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12TH INTERCONTINENTAL EMERGENCY MEDICINE CONGRESS
&
12TH INTERNATIONAL CRITICAL CARE AND EMERGENCY MEDICINE CONGRESS

IN CONJUNCTION WITH

21TH NATIONAL EMERGENCY MEDICINE CONGRESS
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ABSTRACT BOOK

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ORAL PRESENTATIONS

Ref No: 1005

More Than Meets the Eye: Isolated Right Eye Blurred Vision Unveils a Subdural Hematoma

Elif Yaren Ayvaz[1], Bahadir Taslidere[1], Basar Cander[1]

[1]Bezmialem Vakif University

Introduction and Purpose: Subdural hematoma commonly presents with symptoms such as headache, altered consciousness, hemiplegia, gait disturbances, and aphasia; however, visual impairment can also be a presenting feature. Vision loss in patients with subdural haematomas is often characterized by homonymous hemianopias, usually caused by posterior cerebral artery compression during transtentorial herniation. However our patient had blurred vision only in his right eye.

Materials and Methods: Our case is a 50-year-old male patient who was diagnosed with hypertension 1 month before applying to us. He went to the ophthalmology clinic with blurred vision in his right eye and was referred to the neurology clinic due to bilateral papilledema. After 1 day later, he was referred to the emergency department for neurosurgery consultation after a subdural hematoma was seen in the MRI taken in the neurology clinic. The patient only had blurred vision in his right eye. He had no headache, dizziness or other neurological complaints. His neurological examination was normal. In the brain CT taken in the emergency department, a subacute period subdural hematoma measuring 16 mm at its widest point in the right frontoparietal region was observed. Shift is seen in the middle substructures. In the MRI report, there were also T2AG hyperintense signal increases compatible with SAH in the sulci in the right frontoparietal region. The patient was consulted to the neurosurgery. Emergency surgery was not considered for the patient and hospitalization was recommended for further examination and treatment. The patient who refused to be hospitalized refused treatment and left. The patient who underwent surgery at an external center had his hematoma drained. In the eye clinic control performed 1.5 months after the operation, it was observed that the disc edema had passed. The control MRI was normal.

Figure 1. Subdural hematoma

Results and Conclusion: Posterior lesions can manifest with anterior signs; for instance, three patients with occipital infarcts exhibited optic atrophy. Two of them initially presented with disc edema. Necropsy findings have demonstrated that transtentorial herniation may cause injury to the optic tract, optic chiasm, or optic nerves. Therefore, SDH should be considered as a potential cause in the differential diagnosis of patients experiencing visual deficits.

Keywords: Subdural hematoma, Blurred Vision, Emergency

Ref No: 1038

Hiccups and Heart Attacks: An Atypical Presentation of Myocardial Infarction

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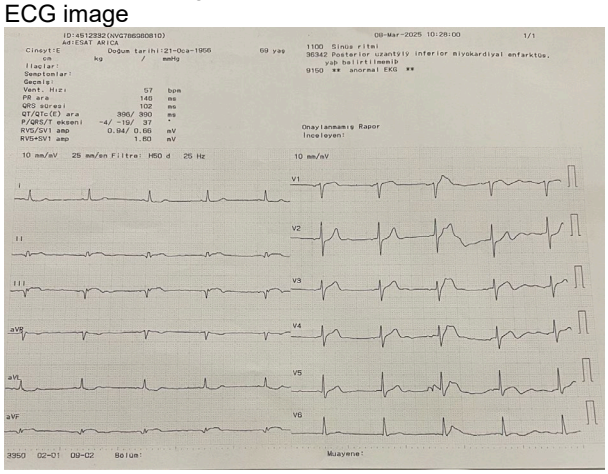
Introduction and Purpose: Acute myocardial infarction is a clinical condition that is frequently seen in the emergency department, can be accompanied by serious mortality and morbidity, and can present with different clinical presentations. Myocardial infarction typically presents with complaints of pain, burning sensation, and numbness in the arms, but it can also present with symptoms that we experience frequently in our daily lives, such as weakness, feeling unwell and hiccups.

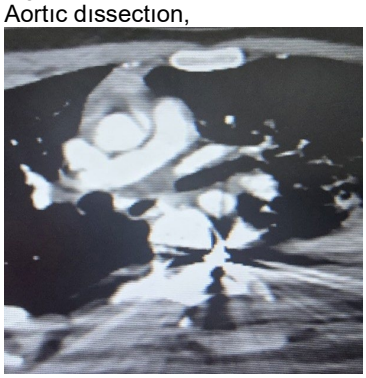
Materials and Methods: A 69-year-old male patient applied to our emergency department with hiccups that have not gone away for 3-4 days. He states that he has made repeated applications to external health institutions with the same complaint, but no tests were taken, he was injected, and his complaint did not go away. He states that the patient has known DM and HT and has no other complaints other than hiccups. An ECG is taken for the patient with suspicion of Acute Coronary Syndrome and blood is taken from the patient for testing. The patient's ECG is compatible with subacute inferior MI and the troponin value is 1159 ng/L (0-14). Inferior septum was found to be severely hypokinetic in echocardiography. Thereupon, the patient is consulted to the cardiology department, hospitalization is given and

treatment is arranged.
ECG image



Results and Conclusion: Emergency departments are chaotic and busy places where many patients are seen. For this reason, we may not care about the symptoms that are encountered very frequently and that we experience in our daily lives. However, especially in elderly patients and patients with a history of chronic diseases, we should pay attention to the symptoms that persist and do not go away, even if they are simple symptoms. Because there may be a life-threatening disease underneath.
Keywords: hiccups, myocardial infarction

Ref No: 1039
Aortic Dissection in Pellet Injury
SEVGİ YUMRUTEPE[1], RAMAZAN AVCU[1]
[1]Malatya Training and Research Hospital, Emergency Department
Introduction and Purpose: IntroductionAortic injury is one of the most critical vascular injuries with life-threatening consequences. It may occur non-traumatically due to underlying conditions such as Marfan syndrome, aortic aneurysm, or hypertension. Alternatively, it can result from traumatic causes, including gunshot wounds, stabbing injuries, or traffic accidents. While many aortic injuries can be detected through diagnostic imaging, some are only identified intraoperatively and treated during surgery.
Materials and Methods: A 16-year-old patient was brought to the emergency department following a gunshot wound. Upon external examination, multiple pellet injuries were observed on the left shoulder and the left side of the neck. Upon arrival, the patient's blood pressure was 60/30 mmHg, and oxygen saturation was approximately 70%. Due to worsening respiratory distress, the patient was electively intubated.Contrast-enhanced computed tomography angiography revealed pneumothorax and hemothorax in the left lung, as well as an aortic dissection at the T4 level, located behind the aorta and in front of the T4 vertebra. The patient was transferred to a higher-level medical center, where emergency surgery was performed.
Aortıc dıssectıon,



Results and Conclusion: In cases of multiple gunshot wounds, pellets or bullet fragments can cause severe injuries to vital organs. When such injuries occur, immediate stabilization of the patient's airway and vital functions is essential before planning and performing the necessary surgical interventionsPellet-induced gunshot wounds can result in injuries that may be overlooked during initial assessments. Therefore, a comprehensive evaluation is crucial. The location of the pellet fragments should be determined using detailed imaging, as they can cause damage along their trajectory. A full-body X-ray should be performed first, followed by an assessment of the distance between the entry point and the current location of the pellet. Additional screening tests should be conducted based on these findings. Even a single undetected injury can be fatal.It is important to remember that a pellet entering through the shoulder, neck, or upper thorax can cause injuries to the heart, thorax, aorta, and abdomen. Therefore, imaging and examination should be conducted over a wide area to ensure no critical injury is missed.
Keywords: Aortıc dıssectıon, gunshot wounds, pellet injuries

Ref No: 1053

Investigation of micro RNA Levels as an Indicator of Potential Fatal Causes in Patients Presenting to the Emergency Department with Chest Pain

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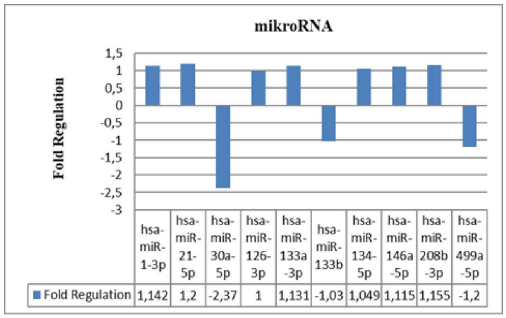
Introduction and Purpose: Chest pain is one of the most common reasons for presentation to emergency departments. Patients presenting with chest pain should be diagnosed early in the emergency department and their prognosis should be determined. Recent studies have suggested that microRNAs may regulate gene expression and play a critical role in various pathophysiological processes. Studies have shown that the levels of several miRNAs in blood and/or plasma are altered during acute coronary syndromes, pulmonary embolism, aortic dissection. This suggests that circulating miRNAs released or derived in pathological processes may be a biomarker for early diagnosis. In our study, we investigated whether the expression levels of hsa-miR-1-3p, hsa-miR-133a-3p, hsa-miR-133b, hsa-miR-146a-5p, hsa-miR-208b-3p, hsa-miR-21-5p, hsa-miR-134-5p, hsa-miR-30a-5p, hsa-miR-126-3p, hsa-miR-499a-5p could be an indicator of ACS.

Materials and Methods: Within the scope of the study, 50 people between the ages of 38-89 years who presented to Selçuk University Faculty of Medicine, Department of Emergency Medicine with complaints of chest pain were selected as the patient group and 19 healthy volunteers without complaints of chest pain were selected as the control group. In the patient group included in the study, the final diagnosis of 20 patients was STEMI and the final diagnosis of 30 patients was NSTEMI. Target miRNA expressions of microRNA-containing total RNA isolated from the plasma of whole blood samples of these individuals were studied with a high-capacity real-time PCR device.

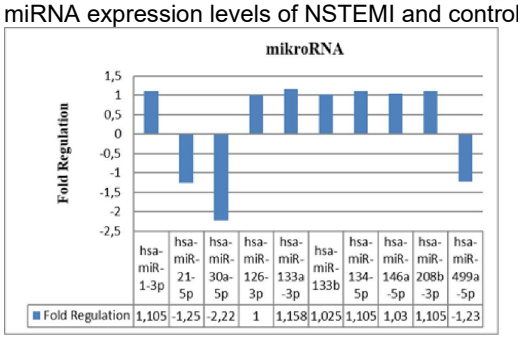
Results and Conclusion: The decrease in the expression level of miR-30a-5p in the STEMI patient group compared to the control group was statistically significant with a fold regulation value of -2.37 ($p<0.05$). No significant difference was found in the NSTEMI patient group compared to the control group and between STEMI and NSTEMI patient groups in terms of changes in the expression levels of the miRNAs studied ($p>0.05$).We think that miR-30a-5p can be used as an ideal biomarker in the diagnosis of STEMI, the other miRNAs studied are not suitable biomarkers for the identification of STEMI and NSTEMI patients and will not provide any additional benefit to the existing diagnostic methods. Our study will be helpful in determining the miRNAs to be selected in future studies and in interpreting the study results.

miRNA expression levels of STEMI and control groups



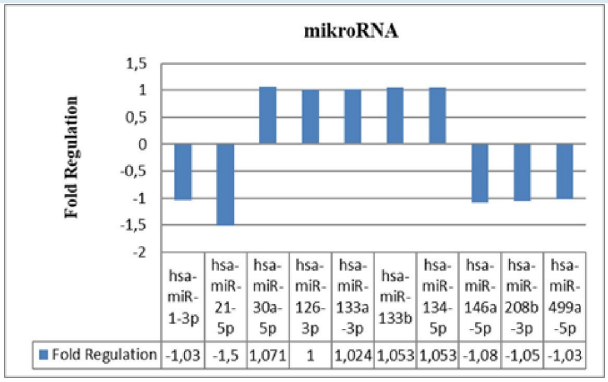
	hsa-miR-1-3p	hsa-miR-21-5p	hsa-miR-30a-5p	hsa-miR-126-3p	hsa-miR-133a-3p	hsa-miR-133b	hsa-miR-134-5p	hsa-miR-146a-5p	hsa-miR-208b-3p	hsa-miR-499a-5p
Fold Regulation	1,142	1,2	-2,37	1	1,131	-1,03	1,049	1,115	1,155	-1,2

miRNA expression levels of NSTEMI and control groups



	hsa-miR-1-3p	hsa-miR-21-5p	hsa-miR-30a-5p	hsa-miR-126-3p	hsa-miR-133a-3p	hsa-miR-133b	hsa-miR-134-5p	hsa-miR-146a-5p	hsa-miR-208b-3p	hsa-miR-499a-5p
Fold Regulation	1,105	-1,25	-2,22	1	1,158	1,025	1,105	1,03	1,105	-1,23

miRNA expression levels of STEMI and NSTEMI groups



Keywords: Acute coronary syndrome, chest pain, microRNA

Ref No: 1088

Pulmonary Embolism with Negative D-dimer: A Case Report

YUNUS SAHIN[1], IBRAHIM DILEKCAN[1], HASIP KIZILAY[1], NESLIHAN YARKIN[1]
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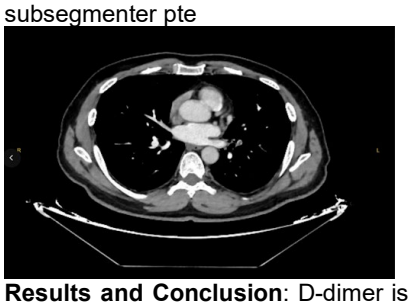
Introduction and Purpose: Pulmonary embolism (PE) is a serious clinical condition caused by obstruction of the pulmonary arteries, most commonly due to thrombosis originating from deep veins of the lower extremities. PE accounts for approximately 5–10% of in-hospital deaths and is often a preventable cause of mortality. The diagnostic process typically includes clinical probability assessment, D-dimer testing, and imaging studies. D-dimer, a fibrin degradation product, is frequently used due to its high sensitivity and ability to exclude PE in low-to-intermediate risk patients. However, its specificity is low, and under certain clinical circumstances, false-negative results may occur

Materials and Methods: A 51-year-old male with a known history of hypertension applied to the emergency department with sudden-onset pain in the left shoulder, back, and flank. He doesn't have symptoms such as; cough, sputum production, chest pain, dyspnea, or hemoptysis. He was a non-smoker and had no prior history of deep vein thrombosis (DVT) or PE. However, he had traveled long distances several times in the past month, and his family history was notable for varicose veins.On physical examination, the patient was alert, cooperative, and oriented. . Troponin and D-dimer levels were within normal limits. Despite the negative D-dimer result, computed tomography pulmonary angiography (CTPA) was performed due to persistent clinical suspicion. CTPA consistent with acute PE.The patient started on low-molecular-weight heparin (LMWH) .
subsegmenter pte



Results and Conclusion: D-dimer is widely used to rule out PE in patients with low or intermediate clinical probability. False-negative D-dimer results have been associated with small, subsegmental emboli, delayed testing, prior anticoagulant therapy, impaired fibrinolytic activity, and assay variability.In a case , a woman using oral contraceptives presented with PE despite a D-dimer level <200 ng/mL.. Therefore, in cases of high clinical suspicion, imaging studies such as CTPA should not be withheld solely based on a negative D-dimer result. In this case, early imaging led to timely diagnosis and management, potentially preventing fatal complications.PE remains a diagnostic challenge in emergency medicine due to its variable presentation. While D-dimer is a valuable tool in the diagnostic algorithm, it should not be used in isolation, especially in high-risk patients.

Keywords: negative d dimer

Ref No: 1105

A syndrome that significantly affects quality of life and causes dysphagia: wallenberg syndrome

Mustafa Polat[1], Hakan Ateş[1], Mustafa Selçuk Solak[1], Muhammet Gökhan Turtay[1], Mehmet Gül[1]
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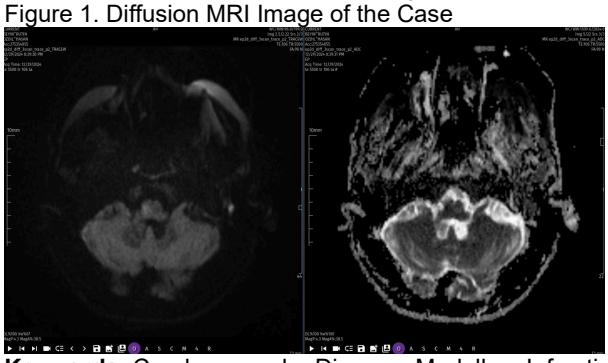
Introduction and Purpose: Wallenberg syndrome (lateral medullary syndrome) is one of the most well-known brainstem stroke syndromes. Since brainstem infarcts are not well visualized on computed tomography (CT), magnetic resonance imaging (MRI) plays a crucial role in diagnosis. The clinical presentation of Wallenberg syndrome varies depending on the specific region of the brainstem affected by the infarct. This case report aims to contribute to the literature by presenting an 84-year-old patient whose initial symptom was dysphagia, ultimately leading to a diagnosis of Wallenberg syndrome.

Materials and Methods: An 84-year-old male patient presented to an external emergency department with difficulty swallowing and was subsequently referred to our center. The patient had congenital speech and hearing impairment. Neurological examination revealed that

he was oriented, cooperative, and fully conscious, but dysphagia was evident. Upon standing, he exhibited imbalance, though no nystagmus was observed. Muscle strength was bilaterally 5/5, and other systemic examinations were unremarkable. Brain imaging showed no acute pathology on CT. However, diffusion-weighted MRI revealed an area in the brainstem consistent with acute infarction. Laboratory tests were unremarkable. The patient was consulted by the Neurology Department and subsequently admitted to the Neurology Ward with a preliminary diagnosis of Wallenberg syndrome.

Results and Conclusion: Dorsolateral medullary ischemic infarction is a complex syndrome that often presents with signs suggestive of central vestibular pathology on audiovestibular evaluation. A comprehensive neurological, otological, audiological, and vestibular assessment is crucial for accurate diagnosis and treatment.

Figure 1. Diffusion MRI Image of the Case



Keywords: Cerebrovascular Disease, Medullary Infarction, Stroke

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Ref No: 1143

Emergency Approach To Aortic Dissection

Yasin Bülbüloğlu[1], Mehmet Soyugüzel[2], Şerife Özdinç[2]

[1]SANLIURFA BALIKLIGOL STATE HOSPITAL

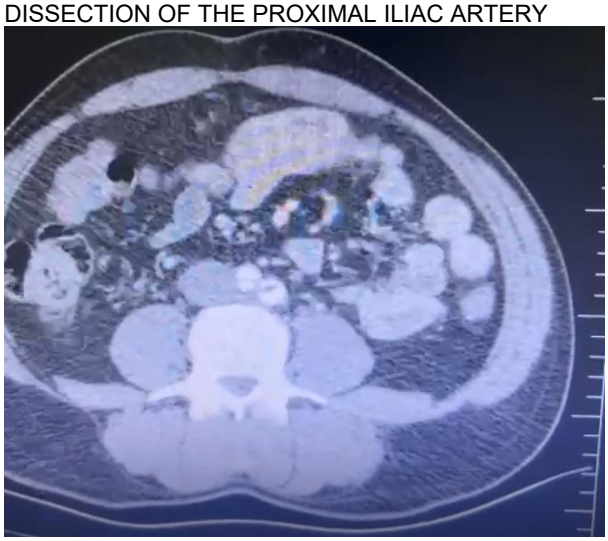
[2]Department of Emergency Medicine, Afyonkarahisar Health Sciences University

Introduction and Purpose: Emergency approach to aortic dissection. A 48-year-old male patient with no comorbidities or history of surgery presented to the emergency department with back pain that started after dinner and left flank pain that started later.

Materials and Methods: Vital Signs:Blood pressure: Left: 135/95 mmHg, Right: 125/80 mmHgPulse: 75 beats/minuteRespiratory rate: 22 breaths/minuteTemperature: 36.5 °CSpO2: 95% (without oxygen support)Physical Examination:GCS (Glasgow Coma Scale): 15Left flank abdominal pain present.CVA tenderness (+) (Costovertebral Angle tenderness positive).Extremity movements normal, no numbness.Bilateral femoral pulses palpable.Findings:Abdominal CT Angiography revealed dissection extending from the aortic arch to the abdominal aorta and proximal to both common iliac arteries.

DISSECTION OF AORTIC ARCUS

DISSECTION OF THE PROXIMAL ILIAC ARTERY



Results and Conclusion: The patient, diagnosed with acute aortic dissection, stated that his pain had subsided and expressed his desire to leave the emergency department during follow-up. The severity of the patient's condition was reiterated, and he was urgently transferred via ambulance (112) to a center with an on-call Cardiovascular Surgery doctor for emergency surgery.
Keywords: Acute, dissection, iliac artery

Ref No: 1162
Managing epistaxis in the emergency department: do laboratory tests add clinical value?
Seyyid Rasim Yanmaz[1]
[1]**Nigde training and research hospital**
Introduction and Purpose: Patients who applied to the emergency department of a tertiary hospital with epistaxis were evaluated in this study in terms of etiological, clinical and demographical characteristics. Our aim is to determine the value of routine laboratory tests in enlightening the etiology of epistaxis.
Materials and Methods: Between 10.01.2024 – 12.31.2025, above 18 years old patients who were diagnosed with epistaxis in the emergency room were retrospectively reviewed from patient charts. Traumatic epistaxis cases were not included in the study. Patients were analyzed in terms of age, sex, vital parameters and blood tests.
Results and Conclusion: Between the specified dates, 82 patients applied to the Emergency Department. Two patients whose epicrisis reports were not complete, 26 patients who did not have a blood test when they applied to the emergency department, and 1 patient whose outcome information could not be obtained were excluded from the study. A total of 55 patients were included in the study. The study consisted of 55 patients (17 male, 38 female) and the median age was 70 (18 -95). Two of the patients (3.6%) were using coumadin and 35 (63.6%) of them had ongoing epistaxis when they applied to the hospital. Median systolic blood pressure was 120 (90-190), while median diastolic pressure was 75(40-120). A statistically significant difference was found between alanin aminotransferaz and glucose levels of cases with and without epistaxis (p=0.038, p=0.025).Conclusion: This study analyzed the clinical and laboratory data of 55 patients diagnosed with epistaxis in the emergency department. The majority were female (69.1%), with a median age of 70 years. The findings suggest that epistaxis is more common in the elderly, possibly due to vascular fragility and comorbidities like hypertension.A significant difference was observed in alanine aminotransferase (ALT) and glucose levels between patients with and without epistaxis (p=0.038, p=0.025), suggesting potential links with liver function and metabolic factors.Although limited by its retrospective design and small sample size, this study highlights key clinical characteristics. Future prospective studies are needed to better understand epistaxis risk factors and improve management strategies.
Table 1.

Gender	Male	38 (69.1%)
	Female	17 (30.9%)
Coumadin usage	Yes	2 (3.6%)
	No	53 (96.4%)
Active Bleeding	Yes	35 (63.6%)
	No	20 (36.4%)

General information of the patients at the emergency department examination
Table 2.

	Mean (±SD)	Median (Min-Max)
Age		70 (18-95)
Glucose		136 (79-343)
Neutrophyl		6.3 (2-12.86)
Lymphocyte		1.35 (0.18-3.97)
Albumin	23.81±3.76	
Platelet		229 (41-660)
INR		1.15 (0.84-6.82)
Hemoglobin		9.9 (7.1-16.4)
CRP		12.5 (0.4-300.6)
Creatinine		1.01 (0.49-5.7)
Urea		71 (22-245)
AST		17 (7-210)
ALT		13 (3-181)
Systolic blood pressure		120 (90-190)
Diastolic blood pressure		75 (40-120)

SD: Standart deviation, Min: Minimum, Max: Maximum

Age and laboratory parameters of patients
Keywords: epistaxis, emergency department, blood parameters

Ref No: 1195
A Case Report of Spontaneous Pneumomediastinum From an Unusual Cause: Turbulence in the Pilot's Lungs
Mustafa Temel[1], Ahmet Melih Savaş[1], Ayhan Aköz[1]
[1]Aydın Adnan Menderes University, Faculty of Medicine, Department of Emergency Medicine
Introduction and Purpose: Spontaneous pneumomediastinum (SPM) usually occurs during activities that increase intrathoracic pressure, such as severe coughing or vomiting, intense physical activity, labor, or the Valsalva maneuver. Physical examination reveals subcutaneous emphysema, hoarse voice, tachycardia, tachypnea, and a crackling sound on cardiac auscultation known as Hamman's sign. This article discusses the diagnosis, early diagnosis and management of SPM in a pilot who presented with dyspnea and cough and had experienced a turbulent flight 2 days earlier.
Materials and Methods: A 30-year-old male patient applied to the ED with complaints of chest pain, shortness of breath, runny nose and sore throat that had been increasing in the last 24 hours. He states that they experienced a sudden loss of altitude due to turbulence on their last flight and that he felt pressure in his chest during this time, and that this pain increased with coughing. His respiratory rate was 24/min (superficial and rapid), oxygen saturation was 92% (room air). Physical examination revealed mediastinal crackling on auscultation (Hamman's sign) and neck crepitation on deep palpation.Among the etiologic factors here, cough due to upper respiratory tract infection and high-altitude exposure were considered. The patient's feeling of chest pressure and aggravation of cough after the turbulence during the flight supported this diagnosis. In the treatment, ceftriaxone 2 gr IV, salbutamol and budesonid as nebules, 80 mg prednisolone IV and pantoprazole 40 mg IV was given.
CT scan image of pneumomediastiunm

CT scan image of pneumomediastiunm

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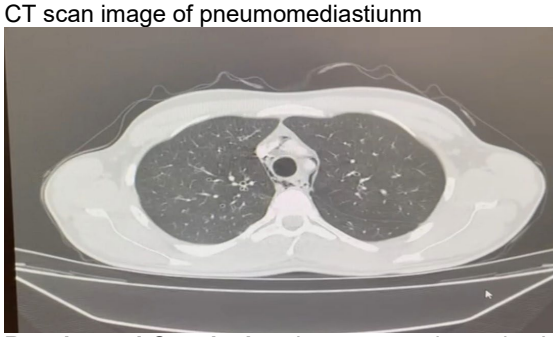

Results and Conclusion: In our case, the patient's severe cough and history of high altitude may have triggered the Macklin effect and led to the development of SPM. In our case, the most important physical examination finding was Hamman's sign and the definitive diagnosis was made by thoracic CT, which is considered the gold standard in the literature. After treatment in the emergency department, the patient was consulted to thoracic surgery and hospitalized in the thoracic surgery service for follow-up and treatment. His complaints regressed during his 2-day stay in the thoracic surgery ward. The patient was then discharged for further follow-up.

Keywords: Spontaneous Pneumomediastinum, Hamman's Sign, Subcutaneous Emphysema

Ref No: 1285

Relationship between red cell distribution width (RDW)/lymphocyte ratio and SYNTAX score in patients with ST segment elevation myocardial infarction

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Introduction and Purpose: Coronary artery disease (CAD) is a common reason for emergency visits, linked to atherosclerosis and increased inflammation. Investigating inflammatory markers and hematological parameters is of clinical interest. This study examines the relationship between the red cell distribution width-to-lymphocyte ratio (RLR) and the anatomical severity of coronary lesions in ST-segment elevation myocardial infarction (STEMI) patients using the SYNTAX score. Additionally, it evaluates parameters associated with SYNTAX scores and patient outcomes.

Materials and Methods: STEMI patients undergoing percutaneous coronary intervention (PCI) between January 2022 and October 2023 were included. Patients with conditions affecting hematological parameters were excluded. Demographics, comorbidities, and laboratory results at admission and within 24 hours post-PCI were recorded. SYNTAX scores were calculated from coronary angiographic images. Post-PCI left ventricular ejection fraction (LVEF), reperfusion status, and need for coronary artery bypass grafting (CABG) were noted.

Results and Conclusion: ResultsA total of 297 patients were included. Reperfusion was achieved in 276 (92.9%), and 27 (9.0%) required CABG. The mean post-PCI LVEF was 43.7 ± 11.3. Based on SYNTAX scores, 208 (70%) were in the low group, and 89 (30%) were in the moderate-high group. No significant differences were found in demographics, risk factors, or baseline laboratory values. However, post-PCI LVEF ($p < 0.001$) and reperfusion rates ($p = 0.001$) were higher in the low SYNTAX group, while CABG was more frequent in the moderate-high group ($p < 0.001$). No correlation was found between admission laboratory values and SYNTAX scores. However, post-PCI RLR ($p = 0.032$) and neutrophil-to-lymphocyte ratio (NLR) ($p = 0.004$) correlated with SYNTAX scores.ConclusionAdmission RLR showed no correlation with SYNTAX scores in STEMI patients. However, post-PCI RLR and NLR were significantly higher in the moderate-high SYNTAX group. Post-PCI LVEF and reperfusion success were greater in the low SYNTAX group, while CABG was more frequently recommended for patients in the moderate-high group.

Keywords: STEMI, RDW, Lymphocyte

Ref No: 1350

Laboratory Predictors of Hospitalization Outcomes in Patients Admitted with Pneumonia: A Focus on ICU Need and Mortality

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Introduction and Purpose: Pneumonia remains one of the leading causes of hospital admissions and mortality worldwide. Identifying clinical and laboratory predictors of hospitalization outcomes is crucial for effective management. This study aimed to identify the predictors of hospital stay length, the need for intensive care unit (ICU) admission, and in-hospital mortality among patients admitted due to pneumonia.

Materials and Methods: A cross-sectional study was conducted. The study included patients aged 18 years and older who were admitted to the emergency department between February 15, 2024, and February 15, 2025, with a diagnosis of pneumonia. Multivariate regression analyses were performed to assess predictive factors, including gender, comorbid conditions, and laboratory test results (e.g., urea, creatinine, sodium, WBC, neutrophils, lymphocytes, immature granulocytes, etc.).

Results and Conclusion: Among the 172 patients included in the study, 61.6% were male, with a median age of 77.5 years. ICU admission was required in 40.7% of patients, and the in-hospital mortality rate was 11%. The length of hospital stay and ICU stay were significantly longer in non-survivors (14 days [3.5-31.0] vs. 6 days[4.0-10.0], $p = 0.042$; and median ICU stay 14 [2.5-30.0] vs. 0 [0.0-3.0] days, $p < 0.001$, respectively). Serum sodium (Na) and urea levels are significant independent predictors of ICU admission. Sodium was the most prominent factor ($p = 0.011$), followed by urea with ($p = 0.026$). Although lower albumin levels were associated with increased in-hospital mortality ($p = 0.022$), albumin was not a significant predictor of ICU need in the regression model ($p = 0.203$). Other variables such as age, creatinine, and monocyte count did not show significant associations with ICU admission. Serum sodium also demonstrated fair discriminative ability in ROC analysis (AUC = 0.617, $p = 0.004$), supporting its role as a potential early marker for ICU requirement.This study found a significant relationship between sodium and urea levels and the requirement for ICU admission. However, the study was conducted on a limited number of patients, and more comprehensive research is needed to ensure the reliability and generalizability of the results.

Keywords: Pneumonia, Prognosis, Critical care

Ref No: 1355

Analysis of the Demographic Characteristics, Injured Body Regions, and Patient Management of Patients Admitted to the Emergency Department Due to Work Accidents

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[1]ERZURUM ŞEHİR HASTENESİ

Introduction and Purpose: IntroductionA work accident is an incident that occurs while a worker is at the workplace or carrying out work-related tasks assigned by the employer, resulting in immediate or delayed physical or mental disability (1)

Materials and Methods: In our study, patients admitted to the Emergency Medicine Clinic of Erzurum City Hospital due to work accidents between January 1, 2022, and January 1, 2023, were retrospectively reviewed through the hospital information management system. A total of 448 patients over the age of 12 who were admitted throughout 2022 were included. In addition to demographic information such as age and gender, data regarding the month of injury, type of injury, injured body region, and patient consultation and hospitalization procedures were examined.
Results and Conclusion: According to our findings, 90% of the patients were male, and 10% were female. The overall mean age of the included patients was 33.3 years. The mean age was 32.3 years for females and 33.5 years for males. Additionally, 8 (1.7%) of the patients included in the study were over 60 years old. The relationship between trauma type, gender, and age is summarized in Table 1.The most common trauma type among our patients was falls (28%), followed by penetrating injuries (21%). Other trauma types included falling objects (16%), blunt trauma (12%), and crush injuries (7.5%). Among our patients, 161 (35.9%) had upper extremity injuries. The injured body regions are shown in Table 2. The distribution of work accidents by month is presented in Table 3.Among the patients, 432 (96.5%) were discharged from the emergency department, while 16 (3.5%) required hospitalization. The majority of hospitalizations were in the orthopedics and traumatology department (10 patients, 2.2%), followed by neurosurgery (3 patients, 0.6%) and ophthalmology (2 patients, 0.4%). No patients died during follow-up. Patient discharge and hospitalization details are shown in Table 4.In the majority of injuries related to occupational accidents, patients sought treatment in the Emergency Department, and most of these patients were from the younger age group. The most common injury location was the extremities, particularly the upper extremities, and most of these injuries were treated in the Emergency Department.
Keywords: WORK ACCİDENT, EMERGENCY, Demographic

Ref No: 1366
Chorea Following Hyperglycemia
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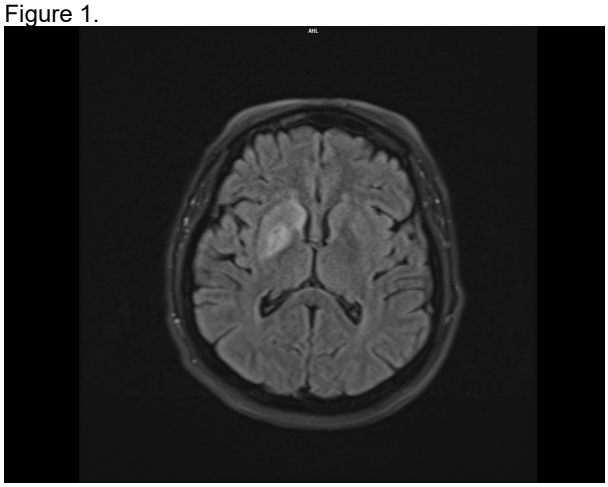
Introduction and Purpose: Hemiballismus-hemichorea is a rare movement disorder often associated with lesions in the basal ganglia or subthalamic nucleus. Hyperglycemia due to diabetes can cause choreiform and ballismus-type movements, particularly characterized by changes in the basal ganglia on magnetic resonance imaging (MRI). This condition is referred to as Hyperglycemia-Induced Hemiballismus-Hemichorea(HIHH)(1). It is known that the clinical presentation and radiological findings in HIHH patients can fully or partially reverse when blood glucose levels return to the normal range(2). This case report presents a patient who developed hemiballismus-hemichorea triggered by hyperglycemia.
Materials and Methods: A 53-year-old female patient presented to the emergency department with involuntary movements in her left upper and lower extremities and choreiform movements on one side of her face. Her medical history included hypertension and type 2 diabetes. The patient also had hypoesthesia on the left side of her face. Her speech rate had slowed, but no dysarthria or aphasia was detected.At admission, her blood glucose level was measured at 496.6 mg/dL, and her HbA1c was found to be 16%. Other blood tests were within normal limits. Urinalysis revealed glucosuria. A cranial CT scan showed no pathology. Contrast-enhanced brain MRI revealed signal changes at the level of the right basal ganglia, specifically in the right caudate nucleus and putamen, which were considered to be associated with hyperglycemia(Figure 1). The patient was admitted to the neurology ward. Treatment was initiated to regulate blood glucose and control the involuntary movements. The choreiform movements regressed by approximately 80%. Her blood glucose levels stabilized, and she was discharged.
Figure 1.



Increased signal in the basal ganglia on the right
Results and Conclusion: In the pathophysiology of HIHH, metabolic dysfunction in the basal ganglia due to hyperglycemia is believed to play a role. Studies have reported an association between high blood glucose levels and MRI changes in the basal ganglia (3). Early glycemic control is considered important for the improvement of clinical symptoms(4). Additionally, in patients diagnosed with HIHH, involuntary movements have been shown to be controlled with the use of neuroleptics and antiepileptic medications(5). In conclusion, in diabetic patients presenting with sudden-onset movement disorders, the possibility of HIHH should be considered, and appropriate

treatment should be initiated.
Keywords: Hyperglycemia, Hemiballismus-hemichorea, neurology

Ref No: 1397
A Rare Case: Empagliflozin Associated Euglycemic Diabetic Ketoacidosis Masked by Pneumonia
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Introduction and Purpose: Diabetic ketoacidosis (DKA) is an endocrine emergency caused by insulin deficiency, characterized by hyperglycemia, ketosis, and metabolic acidosis. Euglycemic DKA (euDKA), first described in 1973, occurs with normal or mildly elevated glucose levels. Although sodium-glucose cotransporter-2 (SGLT-2) inhibitors offer cardiovascular and renal benefits, they may increase DKA risk, primarily leading to euDKA. This report presents a case of euDKA following COVID-19 pneumonia in a patient using an SGLT-2 inhibitor, with a literature review.
Materials and Methods: A 50-year-old male submitted to the emergency department on November 22, 2022, with nausea, fatigue, sputum production with coughing, and dyspnea. He also reported mild abdominal pain. Four days earlier, his SARS-CoV-2 PCR test was possitive and chest CT confirmed COVID-19 pneumonia. His medical history included diabetes, hypertension, hyperlipidemia and depression. His medications included metformin, vildagliptin, empagliflozin, rosuvastatin, venlafaxine, and risperidone. On his physical examination, hypoxemia and tachypnea were detected. Venous blood gas showed pH 7.21, bicarbonate 13 mmol/L, and anion gap 22 mEq/L, with urine ketones 80 mg/dL. Pulmonary embolism was ruled out. Fluid resuscitation, insulin, and potassium replacement were initiated, and empagliflozin was discontinued. The increased anion gap suggested of infection or euDKA which likely triggered by SGLT-2 inhibitors. Metabolic acidosis regressed with fluid resuscitation and insulin therapy, supporting this diagnosis. After endocrinology consultation, the patient was transferred to intensive care.
Results and Conclusion: SGLT-2 inhibitors, usually though second-line therapy for type 2 diabetes mellitus, in some cases used first-line. By lowering the renal glucose clearance threshold, we can not exclude DKA even with normal or mildly elevated glucose. Patients on SGLT-2 inhibitors, especially euglycemic ones, should be evaluated for euDKA. Peters et al. reported 13 cases of DKA with canagliflozin, many presenting with mild hyperglycemia or normoglycemia. In COVID-19, SGLT-2 inhibitors should be discontinued due to dehydration and metabolic risks. Patients using these agents who present with abdominal pain, nausea, vomiting, or respiratory distress should be assessed for euDKA. Clinicians should be particularly vigilant in COVID-19 pneumonia cases.
Keywords: euglycemic diabetic ketoacidosis, sodium - glucose transporter 2 inhibitors, COVID - 19 pneumonia

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Ref No: 1446
Navigating Complexity: A Multidisciplinary Approach to Moyamoya Disease, Sickle Cell Disease, and Postpartum Pre-eclampsia
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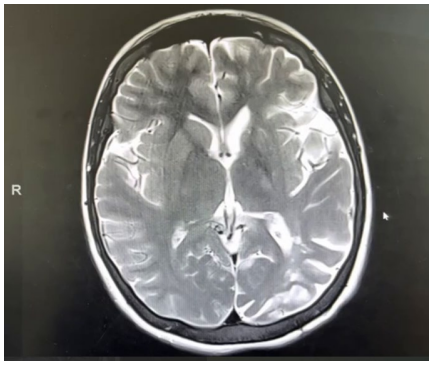
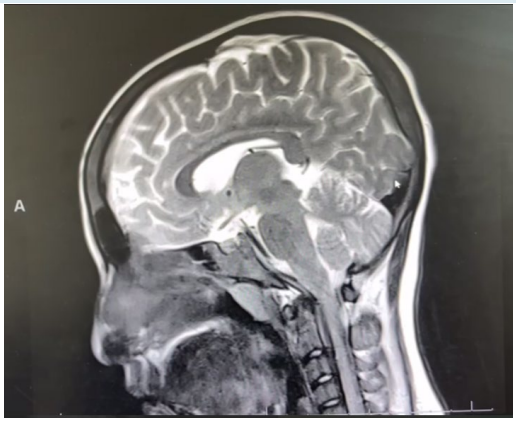
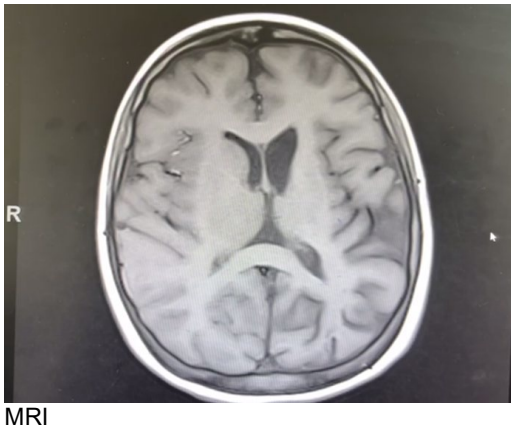
[2]King Faisal General Hospital Al Ahsa
Introduction and Purpose: This case report details the complex clinical course of a 26-year-old female with a convergence of critical medical conditions: Moyamoya disease, Sickle Cell Disease (SCD), and pre-eclampsia following an urgent Cesarean section. Moyamoya disease, a rare cerebrovascular disorder characterized by arterial stenosis and increased risk of stroke, presents unique challenges in pregnancy. SCD, a systemic hematologic disorder, further complicates pregnancy and postpartum management.1 This report aims to illustrate the diagnostic complexities, multidisciplinary management strategies, and potential risks associated with this concurrence of conditions.
Materials and Methods: This is a case report of a 26-year-old female, G1P1+0, who presented postpartum following an urgent Cesarean section at 35 weeks gestation for fetal distress, complicated by pre-eclampsia. Data was collected from medical records, including clinical assessments, laboratory investigations (CBC, biochemistry, coagulation studies), imaging studies (CT, MRI/MRA), and multidisciplinary consultations (Hematology, Neurology, Dermatology, OB/GYN). The patient's clinical course, management strategies, and maternal outcomes were analyzed.
MRI



MRI



MRI



MRI

The MRI reveals evidence of significant chronic cerebrovascular disease, likely related to the patient's sickle cell anemia. There are multiple areas of old infarction and hemorrhage in the left hemisphere, resulting in volume loss. The MRA shows severe narrowing of the left ICA and other major cerebral arteries, with collateral vessel formation, suggestive of Moyamoya disease. There are no signs of acute stroke. The skull changes are consistent with the patient's underlying hematologic disorder.

Results and Conclusion: The patient exhibited a complex clinical picture including postpartum pre-eclampsia, possible new stroke symptoms, and complications related to her underlying Moyamoya disease and SCD. Investigations revealed evidence of chronic cerebrovascular disease (Moyamoya), anemia, liver dysfunction, and pulmonary abnormalities. Management involved a multidisciplinary approach with antibiotics, blood transfusions and exchange, neurological workup, and monitoring for SCD-related complications. This case highlights the significant risks and management challenges associated with the co-occurrence of Moyamoya disease, SCD, and pre-eclampsia in the postpartum period. It underscores the critical importance of prompt diagnosis, vigilant monitoring, and coordinated multidisciplinary care to optimize maternal outcomes and address the potential for severe neurological and haematological complications.

Keywords: MoyaMoya Disease, Pre-Eclampsia, Sickle Cell Disease

Ref No: 1450
Massive PTE case presenting with fatigue
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[1]Meram Devlet Hastanesi
Introduction and Purpose: Case: 83-year-old male patient applied to the emergency room with complaints of weakness and fatigue. The patient, who had hypertension in his medical history, arrived with blood pressure: 80/50, pulse: 120 h02:90, fever: 36.5. There was negative t in v1-v4 on his EKG. In the tests performed; troponin 173 ng/ml, pH 7.29, lactate 7.68, HCO3 13.3 BE -10. The patient was consulted to cardiology with a preliminary diagnosis of NSTEMI. In the echo, EF was 55%, right cavities were wide, PAP 80 mmHg. Pulmonary artery CT angiography was performed with a preliminary diagnosis of PTE. Pulmonary embolism was detected in both main pulmonary arteries and the patient was accepted as Massive PTE because of low blood pressure. Actiliz 50 mg 2-hour infusion was started. After the infusion, the patient was admitted to the intensive care unit for chest diseases.
Materials and Methods: ..
pulmonary embolism

Results and Conclusion: Discussion: PTE is a clinical picture resulting from the migration of blood clots (thrombus or multiple thrombi) from the systemic circulation to the pulmonary vascular bed. The most common cause is thrombus in the deep veins of the lower extremities. Risk factors; immobilization, recent major surgery, malignant DVT or PTE, use of estrogen-containing oral contraceptives, etc. Clinical; may present with non-specific symptoms such as chest pain, palpitations, syncope, dyspnea, hemoptysis, cough or fatigue. Wells score can be used according to clinical findings for diagnosis. If renal functions are normal for definitive diagnosis, CT angiography of the pulmonary artery is performed. If there is an abnormality in renal functions, transthoracic echocardiography, lower extremity venous doppler USG, ventilation-perfusion scintigraphy should be performed. In treatment; hydration, anticoagulant therapy and reperfusion therapy are available. Reperfusion treatments are thrombolytic therapy and pulmonary embolectomy. Since our patient had massive PTE, reperfusion therapy was applied and rTPA was given.
Keywords: weakness, pulmonary embolism, thrombolytic therapy

Ref No: 1496
TRAUMATIC HIP DISLOCATION AT THE AGE OF THREE
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Introduction and Purpose: Traumatic hip dislocation is extremely rare in pediatric patients. Compared to adults, pediatric hip reduction is easier to perform and has a beter prognosis. Delayed reduction may lead to avascular necrosis (AVN) of the femoral head. In our report, we present a three-year-old boy with traumatic posterior hip dislocation who presented to the emergency department. We also discuss the available literature and review the reduction procedures so that subsequent cases can be treated as early as possible to reduce the potential morbidity from this rare injury in the pediatric population.
Materials and Methods: A three-year-old boy presented to the emergency department of our hospital with left hip pain after a fall from a swing set. After the physical examination and radiologic images ordered by the emergency physician, an orthopedic and traumatology specialist opinion was requested. In the physical examination performed by us, it was determined that the left hip movements were painful and limited and the left lower extremity was in flexion, adduction and internal rotation on inspection. Sciatic nevre damage and circulatory pathology were not observed. Pelvic radiography revealed left hip dislocation (Figure-1) and pelvic computed tomography was ordered to exclude additional pathologies. As a result of tomography, possible associated pathologies such as acetabular fracture and slipped epiphysis of the femoral head were excluded (Figure-2).
Figure-1: Pelvic radiography revealed left hip dislocation

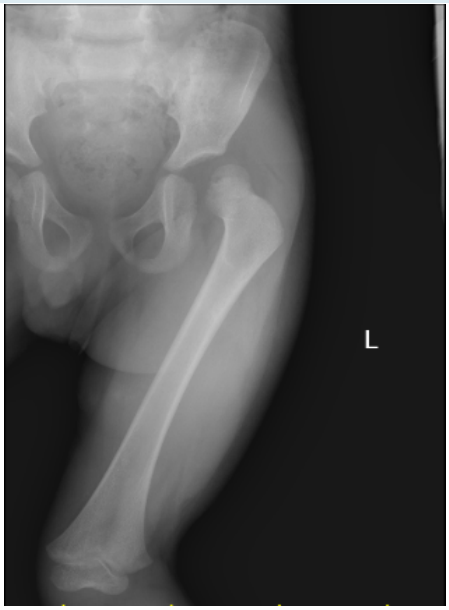

Figure-2: Left hip dislocation on computed tomography

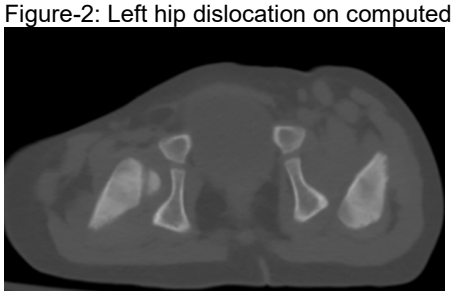
Figure-3: The normal control radiograph after reduction

Results and Conclusion: When the literature is reviewed, traumatic hip dislocation is rare in children. Correct diagnosis and appropriate reduction maneuvers reduce complications such as avascular necrosis of the femoral head. If children have difficulty walking after a trauma such as a fall, the hip should be examined together with pelvic radiographs and even computed tomography should be used if necessary. Since our patient was intervened quickly and treated with plastering in the appropriate position, recovery was achieved with out the need for additional treatment. Since traumatic hip dislocations are rare, especially in pediatric age groups, the preliminary diagnosis of hip dislocation should be remembered in cases of deformity and gait disturbances after trauma, reduction should not be delayed, and follow-up with splinting in the appropriate position should be performed.

Keywords: Allis maneuver, avascular necrosis, hip dislocation

Ref No: 1545
CARDIAC CAUSES OF DIZZINESS: SICK SINUS SYNDROME
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Introduction and Purpose: 62-year-old female patient with no known medical history presented with a two-month history of dizziness. The patient's general condition was moderate, saturation: 92%, pulse: 102, arterial blood pressure: 136/88 mmHg, temperature: 36.4 C. On physical examination, neurological examination was normal, cerebellar tests were skilled, ataxia and nystagmus were absent. The patient's ECG showed normal sinus rhythm (Figure 1). Blood tests were taken and the patient was placed under observation. When the patient's pulse rate dropped to 50 and below during observation, a repeat ECG was performed and sinus pauses associated with sick sinus syndrome were observed (Figure 2). The patient was referred to cardiology and admitted to the hospital for treatment.
Materials and Methods: ECG
Figure 1: The patient's first ECG: Normal sinus rhythm

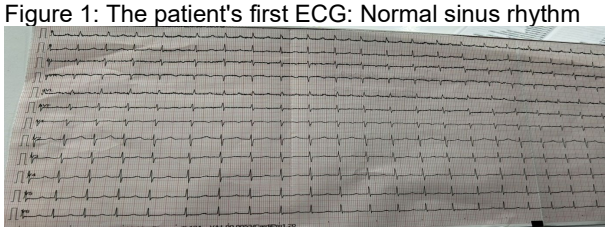
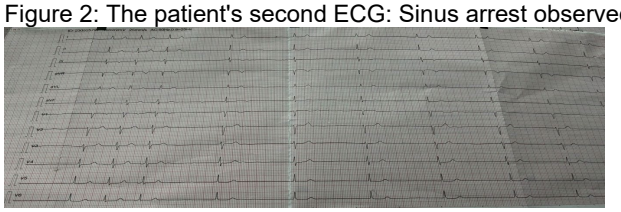


Figure 2: The patient's second ECG: Sinus arrest observed, appearance compatible with SSS



Results and Conclusion: Patients with HSS present with a wide variety of complaints with the main symptoms being dizziness, syncope and palpitations. The clinical manifestations of HSS are analysed in three groups: dysfunction of the automatic cells of the sinus node, symptoms due to dysfunction of T cells and cardiac arrhythmias. The diagnosis of HSS is straightforward when the above findings are present, but arrhythmias are often transient, so ECG should be performed at symptomatic intervals.
Keywords: SICK SINUS SYNDROME

Ref No: 1551
Violence in Healthcare: The Role and Consequences of Social Media
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[2]İzmir Torbalı State Hospıtal, Emergency Department, İzmir, Turkey
[3]Kocaeli Gölcük Necati Çelik State Hospital, Emergency Department, Kocaeli, Turkey
Introduction and Purpose: Encouraging violence and seeing violence as a search for rights are among the situations that increase violence against healthcare personnel. Social media is triggering an increase in incidents of violence across all professions, particularly in the health sector(1,2).In our study, we investigated the level of exposure to violence among health care workers working in a tertiary university hospital and how the increase in violence news through socialmedia affected their biopsychosocial lives.The aim of our study is to identify preventablecauses and to reveal the measures that can be taken.
Materials and Methods: Participants will be asked a questionnaire created by the researchers,which will last approximately 5 minutes,and the answers will be recorded.A voluntary consent form will be obtained from the participants who will participate in the survey.
Results and Conclusion: A total of 1006 people participated in the study.While 87.8% of the participants stated that they had been subjected to verbal violence,17.8% stated that they had been subjected tophysical violence.While79.9% of the women thought that the news about violence on social media increased violence in health,the majority of the participants thought that the news was not reflected objectively.Nurses were the occupational group that was exposed to verbal violence the most with 90.2% and gave the most white codes with 36.6%.All professional groups in our study have the opinion that giving code white does not bring a solution to violence incidents.76.3% of the participants think that X-ray devices and 90.7% think that security guards are ineffective and inadequate in affecting violence.Violence in health is one of the world's leading problems and the measures taken in this regard are insufficient.Today, with the effect of social media, people are encouraged to violence with unconfirmed news and information,and the number of patients resorting to violence is increasing.Almost all of those working in the field of health stated that they have been subjected to violence at least once in their working life and that they would like to change their field of work.In order to improve working conditions and to prevent violence,the necessary and deterrent punitive action should be implemented immediately by the competent authorities.
Keywords: Violence in Health, Social Media, Violence News

Ref No: 1570

Let it be nothing else, this patient is too young for this diagnosis! A case of atypically presenting diverticulitis

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Introduction and Purpose: Diverticulitis is a clinical picture of inflammatory bowel disease that is usually seen in older age groups and can lead to serious complications. While it is typically associated with factors such as low fiber diet and intestinal motility disorders, it is less common in young adults. Although it has been reported in the literature that cases associated with small and large bowel diverticula mostly occur in advanced age, it is known that it is a disease that should not be ignored at an early age. In this study, we report a case of diverticulitis in a 36-year-old young male patient with no history of any comorbidities.

Materials and Methods: A 36-year-old male patient with no known comorbidities presented to the emergency department with a sudden onset of left lower quadrant pain. Physical examination revealed left lower quadrant tenderness, but no signs of defense or rebound. There was no complaint of nausea or vomiting. Bowel movements were normal and gas and fecal output was present. Laboratory tests revealed a white blood cell count (WBC) of 12.000/mm and a C-reactive protein (CRP) level of 11 mg/L. IV hydration and symptomatic treatment did not result in a significant regression in the patient's pain, so a whole abdominal computed tomography (CT) scan with IV contrast was performed. Imaging revealed heterogeneity and increased fatty density in the fatty planes adjacent to the colonic anus in the left paracolic region1. The findings were considered to be compatible with diverticulitis. The patient was consulted for general surgery and hospitalised for follow-up and treatment.

Results and Conclusion: Although diverticulitis is usually diagnosed in elderly patients, it should not be forgotten that it can also occur in young patients. Although it has been reported in the literature that diverticulitis is more common in elderly patients and complication rates are higher in this group, this case shows that the possibility of diverticulitis in young adults should not be ignored. In this case, a successful treatment was achieved with conservative methods thanks to early diagnosis. To prevent the development of complications in the future, dietary habits and lifestyle changes to support intestinal health are recommended.

Keywords: Acute Diverticulitis, Colonic Inflammation, Acute Abdomen

Ref No: 1571

Pulmonary Embolism in a Patient Presenting with Syncope: Case Report

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Introduction and Purpose: Pulmonary embolism is an obstruction caused by clotted blood entering the pulmonary arterial circulation, usually from deep vein thrombosis in the legs, arms or pelvis and less commonly from the jugular vein or inferior vena cava. At least 1/3 of patients with DVT have a concurrent PE, even in the absence of symptoms. DVT is associated with PE in 70-80% of hospitalized and 40% of outpatients in the emergency department. In emergency department patients with PE, in addition to the common complaints of chest pain and shortness of breath, approximately 3% to 4% have syncope and another 1% to 2% have new-onset seizures or confusion.

Materials and Methods: A 68-year-old man was admitted to the emergency department with complaints of headache and weakness after syncope. He had a known history of coronary artery disease and lumbar disc herniation. On physical examination; consciousness was clear, oriented, coherent, GCS:15 and there were no acute pathologic findings in systemic examinations. On admission vital signs; TA:110/68 mmHg, pulse rate:88/min, temperature: 36.5°C, SpO2:94%, fingerstick blood glucose:94 mg/dl, ECG:no acute changes. Laboratory parameters of the patient were as follows: pH:7.42, lactate:1.5 mmol/L, pCO2:37 mmHg, Hb:15.3 g/dl, other CBC parameters were normal, CRP:27.6 mg/L, KCFT and BFT parameters were normal, Troponin:7.14(<14), D Dimer:135 µg/L (0-500). Symptomatic treatment was arranged with monitoring and vital follow-up on admission. Brain CT imaging was performed to determine the etiology of syncope and no acute pathology was detected. During the emergency department follow-up, the patient had a syncope attack that lasted for 5 seconds again and pulmonary CT angiography was performed to exclude PTE, which is one of the other differential low probability diagnoses in the etiology of syncope, and filling defects in the upper, middle, lower lobar and segmental branches of the right pulmonary artery and filling defects in the lower lobar and segmental branches of the left pulmonary artery were observed. The patient was consulted to chest diseases with a diagnosis of pulmonary embolism and transferred to the intensive care unit for follow-up and treatment.

Figure 1

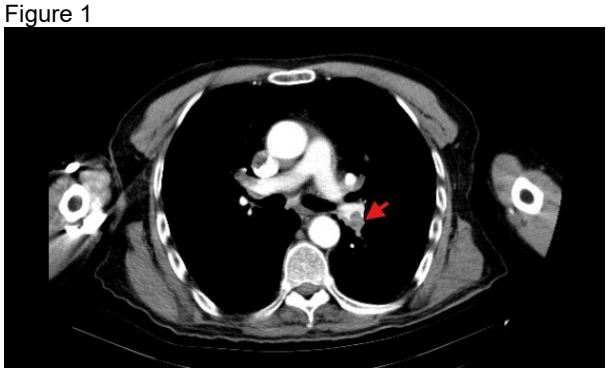
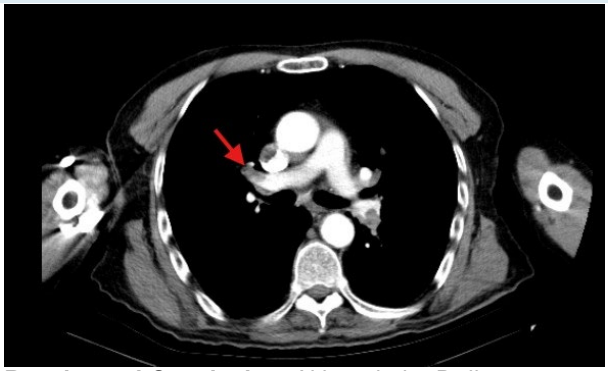


Figure 2



Results and Conclusion: Although the D dimer test excludes PTE with high probability,CT angiography should be performed in case of suspicion.
Keywords: Pulmonary Embolism, CT angiography, D dimer

Ref No: 1589
Axillary artery embolism, a rare condition seen in the emergency department
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Introduction and Purpose: Upper extremity embolism is a rare clinical condition. Patients typically present with sudden onset of symptoms. Since atherosclerotic disease affects the upper extremities less frequently than the lower extremities, sudden upper extremity ischemia is uncommon. The primary symptoms include pain, numbness, pallor, or discoloration. We present this case to emphasize that upper extremity embolism should not be overlooked in patients arriving at the emergency department with complaints of hand numbness, especially when accompanied by specific pain.
Materials and Methods: A 38-year-old male patient with no known chronic diseases was brought to the emergency room by the emergency medical team (112) after experiencing sudden onset of pain and numbness in his right arm while at work. His arterial blood pressure was 113/76 mmHg, oxygen saturation was 99%, and pulse rate was 105/min. Physical examination revealed no motor loss in the right arm, but there was new-onset discoloration of the fingertips, pain exacerbated by movement, and sensory loss. Based on the patient's history, it was determined that the pain, numbness, and difficulty in movement had begun within the last hour. Doppler ultrasound was ordered due to the absence of pathology on central imaging, lack of distal pulse patency, onset of discoloration, and no relief despite analgesia. The ultrasound revealed occlusion of the right axillary artery. Although the right brachial, radial, and ulnar arteries were patent, no significant flow was observed secondary to proximal occlusion. The patient was referred to the relevant department and hospitalized for further monitoring and treatment. Following thrombectomy, the patient was discharged from the hospital with complete patency restored.
Results and Conclusion: As demonstrated in this case, classic findings in a patient's history that raise suspicion of upper extremity arterial embolism include sudden onset of upper extremity pain, numbness, discoloration (e.g., pallor), coldness in the affected extremity, and possibly reduced motor function or paralysis. Additionally, the patient's ability to pinpoint the exact onset of symptoms should serve as a warning sign for this diagnosis.
Keywords: Upper extremity embolism, Axillary artery occlusion, Hand pallor

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Ref No: 1592
A case report of a pediatric patient admitted to the emergency department with eye perforation
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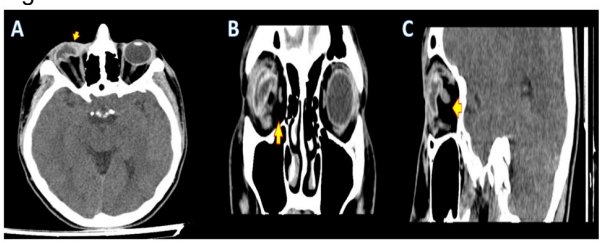
Introduction and Purpose: Perforating eye injuries are the most common causes of sudden vision loss in emergency departments. Perforating eye injuries are most common in children, it is seen in traffic accidents and industrial workers. Diagnosis and treatment despite improved methods, it remains important. In this case, we will present a child who had an eye perforation due to an accidental piece of iron entry into his eye.
Materials and Methods: A 17-years-old man presented to emergency department with a cut in his eye caused by piece of iron. He stated that he was injured while working with iron at home. There were no known co-morbidities and the examination revealed isolated eye trauma (Fig 1). On physical examination, GCS was 15 and right light reflex could not be obtained. As a result of orbital CT, it was determined that the globe integrity in the right eye was disrupted and had a perforated appearance and a millimetric defective appearance on the skin in the right infraorbital area (Fig 2). The patient was immediately consulted to ophthalmology and was operated by ophthalmology with consent.
Figure 1

Perforation of right eye, inspection finding
Figure 2



Axial (A), coronal (B) and sagittal (C) orbital CT images reveal right eye globe integrity is disrupted, perforated appearance and millimetric defect on the skin in the right infraorbital area (arrows).

Results and Conclusion: Considering that perforation may occur in eye injuries, we think that it is of vital importance to take the necessary imaging scans and refer the patient to ophthalmology and related branches immediately and to administer tetanus and antibiotic treatments.

Keywords: eye perforation, emergency department, trauma

Ref No: 1594

The Relationship Between Delta Troponin Levels and the Quantity of Coronary Lesions in Patients with Non-ST Segment Elevation Acute Myocardial Infarction in the Emergency Department

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Introduction and Purpose: Increased troponin levels are a well-recognised biomarker of myocardial injury. High-sensitivity troponin (hs-troponin) assays have been developed and serial measurements at 0 and 1-2 hours are frequently used to support clinical decision as well as clinical prosedures. Monitoring changes in troponin levels over time helps to distinguish acute myocardial infarction (AMI) from chronic conditions that can elevate troponin. Although delta troponin has not yet been fully integrated into guideline-directed protocols, its high negative predictive value may aid clinical prosedures. The aim of this study was to determine the relationship between delta troponin levels and the quantity of coronary artery lesions.

Materials and Methods: This study was conducted in the Emergency Department of Karabük Training and Research Hospital. A total of 125 patients diagnosed with Non ST Segment Elevation Acute Myocardial Infarction (NSTEMI) were included in the study. Laboratory results and coronary angiography reports were analysed retrospectively. Patients were categorised into three groups based on angiographic lesions: No coronary lesions, single-vessel lesions and multivessel lesions. hs-Troponin levels at 0 and 2 hours and delta troponin values were compared between the groups. Data are presented as median [Q1-Q3]. Group comparisons were made using the Kruskal-Wallis test.

Results and Conclusion: The median age of the 125 patients included in the study was 64.0 years [53.0-73.0] and 45 (36%) were female. Coronary angiography revealed no lesion in 26 patients, single-vessel lesions in 61 patients, and multivessel lesions in 38 patients. Although numerical differences were observed in 0-hour hs-troponin, 2-hour hs-troponin and delta troponin values between the three groups, these differences were not statistically significant ($p = 0.787$, $p = 0.395$ and $p = 0.704$, respectively). (Table 1)There was no significant correlation between 0-hour, 2-hour or delta hs-troponin levels and coronary artery disease lesions in patients diagnosed with NSTEMI in the emergency department. Further large-scale studies are needed to better define the diagnostic and prognostic value of delta troponin in this population.

Hs-troponin and Delta Troponin Values by Groups

	No Lesion (n=26)	Single-Vessel (n=61)	Multi-Vessel (n=38)	p-value
0-hour hs-troponin	0.570 [0.080–1.880]	0.350 [0.100–3.360]	0.370 [0.070–1.660]	0.787
2-hour hs-troponin	0.835 [0.190–5.980]	2.330 [0.310–18.030]	1.300 [0.210–8.200]	0.395
Delta troponin	0.060 [0.000–3.620]	0.370 [0.000–9.500]	0.165 [0.020–1.470]	0.704

Keywords: Non-ST Segment Elevation Acute Myocardial Infarction, Delta Troponin, Emergency Department

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Ref No: 1612

Diagnostic Power and Effectiveness of Lumbar Puncture in Patients Presenting with Suspected Meningitis and Encephalitis

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Introduction and Purpose: Lumbar puncture (LP) is a basic diagnostic method used to diagnose central nervous system disease. Meningitis and encephalitis are the means of rapid evaluation in the emergency department. The purpose of this procedure is to consider consecutive LPs in the emergency department with perfection (1).

Materials and Methods: The retrospective designed study included 120 patients over the age of 18 who applied to the emergency department with confusion, fever, disorientation-cooperation disorder and other neurological symptoms and underwent LP between 01.06.2024 and 01.12.2024. The LP results of the patients were evaluated and positive LP rates and diagnoses were tried to be determined.

Results and Conclusion: When the LP results of 120 patients over the age of 18 who presented with confusion, fever, disorientation-cooperation disorder and other neurological symptoms and underwent LP were examined; 24 patients were diagnosed with bacterial meningitis and 12 patients with encephalitis.When the patients' cerebrospinal fluid (CSF) findings were examined; 24 patients (20%): Leukocytosis (all bacterial meningitis patients), 42 patients (35%): High microprotein (24 meningitis, 18 negative culture), 6 patients (5%): Low glucose (meningitis patients) and 6 patients (5%): High glucose (PCR and culture negative patients) were detectedCSF examination is critical in diagnosing meningitis and encephalitis. In our study, the meningitis diagnosis rate was found to be 20% and the encephalitis rate was found to be 10%. CSF leukocytosis, protein and glucose levels are helpful in diagnosis, but PCR and culture results are required for definitive diagnosis (2). LP is a critical procedure in the diagnosis of meningitis and encephalitis in the emergency department. CSF analysis parameters should be evaluated together with clinical suspicion. The diagnostic effectiveness of CSF parameters should be investigated with larger-scale studies (3).REFERENCES1.Tunkel AR, Hartman BJ, Kaplan SL, et al. Practice Guidelines for the Management of Bacterial Meningitis. Clin Infect Dis. 2004;39(9):1267-1284.2.Venkatesan A, Tunkel AR, Bloch KC, et al. Case Definitions, Diagnostic Algorithms, and Priorities in Encephalitis: Consensus Statement of the International Encephalitis Consortium. Clin Infect Dis. 2013;57(8):1114-1128.3.Van de Beek D, Brouwer MC, Thwaites GE, Tunkel AR. Advances in Treatment of Bacterial Meningitis. Lancet. 2012;380(9854):1693-1702.

Keywords: Encephalitis, Lumbar Puncture, Meningitis

Ref No: 1639

Abdominal Aortic Aneurysm Presenting with Vomiting

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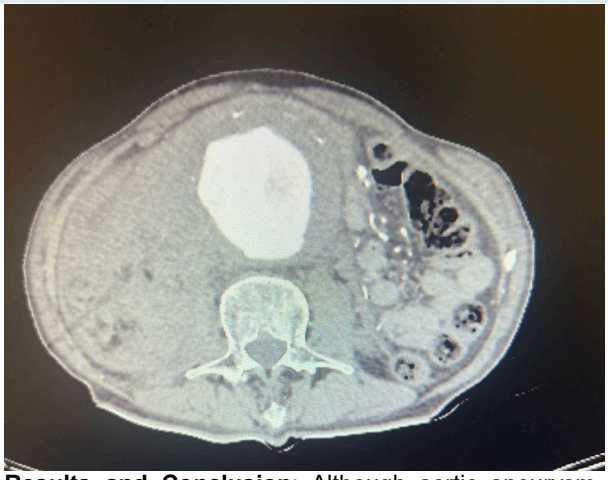
Introduction and Purpose: Aortic aneurysm rupture is life-threatening emergency. Although many patients are characterized by severe, tearing pain in the chest and back, some patients may present with only weakness, fatigue, and vomiting. This case report describes a patient who presented to the emergency department with vomiting with aortic aneurysm rupture.

Materials and Methods: A 75-year-old male patient comes to the emergency room green area with complaints of vomiting and low back pain. The patient's general condition is good, GKS 15 pupils were equal and reactive. The patient vomits during examination, upon which he is taken to the observation room and blood tests are performed, an ECG is taken, ECG was in normal sinus rhythm and antiemetic treatment is started. The patient's vital signs are stable, the patient's HGB level 12.6-10.7-8.2 his blood tests, and the physical examination is repeated upon decrease in the control HGB value. The patient undergoes thoracoabdominal CT angiography upon the patient's pulsation seen with a fossa in the abdomen. CT angiography showed aneurysmal dilatations with peripheral thrombus from the terminal abdominal aorta to the iliac arteries and a hematoma extending to the right retroperitoneal area and pelvis. The patient was operated on with the diagnosis of abdominal aortic aneurysm rupture and was discharged after the follow-up and treatment process.
CT angiography image



Results and Conclusion: Although aortic aneurysm rupture typically presents with severe pain, it can rarely present with more widespread and subtle symptoms such as vomiting and fatigue. In this case, physical examination and vital signs are very useful. Especially in elderly patients, symptoms such as vomiting, back pain should keep aortic aneurysm rupture in mind.
Keywords: vomiting, aortic aneurysm rupture, low back pain

Ref No: 1649
Rapid Management of Pediatric neurological emergency: Case report and Literature review
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[1]Central Asian University
[2]Bolalar Milliy Tibbiyot Markazi
Introduction and Purpose: Pediatric stroke is a critical neurological condition with significant long-term implications, affecting approximately one in 3,500 live births. This case report presents a comprehensive analysis of a 3-month-old male patient with neonatal hydrocephalus and suspected stroke, highlighting the complex diagnostic and management challenges in early neurological disorders. Case: The patient, born prematurely at 29 weeks with an initial weight of 1.5 kg, exhibited clinical signs of hydrocephalus. Diagnostic imaging, including ultrasound and recommended magnetic resonance imaging (MRI), revealed moderate ventricular enlargement, intracranial hemorrhage (I degree intraventricular hemorrhage), and cerebral vasospasm. Follow-up examinations demonstrated progressive neurological deterioration despite medical interventions. Treatment involved neurosurgical consultation, cerebrospinal fluid diversion procedures, and comprehensive rehabilitation therapy. This case emphasizes the importance of early detection and multidisciplinary management approaches in pediatric neurovascular disorders. Regular monitoring and family-centered care proved essential for optimizing outcomes in this challenging neonatal presentation with complex neurological manifestations.
Materials and Methods: Clinical management followed a multidisciplinary protocol that included continuous neurological monitoring, tracking of head circumference growth, and systematic evaluation of developmental markers. Medical interventions focused on targeted pharmacological management to control vasospasm and regulate intracranial pressure. The treatment strategy emphasized stabilization of vital signs, careful management of airway, breathing, and circulation, and implementation of preventive measures against potential brain herniation. Supportive care incorporated specialized physiotherapy consultations and neurology follow-ups, with a comprehensive developmental tracking approach. Magnetic Resonance Imaging (MRI) was recommended to provide precise localization of potential stroke or ischemic injury and enable a detailed neurological assessment. Early intervention and family education were prioritized to enhance long-term outcomes and optimize developmental potential through targeted rehabilitation exercises and consistent home-based therapy protocols.
Results and Conclusion: The case underscores the significant neurological risks associated with perinatal stroke, with approximately 65% of affected children experiencing permanent neurological deficits. These may include one-sided weakness, epilepsy, speech difficulties, and cognitive impairments. This case study emphasizes the critical importance of early detection, comprehensive diagnostic evaluation, and multidisciplinary management in pediatric neurological disorders. Long-term follow-up revealed gradual improvement following rehabilitation. Research indicates early intervention protocols significantly improve outcomes. Neuroplasticity in developing brains offers potential recovery pathways when therapies are implemented promptly.
Keywords: Pediatric Stroke, Neurological Disorders, Premature Infants

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Ref No: 1667
Pectoralis Major Muscle Hematoma Induced by Enoxaparin
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[2]YUZUNCU YIL UNIVERSITY. FACULTY OF MEDICINE, DEPARTMENT OF EMERGENCY MEDİCİNE, VAN, TURKEY
Introduction and Purpose: Enoxaparin, a low molecular weight heparin, exerts its effect by inhibiting thrombin activity and exhibiting anti-factor Xa activity. It is rapidly absorbed after subcutaneous administration and is primarily eliminated by the kidneys. The optimal dose for efficacy is 1-1.5 mg/kg/day. Hemorrhage is a common complication during antithrombotic therapy. Several studies have reported a lower incidence of hemorrhagic complications with enoxaparin compared to unfractionated heparin and warfarin (1). The rate

of major hemorrhagic complications during enoxaparin therapy has been reported to be 1.9-6.5% (2).

Materials and Methods: A 69-year-old female patient, who had been hospitalized in the chest diseases service for 8 days and discharged today, presented to the emergency department approximately 7-8 hours after discharge with a complaint of sudden onset swelling in the left hemithorax, specifically in the anterior thoracic wall. The patient, who was being followed up for hypertension and COPD, had received enoxaparin 1.5 mg/kg/day subcutaneously twice daily in the left or right deltoid muscle regions during her hospitalization in the chest diseases service. There was an 8x10 cm lesion in the left pectoral muscle region causing pain, tenderness, warmth, and a mass effect, which continued to enlarge. Other systemic examinations were unremarkable. The patient had no history of trauma. The patient's laboratory parameters are presented in Table 1.

Figure 1: Thoracic CT scan showing an approximately 9x11 cm hematoma in the pectoral muscle of the left anterior chest wall.

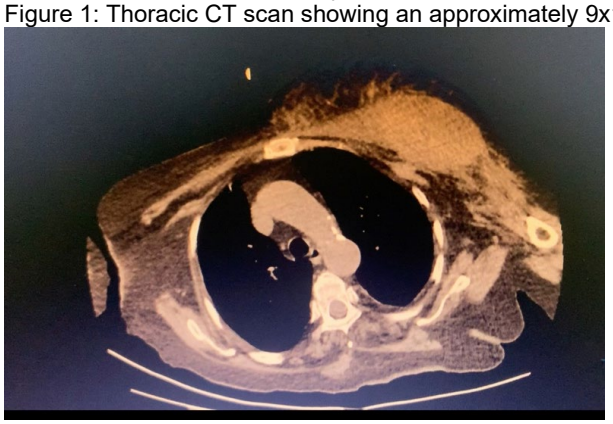

Table-1: Laboratory Parameters

Parameters	Result	Normal Range
Hgb (g/dl)	6.7	11-16
Platelet	170x10^3	100-400x10^3
INR (International Normalized Ratio)	1,1	0,8-1,2

Results and Conclusion: Enoxaparin, a low molecular weight heparin, offers improved bioavailability and a longer half-life compared to unfractionated heparin. While its dose-dependent activity effectively inhibits platelet binding, increased doses raise bleeding risks. Clinicians must be cautious in patients with renal impairment, advanced age, or those on NSAIDs, as these factors enhance enoxaparin's effects. A thorough risk-benefit analysis is essential for enoxaparin therapy (3)In such cases, the first diagnostic tool is ultrasonography. If there is difficulty in diagnosis, CT should be used. If the clinical history is not clear enough or the patient cannot express themselves, CT findings may be interpreted as abscess or tumor. In such a case, MRI may be required to demonstrate. While enoxaparin may rarely cause pectoral hematomas, especially compared to other sites, clinicians should investigate any hemoglobin or blood pressure drops during therapy, considering pectoral hematoma as a possibility.

Keywords: Enoxaparin, hematoma, pectoral muscle

Ref No: 1739

A Rare Complication of Upper Respiratory Tract Infection in the Emergency Department: Pneumomediastinum

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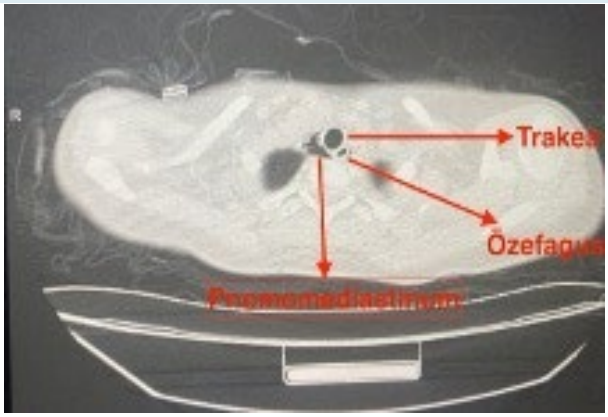
Introduction and Purpose: Spontaneous pneumomediastinum (SPM) is a rare condition caused by free air accumulation in the mediastinum without trauma. It typically occurs due to increased intrathoracic pressure from coughing, vomiting, or physical exertion. It is mainly caused by alveolar rupture due to increased intraalveolar pressure and air travelling along the bronchovascular sheath into the mediastinum. While mostly benign, it must be differentiated from life-threatening conditions like esophageal rupture.In this case report, we aimed to discuss the clinical approach, diagnosis and treatment of spontaneous pneumomediastinum in a previously healthy young female patient.

Materials and Methods: A 19-year-old female presented with sore throat, cough, and sharp chest pain. Despite prior emergency visits and treatment, her symptoms persisted. ECG and laboratory resulst were normal. Chest CT revealed pneumomediastinum. She was admitted for observation and discharged in good condition after four days.

Results and Conclusion: Though SPM has a favorable prognosis, complications like pneumothorax, mediastinitis, and tension pneumomediastinum can occur. Clinicians should consider SPM in patients with persistent chest pain and upper respiratory tract infection symptoms.

Pnomomediastinum appearance on thorax CT



Keywords: Pneumomediastinum, chest pain, upper respiratory tract infection

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Ref No: 1751

A Fatal Complication of Otitis Externa: Subdural Empyema and Bacterial Meningitis – A Case Report

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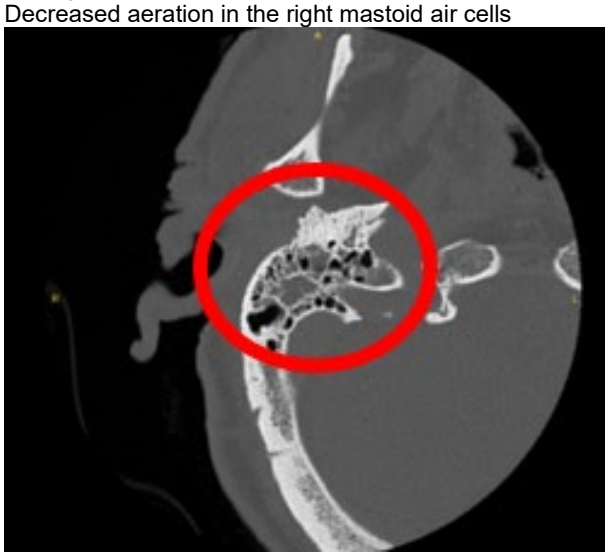
[1]ANKARA BILKENT CITY HOSPITAL

Introduction and Purpose: Otitis externa is a common inflammatory condition of the external auditory canal, typically presenting as a superficial and benign disease. However, the infection may become invasive and extend to adjacent anatomical structures. Particularly in cases of delayed treatment, the infection may spread to the mastoid air cells, temporal bone, and even meningeal tissues, resulting in life-threatening complications such as mastoiditis, subdural empyema, and bacterial meningitis.This report presents a rare and severe clinical case where an initial diagnosis of otitis externa progressed to mastoiditis and subsequently to subdural empyema and meningitis due to contiguous spread of the infection.

Materials and Methods: CASEA 70-year-old male patient was brought to the emergency department by his relatives with complaints of headache, speech disturbance, and impaired cooperation. Vital signs were stable. On the physical examination, the right external auditory canal was edematous and hyperemic, with evident serous discharge. Neurologically, the patient was alert but disoriented, exhibiting nuchal rigidity and a positive Kernig's sign.Cranial CT revealed decreased aeration of the right mastoid air cells and a 6 mm subdural collection in the right frontoparietal region. Cerebrospinal fluid (CSF) analysis revealed markedly elevated protein concentration (978.78 mg/L), increased albumin levels (372.3 mg/L), and pleocytosis (120 cells/mm³), while glucose levels remained within normal limits. Polymerase chain reaction (PCR) testing via a molecular meningitis panel identified Streptococcus pyogenes as the causative pathogen.

Decreased aeration in the right mastoid air cells



Subdural empyema measuring 6 mm in the right frontoparietal region

Results and Conclusion: DISCUSSIONAlthough otitis externa commonly presents as a localized and self-limited infection, in some cases it may progress with deep tissue invasion and result in serious complications. The patients presenting to the emergency department with otologic complaints accompanied by neurological findings, intracranial complications must be ruled out. CSF analysis including evaluation of protein levels, leukocyte count, and glucose concentration provides important diagnostic clues.In this case, Streptococcus pyogenes, a rare but aggressive etiologic agent of meningitis, was isolated from the CSF. Early diagnosis and initiation of empirical antimicrobial therapy are essential for favorable clinical outcomes.In emergency medicine, otologic complaints should not be underestimated. Especially in elderly or high-risk patients, advanced diagnostic workups, including imaging and CSF analysis may be lifesaving.

Keywords: External Otitis, Meningitis, Emergency Medicine

Ref No: 1795

The Clinical Outcomes of ICU Admission After Emergency and Elective Orthopedic Surgeries

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[2]Department of Emergency Medicine, Niğde Ömer Halisdemir University Faculty of Medicine, Niğde/TÜRKİYE

Introduction and Purpose: Intensive care units (ICU) are important for the close follow-up and treatment of patients after surgery. The need for ICU after orthopedic surgery depends on the extent of the surgical intervention, the patient's general condition/comorbidities, and the risk of complications. The aim of this study is to investigate the clinical characteristics of patients admitted in the intensive care units after orthopedic surgery in a tertiary hospital.

Materials and Methods: This retrospective study evaluated patients who were admitted to the ICU of Niğde Ömer Halisdemir University Training and Research Hospital, a tertiary hospital, between January 2023 and December 2024. Patients who underwent orthopedic surgery (emergency/urgent or elective) and were followed in the ICU were included in this study. Patients involving multiple specialties, polytrauma patients, and patients with unavailable data were excluded from the study. Demographic data, diagnoses, length of ICU and ward stay, and hospital mortality of the patients were recorded.

Results and Conclusion: 145 patients were included in the study. 60.7% (n=88) of these patients were female and 39.3% (n=57) were male. The mean age of the patients was 62.46±28.27. 66.2% (n=96) of the patients were admitted to the ICU for emergency/urgent surgery, while 33.8% were admitted for elective surgery. Proximal femur fractures (56.2%) were the most common cause of ICU admission after emergency/urgent surgery, while scoliosis (61.2%) was the most common reason after elective surgery. The mean length of stay in the ICU was significantly longer for patients undergoing emergent/urgent surgery (5.48 ± 7.21 days) compared to those who underwent elective surgery (2.88 ± 3.46 days) (p = 0.0195). The ICU mortality was 30.21% (n=29) after emergency/urgent surgery and 4.08% (n=2) after elective surgery. The ICU mortality after emergency/urgent surgery was significantly higher compared to elective surgery (p=0.0006) (Table 1). No significant relationship was found between the length of stay in the intensive care unit (4.62 ± 6.32 days) and the length of stay in the ward (11.53 ± 12.49 days) (r = -0.08, p = 0.37). As a conclusion, it was shown that patient mortality was higher in emergency/urgent orthopedic surgeries compared to elective surgeries. Multi-center studies are needed on this subject.

Table 1. Comparison of mortality between emergent/urgent and elective ortopedic surgery

Orthopedic surgery type	Deceased, n (%)	Survived, n (%)	P-value*
Emergent/Urgent	29 (30.2)	67 (69.8)	0.0006
Elective	2 (4.1)	47 (95.9)	

*chi-square test

Keywords: Intensive Care Unit (ICU), orthopedic surgery, mortality

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Ref No: 1849

Effectiveness of Right Upper Quadrant Ultrasound Performed by Emergency Medicine Resident

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[1]Tekirdağ Namık Kemal University Health Application and Research Hospital Department of Emergency Medicine

Introduction and Purpose: Abdominal pain is a frequent emergency department (ED) complaint, with right upper quadrant (RUQ) pain often linked to hepatobiliary pathologies such as gallstones and acute cholecystitis. Point-of-care ultrasound (POCUS) has become a crucial tool for rapid diagnosis, reducing reliance on radiology. However, the accuracy of RUQ ultrasound performed by emergency medicine (EM) residents remains under investigation. This study evaluates the diagnostic accuracy of EM resident-performed hepatobiliary ultrasound, particularly in detecting acute cholecystitis and gallstone disease, and its impact on patient management efficiency compared to attending physician-performed ultrasound.

Materials and Methods: This prospective observational study was conducted between May 1, 2024, and February 1, 2025, in a tertiary care ED. Patients with abdominal pain, RUQ pain, epigastric pain, or jaundice requiring RUQ ultrasound were included. Exclusion criteria included prior hepatobiliary surgery, pre-diagnosed hepatobiliary disease, trauma, and resuscitation cases. An EM resident with two years of experience, after structured ultrasound training (22 hours theory, 30 hands-on POCUS exams, 4-hour refresher training), performed RUQ ultrasound using a Philips ClearVue 350 machine. Findings were compared with attending physician-performed ultrasound and final diagnoses. Key sonographic findings included Murphy's sign, gallstones, gallbladder wall thickness, sludge, common bile duct dilation, and pericholecystic fluid. Diagnostic performance was evaluated using sensitivity, specificity, and Cohen's kappa for interobserver agreement ($p < 0.05$).

Results and Conclusion: A total of 140 patients (64.3% female, mean age 56.7 ± 17.9 years) were included. The most common complaints were abdominal pain (67.1%), nausea/vomiting (14.3%), and jaundice (5%). Diagnostic accuracy of resident-performed ultrasound: Murphy's sign: Sensitivity 93%, Specificity 70% Gallstones: Sensitivity 100%, Specificity 96% Pericholecystic fluid: Sensitivity 88%, Specificity 95% Residents demonstrated high accuracy in detecting gallstones and pericholecystic fluid. Statistically significant differences were found between resident and attending ultrasound performance ($p < 0.001$), except for gallbladder wall thickness ($p = 0.717$). Resident-performed hepatobiliary ultrasound showed high diagnostic accuracy, particularly for gallstones. The results emphasize the importance of structured POCUS training in emergency medicine residencies to enhance patient care efficiency and reduce radiology dependency.

Keywords: Point-of-care ultrasound, emergency medicine, hepatobiliary ultrasound

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Ref No: 1866

Hemangioblastoma

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[1]Atatürk Üniversitesi

Introduction and Purpose: Hemangioblastomas are rare, slow-growing tumors of the central nervous system (CNS) that most commonly occur in the cerebellum, brainstem, or spinal cord. They may be incidentally detected during CNS imaging or may present due to neurological deficits caused by direct compression, edema, or tumor-related bleeding. The characteristic magnetic resonance imaging (MRI) appearance of hemangioblastomas includes a cyst associated with a contrast-enhancing nodule in the cerebellum or a homogeneous contrast-enhancing lesion on the surface or within the spinal cord. In this study, we aim to present a 50-year-old male patient with a hemangioblastoma who presented with dizziness and syncope.

Materials and Methods: A 50-year-old male patient presented to the Emergency Department due to dizziness, syncope, and a head injury following the syncope episode that occurred about half an hour prior. On admission, his general condition was moderate, with a Glasgow Coma Scale (GCS) score of 15, heart rate of 96 bpm, blood pressure of 122/80 mmHg, and oxygen saturation of 95%. The patient had no known past medical history. Neurological examination revealed no pathological findings. There was tenderness and crepitus on the nasal bone. A peripheral intravenous line was established, and blood tests were requested. A non-contrast brain CT scan was performed, which revealed hydrocephalus, a mass near the posterior 4th ventricle, and a nasal fracture. The brain MRI showed a hemangioblastoma near the posterior 4th ventricle (Figures 1-2-3). The patient was referred to the Neurosurgery Department and was admitted for further management.

Results and Conclusion: Hemangioblastomas are highly vascular tumors that often reside in neurologically sensitive regions of the neuroaxis. The anatomical location of the lesion plays a critical role in determining the treatment approach. Patients are best managed in a multidisciplinary fashion, involving neurosurgeons with expertise in CNS malignancies, interventional neuroradiologists, radiation oncologists, and neuro-oncologists.

Figure 1

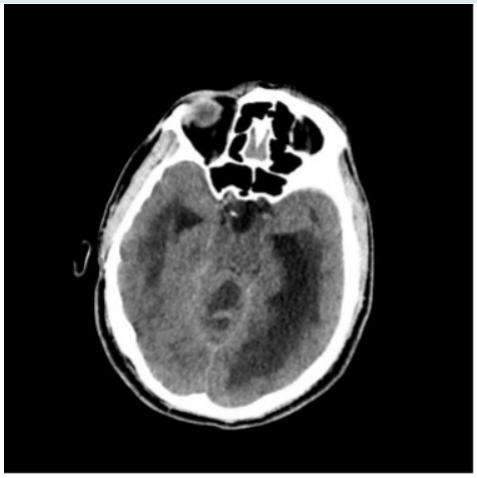
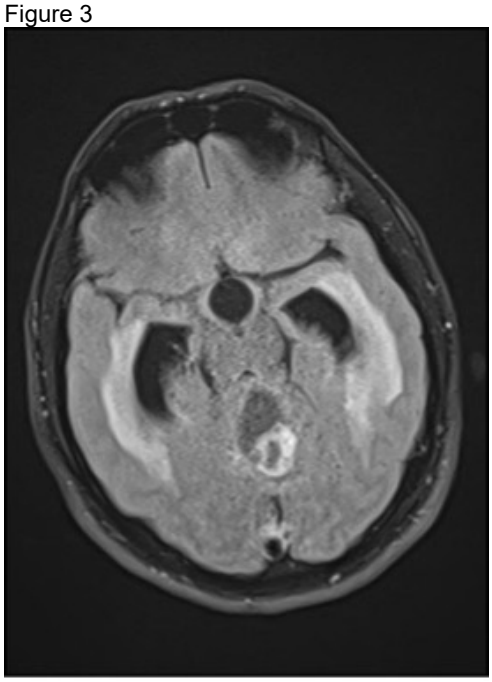


Figure 2

Figure 3



Keywords: Syncope, Hemangioblastoma

Ref No: 1877

Comparison of the Wide-Awake Local Anesthesia with No Tourniquet (WALANT) Technique with Local Anesthesia in Chest Tube Placement Procedures

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Introduction and Purpose: Objective: To compare the wide-awake local anesthesia with no tourniquet (WALANT) technique and the conventional local anesthesia method using lidocaine for chest tube placement.

Materials and Methods: Study Design: This study was a prospective, single-blind, controlled experimental design. A total of 60 patients were included. Pain levels were evaluated using the Visual Analog Scale (VAS). Demographic data such as patient age, gender, and the indication for chest tube placement were gathered. Analyses were guided using IBM SPSS 20 statistical software.

Walant Coctail

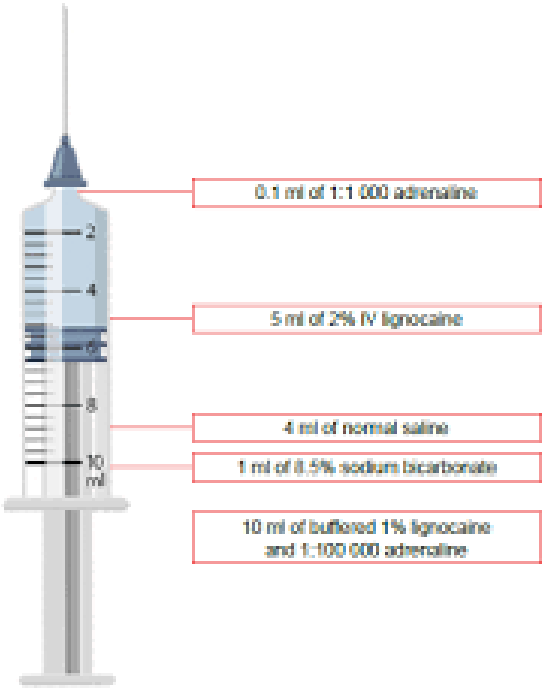
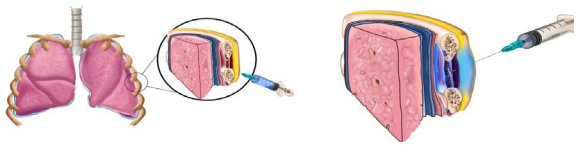


Figure 1. Graphic depicting the ratio, concentrations and volume of constituents to produce 10 ml of WALANT solution

Local Anesthesia Procedure



Results and Conclusion: Results: The study included a total of 66 patients. It was observed that male patients undergoing chest tube placement with lidocaine had reduced VAS scores (p=0.05). Regardless of the anesthesia method used, patients with traumatic pneumothorax (p=0.01) or malignant effusion (p=0.04) seen statistically significant depletions in VAS scores. Among patients experience tube thoracostomy with lidocaine, those with empyema trained the greatest reduction in VAS scores.Conclusion: The WALANT technique, which could be used as a local anesthesia method, did not show significant benefits in reducing pain sense in patients other than those with traumatic pneumothorax. Therefore, no strong evidence was acquired to support its preference for minor surgical interventions in the thoracic area.

Table 1: Distribution of anesthesia methods by patient demographics and indications

Patient characteristic	WALANT group (n = 33)	Lidocaine group (n = 33)	Total (n = 66)
Age			
18–60 years	20 (60.6%)	26 (78.8%)	46 (69.7%)
≥61 years	13 (39.4%)	7 (21.2%)	20 (30.3%)
Gender			
Male	27 (51.92%)	25 (48.07%)	52 (78.8%)
Female	6 (42.85%)	8 (57.14%)	14 (21.2%)
Indication			
Spontaneous pneumothorax	11 (37.90%)	14 (62.10%)	25 (37.90%)
Traumatic pneumothorax	7 (46.6%)	8 (53.3%)	15 (22.7%)
Hemothorax	4 (57.15%)	3 (42.85%)	7 (10.60%)
Empyema	4 (80%)	1 (20%)	5 (7.6%)
Malignant effusion	7 (50%)	7 (50%)	14 (21.20%)

Table 2: Effect of applied method on tube placement indications and VAS scores

				Valid N		Mean ± SD	p*
Applied method	Lidocaine local anesthesia	Tube placement indication	Spontaneous pneumothorax	Pre-treatment VAS score	14	4 ± 2	0.159
				Post-treatment VAS score	14	3 ± 2	
			Traumatic pneumothorax	Pre-treatment VAS score	8	5 ± 3	0.129
				Post-treatment VAS score	8	3 ± 2	
			Hemothorax	Pre-treatment VAS score	3	4 ± 2	0.564
				Post-treatment VAS score	3	3 ± 1	
			Empyema	Pre-treatment VAS score	1	4 ± .	NA
				Post-treatment VAS score	1	2 ± .	
			Malignant effusion	Pre-treatment VAS score	7	4 ± 2	0.025
				Post-treatment VAS score	7	3 ± 2	
	WALANT	Tube placement indication	Spontaneous pneumothorax	Pre-treatment VAS score	11	4 ± 2	0.748
				Post-treatment VAS score	11	4 ± 3	
			Traumatic pneumothorax	Pre-treatment VAS score	7	6 ± 2	0.053

				Post-treatment VAS score	7	4 ± 2	
			Hemothorax	Pre-treatment VAS score	4	6 ± 2	0.450
				Post-treatment VAS score	4	4 ± 3	
			Empyema	Pre-treatment VAS score	4	5 ± 3	0.317
				Post-treatment VAS score	4	3 ± 1	
			Malignant effusion	Pre-treatment VAS score	7	5 ± 2	0.336
				Post-treatment VAS score	7	4 ± 2	

Keywords: Lidocaine, Local Anesthesia, WALANT

Ref No: 1888

Fatal intraparenchymal and intraventricular hemorrhage due to methanol intoxication: a rare case report

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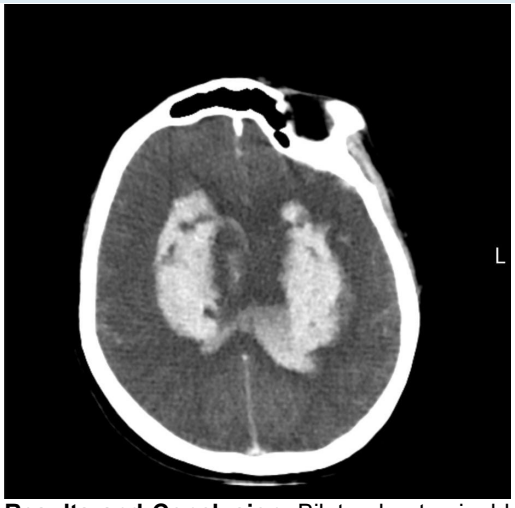
Introduction and Purpose: Methanol intoxication is a life-threatening medical emergency that can result in severe high anion gap metabolic acidosis, visual disturbances and central nervous system injury. While bilateral putaminal necrosis is a well-known radiological finding, intraparenchymal and intraventricular hemorrhages are rare complications. In this case report, we aim to present a fatal case of methanol poisoning with these hemorrhagic findings and to emphasize the importance of early recognition and aggressive management.

Materials and Methods: A 28-year-old male patient presented to the emergency department with nausea, vomiting, and syncope following suspected ingestion alcohol of unknown origin and an unknown psychoactive substance. On admission, he was lethargic Glasgow Coma Scale [GCS]: E3M4V1, had a fixed and dilated right pupil and no light reflex, and his left eye was post-surgical, and no light reflex was observed due to the previous ocular surgery. Arterial blood gas analysis revealed high anion gap metabolic acidosis and elevated serum osmolality. The patient was intubated and admitted to the intensive care unit. Cranial computed tomography revealed bilateral putaminal hemorrhage (image 1) and intraventricular hemorrhage (image 2). Hemodialysis, ethanol infusion, sodium bicarbonate, mannitol, and supportive treatments were administered. Clinical and radiological follow-up continued. Despite all intensive treatment interventions, the patient's neurological status deteriorated. The GCS remained at E1M1Vntt, and he was monitored with worsening bilateral cerebral edema and hemorrhage. The patient developed hypotension and multi-organ failure, and hemodynamic stability could not be achieved despite high-dose inotropic support. On the sixth day, cardiac arrest occurred, and return of spontaneous circulation (ROSC) could not be obtained. The patient was declared deceased.

image 1

image 2



Results and Conclusion: Bilateral putaminal hemorrhage due to methanol intoxication is a rare but serious clinical condition that may result in death despite aggressive treatment. Methanol poisoning should always be considered in patients presenting with unexplained altered consciousness and acidosis. Although early diagnosis and treatment do not always prevent mortality, they are crucial for prognosis.

Keywords: Methanol poisoning, Bilateral putaminal hemorrhage, Intraventricular hemorrhage

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Ref No: 1901

Effect of Platelet Level on Prognosis in Acute Exacerbations of Chronic Obstructive Pulmonary Disease

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Introduction and Purpose: Acute exacerbations of chronic obstructive pulmonary disease (AECOPD) describe the phenomenon of sudden worsening of airway function and respiratory symptoms in patients with COPD. These exacerbations can range from self-limiting illness to episodes of florid respiratory failure requiring mechanical ventilation. AECOPD episodes can be triggered or complicated by other comorbidities such as heart failure, malignancies, renal failure and diabetes. Platelets are one of the main inflammatory cells that can aggregate to the site of inflammation and have the ability to secrete a large number of proinflammatories. Although there are several laboratory parameters thought to affect mortality and morbidity in AECOPD, the effect of platelets is unknown. The aim of this study was to determine the effect of platelet count on the prognosis of hospitalised AECOPD patients.

Materials and Methods: The study is a cross-sectional study and was conducted in the Emergency Department of Karabük Training and Research Hospital. Patients who were hospitalised due to AECOpdbetween April 2022 and December 2024 and who were older than 18 years of age were included in the study. Demographic data, laboratory values, mechanical ventilation needs, intensive care needs, in-hospital mortality data were recorded from the hospital otomation system. Data are presented as median [Q1-Q3]. Group comparisons were made using the Mann Wihtney U test.

Results and Conclusion: There are 248 patients in our study. The median age was 71.00 years [64.00-79.00] and 76 (34.54%) of the patients were female. There was no significant difference in WBC, neutrophil and lymphocyte counts in terms of in-hospital mortality (p = 0.271, p = 0.378, p = 0.807, respectively). (p = 0.834, p = 0.895, p = 0.895, p = 0. 197) When platelet counts were analysed, it was found that the platelet levels of patients who needed intensive care and those who needed mechanical ventilation were significantly lower.(p=0.016, p=0.015, respectively) (Table 1)Platelet counts in AECOPD exacerbation patients indicate the need for intensive care and mechanical ventilation. Patients with lower platelet levels require more intensive care and mechanical ventilation.

Table 1. The Relationship Between Platalet Counts and Outcomes

	Yes	***No***	***P***
In-hospital mortality	166.000 [79.000-282.000]	229.000 [180.000-296.500]	0.063
Need for intensive care unit	207.000 [162.500-287.500]	231.500 [185.500-302.500]	0.016
Need for mechanical ventilation	189.000 [135.500-262.500]	230.000 [180.000-299.000]	0.015
Pneumonia	228.500 [170.000-288.000]	227.500 [176.000-298.500]	0.639
*Mann-Whitney U was used.			

Keywords: platelet count, acute exacerbations of chronic obstructive pulmonary disease

Ref No: 1942

Fournıer's gangrene: a silent threat with fatal consequences

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Introduction and Purpose: Fournier's gangrene is a rare infectious disease characterized by rapidly progressing necrotizing fasciitis in the perineal, genital, and perianal regions, with high mortality rates. It has a polymicrobial etiology and is caused by both aerobic and anaerobic microorganisms. It is ten times more common in men than in women, with anorectal, urogenital, and dermatological infections being the most common etiological factors. Predisposing factors such as diabetes mellitus, obesity, immunodeficiency, and perianal abscesses play a role in disease development. Initially presenting with perineal pain, swelling, and erythema, the infection can progress to necrosis, foul-smelling discharge, and sepsis.

Materials and Methods: A 49-year-old male patient with a known diagnosis of diabetes mellitus. He reported experiencing redness and pain in the groin area for about a week, which had spread to the scrotum over the past two days, accompanied by increasing pain and edema. The patient had stable vital signs upon arrival. Physical examination revealed an edematous, erythematous scrotum with a necrotic area measuring approximately 4x10 cm underneath. The patient was urgently consulted with urology with a preliminary diagnosis of Fournier's gangrene. After emergency department preparations, he was admitted for surgery under the urology department.

Figure 1: Edematous scrotum

Figure 2: 4x10 cm necrotic area in the scrotum

Results and Conclusion: In emergency departments, especially in crowded outpatient settings, examining patients presenting with symptoms such as genital pain, swelling, erythema, and discharge is often challenging. As seen in our case, regardless of circumstances, a thorough physical examination is essential to protect patients from potentially fatal consequences. The purpose of presenting this case is to highlight the importance of physical examination and to emphasize that diagnoses of potentially fatal conditions such as Fournier's gangrene can be made based solely on clinical examination.

Keywords: Fournier's gangrene, Infection, Necrotizing fasciitis

Ref No: 1959

Extremity Arterial Injuries: Insights from Computed Tomography Angiography

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Introduction and Purpose: Background: Extremity arterial injuries (EAIs) pose a significant clinical challenge due to the risk of limb ischemia, amputation, and mortality. Computed tomography angiography (CTA) has become a valuable tool for rapid and non-invasive assessment.Objectives: This retrospective study aimed to delineate the clinical course, treatment strategies, and outcomes of patients with trauma-induced EAIs undergoing CTA, and to identify predictors of adverse outcomes

Materials and Methods: Data from 1257 patients were retrieved from our hospital's database. After applying inclusion and exclusion criteria, 168 patients with confirmed extremity arterial injuries were included in the study. Data collected included demographics, injury mechanism, clinical presentation, laboratory findings, treatment modalities and patient outcomes. Statistical analyses included chi-square tests, t-tests, and multiple logistic regression.

Results and Conclusion: Blunt trauma and penetrating injuries, including gunshot wounds, were the primary etiologies. Upper extremity injuries were predominantly caused by penetrating trauma, while lower extremity injuries were primarily due to blunt trauma. Clinical presentation varied, with significant associations between injury etiology and symptoms. Hypertension, pulselessness, hypoesthesia, and elevated INR were identified as independent predictors of adverse outcomes. Base deficit (BD) was significantly associated with adverse outcomes in upper extremity EAIs. Treatment modalities included primary repair (51.2%), grafting (10.1%), endovascular intervention (8.2%), and conventional management (28%). Amputation rates were 1.3% for upper and 5.3% for lower extremity injuries. Mortality rates were 2.6% for upper and 3.3% for lower extremity injuries, consistent with published data.Conclusions: CTA is crucial for evaluating EAIs. Clinical presentation and outcomes vary based on injury mechanism and location. Hypertension, pulselessness, hypoesthesia, and elevated INR are significant predictors of adverse outcomes. Early diagnosis, prompt intervention, and a multidisciplinary approach are essential for optimal patient management. Further multicenter studies are needed to validate these findings and improve patient outcomes.

Demographics of Patients

	Total	Upper Extremity	Lower Extremity	p value
	168	76	92	
Age (years)	37 (11-81)	37 ± 14	37 ± 16	0,533
Male	145	66	79	0,855
Affected Arteries		Axillary 1 (0,6%) Brachial 6 (3,6%) Radial 41 (24,4%) Ulnar 29 (17,3) Other 3 (1,8%)	Femoral 25 (14,9 %) Popliteal 18 (10,7%) Tibial 33 (19,6%) Peroneal 17 (10,1%) Fibular 2 (%1,2) Other 7 (4,2%)	
Mechanism				
Blunt (n, age)	64 (38,1%) 39±17 years	17 (22,4%)	47 (51,1%)	<0,001
Penetrating (n, age)	75 (44,6%) 35±15 years	54 (71,1%)	21 (22,8%)	<0,001
Gunshot (n, age)	29 (17,3%) 35±10 years	5 (6,6%)	24 (26,1%)	<0,001
Examination Findings				
Pulsatile Bleeding	42 (25%)	25 (32,9%)	17 (18,75%)	0,032
Pulselessness	54 (32,1%)	24 (31,6%)	30 (32,6%)	0,887
Hypoesthesia	74 (44%)	38 (50%)	36 (39,1%)	0,158
Hematoma	67 (39,9%)	24 (31,6%)	43 (%46,7%)	0,046
Accompanying Injuries				
Nerve injury	40 (23,8%)	39 (51,3%)	1 (1,1%)	<0,001
Vein injury	11 (6,5%)	1 (1,3%)	10 (10,9%)	<0,001
Bone fracture	72 (42,9%)	18 (23,7%)	54 (58,7)	0,013
Laboratory Findings				
Hematocrit	39,3±6,6	39,9±5,7	38,7±7,2	0,265
Leukocyte	13,87±6,74	11,5±4,4	15,82±7,67	<0,001
Platelets	263000±74000	247±63	276±81	0,026
Lactate	3,45±2,61	2,60±1,15	3,94±3,06	0,015
Base excess	-3,8± 4,7	-2,7±2,9	-4,4±5,5	0,128
Neutrophil	10,49± 6,47	8.32±4.54	12.28±7.26	<0.001

Monocyte Lymphocyte Neutrophil/Lymphocyte	0,63± 0,32 2,47± 1,5 6,44± 6,59	0,50±0,17 2,40±1,32 5,48±5,87	0,74±0,37 2,53±1,63 7,24±7,06	<0,001 0,943 0,028
Treatment Patient given ES Operation (total) Primary Repair Graft Repair Amputation (initial) Endovascular procedure Conventional Follow up	 44 (26,2%) 107 (63,7%) 86 (51,2%) 17 (10,1%) 4 (2,4%) 14 (8,3%) 47 (28%)	 11 (14,5%) 63 (82,9%) 57 (75%) 5 (6,6%) 1 (1,3%) 3 (3,9%) 10 (13,2%)	 33 (35,9%) 44 (47,8%) 29 (31,5%) 12 (13,0%) 3 (3,3%) 11 (12%) 37 (40,2%)	 0,002 <0,001 <0,001 <0,001 <0,001 <0,001 <0,001
Amputation at the end of the treatment process	6 (3,6%)	1 (1,3%)	5 (5,4%)	0,223
Mortality (Emergency dept/Hospital)	5 {1(0,6%) /5(3%)}	2 {0 (0%)/2 (2,6)}	3 {1 (1,1%)/3 (3,3%)}	<0,001/ 1
Poor outcome (amputation +mortality)	11 (6,5 %)	3 (3,9%)	8 (8,7%)	0,348

Statistical evaluation of the association between injury mechanisms and arterial injury.

	Blunt (n /%)	Sharp penetrating (n, %)	Gunshot wound (n, %)	p value
Male	48 /75,0%	69/92,0%	28/96,6%	0,003
Pulsatile Bleeding	6/9,4%	30/40,0%	6/20,7%	<0,001
Pulselessness	25/39,1%	21/28,0%	8/27,6%	0,321
Hypoesthesia	39/60,9%	25/33,3%	10/34,5%	0,003
Hematoma	24/37,5%	28/37,3%	15/51,7%	0,359

Association between Trauma Mechanism and Injured Structures

	Blunt	Sharp penetrating	Gunshot wound	p value
Upper Extremity-Total	17 (22,4%)	54 (71,1%)	5 (6,6%)	<0,001
Axillary Artery	0 (0,0%)	0 (0,0%)	1(100,0%)	-
Brachial Artery	1 (16,7%)	5 (83,3%)	0 (0,0%)	-
Radial Artery	12 (29,3%)	27 (65,9%)	2 (4,9%)	0,003
Ulnar Artery	7 (24,1%)	22 (75,9%)	0 (0,0%)	<0,001
Other Upper Arteries	0 (0,0%)	3 (100,0%)	0 (0,0%)	-
Lower Extremity- Total	47 (51,1%)	21 (22,8%)	24 (26,1%)	<0,001
Femoral Artery	10 (40,0%)	9 (36,0%)	6 (24,0%)	0,524
Popliteal Artery	6 (33,3%)	4 (22,2%)	8 (44,4%)	0,004
Tibial Artery	19 (57,6%)	5 (15,2%)	9 (27,3%)	0,001
Peroneal Artery	16 (94,1%)	1 (5,9%)	0 (0,0%)	<0,001
Fibular Artery	2 (100,0%)	0 (0,0%)	0 (0,0%)	-
Other Lower Arteries	2 (28,6%)	2 (28,6%)	3 (42,9%)	-
Proximal/Distal	17 (32,7%)/47 (40,5%)	17(32,7%)/58 (50,0%)	18 (34,6%)/11 (9,5%)	<0,001
Nerve Injury	6 (15%)	33 (82,5%)	1 (2,5%)	<0,001
Vein Injury	3 (27,3%)	4 (36,4%)	4 (36,4%)	-
Bone Fracture	52 (72,2%)	6 (8,3%)	14 (19,4%)	<0,001

Multiple logistic regression analysis of bad outcome, conducted following INR categorization

	B	p value	Odds Ratio (CI 95%)
Hypertension	2,828	0,012	16,919 (1,88-152,235)
Pulselessness	2,042	0,012	7,704 (1,558-38,097)
Hypoesthesia	2,201	0,019	9,031 (1,442-56,571)
Elevated INR	1,604	0,026	4,975 (1,213-20,399)
Constant	-1,824	0,001	0,161 (-)

Keywords: Extremity Arterial Injuries, Tomography Angiography, CT Angiography

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Ref No: 1973

Serotonin syndrome due to high dose SSRI intake: a case report

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Introduction and Purpose: Serotonin syndrome (SS) arising from serotonergic activity is associated with interactions between drugs, therapeutic or overdose of selective serotonin reuptake inhibitors (SSRIs). Early diagnosis and treatment are vital, as the condition can be fatal.

Materials and Methods: We hereby present a 27-year-old male patient who presented to the emergency department (ED) with complaints of agitation, sweating, tremors, and palpitations that developed six hours after ingesting high doses of sertraline, phenprobamate, chlorzoxazone, and dexketoprofen tablets for suicidal purposes. On presentation to the ED, the patient was disoriented, non-cooperative, sweaty, flushed, tachypneic, tachycardic, bilaterally mydriatic, had no light reflexes, and had generalized tremor. While under observation in the intensive care unit (ICU) with a diagnosis of SS, the patient was administered intravenous diazepam due to the emergence of hyperreflexia and clonus. Following the administration of supportive treatment in ICU, a decrease in symptoms was observed on the third day, and the patient was discharged on the fifth day due to clinical recovery.

Results and Conclusion: Despite their rarity, SS should be considered a serious complication by ED physicians, given the potential consequences.

Keywords: Serotonin syndrome, poisoning, emergency department

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Ref No: 1991

A YOUNG ATHLETE'S EXPERİENCE WİTH RHABDOMYOLYSİS

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Introduction and Purpose: 25-year-old male patient with no known systemic disease presented to the emergency department with complaints of body aches, muscle weakness and darkening of urine colour for the previous two days. The patient, a professional athlete, had initiated an intensive training period one week prior and had engaged in overtraining with some of his teammates for the previous two days. During this period, the patient engaged in training that incorporated running and weightlifting with an unprecedented level of intensity. The patient reported an increase in muscle aches and fatigue over the previous few days. He also reports experiencing muscle tension and pain during the night following his training. The patient further noted a change in the colour of his urine, which had turned brown. The patient further reports that these symptoms are causing significant disruption to his daily activities. The patient's body temperature has increased, and his general condition has worsened. The patient's vital signs were as follows: blood pressure: 110/70 mmHg, pulse rate: 90/minute, respiratory rate: 18/minute, body temperature: 37.6°C. A physical examination revealed diffuse tenderness, swelling and tension in the muscles. No other significant physical examination findings were observed. Serum creatine kinase (CK) levels were measured in both blood and urine tests. 15,000 U/L (normal: <200 U/L).Serum potassium: 5.1 mmol/L (normal: 3.5-5.0 mmol/L)Serum lactate dehydrogenase (LDH): 450 U/L (normal: <250 U/L)Serum urea and creatinine: NormalUrine colour: dark red (presence of myoglobin) Rhabdomyolysis was diagnosed and the patient responded positively to treatment. Levels of creatine kinase decreased. Following several days of hospital follow-up, the patient exhibited a return to normal urine colour and muscle strength.

Materials and Methods: LABORATORY TESTING

Results and Conclusion: It is imperative that athletes are made aware of the potential dangers associated with rhabdomyolysis, as well as the repercussions of both excessive exercise and incorrect techniques on the body.

Keywords: RHABDOMYOLYSİS

Ref No: 1996

THE EFFECT OF LAR RATIO ON MORTALITY IN POSTTRAUMATIC SUBDURAL HEMORRHAGE

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Introduction and Purpose: Subdural hemorrhage is a hemorrhage between the dura mater and the arachnoid membrane. If not treated appropriately, they have high mortality and morbidity. There are some markers and indices to make the decision for intensive care unit hospitalization and to predict mortality. The most common symptom is headache. Predicting the mortality rate of subdural hemorrhage, which is a serious cause of mortality, is uncertain for physicians.The aim of our study was to determine the importance of lymphocyte/albumin(s) ratio in mortality prediction.

