning from the right side of uvula and extending through the right epiglottis and larynx. INR level was immeasurably high in the testing. INR decreased to 1.3 after the therapy with vitamin K and fresh frozen plasma. On the follow-up, the patient was clinically stable and she was transferred to otorhinolaryngology service.

Conclusion: Peritonsillar hematoma secondary to use of warfarin is a rare but serious complication that may be life threatening. INR should be carefully monitored in these patients. The patients should be informed about the potential complications of warfarin treatment and importance of INR monitoring.

Keywords: Warfarin, peritonsillar hematoma, intoxication

P-0705 Toxicology

Electrolyte disturbances in patients who have arrival complaint of suicide by taking drugs/medications to emergency department

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Objective: Intoxication cases are considered one of the most important causes of morbidity and mortality among the patients admitting to emergency departments. Evaluation of blood electrolyte levels is recommended in drug specific treatment guidelines in intoxication cases. In the present study, it was aimed to evaluate patterns of electrolyte disorders and their relationship with drugs ingested in patients presented to ED with suicidal attempt by drug ingestion.

Materials-Methods: In this study the files of patients above 18 years old who were diagnosed drug intoxication in Hacettepe University Faculty of Medicine Adult Emergency Department. between 1st January 2005 and 1st February 2013 were retrospectively evaluated. We recorded demographic characteristics, presentation time, biochemical values including Na⁺, K⁺, blood urea nitrogen (BUN), Cr, AST, ALT, total bilirubin (T.Bil), gamma glutamyl transferase (GGT), alkaline phosphatase (ALP) and cardiac enzymes including troponin T, creatinine kinase MB (CK-MB), myoglobin, and arterial blood gas parameters including pH, HCO₃, lactic acid, and complete blood count values including white blood cell, Hb, platelet and coagulation parameters including activated partial thromboplastin time (aPTT) and international normalized ratio (INR) were reviewed.

Results: There were 323 patients and the median age was 27 (18-72) years. Sixty seven (20.7%) patients were male. It has been detected that 77.1% of patients have taken more than the daily recommended dose. As we compare the drugs: nonsteroidal anti-inflammatory drugs (NSAID's) were the first with 21.1%; paracetamols were second with 20.5%; selective serotonin reuptake inhibitors were third with 17.7% and tricyclic antidepressants were fourth with 15.5% ratio. The relations between toxic dose intake of these drugs and blood sodium, potassium, BUN, creatine, AST, ALT, INR, cardiac markers and blood gas analyses were investigated. Only relation between serum sodium levels and intake of toxic dose of NSAID's have been found statistically significant.

Conclusion: In drug-specific treatment guidelines for cases with poisoning, it is recommended to routinely evaluate blood electrolyte values. However, we demonstrated that changes detected in blood values weren't significant even in ingestion of drug overdose. In cases with intoxication, blood tests that guide treatment should stand forefront given type, pharmacokinetic and pharmacodynamic of the drug ingested.

Keywords: electrolyte, drug overdose, nonsteroidal anti-inflammatory drugs

P-0706 Toxicology

Incorrect Alternative Medical Procedures: Agave americana L. related Irritant Contact Dermatitis

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Patients sometimes resort to alternative medical procedures for pain relief. Incorrect and uninformed procedures during such treatments may result in severe pathologies. A 54-year-old woman was brought to the emergency department with skin reddening, pain and a burning sensation in both knees. Three days previously she had wrapped the ground leaves of the plant Agave americana L., which she grew at home for therapeutic purposes and had already used before, around her knees and kept them there for half an hour. One hour later, however, a red-colored skin eruption appeared on both knees, immediately followed by pain and a burning sensation. Irritant contact dermatitis may develop as the result of the improper alternative medical application of the species Agave americana L. (Amaryllidaceae).

Keywords: Alternative Medicine, Irritant Contact Dermatitis, Agave americana, Plant Therapy, American Aloe

P-0707 Cardiovascular Emergencies

An atypical cause of sudden vision loss: aortic dissection

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Aortic dissection is one of the most fatal pictures that can be encountered in the emergency department. Sudden onset severe chest pain is the most common presentation, while atypical symptoms make diagnosis difficult. A 40-year-old man presented to the emergency department with chest pain accompanying sudden vision loss. Anxiety was initially suspected. Thoracic CT was performed when blood pressure fell and pain increased during monitoring, and aortic dissection was identified. Aortic dissection still involves high mortality despite early diagnosis and treatment, and it is important for emergency physicians to be able to consider dissection in diagnosis in patients with atypical presentations.

Keywords: Vision loss, Chest Pain, Aortic Dissection, Hypotension

P-0708 Toxicology

Is hypothermia a condition accompanying mad honey intoxication?

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Mad honey-related intoxication frequently leads to bradycardia, hypotension and syncope. Hypothermia has not previously been reported to accompany mad honey intoxication in the literature. The first of three cases presenting to the emergency department with mad honey intoxication was a 66-year-old man. He was brought to the emergency department with nausea, vomiting and faintness emerging 2 h after eating honey. Body temperature was 34 °C, blood pressure 70/40 mmHg and heart rate 30 /min. The second patient, a 57-year-old man, presented to the emergency department with headache, feeling cold and fainting that started 3 h after eating honey. Body temperature was 35 °C, blood pressure 60/40 mmHg and heart rate 46 /min. The third case presented with nausea, vomiting and headache 2 h after eating honey. Body temperature was 35 °C, blood pressure 70/40 mmHg and heart rate 40 /min. All three patients were discharged in a healthy condition after appropriate therapy. Bradycardia and hypotension are frequently encountered in mad honey intoxication. However, intoxication accompanied by hypothermia has attracted little attention to date.

Keywords: Mad honey, Hypothermia, Bradycardia, Hypotension, Syncope



POSTER PRESENTATIONS

P-0709 Imaging in Emergency Units

Late diagnosed postspinal intracranial hematoma

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Intracranial subdural hematoma developing following spinal anesthesia is a rare but serious complication. A 33-year-old woman presented to the emergency department with headache. The patient had been administered spinal anesthesia for Cesarean surgery 45 days previously and had been discharged on the 2nd day postoperatively with appropriate advice. No imaging had been performed during her stay in hospital. Non-violent headache persisted after discharge despite use of oral analgesics and plentiful fluid intake. CT of the brain and MRI revealed left frontoparietal hypodense subdural collection and left to right midline shift in structures. The patient was operated and discharged without sequelae on the 7th day. Subdural hematoma should be borne in mind in the presence of headache after spinal anesthesia that does not respond to fluid intake and medical treatment.

Keywords: spinal anesthesia, subdural hematoma, headache, intracranial hemorrhage

P-0710 Imaging in Emergency Units

Dysphagia Resulting From A Blow to the Head from a Football: Vertebral Artery Dissection

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Traumatic vertebral artery dissection may develop following blunt trauma to the head or neck. A 37-year-old male presented to the emergency department after the developing neck pain followed by numbness in the left fingers and subsequently the left arm after being hit in the head by a football. Cerebral angiography revealed total occlusion of the intracranial segment of the left vertebral artery and left posterior inferior cerebellar artery. Prognosis is good in such patients if they are diagnosed and treated early. Since there is a risk of cerebral ischemia and neurological deficit, and even death, in the subsequent period, dissection should be borne in mind in the suspect patient group.

Keywords: Football blow to the head, trauma, vertebral artery dissection

P-0711 Toxicology

Retrospective Analysis of Acute Intoxicated Patients Treated with Extracorporeal Therapy

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Objective: Accidental and intentional intoxications are a common cause of major medical catastrophe. The emergency doctors must have a working knowledge of clinical pharmacokinetics and the relationship between a toxin's characteristics and the ability to enhance its elimination with extracorporeal therapy. The aim of this study was to present acute intoxicated cases treated with extracorporeal therapy.

Materials-Methods: A retrospective cohort study was conducted of adult intoxicated patients (>18) admitted to Emergency department of Ondokuz Mayıs University Faculty Hospital between dates of 1/7/2006-1/1/2012.

Results: Thirty-six patients were included to this study. The mean age was 40±17.9 years old (median age: 37 years). The range of age was 16-80 years. Twenty of the patients (%55,6) were male and 16/36 patients (%44,4) were female. There were intentional intoxications in 31 patients (%86,1) and accidental intoxications in 5 patients (%13,9). The poisonings were related with antiepileptic drugs (n=6), organophosphate (n=2), antidepressants (n=7), paracetamol (n=1), mushroom poisoning (n=4), ethanol (n=2), lithium (n=3) and methyl alcohol (n=10) respectively. There were history of psychiatric disorders in 5 patients, alcohol addict in 10 patients and epilepsy in 5 patients. Twenty-five patients were admitted to our emergency service in the first suicidal attempt. Eleven patients had a history of recurrent intoxication. Glasgow Coma Score on admission was 14-15/15 in 16 patients, 9-13/15 in 6 patients and 3-8/15 in 4 patients. Rhabdomyolysis in one patient, aspiration pneumonia in 4 patients, cardiac arrest in one patient, acute pancreatitis in one patient and optic neuropathy in one patient were seen as complications related to intoxications. Extracorporeal therapy was included hemodialysis in 30 patients, hemoperfusion in 4 patients, hemodialysis and hemoperfusion in 2 patients. Eleven patients were died after acute intoxication and 25/36 patients were treated successfully after extracorporeal therapy.

Conclusion: Extracorporeal therapy appears to be a good choice in acute poisoning of selected cases. Controlled, randomized trials are required to better characterize the effect of extracorporeal treatment on clinical outcome.

Keywords: intoxication, extracorporeal, emergency

P-0712 Imaging in Emergency Units

Abscess of Psoas After Bone Marrow Puncture

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Objective: To present our experience in diagnosis of retroperitoneal abscess after bone marrow puncture.

Case: Fifty-eight years old female patient presented to our emergency department (ED) with complaints of pain on right hip, fever and difficulty in walking. She had a history of anemia. A bone marrow puncture was performed in right posterior surface of ilium to determine the aetiology of anemia about 3 days before her admission. In her physical examination, she had no tenderness and redness on right hip, but there was a limitation of right hip movement and severe pain, especially at flexion of right hip. Her abdominal examination was normal. The patient's blood pressure was 100/60 mmHg, her heart rate was 100 bpm, her temperature was 38,4°C, her respiratory rate was 20. She was agitated due to severe pain. The patient had WBC: 10700/uL, hemoglobin: 9,6 g/dL, platelet: 304000/uL in laboratory tests. Electrolytes and the other laboratory findings was normal. Superficial tissue ultrasonography was normal. Computed tomography performed for lumbar vertebrae pathology was normal. Magnetic resonance imaging of lower abdomen showed an abscess of right psoas muscle (4x1 cm). Analgesic treatment was administered. She discharged with analgesic treatment and fucidic acid 500 mg three times a day with recommendation of infectious disease department.

Conclusion: Pyogenic abscess of the psoas muscle is a rare disease. The relation between abscess of psoas and bone marrow puncture is unclear. To make diagnosis is important to consider this condition in differential diagnosis in presence of fever and difficulty in walking.

Keywords: psoas, abscess, emergency

P-0713 Toxicology

Aluminium Phosphide Poisoning: A Case Report

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Objective: Aluminium phosphide is a highly toxic pesticide that inhibits cytochrome oxidase c and causes oxidative stress. Death results from refractory cardiogenic shock due to myocardial dysfunction. We presented a case died due to cardiogenic shock after ingestion of aluminium phosphide.

Case: A 17 years-old female patient with altered mental status was referred to our emergency department (ED) due to drug intoxication from a public hospital. She has ingested one tablet of aluminium phosphide named as "CELTHOS" about 4 hours ago (her first suicidal attempt). Altered mental status, nausea and vomiting have started at the first hour of the drug ingestion. The activated charcoal and gastric lavage was given at ED of public hospital. In the initial physical examination on admission to our ED, she was alert and pupils were normal. Glasgow Coma Scale score was 15/15. Her vital signs were: blood pressure 110/80 mmHg, pulse rate 100 / minute, respiratory rate 20 / minute, temperature 36,8 °C and fingerstick glucose was 90 mg/dL. The electrocardiogram (ECG) demonstrated a sinus tachycardia (102 beats/min) and the duration of QRS was 100 msec. The patient had WBC: 13900/uL, hemoglobin: 12,6 g/dL, Na: 143 mEq/L, K: 3,7 mEq/L, glucose:102 mg/dL, creatinine: 0,8 mg/dL, Ca: 9,8 mg/dL, CPK:176 u/L, troponin:0,02 ng/mL, CK-MB:3,8 ng/mL in laboratory tests and pH: 7,16, pCO₂: 28 mmHg, pO₂: 109 mmHg, HCO₃: 10 mmol/L, BE: -17,2, O₂ saturation: 97% in blood gas analysis, respectively. The infusion of sodium bicarbonate was administered. She was intubated due to change in general status and the presence of tachypnea at 11 hours of drug ingestion. The patient had WBC: 11250/uL, hemoglobin: 12,5 g/dL, Na: 149 mEq/L, K: 4 mEq/L, glucose:98 mg/dL, creatinin: 1,71 mg/dL, Ca: 9 mg/dL, CPK:187 u/L, troponin:0,4 ng/mL, CK-MB:9,38 ng/mL and pH: 6,92, pCO₂: 68 mmHg, pO₂: 27 mmHg, HCO₃: 13,5 mmol/L, BE: -19,5, O₂ saturation: %22,7 in blood gas analysis in the control laboratory tests. The control ECG demonstrated ST-segment elevation (3-4 mm) in derivations of DII, DIII, aVF. She was in cardiogenic shock and severe



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hypotensive at the 12. hours of drug ingestion. The inotropic agents was started. CPR was performed about 10 minutes due to cardiac arrest. She was died at 13. hours after drug ingestion.

Conclusion: We presented a case with poor prognosis after aluminium phosphide poisoning. This case report showed a need to a new antidote and treatment for this toxicity.

Keywords: aluminium phosphide, poisoning, emergency

P-0714 Toxicology

Persistent Binocular Diplopia After Snakebite: A Case Report

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Objective: A snakebite is an injury caused by a bite from a snake, often resulting in puncture wounds inflicted by the animal's fangs and sometimes resulting in envenomation. Although the majority of snake species are non-venomous and typically kill their prey with constriction rather than venom, venomous snakes can be found on every continent. Cases related to snakebite are usually seen in emergency departments, especially in the summer months. We present a case with bilateral diplopia and ptosis that were recovered after the use of anticholinesterase therapy and antivenom.

Case: A 48 year-old man admitted to emergency room with complaints of nausea, vomiting, fatigue, diarrhea as well as swelling, redness and pain on the lateral malleolus of right foot after snakebite. He was brought to our emergency service of university hospital due to onset of hypotension (80/60 mmHg) after the administration of antivenom. The initial physical examination was normal without swelling and redness on lateral malleolus of right foot. The vital signs were temperature: 36.1, blood pressure: 110/70 mmHg, pulse rate: 90/min and respiratory rate: 18/min respectively. In the patient's laboratory tests, electrolytes and cardiac enzymes were normal. PT and aPTT were at normal range, but white blood cell count (WBC) was elevated (14.61 thousand/uL), creatine phosphokinase (CPK; 765 u/L) and INR (1.33) was minimally elevated. His ECG showed a normal sinus rhythm. The patient was followed up and sultamicillin 2 gr per a day and %0.9 NaCl were administered intravenously. At the tenth hours of the follow up, he was complained of blurred vision. In the second physical examination, binocular diplopia and bilateral ptosis were detected.

The examination of eye movements showed a presence of partial bilateral paresis of 3. cranial nerves. The second dose of antivenom was administered. The visual field was evaluated to be normal by ophthalmologist. The patient was consulted to the neurologist and pridostigmin 60 mg was suggested to use for three times per a day for treatment. After 12 hours, the symptoms were improved and the eye movements were normal. At the third day, WBC, INR and CPK was at normal range. The patient was discharged from our emergency service with full recovery in the third day after the admission.

Conclusion: Ophthalmoplegia is a rare symptom of snake bites. It may induce anxiety and ocular discomfort for a long period. Treatment of anticholinesterase with antivenom may facilitate the recovery from ophthalmoplegia.

Keywords: binocular diplopia, snakebite, venom

P-0715 Cardiovascular Emergencies

Peripartum cardiomyopathy: Case Report

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Objective: Peripartum cardiomyopathy (PPCM) is a disorder in which initial left ventricular systolic dysfunction and symptoms of heart failure occur between the late stages of pregnancy and the early postpartum period. PPCM was introduced by Demekais and friends, for the first time in 1971 and it was defined as heart failure developing within the period between the last month of pregnancy and 5 months postpartum, in the absence of defined causes of heart failure. Later, echocardiography findings has been added to this definition. Although the underlying cause of the disease is not clear, key factors include viral or autoimmune causes, hormonal imbalances, volume overload, alcohol, physiologic stress of pregnancy, abnormal immune response to pregnancy, unmasking of latent idiopathic dilated cardiomyopathy, inflammation, and apoptosis. Most patients present with typical signs and symptoms of heart failure such as dyspnea, peripheral edema, fatigue, and sometimes cough and abdominal discomfort. The diagnosis is based on the symptoms and clinical findings in combination with appropriate investigations such as ECG, chest radiograph, biomarkers, for example, brain natriuretic peptide (BNP) and echocardiography.

Case: A 34 year old female patient admitted to ED with complaints of dyspnea and cough lasting for 2 days. The patient told that shortness of breath was worsening when he was lying in supine position. In the history of the patient, she had known disease and delivered by C/S five days ago. In the examination crepitant rales in bilateral lower lung zones and peripheral edema were detected. Oxygen saturation was 90%. Biochemical values were normal. Cardiac enzymes were Troponin T hs: 46.17 (high), Mass CK-MB: 3.98, and Myoglobin: 21.0. In the chest radiography increased density in middle and lower zones bilaterally and cardiomegaly. In thorax BT bilateral pleural effusion and cardiomegaly were seen and there was no finding of significant pneumonic infiltration. The patient was consulted with cardiology clinic. In the echocardiographic evaluation global hypokinesia of the left ventricle was present, and PAP:35 mmHg, EF 35%, respectively. Patient was hospitalized in the coronary intensive care unit with diagnosis of peripartum cardiomyopathy.

Conclusion: PPCM has a high morbidity and mortality and diagnosis is often delayed. If the other causes of heart failure is absent, the onset of heart failure in women near the end of pregnancy or in the first few months postpartum, PPCM should be considered by the Emergency Department physicians.

Keywords: heart failure, cardiomyopathy, postpartum period

P-0716 Toxicology

Hemodialysis In Acute Valproic Acid Intoxication: A Case Series and Review of the Literature

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Objective: The aim of this study was to present five cases with valproic acid poisoning treated with hemodialysis and to review the literature.

Materials-Methods: A retrospective cohort study was conducted of adult patients intoxicated with ingestion of valproic acid (>18) admitted to Emergency department of Ondokuz Mayıs University Faculty Hospital between dates of 1/7/2006-1/1/2012.

Results: Symptoms of VPA intoxication are diverse and are related to VPA plasma concentration. Although total plasma concentrations of less than 450 µg/mL produce limited toxicity, severe intoxications (>850 µg / mL) can induce coma and are ultimately life threatening (6). The VPA levels of the two patients were very high (case 1: 763 µg / mL, case 4: 1100 µg / mL). In the case 3, there was not an accurate titrated VPA level (case 3: VPA level >150 µg / mL). In the case 5, the VPA level at the admission was not measured due to laboratory problems.

Extracorporeal methods of elimination should be considered in patients with features of severe VPA poisoning (coma or hemodynamic compromise) and plasma VPA concentration >850 mg / L (coma is more likely to be present at concentrations >850 mg / L), particularly if severe hyperammonemia and electrolyte and acid-base disturbances are present (8). According to Thanacoody's study which identified 31 reports of the use of extracorporeal elimination in VPA poisoning. They consistently showed that during hemodialysis the elimination half-life of VPA could be reduced to around 2 h and the enhanced VPA clearance was often associated with improvement clinically (8). Hemodialysis was applied due to altered mental status, the reduce of GCS (Glasgow Coma Scale), the presence of seizure and hyperammonemia. The all of patients were conscious and their symptoms and levels of VPA and ammonia were reduced. Finally the clinical improvement was provided after hemodialysis similarly to the study of Thanacoody.

Hemoperfusion also enhances VPA elimination, but its effectiveness may be limited by column saturation.

Conclusion: We report the successful use of hemodialysis in five patients with acute valproic acid intoxication. The patient's hemodynamic status and mental function improved in conjunction with the acute reduction in VPA concentrations. Hemodialysis appears to be a good choice to enhance VPA elimination in acute poisoning. Controlled, randomized trials are required to better characterize the effect of extracorporeal treatment on clinical outcome.

Keywords: Hemodialysis, valproic acid, intoxication



POSTER PRESENTATIONS

P-0717 Toxicology

Post-interval Syndrome: Case report

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Objective: Carbonmonoxide (CO) is a colorless, odorless, tasteless, and non-irritant gas. CO appears as an end product of poor combustion of fuels CO poisoning may be potentially fatal due to its acute effects and it may also cause serious permanent disorders as a result of its late effects.

Case: An 11-year-old patient was brought to emergency department due to CO intoxication. He was confused and had intermittent agitation attacks at admission. His Glasgow Coma Score (GCS) was 12 over 15 (E:3, M:5, V:4). Normobaric oxygen therapy with 100% oxygen was administered via a non-rebreathing face mask with reservoir. His vital signs and laboratory studies were totally normal. He started to respond verbal stimuli at the 6th hour of admission. He was discharged after 2 days of hospital stay because he totally healed clinically, and his all laboratory parameters returned to normal. The patient, and his relatives were informed about late neurologic symptoms and advised outpatient clinic follow up. He was brought to our emergency department again due to confusion and agitation 3 days after his discharge. His GCS was 10 over 15 (E:2, M:5, V:3). Carboxyhemoglobin level, and the other laboratory studies were in normal range. Computed tomography scan of his brain was normal, too. Normobaric oxygen therapy with 100% oxygen, and supportive treatment were started. He had an epileptic convulsion during his hospital stay. An antiepileptic agent (Valproate Sodium Solution 200 mg per ml, Sanofi-Aventis, Istanbul) was added to his treatment. Arterial blood gas analysis revealed pH:7.36, pCO₂:46.6 mmHg, pO₂:95.8 mmHg, and SpO₂: 98%. His clinical condition changed towards delirium during his follow up. His electroencephalogram performed on the 6th day showed rare slow waves together with normal basal activity. Axial T2 weighted magnetic resonance imaging of his brain revealed heterogeneous appearance in globus pallidi bilaterally, and axial T1 weighted magnetic resonance imaging with intravenous contrast enhancement showed contrast enhancement in globus pallidi bilaterally. He started to respond verbal stimuli on the 7th day. He was oriented, and cooperative on the 8th day. After his symptoms totally healed with normobaric oxygen therapy the patient was discharged on the 10th day. No abnormality was detected at his outpatient follow up visits.

Conclusion: Neuro-psychiatric signs and symptoms may be seen in late stages of CO poisoning. Therapeutic approach should be planned keeping that in mind, and the patient should be followed up for a longer period.

Keywords: Carbonmonoxide, poisoning, brain

P-0718 Cardiovascular Emergencies

Managment of Supraventricular Tachycardia in Pregnancy

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Objective: Arrhythmias in pregnancy are common and may cause concern for the wellbeing of both the mother and the fetus. For some mothers the arrhythmias may be a recurrence of a previously diagnosed arrhythmia or the first presentation in a woman with known structural heart disease.

Symptoms of shortness of breath, palpitations, dizziness, presyncope, and syncope frequently occur during normal pregnancy. Paroxysmal supraventricular tachycardia (SVT) is the commonest cardiac arrhythmia in women of reproductive age group. Pregnancy has been identified as a risk factor for paroxysmal SVT as a result of the associated haemodynamic, hormonal, autonomic and emotional changes. The presence of SVT is likely to cause an exacerbation or new onset of these symptoms and in particular, the patient feels unwell. The diagnosis is confirmed by ECG.

We report a case of SVT in a pregnancy patient.

Case: A 32-year-old woman, at 34 weeks of gestation with no significant previous medical history, was admitted to our hospital complaining of palpitation the last 1 hour. She presented in her third pregnancy with a history of two normal vaginal deliveries. During this pregnancy she had had intermittent hypertension without proteinuria, which settled spontaneously. Her heart rate was noted to be 191 beats minute and regular. Arterial pressure remained stable and a 12 lead ECG revealed SVT with LBBB (figure 1). Adenosine 6 mg was given in divided doses with no effect. A further 12 mg bolus was given but not reverted into sinus rhythm. Metoprolol 5 mg was given slowly converted her back into sinus rhythm. 12 lead ECG showed sinus rhythm (figure 2). Transthoracic echocardiography was performed, which revealed a mildly dilated left ventricle with normal function and an ejection fraction of 60%. After administration of intravenous metoprolol and control of heart rate our patient was discharged with recommendation of treatment with verapamil.

Conclusion: The goal of management of SVT in pregnancy is rate control or conversion to sinus rhythm. Adenosine and verapamil has been advocated as the first line drugs in the treatment of SVT and are equally effective. Synchronized electrical cardioversion may be indicated in patients resistant to pharmacological therapy and it has been shown to be safe in pregnancy. Besides these, use a cardioselective -blocker and/or digoxin, both of which are safe in pregnancy and with unchanged dosages.

Keywords: management, pregnancy, tachycardia

P-0719 Toxicology

Occupational dermatosis: Epoxy resins

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Objective: Epoxy resins have a wide range of applications (water transportation, metal coating, electronic and electrical components and structural adhesives) and their adverse health effects have been mostly reported in occupational settings. The most frequent adverse effects of overexposure to the chemicals used in epoxy resin systems are eye, nose, throat, and skin irritation, skin allergies, and asthma.

Case: A 36-year-old male presented with the complaint of periorbital eczema around the eyes (figure 1). He had been admitted with the same symptoms one month ago. He had no personal or family history of allergic diseases. He had been working in a water transportation company. The symptoms appeared after returning home from work. Any systemic pathology was not found on physical examination. The patient's hematological and urinalysis were normal values. After medical treatment (50 mg diphenhydramine, 120 mg methylprednisolone IV and Normal Saline infusion) the symptoms subsided. When he handled these materials, he wore cotton or rubber gloves, but the substances sometimes adhered to his skin. The patient was discharged after 4 hours observed.

Conclusion: Occupational dermatosis caused by occupational exposure is defined as any pathology of the skin. Epoxy resins cause allergic and irritant dermatitis, leucoderma and urticaria. Besides, occupational dermatoses has not only individuals, but also financial and psychosocial effects on community. Therefore, in recent years, occupational dermatoses are one of the important public health problems. Essential precautions should be taken for employees.

Keywords: dermatosis, epoxy, occupational

P-0720 Toxicology

First And Low Dose Gabapentin-Induced Hypomania

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Objective: GBP is an antiepileptic drug structurally related to gamma-aminobutyric acid (GABA). GBP was primarily approved by the Food and Drug Administration (FDA) in 1993 for treating partial seizures with or without generalization. It is a lipophilic structural analogue of the neurotransmitter i.e Gamma-aminobutyric acid (GABA). Despite its design as a GABA agonist, it does not bind to GABA-A or GABA-B receptors. It is neither converted to GABA, nor it is a GABA agonist and even it is not an inhibitor of GABA re-uptake or degradation. Gabapentine may promote nonvesicular release of GABA.

Case: A 60-year-old woman, who has chronic cervical pain for a long time, admitted to the emergency department with complaints of elevated mood, euphoria, and increased energy. She is of normal intelligence and does not have a past history of psychiatric, behavioural and neurological disorder, and also no diabetes mellitus, hypertension, cerebrovascular disease and head trauma. She is married and not works. Also her birth history was normal. From patient's history, it was learned that these complaints first started at last night. One day ago she received one tablet, which includes thiocolchicoside and 600 mg GBP for her chronic cervical pain. Yesterday, she did not sleep, and did not eat. She markedly disinhibited, extreme psychomotor



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activation, excessive talkativeness, decreased need for sleep and eat, elevated mood, euphoria, increased energy, spreading around the state. In the emergency department she said to us there is no pain in her body, she ate her dinner with queens and kings. She repeated that she feels good, and consistently wanted to urinate. She cared nothing around her while people watching and laughing at her. She urinated at her bed yesterday night.

She has prescription GBP for chronic cervical pain one day ago and who developed symptoms of hypomania on starting one dose GBP. Within the next 3 hours her behaviors began to change. In our emergency department, we consultate her to neurology and psychiatry departments. Both of these departments decided that, the patient had adverse effect of GBP and she had to discontinue the drug. We did not use any medical treatment for her. These symptoms were transient and fully reversible.

Conclusion: Although the severity of mood changes in our adult patient has been mild and self-limiting or reversible, clinicians should recognize the possibility of adverse behavioural changes, especially hypomania-like episodes could be seen on the initiation of first and low dose GBP therapy.

Keywords: dose, gabapentin, hypomania

P-0721 Imaging in Emergency Units

A Comparison Study Of Clinical And Laboratory Data Of Pulmonary Thromboembolism With Tomography Findings

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Objective: 62 patients with high/moderate/low risk of embolism due to Well' pulmonary embolism score, 31 males and 31 females, were enrolled in this prospective study. The patients with clinical or laboratory findings of elevated D-dimer level or elevated LDH level were suspected of embolism and were underwent tomography

Materials-Methods: PTE was detected in 26 patients (42%). A significant difference between tomography emboly positive and tomography emboly negative patients group in terms of age or sex distribution was not detected (p=0,221 and p=0,416 respectively).

A significant difference between tomography emboly positive and tomography emboly negative patients group in terms of elevated LDH or/and elevated D-dimer levels was not detected (p=0,263, p=1,000 respectively).

The distribution of low risk factor patients in non-emboly group, and the distribution of high risk factor patients in emboly positive group was statistically significant high (p<0,001).

Although the medium-risk patients number was found more in emboly positive group there was no statistically significant difference between the groups (p=0,053).

Results: In diagnosing or excluding the pulmonary thromboembolism the findings of tomography and the findings of Wells clinical scoring system or LDH level or D-dimer levels

Keywords: Pulmonary thromboemboly, D-dimer, LDH, Pulmonary tomography

P-0722 Toxicology

A Case of Suicide Attempt with High Dose Insulin Glargine and Insulin Aspart

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Objective: Insulin therapy is one of the treatment choices of diabetes mellitus. With the widely used of insulin therapy, diabetics or non-diabetics have used insulin overdose as a mode of suicide (1,2). All types of insulin have been used for suicidal intention, including the short- and long acting insulins (3,4). A review of the literature revealed rare reports of overdose attempts with either insulin glargine or insulin aspart. Therefore we want to present a case of a 25-year-old type 1 diabetic woman who self-administered 600 units of insulin glargine and 400 units of insulin aspart as a suicidal attempt.

Case: A 25-year-old type 1 diabetic woman who intentionally injected herself with overdose of insulin glargine and aspart was brought to the emergency department about 2 hours after her suicide attempt by an ambulance. The patient had no any history of psychological disorders such as depression and she had no a history of suicide attempts. Her blood glucose was measured as 104 at home by a paramedical personnel. There were no any abnormalities in her mental status. At emergency service admission, she presented with mild drowsiness with hypoglycemia (blood glucose level 45 mg/dl). The patient also had mild sweating, and dizziness. Hence, 25 gram dextrose (as bolus) was given and 5% dextrose infusion started. On the other hand, her vital signs were normal and her systemic examination was unremarkable. Her blood gases and electrocardiogram (sinus rhythm, rate: 80) were normal. During the course of her 6 hours of emergency service stay, we followed the patient in terms of the risk of hypoglycemia and electrolyte abnormalities such as hypokalemia, hypophosphatemia, and hypomagnesemia. Hypokalemia (level: 2.9) was detected only at follow-up and replacement therapy was performed. She was admitted to intensive care unit for follow-up because of receiving high-dose insulin and the risk of hypoglycemia attacks and electrolyte abnormalities. During the course of her 2 days of hospital stay, her blood glucose was measured hourly and a total of 245 g of dextrose (dextrose infusion rate adjusted according to blood glucose level) was infused to maintain blood glucose between 100-200. No other complications of insulin overdose were observed during her stay in the hospital.

Conclusion: In this case, the patient who intentionally injected herself with an overdose of insulin glargine and aspart was successfully treated. Dextrose infusion, if needed, and monitoring for electrolyte abnormalities are recommended for the treatment of insuline poisoning with suicidal intent.

Keywords: Hypoglycemia, insulin, suicide

P-0723 Imaging in Emergency Units

Retrospective analysis of patients with pulmonary angiography taken

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Objective: Pulmonary thromboembolism is a preventable disease which can be difficult sometimes to diagnose, can have recurrences and has high morbidity and mortality rate. Nowadays, we use mostly Computed Tomography pulmonary Angiography (CTPA) to diagnose pulmonary thromboembolism. In our study, we searched for the appropriate use of CT pulmonary angiography in diagnosis of PTE and compared interpretation of CTPA between emergency department residents and the radiologists.

Material-Method: Patients who admitted to İzmir Atatürk Training and Research Hospital Emergency Department between the dates 01/01/2012 – 31/12/2012 and had suspects of PTE and investigated with CTPA, are accepted as the research universe of our study. Informations of patients were gained from Hospital Information Management System (HIMS). 228 patients which are older than 18 years old and investigated with CTPA for the suspect of PTE were included in our study.

PTE is diagnosed in clinically suspected patients with a thrombus seen in pulmonary arteries and its branches in CTPA. Radiologist interpretation of CTPA is accepted as gold standard.

Patients' demographic characteristics, predisposing factors for PTE, symptoms, vital signs, drugs and clinical progresses were searched from HIMS and recorded in the study form.

Statistical analysis of the results were made by SPSS 15.0 with the 95% CI. P < 0,05 values are accepted significant statistically.

Results: 191 patients included in our study and 48.2% of the patients were men, 51.8% were women. 8.9% of patients age were less than 40 years old. 57.6% of patients were older than 65 years and 33.5% of the patients were between the ages of 40-65. The most common comorbid disease was hypertension in our patients. In PTE suspected patients, most common initial symptoms were dyspnea and chest pain. 19.9% of 191 patients diagnosed as PTE. PTE predictive powers between ED Residents and Radiologists were significant statistically (Sensitivity %93.5, specificity %94.4, PPV % 76.3, NPV % 98.7, AUC: 0.940 %95 CI: 0.885-0.994 p<0.001 p<0.05). 93.5% of PTE diagnosed patients were also evaluated as PTE by ED residents. 55% of patients evaluated with CTPA were externated from ED, 26.7% were sent to another hospital and 14.1% of the patients were hospitalized.

Conclusion: This study will help the ED residents to decide CTPA indications by using demographic characteristics, predisposing factors for PTE, symptoms, vital signs and reduce unnecessary indications for CTPA. In PTE existing patients, CTPA interpretation is highly consistent between the radiologist and ED residents.

Keywords: Pulmonary thromboembolism, pulmonary angiography, emergency department



POSTER PRESENTATIONS

P-0724 Cardiovascular Emergencies

Evaluation of emergency medicine residents adaptation to the changes in the 2010 AHA guidelines for cardiopulmonary resuscitation and emergency cardiovascular care

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Objective: In our study, we aimed to evaluate emergency medicine residents who are working in İzmir Atatürk Training and Research Hospital, Bozyaka Training and Research Hospital, Tepecik Training and Research Hospital, Dokuz Eylül University Faculty of Medicine Hospital ve Ege University Faculty of Medicine Hospital, adaptation to changes made in 2010 cardiopulmonary resuscitation guideline.

Material–Method: Data of study were collected between 01.05.2013 – 15.05.2013 by the researcher. The prepared questions were asked to each of 108 emergency department residents in the face-to-face interviews. The residents that refused to participate to the study and the resident that could not seen in their departments for the reasons of holiday, rotation and off duty were excluded from the study.

Results: In our study 58%(n=63) of the residents job duration was less than 5 years. 32% of our participants(n=35) were the first year residents. %56 of the residents(n=61) were educated less than 3 times about ACLS. %20 of them(n=22) explained that they had no education about ACLS. 72% of the residents that had education, got it by verbal presentation. In the group of 36-48 month residents, the rate of true answers was significantly better when compared to the 0-12 and 12-24 month residents.(p<0.05) when the residents who were educated with verbal presentations, video images and bedside practice compared to the non-educated residents, the rate of true answers in the educated group was better significantly.(p<0.05) In the analysis of the rate of true answers between the group of residents that gave education to the others about ACLS with the other group, the rate of true answers was significantly better in the of education giving group.(p<0.05) The rate of true answers of the resident group that managed more than 100 arrested patients was better significantly when compared to the 0-25 and 25-50 arrest groups.(p<0.05). In the analysis between the groups according to their job seniority, number of ACLS educations since 2010 and ACLS education on a model, the result was insignificant statistically(p>0.05)

Conclusion: We think, for resident education, providing active participation of the residents to arrested patients, giving more emphasis on bedside and practical education will increase the knowledge over primary education and update the clinical practice

Keywords: 2010 AHA guidelines, adaptation, emergency department

P-0725 Toxicology

Symptomatic bradycardia due to oleander poisoning

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Objective: Nerium oleander is an evergreen plant native in the Mediterranean region. It have many side effects including cardiac effects that may be lethal. Oleander leaves and seeds contain more than 30 different cardiac glycosides (e.g. oleandrin, oleandrogenin, desacetyloleandrin, glucosyloleandrin, gentiobiosyloleandrin, nerigoside, odorosides, oleasides) at various concentrations. A dose of 5 to 15 leaves of oleandrin may be lethal for adults, but a single leaf may be lethal in children. Nerium oleander produces typical clinical signs of cardiac glycoside poisoning. The first signs are gastrointestinal discomfort, nausea, and vomiting, followed by neurological symptoms that include weakness, mental confusion, and cardiac involvement that presents as cardiac arrhythmias (atrial and ventricular ectopic arrhythmias) and conduction disturbances (sinoatrial and AV node conduction disturbances) usually manifesting as bradycardia which may progress to AV block and asystole. In some cases, ectopic beats may be followed by ventricular tachycardia and fibrillation. In treatment, decontamination by lavage, correction of electrolyte imbalance, correction of severe bradycardia with atropine or electrical pacing, corrections of ventricular dysrhythmias, and administration of digoxin-specific antibody (Fab) fragments if available should be done. In this paper, we presented a rare case of symptomatic bradycardia due to oleander poisoning.

Case: A 52 year old female patient was admitted to the emergency department with complaints of weakness, dizziness, nausea, vomiting, diarrhea. We learned that she had not any known disease, but her complaints had begun 2 hours after drinking boiled 2 pieces of oleander leaves for the purpose of cancer prevention. The patient was conscious, oriented, cooperative, and her blood pressure was 100/60 mmHg, pulse rate: 42 / minute, respiratory rate: 22 / min. Heart sounds was rhythmic, bradycardic. Neurological examination was normal. Sinus bradycardia was detected on ECG. Patient was monitored, oxygen and intravenous saline infusion was started. Blood tests including cardiac enzymes were within normal limits. Bradycardia of the patient was continued until 24 hours after oleander intake. In the follow up of patient, five times her pulse rate decreased under 40 / min, and 0.5 mg atropine was given each time. On the second day of the follow-up, bradycardia and symptoms of the patient was recovered, her vital signs were clinically stable, and she was discharged with recommendations.

Conclusion: Oleander poisoning should be considered in the differential diagnosis of bradyarrhythmias. Also people should be warned about the appropriate use of herbal therapies such as oleander which might be useless, harmful, and sometimes lethal.

Keywords: Oleander poisoning, bradycardia, herbal therapy

P-0726 Imaging in Emergency Units

A Case With An Interesting Foreign Body Image on Endoscopy

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Objectives: The literature commonly reports children inadvertently swallowing small button (coin) batteries. The deliberate ingestion of multiple large cylindrical batteries by an adult is an unusual presentation of deliberate self-harm due to the size and difficulty of swallowing these batteries. We present a 23 year-old patient who has ingested cylindrical batteries for suicide because of his interesting endoscopic image.

Case: 23 year-old male prisoner patient has been prediagnosed and referred by Emergency Department for foreign body ingestion to Gastroenterology Clinic. The patient was brought to Emergency Room upon suspicion after he has been caught by X-ray machine multiple times giving alarms at routine security check. There were images related with cylindrical batteries on upright abdominal X-ray at epigastric location. The patient had no complaints. He noted that he had ingested a number of batteries for suicide a week ago. Upon endoscopy, five 5 cm. long, 1,5 cm. wide cylindrical batteries were found in the gastric lumen. The patient was referred to an advanced hospital on his 2nd day because of the technical deficiencies about removing the large number of batteries. There were no batteries upon endoscopy and the batteries could not be seen on his abdominal X-ray at the referred hospital; therefore the patient was sent back to our hospital. He had another abdominal X-ray which also showed no foreign bodies. The patient is asked how he removed the batteries, he reported that he had technical information about ingesting and removing the batteries but he denied giving any detailed information about it.

Conclusion: The natural course after ingestion of a foreign body is asymptomatic in 80% of cases, and the foreign body passes without problems. Endoscopic intervention is indicated in some 20% of cases. Surgery is required in less than 1% of cases. Some authors have described using metal detectors to diagnose swallowed foreign bodies. Ingestion of cylindrical batteries with any signs of airway compromise, oesophageal obstruction or perforation are an indication for emergency endoscopy, preferably with conscious sedation if appropriate. Necroses may develop subsequent to pressure on the mucosa (pressure necrosis) and/or subsequent to the release of alkaline substances (liquefactive necrosis), as may fistulas or mercury poisoning such patients should be admitted as inpatients.

The batteries were removed by the patient in our case without applying to any of these ways with a method we could not understand.

Keywords: Foreign body, emergency endoscopy, cylindrical batteries

POSTER BİLDİRİLER

P-0727 Cardiovascular Emergencies

Complete heart block in mumps myocarditis

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Objective: Mumps is an acute, self-limited, highly infectious, systemic viral illness characterized by the swelling of the parotid glands. It is more common in school-aged children, however adults tend to be more severely affected. The transmission mode is person to person via respiratory droplets and saliva. Mumps has an incubation period of 16-18 days. After this period, prodromal symptoms (such as low-grade fever, malaise, myalgias, headache) occur. After 3-5 days, organ involvement is seen. The most common presentation is a parotitis. Other reported sites of infection are the central nervous system, pancreas, kidneys, testes, ovaries, joints and myocardium. The incidence of myocarditis is 15%. It's typically asymptomatic. Thirteen percent of adults with myocarditis had significant electrocardiographic findings of depressed ST segments and bradycardia. We report a case of 80 years old woman with mumps myocarditis-complete heart block.

Case: 80 years old woman admitted to emergency room with complaints of swelling around the right ear, dizziness, fatigue and chest pain. In her history, she had had a pyrexia of 38°C and swelling of right parotid gland and had complained of dizziness about a week before. His grandson had had fever and swelling of the parotids about two weeks before the onset of her own illness. Finally, she complained of general fatigue and chest pain. There were no any features in her self and family history. Her temperature was 37,5°C, blood pressure 120/60 mmHg and pulse 37 per minute. There was swelling of the right parotid glands. Epigastric tenderness was detected. Examination of all other systems disclosed no abnormalities. There was a complete atrio ventricular block in her electrocardiogram. The haematocrit, white blood cell count, sedimentation rate, C reactive protein, blood urea nitrogen, serum electrolytes, and transaminases were all within the normal range. Serum amylase level was 2307 (28-100) Unit/liter. Serum troponin T level was 0.037 (0-0.014) ng/ml, serum creatinin kinase and creatinin kinase MB level were normal. Serum mumps IgG was detected. An echocardiogram showed no pericardial effusion and normal left ventricular function. The patient was consulted with clinic of cardiology and hospitalized. A permanent demand pacemaker was implanted in clinic of cardiology. Patient whose symptoms improved was discharged with recommendations.

Conclusion: Mumps is more common in children and the most common presentation is a parotitis. But, it should not be forgotten that mumps can also occur in old person and cause complete AV block associated with myocarditis.

Keywords: adult, complete heart block, mumps

P-0728 Imaging in Emergency Units

Diffuse Subcutaneous Emphysema Occurred After Emphysema Surgery: A Case Report

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Objective: Dyspnea is one of most common symptoms presented in ED. Etiology may differs related to age but pulmonary and cardiac pathologies are the main causes of dyspnea. Postoperative pulmonary embolism and atelectasia are the main causes of postoperative dyspnea and diffuse subcutaneous emphysema may also cause dyspnea postoperatively.

Case: A 69-year-old male patient admitted to ED with dyspnea. Dyspnea started one day ago and worsened progressively. In his medical history he was operated for Larynx Ca 15 years ago, had a tracheotomy and gone under surgery just 7 days ago for emphysema. Vital signs were fever: 36.4 OC, blood pressure: 120/75 mmHg, pulse: 125 beat/min and SO2: %83. We detected subcutaneous crepitation started within both hemithorax till neck and mandible. ECG only showed sinus tachycardia, routine biochemistry values and ABG were in normal range. At chest x-ray, we observed diffuse subcutaneous air. The patient referred to thorax surgery and diagnosed as diffuse subcutaneous emphysema occurred after emphysema surgery.

Conclusion: Emphysema is a disease that characterized with irreversible alveolar expansion. It causes dyspnea and downgrades life quality. Surgery is one of the treatments of emphysema. The air that spreads to subcutaneously may cause emphysema in another location and may cause the dyspnea to endure. In these patients if subcutaneous emphysema would drained advanced airway alternatives must be considered.

Keywords: Diffuse, Subcutaneous Emphysema, Surgery

P-0729 Imaging in Emergency Units

Misplacement of central venous catheter: case report

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Objective: Central venous catheters (CVCs) are used in various clinical conditions. CVCs are typically inserted through the internal jugular, subclavian, or femoral veins. Subclavian (SV) vein has anatomic advantages such as large diameter, absence of valves and lower risk of catheter-related infection and thrombosis than other veins. Various rates of acute complications such as arterial puncture, hemothorax, pneumothorax, hematoma due to catheter placement, as well as catheter misplacement have been reported. An anterior posterior chest X-ray is usually obtained after cannulation to assess the location of the catheter tip.

Case: An 87-year old female patient admitted to our emergency room with dyspnea. She had been receiving hemodialysis three times a week for two years. Her dialysis catheter had not worked for three days. Her vital signs were as follows; blood pressure 147/93 mmHg, heart rate 100/min, respiratory rate 21/min and pulse oxygen saturation 82% with room air. On physical examination, she had inspiratory crepitation rales that were heard bilaterally on auscultation, distended abdomen and pretibial edema in both lower extremities. Her dialysis catheter was withdrawn and a new CVC was inserted through right SV and post-procedural chest X-ray was performed. It was seen that the catheter was placed in the ipsilateral internal jugular vein (Figure). It was withdrawn and inserted into the correct position.

Conclusion: The misplacement of CVCs may be seen during central catheterizations and SV insertions have higher rates of misplacement with various positions. Findings reported in the literature emphasize that taking routine chest radiograph to confirm appropriate catheter tip position after central catheterization is easy and useful.

Keywords: Central catheters, subclavian vein, misplacement

P-0730 Toxicology

Mad Honey Poisoning

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Objective: In our country mad honey poisoning is usually seen in Blacksea region. The cause of this poisoning is grayanotoxin, which is produced by Ericaceae family honey bees from rhododendron genus flowers. Patients are usually discharged without any complication. Only observation with symptomatic therapy is enough. However, there are cases that undergo cardiovascular collapse and coma in literature.

Case: 38 year old male patient was brought to emergency service with vertigo and dizziness complaints. The patients heart rate was 32/min and blood pressure was 60/40 mmHg. The rythm was sinus bradycardia in his ECG. In his history the patient said that he ate 2 tablespoons of honey which came from Artvin region. After intravenous fluid and atropin therapy heart rate increased up to 62/min and blood pressure increased up to 110/80 mmHg. Patient was discharged from emergency service after observing 8 hours without any additional problem.

Conclusion: In mad honey toxications grayanotoxin increases sodium channel permeability and cholinergic toxidrome effects are dominant. It also innervates nervus vagus and leads to sinus node dysfunction. The most common symptoms are vertigo, nausea-vomiting, fatigue and the most seen findings are bradycardia and hypotension. In a review of 12 different case series; it sinus bradycardia and non spesifik bradycardia was seen in %70 of the cases, while nodal rythm and 3rd degree AV block was seen in %11 of the cases, and 2nd degree AV block.WPW syndrome and asystol was seen in %1,4 of the cases. In mad honey poisoning symptomatic therapy is usually enough while positive inotropic support or advanced life support is rarely required. In our patients iv fluid and atropin therapy was sufficient. In patients who are admitted to emergency service with symptoms like vertigo, nausea, vomiting, syncope and bradycardia, mad honey poisoning should be kept in mind.

Keywords: bradycardia, honey, poisoning



POSTER PRESENTATIONS

P-0731 Toxicology

Neuroleptic malignant syndrome induced by quetiapine and aripiprazole overdose

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Objective: Neuroleptic malignant syndrome (NMS) is a rare and potentially life-threatening neurologic emergency commonly associated with the use of antipsychotic medications. Atypical antipsychotic agents have lower associated rates of extrapyramidal symptoms and are less likely to induce NMS as compared to conventional antipsychotics. Quetiapine an atypical antipsychotic agent is approved for the treatment of schizophrenia, bipolar disorder and major depressive disorder. And also one of the newest agents in the atypical antipsychotic class is aripiprazole. We report the case of a 33-year-old man with paranoid schizophrenia, who presented with NMS after a suicide attempt with high dosages of aripiprazole and quetiapine.

Case: A 33 year old man arrived at the emergency department with a chief complaint of delirium, urinary incontinence and fever. He had a medical history of paranoid schizophrenia was taking aripiprazole 20mg/day and quetiapine 300mg/day. His parents found empty blister packs in his room. He had taken unknown amount of his medicine. The temperature was 38 °C, heart rate 136 beats/minute, respiratory rate 16 breaths/minute, blood pressure 130/67 mmHg. He had diffuse rigidity of skeletal muscles of all four extremities. Laboratory investigation revealed mild leukocytosis (13,85 10x3/μL) and high creatinine level (2,65 mg/dL). His creatine kinase (CK) level was markedly elevated (15920 U/L), with mildly elevated CK MB fraction and cardiac troponin level is normal. Other laboratory results, including electrolyte levels were normal. Cranial CT, lumbar puncture and septic screen were all negative. He was diagnosed as NMS and hospitalized in the intensive care unit. He was treated with intravenous midazolam infusion, nasogastrically administered bromocriptine and external cooling. Also electrolyte management and blood pressure control was provided to the patient. Within a few days, the patient's NMS symptoms improved and his CK level returned to normal. The patient was transferred to psychiatry department. He was discharged well with no deterioration from his premorbid neurologic state.

Conclusion: The NMS often develops after a sudden increase in dosage of the neuroleptic medication or in states of dehydration. Treatment is mainly supportive and includes withdrawal of the neuroleptic medication and administration of drugs such as dantrolene and bromocriptine. Complications of NMS include acute renal failure, acute respiratory failure and death. To our knowledge, although there are numerous cases reported with therapeutic use, but NMS has not been reported to develop following acute aripiprazole and quetiapine overdose. Emergency Medicine physicians need to be able to recognize and appropriately manage NMS.

Keywords: neuroleptic malignant syndrome, aripiprazole, quetiapine, drug overdose

P-0732 Cardiovascular Emergencies

Kounis Syndrome in ED

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Objective: Kounis syndrome refers to the concurrence of acute coronary event and mast cell activation with allergic or hypersensitivity reactions. Syndrome described as two type; 1: patient who has normal coroner artery, has ST segment elevation because of vasospasm. Type 2: plaq rupture or trombosis is developed because of mediators in patient with underlying coronary artery disease.

In this case report we described a patient referred to emergency department (ED) with rush after taking diclofenac sodium

Case: A 60 year-old-man referred to our ED with rush after taking diclofenac sodium for his stiff neck. His medical history includes coronary artery disease and hyperlipidemia. His vital signs recorded as; blood pressure 126/84 mmHg, a sinus cardiac rhythm of 79 beats per minute, oxygen saturation 92 and 36.5 oC body temperature. Diffuse redness was observed without uvula edema. In his detailed questionnaire, patient whom seen uncomfortable asked for chest pain and sweating. He confirmed non spesifik mild chest pain and cold sweating which was started in ED. Immediately taken electrocardiography showed ST segment elevation. Urgently cardiology consultation was requested. Both adjunctive therapy for STEMI and antihistaminic medications for anaphylaxis were given to patient at the same time. Patient prompted coroner angiography which revealed circumflex artery occlusion.

Conclusion: In this case, we reported Kounis syndrome (type 2), as acute coronary syndrome due to allergic reaction. Clinicians should consider coexistence of acute coronary syndrome in patient admitted to ED with allergic reactions and also the patient who had coronary artery disease should be questioned carefully about cardiac symptoms.

Keywords: Allergic reactions, Emergency Department, Kounis syndrome

P-0733 Toxicology

Management of anaphylaxis due to bee sting

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Objective: Allergic reactions due to insect bites are most common by bees. Bee venom contain proteins (apamin, melitin, kinin, mastoparan), enzymes (phospholipase A and B, hyaluronidase) and vasoactive amines (histamine and serotonin). Toxic immunological response varies depending on individual sensitivity. Only local symptoms, non-toxic immunological symptoms, or hypersensitivity symptoms can occur as a result of bee stings according to the person's immune structure. Pain in sting area, itching and redness can be seen locally. Mild symptoms (headache, fever, fatigue, rash, joint pain), moderate symptoms (dizziness, abdominal pain, nausea, vomiting, wheezing, swelling of inserted location) or severe symptoms (difficulty of breathing and speech, sensorial attenuation) can be seen as hypersensitivity symptoms. Low blood pressure, loss of consciousness and respiratory distress are signs of deterioration. Edema which causes difficulty in breathing due to bee stings in regions such as mouth, tongue and throat have much worse results. Severe symptoms in sensitive patients may occur within 5-8 minutes. Within 20-30 minutes, unconsciousness, respiratory depression and hypotension may occur. Rarely non-immunological toxic symptoms such as convulsions, coma, kidney failure occur due to the result of a large number of bee stings. Late symptoms of bee stings are hemolysis, coagulation disorders, thrombocytopenia, rhabdomyolysis, liver failure and disseminated intravascular coagulation. In this paper, we present a anaphylaxis case occurred due to bee sting from his face for the aim of drawing attention to this life-threatening situation.

Case: A 19 year old male patient was brought to the emergency department with complaints of swelling around the eyes and shortness of breath occurred after bee sting from his face. The patient was confused, his blood pressure was 80/30 mmHg, his pulse was filiform, respiration was superficial and dyspneic, oxygen saturation: 88%. The patient had periorbital edema, uvula edema and wheezing. Intravenous access was opened, oxygen was installed by mask and the patient was monitored. Intravenous adrenaline, prednol, antihistamines, inhaled beta-mimetics, rapid intravenous saline infusion was given. During the follow-up, respiratory distress of the patient was recovered, and patient was discharged with recommendations after 12-hours.

Conclusion: The most important and life-saving point in the treatment of anaphylaxis is considering appropriate dose of epinephrine administration by the right way without waiting for clinical worsening.

Keywords: anaphylaxis, bee sting, epinephrine

P-0734 Toxicology

Seizure associated with the use of bonzai (synthetic cannabinoid product)

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Objective: Synthetic cannabinoids recently appeared on the drug market, mostly as undeclared additives in herbal mixtures named for example Bonzai or Jamaica. They were officially registered as illegal substances on 13.02.2011 in Turkey. Synthetic cannabinoids are a large group of drugs of abuse that have an effect similar to cannabis, but may be considerably more potent. Moreover, their consumption cannot be verified by standard drug tests, which is particularly interesting for people facing regular drug testing. Easy afford ability also contribute to the popularity of these drugs. The frequent use of synthetic cannabinoids led to a recent increase in emergency admission.

Case: A 18 year old male admitted our emergency medicine clinic with his relatives. His relatives said that he had smoked "Bonzai" and a few minutes after consumption he became unresponsive. On arrival in the emergency department he vomited repeatedly while lying on his back. He had also confusion, somnolence, and mydriasis. Tonic-clonic seizures was developed while the examination was performed. The patient received 5 mg of diazepam IV for seizure. His vital signs were unremarkable with the exception of a sinus tachycardia (130 beats/min). His cardiac, abdominal, and pulmonary examinations were normal. He had a normal complete blood cell count and basic metabolic panel except metabolic acidosis with 7,10 pH. After the initial



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assessment, he received a normal saline bolus of 1000 mL. He was observed overnight, during which time he recovered her motor and verbal functions. In the morning he was discharged from hospital.

Conclusion: Synthetic cannabinoids are marketed over harmless cannabis, but can cause severe intoxication and death. There are case reports of cardiac infarction in teenagers, severe psychoses and also deaths after consumption of synthetic cannabinoids. There is a considerable need for more knowledge about the action and harmful effects of these substances. Emergency medicine physicians should suspect from synthetic cannabinoids abuse in young males who apply with first time generalized tonic clonic seizure.

Keywords: bonzai, synthetic cannabinoid, seizure

P-0735 Toxicology

Analyzed to patients who excessive intake of lithium in emergency medicine

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Objective: Lithium used for many years in the treatment of bipolar disorder and is a medicament with activity. Due to narrow therapeutic index of lithium during its use has lead to the emergence of some undesirable effects. The purpose of this study of patients presenting to emergency department using lithium to identify the differences and complications, is to emphasize the importance of early diagnosis and treatment.

Materials-Methods: Between 01.01.2011 - 04.15.2014 from patients admitted to the emergency department lithium level was examined and was admitted due to excessive intake were included in the study. Records scanning patient records and follow-up with the hospital's computer program was utilized.

Results: Lithium levels were analyzed in 22 patients. They were included in the study. The age range was between 21 to 69 cases. Average age was 37.6. Sixteen patients were women and six patients were male. It was observed more neurological symptoms in the patients. Three patients appeared with acute renal failure. In 4 patients with high levels of lithium severe intoxication identified and underwent hemodialysis. Early improvement was seen in all patients on hemodialysis.

Conclusion: Lithium is a drug still used to treat bipolar disorder. Due to the narrow therapeutic index, even at doses normally use lithium clearance due to degradation of the advancing age of the symptoms of toxicity may be seen in advanced age. Patients after excessive intake of lithium may present with different clinical situations. Neurological, cardiac, and renal involvement is a life-threatening complications of this drug in patients using lithium side effects and complications is important to be informed despite. In addition, patients admitted to the emergency use of lithium in the lithium levels should be looked at to do and should be evaluated for early hemodialysis. Patients under intensive care conditions to be monitored and to take IV hydration.

Keywords: lithium toxicity, hemodialysis, emergency department

P-0736 Imaging in Emergency Units

Huge left atrial thrombus

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Objective: Left atrial thrombus is an infrequent clinical syndrome, which can have a catastrophic outcome but can be treated when recognized. Thrombus in the left atrium may cause fatal systemic emboli or sudden death due to the occlusion of mitral valve orifice. Mitral valve stenosis and atrial fibrillation are well known risk factors for left atrial thrombus and they increase the risk of stroke and thromboembolism. In this case report, we present a 64 year-old woman who had atrial fibrillation with a huge thrombus in the left atrium.

Case: A 64 year-old woman referred to the emergency department with diarrhea, vomiting and reduced oral intake. She had hypertension and diabetes mellitus, however had no regular drug use. In her physical examination, she had poor general condition and impaired peripheral circulation with cold limbs and cyanotic mucosa. Arrhythmic heart sounds and tachycardia were observed. Arterial blood pressure was 100/60 mmHg, heart rate was 179/min. In electrocardiography atrial fibrillation with high ventricular response was detected. Laboratory tests showed high liver function tests, muscle enzymes and lactic acid levels. Initial diagnosis was thromboembolism due to sepsis or venous thrombus. Investigations were made to determine a possible infection site. All contrast-enhanced chest and abdominal computed tomography was undertaken to explain a possible embolism as the infection site was not clear. Tomography showed a 5x3 cm size ball-shaped thrombus in the left atrium. Of the patient's current clinical status depended on microembolism caused by atrial thrombus and anticoagulant treatment started, referral to appropriate centers were provided.

Conclusion: A thrombus in the left atrium has a variable symptomatic presentation. Fragmentation of the thrombus followed by peripheral embolization will produce ischemia or infarction in the myocardium, brain, viscera, or extremities. Partial or total occlusion of the mitral valve orifice may cause syncope and/or pulmonary congestion. Although left atrial thrombi are not seen frequently, they need treatment when detected as they can lead to catastrophic outcomes.

Keywords: Huge, Left, Atrial, Thrombus

P-0737 Toxicology

Bupropion Intoxication

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Background: Smoking remains to be the major preventable cause of early mortality and morbidity. At least 70% of the smokers who quit smoking don't succeed despite the use of the best nicotine replacement treatment with behavior treatment. Findings that there is an increased prevalence of depression among smokers and that smokers with depression, have greater difficulty quitting than those without depression led to the investigation of antidepressants as aids for smoking cessation. Bupropion, which seems to be effective in smoking cessation treatment, reduces withdrawal symptoms and weight gain, which occurs after quitting smoking, and throughout out the treatment. With these properties, bupropion comes in view as a useful treatment intervention in smoking cessation.

Case: A 35 year old man presented to the emergency department (ED) after a deliberate overdose of 30x150 mg sustained release bupropion tablets six hours earlier. No other drug or alcohol had been ingested. These tablets had been prescribed by her general practitioner to aid smoking cessation. He was not known to be taking any recreational drugs, and had not previously taken an intentional overdose or expressed any suicidal thoughts.

On examination the eyes were close, she obeyed no commands, and was nonorientated to time and place (GCS 7/15). An electrocardiogram revealed a sinus tachycardia (108 beat/min) with no QRS or QTc abnormality, and blood pressure was measured as 100/60. Laboratory sodium 140 mmol/L, potassium 4.0 mmol/L, corrected calcium 2.4 mmol/L, magnesium 0.9 mmol/L, and no detectable paracetamol or salicylate. Arterial blood gas measurements taken two hours after ED admission revealed no evidence of a metabolic acidosis (pH 7.40, PCO2 4.6 kPa, PO2 11.0 kPa, HCO3 23 mmol/L).

Because of the delay in presentation, no gastric lavage was performed and no activated charcoal was administered. After admission to the ED, he had need resuscitation. The patient was asymptomatic upon discharge two days after admission, with psychiatric follow up arranged.

Conclusion: Bupropion is a unique monocyclic antidepressant, with structural similarities to amphetamines. It weakly inhibits neuronal reuptake of dopamine, norepinephrine, and serotonin and has moderate anticholinergic activity. In smoking cessation it is believed to act by increasing dopamine concentration in the nucleus accumbens. Therapeutic peak plasma values are reached within three hours of ingestion with a mean elimination half life of 21 hours; bupropion is extensively metabolised by multiple pathways with no single pathway predominating. So we might use this drug carefully.

Keywords: bupropion, intoxication, smokers

P-0738 Cardiovascular Emergencies

Myocardial Infarction In Young Population

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Objective: The incidence of myocardial infarction (MI) and symptomatic coronary artery disease is low in young adult population. 3% of all coronary artery diseases are seen in population aged under 40. The most important risk factor related to coronary artery disease in young adults is smoking

Case: A 22-years-old male admitted to emergency department with the complaint of chest pain. He described his pain as a feeling of pressure on his chest which was begun one hour ago. He was a smoker but denied any drug abuse. His past medical history did not show any disease. He wasn't using any medication and he had not any medical family history.

His blood pressure was 120/80 mmHg, heart rate was 90/min, and respiratory rate was 12/min. His physical exam was unremarkable. His electrocardiography showed ST elevation on



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derivations D1 and aVL. CK-MB was 31.73 ng/ml (0-5 ng/ml) and troponin-I was 14,78 ng/ml (0-0,06 ng/ml). Quick urine analysis for drugs was negative. He had consulted to cardiologist and admitted to angiography unit for coronary angiography. His coronary angiography did not show any vascular pathology. Two days later, his CK-MB and Troponin-I levels were still high but our patient leaved hospital by his own decide.

Conclusion: MI is not the initial diagnosis in adult young population admitted to emergency department with chest pain, but it can be diagnosed in this population, too. Researchs conducted on patients' coronary angiography results aged under 40 showed 62% single vessel disease, 24% multipl vessel disease and 14% normal coronary vessels. Our patient's coronary angiography shwed normal coronary vessels. Although in-hospital and early out-hospital results are better than older-aged popuation, factors such as previous coronary disease, smoking and low ejection fraction cause increased mortality which can be high as 30% in young adult population. For this reason, chest pain in adult young population must be managed with caution and management must be planned by this way.

Keywords: Myocardial Infarction, Young Population, ER

P-0739 Imaging in Emergency Units

Ruptured intracranial dermoid cyst manifesting as acute severe headache and vomiting

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Objective: Dermoid cysts account for approximately 0.5 % of all primary intracranial tumours, and are a little more commonly found in females. Many intracranial dermoid cysts are asymptomatic, and are only found incidentally. Here we present a 73-year-old woman with acute severe headache and vomiting diagnosed as ruptured intracranial dermoid cyst.

Case: A 73-year-old woman, without significant past medical history, admitted to our emergency department because of acute severe headache and vomiting. The patient suffered from headache for 1 month's duration. But her complaints has increased in last two hours. On presentation, vital signs were normal. Laboratory evaluation was also normal. No focal neurologic deficits were identified. To rule out acute subarachnoid hemorrhage initial non-contrast cranial computed tomography was performed. Multidetector axial CT images demonstrate a 3.8 x 2.4 cm diameter fat density mass in the middle cranial fossa. Additionally, triventricular hydrocephalus and multiple locules of fat throughout the left lateral ventricular system was presented.

Conclusion: Intracranial dermoid cysts are congenital ectodermal inclusion cysts. They are usually non-malignant lesions. They tend to occur in the midline, sellar, parasellar or frontonasal regions. They are usually asymptomatic but have a high morbidity and mortality risk, especially when rupture occurs. Rupture is usually spontaneous but in some cases occurs due to head trauma or surgery. Clinical symptoms of acute rupture are headache, nausea, vomiting, vertigo, vision problems, aseptic chemical meningitis, hemiplegia, mental changes, and coma. CT is the initial imaging method in emergency departments. On CT scans these lesions have internal density characteristics consistent with fat (negative Hounsfield units) and their wall is usually calcified. When a dermoid cyst ruptures, fat droplets appear hypodense on CT within ventricular system and/or subarachnoid space. This case report illustrated the importance of investigating a cause of the headache, CT being the initial diagnostic method.

Keywords: Computed tomography, dermoid cyst, headache

P-0740 Toxicology

Rare presentation of botulism with mushroom food

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Objective: Botulism is a dreadful, life-threatening, neuroparalytic disease caused by gram positive bacteria Clostridium botulinum. Food borne botulism has been described following ingestion of preformed toxins in canned food or food products that have not been preserved properly. Botulinum toxin acts on neuromuscular junction and manifests as ophthalmoplegia, bulbar and limb weakness, and autonomic features along with respiratory compromise. The literature and case reports regarding neuroparalytic botulism in Turkey are sparse. Mushroom food intake have been rarely reported in literature as manifestation of food borne botulism. We present a 40-year-old male presenting with usual features described and which rapidly responded to treatment.

Case: a 40-year-old male patient presented with nausea, vomiting, blurred and double vision was admitted to the emergency room. The arrival of the patient's vital signs were normal. He said he ate canned mushrooms, 3 hours ago in his story. There was no abnormal findings in the examination and imaging methods. The development of the patient's difficulty swallowing and blurred vision to the front with Botulism infectious diseases on the increase the move when he was referred to Botulism-Antitoxin treatment starting from patient in intensive care.

Conclusion: Botulism is a rare neuroparalytic disease caused by potent neurotoxin of anaerobic bacteria Clostridium botulinum. Most human cases of food borne botulism are described with toxin A, B, and E. The botulinum toxin has been described as most potent neurotoxin and clinical manifestations depend on dose and toxin type. Home canned food, preserved food, alkaline food, and seafood are commonly implicated in food borne botulism. The incubation period of food borne botulism is 12-36 h after toxin ingestion. Clinical manifestations in initial phase are nausea, vomiting, and dryness of mouth. Eventually signs and symptoms of oculobulbar muscle weakness including diplopia, ptosis, ophthalmoplegia, dysarthria, and dysphagia along with blurring of vision supervene.

In the present case, patient presented with above mentioned features along with disfaji. Very few cases of botulism with associated canned mushroom intake have been reported. Because Clostridium botulinum spores are resistant to high temperatures with the wrecked while boiling for 2-3 hours and 10 minutes to heat-sensitive toxins, however, boiling with denatured. Canned mushrooms are prepared at high temperature

Keywords: Botulism, Food borne, Canned mushroom

P-0741 Toxicology

A Beta Blocker Intoxication Case Resulting With Death

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Objective: Beta-receptor antagonists are the most commonly used groups of drugs in suicide attempts worldwide. In case of intoxication, the prognosis is determined by the answer to the first intervention in the first 6 hours.

In this case, it is mentioned about a patient who admitted Emergency Department with beta receptor antagonist intoxication.

Case: Twenty-nine-year-old female patient was admitted Emergency Department for using a large number of metoprolol half an hour before. The time of admission, the patient's GCS was 15, she was conscious, oriented, and cooperative, blood pressure was 71/46 mmHg and pulse rate was 51/min. Her past medical history revealed hypertension and dysrhythmia. After monitoring GI decontamination was performed with 3000 ml water. Before giving activated carbon a generalized tonic-clonic seizure was observed. At this time her pulse rate was 21/min and GCS was 4. Benzodiazepine, atropine, central venous catheter and endotracheal intubation were performed. CPR was started at the same time.

The patient was considered as beta-blockers toxicity and we decided to give glucagon as antidote but there was not any glucagon in our hospital. After starting noradrenaline infusion, 1 unit/kg crystallized insulin IV bolus, 1 unit/kg/h crystallized insulin IV infusion and 200 ml/h %20 dextrose IV infusion were performed. The patient was planned for giving phosphodiesterase inhibitor but could not be obtained.

Because of metoprolol is moderate lipid soluble, we medicated the patient with 400 ml IV lipid emulsion treatment in 30 minute after 150 ml IV bolus. During CPR in all cycles we looked the parasternal short-axis with echocardiogram for cardiac contractility. In the 185. minute the patient did not respond the medication and she accepted exitus.

Conclusion: Beta-adrenergic receptor agonists like norepinephrine, dopamine, epinephrine and isoproterenol are used routinely in treating beta blocker toxicity. The ability of increasing heart rate and blood pressure makes norepinephrine the most effective adrenergic receptor agonist in beta blocker toxicity.

Although beta-blockers toxicity seen commonly, few cases result in death. In addition, in this toxicity there is not effective treatment continuously, many treatment methods may be needed at the same time during resuscitation of patients in critical condition.

Keywords: Beta blocker intoxication, hypotension, bradycardia



POSTER BİLDİRİLER

P-0742 Imaging in Emergency Units

A new technique in verifying the placement of a nasogastric tube: Obtaining the longitudinal view in addition to transverse view with ultrasound

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Objective: Nasogastric tube (NGT) placement is performed frequently in emergency department (ED). Misplacement can cause serious complications. Many techniques were defined to verify the placement of NGT and ultrasound (US) is one of them. In this study we reported a case and defined a new US technique as obtaining the longitudinal view in addition to transverse view.

Case: A 20-year old man was presented to ED with vomiting after suicidal drug overdose. His vital signs were stable and conscious (GCS: 15). In physical examination any abnormality could not have been detected. NGT placement was needed to for gastrointestinal decontamination. The procedure was performed and to verify the proper placement of NGT, bedside US was used. In transverse view, we had difficulty to have a clear view of the tube because of complex neck anatomy. We tried to obtain longitudinal view of the NGT and it was better than the transverse view in visualization. In color doppler study any flow was not seen and the view of NGT was distinguished from other vascular structures. The diameter of NGT was measured and additional objective evidence was achieved. The gastric lavage procedure was accomplished and any complication was not observed.

Conclusion: Confirmation of NGT placement is crucial and confirmation with US was determined in literature as a useful method. In literature obtaining transverse view and observe the hyperechogenic "fog" was reported. We suggested the use of longitudinal view and measure the diameter of NGT additional these methods

Keywords: Intubation, gastrointestinal, ultrasound, emergency medicine

P-0743 Trauma Emergencies

Kayseri Eğitim Araştırma Hastanesi Adli Çocuk Travma Vakalarımızın Değerlendirilmesi

İsmail Altıntop

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Amaç: Bu çalışmada hastanemiz acil servisine çocukluk çağı adli travması nedeniyle gelen hastalarımızın retrospektif olarak demografik ve klinik verileri incelenmiştir. Çalışmanın ilerdeki çocuk yaş grubu adli travma hastaları ile ilgili yapılacak çalışmalara katkı sağlaması amaçlanmıştır.

Gereç-Yöntem: Çalışma için Kayseri Eğitim Araştırma Hastanesi Eğitim Koordinasyon kurulundan onay alındı. Çalışma retrospektif olarak acil travma ünitesine 01.08.2013 ile 01.02.2014 tarihleri arasında adli nedenlerden dolayı başvuran 0-16 yaş aralığındaki çocuklarda yapıldı. 495 hasta ile çalışma tamamlandı. Trafik kazalarına bağlı adli travma vakaları çalışmaya alınmadı.

Bulgular: Erkek hasta sayısı 376 kadın hasta sayısı 119 idi. Erkek hasta oranı % 76 idi. Vakaların çoğunluğunu % 40,3 ile ile darp oluşturmaktadır. Sırasıyla; yüksekte düşme % 26,7, başın yüzeysel yaralanması % 7,8, yumuşak doku travması % 7,2, kesici delici alet yaralanması % 4,8, ön kol el bileği ve parmak travmaları % 4,4, keskin cisimle yaralanma % 2,6 ve diğer adli travmalar % 7,2 olarak bulunmuştur. Darp nedeniyle başvuranların sayısı 199 idi. Darp nedeniyle başvuran hastaların 45'i kız, 156'sı erkekti. Kadın erkek oranı 0,29 idi. Belirgin şekilde erkeklerde darp vakaları fazlaydı. Hastaların ortalama hastanede kalış süreleri 3,12 saat idi. Ateşli silahla yaralanması ile başvuran 4 hasta vardı. Ülkemizde yapılan benzer çalışmalara paralel çalışmamızda erkek hasta oranı % 76 dir. Bu oranın yüksek olması bölgemizde erkek çocuklarının daha serbest büyütülme tarzından kaynaklanmış olabilir. Acilde kalış süreleri oldukça düşük çıkmıştır. Çalışma yapılan dönemde bir hasta eksitus olmuştur. Yapılan çalışmalar sonucunda mortalite oranlarının oldukça düşük olmasının başlıca nedeni travma esnasında ölümlerin % 50'sinin olay yerinde, % 30'unun ilk 1-2 saatte olmasına bağlı olabilir. Çalışmamızda cinsiyete göre sınıflandırıldığında adli travmada önemli farklar olduğu tespit edilmiştir. Ayrıca kesici delici alet yaralanmaları önemli oranda erkek çocuklarda fazladır. Erkek hastaların şiddet eğilimlerinin azaltıcı çalışmalar yapılmalıdır. Hastaların acil servislerde kalış sürelerinin azaltılabilmesi için ayrı çocuk travma üniteleri önerilir. Hasta yatış oranı % 17 olarak bulunmuştur. Adli çocuk travmalarında çocuk psikiyatri konsültasyonu gerekmektedir. Hastanemizde travma sonrası çocuk psikiyatri konsültasyonu istenmediği tespit edilmiştir.

Sonuç: Çocuk adli vakalar acil servislerde gerekirse ayrı bir bölümde; kendilerini çok daha güvenli hissedecekleri ortamda değerlendirilmelidir. Küçük travma ve basit adli travmalar için çocuk travma bölümünün ayrı şekilde planlanması önerilir. Travma sonrası stres bozuklukları ile ilgili yeni çalışmalara ihtiyaç vardır. Erkek çocuklarda kız çocuklara olduğu gibi koruyucu ve eğitici şekilde yaklaşılmalıdır. Cinsiyet ayırt etmeden çocuklar adli durumlara karşı bilgilendirilmelidir.

Anahtar Kelimeler: adli çocuk, travma, adli aciller

P-0744 Toxicology

Delibal zehirlenmesi: Olgu sunumu

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Amaç: Deli bal zehirlenmesi, grayanotoksin içeren balın yenilmesiyle oluşmaktadır. Balın içinde yer alan grayanotoksinler etkililerini hücre membranlarındaki sodyum kanallarına bağlanarak göstermektedir. Acil servise başvuran hastada spesifik olmayan şikayet ve bulgular sebebiyle bir çok hastalıkla karışabilecek deli bal zehirlenmesinin tanı ve tedavisini sunmayı amaçladık.

Olgu: 64 yaşındaki erkek hasta acil servise uzun bulantı, kusma, baş dönmesi ve senkop şikâyetleri ile geldi. Fizik muayenede; arteriyel basınç 70/45 mmHg ve kalp tepe atımı 53 atım/dak, solunum sayısı 14/dk idi. Elektrokardiyografiye sinüs bradikardisi vardı. Yaklaşık 1 saat önce 2 çorba kaşığı deli bal yediği öğrenildi. Hastaya 1 mg atropin ve 100 ml serum fizyolojik verildi. 8 saatlik izlem sonrasında hasta taburcu edildi.

Sonuç: Bulantı, kusma ve bradikardi ile başvuran hastalarda deli bal yeme öyküsü de sorgulanmalıdır.

Anahtar Kelimeler: delibal, zehirlenme, acil

P-0745 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

İnguinal herni ameliyatı sonrası gelişen kontrateral epididimoorşit olgusu

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Amaç: İnguinal herniler cerrahi pratiğinde sık karşılaşılan patolojilerdir. Tedavisi cerrahi olarak düzeltilme olan bu durumlarda cerrahi sonrasında komplikasyonlar aynı taraf testis ve epididim boyunca izlenebilmektedir. Bu tip hastalarda epididimit, iskemik orşit, skrotal hematoma görülebilen komplikasyonların bazılarıdır. Karşı taraf epididim dokusu veya testis dokusunda cerrahi sonrasında soruna karşılaşılmaması beklenen bir durum değildir. Epididimit veya orşit şikâyeti genellikle acil servislere ilgili epididim boyunca ve testiste ağrı, ödem, şişlik gibi şikâyetlerle başvurulur. Tanıda hastanın öyküsü ve fizik muayenesi yanında laboratuvar yöntemleri ve görüntüleme yöntemleri kullanılmaktadır. Genellikle konservatif tedavi edilse de orşitektomiye kadar gidebilen tablolarla da karşımıza çıkabilir. Acil Servisimize sol inguinal herni nedeniyle opere olan sağ skrotal ağrı ve şişlik şikâyeti ile başvuran epididimit ve orşit tablosu olan vakayı sunmak istedik.

Olgu: 33 yaşında erkek hasta; sabah saatlerinde başlayan sağ testis ağrısı şikâyeti ile Acil Servisimize başvurdu. Hastanın öyküsünde; iki gün önce sol inguinal herniden opere olduğu ve bir gün sonrasında şifa ile taburcu edildiği öğrenildi. Ek hastalığı yoktu. Yapılan fizik muayenesinde GKS:15, TA: 120/90 mmHg, Nabız:95, Solunum sayısı: 22, Ateş: 36.7°C idi. Batın muayenesinde sol inguinal herni operasyon skarı ve sağ testiste hiperemi ve hassasiyet izlendi. Laboratuvar tetkiklerinde WBC:12600 olup, nötrofilik hakimdi. Biyokimyasal değerlerinde anormal sonuç izlenmedi. Hastaya epididimit – orşit ön tanısı ile acil skrotal us yapıldı. Sağ epididim dokusunun ödemli olduğu, sağ testis dokusunda ödeme beraber yer yer iskemik odaklar olduğu izlendi. Tetkiklerinin sonucunda Genel Cerrahi ve Üroloji Kliniği'nce değerlendirilen hastaya konservatif tedavi planlandı ve kontrollere başvurmaya belirtilerek taburcu edildi.

Sonuç: Bu vakamızda olduğu gibi kaskı fitiği ameliyatlarından sonra sadece cerrahi olan tarafta değil diğer tarafta da epididimit ve orşit tablosunun izlenebileceği unutulmamalıdır.

Anahtar Kelimeler: İnguinal Herni, Epididimit, Orşit



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P-0746 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Çamaşır suyu inhalasyonuna bağlı akut pankreatit olgusu

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Amaç: Deterjanlar günlük hayatımızda birçok alanda faydalanılan ürünlerken, içerdiği kimyasal bileşimlerle birçok olumsuz sonuçlar doğurmaktadır. Allerjik astım, kontakt dermatit ve solunum yolu enfeksiyonları; deterjanların, yol açtığı bilinen literatüre geçmiş birkaç yan etkidir. Allerjik pankreatite, akut pankreatitin çok nadir görülen sebeplerindendir. Bilgilerimiz ışığında literatürde ilk defa karşılaşılan çamaşır suyu inhalasyonuna bağlı gelişen akut pankreatitli hastayı sunacağız.

Olgu: Göbek çevresinden başlayıp kuşak tarzında sırta ve bele yayılan karın ağrısı şikayeti ile acil servise başvuran 56 yaşındaki bayan hastanın yapılan tetkiklerinde, beyaz küre 12.300/mm3, amilaz seviyesi 3200 IU/L olarak saptanarak, hasta akut pankreatit tanısıyla genel cerrahi servisine yatırılıp medikal tedavi başlandı. Hastanın yapılan abdomen ultrasonografisinde (USG) safra kesesi patolojisi görülmedi ve bilinen hiçbir pankreatit predispozan faktörünün ve allerjik öykünün bulunmadığı tespit edildi. Tedavi sonrası 4. gününde klinik ve laboratuvar değerleri düzelen hasta şifa ile taburcu edildi. On gün sonra benzer şikayetlerle acil servise tekrar başvuran hastanın öyküsü sorgulandığında, hastanın çamaşır suyu ile ev temizliği sonrasında şikayetlerinin başladığı öğrenildi. Hastanın 3 günlük medikal tedavi ile takibi sonrası kliniğinde düzelme olması üzerine hasta taburcu edilmiş ve çamaşır suyu ile temas sonrası mükerrer kereler daha akut pankreatit tanısıyla tedavi edilmiştir.

Sonuç: Her geçen gün akut pankreatite neden olan predispozan faktörlerin sayısı giderek artmaktadır. En sık sebep tüm dünyada hala kolelitiazis ve alkolüdür. Akut pankreatit saptanıp etyolojide herhangi bir predispozan faktör tespit edilemeyen hastalarda alınan ayrıntılı anamnezlerin, bazı olgularda hiç düşünülmeyecek allerjik faktörleri tanımlayarak hem tanı hem de tedaviyi belirleyebileceği akılda tutulmalıdır.

Anahtar Kelimeler: Akut pankreatit, allerjik reaksiyon, çamaşır suyu

P-0747 Toxicology

İskemik Serebrovasküler Hastalıkların (SVH) Prognozunda Ortalama Platelet Hacminin (MPV) Değeri

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Giriş-Amaç: Serebrovasküler hastalıklar (SVH), en sık görülen nörolojik acillerdir. Ciddi mortalite ve morbidite oranları nedeniyle, prognoz tayini önemlidir. SVH'lar, genellikle ateroskleroz (AS) komplikasyonu olarak ortaya çıkar. AS komplikasyonlarının patogenezinde plateletlerin önemli rol oynadıkları bilinmektedir. Platelet fonksiyonlarının iyi bir göstergesi sayılan ortalama platelet hacmi (MPV)'nin miyokard infarktüsü ve iskemik SVH gibi AS zeminde gelişen hastalıklarda yüksek bulunduğu gösterilmiştir. Bu çalışmanın amacı, bir akut faz reaktanı olan MPV'nin, iskemik SVH'daki prognostik değerini incelemektir.

Gereç-Yöntem: Ocak 2011 ile Kasım 2011 tarihleri arasında acil servise başvurmuş ve iskemik SVH tanısıyla nöroloji servisine yatırılmış olan 153 hastanın kayıtları retrospektif olarak incelendi. Hastaneye başvurduğu anda ve taburculuk sırasında alınan hemogram değerleri ile NIHSS (National Institutes of Health Stroke Scale) skorları kaydedildi. Ayrıca taburculuk Modifiye Rankin Skoru (MRS) hesaplandı. Başvuru ve taburculuk MPV değerlerinin prognoz ile ilişkisi araştırıldı.

Bulgular: Çalışmaya 153 hasta dahil edildi. Hastaların 77'si (%50.3) bayandı. Hastaların ortalama yaşı 71 (29-89), yaş ortalaması 67.73±13.41 idi. Hastaların yatış gün sayılarının ortalaması 10.50±4.71 bulundu. En sık görülen ko-morbid hastalıklar sırasıyla, hipertansiyon ve koroner arter hastalığı idi. Hastaların taburculuk esnasındaki MPV değerleri, hastaneye başvuru değerlerinden anlamlı olarak daha yüksek bulundu (p<0.001, t=-6.5). Diğer parametrelerde, başvuru ve taburculuk değerleri arasında fark yoktu. Koagülasyon parametreleri ise taburculuk sırasında anlamlı olarak daha yüksekti (p<0.001). Bunun hastalara yatış sırasında verilen antikoagülan tedaviye bağlı olduğu düşünüldü. Toplam NIHSS skoru başvuruya göre taburculuk sırasında anlamlı olarak daha düşüktü. Bu da hastaların yatış sırasında nörolojik açıdan daha iyi bir durumda taburcu olduklarını göstermektedir. Hastaların başvuru sırasında MPV değeri ile geliş veya taburculuk sırasında NIHSS skoru arasında anlamlı bir ilişki saptanmamıştır. Sadece geliş MPV değeri ile taburculuk sırasında MRS skoru arasında zayıf bir korelasyon saptanmıştır (p=0.032, r=0.173). Bunun haricinde hastaların taburculuk esnasındaki MPV değerleri ile NIHSS veya MRS skoru arasında anlamlı bir ilişki saptanmamıştır. Diabetes Mellitus (DM) öyküsü olan hastaların MPV değerleri, DM öyküsü olmayanlardan anlamlı olarak daha yüksek bulunmuştur. Aynı şekilde Hiperlipidemi (HL) öyküsü olan hastaların hem başvuru hem de taburculuk sırasında MPV değerleri, HL öyküsü olmayanlardan anlamlı olarak daha yüksek bulunmuştur.

Sonuç: Çalışmamızın sonuçlarına göre, özgeçmişinde HL ve DM bulunan hastalarda, MPV düzeyleri yüksek saptanmıştır. Ancak hastaların hastaneye başvuru ve taburculuk sırasında MPV değerleri ile geliş ve taburculuk NIHSS skorları arasında anlamlı bir ilişki saptanmamıştır. Sadece geliş MPV değeri ile taburculuk MRS skoru arasında zayıf bir korelasyon saptanmıştır. Daha kapsamlı çalışmalara ihtiyaç olmakla beraber, MPV'nin iskemik SVH prognoz tahminine bir katkısı tespit edilmemiştir.

Anahtar Kelimeler: iskemik SVH, MPV, Prognoz

P-0748 Trauma Emergencies

Koç fiskesi nedenli dalak yaralanmasına sahip 4 yaşında erkek çocuk

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Özel osm ortaoğlu hastanesi, şanlıurfa

4 yaşında bir erkek çocuk ebeveynleri tarafından koç fiskesi nedeniyle acil servisimize getirildi. Travma sol torakoabdominal bölgeye lokalizeydi. Ekokardiyografide herhangi bir kardiyak travma kanıtı yoktu. Ancak bilgisayarlı tomografiyle dalak laserasyonu saptandı. Bu yüzden hasta hastaneye yatırıldı ve klinik takiplerinde hemodinamik olarak stabil idi ve aynı zamanda tam kan sayımlarında da değişiklik yoktu.

Kırsal bölgede yaşayan insanlar için (özellikle çocuklar için), çiftlik hayvanları tarafından oluşturulan abdominal travmalar bir tehdit olabilir. Buna rağmen, küçükbaş hayvanların neden olduğu intrabdominal organ yaralanmaları nadiren görülür. Bu nedenle, küçük baş hayvanların neden olduğu abdominal travmalı hastalar acil servislere başvurdıkları zaman tıp profesyonelleri abdominal künt organ yaralanmaları için dikkatli olmalıdırlar.

Anahtar Kelimeler: Abdominal travma, dalak laserasyonu, küçükbaş hayvan, çocuklar

P-0749 Trauma Emergencies

Travmatik Diafragma Ruptürü

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Amaç: Travmatik diafragma ruptürü(TDR), çoğunlukla diğer organ yaralanmalarının da eşlik ettiği mortalite ve morbiditesi yüksek bir klinik durumdur. Travma hastalarındaki diafragma ruptürünün tespiti için en önemli nokta diafragma yaralanmasının ön tanılarımız arasında olmasıdır. Olgularda diafragma ruptürüne ait klinik bulguların başlangıçta olmaması mortalite ve morbiditeyi arttıran en önemli sebeplerin başında gelmektedir. Biz bu olgumuzda araç içi trafik kazası sonrası batında yaygın hassasiyeti, dalak ve böbrek yaralanması saptanan olgudaki diafragma ruptürünü sunmaya çalıştık.

Olgu: 29 yaş bayan hasta araç içi trafik kazası sonrası acil servise getirildi. Gelişinde genel durumu orta, glasgow koma skalası: 14, tansiyon arteriyel: 100/60 mmhg, nabız: 125 atım/dakika saptandı. Fizik bakıda toraks da solunum sesleri sol bazalde azalmış, her iki hemitoraks solunuma eşit katılıyordu. Batın muayenesinde yaygın hassasiyet ve defans saptandı. Hastanın toraks ve batın BT'lerinde dalakta subkapsüler hematoma ve multipl laserasyonu ve sol böbrekte kontüzyon ve hematoma saptandı. Sol diafragmada düzensizlik ve diafragma üstüne herniye olmuş dalak izlendi. Genel cerrahi ve göğüs cerrahisi ile konsülte edildi. Hastanın takibinde solunumunda kötüleşme, nefes darlığı ve göğüs ağrısı şikayetleri eklendi. Hasta sol diafragma ruptürünün eşlik ettiği dalak ve böbrek yaralanması tanısı konulup göğüs cerrahisi ve genel cerrahi tarafından ameliyata alındı.



POSTER BİLDİRİLER

Sonuç: TDR'nin etiyolojisinde künt travmalarının oranının penetran travmadan çok daha fazla olduğu literatürde bildirilmektedir. Yine TDR olgularında cinsiyet açısından incelendiğinde erkeklerin oranının daha fazla olduğu saptanmıştır. Bizim olgumuz bayan olması itibarıyla daha az görülen cinsiyet grubunda olmakla birlikte künt travmaya bağlı olması ve daha sık olan sol tarafta görülmesi itibarıyla sık görülen gruba ait özellikler barındırmaktadır. Künt travmaya bağlı diafragma rüptürlerinde çok yüksek oranlarda extraabdominal (intrakraniyal hematom, pelvik fraktür) ve intraabdominal (dalak, karaciğer) organ yaralanmaları eşlik etmektedir. TDR'de mortalite ve morbiditenin en önemli sebebi tanın gecikmesi ve dolayısıyla tedavinin gecikmesidir. Bu durumun en önemli sebebinin hayati organ yaralanmalarına odaklanıp diafragma rüptürünün gözden kaçırılması oluşturmaktadır. Bizim olgumuzda da fizik muayenede torakstan ziyade batındaki hassasiyet ile beraber saptanan dalakta subkapsüler hematom ve multipl laserasyon, sol böbrekte kontüzyon ve hematom bulguları diafragma rüptürünün gözden kaçmasına neden olabildi. Sonuç olarak tüm torakoabdominal travmalı hastalarda diafragma rüptüründen şüphelenilmelidir. TDR olgularında mortalite ve morbiditeye tanıda gecikmenin neden olduğu unutulmamalıdır.

Anahtar Kelimeler: Diafragma rüptürü, Travma, Acil

P-0750 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acil Servise Kişilik Değişiklikleri ile Başvuran Glioblastoma Multiforme Olgusu

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Amaç: Glioblastoma Multiforme (GBM) bütün beyin tümörlerinin içinde en sık rastlanan primer kötü huylu beyin tümörüdür. Ayrıca bu tümör tedavi edilmesi en zor olan tümörlerden biridir. Bu tümör beyin içindeki yıldız şeklindeki glial destek dokularından yani astrositlerden köken alan kötü huylu bir tümördür. Bu tümör yaklaşık 100.000'de 5 kişide görülür. GBM bütün primer beyin tümörlerinin yaklaşık olarak %20-30'unu oluşturmaktadır. Genellikle 40-60 yaş arasında ve erkeklerde kadınlara oranla biraz daha fazla görülmektedir. Glioblastomada en sık görülen bulgular baş ağrısı, hafıza kaybı, havale ve davranış değişiklikleridir. Bu bulgular tümörün hızla büyümesi sonucunda artan basınç nedeniyle ortaya çıkar. Tümör büyüdükçe, bası yaptığı yerin özelliğine göre bazı beden işlevlerinde kayıplar ortaya çıkabilir. Acil servise bu şikayetlerle başvuran hastalarda GBM düşünülmelidir.

Olgu: 54 yaşında kadın hasta stres, ajitasyon şikayetiyle acil servise başvurdu. Anamnezde daha önce herhangi bir hastalığı olmayan hastanın son bir aydır olan Anksiyete bozukluğu ve kişilik değişimi nedeniyle psikiyatri polikliniğine başvurmış ve medikal tedavi başlanmış. Son iki gündür sol tarafta kuvvet kaybı başlayan hastaya intrakraniyal patoloji için Kranial BT (BBT) çekildi. BBT'de sağ frontoparietalde 3'cü ve lateral ventriküllere bası yapan kitle ile uyumlu görünüm saptanması üzerine (Figure 1) hastaya Kranial MR çekildi. Sağ temporal bölgede kortikal-subkortikal ve derin beyaz cevher alanlarında yaklaşık 85x52x67mm. Boyutlarında ve Sağ serebral pedikül, 3. ventrikül ve sağ lateral ventrikül lezyon ve ödem etkisine bağlı olarak basılı yapan kitle saptanması üzerine (Figure 2) hasta Glioblastoma multiforme (GBM) ön tanısı ile beyin cerrahi bölümüne yatırıldı. Operasyona alınan hastaya sağ fronto-temporo-parietal cilt insizyonu ve 10x10 cm lik kraniotomi yapılarak kitle eksizyonu yapılıyor. Postoperatif 10. Gününde hastanın mevcut motor defisiti ve psikiyatrik yakınmaları tamamen düzeliyor. Kitlenin Patolojik incelemesinde Glioblastoma Multiforme (GBM) tanısı konan hastaya kemoterapi ve radyoterapi başlanmış.

Sonuç: sebpsiz kişilik değişikliği ile başvuran hastalarda yaş gibi diğer unsurlarında göz önüne alınmasıyla kranial bir kitlenin varlığı düşünülerek hastaların araştırılmasının uygun olacağı kanaati ortaya çıkmaktadır.

Anahtar Kelimeler: Glioblastoma Multiforme, Anksiyete bozukluğu, ajitasyon

P-0751 Toxicology

Olgu Sunumu: Yüksek Doz Karbamazepin İntoksikasyonu

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Amaç: Karbamazepin oldukça sık kullanılan bir antiepileptik ajandır. Terapötik konsantrasyonları 4-15 µg/ml olup nörolojik yan etkiler sıklıkla 9 µg/ml üzerindeki ortaya çıkmaktadır. İntoksikasyon durumunda komaya kadar ilerleyebilen nörolojik semptomlar, kardiyak aritmiler, solunum depresyonu görülebilir. Yüksek oranda proteine bağlı bulunması nedeniyle karbon hemoperfüzyon standart bir tedavi yaklaşımıdır. Biz bu yazıda yüksek doz karbamazepin aldıktan sonra acil servisimize bulantı, kusma ve ajitasyon ile başvuran bir olguyu sunmayı amaçladık.

Olgu: 19 yaşında bayan hasta, suisit amaçlı olarak 200 mg'lık karbamazepin tabletten yirmi adet aldığı söylenerek 112 tarafından acil servisimize getirildi. Hastanın bulantı, kusması ve ajitasyonu mevcuttu. Hastanın fizik muayenesinde vital bulguları stabil, bilinci açıktı. Nörolojik muayenesi doğaldı. Gastrik lavaj yapıpı, aktif kömür verildi. Laboratuvar tetkikleri ve serum karbamazepin düzeyi istendi. Elektrokardiyografi çekildi ve normal olarak değerlendirildi. Toksikoloji yoğun bakım ünitemize yatırıldı. Rutin laboratuvar tetkikleri normaldi. Takibi sırasında bilincinin kapanması ve karbamazepin düzeyinin 69,2 mg/l gelmesi üzerine nöroloji kliniği ile konsülte edilerek hemoperfüzyon uygulandı. Hemoperfüzyon sonrası bilinci düzeldi ve karbamazepin düzeyi 11,5 mg/l'ye geriledi. 3 gün boyunca takip edilen hastanın durumu stabil seyretmesi üzerine önerilerle taburcu edildi.

Sonuç: Literatürü incelediğimizde, karbamazepin zehirlenmesi olgularında serum karbamazepin düzeylerinin genellikle 10 ile 40 mg/l arasında değiştiği görülmektedir. Özellikle 40 mg/l üzerindeki değerler fatal seyretmektedir. Bizim olgumuzda serum karbamazepin düzeyinin literatüre oranla çok yüksek seviyede olması oldukça önemlidir.

Anahtar Kelimeler: Karbamazepin, İntoksikasyon, Yüksek Doz

P-0752 Trauma Emergencies

Travmanın Savunma Hücrelerine Etkileri

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Amaç: Travmanın savunma hücrelerine etkilerini incelemek

Gereç-Yöntem: Şubat ve mart aylarında Okmeydanı Eğitim ve Araştırma Hastanesine başvuran motor kazası vakalarında lökosit nötrofil ve lenfosit oranları hastaların verileri toplanarak değerlendirildi. Kayıtlı 100 vakadan 29 vakanın verilerine net bir şekilde ulaşıldı. Bu veriler birbirine oranlanarak normal popülasyondaki insanların verileriyle karşılaştırıldı.

Bulgular: Mekanik travmalar (kesici ve delici cisimler, vurma, çarpma gibi darbeler vs.) sıcak ve soğuk etkiler, elektrik, ultraviyole ışınlar, iyonizasyon yapan ışınlar, çeşitli yabancı cisimler ile savunma reaksiyonları klasik olarak oluşur. Organizmaya yabancı bir durum gelişmiştir ve şekillenen savunma adeta standart bir cevaptır. vakaların verileri ayrı bir dosya şeklinde sunulacaktır.

Sonuç: Vücutta wbc'neu oranı normal aralığı 1.33 ila 1.60 arasında beklenir. Neu'lym oranı 1.66 ila 2.14 arasında beklenir. Bizim yaptığımız çalışmada wbc'neu oranı 1.50 tespit edilmiş ancak neu'lym oranında belirgin bir artış tespit edilerek 4.27 saptanmıştır. Motor kazası travmaları nötrofil hakimiyetinde belirgin artışa yol açmıştır.

Anahtar Kelimeler: lenfosit, lökosit, nötrofil

P-0753 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Elektrik Yanığı ile Oluşan Cilt Defekti

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Amaç: Elektrik çarpmaları diğer kazalarla oranla seyrek görülmekle birlikte yüksek mortalite ve morbi-diteye yol açabilirler. Özellikle yüksek voltajlı elektrik akımı aritmiye ya da solunum kası paralizisine yol açarak ani ölüme neden olabileceği gibi, ağır yaralar ve çoklu sistem etilenimi sonucu morbi-diteye ve uzun dönemde sekillere yol açar. (1) Bebekler ve küçük çocuklar genellikle ev içi ortamda elek-trik kablolarından kaçak, bu kabloların ısınması ve duvar prizlerine iletken cisim sokulması sonucunda düşük voltajlı elektrik akımına maruz kalırlar. Daha büyük çocuklar ve ergenlerse dış ortamda ağaçla-ra ve elektrik direklerine tırmanma sırasında ya da iş ortamında sanayi makineleriyle temas sırasında yüksek voltajlı elektrik akımına maruz kalırlar. (2) Bu tür yaralanmaların fiziksel ve psikolojik sekellerinin tedavisi için uzun dönemli rehabilitasyon ve tekrar-layan operasyonlar gerekmektedir. (3)

Olgu: 32 yaşında erkek hasta 112 tarafından elektrik çarpması nedeni ile acil servise getirildi. Hasta inşaatta çalışırken elindeki metal cismin yüksek voltajlı elektrik tellerine değmesi sonucu yandığını belirtti. Özgeçmişinde ve soyegeçmişinde özellik yoktu. Fizik muayenede TA:130/80, Nabız 106, Ateş 38,5, pulse oksimetre 97 idi. Genel durumu kötü, bilinç açık, koopere ve oryante idi. Hastanın sağ el bileği volar bölgenin yaklaşık 5 cm üzerinden başlayıp sağ aksiller bölgeye de içine alan 2. ve 3. derece yanık alanı (% 5), sağ üst kadranda yaklaşık 30 x 25 cm 2. derece yanık alanı (% 7), sol kask anterior bölgesinden sol ayak bileğine kadar uzanan 2. Ve 3. Derece yanık alanı (%15) olmak üzere toplam % 27 yanık alanı mevcut idi. (Şekil 1,2,3,4) Sağ el parmak pulpasında elektrik girişi yanığı ve ayaklarında elektrik çıkışı yeri mevcuttu. İlk çekilen EKG'sinde aritmi saptanmadı. Laboratuvar tetkiklerinde AST: 56 (5-34 U/L), LDH 836 (125-243 U/L), CK-320 (29-168 U/L), CKMB 116 ng/mL, miyogloblin 759 ng/mL olarak ölçüldü Troponin ve diğer parametreler normal idi. Hasta tetkik ve tedavi amaçlı Plastik Cerrahi kliniğine yatırıldı. Hasta ilk 24 saat monitörize edildi. Günlük elektrolit ve myoglobin değerleri takibi yapıldı. Saatlik idrar çıkışı 100 cc üzerinde tutuldu. Hastaya 3. Günden itibaren debridmanları yapıldı. Hastanın ekstremitte bölgelerinde kompartman sendromu gelişmemesi sonucu 7. Günde cilt greftleri ile defektleri kapatıldı.

Sonuç: Yanık akut ve kronik dönemde ciddi fiziksel ve psikolojik sekillere neden olan bir durumdur. Her ne kadar son zamanlarda gelişen tek-noloji sayesinde yanık tedavisinde ilerlemeler



POSTER PRESENTATIONS

kay-dedilmiş olsa bile, yanığın oluşumunu engellemek; hem daha kolay hem de daha az maddi ve manevi kayba neden olan bir durumdur.

Anahtar Kelimeler: Elektrik yanığı, el, greft

P-0754 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Diyabetik Ayak Yaralarının Takibi

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Amaç: Diyabetik ayak yaraları diyabetin sık görülen ve ciddi bir kronik komplikasyonudur. Diyabetik hastaların hayatları boyunca %12-15 oranında ayak ülseri gelişme riski vardır (1). Diyabetik ayak ülserleri morbidite artışına, hayat kalitesinin bozulmasına, yüksek tedavi maliyetlerine ve yüksek oranda alt ekstremité amputasyonlarına neden olurlar. Non-travmatik ayak amputasyonlarının %40-60'ı diyabetiklere yapılmaktadır (2). Diyabetik ayak ülserlerinin uygun şekilde değerlendirilmesi ile enfeksiyona bağlı morbidite, hastaneye yatış, hastanede kalış süresi ve major ekstremité amputasyonu oranları azaltılabilmektedir. (3)

Olgu: 52 yaşında erkek hasta sol ayakta akıntılı yara nedeni ile acil servise geldi. Hasta 10 gündür ayağında akıntının olduğunu ve yara koku olduğunu belirtti. Özgeçmişinde 10 yıldır diyabetes mellitus olduğu ve 1 yıl önce 5. parmağının ampute edildiği belirtildi. Fizik muayenede TA:130/80, Nabız 106, Ateş 38,5, pulse oksimetre 97 idi. Genel durumu iyi, bilinç açık, koopere ve oryante idi. Hastanın sol ayak metatars orta hat dorsalinden MP seviyesine kadar nekroze ve akıntılı yarasının olduğu, kemik ve tendonlarının ekspoze olduğu ve yaklaşık 6x4 cm doku defektinin olduğu görüldü. (Şekil 1) Laboratuvar tetkiklerinde lökosit:16.200 mm3, glukoz 220, sedimantasyon 40mm/saat, CRP 55,3 idi. Diğer laboratuvar bulguları normal idi. Doppler USG de sol ayakta monofazik akımının olduğu tespit edildi. Yara kültürü alındı, profilaktik antibiyoterapi başlandı. Hasta tetkik ve tedavi amaçlı Plastik Cerrahi kliniğine yatırıldı. Hastanın acil debridmanları yapıldı. (Şekil 2) Hastanın defekt alanı VAC tedavisi ile küçültüldü. Yara yeri 7. Günde deri greftleri ile kapatıldı. (Şekil 3)

Sonuç: Diyabet, birtakım sorun ve sorumlulukları beraberinde getiren ve yaşam boyu süren bir hastalıktır. Diyabetli kişilerin yaklaşık %50'si tüm yaşamları boyunca diyabetik ayak gelişme riski altındadır. Uygun tedavi yaklaşımı ile hastalara amputasyon uygulanmadan yaşam kaliteleri artırılabilir.

Anahtar Kelimeler: Diyabetik Ayak, acil, greft

P-0755 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Nadir Bir Rekonstrüktif Cerrahi Vakası

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Amaç: Hidradenitis suppurativa tekrarlayan apseler, sinuslar ve skarlar ile karakterize apokrin glandların kronik inflamatuvar bir hastalıdır. (1) Hastalık sıklıkla aksilla, kasıklar, perineal ve perianal bölgeleri tutar. Etiyolojisi tam olarak açıklanamamasına rağmen, primer patolojinin foliküler okluzyon olduğu düşünülmektedir. (2) Medikal tedavi, hafif ve orta dereceli hastalık için tercih edilirken daha şiddetli hastalık için cerrahi tedaviler seçilir. Medikal tedavi seçenekleri arasında sistemik ve topikal antibiyotikler, intralezyonel steroid enjeksiyonu, sistemik retinoidler ve hormonal tedavi yer almaktadır. Cerrahi tedavide ise drenajdan radikal eksizyon ve rekonstrüksiyona kadar değişen bir yelpazede tedavi seçeneği vardır. (3)

Olgu: 52 yaşında erkek hasta acil servise koltuk altında akıntı şikayeti ile geldi. Hasta şikayetinin 1 yıldır aralıklarla tekrar ettiğini ve birkaç gün önce yeniden şişlik ve akıntı olduğunu belirtti. (Şekil 1,2) Özgeçmişinde ve soygeçmişinde özellik yoktu. Fizik muayenesinde TA:130/80, Nabız 86, Ateş 38,5 idi. Genel durumu iyi, bilinç açık, koopere ve oryante idi. Hastanın sol aksilla bölgesinde 8x6 cm alanda multipl fistül ağızlarının olduğu pürülan akıntı mevcut idi. Diğer sistem muayenelerinde özellik yoktu. Laboratuvar da lökosit:15.200 mm3, sedimantasyon 30mm/saat, CRP 45,3 idi. Diğer laboratuvar bulguları normal idi. Hastanın akıntılı yara alanından kültür alındı. Dermatoloji ve Enfeksiyon Hastalıkları konsültasyonu istendi. Tekrarlayan akıntılı yara nedeni ile Enfeksiyon Hastalıkları kliniğinde tedavisi yapıldı. Yara yerinde akıntısı azalan, sedimantasyon ve CRP değerleri gerileyen hasta rekonstrüksiyon amaçlı Plastik Cerrahi Kliniğine devir alındı. Hastanın multipl fistül ağızları eksize edildi ve oluşan defekt fasyokutanöz flep ile kapatıldı. (Şekil 3)

Sonuç: Hidradenitis suppurativa vakalarında hastalar genellikle medikal olarak tedavi edilir ve nüks oranları yüksektir. Bu olguda nadir olarak yapılan rekonstrüksiyon amaçlı cerrahi uygulanmıştır. Böylelikle nüks oranı azaltılmıştır.

Anahtar Kelimeler: Hidradenitis suppurativa, fistül, fasyokutanöz flep

P-0756 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Safra kesesinde multipl kolesterol polipleri ve kolesterolozis olgu sunumu

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Amaç: Kolesterolozis safra kesesinde epitelial makrofajlar içerisinde kolesterol esterlerinin birikmesi ve mukozal villöz hiperplazi ile karakterize lezyondur. Lamina propriada belirgin makrofaj birikimi ile oluşan kolesterol polipleri kolesterolozin bir başka formudur. Kolesterolozis sıklıkla klinik bulgu vermez ve kolelistektomi sırasında tesadüfen farkedilir. Kolesterolozis ve kolesterol polipleri ile birlikte safra kesesinde genellikle inflamasyon bulgusu yoktur. Burada kronik kolelistit ön tanısı ile patoloji laboratuvarına gönderilen safra kesesi örneğinde kolesterozis ve yaygın kolesterol poliplerini içeren olguyu sunduk.

Olgu: 64 yaşında kadın hasta zaman zaman görülen belirgin sağ üst kadranda ağrısı şikayeti ile Acil Servise başvurdu. Hasta yapılan fizik muayene ve laboratuvar tetkiklerinin ardından genel cerrahi konsültasyonu yapıp genel cerrahiye devir yapıldı. Kronik kolelistit ön tanısı ile opere edildi. Patoloji laboratuvarına gönderilen kolelistektomi materyali, açılmış halde 8x6 cm ölçülerinde 0.3 cm duvar kalınlığına sahipti. Safra içeriği yoğun, koyu renkli idi. Makroskopik olarak, safra kesesinin mukozal yüzünde belirgin sarı çizgilenmeler görüldü. Mukozada aynı zamanda lümenine doğru protrüde olmuş en büyüğü 0.3 cm çapında çok sayıda kolesterol polibi dikkate çekti. Safra kesesinden alınan doku örneklerinde Eozin ile boyalı kesitler hazırlandı. Kesitlerde Lamina propriada çoğu lümenine doğru protrüde olarak polip halini almış, köpüksü makrofajlar izlendi. Yine kesitlerde lamina propriada inflamasyon bulguları, epitelde intestinal metaplazi görüldü. Olgu yaygın kolesterol polipleri, kolesterolozis, kronik kolelistit, epitelde intestinal metaplazi olarak rapor edildi.

Sonuç: Kolesterolozis ve kolesterolo polipleri klinik olarak bulgu vermeyen lezyonlardır. Çoğu zaman ultrasonografik olarak da farkedilmeyebilir ve ameliyat sırasında tesadüfen tespit edilebilir. Kolesterol polipleri tüm safra kesesi poliplerinin %95'ini oluştururlar. Diğer poliplerde olduğu gibi 10mm çapı geçtiklerinde karsinom gelişim riski nedeni ile profilaktik kolelistektomi önerilir. Kolesterolozis ve kolesterol polipleri nadiren kolelistit bulgusu gösterir. Kolesteroloziste görülen inflamasyonun lipit depositlerinin rezorpsiyonu sonucu oluştuğu düşünülmektedir.

Anahtar Kelimeler: Kolesterolozis, kolesterol polibi, safra kesesi

P-0757 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Olgu Sunumu: Devasal Kalsifiye Kist Hidatik

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Giriş: Kist hidatik Türkiye'de endemik olup, Echinococcus granulosus tarafından oluşturulan paraziter bir hastalıktır. En sık karaciğer, daha sonra akciğerler ve beyine yerleşir. Köpek başta olmak üzere tilki kurt gibi etçil hayvanların fekal yolla attığı yumurtalarla insanlara bulaşır. Biz burada ayakta direkt batin grafisindeki (ADBG) görüntüden şüphelenerek tanı koyduğumuz bir kist hidatik olgusunu sunmayı amaçladık.

Olgu: 78 yaşında erkek hasta 1 aydır olan karın ağrısı sebebiyle acil servise başvurdu. Hastanın özgeçmişinde 2 yıl önce geçirilmiş testis torsiyonu dışında herhangi bir hastalık ve ilaç kullanım öyküsü yoktu. Vital bulguları stabil idi. Batin muayenesinde sağ üst kadranda hassasiyeti olan hastanın murphy bulgusu pozitif idi. Defans ve rebound yoktu. Diğer sistem muayeneleri normaldi. Hastanın laboratuvar tetkiklerinde her hangi bir anormallik yoktu. ADBG'de batin sağ üst kadranda yaklaşık 10-12 cm çapında yuvarlak dış çeperi tamamen kalsifiye olmuş kitle görüntüsü mevcuttu. Bunun üzerine yapılan ultrasonografide, karaciğer sağ lob subdiaphragmatik alanda yaklaşık 10 cm çapında periferi yoğun bir şekilde kalsifiye olmuş kist hidatik izlenmiştir. Hasta genel cerrahi ile konsülte edilerek hastaneye yatırılmıştır. Genel cerrahi kliniği medikal tedavi ve poliklinik takibi önerdi.

Sonuç: Kist hidatik özellikle gelişmekte olan ülkelerde ve özellikle kırsal kesimlerde yaşayan insanlarda hala sık görülen bir sağlık problemidir ve her zaman aklımızın bir köşesinde bulunmalıdır. Bununla birlikte yıllar geçmesine rağmen ADBG'nin karın ağrısı olan hastaların tanısında faydası yadsınmaz bir gerçektir.

Anahtar Kelimeler: Kist Hidatik, Kalsifikasyon, ADBG



POSTER BİLDİRİLER

P-0758 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Penetran batın travmalı çocuk olgu

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Tayma, çocuklarda önemli morbidite ve mortalite nedenidir. Çocuklarda görülen travmaların % 80-90'ı künt ve % 10-20 "si penetran travmalar oluşturmaktadır. Ancak penetran travmalar, künt travmalara göre daha sık ölüme neden olabilmektedir. Çocuklarda karın duvar kalınlığı yetişkinlere göre daha ince olduğunda batın iç organların daha fazla ciddi yaralanma olasılığı vardır. Bu yüzden penetran travmalar, yetişkinlere göre daha ender olmasına rağmen, daha ciddi mortalite ve morbiditeye neden olabilmektedir.

Olgumuz 6 yaşında erkek hasta yakınları tarafından acil servisimize getirildi. 2 metre yükseklikteki bir ağaçtan düştüğü iddia edilen hastanın batın sağ alt kadranda 3-4 cm lik kesi ve kesi içerisinde bağırsak eversionu mevcut idi. Olgumuzda; acil serviste penetre batın travmalı hasta yönetimi üzerinde durduk.

Anahtar Kelimeler: penetre batın travması, acil servis, barsak eversionu

P-0759 Toxicology

Nadir Bir Zehirlenme Olgusu: Cinacalcetin Zehirlenmesi

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Cinacalcetin bir calcimimetik ajandır. Extracellüler kalsiyum-sensing reseptörlerinin duyarlılığını artırarak paratiroid hormon seviyelerini azaltan kalsiyum reseptör agonistidir. Genellikle, dializ gerektiren son-dönem böbrek yetmezliği ve paratiroid kansinomu sonrasında gelişen sekonder hiperparatiroidizm sonrasında meydana gelen hiperkalsemiye kullanılır. Cinacalcetin 2010 yılından beri ülkemizde kullanılmaktadır.

Olgumuz, 19 yaşında erkek hasta yakınları tarafından suidit amaçlı ilaç alımı nedeniyle hastaneye getiriliyor. 90 mg/lık cinacalcetinden 8 adet almış.

Cinacalcetin toksisitesi ile ilgili olarak literatürde çok az yayın bulunmaktadır. Ülkemizde ise Cinacalcetin toksisitesi ile ilgili olarak literatürde yayınlanmış olgu veya makale yoktur. Bu olgu için Sağlık Bakanlığı 114 Ulusal Zehir Danışma Merkezi arandığında veri tabanlarında böyle bir ilacın olmadığı belirtilmiştir. Bu olgu sunumunda cinacalcetin toksisitesi üzerinde durmayı değerli bulduk.

Anahtar Kelimeler: cinacalcetin zehirlenmesi, acil servis, Ca reseptör agonisti

P-0760 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Psödotümör Serebri Hastasında Endoskopik Endonazal Optik Sinir Dekompresyonu: Olgu Sunumu ve Literatürün Gözden Geçirilmesi

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Amaç: Psödotümör serebri (PTS), diğer adları ile benign intrakraniyal hipertansiyon veya idiyoptik intrakraniyal hipertansiyon, intrakraniyal yer kaplayan lezyon olmaksızın intrakraniyal basınç (IKB) artışı ve buna bağlı gelişen semptomlarla karakterize klinik bir antitedir. Semptomlar artmış KİB 'a ve pupil ödemeine bağlı olarak baş ağrısı, bulantı, kusma, görme kaybı ve nadiren diplopidir. Bazen medikal tedaviye yanıt alınmayan veya semptomların progresyon gösterdiği hastalarda cerrahi tedavi gerekmektedir. Görme kaybının ön planda olduğu psödotümör serebri hastalarında optik sinir dekompresyonu etkinliği bilinen ve önerilen bir tedavi yöntemi değildir. Endoskopik kafa tabanı yaklaşımlarında tecrübenin artması ile bu yaklaşım birçok hastalıkta alternatif ve etkili bir tedavi yöntemi olarak kullanılmaya başlamıştır. Biz de bu çalışmamızda, medikal tedaviye rağmen şikayetleri düzelmeyen ve hatta görme kaybı artışı gösteren psödotümör serebri tanımlı bir hastada yeni bir yöntem olan endoskopik endonazal optik sinir dekompresyonu sonucumuzu sunmayı ve bu tedavi ile ilgili literatürü gözden geçirmeyi amaçladık.

Olgu: 31 yaşında kadın hasta 8 aydır özellikle sol gözündeki görme kaybı ve ara sıra olan baş ağrısı şikayeti ile PTS tanısı alıp kortikosteroid, diuretik ve karbonik acetazolamide tedavisi başlanmış. Mevcut şikayetlerinde düzelmeye olmayan hasta görme kaybı şikayetiyle acil servise başvurdu. Hastanın yapılan incelemelerinde funduskopide bilateral masif pupil ödemi ve görme keskinliğinde sağ göz 7/10, sol göz 2/10 olarak saptandı. Görme alanında özellikle sol gözde her iki üst kadrantlarda belirgin alan defekti saptandı (figure 1). MRI incelemesinde lezyonu olmayan ve ventrikülleri küçük olan hastaya LP yapıldı ve CSF basıncı 400 mmH2O olarak ölçüldü. CSF incelemesi normal olan hastaya endoskopik endonazal optik sinir dekompresyonu planlanarak hasta opere edildi. Endoskopik endonazal bilateral optik sinir kılıfı dekompresyonu tek taraflı sağ nazal nostril girişimi ile yapıldı. Operasyon için 4 mm 0 derece endoskop (Hopkins; Karl Storz Endoscope, Germany) kullanıldı.

Sonuç: Postoperatif serviste takip edilen hastada hiçbir komplikasyon olmadı ve yapılan muayenesinde görme keskinliği ve görme alanı preoperatif dönemle aynı olarak saptandı (figure 4). Baş ağrısı ve funduskopik olarak pupil ödemi bir miktar azalan hasta 4. günde taburcu edildi. 1. ay kontrolünde baş ağrısı şikayeti bariz olarak azalan hastanın görme muayenesinde belirgin bir değişiklik yoktu. 6. ay kontrolünde ise hastanın ara ara baş ağrısı şikayeti olmakta, funduskopik muayenede pupil ödemi belirgin ölçüde gerilemiş, görme keskinliğinde sağ göz 7/10, sol göz 4/10 olup görme alanında sol gözde belirgin düzelmeye saptandı (figure 5). Hastanın 12 aylık takiplerinde ise durumu stabil olarak devam etmektedir.

Anahtar Kelimeler: Psödotümör serebri (PTS), Benign İntrakraniyal Hipertansiyon, Endoskopik Endonazal Optik Sinir Dekompresyonu

P-0761 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Supraskapulir Sinir Bloğu ile Omuz Çıkığı Redüksiyonu

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Amaç: Omuz eklem çıkığı redüksiyonu işlemi ağırlı bir prosedürdür. Bu işlem esnasında ağrı kontrolü için supraskapulir sinir bloğu ultrason yardımı ile kolaylıkla uygulanabilir. Bu çalışmada acil serviste supraskapulir sinir buloğu ile redükt edilen bir omuz çıkığı olgusunun paylaşılması amaçlanmıştır.

Olgu: Yaşlı bir hasta düşme sonrası sağ omuzda ağrı ve fonksiyon kısıtlılığı ile acil servise müraacaat etti. Sağ ön kol ve elin duyu hareket ve periferik arter muayenesi normaldi. Radyolojik görüntülemde sağ omuzun çıkık olduğu tespit edildi. Hipertansiyon ve KOAH tanısı olan hastanın Tansiyon arteriyel: 180/110 mmHg ve SpO2: 86 (Oda Havasında) ölçüldü. Diğer vital bulguları normal olarak değerlendirildi. Sistemik hastalıkları nedeniyle prosedural sedasyon yerine omuz ekleminin çoğunluğunu innerve eden supraskapulir blok uygulamasına karar verildi. Ultrason yardımı ile supraskapulir sinir tespit edildi. Sinir etrafına 5 ml % 2 prilokain enjekte edildi. 5 dakika beklendi omuz bölgesinin duyusunun azaldığı teyit edilince omuz redüksiyon işlemi modifiye koher yöntemi ile gerçekleştirildi. Bandaja alınan hasta kontrol için ortopedi polikliniğine yönlendirildi.

Sonuç: Supraskapulir sinir bloğu ile yapılan omuz çıkığı redüksiyon işleminde yan etki görülmedi. Hastaya sedasyon analjezi uygulanmadığı için acil servisten daha erken taburcu edildi. Acilde serviste USG eşliğinde supraskapulir sinir bloğu omuz çıkığı redüksiyonlarında sedasyon analjeziye alternatif olabilir.

Anahtar Kelimeler: Supraskapulir sinir bloğu, ultrason, omuz çıkığı

P-0762 Toxicology

Yılan ısırması sonrası gelişen nadir bir komplikasyon: hidrosel

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Amaç: Tüm dünyada yaklaşık 2500 yılan türünden sadece %8'i insanlar için tehlike oluşturabilecek kadar zehirlidir. Yılan zehirlenmeleri ciddi mortalite ve morbidite nedenlerinden olup toksinin şiddetine göre lokal ve sistemik belirtilerle karşımıza çıkabilir.

Olgu: 38 yaşında erkek hasta acil serviste testislerinde şişlik ve morarma, sağ koltuk altında ağrı şikayetiyle başvurdu. Anamnezinde hastanın iki gün önce yılan tarafından göğsünün sağ tarafından ısırıldığı ve olayın ardından başvurduğu dış merkezde kendisine semptomatik tedavi uygulandığı öğrenildi. Hastadan edinilen bilgilere göre yılanın cinsinin yöresel isminin bozyörük (Dolichopis caspius, Coluber caspius, Hazer Yılanı, Caspian Large White) olduğu öğrenildi. Hastanın daha önce de birkaç kez aynı tür yılan tarafından ısırıldığı ve bu sırada yapılan yılan antiserumuna alerjisinin geliştiği öğrenildi. Muayenede; göğüs sağ taraf orta aksiler hatta yılan ısırığının olduğu bölgede 5 cm çapında ekimoz, çevresinde ödem ve hiperemi, ürogenital sistem muayenesinde sağ skrotal bölgede morluk ve şişlik tespit edildi, testiste ağrı ve hassasiyet yoktu. Hastanın skrotal ultrasonografik görüntülemesinde sağ testiste seminifer tübüllerde belirginleşme, skrotum duvar kalınlığında artma ve sağda hidrosel tespit edilmiştir. Patofizyolojisi tam olarak bilinmeyen hidroselin bizim vakamızda yılan ısırmasına bağlı olabileceği düşünüldü. Hastaya üroloji bölümünün önerisi ile nonsteroid antienflamatuvar tedavi düzenlenip üroloji polikliniği önerilerek taburcu edildi.

Sonuç: Toksinin şiddetine göre hastalarda lokal ve sistemik belirtiler ortaya çıkabilir. Lokal olarak ödem, hematoma ve gangrenöz lezyonlar, sistemik olarak ise ateş, bulantı, kusma, dolaşım



POSTER PRESENTATIONS

kollapsı, sarılık, delirium, konvulziyon, koma gibi bulgular ortaya çıkabilir. Bizim vakamızda da olduğu gibi bazı lokal bulgular ısırılan bölgeden uzakta oluşabilir. Bundan dolayı tüm hayvan ısırıklarında özellikle de yılan ısırıklarında fizik muayenede ısırılan bölgenin yanısıra tüm sistemlerin muayanesi hem uzak lokal bulguları hem de sistemik bulguları tespit etmede önemlidir.

Anahtar Kelimeler: Acil, fizik muayene, yılan toksini

P-0763 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acil Serviste Karın Ağrısının Nadir Bir Nedeni: Dev Karaciğer Kist Hidatiki

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Amaç: Kist hidatik, Echinococcus granulosus tarafından oluşturulan paraziter bir hastalık olup Türkiye'nin Doğu ve Güneydoğu illerinde endemik olarak görülmektedir. En sık karaciğer yerleşimlidir. Karın ağrısı acil servise başvuru nedenleri arasında önemli bir yere sahiptir. Özellikle endemik bölgelerde karın ağrısı ve dispeptik yakınmalarla acil servise başvuran hastalarda ayırıcı tanıda batin içi organ yerleşimli kist hidatik tanısı düşünülmelidir. Biz bu yazımız ile karın ağrısı şikayeti ile acil servise başvuran başvuran ve dev karaciğer kist hidatiki saptanan bir olguyu sunduk.

Olgu: Acil servise 42 yaşında bayan hasta karın ağrısı şikayeti ile başvurdu. Hastanın öyküsünde uzun zamandır olan dispeptik yakınmalarda giderek artış, son iki gündür olan karında şiddetli ağrı, bulantı ve kusma mevcuttu. Fizik muayenede tansiyon arterial: 130/85 mmHg, nabız: 98 atım / dk, ateş: 37 derece idi. Batında sağ üst kadranda hassasiyet, defans ve murphy bulgusu pozitif saptandı. Yapılan kan tetkiklerinde WBC:13000 olması dışında ek patoloji saptanmadı. Çekilen EKG' de akut iskemik yok ve normal sinüs ritmi saptandı. Batin bilgisayarlı tomografisinde karaciğerde dev kist hidatik ile uyumlu görünüm mevcut olup safra kesesi normal sınırlarda ve batin içi diğer organlara yönelik patoloji izlenmedi. Hasta genel cerrahi servisine karaciğer kist hidatiki tanısı ile yatırıldı.

Sonuç: Literatürde kist hidatik olgularının en sık başvuru şikayeti karın ağrısı ve dispeptik yakınmalar olarak bildirilmektedir. Bizim olgumuzda da literatür ile uyumlu olarak karın ağrısı, bulantı ve kusma şikayeti mevcuttu. Akut batin açısından yaptığımız tetkiklerde saptanan abdominal kist hidatik yine literatür ile uyumlu olarak en sık yerleştiği organ olan karaciğerde saptanmıştır. Sonuç olarak, geçim kaynaklarının başında tarım ve hayvancılığın olduğu kist hidatik açısından endemik bölge olan ilimiz gibi yerlerde karın ağrısı ve dispeptik şikayetlerle acil servise başvuran olguların tanısında kist hidatik akılda tutulmalıdır.

Anahtar Kelimeler: Kist hidatik, karın ağrısı, acil

P-0764 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Klavikula Cerrahisinde Kullanılan Kirschner Telinin Üzun Sürede Yaptığı Hemopnomotoraks Olgu Sunumu;

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Amaç: Klavikula üst ekstremitte fonksiyonlarında önemli bir role sahiptir. Bundan dolayı klavikula kırıklarının tedavisine gerekli önemi vermek gerekir. Çoğunlukla bu kırıkların konservatif yöntemlerle tedavi edilmesine rağmen cerrahi gerektiren kırıklarda vardır. Klavikula kırıkları çok görülmesine karşın kaynama sorunu çok azdır. Klavikula da psödoartroz oranı %0,1-0,5 arasında değişmektedir. Bundan dolayı klavikula kırıklarının tedavisinde cerrahi sonrası ortaya çıkan komplikasyonlar cerrahi tedaviden kaçınılması sonucunu ortaya çıkarmaktadır

Olgu sunumu: Yaklaşık 6 ay önce travma sonrası sağ klavikula kırığı olmuş. Olguya dış merkezde operasyonla Kirschner teli uygulanmış. Ancak post-operatif yaklaşık 6 ay sonra omuzun da ki ağrı şikayetlerinde artış, sağ klavikula bölgesinde şekil bozukluğu ve genel durumun bozulması üzerine hastanemizin acil servisine başvurdu. Fizik muayenede sağ omuz şekil bozukluğu ve sağ hemitoraksta akciğer sesleri alınmıyordu. Ayrıca perküsyonla üst ve orta zonlarda timpanik ses, alt zonda ise matite alınıyordu. Solunum sıkıntısı ve göğüs ağrısı şikâyeti olan olguya direkt akciğer grafiği çekildi. Çekilen akciğer grafiğinde sağ klavikula ya uygulanan kirschner telinin distal ucu klavikuladan ayrıldığı ve sağ hemitoraksta hava-sıvı seviyesi veren hidro-pnö-motoraksı mevcuttu. Olgunun laboratuvarında üre:116, kreatin:1.78, açlık kan şekeri: 85, albümin:1.7, Hgb:11.3, Htc:35, CRP:3, arteriyel kan basıncı: 80/50, arteriyel kan gazında PH:7.22, PO2:91 PCO2: 28 idi. Olguya orta aksiler hat altıncı interkostal aralıktan torasentez yapıldı. Hemorajik vasıfta mayı alındı. Aynı tarafa 32 F tüp torakostomi uygulandı. Yaklaşık 2000 cc kadar birikmiş hemorajik vasıfta mayı boşaltıldı. Olguya için ortopedi ve nefroloji kliniklerinden görüşü istendi. Ortopedi kliniğince Kirschner teli çıkarıldı ve hastaya ek cerrahi tedavi yerine, konservatif yaklaşım önerdi. Nefroloji kliniği ise sıvı, elektrolit tedavi desteğini ve laboratuvar takibini önerdi. Ancak olgu göğüs cerrahi kliniğine transfer edildiğinde çekilen akciğer grafiğinde akut akciğer yaralanması (ALI: Akut Lung Injury) düşünüldü. Olguya gerekli tüm tetkik ve tedaviler çok hızlı yapıldı. Ancak yatışın ikinci gününde genel durumu daha da bozuldu ve olgu göğüs hastalıkları yoğun bakımına alınarak entübe edildi. Ancak yapılan tüm tedavilere rağmen hasta Akut akciğer yetmezlik sendromuna girdi. (ARDS: Akut Respiratory Distres Syndrome). Ancak yapılan takip ve tedaviye rağmen olgu ex oldu

Sonuç: Klavikula kırıklarının açık redüksiyonu ve internal tespit ile önemli ölçüde düzelme sağlanmasına rağmen ortopedistlerin büyük çoğunluğu bu kırıkların tedavisinde konservatif tedavi yaklaşımını daha çok benimsiyorlar. Ancak bu kırıkların tamamının konservatif tedavi ile uygun bir şekilde kaynaayacağı görüşü çok gerçekçi değildir. Yer değiştirme önceden öngörülemede-çeğinden hastalar rutin kontrollere çağırılmalı veya göğüs cerrahisinde kullanılan kot kipleri tercih edilmelidir.

Anahtar Kelimeler: Klavikula, Kirschner Teli, Hemopnomotoraks

P-0765 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acil Serviste Göğüs Ağrısının Nadir Bir Nedeni: Dev Akciğer Kist Hidatiki

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Amaç: Hidatik kist, Echinococcus granulosus tarafından oluşturulan paraziter bir hastalıktır. En sık karaciğer, daha sonra akciğerler ve beyine yerleşir. Hastaların büyük bir bölümü asemptomatik olmakla birlikte akciğer kist hidatikiğinde öksürük, göğüs ağrısı, dispne, balgam çıkarma, hemoptizi, allerjik deri reaksiyonları görülebilir. Bu yazımız ile göğüs ağrısı şikayeti ile acil servise başvuran hastada saptanan dev akciğer kist hidatikiğini sunmaya çalıştık.

Olgu: 22 yaşında erkek hasta acil servise göğüs ağrısı şikayeti ile başvurdu. Hastanın öyküsünde göğüs ağrısının uzun zamandır olmakla birlikte son 2 gündür arttığı öğrenildi. Fizik muayenede TA:110/70 mmHg, nabız: 78 atım/dakika ritmik, ateş:37.20 C olarak saptandı. Her iki akciğer solunuma eşit katılıyor; sağ akciğer bazalde solunum sesleri azalmıştı. Batında sağ üst kadranda hassasiyet saptandı. Elektrokardiyografisi normal sinüs ritmindeydi. Rutin kan tetkiklerinde acil patoloji saptanmadı. Akciğer grafisinde sağ akciğer alt lobda sınırları düzenli homojen dansite artışı ve sağ sinüs künt olarak saptandı. Toraks bilgisayarlı tomografisinde sağ akciğer alt lobda dev kist hidatik ile uyumlu kistik lezyon izlendi. Hasta göğüs cerrahisi servisine operasyon amacı ile interne edildi.

Sonuç: Göğüs ağrısı acil servise en sık başvuru nedenlerinden birisidir. Göğüs ağrısı ile başvuran hastalarda öncelikle yaşamı tehdit eden nedenlerin (akut koroner sendromlar,aort disseksiyonu, pulmoner emboli, pnömotoraks) dışlanması gerekmektedir. Bizim hastamızda da öykü, fizik muayene ve yapılan tetkikleri sonucunda hayatı tehdit eden nedenler saptanmamıştır. Bununla birlikte akciğerde dev kist hidatike rastlanmıştır.

Sonuç olarak özellikle rüptür riski olan ve santral sinir sistemi, akciğer gibi yaşamsal organ yerleşimli dev hidatik kistlerde tedavi geciktirilmemelidir. Bu tür yerleşimli kistlerde oluşabilecek olan rüptür (travmatik, spontan, iyatrojenik) ve benzeri komplikasyonlar hayati tehdit edici tablolara neden olabilir. Bu komplikasyonların engellenmesi için tanı ve tedavi konusunda mümkün olduğunca hızlı davranılmalıdır.