Materials and Methods: The data of adult patients who were admitted to the emergency department of Malatya Training and Research Hospital with a diagnosis of subdural hemorrhage in the last 1 year were retrospectively analyzed. 30-day mortality and prognosis estimation of blood parameters [hemogram:leukocyte(10⅜uL) (WBC),neutrophil(10/uL) (neu),lymphocyte(10¾uL) (lym), biochemistry: albuming/dL) (alb), LAR index importance and whether there are inflammatory parameters that can be used in prognosis estimation.
table 2

Association of survivors and ex-patients with mortality

	ALİVE AND EX	N	VALEU
WBC	ALİVE EX	38 8	0,9
NEU	ALİVE EX	38 8	0,79
LYM	ALİVE EX	38 8	0,62
ALB	ALİVE EX	38 8	0,036
LAR	ALİVE EX	38 8	0,839

**Mann Whitney U test, yb: intensive care unit

Table 3

Association of blood parameters and LAR score with hospital and intensive care unit length of stay

parametres	N	R	P value	parametres	N	R	P value
ALB	HOSPİTAL	-0,435	0,003**	ALB	intensive care	-0,296	0,046*
LAR		o,176	0,242	LAR		0,171	0,255

*. Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).

Results and Conclusion: Initially 58 patients were included in our study. Forty-six patients who met the inclusion criteria were included. 21.7% (10) of were female and 78.3% (36) male. While 82.6%(38) of survived, 17.4%(8) of them died. All of our patients were followed up in intensive care unit. The mean age of our patients was 77.5 years (72.5-84.2) and blood values were respectively. In literature male gender was predominant. Because the male gender is more active in social life. In geriatric patients, rupture of the bridge veins which are stretched secondary to brain atrophy and loss of the properties and flexibility. It is a known fact that albumin, which is a negative acute phase reactant, is low in traumatized patients or in patients with poor general condition. In our study, low levels of albumin were found in patients with mortal course.No study was found between LAR ratio and mortality in subdural hemorrhage. Although the LAR rate was not statistically different in patients with mortal outcome, the LAR rate was higher in patients with mortal outcome, the LAR rate was higher in patients with mortality.We think that future studies with large patient groups will provide a new scale that can be used in the prediction of mortality with LAR
table 1

Median and IQR (Inter Quantile Range) values of blood parameters with nonparametric distribution

	Median	IQR

WBC(103/uL)	8,4	7,1-11,0
Neu(103/uL)	6,2	4,5-9,6
Lym(103/uL)	1,4	0,8-1,9
ALB(g/dL)	3,55	3,15-3,85
LAR	0,46	0,38-0,66

Keywords: SUBDURAL HEMORRHAGE, LAR Indexs, Emergency Department

Ref No: 2002

Severe Necrotizing Soft Tissue Infection Following A Human Bite In An Elderly Woman, Complicated By Pulmonary Embolism: A Case Report

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Introduction and Purpose: Human bite wounds are known to carry a high risk of infection due to the rich oral flora, often leading to severe complications if not promptly treated. Necrotizing soft tissue infections (NSTIs), though rare, can arise from seemingly minor bite injuries, especially in vulnerable patients. We report a case of a 70-year-old woman who developed necrotizing fasciitis of the forearm following a human bite from her grandchild, to underscore the importance of early recognition, aggressive management, and awareness of potential systemic complications.

Materials and Methods: We retrospectively reviewed the clinical course of the patient from emergency admission through treatment and follow-up. Clinical findings, laboratory and imaging results, surgical interventions, antibiotic therapy, and outcomes were analyzed. A literature review was conducted to contextualize this case with current knowledge on human bite infections, necrotizing fasciitis management, and related complications.

Results and Conclusion: The patient presented 4 days post-bite with rapidly progressive swelling, hemorrhagic bullae, and necrosis of the left forearm (Figure 1). Broad-spectrum antibiotics (piperacillin-tazobactam and teicoplanin) were initiated immediately, and urgent surgical debridement and fasciotomy confirmed extensive necrotizing infection. Despite multiple debridements and intensive care support, the patient's hospital course was complicated by an acute pulmonary embolism on day 23, requiring anticoagulation. Cultures remained negative, likely due to early antibiotic administration. After a total of four surgical debridements and eventual skin grafting, the infection was controlled and the patient recovered fully. This case illustrates the potential severity of human bite wounds in elderly hosts, the critical need for prompt surgical intervention and broad antibiotic coverage in NSTIs, and the importance of vigilant monitoring for systemic complications such as thromboembolism.

Figure 1.

Marked swelling of the left forearm, with skin tension, erythema, and patchy areas of dusky discoloration, widespread hemorrhagic bullae over the bite region, black necrotic patches, and foul-smelling purulent discharge indicative of deep infection.

Keywords: Human bite, Pulmonary embolism, Soft tissue infection.

Ref No: 2052

Colchicine Intoxication: An Innocent Drug or a Deadly Poison?

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Introduction and Purpose: Colchicine is a drug used in the chronic treatment of Familial Mediterranean Fever (FMF),as well as in the management of acute attacks of gout arthritis and pseudogout.Although colchicine intoxication is not frequently encountered in emergency departments,it is a condition that requires attention due to its life-threatening symptoms(1).Acute poisoning is rare but can present with a wide range of clinical manifestations,from gastrointestinal and hematological changes to cardiogenic shock(2).

Materials and Methods: An 18-year-old female patient presented to our emergency department with severe nausea,vomiting,diarrhea that had started a few hours before her admission.Her family history revealed FMF in her mother and sibling and Ankylosing Spondylitis in her father.On physical examination,she exhibited diffuse abdominal tenderness, more pronounced in the upper quadrants.Laboratory results were as follows:WBC: 13,100, NEU%: 85.1, CRP: 21.05 mg/dL, LDH: 4,485 U/L, ALT: 914 U/L, AST: 2,416 U/L, CK: 1,244 U/L, INR: 1.83, and Troponin I: 1,544 ng/L.Abdominal imaging revealed a heterogeneous liver appearance with reduced density,hepatosteatosis, and pericholecystic fluid accumulation.Upon admission,the patient denied any drug intake or unusual food consumption.However,during follow-up and upon further questioning, she admitted to having taken 3-4 boxes(approximately 30 tablets)of colchicine three days prior in a suicide attempt.Consultation with the national poison control center was conducted.Due to the risk of cardiogenic shock, the patient was admitted to the intensive care unit for close monitoring.

Results and Conclusion: Although colchicine is primarily used to treat acute attacks of gout and pseudogout,it has also been effective in the treatment of FMF and Behçet's syndrome for the past 50 years.Studies indicate that doses of <0.5 mg/kg cause minor toxicity with a 100% recovery rate,while doses between 0.5-0.8 mg/kg lead to major toxicity with a 10% mortality rate(3).At doses exceeding 0.8 mg/kg, mortality occurs within 72 hours due to cardiogenic shock. Currently, there is no known antidote for colchicine toxicity (2).Patients exposed to high doses of colchicine should be monitored in the ICU with appropriate fluid-electrolyte therapy, hemodynamic monitoring,and respiratory support. Fluid and electrolyte replacement therapy is a priority to reduce gastrointestinal losses(1).Daily complete blood count monitoring is essential to detect anemia, leukopenia, and thrombocytopenia, and preventive measures should be taken to mitigate potential hemorrhagic complications(4).

Keywords: Familial Mediterranean Fever, Colchicine, Suicide

Ref No: 2080

A Rare Complication of Acute Myocardial Injury and Successful Patient Management: Ventricular Septal Defect

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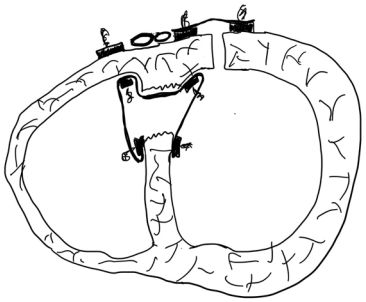
Introduction and Purpose: Mechanical complications due to myocardial infarction are associated with high mortality rates. Due to the high mortality rate of the conservative approach, surgical treatment is the preferred option despite its significant risk of death. The ischemic tissue is excessively fragile, rendering it unsuitable for surgical repair. Ventricular septal defect (VSD) following myocardial infarction (post-MI VSD) is a rare yet life-threatening complication. The hemodynamic instability of patients at the time of presentation, along with the fragility of the ischemic myocardial tissue in the intervention area, significantly contributes to the high mortality risk.

Materials and Methods: A 70-year-old male patient presented to our emergency department with a four-day history of angina and holo-systolic murmur with auscultation. Coronary angiography revealed total occlusion in the left anterior descending (LAD) artery and the first diagonal branch. Transthoracic echocardiography identified a post-MI VSD measuring 3 × 4 cm in the apical region. Surgical intervention was planned for simultaneous revascularization and VSD repair. The patient was taken to surgery under intra-aortic balloon pump (IABP) support. VSD was closed using a different technique. Both sides of the septum were reconstructed by folding a single patch. The patient was weaned off cardiopulmonary bypass under IABP support without the need for inotropic agents. The patient was extubated six hours postoperatively. IABP support was weaned off on the first postoperative day. On the second postoperative day, the patient was transferred to the ward for further monitoring and was discharged on the seventh day. Echocardiography performed at the 12-month follow-up revealed an EF of 40%, with no residual shunting across the interventricular septum.

Post-MI VSD Surgical Image

The exploration of the VSD/The closure of the VSD with our technique using a folded single patch/The final image of the surgical correction with the ventriculotomy closed

Schematic Drawing



The cross-sectional schematic drawing of the surgically repaired VSD

Results and Conclusion: The mortality rate of post-MI VSD is high. In the preoperative period, afterload should be reduced through medical and, when necessary, mechanical support before proceeding with surgery. One of the challenges in surgery is the fragility of ischemic tissue, especially around the VSD. The presence of a residual shunt after surgery or the formation of a new tear at the patch site during the procedure are significant factors increasing mortality. The technique we applied is also a safe and easily implementable method.

Keywords: Ventricular Septal Defect, Myocardial Infarction, Myocardial Rupture

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Ref No: 2123

A Case of Extensive Ulcerative Cutaneous Tuberculosis on the Head and Neck with Pulmonary Tuberculosis

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Introduction and Purpose: Tuberculosis (TB) is caused by Mycobacterium tuberculosis complex bacilli. Although tuberculosis mostly affects the lungs, it is a clinical condition that can affect all organs and systems and continues to be a health problem in our country. Cutaneous tuberculosis should also be considered in chronic wounds that do not heal despite many treatments. In this article, a tuberculosis case that was diagnosed and treated correctly with Acid-Resistant Staining (ARB) in a skin sample taken from a patient with open necrotic wounds on the head and neck for years due to suspicion of TB will be presented.

Materials and Methods: A 66-year-old male patient with no known chronic disease and poor self-care was admitted to the emergency department with chills, shivering, fever, and shortness of breath. In the physical examination performed in the emergency department, arterial blood pressure was 110/75, pulse: 90 beats/min, fever: 38.3, respiratory rate 22/min, oxygen saturation 90%, rales were heard in lung sounds, and a foul-smelling, large, and deep wound was observed in the head and neck region. Leukocytes were 19840/mm3, neutrophils were 17830/mm3, C-reactive protein was 217 mg/L. The patient, who had widespread pneumonic infiltrates in the thorax CT, was admitted to the chest diseases ward with the diagnosis of pneumonia and treatment was started. Considering that the patient's self-care was poor and he was admitted to the chest diseases clinic with a lung infection, it was also considered as a preliminary diagnosis that his chronic wound might be related to skin tuberculosis. Since the patient could not expectorate, a sputum culture could not be obtained. A tissue culture was taken from the wound, a nonspecific culture and ARB staining were performed. 4+ bacilli were observed in the ARB staining of the tissue. Pseudomonas aeruginosa was observed in the wound culture.

Appearance of the initial state of the wound

Deep, extensive ulcerated wound in the head and neck region that also destroys the auricle

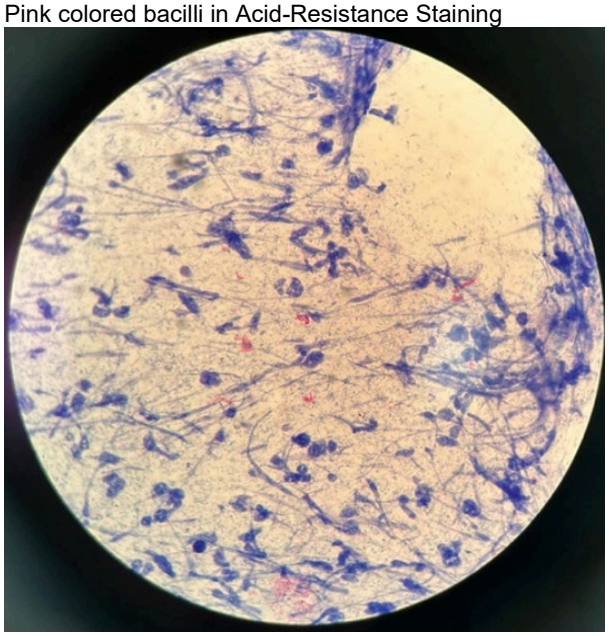
Appearance of the wound after care

Deep, extensive ulcerated wound in the head and neck region that also destroys the auricle

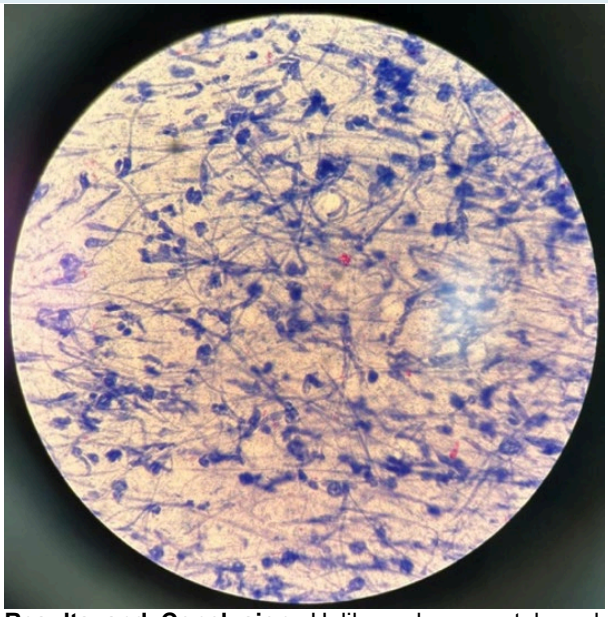
Thorax CT image

Consolidated areas and cystic formations in the superior segment of the right lung lower lobe

Pink colored bacilli in Acid-Resistance Staining



Pink colored bacilli in Acid-Resistance Staining



Results and Conclusion: Unlike pulmonary tuberculosis, cutaneous tuberculosis is rare. It occurs in only 1%-2% of all patients presenting with extrapulmonary manifestations of tuberculosis. Clinical suspicion and skin culture and pathological examination are essential for diagnosis. It should not be forgotten that tuberculosis is still common in our country and can present with extrapulmonary manifestations.

Keywords: Tuberculosis, Cutaneous Tuberculosis, Chronic Wound

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Ref No: 2145

A Rare Cause of Childhood Stroke: Minor Head Trauma

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Introduction and Purpose: Head trauma is an important cause of mortality and morbidity in pediatric patients. Many patients develop intracerebral hemorrhage due to head injury. However, ischemic stroke after head trauma is a very rare condition.

Materials and Methods: A 3-year-old girl was admitted to our emergency department (ED) after falling from a seat approximately 25 inches high, 12 hours earlier. She presented with malaise and impaired consciousness. Her parents reported that she had initially been evaluated at a local ED after the fall, where her head computed tomography (CT) and laboratory results were normal, and she was discharged. However, due to her persistent symptoms, they brought her to our ED.She had a history of isolated head trauma, and her systemic examination was normal. On admission, she was lethargic, uncooperative, and had a Glasgow Coma Scale (GCS) score of 11. Neurological examination revealed weakness in her left arm and leg, with muscle strength graded at 4/5. Both head and spinal CT scans were normal.Diffusion-weighted magnetic resonance imaging (MRI) revealed an ischemic stroke. She was admitted to the pediatric intensive care unit for further management.She was evaluated by pediatric neurology and cardiology teams. Her echocardiography and laboratory tests, including workup for iron deficiency anemia, dyslipidemia, and homocystinuria, were all normal. No risk factors for stroke were identified.The patient was diagnosed with ischemic stroke secondary to minor head trauma. She was discharged after 8 days of intensive care follow-up. Her left-sided weakness gradually improved and fully recovered within one week after discharge.

Results and Conclusion: In pediatric patients, head trauma commonly causes intracerebral hemorrhage; however, in rare cases, it can also lead to ischemic stroke. Clinicians should be aware of this rare complication, especially when neurological deficits persist despite normal initial imaging.

Keywords: Minor head trauma, childhood stroke, pediatric head trauma

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Ref No: 2151

Ruptured Pulmonary Hydatid Cyst Presenting as Massive Pleural Effusion in a 10-Year-Old Boy: A Case Report

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Introduction and Purpose: Hydatid disease (echinococcosis) is a zoonotic parasitic infection caused by Echinococcus granulosus. The liver is the most commonly affected organ, but in pediatric patients the lungs are often the primary site. Pulmonary hydatid cysts grow slowly and may remain asymptomatic until they reach a large size or rupture. Cyst rupture is a feared complication that can lead to acute presentations. We report a pediatric case in which a ruptured pulmonary hydatid cyst presented atypically as a massive pleural effusion causing respiratory distress.

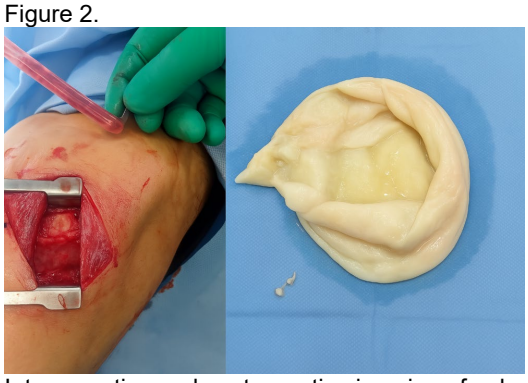
Materials and Methods: A 10-year-old boy was evaluated at a district emergency department with severe respiratory distress. Physical examination revealed decreased breath sounds and dullness over the left hemithorax. Chest radiography showed near-complete opacification of the left lung field consistent with a massive pleural effusion. Diagnostic thoracentesis yielded serous fluid. Ultrasound and subsequent contrast-enhanced chest CT demonstrated a large cystic lesion in the left lung with collapse of adjacent parenchyma (Figure 1). The patient was stabilized and transferred to a tertiary center for definitive management. Surgical intervention (left thoracotomy) was performed, and the cyst was excised. The diagnosis of hydatid cyst was confirmed intraoperatively and by pathological examination of the cyst contents.

Figure 1.

The CT scan; a large cystic lesion (~10 cm in diameter) occupying the left lower lobe, with evidence of partial rüptüre.

Results and Conclusion: Intraoperatively, a ruptured pulmonary hydatid cyst was identified as the cause of the pleural effusion. The cyst was successfully removed, and the pleural space was thoroughly irrigated with scolicidal solution (Figure 2). The patient's postoperative course was uneventful, and he was started on oral albendazole for 3 months to prevent recurrence. This case illustrates that in endemic regions, a hydatid cyst rupture can masquerade as a large pleural effusion in children. Early recognition and surgical management are crucial for a good outcome.

Figure 2.



Intraoperative and postoperative imaging of pulmonary hydatid cyst.

Keywords: Echinococcus, Hydatid cyst, Pleural effusion

Ref No: 2181

ASSESSMENT OF THE RELATIONSHIP OF CLINICAL AND LABORATORY PARAMETERS WITH PAST CORONAVIRUS INFECTION IN PATIENTS WITH CORONARY ARTERY RESTENOSIS.

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[1]Semey Medical University

Introduction and Purpose: Background: Understanding risk factors for stent thrombosis and restenosis is particular importance for individuals at risk for adverse outcomes, particularly in older patients with previously revascularized myocardium and associated medical conditions who have had COVID-19.The aim of our study is to evaluate the relationship between clinical and laboratory parameters and previous coronavirus infection in patients with coronary artery restenosis.

Materials and Methods: Materials and methods. A total of 931 patients were included in the study. 420 had coronary artery stent restenosis, of which 162 (38.5%) patients had previous COVID-19. The control group included 511 patients with repeated myocardial revascularization without stent restenosis. All statistical calculations were performed using SPSS version 20.0 software. The study was supported by the Science Committee of the Ministry of Education and Science of the Republic of Kazakhstan (grant No. AP19677465).

Results and Conclusion: Results. Analysis of laboratory parameters in patients demonstrated the presence of statistically significantly higher levels of IgG antibodies to coronavirus and C-reactive protein in the main study group compared to the control group. With regard to laboratory parameters, statistically significant differences were found in the level of troponin ($p < 0.001$). The level of D-dimer had statistically significant differences in the groups with a history of COVID-19 compared to the groups without COVID-19. The same trend was found for CPK, CPK-MB, CRP (with regard to this indicator, it should be noted that statistically significant differences were found even for groups with restenosis without COVID-19 compared to the group without restenosis and without COVID-19) and APTT.Conclusions. The results of our study indicated statistically significant differences in the indicators of C-reactive protein and IgG antibodies to coronavirus, which is probably due to the large proportion of patients who had coronavirus infection in the main group, even in the late period. After dividing the study groups by the presence of coronavirus infection in the anamnesis, statistically significantly higher values were also found for troponin, CPK, CPK-MB, D-dimer and APTT among individuals who had COVID-19. These data indicate a connection between clinical and laboratory parameters in patients who had coronavirus infection and the

processes of coronary artery restenosis.
Keywords: restenosis, coronavirus infection, stent thrombosis

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Ref No: 2193
On the Right? On the Left? Or Both Sides of It? Unexpected Fracture Case Report
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Introduction and Purpose: Introduction and purpose:In patients presenting to the emergency department trauma department, upper extremity and specifically elbow joint traumas are a subject that requires utmost attention in terms of anamnesis, physical examination and examination. We evaluated a very rare case of bilateral radial head fracture resulting from a simple fall.
Materials and Methods: Case:A 36-year-old male patient presented to our emergency room trauma unit shortly after 00:00 on Saturday night with complaints of pain in both elbows after falling from a chair 6 days before his admission. Physical examination revealed normal range of motion in both upper extremities, no restriction in supination and pronation movements of both forearms. Neurovascular examination was normal in both extremities, no edema or swelling in both arms upon palpation, and a mild pain complaint at the level of the raidus head in both arms. The patient was asked for the necessary imaging tests. The x-ray revealed a Mason type-2 fracture in the left raidus head and a Mason type-1 fracture in the right radius head.Oral analgesia was prescribed and he was treated conservatively with bilateral slings for approximately 2 weeks, followed by elbow mobilization and physical therapy. When the patient was first examined, the mechanism of trauma, the time that had passed, the day and time of emergency room application, and the findings obtained as a result of the physical examination were taken into consideration, there was a suspicion and prejudice that there could be abuse of emergency room services and unnecessary report requests. In cases of such patient applications, loss of motivation and attention is frequently observed in emergency room doctors regarding the necessary anamnesis, physical examination, and evaluation of requested tests.
right radius head fracture

right radius head fracture
right radius head fracture

right radius head fracture
left radius head fracture

left radius head fracture

left radius head fracture

left radius head fracture

Results and Conclusion: Results:Isolated radial head fractures are not a common type of fracture. They comprise approximately 2% of all fractures around the elbow. Bilateral radial head fractures are rare and are usually seen with fractures and dislocations associated with severe trauma. In this case, we wanted to emphasize the importance of carefully examining all requested tests after a good history and physical examination of patients presenting to the emergency department with mild trauma, regardless of external factors

Keywords: Radial head fractures, trauma, emergency medicine

Ref No: 2220

Infective Endocarditis Presenting with Typical Chest Pain due to Catheter-Related Intracardiac Mass

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Introduction and Purpose: Chest pain is one of the most common complaints in emergency departments. The etiology ranges from benign musculoskeletal pain to life-threatening cardiac events. Although infective endocarditis is rare, the increasing use of prosthetic heart valves, intracardiac pacemakers, and catheters has made it a growing cause. Catheter tip-related mass lesions can present with signs of myocardial ischemia due to impaired perfusion, especially if they exert a space-occupying effect. Depending on the severity of findings, treatment may vary from antibiotic therapy to mass resection. We present a case of infective endocarditis admitted with typical chest pain.

Materials and Methods: A 41-year-old male with a history of diabetes, hypertension, chronic renal failure, coronary artery disease, and congestive heart failure presented to the emergency department with severe typical chest pain that started during the night. Vital signs: BP 170/90 mmHg, HR 120 bpm, RR 18/min. Physical examination revealed bilateral rales and an S3 gallop. ECG showed T-wave inversions in leads D1 and aVL. Troponin levels were 653 initially and 769 after 2 hours. Echocardiography demonstrated an EF of 45% and a 2.6×1.6 cm mass at the catheter tip in the right atrium. The patient had metabolic acidosis and volume overload findings. The patient consulted with neprology and cardiovascular surgery. Emergency hemodialysis(HD) was performed after cardiovascular surgery placed a temporary catheter. Empirical antibiotics were initiated. The mass was unresponsive to antibiotics and anticoagulants. Staphylococcus epidermidis grew in blood and catheter cultures. Cardiac surgery consultation recommended mass resection, but the

patient refused and was discharged with follow-up advice.
Results and Conclusion: Infective endocarditis and intracardiac thrombus should be considered in patients presenting with acute chest pain and predisposing factors. Long-term use of central venous catheters, especially in HD patients, increases the risk of infection with resistant bacteria like MRSA. Early catheter removal and appropriate antibiotic therapy are critical in reducing mortality. Timely diagnosis and treatment are vital in emergency settings, especially in high-risk patients.
Keywords: Infective endocarditis, chest pain, catheter

Ref No: 2239
STEVEN JOHNSON SYNDROME
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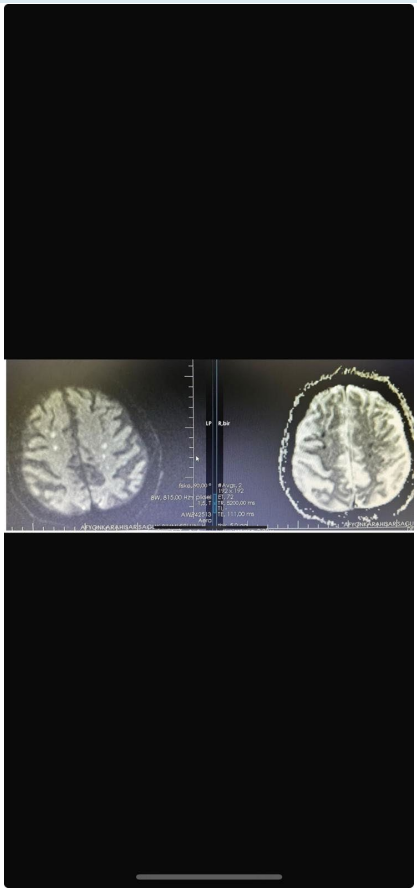
Introduction and Purpose: Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) are severe mucocutaneous adverse reactions characterized by fever, extensive necrosis, and detachment of the epidermis, most commonly induced by drugs. In more than 90 percent of patients, the mucosa is affected, usually at two or more separate sites. The estimated incidence across the disease spectrum is five to six cases per million per year. SJS/TEN is more common in women, with a female-to-male ratio of approximately 2:1.
Materials and Methods: An 80-year-old female patient presented to the emergency department as an outpatient with a complaint of a widespread rash on her body. She has a known history of heart failure, hypertension, and a 5-year history of coronary artery bypass surgery.Vital signs: Blood pressure: 100/70 mmHg, Pulse: 62 beats/minute, Respiratory rate: 24 breaths/minute, Temperature: 36.1°C, SpO2: 88% (without oxygen support).Examination: Glasgow Coma Scale (GCS): 15, Neurological examination: normal, Abdomen: soft, Respiratory system examination: bilateral fine rales present, no rhonchi, Widespread erythematous macules (red spots) on the skin (Figure 1).Due to elevated renal function test (RFT) results from an outside facility, non-contrast chest and abdominal CT scans were performed. No acute pathology was observed.Dermatology was consulted for the skin lesions, and Stevens-Johnson Syndrome (SJS) was suspected. Prednisolone treatment was administered.Nephrology did not consider dialysis indicated due to the etiology of acute kidney injury (AKI).During follow-up, the patient experienced a change in consciousness, and a diffusion-weighted brain MRI revealed multiple diffusion restrictions (Figure 2). Neurology did not consider acute thrombolytic therapy.Subsequent routine blood tests revealed elevated cardiac markers. The electrocardiogram (ECG) did not show any signs of acute myocardial infarction . Cardiology recommended transfer to the intensive care unit with a preliminary diagnosis of non-ST-elevation myocardial infarction (NONSTEMI).
Image 1

patient's skin lesions
Image 2



Results and Conclusion: The patient, who requires multidisciplinary follow-up, was consulted with the anesthesiology department for admission, and was transferred to an external intensive care unit. Stevens-Johnson Syndrome is a rare condition. It is thought that it can cause end-organ damage in patients. In our case, the patient was diagnosed with ischemic stroke and NONSTEMI, and it was observed that it caused damage to the cardiac and central nervous

Keywords: Cerebrovascular event, Stevens-Johnson syndrome, Nonstemi

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Ref No: 2249

Relationship between Laboratory Parameters and Balthazar Severity Score in Acute Pancreatitis

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Introduction and Purpose: Acute pancreatitis is a disease characterized by the activation of digestive enzymes, which are not normally active in the pancreas under normal conditions, by various etiologic factors,causing digestion and inflammation of pancreatic tissues and surrounding adjacent tissues(1).In 25-30% of patients, the clinical picture may become severe enough to threaten life and mortality rates may increase up to 15%(2).In the diagnosis of AP,sudden onset of abdominal pain in the back, elevation of serum lipase and amylase ratios more than 3 times higher than normal values and imaging methods are used(3). Various scores are used to determine the severity and prognosis of the disease in patients diagnosed with AP. Immature granulocyte percentage (IG%) has started to be used in clinics as a new inflammatory indicator(4).

Materials and Methods: The study was conducted on 250 patients who presented to the Emergency Department of XXX University Faculty of Medicine Hospital with abdominal pain and were diagnosed with "Acute Pancreatitis" between January 01,2018 and August 01, 2021.The relationship between the blood values of the patients we recorded and the patients grouped according to the Balthazar Severity Score was examined

Results and Conclusion: According to the Balthazar Severity Score we calculated, there were 194(77.6%)patients in the mild group and 56(22.4%)patients in the moderate group.When we compared these clinical severity groups according to laboratory values, a statistically significant difference was found between the two groups in terms of WBC,neutrophil, lymphocyte, NLO and PLO among the complete blood count parameters(p values 0.001, <0.001, 0.016, <0.001, 0.006,respectively). Immature granulocyte percentage(IG%)was not statistically significant between the two groups, whereas LDH and Lipase/Amilase ratio were statistically significant (p values <0.001 and 0.001, respectively).In terms of CRP, the results can be considered borderline significant (p= 0.051).When the cut-off for NLO was 14.9082,the sensitivity was 46.4%, specificity 85%, PPV 47.2% and NPV 84.6%. When the cut-off for lipase/amylase ratio was 2.2773, 69.6% sensitivity, 57.2% specificity,26.3% PPV and 86.7% NPV were found.Contrary to the studies conducted to recognize severe AP cases early,IG% was not statistically significant in our study.Lipase/Amilase ratio seems to be one of

the parameters that can be used to differentiate severe cases.
Keywords: Acute Pancreatitis, Balthazar Severity Score, Immature Granulocyte Percentage

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Ref No: 2284
ACUTE MASSIVE EMBOLISM
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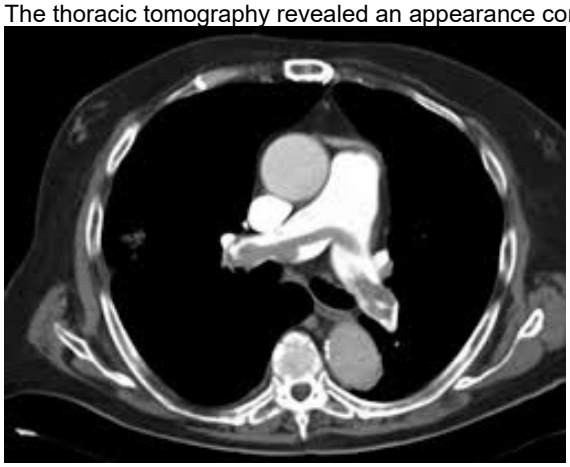
[1]ERZURUM ATATURK UNIVERSITY EMERGENCY MEDICINE DEPARTMENT
Introduction and Purpose: 57-year-old female patient with a history of hypertension, three previous angioplasties and one stent was not taking her medication regularly. The patient presented with sudden on set of dyspnoea at night. Upon examination of the system, it was discovered that the patient had been admitted to the hospital three days prior. Upon questioning, it was learned that the patient had presented with nosebleed three days prior. The patient's general condition was moderate, with a saturation of 85%, a pulse rate of 113, an arterial blood pressure of 89/56 mmHg, and a temperature of 36.3°C. A physical examination revealed decreased bilateral lung sounds. An electrocardiogram (ECG) showed sinus tachycardia, and hypoxaemia was present in the blood. The D-dimer value was 21,310, and acute massive embolism was observed on imaging (Figure 1). The patient was referred to the department of chest diseases for further assessment and treatment.
Materials and Methods: The thoracic tomography
The thoracic tomography revealed an appearance compatible with a massive embolism in both pulmonary arteries.



Results and Conclusion: In patients presenting with hypoxia and hypotension and a PERC score that cannot be excluded as the cause of sinus tachycardia, an embolism should be considered in the absence of sudden-onset dyspnoea and accompanying symptoms, provided that they are in the intermediate high-risk group according to the Wells score.
Keywords: EMBOLISM

Ref No: 2293
DO NOT IGNORE ANTICOAGULANTS !!! COMMON THROMBOSIS IN THE BODY
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Introduction and Purpose: Ischemic stroke and systemic embolism are the major potentially preventable complications of atrial fibrillation(AF) that lead to serious morbidity and mortality.Anticoagulation using vitamin K antagonists or non-vitamin K oral anticoagulants is mandatory for stroke prevention in AF.Anticoagulants have been used in medicine for many years to prevent thrombus, embolism and complications. Adequate knowledge and education of the patient and their relatives about the use of these drugs, which play an effective role in reducing morbidity and mortality in patients, play a key role in the proper use of these drugs.
Materials and Methods: A 77-year-old female patient, referred from an external center with a preliminary diagnosis of decompensated heart failure due to complaints of chest pain, shortness of breath, and swelling in the feet, was brought to the emergency department.The patient had a history of heart failure and COPD. She had been immobile for the last month and was started on oral anticoagulants. However, the patient did not use regular medications. At the time of admission; pulse was 142/min, respiratory rate was 26/min, and oxygen saturation was 85%. The electrocardiogram showed AF with a rapid ventricular response. Physical examination revealed GCS 14, dysarthric speech, fine crackles on respiratory system auscultation, tachycardic heart. Edema and homancy were positive in the right leg. Laboratory parameters are presented in Table 1. The patient was scheduled for transthoracic echocardiography (Figure-1), lower extremity venous doppler ultrasonography (Figure-2), pulmonary angiography (Figure-3), and diffusion MRI (Figure-4) in the emergency room. The patient was admitted to the cardiology intensive care unit, and thrombolytic and heparin treatment was administered. On the 3rd day of the follow-up, the patient developed cardiopulmonary arrest and was accepted as exitus.
Figure-1: Transthoracic echocardiography, thrombus in the right atrium in the apical 4-chamber window

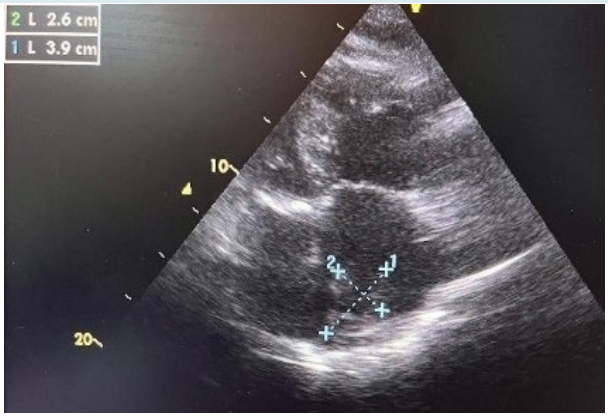

Figure-2: Thrombus in the superficial femoral vein on lower extremity venous doppler ultrasound

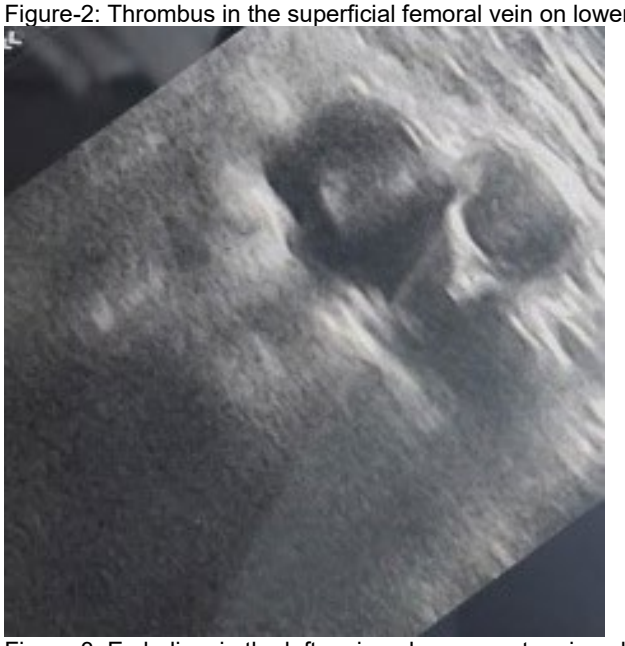

Figure-3: Embolism in the left main pulmonary artery in pulmonary angiography

Figure-4: Lacunar infarction in the parietal lobe in brain diffusion MRI

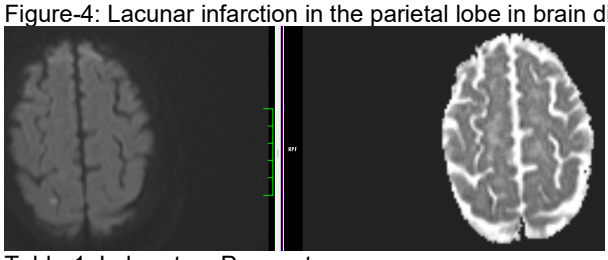

Table-1: Laboratory Parameters

Parameter	Result	Normal Range
D-dimer (µg/mL)	4.09	0-1
C reaktif protein (mg/dl)	201	0-5
INR(International Normalized Ratio)	1.47	0.8-1.2
Laktat (mmol/L)	4.09	0-2
Pro-BNP (pg/mL)	16036	5-624
Troponin (µg/L)	0,064	0-0,026

Results and Conclusion: The use of anticoagulant drugs is of vital importance in patients with indications. Patients' regular or non-regular use of drugs may lead to mortality and morbidity. Continuing patient education programs at intervals, increasing patients' knowledge levels about drugs, and eliminating concerns about safe drug use will increase the compliance of patients and their relatives, and reduce complications related to the use or non-use of drugs.
Keywords: Thrombus, Anticoagulation, drug

Ref No: 2315
Hair-thread tourniquet syndrome: A case report
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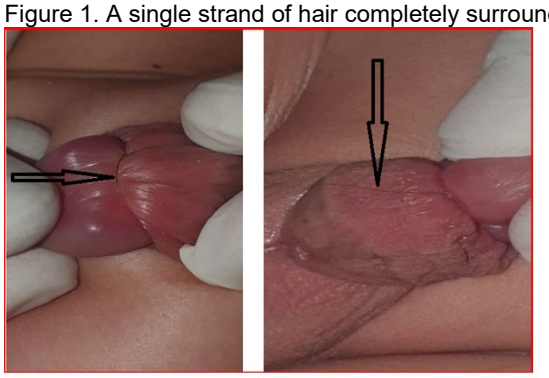
Introduction and Purpose: Introduction: Hair-thread tourniquet syndrome (HTTS) is a rare condition that occurs when hair strands wrap around body appendages, potentially leading to serious complications such as tissue loss. In this case report, we aim to present an HTTS case identified in a 2-year-old male child who presented to the emergency department with penile pain and dysuria.
Materials and Methods: Case report: A two-year-old male patient presented to the emergency department with complaints of penile pain, redness, and burning sensation during urination that had persisted for 24 hours. Physical examination revealed edema, erythema, and circular constriction on the penile shaft. Detailed examination showed a hair strand wrapped around the penis shaft. The hair was removed by cutting under local anesthesia. Doppler ultrasonography confirmed normal circulation. The patient was discharged after four hours of observation as his complaints subsided.
Figure 1. A single strand of hair completely surrounding the shaft of the penis



Results and Conclusion: Conclusion: In infants with unexplained restlessness, one should be cautious about HTTS, and it should not be forgotten that areas where this syndrome may occur should be carefully examined.
Keywords: Hair-thread tourniquet syndrome, pediatric emergency, penis

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Ref No: 2326
Acute Colchicine Toxicity in a Patient with Long-term Colchicine Therapy: Report of a Patient
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Introduction and Purpose: Despite colchicine toxicity being well documented in acute overdoses, it can occur in older adults with prolonged therapy, and in cases with a background of preexistent renal impairment. Even a relatively mild elevation in colchicine intake or impaired drug clearance secondary to renal impairment enormously multiplies the risk of severe toxicity In a similar manner, in colchicine-poisoned subjects, gastrointestinal symptoms (e.g., diarrhea) can exacerbate loss of fluids and renal impairment, creating a positive feedback loop of toxicity.Here we represent a rare case in which we have seen an acute-on-chronic colchicine toxicity.
Materials and Methods: A 76-year-old female with a history of giant cell arteritis, polymyalgia rheumatica, hypertension, type 2 diabetes mellitus, and prior triple-vessel CABG presented with presyncope and a fall. She had recent diarrhea (12 days prior) but no other preceding symptoms. She had been on long-term colchicine therapy but recently increased her dosage to 3-4 times daily for a month due to worsening knee pain.On examination:Hypotension (BP: 90/60 mmHg), tachycardia (HR: 90/min), and dehydration with Severe metabolic abnormalitiesK^+: 7.9 mmol/L,Na^+: 121 mmol/L,pH: 7.21,HCO_3: 6.2 mmol/L,Lactate: 10.9 mmol/L,Cr: 2.46 mg/dL,BUN: 160 mg/dL,AST: 2927 U/L,ALT: 3001 U/L,PT: 49 sec,INR: 4.61,Hb: 6.8 g/dLPlt: 71×10³/μL were noted. ECG revealed changes consistent with extreme hyperkalemia.
Results and Conclusion: In this case, long-term administration of colchicine, compromised renal function, and development of diarrhea most likely participated in reduced drug clearance and secondary acute-on-chronic colchicine toxicity. Clinically, such a picture manifested in unexplained acidosis and early multi-organ impairment, in agreement with the recognized first and second phases of colchicine toxicity. Gastrointestinal symptoms (nausea, emesis, and diarrhea) form stage one, and in contrast, stage two can have a seemingly mild picture but with impending multi-organ impairment. Old age can even make them less adherent to prescription orders, and hence, at high risk for accidental overdosing. Supportive therapy, rehydration with vigor, and hemodynamic support remain at the backbone of therapy, in consideration of no universally available antidote. Colchicine, therefore, must therefore be started with utmost caution in older adults, and in case its use cannot be avoided, proper observation of renal function is advisable to prevent acute toxicity.
Keywords: Toxicology, Colchicine

Ref No: 2345
Rare ıntussusception in pregnancy: challenges in diagnosis and treatment
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Introduction and Purpose: This study highlights the definition of intussusception and its risk factors during pregnancy. Although common in children, intussusception is rare in adults, especially during pregnancy. Factors such as hormonal changes and increased intra-abdominal pressure during pregnancy may contribute to the risk of intussusception. This case report discusses the clinical management of a 28-week pregnant patient who developed small bowel intussusception.
Materials and Methods: A 23-year-old, 28-week pregnant patient presented to the emergency department with abdominal pain and was referred for further evaluation. The abdominal pain was intermittent and severe, accompanied by nausea and loss of appetite. The patient had no pathological obstetric history, and physical examination revealed tenderness in the left upper and lower quadrants. Obstetric ultrasonography showed normal fetal biometry at 28 weeks, whereas abdominal ultrasonography indicated bowel wall thickening and lumen narrowing. Due to the suspicion of intussusception, further imaging was planned, but the patient was non-compliant. The patient was monitored in the general surgery ward, where her condition improved, leading to discharge without the need for surgical intervention.
Results and Conclusion: Intussusception during pregnancy is a rare but high-risk gastrointestinal pathology. In adults, it is usually secondary to an underlying cause, whereas in pregnancy, most cases are idiopathic. Diagnosis is challenging due to nonspecific symptoms. While ultrasonography is the primary imaging method, MRI provides higher diagnostic accuracy. Conservative treatment is generally unsuccessful, and surgical intervention is required in most cases. In this particular case, the patient improved without the need for surgery.
Keywords: Pregnancy, Intussusception, Small intestine

Ref No: 2435
HEREDITARY SPHEROCYTOSIS IN ADULT EMERGENCY
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[1]emergency department of ataturk university
Introduction and Purpose: The diagnosis of hereditary spherocytosis is based on clinical findings, presence of spherocytosis in peripheral smear, family history of hemolytic anemia, and abnormal osmotic fragility (OF) test. The main diagnostic criterion in this disease is the presence of spherocytes in the peripheral smear. Clinically, the disease can progress in severe and mild forms. It is usually recognized and diagnosed in childhood. If the clinical progression is severe, splenomegaly may reach advanced dimensions and splenectomy may be required.
Materials and Methods: A 20-year-old male patient presented to us with complaints of malaise, anorexia and palpitations. The patient's vitals showed nb:108 ta: 106/62 sat:92 ss:14 temperature:36.2. On inspection, conjunctivae, face and neck were icteric. When the patient was asked about this condition, he stated that he was the youngest of 8 siblings and his eyes had been yellow since birth. He said that he had occasional fatigue but it resolved spontaneously. In the abdominal examination, the spleen was palpable 4 fingers from the left inferior ribs. Rectal touch was observed as fecal matter. No external acute pathologic examination was observed. Direct bilirubin:0.48 total bilirubin:3.42 ldh:2388 hgb:4.9 was found in the tests of the patient. On abdominal USG, 'Liver and pancreas were in normal tissue integrity as far as can be observed and no obvious acute gross pathology was observed. The gallbladder has a semicontracted appearance. Choledochal and intrahepatic bile ducts are normal. No hydronephrosis was observed in bilateral kidneys. No free fluid was observed in the abdomen. Bladder was empty and could not be evaluated. Spleen CC measured 152 mm and clinical evaluation is recommended if necessary.' It was reported as follows. A peripheral smear was performed. He was hospitalized with a

prediagnosis of hereditary spherocytosis.
Results and Conclusion: Although hereditary spherocytosis should be diagnosed in children, it can also be diagnosed in adult patients like our patient. We should not reduce the preliminary diagnoses we should consider just because our patient is an adult. It should be kept in mind that even if every prediagnosis is not compatible with age, it is always more valuable whether it is clinically compatible or not.
Keywords: hereditary spherocytosis, adult patient

Ref No: 2438
Pulmonary Embolism (PE)
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[1]Ataturk University
Introduction and Purpose: Pulmonary Embolism (PE) is commonly caused by deep vein thrombosis. Pulmonary embolism leads to clinical symptoms such as shortness of breath, back pain, and others.
Materials and Methods: A 20-year-old female patient presented to our emergency department with complaints of throat, back, and side pain, as well as shortness of breath, lasting for one week. The patient had previously visited the hospital a week ago with similar symptoms and was discharged with prescriptions for cystitis and upper respiratory tract infection (URI). The patient has no chronic illnesses or medication use, except for oral contraceptives (OCP) for known PCOS. Upon arrival, her vital signs were as follows: BP: 93/62, O2 saturation: 72%, Pulse: 132, Temperature: 36.8°C. In the physical examination, the only finding was reduced breath sounds in the lung bases. Given the patient's moderate to poor clinical condition, the most likely diagnosis of PE, tachycardia, and OCP use, the patient was immediately evaluated and imaged without waiting for the D-Dimer test. A CT angiogram of the pulmonary arteries revealed pulmonary embolism. The patient was referred to cardiology for echocardiography and to pulmonology for PE management. The patient was admitted for thrombolytic therapy.
Results and Conclusion: Pulmonary embolism should be considered in patients, even young ones, with abnormal vital signs, a history of OCP use, and repeated visits due to shortness of breath.
Keywords: Pulmonary Embolism, Oral Contraceptive, Shortness of Breath

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Ref No: 2449
Comprehensive Evaluation of Splenium Lesions: A Multitude of Potential Causes
Cesareddin Dikmetaş[1], Boran Polat[1], Yunus Emre Gülel[1], Aslıhan Onuralp[1], Burcu Sena Aydın[1], Dilek Atik[1]
[1]Karamanoglu Mehmetbey University
Introduction and Purpose: Transient splenial lesions of the corpus callosum can occur in many conditions, including cancer, drug use, metabolic and cerebrovascular disorders, and infections.Brain magnetic resonance imaging often reveals signs of cytotoxic edema in the splenium, which typically resolve as clinical symptoms improve.In most cases, the prognosis is favorable (1).We present a case of 31-year-old-male with a corpus callosum lesion with a complaint of leg pain and numbness which was resolved 2 days after its presentation.
Materials and Methods: A 31-year-old male patient presented with complaints of left leg pain and numbness on the left side of his face. He uses hydroxychloroquine for known Sjögren's disease. There are no other known medical conditions.On examination:Vital signs: Blood pressure was 120/60 mmHg, pulse was 80 beats per minute, oxygen saturation was 98%, and temperature was 36.6°C.Neurological examination: No focal deficits were observed. Cranial nerves were intact, and there were no signs of motor or sensory deficits. The patient demonstrated normal coordination and cerebellar function. Reflexes were normal, and there were no signs of meningeal irritation.No significant findings were observed in laboratory tests. Acute diffusion restriction was noted in the corpus callosum on diffusion MRI (Figure 1). No acute pathology was detected on brain tomography.The patient was referred to neurology, and a brain MRI was performed to exclude malignancy. Subsequently, the patient was admitted to the neurology department and consulted with rheumatology to exclude rheumatologic causes. The lesion was attributed to an ischemic etiology. He was discharged on the second day of hospitalization, as he had no further complaints and no acute pathology was detected in follow-up examinations.
Results and Conclusion: Splenium lesions of the corpus callosum have a broad differential diagnosis, including ischemic, inflammatory, neoplastic, and demyelinating etiologies. Their clinical presentation varies widely, ranging from asymptomatic findings to significant neurological deficits. Diffusion MRI plays a key role in identifying these lesions, which typically present as restricted diffusion without contrast enhancement. Given the diverse underlying causes, a comprehensive evaluation is essential for accurate diagnosis and appropriate management
Keywords: cerebrovascular disorders, corpus callosum lesion, hydroxychloroquine

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Ref No: 2478
A CASE OF TYPE A AORTIC DISSECTION PRESENTING WITH INFERIOR STEMI
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[1]Manisa Celal Bayar University School of Medicine, Emergency Department, Manisa, Turkey
Introduction and Purpose: The most common symptom in patients with Type A Acute Aortic Dissection is chest pain,which is present in 64–82% of cases at the time of admission.Since treatment strategies differ significantly,the most crucial differential diagnosis is acute coronary syndromes(1,3).The use of point-of-care ultrasound(POCUS)in the emergency department can facilitate the early diagnosis of aortic dissection,potentially improving patient mortality and morbidity
Materials and Methods: A 66-year-old male patient presenting with chest pain was brought to our emergency department by EMS The initial electrocardiogram revealed ST elevation in the inferior leads,leading to a diagnosis of STEMI,and the patient was administered 300 mg of aspirin.Upon arrival,his blood pressure was 98/53 mmHg,heart rate was 57 bpm.His medical history included hypertension and diabetes mellitus,along with a family history of cardiac disease.The ECG obtained in the emergency department showed >2 mm ST-

segment elevation in leads D3 and AVF,accompanied by complete AV block,along with reciprocal >2 mm ST-segment depression in leads D1 and AVL.POCUS revealed an aortic root dilation of 58 mm in the parasternal long-axis view,with a mobile echogenic structure suggestive of a dissection flap.In the suprasternal notch window,a mobile echogenic structure consistent with a dissection flap was also observed within the aorta.To confirm the extent and location of the dissection,CT angiography was planned.The patient was diagnosed with Type A Aortic Dissection and was taken for emergency surgery by the cardiovascular surgery team

figure1

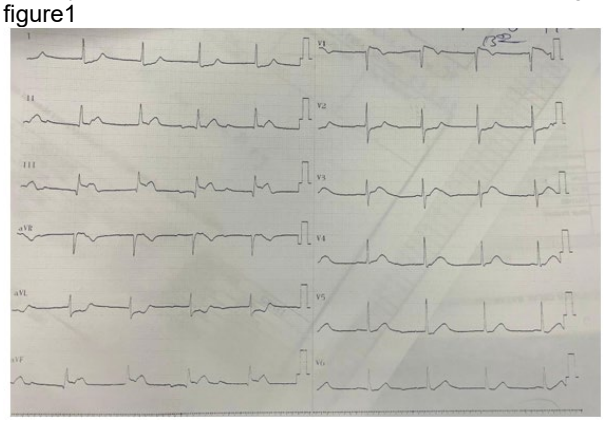


figure 2

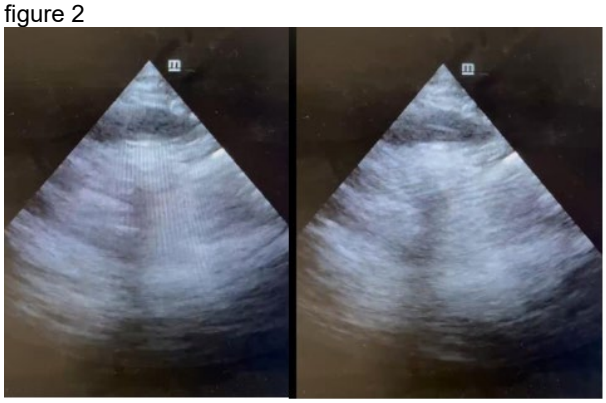
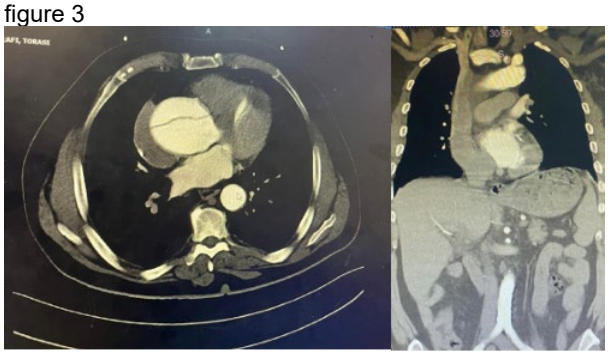


figure 3



Results and Conclusion: Acute myocardial infarction (AMI) due to the propagation of acute Stanford Type A Aortic Dissection is a rare but devastating event, occurring in approximately 3% of patients with aortic dissection(1).Differentiating patients with coronary malperfusion due to acute Stanford Type A Aortic Dissection from true acute myocardial infarction poses a significant challenge for emergency physicians. Misdiagnosis is particularly common in patients presenting with ST-segment elevation on ECG (5,6).A key diagnostic finding is the presence of an intimal flap separating the true and false lumens.Considering that delayed diagnosis is a major contributor to mortality, the use of point-of-care ultrasound (POCUS)in the emergency department enables early diagnosis and improves survival outcomes. Greater emphasis should be placed on ultrasound training and POCUS education in emergency medicine residency programs and medical school curricula.

Keywords: POCUS, Chest Pain, Aortic Dissection

Ref No: 2493

Investigation of the Effectiveness of the Emergency Department Chest Pain Assessment Score in Patients Followed with a Preliminary Diagnosis of Acute Coronary Syndrome

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[1]Bezmialem Vakıf University

Introduction and Purpose: Chest pain assessment in emergency departments is crucial for early diagnosis and safe discharge decisions. Current scoring systems may be insufficient in predicting major cardiac events. Recently,a clinical scoring system called the Emergency Department Acute Chest Pain Score (EDACS) has been proposed to facilitate a rapid assessment without the need for additional tools. EDACS is a scoring system specifically developed for ED settings, designed to be simple to apply, capable of making early and high-discharge decisions for chest pain patients, and associated with a low false-negative rate. This study evaluates the effectiveness of the Emergency Department Chest Pain Score (EDACS) in risk assessment.
Materials and Methods: This retrospective study included patients over 18 years old admitted to the emergency department with suspected acute coronary syndrome between 01.06.2023 and 31.12.2023. Data were obtained from the hospital automation system, and patients' demographic and clinical characteristics, along with EDACS scores, were recorded. Patients were classified as low or high risk, and the concordance of this classification with clinical outcomes was analyzed. The study has received Ethics Committee approval with the number 2024/115 on 01.04. 2024.
Results and Conclusion: Of the total patient population, 48.4% were female and 51.6% were male. The mean age was 56.7 (±1.17) years (p=0.275). Among patients presenting with chest pain, 22.5% (N=36) were classified as high-risk according to the EDACS score. MACE (major adverse cardiac events) occurred in 25% (N=9) of these high-risk patients. In contrast, 77.5% (N=124) of the patients were classified as low- risk based on the EDACS score. Among this group, 16.93% (N=21) experienced MACE. While a higher percentage of high-risk patients (22.5%) experienced MACE compared to low-risk patients (16.93%), the overall relationship between the EDACS score and MACE occurrence was not statistically significant. These results suggest that the EDACS score alone may not be a reliable predictor of MACE in patients presenting with chest pain. Further studies are needed to explore additional factors that could improve the accuracy of risk stratification.
Keywords: Acute coronary syndrome, emergency department, EDACS

Ref No: 2500
Geospatial and seasonal patterns of emergent air transfers from hospitals on Greece's Aegean islands
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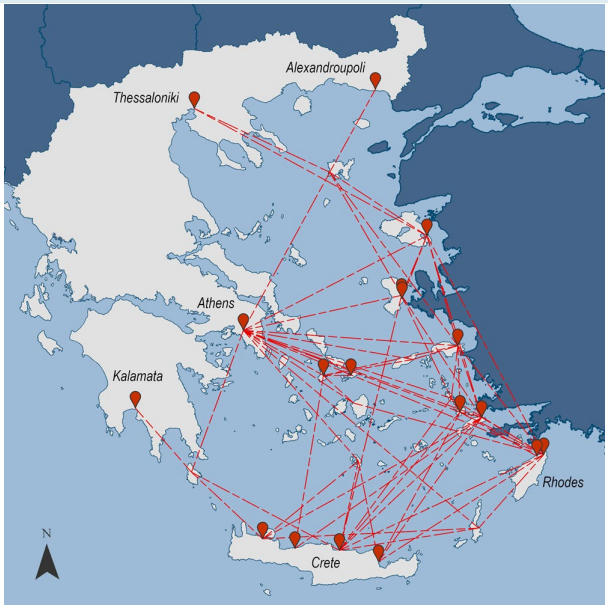
[2]2nd Regional Health Authority of Piraeus and the Aegean islands – Ag. Ioannis Rentis, Greece
[3]National Centre of Emergency Care (EKAB) – Athens, Greece
[4]Department of Geography, Harokopio University of Athens – Athens, Greece
[5]Nikaia General Hospital – Nikaia, Greece
Introduction and Purpose: Although one-third of Greece's residents live on its islands, emergency care capacity in these regions remains largely understudied. Healthcare facilities on island chains frequently need to transfer patients to a higher level of care and emergent transport by air ambulance incurs significant financial cost. This cross-sectional observational study focused on fourteen Greek islands in 2023, examining monthly emergency department (ED) visits, air ambulance transfers, hospital capacity, and population fluctuations due to tourism.
Materials and Methods: Data was obtained from the Administration of the 2nd Regional Health Authority of Piraeus & Aegean Islands, the Institute of SETE, and Hellenic National Center of Emergency Care. The islands of Chios, Ikaria, Kalymnos, Karpathos, Kythera, Kos, Leros, Limnos, Mytilene, Naxos, Rhodes, Samos, Santorini and Syros were chosen due to data availability. A negative binomial regression was performed to assess factors related to emergent air transfers. Predictor variables included the month, ED visits per capita, hospital bed capacity, and monthly changes to population from tourist arrivals by air. ArcGIS Pro software was utilized to create a map illustrating routes of air ambulance transfers.
Results and Conclusion: The number of tourist arrivals were a significant predictor of air transfers, with each additional 1,000 tourists associated with approximately 4 additional transfers per month ($p<0.001$). ED visits per capita were also a significant positive predictor ($\beta=10.54$, $p=0.0065$), indicating that islands with higher ED utilization per capita had more air transfers. Conversely, bed capacity per capita was strongly negatively associated with transfers ($\beta=-44.66$, $p<0.001$). There was no significant association between month and transfer volume ($p>0.05$), suggesting that seasonal patterns in air transfers are driven by tourist influx. These findings underscore the importance of strengthening healthcare capacity on islands to accommodate seasonal population surges. In addition to increasing bed capacity, improving emergency medicine training may enhance the ability of local providers to stabilize and manage complex patients, reducing the need for costly air ambulance transfers. Countries facing geographic barriers to patient transport and seasonal variations in ED demand can apply these insights to optimize emergency care planning.
Air Ambulance Transfers 2023



Keywords: GIS, Aegean, emergency medicine

Ref No: 2546

Comparison of the efficacy of urapidil and nicardipine in hypertensive emergency and urgency patients with chronic renal failure

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[1]**Ataturk University Faculty of Medicine Research Hospital**

Introduction and Purpose: Chronic Kidney Disease (CKD) is a worldwide common disease characterized by progressive loss of kidney function. Hypertension is frequently seen in CKD patients, and hypertensive emergency and urgency increase the risk of serious complications in these patients. Hypertensive emergency patients presenting to the emergency department need to be treated effectively and rapidly. The aim of this study was to compare the efficacy of urapidil and nicardipine in CKD patients admitted to the emergency department for hypertensive emergency or urgency and to determine which drug is more effective in terms of blood pressure control.
Comparison of systolic and diastolic blood pressures between drug groups

İlaç grubu p	Urapidil	Nikardipin
Ort±s.s. Medyan (Min-Max)	190,96±22,53 188 (160-249)	190,32±21,18 189 (160-235)
0.dk TA Sistolik	0,913[2]	
2.dk TA Sistolik	163,82±26,17 163,5 (113-220)	177,93±19,26 175,5 (131-225)
5.dk TA Sistolik	0,026[2]	
	162,43±22,31 163 (130-218)	169,5±24,01

166 (117-219)
0,259²
15.dk TA Sistolik
163,57±21,42
164 (124-212)
161±19,49
160 (119-207)
0,640²
45.dk TA Sistolik
165,61±28,63
160,5 (127-228)
153,89±13,56
151 (125-183)
0,225¹
1.sa TA Sistolik
164,04±32,13
157,5 (116-241)
154,39±13,96
152 (134-187)
0,481¹
2.sa TA Sistolik
166,89±25,71
161,5 (123-234)
154,71±16,94
153 (113-186)
0,041²
6.sa TA Sistolik
162,54±18,23
167,5 (124-198)
155,36±15,46
156 (120-187)
0,118²
0.dk TA Diastolik
105,57±19,59
103 (68-141)
102,57±13,23
105 (71-129)
0,505²
2.dk TA Diastolik
91,57±18,51
94,5 (60-127)
93,64±16,4
91,5 (55-125)
0,659²
5.dk TA Diastolik
90,96±17,46
89,5 (56-126)
89,14±16,84
90 (55-129)
0,693²
15.dk TA Diastolik
91,43±15,6
90,5 (67-120)
85±15,41
85 (60-111)
0,127²
45.dk TA Diastolik
91,61±16,41
93 (67-123)
80,5±11,9
80 (62-102)
0,019¹

1.sa TA Diastolik
93,39±17,77
88,5 (70-133)
79,93±12,42
79,5 (59-107)
0,002²
2.sa TA Diastolik
90,82±17,31
90 (62-131)
83,11±12,34
82 (61-104)
0,060²
6.sa TA Diastolik
90,32±13,01
91,5 (68-118)
85±9,7
87,5 (70-110)
0,088²

The 2nd minute systolic blood pressure was significantly (p=0.026) higher in the nicardipine group, while the 2nd hour systolic blood pressure was significantly (p=0.041) higher in the urapidil group. In addition, diastolic blood pressures at 45 minutes and 1 hour were significantly (p=0.019 and p=0.002) higher in the urapidil group.

Materials and Methods: This study was designed as a randomized single-blind study and conducted in a single center after ethics committee approval. A total of 56 patients diagnosed with hypertensive emergency or urgency were randomly divided into two groups. One group received urapidil (25mg/5ml intravenous push) and the other group received nicardipine (25mg/10ml, 5mg/hour infusion).Blood pressure values at 0.min, 2.min, 5.min, 15.min, 45.min, 1.h, 2.h and 6.h were recorded in all patients. In addition, vital signs, physical examination findings, electrocardiography and echocardiography results, and laboratory values (EGFR (estimated glomerular filtration rate), creatinine, troponin, electrolytes, blood gases) were analyzed.

Results and Conclusion: Of a total of 56 patients, 32 were male and 24 were female and the patients were equally distributed to the urapidil (n=28) and nicardipine (n=28) groups.- The 2nd minute systolic blood pressure value was found to be higher in the nicardipine group than in the urapidil group.- The 2nd hour systolic, 45th minute and 1st hour diastolic blood pressure values were higher in the urapidil group than in the nicardipine group.- When 0.min blood pressure values were compared with other time intervals, a significant decrease was found in both drug groups.- Troponin values were higher in the nicardipine group than in the urapidil group.In conclusion, urapidil and nicardipine can be safely used for blood pressure control in CKD patients with hypertensive emergency and urgency. However, it was concluded that urapidil should be preferred to nicardipine because of its superior ability to provide immediate blood pressure reduction and its more advantageous both economically and in terms of labor saving.

Keywords: cronic kidney disease, urapidil, nicardipin

Ref No: 2575

Göz Hareketleri ve Dengeyi Kaybeden Bir Hasta: Miller Fisher Sendromunun Nadir Bir Vaka İncelemesi

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Introduction and Purpose: Miller-Fisser sendromu(MFS), immün aracılı inflamatuar demiyelinizan periferik nöropatidir.MFS'nin klinik ayırt edici özelliği, bakteriyel veya viral bir hastalığın öncesinde akut oftalmopleji, arefleksi ve ataksi üçlü sunumudur.

Materials and Methods: 14 yaşında çift görme ve dengesizlik şikayeti ile başvuran hastanın takiplerinde derin tendon reflekslerinde azalma saptanmıştır.Bu vakada Miller Fisser sendromu düşünülüp tedavi başlanmıştır hasta tedaviye yanıt vermediği için beyin sapı tutulumu da mevcut olması sebebiyle entübe edilip üst merkeze sevk edilmiştir.

Results and Conclusion: Periferik sinir ile mikrobiyal/viral antijenler arasındaki moleküler taklitin adaptif bağışıklık sisteminin aktivasyonu yoluyla gerçekleştiği düşünülmektedir. Fizik muayene bulguları arasında yüz felci, üst motor nöron disfonksiyonu belirtileri olmadan distal hiporefleksi ve distal ekstremitelerde ışık ve titreşim duyusunun kaybı gibi GBS için tipik bulgular bulunur. MFS ve/veya GBS için klinik şüphe varsa, ayırıcı tanıyı daha da daraltmak için uygun beyin omurilik sıvısı (BOS) çalışmaları ile lomber ponksiyon gereklidir. MFS esas olarak yeterli destekleyici bakım, ağrı kontrolü, gerektiğinde solunum desteği ve immünoterapi ile tedavi edilir. Akut GBS ve varyantı MFS'li bir hasta için yatan hasta ve yoğun bakım ünitesi (YBÜ) yerleşimi önemli bir husustur. Bu, semptomların şiddetine ve en önemlisi solunum durumuna dayanmaktadır. MFS'nin sonucu genellikle %5'ten az bir vaka ölüm oranıyla iyidir.Miller Fisher sendromu, nadir ve karmaşık bir nörolojik hastalıktır. Erken tanı ve tedavi, iyileşme sürecini önemli ölçüde hızlandırabilir.

Keywords: Miller Fisser sendromu, nöropati, ataksi

Ref No: 2590

Predictive value of the Hemoglobin, Albumin, Lymphocyte and Platelet score for mortality in geriatric patients presenting to the emergency department

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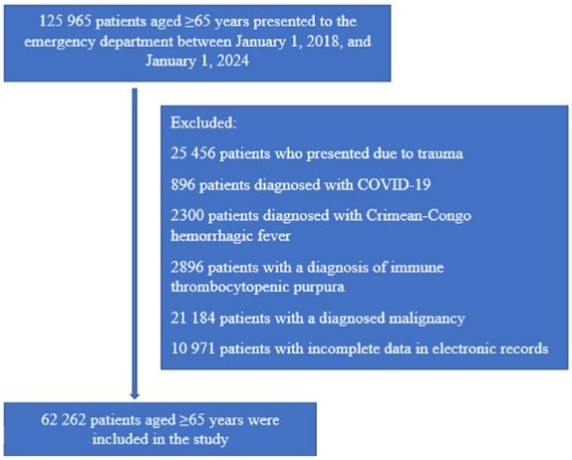
Introduction and Purpose: The Hemoglobin, Albumin, Lymphocyte and Platelet (HALP) score, calculated as hemoglobin, albumin, lymphocytes/platelets, serves as a novel biomarker that can provide insights into a patient's nutritional status, anemia status and inflammatory processes. This study aimed to investigate the predictive value of the HALP score for mortality among geriatric patients presenting to the emergency department.

Materials and Methods: This retrospective study was carried out at the emergency department of a tertiary hospital. Patients aged ≥65 years who presented to the emergency department between 1 January 2018 and 1 January 2024 were included in the study. A total of 62,262 patients who visited our emergency department were enrolled. Patient data, including hemoglobin, albumin, lymphocyte and platelet values; age; sex, the reason for hospital presentation; and outcome (mortality or discharge) were obtained from electronic medical records. HALP scores were calculated for the patients, and statistical analyses were carried out.

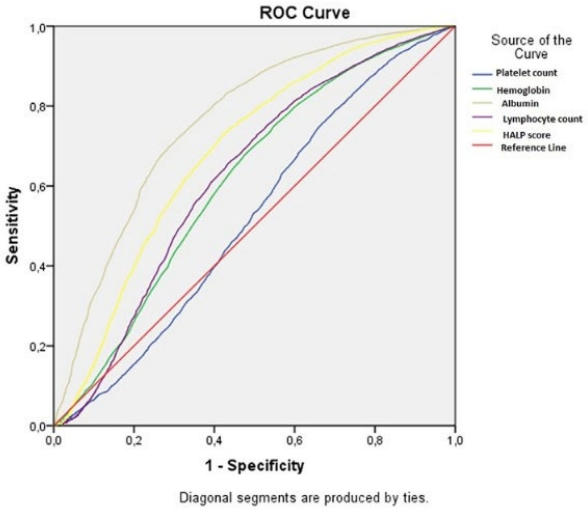
Results and Conclusion: Table 1 summarizes the demographic characteristics of the patients, including age, gender, platelet count, hemoglobin level, albumin level, lymphocyte count, and HALP scores, categorized by outcome. When evaluating the correlation between patient outcomes and other variables, a negative correlation was observed between the HALP score and patient outcome. There was also a negative correlation between age and patient outcome. Both age and the HALP score showed statistically significant relationships with patient outcome ($p < 0.001$ for both). Upon analyzing the utility of platelet count, lymphocyte count, albumin, and hemoglobin levels measured at the time of emergency department presentation for predicting patient outcomes, it was observed that the albumin level at presentation was the most effective predictor of patient outcomes. Following albumin, the HALP score, which involved the evaluation of all parameters simultaneously, emerged as the second most valuable predictor of patient outcomes based on the ROC analysis (Figure 2, Table 2). Geriatric patients initially presenting with a low HALP score should be considered at increased risk for mortality and may benefit from hospitalization and further evaluation by a geriatric specialist rather than being discharged from the emergency department.

Figure 1



Flow chart for patientselection

Figure 2



Receiver operatingcharacteristic (ROC) analysis forpredicting patient outcomes. HALP,Hemoglobin, Albumin, Lymphocyteand Platelet.

Table 1

Variables	Total (n = 62,262)	Mortality (n = 3093)	Discharge (n = 59,169)	p value
Age, median (IQR)	73 (69–79)	77 (71–83)	73 (69–79)	**<0.001**
Gender, n (%) **Male** **Female**	 32,410 (52.1%) 29,852 (47.9%)	 1,618 (52.3%) 1,475 (47.7%)	 30,792 (52.0%) 28,377 (48.0%)	**0.769**
Platelet count (×10³ µl), median (IQR)	236 (191–288)	230 (173–300)	236 (192–288)	**<0.001**
Hemoglobin (g/dL), median (IQR)	13.3 (11.8–14.7)	12.2 (10.2–14.1)	13.2 (11.8–14.7)	**<0.001**
Albumin (g/dL), median (IQR)	3.75 (3.42–4.03)	3.2 (2.7–3.6)	3.8 (3.4–4.0)	**<0.001**
Lymphocyte count (×10³ µl), median (IQR)	1.78 (1.02–2.09)	1.1 (0.7–1.8)	1.5 (1.0–2.1)	**<0.001**
HALP score, median (IQR)	37 (29–43)	17.0 (9.2–31.7)	39.2 (18.8–47.5)	**<0.001**

Basic characteristics of patients by outcome
Table 2

Parameter	Cut off	AUC	p value	Sensitivity (%)	Specificity (%)	95% CI
Platelet count	219.5	0.520	<0.001	59.5	45.1	0.509-0.532
Hemoglobin	12.5	0.615	<0.001	70.8	49.3	0.603-0.626
Albumin	3.7	0.762	<0.001	60.3	77.6	0.752-0.771
Lymphocyte count	1.31	0.624	<0.001	61.0	60.7	0.612-0.635
HALP score	21.2	0.685	<0.001	70.1	60.0	0.674-0.696

Optimal cut-off points of the HALP score for predicting patient outcomes
Keywords: Emergency department, HALP score, Geriatric patients

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Ref No: 2675
Pseudocyst Complication After Pancreatitis: A Case Report
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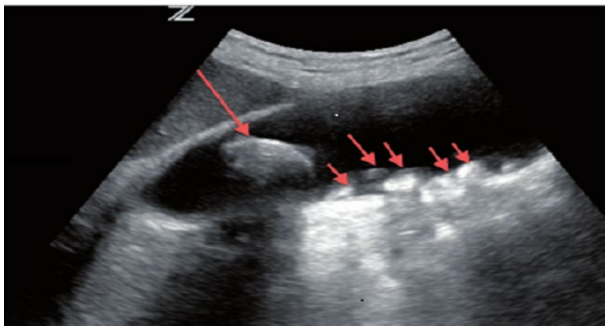
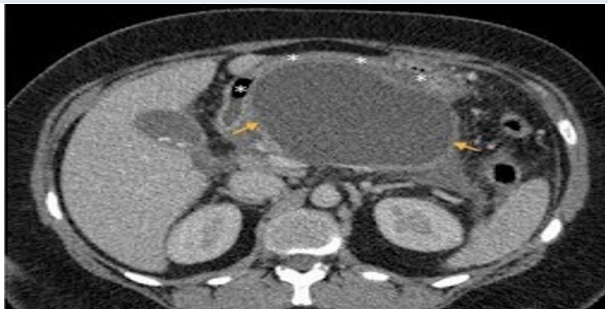
[1]ERZURUM ŞEHİR HASTANESİ
Introduction and Purpose: Acute pancreatitis is a common inflammatory disorder of the pancreas, with complications such as pancreatic pseudocysts occurring in a significant proportion of patients. Pseudocysts are fluid-filled collections that form after episodes of acute pancreatitis, often due to the accumulation of pancreatic enzymes and inflammatory exudates.
Materials and Methods: This case report presents a 46-year-old male with a history of acute pancreatitis, who presented with abdominal pain and nausea. Laboratory tests and imaging confirmed acute pancreatitis, likely due to gallstones, and a Ranson score of 3 suggested moderate risk for complications. Initial management included symptomatic treatment and hydration, followed by endoscopic retrograde cholangiopancreatography (ERCP) to remove a stone obstructing the common bile duct, which normalized bile flow. On the fifth day of hospitalization, an abdominal ultrasound revealed a 25×13 mm pseudocyst. As no complications arose, the pseudocyst was conservatively monitored, with oral intake discontinued. The patient's clinical and laboratory parameters improved, and he was discharged on the 16th day.
Red arrows indicate stones



Yellow arrows indicate pseudocyst



Results and Conclusion: This case highlights the importance of early diagnosis and intervention in acute pancreatitis, particularly with the use of ERCP in managing biliary obstruction. It also underscores the necessity of close monitoring for complications such as pseudocyst formation, with conservative management being appropriate for asymptomatic cases. A multidisciplinary approach and timely therapeutic interventions are critical for optimal patient outcomes in acute pancreatitis

Keywords: acute pancreatitis, pancreatic pseudocyst, gallstones

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Ref No: 2679

From Emergency Department to Infectious Diseases: The Hidden Faces of Crimean-Congo Hemorrhagic Fever Mimickers

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Introduction and Purpose: Crimean-Congo Hemorrhagic Fever (CCHF) is a severe viral hemorrhagic fever with a high mortality rate. The disease causes leukopenia, thrombocytopenia, and elevated liver enzymes. Conditions such as brucellosis, leptospirosis, Q fever, sepsis, and hematologic malignancies can mimic CCHF. This study presents four cases from our hospital's emergency department in 2024 that were evaluated in the differential diagnosis of CCHF.

Materials and Methods: Case 1: A 42-year-old female patient presented to the emergency department with fever, abdominal pain, and bloody diarrhea. Laboratory results revealed a leukocyte count of 4,250/mm³,platelet count 112,000/mm³. The patient was hospitalized with a preliminary diagnosis of CCHF, but the PCR test was negative. During follow-up, hemoglobin and platelet levels decreased, and BUN/creatinine levels increased. Internal medicine consultation was requested, and the patient was diagnosed with hemolytic uremic syndrome (HUS). Case 2:A 26-year-old male patient presented with fever, fatigue, and joint pain. A tick was detected on his back. He was hospitalized with suspected CCHF, but the PCR test was negative. Upon further anamnesis, it was discovered that he was engaged in livestock farming and consumed raw milk. Brucella STA test was positive at 1/1280. Case 3: A 22-year-old male patient presented with fever, diarrhea, and abdominal pain. Physical examination revealed subicteric sclerae, gum bleeding. Laboratory tests showed leukocytes of 6,500/mm³, platelets 78,000/mm³. The CCHF PCR test was negative. Further anamnesis revealed a history of fishing and swimming in a pond. A leptospira test was performed, and the result was positive. The patient received appropriate treatment and was discharged.Case 4: A 54-year-old female patient presented to the emergency department with fever, fatigue, and widespread body pain. Laboratory results showed leukocytes of 14,750/mm³,platelets 76,000/mm³. Due to her origin from an endemic region, she was hospitalized with a preliminary diagnosis of CCHF, but the PCR test was negative. Given the presence of epistaxis and thrombocytopenia, a hematology consultation was requested. Bone marrow biopsy revealed a diagnosis of B-cell acute lymphoblastic leukemia (ALL) (Table 1).

Comparison of selected clinical and laboratory characteristics off our patients

Table1.Comparisonofselectedclinicalandlaboratorycharacteristicsoffourpatients

Feature	Case1 (HUS)	Case 2 (Brucellosis)	Case (Leptospirosis)	Case 4 (BCellALL)
Age (years)	42	26	22	54
Gender	Woman	Male	Male	Woman
Application Complaints	Fever, abdominal pain, bloodydiarrhea,boneand joint pain	Fever, weakness, abdominalpain,nosebleeds	Fever,diarrheaand abdominal pain	Fever,malaise,widespread bodypain
WBC (/µL)	4250	4310	6500	14750
PLT (/µL)	112000	96000	78000	76000
Hb (g/dL)	11.3	11.2	9.1	8.27
Creatinine (mg/dL)	1.19	1.21	1.1	0.72
AST (U/L)	17	136	210	194
ALT (U/L)	13	152	95	96

LDH (U/L)	416	528	180	616
CK(U/L)	755	379	65	657
KeyFindings	Hemoglobin and platelet decrease,BUN/creatinine increase	Tick on back, splenomegaly,brucellosis STA test positive	Subicteric sclera, bleeding gums, hepatomegaly,history of pond swimming	Nosebleeds,B-cellALLon bone marrow biopsy
CCHF PCRResult	Negative	Negative	Negative	Negative
Definitive Diagnosis	HUS	Brucellosis	Leptospirosis	BCellALL
Applied Treatment/ Result	Transferredtointernal medicine clinic	Brucellosistreatment started	Leptospirosistreatment started	Transferredtohematology clinic

WBC: White blood cell (leukocyte) count; PLT: Platelet; AST: Aspartate aminotransferase; ALT: Alanine aminotransferase;LDH:Lactatedehydrogenase;CK:Creatinekinase.CCHF:CrimeanCongoHemorrhagic Fever; PCR: Polymerase Chain Reaction.

Results and Conclusion: CCHF should be considered in patients presenting to the emergency department with fever, thrombocytopenia, and bleeding symptoms.
Keywords: Crimean-Congo Hemorrhagic Fever Mimickers, fever, thrombocytopenia

Ref No: 2795
Chemotherapy Regimens and Clinical Outcomes in Neutropenic Enterocolitis: A Retrospective Emergency Department Analysis
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[2]Turhal State Hospital, Emergency Clinic
[3]Ondokuz Mayıs University Faculty of Medicine, Department of Emergency Medicine
[4]Ondokuz Mayıs University Faculty of Medicine, Department of Oncology
Introduction and Purpose: Neutropenic enterocolitis (NE) is a potentially fatal complication in oncology patients receiving chemotherapy. While its clinical presentation and radiological features have been well described, limited data exist on the prognostic implications of different chemotherapeutic agents. To evaluate the association between commonly used chemotherapy agents and clinical outcomes—including mortality and adverse events—in adult patients diagnosed with neutropenic enterocolitis upon presentation to the emergency department (ED).
Materials and Methods: This retrospective cohort study included 113 adult patients diagnosed with NE following recent chemotherapy between January 2020 and January 2024. All patients presented to the ED with abdominal symptoms, neutropenia (ANC <1000/mm^3), and radiological signs of bowel wall thickening. Data regarding chemotherapy regimens were extracted from hospital pharmacy records and oncological consultation notes. Univariate logistic regression analysis was performed to assess the association between specific chemotherapeutic agents and mortality or adverse clinical outcomes.
Results and Conclusion: The most frequently administered chemotherapy agents included Docetaxel (27.5%), 5-Fluorouracil (24.8%), and Cisplatin (18.3%). Mortality and adverse event rates did not differ significantly across chemotherapy groups. None of the agents examined—including Paclitaxel, Carboplatin, Doxorubicin, Oxaliplatin, Irinotecan, Cyclophosphamide, and Vinca alkaloids—showed a statistically significant association with mortality (p>0.05) or adverse outcomes (p>0.05). No significant relationship was observed between individual chemotherapy agents and the risk of mortality or adverse outcomes in patients with neutropenic enterocolitis presenting to the ED. These findings suggest that while chemotherapy is a known risk factor for NE development, the specific agent may not influence prognosis once the condition has developed.
Univariate Analysis of the Association Between Chemotherapy Agents and Mortality or Adverse Outcomes

	n (%)	Death (OR 95% CI)	p (Death)	Adverse Outcome(OR 95% CI)	p (AO)
Docetaxel	30 (27.5)	1.55 (0.55 - 4.35)	0.410	1.26 (0.5 - 3.21)	0.622
5-Fluorouracil (5-FU)	27 (24.8)	1.02 (0.33 - 3.11)	0.979	0.73 (0.26 - 2.05)	0.553
Cisplatin	20 (18.3)	0.77 (0.20 - 2.92)	0.699	0.66 (0.2 - 2.17)	0.493
Paclitaxel	19 (17.4)	0.47 (0.10 - 2.23)	0.342	0.27 (0.06 - 1.27)	0.098
Carboplatin	18 (16.5)	0.51 (0.11 - 2.41)	0.393	0.3 (0.06 - 1.38)	0.121

Doxorubicin	16 (14.7)	0.60 (0.12 - 2.86)	0.517	0.91 (0.27 - 3.07)	0.875
Oxaliplatin	17 (15.6)	1.46 (0.42 - 5.07)	0.550	0.82 (0.25 - 2.77)	0.755
Irinotecan	15 (13.8)	1.13 (0.29 - 4.46)	0.859	1.46 (0.45 - 4.7)	0.527
Cyclophosphamide	12 (11.0)	0.88 (0.18 - 4.36)	0.873	1.44 (0.4 - 5.2)	0.578
Vinca alkaloids	12 (11.0)	0.88 (0.18 - 4.36)	0.873	1.44 (0.4 - 5.2)	0.578
Etoposide	7 (6.4)	0.73 (0.08 - 6.41)	0.775	1.11 (0.2 - 6.07)	0.903

Keywords: Neutropenic Enterocolitis, Emergency Department, Chemotherapy Agents

Ref No: 2828

COMPARISON OF THE VALUE OF ROME CRITERIA WITH DECAFSCORE IN PREDICTION OF 7-DAY POOR OUTCOME IN PATIENTS DISCHARGED AFTER DIAGNOSIS AND TREATMENT OF EXACERBATION OF COPD in ED

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[5]Manisa Celal Bayar University Department of Emergency Medicine

Introduction and Purpose: This study aims to compare the predictive value of the Rome criteria and the DECAF score (Dyspnea, Eosinopenia, Consolidation, Acidemia, Atrial Fibrillation) for 7-day adverse outcomes in patients with Chronic Obstructive Pulmonary Disease (COPD) exacerbation and discharged after treatment from the emergency department.
Materials and Methods: Conducted prospectively as an observational study between December 2023 and August 2024. A total of 188 patients diagnosed with COPD exacerbation and discharged from the emergency department were included in the study. Each patient's severity classification according to the Rome criteria and the DECAF score were calculated. Patients were followed up on the seventh day after discharge through phone calls and hospital records, and their outcomes (revisit to the emergency department, hospitalization, death) were recorded.
Results and Conclusion: The study found that an SpO2 of <92% at the time of admission was significantly associated with a 7-day adverse outcome (p=0,018). However, the severity of dyspnea, respiratory rate, and pulse values from the Rome criteria were not found to be significantly related to adverse outcomes. Similarly, the sub-criteria of the DECAF score, including eosinopenia, presence of consolidation, acidemia, and atrial fibrillation were not significantly related to adverse outcomes. Additionally, factors such as age, gender, use of nebulizer, oxygen, and BiPAP at home were not found to be significantly related to adverse outcomes. Finally, the Rome criteria exacerbation severity classes and the DECAF score were not statistically significant in predicting 7-day adverse outcomes in patients.ConclusionThe Rome criteria exacerbation severity classes and the DECAF score risk groups were not statistically significant in predicting 7-day adverse outcomes in patients. Further research is needed to develop clinical decision tools that can assist in discharge decisions and predict short-term prognosis for patients presenting to the emergency department with COPD exacerbation.
Keywords: COPD, Rome criteria, DECAF score

Ref No: 2836

Arterial blood gas analysis as a systematic diagnostic approach in the evaluation and treatment of critical illnesses in emergency departments

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Introduction and Purpose: The analysis of arterial blood gases (ABG) is a pivotal component of evaluating and treating critically ill patients in emergency departments. We aim to improve the interpretation of arterial blood gases (ABG) results in emergency departments and to facilitate clinical decision-making processes and a more general understanding of acid-base disorders from these interpretations.
Materials and Methods: Normal values in ABG test: pH is between 7.35 and 7.45. PaO□ is in the range of 75-100 mmHg and is the partial oxygen pressure in arterial blood. PaCO2 measures the partial pressure of carbon dioxide in arterial blood between 35 and 45. The standard value of bicarbonate [HCO3-]is 22-28 mEq/L.
Results and Conclusion: Healthcare professionals can interpret the acid-base balance with ABG analysis by following these steps. Step 1: Acidosis occurs when the ABG pH falls below 7.4, and alkalosis occurs when the ABG pH rises above 7.4.Step 2: If the changes in pH and PaCO2 are in the same direction, that is, if both increase or decrease, it indicates that the event is metabolic.3. If the direction of change of pH and PaCO2 are in different directions, the event is respiratory. These first three steps allow us to detect primary acid-base disorders such as metabolic acidosis, metabolic alkalosis, respiratory acidosis, and respiratory alkalosis.4. If metabolic acidosis or metabolic alkalosis is present, the expected PaCO2 is calculated and compared to the ABG. If equal, isolated metabolic acidosis or metabolic alkalosis is present. This primary acid-base disorder is accompanied by respiratory acidosis when PaCO2 increases and respiratory alkalosis when it decreases.5. If respiratory acidosis or respiratory alkalosis is present, the expected [HCO3-] is calculated and compared to the ABG. If equal, isolated respiratory acidosis or respiratory alkalosis is present. This primary acid-base disorder is

accompanied by metabolic alkalosis when [HCO3-] increases and metabolic acidosis when [HCO3-] decreases. In conclusion, correct interpretation of blood gas test provides valuable information about the patients' condition. It guides the treatment according to the clinical situation and can accelerate the recovery process of the patients.
Primary acid-base disorders, calculation of the states of compensation

Acid-Base Disorders	Primary change	Expected compensation	Compensation Formula
Metabolic acidosis	↓ [HCO_3^-]	$PaCO_2$	$PaCO_2$=1,5 x [HCO3) +8
Metabolic alkalosis	↑ [HCO_3^-]	$PaCO_2$	$PaCO_2$=0,9 x [HCO_3^-] +16
Respiratory acidosis	↑$PaCO_2$	[HCO_3^-]	[HCO_3^-] =24+($PaCO_2$- 40) / 10
Respiratory alkalosis	↓$PaCO_2$	[HCO_3^-]	HCO3=24- 2x ($PaCO_2$- 40) / 10

Keywords: Arterial blood gas analysis (ABG), Partial pressure CO2 (PaCO2), Serum bicarbonate [HCO3-].

Ref No: 2843
Clinical cerebrovascular event but diagnosis is aortic dissection
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Introduction and Purpose: Aortic dissection is a cardiovascular condition characterized by the formation of a false lumen between the intima and media layers of the aorta due to a tear in the intima. Due to its rarity, a high index of suspicion is required to achieve rapid and accurate diagnosis. The most important diagnostic methods for aortic dissection are computed tomography (CT) and echocardiography. Timely diagnosis and rapid surgical intervention are critical for treatment success. Aortic dissection is a treatable condition if diagnosed early and managed promptly; however, it does not always present with a typical clinical picture and can mimic a variety of other diseases.
Materials and Methods: An 83-year-old male patient with a known history of hypertension presented to our emergency department after being found in a supine position by a family member at home. Upon arrival, the patient's vital signs were as follows: blood pressure, 111/77 mmHg; oxygen saturation, 97%; pulse, 132 bpm; Glasgow Coma Scale score, 13; and blood glucose level, 132 mg/dL. Physical examination revealed pathological signs of aphasia and left-sided hemiplegia. The imaging studies were ordered. The brain CT revealed no acute pathology. Due to severe cervical lordosis, the patient was unable to undergo diffusion MRI. Consequently, brain CT angiography and carotid CT angiography were performed to assess the vascular structures of the brain. No acute pathology was detected on brain CT angiography; however, carotid CT angiography showed a "flap" appearance consistent with dissection at the aortic arch. Based on these findings, a preliminary diagnosis of aortic dissection was made, and CT angiography of the aorta was ordered. CT angiography revealed dissection. Urgent consultations with cardiovascular surgery and cardiology were requested. The cardiovascular surgery team diagnosed a Type 1 aortic dissection and planned an emergency operation.
Results and Conclusion: Aortic dissection is a high-mortality cardiovascular condition requiring rapid diagnosis and treatment. Accurate and early diagnosis in the emergency department, followed by appropriate treatment, is crucial for prognosis. However, due to the non-specific nature of the presenting symptoms, the most important diagnostic factor for aortic dissection is a high level of suspicion.
Keywords: Aortic dissection, Angiography, Emergency department

Ref No: 2886
Unexpected density on CT imaging in a case of esophageal atresia
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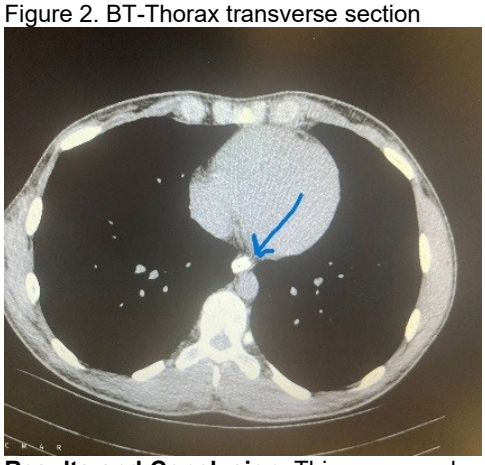
Introduction and Purpose: Foreign body (FB) ingestion is a daily occurrence and a common emergency. Many swallowed FBs usually become stuck in the esophagus and have the potential to cause serious complications as well as significant distress to the patient and family. This case report presents the detection and treatment process of esophageal foreign body in a patient with a history of esophageal atresia who underwent balloon dilatation due to stenosis.
Materials and Methods: A 23-year-old male patient applied to the emergency department after feeling a tightness in the esophagus after eating a biscuit in the morning and then vomiting repeatedly. The patient, who had a history of postpartum surgery due to esophageal atresia and 6 subsequent endoscopic balloon dilatation due to stenosis, had a hyperdense lesion in the esophagus when his tomography was examined, but no significant stenosis was detected in the esophagus. The patient, who was consulted to the general surgery and gastroenterology clinics, was scheduled for endoscopy by the gastroenterology department, and food residue was found in the esophagus in the endoscopy performed the following day. The food residue was advanced endoscopically into the stomach. An area compatible with 'Barret's Esophagus' was observed at the lower end of the esophagus and a biopsy was taken. The patient, who had no additional pathology, was discharged with recommendations.
Figure 1. BT-Thorax sagittal section

Figure 2. BT-Thorax transverse section



Results and Conclusion: This case emphasizes that unexpected foreign bodies and food substances can also cause obstruction in the esophagus in patients with a history of esophageal atresia, the importance of detecting these foreign bodies and the role of endoscopic intervention in the treatment process. Such complications can be seen in patients treated for esophageal stricture, therefore a multidisciplinary approach and regular follow-up are necessary.

Keywords: Esophageal atresia, Foreign body, Endoscopic balloon dilatation

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Ref No: 2927

A Transport Method "Body Packing": Case Report

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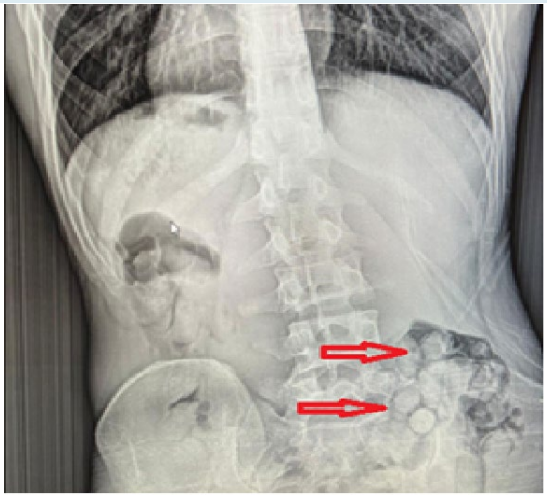
[1]Republic of Türkiye Ministry of Health Çarşamba State Hospital

Introduction and Purpose: One of the methods used in drug trafficking is "bodypacking," where drugs are transported by placing them in airtight packages within the gastrointestinal system. This method can lead to serious complications such as bowel obstruction, package leakage, and toxic effects. Early diagnosis and appropriate management of body packer cases are critical to preventing life-threatening conditions. This case report discusses the successful conservative management of a 21-year-old male patient carrying 51 packages of methamphetamine in his gastrointestinal system. The aim of this report is to shed light on the diagnostic and therapeutic processes for similar cases encountered in emergency departments.

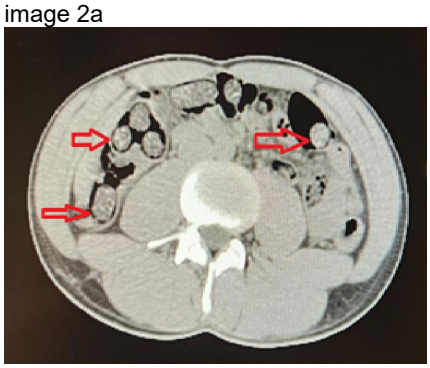
Materials and Methods: A 21-year-old male patient was apprehended while attempting to enter the country illegally through a port and was referred to the emergency department for routine medical evaluation. On physical examination, the patient was conscious, with stable vital signs but tachycardic (heart rate: 110 bpm), and diffuse abdominal tenderness was noted. An upright abdominal X-ray revealed hyperdense lesions within the intestinal loops, and a non-contrast abdominal CT scan identified multiple foreign bodies, measuring 33x11 mm on average, extending from the duodenum to the rectum. As there were no signs of acute abdomen or bowel obstruction, the patient was treated with laxatives and enemas, resulting in the expulsion of 51 methamphetamine packages wrapped in condoms. The patient was asymptomatically monitored for 48 hours and discharged after stabilization.

İmage 1



Hyperdense lesions seen in the abdominal X-ray.
image2 b

Tubular hyperdense lesions in the shape of foreign bodies (coronal)
image 2a



Hyperdense lesions in the form of tubular foreign bodies (axial)

Results and Conclusion: The diagnosis of body packer cases is based on physical examination and imaging methods. While an upright abdominal X-ray is often the first diagnostic tool, non-contrast abdominal CT is considered the gold standard for determining the number, size, and location of the packages. Treatment varies depending on the patient's clinical condition and the risk of complications. Conservative management is generally a safe and effective approach for asymptomatic patients. However, surgical intervention may be required in cases of bowel obstruction, perforation, or package leakage. This case demonstrates that conservative treatment can be a successful option in appropriate patients. Early diagnosis and a multidisciplinary approach are crucial in managing body packer cases to prevent complications.

Keywords: Body Packing, Toxins, Conservative Treatment

Ref No: 2937

Prognostic significance of fibrosis-4 (FIB-4) index in patients with hypertensive pulmonary edema

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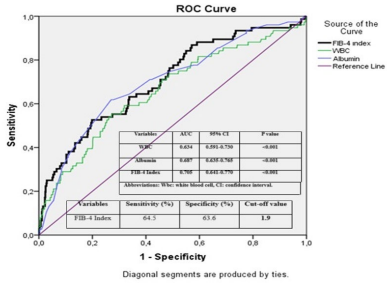
Introduction and Purpose: Hypertensive pulmonary edema (HPE) is a hyperacute complication of chronic heart failure (CHF). Patients with HPE account for about 25% of hospitalizations due to CHF and experience a high mortality rate of 15–20%. Due to the high mortality rate, there is a need to identify prognostic predictors of HPE. The fibrosis-4 (FIB-4) index, calculated by age, aspartate aminotransferase, alanine aminotransferase, and platelet count, is a simple marker to evaluate liver fibrosis. Recent studies have identified a significant relationship between the FIB-4 index and CHF mortality. However, the data on the relationship between HPE and the FIB-4 index were limited. Therefore, this study aimed to investigate the relationship between the FIB-4 index and mortality in patients with HPE.

Materials and Methods: Our study was designed as a retrospective observational study, including 1007 patients admitted to Atatürk University Emergency Medicine Department diagnosed with HPE between 2015 and 2024. We obtained patients' medical histories, medication use information, laboratory parameters, and mortality status from patient files, the hospital's electronic information system, and the Ministry of Health's MERNIS system.

Results and Conclusion: The mean age of the patients was 69±12.9 years. 59.7% of the patients (529 patients) were male. The mortality rate was 8.1% (82 patients). The mean follow-up period was 2272±600 days. Patients were divided into two groups: those with and without mortality. Hemoglobin and albumin levels were statistically significantly lower in the mortality group. In contrast, age, white blood cells (WBC), aspartate aminotransferase, alanine aminotransferase, C-reactive protein, creatinine, glucose, and the FIB-4 index were statistically significantly higher in this group. Univariate and multivariate Cox regression analyses were performed to determine the predictors of mortality. The FIB-4 index (Hazard ratio: 1.086 (95% CI: 1.003-1.175), p: 0.043) was an independent predictor of mortality. Receiver Operating Characteristic (ROC) analysis was conducted to assess the predictive capability of mortality predictors. The FIB-4 index identified mortality with a sensitivity of 64.5% and a specificity of 63.5% at a cutoff value of 1.9 (p<0.001). The FIB-4 index can be a potential parameter for predicting mortality in patients with HPE.

Figure 1



Receiver operating characteristic (ROC) curve analysis and area under the curve (AUC) values of parameters

Keywords: Pulmonary Edema, Mortality, FIB-4 index

Ref No: 2938

Retrospective Analysis of Patients Treated with Thrombolytic Therapy for Pulmonary Thromboembolism in the Emergency Department

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[1]Niğde Ömer Halisdemir Eğitim Araştırma Hastanesi

Introduction and Purpose: Pulmonary embolism (PE) is a disease characterized by thromboembolic occlusion in the pulmonary arteries, carrying a significant risk of morbidity and mortality. This study aims to examine the age, gender, laboratory findings, and other relevant data of patients diagnosed with PE and treated with thrombolytic therapy in the emergency department of a tertiary healthcare institution.

Materials and Methods: Patients aged 18 and above, who were diagnosed with PE and received thrombolytic therapy between September 1, 2022, and September 1, 2025, were included in the study, and their patient files were examined retrospectively.

Results and Conclusion: Of the 20 cases in the study, 11 were female and 9 were male, with a mean age of 61.9 ± 3 years. The mean hemoglobin (Hgb) value was 11.6 ± 5, and the median white blood cell (WBC) value was 9.1 (5.7-18.6). The mean D-dimer value was 7205.2 ± 1672.2. In our study, a detailed analysis of the demographic, hematologic, and biochemical characteristics of patients treated with thrombolytic therapy for pulmonary thromboembolism was conducted. The findings reaffirm the diagnostic value of elevated D-dimer levels in PE patients and emphasize the importance of this parameter in clinical decision-making. The decrease in hemoglobin levels and the wide range in platelet values reflect the effects of PE on the hemodynamic and coagulation systems. The higher proportion of female patients suggests a potential association with gender-related risk factors; however, more comprehensive studies are needed to explore this issue. The mean length of hospital stay of 7.5 days is significant for evaluating the effects of thrombolytic therapy on hospital resource utilization and patient survival. The results indicate a higher representation of female patients and a mean age of 61.9 years. 2 The generally low hemoglobin values and markedly high D-dimer levels are consistent with the biochemical manifestations of PE. 3 Examination of platelet and MPV values revealed a heterogeneous distribution of hematologic parameters among the patients. 4 Additionally, the median INR value being close to normal limits and the mean length of stay being 7.5 days reflect both the efficacy and management processes of thrombolytic therapy.

General information of the patients at the emergency department examination

Gender	Male Female	9 (45%) 11 (55%)
Hospitalizasyon	Min 1 Max 17	Median 7.5

Age and laboratory parameters of patients

	Mean (±SD)	Median (Min-Max)
Age	61,9±3	
Hemoglobin	11,6±5	
Wbc		9,1(5,7-18,6)
Platelet		216,5(130-502)
Mpv	10,4±0.13	
Rdw		14,8(12,4-25,8)
D-dimer		6000(1655-32500)
Ph	7,37±0,11	
İnr	1,17±0,31	
Troponin		43,5(18-174)
Pco2		38,4(25,5-437)

SD: Standart deviation, Min: Minimum, Max: Maximum, INR: International ratio, WBC: Wight Blood Cell, MPV: Mean Platelet Volum, RDW: Red Cell Distribütion PCO2: Partial Pressure Of Carbon Dioxide

Keywords: tromboemboli, antitrombolitik

Ref No: 2951

Fahr Syndrome: A Case Diagnosed After Syncope

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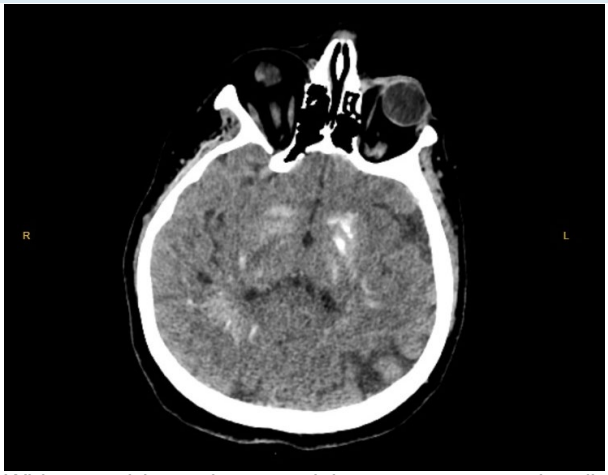
[1]ANKARA BILKENT CITY HOSPITAL, EMERGENCY MEDICINE DEPARTMENT

Introduction and Purpose: Fahr syndrome is a rare neurodegenerative disease characterized by symmetric calcifications in the basal ganglia, cerebellar nuclei, and periventricular white matter. It is often associated with hypoparathyroidism, pseudohypoparathyroidism, genetic mutations, or metabolic disorders. The clinical presentation can vary widely, ranging from seizures, movement disorders, psychiatric symptoms, and cognitive decline to asymptomatic cases. Patients presenting to the emergency department with syncope, head trauma, or altered consciousness are common. However, these symptoms can sometimes mask underlying metabolic or neurological causes. Here, we present a case of a patient diagnosed with Fahr syndrome following a syncope episode and head trauma.
Materials and Methods: A 54-year-old female presented to the emergency department with complaints of syncope and head trauma one hour prior.On physical examination, she was conscious, cooperative, and oriented with a Glasgow Coma Scale (GCS) score of 15. An ecchymosis was observed in the left periorbital region. Pupils were equal and reactive to light, with no lateralizing neurological signs. Motor strength was assessed as 5/5 in all extremities.A non-contrast computed tomography (CT) scan of the brain revealed extensive bilateral calcifications in the basal ganglia, cerebellar nuclei, and periventricular white matter. Given the absence of metabolic disorders such as hypocalcemia or hypoparathyroidism, the patient was diagnosed with idiopathic Fahr syndrome.
Intracranial calcifications



Widespread hyperdense nodular appearances primarily suggestive of calcifications in the bilateral basal ganglia, dentate nuclei, and bilateral cerebral white matter.

Results and Conclusion: Fahr syndrome, can be inherited or idiopathic. Metabolic disorders like hypoparathyroidism, pseudohypoparathyroidism, and hypomagnesemia are common secondary causes. In cases without identifiable metabolic or genetic causes, a diagnosis of idiopathic Fahr syndrome is established. Clinical manifestations are diverse, with seizures, extrapyramidal symptoms, psychiatric disorders, and cognitive decline being the most common. Extrapyramidal features, including parkinsonism, dystonia, and choreiform movements, may lead to motor dysfunction. Psychiatric symptoms such as depression, anxiety, and psychotic disorders are also prevalent, while cognitive decline resembling dementia significantly impacts quality of life. Fahr syndrome should be considered in patients presenting with syncope and head trauma, particularly in cases of unexplained loss of consciousness. Radiological findings play a crucial role in diagnosis, and long-term neurological and psychiatric follow-up is recommended for these patients. Further studies are needed to explore the underlying mechanisms and potential therapeutic approaches for Fahr syndrome.

Keywords: FAHR SYNDROME, NEUROLOGY, SYNCOPE

Ref No: 2978

Spontaneous Pneumomediastinum

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Introduction and Purpose: Spontaneous pneumomediastinum, a rare but potentially life-threatening condition, typically affects young males.Since spontaneous pneumomediastinum is less common than pneumomediastinum secondary to trauma, we wanted to draw attention to spontaneous pneumomediastinum through this case.

Materials and Methods: An 86-year-old bedridden female with Alzheimer's and a history of stroke was admitted with hypotension and general deterioration. When the patient's history was examined, it was seen that she had Alzheimer's disease and had a stroke. The patient's vital signs showed F: 36.5 °C HR: 140/min BP: 80/50 mmHg SpO2: 92. The patient's relatives did not describe any trauma history. Physical Examination: Glasgow Coma Score was calculated as 10 (G4,S2,M4). The patient had a decubitus wound in the lumbosacral region. There were no pathological examination findings other than these findings in the patient's physical examination. CT imaging revealed pneumomediastinum despite no reported trauma.

Results and Conclusion: Given the patient's age and gender, this case highlights the importance of considering spontaneous pneumomediastinum in differential diagnoses across all demographics, especially in hypotensive patients with nonspecific symptoms.

Keywords: Pneumomediastinum, hypotensive, gender group

Ref No: 2983

Use of artificial intelligence in emergency department triage: Evaluation of patient referral accuracy

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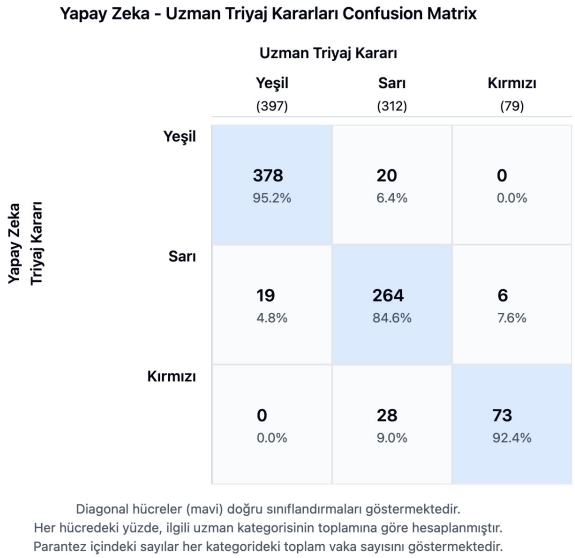
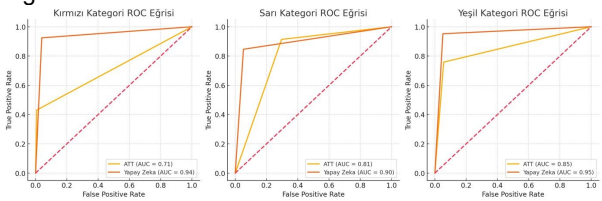
Introduction and Purpose: Emergency departments (EDs) face challenges such as overcrowding and human error in triage, impacting patient safety and resource allocation. Artificial intelligence (AI) offers potential for objective, rapid decision-making. This study evaluates the accuracy of an AI-based triage system compared to emergency physicians (gold standard) and emergency medical technicians (EMTs), focusing on high-risk populations and workflow optimization.

Materials and Methods: A prospective observational study was conducted at Pamukkale University Hospital ED (June–November 2024) with 788 adult patients. Exclusion criteria included psychiatric disorders, language barriers, and cardiac arrest cases. A ChatGPT-4o-based AI system analyzed patient demographics, vital signs, and complaints to generate triage recommendations (red, yellow, green zones). EMT and physician triage decisions were recorded. Statistical analyses (SPSS 28.0) included Cohen's Kappa, ROC curves, and confusion matrices.

Figure 1



Artificial Intelligence-Specialist Triage Decisions Confusion Matrix
Figure 2



ROC Curves by Triage Categories.

Results and Conclusion: The AI system demonstrated high alignment with physician triage (κ=0.842, 90.74% accuracy), outperforming EMTs (κ=0.629, 78.68% accuracy). AI showed superior sensitivity in red zone cases (92.41% vs. EMTs: 43.04%) and excelled in identifying high-risk complaints (e.g., chest pain: 88.1% accuracy vs. EMTs: 71.4%). ROC analysis highlighted AI's discrimination ability (AUC: 0.942 for red zone). Subgroup analyses confirmed consistent performance across age and gender. AI's integration may enhance patient safety through early critical case identification and reduce triage variability. Future studies should validate these findings in multicenter settings and assess cost-effectiveness.

Keywords: Artificial intelligence, Clinical decision support, Patient safety

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Ref No: 2996

Relationship Between Seizure Type, EEG Findings, and Inflammatory Markers in Epilepsy Patients Presenting to the Emergency Department

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Introduction and Purpose: Epilepsy is a prevalent neurological disorder characterized by recurrent seizures, with inflammation playing a crucial role in its pathophysiology. Inflammatory markers such as systemic immune-inflammation index (SII), neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR), lymphocyte-to-monocyte ratio (LMR), C-reactive protein/albumin ratio (CAR), and leukoglycemic index (LGI) have been associated with seizure activity and severity. This study aims to investigate the relationship between seizure type, electroencephalographic (EEG) findings, and inflammatory markers to elucidate their potential role in epilepsy management.

Materials and Methods: A retrospective study was conducted at Niğde Ömer Halisdemir University Hospital between September 1, 2024, and March 1, 2025. A total of 102 epilepsy patients diagnosed with ICD-10 codes G40.0-G40.9 were included, excluding those under 18 years old, patients with traumatic seizures, and those with intracranial mass lesions. Data on age, gender, seizure type (partial/tonic-clonic), and EEG findings (focal/generalized) were collected. Inflammatory markers were calculated using hemogram and biochemical parameters. Statistical analyses were performed using SPSS v.27, with Mann-Whitney U and Spearman correlation tests applied.

Results and Conclusion: The study included 59 male (57.8%) and 43 female (42.2%) patients, with a median age of 31 years (IQR: (21-78; 22-46). Among them, 55 (53.9%) had tonic-clonic seizures, and 47 (46.1%) had partial seizures. EEG findings showed generalized discharges in 63 patients (61.8%) and focal discharges in 39 (38.2%). LGI levels were significantly higher in patients with tonic-clonic seizures and generalized EEG findings ($p<0.001$), while PLR was elevated in those with partial seizures ($p=0.006$) and focal EEG findings ($p=0.019$). A weak negative correlation was observed between LGI and PLR ($r=-0.252$, $p=0.011$). No significant association was found between other inflammatory markers and seizure type or EEG findings.This study suggests a link between

seizure type, EEG patterns, and specific inflammatory markers in epilepsy patients. The higher LGI levels in tonic-clonic seizures indicate a stronger systemic inflammatory response, whereas elevated PLR in partial seizures suggests localized inflammation. Further prospective studies are needed to explore the potential of inflammatory markers as biomarkers for seizure prediction and management, potentially contributing to personalized epilepsy treatment strategies.
Keywords: Emergency department, Epilepsy, Inflammatory markers

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Ref No: 3039
Bilateral luxatio erecta humeri: A case report
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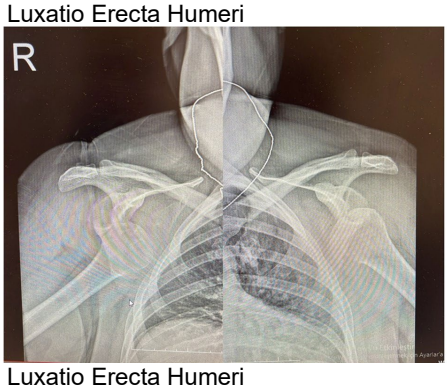
Introduction and Purpose: INTRODUCTION: Inferior glenohumeral dislocation, commonly termed luxatio erecta humeri, is an exceptionally rare form of shoulder dislocation, accounting for less than 0.5% of cases. It occurs due to forced hyperabduction of the upper limb, resulting in the humeral head being displaced inferiorly below the glenoid fossa. Bilateral cases are particularly rare, usually associated with high-energy trauma such as falls or motor vehicle accidents.
Materials and Methods: CASE: A 52-year-old female presented to the emergency department with severe bilateral shoulder pain and immobility following a fall from a two-meter height while working on a ladder. Her arms were fully extended overhead at the time of impact. She reported immediate pain and numbness over the lateral shoulders but no vascular compromise. Physical examination revealed both arms locked in abduction with elbows flexed and forearms pointing superiorly, a classic presentation of bilateral luxatio erecta humeri. Palpation confirmed inferior displacement of the humeral heads, and sensory deficits suggested axillary nerve involvement. Radiographs confirmed bilateral inferior glenohumeral dislocations without fractures. Procedural sedation with midazolam (5 mg) and fentanyl (100 mcg) was administered. Using a two-step reduction technique, the left shoulder was successfully reduced, while repeated attempts for the right shoulder failed. The patient was admitted for surgical intervention, where reduction under general anesthesia was achieved. Both shoulders were immobilized with slings post-reduction. Sensory deficits resolved within two weeks, and follow-up at six weeks demonstrated full range of motion without instability or recurrent dislocations.
Bilateral Luxatio Erecta Humeri



Bilateral Luxatio Erecta Humeri
Results and Conclusion: DISCUSSION: Bilateral luxatio erecta humeri is a rare but significant clinical condition requiring prompt recognition and management in the emergency department. Early diagnosis based on clinical and radiological findings, combined with effective reduction techniques and timely surgical intervention when necessary, can prevent long-term complications. Emergency physicians should remain vigilant for this rare presentation, especially in patients with high-energy trauma and characteristic clinical findings.The integration of evidence-based reduction techniques, timely imaging, and a multidisciplinary treatment approach is essential for optimizing patient outcomes. The successful outcome in this case underscores the importance of a comprehensive and collaborative approach to managing complex orthopedic emergencies.
Keywords: Inferior glenohumeral dislocation, luxatio erecta humeri, Bilateral Luxatio Erecta Humeri

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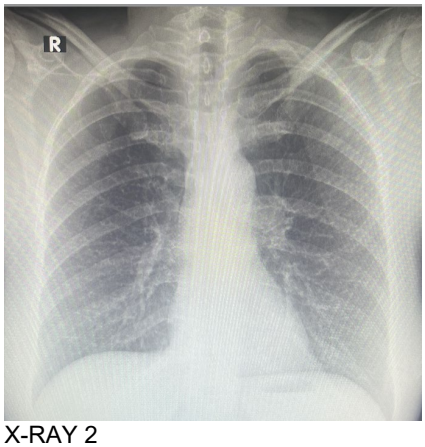
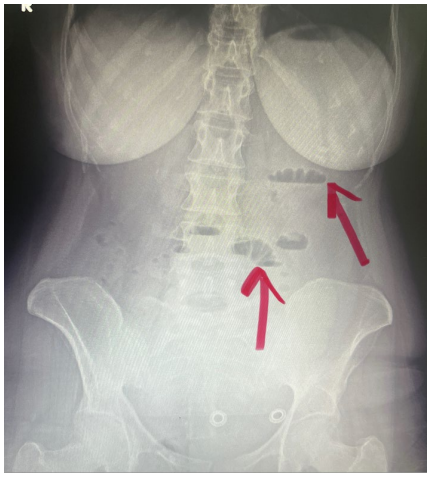
Ref No: 3068
How Safe Is A Gastrıc Balloon? A Case Of Ileus
Sema Ayten[1], Muhammet Talha Eroğlu[1]
[1]İstanbul Göztepe Prof. Dr. Süleyman Yalçın Şehir Hastanesi
Introduction and Purpose: Recently, the spread of unhealthy diet and sedentary lifestyle around the world has caused obesity to become a global problem. Obesity brings with it both physical and mental problems. These problems have led to the development of ways to deal with obesity in the health sector. One of the most common of these is gastric balloon application.
Materials and Methods: A 47-year-old female patient was admitted to the emergency department of a tertiary care hospital with complaints of nausea and abdominal pain that started in the morning. Three weeks ago, there was a history of gastric balloon insertion at another center. She stated that she had nausea and abdominal pain around 6.30 in the morning and that his complaints continued throughout the day. She said she went to the bathroom around 8:30 a.m. and took off the faeces and she vomited 5-6 times around 6:00 p.m. and that her vomit was yellow. Physical examination revealed widespread abdominal pain, but no rigidity or rebound. Rectal examination revealed normal fecal contamination. The blood samples results are, WBC: 8.9, HB: 16.9, Neutrophil (%): 89.7, CRP: 10.54. Apart from these, no significant results were detected. The patient underwent imaging with X-RAY. In X-RAY, air-fluid levels were seen at the small intestine level. After that, for more detailed imaging, computed tomography (CT) scan was performed. The CT scan result was, revealed a segment with a foreign body or food content and a wall-related structure at the entrance of the pelvis from the small

bowel segments. A general surgery consultation was requested for the patient, but the patient left the hospital voluntarily to go to the center where she had the procedure.

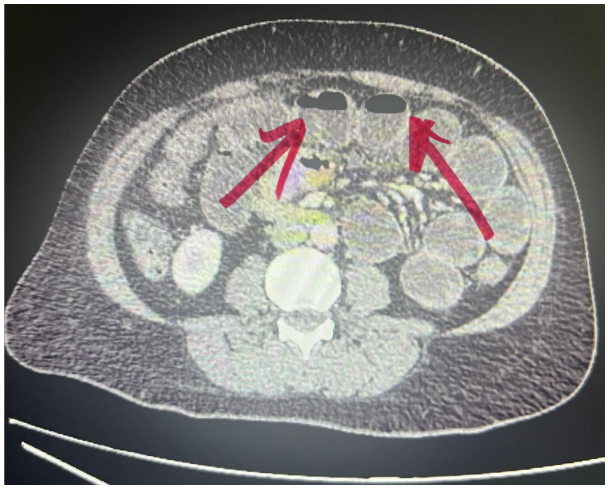
X-RAY 1



X-RAY 2

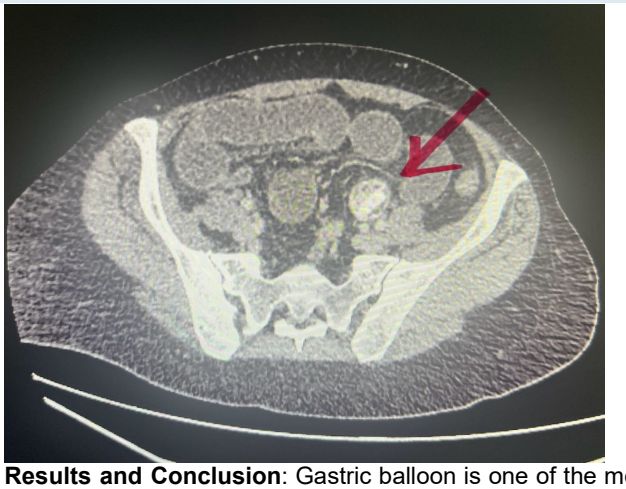


CT 1



CT Scan ileus

CT-2



Results and Conclusion: Gastric balloon is one of the most preferred treatment methods by both physicians and patients today. In the first ten days after treatment, nausea, vomiting, bloating, stomach cramps are expected symptoms. However, rarely, as a result of the deflating of the balloon, it can pass into the intestines and cause ileus in patients. In such cases, care should be taken especially in complaints that develop after the first ten days and advanced imaging methods should be applied.
Keywords: Gastric balloon, complication, ileus

Ref No: 3069
Severe acute pancreatitis due to hypertriglyceridemia: a case report.
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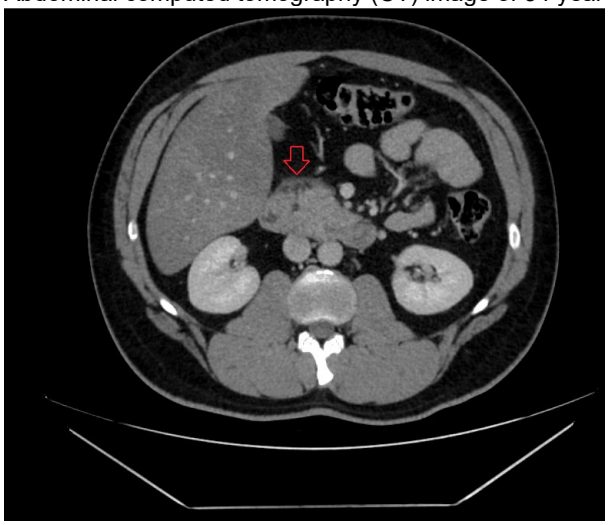
Introduction and Purpose: Acute pancreatitis is a disease characterized by the sudden onset of inflammation of the pancreas, which can develop due to various etiologies and can present with variable clinical severity. While gallstones and alcohol are the most common causes in etiology, hypertriglyceridemia (HTG) is a rarer but important risk factor. Especially when serum triglyceride (TG) levels are above 1000 mg/dL, the risk of HTG-related acute pancreatitis increases significantly. In this case report, a 34-year-old male patient presented with sudden onset of severe abdominal pain and nausea will be discussed.
Materials and Methods: However, despite these treatments, there was no significant regression in the patient's clinical symptoms (severe abdominal pain and vomiting). The need for analgesics continued. Follow-up laboratory values showed no significant decrease in triglyceride levels, with the triglyceride level seen as 1251 mg/dL, and hypocalcemia and borderline hyponatremia (Na=133) developed.Due to unresponsiveness to medical treatment and insulin infusion, ongoing symptoms, and persistent high triglyceride levels, the patient was transferred to a third-level tertiary center where more advanced treatment modalities (plasmapheresis) could be applied. Due to the diagnosis of severe AP on the basis of hypertriglyceridemia and unresponsiveness to medical treatment, an urgent plasmapheresis decision was made.
Abdominal computed tomography (CT) image of 34 year old patient.



Abdominal computed tomography (CT) image showing stranding and inflammatory findings in the fatty planes at the head of the pancreas (red arrow).
Results and Conclusion: Hypertriglyceridemia is a significant cause of acute pancreatitis, although it rarely leads to serious complications. It should be considered, particularly when serum triglyceride levels are above 1000 mg/dL. Early diagnosis, aggressive

fluid replacement, and pain control are the cornerstones of treatment. Intravenous insulin infusion can be initiated to rapidly lower serum triglyceride levels. However, in severe cases that do not respond to conservative treatment and insulin infusion, or in those presenting with very high triglyceride levels, plasmapheresis is an effective and safe treatment method that can rapidly reduce triglyceride levels and lead to clinical improvement. This case once again demonstrates the role of plasmapheresis in the management of severe HTG-AP and the importance of a multidisciplinary approach. After the acute attack is controlled, investigation of the underlying cause, appropriate dietary adjustments, and long-term lipid-lowering medical treatment (fibrates, omega-3, etc.) are necessary to prevent recurrences.
Keywords: Acute pancreatitis, Hypertriglyceridemia, Plasmapheresis

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Ref No: 3087
FOURNİER GANGRENE; CASE REPORT
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Introduction and Purpose: Fournier's gangrene is a rare but life-threatening necrotizing fasciitis of the external genitalia, perineum, or perianal region, with a high mortality rate despite medical advancements. We present a 50-year-old male diagnosed with Fournier's gangrene, possibly originating from a transsphincteric fistula and abscess.
Materials and Methods: 50-year-old patient presented to the emergency department with swelling and pain in scrotal area. Patient had a history of transsphincteric grade 3 perianal fistula, recurrent urinary tract infections and inferior myocardial infarction.In physical examination patient's vital signs were stable with a blood pressure of 131/80, heart rate of 81 and SpO2 of 96 in room air. His fever was 37.2 and his neurological exam was insignificant with a GCS score of 15. Upon inspection of testes major swelling and hyperemia in right testis was noted. Furthermore, there was crepitation upon palpation. Additionally, a necrotic area was noted on the right testis (figure 1). The Phren sign was positive.
Results and Conclusion: Given its severe prognosis, early recognition and intervention are vital. This case highlights key clinical and radiological features, underlines the need for awareness and fast management in at-risk patients
Keywords: Fournier gangrene, mortality, radiological findings

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Ref No: 3089
Adams-Stokes Syndrome
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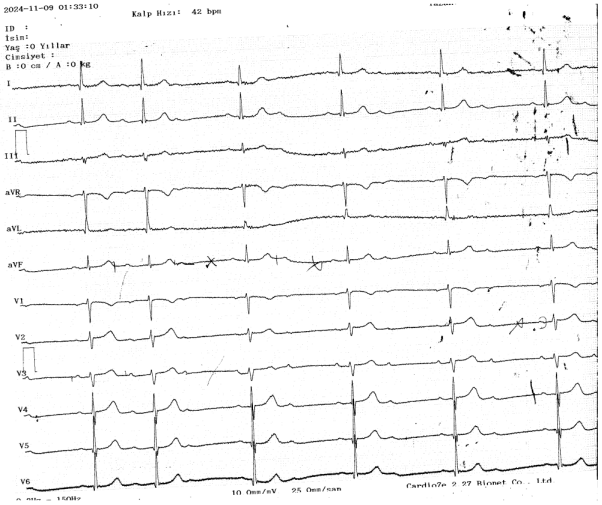
Introduction and Purpose: Adams-Stokes Syndrome is a syncope brought on by atrioventricular (AV) block-related cardiac arrhythmias. Adams-Stokes syndrome is most frequent above fifty years of age but about 30 percent of the patients had their first attack below fifty. Sinoatrial block (30–40%), paroxysmal or chronic AV block (50–60%), and paroxysmal tachycardia or fibrillation (0–5%) are among the causes.
Materials and Methods: A 83-year-old male patient apply to our clinic with syncope and head trauma. He has shortness of breath before syncope. The patient has no chronicle disease, no allergies, and no medication. When the patient arrives at the cricital care unit vital signs were; fever:36,3oC, pulse:42/min, oxygen saturation (SpO2): 98%, respiratory rate:18/min, arterial blood pressure:178/63 mmHg, fingertip blood sugar:148mg/dl. On physical examination, the patient's general condition was fine, Glasgow Coma Scale: 15 (Verbal5, Motor6, Eye4) The patient was oriented and cooperative. In laboratory findings were, urea: 45 mg/dl, blood ure nitrogen: 21 mg/dl, creatinine: 1.03 mg/dl, eGFR: 67 ml/min, calcium: 9.6 mg/dl, potassium 3.77 mmol/L, troponin-I: 7.5 ng/L, mass CK-MB: 0.7 µg/L, CRP: 0.6 mg/L.The patient's ECG findings revealed second degree Mobitz type I and second degree Mobitz type II AV block.
Patient's ECG



ECG shows the Mobitz Type 1 and Mobitz Type 2 AV-Block
Results and Conclusion: Stokes-Adams syndrome is characterized by transient cerebral ischemia due to impaired cardiac output, leading to sudden episodes of syncope. The most common causes include high-degree AV blocks, ventricular fibrillation, and severe

bradycardia. In our case, the coexistence of Mobitz type I and Mobitz type II AV blocks on the same ECG indicated a significant conduction disturbance. Mobitz type I (Wenckebach phenomenon) occurs due to progressive prolongation of the PR interval until a P wave is blocked. This type of block is generally benign but can occasionally progress to more severe conduction abnormalities. In contrast, Mobitz type II is a more serious condition characterized by sudden, unpredictable failure of atrial impulses to reach the ventricles without prior PR interval prolongation. Mobitz type II carries a high risk of complete heart block and sudden cardiac arrest, making early recognition and intervention crucial.Given the potential for rapid deterioration, pacemaker implantation is the primary treatment for symptomatic high-degree AV block, particularly Mobitz type II.

Keywords: Adams-Stokes Syndrome, syncope, emergency, Adams-Stokes Syndrome, syncope, emergency

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Ref No: 3104

Aortic Dissection with STEMI Appearance: Case Report

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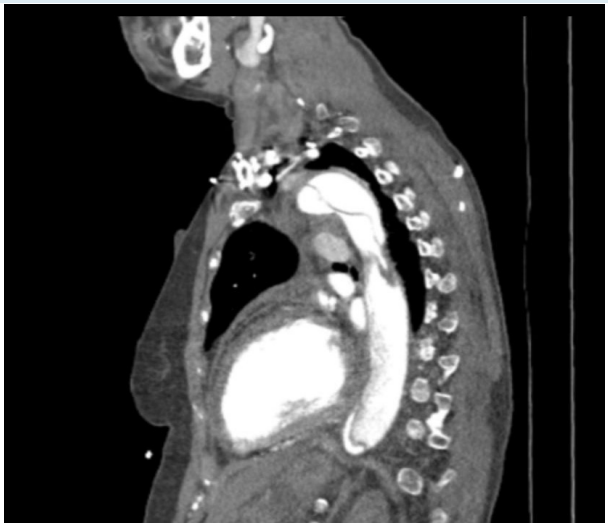
Introduction and Purpose: STEMI is caused by complete occlusion of a coronary artery, usually presenting with pressing chest pain, and accounts for approximately 30% of all ACS cases. STEMI is characterized by myocardial injury or necrosis caused by transmural myocardial ischemia. STEMI is caused by a sudden blockage of one or more coronary arteries that supply blood to the heart. Mechanisms such as plaque rupture, endothelial erosion, plaque fracture or dissection with obstructive thrombus in the coronary arteries usually underlie this sudden interruption in blood flow.Aortic dissection usually presents to the emergency department with sudden onset, tearing, anterior or interscapular chest pain. Symptoms are dominated by obstruction due to flap obstruction or malperfusion syndrome. After the onset of symptoms, it is important to provide urgent surgical management as the mortality risk and rate increases as time progresses. With this case report, we aimed to remind that a patient presenting with chest pain in the setting of ACS may have aortic dissection despite ECG findings supporting ACS.

Materials and Methods: A 51-year-old woman with a known diagnosis of hypertension presented to the emergency department with complaints of pressing chest pain and shortness of breath that started 3 hours ago. On arrival vital values were TA: 80/51mmHg, Pulse: 107/min, Saturation: 97% (with mask oxygen support). After ST segment elevations were observed on ECG, 300 mg ASA was administered. Cardiology consultation was made. Cardiology performed coronary angiography with a prediagnosis of acute anterior MI. No coronary occlusion was detected in coronary angiography and bedside transthoracic echocardiography was performed. Thoracic CT angiography was performed after a dissection flap was observed. CT angiography revealed dissection along the entire aortic trace and the patient was consulted to cardiovascular surgery. Preop preparations were made and the dissection was scheduled for emergency surgery. However, the patient suffered an arrest during the operation and died.

Figure 1

Figure 2

Figure 3



Results and Conclusion: Although the initial prediagnosis is highly probable based on the clinical picture and investigations at presentation, other prediagnoses in the differential diagnosis should always be kept in mind.
Keywords: STEMI, Aortic Dissection, chest pain

Ref No: 3125
A rare and potentially fatal condition easily missed in the emergency department: ludwig's angına
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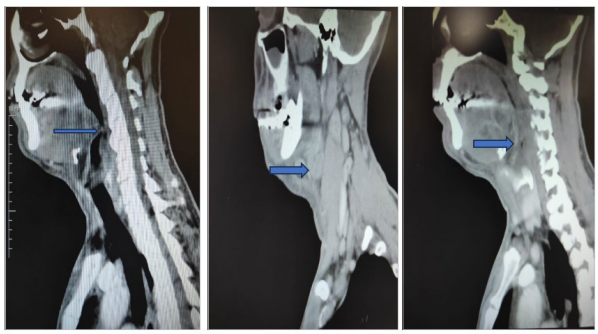
Introduction and Purpose: Emergency department visits with soft tissue infections and related complaints are quite frequent. While the management of these patients in the emergency department is often simple drainage and antibiotic therapy, some rare soft tissue infections can be fatal. One of the most important of these is Ludwig's Angina.
Materials and Methods: A 32-year-old male patient presented to the emergency department with complaints of right cheek pain and sublingual swelling. The patient reported experiencing swelling and pain in his jaw and right cheek for approximately 5-6 days. Upon arrival at the emergency department, the swelling had spread toward his neck, and the base of his tongue was edematous. In addition to the pain, he reported difficulty swallowing and shortness of breath. The patient had difficulty speaking. Physical examination revealed limited mouth opening. There was redness and increased warmth in the swelling extending from the right mandible to the neck. Laboratory tests were consistent with an infectious process. Neck ultrasound showed increased and edematous right submandibular gland with hypoechoic areas in the posteromedial gland, thickening and heterogeneity in the muscle plane superior to the mandible, suggestive of an infectious process, and follow-up was recommended for possible abscess. Initial treatment was administered in the emergency department, and the patient was admitted to the otolaryngology service with a preliminary diagnosis of Ludwig's angina.
Figure 1:

Right cheek and neck swelling, sublingual edema.
Figure 2:



Increased soft tissue thickness narrowing the air column at the oropharyngeal level, a lymph node measuring approximately 15x7 mm at the right submandibular gland level, and edematous appearance in the fatty planes between the lymph nodes at this level.
Results and Conclusion: Ludwig's angina should be considered in patients presenting to the emergency department with soft tissue infection findings in the face, neck, and jaw. Early diagnosis and early treatment of Ludwig's angina, which can have a serious fatal course, especially due to airway obstruction, significantly reduces the mortality of patients with Ludwig's angina.
Keywords: Ludwig's Angina, Cellulitis, Neck abscess.

Ref No: 3173
Did you eat salad too? Anticholinergic poisonings
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Introduction and Purpose: Anticholinergic syndrome is a clinical condition that can arise from 600 different substances. The involvement of muscarinic and nicotinic receptors can lead to various central and peripheral responses in the patient. We described one of the three similar cases that came to our emergency department within two days.
Materials and Methods: A 60-year-old female patient was brought to the emergency department with complaints of nonsensical speech and movements, inappropriate laughter, and altered consciousness, which began one hour ago. Vital signs: Blood pressure (BP): 154/108 mmHg, blood sugar (BS): 163 mg/dl, pulse: 121 beats/min, temperature: 37.5°C, SpO2: 98%, electrocardiogram (ECG): sinus tachycardia. Her medical history includes Diabetes Mellitus (DM) and Hypertension (HT). She is taking oral antidiabetic and antihypertensive medications.On examination, the patient was partially cooperative and disoriented. Light reflex (LR) was bilaterally negative, and pupils were bilaterally 4 mm and mydriatic. There was no neck stiffness. Her skin was dry, and there was redness on her face. Imaging and laboratory tests did not reveal any pathology that could explain the current clinical picture.The patient's history revealed that she had eaten a full plate of salad containing arugula and watercress two hours before the onset of symptoms. Despite treatment, the patient's agitation continued. Following the administration of 2 mg of physostigmine, the patient's level of consciousness returned to normal.
Results and Conclusion: Atropa Belladonna (deadly nightshade) has a strong anticholinergic effect. It can cause toxicity within 1 to 4 hours after ingestion. Central effects can lead to clinical conditions and symptoms such as fever, memory loss, agitation, hallucinations, delirium, and coma. Peripheral effects include mydriasis and increased intraocular pressure in the eyes, dryness in mucous membranes and sweat glands, skin redness, and retention in the gastrointestinal and urinary systems.Treatment generally involves observation, monitoring, and supportive care. For moderate to severe anticholinergic syndrome, pharmacological sedation is strongly recommended to achieve adequate control. Physostigmine may be used in patients with severe agitation and delirium due to pure anticholinergic toxicity who do not benefit from benzodiazepines.The occurrence of a large number of cases within a short period should be regarded as a public health issue.
Keywords: Anticholinergic syndrome, Atropa Belladonna, Physostigmine

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Ref No: 3191
A Case of Hepatorenal Syndrome Developed in a Patient Using Denosumab
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Introduction and Purpose: Denosumab is the first human monoclonal RANKL antibody. It exerts a negative effect on osteoclast formation and function by reducing the impact of RANK molecules on osteoclasts in bone tumors.Hepatorenal syndrome (HRS) is the development of renal failure without any clinically, laboratorial, or histologically demonstrable cause in acute or chronic severe liver disease.In this article, we aim to describe a case of hepatorenal syndrome that developed in a patient who received Denosumab injection.
Materials and Methods: An 82-year-old female patient presented to our emergency department with complaints of inability to urinate and weakness. Her physical examination showed a Glasgow Coma Scale (GCS) of 15 and her general condition was good. Neurological examination was normal. There was tenderness in the right upper quadrant of the abdomen. Respiratory sounds were normal. The patient's laboratory results showed the following: AST: 1585, ALT: 1385, Creatinine: 2.57, Urea:135, Uric Acid: 13,2, GFR:16, Kalsiyum: 7. Arterial blood gas values: pH:7.27 HCO3 :15, CO2: 44. Urine values are normal. The patient's anamnesis revealed that she had not used any herbal products, had not eaten mushrooms or used any other herbs recently, had no chronic diseases, and was not taking any medications. Upon further investigation of the anamnesis, it was revealed that the patient had knee pain and had received a Denosumab injection one week before. After the injection, she developed complaints of inability to urinate. An ultrasound of the patient showed hepatomegaly. The patient, with no other significant findings, was assessed as having hepatorenal syndrome secondary to Denosumab injection. The patient, who was admitted to the internal medicine department, was discharged with full recovery after her symptoms improved and her lab values normalized during follow-up.
Results and Conclusion: In patients presenting with hepatorenal syndrome, orthopedic symptoms and the Denosumab injections administered as a result of these symptoms should also be considered.

Keywords: Denosumab, Hepatorenal, İntoxication

Ref No: 3214

Severe Hyponatremia Following Riluzole Use

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[1]Medeniyet Üniversistesi Prof Dr. Süleyman Yalçın Şehir Hastanesi

Introduction and Purpose: Used in the treatment of amyotrophic lateral sclerosis (ALS), riluzole is a glutamate-release inhibitor meant to extend survival and slow down disease progress. Although its adverse effect profile includes hepatotoxicity, dizziness, tiredness, nausea, it is usually well-tolerated. Though rare, severe hyponatremia linked to riluzole treatment can cause major neurological and systemic problems including disorientation, respiratory failure, and coma. This case report describes a patient who started riluzole and experienced severe hyponatremia after dosage increase.

Materials and Methods: Over one month, the patient showed up to the emergency department with increasing dyspnea. He denied back, chest, fever, chills, or rigors but over the past two days he described extreme tiredness and visual hallucinations—seeing moving objects on walls. According to his relatives, he had attended a neurology clinic earlier but was directed to the emergency hospital because of growing respiratory problems.His medical record includes gout, asthma, hypertension, and ALS diagnosed three months ago. Initiated 3 months before, riluzole 50 mg once daily increased to 50 mg twice daily following one week. In examination The patient was orienting, cooperative, and cognizant. Pupils were equal and reactive. There was no wheezing or crackling; breath sounds were harsh bilaterally. The patient's sodium level was112 mmol/L—indicated severe hyponatremia in a laboratory sense.; HCO3-34.1 mmol/L; pH 7.26 Consistent with hypercapnia, PO2 was 79.7mmHg whereas PCO2 was 78.6mmHg. Included among liver enzymes were AST 57 U/L and ALT 36 U/L. while CRP came up at 1.89 mg/L.

Results and Conclusion: One unusual but possibly fatal side effect of riluzole is hyponatremia. In this example, a drug-induced impact was suggested by the commencement and subsequent dose escalation of riluzole corresponding with worsening hyponatremia. Although the exact process riluzole causes hyponatremia is unknown, it might be renal sodium squandering, improper ADH release, or changes in sodium balance. Severe hyponatremia can cause neurological problems, respiratory depression, even coma, which calls for strict observation.Riluzole-taking ALS patients should routinely have their serum sodium levels checked. One should avoid fast sodium correction to avoid central pontine myelinolysis. Patients should be under great observation, and if needed, intensive care assistance should be given.

Keywords: Riluzole Use, Hyponatremia

Ref No: 3233

Etiology and Outcomes of Upper Extremity Venous Thrombosis: A Retrospective Cohort Study

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Introduction and Purpose: While traditionally considered less frequent and less severe than lower extremity deep vein thrombosis (LEDVT), Upper extremity deep vein thrombosis (UEDVT) can lead to significant morbidity, including post-thrombotic syndrome and pulmonary embolism.The escalating prevalence of invasive medical procedures, coupled with the ubiquitous use of diagnostic imaging, has significantly increased the incidence of upper extremity vein throm-bosis (UEVT) in recent decades.This study comprehensively investigates the clinical presentation, etiology, diagnostic ap-proach, and management of patients presenting to the emergency department with acute up-per extremity venous thrombosis. We specifically focus on delineating the spectrum of clinical presentations, identifying risk factors, and evaluating the impact of various treatment strate-gies on patient outcomes.

Materials and Methods: This retrospective cohort study included 304 consecutive adult patients (≥18 years) diagnosed with acute UEVT (2019-2024) at a tertiary care center. Data collected included demographics, medical history (including comorbidities such as malignancy, heart failure, rheumatologic diseases, and hematologic disorders), thrombosis characteristics (location, extension), treatment modalities, and outcomes (thrombosis resolution, PE, mortality). Statistical analysis included comparisons between UESVT and UEDVT groups (excluding fistula-related cases).

Results and Conclusion: The cohort comprised 115 (37.8%) patients with secondary UEDVT (predominantly catheter-related), 112 (36.8%) with UESVT, and 73 (24.0%) with fistula-related UEVT. UEDVT was strongly associated with central venous catheterization, malignancy (38.3%), rheumatologic diseases (15 patients with complex thrombotic phenotypes), and hematologic disorders (including polycythemia vera and various thrombophilias). Genetic testing in 25 patients revealed multiple coagulation abnormalities, suggesting a hypercoagulable state in some cases. UESVT was frequently associated with recent interventions (post-operative/anesthesia, post-transfusion, post-chemotherapy, post-IV contrast) and intravenous drug use. PE occurred in 29.6% of UEDVT patients, with a 27.1% mortality rate among those with PE. Notably, mortality was significantly higher in UEDVT patients with malignancy and dialysis catheter-related thrombosis.This study demonstrates the diverse etiologies and clinical course of UEVT. While UESVT often has an iatrogenic or substance-use related etiology, UEDVT is associated with a substantial risk of PE and mortality, particularly in the context of malignancy and catheter-related thrombosis, rheumatologic diseases, and catheter use especially in hemodialysis patients. The high risk of PE and mortality in UEDVT emphasizes the need for prompt diagnosis, risk stratification, and appropriate management.

Clinical Characteristics, Thrombosis Features, Treatment, and Outcomes in UEVT Patients

Patients	History of DVT/PE	Concomitant Diseases	Thrombosis Extension	Additional Informations	Treatment	Disease Outcome	
UEDVT in Patients	DVT (n 18)	Diabetes 18,	66,66%	The association	LMWH therapy was	Mortality: 24 patients	

with Cancer (n 37) Male (n 24) 64,64 ±12,98 years	48,64% PE (n 19) 51,35	COPD (n 17) (15 COPD in Lung Cancer) Renal failure 4 Immobile 5	Axillary, 55,55% Subclavian, 55,55% Brachial	between upper extremity deep vein thrombosis (UEDVT) and lung, gastrointestinal, and breast cancers was particularly noteworthy.	initiated for all patients, 12 patients continuing to receive warfarin and NOACs	64,86% within a 1-6-month period, PE incidence:48,64% Total Recovery:9,37%	
UEDVT in Patients with Catheter, Implanted Devices, Port and Vascular Intervention (n 21) 60,8±14,76 years	DVT (n 9) 42,85% PE (n 4) 19,04%	Heart Failure 14, Coronary artery disease 13, Diabetes 13, Renal Failure 6, COPD 3	71,42% Axillary, 61,9% Subclavian, 52,38% Brachial	80% mortality in 1-3 weeks in Dialysis catheter patients (no catheter removal); 0% mortality with port removal	LMWH therapy was initiated for all patients, 5 patients continued to receive warfarin and 2 patients received NOACs.	For Dialysis catheter patients (n 5) Mortality: 80% within a 1-3-week period PE incidence: 80% The other patients had good outcomes. 0% mortality, 0% PE. Treatments were ended in 2-4 weeks, no l no long-term treatment.	
Rheumatologic disorders (n 15) Lupus (n 6) Behcet's (n 4) rheumatoid arthritis (n 2) Ankylosing spondylitis (n1) Sjogren's syndrome (n 1) Vasculitis (n 1) Male (n 12) 42,33 ±9,21 years	DVT (n 11) 73,33%; (n 5) 33,33% frequent, (n 3) 20% upper extremity PE (n 10) 66,66%; (n 2) 13,33% frequent	Diabetes 3	60% Axillary, 53,33% Subclavian, 53,33% Subclavian, patchy involvement	10 patients underwent evaluation for a thrombotic predisposition. One patient was diagnosed with acquired thrombophilia, and another with hyperviscosity syndrome. Two weeks subsequent to the initial evaluation, one patient developed central nervous system vasculitis.	13 patients (86.66%) commenced LMWH therapy. 2 patients (13.33%) initiated therapy with NOACs. Eleven patients (73.33%) continued to be monitored on warfarin therapy. Four patients were monitored on NOACs. The patients were provided with close rheumatological follow-up and intensive immunosuppressive therapy.	Mortality: 0% PE incidence: 13,33% Total Recovery: 86,66 in 2-6 months Chronic thrombosis:13,33%	
Disseminated intravascular coagulation (n4) Male (n 3) 80,75±15,1 years	DVT (n 3) 75% PE (n 3) 75%	Heart Failure 3, Diabetes 3, Nephrotic syndrome 1, Renal failure 1, Immobile 1	75% Axillary, 75% Cephalic, 50% Barchial,	Concomitant pulmonary embolism, superior vena cava thrombosis, and lower extremity deep vein thrombosis, in conjunction with sepsis	LMWH therapy was initiated for all patients	Mortality: 100% in ICU in 4-14 days	
Hematological disorders (n 10) Male (n8) 45,1±10,57 years	DVT (n 6) 60% (n 3) 30% Frequent PE (n 3) 30%	Diabetes 2 thyroid cancer 1, Polycythemia Vera 3, Factor V Leiden mutation 5, MTHFR gene mutation 2, activated protein C resistance, protein S deficiency,	60% Axillary, 50% Brachial, 50% Cephalic patchy involvement	In 2 patients, on this visit, pulmonary embolism was the initial diagnosis.	Initial treatment was with low molecular weight heparin (LMWH). One patient with extensive thrombosis received localized thrombolysis in the interventional radiology.	Mortality: 0% PE incidence:30% Total recovery in 4-12 months.	

		elevated factor VIII and factor VII levels, beta-2 glycoprotein I antibody positivity, von Willebrand factor deficiency.					
Cessation of warfarin therapy (n 5) **Male (n 4)** **52,2±20,98 years**	DVT (n3) 60% PE (n 2) 40%	Mechanical heart valve replacement 4, PE history 1, Heart Failure 3, Diabetes 2	60% Cephalic, 40% Basilic, 20% Axillary, 20% Brachial	Blood INR level 1,1-1,6	LMWH therapy was initiated for all patients, and the dosage of warfarin was adjusted accordingly.	Mortality: 20% (other causes), PE incidence:25% Total recovery in 4-12 months.	
Trauma (n 11) **Male (n 8)** **56,6±17,69 years**	DVT (n 4) 36,36% PE (n 1) 9,09%	Heart Failure 2, COPD 2, Diabetes 3, Cast applied 2, Velpeau Immobilization 1, Immobile 3	54,54% Brachial, 45,45 Basilic, Multi-zone	2 patients were earthquake victims, 6 patients have fractures, 2 patients also have arterial injuries	Surgical intervention was performed on five patients (45.45%) at the time of admission. LMWH therapy was initiated in six patients (54.54%).	Mortality: 0% PE incidence:0% Total recovery.: 81,81% in 2-4 weeks months, chronic thrombosis:18,18%	
Obstetric causes (n 4) **Female (n 4)** **32,5±6,2 years**	DVT (n 2) 50% PE (n 0) 0%	Thrombophilia 1, Abortion 1, recent childbirth 2	75% Axillary, 75% Brachial	A patient presented with thrombosis in both the upper and lower extremities.	LMWH therapy was initiated in all patients.	Mortality: 0%, Total recovery:100% in 2-4 weeks	
UESVT Patients with Thrombophlebitis (n 112) **51,23±18,91 years** **Male (n 62) 55,35%**	DVT (n 26) 23,21% PE (n 5) 4,46%	Diabetes 29, Heart failure 20, COPD 9, Immobile 11	Cephalic (n 72) 64,28% Basilic (n 42) 37,5% Both (n 2) 1,78%	Cessation of warfarin therapy 4, Patient's history of Anesthesia 16, Patient's history of iv contrast 14, Patient's history of iv drug abuse 12, Stasis of blood, heart failure etc. 16, history of transfusion, history chemotherapy4, Mechanical compression 5	In 97 patients (86,6%) LMWH therapy and 4 patients (3,57%) NOACs was initiated. 100% of patients also received antibiotic treatment.	Mortality: 0% PE incidence:0,8%	
UESVT Patients with Dialysis Fistulas (n 73) 55,43±15,33 years **Male (n 48)** **65,75%**	DVT (n 13) 17,8% PE (n 2) 2,73%	Diabetes 34, Heart failure 17, Coronary artery disease 15, COPD 6, Oncologic disease 5, Immobile 1	cephalic vein involvement 52, 71,23%	24 patients had inflow vein thrombosis, 20 had outflow vein thrombosis, and 29 had fistula-centered thrombosis. Five patients experienced both venous and arterial thrombotic events.	Of the patients, 13 underwent fistula revision. Anticoagulation was initiated with LMWH in 43 patients, while 13 initially received no anticoagulation. Warfarin dosage was adjusted in 3 patients, and one patient underwent interventional radiology.	Mortality:1,3% 50,68% fistula use has ended. Spontaneous recanalization occurred in 22 patients, while 11 patients underwent surgical intervention with successful recanalization. Two patients failed to recanalize despite surgical intervention, and two others underwent interventional radiological procedures.	

Demographic Characteristics of UESVT and UEDVT

Characteristic	UESVT Total (n 185)	Dialysis Fistulas (n 73)	**Nonfistula UESVT (n 112)**		
Age in years, mean SD (min-max)	53,15±17,89	56,15 ±15,98	51,23±18,91 (18-100)	55,57±17,22 (24-91)	0,256 (t=1,85)
Male sex, n (%)	110	48	62 (55,35%)	82 (71,3%)	0,012
Diabetes	63	34	29 (25,89%)	44(38,26%)	**0,003**
Heart Failure	37	17	20 (17,85%)	31(26,95%)	0,125
Risk Factors					
Cancer	15	5	10 (8,92%)	44(38,26%)	**<0,001**
Central venous device		(73)	10 (8,92%)	29(25,21%)	**0,002**
Stasis, Immobilization	14	1	13 (11,6%)	16(13,91%)	**0,001**
Previous DVT	39	13	26 (23,21)	58(50,43%)	**<0,001**
Previous PE	7	2	5 (4,46)	42(36,52%)	**<0,001**
Thrombophilic defect	2	1	1 (0,8%)	22	**<0,001**
Pulmonary Embolism	2 (1,6%)	1 (0,8%)	1 (0,8%)	34(29,56%)	**<0,001**
Mortality, itself	1 (0,8%)	1 (0,8%)	0 (0%)	27(27,11%)	**<0,001**

Risk factor analysis of UEDVT and UESVT

Risk Factors	**Risk of UEDVT**	**Risk of UESVT**	**p value**
Age (>70 years)	85,7	14,3	**p<0,05**
Cancer	71,4	28,6	**p<0,05**
Heart Failure	70,6	29,4	**p<0,05**
Immobilization	41,7	58,3	**p<0,05**
Protein C/S metabolism disorder	75	25	**p<0,05**
Antithrombin III Deficiency	66,7	33,3	**p<0,05**

Logistic regression and Random Forest results

	Logistic Regression			**Random Forest**
	Coefficient	**Odds ratio**	**p value**	**Importance level**
Cancer	1,2	3,32	p<0,05	0,45
Age	0,05	1,05	p<0,05	0,27
Heart Failure	0,8	2,23	p<0,05	0,15
Male	0,2	1,22	p>0,05	0,13

Keywords: Upper extremity venous thrombosis, cancer, Catheter

Ref No: 3241

The unexpected culprit of abdominal pain: a case of mesenteric panniculitis

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Introduction and Purpose: Mesenteric panniculitis (MP) is a rare, benign disease characterized by inflammation, fat necrosis, and fibrosis of mesenteric fat tissue. First described by Jura in 1924, it is also known as sclerosing mesenteritis and mesenteric lipodystrophy. Although MP primarily affects the mesentery of the small intestine, it can, in rare cases, involve the mesocolon, omentum, and retroperitoneal space. The exact etiology remains unknown, but MP has been associated with prior abdominal surgery, trauma, mesenteric ischemia, pancreatitis, autoimmune diseases, and malignancies. While MP may be asymptomatic, it can also present with

nonspecific symptoms, including abdominal pain, loss of appetite, weight loss, nausea, vomiting, diarrhea, constipation, and fever. Imaging modalities play a crucial role in diagnosis. Ultrasonography (USG) may demonstrate increased echogenicity and heterogeneity in mesenteric fat tissue, but computed tomography (CT) provides a more definitive diagnosis. CT findings may include increased fat density due to inflammation, involvement of adjacent vascular structures, and the characteristic "mesenteric swirl sign." Magnetic resonance imaging (MRI) is particularly useful for excluding malignancies. Treatment depends on symptom severity; asymptomatic cases generally do not require intervention, while mild symptomatic cases may be managed with NSAIDs or low-dose corticosteroids.
Materials and Methods: A 49-year-old female patient with no known chronic illnesses presented to the emergency department with sudden-onset abdominal pain, nausea, and vomiting. On physical examination, her vital signs were stable, and mild abdominal tenderness was noted, without guarding or rebound tenderness. Laboratory tests revealed a mild elevation in inflammatory markers. As the patient did not respond to symptomatic treatment, contrast-enhanced abdominal CT was performed for further evaluation, revealing imaging findings consistent with mesenteric panniculitis. The patient was subsequently consulted with the general surgery department and admitted for further assessment and management.
Results and Conclusion: Mesenteric panniculitis has a broad clinical spectrum and is often characterized by nonspecific symptoms. As observed in other reported cases, diagnosis primarily relies on imaging techniques, and management is typically symptomatic. However, given the potential association with underlying malignancies or inflammatory processes, each case should be evaluated on an individual basis.
Keywords: Mesenteric panniculitis, Abdominal pain, Acute abdomen

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Ref No: 3257
Retrospective Analysis of Patients Presenting to the Emergency Department with Thoracic Trauma
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Introduction and Purpose: Thoracic traumas are the third most common trauma, following head and extremity traumas. Various trauma scoring systems, such as the Abbreviated Injury Scale (AIS) and the Glasgow Coma Scale (GCS), are commonly used to predict morbidity and mortality in trauma cases. This study aims to evaluate the demographic characteristics, trauma mechanisms, causes of injury, accompanying injuries, and the relationship between GCS and AIS trauma scores and prognosis, morbidity, and mortality.
Materials and Methods: The records of 99 thoracic trauma cases aged 18 years and older admitted to Niğde Ömer Halisdemir Training and Research Hospital Emergency Department between 01.01.2024 and 01.01.2025 were analyzed. Demographic data, trauma mechanisms, causes of injury, accompanying injuries, and the specificity of GCS and AIS scores in predicting prognosis, morbidity, and mortality were reviewed. The Shapiro-Wilk test assessed the data distribution. Numerical variables were summarized as mean ± standard deviation, while categorical variables were summarized as frequency and percentage. Pearson correlation analysis examined relationships between numerical variables, and the independent t-test compared two groups. Statistical significance was set at $p<0.05$.
Results and Conclusion: There was a significant difference in the AIS and GCS trauma scores between patients who survived and those who did not. The mean AIS scores were significantly higher in deceased patients ($p<0.001$), while the mean GCS scores were significantly lower ($p<0.001$). A strong negative correlation between AIS and GCS scores was found ($p<0.001$; $r = -0.909$), indicating that as GCS scores increased, AIS scores decreased.Most of the patients were male, aged between 18 and 45 years, and the most common cause of thoracic trauma was traffic accidents. Rib fractures were the most frequent injury. Higher AIS scores and lower GCS scores may serve as specific indicators for predicting prognosis, morbidity, and mortality in thoracic trauma patients.
Keywords: Thoracic Trauma, Abbreviated Injury Scale, Glasgow Coma Scale

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Ref No: 3277
Rectal foreign body: a case report
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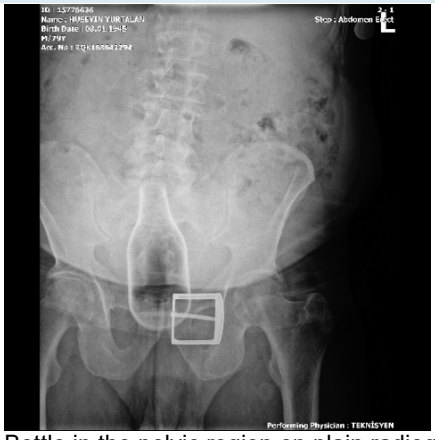
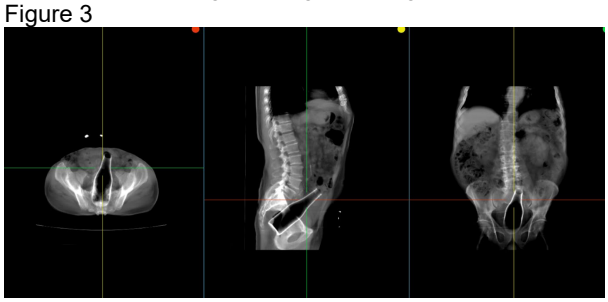
Introduction and Purpose: Rectal foreign bodies may be inserted into the rectum as a result of sexual assault, self-treatment of anorectal disease, accidentally, rarely swallowing and most commonly for sexual satisfaction. They may cause rectal bleeding, perforation and laceration. It is most common in men aged 30-40. Rarely, it can be seen in older ages. Patients mostly presents with rectal and lower abdominal pain. Unreliable anamnesis, foreign body palpable on rectal examination, and foreign body opacity on plain abdominal radiography are important for diagnosis.
Materials and Methods: 80-year-old male presented to the emergency department with complaints of tenesmus and lower abdominal pain. On physical examination there was no abdominal defense or rebound. A bottle-shaped foreign body was observed at pelvic level on plain radiography (Figure 1) . Since no perforation was observed in the abdominal computerized tomography (CT), the foreign body was removed (Figures 2,3). The patient was followed up in the general surgery ward for 3 days and was discharged after no perforation was detected in follow-up imaging. The patient presented with complaints of bloody diarrhea 20 days after discharge. After perforation was ruled out in imaging methods, the patient was started on dual antibiotic therapy.
Figure 1



Bottle in the pelvic region on plain radiography
Figure 2

Bottle in the rectosigmoid region in sagittal CT
Figure 3



The image of the entire bottle was obtained after minimum intensity projection (MinIP) on axial, sagittal and coronal CT reformats.

Results and Conclusion: Rectal foreign bodies have a difficult process that begins with diagnosis in the emergency room, continues with treatment, and then includes patient follow-up. One of the most common problems encountered in treatment is the delay in hospital admissions due to patients' embarrassment and hesitation to seek medical help. Most patients present after failing to remove the foreign body and do not give a realistic anamnesis. Perforation and rectal bleeding may occur in the late period after foreign body removal. Therefore, an approach that includes diagnosis, removal of the object and subsequent evaluation is essential.

Keywords: Foreign body, rectum, CT

Ref No: 3279

Comparison of the efficacy of urapidil and nicardipine in hypertensive emergency and urgency patients with chronic renal failure

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Introduction and Purpose: Chronic Kidney Disease (CKD) is a worldwide common disease characterized by progressive loss of kidney function. Hypertension is frequently seen in CKD patients, and hypertensive emergency and urgency increase the risk of serious complications in these patients. Hypertensive emergency patients presenting to the emergency department need to be treated effectively and rapidly. The aim of this study was to compare the efficacy of urapidil and nicardipine in CKD patients admitted to the emergency

department for hypertensive emergency or urgency and to determine which drug is more effective in terms of blood pressure control.
Materials and Methods: This study was designed as a randomized single-blind study and conducted in a single center after ethics committee approval. A total of 56 patients diagnosed with hypertensive emergency or urgency were randomly divided into two groups. One group received urapidil (25mg/5ml intravenous push) and the other group received nicardipine (25mg/10ml, 5mg/hour infusion).Blood pressure values at 0.min, 2.min, 5.min, 15.min, 45.min, 1.h, 2.h and 6.h were recorded in all patients. In addition, vital signs, physical examination findings, electrocardiography and echocardiography results, and laboratory values (EGFR (estimated glomerular filtration rate), creatinine, troponin, electrolytes, blood gases) were analyzed.
Results and Conclusion: Of a total of 56 patients, 32 were male and 24 were female and the patients were equally distributed to the urapidil (n=28) and nicardipine (n=28) groups.- The 2nd minute systolic blood pressure value was found to be higher in the nicardipine group than in the urapidil group.- The 2nd hour systolic, 45th minute and 1st hour diastolic blood pressure values were higher in the urapidil group than in the nicardipine group.- When 0.min blood pressure values were compared with other time intervals, a significant decrease was found in both drug groups.- Troponin values were higher in the nicardipine group than in the urapidil group.In conclusion, urapidil and nicardipine can be safely used for blood pressure control in CKD patients with hypertensive emergency and urgency. However, it was concluded that urapidil should be preferred to nicardipine because of its superior ability to provide immediate blood pressure reduction and its more advantageous both economically and in terms of labor saving.
Keywords: cronic kidney disease, urapidil, nicardipin

Ref No: 3290
Cold agglutinin disease: ice-cold effects, warm solutions
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Introduction and Purpose: Cold Agglutinin Disease (CAD) is a rare type of autoimmune hemolytic anemia that occurs when IgM antibodies activated in cold environments bind to antigens on the erythrocyte surface. This mechanism initiates the process of erythrocyte agglutination and hemolysis. CAD is typically triggered by infections (especially Mycoplasma pneumoniae or viral agents) or lymphoproliferative diseases. Clinical manifestations include anemia, jaundice, peripheral vascular disorders, and acral distress. Early diagnosis and accurate laboratory practices are crucial for disease management.
Materials and Methods: A 25-year-old male patient presented with complaints of high fever, cough, and shortness of breath persisting for two weeks. He reported recent exposure to extreme cold and experiencing cyanosis in his hands and feet. On physical examination, his temperature was 38.8°C, heart rate was 104 bpm, respiratory rate was 90 breaths per minute, and blood pressure was 99/67 mmHg. Computed tomography (CT) revealed reticular and nodular infiltrative areas in both lower lung lobes, suggesting atypical pneumonia. Blood samples taken at room temperature showed agglutination, leading to falsely low erythrocyte count and hematocrit levels reported by the automated device; however, warming the sample to 37°C in a water bath provided accurate laboratory values. The direct Coombs test was positive, and immunofixation electrophoresis detected a monoclonal IgM kappa band, confirming the diagnosis.
Results and Conclusion: This case emphasizes the importance of proper sample collection and laboratory practices in the diagnosis and treatment of CAD. It highlights the role of excessive immune activation due to infection and exposure to cold environments in the disease pathogenesis. Preventing the patient from cold exposure, controlling infections, and utilizing advanced treatment methods such as plasmapheresis when necessary play a crucial role in preventing complications. A multidisciplinary approach strengthens coordination between clinical and laboratory teams, improving patients' quality of life. This case demonstrates that early intervention and appropriate treatment strategies positively impact patient prognosis.
Keywords: Cold Agglutinin, Hemolytic Anemia, Mycoplasma Infection

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Ref No: 3343
Aortic dissection presenting to the emergency department with altered mental status
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Introduction and Purpose: Aortic dissection is a fatal disease that occurs when different layers of the aortic wall are separated as a result of a tear in the intimal layer of the aorta. Risk factors include age, hypertension, hyperlipidemia and connective tissue diseases. Rapid diagnosis and treatment are very important for the survival of patients. In this case report, we wanted to present an aortic dissection that was admitted to the emergency department due to altered mental status.
Materials and Methods: CaseA 69-year-old female patient was admitted to the emergency department with complaints of sudden collapse at home and impaired consciousness. The patient had hypertension and coronary artery disease. On admission, blood pressure was 90/50 mmHg, pulse was 55 beats/min and ECG showed sinus bradycardia. Physical examination revealed GCS: 7, and four extremities were moving to painful stimuli. Bilateral Babinski reflex was positive, direct light reflex was absent in the left eye, and decreased in the right eye. No pathology was detected in the cranial computed tomography (CT) scan. Diffusion-weighted magnetic resonance (MR) imaging revealed a large infarct area in the right middle cerebral artery irrigation area (Figure 1). In the cranial angiography CT images taken to determine the need for endovascular intervention, a dissection flap extending from the aortic arch to the left subclavian artery and the common carotid artery was detected (Figure 2). The dissection flap was observed to have a thrombosed appearance along the carotid artery. The patient was consulted to cardiovascular surgery. The patient died on the 2nd day of intensive care unit follow-up.
Figure 1

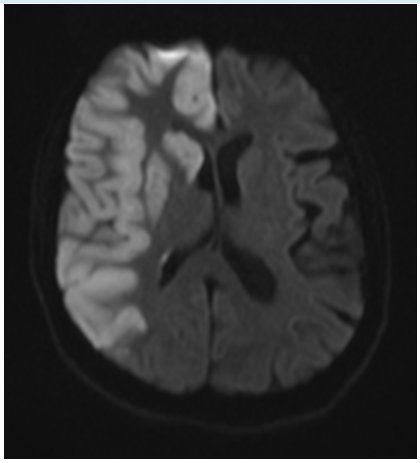
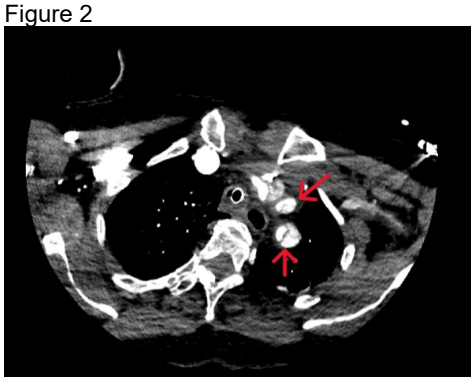


Figure 2



Results and Conclusion: Stanford type A aortic dissections present with 60% of patients complaining of severe chest pain that radiates to the back. However, approximately 10% of patients may present with syncope. Dissections in the carotid artery or nearby show signs of stroke. Approximately 20% of type A dissections are accompanied by neurological symptoms, which is a poor prognosis. It is important for emergency physicians to be aware of the different clinical presentations of aortic dissections in order to avoid delays in diagnosis and treatment.

Keywords: Aortic dissection, Altered mental status, Stroke

Ref No: 3404

An interesting cause of abdominal pain in the emergency room

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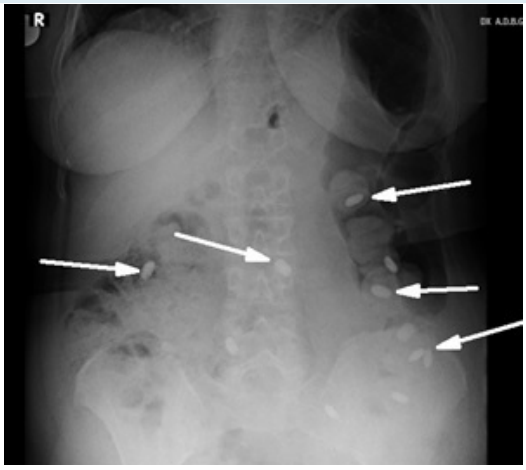
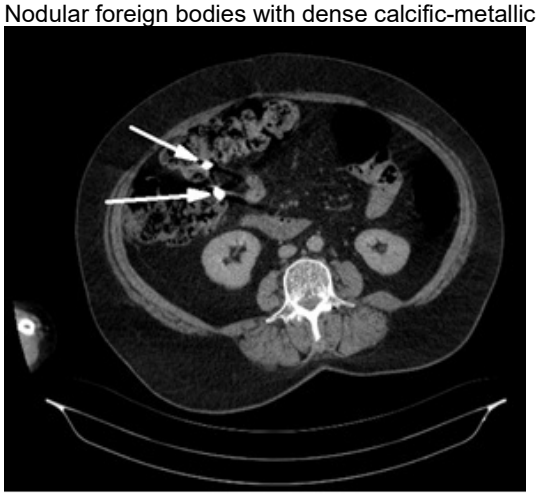
Introduction and Purpose: Introduction: In this case report, we aimed to present a case of abdominal pain who presented to the emergency department with complaints of abdominal pain and constipation for 2 days.

Materials and Methods: Case report: A 76-year-old woman presented to our emergency department with complaints of abdominal pain and constipation for 2 days. Physical examination revealed a distended abdomen, diffuse tenderness and hypoactive bowel sounds. Abdominal plain abdominal radiography showed approximately 10-12 similarly shaped hyperdense foreign bodies (long dimension measured 15 mm and short dimension measured 5 mm) in the left lower quadrant and left upper quadrant. Abdominal computed tomography showed similarly shaped nodular foreign bodies with dense calcific-metallic characteristic foreign bodies with different locations and contents, one in the stomach and the others in the colon. The next day, black stools were added to her complaints. Endoscopy and colonoscopy performed 3 days later revealed no nodular foreign body with calcific-metallic appearance. The patient was followed up by the gastroenterology department and discharged after her general condition improved.

Hyperdense foreign bodies on standing plain abdominal radiography



Nodular foreign bodies with dense calcific-metallic character on abdominal computed tomography



Results and Conclusion: Conclusion: It should be kept in mind that atypical eating disorders may underlie high-density calcific-metallic nodular lesions in the stomach and intestines in patients presenting with abdominal pain.
Keywords: Abdominal pain, constipation, eating disorders

Ref No: 3420

DETERMINATION OF BRAIN CT INDICATIONS IN CHILDREN PATIENTS APPLIED TO THE EMERGENCY SERVICE WITH MINOR HEAD TRAUMA USING PECARN SCORE AND EMERGENCY MEDICINE EXPERT OPINION WITH ARTIFICIAL INTELLIGENCE ALGORITHM

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Introduction and Purpose: Pediatric traumatic brain injury (TBI) is one of the most common causes of acquired disability and death. In addition, traumatic brain injury is a very heterogeneous condition and the risk of long-term disability after survival is high in children with head trauma. Fast and correct use and prompt intervention will reduce bad results. In addition to classical diagnostic methods, modern diagnostic methods will also contribute to this situation.Our aim in our research is to create an artificial intelligence (AI) cleaner with the pediatric expanding ChatGPT-4o program in emergency services with minor head trauma and to capture brain CT scan indications with PECARN score and emergency medicine expert assistance. This is envisaged to assist in decision making for minor head trauma and follow-up brain CT scans, as well as the PECARN head trauma clinical scoring system and clinics, as well as the major trauma language models (LLM) stored with AI systems.

Materials and Methods: Our retrospective study included patients aged 18 and under who had minor head trauma and had computed tomography images taken at Ankara Bilkent City Hospital Emergency Medicine Clinic between March 2019 and March 2024. Our study included 1169 patients whose incident history, physical examination, age, gender and tomography records were taken at the hospital. We formulated the data for the study, calculated the PECARN score for the patient and also interviewed the emergency medicine specialist for the patient. The obtained data were labeled using ChatGPT-4o.

Results and Conclusion: When ChatGPT-4o recommendations were compared according to CT findings, a statistically significant difference was found between the groups, and this difference stems from the difference between the decisions it makes for findings that may have clinical significance and those that do not (Table 1). When compared with the comparison imaging results, it was seen that ChatGPT was more successful in terms of results according to expert opinions and PECARN guideline recommendations (Table 2). In

addition, the compatibility between ChatGPT-4o recommendations and expert opinions was lower than that with PECARN (Table 3). A general overview of CT scan request distributions by PECARN guidelines, expert opinion, and ChatGPT-4o recommendations is presented in Table 4.

Number of Patients Requesting CT According to PECARN Guidelines and ChatGPT-4o Recommendations

			PECARN Guide		total patient	
		BT not recommend	BT recommend	follow it		
	BT not recommend	331(35.1)	6(7.1)	16 (11.3	335	
ChatGPT-4o	BT recommend	141 (15.0)	62 (72.9)	59 (41.5)	262	
	follow it	470 (49.9)	17 (20.0)	67 (47.2)	554	
		942 (100.0)	85 (100.0)	142 (100.0)	1169	
	kappa value:0,112 (p<0,001)					

Table 1
Number of Patients Requesting CT According to PECARN Guidelines and Expert Opinion

		PECARN Guidelines			
		BT not required	BT is required	Follow-up	total
	BT not required	764	11	44	819
	BT is required	89	73	64	225
expert opinions	Follow-up	89	1	34	124
	total	941	85	142	1169
	kappa value	0.377(p<0.001)			

Table 2
Number of Patients Requesting CT According to ChatGPT-4o and Expert Opinion

			expert opinions		
		BT not required	BT is required	Follow-up	total
	BT not required	309	29	24	353
ChatGPT-4o	BT is required	109	125	28	262
	Follow-up	410	71	72	553
	total	819	225	124	1168
	kappa value:**0.173 (p<0,001)**				

Table 3
CT Request Evaluation from Patients Aaccording to PECARN Guidelines, Expert Opinion, and ChatGPT-4o Recommendations

Parameters (n=1169	**n(%)**
PECARN Guide	
CT is not recommended	942 (80.6)
CT is recommended	85 (7.3)
Follow-up (Requested if clinical observation result is necessary)	142 (12.1)
Expert Opinion	
I don't want	819 (70.1)
ı want	225 (19.3)
Follow-up (Requested if clinical observation result is necessary)	124 (10,6)
CHATGPT-4o	
BT Not Recommended	53 (30.2)
BT Recommended	262 (22.4)
Follow-up	554 (47.4)

Table 4

Keywords: Artificial intelligence, Emercency Medicine, Head Trauma

Ref No: 3448

Bile duct obstruction: Mirizzi syndrome

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Introduction and Purpose: Mirizzi syndrome is an obstruction of the common bile duct caused by external compression of the common bile duct by a large stone sitting in the Hartman pouch of the gallbladder. Obstructive jaundice (obstructive icterus) develops in these patients. Obstructive jaundice is usually accompanied by fever and right upper quadrant pain. Inflammation also develops here. Chronic inflammation can lead to necrosis of the wall of the main hepatic duct and choledochal wall and eventually to fistula (cholecystohepatic and cholecystocholedochal fistula).

Materials and Methods: A 75-year-old woman patient. She presented to the emergency department with right upper quadrant pain. On examination, the patient had deficiency and rebound in the right upper quadrant. Other quadrant examinations were normal. There was gas stool discharge. The patient's medical history: hypertension, coronary artery disease. Vital signs fever: 36.7 C saturation:%96 blood pressure: 123/76 mm/hg. Blood sugar : 109 mg/dl.In the tests performed, wbc:10.7 10^3/dl , total bilirubin:1.36 mg/dl direct bilirubin:0.76 mg/dl AST:36 U/L, ALT:53 U/L, CRP:6 mg/L. Computed tomography was performed in the emergency department. Imaging showed a collection area in the gallbladder bed and centralization of the intrahepatic bile ducts (Image 1-4). Mirizzi syndrome was considered and the patient was consulted with general surgery. Percutaneous gallstone drainage was performed in the follow-up of the patient and this procedure was repeated in the following periods, but complete recovery was not achieved in the follow-up of the patient. Cholecystectomy was planned.

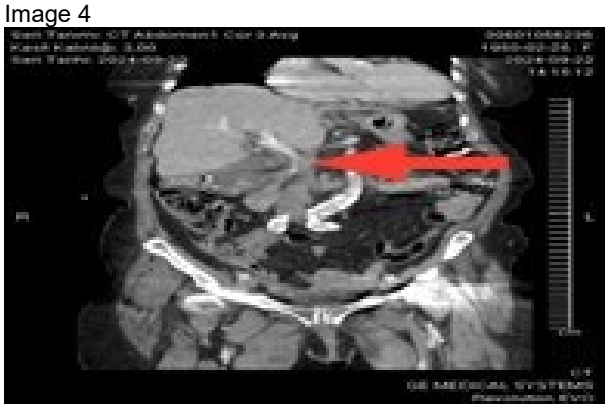
Image 1

A collection area in the gallbladder bed and centralization of the intrahepatic bile ducts

Image 2

Image 3

Image 4



Results and Conclusion: The most important point in the diagnosis of Mirizzi syndrome is to suspect this syndrome. The absolute solution of the disease is surgery. Complications in delayed diagnosis and treatment will significantly decrease the success of the treatment and reduce the comfort zone of the patient. Therefore, it should be ensured that these patients receive surgical treatment immediately.

Keywords: Emergency department, Mirizzi syndrome, Gallstone

Ref No: 3460

Brain Abscess

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Introduction and Purpose: A brain abscess is a focal collection of pus within the brain parenchyma, which can occur as a complication of various infections, trauma, or surgery. It can develop through direct spread or hematogenous dissemination. The clinical signs of a brain abscess typically include headache, fever, and focal neurological deficits. However, symptoms can vary, and in the early stages of the disease, the signs are often nonspecific. In this study, we aim to present a 51-year-old female patient with a brain abscess who presented with a generalized tonic-clonic seizure.

Materials and Methods: A 51-year-old female patient was brought to the Emergency Department by the 112 emergency response team after experiencing a generalized tonic-clonic (GTC) seizure lasting about one minute. She had a known diagnosis of systemic lupus erythematosus (SLE). On admission, her Glasgow Coma Scale (GCS) score was 15, blood pressure was 115/65 mmHg, oxygen saturation was 92%, heart rate was 76 bpm, and her temperature was 38.5°C. Her neurological examination revealed no abnormalities. A peripheral intravenous line was established, and blood tests were requested. Her laboratory results showed a white blood cell count

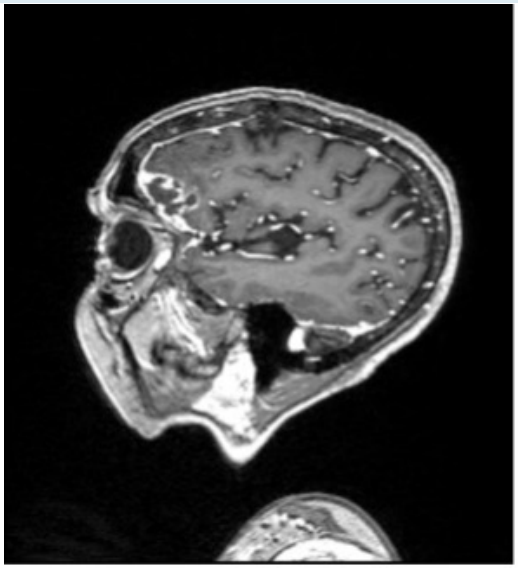
(WBC) of 6000 and a C-reactive protein (CRP) level of 150. To explore the etiology of the seizure, a non-contrast brain CT scan was performed, which showed a suspicious abscess in the right frontal region. The patient then underwent contrast-enhanced brain magnetic resonance imaging (MRI) (Figures 1-2-3), confirming the diagnosis of a brain abscess. The patient was consulted to the Neurosurgery Department and was admitted for further management.

Results and Conclusion: In patients being investigated for seizures, a brain abscess should not be overlooked. For all patients, a neurosurgical consultation should be made when brain abscess is suspected. In most cases, needle aspiration or surgical excision should be performed to identify the causative pathogen and reduce the size of the collection before starting antibiotic therapy. Patients diagnosed with a brain abscess should begin antibiotic treatment immediately after stereotactic or open biopsy/aspiration. However, if biopsy or aspiration is not possible (e.g., due to the location of the lesion), antibiotic therapy should still be initiated.

Figure 1

Figure 2

Figure 3



Keywords: Seizure, Brain Abscess

Ref No: 3493

Investigation of the Clinical Importance of Blood Gas Monitoring During Resuscitation in Cardiac Arrest Patients

Ayse Busra OZCAN[1], Mervenur Polat[1], Bahadır TASLIDERE[1], Basar CANDER[1]

[1]Investigation of the Clinical Importance of Blood Gas Monitoring During Resuscitation in Cardiac Arrest Patients

Introduction and Purpose: Cardiac arrest is characterized by the sudden cessation of blood circulation due to the heart's ineffective contraction during systole, leading to insufficient cerebral blood flow and resulting in an abrupt loss of consciousness. we aimed to investigate the changes in blood gas parameters during resuscitation in patients with cardiac arrest and to assess whether we can predict the time until spontaneous circulation resumes by examining the trends in these values.

Materials and Methods: This retrospective study is planned to include all patients aged 18 and over who were brought to the emergency department of our hospital with cardiopulmonary arrest or who experienced in-hospital cardiopulmonary arrest and were intervened in the emergency department during a one-year period (January 1, 2023, to December 31, 2023) after receiving ethical approval. Patients under the age of 18, those with missing data, cases of witnessed cardiac arrest, terminal-stage cancer patients, and patients deemed to have prolonged cardiopulmonary resuscitation without adequate tissue perfusion will be excluded from the study. The study will adhere to the Helsinki criteria. . The forms prepared in the emergency department will record patients' demographic information (age, gender), medical and family history, chronic diseases, complaints, mode of arrival, time of arrival, interventions performed, blood gas results, and outcomes. Using the sample calculation formula, the minimum number of patients with a standard deviation of 0.5% and a Z score of 1.96 was found to be 101.

Results and Conclusion: According to the statistical evaluation of blood gas analysis results, a significant difference was found in pH values between the groups of patients who survived and those who died following cardiopulmonary resuscitation (CPR) (p-value = 0.002). The average pH value of the surviving group was 7.12 (SD: 0.17), while that of the deceased group was 6.92 (SD: 0.18). No statistically significant difference was found between the two groups in terms of lactate levels (p-value = 0.202). The average lactate level for the surviving group was 6.60 (SD: 4.20), whereas for the deceased group, it was 9.02 (SD: 5.56). These results indicate that there is a significant difference in pH values between the groups, but no notable difference in lactate levels.

Table 1 : Group Statistics

Result		N	Mean	Std. Deviation	Std. Error Mean
pHA	0	19	7,05179	0,129789	0,029776
	1	59	6,90425	0,189171	0,024628
phB	0	19	7,13311	0,174001	0,039919
	1	59	6,87375	0,175250	0,022816
hco3A	0	19	14,732	5,0389	1,1560
	1	59	15,153	5,6934	0,7412
hco3B	0	19	15,058	4,7929	1,0996
	1	59	12,653	5,3017	0,6902
beA	0	19	14,826	5,0589	1,1606
	1	59	17,739	7,2290	0,9411
beB	0	19	13,105	6,3165	1,4491
	1	59	20,003	5,6685	0,7380
hbB	0	19	11,516	2,5382	0,5823
	1	59	11,692	2,8778	0,3747
naA	0	19	135,863	4,3981	1,0090
	1	59	139,710	6,8584	0,8929
kB	0	19	4,2332	0,93788	0,21516
	1	59	5,7919	1,44874	0,18861

Table 1 : Group Statistics

Table 2. Test Statistics (Grouping Variable Results)

	pco2A	pco2B	hbA	naB	kA	bgA	bgB	lacA	lacB
Mann-Whitney U	416,000	342,500	532,500	400,500	322,000	421,000	526,000	528,500	349,500
Wilcoxon W	606,000	532,500	722,500	590,500	512,000	611,000	716,000	2298,500	539,500
Z	-1,682	-2,538	-0,326	-1,863	-2,776	-1,624	-0,402	-0,373	-2,456
Asymp. Sig. (2-tailed)	0,093	0,011	0,744	0,063	0,005	0,104	0,688	0,710	0,014

Table 2. Test Statistics (Grouping Variable Results)

Table 3. Sex and Age

Result	Cases	Valid		Missing		Total	
		N	Percent	N	Percent	N	Percent
Age	0	19	%100,0	0	%0,0	19	%100,0
	1	59	%100,0	0	%0,0	59	%100,0
Sex	0	5	%26,3	17	%28,8	22	%28,2
	1	14	%73,7	42	%71,2	56	%71,8
Total		19	%100,0	59	%100,0	78	%100,0

Table 3. Sex and Age

Keywords: Cardiopulmonary resuscitation, blood gas, survival.

Ref No: 3500

Maxillofacial Trauma

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Introduction and Purpose: A horse kick is one of the high-energy blunt traumas and is frequently seen in individuals working in rural areas. In addition to causing maxillofacial injuries, it can be associated with other morbidities such as intracranial hemorrhages, cervical spine injuries, and thoracoabdominal organ damage.

Materials and Methods: A 63-year-old male patient presented to the emergency department following a horse kick. The patient was conscious but described significant facial deformity and widespread facial pain. On physical examination, there were periorbital ecchymosis and edema, nasal deformity with epistaxis, tenderness in the maxilla and zygomatic regions, malocclusion and dental trauma, as well as lacerations and soft tissue injuries. Imaging studies revealed bilateral maxillary fractures, a left zygomatic arch fracture, a nasal bone fracture, and mild subcutaneous emphysema (Figures 1, 2).The patient was managed conservatively in the emergency department due to hemodynamic stability. Analgesics and intravenous hydration were initiated for pain management. An anterior nasal packing was applied to control the epistaxis, and consultations with the plastic surgery and otolaryngology departments were obtained regarding the maxillofacial fractures. The patient was admitted to the maxillofacial surgery clinic for surgical repair of the fractures.

figure 1

figure 2

Results and Conclusion: Trauma resulting from a horse kick is a high-energy injury that can lead to serious maxillofacial fractures. The maxilla and zygomatic bones are among the most commonly affected structures.A multidisciplinary approach is essential in such traumas. Airway security should be prioritized in these patients. In patients with facial fractures, a cranial nerve examination should be performed and additional head trauma should be carefully evaluated. The type of fractures should be determined through imaging, and surgical intervention should be planned if necessary.

Keywords: Maxillofacial Trauma, Horse Kick, Fracture

Ref No: 3518

AN INCİDENTAL CASE OF NUTCRACKER SYNDROME

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Introduction and Purpose: Nutcracker syndrome(NCS), is the compression of the left renal vein(LRV). It is a rare and often overlooked condition. Anatomically, the LRV passes through the space between the superior mesenteric artery and the aorta, near the origin of the artery. In affected individuals, the LRV is compressed between these two structures, leading to renal venous hypertension.The clinical symptoms of NCS include left flank pain along with macroscopic or microscopic hematuria. Patients are typically children or young adults, and there may be a slight predisposition in females. Women may also present with pelvic congestion symptoms such as pelvic pain and dyspareunia(1).

Materials and Methods: A male patient presented to the emergency department with complaints of abdominal pain, nausea, and vomiting that started in the morning. The 25-year-old patient had no history of additional diseases or medication use. On physical examination, defense and rebound were observed in the lower right quadrant of the abdomen. Other systemic examinations were normal, and his vital signs were stable. Laboratory parameters are presented in Tables 1 and 2. Imaging studies revealed that the appendix was not sonographically visualized during abdominal ultrasonography. Due to the presence of defense on abdominal examination, the patient was referred to general surgery.For further investigation, a contrast-enhanced abdominal computed tomography (CT) scan was performed. The CT report indicated narrowing of the calibration of the left renal vein between the superior mesenteric artery (SMA) and the aorta, suggesting Nutcracker syndrome, and recommended clinical correlation. (Figure 1). Follow-up in the general surgery and urology outpatient clinics was advised, and the patient was discharged.

Figure 1 (Abdominal CT): Narrowing in the calibration of the left renal vein between the superior mesenteric artery (SMA) and the aorta is notable

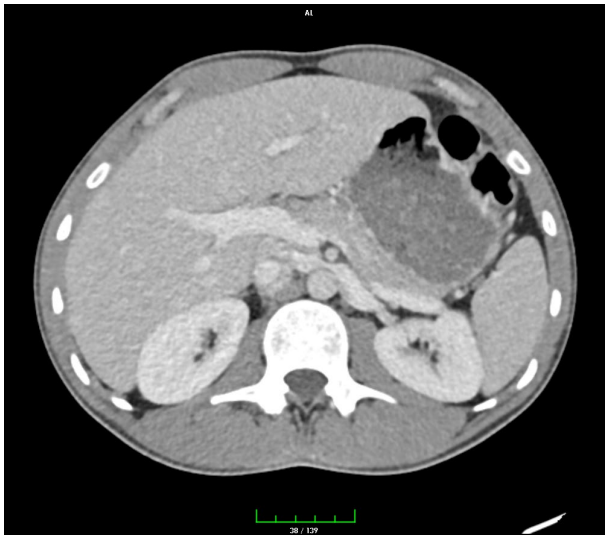

Table-1: Laboratory Parameters

Parameter	Result	Normal Range
WBC(White Blood Cell) (10^3/uL)	10.35	3.91-10.9
HGB(Hemoglobin) (g/dl)	16.8	13-16.9
Hct (%)	47.5	36,6 - 50
Mcv (fL)	83.8	81,8 - 95,5
Neutrophil (10^3/uL)	5.5	1.8-6.98
Lymph (10^3/uL)	3.94	1,26 - 3,35
C reactive protein (mg/dl)	<2	0-5

Table 2 :urine test parameters

Urine Test Parameter	Result	Normal Range
Dansit	1.020	1015 - 1025
Glucose	Neg.	Negative
Ketone	Neg.	Negative
Protein	Neg.	Negative
Bilirubin	Neg.	Negative
Urobilinogen	1+	Negative
Nitrite	Neg.	Negative
Leukocyte (Strip)	Neg.	Negative
Erythrocyte (Strip)	Neg.	Negative
Non squamous apithelium (/hpf)	1	Negative

Results and Conclusion: The diagnosis of NCS is challenging and typically presents as clinical complaints including microscopic and sometimes macroscopic hematuria, less frequently orthostatic proteinuria, vague flank pain, and pelvic congestion symptoms(2). One of the most important factors contributing to the rarity of this syndrome being diagnosed is its low recognition and the lack of consideration during emergency and outpatient visits as well as advanced radiological diagnostic examinations. In the diagnosis of this syndrome, after excluding conditions such as nephrolithiasis and urinary system infection, NCS should also be taken into consideration in the differential diagnosis.

Keywords: Nutcracker syndrome, pelvic pain, hematuria

Ref No: 3534

Glucocorticoid-Induced Hypokalemic Periodic Paralysis

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Introduction and Purpose: Hypokalemic periodic paralysis (HPP) is a rare neuromuscular disorder associated with muscular dysfunction caused by hypokalemia. Disease severity and degree of paralysis vary with time and range(1). Most cases of periodic paralysis are hereditary. Familial form is inherited from anautosomal dominant pattern. Nonfamilial HPP may occur in the presence of hyperthyroidism called as thyrotoxic periodic paralysis(TPP) or in the absence of hyperthyroidism called as spontaneous periodic paralysis(2). Most cases of acquired HPP are thought to be associated with hyperthyroidism. HPP can be accompanied by heavy exercise, fasting, or a high-carbohydrate meal. In addition, glucocorticoid treatment could be a trigger of HPP(1,3).

Materials and Methods: A 33-year-old man presented to our hospital emergency room complaining of acute weakness involving all four limbs. The patient was diagnosed upper respiratory tract infection in the morning and intramuscular dexamethasone was administered.That night, he visited the emergency room with weakness and numbness in both extremities. On physical examination, the muscle power was 2/5 grade in all extremities. No other localized neurological abnormalities were observed. Laboratory test results were as follows: serum potassium, 1.63 mmol/L. In the patient's ECG taken during her first application, T and U waves merged and caused false QTc prolongation. The patient’s potassium and phosphorus levels were replaced with intravenous supplements. After admission, thyroid values were checked and a thyroid ultrasound was performed. In the patient's thyroid USG; the parenchymal echogenicity of both thyroid lobes appeared heterogeneous and pseudonodular hypoechoic areas were observed. Tests performed after the patient was admitted to the hospital revealed that the patient had hyperthyroidism and Graves' disease.

Figure 1. Shows ECG changes at diagnosis, U waves and QTc prolongation

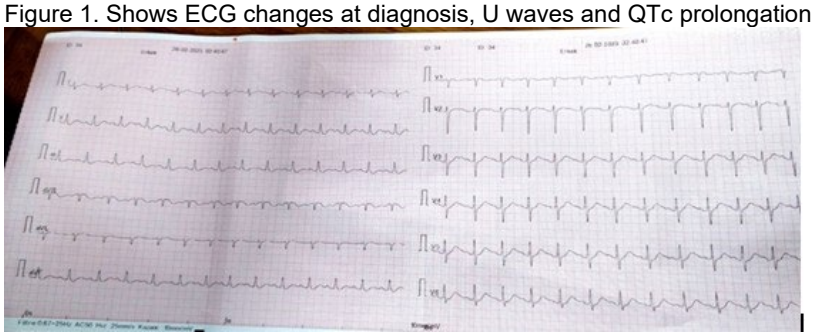

Table 1. Shows the tests performed after the patient is admitted to the hospital

Parameters	test result	Normal value Range

TSH	0.005	0.27-4.2 mIU/L
T_3	8.07	2-4.40 ng/L
T_4	2.7	0.93-1.70 ng/L
TSI	37.1	0-0.55 U/L

Results and Conclusion: The principle biochemical abnormality during a TPP attack is hypokalemia. Pathophysiologic details of this transcellular potassium shift into the cells are, however, not well understood. Glucocorticoids may induce hypokalemia from a transcellular potassium shift caused by several mechanisms such as an increased Na+ and steroid-induced hyperinsulinemia and hyperglycemia. Steroids can also cause muscle weakness rooting renal potassium loss and myopathy(4). As a result, if a patient comes to the emergency medicine with complaints of loss of strength and numbness in 4 extremities, we should definitely question TPP and the use of glucocorticoids.

Keywords: Hypokalemic periodic paralysis, hypokalemia, glucocorticoid

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Ref No: 3536

INABILITY TO WALK AFTER GASTROENTERITIS: GUILLAIN-BARRE SYNDROME

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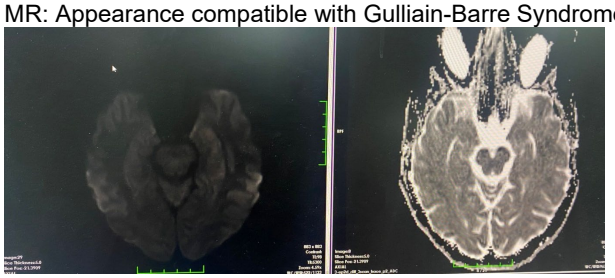
Introduction and Purpose: 25-year-old female patient with no known medical history was diagnosed with gastroenteritis one week ago. She presented with complaints of muscle weakness and inability to walk for two days. The patient's general condition was moderate, saturation: 98%, pulse rate: 113, arterial blood pressure: 108/69 mmHg, temperature: 36.8 C. On physical examination, cranial nerve examinations were normal and strength examination of both lower extremities was 2/5. There were no significant abnormalities in the blood tests of the patient, who was able to walk with difficulty and robotic gait alone. The imaging studies suggested GBS (Figure 1), and the patient was referred to the neurology department for admission and treatment.

Materials and Methods: MR

MR: Appearance compatible with Gulliain-Barre Syndrome



Results and Conclusion: GBS can occur at any age but is most common in childhood. The clinical presentation of GBS is similar in children and adults. There is no single test to diagnose GBS, but progressive motor weakness and areflexia on examination are leading signs.

Keywords: GUILLAIN-BARRE SYNDROME

Ref No: 3634

Ketamine and Esketamine for Treatment-Resistant Depression, Anxiety, and Postpartum Depression: A Systematic Review of Efficacy, Safety, and Clinical Applications

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Introduction and Purpose: Ketamine, originally developed as an anesthetic, has emerged as a promising treatment for mental health disorders, particularly treatment-resistant depression (TRD), anxiety, and suicidality. With increasing cases of postpartum depression (PPD), ketamine and esketamine have been investigated for their potential to prevent depressive symptoms following cesarean delivery. This meta-analysis evaluates the efficacy, safety, and administration methods of ketamine in these conditions, highlighting its role in addressing refractory anxiety, suicidality, and PPD.

Materials and Methods: This study systematically reviewed 14 randomized controlled trials and one retrospective study, encompassing 2,916 patients, sourced from PubMed, Embase, and the Cochrane Library. The primary outcome measures included PPD incidence and Edinburgh Postnatal Depression Scale (EPDS) scores, while secondary outcomes assessed adverse effects such as nausea, dizziness, hallucinations, and headaches. In parallel, additional studies on ketamine's role in TRD, anxiety, and suicidality were reviewed. Data analysis focused on the impact of dosage, administration method, and drug type (ketamine vs. esketamine).

Results and Conclusion: Ketamine significantly reduced PPD incidence and EPDS scores at one and four weeks postpartum, particularly when administered via patient-controlled intravenous analgesia (PCIA). Esketamine demonstrated greater efficacy than ketamine, though both drugs led to mild and transient adverse effects. In mental health treatment, over 70% of TRD patients reported symptom relief after three ketamine infusions, with effects lasting up to 14 days. Additionally, 78% of individuals experiencing suicidality showed rapid or gradual improvement post-infusion. While ketamine offers a promising intervention for treatment-resistant anxiety, its anxiolytic effects are temporary, necessitating repeated administrations. Future research should explore long-term efficacy, maintenance protocols, and optimal patient selection criteria.

Keywords: ketamine, anxiety, postpartum depression

Ref No: 3650

A RARE CASE: TOTAL GASTRIC NECROSIS—BUT WHY?

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Introduction and Purpose: Total gastric necrosis is an exceptionally rare clinical entity due to the extensive vascular supply to the stomach.It is frequently associated with high mortality and may result from vascular,mechanical,chemical,infectious etiologies.In most cases,the underlying cause can be identified preoperatively,or an intraoperative mechanical insult can be demonstrated.A high index of clinical suspicion and thorough physical examination are crucial for early diagnosis.The most common presenting symptoms include nausea,vomiting,and severe abdominal pain.

Materials and Methods: A 22-year-old female patient presented to the emergency department with complaints of lower abdominal pain,bloating,and difficulty in passing flatus, which had begun one day prior.She reported experiencing similar symptoms during every menstrual cycle and stated that she had started menstruating the previous day.On physical examination,there was significant tenderness in the lower quadrants without signs of peritoneal irritation.Initial venous blood gas analysis revealed metabolic acidosis with a pH of 7.33, bicarbonate of 18.2 mmol/L,and a markedly elevated lactate level of 10.09 mmol/L.Intravenous fluid resuscitation was initiated.A follow-up examination performed 45 minutes later revealed worsening abdominal pain,raising suspicion of an acute abdomen.Additional laboratory results showed leukocytosis(WBC: 33,400/mm^3),neutrophilia (NEU%: 93.6), elevated amylase(343 U/L),lipase (1007 U/L),CRP (0.57 mg/dL).A contrast-enhanced abdominal computed tomography(CT)scan was performed.CT imaging demonstrated extensive pneumoperitoneum and free intra-abdominal fluid, suggestive of upper gastrointestinal perforation.Additionally,there was an absence of gastric wall enhancement with diffuse intramural gas(suggestive of total gastric necrosis).A filling defect of approximately 5 mm was noted at the origin of the celiac trunk,along with non-enhancing areas in the spleen, consistent with splenic infarction. Given these findings, median arcuate ligament syndrome(MALS) and celiac artery compression syndrome were considered as possible underlying etiologies.The general surgery team was consulted, and the patient underwent emergency total gastrectomy and splenectomy.Postoperatively,she was admitted to the anesthesia intensive care unit for further management.

Results and Conclusion: MALS is a rare vascular compression disorder caused by excessive pressure from the median arcuate ligament on the celiac artery and the surrounding celiac plexus. This condition is predominantly observed in young,thin females and presents with postprandial epigastric pain and weight loss.MALS remains a diagnostic challenge and often requires extensive workup.The definitive treatment is surgical release of the median arcuate ligament,with reported success rates of approximately75%.

Keywords: Total Gastric Necrosis, Median Arcuate Ligament Syndrome, Vascular Compression Syndrome

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Ref No: 3674

GLOBUS PALLIDUS INFARCTION SECONDARY TO CARBON MONOXIDE INTOXICATION

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Introduction and Purpose: Carbon monoxide (CO) poisoning is a life-threatening condition that can lead to severe complications in myocardial and brain tissues. It may cause permanent neurological deficits and even death. Therefore, patients presenting to the emergency department should receive 100% oxygen as quickly as possible.

Materials and Methods: A 60-year-old female patient was brought to the emergency department by EMS (112) due to suspected smoke inhalation following a stove malfunction at home. It was reported that the patient remained in the environment for over 24 hours after exposure and that her husband had succumbed to carbon monoxide (CO) intoxication.On physical examination, the patient was conscious, cooperative, and oriented; however, lower extremity muscle weakness and aphasia (inability to speak) were noted. Her vital signs upon admission were as follows: oxygen saturation: 85%, blood pressure: 120/80 mmHg, heart rate: 140 bpm, temperature: 36.6°C, with bilateral coarse crackles on auscultation. Electrocardiography (ECG) revealed atrial fibrillation with a rapid ventricular response, and arterial blood gas analysis showed a negative carboxyhemoglobin (COHb) level.The patient was placed in a secured environment and initiated on 100% oxygen therapy. Intravenous diltiazem was administered for rate control, which was successfully achieved. Due to the presence of neurological deficits following intoxication, brain computed tomography (CT) and diffusion-weighted magnetic resonance imaging (MRI) were performed. MRI revealed bilateral globus pallidus involvement. The neurology department was consulted for further evaluation and management. The findings were considered consistent with carbon monoxide intoxication.

Results and Conclusion: In cases with neurological deficits, loss of consciousness, cardiac ischemia, or high carboxyhemoglobin (COHb) levels, the need for hyperbaric oxygen therapy (HBOT) should be promptly evaluated.Although there are no definitive guidelines for HBOT, therapeutic decisions focus on preventing long-term sequelae such as cognitive dysfunction and cardiac complications, as well as reducing mortality.

Keywords: CO intoxication, neurological deficit, HBOT

Ref No: 3682

A CASE REPORT: TENDON RUPTURE, A RARE CONDITION IN DOG BITES

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Introduction and Purpose: In Turkey, 437,601 rabies risk-related exposure cases were recorded in 2023, with a significant proportion (approximately 91%) being attributed to dog bites. In the United States, studies indicate that 70% of bite injuries presenting to healthcare facilities involve the hand or upper extremity, and about 10% of these result in vascular, nerve, or tendon damage. To highlight the occurrence of rare conditions such as tendon rupture, we present this case to our colleagues.

Materials and Methods: Case Presentation: A 30-year-old male patient presented to our hospital's emergency department due to a dog bite sustained one hour prior. The biting animal was identified as an ear-tagged stray dog with no possibility of follow-up. The injuries consisted of an approximately 1 cm lacerated wound with tissue loss on the thenar region of the right hand, with a protruding approximately 10 cm tendon (Musculus flexor digitorum superficialis tendon), and a 2 cm longitudinal lacerated wound with tissue loss on the lateral aspect of the proximal phalanx of the second finger of the right hand. Motor examination revealed a loss of flexion in the second finger of the right hand, while sensory examination showed hypoesthesia distal to the injury site on the second finger of the right hand. Following wound debridement, 1500 IU of Albies® equine immunoglobulin was administered around the wound, and another 1500 IU was administered intramuscularly. Rabies and tetanus vaccinations were provided, and 1 gram of Cefazolin was administered intravenously for prophylaxis. The patient was consulted with the on-call orthopedist regarding the tendon injury and subsequently referred to a center specializing in hand surgery.

Results and Conclusion: Dog bites to the hand can lead to functional impairment, time off work, and significant costs to society in terms of hospitalization, surgery, rehabilitation, and social security. These injuries are frequently encountered in the emergency department. While initial considerations in dog bite cases often revolve around rabies prophylaxis, it is crucial not to overlook the possibility of rare but significant neurovascular and muscular injuries, including complete tendon rupture. Therefore, a thorough motor and sensory examination should be meticulously performed in all cases of dog bites presenting to the emergency.

Keywords: Dog bite, Musculary injury, Tendon rupture

Ref No: 3706

Traumatic Aortic Transection Following Motor Vehicle Collisions: A Four-Patient Case Series

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Introduction and Purpose: Traumatic aortic transection (TAT) is a rare but often fatal injury resulting from high-energy blunt thoracic trauma, most commonly due to motor vehicle collisions (MVCs). The aortic isthmus is the most frequently affected site due to its anatomical vulnerability. Early recognition in the emergency department (ED) is critical to improve outcomes, yet diagnosis may be delayed due to nonspecific clinical presentations and the presence of distracting injuries. This case series aims to describe the ED presentation, imaging findings, and early management of four patients with confirmed TAT following MVCs, emphasizing the pivotal role of emergency physicians in the initial phase of care.

Materials and Methods: We retrospectively reviewed four male patients, aged 26, 32, and 38 (two patients), with a mean age of 33.5 ± 5.7 years, who presented to a tertiary ED between January 2019 and January 2024. All patients sustained TAT secondary to MVCs and were diagnosed by contrast-enhanced thoracoabdominal computed tomography angiography (CTA). Clinical data, imaging, interventions, and outcomes were evaluated.

Results and Conclusion: All patients were hemodynamically stable at presentation and had a Glasgow Coma Score of 15. One patient was a pedestrian struck by a vehicle; the others were in-vehicle occupants. Aortic injury was located at the isthmus in all cases. Associated injuries included pneumothorax, hemothorax, hepatic and splenic lacerations, renal trauma, and long bone or vertebral fractures. CTA confirmed aortic transection in all patients. Blood pressure control and resuscitation were promptly initiated. All patients were admitted to the intensive care unit and underwent thoracic endovascular aortic repair. The median hospital stay was 13 days (IQR 7–21). No mortality occurred. This case series underscores the importance of maintaining a high index of suspicion for TAT in patients presenting after high-velocity MVCs, even in the absence of shock. CTA should be performed early in the evaluation of suspected cases. Emergency physicians are essential in initiating hemodynamic control, imaging, and surgical coordination, all of which contribute to improved survival in TAT.

Keywords: Traumatic aortic transection, Emergency physician, High index of suspicion

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Ref No: 3714

FEATURES OF THROMBOSIS AND RESTENOSIS OF STENTS IN PATIENTS AFTER CORONAVIRUS INFECTION: A SYSTEMATIC REVIEW OF CLINICAL CASES

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Introduction and Purpose: Introduction. Some of the most serious complications of coronary stenting are restenosis and in-stent thrombosis, the prevalence of which can reach 20-25%. One of the important factors for formation of restenosis and thrombosis in patients is the presence of systemic inflammation, including infectious, which can damage the endothelium, plaques and trigger hypercoagulation mechanisms , creating a prothrombotic effect. In recent years, the situation has been greatly complicated by the coronavirus pandemic .The purpose of the study is to study the impact of COVID -19 on the formation of thrombosis and restenosis. coronary artery stents in patients with coronary artery disease.

Materials and Methods: Materials and methods : We searched PubMed and Scopus databases for relevant publications containing case reports and case series of restenosis stent and stent thrombosis associated with coronavirus infection. The study was carried out with the financial support of the Science Committee of the Ministry of Education and Science of the Republic of Kazakhstan (grant No. AP 19677465).

Results and Conclusion: Results: In scientific sources, we found 18 publications describing cases of thrombosis and restenosis stents

associated with coronavirus infection, of which only 3 publications were case series (from 3 to 10 cases). In total, we analyzed 32 cases. In the structure of in-stent Of the restenoses and thromboses, 59.4% (19 cases) were very late (more than a year after the previous revascularization), 15.6% (5 cases) were late (from 1 month to 1 year after revascularization); 18.75% (6 cases) were assessed as subacute (from one day to one month) and 6.25% (2 cases) as acute (within 24 hours after the previous revascularization). The main localization of restenosis or thrombosis was the left coronary artery (23 cases or 71.9%), thrombosis of the RCA and circumflex artery occurred with the same frequency - 21.9% (seven cases each). Conclusion. The analysis of publications shows an increase in the frequency of restenosis and in-stent thrombosis in patients with coronary artery disease associated with coronavirus infection.

Keywords: restenosis, coronavirus infection, thrombosis of stent

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Ref No: 3719

A PARASİTİC EGG İN THE PANCREATİC DUCT?

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Introduction and Purpose: Gastrointestinal infections can present with various clinical manifestations and lead to emergency department admissions. Parasitic infestations are more commonly observed in individuals residing in endemic regions or those exposed to risk factors. This case report discusses the evaluation of a patient presenting with severe nausea and vomiting, who was diagnosed with acute biliary pancreatitis and found to have gastrointestinal parasitic infestation.

Materials and Methods: A 70-year-old female patient with a known history of hypertension and diabetes mellitus presented to the emergency department with severe nausea and vomiting. Upon admission, her general condition was moderate, and she appeared toxic. However, her vital signs were within normal limits and stable. Physical examination revealed tenderness in the upper abdominal quadrants, but there was no rebound tenderness or guarding.During observation in the emergency department, the patient experienced projectile vomiting, after which a parasite, suspected to be Taenia saginata, was observed in the oral cavity and subsequently removed (image 1). Laboratory tests and contrast-enhanced abdominal CT imaging revealed findings consistent with pancreatitis (image 2), along with multiple lesions in the stomach suspected to be parasites (image 3). Following a consultation with the infectious diseases department, the patient was diagnosed with acute biliary pancreatitis and admitted to the internal medicine gastroenterology service for further management.

image 1

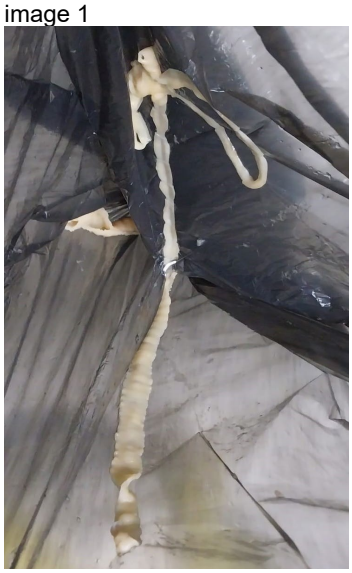

image 2

image 3

Results and Conclusion: This case highlights the importance of considering parasitic infestations in the differential diagnosis of acute pancreatitis. While rare, parasitic involvement in the gastrointestinal tract can contribute to pancreatitis and should not be overlooked, especially in patients with risk factors or gastrointestinal symptoms. Early diagnosis and appropriate management are crucial in preventing complications and ensuring optimal patient outcomes.
Keywords: TENİA SAGİNATA, PANCREATİTİS

Ref No: 3732
Evaluation of Consultations Requested from the Green Zone in the Emergency Department
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Introduction and Purpose: Emergency departments (EDs) serve as the primary point of care for patients requiring urgent medical attention. The green zone within the ED is designated for patients with stable conditions who do not require immediate intervention. Despite their lower urgency, some green zone patients necessitate consultations from various specialties. This study aims to evaluate the characteristics and frequency of consultations requested for green zone patients in a tertiary ED, analyzing trends based on patient demographics, consultation timing, and outcomes
Materials and Methods: This retrospective, observational study analyzed consultation requests for green zone patients who presented to a tertiary ED during the first three weeks of January 2024. A total of 922 patients requiring consultation were included. Data collected included patient demographics, consultation timing (working hours, after-hours, night shifts), requested specialty, time to consultation request, repeat consultation rates, and patient outcomes. Statistical analysis was conducted using Jamovi and Python, with $p<0.05$ considered statistically significant.
Results and Conclusion: Out of 38,337 green zone visits, 922 (2.4%) required consultations, totaling 1,079 requests. The majority (65.1%) were male, with a median age of 41 years. Most consultations were requested during after-hours (46.42%) and working hours (45.12%), while night shift consultations were less frequent (8.46%). The most frequently consulted specialties were ophthalmology (30.77%), general surgery (12.46%), and orthopedics (12.13%). The primary diagnoses leading to consultations included ocular foreign bodies (15.18%), abdominal pain (10.63%), and unspecified soft tissue disorders (9.98%). Most patients were discharged (67.03%), while 24.19% were admitted to the ward, and 4.66% required intensive care unit admission.In conclusion, green zone consultations constitute a small but significant proportion of ED workflow. Understanding consultation trends can help optimize resource allocation and improve patient management strategies. Further research is needed to assess the efficiency of consultation processes in non-critical emergency cases.
Keywords: Emergency department, green zone, consultation

Ref No: 3774
A rare anaphylaxis in the emergency department: anaphylaxis in elderly patients and sesame
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Introduction and Purpose: Sesame has been eaten and used as medicine since prehistoric times. Sesame allergy, a life-threatening condition, is more prevalent in the Middle East than in the West with mechanisms that remain unclear. Studies indicate that sesame allergy and anaphylaxis are increasing in Saudi Arabia, Iran, Kuwait, and Turkey. Many food allergies, including sesame, begin in infancy or childhood. A recent study found that 25% of sesame allergies develop in adulthood. While sesame allergies have been reported, our case is unique due to its late onset and its rarity in emergency settings. This case highlights the importance of inquiring about recent meals in emergency department patients presenting with anaphylaxis, particularly in cases of food allergies.
Materials and Methods: A 75-year-old patient was brought to the family emergency service by a 112 Ambulance. It was reported that the patient called 112 after suddenly feeling unwell and experiencing shortness of breath, skin redness, itching, and urticaria after eating cake. The patient, diagnosed with anaphylaxis, was administered intramuscular adrenaline. A detailed medical history obtained while the

patient was in the intensive care unit revealed that they had no sesame allergy during childhood or early adulthood, with the first allergic reaction occurring at the age of 60 after consuming halva. The patient later experienced similar symptoms after eating sesame bagels and tahini sauce. The patient was monitored in the intensive care unit for three days and received symptomatic treatment. By the end of the third day, with stable vitals and no complaints, the patient was discharged with a prescription and advised to follow up at the allergy and immunology outpatient clinic.

Results and Conclusion: Patients with hypersensitivity reactions may present to the emergency department with mild symptoms such as urticaria, itching, and redness, or with severe anaphylaxis. Food-related allergies or anaphylaxis generally manifest clinically in childhood or infancy, but as seen in our case, they can also first appear later in adulthood. Studies suggest that our country has a higher risk of sesame allergy compared to most other countries in the world.

Keywords: Sesame Allergy, Anaphylaxis, Food Allergy

Ref No: 3789

Evaluation of Blood Parameters Affecting Positive Endoscopic Findings in Patients Undergoing Endoscopy Due to Suspected Upper Gastrointestinal Bleeding in the Emergency Department

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Introduction and Purpose: Upper gastrointestinal (GI) bleeding is a common clinical condition encountered among patients presenting to emergency departments and can lead to severe morbidity and mortality. Endoscopy is one of the most crucial methods for both the diagnosis and treatment of these patients. This study aims to evaluate the blood parameters influencing positive endoscopic findings in patients who underwent endoscopy due to suspected upper GI bleeding in the emergency department. Our study is expected to provide supportive data for the clinical management of patients with upper GI bleeding.

Materials and Methods: In this study, the data of 48 patients over the age of 18 who presented to the Emergency Department of Niğde Ömer Halisdemir Training and Research Hospital between October 1, 2024, and December 31, 2024, and underwent endoscopy due to suspected upper gastrointestinal (GI) bleeding with the ICD code K92.2 were retrieved from the hospital automation system. The patients' age, gender, selected laboratory parameters (urea, INR, creatinine, CRP, WBC, PLT, hemoglobin [Hb]), and in-hospital mortality were recorded. Patients were categorized based on the presence or absence of bleeding according to positive endoscopic findings.

Results and Conclusion: Of the 48 patients, 23 (47.92%) were female, and 25 (52.08%) were male. Endoscopic findings of bleeding were detected in 19 patients (39.58%), whereas no signs of bleeding were observed in 29 patients (60.42%). Additionally, in-hospital mortality occurred in 2 patients (4.16%).The median urea level was found to be 122 mg/dL (33–259) in patients with endoscopic evidence of bleeding, while it was 58 mg/dL (11–110) in those without bleeding, with a statistically significant difference between the two groups (p = 0.01). Similarly, the median creatinine level was 1.4 mg/dL (0.59–3.49) in patients with endoscopic bleeding, compared to 0.81 mg/dL (0.45–1.78) in those without, which was also statistically significant (p = 0.016).In conclusion, urea and creatinine levels are significantly associated with positive endoscopic findings in upper GI bleeding. Assessing these parameters may aid clinical management and risk stratification. Larger-scale studies in the future would be beneficial to validate these findings and explore new biomarkers.

Table 1

		Median (Min-Max)	Mean (±SD)
Age		75 (18-90)	
Urea		62 (11-259)	
Creatin		0.91 (0.45-3.49)	
INR		1.19 (0.83-6.72)	
CRP		8.9 (0.2-148.3)	
WBC		8.2 (1.5-30.3)	
PLT		261.5 (41-660)	
HB			8.98±3.22
Bleeding (Endoscopy)	Yes	19 (39.58 %)	
	No	29 (60.42%)	
Gender	Female	23 (47.92 %)	
	Male	25 (52.08 %)	
Mortality	Alive	46 (95.84 %)	
	Ex	2 (4.16 %)	

Descriptive Statistics of the Data Analyzed in the Study

Table 2

	Presence of Bleeding in Endoscopy		
Factors (Median (Min-Max))	Yes. n=19	No. n=29	p

(Mean ± SD)			
Age	75 (47-89)	75 (18-90)	0.642
Urea	122 (33-259)	58 (11-110)	0.01
Creatin	1.4 (0.59-3.49)	0.81 (0.45-1.78)	0.016
INR	1.29 (0.93-3.75)	1.15 (0.83-6.72)	0.841
CRP	12.2 (0.4-115.3)	7.4 (0.20-148)	0.301
WBC	8.8 (1.5-30.3)	8 (1.7-20.9)	0.520
PLT	241 (41-660)	269 (109-607)	0.132
HB	8.33 (3.04)	9.41±3.32	0.264

T-Test for Parametric Data (Hb) and Mann-Whitney U Test for Non-Parametric Data (Age, Urea, Creatinine, INR, CRP, WBC, PLT)
Keywords: Upper Gastrointestinal Bleeding, Endoscopy, Urea

Ref No: 3793
Valvular Regurgitation in Acute Ischemic Stroke: A TOAST Analysis of Cardioembolic Subtypes
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Introduction and Purpose: Acute ischemic stroke (AIS) is a leading cause of global morbidity and mortality, with cardioembolic strokes accounting for 20–30% of cases. While atrial fibrillation (AF) is the primary etiology, the role of valvular regurgitation—mitral regurgitation (MR) and tricuspid regurgitation (TR)—in thromboembolic risk remains understudied. Current guidelines do not classify MR or TR as independent stroke risk factors, despite their potential to promote thrombogenesis through atrial stasis and endothelial dysfunction. This study aimed to investigate the prevalence of MR and TR in AIS subtypes, particularly cardioembolic strokes, and their association with AF, to clarify their contribution to stroke mechanisms and refine risk stratification strategies.
Materials and Methods: This retrospective study analyzed data from 403 AIS patients admitted to Kırşehir Ahi Evran University Hospital between 2019 and 2021. Inclusion criteria comprised patients aged >18 years with confirmed AIS, while exclusions included hemorrhagic stroke, transient ischemic attack, incomplete data, lack of CT imaging, and pregnancy. Data were extracted from medical records, including echocardiography, electrocardiography (ECG), and imaging (CT/CTA/DWI). Stroke subtypes were classified using the TOAST criteria. Statistical analyses (SPSS 23.0) included ANOVA, Chi-square tests, and post-hoc Duncan tests, with significance set at $p<0.05$.
Results and Conclusion: The cohort (mean age 72.4±12.4 years; 50.4% female) demonstrated a significant association between valvular regurgitation and cardioembolic strokes: MR (19.3%) and TR (16.7%) were most prevalent in this subgroup (p=0.000). AF coexisted in 88.6% of cardioembolic strokes, with 57.1% of MR and 77.4% of TR cases also exhibiting AF, suggesting synergistic thromboembolic risk. Reduced ejection fraction (<40%) was more frequent in cardioembolic strokes (26.3%, p=0.000), while left ventricular hypertrophy (21.1%, p=0.000) was linked to atherothrombotic strokes.These findings challenge the notion that MR/TR are incidental to stroke pathogenesis. Instead, their coexistence with AF may identify high-risk patients requiring tailored anticoagulation. The study advocates for integrating valvular assessment into stroke risk models, particularly for borderline CHA□DS□-VASc scores. Limitations include its retrospective design and single-center cohort. Prospective studies are needed to explore causal relationships and optimize secondary prevention strategies for valvular-related strokes.
Age and gender characteristics of acute ischemic stroke patients.

Parameter	**Patients**
Age (years)	72.4 ± 12.4
Gender	
Female	203 (50.4%)
Male	200 (49.6%)

The values are expressed as n (%) or mean ± SD.
Diagnostic cardiological test analysis of acute ischemic stroke subtypes according to the TOAST classification.

	TOAST Classification					
Parameter	Atherothrombotic n (%)	Cardioembolic n (%)	Lacunar n (%)	Other Etiologies n (%)	Undetermined n (%)	***p*-value**
Age (mean)	72.2±12.4a	74.7±13.2a	68.3±12a	51.8±19b	72.8±11a	**0.000**

Female (n, %)	100 (49.0%)	64 (56.1%)	26 (52.0%)	2 (33.3%)	11 (37.9%)	0.378
ECG Findings						
SR	185 (94.9%)	14 (11.4%)	48 (96.0%)	5 (83.3%)	22 (75.9%)	**0.000**
AF	10 (5.1%)	109 (88.6%)	2 (4.0%)	1 (16.7%)	7 (24.1%)	
Ejection Fraction						
≥50%	186 (91.2%)	73 (64.0%)	49 (98.0%)	6 (100.0%)	24 (82.8%)	**0.000**
41–49%	10 (4.9%)	11 (9.6%)	0 (0.0%)	0 (0.0%)	1 (3.4%)	
<40%	8 (3.9%)	30 (26.3%)	1 (2.0%)	0 (0.0%)	4 (13.8%)	
Echocardiography						
MR	10 (4.9%)	22 (19.3%)	0 (0.0%)	0 (0.0%)	3 (10.3%)	**0.000**
TR	8 (3.9%)	19 (16.7%)	1 (2.0%)	1 (16.7%)	2 (6.9%)	
LVH	43 (21.1%)	13 (11.4%)	4 (8.0%)	0 (0.0%)	1 (3.4%)	
Normal	142 (69.6%)	50 (43.9%)	45 (90.0%)	5 (83.3%)	21 (72.4%)	

Values are expressed as n(%) or mean ± SD. TOAST: Trial of ORG 10172 in Acute Stroke Treatment; SR: Sinus Rhythm; AF: Atrial Fibrillation; MR: Mitral Regurgitation; TR: Tricuspid Regurgitation; LVH: Left Ventricular Hypertrophy. *ANOVA; &: Chi-square test; €: Fisher-Freeman-Halton exact test.

Keywords: Acute ischemic stroke, Valvular regurgitation, Cardioembolic stroke

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Ref No: 3803

Emergent Management of Ruptured Ovarian Ectopic Pregnancy: A Case Report and Literature Review

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Introduction and Purpose: Ovarian ectopic pregnancy (OEP), a rare entity comprising 0.5-3% of ectopic gestations, poses significant diagnostic and therapeutic challenges. This case report details the emergent management of a ruptured OEP in a 26-year-old female with a history of prior Cesarean section, emphasizing the critical role of prompt intervention in mitigating life-threatening complications. We further provide a succinct literature review to contextualize the clinical presentation, diagnostic modalities, and management strategies for OEP.

Materials and Methods: The patient presented with acute abdominal pain and hemodynamic instability, necessitating immediate clinical evaluation. Diagnostic workup included serial beta-hCG measurements, transvaginal ultrasonography, and laboratory investigations. An emergency exploratory laparotomy and salpingectomy were performed to address the ruptured OEP and control hemorrhage. Post-operatively, the patient's hemodynamic parameters were closely monitored, and blood transfusions were administered. A comprehensive literature review was conducted, focusing on published studies concerning OEP diagnosis, surgical management (laparoscopy vs. laparotomy), and medical management options.

Results and Conclusion: The patient underwent successful surgical management, demonstrating the efficacy of rapid intervention in ruptured OEP. The literature review supports laparoscopy as the preferred surgical approach in hemodynamically stable patients, associated with reduced morbidity and expedited recovery. However, in cases of rupture with hemodynamic instability, laparotomy remains the standard of care. This case underscores the importance of a high index of suspicion and timely intervention in OEP to optimize patient outcomes. Further research is warranted to refine diagnostic algorithms, explore conservative management strategies for unruptured OEP, and establish standardized guidelines for clinical practice.

Keywords: Ovarian Ectopic Pregnancy, Laparotomy/Salpingectomy, Hemorrhage/Blood Transfusion

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Ref No: 3806

From Rat Poison to Phosphine Gas: A Case of Zinc Phosphide Poisoning and Clinical Management

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Introduction and Purpose: Zinc phosphide is a highly lethal rodenticide that reacts with gastric acid to release toxic phosphine gas (PH), causing multi-organ failure with a high mortality rate. Cases of zinc phosphide poisoning are rare but require prompt recognition and management. We present a case of intentional zinc phosphide ingestion in a 42-year-old male, highlighting the clinical presentation, treatment, and outcome of this life-threatening poisoning.

Materials and Methods: A 42-year-old man presented to the emergency department approximately one hour after intentionally ingesting a rodenticide containing zinc phosphide in a suicide attempt (Figure 1). He was symptomatic with nausea, vomiting, and

dizziness, but remained hemodynamically stable. Initial evaluation showed mild diffuse abdominal tenderness and a slight metabolic acidosis on arterial blood gas analysis (pH 7.30). Prompt gastric decontamination with activated charcoal was performed, and intravenous fluids were initiated. The patient was admitted to the Intensive Care Unit (ICU) for close monitoring and supportive care due to the risk of delayed systemic toxicity.

Figure 1.

The zinc phosphide-containing rodenticide product ingested by the patient. The packaging (in Turkish) indicates a high concentration (80%) of zinc phosphide (active ingredient, "Çinko Fosfür"), marked with a skull-and-crossbones icon and the warning "Çok zehirli" (very poisonous). Such baits release phosphine gas upon contact with stomach acid, leading to the toxic effects described in the text.

Results and Conclusion: In the ICU, the patient's condition remained stable and he did not develop severe complications such as cardiovascular collapse, pulmonary edema, or organ failure. Over the next 72 hours, his symptoms resolved with supportive care; he was transferred to the ward and subsequently discharged in good health with appropriate psychiatric follow-up. Early identification of the poisoning and prompt intervention likely contributed to his full recovery. This case underscores that even a potentially fatal zinc phosphide intoxication can have a favorable outcome with timely gastrointestinal decontamination and aggressive supportive management, highlighting the importance of high clinical suspicion and preparedness in the emergency setting.

Keywords: Phosphine gas, Rodenticide poisoning, Zinc phosphide.

Ref No: 3831

Evaluation of Initial and Secondary Triage Procedures in Patients Admitted to the Emergency Department of Tekirdağ Dr. İsmail Fehmi Cumalıoğlu City Hospital

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Introduction and Purpose: This study aims to evaluate the accuracy and effectiveness of the triage process in the Adult Emergency Department of Tekirdağ Dr. İsmail Fehmi Cumalıoğlu City Hospital. Specifically, it investigates the discrepancies between initial and secondary triage codes and assesses the appropriateness of emergency department use based on changes in triage levels.

Materials and Methods: This is a prospective, descriptive, and cross-sectional study conducted in March 2025. A total of 4,854 patients who presented to the adult emergency department and were recorded in the Hospital Information Management System (HIMS) were included. Initial triage codes were compared with those modified during follow-up. Data were analyzed using basic statistical methods.

Results and Conclusion: Of the 4,854 patients, 4,841 were upgraded from green to yellow triage, 11 from yellow to red, and 2 were downgraded from yellow to green. Observation was required for 1,953 patients in the green-to-yellow group and 6 in the yellow-to-red group, with mean observation times of 100.93 and 167.5 minutes, respectively. Seven patients from the green-to-yellow group were admitted to inpatient units, such as coronary ICU and internal medicine, with an average observation time of 188.28 minutes.The high rate of triage code modification observed in this study highlights potential inaccuracies in initial triage assessments. These findings suggest a need for clearer triage criteria, continuous training, and systemic improvements to ensure safe, timely, and effective emergency care. Enhancing triage practices will improve both patient outcomes and the efficiency of emergency services.

Keywords: .

Ref No: 3902

Isolated pulmonary laceration: a case report

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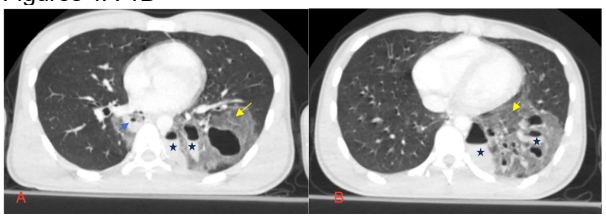
Introduction and Purpose: Thoracic trauma is observed in two-thirds of motor vehicle accidents. Blunt traumas constitute a significant portion of thoracic traumas. Pulmonary laceration is more common in penetrating chest trauma but can also occur with blunt thoracic trauma.

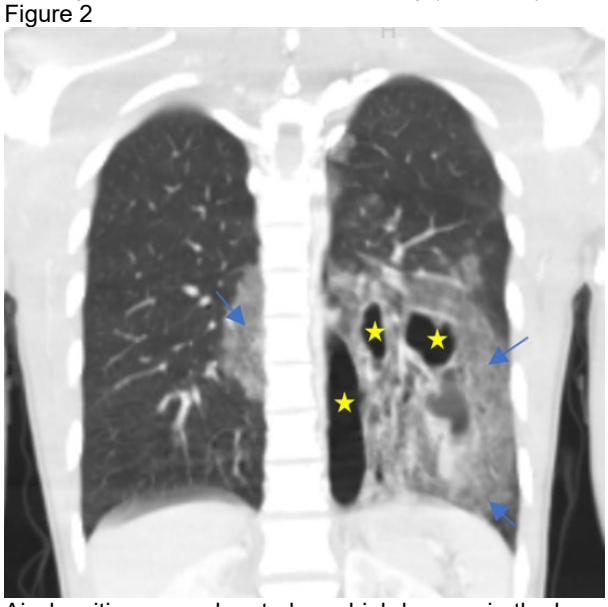
Materials and Methods: 18-year-old male patient was brought to the emergency department following a motor vehicle accident. On physical examination, there was widespread tenderness in the left posterior thoracic wall. No significant feature was detected in the medical history. Contrast-enhanced thorax and abdomen computed tomography (CT) was performed on the patient with multiple trauma. In thoracic CT, multiple laceration areas with hemorrhagic fluid-air levels and widespread ground glass areas compatible with contusion were observed in all basal segments of the left lung lower lobe and in the paravertebral areas of the right lung lower lobe (Figures 1A-1B,2). No accompanying rib or vertebral fractures were observed. In abdominal CT, traumatic organ damage, free air, and fluid were not observed. The patient, who was consulted to chest surgery, was admitted to the intensive care unit for follow-up and treatment.