Anahtar Kelimeler: Kist hidatik, göğüs ağrısı, acil



POSTER BİLDİRİLER

P-0766 Trauma Emergencies

Basıncılı Gaz Tüpünün Yanlış Taşınmasına Bağlı Yanık Vakamız

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Amaç: Ülkemizde "tüp gaz" adıyla bilinen LPG; sıvılaştırılmış petrol gazı olup % 70 bütan, %30 propan dan oluşmaktadır. Olgumuzda mutfak tüplerini aracın içinde taşıırken, sigara içmek için çakmağını yakması sonucu aracının alev almasıyla kollarında, yüzünde ve boynunda yanık meydana gelen 45 yaşında erkek hasta sunulmuştur. Literatürdeki vakalardan farklı olarak tüp gazı araç içinde taşınması sonrası maddi hasarlı trafik kazası ve yanık oluşmuştur. Amacımız; basınçlı tüplerin yanlış taşınması sonucu oluşan yanık olgusundan elde ettiğimiz tecrübeyi paylaşmak ve bundan sonra yapılacak çalışmalara katkı sağlaması amaçlanmıştır.

Olgu: Olgumuzda 45 yaşındaki erkek hasta acil servisimize kollarında, boynunda ve yüzünde yanık ile başvurdu. İşyerinde mutfakta kullanılması için 3 adet mutfak tipi tüpgaz LPG tüpünü dizel ile çalışan minivan tip aracı ile taşımakta iken aniden bir alev alma olduğunu söyledi. Seyir halinde iken sigara içmek için aracının çakmağını çalıştırdığı anda çıkan yangın sırasında kollarında, yüzünde, saçlarında, sakalında yanıklar meydana geldiğini söyledi. Hastanın yapılan fizik muayenesinde; yüzünde ve boynunda %5 ikinci derece, sol üst ekstremitede %3, sağ üst ekstremitede %2 ikinci derece yanık olmak üzere toplamda % 10 ikinci derece yanığı bulunmaktaydı. Aynı zamanda hastanın saçları ve sakalı yüzeyel olarak yanmıştı. Hastamızda herhangi bir solunum sıkıntısı bulunmamaktaydı. Hastadan alınan örneklerde hemoglobin 14.7 gr/dl, beyaz küre 8830 uL, trombosit 247000 uL olarak ölçüldü. Karaciğer ve böbrek fonksiyonları normal sınırlarda ölçüldü. Hastanın kan gazı örneklemesinde pH: 7.48 olup oksijen saturasyonu % 94, pO2 67,8 mmHg ve pCO2 28.1mmHg olarak ölçülmüştür. Takiplerinde solunum problemi olmadı. Hastamızın ilk müdahalesi acil servisimizde yapıldı. Yüzeyel pansuman, sıvı tedavisi ve analjezik verildi. Hastanın yanık ünitesine yatırıldı. Hasta servisteki takiplerinden sonraki 5. gününde taburcu edilmiştir.

Sonuç: Tüp gaz dolum tesislerinde kontrol altında ve garantili olarak doldurulan mutfak tüplerinin çok iyi denetiminin iyi yapılması gerekmektedir. Kaçak tüpler kesinlikle kullanılmamalıdır. Oluş mekanizması nedeniyle koruyucu önlemlerle engellenebilir bir vaka olduğu için bu vakayı sunduk. Ayrıca benzer vakalar genellikle LPG li araçların patlaması ile ilgili hazırlanmışken; bizim vakamız araç içinde Basıncılı LPG tüpünün taşınması sonucu meydana gelmiştir. Oluş mekanizması nedeniyle vakamız farklıdır. Basıncılı tüpe bağlı kazalar yoğun trafikte hasarlı ve ölümlü kazalara neden olabilir. Sürücüler basın ve yayın yoluyla bu tür kazalar konusunda uyarılmalıdır. Basıncılı tüpler kesinlikle araç içinde taşınmamalıdır. Taşıyanlarla ilgili her türlü caydırıcı ceza işlem uygulanmalıdır. Acil servislerde bu tür vakalarda ayrıca inhalasyon yanığı olup olmadığı araştırılmalıdır. Sıvı elektrolit tedavileri bu hastalarda önemlidir. Ayrıca hastaneye yatış gerekebilir. Hastalarda karbonmonoksit zehirlenmesine karşı dikkatli olunmalıdır. Kaza durumunda olay yerine giden ekipler devam eden patlamaların olabileceğini unutmamalıdır.

Anahtar Kelimeler: Basıncılı tüp gaz, araç içi yanık, araç güvenliği

P-0767 Toxicology

Deneyisel özofagus ve mide alkali koroziv yanıklarında hypericum perforatum'un (sarı kantaron) iyileştirici etkisinin araştırılması

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Amaç: Hypericum Perforatum'un deneyisel özofagus ve mide alkali koroziv yanık modelinde etkili olup olmadığının belirlenmesi ve yeni tedavi arayışlarına ışık tutması amaçlandı.

Gereç-Yöntem: Araştırmada 42 adet, 200-300 gram ağırlığında, Wistar Albino sıçanlar seçildi. Koroziv maddeler ve diğer ajanlar sıçan ağızından girilip servikal özofagus seviyesinde sonlandırılan bir infant feeding tüp ile verildi. Grup1'e (kontrol grubu) herhangi bir işlem veya tedavi uygulanmadı. Grup2'de (yanık grubu) sodyum hidroksit (%5 NaOH, 0.2 ml) ile hafif-orta derecede koroziv yanık oluşturulduktan ve serum fizyolojik ile irrigasyondan sonra herhangi bir tedavi metodu uygulanmadı. Grup3'te (kantaron grubu) koroziv yanık oluşturulduktan sonra Hypericum perforatum'un oral formülasyon formu 50 mg/kg/gün verildi. Grup4'e (plesabo grubu) koroziv yanık oluşturulduktan sonra aynı orana sahip dozda boş jel uygulandı. Deneyisel yanık modelinin olmadığı Grup5'te (normal doku etki grubu) Hypericum perforatum'un normal doku üzerine etkisini incelemek için oral formülasyon aynı oranda uygulandı. Deneyisel yanık modelinin olmadığı Grup6'da (normal doku plesabo grubu) ise boş jel formülasyonundan aynı dozda uygulandı. 14 gün süren (subakut dönem) bu işlemlerden sonra 15. gün diseksiyon uygulanarak alınan özofagus, mide ve karaciğer doku örneklerinden, histopatolojik ve biyokimyasal parametrelere (SOD, GPX, MDA, CAT) bakıldı. Uygulanan ilaç formülasyonunun fibroblastlar üzerine sitotoksitesisi için invitro koşullarda erişkin insan dermal fibroblast hücre hattı kullanıldı.

Bulgular: Ağırlık değerlerinin karşılaştırılmasında Grup 1, 3, 4 ve 6 da ağırlık artışı saptanırken, Grup2'de ağırlık kaybı saptandı. Grup5'te ise anlamlı bir fark saptanmadı. Ağırlık kaybı bulgusu olan muskularis mukoza hasarı açısından tüm grupların karşılaştırılmasında anlamlı bir fark saptanmadı. Özofagusun histopatolojik değerlendirilmesi sonucunda, inflamasyon bulgusu olan; submukozal kollajen birikimi, tunika muskularis hasarı ve kollajen birikimi açısından, kontrol grubu ve kantaron grubu arasında anlamlı bir fark saptanmadı. Mide dokusunun histopatolojik değerlendirilmesi sonucunda, mukozal hasarı gösteren; PMNL infiltrasyonu, mukozal ödem, gastrik bez dilatasyonu ve submukozal PMNL infiltrasyonu açısından kontrol grubu ve kantaron grubu arasında anlamlı fark saptanmadı. Özofagus hasarı ve etkilenme derecesini gösteren, stenoz indeksi ve epitel kalınlığı ile oksidatif stres parametrelerinin değerlendirilmesi sonucunda; gruplar arasında Süperoksit dismutaz (SOD) ve Glutasyon peroksidaz (GPX) değerleri açısından anlamlı fark saptanmadı. Kontrol grubu ve kantaron grubu arasında yapılan analizde; stenoz indeksi, epitel kalınlığı ve lipid peroksidasyonunu gösteren Malondialdehid (MDA) arasında anlamlı fark saptanmışken, Katalaz (CAT) değerleri arasında anlamlı fark saptanmadı. Yanık grubu ve kantaron grubu arasında yapılan analizde; Stenoz indeksi, epitel kalınlığı ve MDA arasında anlamlı fark saptanmasına karşın CAT değerleri arasında ise anlamlı fark saptanmadı. H. Perforatum formülasyonunun verildiği Grup 3 ve Grup5'te ise MDA düzeylerinde artış saptandı. Oral formülasyonun insan dermal fibroblastlarına uygulanması sonucunda sitotoksite gözlenmedi.

Sonuç: Yanık iyileşmesinde histopatolojik olarak, tedavi grubuyla yanık grubu arasında belirgin farklılıklar mevcutken, kontrol grubuyla tedavi grubunun benzer olduğu gözlemlendi. Lipid peroksidasyonunu gösteren MDA düzeylerine bakıldığında sayısal olarak belirgin bir fark olmamasına rağmen, oral formülasyonun uygulandığı grup 3 ve grup 5'te istatistiksel olarak anlamlı fark bulundu. Bu çalışmada, 14 günlük H. Perforatum tedavisinin hafif-orta dereceli ve subakut dönemdeki alkali koroziv yanıklarında etkili olduğu gösterilmiştir.

Anahtar Kelimeler: koroziv, alkali, yanık, hypericum perforatum, St. John's Wort

P-0768 Trauma Emergencies

Yüksekten Düşme Sonucu Gelişen Odontoid Fraktür ve İCA Diseksiyonu

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Amaç: Acil servislere yüksekten düşme nedeniyle pek çok travma vakası gelmektedir. Odontoid fraktür ve diseksiyon gibi vasküler yaralanmaların birlikteliği nadir görülmekle birlikte tanı konulamadığında ciddi morbidite ve mortalite ile sonuçlanabilmektedir. Burada yüksekten düşme sonucu başvuran ve gelişinde nörolojik muayenesi tamamen normal olan odontoid fraktür ve Internal Karotis Arter (ICA) diseksiyonu birlikteliği tespit edilen vakayı sunuyoruz.

Olgu: Otuz yedi yaşında kadın hasta 3. kattan düşme sonucu acil servisimize getirildi. Geliş vitalleri normal sınırlarda idi. Fizik muayenesinde C2-C3 hassasiyeti dışında anormal bir bulgu yoktu. Alınan hemogram ve biyokimya testlerinde herhangi bir patolojik bulgu tespit edilmedi. Servikal hassasiyeti olan hastaya çekilen servikal bilgisayarlı tomografide (BT) C2 düzeyinde densde anteriore deplase tip 3 fraktür ve yine C2 korpusundan sağ foramen düzeyine ulaşan fraktürü tespit edildi. İki saat sonraki kontrol fizik muayenesinde sağ elde uyuşma ve sağ üst ekstremitede 2/5 kuvvet kaybı gelişen hastaya kontrol kranial BT ve servikal BT anjiyografi çekildi; Kranial BT'de yeni bulgu görülmedi ancak sol ICA'da bifurkasyon düzeyinden intrakranial düzeye kadar olan segmentte damar kalibrasyonunda ileri derecede azalma ve yaklaşık 1 cm'lik alanda diseksiyon ile uyumlu olabilecek şüpheli görünüm izlendi. Servikal MR anjiyografi ile diseksiyon tanısı teyit edilen hasta yoğun bakım ünitesine yatırılarak gerekli konsültasyonlardan sonra antikoagülan tedavi başlandı. Hastanın takiplerinde durumunun stabil seyretmesi sonucu 7. günde servikal boyunluk ve antikoagülan tedavi düzenlenerek seksiz taburcu edildi.

Sonuç: Travma vakalarında odontoid fraktür ve ICA diseksiyonu gibi vasküler yaralanmalarda multidisipliner yaklaşım gerekmektedir. Bizim vakamızda olduğu gibi yüksek enerjili travmalarda tekrarlayan nörolojik muayene önemlidir. Özellikle ekstremitelerde güç veya his kaybı olan travma vakalarında orjin serebral olabileceği gibi vasküler yaralanmaya sekonder gelişebileceği de akılda tutulmalıdır. Özellikle bariz servikal travması olan tüm vakalarda nörolojik muayene normal olsa bile servikal vasküler görüntüleme yapılması gerektiğini düşünmekteyiz.

Anahtar Kelimeler: acil servis, karotis arter diseksiyonu, odontoid fraktür, yüksekten düşme



POSTER PRESENTATIONS

P-0769 Trauma Emergencies

Künt Travma Sonrası İzole Femoral Ven Yaralanması

Serdar Özdemir, Tuba Cimilli Öztürk, Oktay Öcal, Rohat Ak, Mazlum Kılıç, Yasin Metiner, Gökhan İşat, Özge Ecmel Onur

Fatih Sultan Mehmet Eğitim Araştırma Hastanesi, Acil Tıp Kliniği, İstanbul

Amaç: Erken tanı ve erken müdahale travmatik vasküler yaralanmalarda mortalite ve morbiditeyi azaltmakta büyük önem taşımaktadır. Teknolojinin hızlı gelişimi vasküler yaralanmalar için yeni tanı ve tedavi yaklaşımlarını beraberinde getirmektedir. Ateşli silah yaralanması müdahale gerektiren tüm vasküler yaralanmaların % 70-80'inin etiyolojisinde yer almaktadır. Kesici delici alet yaralanması vakalarının ise sadece % 5-10'u müdahale gerektirir. Künt travma ise vakalarının % 5-10'unu oluşturmaktadır. Bir kırık veya çıkık varlığı riskini artırır. Künt yaralanmalardan sonra vasküler hasar daha nadir olmasına rağmen komşu yapılara travma nedeniyle penetran yaralanmalardan daha şiddetli seyreder. Nihai bacak amputasyon riski yaralanma künt mekanizmaları ile daha yüksektir. Çevre kemik dokularda hasar olmadan izole femoral ven yaralanması tespit edilen olgu sunulmaktadır.

Olgu: 11 yaşında erkek hasta bisikletten düşme şikâyeti ile acil servise getirildi. Hastanın alınan anamnezinden bisiklet gidonunun sağ kasiğine çarptığı öğrenildi. TA 1150/63mmHg, nabız:104/dk, spO2:%99, solunum sayısı:17/dk ölçüldü. Hastanın muayenesinde bilinç açık, GKS 15 puanda idi. Batın serbest; toraks muayenesi olağandı. Sol inguinal alanda yaklaşık 10x8 cm şişlik ve şişlik üzerinde hassasiyet mevcuttu. Sol kalça hareketleri kısıtlıydı. Periferik nabızlar alınabiliyordu. Yatak başı yapılan E-FAST değerlendirmesinde pnömotoraks ve batın içi serbest mayi izlenmedi. Şişlik üzerine yapılan USG'de ise hematoma ile uyumlu bulgular saptandı. Hastaya çekilen batın BT'de; sol uyluk proksimalinde 86x56mm boyutunda heterojen yoğunlukta vasküler yapılardan net sınırlarla ayrılmayan cilt altına kadar uzanan hematoma izlendi. Hasta kalp damar cerrahi ile konsülte edildi. Acil olarak ameliyata alınan hastada femoral ven yaralanması ve femoral artere baskı yapan hematoma görüldü. Hematom boşaltılarak vasküler yaralanma onarıldı.

Sonuç: Periferik damar yaralanmaları genellikle çoklu organ yaralanmalarının eşlik ettiği travmatik yaralanmalardır. Hasta stabilize edildikten sonra, periferik damar yaralanmaları belirlenmeli ve mümkün olduğunca çabuk normal dolaşım sağlanmalıdır. Yaralanmanın klinik prezentasyonu kanama veya iskemik şeklinde olabilir. İskemi süresi sadece uzun işlevi ve canlılığı için değil; revaskülarizasyon sonrası komplikasyonlar açısından da kritik öneme sahiptir. Uzun kurtarmak için yapılan revaskülarizasyon yaşamı tehdit edici kompartman sendromu veya reperfüzyon sendromları ile sonuçlanabileceği sürekli akılda tutulmalıdır. Zamanında revaskülarizasyon bu nedenle periferik vasküler yaralanmalarda yönetimin temel ilkelerinden biri olmalıdır. Ekstremiteler kemik yapılarla fraktür veya dislokasyon olmayan vakalarda da vasküler yaralanma olasılığı her zaman akılda tutulmalı ve klinik şüphe halinde ileri tetkikler yapılmalıdır.

Anahtar Kelimeler: bisikletten düşme, femoral ven yaralanması, uzun kurtarma

P-0770 Trauma Emergencies

Frontal Sinüs Fraktürü

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Amaç: Frontal sinüsün anterior duvarı yüz bölgesinin diğer kemiklerine göre nispeten daha kalın bir kemik tarafından oluşturulduğu için travmalara iki kat daha dayanıklıdır. Bundan dolayı frontal sinüs kırıkları diğer yüz bölgesi kırıklarına göre daha az görülmektedir. Frontal sinüs kırıkları az görülmekle birlikte hayatı tehdit eden ciddi komplikasyonlara açık kırıklardır. Doğru tedavi edilirse bu komplikasyonların çoğu önenebilir komplikasyonlardır. En sık etiyolojik etken, hemen tüm araştırmalarda motorlu taşıt kazaları olarak rapor edilmiştir.

Olgu: 37 yaşında erkek hasta motosikletle duramayıp başını beton zemine çarpma şikâyeti ile acil servise getirildi. TA:123/78mmHg, nabız 88/dk, spO2:%100 olarak ölçüldü. Hastanın muayenesinde bilinç açık, GKS 15 puanda idi. Her iki göz arasında ekimoz; alında krepitasyon mevcuttu. Batın serbest; toraks muayenesi olağandı. Hasta baş ağrısından şikâyetçiydi. E-FAST değerlendirmede pnömotoraks ve batın içi serbest mayi izlenmedi. Hastanın çekilen beyin ve servikal BT'nde; Frontal sinüs ön ve arka duvarda multiple fraktür, frontal bölgede pnömosefalus ve yaygın parankimal ödem ve bazal sisternlerde subaraknoid hemoraji izlendi. Hastaya seftriakson 1 gram, epanutin 18 mg/kg IV verildi. Hasta nöroşürüj servisine yatırıldı. Hasta 5 günlük izlemden sonra cerrahi müdahale yapılmaksızın nöroşürüj poliklinik kontrol önerilerek taburcu edildi.

Sonuç: Frontal sinüs kırıklarını diğer yüz bölgesi kırıklarından ayıran en önemli özelliği daha fazla oranda hayatı tehdit eden veya çok ciddi olabilecek durumlarla karşılaşılabilmesidir. Bunun iki nedeni vardır: 1) frontal sinüsün anatomisi 2) frontal sinüs kırıklarının genellikle yüksek enerjili travmalar sonucu ortaya çıkması. Frontal sinüs arka duvarının beyin frontal lobu ile olan komşuluğu, sinüs tabanının orbita süperiorunu oluşturması ve nazofrontal duktusun nazal kanalda orta meaya açılması frontal sinüs kırıklarını ciddi komplikasyonlara açık hale getirir ve tedavi tercihinin belirler. Hastanın resüsitasyonu ve stabilizasyonu esnasında frontal sinüs kırığı öncelikli bir mesele gibi görünmemekle birlikte genel durumunun operasyona uygun hale gelmesinden sonra vakit kaybetmeden gerekli müdahaleler yapılmalıdır. Frontal sinüs kırıklarında menenjit, mukopiyelozel ve pneumosefalus gibi hayatı tehdit eden komplikasyonlarının olabileceği unutulmamalıdır.

Anahtar Kelimeler: frontal sinüs, frontal sinüs kırıkları, yüksek enerjili travmalar

P-0771 Trauma Emergencies

Mandibula Fraktürü

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Amaç: Mandibula fraktürleri fasyal fraktürler içinde en çok görülenlerdendir. Erişkin popülasyonunda nasal fraktürden sonra ikinci sıklıkla rastlanan fasyal fraktürdür. Bunun nedeni mandibulanın çıkıntılı şekli, yüzün alt tarafındaki pozisyonu, anatomik konfigürasyonudur. Acil kliniğine başvuran yüz travmalı hastalarda ilk görüldüğünde, hava yollarını temizleyip, üst solunum yollarının açıklığının sağlanması gerekmektedir. Servikal immobilizasyon servikal fraktür radyolojik olarak dışlanana kadar sağlanmalıdır. Yüz kemik fraktürü tespit edildiğinde, beraberinde hemen girişim gerektiren yaşamsal önemi olan bir patoloji varsa, o patolojilerin giderilmesi için yüz kemiklerinin onarımına 7-10 gün kadar ertelenebilir.

Olgu: 19 yaşında erkek hasta balkonda ayağı kayıp 3 kat mesafesinden düşme şikâyeti ile acil servise getirildi. TA 100/63mmHg, nabız:100/dk, spO2:%100, solunum sayısı:15/dk ölçüldü. Hastanın muayenesinde bilinç açık, GKS 15 puanda idi. Ağız içinde hematoma ve çene altında yaklaşık 5cm kesi hattı mevcuttu. Batın serbest; toraks muayenesi olağandı. Sol uyrukta deformite ve hassasiyet izlendi. E-FAST değerlendirmede pnömotoraks ve batın içi serbest mayi izlenmedi. Hastaya çekilen tüm vücut BT'de ve ekstremiteler grafilerinde; mandibulanın korpusunda sol paramedian kesimde, sağ ramus mandibulada, sol mandibular kondilde fraktür hatları ve sol femurda subtrokanterik fraktür görüldü. Hastaya mandibula stabilizasyonu amaçlı elastik bandaj yapıldı. Sol bacağına uzun bacak atel uygulandı. Çene altında, fraktür hattı ile uyumlu kesi sütüre edildi. Sefazolin 1gram, gentamisin 160mg, fentanyl 100mg ve tetanoz profilaksisi yapıldı. Hasta takip amaçlı yoğun bakıma devredildi.

Sonuç: Fasyal travmayla başvuran hastalarda öncelikle eşlik eden hayatı tehdit edici patolojiler dışlanmalıdır ve hava yolu güvenliği sağlanmalıdır. Ağız içi muayene açık kırık ile birlikte görülen sublingual hematoma, ekimozları, mukozadaki küçük kırıklar veya alveolar dizi kırıklarını dışlamak adına önemlidir. Dış kulak yolu yaralanmaları ve kondil kırıklarının teşhisi için kulak muayenesi yapılmalıdır. Sabit hava yolu olan hastalarda başın üstünden çenenin altına kadar saran Barton bandajı kırığı sabitlemek ve ağrıyı dindirmek için kullanılabilir. Açık kırıklarda ağrı kontrolü ve antibiyoterapi unutulmamalıdır.

Anahtar Kelimeler: fasyal fraktür, fasyal travma, mandibula fraktürü

P-0772 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Intervertebral Alanda Hava: Vakum fenomeni

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Amaç: Snoviyal boşlukta, intervertebral diskte ve vertebrada radyolüsen alan olarak görülen hava görüntüsü, vakum fenomeni olup mekanizması kesin olarak bilinmemektedir. Genellikle nukleus pulposus ve anulus fibrozis dejenerasyonuna bağlı olarak intervertebral disk mesafesinde ortaya çıkan bu boşlukların, etraftaki sıvıların vakum ile vaporizasyonu sonucu düşük dansiteli gaz ile dolmasından kaynaklandığı düşünülmektedir. Bu gazın %92'si azot, geri kalanı oksijen ve karbondioksittir.

Olgu: 71 yaşında bayan hasta aynı seviyeden düşme sonrası bel ağrısı şikâyeti ile başvurdu. Hastanın TA:136/76 mmHg, nabız:75/dk, spO2: %94 solunum sayısı: 14 olarak ölçüldü. Fizik muayenede batın serbest; rebound, defans yoktu. Toraks muayenesi olağandı. Hastanın lomber bölgede orta hat hassasiyeti mevcuttu. Çekilen BT de intervertebral disklerde dural keseyi indente eden annüler taşınmalar ve L5-S1 intervertebral diskinde hava izlendi. Daha önceden lomber disk hernisi semptomları tarifleyen hastada saptanan bu bulgu vakum fenomeni olarak yorumlandı ve ağrı kontrolü sağlanarak poliklinik takibine bağlandı.

Sonuç: Vakum fenomeni dejeneratif intervertebral disklerde sık rastlanan bir bulgudur. Vakum fenomeni çoğunlukla dejeneratif intervertebral disklerde ve genellikle lomber bölgede görülür. Acil servise bel ağrısı nedeniyle başvuran özellikle disk dejenerasyonu olan yaşlı hastaların, direk grafi ve vertebra tomografilerinde vakum fenomenine rastlanabileceği, bu hastalarda vakum fenomeni-nin kitle etkisi yaparak ağrı yapabileceği akılda tutulmalıdır.

Anahtar Kelimeler: bel ağrısı, intervertebral alanda hava, vakum fenomeni

POSTER BİLDİRİLER

P-0773 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

The Clinic Was Consistent With Renal Colic But The Diagnosis Of Acute Appendicitis

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Objective: Diagnosis of acute appendicitis is more difficult in the elderly. Leukocytosis may not be seen in the elderly. Physical examination may be normal. Urinalysis, urinary tract infection and renal colic used to rule out. But of patients with 1/3 thirds of the appendicitis were seen pyuria and hematuria For all these reasons it is difficult to recognize and mortality is higher in the elderly.

Case: 79 years old male patient came to the emergency department with side pain and hematuria. The patient had abdominal pain for two days in the story. Patient had hematuria today. On her physical examination; blood pressure 110/60 mmHg, pulse 77 beats / min, body temperature 36.7 °C, gks 15 was observed. The patient's physical examination was positive in the right costovertebral angle tenderness Other physical examination was normal. There was leukocytosis in lab experiments examinations. On urinalysis; hematuria and increase leukocytes were present. Patient's general condition was fond of. Therefore, abdominal ultrasonography was planned. Abdominal ultrasound examination revealed perforated appendicitis. General surgery consultation was requested. The patient was admitted to a general surgical ward.

Conclusion: In elderly patients admitted to the emergency, further investigations should be requested if there is doubt in the diagnosis.

Anahtar Kelimeler: Acute Appendicitis, hematuria, elderly

P-0774 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Kolonun hepatodiyafragmatik interpozisyonu (Chilaiditi Sendromu): Asemptomatik formda bir olgu örneği

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Amaç: Hepatodiyafragmatik interpozisyon oldukça nadir görülen bir durum olup genel popülasyonda yüzde 0,02-0,08 oranında görülmektedir. Chilaiditi sendromu olarak da bilinen tabloda, sıklıkla sağ hemikolon veya transvers kolon segmentinin hepatodiyafragmatik interpozisyonu gözlenir. Olgumuzda, nadir rastlanan ve çoğu zaman klinisyenlere farklı tanıları düşündürbilecek bu duruma dikkat çekmeyi hedefledik.

Olgu: Kırk dokuz yaşındaki erkek hasta, göğüs ağrısı şikayetiyle kliniğimize başvurdu. Sorgusunda, başvurudan iki gün önce çalışırken dengesini kaybedip göğsünü kapı girişine çarptığı öğrenildi. Travma sonrası başlayan göğüs ağrısı olan hastada sağ parasternal beşinci interkostal mesafede palpasyonla hassasiyet ve hafif ekimotik görünüm dışında anlamlı bulgu mevcut değildi. Rutin laboratuvar tetkikleri ve vital bulguları da normal sınırlarda idi.

Hastanın çekilen akciğer grafisinde, sağ diyafragmanın normalden yüksek olduğu ve hemen altında kalın bağırsağa ait gaz gölgelerinin varlığı gözlemlendi. Bilgisayarlı toraks tomografisinde, kolonun hepatodiyafragmatik interpozisyonunu gösteren, sağ diyafragma altında karaciğer sağ lob komşuluğunda, kolona ait bağırsak ansları gözlemlendi.

Asıl başvuru şikayeti yönünden ayrıntılı değerlendirilerek acil müdahale gerektirecek herhangi bir durum tespit edilmeyen hasta, asemptomatik Chilaiditi Sendromuna örnek olabileceği düşünüldü ve bu yönüyle de değerlendirildi.

Sonuç: Chilaiditi sendromu olarak bilinen kolonun hepatodiyafragmatik interpozisyonu çok nadir görülen, olgumuzda olduğu gibi genellikle asemptomatik seyreden ve çoğu kez başka bir sebeple çekilen radyolojik görüntülerde rastlantısal olarak saptanan bir anomalidir. Bu durumun klinisyenlerce tanınması ayrıntılı tanı açısından önemlidir.

Anahtar Kelimeler: Chilaiditi sendromu, diyafragma, kalın bağırsak

P-0775 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

İatrojenik Rektum Perforasyonu

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Amaç: Kolonoskopi, alt gastrointestinal sistem hastalıklarının teşhis ve tedavisinde en sık kullanılan girişimsel bir tekniktir. Kolonoskopi esnasında kolon perforasyonu daha çok tedavi amaçlı yapılanlarda görülürken nadir olarak tanısal amaçlı yapılanlarda da görülmektedir. kolonoskopi esnasında kolonik perforasyon barsak duvarına mekanik kuvvet uygulanması, barotrauma veya terapötik işlemler esnasında meydana gelebilir. Perforasyonun erken semptomları en sık persiste abdominal ağrı ve distansiyondur. Daha sonra peritonit bulguları gelişir. Seçilmiş vakalarda perforasyonun tamirinde endoskopik klips veya klempleme yapılır ve bunların sayısı her geçen gün artmış bir şekilde bildirilmektedir.

Olgu: 59 yaşında erkek hasta dış merkezde kolonoskopi sonrası rektum perforasyonu ön tanısıyla 2. saatinde hastanemiz acil servisine yönlendirildi. Hastanın başvurusunda genel durumu iyi, şuur açık, koopere idi. Ta:120/80 nabız:70, ateş:37, Bmi:35.73 idi. FM'de batın hassas ve defansı mevcuttu. Diğer sistem muayeneleri normaldi. RT de rektumda hassasiyet ve hematokleza mevcuttu. Hastanın hemogram ve acil biyokimya parametrelerinde patoloji izlenmedi. Hastaya eşzamanlı IV sıvı tedavisi, seftriakson, ornidazol, famotidin, tenoksikam, tramadol başlandı. Hastaya kolonoskopi planlandı. Hastaya 20 mg pethidine ve 2 mg midazolam ile sedoanaljezi yapılarak işleme başlandı. Rektum proksimalde 1.5 cm'lik perforasyon görüldü. Endoskopik klemp ile perforasyon alanı kapatıldı. İşlem sonrası 24. saatte rejim başlandı. 3 gün servis takibinde kalan hasta salih ve öneriler ile taburcu edildi.

Sonuç: Rektum perforasyonu kolonoskopinin major komplikasyonlarından biridir. Hastaya erken dönemde müdahale edildiğinden primer kapatma uygulandı. Bu vakanın özelliği cerrahi işlem uygulanmadan endoskopik klempleme ile perforasyon alanının kapatılması olmasıdır.

Anahtar Kelimeler: iatrojenik, rektum, perforasyon

P-0776 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Üç Tromboemboli Birlikte: Kronik Pulmoner Tromboembolisi Bulunan Hastada Eş Zamanlı Gelişen Akut Renal İnfarkt ve Mezenterik İskemi: Olgu Sunumu

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Amaç: Multisistemik emboli acil servislere nadir de olsa görülmektedir. Multisistemik embolilerin nedeni antitrombotik sendromu, protein S ve C eksikliği, bazı paraneoplastik hastalıklar, SLE gibi otoimmün hastalıklar, Behçet hastalığı, atriyal fibrilasyon, atriyal mixoma ve infektif endokardit gibi bir çok hastalıklardır.

Renal infarkt ve mezenterik iske mi acil servislere nadir tanı konulan abdominal acillerdendir. İkisinin de tanısında klinik şüphe önemlidir. Renal infarktli hastaların % 65 i flank, % 53 ü abdominal ile başvururlar. Pulmoner emboli tanısı göreceli olarak acil servislere daha sık konmaktadır. Multisistemik embolilerin tedavisi cerrahi müdahale ve antikoagulan, trombolitiklerden oluşmaktadır. Burada kronik tromboemboli zemininde gelişen pulmoner, renal ve intestinal embolinin birlikteliğinin olduğu bir multi emboli vakası sunulmuştur.

Olgu: 65 yaşında erkek hasta yarım saat önce başlayan karın ağrısı ile başvurdu. ağrı göbek etrafında daha çok olmak üzere tüm batında mevcuttu. Özgeçmişinde bildiği hiçbir hastalığı yok. Daha önce hiç doktora gitmemiş, sürekli kullandığı ilaç yok, kronik sigara içicisi. Genel Durumu iyi, şuur açık, oryante, koopere. TA: sağ kol 160/100, sol kol 170/110 mmHg, Nabız:80, Ateş: 36,4, saturasyonu %87. Fizik muayenede sağda bazalde minimal rali mevcut, batın hassas ancak defans ve rebound mevcut değil, barsak sesleri hafif hiperaktif. Hastada DVT bulgusu yok. Nörolojik muayenesi normal. Rektal tuşede normal gaita buluşu mevcut. Diğer sistem muayeneleri normal olarak saptandı. EKG: Sinüs ritmi, sağ dal bloğu, V1-V3 de T negatifliği mevcut, elevasyon ve depresyonu ve atriyal fibrilasyon yok. Hastaya 2 lt/ dk'dan O2 ve IV salin başlandı, 40 mg esomeprazol yapıldı. Hastaya yatak başı ekokardiyogram yapıldı. EF: % 60, duvar hareket bozukluğu yok, sağ boşluklar geniş, intrakardiyak trombus saptanmadı.

Laboratuvar değerleri olarak hemogram ve biyokimya normal, troponin 0,67 mg/dL (0-0,3), D-dimer yüksek. Kreatinin değerleri normal gelen hastaya pulmoner BT anjiyo ve kontrastlı batın BT çekildi. BT çekimleri kronik pulmoner emboli, sağ renal infarkt ve sma 'da 8 cm lik oklüzyon olarak raporlandı. Hastaya kanama ve diseksiyon ekrante edildikten sonra enoxaparin 0,6 ve tramadol HCl yapıldı. Hasta yoğun bakım ünitesine alındı. Yoğun bakım ünitesinde vitaller hızlı bir şekilde kötüleşti. Operasyon için hazırlık yapılan hastanın hemodinamisi bozuldu ve hasta ex oldu.

Sonuç: Acil servis hekimleri karın ağrısı şikayeti olan hastaların klinik yönetimi sırasında renal infarkt ve mezenterik iske mi tanısını da aklında bulundurmaları, çünkü ikisinde taniya giden



POSTER PRESENTATIONS

ilk yıl klinik şüpheye dayanır. Ayrıca karın ağrılı hastada tek bir hastalıkta bulunmayabilir yanında çok ciddi başka bir hastalıkta bulunabilir, bu da acil hekimlerinin aklında bulunmalıdır.

Anahtar Kelimeler: Tromboemboli, pulmonari, renal, mesenteriy

P-0777 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Yabancı cisim batması olgusu: Ayakta Tornavida

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Yabancı cisim batması şüphesi olan bir hastanın değerlendirilmesi dikkatli bir öykü ve fizik muayene ile başlar. Yumuşak dokudaki yabancı cisimler sık karşılaşılan bir problem olmakla beraber, penetre oldukları dokularda başta enfeksiyon olmak üzere bir çok komplikasyona da yol açabilmektedir. Acil serviste saptanan en sık yabancı cisimler ahşap, cam ve metaldir.

Olgumuz 9 yaşında erkek hasta evde koşarken sol ayağına tornavida batmış, yakınları tarafından ilçe hastanesine götürülen hasta oradan acil servisimize getirildi. Hastanın sol ayak tabanında tornavida batmış şekilde bulunuyordu. Distal dolaşımı normal olan hastanın nörolojik defisiti yoktu. X-ray çekildi. Lokal anestezi altında tornavida çıkarıldı. Uygun antibiyoterapi ile taburcu edildi.

Sonuç olarak acil serviste sık görülen bu hasta grubunda eğer yabancı cisim yüzeyli bir konumda ise uygun sedasyon ve analjezi ile kolayca çıkarılabilir. Derin dokulara penetre olmuş ise X-ray, USG gibi görüntüleme yöntemleri yardımı ile çıkarılabilir.

Anahtar Kelimeler: acil servis, ayakta yabancı cisim, tornavida

P-0778 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Boyuna Ateşli Silah Yaralanmasından Sonra Gelişen Karotiko-Kavernöz Sinüs Fistülü Olgusuna Yaklaşım

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Amaç: Karotiko-kavernöz fistüller (KKF'ler), karotis sistemi ile kavernöz sinus arasındaki anormal arteriyovenöz bağlantılar olarak tanımlanabilirler. KKF'ler arteriyel beslenme biçimleri ve vasküler mimarilerine göre direkt ve indirekt KKF'ler olarak sınıflandırılır. Direkt KKF'lerde (Tip A), internal karotis arteri (İKA) ile kavernöz sinus arasında travmaya bağlı arter hasarı ya da kavernöz İKA anevrizmasının kavernöz sinus içine yırtılması sonucunda gelişen hızlı akımlı bir arteriyovenöz fistül söz konusudur. İndirekt KKF'ler (Tip B, C, D) ise, İKA, eksternal karotis arteri (EKA) veya her ikisinin dural dallarından beslenerek kavernöz sinüse boşalan daha yavaş akımlı dural tipte arteriyovenöz fistüllerdir. Budört tip KKF'nin etyolojisi, klinik bulguları ve servisi ile tedavi yaklaşımları farklıdır. Bu sunumda boyun bölgesine ateşli silah yaralanmasından sonra gelişen Karotikokavernöz fistül olgusu ele alındı.

Olgu: 26 yaşında erkek hasta, sağ gözünde 15 gündür başlayan ve giderek artan sağ gözde hafif ağrı, kızarıklık, öne doğru büyüme, bulanık görme ve görme kaybı şikayetiyle acil servise başvurdu. Öyküsünde hastanın 35 gün önce boyundan ateşli silah yaralanması geçirdiği ve gittiği hastanede operasyon düşünülmeyerek medikal tedavi başlanıldığı anlaşıldı (Resim 1).

Hastanın yapılan muayenesinde genel durumu şuuru açık, koopere oryante, motor defisit yoktu. Boyun sağ tarafından ateşli silah mermi çekirdeği giriş deliğine ait olduğu düşünülen skar dokusu mevcut. Hastanın fizik muayenesinde lezyon üzerinde oskültasyon ile üfürüm duyulması üzerine hastaya kavertiko-kavernöz sinüs fistülü (KKF) düşünülerek ileri tetkikler planlandı. Hastanın ilk yapılan muayenesinde düzeltilmiş görme keskinliği sağda 0.3, solda 1.0 düzeyinde tespit edildi. Biyomikroskopik muayenesinde, sağ gözde kapaklarda ödem, konjonktivada hiperemi ve kemozis, proptozis, pupilla fiks dilate, ışık reaksiyonu (-) bulunurken, sol göz tamamen normaldi. Göz içi basıncı applanasyon tonometresi ile sağda 34 mmHg, solda 16 mmHg olarak ölçüldü. Hastaya ayrıntılı göz muayenesini takiben orbita renkli Doppler ultrasonografi, aksiyel planda kontrastlı ve kontrastsız orbital tomografi, kranyal manyetik rezonans incelemesi, manyetik rezonans anjiyografi ve karotis ve serebral Digital Subtraction anjiyografi (DSA) tetkikleri yapıldı. Yapılan tetkikte sağ internal karotis ile sağ kavernöz sinüs arasında fistül olduğu saptandı. Bu radyolojik tetkiklerin sonucunda hastaya kavertiko-kavernöz sinüs fistülü (KKF) tanısı konuldu. Hastaya genel anestezi altında femoral yoldan uygulanan endovasküler tedavi yöntemi ile fistül kapatma tedavisi uygulandı. İşlem esnasında komplikasyon gözlenmedi. Hastanın kontrollerinde yapılan tetkiklerinde herhangi bir patolojiye rastlanmadı.

Sonuç: Acil serviste öykü ve FM ile şüphelenilen gelişmiş radyolojik tetkik ve girişimlerle karotiko-kavernöz sinüs fistülünün tanı ve tedavisi yapılan ve oldukça kısa zamanda çok yüz güldürücü bir sonuç elde ettimiz bu olgu, karotiko-kavernöz fistül varlığının erken dönemde radyolojik olarak tespitinin çeşitli oküler ve serebral komplikasyonların önüne geçilmesi açısından ne kadar önemli olabileceğini göstermiştir.

Anahtar Kelimeler: Karotiko-kavernöz fistül, endovasküler girişim, görme kaybı

P-0779 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Çocuklarda Nadir Görülen Minör Travmatik Kalça Çıkığı: Olgu Sunumu

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Amaç: Çocuklarda düşük enerjili travmatik kalça çıkıkları nadir görülen vakalardır. 15 yaş altı tüm çıkıkların % 5 ini oluştururlar. Çıkıklar minör ve majör travma geçirme durumuna göre ayrılabilir. Çıkıklar öne veya arkaya olabilmektedir. Daha çok erkek çocuklarda görülmektedir. Çocuklarda travmatik kalça çıkıklarında bir çok komplikasyon bildirilmiştir: femur başı avasküler nekrozu, miyositis ossifikans, travma sonrası osteoartrit, femur başı deformiteleri, siyatik sinir yaralanması, tekrarlayan kalça instabilitesi ve ipsilateral femur kırıklarıdır. Çıkıkta redüksiyon işlemi geciktikçe komplikasyon oranının da arttığı, redüksiyonun ilk 12 saatte yapılması gerektiği eğer başarılı olunmazsa açık cerrahi redüksiyon için gecikilmemesi gerektiği bildirilmiştir. En sık görülen komplikasyon osteonekrozdur. Redüksiyon süresi prognozu doğrudan etkiler. Osteonekrozun en sık nedeni de uzamış redüksiyon süresi olarak belirtilmiştir. redüksiyon süresinin 6 saati geçmesi osteonekroz riskini 20 kat arttırdığı belirtilmiştir. Çocuklarda travmatik kalça çıkığı daha çok düşme, spor gibi düşük enerjili faaliyetler ile oluşabilmekle beraber trafik kazası gibi yüksek enerjili majör travmalar ile de gelişebilmektedir.

Burada düşük enerjili minör travmaya maruz kalmış ek yaralanması olmayan, kapalı redüksiyonu yapılmış bir olgu sunulmuştur.

Olgu: Sonuç:

Anahtar Kelimeler: minör travma, kalça çıkığı, çocuk

P-0780 Trauma Emergencies

Servikal Travmada İzole Disk Hernisine Bağlı Paraparezi

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Amaç: Spinal kord yaralanmaları modern yaşamda sıkça karşılaşılan bir yaralanma şeklidir. Her ne kadar patogenezi netlik kazanmış, tanısı ve tedavisinde gelişmeler olsa da ciddi ve kalıcı bulgularla sonuçlanabilecek bir durum olarak önemi korunmaktadır. Etiolojisinde en sık neden %47 ile motorlu araç kazalarıdır. İkinci sıklıkla düşmeler (%23) görülmektedir. Genellikle kemik dokularda fraktür, dislokasyon, ligaman yırtıkları ve intervertebral disk hernileri spinal kord hasarına yol açmaktadır. Akut travmatik disk hernisi genellikle fraktür veya dislokasyonla beraber görülür. İzole akut servikal disk hernisi oldukça nadirdir.

Olgu: 74 yaşında erkek hasta, otobüse binerken takılarak sırt üstü düşme ve sonrasında 1. saate başlayan sol vücut yarısında kuvvet kaybı ile acil servise başvurdu. Başvuru sırasında vital bulguları normal, glasgow koma skoru 15 olarak değerlendirildi. Genel sistemik muayenede oksipital bölgede sütür gerektirmeyen laserasyon dışında patolojik bulgu saptanmadı. Nörolojik muayenesinde ışık refleksleri bilateral doğal, babinski sağda fleksör solda lakayt. Kas gücü sağ üst ekstremité proksimalde ve distalde 4/5, solda proksimal ve distal 3/5, alt ekstremitelerde ise sağda 4/5 solda 2/5 saptandı. Sensorial muayenede sağda hemihipoestezi solda ise hiperaljezi tespit edildi. Vital bulgular stabil olan hastadan kranial ve servikal bilgisayarlı tomografi (BT) istendi. Kranial BT'de serebral atrofi ve sağ optik bulbusta protez dışında patolojik görüntü saptanmadı. Servikal BT tetkikinde kemik yapılarla herhangi bir hasar saptanmadı ancak 3 seviyede spinal korda bası yaptığı gözlenen disk herniasyonları tespit edildi. Bunun üzerine daha öncesinde olası diğer kranial lezyonları dışlamak amaçlı kranial difüzyon MR istendi. Herhangi bir patoloji saptanmayan hastada bulguların travmaya sekonder disk hernisi ve olası spinal kanamaya bağlı olabileceği şüphesiyle spinal manyetik rezonans görüntülemesi planlandı. Servikal MR tetkikinde C2-C3 diskinde parasantral protüzyon hafif derecede bası. C3-C4 diskinde dejeneratif değişikliklerin eşlik ettiği posterior bulging ve spinal korda sol parasternal bası saptandı.



POSTER BİLDİRİLER

Hastanın şikayetlerinin akut başlangıçlı olması, klinik belirtileri ve tetkikleri sonucunda akut travmatik servikal disk herniasyonu tanısıyla hasta Beyin ve Sinir Cerrahisi Kliniğine yatırıldı ve acil olarak ameliyata alındı.

Sonuç: Travmaya bağlı spinal yaralanmalarda genellikle kemik yapılar da fraktür veya dislokasyon ile beraber akut disk hernileri sık rastlanan bir bulgudur. İzole spinal disk hernileri ise daha nadirdir. Nörolojik şikayetlerle başvuran ve intrakranial bir nedenle açıklanamayan semptomları olan hastalarda servikal kemik yapılar da patoloji olmasa bile akut disk hernisi olasılığına karşı servikal mr tetkiki acil olarak kalıcı nörolojik defisitlerin önlenmesi için gereklidir. Ancak bu tanı koyulmadan önce benzer bulguları yapan serebrovasküler olaylar, vertebral fraktürlere bağlı oluşan basılar, spinal kord hemorajileri ve metabolik nedenler dışlanmalıdır.

Anahtar Kelimeler: disk hernisi, spinal travma, paraparezi

P-0781 Trauma Emergencies

Travmatik Tek Taraflı Vertebral Arter Diseksiyonu Sonucu Serebellar Enfarkt

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Giriş: Arteriyel diseksiyon arterin intima tabakasındaki yırtık ve bunun sonucu oluşan intramural hematoma olarak tanımlanmıştır. Genç yaşta görülen serebrovasküler olayların %10 ila 25' inde karotis veya vertebral arter diseksiyonu (VAD) rol oynarken, ileri yaşlarda bu oran %2.5' larda kalmaktadır. Vertebral arter diseksiyonu, spontan olabileceği gibi boyun manipülasyonlarını veya travmayı takiben de ortaya çıkabilir.

Olgu: 50 yaşında, özgeçmişinde özellik olmayan bayan hasta, araç içi trafik kazası (AİTK) sebebiyle acil servisimize getirildi. GKS, E2M4V2 olan hasta entübe edildi. Hastanın yatak başı ultrasonografisinde bilateral hemopnömotoraks saptandı. Bilateral tüp torakostomi uygulanan hastaya tüm vücut bilgisayarlı tomografi (BT) görüntülemesi yapıldı. BT'de; bilateral hemitoraksta deplase seri kot fraktürleri, pulmoner kontüzyon, laserasyon, hemopnömotoraks, pubik ramusta ve sakrum sağ yarısında fraktürler, yaygın cilt altı amfizem, sağ vertebral arterde diseksiyon (V2 segmentinden itibaren okluda) izlendi. Kan transfüzyonu sonrası vitalleri stabilizeşen ve bilinci açılan hasta izlemde ekstübe edildi. İlgili klinikler tarafından konservatif tedavi ve izlem önerildi. Antikoagulan tedaviye başlandı. Takibinde 48. saatte şiddetli boyun ve ense ağrısı tarifleyen hastamızın, nörolojik muayenesinde sağda dismetri ve bilateral horizontal nistagmus gözlemlendi. Bu nedenle görüntülenen beyin BT' sinde sağ serebellar subakut enfarkt saptandı ve anestezi yoğun bakımda yer açılması üzerine nakledildi.

Tartışma: Genellikle boyun bölgesinde travmaya neden olabilecek, herhangi bir sportif faaliyet, kaza veya boyunda aşırı bir germeye (hiperekstansiyon, hiperfleksiyon), zorlanmaya neden olabilecek servikal bir manipülasyon veya ani bir hareket nedeniyle VAD oluşabilir. Ciddi travmalar sonrası ön planda birçok sisteme ait problemin varlığı, diseksiyonun fark edilememesine ve tanının gecikmesine neden olabilmektedir. Semptomlar, iskemik inmeye, transient iskemik atak veya lokal kompresyona bağlı olarak gelişebilir. VAD' da vakaların %70' inde oksipital baş ağrısı ve boyun ağrısı, vakaların %60' ında ise vertebrobasiler sistem iskemisine ait semptomlar bulunmaktadır. Bizim olgumuzda da ciddi bir travma sonrası, VAD ve en sık görülen semptomlardan boyun, ense ağrısı ve dismetri mevcuttu. VAD tanısı, sonografik incelemeler, dijital substraksiyon anjiyografi (DSA), manyetik rezonans görüntüleme (MRG) ve BT anjiyografi ile koyulabilir. BT anjiyografinin diseksiyonların saptanması açısından spesifitesi ve sensitivitesi %100' dür. Bu vakada da tanı BT anjiyografi ile konulmuştur.

Sonuç: VAD tanısı, başvuru için klinik özelliklere, travma öyküsüne ve nöroradyolojik bulgulara dayanmaktadır. Bir inme sebebidir. Eskiden çok iyi bilinmeyen bu inme nedeni, sadece otopsislerde fark edilebilirken, klinik özelliklerin anlaşılması ve radyolojik gelişmeler sayesinde günümüzde daha fazla tanınır ve bilinen hale gelmiştir.

Anahtar Kelimeler: diseksiyon, enfarkt, serebellar, travmatik, vertebral arter

P-0782 Trauma Emergencies

Anormal Vajinal Kanamanın Nadir Bir Nedeni: Travmatik Servikovajinal Arter Psödoanevrizması

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Giriş: Anormal vajinal kanamalar, acil serviste sık görülen jinekolojik problemlerden biridir. Reprodüktif çağlarda görülen kanamaların en sık sebebi disfonksiyone uterusur. 30-49 yaş aralığında %5 oranında görülür. Travmaya bağlı psödoanevrizma nadir görülen bir vajinal kanama nedenidir.

Olgu: Orta yaş kadın hasta, şiddetli vajinal kanama ile acil servisimize başvurdu. Geliş vitaleri stabil olan, bilinen hastalığı olmayan hastanın batın muayenesi normal olarak değerlendirildi. İlk laboratuvar değerlerinde hemoglobinin: 13.4 gr/dl, B-hcg: Negatif olarak saptandı. İzlemi sırasında ortostatik hipotansiyonu olan hastanın kısa sürede 25 ped kullanımı olduğu, kontrol hemoglobin değeri, 9.3 gr/dl ' e gerilediği görüldü. Aktif kanaması devam eden hastaya ERT replasmanı yapıldı. Vajinal muayeneyi kabul etmeyen, hemodinamisi bozulan hastaya batın tomografisi çekildi. BT'de vajen içerisinde yaklaşık 5.5x3 cm çaplı hematoma, uterin arterin servikovajinal dalında yaklaşık 6 mm çaplı psödoanevrizma izlendi. Hastanın aktif kanaması devam etmesi üzerine cerrahi girişim için kadın hastalıkları ve doğum servisine yatırıldı.

Tartışma ve Sonuç: Anormal vajinal kanamalar, organik sebebe (myom uteri, endometrial polip, over kistleri, granuloza hücreli tumor; endometrit, servisit gibi enfeksiyonlar, diğer endometrial maligniteler, Von Willebrand hastalığı gibi koagülopatiler, İTP, hipersplenizm, nadiren lösemi, hipotiroidizm ve hiperprolaktinemi gibi endokrinopatiler, karaciğer yetmezliği, obeziteye bağlı hipoprotegesteronomi, ilk trimester gebelik, hipotalamopitüiterovaryan aksı etkileyen herhangi bir ilaca, antidepresan, antipsikotik, hormonal kontrasepsiyon ilaçları) bağlı veya disfonksiyonel uterus kanaması olarak temel olarak iki ana grupta toplanır. Disfonksiyonel uterus kanaması, kanamayı açıklayacak herhangi bir organik sebep bulunamadığı durumda konan teşhistir, en sık sebebi anovulasyondur. Bizim olgumuzda da hastanın verdiği anemnez dolayısıyla öncelikle disfonksiyone uterus kanaması düşünülmüş, kontrol hemogram ve takibinde asemptomatik seyretmesi halinde taburcu etmeyi planlamıştık. Ancak hastanın ciddi kanaması, ortostatik hipotansiyonu ve taşikardisinin olması nedeniyle hem ERT replasmanının yapılması hem de hastayı bu şekilde anstabil hale getirecek kanamanın etyolojisinin araştırılması gerekli hale geldi. Psödoanevrizma, arteriyel kaçak sonrası gelişmiş, etrafı yumuşak doku ya da arterin adventitsiyası ile çevrili hematomdur. İçerisindeki kanın bir boyun aracılığı ile arterle ilişkisi devam ettiği görülür. Psödoanevrizma gelişiminin etyolojisinde travma, cerrahi ve arteriyel kateterizasyonlar yer almaktadır. Literatürde anormal vajinal kanama nedeni olarak servikovajinal arter psödoanevrizması bildirilmemiştir. Bizim olgumuz da, tomografi çekildikten ve psödoanevrizmanın nedeninin travmatik olduğunu düşündüğümüzü söyledikten sonra kendisinin vajinal travma (koitus) yaşadığını belirtti.

Sonuç olarak, vajinal kanamanın altına yatan ciddi bir nedeni yoksa geçici hormonal tedavilerle kanama düzensizliği rahatlıkla kontrol edilebilir. Kanama miktarı, hastanın kliniği ve anemnezi acil servise vajinal kanama nedeniyle başvuran hastaların yönetimini değiştirebilir. Genellikle, utanma ve korku nedeniyle eksik anemnez alınabileceği akıldan çıkarılmamalı ve travmaya bağlı vajinal kanamaların olabileceği düşünülmelidir.

Anahtar Kelimeler: vajinal travma, servikovajinal arter, psödoanevrizma

P-0783 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Kronik Obstruktif Akciğer Hastalığı Komplikasyonu; Sekonder Spontan Pnömotoraks

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Amaç: Spontan pnömotoraks (SP), travmatik veya iatrojenik müdahale olmaksızın kendiliğinden plevral mesafede hava toplanmasıdır. Akciğer hastalığı olmaksızın akciğer apeksindeki subpleural bleblerin perforasyonu ile oluşan pnömotoraks primer spontan pnömotoraks (PSP), akciğerdeki altta yatan bir hastalığa bağlı gelişen pnömotoraks ise sekonder spontan pnömotoraks (SSP) olarak adlandırılır. SSP genellikle ileri yaşlarda ve erkeklerde daha sık görülmektedir. SSP 'ın en sık nedeni kronik obstruktif akciğer hastalığıdır (KOA). SSP'li hastalar genellikle yüksek mortalite oranı taşımaları nedeniyle acil teşhis ve tedavi gerektirirler. Tedavide pnömotoraksın ciddiyetine göre oksijen inhalasyonu, tüp torakostomi ve cerrahi torakotomi uygulanmaktadır. Acil servisimize ani başlayan göğüs ağrısı ve nefes darlığı şikayetiyle başvuran ve SSP tanısı konan vakamızı sunmak istedik.

Olgu: 65 yaşında erkek hasta acil servisimize ani başlayan göğüs ağrısı, nefes darlığı şikayetiyle başvurdu. Hastanın göğüs ağrısı; sol meme altında bıçak saplanır tarzdaydı. Öksürük, balgam, ateş, terleme, baş dönmesi, bulantı ve kusması yoktu. Daha önce KOAH tanısı alan ancak tedavi görmeyen hastanın göğüs ağrısı ile birlikte nefes darlığı şikayeti olmaya başlamış. Hastanın alkol ve sigara alışkanlığı yoktu. Fizik muayenesinde vital bulgular; tansiyon arteriyel: 130/80 mmHg, nabız: 90 atım/dakika, SaO2: 89 idi. Solunum sistemi muayenesinde; sol orta ve alt zonda solunum sesleri azalmıştı. Diğer sistem muayeneleri doğaldı. Elektrokardiyografisinde özellik yoktu. TroponinT: negatif, D-dimer testi <500 idi. Diğer laboratuvar tetkiklerinde özellik yoktu. Çekilen akciğer grafisinde sol alt zonda pnömotoraks tespit edildi. Göğüs cerrahi konsültasyonu istenen hastanın çekilen kontrastsız bilgisayarlı toraks tomografisinde; sol akciğerde pnömotoraks ve bilateral bullöz amfizem tespit edildi. Acil serviste tüp torakostomi uygulanan hasta göğüs cerrahi kliniğine yatırıldı.

Sonuç: Sekonder spontan pnömotoraks altta yatan akciğer hastalığına bağlı olarak ortaya çıkan bir durumdur. KOAH ve bullöz akciğer, SSP 'ın en çok karşılaşılan iki nedenidir. Acil servislere nefes darlığı, göğüs ağrısı şikayetiyle başvuran ve öyküsünde akciğer hastalığı olduğu bilinen hastalarda SSP olabileceği akıldan tutulmalıdır.

Anahtar Kelimeler: Sekonder Spontan Pnömotoraks, KOAH, Bullöz Akciğer, Nefes Darlığı



POSTER PRESENTATIONS

P-0784 Trauma Emergencies

Emniyet kemerine bağlı künt batin travması sonucu barsak perforasyonu olgusu

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Karın travmaları tüm travmalara bağlı ölümlerin % 15-20'ni oluşturmaktadır. Karın yaralanmaları künt veya penetran ya da her ikisinin birlikte olduğu mekanizmalarla ortaya çıkabilir. Künt karın travmasının en sık nedeni motorlu taşıt kazalarıdır. Bu yaralanma şekli bütün karın içi organlar için risk oluşturur. Künt karın travması biyomekanik olarak basınç, kesme ve gerilme gibi etkilere uğur. Bunların sonucu solid organ veya içi boş organ yaralanması olabilir. Karın yaralanmaları genellikle sinsi bir klinikle seyreder.

İç boş organ yaralanmaları kan kaybı ve peritoneal kirlenme birleşimi ile belirti ve bulgular verir. Mide, ince barsak ve kolon delinmesine genellikle eşlik eden bir mezenterik yaralanma olduğundan kan kaybı bu tabloya eşlik edebilir. İnce barsak ve kolon yaralanmalarında bakteriyel içerik süpüratif peritonit geliştirdiğinden bulgular hemen ortaya çıkar. İnflamatuvar değişiklikler 6-8 saatte belirgin hale gelir. Tanıda fizik muayeneye ek olarak ultrasonografi, tomografi, diagnostik peritoneal lavaj kullanılabilir.

Olgumuz 27 yaşında bayan hasta, araç içi trafik kazası nedeniyle 112 tarafından acil servise getirildi. Hastaya ilk müdahale sonrası yapılan tetkiklerinde karın duvarı yırtığı ve barsak perforasyonu teşhisi kondu. Bu vaka sunumunda künt batin travması ile başvuran stabil olmayan hastanın acil servis yönetimi üzerinde durmayı düşündük.

Anahtar Kelimeler: künt batin travması, acil servis, barsak perforasyonu

P-0785 Trauma Emergencies

Ateşli silah yaralanması izole renal travma

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Amaç: Retroperitoneal yerleşimli olan böbrek; faysalar, yağ dokusu, kaslar ve vertebra ile desteklenmiş olup, anatomik olarak iyi korunaklı bir alandır. Böbrek hasarlanmalarının en sık iki sebebi sırasıyla trafik kazaları ve sportif yaralanmalardır. Böbrek hasarının olduğu yaralanmalarda çoğunlukla (%80) iç organ yaralanmaları da eşlik eder. Genellikle künt abdominal travmalar şeklinde gerçekleşen yaralanmalar, erişkinlere kıyasla çocuklarda çok daha sık olarak görülmekte ve daha ciddi sonuçlara yol açabilmektedir. Ateşli silah ve bıçak yaralanmaları sonucu oluşan penetran böbrek travmaları ise daha az sıklıkla görülmekte olup künt travmalara benzer şekilde bu yaralanmalarda da diğer organların hasarlanması tabloya eşlik etmekte ve izole penetran yaralanmalara oldukça nadir rastlanmaktadır. Bu olguda, ateşli silah yaralanması sonucu izole böbrek travması gelişen bir hasta sunuldu.

Olgu: 43 yaşında bayan hasta, acil servisimize ateşli silah yaralanması sonucu getirildi. Hasta geldiğinde bilinç açık koopere oryante idi (Glasgow Koma Skalası:15), tansiyon arteryel: 100/60 mmHg, nabız:100 atım/dk, fizik bakışında akciğer sesleri doğal, batin hassas, sol alt ve üst kadranda defans mevcuttu. Orta hat vertebral kolon sağında ateşli silah girişi deliği mevcuttu ancak çıkış deliği gözlenmedi. İlk laboratuvar tetkiklerinde Hb:11,5 g/dl, Plt:192000, INR: 2,1, AST: 24 U/L, ALT:8 U/L, Cr 0,6 mg/dl, tam idrar tetkikinde makroskopik hematüri mevcuttu. Yarım saat sonra kontrol hemoglobini:10,8 g/dl olan hastanın çekilen batin tomografisinde: sol böbrek orta alt pol bileşkesinde laserasyon alanı içerisinde yaklaşık 4 mm boyutunda hiperdens yabancı cisim, sol böbrek alt polde en geniş yerinde yaklaşık 9 mm'e ulaşan parankimi tamamen kat eden birbirine komşu hipodens laserasyon alanları mevcuttu (Grade III laserasyon). Sol böbrek orta alt pol bileşkesi düzeyinde anteriorda perirenal mesafede yaklaşık 9 mm boyutunda belirgin metalik artefakta neden olan yabancı cisim görüldü. Sol renal hilusa ve paraaortik alana uzanan en geniş yerinde 1,5 cm olan düzensiz kenarlı pararenal hematoma mevcuttu. Sol psoas kasi içinde milimetrik hava dansiteleri mevcuttu. Diğer intraabdominal organlarda patoloji saptanmadı. Hasta Üroloji Kliniğine yatırılan hastada konservatif yaklaşım tercih edildi ve hasta opere edilmedi. Takiplerinde herhangi bir komplikasyon gelişmeyen hasta kontrol önerileri ile taburcu edildi.

Sonuç: Böbrek travmaları erkeklerde kadınlara göre %70-80 daha fazla rastlanmaktadır. Penetran yaralanmalar olguların sadece %10'unu oluşturmaktadır, %70-80'ine iç organ hasarı eşlik etmektedir. Penetran yaralanmalarda günümüzde konservatif yaklaşımlar tercih edilmeye başlanmıştır. Olgumuzda da hastanın genel durumunun stabil olması nedeniyle konservatif yaklaşım uygun görüldüğüne operasyona gerek duyulmamıştır. Olgumuzdaki benzer şekilde ateşli silah yaralanması sonrasında hematürinin eşlik ettiği vakalarda böbrek yaralanması açısından hastaların radyolojik yöntemler ile ayrıntılı olarak analiz edilmesi ve olaya renal arter hasarının eşlik edip etmediğinin belirlenmesi büyük önem taşımaktadır.

Anahtar Kelimeler: Acil, ateşli silah yaralanması, penetran, böbrek

P-0786 Toxicology

Psikiyatrik Vakalarda Nöbetin Hatırlanması Gereken Nadir Bir Nedeni: Akut Su İntoksikasyonu!

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Amaç: Su zehirlenmesi, aşırı miktarda su içimi sonrası hiponatremi ve serebral ödem gibi hayatı tehdit edici tablolara yol açan nadir bir durumdur (1,2). Kronik psikiyatrik hastalarda nadiren tanınmakta ve genellikle gözden kaçmaktadır (3). Bu yazıda psikiyatrik hastalığı nedeniyle polidipsisi olan su intoksikasyonunu sunuyoruz.

Olgu: 39 yaşında erkek hasta yürürken aniden gelişen, idrar inkontinansının eşlik ettiği tonik klonik kasılmalarla seyreden ve 8-9 dakika süren generalize nöbet geçirme yakınması ile 112 tarafından acil servise getirildi. Gelişinde bilinci konfü olan hastanın daha sonra ajitasyonu gelişti. Fizik muayenesinde suprapubik alanda şişlik ve hassasiyet dışında bulgusu yoktu. Vital bulguları stabildi. Öz geçmişi 18 yaşından beri şizofreni nedeniyle takipli olduğu, en son 3 yıl önce nöbet geçirdiği ve nöroloji kliniğine yattığı öğrenildi. Hastanın son 2-3 yıl içerisinde ara ara ajitasyonlarının ve uykusuzluk yakınmalarının geliştiği ve bu dönemlerde su ve sigara içmesinin arttığı öğrenildi. Hastanın birkaç gündür su içmesinde artmanın başladığı, dünden beri üç yıl önceki nöbet geçirdiğinde olduğu gibi 15 litreye yakın su içtiği, ailenin hastayı engellemek için su vanalarını kapatmak zorunda kaldıkları öğrenildi. Yapılan kan tetkiklerinde 118 mmol/l olan sodyum değeri dışında biyokimya, kan gazı ve kan sayımı değerleri ile kraniyal BT'si doğal sınırlardaydı. Eldeki verilerden hastanın psikiyatrik hastalığına sekonder polidipsisi olduğu ve metabolik nedeni konvülsiyon geçirdiği düşünüldüğüne mutlak su kısıtlaması uygulandı. 12 saatlik izleminde hastanın 12-14 litre idrar çıkışı oldu. Gelişinden 10-12 saat sonra ajitasyonu geriledi, Kontrol tetkiklerinde Na değeri 131 mmol/l oldu. Nefroloji, nöroloji ve psikiyatri bölümlerinin ek önerileri olmayan hasta poliklinik kontrol günü belirlenip eksterne edildi.

Sonuç: Psikiyatrik hastalardaki, psikojenik polidipsiye sekonder hiponatreminin yaygınlığı tam olarak bilinmese de çoğunluğunu şizofreni ve anoreksiya nervoza hastaları oluşturmaktadır(1). Sağlıklı bir erişkinin böbrekleri 15 Lt'ye kadar olan su alımlarını diürezis artırarak kompanse edebilir. Su alımı böbreklerin kompanse kapasitesini aştığında hipotonik hiperhidrasyon gelişir. Ekstrasellüler ve intrasellüler kompartmanlar arasında oluşan konsantrasyon farkı özellikle beyin dokusunda ödeme ve beyin hasarına neden olur (2). Dilüsyonel hiponatremi serebral ve visseral ödemin yol açtığı somatik ve psikiyatrik semptomlara özellikle yol açar (3). Hastalarda baş ağrısı, davranış değişiklikleri, kas güçsüzlüğü, seyirme ve kramplar, bulantı, kusma, algi bozuklukları, konfüzyon, sinirli, uykuya meyil ve ölüm görüldü (2). Çoğu şizofreni tanısına sahip olan psikojenik polidipsi vakaları aşırı su alımlarını gizleyebildiklerinden, bu hastalarda polidipsinin tanınması ve yönetimi güçtür(1,4). Bahsedilen bulgu ve semptomlara sahip şizofrenik hastalar polidipsik hiponatremi açısından değerlendirilmelidir (2). Psikojenik polidipsi vakalarında su alımının kısıtlanmasını sağlayan davranışsal yönetim tedavinin temelini oluşturmaktadır (5).

Anahtar Kelimeler: Psikojenik Polidipsi, Hiponatremi, Su İntoksikasyonu

P-0787 Trauma Emergencies

Parmağa sıkışan çelik yüzük nasıl çıkartılır?: Olgu sunumu

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Amaç: Parmakta yüzük sıkışması parmak yaralanmalarının çok az bir kısmını oluşturmaktadır. Parmakta yüzük sıkışması nadir bir durumdur. Genellikle başkasının yüzüğünü hasta kendi parmağına takınca meydana gelir. Bizde bu olguda parmağına yüzük sıkışan bir hastayı sunacağız.

Olgu: Yirmiiki yaşında erkek hasta acil servisimize parmağına yüzük sıkışması ile başvurdu. Öyküsünde arkadaşının başkasının yüzüğünü cafede otururken aniden hastanın parmağına taktığı ve geri çıkaramadığı öğrenildi. Hastanın sağ el 4. parmağında çelik malzemeden imal edilmiş bir yüzük mevcuttu. Parmak yüzüğün distalinden itibaren ödemli ve kızamık idi. Acil serviste



POSTER BİLDİRİLER

sabunla ve jelle kayganlaştırılarak yüzük çıkartma işlemi denendi ama başarılı olunamadı. Yüzük yan keski ile kesilmek istenendi fakat yine başarısızlıkla sonuçlandı. Son olarak demir testeresi ile aşındırılmak istendi ve bu işlemde de başarısız oldu. Hasta yakınının önerisi ile hasta acil servisin yakınında bulunan ağız diş sağlığı merkezine götürüldü. Burada diş hekimlerinin kullandığı aerator ucuna takılan elmas frez ile yüzük karşılıklı iki taraftan sırayla kesilerek parmaktan çıkartıldı. Parmağında dolaşım problemi izlenmeyen hasta önerilerle taburcu edildi.

Sonuç: Parmakta yüzük sıkışması durumlarında bazı durumlarda basit yöntemler işe yarayabilir. Yüzük çelik ise acil servis şartlarında kesilmesi için zaman harcanmamalıdır. Diş hekimlerinin kullandığı aerator ucuna takılan elmas frez iyi bir çözüm yoludur.

Anahtar Kelimeler: Yüzük, çelik, parmak, acil servis

P-0788 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acil serviste invajinasyon saptanan olguda peutz-jeghers sendromu: olgu sunumu

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Amaç: Peutz-Jeghers Sendromu (PJS), otozomal dominant geçişli, kalıtsal bir hastalıktır. Hastaların %90-100'ünde STK11/LKB1 geninde mutasyon olduğu bildirilmiştir. Tipik özelliği gastrointestinal sistemde hamartomatöz polipler ve ciltte pigmentasyonları içermesidir. PJS insidansı yaklaşık olarak 25.000 ila 300.000 doğumda bir görülmektedir. Kliniğinde tekrarlayan karın ağrıları, açıklanamayan bağırsak kanamaları ve bazen de rektumda doku sarkması ile kendini belli eder. Her ne kadar polipler hamartomatöz tipde de olsa bu hastalarda GİS'te malignite gelişme riski artmıştır. Hastalarda poliplere bağlı intususepsiyon önemli bir komplikasyonunu oluşturur. Acil servise karın ağrısı ile gelen erişkin hastada, invajinasyon saptanması ve PJS tanısı alması nedeniyle bu olguyu literatüre kazandırmayı amaçladık.

Olgu: 43 yaşında bayan hasta acil servisimize 2 gündür olan karın ağrısı şikayeti ile başvurdu. Özgeçmişinde özellik yoktu. Fizik bakışında vitalleri stabil, batında yaygın hassasiyet, rebound ve istemli defansı mevcuttu. Rektal tuşesinde normal gayta buluşu mevcuttu. Laboratuvar tetkiklerinde Hb: 10,7 gr/dl, Wbc: 12200 ve CRP: 6,1 mg/l olarak olan hastanın direk grafilerinde belirgin patoloji gözlenmedi. Yapılan sonografik görüntülemesinde, sol üst kadranda jejunal ansların internal herniasyonu, ince barsakta ödem ve herniye barsak ansları mevcuttu ve barsak mezosu etrafında sıvı saptandı. Çekilen batin tomografisinde batin orta hatta yaklaşık 20 cmlik bir segmentte ince barsak anslarının mezenterileri ile birlikte invajine olduğu ve proksimal segmentteki barsak anslarında dilatasyon olduğu görüldü. Hastaya Genel Cerrahi konsültasyonu istendi. Hasta genel cerrahi servisine yatırılıp operasyona alındı. Hastaya segmenter ince barsak rezeksiyonu ve ince barsakta multiple polipler gözlenmesi üzerine polipektomi yapıldı. Hastadan patolojik tanı amaçlı örnekler alındı. Hastanın alınan örneklerinin patolojisinde, Peutz-Jeghers polipleri karakterinde multiple hamartamatöz polipozis saptandı.

Sonuç: Karın ağrısı acil servis başvurularının önemli bir kısmını oluşturur. PJS de poliplere bağlı invajinasyon yapması nedeni ile karın ağrısı nedenleri arasında oldukça nadir yer almaktadır. Karın ağrısına yönelik sebeplerin dışlanması sırasında aile hikayesinin sorgulanması (PJS'nin otozomal dominant kalıtıma sahip olması nedeniyle bu hastalığa sahip kişilerin çocuklarında PJS görülmeye olasılığı %50'dir) ve özellikle oral mukozada (gingiva ve sert damak gibi) hiperpigmente lezyonların varlığının araştırılması PJS ayırıcı tanısı açısından önem taşımaktadır. Her ne kadar nadirde olsa PJS tanısının zor olması ve komplikasyonlarına bağlı cerrahi müdahalenin erken yapılması morbidite ve mortaliteyi azaltmasına katkıda bulunacağından acil servis hekimleri bu hastalığın tanısını akılda tutması önemlidir.

Anahtar Kelimeler: Acil, karın ağrısı, invajinasyon, Peutz-Jeghers sendromu

P-0789 Toxicology

Ülkemizde giderek kullanımı artan yeni bir tehlike: Jamaika

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Amaç: Jamaika, sentetik tetrahidrokanabinol grubuna giren bir uyuşturucu ajandır. Nargile şeklinde kullanımı yaygındır. Hastada terleme, ağız kurulu, halüsinasyon görme ve bilinç bulanıklığı yapabilir. Bu yazıda jamaika kullanımı sonrası bilinç bulanıklığı ile acil servise gelen bir hasta sunulmuş ve ülkemizde giderek yaygınlaşan bu sentetik uyuşturucu şekline dikkat çekilmiştir.

Olgu: Yirmibeş yaşında erkek hasta acil servisimize yakınları tarafından jamaika kullanımı sonrası bulantı, kusma ardından gelişen bilinç bulanıklığı ile getirildi. Hastanın GKS: 7 (E2M3V2) olarak değerlendirildi. Hastanın vital bulguları TA:140/90 mmHg, kalp hızı:115/dk, SS: 20/dk, parmak oksijen saturasyonu:%82 olarak ölçüldü. Hastanın çekilen EKG'sinde sinus taşikardisi dışında özellik saptanmadı. Yerinde akciğer grafisi olağandı. Laboratuvar tetkiklerinde hemogram ve biyokimya değerleri normal sınırlarda idi. Hastanın idrarında THC(+) pozitif saptandı. Hastanın kan gazında pH:7.16 satO2:84 saptandı. Tedavide hastaya öncelikle %100 oksijen başlandı. IV %0.9 izotonik sodyum klorür (NaCl) 500 ml bolus verildi. Anestezi ile konsülte edilen hasta yoğun bakıma (YB) yatış kararı verildi. YB'de yer olmadığı için acil serviste izleme alınan hastanın bir saat içinde bilinci giderek açıldı. GKS'ü 15 oldu. Bir saat daha müşade gözlemlen ve tedavi alan hasta GKS:15, satO2:98 olarak acil servisi izinsiz terk etti.

Sonuç: Sonuç olarak sentetik tetrahidrokanabinol grubuna giren bir uyuşturucu ajan olan Jamaika kullanımı ölümcül sonuçlara neden olabilir. Hastanın adli süreçleri ve komplikasyon gelişmesi açısından konsültasyonların düşünülmesi uygundur. Fakat çoğu olgu %100 oksijen tedavisi ve IV hidrasyonla tedavi edilebilmektedir.

Anahtar Kelimeler: Jamaika, sentetik uyuşturucu, nargile, koma, acil servis

P-0790 Trauma Emergencies

Omurgaya Ateşli Silah Yaralanması Olgusu Sunumu

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Amaç: Ateşli silah yaralanmalarında(ASY) kurşunun giriş-çıkış deliği, izlediği trase, hızı yaralanmayı etkileyen önemli faktörlerdir. ASY etki ettiği bölgeye göre pek çok akut patoloji ve komplikasyonlara neden olabilir. Omurganın ASY'leri izole veya komşu olduğu boyun, göğüs, batin ve pelvis yaralanmaları ile olabilir. Batin yaralanması ile beraber ise profilaktik antibiyotik tedavisi gerekir. Kurşun gibi metalik cisimleri değerlendirmek için en iyi yöntem bilgisayarlı tomografi(BT). Metalik olmayan cisimleri veya nörolojik bozukluğu değerlendirmek için ise en iyi yöntem manyetik rezonans görüntülemidir. Etkilenen organda meydana gelen hasara göre tedavisi cerrahi veya konservatif tedavi olabilir. Nörolojik bozukluğun ilerleyici olduğu durumlarda cerrahi tedavi gerekebilir. Omurganın stabil olduğu durumlarda tedavi semptomatik destek tedavisidir(destekleyici ortezler, analjezik, antibiyotik). Biz bu olguda omurganın ASY'lerinde değerlendirme ve tedavi prensiplerine vurgu yapmak istedik.

Olgu: Acil servise 21 yaşında erkek hasta ASY ile geldi. Genel durumu kötü şuuru kapalı idi. Tansiyon arteriyeli ve nabız alınamıyordu. Monitörde sinüs taşikardisi vardı ve ritim 150 atım/dk idi. Batin orta hatta etrafında barut izi olan 1 cm'lik ASY ile uyumlu giriş deliği mevcut. Çıkış deliği yoktu. Diğer sistem muayenesi doğaldı. Hastaya çift damar yolu açıldı. Saatte 1000 cc hızında sıvı infüzyonuna başlandı. İdrar sondası takıldı. Tam kan, biyokimya, kan grubu tayini yapıldı. Eritrosit süspansiyonu istendi. Antibiyotik başlandı, tetanoz profilaksisi yapıldı. Genel cerrahi konsültasyonu alınarak hasta acil ameliyata alındı. Ameliyatta deodenum ve abdominal aorta yaralanması saptandı. Kurşun bulunamadı. Cerrahi tedavisi yapıldı. Postop ikinci günde vital bulguları sabit olan hastaya abdominal bilgisayarlı tomografi çekildi. L1 seviyesinde spinal kanalda kurşun ile uyumlu opak cisim görüldü. Hastada nörolojik bozulma gelişmediği için omurga yaralanmasına cerrahi tedavi yapılmadı. Onuncu günde nörolojik bozulma gelişmeden taburcu edildi.

Sonuç: Omurgaya ateşli silah yaralanmalarında acil serviste detaylı bir fizik muayene ve vital bulguları korumaya yönelik destek tedavisi yapılmalı, batına nazif ise ameliyata alınmalı. Mermi trasesine göre uygun bölgelerin BT'si çekilir. Nörolojik bozulma olan hastalarda cerrahi müdahale, olmayan hastalarda konservatif tedavi düşünülebilir.

Anahtar Kelimeler: ateşli silah yaralanması, omurga yaralanması, tedavi



POSTER PRESENTATIONS

P-0791 Toxicology

Formaldehit Zehirlenmesi; Tek Seferde İki Zehir mi?

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Amaç: Formalol %37-40'lık formaldehidin distile su ile %10'a sulandırılarak hazırlanan solüsyondur. Dezenfektan olarak ve patoloji preperatlarının saklanması için kullanılır. %37-40'lık formaldehit solüsyonu %9-15 oranında metil alkol içerir. Metil alkol tedavisinin en önemli basamağı metil alkolü formaldehite dönüştüren alkoldehidrogenaz enziminin etil alkol veya fomepizolle bağlanması ve metil alkolün böbrek yoluyla atılması sağlanmasıdır. Formalol solüsyonu metil alkol içerdiği için kılavuz kitaplar formaldehit zehirlenmesine metil alkol zehirlenmesi gibi yaklaşmışlardır. Ancak direk formaldehit alımıyla ve tedavisiyle ilişkili literatürde yeterli veri yoktur.

Olgu: 47 yaşında erkek hasta acil servise yaklaşık 50 cc formalol içimi sonrası başvurdu. Hastada herhangi bir şikayet veya semptom yoktu. Vitalleri normal sınırlardaydı. Yapılan fizik muayenede sağ gözde göz tansiyonuna bağlı görme kaybı mevcuttu. Diğer fizik muayene bulguları normaldi. Hastaya pantaprazol 80 mg IV bolus ve 8 mg/saat idame tedavisi başlandı. Midede formaldehit yoğunluğunu azaltmak için su içirildi. İzotonik sodyum klorürle 250 cc/saat IV hidrasyon başlanan hastaya aynı zamanda %40'lık etil alkolde 2 mg/kg içirildi. Tüm laboratuvar tahilleri normal sınırlarda olan ve asidozu olmayan hasta takip amaçlı yoğun bakım ünitesine yatırıldı. Kan gazı takiplerinde asidoz gelişmeyen hastaya 48 saat sonra endoskopi yapıldı. Endoskopisinde herhangi bir lezyona rastlanmayan hasta önerilerle taburcu edildi.

Sonuç: Formaldehit protein koagülasyon nekrozuna yol açarak tahriş edici etki yaratır. Cilt üstünden, havayoluyla, ağızdan ve intravenöz maruziyet görülür. Öldürücü doz ağız yoluyla %40 formaldehitten 30-60mL, havayoluyla 125mg/m3. İntravenöz 400mg alım sonrası uygun tedaviyle sekelsiz iyileşme görülmüştür. Alımların çoğu vakamızda ki gibi kaza eseri olmaktadır. Özkıymı amaçlı alımlar daha çok sağlık personellerinde görülmektedir. Yayınlanan vakalarda özellikle ağızdan alım sonrası gastrointestinal mukozada tahriş edici etkisi gözlenmiştir. Kan gazında ciddi asidoz, böbrek yetmezliği ve çok yapabilmektedir. 20-50 mL formalin (%25) içimi sonrası ölüm bildirilmiştir. Tedavisinde mide koruyucu tedavi ve hemodiyaliz önerilmektedir. Oral alım sonrası mide tahrişini önlemek için su içirilmesi önerilmektedir. Ayrıca kostik alımlar gibi endoskopide gastrointestinal sistem yan etkileri için ilk 12 saatte yada 48 saat sonra önerilmektedir. Bizim vakamızda 48 saat sonra endoskopi yapılmıştır. Formaldehit ağız yoluyla alımdan sonra kanda hızla formik asite dönüşebilir. Metabolik asidozun bulguları sorumlusu bu metabolitir. Formaldehitin kanda ki ölümcül düzeyi veya hemodiyaliz gerektirecek düzeyi bilinmemektedir. Formaldehit zehirlenmesinde de metanol zehirlenmesinde olduğu gibi asidoz gelişmesi durumunda hemodiyaliz önerilmektedir. Vakamızda seri kan gazı takibinde asidoz gelişmemiştir. Formaldehitin kronik maruziyeti ve uzun dönem etkileri üstünde çalışılmasına rağmen akut zehirlenmelerle ilgili veri azdır. Hızlı ve uygun tedavi hayat kurtarıcıdır. Doğru tedavi stratejilerinin belirlenmesi için ileri araştırmalara ihtiyaç vardır.

Anahtar Kelimeler: Formaldehit zehirlenmesi, Metil Alkol, Formik Asit

P-0792 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Portal ven trombozuna bağlı venöz mezenterik iskemii, barsak perforasyonu; olgu sunumu

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Amaç: Portal ven trombozu (PVT) portal vende trombus oluşumu ile kendini gösteren klinik bir hadisedir. PVT ilerlediğinde eş zamanlı splenik ven ve/veya superior mezenterik ven (SMV) trombozu görülebilir. Mezenter arter trombuslarına kıyasla PVT daha nadirdir, %1 oranında görülür. PVT mezenterik dallara ilerlediğinde, total veya parsiyel tıkanıklığa bağlı olarak barsakta iskemii, enfarkt veya ileus tablosu gelişebilir. Acil servise başvuruların yaklaşık olarak %4-7'sini karın ağrıları oluşturur. Karın ağrıları içerisinde PVT nadir rastlanan ve ayırıcı tanıda göz önünde bulundurulmayan, hayati tehlike arzedeabilen, bu nedenle erken tanı ve tedavi gerektiren acil bir durumdur. Hastalar asemptomatik olabileceği gibi, karın ağrısı, ateş, kusma, gastrointestinal kanama, şişkinlik, diyare ve bulantı gibi nonspesifik belirti ve bulgularla acil servise başvurulabilirler. Semptomlarının başlangıcı ile altmış gün içerisinde saptanan ve herhangi bir portal hipertansiyon bulgusu olmayan vakalar akut PVT olarak kabul edilir. Karın ağrısı ile acil servise başvuran, akut PVT tanısı konan hastada, ince barsak iskemisi sonrası gelişen barsak perforasyonu olgusunu sizlerle paylaşacağız.

Olgu: 33 yaşında erkek hasta, son 24 saat içerisinde başlayan ve ağrı kesiciye yanıt vermeyen karın ağrısı ve eşlik eden bulantı-kusma şikayeti ile acil servise başvurdu. Hastanın vitalleri stabil ve parmak ucu kan şekeri 270 mg/dl ölçüldü. Elektrokardiyogramında normal sinus ritmi mevcuttu, patoloji saptanmadı. Hastanın sağ üst kadranda hassasiyeti ve istemli defansı mevcuttu, rebaundu yoktu, barsak sesleri alınabiliyordu. Hastanın özgeçmişinde Tip 2 diyabeti ve panik atak bozukluğu nedeni ile antidepresan kullanımı öyküsü mevcuttu. Hastanın tam idrar tetkikinde 80 eritrosit/saha ve ketonüri saptandı. Hastanın hemogramında; WBC:11,3 x10⁹/mikroL saptandı. Ayakta direkt batin grafisinde yoğun gaz gölgesi dışında patoloji saptanmadı. Sağ kadranda karın ağrısının şiddetlenmesi üzerine batin ultrasonografisi (USG) yapıldı. USG'de karaciğer etrafında minimal serbest sıvı saptandı, apandiks çapı 7 mm olarak ölçüldü. Genel Cerrahiye akut batin ön tanısı ile konsulte edilen hastaya intravenöz kontrastlı batin tomografisi (BT) çekildi. BT'sinde portal ven ve splenik vende trombus, karaciğer etrafında serbest mayı saptandı. Hastaya diyabetik ketoasidoz ve portal ven trombozu ön tanılarla Dahiliye konsültasyonu istendi. Hastanın Gastroenteroloji kliniğine yatırılıp planlandı. Takiplerinde karın ağrıları çok şiddetlenen hastanın WBC:16,3 x10⁹/mikroL saptandı. Genel Cerrahi rekonsültasyonu istendi. Operasyona alınan hastada ince barsakta nekroz alanı ve perforasyon saptandı, primer onarım yapıldı. Takipinde komplikasyon gelişmeyen hastaya antikoagülün tedavisi başlanarak, poliklinik kontrolü önerisi ile taburcu edildi.

Sonuç: Acil servise karın ağrısı ile başvuran hastalarda, nadir görülen ve hayati tehlike oluşturan PVT her zaman ayırıcı tanıda akıld tutulmalıdır. Ayrıca akut PVT saptanan hastada trombusün dalak ve superior mezenterik vene uzayabileceği ve iskemii, infarkt ve perforasyon gibi komplikasyonlara neden olabileceği unutulmamalıdır.

Anahtar Kelimeler: Acil, pulmoner ven trombozu, akut, komplikasyon

P-0793 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Kulak Ağrısı: Spontan Bilateral Subdural Hematomun Atipik Bir Prezantasyonu

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Amaç: Subdural hematom genellikle ciddi bir kafa travması sonrası gelişen ancak yaşlılarda hafif kafa travması sonrası da ortaya çıkabilen hayati tehdit edici bir durumdur. Köprü venlerde yırtılmaya bağlı duramater ve araknoid mesafede hematoma oluşumu temel patofizyolojisidir. Bu bildiride tedaviye dirençli kulak ağrısı şikayeti ile gelen spontan bilateral subdural hematoma tespit edilen hastayı sunmayı amaçladık.

Olgu: 52 yaşında bayan hastanın bilinen primer meme, primer over ve metastatik akciğer kanseri, atriyal fibrilasyon hikayesi mevcuttu. Hasta atriyal fibrilasyonu için coumadin ve malignitesi için kemoteropatik ilaç kullanıyor. Son kemoteropatik ilacını on gün önce almış. Üç gün önce sol kulak ağrısı şikayeti ile başvurduğu kulak burun boğaz polikliniğinde otitis media tanısıyla antibiyoterapi başlanan hasta şikayetlerinin geçmemesi ve kulak arkasına, boyna yayılması nedeni ile acil servise başvuruyor. Travma hikayesi tariflemeyen hastanın genel durumu iyi, bilinç açık oryante, koopere, glaskow koma skalası 15 idi. Vitalleri stabil olan hastanın fizik muayenesinde sol mastektomi, disritmi dışında patoloji saptanmadı. Bilateral dış kulak yolu ve kulak zarları doğaldı. Kan tahlillerinde beyaz küre: 5,5 /mikroL, hemoglobin: 11,4g/dL platelet:204 bin, INR: 1,19, APTT: 21,7 bulundu. Hastada intrakraniyal kanama ve tümör metastazı düşünüldükten sonra beyin tomografisi çekildi. Tomografisinde solda belirgin bilateral frontopariyotemporal bölgede ekstraaksiyel alanda en geniş yerinde solda 11 mm, sağda 7 mm ye varan beyin parankimine oranla izo-hipodens alan (subakut-kronik subdural hematoma) mevcut olduğu görüldü. Beyin Cerrahisi bölümüne konsülte edilen hasta medikal tedavisi planlanarak servise yatırıldı. Takiplerinde şikâyetleri gerileyen ve tomografilerinde subdural hematoma artmayan hastaya cerrahi planlanmadı. On günlük takip sonrası KİBAS bulguları anlatılarak hasta taburcu edildi.

Sonuç: Sıklıkla tek taraflı olan subdural hematoma, %16 -20 oranında bilateral de görülebilmektedir. Ancak bu hastalar çoğunlukla bilateral subdural hematoma durumu için; koagülasyon bozukluğu, antiplatelet veya antikoagülün ilaç kullanımı, 75 yaş üzeri olmak ve hemodiyaliz hastası olmak gibi risk faktörleri taşırlar. Risk faktörleri olmaksızın spontan bilateral subdural hematoma çok nadir görülür ve atipik klinikte presente olabilirler. Hastamızda her ne kadar risk faktörlerinden coumadin kullanımı bulunuyor olsa da, daha önceki takiplerinde INR değerinin 1,2'nin üzerine hiç çıkmaması olması kanamanın coumadine bağlı geliştiği ihtimalinden bizi uzaklaştırmıştır. Kemoteropötik kullanıyor olması hastada kemik iliğinin baskılayarak kanamaya yatkınlığı arttırması olabileceği düşüncesi ile ilaç aldığı dönemlerdeki kan değerleri incelenmiş ancak hastada kemik iliği supresyonu hiç gelişmemiştir. Travma hikayesinde bulunmayan hastamızda bilateral subdural hematoma spontan geliştiği düşünülmüştür. Risk faktörleri olmaksızın inatçı kulak ağrısı gibi atipik ağrılarla başvuran hastalarda, intrakraniyal kanamalar ayırıcı tanılarda düşünülmelidir.

Anahtar Kelimeler: Kulak, Ağrısı, Bilateral, Subdural, Hematom



POSTER BİLDİRİLER

P-0794 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

İleus ön tanısı ile gelen hastada abdominal aortada trombus: olgu sunumu

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Amaç: Akut karın ağrısı; yedi günden daha az sürede ortaya çıkan, travma dışı nedenlerle oluşan, batin içi ve batin dışı hastalıkların seyrinde meydana gelen, cerrahi veya medikal acil bir olaydır. Karın ağrıları acil servis başvurularının yaklaşık %4-7'sini oluşturmaktadır. Karın ağrısı nedeni ile acil servis başvurularında yatış oranı yaklaşık olarak %20-25 kadardır. %35-40 vakada ise hiçbir neden saptanamayan, kendiliğinden sonlanan karın ağrıları gözlenir. Abdominal aort anevrizma (AAA)'sı; diyafragma altındaki aortanın olağan yapısını kaybetmesi neticesinde damar duvarında oluşan bölgesel zayıflık ve damar çapında 1.5 kat üzerinde anormal genişleme ile kendini belli eden progresif bir damar hastalığıdır. 55 yaş üzerindeki ölüm nedenlerinin %1.5'ini AAA rüptürü oluşturur. Medial elastin tabakasının infrarenal aorta düzeyinde daha az bulunması nedeniyle AAA infrarenal bölgede daha sık görülmektedir (Halloran BG et al.). AAA sürekli büyüyerek neticede rüptür ile sonlanmaktadır. Risk faktörleri arasında koroner arter hastalığı (KAH), hipertansiyon (HT), sigara, diyabetes mellitus, hiperkolesterolemi ve kronik obstrüktif akciğer hastalığı sayılabilir. AAA'nda rüptüre gidış beklenirken, diseksiyon saptanmadan büyük bir trombus saptanması ve AAA'nın suparenal düzeyde görülmesi oldukça ender rastlanan bir durumdur, bu nedenle bu olguyu sizinle paylaşmak istedik.

Olgu: Seksen yaşında erkek hasta, karın ağrısı ve üç gündür olan gaz-gayta çıkaramama nedeniyle dış merkezden acil servisimize ileus ön tanısı ile sevkli olarak getirildi. Hastanın özgeçmişinde HT ve KAH öyküsü mevcuttu. Vital parametreleri stabil olarak ölçüldü. Laboratuvar bulgularında lökositoz, sedimentasyon ve CRP yüksekliği ile hematüri saptandı, çekilen elektrokardiyogramında acil patoloji saptanmadı. Hastada batin alt kadranda belirgin hassasiyet tesbit edildi, rebound, defans saptanmadı. Rektal tuşesinde ampullası boş ve barsak sesleri azalmış olarak saptandı. Çekilen ayakta direkt batin grafisinde belirgin hava-sıvı seviyeleri saptanmadı. Hastanın alt ekstremitelerde distal periferik nabızları bilateral zayıf alındı. Hastaya aort anevrizması, aort diseksiyonu ön tanısı ile intravenöz kontrastlı toraks+abdomen tomografi (BT) çekildi. Hastanın BT'sinde aortada çölyak trunkus düzeyinden itibaren, iliak bifurkasyonun hemen proksimalinde 45 mm'ye ulaşan anevrizmatik görünüm tesbit edildi. Bu düzeyde en kalın olduğu yerde yaklaşık 20 mm'ye ulaşan ve 10 cm lik segment boyunca devam eden trombus hattı saptandı. Bu hattın sağ ana iliak proksimalinde 18 mm ve sol ana iliak arter proksimalinde 14 mm kalınlığa ulaşır şekilde devam ettiği gözlemlendi. Hastaya Kalp Damar Cerrahisi konsültasyonu istendi ve hasta medikal tedavi ve takip amaçlı interne edildi.

Sonuç: Acil servise karın ağrısı şikayeti ile gelen hastalarda nadir görülmesine rağmen, mortalitesi çok yüksek olan AAA hatırla tutulmalıdır. Alt ekstremitelerde nabızlarının zayıf palpe edilmesi veya alınmaması gibi durumlarda diseksiyon ön tanısının yanısıra, abdominal aortada trombus mevcudiyeti, acil hekimleri tarafından göz önünde bulundurulmalıdır.

Anahtar Kelimeler: Acil, Abdominal aort anevrizması, trombus

P-0795 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Mekanik bağırsak obstrüksiyonu: Atipik formda bir olgu örneği

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Amaç: Mekanik bağırsak obstrüksiyonunda, bağırsağın herhangi bir bölgesi fiziksel olarak tıkanmış ve içerik tıkanmanın olduğu bölgeden daha aşağıya inemez hale gelmiştir. Bu tıkanma çeşidi sıklıkla bağırsağın kendi etrafında dönmesi olarak tanımlanan volvulusa bağlı olarak veya fıtıklaşma sonucu meydana gelir. Olgumuzda atipik formda bir mekanik bağırsak obstrüksiyonu örneği sunmayı amaçladık.

Olgu: Ani gelişen bilinç bulanıklığı, ve sol yan güçsüzlüğü şikayetleriyle acil servisimize yönlendirilen 78 yaşında erkek hasta yakın izleme alındı. Yakınlarından alınan anamneze göre KOAH ve paroksizmal AF tanıları olan hastanın uzun süredir tedavisini aksattığı öğrenildi. Bilinç bulanıklığı ve tekrarlayan bulantı kusması olan hasta gerekli tanısal görüntülemeler öncesi havayolu güvenliğini sağlama amacıyla entübe edildi. Yapılan görüntülemeleri sonrasında hasta sağ MCA infarktı teşisiyle nöroloji yoğun bakımına alındı.

Takibinin üçüncü gününde, karında yaygın distansiyonu olan ve gaita deşarjı gözlenmeyen hastanın, çekilen direkt grafi ve batin tomografisinde distal ileum seviyesinde obstrüksiyon olduğu görüldü. Ayrıca aynı seviyede metalik refle veren ve obstrüksiyon sebebi olabilecek yabancı cisim görüntüsü de gözlemlendi. Cerrahi müdahale ile çıkartılan yabancı cismin hastaya ait diş protezi parçası olduğu görüldü. Hasta takibinin onikinci gününde sepsis ve buna bağlı çoklu organ yetmezliği sebebiyle kaybedildi.

Sonuç: Yabancı cisimlere bağlı mekanik bağırsak obstrüksiyonu sık olmasa da klinikte karşılaştığımız bir durumdur. Özellikle acil şartlarda yapılan endotrakeal entübasyonlardan önce, ağız içerisinde yabancı cisimler açısından titizlikle kontrol edilmesi ve diş protezi gibi ağız içerisinde mobil olabilen implantların çıkartılması hayati öneme sahiptir

Anahtar Kelimeler: Mekanik bağırsak obstrüksiyonu, yabancı cisim, diş protezi

P-0796 Trauma Emergencies

Penetran Kafa Travması ve İnme: Olgu Sunumu

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Giriş: İnme genel olarak beyne giden kan akımının kesintiye uğraması sonucu oluşan acil bir durumdur. Çocukluk yaş grubunda nadiren travma sonrasında da ortaya çıkabilir. Gelişebilen ödem ve kitle etkisi nedeni ile daha fazla nöron hasarı ortaya çıkabilir. Kafa travması sonrası 12. günde üst ekstremitelerde motor defisiti saptanan bir inme olgusu sunuluyoruz.

Olgu: Altı aylık erkek hasta sağ kolunu hareket ettirememeye ve oynatamama nedeniyle yakınları tarafından getirildi. Anamnez hastanın annesinden alındı. Son iki ayda aynı durumda iki kez karıştıkları, dirsek çıkığı dendiği ve redüksiyonla yerine getirildiği öğrenildi. Fizik muayenede hastanın genel durumu iyi, şuur açık ancak huzursuz olduğu gözlemlendi. Hastanın sağ kolunu kendi kendine hareket ettiremediği ve hareket ettirildiğinde de huzursuzluğunun arttığı saptandı. Hastadan olası bir radius başı çıkığı ekarte etmek için istenen iki yönlü dirsek grafisinde dirsek ekleminde herhangi bir anormallik saptanmadı. Bunun üzerine anamnez derinleştirildiğinde hastanın 12 gün önce kafasına saplanan bir çivi nedeni ile hastaneye yattığı, intraserebral kanama tespit edildiği, iki gün yoğun bakım ünitesinde ardından beş gün ise Beyin Cerrahi servisinde takip edildikten sonra şifa ile taburcu edildiği öğrenildi. Hastanın taburculuk sonrası beşinci günde Acil Servisimize başvurduğu öğrenildi. Koldaki hareketsizlik nedeni ile yapılan kuvvet kaybı muayenesinde sağ üst ekstremitelerde 2/5 oranında kuvvet kaybı saptandı. Sağ alt ekstremitelerde ve sol tarafta ise kuvvet kaybı yoktu. Kuvvet kaybı dışında ek nörolojik defisit ise saptanmadı. İstenen beyin BT'de sol sentrum semiovalde yaklaşık iki santimetre çapında hematoma alanı ve çevresinde ödem tespit edildi. Hasta travma alanında ortaya çıkan ödemle ilgili inme ön tanısı ile pediatrik nöroloji tarafından hospitalize edildi ve düzenlenen antiödem tedavisi sonrasında da şifa ile taburcu edildi.

Sonuç: İki yaş altında iskemik serebrovasküler hastalıklar sık görülmektedir. Travma sonrası iskemik inme ise nadirdir. Sunulan olguda olduğu gibi inme semptomları travma anında değil travmadan günler sonra da ortaya çıkabilir. Bu açıdan acil hekimleri dikkatli olmalıdır.

Anahtar Kelimeler: çocuk, inme, acil, anamnez

P-0797 Toxicology

Karbonmonoksit Zehirlenmesi: Olgu Sunumu

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Amaç: Karbonmonoksit zehirlenmesi sık görülen zehirlenmeler arasında yer alır. Gribal enfeksiyon benzeri hafif belirtilerden etkilenen organa özgü uç organ hasarlarına işaret eden değişken bir klinik ile de karşımıza gelebilir. Bu yazıda karbonmonoksit zehirlenmesi sonrası kardiyak ve nörolojik etkilenimi olan bir hasta sunularak konuya dikkat çekilmek istendi.

Olgu: 71 yaşında bayan hasta bilinç bulanıklığı ve bayılma şikayetiyle 112 il ambulans servisi ile hastanemize getirildi. Hasta ile ilgili anamnez hasta yakınlarından alındı. Hastanın tek başına ve sobalı bir evde yaşadığı öğrenildi. Hasta ile bir gün öncesi telefon ile görüşen yakınlarının hastadan yaklaşık olarak 12 saat haber alamaması nedeni ile 112'yi aradıkları ve hastayı evde yerde baygın bir şekilde yataktan buldukları ve içeride yoğun bir duman ve is kokusunun olduğu belirtildi. Hastanın genel durumu orta, konfüze vaziyette ve kooperasyon ve oryantasyonu yoktu. Vital bulgularında; TA: 110/70 mmHg, Nb: 122/dk, Ateş: 36,1°C, SS: 20/dk ve SaO2: 96 (%100 oksijen ile) olarak ölçüldü. Hastanın nörolojik muayenesinde pupiller izokorik, IR+/+, spontan göz hareketlerinin olduğu, fasial asimetrisinin olmadığı ve sözel uyarılara yanıt verdiği saptandı. Lateralize motor defisit ise saptanmadı. Kardiyak muayenesinde ise S2'nin sert ve taşikardisin olduğu belirtildi. Diğer sistem muayeneleri ise normal olarak değerlendirildi. Hastaya karbonmonoksit zehirlenmesi ön tanısı ile rezervuarlı maske ile oksijen başlandı. EKG'de sinüs



POSTER PRESENTATIONS

taşikardisi ve V5-V6'da T dalga negatifliği saptandı. Kan gazında pO₂: 85,9 (83-108), pCO₂: 31,4 (35-48), pH: 7,47 (7,350-7,450), COHb: 11,6 (0,5-1,5), cHCO₃: 24,9 (22-26) tespit edildi. Hastanın biyokimyasal tetkiklerinde ise Troponin I: 1,028 (0,00-0,13), Miyogloblin: >1200 (0-106), LDH: 394 (135-214), CK: 5595 (0-180) ve CK-MB: 200 (0-25) yükselmiş olarak bulundu. Hastanın bilinç durumu sebebiyle istenen bilgisayarlı beyin tomografisinde sol PCA alanında geniş subakut enfarkt alanı saptandı. Hasta anestezi, kardiyo-ve nöroloji bölümlerince konsülte edildikten sonra karbonmonoksit zehirlenmesine bağlı uç organ hasarlanmaları ön tanıları ile hiperbarik oksijen tedavisi planlanarak ileri bir merkeze sevk edildi.

Sonuç: Karbonmonoksit zehirlenmesi nedeni ile başvuran hastalarda başta kalp ve nörolojik sistem olmak üzere uç organ hasarlanmaları açısından klinisyen dikkatli olmalı ve gerektiğinde ileri tanısal testleri kullanmaktan kaçınmalıdır.

Anahtar Kelimeler: karbonmonoksit zehirlenmesi, inme, acil

P-0798 Trauma Emergencies

Künt Batın Travması Sonrası Lateral Abdominal Herni: Olgu Sunumu

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Amaç: Erişkinlerde künt karın travmaları nadirde olsa travmatik abdominal duvar hernisine neden olabilir. Tanısı zordur ve kolaylıkla gözden kaçırılabilir. Tanı ve tedavide gecikme ciddi mortalite ve morbidite sebebi olabilir. Bu yazıda künt batın travması sonrası lateral abdominal herni gelişen nadir bir olgu sunulmuştur.

Olgu: Acil servisimize yüksekten düşme sonrası getirilen 82 yaş erkek hasta resüsitasyon odasına alındı. Hastanın bilinci açık, koopere-oryante ve GKS:14 (E3M6V5) idi. Vitallerinin TA:109/66 mmHg, Nb:92/dk ve puls oksimetre %81 olarak saptandı. Hasta yakınlarından alınan anamnezde hastanın 6-7 basamak merdivenden yuvarlanarak düştüğü öğrenildi. Hastada post-travmatik amnezi vardı.

Fizik muayenede; her iki göz çevresinin ve burun kökünün ödemli olduğu, sol gözde görme kaybı olduğu, dilde ve ağız içinde kesilerin olduğu, batın sağ yan duvarda yaklaşık 20x20 cm'lik herni ve ekimoz olduğu görüldü. Hastaya oksijen tedavisi ve sıvı resusitasyonu başlandı. Kan grubu, hemogram ve biyokimya tetkikleri yapıldı. Yatak başı ultrason ile FAST yapıldı. Hasta stabilize edildikten sonra tomografiye alındı. Beyin ve maksillofasiyal BT'de her iki frontal lobta, sağda daha belirgin hiperdens kontüzyon alanları, her iki maksiller sinüste, nazal kemik ve septumda, etmoid sellülerde yaygın hemoraji ve fraktür hatları saptandı. Sol sfenoid ve zigomatik kemikte fraktür, sol gözde perforasyon görüldü. Her iki hemitoraksta sağda daha belirgin çok sayıda kot fraktürü ve hemotoraks saptandı. Karaciğer 7. segmentte laserasyon lehine hipodens alan, sağda retroperitoneal alanda, karaciğer anteriorında ve hepatik fleksura komşuluğunda milimetrik hava dansiteleri ve duodenum 2.kısım komşuluğunda perforasyon lehine kirlenme ve fokal sıvı görünümü saptandı. Batın sağ kadranda 9 cm'lik anterior kas ve fasya defektinden ince barsak ve omental yağlı dokunun herniye olduğu görüldü.

Hastaya acil serviste tüp torakostomi uygulandı. Hastanın kontrol hemoglobin değerinin 12,2 g/dL'den 9,6 g/dL'ye düştüğü görüldü. Sonrasında Genel Cerrahi tarafından acil operasyona alındı. İntraoperatif kolonik ve ince barsak perforasyon anamirleri yapıldı. Sağ lateraldeki kırık kot ucunun kesisine bağlı karaciğer laserasyonu ve sol diyafragmatik yüzdeki rüptür, diyafram defektiyle beraber onarıldı, kotun keskin ucu düzeltildi. Dalak hilusunda minimal sızıntı ve pankreas anteriorunda venöz kanama saptandı, sütürasyonla onarım yapıldı. Sonrasında da sol göz perforasyonu ve intraoperatif saptanan sağ göz kesisi onarıldı. Hasta Anestezi Yoğun Bakım Ünitesine alındı, hipotansif seyreden hasta yaklaşık 2 saat sonra eks oldu.

Sonuç: Literatüre bakıldığında künt batın travması sonrası lateral abdominal hernisi nadir görülen bir durumdur. Ayrıca, sunulan hastada görülen bulgular ve mortalite travma hastalarında travmanın mekanizmasının iyi sorgulanması gerektiğine, erken tanı ve tedavinin önemine dikkat çekmektedir.

Anahtar Kelimeler: Künt Batın, Travma, Abdominal Herni, Acil servis

P-0799 Trauma Emergencies

Acil Serviste Bilateral İntrakranial Hemoraji Tanısı

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Amaç: İntrasebral hemorajiler, yüksek mortalite ve morbidite riski taşıyan, semptomların hızı ilerlediği bir klinik tablodur. Antikoagülan ve trombolitik tedavi riski artırır.

Olgu: Acil servisimize bilinç değişikliği ve kusma yakınmasıyla getirilen 63 yaşındaki erkek hasta monitörlü gözlem odasına alındı. Hastanın yakınlarından alınan anamnezde, bugün sabah Kalp-Damar Cerrahisi servisinde taburcu olduğu, çıkarken ve evde birkaç kez tekrarlayan unutkanlık ve nerede olduğunu bilememe, sonrasında da bir kez kusması olduğu, travma öyküsünün olmadığı öğrenildi. Hastanın daha önce demans ve anksiyete bozukluğu tanıları olduğu ve buna yönelik medikal tedavi aldığı, kusma hariç diğer yakınmalarının daha önce de ara ara görüldüğü öğrenildi. Hastanın bilinci açık, GKS:15 ve vital bulguları stabildi. Fakat sorulan sorulara geç cevap veriyordu. Nörolojik muayenede lateralizan defisit ve patolojik refleks saptanmadı. Hastanın hastaneye yatış nedeninin sol bacakta derin ven trombozu olduğu, buna yönelik 3 gün önce cerrahi geçirdiği, vena cava inferiora filtre konduğu, sol alt ekstremitedeki trombozun temizlendiği ve antikoagülan-trombolitik tedavi uygulandığı görüldü. INR değerinin 1,17 olarak saptandı. Acil serviste çekilen beyin tomografisinde; sağ temporal lobta 5x3 cm, sol temporal lobta 2x2,5 cm intraparaklimal hemoraji ve çevresinde ödem alanları görüldü. Bunun üzerine hasta Beyin Cerrahisi Yoğun Bakım Ünitesine yatırıldı.

Sonuç: Hastanın kliniğinin, görüntüleme yönteminde görülen kanama ile kıyaslandığında beklenenden iyi olması, hastanın geçmiş nörolojik ve psikiyatrik yakınmalarının benzer olması nedeniyle bu tür olguların yoğun acil servislere rahatlıkla atlanabileceğini düşünüyoruz.

Anahtar Kelimeler: Beyin, intrakranial Hemoraji, klinik, BT, acil servis

P-0800 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Nadir Bir Akut Batın Nedeni: Mezenterik Kist Torsiyonu

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Amaç: Bu makale de karın ağrısı nedeniyle dış merkezden acil servisimize başvuran 74 yaşındaki bir hasta tartışılmıştır

Mezenterik kistler yetişkinlerde nadir olup 1/100 000 oranında görülmektedir (1,2). Nadir olmasına rağmen kanama, enfeksiyon, torsiyon, rüptür, intestinal obstrüksiyon gibi komplikasyonlara neden olarak yaşamı tehdit edici akut batın tablosuna yol açabilirler. Mezenterik kistlerin sebepleri tam olarak bilinmemekle birlikte lenf kanalı obstrüksiyonu, lenf nodu dejenerasyonu, lenf kanallarının yaralanması ve mezenter yapraklarının birleşim hatlarından kaynaklandığı düşünülmektedir. Etiyolojide konjenital hastalıklar, divertikül, pelvik bölge cerrahisi ve inflamatuvar barsak hastalıkları suçlanmaktadır. (1,2,3). Yerleşim yerleri en sık olmak üzere ileum ve jejunumdur (%80). Daha az sıklıkla da transvers kolon ve kolonun diğer kısımlarında görülmüştür (4). Bu tümörler genellikle benign karakterlidirler. Malign dejenerasyonları nadirdir. Boyutları genellikle 5-30 cm arasında değişir. Kistlerin içeriği seröz, şilöz veya hemorajik olabilir.

Olgu: 74 yaşındaki kadın hasta acil servisimize bulantı, kusma, karın ağrısı, karın şişkinliği şikayetleriyle başvurdu. Hasta yaklaşık 6 aydır giderek büyüyen karın şişkinliği tarifliyordu. Özgeçmiş ve soygeçmişinde özellik yoktu. Biyokimyasal ve hematolojik parametreleri normaldi. Fizik muayenede batın sağ tarafta göbekten pelvise kadar kitle imajı veren asimetrik görünüm vardı. Barsak sesleri azalmıştı. Palpasyonda sağ alt kadranda kitle palpe edildi. Batında yaygın defans ve rebound vardı. Karaciğer ve dalak palpe edilemedi. Hastanın yapılan rutin tetkiklerinde anormal bulgu tespit edilmedi. Ayakta direk batın grafisinde barsaklarda yoğun gaz görünümü mevcut olup, hava-sıvı seviyesi mevcut değildi. Bilgisayarlı tomografi de pelvik bölgede 108x55 mm boyutlarında kalın septasyonlu kistik lezyon izlendi (resim:1). Bu lezyonun inferior lateral komşuluğunda multiloküle birbirlerine açılımları olan ikinci bir lezyon izleniyordu. Kistik lezyon duvarında 17x16 mm sboyutlarında solid bir kitle vardı. Batın içindeki diğer abdominal organlarda herhangi bir patoloji tespit edilmedi. Batında serbest sıvı yoktu. Hasta gerekli hazırlıklardan sonra operasyona alındı. Batında umbilikustan pelvise kadar uzanan yer yer nekroze içi şilöz karakterde kistik kitlesel lezyon vardı. Kitlenin ilüem mezosunda köken aldığı ve beslendiği pedikül etrafında torsiyona olduğu görüldü. Mezenterik kist komşu organlara zarar verilmeden total olarak eksize edildi. Post operatif dönemde komplikasyon gelişmeyen hasta postop 2. günde taburcu edildi.

Sonuç: Mezenterik kistler kullanılan görüntüleme yöntemleri sonucu ya tesadüfen veya mezenterik kistlerin bazı durumlarda enfeksiyon, kanama, volvulus, perforasyon, bağırsak tıkanıklığı gibi ölümcül komplikasyonlara yol açtıklarında tespit edilmektedirler. Bu nedenle mezenterik kistler tesadüfende olsa tespit edildiklerinde rezeksiyon düşünülmelidir.

Bu çalışmada akut batın ile karşı karşı geldiğimizde mezenter kistlerini ve komplikasyonlarını literatürte eşliğinde tekrar hatırlatmak istedik.

Anahtar Kelimeler: mezenter kisti, karın ağrısı, karın şişkinliği, akut batın



POSTER BİLDİRİLER

P-0801 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Boyunda ateşli silah yaralanması: bir vaka sunumu

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Amaç: Ateşli silah yaralanmaları, acil servise başvurularda sık karşılaşılan yaralanmalardan biri olup özellikle baş ve boyun bölgesinde meydana gelirse önemli derecede morbidite ve mortaliteye yol açabilmektedir. Boyun bölgesindeki penetran yaralanmaların %80-90'ı ateşli silahlar ile gerçekleşmektedir. Boyun yaralanmaları sonrasında en sık ölüm sebebi vasküler yapıların zarar görmesi olsa da merminin izlediği yol nedeniyle farklı karakterlerde klinik tablolar oluşabilmektedir. Bu olguda, merminin düzensiz bir seyir göstererek boynun sağ ve sol taraflarında karotis kılıfı içindeki nöro-vasküler yapılara zarar vermeyen bir ateşli silah yaralanması vakası sunulmuştur.

Olgu: 44 yaşında kadın hasta, boyun bölgesindeki ateşli silah yaralanması nedeniyle dış merkezden sevkli olarak acil servisimize getirilmiş ve yapılan fizik muayenede vital bulgularının normal olduğu, kan tetkiklerinde hematokrit değerlerinin normal sınırlarda olduğu ve istenen bilgisayarlı tomografi (BT) tetkiklerinde herhangi bir damar ve major organ yaralanması olmadığı belirlenmiştir. Hastanın BT'sinde kurşunun, servikal dördüncü omur seviyesinde boynun sağ tarafından girerek karotis kılıfı içindeki nöro-vasküler yapıların önünden geçtiği, daha sonra retrofaringeal aralıktan ilerleyerek karşı tarafa geçtiği ve sol tarafta ise karotis kılıfı içindeki yapıların arkasından geçerek m. sternocleidomastoideus'un posterolateralinde sessiz bir şekilde kaldığı ve bu nedenle herhangi bir çıkış deliği oluşturmadığı gözlenmiştir. Boynun sol tarafındaki kurşunun çıkarılması ve boynun explore edilmesi amacıyla hasta ameliyata alınmış ve merminin dikkatlice çıkarılması sağlandıktan sonra operasyona komplikasyonsuz olarak son verilmiştir. Postoperatif dönemde problemi olmadığı gözlenen hasta taburcu edilmiştir.

Sonuç: Boyun bölgesini içeren ateşli silah yaralanmalarında, yara balistisinin ve bölge anatomisinin bilinmesi büyük önem taşımaktadır. Silahların yaralama gücü, merminin çarpma sırasındaki kinetik enerjisi ve bu enerjinin dokulardaki yayılımıyla ilişkilidir. Yüksek hızlı silahlar, daha fazla kinetik enerjiye sahiptir fakat düşük hızlı silahların da yakın mesafe atışlar sırasında hızlı silahlar kadar kinetik enerji üretebildiği bilinmektedir. Mermiler, dokuya girdikten sonra sadece geçiş yolu üzerindeki yapılarda değil, çevre dokularda da hasar oluşturabilmektedir. Bu durum, yüksek hızlı mermilerde daha fazla gözlenmekte ve uzaktaki dokuları hasarlayabilmektedir. Yüksek hızlılardan farklı olarak yavaş hızlı mermilerde, geçiş seyri düzensiz ve değişken olmaktadır. Olgumuzda, mermi, boynun sağ tarafından girdikten sonra görece olarak düzensiz bir seyir göstermiş ve m. sternocleidomastoideus'un arka-dış tarafında kalmıştır. Merminin bu seyri göz önünde bulundurulduğunda, olgumuzun yavaş hızlı ve düşük kinetik enerjili bir ateşli silah yaralanması olduğu düşünülmektedir. Olgumuzda da görüldüğü şekilde ateşli silah yaralanmalarında, merminin taşıdığı kinetik enerji mortalite ve morbidite açısından büyük önem taşımaktadır.

Anahtar Kelimeler: ateşli silah yaralanması, komplikasyonsuz, acil servis

P-0802 Trauma Emergencies

Tekrarlayan Glenohumeral Eklem Çıkığında Hill-Sachs Lezyonu

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Amaç: Glenohumeral eklem çıkıkları majör eklem çıkıklarının %50 sini oluşturmaktadır. Literatüre bakıldığında çıkıklar %95-97 sıklıkla en az korunaklı bölge olan anteriora, % 2-4 oranında posteriora, %0,5 oranında ise inferiora olduğu görülmektedir. Glenohumeral eklem çıkıklarında glenoidin ön dudaklarının humerus başında oluşturduğu kortikal çökme kırığına Hill-Sachs lezyonu adı verilir. Tekrarlayan çıkıklarla birlikte Hill-Sachs lezyonunun görülme sıklığı giderek artar. Hill-Sachs lezyonu varlığını göstermede radyografinin tanı değeri %60 larda iken USG, MRI gibi ileri görüntüleme teknikleri ile % 90'ın üzerinde tanı konulabilmektedir.

Olgu: Sağ omuzda ağrı ve hareket kısıtlılığı şikayeti ile acil servisimize başvuran 60 yaşında bayan hastanın anamnezinde ciddi bir travma öyküsü olmadığı ve tekrarlayan omuz çıkıkları olduğu öğrenildi. Hastanın fizik muayenesinde sağ humerusunda ağrı ve hareket kısıtlılığı mevcuttu. Radyografik incelemesinde sağ humerus başının anterior ve inferiora çıkığı tespit edildi. Çıkığı Modifiye Hipokrat tekniği ile redukte edilmeye çalışıldı ancak hastanın aşırı hassasiyeti nedeni ile reduksiyon gerçekleştirilemedi. BT incelemede humerus başındaki Hill-Sachs lezyonu içerisinde glenoidin anterior dudaklarının oturtulduğu görüldü. Hastanın çıkığı iv sedasyon analjezi uygulanarak simpson tekniği ile yaklaşık 30 dk sonra redukte edildi.

Sonuç: Tekrarlayan nontravmatik çıkıklarda Hill-Sachs lezyonu varlığı düşünülmektedir radyografinin yanı sıra USG, MRI, BT gibi ileri görüntüleme tekniklerinde göz önünde bulundurulmalıdır.

Anahtar Kelimeler: Hill- Sachs, glenohumeral eklem çıkığı, reduksiyon

P-0803 Toxicology

Metanol Ve Etanolün Birlikte Alımı İle Geciken Semptomlar

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Amaç: Metanol endüstride, karbonmonoksit ile hidrojenin reaksiyonundan elde edilen şiddetli intoksikasyon ve ölüme sebep olabilen bir alkol çeşididir. Zehirlenmeler daha çok metanolün metabolit olan formik asit tarafından oluşturulmaktadır. İntoksikasyon durumunda metabolik asidoz, körlük, kardiyovasküler etkiler ve ölüm olası sonuçlardır. Yaralanma ömrü hafif zehirlenmelerde 14-20 saat, şiddetli zehirlenmelerden sonra ise 24-30 saatir. Tedavide fomepizol, etanol ve hemodiyaliz uygulaması esastır. Çalışmamızda metabolik asidozla gelen öyküsünde aynı gün içinde alkol alımı olmayan bir intoksikasyon vakası sunuldu.

Olgu: Solunum sıkıntısı, çarpıntı ve bulantı ile acil servisimize başvuran 43 yaşındaki erkek hastanın fizik muayenesinde TA:130-80 mm/Hg, nabız:110/dk, SAT:97%, solunum sayısı:26/dk, bilinç bulanıklığı mevcut idi. Hastanın özgeçmişinde 30 yıldır alkol aldığı ve ara ara antidepresan kullanıldığı öğrenildi. Hastanın öyküsünde son 24 saatte 1 adet bira dışında alkol alım öyküsü yoktu. EKG'sinde sinüs taşikardisi mevcut olan hastanın kan gazında AKG: pH:7,2, pCO2:15,2mmHg, pO2:57,2mmHg, HCO3:5,7mmol/l, lac:15mmol/l, sO2:78,3% idi. Acil laboratuvar tetkiklerinde: AST:89u/l, kreatinin:1,35mg/dl, troponinT:216pg/ml, CKMB:14ng/ml, etanol:21mg/dl, Na:124mmol/l, cl:85mmol/l olarak tespit edildi. Hastanın etanol seviyesinin çok yüksek olmaması ve açıklanamayan metabolik asidozu olması nedeniyle metanol intoksikasyonu olabileceği düşünüldü. Hastanın öyküsü derinleştirildiğinde 2-3 gün önce alkol içeren içeceklerden karıştırarak içtiği öğrenildi. Hastaya iv %0,9NaCl ve sodyumbikarbonat infüzyonu (1-2meq/kg) başlanarak acil hemodiyalize alındı. Fomepizol hastanemizde bulunmadığı için hataya hemodiyaliz esnasında ve sonrasında etanol seviyesi kontrol edilerek nazogastrik sondadan etanol verildi. Kliniği ve laboratuvar bulguları düzelen hasta takibinin 4. günü taburcu edildi.

Sonuç: Hastamızda metanol ile beraber etanolde alımı ile metanolün metabolize olması baskılanarak semptomların ortaya çıkması gecikmiştir. Bu durum ilk etapta öyküde yakın zamanda alkol alım öyküsü olmaması ile gözden kaçabilecek bir durumdur. Açıklanamayan metabolik asidozlarla öykü derinleştirilmeli ve metanol ve etanolün birlikte alımı ile zehirlenme bulgularının geç ortaya çıkabileceği hatırlanmalıdır.

Anahtar Kelimeler: metanol intoksikasyonu, geciken semptomlar, acil servis



POSTER PRESENTATIONS

P-0804 Trauma Emergencies

Servikal Disk Protezinin Anterior Dislokasyonu: Olgu Sunumu

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Amaç: Servikal disk hernileri, 30-45 yaş arası erkeklerde daha sık görülen ve tüm disk hernileri içinde ikinci sırada yer alan diskopatilerdir. Hastalığın klinik belirtileri herniasyonun yerine, hastalığın süresine ve ciddiyetine göre değişiklik gösterir. Klinik olarak boyun ağrısı, radikülopati ve myelopati şeklinde bulgular verebilir. Servikal disk hernileri sıklıkla torakal vertebraların hemen üstünde yer alan C5-C7 vertebraları arasındaki disklerde ortaya çıkar. Günümüzde anterior diskektomi ve füzyon ameliyatı, servikal disk hernilerinin cerrahi tedavisinde en sık kullanılan yöntemlerdir. Fakat bu ameliyatlarda disk çıkarıldıktan sonra diske komşu olan bir üst ve bir alttaki servikal vertebraların hareketlerinde kısıtlılık gelişmekte ve bu nedenle yeni bir yaklaşım olarak diskektomi sonrasında vertebralar arasına servikal protez konularak ilgili vertebraların hareketlerine devam etmesine olanak sağlanmaktadır. Bu olguda, servikal disk hernisinin tedavisi için diskektomi ve servikal protez operasyonu geçiren bir bayan hastada, ameliyattan 25 gün sonra motorsikletten düşme sonucu servikal protezin yerinden çıktığı ve öne doğru dislokasyon gösterdiği bir boyun travması, travma, boğaz ağrısı.

Olgu: Boyun ağrısı ve kolun dış kısmına doğru uzanım gösteren ağrı şikayetiyle Devlet Hastanesine başvuran 32 yaşındaki kadın hastada, çekilen MR sonrası C5-C6 seviyesinde disk herniasyonu saptanmış ve cerrahi tedavi planlanarak diskektomi ve servikal protez operasyonu uygulanmıştır. Postoperatif dönemde problemi olmadığı gözlenen hasta taburcu edilmiştir. Taburcu olduktan 25 gün sonra boyun ve kollara doğru uzanan ağrısının tekrarlaması nedeniyle acil servise başvuran hastanın ciddi olmayan travma öyküsü sonrası ağrılarının başladığı öğrenildi. Hastanın boğaz ağrısı ve yutma güçlüğü şikayetleri de mevcuttu. Çekilen servikal direkt grafilerinde beşinci ile altıncı servikal vertebralar arasına konan servikal protezin öne doğru dislokasyon gösterdiği belirlenmiştir. Servikal protezin yer değiştirmesine bağlı olarak intervertebral mesafenin azaldığı ve bunun neticesinde C6 spinal sinir köklerine baskı yaparak şikayetlerinin ortaya çıktığı anlaşılmıştır. Hasta tekrar preoperatif hazırlıkları yapılarak eski servikal protez yerinden çıkarılmış ve tekrar yeni protez uygulanmıştır. Operasyon sonrası sinir basısına bağlı şikayetlerin geçtiği görülmüştür.

Sonuç: Servikal herniasyonun cerrahi tedavisi için yapılan diskektomi ve füzyon ameliyatları sonrası %10 oranında komplikasyon geliştiği bildirilmiştir. Füzyon ameliyatları sonrası komplikasyon oranını yüksek olması nedeniyle diskektominin ardından kafes (cage) ve protez takılması önerilmekte fakat bu operasyonlar sonrasında da daha az olarak komplikasyon geliştiği bildirilmektedir. Kullanılan protezin santral veya laterale dislokasyonuna sonucu spinal sinir köklerine veya medulla spinalise baskıya bağlı nörolojik bulgular ortaya çıkabilmekte iken öne doğru olan dislokasyonlarında farinks, özofagus ve trakea basısı neticesinde boğaz ağrısı ve yutma güçlüğü gibi semptomlar ortaya çıkabilmektedir. Boğaz ağrısı, yutma güçlüğü ve spinal sinir köklerine baskı bulgularıyla acil servise gelen ve operasyon öyküsü olan hastaların servikal protez veya cage'lerin yerinde olup olmadığı değerlendirilmelidir.

Anahtar Kelimeler: Servikal protez, travma, boğaz ağrısı

P-0805 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

apendiksin karsinoid tümörü:olgu sunumu

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Amaç: Karsinoid tümörler endodermiden gelişen bütün organlarda lokalize olabilen nöral krest hücrelerinden kaynaklanan nadir görülen tümörlerdir..prevalansı yüzbin kişide birdir.Tüm malignitelerini %0,05 ini oluştururlar. Gastrointestinal sistemde en sık yerleşim yeri apendikstir.Karsinoid tümörler urogenital trakt ve bronşlar gibi gastrointestinal sistem dışında da yerleşim gösterebilmektedirler.Karsinoid tümörler ilk kez Luborsch (1888) tarafından tanımlanmıştır.Bu olgu sunumunda Akut batın tanısıyla diagnostik laparoskopi yapılan ve apandisit saptanıp apendektomi uygulanan hastanın patolojik incelemesinde karsinoid tm tanısı konulan kırkbeş yaşındaki hasta sunulmuştur.

Olgu: Kırkbeş yaşındaki erkek hastanın yaklaşık 2 saat önce başlayan ve özellikle göbeğin sağ tarafında başlayan karın ağrısı,bulantı,kusma şikayetleriylebaşvurduğu acil polikliniğimizde hastada akut batın bulgularının tespiti üzerine hastaneye operasyon amaçlı yatış önerildi,hastanın özgeçmişinde 5 yıl önce karaciğer apsesi nedeniyle geçirilmiş operasyon öyküsü mevcuttu,Fizik muayenesinde palpasyonla özellikle sağa lokalize perumbilikal hassasiyet mevcuttu,defans,rebaund yoktu,sağ üst kadranda subkostal kesi izi mevcuttu.TA:120/80,nabız:90/dk,ateş:36,6 olarak ölçüldü.laboratuvar incelemede WBC:7750, Biyokimyasal değerlerinden AST:66 (0-38),ALT:115(10-41),LDH:280 (135-225)IU/L olduğu görüldü.Abdominal ultrasonografisinde batın içi patolojik bir görünüme rastlanmadığı belirtildi.Hastanın acil şartlarda yapılan operasyonunda hastaya diagnostik laparoskopi uygulandı,eksplozasyonda apendiks erektıl olarak gözlemlendi,diğer batın içi organlarda patolojik bulguya rastlanmaması üzerine hastaya apendektomi uygulandı,herhangi bir komplikasyon görülmeyen hasta postoperatif 3. gününde salahl ile taburcu edildi.Apendektomi materyalinin patolojik incelenmesinde,yapılan kesitlerde 0,5 cm çapında mukoza ile bağlantılı olmayan kas dokusuna yayılım gösteren karsinoid tm olarak yorumlandı

Sonuç: Akut batın ön tanısıyla ileameliyata alınan hastalarda öykü önemli olup,flushing, diare, kilo kaybı gibi şikayetler karsinoid tümör açısından göz ardı edilmemelidir. Apendektomi, salpingektomi, sırasında makroskopik görüntüsü küçük sert, submukozal nodül kitle şeklinde, kesildiğinde sarı renkte yüzeye sahip kitle mevcutsa, karsinoid tümör akla getirilip patolojisi takip edilerek, gerekirse ileri tedavi ve tetkik planlanmalıdır.

Anahtar Kelimeler: karsinoid tümör, apendiks, tümör

P-0806 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Fleksibl Kolonoskopi Sonrası Pnömoeritoneum ve Subkutan Amfizem: Olgu Sunumu

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Amaç: Kolonoskopi, alt gastrointestinal sistem hastalıklarının teşhis ve tedavisinde en sık kullanılan girişimsel tekniktir. Kolonoskopi sonrasının ağrısından yakınan her hastada, perforasyon akla gelmelidir. Yaygın peritoneal irritasyon bulgulariolması durumunda cerrahi girişim şarttır..Biz yazımızda tanısıl amaçlı yapılan kolonoskopi sonrası pnömoeritoneum gelişen olgumuzu sunmayı amaçladık

Olgu: Elli yedi yaşında erkek hasta;özgeçmişinde operasyon öyküsü olmayan hasta 5 yıl önce mekanik intestinal obstruksiyon tablosu ile başvurduğunda kolon obstruksiyonu ön tanısı ile acil şartlarda eksploratif laparotomi yapılmış, eksplorasyonda sağ kolonda önce-likle inflamatuvar barsak hastalığına bağlı olduğu düşünülen etraf dokulara yapışık kitle ve bridler saptanmış hastaya bridektomi uygulanmış, ileo-çekal valvin tam olabileceği düşünülerek loop ileos-tomi açılmış. Hastanın ileostomisi 3 ay sonra kapatılmış.Bundan sonraki süreçte aralıklı karın ağrıları olan hastanın herhangi bir sağlık kurumuna başvurmamış, ağrılarının artması üzerine hastanın başvurduğu merkezde yapılan tetkiklerinde çıkan kolonda şüpheli duvar kalınlaşması ön tanısıyla hastanın acil kliniğimizde başvurması neticesinde hastaya tanısıl amaçlı kolonoskopi yapıldı.Kolonoskopi esnasında kalın barsakların segmenter tutulduğu,inflame olduğu ve incelendiği görüldü. Kolonoskopiden sonra hastada gelişen ağrılar sonrasında yapılan fizik muayenesinde,batında minimal hassasiyet ve subkutan amfizem saptandı. Tüm abdomen kontrastlı tomografisinde batında yaygın hava tespit edilmesi üzerine.hasta perforasyon tanısı ile acil olarak operasyona alındı.Batın içi eksplorasyonda sigmoid kolonda 1 adet yaklaşık bir santimetrelilik perforasyon alanıgörüldü ve primer onarım uygulandı, eksplorasyon esnasında kalın ve ince barsakta multipl bridler olduğu görüldü ve bridektomi uygulandı kolonun çepeçevre kalınlaştığı ve çekum bölgesinin inflame olduğu görüldü, görünüm itibarıyla inflamatuvar bağırsak hastalığından şüphelenildi. kolon onarımı sonrası hastanın douglas bölgesine 1 adet dren konarak operasyona son verildi.Postoperatif takiplerinde orali kesilip antibiyotik profilaksisine başlanan ve genel durumu stabilizeşen hastanın 5. günde drenen kolonik partiküllerin gelmesi üzerine hastada kolon fistülü geliştiği düşünüldü ve orali kesilip total parenteral nutrisyon tedavisine başlandı, drenen gelen materyalin postoperatif 12. günde deşarjının kesilmesinden 2 gün sonra hastaya sulu gıdalar başlandı, hastanın gaz gaita deşarjının olması ve drenen geleninin olmaması üzerine postoperatif 17. günde dreni çekilen hasta önerilerle taburcu edildi. Bir ay sonra hasta gastroenteroloji kliniğinde yapılan, tetkiler sonucunda crohn hastalığı tanısı konan hasta medikal tedavisine başlanarak kontrol grubuna alındı.

Sonuç: Kolonoskopiye bağlı barsak delinmeleri ya işlem sırasında ince barsak, omentum gibi karın içi organların görülmesiyle ya da gecikmeyle fark edilir. Sonuç olarak, Unutulmaması gereken kolon perforasyonunun ciddi bir komplikasyon olduğu ve hasta ve hekim açısından takibinin de bir o kadar riskli olabileceğidir.Bundan dolayı hastalar her türlü komplikasyondan haberdar edilerek, hasta ve doktorun alacağı ortak karar sonrasında operasyon ve tedavinin uygulanması gerektiğini düşünmekteyiz.

Anahtar Kelimeler: Pnömoeritoneum, Kolonoskopi, amfizem



POSTER BİLDİRİLER

P-0807 Toxicology

Sentetik Kannabinoid Kullanımına Bağlı Kardiyak Etkilenme: Olgu Sunumu

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Amaç: Sentetik kannabinoidler yaygın olarak kullanılan yasa dışı maddelerdir. Dünyada 15-64 yaş grubunun yaklaşık olarak % 4 ünde bu maddelerin kullanıldığı tahmin edilmektedir. Akut etkileri öfori, zaman algısında yavaşlama, analjezi, bellek ve problem çözmede zorluklar, ataksi, taşikardi, sistolik hipertansiyon, postural hipotansiyon, anksiyete, paranoid düşünceler ve depresyondur. Yüksek doz alımlarda reversibl P ve T dalga, ST segment değişikliği gibi elektrokardiyogram (EKG) bulguları ile artmış supraventriküler ve ventriküler ektoptik aktivite gözlenebilir. Artmış kardiyak iş yükü, yükselmiş katekolamin ve karboksil hemoglobin (CoHb) seviyeleri ve altta yatan kardiyak hastalıklara bağlı olarak kardiyovasküler olaylara neden olabilirler. Biz bu

yazıda sentetik kannabinoid kullanımına bağlı kardiyak etkilenmesi olan bir vaka sunduk

Olgu: 17 yaşında erkek hasta bilinç bozukluğu yakınması ile acil servise getirildi. Öyküsünden şikayetlerinin sentetik kannabinoid alımından bir saat sonra başladığı ve psikoz nedeniyle psikiatrik tedavi gördüğü öğrenildi. Başvuruda tansiyon arteriyel: 160/90 mmHg, kalp hızı 120/dakika, solunum sayısı: 16/ dakika, ateş 37.4°C idi. Yapılan fizik muayenesinde şuur uykuya eğilimli, pupiller dilate idi. Diğer fizik muayene bulguları normaldi. Çekilen EKG de sinus taşikardisi ile DII, DIII, aVF, V5-V6 derivasyonlarında 1mm ST dalga elevasyonu mevcuttu. Başvuru sırasındaki laboratuvar incelemesinde CoHb: 5.2 (NA:0-2), laktat: 3.09 mmol/L (NA:0-1.8) düzeyi yüksekliği olması dışında anormal bir bulgu saptanmadı. Hastaya 300 mg asetil salisilikasit başlandı. Takibinin 4. saatinde bilinç bozukluğu düzeldi ancak kardiyak belirtiler yükselmeye başladı ve takibinin 12. saatinde troponin I değeri bazal değerine oranla 20 kat artarak pik düzeyine ulaştı. Yine bu saatte alınan EKG de taşikardi ve ST dalga elevasyonu düzeldi. Takibinin 20. saatinde kardiyak belirtiler normal laboratuvar aralığına geriledi. Hasta komplikasyonsuz olarak taburcu edildi.

Sonuç: Acil servise bilinç bozukluğu yakınması ile başvuran olgularda madde kullanımı sorgulanmalı ve sentetik kannabinoid kullanımı olan hastalar seri fizik muayene, EKG ve laboratuvar bulgularıyla 24 saat izlenmelidir.

Anahtar Kelimeler: sentetik kannabinoid, acil servis, elektrokardiyogram

P-0808 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Hemoptizi ile prezente olan Gastrointestinal traktın Schwann cell hücreli tümörü: Nadir bir olgu sunumu

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Amaç: Schwannomalar, schwann hücresi kılıfından köken alan genellikle benign, yavaş büyüyen neoplazilerdir. GİS schwannomaları, gastrointestinal-nal duvardaki nöral plexusların schwann hücrelerinden köken alırlar. Mezenkimal gastrointestinal tümörlerin %2-7'sini schwannoma-lar oluşturur. Schwannomalar gastrointesital sistem (GIS) de en sık midede ikinci sıklıkta ise kalın barsaklarda bulunur. Tüm gastrik neoplazilerin de %0.2'sini, gastrik benign neoplazilerin %4'ünü schwannomalar oluştururlar. Gastrik schwannomalar, klinik olarak karşımıza epigastrik ağrı şikayeti ile gelebileceği gibi, kanama ve perforasyon gibi acil girişim gerektirilen durumlarla karşımıza çıkabilir. Bu çalışmada epigastrik ağrı, hemoptizi şikayeti ile acil kliniğine başvuru göğüs hastalıkları kliniğimize konsülte edilen ve tetkikler neticesinde schwannoma tanısı alan olgumuzu klinik ve patolojik verilerle sunmaktayız.

Olgu: 81 yaşında kadın hasta epigastrik ağrı ve öksürük sonrası ağza gelen kanlı balgam ile acil kliniğinden göğüs hastalıkları kliniğimize konsülte edilen ve tetkiklerin ardından genel cerrahi polikliniğimize konsülte edilen hasta. Yapılan fizik muayenede patolojik bulguya rastlanmadı, hastadan istenen kan tahlillerinde wbc:12000,hbg:10,hct:30,plt:367000,biyokimyasal değerlerde patolojik bulguya rastlanmadı, akciğer grafisinde patolojik bulguya rastlanmadı ve abdomen ultrasonografisi (USG) sonucunda "Epigastrik bölgede 43x40 mm boyutunda düzgün sınırlı hipoekoik solid kitle lezyonu izlendi. Radyolojik olarak gastrointestinal stromal tümörden şüphelenildi. Yapılan üst gis endoskopisinde mide antrumunda submukozal yerleşimli yaklaşık 4 cm çapında mide lümenine protrübe olmuş düzgün sınırlı semi-mobil frajil kitlesel lezyon tespit edildi biyopsi alındı ve patolojiye gönderildi. tarama amaçlı çekilen abdominal bilgisayarlı tomografisinde submukozal kaynaklı multiloküle hipodens kitle tespit edildi. Kliniğe yatışı yapılan hasta patoloji sonucunda schwannom şüphesi üzerine Operasyona hazırlandı, operasyonda genel anestezi altında yapılan eksplorasyonda batında endoskopi esnasında saptanan kitle midede palpabl olarak görüldü ve kitleye mide wedge rezeksiyonu uygulandı, operasyon esnasında intraoperatif frozen çalışması yapıldı ve cerrahi sınırların intakt olduğu raporu üzerine operasyona son verildi. Operasyon sonrası izleminde herhangi bir şikayeti olmayan hastaya 3. Gün oral gıda alımına başlandı 5. gün de ise önerilerle taburcu edildi. Operasyonda çıkan spesmenin histopatolojik incelemesinde submukozal ve intramural yerleşmiş 3.5 cm çapında benign neoplastik lezyon saptandı. İmmünohistokimyasal çalışmalarda S- 100 ve GFAP ile kuvvetli pozitif, CD - 34 ile fokal pozitif, Pansitokeratin ve Aktin ile negatif sonuç alındı. Ki- 67 indeksi % 2-3 olarak değerlendirildi. Bu sonuçlarla hastaya gastrik schwannom tanısı koyuldu.

Sonuç: Mide duvarından kaynaklanan, homojen, sınırları düzgün görünümlü submukozal kitlesel lezyonların ayırıcı tanısında benign potansiyele sahip gastrik schwannoma akıld tutulmalıdır. Gastrointestinal sistemden kaynaklı schwannomalarda salim cerrahi sınır elde edilerek yapılan rezeksiyon tedavisi için yeterli olup geniş rezeksiyonlara ihtiyaç yoktur.

Anahtar Kelimeler: gastrik, schwannom, stromal tümör

P-0809 Toxicology

Bizmut Masum Mu?

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Gaziosmanpaşa Taksim E.A.H

Amaç: Bu çalışmanın amacı, nadir karşılaşılan bir renal yetmezlik nedeni olarak aşırı bizmut alımını irdelemek. Bizmut Bi olarak sembolize edilen kimyasal bir elementtir. Kolloidal bizmut subsitrat (CBS) ve bizmut subsalisilat yaygın olarak peptik ülser tedavisinde, fonksiyonel dispepsi ve kronik gastrit tedavisinde kullanılan bizmut tuzlarıdır. CBS zehirlenmeleri nadir karşılaşılan bir durumdur.

Olgu: 21 yaşında bayan hasta 4 gündür süren bulantı kusma şikayetleri ile acil servisimize başvurdu. Hastanın bu şikayetleri 4 gün önce ilaçla suisid girişiminden sonra başlamış, Hasta 20 adet Denol(Bismuth subsitrate 300 mg) almış ve ilaç alımından 5 saat sonra özel bir hastaneye başvurmuş.Burada hastaya gastrik lavaj yapılarak aktif kömür verilmiş. Yapılan Tetkiklerin normal olması sonucunda 16 saat gözlem altında tutulduktan sonra taburcu edilmiş. Hastanın daha önceden bilinen gastrit öyküsü olması ve iç hastalıkları uzmanı tarafından takipli olması şikayetlerinin nedeni olarak gastriti düşündürmüş ve ilaç alımından 2 gün sonra takipli olduğu hastaneye başvurmuş. Bu hastanede ilaçları düzenlenmiş ve ayaktan takip önerilmiş. Ancak bulantı ve kusma şikayetlerinin devam etmesi üzerine hastanemiz acil servisine başvurdu. Vital bulguları TA: 100/60 Nb:78 S.S: 14 Ateş: 37.1 idi.Çekilen EKG sinde patolojik bir durum gözlenmedi. Bulantı ve kusma dışında hiçbir patolojik muayene bulgusuna rastlanmadı. Tetkiklerinde BUN:38 Kr:4.68 K:3.05 Ca:8.7 AST:41 ALT:57 idi. Ulusal zehir danışma merkezi aranarak tedavi önerileri alındı ve hastaya antidot olarak önerilen D- Penisilamin temin edildi ve dahiliye servisine yatırılarak takibe alındı. Hasta bir hafta boyunca yatırılarak sadece intra venöz sıvı tedavisi ile takip edildi ve tedavi sonunda kreatinin değerinin düşmesi ve vital bulguların stabil seyretmesi üzerine taburcu edildi. Bir ay sonra kontrole çağırıldı ve değerlerinin normal olduğu tespit edildi. Bazı benzer çalışmalarda aşırı bizmut alımı sonrası hastaların dializ tedavisi aldığı ve başka bir çalışmada da dializ bağımlı kronik renal yetmezlik hastası olarak kaldığı görülmüştür. Bizim olgumuz ise akut renal yetmezlik tanısı ile hastanemiz dahiliye servisine yatırılarak ve uygun tedaviyi alarak kalıcı böbrek hasarı oluşmadan sağlığına kavuşmuştur.

Sonuç: Sonuç olarak ilaç zehirlenmelerinin önlenabilir morbidite ve mortalite nedenleri arasındadır. Ailelerin suisidal girişimleri engelleme konusunda daha etkin rol oynamaları gerektiği, acil servislerde gerekli ve yeterli düzeyde önlem alınması gerektiği ve fiziki şartlarının yeterli hale getirilmesi gerektiği görülmüştür.

Anahtar Kelimeler: bizmut, suisid, renal yetmezlik

P-0810 Trauma Emergencies

Elektrik Çarpması Sonucu Humerus Fraktürü

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Gaziosmanpaşa Taksim E.A.H

Amaç: Bu çalışmanın amacı, elektrik çarpması sonrası meydana gelebilecek nadir görülen bir durum hakkında acil tıp camiasını bilgilendirmektir. Elektrik günümüzde evlerde ve sanayide yaygın olarak kullanılmaktadır. Evlerde ve sanayide görülebilen ölümler çoğu zaman kaza sonucu meydana gelir. Elektrik akımının en sık girdiği bölgeler eller ve baş, vücudu en sık terk ettiği yerler ayaklar, bacaklar ve ellerdir. Giriş ve çıkış lezyonlarının bulunması için dikkatli bir dış muayene şarttır. Şüpheli ani ölümlerde araştırmanın en önemli kısmı, elektrik taşıyan iletici ile temas sonucunda oluşan elektrik akımı giriş lezyonunun saptanmasıdır.

Olgu: Olgumuz 45 yaşında erkek hasta evde sağ eli ile tuttuğu elektrik kablосundan elektrik kaçacağı olması sonucu elektrik çarpması ile sağ kolunda ağrı hissetmesi üzerine hastanemiz acil



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servisine başvurdu. Hasta elektrik çarpması sonrası bilincini hiç kaybetmediğini ve düşme yada kolunu bir yere çarpma gibi bir travmaya maruz kalmadığını belirtmekte idi. Hastanın şikayeti sağ kolda ağrı hissi ve hareket ettirememesi idi. Hastanın TA 120/70 Nabız:88 ateşi 36,5 C derece idi. Çekilen eksg sin de bir özellik yoktu. Yapılan laboratuvar tetkiklerinde hemogram, tam idrar tahlili ve biyokimya değerlendirmesi normaldi. Fizik muayenesinde herhangi bir elektrik yanığı, giriş yada çıkış deliğine rastlanmadı. Ancak hastanın sağ humerus ta hassasiyeti ve humerus üzerinde krepitasyonu mevcuttu. Bunun üzerine hastaya humerus röntgeni çekildi ve humerus ta kırık olduğu tespit edildi. Hastanın humerus kırığı için Ortopedi konsültasyonu istendi ve hasta Ortopedi servisine yatırılarak tedavi altına alındı ilerleyen günlerde operasyona alınan hasta başka herhangi bir patoloji ile karşılaşmadan bir hafta sonra şifa ile taburcu edildi.

Sonuç: Elektrik sistemlerinin doğru kullanımı ile ilgili toplumsal eğitimin verilmesi, ev içi ve ev dışı elektrik hatlarının gizli döşenmesi gibi basit önlemlerin alınması ile kazalar en aza indirilebilecektir.

Anahtar Kelimeler: elektrik, humerus, operasyon

P-0811 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Beklenmedik bir yerleşim yeri Olgusu:Peniste Pilonidal Sinüs

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Amaç: Pilonidal sinüs (PS) toplumda oldukça sık rastlanır (insidans, %0.7) ve genellikle genç erkek erişkinleri etkiler (literatür ekle-LE). 16-25 yaşları arasında zirve yaptığı ve 25 yaşlarından sonra azaldığı görülür. Bir ya da daha çok sinüs kanalı ve kıl demeti içeren, akut ataklar gösteren kronik seyirli bir hastalık olup sıklıkla sakrokoksigeal bölgede intergluteal sulcus üzerinde yerleşir. Bunun yanı sıra seyrek olarak umbilikal bölgede, nadiren elde parmak arası bölgede, peniste, aksillada, amputasyon güdüğünde, anal kanalda, suprapubik bölgede, meme ve memeler arası bölgede görülür. Uygulanan temel tedavi cerrahi eksizyondur. Bu çalışmada oldukça nadir görülen bir peniste pilonidl sinüs olgusunu sunmaktayız.

Olgu: 20 yaşında erkek hasta Üroloji polikliniğine peniste akıntılı,kanamalı ve kaşıntılı akıntılı yara şikayeti ile acil servise başvurdu. Fizik muayenede penis ventral yüzde 3x2 cm boyutlarında, üzeri kurutlu, akıntılı, ortasında sinüs ağız olan, ülseratif yara tespit edildi. Yapılan serolojik testlerden VDRL, Hep B-C, HIV testleri negatif olarak raporlandı, hematolojik incelemelerde ise sonuçların normal değerlerde olduğu gözlemlendi

Hastaya yara yeri kültürü alınarak eksizyonel biyopsi ve primer sütürasyon uygulandı. Biyopsi sonucunun pilonidal sinüs ile uyumlu olarak rapor edildi. Kültür sonucunda normal cilt florası ve Gr (+) kok ürettiği gözlemlendi.Hastaya medikal tedavi olarak ciprofloksasin 500 mg 2x1 ve ornidazol 500 mg 2x1 beş gün uygulanarak taburcu edildi. Ameliyat sonrası 7. Günde sütürler komplikasyonsuz olarak alındı.

Sonuç: Özette PS sıklıkla intergluteal bölgede sakral olukda gözlenir. Bununla birlikte vücudun diğer bölgelerinde de nadir yerleşim yerleri bildirilmiştir. Bu nedenle vücudun değişik yerlerinde ve bilhassa kıllı bölgelerde oluşan inflamasyon ve granülasyon doku varlığında PS akla gelmeli ve gerekli cerrahi tedavi yapılmalıdır (8). Peniste nadir olarak görüne de yara, şişlik, akıntı şikayetiyle başvuran hastalarda pilonidal sinüs tanısı mutlaka akla getirilmelidir

Anahtar Kelimeler: Pilonidal sinüs, penis, enfeksiyon

P-0812 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Abdominal Aort Anevrizması Ruptürünün Nadir Bir Prezantasyonu

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Amaç: Abdominal aortada 3,5 cm ve üzerinde genişleme anevrizma olarak adlandırılır. Abdominal aorta anevrizmalarında en korkulan ve hayati tehdit eden komplikasyon ruptür gelişmesidir. Abdominal aorta anevrizması ve ruptür bulguları son derece atipik olarak karşımıza çıkabilir. Bu nedenle ruptüre abdominal aort anevrizmasının acil serviste tanısını koymak önemli ve hayat kurtarıcıdır. Burada sağ yan ağrısı ve sağ alt kadranda ağrısı ile başvuran bir abdominal aorta anevrizma ruptürü olgusunu sunmayı amaçladık.

Olgu: 62 yaşında erkek hasta acil servismize 2 gündür devam eden sağ yan ağrısı ve sağ alt kadranda ağrısı şikayetiyle başvurdu. Hastanın bilinen bir hastalığı yoktu. Tansiyon arteriyel sağ kolda 140/85 mm Hg, sol kolda 130/80 mm Hg ölçüldü. Nabız düzenli ve 90/dk, vücut sıcaklığı 36,50 idi. Hasta fizik muayenesinde koopere ve oryantasyon ve nörolojik defisiti yoktu. Radial ve femoral nabızlar her iki tarafta mevcut ve simetrik. Birinci ve ikinci kalp sesleri duyulan hastada dinlemekle patolojik ses yoktu. Karın muayenesinde sağda kostovertebral açı hassasiyeti, derin palpasyonla sağ alt kadranda defans ve rebound mevcuttu. Diğer sistem muayeneleri doğaldı. Laboratuvar incelemelerinde beyaz küre 15.600 / mm³, kreatinin 1,96 mg/dl, tam idrar tetkikinde lökosit 81 HPF, eritrosit 3315 HPF idi. Hastanın üriner sistem ultrasonografi incelemesi normal olarak değerlendirildi. Akut apandisit şüphesiyle istenilen yüzeyel ultrasonografi incelemesinde ise pericekal minimal serbest mayi saptanması üzerine yapılan kontrastlı abdomen bilgisayarlı tomografi incelemesinde; abdominal aortada renal arter orifislerinin yaklaşık 2 cm distalinden başlayan ve çapı 9 cm'ye kadar ulaşan tromboze anevrizma ile, renal arter orifislerinden yaklaşık 4,5 cm distalde anevrizma lümeninden trombus içine ve peritoneal kaviteye belirgin kontrast madde ekstrasvazasyonu saptandı. Ek olarak sağ pararenal alanda konturları anevrizmadan ve psoas kasından ayrırt edilemeyen 8x6 cm ölçülerinde hematoma izlendi (figür 1,2). Hastaya abdominal aorta anevrizma ruptürü tanısı konuldu. Hastaya 3 ünite eritrosit süspansiyonu ile replasman yapıldı. Hasta kalp-damar cerrahi kliniğine konsulte edildi ve endovasküler stent-graft operasyonu için hospitalize edildi.

Sonuç: Acil servis hekimleri, abdominal aort anevrizma ruptürünün farklı ve geniş klinik tablolarla başvurabileceği konusunda uyanık ve dikkatli olmalıdır.

Anahtar Kelimeler: anevrizma, nadir, ruptür, karın ağrısı, hematüri

P-0813 Trauma Emergencies

Araç içi trafik kazasında emniyet kemeri bağli sternum fraktürü

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Giriş: Sternum fraktürleri, göğüs travması nedeniyle acil servise başvuran hastalarda görülen patolojilerin küçük bir yüzdesini oluşturmaktadır. Künt göğüs travmaları olguların %3-8'inde sternum fraktürü izlenmektedir. Ancak, kardiyak yaralanmanın habercisi olabilmeleri nedeniyle tanı ve izlemleri önem kazanmaktadır. Sternal fraktür eşliğinde kardiyak yaralanma riski %18-62 arasında değişmektedir. Trafik kazaları nedeniyle, sıklıkla ön koltuklarda oturan kişilerde meydana gelen bu fraktürlerin sıklığı, emniyet kemeri kullanımının zorunlu hale getirilmesiyle son yıllarda artmıştır. Tanıda lateral göğüs grafisi yeterli iken, travmalı olguların ilk değerlendirilmesi sırasında bazen bu inceleme ihmal edilmekte veya ağırlı hastaya pozisyon verilememesi nedeniyle çekilemediği için sternum fraktürü gözden kaçabilmektedir. Bu olgumuzda sternum fraktürünün acil serviste tanısına dikkat çekmek amaçlanmıştır.

Olgu: 57 yaşında bayan hasta araç içi trafik kazası nedeniyle acil servismize ambulans ile getirildi. Hastanın kaza esnasında ön yolcu koltuğunda oturduğu ve emniyet kemeri takılı olduğu öğrenildi. Hastanın yapılan fizik muayenesinde vital bulguları TA: 120/70mmHg SO2:98% Nabız: 82/dk olarak değerlendirildi. Sağ ön kolda açık kırık saptandı. Sağ hemitoraksta ve sternum üzerinde hassasiyeti ve inspiryumda batıcı tarzda ağrısı olan hastanın solunum sesleri bilateral eşit ve doğal olarak değerlendirildi. Diğer sistem muayenelerinde ek bir patolojiye rastlanmadı. Hastanın çekilen direk grafilerinde ulna ve radius shaft fraktürü saptandı. Çekilen PA akciğer grafisinde sağ hemitoraksta multipl kot fraktürleri izlendi. Toraks bilgisayarlı tomografisinde (TBT) hemopnömotoraks bulgusuna rastlanmadı; ancak sternumda fraktür saptandı. Miyokard ve büyük damar yaralanması ihtimaline karşın yapılan tetkiklerinde herhangi anormal bir bulguya rastlanmayan hasta ortopedi ve göğüs cerrahisi ile konsülte edildi. Genel anestezi altında, ön kol ve sternum fiksasyonları yapıldıktan sonra göğüs cerrahi kliniğine yatırılan hasta ameliyat sonrası 9. günde takip önerileri ile taburcu edildi.

Sonuç: Sternal kırıklar yüksekten düşen ya da göğüse alınan direkt darbelerle meydana gelir. Bu yaralanmalarda basamak bulgusu görülür ve lateral ya da oblik grafilerle tanısı konur. Birçok klinisyen sternumun büyük damarlar ve kalbin önünde yer aldığından bu yapılarda okült travmaya neden olabileceğine inanmaktadır. Klasik olarak sternal fraktüre bağlı miyokardiyal travma en sık karşımıza çıkan komplikasyondur. Bu nedenle sternum fraktürü olan hastalar miyokard yaralanması olasılığı düşünülerek elektrokardiyografi ve kardiyak enzimler ile değerlendirilmelidir. Tedavide, cerrahi kozmetik nedenler dışında önerilmezken; hastaların çok az bir kısmında operasyon yapılmadan solunum yetmezliğinin gerilemediği tespit edilmiştir. Ameliyatta çelik tel ile redüksiyon ve fiksasyon uygulanmaktadır. Bu olgumuz ile göğüs travması nedeniyle acil servise başvuran hastalarda sternum fraktürünün hatıra gelmesi ve olası komplikasyonlarının değerlendirilmesinin önemi vurgulanmıştır.

Anahtar Kelimeler: fraktür, sternum, toraks, travma

POSTER BİLDİRİLER

P-0814 Trauma Emergencies

Künt Travmaya Bağlı Sürrenal Hematom: İnsidental bir olgu sunumu

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Amaç: Adrenal Bölge ve Böbrekler lokalizasyonları nedeniyle nadiren travmaya maruz kalır. Renal ve sürrenal travma tüm travma başvurularının %1'ünü, abdominal travmaların ise %4'ünü oluşturur. Amacımız travma sonrası gelişen adrenal hematom olgusunun konservatif yöntemle yapılan tedavisini tartışmaktır. Olgumuzda Arac dışı trafik kazası nedeniyle görülen künt abdominal travmaya sekonder izole sağ sürrenal hematom olgumuzu klinik takip ve nonoperatif tedavi yöntemlerini rapor etmekteyiz

Olgu: 54 yaşında erkek hasta, yolda seyir halinde bir aracın yan aynasının carpması sonucunda ani oluşan şiddetli karın ağrısı ve akut batin nedeni ile acil servisimize başvurdu. İlk değerlendirmede batin muayenesinde sağ üst kadranda hafif ağrı ve hassasiyet olduğu görüldü ve tetkiklerinde wbc:15000(3,5-10,5) hgb:13(13,5-17,5),hct:37(38-50),plt 256000(150-450),biyokimyasal değerlerinde Glukoz 85(75-105)BUN:34,3(18-55) kreatin:0,85(0,7-1,2) AST: 88(5-34) ALT:95(0-55)olarak ölçülen hastanın vital bulgularında nbz:125 olup taşikardikti,TA 120/80,Oksijen saturasyonu %95 idi ve hastada ek bir patolojik bulgu yoktu. Yapılan ultrasonografisinde sağ sürrenal lojda 3*4 cm çapında hematom saptandı. Batin BT de; sağ sürrenal lojda 3x4 cm ebadında hematom olduğu,batin iç serbest sıvı görülmediği raporlandı. Hasta yoğun bakım ünitesinde monitorize edilerek takip altına alındı. Takipleri sorunsuz seyreden,tasikardisi gerileyen ve tam kan sayım,biyokimyasal değerleri stabil olup herhangi bir komplikasyon gelişmeyen hasta yatışının 4. gününde taburcu edildi.

Sonuç: Bu gelişimimizdeki amacımız, künt batin travması sonrası gelişen solid organ yaralanmalarında uyguladığımız tanı, takip ve tedavi prensiplerimizdeki zaman içerisindeki değişiklikleri gözden geçirerek, son yıllarda giderek artan oranda başarılı sonuçlar alınan nonoperatif ve konservatif tedavi protokollerindeki uygulamalarımız ve bu konuya olan yaklaşımımızın güncelliğini irdelemektir

Anahtar Kelimeler: adrenal, hematom, travma

P-0815 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Diyafragma Yerleşimli Karaciğer Kist Hidatik: Vaka Sunumu

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Amaç: Ülkemizde endemik bir hastalık olan kist hidatik hastalığının çok farklı anatomik bölgelerde rastlanabileceği bilinmektedir. Subkutanöz, intramusküler ya da retroperiton yerleşimli kistlere oldukça nadir olarak rastlanılmaktadır. Başka bir primer kaynağı saptanmayan intramusküler, subkutanöz ve retroperiton yerleşimli kist hidatik vakası sunulmuş ve bu olguda Kist Hidatik hastalığının atipik lokalizasyonlarının literatür doğrultusunda tartışılması amaçlanmıştır

Olgu: 59 Yaşında erkek hasta aralıklı olarak meydana gelen nefes darlığı, şişkinlik ve karın ağrısı şikayetlerinin artması üzerine başvurduğu dış merkezdeki tetkiklerinde karaciğer de diyaframatik yüzde yerleşmiş kist hidatik şüphesi üzerine acil kliniğimize sevk edilmiştir,hastanın yapılan tetkiklerinde Acil Kontrastlı üst Abdomen MR sonucunda:Karaciğer kraniokaudalde 18 cm olup normalden büyüktür,sağ adrenal lojda adrenal bez karaciğer ve diafragmayı indente eden ve deplasmana neden olan 8*7 cm boyutlarında subdiaframatik yerleşimli tip 3 kist hidatik izlenmiştir.Portal,venöz sistem,intrahepatik ve extrahepatik safra yolları doğaldır.Safra kesesinde en büyüğü 2*1 cm boyutunda birkaçadet kalkül görülmüştür,kese duvarında hafif kalınlaşma ve ödem mevcuttur,perikolesistik sıvı izlenmemiştir.olarak rapor edilmesi üzerine hasta operasyona hazırlandı ve operasyonda diyafragma ve karaciğer kubbesine yerleşmiş olan kist diyafragma zarar verilmenden eksize edildi.Postoperatif takiplerinde herhangi bir komplikasyon saptanmayan hasta postoperatif 5. günde önerilerle taburcu edildi.

Sonuç: Sonuç olarak ülkemizin hidatik kist hastalığı açısından endemik bir bölge olması nedeniyle, bu tür atipik yerleşimlerin karaciğerde ve dışında pek çok farklı anatomik bölgede rastlanabileceği düşünülmesi gerektiğini vurgulamak isteriz

Anahtar Kelimeler: kist hidatik, karaciğer kubbe, atipik

P-0816 Trauma Emergencies

A case of a traffic accident outside the vehicle

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Introduction: Renal injury is present in 8-10% of the patients with abdominal trauma. Genitourinary system examination should not be overlooked and examined carefully in patients presenting with multiple trauma to the emergency service.

Case: An 32-year-old male admitted to the emergency service (room) because of a traffic accident outside the vehicle. Vital signs at the presentation were detected as follows: the Glasgow coma scale 15 points, blood pressure 130/85 mmHg, heart rate 88 beat/min and the body temperature 37C. On physical examination, there was pain on the right upper and lower quadrants of the abdomen by palpation without defence and rebound signs. We examined (detected) pain and sensitivity on the right fibula. A urinary catheter was inserted and 200 mL of macroscopic hematuria was detected. After that, we performed FAST-USG to the patient and it revealed right kidney laceration accompanied by minimal free fluid in the abdominal cavity. However, it could not able to give any information about the left kidney. So, an abdominal CT angiography was performed and it detected stage 5 right kidney injury according to the kidney injury scale accompanied by left kidney agenesis. During the follow up in the emergency room, heart rate increased up to 120 beats/mn and blood pressure declined to 100/70 mmHg levels. Thus, we consulted the patient with an urologist about the operation indication. In the control blood count, Hgb level was found 9.2 g/dL. The patient was transferred to urology clinic for the operation with stage 5 kidney injury and new left kidney agenesis diagnosis.

Results: In patients admitting to the emergency services with multiple trauma, the aim is to detect all the life-threatening conditions and make an accurate treatment plan. Observation of no life-threatening condition at the presentation of the case reveals the importance of the second look. Detailed physical examination and monitorization with short intervals are life saving for the patients presenting with trauma.

Anahtar Kelimeler: Abdominal trauma, Kidney agenesis, Renal injury

P-0817 Trauma Emergencies

Delici Kesici Aletle Yaralanma

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Amaç: Delici ve kesici alet yaralanmaları bir yabancı cismin cildi delerek açık bir yara oluşturduğu yabancı cismin türüne,enerjisine ve giriş lokalizasyonuna göre hafiften hayatı tehdit edici düzeylere varabilecek şekilde olabilen yaralanmalardır. Bu yazıda kesici delici alet ile yaralanma durumunda çıkarma yöntemi sunulmuştur

Olgu: 48 yaşında bayan hasta evde mutfakta yemek yaparken ayağına bıçak saplanmış. Fizik bakıda genel durum iyi şuurlu açık oryante ve koopere idi. Ayak tabanı medialinde girişi ve ayak sırtı medialinde çıkışı olan bıçak inspeksiyonla görülmüyordu. Hastaya tetanoz profilaksisi ve profilaktik antibiyotik uygulandıktan sonra direk grafileri çekildi. Ortopedi ve travmatoloji ile konsülte edildi. Bıçağın keskin olmayan tarafına doğru bastırılarak keskin ucun dokulara hasar vermesi engellenerek çıkartıldı. Hasta tekrar değerlendirilerek major kanaması olmadığı tespit edildi minor kanamaların hemostazı sağlandı sonrasında motor ve duyu defisiti olmadığı tespit edilen hastanın primer sütürasyonla yara yeri kapatıldı ve şifahi taburcu edildi.

Sonuç: Delici kesici aletle yaralanma günlük hayatta sıkça karşılaşılan bir durumdur. Yeterli bilgi donanımı ve doğru teknik uygulanarak damar sinir paketi hasarın olmadığı durumlarda basit tıbbi müdahale ile giderilebilecek bir yaralanmadır.

Anahtar Kelimeler: Delici Kesici Alet Yaralanması, Delici Kesici Alet Çıkarılması, Damar-sinir Paket hasarı



POSTER PRESENTATIONS

P-0818 Toxicology

Eroin zehirlenmesine bağlı akut akciğer hasarı: Olgu sunumu

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Amaç: Eroin kullanımı Amerika Birleşik Devletleri'nde acil servislere akut zehirlenme nedeni ile yapılan başvuruların yaygın nedenlerinden biridir. Ülkemizde eroin kullanımına bağlı acil servislere başvurular giderek artmaktadır. Bilinç düzeyinde azalma, solunum sayısının azalması ve miyozis eroin zehirlenmesinin tanısında %92 sensitivite, %76 spesifiteye sahiptir. Akut zehirlenme vücutta birçok organ sistemini etkileyebilir. Ciddi olgularda supraventriküler ve ventriküler disritmi, miyokardiyal iskemi, strok, ileus, akut akciğer hasarı, akut böbrek yetmezliği gelişebilir. Akut akciğer hasarı eroin alımına bağlı hemen gelişebileceği gibi alım sonrası 24 saate kadar gecikebilir. Bu makalede eroin kullanımına bağlı ciddi zehirlenme bulguları gösteren ve akut akciğer hasarı gelişen bir olgu sunuldu.

Olgu: 19 yaşında erkek hasta solunum sıkıntısı yakınması ile acil servise getirildi. Öyküsünden eroin bağımlılığı için tedavi gördüğü ve son eroin alımından dört saat sonra şikayetin başladığı öğrenildi. Başvuruda tansiyon arteriyel (TA): 90/60 mmHg, solunum: 8/ dakikada, kalp hızı 140: /dakika, ateş: 37,2°C idi. Yapılan fizik muayenesinde bilinç uykuya eğilimli, pupiller miyotik ve her iki akciğer bazalinde ince ralleri mevcuttu. Elektrokardiyogramında (EKG) sinus taşikardisi tespit edildi. Başvurudaki laboratuvar incelemesinde pH: 7,21 (NA: 7,37-7,45), pCO₂: 57,9 mmHg (NA: 35-46), pO₂: 70 mmHg (NA: 70-100), HCO₃: 24,6 mmol/L (NA: 21-26), üre: 49,2 mg/dl (NA: 19-48), kreatinin 2,3 mg/dl (NA: 0,7-1,3), AST: 106 u/L (NA: 9-48), ALT: 81 u/L (NA: 10-49), kreatin kinaz: 420 u/L (NA: 32-294), CK-MB: 46 u/L (NA: 0-25), troponin I: 1,07 ng/ml (NA: 0-0,06) idi. Bilgisayarlı toraks tomografisinde anterior mediastende pnömomediastinum ve her iki akciğer alt loblarda akut akciğer hasarı ile uyumlu yaygın alveolar dansite artışları saptandı. Bilgisayarlı beyin tomografisi ve ekokardiyogram normaldi. Hasta entübe edilerek mekanik ventilatöre bağlandı. İntravenöz (iv) sıvı resüstasyonu, naloksan, asetil salisilikasit, iv esmolol, iv antibiyoterapi başlanarak izleme alındı. Takibinin 4. saatine asidozu ve hipoksisi düzeldi. Birinci günün sonunda extübe edildi. Takibinin ikinci gününde serum kreatinin değerleri normal sınırına gerilemekle birlikte troponin I değeri: 5,1 ng/ml idi. Kontrol bilgisayarlı toraks tomografide yaygın alveolar dansite artışının ve pnömomediastinum görüntüsünün azaldığı görüldü. Takibinin dördüncü gününde karaciğer fonksiyon testleri ve kardiyak belirteçleri düzeldi. Hasta komplikasyonsuz olarak taburcu edildi.

Sonuç: Acil servise solunum sıkıntısı yakınması ile başvuran bilinç düzeyinde azalma, solunum sayısının azalması ve miyozis tespit edilen olgularda madde kullanımı sorgulanmalı ve eroin kullanımı olan hastalar yakın gözlem altında tutularak tekrarlayan fizik muayene ve laboratuvar incelemeleriyle takipleri yapılmalıdır. Ayrıca eroin kullanan ve solunum sıkıntısı olan hastalar akciğer ve kalp hasarı açısından detaylı olarak değerlendirilmelidir.

Anahtar Kelimeler: eroin, akut akciğer hasarı, acil servis

P-0819 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Nefes Darlığı ile Başvuran Yabancı Cisim Aspirasyon Olgusu

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Amaç: Yabancı cisim aspirasyonu acil tanı ve tedavi gerektiren hayatı tehdit edebilecek sonuçları olan bir durumdur. Erken dönemde öksürük, nefes alıp vermede güçlük, ses kısıklığı gibi semptomlara; geç dönemde ise solunum arrestine kadar gidebilecek komplikasyonlara yol açabilmektedir. Bu yazıda yemek yedikten sonra üst havayoluna kemik takılan bir olgu sunulmuştur. **Olgu:** Seksen yaşında kadın hasta yemek yedikten sonra başlayan boğazda takılma hissi ve nefes almada güçlük şikayeti ile acil servise başvurdu. Hasta akşam yemeğinde haşlanmış et yediğini ve sonrasında şikayetlerinin başladığını belirtti. Hastanın özgeçmişinde hipertansiyon dışında bilinen ek hastalığı yoktu. Antihipertansif olarak amlodipin kullanmaktaydı. Sigara ve alkol kullanım öyküsü yoktu. Fizik bakışında genel durumu iyi, bilinci açık, oryante ve koopere idi. Vital bulguları; TA:130/90, nabız 72/dk, ateş 36,4 C, solunum sayısı 24/dk, oksijen saturasyonu %96 idi. Baş boyun muayenesinde özellik yoktu. Oskültasyonda akciğer sesleri doğaldı. Kan tetkikleri normal sınırlardaydı. EKG normal sinüs ritmindeydi. Çekilen anteroposterior ve lateral servikal grafisinde yabancı cisim ile uyumlu hiperdens görüntü mevcuttu. Hasta kulak burun boğaz bölümü ile konsulte edildi ve trakeada 0,6x0,8x2,9 cm boyutlarında kemik dokusu olduğu tespit edildi. Mevcut yabancı cisim laringoskopi ile çıkarıldı. İşlem sonrası hastanın şikayetleri geriledi ve çekilen kontrol grafiler normal olarak değerlendirildi.

Sonuç: Yemek sonrasında ani başlayan nefes darlığı ve boğazda takılma hissi ile gelen hastalarda yabancı cisim aspirasyonu olabileceği akılda tutulmalıdır. Yabancı cisim öyküsü veya şüphesi olan olgularda servikal iki yönlü grafi çekilmelidir. Ayrıca non-opak maddelerin sıklıkla özefagusta takılı kaldığı da unutulmamalıdır. Gerek görülürse kulak burun boğaz ve göğüs hastalıkları ile konsulte edilmelidir. Laringoskopi ve bronkoskopi vakit kaybetmeden planlanmalıdır.

Anahtar Kelimeler: Yabancı cisim aspirasyonu, Nefes darlığı, Laringoskopi ile YC çıkarma

P-0820 Toxicology

Boru çiçeği Zehirlenmesi

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Antalya Eğitim ve Araştırma Hastanesi

Amaç: Datura stramonium Türkiye'de doğal florada yaygın olarak bulunan yabancı bir bitkidir. Bu bitki, yapısında antikolinerjik zehirlenmeye neden olan atropin, hiyosiyamin ve skopolamin içermektedir. Bu bitki halk arasında şeytan elması, boru çiçeği, abu zambak, cin otu, tatula, tatala ve domuz pıtırı isimleriyle bilinmekte olup bazı bölgelerde süs bitkisi olarak bahçelerde yetiştirilmektedir.

Olgu: 81 yaşında erkek hasta konuşma bozukluğu görmede bozukluk, ve etrafındakileri tanıyamama şikayeti ile acil servise getirildi. Hastanın öyküsünde yaklaşık 4 saat önce namaz çıkışı caminin bahçesinden bir başka arkadaşı ile boru çiçeği adı verilen çiçekten yedikleri, ve diğer arkadaşlarında benzer semptomlarla başka bir acil serviste takip edildiğini öğrendik. Fizik muayenesinde vücut ısı 36,4°C, kan basıncı 140/70 mmHg, kalp tepe atımı 100/dk ve ritmik, solunum sayısı 18/dk idi. Bilinci konfü, oryantasyon ve kooperasyonu kısıtlı idi. Hastanın pupilleri izokorik, bilateral midriyatikti ve ışık refleksi zayıf olarak alınıyordu. Göz dibi ve kranial sinirlerin muayenesi normaldi. Tüm ekstremitelerde derin tendon refleksleri, motor kuvveti, duyu muayenesi olağandı. Deri, mukozal membranlar, dil kuru, idrar retansiyonu ve bağırsak ses-leri azalmıştı. Laboratuvar incelemelerinde tam kan sayımı, tam idrar tetkiki, kan biyokimyası ve elektrokardiyografik incelemesi normaldi. Bilgisayarlı beyin tomografisi normal idi. Hastaya 1gr/kg'dan aktif kömür verildi. Damar yolu açılarak hidrasyonu sağlandı. Ve hasta dahiliye yoğun bakıma yatırıldı.

Sonuç: Datura stramonium ülkemizin hemen her bölgesinde yol kenarlarında, boş alanlarda yetişen yabancı bir bitkidir. Zehirlenmede basit anti kolinerjik semptomlardan, konvülsiyonlar, santral sinir sistemi depresyonu, dolaşım kollapsı ve hipotansiyona bağlı olarak ölüm meydana gelebilir Bu nedenle anti kolinerjik semptomlarla acil servise başvuran hastalarda akla getirilmesi gereken nadir nedenlerden biridir.

Anahtar Kelimeler: antikolinerjik, boru çiçeği, zehirlenme

P-0821 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Künt Batın Travması sonrası barsak perforasyonu

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Amaç: Barsak perforasyonu, ölümcül bir acildir. Künt batın travmasının bir komplikasyonu olarak görülebilir. Sunacağımız olguda bunu anlatılmaktadır.

Olgu: Yetmişiki yaşında, erkek hasta, trafik kazası tanısıyla traktör devrilmesi sonucu römork ve yer arasında sıkışma olarak getirildi. Diabetes mellitus (DM) ve Kronik Obstruktif Akciğer Hastalığı (KOAH) tanılarını mevcut. Travmayı batın bölgesine alan hastanın fizik muayenesinde bilinci açık, Glasgow Koma Skalası:15, TA:150/80, NB:86/dk, solunum sayısı:14/dk, oda havası saturasyonu:%96, solunum ve kardiyovasküler sistem muayenesi normaldi. Batın muayenesinde; yaygın hassasiyeti vardı. Yatakbaşı expanded-FAST Ultrasonografisinde serbest sıvı yoktu. Çekilen Akciğer grafisinde (PAAC) ve tüm Batın Bilgisayarlı Tomografisinde serbest hava tespit edildi. Hasta derhal operasyona alındı.

Sonuç: Künt batın travmalarının bir komplikasyonu olarak görülebilen barsak perforasyonu, ölümcül bir acildir. Her multi-travma hastasına ayakta veya Sol yan PAAC grafisi çekilmelidir.

Anahtar Kelimeler: barsak perforasyonu, PAAC, künt batın travması

POSTER BİLDİRİLER

P-0822 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Künt Batın Travmalı Pediatrik Olguda İzole Pankreas Yaralanması

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Amaç: Pediatrik yaş grubundaki künt batın travmalı olgularda izole pankreas yaralanması nadir görülen bir durumdur. Spesifik bir muayene bulgusu olmaması, geç semptom oluşturmaları ve ilk planda akılda bulundurulmamasının da etkisiyle tanı gözden kaçabilir veya gecikebilir. Tanı fizik bakı, laboratuvar ve Kontrastlı Abdominal BT ile konur. Olgumuzda künt batın travması sonrası izole pankreas yaralanmasının ayırıcı tanıda göz önünde bulundurulmasını vurgulamayı amaçladık.

Olgu: 11 yaşında erkek hasta tekme ile karına vurulma sonrasında başlayan, kusma şikayeti ile olaydan 6 saat sonra acil servisimize başvurdu. Genel durum iyi, GKS:15 suur açık, koopere, oryante idi. TA:100/70 mmHg Nabız:85/dk SatO2:%99 Ateş:36°C Glukoz:79 mg/dl idi. Batın muayenesinde saptanan sol üst kadranda ve epigastrik bölgede hassasiyet dışında fizik muayenede patolojik bulguya rastlanmadı. WBC:13.710/ul Hgb:13g/dl Hct:%39 Amilaz: 678 SU idi. FAST USG'de rektovezikal bölgede minimal serbest sıvı görüldü. Çekilen IV kontrastlı Abdominal BT'de batında serbest sıvıya ek olarak pankreas distal kesimde konturlarda düzensizlik ve ödem gözlemlendi. Hastanın oral alımı kesildi. Nazogastrik sonda yerleştirildi. İntravenöz sıvı tedavisi başlandı. İzole pankreas yaralanması tanısıyla izlem ve tedavi amaçlı Çocuk Cerrahisi servisine devredildi.

Sonuç: Künt batın travması olan pediatrik olgularda, solid organ yaralanmaları, (karaciğer, dalak, böbrek) ve içi boş organ perforasyonu daha sık görülmekle beraber gerek erken dönemde semptom oluşturmaları, gerekse fizik bakıda bulgu vermelerinden dolayı tanıda daha sık akla gelmektedir. İzole pankreas yaralanmasının geç semptom oluşturmaları ve nadir görülmesi nedeniyle ayırıcı tanıda akılda bulundurulmaması tanının geç konmasına veya gözden kaçmasına sebep olur. Pankreas retroperitoneal yerleşimli olması sebebiyle batın muayenesinde bulgu veremeyebilir. Kusma gibi spesifik olmayan semptomları bulunan künt batın travmalı pediatrik hastalarda fizik bakıda herhangi bir anormal bulgu saptanmasa da izole pankreas yaralanması olabileceği göz önünde bulundurulmalıdır.

Anahtar Kelimeler: Künt Batın Travması, İzole Pankreas Yaralanması, Pediatrik Travma

P-0823 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Fahr hastalığı. Olgu sunumu

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Amaç: Çok nadir görülen intrakraniyal kalsifikasyonlarla seyreden fahr hastalığını acil servise başvuran yeni tanı fahr hastası eşliğinde sunmayı amaçladık.

Olgu: 48 yaşında bayan hasta altı aydır olan ara ara giren baş ağrısı ve ellerde uyuşma ile acil servisimize başvurdu. Hastanın son üç gündür baş ağrıları artmış. Acil servise başvurduğu gün de halüsinasyonlar görmeye başlamış. Hastanın yapılan fizik ve nörolojik muayenelerinde patolojik bulguya rastlanmadı. Hastanın tam kan tetkiki ve biyokimyasal parametreleri doğaldı. Hastanın bilgisayarlı beyin tomografisi incelemesinde; bilateral serebellum, bazal ganglionlar, supratentorial kesitlerde kalsifikasyonları mevcuttu. Hasta mevcut bulgularıyla birlikte fahr sendromu olarak değerlendirildi.

Sonuç: Sonuç olarak bazal ganglionlarda, serebellumda ve derin kortikal yapılarda saptadığımız kalsifikasyonlarda Fahr hastalığını ayırıcı tanıda düşünelim ve bunun da çok

çeşitli nörolojik semptomlara yol açabileceğini bilmeliyiz.

Anahtar Kelimeler: Fahr hastalığı, intrakraniyal kalsifikasyon, halüsinasyon

P-0824 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Nedensiz Diyabetik Ketoasidoz (DKA) olmaz: Mezenter iskemisi tanısı alan DKA olgusu

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Amaç: Karın ağrısı acil servise sık başvuru sebeplerindendir. Karın ağrılı hastaların ayırıcı tanısına birçok cerrahi ve dahili hastalık girmektedir. Acil serviste karın ağrısı tanı algoritmasında rutin laboratuvar tetkiklerinin yanında görüntüleme yöntemleri de kullanılır. Fizik muayene ve tetkik sonuçlarına göre çoğu kez hastaya kesin bir tanı koyulabilmektedir. Ancak bazen atipik prezentasyon veya birbirine eşlik eden birden çok hastalık varlığında tanı koymak zorlaşır. Bu sunumda acil serviste diyabetik ketoasidoza (DKA) bağlı karın ağrısı nedeniyle takip edilen bir hastada eşlik eden mezenter iskemisinin tespit edilmesi anlatılmaktadır.

Olgu: 47 yaşında erkek hasta acil servise bir gündür olan karın ağrısı şikayeti ile başvurdu. Gelişinde kan basıncı 157/96mmHg, nabız 104/dk ölçüldü. Hastanın bilinen diyabetes mellitus dışında hastalığı olmayıp oral antidiyabetik ilaç almakta idi. Öyküsünde ağır yük kaldırdıktan sonra artan, 1 defa kusmanın eşlik ettiği bir ağrı tarif ediyordu. Fizik muayenede batın orta hatta hassasiyet mevcuttu. Rebound ve defans tespit edilmedi. Çekilen EKG'de normal sinüs ritmi görüldü. Laboratuvar tetkiklerinde WBC 21.100 10³ uL, glukoz 467 mg/dl, kan gazında pH 7.27, laktat 10.5 mmol/L, HCO3 13.9, tam idrar tahlilinde 4+glukoz, 2+ keton izlendi. Diyabetik ketoasidoz ön tanısıyla tedavisi başlandı. Çekilen kontrastsız batın tomografisinde herhangi bir patolojik bulgu görülmüdü. Takiplerinde laboratuvar bulguları düzelmesine rağmen karın ağrısı ilerleyen hastanın kontrol fizik muayenesinde batında yaygın hassasiyet mevcut olması üzerine hastaya intravenöz kontrastlı batın tomografisi çekildi. Tomografi sonucunda mezenter iskemisi tespit edilerek genel cerrahi ile konsülte edildi. Hasta acil operasyona alındı.

Sonuç: Mezenter iskemisi acil serviste sık tanı alan ölümcül bir hastalıktır. Atipik prezentasyonu nedeniyle zor tanı koyulabilmektedir. Bu vakada da endokrinolojik bir acil olan DKA ön tanısıyla takip edilen hasta, karın ağrısının geçmemesi üzerine ileri tetkik edilmiş ve mezenter iskemisi tanısına ulaşılmıştır. Laboratuvar ve muayene bulguları örtüşen hastalıkların ayırıcı tanısında klinik şüphe ve hastaya tekrarlayan fizik muayeneler yapılması taniya ışık tutabilmektedir.

Anahtar Kelimeler: Karın ağrısı, Ayırıcı tanı, Diyabetik ketoasidoz, Mezenter iskemisi

P-0825 Trauma Emergencies

Maganda Kurşununu Vücudundan Kusarak Uzaklaştırdı

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Amaç: Ateşli silah yaralanmaları (ASY) morbidite ve mortalitenin önemli nedenlerindendir. ASY sonrası görülen kafa ve boyun yaralanmaları farklı klinik durumlarla karşıma çıkabilmektedir. Gelişmekte olan ülkelerde ateşli silahlarla havaya ateş açıp sevinç gösterilerinde bulunmak hiç de nadir değildir. Sebebi bilinmeyen penetran kafa travması geçirmiş 10 yaşında bir çocuk hastanın, vücudunda kalan kurşun çekirdeğini yaralanmadan 5 ay sonra kusarak vücudundan uzaklaştırmasını sunmayı amaçladık.

Olgu: Acil servisimize (AS) 10 yaşında bir kız çocuk yabancı cisim kusma şikayeti ile getirildi. Hasta yaklaşık 5 ay önce de AS'ye düşme sonrası kusma şikayeti ile getirilmişti. Hastanın o tarihteki başvurusunda hastanın başka bir merkeze bisikletten düşme şikayeti ile başvurduğu, sol frontal bölgedeki açık yarasının suture edildiği ve sonrasında hastaneden taburcu edildiği anlaşılmıştır. Taburculuk sonrası evde kusma şikayeti olduğundan bu kez AS'imize başvurmuştu. Hastanın yapılan muayenesinde biliç açık, oryante ve koopere, gks:15, TA: 100/60 mmHg, SS:18, so2:98, ateş:36.7, ense sertliği yok, sol frontalde midpupiller hatta koronal sütünün 2 cm önünde 1 cm lik suture edilmiş yarası mevcut idi. Motor defisit duyu defisti yok. Diğer sistem muayeneleri doğal olarak izlendi. Hasta takibe alındı. Hastanın takibinde kusmaları başladı. Tekrar muayenesinde gks:14 olan hastanın sol gözde görme kaybı ve IR-/+, ind IR+/+ saptandı. Hastanın yapılan tetkiklerinde frontal ve yüz kemiklerinde multiple fraktürler tespit edildi. Sol frontal lobdan orbita apeksine uzanan trakt hattı izlendi. C 2 vertebra seviyesinde sağ parafaringeal alanda parafaringeal kas planları arasında kurşun çekirdeği ile uyumlu yabancı cisim izlendi. Hastaya yapılan bialteral karotis doppler ve boyun bt anjiyografisinde her hangi bir vasküler yaralanma saptanmadı. Gerekli konsültasyonlar sonucu beyin cerrahisi servisine yatırılan hasta 3. gün operasyon planlanmadan poliklinik kontrol randevusu ile hastaneden taburcu edildi. Hasta son AS'imize başvurusunda 5 ay önceki yaralanma sonrası sağ parafaringeal bölgede bırakılan kurşun çekirdeğini kusması üzerine acil servisimize gelmiştir. Hastanın tetkikleri ve endoskopisi planlanırken AS'simiden izinsiz olarak ayrılmıştır.

Sonuç: Kafa ve maksillofasyal travmalar her zaman semptomatik olmayabilir. Basit gibi görünen yaralanmaların altından ciddi problemler çıkabilir. Oluş nedeni tam izah edilemeyen özellikle pediatrik yaş grubundaki hastalar asemptomatik dahi olsalar, ayrıntılı irdelenmelidir. Serseri kurşunla yaralanmalar mutlaka akılda bulundurulmalıdır. Literatürde özellikle kafa içinde bırakılan mermi çekirdeklerinin yer değiştirmesi ile ilgili vakalar bildirilmiştir. Ancak bizim vakamızdaki gibi kas ve yumuşak doku alanından gastrointestinal trakta fistüle olarak yer değiştirme ile ilgili olgu bildirilmemiştir.

Anahtar Kelimeler: Acil tıp, kafa travması, kusma, trakt fistülü



POSTER PRESENTATIONS

P-0826 Toxicology

Suicid amaçlı ilaç alımı ile gelen hastalarda, klinik bulgular ile ilaç düzeyleri arasındaki ilişkinin belirlenmesi

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Amaç: İlaç ve ilaç dışı maddelerle oluşan zehirlenmeler günümüzde hala önemli bir sağlık sorunu oluşturmaktadır. Bu çalışmada, suicid amaçlı ilaç intoksikasyonu tanısı ile başvuran hastaların yaş, cinsiyet, ilacın cinsi gibi demografik özelliklerinin tespiti, ve alınan ilacın serum düzeyi ile klinik takip sonucu arasındaki ilişkiyi araştırmak amaçlanmıştır.

Gereç-Yöntem: Çalışmaya suicid amacıyla ilaç aldığı saptanan ve serumda düzeyi tespit edilebilen ilaç zehirlenmesi olan 18 yaş üstü hastalar alındı. Hastaların yaş, cinsiyet, geliş vital bulguları kayıt altına alındı. Taburcu edilen ve yoğun bakım ünitesine kabul edilen hastalar olarak 2 grup oluşturuldu. Böylelikle serum ilaç düzeyine göre klinik korelasyon arasındaki ilişki incelendi. Sonuçlar, sürekli değişkenler için ortalama ve standart sapma ile beraber güven aralıklarıyla verildi. Univariate istatistiksel analizler kategorik değişkenler için ki-kare testi ve sürekli değişkenler için student-t testi kullanılarak yapıldı. Grup içi karşılaştırmalarda gruplar normal dağılım göstermediği ve gruplardaki denek sayısı eşit olmadığından dolayı çoklu karşılaştırma yöntemi olarak Mann-Whitney U testi kullanıldı. Tip 1 hata %5 olarak kabul edilerek bunun altındaki p değerleri (p<0,05) istatistiksel olarak anlamlı kabul edildi.

Bulgular: Şubat 2013-Ağustos 2013 arasında acil servisimize başvuran çalışma normlarına uygun 60 hasta incelenmiştir. Hastalarımızın %71,7 si bayan (n=43), %28,3 ü erkekti (n=17). Yaş ortalaması 26,88±8,88 tespit edildi. Klinik seyre göre dağılımda hastaların 38' i (%63,3) acil serviste en az altı (6) saat, en fazla 24 saat gözlemlendikten sonra taburcu edildiği, 22'sinde (%36,7) yoğun bakıma nakledildiği görülmüştür. Trisiklik antidepresanın (TSA) yüksek serum düzeylerinin artmış yoğun bakım yatışı ile ilişkili idi. Her 2 gruptaki parasetamol seviyeleri birbirine yakın değerde idi, ve bu seviyelerin yoğun bakım yatışı üzerinde anlamlı bir etkisi yoktu. Ve yine, çalışmamızda vital bulgular ile ilaçlar arasındaki ilişki de tespit edildi. Bununla birlikte, TSA alan grup, istatistiksel olarak anlamlı düzeyde düşük ortalama arteriyel basınç (OAB), artmış kalp hızı ve solunum hızına sahipti.

Sonuç: Aldığı ilaç miktarı tam olarak bilinmeyen ya da ifade edemeyen hasta grubunda taburculuk veya yatış kararının verilmesinde, serum ilaç düzeylerinin yanında klinik bulguların özellikle OAB, nabız gibi vital parametrelerin de beraber değerlendirilmesi gerekmektedir.

Anahtar Kelimeler: Suicid, ilaç intoksikasyonu, serum ilaç düzeyi, klinik korelasyon

P-0827 Toxicology

DIAZINONUN ve TIMOKINONUN SIÇANLARDA BEYİN DOKUSUNDA NİTRİK OKSİT VE SÜPEROKSİT DİSMUTAZ SEVİYELERİ ÜZERİNE ETKİSİ

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Giriş-Amaç: Diazinon (DI) organofosfat insektisittir, oksidatif stresi artırarak ve DNA'da hasar yaparak vücut da birçok patolojiye yol açabilir. Timokininun(TQ) çörek otundan üretilir, anti-oksidan etkisi vardır. Timokininun diazinon ile oluşturulan beyin hasarına karşı koruyucu etkisinin araştırılmasının önemli olacağı kanısındayız.

Gereç-Yöntem: Çalışma için 32 adet Wistar Albino cinsi dişi siçan kullanıldı. Siçanlar; 1. grup; kontrol, 2. grup; DI, 3. grup DI + TQ, 4.gruba TQ, şeklinde 4 gruba ayrıldı. 2 ve 3. Gruplara 335mg/kg dan DI tek doz oral olarak verildi. Bir hafta süreyle 3. ve 4.gruba 10 mg/ kg / gün oral TQ verildi. 7. Gün sonunda tüm siçanlardan kan ve doku örnekleri alındı. Siçanların beyin dokusunda NO ve SOD ELISA yöntemiyle çalışıldı. Ayrıca serumda comet assay yöntemiyle DNA kırıklarına bakıldı.

Bulgular: Kontrol grubu ve diazinon verilen grup karşılaştırıldığında diazinon verilen grupta NO seviyesi anlamlı olarak kontrol grubundan yüksek bulunmuştur. Aynı şekilde diazinon verilen gruba DI + TQ, verilen grup NO seviyesi yönünden karşılaştırıldığında NO seviyeleri anlamlı olarak düşük bulunmuştur. Ayrıca timokinin verilen gruba Kontrol grubu NO seviyesi yönünden karşılaştırıldığında NO seviyeleri anlamlı olarak düşük bulunmuştur.

Kontrol ve diazinon verilen grup karşılaştırıldığında diazinon verilen grupta SOD seviyesi anlamlı olarak kontrol grubundan düşük bulunmuştur. Benzer olarak diazinon verilen gruba DI + TQ, verilen gruplar SOD seviyesi yönünden karşılaştırıldığında SOD seviyesi anlamlı olarak yüksek bulunmuştur. Ek olarak timokinin verilen gruba Kontrol grubu SOD seviyesi yönünden karşılaştırıldığında SOD seviyeleri anlamlı olarak yüksek bulunmuştur.

DNA hasar skoru ortalaması kontrol grubunda 15,00±3,00 bulunmuştur. DI uygulanmış örneklerde DNA hasar skoru ortalaması 26,00±5,29 olarak bulunmuştur. Kontrol grubuna göre DI grubunda DNA hasarındaki artış istatistiksel olarak anlamlıdır. Tek başına TQ uygulanmış grupta DNA hasarı DI grubuna göre azalmış olup bu azalış istatistiksel olarak anlamlıdır

Sonuç: Yapılan çalışmalar bazı organofosfatların serbest oksijen radikalleri üretimini artırarak oksidatif doku hasarına neden olduğunu göstermektedir. Yılmaz ve arkadaşlarının yaptığı benzer bir çalışmada diazinon verilen siçanlarda vitamin E ve C'nin antioksidan etkiyle diazinonun etkilerini azalttığını göstermişlerdir. Bizde çalışmamızda diazinonun oksidatif etkilerini timokininun SOD seviyelerini artırarak istatistik olarak anlamlı bir şekilde azaltıldığını tespit ettik.

Diazinon uygulanmış örneklerde DNA hasarı kontrol grubuna göre anlamlı artış olmasına rağmen timokininla beraber uygulanan grupta DNA hasarı oranında anlamlı bir azalma olmamıştır. Literatürde bu konuyla ilgili bir yayın bulunamadı.

Sonuç olarak çalışmamızda siçanlarda diazinonun oksidatif stresi artırarak beyin hasarı oluşturduğu ve timokinin'un antioksidan etisiyle oluşan bu beyin hasarını düzeltebilir. Diazinonla olan zehirlenmelerin tedavisinde TQ'nun kullanılabileceğini düşünmekteyiz. Ancak bunun için daha üst çalışmalar gerekir.

Anahtar Kelimeler: Diazinon, timokinin, beyin, oksidatif stres

P-0828 Trauma Emergencies

Elektrik çarpması sonrası cilt altı amfizem: vaka sunumu

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Giriş: Elektrik çarpmasına bağlı yaralanma yaklaşık 300 yıldır bilinmektedir. Çevresel aciller içinde önemli bir yer tutmaktadır. Elektrik çarpması sonucu vücuttaki elektrik iletiminin bozulması (aritmler, nörolojik olaylar) ve yumuşak dokularda oluşan yanıklar morbidite ve mortalitenin başlıca sebepleridir.

Olgu: 26 yaşında erkek hasta elektrik çarpması nedeniyle acil servisimize başvurdu. Geldiğinde bilinci açık, vital bulguları stabildi. Sol antekubital bölgede çıkış delikleri mevcuttu. Sol kolda önkol ve göğüs ön yüzüne ulaşan cilt altı amfizemi mevcuttu. Yapılan tetkiklerinde kreatin kinaz (CK) düzeyi 426 U/L olarak saptandı. Diğer kan tetkikleri normal olarak bulundu. EKG'de anlamlı bir değişiklik yoktu. Direk görüntüleme ve toraks BT'de kol, önkol, toraks ve mediastende amfizemle uyumlu değişiklikler mevcuttu. Acil Toksikoloji Yoğun Bakım yatışı yapılan hasta kompartman sendromu ve enfeksiyon açısından ilgili bölümlere danışıldı. Gerekli sıvı-elektrolit ve antibiyotik tedavisi planlandı. Takiplerinde CK düzeyi en çok 463 U/L olarak bulundu. EKG ve kardiyak enzim değişikliği olmadı. Tedavisi devam ederken kendi isteğiyle taburcu olmak istediğini ifade eden hasta önerilerle ve haliyle taburcu edildi.

Anahtar Kelimeler: Elektrik çarpması, cilt altı amfizem, travma

P-0829 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Karın Ağrısı ile Başvuran İlginc Bir Tip 3 Aort Disseksiyon Vakası

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Amaç: Aort disseksiyonu (AD), Aort intimasında meydana gelen yırtık sonucu media tabakasının ayrılarak kanın aort duvarının içine dolması disseksiyon olarak adlandırılır. Başvuru şikayetlerinin nonspesifik olduğu durumlarda acil servislere tanıda sıkıntılar yaşanabilmektedir. AD olan hastaların %28'inin tanısı ancak ölüm sonrası incelemelerde konabilmektedir. Hastalar yırtıcı semptom, sırt yayılan, çok şiddetli göğüs ağrısından senkop, hemiparezi, hemipleji gibi nörolojik bozukluklar, akut miyokard enfarktüsü ve akut böbrek yetmezliği gibi çok geniş klinik yelpazeye karşımıza çıkabilir. AD'da acil serviste doğru ve erken tanı konulması ile uygun tedavinin yapılması prognoz açısından oldukça önemlidir. Biz bu yazıda atipik şikayetlerle acil servise başvuran ve AD saptanan bir vakayı sunmak istedik.

Olgu: Altmış yaşında kadın hasta, bir gün önce başlayan karın ağrısı, sol bacakta güçsüzlük şikayeti ile acil servise başvurdu. Özgeçmişinde hipertansiyon dışında bilinen bir rahatsızlığı yoktu. Hastanın yapılan değerlendirmesinde genel durum orta, bilinç açık koopere, oryante. TA:90/60 mmHg, nabız:100 atım/dk, ateş:36,5 derece solunum: 20/dk, batın distandü, yaygın hassasiyet

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mevcuttu. Sol alt ekstremitede 1/5 kas gücü vardı ve soğuk, soluk, siyanoze idi. Femoral ve distal ekstremitte nabızları alınamıyordu. Sol üst ekstremitte 4/5 kas gücü, soğuk ve soluk idi. Radial ve brakial nabız alınamıyordu. Laboratuvar değerleri; Beyaz küre:13100 Hemogloblin:8.2 gr/dl, Platelet:62000, BUN:35, Kreatinin:1.8, AST:170, ALT:79, Na:142, K:4.1, INR:1.15idi. Elektrokardiyografide sinüs taşikardisi mevcuttu. Bilgisayarlı Batın Tomografisinde: Arcus aorta ve desenden aortada mural trombus, desenden aorta distalinden başlayıp bilateral iliak arterlere kadar ilerleyen diseksiyon flebi, Sol ana iliak arterde doluma izin vermeyip trombus görünümü mevcuttu. Bu bulgularla hasta DEBAKEY Tip 3, STANFORD Tip B diseksiyon ile uyumlu idi. **Sonuç:** Acil tanı ve tedavi gerektiren AD vakalarının acil servislere, batında distansiyon ve karın ağrısı gibi atipik semptomlarla başvurabileceği konusunda acil hekim alert olmalıdır.

Anahtar Kelimeler: Aort diseksiyonu, Karın ağrısı, Acil

P-0830 Trauma Emergencies

Epileptik nöbete bağlı vertebra fraktürü: Vaka sunumu

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Giriş: Epilepsi hemen her yaşta görülebilen ve uzun süreli tedavi ve izlem gerektiren bir hastalık olup yaşam kalitesini önemli ölçüde etkiler. Nöbet ise bir grup kortikal nöronun aşırı ve senkronize deşarjına bağlı olarak ortaya çıkan ve klinikte gelip geçici motor, duysal, duyuşsal, duygusal, bilişsel ve otonom belirtilerle şekillenen bir durumdur. Akut nöbet ile acil servise başvuran bir hastaya yaklaşım da öncelikle hastanın hava yolunun açık olması sağlanmalı, solunum ve dolaşım desteği verilmelidir. Nöbetin durdurulması ve tekrarlamasının önlenmesi, nöbetin altta yatan nedeninin veya provoke eden faktörün bulunarak mümkünse tedavisi yapılmalıdır.

Ancak aşağıdaki vakada olduğu gibi nöbete bağlı komplikasyonlarda her zaman göz önünde bulundurulmalı ve atlanmamalıdır.

Vaka: 30 yaşında, erkek hasta, epilepsi tanısıyla antiepileptik ilaç kullanmaktadır. Evinde nöbet geçirmesi üzerine yakınları tarafından acil servise getiriliyor.

Hasta acil serviste ilk değerlendirilmesinde; o an için nöbet geçirmediği, suyunun açık, koopere, oryante olduğu görüldü. Alınan anamnezinde hastanın zaman zaman nöbet geçirdiği ve nöbetler sonrasında özellikle bel bölgesinde ağrısının olduğunu anlatıyor. Hastanın muayenesinde lumbal vertebralarda palpasyonda hassasiyeti mevcuttu. Bunun üzerine hasta sırt tahtasına alınarak lumbal iki yönlü direkt grafileri çekildi. Çekilen grafide L3 vertebra yükseklik kaybı olması üzerine lumbal vertebralarda tomografik görüntüleri alındı. L3 vertebra korpusunda santral kesimde belirgin olmak üzere akut kompresyon fraktürü ile uyumlu yükseklik kaybı ve sinyal değişiklikleri tespit edildi. Buna sekonder vertebra korpus AP boyutu artmış olup tekal kesenin anteriorından hafif basılı olduğu görüldü. Beyin cerrahisi ile konsülte edilen hasta için operasyon planlandı ve beyin cerrahi servisine transfer edildi.

Anahtar Kelimeler: Epilepsi, epileptik nöbet, Kompresyon fraktürü

P-0831 Trauma Emergencies

İki çocuğun çarpışması ile oluşan nefroüretrektomi ile sonuçlanan travma

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Çocuklarda olan künt karın travmalarının sonucunda böbrek yaralanmaları sık görülür. Bu yaralanmalar düşme, trafik kazası ve spor aktiviteleri sırasında olabilir. Renal yaralanmaların çoğunda konservatif tedavi ile yüz güldürücü sonuçlar alınabilir, fakat bazı vakalar nefrektomi ile sonuçlanabilir. 11 yaşında erkek hasta okul bahçesinde koşarken arkadaşıyla çarpışıp sonra direğe çarpma sonrası acil servise getirildi. Hastaya yapılan yatak başı ultrasonografide batında yaygın mai, sağ böbrek konturlarında düzensizlik tespit edildi. Yapılan bilgisayarlı tomografi tetkikinde batında yaygın mai, sağ böbrek üst polde ve orta kesimde yaygın laserasyonlar mevcuttu. Hastanın takibinde hemoglobin değerlerinin düşmesi nedeni ile nefroüretrektomi yapıldı. Zamanının büyük çoğunluğunu kendi yaşattı olan çocuklarla okulda geçiren okul çağı çocukları bu tip yaralanmalara açıktır. Basit görülebilen bu tip yaralanmaların hayatı tehdit eden sonuçları olabilir.

Anahtar Kelimeler: Nefroüretrektomi, renal travma, okul çağı yaralanmaları

P-0832 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Sağ alt kadranda ağrısı: epiploik apandisit

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Epiploik apandiksler zayıf kan akımı ve serbest hareketlerine izin veren pediküllü yapıları nedeniyle torsiyon ve infarkta sık maruz kalırlar. Epiploik apandisit kolon serozasından kaynaklanan epiploik apandiks torsiyonu veya apandiks venlerin spontan venöz trombusu nedeniyle oluşan iskemik ve inflamatuvar bir durumdur. Kendi kendini sınırlayan bu inflamatuvar durum, klinik bulgularıyla akut karın yapan diğer hastalıklarla taklit eder ve bu hastalıklarla karışır. Cerrahi tedavi gerektirmemesine rağmen, cerrahi tedavi gerektiren diğer akut karın hastalıklarının ayırıcı tanısında önemli bir yer tutar.

Bu yazıda acil servise akut karın ağrısı sebebiyle başvuran, akut apandisit düşünülen ve bilgisayarlı tomografi sonuçlarıyla epiploik apandisit tanısı konulan iki olgu sunulmaktadır.

Anahtar Kelimeler: Karın ağrısı, apandisit, epiploik apandisit, sağ alt kadranda ağrısı

P-0833 Toxicology

Evdeki Tehlike Difenbahya: Olgu sunumu

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Amag: Dieffenbachia evlerde yetiştirilen bir süs bitkisidir. Bitki çok toksik olmamasına rağmen özellikle çocuklarda yakın takibi önerilir ancak çiğnendiği zaman orofaringeal ödeme neden olabilir. Bu bitki toksisiteye neden olan mekanizma bilinmemekle birlikte kalsiyum oksalat kristalleri ve tesisinidioblast proteazın neden olduğu kabul edilir. Özellikle uvul ödemi hayatı tehdit edici olabilir. Dieffenbachia ciddi klinik tablolara nadiren sebep olabilir ancak evlerde bulunmasından dolayı dikkatli olunmalıdır.

Olgu: 3.5 yaşında erkek çocuk evde Dieffenbachia türü olan halk arasında difenbahya diye isimlendirilen süs bitkisinden 10 cm2 yeme sonrası ağız içerisinde uyuma, dilde yanma şikayeti ile acil servise annesi tarafından getirildi. Yanlarında getirdikleri bitkinin türü tesit edildi.

Hastanın muayenesinde vitalleri stabil olan hastanın oral bakımında yanak iç kısmında hiperemisi mevcuttu. Ulusal zehir danışma merkezine hasta danışıldı ve durum bildirildi. Zehir danışma merkezi yenilen bitkinin gastroenterolojik yan etkisinin olduğu; mide lavajı önerilmediği aktif kömür verilmesinde de gerekmediği ancak hastanın GİS yan etkisi açısından mide koruyucu verilmesi gerektiği, hastanın en az 24 saat takip edilmesi için yatırılmasını önerdi. Ayrıca yenilen bitki türünün hepatotoksik ve nefrotoksik olabileceği için böbrek fonksiyon ve karaciğer fonksiyon testlerinin yapılmasını, bitkinin idrarda kalsiyum oksalat kristalleri oluşturabileceğinden dolayı idrar çıkışını takip edilmesini önerdi.

Hastadan tam kan sayımı; biyokimya ve INR-PTZ yollandı. Sonda takıldı. Çocuk uzmanına yatış açısından konsülte edildi ve yatırıldı. Çıkan kan sonuçlarına göre Hb:12.0µl, Wbc:9200µl, Plt:29300µl, Glukoz:95mg/dl, ALT:16 U/dl, AST:37 U/dl, Kreatin:0.9 mg/dl, BUN: 34 mg/dl, Na:137mmol/L, K:4.5mmol/L, INR:0.96 PTZ:11 sn 'idi. Yatış sonrası takibinde problem olmayan; karın ağrısı gelişmeyen ve idrar çıkışında da sorun gelişmeyen çocukta 24 saat sonra yollanan kontrol parametres olan sonuçlarına göre Hb:12.3µl, Wbc:9200µl, Plt:293µl, Glukoz:101mg/dl, ALT:16U/dl, AST:37U/dl, Kreatin:0.6 mg/dl, BUN:12, Üre:26 mg/dl, Na:137mmol/L, K:4.7mmol/L, INR:0.91, PTZ:10.5sn'idi. Hastanın 36 saatlik takibinde problem olmaması üzerine hasta 2 gün sonra çocuk hastalıkları polikliniğine kontrole gelmesi önerildi.

Sonuç: Evlerde bulunan süs bitkilerinin hepsinin masum olmadığı bilinmeli, evde yetiştirilen bitki türleri ve toksisite durumları önceden bilinerek önlemler alınmalıdır. Özellikle evde küçük çocuk bulunan evlerde çocuğun bu bitkileri çiğneyip yutabileceği akılda tutulmalı ve önlemler alınmalıdır.

Anahtar Kelimeler: Dieffenbachia, toksite, çocuk, bitki

P-0834 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Pektoral kasta ağrı ve hiperemi altından iğne çıktı: olgu sunumu

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Amag: Travmalar içerisinde göğüs travmaları üçüncü sıklıkla gözlenen ve mortalitesi yüksek olabilir. Toraks travmalarının yaklaşık %20-30 kadarı penetran travmalardır ve kalp, akciğer ve vasküler yaralanmalar açısından büyük risk taşırlar ve büyük bir bölümü delici kesici alet yaralanması veya ateşli silah yaralanması neticesinde meydana gelir. Burada penetran bir travmayı sizinle tartışacağız.

Olgu: 20 yaşında erkek hasta sabah uyandığında sol omuz ve koltuk altına yayılan hareketle artan ağrı şikayeti ile acil servise başvurdu. Vitalleri stabildi, dispnesi, taşikardisi yoktu, dinlemekle

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akciğer sesleri doğal olarak saptandı. Hareketle artan şiddetli ağrısı mevcuttu. Sol pektoral adale lateralinde hiperemik ve ağrılı alan dışında patolojik bulguya rastlanmadı. Kırsalda yaşayan hastada zehirli böcek ısırığı olup olmadığı sorgulanınca, emin olmadığı uyardığında ağrı hissettiğini belirtti. Bu esnada tesadüfen kontrol amaçlı hastaya çekilen akciğer grafisinde, sol pectoralis major dış kenarında yabancı cisim saptandı. Göğüs cerrahisi ile birlikte lokal anestezi altında hastanın lezyon bölgesi explore edildi ve yabancı cisim çıkarıldı. Yabancı cismin bir dikeş ginesi olduğu saptandı.

Sonuç: Penetrant toraks travmaları daha çok genç erişkin yaşta (20-40 yaş) ve %20-30 oranında gözlenir. Penetrant travmalarda sıklıkla pnömotoraks, hemotoraks veya her ikisine birlikte rastlanır, kot kırıkları (daha çok künt travmalarda) gözlenebilir. Hemodinamik açıdan hastalar hızla değerlendirilmeli ve ileri tetkikler yapılmalıdır. Bizim vakamızda sadece lokal ağrı, hassasiyet ve hiperemi mevcuttu, bu durum enfeksiyon, travma, zehirli böcek ısırıkları gibi birçok durumda meydana gelebilir. Toraks ile ilgili bu tür hadiselerde kolay ulaşılabilir ve ucuz bir tetkik olan akciğer grafisi bize kolayca yol gösterebilir. Bu olayla elimizin altında olan tetkikleri kullanarak kolayca tanıya ulaşabileceğimizi bir kez daha vurgulamak istedik

Anahtar Kelimeler: Acil, yabancı cisim, toraks

P-0835 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Her karın ağrısı cerrahi midir?

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Amaç: Olgu: Chilaiditi Sendromu transvers kolonun yalnız başına veya ince barsakla birlikte hepatodiyafragmatik aralığa sıkışması sonucu gelişen, nadir görülen bir sendromdur. Subfrenik interpozisyon sendromu olarak da adlandırılır. Genellikle asemptomatik olan vakalar radyolojik tetkikler sırasında tesadüfen saptanır. Bu hastalarda bazen karın ağrısı, bulantı, kusma, kabızlık gibi gastrointestinal sisteme ait tipik semptomlar da görülebilir.

Olgu: Yetmiş yaşında erkek hasta acil servise uzun süredir devam eden karın ağrısı ve kabızlık şikayeti ile başvurdu. Özgeçmişinde hipertansiyonu mevcut. Soy geçmişinde özellik yoktu. Hastanın fizik muayenesinde derin palpasyonla batın tüm kadrantlarda hassasiyet ve istemli defans mevcut iken rebaund yoktu. Diğer sistemik muayenelerinde özellik yoktu. Vital bulguları kan basıncı: 140/90 mm/Hg, Nabız: 89 atım/dakika, Vücut ısı: 36.8 OC ve pulsoksimetresi 92 idi. Hastanın laboratuvar bulgularında; Hb: 11.6 gr/dl, Htc: %34.9, beyaz küre 8.25/mikrol, trombosit: 14.000/mikrol idi. ALT: 40 U/L, AST: 71 U/L, ALP: 245 U/L, GGT: 80 U/L (N: 12-64), total bilirubin: 0.8 mg/dl (N: 0.2-1.2), direkt bilirubin: 0.2 mg/dl, üre: 51 mg/dl ve kreatinin: 0.69 mg/dl idi.

Çekilen ayakta direk batın grafisinde ve batın tomografisinde kolonun hepatodiyafragmatik interpozisyonu görülmektedir (Resim 1,2). Hasta Chilaiditi sendromu düşünüldü. Hasta semptomatik tedavi ile rahatladı. Diyet önerileri (lif tüketiminin daha yüksek, artmış sıvı alımı) ve antispazmodik ajanlar ile taburcu edildi.

Sonuç: Chilaiditi sendromlu hastalar acil servise nonspesifik karın ağrısı ile gelebildiği gibi barsak perforasyonuna kadar ilerleyebilen şikayetle gelebilir. Karın ağrısı olan hastaların ayırıcı tanıları arasında chilaiditi sendromunu olabileceği akılda tutulmalıdır

Anahtar Kelimeler: karın ağrısı, chilaiditi sendromu, cerrahi

P-0836 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Bel ağrısı - üst üreter obstrüksiyonu - nefrektomi: olgu sunumu

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Amaç: Üst üreter sistem tıkanıklıkları organ kaybına sebep olabileceğinden dolayı, önemli bir yere sahiptir. Tıkanıklığın seviyesi, ne ölçüde tıkanıklık yaptığı ve süresi, tedavi açısından çok önemlidir. Önemli olan uzun süreli ve ciddi tıkanıklıkta irreversibl renal fonksiyonel rezerv kaybının meydana geliyor olmasıdır ve nefrektomi kaçınılmaz hale gelebilir. Sizlerle önemsenmeyen bel ağrıları nedeni ile nefrektomiye giden üst üreter sistem tıkanıklığını tartışacağız.

Olgu: Lomber disk hernisi tanısıyla takip edilen 70 yaşında erkek hasta, son üç aydır bel ağrısı nedeniyle acil servislere başvuruyor ve analjezik ile taburcu ediliyor. Hasta acil servisimize bel ağrısı ve sol yan ağrısı şikayeti ile başvurdu. Vital parametreleri normaldi ve sistem muayenesinde ek patolojik bulguya rastlanmadı. Yapılan laboratuvar tetkiklerinde üre- kreatin değerleri normal ve hastanın hematürisi mevcut değildi. Çekilen direkt üreter sistem grafisinde sol böbrekte 15x25 mm boyutlarında taş ile uyumlu görüntü saptandı. Sonografik incelenmesinde sol böbrek pelviste 14x23 mm taş ve grade 5 hidronefroz saptanan hasta Ürolojiye konsulte edildi. Hastaya Üroloji önerisi ile tomografi çekildi. Yapılan tetkikler neticesinde ileri derece böbrek fonksiyonel rezerv kaybı saptanan hastaya Üroloji tarafından nefrektomi planlandı.

Sonuç: Üreter sistem taşları en sık görülen ürolojik problemler arasında yer alır ve üreter sistem taşlarına en sık 30 ve 40'lı yaşlarda rastlanır. Taşlar asemptomatik olabileceği gibi hastaneye yatış gerektirebilecek kadar şiddetli ağrı sebebidir olabilirler. Tek taraflı kronik tıkanıklıklarda aşırı diürez sırasında tipik yan ağrısı yerine lomber ağrı meydana gelebilir, bu ağrıda lomber disk hernisine bağlı ağrı ile karışabilir. Nitekim bizim hastamızda da lomber disk hernisi mevcuttu. Hastada ateş, lökositöz, üremi, kreatin yüksekliliği, idrar bulguları olmadan da böyle bir durumla karşılaşılabilir. Bizim bu vakayı tartışmamızın nedeni tipik yan ağrısı yerine lomber ağrı ile hastanın tarafımızda başvurması, ateş, lökositöz, idrar ve biyokimya bulguları olmadan taşa bağlı gelişen hidronefroz sonrası nefrektomiye gitmesi nedeniyledir. Bu vakalarda kolay erişilebilir ve noninvasif olan üreter sistem direkt grafileri istenmeli ve özellikle çapı 8mm ve üzerinde olan üst üreter sistem taşlarında ileri tetkik ve takip yapılmalıdır.

Anahtar Kelimeler: Bel ağrısı, hidronefroz, taş, nefrektomi

P-0837 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Bilinç kaybının sıra dışı nedeni: Aort Diseksiyonu

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Amaç: Aort diseksiyonu yüksek mortaliteye sahip acil müdahale edilmesi gereken kardiyovasküler acilerden biridir. Acil servise başvuru semptomları genellikle göğüs ağrısı, boyun ve intraskapular bölgede şiddetli ağrı şeklindedir. Bu semptomlara ek olarak %20 kadar olguda nörolojik defisitler görülebilir. Senkop aort diseksiyonunun erken evresinde olguların yaklaşık %5'inde görülür ve artmış vagal uyarı, hipovolemi veya disritmiye bağlı olabilir. Serebrovasküler olay semptomları hemianestezi, hemiparazi, hemipleji şeklinde görülebilir ve nadiren de bilinç değişikliği bildirilmiştir. Klasik semptomlara göre daha nadir görülen nörolojik defisitler ile presente olan olgularda ayırıcı tanıda aort diseksiyonunun da hatırlatılması açısından olgumuzu paylaşmak istedik.

Olgu: Senkop nedeniyle acil servise 112 ekibi tarafından 45 yaşında, erkek, bilinen hastalık ve ilaç kullanım öyküsü olmayan hasta getirildi. Vital bulguları: kan basıncı 154/115, nabız 90/dk, SpO2: %91, kapiller kan glukoz düzeyi 159 mg/dl, olan hastanın EKG sinde anlamlı bulgu görülmedi. Havayolu açık, solunumu spontan, dolaşımı stabil olan hastanın Glasgow koma skalası 6 olarak hesaplandı. Pupilleri normoizokorik ve ışık refleksi bilateral pozitif olan hastanın genel vücut muayenesinde ek özellik saptanmadı, travma bulgusu görülmedi. Hasta yakınları hastanın madde bağımlılığı olmadığını, birkaç saat öncesinde tamamen sağlıklı ve normal hareket ettiğini ifade etti. Hasta entübe edilerek kraniyel, boyun anjiyo ve toraks anjiyo bilgisayarlı tomografi görüntüleri elde edildi. Kraniyel tomografide akut patoloji görülmedi fakat toraks anjiyo tomografisinde asendan aortadan başlayıp arcus aortaya ve brakiosefalik artere uzanan diseksiyon hattı izlendi. Sağ ana karotis arter proksimalinden bifurkasyon noktasına kadar total oblitere olup diseksiyon bifurkasyon noktasına kadar uzanmakta idi. Hasta kalp damar cerrahisi kliniği ile konsulte edilerek operasyon için interne edildi.

Sonuç: Aort diseksiyonu yüksek mortaliteye sahip kardiyovasküler bir acildir. Klasik semptomların dışında daha az görülen senkop, serebrovasküler olaylar gibi belirti ve bulgularda da ayırıcı tanıları arasında aort diseksiyonunun olması hayat kurtarıcı olabilir

Anahtar Kelimeler: Aort diseksiyonu, bilinç kaybı, Senkop



POSTER BİLDİRİLER

P-0838 Trauma Emergencies

Karbon Ok ile Yaralanma

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Amaç: Oklar ise fiber, karbon, alüminyum tahta veya çelikten olabilir Karbon oklar, daha küçük çaplı ve daha hafiftirler. Genellikle, üst üste 5 kat sarılan karbon liflerinden oluşmaktadırlar. Ok esneme değerleri, çapları fazla büyümeden de yüksek tutulabileceğinden, hem avcılar hem sporcular tarafından sevilerek kullanılmaktadır. Çaplarının küçük olması, çapraz hava akınlarından fazla etkilenmemeleri avantajını da getirmektedir. Bu olumlu özelliklere ağırlıklarının düşük olması da eklenince, uzun mesafe atışlarının vazgeçilmez okları olurlar.. Dezavantajları, sert bir yüzeye çarptıklarında ve çok esnediklerinde kırılmalarıdır ve lif şeklinde parçalar halinde dağılmalarıdır

Olgu: 18 yaşında erkek lise öğrencisi okçuluk yarışması sırasında atış esnasında okun gerilmeye bağlı kırılması sonucu sol el tenar bölgede yaralanma ile başvurdu. yüzeyde görülen çok sayıda kıymık şeklindeki parçalar alındı, çekilen radyografisinde yaralanma bölgesinde opasite artışı vardı. yabancı cisimler tamamen temizlendikten sonra pansumanı yapıldı antibiyoterapi ile taburcu edildi. kontrolünde yara yerinde herhangi bir komplikasyon gelişmedi.

Sonuç: Bu tip yaralanmalar bir kaç forum sitesinde paylaşılmış olsada literatürde bu tip yaralanma ile ilgili bir bilgiye ulaşamadık.

Anahtar Kelimeler: karbon oklar, okçuluk, karbon lifleri

P-0839 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Hava Kompresörüyle Oluşan Kolon Perforasyonu

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Vaka: 28 yaşında erkek hasta yaklaşık 4 saat önce başlayan şiddetli karın ağrısı, bulantı, kusma ve karında yaygın şişlik nedeniyle acil servise başvurdu. Acil serviste akut batın ön tanısıyla genel cerrahi konsültasyonu istendi. Yapılan muayenesinde karında yaygın hassasiyet, defans, sağ alt kadranda daha yaygın olmak üzere rebound olduğu görüldü. Mevcut bulgular ve laboratuvar sonuçlarıyla hasta akut apandisit olduğu düşünülerek amaliyata alındı. Genel anestezi altında Mc-Burney insizyonu ile laparotomi yapıldı. Eksplozasyonda apandiksin apandisit hali ile uyumlu olmadığı ve batın içerisinde yaklaşık 300-400mlt serbest kan olduğu görüldü. Bunun üzerine orta hat kesiye geçilerek laparotomi yapıldı ve eksplozasyonda serbest kana ek olarak tüm kolonun gekumda daha fazla olmak üzere aşırı gaz ile distandü, rektumda daha fazla olmak üzere sigmoid kolon, inen kolon, transvers kolonda yer yer ve multiple en büyüğü 3-4cm olan serozal lineer defektlerin olduğu ve buralardan kanama olduğu görüldü. Büyük defektler primer kapatıldı. Batın yıkanarak douglaşa diren konarak kapatıldı. Hasta uyandırıldıktan sonra yapılan derin anamnezinde arkadaşlarıyla şakalaşırken yüksek basınçlı hava kompresörüyle anüsüne hava basıldığı öğrenildi.

Sonuç: Kolonoskopi ve baryumlu lavman tetkikleri esnasında gelişen iyatrojenik kolon ve rektum perforasyonları cerrahi literatürde sıklıkla yer almıştır. Daha nadir olarak sıkıştırılmış hava kaynakları ile yapılan şakalara bağlı pnömatik kolon hasarları bildirilmiştir. Barotravma sonucu oluşan ve geç dönemde tespit edilen hastalarda kolostomi açılması önerilmektedir. Ancak erken dönemde saptanan, genç ve peritonit bulgusu olmayan hastalarda rezeksiyon anastomoz tercih edilebilir. Bizim vakamızda tüm kolonda farklı büyüklükte serozal yaralanmalar vardı. Hastanın erken dönemde başvurması ve peritonit bulgularının olmaması nedeniyle kolostomi açılmadı. Büyük defektler primer kapatılarak Hartman's kolostomi operasyonu tercih edildi. Sonuç olarak yüksek basınçlı hava kompresörü ile meydana gelen kolon yaralanmaları çok nadiren rapor edilmektedir. Hasta ve yakınları hikaye vermemektedir. Barotravma yaralanmalarının cerrahi tedavisi hastanın yaşına, yaralanmadan ameliyata kadar geçen süreye, yaralanmanın yerine ve şiddetine, eşlik eden ek yaralanma varlığına, hastanın genel durumuna ve cerrahin tecrübesine göre farklılık gösterir. Bu nedenle acil servise karın şişliği, ağrı, rebound ve yaygın hassasiyet şikayetiyle başvuran bir hastada peritonit tablosu da varsa ayrıncı tanıda barotravma akla gelmelidir.

Anahtar Kelimeler: Acil, kompresör, hava, kolon perforasyonu

P-0840 Toxicology

Nörotoksik Sendrom

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Vaka: 23 yaşında bayan hasta, ailesiyle tartıştıktan sonra evdeki ağır kesicilerden bir avuç, daha sonra adını bilmediği kilerdeki şuruptan da bir yudum içiyor. Yaklaşık 4 saat sonra bulantı, kusma ve karın ağrısı nedeniyle periferdeki bir hastaneye götürülerek suisid amaçlı ilaç intoksikasyonu nedeniyle yoğun bakım ünitesinde 2 gün takip ediliyor. Takiplerinde bir komplikasyon gelişmeyen hasta önerilerle taburcu ediliyor. İlaç alımından yaklaşık 18 gün sonra baş ağrısı, kol ve bacaklarında güçsüzlük, uyuşma başlıyor. 2 gün sonrada yürüyememe şikayeti ile acil servisimize başvuruda bulunuyor.

Fizik Muayene: Genel durumu iyi, bilinç açık. Vital Bulguları: TA:110/70 mmHg, Nb: 86/dk ritmik, SS: 18/dk, A:36,7°C. Baş-boyun muayenesi doğal. Solunum sistemi dinlemekle doğal, ral ve ronküs yoktu. Kalp dinlemekle doğal, ek ses ve üfürüm yoktu. Batın rahat. Nörolojik muayenesinde üst extremiteelerde hafif güç kaybı, her iki alt extremiteelerde 3/5 kas gücü kaybı ve derin tendon refleksi kaybı ve minimal duyu kaybı mevcuttu.

Acilimizde detaylı anamnezinde içtiği şurubun organofosfat olduğu öğreniliyor. Hastada organoafosfata bağlı geç polinöropati ön tanısıyla nöroloji konsültasyonu istendi. Hasta nöroloji servisine yatırıldı. Hasta geliş şikayetlerinin çoğunun düzelmesi sonucu taburcu edildi.

Sonuç: Organik fosforlu pestisitlerin neden olduğu gecikmiş polinöropati insanlarda nispeten nadir görülen nörodejeneratif bozukluktur. Bu komplikasyon çok az organik fosfor bileşiğinde görülmektedir. Uygun tedavi alan hastaların çoğunda bu olay görülmemektedir. Omuriliğin inen ve çıkan kolunda ve periferik sinirlerin duyu ve motor aksionlarda işlev kaybı vardır. Polinöropati zehirlenmeden sonraki 14-28 gün içinde oluşur. Hastalarda iki taraflı periferik kas güçsüzlüğü vardır. Beraberinde duyu bozukluğu da olabilir fakat daha hafiftir. Hastalar ayakta duramaz ve dengelerini koruyamaz. Üst ekstremiteelerde benzer şekilde etkilenir. Olgumuzda da literatürde belirtildiği gibi organofosfata maruziyet vardı ve uygun tedavi verilmemişti. Ayrıca bilateral kas güçsüzlüğü ve duyu kaybı oluşmuştu. Sonuç olarak ilaç zehirlenmelerinde eğer suisid amaçlı alım varsa şahıs bu maddeleri tam olarak söyleyemez. Bu nedenle hikaye çok iyi alınmalıdır. Organofosfor zehirlenmelerinde morbidite ve mortalitenin engellenmesi için erken tanı ve tedavi şarttır. Akut zehirlenen hastalarda yeterli solunum ve dolaşım sağlanmalı, antidot tedavi yeterli dozda ve gecikmeden uygulanmalı, kronik ve yeterli tedavi edilmemiş olgularda gelişebilecek komplikasyonlar açısından dikkatli olunmalı ve tedavinin her aşaması yakın takip edilmelidir.

Anahtar Kelimeler: Acil, zehirlenme, organofosfat, nöropati

P-0841 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Atipik Başvuru: Batında Kürdan

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Vaka: 54 yaşında erkek hasta acil servisimize 3 gündür devam eden karın ağrısı, bulantı ve kusma şikayetleriyle başvurdu. Yapılan fizik muayenesinde sağ alt kadranda hassasiyet, defans ve rebound mevcuttu. Acil serviste akut batın (akut apandisit) ön tanısıyla genel cerrahi konsültasyonu istendi. Hastanın mevcut fizik muayene bulguları ve laboratuvar sonuçlarıyla akut apandisit ön tanısıyla genel anestezi altında aynı gün appendektomi amaçlı operasyona alındı. Mc-Burney insizyonu laparotomi yapılarak appendiks vizüalize edildi. Mevcut halıyla apandisit lehine görsel bir bulguya rastlanmamakla birlikte appendektomi yapıldı. Bunun üzerine intestin explore edildi. Eksplozasyonda mevcut kliniği açıklayacak herhangi bir bulguya rastlanmadı. Mc-Burney insizyonu bölgesinden yapılan palpasyonda batında sağ parakolik bölgede, serbest vaziyette bir adet kürdan saptandı. Dikkatli bir şekilde mevcut kesiden batın dışına alındı. Kanama kontrolünü takiben sağ parakeal bölgede bir adet küçük dren konularak batın usulüne uygun olarak kapatıldı. Post-op 2. günde dren çekilerek şifa ile taburcu edildi. Post-op anamnezde hastanın kürdan yutma ile ilgili bir yakınması olmadığı öğrenildi.

Sonuç: Yabancı cisme maruziyet; aspirasyonu, yutulma veya batma nedeniyle olmaktadır. Erişkinlerde daha çok yabancı cisim yutulması, aspirasyonu veya suistimali şeklinde başvuru olmak-tayken, çocuklarda bunlara ilave olarak kazayla yabancı cisim batması, saplanması şeklinde başvurular da olmaktadır. Yapılan literatür taramasında vücuda tamamen saptanmış ve dışardan gözle görülmeyen bir yabancı cisim olgusuna rastlanılmıştır(1-4). Yaralanmalar acil servislere sık başvuru nedenleridir. Yaralanmanın mekanizmasının doğru anlaşılması, gelişebilecek



POSTER PRESENTATIONS

hayati tehlike oluşturabilecek organ yaralanmalarının belirlenmesi için önemlidir(5). Sonuç olarak akut batın tablosuyla gelen, nedeni bilinmeyen yabancı cisimler nadiren rapor edilmektedir. İnsan vücudunda yabancı cisimlere tüm yaş gruplarında rastlanılmaktadır. İnsanlar genellikle yabancı cisim yutulması şikayeti ile acil servislere başvururlar. Olgumuzda yabancı cismi yutma ya da batma öyküsü yoktu ve cismin ne yolla, ne zaman vücuda alındığı bilinmiyordu. Yabancı cisim yutma olguları; hastanın yaşına, eşlik eden ek bulgulara, yaralanmanın yerine, yutulan cismin boyutuna ve niteliğine, hastanın genel durumuna ve cerrahin tecrübesine göre farklılıklar gösterir. Bu nedenle acil servise karın ağrısı, rebound ve yaygın hassasiyet şikayetiyle başvuran hastalarda 'yabancı cisim' de akla gelmelidir.

Anahtar Kelimeler: Acil, karın ağrısı, yabancı cisim

P-0842 Toxicology

Mayıs Çiçeği

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Mayıs Çiçeği kullanımına bağlı iki olgu

VAKA-1: 54 yaşında bayan hasta, kronik diz ağrıları nedeniyle komşuları tarafından ağrılarına iyi gelebileceği söylenen mayıs çiçeğini ezip, dizine sürmüştü. Yaklaşık 10 saat sonra dizinde şiddetli bir yangı oluşunca acil servisimize başvurmuştur.

VAKA-2: 55 yaşında bayan hasta, fizik tedavi kliniğinde osteoporoz ve atralji tanısıyla tedavi görürken, köyünde mayıs çiçeğinin ağrılarına iyi geleceğinin söylenmesi üzerine tedavisini keserek, mayıs çiçeğini ezip kaynatmış ve dizlerine sürmüştü. Yaklaşık 4 saat sonra dizlerinde yangı oluşması üzerine acil servisimize başvurmuş.

Fizik Muayene: Her iki olguda da hikaye ve fizik muayene aynıydı. Genel durumları iyi, bilinç açıktı. Vital bulguları stabildi. Olgularımızda her iki diz ön yüz, femur alt uç ve tuberostaz tibia yı içine alacak şekilde birinci ve/veya

Vakalarımız acil serviste mayıs çiçeğine bağlı ikinci derece yanık tanısıyla genel cerrahi konsültasyonu istendi. Hastalar yanık ünitesine yatırıldı. Bactigraslı yanık pansumanı yapıldı. Hastaların takiplerinde komplikasyon gelişmedi, önerilerle taburcu edildi.

Sonuç: Bitkilere bağlı dermatitler mekanik ve farmakolojik injuriler şeklinde ya da primer iritan fitodermatitler, allerjik fitodermatitler, psödoftodermatitler, fitofotodermatitler ve psödoftotodermatitler şeklinde ortaya çıkabilir(1). Kimyasal irritasyon yapan önemli bitki cinslerinden biri Ranunculus (dügün çiçeği, mayıs çiçeği)'dur. Ranunculus türleri yakıcı, tahriş edici, kızartıcı ve zehirli bitkiler olarak tanınırlardır(2). Ranunculaceae familyasında bulunan bitkilerin zehirlenmesiyle, doymamış bir lakton olan protoanemoninin ortaya çıkması irritasyona yol açar(3). Zedelemiş olan mayıs çiçeği bitkisinin yapraklarının ve sapının çiğnenmesi ile dudak etrafında ve yüzde büller gelişebilir. Ranunculaceae ailesi içerdiği furokumarinler nedeniyle fitofotodermatit oluşumuna neden olabilir(4). Paramedikal tedavilere yönelimin daha çok kronik hastalıklarda görüldüğü bilinmektedir. Mayıs çiçeğinin yöremizde romatizmal hastalıkların tedavisinde kullanıldığı bilinmektedir. Bitkilerin çoğu zararsız olmasına rağmen deriye teması halinde iritan alerjik ya da olgularımızda ki gibi dermatite neden olabilir. Olgularımızda kronik ilaç kullanımı mevcuttu. Ancak fayda göremediklerini düşündükleri için paramedikal tedaviye yönelmeleri literatür ile uyumluydu. Bu olgularda, kronik hastalıklara yaklaşımda destekleyici bakımın sağlanması, erken koruyucu önlemlerin alınması, destekleyici tedavi sonrası hayat standardının sağlanması amaçlanmıştır. Bu olgularda görüldüğü gibi geleneksel tıbbi tedavi yaklaşımları dışında paramedikal tedavi yöntemlerinin giderek güncellik kazandığı görülmektedir. Paramedikal tedavi yaklaşımları, hekimlerin ve acil servislerin iş yükünü, beraberinde tedavi sürelerini ve masraflarını artırmaktadır.

Anahtar Kelimeler: Acil, dermatit, yanık, mayıs çiçeği

P-0843 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Retroperitoneal Nekrotizan Fasiit

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Konya Eğitim Araştırma Hastanesi Meram/Konya

Amaç: Nekrotizan yumuşak doku enfeksiyonları (NYDE) nadir görülen enfeksiyonlardır. Teknolojideki tüm gelişmelere rağmen hala mortalitesi çok yüksektir. Genelde cerrahi bir müdahale veya travma sonrasında oluştuğu gibi diyabetik ve immunsupresif hastalarda cilt bütünlüğünde herhangi bir bozulma olmaksızın da gelişebilirler. Burada herhangi bir risk faktörü olmayan nekrotizan fasiit olgusu tartışılacaktır.

Olgu: 83 yaşında erkek hasta, 2 gün boyunca karın ağrısı sebebi ile ilçe devlet hastanesinde takip edildikten sonra genel durumunun kötüleşmesi üzerine hastanemiz acil servisine sevk edildi. Hastanın anamnezinde bilinen hastalığının olmadığı, iki gün önce başlayan karın ağrısı sebebi ile bir hastanede takip edildikten sonra durumunun kötüleşmesi üzerine hastanemize sevk edildiği öğrenildi. Özgeçmişinde herhangi bir ilaç kullanım öyküsü olmayan hastanın vitalleri, TA: 70/50mmHg, nabız: 130/dk ateş: 37.1 idi. GKS:10 du. Hastanın batın muayenesinde suprapubik bölgeden başlayıp her iki üst kadrana kadar uzanan palpasyonla yaygın krepitasyonları vardı. Batın hassas yaygın rebound pozitif defans yoktu. Herhangi bir açık yaraya ya da yatak ülserine rastlanmadı. Hastaya gift damar yolu açılıp yoğun sıvı resüsitasyonuna başlandı. Hastanın rutinlerinde glukoz: 62mg/dl kreatinin: 1.9 mg/dl üre: 96 mg/dl, WBC: 8000, prokalsitonin: 17.5 Hb: 11.8gr/dl, CRP: 256, lac: 8.4mEq/l idi. Çekilen batın BT'de, Batın ön duvarında, sol gluteal kaslar komşuluğunda, perirektal bölgede ve pelvis içerisinde mesane sol lateral komşuluğunda, sol böbrek komşuluğunda retroperitoneal bölgede nekrotizan fasiit tespit edildi. Hasta acilen genel cerrahiye konsulte edildi. Genel cerrahiye konsulte edilen hastaya acil ameliyat kararı verildi. Ameliyathaneye gönderilen hasta postop 1. günde kaybedildi.

Sonuç: Nekrotizan fasiitte klinik tablo her zaman belirgin olmayabilir. Özellikle vakamızda olduğu gibi yaşlı, intrapelvik ve retroperitoneal yayılım olan vakaların tespiti zordur. Mortalitede en önemli faktör erken tedavi ve antimikrobiyal tedavidir. Olgumuzda hasta 2 gün boyunca karın ağrısı etyolojisi araştırılmak üzere başka hastanede yatarak tedavi görmüş, kötüleşmesi üzerine kliniğimize sevk edilmiştir. Akut dönemde tanı konması zor olduğundan özellikle risk faktörü olan hastalarda nekrotizan fasiit mutlaka akılda tutulmalıdır.

Anahtar Kelimeler: Nekrotizan fasiit, Nekrotizan yumuşak doku enfeksiyonları, retroperiton

P-0844 Toxicology

İntihar amaçlı intoksikasyonlarda cinsel fonksiyon bozukluğu, evlilik uyum, depresyon ve yaşam kalitesi ilişkisi

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Konya Eğitim Araştırma Hastanesi Meram/Konya

Amaç: İntihar ve intihar girişimleri tüm dünyada en önemli ölüm ve morbidite nedenleri arasında yer almaktadır. Cinsel fonksiyon bozukluğu ve evlilikteki sorunlar yaşam kalitesini, kişinin duyu durumunu sıklıkla etkilediği gibi istenmeyen kötü sonuçlarla (intihar, boşanma vs) da karşımıza çıkmaktadır. İntihar amaçlı intoksikasyonlarda cinsel fonksiyon bozukluğu, evlilik uyumu ve doyumunu ile depresyon ve yaşam kalitesi ilişkisi çeşitli ölçekler kullanılarak araştırıldı.

Gereç-Yöntem: Hastanemiz acil servisine intihar amaçlı intoksikasyon nedeniyle başvuran cinsel aktif dönemde (18-65 yaş) evli olan 125 hasta (75 kadın, 50 erkek) alındı. Çalışmayı kabul eden 69 hasta (yaş ortalaması 33.0±7.7 yıl (18-55)) ve 45 kontrol (32.06±7.4 yıl (20-55)) grubu çalışmaya dahil edildi. Hasta grubunun 38 (%55,1)'i kadın (yaş ortalaması 29.8±6.3 (18-45)) ve 30 (%44,9)'u erkek (yaş ortalaması 36.8±7 (26-55)) idi.

Kontrol grubuna göre, tüm hastaların, SF-36 yaşam kalitesi ölçeğinin fiziksel komponent skoru (52,1±21,9 (p=0,01)) anlamlı olarak düşük, mental komponent skoru (38,9±12,9 (p=0,000)) anlamlı olarak düşük saptandı. Seksüel disfonksiyon her iki cinsde de oldukça yüksek oranda saptandı (kadınlarda %92,1 ve erkeklerde %87,1). Kontrol grubuna göre, tüm hastaların, evlilik ölçeği skoru (31,1 ±12,0 (p=0,000)) anlamlı olarak daha düşük bulunmuştur. Kontrol grubuna göre, tüm hastaların Beck depresyon ölçeği ortalama puanı (30,6 ±11,9 (p=0,000)) anlamlı olarak yüksek bulunmuştur. Hastaların % 92,2'sinde (kadın hastaların %89,5'inde, erkek hastaların ise %96,8'inde) depresyon tespit edildi. Hastaların %92,8'inde evliliklerinde uyumsuzluk saptandı

Bulgular: İntoksikasyon nedeniyle intihar eden hastalarda, yüksek oranda depresyon ve cinsel fonksiyon bozukluğu saptandı. bu hastaların hemen tümüne yakınında evliliklerinde uyumsuzlukta tespit edildi. depresyon ve cinsel fonksiyon bozuklukları hem kişilerin yaşam kalitesinde bozulmaya hem de evlilik uyumsuzluğuna yol açarak intihar gibi istenmeyen sonuçlara yol açabilir.

Sonuç: İntoksikasyon nedeniyle intihar eden hastalarda, yüksek oranda depresyon ve cinsel fonksiyon bozukluğu saptandı. bu hastaların hemen tümüne yakınında evliliklerinde uyumsuzlukta tespit edildi. depresyon ve cinsel fonksiyon bozuklukları hem kişilerin yaşam kalitesinde bozulmaya hem de evlilik uyumsuzluğuna yol açarak intihar gibi istenmeyen sonuçlara yol açabilir.

Anahtar kelimeler:İntihar, intoksikasyon, cinsel fonksiyon bozukluğu, evlilik uyumu, depresyon, yaşam kalitesi

Anahtar Kelimeler: İntihar, intoksikasyon, evlilik, depresyon, y.kalitesi



POSTER BİLDİRİLER

P-0845 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Osgood-Schlatter hastalığı

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Antalya Eğitim ve Araştırma Hastanesi

Amaç: Osgood-Schlatter hastalığı (OSD) aktif, hızla büyüyen adolesanlarda yaygın olarak görülen ve diz ağrısının en sık nedenlerinden biridir. Patellar tendon ve tibial tüberkül apofizinde görülen, genellikle benign bir rahatsızlıktır. OSD tipik olarak büyüme çağındaki kızlarda 8-13 yaş, erkeklerde 10-15 yaş arasında daha sıktır. OSD prevalansı aynı yaşlarda ki sporla uğraşan adolesanlarda %21, spor yapmayanlarda %4.5 rapor edilmiştir. Erkeklerde daha sık olarak görülmesine rağmen spor yapan kızlarda da görülme oranı artmaktadır

Olgu: 13 yaşında erkek hasta her iki diz altında şişlik ağrı ve hassasiyet şikayeti ile başvurdu, bu şikayetleri yaklaşık 6 aydır varmış, yaklaşık 4 yıldır taekwondo sporu yapıyormuş, müsabakalara katılmasını engelleyeceği düşüncesi ile doktora gelmekten kaçınmış. Fizik muayenesinde her iki dizde tibial tüberkül üzerine lokalize olmuş hassasiyeti ve tüberkülün belirginliğinin artması tespit edildi. Çekilen radyografisinde tibial tüberkülün düzensizliği dışında bulgu yoktu. Hastaya semptomları şiddetli olduğu için spora bir süre ara vermesi dizlik yada koruyucu kullanılması önerilerek, ayırıcı tanı yönündende aile bilgilendirilerek taburcu edildi

Sonuç: Acil servise çok nadir bir başvuru nedeni olmasına rağmen, böyle bir hastalığında acil başvuru nedeni olabileceği ve genelde tek dizde semptom ve bulgular olurken bizim hastamızda her iki dizdede olması ilgi çeken bir yönüdür.

Anahtar Kelimeler: Osgood-Schlatter hastalığı, Ağrı, Diz

P-0846 Toxicology

Bir Demonstratif Karbonmonoksit İntoksikasyonu

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Giriş: Karbonmonoksit (CO) renksiz, kokusuz, tatsız ve iritan olmayan bir gazdır. Akut yada kronik zehirlenmelere neden olabilir. CO zehirlenmesinde inhale edilen gaz hızla alveolo-kapiller membrandan geçer, intravasküler alana girer ve Hemoglobine (Hb) bağlanır. Moleküllerin oksijen taşıma kapasitesini bozar. CO'nin Oksijene (O2) göre Hb'e afinitesi 200 kat Myoglobine afinitesi 60 kat daha fazladır. Bu yüzden erken tanı ve tedavi mortalite ve morbiditeyi azaltmaktadır.

Olgu: 34 yaşında bayan hasta yemek pişirmek için yaktığı zeytin kütüğünü mangal içinde odanın içine getirmiş. Yaklaşık 18 saat sonra yakınları tarafından evde baygın olarak bulunmuş. Hasta getirildiğinde genel durumu kötü şuurunu konfüze Glasgow Koma Skalası(GKS):8(E1-M5-V2), pupiller izokorik ağızda sekresyon artışı mevcuttu. TA:110/70mmHg, Nabız:110/dk, Ateş:36,8 C, Oksijen saturasyonu %83. Sağ ayak bileğinde 6x7 cm., sol ayak bileğinde 7x8 cm bül vardı, hastanın diğer sistemik fizik muayene bulguları doğaldı.

Hasta acil gözlemede takibe alındı. Kan gazında özellik yoktu. Hastaya 10 lt/dk oksijen tedavisi başlandı. Hastanın kan sayımında WBC 9,7 Hgb 10 Hct 30 PLT 112000 Glukoz 112 mg/dl BUN 24 Kreatin 0,7 AST 75, ALT 33, Na 132, K 4, CL 108, Kolinesteraz 7600. Hastaya Beyin BT çekildi ve sonucu normal olarak yorumlandı. Hastanın karbonmonoksit düzeyi %27. Hastaya beyin MR'nda bilateral globus pallidusda hiperintens odaklar mevcuttu. Hastanın şuurunu tedaviye başladıktan 4 saat kadar sonra açıldı. Ancak hasta takibinin Yatışının 24. Saatinde AST 435 ALT 139 olması üzerine hastaya abdomen USG yapıldı; USG normaldi. Batın muayenesi tamamen normaldi. Yatışının 48. Saatinde AST 461 ALT 162'ye yükseldi. Ancak 3. Gün karaciğer enzimleri düşmeye başladı. (AST 245 ALT 137)

Sonuç: Spesifik anamnezin varlığı teşhis ve tedavide sonuca kolay gidilmesini sağlamıştır. Hastanın bilateral ayak iç yüzlerinde büllerinin olması, globus pallidusda CO zehirlenmesinde görülebilecek radyolojik görüntülerin olması, nadir görülen hepatotoksitenin reversibl olarak gözlenmesiyle bu olgunun demonstratif bir CO zehirlenmesi olgusu olduğunu düşündürmüştür.

Anahtar Kelimeler: CO zehirlenmesi, bül, globus pallidus

P-0847 Trauma Emergencies

Penetran yaralanma sonucu oluşan Tiroit kırıkarak yaralanması

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Amaç: Boyun bölgesi penetran tip yaralanmalarda arter, ven ve hava yolu nedeniyle oldukça savunmasızdır. Larenks bölge kırıkları nadir olsa da potansiyel hava yolu aciliyeti nedeniyle önemlidir. Penetran yaralanmaya bağlı tiroit kırıkarak kırığı olgusu ile bu durumun önemini hatırlatmayı amaçladık.

Olgu: Acil servise 40 yaşında erkek hasta penetran boyun yaralanması ile başvurdu. Yaralanma mekanizması spiral makinası ile çalışırken parça kopması sonucunda oluştuğu söylendi. Fizik muayenede tiroit kırıkarak lokalizasyonunda oblik seyirli yaklaşık 5-6 cm uzunluğunda cilt altına doğru ilerleyen kesi mevcuttu. Hastada herhangi bir dispne, stridor bulgusu yoktu. Larengeal sinir felci bulgusu muayenede saptanmadı. Çekilen boyun anjiyo tomografide tiroit kırıkarak kırık sağ yanında deplase fraktür, tiroit kırıkarak ve tiroit bezi anteriorunda travmatik dansite değişikliği, boyun anteriorunda travmatik cilt defekti, glottik mesafede hava yolu obliterasyonu saptandı.

Sonuç: Penetran boyun yaralanmalarında tiroit kırıkarak yaralanmaları ciddi semptom olmasa bile boyun anjiyo tomografi çekimi gerekebilmektedir.

Anahtar Kelimeler: Boyun, penetran yaralanma, tiroit kırıkarak

P-0848 Trauma Emergencies

Yanık Nedeni: Kupa Çekme

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Amaç: Kupa çekme (cupping therapy) halk tarafından geçmişten beri uygulanan geleneksel tedavi yöntemidir. Kupa içerisindeki oksijenin tüketilmesi esasına dayanan bu yöntem yanıcı maddelerin bir kap içinde yakılmasıyla uygulandığı bölgede vakum ve ısı artırıcı etki yaparak; kan dolaşımını hızlandırdığı, laktik asiti dağıttığına inanılır. Ancak ciddi yanıklara neden olabilmektedir. Biz de servimize kupa çekme sonrasında sırt bölgesinde yaygın yanık ile başvuran bir olguyu sunduk.

Olgu: On dokuz yaş bayan, genel vücut ağırsı sebebiyle bir hafta önce sırt bölgesine kupa çektiği öğrenildi. Öyküsünden daha önce fibromiyalji tanısıyla tedavi aldığı öğrenildi. Özel bir güzellik merkezinde sırt ağrıları için kupa çekme tedavisini uygulatan hastanın ilk bakıda sırtında yaklaşık 6x6 cm çaplarında çok sayıda yuvarlak, keskin sınırlı, bül içeren lezyonu mevcuttu. Hastanın bilinen bir sistemik hastalığı yoktu. Tansiyonu:120/80 mmHg, nabız:82/dk, ateş:36.2 derece idi. Yaygın kas ağrıları sebebiyle hastaya 75 mg intramüsküler diklofenak sodyum uygulandı. Bülleri bulunmayan ancak lezyonlarında kaşıntısı olan hastaya %5 lidokain içeren pomad ile pansuman yapıldı. Gümüş sülfadiazin ile yanık pansumanı önerildi. Düzenli pansuman ve plastik cerrahi poliklinik kontrolü önerilerek taburcu edildi. On gün sonra yanık lezyonlarının renk değişikliği ile birlikte gerilemiş olduğu görüldü.

Sonuç: Tedavi amaçlı kullanılan kupa çekme yöntemi dikkatli uygulanmadığında ciddi cilt yanıklarına neden olabilmektedir. Bu durumun yaşlı hastalar ve diyabet gibi yandaş hastalığı olanlarda daha ciddi komplikasyonlara neden olabileceğini düşünmekteyiz.

Anahtar Kelimeler: Acil Servis, Kupa Çekme, Yanık

P-0849 Toxicology

Bir baldıran otu vakası daha, olgu sunumu

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Amaç: Maydanozjiller familyasından zehirli bir bitki olan baldıran otu (Conium Maculatum) ile zehirlenme vakalarına son zamanlarda acil servislerde sık karşılaşılmaktadır. Ülkemizde dişiçilik ve tıp alanında (ağrı kesici ve spazm giderici olarak) kullanılan baldıran otunun uygun dozda ve kontrollü kullanımında tetanoz, epilepsi, boğmaca, nefes darlığı, siyatik sinir ağrısı, nevralsi, dalak ve karaciğer büyümelerinin tedavisinde kullanıldığı bilinmektedir. Diğer taraftan baldıran otunun yaprağından 6 gram tüketilmesi sonucu ölümler bildirilmiştir. Acil servisimize tavsiye üzerine baldıran otu yedikten 1 saat sonra baş dönmesi, halsizlik, dengesizlik ve yürüyememe şikayeti ile getirilen hastayı sunarak baldıran otunun ölüme kadar giden toksisiteye neden olabileceğine dikkat çekmek istedik.

Olgu: 59 yaşında bayan hasta, baş dönmesi ve halsizlik, dengesizlik ve bacakları üzerine basamama şikayetiyle getirildi. Fizik muayenede kardiyovasküler-pulmoner sistem bulguları doğaldı. TA:100/65 mmHg, Nb: 87/dk, GKS:15 nörolojik muayenede lateralize defisit yok ve arka sistem muayenesi doğaldı. Kas gücü muayenesinde kuvvet kaybı olmamakla birlikte harekete başlamakta zorlanma ve güçsüzlük mevcuttu. Periferik vertigo düşündürmeyen hastanın laboratuvar sonuçlarındaki K+3.3 mmol/L olması halinde anormal değerle karşılaşılmadı. Çekilen beyin tomografi ve MRG'de patoloji tespit edilemedi. Tekrar anamnez alındığında bahçede bulunan maydanoza benzeyen bir bitkiden, tavsiyesi üzerine eklem ağrılarına faydası olacağı düşüncesi ile 3 parça çiğ olarak yedikten 1 saat sonra yakınmalarının başladığı öğrenildi. Yakınlarının getirdiği bitki incelemesi ve klinik bulgulardan baldıran otu olduğu kanısına varıldı (şekil 1). Hasta



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acil serviste 24 saatlik takibe alınıp masif hidrasyon ve semptomatik tedavi yapıldı. Takipte ek sorunu olmayan hasta önerilerle taburcu edildi. Olayın 48.ci saatinde yapılan kontrolde sorun olmadığı görüldüğü üzerine önerilerde bulunulup takipten çıkartıldı.

Sonuç: Acil servise gelen hastaların anamnez ve fizik muayenelerinin birbirini tamamlamadığı durumlarda mutlaka detaylı bir anamnez alınmalıdır. Hasta ve yakınlarının önemli olduğunu düşünmediği bazı detaylar ölümcül olabilmekte ve tedavi planımızı yönlendirebilmektedir. Bu tür vakalarla sık karşılaşmakla birlikte bazı bitkilerin bilinçsiz ve aşırı kullanımının toksisite bulguları ve hatta ölüme sonuçlanacağını unutulmaması gerekmektedir.

Anahtar Kelimeler: Acil Servis, toksisite, balırcan otu

P-0850 Trauma Emergencies

Primer Travmatik Patella Luksasyonu

Yusuf Ali Altuncu, Mustafa Serkan Vurucu, Enver Özçete, Murat Ersel, Funda Akarca, Selahattin Kıyan

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Amaç: Akut travmatik patellar dislokasyon travmatik hemartrozların en sık görülen ikinci sebebidir. Sıklıkla spor yaralanmaları sonucu oluşur. Olgumuzdaki disloke patella görüntüsü ile fizik muayenenin tanıdaki önemini vurgulamayı amaçladık.

Olgu: Profesyonel masa tenisi sporcusu olan 16 yaşında erkek hasta antreman esnasında dizin ani abduksiyonu sonrasında dizde ağrı şişlik, dizi bükememe şikayetleri ile başvurdu. Fizik muayenede diz 45-50 derece fleksiyonda idi ve patellanın dizin lateraline doğru lukse olduğu saptandı. Sedo analjezi altında patella redukte edildi ve uzun bacak ateli ile hasta taburcu edildi.

Sonuç: Hastanın öyküsü ve fizik muayenedeki patellanın pozisyonu luksasyon tanısı için yeterli olabilmektedir.

Anahtar Kelimeler: patella luksasyonu, spor yaralanma, travma

P-0851 Trauma Emergencies

Torakotomiye İlerleyen Basit Pnömotoraks

Damla Selma Özalp, Tuba Cimilli Öztürk, Yılmaz Aydın, Serdar Özdemir, Özlem Küsken, Mazlum Kılıç, Rohat Ak, Özge Ecmel Onur

Fatih Sultan Mehmet Eğitim Araştırma Hastanesi, Acil Tıp Kliniği, İstanbul

Amaç: Travma özellikle 40 yaş altı hasta grubunda en önemli ve sık görülen morbidite ve mortalite sebebidir. Gerek gelişmiş ve gerekse gelişmekte olan ülkelerde, trafik kazaları künt toraks travmalarının en sık sebebidir ve en fazla genç erkeklerde görülür. Künt toraks travmaları tüm travma olgularının %10'unu oluşturmaktadır ve genellikle diğer sistem travmaları ile birlikte görülmektedir. Travmaya bağlı ölümlerin %25'inden toraks travmaları sorumlu tutulmaktadır.

Olgu: 16 yaşında erkek hasta motorsiklet kazası nedeniyle kliniğimize başvurdu. Hastanın başvurusunda bakılan vitalleri TA:80/56 mmHg, Nabız:100/dk, SpO2:%98, Solunum sayısı:15/dk idi. Hastanın muayenesinde bilinç açık, koopere, oryante ve GKS 15 idi. Yapılan fizik muayenede toraks ve batin her iki üst kadranda yaygın hassasiyet mevcuttu. E-FAST değerlendirmede batin içi serbest mayi ve perikardiyal, plevral efüzyon izlenmedi; ancak sol pnömotoraks görüldü. Hastaya çekilen tomografilerinde sol IV. ve V. kosta proksimalinde şüpheli kırık izlenmekte olup sol kostada deplasman fraktürü hatta, sol toraksta minimal pnömotoraks görüldü. Batin içi solid organ yaralanması görülmeydi. Laboratuvar incelemelerinde hemoglobin 13,7gr/dl hematokrit % 41,4 idi. Karaciğer ve böbrek fonksiyon testleri normal sınırlarda değerlendirildi. Gelişindeki hipotansiyonu iv hidrasyon sonrası düzeldi. Göğüs cerrahisi konsültasyonu sonrasında hastanın medikal olarak takip edilmesi planlandı. Acil servisteki takibi sırasında 4. saatte hastada aniden şok tablosu gelişti (TA: 60/40mm/Hg, nabız: 140/dk, solunum sayısı:35, SpO2:%87). Kontrol E-FAST'de sol plevral alanda efüzyon tespit edildi. Batin ve perikarda sıvı gözlenmedi. Bunun üzerine acil tüp torakostomi yapılan hastada 1200ml hemorajik mayi drene edildi. Masif hemo-toraks kabul edilerek ameliyathane acil torakotomi yapılarak yoğun bakım ünitesine alındı. Takiplerinde genel durumu düzelen hasta 15. gününde taburcu edildi.

Sonuç: Toraks travmalarının tedavisinde ameliyatsız yaklaşımlar çoğunlukla yeterli olmaktadır. Özellikle izole toraks travmalarının ameliyatsız yönetimi ve gerektiğinde tüp torakostomi ile etkin bir şekilde tedavi edilmesi mümkündür. Fakat bu hastaların hastane ortamında yakın klinik izlemi gerekmektedir. Genel durumu stabil olan hastaların rutin takipleri için akciğer grafisi önerilmektedir. Ancak özellikle yatar pozisyonunda takip edilen çoklu travma hastalarında plevral sıvının erken tanınması için direk grafi yetersiz kalmaktadır. Ultrasonografi ise bu tür hastalarda son yıllarda %100'e yakın sensitivitesi ile tercih edilmektedir. Genel durumu stabil olan ve ilk tetkiklerinde belirgin patolojisi olmayan künt toraks travması ile takip edilen genç hastalarda bir kaç saat içerisinde bile masif hemo-pnömotoraks gelişmesine rağmen çok bulgularının son ana kadar silik olabileceği akılda tutulmalıdır. Tekrarlayan yatak-başı akciğer ultrasonografisi güvenilir ve basit bir yöntem olmasından dolayı rutin olarak kullanılmalıdır.

Anahtar Kelimeler: torakotomi, acil servis, pnömotoraks, E-FAST

P-0852 Trauma Emergencies

Extremitede yabancı cisim, olgu sunumu

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Amaç: Acil servislerde karşılaşılan hasta popülasyonu içerisinde vücudun çeşitli bölgelerinde yabancı cisim batmaları çok sık karşılaşılan vaka türleridir. İlginç bir yabancı cisim batması olması nedeni ile bu olguyu sunmak istedik

Olgu: 12 y erkek hasta, okulda kapıya çarpma sonrası kapı kulpuğun koluna batması nedeniyle 112 tarafından acil servise getirildi. Fizik muayenede sağ kol kubital bölgede saplanmış ve tamama yakınının kas içine invaze olmuş şekilde kapı kulpu olduğu görüldü. Extremit muayenesinde Periferik nabızlar açıktı. Başka bir patolojisi olmayan hastaya çekilen X-ray de yabancı cisim görülmele birlikte kemik patolojisi tespit edilemedi. 1 mg/kg Ketamin ile sedasyon yapılan hastanın kolundaki yabancı cisim çıkartıldı. Aktif kanamaması olmayan hastaya yapılan üst extremitte doplerinde ek sorunu olmaması üzerine eklem istirahatı amacı ile alçı-atele alınıp oral antibiyotik ve 3 gün sonra acil servis kontrolü önerisi ile taburcu edildi. Aralıklı olarak 10 günlük kontrolde komplikasyon ile karşılaşmadı ve hasta takipten çıkartıldı.

Sonuç: Acil servislerde vücudun farklı lokalizasyonlarına çeşitli yabancı cisimlerin batması sonucu müracaat eden hastalarla sık sık karşılaşılmaktadır. Nadir görülebilecek türden bir yabancı cisim vakası olması nedeni ile sunmayı planladığımız bu vakada olduğu gibi komplikasyonsuz, stabil yabancı cisim batması vakalarında acil serviste müdahale edilip kontrol muayenelere çağırılması uygun olacaktır.

Anahtar Kelimeler: acil servis, extremitte travmaları, yabancı cisim

P-0853 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Splenik infarkt: olgu sunumu

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Amaç: Splenik infarkt akut karın yapan nedenleri arasında nadir görülen bir dalak patolojisidir. Etiolojisinde atrial fibrilasyon, hematolojik hastalıklar, vasküler patolojiler, kollajen doku hastalıkları, hemoglobinopatiler gibi birçok neden suçlanmıştır. En sık gözüken semptomu sol üst kadranda ağrı ve bu ağrının sıklıkla sol omuza yayılmasıdır. Teşhis klinik olarak şüphelenmek ve bunları radyolojik görüntüleme ile desteklemekle konulur. Radyolojik görüntülemeye en sık USG, CT ve nükleer görüntülemeye. Splenik infarkt tanısı konduktan sonra hidrasyon, oksijen desteği ve analjezi sağlanarak gözlenen hastaların büyük bir kısmında 7-10 gün içerisinde semptomların gerilediği görülmektedir. Hastaların %20'sinde ise splenik abse, hemoraji, rüptür ve psödotokist oluşumu gibi komplikasyonlar gelişmektedir. Tekrarlayan semptomları olan ve komplikasyon gelişen hastalarda splenektomi endikasyonu bulunmaktadır.

Olgu: 61 yaşında kadın hasta, servismizde 3 gündür olan, devamlı, künt tarzda karın ağrısı şikayetiyle başvurdu. Ek şikayeti olmayan hastamızın ögeçmişinde diyabetes mellitus, hipertansiyon, hiperlipidemi ve koroner arter hastalığı mevcuttu. 15 yıl kadar önce koroner anjiyografi öyküsü mevcuttu. Yapılan fizik muayenede; TA: 110/70mm/Hg, ateş: 36 °C, nabız: 89/dk, SS: 18/dk idi. Çekilen ekg: sinüs ritminde. Batin muayenesinde, yaygın hassasiyeti mevcuttu. Defans ve rebound bulguları pozitif idi. Laboratuvar bulgularında, WBC: 19.000 K/mm3, Hb:12,25 g/dl, PLT: 207.000 /mm3, INR: 1,25 olarak raporlandı. Hastada akut batin düşünüldü. Hastaya kontrastlı batin CT planlandı. CT raporunda: dalak orta kesimde 2.5 cm* 2.5 cm lik üçgen alanda hipodens infarktla uyumlu alan izlenmiştir. Hastada splenik infarkt düşünülerek genel cerrahi konsültasyonu istendi. Hasta genel cerrahi servisinde yatış yapılarak takiplerinde klinik olarak rahatlaması üzerine poliklinik önerisi ile taburcu edildi.

Sonuç: Acil serviste çalışan hekimlerin, sol üst kadranda ağrısı ile başvuran hastalarda predispozan faktörler eşliğinde, splenik infarktı ayırıcı tanıda düşünceleri önem arz etmektedir.

Anahtar Kelimeler: Acil, splenik infarkt, karın ağrısı



POSTER BİLDİRİLER

P-0854 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acil Serviste Atıptık Göğüs Ağrısı Ve Yabancı Cisim

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Amaç: Acil servise müracaat eden göğüs ağrılı hastaların yönetiminde, basit bir miyaljiden akut koroner sendrom ve akciğer enfeksiyonları gibi geniş bir etyoloji göz önünde tutulmalıdır. İlk görüşünüşte hekimi yanıltan bir olgu olması nedeni ile sunmak istedik

Olgu: 33 yaşında bayan hasta, yataarken ani başlayan göğüs sağ hemitoraks posterolateralde batma tarzında ağrı ile acil servise getirildi. Hastanın özgeçmişinde herhangi bir hastalığı ve sigara öyküsü yoktu. Fizik muayenede solunum sesleri doğal, her iki hemitoraks solunuma eşit katılıyor ve ral (-), ronkus (-) yoktu. Sağ alt kostalar hizasında hareketle artan ve hareketi kısıtlayacak şiddette batma tarzında ağrı tarif eden hastanın EKG'si normaldi. Çekilen akciğer grafisinde sağ alt kostalar hizasında metal dansitesinde yabancı cisim görüldü. Toraks BT'de sağ 8.ci kostanın dış komşuluğunda, ince uzun yapıda yabancı cisim görüldü ve hemo-pnömotoraks tespit edilmedi. Görüntülerde cismin plevrar boşluk ile ilişkili olmadığından emin olduktan sonra, USG eşliğinde işaretlenen alana lokal anestezi altında insizyon yapıldı. Yaklaşık 7-8 cm uzunluğundaki palpasyonla hissedilemeyen yabancı cisim, komplikasyonsuz olarak çıkartıldı ve insizyon alanı primer suture edildi. İşlem sonrası çekilen kontrol grafide komplikasyon ile karşılaşmayan hasta önerilerle taburcu edildi.