Figures 1A-1B



Thorax CT axial sections; laceration cavity in the lower lobe of the right lung (blue arrow).Laceration cavities causing multiple air-fluid leveling in the lower lobe of the left lung (asterisks), with contusional ground-glass areas around them (yellow arrow).

Figure 2



Air densities secondary to bronchial damage in the laceration areas (asterisks) and widespread contusional ground glass appearance in the parenchyma on coronal CT sections (arrows)

Results and Conclusion: In pulmonary lacerations, due to the damage to vascular structures and bronchial structures together, an image resembling a cavitary mass with air-fluid leveling occurs in the parenchyma. The patient's history of trauma is an important clue in the differential diagnosis. Accompanying parenchymal contusion areas are frequently observed. Rib fractures and pneumothorax accompany in most patients. These findings were not observed in our case. It should be kept in mind that, although rare, isolated contusion and laceration may occur in thoracic traumas.

Keywords: lung laceration, thorax CT, trauma

Ref No: 3911

Retrospective analysis of neonatal patients admitted to Pediatric Emergency Departments of SB Bilecik Training and Research Hospital and Bozuyuk State Hospital

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Introduction and Purpose: To evaluate the clinical characteristics of neonatal patients admitted to the Pediatric Emergency Departments of Bilecik Training and Research Hospital and Bozuyuk State Hospital, which provide 24-hour pediatric emergency services with pediatricians in Bilecik Province, within a 1-year period.

Materials and Methods: Between October 1, 2021, and September 30, 2022, information on neonates (0-28 days) referred to the pediatric emergency departments of these two hospitals from hospitals in and around Bilecik and in-hospital departments was obtained from the hospital's patient registration system after obtaining the necessary permissions. Brief demographic information (age, gender distribution, and nationality), complaints on arrival, laboratory tests performed on arrival, distribution of consultations requested for the patients, preliminary diagnoses, and fate of the patients were analyzed. Statistical analyses were performed using SPSS 22.0 software for Windows.

Results and Conclusion: According to the data obtained from a total of 253 neonatal patients brought to pediatric emergency departments, 129 (51%) were male and 124 (49%) were female, and the most common age group was 0 days old (61.3%).Besides, 81% (205 patients) were newly registered patients from the Emergency Department, the number of newborns received treatment in the

emergency department was 104 (41.1%). The most frequently requested laboratory tests for newborns were direct Coombs test 19.4% (49 patients).When the diagnoses of the neonatal patients in the Emergency Department were analyzed, 88 (34.8%) had general medical examination (ICD-10:Z00.0), 82 (32.4%) had preventive screening examination (ICD-10:Z00.1), and 30 (11.9%) had undiagnosed jaundice (ICD-10:R17). It was determined that 102 neonatal patients (40.3%) evaluated in the Emergency Department were discharged, and only 2 (0.8%) of them had readmissions. In conclusion, it is noteworthy that the majority of neonatal patients admitted to the Pediatric Emergency Departments of Bilecik Training Hospital and Research and Bozuyuk State Hospital were newly admitted to the Neonatal Intensive Care Unit from the Delivery Room mainly for general examination and screening purposes, and most of them were hospitalized. Specific prediagnoses may include jaundice, ear and hearing examination, and upper respiratory tract infections.These data provide important information for the identification and management of various health conditions to which neonatal patients in Bilecik Province are exposed.

Keywords: Neonatal, patients, pediatric emergency medicine

Ref No: 3936

Ketamine as a Novel Therapeutic Approach for Chronic Stress and Sleep Disorders: Advances in Neuroplasticity and Sleep Regulation

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Introduction and Purpose: Chronic stress and sleep disturbances are significant contributors to neuropsychiatric disorders such as major depressive disorder (MDD) and post-traumatic stress disorder (PTSD). Traditional pharmacological treatments, such as selective serotonin reuptake inhibitors (SSRIs), often take weeks to achieve efficacy and may not fully address the underlying neurobiological mechanisms. Ketamine, an N-methyl-D-aspartate (NMDA) receptor antagonist, has emerged as a promising alternative due to its rapid action and ability to modulate synaptic plasticity. This study reviews the literature on ketamine's role in treating chronic stress and sleep disorders, with a focus on its effects on sleep architecture, neuroplasticity, and inflammatory response

Materials and Methods: A systematic review of recent clinical and preclinical studies was conducted using databases such as PubMed, Web of Science, and Google Scholar. The inclusion criteria consisted of studies investigating ketamine's impact on sleep regulation, stress resilience, and its underlying neurobiological mechanisms. Key parameters analyzed included changes in sleep architecture (slow-wave sleep, REM latency), neuroinflammation markers, and synaptic plasticity in stress-related brain regions.

Results and Conclusion: Findings indicate that ketamine enhances slow-wave sleep (SWS) and reduces sleep fragmentation. Duncan and Zarate (2013) reported that ketamine administration increased SWS and high-amplitude slow waves, which correlated with improved mood. Additionally, Kwaśny et al. (2023) demonstrated that ketamine positively influenced circadian rhythms, mitigating sleep disturbances. In terms of stress resilience, Krzystyniak et al. (2019) found that ketamine increased dendritic spine density in the hippocampus, while Edem et al. (2021) reported reductions in pro-inflammatory cytokines, suggesting anti-inflammatory effects.Ketamine exhibits significant potential as a treatment for chronic stress and sleep disorders by modulating neuroplasticity, inflammation, and sleep architecture. Its rapid antidepressant action makes it a valuable alternative to conventional treatments. Further research is needed to optimize dosing regimens and assess long-term effects. Integrating ketamine into psychiatric and neurological treatment plans could offer a transformative approach to managing stress-related and sleep disorders.

Keywords: sleep disturbances, chronic stress, ketamine

Ref No: 3945

The Relationship Between Wells Score and Troponin Levels in Patients with Pulmonary Embolism

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Introduction and Purpose: The Wells score is a crucial clinical scoring system used to assess the probability of pulmonary embolism (PE). PE leads to obstruction in the pulmonary arteries, resulting in increased right ventricular pressure and dysfunction. This process contributes to the elevation of cardiac biomarkers, particularly troponin. In massive PE, increased right ventricular wall tension may lead to myocardial ischemia, further elevating troponin levels. Although troponin elevation is primarily associated with myocardial infarction, cardiopulmonary conditions such as PE should also be considered. Several studies have demonstrated a relationship between the Wells score and troponin levels. Our study investigates the association between the Wells score and troponin, emphasizing the importance of troponin assessment in risk stratification for pulmonary embolism.

Materials and Methods: This study retrospectively analyzed patients diagnosed with pulmonary embolism (PE) based on clinical, laboratory, and imaging findings. Patients were stratified into three groups according to their Wells score: low (0 points), moderate (1 point), and high (2 points). Serum troponin levels were measured at the time of admission and compared among these groups. Statistical analyses were performed to assess the relationship between Wells score and troponin levels. This retrospective study was conducted between 2021 and 2022. Ethical approval was obtained from the Ethics Committee with decision number 2024/23 on January 17, 2024.

Results and Conclusion: Our findings indicate a statistically significant relationship between Wells score and troponin levels in patients with pulmonary embolism (PE). While there was no significant difference in troponin levels between the low and moderate Wells score groups (p = 0.459), a significant increase was observed between the low and high groups (p = 0.003) and between the moderate and high groups (p = 0.032). These results suggest that troponin levels tend to rise as the Wells score increases, reflecting the potential impact of PE severity on myocardial strain. Elevated troponin in PE should not be solely attributed to acute coronary syndrome but also considered as a marker of right ventricular dysfunction. Incorporating troponin levels into PE risk stratification may enhance clinical decision-making and patient management.

Figure 1. Wells score and troponin

Wells score	**n**	**Mean ±SD**
Low	54	30,47 ± 52,88
Moderate	95	125,42 ± 482,59
High	16	153 ± 209,81
Total	165	97,02 ± 375,03
Intergroup comparison		**P- value**
Low-moderate		,459
Low-high		,003
Moderate-high		,032

Keywords: Pulmonary Embolism, Troponin, Wells score

Ref No: 3979

A critical patient, two critical diagnoses

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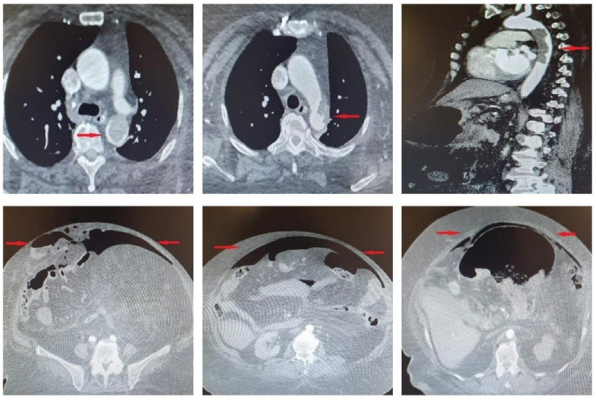
Introduction and Purpose: Thoracic aortic mural thrombus is a rare condition that can lead to systemic arterial thromboembolism, a serious and potentially life-threatening complication that may cause ischemia due to vascular occlusion in various organs and systems. Gastrointestinal system perforation is another life-threatening condition that results from the disruption of the organ wall at any point along the digestive tract.

Materials and Methods: A 71-year-old female patient presented to an external medical center with abdominal pain. During follow-up, her condition deteriorated, necessitating intubation, and she was referred to our facility for further evaluation and treatment. Her medical history included diabetes mellitus, hypertension, umbilical hernia surgery, and anemia. On admission, her vital signs were: BP 100/60 mmHg, HR 97 bpm, SpO 99%, and blood glucose 287 mg/dL. Physical examination revealed melena on rectal examination, with no other remarkable findings. Laboratory tests showed WBC 49.6/mm³, HGB 6 g/dL, blood glucose 261 mg/dL, creatinine 1.89 mg/dL, BUN 34 mg/dL, AST 18 U/L, ALT 7 U/L, potassium 6.5 mmol/L, sodium 131 mmol/L, pH 7.22, PCO 35 mmHg, HCO 14, lactate 9.6, and troponin 17.8 ng/L (<14). Computed tomography angiography (CTA) revealed a mural thrombus causing 80–90% occlusion in the aortic arch and descending thoracic aorta, as well as gastrointestinal perforation (Figure 1). The patient was evaluated by multiple specialties. Cardiovascular surgery recommended close monitoring, while general surgery planned an operation. The patient was admitted to the intensive care unit. Despite surgical intervention, she unfortunately passed away on the third day of hospitalization.

Results and Conclusion: Thoracic aortic thrombus, which can present with systemic involvement, most commonly manifests with extremity symptoms, followed by abdominal pain. Gastrointestinal perforation is a life-threatening condition that can occur anywhere along the digestive tract. While abdominal pain is one of the most frequent complaints in emergency departments, as demonstrated in this case, it can be an indicator of life-threatening conditions with high morbidity and mortality. This case highlights the importance of considering multiple critical diagnoses in critically ill patients presenting with abdominal pain in the emergency department.

Figure 1: CT Images of the Patient



Keywords: Abdominal pain, Gastrointestinal perforation, Thoracic aortic mural thrombus

Ref No: 3998
pubic diastasis
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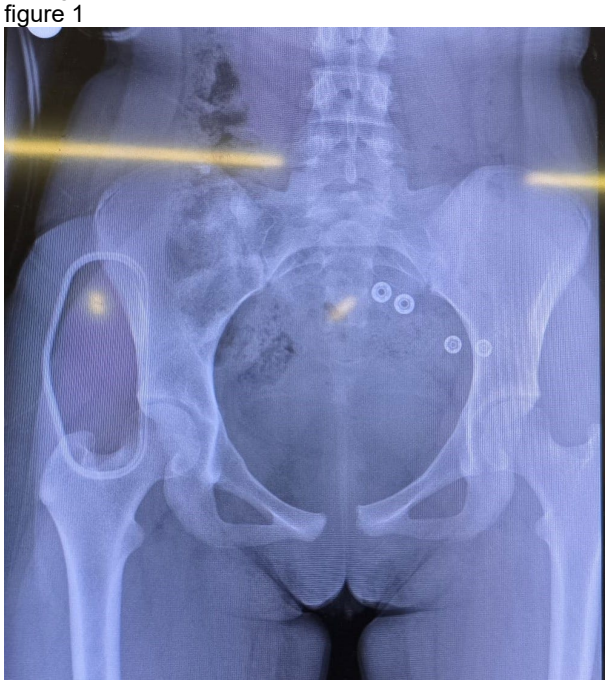
Introduction and Purpose: Spinopelvic injuries are generally associated with high-energy trauma in young adults and primarily develop due to excessive axial loading transmitted from the spine to the sacrum. In addition to fractures and ligament injuries related to the trauma, these injuries are often accompanied by severe organ damage that can be life-threatening due to the high-energy nature of the trauma.
Materials and Methods: A 14-year-old female patient presented with a complaint of falling while skiing. During the fall, she hit her pubic region against a pole and experienced severe pain in the area. The patient was examined, and necessary tests were ordered. Peripheral pulses were intact, and lower extremity movements were normal. A direct radiograph revealed pubic diastasis (Figure 1). The patient was consulted with the orthopedic clinic. During the follow-up examination, a deformity was noticed in the left forearm, and a direct radiograph confirmed a distal radius fracture.
figure 1

Results and Conclusion: Since spinopelvic injuries are often the result of high-energy trauma, a thorough systemic examination must be performed. Associated injuries should not be overlooked. The stabilization of the patient should be ensured, and consultation with the relevant clinical department should be arranged.
Keywords: pubic diastasis, spinopelvic injuries, trauma

Ref No: 4018
A RARE CASE OF PERINEAL LACERATION FOLLOWING BLUNT TRAUMA: DIAGNOSTIC AND THERAPEUTIC APPROACH
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Introduction and Purpose: Perineal lacerations resulting from blunt trauma are rare but potentially severe injuries that require careful evaluation due to their impact on functional structures responsible for defecation, urination, and sexual function. .
Materials and Methods: We present a case of a 24-year-old male who sustained a perineal laceration following a minibus rollover accident. Initial examination revealed abrasions and two small lacerations in the perianal region, with rectal bleeding suggesting possible deeper tissue damage. Further diagnostic procedures, including rectosigmoidoscopy, confirmed the preservation of rectal and anal canal integrity, with no deeper tissue injuries. Conservative management was implemented, and the wound showed signs of healing without complications
Results and Conclusion: This case highlights the importance of thorough assessment, including endoscopic examination, to rule out deeper injuries. Perineal trauma management must prioritize wound care, prevention of infection, and monitoring for associated injuries. This case emphasizes the need for early diagnosis, conservative treatment, and a multidisciplinary approach to ensure optimal outcomes in such rare yet significant injuries.
Keywords: Perineal injury, high-energy trauma, trauma

Ref No: 4034
Acute Carbon Monoxide Poisoning Following Waterpipe Use: A Case Report
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Introduction and Purpose: Carbon monoxide (CO) poisoning is a potentially life-threatening clinical condition that arises from exposure to carbon monoxide, a colorless, odorless, and non-irritating gas. CO binds to hemoglobin with an affinity approximately 250 times greater than that of oxygen, forming carboxyhemoglobin (COHb), and thereby significantly impairs tissue oxygenation. The clinical presentation can vary widely, ranging from mild symptoms such as headache and fatigue to severe neurological and cardiovascular complications including seizures, coma, and death.In recent years, waterpipe smoking has gained popularity among young adults. When performed in poorly ventilated environments, it can result in significant CO exposure. Compared to cigarette smoking, waterpipe use has been shown to produce much higher levels of COHb. This report presents a case of a young adult who developed acute CO poisoning after prolonged waterpipe use and required hyperbaric oxygen therapy.

Materials and Methods: A 25-year-old male presented to the ED with dizziness, chest pain, and syncope after prolonged exposure in a waterpipe café. He was alert with stable vitals and a GCS of 15. ECG and cardiac biomarkers were normal. COHb level was 30%. High-flow oxygen was administered, leading to symptom improvement. Due to the elevated COHb and syncope, he was referred for hyperbaric oxygen therapy.

Results and Conclusion: In Turkey, faulty heating systems and gas leaks are common causes of CO poisoning, but waterpipe smoking in enclosed spaces is an emerging risk. Waterpipe smoke contains CO from both tobacco and charcoal, leading to elevated COHb levels. Symptoms are often non-specific, including dizziness, headache, and nausea, with severe cases presenting with syncope or arrhythmias. Diagnosis relies on clinical history and COHb levels. Treatment includes oxygen therapy, and hyperbaric oxygen therapy is indicated in severe cases, especially with syncope, altered mental status, or COHb >25%.

Keywords: CO toxicity, Waterpipe, Emergency

Ref No: 4067

Acute respiratory distress syndrome due to diabetic ketoacidosis: a case report

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Introduction and Purpose: Acute Respiratory Distress Syndrome (ARDS) due to Diabetic Ketoacidosis (DKA) is a rare but fatal complication

Materials and Methods: A 65-year-old male patient was admitted to the intensive care unit (ICU) with a diagnosis of DKA. The patient, who developed sudden respiratory distress on the fourth day while being followed up in the ICU, had arterial O2 pressure/inspiratory O2 fraction (PaO2/FiO2): 200, bilateral widespread infiltration on chest X-ray and thoracic tomography, and normal echocardiography, was diagnosed with ARDS (Figure1,2). Non-invasive mechanical ventilation was applied before and invasive afterwards. Despite supportive treatment, the patient died on the ninth day due to sudden cardiac arrest.

Figure 1

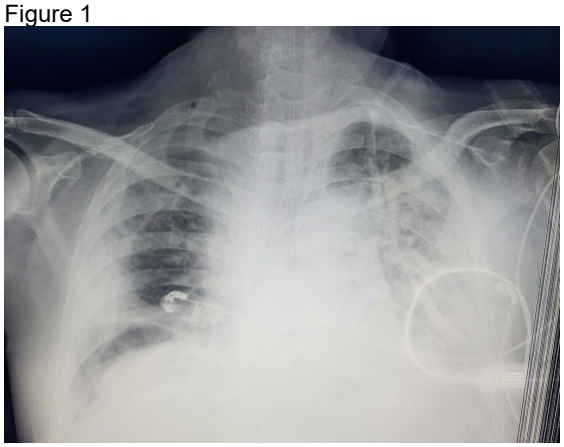

Figure 2

Results and Conclusion: In this case report, the importance of early recognition and appropriate treatment of ARDS that may develop due to DKA is emphasized.
Keywords: Diabetic ketoacidosis, acute respiratory distress syndrome, emergency department

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Ref No: 4082
The Level of Professional Anxiety in Students Studying in the First and Emergency Aid Programs
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[3]Erciyes University, Public Health, Vocational Health College, Kayseri, Turkey
Introduction and Purpose: This study aims to determine the level of professional anxiety and the factors affecting it in students studying in the first and emergency aid programs.
Materials and Methods: This study was conducted with students enrolled in the first and emergency aid programs at vocational schools during the spring semester of the 2024–2025 academic year. This study aimed to reach the entire population without a predefined sample size. A total of 200 students' data were evaluated in the study. The questionnaire consisted of two parts: the first part included socio-demographic and educational questions, while the second part included a scale developed by Çelebi et al., which measures the professional anxiety of health services vocational school students. The scale consists of 30 questions and 4 subdimensions. The scale is a three-point Likert-type scale, where each question is evaluated as: “(1 point) I am not worried,” “(2 points) I am undecided,” and “(3 points) I am worried.” The total score of the scale ranges from 30 to 90, with higher scores indicating higher anxiety levels.
Results and Conclusion: Among the study participants, 74.5% were female, 51.5% were graduates of Anatolian High Schools, and 61.0% lived with their families. 53.5% of the participants stated that their economic situation was average. 50.5% of the participants were in their first year, and 51.0% had a GPA of 3.01 or higher. 85.5% of the participants expressed that they chose the first and emergency aid program voluntarily, 18.5% stated that they would change the program if given the opportunity, and 57.0% stated they would like to go abroad after graduation if given the chance. The average score for professional knowledge was 24.8±6.9, for work life was 12.8±4.6, for occupational health was 6.8±2.7, for communication was 13.6±4.2, and the average professional anxiety level was 58.0±15.3. The question that caused the most anxiety was “Being perceived as lacking professional knowledge and skills by patients/patient relatives” (50.5%), while the question with the least anxiety was “Being unemployed” (13.0%). The students in the study group have a high level of professional anxiety. To reduce their anxiety levels, activities such as training, seminars, and conferences can be organized.
Keywords: anxiety, first aid, emergency department

Ref No: 4083
Optic nerve sheath diameter (ONSD) in the treatment of hyponatremia
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Introduction and Purpose: Hyponatremia is one of the most common electrolyte disorders, characterized by a serum sodium (Na) level falling below 135 mmol/L. Clinical symptoms can range from mild dizziness to life-threatening cerebral edema. In hyponatremia, the swelling of brain cells due to water uptake can lead to an increase in intracranial pressure (ICP). The measurement of optic nerve sheath diameter (ONSD) offers a non-invasive, reliable, and increasingly utilized alternative for ICP assessment.This study aimed to evaluate changes in ONSD following hypertonic saline treatment in patients presenting to the emergency department with hyponatremia and to investigate whether ONSD measurement could serve as a monitoring tool in the management and treatment of hyponatremia.
Materials and Methods: This prospective observational study included 40 patients diagnosed with hyponatremia (Na < 135 mmol/L) upon presentation to the emergency department. Written informed consent was obtained from all patients, and ethical approval was granted. Baseline and post-treatment venous blood gas sodium levels were recorded, and ONSD measurements were performed using transorbital ultrasonography. ONSD measurements were conducted by an emergency medicine specialist experienced in ultrasonography. Statistical analysis was performed using SPSS 29.0 software, with a significance level set at $p < 0.05$.
Results and Conclusion: At the time of hospital admission, the mean sodium level of patients was 115.7 mEq/L, which increased to

135.9 mEq/L following treatment. The mean pre-treatment ONSD was 5.46 mm, while the post-treatment value was measured at 5.12 mm.•Relationship between Hyponatremia and ONSD: A negative correlation was found between sodium levels and ONSD (r = -0.32, p = 0.043).•Sodium Increase and ONSD Change: A moderate negative correlation was observed between the increase in sodium levels and the decrease in ONSD (r = -0.54, p = 0.0003).•ROC Analysis: The optimal threshold for predicting ONSD reduction based on sodium increase was determined as a 14 mmol/L sodium increase; however, its predictive power was low (AUC = 0.56).Conclusion:A significant reduction in ONSD was observed following the treatment of hyponatremia. However, ONSD measurements alone may not be sufficient for the monitoring and management of hyponatremia, highlighting the necessity of integrating other clinical assessment methods.

Keywords: Hyponatremia, Optic Nerve Sheath Diameter (ONSD), Intracranial Pressure

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Ref No: 4103

Paraneoplastic Polyneuropathy Associated with Lung Cancer: A Case Report

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Introduction and Purpose: Paraneoplastic neurological syndromes (PNS) are rare but clinically significant complications of malignancy, often mediated by autoimmune mechanisms rather than direct tumor effects or metastases. Among these, paraneoplastic polyneuropathy (PNP) is a frequently overlooked condition that may significantly impact functional status and quality of life. Small cell lung cancer (SCLC) is the malignancy most commonly associated with PNP. The pathogenesis often involves anti-neuronal antibodies such as anti-Hu (ANNA-1), which may result in widespread sensorimotor and autonomic dysfunction. Early recognition is essential, as PNP may precede the diagnosis of malignancy and guide oncological evaluation.

Materials and Methods: A 74-year-old male with a known diagnosis of lung cancer presented to the emergency department with a 10-day history of bilateral weakness in the upper and lower limbs. His medical history included prior treatment with intravenous immunoglobulin (IVIG) for paraneoplastic polyneuropathy in February 2024. On examination, he was alert, oriented, and hemodynamically stable. Neurological examination revealed bilateral upper limb proximal muscle strength of 4/5, with distal strength of 4/5 in the elbows and hands. Lower limb strength was 3/5 proximally and 1/5 dorsally. Paresthesia was noted in the hands, and deep tendon reflexes were globally absent. Laboratory tests and neuroimaging were unremarkable. The patient was admitted to the neurology department following consultations with neurology and pulmonary medicine.

Results and Conclusion: This case underscores the importance of recognizing PNP as a recurrent manifestation of paraneoplastic processes, particularly in patients with established malignancy. The absence of acute systemic or imaging findings supports a neurologically driven pathophysiology. Management involves a multidisciplinary approach, targeting the underlying cancer, immune modulation (e.g., IVIG), and supportive care. In this patient, the recurrence of neurological symptoms suggests reactivation or progression of the paraneoplastic process, warranting reconsideration of immunotherapy.Paraneoplastic polyneuropathy is a rare but critical entity in the differential diagnosis of progressive sensorimotor symptoms, particularly in cancer patients. Timely recognition and coordinated care are essential to improve functional outcomes and quality of life.

Keywords: Paraneoplastic Neurological Syndromes, Lung Cancer, Intravenous Immunoglobulin

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Ref No: 4120

Mortality due to pneumonia: A retrospective chart review of patients diagnosed with pneumonia

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Introduction and Purpose: Pneumonia is a leading cause of morbidity and death in children and adults worldwide, and represents a large proportion of health-related costs for all healthcare systems. The development of severity scoring systems is a cornerstone of the pneumonia literature, as they have been developed for pneumonia since the 1990s. In this study, we describe the current understanding and potential clinical applicability of severity scoring systems in pneumonia.

Materials and Methods: A retrospective chart review of all patients diagnosed with pneumonia between January 1, 2024 and December 31, 2024 was performed. Patient demographics, qSOFA score, pneumonia severity index (PSI) score, CURB-65 score, length of hospital stay, intensive care unit (ICU) admission, and mortality were recorded.

Results and Conclusion: A total of 248 patients with a mean age of 70.42 ± 16.30 years were included in the study. One hundred and thirty-seven (55.2%) patients were male and 111 (44.8%) were female. Comparison of qSOFA, CURB-65 and PSI scores between patients who died and those who survived showed statistically significant differences. Logistic regression analysis was performed. All of these scores were successful in predicting mortality. All data are shown in Table 1 and Table 2.The results of this study showed that qSOFA, CURB-65 and PSI were independent predictors of mortality. It is important to predict mortality in patients with pneumonia to avoid complications and possible death.

Table 1

Table 1. The comparion of qSOFA, CURB-65 and PSI between patients who died and survived.			
	Survival (n=201)	Dead (n=47)	*p* value
qSOFA, high risk	40 (19.9)	42 (89.4)	<0.000
CURB-65, high risk	44 (21.9)	42 (89.4)	<0.000
PSI, high risk	67 (33.3)	45 (95.7)	<0.000

Table 2

Table 2. The logistic regression analysis resuls			
	Wald	%95 Confidence interval	P value
qSOFA, high risk	18.32	3.61 – 31.69	<0.000
CURB-65, high risk	7.09	1.51 – 15.25	0.008
PSI, high risk	8.46	2.14 – 50.56	0.004

Keywords: pneumonia, QSOFA

Ref No: 4126

POST-PSYCHOSIC SCROTAL STRANGULATION

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[1]Karamanoglu Mehmetbey University

Introduction and Purpose: Penile strangulation by a foreign body is a rare condition. It requires immediate intervention and treatment as it can lead to vascular injury or even necrosis . This is a surgical emergency and delayed intervention can lead to penile necrosis, gangrene and amputation, therefore time plays a critical role in the management of these patients.Given the rarity of these presentations, there is no standard protocol for the management of these patients and in most cases clinicians have to think outside the box when dealing with these cases.

Materials and Methods: A 40-year-old male prisoner was brought in with complaints of back pain. The patient was unresponsive to verbal communication. He was conscious, oriented and cooperative. Glasgow coma scale 15 points. The abdomen was relaxed, there was no defensive rebound. There was no palpable mass in the inguinal region. There was no neuromotor deficit. Distal pulses were bilaterally equal and open. During inspection, a rope was seen wrapped around the scrotum and proximal penis. The scrotum and penis were edematous and cyanotic. Doppler USG was performed on the patient. Both testicles and epididymis are in normal position, size and morphology. Their vascularization is normal in the CDUS examination. No pathological amounts of free fluid was detected between the tunica vaginalis leaves. The patient was consulted to a urologist. The urologist did not consider urgent surgical pathology. The patient was consulted to a psychiatrist. He was kept under observation against the risk of suicide because he was unable to verbally communicate during his psychiatric examination. 1 hour after the rope was removed, the penis and scrotum returned to their normal color and size. After being kept under observation for 1 day, he was admitted to the psychiatric ward.

Results and Conclusion: Penile strangulation with a constriction device is a urologic emergency with potentially serious clinical consequences. Clinicians should use the least traumatic technique to remove a constriction device from the genital area as soon as possible after incarceration.

Keywords: urologic emergency, Penile strangulation, Penile necrosis

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Ref No: 4222

A Rare Occurrence in Bicycle Handlebar trauma; Evisceration : A Case report

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[1]Usak University Training and Research Hospital

Introduction and Purpose: Trauma patients constitute 1 in 3 pediatric patients presenting to the emergency department. Blunt abdominal trauma, in particular, accounts for 90% of childhood trauma. Bicycle injuries commonly result in blunt abdominal trauma in children. Bicycle accidents generally result in simple, nonfatal collisions, while fatal and permanent bicycle injuries are particularly seen in head trauma, bone and muscle injuries, and internal organ damage. Since most bicycle handlebar injuries are to the anterior abdominal wall, injuries to internal organs (liver, spleen, pancreas, etc.), abdominal wall herniation due to trauma, and evisceration are common. In this case, we will describe the intestinal evisceration of a 12-year-old boy due to bicycle handlebar trauma. In these cases, early intervention provides very good clinical results without complications after abdominal exploration and surgical repair.

Materials and Methods: Case report and literature review of bicycle traumas in childhood

Picture 1

Picture 1: Intestinal evisceration due to bicycle handlebar trauma

Results and Conclusion: A 12-year-old boy presented to the emergency department after a bicycle accident involving a 112 call. The patient's general condition was moderate; he was conscious, and his other vital signs were normal except for tachycardia. He underwent

emergency surgery. The patient was admitted through a median incision below the umbilicus. All intestinal segments were examined, and it was noted that there was a perforated area measuring approximately 4 cm in the ileum and serosal defects in some locations. The patient's bladder, spleen, and liver were clear. A resection anastomosis was performed on the patient's perforated intestinal segment. The serosal defects were repaired. After controlling the bleeding, the layers were closed according to the anatomy. A catheter and nasogastric tube were inserted into the patient. The procedure concluded with wound dressing. The recommendations were implemented. On the fourth postoperative day, oral feeding was initiated, the nasogastric tube was removed, and total parenteral nutrition treatment was discontinued. During follow-up, the wound site was observed to be clean. The patient was discharged with recommendations.Abdominal hernias, pancreatitis, lacerations of other organs, and intestinal evisceration due to bicycle handlebar trauma have been reported in the literature. However, due to the area of intestinal evisceration (near the pelvic region) and additional intestinal perforation, a case report was submitted.

Keywords: Evisceration, Trauma, Handlebar

Ref No: 4262

Acute Heart Failure and Serotonin Syndrome Induced by Venlafaxine Overdose: A Lethal Case Report

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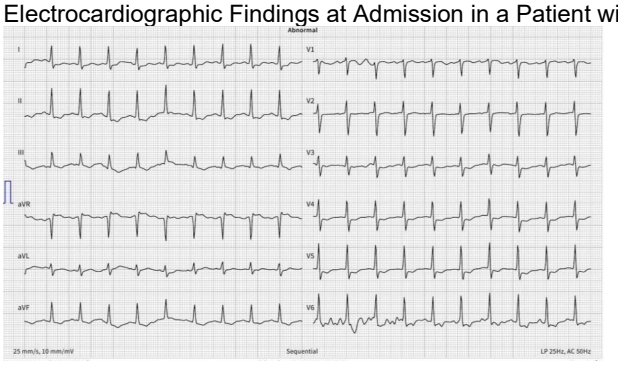
[2]Turhal State Hospital
[3]Ondokuz Mayis University

Introduction and Purpose: Venlafaxine is a serotonin-norepinephrine reuptake inhibitor (SNRI) widely used in the treatment of major depressive disorder and treatment-resistant depression. Although it is generally considered safe at therapeutic doses, overdoses have been associated with an increased risk of severe toxicity, including serotonin syndrome and cardiotoxicity.

Materials and Methods: We report the case of a 42-year-old female with major depression who presented to the emergency department six hours after ingesting 6.3 g of extended-release venlafaxine with suicidal intent. Upon admission, she exhibited confusion (GCS: 12), mydriasis, sinus tachycardia (145 bpm), and hypertension (180/100 mmHg). Serotonin syndrome was clinically diagnosed, and supportive treatment was initiated. The patient experienced recurrent generalized tonic-clonic seizures requiring benzodiazepine treatment and developed worsening hemodynamic instability despite intensive care. Initial cardiac evaluation revealed normal left ventricular function (EF: 65%); however, by the 40th hour of admission, the patient developed acute heart failure with reduced ejection fraction (EF: 35%), global hypokinesia, and pulmonary edema. Laboratory findings at that time showed elevated creatinine (1.67 mg/dL), high-sensitivity troponin (258.0 ng/dL), and markedly increased creatine phosphokinase (CPK). The patient's clinical status progressively deteriorated, leading to refractory hypotension, anuria, and multi-organ failure. Despite intensive supportive care, she succumbed on the 90th hour of hospitalization.

Results and Conclusion: Venlafaxine toxicity is associated with serotonin syndrome, neurological complications, and cardiovascular effects, but the development of delayed-onset acute heart failure remains a rare and underrecognized consequence. The underlying mechanism is hypothesized to involve catecholamine-induced myocardial injury due to norepinephrine reuptake inhibition. This case highlights the importance of vigilant cardiac monitoring in cases of venlafaxine overdose, even in the absence of initial cardiac dysfunction. Early recognition and aggressive supportive therapy remain crucial in managing such cases. This case underscores the potential for severe cardiotoxicity following venlafaxine overdose, emphasizing the need for heightened clinical awareness and multidisciplinary management. Emergency physicians should be alert to the possibility of delayed cardiac complications in patients with venlafaxine toxicity

Electrocardiographic Findings at Admission in a Patient with Venlafaxine Overdose



The patient's ECG was consistent with sinus tachycardia of 125 bpm

Keywords: Venlafaxine Hydrochloride, Serotonin Syndrome, Cardiotoxicity

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Ref No: 4283

Copper sulfate (Bordeaux mixture) exposure and myocardial infarction

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Introduction and Purpose: This report presents a case of a 62-year-old male patient with no known comorbidities who suffered a myocardial infarction following exposure to a pesticide containing copper sulfate, commonly known as "Bordeaux mixture." The toxic effects of copper sulfate, associated cardiovascular risks, and clinical management after exposure are evaluated.

Materials and Methods: A 62-year-old male patient presented to an external emergency department with chest pain radiating to the

back, accompanied by sweating. Due to suspected pesticide exposure, the patient was referred for further evaluation and toxicology-intensive care. Upon arrival, he continued to experience severe chest pain and sweating. His vital signs were stable, and his ECG showed a normal sinus rhythm. However, follow-up tests revealed elevated troponin levels, prompting a cardiology consultation. An echocardiogram was performed, and coronary angiography was planned. Following monitoring in the cardiology department, the patient was discharged.

Results and Conclusion: This case highlights the severe cardiovascular consequences of pesticide exposure, emphasizing the need for safety precautions among agricultural workers, regular health screenings, and education on the toxic effects of these chemicals. Increased awareness of the potential health risks associated with substances like copper sulfate is essential.

Keywords: Copper sulfate, Bordeaux mixture, Pesticide exposure

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Ref No: 4285

Tuberculosus Meningitis: A Rare Case Report

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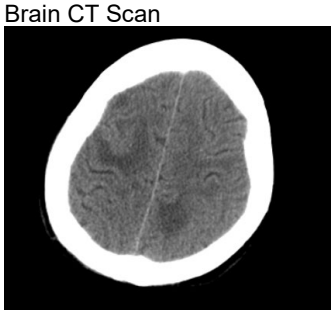
[1]Tekirdağ Namık Kemal University Health Application and Research Hospital

Introduction and Purpose: Tuberculous meningitis (TBM) is a rare yet severe manifestation of tuberculosis that affects the central nervous system and is often associated with high morbidity and mortality due to delayed diagnosis. Its clinical presentation is typically insidious, with nonspecific symptoms that make early recognition difficult, particularly in emergency settings. Without timely treatment, it may lead to significant neurological sequelae. In this case report, we aim to highlight the diagnostic challenges and clinical course of a patient who presented to the emergency department with nonspecific symptoms and was subsequently diagnosed with tuberculous meningitis. Our goal is to emphasize the importance of early suspicion, multidisciplinary evaluation, and appropriate use of imaging and cerebrospinal fluid analysis in improving patient outcomes.

Brain CT Scan

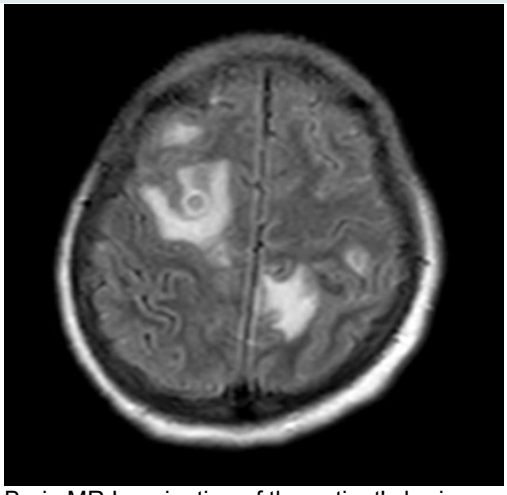


CT scan of the patient's brain.

Thorax CT Scan

CT scan of the patient's lung

Brain MR Imagination, Flair Sequence



Brain MR Imagination of the patient's brain.

Materials and Methods: This case report was prepared based on a retrospective review of the patient's clinical data, including history, physical examination findings, laboratory and radiological results, and cerebrospinal fluid (CSF) analysis. Brain imaging techniques such as computed tomography (CT) and contrast-enhanced magnetic resonance imaging (MRI) were utilized to evaluate central nervous system involvement. Lumbar puncture was performed to obtain CSF samples for biochemical, cytological, microbiological, and molecular analyses, including Ziehl-Neelsen staining and polymerase chain reaction (PCR) testing for Mycobacterium tuberculosis. The patient's clinical course, treatment response, and follow-up were documented through hospital records. A multidisciplinary approach involving emergency medicine, neurology, pulmonology, and infectious disease specialists guided the diagnostic and therapeutic process.

Results and Conclusion: The patient was diagnosed with tuberculous meningitis based on clinical presentation, imaging findings, and cerebrospinal fluid analysis, which revealed lymphocytic pleocytosis, elevated protein levels, and reduced glucose concentration. Acid-fast bacilli were detected with Ziehl-Neelsen staining, and TB PCR returned positive, confirming the diagnosis. Brain MRI showed multiple nodular lesions with ring enhancement and vasogenic edema, while chest imaging supported the presence of miliary tuberculosis. Following the initiation of anti-tuberculosis therapy and corticosteroids, the patient was monitored closely for neurological complications and hepatic side effects. This case underscores the critical importance of early recognition and multidisciplinary management in TBM, particularly in patients presenting with atypical symptoms. Prompt diagnosis and appropriate treatment significantly improve outcomes and help prevent severe neurological sequelae.

Keywords: Tuberculous meningitis, Cerebrospinal fluid analysis, Emergency diagnosis

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Ref No: 4289

Diffuse Axonal Injury in the Corpus Callasum That Should Not Be Forgotten in Severe Post-Traumatic Headache; Case Report

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Introduction and Purpose: Diffuse axonal injury (DAI) is a type of traumatic brain injury(TBI) that occurs as a result of blunt trauma to the brain. In the United States, traumatic brain injury is the leading cause of death and disability among children and young adults.Diffuse axonal injury (DAI) primarily affects the white matter tracts in the brain.This can range from clinically insignificant to comatose. Patients are classified according to the Glasgow coma scale from mild to severe.DAI should be kept in mind, especially if patients classified as mild as GKS 12-15 don't have neurological deficits. In this case, we planned to present the development of DAI in the corpus callasum of a young patient who presented to the emergency department due to recurrent headache after blunt trauma.

Materials and Methods: Case Report: 22-year-old female patient 5 days ago Falling from own level Blunt Trauma After Emergency Application Present. Initial Admission Examination Neck Stiffness Negative. Kernic Negative. Neurological examination natural.TA:110/60 GCS:15 IR +/+,5 After applying to the emergency room with headache intermittently throughout the day and no bleeding or subacute ischemia image in repeated CT scans, the patient was examined on the 5th day after the examination.DIFF.MR imaging suggested acute ischemia image/diffuse axonal damage at the level of corpus callosum splenium. The patient's 5-day examination General Condition Good, Conscious, Oriented-Cooperative, Pupils Isochoric, Ir +/+. No pathology was observed in Cranial Nerve examination. four extremities were mobile, muscle strength was full. Vitals were stable. Neurology and brain surgery were consulted.Since 5 days had passed and the patient was stable, he was discharged as an outpatient clinic control.

Results and Conclusion: In the case we presented,although the persistent headache,especially despite the low-energy trauma, initially alerted emergency medicine clinicians in terms of bleeding,it is useful to examine patients in whom no bleeding was detected in examination and computed tomography in terms of DAI in further examination.We think that it will be important in terms of contributing to the literature, as it is a case that was rarely detected before and was diagnosed more often in postmortem cases,and that our case had high GCS,did not cause any neurological deficits and presented with only headache.

Keywords: Diffuse Axonal Injury, Corpus Callasum, Trauma

Ref No: 4322

A Survey Study on Emergency Department Density: The Case of Istanbul Prof. Dr. Cemil Taşcıoğlu City Hospital

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[1]**Prof. Dr.Cemil Tascioglu City Hospital**

Introduction and Purpose: Emergency services are critical units that provide uninterrupted medical services 365 days a year. In big city hospitals such as Istanbul Prof. Dr. Cemil Taşcıoğlu City Hospital, patient density reduces the quality of service and increases employee-patient conflicts. This study aims to analyze the patient-related causes of emergency department density and to develop solutions suitable for the dynamics of Istanbul.

Materials and Methods: The study was conducted on 516 patients admitted to the emergency department between January 2024 and January 2025. To the participants; A 25-question questionnaire was applied to evaluate triage awareness, family physician preferences, frequency of emergency department admissions and satisfaction levels. The data were analyzed with the SPSS 25 program and presented with frequency and percentage distributions.

Table 1: Triage Information and Response Distribution

Triyaj Tanımı	Hasta Sayısı (n)	Yüzde (%)
Bilmiyorum	402	78
Öncelikli Muayene	52	10
Doğru Tanım	62	12
Toplam	516	100

Correct Definition: "Classification of patients according to priority level in emergency situations". 78% of the patients are unaware of the concept of triage. This situation increases the unnecessary use of emergency services.

Results and Conclusion: While 78% of the participants stated that they did not know the concept of triage, only 62 patients (12%) were able to define it correctly. Although 76% of the patients knew their family doctor, they applied to the emergency department an average of 4 times in the last year. Among the reasons for preference, "quick inspection" with 55% and "easy access" with 30% came to the fore.In order to reduce the density of the emergency department, it is recommended to support patient education programs, the triage system with visual materials and to activate family medicine 24/7.

Table 2: Reasons for Choosing Emergency Services

Reason for Preference	Number of Patients (n)	Percent (%)
Quick Inspection	284	55
Easy Access	155	30
Free Service	41	8
Inability to Reach a Family Doctor	36	7
Total	516	100

Explanation: More than half (55%) of patients prefer the emergency department due to long waiting times in outpatient clinics.

Table 3: Patient Satisfaction

Satisfaction Level	Number of Patients (n)	Percent (%)
Very satisfied	259	50
Satisfied	200	39

Intermediate	45	9
Dissatisfied	12	2
Total	516	100

Explanation: More than half (55%) of patients prefer the emergency department due to long waiting times in outpatient clinics.
Keywords: Emergency department, intensity, triage

Ref No: 4348
The Importance of Long-Term Follow-Up in Traumatic Patients
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Introduction and Purpose: Gray platelet syndrome (GPS) is an inherited bleeding disorder characterized by macrothrombocytopenia and absence of platelet α-granules and platelets have a gray appearance on peripheral smear with Romanovsky stain due to the absence of alpha-granules(1). It is thought to have autosomal recessive inheritance(2). It was first described in 1971(3). Alpha granules, which are the most abundant vesicles in platelets, store proteins that support platelet adhesiveness and wound healing when secreted during platelet activation(4,5). With this case report, we aimed to remind that patients with thrombocytopenia such as GPS should be followed up for a longer period of time than other patients when they present to the emergency department due to trauma.
Materials and Methods: A 15-year-old male patient presented to the emergency department with nausea and headache. In the anamnesis, it was learned that he presented with the complaint of hitting his head after a fall about 24 hours ago. Brain CT was performed at the first presentation, no acute pathology was detected, general condition was good and the patient was followed up for 12 hours for head trauma and discharged. The patient had a history of Gray Platelet Syndrome and no other comorbidities. The patient had no history of any surgical procedure and was routinely using tranexamic acid. Apart from old traumatic findings, there were no acute pathologic findings on systemic physical examination. GCS:15, temperature:36.4 °C, pulse rate:95 beats/min, TA:114/74 mmHg, SpO2: 98%. WBC: 7900/μL, Hgb: 13.6 g/dl, Plt: 29000/μL. There were no pathologic findings in other laboratory parameters. Although there was no pathology in the systemic examination of the patient who had a recent history of trauma and whose follow-up process was completed, a control brain CT was performed at the new admission and hyperdense hemorrhagic foci with a diameter of 13 mm were observed in the anterosuperior part of the left temporal lobe adjacent to the sylvian fissure. The patient was transferred to the neurosurgery department for follow-up.
Figure 1

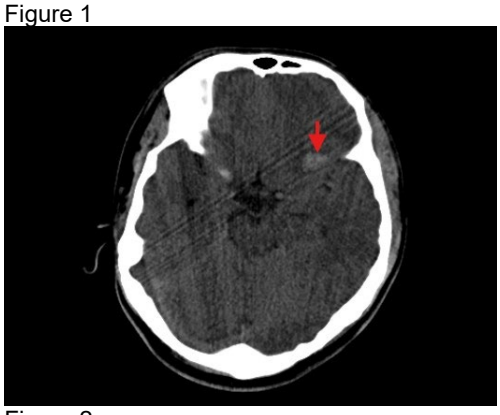
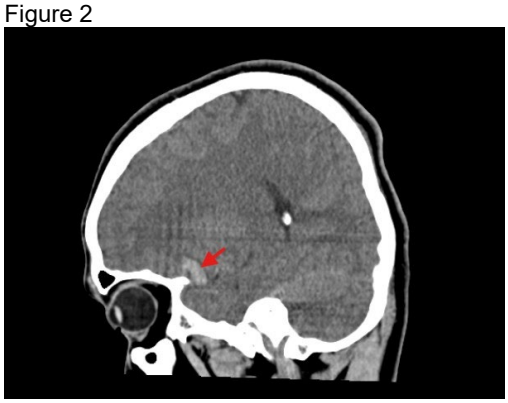


Figure 2



Results and Conclusion: In conclusion, patients with thrombocytopenia such as GPS should be followed up for a longer period of time than other patients when they present to the emergency department due to trauma.

Keywords: Gray platelet syndrome, thrombocytopenia, head trauma

Ref No: 4371

AN URGENT CAUSE OF CHEST PAIN: ACUTE AORTIC DISSECTION

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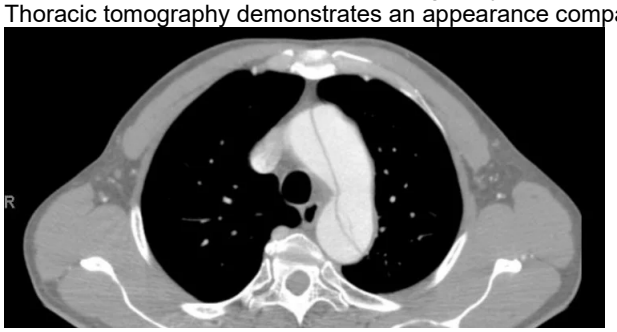
Introduction and Purpose: 20-year-old male patient with a known diagnosis of Marfan syndrome presented to us with severe, tearing chest pain and accompanying severe neck pain that had started half an hour ago. The patient's general condition was moderate, with a saturation of 94%, a pulse of 91, a right arm arterial blood pressure of 113/72 mmHg, a left arm arterial blood pressure of 121/77 mmHg, and a temperature of The patient's temperature was 36.4°C. On physical examination, lung sounds were normal with bilateral auscultation. Four extremity pulses were equal and open. Contrast-enhanced upper/lower abdominal tomography was performed in the patient who stated that her pain was getting more severe although her examinations were normal. Dissection in the arcus aorta was detected in the tomography (Figure 1). The patient was referred to the cardiovascular surgery department and was hospitalised by the relevant department and operated rapidly.

Materials and Methods: Thoracic tomography

Thoracic tomography demonstrates an appearance compatible with dissection in the arcus aorta.



Results and Conclusion: In patients presenting with sudden onset of chest pain and neck pain, particularly those with systemic diseases, consideration should be given to the possibility of performing a dissection.

Keywords: DISSECTION

Ref No: 4429

Protein-losing enteropathy

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Introduction and Purpose: Protein-losing enteropathy is a rare condition that is difficult to diagnose, presenting with symptoms such as unexplained abdominal pain, diarrhea, and swelling in the legs.

Materials and Methods: A 22-year-old male patient presented to our emergency department with intermittent abdominal pain, diarrhea, and swelling in the legs, which had been occurring since he returned from military service two months ago. The patient had no known history of chronic illness or medication use. On physical examination, there was tenderness in the abdomen, and the pretibial edema was rated ++ / ++. His vital signs were stable, and laboratory results showed albumin: 0.8 and calcium: 6.6 (corrected calcium: 9.16), with no other abnormalities. Given the patient's young age and the presence of pretibial edema, further investigations and imaging were performed in our emergency department. A contrast-enhanced abdominal CT scan showed no acute pathology. The patient was referred to the Internal Medicine Gastroenterology Clinic for consultation and was admitted for further investigation.

Results and Conclusion: Protein-losing enteropathy should be considered in patients presenting with diarrhea, abdominal pain, and leg swelling.

Keywords: Enteropathy, Diarrhea, Edema

Ref No: 4436

The Silent Attack: Acute Hepatitis Triggered by Epstein-Barr Virus – A Rare Case Report

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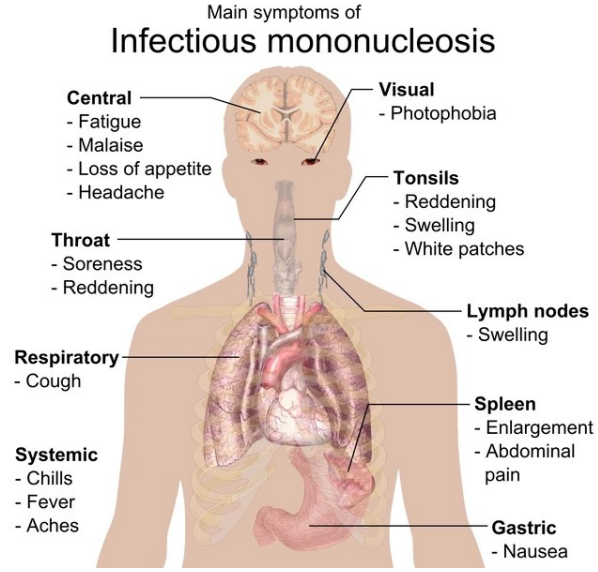
Introduction and Purpose: Epstein-Barr Virus (EBV) is a ubiquitous herpesvirus, primarily known for causing infectious mononucleosis, particularly in adolescents and young adults. While the classic triad of fever, pharyngitis, and lymphadenopathy is well-documented, EBV can rarely present with atypical and potentially serious complications such as acute hepatitis.In this case, we report a 20-year-old male with no significant travel or alcohol history, presenting with progressive abdominal pain, elevated inflammatory markers, and hepatomegaly. Imaging revealed periportal edema, gallbladder wall thickening, ascites, and pleural effusions, prompting evaluation for acute hepatitis of viral etiology.The purpose of this case is to highlight the diagnostic challenges and clinical course of EBV-induced acute hepatitis, emphasizing the importance of considering EBV in patients with systemic symptoms and abnormal liver imaging, even in the absence of classic mononucleosis features.

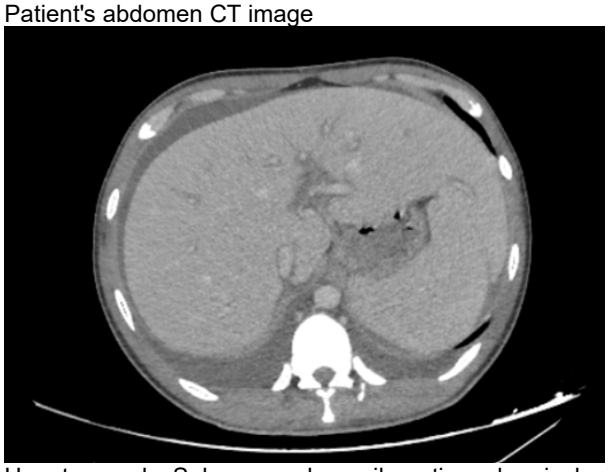
Symptoms of infectious mononucleosis



symptoms of infectious mononucleosis

Materials and Methods: This case report is based on the clinical evaluation, laboratory investigations, and imaging studies of a 20-year-old male patient admitted to the emergency department with complaints of progressive abdominal pain, dysuria, and a history of recent antibiotic use.The diagnostic process included:Comprehensive physical examinationLaboratory tests: complete blood count, liver and renal function tests, inflammatory markers (CRP, procalcitonin), coagulation profile, urinalysis, and serologic screening (including ELISA for EBV and other viral markers)Radiologic imaging: abdominal ultrasound and contrast-enhanced computed tomography (CT)Clinical follow-up to assess symptom progression, treatment response, and ruling out alternative diagnosesAll findings were evaluated in accordance with the patient's medical history, medication use, and risk factors. The final diagnosis of EBV-related acute hepatitis was made by exclusion and supported by clinical presentation, laboratory abnormalities, and radiological features.

Patient's abdomen CT image



Hepatomegaly, Splenomegaly; perihepatic and perisplenic fluid

Results and Conclusion: The patient was diagnosed with EBV-associated acute hepatitis based on clinical findings and exclusion of other causes. Despite the absence of classic mononucleosis symptoms, he developed renal dysfunction and bilateral pleural effusions, requiring ICU admission.Supportive treatment led to gradual improvement without the need for invasive interventions.Conclusion:This case underscores the importance of considering EBV in atypical hepatitis presentations, especially in young adults. Early recognition and supportive care are essential in preventing unnecessary treatments and managing potential multi-organ complications.

Keywords: Atypical Hepatitis Presentation, Epstein-Barr Virus Infection, Systemic Inflammatory Response

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Ref No: 4490

Reversible Splenial Lesion Syndrome Presenting with Acute Transient Upper Limb Spasticity in a Febrile Adult Patient

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Introduction and Purpose: Reversible Splenial Lesion Syndrome (RESLES) is a rare neurological condition that presents with transient lesions in the splenium of the corpus callosum often following infection, antiepileptic drug withdrawal, high-altitude cerebral edema, or other metabolic disturbances. The clinical presentation can include acute neurological symptoms such as motor dysfunction, cognitive

disturbances, and occasionally seizures.

Materials and Methods: A 27-year-old male patient presented to the emergency department with a claw-like spasm of his left hand and a low-grade fever of 37.8°C. He reported experiencing general malaise, fever, and cough for the past 2-3 days, for which he had been prescribed antibiotic therapy. The patient stated that earlier that morning, he had visited another emergency department due to a high fever of 39°C. He received symptomatic treatment and was discharged home. Later that evening, while taking a shower, he experienced a sudden sensation of unwellness and near-syncope. Immediately following this episode, he developed bilateral hand spasms, which began in the right hand and subsequently involved the left hand, resulting in a claw-like contraction. Upon arrival at our emergency department, his fever had subsided, but he continued to experience a persistent spasm in his left hand.The patient had a history of febrile seizures during childhood. Motor examination revealed mild weakness in the left hand. Brain CT was normal, while MRI diffusion-weighted imaging revealed a restricted diffusion lesion in the splenium of the corpus callosum. The patient was administered intravenous acetaminophen, after which his hand spasm gradually resolved. He was subsequently admitted to the neurology ward for further evaluation and monitoring. During hospitalization, he remained clinically stable, and his left-hand motor strength returned to normal. No additional neurological symptoms developed, and he was discharged with complete recovery.

Results and Conclusion: This case highlights the importance of recognizing RESLES in patients presenting with transient neurological symptoms, particularly in young adults in the setting of febrile illness.The rapid resolution of symptoms following symptomatic treatment, along with the characteristic MRI findings confirm the diagnosis. It is a reversible condition, and the prognosis is generally favorable with conservative management. Early diagnosis and appropriate management are essential for ensuring a full recovery and minimizing potential complications.

Keywords: Reversible Splenial Lesion Syndrome, Motor Dysfunction, Transient Neurological Deficit

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Ref No: 4511

Inferior Vena Cava Syndrome Accompanying Chronic Obstructive Pulmonary Disease

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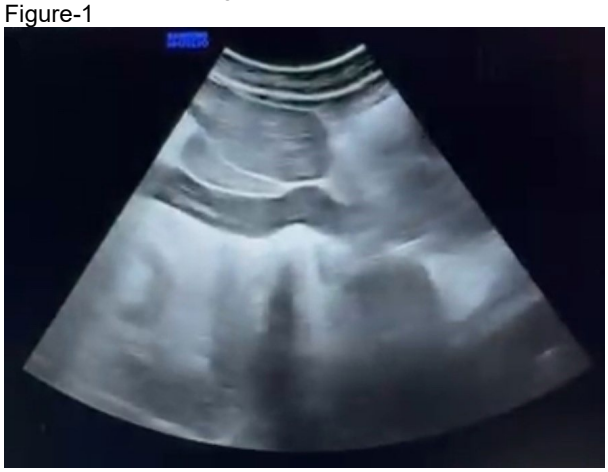
Introduction and Purpose: Inferior vena cava syndrome (IVCS) is an uncommon set of symptoms caused by obstruction or stenosis of the inferior vena cava. It may result from physical invasion or compression due to a pathological condition, or from thrombosis within the vein itself. It may also manifest during gestation. Symptoms such as elevated venous pressure in the lower extremities, reduced venous return to the heart, diminished cardiac output, placental abruption, and impaired renal function have been noted in late-term pregnancy. Less commonly, IVCS has been reported in chronic obstructive pulmonary disease (COPD). In this case report, we present the typical clinical characteristics of IVCS with comorbid COPD and a proggresive course.

Materials and Methods: After obtaining the necessary permissions, epicrisis information, and radiologic images of the patient were obtained from the patient record system of Bilecik Training and Research Hospital.

Results and Conclusion: A 79-year-old man with known COPD has been receiving long-term oxygen therapy at home for the last 6 months. This afternoon, despite receiving oxygen with a concentrator, he was transferred from the district to the emergency department of our hospital in Bilecik province by 112 Emergency Ambulance due to oxygen deficiency, impaired consciousness, low blood pressure, and deterioration in his general condition and non-orientated (GCS:12-13).The patient had hypoxia, hypercarbia, and acidosis on arrival to the Emergency Department (GCS: E2M4V2:8). The patient was immediately intubated, underwent short-term CPR, and consulted with the cardiology department. ECG showed RBBB, and echocardiogram showed EF 30% global hypokinetic and LVH. In addition, Grade 3 SEC and thrombus formation extending to the right atrium were detected in the VCI. The patient was heparinized and interned to the general ICU. Pulmonary embolism and SVA were not detected. The general condition of the patient whose follow-up and treatment continued with inotropic support improved.IVCS may accompany comorbid COPD. This can worsen the course of the disease and the patient's prognosis.

Figure-1



Grade 3 SEC and thrombus formation extending to the right atrium in the VCI (on the right side of the echocardiographic image)

Keywords: COPD, IVCS, prognostics

Ref No: 4516

Emphysematous Hepatitis: A Rare and Fatal Cause of Acute Liver Failure

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[2]Bursa Yenişehir State Hospital
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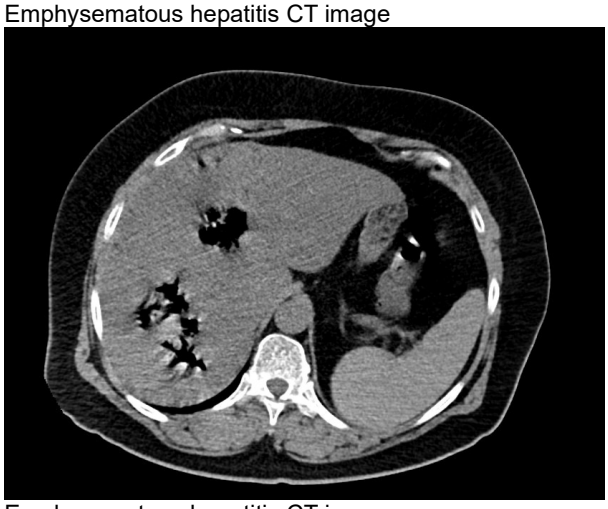
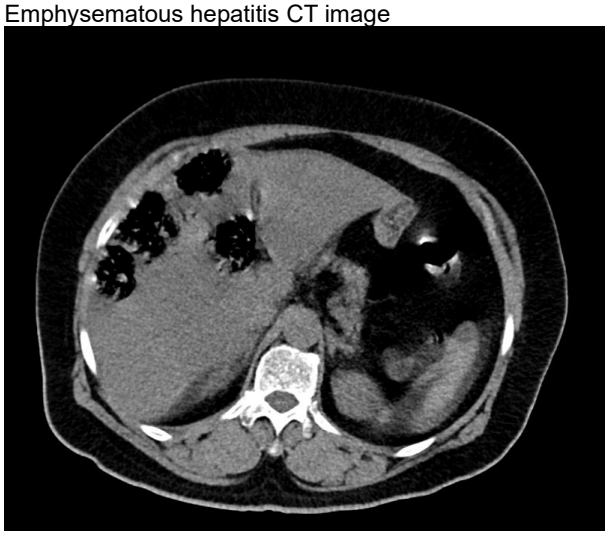
Introduction and Purpose: Abdominal pain is a common cause of emergency room visits. It has a wide spectrum, from conditions that can be managed with outpatient treatment and symptomatic support to mortal conditions that require emergency surgery. In this case, we wanted to draw attention to the rare emphysematous hepatitis.

Materials and Methods: A 61-year-old female patient was admitted to the emergency room with complaints of dyspepsia. She had no known chronic disease. Her general condition was good, her vitals were stable, and she was discharged with symptomatic treatment. She re-admitted 8 hours after her first admission with complaints of abdominal pain, vomiting, and diarrhea. Fever: 37.2 BP: 130/80 mmHg, pulse: 85/min, and SpO2: 98%. Diffuse tenderness and defense were detected in the abdomen. Laboratory tests were performed and she was taken to the emergency room for symptomatic treatment. During follow-up, the patient's general condition deteriorated, and an abdomen CT was performed. Multifocal foci measuring 4.5 cm at the widest point in the liver, containing dense air density with a tendency to cluster, were observed. While procedures were initiated to refer her to an advanced center with the diagnosis of emphysematous hepatitis, the patient developed cardiac arrest and exitus occurred despite effective cardiopulmonary resuscitation. Laboratory tests revealed WBC: 24,700/mm³, HGB: 11.7 g/dL, HCT: 35.9%, PLT: 201,000 /mm³, CRP: 105.5 mg/L, and unmeasurable ALT, AST, and Bilirubin.

Emphysematous hepatitis CT image



Emphysematous hepatitis CT image



Results and Conclusion: Emphysematous hepatitis is a rare condition characterized by gas replacement of the hepatic parenchyma and leads to acute liver failure. It is usually seen in patients with diabetes mellitus, liver disease or recent abdominal surgery. The presence of gas in the liver can be caused by various causes, usually liver abscesses, iatrogenic causes and rarely infection with gas-forming bacteria; pyogenic liver abscesses should be excluded. Effective treatment methods include urgent surgical debridement, percutaneous catheter drainage, antibiotic therapy and strict glucose control.Our case is different in that none of the risk factors reported

in the literature were present. Since emphysematous hepatitis is a rare disease that often progresses with high mortality, we recommend that clinicians keep it in mind.

Keywords: emphysematous hepatitis, abdominal pain

Ref No: 4529

Management of Spontaneous Ureteral Perforation: A Case Report and Literature Review

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[1]Karamanoglu Mehmetbey University

Introduction and Purpose: Spontaneous ureteral perforation is an uncommon but potentially severe condition, often caused by ureteral stones.

Materials and Methods: A 61-year-old hypertensive female presented with sudden abdominal pain and nausea. In the scan the left ureter and collecting system were dilated. A 4 mm calculus was observed in the proximal ureter. Parapelvic and cortical cysts were present in both kidneys. There was significant contamination in the perirenal area of the left kidney. Contamination suspected to be due to calixyal rupturing and a new CT scan was done in order to see contrast's excretion from the urinary tract and confirming ureteral perforation.A double-J stent was placed, and the patient was managed conservatively.

Results and Conclusion: Spontaneous ureteral rupture should always be considered in the differential diagnosis of patients presenting with complex symptoms following renal colic. In our case, although initial urine analysis did not immediately suggest perforation, the clinical presentation was unclear. This emphasizes the importance of considering further diagnostic evaluation in cases of suspected complex renal colic.

Keywords: Spontaneous Ureteral Perforation, Renal colic, Emergency medicine

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Ref No: 4547

In the shadow of a heavy body: neurological reflections of sacral trauma

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Introduction and Purpose: Sacral fractures are serious spinal injuries that develop as a result of high-energy trauma and are frequently seen in traffic accidents, falls from heights and work accidents. The sacrum plays a critical role in axial load transfer and due to its close relationship with nerve structures, fractures in this region can lead to neurological deficits. The most common complications in such fractures include loss of strength in the lower extremities, loss of sensation and sphincter dysfunction. Decreased sphincter tone and urinary/fecal incontinence are among the important findings that require urgent surgery. Computed Tomography (CT) is required for definitive evaluation and magnetic resonance imaging (MRI) is required to see the extent of nerve root involvement. Early surgical intervention and rehabilitation can positively affect the long-term functional outcomes of patients. Management of sacral fractures requires a multidisciplinary approach, and early diagnosis and appropriate treatment are vital to prevent permanent neurological deficits.

Materials and Methods: A 36-year-old male patient was admitted to the emergency department with compression and high-energy trauma after a heavy object fell on his back at work. The patient's symptoms were loss of sensation in the scrotal region, urinary incontinence, fecal discharge, and severe pain in the lumbar and sacral regions. No signs of trauma or hematoma were observed in the scrotal region during physical examination. Mild loss of strength was detected bilaterally in the lower extremities. Fractures were detected at the S1 and S2 levels, and it was seen that the fracture fragments created compression towards the posterior spinal canal. Emergency stabilization was provided to the patient, advanced evaluation was recommended by the neurosurgery and neurology departments, and an operation was planned.

Results and Conclusion: Neurological evaluation is of great importance in the diagnosis and management of sacral fractures. The sacral nerve roots should be evaluated and early surgical intervention should be planned fort he patients who develop urinary and fecal incontinence, Similar cases in the literature show that neurological recovery is possible with early diagnosis and appropriate surgical intervention.

Figure 1. X-ray after the surgery

Keywords: Spinal trauma, Neurological deficit, Lumbosacral fracture

Ref No: 4548

The Predictive Value of the Hemoglobin-Albumin-Lymphocyte-Platelet (HALP) Score in the Prognosis of Crimean-Congo Hemorrhagic Fever

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Introduction and Purpose: Crimean-Congo Hemorrhagic Fever (CCHF) is a zoonotic viral infection with a high mortality rate, representing a significant public health concern, particularly in endemic regions. The identification of early prognostic biomarkers is of great importance in facilitating clinical management and reducing mortality. In this study, the predictive power of a combined scoring system—based on hemoglobin, albumin, lymphocyte, and platelet values—was evaluated in forecasting the prognosis of patients with CCHF.

Materials and Methods: This retrospective study was conducted in the emergency department of Erzurum City Hospital. A total of 79 patients diagnosed with CCHF, aged over 18 years and without missing data, were included in the study. Hemoglobin, albumin, lymphocyte, and platelet values at the time of admission were obtained from the electronic medical record system. The Hemoglobin-Albumin-Lymphocyte-Platelet (HALP) score was calculated individually for each patient using these parameters.

Results and Conclusion: A total of 79 patients diagnosed with Crimean-Congo Hemorrhagic Fever (CCHF) were included in the study. The mean age of the patients was 50.89±16.70 years, and 64.6% (n=51) were male. Among the included patients, 76 were discharged, while 3 patients died. When comparing these two groups, the lymphocyte count was found to be significantly lower in the non-survivor group ($p = 0.021$). However, no statistically significant differences were observed in terms of hemoglobin, albumin, platelet count, or HALP score ($p > 0.05$). The clinical and laboratory characteristics of the patients are presented in Table 1.In this study, the potential predictive value of the HALP score and its individual components (hemoglobin, albumin, lymphocyte, and platelet) in estimating in-hospital mortality among patients diagnosed with Crimean-Congo Hemorrhagic Fever (CCHF) was investigated. According to our findings, the lymphocyte count was significantly lower in the non-survivor group compared to the survivors ($p = 0.021$). This finding is consistent with previous studies in the literature suggesting that lymphocytopenia in viral infections may be associated with disease severity and poor prognosis.Limitations of our study include the small number of fatal cases and its retrospective design. Nevertheless, it is one of the few studies examining the role of the HALP score and basic hematological parameters in the prognosis of CCHF, highlighting its significance.

TABLE 1

Variable	Total (mean±SD)	Survivors (mean±SD)	Non-survivors (mean±SD)	P value
Age	50.89 ± 16.70	50.55 ± 16.70	59.33 ± 17.62	0.480
Gender, male	51 (64.6%)	48 (63.2%)	3 (100%)	0.488
Albumin	37.48 ± 4.68	37.66 ± 4.58	32.83 ± 6.01	0.297
HGB	13.35 ± 2.31	13.35 ± 2.25	13.28 ± 4.18	0.980
LYMPH#	0.95 ± 0.63	0.95 ± 0.64	0.77 ± 0.04	**0.021**
PLT	119.60 ± 90.27	121.61 ± 91.11	68.78 ± 49.83	0.198
HALP Score	5.74 ± 5.71	5.64 ± 5.63	8.19 ± 8.67	0.663

WBC	4.34 ± 3.64	4.37 ± 3.70	3.59 ± 1.37	0.445
ALT	105.09 ± 119.00	105.01 ± 120.26	107.00 ± 99.86	0.976
AST	160.80 ± 228.16	155.09 ± 222.34	305.33 ± 379.32	0.564
Creatinine	1.01 ± 0.76	0.95 ± 0.61	2.57 ± 2.24	0.336

HGB: Hemoglobulin, Lymph: Lymphocyte, Plt: Platelet, WBC: White Blood Cell, ALT:Alanin aminotransferaz, AST: Aspartat aminotransferaz

Keywords: CCHF, PROGNOSİS, HALP SCORE

Ref No: 4553

Case series with Artificial İntelligence (AI) in the Emergency Department: Diagnostic accuracy of Chatgpt-4 in intracranial hemorrhage

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Introduction and Purpose: The aim of this study is to evaluate the performance of Chatgpt-4, an artificial intelligence program that can automatically detect, subtype, and localize acute or subacute bleeding in head CT scans, inform human interpretation, and facilitate the work of physicians working in busy emergency departments.

Materials and Methods: Brain images of patients with intracranial hemorrhage who were admitted to the emergency department within the last year were scanned. Patients with bleeding as a result of trauma were excluded from the study. Images of patients with intracranial hemorrhage were interpreted by experienced specialists. Glascow coma scores of the patients were recorded. Patient images were uploaded to the Chatgpt-4 system online and analysis results were obtained. We evaluated diagnostic performance by calculating diagnostic accuracy, availability, specificity (with Clopper-Pearson CIs), predicted values (with logit CIs), and F1 score, and false-positive and false-negative results.

Results and Conclusion: Intracranial diseases can present to the emergency department with a devastating picture and these diseases are often life-threatening. These diseases include cerebrovascular diseases such as cerebral infarction, cerebral hemorrhage and traumatic lesions such as brain contusion, acute subdural hematoma, acute epidural hematoma and chronic subdural hematoma.Data from 56 accepted patients were analyzed and the F1 score was found to be 0.78, accuracy 93%, sensitivity 87%, specificity 93%, positive predictive value 70 % and negative predictive value 97%. We observed high overall detection rates for intraventricular hemorrhage (97%) but lower rates for subarachnoid hemorrhage (SAH) (84 %) and subdural hemorrhage (69%)The results obtained in this study showed us that the existence of an artificial intelligence program similar to Chatgpt-4 that can diagnose these diseases can be extremely useful in both diagnosis and differential diagnosis. It is recommended that it be supported by studies with large sample sizes.

Keywords: Artificial intelligence, intracranial hemorrhage, brain tomography

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Ref No: 4562

Chronic Methemoglobinemia: A Rare Case with Dramatic Response to Methylene Blue Following Informed Refusal and Recurrent ICU Indication

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Introduction and Purpose: Methemoglobinemia is a rare hematologic disorder characterized by the oxidation of hemoglobin's iron from the ferrous (Fe^{2+}) to the ferric (Fe^{3+}) state due to oxidative agents, impairing its oxygen-carrying capacity. Under normal physiological conditions, methemoglobin levels in the blood remain between 1–2%. Clinically, methemoglobinemia presents with decreased oxygen saturation and central cyanosis that does not respond to oxygen therapy. The diagnosis is confirmed by arterial blood gas analysis, and treatment involves the use of reducing agents such as methylene blue.

Materials and Methods: A 46-year-old female patient with a lifelong history of cyanosis affecting the lips and fingertips since childhood presented to the emergency department during a trip. On admission, she exhibited mild dyspnea and low oxygen saturation (84%). Arterial blood gas analysis revealed a pH of 7.39, pCO □of 40.7 mmHg, HCO □of 22.2 mmol/L, hemoglobin level of 12.4 g/dL, and a methemoglobin level of 38.1%. The patient initially refused referral and left the hospital, but returned two days later with recurrent symptoms. In the blood gas analysis at the second hospital she applied to, her methemoglobin level was 36.8%, pCO2 was 29.6 mmHg, pH was 7.4, and hemoglobin level was 12.3 g/L. Intravenous methylene blue was administered at a dose of 1 mg/kg. Following treatment, the MetHb level decreased to 3.7 %, and the patient's symptoms resolved.

Methemoglobin level and associated symptoms

%Met Hb	Symptoms
<15	Generally asymptomatic

15-30	Cyanosis, anxiety, light-headedness, fatigue, headache
30-50	Tachypnea, confusion, syncope
50-70	Seizures, arrhythmias, metabolic acidosis, coma
70>	Death

Results and Conclusion: This case highlights that acute episodes in patients with chronic methemoglobinemia can be effectively managed with early diagnosis and timely intervention. Diagnosis of chronic methemoglobinemia may be delayed due to stable vital signs and the presence of long standing symptoms. Prompt recognition and administration of methylene blue led to rapid symptom resolution in this patient, emphasizing the importance of a multidisciplinary approach in such rare presentations.
Keywords: Emergency Medicine, Methemoglobinemia, Acute Care

Ref No: 4623
The Frequency of Hyponatremia in Intensive Care Unıt and Its Relationship with Mortality
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Introduction and Purpose: This study was designed to assess the relationship between plasma sodium levels at ICU admission and patient outcomes, with a particular focus on mortality.
Materials and Methods: A retrospective analysis was performed on ICU patients from a cohort of 500 individuals. Patients were categorized into two groups based on their admission plasma sodium concentrations: those with hyponatremia (sodium < 135 mM, n = 125) and those with normonatremia (sodium ≥ 135 mM, n = 375). Categorical variables were compared using Pearson's chi-squared test, while continuous variables were evaluated using the Student's T-test. Additionally, a multiple logistic regression model was employed to investigate the independent association between clinical data and patient outcomes.
Table 1. Demographic, Clinical, and Laboratory Characteristics of the Study Population

Variable	**Total (n=500)**	**Hyponatremia Group (n=125)**	**Normonatremia Group (n=375)**	**p-value**
Age (mean ± SD)	68.5 ± 17.2	67 ± 16	69 ± 18	0.517
Gender (Male, %)	159 (53%)	61 (66%)	98 (50%)	**0.014***
Comorbidities				
Diabetes, n (%)	49 (17%)	18 (19%)	31 (16%)	0.536
Congestive heart failure, n (%)	30 (10%)	5 (5%)	25 (13%)	0.064
Coronary artery disease, n (%)	44 (15%)	14 (15%)	30 (15%)	1.000
Cirrhosis, n (%)	3 (1%)	1 (1%)	2 (1%)	1.000
Active neoplasia, n (%)	18 (6%)	6 (7%)	12 (6%)	1.000
Current smoker, n (%)	22 (8%)	9 (10%)	13 (7%)	0.485
Chronic obstructive pulmonary disease (COPD), n (%)	27 (9%)	11 (12%)	16 (8%)	0.386
Respiratory insufficiency, n	2 (1%)	1 (1%)	1 (1%)	0.538

(%)				
Medications Used				
ACE inhibitors, n (%)	30 (11%)	13 (14%)	17 (9%)	0.214
ARBs, n (%)	28 (10%)	8 (9%)	20 (10%)	0.832
Loop diuretics, n (%)	17 (6%)	9 (10%)	8 (4%)	0.065
Thiazide diuretics, n (%)	23 (8%)	3 (3%)	20 (10%)	0.060
Vital Signs				
Body temperature (°C, mean ± SD)	38.6 ± 0.9	38.9 ± 0.9	38.4 ± 0.9	**<0.001***
Body temperature >38.5°C, n (%)	135 (50%)	55 (65%)	80 (47%)	0.010*
Systolic blood pressure (mmHg, mean ± SD)	148 ± 20	148 ± 18	149 ± 22	0.709
Diastolic blood pressure (mmHg, mean ± SD)	85 ± 11	83 ± 9	86 ± 12	0.110
Respiratory rate (breaths/min, mean ± SD)	29 ± 7	30 ± 7	28 ± 7	**0.034***
Clinical Outcomes				
Need for mechanical ventilation, n (%)	27 (9%)	16 (17%)	11 (6%)	**0.003***
Mortality, n (%)	35 (12%)	17 (18%)	18 (9%)	**0.042***

SD: Standard deviation, IQR: Interquartile range. p<0.05 is considered statistically significant. Results are expressed as mean ± standard deviation (SD) or median [Inter Quartile Range] for quantitative variables, and comparability between groups was evaluated by Student's t or non-parametric Wilcoxon test (*).

Table 2. Univariate and Multivariate Logistic Regression Analysis for Predicting Mortality

Variable	Univariate OR (95% CI)	p-value	Multivariate OR (95% CI)	p-value
Age (per 1-year increase)	1.03 (1.01–1.06)	0.008*	1.02 (1.00–1.05)	0.045*
Male gender	1.80 (1.10–2.95)	0.020*	1.50 (0.90–2.50)	0.120
Hyponatremia (<135 mmol/L)	2.50 (1.40–4.40)	0.002*	2.10 (1.10–3.90)	0.025*
Respiratory rate (per 1 increase)	1.05 (1.01–1.09)	0.015*	1.04 (1.00–1.08)	0.048*
Mechanical	5.20 (2.60–	<0.001*	4.50 (2.10–	<0.001*

ventilation	10.40)		9.60)	

OR: Odds Ratio, CI: Confidence Interval (95%).• *p<0.05 is considered statistically significant (marked with).

Results and Conclusion: In this retrospective study of 500 ICU patients (mean age 64.8 ± 13.7 years; 58% male), we assessed the impact of hyponatremia on mortality and ICU length of stay. Common comorbidities included hypertension (45%), diabetes (30%), and cardiovascular diseases (25%). Hyponatremia (plasma sodium < 135 mM) was present in 25% of the patients. The mortality rate was significantly higher in the hyponatremia group (40%) compared to the normonatremia group (18%) (p<0.01). Univariate analysis revealed significant associations between mortality and factors such as age, cardiovascular disease, renal failure, and hyponatremia, with hyponatremia showing a strong association (OR=2.8, 95% CI: 1.9–4.1, p<0.001). In multivariate logistic regression—including age, cardiovascular disease, and renal failure—hyponatremia remained an independent predictor of mortality (OR=2.3, 95% CI: 1.5–3.5, p<0.001). ROC curve analysis demonstrated that serum sodium levels predicted mortality with an AUC of 0.74 (95% CI: 0.69–0.79); a threshold of 132 mEq/L yielded 78% sensitivity and 65% specificity. Furthermore, hyponatremic patients had a significantly longer ICU stay (9.5 vs. 6.2 days, p<0.01).Our findings suggest that close monitoring of electrolyte imbalances and early intervention, particularly in correcting hyponatremia, may play a potential role in reducing mortality risk in ICU settings. This study highlights the clinical importance of hyponatremia in ICUs and serves as a foundational step in developing hyponatremia management strategies for future research and clinical applications.

Keywords: Hyponatremia, Intensive Care Unıt, Mortality

Ref No: 4634

Vertebral Artery Dissection Causing A Posterior Circulation Ischemic Stroke Following Chiropractic Cervical Manipulation

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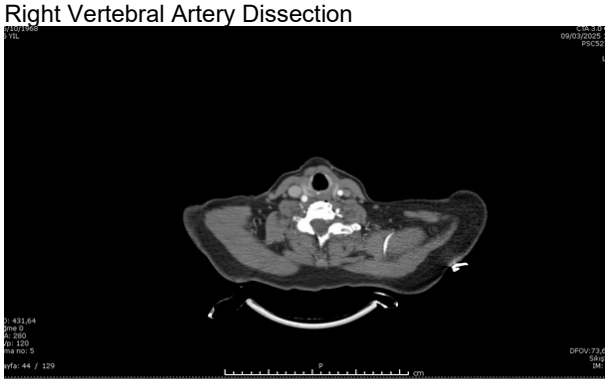
Introduction and Purpose: Vertebral artery dissection (VAD) is a well-documented but often under-diagnosed cause of posterior circulation ischemic stroke, particularly in younger and middle-aged patients. While VAD can occur spontaneously, it is frequently associated with minor neck trauma or cervical manipulations. Chiropractic neck adjustments involve forceful rotational movements, which can stretch or tear the vertebral artery, leading to thrombosis, embolism, or ischemia.

Materials and Methods: A 55-year-old female patient with a history of hypertension presented to the emergency department with dizziness, nausea, and vomiting. Fifteen days before admission, she had undergone cervical chiropractic manipulation after which she experienced a sharp sudden neck pain immediately after the procedure. Additionally, the patient stated that she had undertaken a 24-hour bus journey one week before admission. Two to three days after the trip, she woke up with severe dizziness that initially improved with lying down and experienced a brief visual blackout lasting a few seconds. She subsequently developed neck pain particularly on the right side and stated that her dizziness recurred intermittently and worsened over the few next days particularly upon waking. Cerebellar testing revealed mild dysmetria on the left and tandem walking revealed ataxia. Diffusion-weighted MRI identified an acute infarct in the right cerebellar tonsil and posteromedial right cerebellar hemisphere. CT angiography revealed right vertebral artery dissection. The patient was diagnosed with an ischemic stroke secondary to vertebral artery dissection and was admitted to the neurology ward for further management.

Right Vertebral Artery Dissection



CT angiography revealing right vertebral artery dissection

Results and Conclusion: This case highlights the importance of considering vertebral artery dissection in patients with stroke symptoms and a history of cervical manipulation or trauma especially in patients with predisposing vascular factors like hypertension. Early recognition and imaging are crucial for appropriate management and stroke prevention.

Keywords: Vertebral artery dissection, Ischemic stroke, Chiropractic neck manipulation

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Ref No: 4652

PRESSURE-RELATED DAMAGE IN PATIENT WITH NEARBY EXPLOSION

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[1]ATATURK UNIVERSITY EMERGENCY DEPARTMENT

Introduction and Purpose: In traffic accidents, falls from heights, explosions, etc., the pressure can cause fatal trauma to the patient, from bleeding to direct damage to organs such as intra-abdominal solid organs, heart, lung and brain, in addition to direct trauma.

Materials and Methods: A 28-year-old male with no prior medical history was brought to the emergency department after being thrown by an explosion while escaping a house fire. On arrival, he had a 4 cm laceration on the occipitoparietal region, hyperemia, and tenderness in the left shoulder and femur, with normal neurovascular and systemic examinations. His vital signs and imaging studies were normal, showing no acute or bone pathology.The patient was hospitalized in the emergency ICU for observation. On the second day, he developed flank and abdominal pain. Imaging via ultrasound suggested a possible 9x8 mm laceration in the left kidney capsule, but surgery was not recommended as his creatinine levels and hematuria were normal.The following day, he reported blood from his right ear. Examination showed traces of blood and a false membrane in the external auditory canal, but no active bleeding or external abnormalities. Surgery was again not indicated. The patient was discharged with instructions for follow-up and a prescription.
Results and Conclusion: Since the main presentation of our patient was tube explosion, the first injuries that come to mind may be burns or direct injuries. However, as in this patient, pressure-related injuries should always be considered. In our examinations, we should check for damage to pressure sensitive points such as the tympanic membrane.
Keywords: pressure, kidney laceration

Ref No: 4673
Assessment of the Predictive Ability of the Neutrophil-to-Lymphocyte Ratio in Patients with In-Stent Restenosis after COVID-19
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Introduction and Purpose: The neutrophil-to-lymphocyte ratio (NLR) is an independent predictor of the severity of coronary heart disease, coronary occlusion with the development of myocardial infarction. This index was an independent risk factor for severe coronavirus infection during the COVID-19 pandemic . The aim is to assess the relationship between NLR, laboratory and clinical parameters in individuals with repeated myocardial revascularization after coronavirus infection.
Materials and Methods: A cross-sectional study included 931 patients underwent repeated myocardial revascularization between May 2020 and May 2023. The 420 patients of the main group had in-stent restenosis, of which 162 patients had COVID-19 previously. The control group included 511 patients without stent restenosis (107 patients had COVID-19). All events were verified by electronic records from the Complex Medical Information System. Laboratory tests included complete blood count, high-sensitivity troponin I, D-dimer, creatine kinase (CK), creatine kinase-MB (CK-MB), serum creatinine and glucose, ESR, C-reactive protein, alanine aminotransferase (ALT), aspartate aminotransferase (AST), and fibrinogen. IgG and IgM antibodies to SARS-CoV-2 were determined. Statistical significance was set at $p<0.05$. All statistical calculations were performed using SPSS version 20.0 software . The study was carried out with the financial support of the Science Committee of the Ministry of Education and Science of the Republic of Kazakhstan (grant No. AP19677465).
Results and Conclusion: The mean values of the NLR were 2.51 and 2.68 in the study groups, respectively. A statistically significant positive relationship in both groups was found between the NLR and troponin, D-dimer, C-reactive protein, creatinine, ALT, and AST. A statistically significant positive relationship was found between NLR and myocardial infarction (MI) in patients of both groups ($p = 0.004$; $p < 0.001$, respectively) and a negative relationship with the ejection fraction ($p = 0.001$; $p < 0.036$, respectively). An evaluation of the predictive ability of the clinical and laboratory predictors of recurrent myocardial infarction shows a high degree of utility of this model. The area under the ROC curve for AUC for NLR was 0.664 with 95% CI from 0.627 to 0.700 ($p < 0.001$). NLR is one of the significant factors for predicting the development of adverse outcomes in patients with revascularized myocardium after COVID-19.
Keywords: in-stent thrombosis, neutrophil-to-lymphocyte ratio, COVID-19

Ref No: 4705
Tracheobronchial Foreign Body Aspiration: An Evaluation of Two Cases
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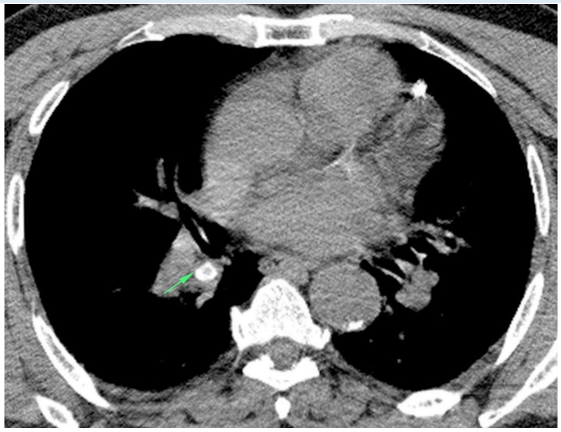
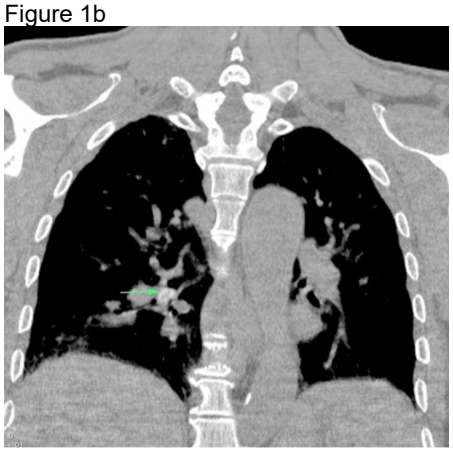
Introduction and Purpose: Tracheobronchial foreign body aspiration is a serious, life-threatening clinical condition that requires immediate intervention. It is more common in children than in adults, and it can cause respiratory arrest and sudden death, especially in children under six years of age. Herein, we discuss two cases of tracheobronchial foreign body aspiration with radiological and bronchoscopic imaging findings.
Materials and Methods: Case 1A 65-year-old male patient was admitted to the emergency department with complaints of shortness of breath and cough after aspirating an olive pit while eating breakfast. No tracheobronchial foreign body was found on the chest X-ray (Figure 1a). No atelectasis, consolidation, or air trapping was detected in the parenchyma. Thorax computed tomography (CT) revealed a hyperdense foreign body, thought to be compatible with an olive pit, in the right side of the lower lobe bronchus (Figure 1b). During rigid bronchoscopy, a foreign body was seen on the lower lobe bronchus and was removed with forceps. The patient was discharged without any complications.Case 2A 60-year-old male patient with a tracheostomy was admitted to the emergency department due to voice prosthesis aspiration. Although the chest X-ray was not of optimal quality, no foreign body was detected (Figure 2). However, due to the patient's history of aspiration, rigid bronchoscopy was performed under emergency conditions. A foreign body was detected in the right intermediate bronchus during rigid bronchoscopy and removed with forceps. The patient was discharged without any complications.
Figure 1a



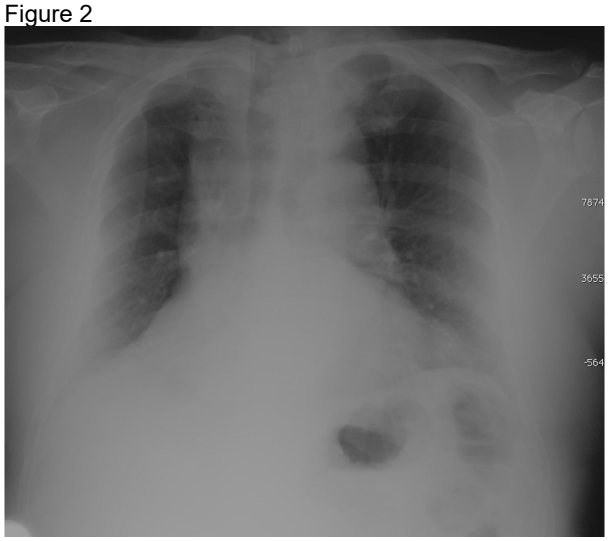
Non-enhanced axial (a) and coronal (b) images of the chest CT scan shows hyperdense foreign body, thought to be compatible with an olive pit, in the right side of the lower lobe bronchus (arrow).

Figure 1b



Non-enhanced axial (a) and coronal (b) images of the chest CT scan shows hyperdense foreign body, thought to be compatible with an olive pit, in the right side of the lower lobe bronchus (arrow).

Figure 2



The chest X-ray was not performed at the proper position. However, there were no foreign bodies in the tracheobronchial system. The mediastinum appears to be wider than normal. Cardiothoracic rate is increased.

Results and Conclusion: Radiological evaluation should be performed in all cases in which a tracheobronchial foreign body is suspected. Among these, chest X-ray is the preferred first imaging method because it is noninvasive, inexpensive, and easily accessible. Radiopaque foreign bodies are easy to distinguish using radiographs, while nonopaque objects, such as food residues, nuts, or plastics cannot be distinguished. In suspected cases of a tracheobronchial foreign body, even if the chest X-ray is normal, thoracic CT should be performed to distinguish the foreign body and localize its location. In conclusion, it is very important to diagnose and remove the foreign

body as soon as possible after suspected aspiration in the early to reduce the incidence of mortality and postoperative complications.
Keywords: Foreign body, Tracheobronchial, Computed Tomography

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Ref No: 4743
A rare case: Ischemic Stroke in A Young Woman Without Risk Factors
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Introduction and Purpose: Ischemic stroke typically occurs in older individuals and is associated with well-established risk factors such as hypertension, diabetes, dyslipidemia, and smoking. However, ischemic stroke in young individuals, although less common, can lead to serious clinical outcomes. In patients with stroke at a young age, the absence of classic risk factors necessitates a more thorough investigation into the pathophysiological mechanisms and potential underlying causes.
Materials and Methods: A 19-year-old female patient, with no known medical history or regular medication use, presented to the emergency department with complaints of numbness in her right arm and leg, and blurred vision in her right eye upon waking from sleep. Physical examination in the emergency department revealed no acute pathology. Imaging and laboratory tests also showed no acute abnormalities, and the patient was relieved with symptomatic treatment and discharged. However, after returning home, the patient experienced worsening of her symptoms, and the sensation of numbness intensified, prompting her to seek further medical attention. A repeated physical examination revealed horizontal nystagmus. Blood samples were taken, and brain CT and diffusion-weighted MRI were planned. Brain MRI revealed diffusion restriction in the posterior left thalamus and left parahippocampal gyrus. The patient was consulted by neurology and admitted to the neurology department for further management.
Results and Conclusion: This case presents a rare example of ischemic stroke in a young female patient without any known cardiovascular or metabolic risk factors. Ischemic stroke in young individuals is often a challenging condition to diagnose due to the absence of classic risk factors. However, detailed clinical and imaging evaluations in this case revealed diffusion restriction in the posterior left thalamus and left parahippocampal gyrus, confirming the presence of acute ischemic lesions. Although ischemic stroke is a rare occurrence, especially in young patients, early diagnosis and intervention are of critical importance. This case emphasizes that the risk of ischemic stroke in young individuals should not be overlooked, and that patients should be closely monitored with detailed neurological assessment. Furthermore, even in the absence of classic risk factors, stroke should be considered in these patients, and their management should follow a multidisciplinary approach.
Keywords: Emergency Department, Ischemic Stroke, Young Woman

Ref No: 4744
Indispensable in emergency cases of dichloromus (dichloromuscorıol) and acute coronary syndrome: kounis syndrome
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Introduction and Purpose: Kounis syndrome is defined as the simultaneous occurrence of acute coronary syndrome with allergy, hypersensitivity and anaphylaxis due to allergy, hypersensitivity and anaphylaxis conditions related to food, especially drugs, environmental factors (insect bites, bee stings, pollen, latex contact, etc.). Histamine released by degranulation of mast cells, which are the main inflammatory cells in pathophysiology, is usually associated with severe allergic and anaphylactic reactions, and these reactions may lead to atheromatous plaque erosion with severe coronary artery spasm or rupture in some cases. Three different variants of the syndrome have been defined, and the most important point in the diagnosis is to suspect this syndrome with the combination of anamnesis, physical examination, laboratory results, and ECG results. The treatment protocol requires simultaneous treatment of cardiac and allergic symptoms.
Materials and Methods: A 61-year-old female patient was brought to us by 112 teams after developing chest pain, shortness of breath, nausea, and vomiting complaints after receiving dichloron-muscoril IM injection due to low back pain. The patient's physical examination and vital findings were pulse: 59 beats/min, blood pressure: 100/60 mmHg, oxygen saturation was 87% in room air, body temperature was 36.8 °C, uvula edema and shock findings were absent. ECG (electrocardiography) of the patient showed ST-segment elevation in inferior leads (D2, D3, aVF) and ST depression in D1, aVL. Necessary medical treatment for anaphylaxis and Inferior MI was started in the emergency department, and cardiology consultation was requested. After ECHO (echocardiography) was performed in the emergency department, emergency coronary angiography was performed. The patient was discharged after 2 days of follow-up and treatment in the coronary intensive care unit.
Results and Conclusion: Diclofenac sodium and thiocolchicoside injection is a common symptomatic treatment preferred for the symptoms of different diseases, such as LDH (lumbar disc herniation) pain and myalgia. Chest pain, dyspnoea, nausea and vomiting complaints, anamnesis, physical examination, disturbances in vital signs, ECG changes, and blood cardiac marker elevations should suggest Kounis syndrome, and urgent anaphylaxis and allergic and acute coronary syndrome treatments should be initiated.
Keywords: Chest pain, Acute coronary syndrome, Kounis syndrome

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Ref No: 4752
Isolated Truncal Ataxia as the Sole Presentation of Suspected Vertebral Artery Dissection: A Diagnostic Challenge in the ED
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Introduction and Purpose: Truncal ataxia, defined as impaired control of axial posture resulting in instability during sitting or walking, is a clinical sign often associated with midline cerebellar or brainstem dysfunction. In emergency settings, isolated truncal ataxia can be

overlooked or misattributed to benign causes such as peripheral vertigo, alcohol intoxication, or medication effects. However, it may represent an early and sole manifestation of posterior circulation ischemia or vertebral artery dissection (VAD), both of which require urgent recognition and management.

Materials and Methods: Case Presentation: A 64-year-old previously healthy woman presented to the emergency department with sudden-onset inability to maintain an upright seated position and progressive unsteadiness. She also reported nausea but denied headache, vertigo, trauma, or limb weakness. Neurological examination revealed isolated truncal ataxia without limb dysmetria, cranial nerve deficits, or focal motor findings. Cerebellar testing was normal in the extremities, but she was unable to sit or stand without support. Initial laboratory tests were unremarkable. Emergent brain CT and diffusion-weighted MRI (DWI) revealed no acute findings. Symptomatic treatment with intravenous fluids, dimenhydrinate, and nootropics provided mild improvement. Due to ongoing postural instability, repeat neuroimaging was performed eight hours later. Although the follow-up DWI MRI remained negative for acute ischemia, CT angiography of the head and neck demonstrated a double-lumen appearance in the left vertebral artery, consistent with fenestration or possible dissection. The patient was admitted to the neurology service, and antiplatelet therapy was initiated. Her symptoms gradually improved, although mild gait ataxia persisted at discharge.

Results and Conclusion: This case underscores the importance of considering vertebral artery dissection in the differential diagnosis of isolated truncal ataxia, even when initial imaging is unrevealing. Emergency physicians should maintain a high index of suspicion in patients with axial instability and pursue serial imaging to detect posterior circulation pathology. Recognition of subtle central signs such as truncal ataxia may prevent misdiagnosis and facilitate early intervention in potentially life-threatening vascular events.

Keywords: Truncal ataxia, vertebral artery dissection, posterior circulation

Ref No: 4754

A Rare Case in Emergency Department: A Patient with Digoxin Intoxication

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Introduction and Purpose: Digoxin works by blocking the NaK-ATPase enzyme, which has an impact on smooth muscle and neuronal tissues as well as cardiac contractility and conduction. Although the drug helps with conditions like supraventricular tachycardia and systolic heart failure, it can also be toxic. Early signs of digoxin toxicity often include gastrointestinal symptoms (nausea, vomiting, abdominal pain), while cardiac toxicity may result in life-threatening arrhythmias. Other findings include fatigue, weakness, confusion, and anorexia. Risk is increased by hypokalemia and co-administration of drugs that raise serum digoxin levels, such as quinidine, calcium channel blockers, amiodarone, propafenone, and spironolactone.

Materials and Methods: : A 78-year-old female patient was brought to the emergency department of Bezmialem Vakif University by ambulance due to complaints of chest tightness and shortness of breath. Her medical history includes hypertension, arrhythmia, and positive hepatitis B surface antigen (HBsAg [+]). She is on regular medication, including digoxin (0.25 mg), furosemide (40 mg twice daily), metoprolol (100 mg twice daily), and rivaroxaban (20 mg daily). The patient's vital signs exhibited an abnormal pulse of 17 beats per minute, and Glasgow Coma Scale was 15 however there were a tenderness on right upper quadrant other physical findings were unremarkable. The ECG and laboratory tests were performed concomitantly. Her first ECG showed bradycardia and revealed J point depression, ST segment sagging known as Salvador Dali sign (Figure 1). The patient was diagnosed with digoxin intoxication based on patient's medical history, presented symptoms, signs and pathognomonic ECG findings. After those evidences, we confirmed our diagnosis based on patient serum concentration of digoxin which was 8,39 ng/mL. The patient was stabilized. Afterwards atropine and dobutamine were applied for bradycardia and hypotension. After she was admitted to coronary intensive care unit her first serum digoxin level was measured 10 ng/mL and Glasgow Coma Scale was 12 (Eye3, verbal4, motor5). Temporary pace-maker was applied for persistent bradycardia and digoxin specific antibody was immediately started. Patient was followed 5 consecutive days in coronary intensive care unit.

Salvador Dalí sign

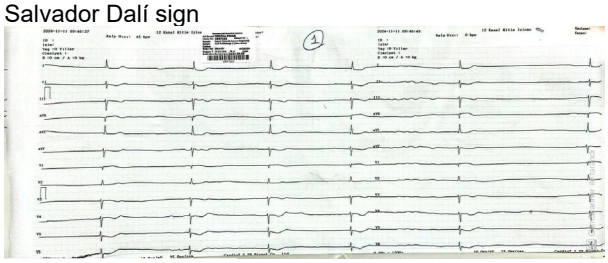


Figure 1: Initial electrocardiogram (ECG) showing sinus bradycardia with J-point depression and downsloping ST segments, known as the Salvador Dalí sign

ECG taken after the first administration of atropine

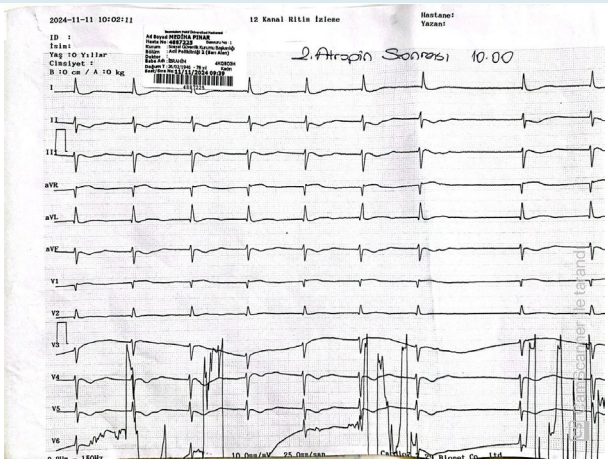


Figure 2: ECG taken after the first administration of atropine
ECG taken after the second administration of atropine

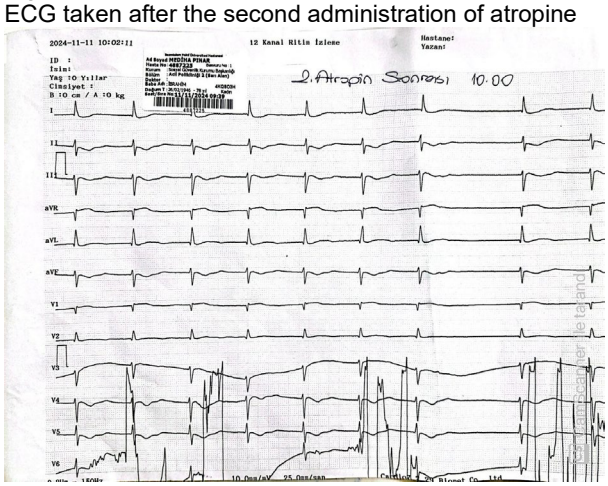


Figure 3: ECG taken after the second administration of atropine
ECG taken after the third administration of atropine

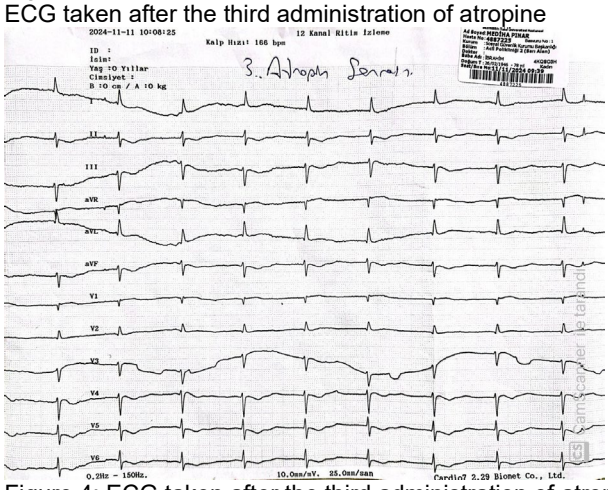


Figure 4: ECG taken after the third administration of atropine

Results and Conclusion: Serum digoxin concentrations play an important role in the clinical presentation of digoxin toxicity, and a better understanding of these levels can help guide patient management.

Keywords: Digoxin, Intoxication, Salvador Dali Sign

Ref No: 4932

Pneumomediastinum and tooth extraction: A case report

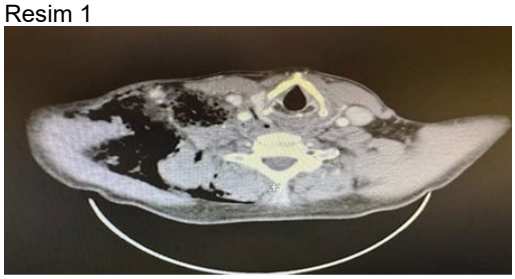
Müslime Kasa[1]

[1]S.B.Ü. KONYA BEYHEKİM EĞİTİM ARAŞTIRMA HASTANESİ ACİL TIP KLİNİĞİ

Introduction and Purpose: Pneumomediastinum is defined as free air in the mediastinum. Although it may occur spontaneously in most cases, it is a rare complication that may occur after trauma, head and neck surgery, secondary to infection and routine tooth extraction. It is mostly self-limiting in young people. The reason for its development after tooth extraction is the use of tools that provide compressed air in dental applications. High-pressure air dissects the soft tissues starting from the disrupted dento-alveolar membrane and reaches the mediastinum. Contaminated fluid and air can reach the mediastinum after disruption of the intraoral barrier and can lead to mediastinitis and mediastinal abscess, which can be extremely fatal. Conservative methods are tried primarily in treatment. While emphysema is monitored with nasal oxygen, antibiotic and analgesic treatment, cases requiring surgical intervention are determined according to the patient's condition.

Materials and Methods: We wanted to present a 49-year-old male patient who presented to the emergency department with chest pain and swelling in the neck and developed pneumomediastinum after tooth extraction. The diagnosis may be delayed because it is rare and not considered as a differential diagnosis. The diagnosis can be made by taking a detailed anamnesis from the patients. Chest diseases, thoracic surgery specialists and dentists should keep in mind that there is a connection from the lower jaw to the mediastinum.

Resim 1



Resim 2

Resim 3

Results and Conclusion: In conclusion, pneumomediastinum should be considered by the clinician in the complaint of shortness of breath or chest pain after tooth extraction. Pneumomediastinum is a life-threatening complication that can be seen after dental interventions. Dentists should avoid the use of compressed air equipment as much as possible, considering that mediastinal emphysema may develop after tooth extraction, although rare.

Keywords: Tooth extraction, Pneumomediastinum, Mediastinal abscess

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Ref No: 4933

A retrospective study, analysis of Syrian patients under temporary protection presenting to the emergency department

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Introduction and Purpose: The immigration problem, because of war and economic difficulties, stands out as a multidimensional social and economic issue worldwide. Following the Syrian civil war, millions of people were forced to leave their country and migrate to different regions, especially neighboring countries. As of 2024, Turkey is hosting the most significant number of Syrians worldwide. In terms of health services, it is known that emergency services are the units that these people use most intensively. This is due mainly to the lack of access to primary health services. This study aimed to analyze the demographic data, emergency room usage characteristics, and outcomes of Syrian patients and to investigate their compatibility with the existing literature.

Materials and Methods: Demographic data, emergency department usage characteristics, and outcomes of Syrian patients who applied to the emergency department between October 1, 2023, and April 1, 2024, were analyzed retrospectively.

Results and Conclusion: A total of 1780 patients were included in the study. Most patients presented to the emergency department during off-duty hours (57.1%), on weekdays (70%), and as self-presentation (%97.7). The most common reason for presentation was symptoms of upper respiratory tract disease (27%). Many patients stayed in the emergency department for less than an hour (71%). The length of stay in the emergency department was significantly higher in patients who arrived by ambulance and for whom consultation was requested ($p<0.001$). Consultation was not requested for most patients (87.8%). The rate of consultation requests was significantly higher in patients who arrived by ambulance than in self-presentation ($p<0.001$). Syrian patients' visits to emergency services for non-urgent reasons are a significant health problem. Educating patients about the functioning of the health system and effectively planning and implementing primary health services will significantly reduce the burden on emergency services and the cost of health services.

Analysis of emergency department application times and types

	Number(n)	Percentage (%)
Application time		
08:00-16:00	763	42.9%
16:00-08:00	1017	57.1%
Application day		
Mid-week	1246	70%
Weekend	534	30%
How to apply		
Self-presentation	1739	97.7%
Ambulance-arrival	41	2.3%

Reasons for application of patients

Reason for Application	Number(n)	Percentage (%)
Symptoms of upper respiratory tract disease	480	27.0%
Trauma	299	16.8%
Gastroenterological symptoms	250	14.0%
Musculoskeletal symptoms	250	14.0%
Symptoms associated with the urinary system	111	6.2%
Eye-related symptoms	90	5.1%
Neurological symptoms	86	4.8%
Cardiological symptoms	86	4.8%

Dermatological symptoms	82	4.6%
Other symptoms	46	2.7%
Total	1780	100%

Length of stay of patients in the emergency department

Length of stay	Number (n)	Percentage (%)
Less than an hour	1268	71%
One to four hours	486	27.3%
More than four hours	31	1.7%
Total	1780	100%

Outcomes of patients in the emergency department and during hospitalization

Patient outcomes	Number (n)	Percentage (%)
Discharged from the emergency department	1700	95.6%
Hospitalization	52	2.9%
Discharged from hospital Transfer to another hospital Death in hospital	46 3 3	
Leaving the emergency department with a treatment refusal signature	24	1.3%
Transfer from the emergency department to another hospital	4	0.2%
Total	1780	100%

Keywords: emergency department, Syrian, refugee

Ref No: 4935

Acute Lower Extremity Ischemia at an Early Age: A Rare Case Report

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Introduction and Purpose: Peripheral arterial disease (PAD) is a chronic vascular disorder commonly seen in the elderly and associated with atherosclerosis. It can lead to intermittent claudication, rest pain, and in advanced stages, critical limb ischemia (CLI). PAD in young adults is rare and often overlooked, especially in the absence of known chronic diseases. However, risk factors like smoking, obesity, and uncontrolled glucose levels may contribute significantly to early-onset PAD. Acute limb ischemia (ALI), on the other hand, is a vascular emergency caused by sudden arterial blockage requiring urgent diagnosis and treatment.

Materials and Methods: A 35-year-old male presented with sudden, severe left leg pain. He had a history of exertional leg pain over the past 5–6 months, which had recently progressed to rest pain. The patient was a chronic smoker (15+ years) and had a BMI of 43.3. Physical exam revealed a cold, pale left leg with absent distal pulses. ABI was 0.5. Blood glucose was 350 mg/dL, with no prior diabetes diagnosis. Arterial Doppler showed monophasic flow in the femoral arteries and thrombosis in distal arteries with no flow. CT angiography revealed occlusion in the distal superficial femoral artery. The clinical picture suggested acute-on-chronic limb ischemia. Cardiovascular surgery performed urgent endovascular intervention to restore blood flow. Postoperatively, the patient received

antithrombotic therapy and was monitored closely.

Results and Conclusion: This case demonstrates that PAD can develop even in younger individuals when significant risk factors are present. Chronic symptoms were likely missed, and acute thrombotic progression led to emergent presentation. Recognizing acute-on-chronic limb ischemia is crucial for timely, limb-saving interventions. PAD should not be ruled out in young adults, especially those with a smoking history and metabolic risk factors. ABI, Doppler, and CT imaging are key diagnostic tools. Acute arterial events superimposed on chronic disease require immediate recognition and treatment to prevent limb loss.

Keywords: Peripheral arterial disease, Critical limb ischemia, Intermittent claudication

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Ref No: 4940

EVALUATION OF TRAUMA SEVERITY IN ELECTRIC BICYCLE INJURIES

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[2]Kayseri City Hospital

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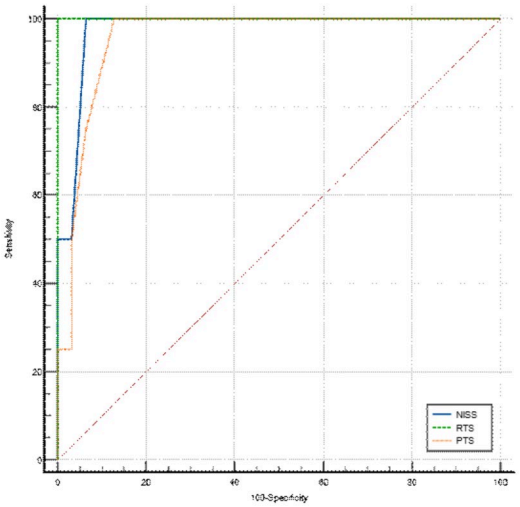
Introduction and Purpose: In our study, we aimed to determine the demographic data of the patients who visited the emergency department with electric bicycle (EB) injuries and evaluated the severity of trauma by using anatomical and physiological trauma scoring systems [New Injury Severity Score (NISS), Revised Trauma Score (RTS) and Pediatric Trauma score (PTS)].

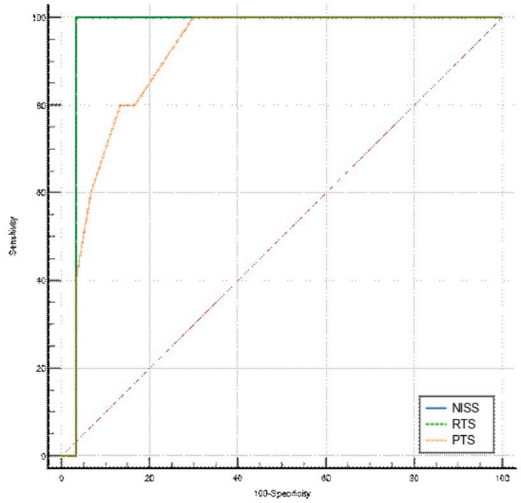
Materials and Methods: This prospective, descriptive, and single-center study was conducted on 106 patients with EB injuries who visited the Kayseri City Hospital emergency department between September 15, 2023, and December 15, 2023. Written consent was obtained from the patient and their relatives. ROC (receiver operator characteristic) analyses were performed on NISS, RTS, and PTS scores.