Tartışma: Hastaya, yatağında unutulmuş bir iğnenin battığı ve kostaya çarpması sonucu kavis alarak dışarı doğru yöneldiği düşünüldü. Olayın uyku esnasında gelişmesinden dolayı hastanın yabancı cisim battığını tarif edememesi, Yabancı cismin cilt altına kadar ilerlemiş olması, herhangi bir kanama bulgusu olmaması nedeni ile external muayene ile tespit edilemedi. Gelişinde fibromiyalji olarak kabul edilen vakanın aslında hızlı bir hareket ile derinin altına nüfuz eden bir yabancı cisim batması olduğu görülmüştür. Bu nadir görülen prezentasyon, akciğer grafisinin göğüs ağrılı hastalardaki önemini birkez daha kanıtlamış olması nedeni ile değerlidir.

Sonuç: Acil servislerde fibromiyalji tanısı konmadan önce, altına yatabilecek diğer tüm nedenlerin ekarte edilmiş olması gereklidir.

Anahtar Kelimeler: Acil Servis, göğüs ağrısı, toraks, Yabancı cisim

P-0855 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Farklı Yaşlarda Kronik nontravmatik Subdural Hematom

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Amaç: Subdural Hematomların akut, subakut ve kronik formları için değişik yazarlar tarafından değişik zaman süresi verilmektedir. Ancak genellikle subdural hematomun kronik kabul edilebilmesi için travmadan sonra iki haftanın geçmesi gerektiği kabul edilmektedir. Kronik subdural hematomlar herhangi bir yaşta olabilirler. Fakat kafa kemikleri ile beyin dokusu arasındaki mesafenin özelliğinden dolayı en çok çocuklar ve yaşlılarda rastlanır. Etiyolojide öncelikle travma olmak üzere daha az sıklıkla anevrizma ve anjiom rüptürü, tümörler, koagülopatiler ve diğer başka nedenler bildirilmiştir. Bizim olgumuz tanı almamış kronik subdural hematomla birlikte akut subdural hematomun birlikte olabileceğini bize hatırlatan bir olgu.

Olgu: 76 yaşında kadın hasta, dün akşam başlayan bulantı ve kusmaları takiben gelişen bilinç bulanıklığı şikayeti ile getirildi. Travma öyküsüne koagülopati yok, ilave öykü alınmadı. Özgeçmişte özellik yok. GKS: 8, E:2 V:2 M:4. Gözler sağa devrile ve sol hemipleji mevcut, solda babinski +. BBT: Sağ paryetalde oksipitalden frontale uzanım gösteren en derin yerinde 22 mm subakut-kronik subdural hematom mevcut, sağ serebral parankinde serebral öden görüntüsü ve sağ lateral ventriküle bası bulgusu mevcut, ayrıca sol paryetooksipital bileşke üzerinde en geniş yerde 11 mm ölçülen akut subdural hemoraji mevcut. Tanı: Non-travmatik subakut-kronik subdural hematom ve akut subdural hematoma bağlı KİBA sendromu ve pleji kliniği. Hasta entübe edilerek solunumu güvence altına alındı nöroşirürji adına yoğun bakıma yatırıldı. Kraniyotomi ile eksizyon sağlandı.

Sonuç: Bugün en çok kullanılan tanı yöntemi olan bilgisayarlı tomografi ile Kronik Subdural Hematomlarda elde edilen görüntü İzodens, Hipodens ve Hiperdens olabilmektedir. Bu dansite değişikliğinde akut formdan kronik forma geçiş seyrinde cereyan eder. Tanıda güçlük olan izodens görünümde kitle etkisi ile ventriküllerin durumu değiştiği gibi orta hattın sapma da görülebilir. Bizim olgumuzda olduğu gibi yaşlanmış hematom kliniğe neden olmayabilir ve yeni gelişen hematom ödem etkisi yapabilir.

Anahtar Kelimeler: hematom, nontravmatik, subdural

P-0856 Trauma Emergencies

Havuzda Dalma Sonrası Pnömotoraks

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Amaç: Pnömotoraks, göğüs boşluğu içerisindeki parietal ve visseral yapraklar arasında hava olması anlamına gelmektedir. Pnömotoraks spontan, travmatik ve iyatrojenik olarak gelişebilir. Spontan olarak meydana gelenler primer ve sekonder olarak ikiye ayrılır: Primer Spontan Pnömotoraks ek bir akciğer hastalığı bulunmayan sağlıklı bireylerde akciğer apeksindeki subplevrar bleblerin perforasyonu ile oluşur. Sekonder pnömotoraks ise akciğerde pnömotoraks gelişmesine zemin hazırlayan altta yatan bir sebep vardır.

Olgu: 19 yaşında erkek hasta sol göğüsde ağrı şikayeti ile acil servisimize başvurdu. Hasta anamnezinde bugün havuza gittiğini ve yüzme havuzuna daldıktan sonra göğüs ağrısı şikayetinin başladığını söyledi. Özgeçmişinde sigara kullanımı dışında özellik yoktu. Hastanın muayenesinde bilinç açıktı, oryante ve koopereydi. Glaskow koma skalası 15 idi. Başvuru esnasında ölçülen kan basıncı 110/70 mmHg, nabız 70 at/dk, parmak ucu saturasyonu %98 idi. Diğer sistem muayeneleri normaldi. Çekilen posteroanterior akciğer grafisinde kollaps olmuş sol akciğerin etrafındaki visseral plevrar hattı görüldü. Hastaya nazal kanül ile oksijen verildi ve acil serviste tüp torakostomi uygulandı. Kontrol posteroanterior akciğer grafisinde sol akciğerin reekspansiyon olduğu görüldü. Hastanemizde göğüs cerrahisi uzmanı olmadığı için hasta dış merkeze sevk edildi.

Sonuç: Primer spontan pnömotoraksın zorlu olmayan fiziksel aktivite sırasında oluşması çok sık karşılaşılan bir durum olmasa da bizim olgumuzdaki gibi sigara içen, zayıf, uzun boylu, erkek hastalarda her zaman akıldan bulunması gereken bir tanidir. Bu tip hasta gruplarında travmanın şiddeti düşük olsada hasta anamnezi her zaman dikkatli şekilde alınmalıdır. Hastalara erken tanı konulduğunda pnömotoraksın ölümcül komplikasyonlarından korunulmuş olunur.

Anahtar Kelimeler: pnömotoraks, yüzme, travma

P-0857 Trauma Emergencies

dirsek travmasında posterior yağ yastıkçığına dikkat eden var mı ?

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Dirsek eklemi günlük yaşamda travma ile en sık karşılaşılan anatomik bölgeler arasındadır. Oluş mekanizması ise genellikle kol dışa açık, dirsek ekstansiyonda, önkol supinasyonda el üzerine düşme sonucu valgus zorlanması ile oluşur. Bu valgus zorlanması medial epikondilde kopma kırığı, medial kollateral bağ yırtığı, olekranon, proksimal ulna ve lateral kondil kırığı gibi başka yaralanmalara da neden olabilir.

Olgu: Hali saha futbol maçı yaparken aldığı darbe ile dirseği üzerine düşen 30 yaşındaki erkek hasta acil servise dirsekte ağrı şikayeti ile başvurdu. Hastanın fizik muayenesinde dirsek üzerinde 2x2cmlik abrazyon ve yaygın şişlik mevcuttu. Dirsek eklemide supinasyon, pronasyon ve fleksiyon kısıtlılığı ve hareketle oluşan şiddetli ağrı mevcuttu. Çekilen dirsek iki yönlü direk grafide kemik kortekste düzensizlik, dislokasyon, fraktür hattı vs saptanmadı. Sadece direk grafide posterior yağ yastıkçığı ile uyumlu hipodens alan mevcut idi. Posterior yağ yastıkçığı bulgusu saptanan hastaya dirsek tomografisi çekildi ve radius proksimal uç fraktürü olduğu saptandı. Hasta ortopedi doktorları ile konsulte edildi. Hastanın dirseği uzun kol atel uygulaması ve medikal tedavi ile taburcu edildi.

Sonuç: Özellikle hekimlerin yoğun ve yorgun saatlerinde dirsek travmalı hastalarda radius kırıklarını gözden kaçırabilmektedir. Dirsek travmalı hastaların tanı ve tedavilerini doğru şekilde almaları ve hekimlerin malpraksis davalarına maruziyetlerini önlemek için posterior yağ yastıkçığı bulgusuna bakılmalıdır.

Anahtar Kelimeler: dirsek travması, posterior yağ yastıkçığı, malpraksis



POSTER PRESENTATIONS

P-0858 Trauma Emergencies

Kafa Travması ve Servikal Vertebra Yaralanması Birlikteliği

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Amaç: Kranial travmalı hastalarda servikal tomografi çekilmesi midir?

Giriş: Ciddi kafa travmalarının yaklaşık %10'una servikal vertebra yaralanmaları eşlik eder. Kafa travmalarında mental durum değişikliği yada servikal omurga yaralanma riskini arttıran mekanizma ile yaralanmış hastalarda kranial BT (Bilgisayarlı Tomografi) ile birlikte servikal BT'de çekilmelidir.

Gereç-Yöntem: Kahramanmaraş Sütçü İmam Üniversitesi Tıp Fakültesi acil serviste 01.01.2012-31.01.2014 tarihleri arasında travma sonrası hem kranial hem de servikal BT çekilen hastalar geriye dönük olarak incelendi. Çalışmaya eş zamanlı hem kranial hem de servikal spiral BT çekilen 88 hasta dahil edildi.

Bulgular: Seksen Sekiz hastanın 40'ının kranial BT'sinde herhangi bir patoloji tespit edilmezken 48 hastada patoloji tespit edildi. 14 tanesinde ekstrakraniyal (cilt altı hematoma, doku kaybı vs) lezyon tespit edilirken 2 tanesinde şüpheli fraktür, 1'inde şüpheli beyin ödemi, 1 tanesinde de nazal fraktür tespit edildi. Geri kalan 30 hastanın Kranial BT'sinde fraktür yada intrakraniyal lezyon saptandı. Ayrıca 88 hastanın 10'unun servikal BT'sinde de lezyon saptandı. Servikal BT'sinde lezyon saptanan 4 hastanın kranial BT'si normal, 2 hastanın Kranial BT'sinde cilt altı hematoma, 3 hastanın kranial BT'sinde kırık ve intrakraniyal kanama, 1 hastada ise kırık ve pnömosefali vardı.

Sonuç: Travma sonrası servikal vertebra yaralanması olan hastalarda intrakraniyal patoloji eşlik etme olasılığı yüksektir.

Anahtar Kelimeler: kafa travması, servikal tomografisi, kranial tomografi

P-0859 Toxicology

Verapamil İlk Dozuna Bağlı Atrio-ventriküler Tam Blok, Olgu Sunumu

Nihat Danlı, Aynur Yurtseven, Ender Kaya, Cihangir Doruk, Fuat Kulaksız

Dr. Nafiz Körez Sincan Devlet Hastanesi, Acil Tıp Kliniği, Ankara

Amaç: Kalsiyum kanal blokleri olan verapamil uzun yıllardır antihipertansif, antiiskemik ve antiaritmik olarak kullanılmaktadır. ilacın antiaritmik etkileri; sinüs düğümünden uyarı çıkış hızını azaltarak bradikardi oluşturması ve atriyoventriküler (AV) düğümü üzerinde (A-H süresini uzatarak) iletiyi geciktirerek P-R uzaması şeklindedir. Maksimum 480 mg dozda verilebilen verapamilin, teröpatik dozlarda nadiren AV bloğa yol açabildiği bildirilmiştir.

Olgu: Baş dönmesi nedeniyle 112 tarafından acil servise getirilen 60 yaşında bayan hasta. Anamnezde 10 gündür hipertansiyon nedeniyle takip edilip bir gün önce kardioloji kliniği tarafından 240 mg verapamil hidroklorür / 4 mg trandolapril ile 1,5 mg İndapamid içeren antihipertansif ilaçlar ile kombine tedavi başlanmış. Daha önce benzer bir şikâyeti olmayan hastanın verapamil hcl+trandolapril içeren ilaç alımından 6 saat sonra baş dönmesi ve bulantı şikâyetleri ile uykudan uyanmış. Sabah saatlerinde baş dönmesinin geçmemesi nedeniyle 112 tarafından acil servise getirilen hastanın çekilen Elektrokardiyogramında (EKG) 2D derece Atrio-ventriküler tam blok (34/dk) tespit edildi. 1 mg atropin IV uygulaması sonrası ritmi 55/dk sinüs olan hastanın baş dönmesi dramatik olarak azaldı. Hastanın ilaçları stoplanıp Koroner yoğun bakım ünitesinde takibe alındı. Yapılan EKO normal olarak bulundu. Semptomatik izlem ile 48 saat takip edilen ve kardiyak indeksleri stabil olan hastada ek sorun veya blok ile karşılaşmadı. Pace-maker endikasyonu doğmadı ve önerilerle taburcu edildi.

Sonuç: Acil servislerde antihipertansif tedavi başlanması mümkün olmakla birlikte, öncesinde hastaların detaylı bir şekilde incelenmesi, özellikle sol ventrikül disfonksiyonu, hasta sinüs sendromu, 2 ve 3 derece AV blok, atrial flutter veya atrial fibrilasyon ve accessory bypass tract (Wolff - Parkinson - White, Lown - Ganong-Levine syndromes) varlığı veya şüphelenilmesi durumunda kalsiyum kanal blokerlerinden uzak durulması gerekmektedir.

Anahtar Kelimeler: Acil servis, Verapamil, AV tam Blok

P-0860 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Grandmal Epileptik Nöbet Sonrası Bilateral Anterior Omuz Çıkığı

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Amaç: Çok az görülen bilateral anterior omuz çıkığına sebep genellikle ani ve aşırı kas kasilmalarına neden olan epilepsi, elektrik şoku, alkol yoksunluğu, hipoglisemiye bağlı gelişen konvulziyonlardır. Diğer nedenler arasında ağırlık kaldırma, suya dalma, traksiyon yaralanmaları sayılabilir. Çıkık mekanizması humerusun zorlamalı abduksiyon ve dış rotasyonu ile tuberkulum majusun akromiona dayanması ve kaldırıcı kolu etkisi oluşmasıdır. Biz bu olgu sunumu ile epilepsi hastalarında travma olmaksızın omuz çıkığı gelişebileceğine dikkat çekmeyi amaçladık.

Olgu: 5 yıldır Epilepsi tanısı ile tedavi gören 22 yaşındaki erkek hasta, geçirdiği grand mal nöbet sonrası acil serviste değerlendirildi. Hastanın Valproik asit 500 mg 2x1 kullanılmıyormuş. Hastanın vitalleri stabil, bilinci açık oryante ve koopere GKG 15, diğer sistemik muayneleri doğaldı. Hastanın tüm yapılan laboratuvar tetkikleri normal saptandı. Her iki kol hafif abduksiyon ve iç rotasyonda idi. Omuzlar normal yuvarlak konturlarını kaybetmişler ve akromion altında tipik çöküntü oluşmuştu. Omuz hareketleri çok kısıtlı ve ağrılı idi. Damar sinir yaralanması saptanmadı. Röntgen tetkikinde bilateral anterior omuz çıkığı tespit edildi. Hasta bunun ilk çıkığı olduğunu ifade etti. Acil serviste her iki omuz dış rotasyon metodu ile sedasyon anestezi altında (0,05 mg/kg midazolam intravenöz) analjezi olarak fentanyl 1 mikrogram /kg dozunda yapılarak redukte edildi. Hastanın çekilen kontrol röntgeninde her iki omuz başı yerinde tesbit edildi. Omuz bandajına alınan hasta noroloji ve ortopedi polikliniği önerisi ile taburcu edildi.

Sonuç: Epilepsi hastalarında fizik muayenede omuz çıkığı gelişebileceği akıld tutulmalıdır mutlaka fizik muayene tam yapılmalıdır.

Anahtar Kelimeler: Bilateral Omuz Çıkığı, Anterior, Epilepsi

P-0861 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Nadir Bir Gastrointestinal Obstrüksiyon Sebebi: Abdominal Aort Anevrizması

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Amaç: Gastrik çıkım obstrüksiyonu (GÇÖ), her ne kadar ismi mide patolojilerini çağırırsa da sıklıkla duodenumun intralümenal veya ekstralümenal nedenlere bağlı olarak tam veya kısmi olarak tıkanması sonucunda barsak pasajından gıda ve barsak içeriğinin düzenli geçişinin engellendiği durumdur. Alttan yatan neden %50-80 oranında malignitedir. Diğer nedenler arasında azalan sıklıkla peptik ülser hastalığı, pankreatit, kostik hasar, büyük gastrik polipler ve gastrik volvuluslar sayılabilir. Vasküler nedenlerle duodenumun ekstralümenal olarak obstrüksiyonu vakaları oldukça nadir olup, literatürde görülme sıklığı konusunda net bir veri yoktur.

Olgu: 74 Yaşında erkek hasta 7-8 saatir olan koyu bordo renkli kusma şikâyeti ile acil servisimize başvurdu. Özgeçmişinde stabil durumda KOAH dışında özellik tariflemeyen hastanın geliş vitallerinde ateşi: 36,5 C SPO2: %92 tansiyonu:100/71 mmHg Nabız:79 / dk idi. Yapılan sistemik muayenesinde batında hassasiyet dışında patolojik bulguya rastlanmadı. Hastaya GIS kanama ve ileus ön tanılarıyla nazogastrik sonda takıldı ve 2000 cc retansiyon mayisi niteliğinde geleni olduğu görüldü. Laboratuvar değerleri nötrofil hakimiyetinde lökositoz dışında normal sınırlardaydı. Konstrastlı bilgisayarlı tomografi (BT)'de; Abdominal aorta renal arter seviyesinden bifürkasyona kadar 127 mm'lik bir segmentte yaklaşık 82 mm'lik çapa ulaşan anevrizmatik dilatasyon izlendi. Anevrizmada gerçek lümen en geniş yerinde 53 mm olarak ölçüldü. Anevrizma lümeninde sirküler şekilde izlenen 28mm derinliğe ulaşan trombüs izlendi. Mevcut anevrizma duodenum 3. kıtasına basmaktaydı. Hastada anevrizmaya bağlı gastrik çıkım obstrüksiyonu düşünüldü. Hasta kalp damar cerrahisine sevk edildi. Kalp damar cerrahisi tarafından ameliyat için yüksek riskli olarak değerlendirilen hastaya girişim düşünülmüdü. Hasta konservatif olarak takip edildi. Takiplerinde bulantı kusma şikâyetlerinin gerilemesi üzerine hasta önerilerle kontrole çağırılarak taburcu edildi.

Sonuç: Gastrik çıkım obstrüksiyonunun tedavisi sıklıkla alttan yatan durumun tedavisine dayanmaktadır. Nedenlerin arasında maligniteler birinci sırada olup tedavisinde primer tümör ekzisyonu veya palyatif olarak stent uygulaması yer almaktadır. Diğer benign nedenler için ise genellikle medikal veya endoskopik dilatasyon gibi daha konservatif yaklaşımlar önerilmektedir. Bizim olgumuzda olduğu gibi vasküler nedeni ekstralümenal GÇÖ vakalarında net bir tedavi şeması bulunmaması birlikte bildirilen az sayıda vakada yine nedene yönelik yaklaşım yapıldığı görülmüştür. Bizim vakamızda hastanın operasyon için yüksek risk taşımasından dolayı ailenin de onayı ile hasta medikal olarak oral alımı kısıtlanarak takip edilmiştir. Obstrüksiyon bulguları sonrasında spontan olarak gerilemiş ve hasta taburcu edilmiştir. Bu tür zor vakalarda anevrizmaya acil cerrahi olarak müdahale edilmesi mümkün olmadığında gastrik drenajın sağlanması için nazogastrik sonda takılması, inflamasyonu baskılamak için proton pompa inhibitörü infüzyonu ve oral alımın kesilerek parenteral nutrisyon tedavisine geçilmesi kesin tedavi sağlanana kadar duodenum obstrüksiyonunun giderilmesine yardımcı olacaktır.

Anahtar Kelimeler: abdominal aort anevrizması, gastrik çıkım obstrüksiyonu, acil servis



POSTER BİLDİRİLER

P-0862 Trauma Emergencies

Nadir bir vaka travmatik diyafragma rüptürü

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Amaç: Diyafragma rüptürü olan hastaların erken tanı ve tedavi almasını sağlamak.

Giriş: Diyafram kubbe şeklinde düz ve oldukça kuvvetli bir kastır. Solunumun sisteminin temel kasıdır, solunum işinin %70'ini sağlamaktadır. Toraks ve abdomeni birbirinden ayırır. Diyafram yaralanmaları hem künt hem de penetran toraks travmaları sonucunda nadir de olsa görülmektedir. Pek çok çalışmada diyafram yaralanması künt travmadan sonra sol tarafta daha fazla bildirilmiştir. Sağ tarafta karaciğerin koruyucu etkisinden ve lombo kostal üçgenin sol tarafta yer alması nedeniyle sol tarafta diyafragma rüptürü daha sık olmaktadır. Sıklıkla daha ağır başka yaralanmalarla birlikte bu sebeple diyafram rüptürlü hastalara tanı koymak her zaman kolay olmamaktadır. Tanıda gecikme ciddi komplikasyonlara yol açabilir.

Olgu: Elli beş yaşında ek hastalığı olmayan hasta acil servise araç içi trafik kazası sebebiyle 112 sağlık ekipleri tarafından getirildi. Hastanın fizik muayenesinde genel durumu iyi, şuuru açık, koopere idi. GKS 15 lateralizan bulgusu yoktu. Solunum sesleri sol tarafta azalmış, ral, ronküs yoktu. Hastanın sol göğüs posterior duvarda 8 ile 10. kot arasında 2x2cmlik hiperemik alan ve palpasyonla hassasiyet mevcut. Hastanın diğer sistemik muayenesi doğal idi. Hastanın tansiyon 100/70 mmHg, nabız 115/dk, takipneik, oksijen saturasyonu %75-80 idi. Laboratuvar bulguları: WBC; 12.780/mm3, Hb; 14.88 gr/dL, PLT; 365.000/mm3, AST: 103 U/L, ALT: 83 U/L, LDH: 643 U/L idi. Hastanın çekilen toraks tomografisinde sol tarafta diyafragma rüptürü olduğu tespit edildi. Hasta göğüs cerrahisi doktorları ile konsulte edildi. Hastanın daha ileri bir merkezde opere olması için 112 sağlık ekipleri ile üniversite hastanesine sevk edildi.

Sonuç: Trafik kazalarında özellikle lateralden carpmının anteriopordan carpmalara göre 3 kat daha fazla rüptüre neden olduğu bilinmektedir. Bu yaralanmalarda göğüs duvarı biçimi bozulur ve ipsilateral diyaframda yırtılma, ayrılma olabilir. Göğüs travması olup, nefes darlığı ile gelen hastaların ayrıntı tanıları arasında diyafragma rüptürünün de olabileceği akılda tutulmalıdır. Mortalite ve morbiditeyi azaltmak için erken dönemde diyafragma rüptürüne yönelik ileri tetkik yapılmalıdır

Anahtar Kelimeler: travma, diyafragma rüptürü, dispne

P-0863 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Gözde ağrı ve şişlik: Retroorbital Arteriovenöz Malformasyon

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Amaç: Ağrı, kaşıntı ve gözde şişlik orbital hastalıklarda başlıca semptomlardır. İleri görüntüleme yöntemlerinin kullanılmasını gerektiren orbital patolojilere nadir de olsa acil servislerde de rastlanabilir. İntrakraniyal basınç artışı ile ortaya çıkan orbital patolojilerde vasküler nedenler düşünülmelidir.

Olgu: 20 yaşında bayan hasta sol gözde ağrı ve şişlik nedeni ile acil servise başvurdu. Gözündeki şişliğin özellikle boyun hareketleri ile oluştuğunu ve ıkmına öksürme gibi olaylar sonrasında şişliğin arttığını ifade etti. Özgeçmişinde bir özellik olmayan hastanın sol periorbital bölgesinde minimal ödem dışında patoloji izlenmedi. Hastanın görme muayenesi de tabii idi. Hastaya valsalva manevrası uygulanması ile şişliğin geçici olarak arttığı görüldü. Oküler USG de anlamlı bir patoloji izlenmeyen hastanın kontrastlı BT de sol göz arkasında arteriovenöz malformasyon izlendi. Hasta ileri değerlendirme için göz hastalıkları bölümüne yönlendirildi.

Sonuç: Orbital arteriovenöz malformasyonlar nadir olarak görülürler ve genellikle asemptomatikdirler. Postürel değişikliklerle ya da intrakraniyal basınç artışına neden olan öksürme, hapşırma gibi manevralarla ortaya çıkarlar. Ayırıcı tanıda Karotid Kavernoöz fistül, orbital psödötümör ve Kavernoöz hemanjyomlar akılda bulundurulmalıdır. Tanı için USG planlanan hastalara görüntülemenin valsalva manevraları ile yapılması tanı koymayı kolaylaştıracaktır.

Anahtar Kelimeler: Arteriovenöz Malformasyon, Valsalva Manevrası, Oküler USG, Kontrastlı Bilgisayarlı Tomografi

P-0864 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Preeklampsili hastada plasenta dekolmanı ve HELLP sendromu

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Arka plan: Preeklampsi; hipertansiyon, proteinüri, HELLP sendromu (karaciğer enzimlerinde yükselme, trombosit sayısında düşme, proteinüri, hipertansiyon ve hemoliz), hipertansif ensefalopati ve koagülopatinin tipik ve atipik klinik görünümleriyle seyreden multipl organ disfonksiyonudur. Preeklampsinin şiddetinden bağımsız olarak plasenta dekolmanı tabloya eşlik edebilir.

Olgu: Otuzaltı yaşında gebe kadın acil servise ayaklarda şişme şikayeti ile başvurdu. Hastanın ikinci gebeliğinin 33.haftasında olduğu öğrenildi. Tansiyon arteriyel: 140/80 mmHg, nabız:76/dk, solunum sayısı 18/dk ve puls oksimetre 97% olarak saptandı. Fizik muayenede pretibial ödem vardı. Laboratuvar tetkiklerinde AST:22 U/L, ALT:17 U/L, Hb:11.7 g/dl, trombosit: 248 bin/mL saptandı. İdrar tetkikinde 2 (+) proteinüri vardı. Kadın Hastalıkları ve Doğum ve Kardiyoloji konsültasyonu istendi, normal obstetrik USG değerlendirmesi ile betametazon ampul planlandı, amliodipin 5mg 2x1 önerildi. Takibin ikinci saatinde kusma ve epigastrik ağrı başladı. Yapılan üst batin USG'de hepatik hematoma yoktu, TA: 180/120 mmHg olması üzerine nifedipin sublingual uygulandı. Kusma ve epigastrik ağrı şikayetleri azalan olgu rahatladı. NST'lerde fetal kalp hızı reaktif ve kontraksiyon yoktu. TA:140/100 mmHg'ya düştü. Üç saat kadar sonra ikinci kusma atağı sırasında şiddetli karın ağrısı tarif eden olguda palpasyonda uterusu devam eden kontraksiyon saptanması üzerine dekolman plasenta ötanısı ile yükleme dozu magnezyum sülfat başlanarak acil olarak sezaryana alındı. Operasyon öncesi ta: 190/120 mmHg idi. 1500 gr 9/10 APGAR'lı canlı kız bebek doğurtuldu, plasenta dekolmanı. Postop olgu yoğun bakım takibine alındı. Magnezyum sülfat profilaksisi ara verilmeksizin 24 saate tamamlandı. Operasyondan 10 saat sonra AST:239 U/L ALT: 122 U/L, BUN:79, kreatinin 1.3, K: 5.2, Na:131 Hgb:10.2, trombosit 20 bin/mL altındaydı, bu değerlerle HELLP sendromu teşhisi konuldu. İki ünite trombosit transfüzyonu sonrası 3 gün yoğun bakımda takip edilen olgu 149bin/mL trombosit ve AST:42 U/L, ALT:49 U/L düzeyinde servise alındı.

Sonuç: Bu yazıda plasenta dekolmanına neden olmuş, çok hızlı seyreden atipik bir preeklampsisi tablosu sunulmuştur. Bu tür olgularda yakın klinik takip ile anne ve bebek, mortalite oranı yüksek olası komplikasyonlardan korunabilir.

Anahtar Kelimeler: Preeklampsi, plasenta dekolmanı, HELLP sendromu

P-0865 Trauma Emergencies

Travma Yoksa Nasıl Oldu?

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Arka plan: Sarsılmış Bebek Sendromu (SBS), 2 yaşından küçük bebeklerde potansiyel hayatı tehdit eder kafa travması nedenidir. Dışarıdan görünür bulgu olmayabilir. Direkt travma olmadan, kraniyoservikal akse karşı rotasyonel akselerasyona bağlı olarak da gelişebilir. Retinal hemorajinin olması, kaza olmadığına işaret eder.

Olgu: 4 aylık kız bebek, nöbet geçirme öyküsü ile annesi tarafından acil servise getirildi. Annenin hikayesine göre önceden tamamen sağlıklı olan çocuk aniden kusmaya başlamış sonrasında nöbet geçirmişti. Travma öyküsü yoktu. Fizik muayenede genel durum kötü, bilinç kapalı, Nabız: 145/dk, tansiyon: 95/70 mmHg, solunum yüzeyel, pupiller dilate idi, ışık refleksi alınmadı. Bebek entübe edildi. Göz dibinde sağda retinal yaygın hemorajik alanlar olduğu belirlendi. Sol göz dibi normaldi. Beyin BT'de oksipital lobda en geniş yerinde 4 mm ölçülen subdural hematoma



POSTER PRESENTATIONS

saptandı. Servikal, torakal ve batin BT'de patoloji saptanmadı. Tüm iskelet sistemi X-ray ile değerlendirildi. Kırık ya da kallus oluşumu izlenmedi.

Sonuç: SBS, özellikle süt çocukluğu döneminde travma öyküsü olmasa da akla getirilmelidir. Tutsarsız hikaye uyarcı olmalıdır. Olgular, daha çok aniden ortaya çıktığı söylenen klinik bulgular sebebiyle acil servise getirilirler.

Anahtar Kelimeler: Sarsılmış bebek sendromu, retinal hemoraji, akselerasyon

P-0866 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Travmatik Dev Epidural Hematom: Bir Olgu Sunumu

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Amaç: Epidural hematoma kranium ile dura arasında olan kanamalıdır. Genellikle arteriyel meningeal media ve dallarında meydana gelen yırtık sonucu olur. Temporal kemik ve kafanın lateral tarafına olan travmalarda risk yüksektir. Epidural hematoma kafa travmasını takiben bilinç değişikliğinin (lucid periyodu) ardından tedavi edilmediğinde hızla nörolojik bozulma ve ölüme sonuçlanabilir. Faktör VII (prokonvertin), vitamin K'ya bağımlı bir glikoproteindir. Faktör VII eksikliğinin klinik bulguları homozigot ve birleşik heterozigot olgularda farklıdır. Vücutta kolay morarmalar, burun ve diş eti kanamaları, eklem içi kanamalar sık görülen kanama bulgularıdır. En sık ölüm nedeni kafa içi kanamadır. Biz bu olgumuzda faktör VII eksikliği olan ve travma sonunda tanısı geciken bir hastada oluşan dev epidural hematoma olgusunu sunacağız.

Olgu: İki gün önce 2m kadar yüksekten düşen şuuru kaybolan ve ailesi tarafından acil servise getirilen tetkiklerinde patoloji saptanamayan hasta şuuru açılınca eve yollanmış. Hastanın şuuru iki gün içinde giderek bozulan hasta tekrar acil servise getirilmiş. Çekilen bilgisayarlı beyin tomografisinde epidural hematoma saptanmış. Hasta epidural hematoma ve faktör VII eksikliği nedeniyle hastanemize sevk edildi. Acil servisimize hasta ilk geldiğinde genel durumu kötü, şuuru kapalı, PIR: +/+, GKS: 7 idi. Sağ temporal bölgede skalpte hasasiyeti mevcuttu. Diğer sistem muayenelerinde anlamlı bir özellik yoktu. Bilgisayarlı beyin tomografisinde sağ temporoparietal bölgede sola çift yapmış dev epidural hematoma görüldü. Hastadan tam kan, biyokimya, kan gürubu ve kros için kan örnekleri alındı. Teze donmuş plazma ve eritrosit süspansiyonu istendi. Acil operasyona alındı.

Sonuç: Tüm travma hastaları kanama diyatezi açısından sorgulanmalıdır. Epidural hematomlar arteriyel kanamalar olduğundan geciken veya kanama diyatezi olan olgular morbidite ve mortalitesi yüksek dev epidural hematomlara dönüşebilir.

Anahtar Kelimeler: Dev epidural hematoma, faktör VII eksikliği, travma

P-0867 Trauma Emergencies

Kaza mı, istismar mı?

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Arka plan: Acil servis başvuruları içinde olası istismar olgularının saptanması, hem medikolegal açıdan hem de kötüleşebilecek sonraki travmalardan korunma, sosyal destek kurumlarının sürece dahil olabilmeleri açısından kritik önem taşır.

Olgu: Beş aylık erkek çocuk, yüksekten düşme şikâyeti ile ailesi tarafından acil servisimize getirildi. Annesinden alınan hikâyede, evde bulunan mama masasının devrilmesi ile beton zemine düştüğü ve başını çarptığı öğrenildi. Fizik muayenede bilinç bulanık, bilateral periorbital ekimoz, frontal bölgede 3x3 cm boyutlarında hematoma, üst dudakta ödem, sol ayakta 2x3 cm boyutlarında vezikül ve sağ ayak çevresinde hiperemik 3x5 cm boyutlarında kabuklu yara olduğu belirlendi. Son iki yara iyileşmekte olan yanık yarası olarak değerlendirildi. Tüm vücut BT istedi. Beyin BT'de bilateral fronto-temporoparietal subdural hematoma ve sağ temporal parankimal bölgede intraparakimal kanama saptandı. Batin tomografisinde dalakta laserasyon ve minimal serbest sıvı tespit edildi. Tüm vücut iskelet taraması ve göz muayenesi yapılmadı. Hasta entübe edilerek yoğun bakıma yatırıldı. Olay adli olgu olarak polise bildirildi. Annenin polise verdiği ifadede çocuğun üvey babası tarafından dövüldüğü ortaya çıktı. Ayaklardaki yanık yaralarının da baba tarafından yapıldığı öğrenildi. Baba tutuklandı.

Sonuç: Acil servis başvuruları, hikaye ve bulguların tutarlılığı, eski travmalar açısından dikkatle ele alınmalıdır. Olası istismar olguları göz dibi ve tüm vücut iskelet taraması ile değerlendirilmelidir.

Anahtar Kelimeler: Çocuk istismarı, tüm vücut iskelet tarama, subdural hematoma

P-0868 Surgical Emergencies (General Surgery, Orthopeadics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Deliryumda aort diseksiyonunun yeri?

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Amaç: Aort diseksiyonu olan hastaları acil serviste erken tanı almasını sağlamak

Giriş: Aort diseksiyonu; tanısı konulmadığında veya geç tanı konulduğunda yüksek mortaliteyle seyreden acil klinik bir durumdur. Tedavi edilmediği takdirde her saat mortalitesi %1-2 oranında artmaktadır. Hastalar yırtıcı vasıfta, sırta yayılan, çok şiddetli göğüs ağrısı, senkop, hemiparezi, hemipleji, deliryum gibi nörolojik bozukluklar, akut miyokard enfarktüsü ve akut böbrek yetmezliği gibi çok çeşitli klinik tabloyla karşımıza çıkabilmektedir. Torasik aort diseksiyonları sol subklavyan arter çıkışı öncesi ve sonrası başlangıçlı olarak, proksimal (Stanford tip A) ve distal (Stanford tip B) şeklinde; oluş süresi açısından da akut (14 günden önce) ve kronik olarak ikiye ayrılabilir. Aort diseksiyonları sıklık sırasına göre % 40-50 oranında çıkan, %10-15 oranında arkus ve %30-35 oranında inen aortta görülmektedir. Beraberindeki hipertansiyon, koroner arter hastalığı, böbrek yetmezliği, periferik ve serebral arter hastalıkları ve kronik obstrüktif akciğer hastalığı cerrahi mortaliteyi artıran faktörlerdir.

Olgu: Elli bir yaşındaki ek hastalığı olmayan erkek hasta aynı gün ani başlangıçlı karakter değişikliği şikâyeti ile acil servise yakınları tarafından getirildi. Hastanın özgeçmişinde özellik yok. Soy geçmişinde babasında hipertansiyon mevcut idi. Yapılan fizik muayenesinde genel durumu orta, şuuru uykuya meyilli, kooperasyonu kısıtlı idi. Nörolojik muayenesinde lateralizan bulgu saptanmadı. Ense sertliği yok, babiniski bilateral lakayt idi. Hastanın tansiyonu 110/75 mmHg, nabız 105/dk, oksijen saturasyonu %93, Vücut ısı; 36.8 derece idi. Laboratuvar bulguları: WBC; 11.580/mm3, Hb; 15.88 gr/dL, PLT; 265.000/mm3, AST: 23 U/L, ALT: 33 U/L, LDH: 343 U/L idi. Hastanın difüzyon magnetik rezonans ve beyin tomografisinde patolojik bulgu saptanmadı. Hasta nöroloji doktoruna konsülte edildi ve ensefalit ön tanısı ile yatırıldı. Hastaya yattığı serviste yatışından bir gün sonrası yapılan ekokardiyografisinde aort diseksiyonu ile uyumlu görüntü saptandı. Yapılan kontrastlı aortografisinde asendan aortadan başlayıp, iliaik arterlere kadar devam eden aort diseksiyonu ile uyumlu görüntü saptandı. Hastaya aort diseksiyonu tanısı konduktan sonra hastanemiz göğüs kalp damar cerrahisi doktorları tarafından opere edildi ve hasta şifayen taburcu edildi.

Sonuç: Aort diseksiyonu her zaman acil servise tipik semptomlarla gelmeyebilir. Nadiren de olsa deliryum gibi nörolojik semptomlarla gelebilir. Nörolojik semptomlarla gelen hastaların ayırıcı tanıları arasında aort diseksiyonu da olabileceği akılda tutulmalıdır.

Anahtar Kelimeler: Aort diseksiyonu, deliryum, atipik semptom

P-0869 Trauma Emergencies

Olekranon kırıklarının tanımada bilgisayarlı tomografinin yeri

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Amaç: Olekranon kırıkları çoğunlukla direkt veya indirekt travma sonucu oluşan sık gözlenen kırıklardır(1). İndirekt travma ile oluşan kırıklar genellikle dirsek ekstansiyonda açık el üzerine düşme sonucu oluşur

(1). Üst extremite kırıklarının yaklaşık % 10 unu olekranon kırığıdır. Ancak olekranonun avülyon kırıkları nadir görülür ve sıklıkla direk grafi ile tespit edilmesi zordur(2). Düşme sonucu dirsek yaralanması ile başvuran ve avülyon kırığı şüphesi olan hastaların acil serviste bilgisayarlı tomografi ile değerlendirilmesi uygun bir yaklaşımdır

Olgu: 26 yaşında bayan hasta koldurumda yürürken ayağının takılması sonucu sağ dirseğinin üstüne düşme ve sağ dirsekte ağrı ve şişlik şikâyeti ile acil servise başvurdu. Fizik muayenesinde sağ dirsekte hassiyet, ödem ve eklem hareketinde kısıtlılık mevcuttu. Diğer sistem muayenelerinde ek patoloji saptanmadı. Çekilen lateral dirsek grafisinde humerus distalinde şüpheli görünümlü mevcuttu (resim 1). Sonrasında çekilen dirsek BT'sinde olecranon triseps insersiyosunun yapışma yerinde avülyon kırığı tespit edildi.(resim 2). Hastamızda kırık oluşumu travma

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sonrası dirsek ekstansiyonda el üzerine düşme sonrası trisepsin traksiyonu sonucu avulsiyon kırığı şeklinde meydana gelmiştir

Sonuç: Olecranon apofizini ilgilendiren kırıklar genellikle çekme kuvvetleri sonucu oluşur(1). Triceps kasının ani kasilması sonucu oluşan bu tip kırıklar sıklıkla açık el üzerine düşme sonucu oluşur(2). Bu hastalarda tedavi, kırığın şekline ve hastanın genel durumuna, hastanın hastaneye başvuru süresine göre değişir. Internal fiksasyon için gergi bandı yöntemi ile dengeli stabilizasyon sağlandığı ve erken harekete izin verdiği için iyi bir yöntemdir(3,4). Olgumuz da dirseğe gergi bandı tekniği ile internal fiksasyon uygulandı. Ve sekelsiz eklem hareket açıklığı tam olarak iyileşme sağlandı. Diğer taraftan eğer bu kırıkların tanısı erken dönemde konmaz ve tedavi edilmezlerse apofizin yukarı yer değiştirmesiyle humerusun alt ucuna yapışması sonucu dirsek ekstansiyon kusuru gelişebilir(4). Ayrıca tekrarlayan küçük kopmalarla olecranon ucunda ektopik ikincil kemik gelişimi dirsek ekstansiyonuna engel olabilir(3). Bu yüzden el ayası üzerine düşme ile dirsek yaralanması ile acil servise başvuran hastalarda olecranon avulsiyon kırıkları düşünülmelidir. Eğer direkt grafi sonucu kırık açısından klinik şüphe devam ediyorsa ileri görüntüleme yöntemleri kullanılmalıdır

Anahtar Kelimeler: Bilgisayarlı Tomograf, Olecranon, Avülsiyon

P-0870 Trauma Emergencies

Arı sokmasına bağlı gelişen kompartman sendromu

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Amaç: Kompartman sendromu kapalı osteofasial veya fasial bir boşluğun içinde çeşitli nedenlerle basıncın artması sonucunda, bu bölme içindeki dokuların (damar, kas, sinir) basıncı altında kalmasıdır. Kompartman sendromu kompartman hacminin azalması (Fasia defektlerinin kapatılması, sıkı bandaj ve alçılar vs.) kompartman içeriğinin artması (kanama, vasküler yaralanma, geçirgenliğin artışı, yanık, postiskemik perfüzyon, intraarteriyel ilaçlar, soğuk, donma, cerrahi girişimler, böcek ısırıkları, venöz obstrüksiyon vs.) ya da kırıklara bağlı gelişmektedir. Etkilenmiş ekstremitenin distalinden nabız alınamaması, duyu kaybı, paralizi ve ağrı kompartman sendromunun belirtilerindendir. Böcek ısırıklarında da kompartman sendromu dikkat edilmesi gereken bir durumdur.

Olgu: 40 yaşında bayan hasta acil servise arı sokması üzerine kolunda ağrı ve şişlik şikayetiyle geldi. Hastanın vitalleri stabildi. Hastanın ön kol volar yüzünde arı sokmasına bağlı etrafında halo olan bülöz bir lezyon bulunmaktaydı (resim). Lezyonun olduğu ön kolda diğer kola göre çap artışı, sirküler tarzda kızamıklık, ısı artışı mevcuttu. Hastanın arteria radialis nabazını el ile alınamadı. Doplerde akımın azaldığı bildirildi. Hastaya bu hali ile fasyotomi için plastik cerrahi konsültasyonu istendi. Plastik cerrahi hastada soğukluk ve solukluk olmadığı için acil fasyotomi endikasyonu düşünmedi. Hasta bu haliyle acil serviste ekstremita elevasyonu ile takip edildi. Hastaya 1 gr seftriakson, 60 mg metilprednizolon ve antihistaminik tedavisi verildi. Hastanın 8 saatlik takibi sonrası ödemi çekildi, nabazları alınmaya başlandı. Hastaya bu hali ile sistemik antibiyotik ve anti histaminik tedavi reçete edilerek eksterne edildi.

Sonuç: Kompartman sendromu yaygın olarak görülmez. Ancak olduğu zaman acil tedavi gerekir, çünkü oluşturduğu nöro-musküler hasar 4-6 saat içinde irreversible olur. Genellikle fasyotomi ile acil müdahale gerektirdiğinden hastaneye yatırılıp müdahale edilmelidir. Ancak hastamızda medikal tedaviyle gerilemiştir.

Anahtar Kelimeler: Böcek sokması, alerjik reaksiyon, kompartman sendromu

P-0871 Trauma Emergencies

Ata biner tarzda düşme sonrası gelişen üretral rüptür

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Amaç: Üretral yaralanmaların % 75 i motorlu taşıt kazası ve % 25 i yüksekten düşme olmak üzere yaralanmaların % 90 dan fazlası künt travmalardan sonra oluşur. Ata biner tarzda travma ve buna eşlik eden sakroillak bileşke diastazi en sık nedendir. Üretra yaralanmaları uygun tedavi edilmedikleri durumda yaşam boyu inkontinans, impotans ve tekrarlayan striktürler gibi anlamlı morbiditelere neden olabilmektedir. Tedavinin erken ve geç dönemde yapılması konusunda tartışmalar bulunmaktadır. Erken dönem tedavilerin geç dönemde görülebilecek komplikasyonlara neden olabileceğini iddia edenler olduğu gibi üretral devamlılığın sağlanmasında gerekebilecek cerrahi girişimlerin sayısını ve boyutunu azaltabileceğini de ileri sürenler bulunmaktadır.

Olgu: 42 yaşında erkek hasta acil servise inşaat çalışırken iskele üzerine ata biner tarzda yüksekten düşme sonrası gelişen pelvik ağrı şikayeti ile başvurdu. Hastanın bakılan vitalleri stabildi. Yapılan fizik muayenesinde skrotal şişlik ve hassasiyeti mevcuttu. Skrotum kökünden başlayan ve anal bölgeye kadar uzanan ekimozu mevcuttu. Hastanın eksternal measında kan mevcut olduğu için hastaya mesane sondası uygulanmadı. Pelvis muayenesi doğal olan hastanın çekilen retrograt üretrografisinde üretral rüptür tespit edildi (resim). Mesane kontürleri doğal olan hastaya penil doppler çekildi. Doppler sonucunda penis kökü komşuluğundan inferiora ve her iki hemiskrotuma uzanan, interskrotal alanda belirgin olan heterojen yapıda komplike vasfıta sıvı içerik bulunan lezyon hematoma olarak yorumlandı. Hastanın bakılan kan parametrelerinde herhangi bir anormallik yoktu. Hasta bu haliyle üroloji servisine yatırıldı. Hastaya perkütan sistostomi uygulandıktan sonra geç dönem cerrahi tedavi planlandı.

Sonuç: Üretral rüptür ileri dönem komplikasyonları nedeniyle acil serviste tanısı atlanmaması gereken bir ürolojik acildir. Ata biner biner tarzda düşme şikayeti ile gelen hastalarda acil servis hekiminin üretral rüptür açısından uyanık olması gerekir.

Anahtar Kelimeler: Düşme, ata biner tarzda, üretral yaralanma, retrograt üretrografi

P-0872 Toxicology

nitrik asit alımına bağlı mide nekrozu

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Amaç: Koroziv madde alımı gastrointestinal sistemde ölümlü sonuçlanabilecek birçok hasar yapabilir. Hasarın derecesi ve kapsamı alınan ajanın tipi, morfolojik yapısı, miktarı ve maddeyi alma amacı gibi bir çok faktöre bağlıdır.

Olgu: 45 yaşında kadın hasta, yanlışlıkla yarım çaybardağı kadar havuz suyu temizleyicisi içtikten sonra ağız, göğüs ve karnında yanma hissi gibi şikayetlerle acil servise başvurdu. TA:132/76, nabız:62, solunum sayısı: 26, oksijen saturasyonu %98' di. Bilinen kronik bir hastalığı yoktu. Rutin tetkiklerinde ılımlı lökositoz dışında anormal bir parametre yoktu. Acil olarak yapılan ağız ve endoskobik larenks bakışında tümşak damakta ödem ve hiperemi, epiglot, vokal kordlar, aritenoid hafif ödemliydi. Hava pasajı laringeal düzeyde yeterli olacak kadar açıktı. Takibinde endoskobisi de yapılan hastanın yumuşak mukoza soluk ve ödemli, kardias, fundus, korpus ve antrum proximalinde çok sayıda nekrotik ülser ve erozyon gözlemlendi (grade 3b yanık). Hasta gastroenteroloji servisine takip ve tedavi amaçlı yatırıldı.

Sonuç: Koroziv madde alımı ile üst gastrointestinal sistemde hızlı, ilerleyici ciddi yanıklar meydana gelir. Bu klinik tablo koroziv özofajit olarak adlandırılır. Koroziv maddelerin intihar amaçlı alımları genellikle yetişkinlerde görülür. Çocuklarda ise kazara içilir. Son 10 yılda koroziv madde içeren ev temizlik ürünlerinin orijinal ambalajları dışında satışının artması ile özofajitlerde artış görülmüştür. Boş içecek şişelerinde saklanan bu maddeler yanlışlıkla içilmekte ve özofagus yanıklarına neden olmaktadır. Ambalajı olmayan bu maddelerin konsantrasyonu hakkında da bilgi edinilememektedir. Oysa koroziv özofajitte kostik maddenin konsantrasyonu ve pH' sı, alınan miktar ve mukoza ile temas süresi önemlidir. Alkali ajanlarda pH>7 dir. Günlük hayatta sıkça kullanılan birçok temizlik maddelerinde pH 9-11 arasındadır. Ancak çok miktarda alımlarda ciddi hasar meydana gelir. pH>11 alkali maddelerin az miktarlarda içimlerinde bile ciddi yanıklar görülür. Alkali ajanlar lifefaksiyon nekrozu ile dokuyu eritir, daha derine ve hızla penetre olur. Asit ajanlarda pH<7 dir. Genellikle pH<2 asitler korozivdir. Bizim olgumuzda da, yaptığımız inceleme sonucu, acil servislerde çok nadir karşılaşılan, alınan havuz suyu temizleyicisinin içeriğinin pH<1 olduğunu öğrendiğimiz nitrik asit içerikli bir kimyasaldı. Asit ajanlar mideye daha fazla zarar verir. Özofagusta pH' nın alkolik düzeyde olması ve skuamöz epitel, asit ajanların etkisinden özofagusu korur. Asit ajanların penetrasyonu özofagus yüzeyinde sınırlıdır. Skar oluşumuyula karakterize koagülasyon nekrozu yapar ve derine inmez. Bu nedenle asit ajanlar özofagusu alkalilerden daha az zarar verir. Olgumuzda da çok az bir miktar alınmasına rağmen mide de nekroza sonuçlanan grade 3b yanık oluşmuştur.

Sonuç olarak gastrointestinal sistemin kostik yanıklarının akut dönemde hava yolu ödemi, nekroz ve perforasyon oluşturup mortal seyredebileceği unutulmamalıdır. Hasta değerlendirilirken alınan maddenin kimyasal içeriği ve pH değeri öğrenilmeli ve hasar tahmini yapılabilir.

Anahtar Kelimeler: havuz suyu, nitrik asit, koroziv, nekroz

P-0873 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Erişkin bir vakada intestinal invajinasyon

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Amaç: İnvajinasyon; gastrointestinal traktın birbirini takip eden iki segmentinin iç içe geçmesi olarak tanımlanabilir. İki intestinal segment arasındaki motilite farklılığı sonucu oluşur. Pediatrik hasta grubunda akut apandisit tablosundan sonra en sık rastlanan ikinci abdominal acil olmasına rağmen, yetişkin popülasyonda nadir görülen bir hastalıktır. İnvajinasyon için acil laparotomi oranı literatürde %20-61,5 arasında değişmektedir. İnvajinasyon tanısında ultrasonografi sık kullanılan bir yöntemdir. Bilgisayarlı tomografi (BT), invajinasyon tanısı için altın standart olmakla birlikte %50-80 oranında diagnostik veri sağlamaktadır. Erişkin hasta grubunda görülen invajinasyonun temel tedavisi; cerrahidir. Postoperatif adezyona bağlı invajinasyonlarda, barsak



POSTER PRESENTATIONS

beslenmesi problemleri değilse; deinvajinasyon ile tedavide başarı sağlanabilir. Ancak inflame, iskemik ve kolonik invajinasyonu olan hasta grubunda deinvajinasyon işlemi perforasyona neden olabileceğinden ve özellikle kolonik invajinasyonu olan hastalarda olası tümör hücrelerinin yayılmasına yol açacağından önerilmemektedir.

Olgu: 24 yaşında bayan hasta acil servise 3 saattir devam eden karın ağrısı, bulantı ve kusma şikayeti ile başvurdu. Daha öncesinden herhangi bir hastalık ve operasyon öyküsü olmayan hastanın vitalleri sitabildi. Yapılan fizik muayenesinde epigastrik bölgede daha fazla olmak üzere yaygın hassasiyeti ve istemli defansı vardı, rebound bulgusu yoktu. Gaz-gaita çıkışı olan hastanın rektal tuşesinde normal gaita mevcuttu. Hastanın çekilen ayakta direkt batin grafisinde hava sıvı seviyeleri vardı. (resim 1). İstenilen kan tetkiklerinde WBC: 20,7 x 10³, başka da bir anormallik tespit edilemedi. Hastaya ileus ön tanısıyla batin BT çekildi. Çekilen batin BT'si sol alt kadranda ileo-ileal invajinasyon olarak raporlandı (resim 2). Hasta bu haliyle genel cerrahi servisine yatırıldı. Medikal tedavi ile izlenen hastanın kliniğinin ve hava sıvı seviyelerinin gerilemesi üzerine (resim 3) hasta önerilerle taburcu edildi.

Sonuç: Erişkinde invajinasyon, çocuk yaş grubunda göre daha az görülmesine karşın, geniş bir etiyolojik yelpazesi ve değişken klinik tablosu olduğundan, özellikle akut karın tablosuyla karşılaşılan her hekim ayrırcı tanıda invajinasyon tanısını da göz önünde bulundurmalıdır. Erişkinde genellikle cerrahi müdahale gerekirken hastamızda konservatif yaklaşımla spontan iyileşme görüldü.

Anahtar Kelimeler: Akut batin, acil servis, erişkin, intestinal invajinasyon

P-0874 Trauma Emergencies

Acil Serviste Alzheimer Hastasında Rektal Yabancı Cisim: Deodorant Kapağı

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Amaç: Acil servislere rektal yabancı cisim sebebiyle başvurular olabilmektedir. Bu hastalar çoğu kez doğru bilgi vermek yerine karın ağrısı, rektal kanama veya akıntıdan yakınır. Yabancı cisimlerin çoğu ampulladadır ve rektal tuşe ile palpe edilebilir düzeydedir.

Olgu: 78 yaşında erkek hasta yanında kızı olduğu halde rektumda yabancı cisim şikayetiyle acil servise başvurdu. Alzheimer hastası olduğu öğrenilen hastanın kızı evde kapağı olmayan deodorant şişesini bulduklarını ifade etti. Yapılan fizik muayenede tüm sistem muayenelerinin normal olduğu, rektumda 4 cm çaplı, yüzeyi oval siyah renkli deodorant kapağının açık kısmı yukarı bakacak şekilde gözüktüğü fakat herhangi bir şekilde çıkartmanın imkansız olduğu görüldü. Hasta lateral dekübit pozisyonunda, iki kişinin karşılıklı penset ve portegü ile nazikçe kapağı sıkıştırılarak kavranmasıyla kapak rektumdan çıkartıldı.

Sonuç: Bazı aşağı yerleşimli rektal yabancı cisimler acil serviste çıkarılabilir de özellikle camdan yapılmış olan veya keskin kenarlı cisimler cerrahi konsültasyon ve girişime ihtiyaç duyarlar. Biz olgumuzda, sedasyona ihtiyaç duymadık ancak genellikle girişimsel sedasyona mutlaka perianal ve submukozal sedasyon da ilave edilmelidir. Özellikle obstetrik forceps, anal lubrikasyon, spekulum veya kement (snare) yabancı cisim çıkarılmasında faydalı olabilir.

Anahtar Kelimeler: yabancı cisim, rektum, alzheimer hastalığı

P-0875 Trauma Emergencies

Hematüri olmadan künt travmaya bağlı gelişen mesane rüptürü

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Amaç: Mesane yaralanması penetran yaralanmalarının % 4'ünde, künt batin travmalarının % 2'sinde görülür. % 80 pelvik kırıklarla ilişkilidir. Alt karında ağrı ve hassasiyet, batında şişlik, üriner kaçığa bağlı perine ve skrotumda şişlik, idrar yapamama ve belirgin hematüri muayene bulguları arasındadır. % 95'inde makroskobik hematüri eşlik eder. Bütün mesane yırtılmalarının %25'i intraperitonealdır. Mesanenin en mobil olan bölgesi kubbese olduğundan intraperitoneal rüptürler çoğunlukla bu bölgede olur.

Olgu: 34 yaşında erkek hasta, araç içi trafik kazası sonrası pelvis bölgesinde ağrı şikayeti ile acil servise başvurdu. Vitalleri stabil olan hastanın muayenesinde batin alt kadranda hassasiyeti mevcuttu, pelvis muayenesinde lateral kompresyonla hassasiyet mevcuttu. Sondası takılı halde gelen hastada makroskobik hematüri yoktu. Hastanın alt kadranda yaygın hassasiyeti olması üzerine direkt grafileri ve kontrastlı batin tomografisi çekildi. Kontrastlı batin BT'nden sonra çekilen direkt grafisinde göz yaşı damlası haline gelen mesane ve mesane boynu yaralanmasına bağlı ekstrasvazyon görülmekteydi (resim 1). Kontrastlı batin tomografisinde kontrast batin içine ekstrasvaze olmuştu (resim 2). Ayrıca sağ iliac kanatta ve simfizis pubis superior ve inferior kolunda da fraktür mevcuttu. Hasta bu haliyle üroloji kliniğine mesane perforasyon onarımı için yatırıldı.

Sonuç: Yüksek enerjili künt travmalarda batin içi organ yaralanmaları akılda bulundurulmalıdır. Mesane rüptürü acil onarım gerektirir ve atlanması halinde peritonite ve sepsise neden olabilir. İdrar sondasında makroskobik hematüri olmasa da pelvis kırıklarında mesane rüptürün akılda bulundurulmalıdır.

Anahtar Kelimeler: künt travma, pelvik travma, mesane rüptürü

P-0876 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Aspirin kullanımına bağlı sol rektus kılıf hematomu

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Amaç: Anterior rektus abdominis kılıfının içindeki epigastrik damarların veya rektus kas liflerinin yırtılmasına bağlı olarak oluşan kanamanın rektus kılıfı içinde toplanması durumu rektus kılıf hematomu olarak adlandırılır ve nadir görülen bir durumdur. Akut karın ağrısı acil servis başvurularının sık nedenlerinden birisidir. Bu hastaların sadece üçte birinde altta yatan cerrahi bir neden bulunmaktadır. Rektus kılıf hematomu da akut karın ağrısına neden olabilen nadir nedenlerden birisidir. Bu vakada acil servise akut karın ağrısı ile başvuran ve rektus kılıf hematomu tanısı alan bir olguyu sunduk.

Olgu: Altmış yedi yaşında erkek hasta acil servise karın ağrısı yakınmasıyla başvurdu. Anamnezinde ağrının 2 gün öncesinde başladığı ve şiddetinin giderek arttığı öğrenildi. Şikayetin ani başladığını daha öncesinde benzer bir yakınmasının olmadığını belirtti. Eşlik eden semptomu yoktu. Travma öyküsü tariflemeydi. Özgeçmişinde hastalık öyküsü yoktu ancak düzenli olarak asetilsalisilikasit 100 mg/gün kullandığını öğrenildi. Soygeçmişinde özellik saptanmadı. Geçirilmiş abdominal operasyon öyküsü yoktu. Genel durumu iyi, koopere, oryante ve vital parametreleri stabildi (TA:120/65mmHg, nabız: 74/dk, solunum sayısı: 12/dk, ateş: 36,5 C). Abdomen muayenesinde sol alt kadranda defansın eşlik ettiği hassasiyet saptandı. Diğer sistem muayenelerinde anormal bulgu tespit edilemedi. Laboratuvar tetkiklerinde WBC:8,74 K/uL, Hb:11,0 gr/dl, Plt:195, AST:17 U/L, ALT: 11U/L, ALP:62 U/L, GGT: 25 U/L, Üre:32 mg/dl, Cre:0,6 mg/dl, LDH:175 U/L saptandı. Hastanın PTZ, aPTT ve INR değerlerinde anormallik saptanmadı. Abdomino-pelvik ultrasonografide sol rektus abdominis kasında hematom ile uyumlu olabilecek hipoekoik alan saptandı. İntravenöz ve oral kontrastlı tüm batin bilgisayarlı tomografide sol rektus kası sola göre asimmetrik olarak kalın izlendi (Resim 1). Genel cerrahi konsültasyonu istenen hastaya cerrahi girişim düşünülmeydi. Kanama açısından takibe alınan hastanın yapılan seri hematokrit takiplerinde düşüş olmadı, hemodinamik olarak stabil seyreden ve hematomunda artış tespit edilmeyen hasta nonoperatif izlem sonrasında önerilerle taburcu edildi.

Sonuç: Rektus kılıf hematomu her ne kadar çoğunlukla iyi huylu karakter gösterip konservatif tedaviyle kendisini sınırlasa da, bazen hızlı progresyonla hayatı tehlikeye neden olabilen akut karın ağrısının nadir bir nedenidir. RKH acil serviste akut karın ağrısının farklı nedenleri araştırılırken sıklıkla gözden kaçır ve gereksiz cerrahi girişimlere neden olarak morbidite ve mortaliteyi artırır.

Anahtar Kelimeler: Rektus kılıf hematomu, akut karın, acil servis

P-0877 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Acil serviste gastroenterit kliniği ile başvuran akut divertikülit olgusu

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Amaç: Divertikül kolon duvarının kese biçiminde çıkıntısıdır. Divertiküllerin dağılımı incelendiğinde çoğunun inen kolon ve sigmoid kolonda yerleştiği görülür. Divertiküllerin herhangi bir nedenle olan inflamasyonu ile divertikülit gelişir. Divertikülitlerin klinik spektrumu oldukça geniştir. İyi sınırlı hafif bir tablodan, perforasyon ve generalize peritonit gibi ağır klinik tablolara yol açabilir. Akut divertikülitli hastalarda genellikle lökositozun eşlik ettiği lokalize sol alt kadranda ağrısı mevcuttur. Bunun yanında iştahsızlık, ateş, bulantı, kusma, ishal ya da kabızlık görülebilir. Biz bu bildirimizde ishal, karın ağrısı gibi non-spesifik şikayetlerle başvuran divertikülit olgusunu sunduk.

Olgu: 45 yaşında erkek hasta bir gündür olan kanlı ishal, bulantı, karın ağrısı şikayeti ile acil servise başvurdu. Hastanın daha önce herhangi bir kronik hastalığı ya da bu ağrısına benzer herhangi bir karın ağrısı olmamış. Herhangi bir ilaç kullanımı ya da ameliyat öyküsü yok. Hastanın vitallerinde; ateş: 37,8, tansiyon: 132/78 mmHg, nabız: 85/dk ritmik, parmak ucu oksijen saturasyonu: oda havasında %97 idi. Yapılan muayenesinde barsak sesleri hiperkinetik, batin sol alt kadranda belirgin olmak üzere sağ ve sol alt kadranda hassasiyet mevcut, rebound ve defans bulgusu yoktu. Rektal tuşede yumuşak kıvamlı normal renkte gaita mevcuttu. Muayenesinde başka özellik yoktu. Hastanın çalışılan hemogramında WBC: 17600 idi ve biyokimyasal parametrelerinde bir değişiklik yoktu. Gastroenterit düşünülen hastadan gaitada direkt parazit incelemesi gönderildi herhangi bir özellik yoktu. Çekilen ayakta boş batin grafisi normaldi. Hastada



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ön planda gastroenterit düşünüldü ancak şikayetleri gerilemediğinden acil serviste müşahade edildi. Semptomatik tedavi verilen hastanın 1-2 saat sonra sol alt kadranda rebound bulgusu gelişti. Hastaya batin ultrasonografi yapıldı. Gaz ve obezite nedeniyle tetkik suboptimaldı. Hastaya kontrastlı batin tomografisi çekildi. Batin sol alt kadranda sigmoid kolonu etkileyen yaklaşık 8 cm uzunluğunda segmentte duvar kalınlaşması, periintestinal alanda yağlı dokularda yaygın ödem ve inflamasyon ve birkaç adet lenf nodu görünümü mevcuttu. Bu alan içinde 10 mm'lik inflame divertiküle ait görünüm izlendi bulgular divertikülit açısından anlamlı bulundu (figür). Hasta genel cerrahi servisine akut divertikülit tanısı ile yatırıldı.

Sonuç: Acil servislere en sık değerlendirildiğimiz hasta grubu olan karın ağrılı hastalarda klinik takip çok önemlidir. Özellikle semptomatik olarak rahatlama olmayan veya şikayetleri artan hastalar takip edilmeli ve ileri değerlendirme yöntemleri kullanılmalıdır. Ayrıca divertikülit gibi nadir akut batin nedenleri de aklımızda bulunmalıdır.

Anahtar Kelimeler: akut batin, acil servis, divertikülit

P-0878 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Intravenöz ilaç kullanımına bağlı femoral tromboflebit

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Amaç: Tromboflebit, ven duvarının iltihabı ve buna bağlı endotelde yıpranma sonucu meydana gelen bir intravenöz pıhtılaşma durumudur. Hiperkoagülabilité, travma ve intravenöz infüzyon tedavileri tromboflebite yatkınlığa neden olur. Tromboflebitler genelde varikoflebit, infüzyon flebiti, tromboflebitis migrans, enfeksiyöz/septik tromboflebit şeklinde görülür. Yüzde 40'ında etiyolojisi belli değildir. Kadınlarda hafif fazla görülür. Hastaları son derece rahatsız eden ve hayatı tehlikeye yol açabilecek bir problemdir. Küçük bir alanı kapsaması ve hastanın görünüşte daha önemli olarak değerlendirilen diğer problemlerinin olması damar içi uygulamalardan kaynaklanan tromboflebitin gözden kaçmasına, ciddi medikal ve hukuki sorunlara neden olabilmektedir. Bu vakada bacak ağrısı nedeniyle acil servise başvuran bir olguda saptanan femoral tromboflebit sunuldu.

Olgu: 30 yaşında erkek hasta sağ bacakta kızamıklık, şişlik ve ağrı yakınmasıyla acil servise başvurdu. Anamnezinde şikayetlerinin 24 saat önce başladığı öğrenildi. Travma öyküsü tarifilemedi. Özgeçmişinde hastalık öyküsü yoktu, ancak madde bağımlısı (eroin) olduğu ve şikayetlerinden bir gün öncesinde de kasıktan eroin enjeksiyonu yaptığı öğrenildi. Soygeçmişinde özellik saptanmadı. Genel durumu iyi, koopere, oryante ve vital parametreleri stabil olarak değerlendirildi (TA:120/65mmHg, nabız: 74/dk, solunum sayısı: 12/dk, ateş: 36,5 C). Sağ alt ekstremitede sola kıyasla belirgin hiperemi, ısı ve çap artışı saptandı (Resim 1). Alt ekstremité venöz doppler ultrasonografide cilt-ciltaltı dokuda ödem, sağ ana femoral ven, vena sefena magna bileşkesinde, vena sefena magna bileşkeye yakın seviyede ve superfisial femoral ven (SFV) kranialden kaudale uzanan komprese olmayan trombüs materyali saptandı. Kalp ve damar cerrahisi ile konsülte edilen hasta elevasyon, soğuk uygulama, düşük molekül ağırlıklı heparin ve oral antibiyoterapi başlanarak taburcu edildi. 10 gün sonraki kontrolünde bulguların belirgin olarak gerilediği görüldü.

Sonuç: Acil serviste komorbid hastalığı olmayan genç hastalarda tromboflebit etyolojisinde intravenöz ilaç kullanımı medikal tedavinin planlanması ve hukuki problemler yaşanmaması açısından mutlaka aklıda tutulmalıdır.

Anahtar Kelimeler: Tromboflebit, madde bağımlılığı, acil servis

P-0879 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Post-partum hastada nadir görülen bir tanı: ovarian ven trombozu

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Amaç: Postpartum ovarian ven trombozu (OVT) klinikte nadir görülen ama ciddi komplikasyonlara sahip bir durumdur. Tüm gebeliklerin %0,02'si ile %0,20'si arasında, normal doğumların %0,05'inde ve C/S ile olanların ise %1-2'sinde görülmektedir. OVT'nin klinik bulguları non-spesifik olmasına rağmen günümüzde uygun non-invasif radyolojik tetkikler sayesinde kesin tanısı konulabilir. Bu sayede antibiyotik ve antikoagülan tedavisi erkenden başlanabilir. OVT %80-90 sağ ovarian vende görülür. Pulmoner emboli, sepsis, vena cava inferior ve renal ven trombozu OVT'nin komplikasyonlarındandır. %4 mortal seyredir.

Olgu: 32 yaşında bayan hasta acil servise karın ve kasık ağrısı şikayetiyle başvurdu. 1 hafta önce spontan vajinal doğum öyküsü olan hastanın iki gün önce suprapubik ve sağ alt kadranda başlayan ve giderek artan karın ağrısı olmuş. Son 4 saatir bulantı ve iki defa da kusma şikayetleri eklenmiş. Özgeçmişinde herhangi bir hastalık hikayesi yoktu. Hastanın vital bulguları: Ateş:38,4°C, TA:115/75 mm/hg, SS:18/dk, Nb:76/dk idi. Fizik muayenesinde; suprapubik bölgede hassasiyet ve sağ alt kadranda hassasiyet ile birlikte defans ve rebound bulguları mevcuttu. Hastanın laboratuvar bulguları: Lökosit:15600, Nötrofil:13000, hemoglobin:12,6 g/dl, CRP: 91 olarak geldi. İdrar mikroskopisinde beyaz küre: 84/HPF, RBC:218/HPF olarak bulundu. Hastaya acil serviste hidrasyon, analjezik ve idrar yolu enfeksiyonuna yönelik antibiyotik tedavisi başlandı. USG sonucunda uterus normalden büyük, bilateral overler izlenebildiği kadarıyla normal boyutta olup RDUS de kanlanma kodlanmıştır. Sağ alt kadranda 20x15 mm'lik uterus basısına uğramış ve ans yapısından net ayrımı yapılmayan heterojen hipoeoik alan izlendi. Standart çekilen abdominal CT sonucunun non-spesifik olması üzerine ovarian ven trombozu ön tanısıyla ven fazında kontrastlı CT çekildi ve uterusun postpartum involüsyonunu tamamlamadığı ve umbilikal seviyeye doğru uzandığı görüldü. Endometrial kavitede hava dansiteleri, periuterin mesafede minimal sıvı dansiteleri ve sağ adneksiyel lojdan, renal hilus seviyesinde süperior vena kava kadar uzanan kalibrasyonu artmış kontrast dolumu göstermeyen overyan vene ait görünüm izlendi (figür). Sağ OVT tanısı konulan hasta; kadın hastalıkları ve doğum kliniği konsültasyonu ile aynı servise yatırıldı. 1 hafta boyunca DMAH ve antibiyotik tedavisi alan hasta; şikayetlerinin düzelmesi üzerine taburcu edildi.

Sonuç: OVT klinikte çok karşılaştığımız bir durum olmamakla birlikte tedavi alamayan hastalarda fatal seyredir. Bunun için post-partum akut karın ile gelen hastada ayrıca tanıda mutlaka aklıda tutulmalıdır.

Anahtar Kelimeler: post-partum, akut batin, ovarian ven trombozu

P-0880 Trauma Emergencies

Gluteal Enjeksiyon Sonrası Gelişen Düşük Ayak Sendromu

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Antalya Eğitim ve Araştırma Hastanesi, Antalya

Amaç: Siyatik sinir pelvis içi duvarı boyunca laterale ve aşağı doğru seyrederek, büyük siyatik centikten pelvisi terk eder. İki ayrı trunkusdan oluşur: Lateral trunkus (fibuler divizyon) ve medial trunkus (tibial divizyon). Siyatik sinir alkol, kursun, arsenik gibi toksik maddelere maruziyete, enfeksiyöz orijinli noropatilere, kompresif lezyonlara, popliteal fossanın penetran yaralanmalarına, femur basi fraktürlerine, direkt veya sinir yakınına yapılan ilaç enjeksiyonlarına bağlı olarak hasara uğrayabilir. Enjeksiyonun uygun olmayan bir yere yapılması, enjekte edilen materyalin bulunduğu yer ve kendine özgü etkisi zedelemeye rol oynar.

Gluteal bölgeye yapılacak enjeksiyonların üst dis kadrana yapılması gerekirken, daha medial ve inferiora yapılması hem igrinin kendisinin hem de enjekte edilen maddenin doğrudan doğruya sinire ulaşması ile zedelemeye yol açar. Ayrıca enjekte edilen materyalin kendisinin, odeminin ve oluşan nedbe dokusunun kitle etkisi ile de zedelemeye yol açar. Gluteal kasın ince ve gluteal yağ dokusunun az olması halinde uygun olmayan yere yapılan enjeksiyonlarda siyatik sinirin zedelemeye riski artar. Bu nedenle bebekler ve ileri yastaki zayıf kişilerde siyatik zedelenmeler daha sık görülmektedir. Uzun iğne kullanılması, uygulamanın dik acı ile değil de daha paralel bir acı ile yapılması, bireysel anatomik farklılıklarda zedelemeye riskini artırır.

Olgu: 28 yaşında erkek hasta sol ayağında uyuşma ve ayağını kaldıramama şikayeti ile acil servise başvurdu. 1 gün önce gluteal bölgeye yapılan intamuskuler analjezik(diklofenak sodyum) uygulamasından 3 saat sonra şikayetlerinin başladığı öğrenildi. Özgeçmişinde önemli bir özellik saptanmadı. Genel durumu iyi bilinci açık olan hastanın vital bulguları stabildi. Hastanın nörolojik muayenesinde kranial sinirler ve serbeller sistem normaldi. Sağ alt ve üst ekstremitelerde kas gücü 5/5'di; sol ayak dorsifleksiyonunda ise kas gücü 2/5'di. Ayak başparmağında hiperestezi, ayak dorsumunda duyu azalması vardı. Diğer sistem bulguları normaldi. Gluteal bölge yumuşak doku ultrasonografi incelemelerinde nekroz, apse, hematoma veya fibroz doku izlenmedi. Nörolojiyle konsülte edilen hastaya sinir iletim çalışması planlandı. Yapılan sinir ileti çalışmasında, sol siyatik sinirin peroneal dalının süperfisial dalında çok daha belirgin olmak üzere parsiyel lezyon izlendi.

Sonuç: Enjeksiyonu yapacak sağlık çalışanları, yanlış yapıldığında sonuçları yaşam kalitesini kötü yönde önemli derecede etkileyen, kalıcı ozurluluğa yol açan konuyla ilgili bilgilendirilmeli ve beceri kazandırılmasında titiz eğitim aşamaları eksiksiz olarak yerine getirilmelidir.

Anahtar Kelimeler: düşük ayak, enjeksiyon, intramuskuler

P-0881 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Nekroze umbilikal herni sonucu total kolektomi: Vaka Sunumu

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Konya Eğitim ve Araştırma Hastanesi, Acil Tıp Kliniği, Konya

61 yaşında bayan hasta 3 gündür karındaki umbilikal hernisinden kanamanın durmaması ve ağrıya dayanamaması üzerine komşuları tarafından acil servise getiriliyor. Hastanın anamnezi derinleştirildiğinde hasta daha önce bu hernisi için polikliniğe başvurmuş fakat morbid obez olduğu için ve ek hastalıkları olduğu için opere edilmediği anlaşıyor. Hasta sedanter bir yaşama sahip, yakınları tarafından terk edilmiş, komşularının baktığı bakimsiz bir hastadır. Hernisini muayene ettiğimizde, herninin olduğu bölge nekroze olmuş, sızıntı şeklinde kanaması var. Nekroze



POSTER PRESENTATIONS

bölgeden gaita çıkışı ve çok ağır pis bir kokusu mevcut. Hasta için genel cerrahiden konsültasyon isteniyor. Genel cerrahi yüzeyel doku usg istiyor. Yapılan yüzeyel doku usg; "Periumbilikal bölgede masif geniş boyutlu mezenter ve barsak ansları içeren irreduktabl herni izlenmektedir. Dopplerde kanlanma izlenmedi. Herniye dokuda ve komşu cilt altında ödem mevcuttur." şeklinde rapor ediliyor. Hasta, genel cerrahi tarafından acil operasyona alındı. Genel cerrahi tarafından cilt yüzeyinden görülen 10x15 cm boyutlarındaki oluşum cilt, cilt altı rektum kasının bir kısmı ve faysa ile birlikte çıkarıldı. Umblikustan herniye olan transvers kolon ve omentum nekroze olmuştu. Çıkan kolon serbestleştirildikten sonra inen kolon ve transvers kolonun bir kısmı toksik megakolon şeklinde perforasyon olmuştu ve tümü ileoçekal valve kadar çıkarıldı. İleum ile inen kolon yan yana anastomoz yapıldı, mezosu kapatıldı, karın içi yıkandı ve nekrotik yapıların hepsi temizlendi. Reanimasyon yoğun bakımda postop 1 gün takip edildikten sonra hasta extübe edilip ara yoğun bakıma yatırıldı. Hastanın postop 5.gün genel durumu kötüleşti ve septik şok tablosuna giren hasta arrest oldu ve kardiyopulmoner resusitasyona yanıt alınamaması üzerine exitus olarak kabul edildi.

Anahtar Kelimeler: Umblikal herni, total kolektomi, septik şok

P-0882 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Ağrısız aort diseksiyonu

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Amaç: Aort duvarında intima tabakası ile media tabakası arasındaki bağlantının kopması ve intima tabakasının kan akımı yönünde distale doğru ayrılmasına aort diseksiyonu denir. Aort diseksiyonu aortun en katastrofik hastalığıdır ve aortik patolojiler içinde en önde gelen ölüm nedenidir. Ani başlayan çok şiddetli, yırtılır tarzda göğüs veya sırt ağrısı ile başvuran 50-60 yaşlarında hipertansif erkek hasta tipik bir aort diseksiyonu hastasıdır. Ağrı dışında serebrovasküler olaylar, konjestif kalp yetmezliği, akut aort kapak yetmezliği, hipovolemik sok, tamponad ve malperfüzyon bulguları görülebilir. Aort diseksiyonu erkeklerde daha siktir ve çoğunlukla 40-70 yaşları arasında görülür. Bu vakada acil servise göğüs ağrısı olmaksızın başvuran bir hastada saptanan aort diseksiyonu sunuldu.

Olgu: Kırkaltı yaşında erkek hasta bulantı ve kusma yakınması ile acil servise başvurdu. Anamnezinde şikayetlerinin 6 saat önce başladığı öğrenildi. Eşlik eden başka yakınması mevcut değildi. Özgeçmişinde hastalık öyküsü yoktu ve herhangi bir ilaç kullanımı bulunmamaktaydı. Söygeçmişinde özellik saptanmadı. Hastanın bilinci açık, koopere ve oryante idi. Vital bulguları normal olarak değerlendirildi (TA:115/60mmHg, nabız: 76/dk, solunum sayısı: 10/dk, ateş: 36,6 C). Sinüs ritminde olan EKG'sinde iskemik değişiklik saptanmadı. Fizik muayenesinde anormal bir bulgu tespit edilmedi. Ekstremitelerinde TA farkı ve nabız defisiti saptanmadı. İntravenöz kontrastlı tüm batin bilgisayarlı tomografide subklavian arter distalinde başlayan en kalın yerinde 2 cm'ye ulaşan descendan aort boyunca abdominal aorta infra renal alana kadar ulaşan içinde kontrast ekstrasvazasyonu dikkat çeken diseksiyon ile uyumlu görünüm saptandı. Kalp damar cerrahisi servisine devredilen hasta servis izlemi sonunda medikal izlem kararı alınarak 3 ay sonra kontrole çağırılarak taburcu edildi.

Sonuç: Ani başlayan göğüs-sırt ağrısı aort diseksiyonu'nun en sık semptomudur. Her ne kadar klasik olarak yaşlı ve diyabetik hastalarda nedeni açıklanamayan, ağrının eşlik etmediği atipik yakınmaların aort diseksiyonu nedeniyle olabileceği söylene de benzer klinik durumların komorbid hastalığı olmayan genç hastalarda da görülebileceği mutlaka akılda tutulmalıdır.

Anahtar Kelimeler: Aort diseksiyonu, göğüs ağrısı, acil servis

P-0883 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Apendektomi Sonrası Erken Dönemde Gelişen Nadir Bir Komplikasyon

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Amaç: Psoas apsesi, ender rastlanan genellikle tanı zor ve geç konulan bir antitedir. Psoas kası retroperitoneal organlar, gastrointestinal sistem ve iskelet sistemi ile yakın komşuluğundan dolayı bunların enfeksiyöz hastalıklarında olaya eşlik edebilir. Primerde etiyoloji belli değildir. Sekonder psaoas apselerinin etiyolojisinde apendisit en sık ikinci nedendir. Bu olguda apendektomi sonrası gelişen psaoas absesi sunulacaktır.

Olgu: 50 yaşında bayan hasta, 10 gündür devam eden ateş ve son 4 gündür ateşe eşlik eden karın ve sağ bacak ağrısı şikayeti ile acil servise başvurdu. Öyküsünde 20 gün önce Apendektomi ameliyatı olduğu, ameliyat sonrasında yara yeri akıntısı yada yara yerinde ağrı şikayeti olmadığı öğrenildi. Fizik bakışında; genel durumu orta, şuuru açık, oryante ve koopere idi. Vital bulgularında, kan basıncı; 130/80 mm/hg, nabız; 110 atım/dakika, vücut ısı; 38 OC idi. Nörolojik ve solunum sistemi muayenesi normal idi. Batin muayenesinde; sağ alt kadranda apendektomi skarı vardı. Barsak sesleri normoaktif idi. Sağda kostovertebral açığı hassasiyeti ve sağ alt kadranda hassasiyet vardı. Sağ bacakta ısı artışı, soğukluk ve solukluk yoktu, dokunmakla hassasiyet vardı. Periferik nabızlar açıktı. Laboratuvar incelemesinde; hemoglobin 9,1 gr/dl (12,2-18,1), hematokrit %29,5 (37-53), trombosit sayısı 240.000 K/uL (142.000-424.000), lökosit sayısı 12.070 (4000-10.500), glukoz 117 mg/dl (74-106) AST 40 IU/L (15-37), ALT 39 IU/L (30-65), C-Reaktif protein 108 mg/dl (0-5). Tam idrar tetkikinde; lökosit (+++), eritrosit (+). Adomen USG'sinde; sağ böbrek atrofik, sağ psaoas kasi anterior boyunca uzanan 6,5x6x14 cm boyutlarında ölçülen absesle uyumlu görüntü izlendi. Abdominal Bilgisayarlı Tomografisinde; sağ psaoas kasi lifleri arasında 6,5x6x17 cm boyutlarında kalın kontrastlanan duvarı bulunan yoğun içerikli koleksiyon vardı. Hastada psaoas absesi düşünüldü Genel Cerrahi ile konsülte edildi. Hasta cerrahi kliniğine yatırıldı. Hastanın cerrahi kliniğinde perkütan apse drenajı ile tedavi edildiği öğrenildi.

Sonuç: Karın ağrısına eşlik eden uyluk ağrısı olan hastalarda özellikle özgeçmişinde bir opresyon hikayesi varsa bizim olgumuzda da olduğu gibi psaoas absesi akılda bulundurulması gereken tanılarından birisidir.

Anahtar Kelimeler: Apendektomi, karan ve bacak ağrısı, psaoas apsesi

P-0884 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Erişkin Yaşta Tanı Alan Konjenital Morgagni Hernisi

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Amaç: Dispn ve baş dönmesi acil servislerde sık karşılaşılan şikayetler olsa da ikisinin bir arada bulunması oldukça nadirdir. Pulmoner ve kardiyak patolojiler her iki duruma doğrudan neden olabilirken, abdominal ve diyafragma patolojileri ise indirekt olarak özellikle nefes darlığı açıklayabilir. Bazen bu şikayetler yıllar sonra tanı koyulan konjenital patolojilere işaret ederler.

Olgu: 21 yaşında erkek 2 gündür devam eden nefes darlığı ve özellikle sık nefes aldığından artan baş dönmesi şikayeti ile acil servise başvurdu. Herhangi bir hastalık öyküsü olmayan hastanın vital bulguları TA: 178/90mmHg, nabız:98/dk, ateş:36°C, SatO2:%99 idi. Hastanın fizik muayenesinde vertigoyu açıklayacak muayene bulgusu mevcut değildi. Sağ hemitoraksta solunum sesleri bazalde azalmış olarak duyuldu. Hastanın EKG'si normal sinüs ritmindeydi. Çekilen akciğer grafisinde sağda intraforasik kitle görünümü izlenmesi üzerine hastaya toraks tomografisi planlandı. Tomografide sağ hemitoraks yerleşimli yağ densesinde geniş morgagni hernisi izlendi. Cerrahi kliniklere refere edilen hastaya mevcut lezyon lokalizasyonu nedeni ile batin yaklaşımı kararı alınarak operasyon planlandı.

Sonuç: Morgagni hernileri konjenital diyafragma hernilerinin en az görülenidir ve %5'ten azını oluşturlar. Yetişkinde Morgagni hernisi genellikle nadir görülen ve komplike olmadıkça asemptomatik seyreden bir diyafragma hernisidir. Solda perikardın koruyucu etkisi nedeniyle genellikle sağ taraftadırlar. Fıtık kesesi içinde genellikle omentum bulunur, kolon, mide ve nadiren de ince barsak içerirler. Tanıda posteroanterior ve lateral akciğer grafilerinin yanında toraks tomografisi oldukça etkindir. İleri yaşlarda travma olmadan da görülebileceği unutulmamalı, dispenin ayrırcı tanısında akılda bulundurulmalıdır.

Anahtar Kelimeler: Dispn, Morgagni hernisi, İntratorasik kitle

P-0885 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Travmatik Diyafram Yaralanması Hastalarının Acil Servis Presentasyonu

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Amaç: Künt veya penetran travma ile oluşan diyafram hasarları rölâtif olarak nadirdir. Künt travmaya bağlı yırtılma daha az sıklıkla görülmekte olup göğüs travması nedeniyle hastaneye yatırılan hastaların <%5'inde görülür. Sağ hemidiyafram üzerine karaciğerin koruyucu etkisi ve sol posterolateral diyaframın olası güçsüzlüğündeki artış nedeniyle daha önceleri künt travma sonrasında diyafram yaralanmalarının çoğunluğunun solda gerçekleştiği düşünülüyordu. Ancak sağ ve sol tarafta diyafram yırtığı görülme sıklığının hemen hemen eşit olduğu görülmektedir. Yaptığımız literatür taramasında travmatik diyafram yaralanmaları, genellikle birden fazla yaralanma ile ilişkili bulunmuştur. Bizim sunacağımız vaka izole travmatik diyafram rüptürü görülmesi ve AS prezentasyonu hakkındadır

Olgu: 38 yaşında erkek hasta 1,5 metre yüksekten düşme sonucu karın sol alt-üst kadranda ve sol alt ekstremitede ağrı ile acil servise başvurdu. Diğer sistem muayene bulguları normaldi. Vitalleri stabil olup FM de sol üst-alt kadranda ve alt ekstremitede hassasiyet saptandı. Abdominal kontrastlı BT çekildi ve sol hemidiyafram posteriorunda 2 cm lik yırtık tespit edildi buradaki yırtıktan retroperitoneal yağ dokunun toraksa herniasyonu saptandı. Göğüs cerrahi konsültasyonu istendi. Göğüs cerrahi servisine yatırılıp laparoskopik diyafram onarımı yapıldı. İzleminde

POSTER BİLDİRİLER

herhangi bir komplikasyon gelişmedi.

Sonuç: Küçük diyafram hernilerine genellikle hasta semptomatik oluncaya kadar aylar yıllar sonrasına kadar tanı konulamaz. Geç tanı konulduğunda ise yüksek mortalite ve morbidite ile ilişkilidir. AS e künt travma ile gelen hastalarda diyafram yaralanması olacağı düşünülmeli gerekli tetkikler yapılarak atlanmamalıdır.

Anahtar Kelimeler: Diyafram rüptürü, künt travma, yüksekte düşme

P-0886 Trauma Emergencies

Acil Servise Nadir Bir Başvuru Nedeni; At Isırığı

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Amaç: Hayvanlar tarafından saldırı yada ısırılma acil servise sık başvuru nedenlerindendir. Kent ve kırsal bölgelerde en sık neden köpek ısırımıdır. At ısırıkları da nadir başvuru nedenlerinden biridir.

Olgu: 57 yaşında erkek hasta, at ısırması sonucu 112 ekibi tarafından acil kliniğimize getirildi. Öyküsünde yaklaşık 1 saat önce tarlada at ile bağı sürerken daha önceden herhangi bir saldırı-ganlığı olmayan at tarafından alt çene ve belinden ısırıldığı öğrenildi. Fizik bakışında; genel durumu iyi, şuuru açık, oryante ve koopere idi. Vital bulguları normaldi. Yüzde; çene alt sınırından alt dudığa uzanan ve alt dudak mukozasını, cilt altı dokuları ve deriyi tam kat içeren yaklaşık 5x5 santimetrelilik alanda doku defekti mevcuttu. Sol lomber bölgede 10x5 santimetrelilik ekimotik alan ve bu alanın ortasında diş izleri ve doku abrazyonu vardı. Direk kafa grafisinde mandibulada fraktür izlenmedi. Laboratuvar incelemesinde; hemoglobin 14,1 gr/dl (12,2-18,1), hematokrit %38,9 (37-53), trombosit sayısı 226.000 K/uL (142.000-424.000), lökosit sayısı 12.000 (4000-10.500) idi. Hastaya lokal yara temizliği, tetanoz profilaksisi, kuduz immünglobulini ve kuduz aşısı yapıldı. Hasta kuduz aşısı programına alındı. Çenedeki doku defekti onarımı amacıyla plastik cerrahi ile konsülte edildi ve sonrasında hasta plastik cerrahi kliniğine yatırıldı.

Sonuç: At ısırması sonucu acil servise başvuran hastalarda yara deformitesi tedavisi ile birlikte kuduz profilaksisi de tedavinin önemli ve unutulmaması gereken bir parçasıdır.

Anahtar Kelimeler: At ısırması, cilt deformitesi, kuduz profilaksisi

P-0887 Toxicology

Deli Bal Zehirlenmesi: Olgu Sunumu

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Amaç: Deli bal zehirlenmeleri, "Rhododendron" çiçeklerinden beslenen arıların ürettiği balın tüketilmesiyle oluşmaktadır. Balın içinde yer alan grayanotoksinler etkilerini hücre membranlarındaki sodyum kanallarına bağlanıp inhibe ederek göstermektedir. Türkiye'de özellikle Doğu Karadeniz'in dağlık kesiminde elde edilen balın yenilmesiyle ortaya çıkmaktadır. Zehirlenmelerde birçok sisteme ait etkiler (vücutta kaşıntı, deride ve gözlerde kızarıklık, baş ağrısı, vertigo, karın ağrısı, bulantı, kusma, halsizlik, görme bulanıklığı veya geçici körlük, ateş, deliryum vb.) görülebilmekte iken en sık görülen etkiler %90 ile bradikardiler ve hipotansiyondur. Ortaya çıkan klinik bulgular alınan miktarla ilişkilidir ve hayatı tehdit edici tablolara neden olabilmektedir.

Olgu: 21 yaşında erkek hasta acil servise bulantı, kusma, fenalık hissi ve bulanık görme şikayetleriyle başvurdu. Anamnezinde 3-4 saat öncesinde Gümüşhane'den getirilen 3-4 kaşık kestane balı (deli bal) yediği öğrenildi. TA: 60/40 mmHg, nabız: 39/dk olarak saptandı. Diğer vital bulguları normal olarak değerlendirilen hastanın fizik muayenesinde anormal bulgu saptanmadı. Çekilen EKG'sinde P dalgalanının seçilemediği, R-R aralıklarının düzenli ve QRS genişliğinin normal olduğu bir ritim saptandı. İntravenöz atropin (tekrarlanan 0.5 mg dozlarla toplamda 3 mg IV) ve transkutanöz pace ile hemodinamik durumu düzelmeyen hasta koroner yoğun bakım ünitesine devredildi. Koroner yoğun bakım ünitesinde geçici pace-maker takılan hasta 48 saat sonra hemodinamik bulguları stabil olarak taburcu edildi.

Sonuç: Acil servise bulantı, kusma ve bradikardi ile başvuran ve herhangi ilaç kullanımı ve kalp hastalığı öyküsü bulunmayan hastalarda ayırıcı tanıda mutlaka deli bal zehirlenmesi akılda bulundurulmalıdır.

Anahtar Kelimeler: Deli bal, grayanotoksin, acil servis

P-0888 Toxicology

Afyonkarahisar'da Nadir Görülen Bir Olgu: Deli Bal Zehirlenmesi

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Amaç: Deli bal zehirlenmesi nadir bir gıda zehirlenmesi türüdür. Arıların ponticum ve avum türü yaban bitkilerinin çiçeklerinden ve yapraklarından elde ettikleri balda yoğun olarak bulunan bir toksin olan grayanotoksin (andromedotoksin) zehirlenmeden sorumlu ajandır. Bu bitki Doğu Karadeniz bölgesinde yaygın olduğu için Karadeniz bölgesinde deli bal zehirlenmesi yaygın olarak görülür.

Olgu: 56 yaşında erkek hasta; Terleme, sırt ağrısı, baş dönmesi ve bayılma sonrasında 112 tarafından acil servise getirildi. Özgeçmişinde geçirilmiş inguinal herni operasyonu ve gastroözofajial reflü dışında özellik olmayan hastanın soy geçmişinde özellik yoktu. Bir gün önce gece saat 24:00 civarında Karadeniz bölgesinden getirdiği baldan 2-3 kaşık ve sabah 5-6 sıralarında 1-2 kaşık yiyen hastada 08:00 de şiddetli göğüs ve sırt ağrısı, baş dönmesi, terlemesi olan hasta bilinci kapalı bir şekilde acil servise getirildi. Acile geldiğinde genel durumu orta kötü, kooperasyon tam olarak kurulamıyordu. Arteriyel kan basıncı (AKB) 50/30 mmHg ve nabız 49 atım /dk olarak ölçüldü. Çekilen elektrokardiyografi'de (EKG) sinüs bradikardisi mevcuttu. Hastanın hemodinamisinin bozuk olması üzerine monitörize edilerek, 0.5 mg atropin intravenöz bolus olarak uygulandı ve hızlı serum fizyolojik infüzyonuna başlandı. Beş dakika sonra hastanın nabızı 60 atım/dk, AKB'yi 70/50 mmHg olarak ölçüldü. Hasta acil serviste yakın gözlem altına alındı ve serum fizyolojik 300ml/saat'te gidecek şekilde infüzyona devam edildi. Çekilen kontrol EKG'de NSR, normal aks, 71 atım/dk idi. AKB 1 saat sonra 110/70 mmHg olarak ölçüldü. Göğüs ağrısı ve T dalga değişiklikleri olan hasta için kardiyoloji konsültasyonu istendi. Hasta koroner yoğun bakım ünitesine yatırıldı. Takipleri sırasında aktif yadınması olmayan, AKB ve ritmi normal seyreden hasta önerilerle taburcu edildi.

Sonuç: Deli bal özellikle Karadeniz Bölgesinde mide rahatsızlıklarından hipertansiyona, koroner kalp hastalığından iktidarsızlığa kadar birçok rahatsızlıkta alternatif tedavi yöntemi olarak kullanılır. Bu balın tüketilmesi sonucunda gastrointestinal, respiratuvar, kardiyovasküler ve nörolojik sistemlerle ilgili bulgular ortaya çıkabilmektedir. Semptomlar 1,5-3 saat sonra başlar. Deli bal herkeste toksik etki yapmayabilir, doza bağlı olarak kişilerin etkilene dereceleri farklıdır. Hastalar genellikle atropin tedavisi ve serum fizyolojik infüzyonu ile düzelir, ancak ölümler de bildirilmiştir. Ülkemizde vakalar genellikle Karadeniz bölgesinden bildirilmiştir. Olgu dolayısıyla bölgemizde nadir görülen deli bal zehirlenmesinin etkilerine dikkat çekilerek tedavi yaklaşımımız anlatılmıştır.

Anahtar Kelimeler: Afyonkarahisar, deli bal, zehirlenme

P-0889 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Akut Batında Nadir Bir Neden; Splenik Enfakt

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Amaç: Splenik infarkt nadir görülen bir dalak patolojisi olup, çoğunlukla başka hastalıkların komplikasyonu olarak görülür. Splenik infarktın 1/3 ünden fazlasının sebebi atrial fibrilasyon ve atrial trombüsü olan hastalar oluştururken diğer sebepler arasında hematolojik, vasküler ve anatomik sebepler yer alır. Klinik tablo çeşitli akut batın durumunu taklit edebileceğinden acil servislere kolaylıkla gözden kaçabilir. Bizde burada acil serviste karşılaştığımız bir splenik infarkt olgusunu tartışarak sizlerle paylaşmak istedik.

Olgu: 58 yaşında bayan hasta uzun süredir ara ara olan karın karın ağrısı, 2 gündür şiddeti giderek artan sol üst kadranda ağrısı sebebiyle acil servise getirildi. Öyküsünde ağrının sol tarafta başlayıp tüm karına yayıldığını ve beraberinde bulantı, kusma ve halsizliğin eşlik ettiği öğrenildi. Hastanın daha önceden bilinen sadece diyabet hastalığının olduğu ve bunun için oral antidiyabetik kullandığı öğrenildi. Bunun dışında künt batın travma öyküsü yoktu. Yapılan fizik muayenede genel durumu iyi, kan basıncı 110/70, nabız 75, kalp atışları ritmik, ateş 36,7 derece idi. EKG normal sinüs ritminde idi. Batın muayenesinde barsak sesleri normoaktif, minimal yaygın hassasiyet ve sol üst kadranda mikro ve derin palpasyonda ciddi defansı mevcuttu, rebound şüpheli pozitif olarak değerlendirildi. Diğer sistemik muayeneleri normal sınırlarda idi. Laboratuvar değerlerinde WBC: 12.500mm³, Hb: 10.8g/dl, Plt: 269.000mm³, biyokimyasal değerlerinde kan şekeri: 250mg/dl dışında herhangi bir anormallik görülmedi. Hastanın çalışılan bakılan tam idrar tetkiki normal, çekilen akciğer grafisi ve ayakta direkt batın grafisi normal sınırlarda



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tesbit edildi. Hasta yaklaşık dört saate yakın acil serviste takip edildi. Uygulanan hidrasyon ve analjezik tedaviye rağmen fiziki muayene bulgularında herhangi bir gerileme olmaması sebebiyle kontrastlı bilgisayarlı batin tomografi (BT) çekildi. Çekilen BT nin değerlendirilmesi acil serviste yapıldı ve dalakta şüpheli bir hipodens alan tesbit edildi. Radyoloji ile teğit edilen BT splenik infarkt olarak değerlendirildi ve hasta genel cerrahi servisine yatırıldı. Bir hafta süreyle serviste takip edilen hastamızda hiçbir ciddi komplikasyon ve mortalite gelişmedi. Konservatif tedavisi düzenlenek taburcu edildi.

Sonuç: Dalak enfarktı olan hastalarda klinik, spesifik olmayan karın ağrısı şeklinde olabildiği gibi masif subkapsüler kanamaya bağlı hemorajik çok tablosu ile de karşımıza çıkabilir. Belirti olarak, 2/3'ünden fazlasında yaygın karın ağrısı veya sol üst kadranda ağrısı görülmektedir. Bulantı, kusma erken belirtiler arasındadır. Ateş, titreme, plöritik göğüs ağrısı ve sol omuz ağrısı (Kehr bulgusu) karın ağrısına eşlik edebilir. Ağrının başlama zamanı 1/2'sinde bir haftadan uzun sürebilir. Splenik enfarkt nadir görülen ancak göz ardı edilmemesi gereken bir akut karın nedenidir. Tanısı şüpheli edildiği takdirde görüntüleme ile konulur. Sol üst kadranda ağrısı ile gelen hastalarda, alta yatan predispozan faktörlerin varlığında ayırıcı tanıları arasında akla tutulması gerekir.

Anahtar Kelimeler: karın ağrısı, dalak enfaktı, kontrastlı batin tomografisi

P-0890 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Karın ağrısı ve dispne nedir bir neden: Safra taşı ileusu

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Amaç: Tüm intestinal obstrüksiyonların %1-4'ünü oluşturan safra taşı ileusu, kolelitiazisin bir komplikasyonudur. Genellikle 6-7'nci dekantaki hastalarda görülür. Hastaların ileri yaşı, sıvı elektrolit bozuklukları, ayırıcı tanıda akla bulundurulmaması gibi nedenler mortalite oranlarının %12-18 gibi yüksek değerlerde olmasına sebep olur. Kadınlarda daha sık görülen safra taşı ileusları ile safra taşlarının büyüklüğü 2,5 cm üzerinde olduğunda karşılaşırlar.

Olgu: 71 yaşında erkek hasta 2 gündür devam eden karın ağrısı ve nefes darlığı şikayetleri ile acil servise başvurdu. Herhangi bir cerrahi öyküsü olmayan hasta hipertansiyon ve KOAH nedeni ile medikasyon almaktaydı. Vital bulguları TA:188/79mmHg, nabız:130/dk, ateş:36,5°C, SatO2:%87 olan hastanın batında yaygın hassasiyeti, defans ve reboundu mevcuttu. Rektal tuşede ampulla boş olarak değerlendirildi. Ayakta direkt batin grafisinde ince barsak seviyeleri izlendi. Batin Ultrasonografisinde pnömobilite görülen hastaya, yaşı dolayısı ile etyolojik faktörün malignite olma olasılığı göz önünde bulundurularak kontrastlı batin tomografisi planlandı. Hastada, duodenum lümenini tıkayan safra taşı tespit edildi. Hasta safra taşı ileusu tanısıyla cerrahi kliniğine yatırıldı.

Sonuç: Safra taşı ileuslarında anamnez, fizik muayene ve laboratuvar bulgularının özgüllüğü düşük olması nedeni ile tanı koyulması geç olmaktadır. Hastaların ortalama başvuru süreleri de 2 günün üzerindedir. Tanıda görüntüleme yöntemleri etkin olarak kullanılmalı, hava sıvı seviyeleri ve ektopik safra taşının görünmesinin yanında olguların yaklaşık olarak %30-40'ında pnömobilite görülmesi unutulmamalıdır.

Anahtar Kelimeler: Karın ağrısı, dispne, pnömobilite, kolelitiazis, ileus

P-0891 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Köpek Isırığı Sonrası Gelen Kompartman Sendromu

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Amaç: Kompartman sendromu, ekstremitelerde kapalı kas fasyalarının içinde artmış perfüzyon basıncı nedeni ile sinir ve kas dokularında meydana gelen, iskemik sonucu gelişen fonksiyon kaybı ile karakterize bir tablodur. En sık, ön kol volar yüz ile alt ekstremitenin anterior ve derin posterior kompartmanlarına ait bir tablo olmasına rağmen, vücutta, iskelet kasının fasya ile çevrili olduğu her yerde gözlenebilir. Kompartman sendromunun klinik bulguları kompartman bölgesindeki kasların pasif gerilmesiyle ağrı oluşumu, parestezi, güçsüzlük, kompartmanın palpasyonuna bağlı ağrı şeklinde özetlenebilir.

Olgu: 71 yaşında erkek hasta köpek ısırığı sonrası sol kolda yaralanma şikayetiyle acil servise başvurdu. Öyküde hastanın birkaç kez ciddi şekilde ısırılıp sürüklediği öğrenildi. Hastanın dış merkezde kuduz aşısının yapıldığı ve takibe alındığı öğrenildi. Hastanın fizik muayenesinde genel durumu iyi şuuru açık koopere oryante, TA:130/70 mmHg, nabız: 86/dk, SS:20/dk, SO2:%96 idi. Hastanın sol ön kolda multiple dış izleri mevcuttu. Hastanın dorsal yüzde 3x4 cm açık yarası ve aynı alanda yaklaşık 3-4 cm yüksekliğinde şişliği mevcuttu. Hastanın sol ön kol volar yüzde proksimal 1/3 'te dış izi ve bu bölgede 3x4x4 cm'lik ciltten kabarıklık alanı mevcuttu (Resim 1). Yapılan muayenede tüm parmakların aktif ve pasif MP, PIP ve DIP eklemlerinde fleksiyon ve ekstansiyon hareketi kısıtlı ve 3 ve 4. parmaklarda hipostezi tarifliyor. Hastanın sağ ön kol ve eldede multiple dış izleri ve 2x2x2 boyutunda ciltten kabarıklık lezyonu mevcuttu. Hasta mevcut bulgularla kompartman sendromu ve tendon kesisi ön tanılarıyla plastik cerrahi ve ortopedi bölümlerine konsülte edildi. Plastik Cerrahi Bölümü tarafından hastanın mevcut kesileri suture edildi, sol ön koldaki yara kompartman sendromu ön tanısıyla eksplore edilerek hematoma boşaltıldı ve kompartman sendromunun tekrar oluşma olasılığına karşın yara açık bırakıldı. Diğer kesiler suture edildi ve tendon hasarı saptanmadı. Hastaneye yatırılarak Kanama ve pansuman takibi yapılan hasta 1 hafta sonra şifayla taburcu edildi.

Sonuç: Kompartman sendromunun klasik semptomları, sürekli devam eden özellikle kasın pasif olarak gerilmesi ile belirgin artış gösteren şiddetli ağrı ve parestezidir. Şişlik, renk değişikliği, nabız alınamaması gibi dolaşım bozukluğuna ait bulgular da olabilir. Periferik sinir etkilenmesine bağlı olarak duyu ve motor defisitler kliniğe eşlik edebilir. Hayvan ısırıkları sonucu bu tür şikayetlerle acil servise başvuran hastalarda kompartman sendromu düşünülmelidir.

Anahtar Kelimeler: kompartman sendromu, köpek ısırığı, hipostezi

P-0892 Trauma Emergencies

Kafa travması sonrası geç ortaya çıkan epidural kanama

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Amaç: Kafa travmaları özellikle genç erişkin ve çocuklarda önemli bir ölüm ve sakat kalma nedenidir. En sık 15-24 yaşlarda ve erkeklerde 2-3 kat daha fazla görülür. Hasarın derecesini belirleme, hangi tedavinin yapılacağına karar verme sürecinde bilgisayarlı beyin tomografisi ile görüntüleme önemli bir yer tutmaktadır. Ancak infratemporal bölge, subfrontal bölge, posterior fossa kanamaları ve diffüz aksonal yaralanmalarda bilgisayarlı beyin tomografisi lezyonu görüntülemede yetersiz kalabilmektedir. Bu vakada acil servise tekrarlayan başvurusu olan ve travma sonrası geç dönemde ortaya çıkan epidural kanama vakası sunuldu.

Olgu: Onbir yaşında erkek hasta kusma ve uykuya eğilimde artış şikayetleriyle acil servise getirildi. Anamnezinde 24 saat önce bisikletten düşme sonrasında şikayetlerinin başladığı öğrenildi. Aynı yakınmalarla iki ayrı dış merkezde başvurduğu ve bu merkezlerde bilgisayarlı beyin tomografisi çekildiği öğrenildi. Travmanın 4. ve 10. saatlerinde dış merkezde çekilen her iki tomografi incelendiğinde kırık ya da kanama bulgusu saptanmadı. Hastanın acil servise gelişindeki vital parametreleri normal olarak değerlendirildi. Genel durumu iyi, koopere ve oryante olan hastanın fizik muayenesinde uykuya eğilim haricinde başkaca anormal bir bulguya rastlanmadı. Glasgow koma skalası 14 olarak belirlendi. İzleminde bir defa fişkirir tarzda kusması olan hastanın biyokimyasal parametrelerinde anormallik saptanmadı. Çekilen bilgisayarlı beyin tomografisinde sağ frontal bölgede ince epidural kanama ile uyumlu görünüm saptandı. Hasta izlem amaçlı beyin ve sinir cerrahisi kliniğine devredildi. Kontrol bilgisayarlı beyin tomografilerinde kanamada artış saptanmayan hasta nonoperatif izleminin 5. gününde asemptomatik olarak taburcu edildi.

Sonuç: Genç nüfusta önemli bir morbidite ve mortalite nedeni olan kafa travmalarının acil serviste değerlendirilmesi sonrasında hastalar sıradışı herhangi bir şikayet anında acil servise tekrar başvurmaları konusunda mutlaka bilgilendirilmelidir.

Anahtar Kelimeler: Epidural kanama, travma, acil servis

P-0893 Trauma Emergencies

Posttravmatik Pulmoner Psödokist: Olgu Sunumu

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Amaç: Toraksın künt travmaları sonrasında akciğer parankiminin de oluşan hasar kendini sıklıkla kontüzyon veya hematoma şeklinde gösterir. Kaviter bir lezyon oluşumu veya psödokist oluşumu nadir görülen bir olaydır. Posttravmatik pulmoner psödokistler (PPP) genellikle çocuk ve erişkin yaş grubunda göğüs kafesinin aşırı esnekliği nedeniyle oluşan ağır travmalar dahi visseral bütünlüğü bozmamaktadır. Dolayısıyla akciğer parankimi içerisinde hava, sıvı veya kanla dolu bronşial duvar elementleri ile epitelyum içermeyen ince duvarlı belirgin sınırları olan PPP 'ler

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daha sık olmaktadır. PPP bening klinik seyirlidirler ve çoğunlukla destekleyici tedavi ile 1-4 ay içerisinde kendiliğinden rezorbe olurlar. Ancak medikal tedaviye yanıtız ikinci enfeksiyonun gelişmesi kist duvarında oluşan belirgin gerginlik nedeniyle kavite boyutlarında büyüme oluşması ve kistin çevre akciğer parankimine basısı nedeniyle oluşan atelektazinin ciddi restriktif ventilasyon defektine neden olması dolayısıyla cerrahi girişim gerekebilir. Bizde burada acil servise gelen künt göğüs travmalı bir hastada tesbit edilen PPP olgusunu sizlerle paylaşmak istedik.

Olgu: 43 yaş erkek hasta trafik kazası sonrasında acil servise getirildi. Hasta göğsünü direksiyona çarptığını ve ağrısı olduğunu ifade ediyordu. Yapılan fizik muayenede genel durumu iyi, bilinç açık oryante, koopere, vital bulguları stabil, nefes darlığı ve özellikle sağ hemitoraksta palpasyon ile hassasiyeti mevcuttu. Sol hemitoraksta da solunum sesleri minimal azalmıştı. Diğer sistemler doğaldı. Hastanın bakılan tam kanda WBC: 18.300/mm³, Hb: 13.0, Plt: 185.000/mm³ idi. Biyokimya değerlerinde herhangi bir anormallik tesbit edilmedi. Göğüs kafesindeki hassasiyet ve nefes darlığının olması sebebiyle çekilen bilgisayarlı toraks tomografisinde kalp inferior kesiminden geçen kesitlerde orta hattın solunda şüpheli pnömotoraks ile uyumlu serbest hava görünümü izlendi. Sol hemitoraksta da belirgin plevral efüzyon ve komşuluğunda pulmoner kontüzyon ile uyumlu konsolide alanlar tesbit edildi. Ayrıca sağ akciğer alt lob bazal segmentte 20 mm çapında kistik bir görünüm dikkati çekmiştir. İnceleme alanına giren kemik yapılar ve çevre yumuşak dokularda herhangi bir patolojiye rastlanmadı.

Hasta acil serviste ilk müdahaleleri yapıp göğüs cerrahisine konsülte edildikten sonra takip amaçlı servise yatırıldı.

Sonuç: Akciğerin PPP'leri genellikle spesifik bir tedaviye gerek duymadan uzun süre akciğer grafileri ile takip edilebilir. Gerekli olgularda posttravmatik birkaç günde çekilecek akciğer grafileri daha sonra yaşanacak bir tanılal karmaşayı önlemesi ve takip için referans olması açısından önemli taşır. Psödokistlerin resorbsiyonu gecikmiş vakalarda önemli komplikasyonlara neden olacağı göz ardı edilmemelidir. Bu nedenle bu kistler özellikle çocuk ve genç hastalarda künt toraks travması sonrasında daha sık karşılaşılabileceği sebebiyle acil serviste tesbit edildiği takdirde takibinin önemli olması nedeniyle hasta bilgilendirilmeli ve ilgili bölüme yönlendirme yapılması önemlidir.

Anahtar Kelimeler: travma, akciğer, psödokist

P-0894 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Atriyal fibrilasyona bağlı nadir bir akut batın sebebi: dalak infarktı

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Amaç: Dalak infarktı nadir görülen bir dalak patolojisi olup, çoğunlukla başka hastalıkların komplikasyonu olarak görülür. Dalak infarktının, üçte birinden fazlasının sebebi atrial fibrilasyon ve atrial trombüstür. Diğer nedenler hematolojik, vasküler ve anatomik olabilir. Dalak infarktı; karın ağrısı, bulantı, kusma, halsizlik şikayetleri ile diğer akut batın sebeplerini taklit edebilir. Hastaların %53'ünde anemi, %49'unda lökositoz, %7'sinde trombotizoz görülür. Tanısı klinik ve görüntüleme ile konulmaktadır. Tanı konulduktan sonra hastalarda hidrasyon, oksijen desteği, aneljezi ve sıkı takiple infarkt alanının geriletiği görülmüştür. Yaklaşık 1/3'ünde cerrahi endikasyonu vardır.

Olgu: 83 yaşında erkek hasta 3 gündür devam eden karın ağrısının artması nedeniyle acil servise başvurdu. Vitalleri TA:140/95 mmHg, aksiler ateş 37 C, kalp aritmik ve nabız yaklaşık 95/dakika idi. Fizik muayenesinde barsak sesleri normoaktif, sol üst kadranda daha fazla olmak üzere her iki üst kadranda hassasiyeti ve defansı mevcuttu. Gaz gayta çıkışı vardı. EKG sinde atrial fibrilasyonu vardı. Hastamızın özgeçmişinde ileustan opere, hipertansiyon ve atrial fibrilasyon hikayesi olduğunu öğrendik. Laboratuvar bulgularında 14.000 WBC dışında anormal bir sonuç yoktu. INR'si coumadin kullanmasına rağmen normal sınırdı. Ayakta direk karın grafisi ve ultrasonografisi normal olarak değerlendirildi. Çekilen kontrastlı batın tomografisinde dalağında infarkt alanlarına rastlandı (Resim 1). Hasta genel cerrahi servisine yatırıldı.

Sonuç: Dalak infarktı nadir görülse de, karın ağrısı ile başvuran ve predispozan faktörleri olan hastalarda ayırıcı tanıda düşünülmesi gereken bir tablodur.

Anahtar Kelimeler: atriyal fibrilasyon, komplikasyon, dalak infarktı, akut batın

P-0895 Trauma Emergencies

Balon Şişirirken Yanağım'da Şişti: Olgu Sunumu

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Amaç: Cilt altı amfizemi, cilt altı dokularda hava veya gazın bulunması ile karakterize anormal bir durumdur. Cilt altı amfizeminin en önemli nedenleri kot kırığı, akciğer parankim yaralanmaları ve özefagus travmalarıdır. Bununla birlikte dental, oral ve nazal cerrahi uygulamalarla, maksillofasial travmalara bağlı olarak gelişen bir komplikasyondur. Bu sunudaki amacımız minör bir mukozal travmayla dahi cilt altı amfizemi gelişip daha sonrasında ciddi komplikasyonlara sebep olmaması sebebiyle gözlem altına alınıp erken dönemde müdahale etmek gerekliliğini vurgulamaktır.

Olgu: On üç yaşında bayan hasta balon şişirirken sağ yanağında oluşan şişlik nedeniyle acil servise başvurdu. Fiziki muayenesinde bilinç açık oryante, koopere, glaskow koma skoru: 15, sağ yanaktan başlayıp kulağa doğru yayılan şişlik ve palpasyonda krepitasyon veren cilt altında amfizemi mevcuttu. Diğer sistemler doğaldı. Hasta gözlem altına alındı ve bu süreçte bilgisayarlı maksillofasial tomografisi (BT) planlandı. Hastanın çekilen BT'sinde sağda parotis, karotis ve paralarangeal spacelerde amfizem ile uyumlu hava değerleri tesbit edildi. Hasta takip amaçlı on iki saat acil serviste gözlem altına alındı. Herhangi bir komplikasyon gelişmemesi üzerine önerilerle taburcu edildi.

Sonuç: Çoğu zaman yüz bölgesinde oluşan maksillofasial veya periorbital cilt altı amfizemleri kendini sınırlamasına rağmen enfeksiyon, görme kaybı, pnömotoraks ve pnömomediastinum gibi ciddi komplikasyonlara da neden olabilmektedir. Bu nedenle acil servise başvuran minör yüz travmaları ancak cilt altı amfizemi de mevcut ise göz ardı edilmemelidir, yakın takipte bulunulup erken müdahale açısından alert olunması gereklidir.

Anahtar Kelimeler: travma, cilt altı amfizem, klinik takip

P-0896 Trauma Emergencies

Bilateral Scafoïd Fraktürü

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Giriş: El bileği 8 karpal kemik ve distal radius ile ulna arasındaki eklemlerden oluşan bir komplekstir. Bu alanda travma sıkır ve tanısı zordur. Kişinin yaşı kemiğin matüritesini ve yaralanma tipinin etkilerini etkiler. Yaralanma sıklıkla el üzerine düşme şeklindedir. Scaphoid kemik bu travmalarda en sık kırılan kemiklerdendir. Ancak direkt grafide scaphoid kırığı gözükmez. Bu nedenle tanısı zor konulmakta ve proksimalde kemik dokuda avasküler nekroz gelişebilmektedir.

Olgu: 23 Yaşında erkek hasta el bileği üzerine 24 saat önce düşmüş ve ağrısının devam etmesi nedeniyle acil servise başvurmuş. Hastanın fizik muayenesinde bilateral hassasiyeti mevcuttur. Hastaya çekilen direkt grafilerde bilateral scaphoid kırığı gözükmemektedir. Hastaya alçı uygulanmış olup ortopedi tarafından takibe alınmıştır.

Sonuç: El bileği travmalarında fizik muayenede hassasiyeti olan hastalarda direkt grafide kırık görülmesi dahi hasta da scaphoid kırığı olabileceği de akla getirilmelidir.

Anahtar Kelimeler: scaphoid, fraktür, ağrı

P-0897 Toxicology

Gözde Kızarıklık ve Yanma: Genç Vakada İyonize Işınlr İle Oluşan Konjonktivit

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Antalya Eğitim Araştırma Hastanesi, Acil Tıp Kliniği

Amaç: Konjonktivit, konjonktivanın inflamatuvar durumudur¹. Bir çok farklı etyolojiye bağlı olarak görülebilse de genellikle viral enfeksiyonlara sekonder gelişerek kendi kendini sınırlayan bir hastalıktır. Nadiren iyonlaştırıcı radyasyon maruziyetleri de konjonktivite neden olabilmektedir. İyonlaştırıcı radyasyon direkt grafilerde, tomografi cihazlarında, radyoterapi cihazlarında vb olmak üzere tip dünyasında sıkça kullanılmaktadır. Üzerinde bulunan enerjiyi dokulara aktarmak sureti ile dokulara zarar vermektedir². Akut dönemdeki konjonktivit, deride eritem ve akut radyasyon sendromu gibi hasarların yanında geç dönem komplikasyon olarak katarakt, kanser veya genetik bozukluklara da neden olabilmektedir. Bu olgumuzda acil servise gözlerde kızarıklık, yanma ve batma şikayeti ile gelen iyonlaştırıcı radyasyon maruziyetine bağlı geliştiğini düşündüğümüz konjonktivit hastalığını tartışacağız.

Olgu: 32 yaşında bir erkek hasta, bir gün öncesinde başlayan her iki gözde kızarıklık, yanma ve batma şikayeti ile acil servisimize başvurdu. Herhangi bir ek şikayeti yoktu. Pürülan akıntı, görme bozukluğu ya da ağrı tariflemeyen hastanın fizik bakışında konjonktivalarda hafif bir ödem ve hipereminin dışında patoloji saptanmadı. Ayrıca yabancı cisim ya da flüoresinle tutulum da görüldü. Hikayesinde atopi varlığı, mevsimsel alerji öyküsü, yakın dönem üst solunum yolu enfeksiyonu ya da iş yerinde toz, UV ışık maruziyeti vb konjonktivit nedeni olabilecek çevresel bir etkenle temas öyküsü yoktu. Hastadan alınan öyküye göre iş arkadaşlarından birinde tüberküloz saptanması üzerine yedi iş arkadaşı aynı verem savaş dispanserine giderek tarama yaptırmışlar. Her hastaya mikrofili şeklinde apikolordotik akciğer grafisi çekilmiştir. Bir gün sonrasında ise her hastada değişen ciddiyet derecelerine göre konjonktivit semptomları başlamıştır. Hastaya akut radyasyon toksikasyonu açısından sorgulama yapıldı ve herhangi bir semptom (bulantı, kusma, diyare, vücut ve baş ağrısı vb) saptanmadı. Bu bulgularla hastada iyonize

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radasyona bağlı konjonktivit düşünüldü. Semptomatik tedavisi düzenlenen hasta önerilerle taburcu edildi.

Sonuç: Gözler radasyona karşı duyarlıdır ve 1-2 Gy (100-200 rad) ile maruziyet sonrası akut konjonktivit gelişebilmektedir. Ülkemizde tüberküloz tanısı amacıyla verem savaş dispanserlerinde hala apikal-lordotik akciğer grafileri çekilmektedir. Bu grafide hasta ışın kaynağına bakacak şekilde arkaya doğru eğimli dururken ışınlar direkt olarak yüze ve dolayısıyla gözlerle doğru gelmektedir. Ayrıca bu grafiler mikrofilm şeklinde basılmaktadır. Bir akciğer grafisinde 10 mrem iyonlaştırıcı radasyon maruziyeti söz konusu iken mikrofimlerde bu maruziyet 10 kat artmaktadır^{3,4}.

Radasyon konjonktivitisinin tedavi semptomatiktir. Suni gözyaşı damlaları, lokal analjezikler ve daha ileri vakalarda kortikosteroidli damlalar kullanılabilir. Her ne kadar sık karşılaşılan bir durum olmasa da özellikle belirgin bir etyolojik neden saptanamayan konjonktivit vakalarında iyonize radasyona bağlı konjonktivit akıldaki tutulmalı ve akut radasyon toksisitesi açısından da dikkatli olunmalıdır.

Anahtar Kelimeler: iyonlaştırıcı radasyon, konjonktivit, akciğer grafisi

P-0898 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Bel ve diz ağrısının beklenmedik nedeni: abdominal aort anevrizması

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Amaç: Abdominal aort anevrizması (AAA) aortun ≥ 3 cm olmasıdır. Hastalar senkop, sırt ağrısı, bögür ağrısı, karın ağrısı gibi değişik semptom ve bulgularla gelebilirler. Sigara kullanımı, erkek cinsiyet, 60 yaşın üzerinde olma ve periferik arter hastalığı mevcudiyeti AAA riskini artırır.

Olgu: 54 yaşında kadın hasta belinden her iki dizine kadar yayılan ani başlangıçlı ağrı ile acil servise başvurdu. Muayenesinde vital bulguları tansiyonun 168/112 mmHg olması dışında normaldi. Obez olan hastanın karın muayenesinde oskültasyonda normokinetik barsak sesleri duyuldu. Dört ekstermite nabızları alınıyordu. İki yönlü lomber grafisi normal olarak değerlendirildi. Düz bacak kaldırma testi de negatif olan hastada miyalji düşünülerek analjezik yapıldı. Yapılan tedaviye cevap vermeyen hastanın ağrısının devam etmesi üzerine abdominal aort diseksiyonu açısından batin tomografi çekildi. Batin tomografisinde (Resim 1) abdominal aortun 5,4 cm olması nedeniyle hasta kalp ve damar cerrahisi servisine yatırıldı.

Sonuç: Abdominal aort anevrizmasının ayırıcı tanısı; senkop, karın ağrısı, göğüs ağrısı, sırt ağrısı ve çok nedenlerini içerir. Acil servise başvurup bu ağrıların nedeni bulunamadığında hastayı kas iskelet sistemi kaynaklı ağrı diyerek acil servisten taburcu etmemeye özen göstermeliyiz. Hastanın ağrısının ani başlangıçlı ve çok şiddetli olması açısından bizi uyanık tutmalı. AAA'sının her zaman değişik semptom ve bulgularla gelebileceği unutulmamalıdır.

Anahtar Kelimeler: ekstremit ağrısı, abdominal aorta, anevrizma

P-0899 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Nadir Akut Batın Nedenlerinden: Splenik Arter Anevrizma Ruptürü

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Amaç: Splenik arter anevrizması (SAA), visseral arter anevrizmaları içerisinde en sık görülen ve ruptür ihtimali ya da komşu organ erezyonu nedeni ile önem taşıyan abdominal bir lezyondur. Yaş ile birlikte ruptür olasılığı artmaktadır. Bu yazımızda elli iki yaşında bayan hastanın acil servise karın ağrısı nedeniyle başvurusu sonucunda tesbit edilen SAA ruptürü olgumuzu sizinle paylaşmak istedik.

Olgu: Elli iki yaşında bayan hasta acil servise yaklaşık iki saat öncesinde başlayan sırta vuran ve şiddeti giderek artan karın ağrısı nedeniyle getirildi. Hastanın alınan öyküsünde öncesinde miyom nedeniyle kadın doğum tarafından takip edildiği ve başka bir hastalığı olmadığı öğrenildi. Batın travma öyküsü yoktu. Yapılan fizik muayenesinde genel durumu orta, bilinç açık, oryante ve koopere idi. TA: 80/ 50mm/ Hg, Nabız: 110/dk, sat 02:99, Ateş: 36,5, batında yaygın hassasiyet ve periton irritasyon bulguları mevcuttu. Hastaya ilk müdahalesi yapıldıktan sonrasında gönderilen laboratuvar değerlerinde; WBC: 13.000 mm³, Hb:12,2. Plt:408.000, iken biyokimyasal değerleri normal sınırlarda idi.Hastanın takipleri sırasında kliniğinin ilerlemesi sebebiyle kontrastlı batin tomografisi (BT) planlandı. Bu süre içerisinde bir saat sonrasında gönderilen tam kan tekrarında Hb: 10,7 ye düştü. Çekilen batin BT'sinde splenik arter trasesinde pankreas kuyruğu ile dalak arasında yoğun kontrast tutan yaklaşık boyutu 7x6 cm olan lezyon tesbit edildi. Öncelikle splenik arter anevrizması olduğu düşünüldü. Periferinde perisplenik alanda ve omental resese uzanan kanamaya ait olabilecek yoğun serbest sıvı mevcuttu. Hasta bu nedenle genel cerrahi tarafından acil operasyona alındı.

Sonuç: SAA herhangi bir yaşta görüle bile daha çok kadınlarda ve sıklıkla 5-6. dekada splenik arterin distal segmentinde ortaya çıkar. Spesifik bir neden bilinmesede etyolojik faktörler arasında ateroskleroz, fokal arteriyel enflamasyon, pankreatit, hipersplenizm, portal hipertansiyon, travma, gebeliğe bağlı hormonal ve hemodinamik değişiklikler yer alabilir. Ruptüre SAA hastalarda hipotansiyon, taşikardi ve hemodinamik kollaps ile beraber kardiyak arrest kaçınılmazdır. Klinik şüphe, erken tanı, resüsitasyon, operasyonöncesi ve intraoperatif yeterli kan ve sıvı replasmanı ile beraber erken cerrahi müdahale tedavinin ana unsurudur. Karın ağrısı şikayeti ile gelen ve hemodinamik olarak stabil olmayan hastalarda splenik arter anevrizmasında ayırıcı tanıları içerisinde göz ardı edilmemesi gereken bir akut batın nedenidir.

Anahtar Kelimeler: karın ağrısı, splenik arter anevrizması, ruptür

P-0900 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Gis Kanama Düşünüldükçe Acile Yönlendirilen Akut Batın Olgusu

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Amaç: Karın travmaları travmaya bağlı ölüm nedenleri içerisinde üçüncü sıklıktadır. Karın travmaları kafa ve göğüs travmalarından daha az ölümcül olmalarına rağmen kendisine bağlı ölüm-lerin erken tanı ve tedavisi yapıldığında en yüksek oranda önlenabilir travma grubu olması nedeni ile önemini korumaktadır. Bizde burada acil servise poliklinik muayene ve tetkik sonrasında gis kanama şüphesi ile gönderilen ve akut batın tablosu ile operasyona alınan olguyu sizlerle paylaşmak istedik.

Olgu: Altmış altı yaş bayan hasta karın bir haftadır olan baş dönmesi ve karın ağrısı sebebiyle nöroloji polikliniğine başvurdu. Poliklinikte değerlendirilmesi yapılan hasta hemoglobin düşüklüğü tespit edilmesi üzerine gastrointestinal (gis) kanama ön tanısıyla acil servise yönlendirildi. Acil serviste değerlendirilen hastanın alınan öyküsünde daha önceden sebebinin bilmedikleri bir batin operasyonu geçirdiği, ara ara karın ağrılarının olduğu ancak son günlerde baş dönmesinin artması sebebiyle polikliniğe başvurduğu öğrenildi. Bir hafta öncesinde de şüpheli bir travma öyküsü olduğu hasta yakınları tarafından bildirildi. Yapılan fiziki muayenede TA: 110/70, nabız: 75/dk ve aritmik, ateş:36,7, batında yaygın hassasiyeti mevcuttu. Rektal tuşesi negatif olan hastanın nazogastrik sonda takılması sonrasında herhangi bir gis kanama bulgusu tesbit edilmedi. Diğer sistemik bulgular normal olarak değerlendirildi. Laboratuvar değerlerinde Hb: 5,5, WBC: 7.600, Plt: 536.000, üre:70, Kre: 1.70, olarak tesbit edildi, diğer değerleri normaldi. Acil serviste takibe alınan hastanın kliniğinde herhangi bir gerileme tespit edilemediği için hastaya bilgisayarlı batin tomografisi (BT) planlandı. Çekilen batin BT'de karaciğer sol lob komşuluğunda subdiyafragmatik bölgede orta dereceli serbest sıvı izlendi. Hasta daha sonra genel cerrahi tarafından operasyona alındı ve takip amaçlı yoğun bakım ünitesine yatırıldı.

Sonuç: Hemoglobin düşüklüğü sebebiyle acil servise başvuran hastalarda gis kanama ön tanısı ekarte edildikten sonra kan değeri düşüklüğü sebebiyle ayırıcı tanıları arasında batin içi kanama- da düşünülür. Böyle durumlarda en güvenilir tetkik kontrastlı batin BT'dir. Biz bu hastada böbrek fonksiyon bozukluğu sebebiyle kontrast madde veremediğimiz için sıvı koleksiyonunun ayırıcı operasyon esnasında yapılmıştır. Derinleştirilen anemnez sonrasında alınan şüpheli travma öyküsü bizi alert etmiştir.

Anahtar Kelimeler: karın ağrısı, hemoglobinin düşüklüğü, akut batın



POSTER BİLDİRİLER

P-0901 Trauma Emergencies

Travmatik Yelken Göğüs: Olgu Sunumu

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Amaç: Yelken göğüs travmatik göğüs travmalarının en ciddi formu olup, göğüs duvarının anterior ya da lateralinde üç veya daha fazla kaburganın en az iki yerinden kırılması sonucunda sternum fraktürü ve/veya kostakondral eklem ayrışması durumu olarak tanımlanır. Yaşamı tehdit eden fizyopatolojik değişiklikler olması olguların klinik durumunu her zaman etkileyebilir. Tipik olarak kırık segment soluk alırken içe soluk verirken dışa doğru hareket eder ve bu durum yelken göğüs olarak adlandırılır. Bide burada acil servise gelen bir yelken göğüs olgumuzu sizlerle paylaşmak istedik.

Olgu: Kırk yaşında erkek hasta gece hayvan tarafından darp edilmesi ve göğsüne künt travma alması sonucunda acil servise getirildi. Alınan öyküsünde daha önceden herhangi bir hastalığı olmadığını, senkop ve diplopi de görülebilmektedir. Hastaların aritmi, sinüs bradikardisi şeklindedir ve genellikle atropine yanıt verir. Burada Deli bal zehirlenmesine bağlı literatürde bildirilmemiş 2. ve 3. Derece AV bloğun birlikte geliştiği hasta sunularak gelişebilecek ritim bozuklukları konusunda acil servis hekimlerinin bilgilendirilmesi amaçlanmıştır.

Sonuç: Sonuç olarak yelken göğüsün tanısı solunum siklusunun tam olarak gözlendiği tam bir fizik muayene ile konulur. Buna karşılık yelken göğüs olgularının %75'i mekanik ventilatör tedavisine gereksinim gösterir. Bizim olgumuzda mekanik ventilatöre ihtiyaç kalmamıştır. Operasyon dışı tedavi yöntemleri arasında dıştan bandajlama, kum torbası ile baskı uygulama, yaralı tarafa doğru pozisyonel önlemler mevcuttur. Erken stabilizasyon için en kullanılan yöntem mekanik ventilasyondur. Bağırsız alanın altındaki akciğer dokusu ventilasyona katılmaz ve hipoksik durum giderek derinleşir. Solunum yetmezliği gelişecek olursa başvurulacak yegane durum mekanik ventilasyondur. Bu nedenle bu hastaların genel durumları iyi olsa dahi yoğun bakım takibi uygun olacaktır.

Anahtar Kelimeler: Travma, kot fraktürü, yelken göğüs

P-0902 Toxicology

2. Derece Mobitz Tip II Bloktan 3. Derece AV Bloğa Deli Bal Zehirlenmesi Sonrası

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Amaç: Deli bal zehirlenmesi özellikle doğu Karadeniz bölgesinde görülen, hipotansiyon ve bradikardiye neden olan bir gıda zehirlenmesidir. Bu iki ana bulgu dışında hastalarda sersemlik hissi, terleme, senkop ve diplopi de görülebilmektedir. Hastaların aritmi, sinüs bradikardisi şeklindedir ve genellikle atropine yanıt verir. Burada Deli bal zehirlenmesine bağlı literatürde bildirilmemiş 2. ve 3. Derece AV bloğun birlikte geliştiği hasta sunularak gelişebilecek ritim bozuklukları konusunda acil servis hekimlerinin bilgilendirilmesi amaçlanmıştır.

Olgu: 43 yaşında erkek hasta bulantı kusma şikayeti ile acil servise başvurdu. Herhangi bir hastalık öyküsü olmayan hasta sabah 1 kaşık bal yedikten sonra şikayetlerinin başladığını ifade etmekteydi. Bala bağlı zehirlenme düşünülen hastanın vital bulguları; TA: 80/60 mmHg, Nb: 38/dk, ateş 37 C idi. Hastanın bradikardi açısından çekilen EKG sinde 2. Derece Mobitz Tip II olduğu görüldü. Hastaya 0,5 mg atropin uygulandı. Monitörize edilen hasta transkutan pacemaker için hazırlık yapılırken ritmin 3. Derece AV bloğa döndüğü izlendi, 3. Derece AV blok EKG ile doğrulandı. Transkutan pacemaker takılan hasta gözlem amacıyla koroner yoğun bakıma nakledildi.

Sonuç: Deli bal zehirlenmesinde hastaların %25 inde kalp blokları görülebilmektedir. En sık görülen bloklar %11 ile nodal ritim, %8.7 tam blok, %2.9'ikinci dereceden kalp bloğudur. Bunun yanında asistoli gelişen hastalarda bildirilmiştir. Deli bal zehirlenmesi sonrası ritim bozukluğu gelişen hastalar, ritim ne olursa olsun 24 saat monitörize takip edilmeli, blokların derecesinin değişebileceği düşünülerek geçici pacemaker hazırlığı erken dönemde planlanmalıdır.

Anahtar Kelimeler: deli bal, bradikardi, 3. derece blok, 2. derece blok

P-0903 Trauma Emergencies

Yüksekten düşme sonrası gelişen izole sol ventrikül rüptürü; olgu sunumu

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Amaç: Yüksek kinetik enerjili kardiyak travmaların en sık nedeni trafik kazalarıdır. Kardiyak yaralanmanın eşlik ettiği vakaların büyük bir kısmı travma esnasında kaybedilmekte, ancak %5'i müdahale şansı bulabilmektedir. Olguların büyük çoğunluğu 25-40 yaş arası Yüksekten düşme, motorlu taşıt kazalarından sonra en sık görülen ve mortalitesi en yüksek olan travma grubunu oluşturur. Zehirlenmeler, yanıklar ve boğulmalar nedeni ile olan ölümlerin toplamından daha fazla yüksekten düşmeye bağlı ölümler meydana gelmektedir. Literatür verileri göz önünde bulundurulduğunda, kalbin künt travmaları iyi tolere ettiği, fakat kalbe iletilen enerji miktarı arttıkça erken dönemde miyokard kontuzyonu ve sonrasında miyokardda laserasyonu geliştiği bildirilmiştir. Künt travma ile meydana gelen kardiyak yaralanmalarda oluş mekanizmaları, kalbin sternum ve omurga arasında sıkışması, aşırı ivmelenmeye bağlı ters kuvvetler, hidrolik çarpmanın oluşturduğu etkidir. Atriyoventriküler, ventriküler septumda ve papiller adalelerde rüptür gözlenebilir. Travmalı olgularda kardiyak yaralanma ihtimali, travmanın şiddetiyle orantılı olarak % 15-75 arasında değişebilmektedir. Bu olguda çok nadir görülen yüksekten düşmeye bağlı künt travma sonrası gelişen kardiyak laserasyon olgusunu sizinle paylaşmak istedik.

Olgu: 11 yaşında erkek çocuk, yüksekten düşme sonrası arrest olarak acil servise getirildi. Hastanın tansiyon arteryel, nabazları alınamadı ve solunum arresti mevcuttu. Hastanın sol frontalde çökme kırığı, sol dirsekte ve sol bilekte laserasyon, sağ humerus kırığı ve sol radius ve ulna açık parçalı kırık, sol tibia ve fibula parçalı kırığı tesbit edildi. Sternum sağlam ve sol 6-8. kotlarda fraktür mevcuttu, pelvis fraktürü saptanmadı. Yapılan tüm acil müdahalelere rağmen, hasta resüsitasyona cevap vermedi. Exitus kabul edildi. Hastanın yapılan otopsisinde kalbin sol ventrikülünde büyük bir laserasyon alanı tesbit edildi.

Sonuç: Kalp rüptürü meydana gelen vakaların çok büyük bir kısmı, resüsitasyona cevap vermeden olay yerinde kaybedilmektedir. Postmortem saptanan kardiyak rüptürlerde kalbin tüm boşlukları eşit etkilendirken, bizim vakamızda yüksekten düşme sonrası künt travmaya bağlı, sternum ve ciddi kot kırıkları olmadan, izole sol ventrikül rüptürü saptanmıştır. Ayrıca erişkinlerde daha sık rastlanırken bizim vakamızda olduğu gibi pediatrik yaş grubunda nadir görülmesinde ayrı bir özellik arzemektedir.

Anahtar Kelimeler: Travma, yüksekten düşme, kardiyak rüptür

P-0904 Surgical Emergencies (General Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Jenaralize tonik klonik nöbet sonrası gelişen bilateral anterior omuz çıkığı

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Amaç: Omuz çıkıkları acil servise başvuran büyük eklem çıkıklarının en sık görülenidir. Omuz çıkıkları içinde en çok %96 ile anterior omuz çıkığı çıkıkları izlenmektedir. Travmatik anterior omuz çıkıklarının en sık görülen tipi ise subkorakoid çıkıktır. Bilateral omuz çıkıkları daha az görülür ve genelde posterior çıkık şeklindedir. Bilateral anterior omuz çıkığı ise nadir görülür ve literatürde 31 kadar bilateral anterior omuz çıkığı bildirilmiştir.

Biz bu yazıda literatürde nadir olarak bildirilmiş olan nöbet sonrası bilateral anterior omuz çıkığını sunmaktayız.

Olgu: 20 yıldır epilepsi nedeniyle takipli yirmi altı yaşındaki erkek hasta, geçirdiği jenaralize tonik klonik (JTK) nöbet sonrası acil servise başvurdu. Fizik muayenede her iki kol hafif abduksiyon



POSTER PRESENTATIONS

ve iç rotasyonda idi. Omuzlar normal yuvarlak konturlarını kaybetmiş ve akromion altında tipik çöküntü oluşmuştu (Apolet belirtisi). Omuz hareketleri çok kısıtlı ve ağrılı olup nörovasküler muayenesi normal idi. Radyolojik incelemede direk grafilerinde bilateral anterior omuz çıkığı saptandı. Acil serviste her iki omuz modifiye Hipokrat tekniği ile sedasyon aneljezi altında (0,05 mg/kg midazolam IV) redukte edildi. Her iki omuz velpau bandaja alındı ve hasta önerilerle taburcu edildi

Sonuç: Sonuç olarak JTK nöbet geçirerek acil servise başvuran hastaların fizik muayeneleri detaylı olarak yapılmalı ve olası omuz dislokasyonları erken dönemde tespit edilerek tedavi edilmelidir.

Anahtar Kelimeler: Omuz çıkığı, epileptik nöbet, anterior dislokasyon

P-0905 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Kumadin Kullanımına Bağlı Akut Batın Tablosu: Nadir Bir Antite

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Amaç: Günümüzde, bu tip oral antikoagülan ilaçlar çeşitli Endikasyonlar ile sıklıkla kullanılmakta ve nadiren hayatı tehdit eden düzeyde kanamalara da yol açabilmektedir. Bu yazımızda, amaç: oral antikoagülan kullanıma bağlı karın içi serbest kanama ve buna bağlı akut karın tablosuyla acil servise başvuran 68 yaşındaki bir kadın hasta, literatürde nadir rastlanması nedeniyle sunulmuştur

Olgu: Sekiz yıl önce koroner arter hastalığı nedeniyle koroner bypass operasyonu geçiren ve bu nedenle oral antikoagülan kullanan 68 yaşındaki bayan hasta, son 6 saattir başlayan karın ağrılarının artması üzerine acil kliniğimize başvurdu. Öz geçmişi sorgulandığında gün aşırı olarak aldığı 1,5 mg kumadin dışında kanama yapabilecek herhangi bir ilaç kullanmadığı öğrenildi. Yapılan fizik muayenesinde; genel durumu orta ve şuuru açık, arteriyel kan basıncı 130/90 mmHg, nabız 112/dk ritmik-tasikardik olarak saptandı. Ağız-mukozamüayenesinde diş etlerinde ve oral mukozada hafif ekimotik alanlar görüldü. Batın muayenesinde ise tüm kadrarlarda yaygın hassasiyet belirlendi. Diğer sistem muayenelerinde patolojik bir bulgu saptanmadı.

Tam kan sayımı ve biyokimyasal değerlerin incelemesinde hemoglobulin (HB) 8.7 g/dl, hematokrit (Htc)%26.7, trombosit sayısı 213.000/mm3, Glukoz 105(75-105)BUN:48(18-55) kreatin:1,1(0.7-1.2) AST: 68(5-34) ALT:92(0-55) olarak ölçülen hastanın olarak saptanırken protrombin zamanının uzamış (PTZ: 147 sn, INR:10.3) olduğu saptandı. Hastaya uygulanan iv kontrastlı tüm abdomen tomografisinde batın içinde perihepatik alanda orta derecede serbest sıvı saptanması üzerine hastaya 4 ünite taze donmuş plazma ve 2 ünite taze eritrosit süspansiyonu takviyesiyle operasyona alındı. Operasyonda batın içinde duodenumda 1. ve 2. Kitada izole olmuş ve kendini sınırlamış duodenal kanama görüldü, müdahale edilmedi, eksplorasyonda batın içinde diğer organlarda ek bir patoloji saptanmadı, serbest sıvı aspire edildi, batın içine dren konarak operasyona son verildi. Yoğun bakımdaki takiplerinde genel durumu iyileşip vital bulguları stabilleşen hastanın tedavileri neticesinde inr değerlerinin gerilediği, batın muayene bulgularının normal sınırlara geldiği görüldü. genel durumu iyileşen hasta postoperatif 3. Gününde dreninden gelen serohemorajik sıvının kesilmesi üzerine dreni çekilerek oral gıdaya baslandı, herhangi bir komplikasyon görülmeyen hasta servise alındı ve Hastaya, düşük dozda kumadin tedavisi başlandı ve postoperatif 7. Gününde hastaya daha sık INR takibi yapılması gerektiği söylenerek önerilerle taburcu edildi

Sonuç: Sonuç olarak kumadin kullanan hastalarda, her bir hastanın risk durumuna göre INR hedef değer aralığı belirlenmeli, hedeflenen INR değerine ulaşma-kadar yakın kontrollerle INR değerlerine bakılmalıdır. Olası bir doz aşımı durumunda kana-ma en önemli morbidite sebebidir. Öncelikle kumadin kullanımının kesilmesi, hastanın risk durumu ve kanamanın varlığına göre taze don-muş plazma transfüzyonu ve taze eritrosit süspansiyonları verilmesi gerekmektedir. Hastalara potansiyel komplikasyonlar ve INR takibinin önemi açısından da tedavi esnasında ve sonrasında aydınlatıcı yeterli bilgiler verilmelidir

Anahtar Kelimeler: kumadin, akut batın, kanama

P-0906 Trauma Emergencies

Acil Serviste Skrotal USG Deneyimi: Olgu Sunumu

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Amaç: Testiküler travma nadir görülen ancak skrotal hematoma, testis dislokasyonu ve torsiyon gibi komplikasyonlara neden olabilen klinik bir antitedir. Genellikle künt travmalar sonrası gelişen testis yaralanmalarında en sık semptom batın alt kadrarlara yayılan şiddetli ağrıdır. Karın ağrısı bazen akut batını taklit edebilir. Ayırıcı tanının yapılmasında acil serviste skrotal görüntüleme ciddi bir öneme sahiptir.

Olgu: 21 yaşında erkek hasta eşya taşıdığı merdivenin skrotal bölgesine çarpması sonrası başlayan ağrı şikayeti ile acil servise başvurdu. Ağrısının karnına yayıldığını ifade eden hastanın öz geçmişi her hangi bir özellik mevcut değildi. Vital bulguları stabil olan hastanın batın sol alt kadrar hassasiyeti dışında anlamlı bir fizik muayene bulgusu yoktu. Hastaya post-travmatik torsiyon ekartasyonu için acil serviste USG yapıldı. Karşılaştırılmalı olarak yapılan görüntülemelerde sol testis inferior kesim lateralde 5x4 mm boyutunda, medialde daha küçük olmak üzere hiperekojen yamasal lezyon izlendi. Her iki testisin kanlanması normal olarak izlendi. Torsiyon ekarte edilen hastadaki lezyonlar akut hematoma lehine yorumlandı. Görüntüleme radyoloji tarafından teyit edildi. Hasta kontrole çağırılarak taburcu edildi.

Sonuç: Skrotal görüntüleme acil servisler için torsiyon gibi morbiditesi yüksek klinik durumların ayırt edilmesi açısından oldukça önemlidir. görüntülemenin aynı ekran üzerinde her iki testisin yer aldığı çift pencere özelliğinde yapılması, olası lezyonların ve karşılaştırılmalı kanlanmanın net ortaya konulmasına yardımcı olacaktır. Görüntüleme yöntemlerinin etkin olarak kullanılması ile acil serviste gereksiz konsültasyonların da önüne geçilmiş olacaktır.

Anahtar Kelimeler: travma, testis, USG

P-0907 Surgical Emergencies (General Surgery, Orthopaedics, Neurosurgery, Cardiovascular, Anesthesia etc.)

Arteriyel kateterizasyondan sonra görülen iyatrojenik femoral pseudoanevrizma olgusu

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Amaç: Arteriyel kateterizasyondan sonra görülen psödoanevrizmaların hemostatik yetmezlik sonucu kanın damar duvarındaki defekten ektravaze olması ve bir psödokapsülle çevrilmesiyle oluşur. Kateterizasyona sekonder oluşan psödoanevrizmaların en sık görüldüğü lokalizasyon ana femoral arterdir. Diyagnostik arteriyel kateterizasyona sekonder iyatrojenik femoral psödoanevrizma oluşma insidansı %0.2'dir. Psödoanevrizma teşhisinde renkli Doppler ultrasonografinin (RDUS) sensitivite ve spesivitesi %100'e yakın olup psödoanevrizmaların hem teşhisinde hem de tedavisinde kullanılabilir. Serebral anjiyografide sol MCA'da bulunan trombüse yönelik trombekтоми işlemi başarısız olmuş. 10 gün boyunca nöroloji servisinde yatan hasta aspirin ve enoxaparin tedavileri almış. Nörolojik muayenesinde kısmi düzelme olan hasta önerilerle taburcu edilmiş. Hasta nisan ayında hastanemiz acil servisine sağ inguinal bölgede şişlik ve morarma şikayetleri ile tekrar başvuruyor. Hastanın şikayetleri taburculuğundan itibaren giderek artmış. Yapılan fizik muayenede sağ inguinal bölgede 20 cm boyunda hematoma ve skrotal şişlik saptandı. Acil serviste yapılan RDUS incelemede sağ inguinal bölgeden proksimal uyluk bölgesine uzanan yaklaşık 15x8 cm boyutunda hematoma saptanıyor. Hematom alanının distalinde arteriyel trifazik, venöz ise bifazik akım izlendi. Hastanın hemoglobin değeri 2 ay önce 14,2 değerinde iken bu başvurusunda 7,7'ye düşmüş. Hasta acil olarak hastanemiz kalp ve damar cerrahisi birimine konsulte edildi. Hasta 2 ünite eritrosit süspansiyonu transfüzyonu ardından acil ameliyata alındı. Operasyonda hastanın hematoma oluşturan lezyonundan bol miktarda trombüs çıkarıldı. Sağ superfisial femoral arterden 3cm çapından psödoanevrizma ve rüptür tespit edildi. Psödoanevrizma kesesi çıkarılarak suture edildi. Takiplerinde komplikasyon gelişmeyen hasta önerilerle taburcu edildi.

Sonuç: Psödoanevrizma gelişimini antikoagülan tedavilerin arttırabileceği ve psödoanevrizmaların kateterizasyon sonrası komplikasyon sonucu gelişmiş olabileceği acil hekimleri tarafınca unutulmamalıdır.

Anahtar Kelimeler: psödoanevrizma, femoral arter, kateterizasyon



POSTER BİLDİRİLER

P-0908 Resuscitation

Kardiyopulmoner Resüstasyona Bağlı Karaciğer Yaralanması

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Amaç: Kardiyopulmoner resüstasyon sırasında göğüs basısına bağlı gelişen en sık komplikasyon kot kırıklarıdır. Kot ve sternum kırığına bağlı olarak akciğer, kalp, karaciğer ve dalak yaralanmaları görülebilir.

Olgu: Yetmiş sekiz yaşında bayan hasta nefes darlığı şikayeti ile acil servise başvurdu. Nefes darlığının son beş gündür olduğu öğrenildi. Bilinen koagülasyon bozukluğu, kalp ve akciğer hastalığı yoktu. 5 yıldır yatağa bağımlı şekilde yaşadığı öğrenildi. Fizik bakışında genel durumu kötü idi. Vital bulgularında, kan basıncı; 100/60 mm/Hg, nabız; 131 atım/dakika, solunum sayısı 25 soluk/dakika, vücut ısısı; 36.5 OC ve oksijen saturasyonu %80 idi. Solunum sistemi muayenesinde akciğer bazallerinde ralleri vardı. Kalp ritmik ve taşikardikti. Diğer sistem muayenelerinde anormal bulgu saptanmadı. 4 litre/dakikadan oksijen başlandı. Hastadan kan gazı, tam kan sayımı, biyokimya, C-reaktif protein (CRP), kardiyak enzimler, koagülasyon parametreleri, elektrokardiyogram (EKG) ve yatak başı akciğer grafisi istendi. EKG'de sinüs taşikardisi vardı. Kan tetkiklerinde; hemoglobin 14,1 gr/dl (12.2-18.1), hematokrit %43,1 (37-53), trombosit sayısı 352.000 K/uL (142.000-424.000), lökosit sayısı 9.370 (4000-10.500), glukoz 117 mg/dl (74-106) AST 95 IU/L (15-37), ALT 180 IU/L (30-65), protrombin zamanı 15,2 saniye (10,9-15,2), uluslararası normalize oran (INR) 1,26 (0,8-1,2), CRP 120 mg/dl (0-5) CK-MB 6,64 ng/ml (0-5,2), Troponin I 1,49 ng/ml (0-1) idi. Arteriyel kan gazı analizinde Ph; 7,402, PCO₂; 41, PO₂; 40, SO₂; 70, HCO₃; 27 idi. Hastada gelişen 20 dakika sonra solunum arresti ve asistoli gelişti. 10 dakika CPR uygulandı. 10 dakikalık CPR sonrasında sinüs ritminde kalp atımları döndü, kan basıncı 100/70 mm/Hg idi. Hastanın solunum sıkıntısı ve arrest sebebine yönelik yatak başı ekokardiyografi (EKO) yapıldı. EKO'da sağ ventrikülde trombus tespit edildi. Pulmoner emboli olabileceği düşünülerek pulmoner bilgisayarlı tomografi anjiyo çekildi. Tomografide pulmoner emboli tespit edilmedi. Fakat sağ 10. kotta fraktür (Resim 1), ciltaltı amfizem ve minimal pnömotoraks (Resim 2), karaciğer sağ lob posteriorunda subkapsüler yerleşimli 10x4,5 cm genişliğinde hematom tespit edildi (Resim 3). Hasta yoğun bakım ünitesine yatırıldı. Hematokrit ve hemoglobinin takibi yapıldı. 3 saat sonra bakılan tam kan sayımında hemoglobin 10,6 gr/dl, hematokrit %34,5 olarak ölçüldü. Devam eden takiplerinde bu değerlerden daha aşağı düşmedi. Kan transfüzyonuna ihtiyaç duyulmadı. Subkapsüler hematom konservatif olarak takip edildi. Pnömotoraksında ilerleme olmadı. Hasta yatışının 6. gününde ex oldu.

Sonuç: CPR sırasında göğüs basısına bağlı kot kırıkları, pnömotoraks ve karaciğer yaralanmasının oluşabileceği göz önünde bulundurulmalıdır. CPR sonrası hematokrit değerinde düşüklük tespit edilen ya da hemotokrit takiplerinde düşüş olan hastalarda karaciğer yaralanmasından şüphelenilmelidir.

Anahtar Kelimeler: Göğüs basısı, Karaciğer yaralanması, Kardiyopulmoner resüstasyon

P-0909 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Metil Alkol (Metanol) Zehirlenmesi: Bir Olgu Sunumu

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Amaç: Metanol (dun alkoli), çözücü özelliği olan, uçucu ve renksiz bir sıvıdır. Metanolün metabolitleri toksik etkilidir. Kaza ya da intihar amaçlı olarak ve en çok oral yolla alınır. Metil alkol zehirlenmesinde primer toksik faktör metabolik asidozudur. Esas olarak metil alkol toksik değildir. Metanolün metabolitleri olan formik asit ve formik asit toksiktir. Biz bu olgu sunumu ile atılanması durumunda ölümlerle sonuçlanabilecek metanol zehirlenmesini işleyerek konuya dikkat çekmeyi planladık.

Olgu: Altmış iki yaşında erkek hafif nefes darlığı şikayeti ile acil servise geldi ve eşisi ile geldi. Geldiğinde bilinci açık, oryante, koopere, tansiyon arteriel: 110/70 mmHg, nabız: 88/dk (ritmik), ateş: 36,7 santigrad derece, solunum sayısı: 14/dk (ritmik), EKG: normaldi. Hastanın öyküsü de kronik bronşit olduğu öğrenildi. Fizik muayenesinde akciğer seslerinde sibilan ronküsler ve expirium uzunluğu dışında patolojik bir bulguya rastlanmadı. Arteriyel Kan Gazı (AKG) da hafif CO₂ yüksekliği dışında olumsuz bir bulguya rastlanmadı. laboratuvar sonuçları wbc: 15,6, glukoz: 194, K: 5,9 olarak öğrenildi. Takibinde hastanın genel durumu bozuldu nefes darlığı belirginleşti, tekrar alınan kan gazı sonuçlarında pH: 6,917, pCO₂: 13,1, HCO₃: 6,9 şeklinde değerlendirildi. Hasta entübe edildi. TA: 50/20mm-Hg olarak ölçüldü. Sekiz ampul NaHCO₃ yapıldı. Hastanın öyküsü derinleştirildiğinde kronik alkolik olduğu ve son bir haftadır düzenli olarak alkol aldığı, son yirmi dört saatte içmediği, hastanın geçen yıl kolonya içmesi nedeniyle hastanede yattığı, bu gün hastaneye gelirken kustuğunu ve görememe problemi yaşadığını belirttiler. Hasta metil alkol zehirlenmesi düşünülerek acil hemodiyaliz planlanarak femoral ven kateterizasyonu esnasında tekrar arrest oldu. Tüm çabalara rağmen exitus ile sonuçlandı.

Sonuç: Acil servise başvuran alkol bağımlılarında; metil alkol zehirlenme vakaları; santral sinir sistemi, gastro intestinal sistem ve görme problemleri dışında, nefes darlığı gibi şikayetlerle de gelebildiği, 30-40 yaş grubu erkek hastalar dışında bu olguda olduğu gibi 60'lı yaşlarda da ayırıcı tanıda düşünmek gerekir. Biz bu olgu sunumuyla metabolitlerin bazen geç oluşması (72 saate kadar uzaması) nedeniyle kliniği silikleştirmesi, prognozu kötüleştirilmesi ve ailelerin sosyal nedenlerle alkol bağımlılığı öyküsünü gizlemesi gibi sebeplere dikkat çekmek istedik.

Anahtar Kelimeler: Metil alkol, intoksikasyon, ölüm

P-0910 Imaging in Emergency Units

Kokain kullanımı sonrası meydana gelen yüksekten düşme ve medulla spinalis tam kat kesisi

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Amaç: Spinal kord travmaları sıklıkla genç erişkin erkeklerde görülmektedir. Etiyolojideki en sık neden; motorlu taşıt kazaları iken ikinci sırada yüksekten düşmeler gelmektedir. Hafta sonları, tatiller ve yaz ayları spinal yaralanmaların en sık meydana geldiği dönemlerdir. Spinal kord travmaları; yüksek morbidite ve mortalite oranları ile işgücü kaybı ve yüksek maliyetli tedavi masraflarına neden olmaktadır. Biz olgumuzda; günümüzde gençleri bekleyen en büyük tehlikelerden biri olan kokain alımı sonrasında asansör boşluğuna düşerek spinal kord travması geçiren hastayı sunacağız.

Olgu: Askerden izinli olarak geldiği evinde kokain alımı sonrası 5 metre yükseklikten asansör boşluğuna düşen 21 yaşındaki erkek hasta, acile getirildiğinde genel durum orta, şuurlu, koopere-oryante ve Glasgow Koma Skoru: 15 idi. Solunum sesleri her iki hemitoraksta eşit alınmakta ve palpasyonla bilateral kotlarda krepatasyon mevcut idi. Batında yaygın hassasiyet ve rebound mevcuttu. Spinal kord muayenesinde; torakolomber bölgede düzensizlik mevcut olup alt ekstremiteler pararejik idi. Çekilen abdomen tomografisinde multipl kot fraktürleri ve 1. lomber (L1) vertebra korpusunun posteriora tamamen disloke olduğu tespit edildi. Nörolojik bulguları da tomografik görüntülemeyle uyumlu olan hastanın MR görüntülerinde; L1 vertebra posteriora deplasman gösteren fraktür ve tam kat spinal kord kesisi saptanması üzerine hasta beyin cerrahi tarafından acil operasyona alındı. Dekompresyon tedavisi uygulanan hasta pararejik halde taburcu edildi.

Sonuç: Milattan önce dönemlerden itibaren tıp alanında kullanıma giren, ancak günümüzde bağımlılık yapan keyif verici madde olarak kullanılan uyuşturucular, hem bireysel hem de toplumsal anlamda çözülmesi gereken sorunların başında gelmektedir. Vakamızda olduğu gibi, uyuşturucu ya da uyarıcı madde alımına bağlı yaralanmalar, kimi zaman genç bir insanın hayatını zindana çevirecek şekilde sonuçlar doğurmaktadır. Bu sebeple özellikle gençleri bağımlılık yapıcı madde bağımlılığından koruyacak eğitimler ve tedbirleri almak, toplum olarak yeni nesle karşı ödememiz gereken borçlarımızın başında gelmektedir.

Anahtar Kelimeler: Kokain, yüksekten düşme, bağımlılık

P-0911 Cardiovascular Emergencies

Akut Koroner Sendrom Düşünülen Hastalarda Fosfodiesteraz İnhibitörü Kullanımının Sorgulanması

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Amaç: Sildenafil, verdenafil ve tadalafil, gerek endikasyon ile erektil disfonksiyon tedavisinde, gerekse ilaca kolay ve kontrolsüz ulaşılabilmesinden dolayı cinsel aktivitede performans artışı amacı ile reçetesiz kullanımı sık karşılaşılmış ilaç gruplarındandır. Bu çalışmada, tadalafil kullanımı sonrası kliniğimize göğüs ağrısı şikayeti ile başvuran, antiiskemik tedavi başlandıktan sonra ani gelişen derinçil hipotansiyon vakası tartışıldı.

Olgu: 67 Yaşında erkek hasta kliniğimize yeni başlayan, sıkışma tarzı göğüs ağrısı ve terleme şikayeti ile başvurdu. Hastanın başvuru anında kan basıncı 195/125 mmHg, nabız 82/dk, solunum



POSTER PRESENTATIONS

22/dk ve elektrokardiyografisi (EKG) normal sinus ritminde idi. Diğer tüm sistem muayenesi ve PA akciğer grafisi normal idi. Hikâyesinde hipertansiyon nedeni ile on yıldır düzenli candesartan (1x16 mg) kullanıyordu. Hasta anstabil anjina pectoris ön tanısı ile acil serviste monitorize edildi. Anti-iskemik tedavi (5000 ünite unfrafraksiyone heparin, 10 mg isosorbid dinitrat tablet, 300 mg asetil salisilik asit) başlandı. Tedavi başladıktan 25 dakika sonra kan basıncı 75/40 mmHg olarak ölçüldü. Hastada oryantasyon bozukluğu, soğuk terleme, konuşma bozukluğu gelişti. Sıvı reüsütasyonu ve trandelenburg pozisyonundan sonra şuuru düzeldi, kan basıncı 90/55 mmHg oldu. Hikâye derinleştirildiğinde hastanın haftada iki gün cinsel aktivite için 20 mg tadalafil kullandığı tespit edildi. Ekokardiyografisinde (EKO) şüpheli hipoknetik alanlar görülmesi üzerine acil perkutan girişim için yoğun bakıma alındı. Yapılan koroner anjiyografide LAD proximalinde %30, OMI de % 90, RCA da %30 ve RCA distalinde %30 darlık tespit edildi. OMI ye stent yerleştirildi; diğer yerlere balon dilatasyon yapıldı. Yatışının beşinci günü hali ile taburcu edildi.

Sonuç: Acil servis çalışanları, acil servislere göğüs ağrısı ile başvuran ve akut koroner sendrom düşünülen ve özellikle antiiskemik tedavi için nitrat grubu başlamadan önce tüm erişkin erkek hastalarda fosfodiesteraz inhibitörlerinin kullanımını sorgulamalıdır.

Anahtar Kelimeler: Akut Koroner Sendrom, Fosfodiesteraz İnhibitörü, erişkin erkek

P-0912 Cardiovascular Emergencies

Acil serviste Analjezik tedavisine yanıtız yan ağrısının Nadir sebeplerinden biri; renal enfarkt Olgu sunumu

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Amaç: Renal Enfarkt (RE) akut yan ve abdomen ağrısının nadir sebeplerinden biridir. Genellikle kardiyak hastalığı olan veya atmış tromboemboli riski taşıyan hastalarda görülür. Renal arter veya segmentlerinin tıkanıklığı tanısı zor ve klinisyen tarafından gözden kaçabilecek bir durumdur. Tanı için kontrastlı batin tomografisi veya renal arter anjiyografi çekilmesi gerekir.

Olgu: Bu olguda acil servise sağ yan ağrısı ile başvuran 40 yaşında erkek hastadan bahsedilmiştir. 3 yıldır hipertansiyon tanısı olan hastanın 4 gün önce inferior miyokard enfarktüs tanısı ile kardiyoloji kliniğinde sağ femoral ven yolu ile koroner anjiyografik girişim (KAG) yapıldığı, sonrasında antikoagulan ve antiagregan tedavi başlandığı öğrenildi. Tedavinin 4. gününde Yan ağrısı başladıktan sonra KAG yapıldığı merkeze başvuran ve orada analjezik tedavi verilen hasta ağrısında değişiklik olmaması üzerine acil servisimize başvurdu.

Hastanın vital bulguları normal olarak değerlendirildi. Fizik muayenesinde sağ kostovertebral açısı hassasiyeti mevcuttu. Laboratuvar tetkiklerinde üre kreatin değerleri normal olarak saptandı. Ağrısı sürekli, sıvıyalıcı ve künt vasıflı olan hastaya nefrolitiyazis ve RE ön tanısı ile kontrastlı/kontrastsız batin bilgisayarlı tomografi (BBT) görüntülemesi yapıldı. BBT de sağ böbrekte minimal kontrast madde tutulumu izlendi (Resim1). Radyoloji ile konsülte edildi, RE olarak değerlendirildi (Resim2). Hasta kalp damar cerrahisi ile konsülte edildi ve tedavisinin devamı için servise yatırıldı.

Sonuç: RE, nadir görülen, tanı ve tedavinin gecikmesi durumunda organ kaybına neden olabilen bir durumdur. Özellikle tromboemboli riski taşıyan, vasküler hastalık tanısı olan ve ağrı kesici ilaçlara rağmen devam eden yan ağrısı olan hastalarda, diğer iskemik ağrılar gibi akla gelmeli ve ayrırcı tanımlar arasında yerini almalıdır.

Anahtar Kelimeler: Enfarkt, Renal, Yan Ağrısı

P-0913 Other

Gaziantep Üniversitesi Acil Tıp Anabilim Dalına 11 Ayda Başvuran Hastaların Dağılımı

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Amaç: Bu çalışmada on bir ay içinde acil servisimize müracaat eden hastaların dağılımı değerlendirilmiştir.

Gereç-Yöntem: Gaziantep Üniversitesi Şahinbey Araştırma ve Uygulama Hastanesi Acil Servisine 1 Ocak 2012 ile 30 Kasım 2012 tarihleri arasında Hastane Bilgi Yönetim Sisteminde yer alan kayıtlardan yola çıkılarak yapılan başvurular çalışmaya dâhil edilmiştir. Başvuran hastaların yaş, cinsiyet, başvuru tekrar sayısı, acilde yatış sayısı, konulan tanımlar, mortalite oranları ile acilden başka bölümlere yapılan yatışların sayıları ve dağılımları ele alınmıştır.

Bulgular: On bir ayda acil servisimize %49.7'si (n=29171) erkek ve %50.3'ü kadın olmak üzere, toplam 58722 hasta başvurmuştur. Hem erkeklerde (n=14105), hem de kadınlarda (n=13343) en fazla başvurular 26-40 yaş arasında olmuştur. Başvurular en yüksek oranlarda Ekim (%14.8) ve Kasım (%14.8) aylarında gerçekleşmiştir. Mükerrer başvurularda hastaların %74.9'u (n=43913) on bir ay içinde bir kez, %24.0'ı (n=14101) 2-5 kez, %1.1'i (n=595) 6-10 kez, 70 hasta 11-15 kez, 23 hasta 16-20 kez, 12 hasta 21-25 kez ve 6 hasta da on bir ayda 25 defadan fazla acil servisimize başvurmuştur. Hastaların çoğunluğu Gaziantep, Şanlıurfa, Kahramanmaraş ve Adıyaman illerinden gelenlerden oluşuyordu. On bir içerisinde acil servise başvuru ölen hastaların 68 (%0.001) acil serviste, 92'si (%0.002) yoğun bakımlara yatırıldıktan sonra olmak üzere toplam 160 hasta ölmüştür. Acil servisten ilgili kliniklere ve yoğun bakımlara yatırılan hasta oranı %7.1 (n=4168). En fazla hasta yatırılan ilk üç servis kadim doğum (n=208), gastroenteroloji (n=123) ve ortopedi (n=94). En fazla tanımlar akut tonsilit (n=7029), akut koroner sendrom (n=6552) ve üst batin ağrısıdır (n=6543).

Sonuç: Genç erişkin erkek ve kadınlar, üst solunum yolu hastalıkları, akut koroner sendrom ve akut batin tanımları olan hastalar en çok acil servisimize başvurmuştur. Yatış oranımız %7.1 mortalite oranımız %0.002 dir.

Anahtar Kelimeler: acil servis, mükerrer başvurular, mortalite, yatışlar

P-0914 Cardiovascular Emergencies

Anksiyete ile başvuran Miyokardiyal Enfarktüs: Olgu Sunumu

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Amaç: Anksiyete ve yas reaksiyonu ile baş vuran göğüs ağrılı her hastanın psikojenik olmadığı düşünülmeli ve risk faktörü olan hastaların uygun şekilde değerlendirilmesi yapılmalı ve gerektiğinde takibi yapılmalıdır.

Olgu: 84 yaşında hasta acil servise yakınları tarafından dahiliye yoğun bakım ünitesinde oğlunun glioblastoma multiforme tanısı ile yattığı ve az önce öldüğünü; hastanın annesinin de yas sürecini rahat atlattığını, yarın cenaze işlemleri için gece rahat uyumasını istemesini ısrar etmesi üzerine hastaya 5mg diazepam intra musküler uygulanmış ve taburcu edilmiştir. Hasta koridorunda beklerken göğüs ağrısı olması üzerine tekrar acil servise başvurmuştur. Hastanın anamnezinde 2 yıl önce miyokardiyal enfarktüs sonrası koroner bypass cerrahisinde damar değişimi yapıldığı öğrenilmiştir. Kan basıncı 110/70mmHg, Nabız:95/dk, Solunum:14/dk, Spo2:98 idi. Hastanı çeken elektrokardiyografisinde sol dal bloğu tespit edildi. Hasta yakının yanında bulunan geçen hafta çekilen elektrokardiyografisinde de sol dal bloğu bulunduğu ve yeni elektrokardiyografisinde sgarbossa kriterlerine göre miyokardiyal enfarktüs olmadığı ancak V5-V6 derivasyonunda eskiden olmayan ST segment depresyonu tespit edildi. Hastanın hemogramı, biokimya parametreleri, İNR-PTZ ve kardiyak enzimleri alınarak 300 mg asetil salisilik asit verildi. Hasta monitorize edilerek oksijen 5lt/dakika başlanarak hasta kardiyoloji ile konsülte edildi. Hasta kardiyoloji hekimi ile konsülte edilirken kardiyak enzimleri ve kan parametreleri sonuçlandı. Kardiyak enzimleri normal sınırlarda sonuçlandı. Hastanın elektrokardiyogram ve kardiyak enzimlerinin mevcut bulgular ile miyokardiyal enfarktüs düşünülmeyişi ancak hastanın kontrol kardiyak enzimleri çıkana kadar takibinin uygun olduğu kararına bağlandı. Hastanın takibinde sorun yaşanmayan hastanın 4 saat sonraki kontrol kardiyak enzimleri 50 kat artması üzerine hasta kardiyoloji ile tekrar konuşularak koroner anjiyografi işlemine alındı. Koroner anjiyografisinde daha önceden bypass cerrahisinde kullanılan koroner damarın internal mamarian arterin dar olduğu ve aktif trombüsünün olmadığı tespit edildi. Koroner balon anjiyoplasti uygulandı. Hasta koroner yoğun bakım ünitesine yatırılarak takip edildi. Takiplerinde sorun olmayan hasta medikal tedavisi düzenlenerek taburcu edildi.

Sonuç: Acil servise başvuran her anksiyete ve psikojenik hastanın ayrıntılı değerlendirilmesi, daha önceden olan organik patolojilerin tespit edilmesi, gerekli ise tetkik ve takibinin yapılması uygundur. Özellikle geçirilmiş miyokardiyal enfarktüs, geçirilmiş bypass cerrahisi ve geçirilmiş intra kranial kanamanın yakın takibi uygundur.

Anahtar Kelimeler: yas sürecini, göğüs ağrısı, miyokardiyal enfarktüs, anksiyete

P-0915 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Nadir görülen intrakranial kalsifikasyon olgusu, Fahr Hastalığı

Mehmet Akçimen, İktbal Şaşmaz, Kamil Can Akçol, Umut Çakır, Taylan Kılıç, Mümine Yiğit Doruk, Adeviyye Karaca, Ali Boz

Antalya Eğitim ve Araştırma Hastanesi Acil Tıp Kliniği, Antalya

Amaç: Fahr hastalığı bilateral simetrik intrakranial kalsifikasyon ve nöropsikiyatrik semptomlarla seyreden çok nadir bir patolojidir. Etiyolojisi kesin olarak bilinmemekle birlikte sıklıkla kalsiyum ve fosfor metabolizma bozukluklarına bağlı olarak meydana gelir. Ancak serum kalsiyum metabolizmasında değişiklik olmaksızın genetik hasar sonucunda da hastalığın geliştiği tanımlanmıştır. Fahr hastalığı en sık hareket bozukluğu, kognitif bozukluklar ve serbellar bozukluklarla ortaya çıkmaktadır. Biz ise nöbet ile bulgu veren Fahr hastalığı olgusundan bahsedeceğiz.

Olgu: 60 yaşında erkek hasta şuur kaybı, bayılma ve vücutta kasılmaların olması şikayeti ile acil servisimize getirildi. Hastanın anamnezinde yaklaşık 1-2 dakika süren jeneralize tonik-klonik nöbet geçirdiği tarif ediliyor. Hasta geldiğinde postiktal dönemdeydi. Hastanın tansiyonu 130/90 mmHg, nabızı 94 atım/dk, ateşi: 37.2, oksijen saturasyonu %99 idi. Fizik muayenede kooperasyon, oryantasyonu zayıftı. Ekstrapiramidal bulguları mevcuttu. Pupiller izokorik, motor defisiti yoktu. Hastanın laboratuvar tetkiklerinde anormallik yoktu. (kalsiyum:9.1 mg/dl, fosfor:4.6mg/dl) Hastanın kontrastsız beyin tomografisinde: bilateral serebellar hemisferlerde beyaz cevherde ve bilateral kaudat nükleuslarda ve putamen lokalizasyonlarında simetrik hiperdens

POSTER BİLDİRİLER

kalsifikasyonlara ait görünümüler izlendi. Hasta Fahr hastalığı tanısıyla nöroloji servisine yatırıldı.

Sonuç: Fahr hastalığı sıklıkla erkeklerde görülen genellikle hipokalseminin eşlik ettiği, bazal ganglionların bilateral simetrik kalsifikasyonlarıyla karakterize bir klinik tablodur. Tanıda en önemli inceleme metodu beyin tomografisidir. Kalsifikasyonlar globus pallidus başta olmak üzere sıklıkla putamen, kaudat nükleus, internal kapsül, dentat nükleus ve serebellumda görülürler. Kalsifikasyonların en önemli özelliği simetrik olmasıdır. Fahr hastalığında en sık bulgu parkinsonizm, kore, tremor, distoni ve atetozdur. Fakat eğer kalsifikasyonlar yoğunsa, ekstrapiramidal ve serebellar bulgular ve nadiren de olsa nöbet atakları ortaya çıkabilir.

Anahtar Kelimeler: Fahr Hastalığı, nöbet, intrakraniyal kalsifikasyon

P-0916 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Herpes keratiti: Nadir görülen bir olgu

Mehmet Akçimen, İkbâl Şaşmaz, Mustafa Keşaplı, Nalan Kozacı, Dilek Soydam, Zeynep Aslı Kartal, Mustafa Avcı, Ömer Harun Sarnıç
Antalya Eğitim ve Araştırma Hastanesi Acil Tıp Kliniği, Antalya

Amaç: Herpes simpleks virüsü (HSV) asemptomatik veya aktif hastalığa neden olabilen patojen bir ajandır. Virüs spesifik antijenin farklılığına göre 2 tipe ayrılmaktadır; HSV1 ve HSV2. Göz tutulumu genellikle tip 1 HSV'ye bağlı olarak ortaya çıkmaktadır. Herpes virüsleri latent enfeksiyona neden olabile kapasitesine sahiptir, korneal hastalık sıklıkla latent enfeksiyonu takiben ortaya çıkmaktadır. Herpes simpleks keratiti gelişmiş olan ülkelerde korneal körlüklerin en sık nedenidir. HSV'ye bağlı göz tutulumu; blefarit, konjonktivit, korneada epitelyal enfeksiyöz ülserler, epitelyal trofik ülser, nekrotizan stromal keratit, immün stromal keratit, endoteli ve iridosiklit şeklinde ortaya çıkabilir. Yazımızda herpes simpleks virüsüne bağlı oküler tutulumu olan, herpes keratiti tanısı alan olguyu sunduk.

Olgu: 52 yaşında bayan hasta yüzünün sol kısmında kızarıklık, sol gözde şişlik ve bulanık görme şikayetleri ile acil servisimize başvurdu. Hastanın şikayetleri 4-5 gün önce başlamış. Şikayetlerinin giderek artması ve sol gözünün giderek kapanması nedeniyle acilimize geldi. Hastanın özgeçmişinde diyabet tanısı mevcut. Hastanın başvuru anında tansiyonu:140/90 mmHg, nabızı: 77 atım/dk, ateşi:36.2°C, oksijen saturasyonu: %98 saptandı. Fizik muayenede; sol fasyal bölgede sol göz kapağını da tutan veziküler lezyonları mevcuttu. Sol göz kapağı hiperemikti. Sol gözde ağrısı ve bulanık görmesi mevcuttu. Göz muayenesinde kornea ödemli ve mat, ön kamerada hücre gözlenmedi, fluresein ile boyamada korneada yaygın dendritik tutulum mevcuttu. Laboratuvar tetkiklerinde; crp:44.1 mg/L, wbc:11400 mm3 dışında diğer parametreler normal saptandı. Hasta herpes keratiti tanısıyla, tedavi için göz hastalıkları servisine yatırıldı.

Sonuç: HSV yaygın görülen enfeksiyonlardandır. Ancak HSV'ye bağlı klinik formlar, enfeksiyonun yeri, yaş, konağın immün durumu, virüsün tipine göre değişiklik gösterir. HSV'ye bağlı göz tutulumu nadir görülen fakat erken tanı ve tedavi yokluğunda görme kaybına kadar giden önemli bir klinik tablodur.

Anahtar Kelimeler: Herpes, keratit, dendritik tutulum

P-0917 Other

hardal yemeye bağlı gelişen akut pankreatit

İsmail Toğun, Murat Çavdar

özel osm ortadoğu hastanesi, şanlıurfa

Günümüzde bitkisel ilaçlarla tedaviye ilgi giderek artmaktadır. Bitkisel ilaçlar, geleneksel ilaçlar ile hayal kırıklığının bir sonucu olarak popüler hale gelmiştir. Genellikle halk tarafından zararsız olarak kabul edilmektedirler. Ancak bu ürünler veya bunların metabolitleri pankreatite neden olabilir. Bu çalışmada bitkisel ilaç kullanımına bağlı akut pankreatit gelişen bayan hasta tartışılmıştır.

Altmış altı yaşında kadın hasta; karın ağrısı, mide bulantısı, kusma, halsizlik şikâyeti ile kliniğimize başvurdu. Serum amilaz düzeyleri artmıştı. Akut pankreatit gelişimi için risk faktörlerinin olmadığı hastada hardal bitkisini yemeye bağlı akut pankreatit geliştiğini saptadık.

Bizim bilginize göre bu muhtemelen, hardal bitkisi kullanımı ile ilgili ilk pankreatit raporudur. Klinisyenler nedeni belli olmayan akut pankreatit olgusu ile karşı karşıya kalabilirler. Böyle durumlarda bitkisel ilaç kullanımı olasılığı ve buna yönelik hastadan hikaye alma akılda tutulmalıdır.

Anahtar Kelimeler: Akut pankreatit, hardal bitkisi, karın ağrısı

P-0918 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Non-Steroidai Antienflamatuvar İlaç Kullanımı Yanık Ünitesine Yatış Gerekir mi: Toksik Epidermal Nekroliz Olgusu

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² Acil Servis, Elazığ Eğitim ve Araştırma Hastanesi/Elazığ

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Amaç: Dermatolojik aciller acil servis başvurularının önemli kısmını oluşturur. Non-steroidal antienflamatuvar ilaçlar kendiliğinden sonlanan lokal cilt reaksiyonlarına neden olabilirken hayatı risk içeren ve yoğun bakım yatışı gerektiren toksik epidermal nekroliz nedeni de olabilir. Bu yazıda lumbalji yakınması ile iki hafta önce non-steroidal antienflamatuvar ilaç kullanan hastada gelişen toksik epidermal nekroliz olgusu bildirildi.

Olgu: Kırk altı yaşında herhangi ek hastalığı olmayan erkek hasta tüm vücudunun yaklaşık %25'ini etkileyen, yüz ve gövdenin üst bölümünden başlayarak hızlı vücudun alt bölgesine yayılım gösteren diffüz, eritemli cilt ve mukoza erozyonları ile acil servise başvurdu. Hastanın öyküsü derinleştirildiğinde yaklaşık iki hafta önce lumbalji yakınması ile oral non-steroidal antienflamatuvar ilaç aldığı öğrenildi. Hemogram sonucu, renal ve karaciğer fonksiyon testleri normal saptanan, PA-Akciğer grafisinde patoloji olmayan, ayırıcı tanıda kimyasal yanık, hipersensitif vaskülit, pemfigus vulgaris, psödo porfir, toksik şok ve stafilocokkal şaşlanmış deri sendromu düşünülmeyen hastaya öykü ve fizik muayene bulguları doğrultusunda toksik epidermal nekroliz tanısı koyuldu ve yanık ünitesine yatırıldı. Ağrı medikasyonu sağlanan, intravenöz sıvı desteği başlanan, eksternal ısı ile hipotermiden korunan, yakın kan elektrolit takibi yapılan hastanın açık yaraları steril örtüler ile kapatılarak sekonder kontaminasyondan korundu. Tedaviye etkin yanıt veren hasta komplikasyonsuz taburcu edildi.

Sonuç: Acil servise başvuran hastalarda haftalar önce alınan non-steroidal antienflamatuvar ilacın toksik epidermal nekroliz nedeni olabileceği bilinmeli, yaklaşık %30 oranında ölümcül risk taşıyan hastalığın tedavisinin yanık ünitesinde yoğun bakım şartları altında yapılması gerektiği unutulmamalıdır.

Anahtar Kelimeler: Nonsteroid antienflamatuvar, Toksik epidermal nekroliz, Yanık Ünitesi

P-0919 Cardiovascular Emergencies

Anjio Uygulaması Sonrasında Gelişen Aort Disseksiyonu

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Amaç: Göğüs ağrısı hastaların acile en sık nontravmatik başvuru şikayetlerindendir. Ağrı kimi zaman sabit, kimi zaman da gezici tarzda olabilir. Ağrının göğüsten sol omuza, kola ve ellere yayılması genellikle koroner iskemiyi düşündürmektedir. Ancak özgeçmişinde koroner anjio ve stent öyküsü olan hastalarda aort diseksiyonu gelişebileceği de unutulmamalıdır. Aort diseksiyonu tanısını koymak zordur. Non spesifik ST değişiklikleri olsa da tanıda kontrastlı tomografi mutlaka tercih edilen tanı yöntemidir. Olgumuzda, geçirilmiş koroner anjio sonrası göğüs ağrısı şikayeti acile başvuran ve ayrıntılı anamnez sonrası aort diseksiyonu tanısı alan hastayı sunacağız.

Olgu: Akşam saatlerinde sol omuza başlayan ağrı şikayeti ile acil servise başvuran 43 yaşındaki bayan hastanın öyküsünde 1 hafta önce akut miyokard infarktüsü geçirdiği ve 2 gün önce de dış merkezde balon anjioplasti işlemi yapıldığı öğreniliyor. Çekilen EKG'sinde non spesifik değişiklikler saptanan hastada başvuru anında üst ekstremiteler arası anlamlı tansiyon arteriyel fark saptanmadı. Nabız 89/dakika, saturasyon 90 olarak tespit edildi. Çekilen akciğer direkt grafisinde mediastende patolojik düzeyde genişleme tespit edilen hastanın yapılan toraks tomografisinde perikardial efüzyon ve asendan aortun anevrizmatik dilatasyonu ve yaygın diseksiyon tespit edildi. İlgili branşlar konsülte edildi. Bu esnada hastanın göğüs ağrısında artma ve üst ekstremitelerde solda sağa nazaran nabız alımında zayıflama tespit edildi. Hastanın dakikalar içinde genel durumu ve kooperasyonu bozuldu. Ani kardiak arrest gelişen hasta tüm medikal tedavi ve kardiyopulmoner resüsitasyonlara rağmen ex oldu.

Sonuç: Göğüs ağrısı şikayeti ile acil servise başvuran hastalarda, her ne kadar iş yoğunluğumuz fazla olsa da, altında yatan mortaliteye neden olabilecek aort diseksiyonu ve tamponad gibi hastalıklar gözönünde bulundurularak, alınacak ayrıntılı anamnez ve yapılacak sistemik fizik muayene, hastada çok ciddi hastalıkların tanısını koymamıza ve hatta bu erken tanı sayesinde hastanın hayatını kurtarabileceğimize neden olabilir.

Anahtar Kelimeler: Anjio, Aort Disseksiyonu, Göğüs Ağrısı



POSTER PRESENTATIONS

P-0920 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Akılci Antibiyotik ve Analjezik Kullanımı

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Amaç: Dünya Sağlık Örgütü'ne göre Akılci İlaç Kullanımı; " kişilerin klinik bulgularına ve bireysel özelliklerine göre uygun ilacı, uygun sürede ve dozajda, en düşük fiyata ve kolayca sağlayabilmeleri" olarak tanımlanmıştır.

Peki amaç nedir?

Aşırı ilaç ve yanlış kullanımının önlenmesi,

Ekonomik kayıpların önüne geçilmesi,

İlaçlara bağlı yan etkilerin azaltılması,

Antimikrobiyal direncin azaltılmasıdır.

Bu çalışma antibiyotik ve analjezik ilaç kullanım durumlarının belirlenmesi ve veri tabanı oluşturulması amacıyla yapılmıştır.

Gereç-Yöntem: Çalışmamızı Afyonkarahisar ilindeki 380 kişiye yüz yüze görüşerek anket biçiminde uyguladık.

Verilerin istatistiksel analizini SPSS 20 paket programı ile yaparak analizde; yüzde ve frekans kullandık

Bulgular: Çalışmaya katılan 380 kişinin 237'si (%62.4) kadın, 143'ü (%37.6'sı) erkektir. Yaş ortalaması 24.25'dir (15-77).

Antibiyotik kullanımı sorgulandığında katılımcıların % 28.4'ü doktor tavsiyesi olmadan kendi kendine antibiyotik kullandıklarını belirtmişlerdir (Tablo-1).

Katılımcıların %64.5'u doktorun önerdiği antibiyotiği bitirene kadar kullandıklarını belirtmişlerdir. Yan etki görüldüğünde ya da antibiyotikten yarar görmüyorsam doktora başvurur musunuz sorusuna katılımcıların %80.3'ü evet şeklinde yanıtlamışlardır. (Tablo-2).

Analjezik ilaç kullanımı sorgulandığında katılımcıların %82.1'inin doktora başvurmadan ağrı kesici kullandığı ve %80.3'ünün ağrı başladıktan sonra ağrı kesici kullandığı saptanmıştır (Tablo-3).

Katılımcıların %31.6'sının ağrı olduğunda ilaç dışı şeyler kullandıkları (haşhaş,bitki...) belirlenmiştir. İlaçın yan etkilerini bilirim, kullanma talimatını okurum sorusuna katılımcıların %82.1'i evet, ilacın son kullanma tarihine bakar, dikkat ederek kullanım sorusuna katılımcıların %82.4'ü evet şeklinde yanıtlamışlardır (Tablo-4).

Sonuç: Toplumun ilaç kullanma alışkanlıkları konusunda eğitime destek olmak amacıyla kişilerin ilaç kullanım alışkanlıklarının saptanması önemlidir.

Doktora danışmadan ilaç kullanımı geç tanı konulmasına, hastalık sürecinin uzamasına, antibiyotik direnci gelişmesine, komplikasyonların daha sık görülmesine, dolayısıyla iş gücü kaybına yol açmaktadır ve sağlık harcamalarının genel sağlık harcamalarındaki payını artırmaktadır.

Yapılan bir çalışmada kişilerin doktora başvurmadan ilaç kullanım eğiliminin olduğu ve kişilerin %98'inin analjezik ilaç ve %34.3'ünün antibiyotik kullandıkları saptanmıştır. Çalışmamızda benzer şekilde katılımcıların %82.1'i doktora başvurmadan ağrı kesici ilaç, %28.4'ü doktor tavsiyesi olmadan kendi kendine antibiyotik kullandıklarını belirtmişlerdir.

Bu çalışmanın sonucunda akılci ilaç kullanımı göreceli olarak yeterli görünse de topluma çeşitli halk eğitim programlarıyla akılci ilaç kullanımı bilgisi verilmeli, doktora danışmadan kullanılacak ilaçların sağlığını nasil etkileyebileceği ve ekonomik sonuçları anlatılmalıdır.

Anahtar Kelimeler: Analjezik, Antibiyotik, Akılci kullanım

P-0921 Other

Hemanjiom ve Bel Ağrısı

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Amaç: Bel ağrısı acil servise sık başvuru nedenleri arasında yer alır. Travmatik olmaya olgular çoğunlukla analjezik ve kas gevşetici tedavisi ile taburcu edilir. Bu çalışmada mekanik bel ağrısı tanısı konup tedavi edilmeye çalışılan bir olgudaki atipik bir bel ağrısı nedeninin paylaşılması amaçlanmıştır

Olgu: Bel ağrısı yakınması olan 34 yaşındaki bayan hasta şikayetlerin artması nedeniyle acil servise müracaat etti. Vital bulguları stabil olan hastanın bel ağrısı bir haftadır varmış. Üç gün önce başka bir sağlık kuruluşunda mekanik bel ağrısı tanısı ile analjezik ve myeloreksan tedavisi başlanmış. Hasta bu tedaviden fayda görmemiş hatta ağrıları giderek artmış. Fizik muayenede düz bacak kaldırma testi her iki bacakta 40 derecede pozitif. Alt ekstremité duyu, hareket ve derin tendon refleksi muayeneleri normaldi. Patolojik refleks yoktu. Biyokimyasal testlerde acil patoloji saptanmadı. Hastanın radyolojik grafisinde lomber aksta düzleşme vardı. Lomber MR çekilen hastanın L3-L4 vertebra korpus düzeyinde spinal kanalda intra ve extrameduller yerleşimli 38x16 mm boyutunda kistik komponenti bulunan kitle lezyonu (dermoid kist ?, hemanjiom ?) izlendi (Resim). Hasta beyin cerrahisi kliniğine yatırıldı ve opere edildi. Klinik takip ve tedavileri devam eden hastanın kesin tanısı hemanjiom olarak belirlendi.

Sonuç: Tedavi edilmesine rağmen devam eden bel ağrıları acil servislere müracaat edebilir. Bu olgularda alt ekstremité duyu, hareket ve refleks muayeneleri mutlaka yapılmalıdır. Ayrıca hastaların daha önce benzer şikayetlerinin varlığı, tedavi alıp almadığı mutlaka sorgulanmalıdır. Bizim olgumuzda olduğu gibi tedaviye rağmen şikayetleri devam eden hastalarda spinal kolonda yer alan bir kitle bel ağrısı nedeni olabilir. Bunun tespiti ve hastanın tedavi için yönlendirilmesi acil servis ve hasta için değerli bir durumdur.

Anahtar Kelimeler: Bel Ağrısı, Hemanjiom, Acil Servis

P-0922 Other

Sünnette Kullanılan Lokal Prilokaine Bağlı Methemoglobinemi Olgusu

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Amaç: Methemoglobin (MetHb), hemoglobinin molekülündeki demirin okside formda (Fe+3) olması olarak tanımlanabilir. Sağlıklı bireylerde gastrointestinal enfeksiyonlar ve orak hücreli anemilerde görülen ağırlı krizler gibi bazı medikal durumlarda, toksik ilaçlar ve kimyasal maddeler ile temas sonrasında MetHb oluşabilir, ancak hücre içi MetHb indirgeyici sistem olan sitokrom - b5 MetHb redüktaz enzim sistemi tarafından konsantrasyonu %1'in altına indirilir. İnfantlar, sitokrom -b5 redüktaz enzim düzeyleri erişkinlere göre %50 daha düşük olduğu için oksidasyona daha duyarlıdır. Kanda MetHb düzeyi %10-15'i geçtiğinde siyanoz gelişir, %35'in üzerine çıktığında ise doku hipoksisi sonucu halsizlik, taşikardi, solunum sıkıntısı, bulantı ve kusma gibi sistemik semptomlar görülür. Kanda MetHb %55 ve üzerine çıktığında letarji, stupor ve senkop gelişirken, %70'in üzerinde olduğunda ve tedavi edilmediğinde ise genellikle ölümcüldür. Methemoglobinemi, nadir ama ölümcül bir lokal anestezi komplikasyonudur. Prilokain ile lokal anestezi, ayaktan sünnet girişimlerinin rutin bir parçası haline gelmiştir. Bu nedenle sünnet sonrası methemoglobinemi gelişme riski söz konusudur. Burada sünnet öncesi prilokain uygulamasına bağlı methemoglobinemi gelişen 8 aylık bir erkek hasta sunmak istedik.

Olgu: Acil servise morarma şikayeti ile getirilen 8 aylık erkek hastaya, başvurusundan yaklaşık 3-4 saat önce genel cerrahide maske anestezi ile beraber lokal anestezi olarak 1 cc %2 lik prilokain (Citane®) uygulanarak sünnet operasyonu yapılmış morarma şikayeti ile getirildi. Geldiğinde peroral ve periferik siyanozu vardı diğer fizik muayenesi doğaldı, kan basıncı 90/60 mmHg, solunum sayısı 36/dk ve kalp tepe atımı 133/dk'dı. Ekg'si ve akciğer grafisi normaldi. Pulse oksimetre ile oksijen saturasyonu 88 olarak ölçüldü. Bakılan arteriyel kan gazında pH:7.41, pO2 110mmHg, pCO2 35 mmHg ve MetHb düzeyi %17.2 ölçüldü. Tam kan sayımında hemoglobin 12 gr/dl, lökosit sayısı 12000/mm3. Maske ile %100 O2 verilen hastanın siyanozu düzeldi. Hasta daha sonra pediatri uzmanı ile konsülte edilerek pediatri yoğun bakımına takip amacı ile yatırıldı. Hastanın takiplerinde sırasıyla MetHb seviyesi 11,4--> 8-->0.2 ye düştü 24 saat içinde yoğun bakımdan çıkarılan hasta 1 günde serviste kaldıktan sonra problemsiz bir şekilde taburcu edildi.

Sonuç: Methemoglobin seviyesi %20'nin altında ise sadece neden olan ilacın kesilmesi ile düzelme sağlanabilmektedir. Ancak yenidoğan ve süt çocuğunda yine de tedavi gerekebilmektedir. Lokal anestetiklerden prilokain yenidoğan ve süt çocuklarında edinsel methemoglobinemiye neden olabilmektedir. Methemoglobinemiye neden olan faktörün saptanması, erken ve etkin şekilde askorbik asit veya metilen mavisi uygulaması yaşam kurtarıcı olmaktadır.

Anahtar Kelimeler: Sünnet, Prilokaine, Methemoglobinemi

P-0923 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Baş ağrısı ve senkop: Genç vakada astrositom

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Amaç: Senkop pek çok tıbbi terim gibi Yunanca'dan gelmez. Serebral perfüzyonun, ani geçici olarak düşmesi, azalması ile ortaya çıkan geçici şuur kaybı olarak tanımlanır. Klinik duruma,



POSTER BİLDİRİLER

olmazsa olmaz tonus kaybı da eşlik eder.

Baş ağrısı ise toplumda en sık görülen şikâyetlerin başında gelir. Baş ağrısı şikâyeti olanların oranı toplumda yüzde 90'lara ulaşır. Tüm baş ağrılarının yüzde 90'ını ise migren ve gerilim tipi baş ağrıları oluşturur. Geri kalan %10'luk kısım sekonder baş ağrısı olarak tanımlanır.

Beyin tümörleri her iki semptomu da oluşturabilecek diğer nedenlere nazaran nadir görülen bir nedendir. Bu olgumuzda acil servise senkop ile gelen hastayı irdeleyeceğiz.

Olgu: 23 yaş bayan hasta 2 gündür olan baş ağrısı ve 3 kez senkop atakları nedeniyle acil servisimize başvurdu. Nöbet aktivitesi tarifenmedi. Hastanın gelişinde GCS 15, oryante, koopere, bilinç açıktı. Fizik muayenesinde fokal norolojik defisit, meningeal irritasyon bulguları yoktu. 3 gün önceki noroloji poliklinik muayenesinde hasta için yapılan EEG ve beyin MR görüntüleme normal olarak rapor edilmiş ve gerilim tipi baş ağrısı teşhisi ile hasta noroloji poliklinik takip önerisiyle taburcu edilmiş. Buna rağmen acilde çekilen beyin BT'de; sağda frontal bölgede orta hattın hemen komşuluğunda yaklaşık 57x37 mm boyutunda orta hattın soluna doğru da uzanım gösteren ve orta hat yapılarında hafif şifte neden olan 3. ventrikül ile her iki lateral ventrikül anterior hornuna bası etkisi oluşturan ve çevresinde ödem görünümünün de izlendiği geniş kitle lezyonu görüldü. Yine sağda frontalde temporalde ve parietal loblarda benzer hipodens yer kaplayıcı oluşumlar ve bu oluşumlar çevresinde de yine ödemde ait hipodens görünümüler izlenmekle birlikte kitle ve ödem etkisine sekonder sağ serebral hemisferde sulkuslar sola oranla belirgin siliik görünüm ortaya çıktı. Hasta bu bulgularla beyin cerrahisi servisine yatırıldı. Opere edilen hastaya grade II astrositom teşhisi kondu.

Sonuç: Astrositom tümörler, gliomların ve birincil beyin tümörlerinin en sık görülen türüdür. Bu tümörler, beyin sapı, omurilik veya beyin gibi merkezi sinir sistemi bölümlerinden birinde büyüyebilir. Astrositomlar en az kötü huylu olan beyin tümörleridir. Grade II astrositomlarda yüksek derece tümörlerdeki gibi tekrarlama söz konusu olabilir. Cerrahi tedavi tek başına en önemli tedavi yöntemidir. Zorunlu olmadıkça kemoterapi ve radyoterapi önerilmez.

Senkop, baş ağrısı ve nöbet ile gelen hastalarda beyin tümörleri akılda tutulması gereken ön tanılardan biri olmalıdır.

Anahtar Kelimeler: senkop, baş ağrısı, nöbet, astrositom

P-0924 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Gebelikte Karın Ağrısı; Nadir bir Neden Akut Pankreatit

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Amaç: Akut pankreatit (AP), pankreasın çeşitli derecelerde etkilendiği, geri dönüşümlü inflamasyonu olarak tanımlanabilir. Pankreas ile sınırlı kalabileceği gibi peripankreatik dokulara ve diğer organ sistemlerine yayılabilir.

AP gebelikte nadir bir durum olmakla birlikte her 10.000 gebelikte 3 oranında görülmektedir. Özellikle 3. trimester de insidansı yüksektir. AP %70 biliyer kaynaklıdır bunların maternal ve prenatal prognoz oldukça iyidir. Hipertrigliseridemi (HTG) ve alkol kullanımı %20 oranında etyolojide yer almaktadır. Non-biliyer nedenler artmış maternal ve neonatal risk ile ilişkilidir. Burada acil servise karın ağrısı ile başvuran gebeliğe bağlı akut pankreatit tanısı alan bir olgu sunulmuştur

Olgu: Ondokuz yaşında 20 haftalık gebe son iki gündür olan sırta vuran karın ağrısı bulantı, kusma şikâyetleri ile acile servise başvurdu. Genel durumu iyi, vital bulguları stabildi. Batında muayenesinde, yaygın hassasiyet ve derin palpasyonla defansı mevcuttu. Noroloji ve diğer sistem muayeneleri normaldi. Hastanın laboratuvar tetkiklerinde WBC:12.200 bin/uL, HGB:10.3g/dl, PLT:220.000 bin/uL, Na:137mEq/L, K:3.37 mEq/L, Cl:104 mEq/L, Ca:8.8 mg/dL, AST:75U/L, ALT:28U/L, INR:1.1, B-HCG>1000, Pankreatik Amilaz:2852 U/L, lipaz: 4110 U/L idi. Yapılan batin ultrasonografisinde (USG); karaciğer, portal yapılar, safra kesesi, safra yolları normal olarak değerlendirildi. Pankreas gaz süperpozisyonu nedeniyle ayırt edilemediği belirtildi. Obstetrik açıdan herhangi bir patoloji saptanmadı.

Bu sonuçlarla hasta gebeliğe bağlı akut pankreatit olarak değerlendirildi. Gastroenteroloji servisine yatırılarak takip ve tedavisi yapıldı. Sekizinci günün sonunda önerilerle taburcu edildi.

Sonuç: Gebelikte gelişen AP değişken klinik özelliklere sahip olması ve gebede tanı yöntemlerindeki yetersizlikler nedeniyle özellikle acil servislere tanı güçlüğü oluşturabilir. Gebeliğe bağlı AP acil servise karın ağrısı ile başvuran gebelerde ayırıcı tanıda düşünülmelidir.

Anahtar Kelimeler: Akut Pankreatit, Gebe, Karın Ağrısı, Acil servis

P-0925 Imaging in Emergency Units

Solumun sıkıntılı hastalarda ultrasonografinin önemi

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Amaç: Acil servise solumun sıkıntısı ile başvuran hastalarda yatak başı ultarsonografi (USG) bakısı giderek yaygınlaşmaktadır. USG pulmoner emboli, pnömotoraks, kalp yetmezliği, kardiyak tamponad, aort diseksiyonu gibi bir çok ölümcül hastalığın ayırıcı tanısında bize yardımcı olabilir.

Olgu: Yetmiş dört yaşında bayan hasta acil servise solumun sıkıntısı ile başvurdu. Anamnezinden hastanın üç yıldır astım nedeniyle takipli olduğu ve bir hafta önce pnömoni nedeniyle başka bir sağlık merkezinde yatırılarak tedavi aldığı öğrenilmiştir. Hasta bu sabah kendi isteği ile taburcu edilmiş ve şikâyetlerinin artması üzerine tarafımıza başvurmuş. Hastanın vitallerinde TA: 100/60 mmHg, nabız: 100 atım/dk, solumun sayısı: 24/ dk, ateş:36,1 C, sat O2: % 86 olarak ölçüldü. Fizik muayenesinde solumun sesleri azalmış ve hasta takipneik idi. Hastaya yatak başı USG ile kardiyolojik görüntüleme yapıldı. Hastanın sağ kalp yapıları genişlemiş olup, kardiyak septum ve duvar hareketleri olağan idi, trombüs yoktu. Hastanın laboratuvar bulgularında, D-dimer >5000, lökosit: 20020, kan gazında pO2: 74 mmHg, pCO2: 23,1mmHg idi. Pulmoner BT anjiyografi çekilen hastada bilateral ana pulmoner arterlerde trombüs izlenmiştir. Hasta Göğüs hastalıkları bölümüne yoğun bakıma yatırılarak tedavi altına alındı. On gün sonra şifa ile taburcu oldu.

Sonuç: Pulmoner emboli nispeten zor tanı konulan morbidite ve mortalitesi yüksek bir hastalıktır. Tanı için altın standart yöntem Pulmoner BT anjiyografidir. Radyasyonun olumsuz etkileri nedeni ile kimlere BT anjiyografi çekileceği önemlidir. Bu konuda diğer yardımcı tanı yöntemleri ile birlikte hasta başı USG bize önemli katkı sağlayabilir. Bu nedenle acil servise solumun sıkıntısı ile başvuran hastalarda yatak başı USG kullanılmalı ve pulmoner embolide ultrasonografik bulgular her acilci tarafından bilinmelidir.

Anahtar Kelimeler: Acil, pulmoner emboli, ultrason

P-0926 Cardiovascular Emergencies

Ölümcül Ritm: Brugada Sendromu: Olgu Sunumu

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Amaç: Brugada sendromu ilk kez 1992 yılında tanımlanan, kalpte bir sodyum iyon kanalı olan SCN5A' nın mutasyonu sonucu gelişen, ani kardiyak ölümlerin sebeplerinden birisidir. Tipik EKG bulgusu sağ dal bloğu ve V1-V3 derivasyonlarında ST segmentlerinin elevasyonu olup yapısal bir kalp hastalığı yoktur. Bazen EKG'de belirti yoktur. Senkop geçirenler ve ailede ani ölüm hikayesi olanlar kardiyak ağıdan en riskli gruptur. Bu gruba elektrofizyolojik çalışma yapılmalı ve ventriküler aritmi (VT, VF) saptananlara ICD takılmalıdır. Senkopu olmayan, aile hikayesi olmayan sadece EKG bulgusu olanlar takip edilir. En sık dördüncü dekada ve erkeklerde görülür. Bütün ani ölümlerin yaklaşık %4-12'sinden, yapısal olarak normal olan kalplerdeki ani ölümlerin ise yaklaşık %20'sinden sorumlu olduğu düşünülmektedir. EKG bulgusuna göre 3 tip tanımlanmıştır. Brugada sendromunda ani ölümlerin çoğu istirahat anında ve gece meydana gelmektedir.

Olgu: 28 yaşında erkek hasta, gece 23.00 sıralarında kliniğimize göğüsde daralma ve çarpıntı şikâyeti ile başvurdu. Özgeçmişinde daha öncede bu şikâyetlerinin olduğu doktora gittiği ancak kendisine net bir teşhis konulamadığını beyan etti. En son çarpıntı ve daralması 6 ay önce olup İstanbul'da bir hastaneye gittiğini, kendisine yatış verildiğini ancak çalışmak zorunda olduğundan yatışı kabul etmediğini ve tanısını bilmediğini söyledi. Ailesinde genç yaşta kalp hastası olan ve kalp hastalığından ölen kimse olmadığını beyan etti. Fizik Muayenesi tamamen doğaldı. TA: sağ koldan 140/90, sol koldan 130/80. Nabız 82, ateş:36,7 sat:%98, Çekilen EKG sinde tip 1 Brugada saptandı. Hemogram ve biyokimyasal parametreleri normal olarak saptandı. Troponin negatifti. Hasta monitorize halde defibrilatöre bağlı olarak takip edildi. Saatlik aralıklarla çekilen 2. ve 3. EKG' lerinde herhangi bir değişiklik saptanmadı. Kardiyoloji ile konsulte edilen hasta kardiyolojiye devredildi. Kardiyolojide 3 günlük holter takıldı, sonucunun normal olması ve hasta yüksek riskli gruba dahil olmadığından ve ekokardiyografi ile yapısal kalp hastalığı tespit edilmediğinden hasta ayaaktan takiplere çağrıldı.

Sonuç: Mevcut bulgularla hastamızı Brugada sendromu kabul ettik. Hastalık hakkında ayrıntılı olarak bilgilendirme yapıldı. Sonuç itibari ile Brugada sendromunun EKG bulguları bilinmeli, EKG bulguları olmasa bile çarpıntı, senkop, VT ve VF olanlarda Brugada sendromu akla gelmeli ve aile hikayesi sorgulanmalıdır.

Anahtar Kelimeler: ölümcül ritm, Brugada, EKG



POSTER PRESENTATIONS

P-0927 Imaging in Emergency Units

Santral venöz kateterizasyonda nadir bir komplikasyon

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Amaç: Santral venöz kateterizasyon (SVK) acil servis ve yoğun bakım ünitelerindeki hastalarda monitorizasyon, nütrisyon desteği ve uzun süreli medikasyon için sıkça başvurulmuş invaziv bir işlemdir. Bu amaçla en sık internal juguler ven (IJV) ve subklavyan ven kullanılmaktadır. Nadiren femoral, eksternal juguler, basilik ve sefalik ven gibi diğer periferik venler de kullanılabilir. SVK uygulamalarında ultrasonografinin (USG) kullanımı ilk seferde başarı oranını artırmış ve komplikasyon gelişme oranlarını anlamlı olarak azaltmıştır. Literatürde USG kullanılmadan yapılan internal juguler vene katater uygulamada ilk giriş te başarı oranı ortalama % 68,9 iken USG eşliğinde bu oranın %93,1 olduğu belirtilmiştir. Önemli komplikasyonlar arasında internal karotis arter (İKA) ponksiyonu, pnömotoraks, damar erezyonları, tromboz ve enfeksiyonlar yer alır. En sık rastlanan komplikasyon İKA ponksiyonu olup, tüm komplikasyonların %80-90'ını oluşturmaktadır. Seksen yaşında erkek hasta acil servise solunum sıkıntısıyla başvurdu. Yakınlarından alınan anamnezde ileri evre kronik obstrüktif akciğer hastası olduğu öğrenildi. Hastanın geldiğinde vital parametreleri TA: 90/60 mmHg, satO2: 79, nabız:138 atım/dk, ateş: 37.1 C tespit edildi. Acil serviste takip ve tedavisi süren hastada solunum arresti gelişti. Hasta entübe edilerek acil yoğun bakımda takibe alındı. Yoğun bakım ünitesinde hastaya monitorizasyon ve medikasyon amacıyla USG eşliğinde sağ internal juguler venden santral venöz kateter uygulandı. Internal juguler ven ilk denemede ponksiyone edildi. Yapılan kontrollerle kataterin uygun olarak çalıştığı tespit edildi. İşlem sonrası komplikasyonların ve katater yerinin tespiti için posteroanterior akciğer (PA AC) grafisi çekildi. PA AC grafisinde pnömotoraks yoktu fakat, kataterin ucunun sol subklavyen vende olduğu tespit edildi. Doppler USG ile kontrol edilen bölgede herhangi bir hematoma ve fistül tespit edilmedi. Bu durumu santral venöz katater malpozisyonu olarak değerlendirdik. Kateteri çıkardık ve tampon uyguladık. Göğüs hastalıkları kliniği ile birlikte tedavisi düzenlenen hastada yoğun bakımdaki takipleri sırasında ek sıkıntı gelişmedi. Hasta bilinci açık vitalleri stabil olarak on gün sonra şifa ile taburcu edildi.

Sonuç: Acil servisler ile acil yoğun bakımlarda USG kullanımının giderek yaygınlaşması SVK gibi girişimsel işlemlerde komplikasyon riskini giderek azaltmıştır. İşlem sonrası santral ven kataterinin doğru yerde olduğunun tespiti son derece önemlidir. Hatalı santral katater yerleşimine bağlı olarak aritmi, kardiyak tamponad, vasküler erozyon gibi bir çok komplikasyon gelişebilemektedir. SVK sık kullanılan bir işlem olması ve ciddi komplikasyonları nedeni ile deneyimli klinisyenler tarafından uygulanmalı, her işlem sonrası mutlaka PA AC grafisi çekilerek katater yerinin doğruluğu kontrol edilmelidir.

Anahtar Kelimeler: Acil, katater, komplikasyon, ultrasonografi

P-0928 Other

Enerji içeceğine Bağlı Atipik Cilt Bulguları Olan Vakamız

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Amaç: Acil servisimize enerji içeceği içtikten sonra halsizlik, kırılgılık ve vücudunda ekimoz ve ellerinde morarma ile gelen 21 yaşında erkek hasta vaka olarak sunulmuştur. Enerji içecekleri aşırı miktarda tüketildiğinde, sıklıkla taşikardi, çarpıntı, hipertansiyon, uyku bozukluğu, hiperglisemi ve alerji neden olmaktadır. Amacımız acil servise benzer cilt değişiklikleri ve lezyonları ile gelen hastalarda enerji içeceklerinin ayırıcı tanıda düşünülmesini sağlamaktır.

Olgu: Acil servisimize 19 yaşında erkek hasta bacaklarında yaygın ekimoz, ellerinde morarma, halsizlik, kırılgılık şikayetleri ile geldi. Hasta hikayesinde son üç yıldır her gün enerji içeceği içtiğini, o gün de enerji içeceği içtikten sonra ellerinde morarma olduğunu söyledi (resim 1). Hastanın yapılan fizik muayenesi sonucunda, ellerinde ve her iki bacak iç kısmında yaygın morarma vardı. Özellikle uylukta olmak üzere her iki bacakta femoral anterior ve medial bölgede yaklaşık 5x6 cm ebatlarında ekimotik alanlar mevcuttu. Hastanın ateşi 36,4 C ve tansiyon arteriyel 130/80 mmHg idi. Yapılan tetkiklerine WBC 7,27 103/ul, HGB 14,8 gr/dl, RBC 4,86 106 /ul, MCV 95,3 fL, PLT 216000 103/ul idi. Glukoz 96 mg/dL, kreatinin 0,9mg/dl, BUN 10 mg/dL, Total bil 0,3mg/dl, Direkt bil 0,1 mg/dL, Kalsiyum 9,8mg/dL, Sodyum 4,5 mmol/L/dL, Klor 108 mmol/L, Potasyum 4,5 mmol/L, Amilaz 93 U/L, GGT 13 U/L. PT 12,8 sn, INR 1,01, APTT 24,3 sn idi. Elektrokardiyografi normal sinüzal ritimde ve patolojik değişiklik yoktu. Hastada cilt bulguları ve ellerindeki periferik siyanoz dışında ek patolojiye rastlanmadı. Özgeçmişinde herhangi bir hastalık hikayesi yoktu. Daha önce ellerinde morluk olmadığını söyledi. Acil gözlem ünitesinde takibe alındı. Ancak hastadan alınan hikayesinde daha önce benzer hastalık geçirmediğini ilk kez o gün rahatsızlığını söyledi. Ayrıca enerji içeceği her zaman tükettiği içecek markasıyla aynı olduğunu söyledi. Takiplerinde ek patoloji olmayan hasta tavsiyelerle taburcu edildi. Hastanın iletişim bilgileri alındı. Lezyonların resimleri çekildi. Hastaya enerji içeceği içmemesi önerildi. Hastaya 2 kez telefonda görüldü. Telefon görüşmelerinde lezyonların gerilediği bilgisine ulaşıldı. Hasta 15. Gününde tekrar kontrole çağırıldı. Hastamız lezyonlarının geçtiğini, enerji içeceğini içmediğini söyledi. Kontrollerinde kan değerleri ve fizik muayenesi normal olarak değerlendirildi.

Sonuç: Enerji içeceklerindeki kafein miktarından dolayı tüketiminde dikkatli olunmalıdır. Özellikle hipertansiyon ve diyabet hastaları kesinlikle kullanmamalıdır. Enerji içeceğine bağlı alerji, ekimoz, diğer cilt bulguları gelişebilir. Tedavisi semptomatik tedavidir. Atipik cilt bulguları görüldüğünde kullanılması bırakılmalıdır. Enerji içecekleri ile ilgili daha fazla çalışmaya ihtiyaç vardır. Ayrıca sebebi bilinmeyen cilt lezyonu, ekimoz olan hastalarda bu durumun enerji içeceğine bağlı olabileceği düşünülmelidir. Başta kardiyolojik yan etkiler olmakla birlikte; periferik siyanoz etyolojisinde düşünülmelidir.

Anahtar Kelimeler: Enerji içeceği, alerji, ekimoz

P-0929 Cardiovascular Emergencies

Nadir görülen akut dispne nedeni: gerbode defekt

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Amaç: Sol ventrikül ve sağ atrium arasındaki bağlantı gerbode defekt olarak bilinmektedir. Konjenital kalp hastalıkları arasında çok nadir gözlenmektedir. (% 0,08). Ventriküler septal defektlerin özel bir tipi olarak değerlendirilir. Genellikle konjenital olmakla beraber bazen infektif endokardit sonrası da görülebilir. Ekokardiyografide trikuspid kapak rejurjitan akımı ile karışabilmektedir. Kesin tanısı transözafagial ekokardiyografi ile konulur.

Olgu: 20 yaşında erkek hasta acil servise son zamanlarda artan nefes darlığı ile başvurdu. Hikayesinde biline kardiyak hastalığı yok idi. Başvuru esnasında tansiyon arteriyel 120/80 mmHg, nabız 110/dk idi. Muayenesinde her iki akciğer bazallerinde kreptan raller mevcuttu. Mitral odakta 4/6 şiddetinde sistolik üfürüm duyuldu. Her iki bacakta +/- pretibial ödem mevcuttu. Akciğer grafisinde bir özellik yok idi. Elektrokardiyografisinde sinüs taşikardisi dışında bir bulguya rastlanmadı. Ekokardiyografisinde sol ventrikül çaplarında hafif artış (LVDD:5,8 cm) ve trikuspid kapakta orta şiddette rejurjitan akım tespit edildi. Kesin teşhis için transözafagial ekokardiyografi (TEE) uygulandı. TEE' de sol ventrikül ile sağ atrium arasında çok nadir görülen konjenital defekt izlendi (Gerbode defekt). Hasta stabilize edildikten sonra kalp ve damar cerrahisine yönlendirildi. Opere olan hastanın 6 ay sonraki takiplerinde defekte rejurjitan akım izlenmedi.

Sonuç: Gerbode defekt çok nadir görülen konjenital kalp hastalıklarından biridir. Ventriküler septal defektler arasında sınıflandırılır. Çok sık gözlenmediğinden ekokardiyografide trikuspid rejurjitan akımı ile karışabilir. İlk anda tanı koyabilmek deneyim gerektirmektedir. Gerbode defektler genellikle erken yaşlarda (2-15) bulgu vermektedir. Bizim vakamız 20 yaşında semptomları başlamış idi. Geleneksel tedavisi primer cerrahi olmasına rağmen son zamanlarda peruktan kapama teknikleri uygulanabilmektedir. Nefes darlığı ile acil servise gelen hastalarda gerbode defekt tanısı da göz önünde bulundurulmalıdır.

Anahtar Kelimeler: gerbode defekt, ventriküler septal defekt, akut dispne

P-0930 Cardiovascular Emergencies

Tako-Tsubo Kardiyomiopatisi

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Amaç: Tako-tsubo sendromu koroner arterlerinde anlamlı darlık olmayan kişide, sol ventrikül apikal kısmının, geçici balonlaşması ile karakterize bir sendromdur. Apulla kardiyomiopatisi, insan stres kardiyomiopatisi, kırık kalp sendromu da denmektedir. Bu hastalık nadir görülen fakat hayatı önem taşıyan bir durum olduğu için sunulmak istenmiştir.

Olgu: Otuz yaşında erkek hastada ön planda nefes darlığı, göğüs ve sırt ağrısı şikayeti mevcuttu. Dün akşam yumurta yedikten 1-2 saat sonra şikayetleri başlamış, başka bir hastalık öyküsü ve ilde erken yaşta kalp krizi öyküsü ve ilaç kullanımı öyküsü yoktu.

Hasta bekar, köyde öğretmenlik yapmaktaydı. TA: 130/80 mmHg, NB: 96, Ateş: 36,8, SS: 28

FM: genel durum orta, GKS: 15, terli, interkostal çekimeleri var, burun kanatları hareketli tespit edildi. Akciğerde Bilateral bazallerde minimal kreptan ralleri vardı. Diğer sistem muayeneleri doğaldı. Rutin kan tetkikleri, Arteriyel kan gazı, CRP, Sedim kanları alındı, hasta aort disseksiyonu, pulmoner emboli ön tanıları ile CT ye gönderildi. Normal sonuçlar alınınca Ekokardiyografi planlandı. Sol ventrikül duvar hareketleri deprese bulundu.



POSTER BİLDİRİLER

Sonuç: Tanının atlanmaması için bu tip klinik bulgu ile gelen ve çok rastlanılan tanılar dışlanan hastalarda Tako-tsubo sendromu düşünülerek ekokardiyografik inceleme yapılmalıdır.
Anahtar Kelimeler: Tako-tsubo sendromu, ekokardiyografi, acil servis

P-0931 Other

Acil Servise Başvuran Yılan Sokması Olgularının Değerlendirilmesi

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Amaç: Yılan sokma vakaları özellikle tropikal ve subtropikal iklimin hakim olduğu bölgelerde görülür. Ülkemiz subtropikal iklim hakimiyetinde olup özellikle Akdeniz ve Güneydoğu Anadolu bölgelerinde daha sık olgu görülmektedir. Bu çalışmamızın amacı yılan sokmaları nedeni ile acil servise başvuran 132 hastanın epidemiyolojik ve klinik özelliklerini incelemektir.

Gereç-Yöntem: Bu çalışmada bir yıllık hastanemiz acil servise yılan sokması nedeni ile başvuran 132 hastanın epidemiyolojik ve klinik özellikleri retrospektif olarak incelendi.

Bulgular: Çalışmaya alınan 132 hastanın %76.5'i (n=101) erkek, %23.5'i (n=31) kadındı. Hastaların yaş ortalaması 34.32±20 idi. En genç hasta 3 yaşında, en yaşlısı 84 yaşındaydı. 20 hasta (%15) 12 yaş altında, 14 hasta (%9) 65 yaş üzerindeydi. Yılan tarafından en çok sokulan bölge üst ekstremite idi (%53). Alt ekstremite (%45), baş-boyun (%1), gövde (%0) idi. Hastalarda en sık görülen semptom lokal eritem (%92), lokalize ağrı idi (%90) ve Lokalize ödem (%76) idi. Klinik evrelemede (%42.9)'u Evre 0, (%28.6)'sı Evre I, (%22.1)'i Evre II, (%3.9)'u Evre III, (%2.6)'sı Evre IV olarak sınıflandırıldı. Hastaların %100'üne antibiyoterapi (1000mg amoksisilin+ 200mg klavulanat) uygulandı. Tetanoz profilaksi (%94.7), yılan antivenomu (%46), immobilizasyon amaçlı atel (%27), mannitol (%16), fasyotomi-debridman (%2) uygulandı. Yılan antivenomuna karşı 1 hastada anafilaksi, 1 hastada alerjik bilateral periorbital ödem gelişti. 6 hasta (%4.5) yoğun bakım olmak üzere, 69 hasta (%52) hastaneye yatırıldı. 63 hasta (%48) acil serviste 6 saatlik gözlem sonucu toksikasyon bulgusu gelişmemesi üzerine taburcu edildi.

Tartışma: Yılan zehirinde bulunan hematoksinler eritrositleri, damar endotel hücrelerini, trombositleri tahrip ederler. Hastaların acil servise başvuru anında ortalama hemoglobin (14g/dL) ve hemotokrit (%41.7) olduğu saptandı. Takipte en düşük değerler alındı. İkinci hemogram (12g/dL) ve hemotokrit (%36) olduğu saptandı. 6 hastaya (%5) takipte hemotokrit değerinin aşırı düşmesi nedeniyle Eritrosit Süspansiyonu verildi. Hastalarımızın tamamı şifa ile taburcu oldu. Ölüm vakası görüldü.

Sonuçlar: Yılan sokmalarında her hastaya yılan antivenomu gerekmektedir. Yılan antivenomu endike olduğu durumlarda anafilaktik etkilerinden dolayı kontrollü verilmelidir. Yılan zehirinde bulunan hematoksinler eritrositlerde hemolize neden olduğu için yatan hastalarda günlük hemogram takibi önermekteyiz.

Anahtar Kelimeler: Yılan Sokması, Antivenom, hemoglobin ve hemotokrit düşüklüğü

P-0932 Other

Acil Servise Başvuran Akrep Sokması Olgularının Değerlendirilmesi

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Amaç: Akrep sokmaları vakası özellikle tropikal ve subtropikal iklimin hakim olduğu bölgelerde görülür. Ülkemiz subtropikal iklim hakimiyetindedir, özellikle Akdeniz ve Güneydoğu Anadolu bölgelerinde daha sık olmakla birlikte, Doğu Anadolu, İç Anadolu ve Ege Bölgesinde de görülmektedir. Bu çalışmamızın amacı akrep sokmaları nedeni ile başvuran 467 hastanın epidemiyolojik ve klinik özelliklerini araştırmaktır.

Gereç-Yöntem: Bu çalışmada bir yıllık hastanemiz acil servise akrep sokması nedeni ile başvuran 467 hastanın epidemiyolojik ve klinik özellikleri retrospektif olarak incelendi.

Bulgular: Çalışmaya alınan 467 hastanın %43.5'i (n=203) erkek, %56.5'i (n=264) kadındı. Hastaların yaş ortalaması 33.98±20 idi. En genç hasta 1 yaşında, en yaşlısı 84 yaşındaydı. 38 hasta (%8.1) 7 yaş altı, 38 hasta (8.1) 65 yaş üzerindeydi. Akrep tarafından en çok sokulan bölge alt ekstremite idi (%65.2). Üst ekstremite (%32), gövde (%1.3), baş-boyun (%1.8) idi. Hastalarda en sık görülen semptom lokalize ağrı idi (%77.3). Lokalize ödem (%61.7), uyuşma (%33), bulantı ve kusma (%6), nefes darlığı (%4.1), bilinç değişikliği (%2.6), baş dönmesi (%2.1), halsizlik (%2.1), erkek hastalarda priapizm (%1.47), ateş (%0.2) olarak tespit edildi. Klinik evrelemede (%92)'sı Evre I, (%5)'i Evre II, (%1.5)'i Evre III, (%1.5)'i Evre IV olarak sınıflandırıldı. Hastaların (%74)'üne ağrı kesici tedavi verildi. NSAİİ (%60), narkotik ilaç (%14), lokal anestezi (%10), tetanoz profilaksi (%85.4), akrep antivenomu (%2.1) olarak uygulandı.

Tartışma: Akrep antivenomu olası anafilaksi ve serum hastalığı gibi yan etkilerinden dolayı sadece Evre III ve Evre IV hastalara uygulandı. Toplam 8 hastamızda akrep antivenomu uygulandı. Hiçbirinde akrep antivenomuna karşı alerjik reaksiyon gelişmedi. Hastalarımızın tamamı şifa ile taburcu oldu. Ölüm vakası görüldü.

Sonuçlar: Akrep sokmalarının çoğunda nonspesifik tedavi gerekir. Öncelikli olarak destek tedavisi ve vital bulguların stabilizasyonudur. Ciddi sistemik toksite olan hastalarda kontrollü akrep antivenomu uygulanmalıdır. Lokal semptomu olanlara akrep antivenomu önermemekteyiz.

Anahtar Kelimeler: Akrep Sokması, Antivenom, nonspesifik tedavi

P-0933 Cardiovascular Emergencies

Alerji ve Göğüs Ağrısı: Kounis sendromu

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Giriş: Kounis sendromu, mast hücrelerinin etkinleşmesi ile seyreden alerji, hipersensitivite, anafilaksi veya anafilaktoid reaksiyonlarla ilişkili olarak akut koroner sendrom (AKS) gelişmesi durumudur. Alerjik miyokard infarktüsü (MI) olarak da adlandırılan bu durumun patofizyolojisine ve koroner arter hastalığı varlığına göre iki tipi vardır. Tip I'de aterosklerotik risk faktörleri ve koroner arter hastalığı olmaksızın hastada histamin, tromboksan ve lökotrienler gibi alerjik mediyatörlerin neden olduğu koroner vazospazm mevcuttur. Tip II'de, aterosklerotik koroner arter hastalığı olan hastalarda bu mediyatörlerin tetiklediği koroner vazospazm, plak aşınması veya yırtılması sonucu gelişen AKS söz konusudur. Bu yazıda 1 gram amoksisilin+klavulanik asit içeren tabletin oral olarak alınması sonucu akut ST-segment yükselmeli miyokard enfarktüsü gelişen bir olgu sunuldu.

Olgu: 46 yaşında erkek hasta, 1gr amoksisilin+klavulanik asit alımından yaklaşık 15-20 dakika sonra vücudunda kızamıklık, baş dönmesi, bulantı, kusma, nefes darlığı ve baygınlık geçirme şikayetleri ile yakınları tarafından acil servise getirildi. Hastanın özgeçmişinde her hangi bir hastalık ve kronik ilaç kullanımı yoktu. Fizik muayenesinde arteriyel tansiyon: 70/40 mmHg, nabız 72 vuru/dk, ateş: 37.5°, solunum sayısı: 28/dk ve oksijen saturasyonu: %90 idi. Vücudunda yaygın şekilde, kaşıntılı ürtiker benzeri döküntüler vardı. Çekilen elektrokardiyografide (EKG) DII-DIII ve aVF derivasyonlarında ST-segment yükseliği vardı. Bunun üzerine kardiyoloji kliniği ile konsülte edilen hastanın laboratuvar değerlerinde troponin I ve ck-mb de belirgin bir şekilde artmıştı. Hasta kardiyoloji tarafından koroner anjiyografiye alındı. Sağ koroner arterde % 100 tıkanıklık saptandı. Sağ koroner artere stent yerleştirilerek tama yakın açıklık sağlandı. Koroner yoğun bakım ünitesinde takip edilen hastanın aktif şikayetleri geriledi. Troponin I düzeylerinde düşme saptandı. Transtorasik ekokardiyografide ejeksiyon fraksiyonu: %58 olarak tespit edilirken ayrıca sol ventrikül segmenter duvar hareket bozukluğu saptandı. Koroner yoğun bakımda takibinin ardından hasta şifa ile taburcu edildi.

Sonuç: Alerji nedeni olabilecek etkenlerle karşılaşma sonucu gelişen göğüs ağrısı, hipotansiyon, nefes darlığı, senkop ve EKG değişikliği olan hastalarda Kounis sendromu düşünülmelidir.

Anahtar Kelimeler: Alerji, Göğüs Ağrısı, Akut Koroner Sendrom

P-0934 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

4 yıllık atralji: Multipl miyelom

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Giriş-Amaç: Miyelom, kemik iliğindeki plazma hücrelerinin kanseridir. Genellikle yaşlı hastalarda görülür. Miyeloma hastalarının yaklaşık %90'ında tanı anında birden fazla bölgeyi tutan hastalık mevcuttur; zaman zaman hastalık en yaygın formu olan "multipl miyeloma" ile adlandırılır. "Semptomatik miyelomalı" hastalarda hastalıkla birlikte anemi, kan kalsiyum seviyesinde artış, böbrek hasarı, kemik hastalığı veya sık enfeksiyonlar gibi miyelomayla ilişkili sorunlar vardır. Bazı hastalarda, özellikle yavaş gelişen miyelomalı bireylerin bazılarında herhangi bir belirti ortaya çıkana kadar biraz zaman geçebilir. Bazen de hastalığın tanısı bizim vakamızda olduğu gibi tanı düşünülmemesi nedeniyle yıllarca gecikebilir. Biz bu olgu sunumu ile uzun dönem atralji gibi tedavi edilen myelom vakasını sunarak dikkat çekmeyi amaçladık.

Olgu: 72 yaşında erkek hastanın yaklaşık 4 yıldır devam eden bel ve sırt ve göğüs ağrısı şikayeti ile acil servisimize başvurdu. Öyküsünde bu şikâyetle daha önce fizik tedavi, ortopedi ve beyin cerrahisi polikliniklerine başvuruları olan hastaya, o dönemlerde çekilen MR ve diğer tetkiklerle osteoporoz, bel fıtığı ve torakal ve lomber vertebralarda kompresyon fraktürü tanısı konulup



POSTER PRESENTATIONS

tedavileri planlandığı öğrenildi. Yine benzer ağrıları nedeniyle Kardiyoloji polikliniğe başvurduğu ve koroner anjiyografi yapıp patolojik damar lezyonu saptanmadığı, en son başvurduğu göğüs hastalıkları bölümünde de KOAH tanısı konarak tedavi planlandığı, ancak şikâyetlerinde bir gerileme olmadığı anlaşıldı. Hasta ilaçlarını düzenli kullanmasına rağmen şikâyetlerinde gerileme olmayınca verilen tüm ilaçları kullanmayı bırakıp, dönem dönem ağrıları için acil servise başvurduğu ifade etti. Çalışılan tetkiklerde hemogloblin: 10.83 g/dL (D), sedimentasyon:83 (D), total protein:8.89 g/dL(D), albumin:3.25 gr/dL(D), kreatinin:0.66 mg/dL(N), kalsiyum:8.82 mg/dL(D) saptanan hastada mevcut anamnez, fizik muayene ve laboratuvar bulguları ile multipl myelom olabileceği düşünüldüğü dâhiliye konsültasyonu yapılarak hematoloji bölümü olan bir merkeze sevk edildi. Daha sonrada hastaya multipl myelom hafif zincir evre 3A tanısı konulduğu ve tedavi sonrası hastanın semptomları düzeldiği öğrenildi.

Sonuç: Kemik ağrısı şikâyeti ile polikliniğe başvuran, sedimentasyon yüksekliği, anemisi, albumin/globulin tersleşmesi, patolojik kırık ya da osteoporozu olan yaşlı hastada mutlaka ayrırcı tanıda multipl myelomda düşünülmalıdır. Erken tanı ile hastanın yaşam kalitesi, hemde tedavi maliyetleri azaltılmış olacaktır.

Anahtar Kelimeler: Artralji, Multipl myelom, acil servis

P-0935 Imaging in Emergency Units

Plevral Efüzyon ve Ultrasonografi

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Amaç: Plevral efüzyona bağlı nefes darlığı acil servisin önemli başvuru nedenleri arasında yer alır. Plevral efüzyon varlığında kardiyak ve solunumsal nedenler ayrırcı tanıda birlikte değerlendirilmelidir. Plevral efüzyon nedenleri arasında da kalp yetmezliği, pulmoner emboli, enfeksiyonlar ve kanserler gibi hastalıklar yer alır. Plevral efüzyonun erken tespiti ve masif efüzyonların tedavisi (boşaltılması) yaşamsal tehlikenin giderilmesi için gereklidir. Bu çalışmada akciğer malignitesi bağlı plevral efüzyon gelişen bir hastanın acil serviste ultrason (USG) ile erken tanı ve tedavisi aktarılmaktadır.

Olgu: Nefes darlığı şikâyeti ile acil servise müracaat eden 62 yaşındaki bayan hastanın, Tansiyon arteryal: 80/45 mmHg, ateş:38.5 C, nabız: 134/dk, SpO2: %62 (oda havasında), solunum sayısı: 32/dk olduğu tespit edildi. Hastamızdan akciğer kitlesi nedeniyle patolojik örnek alınmış ve kesin tanı konmamıştı. Semptomatik tedavi alan hasta nefes darlığı şikâyetinin birkaç gündür gittikçe arttığını belirtti. Anstabil durum nedeniyle hasta kritik bakım bölümüne alındı. EKG, kan gazı, rutin biyokimyasal tetkikler, akciğer grafisi planlandı. Lineer prob kullanılarak hasta başı USG tetkiki yapıldı ve sağ akciğer bölgesinde masif plevral efüzyon varlığı tespit edildi. EKO uygulamasında acil kardiyak patoloji görülmedi. Plevral efüzyon pleurocan yardımı ile boşaltılmaya çalışıldı. Aralıklarla 1500 cc boşaltıldıktan sonra hastamızın vital bulgularında düzelleme görüldü. Hasta ileri tetkik ve tedavi için göğüs hastalıkları kliniğine yatırıldı.

Sonuç: Dispne acil bir durumdur. Ayrırcı tanıda kardiyak ve solunumsal hastalıklar öncelikli değerlendirilmelidir. Acil serviste hızlı ve etkin bir şekilde yapılacak torasik ultrasonografi ve eko-kardiyografi ayrırcı tanıda gereklidir. Bu olgularda mutlaka ultrasonografi ile dispneye neden olabilecek plevral efüzyon gibi solunumsal patolojilere yönelik görüntüleme yapılmasının önemli olduğu değerlendirilmektedir. Bizim olgumuzda olduğu gibi masif plevral efüzyon varlığı USG ile kolay ve hızlı bir şekilde tespit edilebilir. Bu işlemlerin acil servislerde etkin ve hızlı bir şekilde yapılması hasta için yaşam kurtarıcı olabilmektedir.

Anahtar Kelimeler: Plevral Efüzyon, Ultrasonografi, Acil Servis

P-0936 Resuscitation

Konuşma tüpünün aspirasyonu:

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Bu çalışmada larinks kanseri nedeni ile trakeostomi kanülü kullanan hastada t konuşma tüpünün aparatının aspirasyonu ile acil servise başvurmış bir vaka tartışılacaktır.

Vaka: 62 yaşında erkek hasta, kliniğimize, bir gün önce aniden başlayan ve şiddetlenen nefes darlığı ve çarpıntı yakınmaları ile başvurdu. Hasta larenks karseri tanısı nedeni ile operasyon geçirip trakeostomi kanülü kullanmakta idi. Başvuru anında kan basıncı 128/68 mmhg, nabız 111/dk, ateşi 36.4 C ve periferik oksijen saturasyonu %82 idi. Fizik muayenede solda akciğer sesleri ileri derecede azalmış ve akciğer bazalinde minimal raller mevcuttu. Elektrokardiyografide sinus taşikardisi vardı. Bir ay önce çekilen akciğer grafisi normal olarak değerlendirilmiş. Acil serviste yeni çekilen konvansiyonel akciğer grafisinde sol akciğerde yaygın ateletaksi mevcuttu. Toraks tomografi ile değerlendirildiğinde sol akciğer hiller alana denk gelen bölgede, metalik dansite ile uyumlu hiperdens görünüm mevcuttu. Yabancı cisim aspirasyonu ön tanısı ile hastaya fleksibil bronkoskopi yapıldı. Bronkoskopi ile çıkarılan objenin konuşma tüpünün uç kısmındaki metal aparat olduğu anlaşıldı. Kontrol akciğer grafisinde her iki akciğer havalanması düzeldi.

Sonuç: Trakeostomi kullanan hastalarda konuşma aparatının aspirasyon riskinin olabileceği hem hastalara anlatılmalı, hem de acil servis çalışanlarına göz önünde bulundurulmalıdır.

Anahtar Kelimeler: larinks kanseri, trakeostomi, konuşma tüpü, aspirasyonu, acil servis

P-0937 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Minör Travmaya İkincil Gelişen Sol Karotid ve Bilateral Vertebral Arter Diseksiyonu Olgusu

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Arka plan: Karotid ve vertebral arter diseksiyonu (KVAD), genç hastalardaki inmelerin yaklaşık %25'inden sorumludur. Öksürme, hapşırma, hıçkırık, boynun geriye atılması gibi minör travmaya ikincil ya da kendiliğinden gerçekleşebilir. Erken tanı, görüntülemenin zamanlaması, tedavi iskemik komplikasyonların önlenmesinde önemli rol oynar. Burada, migreni olduğu bilinen, minör travma sonrası, bilateral vertebral arter ve sol internal karotid arter olmak üzere 3 damarda diseksiyon saptanan olgu sunulmaktadır.

Olgu: Otuz dört yaşında kadın hasta, bir haftadır sağda boyundan enseye ve sağ kola yayılan ağrı yakınmaları ile Acil servisimize başvurdu. Hastanın tanıdığı, yarım, zonklayıcı, fonofobi, fotofobinin eşlik ettiği, ilaç alımı sonrası rahatlayan migren ataklarından farklı olarak, sürekli, ilaca yanıt vermeyen farklı nitelikte baş ağrısı yakınması vardı. Yaşamsal bulguları normaldi, nörolojik muayenesinde patolojik bulguya rastlanmadı. Hastanın şikâyetleri ensede lokalize olduğu ve kola yayıldığı için öncelikle servikal radikulopati düşünüldüğü servikal Magnetik Rezonans (MR) incelemesi yapıldı. Yağ baskılı T1 sekansında diseksiyon saptanması üzerine ileri tetkik planlandı. Hastanın kraniyal MR ve difüzyon incelemesi normal bulundu. Kraniyal MR anjiyografide sağda vertebral arter proksimalinde, solda vertebral arter distal kesiminde daha belirgin subintimal hematoma eşlik ettiği diseksiyon, sol Internal Karotid Arter petroz segmentinde lümende % 90 daralmaya neden olan diseksiyon saptandı. Hikaye derinleştirildiğinde yakınmaları başlamadan önce hastanın kuaföre gittiği boynu geriye eğik pozisyonunda uzun süre kaldığı; saçlarına boya ve yıkama işlemlerinin uygulandıktan sonra aynı pozisyonunda zorlanarak dolaşık saçlarının tarandığı öğrenildi. Altı aylık varfarin tedavisi sonrası yapılan servikal MR anjiyoda diseksiyon bulgularının tamamen düzeldiği görüldü.

Tartışma: Genç hastalarda inme etyolojisinde önemli yer tutan servikal diseksiyon, özellikle migren öyküsü olduğu bilinen hastalarda kolaylıkla atlanabilir ya da enseden başlayan ağrı servikal radikulopati olarak düşünülebilir. Acil hekimleri açısından daha önce baş ağrısı öyküsü olan genç olgularda hastanın tanıdığı ağrının başvuru sırasındaki ağrı ile benzer özellikte olup olmadığının ve travma öyküsünün sorgulanması kritik öneme sahiptir. Olgumuz görüntüleme yöntemiyle tanı konulabilen ve tedavi edilebilir şanslı olan bu klinik antitenin önemini vurgulanması amacı ile sunulmuştur.

Anahtar Kelimeler: Karotid, vertebral, arter diseksiyonu, kraniyal MR

P-0938 Imaging in Emergency Units

Üst Solunum Yolu Enfeksiyonunun Nadir bir Komplikasyonu; Epidural- Subdural Ampiyem

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Amaç: Ampiyem boşlukların enfeksiyonudur. Kemik ile dura arasındaki boşluğun pürülan enfeksiyonu epidural ampiyem, dura yaprakları arasındaki boşluğun enfeksiyonu ise subdural ampiyem olarak adlandırılır. Epidural ampiyemler oldukça nadirdir, ancak tüm intrakranial enfeksiyonların % 30'nu oluştururlar. Her yaşta ve cinsiyetler arasında eşit görülür. Hastalığa en sık yol açan patojenler streptococci, Haemophilus influenzae, Staphylococcus aureus ve Staphylococcus epidermidistir. Epidural ampiyemli olguların yaklaşık 2/3'si sinüzit komplikasyonu, %

POSTER BİLDİRİLER

20'si ise mastoidit komplikasyonları sonucu meydana gelir. Epidural ampiyemler ayrıca travmatik beyin hasarı, beyin cerrahisi operasyonları veya menenjitin bir komplikasyonu olarak ortaya çıkabilir. Bu olguda ÜSYE tedavisi sonrası şikayetleri geçmeyen ve komplikasyon olarak intrakranial ampiyem gelişen hasta sunuldu.

Olgu: 6 yaşında kız çocuğu, 1 hafta önce ÜSYE geçirmiş ve medikal tedavi başlanmış. Ancak hasta baş ağrısı, gözünde şişlik olması ve nöbet geçirme şikayetiyle acil servise başvurdu. Acil serviste çekilen BBT'de Bilateral epidural apse ile uyumlu görüntü saptanması üzerine hasta Beyin Cerrahi Bölümüne konsülte edildi. KBB bölümünde konsülte edilen hastanın otolajik ve rinolajik muayenesinde sağda periorbital sellülit dışında herhangi bir enfeksiyon odağı saptanmadı. Hastanın yapılan tetkiklerinde EKO'da enfektif endokardit izlenmedi. Hastanın yapılan Lab. tetkiklerinde WBC 17.640, CRP: 98, sedim 51 saptandı. Beyin cerrahi tarafından operasyon amacıyla hospitalize edilen hasta bikoroner cilt insizyonu sonrası sarı renkli mukoid kıvamda koyu kıvamda pürülan materyalin oluşturduğu sağ frontalde epidural apse, solda frontalde subdural apse boşaltıldı (Resim1). Operasyon esnasında alınan materyalin kültür incelenmesinde staph.aureus enfeksiyonu saptandı. Operasyon sonrası hasta 3 hafta IV, 6 hafta ise oral antibiyoterapi aldı. Hastanın takiplerinde ek problemi olmadı.

Sonuç: İntrakraniyal enfeksiyonlar taşıdıkları yüksek morbidite ve mortalite nedeniyle erken tanınmaları ve tedavi edilmeleri gereken hastalıklardır. ÜSYE sonucu şikayetleri geçmeyen hastalarda Epidural Ampiyem düşünülmelidir

Anahtar Kelimeler: Epidural ampiyem, baş ağrısı, nöbet

P-0939 Other

Psikojenik polidipsi: Nadir karşılaşılan formda bir olgu örneği

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Amaç: Psikojenik polidipsi herhangi bir fizyolojik uyarıcı olmadan fazla su içmeyle karakterize, az rastlanan klinik bir durumdur. Bu hastalarda aşırı sıvı alımı çoğu zaman hiponatremiye neden olmaksızın iyi tolere edilmektedir. Burada nadir karşılaşılan formda bir olgu örneğiyle konuya dikkat çekmeyi amaçladık.

Olgu: Acil servise nefes darlığı ve bilinç bulanıklığı şikayetleriyle getirilen 34 yaşında erkek hasta yakın izleme alındı. Yakınlarına göre hastada davranış bozuklukları olduğu ancak bu durumu kabullenmediği ve herhangi bir tedavi almadığı öğrenildi.

İlk değerlendirmesinde hastanın konfüze ve dispneik olduğu ayrıca idrar inkontinansı olduğu gözlemlendi. Ateş yüksekliği olmayan hastada ılımlı taşikardi ve hipertansiyon gözlemlendi. Ayrıca oksijen saturasyonu 88 olarak ölçüldü. Koopere olmayan ve ajite davranışlar sergileyen hastada dinlemekle akciğer sesleri kabalaşmış olarak alındı. Arteriyel kan gazında pH: 7.14, PaO2:79.8 mmHG, PCO2: 30.8 mmHG ve HCO3: 10.6 mEq/L olarak ölçüldü.

Mevcut bulgularla overvolemi olduğu düşünülen ve idrar çıkışı olan hastaya antiödem tedavi başlandı. Hastanın serum Na seviyesi 112 mmol/L, K: 3.2 mmol/L, CL:92 mmol/L olarak ölçülmesi üzerine tedavisine hipertonic salin eklendi. Semptomlarında düzelme gözlenen ve asidozu gerileyen hastanın yapılan görüntülemelerinde akut akciğer ve beyin ödemi bulguları gözlemlendi. Takibinde iletişim kurulabilen hastadan birkaç saat içerisinde yaklaşık 12 litre su içtiği öğrenildi. Hasta daha önce de aşırı su içme isteği olduğunu ve son dönemde bunun giderek arttığını ifade etti. Genel durumunda düzelme olan hasta, polidipsi etyolojisi araştırılmak üzere iç hastalıkları servisine alındı. Yapılan ayrıntılı incelemeler sonunda organik bir sebep saptanmadı. Psikiyatrik değerlendirme sonrası hastada psikojenik polidipsi düşünüldü ve bu açıdan ayakta takibe alındı. Takibinde ayrıca şizoid kişilik bozukluğu teşisiyle hastaya tedavi başlandığı öğrenildi.

Sonuç: Acil serviste sık karşılaşılan dispne ve bilinç bulanıklığı ayırıcı tanısında nadir görülmesine karşın psikojenik polidipsi ve buna bağlı dilyusyonel hiponatremi aklıda tutulmalıdır. Bu açıdan hastanın klinik durumu yanında önceki yaşantısına ait ayrıntılı anamnez alınması yol gösterici olacaktır.

Anahtar Kelimeler: Psikojenik polidipsi, hiponatremi, beyin ödemi, akciğer ödemi

P-0940 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Her intrakranial lezyon Tümör müdür?

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Santral Sinir Sistemi (SSS) enfeksiyonları tüm hastane yatışlarının % 1'inden azını oluşturmaktadır. Ancak morbidite ve mortalite oranları oldukça yüksektir. Beyin apsesi beyin parankiminin pyojenik fokal enfeksiyonudur. Daha çok sinüzit,otitis media,mastoidit ve diş kökü enfeksiyonları gibi enfeksiyöz ajanların direk yayılımı ile gelişir. Kronik akciğer enfeksiyonları, enfektif endokardit, batin içi enfeksiyonlar ve siyanotik kalp hastalığı gibi hematogen yayılım ile de gelişebilir. Hematojen yayımda genellikle multipl lezyonlar görülür ve daha çok orta serebral arterin suladığı alanda görülür. En sık etkenler anaeroblar ve gram pozitif koklardır. En sık frontal, temporal ve pariyetal loblarda görülür. Mortaliteyi etkileyen başlıca faktörler; hastanın şuur düzeyi, multiple beyin apselerinin olması ve hematogen yayımdır. Geç dönemde epilepsi ve davranış bozukluklarına sebep olmaktadır.

Olgumuz 40 yaşında erkek hasta bilinç bulanıklığı şikayeti ile acil servisimize 112 tarafından getirildi. Dış merkezde intrakranial kitle? beyin metastazı? tanısıyla takip ediliyor. hastaya PET CT çekilmiş. Hastanın beş önce dış merkezde çekilen beyin BT'nde sol hemisferde 3 adet lezyonu vardı. Hastanın bilincinde hızlı kötüleşme olması üzerine hastaya acilde beyin BT çekildi. Hastanın lezyonlarının 5 gün önceye göre dramatik bir şekilde büyüdüğü, etrafında yaygın ödem geliştiği, ve aynı zamanda şift yaptığı tespit edildi.

Hiçbir agresif tümörün beş günde böylesine hızlı bir şekilde büyümesinin söz konusu olmadığından ayrıca hastanın bir yıl önce TBC öyküsünün bulunduğu göz önüne alınarak ön planda apse? düşünüldü. Kontrastlı beyin BT çekildi. Çekilen beyin BT'sinin apse ile uyumlu olması üzerine beyin cerrahi tarafından acil operasyona alındı.

Sonuç olarak her gün acil servislere çeşitli merkezlerden, çeşitli tanımlarla çok sayıda hasta gelmektedir. Acil servis hekimlerinin gelen her hastayı bir bütün olarak yeniden değerlendirmesi gerekmektedir. Hastaların dış merkezde aldığı tanıya dikkat etmekle beraber alternatif tanıları da düşünmek gerekir

Anahtar Kelimeler: acil servis, beyin absesi, intrakranial kitle

P-0941 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Sol internal karotis arter total oklüzyonu vakası

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İnme genel olarak beyine giden kan akımının kesintiye uğraması sonucu oluşan bir hastalıktır. İnmenin tanısı ve tedavisi, beynin ilgili vasküler kanlanma alanlarının ve nöroanatominin bilinmesiyle başlar. İnme iki temel mekanizma ile oluşur ve sınıflandırılabilir: iskemi ve hemoraji. İskemik inme bütün inmelerin % 87'ni oluşturur ve trombotik, embolik mekanizmalar veya hipoperfüzyona bağlı meydana gelir.

Olgumuz 88 yaşında erkek hasta yeni başlayan şiddetli boyun ağrısı nedeniyle yakınları tarafından bir ilçe hastanesine götürülüyor. Orada tetkik ve tedavileri yapılırken bilincinde kötüleşme olması üzerine acil servisimize getiriliyor. Geliş fizik muayenesinde Glasgow Koma Skalası(GKS):E2V2M4:8 pupiller sola devie ve miyotik idi. Sağ tarafta motor defisiti mevcut. Ön tanıda Serebrovasküler hastalık(SVH) düşünülen hastaya bilgisayarlı Beyin Tomografisi(BBT) çekildi. BBT'si normal olan hastada karotis arter oklüzyonu düşünülerek İV kontrastlı beyin ve boyun BT anjiyografi çekildi. Çekilen anjiyo sonucunda beyin sol hemisferinde dolum defekti ve sol internal karotis arterde oklüzyon saptandı. Heparinize edilen hasta nöroloji ve kalp damar cerrahisi ile konsülte edildi. Hasta nöroloji yoğun bakımına yatırıldı.

Sonuç olarak çok nadir görülen karotis arter oklüzyonları şiddetli boyun ağrısı ile gelen, nörolojik muayene bulgusu olan hastalarda mutlaka düşünülmesi gereken acil bir durumdur. Acil servis hekimleri bu konuda dikkatli olmalıdır.

Anahtar Kelimeler: acil servis, karotis arter oklüzyonu, iskemik inme

P-0942 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Acil serviste Posterior Reversible Ensefalopati Sendromu olgusu: PRES

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Posterior reversible ensefalopati sendromu (PRES); baş ağrısı, bilinç bulanıklığı, epileptik atak, görme kaybı ve bulantı kusma ile seyreden geçici bir klinik durumdur. Sıklıkla ani gelişen hipertansiyon eşlik etmektedir. Hipertansif ensefalopati, eklampsi- preeklampsi, siklosporin A toksisitesi, akut glomerülonefrit ve otoimmün hastalıklarda ortaya çıkabilir. Tanıda klinik şüphe ve MR önemlidir. Tedavi altta yatan nedenin öncelikle ortadan kaldırılmasıdır.

Olgumuz 30 yaş bayan hasta. Acil servise baş ağrısı bulantı ve kusma şikayeti ile başvurdu. Genel durumu iyi bilinç açık oryante, koopere olan hastanın TA: 180/90 mmHg, nörolojik mua-



POSTER PRESENTATIONS

Yenesinde bir özellik yoktu. Yapılan sorgulamada bekar olduğunu ve gebelik durumu olmadığını belirten hastaya beyin BT çekildi. Beyin BT'si normal olan hastaya antihipertansif başlanarak hasta gözleme alındı. Acil takibinde hastanın önce görme kaybı gelişti ve sonrasında epileptik atak geçirmesi üzerine hastaya beyin MR çekildi. MR sonrası PRES sendromu tanısıyla nöroloji kliniğine yatırıldı.

PRES tanısı klinik bulgular, etyolojik nedenler ve nöro radyolojik bulgularla birlikte konulmakta. Erken tanı ve tedavi oluşabilecek ciddi sekelleri önlemekte. Olgumuzda; nadir görülen bu klinik durumun acil serviste erken tanınmasının önemi üzerinde durduk

Anahtar Kelimeler: posterior reversible ensefalopati sendromu(PRES), acil servis, epileptik atak, görme kaybı

P-0943 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Ateş ve Bilinç Bulanıklığıyla Başvuran Travma Öykülü Olguda Saptanan Dalak Absesi

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Giriş ve Amaç: Dalak absesi, nadir görülen, tanı ve tedavisi zor, genellikle ölümcül olan bir durumdur. Sıklığı otopsi serilerinde %0.2-0.7 arasında değişmektedir. Dalak abselerinin %70'e yakını uzak bir primer septik odaktan hematolojik olarak yayılan bakteriler sonucu gelişir. Endokardit, pyelonefrit ve intravenöz ilaç kullanımı bunlara sebep olabileceği gibi travma, orak hücreli anemiye bağlı enfarktler ve primer dalak kistlerine bağlı dalak hematomları da diğer nedenler arasındadır.

Bu yazımızda, acil servise bilinç bulanıklığı ve ateş yüksekliği başvuran travma öyküsü bulunan hastada, saptanan dalak absesi olgusunu sunmayı amaçladık.

Olgu sunumu: Yaklaşık 1 ay önce araç içi trafik kazası öyküsü olan 53 yaşında erkek hasta son bir haftadır devam eden ateş yüksekliği ve bilinç değişikliği yakınmalarıyla kliniğimize başvurdu. İlk fiziki bakıda, hastanın genel durumu orta, şuuru açık, pupiller izokorik, GKS 15 idi. Vital bulguları; kan basıncı 130/80 mmHg, kalp tepe atımı 112/dk, ateş: 38,7°C, solunum sayısı 32/dakika idi. Solunum sistemi muayenesinde sol meme 2 cm altında palpasyonla hassasiyet ve takipne dışında özellik tespit edilmedi. Kardiyovasküler sistem muayenesinde oskültasyonda kalp ritmik ve taşikardik idi. Nörolojik sistem muayenesinde nörolojik defisit ve ense sertliği yoktu. Karın ve lokomotor sistem muayenelerinde özellik tespit edilmedi.

Yapılan laboratuvar incelemeleri: WBC: 5170, Hb: 9.58, CRP: 7.04, pH: 7.50, pO2 67.9, pCO2 24.5, SO2 66.2. Tam idrar tahli ve idrar direk bakısı normal olarak değerlendirildi.

PA-AC grafisinde, sol tarafa eskiye ait multipl kot fraktürleri saptandı. Kranial BT'sinde özellik olmayan hastada bilinç değişikliğini açıklamak için Diffüzyon MR çekildi ve normal olarak değerlendirildi. Takipne ile beraber arter kan gazlarında hipoksisi ve hipokarbisi olan hastada pulmoner tromboemboli şüphesiyle Kontrastlı Toraks BT çekildi. Pulmoner tromboemboli saptanmayan hastanın üst batından geçen kesitlerinde dalak boyutlarının arttığı ve 20x14 cm boyutlarında içerisinde hava sıvı seviyelenmesi ve hava habbecikleri içeren dalak apsesi ile uyumlu kistik görünüm saptandı. Parenteral antibiyoterapi başlandı. Takip ve tedavi amaçlı genel cerrahiye konsulte edilen hastaya splenektomi yapıldığı ve 1 hafta sonra şifa ile taburcu edildiği öğrenildi.

Dalak abseleri erken dönemde bulgu veremeyebilir ve belirtileri nonspesifik olabilir, ancak genellikle hastalarda ateş, lökosit ve sol-üst kadranda ağrısı mevcuttur. Hastalarda splenomegali bulunma sıklığı yaklaşık %40'dır. Dalak absesi düşündürülecek diğer belirtiler; sol omuz ağrısı ve sol diaphragmada yükselme veya sol plevral effüzyonu gösteren göğüs grafileridir. Başlangıçta tanıda dikkatler primer septik odağa çevrildiği için splenik enfeksiyon tanısı sıklıkla atlanır. Erken tanıda karın BT oldukça önemlidir. Dalak absesi tanısı konulduğunda tedavide geniş spektrumlu antibiyotikler başlanmalıdır. Bununla birlikte, dalak abselerinin büyük çoğunluğunda splenektomi altın standarttır.

Sonuç olarak, travma öyküsü bulunan ve nedeni bilinmeyen ateş yakınmaları olan hastalarda dalak absesininde akılda bulundurulması gereken ayırıcı tanılardan biridir. Biz bu olgu sunumu ile acil servislere nadir görülen bir klinik durumun oluşumunu sağlayan nedenlerinden biri olan travmaya dikkat çekmek istedik.

Anahtar Kelimeler: Dalak absesi, Travma, Nedeni bilinmeyen ateş

P-0944 Imaging in Emergency Units

Parmak burkulmalarının yönetiminde yatak başı USG kullanımı

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Amaç: Elde yaralanmaları en sık parmaklarda olur(1). Parmak burkulmaları gençlerde ve özellikle spor yaralanmalarında sık gözlenir. İkinci ve beşinci parmak burkulmaları en sık(2). En sık proksimal interfarengial eklem etkilenir(1). Yanılamama mekanizması genellikle hiperekstansiyona bağlıdır. Fraktür gözlene bilmesine rağmen sık değildir. Klinik değerlendirme de aşkar deformitesi olan hastalar dışında sprain ile anlaşılan fraktür ayırımı yapacak bulgu yoktur(3). Bu hastaların çoğunluğuna günlük pratikte X-ray çekilmektedir. Ultrasonografi (USG) ucuz ve yüksek görüntü kalitesi vermesi yanı sıra kemik yapı ile birlikte yumuşak dokuyu ve ligamentöz yapıların değerlendirilmesine de imkan tanır. USG kullanımı hastaları özellikle gençleri radyasyondan maruziyetinden korur

Olgu: 12 yaşında erkek hasta basketbol oynarken sağ el ikinci parmağına top çarpması sonucu acil servise başvurdu. Sağ el ikinci parmak proksimal interfarengial eklem şiş, ödemli ve ağrılıydı. Eklem hareket açıklığı kısıtlı idi. Palpasyonla krepitasyon tespit edilmedi. Hastaya yatak başı USG ile değerlendirildi (figür-1). USG ile fraktür saptanmadı, eklem ve çevresinde sıvı koleksiyonu gözlemlendi. Daha sonra çekilen X-ray ile de fraktür saptanmadı (figür-2). Diğer olgu 3 yaşında kız benzer hiperekstansiyon yaralanması nedeniyle acil servise başvurdu. Yatak başı USG ile proksimal falanks proksimalinde fraktür saptandı, bu bulgu X-ray (fig3-4) ile doğrulandı. Her iki hastaya parmak ateli uygulandı ve poliklinik kontrol ile taburcu edildi.

Sonuç: Günümüz acil tıp pratiğinde yatak başı USG kullanımı, acil hekiminin vazgeçilmez muayeneye yardımcı yöntemi olmuştur. Açıklanamayan hipotansiyon, dispnenin ayırıcı tanısında, travmaya yönelik odaklanmış USG gibi birçok alanda acil hekimleri hasta yönetiminin önemli bir parçası olarak yatak başı USG kullanmaktadır(4). Son zamanlarda minör travmalı hastalarda kemik yapıların ve yumuşak dokuların yatak başı USG ile değerlendirilmesi gündemdedir(5).

Parmak burkulmaları özellikle genç sporcularda sık gözlenen bir yaralanmadır. Parmak yaralanmalarında en sık proksimal interfarengial eklem etkilenir. En fazla hiperekstansiyona bağlı yaralanma gerçekleşir. Fizik muayenede kırık varlığını öngörecektir veya hangi hastaların direkt grafi ile değerlendirilmesi gerektiği konusunda literatürde yeterli veri yoktur. Hastaların tedavilerinin temelini X-ray de fraktür varlığı veya yokluğu belirler. Bu hastaların sprain ve minör fraktürleri konservatif tedaviye iyi yanıt verirler. Deformite yaratan, eklem bütünlüğünü bozan, rotasyon gösteren kırıklara cerrahi girişim gerekir.

Literatürde yatak başı USG ile birçok anatomik bölge yaralanmalarının etkili ve yeterli değerlendirildiği gösterilmiştir(2). Parmak burkulmalarında özellikle proksimal interfarengial eklem yaralanması olan hastaların değerlendirilmesinde yatak başı ultrasonografi kullanımı ucuz, yüksek görüntü kalitesi ile kemik yapı ile birlikte yumuşak doku ve ligamentöz yapıların değerlendirilmesine imkan tanır. Ve hastaları özellikle gençleri radyasyon maruziyetinden korur.

Anahtar Kelimeler: parmak burkulması, yatak başı USG, hiperekstansiyon

P-0945 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Görüntüleme Yeterli mi?: Acil Serviste Bir İskemik Serebrovasküler Hastalık Olgusu

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Amaç: Serebrovasküler hastalık(SVH); beyin damarlarının tıkanması veya kanaması sonucunda meydana gelen, kısmi veya tam felç olarak tanımlanabilir. Acil servislere tani için görüntüleme yöntemleri olarak magnetik rezonans (MR) ve bilgisayarlı tomografi(BT) kullanılmaktadır. Akut iskemik immede hastaların yaklaşık %50'sinde kranial BT inceleme normal olarak bulunur. Erken dönemde diffüzyon MR görüntüleme ile iskemik beyin bölgesi ilk dakikalardan itibaren belirlenebilir. Ancak enfarkt boyutunun yeri ve boyutu, akut iskemi tanısının erken dönemde konmasını güçleştirir. Bu durumda hastanın anamnez ve klinik muayenesi tanıda önem kazanmaktadır. Acil servisimize SVO ön tanısı ile getirilen ve yapılan ilk görüntülemelerinde acil patoloji saptanmayan ancak takiplerinde yapılan kontrol MR görüntülemesinde iskemi saptanan olgumuzu sunmak istedik.

Olgu: Yetmiş dört yaşında erkek hasta, acil servisimize başvurudan 4 saat önce başlayan, baş dönmesi, sağ üst ekstremitede olan kuvvet kaybı ve uyuşma şikayetiyle yakınları tarafından getirildi. Fizik muayenesinde, vital bulgular; nabız 80/dakika, tansiyon arteriyel 110/70 mm-Hg, kan glukozu 179 mg/dl. idi. Nörolojik muayenesinde sağ üst ekstremitede 3/5-4/5 motor kuvvet tespit edildi. Diğer sistem muayenelerinde patolojik bulgu saptanmadı. Hastanın bakılan tam kan ve biyokimya değerleri normaldi. Çekilen elektrokardiyografisinde özellik yoktu. Hastanın kontrastsız kranial BT'sinde; bilateral periventriküler beyaz cevher alanlarında, sentrum semiovalelerde ve bazal ganglionlar düzeyinde kronik iskemik gliotik değişiklikler ile uyumlu hipodens görünüm tespit edildi. Nöroloji konsültasyonu istenen hastaya diffüzyon MR istendi. 6.saatte çekilen ilk diffüzyon MR'da; akut iskemi ile uyumlu görüntü izlenmedi. 10. saatte çekilen ikinci diffüzyon MR'ında; bulbus santralinde milimetrik boyutlu DAG serilerde diffüzyon kısıtlılığı gösteren ADC serilerde sinyalsiz olarak izlenen patolojik intensite izlendi. Hasta SVH tanısı ile nöroloji kliniğine yatırıldı.

Sonuç: Acil servislere hastaların tanıları koymada tetkik ve görüntüleme yöntemlerinin yardımcı olacağı, asıl olanın hastanın kliniği olduğu unutulmamalıdır. Olgumuzda da olduğu gibi tetkikle hasta değerlendirilmesinin; hastanın yatış için acilde kalış süresini uzatacağı ve tedavisinin başlanmasında gecikmelere neden olabileceği akılda tutulmalıdır. Bu konuda acil servis ve nöroloji hekimlerine büyük görev düşmektedir.

Anahtar Kelimeler: Acil servis, İskemik, Magnetic Rezonans, Serebrovasküler Hastalık



POSTER BİLDİRİLER

P-0946 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Acil Serviste Hipertrigliseridemi Tedavisinde İnsülinin Yeri

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Giriş: Kan lipid değerlerinin yüksekliği kalp damar hastalıklarına zemin hazırlarken, trigliserid düzeyinin 500 mg/dl üzerinde olması nonbilyer akut pankreatit gelişiminde önemli risk faktörüdür. Trigliserid >800 mg/dL geçtiğinde pankreatit riski klinik açıdan önem kazanır ve akut pankreatiti önlemeye yönelik girişimler zorunlu hale gelir. Hipertrigliseridemisinin, tüm pankreatit olgularının yaklaşık %10'unu oluşturması kayda değerdir. Hiperlipidemik hastaların %12-38'i arasında akut pankreatit gelişimi izlenmiştir. Komplikasyon gelişmesini engellemek amaçlı hızlı trigliserid kontrolü önemlidir. Niasin ve fibratlar özellikle trigliserid üzerine etkili preparatlardır. İnsülin ve heparinin etkisi üzerine yayınlar vardır. Acil durumlarda kısa süreli veno-venöz hemofiltrasyon ve plazmaferez de trigliserid düzeylerini hızla düşürebilir.

Olgu: Orta yaş erkek hasta, poliklinik kontrolü sırasında, trigliserid düzeyinin 3326 mg/dl, glukozunun 286 mm/dl saptanması üzerine ayakta acil servisimize yönlendirilmişti. Özgeçmişinde daha önce de hiperlipidemi nedeni ile fibrat kullanımı olduğu fakat alerjik reaksiyon geliştiği için kullanımın kesildiği öğrenildi. Fizik muayenesinde bir özellik olmayan, idrarda ketonu ve kan gazında asidozu saptanmayan hastaya, hiperlipidemi ve hipertrigliseridemi için başladığımız insülin infüzyonuna, normoglisemik olmasına rağmen devam edildi. Takiplerinde 4-6 ünite/saat kristalize insülin ve 30-40 cc/saat %10 dextroz infüzyonları ile normoglisemik seyreden hastanın 12. Saat kontrol trigliserid düzeyi 1620mg/dl bulundu. Tedavisinin devamı ve takip için dahiliye servisine yatırıldı.

Tartışma: Hipertrigliseridemi ile seyreden pek çok sekonder neden (diyabetes mellitus, üremi, kortikosteroid fazlalığı, ekzojen östrojenler, alkol tüketimi, nonalkolik steatohepatit, nefrotik sendrom, akromegali, hipotiroidizm, tiiazid diüretikler, beta adrenerejik blokerler) olduğu gibi, primer nedenler de vardır. Ailesel disbetalipoproteinemi, lipoprotein lipaz ve kofaktörü olan apolipoprotein CII eksikliği, endojen ve mikst lipemiler, familiyal kombine hiperlipidemiler bunlardan bazılarını oluşturur. Tip 1 diyabetes mellitusta diyabetik lipidemi (şilomikronemi sendromu) denilen tabloda 2000 mg/dL'nin üzerinde serum trigliserid düzeyleri olabilir. Tip 2 diyabetes mellitusta orta düzeyde hipertrigliseridemi vardır. Hastamızın diyabet öyküsü olmamasına rağmen yeni tanı diyabetes mellitusa bağlı hipertrigliseridemi düşünülmüştür. Üremide orta düzeyde artmış VLDL'den, insülin rezistansı ve bozulmuş VLDL katabolizması sorumludur. Hastamızın üremi ve proteinürisi yoktu. Alkol, özellikle zeminde hiperlipidemisi olan bireylerde düzey artışlarına neden olmaktadır. Hasta, diüretik, betabloker ilaç veya alkol kullanım öyküsü vermemektedir. Bilinmesi gereken diğer bir ayrıntı da, şiddetli akut pankreatite rağmen, hiperlipidemik plazmada serum pankreatik enzimlerinin ölçümünün yanlış düşük sonuç verebileceği ve bundan dolayı bu olgularda pankreatit sırasında enzim düzeylerinin normal bulunabileceğidir. Bizim olgumuzda da pankreatit enzimleri normal düzeylerdeydi.