Results and Conclusion: The median age of the patients was 21.5 (15-39.5) years, and 69.8% (n=74) were male. While 12.8% (n=13) of the patients were admitted to the ICU, 6.6% (n=7) were found to have died. A statistically significant difference was detected between NISS, RTS, and PTS scores and ICU admission (p values=<0.001, <0.001, and 0.002, respectively). A statistically significant difference was found between NISS, RTS, and PTS scores and mortality (p values =<0.001, <0.001, and 0.002, respectively). The NISS score (AUC= 0.982) had the highest discriminatory ability in predicting ICU admission (p < 0.001). When the NISS score was greater than 13, its sensitivity in predicting ICU admission was 100%, specificity was 97.9%, positive predictive value was 86.7%, negative predictive value was 100%, positive likelihood ratio was 46.5, and negative likelihood ratio was 0.0. The RTS score (AUC= 0.996) demonstrated the highest discriminatory ability in predicting mortality (p< 0.001). When the RTS score was ≤10, its sensitivity in predicting mortality was 100%, specificity was 93.9%, positive predictive value was 53.8%, negative predictive value was 100%, positive likelihood ratio was 16.5, and negative likelihood ratio was 0.0. In our study, NISS, RTS, and PTS scores all had very high discriminatory ability in predicting ICU admission and mortality in patients presenting with EB injuries. Its sensitivity and negative predictive value were 100%, particularly in predicting ICU admission when the NISS score was greater than 13 and in predicting mortality when the RTS score was equal to or less than 10.

Comparison of ROC curves of scores for mortality



Comparison of ROC curves of scores for ICU admission



Distribution of injury sites in patients presenting with electric bicycle injuries

Injury area	n	%
Head	54	50,9
Neck	3	2,8
Anterior thorax	10	9,4
Posterior thorax	8	7,5
Abdomen	11	10,4
Shoulder	24	22,6
Arm	6	5,7
Forearm	28	26,4
Wrist	10	9,4
Hand	20	18,9
Pelvis	12	11,3
Thigh	10	9,4
Knee	37	34,9
Leg	8	7,5
Ankle	14	13,2
Foot	10	9,4
Vertebra	4	3,8

Keywords: Electric bicycle/scooter, multi-trauma, injury severity score

Ref No: 5012
Incidentally Detected Pulmonary Hydatid Cyst Following Trauma: A Case Report of a 10-Year-Old Male Patient
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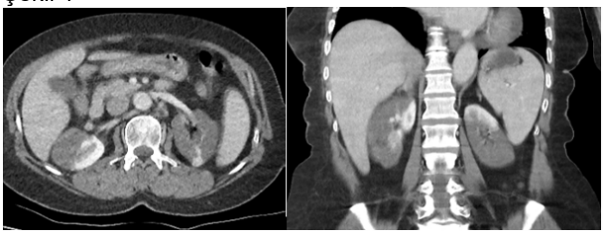
[1]**Department of Pediatrics, Faculty of Medicine, Aksaray University**
Introduction and Purpose: Introduction: Hydatidosis is a parasitic infection caused by Echinococcus granulosus, predominantly endemic in rural areas. Although hydatid cysts (HC) are relatively uncommon in children, they primarily affect the lungs when present. Humans act as incidental intermediate hosts upon ingestion of contaminated food or water containing parasite eggs excreted in the feces of infected dogs. Pulmonary hydatid cysts may present clinically with cough, chest pain, dyspnea, and hemoptysis. Here, we present the case of a 10-year-old male patient diagnosed incidentally with a pulmonary hydatid cyst following trauma.
Materials and Methods: Case Report: A 10-year-old male presented to the emergency department with difficulty breathing. Physical examination and vital signs led to further imaging to investigate potential underlying respiratory pathology. Thoracic computed tomography (CT) revealed a well-demarcated cystic lesion located in the posterior segment of the lower lobe of the right lung. The patient was subsequently referred to the pediatric emergency department for further evaluation. He reported a history of progressively worsening cough over the past 4-5 months. Physical examination findings included a good general condition, body temperature of 37.1 °C, pulse rate of 102 beats/min, respiratory rate of 22 breaths/min, and oxygen saturation of 97% on room air. Auscultation revealed decreased breath sounds in the right lower lung fields, while other systemic examinations were normal. Laboratory results showed leukocytes: 12,600/mm³, hemoglobin: 11.8 g/dL, platelets: 310,000/mm³, C-reactive protein: 9.8 mg/L, erythrocyte sedimentation rate: 14 mm/h, ALT: 96 U/L, AST: 88 U/L, LDH: 276 U/L, and eosinophil percentage: 6%. Chest radiography demonstrated opacity in the right hilar region and infiltrative changes in the lower zone. Thoracic ultrasonography identified a smooth-bordered, anechoic cystic lesion without septations. Clinical and radiological findings were consistent with pulmonary hydatid cyst. The patient was referred to thoracic surgery and infectious diseases departments for definitive management.
Results and Conclusion: Discussion: Pulmonary hydatid cysts in children are frequently asymptomatic and commonly detected incidentally. Clinical presentations can mimic respiratory infections, complicating differential diagnosis. Imaging studies following trauma may facilitate incidental identification of such lesions. Diagnosis is confirmed through radiological imaging and serological tests. Standard treatment involves surgical excision combined with antiparasitic therapy, typically albendazole.
Keywords: Pulmonary Hydatid Cyst, Pediatric Parasitic Infection, Incidental Radiological Finding

Ref No: 5082
Mekanik Trombektomi Uygulanan Nadir Bir Vaka: Bilateral Renal Enfarktüs
Merve Sandıkçı[1], **Gürkan Altuntaş**[1], **Özlem Bilir**[1]
[1]**Recep Tayyip Erdoğan Üniversitesi Eğitim ve Araştırma Hastanesi, Acil Tıp Anabilim Dalı, Rize, Türkiye**
Introduction and Purpose: Renal enfarktüs, böbreklerdeki kan akışının kesilmesi sonucu ortaya çıkan bir durumdur ve genellikle kardiyak emboli nedeniyle gelişir. Renal enfarktüs, çoğunlukla acil servise başvuran hastalarda, akut böbrek yetmezliği, karın ağrısı veya kanlı idrar gibi semptomlarla kendini gösterir. Bu olguda acil servise şiddetli karın ağrısı ile başvuran ve bilgisayarlı tomografi (BT) anjiografisi kullanılarak renal enfarktüs tanısı alan bir vaka anlatılacaktır.
Materials and Methods: 75 yaşında kadın hasta acil servise umblikus çevresinde başlayan şiddetli karın ağrısı şikayeti ile başvuruyor.Atrial fibrilasyon tanısı olan hastanın ağrısı rahatlamayınca çekilen BT anjiografisinde bilateral renal enfarktüs saptanıyor. Girişimsel radyolojiye konsülte ediliyor, trombektomi yapılan hasta nefroloji servisine interne ediliyor.
Şekil 1



Her iki böbreğin kontrast tutulumunda azalma mevcut
Şekil 2

Postoperatif 10.gününde sol renal arterde kanamaya bağlı gelişen retroperitoneal hematom

Results and Conclusion: Patofizyolojide embolik veya trombotik tıkanıklık nedeniyle vasküler akışta tam veya kısmi bir azalma, renal iskemisiye ve böbreğin fokal doku nekrozu ile enfarktüse yol açar. Renal BT arteriyografi, renal enfarktüs için altın standart incelemedir ve kesin tanıyı koyarak uygun tedavi kararının alınmasını sağlar. Renal enfarktüsü tedavi etmek genel olarak kateter yönlendirmeli tromboliz, sistemik tromboliz, antikoagülasyon, cerrahi tedavi olarak kategorize edilebilir.SonuçKlinik bulguları non spesifik olması sebebiyle renal enfaktüsten şüphelenmek ve hızlıca tanı koymak; en iyi önerilen tedavi olan ve ideal olarak enfarktüsten sonraki 6 saat içinde uygulanan katater yönlendirmeli tromboliz tedavisine olanak sağlar.

Keywords: renal enfarktüs, bt anjiografi, trombektomi

Ref No: 5121

"Silent Killer's Mark: Putaminal Hemorrhage in Carbon Monoxide Poisoning"

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Introduction and Purpose: Carbon monoxide (CO) is an odorless, colorless, and tasteless gas that is released from the incomplete combustion of carbon compounds. Patients commonly present to the emergency department with symptoms such as headache, nausea, vomiting, dizziness, shortness of breath, chest pain, and altered consciousness. Etiologies of intracerebral hemorrhage (ICH) include vasculopathies, coagulopathies, and drugs, with hypertension being the main cause. Hypertensive cerebral hemorrhages most frequently occur in the basal ganglia. Within the basal ganglia, they are most commonly seen in the putamen region.

Materials and Methods: A 37-year-old male patient, who was found unconscious at home by his wife, was brought to the emergency room by ambulance. In the patient's systemic examination, his general condition was moderate, and his Glasgow Coma Scale (GCS) was calculated as 14. The patient was confused, somnolent, and responsive to verbal stimuli. The patient's other system examinations were normal. In the anamnesis,It was learned that the patient lived in a house with a stove and that they had fallen asleep after lighting the stove. The patient was evaluated for CO poisoning. The patient was monitored, and his vital signs were stable.100% normobaric oxygen therapy (NBOT) was immediately initiated with a face mask. Complete electrocardiogram (ECG), blood count, biochemistry, blood gas, troponin,,coagulation values a brain computed tomography (BBT) scan and diffusion magnetic resonance imaging were requested. The patient's blood gas analysis revealed respiratory alkalosis, and the COHb level was measured at 41%. BBT showed a hyperdense area of approximately 10 mm in diameter in the right putamen region. The patient was consulted with a neurology specialist. Since hyperbaric oxygen (HBO) therapy could not be performed in our hospital, the patient was transferred to a tertiary center. The patient it was learned that he was discharged with complete recovery.

Results and Conclusion: CO poisoning is still very common in our country, especially in the winter months. The initial treatment in these patients is NBOT. However, patients with COHb levels above 25%, pregnant women with levels above 15%, those with ischemic chest pain and elevated troponin or ECG changes, patients with pH < 7.1, and patients with neuropsychiatric findings should definitely receive HBO therapy.

Keywords: CO intoxication, Putamen hemorrhage, HBO

Ref No: 5148

Imaging Techniques Preferred in Patients Presenting to the Emergency Department with Renal Colic: Which Technique for Which Patient

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[2]**Health Sciences University, Erzurum City Hospital, Urology Clinic**

Introduction and Purpose: Objective: Renal colic is one of the frequently encountered acute conditions in the emergency department. In most cases, pain is alleviated with simple analgesics, but in some instances, even the strongest painkillers may not be effective. Although patients sometimes present with additional complaints such as macroscopic hematuria, decreased urine output, fever, nausea, and vomiting, in other cases, the only symptom may be flank pain. The aim of this study is to determine when and which imaging techniques should be used in these patients.

Materials and Methods: Method: A total of 132 patients who presented to the emergency department with renal colic between January

2025 and February 2025 were retrospectively evaluated. The patients' presenting complaints, laboratory techniques, imaging methods, and treatment procedures were recorded.

Results and Conclusion: Results: All 132 patients presented with flank pain, 6 of whom had macroscopic hematuria, 101 had microscopic hematuria, 12 had microscopic hematuria with fever, 8 had fever along with nausea and vomiting, and 5 patients had isolated flank pain. A total of 64 patients had no imaging performed, all of whom had a history of prior stone passage. 41 patients had a radiograph (KUB), 27 had an ultrasound (USG), and 23 underwent spiral CT. It was observed that 5 patients were pregnant, and all of them underwent ultrasound.Conclusion: Asking whether patients with renal colic have a history of prior stone passage and referring them to urology after pain relief helps protect patients from unnecessary imaging and radiation. Additionally, for stones that cannot be visualized on KUB and do not cause microscopic hematuria, we believe that performing an ultrasound (USG) or, if necessary, a spiral CT scan would be beneficial to clarify the cause of pain.

Keywords: Renal colic, Imaging, Stone

Ref No: 5195

Myasthenia Gravis Secondary to Thymoma

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[1]ANKARA BİLKENT ŞEHİR HASTANESİ

Introduction and Purpose: Myasthenia Gravis (MG) is an autoimmune disease that causes muscle weakness due to dysfunction at the neuromuscular junction (the connection between nerves and muscles). The disease results in impaired transmission of nerve signals that control muscle contractions, due to autoantibodies developed against acetylcholine receptors.The clinical symptoms of Myasthenia Gravis are characterized by muscle fatigue and weakness, which may improve with rest or become more pronounced later in the day.Diagnosis is based on clinical findings, electrophysiological tests, and antibody screening, with special consideration given to the role of the thymus gland and other potential etiological factors.

Materials and Methods: A 46-year-old male patient presented to the emergency department with complaints of slurred speech, throat burning, itching, and difficulty swallowing for the past 15 days. The patient has no known chronic medical history and is not on regular medication. On physical examination, Glasgow Coma Score:15, blood pressure:110/80mmHg,Heart rate:86 bpm,blood glucose level:106 mg/dL. Electrocardiogram:Sinus rhythm.Neurological examination revealed the patient was alert, cooperative, and oriented, with slurred but meaningful speech. Pupils were equal and reactive to light (direct and indirect reflexes ++/++).Muscle strength in both upper and lower extremities was 5/5 bilaterally.Cerebellar tests were bilateral and coordinated.Routine laboratory tests were ordered, and to rule out acute cranial pathologies, a brain CT and diffusion MRI were performed.Results revealed no significant abnormalities.The differential diagnosis included viral upper respiratory tract infections, cranial nerve palsies, oropharyngeal masses, vocal cord paralysis, and Myasthenia Gravis. Consequently, a neck CT and thoracic CT were requested. The thoracic CT report noted "A 39x23 mm soft tissue density nodule in the anterior mediastinum, potentially indicative of lymphoma or thymoma."Consultation with neurology and thoracic surgery.The patient’s symptoms improved with IVIG treatment, and no active symptoms were observed post-surgery.

Results and Conclusion: Myasthenia Gravis is an autoimmune neuromuscular disorder characterized by muscle weakness and fatigue.This case highlights the rare but significant association between Myasthenia Gravis and thymoma.Early diagnosis and appropriate treatment can significantly improve patients' quality of life. In the differential diagnosis of Myasthenia Gravis, early and careful neurological evaluation, along with comprehensive diagnostic testing, plays a crucial role in increasing diagnostic accuracy and guiding treatment decisions.

Keywords: Myasthenia Gravis, thymoma, parathymic syndrome

Ref No: 5198

Can Microbiome Affect Your Intelligence?

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[1]Central Asian University

Introduction and Purpose: Recent scientific research has highlighted a significant connection between the gut microbiome and cognitive function, mediated by the gut-brain axis—a bidirectional communication system linking the digestive tract and the brain. Microorganisms in the gut influence brain activity by producing substances such as short-chain fatty acids and neurotransmitters that can cross into the brain and affect cognitive processes. This growing body of evidence suggests that the gut microbiota may play a crucial role in maintaining brain health and cognitive performance. The purpose of this study is to explore how diet and specific gut-related interventions impact the microbiome and, in turn, influence cognitive function.

Materials and Methods: Dietary patterns are key modulators of the gut microbiome. The Mediterranean diet, characterized by high intake of fruits, vegetables, whole grains, and healthy fats, has been examined for its effects on cognition and microbial diversity. In contrast, diets rich in processed foods and low in fiber have been associated with dysbiosis and mental decline. Studies also consider the effects of fermented foods such as kimchi and miso, which are high in probiotics, and prebiotic-protein supplements that aim to enhance gut health. These interventions are assessed through their influence on anxiety, depression, memory, and overall cognitive ability, with measurements of microbial composition, neuroactive chemical production, and immune markers used to evaluate outcomes.

Results and Conclusion: Evidence indicates that dietary interventions positively influencing gut microbiota—such as consuming fermented foods or following a Mediterranean diet—can lead to improvements in memory, reduced anxiety and depression, and better overall cognitive health. Gut bacteria affect the brain by producing neuroactive chemicals, regulating immune responses, and maintaining the integrity of gut and brain barriers. When gut microbial balance is disrupted, inflammation and harmful immune responses

may contribute to cognitive decline. Therefore, maintaining a healthy and diverse gut microbiome through diet may serve as an effective strategy to enhance brain function and prevent mental deterioration. Continued research is necessary to fully understand the underlying mechanisms and to develop targeted gut-based therapies for supporting cognitive health.

Keywords: Gut-brain axis, probiotics, mental health

Ref No: 5202

Basilar Artery Thrombosis: Management of a Challenging Cerebrovascular Crisis

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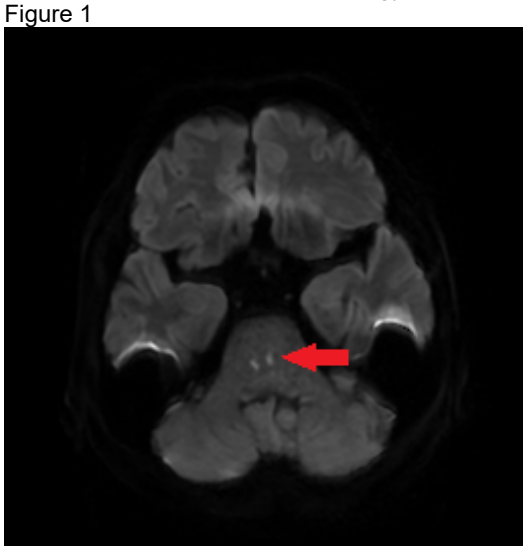
Introduction and Purpose: Ischemic stroke is a significant cause of cerebrovascular diseases, and basilar artery occlusion is one of its severe forms. Early diagnosis and treatment can improve patient prognosis. This case report presents a patient diagnosed and treated for a thrombus at the basilar artery level.

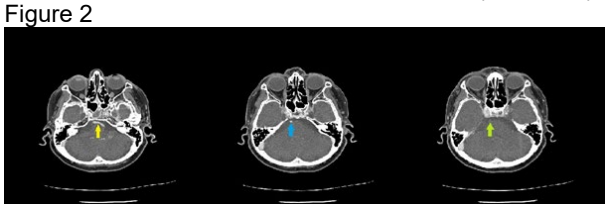
Materials and Methods: A 56-year-old female patient presented with complaints of headache, drowsiness, weakness, and vomiting. On physical examination, there was no motor or sensory deficit in the extremities, but the patient had difficulty walking. Her blood pressure was approximately 240/140 mmHg, and a nicardipine infusion was initiated. Imaging revealed a thrombus at the basilar artery level, and neurology was consulted. Due to the timing of presentation, thrombolytic therapy was contraindicated, and the patient did not receive thrombolytics. She was promptly referred to interventional radiology; however, thrombectomy was unsuccessful due to chronic stenosis. During the procedure, the patient received heparin, and ASA, clopidogrel, and enoxaparin were subsequently recommended. The patient was admitted to the neurology stroke unit.

Figure 1



DWI- MRI demonstrated diffusion restriction (red arrow)

Figure 2



Contrast-enhanced imaging demonstrating persistent basilar artery flow (yellow and blue arrows) and the occluded basilar artery segment following thrombus formation (green)

Results and Conclusion: Early intervention is critical in the treatment of ischemic stroke. In this case, despite the contraindication for thrombolytic therapy and the unsuccessful thrombectomy due to chronic stenosis, appropriate anticoagulation and antiplatelet therapy may improve patient prognosis. The literature includes various studies on the treatment of basilar artery thrombosis and thrombectomy outcomes.Basilar artery thrombosis is a significant cause of cerebrovascular disease and requires timely treatment. This case highlights the importance of early detection and initiation of treatment in managing thrombus formation.

Keywords: Ischemic stroke, basilar artery, thrombectomy

Ref No: 5203

Potentially Fatal Teleradiology Error in Tomography Reporting – A Case Presentation of Pulmonary Embolism

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Introduction and Purpose: Imaging techniques are an indispensable tool in modern medicine. One of the significant challenges in this field is the increasing number of diagnostic examinations. Here, our aim is to present a case where pulmonary embolism was detected in

CT angiography images, despite being reported as normal in the teleradiology report.
Materials and Methods: Case: A 70-year-old female patient presented to an external center with complaints of dyspnea. After evaluation there, she was referred to our ED for further imaging needs. Upon arrival, vital signs were within normal limits, and she had no fever. The electrocardiogram (EKG) showed a normal sinus rhythm. D-dimer was elevated at 2.77 (<0.55). Contrast-enhanced CT pulmonary angiography (CTA) revealed a filling defect consistent with emboli in the right main pulmonary artery. Surprisingly, the teleradiology report provided via telemedicine reported the CT image as normal. She was admitted to the Chest Diseases service.
Results and Conclusion: We believe that accuracy percentages of teleradiology reports can be revealed, and a transition to a more patient-centric teleradiology reporting system can be facilitated. Additionally, there is a need for legal and administrative studies that clearly outline the legal aspects of teleradiology reports.
Keywords: Emergency Medicine, Pulmonary Embolism, Teleradiology

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Ref No: 5258
SILENT DANGER: THE HIDDEN RISKS OF HYPOCALCEMIA IN ELDERLY PATIENTS UNDERGOING COLONOSCOPY PREPARATION
Dilek Atik[1], Aslıhan Onuralp[1], Burcu Sena Aydın[1], Boran Polat[1], Hatice Şeyma Akça[1]
[1]Karamanoglu Mehmetbey University
Introduction and Purpose: Hypocalcemia is a common and often underrecognized electrolyte imbalance that can present with a range of clinical manifestations, from mild neuromuscular irritability to life-threatening conditions like tetany and arrhythmias.
Materials and Methods: We report the case of a 78-year-old woman who developed symptomatic hypocalcemia following a 3-day liquid diet in preparation for a colonoscopy. The patient presented with muscle spasms in her fingers, which were suggestive of neuromuscular irritability due to hypocalcemia. Laboratory tests revealed a serum calcium level of 6.5 mg/dL, confirming the diagnosis. The patient's hypocalcemia was likely precipitated by the prolonged restriction of calcium intake during colonoscopy preparation. Calcium replacement therapy was initiated, and the patient's symptoms improved. .
Results and Conclusion: This case highlights the importance of recognizing and managing hypocalcemia in elderly patients, particularly in situations involving dietary restrictions, and underscores the need for careful pre-procedural management to prevent electrolyte disturbances.
Keywords: Hypocalcemia, colonoscopy, emergency medicine

Ref No: 5274
A case of necrotising fasciitis after intramuscular injection
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Introduction and Purpose: Necrotising fasciitis (NF) is a life-threatening soft tissue infection that spreads rapidly and affects subcutaneous tissue and fascia. NF usually develops after traumas, surgical interventions or microtraumas and mortality and morbidity rates increase if not treated in time. NF can develop even after simple medical interventions such as intramuscular injection and is a rare and fatal complication.
Materials and Methods: A 67-year-old male patient presented to the emergency department with complaints of pain, redness and swelling in the left thigh after intramuscular injection. On physical examination, left thigh swelling, increased temperature and pain with passive movement were observed. In the following days, ecchymotic bullous lesions developed in the affected area and spread to the perineal region. Cultures grew Staphylococcus aureus and broad-spectrum antibiotherapy was started, but the patient's condition deteriorated rapidly and the patient died in intensive care unit due to cardiopulmonary arrest.
Results and Conclusion: Early diagnosis, aggressive surgical debridement and appropriate antibiotherapy are important treatment modalities that increase the chance of survival in NF. In addition, differentiation of streptococcal toxic shock syndrome is vital in the treatment process.
Keywords: Necrotising fasciitis, Intramuscular injection, Mortality

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Ref No: 5281
A Rare Case Report: Isolated Oculomotor Nerve Palsy
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Introduction and Purpose: The oculomotor nerve (3rd Cranial Nerve), trochlear nerve (4th Cranial Nerve), and abducens nerve (6th Cranial Nerve) are considered the motor nerves of the ocular structure and provide innervation to the eye muscles. Third cranial nerve palsy is typically a cranial nerve injury occurring around the age of 60, associated with vascular risk factors (such as diabetes mellitus, hyperlipidemia, hypertension, coronary artery disease, etc.), which often resolves spontaneously and is not attributed to another diagnosis upon further investigation. The aim of this study is to emphasize the necessity of considering rare third cranial nerve palsy in patients presenting with sudden onset headache, diplopia, and loss of balance.
Materials and Methods: 62 year old female patient presented to the emergency department complaining of sudden onset dizziness, headache, and diplopia. The patient reported no history of trauma and stated that these complaints were occurring for the first time and had a sudden onset. Upon reviewing her medical history, she reported diagnoses of hypertension (HT) Type 2 Diabetes Mellitus (DM). On physical examination, the neurological assessment revealed no lateralizing signs or loss of strength. Pathologically, our examination detected outward and downward deviation of the right eye, with limitation of inward, upward, and downward gaze. Laboratory parameters showed no abnormalities except for a blood glucose level of 320 mg/dl. Brain computed tomography (CT) and diffusion-weighted magnetic resonance imaging (MRI) revealed no pathological findings. Review of her records indicated periods of poor blood

glucose regulation. Following the examination in this patient with a long-standing diagnosis of DM, isolated 3rd cranial nerve palsy was suspected. The patient was consulted by the Ophthalmology and Neurology departments. She was admitted to the Neurology Service for blood glucose regulation and monitoring of her condition

Results and Conclusion: Isolated oculomotor nerve palsy (ONP) is a clinical condition often attributed to microvascular ischemia resulting from causes such as diabetes, hypertension, aneurysms, and trauma. In our case, the long-standing history of diabetes mellitus (DM) suggests a microvascular ischemic origin for the ONP.Furthermore, diabetic patients presenting to the emergency department require a detailed neurological examination and a comprehensive ophthalmological assessment. Early diagnosis and follow-up are crucial in such cases.

Keywords: Oculomotor, Palsy, Diabetes Mellitus

Ref No: 5298

Beyond Eye Pain: Diagnosis of Bilateral Posterior Scleritis in the Emergency Department

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[2]Department of Emergency Medicine, Ankara Bilkent City Hospital, Ankara, Türkiye

Introduction and Purpose: Scleritis is a rare but serious chronic inflammation of the sclera, often associated with autoimmune systemic diseases. In patients presenting with eye pain, delayed diagnosis may lead to permanent vision loss. Therefore, scleritis should be considered in the evaluation of patients with eye pain in the emergency department. In this case, we aimed to emphasize the importance of early recognition of scleritis in the emergency department.

Materials and Methods: Case Presentation: A 54-year-old female patient presented to the emergency department with eye pain persisting for about three weeks. Her medical history included diabetes mellitus (DM), but she was not using medication. On physical examination, swelling, pain, tearing, and redness spreading from the left eye to both eyes and eyelids were observed (Figure 1). The pain was more severe in the left eye. Orbital CT imaging revealed thickening and contrast enhancement in the posterior segments of the bilateral sclera, along with mild infiltration in the retrobulbar fat tissue (Figure 2). The findings suggested scleritis, and the patient was referred to ophthalmology.In the ophthalmologic evaluation, eye movements were free but painful bilaterally. Color vision assessment was limited due to poor patient cooperation. On biomicroscopy, both eyelids were red and edematous; conjunctiva was hyperemic, cornea was clear, anterior chambers were calm, and pupils were central and regular. Posterior synechia was present in the left eye. On ocular ultrasonography, bilateral scleritis was suspected (Figures 3 and 4 - T sign). Fundus examination of the right eye was normal. OCT of the right eye showed papillomacular subretinal fluid (SRF); choroidal fold and papillitis were seen in the left (Figure 5). With a diagnosis of bilateral scleritis, the patient was admitted to the ophthalmology ward for further investigation and treatment for immune system diseases such as rheumatoid arthritis, systemic lupus erythematosus, and granulomatosis with polyangiitis.

Figure 1. Swelling, pain, tearing, and redness starting in the left eye and later spreading to both eyes and eyelids.

Figure 2. Thickening and increased contrast enhancement in the posterior segments of the bilateral sclera, with mild haziness in the retrobulbar fat tissue.

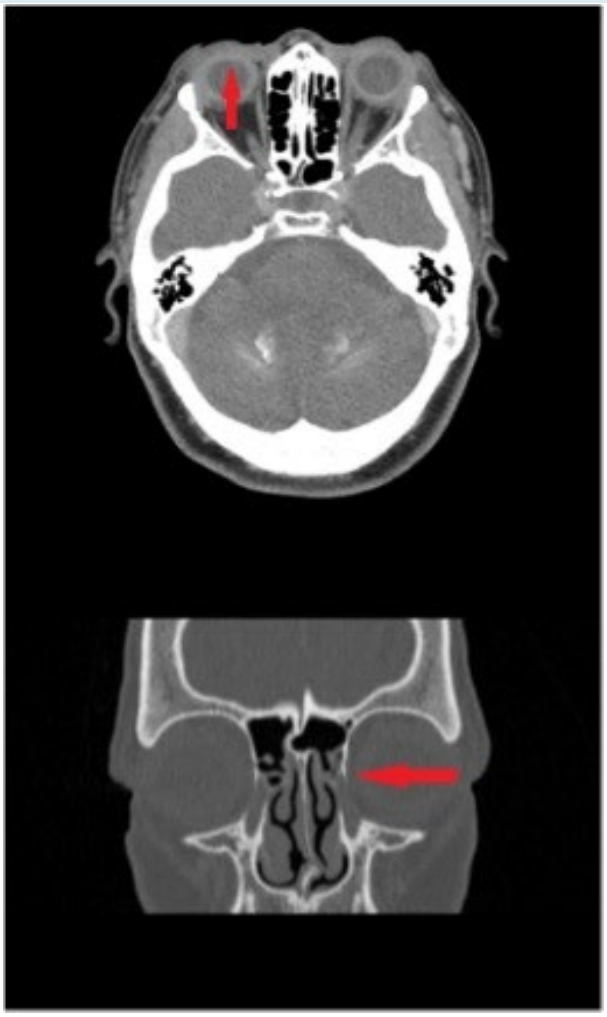


Figure 3. Scleral thickening on ultrasonography.

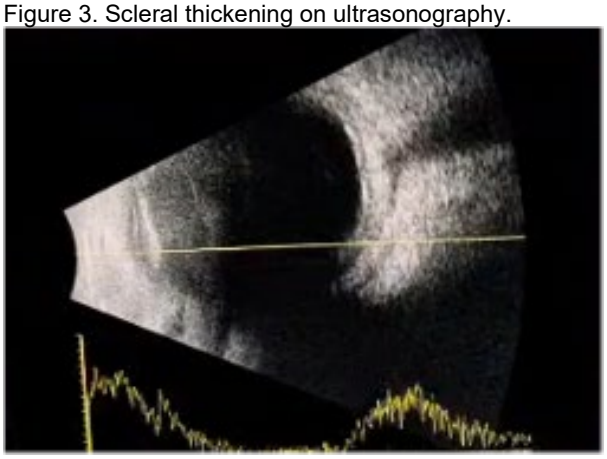


Figure 4. T sign on ultrasonography.

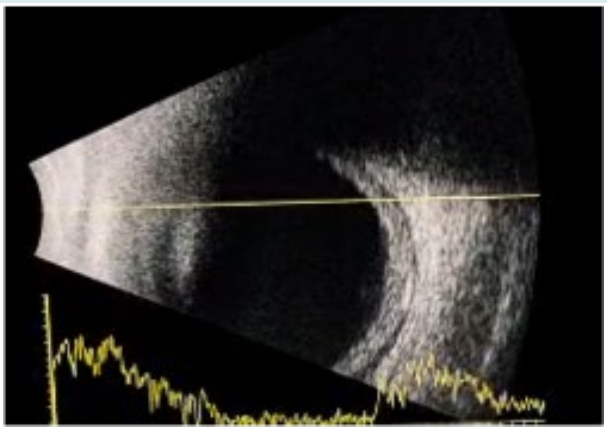
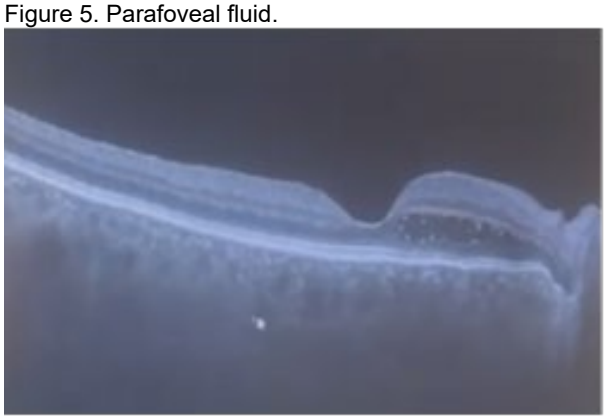


Figure 5. Parafoveal fluid.



Results and Conclusion: This case highlights the critical role of early diagnosis and appropriate treatment of scleritis in the emergency department in preventing vision loss. As scleritis may be linked to systemic diseases, comprehensive evaluation is needed. Immunosuppressive agents and corticosteroids may be effective in treatment; however, regular follow-up is crucial to prevent possible complications.

Keywords: Posterior Scleritis, Emergency Department, Ocular Ultrasonography

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Ref No: 5377

Datura Stromonium Poisoning: A Report On Six Cases

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[2]Ondokuz Mayıs University Faculty of Medicine, Department of Emergency Medicine,

Introduction and Purpose: Datura stramonium is a plant that contains tropane alkaloids (scopolamine, atropine, hyoscyamine) and exhibits anticholinergic toxic effects. These toxins can affect the central and peripheral nervous systems, leading to symptoms such as hallucinations, agitation, delirium, tachycardia, and euphoria. Poisoning typically occurs due to misidentification of the plant, accidental ingestion, or misuse. Particularly in rural areas, cases of poisoning are frequently observed due to insufficient awareness of the plant's toxic effects. In this study, six patients who experienced poisoning related to Datura stramonium consumption were evaluated.

Materials and Methods: The patients presented to the emergency department with symptoms approximately 2 hours after consuming a meal that contained a wild herb. The ages of the patients ranged from 50 to 86, with 2 patients having diabetes and hypertension, and 1 patient having only hypertension. Datura stramonium was identified in the plant samples brought in by the family. No pathological findings were observed in the patients' blood and imaging tests. The clinical picture exhibited typical symptoms of anticholinergic syndrome, including hallucinations, agitation, tachycardia, euphoria, nausea, and vomiting. Symptomatic approaches were applied during the treatment process, and one patient was administered physostigmine. Some patients underwent gastric lavage and received activated charcoal, while haloperidol was used for agitation control. All patients fully recovered and were discharged within 24 hours. Two patients chose to be discharged early at their own request.

Table 1

#####	WBC	Neu	Hb	PLT	BUN	Cre	ALT	AST	pH	HCO3	CO2	CRP	Plasma Cholinesterase Level
Case1	8,27	5,57	11	357	24	0,75	7	13	7,39	24	40	6	-

Case2	7,1	4,5	11,2	380	19	0,88	7	15	7,38	24	41	3	-
Case3	8,1	4,5	12,8	282	14	0,6	8	18	7,40	25	43	3	9624
Case4	8,2	6,3	12,3	339	17	1,35	22	14	7,36	28	57	17	8607
Case5	10,6	8,9	14,4	185	14	0,56	13	17	7,35	26	56	8	8748
Case6	11,4	9,4	12,6	310	16	0,87	8	26	7,37	23	43	11	9650

Patients Laboratory Values

Results and Conclusion: Datura stramonium poisoning is frequently observed, especially in rural areas, due to the misidentification of plants. The prominent symptoms of anticholinergic syndrome, such as hallucinations, agitation, and tachycardia, are noteworthy. Symptoms can vary depending on the amount consumed, the individual's age, and metabolic characteristics. Treatment is generally symptomatic; physostigmine may be used in severe cases. It is important to raise public awareness about toxic plants and to educate healthcare professionals in the management of such cases to prevent poisoning. This case series shows that positive outcomes can be achieved with effective management of Datura stramonium poisoning.

Keywords: Toxins, Datura Stromonium, Anticholinergic Toxidroms

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Ref No: 5420

A Rare and Distressing Case

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[1]Atatürk University Faculty of Medicine Department of Emergency Medicine

Introduction and Purpose: A 6-year-old male patient was brought to the emergency department following a dog bite. His general condition was moderate upon arrival, with a Glasgow Coma Score (GCS) of 15, and his vital signs were stable. The incident occurred while the child was walking on the street, and the dog attacked him for an unknown reason.

Materials and Methods: The patient presented with a 2 cm-wide wound located laterally to the umbilicus, which appeared deep enough to potentially penetrate the abdominal cavity. Additionally, subcutaneous emphysema was noted in the neck. Given the potential for abdominal perforation and a life-threatening neck injury, immediate radiographs and computed tomography (CT) scans were performed after all necessary emergency procedures.Imaging confirmed an abdominal perforation, prompting a pediatric surgery consultation. The patient was subsequently transferred to the pediatric surgery department for further evaluation and surgical intervention.

image 1

image 3

image 2

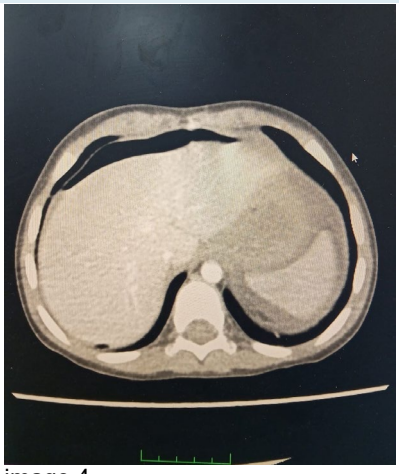
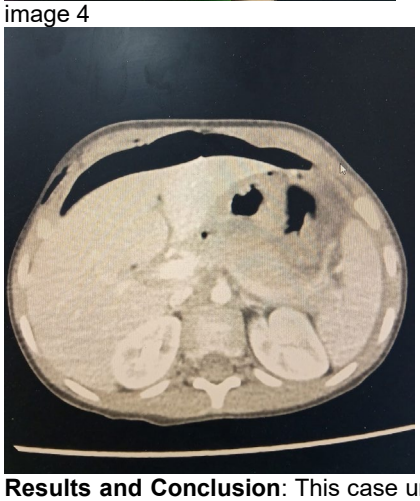


image 4



Results and Conclusion: This case underscores the heightened likelihood of severe injuries in pediatric patients compared to adults. If the same bite had occurred in an adult, surgery may not have been required. Key factors in this case included the length of the dog's teeth, as well as the thinner subcutaneous fat and abdominal wall in children, which make them more vulnerable to penetrating injuries. Early recognition and appropriate management of such injuries are crucial for positive outcomes in pediatric trauma cases.

Keywords: dog, bite, perforation

Ref No: 5462

Rib Fractures

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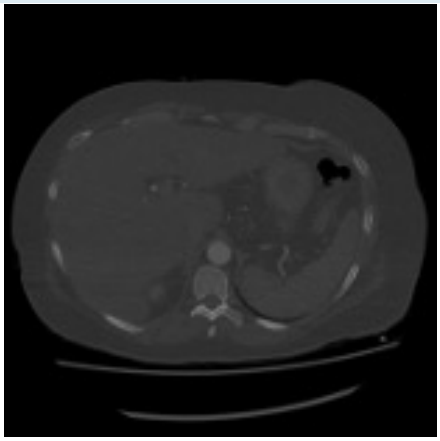
[1]Atatürk Üniversitesi

Introduction and Purpose: Rib fractures are common injuries that typically occur following blunt thoracic trauma, but they can also result from severe coughing, athletic activities (such as rowing, swinging a golf club, or throwing), and non-accidental trauma (such as child abuse). Associated injuries and complications can range from mild discomfort to life-threatening conditions such as pneumothorax, splenic rupture, and pneumonia. In this study, we aim to present a 55-year-old female patient with rib fractures who presented with abdominal pain.

Materials and Methods: A 55-year-old female patient presented to the Emergency Department with abdominal pain that had been ongoing for 2 days. On admission, her general condition was moderate, with a Glasgow Coma Scale (GCS) of 15, and her vital signs were normal. Her medical history included daily alcohol consumption, hypertension, diabetes mellitus, and coronary artery disease. On physical examination, there was guarding in the left upper quadrant. A peripheral intravenous line was established, and blood tests were requested. Her gamma-glutamyl transferase (GGT) level was found to be 1008. A contrast-enhanced abdominal CT scan was performed, which showed displaced fracture lines in the anterior aspects of the 6th, 7th, and 8th ribs on the left side (Figure 1). The patient, who was an alcoholic, did not recall the trauma. She was consulted to the Thoracic Surgery Department, admitted, and treatment was initiated.

Results and Conclusion: It should be remembered that in patients with alcohol dependency, rib fractures may occur if there is a history of thoracic trauma. The treatment of rib fractures should focus on early and adequate pain management to prevent complications such as splinting and atelectasis (e.g., pneumonia). For isolated rib fractures, analgesia may involve non-opioid or opioid analgesics, as well as nonsteroidal anti-inflammatory drugs (NSAIDs). For more severe injuries, intercostal nerve blocks are an effective approach but usually require hospitalization.

Figure 1



Keywords: Rib Fracture, Alcohol Dependency

Ref No: 5471

From chest trauma to Ewing sarcoma

erhan şahin[1], ayça çalbay[1]
[1]atatürk üniversitesi

Introduction and Purpose: Ewing's sarcoma is a rare and aggressive tumor that arises in bones and soft tissues. It is typically seen during childhood and adolescence. It is commonly found in the chest cavity, pelvis, long bones, and spine. In many cases, it is incidentally detected during radiological imaging following trauma.

Materials and Methods: A 14-year-old male patient presented to the emergency department with severe chest pain following trauma. Physical examination revealed tenderness in the left chest wall. A chest X-ray and thoracic CT scan, performed due to the trauma history, revealed a solid mass lesion in the left ribs. The patient was referred to oncology, and subsequent follow-up biopsies confirmed the diagnosis of Ewing's sarcoma.

Results and Conclusion: Ewing's sarcoma is a tumor that can be successfully managed with chemotherapy and surgical treatment when diagnosed early. This case emphasizes that a simple trauma complaint can lead to a serious diagnosis and that malignancy should be ruled out in patients with persistent pain after trauma. Tumors located in the chest wall have a better prognosis with early diagnosis and a multidisciplinary approach.

image1

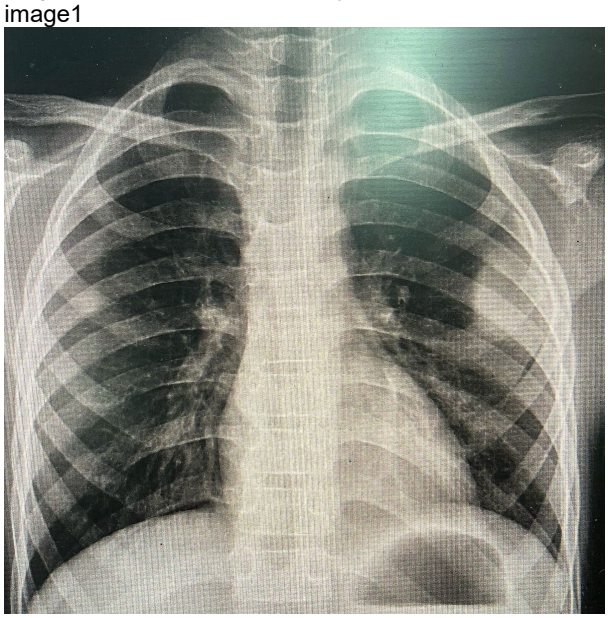


image2

Keywords: ewing sarcoma, chest travma, pediatric oncology

Ref No: 5472

Evaluation of the relationship between blood lipase level and computed tomography severity index in patients presenting to the emergency department with abdominal pain

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Introduction and Purpose: Acute pancreatitis (AP) is an inflammatory condition affecting the pancreas, typically caused by gallstones or excessive alcohol consumption. Most AP cases present a mild course, with patients often experiencing rapid improvement after receiving fluid resuscitation, pain control, and early initiation of oral feeding. Nonetheless, around 20-30% of cases can be severe, with a mortality rate up to 15% among those affected. Therefore, early recognition of these patients is critical, and treatment should be initiated promptly and more intensively. The computed tomography severity index (CTSI) score is one of the most frequently used scores in predicting the severity of acute pancreatitis. This study aimed to evaluate whether there was a correlation between lipase levels and CTSI scores. Also, whether there was a relationship between lipase levels and pancreatic necrosis and non-pancreatitis causes of lipase elevation was evaluated.

Materials and Methods: Demographic data and lipase values of patients presenting to the emergency department (ED) with abdominal pain were evaluated retrospectively. CT images which have taken at the time of ED admissions were re-interpreted by a radiologist. The CTSI scores were calculated.

Study flow chart

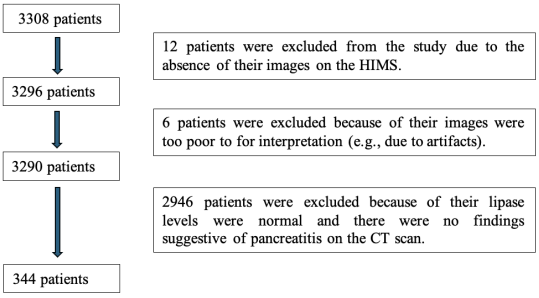

Figure 1: Study Flow Chart

Parameters and calculation of CTSI score

Grade	Grading of pancreatitis	Score
A	Normal pancreas	0

B	Pancreatic enlargement	1
C	Pancreatic inflammation and/or peripancreatic fat	2
D	Single peripancreatic fluid collection	3
E	Two or more fluid collections and/or retroperitoneal air	4
Necrosis Percentage		Score
0		0
<30		2
30-50		4
>50		6
Result (Multiply by grading of pancreatitis score and necrosis percentage score)		
0-3		Mild acute pancreatitis
4-6		Moderate acute pancreatitis
7-10		Severe acute pancreatitis

Results and Conclusion: 344 patients were included in the study. Eleven (9.7%) of the patients with pancreatitis on CT, had normal lipase levels. We found that the blood lipase levels of patients with pancreatitis on CT were statistically significantly higher when compared to patients without pancreatitis on CT [2378 U/L - 285 U/L; ($p<0.01$)]. Lipase levels were significantly lower in patients who have necrosis on CT scans than in those without [392.3 U/L - 2500.6 U/L; ($p<0.01$)]. We found a significant inverse relationship between CTSI score and lipase level [Mild: 2061.2 U/L; Moderate: 3426.4 U/L; Severe: 89 U/L; ($p<0.01$)]. CT imaging and CTSI scoring should be used in conjunction with lipase levels to provide a more comprehensive assessment of pancreatitis severity.
Relationship between lipase level and pancreatitis

	Elevated Lipase Levels		
Pancreatitis on CT	Yes	No	Total
Yes	102	11	113
No	231	2946	3177
Total	333	2957	3290

Distribution of patients according to CTSI score

CTSI Score	Patients (n)	Mean Lipase Level (U/L)
Mild Pancreatitis (0-3)	81	2061.2
Moderate Pancreatitis (4-6)	30	3426.4
Severe Pancreatitis (7-10)	2	89

Keywords: acute pancreatitis, computed tomography severity index (CTSI), lipase

Ref No: 5523

PATIENT ADMITTED TO CARDIOLOGY FOR UPPER RESPIRATORY TRACT INFECTION

şamil emin yalçın[1], sultan tuna akgöl gür[1], muhammet emin akgün[1]
[1]emergency department of ataturk university

Introduction and Purpose: sinus tachycardia is a physiologic response of the body to fever, exertion, excitement, stress, shortness of breath, etc., in which the pulse rate is above 100 but the impulses originate from the sinoatrial node. No matter how physiologic the reaction of the patient, we need to correct the tachycardia by correcting the underlying cause.

Materials and Methods: A 50 y male patient with known diabetes mellitus and hypertension was admitted to the emergency department with complaints of fever and joint pains for 2 days. The patient's vitals showed ta:112/68 sat:96 nb:148 fever:39.2. The patient's ECG showed sinus tachycardia with a rate of 150. The patient had cryptic tonsillitis on examination. No acute pathology was observed in external examinations. No acute pathology was observed in the patient's tests and imaging including troponin. The patient's fever was reduced to 36.8 with symptomatics. The patient stated that his complaints were relieved, but his tachycardia did not fall below 140s. When a control ECG was performed 1 hour later, elevations and depressions around 1 small square in the patient's ECG were observed and the patient was consulted to the cardiology clinic. The cardiology clinic started to perform rate-breaking intervention. After 3 doses of diltizem were repeated, the patient's ECG was observed as af with rapid ventricular response and the patient was hospitalized by cardiology. Af was corrected with cordarone infusion and the patient was discharged.

Results and Conclusion: When we see sinus tachycardia in our patients, we usually do not panic because we all know that if we correct the underlying cause, the tachycardia will resolve. However, if the patient's tachycardia does not resolve and there are no other symptoms, it may be of cardiac origin or if it persists for a long time, cardiac involvement may start. Even if the patient has sinus tachycardia, we should always keep in mind the cardiac involvement and that there is no cardiac cause until the tachycardia resolves.

Keywords: sinus tachycardia, fever

Ref No: 5528

The Contribution of Establishing a Critical Care Unit in the Emergency Department to Healthcare Delivery

Bahri Oğulcan Tabak[1], Burcu Simge Eroğlu[1], Lütfi Anıl Güdek[1], Akın Seçkin[1], Eda Harun[1], Buse Betül Küçükkaya Gündoğdu[1], Mustafa Köksal[1], Bora Çekmen[1]
[1]Department of Emergency Medicine, Karabük University School of Medicine, Karabük, Turkey.

Introduction and Purpose: The growing elderly population has led to an increased demand for intensive care services. In Turkey, high ICU occupancy rates result in critically ill patients remaining in emergency departments (EDs) for extended periods. To address this issue, a critical care unit was established within the ED of Karabük Training and Research Hospital in October 2024. This study aims to evaluate the impact of the critical care unit on patient outcomes and ED processes.

Materials and Methods: This retrospective study was conducted in the emergency department of Karabük Training and Research Hospital. Patients who presented to the emergency department between October 1, 2023, and February 28, 2024 (prior to the establishment of the critical care unit), and between October 1, 2024, and February 28, 2025 (after the unit was established), were included if they were triaged as yellow or red by the triage team and were subsequently determined to require intensive care.Data collected included demographic characteristics, length of stay in the emergency department and intensive care unit, in-hospital mortality, 28-day mortality, and the need for inotropic support in the emergency department.Demographic data are presented as mean ± standard deviation (SD) or median [interquartile range, IQR]. For group comparisons, the Kruskal-Wallis and Mann-Whitney U tests were used for non-parametric data, and Pearson's chi-square test was applied for categorical variables.

Results and Conclusion: A total of 625 patients were included in the study. The median age of the patients was 76 years [64–84], and 276 (44.2%) were female. Patients were classified into 14 diagnostic categories (Figure 1). When 28-day mortality rates were evaluated, a significant reduction in mortality was observed following the establishment of the critical care unit ($p = 0.017$). Additionally, the median emergency department length of stay increased from 282 minutes [180–432] before the implementation of the critical care unit to 341 minutes [200–610] afterward ($p = 0.003$) (Table 1).While the establishment of the critical care unit in the emergency department was associated with a reduction in 28-day mortality, it also led to delays in the transfer of patients to the intensive care units.

Figure 1. Diagnostic Categories

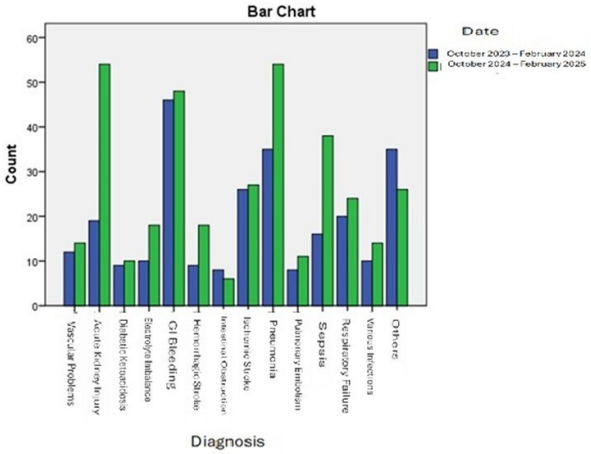

Table 1.Pre- and Post-Critical Care Unit Data

	Total (n:625)	Critical Care		P Value
		Before (n:263)	After (n:362)	
Vasopressor	108 (%17.3)	39 (%14.8)	69 (%19.1)	0,167*
Mortality	189 (%30.2)	90 (%34.2)	99 (%27.3)	0,065*
28-Day Mortality	164 (%26.2)	82 (%31.2)	82 (%22.7)	**0,017***
Emergency Department Length of Stay (min)	310 [194-531]	282 [180-432]	341 [200-610]	**0.003****
Hospital Length of Stay (days)	8.0 [4.0-16.5]	7.0 [4.0-17.0]	9.0 [4.0-16.0]	0.910**
Intensive Care Unit Length of Stay (days)	4.0 [2.0-10.0]	4.0 [2.0-10.0]	4.0 [2.0-10.0]	0.287**
* Pearson's chi-square test was applied. ** Mann–Whitney U test was used.				

Keywords: emergency medicine, critical care unit, mortality

Ref No: 5550

Expanding the Horizons: Ketamine's Impact on Neuroplasticity, Sleep, and Stress Resilience

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Introduction and Purpose: Ketamine, an NMDA receptor antagonist, has emerged as a rapid-acting intervention for treatment-resistant depression. This review explores its potential beyond traditional antidepressant use, focusing on its efficacy in treating chronic stress and sleep disorders. Both conditions are intricately linked to neuropsychiatric pathologies, yet conventional treatments often fall short of addressing underlying neurobiological mechanisms. We aim to synthesise current literature to elucidate ketamine's impact on neuroplasticity, sleep architecture, and stress resilience, assessing its viability as a therapeutic agent for these interconnected disorders.
Materials and Methods: This review systematically examined existing literature from peer-reviewed journals and databases, focusing on studies investigating ketamine's effects on sleep regulation and chronic stress resilience. Key search terms included "ketamine," "sleep disorders," "chronic stress," "neuroplasticity," and "NMDA receptor." Studies were selected based on their relevance to neurobiological mechanisms, clinical implications, and experimental designs, encompassing EEG studies, animal models, and clinical trials. Data were extracted and synthesised to evaluate ketamine's impact on sleep architecture, cytokine modulation, and synaptic plasticity
Results and Conclusion: Findings indicate that ketamine enhances slow-wave sleep (SWS) and improves sleep quality by modulating circadian rhythms. It promotes resilience to chronic stress by augmenting dendritic spine density, downregulating pro-inflammatory cytokines, and upregulating BDNF, thereby enhancing synaptic plasticity. Ketamine's rapid antidepressant effects are attributed to NMDA receptor antagonism, leading to glutamatergic signalling and neuroprotection. While ketamine shows significant promise, further research is needed to determine optimal dosing, long-term effects, and alternative administration methods. Its potential to improve cognitive function and treat PTSD warrants further investigation, paving the way for its integration into routine psychiatric and

neurological treatments.
Keywords: ketamine, chronic stress, sleep disorder

Ref No: 5601
Simultaneous Acute Myocardial Infarction and Ischemic Stroke: A Rare but Challenging Case
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Introduction and Purpose: Cardiovascular and cerebrovascular diseases remain the leading causes of morbidity and mortality worldwide. Acute ischemic stroke (AIS) and acute myocardial infarction (AMI) share common risk factors, and both conditions require prompt diagnosis and treatment. The incidence of acute cardio-cerebral infarction (CCI) is as low as 0.009%. AMI and AIS may occur simultaneously or sequentially, with one preceding the other. When both conditions coexist, the clinical course deteriorates rapidly. Due to the varied onset patterns, types of AMI, and reperfusion strategies, the optimal treatment approach remains unclear, posing a significant challenge for clinicians.
Materials and Methods: A 62-year-old male patient presented with complaints of dizziness and chest pain. His medical history included diabetes mellitus, hypertension, and coronary artery disease. Upon admission, his blood pressure was 154/96 mmHg, while other vital signs were within normal limits. Physical examination revealed ataxic gait, dysmetria, and dysdiadochokinesia, while other systemic findings were unremarkable. Electrocardiography (ECG) showed ST-segment elevation in anterior leads, and the patient was referred to cardiology for evaluation of ST-elevation myocardial infarction (STEMI). However, imaging revealed an acute infarct in the left cerebellar region, and STEMI was ruled out. During follow-up, troponin I levels were elevated at 1123 and 5622 pg/ml, prompting re-evaluation by cardiology and neurology. The patient was admitted to the cardiology department for urgent invasive intervention, where a stent was placed in the left main coronary artery. Following the procedure, the patient was transferred to neurology for further management of cerebellar infarction.
Results and Conclusion: The coexistence of STEMI and AIS is rare but presents a unique therapeutic challenge when it occurs. Despite its rarity, this complex scenario warrants greater recognition and discussion within the medical community.
Keywords: Acute Myocardial Infarction, Ischemic Stroke

Ref No: 5608
Demographic Characteristics and Mortality Status of Patients who were Treated with Inotropes and Vasopressors During Their Initial Admission to the Emergency Department: A Cross-sectional Study
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Introduction and Purpose: Vasopressors and inotropes are essential pharmacologic agents used to restore hemodynamic stability in critically ill patients by increasing mean arterial pressure (MAP). While vasopressors primarily raise peripheral vascular resistance, inotropes enhance myocardial contractility; however, most agents exhibit overlapping properties. The choice of agent is typically guided by the underlying pathology, type of shock, patient-specific factors, and clinician experience. Although numerous studies have investigated the effects and comparative efficacy of these agents, there is a paucity of data from Turkey regarding the demographic and clinical characteristics of ED patients treated with vasopressors/inotropes and their associated outcomes. This study aims to address this gap by describing the patient profile, treatment modalities, and mortality outcomes in a tertiary care ED setting.
Materials and Methods: This cross-sectional study was conducted in the emergency department, encompassing patients who received vasopressors or inotropes between March 2024 and 2025. Among 159 initially identified cases, we excluded patients who received these medications as non-infusion boluses (e.g., IV adrenaline during cardiac arrest, endotracheal intubation, or inhalation therapy for URTIs) and those under 18. Ultimately, 101 patients were included. Data collected included demographics, comorbidities (e.g., hypertension, diabetes, coronary artery disease, renal failure), primary diagnosis, type of shock, agents used (adrenaline, noradrenaline, dopamine, dobutamine), respiratory support, mortality, admission timing, and duration of hospital and ICU stay. Cases with incomplete records or unknown mortality status due to inter-facility transfers were excluded from the final mortality analysis.
Results and Conclusion: The study population comprised 51.5% females (n=52) and 48.5% males (n=49), with a median age of 75 years. The most common diagnoses were Acute Renal Failure (18.8%) and Pneumosepsis (16.8%). Hypertension (62.4%) and Chronic Heart Failure (25.7%) were the most prevalent comorbidities. The leading shock types were Cardiogenic (31.7%) and Hypovolemic Shock (26.7%). Noradrenaline was the predominant agent used (95%), followed by Dopamine (15.8%). The 28-day mortality rate was 52.5%, with outcomes unknown in 14.9% due to transfer. Noradrenaline was the most frequently administered agent in this cohort, with Cardiogenic and Hypovolemic Shock being the leading indications. Despite pharmacologic intervention, mortality remained high. Larger, multicenter studies are warranted to elucidate associations between specific agents and patient outcomes.
Keywords: Inotropic Agents, Shock, Mortality

Ref No: 5613
PATELLAR FRACTURE
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Introduction and Purpose: The knee joint is one of the major joints in the body, and injuries involving its components are frequently encountered in the emergency department. The patella is the most commonly affected bone in knee injuries, particularly in active individuals and those engaged in sports. Patellar fractures account for 1% of all bone fractures.
Materials and Methods: A 25-year-old male patient presented with knee pain after falling while playing football the previous day. His

friends suspected a patellar dislocation and attempted a reduction. However, since his pain did not subside and he was unable to move his leg, he visited the emergency department. On examination, swelling (Figure 1) and tenderness were observed in his right knee, while peripheral pulses were intact. Imaging revealed a patellar fracture (Figure 2) and hematoma (Figure 3). The patient was consulted with the orthopedics clinic and was admitted for further treatment.

figure 1

figure 2

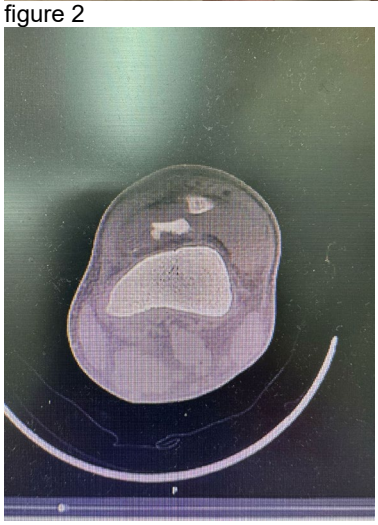
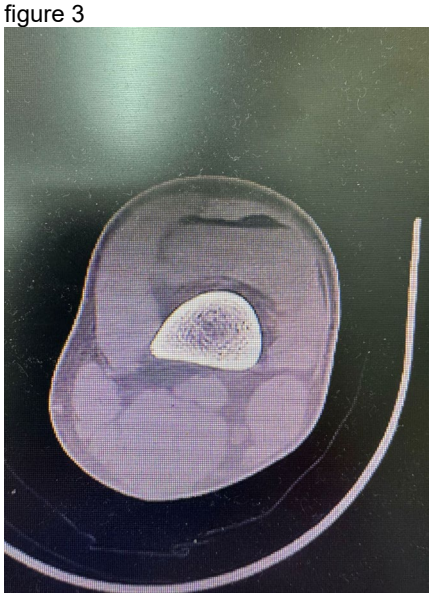


figure 3



Results and Conclusion: In patellar fractures, patients typically present with acute post-traumatic knee pain, swelling, inability to fully extend or flex the knee joint, and difficulty bearing weight. If the fracture is non-displaced, knee movements may not be significantly affected. Diagnosis is confirmed by direct radiography. Even if a patellar dislocation is suspected, obtaining direct radiographs after reduction is crucial to avoid missing fractures.

Keywords: patella, fracture, hematoma

Ref No: 5679

60 Yaş Üzeri Hastalarda Protrombin Kompleks Konsantrasyonu Kullanımına Bağlı Tromboembolik Komplikasyonlar

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Introduction and Purpose: Oral antikoagülanlarla (OAC) ilişkili yaşamı tehdit eden kanama ile gelen hastaların tedavisi zordur. Ancak Protrombin kompleks konsantresi (PCC), güvenli profilleri nedeniyle böyle bir durumda OAC etkisini geri çevirmek için bir seçenek olarak kullanılabilmektedir. Bu çalışmanın amacı, 60 yaş üzeri hastalarda PCC kullanımı sonrasındaki Tromboembolik Komplikasyon (TEC) oranını belirlemektir.

Materials and Methods: Yaşamı tehdit eden kanama nedeniyle 4 Faktörlü PCC ve TDP alan 60 yaş ve üzeri hastalar, 1 yıllık zaman dilimi boyunca retrospektif olarak değerlendirildi. Toplanan veriler antikoagülan ve endikasyon, kanama odağı, tedavi olarak seçilen protokol (PCC, Taze Donmuş Plazma (TDP) ve/veya bunlarla birlikte K vitamini kullanımı) ve dozu, venöz tromboembolizm (VTE), akut miyokard enfarktüsü ve iskemik inme dahil olmak üzere uygulanan tedavi protokolünün ardından ilk 60 gün içerisindeki TEC'u içeriyordu.

Results and Conclusion: Yüz altmış altı hastanın %28.9'u toplam 99 PCC dozu alırken %71.1'i toplam 163 ünite TDP aldı. Hayatı tehdit eden kanama odağı olarak Gastrointestinal sistem ilk sırada yer almaktaydı (%34.3). Hastaların 15'inde (%9) VTE, iskemik inme ve akut miyokard enfarktüsü dahil olmak üzere TEC gelişti. Hastaların 4'ü PCC ile 11'i ise TDP tedavi protokolü uygulanan grup içerisindeydi. Komplikasyon olarak TDP alanlarda en sık %2.4 hastada Myokard Enfaktüsü, PCC alanlarda %1.2 ile Unstabil Angina Pektoristi. TEC gelişenlerde Warfarin kullanımı en sıktı. TEC gelişim oranı her iki tedavi grubu arasında anlamlılığa sahip değil gibi görünüyor olsa da (p=0.84) hayatı tehdit eden kanamalar karşısında cevap alma süresi ve tedavi sonrası INR düzeyinin normalleşmesi açısından anlamlı farklılık tespit edilmiştir (p<0.001). Hayatı tehdit eden kanama durumunda PCC uygulaması erken dönemde oluşturduğu tedavi cevabı ve INR değerindeki normalleşme süresi açısından TDP'e göre daha iyi bir etki oluşturabilmektedir. Ayrıca Konjestif Kalp Yetmezliği gibi komorbit hastalık varlığında daha az sıvı yükü oluşturması da tedavi tercihlerinde önde yer almasına neden olmaktadır. Ancak çalışmanın kısıtlı bir süre aralığında geriye dönük olarak planlanmış olması her iki tedavi grubu arasında istatistiksel açıdan anlamlılığın önüne geçmiştir. Bu nedenle daha geniş çalışma evreniyle tasarlanan çalışmalara ihtiyaç duyulmaktadır.

Keywords: oral antikoagülan, Kanama, tromboembolik komplikasyon

Ref No: 5702

Cardiopulmonary arrest in contrast-enhanced tomography: typical imaging findings with 2 cases

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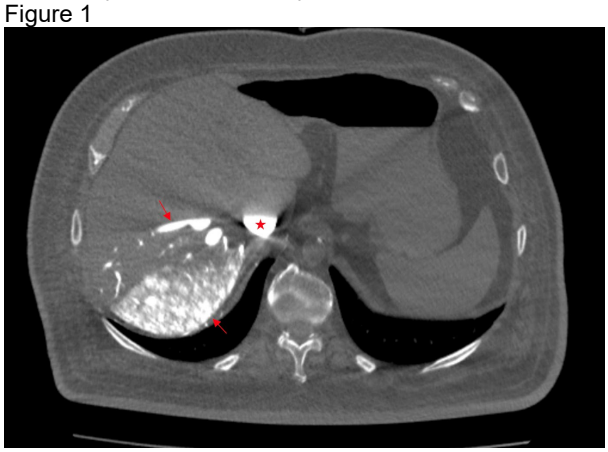
Introduction and Purpose: In-hospital cardiopulmonary arrest (CPA) mortality remains high despite improved survival in recent years. Early recognition of CPA with prompt initiation of cardio-pulmonary resuscitation (CPR) to restore circulation leads to better outcomes. While the majority of CPA is detected by clinical signs or monitoring, in some cases it can develop during computed tomography (CT) imaging. Herein, we report CPA's CT findings through two cases.

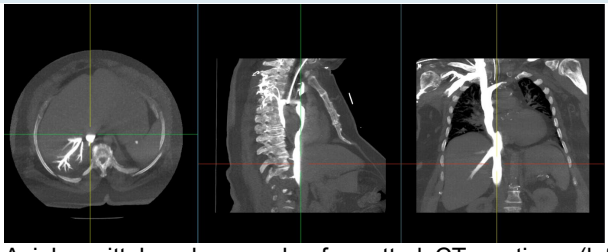
Materials and Methods: Patient 1; 74-year-old female with hypertension was brought to the emergency room with shortness of breath and confusion. CT scan performed to rule out aortic dissection. After the CPA findings were seen, the scan was terminated and CPR was started on the patient. Patient 2; 67-year-old male patient with no additional illness was admitted to the emergency room with shortness of breath. Pulmonary CT angiography was performed with suspicion of pulmonary embolism, and CPA was observed. High-density contrast material pooling was observed in the right atrium, inferior vena cava, hepatic veins, and liver parenchyma on CT of patient 1(Figure 1). On patient 2's CT, the contrast material coming through the venous vascular access is observed with high density in the superior vena cava (SVC), right atrium, inferior vena cava (IVC), azygos vein, and hepatic veins, but not in the right ventricle, pulmonary cardiovascular systems, and left heart centers (Figure 2).

Figure 1



Typical appearance of contrast material shows venous pooling in IVC (asterisk) and hepatic veins (arrows) in a CPA patient.

Figure 2



Axial sagittal and coronal reformatted CT sections (left to right, respectively). Dependent venous pooling and layering of contrast material within SVC, right atrium, IVC, and other dependent venous structures.

Results and Conclusion: In CPA, typical CT imaging findings are that the contrast material given intravenously does not progress to the left heart chambers and pulmonary arterial system, but refluxes from the right heart chambers to the IVC and hepatic veins, and accumulates in the venous system. Knowing the CT findings essentially prevents wasting time on differential diagnosis and facilitates rapid intervention

Keywords: Cardiopulmonary arrest, CT, venous contrast pooling

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Ref No: 5716

Pleural Effusion; Single Centre Experience

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Introduction and Purpose: Pleural effusion is defined as an abnormal accumulation of fluid between the parietal and visceral pleura. The nature of the fluid varies depending on the underlying etiology. Transudative effusion develops in heart failure and hypoalbuminemic conditions such as nephrotic syndrome and liver failure. Exudative effusion develops in conditions such as infection, malignancy, and connective tissue disease. Parapneumonic effusion is the most common type of pleural effusion in children. This study aims to present the single center experience of patients followed up for pleural effusion in our hospital.

Materials and Methods: A retrospective analysis was performed on the data of 53 pediatric patients under the age of 18 years who were followed up for pleural effusion at the Department of Pediatrics, Necmettin Erbakan University Faculty of Medicine Hospital between 2019 and 2024. The study evaluated age, gender, etiology of pleural effusion, fluid characteristics, and treatment modalities.

Results and Conclusion: Of the patients included in the study, 50.9% were male. The mean age was 132.42 (12-214) months. Radiological examination revealed a unilateral effusion in 67.9% of patients with a median effusion depth of 30 mm (14-47.5). Thoracentesis was performed in 81.1% of patients, while in 10 patients (18.9%) thoracentesis was not performed due to minimal effusion. It was observed that 81.4% of the thoracentesis fluid was exudative. The median CRP was 88.1 mg/L (17.2-154) and the median fluid LDH was 572 U/L (228-1139). A statistically significant positive correlation was found between these two levels (r:0.488, p:0.001). When analyzing the etiology of the pleural effusion, pneumonia was found in 64.2% of patients, tuberculosis in 22.6%, and other causes in 13.2%. A total of 27 patients (50.9%) underwent tube thoracostomy, and 48.1% of these patients received fibrinolytic therapy. The mean hospital stay was 16 days (12-21.5). Patients with an effusion depth greater than 1 cm had a longer hospital stay (p=0.02). Determining the etiology of pleural effusion is important for treatment and follow-up. Our study found that the most common cause of pleural effusion was pneumonia, which is consistent with the existing literature. However, it is also important to consider rare conditions such as childhood malignancy.

Table 1

Table 1: The relationship between the day of hospitalisation and age at diagnosis, effusion depth, fluid LDH level and serum CRP level

		Age at diagnosis (month)	Depth of effusion (mm)	Fluid LDH level (U/L)	Serum CRP level (mg/L)	Day of admission
Age at diagnosis (month)	r	1,000	,067	-,089	,028	-,209
	p	.	,634	,570	,842	,134
	n	53	53	43	53	53
Depth of effusion (mm)	r	,067	1,000	,255	,219	,337*
	p	,634	.	,099	,115	,013
	n	53	53	43	53	53
Fluid LDH level (U/L)	r	-,089	,255	1,000	,488**	-,024
	p	,570	,099	.	,001	,877
	n	43	43	43	43	43
Serum CRP level (mg/L)	r	,028	,219	,488**	1,000	,174
	p	,842	,115	,001	.	,214
	n	53	53	43	53	53
Day of admission	r	-,209	,337*	-,024	,174	1,000
	p	,134	,013	,877	,214	.
	n	53	53	43	53	53

* p<0.05, ** p<0.01

Keywords: pneumonia, tuberculosis, thoracentesis

Ref No: 5760

Right ICA Dissection Following Extension

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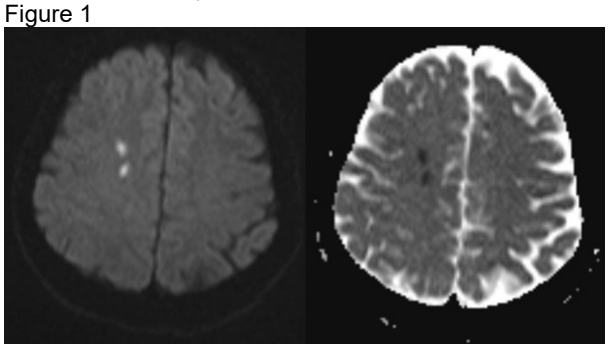
Introduction and Purpose: Internal carotid artery(ICA) dissection accounts for 2% of strokes and 10-25% of strokes in young individuals.(1) ICA dissections mostly develop spontaneously. The main risk factors include connective tissue diseases, trauma, and

cervical spine manipulation.(2) Medical treatment, mechanical thrombectomy, and stent placement are preferred endovascular treatment methods.(3) In this case, we present a case of cerebral infarction caused by ICA dissection in a patient whose neck was placed in an extension position for the excision of a lesion on the lip.

Materials and Methods: A 43-year-old female patient visited the emergency department with complaints of numbness in her left arm and leg two days after undergoing a 10-minute local anesthesia procedure in which her neck was placed in an extension position for the excision of a lesion on her lip. Her Glasgow Coma Score was 15, and her vital signs were stable. Hypoesthesia was detected in the left upper and lower extremities, while sensory and motor functions in the right upper and lower extremities were completely normal. Diffusion MRI revealed two areas of diffusion restriction at the level of the centrum semiovale and the right periventricular white matter(Figure 1). Brain and neck CT angiography(CTA) revealed dissection and thrombosis in the right ICA(Figure 2). Routine laboratory tests were normal. Tests for vasculitis showed no specific findings. Echocardiography revealed an ejection fraction of 60%, with no vegetations or thrombi. Tumor marker tests and thoracoabdominal CT performed for malignancy screening showed no abnormal findings. It was decided that stent placement would not be necessary unless the patient had clinical deterioration and that dual antiplatelet therapy would be administered for 6 months.

Figure 1



Two areas of diffusion restriction at the level of the centrum semiovale and the right periventricular white matter.

Figure 2

Thrombus in the right ICA.

Results and Conclusion: ICA dissection can occur spontaneously or due to trauma. Movements such as cervical vertebral hyperextension, sudden head rotation, or lateral flexion can cause tension in the internal carotid artery and lead to damage in the intimal layer.(4) In this case, it is thought that hyperextension of the neck led to tearing of the vessel wall, resulting in thrombosis. It is important for physicians to avoid head and neck maneuvers that may cause carotid artery dissection and to be aware of such complications.

Keywords: Cerebral Infarction, Internal Carotid Artery, Dissection

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Ref No: 5766

Utilization of an AI Chatbot in Descriptive Statistics of an Emergency Medicine Study

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Introduction and Purpose: Descriptive statistics are crucial in medical research for summarizing and interpreting data before inferential analysis. With the growing use of artificial intelligence (AI) in various fields, AI-based language models have gained attention for their potential role in statistical analysis. This study aims to evaluate the performance of ChatGPT, a large language model, in conducting descriptive statistical analyses for a medical dataset from an emergency department.

Materials and Methods: This retrospective study analyzed data from 53,308 patients who presented to the green zone of a tertiary emergency department in January 2025. Data were extracted from the hospital information system and processed for statistical analysis. The dataset included variables such as patient ID, gender, age, admission day, admission time, case type, and diagnosis code. Descriptive statistics, including frequency distributions, central tendency measures, and graphical visualizations, were generated using ChatGPT (GPT-4). AI-generated results were cross-validated with Python-based statistical libraries.

Results and Conclusion: The dataset comprised 51.47% female and 48.53% male patients, with a median age of 33 years (IQR: 24-48). Most visits occurred between 08:00-15:59 (42.1%), followed by 16:00-23:59 (39.6%) and 00:00-07:59 (18.3%). The most common diagnoses were respiratory infections, soft tissue injuries, and non-specific abdominal pain. ChatGPT successfully executed statistical

analyses and visualizations (e.g., histograms, heatmaps, frequency tables) without errors. The AI model's ability to interpret queries and provide alternative graphical recommendations demonstrated its potential for enhancing medical research workflows.ChatGPT showed promising capabilities in performing descriptive statistics for large medical datasets. AI-assisted statistical tools can improve data processing efficiency; however, human oversight remains essential to validate outputs. Future studies should explore AI integration into automated medical data analysis systems.

Keywords: Artificial intelligence, descriptive statistics, ChatGPT

Ref No: 5767

Ruptured Abdominal Aortic Aneurysm: A Case Report from an Emergency Medicine Perspective

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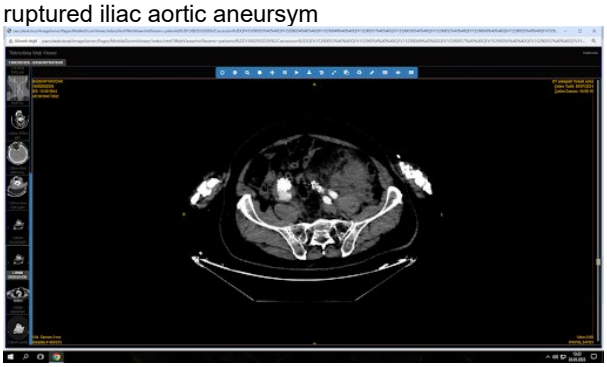
Introduction and Purpose: An abdominal aortic aneurysm (AAA) is defined as a focal dilation of the aorta measuring more than 1.5 times the normal diameter. While most AAAs are asymptomatic and incidentally discovered, rupture is a life-threatening complication associated with extremely high mortality. It is estimated that a significant proportion of patients with ruptured AAA's die before reaching medical care. The emergency department plays a critical role in the early recognition and management of this vascular emergency. This case report presents the clinical course of a patient with a prior history of endovascular aneurysm repair (EVAR) who developed syncope following physical exertion and was diagnosed with a ruptured AAA.

Materials and Methods: A 79-year-old male presented to the emergency department following a syncopal episode that occurred shortly after climbing a tree. He had a known history of abdominal aortic aneurysm and had undergone EVAR several years prior. Upon arrival, his level of consciousness was preserved; however, he appeared pale, diaphoretic, and lethargic. He also reported pain in the left inguinal region. Vital signs were as follows: blood pressure 71/53 mmHg, heart rate 92 bpm, and oxygen saturation 95% on room air. Despite aggressive intravenous fluid resuscitation, hypotension persisted. Marked aneurysmal dilatation of the distal abdominal aorta and both iliac arteries were noted, measuring up to 185 mm at its widest point.A heterogeneous hematoma was present within the aneurysm sac. Based on these radiological findings, a diagnosis of ruptured abdominal aortic aneurysm was established.

ruptured iliac aortic aneursym



Results and Conclusion: Ruptured AAA is a catastrophic vascular emergency that requires immediate recognition and intervention. Mortality remains exceedingly high; retrospective data suggest that nearly 50% of patients with ruptured AAA die before reaching the hospital.From an emergency medicine standpoint, elderly patients presenting with syncope, flank or groin pain, and signs of shock must be evaluated for potential AAA rupture. Bedside ultrasonography is a rapid and useful initial imaging modality, particularly in unstable patients. In hemodynamically stable cases, CTA remains the gold standard for anatomical assessment and surgical planning. Early diagnosis and expedited vascular surgery consultation are paramount to improving survival in this time-critical condition.

Keywords: Ruptured AAA

Ref No: 5776

THE ROLE OF SOCIAL MEDIA IN MEDICAL EDUCATION AND TRAINING

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Introduction and Purpose: It is obvious that social media is with us at every moment of our lives in this information and information age. Although social media is generally thought to be used for entertainment, it is possible to access different content in every field of education on many platforms (1,2). SM, whose use is increasing in every sector today, offers great convenience and opportunities to users in the health sector (3).

Materials and Methods: The study was conducted on medical faculty students at XXX university and the contribution of SM to medical education was investigated. The participants were asked a questionnaire created by the researchers, which lated approximately 5 minutes.

Results and Conclusion: In the study with 541 participants, only 9 (1.7%) of the participants stated that they did not use social media. The study was completed with 532 (98.3%) participants who reported using social media. 63.3% of the students stated that they had received online education before their university education. While 31.1% of the participants were not satisfied with online education, 29.9% of them were undecided about their satisfaction with online education. While 48.4% of the students preferred a system that combines classical and online education, 45% did not prefer such a hybrid system. 70.3% of the participants thought that SM has an impact on medical education. Students stated that they felt the need to research interventional procedures (69.9%) and physical examination (56.6%) the second most on SM.318 of the students (60.6%) stated that they needed to confirm the information from the

source books related to that subject.Today, with the effect of the digital transformation in the world, there is almost no area where social media is not used. When the literature is examined, it can be said that social media is becoming an indispensable part of life day by day (4,5). With the impact of developing technology, social media has become an important part of information acquisition and medical education. It should be aimed to make the use of SM a part of medical education by eliminating the barriers due to information pollution in SM, increasing the experience and skills of trainers related to online education.

Keywords: Social media, Medical education, Medical students

Ref No: 5806

In ischemia, the vessels is not always occluded

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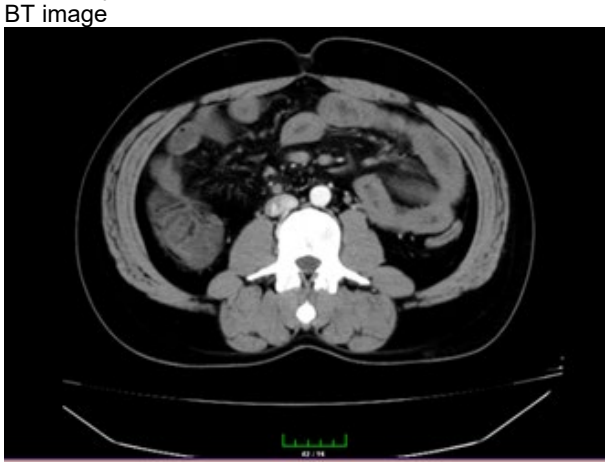
Introduction and Purpose: Acute mesenteric ischemia is one of the causes of acute abdomen especially in patients with additional diseases, the frequency of which increases with age, and the prognosis is quite poor, if it cannot be diagnosed early. Therefore, the most important way to minimize morbidity and mortality; to diagnose early and to go to treatment procedures as soon as possible. Non-occlusive mesenteric ischemia is a type of acute mesenteric ischemia diagnosis and treatment are important for survival.

Materials and Methods: "A 40-year-old male patient presented to us with complaints of abdominal pain. Vital signs were normal upon arrival. On examination, there was guarding present. No acute pathology was observed on the direct X-ray of the patient. On contrast-enhanced abdominal CT imaging, thickening of the wall at the level of the cecum and transverse colon and widespread contamination in the mesentery were observed. Following the onset of gastrointestinal bleeding, the patient was taken for resuscitation. After the interventions, the patient was admitted to the internal medicine intensive care unit, where endoscopy was performed, revealing ischemic foci and bleeding in the colon. The patient was then transferred to general surgery with a preliminary diagnosis of non-occlusive mesenteric ischemia."

Results and Conclusion: Examination is more important than imaging in abdominal pain. Although there is no mesenteric ischemia in imaging, ischemia has been detected in the endoscopic examination. It should not be forgotten that mesenteric ischemia is not only caused by vascular obstruction.

BT image



Keywords: Non-occlusive, mesenteric ischemia

Ref No: 5807

CHOLANGIOSEPSIS

Assoc. Prof. Dr. Ali Gür[1], Dr. Alara Nergiz Soslu[1]

[1]Atatürk University Faculty of Medicine Department of Emergency Medicine

Introduction and Purpose: Cholangitis, known as the triad of fever, jaundice, abdominal pain (Charcot's Triad), is a clinical syndrome that can be encountered frequently in the ER and can result in life-threatening conditions if not treated. Cholelithiasis, biliary stricture, malignancy and ERCP are the most common causes of cholangitis. If hypotension and mental status change are added to Charcot's triad, a clinical condition called Reynolds pentad arises.

Materials and Methods: A 48-year-old male patient is admitted to the ER with abdominal pain, weakness, fever. The patient's arrival GCS:13 and his consciousness was somnolent. His vital signs: temperature of 39.5°C, blood pressure of 105/55, heart rate of 95 and regular, oxygen saturation was 89. In the anamnesis taken from the patient, it was learned that ERCP was performed 15 days ago. He had a history of cardiac failure, coronary artery disease, hypertension, diabetes mellitus, ICD and hydatid cyst in the liver. During the physical examination of the patient, abdominal palpation reveals generalised tenderness. Cardiorespiratory examination is unremarkable. There was no pretibial edema.In routine tests taken from the patient Hb: 12.1 g/dL Plt: 94.000 µL Wbc: 5920 µL; Blood gas ph 7.47 Na: 121 mmol/L K 2.9 mmol/L Glucose: 327 Lac: 3.8 mmol/L Base deficit: 2 HCO3 25.8; in broad biochemistry: ALP 1012 U/L GGT:346 U AST: 353 U/L ALT: 219 U/L LDH: 636 U/L Direct bilirubin: 5.83 mg/DL Total bilirubin: 8.29 mg/DL Creatine: 1.33 Na: 122 mmol/L K: 2.76 mmol/L CRP: 197.4 mg/DL. Hepatobiliary USG performed on the patient was interpreted as hydatid cyst? cholelithiasis? Broad-spectrum empirical antibiotic therapy was started. He was consulted to the gastroenterology department. He was admitted to the Internal medicine Intensive Care Unit with the diagnosis of cholangiosepsis.

Results and Conclusion: It should be kept in mind that especially in elderly patients, clinics such as cholelithiasis, cholecystitis can quickly disrupt the patient's clinic if an oral intake disorder is added. Empirical antibiotics should be started in patients diagnosed with cholangitis. If conditions such as hypotension, mental deterioration, tachypnea, oliguria are added to the clinic, the patient should be suspected of sepsis and the necessary blood tests and imaging should be requested as soon as possible.
Keywords: cholangitis, sepsis, cholelithiasis

Ref No: 5819
Adrenal Insufficiency: A Life-Threatening Endocrine Crisis in the Emergency Department – A Case Report
İBRAHİM DİLEKCAN[1], YUNUS ŞAHİN[1], HASİP KIZILAY[1], NESLİHAN YARKIN[1], SAFA DÖNMEZ[1]
[1]ANKARA BILKENT CITY HOSPITAL
Introduction and Purpose: Adrenal insufficiency is a rare but potentially life-threatening endocrine disorder characterized by the inadequate production of cortisol and/or aldosterone from the adrenal cortex. The acute form of this condition, adrenal crisis, carries a high risk of mortality, particularly in undiagnosed patients or in those with known insufficiency who fail to receive adequate steroid replacement during periods of physiological stress. In the emergency department (ED), adrenal crisis should be considered in the differential diagnosis of patients presenting with unexplained hypotension, hypoglycemia, or altered mental status.This case report presents the emergency evaluation and management of a male patient with a history of diabetes mellitus (DM), hypertension (HT), and coronary artery disease (CAD) who presented with clinical features consistent with adrenal crisis.
Materials and Methods: A 65-year-old male with DM, HT, and CAD presented with decreased urine output, vomiting, and altered mental status. He was hypotensive, hypoglycemic, and in metabolic acidosis. Despite norepinephrine infusion, hypotension persisted. Empiric intravenous hydrocortisone was administered, leading to rapid clinical improvement.
Results and Conclusion: Adrenal crisis is a medical emergency caused by the acute inability of the body to mount an adequate cortisol response during stress. It typically presents with hypotension, hypoglycemia, hyponatremia, and metabolic acidosis, and can rapidly progress to shock and death if not promptly recognized and treated. Although relatively rare in emergency practice, the consequences of delayed diagnosis can be fatal.In this case, features such as refractory hypotension, recurrent episodes of hypoglycemia, and uncompensated metabolic acidosis strongly supported the diagnosis of adrenal crisis. Prompt initiation of glucocorticoid therapy, even prior to laboratory confirmation, was life-saving and aligned with current emergency medicine guidelines.Emergency physicians must maintain suspicion for the patients presenting with unexplained hemodynamic instability, particularly when vasopressor therapy is ineffective. Recognition of the adrenal crisis triad, hypotension, hypoglycemia, and altered mental status, is critical to ensure timely management.
Keywords: adrenal insufficiency, emergency, endocrine emergencies

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Ref No: 5829
Retrospective analysis of patients referred to the Emergency Department of Bilecik Training and Research Hospital by 112 Emergency Aid Ambulances from surrounding districts
Ahmet Tugrul Zeytin[1], Erhan Arikan[1], Selim Degirmenci[1]
[1]Bilecik Seyh Edebali University, Faculty of Medicine, Department of Emergency Medicine
Introduction and Purpose: To evaluate the typical clinical characteristics of patients referred to the Emergency Department of Bilecik Training and Research Hospital by 112 Emergency Aid Ambulances from 7 districts of Bilecik Province.
Materials and Methods: Between July 31, 2024 and December 31, 2024, information on patients referred by 112 Emergency Aid Ambulance was obtained from the patient registration system of the hospital after obtaining the necessary permissions. The age and gender distribution of the patients, referral diagnoses, distribution according to the districts of origin, distribution of consultations requested from different specialties for the patients, and the fate of the patients were analyzed. Statistical analyses were performed using SPSS 22.0 Software for Windows.
Results and Conclusion: The mean age of 1368 patients admitted to the emergency department was 56.2±25.2 years (Min-Max: 0-99); the age and gender distributions were 796 (58.2%) males (mean age: 53.3±24.6) and 572 (41.8%) females (mean age: 60.4±25.5), respectively. The first 3 districts that referred emergency patients were Osmaneli (415 patients, 30.3%), Sögut (350 patients, 25.6%) and Golpazari (261 patients, 19.1%).Regarding the prediagnoses of the referred emergency patients, the most common diagnosis was acute myocardial infarction with 166 patients (ICD-10: I21.9, 12.1%), followed by cerebrovascular diseases with 147 patients (ICD-10: I67.9, 10.7%) and gastrointestinal bleeding with 96 patients (ICD-10: K92.2, 7%). The distribution of the patients according to the clinics where they were hospitalized was found as Coronary Intensive Care Unit (123 patients, 9%) and General Intensive Care Unit (85 patients, 6.2%) in order of frequency. Regarding the outcomes of the patients in the Emergency Department, 648 (47.3%) patients were discharged as outpatients, 444 (32.4%) patients were hospitalized, 269 (19.6%) patients were referred to tertiary hospitals. In conclusion, when we look at the profile of emergency patients referred to Bilecik Training and Research Hospital from the surrounding districts, it is noteworthy that the male gender predominates and the age group is over 50 years, and the referral diagnoses are frequently cardiovascular, cerebrovascular, and upper gastrointestinal bleeding. This may be due to the high frequency of NSAID and/or antiaggregant drug use due to chronic diseases. Further epidemiologic studies are needed in this regard.
Keywords: 112 Emergency Service, emergency department, referred patients

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Ref No: 5900
Exploring the potential of artificial intelligence models for triage in the emergency department
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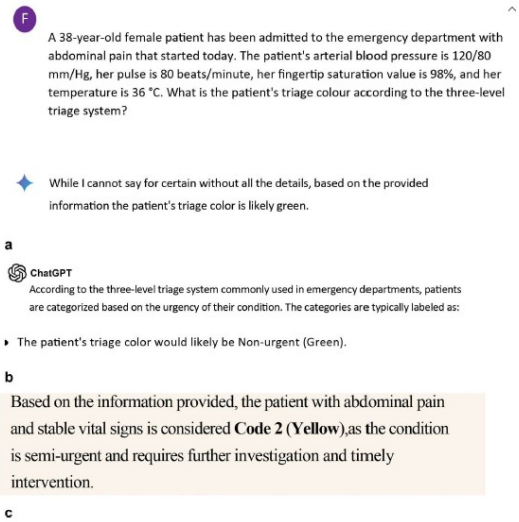
[1]Department of Emergency Medicine, Faculty of Medicine, Ataturk University, Erzurum, Turkey.
[2]Department of Biostatistics, Faculty of Medicine, Ataturk University, Erzurum, Turkey.

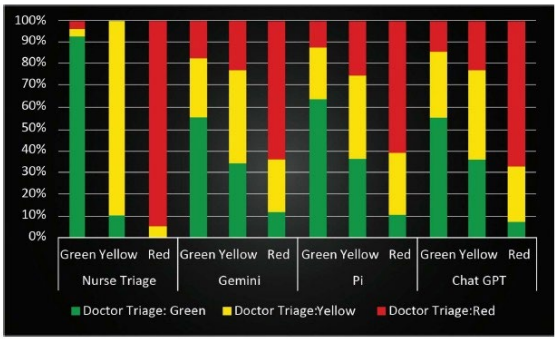
Introduction and Purpose: To perform a comparative analysis of the three-level triage protocol conducted by triage nurses and emergency medicine doctors with the use of ChatGPT, Gemini, and Pi, which are recognized artificial intelligence (AI) models widely used in the daily life.
Materials and Methods: The study was prospectively conducted with patients presenting to the emergency department of a tertiary care hospital from 1 April 2024, to 7 April 2024. Among the patients who presented to the emergency department over this period, data about their primary complaints, arterial blood pressure values, heart rates, peripheral oxygen saturation values measured by pulse oximetry, body temperature values, age, and gender characteristics were analyzed. The triage categories determined by triage nurses, the above-mentioned AI chatbots, and emergency medicine doctors were compared.
Results and Conclusion: The study included 500 patients, of whom 23.8% were categorized identically by all triage evaluators. Compared to the triage conducted by emergency medicine doctors, triage nurses overtriaged 6.4% of the patients and undertriaged 3.1% of the yellow-coded patients and 3.4% of the red-coded patients. Of the AI chatbots, ChatGPT exhibited the closest triage approximation to that of emergency medicine doctors; however, its undertriage rates were 26.5% for yellow-coded patients and 42.6% for red-coded patients.Conclusion: The undertriage rates observed in AI models were considerably high. Hence, it does not yet seem appropriate to solely rely on the specified AI models for triage purposes in the emergency department.

Figure 1



An example patient presentation query directed (a) Gemini, (b) Chat GPT, (c) Pi with their corresponding responses

Figure 2



Comparison of the emergency doctors and triage evaluators

Table 1

		N	%
Triage performed by emergency medicine doctors, triage nurses, Gemini, Pi, and ChatGPT	Patients assigned the same triage code	119	23.8
	Patients assigned a different triage code	381	76.2
	Total	500	100

Distribution of all patients across triage systems
Table 2

		Triage code assigned by emergency medicine doctors											
		G		Y		R		Mcnemar-Bowker test		Kappa			
		n	%	n	%	n	%	Value	p	Value	Std	Appx	p
Triage nurse	G	167	88.8%	7	3.1%	3	3.4%	18.259	**<0.001**	0.867	0.02	26.419	**<0.001**
	Y	20	10.6%	205	91.9%	0	0%						
	R	1	0.5%	11	4.9%	86	96.6%						
Gemini	G	84	44.7%	48	21.5%	12	13.5%	17.754	**<0.001**	0.249	0.035	7.442	**<0.001**
	Y	85	45.2%	127	57%	27	30.3%						
	R	19	10.1%	48	21.5%	50	56.2%						
Pi	G	54	28.7%	24	10.8%	5	5.6%	69.844	**<0.001**	0.189	0.034	6.27	**<0.001**
	Y	118	62.8%	147	65.9%	39	43.8%						
	R	16	8.5%	52	23.3%	45	50.6%						
ChatGPT	G	91	48.4%	59	26.5%	11	12.4%	12.081	**<0.001**	0.240	0.036	7.397	**<0.001**
	Y	86	45.7%	115	51.6%	26	29.2%						
	R	11	5.9%	49	22%	52	58.4%						

Comparison of the triage coding of emergency doctors and other triage evaluators
Table 3

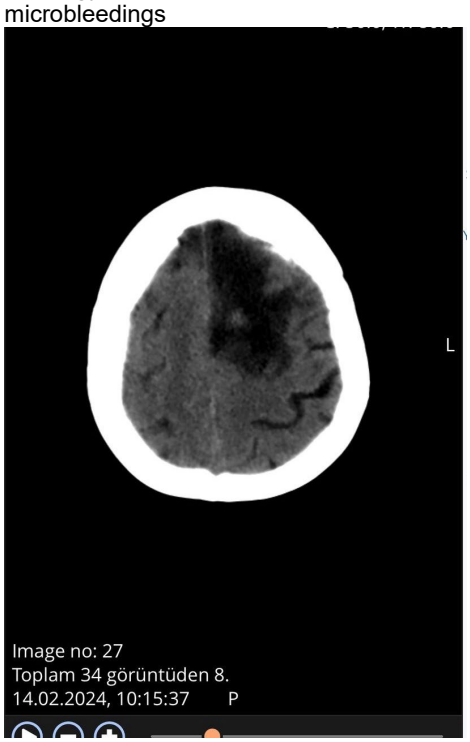
Triage coding system	**ICC**	**Lower bound**	**Upper bound**	**F**	**p**
Emergency medicine doctor vs. triage nurse	946	945	954	18.546	**<0.001**
Emergency medicine doctor vs. Gemini	548	541	616	2.214	**<0.001**
Emergency medicine doctor vs. Pi	542	515	609	2.183	**<0.001**
Emergency medicine doctor vs. ChatGPT	595	592	657	2.469	**<0.001**
Triage nurse vs. Gemini	537	533	608	2.158	**<0.001**
Triage nurse vs. Pi	518	499	587	2.073	**<0.001**
Triage nurse vs. ChatGPT	587	586	653	2.422	**<0.001**
Gemini vs. Pi	713	707	755	3.481	**<0.001**
Gemini vs. ChatGPT	773	773	809	4.412	**<0.001**
Pi vs. ChatGPT	723	711	764	3.612	**<0.001**
Total agreement	832	826	850	5.944	**<0.001**

ICC analysis of two-by-two combinations of five triage evaluators: emergency medicine doctor, triage nurse, Gemini, Pi, and ChatGPT.
Keywords: Chat GPT, Gemini, emergency triage

Ref No: 5923
Balancing bleeding and thrombosis risks: severe thrombocytopenia, cerebral microbleeds, and pulmonary embolism following neurosurgery
Mehmet Emir AKCAY[1], Mahir Utku AYBEY[1], Metin YADİGAROGLU[1], Ayhan AKOZ[1]
[1]Aydin Adnan Menderes University
Introduction and Purpose: Pulmonary embolism (PE) is a life-threatening condition typically managed through anticoagulant therapy. However, cerebral microbleeds significantly complicate management by increasing intracranial hemorrhage risk. Severe thrombocytopenia further complicates clinical decisions. This report highlights therapeutic challenges when balancing risks of bleeding and thrombosis, emphasizing awareness for emergency and internal medicine practitioners.
Materials and Methods: A 72-year-old female presented to the emergency department with fever, purulent cough, and rapid deterioration. She had type 2 diabetes mellitus and underwent surgical resection of glioblastoma multiforme (GBM) three months earlier, followed by temozolomide therapy completed ten days before admission. Her Glasgow Coma Scale (GCS) was 13, and she was lethargic. Examination showed bilateral rales and lower extremity edema. Laboratory tests revealed severe pancytopenia (platelets: 1000/μL, hemoglobin: 7.2 g/dL, leukocytes: 120/μL). Thoracic CT indicated PE in bilateral segmental arteries and ground-glass opacities consistent with pneumonia. Brain imaging showed postoperative changes, microbleeds, and subdural effusion. She received

thrombocyte transfusions and multidisciplinary consultations, then transferred to the intensive care unit (ICU). Anticoagulation therapy with low molecular weight heparin began once platelets reached 50,000/μL on day 30. After seven days in the ICU, she was moved to oncology and later transferred to palliative care due to inoperable GBM progression.

microbleedings



fidure shows cerebral microbleedings in left frontal lobe of cerebrum after resection.

Pulmonary embolism

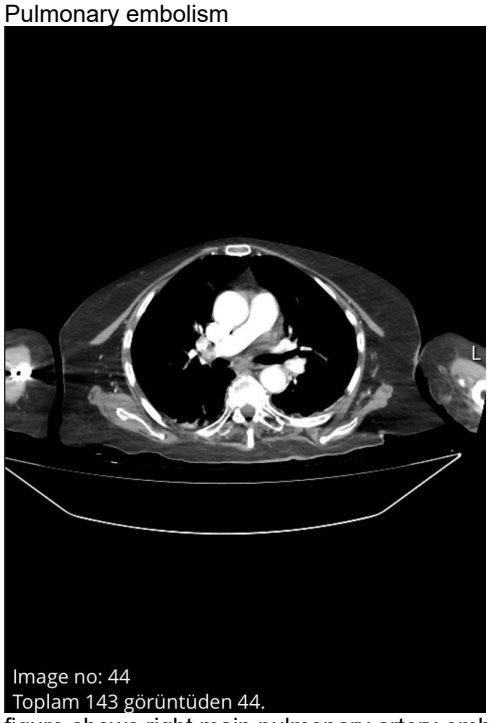
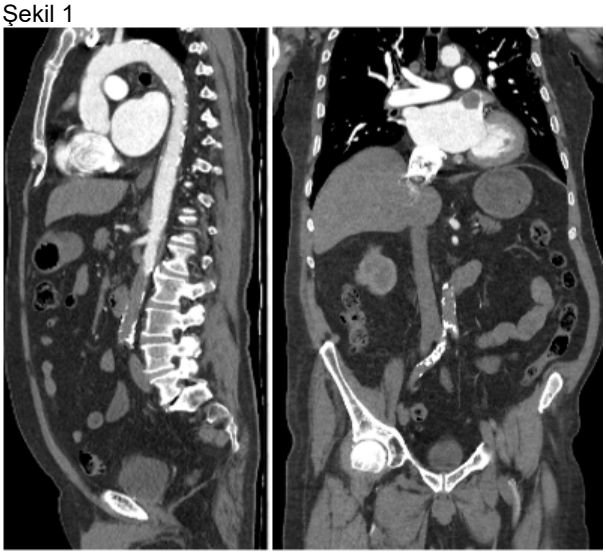


figure shows right main pulmonary artery embolism

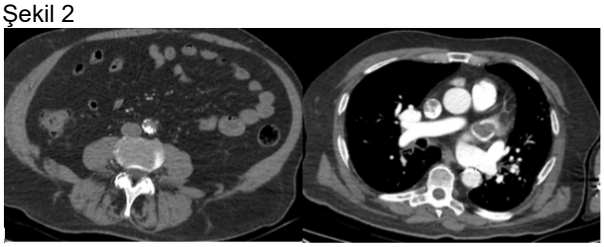
Results and Conclusion: This case illustrates the significant therapeutic dilemma posed by simultaneously occurring cerebral microbleeds, PE, and severe thrombocytopenia. Emergency medicine physicians play an essential role in early recognition, diagnostic evaluation, and initiating multidisciplinary management. Effective anticoagulation therapy, combined carefully with blood product support and close clinical monitoring, is crucial to balance hemorrhagic and thrombotic risks, improving patient outcomes.

Keywords: Pulmonary embolism, Cerebral microbleeds, Thrombocytopenia

Ref No: 5946
Akut Parapleji ile Gelen Acil Bir Hasta: Leriche Sendromu
Merve Sandıkçı[1], Mehmet Altuntaş[1], Özlem Bilir[1]
[1]Recep Tayyip Erdoğan Üniversitesi Eğitim ve Araştırma Hastanesi, Acil Tıp Anabilim Dalı, Rize, Türkiye
Introduction and Purpose: Genellikle aortoiliak oklüzyon hastalığı (AIOD) olarak adlandırılan Leriche sendromu, distal abdominal aort, iliak arterler ve femoropopliteal damarları etkileyen aterosklerozun bir ürünüdür. Bu olguda acil servise ani başlayan her iki bacakta güçsüzlük ve his kaybı ile başvuran hastada Leriche sendromu tanısını anlatılacaktır.
Materials and Methods: 68 yaşında erkek hasta hem sağ hem sol bacakta olan güç kaybı ve ağrı şikayeti ile başvuruyor. Çekilen BT anjiografide aorta infrarenal düzeyden distale doğru oklüzyonu saptanıyor. Hasta kalp ve damar cerrahisine konsülte ediliyor ve acil olarak ameliyata alınıyor.
Şekil 1



Koronal ve sagittal kesitlerde ok ile gösterilen yerde oklüzyon
Şekil 2



Aksiyal kesitte abdominal aorta infrarenal düzeyde oklüzyon ve sağ atriumda trombüs
Results and Conclusion: Akut aorta oklüzyonu yaşamı tehdit eden mortalite ve morbiditesi yüksek bir durumdur. Akut aorta oklüzyonu parapleji ile görülebilir, bu nedenle akut parapleji gelişen olgularda ayırıcı tanıda infrarenal akut arter tıkanması mutlaka düşünülmeli, nabızlar kontrol edilmelidir.Leriche sendromu, periferik arter hastalığının ciddi bir komplikasyonu olup, erken tanı ve uygun tedavi ile başarılı bir şekilde yönetilebilir.
Keywords: Leriche sendromu, aorta oklüzyonu, parapleji

Ref No: 5959
Fascicular ventricular tachycardia confused with supraventricular tachycardia: a case report
Birsen Ertekin[1], Ali Tayyip Kömürcü[1], Süleyman Özcan[1], Ahmet Çağlar[1]
[1]University of Health Sciences, Beyhekim Training and Research Hospital, Konya, Turkey
Introduction and Purpose: Idiopathic fascicular ventricular tachycardia (VT) is a type of arrhythmia characterized by the presence of right bundle branch block (RBBB) and left axis deviation. This condition is often misdiagnosed as supraventricular tachycardia (SVT). Here we present a 27-year-old male patient admitted to the emergency department with palpitations.
Materials and Methods: Electrocardiography (ECG) showed narrow complex tachycardia, indeterminate axis and RBBB (Figure 1). The patient was initially diagnosed with SVT with bundle branch block, and a variety of treatments were administered, including vagal maneuvers, adenosine, metoprolol, amiodarone, and electrical cardioversion. However, these interventions did not produce the desired results. Subsequent ECG analysis revealed atrioventricular dissociation and capture beats. The patient was treated with verapamil in the intensive care unit, and a subsequent return to sinus rhythm was observed, suggesting a diagnosis of fascicular VT (Figure 2).
figure 1

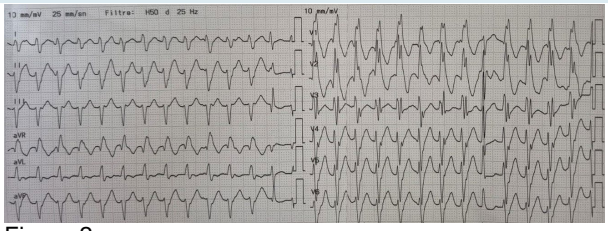
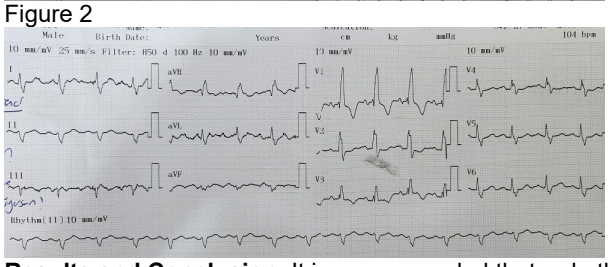


Figure 2



Results and Conclusion: It is recommended that arrhythmias refractory to conventional medical therapy be evaluated for fascicular VT.
Keywords: fascicular ventricular tachycardia, verapamil, arrhythmia

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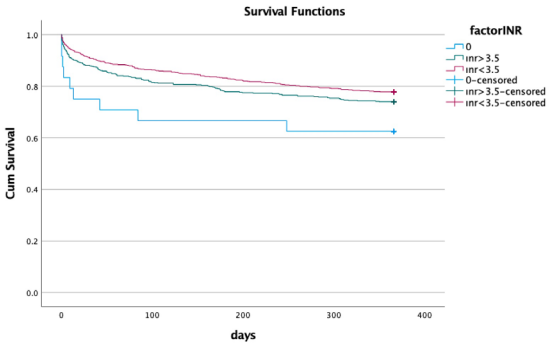
Ref No: 5986
Retrospective analysis of 1-month and 1-year mortality due to bleeding in patients using warfarin
Ismail Erkan Aydin[1], Banu Karakus Yilmaz[1], Erdem Cevik[2]
[1]Department of Emergency Medicine, Alanya Alaaddin Keykubat University, Faculty of Medicine, Antalya, Turkey
[2]Department of Emergency Medicine, Sultan Abdulhamid Han Training and Research Hospital, Istanbul, Turkey
Introduction and Purpose: Warfarin is approved for the prevention and/or treatment of venous thrombosis, pulmonary embolism, and thromboembolic complications associated with atrial fibrillation and/or cardiac valve replacement. international normalized ratio (INR) above the therapeutic range increases the risk of bleeding, its level below the therapeutic range increases the risk of thromboembolic complications. We aimed to evaluate the effect of patients' INR levels on one-month and one-year mortality.
Materials and Methods: The hospital's electronic information management system retrospectively screened between 01.01.2015, and 31.12.2016. Patients who applied to the emergency department (ED) with a history of warfarin use, were included in the study. The receiver operating characteristics (ROC) analysis and the area under the curve (AUC) for the mortality estimation calculations were used for statistical analysis.
Results and Conclusion: Total of 1299 patients with elevated INR due to warfarin use were included in the study. The major ED admission causes were bleeding (n = 338, 26.02%) and INR control with no other complaint (n = 56, 4.31%). Mortality was observed within one month in 118 (9.1%) patients and within one year in 292 (22.5%) patients. The ROC analysis for 1-month and 1-year mortality estimation, AUC values for age, INR, urea, and creatinine were 0.640, 0.549, 0.702, 0.629 and 0.629, 0.532, 0.671, 0.608, respectively. The patients admitted to ED due to high INR values are usually corrected their INR values and then discharged. These patients' one-year mortality is high so to identify and eliminate the underlying cause of the INR elevation is important.
Mortality of the patients according to Kaplan – Meier analysis.



Keywords: Warfarin, Mortality, International normalized ratio

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Ref No: 5988
The Impact of Acidosis on Clinical and Laboratory Parameters in COPD Exacerbations: A Study in Emergency Department Patients
Sarah Sabbagh Sharif[1], Bahadır Taşlıdere[1], Başar Cander[1]
[1]Bezmialem Vakıf üniversitesi Hastanesi, Emergency Medicine
Introduction and Purpose: Chronic Obstructive Pulmonary Disease (COPD) is a progressive and widespread respiratory system disease characterized by exacerbations. The development of acidosis during exacerbations increases the severity of the disease and

negatively affects the prognosis. This study was designed to examine the changes in clinical and laboratory parameters in patients presenting to the emergency department due to COPD exacerbation, based on the presence of acidosis. In addition to respiratory impairments, systemic effects were also evaluated in this research, aiming to provide significant data on the pathophysiological profile of acidosis during COPD exacerbations.

Materials and Methods: In the study, conducted from January 2024 to March 2025, the clinical and laboratory findings of COPD patients who developed acidosis were compared with those who had normal pH levels. The evaluated parameters included pH, PCO , WBC, respiratory rate, systolic blood pressure, body temperature, oxygen saturation, hemoglobin, neutrophil-to-lymphocyte ratio, BUN, and urea.

Results and Conclusion: As a result of statistical analyses, the pH value showed a marked difference between the groups (p = 0.000); the mean pH was 7.27 in the acidosis group and 7.40 in the normal group. Similarly, PCO values also showed a significant difference (p = 0.001); the mean PCO was 61.23 mmHg in the acidosis group and 46.23 mmHg in the normal group. This finding suggests the presence of respiratory acidosis. Additionally, WBC (leukocyte) levels were higher in the acidosis group (mean 14.17) compared to the normal group (mean 9.36), showing a significant difference (p = 0.008). This may be related to inflammation or infection. Variables with borderline p-values included respiratory rate (RR) (p = 0.067), systolic blood pressure (p = 0.068), and body temperature (TEMP) (p = 0.082). The respiratory rate was higher in the acidosis group (mean 24.08) compared to the normal group (mean 20.85), which may indicate compensatory hyperventilation. However, no significant differences were found between the two groups in terms of the other parameters (p > 0.05). In conclusion, the lower pH, higher PCO and increased WBC levels in the acidosis group are notable findings. These data suggest that acidosis has a respiratory component and may indicate a possible infection or inflammatory process.

Keywords: COPD Exacerbation, Clinical and Laboratory Parameters, Respiratory Acidosis

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Ref No: 6049

SPONTANEOUS EXTERNAL CAROTID ARTERY RUPTURE AND SPONTANEOUS SCM MUSCLE HEMATOMA

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Introduction and Purpose: Spontaneous hematomas occurring in the neck in the absence of any comorbid conditions are a rare occurrence in medical literature. These hematomas, which are generally associated with factors such as trauma, bleeding disorders, invasive procedures, or surgical interventions, can manifest in the anterior triangle of the neck, leading to airway obstruction or dysphagia, more serious neurological emergencies such as cervical epidural hematomas can also arise due to intrinsic factors such as prolonged coughing, sneezing, or vomiting (1)

Materials and Methods: A 75-year-old female with a known history of hypertension presented to our department with a complaint of sudden onset of severe pain and swelling in the neck. She had no other known comorbidities. The patient's initial were blood pressure 150/90 mmHg, pulse rate 80 beats/min, oxygen saturation 98%. The patient was taking only amlodipine 5 mg once daily and reported no other medication use. Physical examination revealed an approximately 10x6 cm swelling in the right neck region (Figure 1). The patient reported that the swelling appeared suddenly and increased in size within minutes. Carotid CT angiography revealed an approximately 9x5 cm swelling in the left sternocleidomastoid muscle and contrast medium extravasation from a branch of the external carotid artery (Figure 2). The patient was admitted to the cardiovascular surgery intensive care unit. Due to the continued enlargement of the hematoma, embolization was performed by interventional radiology. The patient was discharged in good condition on the 8th day. The patient's blood laboratory values at the time of admission are shown in Table 1.

Figure 1. There is approximately 10x6 cm swelling in the right neck region

Figure 2. The small arrow indicates the external carotid artery, the curved arrow indicates contrast medium extravasation, and the large thick arrow indicates hematoma in the SCM muscle

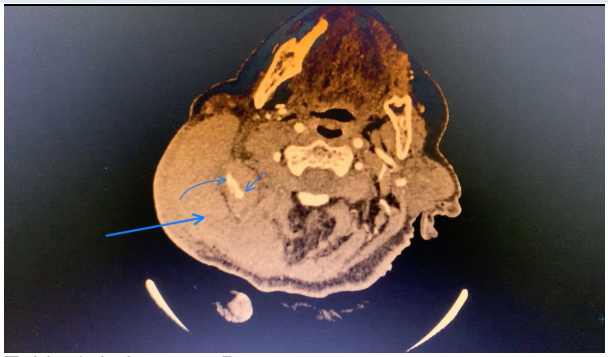

Table-1: Laboratory Parameters

Parameters	Result	Normal Range
Hgb (g/dl)	13.6	11-16
Platelet	241x10^3	100-400x10^3
INR(International Normalized Ratio)	1,1	0,8-1,2

Results and Conclusion: Intramuscular hematomas are classified as either spontaneous or traumatic based on their etiology. Causes of spontaneous hematomas include hemorrhagic diseases, neoplasms, and arterial diseases. Ilio-psoas , Sternocleidomastoid muscle and rectus abdominis muscle hematomas are well-recognized and significant complications, particularly associated with hemophilia and anticoagulant therapy. To our knowledge, this represents the first reported case of acute spontaneous cervical hematoma presenting as swelling in an adult, accompanied by spontaneous rupture of the external carotid artery. Previous reported cases have associated hematoma formation with trauma, bleeding diathesis, invasive procedures, or surgical interventions. None have described spontaneous external carotid artery rupture

Keywords: external carotid artery, cervical hematoma, emergency medicine

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Ref No: 6059

Distal Migration and Fracture of Biliary Stent: A Case Report of a Late Complication

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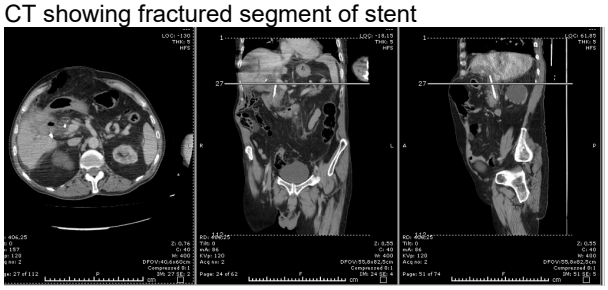
Introduction and Purpose: Biliary obstruction refers to blockage of the bile duct system leading to impaired bile flow from the liver into the intestinal tract. Endoscopic retrograde cholangiopancreatography (ERCP) is a complex endoscopic procedure with complications, which is widely used in the diagnosis and treatment of pancreatic and biliary system diseases.