Sonuç olarak, komplikasyon gelişmesini engellemek için, acil servislerde hızlı trigliserid kontrolü önemlidir. Hipertrigliseridemi zemininde gelişen tablolarda, özellikle de diyabetik hastalarda insülin tedavisi hasta normoglisemik olsa bile yararlıdır ve uygulanmalıdır.

Anahtar Kelimeler: Hipertrigliseridemi, insülin tedavisi, nonbilyer akut pankreatit

P-0947 Cardiovascular Emergencies

Acil Serviste Brugada Sendromu

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Amaç: Brugada Sendromu, tipik EKG bulgularıyla karakterize, senkop ve ani ölüme sebep olabilen bir hastalıktır. Hastalığın yılda 4-10/10.000 ani ölüme neden olduğu tahmin edilmektedir. En sık erkeklerde ve 4. dekadada görülür. Hastalar genellikle asemptomatik ve normal fizik muayene bulguları vardır. Genellikle rutin çekilen EKG'lerde tesadüfen tanınırlar. Tipik EKG bulguları inkomplet sağ dal bloğu ve anterior prekoridal derivasyonlarda ST segment elevasyonudur. Bu hastalar ventriküler fibrilasyon gelişmesi açısından risk altındadır. Spontan veya indüklenbilir ventriküler aritmisi olan hastalar ani kardiyak ölüm açısından risklidir ve Implantable Cardioverter Defibrillator (ICD) ile tedavi edilmelidir. EKG çekimi esnasında tesadüfen tanı alan asemptomatik hastalar, kardiyojloji kliniğine yönlendirilmeli ve hastalık hakkında mutlaka bilgilendirilmelidir.

Olgu: 60 yaşında erkek hasta ateş, halsizlik, idrar yaparken yanma şikayeti ile bir sağlık merkezine başvurmuş, tedavisi başlanmış. Ancak hasta şikayetlerinin geçmemesi, artması üzerine acil servisimize başvurmuş. Öz ve soy geçmişi hakkında özellik bulunmayan hastanın genel durumu iyi, şuurlu, kooperatif, oryante, TA: 100/60 mmHg, Nb: 100 atım/dk, A:37,8°C, SatO2: %96 idi. Sistem muayenesinde patoloji tespit edilmedi. Damar yolu açılan hastaya sıvı tedavisi başlandı, monitörize edildi. Hastanın çekilen EKG'sinde NSR, V1 V2 V3'te sağ dal bloğu, ST yükseliği ve T negatifliği görüldü. Gönderilen tetkiklerinde wbc 12000, idrarda lökosit tespit edildi, kardiyak enzimleri normal sınırlardaydı. Hasta kardiyak enzim ve EKG takibine alındı. Kardiyojloji kliniği ile konsulte edildi. Kardiyak enzim ve EKG takiplerinde değişiklik olmadı. Hikayesinde çarpıntı ve bayılma, soygeçmişinde ani ölüm olmayan hasta asemptomatik Brugada Sendromu olarak kabul edildi. Hastanın enfeksiyonuna yönelik tedavi verildi ve hastalığı hakkında bilgilendirilerek, önerilerle taburcu edildi.

Sonuç: Çoğu zaman asemptomatik Brugada Sendromu, acil servislerde rutin EKG çekimlerinde tesadüfen tespit edilmektedir. Asemptomatik ve ailede ani ölüm öyküsü olmayan hastaların mortalite oranları, semptomatik ve aile öyküsü olanlara kıyasla daha düşüktür. Bu nedenle brugada sendromunun tek tedavisi olan ICD uygulaması asemptomatik hastalarda önerilmemektedir ve bu hastalar önerilerle, hastalıkları hakkında bilgilendirilerek taburcu edilmektedir.

Anahtar Kelimeler: asemptomatik, Brugada Sendromu, EKG bulgusu

P-0948 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Karın ağrısının farklı bir nedeni: Rabdomiyoliz

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Amaç: Karın ağrısı yakınması acil servise başvuruların başında gelmektedir. Tüm acil servis başvurularının %5-8 ini oluşturur. Rabdomiyoliz (RML), iskelet kasının hasara uğramasından sonra hücre içeriğinin serum içine salınması ile karakterize bir sendromdur. Bu içerik miyogloblin, kreatin fosfokinaz (CPK), aldolaz, laktat dehidrogenaz (LDH), serum glutamik-oksalasetik transaminaz (SGOT) ve potasyumdan (K+) oluşmaktadır. RML'in en sık nedenleri kas kompresyonları, alkolizm, ağır egzersiz, status epileptikus, deliryum tremens, kronik potasyum eksikliği, toksinler ve viral enfeksiyonlardır. Bu vakamızda akut batın tablosuyla acile başvuran ve rabdomiyoliz tanısı konulan bir hasta sunulmuştur.

Olgu: 20 yaşında erkek hasta acil servisimize karın ağrısı şikayeti ile başvurdu. Hastanın öyküsünde 5 gün önce askere geldiği bilinmektedir. Karın ağrısı 2 gün önce aniden başlayan sürekli vasıfta ve her iki üst kadranda başlayıp tüm batına yayılmış. Özgeçmişinde herhangi bir özellik yoktu. Fizik muayenesinde bilinç açık oryante kooperatif idi. Batında yaygın hassasiyet ve her iki alt kadranda defans ve rebound tespit edildi. Hastaya çekilen abdominal ve pelvik tomografide lenf nodları dışında belirgin bir patolojiye rastlanmadı. Yapılan laboratuvar tetkiklerinde ALT 91 AST 488 CPK 105277 LDH 1306 K 5,9 tespit edildi. Hasta rabdomiyoliz tanısıyla dahiliye servisine yatırıldı.

Sonuç: Acil servise karın ağrısı ile gelen hastalarda öyküde aşırı fiziksel aktivite mevcutsa rabdomiyolizde her zaman ayırıcı tanıda aklımızda tutulmalıdır. Çünkü son yıllarda yapılan çalışmalar rabdomiyoliz sonrası akut böbrek yetmezliği riskinin yüksek olduğunu göstermektedir. Erken tedavi ile oluşabilecek komplikasyonlar önlenilmektedir.

Anahtar Kelimeler: Acil servis, karın ağrısı, rabdomiyoliz

P-0949 Cardiovascular Emergencies

Acil servise kesici aletle el bileği laserasyonu ile gelen hastada geç dönemde farkedilen post travmatik ulnar arter pseudoanevrizma vakası

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Amaç: acil servise kesici aletle el bileği laserasyonu ile gelen hastada geç dönemde farkedilen post travmatik ulnar arter pseudoanevrizma vakasını sunmayı amaçladık.

Olgu: 16 yaşındaki erkek hasta, ev içinde istemli olarak cama yumruk atması sonucu sol kolunda el bileğinin hemen üst kısmında olan kesici alet yaralanması şikayetiyle acil servise başvurmuş. Hastaya yapılan direk grafide kırığa rastlanmamış. El parmak hareketleri doğalmış. Aktif bir kanama yokmuş. Yapılan muayene sonucunda cilt primer dikilerek, tetanoz aşısı ve antibiyotik yapılarak taburcu edilen hasta kesi yerinde şişlik-ağrı nedeniyle tekrar aynı acil servise başvurmuş. Yapılan sol kol doppler usg sonucunda ulnar arterde pseudoanevrizma ile uyumlu olarak gelmesi üzerine kalp damar cerrahisi kliniğimize sevk edildi.

Hasta yaralanmanın olduğu olaydan yaklaşık 2 hafta sonra kliniğimize başvurduğunda. Kesi bölgesinde hematoma vardı. Ulnar nabız elle alınamıyordu. Hastaya BT anjiyografi çekildi. 3*4 cm hematoma vardı, ulnar arterde akım görülüyordu. Radyal arterde akım mevcuttu. Hastaya operasyon planlandı. Hematom boşaltıldı. Ulnar arter eksplore edildi. Ulnar arter 3F fogarty kateteri



POSTER PRESENTATIONS

ile embolektomi yapıldı. Bol pıhtı eksize edildi. Ulnar arter 8/0 prolenle primer onarıldı. Ciltaltı ve cilt kapatıldı. Hasta ulnar arterde nabızı pozitif olarak, 2 gün sonra taburcu edildi.

Sonuç: Acil servislere gelen üst ekstremité kesici alet yaralanmalı hastalarda, o an için aktif kanama olmaması vasküler patoloji olmadığı anlamına gelmez. Acil servis şartlarında iyi bir fizik muayeneyi takiben dopler usg veya BT anjiyografi tetkikleri gibi ileri tetkikler istenmelidir. Pseudoanevrizma konusunda şüpheli olunmalıdır ve erken dönem kontrole çağrılmalıdır.

Anahtar Kelimeler: ulnar arter, pseudoanevrizma, acil servis

P-0950 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Saf Duyusal Semptomlarla Seyreden Vertebroal Arter Diseksiyonu

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Giriş: Paralişi ile parestezi arasında çeşitli klinik tablolara yol açan vertebroal arter diseksiyonu, son zamanlarda özellikle genç yaş gurubunda, serebrovasküler hastalıkların sebepleri arasında giderek daha sık tanımlanmakta ve bildirilmektedir.

Olgu: Orta yaş kadın hasta, 2-3 aydır var olan, sol ekstremitéde uyuşukluk şikayetlerine, 1 gece önce sol yüz yarısında başlayan uyuşukluğun da eklenmesi nedeni ile acil servisimize başvurdu. Öykü derinleştirildiğinde, ara ara olan dengersizlik atakları olduğu öğrenildi. Vitaleri normal olan hastanın, fizik muayenesinde, pupilleri izokorik, bilateral ışık refleksi pozitif, kranial sinirler normal, ense defansı yoktu. Lateralizan bir motor defisit saptanmayan, serebellar testleri normal olan hastanın, duyu muayenesinde sol yüz yarısı ve ekstremitelerde parestezi tespit edildi. Vertebroal arter diseksiyonu şüphesiyle yaptığımız boyun anjiyo-BT tetkiki sonucu sol vertebroal arter V1-V3 segmentinde diseksiyon flebi izlendi. Nöroloji ile konsülte edilen hastaya 300 mg asetilsalisilik asit ve proton pompa inhibitörü başlandı ve poliklinik kontrolü planlanarak taburcu edildi.

Tartışma ve Sonuç: Genç yaşta görülen serebrovasküler olayların (SVO) %10-25'inde karotis veya vertebroal arter diseksiyonu rol oynarken, ileri yaşlarda bu oran düşer. 40 yaş altı SVO geçiren hastaların % 0.4-20'inde servikosefalik diseksiyonu gözlendiği bildirilmektedir. Vertebroal arter diseksiyonu, spontan olabileceği gibi boyun manipulasyonlarını veya travmayı takiben de ortaya çıkabilir. Ayrıca, fibromusküler displazi, Marfan sendromu, tip 4 Ehler Danlos sendromu, kistik medial nekroz, periarteritis nodosa, sistemik lupus eritematozus, hipertansiyon, enfeksiyonlar, sigara ve oral kontraseptif kullanımı da diseksiyonlarla ilişkili bulunmuştur. Olgumuzun böyle bir travma veya masaj öyküsü, tanı konulmuş bir hastalığı ve kullandığı bir ilaç yoktu. Vertebroal arter diseksiyonu hem iskemik hem de hemorajik serebrovasküler olay ile presente olabilir. Klinik tablo, sıklıkla ani, şiddetli kranioservikal lokalizasyonlu baş ağrısı ile başlar. Bunu biraz gecikmeyle beyin sapına ait iskemik belirtiler izler. İskemik bulgular arasında posterior sirkulasyon kanlanmasındaki bozulma ile uyumlu olarak vertigo, ataksi, kranial sinir felçleri, nistagmus, görme ile ilgili anomaliiler bildirilmiştir. Bizim olgumuzda, baş ağrısı veya iskemik serebellar bulgular ön planda değildi. Hastanın sadece ara ara dengersiz yürüme öyküsü ve parestezi mevcuttu. Vertebroal arter diseksiyonunda mural hematoma, trombüsü ve lümen daralmasını görebilmek için; Doppler US (sensitivitesi %75), anjiyoBT (sensitivitesi %92- 100), MR-MR anjiyografi (sensitivitesi % 60) ve DSA kullanılabilir.

Kalıcı sekellerin ve mortalitenin söz konusu olduğu bu tablonun tedavisinde bugün yaygın olarak antikoagulan tedavi uygulanmaktadır.

Sonuç olarak, arka sistem bulguları ile başlayan genç imlelerde ve olgumuzda olduğu gibi izole saf duyusal semptomları olan hastalarda mutlaka vertebroal arter diseksiyonu tanısı akla getirilmelidir. Acil serviste uygun tetkik boyun anjiyo BT'dir. Klinik duysal semptomlarla ortaya çıktığı takdirde periferik nöropatilerle ayrımının yapılması önemlidir.

Anahtar Kelimeler: genç yaş, vertebroal arter diseksiyonu, serebrovasküler hastalıklar

P-0951 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Üst Gastrointestinal Sistem Kanamasının Nadir Bir Sebebi: Bulbit

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Giriş: Üst gastrointestinal sistem kanaması (ÜGSK), Treitz ligamentine kadar olan proksimal duodenum ile üst özofagus sfinkteri arasında lümen içine olan kanamayı ifade eder. Şiddeti subklinik gizli bir kanamadan hipovolemik şoka kadar geniş bir spektrumu kapsar. Görülme sıklığı 100.000' de 80 – 100, mortalite oranı %7 - 10 arasındadır.

Olgu: 38 yaşında erkek hasta acil servisimize kötü kokulu, siyah dışkılama ve halsizlik şikayetleriyle başvurdu. 1 haftadır nonsteroid antiinflamatuar (NSAI) ilaç alım öyküsü olan ve anemi bulguları gözlenen olgunun rektal tuşesinde melana saptandı. Nazogastrik sonda ile yapılan mide lavajında kanama bulgusu izlenmedi. Laboratuvar bulgularında Hb: 7.6 g/dL, Htc: %23.5 dışında normallik izlenmedi. Anemi, hipotansiyon ve taşikardi nedeniyle hastaya eritrosit süspansiyonu (ES) replasmanı uygulandı. Gastroenteroloji kliniği ile konsülte edildi ve yapılan gastroskopisinde eroziv bulbit dışında aktif kanama odağı bulunamadı. Hospitalizasyonu sağlanan hastamızın 48 saatlik takibinde vital dengersizlik ve kan değerlerinde düşme gözlenmezken kontrol önerilerek taburcu edildi.

Tartışma: ÜGSK' ya erkeklerde ve 60 yaşın üzerinde daha sık rastlanır. Klinik olarak ağır vakalarda varis kanamaları, orta ve hafif şiddetli kanamalarda peptik ülserler daha sık gözlenmektedir. Varis dışı ÜGSK olgularının incelendiği bir çalışmada duodenal ülser %33 ile ilk sırada, gastrik ülser %14 ile ikinci sırada, gastrik erozyon %10 ile üçüncü sıradadır. 524 ve 412 vakalık başka çalışmalarda da aynı sıralama bildirilmiş ve eroziv bulbit %6 oranında saptanmıştır. Hastaların %30 - 50' sinde NSAI ilaç alım öyküsü bulunmaktadır. Vakamızda da NSAI ilaç tek risk faktörüdür ve bulbitin sebebi olarak düşünülebilir. ÜGSK' nın %80' inde kanama spontan olarak durmaktadır. Mortalite ve morbidite, kanaması durmayan veya nüks eden %20' lik grupta ortaya çıktığından; melana, mide lavajında hematemez veya taze kan, hematokrezyası olanlara endoskopik girişim yapılmalıdır. Olgumuzda melana saptanmış ve endoskopisinde kanamanın durduğu görülmüştür. Tedavide en önemli nokta erken ve yeterli kan transfüzyonudur. Mortalite hızı kan ihtiyacıyla yakından ilişkilidir. Hastaların klinik ve laboratuvar bulgularını normal sınırlarda tutabilmek için ne kadar çok transfüzyon gerekiyorsa prognozun o kadar kötü seyretmiş olduğu kabul edilmektedir. Bu vakada 3 ünite ES transfüzyonu uygulanarak hemodinamik stabilize sağlanabilmektedir. Bu tedavinin hastamızın sağkalımını arttırdığını vurgulamak gerekir.

Sonuç: ÜGSK, ilaçlar ve yandaş hastalıklar gibi yatknlaştırıcı faktörlerin çok olması nedeniyle mortalitesi devam eden hastalıklardandır. Bu nedenle erken tanı, destek tedavisi, acil ve yeterli kan transfüzyonu ve ileri bakım, Acil Tıp Klinikleri' ne başvuran hastalarda mortaliteyi azaltacak önemli faktörlerdendir. Eroziv bulbit gibi sık görülmeyen endoskopik tanılar da hayatı tehdit edici düzeye gelebilmektedir. Özellikle NSAI ilaçların kullanımına dikkat edilmesi, bu ilaçların lüzumsuz kullanılmaması ve kullanılacaksa riskli hastalarda önlemlerin alınması gerekliliği ortadadır.

Anahtar Kelimeler: bulbit, gastrointestinal kanama, melana, nonsteroid antiinflamatuar

P-0952 Other

Batın İçi Kitle Mi Yoksa Glob Vezikale Mi?

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Amaç: Glob vezikale, idrar çıkışının aniden ortadan kalkması ile karakterize sıklıkla ağırlı bir durumdur; ağrısız glob vezikale nadirdir ve genellikle merkezi sinir sistemi patolojisi ile ilişkilidir. Etiyolojisinde idrar akışına direnç gösterecek mekanik ya da dinamik bir tıkanma, mesane duvarı ya da detrüör kaslarının motor sinirlerinin innervasyonunun kesintiye uğraması veya ilaç etkisi mevcuttur. Biz bu vakamızda batın içi kitle gibi algılanan bir dev glob vezikale olgusunu sizlere sunacağız.

Olgu: 51 yaşında bayan hasta kabızlık şikayeti sebebiyle Genel Cerrahi polikliniğine başvurmuş. Poliklinikte yapılan muayene sonrası batın içinde yaklaşık 15 cm çapında kitle? olabileceği not edilerek batın bilgisayarlı tomografi(BT) istenmiş. Hasta tomografiye çekildikten sonra acil servisimize tekrar kabızlık şikayeti nedeniyle başvurdu. Hastanın öyküsünde yaklaşık 1 ay önce iskemik serebrovasküler hastalığa bağlı nöroloji servisinde yatışını öğrendik. Hastanın yapılan muayenesinde alt kadranda neredeyse 20 haftalık gebelik cesameti büyüklüğünde kitle mevcuttu. Hastanın çekilmiş olduğu batın BT'sinde mesane boyutları yaklaşık 189x151x147 mm olarak ölçüldü. Acil serviste yapılan yatakbaşı ultrasonda glob vezikale vizüalize edildi. Hastaya foley sonda takıldı. İlk birkaç dakikada 500 ml idrar çıkışı olunca, aralıklı olarak klemlenerek toplam 2600 ml idrar çıkışı gözlemlendi.

Sonuç: Glob vezikale acil servise özellikle erkeklerde nadir olmayan bir başvuru sebebidir. Serebrovasküler hastalıklarlada birlikte olduğu durumların sayısı oldukça manidardır. Her ne kadar hastanın kendisi tarafından idrar yapmadığını ifade etmesiyle kolay tanı konulabilsede; bazen böyle batın içi kitle imajı veren nadir durumlarda, ileri tetkik istemeksizin gözden kaçırılmamalıdır.

Anahtar Kelimeler: Glob vezikale, batın içi kitle, serebrovasküler hastalık

P-0953 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

donan adam

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Amaç: Hipotermi vücut merkez sıcaklığının 35°C' nin altına düşmesi olarak tanımlanır. (1) Hipotermi etyolojik nedene göre; primer ve sekonder hipotermi olarak sınıflandırılmaktadır. Sekonder hipotermi kronik hastalıklar, zehirlenmeler, ileri yaş vb. alta yatan klinik birdurum nedeniyle ısı regülasyon bozukluğu olarak, Primer hipotermi ise sağlıklı bireyin soğukla karşılaşmasına bağlı gelişen hipotermi, olarak tanımlanmaktadır. (2) Primer hipoterminin ileri dönemlerinde azalmış renal perfüzyon ve rabdomiyalize bağlı akut tübüler nekroz gelişebilir. Bu vakada da hipotermi sonrası gelişen akut böbrek yetmezliği (ABY) ve tedavi seçenekleri tartışılacaktır.

POSTER BİLDİRİLER

Olgu: 74 yaşında erkek hasta aynı seviyeden düşmüş, 3 gündür dağda mahsur kalmış ve acil servise hava ambulansı ile getirilmiştir. Geliş vitalleri TA:150/61 mmHg, Nb:67/dk, Ateş: hipotermik SS:20/dk, oda havasında Saturasyonu: %80, KŞ:203 mg/dl idi. Hastanın bilinen kronik hastalığı yoktu. Hastaya ısıtılmış %0,9 Serum Fizyolojik ve %5 destroz %0,45 NaCl infüzyonu başlandı. Isıtıcı ve battaniyeler kullanıldı. Lab. Sonuçları CK:12609, myoglobin>3000, AST:291 U/L, ALT:131 U/L, kreatinin:4.73 mg/dl, üre:366 mg/dl, Na:156 mEq/l, fosfor: 15.30 mg/dl, Mg:4.8 mg/dl. Kan gazında asidozu (Ph:7.33, HCO3:16.7, PCO2:30.8, Lactat:1.9) mevcut olup EKG'inde Osborn dalgalarına rastlanmadı normal sinüs ritminde idi. İdrar çıkışı olmayan hasta derin asidoz ve ABY açısından dahiliye ile konsülte edildi. Hasta tedavi amacıyla diyalize alındı. Diyaliz öncesi timpanik vücut ısı ölçülemeyen hastanın diyaliz sonrası ateşi 35 °C derece ölçüldü. Tedavi sonrası hastanın vücut ısı 36,5 °C ölçüldü. Takibinin ikinci gününde inotrop desteği başlanan hastanın solunumunun yüzeyleşmesi üzerine hasta entübe edildi. Entübasyon sonrası kardiyak arrest gelişti. CPR'a yanıt alınamayan hasta exitus kabul edildi.

Sonuç: Literatürde ülkemizde hipotermi ile ilgili ölüm insidansını veren bir çalışmaya rastlanmamıştır. İzmir gibi donma vakalarının fazla görülmediği sıcak iklime sahip bir bölgede karşılaşılan hipotermi vakasını paylaşmak istedik. Hipotermi ile gelen hastaların rabdomyoliz ve dehidratasyona bağlı, böbrek fonksiyonlarının hızlı bir şekilde bozulabileceği ve Akut Böbrek Yetmezliği tablosuna girebileceği akıldaki tutulmalıdır. Yapılan çalışmalar hemodiyaliz ve kardiy pulmoner by-pas gibi yöntemler ile kanın ekstrakorporal ısıtılması, vücut sıcaklığında beş dakikada 1-2 °C'lik artış sağladığını göstermektedir.(3) Vakamızda da görüldüğü gibi hem böbrek fonksiyonlarının düzeltilmesi hem de hipoterminin tedavisi için hemodiyalizin önemi ve etkisi aşikardır.

Anahtar Kelimeler: Hipotermi, Rabdomyoliz, Donma

P-0954 Cardiovascular Emergencies

Bir Gebede Akut Koroner Sendrom: Tedavide Neler Yaparınız?

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Amaç: Üreme çağındaki kadınlarda akut miyokard infarktüsü (AMI) ender olarak gözlenir ve insidansı hamilelik döneminde 1/10 000'dir. Gebelik sırasında AMI halen yüksek maternal ve fetal mortalite ile birliktedir. Burada, ileri gebelik yaşı haricinde risk faktörü bulunmayan bir hastada gelişen ST yüksekliliği olmayan AMI durumu güncel literatür bilgileri ışığında tartışılacaktır.

Olgu: Otuzdokuz yaşında 35 haftalık gebeliği olan bayan hasta göğüs ağrısı şikâyeti ile acil servise başvurdu. Anamnezinden hastanın ağrısının aniden başladığı, batar tarzda ve şiddetli olduğu, ağrının sol kol daha fazla olmak üzere her iki kolada yayıldığı ve nefes darlığı şikâyeti olduğu öğrenildi. İstirahat halindeyken göğüs ağrısı başlayan hasta yarım saat içinde kliniğimize başvurdu. Hastanın özgeçmişinde ve soygeçmişinde ileri maternal yaş haricinde kardiyovasküler risk faktörüne rastlanmadı. Hastanın geliş TA:127/69 mmHg, nabız 70/dk solunum sayısı 16/dk olarak saptandı. Fizik muayenesinde ek ses, üfürüm saptanmadı. EKG normal sinüs ritmi idi ve anlamlı ST/T patolojisi yoktu. Hastanın geliş kardiyak enzimleri CK-MB: 2.97ng/mL (normal:0-5ng/mL), Trop T: 0.033ng/mL (normal:0-0.014 ng/mL) olarak saptandı. Kan gazında hipoksi olmayan hastanın D-dimer değerinde anlamlı yükseklik saptanmadı. Tetkik sürecinde ağrısının çok şiddetli olduğu söyleyen hastaya analjezi için 100 mg IV parasetamol uygulandı. Parasetamol sonrasında ağrısının kalmadığını belirten hastaya kardiyak enzim takibi önerildi. 6. saat enzim sonuçlarında CK-MB:63.39 (normal:0-5ng/mL) Trop T: 0.591ng/mL (normal: 0-0.014 ng/mL) saptandı. Kardiyak enzimlerin yaklaşık 20 kat arttığı tespit edildi. EKG'de sadece V3-V5'de T negatifliği gözlemlendi. Hastaya enoksaparin (Clexane® 4000anti-Xa IU 0.4 mL-1, Sanofi Aventis) tedavisi uygulandı. Akut koroner sendrom ön tanısı ile ileri tetkik ve tedavi amaçlı kardiyoloji bölümüne interne edildi. Hasta kadın doğum hastalıklarına danışıldı. Kadın doğum tarafından kardiyolojinin önerilerine uyulmasını, gereklilik halinde sezeryan ile gebeliğin sonlandırılacağına bilgisi verildi. Anti agregan tedavi uygulanan hasta EF%65 olarak hastanemizden şifa ile edildi.

Sonuç: Gebelik ile ilgili akut miyokard enfarktüsünün arttıran muhtemel etkenler arasında ileri anne yaşı, obezite, sigara kullanımı, diyabet ve hipertansiyondur. Sıklıkla son üç ayda karşımıza çıkar. Tedavi öncesinde mutlaka kadın doğum ve kardiyoloji konsültasyonları istemelidir.

Anahtar Kelimeler: Göğüs ağrısı, gebelik, akut koroner sendrom, acil servis

P-0955 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Sadece Yutma Güçlüğü ile Başvuran Bir Beyin Sapı Enfarktı: Olgu Sunumu

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Disfaji ile Başvuran Bir Beyin Sapı Enfarktı: Olgu Sunumu

Amaç: Yutma olayı, SSS ve nöromusküler sistem arasında oluşan kompleks bir olaydır. Yutma olayına katılan kaslar, sabit bir sırayla inhibe ya da eskite olarak yutmayı gerçekleştirirler. Beyin sapında yutma ile ilgili iki merkez bulunur. Beyin sapı infarktüslerinde baş dönmesi, boğuk ses, disfaji, yüzde ısı ve ağrı kaybı lezyon lokalizasyonuna bağlı ortaya çıkabilir. Tanıda difüzyon beyin magnetik rezolüsyonlu(MR) görüntüleme bilgisayarlı tomografiden(BT) daha değerlidir. Bu olguda iki haftadır devam eden yutma güçlüğü olan ve beyin sapı enfarktı saptanan bir hasta sunulmuştur.

Olgu: Hastanemize sevk edilen 58 yaşındaki erkek hastanın, iki hafta önce başlayan yutma güçlüğü şikâyeti olmuş; acil başvurdukları sağlık merkezince bilgisayarlı beyin tomografisi çekilmiş; normal olarak değerlendirilmiş ve gastroenterolojiye yönlendirilen hastanın endoskopisinde eritematöz pangastrit ve bulbit saptanmış ve tedavi verilerek taburcu edilmiş. Hastanın şikâyetlerinin devam etmesi üzerine hasta sevk edilmiş. Özgeçmişinde hipertansiyonu olan hasta antihipertansif kullanıyordu. Fizik muayenesinde; tansiyon arteriyali 180/100 mmHg, nabız 98/dakika ve ateş 36.2°C idi. Nörolojik muayenesi doğal olan hastanın çekilen BT' de doğal olarak değerlendirildi. Beyin sapı enfarktını ekarte etmek amacıyla çekilen difüzyon MR T2 kesitlerinde bulbus antero-medialinde hiperintens lezyon tespit edilmesi üzerine hasta nöroloji bölümü ile konsülte edilerek yoğun bakıma yatırıldı. Hasta takibinin üçüncü gününde kardiopulmoner arrest sonucu eksitus oldu.

Sonuç: Disfaji nedeniyle acile başvuran hastalarda etyolojide gastrointestinal patolojiler yanında mutlaka serebrovasküler olaylar da düşünülmelidir.

Anahtar Kelimeler: beyin sapı, disfaji, enfarkt

P-0956 Other

Sol Dal Bloğunun Nadir Bir Nedeni

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Amaç: Gelişen teknolojiye bağlı günümüzde elektrik yaralanması olgularına daha sık rastlanmaktadır. Hafif elektrik yaralanmalarının sayısı bilinmemekle beraber, Amerika'da yılda 17.000 olgu elektrik yaralanmasına bağlı acil servislere başvurmaktadır. Erken dönemde ölümler genellikle ventriküler fibrilasyona bağlıdır. Elektrik yaralanması sonrası Elektrokardiyografide (EKG) ani başlangıçlı belirgin ST segment yükselmesi ve ritim düzensizlikleri, ekokardiyografide sol ventrikül duvar hareket bozuklukları (hipokinezi, akinezi) ile kardiyak enzim yükseklikleri miyokardiyal tutulumun işaretleridir. Morbidite ve mortalite genellikle farklı elektriksel akım türlerine ve temas yerlerine göre etkilenebilir.

Olgu: 39 yaşında erkek hasta 380 volt elektrikle 3 saniye maruz kalma ve yaklaşık 1,5 metre yükseklikten düşme nedeniyle acil servise getirildi. Hastanın şuuru açık koopere, geliş vitalleri Tansiyon: 137/91 mmHg Nabız:97/dakika Ateş:36,2 C, Oda havasında saturasyon:%97 idi. Diğer sistem muayeneleri normaldi. Hastanın EKG'sinde sinüs ritmi, sol dal bloğu mevcuttu. QT ve düzeltilmiş QT süresi sırasıyla 0,372/0,407 saniye idi. Hastanın sigara kullanımı mevcut olup bilinen herhangi bir kardiyak rahatsızlığı ve ek hastalığı yoktu. Hastanın 0-6-12 saat kardiyak enzim takibinde enzim yüksekliliği saptanmadı. Diğer Kan tetkikleri normal sınırlarda idi. Kardiyoloji konsültasyonu istendi. Hastanın yapılan EKO'sunda Sol ventrikül ve sağ ventrikül Ejeksiyon Fraksiyonu normal, duvar hareket kusuru ve kalp kapak bozukluğu yoktu. Monitörize olarak izlenen hastanın takibinde kontrol EKG'si normal sinüs ritmine döndü. Hasta acil serviste 24 saat kardiyak monitörizasyon sonrasında taburcu edildi.

Sonuç: Elektrik yaralanmasına bağlı EKG değişikliklerinden non-spesifik ST segment değişiklikleri ve sinüs taşikardisi en sık görülenleridir. Daha nadir olarak ta QT intervalinin uzaması, dal blokları, atriyal ve ventriküler fibrilasyon, atriyal ve ventriküler prematüre kontraksiyonlar görülür. Bunun yanında miyokardiyal infarkt, geçici hipertansiyon, sol ventrikül disfonksiyonu, kardiyak rüptür ve aritmi gibi kardiyak etkiler de görülebilmektedir. Uzamış QT intervali ventriküler fibrilasyona bağlı ani ölümler için bir risk faktörüdür ve mortaliteyi sekiz kat artırmaktadır. Arrowsmith ve arkadaşlarının yaptığı çalışmada %3, Al ve arkadaşlarının yaptığı çalışmada %67,9 oranında anormal EKG bulguları bildirilmiştir. Başka çalışmalarda bu oranlar %14 ile %54 arasında olduğu vurgulanmıştır. Elektrik yaralanmasına bağlı cilt yanığı, düşme gibi travmalar ile birlikte çarpan elektriğin voltaj şiddeti ve akımın vücuttan geçiş yönüne göre kardiyak etkilenimler olabilmektedir. Elektrik yaralanmasına bağlı bilinç kaybı, başvuru sırasında EKG anormallliği, acil servis izleminde ritim bozukluğu ve hastane öncesi dökümanite disritmisi olan hastalara 24 saatlik kardiyak monitörizasyon önerilmektedir.

Elektrik yaralanmasına bağlı dal bloğu görülebilir ancak literatür taraması sonucunda özellikle sol dal bloğu görülme olasılığı hakkında bilgiye ulaşılmadı. Bu vakamızda Elektrik yaralanmasına bağlı sol dal bloğunun görülebileceği konusunda acil tıp çalışanlarının dikkatini çekmek istedik.

Anahtar Kelimeler: Elektrik Yaralanması, Kardiyak Disritmi, Sol Dal Bloğu



POSTER PRESENTATIONS

P-0957 Other

Acilde Nadir Bir Olgu: Bilateral Psoas Apsesi

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Amaç: Psoas absesi ender rastlanılan, genellikle geç ve güç tanı konulan bir hastalıktır. Klasik bulguları ateş, karın ağrısı, bel ağrısı ve topallayarak yürümedir. Psoas absesinde tanı ve tedavinin gecikmesi veya apse drenajının yapılmadığı durumlarda mortalite %100'e ulaşmaktadır. Ölüm nedeni çoğunlukla tanı ve tedavinin geciktiği olgulardaki septik komplikasyonlara bağlıdır. Tanıda batin ultrasonografisi ve bilgisayarlı batin tomografisi kullanılmaktadır. Bizde bilateral ve sağda dev psosas apsesi olan olgumuzu sunmak istedik.

Olgu: 35 yaşında bayan hasta 20 gün önce dış merkezde sağ kalçada ağrı ve yürümeye zorluk şikayeti ile başvuruyor orada sağ inguinal lenfadenit ön tanısı ile sefuroksim aksetil 2x1 ve metronidazol 2x1 başlanmış. Biraz ilaçlarla rahatlayan hasta 20. günde acil servisimize sağ kalçada ağrı, sağ tarafının üstüne basamama, bel ağrısı ateş ve karın ağrısı şikayeti ile başvurdu. Fizik muayenesinde arteriyel kan basıncı 110/70 mmHg, nabızı 117 /dak, ateşi 38.4°C tespit edildi. Wbc:23.000, Hgb: 12 g/dl, Htc: 37, CRP: 40 biyokimyası doğaldı. Hastanın palpasyonu sağ inguinal ve femoral bölgede hassasiyeti ve lomber vertebralarda hassasiyeti mevcuttu. Hastanın bilateral psosas germe testi pozitif. Batın USG incelemesinde sağ iliak kas içerisinde sıvı koleksiyonu izlenmesi üzerine istenen abdomen BT incelemesinde sağ psosas kasi boyunca sağ böbrek orta düzeyinden başlayan sağ femura kadar uzanan en derin yerinde 50 mm uzanan abse koleksiyonu, sol psosas kasi boyunca renal düzeyden sol iliakus kasına kadar uzanan en derin yerinde 16 mm abse koleksiyonu izlendi. T10-11-12 paravertebral alanlarda ve anterior epidural alanda yumuşak doku görünümü (tüberküloz spondilodiskit veya soğuk apse) izlendi. Genel cerrahi ile konsülte edilen Usg eşliğinde perkutan drenaj önerildi ancak hasta operasyonu kabul etmeyerek hastaneyi terk etti.

Sonuç: Şiddetli kalça ağrısı ve ateşli olan hastalarda özellikle öyküde travma, intravenöz ilaç bağımlısı, gastrointestinal patoloji, TBC ve AIDS varsa tanıda Psosas apsesi öncelikle düşünülmelidir.

Erken tanı ve tedavi, mortalite, rekürrensler ve hospitalizasyonun uzamasının önlenmesi açısından çok önemlidir.

Anahtar Kelimeler: Kalçada Ağrı, Ateş, Psosas Apsesi

P-0958 Resuscitation

CPR Sonrası Pnömotoraks

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Amaç: Kardiyopulmoner resusitasyon fonksiyonunu kaybeden kalp ve akciğeri yeniden çalışmasını sağlanmasını esas neden tespit edilene kadar tedavi edilene kadar yapılan semptomatik bir tedavi şeklidir.

Göğüs kompresyonu CPR 'ın köşe taşlarından biridir. Hava yolu açıklığı ve solunum desteğinin sağlanıp erken defibrilasyon uygulanması ile birlikte olduğunda kardiyak arrestten sonra yaşam şansını artıran bir bütünü oluşturmaktadır. Fakat uygulama sonrası gelişebilecek komplikasyonlar konusunda da dikkatli olmak gerekir.

Kot ve sternum kırıkları erişkin hastalarda CPR sırasında uygulanan göğüs kompresyonuna bağlı en sık bildirilen iskeletin göğüs komplikasyonlarıdır.

Kot ve sternum kırık sonrası oluşan parçalar kalp ve akciğere hasar vererek hemotoraks-pnömotoraks, çok nadir de olsa kardiyak rüptür ve karaciğer yaralanmasına yol açtığı bildirilmiştir.

Vakada kardiyak kompresyon sonrası oluşan pnömotoraksın erken tanı ve tedavisinden bahsedilecektir.

Olgu: KOAH tanısı olan orta yaşlı bayan hasta arrest olarak acil servise getirildi. Kardiyopulmoner resüsitasyon başlandı. Cpr sonrası hastanın yaşamsal fonksiyonları geri döndü, akabinde sağ memeden başlayıp sol memeye yayılan cilt altı amfizem gelişti, akciğer sesleri azalmış olarak saptandı.

Sonrasında hızlı bir şekilde yerinde çekilen akciğer grafisinde cilt altı amfizem saptandı, fakat tipik pnömotoraks görüntüsü yoktu. Pnömotoraks ön tanısıyla çekilen toraks bt'de pnömotoraks saptandı ve yapılan tüp torakostomi sonrasında cilt altı amfizemde hızla gerileme ve akciğer seslerinde artış gözlemlendi.

Sonuç: Kardiyak kompresyon arrest sonrası uygulanan tedavi girişimleri içinde yaşam şansını en fazla artıran uygulama olmakla birlikte, kompresyon sonrası gelişen komplikasyonlar açısından dikkatli olunmalıdır. Bunlar arasında en sık görülen kot fraktürleri, pnömotoraks, hemotoraks gibi acil girişim gerektiren durumlarda akılda tutulmalıdır.

Pnömotoraks plevral aralıkta serbest hava birikimidir. Genellikle spontan ve travmaya görüldü de, tanı veya tedavi amaçlı invazif girişimlerin artmasına paralel olarak iyatrojenik nedenlere bağlı pnömotoraks- larla sıklıkla karşılaşmaktayız. Pnömotoraksın tedavisinde uygulanan klasik tedavi yön- temi konvansiyonel kapalı su altı drenajdır. Özellikle iyatrojenik pnömotoraksta tüp torakostomi ile %99 oranında başarı bildirilmiştir.

Önemli olan komplikasyonların göz ardı edilmeden hızlı bir şekilde tanı konulup tedavi edilmesidir. Bu vakadan da anlaşılacağı gibi CPR sonrası yaşamsal fonksiyonları geri dönen hastaların komplikasyonlar açısından ikincil değerlendirmesinin yapıp, kontrol akciğer grafisi ve gerekirse toraks BT çekilmesi gerektiğinin önemi akılda tutulmalıdır.

Anahtar Kelimeler: CPR, Pnömotoraks, Tüp Torakostomi

P-0959 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Demans Değil, Hashimoto Ensefalopatisi !

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Giriş: Hashimoto ensefalopatisi, yüksek antitiroid antikor titrelere ile ilişkili, otoimmün etiyolojiye bağlı olduğu düşünülen, inme benzeri epizotları olabilen, nöbet, bilinç bozukluğu, global amnezi gibi akut bir şekilde ya da demans, psikoz gibi tablolarla daha sinsi bir şekilde ortaya çıkabilen bir hastalıktır. Ortalama başlangıç yaşı 44'tür, hastaların % 20'si 18 yaşından önce başlar ve kadın erkek oranı 4/1'dir.

Olgu: Unutkanlık ve konuşma bozukluğu nedeniyle acil servisimize başvuran, bilinen hipertansiyon tanısı olan 60 yaş bayan hastanın, yaklaşık 5-6 ay önce başlayan, ilk zamanlar dalgalanma gösteren ve progresif seyreden unutkanlık, kendini kötü hissetme, konuşma bozukluğu ve ellerde titreme şikayetleri varmış. Zaman zaman kendi kendine konuşmaları olan hastaya dış merkezlerde psikiyatri ve nöroloji hekimleri tarafından değerlendirilerek bipolar bozukluk ve depresyon tanıları koyulmuş fakat tedavilerden fayda görmemiş. Mevcut bulguları progresse olduğu için acil servisimize başvuran hastanın yapılan fizik muayenesinde; bilinç açık, apatik, basit emirlere kısmi koöper, dezoriente, motor asimetrisi yok. Duyu muayenesinde koöper olmayan hastanın myoklonileri mevcuttu. Acil serviste bakılan kan tetkiklerinde anlamlı bir patoloji yoktu. Amonyak düzeyi, EEG ve beyin tomografisi normal saptandı. Demans ön tanısı ile nöroloji bölümüne yatırıldı. Burada Kr. MRG ve LP'si normal olan hastanın TSH ve Tiroid antikorları yüksek saptandı. Hashimoto Ensefalopatisi düşünülen hastaya steroid tedavisi düzenlendi. Steroid tedavisi alan hastanın nörolojik muayenesinde oryantasyonu düzeldi, apati tablosu geriledi. Miyoklonilerde belirgin düzelme görüldü.

Tartışma ve Sonuç: Hashimoto ensefalopatisi, son yıllarda daha iyi tanınmasına karşın, halen tanı koymada gecikildiği ya da bazı olgulara tanı koyulmadığı düşünülmektedir. Klinik bulgular çok değişken ve nonspesifik olabilir. Örneğin, Hashimoto ensefalopatisinin izole global amnezi ya da epilepsi gibi bulgularla ortaya çıkabileceği bildirilmiştir. Hastalık, bu tablolar ile ortaya çıktığında genellikle başka hastalıklar düşünülür ve tiroitid semptomları belirgin değilse Hashimoto ensefalopatisi tanısı koymak zordur. Bizim olgumuzda da tanı zor koyulmuştur. Nörolojik muayenede kognitif yıkım ve işlevsellikte kayıp saptanması, biyokimyasal-radyolojik testlerde anlamlı bulgu saptanmaması nedeniyle öncelikli olarak Alzheimer tipi demans tanısı düşünülmüştür. Daha sonraki izlemlerde antitiroid antikorların yüksek saptanması ile Hashimoto tiroitid tanısına varılmıştır. Kortikosteroid tedavisine yanıtın gözlenmesi Hashimoto ensefalopatisi tanısını kesinleştirmiştir. Hashimoto ensefalopatisinde steroid tedavisi ile bulgular geriler ve steroide yanıt genellikle hızlıdır. Bazı hekimler, bu bulguyu tanı kriteri olarak kabul etmişlerdir. Antitiroid ilaçlar, steroid, antiepileptik ilaçlar ve parenteral sıvı desteği ile tedaviye hızlı ve dramatik yanıt alınır.

Sonuç olarak ilerleyici seyirli unutkanlık yakınmasıyla başvuran hastalarda dejeneratif seyirli, sık görülen demans yanında Hashimoto ensefalopatisi gibi daha nadir tablolar da akla getirilerek acil serviste tiroid fonksiyon testleri ve antitiroid antikor düzeyleri istenmelidir. Serum antitiroid antikor düzeylerinin yüksek saptanması tanıda esastır. Bazen hastaların ötiroid olabileceği de unutulmamalıdır. Bu hastalık ancak akla getirildikten sonra tanınabilir ve geriye dönüşümlü olması nedeniyle, kalıcı hasar gelişmeden tanı koyulması önemlidir.

Anahtar Kelimeler: demans, ensefalopati, hashimoto

P-0960 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Koroner Bypass Operasyonu Sonrası Mediastinit: Olgu Sunumu

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Amaç: Mediastinit oldukça ölümcül seyredebilen mediasten dokusunun iltihabıdır. Akut vasküler şekilde enfeksiyon ve enfeksiyon dışı etiyolojiler ile karşımıza çıkabilir. Akut mediastinitlerin



POSTER BİLDİRİLER

çoğu özefagus perforasyonuna veya göğüs travmasına sekonder olarak gelişebilir. Kronik form veya yavaş gelişen form ise tuberküloz, histoplasmozis gibi bakteriel veya fungal enfeksiyonlara veya sarkoidoza ikincil gelişen durumdur. Bu yazımızda koroner bypass operasyonu sonrası acil servise göğüs ağrısı ve nefes darlığı şikâyetleriyle başvuran mediastinitis olan hasta sunulmuştur.

Olgu Sunumu: 68 yaşında erkek hasta koroner bypass operasyonu geçirdikten 10 gün sonra acil servise 2 gündür devam eden göğüs ağrısı, sternum yara yerinde akıntı ve nefes darlığı şikâyetleriyle acil servisimize başvurdu. Genel durum kötü, şuur konfüz, nonkoopere ve nonoryante olan hastanın TA: 105/70 mmHg, Nb: 104/dakika, Ateş: 37,2 C idi. Laboratuvar parametrelerinde Hb: 12,3 gr/dL, Hct: % 37,4, Lökosit: 17214, trombosit: 165000, glukoz: 117 mg/dL, üre: 51 mg/dL, kreatinin: 1,2 mg/dL, Na: 140 mg/dL, K: 5,1 mg/dL, Ca: 8,7 mg/dL, Albumin: 3,4 gr/dL, ALT: 115 U/L, AST: 131 U/L, LDH: 295 U/L idi. Kardiyak enzimleri normal olarak tespit edilen hastanın arteriyel kan gazları pH: 7,32, PO2: 72,1, PCO2: 45,4, HCO3: 14,8, SO2: % 87 idi. Hastaya çekilen kontrastlı toraks tomografisinde; toraks girişi düzeyinde retrosternal bölgeden toraks duvarı dışı doğru uzanım gösteren periferik kontrastlanma gösteren yaklaşık 3 x 2 cm boyutlarında poş, ön mediastende ayrıca retrosternal bölgede alt kesitlerde içerisinde hava değerleri bulunan yaklaşık 5 x 2,7 cm boyutunda poş izlendi. Hasta mevcut klinik ve tetkiklerle mediastinitis tanısıyla yoğun bakım servisine alındı. Hastaya sternum revizyonu yapıldı ve antibiyotik tedavisi başlandı. servise yatırıldı. Takiplerinde genel durumunda düzelmeye gözlenen hasta yatışının 35. Günüde taburcu edildi.

Sonuç: Mediastinitis, toraks cerrahi sonrası görülebilen hayatı tehdit eden bir komplikasyondur. Bu tür hastalarda göğüs ağrısı ve nefes darlığı gibi semptomların varlığında mediastinitis tanısı ayırıcı tanıda akılda tutulmalıdır.

Anahtar Kelimeler: göğüs ağrısı, mediastinitis, toraks

P-0961 Other

Acil Serviste Travma Hastaları, Yapılan Cerrahi Müdahaleler ve Maliyet Analizi

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Amaç: Bu çalışmada acil servise başvuran ve cerrahi müdahale uygulanmasını gerektiren hastaların analiz edilmesi amaçlandı.

Gereç-Yöntem: Bu çalışma 01.01.2013-31.12.2013 tarihleri arasında acil servise başvuran ve cerrahi müdahale uygulanan hastaların retrospektif olarak dosya kayıtlarının incelenmesi ile gerçekleştirildi. Çalışma kapsamında hastaların yaş, cinsiyet, gün içi dağılım (08.00-15.59; 16.00-23.59; 24.00-07.59), aylara ve mevsimlere göre, istenen laboratuvar tetkikleri (kan grubu, hemogram, biyokimya, TIT, beta hCG), istenen görüntüleme tetkikleri (Röntgen, Ultrasonografi, Tomografi, Magnetik Rezonans), uygulanan tedaviler (oksijen, tetanoz aşısı, kuduz aşısı, pansuman, alçı-atelet, kesi sütürasyonu), son tanılar, hasta sonlanımları (konsültasyon, taburcu, yatış, ölüm) ve maliyet analizi yapıldı.

Bulgular: Söz konusu tarihler arasında acil servise başvuru yapan 301204 hastadan 68378 (%22,7) tanesinin travma hastası olduğu ve bunlardan da 33211 (%48,5) hastaya cerrahi müdahale uygulandığı saptandı. Çalışma kapsamındaki hastaların 23148 (%69,7)'sinin erkek ve 10063 (%30,3)'ünün ise bayan olduğu ve yaş ortalamalarının 35,59 (min:1 ay - max: 114 yıl) olduğu belirlendi. Hastaların gün içi dağılımına bakıldığında en fazla başvurunun 16462 (%49,5) hasta ile 08.00-15.59 saat dilimleri arasında olduğu saptandı. Aylara göre dağılımda ise en fazla başvurunun 4339 (%13) hasta ile Ağustos ayında ve mevsimlere göre dağılımda ise 10661 (%32) hasta ile yaz döneminde olduğu tespit edildi. Laboratuvar tetkikleri bakımından 5744 (%17) hastada istenen tam kan sayımının ve görüntüleme açısından ise 7650 (%23) hastada istenen direkt grafinin ilk sırada yer aldığı gözlemlendi. Tedavi yaklaşımında en fazla yapılan uygulamanın 21310 (%63,8) hastadaki yara yeri pansumanı olduğu, son tanının en fazla 17213 (%51,8) hastada yumuşak doku bozukluğu olduğu ve 6348 (%19) hastadan konsültasyon istendiği belirlendi. Travma alanı açısından toplam maliyetin 2.791.128,86 TL ve kişi başına düşen paranın ise 84 TL olduğu saptandı.

Sonuç: Acil servis başvurularının önemli bir kısmını travma hastaları oluşturur ve bunların büyük bir kısmında cerrahi müdahale gerekir. Erkek cinsiyet ve orta yaş grubu en fazla etkilenen kısmı oluşturur. Başvurular çoğunlukla gündüz mesai saatleri içerisinde gerçekleşir. Ay olarak Ağustos ve mevsim olarak yaz dönemi başvuruların en sık olduğu dönemlerdir. En sık istenen tetkik hemogram, görüntüleme direkt grafi ve uygulama ise yara pansumanıdır. Elde edilen verilerin acil servis yapılanması ve iş gücü yönetiminde kullanılması mümkündür. Ancak tek bir merkeze ait veriler olması nedeniyle ile bir genelleme yapmak mümkün değildir. Bu yüzden acil servislerin bu tür analizleri kendilerinin yapmaları ve ortaya çıkan tabloya göre planlama yapmalarının uygun olacağı kanaatindeyiz.

Anahtar Kelimeler: acil, travma, cerrahi işlem, maliyet

P-0962 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Lokalize Apseden Derin Boyun Enfeksiyonuna: Olgu Sunumu

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Amaç: Enfeksiyonlar acil servis başvuruları içerisinde önemli bir yer tutar. Bu hastalarda doğru tanı ve tedavinin düzenlenmesi önemlidir. Bu yazıda yaşlı bir hastada lokalize bir apse şeklinde başlayan ve sonrasında da hastanın ölümüne neden olan bir enfeksiyon vakası sunulması amaçlandı.

Olgu: 82 yaşında bayan hasta acil servise 112 Ambulanısı ile ateş, titreme ve oral alımda azalma şikâyetleri ile getirildi. Anamnezde hastanın iki ay önce boynunun orta hattındaki apse şikâyeti ile Genel Cerrahi polikliniğine başvurduğu ve burada kendisine apse drenajı uygulandığı öğrenildi. Bir ay öncede boynunun sağ tarafında iki adet daha apsenin ortaya çıktığı ve bunlara da Kulak Burun Boğaz polikliniğinde iğne aspirasyonu uygulandığı öğrenildi. Soy geçmişinde özellik yoktu. Hastanın başvuru anındaki genel durumu orta, şuuru açık, koopere ve oryante idi. Vital bulguları: TA:90/60 mmHg, Nabız: 140/dk, Ateş: 38oC ve SaO2: % 88 olarak ölçüldü. Hasta dehidrate görünümde ve cilt turgoru azalmıştı. Sistem muayenelerinde boyun orta hattında içerisinde pürülan mayı gelen açık bir yarası ve akciğerlerinde bilateral tüm zonlarda duyulan ince ralleri mevcuttu. Diğer sistem muayeneleri ise doğaldı. Hastadan alınan kan örneklerinde Lökosit: 11.100 K/ul, Hgb: 15,2 mg/dL, BUN: 138 mg/dL, Kreatinin: 2,2 mg/dL, Na: 150mmol/L, K: 3,0 mmol/L, Cl: 100 mmol/L olarak ölçüldü. Kan gazında ise PH: 7,4, PCO2: 44,4 ve PO2: 88 idi. Hastadan istenen bilgisayarlı tomografide fistül lehine yorumlanacak şekilde servikal bölgede troid lojundan başlayan, ön mediastane doğru uzanım gösteren ve trakea ile ilişkili olduğu gözlenen serbest hava dansiteleri izlendi (Resim 1-3). Akciğer parankiminde ise yaygın buzlu cam görünümü ve yamasal infiltrasyonlar izlendi (Resim 4). Hasta derin boyun enfeksiyonu, mediastinitis ve prerenal böbrek yetmezliği ön tanılarını ile yoğun bakıma yatırıldı. Yatışından bir gün sonra kaybedildi.

Sonuç: Lokalize karakterde olan enfeksiyonların sistemik hale gelebileceği hatta hastanın ölümüne neden olabileceği unutulmamalıdır. Bu konuda hasta enfeksiyon ajanı, yaş ve lokalizasyon gibi parametreler kadar hekim yaklaşımının da etkili olduğu unutulmamalıdır.

Anahtar Kelimeler: apse, acil, ölüm

P-0963 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Dress Sendromu: Olgu Sunumu

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Amaç: Dress Sendromu (Drug Rash with Eosinophilia and Systemic Symptoms) akut başlangıçlı, ateş, cilt döküntüsü ve iç organ tutulumu ile karakterize yaşamı tehdit edebilen bir ilaç reaksiyonudur. En sık tutulan iç organ karaciğerdir. Bu olgu sunumunda fenitoinine bağlı gelişen bir Dress Sendromu vakası sunulurken konuya dikkat çekilmek istenmiştir.

Olgu: 47 yaşında erkek hasta acil servisimize yaklaşık 10 gün önce başlayan ve devam eden ateş ve vücudunda döküntü şikâyetleri ile başvurdu. Özgeçmişinde üç hafta önce geçirdiği, bu nedenle nöroloji kliniğinde bir hafta yattığı ve dokuz gün önce fenitoin başlanarak taburcu edildiği öğrenildi. Hasta gelişinde genel durumu iyi, şuuru açık, koopere ve oryante idi. Vital bulgularında TA: 110/70 mmHg, Nabız: 110/dk, Ateş: 37,6oC ve SaO2: % 100 (Oksijenli) olarak ölçüldü. Fizik muayenesinde özellikle göğüs ve sırt bölgesinde daha belirgin olmak üzere yaygın eritemli makülopapüler döküntü saptandı (Resim 1-3). Diğer sistemik muayeneleri ise doğaldı. Laboratuvar tetkiklerinde ise; WBC: 16,5, Eos: % 13,0, BUN: 28, Kreatinin: 1,3, AST: 71, ALT: 42, LDH: 818 olarak ölçüldü. Diğer değerleri ise normal sınırlarda idi. Hasta Fenitoinine bağlı Dress Sendromu ön tanısı ile dermatoloji tarafından hospitalize edildi. Lezyonları gerileyen hasta yatışının 5. gününde önerilerle taburcu edildi.

Sonuç: Acil servise döküntü şikâyeti ile başvuran hastaların ayırıcı tanısında Dress Sendromu da akla gelmeli ve başta karaciğer fonksiyon testleri olmak üzere buna yönelik tetkikler istenmelidir.

Anahtar Kelimeler: Dress sendromu, döküntü, acil



POSTER PRESENTATIONS

P-0964 Cardiovascular Emergencies

Perikardiyal Effüzyon veya Tamponad: Olgu Sunumu

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Amaç: Kardiyak tamponad hayatı tehdit eden bir durum olduğundan hızla tanı konulup tedavi edilmesi gerekir. Ancak perikardiyal efüzyon ve kardiyak tamponad ayrımının yapılması gereklidir. Perikardiyal efüzyon hemodinamik bozukluğa yol açmayan anatomik bir tanı iken, kardiyak tamponad hemodinamik bozukluğa neden olan fizyolojik bir tanıdır. Bu yazıda radyolojik olarak kardiyak tamponad klinik olarak perikardiyal efüzyon yaklaşımı sergilenen bir hasta sunumu yapılarak konuya dikkat çekilmek istenmiştir.

Olgu: 69 yaşında erkek hasta acil servise birkaç saat önce başlayan göğüs ağrısı ve geçmeyen hıçkırık şikâyetiyle başvurdu. Anamnez hastanın kendisinden alındı. Özgeçmişinde Diabetes Mellitus ve Hipertansiyon dışında özellik yoktu. Hastanın genel durumu iyi, şuuru açık, koopere ve oryante idi. Vital bulgularında; TA: 127/ 70 mmHg, Nabız: 85 /dk, Ateş: 36.60C, SaO2: % 98 ve parmaktan ölçülen kan şekeri 210 mg/dl olarak tespit edildi. Fizik muayenesinde patolojik bir bulguya rastlanmadı. İstenen laboratuvar tetkiklerinde WBC: 6.4 K/uL, Glukoz: 217 mg/dL, Üre: 46 mg/dL, Kreatinin: 1.8 mg/dL ve Troponin I: 0.027 ng/mL olarak ölçüldü. Elektrokardiyografisinde sol aks ve V1-3'te erken repolarizasyon mevcut idi. Hastadan PA Akciğer grafisi ve Torakobdominal Bilgisayarlı Tomografi istendi. PA Akciğer grafisinde kardiyotorasik indeksi hafif artmış ve toraks tomografisinde ise perikardiyal alanda en kalın yerinde 3 cm çapında hipodens efüzyon tespit edildi (Kardiyak tamponad?) (Resim 2). Mevcut bulgulardan hareketle hastadan kardiyoloji konsültasyonu istendi. Yapılan Ekokardiyografide kalbi çevreleyen ve maksimum yerinde 1.9 cm'lik perikardiyal efüzyon görülmesi üzerine, hasta Kardiyoloji servisine yatırıldı. Hastanın ertesi gün ölçülen troponin I değeri 0.081 ng/mL ve taburculuk öncesi 4. gün ölçülen troponin I değeri ise 0.048 olarak ölçüldü.

Sonuç: Perikardiyal efüzyon ve kardiyak tamponad ayrımı acil serviste acil hekimlerince yapılabilir. Ancak bu konuda gerekli eğitimlerin yapılması ve konunun gündemde tutulması önemlidir.

Anahtar Kelimeler: tamponad, efüzyon, acil, kardiyak

P-0965 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

İdrar Yolu Enfeksiyonu Tanısında Direkt Grafi

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Amaç: Bu yazıda beklenilenin dışındaki bir nedenle ortaya çıkan idrar yolu enfeksiyonu (İYE) olgusu sunularak konuya dikkat çekilmek istenmiştir.

Olgu: İdrar yaparken zorlanma ve ağrı şikâyeti ile başvuran 68 yaşındaki erkek hastanın hikâyesi kendisinden alındı. Hastanın şikâyetlerinin son üç aydır olduğu, bu şikâyetlerle birçok kez sağlık kuruluşlarına başvurduğu, kendisine İYE tanısıyla her seferinde antibiyotik yazıldığı ve tedavi ile şikâyetlerinin düzeldiği ancak birkaç gün sonra tekrar başladığı öğrenildi. Hastanın öz geçmişi bir yıl öncesine ait kolon kanseri nedeni ile uygulanan sağ hemikolektomi operasyonu mevcuttu. Başvuru sırasında vital bulguları normal olan hastanın fizik muayenesinde de bir özellik yoktu. Yapılan laboratuvar analizlerinde; lökosit: 9700 K/uL (% 80 nötrofil), hemoglobin: 11 g/dl ve biyokimyasal parametreleri ise normal bulundu. C-Reaktif Protein değeri 135 mg/L ve sedimentasyon hızı 55 mm/s olarak ölçüldü. Yapılan tam idrar tetkikinde bol lökosit, bol eritrosit ve 44 lökosit kümesi saptanması üzerine İYE ön tanısı ile Enfeksiyon Hastalıkları Kliniğine yatırıldı. Hastanın takiplerinde karın ağrısının başlaması üzerine istenen direkt grafide sol üreterde double J katetere ait görüntü tespit edildi. Hastanın hikâyesi derinleştirildiğinde ise bu kateterin bir yıl önceki ameliyatı sonrası idrar yapmada zorluk nedeni ile takıldığı ve sonrasında da çıkarılmadığı ve bunu hastanın bilmediği öğrenildi. Kateteri çıkartılan hastanın şikâyetleri uygulanan tedavi ile tamamen düzeldi ve yatışının 10. gününde şifa ile taburcu edildi.

Sonuç: İYE'nin tanısında yaklaşımda direkt grafi genellikle kullanılmamasına karşın bu hastada olduğu gibi sıra dışı nedenlerin ortaya konmasında yararlı olabilir. Hekimlerin özellikle tek-rarlayan İYE'nin ayırıcı tanısında direkt grafi de göz önünde bulundurmalarının faydalı olacağı kanaatindeyiz.

Anahtar Kelimeler: idrar, enfeksiyon, grafi

P-0966 Cardiovascular Emergencies

Brugada Sendromu: Olgu Sunumu

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Amaç: Bu olgu sunumuyla ölümcül olabilecek Brugada sendromunun hatırlatılması amaçlandı.

Olgu: 36 yaşında erkek hasta acil servisimize göğüs ağrısı ve ateş şikâyeti ile geldi. Ağrısı yaklaşık 4 saat önce başlamış. Ağrı retrosternal bölgede, batma şeklindeymiş ve yayılımı yokmuş. Ağrı 30 dk sürmüştü, geçmiş. 3 gün önce gribal enfeksiyon geçirmiş. Hastanın özgeçmişinde özellik yok, soy geçmişi de özellik yok. FM'de vital bulguları stabil, bilinç açık, oryante, koopere. Fizik muayenede patolojik bulgu yoktu. CBC; biyokimya, troponin istendi. Laboratuvar bulguları normaldi. EKG'de sinüs ritmi, hız 82/dk, V1-2'de ST elevasyonu mevcuttu. Hastaya 300 mg salisilat verildi, monitörize edildi. Hastada bu bulgularla tip 1 Brugada sendromu düşünüldü. Malign aritmi açısından. Kardiyoloji konsültasyonu istendi. EPS planılarak hasta taburcu edildi.

Sonuç: Acil hekimleri EKG değişikliklerini iyi yorumlamalı, ölümcül olabilecek değişiklikleri atlamamalıdır.

Anahtar Kelimeler: acil, brugada, ekg

P-0967 Cardiovascular Emergencies

Astım Dediğin Öksürük, Diseksiyon Dediğin Öldürür

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Aort diseksiyonu (AD) olguların %5-15'inde herhangi bir ağrı tanımlanmadığı, klasik semptomların olmadığı bildirilmiştir. 52 yaşında kadın hasta acil servise öksürük, sık sık balgam çıkarma ve nefes darlığı şikâyeti ile getirildi. Başvuru anında enfekte astım atak olduğu düşünülen hastanın çekilen PA AC grafisinde belirgin aort topuzu ve üst mediasten genişliği nedeniyle AD'dan şüphelenilip, tanısı konulan bir olgu.

Anahtar Kelimeler: öksürük, nefes darlığı, aort diseksiyonu

P-0968 Other

Epileptik Nöbetle Gelen Fahr Hastalığı

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Amaç: Bilateral striopallidodentat kalsinozis olarak da isimlendirilen Fahr Hastalığı (FH) ilk defa 1930 yılında tanımlanmıştır. Kalsifikasyonlar bilateral ve neredeyse tamamında simetriktrik. Striopallidodentat kalsifikasyonlar genellikle kalsiyum-fosfor metabolizması bozukluklarına eşlik eder. Bazı çalışmalarda ise, nöronal dokuda farklı toksinler ve enfeksiyöz ajanlara bağlı gelişen nekroz sonrasında da kalsiyum, demir, bakır gibi elementler ve proteinlerin çökmesi ile gelişen Striopallidodentat kalsifikasyonlar saptanmıştır. Bazı olgular ise serum kalsiyum ve paratiroid hormon seviyelerinde anormallik olmadan kalıtsal olarak, beyin parankiminde yaygın kalsifikasyonlar ile seyredebilir. En sık klinik tablolar ilerleyici mental hasar, konvülsiyon, parkinson benzeri tablolar, nöro psikiyatrik davranış bozuklukları şeklinde olabileceği gibi herhangi bir nörolojik anormalliğin olmadığı olgular da olabilir. Fahr hastalığının tanısında en yararlı görüntüleme tekniği olarak Bilgisayarlı Tomografi kullanılmaktadır. Epileptik nöbete benzer kasılma şikâyeti ile gelen Fahr hastalığı sunmak istedik.

Olgu: 58 yaşında bayan hasta tüm vucutta olan kasılma nedeni ile acil servise getirildi. Öyküsünde 10 yıl önce guatr nedeniyle total tiroidektomi operasyon öyküsü mevcut olan hasta 5 yıldır düzenli olarak oral kalsiyum almaktadır. Son zamanlarda kalsiyum preparatı almamış. Olgunun sistemik muayenesi normal, nörolojik muayenesinde bilinç açık. Biyokimyasal parametrelerinde Ca:5.9 mg/dL (8.8 – 10.2 mg/dL), K:3.8 mg/dL (2.3 – 4.7 mg/dL) idi. Kraniyal tomografisinde bilateral bazal ganglionlarda, sentrum semiovalede ve posterior fossada serebral hemisferlerde parankim içerisinde simetrik kalsifikasyonlar izlenmektedir. Olgu öykü, laboratuvar, klinik ve radyolojik bulgular doğrultusunda iatrojenik hipoparatiroidiye bağlı Fahr sendromu olarak değerlendirildi. Dahiliye servisine yatırıldı. Dahiliyede yapılan tetkiklerinde parathormon:7.3pg/ml (12-72 pg/ml), TSH 7.22 uIU/ml (0.27-4.2 uIU/ml), sT4 1.22ng/ml (0.93-1.7 ng/ml)



POSTER BİLDİRİLER

olarak saptandı. Verilen kalsitriol ve kalsiyum replasmanı ile klinik bulguları düzelen hasta poliklinik kontrolüne gelmek üzere taburcu edildi.

Sonuç: Tiroidektomi sonrası en sık görülen metabolik komplikasyon paratiroid hasarı sonucu hipokalsemi gelişimidir. Biyokimyasal çalışmalarda kalsiyum metabolizmasındaki değişiklikler (hipokalsemi, hiperkalsemi) Fahr Hastalığının etyolojisinde en çok suçlanan durumlardır. Sonuç olarak akut nörolojik veya psikiyatrik bozukluklar gelişen, altta kalsiyum metabolizma bozukluğu olan, uzun yıllar ağızdan kalsiyum kullanan ve özellikle yaşlı hastalarda Fahr sendromu ayırıcı tanıda akılda tutulmalıdır.

Anahtar Kelimeler: FAHR sendromu, Hipoparatiroidi, İntraserebral kalsifikasyon, Epileptik Nöbet

P-0969 Other

Aspirasyon Sonrası Zorlamaya Bağlı Pnömomediastinum

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Amaç: Pnömomediastinum, kısaca mediastende hava bulunmasıdır. Alveol içi basıncın ani artışı sonucu alveoller yırtılır. Kendiliğinden, iyatrojenik ve travmatik olabilir. Spontan pnömomediastinumda hastalar herhangi bir travma tanımlamazlar. İn hale ilaç kullanan astımlı olgularda aşırı öksürük, yoğun egzersiz, zorlama, valsava manevrası, özofagusun aşırı zorlanmasına bağlı olarak ikinci gelişme gösterebileceği gibi, vajinal doğum esnasında veya akciğer tutulumu gösteren sarkomlarda komplikasyon olarak da görülebilir. Genel olarak hava, travmatize olduğu yerden (terminal alveol, bronş, trakea, özofagus) dokular arasından diseksiyonla mediastene ve subkutan dokuya geçer. Eğer diseksiyon fazla ise hava boyna, yüze, kollara hatta batına kadar ilerleme gösterebilir. Hastalar genellikle ani gelişen retrosternal plöretik tipte ağrı, subkutan amfizem ve nefes darlığı şikayetleriyle başvurulabilirler. Kardiyak muayenede sistole senkronize çırtı sesi "crunching" karakteristiktir. (Hamman sign) Bizde Kalem ucunu aspire edip daha sonra onu çıkarmak defalarca öksürükten sonra pnömomediastinum gelişen olgumuzu sunmak istedik. **Olgu:** 15 yaşında erkek hasta acil servisimize kalem ucunu aspire edip sonra defalarca öksürük çıkardıktan sonra başıyla göğüs ağrısı, nefes darlığı şikayetiyle başvurdu. Gelişinde TA:110/70 Nabız:110 SS:13 Ateş:37 SatO2:97 idi. Başvuru anında aktif şikayeti yoktu. Bilinen ek hastalığı olmayan hastanın fiziki muayenesinde özellik yoktu. EKG, PA Akciğer grafisi doğal olarak değerlendirildi. Hemogram ve troponin değerleri normaldi. Bunun üzerine çekilen Toraks BT'de servikal bölgeden başlamak üzere paravertebral alanda ve vasküler yapılar etrafında mediastende hava değerleri izlendi. Pnömomediastinum olarak değerlendirilen hastaya 4-6lt/dk dan nazal O2 başlandı. Göğüs cerrahisi ile konsulte edilen hasta takip ve tedavi amaçlı servise yatırıldı.

Sonuç: Nefes darlığı, göğüs ağrısı şikayetleri ile başvuran hastalarda ayırıcı tanıda spontan pnömomediastinum mutlaka düşünülmelidir. Çoğunlukla kendini sınırlayan ve benign seyirli olmasına rağmen tansiyon pnömomediastinum gelişebileceği unutulmamalıdır.

Anahtar Kelimeler: Pnömomediastinum, Aspirasyon, Göğüs Ağrısı, Öksürük

P-0970 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Ağızdan Gelen Taenia Saginata

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Antalya Eğitim Araştırma Hastanesi

Amaç: Sığır etinden bulaşan ve Türkiye'de en yaygın olan türü Taenia saginata olarak da bilinen, ince bağırsakta yaşayan, yassı solucanlar takımının sestod familyasına ait, omurgasızlar şubesinden bir hayvan cinsidir. Karın ağrısı, bağırsak boşaltımında sorunlara ve kilo kaybına sebep olabilir. En yaygın belirti olarak; Yutaktaki hareketleri tükürük bezlerini uyandırdığı için, uykuda salya akıntısı ile ortaya çıkar.

Olgu: Acil servisimize 22 yaşında erkek hasta ağzından solucan gelmesi şikayeti ile başvurdu. hasta son 1 yıldır karın ağrısı bulantı ve kilo kaybı şikayetleri ile bir çok defa hastane başvuruları olmuş, peptik ulcus tedavisi hatta depresyon tanısı ile antidepresan başlandığını ve hastanın uzun süredir ayda 4-5 defa etli çiğ köfte yediğini öğrendik. Hastanın yapılan fizik muayenesinde tansiyon arteriyel 120/70mmHg ve nabız 92/dakika idi. Solunum hızı: 16/dakika, Ateş: 37.6 oC idi. ek patolojik bulgu saptanmadı. Tam kan sayımında; Hb=12.6 Hct=38.4, BK=11.300 ve %16 eozinofili saptandı. Kusmuğunda mide içeriği ile birlikte 3 adet yaklaşık 5-6cm uzunluğunda tenia saginataya ait yassı kurtlar vardı. antihelmantik tedavi başlanan hasta enfeksiyon hastalıkları kliniğine yönlendirildi.

Sonuç: Acil servise özellikle dispeptik, kilo alamama ve kilo kaybı gibi şikayetlerle başvuran ve anti ülser ve benzeri tedavilere cevap alınmayan hastalarda nadir bir neden olan paraziter hastalıklarda akla getirmek, anamnezde dikkatli olmak yanlış tanı ve tedaviyi engelleyecektir.

Anahtar Kelimeler: Bulantı, Kilo kaybı, Taenia

P-0971 Other

YASADIŞI GÖÇTE SON NOKTA: ACİL SERVİSTE HİPOTERMİ: Vaka Sunumu

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Amaç: Boğulayazma, kaza eseri sıvıya batma olayından kurtarılan bir kişinin, kurtarıldıktan 24 saat sonra sağ olması olarak tanımlanmaktadır.1,2. Ülkemizde acil servislere gelen boğulma ve boğulayazma vakalarının sayısı bilinmemekle birlikte, bazı akademik çalışmadan4-9 öteye bilgiye ulaşmak da mümkün değildir. Oysa 3 tarafı denizlerle çevrili ülkemizde bu oranın küçümsemeyecek kadar yüksek olduğu düşünülmektedir.3

Bu olgu, deniz yoluyla insan kaçakçılığı yapan bir teknenin batması sonucu yaklaşık 15 saat suda kalan bir erkek olgu, hem acil serviste suda boğulma tehlikesi geçiren olguların klinik verileri ve hemşirelik yaklaşımları hem de dünyanın modern köleliği olarak bilinen insan kaçakçılığına dikkat çekilebilecek adına sunulmuştur.

Olgu: 33 yaşındaki Suriyeli erkek olgu 12 kişi ile birlikte deniz yoluyla yasadışı göç sırasında, teknenin batması sonucu 15 saatten fazla tahta parçasına tutunarak suda kalmış, sahil güvenlik tarafından kurtarılarak helikopterle acil servisimize nakledilmiştir. Olgunun geliş kan basıncı(TA):141/87, nabız:89, solunum:26/dk, O2sat:89, rektal ateş:33°C, kan şekeri:61mg/dl, bilinç açık,GKS:13 idi. Olgu travma hastası protokolüyle sedyeye alınıp monitörize edildi. ABCDE değerlendirmesi yapıldıktan sonra, kan gazı alındı, intravenöz(IV) yol açıldı, laboratuvar örnekleri adli olgu protokolü ile alınıp hipotermik hastaya yaklaşım algoritması uygulandı. IV sıvılar ısıtılarak verildi,external ısı uygulaması yapıldı. Hastanın Türkçe bilmemesi nedeniyle Arapça bilen bir sağlık personeli ile hastayla iletişim kurulmaya çalışıldı. Hastanın izleminde kas enzim yüksekliği nedeniyle(CK:4133,CK-MB:62,Miyogloblin:1662) rabdomiyal bulguları,laboratuvar değerleri ve aldığı çıkardığı sıvı takibi ile izlendi. EKG'sinde;hipotermik titremeye bağlı hareket artefaktı dışında patoloji yoktu. 4 saat sonra total parenteral nütrisyon desteği sağlandı ve hasta gelişinden 8 saat sonra oral alıma başladı.Olgu acil servise kabulünden 24 saat sonra nörolojik, kardiyojenik ve renal sekel gelişmeden taburcu edilerek emniyet görevlilerine teslim edildi.

Sonuç: Acil serviste hipotermik hastaya yaklaşım bir ekip işidir.Bu olgularda ekibin başarısı, hemşirenin hipotermik hastaya yaklaşım protokollerini bilmesi,uygulama becerisi ve hızı ile yakından ilgilidir. Hastanın tedavi sürekliliği sağlanırken bakımın yetersizliğine bağlı oluşabilecek komplikasyonlar süreci zora sokabilir. Bu nedenle acil servis hemşiresinin bu ve benzeri olgularda adli süreç dahil olmak üzere bakım yönetimi konusunda yeterliliği dışlanamaz bir gerçektir. Diğer taraftan ülkemiz coğrafi konumu itibarıyla, Ortadoğu'dan Avrupa'ya illegal göç için transit ülke olması nedeniyle,yasal yaptırımların ekonomik ve sosyal boyutu yanında insan hayatının önemi de gözönüne alınarak düzenlenmesi evrensel bir sorumluluktur.

Anahtar Kelimeler: Boğulayazma, acil servis, hipotermi, yasadışı göç

P-0972 Other

Acil Servis Hemşirelerinde Örgütsel Bağlılık Ve Etkileyen Faktörler

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Amaç: Bu araştırmanın amacı, acil serviste çalışmakta olan hemşirelerin örgütsel bağlılıklarına etki eden faktörleri incelemektir.

Gereç-Yöntem: Anketler, Ege Üniversitesi Tıp Fakültesi acil servisinde çalışan 50 hemşire üzerinde uygulanmıştır. Verilerin değerlendirilmesi amacıyla frekans tabloları düzenlenmiş, güvenirlik (cronbach's Alpha), faktör, korelasyon ve varyans analizleri t testi, anova ve tukkey testi kullanılmıştır. Faktör analizi sonuçlarına göre üç örgütsel bağlılık faktörü ortaya çıkmıştır (duygusal bağlılık, devam bağlılığı, normatif bağlılık). Örgütsel stres ile örgütsel bağlılık ve örgütsel bağlılık bileşenleri arasındaki ilişkiler, pearson korelasyon analizi ile test edilmiştir.

Bulgular: Bu analiz sonucunda örgütsel stres ile normatif, devam, duygusal alt ölçekleri arasındaki ilişki istatistiksel olarak anlamsız bulunmuştur (p>0.05). Duygusal bağlılık erkeklerde kadınlara göre istatistiksel olarak yüksek ve anlamlı (p<0.05), ücreti yeterli bulmayanların normatif bağlılığı düşük (p<0.05) bulunmuş ki bu ülkemizdeki işe alım ve istihdam sisteminin bir doğal sonucu olarak beklenmesine karşın total normatif bağlılık beklenenden yüksek bulunmuştur (21,06±4,91). Hemşirelerin orta düzeyde çıkan örgütsel streslerinin bağlılık üzerine etkili olmadığı görüldü.

Sonuç: Bu çalışma sonuçlarına göre, acil servis hemşirelerinin örgütsel bağlılıklarının geliştirilmesinde mevcut ücret uygulamasının iyileştirilmesi ve çalışma koşullarının düzeltilmesi öncelikli ele alınması gereken konular olarak görülmektedir. Sonuçların acil hemşirelerinin sorunlarına yönelik bilimsel toplantılarda kaynak olabilemesi amacıyla bu çalışmamızın diğer hastanelerin acil servislerinde çalışan hemşirelerin de dahil edilerek verilerin çoğaltılması sonucuna varılmıştır.



POSTER PRESENTATIONS

Anahtar Kelimeler: Örgütsel stres, örgütsel bağlılık, acil servis hemşireleri

P-0973 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Toksik Hepatitin Nadir Bir Nedeni

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Amaç: Akut hepatit karaciğer hücreleri nekrozu ve karaciğerin inflamasyonu ile giden bir tablodur. Akut hepatit tablosuna sıklıkla virüsler, ilaçlar ve alkol yol açar. Bu olguda fenofibrat kullanımına bağlı toksik hepatit vakası anlatılmaktadır.

Olgu: 56 yaşında erkek hasta 2 gün önce başlayan bulantı, kusma ve halsizlik şikayeti ile acil kliniğimize başvurdu. Hastanın yapılan fizik muayenesinde batında hassasiyet mevcuttu, defans ve rebound yoktu. Vital bulgularında; kan basıncı: 120/70 mmHg, nabız:72/dk vücut ısısı 36,7 °C ve SaO2:97 idi. Hastanın özgeçmişinde alkol kullanımı, kan transfüzyonu ve sarılıklı hasta ile teması yoktu. Bir ay önce hiperlipidemi tanısı alan hastanın günde 1*200mg fenofibrat kullanımı mevcuttu. Hastanın kontrol amacıyla geldiği üç ay önceki karaciğer enzimleri normaldi. Yapılan biyokimyasal kan tahlillerinde AST:463IU/L, ALT:509IU/L, GGT:420, ALP:109 IU/L bulunurken total bilirubin, albümin, açlık kan şekeri normaldi. Anti-HbsAg antikor pozitif, HBsAg, antiHCV ve AntiHEV negatif bulundu. Yapılan hepatobiliyer ultrasonografide karaciğer boyutu ve parankimi normaldi. Hasta fenofibrata bağlı toksik hepatit ön tanısıyla gastroenteroloji servisine yatırıldı. Fenofibratı stoplanan hasta on gün sonra AST/ALT değerleri tamamen normal olarak taburcu edildi.

Sonuç: Fenofibrat kullanımına bağlı karaciğer enzimlerinde yükselme ve toksik hepatit nadirinde olsa görülmektedir. Karaciğer enzim değerlerindeki yükselmelerde ilaç kullanımını ayırıcı tanıda düşünmek gerekmektedir.

Anahtar Kelimeler: hepatit, toksik, fenofibrat

P-0974 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Alkollü Hastada Görüntülemenin Önemi

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Amaç: Serebral anevrizma serebral arteriyel kan damarlarındaki genişleme ve balonlaşma sonrası meydana gelen zayıflık sonucu oluşan serebro vasküler bir bozukluktur. Anevrizmaların en büyük tehlikesi yırtılarak (rüptüre olması) ölümcül olabilen beyin kanamalarına yol açabilmeleridir. Risk faktörleri arasında hipertansiyon, sigara, diyabet, fazla miktarda alkol kullanımı, travma ve genetik yatkınlık yer almaktadır. Baş ağrısı, bulantı, kusma, çift görme, ense sertlik, fotofobi, his kusurları gibi şikayetlerle ile belirti vermektedir. Bu olguda alkol kullanımı sonrasında baş ağrısı ve bulanık görme şikayetleri ile acil servise gelen ve serebral anevrizma tespit edilen hasta sunulmuştur.

Olgu: 35 yaşında erkek hasta sabaha karşı alkol alımı sonrasında baş ağrısı ve bulanık görme şikayeti ile geldi. Hastanın genel durumu iyi, bilinç açık, KB:120/70mmHg, Nb:72/ dk A:36 °C K:15 idi. Fizik muayenede görmede bulanıklık ve görme alanı eksikliği mevcuttu. Papil ödem yoktu. Hastanın motor muayenesi normal ve facial asimetrisi yoktu. Hastanın laboratuvar bulgularında tam kan, biyokimya ve kan gazı değerleri normaldi. Çekilen beyin tomografisinde hiperdens alan tespit edildi. MR ile korele görüntüsünde anevrizma olarak değerlendirildi. Beyin cerrahisi ile konsülte edilen hasta anjiyografiye alındı. Anjiyografide sağ intraserebral arter proksimalde supraklinodi segmentte yaklaşık 7x6mm boyutlarında, sol intraserebral arter proksimalde supraklinodi segmentte yaklaşık 8x7mm boyutlarında olmak üzere iki adet anevrizma izlenmiş olup hasta beyin cerrahi yoğun bakıma yatırıldı.

Sonuç: Acil servislerde sıkça karşılaştığımız alkollü hastaların şikayetlerini sadece alkolle bağlayarak göz ardı etmemeliyiz. Yeni gelişen görme bulanıklığı, baş ağrısı ve kronik alkol alımı olan hastalarda ayırıcı tanıda serebro vasküler patolojileri düşünmeliyiz ve görüntüleme yöntemlerinden faydalanmalıyız.

Anahtar Kelimeler: anevrizma, serebral, alkol

P-0975 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Millard Gubler Sendromu

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Amaç: Çoğunlukla ventral pons lezyonu sonucu ortaya çıkan Millard-Gubler nadir görülen bir sendromdur. Biz de aşağıda ventral pons düzeyinde coumadine bağlı hematoma nedeniyle Millard-Gubler sendromu oluşan bir olgumuzu sunduk.

Olgu: 60 yaşında bayan hasta bulanık ve çift görme şikayeti ile acil servise başvurdu. Özgeçmişinde hipertansiyonu, diabetes mellitusu, atrial fibrilasyonu olan hasta coumadin kullanıyordu. Vitallerinde kan basıncı: 162/77 mmHg, nabız:132/dk, ateş:37,8 °C, kan glukozu: 133. Hastanın yapılan nörolojik muayenesinde; sağ göz dışı bakış kısıtlı, sağ nazolabial oluk silik, sol üst ve alt ekstremiteler -5/5 kas gücünde, sol yüz yarısı dahil hemihipoestezi mevcuttu. INR düzeyi 2.5 tespit edilen hastanın diğer biyokimyasal değerleri normaldi. Hastanın çekilen bilgisayarlı beyin tomografisinde (BBT) aktif kanama bulgusu yoktu. MRI'da pons-mezensefalon sağ kesiminde T1 ağırlıklı görüntülerde hipointens, T2 ağırlıklı görüntülerde hiperintens sinyal şiddetinde gradient sekans görüntülerde hipointens izlenen fokal alan görüldü (akut hemorajik odakla uyumlu). Coumadin kullanma öyküsü olması sebebiyle hastaya taze donmuş plazma verilerek INR düzeyi 1.5 altına tutuldu. Hastaya genel durumunun kötüleşmesi ve glaskow koma skorunun gerilemesi üzerine kontrol BBT çekildi. Kontrol BBT'de sağ pons-mezensefalon düzeyinde hiperdens alanın arttığı görüldü ve hasta yoğun bakım ünitesine alındı. Medikal tedavi planlanan hastanın takiplerinde nörolojik muayenesi düzeldi ve taburcu edildi.

Sonuç: Pons düzeyinde bir lezyonda, piramidal lifler henüz çapraz yapmadığından karşı vücut yarısında parezi ortaya çıkar, eğer lezyon 6. ve 7. kranial çekirdeklerin etkilemesi ise lezyona ipsilateral periferik tipte yüz felci ve aynı tarafta dışı bakış paralizisi görülür. Millard-Gubler sendromu çoğunlukla ventral pons lezyonu ile oluşur. Acil servise bu şikayetlerle gelen hastalarda Millard-Gubler sendromundan şüphelenmek gerekir.

Anahtar Kelimeler: Millard Gubler, hematoma, pons

P-0976 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Epileptik Nöbetle Gelen Ölüm

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Amaç: Ülkemiz gibi endemik olan bölgelerde Kist Hidatik(KH) tanısı ve tedavisi halen problem olmaya devam etmektedir. KH'in periton içine rüptürü ciddi anafaktik reaksiyonlara neden olabilir. İntraperitoneal KH rüptürünün en önemli nedeni travma sonrası oluşan kist rüptürüdür. Travmatik KH rüptürü incelendiğinde en sık mekanizmanın düşme olduğu bir çalışmada gösterilmiştir. Periton içine rüptüre olan KH hastalığında sistemik anafaktik reaksiyon oranı %1 ile %12.5 arasında bildirilmiştir. Anafaksi gelişen vakalarda ani ölüm oranının %25 olarak çalışmalarda mevcuttur. Karaciğer kist hidatik rüptürü için yaş, kist çapının > 10 cm olması ve yüzeysel yerleşimli olması belirgin risk faktörleri olarak tespit edilmiştir.

Olgu: 25 yaşında, erkek hasta banyoda jeneralize tonik-klonik nöbet geçirdiği şikayeti ile 112 ekibi tarafından acil servisimize getirildi. Hastanın üç gündür viral üst solunum yolu enfeksiyonu nedeni ile analjezik antipiretik ilaçlar kullandığı hasta yakınları tarafından bildirildi. Bilinen Hipotiroidi ve epilepsisi olan hasta mevcut ilaçlarını da düzenli kullanmaktaydı. Birkaç gündür bulantı ve kusması da olan hasta servisimize getirildiğinde genel durumu iyi bilinci açık, koopere, oryanteydi. TA:140/70 mmHg, Nabız:90/dk Ateş:37 °C, Saturasyon: % 95 olarak tespit edildi. Hastanın tüm fiziki muayenesi doğaldı. Nöbetin ayırıcı tanısı için hastadan hemogram, biyokimya, kan gazı, beyin tomografisi ve EKG çalışıldı. White blood cell:7.9 K / u/L, Hemoglobin:15.5 g / dL, PLatelet:265 K / u/L, glukoz:151 mg/dL, üre:64 mg/dL, kreatinin:1.2 mg/dL, Aspartat transaminaz: 46 U/L, Alanin Transaminaz:15 U/L, Na:113 mmol/L, K:4.7 mmol/L Cl:121 mmol/L tesbit edildi. EKG normal sinus ritminde idi. Beyin tomografisi normaldi. Hiponatremisi birkaç gündür olan viral üst solunum yolu enfeksiyonundan dolayı ortaya çıkan oral alım bozukluğuna bağlıydı. Sıvı elektrolit tedavisi yapıldı. Takibinde akut sorun gözlenilmeden ve hiponatremisi düzelen hasta önerilerle taburcu edildi. Hastanın taburculuktan 5 saat sonra yatağında exitus olarak bulunduğu tarafımıza iletili. Hasta yakınlarının şikayeti üzerine savcılığa intikal eden vakaya otopsi yapıldı. Adli tıp kurumu tarafından yapılan otopsi sonrası ölümün karaciğerinde kist hidatik rüptürü nedeniyle gerçekleştiği kararı verilmiştir.

Sonuç: KH fizik muayene ile tanı konulabilen bir hastalık değildir. Olgumuzda muhtemel tonik klonik kasılmalar sırasında meydana gelen minimal bir travmanın rüptüre neden olduğunu düşünmekteyiz. Kist hidatik olgularının sık görüldüğü ülkemizde her zaman ayırıcı tanıda düşünülmesi gereken bir durumdur.

Anahtar Kelimeler: epileptik nöbet, kist hidatik rüptürü, travma



POSTER BİLDİRİLER

P-0977 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Nefes Darlığının Nadir Bir Nedeni

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Amaç: Pulmoner hipoplazi farklı oranlarda azalmış veya az gelişmiş akciğer dokusu ile kendini gösteren gelişimsel konjenital bir anomalidir. Pulmoner hipoplazide hava yollarında, alveollerde ve damarların sayısı ve büyüklüğünde azalma ile seyreden bir anomalidir. Pulmoner hipoplazi daha çok çocukluk çağında yanı alırken yetkinlerde nadiren görülmektedir. Biz olgumuzu 56 yaşında bir kadın hastada pulmonerhipoplazi tanısı konması nedeniyle sunmayı uygun bulduk

Olgu: Hasta halsizlik, ateş çksürük ve eforla artan solunum sıkıntısı ile acil servisimize başvurdu. Hastanın ilk muayenesinde dispneik görünümde, Solda solunum sesleri alınamıyordu sağda ise bazakde ralleri mevcut olup SS:25/dk, TA:140/70 mmHg, Ateş:37,6 C, Nb:115 /dk idi. Kangaıznda: pH: 7,36, SO2 %83, PO2:46, PCO2: 33 idi, diğer Labortuvar bulguları BK:18.000, CRP: 319 idi, Çekilen Akc. filminde solda dansiye artışı görüldü tüp torakostomi planlanırken Akc. BT çekilde ve Pulmoner Hipoplazi tanısı kondu.

Sonuç: pulmoner hipoplazili hastalar eşlik eden hastalık nedeniyle yanlış tanı konulup erken dönemde yanlış tıbbi müdahalelere neden olabilir bu nedenle bu tip hastalarda daha çok dikkatli olunmalıdır.

Anahtar Kelimeler: Pulmoner hipoplazi, dispne, Pulmoner BT

P-0978 Other

Acil Serviste Baş ve Yüz Ağrısının Nadir Sebebi; Maksiller Sinüste Yabancı Cisim

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Giriş ve Amaç: Baş ve yüz ağrısı yaygın olarak acil servise başvuru sebepleri arasındadır. Baş-yüz ağrısı nedeniyle başvuran ve maksiller sinüste yabancı cisim tanısı koyduğumuz hastayı sunmayı amaçladık.

Olgu: Yirmi iki yaşında erkek hasta 2 gündür devam eden, analjezik/anti inflamatuvar ilaçlara yanıt vermeyen baş ve yüz ağrısı nedeniyle kliniğimize başvurdu. Ağrının sağ yüz bölgesinde başladığı ve diş hekimine başvurduğu ve diş çekimi yapıldığı ancak ağrısının devam ettiği öğrenildi. Özgeçmişinde ilaç kullanımı öyküsü yoktu. Fiziki bakışında genel durum iyi şuur açık, kan basıncı 130/75 mmHg, kalp tepe atımı:84/ dk, vücut ısısı 37 C, pupiller izokorik, ense sertliği yok. Nöromusküler sistem muayenesinde özellik yoktu. Laboratuvar bulgularında WBC: 12.000 K/UL diğer değerler normal olarak tespit edildi. Oral kavite muayenesinde sağ 1. molar diş alveolünde maksillere açılan perforasyon tespit edildi. Hastanın çekilen BBT'inde sağ maksiller sinüste posterior tabanda diş ile uyumlu opasite tespit edildi. KBB Kliniğine danışılan hastaya elektif cerrahi planlı, enfeksiyon profilaksisi, NSAİ ilaç ve tuzlu karbonatlı sıvı ile burun lavajı önerildi.

Tartışma ve Sonuç: Maksiller sinüste yabancı cisim, baş-yüz ağrısının nedenleri arasında nadir görülen bir durum olup diş çekiminin bir komplikasyonu olarak karşımıza çıkmaktadır. Diş çekimi sırasında distobukkal kök maksiller sinüse kaçabildiği gibi buradaki yabancı cisim burun boşluğu ve sinüs ethmoidalise migrasyon gösterebilir. Bu nedenle baş-yüz ağrısı ile gelen hastada öykünün iyi sorgulanması ve ayırıcı tanıda olası maksiller sinüste yabancı cisimler akılda tutulmalıdır.

Anahtar Kelimeler: Maksiller sinüs, yabancı cisim, baş-yüz ağrısı

P-0979 Other

Acil Asistanlarının Nöbet Öncesi ve Nöbet Sonrası Anksiyete Düzeyinin Beck Anksiyete Skoru ile Saptanması

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Amaç: Doktorlarda yüksek oranda görülen, iş ve aile hayatını olumsuz yönde etkileyen anksiyetenin acil tıp asistanlarındaki düzeyinin saptanması amaçlanmıştır.

Gereç-Yöntem: Ankara, Gaziantep ve Kahramanmaraş 'taki %63'ü erkek,%37'si kadın olmak üzere toplam 106 acil tıp asistanı araştırmaya dahil edildi. Araştırmanın bağımlı değişkeni Beck Anksiyete parametreleridir. Bağımsız değişkenler; yaş, cinsiyet, medeni hali, çalıştığı kurum, asistanlık süresi, çalışma sistemi, aylık çalışma süresi, sigara kullanımı, alkol kullanımı, kronik hastalık mevcudiyeti, ailede psikiyatrik hastalık mevcudiyeti, kendinde psikiyatrik hastalık olması durumlarıdır.Katılımcılar ile hem nöbet öncesi hem de nöbet sonrası yüz yüze görüşme yöntemi ile anket çalışması yapılmıştır.

Bulgular: Katılımcıların nöbet öncesi anksiyete skoru 9.32±10.42 iken, nöbet sonrası bu değerin 11.51±11.07'ye yükseldiği tespit edildi (p: 0.035). Sigara içenlerin nöbet öncesi beck anksiyete skoru 9.35±11.82 iken, nöbet sonrası beck anksiyete skoru 13.41±11.80 olarak saptanmıştır (p= 0.018). Tüm grupta acil tıp asistanlarının çalıştığı kurum ile nöbet sonrası beck anksiyete skoru arasındaki ilişkiye bakıldı ve üniversite hastanesinde çalışanlarda beck anksiyete skoru daha yüksek bulundu (p=0.013). Üniversite hastanelerinde çalışan acil tıp asistanlarının nöbet öncesi beck anksiyete skoru 10.00±11.22 iken nöbet sonrası beck anksiyete skoru 14,78 ± 14.04 olarak saptandı (p= 0.004). Shift şeklinde çalışan acil tıp asistanlarının nöbet öncesi beck anksiyete skoru8.93±10.33 iken nöbet sonrası beck anksiyete skoru 11.47±11.16 olarak saptandı. (p=0.019).

Sonuç: Acil tıp asistanlarının nöbet öncesi anksiyete skorlarının toplamun anksiyete skorlarına göre daha yüksek olduğu saptanmıştır. Ancak yüksek olan anksiyete skorlarının nöbetten sonra ise daha da arttığı bulunmuştur.

Anahtar Kelimeler: Acil Nöbet Anksiyetesi, Acil tıp asistanı, Acil servis nöbeti

P-0980 Other

ACİL HEMŞİRELİĞİNDE YENİ TREND: Günlük İnovasyon

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Amaç: Acil servisler(AS)ani/beklenmedik bir anda kişinin hayatını tehdit eden hastalık yada yaralanma durumunda,ilk değerlendirilmesinin, tedavisinin/stabilitesinin yapıldığı ve ileri bakım ve takibinin ilgili hekime devredildiği alanlardır.AS'de hasta başvurusu 7 gün 24 saat kesintisizdir.AS'de çalışan personelin öncelikli hizmeti bu kesintisiz başvuruları yanıtlamaktır.Yatırlamadığı için AS'de kalan hastaların uzun süren ve farklı olan bakımı personel için ciddi iş yükü oluşturmakta, hastalar ve genel olarak AS'in bakım kalitesini düşürmektedir.24 h üzerinde AS'te kalıp yatış bekleyen hastanın hemşirelik bakımı,acil yaklaşımın sonlandığı dolayısıyla acil hemşireliğinden(AH), yoğun bakım (YB)hemşireliğine geçiş dönemi olarak değişmektedir.Ancak bu süreçte acil bakım gerektiren hasta sirkülasyonu devam ettiği için AH bir şifte acil veYB hemşiresi olarak değişim göstermektedir.Son yasal düzenlemeyle AH'nin görev ve sorumlulukları zaten hemşire sayısıyla ters yöndeyken,YB hemşireliğinin sorumluluklarıyla taçlandırılan AH'nde, yoğunluğa/yorgunluğa bağlı yaşanabilecek malpraktisler bu kadar özverinin ödülü? olmamalıdır. Bu olgu AH'nin yatış bekleyen acil hastaların izlem ve bakımı sırasında değişen sorumluluklarına dikkat çekmek amacıyla yapılmıştır.

Olgu: Bir gün öncesinde başlayan bulantı-kusma şikâyetiyle gelen 80 yaşındaki,Sağlık Bakanlığı triyaj skoruna göre 2.düzeyde olan bayan hasta Monitörlü Gözlem birimine alınmıştır.Geliş kan basıncı:90/40,nabız:120,ateş:39,AKŞ:125mg/dl,ağrı skoru:9,bilinç açık,GKS:14,ikterik,+ödemli mevcuttu.Bilinen HT,KKY ve 1ay öncesinde kolesistit nedeniyle opere hastanın acil değerlendirilmesi/girişimleri(anamnez,fizik muayene,monitörizasyon,EKG,IV girişimleri,sıvı replasmanı,laboratuvar örnekleri,radyolojik tetkikleri)standartlara uygun yerine getirildi.Konsültasyonlar sonucunda,Genel Cerrahi,İç Hastalıkları ve Gastroenteroloji Kliniği"kapalı safra kesesi perforasyonu"tanısıyla yer olmadığı notuyla AS'te izlenmesine karar verildi.AH yönetiminde;Düşme skoru 13(yüksek risk),bağımlılık düzeyi 121,üst düzey bağımlı hasta,h'likkan şekeri,vital,bilinç septik şok belirtileri,laboratuvar değerleri,aldığı çıkardığı takibi,total parenteral nutrisyon,ödem bakımı,bası yarası değerlendirilmesi ile bakımı/izlemi planlandı.YBhastası olarak 4gün AS'te yukarıda planlanan hemşirelik girişimleriyle takip edildi ve Gastroenteroloji Kliniği'ne yatışı yapıldı. YB hemşireliği girişimleri gerektiren 6 hastayla birlikte izlenen ve diğer 8 sedyede sürekli acil hasta karşılanan 15 sedyeli monitörlü izlem birimindeki hemşire sayısının vardiyada 2 olduğu düşünüldürse,hemşirelik bakım kalitesinin sağlanması doğaüstü çaba gerektirmektedir.

Sonuç: AS'de yaşanan en önemli problemlerden biri uzun yatış süreleri nedeniyle klinik hizmetlerinin verilmesidir.AS'de günlerce süren hasta yatışları yeni hastaların kabulünü engellemekle birlikte personel açığı,acil olmayan hastaların yoğunluğu,beklemeye bağlı tartışma/şiddet vakaları tüm AS'in ortak sorunlarıdır.Üniversite eğitimi/araştırma hastanelerinin 3.basamak sağlık hizmeti vermeleri nedeniyle sevk zincirindeki son noktadır.Ancak bu kurumların AS'ne doğrudan başvuran veya sevkle gelen hastaların tıbbi bakımlarında yatış endikasyonu konulan bölüm tarafından yapılması gerekliliğinde göz ardı edilmemelidir.Hastane yatakları her ne kadar bölümlere belirli sayılarda tahsis edilsede AS'ten yatışı gereken hastalar için tüm yataklar kullanılmalı,yatıran bölüm,hastasının tıbbi bakım sorumluluğunda devralarak takip/tedavisini yapmalıdır.Sorunun en önemli nedeni yatak sayısının azlığı sayılısada,bu sorumluluk,hastalar yada AS çalışanlarına yüklenmemelidir.AH'nden beklenen yasal sorumluluklar YB hemşirelerinden farklıdır ancak güncel durumda yaşananlar birbiriyle çelişmektedir.AH'ni istenir bir hemşirelik uzmanlığı olarak görebilmek bu sorunların çözülmesiyle mümkün olacaktır.



POSTER PRESENTATIONS

Anahtar Kelimeler: acil hemşireliği, acil servis, yatiş bekleyen hasta

P-0981 Imaging in Emergency Units

Akut Batında Nadir bir Neden: Atrial Fibrilasyona Bağlı Splenik İnfarkt

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Amaç: Splenik infarkt günümüzde nadir olarak görülen bir patolojik durum olup genellikle baska hastalıkların komplikasyonu olarak ortaya çıkar.olgumuzda 3 yıldır koroner arter hastalığı ve yüksek ventrikül cevablı atrial fibrilasyon nedeniyle tedavi alan hastanın giderek artan karın ağrısı nedeniyle acil servise basvurması neticesindeki tetkiklerde saptanan splenik infarkt ve tedavisini anlatmayı amaçladık

Olgu: Altmış sekiz yaşında erkek hasta 1 gün önce başlayan sol yan ağrısı, bulantı ve kusma şikayeti ile acil servise başvurdu. Vital bulguları; nabız 125 atım/dakika, kan basıncı 145/90 mmhg, vücut ısı 37.4 OC idi. Özgeçmişinde koroner arter hastalığı ve atriyal fibrilasyon öyküsü vardı. Fizik muayenesinde sol kostovertebral açı hassasiyeti dışında başka patolojik bulgusu yoktu. EKG'sinde ventrikül yanıtı atriyal fibrilasyon vardı. Hastanın tam kan sayımı ve biyokimyasal wbc:18000, hgb:14.3,hct:39.2,plt:342000,glukoz 103,bun28,kreatin:1.2,ast:78,alt:92, tam idrar tetkikinde 5 eritrosit saptandı. diğer bulgular normaldi. Hastaya etyolojik inceleme nedeniyle uygulanan iv kontrastlı ve kontrastsız abdominal bilgisayarlı tomografi (BT) de. dalak üst yarısında normal parankime göre hipodens alan izlendi.radyolojik olarak splenik infarkt ? raporu üzerine hasta yatırılarak antikoagulan tedavi başlandı, sol yan ağrısı geçen,vital bulguları stabil olan ve komplikasyon gelişmeyen hasta yatışının 5. Gününde önerilerle taburcu edildi

Sonuç: KPR serviste çalışan hekimlerimizde sol yan ağrısı ile basvuran hastaların etyolojilerini incelemeye nadir olarak görülen bir patoloji olan splenik infarkt göz ardı etmemeleri gerektiğine inanılmaktadır

Anahtar Kelimeler: splenik, atrial fibrilasyon, infarkt

P-0982 Resuscitation

Kardiyo-pulmoner Resusitasyon Sırasında Oluşan Cilt Altı Amfizem

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Amaç: Kot ve sternum kırıkları, iç organ yaralanması, cilt altı amfizem oluşması gibi durumlar resusitasyon sırasında göğüs kompresyona sekonder gelişen komplikasyonlar arasındadır. Bizim olgumuzda kardiopulmoner resusitasyon sırasında cilt altı amfizem gelişen bir vaka sunulmuştur.

Olgu: Over kanseri ve yaygın metastazları nedeniyle son 10 gündür genel durum bozukluğu olan 45 yaşındaki bayan hastanın; aniden solunumunun yüzeyelleşmesi ve şuurunu kaybetmesi ile yakınları tarafından 112 sağlık ekipleri aranmıştır. Yaklaşık 5 dakika sonra 112 sağlık ekipleri tarafından değerlendirilen hasta kardiopulmoner arrest olarak kabul edilip endotrakeal entübasyonu yapıp kardiak kompresyona başlanmıştır. 10 dakika sonra kliniğimize getirilen hastanın genel durumu kötü, kalp tepe atımı ve solunumu yoktu. Hastaya kardiopulmoner resusitasyon protokolü uygulama sırasında cilt altında krepatasyon oluşmaya başladığı saptandı. Resusitasyonun devamı sürecinde ise cilt altı amfizemin giderek ilerlediği saptandı.

Sonuç: KPR sırasında göğüs kompresyon yerinin doğruluğu, kompresyonun hızı, kopresyonun derinliği ve arrest hastanın göğüs kafesi yapısı gibi birçok değişken faktörlere bağlı komplikasyonlar gelişebilir. Komplikasyonları önlemek için göğüs kompresyonu yaparken dikkatli olunmalıdır.

Anahtar Kelimeler: Kardiopulmoner Resusitasyon, Komplikasyon, Cilt altı amfizem

P-0983 Cardiovascular Emergencies

Hapşırma sonrası gelişen spontan subklavyen arter transeksiyonu

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Amaç: Spontan subklavyen arter yaralanmaları nadir rastlanırlar. Hapşırma sonrası spontan subklavyen arter transeksiyonunu gelişen bir olguyu sunmayı amaçladık.

Olgu: 18 yaşında erkek hasta acil servise hapşırma sonrası sağ omuz ağrısı şikayeti ile başvurdu. Başvuru esnasında asemptomatik olan hastanın vital bulguları stabil, fizik muayenesi normal ve akciğer grafisinde mediasten genişliğinin normalin üst sınırında (7 cm) olması dışında özellik yoktu. Mevcut bulgularla ileri tetkik düşünülmeden hasta taburcu edildi. Hasta yaklaşık beş saat sonra acil servise nefes darlığı ve göğüs ağrısı şikayeti ile tekrar başvurdu. Hipotansif ve taşikardik olan hastanın sağ akciğer orta ve alt zonlarda solunum sesleri azalmıştı, sağ brakial ve radial nabızlar palpe edilemedi. Tetkikleri sonucunda hastada masif hemotoraks tespit edildi. Yapılan uygun sıvı ve kan resusitasyonu sonrası vital bulguları stabil olan hastaya tüp torakostomi yapıldı, hemodimisinin hızla bozulması üzerine acil torakotomi yapılan hastada kanama kontrolü esnasında kardiak arrest gelişti ve yeniden canlandırma işlemine yanıt alınmadı. Postmortem yapılan eksplorasyonda sağ subklavyen arterin arcus aorta birleşme noktasından sirküler olarak tam kat yırtılmaya bağlı olarak tamamen ayrıldığı (komplet transeksiyon) görüldü.

Sonuç: Hapşırma, spontan arter diseksiyonunu tetikleyen minör travmalar arasında yer almaktadır. Mediasten genişliği için belirlenmiş net bir sınır değeri bulunmamaktadır ancak 6 cm ve üzerindeki mediasten genişliği üç kat artmış mortalite ile ilişkili bulunmuştur. Acil servise özellikle ani hareket sonrası başlayan göğüs, sırt, omuz ve kol ağrısı gibi yakınmalarla başvuran ve akciğer grafisinde >=6 cm mediastinal genişlik tespit edilen hastalarda ileri görüntüleme yapılması bu olgudaki gibi nadir ancak mortalitesi yüksek hastalıkların tanınmasında faydalı olabilir.

Anahtar Kelimeler: Minör travma, spontan arter rüptürü, subklavyen arter transeksiyonu

P-0984 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Extremite Yerleşimli Zona

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Amaç: Zona veya zoster olarak da adlandırılan varicella –zoster virüs enfeksiyonu, azalan immün yanıt ile birlikte aktive olan, daha önceden uyku halindeki virüsün reaktivasyonu sonucunda ortaya çıkan bir cilt enfeksiyonudur. Bu yazıda sık rastlanmayan bir tutulum olan bir durum sunulmuştur.

Olgu: 57 yaşında erkek hasta bir haftadır sağ elinde ağrı ve sızlamadan yakınmakta olduğunu ve bir gece önce avuç içinde başlayan birkaç adet yaranın hızla artması üzerine acil servisimize başvurdu. Özgeçmişinde hastalık ve ilaç kullanımı yoktu. Fizik bakıda sağ el avuç içinde püstüller lezyondan başka bir bulgu tespit edilemedi. Vital bulguları TA:120/70 ateş:37 nabız:76 ve saturasyonu:94 idi. Yapılan kan analizinde hemogram, biyokimya ve CRP normaldi. Hasta dermatoloji ile konsülte edildi. Zona reaktivasyonu olduğu tespit edildi. Hasta uygun tedavi düzenlenerek taburcu edildi.

Sonuç: Zona reaksiyonu her zaman bilinen sıkça görülen dermatom alanında tutulumla ortaya çıkmayabilir. El veya kol gibi extremiteelerde simetrisi gövde üzerinde olduğu gibi hemen yanında olmayan vücut bölgelerinde olası lezyonlarda gözden kaçmaması için ön tanımda tutulmalıdır.

Anahtar Kelimeler: Zona, Extremite cilt tutulumu, Nadir zona tutulumu

P-0985 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Bacak ve Ayak Tabanında Veziküler Lezyon Olan Olgu

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Amaç: Herpes zoster, varisella zoster virüsünün reaktivasyonu ile oluşan akut dermatomal viral enfeksiyondur. Genellikle unilateral olarak yerleşen, bir veya iki komşu duysal dermatomda eritemli ve ödemli bir zemin üzerinde grup halindeki ağnız veziküllerle karakterize bir tablodur. Bizim olgumuzda nadir görülen bacak ve ayak plantar yüzde gelişen herpes zoster olgusu sunulmuştur.

POSTER BİLDİRİLER

Olgu: Seksen altı yaşında erkek hasta üç gün önce bacağına ve ayak tabanına başlayan kaşıntı ve ağrı şikayetiyle kliniğimize başvurdu. Aynı şikayetlerle başka merkeze başvurmuş; tüm değerlerinin normal olması üzerine tanı konulamamış. İçin kliniğimize yönlendirilmiş. Özgeçmişinde hipertansiyon dışında bilinen ek hastalığı ve antihipertansif haricinde ilaç kullanım öyküsü yoktu. Fizik bakışında genel durumu orta, bilinci açık, oryante ve koopere idi. Vital bulguları; TA:140/90, nabız 68/dk, ateş 36,4 C, oksijen saturasyonu %96 idi. Sağ alt ekstremitte posterolateralde popliteal bölgeden itibaren S1-S2 dermatom izduşumlarına uyan ayağa kadar inen, ayakta da plantar yüz medialde eritemli zeminde gruplar halinde veziküller vardı. Tam kan, biyokimya ve CRP parametreleri normaldi. Hasta dermatoloji bölümü ile konsülte edildi. Hastaya herpes zoster tanısı konularak tedavisi başlandı.

Sonuç: Ekstremitte ağrıları ile başvuru acil servislere sıklıkla olmaktadır. Ortopedik ve romatolojik sebepler öncelikle düşünülmele birlikte hastanın anamnez ve fizik bakışında inspeksiyon ile dermatolojik ön tanımlar oluşturulabilir. Herpes zoster en sık torasik ve trigeminal ganglionun oftalmik dalı tarafından innerve edilen dermatomlarda görülmesine rağmen bu olguda olduğu gibi nadiren farklı dermatomlarda da tutulum olabilir. Bu gibi atipik yerleşimli lezyonlarda Herpes zoster mutlaka ön tanımda akıldan tutulmalıdır.

Anahtar Kelimeler: Herpes Zoster, Bacakta Zona, Atipik Yerleşim

P-0986 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Tüberküloz tedavisi alan hastaların hemoglobin seviyelerini kontrol ediyor muyuz?

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Amaç: Anti-tüberküloz ilaç tedavisi alan hastalarda, hematolojik parametrelerinde değişiklik olabilmektedir. Sunacağımız olguda, anti-tüberküloz ilaç alımından sonra hemoglobin seviyesindeki düşmeye değinilecektir.

Olgu: Yirmiyedi yaşında, bayan hasta, acil servisimize nefes darlığı, near-senkop, halsizlik şikayeti ile başvurmuştur. Özgeçmişinde tüberküloz peritoniti tanısı olup 4 aydır çoklu anti-tüberküloz ilaç tedavisi aldığı saptanmıştır. Fizik muayenesinde soluk, bitkin gözüken olgunun bilinci açık, Glasgow Koma Skalası:15, TA:80/50 mmHg, NB: 148/dk, konjonktivalar soluk, dil ve mukoza kuru, solunum sistemi normal ve kardiyovasküler sistem taşikardik olarak değerlendirilmiştir. EKG: sinüs taşikardisi. Laboratuvar tetkiklerinde hemoglobin (HGB) seviyesi: 2,3 g/dL, hematokrit: 7,2 %, MCV:75 fL, RDW:18 % olarak saptanan hasta yoğun bakım ünitesine destek tedavisi almak amaçlı yatırılmıştır. Hastaya kademeli olarak 9 Ü eritrosit süspansiyonu verilmiştir. Hemoglobin seviyesi: 14,6 g/dL'e çıkarılan hasta öneriler ile taburcu edilmiştir.

Sonuç: Çoklu anti-tüberküloz ilaç tedavisi alan hastaların düzenli aralıklarla hemoglobin ve karaciğer fonksiyon testlerine bakmak gerekmektedir. Düzenli takip edilen hastaların yaşam konforları ve tedaviye uyumları artacaktır.

Anahtar Kelimeler: anti-tüberküloz tedavi, anemi, tüberküloz

P-0987 Cardiovascular Emergencies

Acil serviste Ultrasonografinin önemi

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Amaç: Yatakbaşı ultrasonografi (USG), acil servislere hastalara daha kolay tanı koymamızı sağlayan bir cihaz olup günümüzün stetoskopu olmaya emin adımlarla ilerlemektedir. Sunacağımız olguda, hastaya USG ile tanısı kolayca konulmuştur.

Olgu: Yetmişdokuz yaşında, erkek hasta acil servisimize 10 gündür şiddetli giderek artan nefes darlığı ve efor dispnesi şikayeti ile başvurmuştur. Bilinen ko-morbid bir hastalığı ve kullandığı herhangi bir ilaç bulunmamaktadır. Fizik muayenesinde TA:90/60 mmHg, NB: 120/dk, Solunum sayısı:20/dk, Oda havası saturasyonu:%94, bilinci açık, Glasgow koma skalası:15, Solunum sistemi olağan, kardiyovasküler sistem taşikardik olarak bulunmuştur. Çekilen Akciğer grafisi (PAAC) olağan, EKG: sinüs taşikardisi (ST-T değişikliği yok), laboratuvar tetkiklerinde değerleri hemogram:normal, üre:79 creatinin:1.31 AST:180, ALT:145, troponin:0.04 olarak saptanmıştır. Yapılan yatakbaşı USG'sinde Ejeksiyon Fraksiyonunun düşük olduğu (<%30) görülmüştür. Öncesinde hiçbir şikayeti olmayan hastaya, Yeni Tanı Konjestif Kalp Yetmezliği tanısı konularak koroner yoğun bakıma tedavi amaçlı yatırılmıştır.

Sonuç: Yatakbaşı USG, acil servislere tanı koymamızı kolaylaştıran, tedaviye başlama zamanını kısaltan, bir nevi "Günümüzün Stetoskopu" olma yolundadır.

Anahtar Kelimeler: yatakbaşı Ultrasonografi, USG, acil servis

P-0988 Cardiovascular Emergencies

Makasla Oluşan Atipik Penetran Kardiyak Yaralanma Vakası

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Amaç: Kalbe penetran yaralanmalar hızlı tanı ve cerrahi girişim gerektiren mortalitesi yüksek travmalardır. Hastaların acil servise canlı olarak ulaştırılma ihtimali çok düşük olmakla beraber hızlı tanı ve cerrahi müdahale ile mortalite azaltılabilir. Olgu sunumumuzda hasta terzi makasıyla yaralanma sonucu acil servise getirilmiştir. Çekilen bilgisayarlı tomografi sonrası hemotoraks ve pnemotoraks olduğu anlaşılan ve kardiyak semptomları olmadan bilgisayarlı tomografide kardiyak yaralanma tespit edilen hastamızın klinik seyrini paylaştık.

Olgu: 38 yaşında erkek hasta kesici alet yaralanması sonrası 112 ekipleri tarafından acil servise getirildi. Hasta acil servis resüsitasyon birimine alındı. Hastanın hikâyesine göre hastanın makasla yaralandığı tespit edildi. Vital bulguları stabil olan ve genel durumu iyi olan hastada yapılan fizik muayenede sol hemitoraksta solunum seslerinde azalma ve sol 7. ile 8. kot seviyesinde orta aksiller hatta yaklaşık 2 cm genişliğinde toraksa nafiz düzgün sınırlı yaralanma tespit edildi. Hastadan çekilen EKG normaldi. Tansiyon 120/80 mmHg, Nb 105 idi. Hastanın oksijen saturasyonunda azalma, dispne, cilt altı amfizem ve buna bağlı krepatasyon olması nedeniyle acil tüp torakostomi planlandı. Hasta Göğüs cerrahi konsülte edildi. Hastaya torasentez yapıldı. Pozitif hava aspirasyonu sonrasında lokal temizlik ve anestezi sonrası; acil tüp torakostomi uygulandı. Antibiyoterapi ve tetanoz profilaksisi yapıldı. Hastaya çekilen toraks BT sonrası değerlendirmede hemopnömotoraks varlığı dışında kalp perikardında yaralanma tespit edildi. Tüp torakostomi sonrası hasta oturur pozisyonda yaklaşık 30 dk takip edildi. Takip sonrası vital bulguları, solunumu, O2 sat % normale döndü. Sat % 99-100 idi. Kontrol EKG normaldi. Hasta kalp damar cerrahi ve göğüs cerrahisi bölümleri ile konsulte edildi. Perikardiyal yaralanma nedeniyle Kalp damar cerrahisi tarafından opere edilen hasta yaklaşık 7 günlük takibi sonrasında taburcu edildi.

Sonuç: Kalbe penetran yaralanmalar mortalitesi yüksek yaralanmalardır. Kalbe penetran yaralanmalar çok hızlı tanı konulması ve tedavi edilmesi gereken vakalardır. Aksi ispat edilene kadar meme, sternum juguler çentik ve üst karın arasında, toraks ön duvarında bulunan yaralanmalar kardiyak yaralanma olarak kabul edilir. Hızlı tanı için ekokardiyografi ve bilgisayarlı tomografi yöntemlerinden yararlanılabilir. Yapılan çalışmalarda genellikle sağ ventrikül yaralanması tespit edilmiştir. Birçok hastada primer suture ile vakalar tedavi edilebilmiştir. Bizim vakamızda hasta makasla yaralandığını söylemiştir. Bu tür metal cisimler öldürücü yaralanmalara neden olabilmektedir. Acil hekimlerinin penetran kalp yaralanmaları konusunda eğitimi önemlidir.

Anahtar Kelimeler: kardiyak yaralanma, kesici alet yaralanması, bilgisayarlı tomografi

P-0989 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Nadir Bir Selülit Vakası: Leptospirozis

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Amaç: Leptospirozis Leptospira cinsi bakterilerle oluşan bir enfeksiyondur. Hastalık hayvanlardan insanlara bulaşan, yaygın, genellikle teşhis konamayan ve sık rastlanan hastalıklardan biridir. Klinik özellikleri hafif grip benzeri bir hastalıktan akut hayatı tehdit edici forma kadar değişir. Leptospirozis en ciddi formu olan Weil hastalığı sarılık, karaciğer ve böbrek fonksiyon bozukluğu, hemorajik diyet ve yüksek mortalite ile karakterizedir. Bu yazıda acil servise bel ağrısı, ateş şikayeti ile başvuran leptospirozis olgusunu literatür ışığında vurguladık.

Olgu: Garson olarak çalışan ve bilinen kronik hastalık öyküsü olmayan 24 yaşında erkek hastanın yaklaşık 1 hafta önce bel ağrısı başlamış. Daha önce bu şikayet ile dış merkeze bir kaç kez başvurmuş ve tedavi olarak analjezik, antiinflamatuvar verilmiş. Hastaneye bir gündür olan ateş ve bel ağrısı ile başvurdu. Muayenede genel durumu orta, bilinci açık koopere, oryante, kan basıncı 90/50 mmHg, nabız:124/dk, A:38.5 °C idi. Lomber bölgede sol paravertebral alandan sakrale kadar uzanan eritem, şişlik ve hassasiyet mevcuttu. Diğer sistemlerin muayenesi normaldi. Beyaz küre 12,78 K/uL, hemoglobin 13,4 g/dL C-reaktif protein 26,6 mg/dL, kreatin 2,5 mg/dL, Aspartat aminotransferaz 111 U/L, Alanin aminotransferaz 61 U/L, Direkt bilirubin 4, mg/dL İndirekt



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bilirubin 7,08 mg/dl, International National Ratio 1,75 INR. Ph:7,37 PCO2:43 PO2:67 idi. Tam idrar tetkiki, glukoz ve elektrolitleri normaldi. Tüm batin ultrasonografisi ve arka-ön akciğer grafisi normaldi. Hastadan kan, idrar ve boğaz kültürü alındı. Hastamızın kontrastsız alt batin magnetik rezolansında L3-S4 düzeylerinde cilt altı yerleşimli enflemasyon ile uyumlu ödem ve sıvı koleksiyonu izlendi. Hastanın takibinde aynı gün içinde skleralarda hemoraji, ekstremitelerden başlayıp yayılım eğiliminde olan peteşi ve purpuraları gözlemlendi. Genel durumu kötüleşen hasta yoğun bakıma yatırıldı. Klaritromisin, Meronem ve Vankomisin başlandı. Hastanın kan, idrar kültürleri ve serolojik testleri tamamen normaldi. Yatışının 6. gününde solunum sıkıntısı ilerlemesi üzerine entübe edildi. Hastaya leptospirozis ön tanısı ile sulperazon ve tigesiklin başlandı. 5 gün sonra ekstübe edildi. 14.günde enfeksiyon servisine alındı. Tedavisi tamamlanan hasta sekelsiz şekilde iyileşerek taburculuğu sağlandı.

Sonuç: Leptospira içerdiği düşünülen tüm örneklerden kültür yapılabilir, sonuçlanması ise uzun zaman alır ve başarısı şansı da çok düşüktür. Erken dönemde başlanan tedavi hastalığın seyrini açısından büyük önem taşımaktadır.

Anahtar Kelimeler: acil servis, leptospira, selülit

P-0990 Other

Acil servise ani başlangıçlı nefes darlığı ile gelen astım hastasında nadir bir sebep: "mermi kovani aspirasyonu" Olgusu

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Amaç: Yabancı cisim aspirasyonu, hastanın kendisinin ağzına koyduğu ya da birisi tarafından ağzına verilen bir maddeyi nefes borusuna kaçırmasıdır. Yabancı cisim aspirasyonları ülkemizde ve tüm dünyada sık görülen ve ölüme neden olan acil hastalıklar arasındadır. Nefes borusuna en sık yiyecekler kaçır (çekirdek, fındık, fıstık, fasulye, nohut gibi taneli gıdalar, kemik parçaları ve meyve çekirdekleri.)

Hastanın yakınmaları, muayene ve akciğer grafisi ile tanı konur. Bazen akciğer grafisi normal olabilir. Bu durumda havayolları acil olarak bronkoskopi ile incelenmelidir.

Olgu: Bu olguda 15 yaşında bilinen astım tanısı olan ve inhaler beta-2 mimetik ajan kullanan, ani gelişen nefes darlığı şikâyeti ile acil servise başvuran hastadan bahsedilmiştir. Öyküsünden 5 yıldır astım tanısı olduğu ve düzenli olarak inhaler tedavi kullandığı öğrenilen hastanın, ağzında mermi kovani ile oynarken aniden aspire ettiği ve nefes darlığı şikâyetinin başladığı öğrenildi. Hastanın vital bulguları normal olarak değerlendirildi. Fizik muayenesinde sağ akciğer orta zonda solunum sesleri azalmış ve wheezing duyuldu. Oksijen saturasyonu oda havasında %97 olarak değerlendirilen hastanın PA akciğer grafisinde sağ ana bronş karına komşuluğunda metal dansitesinde yabancı cisim izlendi (Resim1). Hasta göğüs cerrahi uzmanı ile konsülte edilerek, 6 saatlik açlık sonrası bronkoskopi planlandı. Hasta göğüs cerrahisi kliniğine yatırılarak bronkodilatör inhaler tedavi başlandı. Hasta yatışının 2. Saatinde öksürükle yabancı cisim ekspire etti. Çekilen kontrol grafisinde her iki akciğerin eşit havalandığı ve yabancı cisim görüntüsünün olmadığı izlendi (Resim2). Hasta şifa ile taburcu edildi.

Sonuç: Bu vakada akut başlangıçlı nefes darlığı şikâyeti olan hastalara yaklaşımda, yabancı cisim aspirasyonunu ilk akla gelmesi gereken tanıların arasında olması gerektiği vurgulandı. Yabancı cisim üst hava yollarında olan hastalarda spontan ekspirasyon olabileceği gibi, daha küçük ve keskin cisimlerin alt hava yollarına ilerleyebileceği ve hastalarda torakotomi ihtiyacı doğabileceği de unutulmamalıdır.

Anahtar Kelimeler: Aspirasyon, Mermi Kovani, Yabancı Cisim

P-0991 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Epileptik Atak Nedeniyle Başvuran Hipokalsemik Fahr Sendromu Olgusu

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Amaç: Fahr sendromu bilateral bazal gangliyon kalsifikasyonu ile seyreden klinik bir durumdur.

Fahr sendromu etiyolojisi kesin olarak bilinmemekle birlikte, paratiroid bozuklukları, genetik ve metabolik bozukluklar, enfeksiyöz ve toksik durumlar ile birliktelik gösterebilir. Psikiyatrik bozukluk, yürüme bozuklukları, konuşma bozukluğu, demans ve epileptik nöbetlerle prezente olabilir. Bazı olgularda asemptomatik seyretektedir. Olgumuzda bilinen epilepsi tanısı olan, nöbet geçirme nedeniyle acil servisimize getirilen bir hastanın etiyolojisinin, Fahr sendromuna sekonder elektrolit imbalansı olabileceği ve epilepsi tanısı konmadan önce nöbetlerin elektrolit imbalansı yapabilecek nedenlere bağlı olabileceğinin akılda tutulması gerektiğini vurgulamayı amaçladık.

Olgu: 39 yaşında kadın hasta gün içinde iki kez epileptik nöbet geçirme nedeniyle acil servisimize getirildi. Öyküsünde bilinen epilepsi hastalığı olduğu ve düzenli olarak günde iki kez 100 mg Fenitoin tablet kullandığı öğrenildi. Bir dakika kadar süren kasılması ve ağzından köpük gelmesi sonrasında 15 dakika süren şuur bulanıklığı olduğu öğrenildi. Başvurusunda GKS:15 şuur açık koopere oryante idi. TA:120/70 mmHg Ateş:37.1 °C Nabız:102/dk SatO2:%98 Glukoz:96 mg/dl EKG: normal sinüs ritminde olan hastada fizik bakıda patolojik bulgu saptanmadı. Kan biyokimyasında böbrek ve karaciğer fonksiyonları normal Na: 140 mmol/L K:3.8 mmol/L Cl:102 mmol/L Albümin:4 g/dl Ca:4.7 mg/dl saptanması üzerine kalsiyum replasmanı başlandı. Hastanın çekilen BBT'de bilateral bazal gangliyon kalsifikasyonu gözlemlendi. Radyoloji raporunda Fahr sendromu ile uyumluluğu olduğu söylendi. Fenitoin düzeyi, fosfor ve parathormon düzeyi bakılmadı. Kalsiyum replasmanı sonrası tekrar nöbeti olmayan hasta oral kalsiyum preparatı reçete edilerek kontrol kalsiyum, fosfor, parathormon, seviyeleri ile başvurusu önerilerek taburcu edildi.

Sonuç: Fahr sendromu nadir görülen ve epilepsi ile birlikteliği olabilen bir hastalıktır. Olgumuzda 6 aydır epilepsi tanısı ile ilaç kullanımı olduğu, daha önce hiç BBT çekilmediği ve elektrolit seviyelerine bakılmadığı öğrenildi. Epileptik nöbetlerde elektrolit seviyelerine ve gerektiğinde görüntüleme yöntemlerine başvurulmalıdır. Bu ve benzeri olgularda tedavi ve nöbet kontrolü antiepileptik ilaçlardan ziyade elektrolit seviyelerinin düzenlenmesiyle mümkündür. Olgumuzda epileptik nöbet ile başvuran bir hastada BBT'de bilateral simetrik bazal gangliyon kalsifikasyon varlığında Fahr sendromu düşünülmesi ve eşlik eden elektrolit bozukluklarının tedavisiyle nöbet kontrolü sağlanabileceği nöbete sekonder komplikasyonların önüne geçilebileceği vurgulanmak istenmiştir.

Anahtar Kelimeler: Fahr Sendromu, Epileptik Nöbet, Hipokalsemi

P-0992 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Acil Serviste Akut Pankreatit Tanısı Konulan Hastalarda HAPS, Red Cell Distribution Width ve Neutrophil-Lymphocyte Ratio'nun Prognoz Üzerine Etkisi

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Amaç: Bu çalışmada acil serviste nontravmatik akut pankreatit tanısı konulan hastaların erken dönemde prognozunun saptanmasında kullanılan; klinik Harmless Acute Pancreatitis Score (HAPS), nötrofil/lenfosit oranı ve eritrosit dağılım genişliği (RDW) değerlerinin mortalite üzerine etkisi araştırılmıştır.

Gereç-Yöntem: Bir yıllık çalışma süresince acil servise başvuran ICD10 kodlamasına göre akut pankreatit (K 85.9) tanısı alan hastalar çalışma grubumuzu oluşturdu. Kronik Pankreatitli hastalar ve dosyalarında eksik veri bulunan hastalar çalışmadan dışlandı. Ayrıca acil serviste tanı amaçlı computed tomography (CT) istenmeyen hastalarda çalışmaya dahil edilmedi.

Bulgular: Çalışma kriterlerine uyan 332 hasta çalışma grubumuzu oluşturdu. Hastaların yaş median 53.1 (IQR=36-64) olarak belirlendi. Hastaların % 68.1'de (n=226) bilier etyolojiye sahipti. Hastaların ilk 24 saat içindeki mortalite oranı %4.3 (n=14) olarak belirlendi. Mortalite grubunda yaş ortalaması diğer gruba oranla anlamlı yüksek idi (p=0.001). Baltazar sınıflaması, HAPS skoru, eritrosit dağılım genişliği, nötrofil/lenfosit oranı, yaş, dm ve sistolik kan basıncı kullanılarak yapılan logistic regresyon analizinde mortaliteyi belirlemede tek bağımsız değişken Baltazar sınıflaması olarak belirlendi (OR: 15; 95% CI: 3.5 to 64.4).

Sonuç: Nontravmatik akut pankreatit olgularında ilk 24 saat içindeki mortalite üzerine, Harmless Acute Pancreatitis Score (HAPS), nötrofil/lenfosit oranı ve eritrosit dağılım genişliği (RDW) değerlerinin etkisinin araştırıldığı bu çalışmada hiçbirinin etkili olduğu gösterilememiştir. Mortaliteyi belirlemede tek bağımsız değişkenin Baltazar sınıflaması olduğu belirlenmiştir.

Anahtar Kelimeler: akut pankreatit, N/L oranı, HAPS, RDW

P-0993 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Epileptik Nöbet Sonrası Klavikula Fraktürü

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Amaç: Epileptik nöbet ile ilişkili fraktürler nadir görülen ve bir kısmı nöbet sırasında dış etkenlerle gelişen travmaya sekonder olarak görülen durumlardır(Düşme, çarpma, motorlu araç kazaları vs.).

Olgumuz sol omuz ön yüzde ağrı şişlik ile başvuran travma öyküsü olmayan düzenli ilaç kullanımı mevcut olan bir epilepsi hastasıdır.Olgumuzda epileptik nöbetlerin fraktürlerle olan ilişkisini vurgulamayı amaçladık.

Olgu: 15 yaşında erkek hasta acil servisimize sabah yatağında uyandığında fark ettiği sol omuz ön yüzde şişlik ağrı nedeniyle başvurdu. Gelişinde GKS:15 şuur açık koopere oryante TA: 120/70



POSTER BİLDİRİLER

mmHg Ateş:36 °C Nabız:77/dk idi. Öyküsünde 3 senedir epilepsi tanısı olduğu ve düzenli olarak karbamezapin kullandığı öğrenildi. Ayrıca sabah yorgun uyandığını ve idrar inkontinansı olduğu fark ettiğini ekledi. Fizik bakışında klavikular aralarında belirgin asimetri mevcut olan hastanın sol klavikula üzerinde şişlik, ekimoz ve hassasiyet tespit edildi. Başka bir travma bulgusuna rastlanmadı. Nörolojik muayenesinde motor duysal defisit gözlenmedi, patolojik refleks görülmedi. Serum elektrolit seviyeleri normal ve EKG: normal sinüs ritminde olan hastanın çekilen düz grafisinde sol klavikula orta hatta deplase fraktür gözlemlendi. Omuz Velpau bandajı ile tespit edildi. Analjezik tedavisi başlandı. Hasta Ortopedi ve Nöroloji poliklinik kontrol önerisiyle taburcu edildi. **Sonuç:** Olgumuzda fizik bakıda başka bir travma bulgusu olmadığından ve öyküsünde de çevresel etkenlerden etkilenmediğinin öğrenilmesi üzerine direk bir travma ile ilişkili değil, nöbet sırasındaki kasılmaya bağlı klavikula fraktürü düşünülmüştür. Literatürde epileptik nöbetle ilişkili direk travma veya kasılmaya sekonder çeşitli fraktür olguları mevcuttur. Epileptik nöbetlere bağlı direk travma olmasa da fraktür olabileceği, travma öyküsü olmayan, sebebi açıklanamayan fraktür olgularında etyolojinin epileptik nöbet olabileceği unutulmamalıdır.

Anahtar Kelimeler: Epilepsi, Nöbet, Klavikula Fraktürü

P-0994 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Santral sinir sistemi milier tüberküloz

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Amaç: Santral sinir sistemi tüberkülozu tüm tüberküloz vakalarının %1-2'sini oluşturmaktadır. SSS tüberkülozu üç farklı klinikte karşımıza çıkmaktadır: Menenjit, intrakraniyal tüberküloz ve spinal tüberküloz araknoiditi. Hastalar halsizlik, kişilik değişikliği, baş ağrısı, subfebril ateş, menenjismus, kusma, konfüzyon, hemiparezi, kraniyal sinir felçleri gibi oldukça farklı yakınmalar ile başvurabilirler.

Biz de sol bacakta güçsüzlük yakınması ile gelen bir tüberküloz menenjit vakasını sunacağız.

Olgu: 16 yaşında kadın hasta acil servise sol bacakta güçsüzlük yakınması ile başvurdu. Özgeçmişinde 5 aydır amenore ve 1 ay içinde yaklaşık 10 kg kilo kaybı, soygeçmişinde ise ailede tüberküloz öyküsü mevcuttu. Geliş vitalleri TA: 110/70 mmHg, Nb: 86/dak, Ateş: 37.2°C olan hastada GKS: 15 idi. Yapılan nörolojik muayenede kas gücü sol alt ekstremitte proksimal 3/5, distal 2/5, diğer ekstremiteler 5/5 olarak saptandı. DTR doğal, TDR sağda fleksör, solda ekstansör idi. Başka patolojik muayene bulgusu yoktu. Tetkiklerinde WBC: 14800/mm3, neut: 11900/mm3, Na:128 meq/dL, glukoz:119 mg/dL, üre:15 mg/dL, kreatinin: 0.9 mg/dL, AST: 48 IU, ALT: 97 IU idi. Hastanın kraniyal BT'sinde sol frontoparietal bölgede hipodens olup, difüzyon MRG'de hiperintens görünen bir lezyonu mevcuttu. Toraks BT'de mediastinal LAM, plevral efüzyon, akciğer parankiminde diffüz nodüler tutulum saptandı.

Hastanın takiplerinde ense sertliği, ateş ve kompleks parsiyel tipte nöbet gelişmesi üzerine hastaya LP yapıldı. BOS glukoz: 14 mg/dL, eş zamanlı biyokimya hemolizli, mikro total protein: 72.7, LDH: 53IU, lökosit: 41/mm3 (%90 PNL, %10 lenfosit), RBC yok, PANDY (+) olarak saptandı. Hastanın LP ve kandan areob ve tüberküloz kültürleri gönderildi. Mevcut BOS bulguları ve görüntülemeler sonucunda kraniyal tutulumu olan milier tüberküloz ön tanısı ile hasta interne edildi ve antitüberküloz tedavi başlandı.

Sonuç: Acil servise nörolojik semptomlarla başvuran hastalarda enfeksiyöz nedenler de ayırıcı tanıya girmeli ve aile anemnezi ayrıntılı olarak sorgulanmalıdır. Ülkemizde oldukça sık görülen tüberküloz enfeksiyonunun çok çeşitli klinik bulgularla başvurabileceği akılda tutulmalıdır.

Anahtar Kelimeler: aile öyküsü, anemnez, milier tüberküloz, santral tutulum

P-0995 Other

Acil Serviste İnatçı Hıçkırığın Tedavisi Sırasında Beklenmeyen Bir Yan Etki: Delirium

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Amaç: Hıçkırık, solunum kaslarının istemsiz, spastik kasılmasıdır. Klorpromazin (Largactil) antipsikotik (nöroleptik) ilaçlar grubuna ait ilaçtır. Şizofreninin pozitif semptomlarına (delirium, halüsinasyon) etkilidir. İnatçı hıçkırık tedavisinde de önerilmektedir.

Olgu: Yetmişiki yaşında erkek hasta, 3 gündür olan hıçkırık, nefes darlığı ve ateş yakınmasıyla acil servisimize başvurdu. Özgeçmişte özellik olmayan hastanın sürekli kullandığı bir ilaç da yoktu. Hastanın bilinci açık, koopere, oryante idi. Muayenesinde solunum seslerinin kaba olduğu ve 37.9°C ateşinin olduğu saptandı. TA: 120/70 mmHg, nabız 100/dk, solunum sayısı: 20/dk olarak belirlendi. Hastanın öncelikli yakınması hıçkırık olduğu için, hastaya 25 mg klorpromazin IM yapıldı. Diğer yakınmaları için tetkik edilen hastada, enjeksiyondan bir süre sonra hıçkırığın geçtiği, fakat görsel sanırlar, saçma konuşmalar, psikomotor huzursuzluk, hareketlilik ve ekstrapiramidal semptomların geliştiği fark edildi. Nörolojik muayenede patolojik refleks ve lateralizan defisit saptanmadı. Hastaya biperiden 5 mg IM yapıldıktan sonra beyin tomografisi çekildi. Tomografide, sağ frontal lobta kronik ensefalomalazik alanlar ve sinüslerde inflamatuvar doku kalınlaşması dışında akut patoloji saptanmadı. Laboratuvar sonuçlarında lökositoz ve elektrolit bozukluğu saptanmadı. Hafif CRP ve kardiyak enzim yüksekliği mevcuttu. Takipte hastanın hıçkırığının tekrar başladığı, ajitasyonunun devam ettiği diğer bulguların gerilediği görüldü. Diazepam 5 mg IV verildi. Hastaya Nöroloji konsültasyonu istendi. Organik patolojiyi ekarte edebilmek amacıyla difüzyon MR tetkiki yapıldı, MSS enfeksiyonu şüphesiyle Enfeksiyon Hastalıkları konsültasyonu istendi. Difüzyon MR sonucunda akut santral patoloji rastlanmadı. Hastaya delirium ön tanısı ile psikiyatri konsültasyonu istendi. Hastanın herhangi bir psikiyatrik tanısının olmadığı öğrenildi. Ajitasyonu için yakın takiple haloperidol verildi. Acil serviste delirium ile takip ettiğimiz hastanın bulguları 12 saat içinde düzeldi. Hasta ve yakınları tedaviyi reddederek kliniğimizden ayrıldı.

Sonuç: Antikolinerjik delirium konfüzyon ve ateşle karakterizedir. Delirium tedavisinde kullanılan bir ilaç olan klorpromazinin hastada delirium tablosuna neden olması beklenen bir yan etki değildir.

Anahtar Kelimeler: klorpromazin, delirium, hıçkırık, acil servis

P-0996 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Posterior Reversibl Ensefalopati Sendromu ve Gebelik

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Amaç: Gebelik ve nörolojik semptomların birlikteliği her zaman tehlikeli tanıları düşündürür. Gebede bilateral görme kaybı vakamızı sunmak istiyoruz.

Olgu: 21 yaşında 31 haftalık gravida 1 parite 0 gebe hasta sabahdan başlayan baş ağrısı ve 1 saatir olan görme kaybı ile başvurdu. Bilinen alerji veya hastalığı yoktu. Kan şekeri ve EKGsi normaldi fakat hipertansiyon(170/110 mmHg) Nörolojik muayenesinde taraf bulgusu, konuşma bozukluğu veya serebellar patoloji yoktu. Bilateral pupilleri izokorik, göz hareketleri ve ışık refleksleri normaldi. Her iki gözde de sadece ışığı fark edebildiğini belirtiyordu. Diğer sistem ve jinekolojik muayenesi normaldi. Düşük molekül ağırlıklı heparin başlandı ve serebral venöz tromboz(SVT) ve posterior reversibl ensefalopati sendromu(PRES) ayırıcı tanısını için manyetik rezonans(MR) venografi planlandı. MR venografi PRES ile uyumlu değerlendirildi ve hasta kadın hastalıkları ve doğum servisine yatırıldı. Acil sezaryen ile doğumdan sonra hastanın semptomları geriledi.

Sonuç: Gebelik ve puerperal dönem annenin ve fetüsün hayatını etkileyebilecek bir çok durum için predispozandır. Bizim vakamızda, PRES'in SVT, akut enfarkt ve eklampsi gibi durumlardan ayrımının yapılabilmesi sadece MR ile mümkündür. Seri değerlendirme ve müdahale iki hayatı da kurtarabilmek ve morbiditeyi önlemek için olmazsa olmazdır.

Anahtar Kelimeler: Bilateral görme kaybı, gebelik, posterior reversibl ensefalopati sendromu, acil servis

P-0997 Imaging in Emergency Units

Servikal Travmada Manyetik Rezonans Görüntüleme

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Amaç: Tüm vücut bilgisayarlı tomografi(BT) protokolleri çoklu travma hastalarında okült yaralanmaları kaçırma şansını azaltsa da vertebral yaralanmalar hala yumuşak karındır. Klinik şüphe varlığında manyetik rezonans görüntüleme(MRG) gerekliliğini vurgulamak için vertebral yaralanmalı hastamızı sunmak istiyoruz.

Olgu: 50 yaşında erkek hasta 3 saat önce trafik kazası geçirmiş olarak, her iki üst ekstremitede güçsüzlük ve ağrı yakınması ile ağır merkezden transfer edildi. Vitalleri stabil, Glasgow Koma Skoru 15, koopere, oryante olan hastanın batin toraks, servikal veya diğer vertebralarda hassasiyeti yoktu fakat bilateral omuzdan dirseğe kadar hassasiyeti vardı. Bilateral üst ekstremitelerde kas gücü 1/5, sağ alt ekstremitede 4+/5, sol alt ekstremitede 5/5'ti. Periferik nabızları açıktı ve bilateral babsini pozitifiti. Hasta ve ilk merkezden transferini sağlayan sağlık ekibi hastanın alt ekstremitelerinde de geçici bir güç kaybı olduğunu belirtti. Tüm vücut BT'de, C6 fraktürü dışında travmaya sekonder patolojik bulgu yoktu. Üst ekstremitte grafilerinde ortopedik patoloji yoktu.

Nöroşirürji konsültasyonu sonrası hastaya yüksek doz kortikosteroid başlandı. C6 fraktürü semptomları açıklamadığı için hastaya servikal MRG planlandı. Servikal MRG'da C2-3, C3-4 ve C4-5 seviyelerinde geniş tabanlı santral protrüzyon izlenmiş olup anteriordan subaraknoid mesafe belirgin daralmıştı. C3-4 seviyesinde spinal kordda myelopatik sinyal artışı mevcuttu. Hasta bu bulgularla nöroşirürji kliniğine yatırıldı. Anti-ödem tedavi ve spinal dekompresyon cerrahisi sonrasında semptomları geriledi.



POSTER PRESENTATIONS

Sonuç: Yaralıların emniyet kemeri taktığı motorlu taşıt kazalarında, kamçı yaralanması nedeniyle, hassasiyet, ekimoz ve eşlik eden belirgin yaralanma bulguları olmadan dahi izole vertebral yaralanmalar olabilir. Çoklu travma hastalarının yönetiminde tüm vücut BT olmazsa olmazdır fakat vertebral yaralanmaların tanısında MRG tercih edilmelidir.

Anahtar Kelimeler: Araç içi trafik kazası, servikal travma, manyetik rezonans görüntüleme, acil servis

P-0998 Other

Nöbet geçiren hastaya havayolu güvenliği sağlama girişimi için kullanılan kurşun kalemle oluşan retrofaringeal perforasyon

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Orofaringeal penetran yaralanmalar nadir görülmekle beraber genellikle tedavisiz düzelmetedirler. Yirmi üç yaşında erkek hasta, yakınları tarafından nöbet geçirdikten sonra bilinci konfüze olarak acil servise getirildi. Hastanın iş yerinde nöbet geçirdiği, sonrasında morarması olduğu bu esnada arkadaşları tarafından havayolu açıklığını sağlamak için ağzının içine kalem sokulduğu anlaşıldı. Yapılan tetkiklerde hastada ağız içinde oluşmuş travmaya bağlı retrofaringeal perforasyon tespit edildi. Bu olgu sunumunda daha önce bildirilmemiş bir nedenle oluşmuş retrofaringeal perforasyon tartışıldı.

Anahtar Kelimeler: Retrofaringeal perforasyon, nöbet, kurşun kalem, havayolu açma girişimi

P-0999 Other

Acil Servisinizde Hipertansif Hastalarınızda Anamnezde bir şeyi unutmayın!

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Amaç: Hipertansif acil durumlar hipertansiyonlu hastaların %1'inden daha azında görülür ve diyastolik kan basıncı sıklıkla 120-130 mmHg'nın üzerindedir. Günümüzde erektil disfonksiyon tedavisinde ilk basamak farmakoterapidir. Tadalafil (Cialis) erkeklerde sertleşme bozukluğunu tedavi etmek için kullanılan oral bir ilaçtır. Ülkemizde kullanım oranı giderek artmaktadır.

Olgu: Yetmişaltı yaş erkek hasta, acil servise geçmeyen kulak çınlaması ve baş dönmesi yakınmasıyla geldi. Hastanın geliş vitalleri TA: 200/130 mmHg, nabız: 76/dk, solunum sayısı 17/dk, puls oksimetre %98 ve ateş: 37,2 C olarak ölçüldü. Hastanın öyküsünde hipertansiyon hastalığı yoktu. Diyabet nedeniyle insülin kullanıyordu. Fizik muayenede bir patolojiye rastlanmadı. Dış kulak yolu muayenesi olağandı. Nörolojik muayenesinde nistagmus, patolojik refleks ve lateralizan defisit saptanmadı. EKG normal sinüs ritminde ve anlamlı ST ve T patolojisi yoktu. Hastaya 25 mg kaptopril SL verildi. Yanıt alınamayınca IV nitrat başlandı. Bu arada hastadan Beyin BT istendi ve sonucu normal olarak yorumlandı. Acil serviste izlem sırasında hastanın yanında bekleyen eşinden, hastanın iki gündür tadalafil aldığı ve en son 6 saat önce aldığı öğrenildi. IV Nitrat stoplandı. Hastaya IV furosemide 40 mg bolus ve uygulandı. Hastanın 3 saat sonra TA: 140/90 mmHg olarak ölçüldü. Önerilerle taburcu edildi.

Sonuç: Tadalafil'e bağlı en sık izlenen yan etkiler görme bozukluğu, kızarıklık, baş ağrısı, dispeptik yakınmalar, konjesyon ve kas ağrısıdır. Bu yakınmalar genellikle hafif ve geçicidir. Bununla birlikte nadiren de olsa hipertansiyonda görülebilir.

Anahtar Kelimeler: Tadanafil, hipertansiyon, tedavi, acil servis

P-1000 Other

Testis Torsiyonu: Olgu sunumu

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Amaç: Ürolojik acillerden olan testis torsiyonu genellikle 18 yaş altında görülür. Tedavisi acildir ve ilk 6-8 saat içinde müdahale edilmelidir. Testis torsiyonu tedavisinde başarı, tanının erken konması ve en hızlı biçimde tedavi ile sağlanmaktadır.

Olgu: Yirmibir yaş erkek hasta sabah saat 8 civarlarında uykudan uyandıran sol testiküler ağrı yakınması ile acile başvurdu. Fizik muayenesinde prehn bulgusu pozitif ve epididim normal pozisyonda palpe edilememesi üzerine hastadan skrotal doppler usg istendi. Doppler usg de sol testiste düşük prf değerlerinde akım kodlanmadı. Sol spermatik kordda kalınlık artışı ve tor-tiozite mevcut olup bu düzeyde kanlanma artışı mevcuttu. Bulgular öncelikle torsiyon lehine değerlendirildi. Hastaya ilk 6 saat dolmadan detorsiyon uygulandı. Hastanın ağrısı işlem sonrası kesildi. Kontrol doppler usg de kan akımı izlenmesi üzerine hasta üroloji tarafından elektif testiküler fiksasyon işlemi için yatış verildi.

Sonuç: Testis torsiyonu sıklıkla adölesanlarda izlenen ve zamanında müdahale edilmediği takdirde gonad kaybına kadar gidebilen acil ürolojik bir durumdur. Akut tek taraflı skrotal ağrı en sık başvuru nedenidir. Torsiyon sonrası testis kaybını belirlemede en önemli etken spermatik kordun etrafında kaç tur döndüğü ve iskemi süresidir. Skrotal renkli doppler ultrasonografi testis torsiyonu tanısında altın standarttır.

Anahtar Kelimeler: Testis torsiyonu, skrotal ağrı, doppler ultrasonografi, acil servis

P-1001 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Hiponatremik İnme

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Giriş: Hiponatremi, kan Na (Sodyum) konsantrasyonunun <135 mmol/L olması durumudur. Hiponatremi, genellikle sıvı dağılım bozukluğunda, artan sıvı varlığında görülür. Çoğunlukla da sıvı dengesini ayarlayan vazopressin hormonu ile ilgili bir sorun söz konusudur. Hiponatremi, acil serviste, çok sık görülen bir elektrolit bozukluğudur. Çok çeşitli nedenlere bağlı olarak oluşabilmektedir. Klinik sıklıkla asemptomatik olup klinik belirtileri büyük ölçüde oluşum hızına ve altta yatan patolojiye göre farklılık göstermektedir. Hızlı (<48 saat) ve şiddetli (<125 mEq/L) semptomatik hiponatremi acil tıbbi bir durumdur.

Olgu: 55 yaşında erkek hasta, öz geçmişinde hipertansiyon, HCV ve buna bağlı karaciğer sirozu mevcut olup poliklinik sırasında beklerken fenalaşma, baş dönmesi, dilde peltikleşme ile acil servise başvurdu. İlk vital bulguları stabil olan hastanın, kan şekeri: 157 mg/dl idi. Fizik muayenede, sağ kolun lateralinde hipoestezi dışında patoloji saptanmadı. EKG'sı normal sinüs ritmi olan hastanın, biyokimyasında Na: 121 mmol/L potasyum(K): 2.1 mmol/L olması dışında özellik yoktu. Hastaya çekilen beyin BT: sol frontal bölgede akut enfarkla uyumlu olabilecek hipodens alan şeklinde raporlandı. Sonrasında çekilen beyin MRG normal saptandı. Hastanın tedavi sonrası Na: 132 mmol/L - K: 2.9 mmol/L ölçüldü. Klinik olarak düzelen hasta poliklinik önerilerek taburcu edildi.

Tartışma ve Sonuç: Hiponatremi, sıklıkla nörolojik hastalıklarla, nörocerrahi uygulamaları ve diüretik, psikoaktif ilaçlar gibi ilaç kullanımı ile ilişkili olabilmektedir. Hiponatremi sonucu intrasellüler alandan ekstrasellüler alana sıvı geçişi indüklenir. Bu durum, ciddi nörolojik komplikasyonlara ve serebral ödeme neden olabilir. Bizim olgumuz da baş dönmesi, dilde peltikleşme gibi nörolojik semptomlarla gelmiştir. Beyin tomografisinde, saptanma ihtimali olan ödem yerine, beklenmedik bir bulgu; akut enfarkla uyumlu frontal bölgede hipodens alandan bahsedilmiştir. Hiponatremide, ayrıca tanı ve tedavi için sistematiği bir yaklaşım şarttır. Nörolojik semptomlarla gelen elektrolit bozukluklarında ayırtıcı tanı için nöroradyolojik görüntüleme yöntemlerinden yararlanılabilir. Bizim olgumuzda da ayırtıcı tanı için beyin BT istenmiştir. Ancak tablonun, hastanın mevcut muayene bulgularının tomografi ile uyumlu olmaması ve kliniğinin tedavi ile iyileşmesi nedeniyle hiponatremiye bağlı olduğu düşünülmüştür. Tedavide %0,9 ve %3 lük tuzlu su solusyonları kullanılmaktadır. Son yıllarda ek seçenek olarak ADH reseptör antagonistleri de klinik kullanıma girmiştir. Klasik kitaplarda, hiponatremide morbidite ve mortalite (demyelinizasyon riskinden), serum sodyumunu düzeltileme hızıyla yakından ilişkili olduğu yazılsa da son zamanlarda çıkan klavuz %3'lük hipertonic sıvının verilme hızındaki artıştan bahsetmektedir. Eskiden, hipertonic sıvının 25-100 ml/saat hızında verilmesi önerilirken şimdi daha hızlı (150 ml/20 dk gibi) bir infüzyon verilmesi önerilmektedir. Na konsantrasyonunun saatte 0,5-1'den daha fazla artırılması önerilirken yeni klavuz, ilk saatte 5 mmol artış gibi bir tedavi planlaması önermektedir.

Sonuç: olarak, acil serviste serebral ve serebellar patolojik bulgular ile başvuran hastalarda metabolik nedenler arasında hiponatremi olabileceği akıld tutulmalı ve tanıda, nöroradyolojik görüntülemelerden yararlanırken hastanın kliniğine göre karar verilmelidir.

Anahtar Kelimeler: elektrolit bozukluğu, hiponatremi, inme

POSTER BİLDİRİLER

P-1002 Other

Acil servise konversiyon bozukluğu ile başvuran hastalarda sosyal uyum kendini değerlendirme ölçeğinin uygulanması

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Amaç: Konversiyon bozukluğu; belirtileri telkinle ortaya çıkan ve telkinle kaybolan somatik ve psikik çeşitli belirtiler topluluğu, duyu ya da istemli motor işlevlerini etkileyen, nörolojik ya da diğer bir genel tıbbi durumu düşündüren, bir ya da birden fazla semptomun eşlik ettiği psikiyatrik bir bozuktur. Psikiyatride Hastalıkların Tanımlanması ve Sınıflandırılması Elkitabı, Yeniden Gözden Geçirilmiş Dördüncü Baskı (DSM-IV-TR) kriterlerine göre konversiyon bozukluğu; somatoform bozukluklar altında sınıflandırılmıştır. Bu çalışmada konversiyon tanısı alan hastaların sosyal uyum problemi olup olmadığının araştırılması amaçlanmıştır.

Gereç-Yöntem: Çalışmamız Ocak 2012 – Ocak 2013 yılları arasında Marmara Üniversitesi Acil Tıp Kliniği'ne başvuran, konversif davranışlar sergileyen ve altta yatan organik problemi ekarte edilen hastalar alındı. Çalışma konversif bozukluk sebebiyle acil servise başvuran hastaların sosyal uyum problemlerinin olup olmadığı araştırılması için prospektif olarak planlandı. Aynı bölge toplumu sağlıklı gönüllülerinden oluşturulan kontrol grubunun da alındığı çalışmada, sosyal uyum problemi varlığının araştırılması için Sosyal Uyum Kendini Değerlendirme Ölçeği kullanıldı. Belirlenmiş bir puanlama sistemine göre puanlanan anketler ile hastaların uyum problemlerinin olup olmadığı araştırıldı. Onam vermeyenler veya sonradan vazgeçenler çalışma dışına çıkarıldı. İstatistik analizlerde ki-kare testi kullanıldı. İstatistik anlamlılık sınırı olarak %95 Güven aralığında $p < 0,05$ alındı.

Bulgular: Çalışmaya alınan hasta grubu toplam kişi sayısı 125 (105 kadın, 20 erkek) iken, kontrol grubu 60 (39 kadın, 21 erkek) kişiden oluşmakta idi. Ortalama yaşın, hasta grubunda $31,35 \pm 9,01$ (%95 GA 29,74-32,97); kontrol grubunda ise $31,05 \pm 9,86$ (%95 GA 28,50-33,60) olduğu saptandı. Bu gruplardaki, medyan çocuk sayısı ise sırasıyla 1 ve 0'dı. (Aralık 0-6 ve 0-8). Hasta grubunda, 42 kişi (%33,6) Bekâr, ve 83 kişi Evli (%66,4) iken; diğer grupta, 24 kişi (%40,0) Bekâr ve 36 kişi Evli idi. Hastaların 85' inin işsiz olduğu (%68) hasta grubunda, 39 hasta (%31,2) aile içinde sorun olduğunu, 36 hasta (%28,8) geçim sıkıntısı olduğunu belirtirken bu hastaların SUKDO ölçeğine göre 21' i Sosyal Uyum Bozuk (%16,8), 10' u ise depresif (%8,0), 27 kişinin işsiz (%45,0) olduğu Kontrol grubunda 11 kişi (%18,3) aile içinde sorun, 13 kişi (%21,7) geçim sıkıntısı olduğunu belirtmiştir. SUKDO ölçeğine göre kontrol grubundaki 12 kişinin sosyal uyumu bozuk (%20,0) ve 10 kişinin de depresif (%5,0) idi. Acil servise başvuran hastalar arasında konversiyon tanısı alan hastalar ile sosyal açıdan normal sağlıklı gönüllüler karşılaştırıldığında sosyal uyumsuzluk açısından anlam yaratan istatistik fark olmadığı saptandı. ($p=0,687$).

Sonuç: Çalışmamız sonucunda kontrol grubu ile kıyaslandığında konversif bozukluğu olan hastalarda herhangi bir sosyal uyum problemi veya depresif durumun farkına rastlanmadı.

Anahtar Kelimeler: Konversiyon bozukluğu, Sosyal uyum, Acil servis

P-1003 Other

Acil serviste iletişim ve tanı güçlüğü: ajite otistik hasta

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Amaç: Otizm, ajitasyonun klinik tabloya eşlik edebildiği psikiyatrik bir bozuktur. Sosyal ilişki kurma ve iletişimin zaten sorunlu olduğu bu hastalığa eklenen ajitasyon, algılama ve ifade etme becerilerini tamamiyle kısıtlamaktadır. Otistik hastalarda şiddetli ağrının oluşturduğu ajitasyon nedeni ile acil serviste tanınan zorluklar yaşanması oldukça olasıdır.

Olgu: 21 yaşında erkek son 1-2 saattir devam eden bağırma, iletişimsizden kaçınma şikayetleri ile ailesi tarafından acil servise getirildi. Otistik olduğu öğrenilen hastadan, şikayeti ile ilgili bir veri veya işaret alınmadı. Oldukça ajite olan hastanın özgeçmişinde herhangi bir özellik yoktu. Vital bulguları: TA: 118/70 mmHg, Nb: 119/dk, ateş: 37,4 OC, SatO2: %99 olan hastanın fizik muayenesinde ön tanı oluşturacak bir bulgu elde edilemedi. Ajitasyonu için 5 mg diazepam uygulanan hastaya, enfeksiyon etyolojisi açısından tam kan, rutin biyokimya ve idrar tetkikler ile akciğer grafisi istendi. Wbc: $10,7 \times 10^3/\mu\text{m}^3$ ve idrarda 14.40/HS eritrosit dışında anlamlı bir laboratuvar bulgusu olmayan hastada renal kolik olabileceği düşünüldü. Ketamin 50 mg ve tenoksikam ile ajitasyonu azalan hastanın direkt üriner sistem grafisi normaldi. Taş protokolü ile planlanan batin tomografisinde sağ üreter üst bölümde taş izlendi. Üroloji görüşü alınan hastaya ürolithiasis açısından operasyon planlandı.

Sonuç: İletişimi olmayan hastalar acil servislerin en önemli problemlerindendir. Şikayeti öğrenilemeyen, fizik muayenesi yapılamayan bu hastalarda tanı için eldeki imkanlar son derece etkin kullanılmadığı. Biyokimyasal tetkikler olabildiğince geniş tutulmalı, biyokimyasal anormalliklere göre radyolojik tetkikler planlanmalıdır. İletişimi zaten kısıtlı olan otizm gibi hastalıklarda ani ajitasyona neden olabilecek hastalıklar, sağlıklı popülasyondaki gibi değerlendirilmeli ve renal kolik ayırıcı tanıda üst sıralarda düşünülmelidir.

Anahtar Kelimeler: otizm, ajitasyon, renal kolik

P-1004 Cardiovascular Emergencies

Akut koroner sendrom kliniği ile başvuran erkek hastada yoğun emosyonel stres ile ilişkili sağ koroner arter diseksiyonu

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Amaç: Koroner arter duvarının tabakaları arasında spontan veya iyatrojenik olarak yırtılma oluşması ve ayrılan iki tabaka arasında (yalancı lümen) kan dolmasına "koroner arter diseksiyonu" adı verilir. İlk kez 1931 yılında Prebty tarafından tanımlanan bu durum akut koroner sendrom ve ani kardiyak ölüme sonuçlanabilen nadir bir patolojidir. Sol ön inen arter (left anterior descending artery; LAD) olarak da bilinen a. coronaria sinistra'nın ramus interventricularis anterior'u en sık olarak tutulan arterdir. Klinik olarak hastalar asemptomatik olabileceği gibi akut koroner sendrom, kardiyojenik şok, konjestif kalp yetmezliği veya ani kardiyak ölüm şeklinde de olabilir. Koroner anjiyografi spontan koroner diseksiyonun tanınmasında standart tanı metodudur ve bu metoda yalancı lümenin gösterilmesi tanı açısından patognomoniktir. Trombolitik tedaviler, balon ve stent uygulamaları, koroner arter bypass cerrahisi tedavi seçenekleridir. Bu olgumuzda ciddi emosyonel stres sonrası göğüs ağrısı şikayeti ile merkezimize başvuran ve yapılan koroner anjiyografide sağ koroner arterde (SağKA) diseksiyon ve sol koroner arterin sirkumfleks dalında (CX) total tıkanıklığı yol açan trombüs saptanan hastayı sunmayı amaçladık.

Olgu: 55 yaşında erkek hasta merkezimize 2 saat önce başlayan sol kola ve sırta yayılan şiddetli göğüs ağrısı şikayeti ile başvurdu. Son 1 hafta içerisinde yoğun stres yaşadığını bildiren hastanın öyküsünde daha önce bilinen kalp hastalığı olmadığı, 30 paket/yıl sigara kullanımı öyküsü olduğu ve 10 yıldır tip 2 diabetes mellitus nedeni ile tedavi aldığı öğrenildi. Fizik muayenesinde tansiyon arteriyel 150/80mmHg, nabız 120/dk olup her iki akciğer bazalinde kreptan ral mevcuttu. Elektrokardiyografisinde D1-aVL'de 1mm ST segment elevasyonu, V1-V3 de 4 mm ST segment depresyonu saptanan hasta akut posterolateral miyokard infarktüsü ön tanısı ile hospitalize edildi ve acil olarak kateter laboratuvarına alındı. Koroner anjiyografide; SağKA orta bölgede distal akımı bozmayan diseksiyon izlendi. Sol koroner arterin ramus interventricularis anterior'un proksimalinde %80 lezyon saptanan hastanın CX major optus marginal dalının tromboze total tıkalı olduğu gözlemlendi. Total tıkalı lezyona 2.5x22 mm sirolimus kaplı stent yerleştirildi ve distal TIMI II-III akım sağlandı. Kardiyoloji-kalp damar cerrahisi konseyinde değerlendirilen hastaya koroner cerrahi uygulanmasına karar verildi.

Sonuç: Spontan tip koroner arter diseksiyonu (SKAD), genellikle ateroskleroz risk faktörleri bulunmayan peripartum dönemindeki genç-orta yaş kadınlarda görülmektedir. SKAD'ın genellikle sol koroner arterde geliştiği gösterilmiştir. Olgumuzda nadir görülen bir hastalık olan aort diseksiyonlarının oldukça az karşılaşılan bir alt tipi olan SKAD vakası, erkek bir hastada ve sağ koroner arterde saptanmıştır. Koroner arter hastalığı ile aynı klinik tabloya yol açabilen nadir görülen diseksiyonların da akılda tutulması gerektiği ve klasik olarak tanımlanan hasta profilinin dışındaki erkek hastalarda da diseksiyon saptanabildiği bu nedenle ayırıcı tanıda atlanmaması gerektiği düşüncesindedir.

Anahtar Kelimeler: koroner arter diseksiyonu, koroner arter hastalığı, anjiyografi

P-1005 Other

Acil Serviste Nadir Bir Tanı

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Amaç: Antifosfolipid antikor sendromu (APS), kazanılmış 'antikor-bağımlı tromboza eğilim (trombofili)' sonucunda gelişen multisistemik bir otoimmün hastalık kompleksidir. Nadir görülmesine rağmen sistemik venöz ve arteriyel tromboz oluşturarak ciddi mortalite ve morbiditeye sebep olan bu sendroma dikkat çekmek istedik.

Olgu: 49 yaşında bilinen hastalığı ve ilaç kullanımı olmayan kadın hasta sağ kruris ve ayak bileğinde bir hafta önce başlayan şişlik ve ekimoz nedeniyle acil servise başvurdu. Fizik muayenede genel sistem muayenesi olağan, tüm vücutta yer yer peteşiler, sağ alt ekstremitede ekmotik alanlar, sağ kruris ve ayak bileğinde ödem, şişlik, çap farkı görüldü. Laboratuvar değerlendirmesinde, WBC: 9390, Hb: 10,7, plt: 30.000 INR: 3.3, direk ve indirek coombs negatif saptandı. Sağ alt ekstremitede doppler USG'de sağ eksternal iliak ven, ana femoral ven, yüzeyel ve derin femoral ven, popliteal ven ve krural venlerde heterojen hiperekoik görünümde, yer yer lümeninde rekanalize akımlar izlenen subakut-kronik evre ile uyumlu derin ven trombozu izlendi. Hasta dahiliye ve kalp damar cerrahisi kliniği ile konsulte edildi ve antifosfolipid antikor sendromu ön tanısı konuldu. Hastanın takipte aynı gün sabah saatlerinde ani başlayan nefes darlığı şikayeti oldu. Hastanın elde



POSTER PRESENTATIONS

edilen toraks anjio bilgisayarlı görüntülemesinde bilateral pulmoner arter lobar ve segmental dallarında yaygın emboliler saptandı. Göğüs hastalıkları ve dahiliye kliniği ile konsulte edilerek ileri tetkik ve tedavisinin planlanması için dahiliye servisine transfer edildi.

Sonuç: Antifosfolipid antikorların varlığı ile ilintili hiperkoagülabilité, kendisini sadece bir 'koagülasyon laboratuvar' anormalliği şeklinde gösterebileceği gibi; serebrovasküler olay, venöz tromboz, arteriyel tromboz, veya katastrofik bir obstetrik komplikasyon şeklinde ortaya çıkabilen bir dizi çeşitli heterojen klinik tabloların nedeni olabilir. Antifosfolipid antikorların primer hemostaz (endotel ve trombositler) ve sekonder hemostaz (koagülasyon sistemi ve fibrinolitik sistem) elemanları üzerine çeşitli basamaklarda patolojik etkileşim içerisinde bulunarak trombofil ve tromboz tablolarının çeşitli organ sistemlerinde ortaya çıktığı düşünülmektedir. Acil serviste sistemik tromboz bulguları ile tetkik edilen hastaların ayrıntı tanısında antifosfolipid antikor sendromu tanısının da düşünülmesi gereklidir. Olgumuzda DVT bulguları ile birlikte trombositopeni ve uzamış INR görülmesi, bilinen hastalık ve ilaç kullanımı öyküsü olmaması antifosfolipid antikor sendromu tanısını desteklemiştir. Bu hastalarda yüksek tromboz riski ve mortalite nedeniyle hastaneye yatırılarak izlenmesi, antikoagulan ve antiagregan kullanımı açısından dikkatli olunmalıdır.

Anahtar Kelimeler: antifosfolipid, tromboz, antikor

P-1006 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Kas gücü kaybı ve sistemik enfeksiyon tablosu ile acil kliniğine başvuran bir infektif endokardit olgusu

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Amaç: Günümüzde acil tıp kliniklerine, ateş yüksekliği, kas güçsüzlüğü ile seyreden olgular sıkça başvurmakta, ayrıntı tanı ve tedavi amaçlı incelenmektedir. Bu olgumuzda, Acil servis'e başvuran, 49 yaşında bir erkek hastanın şikayetlerini, tetkik, tanı ve tedavi sürecini paylaşmayı ve klinik pratik sırasında karşımıza çıkabilecek şikayet ve klinik bulguların, değişken ayrıntı tanılarına sebep olabileceği konusunda farkındalık yaratmayı hedefledik.

Olgu: 49 yaşında erkek hasta, Afyon Kocatepe Üniversitesi tıp fakültesi hastanesi acil tıp kliniğine, yürüme ve denge güçlüğü, ateş, vücudunda döküntüler ile başvurdu. Hasta, kliniğimize Afyon Devlet hastanesi acil servisinden beyin tomografisinde iskemik lezyonların bulunması nedeniyle yönlendirilmişti. Öyküde, 10 gün önce üst solunum yolu enfeksiyonu (ÜSYE) geçirdiği, aldığı tedavilere rağmen ateşinin düşmediği, son 3 gündür baacaklarında güç kaybı, son 12 saatte kollarında güç kaybı olduğu öğrenildi. Özgeçmişinde DM olan hastanın soy geçmişinde özellik yoktu. Fizik muayenesinde genel durum orta-iyi, şuur açık, koopere, oryante idi. TA:110/60mmHg, Nb: 130/dk, A: 390C olan hastanın vücudunda yaygın makülopapüller döküntüler, sağ dirsek ve dizde ödem ve ısı artışı mevcuttu. Nörolojik muayenesinde ense sertliği (-), kas gücü bilateral üst ekstremite 5/5, alt ekstremite 4/5, serebellar testler başarılı olarak değerlendirildi. Kalp taşıyıcı ritmik, akciğerler solunuma eşit katılıyor, bilateral bazallerde ince ral mevcuttu, batin muayenesi doğaldı. Hasta güvenli çemberine alındı, kontrollü sıvı verildi, ateş regüle edilmeye çalışıldı. Kan tetkikleri gönderildi. EKG'de sinüs taşikardisi tespit edildi. PA akciğer grafisinde belirgin özellik yok, beyin tomografisinde belirgin akut patoloji tespit edilmedi. Laboratuvar tetkikleri: Sedim: 111(1-5), WBC:15,200 (4-10). Troponin 0.13 (< 0.014) (izole yüksek) ve CRP: 36.5. Kan Gazı: PCO2:26.7, PO2:42.3, PH:7.45, Lac:21, HCO3:18.3. Hastanın acilde yapılan ekokardiyografisinde (EKO) aort ve mitral kapaklarda yeteasyon izlendi. Hasta nöroloji, kardiyoloji, enfeksiyon hastalıkları klinikleri ile konsulte edildi, infektif endokardit (IE) tanısıyla ileri tetkik ve tedavi için enfeksiyon hastalıkları kliniğine yatırıldı.

Sonuç: IE, endokardiyal yüzeyin enfeksiyonudur. Semptom ve bulguları, sistemik enfeksiyon, emboli, metastatik enfeksiyon odakları, konjestif kalp yetmezliği veya immün kompleks lezyonlara bağlıdır. En sık karşılaşılan yakınmalar; ateş, halsizlik, iştahsızlık, terleme, titreme, eklem ağrısı, nefes darlığı, kilo kaybıdır. Olgumuzdaki gibi farklı sistem tutulumları ve iç içe geçmiş fizik muayene bulguları IE'yi de içeren pek çok tanıyı akla getirir. IE'de kesin tanıyı koymak için EKO ve kan kültürü yapılması gerekir. Acil tıp kliniği bakış açısından, IE için uyarıcı olabilecek başka bulgular, bu vakada olduğu gibi, nörolojik bulgular, döküntüler, eklem tutulumları, non-spesifik akciğer bulguları ve persistan ateştir.

Anahtar Kelimeler: ateş, infektif endokardit, tanı

P-1007 Other

Beklenen büyük İstanbul depremi ne kadar yakın? Ne kadar ölümcül?

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Geçtiğimiz 1500 yıl boyunca İstanbul'da ciddi boyutta hasara yol açan 12 deprem ve 30 yıllık zaman aralıklarından hesaplanan %15-25'lik değer, İstanbul'da gelecekte yaşanacak önemli bir yıkımı doğrulamaktadır. Uydudan yapılan detay jeodezik ölçümlere göre Marmara Denizi içinde yer alan Kuzey Anadolu Fay'ının kuzey kolu üzerinde son 247 yıldır yaklaşık 4.92 metrelik bir yer değiştirmesi olmuştur. Fay 22±3 mm/yıl olarak yer değiştirmektedir. Bu bulgu orta Marmara fayında İstanbul'da büyük yıkıma neden olabilecek bir deprem için en az 247 yıldır enerjinin biriktiğini göstermektedir. İstanbul yakınlarındaki fayların deprem tekrarlama döngülerinin yaklaşması depremin tekrarlama olasılığını %49±15'e çıkarıyor. Yapılan bu hesaplamalar, 1999 İzmit depreminin, Marmara denizi altındaki faylar üzerindeki gerilmeyi aynı biçimde artırdığını ortaya koyuyor. Bu da etkileşime dayalı İstanbul'da olabilecek büyük depremin olasılık değerini daha da yukarılara, %62±15'e çıkarıyor.

Anahtar Kelimeler: İstanbul, deprem, Marmara denizi, Kuzey Anadolu Fayı

P-1008 Imaging in Emergency Units

Sağ alt kadranda ağrısı: Sağ divertikülit

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Sağ kolon divertikülleri gastrointestinal sistemde bulunan gerçek divertiküllerdir. Sağ kolonun divertiküler hastalığı görülme sıklığı etnik kökene, kültüre ve diyetle ilgili olarak değişiklik göstermektedir. Sağ kolon divertikülleri genelde asemptomatik olmakla birlikte komplikasyonla birlikte klinik bulgu verirler. En sık rastlanan komplikasyonu divertikülitir. Bu hastalar benzer semptom ve klinik bulgularla seyreden akut apandisit ile çoğu zaman karışır. Tedavi yaklaşımları farklı olan bu iki hastalıkta preoperatif kesin tanıya gitmek oldukça önemlidir. Sağ kolon divertikülitisi tanısı birçok vakada akut apandisit ön tanısıyla acil cerrahiye alınan hastalarda konur. Bu vakada sağ alt kadranda karın ağrısıyla acil servise başvuran akut batin kliniğindeki erkek hastada belirlenen sağ kolon divertikülitisi ile aldık. Karın ağrısı şikayeti ile acil servise başvuran akut batin kliniğindeki hastalarda kolon divertikülitisi ayrıntı tanıda mutlaka düşünülmelidir.

Anahtar Kelimeler: Sağ alt kadranda, karın ağrısı, divertikülit, apandisit

P-1009 Cardiovascular Emergencies

Kene tutması sonrası gelişen miyokard infarktüsü: bir vaka sunumu

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Amaç: Akut koroner sendromlar(AKS)'ın görülme oranı gittikçe artmaktadır. Anksiyete ve stres, AKS ile ilişkilendirilen nedenlerdendir. Kene açısından Tokat ili endemik bir bölgedir ve kene tutmaları ölümlerle sonuçlanabilmektedir. Sizlerle, kene tutması sonrası aşırı stres nedeni ile gelişen miyokard infarktüsü olgusunu tartışacağız.

Olgu: 51 yaşında erkek hasta, ziyaret amaçlı Tokat'ta bulunduğu esnada, sabah insülin enjeksiyonu yaparken bacağına canlı bir kene görmüş. Hasta Tokat ilinde keneye bağlı ölümler olduğunu bildiği için korktuğunu ve bu nedenle keneyi fark eder etmez acile başvurduğunu belirtti. Hastanın özgeçmişinde Tıp 2 DM mevcut insülin kullanıyor. AKS öyküsü veya başka bir ek hastalığı yok. Sol uyluk quadriceps kası medyalinde halen canlı ve deriye invaze olan kene görüldü. Hastadan kene için tetkikler alındı, diyabetik olması nedeniyle elektrokardiyogram(EKG) çekildi. EKG:NSR, hız:70 atım/dk, göğüs derivasyonlarından V4-V5 ve V6'da 2 mm ST depresyonu ve T negatifliği saptanınca, hastanın tetkiklerine ilave olarak troponin eklendi. Bu arada kene tutması, 38.7 derece ateş ve bulantı şikayeti üzerine enfeksiyon hastalıklarına konsulte edildi.

Hastanın laboratuvar tetkiklerinde LDH: 601(135-225) u/l, kütle-CKMB: 9.74(0-4.94) ng/ml ve troponin-T: 686.5 (0-100) pg/ml olarak saptandı. Troponin pozitifliği olan hasta non-STEMI ön tanısı ile kardiyolojiye konsulte edildi ve non-STEMI tanısı ile koroner bakım ünitesine yatırıldı.

Sonuç: Tokat bölgesinde kene endemiktir ve keneye bağlı ölümler olmaktadır, gerek yöre halkı gerekse ziyaretçiler bu konuda bir hayli endişeli olmaktadır.

Kene vakalarında kronik olaylar bildirilmemiştir enkübasyon süresi dahilinde olgu ya Kırım Kongo Kanamalı Ateşi (KKKA)'ne yakalanır veya hiçbir sıkıntı olmadan hayatına devam eder. Bu nedenle enkübasyon süresince insanlar aşırı stres yaşarlar.

Bizim vakamızda hastanın göğüs ağrısı, dispne ve taşikardi gibi herhangi bir şikayeti olmadan keneyi vücudunda gördükten sonra ve keneye bağlı ölüm vakalarından haberdar olması nedeniyle aşırı anksiyete ve stres yapması nedeniyle bizim hastamızın non-STEMI tanısının aşırı anksiyeteye bağlı olabileceğini düşünmemize sebep oldu.

Bildiğimiz kadarı ile kene tutmasına bağlı aşırı stresin tetiklediği Mİ olgusu daha önce bildirilmemiştir. Bu açıdan vakamız bir ilk olma özelliği taşımaktadır. Keneye bağlı ölümlerin ilimizde günden güne azalması mutluluk vericidir ancak yine de bu durumun uzun bir süre daha halkın kafasında büyük bir problem ve endişe kaynağı oluşturacağı açıktır.

Anahtar Kelimeler: Acil, kene, miyokard infarktüsü



POSTER BİLDİRİLER

P-1010 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Acil Serviste Karın Ağrısı ve Anafaksinin Nadir Bir Nedeni: Kist Hidatik Ruptürü

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Amaç: Kist hidatik Echinococcus granulosus'un neden olduğu çoğunlukla karaciğere yerleşim gösteren kaşıntı, karın ağrısından anafalaktik şoka kadar değişik tablolarda acil servise başvurma potansiyeli taşıyan bir durumdur. Acil servise başvuru sırasında olgunun tanınip erken tedavi protokollerine başlanması hayati önem arz eder. Biz, bu olgu sunumunda, acil servise kaşıntı, nefes darlığı ve akabinde karın ağrısı nedeni ile başvuran, öyküde karaciğer ve akciğer de kist hidatik saptanan, izlemde anafalaksis reaksiyon gelişen abdominal tomografisinde kist hidatik mikroporasyonu tanısı alan olguyu paylaşmayı amaçladık.

Olgu: 41 yaşında kadın hasta, ellerinde ani başlayan kaşıntı, nefes darlığı, dudaklarda ödem nedeniyle acil servise başvurdu. Acil serviste değerlendirildiği sırada karın ağrısının da semptomlara eklendiğini belirtti. Geliş vitallerinde hipotansiyonu olan; uvula ödemi ve ya bronkospazmı olmayan hastanın, karaciğerindeki kist hidatik öyküsünden başka ek hastalığı yoktu. Acil servis izleminde near senkop gelişti ve akabinde periumbilikal ürtikeryel lezyonları belirginleşti, semptomatik tedavisi yapıldı. Yatakbaşı ultrasonunda perihepatik sıvı saptanan olguya kist hidatik ruptürü şüphesiyle abdominal tomografi planlandı. Acil servis izleminde anjiyodem tablosu ilerledi, ateş yüksekliği ve hipotansiyonu sebat etti. Anafalaksi tedavisi ile semptomları geriledi. BT'de karaciğer kist hidatik mikroporasyonu saptanan hastanın acil girişim planlanarak genel cerrahi kliniğine yatırışı yapıldı.

Sonuç: Kist hidatik ruptürüne sekonder anafalaktik durum acil servis başvurusu olarak sık görülmemekle birlikte, kuşkulu öyküsü olan hastaların erken tanınması ve yönetimi hayati bir durumdur. Kist hidatik ruptürü akut görüldüğü tabloyla seyredebileceği gibi mikroporasyon gibi sinsi tablolarla farklı klinik bulgularla seyredebilir. Akut ortaya çıkan ürtiker ve alerji tablosunda öykünün derinleştirilmesi altta yatan nadir patolojileri saptamada önemlidir.

Anahtar Kelimeler: Anafalaksi, kist hidatik, ruptür

P-1011 Imaging in Emergency Units

Chiliaditi sendromu: olgu sunumu

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Amaç: Chiliaditi sendromu Demetrius Chialidi tarafından 1910 yılında tarif edilmiştir. Nadir rastlanan ve sıklıkla transvers kolon ve/veya ince bağırsağın hepatodiyafragmatik mesafeye sıkışması sonucu gelişen bir sendromdur. Çoğunlukla semptom vermez ve radyolojik tetkikler esnasında saptanır. Bazen karın ağrısı, konstipasyon, bulantı ve kusma, nadiren dispne ve göğüs ağrısı sempo-tonları tabloya eşlik edebilir.

Olgu: 73 yaşında bayan hasta dört yıldır meme CA nedeniyle takip ediliyor. Üç yıl önce segmenter mastektomi öyküsü, kemoterapi ve radyoterapi öyküsü mevcut. Takip amaçlı başvurduğu poliklinik kontrolü esnasında çekilen antero-posterior akciğer grafisinde (figür I) subdiyafragmatik serbest hava görülmesi üzerine içi boş organ perforasyonu ön tanısıyla acil servise yönlendiriliyor. Hastanın vital bulguları; TA:120/80 mmHg, nabız 86 atım/dk, ateş:36.2 °C. Hastada karın ağrısı, bulantı ve kusma şikayeti yok, gaz-gayta çıkışı mevcut. Fizik muayenesinde; barsak sesleri normoaktif, defans, rebant, belirgin hassasiyet yok. Laboratuvar tetkiklerinde hemogram ve rutin biyokimya sonuçları normal değerlerde. Çekilen bilgisayarlı tomografisinde acil patoloji izlenmedi. Genel cerrahi konsültasyonu sonrası acil patoloji düşünülmeyen hasta, kontrol akciğer filminde (figür II) subdiyafragmatik hava görülmemesi üzerine önerilerle taburcu edildi.

Sonuç: Batın içi, içi boş organ perforasyonları cerrahi acillerdendir ve önemli mortalite ve morbiditeye sahiptir. Bu vakalar bizlere her defasında akut batın tablosu ile gelmeyebilirler bu nedenle acil hekiminin uyanık olması, erken tanı koyması, bir an önce acil serviste intravenöz hidrasyona başlayıp uygun antibiyotik tedavisine başlaması gerekebilir. Diğer yandan Chiliaditi Sendromu nadir rastlanan, sıklıkla transvers kolon ve/veya ince bağırsağın hepatodiyafragmatik mesafeye sıkışması sonucu gelişen diyafram altı serbest hava görüntüsüne neden olmasından dolayı içi boş organ perforasyonunu taklid eden bir durumdur. Çoğunlukla asemptomatik seyreder ve tedavi gerektirmez. Acil hekimleri olarak bizler karın ağrısı ile gelen her hastada ayrıncı tanıda, cerrahi aciller arasında yer alan içi boş organ perforasyonunu ekarte etmek zorundayız. Nadirde olsa, bu vakada olduğu gibi, diyafram altı her serbest havanın içi boş organ perforasyonuna işaret etmediğini görüyoruz. Chiliaditi sendromunu ayrıncı tanıda akılda tutmalı ve hastalarımızı değerlendirirken gerektiğinde veya şüphelendiğimizde tetkiklerimizi tekrar etmeliyiz.

Anahtar Kelimeler: Chiliaditi Sendromu, perforasyon, direkt batın grafisi

P-1012 Imaging in Emergency Units

Femoral ven kateterizasyonu; Unutulan kılavuz tel

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Amaç: Femoral-juguler venöz kateterizasyon işlemi sırasındaki komplikasyon insidansı yaklaşık %12 sıklığında bildirilmiştir. Bu komplikasyonlar arasında arteriyel ponksiyona bağlı kanama, hematoma, aritmi, hemotoraks, pnömotoraks, hava embolisi, kateter enfeksiyonu, kılavuz tel kayıpları bulunur. Yazımızda hemodiyaliz amaçlı femoral venöz kateterizasyon işlemi sonrası hastanemize sevk edilen bir hastada karşılaştığımız ender bir komplikasyonu paylaşmak istedik.

Olgu: 45 yaşında hasta dış merkezde üre-kreatin yüksekliği nedeniyle hemodiyaliz tedavisi görmüş, hastanemiz nefroloji polikliniğinde muayene için beklerken baş dönmesi, fenalaşma, göğüs, sırt ağrısı nedeniyle acil servismize getirildi. Acil serviste geliş elektrokardiyografisi normal sinus ritminde olup arter kan basıncı: 118/73 mmHg, nabız: 79/dk olup yapılan tetkiklerinde Üre: 206 mg/dl, Kreatin: 9.85 mg/dl olarak saptandı.

Hastaya dış merkezde hemodiyaliz için femoral ven kateterizasyonu yapılmış, hemodiyaliz işlemi uygulanmış. Hastanın taburculuğunda kateteri çekilmiş, hastanemize yönlendirilmiş. Polikliniğe kötüleşen, acil servismize getirilen hastanın tetkikleri sonrası hemodiyaliz endikasyonu konması üzerine hastaya juguler ven kateteri takılması planlandı. Santral venöz kateterizasyon için yatakbaşı ultrasonografi yapıldı, ultrasonda sağ internal juguler venede yabancı cisim artefaktı saptandı. Ultrasonla izlenen yabancı cisimin ven boyunca devam ettiği saptandı. Bunun üzerine hastadan 2 yönlü servikal grafi, postero-anterior akciğer grafisi ve ayakta direkt batın grafisi istendi. Çekilen grafilere sağ internal juguler venden sağ iliak ven ayırımına kadar uzanan yabancı cismin daha önceki kateterden kalmış kılavuz tel olabileceği düşünüldü. Hastaya Kalp-Damar cerrahisi konsültasyonu istendi. Hastaneye yatırılan hastanın venöz sistemindeki kılavuz teli radyolojik anjiyografi eşliğinde komplikasyonsuz olarak çıkartıldı.

Sonuç: Santral venöz kateterizasyon işlemi acil serviste sık kullandığımız, ciddi komplikasyonlara sebep olabilecek invaziv bir işlemdir. Düşük komplikasyon insidansı, girişim kolaylığı nedeniyle internal juguler ven en sık tercih edilen yoldur. Gelişebilecek komplikasyonlar arasında erken dönemde pnömotoraks, hava embolisi, enfeksiyon, kateter malpozisyonu, vasküler yaralanmalar, aritmi, nörolojik komplikasyonlar (Serebrovasküler olay, brakial pleksus yaralanması, Horner Sendromu, vb), lenfatik yaralanmalar, kılavuz tel komplikasyonları yer alırken; geç dönemde endokardit, sepsis, venöz tromboz, vena kava superior sendromu yer alır. Girişime ait komplikasyon gelişmesinde risk faktörleri; kötü teknik kullanımı, kullanılan malzemenin kalitesizliği, vücut kitle indeksinin 30 kg/m²'den çok 20 kg/m²'den az olması, koagülopati varlığı, hemodiyaliz kateteri gibi geniş lümenli kateter kullanılması, anatomik bölge seçimidir. Nadir de olsa kılavuz telin kıvrılması, kırılması, kopması, düşümlenmesi, geri çekilememesi gibi komplikasyonlar görülebilir. Venöz kateterizasyon işlemi nadir de olsa morbidite, mortalitesi yüksek ciddi komplikasyonlara sebep olabilecek invaziv bir işlemdir. Bu nedenle deneyimli kişilerce veya onların kontrolünde, mümkünse işlem sırasında ultrason kullanılması, işlemin ultrason eşliğinde yapılması, algoritmilere uyulması gerekmektedir. İşlemin hemen sonrasında erken radyolojik incelemenin kateter yerinin tespitinde, gelişebilecek komplikasyonları önlemede veya komplikasyonun erken farkedilmesinde önemli olduğunu düşünüyoruz.

Anahtar Kelimeler: Femoral ven, Juguler ven, Kateter, Kılavuz tel, Ultrason

P-1013 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Senkopla Gelen Pulmoner Tromboemboli

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Amaç: Senkop; tıbbi müdahale olmaksızın kendiliğinden ve tamamen düzelen postüral tonus kaybı ile ilişkili kısa süreli bilinç kaybını içeren bir semptom kompleksidir. Senkopun en sık nedenleri vazovagal (%21), kardiyak (%10), ortostatik (%9), tedavi ile ilişkili (%7), nöbet (%5), nörolojik (%4,1) ve nedeni bilinmemendir (%37). Pulmoner tromboemboli ise senkopun nadir nedenlerinden olup hayatı tehdit eden bir durumdur. Pulmoner tromboembolide sağ ventrikül disfonksiyonuna bağlı gelişen sistemik hipoperfüzyon merkezi sinir sistemi disfonksiyonu yaparak senkopa neden olabilmektedir. Bu yazıda senkopla başvuran pulmoner tromboemboli olgusuna dikkat çekmek istedik.

Olgu: 87 yaşında erkek hasta senkop nedeniyle 112 eşliğinde getirildi. Öyküsünde diyabetes mellitus hastalığı var bunun için insülin tedavisi alıyordu. Hasta 1 saat önce aniden göğsünde



POSTER PRESENTATIONS

sıkışma hissi olmuş ve sonrasında senkop geçirmişti. Vital bulgularında ateşi 36,50C, arteriyel tansiyonu 148 /82 mmHg, nabızı 100 atım/dk, SPO2: %91, parmakucu kan şekeri: 193 mg/dL idi. 12 derivasyonlu EKGsinde sinüs taşikardisi (100 bpm), D3 ve aVF'de patolojik Q dalgası, V5 ve V6 da 1 mm ST depresyonu mevcuttu. Fizik muayenede şuuru açık, koopere, oryante, pupiller izokorik, ışık refleksi doğal, GKS: 15 duyu ve motor muayenede lateralizan bulgu negatif idi. Oskültasyonda akciğer sesleri doğaldı. Arteriyel kan gazında pH: 7,404, HCO3: 21,9 mmol/L, pCO2: 27,2 mmHg idi. Hastaya kardiyak senkop açısından yatak başı EKO yapıldı. EKO bulgularında LV EF: %65, ciddi pulmoner hipertansiyon (PAB: 70 mmHg), sağ kalp dilate, paradoksal septal duvar hareketleri ve ileri triküspit yetmezlik saptandı. Böbrek fonksiyon testlerindeki bozukluk nedeniyle kontrastlı tomografi düşünülmemeyerek akut DVT açısından hastaya bilateral alt ekstremite venöz doppler USG yapıldı ve akut DVT ile uyumlu olarak sol popliteal ven lümenini dolduran ekojen trombus ile uyumlu görünüm izlendi. Hastanın wells skoru düşük olmasına rağmen klinik, EKO ve venöz doppler USG bulgularıyla hastada pulmoner tromboemboli düşünüldü. Acil serviste yapılan antikoagulan tedavinin ardından hastaneye yatışı yapıldı.

Sonuç: Acil servise senkop nedeniyle her gün onlarca hasta başvurmaktadır. Acil hekimleri klinik izlemde senkop etyolojisindeki nadir sebeplerden biri olan ve tanısı atlandığında mortalitesi yüksek olan pulmoner tromboemboliye de göz önünde bulundurulmalıdır. Wells skorunun düşük olmasına rağmen klinik şüphe durumunda ileri inceleme yapılmalı, senkopun nadir bir nedeni olan pulmoner tromboemboli tanısı açısından değerlendirilmelidir.

Anahtar Kelimeler: DVT, senkop, tromboemboli

P-1014 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Baş Ağrısı Nedeni Olarak Vertebral Arter Disseksiyonu

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Amaç: Baş ağrısı acil servise sık başvuru nedenlerindendir. Ağrının en sık sebebi primer baş ağrısı nedenleri olmakla birlikte sekonder baş ağrılarında sık görülmektedir. Biz burada özellikle genç hastalarda ikincil baş ağrısının önemli bir nedeni olan servikal arter disseksiyonlu bir olguyu sunmayı amaçladık.

Olgu: Otuz bir yaşında erkek hasta baş ve eşlik eden boyun ağrısı şikayeti ile acil servise başvurdu. Hastanın baş ağrısının bir gün önce ağaçtan dal keserken aniden başladığı, bu şikayetle gittikleri hastanede beyin tomografisi çekildiği, tomografisinin normal ve migren ağrısı olduğu söylenerek ağrı kesici ilaç yapıldığı ve takip edildiği öğrenildi. Hasta ağrısının geçmemesi nedeniyle hastanemize başvuruğunu söyledi. Hasta oksipital bölge ve boyunda ağrı tarifliyordu. Hareketle baş ağrısının arttığını söylüyordu. Fizik bakısında genel durumu orta-iyi, şuuru açık, koopere ve oryante idi. Vital bulgularında, kan basıncı: 110/70 mmHg, nabız: 70 atım/dakika, vücut ısı: 37,3 OC idi. Nörolojik muayenesinde; ense sertliği yoktu, baş-boyun hareketiyle ağrı şiddetleniyordu. Pupiller izokorik, bilateral nisitagnus vardı. Sol üst ekstremitede dismetri, disdiadokinezi vardı. Sol alt ekstremitede diz-topuk testi pozitif. Konuşması normaldi. Acil Laboratuvar incelemesinde; lökosit sayısı 17.840 (4000-10.500), diğer kan testleri normaldi. Hastada akut serebrovasküler olay düşünülerek Beyin Tomografisi istendi. Tomografide sol serebral bölgede akut enfarkt ile uyumlu hipodens alan izlendi. Hastanın tipik öyküsünden hareketle servikal arter disseksiyonu ön tanısıyla ve Karotis- Vertebral Dopler istendi. Vertebral arter dopplerinde sağ vertebral arterde normal akım izlenirken sol vertebral arterde akım saptanmadı. Hastaya kontrastlı Boyun ve beyin BT angiyoada çekildi. Sol vertebral arterde minimal akım izlendi. Hasta vertebral arter disseksiyonu tanısıyla nöroloji kliniğine yatırıldı.

Sonuç: Baş ağrılı hastalarda ağrıya yönelik uygun tedavi önemlidir. Fakat birincil amacımız önemli sekonder baş ağrılarını tespit etmek ve hastanın uygun tedavisini sağlamaktır. Belirgin Oksipital bölge ve boyun ağrısı şikayeti ile başvuran hastalarda vertebral arter disseksiyonu tanıda düşünülmelidir.

Anahtar Kelimeler: Baş ağrısı, serebellar enfarkt, vertebral arter disseksiyonu

P-1015 Imaging in Emergency Units

Görsel Tanı: Pankreas Psödokisti

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Amaç: Akut ve kronik pankreatit hastalarının %2-18' inde gelişen en önemli komplikasyonlardan biri pankreas psödokistleridir. Pankreatik psödokistler fibröz, epitel dokusu bulunmayan sıvı dolu kaviteler olup pankreatik kanalın kitle, protein birikimi inflamasyon veya fibrozis sonucu tıkanması ile oluşmaktadır. %5-15 mortalitesi vardır. Batın tomografisinde psödokist saptanan olgumuzu görsel tanı amaçlı hazırladık.

Olgu: Geçirilmiş pankreatit öyküsü bulunan kolesistektomili 34 yaşında bayan hasta, acil servise karın ağrısı şikayeti ile başvurdu. Geliş vitaleri kan basıncı 116/69 mmhg, nabız 72/dk, vücut ısı 36,1 oC, O2 saturasyonu %99 idi. Fizik muayenede epigastrik hassasiyet dışında özellik yoktu. Serum biyokimyasında 165 U/L amilaz değeri dışında anormallik yoktu. Hastanın semptomatik tedavi ile rahatlamaması üzerine çekilen batın tomografisinde pankreas baş kesiminde 7,5X5 cm boyutlarında psödokist ile uyumlu lezyon saptandı. Genel cerrahi ve gastroenteroloji ile konsülte edilen hasta gastroenteroloji bölümüne yatırıldı.

Sonuç: Dirençli karın ağrılarındaki özellikle pankreatit atağı geçirmiş hastalarda pankreas psödokisti akla tutulması gerekli %5-15 mortaliteye sahip bir hastalıktır. Acil Tıp hekimlerinin tanıyı akla getirip tomografide değerlendirebilmesi önem arz eder.

Anahtar Kelimeler: Pankreas, psödokist, Tomografi

P-1016 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Hipersensitivite Pnömonisi Zemininde Gelişen ARDS Olgusu

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Amaç: Akut respiratuar distress sendromu (ARDS) her iki akciğeri de içine alan nonkardiyojenik özellikteki diffüz infiltrasyonla karakterize, oksijen tedavisine cevap vermeyen akut solunum yetmezliği sendromudur. Pulmoner veya ekstrapulmoner nedenlere bağlı olarak gelişebilir. İlk 24 saatteki ekzudatif faz bazen silik ve karışık tablo ile karşımıza çıkabilir ve sonraki 7-10. günlerde fibroproliferatif faza geçebilir. Bu olguda nadir görülen bir durum olan hipersensitivite pnömonisi ARDS nedeni olarak saptanmıştır.

Olgu: 24 yaş erkek hasta 1 haftadır olan ve giderek artan nefes darlığı şikayeti ile acil servisimize başvurdu. Hikayesinden şikayetlerinin 1 hafta önce başladığı dış merkezde pnömoni tanısı konularak, 3. kuşak sefalosporin tedavisi başlanan hastanın nefes darlığının giderek arttığı ve genel durumunun kötüleştiği öğrenildi. Özgeçmişinde 6paket/yıl sigara kullanımı dışında özellik yoktu. Hastanın geliş vital bulguları; ateş:36,0 nabız:130/dak TA:100/70 mmHg solunum sayısı 36/dak saturasyon O2:82% olarak kaydedildi. Fizik muayenesinde bilingç açık, oryante, koopere, GKS 15, spontan solunum var, ışık refleksi bilateral pozitif, pupiller izokorik, meningeal irritasyon bulguları yok, fokal nörolojik bozukluk yok, orofarinks hiperemik, tonsiller hiperemik, takipneik ve yüzeysel solunum mevcut, dinlemekle akciğerlerde yaygın ronküsler mevcut ve expirum uzun, akut batın bulguları yok, periferik nabızlar bütün ekstremitelerde açıktı. Tetkiklerinde; EKG'de sinüs taşikardisi, PAAC grafisinde bilateral yaygın infiltrasyonlar, laboratuvar; WBC 36500/mm.hgb 15,5 g/dl normokrom normositer, dağılım eozinofilik, arter kan gazında; Ph 7,47 PCO2:28,5 PO2: 43,7 HCO3:23,4 K:3,8 mmol/L, çekilen toraks BT'de bilaterale yaygın buzlu cam görünümü mevcut olan hastaya destek tedavi başlandı ve göğüs hastalıklarına konsülte edildi. Klinik durumu akut respiratuar distress sendromu ile uyumlu olan hastaya göğüs hastalıkları bölümü tarafından yoğun bakım şartlarında tedavi ve takip amaçlı yatış verildi. Yoğun bakıma alınan hastaya 2-4l/dk dan oksijen, piperasilin-tazobaktam 3*4,5 gr ve klaritromisin 2*500mg tedavisi uygulandı. Destek tedaviye rağmen oksijen saturasyonunun hızla düşmeye devam etmesi üzerine hastaya CPAP uygulanmak istendi. Bu süreç içinde tekrar detaylı sorgulanan hastanın zaman zaman çeşitli narkotik maddeler aldığı, son olarak inhaler narkotik ajan kullanımı olduğu öğrenilmesi üzerine nadir görülen bir tablo olan hipersensitivite pnömonisi akla geldi. CPAP'ı tolere edemeyen hasta mekanik ventilatör desteğine alındı. Hipersensitivite pnömonisine yönelik metilprednizolon tedavisi başlanan hastanın klinik bulgularında hızla düzelme görüldü. 3 gün mekanik ventilatör desteği sonrası klinik durumu tamamen düzelen hasta extübe edildi.

Sonuç: Solunum sıkıntısıyla gelen hastada, hipersensitivite pnömonisi açısından detaylı hikayenin tanıda ne kadar önemli olduğu ve tedavi ile klinik tabloda oldukça hızlı iyileşmenin sağlanabileceği vurgulanmaktadır.

Anahtar Kelimeler: Hipersensitivite Pnömonisi, pnömoni, ARDS



POSTER BİLDİRİLER

P-1017 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Otitis media komplikasyonu olarak ortaya çıkan pnömosefali

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Amaç: Pnömosefali, serebral boşluklarda hava bulunması durumu olarak tanımlanır. Pnömosefalinin en sık nedeni travma(%73,9) olup diğer olası nedenleri arasında;tümör(%12,9), enfeksiyon ve idiopatik nedenler olarak sıralanabilir. Enfeksiyona bağlı sebepler menenjit, serebrit, abse veya subdural ampiyem neticesinde ortaya çıkabilmekte ve %8,8 oranında görülebilmektedir. Bu vakamızda otitis media ile ilişkili pnömosefali hastası sunulmuştur.

Olgu: Acil servise 50 yaşındaki erkek hasta baş ağrısı, sol kulakta ağrı ve ateş yüksekliği şikayetleri ile başvurdu. Alınan anamnezinde 3 gün önce başka bir hastaneye sol kulağında ağrı şikayeti ile başvurduğunu, otitis media ön tanısı ile reçete düzenlendiği öğrenildi. Hastanın bir gün sonra şiddetli baş ağrısı, ateş yüksekliğinin başladığı ve şikayetinin geçmemesi üzerine acil servisimize başvurdu. Hastanın genel durumu iyi, bilinç açık oryante ve koopere idi. TA:130/70 mmHg, ateş 38°C solunum 20/dk, nabız 86/dk idi. Yapılan fizik muayenede sol kulak zarı perfore, dış kulak yolunda hemoraji tespit edildi. Hastanın şüpheli ense sertliği mevcut olup, kerning-brudzinski negatif olarak bulundu. Yapılan laboratuvar tetkiklerinde 18000/mm³ beyaz küre dışında anormal değer saptanmadı. Hastada SAK, menenjit(LP öncesi beyin ödemi, abse ekartasyonu için) beyin tomografisi (BT) istemi yapıldı. Çekilen BT'de sol temporal bölgede mastoidit, sol occipital ve temporal bölgede pnömosefali ile uyumlu multipl hava dansiteleri saptandı. Hastanın yapılan lomber ponksiyonunda menenjit ile uyumlu bulundu. Seftriakson 2 gr yapılan hasta enfeksiyon hastalıkları servisine menenjit ve pnömosefali ön tanısıyla yatırıldı. Menenjit tanısıyla takip edilen hasta şifa ile taburcu edildi.

Sonuç: Pnömosefali, otitis media sonrası görülen nadir komplikasyonlardır. Pnömosefali genellikle kafa travması ve intrakraniyal cerrahi sonrası görülebilmektedir. Otitis mediasi olan hastalarda ayrıntılı fizik muayene sonrasında pozitif nörolojik bulgusu olan hastalara BT çekilmeli ve erken tanı ile oluşabilecek komplikasyonlar önlenmelidir.

Anahtar Kelimeler: Menenjit, otitis media, pnömosefali

P-1018 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

ESWL sonrası perirenal apse

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Amaç: Nefrolitiyazis vakalarında taşın yerleşim ve büyüklüğü göz önüne alınarak farklı tedavi protokolleri izlenebilir. Ekstrakorporeal şok dalga litotripsi (ESWL) üriner sistem taşlarının tedavisinde ilk seçenektir. Buna rağmen bazı önemli komplikasyonlara neden olabilmekte ve ilave tedavilere ihtiyaç duyulabilmektedir. ESWL olağan komplikasyonları arasında perirenal apse, perirenal hematoma, fibrozis ve malign hipertansiyon sayılabilir. Olgumuzda ESWL sonrası gelişen perirenal apse konusu tartışılacaktır.

Olgu: Orta yaş kadın hasta idrar yapamama, sol yan ağrısı, ateş yüksekliği nedeniyle acil servise başvurdu. Hastanın öyküsünden, multiple renal taşları olduğu ve sonuncusu bir hafta önce olmak üzere 2 kez ESWL işleminin uygulandığı öğrenildi. Fizik muayenesinde hipotansif, taşikardik ve hipertermik olan olgunun sol kostavertebral açığı hassasiyeti ve sol alt kadranda rebound pozitif tespit edildi. İdrar kültür antibiyogramı alındıktan hemen sonra iv hidrasyon ve seftriakson 1x2 g yükleme dozu ile antibiyoterapi başlandı. Serum biyokimya testlerinde kreatinin 1.33 mg/dl, CRP 33.23 mg/dl, beyaz küre 28720 ve idrar direkt bakışında bol lökosit tespit edildi. Yapılan böbrek ultrasonografisi, sol böbrekte grade 2-3 hidronefroz ve perirenal sıvı kolleksiyonu, perirenal apse ile uyumlu bulgular şeklinde rapor edildi. Hastanın pre-post kontrast batin tomografisi sonucu ultrasonografi ile korele perirenal apse lehine değerlendirildi ve multiple taşlar tespit edildi. Hastanın sepiik çok tablosu izlemeye girildi ve üroloji yatılı servisine yatırıldı.

Sonuç: İlk defa 1980'lerde klinik uygulamaya giren ESWL düşük morbidite ve komplikasyon oranı, çoğunlukla hospitalizasyon ve anesteziye gerek olmaması ve yüksek başarıyla özellikle 2 cm'den küçük üst üriner sistem taşlarının tedavisinde ideal bir yöntemdir. ESWL,üriner sistem taş hastalığının tedavisinde ilk seçenek kabul edilse de,tüm taşların başarılı bir şekilde kırılmaması ve oluşabilecek komplikasyonlar nedeniyle bazen ilave tedaviler gerekebilir. Acil servise yakın zamanda ESWL öyküsü olan hastayla karşılaşıldığında komplikasyonlar akla gelmeli ve atlanmamalıdır. Bu vakada da girişim sonrası yan ağrısı olduğu için bu komplikasyonlardan birinin gelişmiş olabileceği düşünülüp böbrek usg ve sonrasında çekilen tomografisinde apse tespit edilmiş ve hastanın tedavisi gecikmeden başlanmıştır. Bu yaklaşımın mortalite ve morbidite üzerine olumlu etki yapacağı kanaatindeyiz.

Anahtar Kelimeler: ESWL, Perirenal apse, böbrek taşı

P-1019 Cardiovascular Emergencies

Konstriktif Perikardit

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Vaka: 58 yaşında erkek hasta, son 4 aydır artan öksürük, balgam, nefes darlığı, kilo kaybı, gece daha fazla olan terlemeler, hafif ateş yüksekliği şikayetleri ile acile başvurmuştur. Hasta hikayesi derinleştiğinde, uzun yol yürüyemediği nefes darlığı geliştiği, ayaklarında şişlik olduğu, hırıltılı bir solunumunun mevcut ayrıca sırt üstü yatınca boyundaki damarlarının şiştiği öğreniliyor. Öz geçmişinde günlük 20/adet sigara içtiği ve yaklaşık 27 yıl kot ütöleme atölyesinde çalıştığı öğreniliyor. Soy geçmişi de özellik yok.

Fizik muayenede; Genel durumu orta, bilinç açık, TA: 80/40mmHg ve Nb: 56/dk, Ateş: 37.2°C idi. Boyun venöz dolgunluk mevcuttu. Solunum sesleri kaba, sağ akciğer alt ve orta zonlarda solunum sesleri azalmış. Kalp sesleri derinden alınıyor, PTÖ++/++.

EKGARDİYOĞRAFI: Perikard kalınlaşmış, yaygın kalsifikasyonlar mevcut. Sağ ve sol atriyumlar genişlemiş. Sol ventrikül duvar hareketleri azalmış ve ejeksiyon fraksiyonu %40 idi.

Sonuç: İnflamasyon sonucu kalınlaşmış, fibrotik ve kalsifiye perikard tarafından ventriküllerin diastolik doluşunun sınırlandırıldığı bir hastalıktır. Konstriktif perikardit nedenleri arasında enfeksiyonlar, bağ doku hastalıkları, üremi, neoplastik hastalıklar, mediastene uygulanan radyoterapi ve hemodiyaliz vardır. Tüberküloz endemik bölgelerde konstriktif perikarditin en sık nedenidir. Hastalar halsizlik, periferik ödem, nefes darlığı ve karında şişlikten yakınırlar. Tipik olarak ilk perikard inflamasyonu ile konstriksiyonun başlangıcı arasında uzun bir süre mevcuttur. Olgumuzda da literatürde belirtilen nefes darlığı, ödem ve konstriksiyon ile perikard inflamasyonu arasında 4 aylık bir süre vardı. Ayrıca en sık enfeksiyon ajanlarından tüberküloz mevcuttu. Bu olgu ile bir kez daha hatırlanmalıdır ki; hem majör hem de minör hastalıklar aynı anda olup, hastanın hayatını tehdit edebilir. Bu yüzden acile özellikle nefes darlığı, ödem ve kilo kaybı gibi şikayetlerle getirilen hastalarda multidisipliner yaklaşım temel sorun ve/veya sorunları ortaya çıkarmak hastaya daha fazla yarar sağlayacaktır. Acil servise nefes darlığı gibi majör bir semptom ile gelen hastalarda eşlik eden minör semptomların gözardı edilmemesi, konstriktif perikardit gibi nadir görülen hastalıklarında tanısı akılda tutularak uygun laboratuvar ve görüntüleme yöntemleri kullanılmalıdır. Hızlı ve doğru tanılama süreci ile erken tedavi sağlanarak mortalite oranı azaltılabilir.

Anahtar Kelimeler: Acil, nefes darlığı, konstriktif perikardit

P-1020 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Weill Hastalığı

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Amaç: Leptospirozis özellikle tropikal bölgelerde daha sık olmak üzere dünyada sık görülen bir zoonozdur. Leptospirozisli hastaların %90'ında non-ikterik form görülür. Weill hastalığı ise leptospirozis olgularının %5-10'unda görülmekte olup, yüksek ateş, hipotansiyon, sarılık, kanama ve hepatorenal yetmezlikle karakterizedir. Kliniğinin çok değişken olması, tanısı için yüksek oranda şüphe gerektirmesi, kesin tanısının mikrobiyolojik izolasyonu veya serolojik testlerle konulabilmesi nedeniyle tanısı zordur. Tanısı kolaylıkla gözden kaçabilmekte, birçok enfeksiyöz hastalıkla karışabilmektedir. Burada KCFT yüksekliği, bilirubin yüksekliği, CK yüksekliği ve akut böbrek yetmezliği ile başvuran ve Weill hastalığı tanısı ile izlenen bir olgu sunulmuştur.

Olgu: 32 yaşında erkek hasta bir haftadır devam eden halsizlik, baş ve gözlerde ağrı, bulantı, karın ağrısı şikayetleri ile acil servise başvurdu. Hastanın önce baş ağrısı şikayeti başlamış ve ağır kesici ile geçmemiş. Daha sonra karın ağrısı ve bulantısı başlamış. Hürda işi ile uğraştığı öğrenilen hastanın olası fare teması öyküsü mevcuttu. Özgeçmişinde ve soy geçmişi de özellik yoktu. Ateşi 36,7 °C, nabızı 80/dk, TA 110/70 mmHg ve solunum sayısı 13/dk idi.

Hastanın genel görünümü biraz toksikti ve kişisel hijyeni iyi değildi. Genel durumu iyi-orta, bilinci açık, oryante, koopere. Skleraları ikterik. Orofarinksi doğal. LAP yok. Ense sertliği ve meningeal irritasyon bulguları yoktu. Kalp sesleri doğaldı, üfürümü yoktu. AC sesleri doğaldı. Batın muayenesinde defans, rebound, duyarlılık yoktu. Vücudunda döküntü izlenmedi.

Laboratuvar bulguları WBC: 12100 10³/mm³ (4,5-10,3) Hb:14 gr/dl(13,6-17,2) PLT:185000 10³/mm³ (156-373) BUN:54 mg/dl (8-20) K⁺:2,6 mg/dl(0,84-1,25) AST:76 U/L (0-50) ALT:55 U/L (0-50) GGT:149 U/L (0-55) LDH:518 U/L (22-80) CK:370 mg/dl (0-170) Total Bilirubin: 7,5 mg/dl (0,3-1,2) D.Bilirubin:4,12 mg/ (0,0-0,2) APTT:30,7 sn (25,1-36,5) PT:10,7 sn (9,4-12,5) INR:0,93 % CRP:169 mg/dl (0-6) Sedimantasyon:100 mm/Saat (0-15) Anti HAV igM(-), HBs Ag(-), Anti HBs(-), Anti HCV(-) Anti Hbc IgM(-) Batın USG normal olarak raporlandı.



POSTER PRESENTATIONS

Baş ağrısı olan hastaya çekilen BBT si normal olarak raporlandı.Yapılan lomber ponksiyonda BOS proteini: 61 mg/dl (15-40) BOS glukozu 58 mg/dl (40-70), anlık kan şekeri 108 mg/dl idi. Hasta infeksiyon hastalıkları ile konsülte edildi. Leptospirozis öntanısıyla infeksiyon hastalıkları kliniğine yatırıldı.

Serviste hastanın BOS, Kan ve idrar kültürleri alınıp 2x2 gr. i.v seftriakson ve i.v hidrasyon başlanmıştır. Takiplerinde KCFT, BFT, CK ve bilirubin seviyeleri normale dönmüştür. Kan, idrar ve bos kültürleri steril gelen, klinik ve laboratuvar yanıtı alınan hasta 7 günlük antibiyotik tedavisi sonrası şifa ile taburcu edilmiştir.

Sonuç: Baş ağrısı, sarılık, akut böbrek yetmezliği ve KCFT bozukluğu birlikteliği olan hastalarda Weil hastalığı ayırıcı tanıda akılda tutulması gereken hastalıklardan biridir. Türkiye'de bildirilen vakaların çoğunun erkekler olduğu Erken tanı önemlidir çünkü tanıda gecikilen olgularda Weil hastalığı ölümcül olabilmektedir.

Anahtar Kelimeler: KCFT, Leptospirozis, Weil

P-1021 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Servikal vertebra osteomiyeliti

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Amaç: Servikal osteomiyeliti nadir görülen ve subklinik bulgu veren bir patolojidir. Tanının gecikmiş veya gözden kaçmış olması ciddi klinik sorunlara yol açabilir. Bu nadir durumu, hastamız aracılığıyla, akla gelebilecek tanıların önemine vurgu yapmak için sunmayı amaçladık.

Olgu: Acil servise 75 yaşında erkek hasta yüksek ateş baş ve boyun ağrısı ve halsizlik yakınmaları ile başvurdu. Şikayetlerinin yaklaşık 15-20 gündür devam ettiğini söyleyen hastanın farklı hastanelere tekrarlayan başvuru öyküsü mevcuttu. Vital bulgularında patolojik olarak 160/dk nabız ve 38.9 oC vücut ısı saptandı. Fizik muayenede genel durumu orta olan hastanın boyun hareketlerinde ağrı dışında belirgin bir bulgusu yoktu. Ense sertliği saptanmadı. Laboratuvar sonuçlarında beyaz küre 16790 10³/µL ve CRP 21,8 idi. Çekilen servikal manyetik görüntüleme C1 ve C2 vertebra korpusları düzeyinde kemik iliği ödemi bulgusu ve bulgular osteomiyelit açısından anlamlı olarak raporlandı.

Sonuç: Yüksek ateş nedenli acil servis başvurularında enfeksiyon odağı araştırılırken hastanın şikayeti ve fizik muayene bulguları nadir olabilecek nedenlerde yol gösterici olabilir.

Anahtar Kelimeler: Servikal vertebra, Osteomiyelit, Yüksek ateş

P-1022 Cardiovascular Emergencies

Genç AF

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Vaka: 19 yaşında erkek hasta, son 1-2 saatte giderek artan halsizlik, aralıklı bulantı, kusma ve ilk kez olan çarpıntı şikayetleri ile acil servisimize başvurdu. Öyküsünde panik atağı ve 2 yıldır efexör 75mg tablet kullanımı vardı.

Fizik Muayene: Genel durumu orta, bilinç açık, kaşektik. Vital Bulguları: TA:70/50 mmHg, Nb: 147/dk aritmik, SS: 22/dk, A:35.5°C. Baş-boyun muayenesi doğal, cilt soluk ve soğuk idi. Solunum sistemi dinlemekle doğal, ral ve ronküs yoktu. Kalp dinlemekle taşikardik, ek ses ve üfürüm yoktu. Batında rebaund ve defans yoktu. Nörolojik muayenesinde deficit yoktu.

Hastaya acil serviste yeni yüksek ventriküler atriyal fibrilasyon tanısı konularak kardiyoloji konsultasyonu istendi. Hasta koroner yoğun bakım ünitesine yatırıldı. Medikal kardiyoversiyon için cordonone (amiodaron) infüzyonu başlandı. Hasta takiplerinde normal sinüs ritmine döndü. Coumadinize edildi. Kalp fonksiyonlarını değerlendirmek için ekokardiyografi yapıldı. Normal bulgular saptandı. Takiplerinde komplikasyon gelişmeyen hasta önerilerle taburcu edildi.

Sonuç: Atriyal fibrilasyon (AF) en sık gözlenen sürekli ritim bozukluğudur (1,2). Genç yaşlarda seyrek olarak gözlenen bu durumun sıklığı yaş ilerledikçe belirgin olarak artar (3). Eşlik eden bir hastalığın gösterilemediği genç hastalarda "lone AF" paroksizmal veya persistan şekilde görülebilir. Ayrıca fizyolojik stres, ilaçlar, pulmoner emboli, kronik akciğer hastalığı, hipertroidi, kafein ve çeşitli metabolik bozukluklarla da ilişkilidir(4). Olgumuzda kronik ilaç kullanımı ve kafein sık tüketimi mevcuttu ve literatür ile uyumluydu. Bu olguda, atriyal fibrilasyonlu hastalıklara yaklaşımda destekleyici bakımın sağlanması, koruyucu önlemlerin erken alınması, tanı ve tedavide ilaç kullanımının azaltılması, destekleyici tedavi sonrası hayat standardının daha iyi olması amaçlanmıştır. Kronik atriyal fibrilasyon ile seyreden hastalıklar çok yaygın oldukları ve çok çeşitli klinik tablolara neden olabildikleri için izole edilmeleri çoğunlukla zordur. Bu vakada olduğu gibi nadir gözlenen acil servise atıf prezantasyonlu halsizlik ve çarpıntı şikayeti ile başvuran hastalarda alta yatan kronik hastalıklar gözardı edilmeden akılda tutulmalıdır.

Anahtar Kelimeler: Acil, çarpıntı, atriyal fibrilasyon

P-1023 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Trakeostomi Gerektiren Bilateral Vokal Kord Paralizisi; Myasthenia Gravis'in Nadir Gözlenen Komplikasyonu

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Amaç: Myasthenia gravis (MG) nöromüsküler bileşkenin alevlenmeler ve remisyonları ile seyreden otoimmün bir bozukluğudur. Literatürde MG tanılı hastalarda trakeostomi gerektiren akut vokal kord paralizisi nadiren raporlanmıştır. Burada acil serviste nefes alma güçlüğü ile değerlendirilen ve öncesinde MG tanısı bulunan hastada saptanan vokal kord paralizisinin MG'de gözlenen nadir bir komplikasyon olması nedeniyle vurgulanması amaçlanmıştır.

Olgu: 63 yaşında erkek hasta, nefes alma güçlüğü ve hırıltılı solunum şikayetleri ile acil serviste değerlendirildi. Öyküsünde, hastanın 6 ay önce farklı bir merkezde myasthenia gravis tanısı alındığı, son 3 gün içinde başlayan ve geçen süre içinde ilerleyen yutma zorluğu şikayetinin geliştiği ve tarafımıza başvurmada yaklaşık bir saat önce ani başlayan nefes alma zorluğu ve hırıltılı solunum şikayetlerinin başladığı öğrenildi. Özgeçmişinde MG dışında hastalık bulunmayan hastanın soygeçmişinde de özellik saptanmadı. Hastanın ilk nörolojik değerlendirmesinde bilinç açık, koopere ve oryante idi. Pupiller bilateral normoizokorik ve ışık refleksi direkt ve indirekt olarak alınıyordu. Göz hareketleri bilateral tüm yönlerde serbestti. Fasial sinir muayenesi normal olarak değerlendirildi. Konuşması ileri derecede nazale olan hastada uvula deviasyonu yoktu, palatal arklar yukarı doğru kalkmıyordu. Hastanın diğer nörolojik muayene bulguları olağandı. Fizik muayenesinde ise genel durumu ortaydı, stridor ve taşikardi mevcuttu. Anamnez, klinik bulguları ve arteriel kan gazı sonuçları ile hastanın miyastenik krizde olabileceği düşünüldü. Hava yolu güvenliğinin sağlanması ve neostigmin infüzyon tedavisi başlanması ile beraber hasta acil olarak stridor varlığı nedeniyle kulak-burun-boğaz (KBB) kliniği ile konsülte edildi. Stridor varlığı nedeniyle KBB kliniğince hasta rutin muayene ile birlikte fleksibl nazofaringolarinoskop ile değerlendirildi. Bilateral kord vokal paralizisi saptanması üzerine hastaya acil trakeostomi uygulandı. Trakeostomi sonrası dramatik olarak rahatlayan hasta medikal tedavisinin düzenlenmesi amacıyla nöroloji kliniğine yatırıldı.

Sonuç: MG farklı kas gruplarını tutabilen ve kas güçsüzlüğü ile karakterize bir hastalıktır. Ekstraoküler, fasial, yutma ve solunum kasları gibi farklı kas gruplarını zaman zaman tutabilmekle beraber nadiren laringeal kasları da etkileyebilmektedir. Uygun ve zamanında acil ve medikal tedavi yapılmazsa mortal seyredebilen bu gibi durumlarda hava yolu yönetimi öncelik taşımaktadır. Burada acil serviste nefes alma güçlüğü ile değerlendirilen ve öncesinde myasthenia gravis tanısı bulunan 63 yaşındaki erkek hastada saptanan ve trakeostomi açılmak zorunda kalınan bilateral vokal kord paralizisinin myasthenia gravis'de gözlenen nadir bir komplikasyon olması nedeniyle vurgulanması amaçlanmıştır.

Anahtar Kelimeler: Myasthenia Gravis, trakeostomi, vokal kord

P-1024 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

2014 yılı H3N2 influenza A salgını esnasında bir acil servisin hasta başvuru yoğunluğunun ve sonuçlarının incelenmesi

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Amaç: Acil servislere başvuru oranı toplum kaynaklı epidemilerde artış göstermekte ve bir halk sağlığı problemi olarak toplumun geniş bir kesimi etkilenmektedir. Özellikle nüfus yoğunluğunun fazla olduğu yerlerde acil servislere bir afet yaşanmaktadır. Bu dönemlerde acil servislere başvuran hasta sayısı ve özelliklerinin belirlenmesi, acil servislere istihdam edilecek sağlık personelinin sayısının artırılması, nöbet durumlarının planlanması gerekmektedir. Bizde 2013 yılı aralık ayı ile 2014 yılı ocak ayı arasında görülen H3N2 grip salgınında Okmeydanı Eğitim ve Araştırma Hastanesi Erişkin Acil Servisine başvuran hastaların acil servis yoğunluğu ve hasta sonuçlarına etkisini araştırmayı amaçladık.

Gereç-Yöntem: Hastanemiz 01.12.2013-31.01.2014 tarihleri arasında erişkin acil servise başvuran tüm hasta sayısı, yatış veya dış merkeze sevk oranları, grip ile ilişkilendirilebilecek aldıkları tanı kodları hastanemiz acil servis bilgi işlem kayıtlarından geriye dönük olarak incelendi. Grip salgınının acil servise hasta başvuru yoğunluğuna etkisini saptamak için bir önceki yıl aynı tarihlerdeki başvuran hasta sayıları ile karşılaştırması yapıldı.



POSTER BİLDİRİLER

Bulgular: Aralık ve Ocak aylarında erişkin acil servisimize toplam 86796 hasta başvurmıştır. 2013 yılının verilerine göre bu sayı 56830'dur. İnfluenza salgını döneminde hasta sayısında %52 oranında artış olmuştur. Bu hastaların influenza ile ilişkili olabilecek tanı kodları bakıldığında toplam 96 hasta hastaneye yatırılarak tedavi edilmiştir. Yoğun bakım ünitesine aynı dönemde 106 hasta ilişkili tanı kodu alarak yatırılmıştır. Yoğun bakım ünitesine yatırılan hastaların 9'u 40 yaş altı, 97'si 40 yaş üstü olmak üzere yaş ortalamaları 68,2(16-89 yaş)'dır. Bir önceki senenin hastane yatak doluluk oranı %89, epidemik salgını döneminde %100 olarak hastane kapasitesinin kullanımı %12 artmıştır.

Sonuç: 2013 yılı aralık ayı başında H3N2 Influenza A virüsü salgını başladı. 2009 yılında görülen H1N1 influenza A pandemisinin aksine mevsimsel grip etkeni olan H3N2 genel olarak hafif semptomlarla seyretmekle birlikte yaşlılarda ve altta yatan hastalığı olanlarda ciddi klinik tabloya neden olmaktadır. İnfluenza A virüslerini tespit etmeye yönelik hızlı antijen testleri mevsimsel veya domuz gribi ayırımı yapamadığı için acil servislerde kullanımı yaygın değildir. Bu nedenle bilinen bir sebep olmaksızın öksürük ve boğaz ağrısı ile birlikte ateş olguları grip salgını ile ilişkilendirilmiştir. Başvuru sayısının fazla olmasının sebeplerinden birisi hastanemizin bulunduğu şehrin büyükşehir olması ve hastanemizin merkezi konumda olması gösterilebilir. Acil serviste planlama yapılırken, beklenmedik durumlara karşı tedbirli olunmalı ve insan kaynakları ve tıbbi donanım açısından sayılar yüksek tutulmalıdır. Bizim hastanemizde de H3N2 salgını nedeni ile dahiliye ve aile hekimliği acil servis dışında grip polikliniği hizmeti vermeye başlamış ve yoğun bakım ihtiyacı olan hastalar için ventilatör desteği artırılmıştır. Acil serviste çalışan sağlık personelinin nöbet planlamaları da yapılmış, asistan doktorların rotasyona girmeleri ertelenmiştir. Salgın dönemi boyunca sağlık personeline tükenmişlik ile birlikte hastaların acilde bekleme sürelerinde artmıştır.

Anahtar Kelimeler: Tip A Influenza H3N2, Acil Servis, Başvuru, Salgın

P-1025 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Acil Serviste Rabdomyoliz Tanısı Alan Hastaların Retrospektif İncelenmesi

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Konya Eğitim Araştırma Hastanesi Meram/Konya

Amaç: Rabdomyoliz ve crash sendromu özellikle Marmara depreminden sonra daha çok gündeme gelen bir sendromdur. Göçük altında kalmanın dışında toksinler, ağır egzersiz ve enfeksiyonlar gibi bir çok etyolojik faktörle meydana gelebilir. Amacımız acil servise gelen hastalar içinde rabdomyolizin sıklığını ve etyolojisini araştırmaktır.

Gereç-Yöntem: Çalışma Konya Eğitim ve Araştırma Hastanesi'nde retrospektif olarak planlandı. Acil servise gelen ve kreatin kinaz (CK) istenen 18 yaş üstü hastalar çalışmaya dahil edildi. Serum CK düzeyinin laboratuvar normalinin 5 katından daha yüksek olması rabdomyoliz olarak kabul edildi. Hastaların demografik özellikleri ve laboratuvar değerleri kaydedildi. Yatış süresi etyolojik faktörler ve akut böbrek yetmezliği açısından izlendi.

Bulgular: 13000 hasta tarandı. 89 (%0.7) hastada rabdomyoliz tespit edildi. Yaş ortalaması 52.7±20.8, erkek cinsiyet %69.7(62) idi. Hastaneye kabulde CK seviyesi median(IQR) 1366(1082), üre 37(19)mg/dl, kreatinin 0.9 (0.37)mg/dl idi. %11.2(10) hastada miyoglobülinüri, %9(10) hastada akut böbrek yetmezliği gelişti. Hastaların %3.4(3) ünde hiperpotasemi, %3.4(3) ünde hipopotasemi görüldü. En sık enfeksiyonun %19.1(17) ile rabdomyolize neden olduğu tespit edildi. Diğer nedenler intoksikasyonlar %4.5(4), ağır egzersiz %7.9(7), travma %9(8), resüsitasyon %7.9(7), %3.4(3) epilepsi ve diğer nedenler olarak sıralandı. ABY gelişmesinde CK seviyesi için ROC eğrisi kullanılarak elde edilen cut-off değeri 1833 olarak tespit edildi. (sensitivity: 75.0%, specificity: 74.7%, area under the curve 0.71, 95% confidence interval 0.60-0.80 p=0.04)

Sonuç: Rabdomyoliz acil servislerde hiç de az rastlanmayan bir sendromdur. Rabdomyolizin oluşumunda birbiri üzerine eklenen birçok neden rol oynayabilir. Vakalarımızda yaklaşık %9 'unda ABY gelişmiş olup literatürle uyumludur. Rabdomyoliz komplikasyonları göz önüne alındığında akılda tutulması gereken bir sendrom olarak karşımıza çıkmaktadır.

Anahtar Kelimeler: akut böbrek yetmezliği, kreatin kinaz, rabdomyoliz

P-1026 Resuscitation

Kardiak arrest ve hipoglisemi

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Amaç: Nabızsız elektriksel aktivite (NEA) acil serviste sık görülen kardiak arrest ritimlerinden biri olup, kardiak arrest olan bir hastada, organize bir ritim izlenirken, palpe edilebilen bir nabızın olmaması olarak tanımlanır. Olası, geri döndürülebilir nedenler arasında hipovolemi, hipoksi, asidoz, hipo/hiperkalemi, hipoglisemi, toksinler, tromboz, travma vb nedenler yer almaktadır. Hipoglisemi NEA olası nedenlerinden biri olup, acil servise kardiak arrest ile gelen ve hipoglisemi açısından risk faktörlerinin olduğu bir hastada akılda tutulmalıdır. Bu vakamızda hipoglisemi ile ilişkili kardiak arrest hastası sunulmuştur.

Olgu: 20 yaşında erkek hasta 112 ekipleri tarafından kardiak arrest ön tanısıyla acil servise getirildi. Hastanın GKS:3 solunum ve dolaşımı yoktu. Hasta entübe edilerek kardiy pulmoner resüsitasyonu (CPR) başlandı. Hasta CPR 'ın 5. dakikasında monitörde dar QRS' li taşikardik bir ritim görüldü, ancak hastada nabız palpe edilmedi. Bu arada hasta yakınlarından alınan anamneze göre hastanın Tip1 diabetes ve kronik böbrek yetmezliği hastası olduğu, haftada 3 kez diyalize girdiği öğrenildi. Hastanın 2 gündür öğünlerine dikkat etmediği tespit edildi. Hastanın stick kan şekeri 29 mg/dl olarak ölçüldü. Bunun üzerine CPR devam ederken hastaya %20 70 cc dextroz iv bolus olarak verildi. %5 dextroz 500 cc infüzyon olarak devam edildi. CPR devam ederken hala monitörde taşikardik dar QRS li bir ritim mevcut ancak nabız palpe edilemiyordu. Bakılan FAST bakısında kardiak kontraktilete görülmedi. Hasta CPR 'ın 15. dakikasında nabız alınmaya başlandı. FAST bakısında da kardiak kontraktilete gözlemlendi. Hipotansif olan hastaya dopamin infüzyonu başlandı. Hastanın yoğun bakıma yatırıldı. Yatışının 15. gününde şifa ile taburcu olduğu öğrenildi.

Sonuç: NEA sık görülen arrest ritimlerinden olup hipoglisemi geri döndürülebilir nedenlerinden biridir. Özellikle risk faktörü olan diabetli hastalarda hipoglisemi akılda tutulmalı, buna uygun tedavi yaklaşımı yapılmalıdır.

Anahtar Kelimeler: Acil servis, hipoglisemi, nabızsız elektriksel aktivite

P-1027 Cardiovascular Emergencies

Anterioinferior ST yükseklikli miyokard enfarktüsü mü? Anevrizma olmasın!

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Amaç: ST segment anormalliklerinin (elevasyon/depresyon) en yaygın sebebi miyokard enfarktüsüdür (MI). Diğer ST segment elevasyonu yapan nedenlerden biri de sol ventrikül anevrizmasıdır. Sol ventrikül anevrizmalarının da altına yatan en yaygın nedeni iskemidir. Sol ventrikül anevrizmasının EKG bulguları; en yaygın olarak prekor diyal derivasyonlarda görülür. Konkav veya konveks morfolojide görülebilir. Genellikle düzgün şekilli Q veya QS dalgaları ile birlikte gösterir. T dalgaları QRS kompleksi ile karşılaştırıldığında göreceli olarak daha düşük amplitüde sahiptir ve T negatifliği izlenir. Acil servislerde çekilen EKG'lerde ST elevasyonlarının saptanması hekimleri MI tanısına yönlendirir. Biz bu olgumuzda acil servisimize göğüs ağrısı şikayetiyle başvuran, EKG'de anteroinferior ST yüksekliği olması nedeniyle uzun segment dolanmış sol anterior inen (LAD) arter tıkanıklığı veya çoklu bölge (anteroinferior) infarktüsü düşünülen, ancak inferior MI ile birlikte sol ventrikül anevrizması tespit edilen bir hastamızı sunmak istedik.

Olgu: Altmış yedi yaşında erkek hasta, yaklaşık 1 saat önce başlayan şiddetli göğüs ağrısı şikayetiyle acil servisimize başvurdu. Hasta monitörize edildi ve güvenlik çemberine alındı. Hastanın göğüs ağrısının baskı şeklinde olduğunu, sol koluna ve sırtına yayıldığını, birlikte soğuk terlemesinin de olduğu anamnezinden öğrenildi. Yaklaşık bir ay önce 20 dakika süren benzer bir göğüs ağrısının olduğunu, ancak ağrının geçmesi üzerine herhangi bir sağlık kuruluşuna başvurmamış olduğunu öğrenildi. Hastanın özgeçmişinde sigara kullandığı, kronik obstrüktif akciğer hastalığı öyküsü olduğu ve inhale betamimetik ve steroid ilaç kullandığı öğrenildi. Hasta ile ilgili herhangi bir kayıt tutulmadığından önceki EKG'leri görülemedi. Hastanın vitallerinde tansiyon arteriyel:140/80 mmHg, nabız:75 atım/dakika, oksijen saturasyonu %97 idi ve fizik muayenesinde anlamlı patoloji yoktu. Çekilen EKG'de inferior ve anteroseptal derivasyonlarda ST segmentinde elevasyon, yüksek lateral derivasyonlarda ST çökmesi gözlemlendi (Şekil 1). Hastaya inferior+anteroseptal MI ön tanısıyla 300 mg asetilsalisilik asit, 60 ünite/kg'den 4000 ünite heparin, 600 mg klopidoğrel verilerek Kardiyoloji konsültasyonu istendi. Kardiyoloji tarafından primer koroner anjiyografiye alınan hastada sağ ana koroner arterde (RCA) tam tıkanıklık, ventrikülografisinde; sol ventrikülde anevrizma tespit edildi. RCA'ya stent yerleştirilerek koroner yoğun bakımda takibe alındı. Takiplerinde çekilen EKG'lerinde inferior derivasyonlarda ST elevasyonunun düzeldiği, ancak prekor diyal derivasyonlarda ST elevasyonunun devam ettiği gözlemlendi (Şekil 2). Hasta kardiyoloji polikliniği kontrolleri önerilerek 10.gün taburcu edildi.

Sonuç: Acil servislerde çekilen EKG'lerde prekor diyal derivasyonlarda ST elevasyonlarının saptanması öncelikle MI tanısını akla getirmesi gerektiği gibi, ST segmentinin eğim yönü ve şekli (kubbe, horizontal, aşağı eğimli, yukarı eğimli) acil hekimlerince ST segment yükselmesi ayırtıcı tanısında dikkate alınmalıdır. Ek olarak hikaye ve fizik muayene ile birlikte dikkatli bir EKG değerlendirilmesinin gerektiğini hatırlatmak istedik.



POSTER PRESENTATIONS

Anahtar Kelimeler: Anevrizma, Myokard Enfarktüsü, Acil Servis

P-1028 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Göz kapağı kırıkta kene

İnan Beydilli, Ertan Ararat, Arefe İmak, Seçil Baran, Zeynep Aslı Kartal, İkbâl Şaşmaz, Asım Arı
Antalya Eğitim ve Araştırma Hastanesi

Amaç: Kırım-Kongo kanamalı ateşi (KKKA), viral hemorajik ateş sendromları arasında yer alan zoonoz karakterli bir enfeksiyondur. Ülkemizde özellikle ilkbahar ve yaz aylarında, başta Tokat, Yozgat, Çankırı, Çorum, Sivas, Erzurum ve Amasya gibi yöreler olmak üzere, Karadeniz Bölgesi'nin iç kesimleri ile İç ve Doğu Anadolu Bölgeleri'nin kuzey kesimleri arasında geniş bir coğrafi alanda görülen iki salgın sonucunda dikkati çekmiştir

Olgu: 32 yaşında bayan hasta piknik sonrasında sol üst göz kapağında kene olabileceği şüphesi ile acil servisimize başvurdu. Üst göz kapağında kırpık koküne yapışmış kene tespit edildi. Kene başın deriye girdiği yere yakın bir bölgeden pensle tutularak yavaşça sağa sola hareketlerle parçalanmadan çıkarıldı. Klinik izlem boyunca takiplerinde problemi olmadı.

Sonuç: Bizim olgumuzda kene ısırması alışık olunmayan bir lokalizasyonda mevcuttu.

Anahtar Kelimeler: enfeksiyon, Kırım-Kongo kanamalı ateşi, kene

P-1029 Imaging in Emergency Units

Bunu da düşünmek lazım: spontan pnömomediastinum!

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Amaç: Pnömomediastinum solunum veya sindirim sistemi organlarının perforasyonu sonucunda serbest havanın mediastende bulunması olarak tanımlanır. İlk olarak 1939 yılında Hamman tarafından tanımlanmıştır. Spontan pnömomediastinum (SPM) çok az görülmekle birlikte çoğunlukla genç erkeklerde periferik pulmoner alveollerin rüptürü sonucunda görülür. Olgular en sık substernal ağrı şikayeti ile başvururlar. Bu olgu sunumuyla amacımız göğüs ağrısı şikayeti ile gelen hastalarda SPM görülebileceğini hatırlatmaktır.

Olgu: 19 yaşında erkek hasta şiddetli göğüs ağrısı şikayeti ile acil servise başvurdu. Hastanın öz geçmişinde özellik yoktu. Yaklaşık 30 dakika önce başlayan, retrosternal bölgede, yayılım göstermeyen göğüs ağrısı tarifliyordu. Travma öyküsü olmayan hastanın fizik muayenesinde akciğer sesleri doğaldı. Kalp sesleri S1 - S2 pozitif ve Hamman Sign duyuldu. Vital bulguları normal olan hastanın EKG'sinde akut patoloji saptanmadı. Çekilen PA Akciğer grafisinde parakardiyak serbest hava görüntüsü gözlemlendi (Şekil 1). Bilgisayarlı Toraks Tomografisinde mediastende tre-kea, özofagus ve kalp çevresinde, boyun hilus seviyesine kadar uzanan serbest hava gözlemlendi (Şekil 2-4). Hastaya SPM tanısı konarak, takip ve tedavi amaçlı göğüs cerrahi servisine yatırıldı.

Sonuç: SPM özellikle genç erkeklerde görülen; ani başlayan göğüs ağrısı, solunum güçlüğü ile giden, kendiliğinden gerileyen nadir gözlenen bir klinik durumdur. Olgumuzda gözlenen Hamman Sign; oskültasyonda kalbin apeksinde duyulan, inspiryumda ve sol lateral dekübit pozisyonunda artan, kalp sesiyle senkronize krepatasyon şeklinde tanımlanmaktadır. Tedavide neden ortaya konabiliyorsa nedene yönelik tedavi yapılırken, sıklıkla oksijen desteği, antibiyoterapi, günlük fizik muayene ve PAAC grafisi ile 24 - 36 saat takip yeterli olmaktadır. Genellikle 48 saat içinde kendiliğinden geriler. Acil Tıp Hekimleri göğüs ağrısı nedeni ile başvuran hastaların ayrırcı tanısında SPM düşünmelidirler.

Anahtar Kelimeler: Spontan pnömomediastinum, Göğüs ağrısı, Hamman sign

P-1030 Imaging in Emergency Units

Herşey görüldüğü gibi değildir

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Amaç: Travma ölüm nedenleri arasında üçüncü sıradadır. Spinal yaralanmalar travma hastalarında görülen tehlikeli yaralanmalardır. Servikal vertebra yaralanmaları ölümlere ve kalıcı sakatlanmalara yol açan ciddi yaralanmalardır. Tüm travmaların yaklaşık %2-4 'ünde servikal vertebra yaralanmaları meydana gelmektedir. Servikal vertebra yaralanmaları genellikle yüksek enerjili multiple travmaları olgularıdır. Çoğunlukla motorlu araç kazaları, sportif yaralanmalar, yüksekten düşme ve ateşli silah yaralanmaları sonrası meydana gelmektedir. Servikal segment spinal travmalarda %42 oranında en çok etkilenen bölgedir. Servikal bölgede ligamentum supraspinale ve ligamentum interspinaleler oldukça kalınlaşarak ligamentum nuchaei oluştururlar. Ligamentum nuchae, kafatasındaki protuberansia oksipitalis eksterna ile yedinci servikal vertebra'nın processus spinosus'u arasında uzanır. Bu vakamızda servikal fraktür ile karışabilen ligamentum nuchae kalsifikasyonu sunulmuştur.

Olgu: 58 yaş erkek hasta araç içi trafik kazası sonrası acil servisimize göğüste batma ve ağrı yakınmaları ile 112 tarafından getirildi. Genel durumu iyi bilinç açık oryantasyon, kooperasyon vardı. KB:130/80 mmHg, N:84/dakika, A:36,8 ° C, SS:20 ve GKS:15 idi. Fizik muayenede sternum ve sağ 3-4 kotta hassasiyet, klavikulada hassasiyet ve sol patellada 2cm kesi mevcuttu. Ekstremitelerde motor ve duyu defisiti yoktu. Hastanın hemogram ve biyokimya sonuçları normaldi. Hastanın görüntülemesinde klavikulada deplase fraktür, sağ akciğer de yaygın kontüzyon ve 3-4-5-6 kotta deplase fraktür mevcuttu. Çekilen beyin tomografisinde herhangi bir patolojiye rastlanmadı. Servikal tomografide C5 spinoz süreçte fraktür ile uyumlu olabilecek yapı dikkati çekmekteydi. Fakat hastanın kliniği ve yapılan fizik muayenesi servikal fraktür ile uyumlu değildi. Tomografi radyoloji ile birlikte tekrar değerlendirildiğinde olayın görüldüğü gibi olmadığı anlaşıldı. Bu yapı ligamentum nuchae kalsifikasyonuuydu.

Sonuç: Ligamentum nuchae kalsifikasyonu servikal travmalarda rahatça karışabilecek yapısal bir durumdur. Erkeklerde % 11,3 ve kadınlarda % 3,5 oranında görülebilmektedir. Multipl travmalı hastalarda detaylı fizik ve nörolojik muayene yapılmalıdır. Aksi ispatlanıncaya kadar servikal yaralanma varmış gibi kabul edilerek servikal collar takılmalı ve spinal kanal stabilizasyonu sağlanmalıdır. Ligamentum nuchae kalsifikasyonu çoğu hekim tarafından karıştırılabilecek seyrek rastlanan bir durumdur. Detaylı fizik, nörolojik muayene ve dikkatli CT yorumlanması ile kolayca ayırt edilebilmektedir.

Anahtar Kelimeler: Acil servis, ligamentum nuchae, servikal travma

P-1031 Other

Acil Serviste İlginç Bir Olgu: Vasküler Patolojiyi Düşündürden Çevresel Etmenler

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Amaç: Acil serviste karşılaşılan ekstremité patolojilerinde öncelikle vasküler ve nörolojik sebepler ekarte edildikten sonra nadirde olsa ciltte renk değişikliğine sebep olacak çevresel etmenler göz ardı edilmemelidir.

Olgu: 27 yaşında bayan hasta her iki kolda yeni oluşan renk koyuluğu nedeni ile acil servise kabul edildi. Anamnezde acil servise gelmeden 2 saat önce her iki kolunda deri renginde koyulaşma fark ettiği, bilinen bir hastalığı veya kullandığı herhangi bir ilaç olmadığı öğrenildi. Fizik muayenede her iki kolun omuzdan başlayıp el bileklerine kadar olan kısmında cilt rengi siyanoze görünümlüydü. Periferik nabızların açık, ekstremité hareketlerinin doğal, duyu muayenesinin normal, ağrısız, kapiller dolum zamanının 2 sn olduğu görüldü. Vücut ısı normal, ekstremité ısısının diğer bölgelerinin ısısından farkı (ekstremitéde ısı artışı veya soğukluk) olmadığı görüldü. (Şekil 1) Hastanın vasküler patoloji ile uyumlu fizik muayene bulguları olmamasına rağmen atipik tabloların ekarte edilmesi için yapılan venöz doppler USG' de vasküler yapıların intakt ve dolaşımın açık olduğu görüldü ve venöz trombus ekarte edildi. Alınan kan gazında methemoglobin değerleri ve pH dahil olmak üzere diğer parametreler normal olarak ölçüldü. Hastanın elbiselerinin çıkartılıp tüm vücudu kontrol edildiğinde, siyanotik görüntünün her iki kolda omuz-bilek arasında olduğu, vücudun diğer bölgelerinin renginin normal olduğu görüldü. Siyanotik olan bölgenin mevcut bulgularla hiçbir klinikle bağdaşmaması üzerine tekrar sorgulama yapıldı ve şahsın herhangi bir boya veya benzeri madde ile temas etmediğinin ısrarı üzerine lavaboda deterjanlı spanç ile cilt silindi. O bölgede rengin açıldığı görüldü. (Şekil 2) tekrar sorgulandığında ve dikkatli incelendiğinde ciltteki söz konusu rengin üzerindeki kazağın rengine yakın olduğu, hastanın bu kıyafeti ilk defa giydiği öğrenildi ve boyalı alanların kıyafet ile temas eden bölgeleri içerdiği tespit edildi.

Sonuç: Acil serviste, özellikle ekstremitelerde karşılaşılan, beklenmeyen şekilde renk değişiklikleri gözlemlendiğinde, vasküler yapılar gözden geçirilip muhtemel patolojiler ekarte edildikten sonra external sebepler düşünülmelidir. Bu gibi vakalarda kumaş boyaları göz önünde bulundurularak cildin deterjanlı solüsyonlarla temizlenmesi faydalı olabilir.

Anahtar Kelimeler: Acil servis, siyanoz, çevresel etmenler



POSTER BİLDİRİLER

P-1032 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

İlk Nöbetle Başvuran Yeni Tanı Beyin Tümörü

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Amaç: Nöbet, beyinde gerçekleşen ani elektrik aktivitesi patlamasının bir sonucudur. Bu durum, beyindeki mesajların geçici olarak durmasına ya da karışmasına neden olmaktadır. Semptomlar her bir nöbet türü ile değişiklik göstermekte olup kas seğirmesini, konvülsiyonları, bellek kaybını, göz seğirmesini, kas sertleşmesini veya gevşemesini, boş bakışları ve bilinç kaybını içermektedir. Beyin tümörü tanısı alan hastaların %25-40'ı acil servise nöbetle başvuruyor, biz de bu olgumuzda bunu vurgulamaya çalıştık.

Olgu: 83 yaşında erkek hasta. Hastaneye başvurmadan önceki gün 3 kez bayılma şikayeti ile geldi, en kısa 30 dakika en uzun 3 saatlik senkop epizotları var, anterograd amnezik hatsa. Hasta kasıldığını ve ağzından köpükler geldiğini ifade ediyor, GKS: 15, oryante koopere hasta. Laboratuvar normal sınırlarda, konvülsyon ön tanısı ile alınan non-contrast beyin BT' de solda bazal ganglionlar ve talamusu içine alan hipodansite dikkati çekmektedir. Talamustaki lezyon 3. Ventriküle hafif bası yapmakta olup solda lateral ventrikül frontal hornunda asimetrik genişleme izlenmektedir. Kitle ayırıcı tanı açısından beyin MRG çekildi ve nöroşirürjiye yatırıldı. Kontrastlı beyin MR: Sol talamusta 3.ventriküle ve foramen monroya bası oluşturan, oldukça iyi sınırlı, düzgün konturlu boyutları en geniş yerinde 40x25 mm kitle tespit edildi. Metastaz açısından da PET CT önerildi ve çekildi, primer beyin tm saptanan hasta opere edildi ve antiepileptik bir ajanla yatışının 21. günü taburcu edildi.

Sonuç: Beyin tümörü, kafatası içerisinde büyüyerek beyin üzerine baskı yapar ve bulunduğu bölgeye ve baskı altında tuttuğu beyin alanına göre belirtiler verir. Fakat kafa içinde yer kaplayan bütün vakalarda olduğu gibi öncelikli olarak kafa içi basıncın artmasına bağlı belirtiler gösterir. Beyin tümörü karakterine göre düzensiz ya da düzenli bir biçimde büyümeye devam eder ve genişleme, büyüme imkânı olmayan kafatası içerisinde beyin üzerine baskı yapmaya başlar. Bizim olgumuzda olduğu gibi nöbet bu hastaların semptomlarından biri olabilir

Anahtar Kelimeler: beyin, nöbet, tümör

P-1033 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Pulmoner Embolide Trombolitik Tedavinin Önemi

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Amaç: Pulmoner tromboembolizm, genellikle derin ven trombozunun bir komplikasyonudur. Pulmoner tromboemboli ve derin ven trombozunun genellikle birlikte olması sebebiyle, tanımlarken iki olayı da ifade eden venöz tromboembolizm terimi de kullanılabilir. Pulmoner emboli ancak ayırıcı tanıda düşünüldüğü takdirde tanısı konabilen ve buz yüzden zor bir hastalıktır. Bu konuda Wells skorlama sistemi kullanılır. Hastalar pulmoner emboli ya da derin ven trombozu hikayesi olmasından 1.5 puan, kalp hızı 100/dakika'nın üzerinde olmasından 1.5 puan, son 4 hafta içerisinde cerrahi geçirmiş olması ya da immobilizasyondan 1.5 puan, hemoptizi 1 puan, malignensi 1 puan, derin ven trombozu klinik bulgusu varlığından 3 puan, mevcut kliniği açıklayacak alternatif tanı olmamasından 3 puan alırlar ve 2 puan altında kalan hastalar düşük olasılık, 2-6 puan arası alan hastalar orta olasılık, 6 puan ve üstü alan hastalar yüksek olasılık olarak sınıflanırlar.

Olgu: 86 yaşında kadın hasta. Beslenememe, genel durum bozukluğu nedeni acil servise getirilen hasta, 1 ay önce sol paryetal kronik subdural hemoraji nedeni ile opere edilmiş. Bir kaç gündür beslenememişi, dehidrate, dil ve kornea kuru, cilt turgoru azalmış. Homans negatif ve alt ekstremitelerde çap farkı yok. Hastanın satüsayonu 90, solunum sayısı dakikada 28, tansiyon 100/60mmHg ateş: 36.6 Nabız: 112/dk tespit edildi. Wells pulmoner emboli skorlama sisteminden hastamız son 4 haftada cerrahi ve immobilizasyondan 1.5 puan, mevcut kliniği açıklayacak alternatif tanı olmayışından 3 puan puan, kalp hızının dakikada 100'ün üzerinde olmasından da 1.5 puan ile toplamda 6 puan aldı.

Arter kan gazında pH: 7.48 pCO2: 34.5 pO2: 62.30 O2sat: 93.6 HCO3: 26.7

Laboratuvarında BUN: 89 Glu: 118 Scr: 1.7 Na: 164 Cl: 123 ALT: 25 AST: 67 WBC: 29.1 Neu: 26.0

Myoglobin > 1.000.00 cTPl: 0.19 CK-MBmass: 6.2

TİT: Bol eritrosit, 3-4 lökosit, ürobilinojen 1+, dansite > 1.030

PAAC: Normal EKG: 117/dk, sinüs taşikardisi

Laboratuvar bulguları dehidratasyona bağlandı, hipoksisini aydınlatmak için pulmoner anjio protokolünde toraks CT çekildi: Her iki pulmoner artere ve segmental dallara uzanım gösteren geniş trombüs formasyonu izlendi. Hasta yoğun bakıma yatırıldı, ilk gün düşük molekül ağırlıklı heparin verilen hastada klinik iyileşme olmadı ve 2. gün anstabil kabul edilen hastaya trombolitik tedavi başlandı. Tedaviye cevap alınmadı ve hasta 4. gün arrest oldu.

Sonuç: Pulmoner tromboemboli mortalite ve morbiditesi yüksek, tekrarlayabilen, bazen tanısı güç olan ve önlenilebilir bir hastalıktır. Klinik belirtiler eşlik eden hastalıklar nedeniyle maskeleyebilir ve gecikebilir. ABD verilerine göre venöz tromboemboli'nin ortalama yıllık insidansı yaklaşık 1/1000 olup, yaşla birlikte artar ve 80 yaşından sonra 45-50 yaşındakine göre yaklaşık 10 katına yükselir. Venöz tromboemboli'nin mevsimsel değişiklik gösterdiği ve insidansın erkeklerde daha yüksek olduğuna dair bulgular mevcuttur. Mortalite genellikle kanser, kronik kardiyopulmoner komorbidite ve ileri yaş ile ilişkilidir.

Anahtar Kelimeler: emboli, major, trombolitik

P-1034 Cardiovascular Emergencies

Genç Hastada Bilateral Derin Ven Trombozu; Neden Varsa... Neden Olmasın!

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Amaç: Derin ven trombozu daha çok alt ekstremitelerde görülür, bacakta ağrı, ısı artışı, ödem, hiperemi ve çap artışı ile seyreden ciddi morbidite ve mortaliteye neden olan bir koagülasyon bozukluğudur. Vakamızda az rastlanan bilateral derin ven trombozu tespit ettiğimiz genç erkek hastayı sunmayı amaçladık.

Olgu: 28 yaşında erkek hasta, bilateral bacak ağrısı şikayeti ile acil servisimize başvurdu. Bilinen herhangi bir hastalığı olmayan hasta her iki bacağında yirmi gündür devam eden ağrı, şişlik şikayetleri ile birkaç kez dış merkezde analjezik ve antibiyotik tedavileri almış ancak şikayetleri gerilememiş. Genel durumu iyi, bilinç açık oryante koopere Glasgow Koma Skalası 15 olan hastanın vital bulguları stabildi. Fizik muayenesinde bilateral alt ekstremitelerde ısı artışı, yaygın ödem ve hassasiyet mevcuttu. Alt ekstremitelerinde çap farkı olmayan hastanın periferik nabızları açıktı. Diğer sistem muayeneleri doğaldı. Hastaya DVT ön tanısı ile Doppler USG planlandı. Yapılan Doppler USG'de sağ popliteal ven kompresibl olup lümeninde rekanalize akım izlenmiştir (subakut dvt?) safena magna, common femoral, derin femoral ven nonkompresibl olup lümen içerisinde akım sinyali alınamamıştır. Lümeninde trombüs materyali ile uyumlu ekojen görünüm izlenmiştir (akut-subakut DVT). Sol common femoral, derin femoral ven, superfisiyal femoral ve. popliteal ven nonkompresibl olup lümeninde akım sinyali alınamamıştır. Lümeninde trombüs materyali ile uyumlu ekojen görünüm izlenmiştir (akut-subakut DVT). DVT tanısıyla kalp damar cerrahisine konsülte edilen hasta ileri tetkik ve tedavi amaçlı servise yatırıldı.

Sonuç: Derin ven trombozu klinik olarak asemptomatik vakadan ölüme kadar değişen klinik tablolarda karşımıza çıkabilmektedirler. Bilateral olma olasılıkları %2,9 civarındadır. Uzun süreli hareketsizliğe bağlı olarak sağlıklı bireylerde gelişebileceği gibi ateroskleroz, diabetes mellitus, vaskulit, venöz sistemde prostetik materyalin varlığı, vasküler staz, hiperviskozite sendromları ile akkiz veya konjenital trombofilili gibi hastalıklara sekonder olarak ortaya çıkmaktadır. Vakamızda her iki bacakta septomatik dvt varlığı nedeni ile altta yatan patoloji varlığı araştırılmış ve faktör 5 leiden mutasyonu tespit edilmiştir. Spontan DVT olgularının ancak %12-30'unda faktör 5 leiden mutasyonu bildirilmiştir. Sonuç olarak bilateral derin ven trombozu nadir görülmektedir ve tanı konusunda mutlaka altta yatan patoloji açısından araştırılmalıdır.

Anahtar Kelimeler: Derin Ven Trombozu, Faktör 5 Leiden Mutasyonu, Bilateral DVT

P-1035 Cardiovascular Emergencies

Sık Rastlanan Bir Anjina sebebi: Anemi

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Amaç: Ülkemizde ölümler en sık kardiyak nedenlerden dolayıdır ve bunun da en sık nedeni akut koroner sendromlardır, erkekler daha fazla risk altındadır fakat ilerleyen yaşla risk eşitlenir. Diğer etiyoloji ve risk faktörleri; hipertansiyon, diabet hastalığı, hiperlipidemi, sigara kullanımı, obezite, sedanter yaşam'dır. Anemi de bir anjina nedenidir biz bu vakamızda buna vurgu yapmaya çalıştık.

Olgu: 59 yaşında erkek hasta, son 2-3 gündür giderek artan nefes darlığı ve tipik göğüs ağrısı şikayeti ile geldi, ilave sistem sorgusunda özellik vermedi. HT mevcut coraspirin 300 mg 1x1 alıyor. TA: 130/70, Sao2: 98, nabız: 88/dk, ateş 36.6. Fizik Muayene: Bibaziller akciğer rali mevcut ve hasta soluk görünümde. Cinsiyet, ağrı tipi, kalp yetmezliği bulguları tespiti ve EKG değişikliği olması nedeniyle yüksek olasılıklı AKS özelliği kazanan hasta monitörize takip edildi, Plaviks medikasyonu yapıldı. EKG: 78/dk-NSR, DI-aVL ST segment depresyonu mevcut. cTPl izole 0.54, Hb: 7.9. Aneminin derin sorgusunda hasta melena tarif etti ve rektal tusede melena tespit edildi. Oral stoplandı, hasta GIS kanama protokolüne alındı. Kardiyoloji EKO yaptı SDHB saptamadı, EF: % 65. Gastroenteroloji hastaya üst GIS kanama tanısı ile yatış verdi hasta anemiye sekonder kalp yetmezliği ve AKS tanısı konuldu. 2 Ü ES verildi ve hasta rahatladı. Takip eden sabah 8.00 kardiyak paneli kontrolü alındı: cTPl: 2.54 ve CKMB:18.4 saptandı.



POSTER PRESENTATIONS

Sonuç: Akut koroner sendromlarda en sık başvuru şekli (%40-50) tipik göğüs ağrısıdır fakat tipik olmayan göğüs ağrısı veya anjina ekivalanı semptomlarla başvuran hastalarda az değildir. Akut koroner sendromların tanınması fizik muayene bulguları olmasa bile hastanın risk düzeyini belirleme açısından çok yararlı bilgiler verir. Juguler ven basıncı yüksekliği, akciğer alanlarında yaş rallerin 1/2 alt alanlara kadar duyulması, galo ritminin ya da yeni ortaya çıkan sistol üfürümlerinin varlığı, inme bulgularının eşlik etmesi, sistemik hipoperfüzyon bulgularının saptanması o hastanın yüksek riskli olduğunu gösterir. Böyle bir hasta nerede görülürse görülsün, o kurumda eğer acil koşullarda girişimli tanı ve tedavi yöntemleri uygulanmıyorsa, uygulanabilen bir merkeze gönderilmelidir. Bizim olgumuzda olduğu gibi her göğüs ağrılı hastada tam kan sayımı yapılmalı ve anemi sorgulanmalı ve araştırılmalıdır.

Anahtar Kelimeler: anemi, anjina, koroner

P-1036 Cardiovascular Emergencies

Akut Koroner Sendrom ve Hipokalemi Birlikteliği

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Antalya Eğitim ve Araştırma Hastanesi, Antalya

Amaç: Akut koroner sendromlarda hastanın en sık başvuru şekli %40-50 ile tipik göğüs ağrısıdır, özellikle yaşlılar ve diyabetik hastalar atipik bir göğüs ağrısı şikayeti ile veya göğüs ağrısı olmaksızın anjina ekivalanı kabul edilen şikayetlerle de başvurabilirler, gastrointestinal semptomlar, nefes darlığı, terleme ve ani gelen halsizlik şikayetleri olabilir. Hastalar ellerde ayaklarda tutmama, güç kaybı şeklindeki şikayetleri de halsizlik olarak nitelendirmekte ve bu durum hipokalemiye bağlı olabilmektedir. Bizim olgumuzda halsizlikle başvuran ve hipokalemi ve akut koroner sendrom tanısı alan bir hastayı işlemektedir.

Olgusu: 43 yaşında erkek hasta, elde ayakta tutmama şikayeti ile geldi. Düünden beri el ve ayaklarda tüm ekstremitelerde güçsüzlük tarifliyor. 10 yıl önce aynıysa olmuş ve hasta 1 ay hospitalize edilmiş, tanısını bilmiyor, dokümantasyon yok. Dizartri yok fasyal asimetri yok, 1-2 kez kusma atağı var, göğüs ağrısı ve nefes darlığı tariflemiyor. 2 gündür metpamid kullanıyor. Komorbid hastalığı yok. EKG: 68/ dk, 2-1 atriyal ekstra ve U dalgası mevcut. Troponin I: 19.95, Myoglobin > 1.000.00, Potasyum: 1.6. Hastaya hipopotasemik paraliz ve akut koroner sendrom tanısı konuldu ve potasyum tedavisine başlandı. Hasta potasyum yüklemesini takiben koroner yoğun bakıma yatırıldı, CAG'de 3 damar hastalığı tespit edilmesi üzerine CABG yapıldı.

Sonuç: Potasyum bozuklukları ve kardiyak hastalık birlikteliği genel olarak karşımıza diüretik ilaç kullanımı (loop diüretikler, anjiotensin dönüştürücü enzim inhibitörleri, anjiotensin reseptör blokajı yapan ilaçlar, tiazidler, aldosteron antagonistleri), heparin kullanımı, digoksin kullanımı ve kalp yetmezliği şeklinde karşımıza çıkar. Bizim olgumuzda olduğu gibi tesadüfi birliktelik de olabilir.

Anahtar Kelimeler: akut, hipokalemi, koroner

P-1037 Pediatric Emergencies

Çocukluk çağı katarakt

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Antalya Eğitim ve Araştırma Hastanesi

Amaç: Normalde saydam olması gereken göz merceğinin saydamlığını kaybedip beyazlaşmasına katarakt denir. Katarakt çoğunlukla yaşlılarda olduğu halde yeni doğan bebeklerde veya çocuklarda da görülebilir. Bu tür katarakt, doğuştan katarakt olarak isimlendirilir. Tek taraflı katarakt hemen her zaman idiyopatik olduğundan klinik açıdan şüpheli bir durum yoksa sistemik açıdan araştırma gerektirmez. Çift taraflı konjenital kataraktların da çoğu idiyopattır. Ancak tek taraflı olanların aksine bunlarda diğer etiyolojik nedenlere de sık rastlanır ve mental retardasyon nispeten sık görülür. 1-2 yaşında, belirgin kataraktı olan, vizyonu alınamayan, ne zamandır kataraktı olduğu bilinmeyen bir çocuk tetkikleri hazır olur olmaz ameliyat edilmelidir. Ayrıca pek çok yayında erken cerrahi ameliyat sonrası glokom için ciddi bir risk faktörü olarak belirtilmiştir.

Olgusu: 2 yaşında erkek hasta yaklaşık 3-4 gündür sağ gözünde bulgulanma nedeni ile acil servisimize getirildi. çocukta herhangi bir travma hikayesi yoktu, çocukluk çağı kataraktı olarak değerlendirilmemiştir sonucunda hasta göz kliniğine yatırıldı.

Sonuç: Çocukluk çağı kataraktları, her ne kadar cerrahi tekniklerde ve görsel rehabilitasyon yöntemlerinde büyük ilerlemeler kaydedilmiş olsa da halen tedavisi zor bir problem olarak karşımıza sürmektedir. Bu kataraktların tedavisinde hekim açısından en önemli faktör kataraktın erken tespiti ve girişimlerin bir an önce başlatılmasıdır. Diğer taraftan çocuğun anne-babasına da büyük sorumluluk düşmektedir. Zira bu hastalar postoperatif dönemde uzun süreli takip, ilgi ve görsel rehabilitasyon gerektirmektedirler. Hikaye alınırken ambliyopi açısından değerlendirilmeye yardımcı olacağı için olgunun yaşı ve kataraktın ne zaman fark edildiği özellikle sorgulanmalıdır. çift taraflı katarakt varlığında Etiyoloji açısından yol göstermesi açısından da sistemik problemi olup olmadığı, annesinin gebeliği esnasındaki enfeksiyonlar, aile hikayesi olup olmadığı mutlaka sorgulanmalı ve aile diğer çocuklarla ilgili olarak uyarılmalıdır.

Anahtar Kelimeler: ambliyopi, glokom, katarakt

P-1038 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Ketoasidozla Prezente Olmuş Alkolün Tetiklediği Yeni Tanı Diabet Olgusu

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Antalya Eğitim ve Araştırma Hastanesi, Antalya

Amaç: Diyabet, insülin eksikliği ya da insülin etkisindeki defektler nedeniyle organizmanın karbonhidrat, yağ ve proteinlerden yeterince yararlanamadığı, sürekli tıbbi bakım gerektiren, kronik bir metabolizma hastalığıdır. Diabetes mellitus tanı kriterleri: 8 saat açlık sonrası kan şekeri > 126 mg/dl, 75 gram glukozlu oral glukoz tolerans testi sonucu 2. saatte kan şekeri > 200 mg/dl, rastgele ölçümlerde kan şekeri 200 mg/dl ve diabet semptomları varlığı, glukozlike hemoglobinin % 6.5' in üzerinde olması. Mutlak insülin eksikliği olan tip-1 diabet ve insülin direnci veya salınım azalması mekanizmalı tip-2 diabet olarak sınıflanır. tip-2 diabette obezite, genetik yatkınlık rol oynar ve alkol hastalığın ortaya çıkışını hızlandırabilir. Bu olgumuzda alkolün diabet üzerine hızlandırıcı etkisini vurgulamaya çalıştık.