Materials and Methods: In 2016, an 87-year-old male patient was admitted to the emergency department with complaints of nausea, vomiting, and weakness. Later, it was learned that duodenal perforation developed after the ERCP procedure and cholecystectomy was performed in 2015. Then in our department, he was diagnosed with choledocholithiasis based on his symptoms and an abdominal computed tomography (CT) scan and he was admitted to the gastroenterology department. In his hospitalization, he was taken to ERCP procedure, and after the stent was removed in the main bile duct, a stone in the duct was removed by mechanical lithotripsy. Biliary stent placement with ERCP was performed approximately on the 45th day after his discharge, and he was discharged from our center with an appointment for elective ERCP stent control later. After this stage, our patient was not followed up in our center. 5.5 years later, the patient was admitted to emergency department with complaints of abdominal distension, and chills for 3 months. Another CT scan performed and it was evaluated in favor of stent migration and stent material related fracture dysfunction. The patient was admitted to the gastroenterology service and ERCP was performed and some of the stones and stent pieces were removed. A fully covered metal stent was placed. He was recommended for a follow-up appointment at the end of the year for stent removal and canal treatment again.

CT showing fractured segment of stent



Computed tomography scan showing fractured segment of stent

Laboratory results

Parameter	Unit	Result (2016)	Result (2021)
WBC	x 10^3/uL	15.9	14.38
Neutrophil	%	92.6	97.1
HGB	g/dL	13.6	13.6
HCT	%	40.5	42.3
CRP	mg/L	2.51	59.63
AST	U/L	838	342
ALT	U/L	422	208
ALP	U/L	321	592
GGT	U/L	298	600
Bilirubin (total)	mg/dL	2.19	3.34
Bilirubin (direct)	mg/dL	1.49	2.43
Amylase	U/L	60	64
Lipase	U/L	21	29
Albumin	g/dL	3.7	-
Potassium	mmol/L	-	5.20

Laboratory Results Comparison Between 2016 and 2021

Results and Conclusion: Stent fracture is an uncommon situation encountered by endoscopists. Every effort should be made to retrieve fractured stent safely endoscopically by employing various techniques, thus avoiding potential complications. This case underscores the importance of timely follow-up in patients with biliary stents and highlights the potential for late complications, which require rapid recognition and management. It is also concluded that fracture of a biliary endoprosthesis should be systematically searched for in patients developing cholangitis after endoscopic drainage.

Keywords: ERCP, biliary stent, stent fracture

Ref No: 6088

A Rare Case of Autoimmune Hepatitis in Emergency Department Presenting with Severe Jaundice in a Young Woman

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Introduction and Purpose: Autoimmune hepatitis (AIH) is a chronic, progressive inflammatory liver disease of unknown etiology that predominantly affects young women. It is characterized by elevated liver enzymes, hypergammaglobulinemia, presence of autoantibodies, and interface hepatitis on histology. Although AIH usually presents insidiously, a subset of patients may exhibit acute or even fulminant hepatitis, making early recognition essential. Failure to initiate timely immunosuppressive treatment can lead to cirrhosis or hepatic failure. In this report, we present a rare case of AIH manifesting with acute severe jaundice in a young woman, emphasizing the importance of considering autoimmune causes in the differential diagnosis of acute hepatitis.

Materials and Methods: A 21-year-old woman presented to the emergency department with a 3-week history of nausea, vomiting, abdominal pain, and progressive jaundice. She had no prior history of liver disease or significant medication use. Initial management at another facility included ursodeoxycholic acid for presumed acute cholestatic hepatitis.On examination, she was hemodynamically stable with normal mental status (Glasgow Coma Scale 15) and had marked jaundice. Other systemic examinations were unremarkable. Laboratory findings included AST 594 U/L, ALT 783 U/L, total bilirubin 23.79 mg/dL (direct bilirubin 18.31 mg/dL), INR 1.80, and CRP 8.10 mg/L. Viral hepatitis markers (HBsAg, anti-HCV, anti-HBc IgG, anti-HIV) were all negative.Abdominal CT revealed a mildly contracted gallbladder with minimal pericholecystic fluid and hepatic parenchymal heterogeneity. Serologic workup showed positivity for autoimmune markers. A liver biopsy confirmed the diagnosis of autoimmune hepatitis with typical interface hepatitis.

Figure 1

Contrast-enhanced abdominal CT image demonstrating a contracted gallbladder with minimal pericholecystic fluid and slight wall thickening. The liver shows subtle parenchymal heterogeneity, suggestive of underlying inflammatory changes.

Results and Conclusion: This case underscores the variability in the clinical presentation of AIH, which can mimic other causes of acute hepatitis, including viral or drug-induced etiologies. In young adults, especially women, autoimmune hepatitis should be a key

consideration in cases of unexplained hepatitis with hyperbilirubinemia and elevated transaminases. Early diagnosis and prompt initiation of corticosteroid-based immunosuppression led to significant clinical improvement in our patient. She was discharged in stable condition after 15 days of hospitalization with a long-term follow-up plan coordinated by hepatology. Early identification and management of AIH are critical to improving patient outcomes and preventing irreversible liver damage.

Keywords: Autoimmune hepatitis, acute liver failure, immunosuppressive therapy

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Ref No: 6117

Adenosine and Ventricular Tachycardia in Surgically Corrected Congenital Heart Disease: A Potential Risk?

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Introduction and Purpose: Supraventricular tachycardia is defined as atrial rates higher than 100 beats per minute originating from tissues at the His bundle and above.Traditionally,all types of tachycardias, except for ventricular tachycardia and atrial fibrillation(AF),are classified as SVT.In patients who have undergone Mustard or Senning repairs, atrial re-entrant tachycardias are common,and the use of antiarrhythmic medications is limited due to proarrhythmic risks.In this case report,we describe a 28-year-old patient with a history of transposition of the great arteries correction surgery who developed monomorphic ventricular tachycardia(VT) following adenosine administration.

Materials and Methods: A 28-year-old male patient presented to the emergency room with a complaint of palpitation.Due to transposition of the great arteries, ventricular septal defect, and pulmonary atresia,he had corrective surgery at the age of nine.The patient has a history of pulmonary embolism–once five years ago and most recently one week ago, which was diagnosed with segmental emboli and resulted in his admission and discharge two days before his presentation.He was prescribed warfarin 5 mg once daily,enoxaparin 6000U twice daily, and amiodarone 200 mg twice daily.However, the patient had not been using amiodarone consistently. e did not have any known rhythm disorder and was regularly followed by the cardiology department.On physical examination, the patient was distressed.His heart rate was 131, blood pressure was 126/84,respiratory rate was 18 per minute,and his oxygen saturation was 90% on room air.Apart from palpitations, he did not report any chest pain or dyspnea.His ECG was evaluated as SVT,and the patient's vitals were monitored,including defibrillator setup.Vagal maneuver and carotid massage started without any clinical response.Subsequently, six mg of adenosine was administered intravenously.Following that, his heart rate increased, and his heart rhythm progressed to monomorphic VT.A 300 mg amiodarone infusion was started,and three minutes after the onset of VT,it resolved.

Results and Conclusion: Managing SVT in patients with surgically corrected congenital heart disease is challenging due to altered anatomy and arrhythmogenic structure.Our case highlights the risk of unexpected ventricular tachycardia following adenosine administration, underscoring the need for caution.Like WPW syndrome,alternative treatments like procainamide or ibutilide may be safer in these patients.Further research is needed to establish clear guidelines for acute arrhythmia management in this high-risk group.

Keywords: Congenital Heart Disease, Adenosine, Ventricular Tachycardia

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Ref No: 6118

Evaluation Of Tenascin-C Parameter Level In Case Of Acute Ischemic Stroke

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Introduction and Purpose: In this study, we aimed to investigate Tenascin-C as a biomarker in order to predict the diagnosis of stroke, the approximate start time of stroke in patients who were admitted to our emergency department and diagnosed with ischemic stroke.

Materials and Methods: 64 patients diagnosed with acute ischemic stroke who applied to Kayseri City Training and Research Hospital Emergency Department, between 01 August 2020 and 31 December 2020 were included in this prospective study. The control group was formed with the same number of participants who were not diagnosed with ischemic stroke, who had the same age and gender characteristics as the patient group. Participants' demographic characteristics, disease history, examination findings, start time and duration of symptoms, radiological findings, vital values at admission, and for differential diagnosis of stroke; hemogram, blood glucose, kidney function tests, electrolytes, coagulation parameters, arterial blood gas, and serum Tenascin-C level and clinical outcomes evaluated. The collected data compared using proper statistical methods. Patients diagnosed with acute ischemic stroke were grouped by anamnesis and physical examination findings according to the US National Institutes of Health Stroke Scale (NIHSS). Participants, group 1; 0-6 points mild-moderate, group 2; 7-15 points moderate-severe and group 3; 16-42 points severe-very severe, were divided into three subgroups by stroke intensity.

Results and Conclusion: In this study, the mean age of the participants was 71.5 ± 11.7 years. There was weakness on one side of the body, the most common symptom, in 46 patients (71.9%).The mean Tenascin-C value (110.2) in the patient group was significantly higher than in the control group (98.6). It was determined that there was a significant relationship between the age and symptom duration of the patients and Tenascin-C levels. The differences between Tenascin-C values, in terms of the NIHSS, of the patient group were found to be statistically significant.There is no determined biomarker in the diagnosis process of ischemic stroke. It was concluded that the Tenascin-C parameter could be used as an auxiliary biomarker to determine the duration and severity of ischemic stroke, thanks to more comprehensive studies, may shorten the time of diagnosis and starting of treatment in the emergency department.

Keywords: emergency, ischemic stroke, tenascin-c

Ref No: 6130

Asymptomatic Severe Hyponatremia

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Introduction and Purpose: Hyponatremia is defined as a serum sodium level of less than 135 mEq/L and is the most commonly encountered electrolyte imbalance. The pathogenesis is primarily attributed to the non-osmotic secretion of antidiuretic hormone (ADH). Typically, as the degree of hyponatremia increases, the severity and symptoms become more pronounced. Symptomatic hyponatremia should be treated with hospitalization. In asymptomatic cases, fluid restriction is recommended. (1)Our patient presents with severe hyponatremia (serum sodium level of 104 mmol/L) but remains clinically stable. This is noteworthy, as hyponatremia is typically associated with symptoms such as confusion, lethargy, or coma. Furthermore, both infectious and chronic etiologies should be considered in the differential diagnosis of hyponatremia.

Materials and Methods: A 50-year-old female patient presented to the emergency department with complaints of cough and fatigue for the past week. She had been started on Beloc one week ago due to a rhythm disorder. Two days ago, she developed nausea, vomiting, and headache. She has no known comorbidities. Her neurological examination was normal, with no pathological findings. Laboratory results:Creatinine: 2.1 g/Dl,Sodium: 104 mmol/L,Potassium: 2.55 mmol/L,LDH: 251 U/L,Urea: 231 mg/dL,WBC: 26.61 × 10^3/µL,Hemoglobin: 14.5 g/dL,Neutrophil percentage: 91.4%,CRP: 41.3 mg/L. Venous blood gas: pH: 7.563 PCo2:34.1 mmHg PO2:30.1 mmHg Hco3:29 mmol/L BE:7.6 mmol/L Na+:107.0 mmol/L K+:2.87 mmol/L Ca++:0.91 mmol/L Glu:178 mg/Dl Lac:2.12 mmol/L. The patient was referred to the internal medicine department for further evaluation and management. During follow-up in the department, imaging studies revealed a lesion in the colon, suggestive of a tumor. Colonoscopy was recommended; however, the patient declined the procedure and left the hospital after signing a form for refusal of further diagnostic workup and treatment.

Results and Conclusion: Hyponatremia can have multiple causes and may present unexpectedly; our patient was fortunate as she remained asymptomatic. Asymptomatic hyponatremia cases are quite rare, which is why we must have an in-depth understanding of the etiologies and consider medical, infectious, hormonal, chronic, and malignancy-related causes of hyponatremia. In this case, we aimed to highlight both a rare condition and its potential etiologies. A review of the literature indicates that more studies need to be conducted regarding conditions associated with hyponatremia.

Types of hyponatremia

Condition	Characteristics	Plasma Sodium (Na+)	Edema	Fluid Status	Examples
Hypovolemic Hyponatremia	Fluid loss in the body, dehydration, sodium loss with fluid loss	Low	No or minimal edema	Decreased fluid volume (dehydration)	Bleeding, vomiting, diarrhea, diuretic use, burns, kidney diseases
Hypervolemic Hyponatremia	Fluid accumulation in the body, increased water and sodium levels	Low	Severe edema (legs, abdomen)	Increased fluid volume (heart, liver, kidney failure)	Heart failure, cirrhosis, kidney failure, nephrotic syndrome
Euvolemic Hyponatremia	Normal fluid volume, but excessive water retention, often due to increased antidiuretic hormone (ADH)	Low	No or minimal edema	Normal fluid volume, water retention	SIADH (Syndrome of Inappropriate Antidiuretic Hormone), hypothyroidism, adrenal insufficiency, medications

Keywords: emergency, hyponatremia, internal medicine

Ref No: 6147

Subarachnoid Hemorrhage Presenting with Acute ST-Segment Elevation: A Neurocardiological Case Report

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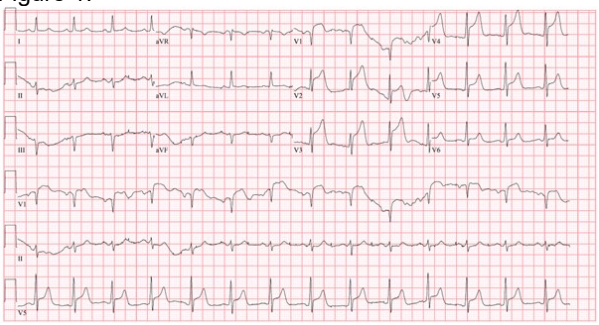
Introduction and Purpose: Subarachnoid hemorrhage (SAH), a severe neurological condition, is commonly due to aneurysm rupture, and is associated with considerable morbidity and mortality. Frequently, SAH-associated electrocardiographic (ECG) abnormalities can imitate acute coronary syndromes (ACS), complicating the initial diagnostic process. According to current literature, neurogenic stunned myocardium, caused by excessive sympathetic activation and a spike in catecholamines, is responsible for these misleading cardiac manifestations. This case highlights the critical neurocardiac interactions and emphasizes the importance of recognizing SAH in differential diagnoses of acute cardiac events.

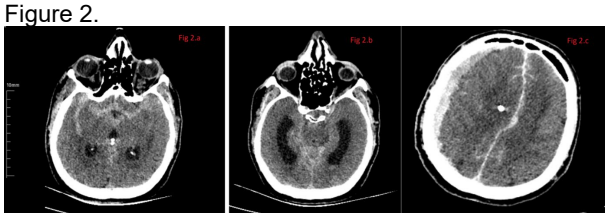
Materials and Methods: A 60-year-old male with hypertension and coronary artery disease presented to the emergency department with sudden-onset syncope. His routine medications included Coraspirin and Plavix. Vital signs: TA 160/90 mmHg, pulse 110/min, SpO □ 96%. Initial ECG showed significant anterior ST-segment elevation, consistent with acute anterior MI (Figure 1). Laboratory investigations revealed elevated troponin (10,000 ng/L) levels. Urgent angiography revealed severe obstruction of left main coronary artery, total obstruction of the proximal left anterior descending artery. Post-angioplasty the patient was transferred to the intensive care unit for observation. The patient subsequently developed headache and vomiting. CT revealed subarachnoid hemorrhage with hydrocephalus, requiring EVD. Follow-up imaging showed an acute subdural hematoma, prompting emergency evacuation and decompressive craniectomy (Figure 2a–c). Despite these interventions, the patient's condition deteriorated, leading to his death from hemodynamic and neurological decline.

Figure 1.



ECG showing ST elevation in V1–V5 consistent with anterior STEMI

Figure 2.



CT scan showing subarachnoid hemorrhage, hydrocephalus, and subdural hematoma post-intervention.

Results and Conclusion: In our case, invasive cardiac procedures based on initial ECG findings were complicated by the subsequent discovery of SAH. ECG alterations in SAH, including ST elevation, QT prolongation, and T-wave inversion, are common yet challenging to distinguish from ACS. These abnormalities are related to the abrupt release of catecholamines, which results in myocardial dysfunction and potential arrhythmias. In SAH cases, these changes are typically diffuse and fluctuate significantly with neurological status, unlike the localized and consistent patterns seen in myocardial infarction. Neurogenic stunned myocardium from intense catecholamine release is the accepted pathophysiological mechanism. Awareness of SAH is critical, particularly in atypical presentations or altered mental status, to prevent diagnostic delays. The emergence of complications like hydrocephalus and subdural hematomas considerably exacerbates the prognosis and necessitates immediate multidisciplinary intervention.

Keywords: Subarachnoid hemorrhage, electrocardiographic anomalies, myocardial infarction

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Ref No: 6150

A Rare Postoperative Complication: Hematoma and Abscess of the Falciform Ligament

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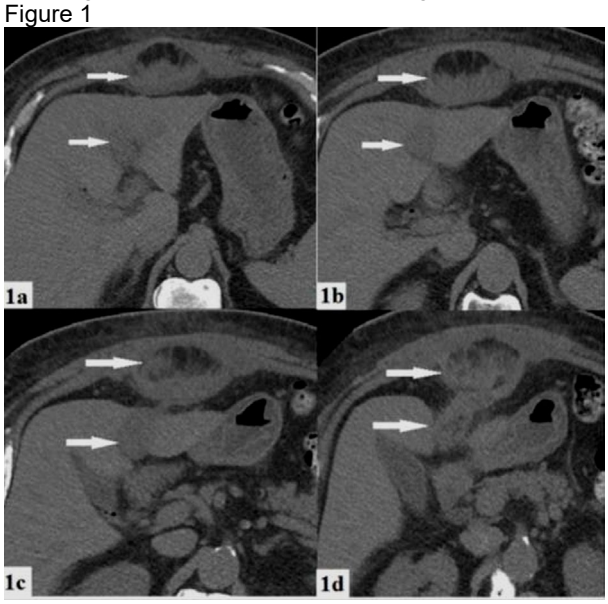
Introduction and Purpose: The etiology of falciform ligament (FL) hematoma includes the use of anticoagulant drugs or abdominal surgeries, while the etiology of FL abscess includes omphalitis in infants and biliary obstruction and infection in adults. Since a case of FL abscess developing on the background of FL hematoma has not been reported in the literature before, we present a rare case of acute abdomen.

Materials and Methods: A 58-year-old male patient presented to the emergency department of our hospital with a painful mass in the epigastric region and discharge from the surgical wound a few days after laparoscopic cholecystectomy. He had no history of drug use

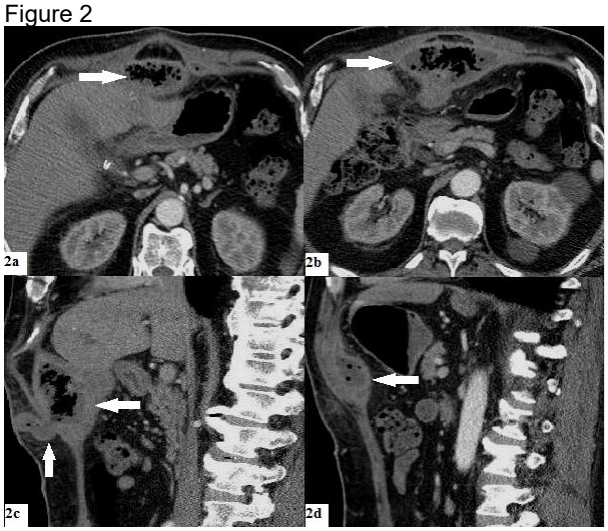
or comorbid diseases. He had undergone surgery for an incarcerated umbilical hernia 2 months prior to admission, and it was thought that the maneuvers performed during this surgery had caused an incision of the paraumbilical veins passing through the round ligament, leading to the development of an FL hematoma. However, this hematoma had been followed up for 2 months without complications (Figure 1). The examination was unremarkable except for tenderness in the right upper quadrant, and no pathology was observed in the vital signs except for subfebrile fever. Contrast-enhanced abdominal computed tomography (CT) revealed a dense fluid collection with air values at the site of the previous falciform hematoma (Figure 2). The patient, who had purulent discharge from the trocar entry site on clinical examination, was diagnosed with an FL abscess. Percutaneous drainage and antibiotherapy were applied. The patient was discharged without complications during follow-up.

Figure 1



The falciform ligament hematoma is shown with arrows on a non-contrast abdominal CT scan.

Figure 2



Contrast-enhanced abdominal CT scan showing a falciform ligament abscess with arrows.

Results and Conclusion: FL abscess is rarely reported in the literature, typically developing due to conditions like ventriculoperitoneal shunt infections, cholecystitis, pancreatitis, or umbilical infections in children. In this case, an FL abscess developed as a complication after laparoscopic cholecystectomy. It is suspected that contamination of a pre-existing FL hematoma during the second surgery led to the abscess. To prevent such complications, trocar insertion away from the FL is recommended. FL hematomas resulting from surgical interventions can occasionally progress into abscesses after subsequent procedures, highlighting the importance of considering this risk when evaluating patients post-surgery.

Keywords: Falciform ligament abscess, Hematoma contamination, Laparoscopic cholecystectomy

Ref No: 6187

Examination of Clinical and Laboratory Features in the Differentiation of Anaphylaxis and Non-Anaphylaxis Allergic Reactions

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Introduction and Purpose: Allergic reactions are inflammatory responses that develop within minutes or hours of exposure to an allergen. Anaphylaxis is the most severe of these reactions. The aim of this study is to examine the clinical and laboratory findings in patients with allergic reactions and to identify the clinical features and laboratory parameters that may be helpful in distinguishing anaphylaxis from non-anaphylactic allergic reactions.

Materials and Methods: Patients presenting to the emergency department with allergic reactions during a one-year period were included in the study. Clinical findings, demographic characteristics, vital signs, allergen, time of presentation, symptoms of presentation and laboratory data of the patients were recorded and divided into two groups as group 1 (anaphylaxis) and group 2 (non-anaphylactic allergic reactions).

Results and Conclusion: A total of 107 patients were included in our study; 36 patients in group 1 and 71 patients in group 2. There was no significant difference between the groups in terms of age and gender. While the most common cause of allergy was drugs (49.5%), 91.7% of allergic reactions in group 1 were due to drugs, and this rate was significantly higher than in group 2 (p<0.001). The rate of patients presenting within the first hour in the anaphylaxis group was 83.3% and this rate was significantly higher than in group 2 (p<0.001). While the most common cause of presentation was skin reactions (70.1%), 86.1% of anaphylaxis patients presented with respiratory problems, and this rate was significantly higher than in group 2 (p<0.001). Lactate levels were higher in group 1 than in group 2 [2.65 (1-11.7) and 1.4 (0.6-4.5), p<0.001]. Albumin levels were lower in group 1 than in group 2 (p=0.001). CK levels were higher in group 2 than in group 1 (p=0.006). No statistically significant difference was found between the two groups for eosinophil levels, CRP/albumin ratio, eosinophil/albumin ratio, MPV values (p=0.238, p=0.397, p=0.431, p=0.341, respectively). The most common cause of anaphylaxis was drugs and most patients presented within the first hour. Respiratory distress, low blood pressure and increased pulse rate were more common in anaphylaxis patients, while lactate levels were high and albumin and CK levels were low.

Table 1. Clinical and Demographic Characteristics of Study Population

Variable	Total (N:107)	Anaphylaxia (N:36)	Allergy (n:71)	P Value
Age	41 (18-89)	44.5 (18-79)	40 (19-89)	0.156
SBP	110 (40-180)	82.5 (40-140)	110 (80-180)	**<0.001**
DBP	70 (20-100)	55 (20-90)	70 (50-100)	**<0.001**
Pulse	92 (67-160)	109 (80-160)	89 (67-126)	**<0.001**
CRP	0.5 (0-3)	0.54 (0.1-3)	0.5 (0-2.3)	0.835
Lactate	1.7 (0.6-11.7)	2.65 (1-11.7)	1.4 (0.6-4.5)	**<0.001**
LDH	210 (100-905)	214.5 (112-905)	207 (100-487)	0.757
CK	124 (12-1192)	97 (17-480)	142 (12-1192)	**0.006**
Albumin	4 (1.6-4.9)	3.9 (1.7-4.5)	4.1 (1.6-4.9)	**0.001**
WBC	8885 (6.02-35330)	9469(5627-35330)	8625 (6.02-18330)	0.059
Eosinophil	122 (7-668)	115.5 (13-611)	140 (7-668)	0.238
MPV	7.98 (5.15-16.44)	7.91 (5.34-16.44)	8.04 (5.15-16.30)	0.341
CRP/Albumin	0.13 (0.01-0.70)	0.14 (0.03-0.7)	0.13 (0.01-0.61)	0.397
Eosinophil/Albumin	33.13 (1.84-180.5)	30.18 (3.33-160.8)	35.16 (1.8-150.8)	0.431
Female Sex	61 (57%)	23 (63.9%)	38 (53.5%)	0.306

Allergen				
Drugs	53 (49.5%)	33 (91.7%)	20 (28.2%)	**<0.001**
İnsect bites	7 (6.5%)	1 (2.8%)	6 (8.5%)	
Food	12 (11.2%)	2 (5.6%)	10 (14.1%)	
Unknown	35 (32.7%)	0 (0)	35 (49.3%)	
Arrival duration				
0-1 hr	54 (50.5%)	30 (83.3%)	24 (33.8%)	**<0.001**
1-24 hr	30 (28%)	6 (16.7%)	24 (33.8%)	
>24 hr	23 (21.5%)	0 (0)	23 (32.4%)	
Symptoms				
Skin problems	75 (70.1%)	5 (13.9%)	70 (98.6%)	**<0.001**
Dyspnea	32 (29.9%)	31 (86.1%)	1 (1.4%)	

Table 2. Correlation Between Duration and Laboratory Values in Patients with Anaphylaxis

	DURATİON	
	rho	P Value
Lactate	0.083	0.63
Albumin	-0.10	0.954
CK	0.228	0.181
SBP	-0.163	0.342
DBP	-0.271	0.110
Pulse	0.041	0.813

Keywords: anaphylaxis, lactate, albumin

Ref No: 6212

Diagnostic Value of Serum Calprotectin Level in Patients with Acute Appendicitis in the Emergency Department

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[1]Adıyaman Training and Research Hospital

Introduction and Purpose: Acute appendicitis is one of the most prevalent diseases that causes abdominal pain. In some cases, patients presenting with acute appendicitis may not be diagnosed promptly. A delayed and erroneous diagnosis can result in perforation, peritonitis, abscess formation, sepsis, ileus, and mortality. Therefore, new non-invasive, easily accessible, with no risk of ionizing radiation, and highly sensitive and specific diagnostic markers for acute appendicitis are needed. Therefore, we aimed to investigate the diagnostic value of the blood calprotectin level in patients with a definitive diagnosis of acute appendicitis and to determine its feasibility in clinical practice.

Materials and Methods: This study was a single-center, prospective, case-control study that included patients diagnosed with acute appendicitis based on clinical, laboratory, and radiological imaging findings. A total of 60 patients and 30 healthy volunteers were included in the study. The SPSS software was used for statistical analysis (v 15.0 for Windows).The serum levels of calprotectin were

analysed using ELISA kits from Wuhan USCN Business Co. Ltd. (Cloud-Clone-Corp, Houston, USA) according to the manufacturer's recommended protocol. The list was constructed in the order of pipetting. The results of the serum calprotectin level were expressed in pg/mL.

Results and Conclusion: The study included 60 patients with acute appendicitis and 30 healthy volunteers. The clinical characteristics of the patient group are summarised in Table 1.The mean calprotectin level of the patient group (626.2±74.8) was significantly higher than that of the control group (40.6±8.0) ($p<0.001$, Table 2).No significant correlation was found between the serum calprotectin level and the Alvarado score ($r=-0.202$, $p>0.05$), appendiceal diameter ($r=-0.182$, $p>0.05$), and WBC ($r=0.033$, $p>0.05$, Table 3).In the ROC analysis conducted to assess the diagnostic efficacy of serum calprotectin levels in identifying the patient cohort, serum calprotectin demonstrated a sensitivity of 95% and a specificity of 99.96% at a cut-off value of 41.85 pg/ml, with an AUC value of 0.957 ($p<0.001$) (Figure 1).ConclusionsOur study showed that the mean serum calprotectin levels of patients diagnosed with acute appendicitis in the emergency department were higher than in the group of healthy volunteers.

Figure 1. ROC analysis showing the diagnostic value of calprotectin in determining the patient group

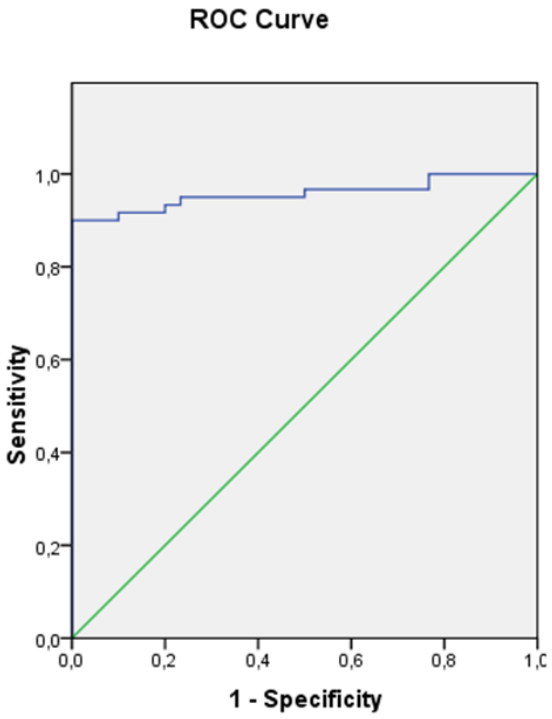

Table 1. Characteristics of patients with acute appendicitis

		n (%)
Reason for presentation Perforation	Vomiting Abdominal pain Nausea Lack of appetite Fever	46 (76.7) 37 (61.7) 36 (60.0) 20 (33.3) 1 (1.7) 5 (8.3)
		Mean (SD)
Time from the onset of complaints to emergency presentation, hours Fever, C° Alvarado score Appendiceal diameter on ultrasonography, mm Appendicealdiameter on computed tomography, mm WBC, uL		17.5 (17.9) 36.7 (0.4) 7.32 (1.38) 8.20 (2.23) 9.48 (2.44) 14711.3 (3475.9) 113.6 (15.8) 71.8 (9.5) 90.3 (20.8)

Systolic blood pressure, mm/Hg Diastolic blood pressure, mm/Hg Pulse, bpm		

Table 2.Comparison of the serum calprotectin levels between the patient and control groups

	Acute appendicitis	Control group	
Calprotectin	Mean (SD)	Mean (SD)	p
(pg/ml)	626.2 (74.8)	40.6 (8.0)	<0.001

Table 3. Relationship between the serum calprotectin level and patient characteristics

		Calprotectin (pg/ml)
Variables	rho	p
Time from the onset of complaints to emergency presentation, hours	0.180	0.168
Alvarado score	-0.202	0.122
Appendiceal diameter on ultrasonography-computed tomography, mm	-0.182	0.164
WBC, uL	0.033	0.803
Systolic blood pressure, mm/Hg	0.179	0.172
Diastolic blood pressure, mm/Hg	0.125	0.340
Pulse, bpm	-0.073	0.580

Keywords: Acute appendicitis, calprotectin, diagnosis

Ref No: 6302

Percheron artery infarction: a case report on differential diagnosis with carbon monoxide and methanol poisoning

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Introduction and Purpose: Percheron artery infarction is a rare type of stroke caused by the occlusion of a single thalamoperforating artery arising from the P1 segment of the posterior cerebral artery, which supplies both paramedian thalami. Clinically, it is characterized by the sudden-onset of alterations in consciousness, confusion, vertical gaze palsy, and memory impairment. However, since these symptoms are non-specific, various differential diagnoses should be considered. In this article, we aim to contribute to the literature by presenting a case of a 67-year-old female patient who was admitted to the emergency department with impaired consciousness.

Materials and Methods: The 67-year-old female patient was admitted to the emergency department (ED) due to impaired consciousness. A neurological examination revealed a stuporous mental state. Arterial blood gas analysis did not indicate findings suggestive of carbon monoxide or methanol poisoning. Brain MRI showed bilateral thalamic diffusion restriction. Based on clinical and radiological evaluations, the patient was diagnosed with Percheron artery infarction.

Figure 1 BT images of the patient

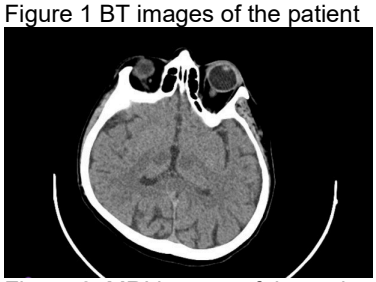
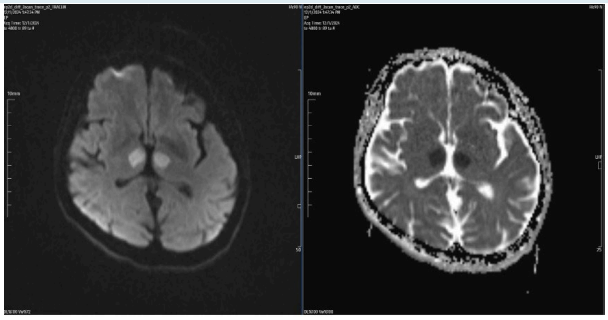


Figure 2: MRI images of the patient



Results and Conclusion: In patients presenting with bilateral thalamic lesions, Percheron artery infarction is an important differential diagnosis. Clinical history, arterial blood gas analysis, and brain imaging should be evaluated together to exclude toxic and metabolic causes. Early diagnosis and treatment can significantly impact the prognosis of the disease.
Keywords: Percheron artery infarction, Carbon monoxide poisoning, Methanol poisoning

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Ref No: 6338
Emergency use of endotracheal tube as a substitute for chest tube in pneumothorax management: a case report
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Introduction and Purpose: Traumatic pneumothorax and hemothorax are life-threatening conditions that require urgent intervention. The standard treatment involves inserting a chest tube to evacuate air and blood from the pleural cavity. However, in resource-limited settings, alternative solutions may be required. This case report presents an emergency approach where a 7.5-mm endotracheal tube (ETT) was used as a temporary chest tube substitute when a standard chest tube was unavailable.
Materials and Methods: A 59-year-old male patient was brought to the emergency department after a fall from a height of approximately six meters. He presented with altered mental status, respiratory distress, and an SpO □ of 85%. Physical examination revealed an open scalp laceration, bilateral periorbital ecchymosis, and absent breath sounds on the right side.A computed tomography (CT) scan confirmed a large right-sided pneumothorax and hemothorax with mediastinal shift to the left. Due to the unavailability of a standard chest tube, a 7.5-mm ETT was inserted into the pleural cavity for emergency pleural drainage.
Results and Conclusion: The intervention led to immediate improvement in oxygenation (SpO □increased from 85% to 99%), allowing temporary stabilization. The patient was transferred to a higher-level trauma center, where the ETT was replaced with a standard chest tube after three hours due to obstruction.This case highlights the importance of adaptability in emergency settings. While an ETT is not a replacement for a standard chest tube, it can serve as a temporary life-saving measure when standard equipment is unavailable. The risks of infection, obstruction, and inadequate drainage should be considered. Training emergency physicians in alternative thoracic drainage techniques and developing standardized protocols can improve patient outcomes in resource-limited settings.
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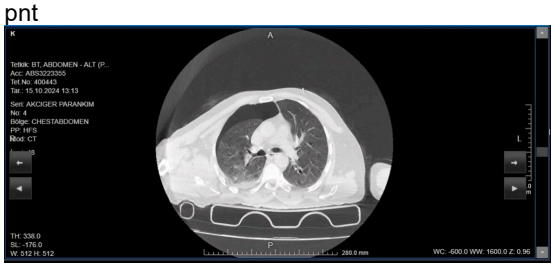

Figure 1: Axial computed tomography (CT) scan demonstrating a significant right-sided pneumothorax and hemothorax. Mediastinal shift to the left is evident, accompanied by partial lung collapse and pulmonary contusion.
ett

Figure 2: Coronal computed tomography (CT) scan showing the placement of a 7.5-mm endotracheal tube as a temporary chest tube substitute within the right pleural cavity. Increased fluid accumulation (hemothorax) and a large pneumothorax are visible in the right hemithorax.
Keywords: Pneumothorax, chest tube, trauma

Ref No: 6355
OVARIAN TORSION
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Introduction and Purpose: OVARIAN TORSIONINTRODUCTION:Ovarian torsion is seen in 2.7% of gynecologic emergencies. In terms of age groups, it is observed in all age groups from female fetuses to menopause, but it is more common in women of reproductive age. The etiology of ovarian torsion is unknown, but in most cases, functional cysts or neoplasms of the ovary are present. Delay or error in diagnosis may lead to loss of the ovary or decreased follicular reserve. When clinical signs of acute abdomen (peritoneal irritation) are present, most cases proceed to diagnostic laparotomy or laparoscopy.
Materials and Methods: CASE: A 19-year-old woman presented with abdominal pain for approximately 24 hours. Her vital signs were normal at presentation (Pulse: 88 SPO2: 96 TA: 120/85 FEVER: 36.5). The patient had no known comorbidities. Physical examination revealed tenderness in the right lower quadrant of the abdomen and external examinations were unremarkable. The tests taken from the patient resulted as HGB: 13, WBC: 9300, there was no feature in other blood tests. In the report of the USG and DOPPLER USG imaging of the patient, a smoothly circumscribed hemorrhagic cyst with a size of approximately 48 * 33MM in the right ovary was observed, and the flow in the right ovary was not coded in Doppler USG. The patient was consulted to the Gynecology and Obstetrics clinic and hospitalized for treatment.
Results and Conclusion: CONCLUSIONS:Ovarian torsion is an important clinical condition that is seen in all age groups and should be intervened without delay among gynecologic emergencies. Because of the difficulties in diagnosis, clinical signs and symptoms should be carefully evaluated and combined with laboratory and ultrasonographic data to make the correct diagnosis.
Keywords: OVARIAN TORSION, ABDOMINAL PAIN, GYNECOLOGIC EMERGENCIES

Ref No: 6363
Effects of dark time and chronobiological time on traffic accidents admitted to the emergency department
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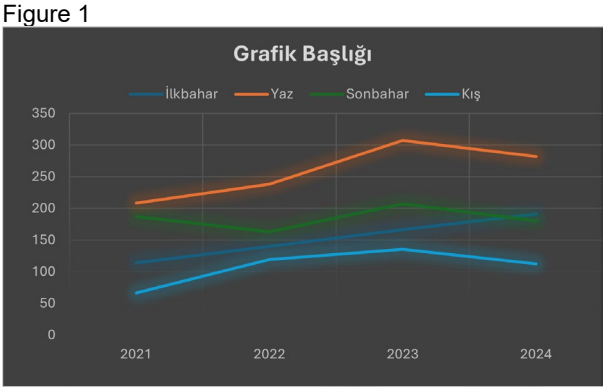
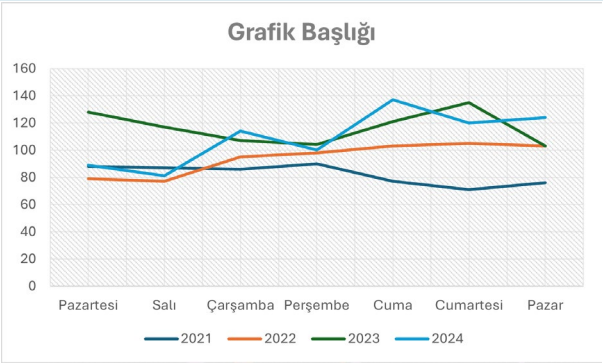
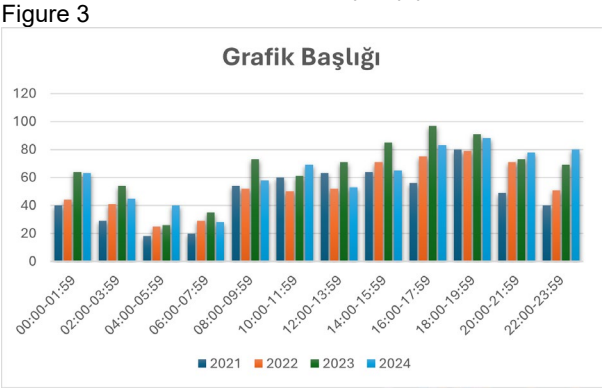
Introduction and Purpose: Accidents and accidental injuries are important public health problems that require multidisciplinary research approaches and solutions, especially with the increasing integration of attention-demanding technologies into work and daily life. The variation in the number and risk of accidents over a 24-hour period depends on many factors, including the nature and intensity of daytime duties and other shifts, the characteristics of working arrangements, and the education and age of workers, so that in some environments accidents and injuries may be more common during the day than at night. Afyonkarahisar is a regional connection point in Turkey. As it acts as a junction point in Turkey, millions of vehicles pass through Afyonkarahisar every year, and hundreds of accidents occur. In our study, patients between the ages of 18-100 who applied to Afyonkarahisar Health Sciences University Health Application and Research Center Adult Emergency Service due to vehicle or non-vehicle traffic accidents between 01.02.2021-30.12.2025 will be included in the study. Our aim in our study is to evaluate the hours, numbers and seasons when accidents are most common and to examine the reasons for this.
Materials and Methods: Our study will determine which season and hour there are more accidents and we aimed to find information about the situations to be careful about. We included 2868 patients in our study between 01.02.2021-30.12.2024. 1962 (68.4%) of them are male and 906 (31.6%) are female. In our study, it was found that the most frequent accidents occurred in the summer months with 36.20% between 2021-2024 (table 1). It was also found that the most frequent accidents occurred on Friday (table 2). It has been determined that accidents are most common between 16:00-20:00 after work (table 3).
Figure 1



Number of accidents between seasons by year
Figure 2



Number of accidents between days by year
Figure 3



Number of accidents between hours by year

Results and Conclusion: In our study, we aimed to find solutions to the questions of how precautions can be taken and how such accidents can be prevented in the light of this information. Especially on Fridays and after work, inspections should be increased and drivers should be more careful. Due to summer vacation and more frequent use of highways, it is necessary to be more careful in the summer in order to prevent accidents.

Keywords: black time, chronobiological time, traffic accidents

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Ref No: 6469

Fatal Cyfluthrin Intoxication Following Accidental Topical Exposure in a 67-Year-Old Woman: A Case Report

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Introduction and Purpose: Cyfluthrin, a synthetic pyrethroid insecticide, is widely used in agricultural and domestic settings. While considered to have low mammalian toxicity, severe outcomes following significant exposure have been reported. We describe a fatal case of presumed cyfluthrin intoxication in a previously healthy elderly woman following topical exposure during routine animal care.

Materials and Methods: Case Presentation:A 67-year-old female shepherd with no significant past medical history presented to the emergency department after collapsing in a pasture shortly after applying a cyfluthrin-based ectoparasitic spray to goats. She reported severe retrosternal chest pain radiating to the shoulders and back, accompanied by repeated vomiting and transient loss of consciousness. Upon arrival, she was hypotensive (BP: 65/45 mmHg), bradycardic (HR: 65 bpm), and hypoxic (SpO □ 88% on room air). Laboratory studies revealed profound metabolic acidosis (pH: 6.95, HCO □□ 14 mmol/L), severe hyperglycemia (glucose: 420 mg/dL), and markedly elevated transaminases (AST: 2900 U/L; ALT: 2200 U/L). A transthoracic echocardiogram demonstrated a 2–3 cm pericardial effusion without tamponade physiology. Despite aggressive fluid resuscitation, bicarbonate therapy, and supportive care in the intensive care unit, the patient developed refractory shock, disseminated intravascular coagulation, and progressive multiorgan failure. She suffered a cardiac arrest on hospital day 8 and could not be resuscitated.

Results and Conclusion: Discussion:This case illustrates a rare but lethal manifestation of cyfluthrin intoxication following accidental dermal exposure. The clinical course was characterized by early-onset metabolic acidosis, hepatic and renal dysfunction, myocardial injury, and coagulopathy. The suspected mechanism involves direct mitochondrial toxicity and disruption of sodium channel kinetics leading to cellular hypoxia and systemic collapse. Although pyrethroids are generally considered safe in mammals, this report underscores their potential for severe systemic toxicity, particularly in elderly or dehydrated individuals with delayed decontamination.In conclusions, topical exposure to cyfluthrin can result in fatal systemic toxicity. Early recognition, rapid decontamination, and aggressive supportive therapy are critical. This case highlights the need for enhanced safety protocols in the use of agricultural insecticides and contributes to the limited body of forensic toxicology literature on pyrethroid-related fatalities.

Keywords: Cyfluthrin Intoxication, Emergency department, Fatal

Ref No: 6491

Unexpected diagnosis in adulthood: diabetic ketoacidosis as the first symptom of diabetes

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Introduction and Purpose: Diabetic ketoacidosis (DKA) is a serious and life-threatening acute complications of diabetes. It usually occurs at the time of the initial diagnosis of type 1 diabetes or due to an insulin deficiency. It is characterized by hyperglycemia, ketosis, and metabolic acidosis and requires prompt diagnosis and treatment. The mechanism of the development of DKA is based on increased gluconeogenesis and lipolysis processes because of insulin deficiency. This leads to the conversion of free fatty acids into ketone bodies and metabolic acidosis. Patients often present with symptoms such as polyuria, polydipsia, weight loss, weakness, nausea and vomiting, abdominal pain, and changes in consciousness. Laboratory findings such as blood glucose level above 250 mg/dL, pH below 7.3, bicarbonate level less than 15 mEq/L and ketonemia or ketonuria are important for the diagnosis. One of the most important steps for treating DKA is fluid replacement. Dehydration should be corrected by intravenous fluid administration, followed by intravenous insulin infusion to control hyperglycemia and ketosis. In addition, potassium and other electrolyte imbalances should be corrected and the patient should be monitored continuously.

Materials and Methods: A 27-year-old woman with no known comorbidities presented to the emergency department with complaints of anorexia, excessive water drinking, dry lips, difficulty in walking and weakness for the last 2 days. On physical examination, her pulse rate was 111 beats/min, blood pressure was 139/58 mmHmm Hgd oxygen saturation was 98%. The blood glucose level was found to be 400 mg/dL. Arterial blood gas analysis revealed pH: 6.88, bicarbonate: 5.1 mmol/L and potassium: 4.3 mmol/L. Complete urinalysis revealed 3+ ketone positivity. The patient was diagnosed with diabetic ketoacidosis in the emergency department, and appropriate fluid and insulin treatment was rapidly initiated. The endocrinology department was consulted, and the patient was hospitalized for further investigation and treatment.

Results and Conclusion: n conclusion, the presented case demonstrates that newly diagnosed diabetic patients in adulthood may also present with DKA and develop severe metabolic acidosis requiring emergency intervention. Therefore, it is important to consider DKA among the differential diagnoses in adult patients without a diagnosis of diabetes in emergency departments.

Keywords: Diabetic Ketoacidosis, Diabetes Mellitus, Metabolic Acidosis

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Ref No: 6498

Bitalamik Enfarkt: İki Olgu Sunumu

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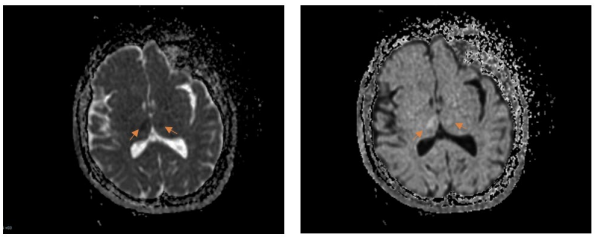
[1]Recep Tayyip Erdoğan Üniversitesi Tıp Fakültesi Eğitim Araştırma Hastanesi Acil Tıp Ana Bilim Dalı, Rize, Türkiye

Introduction and Purpose: Bitalamik enfarkt, nadir görülen bir inme sendromu olup, genellikle Arteria Percheron oklüzyonu ile ilişkilidir. Bilinç değişiklikleri, okülomotor bozukluklar ve bilişsel işlev kaybı gibi semptomlarla ortaya çıkar. Erken tanı ve tedavi, prognoz açısından kritik öneme sahiptir.

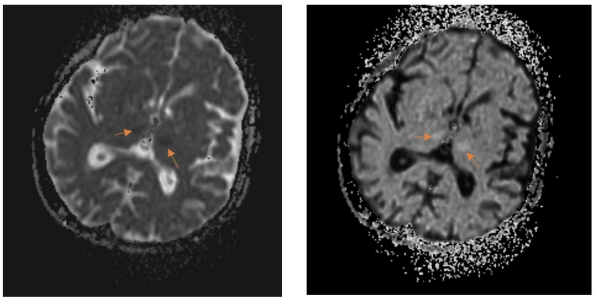
Materials and Methods: Olgu 169 yaşında kadın hasta, bir gün önce başlayan çift görme ve baş ağrısı şikayetiyle acil servise başvurdu. Hipertansiyon, diyabet, atriyal fibrilasyon ve romatoid artrit tanıları olan hastanın anamnezinde gribal enfeksiyon, ateş, travma öyküsü yoktu. Fizik muayenesinde bilinci açık, oryante-koopere, nörolojik lateralizan defisiti yoktu. Işık refreksi bilateral mevcuttu. Vital bulguları stabil olan hastanın laboratuvar testleri normal sınırlardaydı. Görüntülemesinde difüzyon Manyetik rezonans(MR) görüntülemesinde bitalamik enfarkt saptandı. Nörolojiye konsülte edilerek asetilsalisilik asit ve enoksaparin sodyum tedavisi başlandı, takip amacıyla yatırıldı. Görme fonksiyonları sekelsiz düzelen hasta tedavi sonrası taburcu edildi.Olgu 261 yaşında kadın hasta, bir gece önce aniden bilinç kaybı olması sonrası getirildi. Hipertansiyon, hiperlipidemi, diyabet tanıları olan hasta gelişinde nonoryante nonkoopere GKS:4 olarak değerlendirdi ve entübe edildi. Fizik muayenesinde pupiller middilate, ışık refleksi zayıf, babinski pozitifti. Yapılan difüzyon MR görüntülemesinde bitalamik enfarkt saptandı. Hasta yoğun bakıma yatırılarak nörolojik ve hemodinamik takip ve tedavi başlandı. Yoğun bakım takibinde ekstübe edildi. Bilinç durumunda değişiklik olmayan hastada takibinde sağ hemiparazi izlendi. Nazogastrik sonda ile beslenmesi sağlandı. Hasta uzun süren yoğun bakım takibi sonrasında mevcut durumu ile şeker regülasyonu için dahiliye servisine devredildi.

Şekil 1



MR ADC ve TRACE sekansta bitalamik enfarkt görüntüsü

Şekil 2



MR ADC ve TRACE sekansta bitalamik enfarkt görüntüsü

Results and Conclusion: Talamus, bilinç, duyusal entegrasyon, motor kontrol ve bilişsel işlevlerde kritik rol oynar. Bitalamik enfarkt, bilinç değişiklikleri, hafıza kaybı, okülomotor bozukluklar ve bilişsel işlev kaybı ile prezente olabilir. Arteria Percheron tıkanıklığı, genellikle hipertansiyon, diyabet ve kardiyoembolik kaynaklı olaylarla ilişkilidir. Erken tanı için difüzyon MR kullanımı önemlidir. Tedavi, antitrombotik ajanlar ve semptomatik destek üzerine kuruludur.Bitalamik enfarkt, klinik olarak değişken seyreden ve ciddi nörolojik sekellere yol açabilen bir inme sendromudur. Özellikle bilinç kaybı ve okülomotor bozukluklarla başvuran hastalarda, arteria Percheron enfarktı akılda tutulmalı ve erken tanı için uygun görüntüleme yöntemleri kullanılmalıdır.

Keywords: Bitalamik Enfarkt, Arteria Percheron, Serebrovasküler İskemi

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Ref No: 6565

First seizure in the emergency department and contrast-enhanced cranial magnetic resonance imaging (MRI)

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Introduction and Purpose: Renal cell carcinoma (RCC) is a malignancy with high metastatic potential and may rarely present with brain metastases. Brain metastases due to RCC are usually hemorrhagic in nature, and neurological symptoms may be the first manifestation of the disease. This situation necessitates broadening the differential diagnosis, especially in elderly patients with a history of malignancy presenting with sudden clinical onset such as seizures.

Materials and Methods: This study presents the case of a 68-year-old female patient with a history of RCC who experienced her first seizure. Imaging studies revealed a hemorrhagic lesion in the right frontal lobe with surrounding edema and mass effect. Initial evaluation included computed tomography (CT) and diffusion-weighted magnetic resonance imaging (MRI), but the definitive diagnosis was made with contrast-enhanced cranial MRI. The patient underwent surgery by the neurosurgery department, and histopathological examination confirmed RCC metastasis.

Figure 1: Brain CT: A subcortical-cortical hypodense area in the right frontotemporal region with hyperdense areas consistent with hemorrhage was observed. (Acute hemorrhagic infarction?)

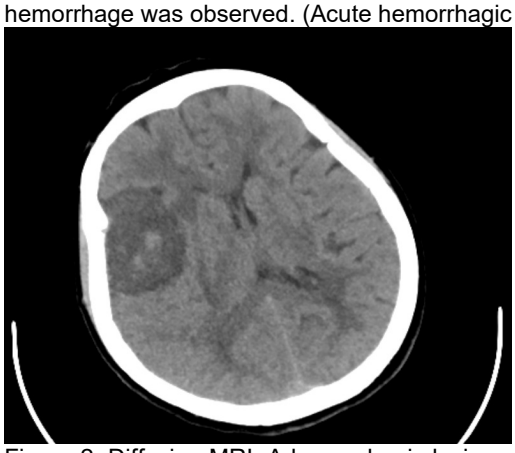
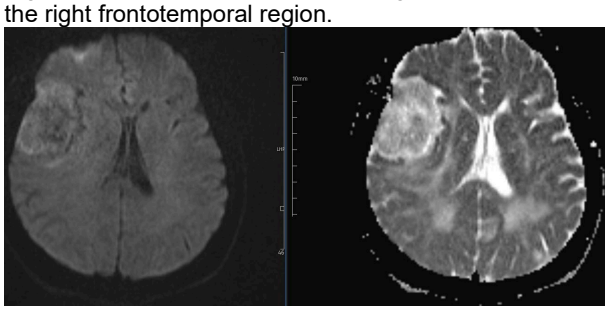
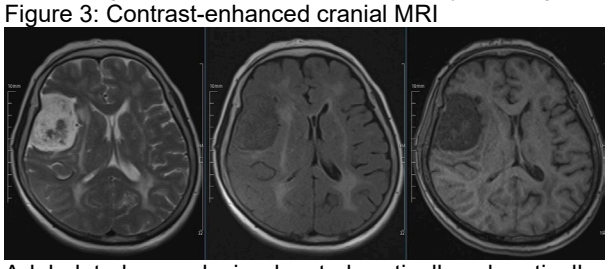


Figure 2: Diffusion MRI: A hemorrhagic lesion approximately 5x4 cm in size with heterogeneous contrast enhancement was detected in the right frontotemporal region.

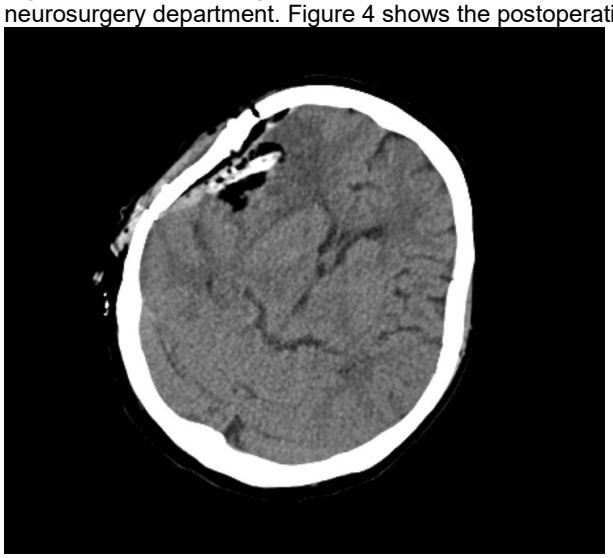


The absence of significant vasogenic edema in the surrounding parenchyma prompted a recommendation for further evaluation for

hemorrhagic infarct versus mass. To clarify the diagnosis, a contrast-enhanced cranial MRI was performed.
Figure 3: Contrast-enhanced cranial MRI



A lobulated mass lesion located cortically-subcortically at the level of the Sylvian fissure in the right frontotemporal region, measuring 46x41x45 mm (APxTRxCC), showing hypointensity on T1-weighted images, marked hyperintensity with hypointense foci on T2-weighted images, and intense heterogeneous contrast enhancement after gadolinium injection. Perilesional edema was noted. Dural enhancement was observed at this level. The right lateral ventricle was compressed. A 5 mm midline shift to the left was present. Additionally, in the medial cortex of the right temporal lobe at the hippocampus and parahippocampal level, an expansile, non-enhancing nodular lesion approximately 23x15 mm in size was observed, appearing hyperintense on T2-weighted and FLAIR sequences. In a patient with RCC history, metastasis was considered most likely, with ischemia as a less probable differential.
Figure 4: These findings were consistent with brain metastasis due to RCC. The patient was evaluated and operated on by the neurosurgery department. Figure 4 shows the postoperative brain CT.



Results and Conclusion: Although brain metastases due to RCC are rare, they can result in serious clinical outcomes. In patients with a history of malignancy, neurological symptoms should be evaluated with a multidisciplinary approach, and the use of advanced imaging techniques such as contrast-enhanced MRI is of vital importance for early diagnosis and treatment.
Keywords: Renal cell carcinoma (RCC), Brain metastasis, Contrast-enhanced magnetic resonance imaging (MRI)

Ref No: 6638
PERC Criteria and Clinical Parameters in the Diagnosis of Pulmonary Embolism
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Introduction and Purpose: Pulmonary embolism (PE) is a common, time-sensitive, potentially fatal condition encountered in the emergency department. To reduce unnecessary imaging, clinical decision rules such as the Pulmonary Embolism Rule-out Criteria (PERC) are used. This study aims to investigate the relationship between PERC positivity and certain vital signs, laboratory parameters, and scoring systems (e.g., Wells score) in patients evaluated based on PERC criteria. Based on the data obtained, the role and significance of PERC in clinical practice are examined to make PE risk management more effective and safer.
Materials and Methods: This retrospective study was conducted between October 1, 2024, and March 31, 2025, on patients diagnosed with pulmonary embolism. Vital signs, laboratory parameters, and scoring systems, such as the Wells score, were collected, and their relationship with PERC positivity was analyzed. The impact of PERC on clinical practice and PE risk management was evaluated using these data.
Results and Conclusion: Among the 12 patients with a low Wells score, 3 (25%) were PERC negative, and 9 (75%) were PERC positive. Among the 32 patients with a high Wells score, 4 (12.5%) were PERC negative, and 28 (87.5%) were PERC positive. Overall, of the 44 patients, 7 (15.9%) were PERC negative, and 37 (84.1%) were PERC positive. No significant relationship was found between the presence of PERC and Wells score categories (low vs. high). Although PERC positivity was more prevalent in the high Wells score group, this difference was not statistically significant. In our study, PERC-positive patients were significantly older, had higher heart rates, and lower oxygen saturation levels. Additionally, CRP levels were significantly higher in PERC-positive patients ($p<0.05$). No

significant differences were found in other parameters, such as fever, blood pressure, respiratory rate, troponin, d-dimer, and BUN ($p>0.05$). These results demonstrate that the PERC criteria are clinically valuable in identifying high-risk patients for pulmonary embolism.

Keywords: PERC, Pulmonary Embolism, Emergency
Ref No: 6641

Superior Mesenteric Artery (Sma) Syndrome In Emergency Room

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Introduction and Purpose: Superior mesenteric artery syndrome, also known as Wilkie's syndrome, is a rare condition caused by the compression of the third portion of the duodenum between the aorta and the proximal part of the SMA, leading to narrowing and obstruction. It is an uncommon clinical condition encountered in emergency departments. The primary symptoms include weight loss, nausea, vomiting, epigastric pain, and bloating. According to the literature, it has been reported in patients with scoliosis, burns, prolonged immobilization, and idiopathic weight loss. SMA syndrome should be considered in patients with unexplained rapid weight loss, abdominal pain, and recurrent obstructive symptoms.

Materials and Methods: A 15-year-old male patient presented to the emergency department with complaints of abdominal pain, nausea, and vomiting. His medical history revealed a 3–4-year history of failure to gain weight, postprandial bloating, nausea, vomiting, and loss of appetite. The patient had a history of Charcot-Marie-Tooth disease and immunodeficiency. He had undergone scoliosis surgery one year prior. Despite having a height of 170 cm, his weight was only 43 kg. On physical examination, abdominal distension and rebound tenderness were observed. An abdominal ultrasound revealed significant gastric dilation. A contrast-enhanced abdominal CT scan (Figure 1) demonstrated compression of the third part of the duodenum between the mesenteric artery and the aorta, resulting in severe dilation of the stomach and duodenum. The stomach was abnormally distended from the diaphragmatic level down to the iliac level. Diffuse mucosal thickening of the duodenum was also noted. These findings were suggestive of superior mesenteric artery syndrome. Due to the presence of an acute abdomen, the patient underwent emergency surgery. Intraoperatively, stenosis due to SMA compression was observed in the third portion of the duodenum, along with proximal duodenal dilation. A duodenojejunostomy was performed, and the surgery was completed successfully.

Figure 1A

Figure 1B

Results and Conclusion: Superior mesenteric artery syndrome should be included in the differential diagnosis of patients presenting to the emergency department with persistent nausea, vomiting, and recent weight loss. Otherwise, superior mesenteric artery syndrome, which is rarely detected in the emergency department and impairs the quality of life of patients for a long time due to the difficulty of diagnosis, may be missed.

Keywords: Superior mesenteric artery syndrome, SMA syndrome, abdominal pain

Ref No: 6646

Investigation of Prior Bleeding History, Medication Use, and Glasgow-Blatchford Score in Patients with Upper Gastrointestinal Bleeding

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Introduction and Purpose: Upper gastrointestinal (GI) bleeding is a common and potentially life-threatening condition that requires prompt evaluation and management. A comprehensive history-taking is crucial for identifying the underlying cause, assessing severity, and guiding treatment strategies. Prior bleeding history provides essential insights into recurrent or chronic conditions such as peptic ulcer disease, esophageal varices, or malignancies. Additionally, the use of medications such as nonsteroidal anti-inflammatory drugs (NSAIDs), anticoagulants, and antiplatelet agents can significantly increase bleeding risk and influence management decisions. To predict prognosis and the need for intervention, scoring systems such as the Glasgow-Blatchford Score (GBS) are widely utilized. GBS helps stratify patients based on clinical and laboratory parameters, facilitating early decision-making regarding hospitalization, endoscopic therapy, or outpatient management. Evaluating bleeding history, medication use, and GBS collectively enhances risk assessment, optimizes treatment strategies, and improves patient outcomes. Understanding these factors is critical for the effective management of upper GI bleeding cases.

Materials and Methods: This retrospective study included patients who presented to the hospital with a diagnosis of upper GI bleeding. Demographic data, prior bleeding history, medication use, and Glasgow-Blatchford Scores were assessed. Data were obtained from patient records and electronic medical databases. The inclusion criteria consisted of patients diagnosed with upper GI bleeding who had complete medical records. Statistical analyses were performed to evaluate the relationship between prior bleeding history, medication use, and Glasgow-Blatchford Scores. Ethics committee approval was obtained for the study.

Results and Conclusion: Our study found that prior bleeding history did not have a significant impact on Glasgow-Blatchford Scores. However, medication use emerged as a crucial risk factor. Patients taking anticoagulant and antiplatelet agents had significantly higher Glasgow-Blatchford Scores, suggesting an increased risk of gastrointestinal bleeding associated with these medications. In contrast, patients using NSAIDs and direct oral anticoagulants (DOACs) exhibited relatively lower bleeding rates, indicating that the risk associated with these drug classes may vary. These findings highlight the importance of carefully assessing bleeding risk based on medication type when determining treatment strategies. Further prospective studies are warranted to better elucidate these associations and optimize risk stratification in upper GI bleeding management (Figure 1).

Figure 1

Variable	Value	p
Gender (%) and Age (years)	Male: %61.4, (60.45 ± 18.71) Female: %38.6, (65.72 ± 18.55)	0.064
Mean GBS	7.90 ± 4.43	
GBS and Bleeding History		
No Bleeding History (n=135)	7.73 ± 4.44	0,372
Bleeding History Present (n=49)	8.39 ± 4.40	
GBS and Medications		
Anticoagulants	9.39 ± 4.43	
Antiplatelet	9.37 ± 4.08	
No Medication Use	8.23 ± 4.18	0.01
DOACs	6.87 ± 4.99	
NSAİD	6.50 ± 4.14	
Upper GI Bleeding and Medications		
Antiplatelet	%22.4	
Anticoagulants	%21.7	
DOACs	%10.2	0.03
NSAİD	%2	
Users of Other Medications	%32.7	

Figure 1. Relationship Between GBS, Bleeding History, and Medication Use

Keywords: Bleeding History, Glasgow-Blatchford Score, Upper Gastrointestinal Bleeding

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Ref No: 6659

A rare complication of toxic megacolon: Acute limb ischemia

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Introduction and Purpose: Toxic megacolon is a rare condition characterized by severe and potentially life-threatening dilation of the colon. It is typically associated with inflammatory bowel diseases (particularly ulcerative colitis) or infectious colitis, although it can also occur due to various underlying causes. Limb ischemia in association with toxic megacolon is extremely rare. This case report discusses the coexistence of toxic megacolon and extremity ischemia in a patient with known mental retardation.

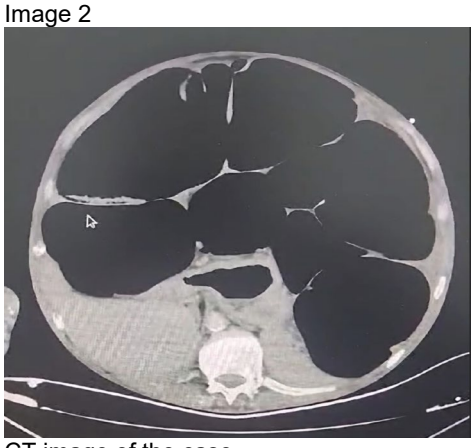
Materials and Methods: A 45-year-old male patient with known mental retardation, but no additional medical history, presented to the emergency department with complaints of constipation and abdominal distension. Upon initial assessment, vital signs revealed a blood pressure of 50/30 mmHg and a Glasgow Coma Scale (GCS) score of 15. While being transported for imaging, the patient developed respiratory arrest and was electively intubated. Due to persistent hypotension, inotropic support and hydration therapy were initiated. Abdominal computed tomography (CT) revealed an intra-abdominal primary pathology compressing the abdominal aorta (Image 1-2), raising suspicion of toxic megacolon. A general surgery consultation was requested. The general surgery assessment indicated that the patient's overall condition was poor, with persistent hypotension, fixed and dilated pupils, and cold, pale lower extremities. Bilateral femoral and popliteal pulses were not palpable. In contrast, Doppler ultrasound detected positive signals from brachial, radial, and ulnar

pulses in the upper extremities. The hands appeared cold and pale. Physical examination revealed signs of a rigid abdomen.

Image 1

CT image of the case

Image 2



CT image of the case

Results and Conclusion: The coexistence of toxic megacolon and acute limb ischemia is an extremely rare and highly fatal condition. This case highlights the importance of early diagnosis and a multidisciplinary approach. Although early imaging and surgical consultation played a critical role in managing the process, the patient was lost due to the advanced and complicated course of the disease. This case underscores the need to consider rare complications of toxic megacolon in emergency settings and the importance of rapid intervention in hemodynamically critical patients. Careful evaluation of the decision for surgical intervention and heightened awareness of potential complications are essential during patient follow-up.

Keywords: Toxic megacolon, Emergency department, Limb ischemia

Ref No: 6679

Self mutilation

Sezen Argın[1]

[1]**Adana 5 Ocak Devlet Hastanesi**

Introduction and Purpose: In psychiatry, self mutilation (self-harm, self-injury) is defined as behavior that intentionally and consciously causes serious damage to body structures without the intention of committing suicide. The prevalence of self-mutilation varies between 700-750 per 100,000 people. It can be examined in three groups. The most severe form is major self-mutilation and can be seen in those with mental retardation, substance addiction, schizophrenia, and bipolar disorder. Actions such as hair pulling, self-biting, head hitting may be observed in stereotypic self-mutilation.mThe superficial-moderate type is the best and most common form. Usually no disability is observed. It can be seen in those with eating disorders, trichotillomania, post-traumatic stress disorder.

Materials and Methods: Case report

Results and Conclusion: An 87-year-old male patient, immobile due to Alzheimer's, was brought to us by his relatives with the complaint that the wound on his finger was increasing. When the anamnesis was examined, it was learned that the patient had bitten his own finger 15 days ago and the wound had a bad odor and was getting worse. The patient's general condition was good, but his cooperation was limited due to Alzheimer's. On examination, the second finger of the right hand was amputated from the middle of the median phalanx, had a necrotic appearance and a foul odor (Figures 1 and 2). There were no pathological results in the patient's examinations other than high CRP. The patient's direct radiograph was taken and the Plastic Surgery Department was consulted. The patient was transferred to the Plastic Surgery Department for the wound to be cleaned and a local flap to be applied instead of amputation (Figure 3). The patient was discharged with healing with antibiotics after the wound was closed, and the patient's control radiograph 1 week later is shown in Figure 4. Since self-mutilation is associated with many psychiatric diseases, patients should be directed to the psychiatry department upon discharge. In patients presenting with mental retardation and bites, attention should be paid to the oral mucosal flora and antibiotics should be started. Since these cases may also be abused, cases may require legal proceedings in case of suspicion.

Figure 1

Figure 2

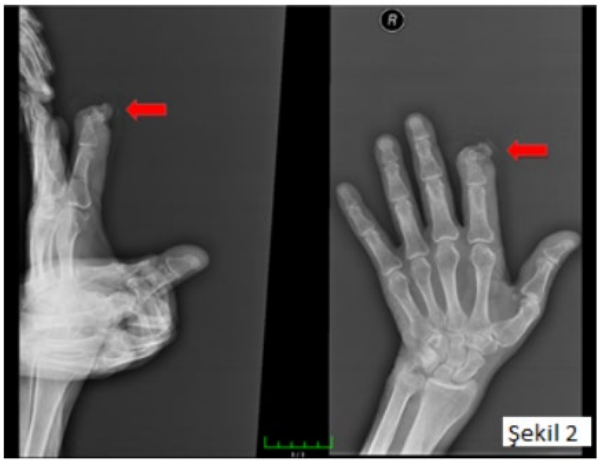
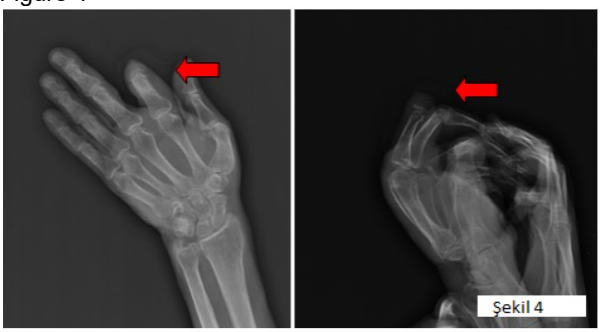


Figure 3

Figure 4



Keywords: self-injury, amputation, self-mutilasyon

Ref No: 6708

Systemic Botulinum Intoxication After Gastric Botulinum Toxin Injection: A Case Report

Şevval AYAN[1], Mehmet Emir AKÇAY[1], Metin YADİGAROĞLU[1], Ayhan AKÖZ[1]

[1]Adnan Menderes University

Introduction and Purpose: Intragastric botulinum toxin (BTX) injections for weight loss are increasingly popular worldwide. Although generally considered safe, rare cases of systemic botulinum intoxication with serious neurological complications have been reported. Early recognition and intervention are crucial, highlighting the importance of awareness among emergency physicians. This report presents a case of systemic botulinum intoxication after gastric BTX injection, aiming to increase clinical awareness among emergency department practitioners.

Materials and Methods: A previously healthy 27-year-old woman presented to the emergency department four days after receiving gastric BTX injection at a private clinic for weight loss, complaining of blurred vision, diplopia, shortness of breath, urinary incontinence, generalized muscle weakness, and fatigue. On examination, her Glasgow Coma Scale (GCS) was 15, and vital signs were stable. Laboratory tests, including complete blood count and biochemical analysis, as well as cranial computed tomography (CT) and magnetic resonance imaging (MRI), were normal.Electromyography (EMG) revealed presynaptic motor endplate dysfunction, confirming systemic botulinum intoxication. The patient was admitted to the intensive care unit (ICU) and treated symptomatically with nasal oxygen support and pyridostigmine (Mestinon). After six days in ICU, her symptoms fully resolved, and follow-up imaging showed no abnormalities.

Results and Conclusion: Emergency physicians should consider systemic botulinum intoxication in patients presenting with neurological symptoms following recent BTX injections. Prompt diagnosis, multidisciplinary management, and supportive care significantly improve patient prognosis.

Keywords: Emergency department, Gastric botulinum toxin, Systemic botulinum intoxication

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Ref No: 6745

Acute Coronary Syndrome Induced by Methanol Intoxication

kübra nur okutan[1], ahmet baydın[1]

[1]ondokuz mayıs üniversitesi

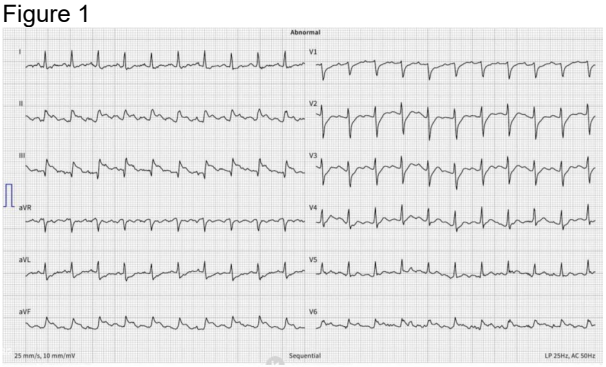
Introduction and Purpose: Methyl alcohol is a raw material used in the production of various chemical substances. Although methanol itself is not directly toxic, it becomes harmful when metabolized in the body. Methanol poisoning can result in brain damage, visual impairments, cardiovascular disorders, epileptic seizures, metabolic acidosis, and even death.

Materials and Methods: Materials and Methods

Results and Conclusion: Case Report:A 73-year-old male patient presented to the emergency department in the morning with complaints of dizziness, shortness of breath, chest tightness, and visual disturbances after consuming approximately two glasses of homemade rakı the previous evening. His general condition was stable, and he was conscious, cooperative, and oriented. His vital signs were: Blood Pressure: 165/100 mmHg, Heart Rate: 90 bpm, Temperature: 36°C, Respiratory Rate: 22 breaths/min. His lung and heart sounds were normal. Arterial blood gas analysis revealed pH: 7.07, PaO2: 91 mmHg, PaCO2: 31 mmHg, HCO3: 9 mmol/L, and oxygen saturation: 86.1%.Laboratory findings were: Creatinine: 1.56 mg/dL, K: 5.4 mEq/L, Troponin: > 25,000 ng/L, Alcohol: < 0 mg/dL. His

ECG showed ST elevation in inferior leads (DII, DIII, aVF) and ST depression in lateral leads (DI, aVL) (Figure 1). The patient was evaluated by the cardiology department, and primary percutaneous coronary intervention (PCI) was planned. Coronary angiography revealed plaques in the LAD and Circumflex arteries, and the patient was treated medically with aspirin (100 mg), clopidogrel (75 mg), and enoxaparin (0.6 mg), with outpatient follow-up recommended.Consultation with the ophthalmology department revealed no pathological findings related to his visual disturbances. His cranial CT scan was also normal. Due to metabolic acidosis, he was consulted with the nephrology department and underwent emergency hemodialysis. Since metabolic acidosis persisted after hemodialysis, intravenous ethanol treatment was administered. The patient was admitted to the intensive care unit for further monitoring and treatment.Conclusion: Intoxications are among the primary conditions encountered in emergency departments. Regardless of the cause of intoxication, ECG should be performed and evaluated in all patients. It should be kept in mind that, besides known complications, rare complications can also occur in poisoning cases. In our case, STEMI was detected on ECG following methanol intoxication, despite the absence of chest pain.

Figure 1



İnferior MI

Keywords: methanol, acute coronary syndrome, intoxication

Ref No: 6770

An Uncommon Diagnosis in a Patient Presenting with Syncope, Ruptured Ectopic Pregnancy: A Case Report

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[1]ERZURUM ŞEHİR HASTANESİ

Introduction and Purpose: Ovarian ectopic pregnancy is a rare form of extrauterine gestation, often diagnosed intraoperatively due to its nonspecific clinical presentation (1). This case report aims to highlight the clinical course, diagnostic challenges, and laparoscopic management of a ruptured ovarian ectopic pregnancy.

Materials and Methods: A 37-year-old patient with a 9-year history of marriage presented to emergency services with syncope. Physical examination revealed tachycardia (106 bpm) and hypotension (80/50 mmHg), with rebound tenderness and guarding on abdominal examination. Laboratory findings showed hemoglobin 8.9 g/dL, hematocrit 27.7%, and serum β-hCG of 503.3 mIU/mL. Transvaginal ultrasonography revealed no intrauterine pregnancy, an endometrial thickness of 11 mm, free fluid in the pouch of Douglas, and a heterogeneous right adnexal mass (46 × 51 mm) with marked vascularization on Doppler imaging but no definitive "ring of fire" sign (2).The patient underwent an emergency laparoscopy with a preoperative diagnosis of ruptured ectopic pregnancy. Intraoperative findings included 2000 mL of hemoperitoneum and bilaterally normal fallopian tubes. A hemorrhagic 5 × 4 cm mass, suspected to be an ectopic pregnancy, was identified within the right ovary. The lesion was laparoscopically resected, hemostasis was achieved, and the specimen was sent for histopathological analysis (3). The patient received two units of erythrocyte suspension, and postoperative β-hCG levels decreased to 136.5 mIU/mL within 48 hours. The patient was hemodynamically stable and was discharged on the second postoperative day.

Results and Conclusion: Ovarian ectopic pregnancy remains a diagnostic challenge due to its rarity and overlapping sonographic features with other adnexal masses (4). This case underscores the importance of early recognition, prompt surgical intervention, and laparoscopic management to minimize morbidity and preserve ovarian function.

Keywords: Ovarian ectopic pregnancy, laparoscopic management, hemoperitoneum

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Ref No: 6801

A rare thoracic trauma: Two cases of flail chest

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Introduction and Purpose: Flail chest is a serious medical condition that occurs when a segment of the rib cage separates from the rest of the thoracic cage due to multiple rib fractures. The purpose of this case report is to examine the emergency department presentation and subsequent management of patients diagnosed with flail chest.

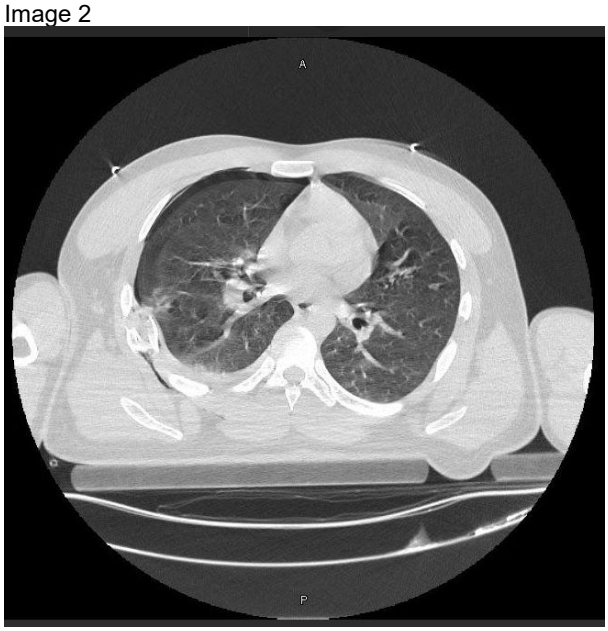
Materials and Methods: Case 1: A 59-year-old male patient was referred to us with a diagnosis of flail chest due to a motor vehicle accident. Intubation and a thoracic tube were applied to the left hemithorax. Computed tomography (CT) images revealed multiple rib fractures in the left hemithorax, pneumothorax, subcutaneous emphysema, hemithorax and lung contusion. (Image 1) He was admitted

to the intensive care unit. A rib plate was applied by the thoracic surgeon. After treatment, the patient was discharged.Case 2: A 22-year-old male patient was brought to our emergency department by 112 teams after a motor vehicle accident and was electively intubated due to confusion and desaturation. CT scans revealed multiple rib fractures in the right hemithorax, widespread contusion areas, subcutaneous emphysema, minimal hemithorax and pneumothorax. (Image 2) The patient underwent a right tube thoracostomy. A rib plate was applied by the thoracic surgeon. After treatment, the patient was discharged.

Image 1

Computed thorax tomography image of the first case

Image 2



Computed thorax tomography image of the second case

Results and Conclusion: Flail chest has a high mortality rate and is usually caused by blunt trauma such as vehicle accidents or falls. Symptoms include severe pain, dyspnea, and visible deformity of the chest wall. It is usually diagnosed by physical examination and imaging techniques such as X-rays or CT scans. However, in a case in shock and with shallow breathing, paradoxical movement may not be evident. During examination of the chest wall, asymmetric movement of this independent area and palpation of crepitation and friction due to friction of the fracture ends are helpful in diagnosis. In addition; paradoxical breathing, dyspnea and respiratory distress, painful breathing, crepitation and subcutaneous emphysema, tachypnea, tachycardia findings support the diagnosis.

Keywords: flail chest, thoracic trauma, emergency department

Ref No: 6817

Approach to epidural hemorrhage

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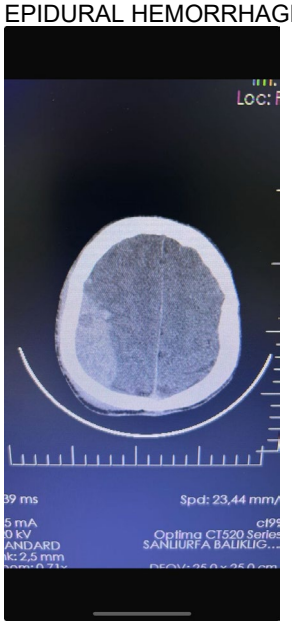
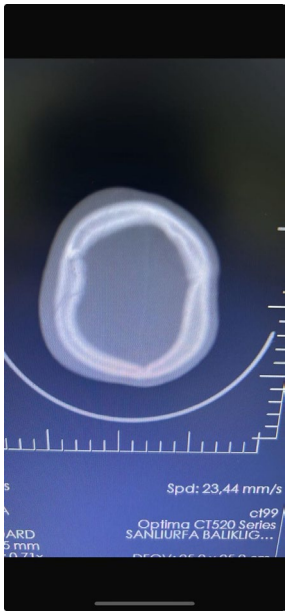
Introduction and Purpose: Emergency approach to epidural hemorrhage. A 22-year-old male patient with no additional disease or history of surgery. He was brought to the emergency room by 112 with a complaint of falling from his own level.

Materials and Methods: Vital Signs:Blood pressure: 128/75 mmHgPulse: 73 beats/minuteRespiratory rate: 23 breaths/minuteTemperature: 36.5 °CSpO2: 95%Physical Examination:GCS (Glasgow Coma Scale): 14Drowsiness present.Headache present.Extremity movements normal.1 cm laceration present in the occipital region.Findings:Brain CT revealed heterogeneous hyperdense density consistent with an epidural hematoma approximately 10 cm long and 2 cm thick adjacent to the right hemisphere.Density consistent with a hematoma was observed in the subcutaneous tissue adjacent to the described area, and a minimally displaced fracture line was observed in the bones adjacent to this area.

EPIDURAL HEMORRHAGE



MINIMAL DISPLACEMENT FRACTURE



Results and Conclusion: The patient diagnosed with acute epidural was urgently referred to an external center neurosurgery clinic for surgery.

Keywords: Acute, Epidural, Fall

Ref No: 6836

Rare Presentation of Congenital Afibrinogenemia: A 5-Year-Old Male with Severe Hemorrhage Concurrent with Hyperferritinemia and Hepatic Dysfunction

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[1]Central Asian University

Introduction and Purpose: Congenital afibrinogenemia is a rare autosomal recessive disorder characterized by the absence of fibrinogen, an essential protein for blood coagulation. This condition can lead to severe bleeding episodes. This case report describes a 5-year-old boy with congenital afibrinogenemia who presented with life-threatening hemorrhage and notable hyperferritinemia, aiming to highlight the clinical manifestations and management of this rare condition and to add to the limited body of literature on its complex presentations.

Materials and Methods: The patient's clinical presentation, including physical examination findings and laboratory results, was documented. Relevant laboratory tests included fibrinogen levels, complete blood count, liver function tests (ALT), and ferritin levels. The immediate management of the acute bleeding episode, including the use of fresh frozen plasma and blood transfusions, was recorded. The patient's subsequent treatment plan, involving regular fibrinogen concentrate infusions, was also detailed.

Results and Conclusion: A 5-year-old male (blood group B+) presented with severe bruising, recurrent and severe epistaxis, and oropharyngeal bleeding. Laboratory analysis revealed a fibrinogen level of 0 mg/dL, elevated ferritin (>3000), and elevated ALT and AST (both >150 U/L). The bleeding was controlled with fresh frozen plasma and blood transfusions. He was diagnosed with congenital afibrinogenemia. Regular fibrinogen concentrate infusions every two weeks were prescribed for long-term management. This case illustrates the potentially severe hemorrhagic manifestations of congenital afibrinogenemia and the importance of prompt diagnosis and fibrinogen replacement therapy. The concurrent hyperferritinemia and elevated liver enzymes represent a less common finding that warrants further investigation in future studies of congenital afibrinogenemia.

Keywords: Congenital Afibrinogenemia, Hemorrhage, Hyperferritinemia

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Ref No: 6843

A Rare Case: Traumatic Diastasis Recti

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Introduction and Purpose: Diastasis recti is the separation of the rectus abdominis muscles, commonly known as the abdominal muscles, along the midline. This condition is most frequently observed during pregnancy, excessive weight gain, or rapid weight loss. Although rare, traumatic events can also cause these muscles to separate, leading to the formation of a gap in the abdominal wall. Symptoms of diastasis recti include a palpable bulge in the abdomen, pain, weakness, and sagging of the abdominal muscles due to laxity.

Materials and Methods: A 9-year-old male patient presented to the emergency department after falling while riding a bicycle. The bicycle's handlebar struck the upper umbilical region of the anterior abdominal wall. The patient was evaluated in the trauma unit. Physical examination revealed abdominal pain and tenderness, but no rebound tenderness or guarding was detected. A superficial abrasion of approximately 2 cm was observed in the upper umbilical region. Systemic examinations were unremarkable.Following the initial assessment, laboratory tests and imaging studies were performed. No acute pathology was detected in the patient's blood tests. Abdominopelvic CT revealed a 5 cm separation of the rectus muscles in the anterior abdominal wall, with herniation of intra-abdominal adipose tissue and a short segment of the transverse-descending colon into the subcutaneous tissue. Additionally, non-specific density increases were observed in the mesenteric adipose tissue surrounding the proximal jejunal loops and the splenic vein. No free fluid or air was detected in the abdominal cavity. No acute pathology was observed in other imaging studies. The patient was referred to the pediatric surgery department with a preliminary diagnosis of traumatic diastasis recti. After evaluation by pediatric surgery, surgical repair was planned, and the patient was admitted to the pediatric surgery ward.

Results and Conclusion: Which is commonly associated with pregnancy and significant weight fluctuations, was observed in our case secondary to trauma. Although rectus muscles are relatively strong, the diagnosis of diastasis recti should be considered in cases of blunt abdominal trauma, especially in young patients with incomplete muscle development. In conclusion, traumatic diastasis recti should be kept in mind in cases of blunt abdominal trauma in pediatric patients, and appropriate evaluation and management should be performed.

Keywords: Traumatic, Diastasis Recti, Rectus Abdominis

Ref No: 6868

Delayed Presentation of a Retained Central Venous Guidewire Mimicking a Clavicular Abscess: A Case Report from the ED

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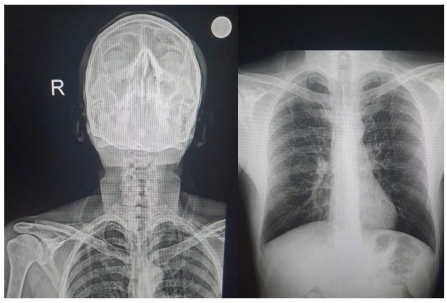
Introduction and Purpose: Central venous catheter (CVC) placement using the Seldinger technique is a critical, frequently performed procedure in emergency medicine. Although complications such as arterial puncture or pneumothorax are well-recognized, the unintentional retention of the guidewire—classified as a “never event”—remains a rare yet serious iatrogenic error. This complication, often resulting from procedural lapses under time pressure, may remain clinically silent for extended periods and present in unexpected ways.

Retained Guidewire Complication



Materials and Methods: Case Presentation: A 41-year-old male presented to the emergency department with a one-week history of localized swelling, erythema, and purulent drainage beneath the right clavicle. He had undergone emergency abdominal surgery one year prior, during which a CVC was placed in the right internal jugular vein. Physical examination revealed a fluctuant lesion suggestive of a soft tissue infection. Point-of-care ultrasound demonstrated a linear echogenic structure, and subsequent chest radiography confirmed the presence of a retained guidewire extending from the right internal jugular vein into the thoracic inlet. The patient was admitted electively for surgical retrieval. The guidewire was successfully removed without complication, and the patient was discharged with short-term oral antibiotics.
Results and Conclusion: This case underscores the concept of “procedural blindness,” wherein the repetition of routine tasks under cognitive overload leads to critical omissions, such as failure to remove the guidewire. The delayed presentation, initially mimicking a superficial infection, highlights the need for a broad differential in patients with prior central venous access. Emergency physicians must maintain a high index of suspicion for retained intravascular foreign bodies and advocate for procedural safety practices, including mandatory imaging and verbal confirmation protocols. In conclusion, retained guidewires, though rare, can result in delayed and potentially serious complications. Emergency departments serve not only as sites of acute care, but also as critical points for the detection of latent procedural errors. This case reinforces the importance of post-procedural vigilance and systems-based interventions to prevent avoidable harm.
Keywords: Central venous catheterization, Retained guidewire complication, Seldinger technique

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Ref No: 6875
Alcohol-Hidden Aortic Dissection
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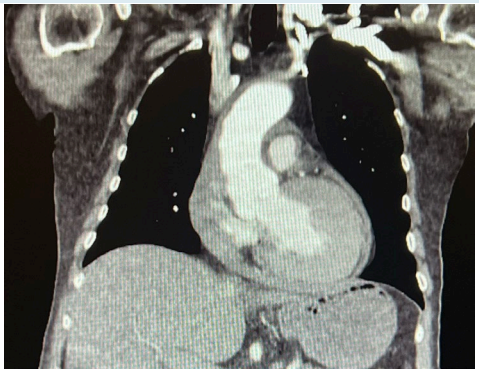
Introduction and Purpose: There are many causes in the etiology of aortic dissection, such as hypertension, aortic aneurysm, connective tissue diseases, trauma, coronary interventions, and it typically presents with severe chest and back pain. In some patients, symptoms may be more subtle and other symptoms may mask the main symptoms.
Materials and Methods: A 60-year-old male patient was admitted to the emergency department with complaints of nausea and dizziness. He stated that he had consumed banded alcohol and that his complaints occurred after drinking alcohol. The patient was conscious, cooperative, and restless due to his complaints. There was widespread tenderness in the abdomen on physical examination. The patient's blood gas pH: 7.26, lactate: 9.57. The patient was followed up with a preliminary diagnosis of methyl alcohol intoxication because his complaints started after alcohol consumption and he had lactic acidosis in his blood tests, but during follow-up, the patient experienced severe chest pain and epigastric pain, and his general condition deteriorated. Thereupon, the patient underwent thoracoabdominal CT angiography with suspicion of aortic dissection. An increased aortic diameter and an appearance consistent with hemorrhage in the paraaortic area were detected on the CT scan. Bedside echocardiography revealed a pericardial effusion surrounding the heart, measuring 1.1 cm at its widest point. The patient, who was in arrest after imaging, was taken into emergency surgery with CPR. The patient was discharged after a successful operation and a long intensive care period.
CT angiography image

CT angiography image



Results and Conclusion: Alcohol causes many symptoms and therefore hides many diseases. The complaints of patients who come to the emergency room with alcohol consumption should not be thought to be related only to alcohol consumption; another underlying disease should also be taken into consideration.
Keywords: aortic dissection

Ref No: 6881
A Case of Lithium Intoxication
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Introduction and Purpose: Lithium, a mood-stabilizing medication, is commonly used to treat bipolar disorder. Despite its effectiveness, it has a narrow therapeutic index, meaning small fluctuations in its levels can lead to toxicity. Lithium intoxication can result in severe neurological, renal, and systemic complications if not detected and managed promptly. This case underscores the importance of early recognition and intervention.
Materials and Methods: A 49-year-old male with a history of bipolar disorder and diabetes mellitus presented to the emergency department (ED) with dizziness and a feeling of faintness for two days. He had a history of multiple psychiatric hospitalizations due to aggressive behavior, auditory hallucinations, and harm to others. His medications included sodium valproate, lithium carbonate, and aripiprazole, though he admitted to irregular use of lithium. On initial assessment, the patient was stable, with a Glasgow Coma Scale (GCS) of 15, and was oriented and cooperative. Neurological examination revealed no abnormalities. Laboratory tests showed mild renal dysfunction, with a creatinine of 1.44 mg/dL and urea of 69 mg/dL. Brain CT and MRI were normal. After being treated with adequate hydration, the patient's symptoms improved, and he was discharged with outpatient follow-up recommendations.However, four days later, the patient returned after experiencing syncope in a supermarket, along with incontinence, altered mental status, and whole-body tremors. On examination, he was conscious but unable to answer questions meaningfully. Tremors were observed throughout his body. Vital signs were stable, but laboratory results showed worsening renal function: creatinine of 1.76 mg/dL and urea of 113 mg/dL. Lithium levels were measured at an external lab and found to be 3.9 mEq/L, indicating toxicity. The patient underwent 4 hours of hemodialysis, which reduced the lithium level to 2.24 mEq/L. However, his condition deteriorated, and he was intubated after a decline in GCS. An additional 3 hours of hemodialysis was performed, and the patient was transferred to an ICU for continued monitoring.
Results and Conclusion: This case highlights the risks of lithium toxicity, particularly in patients with irregular medication use and renal dysfunction. Early diagnosis, hemodialysis, and a multidisciplinary approach are essential to managing severe lithium toxicity and preventing life-threatening complications.
Keywords: Lithium Toxicity, Bipolar disorder, Syncope

Ref No: 6893
Hypertriglyceridemia-induced pancreatitis in the emergency department: a retrospective case series
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Introduction and Purpose: Hypertriglyceridemia-induced pancreatitis (HTG-IP) is a distinct and increasingly recognized cause of acute pancreatitis (AP), commonly associated with metabolic disorders such as diabetes mellitus, obesity, and familial hyperlipidemia. Compared to other causes of AP, HTG-IP is often more severe and requires early recognition and targeted management in the emergency department (ED). This study aims to describe the demographic and clinical characteristics of ED patients diagnosed with HTG-IP and assess disease severity and outcomes.
Materials and Methods: This retrospective cohort study was conducted at Muğla Training and Research Hospital ED between July 1, 2019, and January 1, 2023. Adult patients with lipemic serum at presentation were identified from electronic medical records. Data collected included age, sex, triglyceride levels, and severity scores (Ranson, Imrie, and Harmless Acute Pancreatitis Score [HAPS]). The primary outcome was in-hospital mortality; secondary outcomes included intensive care unit (ICU) admission and hospital length of stay.
Results and Conclusion: Among 419,505 ED visits, 10 patients were diagnosed with HTG-IP, yielding a prevalence of 2.38 per 100,000 ED visits. The cohort included five male and five female patients, with a mean age of 52.7 ± 18.4 years. The mean triglyceride level at admission was 1183.3 ± 1105.6 mg/dL. No in-hospital mortality occurred, and one patient (10%) required ICU admission. The mean hospital stay was 8.7 days. Most patients (80%) had mild AP, while 20% presented with severe disease. Two patients experienced recurrent episodes, emphasizing the need for ongoing metabolic management. The median Ranson score was 1.0 (IQR: 1.0), the median Imrie score was 1.5 (IQR: 1.75), and the median HAPS score was 0.5 (IQR: 1.0).HTG-IP is a clinically significant and potentially

severe AP subtype, particularly in cases of extreme hypertriglyceridemia. The underlying pathophysiology involves excessive free fatty acid release, leading to endothelial dysfunction, ischemia, and pancreatic injury. Despite its low prevalence, HTG-IP carries a high risk of systemic complications. Early diagnosis, lipid-lowering therapy, and aggressive supportive care are essential to improving outcomes. Further prospective studies are needed to refine risk stratification and establish standardized treatment protocols, including the role of plasmapheresis, intravenous insulin, and novel lipid-lowering agents.
Keywords: Hypertriglyceridemia-induced pancreatitis, Emergency department, Lipemic serum

Ref No: 6915
Unexpected Cardiopulmonary Collapse in an Ambulatory Patient: A Case of Resuscitation-Responsive Saddle Pulmonary Embolism
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Introduction and Purpose: Saddle pulmonary embolism (SPE) is classically associated with hemodynamic collapse, yet a subset of patients may paradoxically remain normotensive until sudden decompensation occurs. Such presentations pose a diagnostic challenge and demand heightened vigilance in the emergency setting. This report highlights a rare case of ambulatory-onset saddle SPE in a hemodynamically stable patient who suffered cardiac arrest shortly after ED arrival, and successfully responded to thrombolysis-integrated resuscitation.
Materials and Methods: Case Presentation: A 79-year-old male presented to the ED with progressively worsening dyspnea over the previous three days. Despite a 15-day prodrome of exertional shortness of breath and multiple prior healthcare visits, no definitive diagnosis had been established. His medical history included hypertension and a 55 pack-year smoking history.Upon ED arrival, he was tachypneic (30/min), hypoxic (SpO 83%), and visibly distressed. Blood pressure was 180/83 mmHg, heart rate 72 bpm, and physical examination revealed diffuse bilateral rhonchi without peripheral signs of deep vein thrombosis. Arterial blood gas analysis showed severe hypoxemia. Urgent CT pulmonary angiography demonstrated large saddle emboli extending into both main pulmonary arteries.Intravenous unfractionated heparin was initiated; however, the patient abruptly developed pulseless electrical activity. Cardiopulmonary resuscitation was started, followed by administration of 50 mg alteplase (10 mg bolus, 40 mg infusion). Ventricular fibrillation was identified during CPR and successfully defibrillated. Return of spontaneous circulation was achieved after 15 minutes. The patient was stabilized with vasopressors and sodium bicarbonate, and transferred to the intensive care unit.
Results and Conclusion: SPE represents a severe and often fatal form of venous thromboembolism. Although traditionally associated with hemodynamic compromise, a subset of patients may paradoxically present with normotension and nonspecific respiratory symptoms, as seen in this case. The abrupt transition from a hemodynamically stable state to cardiopulmonary arrest highlights the unpredictable natural history of central PE and the vital importance of early recognition in the emergency department. In elderly patients with prolonged dyspnea and unexplained hypoxemia—particularly those with risk factors such as smoking and immobilization—clinicians must consider PE even in the absence of classic signs. Emergency physicians should be prepared to initiate advanced resuscitative strategies, including fibrinolytic therapy, in select cases of massive SPE with cardiac arrest.
Keywords: Saddle Pulmonary Embolism, Emergency physicians, High index of suspicion

Ref No: 6923
Evaluation of Clinical Parameters Associated with Interventional Treatment and Amputation in Patients Diagnosed with Peripheral Arterial Disease: A Retrospective Study Based on Emergency Department Admissions
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Introduction and Purpose: Peripheral arterial disease (PAD) represents a progressive vascular disorder capable of resulting in limb-threatening ischemia and, in its advanced stages, potential amputation. Prompt and precise treatment decisions within the emergency department are essential for the prevention of limb loss. This study seeks to evaluate the clinical parameters pertinent to interventional treatment and amputation decisions in patients diagnosed with PAD who have presented to the emergency department.
Materials and Methods: Ninety patients diagnosed with PAD between January 2023 and December 2024 were retrospectively analyzed. Demographic data, clinical findings, PAD stages, Doppler flow status, and acute/chronic presentation types were assessed. Type of treatment (medical/interventional) and amputation status were defined as primary outcome variables. Univariable and multivariable logistic regression analyses were performed.
Results and Conclusion: Interventional treatment was more frequently applied in older patients and those in the advanced stages (Stages IIb–III). The absence of capillary refill, deep sensory loss, and motor paralysis were significantly associated with both interventional treatment and amputation ($p < 0.001$). In logistic regression analysis, age (OR: 1.09; $p = 0.029$), chronic-on-acute presentation (OR: 10.32; $p = 0.006$), and advanced PAD stage were identified as independent risk factors for amputation. Parameters such as impaired capillary perfusion, severe sensory-motor dysfunction, and advanced age significantly influence treatment decisions in PAD patients. Early clinical assessment and risk stratification in the emergency setting play a critical role in optimizing treatment outcomes.
Keywords: Peripheral arterial disease, Amputation, Chronic limb ischemia

Ref No: 6938
Broken Heart Syndrome: A Case of Takotsubo Cardiomyopathy Triggered by Sudden Emotional Trauma in the Emergency Department
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Introduction and Purpose: Takotsubo cardiomyopathy, also known as “broken heart syndrome,” is a transient cardiac condition often triggered by significant emotional or physical stress. It mimics the symptoms of acute myocardial infarction but typically presents without significant coronary artery obstruction. Although the classic presentation of Takotsubo cardiomyopathy includes apical ballooning on echocardiography, this feature is not always present, complicating its diagnosis.
Materials and Methods: A 49-year-old female presented to the emergency department by ambulance, accompanying her father, who was in cardiac arrest. Despite immediate resuscitation efforts her father was declared deceased. After being informed of his passing, the patient developed sudden sharp chest pain, which prompted her to seek medical attention. A 12-lead electrocardiogram was performed, which revealed no significant ischemic changes, thus suggesting that the chest pain was a result of psychological stress due to the emotional trauma of her father’s death. Blood tests were promptly obtained, revealing an elevated Troponin I level of 177.9 ng/L, while CK-MB levels were normal at 1.8 ng/mL. Given the elevated troponin levels, continuous ECG monitoring was performed. A subsequent troponin I measurement showed a significant rise to 2358.4 ng/L, and CK-MB levels also increased to 7.4 ng/mL, suggesting myocardial injury. Echocardiography was performed, revealing a reduced ejection fraction of 50% along with dyskinesis of the inferior-lateral wall and mild myocardial thickening. Notably, there was no evidence of apical ballooning, which is typically seen in Takotsubo cardiomyopathy. Coronary angiography was performed and revealed no significant coronary artery obstruction or evidence of atherosclerotic disease, ruling out acute coronary syndrome and myocardial infarction due to coronary occlusion and leading to the diagnosis of Takotsubo cardiomyopathy.
Results and Conclusion: This case highlights the importance of recognizing Takotsubo cardiomyopathy even in the absence of the hallmark feature of apical ballooning, particularly in patients with elevated cardiac biomarkers and a clear emotional trigger. While the clinical presentation of chest pain, elevated troponin levels, and wall motion abnormalities on echocardiography may suggest an acute coronary syndrome, the absence of coronary artery obstruction on angiography is key to distinguishing Takotsubo cardiomyopathy. This condition is typically reversible with supportive care and has a favorable prognosis if identified and treated promptly.
Keywords: Acute Chest Pain, Takotsubo Cardiomyopathy, Emotional Stress

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Ref No: 6979
A rare case in the emergency department: superior vena cava syndrome
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Introduction and Purpose: Superior Vena Cava Syndrome(SVCS) is a constellation of clinical manifestations resulting from the obstruction of superior vena cava(SVC) circulation, impeding blood drainage from the head, neck, arms, and upper thorax into the right atrium. This case has been asked for presentation to maintain awareness of SVCS in patients who commonly arrive at the emergency departmen(ED) exhibiting symptoms such as dyspnea, facial edema, and cyanosis.
Materials and Methods: 62-year-old male patient, without any known chronic illnesses, was sent to the ED after experiencing a decline in condition while awaiting service at the chest diseases outpatient clinic, accompanied by the hospital's blue code team. Upon arrival at the ED, the patient's vital signs were recorded as an arterial blood pressure:113/76 mmHg, an oxygen saturation:91%, and pulse rate:112. The physical examination revealed face erythema, edema, venous engorgement in the cervical region, and the patient expressed dyspnea. The patient's anamnesis revealed that complaints of chronic cough and facial erythema commenced in the last week. A thoracic CT scan of the patient revealed a mass consistent with the superior mediastinum and a 2 cm effusion in the right pulmonary hemithorax. No notable pathology was identified in the laboratory tests performed in the ED. The patient was admitted to the hospital for follow-up and treatment following the completion of consultation procedures with the pertinent departments. The fine needle aspiration biopsy conducted on the patient confirmed a diagnosis of small cell lung cancer. The patient expired on the 13th day of hospitalization due to cardiopulmonary arrest following syncope in the ward, during the time when radiation was scheduled.
Results and Conclusion: In our situation, SVCS may present in ED in either a stable or unstable state. SVCS may manifest with vital signs akin to those of upper respiratory tract infections or allergy-related symptoms, including face erythema or dyspnea. In the absence of a confirmed cancer diagnosis, SVCS should be included in the differential diagnosis for these individuals, and jugular venous distension must be meticulously assessed during the physical examination. Observations of erythema and edema confined to the upper extremities should serve as a caution for this diagnosis.
Keywords: Superior Vena Cava Syndrome, Neoplasm, Thrombosis

Ref No: 7011
A Diagnostic Pitfall: Recurrent Emergency Visits Leading to Pneumococcal Meningitis Diagnosis
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Introduction and Purpose: In emergency services, when young patients without chronic diseases present with mild symptoms, they can often be underestimated by physicians and a prescription for an outpatient treatment plan can be issued and they can be quickly discharged. Especially considering the density in our country, since the examination time per patient is short, there is a high probability of making mistakes. In this case, we wanted to present our patient who was diagnosed with meningitis and presented with more severe symptoms for the third time on the same day.
Materials and Methods: A 43-year-old male patient was admitted to the emergency room with complaints of headache, earache, and fatigue. He had no known chronic disease. Vital signs: Fever: 38.8˚C, BP: 130/70 mmHg, SpO2: 96%, Pulse: 110/min, GCS: 15, general condition was good. A prescription was issued with a preliminary diagnosis of otitis and he was discharged. 6 hours later, he was re-admitted with complaints of fatigue, headache, and diarrhea and was discharged with symptomatic treatment. 8 hours after the second admission, he was brought to the emergency room by ambulance again with complaints of impaired consciousness, headache, and

vomiting. Fever: 36.5 ˚C, Pulse: 120/min, SpO2: 97%, BP: 160/80 mmHg, GCS: 12, neck stiffness was detected. He had 1 generalized tonic-clonic seizure in the emergency room. The patient was referred to an advanced center. His tests revealed HIV+. Treatment was started with the diagnosis of meningitis, and Streptococcus pneumoniae growth was detected in the CSF culture during his follow-up. He was discharged without sequelae after a long intensive care stay.

Results and Conclusion: Bacterial meningitis, an inflammatory disease of the central nervous system (CNS), is associated with high morbidity and mortality rates. Streptococcus pneumoniae is the leading cause of bacterial meningitis worldwide. Pneumococcal meningitis is more common in infants and the elderly, diabetics, and those with malignancies and immunosuppressed populations. Careful examination is necessary in patients with risk factors, but unknown risk factors may also emerge later, as in our case. A detailed history and physical examination of each patient is important, and repeat applications should be carefully reviewed.

Keywords: meningitis, HIV

Ref No: 7023

Snakebite in Pregnancy: Compartment Syndrome and Emergency Fasciotomy

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Introduction and Purpose: With the effect of tropical climate in Turkey, poisoning cases such as snake bites and scorpion stings are frequently encountered.These envenomations may cause serious toxic effects on healthy children and young adults and may lead to high morbidity and mortality(1).In cases of poisoning, local symptoms such as pain,edema,redness,bullae formation and skin necrosis may occur in the bitten or stung area(2,4).

Materials and Methods: A 31-year-old 15-week pregnant patient was brought to our emergency department due to snake bite.When the patient arrived,she was conscious.There was a hyperemic bite lesion on the dorsal surface of the proximal 5th finger of the right hand,there was diffuse edema,hyperemia and tenderness in the distal part of the hand,wrist and forearm.On arrival,sensory motor examination was normal,distal pulses were patent,capillary refill time and other system examinations were normal.Tetanus prophylaxis,iv antibiotherapy,analgesia were administered.During follow-up, edema and hyperemia spread to the proximal forearm and arm.The patient was asked to receive snake antivenom and the procedure and risks were explained. However, the patient did not accept the treatment due to her pregnancy status and possible risks.At the 18th hour of the incident,hypoesthesia,pallor,impaired capillary filling and subsequent limitation in motor movements developed along with severe pain in the right upper extremity.The patient was consulted with orthopedics with a diagnosis of compartment syndrome and was taken into emergency operation for fasciotomy.Right upper extremity fasciotomy was performed under axillary nerve block.On the 10th day of follow-up, edema regressed and motor and sensory examinations were completely normal.The fasciotomy was closed and the patient was discharged with recovery.

figure 1

figure 2

figure 3

Results and Conclusion: The most effective treatment method for coagulation disorders and compartment syndrome related to snake venom is antivenom administration(5,6).In this process,local symptoms such as edema,redness and pain may develop in the bitten area.Findings such as absence of pulse,coldness,severe pain,paresthesia,delayed capillary filling and pain on passive stretching may be indicators of compartment syndrome and these patients should be evaluated for emergency fasciotomy(7).In our case,antivenom treatment could not be administered because of the patient's pregnancy status.However,the patient developed signs of compartment syndrome during follow-up and emergency fasciotomy was performed and the patient was discharged on the 10th day with complete recovery.

Keywords: Snakebite, Pregnancy, Emergency fasciotomy

Ref No: 7037

The Interplay of Hormones and Neuroplasticity: How Hormonal Changes Shape Brain Adaptation to Stress and Learning

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Introduction and Purpose: Neuroplasticity responds to hormonal shifts through brain self-adaptation and reorganization resulting in substantial influence on stress responses along with learning and environmental change adaptation capability. This article investigates how hormones affect neuroplasticity through examination of five significant hormones including cortisol together with estrogen and testosterone and oxytocin and thyroid hormones based on data from literature. Hormones play a critical role in shaping the brain's responses to various stimuli, particularly in the contexts of stress and learning .

Materials and Methods: Published data from past two decades from source such as MedLine, PubMed, Scopus, WebofScience,

Google Scholar regarding hormonal changes in neuroplasticity were analysed and presented as summary.

Results and Conclusion: Stress-induced cortisol regulation affects both synaptic plasticity and memory consolidation processes in the brain while estrogen and testosterone support neurogenesis activities and synaptic remodeling and cognitive functions throughout the areas that include hippocampus and hypothalamus. The hormone estrogen specifically controls serotonin manufacturing processes in the brain as well as controlling serotonin receptor operation to affect cognitive functioning. The stress and memory responses are directly influenced by progesterone and its metabolites although their performance changes throughout the menstrual cycle. When a woman takes hormonal birth control the medicine changes the way her brain looks by modifying gray and white matter structure. The research paper examines sexual brain differences in network connections particularly regarding the default mode network while demonstrating how sex hormones control such functional brain networks. Researchers need to understand how hormones influence brain function because this knowledge enables proper development of treatment methods for neuropsychiatric disorders such as depression and anxiety where sex-specific differences are prominent. Research needs more focus on hormonal treatments of brain disorders because this review establishes that hormone changes affect neural flexibility and mental wellness at varying stages of life.Changes in brain neuroplasticity can affect in dual way: neuroplasticity can changes hormones secretion, hormones disregulation can changes brain functional activity. Underlying molecular mechanisms should been taken in account in treatment neurologic and endocrine diseases. Deep understanding that process can help in improving preventive managements in adaptation to stress and learning.

Keywords: neuroplasticity, impact of hormones, learning

Ref No: 7043

Euglycemic Diabetic Ketoacidosis Induced by Dapagliflozin: A Case Report

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Introduction and Purpose: Introduction: Sodium-glucose cotransporter-2 (SGLT-2) inhibitors are increasingly used in the management of type 2 diabetes mellitus (T2DM) due to their glycemic control and cardiorenal protective effects. However, these agents carry a rare but serious risk of euglycemic diabetic ketoacidosis (eDKA)—a life-threatening condition characterized by high anion gap metabolic acidosis in the absence of marked hyperglycemia. Because its clinical presentation is often subtle, eDKA can be overlooked in emergency department (ED), delaying diagnosis and treatment.

Materials and Methods: Case Presentation: A 62-year-old male with T2DM, hypertension, coronary artery disease, chronic kidney disease, peripheral arterial disease, and prior hemorrhagic stroke presented to the ED with nausea, vomiting, and dizziness following minor head trauma. He was taking dapagliflozin (10 mg/day) as part of his antihyperglycemic regimen. On evaluation, he was hypertensive but alert and neurologically intact. Laboratory results revealed metabolic acidosis (pH 7.30, bicarbonate 18.2 mmol/L), mild hyperglycemia (glucose 247 mg/dL), an anion gap of 12.6 mEq/L, and ketonuria, consistent with eDKA. Brain imaging was unremarkable. Dapagliflozin was discontinued, and the patient was treated with intravenous dextrose and insulin infusion, resulting in rapid clinical and biochemical improvement. He was discharged with resolved acidosis and advised to avoid SGLT-2 inhibitors.

Results and Conclusion: Discussion and Conclusion: eDKA should be considered in any patient on SGLT-2 inhibitors presenting with unexplained high anion gap metabolic acidosis, even in the absence of marked hyperglycemia or classic DKA precipitants. In this case, minor trauma and transient gastrointestinal symptoms may have contributed to insulin deficiency and enhanced ketogenesis. Prompt recognition and management are critical. Treatment entails cessation of the SGLT-2 inhibitor, volume resuscitation, insulin therapy, and dextrose supplementation to prevent hypoglycemia during ketosis resolution. Emergency clinicians must maintain high clinical suspicion for eDKA to avoid missed diagnoses.In conclusion, this case underscores the importance of recognizing eDKA as a rare but serious complication of SGLT-2 inhibitors. Emergency physicians should consider this diagnosis in patients with metabolic acidosis and nonspecific symptoms who are receiving SGLT-2 inhibitors. Early intervention is essential to prevent morbidity and mortality associated with delayed treatment.

Keywords: Euglycemic Diabetic Ketoacidosis, SGLT-2, Emergency physicians

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Ref No: 7087

Retrospective Study on Demographic Analysis and Vitamin K Efficacy in Patients with Elevated INR

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Introduction and Purpose: The International Normalized Ratio (INR) is a standardized test used worldwide to monitor blood coagulation, recognized by the World Health Organization (WHO). Warfarin, an anticoagulant, is commonly used to treat conditions like deep vein thrombosis (DVT), pulmonary embolism (PE), and atrial fibrillation (AF).Excessive warfarin dosing or genetic factors can lead to elevated INR levels. An INR of 5 or higher increases the risk of severe bleeding complications. Vitamin K (phytomenadione) is used to reverse warfarin's anticoagulant effect. This study aims to analyze the demographic characteristics of patients with elevated INR due to warfarin use and evaluate Vitamin K efficacy.

Materials and Methods: This retrospective study included patients aged 18 and older who presented to the emergency department between January 1 and December 31, 2024, with elevated INR levels due to warfarin use and received Vitamin K treatment.