Olgusu: 43 yaşında erkek hasta. Acil servisimize bir haftadır sık idrara çıkma ve düünden beri bulantı kusma şikayeti ile geldi. İlave şikayet yok, özgeçmişte özellik yok, son 10 gündür gün aşırı alkol tüketimi mevcut, soygeçmiş normal. GKS: 15, oryante koopere. Kan şekeri: 715, Na:122, pH: 7.19, HCO3: 14, Serum Osmolaritesi: 274, Ketonüri: ++. Tanı: alkolle bağlı diabetik ketoasidoz, ye yeni tanı diabet. Hidrasyon sağlandı, parenteral insülin tedavisi başlandı ve hasta yoğun bakıma yatırıldı. 4 gün sonra oral antidiyabetik ve diet önerileri ile taburcu edildi.

Sonuç: İnsüline bağımlı olmayan diabetes mellitus (Tip-2) toplumdaki en sık görülen diabetes mellitus tipidir. İnsüline bağımlı olmayan diabetes mellitus ya da tip 2 diabet polidipsi, poliuri, polifaji, pruritus, ağırlık kaybı gibi klasik belirtiler ile ortaya çıkarsa da çoğu kez uzun sürebilen asemptomatik donemi mevcuttur. Genellikle 45 yaş üzerinde ilk yakınmalar başlar. Polidipsi, poliuri ve polifaji gibi yakınmalardan ziyade retinopati, nefropati, noropati ve aterosklerotik kalp hastalığı gibi kronik komplikasyonlarla ilgili yakınmalar hastayı hekime ilk kez getirebilir ve çoğunlukla ilk tanı konulduğunda kronik komplikasyonlar vardır. Hiperglisemiye rağmen kan ve idrarda keton cisimleri azdır veya yoktur. İnsülin tedavisi çoğu kez gerekli değildir. Ketoasidoz spontan olarak oluşmaz. Sadece aşırı hiperglisemi ve hiperozmolarite durumlarında nadiren ketoasidoz koması gelişebilir. Diabetik ketoasidoz koması, şiddetli enfeksiyon veya mezenter arter embolisi gibi acil bir durum olmadıkça gelişmez. Bu hastalarda daha sık görülebilen koma, yeterli sıvı alınmamasına bağlı gelişen hiperglisemik hiperosmolar non-ketotik komadır.

Anahtar Kelimeler: alkol, diyabet, ketoasidoz

P-1039 Imaging in Emergency Units

Araknoid Kiste Bağlı Epilepsi Ve Travma

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Amaç: Araknoid kistler, BOS (Beyin omurilik sıvısı) benzeri sıvı dolu kistik kavitelerdir. Araknoid kistler intrakranial yer kaplayan lezyonların yaklaşık %1'ini oluştururlar. Tüm yaş gruplarında görülebileceği gibi genelde çocukluk çağında tespit edilir. Erkeklerde daha sık görülür. Araknoid kistler konjenital olabileceği gibi travma, enfeksiyon veya kanama sonrası da gelişebilir. Travmatik araknoid kistler ortalamada 1-5 yıl içerisinde oluşurlar. Araknoid kistler beyinde yerleştiği bölgeye de bağlı olarak baş ağrısı, nöbet geçirme, güçsüzlük gibi şikayetlere yol açabilir. Bu olguda ilk kez epilepsi atağı geçiren ve epilepsi sonrası senkop gelişmesi nedeniyle baş ve omuzları pres makinasının altında ezilen iş kazası olguyu sunmayı hedefledik.

Olgusu: 18 yaşında erkek hasta 112 tarafından iş kazası nedeniyle acil servisimize getirildi. Özgeçmişinde özellik yoktu. İş arkadaşlarından alınan bilgiler, hastanın çalışırken bayıldığı ve kafa ve sol omuzunun pres makinasının altında kaldığı yönündeydi. Geliş tansiyonu: 100/50 mmHg, SaO2: %98, nabız: 90 atım/dk idi. Fizik muayenesinde oryantasyon ve kooperasyon yoktu. Jenaralize tonik klonik vasıflı nöbet mevcut idi. Servikal sol tarafta angulus mandibula hizasından başlayıp clavicula orta hatta uzanım gösteren cilt ve cilt altı dokuyu içeren kesi mevcuttu. Sol temporoparietal bölgede 2X2 cm'lik pihltılı alan mevcuttu idi. Takibinde havayolu güvenliği sağlandı. Diazepam ile nöbeti durduruldu. Takibinde Glasgow koma sklası 10 puan idi. Hastanın hemogram, biokimya, INR parametrelerinde anormal değer saptanmadı. Çekilen beyin tomografisinde sağ temporal bölgede 4X5 cm'lik araknoid kist ve sağ hemisferin önemli olduğu görüldü. Maxillo facial tomografisinde mandibular fraktür görüldü. Hastanın ileri tetkik ve tedavisi planlanarak beyin cerrahisi servisine yatırıldı.

Sonuç: Araknoid kistler genellikle bening seyretmesine rağmen boyutları arttıkça kitle etkisi gösterip semptomlara yol açabilirler. Aynı zamanda travma nedeniyle başvuran hastalarda iyi anamnez alınması gereklidir. Travmaya neden olan hadise imkan var ise hastadan yoksa hasta yakınlarından muhakkak öğrenilmelidir. Araknoid kist görülen hastalar takibi açısından beyin cerrahisine yönlendirilmelidir.

Anahtar Kelimeler: konvülsiyon, nöbet, kist



POSTER BİLDİRİLER

P-1040 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Enerji İçeceği Alımı Sonrasında Gelişen Geçici İskemik Atak

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Amaç: Geçici iskemik atak (GİA); kan akımı yetersizliğine bağlı olarak gelişen, akut, focal serebral veya monooküler disfonksiyona ait kısa süreli semptomlarla karakterize olan nörovasküler bir sendromdur. Geçici olarak 24 saatten kısa süren epizodlar GİA olarak kabul edilir. Tanım gereği kalıcı defisit olmamalıdır. Enerji içecekleri (EI) özellikle öğrenci, sporcu ve yaş aralığı 21-35 arası aktif bireylerde oldukça yo-ğun olarak kullanılan popüler kültürün gözde içeceğidir. İçeriğinde yüksek miktarda kafein ve şeker, değişen oranlarda B vitamin kompleksleri, taurin, guarana, ginseng, yohimbin, inositol, glukuronolakton ve karnitin içermektedir. El içimi sonrasında GİA gelişimini ön tanıda düşündüğümüz olguyu paylaşmak istedik.

Olgu: 26 yaşında erkek acil hekimi, nöbet esnasında sağ gözde ani başlayıp ani biten, yaklaşık dört saat süren görme kaybı yaşıyor. Acil serviste olduğu için şikayetlerinin olduğu andan itibaren tansiyon arteryel, nabız, EKG, tam kan ve biokimyasal değerleri normal sınırlarda saptandı. Çekilen kraniyal tomografi ve kraniyal manyetik rezonans (KMR) görüntüleme sonuçlarında patoloji saptanmadı. GİA olarak değerlendirilen tabloya vasküler, kardiyak, hemotolojik, genetik ileri tetkik sonuçlarına göre GİA tablosunu açıklayabilecek etyolojik neden bulunamadı. Sigara, alkol, madde kullanım öyküsü olmayan olgunun öz/soygeçmişinde de bir özellik yoktu. Anamnez derinleştirildiğinde olgunun aç karnına iki adet enerji içeceği (Redbull) içtiği öğrenildi. GİA'ya yönelik yapılan ayrıntılı tetkik sonuçlarına göre olgunun tek gözde, dört saat süre olan görme kaybının oluşumunda enerji içeceğinin sorumlu olabileceğini öngördük.

Sonuç: El nin kullanımı sonrasında olgu sunumu şeklinde kalp krizi, atriyal fibrilasyon, iskemik strok, kardiyak arrest, epilepsi vakaları literatürde yer almaktadır. El nin, özellikle aç karnına içilmesi hızlı emilim sonrasında, endotel disfonksiyonuna neden olarak platelet agregasyonuna artırabilir. El nin içeriğindeki maddelerin vazokonsrictör özelliği de GİA oluşumuna katkıda bulunabilir. Bu durum geçici görme kaybını açıklayabilir. Sonuç olarak klinik bilgilerimize göre ilk defa rastladığımız GİA nedeni olabilecek; El kullanımına bağlı olası GİA olgusunu sunmayı ve kullanımı gittikçe artan El tüketiminin olası zararlarına dikkati çekmek amacıyla olgumuzu sunmayı hedefledik.

Anahtar Kelimeler: TİA, görme kaybı, enerji içeceği

P-1041 Other

Akut Karın Ağrısı Nedeni, İntestinal İntamural hematom

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ondokuzmayıs üniversitesi acil tıp anabilim dalı samsun

Amaç: Warfarin, günümüzde profilaktik oral antikoagülan olarak; atriyal fibrilasyon, derin ven trombozu, prostetik kalp kapağı, pulmoner emboli gibi klinik durumlarda yaygın olarak kullanılmaktadır. Kanama warfarinin en ciddi ve önemli yan etkisidir. Ancak warfarine bağlı intestinal intramural hematoma görülmesi nadir bir durumdur. Biz burada acil servise akut batın tablosu ile başvuran ve warfarin kullanan intestinal intramural hematoma tespit edilen bir vakayı sunmayı amaçladık.

Olgu: Sonuç:

Anahtar Kelimeler: intramural hematoma, coumadin, warfarin

P-1042 Pediatric Emergencies

Lidokainli Pomad Sonrası Solunum Arresti Gelişen Pediatrik Yanık Vakası

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Amaç: Acil servise müraacaat eden pediatrik yanık vakalarının takip ve tedavisinde, uygun sıvı replasmanı ve antibiyoterapiye dikkat edilmeli ve ilk müdahalede kullanılan topikal ajanların içeri göz önünde bulundurulmalıdır.

Olgu: 2 yaşında hasta, sıcak su ile yanık nedeniyle acil servise getirildi. Gelişinde bilinç açık ve ajite olan hastanın fizik muayenesinde yüz bölgesinde; alın, yanak ve çenede, sağ omuz anteriorunda yaklaşık 10 x 10 cm çapında, sağ kol ve elini çepeçevre içine alan, eklem flexör yüzlerinde ve posteriorunda yer yer sağlam derinin görüldüğü ikinci derece yanık alanları mevcuttu. Ağız içi ve çevresinde yanık lezyonu olmadığı, solunum seslerinin doğal olduğu görüldü. Hastanın yanık alanı hesaplanarak IV hidrasyonu başlandı. Plastik cerrahi ile konsülte edilen hastaya yanık pansuman ve debridmanı sonrası poliklinik kontrolü önerilerek taburcu edilmesi planlandı. Pansuman sonrası 5 ci dakikada öğürme refleksi sonrası solunum arresti gelişmesi üzerine entübe edilip CPR başlanan hastanın 10 dakikada ritmi döndü ve peşinden spontan solunumu başladı. Hastanın entübasyonu esnasında trakea ve solunum yollarında herhangi bir patoloji görülmediğinden solunum yolu yaniği veya asfiksi ihtimali ekarte edildi. Hava yolu açık olduğu halde tekrarlayan solunum arrestleri ve takibinde kardiyak arrest olan hastada anafaksi ihtimali göz önünde bulundurularak tedavisi planlanırken, pansumanda kullanılan malzemeler incelendi. Yanıklı bölgeye lokal anestezi olarak %5 lidokainli pomad (30 gr pomad içinde 1,5 gr lidokain içeriği) ve %1 silver sülfadiazin krem uygulandığı öğrenildi. Detay incelemede lidokainli pomadin yaklaşık 0' ünün kullanıldığı, bunun da yaklaşık olarak 375-400 mg lidokain içerdiği hesaplandı. <10 yaş pediatrik hastalarda toplam doz 75-100 mg' ı geçmemesi gerektiği düşünüldüğünde topikal Lidokainin hızlı ve yüksek doz emilimine bağlı lidokain toksisitesi olabileceği düşünüldü. Toksisiteye bağlı olarak santral sinir sistemi depresyonu ve solunum arresti veya miyokard depresyonu sonucu bradikardi ve kardiyak arrest gelişmiş olabileceği kanaatine varıldı. Söz konusu advers etkiler ekarte edilememekle birlikte spesifik bir antidotu olmaması nedeni ile destek tedavi ve mekanik ventilasyon uygulandı. İzlemede yüzeysel spontan solunumu (7-8/dk) ve bradikardisi (64/dk) olan hasta yoğun bakıma alındı. Mekanik ventilatöre bağlı olarak 24 saatlik yoğun bakım takibi sonrası extübe edildiği, 7 günlük yoğun bakım izlemi sonrası komplikasyon gelişmemesi ve ek sorunu olmaması nedeni ile önerilerle taburcu edildiği öğrenildi.

Sonuç: Acil serviste karşılaşılan pediatrik yanık vakalarında uygulanan topikal lokal anesteziğin, epidermisi tahrip olmuş ciltten daha hızlı bir şekilde emilmesi sonrası solunum arrestine sebep olabileceği unutulmamalıdır.

Anahtar Kelimeler: Lidokain, acil servis, çocuk yanıkları, anafaksi

P-1043 Other

Pulmoner Emboli Panik Atak Birlikteliği

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Amaç: Olgu: Sonuç: Pulmoner emboli (PE), mortalite ve morbiditesi yüksek, tekrarlayabilen, bazen tanısı güç olan ve önlenilebilir bir hastalıktır. PE hastalarının %90' ını dispne, takipne, göğüs ağrısı ölüm korkusu olabilir. Panik Atak ise, anksiyete belirtilerinin ani başladığı ve 10 dakika içerisinde en yüksek düzeye ulaştığı yoğun bir korku ve rahatsızlık döneminin olması durumudur. Nadir olgularda pulmoner emboli, panik atak belirtileriyle karşımıza çıkabilir. Biz burada; nefes darlığı, çarpıntı, huzursuzluk ve ölüm korkusu şikayeti ile acil servise başvuran ve PE saptadığımız bir olguyu sunmayı amaçladık.

Anahtar Kelimeler: pulmoner emboli, panik atak birlikteliği, anksiyete

P-1044 Resuscitation

Massif tromboembolide resüsitatif trombolitik uygulamamız

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Antalya Eğitim Araştırma Hastanesi

Amaç: Masif PE sonrası senkop, sistemik arteriyel hipotansiyon, kardiyojenik şok veya kardiyak arrest gelişen hastalar en yüksek riskli grubu oluşturmakta ve hemodinamik olarak stabil olmayan hastalarda mortalite %15-25 civarında tahmin edilmektedir. Kardiyak arrest gelişen hastalarda %50'nin üzerinde mortalite olduğu bildirilmiştir.

Olgu: 65 yaşında erkek hasta ani gelişen nefes darlığı ve göğüs ağrısı ile acil kliniğimize 112 ekibi tarafından getirildi. fizik muayenesinde; Hastanın genel durumu kötü, bilinci konfüze, taşli-kardisi (110/dk), takipnesi (32/dk) ve hipotansiyonu (60/40 mmHg) mevcut idi. hastanın çekilen elektrokardiogramında S1Q3T3 paterni mevcuttu

Kan gazı incelemesinde ise hipoksi ve hipokapni vardı. Ekokardiogramında ileri derecede sağ boşlukları dilate idi, hastada gelişinin 15. dakikasında arrest gelişti hastaya resüsitasyon başlandı beraberinde yüksek olasılıklı massif pulmoner emboli düşündüğümüzden dolayı trombolitik tedavimizi başladık. Kalp tepe atımı ve solunumu dönen hasta kardiyoloji yoğun bakıma yatırıldı. hastanın daha sonra çekilen alt ekstremiteler venöz dopleriyak DVT ile uyumlu geldi. hasta takibi sırasında herhangi bir komplikasyon ve nörolojik sekele kalmadan şifayen taburcu edildi.

Sonuç: Masif pulmoner emboliye sekonder kardiyak arrest sonrası yapılan kardiyopulmoner resüsitasyon sırasında tromboliz uygulanması mortaliteyi ve morbiditeyi azaltması açısından hayati öneme sahiptir. Özellikle PE tanısının kuvvetle muhtemel olduğu ve EKO bulguları ile desteklenen vakalarda CT anjio dan önce hızla trombolitik tedavi başlanması güvenli bir tedavi seçeneği olup, hayat kurtarıcıdır.



POSTER PRESENTATIONS

Anahtar Kelimeler: massif pulmoner emboli, trombolitik, nefes darlığı

P-1045 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Genç Kadın Hastada Pulmoner Emboli: Oral Kontraseptif, Uzun Yolculuk Öyküsü ve Gen Mutasyon Birlikteliği

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Amaç: Acil servise sık başvuru nedenlerinden biri olan Pulmoner emboli (PE) sık görülen ve ölümcül olabilen bir durumdur. İlerleyen tetkik yöntemlerine rağmen PE tanısı halen atlanabilmektedir. Hastalarda görülen nonspesifik klinik semptom ve bulgular tanıyı zorlaştıran ana nedendir.

Olgu: Yirmi altı yaşında kadın hasta beş gündür devam eden ve giderek artan sırt ağrısı ve nefes darlığı şikayeti ile acil servisimize başvurdu. Hastadan, iki gün önce başvurduğu bir sağlık kuruluşunda miyalji düşünülerek reçete verildiği ve yaklaşık üç haftadır polikistik over sendromu (PCOS) nedeni ile oral kontraseptif kullanmakta olduğu öğrenildi. Nefes darlığı eforla artan hastanın özgeçmişinde PCOS dışında bir özellik yoktu. Hasta ve yakınlarından babasında genç yaşta ani ölüm öyküsü olduğu öğrenildi. Vital bulguları stabil olan hastanın fizik muayenesinde akciğer seslerinin kaba olması dışında ek özellik yoktu. D-Dimer değerinin 5746 (0-500 ng/mL) olması dışında laboratuvar tetkikleri normal sınırlarda olan hastanın çekilen elektrokardiyografi (EKG)'sinde kalp hızının yaklaşık 70 atım/dakika ve normal sinüs ritmi (NSR) olduğu görüldü. Akciğer grafisinde özellik saptanmayan ancak bir hafta önce uzun yolculuk öyküsü olan hastaya intravenöz kontrastlı spiral toraks bilgisayarlı tomografi (BT) çekildi. Sağ ve sol pulmoner arter dallarında yaygın embolik dolma defekti saptanan hasta takip ve tedavi amaçlı göğüs hastalıkları servisine yatırıldı. Hastanın yapılan genetik çalışmasında PAL-1 ve MTHFR A1298C heterozigot mutasyonları saptanan hasta yatışının on ikinci gününde önerilerle taburcu edildi.

Sonuç: Mortalite ve morbiditesi yüksek bir durum olan PE özellikle genç hastalarda altta yatan sekonder nedenler ile ilişkili olup klinik yakınma ve bulguların acil hekimleri tarafından uygun şekilde değerlendirilmesi oldukça önemlidir.

Anahtar Kelimeler: Pulmoner emboli, oral kontraseptif, gen mutasyonu

P-1046 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Stroke Hastalarında Nötrofil/Lenfosit Oranı İlişkisi

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Amaç: İnme terimi vasküler olaylara bağlı gelişen ani başlangıçlı fokal nörolojik sendrom bulgularını tanımlar. Dünyada morbiditenin birinci, mortalitenin ise ikinci sırada en çok görülen nedenidir. İnflamatuvar olaylar iskemik inme için risk oluşturmalarının yanı sıra serebral iskemik patofizyolojisinde de önemli bir rol oynarlar. Beyin iskemisi ve izleyen reperfüzyon mikrosirkülasyonda inflamatuvar yanıtın başlamasına neden olur ve bu da hücre yıkımından sorumludur. Öte yandan ateroskleroz gelişiminde sistemik inflamasyonun önemli bir rol oynadığı, inme ve koroner kalp hastalığı için yüksek riskle ilişkili olduğu belirlenmiştir Stroke hastalarında N/L oranı (NLO) ile ilgili yetersiz bilgi vardır. Bizim amacımız hemorajik ve iskemik inme hastaları, kontrol grubu ve iskemik inme alt tipleri arasında NLO'yu karşılaştırmaktır.

Gereç-Yöntem: Bu çalışma, 1 Ocak 2011 – 31 Aralık 2012 tarihleri arasında AKÜ Tıp Fakültesi Araştırma ve Uygulama Hastanesi Acil Servisine başvuran ve iskemik ya da hemorajik inme tanısı konulan hastaların retrospektif olarak incelenmesiyle yapılmıştır. Hastaların akut dönemdeki nötrofil, lenfosit, nötrofil/lenfosit oranı gibi inflamasyon parametreleri, hemorajik, iskemik inme, iskemik inme alt grupları ve kontrol gruplarıyla karşılaştırıldı.

Bulgular: Çalışmaya 118 hasta dahil edildi. Hastaların 58'i kadın (%49,16) ve 60'ı erkek (%50,84) idi. Ayrıca 30 kişilik kontrol grubumuz mevcuttu. Hastalarımızdan iskemik inmeli olanların yaş ortalaması 71,58 hemorajik inmeli hastalarımızın yaş ortalaması 71, 68 ve kontrol grubunun yaş ortalaması 67,93 idi. Akut enfamasyonun göstergesi olan N/L oranı 3,5 ve üzerindeyse literatüre uygun olarak pozitif kabul edildi. Hemorajik ve iskemik grubun ikisinde de N/L oranı yüksekti. N/L oranı iskemik grup ile kontrol grubu arasında anlamlı değiken (p>0,05), hemorajik grubu ile kontrol arasında istatistiksel olarak anlamlıydı (p<0,05).

Serebrovasküler olayın iskemik alt tipine göre nötrofil, N/L ve monosit'den oluşan kan değerleri arasındaki farka bakıldığında; gruplar arasında istatistiksel olarak anlamlı farklılık gözlenmedi. Kan lenfosit değerinin iskemik alt tiplerine göre karşılaştırılmasında ise: laküner ile büyük damar, büyük damar ile kardiyomemboli grupları arasındaki farklar istatistiksel olarak anlamlıydı (p<0,05).

Sonuç: Sonuç olarak çalışmamızda N/L oranının hemorajik inmelerde yüksek olduğu gösterilmiştir. Daha geniş hasta popülasyonunda yapılacak ve enfamasyonun diğer belirteçlerini de içine alan prospektif çalışmalar N/L oranının inme ile ilişkisini daha kesin bir şekilde ortaya koyacaktır.

Anahtar Kelimeler: İnme, nötrofil, lenfosit, nötrofil/lenfosit

P-1047 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Akut ve Persistan Yan Ağrısında Gecikmiş Bir Tanı: Zona Zoster

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Amaç: Akut ve persistan yan ağrısı olan hastalar acil servis pratiğinde sık rastlanan olgulardır. Hastaların ağrısının giderilmesi kadar tanının erken konulması da tedavinin yönlendirilmesi açısından önemlidir. Sıklıkla neden, üriner sistem, gastrointestinal sistem ve pulmoner sisteme ait patolojiler iken, ileri araştırmalara rağmen gecikmiş sürpriz tanılarla da karşılaşmak olasıdır.

Olgu: 55 yaşında bayan hasta 2 saat önce başlayan sağ yan ağrısı şikayeti ile acil servise başvurdu. Özgeçmişinde hipertansiyon dışında herhangi bir hastalık öyküsü olmayan hastanın ağrısı sağ flank bölgesinde idi ve sağ inguinal bölgeye yayılımı mevcuttu. Vital bulguları stabil olan hastanın fizik muayenesinde sağda kostovertebral açı hassasiyeti dışında anlamlı bir bulgu saptanmadı. Kan ve idrar örneklerinde anormal bir değer saptanmayan hastanın ağrısı 100 µg fentanyl ile rahatladı. Grafisi ve ultrasonografi tetkikleri normal sınırlarda olan hasta önerilerle kontrole çağrıldı. Ertesi gün ağrısının aynı şekilde devam ettiğini, kolik tarzında olmadığını belirten hastaya kontrastlı batin tomografisi planlandı. BT sinde patoloji saptanmayan hasta analjezik uygulandıktan sonra taburcu edildi. Hasta 7. Günde sağ flank bölgede hiperemik veziküler döküntüler ve devam eden ağrı şikayeti ile tekrar başvurdu. Zona Zoster tedavisi düzenlenen hasta taburcu edildi.

Sonuç: Zona sıklığı yaşla artan, hastaların yaşam kalitesini olumsuz etkileyen bir hastalıktır. Hastalarda sıklıkla T3-L3 arası dermatomlar etkilenir. Zona tanısı klasik prodromal ağrı-yanma ve veziküler karakterdeki döküntüler ile konur. Lezyonlar ortaya çıkmadan önce şiddetli ağrı ve yanma hastaların hemen tamamlanma görüldür. Yan ağrısının ayırıcı tanısında, lezyonlar olmasa da Zona Zoster düşünülmesi gereksiz tetkiklerin önüne geçilmesi açısından önemlidir.

Anahtar Kelimeler: Zona Zoster, Yan ağrısı, Gecikmiş Tanı

P-1048 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

İnme Hastalarında RDW ve MPV Değerlerinin Araştırılması

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Amaç: İnme nörolojik hastalıklar içinde en sık görülen hastalık grubudur. İnme % 80-85 iskemik, % 15-20 hemorajik nedenlerle ortaya çıkmaktadır. Red Cell weight Distribution (RDW) tam kan sayımından rutin olarak elde edilen bir hematolojik parametredir. Kalp damar hastalıklarında klinik sonucun potansiyel bağımsız bir belirleyicisi olarak ortaya çıkmıştır. İnmeyle ilgili olarak prognoza etkili olabileceği düşünülmektedir. Ortalama trombosit hacminin (MPV: Mean platelet volümü) trombosit aktivitesinin iyi bir göstergesi olduğu, vasküler hastalıklarda arttığı bildirilmektedir. Bu çalışmada MPV ve RDW değerlerinin iskemik, hemorajik ve kontrol grupları arasında ayrıca iskemik inme alt tipleri arasında karşılaştırılması amaçlanmıştır.

Gereç-Yöntem: Bu çalışma, 1 Ocak 2011 – 31 Aralık 2012 tarihleri arasında AKÜ Tıp Fakültesi Araştırma ve Uygulama Hastanesi Acil Servisine başvuran ve iskemik ya da hemorajik inme tanısı konulan hastaların retrospektif olarak incelenmesiyle yapılmıştır. Araştırmamız 55 yaş üzerinde, iskemik inme tanısı alan, etiyolojiyi belirlemek amacıyla yapılan testlerin tümü tamamlanmış 74 hasta, hemorajik inme tanısı alan 44 ve belirgin damar hastalığı olmayan ve benzer yaşta kontrol grubundan 30 hastayla yapılmıştır. Hastaların akut dönemdeki RDW düzeyleri



POSTER BİLDİRİLER

ve MPV değerleri hemorajik, iskemik inme ve kontrol grupları arasında ayrıca iskemik inme alt tipleri arasında karşılaştırıldı. Tüm analizler %95 güven aralığında ve SPSS 17.0 for Windows paket programında yapıldı.

Bulgular: Çalışmaya 118 hasta dahil edildi. Hastaların 58'i kadın (%49,16) ve 60'ı erkek (%50,84) idi. Ayrıca 30 kişilik kontrol grubumuz mevcuttu. Hastalarımızdan iskemik inmeli olanların yaş ortalaması 71,58 hemorajik inmeli hastalarımızın yaş ortalaması 71,68 ve kontrol grubunun yaş ortalaması 67,93 idi. Gruplar arasındaki parametrelerin farklılığı için yapılan test sonuçlarına bakıldığında MPV değerinin, hemorajik ve iskemik grupta kontrol grubuna göre istatistiksel olarak anlamlı farklılık gösterdiği saptandı ($p<0,05$). RDW değeri ise iskemik ve kontrol grubu arasında istatistiksel olarak anlamlı farklılık gösterirken, hemorajik ile kontrol grubu arasında istatistiksel olarak anlamlı farklılık göstermedi.

Serebrovasküler olayın iskemik alt tipine göre kan değerleri arasındaki farka bakıldığında MPV ve RDW değerleri kardiyomiyolitik iskemik inme hastalarında yüksek tespit edilmesine rağmen, iskemik alt tip grupları arasında istatistiksel olarak anlamlı farklılık göstermemiştir.

Sonuç: MPV ve RDW'nin hastalarımızda anlamlı oranda yüksek gözlenmesi bu değerlerin inme için risk faktörü olabileceğini düşündürmektedir. Elde edilen sonuçlar literatür ile uyumluluk göstermektedir. Prognosta etkileriyle ilgili yeni çalışmalara ihtiyaç vardır. Çalışmamızda elde edilen veriler hastanın kliniği, muayenesi ve görüntüleme yöntemleri ile beraber değerlendirildiğinde tedavi ve takipte yol gösterici olabilir.

Anahtar Kelimeler: Inme, MPV, RDW

P-1049 Other

Farkedilemeyen Orbita Sklerasında Yabancı Cisim

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Amaç: Göz travmaları, göz hastalıklarının %10-15'ini oluşturmaktadır ve %35'e varan oranlarda göz içi yabancı cisimlere rastlanmaktadır. Yabancı cisimler sıklıkla iş ortamından kaynaklanmakta olup, en sık metalik ve magnetik özellikteki yabancı cisimlerle karşılaşmaktadır. Bunlar genellikle konjonktiva, kornea ve üst tarsi yerleşimlidirler. Bu bölgelerdeki yabancı cisimler, biyomikroskop eşliğinde kolayca çıkarılabilmektedirler. Buradaki esas sorun, yabancı cisimlerin delinmeye neden olarak göz içinde ilerlemesidir. Penetrant göz yaralanmaları, muhtelif yabancı cisimlerin orbita ya da kraniyal kavite içine girmesi ile sonuçlanabilmektedir.

Olgu: 27 yaşında erkek hasta 2 gün önce iş yerinde spiralle çalışan sol göze parça kaçması nedeni ile dış merkeze başvuran hastada yapılan muayenesi sonucu gözde yabancı cisim olmadığı ve göz yıkaması yapılmış ve netleşmiş göz damlası 5x1 başlanmıştır. Hasta 2 gün sonra göz ağrısı geçmemesi nedeni ile acil servisimize geldi. Hastanın sol göz korneası doğaldı, konjonktivasi kızarıktı, göz hareketleri ve görmesi doğaldı. Hastanın gözde kızarıklığı ve ağrısı olması nedeni ile göz hekimi ile konsülte edildi. Görmesi ve göz içi basıncı doğaldı. Biyomikroskopik muayenesinde sol limbus temporalinin 4 mm uzaklıkta 1 mm boyunda konjunktival kesi tespit edilmesi üzerine hastaya orbita CT'si çekildi. Sol bulbus oculü temporalateralinde sklerada 1-2 mm boyunda matelik yabancı cisim tespit edildi. Hasta göz servisine yatırıldı. Genel anestezi altında konjunktiva kesisi büyütülerek yabancı cisim skleradan forceple alındı. Hasta 2 gün sonra medikal tedavisi düzenlenerek taburcu edildi.

Sonuç: Yabancı cisimler gündelik yaşamda en sık karşılaşılan göz acillerinden biri olup sıklıkla konjonktiva, kornea ve üst tars yerleşimlidirler. Bu bölgelerdeki yabancı cisimler, biyomikroskop eşliğinde kolayca çıkarılabilmektedir. Esas sorun teşkil eden yabancı cisimler ise delinmeye neden olarak göz içine ilerleyenlerdir. Bu yüzden orbital yaralanmalarda şüpheli durumlarda ve şikayeti geçmeyen hastalarda mutlaka ileri tetkik özellikle de orbital CT istenmelidir.

Anahtar Kelimeler: Orbital Yabancı Cisim, Göz Ağrısı, Orbital Tomografi

P-1050 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Tirotoksik Periyodik Paraliz

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Amaç: Periyodik paralizi (PP) nadir görülen, tekrarlayan kas gücü kaybı atakları ile karakterize sodyum (Na), potasyum (K) veya kalsiyum (Ca) kanallarındaki mutasyonlara bağlı oluşabilen herediter bir hastalıklı grubudur. Klinik pratikte hipokalemi, normokalemi ya da hiperkalemi saptanabilir. Genellikle atakların oluşmasını tetikleyen stres, aşırı egzersiz, karbonhidrattan zengin beslenme gibi precipitan faktörler vardır. Atakların süresi ortalama 2-36 saat kadar olup gerekli durumlarda K replasmanı ile bu süre daha da kısaltılmaktadır. Bunun dışında bir grup vakada hipertiroidiye sekonder olarak da PP gelişebilmektedir. Buradaki temel defekt; artmış katekolamin deşarjına sekonder olarak Na/K ATPaze aktivitesinin artması, K'ın hücre içine akışı ve sonrasında gelişen paralizi tablosudur

Olgu: 34 yaşında erkek hasta sabahdan başlayan her iki ayakta tutmama şikâyeti ile acil servise başvurdu. Şikâyeti sabah uandıktan sonra başlamış. Daha önce hiç böyle bir şikâyeti olmamış. Ayaklarda ağrısı olmamış. Hastanın hikâyesinde önceki gece fazla miktarda baklava yeme öyküsü mevcuttu. Özgeçmişinde ve soy geçmişinde bir özellik yoktu. FM; genel durumu iyi bilinci açık oryante, koopere idi. TA:110/70 mmHg nbz:84 atım/dk SS:14 /dk ateş:36.4C Sistem muayenesinde IR +/- göz hareketleri normal ense sertliği yok. kalp S1 + S2+ üfürüm yok Akc. sesleri doğal. Üst extremité muayenesi doğal. Alt extremitéde bilateral motor muayenesinde güç kaybı mevcuttu. Duyu muayenesi normaldi. Laboratuvarında ise WBC:14.8 $10^3/mm^3$ (4,0-10,0) K:2.0 mg/dl (3,5-5,1) diğer parametreler normal sınırlardaydı. Hastanın çekilen beyin tomografisi normal olarak değerlendirildi. Hastaya acil serviste K replasmanı yapıldı. Replasman sonrası hastada klinik iyileşme gözlemlendi. Kontrol K:3.6 mg/dl (3,5-5,1) Hasta mevcut bulgularla periyodik paralizi olarak değerlendirildi. Nefroloji ile konsülte edilen hasta PP tanısıyla nefroloji kliniğine yatırıldı. Nefroloji servisinde yapılan TFT'inde serbest T3:16,30 pg/ml (2,5-3,9) serbest T4:3.98 ng/dl (0,61-1,12) TSH 0.06 uIU/ml (0,34-5,86) gelişti. Tiroid USG ve sintigrafisi sonucunda toksik diffüz guatr olarak değerlendirilen hasta tirotoksik PP tanısı ile takibe alınarak taburcu edilmiştir.

Sonuç: Hipokalemi paralizinin ayırıcı tanısında K+ transsellular distribüsyonunun hâkim olduğu ailesel form, tirotoksik form ve baryum zehirlenmesinin yanında gerçek K+ depleasyonu ve renal tübüler asidoz, sjögren hastalığı, medüller sünger böbrek, kronik toluen maruziyeti, fankoni sendromu, primer hiperaldosteronizm gibi renal kayıplar, çöliak hastalığı, tropikal sprue, akut gastroenterit, kısa barsak hastalığı gibi ekstra-renal kayıplarda göz önüne alınmalıdır.

Tekrarlayan kas güçsüzlüğü veya paralizi epizotları ile başvuran olgularda primer renal patoloji dışında tiroid hastalıkları da araştırılmalıdır.

Anahtar Kelimeler: Hipopotasemi, Paralizi, Tirotoksikoz

P-1051 Imaging in Emergency Units

Apendiksın atipik lokalizasyonu: olgu sunumu

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Amaç: Apendiks ilk olarak embriyolojik gelişimin 8. haftasında çekumun terminal bölümünde bir kabartı olarak ortaya çıkar. çekumun büyümesi apendiksın büyümesinden çok daha fazla olduğundan apendiks mediale doğru yani ilioçekal valfe doğru itilir. Apendiks kolonun başlangıç bölgesinde her üç tenia'nın birleştiği bölgededir. Apendiksın tabanı ilioçekal valvin yaklaşık 2,5 cm altında çekumun arka iç yüzüne tutunmuştur. Organın geri kalan bölümü serbest olarak bulunur. Apendiksın distal ucu serbest olması sebebiyle sağda, pelvis duvarının yanında aşağıya doğru asılı olabilir; resesus retroçekalis de, çekumun arkasında yukarıya doğru kıvrılmış olabilir; çekumun dış yanında, yukarıya doğru uzanabilir; ileumun son bölümünün önünde veya arkasında bulunabilir.

Olgu: Hastamız 39 yaşında erkek hasta bize iki taraflı kasık ağrısı ve her iki bacağına yayılan ağrı şikayeti ile başvurdu. Hastanın öz geçmişinde diyabet hastalığı dışında bir özellik yoktu. Hastanın geliş tansiyonu 139/78 mmHg idi. Nabız 92/dk. Saturasyonu oda havasında %92 idi. Yapılan batin muayenesinde her iki alt kadranda hassasiyeti mevcuttu. Rebaund bulgusu yoktu. Yapılan biyokimyasal testlerde AST:73 ALT:50 WBC:6300 idi. İdrar tahlili normaldi. Hasta testis ağrısı da tariflemesi üzerine testis dopler ultrasonografi (USG) görüntülemesi istendi. USG sonucu normal geldi. Bunun üzerine hastaya batin tomografisi istendi. Batin tomografi sonucu apendiks retroçekal seyir göstermekte olup süperiorde karaciğer kapsülü komşuluğuna doğru atipik seyir göstermektedir şeklinde yorumlandı (Resim). Bunun üzerine hastaya genel cerrahi konsültasyonu yapıldı. Müşahede amaçlı yatış önerildi ancak hasta kabul etmeyerek imzası karşılığında acil servisten ayrıldı.

Sonuç: Apendiks çeşitli varyasyonlar gösterebilir ama karaciğer komşuluğunda apendiks seyir etmesi nadir bir varyasyon olduğu için bu vakayı sunmayı amaçladık.

Anahtar Kelimeler: karın ağrısı, apendiks, atipik lokalizasyon, acil servis



POSTER PRESENTATIONS

P-1052 Cardiovascular Emergencies

Genç kadınlar da kalp krizi geçirebilir!

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Arka plan: Akut koroner sendrom (AKS) gelişmiş batı ülkelerinde olduğu gibi ülkemizde de ölüm nedenlerinin başında yer almaktadır. Son yıllarda sanayileşme ile beraber genç yaşlardan itibaren edinilen kötü beslenme alışkanlıkları, sigaranın küçük yaşlarda kullanılmaya başlanması AKS'nin genç bireylerde daha sık rastlanmasına neden olmuştur. Erken yaşlarda, bahsedilen modifiye edilebilir risk faktörlerinin yanı sıra genetik bazı özellikler de AKS gelişiminde etken olabilir. Bu yazıda üst solunum yolu şikâyetleri ile başvuran genç bir bayan hastada AKS saptanması anlatılmış ve konu güncel literatür bilgileri ışığında tartışılmıştır.

Olgu: Yirmidokuz yaşında kadın hasta acil servisimize boğaz ağrısı, halsizlik, ateş şikâyeti, fenalaşma hissi ile başvurdu. Şikâyetlerini belirtirken eliyle tonsillerini göstererek burası ağrıyor diyordu. Hastanın öyküsünde 2 gün önce işyerinde arkadaşıyla tartışma yaşadığı saptanmıştı. Sabah banyoda fenalaştığını söyleyen hastanın konversif görünümü mevcuttu. Hastanın özgeçmişinde kardiyak yakınması yoktu. Ailesinde erken yaşta MI öyküsü yoktu. Sigara içme öyküsü yoktu. İlaç istismarı öyküsü yoktu. Ek bir hastalığı bulunmayan hastanın bir yıl önce doğum yapmıştı. Vital bulguları; TA: 120/70 mm/Hg, nabız 88/dk, solunum sayısı 20/dk, oksijen saturasyonu: % 98, ateş 38,5 °C olarak ölçüldü. Fizik muayenede her iki tonsilde hiperemi ve hipertofi mevcuttu. Diğer sistem muayeneleri olağandı. EKG'sinde inferior STEMI saptanması üzerine kardiyoloji konsültasyonu istendi. hastaya 300 mg ASA ve IV nitrat başlandı. Hasta Kardiyoloji tarafından primer PTCA'ya alındı.

Sonuç: Acil servise atıf şikâyetlerle başvuran genç olgularda da ayırıcı tanıda AKS akla gelmelidir. AKS için klasik risk faktörlerinin olmaması çok şey ifade edemeyebilir. Bu olgular kalabalık acil servislerde kolaylıkla atlanabilir.

Anahtar Kelimeler: akut koroner sendrom, genç, kadın hasta

P-1053 Imaging in Emergency Units

Nöbette nadir bir neden: Fahr hastalığı

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Amaç: Kardiyak, pulmoner ve metabolik birçok neden hastalarda arreste neden olabilir. Etkilibr kardiyopulmoner resüsitasyon ve sonrasında nedene yönelik yapılacak tedaviler hayat kurtarıcıdır. Arrest nedeninin ortaya konmadığı durumlarda ileri tetkiklerde arreste neden olmayan ancak mevcut hayat konforunu olumsuz etkileyecek bazı nadir hastalıklara da rastlanabilmektedir. Burada arrest sonrası Fahr Hastalığı saptanan olgu sunulmaktadır.

Olgu: 70 yaşında bayan hasta 112 tarafından kardiyopulmoner arrest olarak getirildi. Olayın yaklaşık 25 dk önce gerçekleştiği, olay yerinde ve ambulansda cpr a devam edildiği öğrenilen hasta entübe edildi ve kardiyak masaja devam edildi. Resüsitasyonun 25. Dakikasında nabızı alınan hastaya ileri yaşam desteği sağlandı. Geliş pH:6,9 Phco3: 8,4 mmHg olan hastanın HT'desinde herhangi bir hastalığı olmadığı son zamanlarda unutkanlık başladığı yakınlanınca ifade edildi. Tonik klonik kasılmaları olan hastaya diazepam 10 mg uygulandı. Santral patolojileri dışlamak adına çekilen BBT de her iki taraf bazal ganglionların ve derin gri cevherin kalsinotik olarak etkilendiği izlendi. Subaraknoid kanama saptanmadı. Mevcut tablo fahr hastalığı olarak yorumlandı. Hasta yoğun bakımda hospitalize edildi.

Sonuç: Fahr hastalığı bazal ganglion, serebellar nukleuslar ve derin kortikal yapıların yaygın, ilerleyici kalsifikasyonu ile karakterize ailevi bir hastalıktır. Demans, parkinsonizm, epilepsi gibi tabloların yanında subaraknoid hemoraji ile karışabilen klinik tanılara yol açabilmektedir. Tanısında bilgisayarlı tomografi yeterli olmakta yaygın kalsinotik odaklar tanı koydurmaktadır. Şuur değişiklikleri olan, Nöbeti gözlenen hastalarda ayırıcı tanıda Fahr hastalığının düşünülmesi erken tedaviye olanak sağlayacaktır.

Anahtar Kelimeler: fahr hastalığı, nöbet, acil servis

P-1054 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Steroide Bağlı Asidoz Gelişen Hodgkin Hastalığı: Olgu Sunumu

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Amaç: Kanser hastaları acil servisler için alışılmış semptomların tekrar tekrar değerlendirilmesini gerektiren hasta gruplarıdır. Göğüs ağrısı, karın ağrısı, halsizlik ve ateş gibi yaygın şikâyetlerin, kanser tedavisi ile birlikte normal olarak bulunabilmesi yanlış tanı olasılığını artırmaktadır. Burada, hodgkin hastalığı nedeniyle yüksek doz steroid kullanan ve tedavi sırasında diyabetik ketozis gelişen bir olgu sunulmaktadır.

Olgu: 63 yaşında erkek göğüs ve karında ağrı, yanma ve halsizlik şikâyeti ile acil servise başvurdu. Hodgkin hastalığı nedeni ile 3 gün önce kemoterapi aldığı ifade eden hastanın ek bir komorbiditesi mevcut değildi. Vital bulguları ateş: 36,7 C, TA: 114/64 mmHg, Nbz: 40/dk olan hastanın batın muayenesinde yaygın hassasiyet dışında patolojik muayene bulgusu yoktu. EKG sinüs sinüs bradikardisi izlenen hastanın alınan kan gazında pH 7,31, HCO3 23,3 mEq/L, baz açığı -2,9 12,4 meq/l, sodyum 126 mEq/L, potasyum 5,4 mEq/L, olarak saptandı. Kapiller glisemisi 760 mg/dL olarak bulunan hastanın rutin biyokimyasında glukoz:774 mg/dL olarak bulundu. İdrar tetkikinde keton ++ olan hastanın, KT protokolünde yüksek doz steroid aldığı öğrenildi. Mevcut laboratuvar değerleri ile hasta steroid kaynaklı hiperglisemi olarak değerlendirildi. Sıvı replasmanı ile beraber insülin tedavisine başlandı. Hasta onkoloji kliniğine yönlendirildi.

Sonuç: Hodgkin hastalığı immün sistem hücrelerinden kaynaklanan tedavisi diğer malignitelere göre oldukça iyi olan bir hastalıktır. Tedavi protokollerinde kullanılan kemoterapötik dışındaki steroidler hastalarda çeşitli komplikasyonlar oluşturabilmektedir. Bu hastalarda hiperglisemi ve hatta ketoasidoz akıldan bulundurulmalı, yakın zamanda tedavi alanlarda kapiller glisemi ölçümü ve kan gazı tetkiki mutlaka çalışılmalıdır.

Anahtar Kelimeler: Steroid, Asidoz, Hodgkin Hastalığı

P-1055 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Genç bir hastada meslek hastalığı olarak silikozis: önenebilir miydi?

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Amaç: Silikozis pnömokonyozlar içinde en hızlı seyredip en fatal olanlardan biridir. Solunabilir büyüklükteki silis partiküllerinin (0,5-5 mikrometre) inhalasyonu ile oluşur. Vakayı sunmamızın amacı önenebilir bir meslek hastalığı olan silikozisin tedbir alınmadığında, genç yaşta oluşturduğu hasara dikkat çekmektir.

Olgu: 28 yaş erkek hasta acil servisimize nefes darlığı şikâyeti ile baş vurdu. Hastanın TA:150/82 mmHg, Nb: 110/dk Ateş: 37,5 C, oksijen saturasyonu oda havasında % 75 idi. Yapılan fizik muayenesinde orofarenx doğal, solunum sesleri bilateral azalmış, kardiyovasküler muayenesinde bir özellik ve ek ses-üfürüm yoktu. Pretibial ödem yoktu ve bilateral her iki elinde çomak parmak bulgusu mevcuttu. Hastanın özgeçmişinde 4 yıl kot taşılama fabrikasında çalışma öyküsü mevcuttu. Yapılan laboratuvar testlerinde hemogram ve biyokimyasında özellik yoktu. Alınan arter kan gazında PH:7,39 HCO3:28,8 PCO2:47,8 sO2: %75,8 idi. Çekilen PAAC grafisinde bilateral yaygın infiltrasyonları mevcuttu (resim). Hasta silikozis tanısıyla takibi ve oksijen cihazı kullanım ihtiyacı için göğüs hastalıkları kliniğine devredildi.

Sonuç: Önenebilir meslek hastalıklarının başında olan silikoziste önemli olan riskli iş kollarında gerekli önlemlerin alınması, toz oluşumunun oluşan tozun yayılmasının ve yayılan tozların kişinin solunum sistemine ulaşmasının önlenmesidir.

Anahtar Kelimeler: Dispne, meslek hastalığı, silikozis, acil servis



POSTER BİLDİRİLER

P-1056 Cardiovascular Emergencies

İleusu taklit eden dev abdominal aort anevrizması

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Amaç: Abdominal aort anevrizmaları görece sık görülür ve hayatı ciddi olarak tehdit ederler. 65 yaş üstü ve periferik aterosklerotik damar hastalığı olan erkekler ciddi risk altındadır. Abdominal aort anevrizmaları büyüüp rüptüre oluncaya kadar sıklıkla asemptomatiktir. Büyüyen bir aort anevrizması ani ve şiddetli sırt, karın ya da yan ağrısına neden olur. Ağrı ön planda olmaksızın hipotansiyon ve senkop ana yakınma olabilir. Klinik olarak semptomatik çoğu abdominal aort anevrizması rutin muayene sırasında palpe edilebilir. Pulsatil abdominal kitle tanısaldır, ancak vakaların ancak yarısından azında görülür. Abdominal aort anevrizması olan hastaların %65'inde hastaneye ulaşmadan kardiyovasküler kollaps gelişir. Bu vakada ileus semptomları ile başlayan bir hastada saptanan dev abdominal aort anevrizması sunuldu.

Olgu: Seksen iki yaşında erkek hasta karın ağrısı, bulantı ve kusma yakınması ile acil servise getirildi. Anamnezinde ağrının iki gündür olduğu, giderek şiddetlendiği ve geceden beri bulantı ile birlikte yediklerini içerir tarzda 5-6 defa kusmasının olduğu öğrenildi. Özgeçmişinde hastalık öyküsü yoktu ve herhangi bir ilaç kullanımı bulunmamaktaydı. Soygeçmişinde özellik saptanmadı. Geçirilmiş abdominal operasyon öyküsü yoktu. Genel durumu iyi, koopere, oryante ve vital parametreleri stabildi (TA:120/65mmHg, nabız: 74/dk, solunum sayısı: 12/dk, ateş: 36,5 C). Abdomen muayenesinde batin distandü görünümdeydi ve bilateral alt kadrantlarda hassasiyet saptandı. Diğer sistem muayenelerinde anormal bulgu tespit edilmedi. Sinüs ritminde olan EKG'sinde iskemik değişiklik saptanmadı. Laboratuvar tetkiklerinde WBC:25,17 K/uL, Hb:8.6 gr/dl, Plt:167, AST:20 U/L, ALT:21 U/L, ALP:60 U/L, GGT:24 U/L, Üre:150 mg/dl, Cre:3.4 mg/dl, LDH: 208 U/L saptandı. Hastanın PTZ, aPTT ve INR değerlerinde anormallik saptanmadı. Ayakta direkt batin grafisinde yoğun gaz-gaita yükü ve hava-sıvı seviyesi saptandı (Resim 1). Böbrek fonksiyon bozukluğu nedeniyle gelişen kontrastsız bilgisayarlı batin tomografisinde infrarenal düzeyden başlayıp yaklaşık 17 cm. lik segmente en geniş yerinde 11,5x12,5 cm boyuta ulaşan iç yapısı heterojen ve duvarında kalsifikasyon da izlenen abdominal aorta anevrizması saptandı (Resim 2). Kalp damar cerrahisi ile konsülte edilen hastada kardiyopulmoner arrest gelişti. Medikal tedavi ve kardiyopulmoner resüsitasyona yanıt vermeyen hasta eksitus kabul edildi.

Sonuç: Karında şişkinlik, bulantı ve kusma yakınması ile acil servise başvuran yaşlı erkeklerde ileusu klinik olarak taklit edebileceğinden abdominal aort anevrizması ayırıcı tanıda mutlaka akıldan tutulmalıdır.

Anahtar Kelimeler: abdominal aort anevrizması, ileus, acil servis

P-1057 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Hemoptizi ile başvuran genç hastada akciğerde arteriovenöz malformasyon

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Amaç: Hemoptizi solunum sisteminden öksürükle kan gelmesidir. Sigara içmeyen bir bireyde balgamla kan gelmesi hafif bir enfeksiyonu veya konjenital bir hastalığı gösterirken sigara hikayesi olan bireylerde bu genelde ciddi bir hastalık göstergesidir.

Olgu: 18 yaşında bir erkek hasta acil servisimize öksürükle ağızdan kan gelmesi şikayeti ile başvurdu. Hastanın gelişinde vitalleri; arteriyel kan basıncı: 125/72 mmHg, nabız: 75/dk, ateş: 35,5 C ve oksijen saturasyonu: oda havasında %98 idi. Yapılan fizik muayenesinde orofarinks ve solunum sesleri doğaldı. Diğer sistem muayenelerinde de herhangi bir patoloji saptanmadı. Yapılan laboratuvar testlerinde, kanama diyatizi ile ilgili testler dahil, anormal bir bulgu yoktu. Çekilen PA akciğer grafisinde sağ akciğer alt lop lateral ve posterobazal segmentlerde hiperdens değişiklikler görüldü. Göğüs hastalıkları kliniğine yatırılan hastanın çekilen MR angiosunda aynı bölge ile uyumlu lezyon anevrizmatik genişleme arak değerlendirildi.

Sonuç: Bronşektazi, tüberküloz, akciğer absesi, trombositopeniler, maliniteler ve arteriovenöz malformasyonlar hemoptiziye neden olabilirler. Özellikle vakamızdaki gibi genç ve sigara öyküsü olmayan hastalarda AVM gibi masif hemoptiziye neden olabilecek konjenital nedenler de akıldan bulundurulmalıdır.

Anahtar Kelimeler: hemoptizi, konjenital, arteriovenöz malformasyonlar

P-1058 Imaging in Emergency Units

kahve çekirdeği ve girdap

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EGE ÜNİVERSİTESİ TIP FAKÜLTESİ HASTANESİ ACIL TIP ANABİLİM DALI, İZMİR

Amaç: Sigmoid volvulus gastrointestinal sistemin sık görülen obstrüksiyonlarından olmakla birlikte, karsinom ve divertikülden sonra batı ülkelerinde kalın bağırsak obstrüksiyonun en sık sebebidir. İleri yaşlarda görülme sıklığı artar. Hastalar acil servise tipik olarak karın ağrısı, abdominal distansiyon ve gaz-gaita çıkışının olmaması gibi şikayetlerle gelirler. Predispoze edici faktörler; kronik konstipasyon, mezenter instabilitesine bağlı mobil kolon ve megakolondur. Nadir de olsa doğumsal anomaliler ve psikiyatrik faktörlere bağlı da görülür. Tanı, direkt grafi ve batin tomografisi ile konulur.

Olgu: 52 yaşında erkek hasta, konstipasyon ve bir gündür olan karın ağrısı şikayetiyle acil servise geldi. Özgeçmişinde özelliği olmayan hastanın, vital bulguları stabildi. Fizik muayenede, genel durumu iyi olmayan hastanın, distansiyonu ve suprapubik hassasiyeti harici, fizik muayene bulgusu yoktu. Laboratuvar tetkikleri normaldi. Konstipasyon ve distansiyonu olan hastaya toksik görünümde olması nedeniyle ayakta direkt batin grafisi çekildi. Grafide, dilate kolon ansları olan hastaya ayırıcı tanı için batin BT çekildi. BT' de, sigmoid volvulus tanısı konularak, gastroenteroloji birimi tarafından redüksiyon amaçlı rektosigmoidoskopiye(RSS) alındı. RSS' de barsak ansları redükte edildi. Hasta takip ve elektif cerrahi için genel cerrahi kliniğine yatırıldı.

Sonuç: Acil servise karın ağrısı ve distansiyonla gelen hastalar öncelikle direkt grafi ile değerlendirilip nonspesifik dilate barsak ansları, geniş tabanlı hava sıvı seviyeleri olabilir. Obstrüksiyon açısından anlamlı olan görüntüler için gerektiğinde ayırıcı tanı amacıyla batin BT çekilmelidir. 'Kahve çekirdeği işareti' sigmoid volvulusun klasik konvansiyonel röntgen bulgusudur. Olguların %80'inde sigmoid volvulus sadece düz karın grafileri ile tespit edilebilir. Uzun ve distandü bir transvers kolon, çekal volvulus ve psödoobstrüksiyon sigmoid volvulusu taklit edebilir. Olgumuzda da kahve çekirdeği işaretine benzer görüntü elde edilse de ayırıcı tanı için BT çekilmiştir. BT' de, genişlemiş barsak ansları ve yumuşak dokunun oluşturduğu dönmeye hareketi görülebilir. Bu harekete 'girdap bulgusu' denir. Sıklıkla sigmoid kolon ve çekum nadirde olsa transvers kolon dönmeye hareketi yapar. Tedavide ise endoskopik dekompresyon ve gerekirse acil veya elektif cerrahi uygulanır. Sigmoid volvulus sıklıkla yaşlılarda görüldüğünden, dehidratasyona, şoka, peritonite ve perforasyona neden olup mortal seyredebilir. Bu nedenle erken tanı ve tedavi gereklidir. Acil dekompresyon ve elektif sigmoid rezeksiyonu kombinasyonu en az mortalite oranına sahiptir (%5-10). Eğer bağırsak nekrozu bulgusu varsa, acil rezeksiyon uygulandığında mortalite oranı %50-70'dir.

Sonuç olarak zamanın önemli olduğu bir hastalık olan sigmoid volvulus, distansiyonu ve konstipasyonu olan hastalarda, çekilen direkt batin grafilerini yorumlarken akıldan çıkarılmamalıdır.

Anahtar Kelimeler: girdap bulgusu, kahve çekirdeği, volvulus, konstipasyon

P-1059 Pediatric Emergencies

Özefagusun Birinci Darlığında İki Yabancı Cisim

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Amaç: Yabancı cisim yutulması dünyanın her yerinde sık acil servis başvuru nedenleri arasındadır. Özellikle çocukların çevrelerini tanıma dönemi olan 4 ay - 4 yaş arasında daha yoğun olarak rastlanmaktadır. Yetişkinler sıklıkla yiyecek maddesi gibi radyolüsent cisimler yutarken, çocuklar genellikle bozuk para, iğne, düğme, ya da oyuncak parçaları gibi radyopak cisimler yutmaktadır. Yabancı cisim yutmaları cisimlerin yapısı, şekline ve gastrointestinal sistemde lokalize olduğu yere göre farklı bulgular verebilir ve farklı komplikasyonlara yol açabilirler.

Olgu: 14 aylık erkek hasta hastanemiz acil servisine kusma şikayetiyle getirildi. Vital bulguları stabil olan hastanın fizik muayenesinde orofarenkste hiperemi dışında patolojik bulguya rastlanmadı. Öykü de hastanın 2 gün önce bozuk paralar ile oynadığını ve yutmuş olabileceği öğrenildi. Çekilen AP akciğer grafisinde faringoözefaguel bileşkekte 2 adet değişik boyutta bozuk para ile uyumlu yabancı cisim görüldü. Bunun üzerine hasta pediatrik cerrahi servisine yatış yapıldı. Genel anestezi altında magyl klembi ile özefagustan 2 adet bozuk para çıkarıldı

Sonuç: Yabancı cisim yutmasına bağlı bulgular veya komplikasyonlar başlangıçta asemptomatik olabilirler. Bazı hastalarda ise yabancı cisim yutmaya bağlı yorulamayacak değişik semptomlar olabilir. Bu yüzden hasta bir çocukta yabancı cisim yutma olasılığını akıldan tutmak gerekir. Yutulan yabancı cismin gastrointestinal sistemdeki yerleşim yeri uygulanacak tedavi seçeneğini belirlemede en önemli ölçüttür. Yutulan yabancı cisim mide pylorun proksimalinde ise özefagogastroskopi ile çıkarılmalıdır. Oral alımı normal ve rahat olan hastalarda sivri uçlu ve kesici olmayan yabancı cisimler mide pilorunun distalinde ise gözlemlenmeli ve normal pasaj ile yabancı cismin çıkması takip edilmelidir.

Anahtar Kelimeler: cisim, darlık, özefagus

POSTER PRESENTATIONS

P-1060 Imaging in Emergency Units

İleri Yaş Bir Hastada Akut Transvers Miyelit

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Akut transvers miyelit (ATM), akut veya subakut başlangıçlı, hızla gelişen kas güçsüzlüğü, seviye veren duyu kaybı ve sfinkter kusuru ile karakterize bir tablodur. Medulla spinaliste belli bir segment boyunca motor ve duysal traktuslar tutulur. Myelopati tablosundan önce bazı hastalarda üst solunum yolu enfeksiyonuna benzer belirtiler görülebilir. ATM'in sıklıkla 10-19 ve 30-39 yaşlarında pik yaptığı bilinmektedir. Bu yazıda ileri yaş bir hastada görülen ATM olgusu sunulmuştur.

Yetmişbeş yaşında erkek hasta kollarında ve bacaklarda güçsüzlük, idrar kaçırma yakınmaları ile başvurdu. Şikayetlerinin 3 gündür başladığı ve geçen hafta hastanın gribal bir enfeksiyon nedeniyle aile hekimine gittiği öğrenildi. TA: 140/80 mmHg, nabız 70/dk, ateş: 36,8°C, SS: 18/dk ölçüldü. Nörolojik muayenede; 3/5 düzeyinde kuadriparezi, T2 altında seviye veren duyu kusuru saptandı. İdrar ve gaita inkontinansı mevcut idi. Hastadan istenen beyin BT normal olarak yorumlandı. Sedimentasyon yüksekliği dışında (55 mm/saat) diğer laboratuvar değerleri normal sınırlarda idi. Nöroloji konsültasyonu istendi. Kranyal MRG normal bulundu. Spinal MRG'de ise C5-6 düzeyinde T2A kesitlerde hiperintensite saptandı. Nöroloji servisine yatış yapıldı. ATM olgularında en sık görülen semptomlar; seviye veren duyu kusuru (%80), alt ekstremitelerde parestezi (%90), mesane semptomları (%100) ve sırt ağrısı (%30-50) olarak sayılabilir. Acil servis hekimleri tanıda görüntüleme yöntemi olarak kranyal ve spinal MR'ı tercih etmelidir.

Anahtar Kelimeler: Transvers miyelit, seviye veren his kusuru, MRG

P-1061 Imaging in Emergency Units

Acil Tıp Kliniğinde Ultrasonografinin Öneme Bir Kanıt Daha: Sialolitiazise Sekonder Apse

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Amaç: Sialolitiazis tükürük bezinin veya boşaltıcı kanalının kalkulus ile tıkanmasıdır. Etkilenen bezde şişlik, ağrı ve enfeksiyon görülür. Sialolitiazis tüm tükürük bezi hastalıklarının %30'unu oluşturmaktadır. %80-95 oranında submandibuler bezde, %5-20 oranında parotis bezinde ve %1-2 oranında sublingual ve minör tükürük bezlerinde görülür. Sialolitiazis patogenezi tam olarak anlaşılamamakla birlikte tükürük taşı deskuame epitel, yabancı cisim, bakteri veya bakteri ürünleri ile oluşan santral çekirdek etrafında kalsiyumdan zengin kristallerin birikiminden oluşmaktadır.

Olgu: 56 yaşında erkek hasta acil servise sol kulak önünde 10 gün önce başlayan ve giderek artan şişlik şikayeti ile başvurdu. 10 gün önce diş apsesi tanısı koyulan hastaya oral antibiyotik tedavisi başlanmış. Şişliğin artması üzerine 3 gün önce diş merkeze başvurmuş fakat hastaya yine diş apsesi tanısı konularak intramusküler (IM) antibiyotik tedavisine geçilmiş. Alınan IM antibiyotik tedavisine rağmen hastanın şişliğinde artış olması ve mevcut ağrısının artması üzerine hastanemiz acil servisine başvurdu. Hastanın fizik muayenesinde sol kulağın 3 cm önünde, lokalizasyonu parotis beziyle uyumlu 3D3 cm boyutunda, orta sertlikte, hassas bir kitle saptandı. Tespit edilen kitleye yönelik yüzeyel doku ultrasonografisi (USG) yapıldı. Yapılan USG'de stemon kanalının genişlemiş olduğu ve içerisinde posteriora akustik gölge veren en büyüğü 8 mm çapında olan yaklaşık 5 adet taş ile uyumlu görünüm ve apse tespit edildi (Şekil 2). Yapılan laboratuvar testlerinde beyaz küre sayısı 17900 mm³ ve CRP' de 67,30 mg/L olarak saptandı. Hastanın klinik ve laboratuvar değerlendirmesi sonucunda sialolitiazise sekonder apse düşüldüğü üzerine hasta cerrahi servise yatırıldı.

Sonuç: Tükürük bezi taşlarının tespit edilmesi komplikasyonların gelişmesini önlemek açısından geciktirilmemelidir. Günümüzde tükürük bezlerini incelemede kullanılabilecek birçok yöntem vardır. Çoğu tükürük bezi taşları radyopak ve direk radyografide görülebilir. Opak olmayan taşlar ürüt içerirler ve direk radyografide görünmezler. USG ile, radyografideki opak olmayan taşlar gösterilebildiği gibi, duktus genişlemesi olup olmadığı, taşın yerleşimi, parankimin durumu ve enflamatuvar değişiklikler de izlenebilir.

Anahtar Kelimeler: apse, sialolitiazis, usg

P-1062 Resuscitation

Endotrakeal entübasyon sonrası çok nadir bir komplikasyon; Trakeal rüptür

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Amaç: Akut solunum yetmezliği ve çok nedeniyle entübe edilen 62 yaşında bayan olguda postintübasyon trakeal rüptür ve Çok kesitli Bilgisayarlı Tomografi bulgularını sunmayı amaçladık. Trakeal rüptür nadir bir durum olup en sık nedeni baş ve boyun yaralanmalarıdır(1). İatrojenik yani postintübasyon rüptür ise son derece nadir olup rapor edilen insidansı 0.005% 'dir (2). Genellikle trakea posterior membranöz parçasında lineer laserasyon hattı olarak ortaya çıkmakta olup 50 yaş üstü kadın popülasyonunda siktir. Klinik olarak subkutanöz amfizem, solunum sıkıntısı, pnömotoraks ve mediastinal amfizem olarak karşımıza çıkar. Mekanik, anatomik ve bireysel farklılık gibi pek çok faktör altta yatmaktadır (3). Çoklu entübasyon denemeleri, deneyimsiz sağlık çalışanı, trakeal tüp balonunun fazla şişirilmesi, tüp ucunun yanlış yerleştirilmesi, uygunsuz tüp boyutu, ani hasta baş-boyun hareketleri gibi mekanik faktörlerin yanı sıra, anatomik olarak konjenital trakea anomalileri, pars membranosa zayıflığı ve kronik obstrüktif akciğer hastalığı nedenler sayılabilir.

Olgu: Hastanemiz Koroner Yoğun bakım ünitesinde akut koroner arter patolojisi nedeniyle yatmakta olan 62 yaşında bayan olguda akut solunum yetmezliği ve çok gelişmesi nedeniyle yapılan endotrakeal entübasyon sonrası ciltaltı yoğun amfizem gelişmesi üzerine trakeal rüptür ve pnömomediastinum şüphesi ile acil şartlarda alınan çok kesitli toraks bilgisayarlı tomografi incelesinde; Trakeada endotrakeal tüpe ait görünüm izlenmiş olup endotrakeal tüpün karına düzeyinde sonlama gösterdiği ve servikal düzeyde trakea anterior duvardan boyun kas planlarına doğru uzanımı izlenen ince lineer hava sütunu saptanmıştır. Bu düzeyden başlayarak boyun yüzeyel ve derin fasyaları göğüs ön duvarı cilt altı yerleşimli sağ meme derin planda yerleşimli cilt altı amfizemi ile uyumlu yaygın hasta değerleri saptandı.

Ön mediastende daha belirgin retrosternal alanı dolduran ve aorta kaval reses düzeyinde de mediastende hava izlendi (Pnömomediastinum).

Hasta cerrahi olarak tedavi edildi.

Sonuç: Entübasyon sonrası trakeal rüptür hayatı tehdit eden ciddi bir komplikasyondur. Yüksek klinik şüphe erken terapötik yaklaşımlarına olanak sağlayarak mortalite oranlarını belirgin olarak düşürecektir. Klinik şüpheyi takibeden bronkoskopik inceleme laserasyonun boyutu ve alanını göstererek tanıyı konfirme eder. Ancak Çok kesitli Bilgisayarlı Tomografi ile de trakeal laserasyonu gösterebileceğimiz gibi ek olarak subkutan amfizem, pnömotoraks ve mediastinal amfizemde radyolojik olarak ortaya çıkarılabilir.

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Anahtar Kelimeler: Endotrakeal tüp, entübasyon, trakeal rüptür



POSTER BİLDİRİLER

P-1063 Imaging in Emergency Units

Epistaksis arteri; sfenopalatin arter

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Arka plan: Sfenopalatin arter, eksternal karotik arterden gelen yüzün derin yapılarını kanlandıran maksiller arterin terminal dalıdır. Yaşamı tehdit eder, ciddi posterior kanamaların çoğundan sorumludur. Özellikle konka, septum bölgesini ilgilendiren travma ya da iatrojenik olarak bölge cerrahi girişimleri sonrası kanamalarına rastlanır. Burada selektif serebral DSA(Digital subtraction angiography) ve arteriyel embolizasyon gereken olguyu sunuyoruz.

Olgu: 38 yaşında kadın hasta, iki gündür kontrol edilemeyen burun kanaması nedeniyle acil servise başka bir hastaneden sevk edildi. Tampon uygulamaları, tekrar cerrahi girişim gibi tüm müdahalelere toplam 4 U eritrosit süspansiyonu transfüzyonuna rağmen kanama devam ediyordu. TA:90/60 Nb:130 Hgb:9.5, Hct:30.1, PLT:258000. Klinik ve hayati bulgular hipovolemik şoka işaret ediyordu. Altı ay önce konka operasyonu öyküsü olan, kronik hastalığı bulunmayan hastanın yapılan DS anjiyografisinde, sağ eksternal karotik arter maksiler arter sfenoplatin branşı üzerinden inferior konka medioposterior bölümünde erken ekstrasvazasyon saptandı. İşlem sırasında 2 U eritrosit süspansiyonu verilerek hemodinami stabil tutulabildi. Arteriyel embolizasyon gerçekleştirilen hasta yoğun bakım ve servis izleminden sonra sorunsuz taburcu edildi.

Sonuç: Yaşamı tehdit eder sfenopalatin arter kanamaları invaziv radyolojik girişimlerin yapılabildiği merkezlerde arteriyel embolizasyonla etkin şekilde yönetilebilir. Acil servis bu tür merkezin bulunduğu hastanede değilse, hastanın transport edileceği merkezlerle işbirliği yapmak kritik önem taşıyabilir.

Anahtar Kelimeler: Sfenopalatin arter, epistaksis, DSA, arteriyel embolizasyon

P-1064 Other

Omzum yine çıktı opioide ihtiyacım var!

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Arka plan: Acil servislere opioidlerin etkin kullanımı, hasta ve hekim memnuniyeti, ağırlı prosedürlerin etkin yönetilebilmesi açısından değerlidir. Kronik tekrarlayan ağırlı tıbbi sorunlar süresince opioid kullanımı, nadir de görülsün iatrojenik ilaç kötüye kullanımına zemin hazırlayabilir.

Olgu: 22 yaşında erkek hasta sol omuz çıkığı nedeniyle acil servisimize ilk kez başvurdu. VAS'a göre 10 verdiği şiddetli ağrısı vardı ve yerinde duramayacak kadar kaygılı ve rahatsız görünüyordu. Vital bulguları sinüs taşikardisi dışında normaldi. Omzunun 6 yıllık bir süreçte defalarca çıktığını, glenoid sahayı desteklemek için kemik greftler konulduğunu işe yaramadığını, omuz ekleminde artrodez için önümüzdeki günlerde ameliyat planlandığı öyküsünü verdi. Fizik muayenede sol ön aksiller hatta uyan vertikal yaklaşık 20 cm'lik insizyon skar izleniyordu. Midazolam ve fentanil ile uygun dozda sedasyon analjezi altında xray görüntülemeye izlenen fraktürün eşlik etmediği anterior çıkık redükte edildi. Ardından hastanın istemli şekilde omzunu tekrar çıkarak yeni bir doz opioid istemesi üzerine, opioid ilaç istismarı durumuyla karşılaşıldığı anlaşıldı. Hastayla durum konuşulduğunda, başka bir ülkede yaşarken reçete ettirebildiği opioid ilaçları bittiği için bu şekilde bize başvurduğu ortaya çıktı.

Sonuç: Tekrarlayan omuz çıkığı, opioid ilaç kötüye kullanımı için bir yöntem olarak karşımıza çıkabilir.

Anahtar Kelimeler: Tekrarlayan omuz çıkığı, opioid, ilaç kötüye kullanımı

P-1065 Other

Hipotermi sonrası gelişen serebral infarkt: Vaka Sunumu

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Giriş: Hipotermi çevresel yaralanmalar arasında ciddi sorunlardan biridir. Barınma yetersizliği, bağımlılıklar ve mental durum en önemli risk faktörlerindendir. Biz burada hipotermi sonrası gelişen serebral infarkt vakasını tartışacağız.

Olgu: Serebral palsi ve mental retardasyonu olan; evde yalnız yaşayan hasta; yakınları tarafından baygın bir şekilde evde bulunmuş. Hasta 112 ambulansı ile acil servise getirildi. Genel durumu orta, suuru konfü, ağırlı uyaranlara yanıtı mevcuttu. Hastanın TA:80/50, ateşi:32.7. Işık refleksi +/-, GKS:10 puanı. Diğer sistem muayeneleri normaldi. Acil servise kabulünde alınan laboratuvar tetkiklerinde Glkoz:108 mg/dl, üre:66 mg/dl, kreatinin 1.42 mg/dl, CK:568 U/L, K:3.8 mEq/dl, WBC:13.400 K/u/L, Hgb: 8.2gr/dl olarak tespit edildi. Kan gazında pH: 7.17, pCO2:19.6 mmHg, pO2:62mmHg, sO2:85, HCO3:6.8mmol/L idi. Hastanın EKG'sinde osborne dalgaları mevcuttu. Çekilen beyin BT 'si normal olarak değerlendirildi. Difüzyon MR'da Sağ serebellar hemisferde yaklaşık 1 cm çapında sınırları belirgin akut iskemik ile uyumlu hipodens alan izlenmekte idi. Bunun üzerine hastadan EKO ve BTAngiografi istendi. Normal olarak değerlendirildi. Hasta ısıtıldı. Rabdomiyolize yönelik sıvı, bikarbonat ve mannitol tedavisi ve iskemiyi yönelik antiiskemik tedaviye başlandı. Takiplerinde CK'sı 3000 U/L'ye kadar yükseldi. Üre ve kreatinin değerlerinde yükselme olmadı. Kan gazı normal sınırlara döndü. Osborne dalgası düzeldi. EKG'si normal sinüs ritmine döndü. GKS:14'e yükseldi. Hasta 5 gün takip sonrasında şifa ile taburcu edildi.

Anahtar Kelimeler: Donma, serebral infarkt, osborne dalgaları

P-1066 Cardiovascular Emergencies

Acil Serviste Nadir Görülen Akut Miyokard Enfarktüsü Nedeni: Marihuana

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Amaç: Marihuana kullanımı 18-25 yaş arasında yoğun kullanıma sahip olsa da bu rakam daha genç yaşlara doğru artma eğilimindedir. Hala birçok kişi tarafından masum bir kullanım gibi görülmesine rağmen, kullanıma bağlı kardiyovasküler olaylar vaka örnekleriyle gösterilmiştir. Bu olgu ile nadir de olsa marihuana bağlı kardiyak olayların ciddiyetine dikkat çekmeyi hedefledik.

Olgu: Özgeçmişinde bir hastalık öyküsü olmayan 20 yaşındaki erkek olgu, 1,5 saat öncesinde başlayan ezici tarzındaki göğüs ağrısıyla acil servise başvurdu. Geliş kan basıncı 115/86 mmHg, nabız:86/dk, O2satürasyonu %99 idi. Terleme dışında fizik bulguları normal sınırlar içindeydi. 12 derivasyonlu EKG bulgusu:inferio-lateral akut myokard infarktı ve aVL ve aVR'de 1mm daha az ST segment depresyonu görüldü. Kardiyak enzimleri normal sınırlar içindeydi. Detaylı hasta anamnezi ile marihuana kullanımı bilgisine ulaşıldı. Hasta kardiyak açıdan koruyucu tıbbi tedavi için kardiyoloji kliniğine yatırıldı. 0.25µg/kg/dk perlinganit infüzyonu ile hastanın koroner spazmı ve anjinası geriledi. Hasta 2 gün yoğun bakım izleminden sonra kardiyovasküler ya da nörolojik sekel olmadan 4 gün sonrasında taburcu edildi. Hastanın ekokardiyografik incelemesinde arka duvar bazalinde hipokinezi ve bilateral nornal ejeksiyon fraksiyonu sonucu elde edildi, kardiyak enzimler normal sınırlarda bulundu.

Sonuç: Marihuana, M.O. 8. yüzyılda beri insanoğlu için bilinen bir bitkidir. Bu bitki en güçlü maddesi delta - 9 - tetrahidrokanabinol (Δ9 - THC) olmak üzere kanabinoidler olarak bilinen 60 psikoaktif madde içerir. Marihuana birçok ülkede en yaygın kullanılan yasadışı uyuşturucudur. Literatürde marihuana kullanımına bağlı gelişen kardiyovasküler olayların incelendiği 43 hastanın sadece 6'nda akut myokard enfarktüsü rapor edilmiştir.

Sonuç olarak genç popülasyonda marihuana kullanımı kardiyak olayların ortaya çıkmasını tetikleyebilir. Marihuana kullanımı sonrasında göğüs ağrısı azalabilir ve bu da kardiyak hasarın geç farkedilmesine neden olarak daha ciddi klinik sonuçlar doğurabilir. Bu nedenle akut göğüs ağrısıyla acil servislere başvuran genç hastalarda marihuana kullanımı sorgulanmalı ve marihuananın potansiyel etkileri konusunda acil tıp hekimini farkındalık sahibi olmalıdır. Kardiyak arrest marihuana kullanımı sonrasında gelişen nadir ve ölümcül bir durumdur. Bu nedenle yaygın kullanımı olan bu madde ve potansiyel riskleri ile ilgili toplumsal farkındalık sağlamak sosyal bir sorumluluktur.

Anahtar Kelimeler: akut myokard enfarktüsü, marihuana, acil servis



POSTER PRESENTATIONS

P-1067 Cardiovascular Emergencies

Semptomatik bradikardi ile başvuran aort diseksiyonu

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Amaç: Aort diseksiyonu, aortik intimada oluşan bir yırtığı takiben media tabakasında kanın birikmesi ile ortaya çıkan patolojik bir durumdur. Aort diseksiyonu yüksek mortalite ve morbidite ile seyreden hızlı tanı ve tedavi gerektiren gerçek kardiyovasküler acil durumdur. Topografik olarak Stanford (Daily) sınıflaması en pratik ve sık kullanılan sınıflamadır. Tip A (Proksimal): Asendan ve arkus aortayı tutan diseksiyonları, Tip B (Distal): Desendan aortanın diseksiyonunu tanımlamak için kullanılır. Genel prensip olarak Tip A cerrahi, Tip B medikal tedavi edilir. Bütün yaş gruplarında görülebilmeye karşın, olguların %75'ine 40-70 yaş arasında rastlanmakta ve erkeklerde daha sık görülmektedir. Tanı veya tedavideki gecikmeler mortalite ve morbidite artışına yol açmaktadır. Mortalite oranları tıbbi tedaviye rağmen yaklaşık %10 civarındadır. Bu vakada acil serviste semptomatik bradikardi olarak değerlendirilen bir hastanın ileri tetkik edildiğinde altta yatan aort diseksiyonunun saptanması sunuldu.

Olgu: 73 yaşında erkek hasta acil servise bel ağrısı, bulantı ve kusma şikayetleri ile başvurdu. Anamnezinde şikayetlerinin 3-4 saat kadar önce ve balık yedikten sonra başladığı öğrenildi. Özgeçmişinde hipertansiyon öyküsü (20 yıl) mevcuttu. Soygeçmişinde özellik saptanmadı. Genel durumu orta, semi-koopere, semi-oryante olarak değerlendirildi. Bradikardisi (nabız: 40/dk) haricinde vital parametreleri stabildi (TA:125/65mmHg, solunum sayısı: 12/dk, ateş: 36,5 C). Fizik muayenesinde anormal bulgu tespit edilmedi. Ekstremitelerde tansiyon arteriyel farkı ya da nabız defisiti saptanmadı. Sinüs ritminde olan EKG'sinde iskemik değişiklik saptanmadı. Laboratuvar tetkiklerinde WBC:6,24 K/uL, Hb:13,4 gr/dl, Plt:99, AST:30 U/L, ALT:21 U/L, ALP:40 U/L, GGT:26 U/L, Üre:39 mg/dl, Cre:1,3 mg/dl saptandı. Hastanın PTZ, aPTT ve INR değerlerinde anormallik saptanmadı. Kardiyoloji ile konsülte edilen, EKO'da hafif mitral yetmezlik, orta aort yetmezliği ve aort dilatasyonu saptanan hasta bradikardi ve normotansiyon nedeniyle aort diseksiyonu açısından düşük riskli olarak değerlendirildi. İntravenöz kontrastlı bilgisayarlı torako-abdominal tomografide çıkan aorta düzeyinden başlayarak üst kesimde solda subklavian arter proksimal kesime kadar alt kesimde her iki iliyak arter-sağda eksternal iliyak proksimal kesim, solda internal iliyak proksimal kesime kadar uzanan aort diseksiyonu saptandı (Resim 1-2). Hasta acil operasyon amaçlı kalp ve damar cerrahisi kliniğine devredildi.

Sonuç: Her ne kadar ani başlayan göğüs-sırt ağrısı aort diseksiyonunun en sık semptomu olsa ve hiper-hipotansiyonla birlikte taşikardi görülmesi beklense de özellikle ileri yaş hasta grubunda ve semptomatik bradikardi ile başvuran normotansif hastalarda aort diseksiyonu ayrıntı tanıda akıldan tutulmalıdır.

Anahtar Kelimeler: Aort diseksiyonu, bradikardi, acil servis

P-1068 Imaging in Emergency Units

Acil Serviste Oral Antikoagülan Komplikasyonlarının İnsan Protrombin Kompleksi İle Revers Edilmesi Uygulamalarının Analizi

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Oral antikoagülanlar (OAK) derin ven trombozu pulmoner emboli, kalp kapak hastalıkları gibi birçok kardiyovasküler hastalığın tedavi ve takibinde kullanılır. Doz ayarlaması ilaç metabolizması genetik değişiklikler gösterdiği için kişiye özel yapılır. Özellikle yaşlı hastalarda ilacın yanlısı kullanımı, gerekli Uluslararası Düzeltme Oranı (INR) kontrollerinin yapılmaması, ilaç metabolizmasının birçok faktörden etkilenmesi ve değişken olması gibi nedenlerden dolayı acil serviste OAK'ın kullanımına bağlı INR yüksekliği sıklıkla görülür. Doz aşımının en sık görülen ve en istenmeyen yan etkisi kanama olup hayatı tehdit edebilecek düzeye gelebilmektedir. Protrombin kompleks konsantrasi (PCC) akut olarak OAK'ın etkisinin revers edilmesinde etkilidir. Bu çalışmada acil serviste OAK'ın over dozuna bağlı hayatı tehdit edici kanaması olan olgularda kullandığımız PCC uygulamasına ait verilerin analizini yapmak amaçlanmıştır.

Gereç-Yöntem: Bu çalışma Şişli Hameidiye Etfal Eğitim ve Araştırma Hastanesi Acil Servisinde 2013 yılında OAK'ın kullanımına bağlı INR yüksekliğine bağlı kanama komplikasyonu gelişen hastaların dahil edildiği retrospektif olarak dizayn edilen araştırmadır. Çalışmaya 8'i bayan, 8'i erkek olmak üzere toplam 16 hasta dahil edildi. Hastalarda yaş, cinsiyet, OAK'ın kullanım dozu (mg/gün), kanama lokalizasyonu, tedavi için verilen PCC miktarı (ml), başvurudaki INR, PT, aPTT ve PCC uygulamasından 15'dk sonra INR, PT, aPTT değerlerine bakıldı.

Bulgular: Yaptığımız çalışmada yaş ortalaması 70,31; 9(%56,25) hasta 80 yaş ve üzeri, 6(37,5) hasta 50 yaş üzeri ve bir (%6,25) hastada 25 yaşında idi. Kanama komplikasyonunun görülme sıklığının ileri yaşlarda artmış olduğu gösterildi. 9 hasta (%56,25) gastrointestinal kanama, 4 hasta (%25) intrakranial kanama, 2 hasta %12,5 hematoma, 1 hasta (%6,25) batin içi kanama literatürdeki diğer sonuçlarda olduğu gibi en sık gastrointestinal kanama görüldü. Çalışmamızda 16 hastanın tümünde hedef INR değerlerine ulaşıldı. Hastalara sadece bir kez PCC infüzyonu uygulanmıştır; medyan değeri 60 ml'dir(40-100). PCC infüzyon uygulamasından 15'dk sonra kontrol INR değerleri; %93 hedef INR değerine ulaşılmıştır. PT değeri anlamlı (p< 0,05) düşüş göstermiştir. APTT değeri anlamlı (p< 0,05) düşüş göstermiştir. INR değeri hızlı bir şekilde düşüş göstererek sonraki 5 saat boyunca sabit kalmıştır. Hastalarda hedef INR değerlerine ulaşıldığı için tekrar PCC infüzyonuna gerek duyulmamıştır. Tedavi verilen 16 hastanın kanaması durdurulmuştur ve iki hastaya acil operasyon yapıldı. Ameliyat süresince kanama komplikasyonları ortaya çıkmamıştır. Bu çalışma boyunca PCC uygulamasından 15'dk sonra antikoagülan etki akut olarak emniyetli bir biçimde revers edilmiştir. DİK belirtisi gözlemlenmemiştir.

Sonuç: OAK'ın kullanımına bağlı gelişen INR yüksekliği eşlik eden kanama komplikasyonu olan olgularda INR düzeyinin hızlı ve güvenli bir şekilde normal seviyeye döndürülmesi çok önemlidir. INR yüksekliği olan kanamalı hastalarda PCC, antikoagülan etkiyi hızlı olarak revers edilmesi amacıyla güvenle kullanılabilir.

Anahtar Kelimeler: oral antikoagülanlar, insan protrombin kompleksi, kanama

P-1069 Other

Nadir Görülen Senkop Nedeni: FFA Alerjisi

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Amaç: Fundus Fluorescein Anjiyografi'de (FFA) kullanılan fluorescein oftalmolojide pratiğinde sık kullanılan organik bir boyadır. Ciltte ve idrarda sarı renk değişikliği yapar ve bu etki birkaç gün sürebilir. En sık karşılaşılan yan etkileri bulantı, kusma, kaşıntı-ürtikerdir. Hayati tehdit eden dispne, bronkospazm, senkop, konvulziyonlar nadir de olsa görülmüştür. Hafif ve orta derece reaksiyonlar 1/63 ile 1/1900 arasında sıklıkla görülürken, hayatı tehdit edebilecek anafaktik ve ciddi alerjik yan etkiler yaklaşık 1/222000 oranında izlenmektedir. Olgumuzda FFA sonrasında senkop, hipotansiyon ve bradikardi ile acil servise getirilen bir hasta anlatılmaktadır. FFA sonrasında bu bulguların nadir görülen komplikasyonlar olması ve sağlık personelinin hazırlıklı olmasına dikkati çekmeyi amaçladık.

Olgu: Afyon Kocatepe Üniversitesi Tıp Fakültesi Retina Birimi tarafından sol gözde koroid, retinal patoloji araştırılması amacıyla FFA yapılan 62 yaşında bayan hasta senkop nedeniyle acil servise getirildi. Hastada işlem tamamlandıktan hemen sonra senkop gelişti. Acil servise bilinci açık bir şekilde getirilen hastanın vücudunda yanma şikayeti vardı. Özgeçmişinde özellik olmayan hastanın düzenli kullandığı herhangi bir ilaç yoktu. Soygeçmişinde özellik yoktu. Fizik muayenesinde TA: 80/50 mmHg, nabız:51 atım/dakika, bilinç açık oryante koopere nörolojik muayenesi normaldi. Ciltte, tüm vücutta sarı renk değişikliği mevcuttu. Kardiyovasküler sistem muayenesinde bradikardi dışında tüm sistem muayeneleri olağandı. EKG de kalp hızı 48 atım/dakika, sinüs bradikardisi mevcuttu. Hasta monitorize edildi. Hipotansif olan hastaya hidrasyon başlandı, IV antihistaminik ve steroid tedavisi uygulandı. Tetkiklerinde, WBC:14200 olması dışında patoloji saptanmadı. Senkop etyolojisine yönelik yapılan testler normaldi. Hasta bradikardi ve hipotansiyon açısından 24 saat gözlem sonrası vitalleri stabil olarak acil servisten taburcu edildi.

Sonuç: FFA uygulanan hastaların belli bir süre(en az 30 dakika)hastanede tutulması, hastanın oluşabilecek komplikasyonlar açısından önceden bilgilendirilmesi gerekmektedir. Hekim ve diğer sağlık personelinin FFA yan etkileri açısından bilgili olması acil durumlar açısından hayat kurtarıcı olabilir.

Anahtar Kelimeler: FFA, Göz, Senkop

P-1070 Cardiovascular Emergencies

Elektrik Çarpmasına Bağlı Gelişen SVT Olgusu

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Elektrik akımına maruziyet sonrası; yumuşak dokulardaki zedelenmeler dışında, vücut içinde ilerlediği hat ile ilgili nörolojik ve kardiyak etkilenmeler görülebilir. Kardiyak etkilenme çeşitli aritmilere yol açabilir. Düşük voltajlı yaralanmalarda ventriküler fibrilasyon, yüksek voltajlı yaralanmalarda ise asistoli daha sık görülür. Elektrik çarpması sonrası gelişen supraventriküler aritmiler nadirdir. Burada elektrik çarpması sonrası ortaya çıkan ve kısa süre içinde kendiliğinden normal sinüs ritmine dönen supraventriküler taşikardi (SVT) olgusu sunulmuştur.

Yirmibeş yaşında kadın, banyoda elektrik kaçağı nedeniyle kısa süreli elektrik akımına maruz kalma, bayılma öyküsüyle arkadaşları tarafından acil servise getirildi. Hastanın yapılan değerlendirmesinde bilinç açık, oryante ve koopere idi. Monitörize dildi. Vital bulguları; kan basıncı: 105/60 mmHg, nabız: 140/dk, solunum sayısı: 20/dk, oksijen saturasyonu: %94 olarak saptandı. Sol



POSTER BİLDİRİLER

elden giren elektrik akımının hafif kızamıklık dışında herhangi bir lezyon oluşturmadığı görüldü. Çekilen EKG'de SVT saptandı. Adenozin yapılmasına karar verildi fakat hemşire ilacı hazırlarken hastanın ritmi değişti. Yeni EKG normal sinüs ritminde idi, anlamlı ST-T patolojisi yoktu. Kardiyak enzimleri normal sınırlarda gelen hasta 6 saat izlem sonrası taburcu edildi. Elektrik maruz kalan hastalarda, acil servis hekimleri aritmilere hazırlıklı olmalıdır. Ölümcül aritmiler görülebileceği gibi nadiren supraventriküler aritmiler de görülebilir.

Anahtar Kelimeler: Elektrik çarpması, supraventriküler taşikardi, ventriküler fibrilasyon

P-1071 Other

İstanbul'daki eğitim ve araştırma hastanelerinde çalışan acil tıp asistanlarının yorgunluk ve uyku kalitesi değerleri ve etkileyen faktörler

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Amaç: Yorgunluk, tüm uzmanlık alanlarındaki hekimlerin sık olarak karşılaştıkları ve tedavisinde güçlük yaşadıkları, yaygın ama özgül olmayan tıbbi bir yakınmadır. Yorgunluk, fiziksel ve mental hemen hemen tüm kronik hastalıklarda ortaya çıkan genel bir yakınmadır ve aynı zamanda bireyin iyilik hali, günlük performansı, günlük yaşam aktiviteleri ve ilişkilerini de olumsuz etkilemektedir. Bu çalışmada İstanbul'daki eğitim ve araştırma hastanelerinde çalışan acil tıp asistanlarında uyku kalitesi ve yorgunluk düzeyinin belirlenmesi ve etkileyen faktörlerin değerlendirilmesi amaçlanmıştır.

Gereç-Yöntem: Çalışma prospektif, kesitsel bir anket çalışması olarak düzenlendi. İstanbul'daki Eğitim ve Araştırma Hastanelerinde 2013 yılında çalışmakta olan acil tıp asistanları üzerinde yapıldı. Çalışmanın yapıldığı dönemde toplam 240 acil tıp asistanı olduğu saptandı. Çalışmadan dışlama kriteri gebelik, hastalık, rotasyon gibi nedenlerle izinli olma olarak belirlendi. Çalışmaya katılımda gönüllük esası alındı. Çalışmaya katılan hastane çalışanlarına ankete dayalı form dağıtıldı. Çalışmada yorgunluk ve uyku kalitesi ölçümünde Piper Yorgunluk Ölçeği ve Epworth Uyku Kalitesi Ölçeği kullanıldı. Katılımcılar ayrıca bazı sosyodemografik faktörlere ait anketi cevaplandırdı.

Bulgular: Çalışmaya yaş ortalamaları 29,8±3,7 yıl olan 130 (%67,4) erkek 63 (%32,6) kadın toplam 193 Acil Tıp Asistanı katıldı (Katılım oranı %80,4). Piper Yorgunluk Ölçeğinde acil tıp asistanlarının genel yorgunluk süresi en sık %55,4 ile aylar olarak saptanmıştır Acil Tıp asistanlarının %12,4'ünün yorgunluk hissetmediği belirtilmiştir. Piper Yorgunluk Ölçeğinde genel yorgunluk süresi ile acil tıp asistanlarının yaş ortalamaları, cinsiyet, medeni hal, çocuk, kronik hastalık varlığı ilaç kullanımı, kullandığı ilaç tipi, sigara kullanımı, asistanlık süresi, meslekteki toplam süresi, nöbet saati, aylık çalışma süresi ve pratiklikte acil serviste çalışma durumunda istatistiksel olarak anlamlı fark saptanmamıştır. Epworth Uyku Kalitesi Ölçeğine göre asistanların %66,8'i normal gündüz uyku kalitesi hali, %26,4'ü artmış gündüz uyku kalitesi hali, %6,7'si şiddetli gündüz uyku kalitesi hali saptanmıştır.

Sonuç: Acil Tıp asistanları arasında özellikle ağır çalışma koşulları, yoğun ve vardiyalı iş temposu, eşlik eden stres faktörleri uyku kalitesi ve yorgunluk düzeyini arttırmaktadır. Acil Tıp asistanları kendilerinde yorgunluk ve uykusuzluğa bağlı tıbbi hatalara yatkınlık, performans düşüklüğü olabileceği konusunda bilgilendirilmeli ve bu konuda destek almaları sağlanmalıdır.

Anahtar Kelimeler: Acil Tıp Asistanı, Yorgunluk, Piper yorgunluk ölçeği, Uyku kalitesi, Epworth Uyku Kalitesi Ölçeği

P-1072 Other

İstanbul'daki bir eğitim ve araştırma hastanesi çalışanlarının uyku kalitesinin değerlendirilmesi ve etkileyen faktörler

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Amaç: Uyku insan yaşamında temel ve vazgeçilmez etkinliklerden biri olup yeme, nefes alma, boşaltım kadar önemli bir fizyolojik gereksinimdir. Bu nedenle uyku bireyin yaşam kalitesini ve iyilik durumunu etkileyen, sağlığın önemli değişkeni olarak görülmektedir. Bu çalışmada İstanbul'da bir eğitim ve araştırma hastanesinin çalışanlarının uyku kalitesinin belirlenmesi ve etkileyen faktörlerin değerlendirilmesi amaçlanmıştır.

Gereç-Yöntem: Çalışma prospektif, kesitsel bir anket çalışması olarak düzenlendi. İstanbul Eğitim ve Araştırma Hastanesi'nde 2013 yılında çalışmakta olan toplam 843 hastane çalışanının 472'si üzerinde yapıldı. Çalışmadan dışlama kriterleri gebelik, hastalık, görevlendirme gibi nedenlerle izinli olma ve çalışmaya katılmayı kabul etmeme olarak belirlendi. Çalışmaya katılımda gönüllük esası alındı. Hastane çalışanlarına ankete dayalı form dağıtılarak uyku kalitesi ölçümünde Epworth Uyku Kalitesi Ölçeği kullanıldı.

Bulgular: Çalışmaya katılmayı kabul eden 249 (%52,8) erkek 223 (%47,2) kadın toplam 472 hastane çalışanının alındığı bu çalışmada (katılım oranı %56), çalışmaya katılanların 221'i (%46,8) hemşire, 69'u (%14,6) veri girişi elemanı, 96'sı (%20,3) personel, 14'ü (%3,0) güvenlik görevlisi, 72'si (%15,3) doktor idi. Hastane çalışanlarında uyku kalitesi dereceleri Epworth Uyku Kalitesi Ölçeği ile değerlendirildiğinde uyku kalitesi puanlarının kadınlarda, kronik hastalığı olanlarda, ilaç kullananlarda, uyku problemi olan ve uyku ilacı kullananlarda, doktorlarda veri girişi elemanlarında ve güvenlik görevlilerinde göre, hemşirelerde veri girişi elemanlarına göre, hastanedeki toplam çalışma süresi az olanlarda, aylık çalışma süresi fazla olanlarda, 24 saatlik ve shift şeklinde nöbet tutanlarda tutmayanlara göre, aylık çalışma saati yüksek olanlarda daha az olan gruba göre istatistiksel olarak anlamlı yüksekti.

Sonuç: Sağlık sektöründe çalışan kişilerin uyku kalitesi ve çalışma düzenleri üzerine geniş kapsamlı araştırma ve geliştirmeler çalışma performansları etkileyebilmesi açısından önemlidir.

Anahtar Kelimeler: Hastane çalışanı, Uyku kalitesi, Epworth Uyku Kalitesi Ölçeği

P-1073 Imaging in Emergency Units

Acil Serviste Kardiyopulmoner Resüsitasyon Uygulanan Olguların Analizi

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Giriş: Kardiyopulmoner arrest solunum ve kalbin aniden durması olarak tanımlanır Kardiyopulmoner resüsitasyon (KPR); ilaç ve ekipman desteği ile, havayolunun açılması, yeterli ventilasyonun sağlanması ve kalp masajı işlemlerinden oluşur. KPR başarısı, düzenli bir nabız ve kan basıncının idamesi ile mümkündür. Başarılı bir KPR işlemi hekim açısından mesleki tatmin, hasta ve hasta yakınları tarafından ölçüldüğü olmayan bir olaydır. İlk KPR işlemi 1960 yılında Kowenhoum tarafından yapılmış ve bu dönemden sonra her beş yılda bir yeni kılavuzlar yayınlanarak bilimsel bir çerçevede eksiklikler giderilmeye çalışılmıştır. En son 2010 yılında yayınlanan kılavuzda ise radikal değişiklikler yapılmıştır.

Gereç-Yöntem: Şişli Hamidiye Etfal Eğitim ve Araştırma Hastanesi Acil Tıp Kliniğinde bir yıl süre ile acil servise arrest olarak getirilen veya acil serviste arrest gelişen 155 hasta üzerinden yapılmıştır.

Bulgular: Çalışmaya KPR uygulanan 155 hasta dahil edildi. Hastaların 78'i (%50,3) acil servise arrest olarak getirilirken, 77'si (%49,7) acil serviste arrest oldu. Hastaların yaş ortalaması 66±16 olup, %64'ü erkekti. Yaş ve cinsiyet açısından gruplar arasında fark yoktu (p>0,05) Hastaların acil servise getirilme süreleri ortalama olarak 15 dakika olarak saptandı. Hastalara KPR uygulama süresi ortalama 32 dakika olarak saptandı. KPR'ye toplamda 49(%31,6) hasta yanıt vermiş olup, bu hastaların 28'i acil servise arrest getirilen gruptayken, 21'i acil serviste takipleri esnasında arrest gelişen gruptaydı. KPR'ye yanıt süresi incelendiğinde acil servise arrest getirilen grubun ortalaması 12,5 dakikada, acil serviste arrest gelişen grubun ortalaması ise 18,8 dakikaydı. Hastaların acil servise getiriliş süresi, ortalama KPR yapıma süresi ve KPR'ye yanıt oranı açısından gruplar arasında istatistiksel olarak anlamlı fark yoktu (p>0,05). KPR'ye yanıt verme süresi anlamlı olarak acil serviste arrest gelişenlerde artmıştı (p<0,05). Müdahale esnasında her iki grupta en fazla adrenalin (%98,1) uygulandığı, bunu dopaminin (%25,8) takip ettiği görüldü. Gruplar arasında uygulanan tedavi açısından istatistiksel olarak anlamlı fark yoktu (p>0,05). KPR'ye yanıt veren hastaların 43'ünde tekrar arrest geliştiği ve KPR'ye yanıt vermediği görüldü. Sonuç olarak 5 hastanın taburcu edildiği izlendi. Tekrar arrest gelişme süresi ve taburculuk açısından gruplar arasında istatistiksel olarak anlamlı fark saptanmadı (p>0,05)

Her iki grupta da en sık arrest nedeni, asistoli, arrest ritimlerine göre gruplar arasında istatistiksel olarak anlamlı fark bulundu (p<0,05). Asistoli, nabızsız elektriksel aktivite ve nabızsız VT'de yapılan müdahale sonuçları açısından, her iki grup arasında anlamlı fark yoktu (p>0,05). AS'de gelişen VF ritmine yapılan müdahale daha başarılı bulundu (p<0,05).

Sonuç: KPR işleminde erken müdahale ve tedavinin önemli olduğu görülmektedir.

Anahtar Kelimeler: kardiyopulmoner resüsitasyon, arrest, acil servis



POSTER PRESENTATIONS

P-1074 Imaging in Emergency Units

Sık görülen yakınma epigastrik ağrı, nadir görülen tanı; hepatik artere uzanan çölyak trunkus diseksiyonu

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Arka plan: Epigastrik ağrı, acil servis günlük pratiğinde sık görülen bir yakınmadır. Açıklanamayan ve dirençli epigastrik ağrı varsa, ayırıcı tanıda vasküler aciller akla gelmelidir. Çölyak trunkus diseksiyonunda farklı tedavi yaklaşımları olsa da, cerrahiden çok konservatif, antikoagülan, antiplatelet ve antihipertansif ilaçla tedavi daha geçerli görünmektedir.

Olgu: 39 yaşında erkek, iki saat önce başlayan epigastrik ağrı yakınmasıyla acil servisimize başvurdu. Daha önce de aynı yerde benzer nitelikte daha kısa süreli keskin çok şiddetli orta hat karın ağrıları olmuştur. Bir yıl önce olası kardiyak sorun düşünülerek benzer ağrısı, ekokardiyografi ve efor testi ile tetkik edilmiş, sorun bulunmamıştı. Sigara kullanıcısıydı, kolesterolü yüksekti, bilinen hipertansiyonu yoktu. TA:130/80 mmHg, Nb: 82/dk, SS:19, oksijen saturasyonu %98, ateşi normaldi. Fizik muayenede epigastrik ağrı dışında kayda değer bulgu yoktu. Fentanil ve NSAİ ile ağrısı kontrol edildi. Batın USG'de safra çamuru dışında patoloji rapor edilmedi. Vasküler patolojileri de değerlendirecek şekilde IV kontrastlı batın BT yapıldı. Çölyak trunkus proksimalinden başlayıp yaklaşık 3 cm boyunca bifurkasyona ve ortak hepatik artere uzanan diseksiyon saptandı. Ortak hepatik arter yalancı lümenindeki tromboz, hepatik arter lümenini daraltmıştı. Acil servis izlemi sırasında TA maksimum 150/90 mmHg olarak ölçüldü. Karaciğer enzimleri, böbrek fonksiyonu ve hemoglobinin normal düzeylerdeydi. Enoksaparin sc ve metoprolol 50 mg'dan oluşan tedavi planıyla izlenen hastamizin taburculuğundan 4 ay sonra tekrarlanan görüntülemesinde diseksiyon morfolojisinde anlamlı değişiklik saptanmadı.

Sonuç: Çölyak trunkus diseksiyonu acil serviste uygun görüntüleme ile erken tanınip, tedavi edilebilecek bir klinik antitedir.

Anahtar Kelimeler: Çölyak trunkus, diseksiyon, görüntüleme

P-1075 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Trombositopeniye Sekonder Subdural Hematom

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Amaç: Nörolojik şikayetleri olan her yaş grubunda hastalarla acil servis pratiğinde sıkça karşılaşılmaktadır. Konuşma bozukluğu, kuvvet kaybı gibi temel şikayetler özellikle yaşlı hastalarda santral sinir sistemi patolojilerine işaret eder. Etiyolojik faktör genellikle kronik hastalıklar iken hematolojik problemlerde nörolojik sorunlara yol açabilmektedir.

Olgu: 70 yaşında bayan hasta konuşmasında bozulma ve sağ elinde uyuşukluk şikayeti ile acil servise başvurdu. Şikayetlerinin 3 gündür devam ettiğini aralıklı olarak konuşmasında bozulma olduğunu ve bu bozulmanın kısa sürdüğünü ifade etti. Hastanın hipertansiyon dışında bilinen bir hastalığı yoktu. Vital bulguları TA:186/100mmHg, Nb:115/dk, Ateş:37,9 C olarak bulunan hastanın nörolojik muayenesi normal sınırlarda idi. Tam kan değerlerinde WBC: 2,2 x10⁹/mL, HGB:10,8 g/dL, PLT: 1000 e3/mL ve sedimentasyon>140mm/saat olarak tespit edildi. Sitopenisi olan hastanın beyin tomografisinde sol fronto-orbital alanda subdural hematoma izlendi. Hastaya sitopenisi için yapılan periferik yaymada 10 alanda 0, 20 alanda 1 trombosit izlenmesi üzerine hasta trombositopeniye bağlı subdural kanama olarak değerlendirildi ve prednizolon başlandı, 4 ünite aferez trombosit süpsansiyonu verilen hasta yoğun bakımda hospitalize edildi.

Sonuç: Trombositopeni birçok viral hastalığın seyri sırasında oluşabilirken bazı hematolojik malignitelerde de görülmektedir. Nedeni ne olursa olsun özellikle 20000 e3/mL altındaki değerler hastada kanama komplikasyonlarına neden olması açısından önemlidir. İntrakraniyal kanaması olan hastalarda tam kan profilinin değerlendirilmesi, etyolojik nedenin ortaya konulmasını ve etkin tedavinin gerçekleştirilmesine olanak sağlayacaktır.

Anahtar Kelimeler: trombositopeni, subdural hematoma, acil servis

P-1076 Cardiovascular Emergencies

Tekrarlayan pulmoner emboli kaynağı olarak sakküler popliteal venöz anevrizma olgusu

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Amaç: Tekrarlayan pulmoner emboli kaynağı olarak sakküler popliteal venöz anevrizması saptanan olguyu sunmayı amaçladık.

Olgu: Hastanemiz aciline dispe, hızlı solunum, taşikardi ve 5 gündür devam eden plöritik göğüs ağrısı yakınması ile gelen olguda pulmoner emboli şüphesi ile yapılan pulmoner Çok Kesitli Bilgisayarlı Tomografi anjiyografi incelemesinde subsegmenter emboli ile uyumlu dolum defektleri saptandı. Derin ven trombozu düşünülerek yapılan alt ekstremiteler bilateral renkli Doppler US incelemesinde sağ popliteal ven orta kesimde 5 mm'lik boyun ile bağlanan içerisinde yer yer yavaş hızda venöz akımların kodlandığı anterior duvardan sakküler uzanımlı yaklaşık 3x2 cm boyutlarında anevrizmatik genişleme ve anevrizmatik genişleme içerisinde parsiyel heterojen ekojen trombus izlendi. Ayrıca femoral vende de geçirilmiş derin ven trombozu ile uyumlu damar duvar değişiklikleri saptandı. Sonrasında yapılan indirekt Bilgisayarlı Tomografi Venografide de popliteal vende izlenen parsiyel tromboze sakküler venöz anevrizma doğrulandı. Tedavi aşamasında cerrahi olarak anevrizmektomi kararı alındı.

Sonuç: Popliteal ven anevrizmaları sık olmalarına rağmen pulmoner emboli ve diğer tromboembolik olaylara neden olabileceklerinden ötürü potansiyel olarak fataldır. Tekrarlayan pulmoner emboli epizotları olan olgularda fokal popliteal venöz anevrizmaların/ sakküler anevrizmaların nadir de olsa alta yatabileceği akılda bulundurulmalı ve erken tanı ile antikoagülan tedavinin yetersiz kaldığı bu hasta grubunda venöz sakküler anevrizmektomi ile tedavi şansı elde edilebilecektir. Tabi burada güvenilir ve efektif bir yöntem olan alt ekstremiteler venöz sistem Duplex US tarama incelemesinin doğru değerlendirilmesinin öneminin de altını çizmek isteriz.

Anahtar Kelimeler: Popliteal ven anevrizma, Pulmoner emboli, venöz anevrizmektomi

P-1077 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Valvüler trombüse sekonder gelişen iskemik serebrovasküler olay

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Amaç: Serebrovasküler olay beyinin kontralateral hemisferini besleyen arterlerden birinin yırtılması veya tıkanması sonucu ortaya çıkan nöromusküler fonksiyon bozukluğudur. Tek tarafta kol ve bacakta karakteristik özellikleri olan paralişi görülür. Bir hastalık değil açığa çıkan residüel bozukluklar tablosudur. Beyine giden kan damarlarında oluşan patolojik değişiklikler, travma veya serebro vasküler bazı hastalıklar, bu nörolojik tabloya sebep olabilir. Etiyolojisinde iskemik olaylar (tromboz, emboli) ya da hemorajik bulunur. Bu vakada metalik kalp kapak replasmanı olan bir hastada gelişen trombüse sekonder ortaya çıkan serebrovasküler olay sunuldu.

Olgu: Otuz sekiz yaşında kadın hasta vücutta yaygın güçsüzlük, bayılma ve konuşmama şikayetleriyle acil servise getirildi. Anamnezinde şikayetlerinin 2 saat önce aniden başladığı saptandı. Özgeçmişinde diabetes mellitus, aort kapak replasmanı öyküsü mevcuttu. Oral antikoagülan (warfarin) kullandığı ancak son 1 haftadır ilacını kullanmadığı öğrenildi. Hastanın soygeçmişinde özellik saptanmadı. Genel durumu orta, non-koopere ve non-oryante idi. Vital parametreleri normal olarak değerlendirildi. Sağ üst ve alt ekstremitelerinde hemiparezi saptanan hastanın diğer sistem muayeneleri normal olarak değerlendirildi. Bilgisayarlı beyin tomografide sol orta serebral arter sulama alanında girus ve sulkuslarda silinme saptanan hastanın kraniyal difüzyon magnetik rezonans görüntülemesinde orta serebral arter sulama alanında difüzyon kısıtlılığı belirlendi. Hastanın yapılan ekokardiyografisinde metalik aort kapağında trombus saptandı. INR düzeyi inefektif saptanan hasta IV antikoagülasyon amaçlı kalp ve damar cerrahisi servisine devredildi. Hasta servis izleminin 20. gününde sağ hemiparezi sekilli olarak taburcu edildi.

Sonuç: Acil servise iskemik serebrovasküler hastalık bulguları ile gelen ve metalik kapak replasmanı öyküsü olan hastalar valvüler trombüs açısından mutlaka ekokardiyografi ile değerlendirilmelidir.

Anahtar Kelimeler: Serebrovasküler olay, kalp kapak replasmanı, acil servis



POSTER BİLDİRİLER

P-1078 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Görme Bozukluğu ile Gelen İntrakranial Kanama: Olgu Sunumu

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Amaç: İntrakranial kanamalar beyin her yerinde görülebilen travmatik veya non-travmatik nedenlere bağlı olabilir. Genellikle elli yaş üzerinde bayan hastalarda sık gözlenir. Çoğu intraparakranial damar rüptürüne bağlıdır. Klinik semptom derecesi kanamanın büyüklüğü ve lokalizasyona bağlıdır. Biz de burada baş ağrısı ve görme bozukluğu ile acil servise gelen genç bir hastada tesbit edilen oksibital parankimal kanama olgusunu sizlerle paylaşmak istedik.

Olgu: Yirmi üç yaşında erkek hasta baş ağrısı ve bulanık görme şikayeti ile acil servise başvurdu alınan öyküsünde herhangi bir özellik yoktu. Yapılan fizik muayenesinde TA: 110/70mmHg, nabız: 75/dk, ateş: 36.7, glaskow koma skalası 15 idi. Diğer sistemik muayeneleri normaldi. Görme alanı muayenesi de doğaldı. Hasta takip amaçlı gözleme alındı. Yapılan tetkiklerinde tam kan ve biyokimya değerlerinde herhangi bir anormallik tesbit edilmedi. Hastanın klinik takiplerinde herhangi bir gerileme kayıtlı edilmemesi üzerine bilgisayarlı beyin tomografisi (BBT) istendi. Çekilen BBT'de solda occipital lobda 4x2 cm intraparakranial kanama tesbit edildi. MR ile korelasyonu uygun görülen hastanın yapılan MR anjiyografi incelemesinde her iki anterior serebral arterin A1 segmenti hipoplazik olarak tesbit edilmiştir. Hasta takip amaçlı nöroloji kliniğine yatırıldı.

Sonuç: İntrakranial vasküler yapıların konjanital anormalliklerinde hemodinamik strese bağlı olarak sakküler anevrizma insidansının arttığı bildirilmektedir. Anterior kommunikan arter anevrizması ile A1 hipoplazisi çok sık olarak birlikte görülebilmektedir. Acil servise baş ağrısı şikayeti ile birçok hasta başvurmak ancak bu hastaların yaş, kronik hastalık öyküsü, antiagregan tedavi alıp almadığı sıklıkla sorgulanmakta herhangi bir öyküsü olmayan hastalar yoğunluktan dolayı göz ardı edilebilmektedir. Bu nedenle genç yaş grubunda oluşan baş ağrılarında da hastanın klinik takibinin yapılması oluşabilecek komplikasyonların önüne geçmek açısından önemlidir.

Anahtar Kelimeler: baş ağrısı, görme kaybı, intrakranial kanama

P-1079 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Acil Servise Uzak Bir Hastalık Behçet Hastalığı

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Amaç: Behçet hastalığı nedeni tam olarak bilinemeyen etyolojisinde birçok viral ve bakteriyel nedenin araştırıldığı otoimmün bir hastalıktır. hastalık genellikle 2. Dekatan sonunda görülmeye başlanır ve 20-30 yaşları arasında insidansı pik yapar. İleri yaşlarda görülmesi nedeniyle hastalığın tanı süreci acil servis hekimlerini de ilgilendirebilmektedir.

Olgu: 21 yaşında erkek hasta 10 gündür devam eden genel vücut ağrısı, bacaklarda yaralar ve yürüme zorluğu şikayeti ile acil servise başvurdu. Hastanın özgeçmişinde herhangi bir özellik yoktu. Bacaklarındaki yaraların 10 gün önce başladığını ifade eden hasta 1 haftadır üst solunum yolu enfeksiyonu nedeniyle antibiyoterapi almaktaydı. Hastanın diz altında ve bacak ön yüzünde eritema nodosum karakterinde lezyonlar izlendi. Hasta ayrıntılı olarak sorgulandığında dilinde de 1-2 yıldır ara ara yaralar çıktığı, skrotumunda da beyaz renkli yaraların olduğu öğrenildi. Hastanın muayenesinde oral ve genital ülserlerin olduğu gözlemlendi. Uluslararası Behçet Hastalığı Çalışma Grubu'nun tanı kriterlerine göre hastaya behçet hastalığı tanısı konuldu. Hasta üveit değerlendirilmesi için göz, takip ve tedavi için romatoloji polikliniğine yönlendirildi.

Sonuç: Behçet hastalığı özellikle akdeniz ülkeleri ve uzak doğuda görülmektedir. Bir akdeniz ülkesi olan Türkiye, en sık görüldüğü ülkelerin başında gelmektedir. Hastalık daha çok erkekleri etkilemekte ve erkeklerde daha şiddetli seyretmektedir. Mevcut şikayetler ile acil servise yapılan başvurularda özellikle oral ülseri olan hastaların genital ve alt ekstremitelerde dermatolojik muayenesinin yapılması, Behçet hastalığı tanı kriterlerinin bilinmesi hastalığın erken tanınmasında ve özellikle göz komplikasyonlarının en aza indirilmesinde faydalı olacaktır.

Anahtar Kelimeler: behçet hastalığı, acil servis, eritema nodosum, oral ülser, genital ülser

P-1080 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Yüksek rakımda bu tanıya dikkat: akut dağ hastalığı

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Amaç: Akut dağ hastalığı (ADH) 2000-3000 m' nin üzerine hızlı çıkış yapanlarda baş ağrısı, bulantı, kusma, uykusuzluk gibi hafif semptomlardan akut akciğer ödemi ve akut beyin ödemi gibi ağır bulgulara ilerleyen hastalıklar zinciridir. Yüksek irtifada basınç azaldıkça bununla orantılı olarak oksijen basıncında da azalma görülür. Vücuttaki hayati organların oksijenlenmesindeki azalma mide bulantısı, baş ağrısı, nefes darlığı, idrarda azalma, hipokapni, retinal kanama, huzursuzluk, mental yavaşlama gibi birçok sorunu beraberinde getirir.

Olgu: 37 yaşında kadın hasta baş ağrısı, mide bulantısı ve nefes darlığı şikayetiyle acil servise başvurdu. Muayenesinde vitalleri; TA: 112/73 mm Hg Nabız: 85/dk, sO2: %95 ve ateş: 36.7 °C idi. Solunum sesleri doğaldı, nörolojik muayenesi dahil tüm fizik muayenesi normaldi. Özgeçmişinde bir yıl içerisinde iki kez daha nefes darlığı olduğu ve tetkikler sonucunda herhangi bir hastalık bulgusuna rastlanmadığı öğrenildi. Alınan arteriyel kan gazında pH:7.52 pCO2:25.6 sO2:95 diğer parametreler normaldi. Kreatinin değeri normal olan hastanın gün boyunca idrara bir kez çıktığı öğrenildi. Elektrokardiyografisi ve PA akciğer grafisi normaldi. Hastanın yolculuk yapıp yapmadığı sorgulandığında sabah İstanbul'dan uçakla Erzurum'a geldiği öğrenildi. Hastada ADH düşünüldü. Oksijen ve mayı tedavisiyle hastanın semptomları geriledi. Önceki nefes darlıklarının da aynı öyküden sonra olduğu öğrenildi.

Sonuç: Akut dağ hastalığı Erzurum gibi orta-yüksek irtifadaki yerlerde acil servise başvuran hastalarda gözden kaçırılmaması gereken bir durumdur. Akut dağ hastalığı sonuçları itibariyle ciddi fakat erken müdahaleyle semptomları 3-5 günde gerileyen bir hastalıktır. Biz hastamıza bol sıvı almasını ve yolculuktan bir gün önce oral asetazolamid başlamasını önererek taburcu ettik.

Anahtar Kelimeler: yüksek rakım, akut dağ hastalığı, acil servis

P-1081 Pediatric Emergencies

Mezenterik Lenfadenite Bağlı İnvajinasyon ve Buna Sekonder Gelişen Akut Apendisit: Olgu Sunumu

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Amaç: İnvajinasyon proksimal barsak segmentinin distal segment içerisine teleskopik olarak girmesidir. Bebek ve çocuklarda rektal kanama ve barsak tıkanıklığının en önemli nedenlerindendir. En sık 3-24 ay arası bebeklerde görülmektedir. Klasik invajinasyon da belirgin bir etiyolojik faktör yoktur ve bir çoğu idiyopatik olarak değerlendirilir. Ancak peyer plağı hipertrofisi, mezenter lenfadenit ve rotavirüs gastroenteritinin rolü olduğu sanılmaktadır. Bizde karın ağrısı sebebiyle gelen üç yaşındaki hastanın invajinasyona bağlı apandisit olgusunu burada paylaşmak istedik.

Olgu: Üç yaşında erkek çocuk karın ağrısı bulantı ve kusma şikayeti ile acil servise getirildi. Alınan öyküsünde daha önceden herhangi bir hastalığı olmadığı iki gündür tekrarlayan karın ağrıları olduğu ve son altı saatte ağrının şiddetinin arttığı bula bulantı ve kusmanın eşlik ettiği öğrenildi. Yapılan fizik muayenesinde genel durumu iyi, bilinç açık, oryante, koopere, vital bulguları stabildi. Batin muayenesinde yaygın hassasiyet ve distansiyon mevcuttu. Hastada tahta karın tablosu mevcuttu. Laboratuvar tetkiklerinde WBC: 27.000/mm3, Hb: 12,1g/dl, Plt: 366.000/mm3, CRP:5.34 olarak tesbit edildi diğer tetkikleri normaldi. Direkt karın grafisi normaldi. Oral alımı stoplanan hasta gözetim altına alınarak ultrasonografisi (USG) planlandı. Yapılan USG'de batin sağ alt kadranda distal ileum- çekuma uyan düzeyde yaklaşık 4-5 cm'lik uzanımı olan invajinasyon izlendi. Perikçekal alanda büyüğü 10x18 mm boyutlu birkaç adet lenfadenopati mevcuttu. Yine aynı bölgede invajine segment içerisinden uzanan apendiks uca doğru karın duvarı ödemli olarak tesbit edildi. Ayrıca periapendeküler sıvı ve enflamasyon bulgularında tesbit edildi. Hasta çocuk cerrahisine konsülte edilerek akut batin kliniği ile servise yatırıldı.

Sonuç: İnvajinasyon olgularının çoğu gecikmiş tanı olarak tesbit edilmektedir. klasik kardinal belirti ve bulguları, kusma, karın ağrısı, rektal kanama gibi gastroenterit bulguları olduğu için tanı gecikmekte ve bu da ciddi komplikasyonlara yol açabilmektedir. Direkt karın grafisinde hiçbir bulgu olmayacağı gibi, klasik barsak tıkanıklığında tesbit edilebilecek hava- sıvı seviyeleri görülebilir. Barsak halkalarının barsak ortasında toplanmış olması ve sağ alt kadranda gaz miktarının azalmış olması invajinasyon lehine yorumlanabilecek radyolojik bulgulardır. Deneyimli bir radyoloğun varlığında USG ile invajinasyonun tanınması neredeyse %100 mümkündür. Dolayısıyla karın ağrısı, bulantı, kusma şikayetleri ile gelen özellikle 3-24 ay arasındaki çocuk hastalarda invajinasyon ayırıcı tanısı göz ardı edilmemelidir.

Anahtar Kelimeler: karın ağrısı, invajinasyon, akut apandisit



POSTER PRESENTATIONS

P-1082 Cardiovascular Emergencies

Akut Perikardit: Olgu Sunumu

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Amaç: Perikardit ve perikardiyal efüzyon çocukluk yaş grubunda pek çok değişik sebebe bağlı olarak görülebilir. Etiyolojik faktörlerdeki bu değişiklik tanı yöntemi ve tedavide farklılığa neden olmaktadır. Bazen kendiliğinden düzelen veya çok hafif hemeodinamik değişiklik dışında başka bir bozukluğa yol açmayan bu durum bazı zaman ise perikardiyosentez veya açık cerrahi drenaj gerektiren ciddi hemodinamik bozukluğa neden olabilir. Bizde burada göğüs ağrısı şikayeti ile gelen çocuk hastamızda tespit ettiğimiz akut perikardit olgusunu sizlerle paylaşmak istedik.

Olgu: 15 yaş erkek hasta batıcı vasıflı göğüs ağrısı sebebiyle acil servise başvurdu. Alınan öyküsünde bir hafta öncesinde gribal bir enfeksiyon geçirdiğini ancak hiç ilaç kullanmadığını, iki gündür de şiddetli giderek artan bir göğüs ağrısı olduğu öğrenildi. Fizik muayenesinde genel durumu iyi, bilinç açık, oryante, koopere, vital bulguları stabildi. Çekilen EKG ve akciğer grafisinde göğüs ağrısını açıklayacak herhangi bir patolojiye rastlanmadı. Diğer sistemik muayeneleri doğal, kalpte ek ses ve üfürüm yoktu. Hastanın yapılan laboratuvar tetkiklerinde tam kan tetkiki normal, biyokimyasında CK: 4314U/L, CK-MB: 50 U/L, Troponin-T:414 (yüksek risk >100), CRP: 10,88 mg/dl (0-0,5) olarak tesbit edildi. Hasta acil serviste monitörize edilerek takibe alındı. Dört saat sonra gönderilen kardiyak enzimlerde CK: 4329U/L, CK-MB: 49 U/L, Troponin-T:533 olması üzerine takip amaçlı koroner yoğun bakım ünitesine perikardit ön tanısı ile yatırıldı. Hastanın acil serviste takibi süresince çekilen tekrar EKG'lerinde aktif bir EKG değişikliği tespit edilmedi.

Sonuç: Pediatrik yaş grubunda göğüs ağrılarının çoğu nedeni akciğer kaynaklı olması nedeniyle perikardit vakaları acil servise başvurdıklarında göz ardı ediliyor olabilir. Ancak altta yatan bir yatınlık veya öyküde alarm verici birkaç bulgu tespit edildiği takdirde ayırıcı tanıları içerisinde yer alan bir hastalık olarak aklımızda kalabilir. Hastalığın tanısında göğüs ağrısının tipik göğüs ağrısına benzemez, çoğu vakada EKG 'de herhangi bir patoloji olmaması hastalığın tanısında karşılaştığımız zorluklardandır. Ancak tespit edilmediğinde gelişecek olan komplikasyonların hayatı tehlikeye çok ciddi olması sebebi ile önemlidir. Hayati tehdit edecek komplikasyon gelişmediği sürece semptomatik ve destek tedavi dışında herhangi bir spesifik tedavisi yoktur.

Anahtar Kelimeler: göğüs ağrısı, enzim yüksekliği, perikardit

P-1083 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Antikoagülan Tedavi Altındaki Bir Hastada Gelişen Masif Pulmoner Tromboemboli

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Amaç: ABD'de pulmoner tromboemboli (PE) insidansı 650.000/yıl'dır. Her yıl 200.000'in üzerinde hasta ölmektedir. Bu ölümlerin 1/3'ü ilk 1 saat içinde olur. 16.000'in üzerinde hasta tedaviye rağmen ölmektedir. PE nedeniyle tedavi edilen hastaların mortalite oranı %2-10'dur. Fatal PE lerin %50'den fazlasına tanı otopside konmaktadır. PE eli yaşından önce erkeklerde bayanlardan daha sıkır. PE'lerin çoğunun nedeni tromboembolidir. Pulmoner trombozu nadirdir. Alt ekstremitelerin DVT'si vakaların %10-15'inin sebebidir ve özellikle santral venöz katater ile ilgilidir. PE'nin diğer kaynakları; pelvik ven trombozu, sağ kalp trombozu ve amniotik veya yağ embolisini içerir. Septik embolide görülebilir.

Olgu: ABD'de pulmoner tromboemboli (PE) insidansı 650.000/yıl'dır. Her yıl 200.000'in üzerinde hasta ölmektedir. Bu ölümlerin 1/3'ü ilk 1 saat içinde olur. 16.000'in üzerinde hasta tedaviye rağmen ölmektedir. PE nedeniyle tedavi edilen hastaların mortalite oranı %2-10'dur. Fatal PE lerin %50'den fazlasına tanı otopside konmaktadır. PE eli yaşından önce erkeklerde bayanlardan daha sıkır. PE'lerin çoğunun nedeni tromboembolidir. Pulmoner trombozu nadirdir. Alt ekstremitelerin DVT'si vakaların %10-15'inin sebebidir ve özellikle santral venöz katater ile ilgilidir. PE'nin diğer kaynakları; pelvik ven trombozu, sağ kalp trombozu ve amniotik veya yağ embolisini içerir. Septik embolide görülebilir.

Sonuç: ABD'de pulmoner tromboemboli (PE) insidansı 650.000/yıl'dır. Her yıl 200.000'in üzerinde hasta ölmektedir. Bu ölümlerin 1/3'ü ilk 1 saat içinde olur. 16.000'in üzerinde hasta tedaviye rağmen ölmektedir. PE nedeniyle tedavi edilen hastaların mortalite oranı %2-10'dur. Fatal PE lerin %50'den fazlasına tanı otopside konmaktadır. PE eli yaşından önce erkeklerde bayanlardan daha sıkır. PE'lerin çoğunun nedeni tromboembolidir. Pulmoner trombozu nadirdir. Alt ekstremitelerin DVT'si vakaların %10-15'inin sebebidir ve özellikle santral venöz katater ile ilgilidir. PE'nin diğer kaynakları; pelvik ven trombozu, sağ kalp trombozu ve amniotik veya yağ embolisini içerir. Septik embolide görülebilir. SONUÇ: pulmoner emboli(PE) tanısında klinik şüphe, predispoze faktörlerin farkında olma PE tanısında kullanılan testlerin birlikte yorumlanması gereklidir. Açıklanamayan göğüs ağrısı, dispne veya taşipne varlığında her zaman PE olabileceği düşünülmelidir. Mekanik prostatik kalp kapağı bulunan hastalarda emboli riski çok yüksektir. Uygun antikoagülan tedavi altındaki hastalarda bile bu oran %2-4 civarındadır. Acil servis hekimi antikoagülan tedavi alan hastalarda anemnez ve/veya fizik muayene bulgularının varlığında emboli düşünmeli ve ileri tetkik yöntemlerini kullanarak kesin tanıya ulaşmalıdır.

Anahtar Kelimeler: nefes darlığı, antikoagülasyon, pulmoner emboli

P-1084 Cardiovascular Emergencies

Supraventriküler Taşikardide Adenozin Uygulaması Sonrası Geişen Akut Atrial Fibrilasyon Olgusu

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Amaç: Supraventriküler taşikardi atrioventriküler nodun yukarısından kaynaklanan, ani başlangıçlı olan ve dar QRS kompleksli taşikardilerdir. Ani başlangıçları nedeniyle hastaların ilk başvuru yerleri genellikle acil servislerdir. Taşikardiler spontan, vagal manevralarla, kardiyoversiyonla ya da medikasyon ile geri döndürülebilir. Tedavide kullanılan ilaçlara bağlı olarak Supraventriküler taşikardi sonrası normal sinüs ritmi dışında beklenmeyen ritimlerle de karşılaşılabilir.

Olgu: 21 yaşında erkek hasta çarpıntı ve göğüs ağrısı şikayetleri ile acil servise getirildi. Çarpıntısının yaklaşık 30 dakika önce aniden başladığını ifade eden hastanın özgeçmişinde herhangi bir hastalık yoktu. Vital bulguları ateş: 36,7 C, TA: 172/93 mmHg, Nbz: 157/dk olan hastanın gelişinde çekilen 12 derivasyonlu EKG'sinde Supraventriküler taşikardi saptandı. Hasta monitörize edildi, damar yolu açıldı, oksijenizasyona başlandı. Hastaya vagal manevralar ile müdahale edildi. Vagal manevralar yanıt alınamayan hastaya 6 mg adenozin uygulandı. Taşikardisi düzelmeyen hastaya 12 mg adenozin uygulanması sonrası hastanın atrial fibrilasyona döndü. Hastaya 06 cc Düşük molekül ağırlıklı heparin ve 300 mg amiodaron uygulandı. Geliş EKG'si hızlı ventrikül cevaplı atrial fibrilasyon açısından yeniden gözden geçirildi. İlk ritmin Supraventriküler taşikardi olduğu teyit edilen hasta adenozin sonrası akut atrial fibrilasyon tanısı ile işlem amacıyla koroner yoğun bakımda hospitalize edildi.

Sonuç: Endojen pürin nükleosidi olan adenozin etkisini potasyum kanallarını açarak gösterir. AV nodda iletiyi yavaşlatan adenozinin AV nodu içine alan taşikardilerin sonlandırılmasındaki etkisi oldukça yüksektir. Hastaların %96'sında normal sinüs ritmi sağlanırken, aksesuar yolu antegrad kullanan taşikardilerde etkisiz kalır. Adenozin uygulanması sonrası akut atrial fibrilasyon ise bilindiği kadarıyla literatürde bildirilmemiştir. Adenozine bağlı bu etki bilinmeli, bu hastalara antitrombotik uygulanması sonrası kardiyoloji konsültasyonu planlanmalıdır.

Anahtar Kelimeler: supraventriküler taşikardi, adenozin, atrial fibrilasyon

P-1085 Internal Medicine Emergencies (Neurology, Infection, Chest, Internal Medicine etc.)

Tek Doz Parasetamol Kullanımına Bağlı Gelişen Anafaksi Olgusu

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Amaç: İlaç alerjileri birçok ilaca bağlı olarak oluşabilen, kişinin atopik olmasının çok önemli olmadığı reaksiyonlardır. Basit ürtiker ve anjioödem gibi klinik tablolarla birlikte, anafaksi gibi mortalitesi yüksek reaksiyonlar da görülebilir. Alerjen genellikle IV uygulanan bir ilaç iken duyarlı kişilerde ilaçların oral alınması da anafaksiye neden olabilir. Burada tek doz parasetamol kullanımı sonrası başlayan anafaksi olgusu sunuldu.

Olgu: 42 yaşında bayan hasta nefes darlığı, çarpıntı ve fenalık hissi şikayeti ile acil servise başvurdu. Asetil salisilik asit alerjisi olduğu öğrenilen hasta, tonsillit nedeni ile 10 saat önce amoksisilin klavunat tablet aldığı 1 saat önce de 500mg parasetamol tablet kullandıktan sonra şikayetlerinin başladığını ifade etti. Vital bulguları: TA: 100/60 Nbz:130/dk, ateş:36 C, SatO2:%83 olan hastanın solunum güçlüğü dikkat çekmekteydi. Fizik muayenesinde her iki akciğerde yaygın ronküsleri olan hastaya 0,5 mg adrenalin subkutan uygulanmasını takiben 45.5mg intravenöz

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(İV) pheniramine hidrojen maleat ve 80 mg prednizolon intravenöz olarak uygulandı. Şikâyetleri gerileyen hastaya entübasyon düşünülmeydi. 24 saat gözlemde tutulan hasta önerilerle taburcu edildi.

Sonuç: Parasetamol günlük pratikte en sık kullanılan analjezik ve antipiretiklerdendir. Hekimler tarafından sıkça reçete edilmesinin yanında ucuz ve erişiminin kolaylığı nedeni ile hastalar tarafından sıkça kullanılmaktadır. Genel olarak yan etkileri az bir ilaç olarak bilinse de, olgumuzda olduğu gibi tek dozu ile birlikte dahi anafaksi gelişebileceği unutulmamalıdır.

Anahtar Kelimeler: Anafaksi, Parasetamol, Adrenalin

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Duman, E.
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Emet, M.
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Erbay, A.
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Erdem, A. B.
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Erdoğan, M. Ö.

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