Results and Conclusion: The study included 50 patients, with 50% female and 50% male, and a mean age of 68.14±12.64 years. The most common symptom was dyspnea (18%). Medical histories showed 40% had hypertension, 26% had coronary artery disease, and 24% had diabetes mellitus. All patients received 10 mg of intravenous Vitamin K, reducing their INR from 8.87±2.99 to 2.92±1.41.Of the patients, 66% were discharged, 18% were admitted to the ward, and 12% to the intensive care unit. No significant correlation was found between INR levels (above or below 5) and bleeding symptoms (p=0.63). Among those with bleeding symptoms, 3 were admitted to the ward, while 6 without bleeding symptoms were also admitted. None of the 5 patients in intensive care had bleeding symptoms.In

conclusion, no significant relationship was found between bleeding symptoms and patient outcomes (p=0.17), nor between INR levels and patient outcomes (p=0.92).
Summary

Sign of Bleeding	INR 1-5	INR >5	Inpatient	Intensive Care Unit	p
Yes	1	17	3	0	0,633
No	3	29	6	5	0,633

Keywords: INR, Bleeding, Vitamin K

Ref No: 7098
Review of Emergency Medicine and Primary Healthcare Services during Flood-Induced Disasters: The Example of Hurricane Daniel in Libya
Fatih Cemal Tekin[1], Canan Tekin[2]
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[2]Department of Family Medicine, Konya Numune Hospital, Türkiye
Introduction and Purpose: The Daniel hurricane, which started in Greece on September 5-6, affected Libya on September 10.Strong winds, heavy rainfall, and dam collapses affected the cities of Benghazi, Bayda, Marj, Susa, and Derna, causing a disaster of immense destruction and catastrophe. In our study, the aim was to examine the emergency and essential health services that should be provided in flood-related disasters, using the example of the Libya disaster.
Materials and Methods: In study, the open-source EM-DAT disaster database was used. Emergency and basic health services during flood disasters were examined . Data before 2000 were excluded from the study due to the possibility of bias. No sample calculation was made, and the data up to September 2023 (considering the year the disaster occurred) were included in the study.
Results and Conclusion: EM-DAT database contains over 26.000 records included from the 1900s to the present day. Since 2000, 36.7% of the disasters that have occurred worldwide have been classified as technological, while 63.3% have been classified as natural disasters. The proportion of disasters caused by floods among all disasters is 27.5% (3.954) (Table-1). The numbers of flood disasters by region in the world are provided in Table-2. It has been observed that the highest number of flood-related disasters worldwide occurred in 2006, and between 2020 and 2023, flood disasters were most frequently reported in the 6th, 7th, and 8th months (Figure-1).The Libya flood disaster is an important catastrophe that causes serious destruction and demonstrates the extent to which dam-related flood events can reach. Undoubtedly, the most important step in the management phase of the flood disaster is to ensure that urban planning is conducted away from riverbeds and dam/reservoir evacuation areas. In disaster management, emergency medical services and primary healthcare services are important healthcare services that need to be carried out simultaneously. Although the disasters experienced may have painful consequences, the organization of health services during disasters is of vital importance, and each incident should be evaluated as a lesson to prevent the repetition of mistakes. The Libya flood disaster, being a dam-related flood event and considering the serious consequences that have emerged, should be addressed in detail.
Figure 1 The Frequency of Flood Disasters by Year and Month

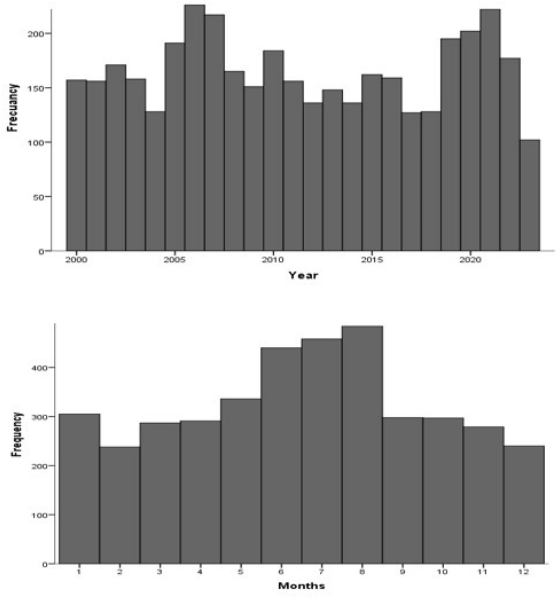

Table 1 Natural Disasters Occurring in the World

Disaster Type	n (%)	Disaster Subtype	n (%)
Technological Disasters	5658 (36.7)	Transportation Accidents	887 (15.7)
		Industrial Accidents	904 (16)
		Others	3867 (68.3)
Natural Disasters	9750 (63.3)	Biological	920 (9.4)
		Climatological	690 (7.1)
		Extraterrestrial	1 (0.01)
		Geophysics	784(8)
		Hydrological	4395 (45.1)
		Meteorological	2960 (30.4)

Table 2 Flood Disaster Incidence Rates by Region

Regions	n	%
Africa	933	23.6
America	856	21.6
Asya	1595	40.3
Europe	469	11.9
Oceania	101	2.6

Keywords: Disaster Medicine, Primary Health Care, Emergency Medicine

Ref No: 7179

Immature Granulocyte Levels and Clinical Severity in Acute Coronary Syndrome: A Preliminary Study

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[1]Terme State Hospital, Emergency Clinic
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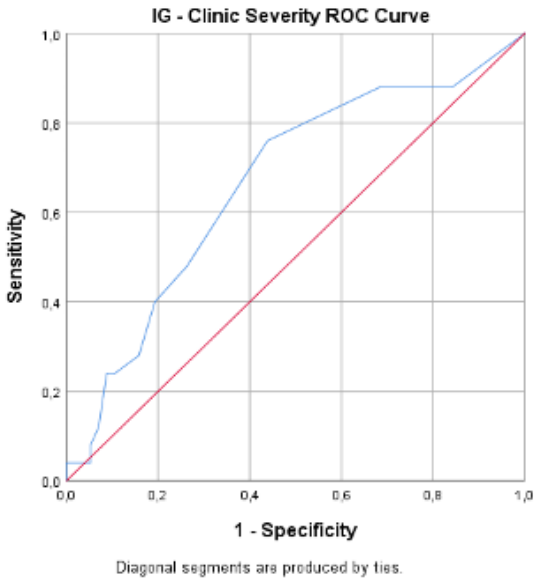
Introduction and Purpose: Systemic inflammation plays a critical role in the pathophysiology and progression of acute coronary syndromes (ACS), particularly in ST-elevation myocardial infarction (STEMI). Immature granulocytes (IG), measurable through automated complete blood count analyzers, have recently gained attention as potential inflammatory markers. However, their clinical relevance in ACS remains underexplored.

Materials and Methods: This retrospective, single-center observational study included 83 patients diagnosed with ACS between January 1, 2022, and March 1, 2022. Patients were classified as having either STEMI or non-ST-elevation myocardial infarction (NSTEMI) based on electrocardiographic findings. IG levels, troponin I, liver enzymes, and ejection fraction were recorded at admission. Killip classification was used to assess clinical severity. The diagnostic performance of IG in identifying STEMI was evaluated using receiver operating characteristic (ROC) analysis.

Results and Conclusion: Of the 83 patients, 61.4% were male and the median age was 68 years. STEMI was present in 30.1% of cases. IG levels were significantly higher in the STEMI group (p = 0.016). A significant association was also found between Killip classification and MI type (p = 0.008), with more severe Killip classes observed among STEMI patients. ROC analysis revealed that IG had a modest but statistically significant ability to identify STEMI, with an area under the curve (AUC) of 0.665 (p = 0.018), a cut-off value of 0.35, sensitivity of 76.0%, and specificity of 56.1%. This preliminary study suggests that IG levels are associated with more severe clinical presentations in ACS, particularly in STEMI. While prognostic conclusions could not be drawn due to limited sample size and mortality events, our findings support further prospective studies to investigate the prognostic utility of IG in ACS.

Receiver Operating Characteristic (ROC) Curve of Immature Granulocyte Levels for Predicting Clinical Severity in Acute Coronary Syndrome



Diagnostic Performance of IG for Identifying STEMI

AUC (95% CI)	0.665 (0.536-0.794)
p	0.018
Cut off value	0.35
Sensitivity	76.0 %
Specificity	56.1 %

Keywords: Acute Coronary Syndrome, Granulocytes, Inflammation Mediators

Ref No: 7180

Transfusion-related acute lung injury (TRALI) and simultaneous acute coronary syndrome in the emergency department: A multidisciplinary case report

Şevval AYAN[1], Ahmet KAPLAN[1], Ahmet Melih SAVAŞ[1], Ayhan AKÖZ[1]
[1]Adnan Menderes Üniversitesi

Introduction and Purpose: Blood transfusions administered in emergency departments are urgent interventions that require rapid decision-making and are often performed under time pressure. However, these interventions can lead to serious complications. Transfusion-related acute lung injury (TRALI) is a rare but life-threatening complication. Its diagnosis can be particularly challenging when accompanied by other critical conditions. This case aims to emphasize the diagnostic and management challenges of TRALI following transfusion in the emergency department, in a patient who simultaneously developed acute coronary syndrome (ACS).

Materials and Methods: A female patient presented to the emergency department with abdominal pain, weight loss, and severe anemia (Hb: 6.5 g/dL). Transfusion of erythrocyte suspension was initiated. Following the transfusion, the patient developed sudden hypoxemia, tachypnea, and bilateral infiltrates in the emergency department, indicating acute respiratory distress (image 1). She was rapidly intubated and admitted to the intensive care unit. Cardiogenic causes were ruled out by echocardiography. Concurrently, a marked rise in troponin levels prompted an emergency coronary angiography, which revealed right coronary artery occlusion (image 2). A stent was successfully placed. Despite partial improvement in oxygenation, the patient later developed multiorgan failure and septic shock, and died on the 11th day following transfusion. The diagnosis of TRALI was supported by the acute onset of non-cardiogenic pulmonary edema within 6 hours of transfusion and the exclusion of other causes.

image 1

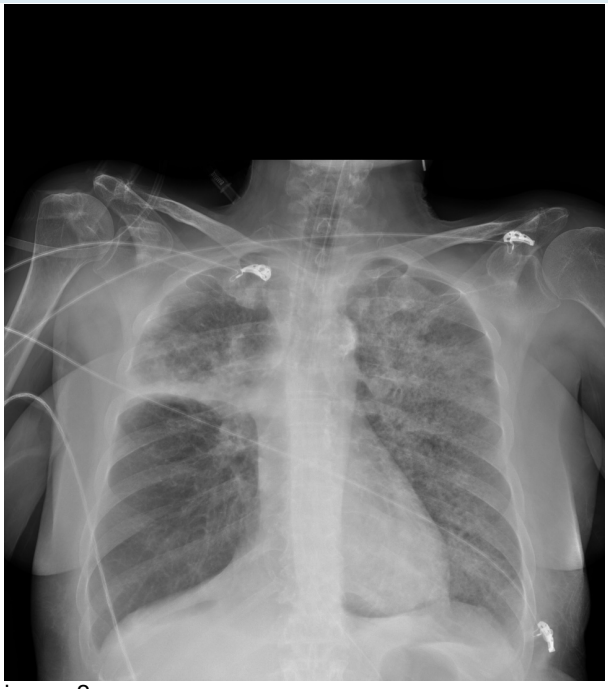
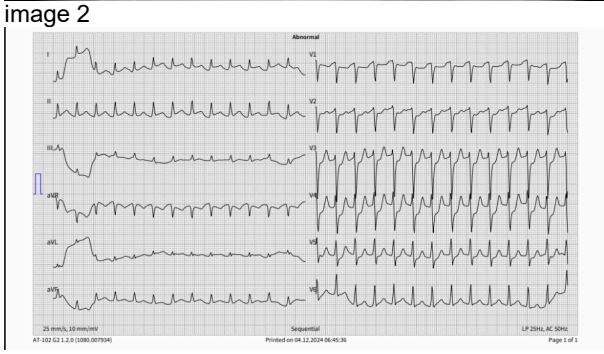


image 2



Results and Conclusion: This case highlights the importance of considering TRALI in the differential diagnosis of patients receiving transfusions in the emergency department and initiating early supportive treatment. The coexistence of TRALI and ACS may worsen prognosis and significantly increase mortality.

Keywords: Transfusion-related lung injury, acute coronary syndrome, blood transfusion complications

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Ref No: 7181

Acute Confusion Associated with Levofloxacin Use: A Rare Adverse Drug Reaction

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Introduction and Purpose: Levofloxacin is a broad-spectrum fluoroquinolone commonly used to treat respiratory, urinary, and skin infections. While generally well tolerated, it is associated with adverse effects, including neuropsychiatric symptoms such as confusion, hallucinations, and delirium, especially in older adults. These manifestations may go unrecognized due to their transient nature and overlap with other conditions. This case highlights acute confusion as a rare but significant adverse reaction to levofloxacin in an elderly patient without prior neurological or psychiatric history.

Materials and Methods: A 65-year-old male with no chronic illnesses presented to the emergency department with acute confusion two days after starting levofloxacin 750 mg daily for suspected community-acquired pneumonia. On arrival, he was conscious but minimally responsive, incoherent, and intermittently followed simple motor commands. He was unable to walk and exhibited disorganized behavior. Vital signs were normal, and there were no signs of infection, dehydration, or meningeal irritation. Neurological examination showed no focal deficits, and his motor responses were inconsistent. Initial blood work, electrolytes, renal and liver functions were within normal limits. Neuroimaging, including CT, diffusion MRI, and CT angiography, revealed no abnormalities. Cerebrospinal fluid analysis was unremarkable. He had no history of psychiatric illness and was not taking other medications. In the absence of metabolic, infectious, or structural causes—and given the close temporal relationship with levofloxacin initiation—a diagnosis of levofloxacin-induced acute confusional state was made. The antibiotic was discontinued, and the patient was managed conservatively with supportive care. Over his hospital stay, mental status improved, and he returned to baseline. He was discharged fully recovered.

Results and Conclusion: This case underscores the importance of considering drug-induced neurotoxicity in elderly patients with acute confusion. Though rare, fluoroquinolone-related neuropsychiatric effects can mimic serious neurological conditions. Early recognition

and prompt discontinuation of the offending agent may prevent unnecessary investigations and ensure full recovery.
Keywords: Acute Confusion, Fluoroquinolones, Adverse Drug Reaction

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Ref No: 7194
Precision Cytokine Profiling for Expedited Diagnosis and Targeted Therapeutic Intervention in Central Retinal Artery Occlusion
Mohizodabegim Yusufbekova[1], Dr. Mohiryam Aliyeva[2], Kamoliddinbekzod Yusupov[1]
[1]Central Asian University
[2]AkfaMedline University Hospital
Introduction and Purpose: Central retinal artery occlusion (CRAO), a time-sensitive ocular emergency, leads to irreversible vision loss due to retinal ischemia. Its pathogenesis involves a complex interplay of inflammatory mediators, where cytokines exert a pivotal role. This abstract underscores the potential of precision cytokine profiling in expediting CRAO diagnosis, differentiating underlying etiologies, and guiding targeted therapeutic interventions to optimize visual outcomes. Prompt differentiation between inflammatory (e.g., Giant Cell Arteritis-associated CRAO) and embolic/thrombotic CRAO is critical for acute management.
Materials and Methods: This review synthesizes studies employing diverse methodologies to quantify cytokine levels in CRAO. These methodologies include aqueous humor sampling via anterior chamber paracentesis, vitreous humor sampling during vitrectomy, and peripheral blood (serum or plasma) analysis. Key cytokines implicated in CRAO pathogenesis, such as vascular endothelial growth factor (VEGF), interleukin-6 (IL-6), interleukin-8 (IL-8), tumor necrosis factor-alpha (TNF-α), monocyte chemoattractant protein-1 (MCP-1), and interleukin-1 beta (IL-1β), are evaluated for their diagnostic and therapeutic utility. Specifically, the relationship between peripheral blood inflammatory indices and the severity of CRAO is examined.
Results and Conclusion: Cytokine profiling offers a promising avenue for refining CRAO diagnosis and treatment strategies. Elevated IL-6 levels may serve as a biomarker for Giant Cell Arteritis (GCA)-related CRAO, mandating immediate systemic corticosteroid therapy to prevent further vision loss. Increased VEGF levels can identify patients at heightened risk for neovascular complications, warranting timely anti-VEGF therapy. Furthermore, peripheral blood inflammatory indices correlate with CRAO severity, providing prognostic information. Integrating cytokine analysis into the clinical workflow can empower ophthalmologists to achieve expedited differential diagnoses, personalize treatment regimens (e.g., anti-inflammatory, anti-VEGF, or antithrombotic therapies), and ultimately improve visual prognosis in patients with CRAO
Keywords: Central Retinal Artery Occlusion, Cytokine Profiling, Precision Medicine

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Ref No: 7244
A rare complication of abdominal pain after upper gastrointestinal endoscopy: iatrogenic gastric perforation
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Introduction and Purpose: Gastric perforation is a life-threatening emergency that requires urgent intervention, with high mortality and morbidity rates. The most common cause of gastric perforation is peptic ulcer disease. Iatrogenic gastric perforation, which is quite rare, most frequently occurs due to upper gastrointestinal (GI) endoscopy.Clinically, patients with gastric perforation usually present to the emergency department with sudden-onset severe abdominal pain, nausea, vomiting, fever, and signs of shock. Abdominal examination often reveals generalized tenderness, rebound, and involuntary guarding. The presence of subdiaphragmatic free air on abdominal radiography supports the diagnosis. Computed tomography (CT) can be used to determine the exact location, size, and associated complications of the perforation. Treatment usually requires emergency surgical intervention.
Materials and Methods: A 63-year-old male patient presented to the emergency department with worsening abdominal pain that started 3 h after endoscopy. On physical examination of the abdomen, diffuse tenderness, guarding, rebound, and a board-like rigidity were detected on palpation; bowel sounds were decreased on auscultation. X-ray showed a double-contour air image under the diaphragm, and abdominal CT with contrast revealed the following: “Free fluid was observed in all quadrants of the abdomen. Free air findings were present in the abdomen. The appearance was interpreted as being consistent with the perforation. The edematous appearance of the distal gastric wall was noted. The perforation site may be located here. Clinical correlation is recommended.” The patient was diagnosed with “Acute abdominal and gastric perforation” and underwent emergency surgery by the General Surgery department. The patient, who was followed up in the General Surgery intensive care unit, was discharged with recovery on the 7th postoperative day.
Figure 1: Abdominal X-ray: A double-contour air image was observed under the diaphragm.

Figure 2: In abdominal CT with contrast, free fluid and free air are observed in all quadrants of the abdomen. The image also highlights an edematous apperance of gastric wall distal to the stomach.

Results and Conclusion: This case report demonstrates how gastric perforation following an endoscopic procedure can be successfully treated with early diagnosis and surgical intervention. Early diagnosis can be achieved through careful clinical evaluation and advanced imaging methods. For treating gastric perforation, early diagnosis, appropriate surgical intervention, and postoperative care are vital in minimizing complications and mortality.

Keywords: Upper gastrointestinal endoscopy, Abdominal pain, Iatrogenic gastric perforation

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Ref No: 7258

A Rare Side Effect of Hyponatremia: A Case Report

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[1]Republic of Türkiye Ministry of Health Çarşamba State Hospital

[2]Ondokuz Mayıs University Faculty of Medicine, Department of Emergency Medicine

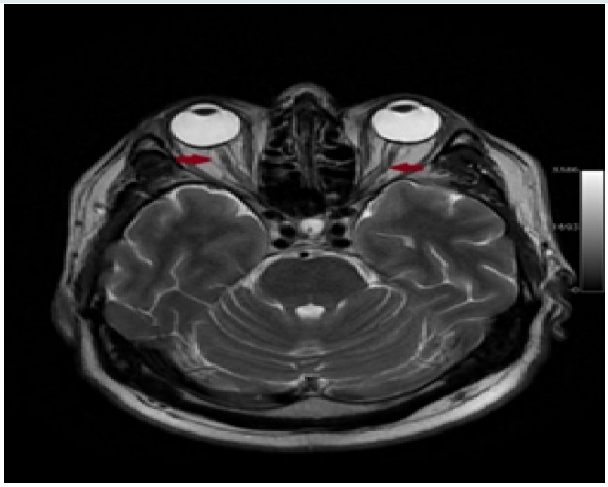
Introduction and Purpose: Hyponatremia, defined as a serum sodium concentration below 135 mEq/L, is the most common electrolyte imbalance seen in emergency departments. It can arise due to reduced dietary sodium intake, excessive water retention, or significant sodium loss. Hyponatremia may present with a wide spectrum of symptoms depending on the severity and rapidity of onset, ranging from asymptomatic cases to nausea, vomiting, headache, lethargy, seizures, and coma. Idiopathic intracranial hypertension (IIH) is a syndrome characterized by increased intracranial pressure without an identifiable cause. Although the exact pathophysiology remains unclear, it is thought to result from excess cerebrospinal fluid (CSF) production, impaired CSF absorption, or increased cerebral venous pressure.

Materials and Methods: A 51-year-old male presented to the emergency department with a 4-5 day history of throbbing headache, dizziness, and diplopia. His medical history included recently diagnosed hypertension and diabetes mellitus, managed with an ACE inhibitor and metformin. The patient had also been following a low-sodium diet since diagnosis. On examination, vital signs were stable, and neurological findings were normal except for ataxia, which resolved when one eye was closed. Ophthalmologic evaluation revealed bilateral papilledema, peripapillary hemorrhage, and horizontal diplopia. While cranial CT was unremarkable, MRI indicated findings consistent with increased intracranial pressure, such as optic nerve sheath distension and partial empty sella. Laboratory results showed severe hyponatremia (116 mEq/L). The patient received two doses of 3% hypertonic saline in the emergency department and was admitted to nephrology. Lumbar puncture performed during hospitalization revealed elevated CSF pressure (42 cmH2O). The patient's sodium levels normalized after further hypertonic saline and diuretic therapy, and his diplopia resolved. Detailed evaluation indicated that the hyponatremia was due to dietary sodium restriction.

image1

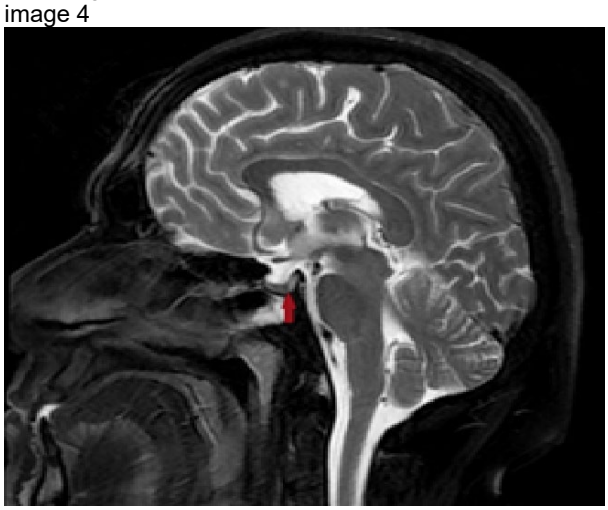
Normal head CT image

image 2



Increase in bilateral optic nerve tortuosity and perioptic cerebrospinal fluid distance.
image 3

flattening of the posterior bilateral ocular bulbs
image 4



partial empty cella
table 1

Test	Results at Admission	Results on Day 5	Reference Ranges

White Blood Cell Count (x10³/uL)	13,5	12,02	4,49-12,68
Hemoglobin (g/dL)	15,5	14,3	13,5-16,9
Platelet Count (x10³/uL)	428	403	173-390
Sodium (mEq/L)	116	137	136-145
Potassium (mEq/L)	3,9	4,01	3,5-5,1
Chloride (mEq/L)	81	99	96-107
Calcium (mg/dL)	9,5	9,61	8,6-10,0
BUN (mg/dL)	13	12	6-20
Creatinine (mg/dL)	0,76	0,72	0,7-1,2
ALT (U/L)	60	17	0-47
AST (U/L)	30	37	0-40
CPK (U/L)	129	131	39-308
Glucose (mg/dL)	174	142	70-110
Lactate (mmol/L)	2,0	1,5	0,4-1,4
Base Excess (mmol/L)	0,8	1,2	2-3
pH	7,42	7,40	7,35-7,45
pO2 (mmHg)	96	96	83-108
pCO2 (mmHg)	39	38	32-48
HCO3 (mmol/L)	25	24	22-26

Laboratory results from the patient's admission and on the 5th day

Results and Conclusion: Hyponatremia can lead to increased intracranial pressure through osmotic imbalances between CSF and blood. While neurological complications of hyponatremia are well-documented, visual disturbances like diplopia are rare. This case highlights the need to consider intracranial hypertension in hyponatremic patients presenting with visual symptoms. Hyponatremia should be included as a differential diagnosis in patients with intracranial hypertension. Emergency physicians must evaluate visual

complaints in hyponatremic patients for potential intracranial pressure elevation.
Keywords: hyponatremia, intracranial hypertension, diplopia

Ref No: 7264
Leriche Syndrome in the Emergency Department: A Four-Patient Case Series
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[1]Department of Emergency Medicine, Faculty of Medicine, Muğla Sıtkı Koçman University
Introduction and Purpose: Leriche syndrome, also known as aortoiliac occlusive disease, is characterized by chronic or acute thrombotic occlusion of the distal abdominal aorta and/or iliac arteries. While classically described as a chronic condition with bilateral claudication and absent femoral pulses, acute presentations involving spinal cord ischemia, severe limb hypoperfusion, and multiorgan dysfunction may occur. Early recognition in the emergency department (ED) is vital to prevent irreversible neurologic or ischemic damage. To present four diverse cases of Leriche syndrome encountered in the ED, emphasizing the variability of clinical presentation, the diagnostic role of computed tomography angiography (CTA), and the importance of emergency physician-led stabilization and coordination of vascular care.
Materials and Methods: We retrospectively reviewed four patients diagnosed with Leriche syndrome between January 2019 and January 2024 in a tertiary ED. The cohort consisted of three men (ages 81, 61, 80) and one woman (age 72). Clinical presentation, physical examination, imaging, treatment strategy, and disposition were extracted from the medical records.
Results and Conclusion: Two patients presented with acute total occlusion of the abdominal aorta, manifesting as sudden-onset paraplegia, syncope, or acute abdomen. In both cases, femoral and distal pulses were absent, and bilateral lower limbs were cold and hypo-perfused. Emergency CTA confirmed complete infrarenal aortic thrombosis. Both patients underwent urgent surgical intervention after ED stabilization. One elderly male had a mega aorta with diffuse mural thrombus without acute ischemia and was managed conservatively. A fourth patient, a 72-year-old woman, presented with subacute worsening limb pain and was diagnosed with chronic aortoiliac occlusion with acute-on-chronic ischemia. She underwent staged endovascular intervention. All patients survived to hospital discharge. Leriche syndrome may present acutely with symptoms mimicking other vascular or neurologic emergencies. Emergency physicians must maintain a high index of suspicion in patients with bilateral lower limb symptoms, absent femoral pulses, or sudden neurologic deficits. CTA remains the cornerstone of diagnosis. Early ED recognition and multidisciplinary coordination can significantly improve outcomes through timely surgical or medical management.
Keywords: Leriche syndrome, High index of suspicion, Emergency department

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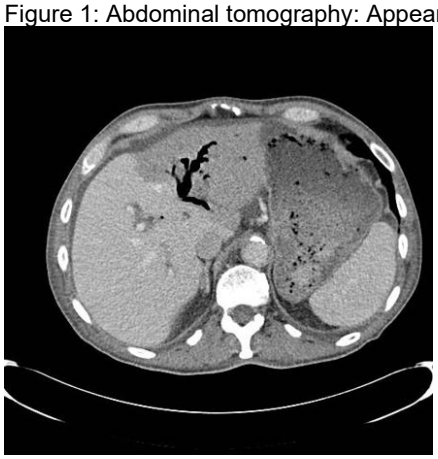
Ref No: 7297
A RARE CAUSE OF ABDOMINAL PAIN IN THE EMERGENCY DEPARTMENT: PORTAL VEIN TOMBOSIS
DR. AYKUT ADIGÜZEL[1], DOÇ. DR. İBRAHİM ÖZLÜ[1]
[1]ERZURUM ATATÜRK UNIVERSITY EMERGENCY MEDICINE DEPARTMENT
Introduction and Purpose: 47-year-old man with known hypertension and a history of Coveryl use presented with abdominal pain, diarrhoea and swelling of the foot. On admission, general condition was moderate, saturation: 94%, pulse: 91, arterial blood pressure: 113/72 mmHg, temp: 36.4°C. Physical examination revealed tenderness in the right upper quadrant. There was no pretibial oedema and no significant increase in diameter of either foot. A contrast-enhanced CT scan of the lower/upper abdomen was performed in the patient, who had no significant abnormalities in blood tests and did not improve with symptomatic treatments. The CT scan showed a thrombus in the portal vein (Figure 1). The patient was referred to the Department of Internal Medicine and was admitted to the hospital for treatment.
Materials and Methods: Abdominal tomography
Figure 1: Abdominal tomography: Appearance consistent with portal vein thrombus



Results and Conclusion: When assessing patients presenting to the emergency department with complaints of abdominal pain and diarrhoea, obstructive lesions, although rare, should be considered in cases where we cannot explain the cause or abdominal pain does not resolve with treatment, and further imaging and investigations should be undertaken for diagnosis.
Keywords: PORTAL VEIN TOMBOSIS

Ref No: 7339

ISCHEMIC INFARCTION IN THE YOUNG PATIENT GROUP

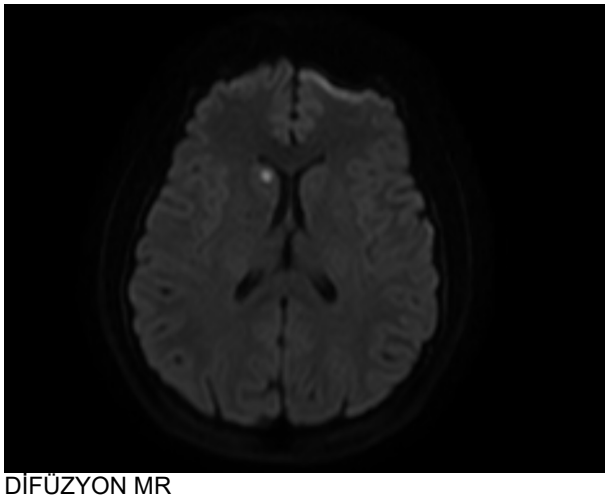
DENİZ TANRIVERDİ[1]

[1]YOZGAT , BOZOK ÜNİVERSİTESİ MEDİCAL FACULTY

Introduction and Purpose: Ischemic infarction is a cerebrovascular event that occurs due to a reduction in blood flow to the brain. Although it is more commonly seen in older age groups, it can rarely occur in young patients and may result in significant morbidity.In the general population, ischemic strokes are primarily associated with atherosclerotic processes, whereas in young patients, the etiology encompasses a broader spectrum and requires a detailed evaluation.The most common causes of ischemic infarction in young patients include cardioembolic events (e.g., patent foramen ovale, arrhythmia), arterial dissections, thrombophilic conditions, and rare genetic disorders. Infections, migraine-related vascular events, and substance use may also play a role in the etiology. Clinically, young patients often present with sudden-onset hemiparesis, dysarthria, altered consciousness, and visual disturbances. Diagnosis is established through brain imaging modalities (CT, MRI) and additional tests to determine the underlying cause. Acute-phase treatment includes thrombolytic agents and mechanical thrombectomy, while long-term management focuses on risk factor control and secondary prevention strategies.

Materials and Methods: A 23-year-old female patient presented to our emergency department with a complaint of persistent headache for three days. She described it as the most severe headache she had ever experienced.Vital signs:•Blood pressure: 120/90 mmHg•Heart rate: 89 bpm•SpO □ 97%•Temperature: 36.5°On physical examination, bilateral horizontal nystagmus was noted. The rest of the neurological examination was unremarkable. Diffusion-weighted imaging (DWI) and susceptibility-weighted imaging (SWI) were performed.Radiology report:A subcentimetric diffusion restriction was observed in the periventricular area of the right frontal region.The patient was admitted to the neurology service for further evaluation and treatment. Appropriate therapy was initiated.

DİFÜZYON MR



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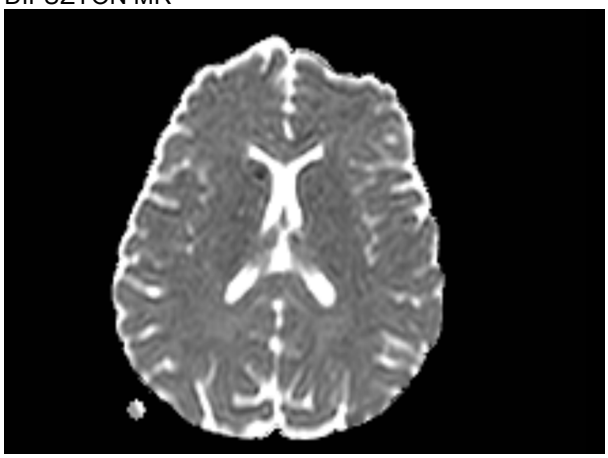

Results and Conclusion: Although ischemic infarction is rare in young patients, its etiology is diverse and requires a comprehensive evaluation. While early diagnosis and appropriate treatment generally lead to a better prognosis, long-term rehabilitation and risk factor management are crucial. Therefore, young patients who experience a stroke should be assessed with a multidisciplinary approach.

Keywords: emergency department, ischemic infarction, stroke

Ref No: 7358
unexpected bleeding
MUHAMMED CENGİZHAN DURMUŞ[1], FATMA TORTUM[1]
[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP
Introduction and Purpose: IntroductionHeadache is one of the most common reasons for emergency department visits, and the rapid and accurate evaluation of underlying pathologies is crucial. A 27-year-old male patient with no known comorbidities presented to the emergency department with a severe headache persisting for three days, unresponsive to analgesic treatment. The patient had no history of trauma, but his physical examination revealed altered consciousness, with a Glasgow Coma Scale (GCS) score of 9. An urgent brain computed tomography (CT) scan showed findings consistent with subarachnoid hemorrhage (SAH) and intracerebral hemorrhage (ICH). These findings suggest a serious neurovascular event as the underlying cause of the patient's symptoms, necessitating immediate medical intervention.
Materials and Methods: Case ReportA 27-year-old male patient with no known comorbidities presented to the emergency department with a severe headache persisting for three days, unrelieved by analgesics. The patient had no history of trauma. On neurological examination, his Glasgow Coma Scale (GCS) score was 9. An urgent brain computed tomography (CT) scan revealed findings consistent with subarachnoid hemorrhage (SAH) and intracerebral hemorrhage (ICH) (image 1).
image 1

Results and Conclusion: ConclusionIn young patients without a history of trauma, persistent and severe headaches should raise suspicion for potential neurological emergencies. Early diagnosis and prompt management of life-threatening conditions such as SAH and ICH are critical factors that directly influence prognosis. This case highlights the importance of considering headache not merely as a common symptom but as a potential indicator of serious underlying pathology. A multidisciplinary approach, involving neurology and neurosurgery specialists, is essential for the appropriate evaluation and management of such cases.
Keywords: BRAİN HEMORRHAGE

Ref No: 7397
Cement Material in the Vena Cava, Right Atrium, and Pulmonary Artery: A Rare Case Presentation From an Emergency Medicine Perspective
Selin Gül[1], Ahmet Melih Savaş[1], Ayhan Aköz[1], Mehmet Emir Akçay[1]
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Introduction and Purpose: Vertebral compression fractures (VCF) are common in osteoporotic patients. Percutaneous kyphoplasty (PKP), treats painful VCF by injecting Poly Methyl Meth Acrylate (PMMA) cement into the vertebral body (VB). This case report presents a patient in whom PMMA cement migrated to the inferior vena cava (IVC) and right atrium (RA), resulting in pulmonary cement embolism (PCE) detected by ultrasonography and computed tomography (CT).
Materials and Methods: A 72-year-old female with a history of PKP for an osteoporotic vertebral fracture at L2 four months ago, presented with intermittent palpitations, blood pressure irregularities and fatigue. The patient was on multiple medications including clopidogrel and acetylsalicylic acid for chronic conditions.The patient’s heart rate was 110 beats/min, respiratory rate was 16 breaths/min, oxygen saturation was 99% and blood pressure was 143/89 mmHg. Breath sounds were diminished bilaterally at the lung bases, with bilateral grade 1 pretibial edema.Point-of-care ultrasound (POCUS) revealed an ejection fraction of 60%, normal right-sided structures. A hyperechoic, long, thin structure extending from the IVC to the RA was observed. (Figure 1)Laboratory results showed normal troponin-I levels, normal prothrombin time and D-dimer of 8600 ng/ml. A posteroanterior chest X-ray revealed radio-opacity in the right hilar region (Figure 2).The patient underwent pulmonary angiography CT. Imaging showed metallic cement in the L2 VB, a tubular dense structure extended from the left paravertebral venous tract to the IVC and RA. Similar dense structures in the right main pulmonary artery and segmental branches suggested PCE. (Figures 3,4)A pulmonology consultation recommended anticoagulation and

cardiology evaluation. Following cardiology consultation, the patient was hospitalized for treatment planning.

Figure 1: A hyperechoic, thin, elongated structure (arrows) extending from the inferior vena cava to the right atrium, as observed on transthoracic echocardiography.

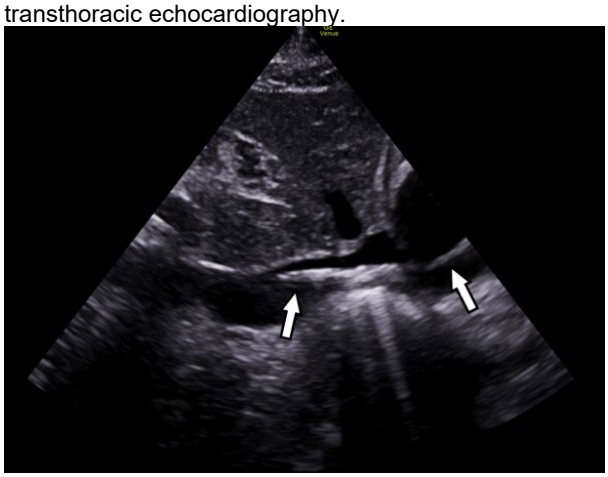


Figure 2: A radiopaque area (arrow) observed in the right hilar region on the posteroanterior chest X-ray.

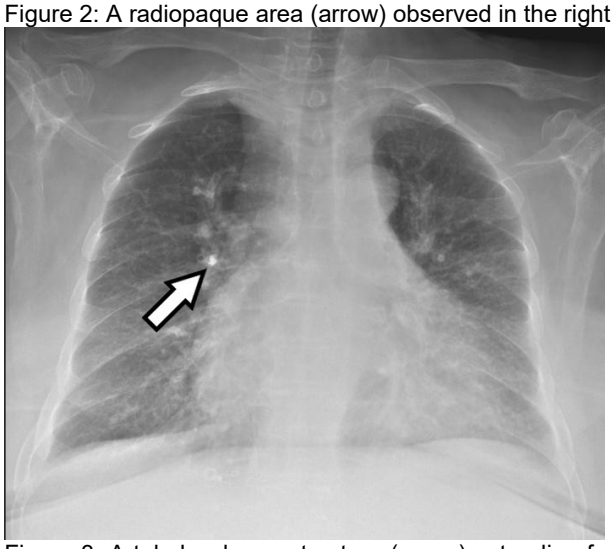


Figure 3: A tubular dense structure (arrow) extending from the left paravertebral venous tract to the inferior vena cava and right atrium on CTPA imaging.

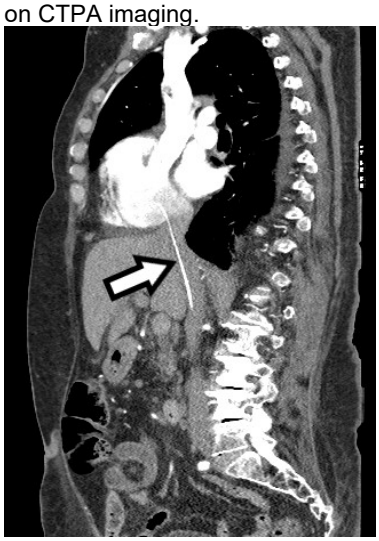
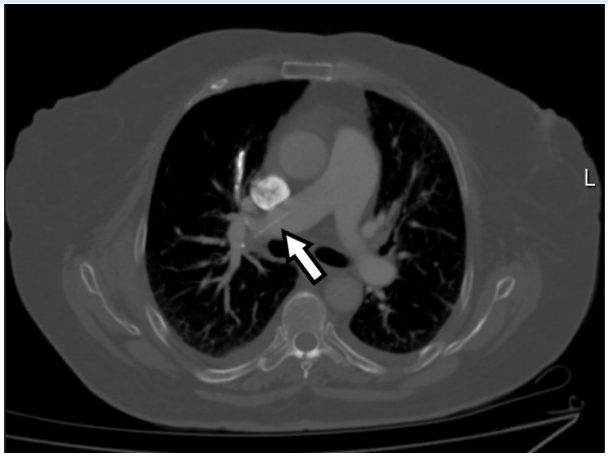


Figure 4: A tubular dense structure (arrow) in the right main pulmonary artery on CTPA imaging.



Results and Conclusion: PKP is a minimally invasive treatment for VCF in osteoporotic patients, using PMMA bone cement. Complications include hypotension, PCE, spinal cord compression and infection. Cement migration to the IVC and PCE occurs in 3,5% to 23% of cases. What is interesting in our case is cement migration to the IVC and RA, with PCE presenting mildly, possibly due to the patient's anticoagulant use for chronic conditions. Based on the patient's medical history and examination findings in the emergency department, POCUS and CT imaging may shed light on rare complications that could have a fatal outcome.
Keywords: Cement Embolism, Pulmonary Embolism, Vena Cava Thrombosis

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Ref No: 7437
A Rare and Easily Overlooked Diagnosis in a Pediatric Trauma Case: Traumatic Asphyxia
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Introduction and Purpose: Traumatic asphyxia is a clinical syndrome characterized by cervicofacial cyanosis, edema, petechiae, subconjunctival hemorrhage, and neurological symptoms following sudden, severe, compressive blunt thoracoabdominal trauma. Morbidity and mortality are related to concurrent cardiovascular, neurological, and pulmonary injuries and their severity.
Materials and Methods: Case Report: 9-year-old male patient was brought to the emergency department (ED) after falling from the trailer of a tractor. Numerous petechiae were observed on the scalp, face, neck, and upper chest wall. Bilateral eyelid edema, bulbar conjunctival hemorrhage, and edema in both eyes were noted. No petechiae, purpura, or ecchymosis were found on other parts of the body. During observation in the ED, the patient's vital signs and clinical condition remained stable. The patient was monitored in the ED for 24 hours and discharged with recommendations after no worsening of symptoms was observed.
Image

Image. Petechiaes on the face and bilateral eyelid edema, bulbar conjunctival hemorrhage.

Petechiaes on the face and bilateral eyelid edema, bulbar conjunctival hemorrhage.
Results and Conclusion: Conclusion: The underlying mechanism of these clinical findings is the increased blood flow from the right atrium to valveless brachiocephalic and jugular veins due to positive pressure generated in the mediastinum following blunt thoracic and upper abdominal trauma. The sudden rise in venous pressure results in petechiae. Prolonged thoracic compression can lead to cerebral anoxia and neurological sequelae. Therefore, in patients with blunt thoracoabdominal trauma, a detailed trauma history should be obtained, and appropriate diagnostic and therapeutic plans should be implemented. In conclusion, the diagnosis of traumatic asphyxia should be considered in pediatric and adult patients with blunt thoracoabdominal trauma. Despite its catastrophic appearance, it is typically a benign condition.
Keywords: Traumatic asphyxia, trauma.

Ref No: 7453

Old enemy at new address: from liver cyst hydatid to pulmonary localization

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Introduction and Purpose: Hydatid cyst disease is a zoonotic parasitic infection caused by Echinococcus granulosus and is most commonly seen in the liver (65%) and lungs (25%). The liver is the most commonly affected organ because it is the first barrier through the portal vein; however, in some cases, the parasite can reach the lungs and form a pulmonary hydatid cyst. Although the disease is usually asymptomatic, in advanced stages it may cause complaints such as cough, shortness of breath, chest pain and hemoptysis. If the cyst opens into the bronchi, a complicated hydatid cyst with air-fluid level may develop. In the treatment, medical (albendazole) or surgical (cystectomy, capitonnage) methods are applied depending on the patient's clinic. If there is new chest pain or respiratory distress in patients with a history of liver hydatid cyst, pulmonary hydatid cyst should be evaluated.

Materials and Methods: A 33-year-old female patient was admitted to the emergency department with complaints of stinging pain under her left breast and occasional shortness of breath. She had a history of asthma and had undergone liver hydatid cyst surgery three years ago. There was no cough or sputum, but mild chest tightness was described. On physical examination, her general condition was good and breath sounds were decreased in the lower zone of the left lung. Laboratory tests revealed infection markers, CRP: 201 mg/L and WBC: 17,000/mm³ were found to be high. In imaging studies, a large cystic lesion was seen in the left lower lobe on chest radiography. Thorax CT scan revealed a lesion measuring 4x6 cm in size, with a wall thickness of 4 mm, occupying space and containing an air-fluid level, in the superior part of the lower lobe of the left lung. The findings suggested a complicated pulmonary hydatid cyst opening into the bronchi. The patient was consulted to thoracic surgery and emergency surgery was planned and the patient was hospitalized.

Figure-1: Axial section of hydatid cyst in the left lower lobe of the AC

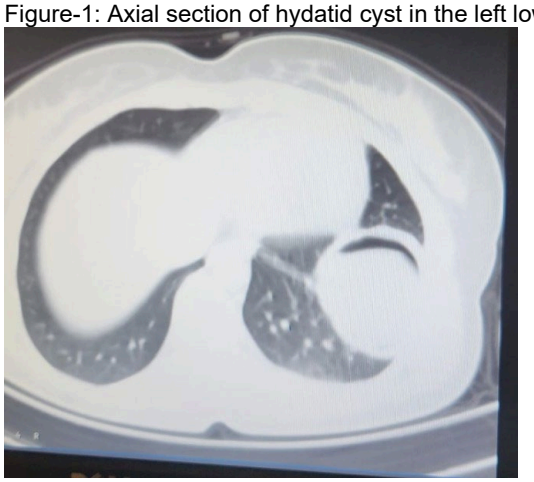

Figure-2: Coronal section of hydatid cyst in the left lower lobe of the AC

Results and Conclusion: In conclusion, pulmonary hydatid cysts should be considered when chest pain and respiratory symptoms develop in patients with a history of liver hydatid cysts. With early diagnosis and appropriate treatment, the prognosis of patients is quite good.

Keywords: Hydatid cyst, Chest pain, Dyspnea

Ref No: 7489

A Case of Diffuse Axonal Injury Following a Pedestrian Traffic Accident

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Introduction and Purpose: Pedestrian traffic accidents can lead to severe neurological injuries, particularly due to blunt head trauma. Diffuse axonal injury (DAI) is a common yet often undetectable brain injury in the early phase using CT imaging.

Materials and Methods: A 17-year-old male presented to the emergency department with a three-day history of altered consciousness and convulsions. He had been involved in a pedestrian traffic accident three days earlier.Vital Signs: Blood Pressure: 138/77 mmHg, Heart Rate: 78 bpm, Temperature: 37°C, SpO □ 98%, Blood Glucose: 115 mg/dL.Glasgow Coma Scale: 15Physical Examination: A 4×4 cm abrasion on the right temporal region was noted. Meningeal irritation signs were absent. No other pathological findings were detected in systemic examination.Findings:Brain CT: Density increase in the right frontal region, consistent with contusion.Diffusion MRI: Diffusion restriction in the splenium of the corpus callosum, indicative of traumatic diffuse axonal injury.Brain MRI: Signal intensity increase in the splenium of the corpus callosum on T2 and FLAIR sequences.Brain and Carotid CT Angiography: Normal.The patient was admitted to the pediatric intensive care unit with a diagnosis of diffuse axonal injury.

Image 1

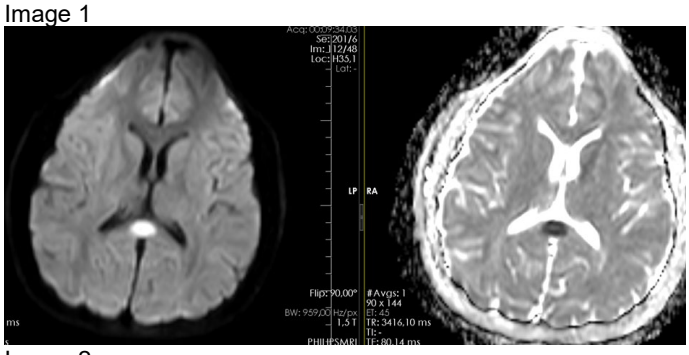

Image 2

Results and Conclusion: Diffuse axonal injury (DAI) is a severe traumatic brain injury caused by blunt head trauma, leading to axonal disruption in the white matter due to shear forces from sudden acceleration-deceleration. It commonly affects the corpus callosum, brainstem, and gray-white matter junctions.CT imaging may not always detect DAI, delaying diagnosis. Diffusion-weighted MRI is crucial for early detection, especially in suspected cases. In our patient, initial CT showed only a frontal contusion, but persistent altered consciousness led to diffusion MRI, which confirmed DAI with diffusion restriction in the splenium of the corpus callosum.ConclusionEven if initial imaging appears normal, the clinical status of the patient must be carefully evaluated, and additional investigations, particularly diffusion-weighted MRI, should be considered in suspected cases. Image 1: Diffusion MRI of the PatientImage 2: Computed Tomography (CT) of the Patient

Keywords: Diffuse Axonal Damage, Traumatic Brain Injury, Emergency Department

Ref No: 7511
Hoigne Syndrome Following Penicillin Injection: A Case Report
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Introduction and Purpose: Introduction Hoigne syndrome, a rare but notable complication, manifests as agitation, delirium, and hallucinatory states shortly after intramuscular penicillin administration. Despite its recognition, the exact pathophysiology of HS remains unclear, involving both allergic and non-allergic mechanisms. Here, we describe a case of Hoigne syndrome triggered by intramuscular penicillin injection.
Materials and Methods: Case Presentation A previously healthy 23-year-old female presented to the emergency department (ED) due to complaints of headache, dizziness, sore throat, and fever lasting three days. Shortly after receiving an intramuscular deposil (penicillin) injection, she developed sudden onset extrapyramidal symptoms, severe agitation, shortness of breath, and intense fear of death within 2-3 minutes. Initially suspecting anaphylaxis, 0.5 mg adrenaline was administered intramuscularly. The patient exhibited normotensive tachycardia and required sedation. Upon ED evaluation, blood pressure was 115/70 mmHg, heart rate 88 beats/minute, temperature 36.8°C, and Glasgow Coma Scale was 15. Neurological examination was unremarkable. Laboratory tests, cranial CT scan, MRI diffusion, and cranial MRI were all normal. The patient did not report substance use, including drugs, cigarettes, or alcohol. All symptoms resolved spontaneously within 24 hours.
Results and Conclusion: Discussion Hoigne syndrome typically results from intramuscular administration of antibiotics such as penicillin, ceftriaxone, cefoxitin, and clarithromycin. Clinical manifestations include acute onset agitation, confusion, depersonalization, derealization, distorted body perceptions, visual and auditory hallucinations, intense anxiety resembling panic attacks, altered consciousness, and rarely seizures. In our patient, characteristic panic-like anxiety and neurotic symptoms were observed. The absence of alternative diagnoses supports HS, particularly following procaine penicillin injections. Literature suggests an association between recurrent injections and symptom onset, often manifesting after multiple exposures. Additionally, symptom severity may increase with age. Emergency clinicians should remain aware of HS to appropriately manage these cases and reduce unnecessary diagnostic interventions in patients recently exposed to penicillin.
Keywords: Hoigne syndrome, Emergency medicine, Neuropsychiatric disorder
Ref No: 7629
Traumatic Subarachnoid Hemorrhages: Bibliometric Analysis of Studies in the Literature
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[2]**Afyonkarahisar Health Science University, Medicine Faculty, Department of Emergency**
Introduction and Purpose: Traumatic subarachnoid hemorrhages (TSK) are serious pathologies that are frequently seen in Emergency Services and Brain Surgery, and are life-threatening and occur as a result of high-energy accidents. It is a medical condition with high morbidity and extremely high mortality and disability rates worldwide. TBI is the leading cause of death and disability in children and young adults. The aim of the study is to analyze the research on TSK and identify the prominent trends. It is aimed to present a panorama of the research area through the analysis of the prominent concepts, names, trends, tendencies and citations in the studies on this subject.
Materials and Methods: The Web of Science (WoS) database was searched for publications related to TSK research using the keywords traumatic subarachnoid hemorrhage, “article” as the publication type, and human health sciences as the subject scope and 1980–2025 as the time range. Metadata of 3215 identified articles were downloaded and analyses were performed. VOSviewer (Version 1.6.20) and R Studio (Version 3.6.0+) Biblioshiny software were used to analyze the data and create visual knowledge maps. Analyses included annual publication trends, keywords, authors, co-citation statuses and research clustering hotspots. Network maps were created to assess collaborations between different authors, countries and institutions
Results and Conclusion: 3215 publications and 5346 authors were analyzed in the study. The journals, authors, citations, distribution of publications by country, and the most frequently used keywords are presented in Table 1. The USA was the country with the most publications with 946 (29.4%), while 77 studies were identified from Turkey. The most frequently used keywords were found to be ‘Subarachnoid Hemorrhage’, ‘Traumatic Brain Injury’, and ‘Management’, respectively.: In this study; international data and our country's data were examined in studies on the Turkish Armed Forces. Bibliometric analyses will guide future studies.
Table 1

Definition	Results			
Journals that contribute the most to literature		n		Citations
	Neurocrit Care	144		2281
	J Neurotraum	120		4179
	J Neurosurg	111		8066
Authors		n	%	Citations
	Taccone FS	35	1.1	41
	Claassen J	33	1	95
	Enblad P	25	0.8	42
Citations		n		Citations
	Murray GD	14		238
	Kelly DF	6		237
	Casanueva FF	1		229
Distribution of publications by country		n	%	Citations
	USA	946	29.4	35505
	China	341	10.6	5781
	Germany	233	7.2	6174
	Japon	202	6.3	2505
	England	142	4.4	5981
	Italy	98	3.0	3220
	Canada	94	2.9	2683
	Türkiye	77	2.4	1570
Most frequently used keywords				n
	Subarachnoid Hemorrhage			725
	Traumatic Brain Injury			611
	Management			373
	Hemorrhage			260
	Head-Injury			239
	Aneurysmal Subarachnoid Hemorrhage			224
	Severe Head Injury			180
	Brain Injury			172
Most cited publication				n
	Hemphill JC, 2001, Stroke			1607
	Steyerberg EW, 2008, Plos Med			980
	Perel P, 2008, Bmj			812
	Masel BE, 2010, J Neurotrauma			699
	Maas Air, 2005, Neurosurgery			639

Journals, authors, citations, distribution of publications by country, most frequently used keywords that contribute the most to the literature

Keywords: Traumatic Subarachnoid Hemorrhages, Bibliometric Analysis, Trrauma

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Ref No: 7653

Artan Yaşam Ömrü İle İlerleyen Tehlike: Geriatrik Suisidal Girişim Olgusu

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Introduction and Purpose: İntihar, dünya genelinde önemli bir halk sağlığı sorunu olarak kabul edilmekte ve özellikle yaşlı nüfus arasında ciddi sonuçlar doğurabilmektedir. Geriyatrik popülasyon, yaşadıkları fiziksel, psikolojik ve sosyal zorluklar nedeniyle intihar riski yüksek bir grup olarak dikkat çekmektedir. Bu olgu sunumunda, geriyatrik popülasyonda intiharın temel etkenlerini ve risk faktörlerini inceleyecek, yaşlı bireylerin ruh sağlığına yönelik önemli bulgular sunacak ve bu zor durumlarla başa çıkmanın yollarını araştıracağız.

Materials and Methods: 68 yaşında erkek hasta suicid amacıyla ateşli silah ile kendini yaraladıktan sonra yakınlarının farketmesi üzerine acil çağrı merkezi aranarak ambulans eşliğinde kliniğimize getirildi. GKS (glaskow koma skoru): 14, hasta ajite ve dezoryante idi. Hastanın muayenesi sırasında sol ön göğüs duvarında, biri ksifoid seviyesinde diğeri arkus kosta seviyesinde olmak üzere iki adet kurşun giriş deliği tespit edildi. Ayrıca, biri sol arka arkus kostada, diğeri umblikus ile arka aksiller çizginin kesişim düzeyinde iki adet kurşun çıkış deliği gözlendi. Batında yaygın hassasiyeti mevcuttu. Yatak başı yapılan fast (focused assessment with sonography for trauma) incelemesi batında serbest mayi, akciğer ultrasonunda toraksta bilateral serbest mayi ve sol akciğerde pnömotoraks saptandı. Genel cerrahi, göğüs cerrahisi, kalp-damar cerrahi konsültasyonları yapıldı. Operasyon sonrası yoğun bakım ünitesinde 3 gün takip edilen hasta sonrasında servise interne edildi ve servis yatışının 5. gününde psikayatrik destek önerileriyle taburcu edildi.

Results and Conclusion: Fiziksel sağlık, geç yaştaki intihar davranışlarının çoğunda katkıda bulunan bir faktördür. Vasküler hastalıklar geç başlangıçlı depresyona yatkınlık yaratabilir ve bunun genellikle hipertansiyon, sigara içme, diyabet ve metabolik sendrom gibi orta yaşta öncülleri vardır. 50 yaş üstü intiharların vaka kontrolü, serebrovasküler risk faktörü puanlarının intihar vakalarında önemli ölçüde daha yüksek olduğunu bulmuştur. Her yıl 10 Eylül'de sorunlara dikkat çekiliyor, damgalama azaltılıyor ve kuruluşlar, hükümet ve genel nüfus arasında bilinç artırılırken intiharın önlenmesinin mümkün olduğuna dair net bir mesaj veriliyor. Dünya İntiharı Önleme Günü'nün 2021'den 2023'e kadar olan üç yıllık teması "eylem yaparak umut yaratmak"tır. Bu temanın temel mesajı, kişinin kendi hayatına son vermesinin yanı sıra diğer seçenekleri vurgulayarak iyimserlik ve pozitiflik aşılamaktır. Kapsamlı ve disiplinler arası bir plan uygulayarak, geriatrik popülasyonda intihar oranının azaltılmasına yardımcı olabilir ve sağlıklı yaşlanmayı teşvik edebiliriz.

Keywords: geriatri, suisid, Acil servis

Ref No: 7669

Traumatic Aort Dissection

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[1]ANKARA BİLKENT ŞEHİR HASTANESİ

Introduction and Purpose: High-energy trauma, particularly from motor vehicle accidents, poses significant risks to elderly patients due to age-related physiological changes. These injuries often involve multiple organ systems, including the spine, abdomen, and thoracic region, leading to complex clinical presentations. This case presents a 77-year-old female patient who sustained severe injuries from a high-energy traffic accident, resulting in spinal fractures, abdominal trauma, and ultimately cardiac arrest. It underscores the challenges of managing elderly trauma patients in critical conditions.

Materials and Methods: A 77-year-old female patient was brought to the emergency department following a high-energy traffic accident. The Glasgow Coma Scale (GCS) score was recorded as 14 (E3, M6, V5). Vital signs were stable, and the patient's general condition was evaluated as moderately poor.On physical examination, widespread abrasions were noted on the scalp and face, along with epistaxis (nasal bleeding). Tenderness was detected upon palpation in both the right and left upper abdominal quadrants. Widespread abrasions were also observed on both lower extremities. No pathological sounds were detected upon auscultation of the lungs. However, there was widespread tenderness on the thoracic wall and in the thoracolumbar spinal region.Computed tomography (CT) revealed a hematoma near the T10 vertebral fracture and a flap appearance in the aorta. Based on these findings, emergency cardiovascular surgery and neurosurgery consultations were requested.The patient suffered a cardiac arrest during follow-up and was pronounced dead in the emergency department despite resuscitation efforts.
Results and Conclusion: This case emphasizes the critical challenges in managing high-energy trauma in elderly patients. Age-related physiological changes increase vulnerability to severe outcomes, including multi-system injuries and cardiac arrest. Prompt recognition, rapid intervention, and multidisciplinary care are essential for improving survival chances. This case highlights the need for heightened awareness and tailored management strategies when treating elderly trauma patients, underscoring the complexity and urgency of care in this demographic.
Keywords: Aortic Dissection, Traumatic Injury

Ref No: 7676
CELLULITIS IN THE LUMBAR REGION
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Introduction and Purpose: The integumentary system functions as a critical protective barrier, preventing commensal skin flora and pathogenic microorganisms from accessing the subcutaneous tissue and lymphatic vasculature. Disruption of cutaneous integrity permits the ingress of resident skin flora and exogenous bacteria into the dermis and subcutaneous layers. This introduction of microbial agents below the skin's surface can precipitate an acute superficial infection involving the deep dermis and subcutaneous tissue, clinically manifesting as cellulitis. Cellulitis most frequently arises from infection with Group A beta-hemolytic streptococcus, specifically Streptococcus pyogenes.[1]Conventional or alternative medical practices must adhere to fundamental principles and guidelines. Alternative medical methods with insufficient or questionable scientific basis may lead to severe complications rather than therapeutic benefits in patients.
Materials and Methods: A 24-year-old male patient with a history of previous lumbar hernia surgery presented to the emergency department with a 2-week history of low back pain. However, he had a history of multiple visits to the emergency department for the same complaint. Due to the persistence of his symptoms, the patient sought alternative treatment and consulted a traditional healer, commonly referred to as a "bone setter," who applied a knotted rope to his lumbar region where he experienced pain. Three to four days after this procedure, the patient presented to the emergency department with complaints of pain and burning in the lumbar region. Physical examination revealed erythema and edema at and around the application site in the lumbar region (Figure 1). Laboratory parameters are presented in Table 1. Subsequently, the rope was cut and removed from the patient's lumbar region. A dressing was applied. A prescription was provided, and the patient was discharged with follow-up at the infectious diseases outpatient clinic.
Figure 1. Demonstration of the rope and soft tissue erythema and edema in the lumbar region.

Table-1: Laboratory Parameters

Parameters	Result	Normal Range
WBC (White Blood Cell) (mm3)	10	3,91-10,9
C reactive protein (mg/dl)	32	0-5

Results and Conclusion: Although cellulitis is primarily observed in areas with increased fat deposition, particularly the thighs, buttocks, and hips, it can rarely develop in unusual locations such as the lumbar region due to inappropriate and non-sterile traditional practices. These practices must adhere to fundamental principles and guidelines. It should be emphasized that alternative medical methods with insufficient or questionable scientific basis may sometimes lead to mortality and morbidity rather than therapeutic benefits.
Keywords: cellulitis, emergency department, alternative medical practices

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Ref No: 7767
A Critical Cause of Respiratory Distress in a Dialysis Patient: Emergency Department Management of a Lung Abscess
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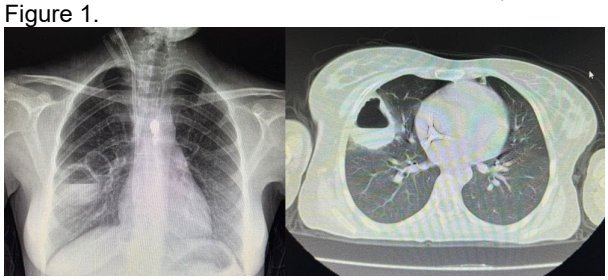
Introduction and Purpose: Lung abscess is a serious necrotizing infection of the lung parenchyma that can cause life-threatening respiratory distress. It remains associated with significant morbidity and mortality, especially in immunocompromised patients such as those with end-stage renal disease (ESRD) on dialysis. We present the case of a young woman on dialysis who developed a large lung abscess, to highlight its clinical presentation and emphasize the importance of prompt emergency department (ED) diagnosis and management.
Materials and Methods: A 20-year-old woman on hemodialysis for ESRD presented to the ED with a 5-day history of high fever, productive cough, and progressive shortness of breath. On examination, she was febrile, tachycardic, hypotensive, and hypoxic, with laboratory tests showing leukocytosis and elevated inflammatory markers. Chest X-ray revealed a right upper lobe opacity with suspected cavitation, and a subsequent chest computed tomography confirmed a large (~8 cm) cavitary lung abscess with an air-fluid level in the right upper lobe (Figure 1). ED management included supplemental oxygen for hypoxemia, immediate broad-spectrum intravenous antibiotics after obtaining cultures, intravenous fluids for sepsis, analgesics, and early consultation with a pulmonologist. The patient was admitted for further multidisciplinary care including pulmonary and infectious disease follow-up.
Figure 1.



Chest radiograph and axial CT images from the patient demonstrate a large cavity in the right lung containing fluid and air, consistent with a lung abscess.
Results and Conclusion: The patient showed marked improvement within 72 hours of treatment: her fever and respiratory distress subsided and oxygenation normalized. She completed a course of IV antibiotics for two weeks followed by oral antibiotics to total six weeks of therapy. Follow-up imaging demonstrated significant reduction of the abscess with near-complete resolution, and no invasive drainage or surgical intervention was required. The patient fully recovered, illustrating that early recognition and aggressive antimicrobial treatment of a lung abscess in the ED can lead to a cure even in an immunocompromised host. This case underscores the pivotal role of emergency physicians in identifying life-threatening infections and initiating timely management to improve outcomes.
Keywords: Emergency medicine, End-stage renal disease, Lung abscess.

Ref No: 7775
A late complication due to intragastric balloon placement, Gastric perforation: A case report
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Introduction and Purpose: The intragastric balloon is a silicone balloon placed in the stomach and inflated with air or liquid, with an average volume of 400-700 cc. In this method, the balloon aims to occupy a specific volume in the stomach, inducing a feeling of fullness with reduced intake, thereby reducing calorie consumption. Serious complications associated with intragastric balloon placement include balloon migration (1.4%), gastric perforation (0.1%), and mortality (0.08%). In this case study, we aim to discuss a rare occurrence of late-onset gastric perforation associated with intragastric balloon placement.
Materials and Methods: A 54-year-old male patient presented to our emergency department with complaints of nausea, vomiting, and abdominal pain. Abdominal X-rays and chest X-rays showed no abnormalities. Due to persistent nausea and vomiting, the patient was admitted to the gastroenterology service for further evaluation. Endoscopy revealed the presence of a gastric balloon, which was subsequently removed. The fundus appeared normal, but a deep, penetrating ulcer, potentially 3-4 cm in size, was observed in the distal corpus along the lesser curvature, incisura angularis, and proximal lesser curvature of the antrum. The planned computed tomography (CT) scan revealed a thickened gastric wall, particularly in the antrum along the lesser curvature, with air bubbles indicating perforation in the gastric wall adjacent to the left lobe of the liver. Additionally, free air was evident in the periportal region in both subpleural areas on the right side. There were also areas of dense content in the pelvis with occasional air images, indicative of free fluid (Figure 1 and

Figure 2).

Figure 1. Computed tomography image of free gas in the abdomen

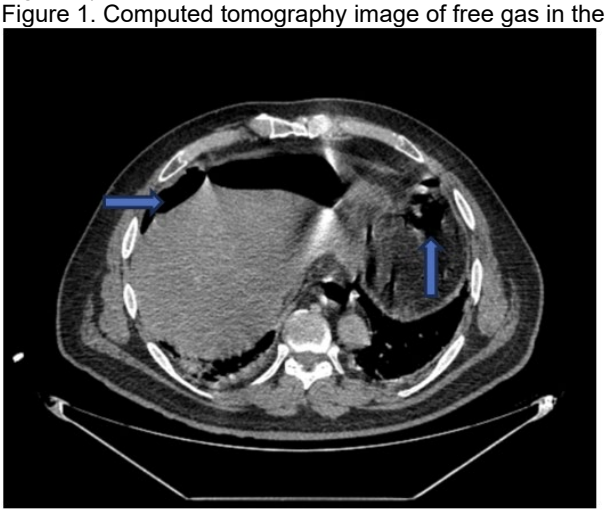

Figure 2. Computed tomography image of free fluid in the abdomen

Results and Conclusion: Intragastric balloon (IGB) application is considered a safe and effective minimal invasive procedure for obese patients by gastroenterologists and surgeons. The mechanism of IGB involves reducing stomach volume and delaying gastric emptying, inducing early satiety. Complications associated with IGB vary and depend on the materials used, including gastrointestinal ulceration, gastric perforation, esophageal perforation, balloon migration, gastric bleeding, and intestinal obstruction. Gastric perforation (GP) is a rare complication occurring in 0.1% of patients with IGB placement . The location of perforation, as observed in our case, is often reported to be on the anterior wall of the stomach.

Keywords: gastric perforation, intragastric balloon, complication

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Ref No: 7776

Cerebral Fat Embolism Syndrome-Case Report

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Introduction and Purpose: Fat Embolism Syndrome (FES) is a rare complication, typically presenting with respiratory insufficiency following orthopedic trauma. The classic presentation includes a triad of respiratory distress, petechial rash, and neurological changes. When neurological symptoms dominate, the condition is referred to as Cerebral Fat Embolism Syndrome (CFES). Early recognition is crucial, especially in orthopedic trauma patients showing sudden neurological decline. Diagnosing CFES is challenging due to the lack of universal criteria; instead, it relies on clinical assessment and the patient's medical history.

Materials and Methods: A 21-year-old male was brought to the Emergency Medicine department complaining of back and leg pain after a traffic accident. There was no history of drug use other than psychiatric medication. Upon arrival at the emergency department, his vital signs were stable, and his Glasgow Coma Scale score was 15. He was conscious, oriented and cooperative, and pupils were isochoric with bilateral positive light reflexes.During the follow-up, the patient's vital signs remained stable. However, a few hours after admission, he suddenly developed confusion and agitation followed by rapid decline in level of consciousness.Thereupon, an emergency bedside ultrasound was performed. Upon the detection of hyperechogenic structures on the echocardiogram (fig 2), CT and diffusion MRI were performed, revealing multiple infarct areas on the diffusion MRI.

Results and Conclusion: In our case, we discussed a patient who was admitted to the hospital after a traffic accident who developed a change in consciousness during follow-up. The diagnosis of Cerebral Fat Embolism Syndrome (CFES) is challenging due to the non-

specific nature of the symptoms and the frequent normality of computed tomography scans. High suspicion should be maintained in patients with orthopedic injuries who experience sudden neurological decline. There are no universal diagnostic criteria for CFES, making the diagnosis dependent on the patient's medical history and clinical manifestations.
Keywords: Fat Embolism, Trauma, Cerebral Fat Embolism Syndrome

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Ref No: 7808
Erythroderma: A Case Report from the Emergency Department
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Introduction and Purpose: INTRODUCTION Erythroderma is a severe and potentially life-threatening condition characterized by widespread erythema and scaling involving most or all of the skin surface (typically ≥90%). It is a clinical manifestation rather than a specific diagnosis and may result from various cutaneous and systemic diseases such as psoriasis, atopic dermatitis, or drug hypersensitivity reactions. Although rare, erythroderma represents a dermatological emergency. Here, we aim to discuss erythroderma by presenting a case diagnosed in our emergency department.
Materials and Methods: CASE PRESENTATION A 39-year-old male patient presented to our emergency department with complaints of chills, shivering, and generalized redness of the body. He had a known history of psoriasis but was non-compliant with medications. Five days prior, he had visited another healthcare facility due to fatigue, skin redness, and pain, where he was prescribed Ciprofloxacin 500 mg (twice daily) and Amoxicillin-Clavulanate 1000 mg (twice daily). On admission, his vital signs were stable: blood pressure 130/70 mmHg, oxygen saturation 97%, pulse rate 79 bpm, and temperature 36.9°C. Physical examination revealed diffuse erythema involving almost the entire skin surface, accompanied by prominent scaling and plaques predominantly on the anterior abdomen and legs (Image). Laboratory findings revealed leukocytosis (WBC: 11,580/μL) and significantly elevated C-reactive protein (CRP: 207 mg/L); other laboratory parameters were within normal limits. With the clinical diagnosis of erythroderma, the patient was consulted with dermatology and admitted to the hospital.
Results and Conclusion: CONCLUSION The clinical diagnosis of erythroderma is straightforward and based primarily on generalized erythema and scaling affecting 90% or more of the body surface area. Identifying the underlying cause requires a detailed history, thorough physical examination, skin biopsy, and appropriate laboratory tests. Patients with symptomatic erythroderma or those who are clinically unstable (particularly hemodynamically unstable patients) should be hospitalized for initial evaluation and treatment. Management includes supportive skin care, topical corticosteroids, oral antihistamines, systemic antibiotics if infection is suspected, and targeted treatment directed toward the underlying cause.
Keywords: erythroderma, erythema, dermatological emergencies

Ref No: 7817
Analysis of Patients Presenting to the Emergency Department After Rabies Risk Contact
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Introduction and Purpose: Rabies continues to be a public health problem in the world and in our country. It causes tens of thousands of deaths each year, of which approximately 40% are children under 15 years of age. Rabies is almost always fatal, but can be prevented with appropriate wound care and prompt prophylaxis after contact. In this study, we aimed to investigate the clinical and epidemiologic characteristics of patients admitted to our emergency department after rabies risk animal contact.
Materials and Methods: Between January 2024 and September 2024, patients admitted to the adult emergency department after rabies risk animal contact were evaluated retrospectively. Data on age, sex, type of animal, whether the animal was owned or not, rabies vaccination, immunoglobulin treatment, tetanus vaccination and category data according to the National Rabies Prophylaxis Guideline were scanned from the hospital automation system and recorded. Data were presented as numbers and percentages using descriptive statistics.
Results and Conclusion: A total of 300 patients were included in the study (mean age 16±15.77 years; minimum 0-maximum 79 years, 66% male gender). One hundred and sixty-six patients (55.33%) were between 0-18 years of age. 62.7% (n:188) had contact with dogs and 29.7% (n:89) with cats. Of the contact animals, 13% (n:39) were owned but 73.7% (n:28) were unvaccinated. Of the contacts, 51.3% (n:154) were category 3 and 31.3% (n:94) were category 2. Rabies vaccination was administered to all patients, rabies immunoglobulin treatment to 7.7% (n:23) and tetanus vaccination to 77.7% (n:233). Antibiotic prophylaxis and wound care were performed in all patients.Rabies remains a public health problem. The most important step to prevent rabies is wound care and thorough washing of the wound with soap and water. The majority of the contacts are with stray dogs and cats. We think that the provision of vaccines for these animals by the relevant units, training in wound care after contact and teaching healthy communication with animals from an early age will reduce the risk of rabies.
Keywords: vaccine, rabies prophylaxis, animal bite

Ref No: 7822
The Danger Behind Loss of Consciousness: Diagnosis and Management of PRES in the Emergency Department
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Introduction and Purpose: Posterior Reversible Encephalopathy Syndrome (PRES) is an acute-onset, reversible neurological condition characterized by headache, visual disturbances, altered mental status, seizures, and focal deficits. It is often associated with hypertensive crises, renal failure, preeclampsia/eclampsia, autoimmune diseases, and immunosuppressive therapies. Diagnosis relies

on clinical features along with characteristic neuroimaging findings, particularly vasogenic edema in the posterior brain regions. While CT may show limited changes, MRI—especially DWI and ADC sequences—offers greater sensitivity. This report presents a PRES case in a hemodialysis patient with chronic kidney disease following a hypertensive crisis.

Materials and Methods: A 46-year-old male patient with end-stage renal disease receiving hemodialysis three times a week presented to the emergency department with altered consciousness following a one-day history of headache, dizziness, nausea, and vomiting. On admission, Glasgow Coma Scale was 5 (M3, V1, E1), blood pressure was 220/110 mmHg, pulse was 110 bpm, SpO was 98%, and blood glucose was 125 mg/dL. The patient was electively intubated and started on intravenous nicardipine infusion. Laboratory results were as follows: glucose 260 mg/dL, urea 111 mg/dL, creatinine 11.3 mg/dL, potassium 3.4 mmol/L, AST 9 U/L, ALT 8 U/L, hemoglobin 10.5 g/dL, platelets 115,000/μL. Brain CT revealed no hemorrhage or mass but showed hypodense areas in both cerebellar hemispheres (Figure 1). DWI MRI showed no diffusion restriction indicative of acute ischemia; however, hyperintense areas with elevated ADC values in the occipital and cerebellar regions were consistent with vasogenic edema (Figure 2).

Figure 1

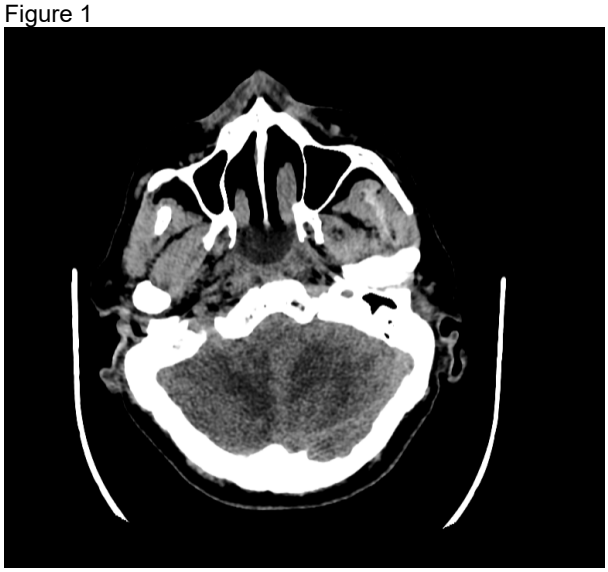
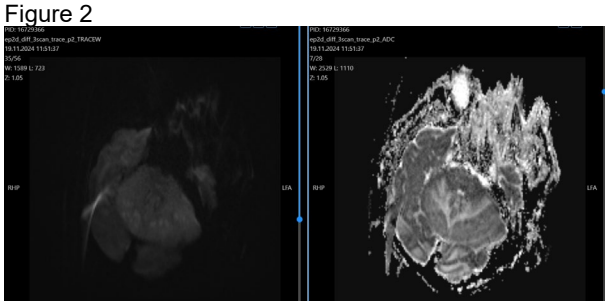


Figure 2



Results and Conclusion: Based on clinical, laboratory, and radiological findings, a diagnosis of PRES was considered. The patient was admitted to the intensive care unit, where regular hemodialysis and intravenous antihypertensive treatment were administered. The patient was extubated on the second day and achieved hemodynamic stability in the following days. Intravenous nicardipine was continued for seven days. Neurological symptoms rapidly improved, and the patient was discharged after approximately one month with full clinical recovery. This case highlights that PRES, particularly when triggered by hypertensive crisis in the setting of renal insufficiency, is a potentially reversible condition if diagnosed and managed promptly. It should be considered in the differential diagnosis of altered mental status in both emergency and intensive care settings.

Keywords: Critical Care, Emergency Medicine, Posterior Reversible Encephalopathy Syndrome

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Ref No: 7867

Observation of Kevorkian Sign in a Patient with Prolonged Cardiac Arrest: A Case Report

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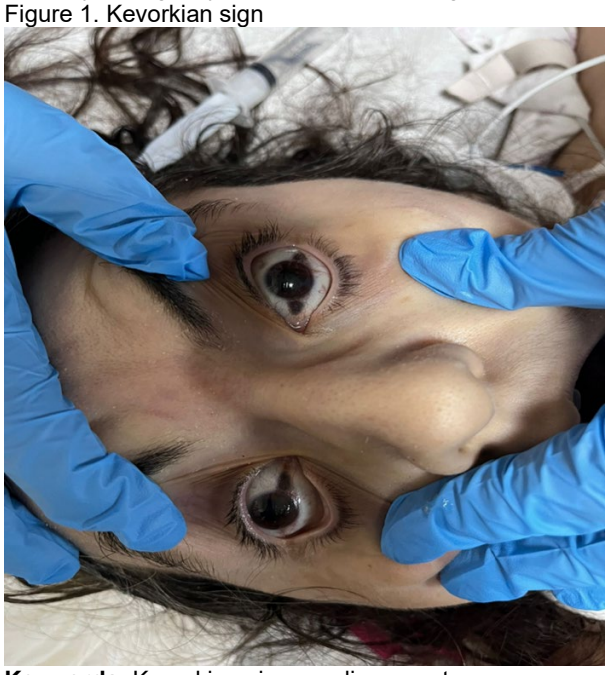
Introduction and Purpose: Kevorkian sign is an important yet rarely reported clinical indicator of severe cerebral hypoxia and anoxia, typically appearing within minutes after death and persisting for approximately one hour. This report details a case in which Kevorkian sign was observed in a patient who underwent an extended resuscitation process but ultimately could not be revived.

Materials and Methods: A 48-year-old female patient was brought to the emergency room by ambulance teams. According to the patient's relatives, the ambulance arrived at the scene 20 minutes after the patient experienced cardiac arrest. On initial examination, the patient had a Glasgow Coma Scale (GCS) score of 3, with fixed and dilated pupils. The patient presented with a shockable rhythm, identified as ventricular fibrillation, necessitating three defibrillation attempts. Arterial blood gas analysis revealed the following values:

pH: 6.90, pCO2: 50.8 mmHg, HCO3: 7.8 mmol/L, Base excess (BE): -21, Lactate: 3.67 mmol/L. Despite a total of 1 hour and 40 minutes of CPR, the patient remained pulseless with an asystolic rhythm on the monitor and no electrical activity on the electrocardiogram. The patient was pronounced deceased.

Results and Conclusion: The Kevorkian sign appears a few minutes after death and persists for about an hour. A continuous increase in potassium levels is observed in the vitreous humor postmortem. The fixed and dilated pupils observed in this case were consistent with severe cerebral hypoxia and anoxia. Kevorkian sign arises from postmortem retinal vascular changes, specifically fragmentation of the intravascular blood column, and is recognized as a significant prognostic marker. The presence of this sign suggested a minimal likelihood of neurological recovery despite aggressive resuscitation efforts. The patient's metabolic acidosis (pH: 6.90), hypercapnia, and mild hyperlactatemia indicated severe systemic hypoxia and metabolic derangement. The absence of brainstem reflexes further supported the diagnosis of severe anoxic brain injury. This case highlights the importance of early intervention and rapid response in cardiac arrest situations. The 20-minute delay in emergency medical services reaching the patient likely contributed to prolonged hypoperfusion and hypoxia, reducing the chances of successful resuscitation. The presence of Kevorkian sign reaffirmed the critical role of timely emergency response in improving survival outcomes

Figure 1. Kevorkian sign



Keywords: Kevorkian sign, cardiac arrest, emergency medicine

Ref No: 7875

A Comparative Analysis of Triage Codes of Patients Transported to Tekirdağ Dr. İsmail Fehmi Cumalıoğlu City Hospital via 112 Emergency Ambulance

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Introduction and Purpose: This study aims to evaluate the triage codes and diagnostic consistency of patients transported to Tekirdağ Dr. İsmail Fehmi Cumalıoğlu City Hospital by 112 Emergency Medical Services (EMS), with a focus on the appropriateness of emergency department and ambulance use.

Materials and Methods: This prospective, descriptive, cross-sectional study included 1,026 patients transferred by ambulance. Data were collected from 112 EMS Case Report Forms and the Hospital Information Management System (HIMS). Descriptive statistical methods were used to analyze demographic information, triage codes, and diagnoses.

Results and Conclusion: While the majority of patients were assigned green or yellow codes in the pre-hospital setting, all ambulance patients were admitted to the red zone upon hospital arrival. Diagnostic analysis revealed that many patients had non-urgent conditions such as soft tissue injury, anxiety, vertigo, or upper respiratory tract infection. Discrepancies were also noted between initial and final diagnoses.The findings indicate a significant level of inappropriate use of EMS and emergency department services, which may lead to overtriage, inefficient resource utilization, and ED overcrowding. To improve the efficiency of emergency healthcare services, it is essential to align pre-hospital and hospital triage practices, enhance EMS training, and raise public awareness regarding the appropriate use of ambulances and emergency care.

Keywords: .

Ref No: 7893

Evaluation of Electrocardiography In Patients Admitted To Emergency Service With Drug Intoxication

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Introduction and Purpose: Intoxications, caused by toxic substance intake, represent 0.8-5% of emergency admissions and significantly contribute to mortality and morbidity. Continuous monitoring and EKG assessments are crucial as toxic agents can impact cardiovascular function. EKG evaluation aids in identifying electrolyte disturbances and involves analyzing heart rate, QRS duration, sodium channel block, QT duration, and ischemia presence. This study aims to enhance the follow-up and treatment of intoxicated patients in emergency services through EKG evaluations, shedding light on their importance and documenting previously unrecorded EKG similarities in such cases.

Materials and Methods: The study examined patients aged 18 and older admitted to emergency services from 01.01.2020 to 31.12.2023, following ethical committee approval and adherence to Helsinki Rules. Intoxicated patients were identified using ICD codes and hospital database reviews. Exclusions include patients under 18, those without poisoning, those lacking EKGs, incomplete data, and referrals from other hospitals. Data on demographics, admission details, interventions, poisoning routes, chronic illnesses, medication history, substance use, EKG interpretation, lab results, consultations, and outcomes were systematically recorded for evaluation.

Results and Conclusion: Among 72 patients, 38 were female and 34 male (average age 56.6±9.8). While the QRS duration was normal, a significant gender difference was noted (p=0.001). QT durations differed based on whether medications were taken knowingly or accidentally (p=0.045), with a significant relationship between certain medications and QT duration (p<0.05 for antidepressants and p=0.007 for paracetamol). When evaluating the results of our research, it was found that while intoxication with antidepressants created a difference in QT duration, knowingly taking the medication also created a significant difference. In cases of intoxication admitted to the emergency service, it should be considered whether the patient knowingly used the medication when assessing QT duration. Our results need to be validated through further experimental and clinical studies.

Results Table

			n (%)	Mean ±SD	P value
Gender	QT Duration	Woman	38 (52.8)	425.18 ± 20.88	0.874
		Man	34 (47.2)	424.44 ± 18.55	
	QRS Duration	Woman	38 (52.8)	109.07 ± 12.12	0.001
		Man	34 (47.2)	99.26 ± 12.62	
Cause of Intoxication	QT Duration	Mistakenly	29 (40.3)	418.51 ± 24.96	0.045
		Knowingly	43 (59.7)	429.09 ± 13.90	
	QRS Duration	Mistakenly	29 (40.3)	106.20 ± 12.22	0.357
		Knowingly	43 (59.7)	103.25 ± 13.88	
Substance	Antidepresssant	QT Duration	16 (22.2)	439.50 ± 11.36	0.000
		QRS Duration		110.00 ± 16.02	0.113
	Antihistamine	QT Duration	8 (11.1)	432.12 ± 29.70	0.269
		QRS Duration		96.25 ± 7.44	0.063
	Antihypertensive	QT Duration	8 (11.1)	417.12 ± 23.03	0.243
		QRS Duration		101.25 ± 8.34	0.312
	NSAID	QT Duration	10 (13.9)	423.40 ± 14.81	0.806
		QRS Duration		106.00 ± 16.46	0.692
	Paracetamol	QT Duration	8 (11.1)	407.37 ± 24.37	0.007
		QRS Duration		105.00 ± 14.14	0.901
Results	QT Duration	Discharged	38 (52.8)	415.55 ± 21.16	
		Rejected Treatment	16 (22.2)	432.56 ± 7.95	
		Service	9 (12.5)	438.22 ± 12.13	
		Intensive Care	8 (11.1)	437.75 ± 15.12	
	QRS Duration	Discharged	38 (52.8)	101.18 ± 11.59	
		Rejected Treatment	16 (22.2)	105.31 ± 10.71	
		Service	9 (12.5)	103.33 ± 15.00	
		Intensive Care	8 (11.1)	120.00 ± 14.88	
Smoke			49 (68.1)		
Alcohol			31 (43.1)		
Chronic Disease	Diagnosed		52 (72.2)		
	Undiagnosed		20 (27.8)		
Psychiatric Illness	Diagnosed		21 (29.2)		
	Undiagnosed		51 (70.8)		

Keywords: Electrocardiography, Intoxication, Emergency

Ref No: 7930

Akut İskemik İnmede Kapı-Litik Ve Kapı-İğne Sürelerinin Sağkalıma Etkisi

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Introduction and Purpose: Akut iskemik inmede kullanılan birincil tedavi yöntemleri olan intravenöz (IV) tromboliz ve mekanik trombektomi, zamana bağlı tedavilerdir. Literatür incelendiğinde akut inmede uygulanan reperfüzyon sürelerin tartışma konusu olduğu ve bu konuda sürekli çalışmalar yapıldığı görülmektedir. Amacımız inme merkezi olan üçüncü basamak bir hastaneye başvuran akut inme hastalarında uygulanan IV tromboliz ve mekanik trombektomi tedavi sürelerinin sağkalıma etkisini araştırmaktır.

Materials and Methods: Çalışma 1 Ocak 2024 ile 31 Aralık 2024 tarihleri arasında üçüncü basamak hastane acil servisine akut iskemik inme başvurarak tanı konan hastaların retrospektif incelenmesi ile yapılmıştır. Acil servise başvuran ve akut inme tanısı alan ardışık hastalara ait veriler, bilgisayar tabanlı Hastane Bilgi Yönetim Sistemi (HBYS) programı ile acil servis hasta dosyalarından elde edildi. “Kapı-litik zamanı”, acil servise varış ile trombolitik tedavinin başlandığı zaman aralığı olarak belirlendi. “Kapı-iğne zamanı” ise acil servise varış ile mekanik trombektomi tedavinin başladığı zaman aralığı olarak belirlendi. “Semptom-litik zamanı”, semptomların başlangıcı ile IV trombolizinin yapıldığı zaman arasındaki aralık, “semptom-iğne zamanı” ise semptomların başlangıcı ile mekanik trombektominin yapıldığı zaman arasındaki aralık olarak belirlendi. Tüm zaman ölçümleri dakika olarak ifade edildi.

Results and Conclusion: Çalışmaya 2024 yılı içerisinde acil servise akut iskemik inme semptomları ile başvuran ve IV tromboliz veya mekanik trombektomi tedavisi alan 130 hasta dahil edildi. Başvuru ile BT çekilme arasında geçen median süre 14.0 (IQR 11.0-22.0) dakika idi. Hastaların %63.1'ine sadece IV rtPA verildi, %36.9'una ise hem IV rtPA verildi hem de mekanik trombektomi işlemi uygulandı. Hastane sonlanımına bakıldığında mortalite oranı %13.1 olarak saptandı. Tedavi uygulanan hastaların semptom-kapı süresi median değeri 65.5 dakika (IQR 43.0-99.3) idi. IV rtPA verilen hastalar için kapı-litik süresi median değeri 87.5 (IQR 67.0-120.0) dakika, semptom-litik süresi median değeri ise 165 (IQR 135-212) dakika saptandı. Mekanik trombektomi işlemi yapılan hastalarda kapı-iğne süresi median değeri 91.0 (IQR 80.8-130.0) dakika, semptom-iğne süresi median değeri 164 (IQR 135-222) dakika olarak tespit edildi. Araştırılan tüm sürelerin hastane sonlanımında mortaliteyi istatistiksel olarak etkilemediği saptanmıştır (p>0.05).Akut iskemik inmede kapı-litik ve kapı-iğne sürelerinin mortaliteye etkisi görülmemiştir. Çalışma daha geniş kapsamlı planlanmalı, örneklem sayısı artırılmalı ve morbiditeye etkisinin de eklenerek yapılması ile anlamlı sonuçlar elde edilebilir.

Tablo 1

Tablo 1. Hastaların demografik verileri ve temel özellikleri

Özellikler, n = 130	Value
Cinsiyet	
Erkek, n (%)	64 (49.2)
Kadın, n (%)	66 (50.8)
Acile Geliş Şekli	
112, n (%)	69 (53.1)
Dış merkezden sevk, n (%)	39 (30.0)
Özel araç, n (%)	22 (16.9)
Başvuru Şikayeti	
Ekstremite güçsüzlüğü, n (%)	111 (85.4)
Konuşma bozukluğu, n (%)	97 (74.6)
Fasiyal asimetri, n (%)	85 (65.4)
Bilinç bozukluğu, n (%)	41 (31.5)
Başvuru Vital Değerleri	
SKB, ortalama ± sd (mmHg)	166 ± 28.8
DKB, median (IQR) (mmHg)	83.5 (78.5-100.0)
Nabız, median (IQR) (atım/dakika)	76.5 (67.0-88.8)
Satürasyon, median (IQR) (%)	96.0 (94.0-97.0)
Komorbiditeleri	
Hipertansiyon, n (%)	103 (79.3)
Atriyal fibrilasyon, n (%)	46 (35.4)
Diyabetes mellitus, n (%)	41 (31.5)
Koroner arter hastalığı, n (%)	39 (30.0)
Serebrovasküler hastalık, n (%)	23 (17.7)
Malignite, n (%)	7 (5.4)
Tanısal Bulgular	
BT (ödem), n (%)	101 (77.7)
BT (dens MCA), n (%)	25 (19.2)
BTA (büyük damar oklüzyonu), n (%)	64 (49.2)
MR (ACA, MCA), n (%)	64 (49.2)
MR (PCA), n (%)	14 (10.8)
MR (Lakküner), n (%)	40 (30.8)
Etiyoloji	
Aterosklerotik, n (%)	78 (60.0)
Kardiyoembolik, n (%)	47 (36.2)
Diğer (hipotansiyon, anemi), n (%)	5 (3.8)
Başvuru-BT süresi, median (IQR) (dakika)	14.0 (11.0-22.0)
Tedavi	
IV rtPA, n (%)	82 (63.1)
IV rtPA + mekanik trombektomi, n (%)	48 (36.9)
Acil Servis Sonlanımı	
Servis yatışı, n (%)	3 (2.3)

Tablo 1 devamı

İnme ünitesi yatışı, n (%)	85 (65.4)
YBÜ yatışı, n (%)	42 (32.3)
Entübasyon Yeri	
Acil servis, n (%)	9 (7.0)
Girişimsel salonu, n (%)	6 (4.7)
İnme ünitesi, n (%)	2 (1.6)
YBÜ, n (%)	8 (6.2)
MV'de Takip Süresi, ortalama ± sd (gün)	2.49 ± 8.61
Yatış Süresi, ortalama ± sd (gün)	12.5 ± 13.5
YBÜ Yatış Süresi, ortalama ± sd (gün)	4.21 ± 9.49
Hastane Sonlanımı, Exitus, n (%)	17 (13.1)
Başvuru NIHSS, median (IQR)	12.0 (5.0-18.0)
Taburculuk NIHSS, median (IQR)	5.0 (0.75-12.0)
Taburculuk mRS, median (IQR)	3.0 (0.0-5.0)
Semptom-Kapı Süresi, median (IQR)	65.5 (43.0-99.3)
Kapı-Litik Süresi, median (IQR)	87.5 (67.0-120.0)
Semptom-Litik Süresi, median (IQR)	165.0 (135.0-212.0)
Kapı-İğne Süresi, median (IQR)	91.0 (80.8-130.0)
Semptom-İğne Süresi, median (IQR)	164.0 (135.0-222.0)

IQR: *Interquartile Range (25p, 75p),* ***sd:*** *standard deviation,* ***SKB:*** *Sistolik Kan Basıncı,* ***DKB:*** *Diastolik Kan Basıncı,* ***BT:*** *Bilgisayarlı tomografi,* ***BTA:*** *Bilgisayarlı tomografi anjiografisi,* ***MR:*** *Manyetik Rezonans,* ***ACA:*** *Anterior serebral arter,* ***MCA:*** *Middle serebral arter,* ***PCA:*** *Posterior serebral arter,* ***IV rtPA:*** *İntravenöz rekombinant doku plazminojen aktivatörü,* ***YBÜ:*** *Yoğun bakım ünitesi,* ***MV:*** *Mekanik vemtilatör,* ***NIHSS:*** Ulusal Sağlık İnme Ölçeği Enstitüsü, **mRS:** Modifiye Rankin Skalası

Keywords: trombolitik, trombektomi, mortalite

Ref No: 7966

Infected Duplication Cysts

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[1]ANKARA BİLKENT ŞEHİR HASTANESİ

Introduction and Purpose: Duplication cysts occurring in the intestine are one of the rare pathological structures of the digestive system. These cysts are generally cysts that develop in the intestinal wall, containing fluid or semi-fluid substances and sometimes showing a two-chambered structure.However, in some cases, these cysts can become infected and lead to serious

complications.Infected intestinal duplication cysts occur when these cysts become contaminated by bacterial, viral, or fungal infections. Depending on the location of the cyst, infection can lead to symptoms such as abdominal pain, fever, swelling, diarrhea, and sometimes abscess formation. Since an infected cyst can lead to serious complications such as perforation and peritonitis, it is crucial to make a quick and accurate diagnosis.

Materials and Methods: A 55-year-old male patient presented to the emergency department with complaints of abdominal pain, nausea, and vomiting.Glasgow Coma Score(GCS):15. Blood pressure:140/80 mmHg,Heart rate: 86 bpm,Axillary temperature: 36.2ºC.ECG: Sinus rhythm.On physical examination, widespread tenderness was noted in the abdomen. There was no defense or rebound tenderness. No organomegaly was detected. No palpable mass.Medical history:Diabetes, hypertension, thyroidectomy, appendectomy, cholecystectomy.Medications:levothyroxine, norvasc, metformin.After symptomatic treatment, there was no relief, and as infectious markers remained high, further investigation was planned. Contrast-enhanced abdominal tomography was performed. The CT scan revealed "A tubular structure approximately 120 mm in length with a blind ending at the umbilical-supraumbilical level, related to ileal loops, showing a fluid-filled, distended appearance with surrounding inflamed and dirty-looking fatty tissue (possible infected duplication cyst?)."The patient's oral intake was stopped. IV fluid replacement and empirical IV antibiotic therapy were initiated. A general surgery consult was requested, and the patient was admitted to the general surgery intensive care unit. During follow-up, the patient did not require surgery, and after antibiotic therapy, the infectious markers decreased, with normal gas and stool passage. The patient was discharged with complete recovery.

Results and Conclusion: Intestinal duplication cysts are rare and typically asymptomatic, but they can lead to serious complications if infected.This case once again highlights that intestinal duplication cysts can become infected, and early diagnosis and appropriate treatment can prevent complications. Furthermore, it emphasizes the importance of a careful approach in the differential diagnosis of acute abdominal conditions.

Keywords: ntestinal duplication cyst, acute abdominal diseases, empirical antibiotic therapy.

Ref No: 7981

Silent killer and the visual impairment they cause: a rare face of carbon monoxide exposure

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Introduction and Purpose: Carbon monoxide(CO) poisoning occurs as a result of the incomplete combustion of carbon-containing fuels. With human exposure to CO, due to CO's high affinity for hemoglobin, the delivery of oxygen to tissues is prevented. Therefore, this condition manifests as hypoxic and histotoxic hypoxia with the disruption of cellular metabolism. Symptoms such as headache and dizziness are observed in mild cases, while in severe cases, coma and neurological deficits may occur. Neurological symptoms are the most commonly and most serious presentation of CO poisoning. However, vision impairment due to CO exposure is a rarely reported finding. We aim to present this case, which was admitted to our Emergency Department(ED) due to blindness, to emphasize the importance of taking a detailed history and conducting laboratory investigations for CO exposure in patients presenting with visual disturbances in the ED.

Materials and Methods: 49-year-old male patient, found unconscious with a strong smell of soot, was admitted to the ED. It was learned that the patient was experiencing difficulty seeing. The patient's GCS were 15, vital signs were normal. EKG: NSR, there was no chest pain. Troponin elevation was considered secondary to hypoxia. In the initial central imaging, an ischemic infarct was detected in the left occipital lobe. The COHb level detected in the patient's laboratory results was 25%. In the repeated Brain MRI Imaging, infarcts were detected in the bilateral occipital, cerebellar, and PCA watershed areas. With the application of 5 sessions of Hyperbaric oxygen therapy (HBOT) during the patient's follow-up, a significant improvement in visual functions was achieved.

Results and Conclusion: In the literature, visual impairment is a rarely reported condition following CO poisoning. There are many different mechanisms for vision loss, In our case, it was thought to have developed due to an infarction in the occipital cortex. The HBO treatment administered to the patient contributed to the recovery of the patient's visual functions and supported neurological improvement. This case emphasizes that vision loss can develop due to CO exposure and can be reversed with HBO therapy.

Keywords: Carbon Monoxide, Poisoning, Vision Disorders

Ref No: 7983

Demographics and Coronary Angiographic Characteristics in DeWinter Syndrome: Does Age Matter?

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Introduction and Purpose: The de Winter pattern (dWP) is considered as an ST-elevation myocardial infarction equivalent. However, there is no well-designed longitudinal study describing its prevalence and outcome. Lack of literature from certain regions in the world attributes to the ambiguous dWP prevalence. We aimed to explore the demographic and angiographic characteristics of dWP/ syndrome in relation to the age of patients.

Materials and Methods: A comprehensive search across electronic databases such as PubMed /Medline and Google Scholar was performed between November 2008 and January 2025. Patients were divided into two groups (<55 versus ≥55 years). The electrocardiographic (ECG) findings suggestive of dWP were: (1) a 1-3 mm upsloping ST- segment depression at the J point in the precordial leads V1- V6 (2) tall, symmetric peaked T waves ; (3) a normal or mildly prolonged QRS complex; (4) poor R wave progression; and (5) mild ST-segment elevation in lead aVR of >0.5 mm. Extracted data included demographics, comorbidities, presenting manifestations, serum troponin status, echocardiographic and coronary angiographic findings, culprit vessels, therapy and

hospital mortality.

Results and Conclusion: There were 120 documented cases with dWP extracted from case reports and case series. There were relevant no retrospective or prospective studies found. The median age was 52 years and 87.2% were males. 58% of the patients aged <55. Among the 7 cardiac arrest cases, 4 were young. The most common risk factor was smoking (44%), hypertension (19%) and diabetes mellitus (14%). The most common culprit vessel was the left anterior descending artery (LAD) at 81.7%. Half of the patients had positive troponin. Three patients died (2.5%). In comparison to the younger group, older patients had more LAD involvement (87% vs 77.9%) and right coronary artery (RCA;4.1% vs 1.5%). The left main CA occlusion was more prevalent in the younger group (7.4% vs 2.0%). The rate of PCI (91.8 vs 88%) was higher in the old age group. Conclusion: in dWP, age matters. Early identification of dWP is crucial as it indicates acute coronary occlusion necessitating urgent intervention. Time to diagnose and intervene was not captured. In-depth, large-scale research is needed to determine real prevalence, high-risk population and outcome of dWP.

Keywords: De Winter Pattern, STEMI- equivalent, Acute Coronary Occlusion

Ref No: 7992

A Rare Complication of Therapeutic Botulinum Toxin: A Case of Iatrogenic Botulism

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Introduction and Purpose: Iatrogenic botulism is a rare adverse effect that can occur after the administration of botulinum toxin injections for medical or cosmetic purposes, particularly in cases of overdose or improper application. Botulinum toxin causes muscle relaxation and temporary paralysis by blocking the release of acetylcholine at the neuromuscular junction. Because of these effects, it is widely used in the treatment of neurological disorders, muscle dystonia, chronic migraine, and for aesthetic purposes. However, incorrect dosage, inappropriate injection sites, or systemic spread of the toxin may result in severe side effects. Here, we aim to present a female patient who developed iatrogenic botulism following therapeutic botulinum toxin injections.

Materials and Methods: A 49-year-old female patient presented to the ED with nausea, vomiting, shortness of breath, dysphagia, hypersalivation, and hoarseness. Her medical history revealed that she had been receiving botulinum toxin type A (BoNT-A) injections into the neck, masseter muscle, base of tongue, and tip of tongue every other day for one week for the treatment of acute dystonia, with the last injection administered 12 hours prior to presentation. On admission, her vital signs were normal. Physical examination revealed intermittent blurred vision. Eye and lid movements were normal. There was no uveal edema. Increased lacrimation and accumulation of saliva in the larynx were observed. The patient had dysphonia and dysarthria. Pharyngeal reflex was absent. Bilateral lung sounds were normal on auscultation, but use of accessory respiratory muscles was noted. Intravenous hydration and antiemetic therapy were initiated. The poison control center was consulted and administration of BoNT-A antitoxin was recommended. The patient was admitted to ICU. Supportive care, including hydration and symptomatic management, was provided in addition to antitoxin treatment. On the fifth day of ICU admission, the patient was discharged on medical advice with full recovery.

Results and Conclusion: In this case, the symptoms after multiple injections for the treatment of acute dystonia were consistent with iatrogenic botulism, and the patient was successfully treated with antitoxin therapy and supportive care. This case highlights the importance of thorough medical history-taking and physical examination for the clinical diagnosis of iatrogenic botulism. Early diagnosis and appropriate supportive treatment are crucial in preventing complications.

Keywords: antitoxin, botulism, iatrogenic

Ref No: 8046

Idiopathic Pulmonary Vein Thrombosis Treated With Rivaroxaban

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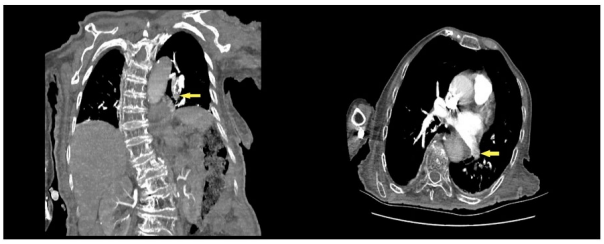
Introduction and Purpose: Pulmonary vein thrombosis (PVT) is a rare but potentially life-threatening condition. It is commonly observed in elderly, immobilized patients and individuals with risk factors for thrombosis. The clinical signs of PVT are generally nonspecific, and early diagnosis and treatment are crucial. This article discusses the diagnosis, treatment process, and management of pulmonary vein thrombosis in an elderly patient.

Materials and Methods: A 96-year-old, immobilized female patient presented to the emergency department with complaints of shortness of breath, cyanosis, tremors, and loss of consciousness, which began at night. The patient's medical history included diabetes mellitus (DM), right hip fracture followed by immobilization, and feeding via percutaneous endoscopic gastrostomy (PEG). She was using long-term oxygen therapy (LTOT) and occasionally required additional O2 support. On examination, the patient's general condition was as follows: Blood pressure 89/54 mmHg, oxygen saturation 94%, pulse rate 56 beats per minute, respiratory rate 20 breaths per minute with tachypnea. Bilateral decreased breath sounds and pretibial edema were observed. There was also a size difference in the right leg compared to the left. Contrast-enhanced pulmonary Computed Tomography Angiography (CTA) revealed a thrombus in the pulmonary vein (Figure 1).The patient was consulted with pulmonology, cardiology, cardiovascular surgery, and anesthesia and was transferred to the adult intensive care unit due to the need for intensive care.

Figure 1



Thrombus material in the pulmonary vein (yellow arrow)

Results and Conclusion: This case demonstrates that diagnosing PVT in elderly and immobilized patients can be challenging. The risk of thrombosis is increased in elderly individuals due to prolonged bed rest and conditions such as diabetes, which can promote venous stasis. The clinical signs of PVT are usually nonspecific and may often be mistaken for other conditions. Additionally, changes in laboratory findings can help determine the course of the disease and the response to treatment. Early diagnosis and intervention play a significant role in preventing complications and promoting recovery.Pulmonary vein thrombosis is a condition that must be recognized early, especially in elderly and immobilized patients. Proper application of treatment strategies such as anticoagulation therapy and oxygen therapy can significantly improve the patient's survival. This case highlights the importance of multidisciplinary approaches and early diagnosis.

Keywords: Pulmonary vein thrombosis, immobilization, dyspnea

Ref No: 8065

AIR IS ONLY BEAUTIFUL INSIDE THE ALVEOLI

yusuf burak eker[1], alara nergiz soslu[1], ayça çalbay[1]

[1]Atatürk üniversitesi acil tıp anabilim dalı

Introduction and Purpose: Pneumomediastinum is defined as the presence of free air within the mediastinum. The underlying mechanism is known to involve alveolar rupture, which releases free air that travels through the affected lung's hilum to the mediastinum and subsequently spreads to the subcutaneous tissues of the chest or neck. Additionally, rupture or perforation of the major airways or esophagus can lead to the same clinical presentation. Pneumomediastinum is classified based on its etiology. Secondary or acquired pneumomediastinum typically develops following thoracic or abdominal surgery, foreign body aspiration, cardiac catheterization, endotracheal intubation, or mechanical ventilation. Another common cause is trauma to the neck or chest, which damages the tracheobronchial structures.

Materials and Methods: A 51-year-old male patient presented to our emergency department with complaints of worsening pain, swelling in the neck and chest, and shortness of breath following a sudden, awkward movement. Two weeks earlier, he had been diagnosed with rib fractures after a fall, though hospitalization or surgery had not been deemed necessary. His pain, which had been ongoing since the incident, had intensified in the past few hours, accompanied by swelling in the chest and neck. His medical history was unremarkable, and his vital signs revealed an oxygen saturation of 92% on room air. A systemic examination detected subcutaneous crepitus in the neck upon palpation, but no other significant pathology. Suspecting pneumomediastinum, a thoracic CT scan was performed, confirming the diagnosis, and the patient was admitted to the thoracic surgery clinic.

figure 1

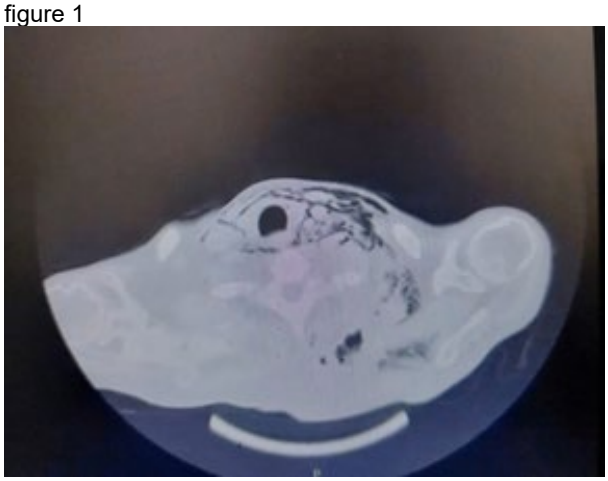
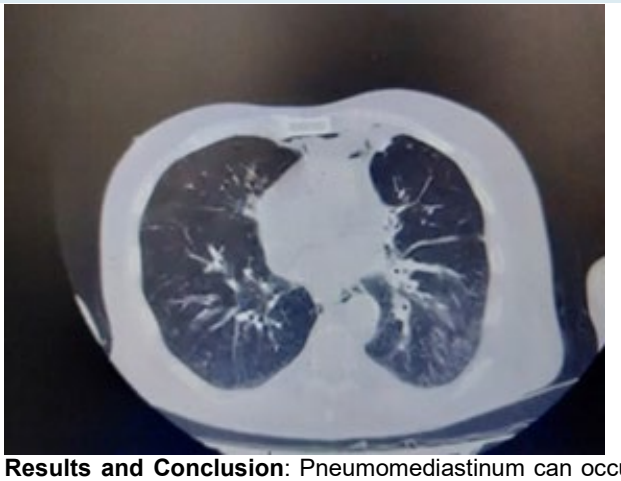


figure 2



Results and Conclusion: Pneumomediastinum can occur spontaneously or as a result of internal or external trauma. As seen in our case, alveolar injury can be secondary to pre-existing rib fractures, making patients with rib fractures at risk for developing pneumomediastinum even in the late phase.
Keywords: Pneumomediastinum, Alveolar Rupture, Subcutaneous Crepitus

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Ref No: 8083
Deltamethrin poisoning rarely seen in the emergency department
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Introduction and Purpose: Deltamethrin is a highly effective insecticide. Although there is increasing resistance to the drug due to its effective activity against pests and parasites, it is widely used worldwide. Although it is generally considered safe to use around people, it is still known to have neurotoxic effects. It also has allergic side effects. Although pesticide poisonings are frequently encountered in the literature, deltamethrin intoxication is not very common. Therefore, we aimed to share the emergency department intervention, treatment, follow-up and outcome of this rare case.
Materials and Methods: A 46-year-old male patient applied to emergency department with the complaint of drinking a bottle of insecticide for suicidal purposes. The patient had drunk 25 grams/liter of deltamethrin active ingredient about an hour ago. HE had a strong odor, had nausea and vomiting. In the physical examination, the general condition was good, cooperative, oriented, and the neurological examination was normal. Complete blood counts, biochemical parameters, coagulation profile, cardiac enzymes and electrocardiogram (ECG) were within normal limits. Gastric lavage was performed, activated charcoal was administered. Antiemetics and hydration were provided for nausea and vomiting. In case of paresthesia, topical vitamin E was administered, and in case of excessive salivation, atropine was kept ready. After consultation with the poison control, the patient was followed up for 24 hours without symptoms. The patient, whose complaints regressed, was discharged with recovery.
Results and Conclusion: It is known that such poisonings exist in agricultural areas and are increasing day by day. We believe that faster intervention in toxicological patients and more publication of atypical cases will bring us closer to the diagnosis and will positively affect our treatment process.
Keywords: deltamethrin, poisoning, insecticide

Ref No: 8103
Isolated Cerebral Fat Embolism Following Long Bone Fracture: Case Report Abstract
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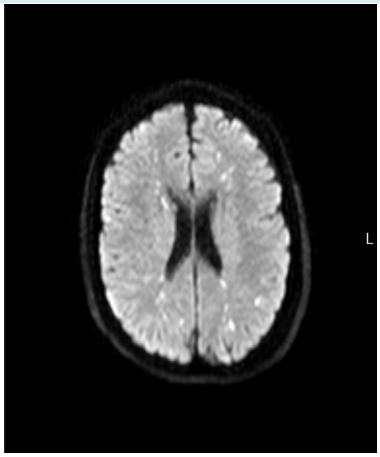
[1]Adnan Menderes Üniversitesi
Introduction and Purpose: Fat embolism syndrome (FES) is characterized by the systemic spread of fat emboli, leading to microcirculatory disruption and systemic inflammatory response syndrome. It is commonly associated with long bone fractures and total hip arthroplasty and is less frequently seen in burns and soft tissue injuries. Respiratory symptoms such as hypoxemia and dyspnea are the most frequently observed manifestations, although neurological symptoms like altered consciousness are also common. Rarely, some cases present solely with neurological findings, a condition termed isolated cerebral fat embolism. The role of patent foramen ovale (PFO) in the pathophysiology of cerebral fat embolism has not been clearly defined. In this report, we present the diagnosis and management of isolated cerebral fat embolism following bilateral femur fracture.
Materials and Methods: A 21-year-old female patient was transferred to our center approximately 24 hours after sustaining bilateral displaced femoral shaft fractures in a traffic accident, due to acute neurological deterioration (Glasgow Coma Scale 7) and seizures. Initial imaging was unremarkable. Due to clinical condition and to secure the airway, elective intubation was performed. Brain MRI revealed multiple diffuse infarct areas (image 1), and thoracic CT showed no evidence of pulmonary embolism. Transesophageal echocardiography (TEE) identified the presence of a PFO. In addition to supportive treatment, the patient received intravenous albumin at 100 mg/day for 3 days, prophylactic low molecular weight heparin, anticonvulsants, and targeted antibiotic therapy following positive blood cultures.
image 1



Results and Conclusion: The patient's neurological status improved significantly with supportive and specific treatments. GCS increased progressively, and full consciousness was achieved by the fifth day. The patient remained stable in the intensive care unit and subsequently underwent surgery by orthopedics. She was discharged on day 36 post-trauma with no neurological or orthopedic sequelae. This case highlights the importance of considering isolated cerebral fat embolism in trauma patients presenting with acute neurological symptoms. Early diagnosis (via MRI and echocardiography) and multidisciplinary intensive care management play a crucial role in patient recovery.

Keywords: Fat embolism syndrome, Cerebral fat embolism, Long bone fracture

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Ref No: 8125

Obstructive Ileus

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Introduction and Purpose: Etiologies include adhesions (65%), hernias (10%), neoplasms (5%), Crohn's disease (5%), and others (15%). Dilatation occurs proximal to the obstruction. The classic clinical presentation is abdominal pain, nausea-vomiting, abdominal distension, and constipation-to-constipation. Physical examination may reveal signs of dehydration and sepsis, such as tachycardia, fever, dry mucosa, hypotension, abdominal distension, and hypoactive bowel sounds. Severe direct tenderness, involuntary guarding, abdominal rigidity, and rebound ileus are suggestive. Leukocytosis, neutrophilia, and lactic acidosis also support ileus. Initial intervention includes intravenous hydration, correction of electrolyte abnormalities, antibiotics, and nasoenteral aspiration. Overall mortality is 10%, but increases to 30% with bowel necrosis/perforation.

Materials and Methods: A 48-year-old male patient presents to the emergency room with abdominal distension and inability to pass gas and stool for 2-3 days. His vital signs are unremarkable except for tachycardia. In his medical history, it is learned that the patient has been examined for Crohn's disease for 4 months, colon cancer, and had an endoscopy-colonoscopy 3 months ago. On examination, the abdomen is distended, there is widespread tenderness on palpation, and there is no defense or rebound. Intestinal sounds are increased on auscultation. His rectal examination is empty. WBC 4.1 10 3 / µlL in his blood, hemoglobin and other biochemistry results are normal. Contrast-enhanced abdominal tomography is seen after ABB radiography and normal creatinine value. In the CT scan, a mass and widespread air-fluid levels are seen around the rectum and terminal ileum. A nasogastric tube is inserted, oral intake is stopped, and he is consulted to the general surgery clinic as ileus and admitted.

Results and Conclusion: The symptoms of ileus usually depend on the location of the obstruction. Appropriate treatment depends on determining the pathogenesis (mechanical or obstructive). Ileus is the most common indication for emergency laparotomy. The small bowel is affected in 70%, and the colorectum in 30%. The time to treat complete mechanical obstruction is short because acute ischemia can lead to necrosis with perforation of the bowel within 6 hours.

Figure 1

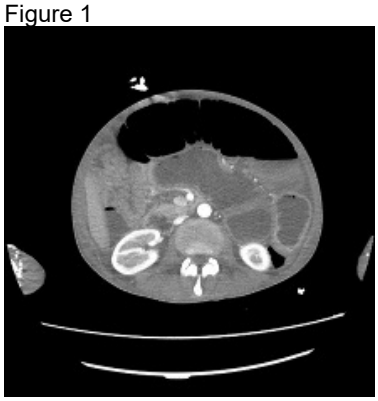

Figure 2

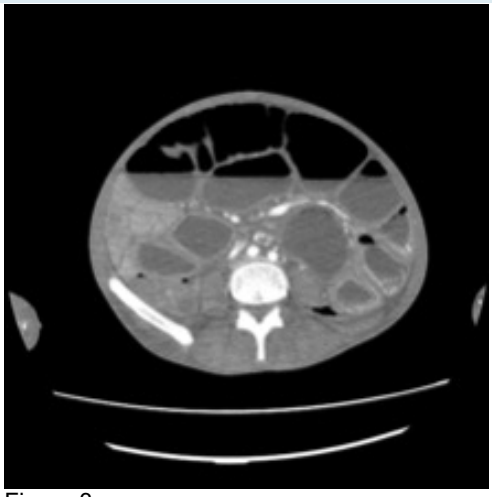

Figure 3

Figure 4

Keywords: Ileus, obstruction, mass

Ref No: 8152
Allergic reaction to pigeon meat consumption: a rare case
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Introduction and Purpose: Food allergies are diseases that develop through immunological mechanisms and can occur with systemic reactions ranging from mild skin reactions to anaphylaxis. Although poultry meat allergy is rare, cases related to chicken and turkey meat have been reported more frequently. Pigeon meat allergy has been described in the literature with a very limited number of cases.
Materials and Methods: Our patient was a 34-year-old male. He reported consuming pigeon meat for the first time during lunch and developed symptoms of widespread itching, facial redness, lip swelling, wheezing, and shortness of breath within approximately 30 minutes. Upon arrival, his vital signs were as follows: blood pressure (BP), 100/60 mmHg; pulse rate (PR), 110/min, respiratory rate, 22/min, and oxygen saturation, 96%. There were widespread erythematous rashes on the face and body. There was bilateral wheezing and prolonged expiration on auscultation. There were no abnormal findings in the tests performed except for Serum total IgE: 350 IU/mL, Eosinophil: 450/mm³. The patient was treated with 1 dose of intramuscular adrenaline (0.3 mg, 1:1000). Antihistamine (IV pheniramine) and corticosteroid (IV methylprednisolone) treatment was started, and oxygen support was provided. The patient was kept under observation until the symptoms regressed.
Results and Conclusion: This case describes a rare pigeon meat allergy in the literature. The absence of cross-reactivity with chicken and turkey meat suggests that an immune response specific to pigeon meat has developed. Since pigeon meat is a rarely consumed food, it is difficult to detect such allergic reactions.
Keywords: Pigeon, Food allergy, Anaphylaxis

Ref No: 8161
ALTERED MENTAL STATUS IN A GERIATRIC PATIENT: DELIRIUM OR ENCEPHALITIS?
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Introduction and Purpose: Meningitis is an inflammatory disease of the meninges and cerebrospinal fluid (CSF).It can be caused by infectious agents(bacteria,viruses,fungi,parasites)or non-infectious factors.There is no specific history, physical examination finding,or scoring system for diagnosis.Clinical suspicion and experience are crucial.CSF evaluation via lumbar puncture is the gold standard.Most viral meningitis cases are idiopathic,but polymerase chain reaction(PCR)has improved the identification of rare causes.Human herpesvirus 6(HHV-6)is usually latent and widespread worldwide.Most people get infected in childhood,but it is generally asymptomatic.
Materials and Methods: A 73-year-old female patient presented to the emergency department with complaints of altered mental status,disorientation,urinary incontinence,reduced oral intake,and inability to recognize relatives for the past two days.One week before symptom onset,she had been hospitalized in intensive care following an angiography.She had previously been diagnosed with delirium and received treatment at another hospital.On examination,she was confused, with limited orientation and cooperation. Her vital signs were stable. Glasgow Coma Scale score was 11. Neck stiffness was questionable, and muscle strength assessment was limited, but spontaneous movement was observed in all four extremities. Laboratory results: GFR: 34,Creatinine: 1.51 mg/Dl,Urea: 183.8 mg/dL,Uric acid: 12.53 mg/dL,CRP: 0.61 mg/dL,WBC: 7.1 x 10^3/µL,Neutrophils: 56.1%.Cranial imaging showed no acute pathology.The patient was monitored in the emergency department, and cranial MRI revealed diffuse subcortical-periventricular diffusion restriction in both cerebral hemispheres.With a preliminary diagnosis of encephalopathy, lumbar puncture (LP) was planned.The CSF PCR panel detected HHV-6 positivity. After neurology and infectious disease consultations,the patient was started on Ganciclovir and Levetiracetam.She showed dramatic clinical improvement and was admitted to the infectious diseases department.
Results and Conclusion: Reactivation of HHV-6,whether primary or latent, can rarely lead to meningitis or meningoencephalitis with a poor prognosis.Few cases of HHV-6 encephalitis have been reported, most of which had fatal outcomes.Due to the widespread nature of the virus and the frequency of childhood infections,HHV-6 infections and reactivations are rare in adults,particularly with central nervous system involvement.Reported cases have shown clinical improvement with intravenous ganciclovir or valganciclovir treatment.
Keywords: Human Herpesvirus 6, Lumbar Puncture, Meningitis

Ref No: 8170
Elevated CK and Kidney Failure: An Overlooked Detail in Medication Use?
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Introduction and Purpose: Elevated CK levels are a sensitive and reliable indicator of muscle damage,and this increase is directly proportional to the extent of muscle damage and the severity of the disease.CK levels can rise due to direct muscle damage in trauma or ischemia in peripheral artery diseases.In addition,heart diseases,some central nervous system disorders,sepsis,thyroid disorders,and certain pharmacological agents can also cause an elevation in CK levels(2,3).Muscle breakdown can lead to a wide spectrum of problems,ranging from asymptomatic elevated muscle enzymes to life-threatening electrolyte imbalances,acute kidney failure,multiple organ failure,and even death.Therefore,early diagnosis and treatment are of great importance(3,4)
Materials and Methods: A 47-year-old male patient presented to the emergency department with abdominal pain that had been ongoing for two days.On systemic examination, widespread abdominal pain was noted.The patient's medical history includes a recent diagnosis of diabetes.For the past 10 days,the patient has been taking Diamicron MR 30 mg twice daily.Laboratory results showed a GFR of 54, creatinine of 1.54 mg/dL,urea of 37 mg/dL,CK of 2797 U/L.The patient's ECG showed sinus rhythm.There is no recent history of exercise, trauma, or additional medication use.Given the elevated CK levels, the patient was started on fluid resuscitation in the emergency department.Following a decrease in CK levels,the patient was advised to increase fluid intake, avoid strenuous physical

activity, and potentially undergo a medication change. He was also recommended to follow up with the endocrinology department, where he is being monitored, and was discharged

Results and Conclusion: Trauma,exercise,muscle diseases,heart diseases,some central nervous system disorders,sepsis,thyroid disorders,certain pharmacological agents can also cause elevated CK levels(2,3).Diamicron MR is an oral antidiabetic drug from the sulfonylurea class that lowers blood sugar levels.Diamicron MR is used in adults for the treatment of insulin-independent diabetes when diet,physical exercise,and weight loss alone are insufficient to control blood sugar.It is used in patients with mild to moderate renal insufficiency,but only with careful monitoring,similar to its use in patients with normal kidney function(5).Considering this information,in elderly patients with borderline kidney function and reduced oral intake who are using Diamicron,the patients' CK levels should be carefully monitored.It should be emphasized that these patients need to pay attention to their fluid intake and avoid strenuous physical activities

Keywords: Creatine Kinase, Oral Antidiabetics, Sulfonylurea Class Antidiabetics

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Ref No: 8193

Rare Complication in Childhood pneumonia: Necrotising Pneumonia

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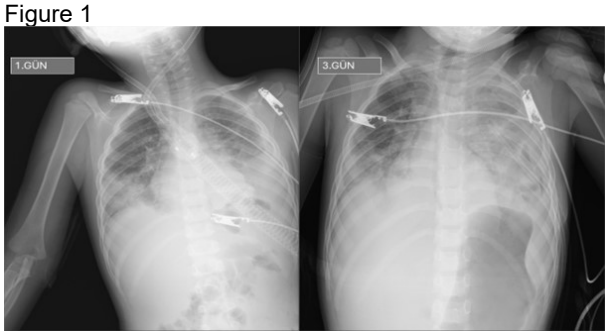
Introduction and Purpose: Necrotising pneumonia is a relatively uncommon and increasing complication of pneumonia in children. It is characterized by parenchymal necrosis, liquefaction, and cavitation, and may lead to severe complications such as parapneumonic effusion, empyema, or bronchopleural fistula. This case illustrates the importance of considering necrotising pneumonia in children with poor clinical response to treatment.

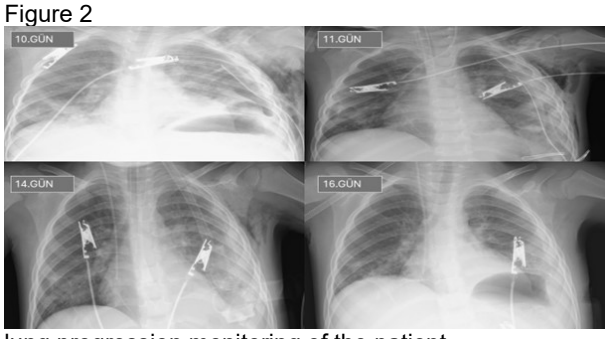
Materials and Methods: A 4-year-old male presented to the emergency department with fever, cough, abdominal pain, and diarrhoea. His medical and family history were unremarkable. On examination, his blood pressure was 100/50 mmHg, pulse 130/min, temperature 38.1°C, and oxygen saturation was 86% on room air, improving to 94% with 2L nasal oxygen. Auscultation revealed bilateral rales. Laboratory findings included CRP 315 mg/L, WBC 14.5×10⁹/L with 72.2% neutrophils, and procalcitonin 26.1 ng/mL.Point-of-care ultrasound (POCUS) revealed hepatisation of the left lung and a 2 cm pleural effusion. The patient was admitted to the paediatric intensive care unit and treated empirically with vancomycin, meropenem, oseltamivir, and salbutamol. By 72 hours, due to persistent effusion, a thoracic tube was inserted.(Figure 1) The pleural fluid showed 7680 leukocytes/mm³, protein 3.6 mg/dL, glucose 33 g/dL, triglycerides 145 mg/dL; cultures remained negative. Despite initial management for empyema, haemorrhagic fluid and lack of bacterial growth led to a revised diagnosis of necrotising pneumonia.On the 11th day, due to persistent air leak, the patient underwent video-assisted thoracoscopic surgery (VATS) and required mechanical ventilation. He was extubated on day 14. By day 27, the patient improved, requiring only nasal oxygen, and was transferred to the pediatric ward.(Figure 2)

Figure 1



lung progression monitoring of the patient

Figure 2



lung progression monitoring of the patient

Results and Conclusion: Abdominal pain in children should not be attributed solely to gastrointestinal causes; pneumonia, including necrotising forms, must be considered. Necrotising pneumonia, although rare, should be suspected in children with complicated pneumonia unresponsive to standard treatment.

Keywords: children, necrotising pneumonia

Ref No: 8205

An Occlusive Oncological Emergency: Spinal Medulla Mass

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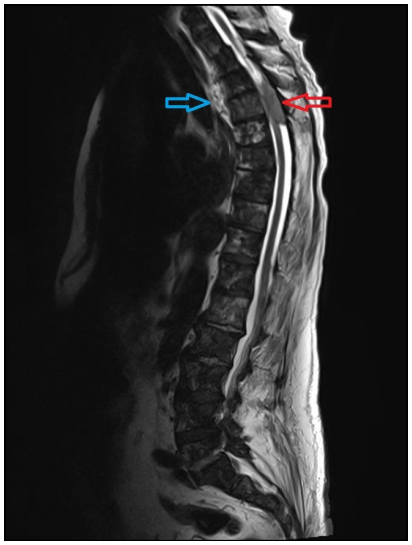
Introduction and Purpose: Complications related to malignancies themselves or their treatments are conditions that increase the mortality of patients with poor prognosis. Delays in diagnosis and treatment may cause irreversible complications in patients.

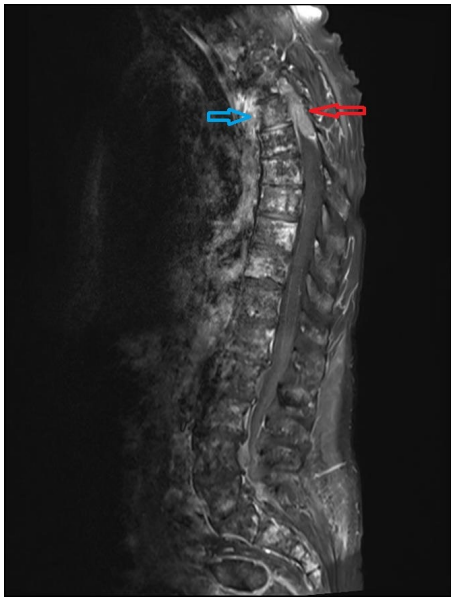
Materials and Methods: A 74-year-old male patient applied to the emergency department with complaints of weakness. The patient, who had a known diagnosis of prostate cea, had a history of weakness that had been present for 1 week and caused difficulty in walking. No acute/pathological findings were found in the examinations and laboratory evaluations of the patient, whose vital signs were stable. The patient, whose neurological examination was also within normal limits, was discharged with recommendations. The patient applied to the emergency department 3 days later with similar complaints. The patient's examination revealed changing findings. In the neurological examination, paralysis was determined in bilateral lower extremities. The patient, who underwent central nervous system imaging, also underwent thoracic and lumbar contrast-enhanced MRI. Multiple metastatic foci and new masses were detected in the patient with primary prostate cea. One of these masses is located at the T6 vertebra level, posteriorly in the spinal canal, extending from the right neural foramen to the right prevertebral area in the sagittal plane, measuring 39x12 mm, and creating pressure on the spinal cord. The patient had multiple metastatic foci at the vertebral level, intercostal space, and spleen (Figure 1-2). The patient was admitted to the neurosurgery clinic.

FİGURE 1



The red arrow indicates the lesion within the ms, the blue arrow indicates the lesion at the vertebral level.

FIGURE 2



The red arrow indicates the lesion within the ms, the blue arrow indicates the lesion at the vertebral level.

Results and Conclusion: Structural and obstructive emergencies are followed with important clinical diagnoses such as Superior vena cava syndrome (SVC), Spinal cord compression, Pericardial tamponade.. Masses belonging to the malignancy itself or its metastases can cause obstruction in the area they are located. Clinical applications of patients should be screened in a wide range. Findings detected in examinations may include pain, spasticity, extensor plantar reflex, decreased anal tone, decreased perineal sensitivity, and globe vesical. In parallel, medical treatment, radiotherapy and surgical treatment options should be evaluated in treatment. Considering oncological emergencies and accelerating the diagnosis and treatment process in oncological patients who come to the emergency room with nonspecific symptoms will create a management style that will positively affect the prognosis of the patients.
Keywords: medulla spinalis mass, oncological emergency, occlusive emergencies

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Ref No: 8265
ACUTE MARAS POWDER INTOXICATION – CASE REPORT
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Introduction and Purpose: Maras Powder, a smokeless tobacco known as Aztec tobacco globally, is made by mixing dried Nicotiana Rustica leaves with tree ashes. It results in absorption of nicotine that is approximately 10 times higher than that from regular cigarettes. Due to its high nicotine content, it can cause severe toxicity and requires prompt treatment in cases of acute intoxication.In our case report, we aim to describe the clinical presentation of confusion and syncope resulting from Maras Powder use.
Materials and Methods: This case report describes a 48-year-old male who developed confusion and syncope from Maras Powder use. Symptoms improved within hours, and the patient was fully recovered after 24 hours.
Results and Conclusion: This is, to our knowledge, the only documented case of acute Maras Powder intoxication in adults. It should be suspected in regions where it is commonly used, with careful attention to patient history.
Keywords: Maras Powder, intoxication, nicotine metabolism

Ref No: 8271
ST Segment Alteration due to cocaine use: A case report
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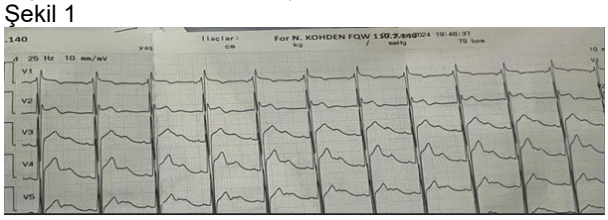
Introduction and Purpose: As a result of cocaine and drug use, they can cause many cardiovascular diseases, including bacterial endocarditis, ischemic heart disease, dilated cardiomyopathy, heart failure, supraventricular and ventricular arrhythmias, pulmonary hypertension, myocardial infarction, and sudden death. The relationship between cocaine use and myocardial infarction is not well understood. Here we present a case of nonspecific ST elevation and depression on the ECG in a 20-year-old man due to cocaine use.
Materials and Methods: A 20-year-old man was admitted to the emergency department with complaints of recent chest pain, epigastric pain and slowing of mental movements. His spasm-like pain in the epigastric region was radiating to his chest, left arm and back. Physical examination findings and vital signs were normal. Electrocardiographic examination showed nonspecific ST segment elevations in chest leads V1-V5. Extensive nonspecific ST depression was detected in extremity leads DII, DIII and AVF. Laboratory results were normal. Echocardiographic examination revealed no wall motion defect, normal right cavities, no pericardial effusion, normal ascending aorta, increased trabeculation in the apical right ventricle, and normal left ventricular systolic function (ejection fraction:70%). Pulmonary CT angiography showed normal mediastinal main vascular structures and diameters, both main pulmonary arteries were patent, and there were no findings in favor of PTE in both main pulmonary arteries and their segmental branches. Electrocardiographic evaluation revealed nonspecific ST elevation in the anterior leads (Figure 1-2) and nonspecific ST depression in the inf leads (Figure 3-4), but no elevation in cardiac enzymes. The patient was followed up in the cardiology ward for three days. Cardiac enzyme levels were not found to be elevated during follow-up. The patient was questioned about substance abuse and it was understood that he had a history of cocaine use before admission to the hospital and a history of substance abuse one year before. The patient whose complaints regressed and cardiac enzyme levels were normal was taken to outpatient clinic follow-up.
Şekil 1



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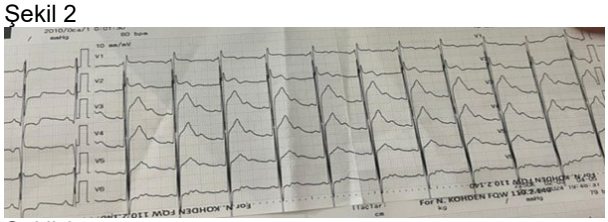

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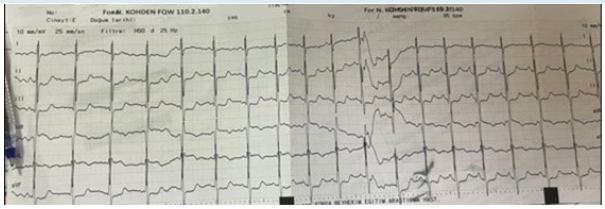
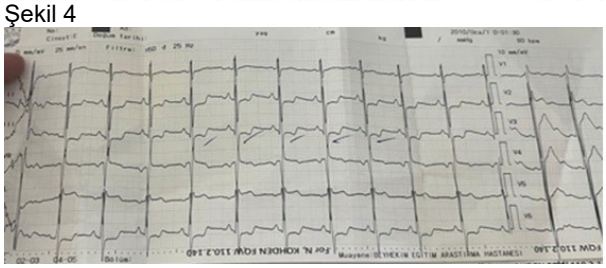


Şekil 4



Results and Conclusion: Although common in the adult age group, chest pain due to myocardial ischemia is rare in adolescents. Therefore, adolescents presenting to the emergency department with chest pain or other symptoms of heart attack should typically be questioned about cocaine use.

Keywords: Substance abuse, Cocaine, ECG changes

Ref No: 8391

Portal Vein Thrombosis in a Patient Presenting with Abdominal Pain: A Case Report

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Introduction and Purpose: Portal vein thrombosis (PVT) is a rare but clinically significant condition characterized by thrombus formation within the portal venous system. Its presentation may range from asymptomatic to life-threatening complications such as bowel ischemia or portal hypertension. Although frequently associated with underlying risk factors such as malignancy, cirrhosis, hypercoagulable states, or intra-abdominal inflammation, PVT can occasionally occur in otherwise healthy individuals. Early diagnosis is critical, particularly in patients presenting with unexplained or persistent abdominal pain.

Materials and Methods: A 32-year-old male with no known chronic illness presented to the emergency department with a one-week history of persistent abdominal pain. On examination, he was alert, oriented, and hemodynamically stable. Abdominal and systemic physical examination findings were unremarkable. Routine laboratory investigations were within normal limits. Abdominal ultrasonography revealed mild heterogeneity of the liver parenchyma and a dilated main portal vein measuring 14 mm in diameter. Color Doppler imaging failed to demonstrate flow within the portal vein, and an intraluminal filling defect consistent with thrombus was noted. The patient was diagnosed with portal vein thrombosis and was admitted to the gastroenterology department following consultations with vascular and general surgery.

CT IMAGE

Results and Conclusion: This case highlights the diagnostic challenge of PVT in patients presenting with nonspecific abdominal pain and no abnormal findings on physical exam or routine labs. Ultrasonography with Doppler plays a key role in early identification of PVT, especially in emergency settings. Although PVT is typically linked to hypercoagulable or inflammatory states, the absence of such risk factors—as in this patient—necessitates further hematologic and genetic evaluation. Anticoagulation remains the mainstay of treatment,

aiming to restore portal flow and prevent complications. Multidisciplinary collaboration ensures comprehensive management and favorable outcomes. PVT should be considered in the differential diagnosis of unexplained abdominal pain, even in young and otherwise healthy individuals. Timely diagnosis, appropriate imaging, and a multidisciplinary approach are essential to reduce morbidity and improve prognosis.

Keywords: Portal Vein Thrombosis, Portal Hypertension, Liver

Ref No: 8406

Sudden development of intraparenchymal hemorrhage in a middle-aged patient with a normal neurological examination

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Introduction and Purpose: Intracerebral hemorrhage (ICH) is the second most common cause of stroke (15–30%) and the most fatal. Blood vessels transport blood to and from the brain. Arteries or veins may rupture due to hypertension, abnormal development, or trauma. The presence of extravasated blood itself can damage brain tissue. Additionally, excess blood increases intracranial pressure (ICP), potentially leading to further brain injury.

Materials and Methods: A 50-year-old male patient presented ambulatory to the green zone of the emergency department with a complaint of a presyncopal episode and severe headache accompanied by dizziness, which had started approximately 30 minutes prior. Despite a completely normal physical and neurological examination, the patient was rapidly referred for imaging based on clinical suspicion. Brain CT revealed a large intraparenchymal hemorrhage in the right parietal lobe. He was urgently consulted with the neurology department and admitted to the stroke intensive care unit.

Results and Conclusion: While a neurological examination is a valuable tool in emergency settings, normal findings do not exclude underlying pathology. As this case illustrates, clinical suspicion and rapid imaging are crucial, particularly in neurological emergencies such as intracerebral hemorrhage, which carries a high mortality rate.

Keywords: Headache, Intraparenchymal hemorrhage, Middle-aged patient

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Ref No: 8413

A Hidden Brake Lever in the Leg: Unexpected Foreign Body

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[1]Karamanoglu Mehmetbey University
[2]Bursa Specialized Training and Research Hospital

Introduction and Purpose: Penetrating injuries with retained foreign bodies can lead to serious complications if undetected.

Materials and Methods: An 11-year-old male patient was brought in to ED after falling while riding a bicycle. The patient, who had no head trauma, came with only a description of pain in the leg. The patient had a 1 cm incision on the anteromedial area of the left thigh and did not describe any foreign body involvement. It was assumed that only a simple incision had occurred during the trauma. X-ray and CT angiography unexpectedly revealed a metallic object near the femoral head, later identified as a bicycle brake lever.The foreign body was successfully removed under local anesthesia.

Results and Conclusion: Although emergency room patients can often provide guidance regarding their condition, the patient in this case was unable to comprehend what had occurred due to the immediate impact of the accident. The individual was visibly astonished when the foreign body was extracted. This case underscores the crucial role of physical examination and imaging, highlighting their significance alongside patient history in accurate diagnosis and management.

Keywords: Foreign bodies, pediatric patients, trauma

Ref No: 8430

Rare But Fatal Necrotizing Pyelonephritis: A Case Report

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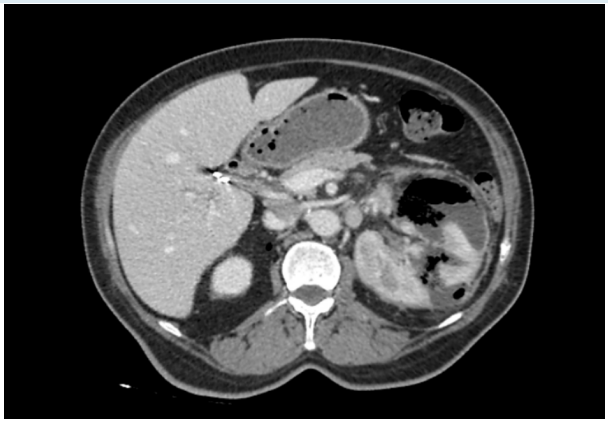
[2]Ondokuz Mayıs University Faculty of Medicine, Department of Emergency Medicine

Introduction and Purpose: Emphysematous pyelonephritis (EPN) is a rare but life-threatening necrotizing infection of the renal parenchyma, characterized by suppurative inflammation and gas formation. Common pathogens include Escherichia coli, Klebsiella pneumoniae, and Proteus species. Diabetes mellitus (DM) plays a significant role in the pathogenesis by contributing to impaired tissue oxygenation, immune dysfunction, and gas formation due to glucose fermentation. Other risk factors include urinary tract obstruction, advanced age, hypertension, and chronic kidney disease. Clinical symptoms are often non-specific, including abdominal pain, fever, nausea, vomiting, and costovertebral angle tenderness. Contrast-enhanced abdominal CT is considered the gold standard for diagnosis, revealing gas within the renal parenchyma and associated abscesses. Management requires a multidisciplinary approach involving antibiotics, percutaneous drainage, and in severe cases, nephrectomy.

Materials and Methods: A 55-year-old female presented to the emergency department with decreased oral intake, fever, and nausea. She had a history of hypertension, diabetes, and hyperlipidemia. Two weeks earlier, she had been hospitalized for presumed pyelonephritis and pneumonia but was discharged prematurely. On examination, costovertebral angle tenderness was noted. Laboratory findings revealed leukocytosis (WBC 12.4K/uL), elevated CRP (49 mg/L), and normal renal function. CT imaging demonstrated a 105x96x133 mm abscess occupying the left kidney with gas-fluid levels, consistent with emphysematous pyelonephritis. Consultations with infectious diseases, nephrology, and urology departments were obtained. The patient received IV hydration, broad-spectrum antibiotics (piperacillin-tazobactam and amikacin), and underwent percutaneous drainage. She was discharged in good condition after three weeks of treatment.

Abdomen CT



Abdomen CT-2

Abdomen CT-3

Results and Conclusion: EPN remains clinically challenging due to delayed diagnosis and rapid progression, particularly in diabetic patients. This case highlights the importance of considering EPN in patients with risk factors and non-specific symptoms. CT imaging played a crucial role in early diagnosis. Multidisciplinary intervention was critical in the successful management of the patient. Timely antibiotic therapy and percutaneous drainage are essential, especially in large abscesses. Early recognition and coordinated care significantly reduce mortality and morbidity.

Keywords: Emphysematous pyelonephritis, Percutaneous Drainage

Ref No: 8435

Emergency Department Management Following Foreign Body Penetration in the Distal Third of the Right Arm

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[1]ANKARA BİLKENT ŞEHİR HASTANESİ

Introduction and Purpose: Falls and trauma are common injuries in the pediatric age group. In this case, a simple fall resulted in a foreign body penetration into the distal third of the right forearm. The injury was successfully managed with timely and appropriate surgical intervention. Foreign body injuries can lead to severe complications, and early diagnosis, proper wound care, and a multidisciplinary approach are essential.

Materials and Methods: A 7-year-old female child presented to the emergency department following a simple fall, resulting in a foreign body penetration in the distal third of the right forearm. Upon initial examination, the Glasgow Coma Scale (GCS) was 15, and vital signs were stable. There was a wound with an entry point on the distal third of the right forearm, and an exit wound located in the extensor zone 8, measuring 2*2 cm. Due to the patient's pain and agitation, the Allen test could not be performed; however, peripheral pulses were palpable.Neurological examination was suboptimal due to the patient's age, but no hypoesthesia was noted. The motor examination of the right wrist and fingers was normal. Antibiotics and tetanus prophylaxis were administered before the foreign body was extracted. The patient was then referred to plastic surgery for consultation.Plastic surgery performed the removal of the foreign body and wound repair. Exploration of the volar aspect of the distal forearm did not reveal any vascular or tendon injury. Penrose drains were placed in both the volar and dorsal aspects to reduce the risk of infection. The skin incisions were appropriately repaired using standard surgical techniques, and the wound was covered with a suitable dressing. Postoperatively, the Allen test was conducted, and vascularization was found to be normal.

Results and Conclusion: This case emphasizes the importance of early intervention, correct diagnosis, and a multidisciplinary approach in the management of foreign body injuries in children. Timely surgical intervention and proper postoperative care have led to a positive outcome in this patient. Regular follow-up showed no complications and a successful recovery. This case demonstrates that, with appropriate surgical techniques and post-operative care, successful outcomes can be achieved in the management of foreign body injuries.

Keywords: pediatric trauma, Foreign body, Basic Fall

Ref No: 8451

A case of hemothorax due to aortic injury following blunt trauma

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Introduction and Purpose: Blunt traumatic aortic injury (BTAI) is a rare but fatal complication of thoracic trauma. Although it occurs in approximately 1% of trauma cases, it is the second most common cause of death . A large proportion of patients with BTAI (up to 80%) die without receiving adequate treatment . BTAI is most commonly caused by sudden deceleration, motor vehicle accidents are the predominant mechanism . The age distribution of BTAI is wide, with a mean age of 35 to 45 years, there is a male predominance .A four-degree classification system is published for traumatic aortic injuries. With the development of thoracic endovascular aortic repair (TEVAR), the advancement of devices over the last decade, endovascular treatment has replaced open surgery, has resulted in lower mortality rates . The 2017 European Society for Vascular Surgery (ESVS) guidelines for the management of descending thoracic aortic diseases recommend TEVAR as the first-line treatment for BTAI in patients with favorable anatomy, except for minimal aortic injuries presenting with intimal tears that can be managed conservatively .

traumatic aortic injuries classification

1. Degree	Intimal Injury
2. Degree	Intramural Hematoma
3. Degree	Pseudoaneurysm
4. Degree	Rupture

Materials and Methods: A 25-year-old male driver applied for a traffic accident. The four-wheeled car lost control while turning at an intersection, resulting in a frontal impact.The patient has no additional disease, history of medication use. There is no alcohol, drug use.General condition is good. GCS is 15. Neurological examination is normal.On physical examination, there are severe abrasions on the anterior thorax. There is a left femur deformity. There are superficial cuts, abrasions on the forehead, various parts of the head.Vital signs TA 90/60, SpO2 92, pulse 115.Laboratory findings: Hb 14.2, ALT 125, AST 162, other tests are normal.In the imaging tests performed, Brain CT is normal. Thorax CT shows aneurysm, rupture at the level of the aortic arch, accompanied by left hemothorax, hemomediastinum. Abdominal CT shows laceration in the right kidney.The patient was admitted to cardiovascular intensive care for

TEVAR.

Figure 1

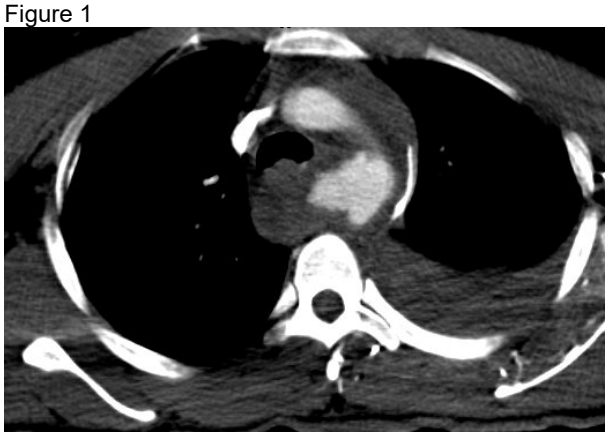
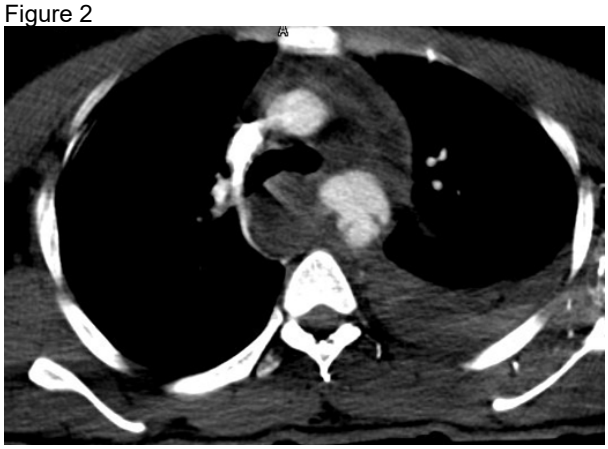


Figure 2



Results and Conclusion: Hemothorax usually occurs due to lung injuries. In cases of blunt trauma with hemothorax without rib fractures, aortic injury should be considered.

Keywords: hemothorax, aortic injury, blunt trauma

Ref No: 8458

The effectiveness of scoring systems in the discharge of patients presenting to the emergency department with chest pain

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Introduction and Purpose: In our study, we aimed to investigate whether the HEART, GRACE, TIMI and VANCOUVER scoring systems used in patients with chest pain and non-ST elevation ACS who came to the emergency department and were evaluated together with a single troponin and whether they contribute to the diagnosis and discharge of the patients. The aim of this study is to determine whether the above-mentioned scoring systems of discharged patients predict acute myocardial infarction that may occur in the patients within 30 days.

Materials and Methods: The study was initiated after receiving approval from the ethics committee of Tekirdağ Namık Kemal University Faculty of Medicine dated 23.06.2023 and numbered 2023.126.06.12. Our study is a prospective descriptive study.

Results and Conclusion: A total of 1000 patients were included in our prospective study. The mean age of the individuals included in the study was 51.12±15.3 years. 56.9%(570) of the subjects were male, 43%(430) were female. The status of the discharged individuals experiencing ACS within 1 month was examined and it was determined that 13(1.3%) cases were hospitalized and treated in the coronary intensive care unit with a preliminary diagnosis of ACS within a month after being discharged from the emergency department. When the scores determined at the first admission of these 13 individuals to the emergency department were examined; According to TIMI, 10(76.9%) patients were determined to be low risk, 3(23.1%) patients were determined to be moderate risk, according to the HEART system, 5(38.5%) patients were determined to be low risk, 8(61.5%) patients were determined to be moderate risk, and according to the GRACE system, 13(100%) patients were determined to be low risk. According to the VANCOVER system, 1(7.7%) patient could be discharged and 12(92.3%) patients should not be discharged. It was concluded that the scoring systems used alone in patients who came to the emergency department with chest pain complaints with suspicion of acute coronary syndrome were insufficient for discharge and more multicenter studies should be conducted for the effectiveness of the scoring systems.

General data related to cases

Table: General data related to cases	
Data	n (%), mean±std
Age	51,12 ± 15,3
Gender Woman Male	 430 (%43) 570 (%57)
Complaint Chest pain	 1000 (%100)

Status of discharged patients with ACS within 1 month

Table: Status of discharged patients with ACS within 1 month					
Scoring system	Low risk	Medium risk	Discharged Be	Discharged Be	Coronary Intensive Care Unit Hospitalization
TIMI	10 (%76,9)	3 (%23,1)	-	-	13
GRACE	13 (%100)	-	-	-	13
HEART	5 (%38,5)	8 (%61,5)	-	-	13
VANCOVER	-	-	1 (%7,7)	12 (%92,3)	13

Sensitivity and specificity of scoring systems used in chest pain in predicting coronary intensive care unit admission

Table: Sensitivity and specificity of scoring systems used in chest pain in predicting coronary intensive care unit admission		
Scoring system	Sensitivity	Specificity
TIMI	%47	%87,8
GRACE	%37	%87,6
HEART	%89	%68,1
VANCOVER	%95	%18,7

Keywords: Emergency department, Chest pain, scoring system

Ref No: 8526

A cerebrovascular event mimic in the emergency room: vitamin B12 deficiency

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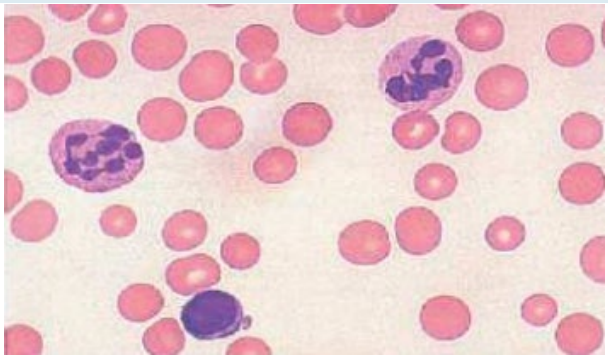
[1]S.B.Ü Erzurum Şehir Hastanesi Acil Tıp Ana Bilim Dalı

Introduction and Purpose: Vitamin B12 is a water-soluble vitamin that is necessary for cell division and proliferation, as a coenzyme in important reactions in the body, and is involved in DNA production. The most common symptom of vitamin B12 deficiency is anemia, followed by fatigue, palpitations and shortness of breath. In addition to anemia symptoms, neurological symptoms may also be seen in vitamin B12 deficiency. Neuropathy is one of the most common complications. Paresthesia and numbness primarily start in the feet and legs, accompanied by loss of reflexes, superficial sensory deficit and loss of vibration sense. Later, similar sensory changes begin in the hands and weakness in the distal leg muscles is added. We aimed to emphasize the neurological symptoms of vitamin B12 deficiency in this case.

Materials and Methods: A 22-year-old male patient was admitted to the emergency department with complaints of numbness in the right face and right arm and lisping in speech. The patient had no history of any disease and his vital signs were normal and stable. Neurologic examination revealed no motor or sensory deficit and no nuchal rigidity. Minimal ecchymotic areas were observed on the anterior chest wall and dorsal surface of the right arm. No intracranial pathology was detected on neurologic imaging. Laboratory values of the patient were as follows: WBC: 4.12 10^9/L, HGB: 9.0 g/dl, MCV: 101.0 Fl, PLT: 18 10^9/L and pancytopenia was present. In addition, LDH value was 750 U/L and indirect dominance of bilirubin was increased. A peripheral smear was sent and the patient was consulted to the hematology unit. Hypersegmented neutrophils (figure-1) and macrocytes were observed in the peripheral smear and the patient was interned to the internal service with the diagnosis of megaloblastic anemia.

figure 1



hypersegmented neutrophils seen in peripheral smear

Results and Conclusion: Vitamin B12 deficiency may present with neurologic, hematologic or psychiatric symptoms. Neurologic findings may include neuropathy, myelopathy, encephalopathy, eye movement disorders and extrapyramidal syndrome. In patients in whom pancytopenia is detected as a result of hemogram performed for any reason, it is extremely important to evaluate them by performing a peripheral smear after a careful anamnesis and physical examination and to plan and perform further investigations according to the results.

Keywords: neuropathy, pancytopenia, Vitamin B12 deficiency

Ref No: 8638

Open Biopsy as a Diagnostic Approach for Chronic Soft Tissue Lesions in the Upper Extremity: A Case Report and Surgical Considerations

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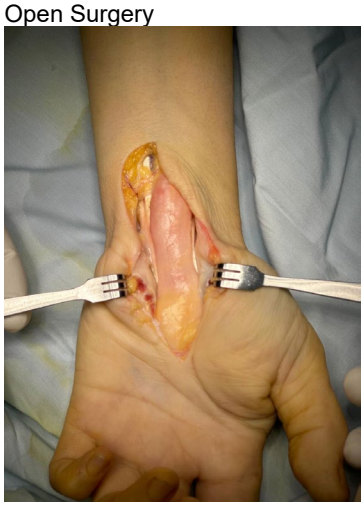
Introduction and Purpose: Nerve compression syndromes in the upper extremity can lead to progressive functional impairment if not addressed appropriately. This case report presents a 30-year-old female patient with chronic pain and swelling in the left hand, initially suspected to have a benign neoplasm. The patient had a history of lipoma excision in 2007, with worsening symptoms over time. MRI revealed a heterogeneous soft tissue formation (3.2 × 1.8 cm) on the radial surface of the wrist joint, raising concerns of neurovascular compression. The objective of this study is to highlight the clinical presentation, imaging findings, and surgical management, focusing on open biopsy for definitive diagnosis rather than nerve decompression.

Materials and Methods: A comprehensive clinical and radiological evaluation was performed, including MRI, laboratory tests, and orthopedic consultation. Neurological examination revealed localized swelling with movement-induced pain. Laboratory investigations, including coagulation profile, renal and liver function tests, and infectious disease screening, were within normal limits. The patient was classified as ASA I for anesthesia risk and underwent open surgical biopsy under local anesthesia to determine the nature of the lesion.

Open Surgery



Suture

Post Operation

Post Operation

FInal

Results and Conclusion: Histopathological examination confirmed a benign soft tissue lesion with no evidence of malignancy. Postoperatively, the patient experienced symptomatic relief with no major complications. Follow-up assessments revealed no recurrence or functional deficits. This case underscores the importance of early imaging and histopathological evaluation in differentiating benign from malignant lesions, thereby guiding appropriate surgical planning. Open biopsy remains a crucial diagnostic tool, ensuring accurate characterization of soft tissue masses before definitive intervention. Future research should explore minimally invasive diagnostic approaches to optimize patient outcomes in cases of uncertain soft tissue lesions affecting the upper extremity.
Keywords: Soft Tissue Lesion, Open Biopsy, Upper Extremity Surgery

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Ref No: 8643
Idiopathic Isolated Oculomotor Nerve Palsy: Case Report
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Introduction and Purpose: The oculomotor nerve (cranial nerve III) innervates four of the six extraocular muscles (superior rectus, medial rectus, inferior rectus, and inferior oblique), the levator palpebrae superioris, and provides parasympathetic fibers to the sphincter pupillae and ciliary muscles, enabling pupillary constriction and accommodation. Dysfunction of this nerve results in ptosis, ophthalmoplegia, diplopia, and sometimes anisocoria.Common etiologies include microvascular ischemia secondary to diabetes mellitus or hypertension, aneurysms, trauma, neoplasms, or infections. However, in rare cases, no specific cause can be identified despite extensive investigations.We present a case of isolated oculomotor nerve palsy in which no underlying etiology could be established, highlighting the diagnostic challenges and importance of careful exclusion of life-threatening conditions.
Materials and Methods: We report a 66-year-old female patient who presented with acute onset right-sided ptosis and diplopia. Neurological examination revealed restricted eye movements and anisocoria, with preserved pupillary light reflexes. Despite a detailed radiological and laboratory workup, no underlying etiology could be identified. The patient was diagnosed with idiopathic isolated oculomotor nerve palsy and admitted for observation and symptomatic treatment.
Results and Conclusion: Discussion The oculomotor nerve can be affected at several anatomical levels, from its nucleus in the midbrain to its course within the orbit. Lesions may present as ptosis, ophthalmoplegia, and pupillary involvement. In patients with diabetes or hypertension, microvascular ischemia is the most common etiology, though it rarely affects the pupil. The presence of pupillary involvement often raises concern for compressive lesions such as posterior communicating artery aneurysms. In this case, although anisocoria was present, imaging ruled out any aneurysmal or mass effect.Although rare, cases of embolic cranial nerve palsy following coronary angiography have been described. However, no ischemic changes were noted in this patient's diffusion-weighted MRI. Other potential causes such as trauma, infection, neoplasms, toxins, or migraine were excluded based on history and workup.Given the absence of identifiable etiology despite a comprehensive evaluation, the case was classified as idiopathic isolated oculomotor nerve palsy, a rare but documented clinical entity.
Keywords: Oculomotor nerve, cranial nerve palsy, emergency

Ref No: 8685
The deadly consequence of uncontrolled diabetes: emphysematous pyelonephritis
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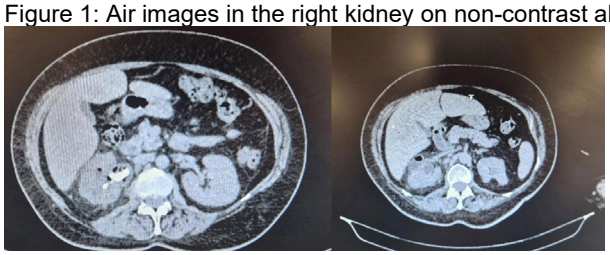
Introduction and Purpose: Emphysematous pyelonephritis is a rare, necrotizing, and suppurative kidney infection characterized by gas formation within the intrarenal or perirenal regions, with a high mortality rate. Diabetes mellitus is the most significant risk factor, observed in more than 90% of patients with emphysematous pyelonephritis. Its findings and symptoms are non-specific, with the most common manifestations being fever, flank pain, and nausea. The gold standard for the diagnosis of emphysematous pyelonephritis is computed tomography. In this case report, we discuss a patient with uncontrolled diabetes who was diagnosed early and successfully managed with conservative treatment.
Materials and Methods: A 56-year-old female patient presented to the emergency department with complaints of right flank pain and

nausea for approximately 10 days. Her medical history revealed a 15-year history of type 2 diabetes mellitus. On admission, her body temperature was 36.8°C, blood pressure was 135/72 mmHg, and pulse rate was 85 beats per minute. Physical examination revealed tenderness in the right costovertebral angle. Laboratory findings showed a white blood cell count of 11.92/mm³, creatinine level of 0.65 mg/dL, C-reactive protein of 71 mg/L, and blood glucose level of 595 mg/dL. Urine microscopy revealed abundant leukocytes and erythrocytes. Computed tomography (CT) demonstrated focal caliectatic dilations at the upper, middle, and lower poles of the right kidney, with air images observed within the calyces. The patient was diagnosed with emphysematous pyelonephritis and was consulted with the urology department for further evaluation and treatment, leading to hospital admission.

Figure 1: Air images in the right kidney on non-contrast abdominal CT.



Results and Conclusion: Emphysematous pyelonephritis is a severe condition with a high mortality rate if left untreated. As seen in our case, it should be considered in patients with a history of diabetes mellitus who present with flank pain or symptoms of a urinary tract infection.

Keywords: Emphysematous pyelonephritis, Diabetes mellitus, Necrotizing pyelonephritis

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Ref No: 8695

ovarian torsion and appendicitis

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Introduction and Purpose: Abdominal pain is one of the most common reasons for emergency department visits and has a broad differential diagnosis. In particular, patients presenting with right lower quadrant (RLQ) pain require careful evaluation for both gastrointestinal and gynecological pathologies. This case report presents the diagnostic and therapeutic approach for a 24-year-old female patient diagnosed with both ovarian torsion and acute appendicitis following a comprehensive evaluation.

Materials and Methods: A 24-year-old female patient presented to the emergency department with complaints of abdominal pain. Upon admission, her general condition was moderate, and her vital signs were stable. Physical examination revealed positive rebound tenderness and guarding in the RLQ. Given the suspicion of a gynecological pathology, a pelvic Doppler ultrasound was performed, demonstrating findings consistent with right ovarian torsion. Additionally, the appendix was not visualized, and its surrounding tissue appeared heterogeneous and unclean. To rule out acute appendicitis, a contrast-enhanced abdominal CT was obtained, revealing an 11 mm dilated appendix with mural edema and surrounding inflammatory fat stranding. Based on these findings, the patient was diagnosed with concurrent acute appendicitis and ovarian torsion. A multidisciplinary approach was adopted, and the patient was consulted with the general surgery and obstetrics and gynecology departments. An urgent combined surgical intervention was planned.

Results and Conclusion: The coexistence of ovarian torsion and acute appendicitis is rare but necessitates early diagnosis and intervention to prevent severe complications. This case highlights the importance of a multidisciplinary approach in the management of RLQ pain to ensure comprehensive evaluation and timely treatment. The successful surgical outcome in this patient underscores the necessity of considering a broad differential diagnosis when assessing young female patients with acute abdominal pain. Close postoperative monitoring is essential to ensure optimal recovery and to prevent potential complications.

Keywords: ovarian torsion, appendicitis

Ref No: 8739

Case series of toxic hepatitis after consumption of ferula communis (Giant fennel)

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Introduction and Purpose: Toxic hepatitis is liver inflammation caused by exposure to chemicals, medications, plants, or toxins. One such toxin is Ferula communis (giant fennel), a Mediterranean plant with medicinal properties but potential hepatotoxicity. Symptoms include nausea, vomiting, and jaundice.This case series presents three patients who developed liver toxicity after consuming Ferula communis, exhibiting nausea, vomiting, and headache.

ferrula communis

Materials and Methods: Three family members consumed Ferula communis and presented to the emergency department a day later with nausea, vomiting, and headache. Physical examination showed no defense or rebound signs. All had a Glasgow Coma Scale (GCS) of 15, were oriented and cooperative, and had stable vital signs, but elevated liver function tests.Case 1: 44-year-old male (no comorbidities)Alanine Aminotransferase(ALT): 113 IU/ml (reference: 0-50 IU/ml)Aspartate Aminotransferase(AST): 126 IU/ml (reference: 0-50 IU/ml)Creatine Kinase(CK): 216 U/L (reference: 46-71 U/L)Lactate Dehydrogenase(LDH): 307 U/L (reference: 120-246 U/L)Case 2: 67-year-old male(hypertension history)Alanine Aminotransferase(ALT): 441 IU/ml (reference: 0-50 IU/ml)Aspartate Aminotransferase(AST): 607 IU/ml (reference: 0-50 IU/ml)Lactate Dehydrogenase(LDH): 636 U/L (reference: 120-246 U/L)Prothrombin Time(PT): 19.5 sec (reference: 10.9-15.0 sec)International Normalized Ratio(INR): 1.51 (reference: 0.80-1.30)Case 3: 48-year-old female (no comorbidities)Alanine Aminotransferase(ALT): 495 IU/ml (reference: 0-50 IU/ml)Aspartate Aminotransferase(AST): 438 IU/ml (reference: 0-50 IU/ml)Creatine Kinase(CK): 319 U/L (reference: 46-71 U/L)Lactate Dehydrogenase(LDH): 750 U/L (reference: 120-246 U/L)Prothrombin Time(PT): 17.9 sec (reference: 10.9-15.0 sec)International Normalized Ratio(INR): 1.38 (reference: 0.80-1.30)Hepatobiliary ultrasonography showed no pathology. The cases were diagnosed as toxic hepatitis by gastroenterology and managed with intravenous hydration in the emergency intensive care. Symptoms improved after three days, and all were discharged.
Results and Conclusion: Ferula communis is widely consumed but may contain toxic species. While its exact toxic mechanism remains unclear, coumarins and furocoumarins are suspected. Some cases may develop serious complications like hemolysis and coagulopathy. This study highlights the hepatotoxic risks of Ferula communis and emphasizes the importance of early diagnosis and treatment in suspected poisoning cases.
Keywords: ferrula communis, Toxic hepatitis, Giant fennel

Ref No: 8746
Acute mesenteric ischemia
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Introduction and Purpose: Although acute mesenteric ischemia (AMI) is rarely encountered in our emergency departments,it is a diagnostic possibility that should always be kept in mind in the differential diagnosis of abdominal pain.Because its mortality rate can reach 60-70% .Here,we present a 92 year old male patient who presented to our hospital with epigastric and diffuse abdominal pain. Our aim in this study is to draw attention to acute mesenteric ischemia,which is a rare but high mortality case in patients presenting with abdominal pain without any examination findings (defence rebound).
Materials and Methods: A 92 year old man was admitted to the emergency department with complaints of epigastric pain for five days and sudden new onset of diffuse abdominal pain.He had a history of congestife heart failure and hypertension.Blood pressure was 130/85,saturation:98%,fingerstick blood glucose:120,ECG:salvo waves were present.On abdominal examination,there was diffuse tenderness but no defense and rebound.The fact that lactate was 6 in the laboratory values of our patient alerted us in terms of vascular ischemia.Contrast enhanced abdominal angio tomography imaging revealed superior mesenteric artery embolism.
normal appearance of the mesenteric artery

mesenteric artery filling defect

Results and Conclusion: As is well known,AMI is a highly mortal condition resulting in ischemia,cellular damage and necrosis due to sudden interruption of small intestinal blood supply.Although the first thing that comes to mind is the cardioembolic process in patients with atrial fibrillation (AF),this definition of AMI is not limited to this.Until proven otherwise,severe abdominal pain should be considered as AMI regardless of physical axamination findings,because newly developing acute mesenteric ischemia may cause pain but may not give any axamination findings.In our case ,although there were no sings of defense and rebound on abdominal examination ,acute mesenteric ischemia with high mortality was diagnosed.

Keywords: Acute mesenteric ischemia

Ref No: 8755

Sudden Liver Collapse: Fulminan Hepatitis

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Introduction and Purpose: Fulminant hepatitis is a severe clinical condition characterized by acute and rapidly progressing liver failure. It typically develops within days to weeks and leads to significant hepatic dysfunction, often accompanied by altered consciousness (hepatic encephalopathy).

Materials and Methods: A 50-year-old male patient presented with acute-onset abdominal pain, epigastric discomfort, and nausea. He had recently been diagnosed with non-small cell lung cancer but had not yet started treatment. He did not report diarrhea or constipation. Upon further anamnesis, it was revealed that the patient had recently consumed an unidentified herb.On admission, his vital signs were unremarkable except for a heart rate of 110 bpm. Electrocardiography (ECG) showed sinus tachycardia with no other abnormalities. Abdominal examination revealed tenderness in the epigastric and upper quadrant regions, with no guarding or rebound tenderness. Murphy's sign and costovertebral angle tenderness were negative. Chest and abdominal radiographs were unremarkable.Laboratory findings included elevated liver enzymes: ALT 2180 U/L, AST 941 U/L, GGT 218 U/L, ALP 142 U/L, and LDH 1798 U/L. Additional abnormalities included hyperglycemia (glucose 410 mg/dL), hyponatremia (Na 120 mmol/L), hypochloremia (Cl 87 mmol/L), elevated CRP (207 mg/L), and an increased INR of 1.62. Arterial blood gas analysis revealed metabolic acidosis with a pH of 7.31.Supportive treatment was initiated. During follow-up, the patient developed a worsening level of consciousness. Hepatobiliary ultrasound (USG) demonstrated mild gallbladder wall thickening and pericholecystic edema, raising suspicion of acute cholecystitis. Portal vein Doppler ultrasound revealed preserved flow in segmental branches, but no detectable flow in the hilar and confluence regions, suggesting portal vein thrombosis. The patient was diagnosed with fulminant hepatitis and admitted to the Gastroenterology Department for further management.

Results and Conclusion: In patients presenting with abdominal pain, it is crucial to investigate any history of unusual medication, herb, or supplement consumption. Identifying these factors early is essential for the prompt diagnosis and management of fulminant hepatitis, a rapidly progressive and potentially fatal condition.

Keywords: Abdominal pain, fulminant hepatitis, nausea

Ref No: 8756

The importance of inquiring about the last tablet in multiple drug intake: concealed bupropion intake and status epilepticus

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Introduction and Purpose: Bupropion is a dopamine and norepinephrine reuptake inhibitor known to lower the seizure threshold, with higher doses significantly increasing the risk of seizures. The likelihood of seizures rises markedly, especially at doses exceeding 600 mg. While bupropion-induced seizures are well-documented in the literature, reports of status epilepticus remain rare. This case report discusses a resistant status epilepticus that developed following high-dose bupropion intake and polypharmacy, as well as its management.

Materials and Methods: A 24-year-old male patient was admitted to the emergency department after ingesting an unknown quantity of quetiapine and gabapentin tablets with suicidal intent. Despite stable vital signs upon admission, he developed generalized tonic-clonic seizures during follow-up in the emergency toxicology intensive care unit. The patient, who experienced multiple seizures without regaining consciousness for over 5 minutes, was diagnosed with status epilepticus. As his seizures persisted despite initial midazolam doses, the sedative dosage was increased, and the patient was intubated. Propofol infusion was initiated.Upon contacting the patient's relatives for further history, additional empty medication boxes were found, revealing that he had also ingested a large dose of bupropion (minimum 4500 mg). Supportive therapy was provided for hypotension and fever, inotropic support was initiated, and sodium bicarbonate therapy was started. The nephrology department recommended dialysis. The patient was transferred to a tertiary intensive care unit for further management.

Results and Conclusion: In cases of polypharmacy with suicidal intent, especially when seizure-inducing drugs such as bupropion and quetiapine are involved, careful clinical follow-up is essential. The initial stability of such patients may be misleading, emphasizing the need for early seizure management and preparedness for severe complications such as status epilepticus.

Keywords: Bupropion, Toxicology, Status Epilepticus

Ref No: 8758

IN ADULT PATIENTS INVAGINATION

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Introduction and Purpose: 24-year-old female patient with no known medical conditions presented with a 3-day history of abdominal pain and constipation. The patient, who had no gas or stools for 3 days, was in good general condition, saturation: 98%, pulse: 98%, arterial blood pressure: 98, arterial blood pressure: 98, arterial blood pressure: 98, arterial blood pressure: 128/85 mmHg, temperature: 36.9 C. On physical examination, there was tenderness in the left lower quadrant, a palpable mass in the same region, and decreased bowel sounds below the mass segment. The patient had no significant abnormalities in blood tests and invagination was observed on contrast-enhanced lower/upper abdominal CT (Figure 1). The patient was referred to general surgery and surgical resection was performed by the appropriate department.

Materials and Methods: Tomography of the abdomen

Tomography of the abdomen: Appearance consistent with intussusception

Results and Conclusion: It should be noted that invagination, which is usually a paediatric pathology, can also be seen in adults. Delay in diagnosis and treatment may lead to life-threatening perforation. CT is a guide with a high diagnostic accuracy.

Keywords: INVAGINATION

Ref No: 8773

Major Pulmonary Laceration Secondary to Blunt Trauma: A Case Report Evaluated with CT Findings

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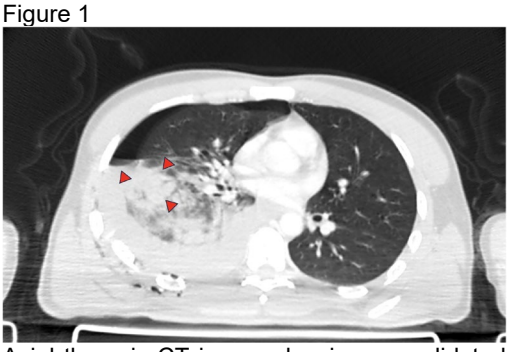
Introduction and Purpose: Thoracic trauma includes a wide range of injuries such as pulmonary contusion, laceration, pneumothorax, hemothorax, rib fractures, and tracheobronchial injuries, all of which can be life-threatening (Apollonatou V et al). Among these, pulmonary contusion is the most common and frequently occurs after blunt trauma (Apollonatou V et al). Pulmonary lacerations, on the other hand, are less frequently encountered and are usually secondary to penetrating injuries (Marchiori E et al). In this case, we aimed to present and discuss a major pulmonary laceration secondary to blunt trauma in light of imaging findings.

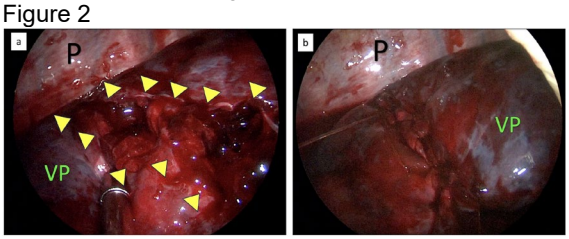
Materials and Methods: A 27-year-old male patient presented to the emergency department with chest pain and shortness of breath following a motor vehicle accident. Upon initial assessment, the patient was in stable condition. Thoracic CT revealed high-density pleural fluid on the right hemithorax measuring up to 6 cm in thickness, consistent with hemorrhagic effusion, as well as a pneumothorax up to 2.5 cm in thickness at the cardiac level. Additionally, diffuse ground-glass opacities and areas of consolidation were noted in the right lower and posterior upper lobes of the lung (Figure 1). Displaced multiple fractures were detected in the posterior and lateral aspects of the right 3rd to 9th ribs. The patient underwent rib stabilization and video-assisted thoracoscopic surgical (VATS) exploration. During the exploration, a major pulmonary laceration extending from the posterior to anterior aspects of the right lower lobe was identified (Figure 2a). The laceration was repaired via thoracotomy using primary suturing (Figure 2b). The displaced rib fractures were stabilized using three linear titanium plates (Figure 3).

Figure 1



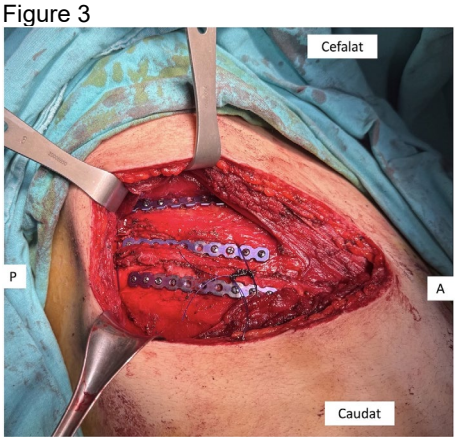
Axial thoracic CT image showing consolidated areas in the right lung. Pulmonary lacerations containing intralesional air densities are marked with red triangles.

Figure 2



(a) Intraoperative view during video-assisted thoracoscopic exploration showing the pulmonary laceration site (marked with yellow triangles). (b) Post-repair image of the same area after primary suturing. (P: Posterior wall of thorax; VP: Visceral pleura.)

Figure 3



Stabilization of rib fractures using linear titanium plates. (A: Anterior side of the patient; P: Posterior side of the patient.)

Results and Conclusion: On thoracic CT, pulmonary lacerations most commonly present as round or oval-shaped cystic lesions with air-fluid levels (Marchiori E et al). Surrounding ground-glass opacities may reflect alveolar hemorrhage and interstitial edema secondary to contusion. Lacerations may be solitary or multiple, unilocular or multilocular, and less commonly, bilateral. Treatment is usually supportive. However, in some cases, the lesions may persist for several weeks, potentially leading to complications such as superinfection, abscess formation, or rupture into the pleural space, resulting in pneumothorax or hemothorax (Apollonatou V et al). In such scenarios, surgical intervention should be considered.

Keywords: Blunt trauma, lung injury, pulmonary laseration.

Ref No: 8796

An interesting Case Report of Peripartum Cardiomyopathy, Successful Diagnosis and Treatment

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Introduction and Purpose: Peripartum cardiomyopathy (PPCM) is a rare and potentially fatal cause of heart failure that develops in late pregnancy or shortly postpartum, in the absence of prior heart disease. The patient exhibited symptoms indicative of peripartum cardiomyopathy, a condition characterized by the development of heart failure shortly after pregnancy. A comprehensive evaluation encompassing physical examination, laboratory tests, and radiological imaging yielded confirmatory evidence of heart failure and pulmonary edema. The following case study aims to underscore the significance of timely diagnosis and effective treatment in managing peripartum cardiomyopath.

Materials and Methods: A 32-year-old woman with a 34-week twin pregnancy, a history of three abortions, and two cesarean deliveries developed respiratory distress post-cesarean. She was intubated and subsequently transferred to the emergency department. Upon examination, the patient exhibited signs of disorientation, pulmonary rales, pretibial edema. Bedside echocardiography revealed global hypokinesia with an ejection fraction (EF) of approximately 35%. Laboratory findings included BNP 2447 pg/ml and troponin 1000 ng/L. PPCM was diagnosed, and the patient was admitted to the intensive care unit (ICU). BOARD (bromocriptine, oral heart failure drugs, anticoagulants, vasorelaxing agents, and diuretics) protocol was initiated: IV furosemide (40 mg bolus + 20 mg/h infusion), dopamine (10 mcg/kg/min), bromocriptine (2.5 mg BID), and enoxaparin (0.4 ml daily). As illustrated in the initial figure, the patient's chest X-ray taken at the time of admission reveals the presence of significant pulmonary edema. (Figure-1) In the subsequent figure, after a period of seven days, the treatment has led to a substantial decrease in pulmonary edema. (Figure-2)

Figure-1

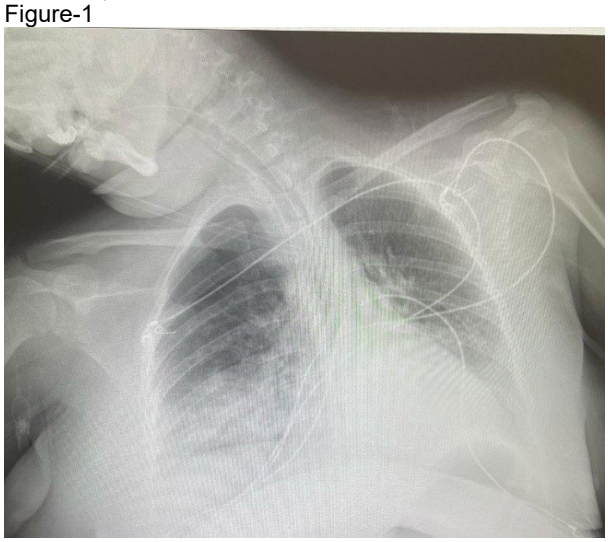
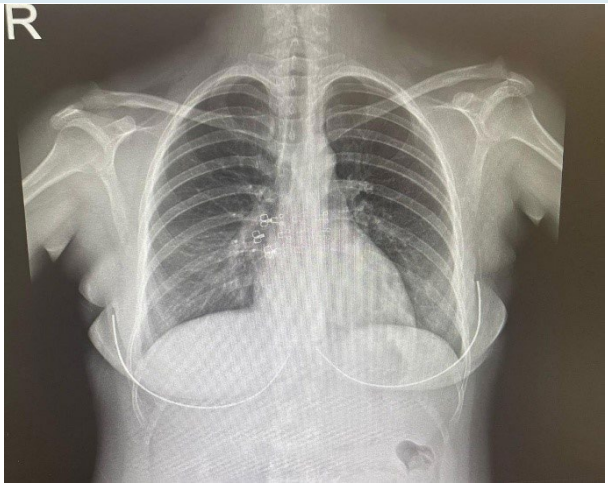


Figure-2



Results and Conclusion: On the seventh day, chest radiography revealed regression of pulmonary edema, bedside ultrasound demonstrated an increase in ejection fraction and regression of the left ventricle wall contractile defect, and symptoms were no longer present. This case underscores the efficacy of expeditious clinical diagnosis and BOARD therapy in the management of PPCM.
Keywords: Peripartum cardiomyopathy, bromocriptine, BOARD protocol

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Ref No: 8843
Behind the curtain: the dark side of embolic obstruction
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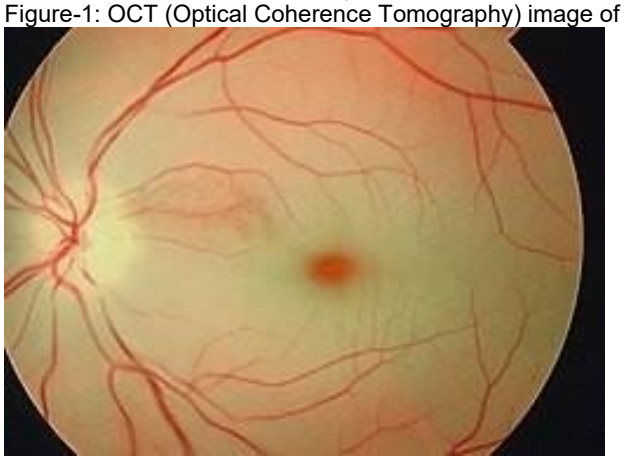
Introduction and Purpose: Central retinal artery occlusion(CRAO) is a serious condition that develops because of occlusion of the retinal artery after it exits the optic nerve, causing sudden and painless vision loss. The most common cause is thrombus due to atherosclerosis, and risk factors such as hypertension and diabetes predispose to the development of the disease. Embolic causes are also common, and emboli originating from the carotid, cardiac, or aorta can lead to occlusion. Inflammatory diseases, thrombophilic disorders, infections, and pharmacological agents are also among the risk factors. Since retinal damage becomes irreversible over time, early intervention is of critical importance. It is recommended to start treatment within the first 24-48 hours.
Materials and Methods: A 56-year-old male patient noticed vision loss in the center of his left eye when he woke up in the morning. Severe vision loss was detected in the emergency department examination. Many tests were performed, including hemogram, biochemistry, CRP, sedimentation, cardiac enzymes, and brain-carotid CT angiography. Intravenous mannitol and ocular massage were applied to reduce the intraocular pressure. Hyperbaric oxygen(HO) was planned and he was admitted to the ophthalmology department. Cherry red spot and retinal edema were detected in the left macula during the examination. Coronary artery disease could not be excluded in the cardiological examinations. The patient received 12 sessions of HO over 12 days. After the treatment, it was stated that the vision loss did not completely improve, but decreased by 30%.
Figure-1: OCT (Optical Coherence Tomography) image of the patient



Results and Conclusion: CRAO is a serious vascular event that requires urgent intervention and often leads to permanent vision loss. Despite early diagnosis and aggressive treatment, the prognosis is generally poor. Patients with retinal embolism are at a high risk of cardiovascular disease and systemic evaluation must be performed. A multidisciplinary approach is of great importance to prevent vision loss and improve the quality of life of patients.
Keywords: Ischemia, Retinal Artery, Visual Loss

Ref No: 8903

Endoskopik Bir Kabus: Özefagus Rüptürü ve Cilt Altı Amfizem

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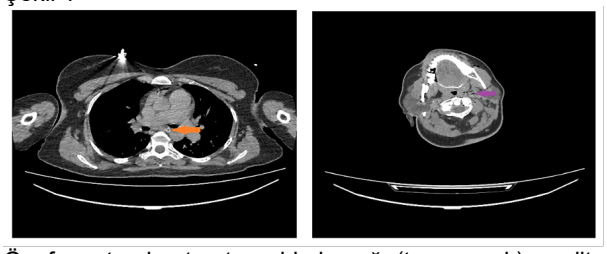
Introduction and Purpose: Endoskopik işlemler sonrası ortaya çıkan özefagus rüptürleri nadir, ancak ciddi komplikasyonlardır. Bu durum, erken tanı ve tedavi gerektiren bir acil durumdur. Özefagus rüptürü, karın ağrısı, hipotansiyon, taşikardi ve cilt altı amfizem gibi bulgularla kendini gösterebilir.

Materials and Methods: 41 yaşında bir kadın hasta, gastrik ülser ön tanısıyla endoskopi planlanan hasta endoskopi sonrası başlayan şiddetli karın ağrısı, düşük tansiyon (60/30 mmHg), taşikardi (115 atım/dakika) ve takipne ile acil servise başvurmuştur. Çekilen bilgisayarlı tomografi (BT) ile özefagus rüptürü ve boyunda cilt altı amfizem tespit edilmiştir. Multidisipliner yaklaşımla hastaya göğüs cerrahisi, genel cerrahi ve gastroenteroloji konsültasyonları alınarak tedavi başlatılmıştır. Hemodinamik durumu stabilize edildikten sonra takip ve tedavi amacıyla dış merkeze sevki gerçekleştirilmiştir. Hastanın ilk acil başvurusunda anstabil olması ve kliniğinin riskli olması nedeniyle dış merkezde cerrahi planlanmış olup rüptüre olan bölge primer tamir edilmiştir. Takiplerinde hemodinamisi stabil seyreden hasta yoğun bakım takibi sonrası göğüs cerrahisi servisine devir edilmiş ve sonrasında komplikasyonsuz şekilde taburcu edilmiştir.

Şekil 1



Özefagustan kontrast madde kaçağı (turuncu ok) ve cilt altı amfizem (mor ok)

Results and Conclusion: Özefagus rüptürü, endoskopik işlemler sonrası nadiren karşılaşılan bir komplikasyon olup, erken müdahale edilmezse ölümcül sonuçlar doğurabilir. Cilt altı amfizem, özefagus perforasyonunun belirgin bir belirtisi olup, tanının konmasına yardımcı olur. Tedavide cerrahi müdahale ve multispidisipliner yaklaşım kritik öneme sahiptir. Bu vaka, multidisipliner tedavi ve hızlı müdahalenin hastaların sağkalımını nasıl artırabileceğini göstermektedir.Özefagus rüptürü, endoskopi sonrası nadir görülen ancak acil müdahale gerektiren bir komplikasyondur. Cilt altı amfizem tanıyı destekleyen önemli bir bulgu olup, tedavi sürecine yön verir. Multidisipliner yaklaşım, tedavi sürecinde kritik öneme sahiptir.

Keywords: Özefagus rüptürü, cilt altı amfizem, multidisipliner

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Ref No: 8904

Pulmonary Embolism

Sümeyye Gündüz Sağır[1], Ali Gür[1]

[1]Atatürk Üniversitesi

Introduction and Purpose: Pulmonary embolism (PE) is the blockage of the pulmonary artery or its branches by material originating from another part of the body. It is commonly caused by deep venous thrombosis (DVT) of the lower extremities. Generally, it is more common in men, but in women, the risk increases with age. Risk factors include both hereditary and acquired factors (such as recent surgery, immobilization, hormone therapy, active cancer, etc.). In this study, we aim to present a 42-year-old male patient with pulmonary thromboembolism who presented with complaints of right-sided chest pain.

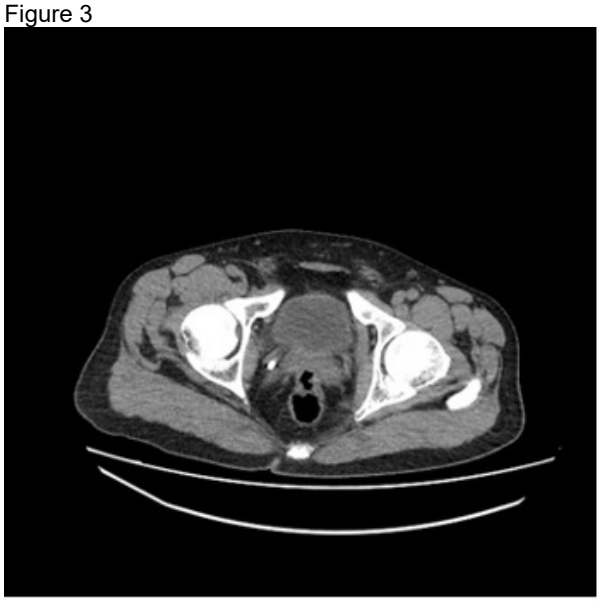
Materials and Methods: A 42-year-old male patient presented to the Emergency Department with complaints of right-sided chest pain. His general condition was moderate, with an alert and cooperative mental state, a blood pressure of 125/75 mmHg, heart rate of 90 bpm, temperature of 36.1°C, and oxygen saturation of 97%. The patient had no known past medical history. Physical examination revealed a non-tender abdomen with no rebound tenderness, but positive right costovertebral angle tenderness. Lung auscultation was normal. No temperature or circumference differences were observed in the legs, and the Homans sign was negative. A peripheral intravenous line was established, and blood and urine tests were requested. The urine analysis showed 2 positive erythrocytes, and a non-contrast abdominal CT was performed, revealing a 4mm stone in the distal right ureter. Additionally, a pulmonary infiltrate (possibly an infarct?) was observed in the right lower lobe of the lung. A contrast-enhanced chest CT angiography was performed with a diagnosis of pulmonary embolism (PE), which showed an embolus in the right subsegmental lower branch and an infiltrate in the right lower lobe (possibly an infarct?) (Figures 1-2-3). The patient was consulted to the Pulmonology Department and was admitted for treatment.

Results and Conclusion: Pulmonary embolisms (PE) are typically multiple, and the lower lobes are affected in most cases. When the thrombus lodges in the lungs, a series of pathophysiological responses, such as infarction, abnormal gas exchange, and cardiovascular dysfunction, may occur. As a result, patients may present with chest pain alone in the Emergency Department. In patients presenting with chest pain, PE should always be considered in the differential diagnosis

Figure 1

Figure 2

Figure 3



Keywords: Chest Pain, Pulmonary Embolism

Ref No: 8915

Evaluation of systemic inflammation indices in the diagnosis of acute appendicitis

Abdullah Talha Demirel[1], Bayram Yıldırım[1], Mehmet Çelik[1], Anıl Çakıcı[1], Murat Balkaya[1], Serhat Örün[1]

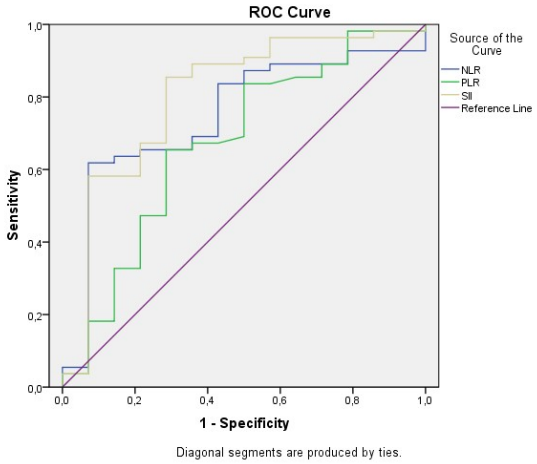
[1]Tekirdağ Namık Kemal University

Introduction and Purpose: Acute appendicitis (AA) is one of the most common surgical emergencies in the emergency department. Timely diagnosis is crucial to prevent complications such as perforation, peritonitis, and sepsis. In addition to clinical examination and imaging, laboratory markers play a significant role in diagnosis. Systemic inflammation indices, including the neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR), and systemic immune-inflammation index (SII), have gained attention as potential biomarkers for AA. This study aims to evaluate the diagnostic efficacy of these inflammatory indices in patients diagnosed with AA.

Materials and Methods: This retrospective study included 69 patients diagnosed with AA at [Institution Name] between January 1, 2023, and January 1, 2024. The inclusion criteria were age between 18-80 years, confirmation of AA diagnosis via computed tomography (CT), and available laboratory data. Exclusion criteria included incomplete patient records and a history of familial Mediterranean fever (FMF). Data regarding NLR, PLR, SII, and Alvarado scores were collected and analyzed. Receiver Operating Characteristic (ROC) curve analysis was performed to assess the diagnostic accuracy of these indices. A p-value of <0.05 was considered statistically significant.

Results and Conclusion: Among the 69 patients, 53.6% were female (n=37), and 46.4% were male (n=32), with a mean age of 41.25±17.46 years. The mean NLR, PLR, and SII values were 5.89±5.71, 162.27±103.24, and 11131±1543, respectively. ROC analysis revealed that SII had the highest diagnostic accuracy (AUC: 0.80, p<0.001), followed by NLR (AUC: 0.81, p=0.004) and PLR (AUC: 0.65, p=0.05). Patients with higher Alvarado scores had significantly elevated NLR and SII values, suggesting a strong correlation between these markers and disease severity. This study demonstrates that SII and NLR are valuable biomarkers in the diagnosis of AA, with SII exhibiting the highest diagnostic performance. These indices may aid in early diagnosis, reducing the need for unnecessary imaging and expediting treatment decisions. However, further multicenter prospective studies are required to validate these findings.

ROC analysis



Keywords: Acute appendicitis, systemic inflammation index, diagnostic accuracy

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Ref No: 8920

Evaluation of the Predictive and Distinctive Value of MAPH Score in Ischemic Stroke

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[1]Department of Emergency Medicine, Faculty of Medicine, Karabuk University

Introduction and Purpose: Stroke is one of the leading causes of morbidity and mortality worldwide. Early identification of ischemic stroke and its severity is crucial for initiating appropriate therapeutic interventions and predicting prognosis. The MAPH score, encompassing Mean Platelet Volume (MPV), Age, Total Protein, and Hematocrit, has been proposed as a potential predictive tool in ischemic stroke. This study aims to evaluate the effectiveness of the MAPH score in differentiating ischemic stroke from non-stroke individuals and its association with in-hospital mortality, length of stay, and stroke localization.

Materials and Methods: A retrospective observational study was conducted with patients admitted to a tertiary care hospital. Patients who presented to the ED with symptoms considered to be neurological in origin and therefore underwent diffusion MRI were included. Demographic data, comorbidities, laboratory findings, and clinical outcomes such as in-hospital mortality and length of stay were recorded. The MAPH score was calculated for each patient. Descriptive statistics, Mann-Whitney U test, independent samples t-test, ROC analysis, and Kruskal-Wallis tests were used for analysis. Statistical significance was set at p<0.05.

Results and Conclusion: 646 participants were categorized into ischemic stroke (n=435) and normal (n=211) groups. 52.6% were male and 47.4% were female. The prevalence of hypertension, diabetes, and cardiac history was 63.9%, 34.5%, and 33.3%, respectively. The mean MAPH score was significantly higher in the ischemic stroke group (2.31 ± 0.91) compared to the normal group (1.84 ± 0.87) (t=6.30, p<0.001).ROC analysis indicated an AUC of 0.638 (p<0.001) for the MAPH score in distinguishing ischemic stroke patients, with an optimal cut-off value of 2, yielding 53.79% sensitivity and 63.03% specificity. In-hospital mortality was 3.9%. Patients with higher MAPH scores showed a trend toward longer hospital stays. No statistically significant difference was found in MAPH scores between

stroke subtypes. Logistic regression revealed that age was a significant independent predictor of ischemic stroke (OR = 1.055, p < .001), while other MAPH components were not statistically significant in multivariate analysis. MAPH score demonstrates a statistically significant, yet clinically moderate, ability to distinguish ischemic stroke patients from non-stroke individuals. Nevertheless, it may serve as a supportive marker in initial clinical evaluation, particularly when combined with other diagnostic tools.
Keywords: maph score, stroke, ischemic

Ref No: 8953
The importance of evaluating pediatric imaging with medical history in the emergency department: The pitfall diagnosis of a healing cephalic hematoma with calcification
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[2]City Hospital, Konya, Türkiye
Introduction and Purpose: Subperiosteal hemorrhages resulting from injury to the vascular structures located between the cranium and the periosteum are termed cephalhematomas (CH). Calcification may impede the healing of CH. Surgical intervention may be necessary for cosmetic reasons for the calcified area that shows no improvement after one year of age. This condition, typically diagnosed sporadically, becomes perplexing when linked to a secondary trauma. Our objective was to highlight this condition in pediatric patients presenting to the emergency department (ED), underscore the significance of medical history during radiologic assessment, and share our experiences in imaging calcified congenital hyperplasia (CH).
Materials and Methods: A 2-year-old male patient was assessed in the emergency department following trauma. The patient presented to the emergency department with increased crying and restlessness following a fall from the couch at home. The preliminary assessment indicated edema and contusion in the right frontal area. The patient exhibited clear consciousness, orientation, and cooperation; her overall condition was satisfactory, demonstrating mobility, activity, and engagement with her environment. It was reported that he experienced a single episode of vomiting. A suspicious region was noted on direct radiography conducted in the emergency department, prompting the ordering of a brain CT (Figure 1). Despite the absence of bone fractures, intracranial hemorrhage, or other pathologies, a lesion was observed external to the base of the brain (Figure 2). Upon inquiring about the patient's medical history regarding the condition that did not align with her complaints, it was revealed that she experienced a challenging delivery and related CH. The structure depicted in the images was identified as a CH that underwent healing through calcification. The patient was discharged with a head trauma documentation and recommendations following appropriate observation in the emergency department.
Figure 1 Head Direct Radiograph Images of the Patient

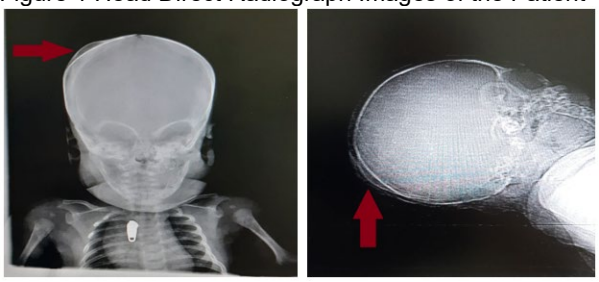
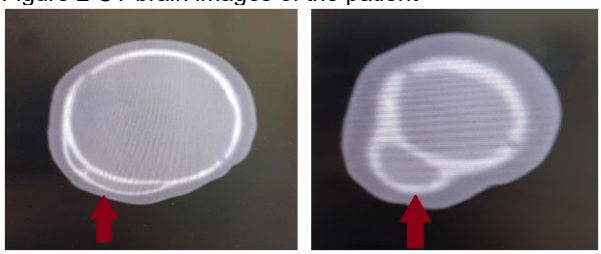


Figure 2 CT brain images of the patient



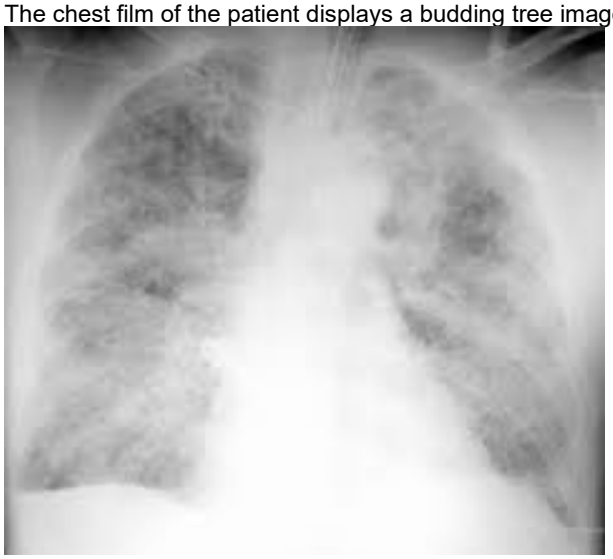
Results and Conclusion: Given that a comprehensive initial history of this case could have diminished the necessity for brain CT scans and X-ray exposure, it is crucial to inquire about the history of pediatric trauma patients, encompassing birth and prenatal periods, and to conduct radiologic assessments informed by this data.
Keywords: Calcification, Diagnostic X-Ray, Head Trauma

Ref No: 8977
SUDDEN RESPIRATORY DISTRESS ACUTE RESPIRATORY DISTRESS SYNDROME
DR. AYKUT ADIGÜZEL[1], DOÇ. DR. ERDAL TEKİN[1]
[1]ERZURUM ATATURK UNIVERSITY EMERGENCY MEDICINE DEPARTMENT
Introduction and Purpose: 38-year-old male patient with no known disease presented to us with the complaint of shortness of breath for one week. The patient had been examined by a family physician four days ago and a prescription was issued. He was admitted to our hospital with increasing shortness of breath. The general condition of the patient was moderate, with a saturation of 74%, pulse of 132, blood pressure arterial of 136/78 mmHg, and temperature of The patient's temperature was 39.4°C. A physical examination revealed bilateral diffuse rales and bilateral +2 pretibial oedema. A budded tree image was present on the chest radiograph (Figure 1).

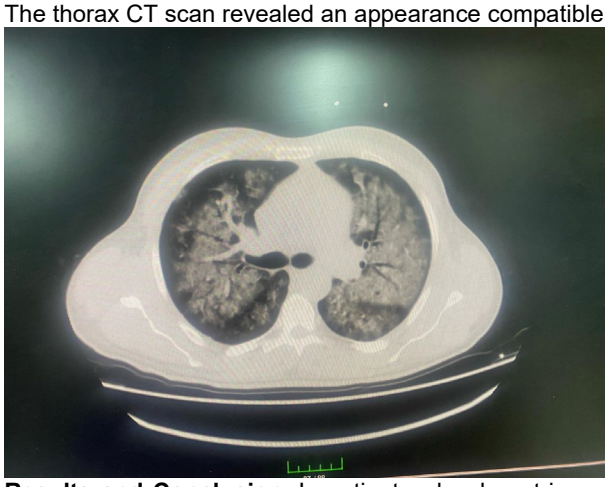
Blood tests revealed hypoxic respiratory failure, with a potassium value of 8.1 and a creatinine value of 12.34. A computed tomography (CT) scan showed an image compatible with acute respiratory distress syndrome (ARDS) (Figure 2). The patient was referred to the department of cardiology for further assessment and treatment. Following this, the patient was admitted to hospital for further management by the relevant medical team. Hyperkalaemia treatment was initiated and the patient was subsequently referred to the departments of internal medicine and pulmonology for further management. Finally, the patient was admitted to hospital for further treatment of his chest disease.

Materials and Methods: The chest filmThe thorax CT

The chest film of the patient displays a budding tree image.



The thorax CT scan revealed an appearance compatible with acute respiratory distress syndrome (ARDS).



Results and Conclusion: In patients who do not improve despite the use of medication, further investigations and imaging should be performed.

Keywords: ARDS

Ref No: 9013

An Observational Study Evaluating Complete Blood Count and CRP in Predicting Complicated Appendicitis

Akın Seçkin[1], Mustafa Köksal[1], Bahri Oğulcan Tabak[1], Ensar Olçay[1], Beşir Çaylı[1], Nurbanu Akdoğan[1], Bora Çekmen[1]

[1]1. Department of Emergency Medicine, Karabük University School of Medicine, Karabük, Turkey.

Introduction and Purpose: Acute appendicitis is an urgent condition requires surgical intervention, and timely detection of perforation can directly affect patient prognosis. Therefore, a rapid and reliable testing method is needed to predict perforation. This study aims to evaluate the effectiveness of various blood tests in predicting appendiceal perforation in patients diagnosed with acute appendicitis.

Materials and Methods: The study included patients diagnosed with acute appendicitis at Karabük Training and Research Hospital in 2024. Cases with perforation (complicated) and those without perforation (simple) were evaluated in two groups. The success of predicting perforation was analyzed based on CRP, cell counts in the complete blood count, and the ratios of neutrophil-lymphocyte (NLR), monocyte-lymphocyte (MLR), and immature granulocyte-lymphocyte (ILR) counts.

Results and Conclusion: Among the 86 cases included in the study, 37.2% were male, and the median age was 25 [IQR: 15-43] years. Vomiting was significantly less common in the complicated group (p: 0.031). While the white blood cell count, neutrophil, lymphocyte, and monocyte counts differed between the groups ($p<0.05$), no difference was found in the immature granulocyte count (p: 0.828). NLR,

MLR, and CRP levels were higher in the complicated group ($p<0.05$). ILR levels did not differ between the groups. In regression analysis, a high white blood cell count and neutrophil count were not predictors of perforation (p: 0.198, p: 0.079, respectively) (Table 1). Among the variables, CRP had the most reasonable discriminatory value, with an AUC = 0.83 (0.69-0.97; 96% CI; $p<0.001$), and a cut-off value of 131.5 mg/L (sensitivity: 48%, specificity: 99%).This study found a significant relationship between CRP and white blood cell count with the perforation of acute appendicitis cases. The study was conducted on a limited number of patients, and more comprehensive research is needed to ensure the reliability and generalizability of the results.

Table 1. Laboratory Parameters

	Total (n:86)	Groups		P
		Complicated Appendicitis(n:15)	Simple Appendicitis (n:71)	
WBC	13.21±5.09	16.05±5.30	12.60±4.87	**0.016^{S}**
Hb	13.15±1.80	12.56±2.09	13.27±1.72	0.165^{S}
Neu (n/nL)	10.43±4.90	13.65±5.23	9.75±4.58	**0.004^{S}**
Neu %	77.6 [69.85-84.58]	84.2 [78.5-87.8]	76.2 [67.9-83.6]	**0.002^{M}**
Lym (n/nL)	1.65 [1.1-2.5]	1.2 [1.1-1.5]	1.8 [1.2-2.7]	**0.039^{M}**
Lym %	14.25 [8.48-22.05]	9.4 [6.3-13.8]	15.8 [9.2-24.2]	**0.003^{M}**
Mono (n/nL)	0.71 [048-0.94]	0.84 [0.74-0.98]	0.65 [0.42-0.91]	**0.032^{M}**
Img (n/nL)	0.05 [0.03-0.14]	0.06 [0.02-0.09]	0.04 [0.03-0.14]	0.828^{M}
Img %	0.4 [0.20-0.93]	0.3 [0.2-0.8]	0.4 [0.2-1.0]	0.410^{M}
NLR (n/n)	5.43 [3.22-10.11]	9.33 [6.13-14.75]	4.75 [2.95-9.60]	**0.002^{M}**
NLR (%/%)	5.37 [3.19-9.93]	8.96 [5.81-14.19]	4.70 [2.88-9.34]	**0.003^{M}**
MLR (n/n)	0.41 [0.26-0.63]	0.70 [0.51-0.94]	0.37 [0.23-0.55]	**0.001^{M}**
ILR (n/n)	0.29 [0.016-0.088]	0.038 [0.020-0.099]	0.026 [0.014-0.086]	0.280^{M}
ILR (%/%)	0.03 [0.02-0.083]	0.04 [0.02-0.08]	0.03 [0.01-0.09]	0.309^{M}
CRP (mg/L)	20.35 [3.35-62.45]	120.7 [30.0-300.0]	14.0 [3.0-39.3]	**<0.01^{M}**

^{M}: Mann Whitney U Test; ^{S}:Student T Test

Keywords: acute appendicitis, complete blood count, C-reactive protein

Ref No: 9036

Isolated Cerebral Fat Embolism Following Femoral Shaft Fracture: A Case Report

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[1]Kahramanmaraş Sütçü İmam University Faculty of Medicine, Department of Anesthesiology and Reanimation

[2]Niğde Ömer Halisdemir Training and Research Hospital, Emergency Department

Introduction and Purpose: Fat embolism syndrome typically manifests within 24 hours of trauma and is defined by the triad of cerebral dysfunction, petechial rash, and respiratory failure. Isolated cerebral fat embolism is a rare clinical entity where embolic fat enters the systemic circulation, affecting the central nervous system without significant pulmonary involvement. MRI is the most sensitive imaging modality for diagnosis due to the variability of neurological presentations.

Materials and Methods: A 27-year-old male was brought to the emergency department after a pedestrian traffic accident. On arrival, vital signs were stable (HR: 68 bpm, BP: 130/70 mmHg, SpO □ 99%), and he was alert, oriented, and cooperative. No cranial trauma was noted. Systemic examination was normal. A left femoral shaft fracture was diagnosed, and a long leg splint was applied.Two hours into observation, the patient developed sudden confusion and generalized tonic-clonic seizures. He was administered 4 L/min oxygen and 2 mg IV midazolam, terminating the seizure. Arterial blood gas showed mild acidosis (pH 7.32), with SpO □at 95%. Brain and thorax CT scans were unremarkable. Diffusion-weighted MRI revealed bilateral diffusion restriction in the basal ganglia, occipital, and parietal lobes—indicative of cerebral fat embolism.Neurologically, the patient lacked visual, auditory, and verbal responses. Light reflexes were present, while corneal and gag reflexes were absent. He exhibited aphasia and right-sided decerebrate posturing to pain. He was treated with prednisolone, mannitol, phenytoin, and low molecular weight heparin, and transferred to the ICU for further management.

Results and Conclusion: Isolated cerebral fat embolism is a rare manifestation of FES, typically seen following long bone fractures. Diagnosis is primarily clinical but supported by characteristic MRI findings multiple small hyperintense lesions in a 'starfield' pattern. In this case, rapid neurological deterioration prompted imaging despite a normal CT, underscoring the role of MRI. Early recognition and supportive treatment may improve outcomes, though prognosis remains guarded in severe cases. Clinicians should maintain a high index of suspicion for cerebral fat embolism in trauma patients presenting with sudden neurological symptoms. MRI is invaluable for early diagnosis, and immediate multidisciplinary management is essential for optimal outcomes. Our case was discharged with full recovery one week later after supportive treatment.

Keywords: Fat embolism syndrome, cerebral embolism, long bone fracture

Ref No: 9042

Bibliometric analysis of articles in emergency medicine for 2022-2024, Research Trends and Global Collaboration

SEFA YURTBAY[1], YUSUF KENAN TEKİN[1], ŞİMŞEK ÇELİK[1], İSMAİL KIVANÇ CEBECİOĞLU[1], İLHAN KORKMAZ[1]

[1]Sivas Cumhuriyet University, Faculty of Medicine

Introduction and Purpose: Emergency medicine has a dynamic and rapidly developing position in the field of health. Therefore, the analysis of research conducted in this field is important in terms of determining research trends and future studies. In this context, a bibliometric analysis study covering the last three years is of great importance in terms of determining current trends, research gaps and future research needs in the existing literature.

Materials and Methods: The Scopus database was used for this study. The literature on “emergency medicine” was queried in Scopus and it was found that there were 96436 data. When the publication period of the literature was limited to 2022-2024, 15763 studies were identified. Then, 5410 data were included in the study by limiting them as ‘’medicine, article, English, journal and open access’’. Analyses were performed using R application and VOSviewer software.

Results and Conclusion: Data were obtained from 1409 different sources. Academic publications have a growth rate of -13.27% from year to year (Figure 1).The number of articles, which was 2042 in 2022, decreased to 1536 in 2024 (Figure 2).BMJ Open (453 articles) is by far the source with the most articles published (table 1).Figure 3 shows the countries with the highest number of publications in the field of "Emergency medicine". In Figure 4, the keywords “Overlay visualization” are colored differently according to the publication year using the VOSviewer software.Bibliometric analysis of research in the field of “emergency medicine” between 2022-2024 reveals important findings and trends in this field. Citation rates of articles published in 2024 are low. An average citation rate of 4.66 is quite good considering the average publication age of 2.09 and can be considered an indicator of interest in the field. Studies focused on age groups (elderly and middle-aged) and made a distinction between male and female participants. Overall, the shift from clinical and experimental research to a research agenda that encompasses AI and public health perspectives demonstrates the field’s sensitivity to changing healthcare needs. In the future, global equity, increased multidisciplinary work, and prioritizing the integration of AI technologies into emergency services will contribute to improved outcomes in emergency medicine research.

Figure 1

Figure 1: Main information

Figure 2

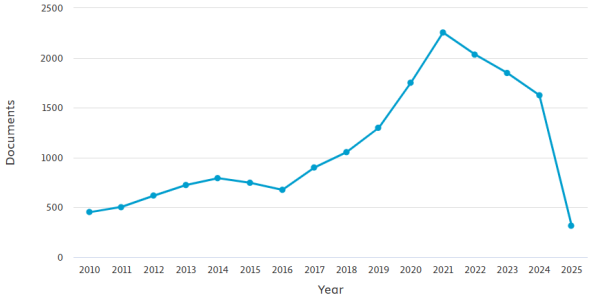


Figure 2: Number of publications by year

Figure 3

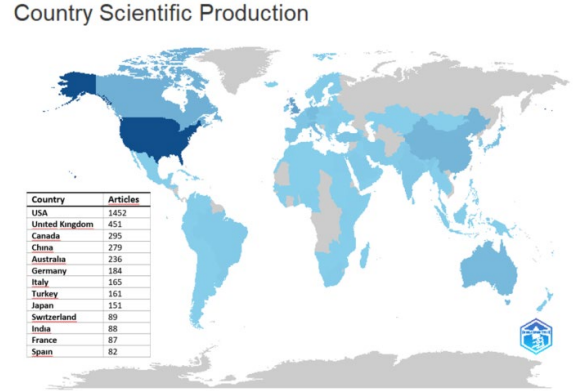


Figure 3: Country scientific production
Figure 4

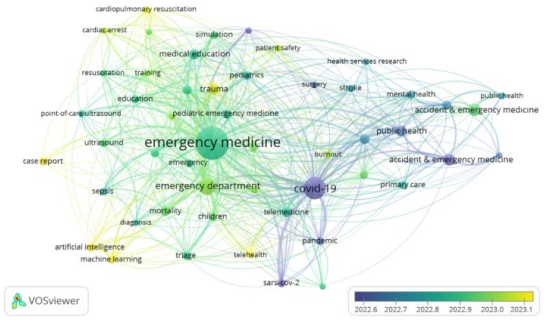


Figure 4:Keyword timeline
Tablo 1:The most published journals for emergency medicine

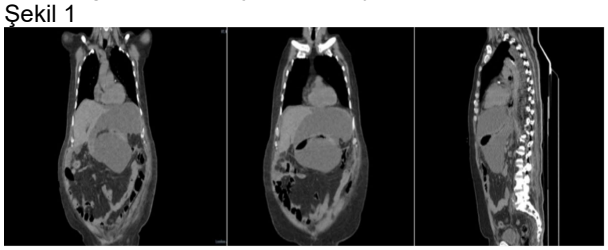
Sources	Articles
BMJ Open	453
AEM Educatıon and Traınıng	143
Western Journal of Emergency Medıcıne	113
BMJ Case Reports	91
JACEP Open	85
BMC Emergency Medıcıne	82
Journal of Clınıcal Medıcıne	69
Internatıonal Journal of Envıronmental Research and Publıc Health	68
BMC Health Servıces Research	59
Internatıonal Journal of Emergency Medıcıne	59

Tablo 1:The most published journals for emergency medicine
Keywords: emergency medicine, bibliometric analysis, biblioshiny

Ref No: 9071
Gastrik Kompresyona Bağlı Oral Alım Bozukluğu İle Seyreden Pankreas Psödokisti: Olgu Sunumu
Fatma Sontay[1], İsmail Ataş[1], Gökhan Ersunan[1], Özlem Bilir[1]
[1]Recep Tayyip Erdoğan Üniversitesi Tıp Fakültesi Eğitim Araştırma Hastanesi Acil Tıp Anabilim Dalı, Rize, Türkiye
Introduction and Purpose: Pankreasın psödokisti, amilaz ve diğer pankreas enzimleri açısından zengin, epitel ile kaplı olmayan fibröz doku ile çevrili lokalize bir sıvı koleksiyonudur. En yaygın nedenler akut veya kronik pankreatit, safra kesesi taşları, alkol kullanımı ve travmadır. Çoğunlukla karın ağrısı, bulantı, kusma, kilo kaybı, iştahsızlık ve bazen sarılık gibi şikayetlerle kendini gösterir. Pankreas psödokistlerinin tanısı, klinik semptomlar ve görüntüleme yöntemlerinin birleşimiyle konur. Asemptomatik kistlere semptom vermediği sürece ve büyüklüğünde bir artış olmadıkça konservatif yaklaşılır. Drenaj için ana endikasyon; enfeksiyon, kanama, mide veya duodenuma bası sonucu mide çıkış obstrüksiyonu ve biliyer obstrüksiyon gibi komplikasyonların varlığıdır. Burada biliyer pankreatit öyküsü olan, oral alım bozukluğu ile acil servise baş vuran ve bilgisayarlı tomografi (BT) ile pankreas psödokisti tanısı konulan 75 yaşındaki bir erkek hasta anlatılacaktır.
Materials and Methods: 75 yaşında erkek hasta bulantı, kusma ve oral alım bozukluğu ile acil servise baş vurdu. Batın distandü, palpasyonda üst kadranlarda hassasiyeti mevcut. BT'de mide komşuluğunda perisplenik alana kadar uzanan loküle mayi görünümü

saptandı. Büyük kurvatür üzerinde 11cm, küçük kurvatür altında ise 7cm boyutunda pankreas psödokisti olarak değerlendirildi. Gastroenteroloji ve girişimsel radyoloji konsültasyonu istendi. Girişimsel radyoloji tarafından perkütan kist drenajı yapıldı. Hasta işlem sonrası gastroenteroloji servisine yatırıldı.

Şekil 1



BT koronal ve sagittal kesitlerde mideye kompresyon yapan pankreas psödokisti

Results and Conclusion: Pankreatik psödokistlerin en yaygın nedeni pankreatittir ve özellikle akut ya da kronik formdaki pankreatit ataklarıdır. Dev psödokistlerin birçok komplikasyonu görülebilir. Psödokist içine masif kanama, dalak enfarktüsü ile birlikte sepsis , splenik ven trombozu, kist rüptürü ile gastrointestinal kanama ve peritonit, pankreas başı bölgesinde büyük bir kistin ortak safra kanalını tıkaması ile obstrüktif sarılık, kistin splenik vene veya portal vene basısı ile portal hipertansiyon bu komplikasyonlardandır. Karın ağrısı, bulantı, kusma ve oral alım bozukluğu olan hastalar akut dönemde sıklıkla acil servise baş vurduğundan erken tanı ve komplikasyonların önlenmesinde acil servisin rolü önemlidir. Özellikle bizim hastamızda olduğu gibi pankreatit öyküsü olan hastalarda pankreas enzimlerinde yükselme olmasa da semptomların sebat etmesi durumunda pankreas psödokistleri ayırıcı tanıda göz önünde bulundurulmalıdır.Bilinen pankreatit öyküsü olan hastalar gastroistestinal obstrüksiyon bulguları ve oral alım bozukluğu ile baş vurduğunda gecikmeden abdominal tomografi çekilmesi hızlı bir şekilde tanı koyulup komplikasyonlar gelişmeden tedavinin başlatılması açısından faydalı bir yaklaşım olacaktır.

Keywords: Pankreas psödokisti, kist drenajı, girişimsel radyoloji

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Ref No: 9094

New diagnosis multiple sclerosis

Hasan Gazi Uyar[1], Gökhan Yılmaz[1], Havva Serin Yiğit[1]

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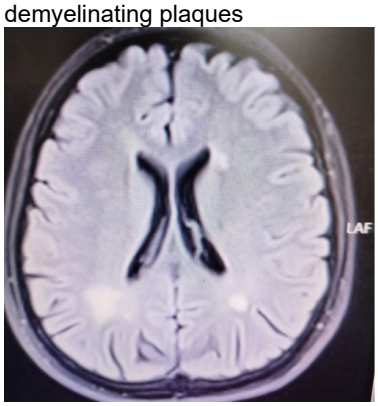
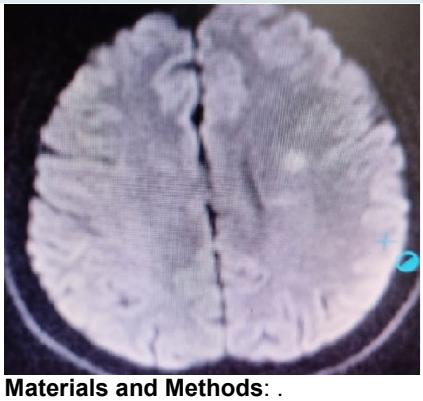
Introduction and Purpose: Case: A 29-year-old female patient applied to the emergency room with complaints of numbness and tingling in the left half of her face for 2 days. When she arrived, her vital signs were stable, but her medical history was unremarkable. In the neurological examination, there was no loss of muscle strength. All cranial nerve examinations were normal. Brain CT and Diffusion MRI were performed to rule out central causes. In the diffusion MRI, areas with no ADC response showing faint diffusion restriction in the neighborhood of the bilateral lateral ventricles were observed, and it was called multiple sclerosis (?). The patient underwent contrast-enhanced brain MRI upon the recommendation of the neurologist. The MRI report showed T2-FLAIR hyperintense foci consistent with MS plaques located perpendicular to the bilateral lateral ventricles. No pathological staining was observed in the contrast-enhanced examination. It was interpreted as an inactive plaque. The patient was admitted to the neurologist.

demyelinating plaques



demyelinating plaques



Materials and Methods: .
Results and Conclusion: Discussion: Multiple Sclerosis (MS) is an autoimmune central nervous system disease characterized by inflammation, demyelination and axonal damage.It is seen 2-3 times more frequently in women than men and is diagnosed at an average age of 28-31.Demyelinating plaques can be seen in many areas such as the brain, brainstem and spinal cord. Depending on the location of the involvement, the patient's symptoms can vary in a wide range. In the physical examination of the patients; widespread weakness, hyperreflexia, clonus, positive Babinski test, increased tone, decreased joint proprioception and pain and temperature sensations can be seen. Most patients experience symptoms such as blurred vision, impaired color vision and eye pain at some point during the disease. In the early stages of the disease, almost complete recovery after acute exacerbation is more common than in later years.MS is largely diagnosed clinically. MS is a chronic, relapsing autoimmune disease that causes neurological disability. As physicians working in emergency departments, which are clinics frequently visited by patients who have not yet been diagnosed or who are experiencing relapses, it is important for us to keep our threshold for suspecting MS low so that patients can receive early diagnosis and treatment.
Keywords: facial numbness, multiple sclerosis, demyelinating plaques

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Ref No: 9133
Aneurysm rupture
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[1]Atatürk University
Introduction and Purpose: Aneurysm rupture is a challenging diagnosis when no prior aneurysm diagnosis exists. Aneurysm ruptures can occur in various locations and are life-threatening conditions.
Materials and Methods: A 58-year-old female patient presented to our emergency department with complaints of fainting and left-sided flank pain. She reported a history of similar recurrent visits to the emergency department with these complaints, as well as a history of nephrolithiasis. The patient had a known diagnosis of hypertension, for which she was taking an ACE inhibitor. On physical examination, the abdomen was soft, and there was left costovertebral angle tenderness. Vital signs were stable, and urinalysis revealed minimal hematuria. Creatinine, BUN, liver function tests, and white blood cell count were within normal limits, and there were no abnormalities in gas or stool output. Blood gas analysis showed a lactate level of 4.3, with no other significant findings. A spiral CT was requested for central imaging and to confirm possible nephrolithiasis. Despite the administration of opioid analgesia for the patient's agitation, there was no relief. The central imaging did not show any significant findings, but the spiral CT scan did not reveal any stones. However, there were findings consistent with an aneurysm or possible aneurysm rupture, prompting a contrast-enhanced CT. The patient was diagnosed with a ruptured abdominal aortic aneurysm at the renal level, and an urgent consultation was made with the Cardiovascular Surgery team, after which the patient was taken to surgery.
Results and Conclusion: In patients with severe kidney pain, unrelieved pain, and elevated lactate levels in blood gas, aneurysm rupture should be considered as a possible diagnosis.
Keywords: Aneurysm rupture, Flank pain

Ref No: 9139
Concurrent Submassive Pulmonary Embolism and Suspected Infective Endocarditis: A Diagnostic Challenge in a High-Risk Patient with Disability
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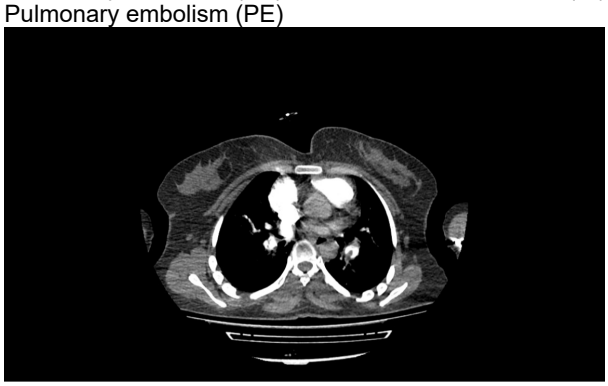
[1]Kırşehir Training and Research Hospital
[2]The Scientific and Technological Research Council of Türkiye (TÜBİTAK)
Introduction and Purpose: Introduction: Pulmonary embolism (PE) and infective endocarditis (IE) are life-threatening conditions with significant morbidity and mortality. PE often arises in patients with immobility or hypercoagulable states, while IE may result in complications such as septic emboli. Though rare, these two conditions can coexist, particularly when septic emboli originate from right-sided valve vegetations. Early diagnosis and a multidisciplinary approach are crucial in such complex cases.
Materials and Methods: Case: A 42-year-old bedridden woman with intellectual disability presented with dyspnea and abdominal pain. On admission, she was hypotensive, tachycardic, febrile, and hypoxic. Laboratory tests showed elevated troponin, D-dimer, and

creatinine. ECG revealed T-wave inversions, and echocardiography showed right heart dilation and a tricuspid valve vegetation. Pulmonary CT angiography confirmed a submassive PE. She was diagnosed with submassive PE and suspected IE. Treatment with enoxaparin was initiated, and she was admitted to the ICU. She improved clinically and was discharged on day eight with follow-up instructions.

Pulmonary embolism (PE) and infective endocarditis (IE)

Pulmonary embolism (PE) and infective endocarditis (IE)

Pulmonary embolism (PE)



Pulmonary embolism (PE)

Results and Conclusion: Discussion: This case illustrates the challenge of diagnosing coexisting submassive PE and suspected IE. The patient's immobility likely contributed to thromboembolism, while tricuspid valve vegetation suggested right-sided IE. Although blood cultures were not available, echocardiography played a key role in detecting vegetation. Elevated biomarkers and imaging findings confirmed the dual pathology. The case highlights the importance of rapid imaging and multidisciplinary care, especially in high-risk, immobile patients. PE requires prompt anticoagulation, while IE demands antibiotic therapy once confirmed.Conclusion: This case underscores the clinical complexity of simultaneous PE and suspected IE in a high-risk patient. The overlapping symptoms—dyspnea, fever, and hemodynamic changes—necessitate early suspicion and multimodal imaging. Anticoagulation remains essential for PE, while IE management requires microbiological confirmation and targeted therapy. Interdisciplinary collaboration is critical for diagnosis and treatment. Further studies are needed to understand the prevalence and outcomes of coexisting PE and IE in vulnerable populations.

Keywords: "Pulmonary Embolism, Infective Endocarditis, Medical Imaging"

Ref No: 9140

Evaluation of Risk Factors Determining Early Mortality in Patients with Proximal Femur Fracture

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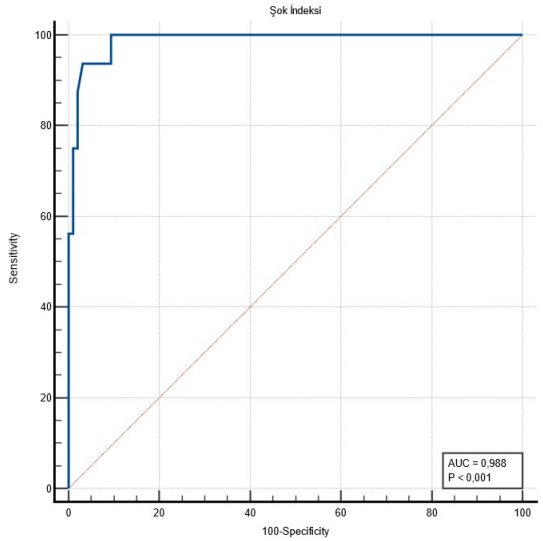
[2]Kayseri City Hospital
[3]Kayseri State Hospital

Introduction and Purpose: Our study aimed to determine early-term in-hospital mortality rates and identify risk factors associated with

mortality in patients diagnosed with proximal femur fractures in the emergency department (ED).
Materials and Methods: Our study was conducted prospectively on patients admitted to the trauma unit of the ED between November 1, 2022, and May 31, 2023, who had a proximal femur fracture detected by radiological examinations and whose diagnosis was confirmed by an orthopedic specialist.
Results and Conclusion: 112 patients with proximal femur fractures were included in our study. The average age of the patients was 79.6±12.3 years, and 59.8% (n=67) were women. The 28-day mortality rate for patients is 14.3% (n=16), in-hospital mortality is 11.6% (n=13), and out-of-hospital mortality is 2.7% (n=3) within the first 28 days. While 50% of the patients had an intertrochanteric fracture, 49.1% had a femoral neck fracture. Univariate analysis revealed significant differences in age, systolic and diastolic blood pressure, heart rate, respiratory rate, shock index, length of hospital stay, and ICU admission. In the multiple binary logistic regression analysis of these variables, heart rate and hospitalization duration were found to be statistically significant (p-values of 0.016 and 0.023, respectively). As the heart rate increased by one unit in the hospital, the risk of mortality increased by 1.24 times, while as the length of stay increased by one day, the risk of mortality increased by 1.65 times. When we examined the ROC analyses for predicting mortality, the shock index had the highest AUC value (AUC = 0.988, p <0.001). When the shock index was greater than 0.76, its sensitivity in predicting mortality was 100%, and its specificity was 90.6%. When we evaluated heart rate as a predictor of mortality, the AUC value was 0.975 and was statistically significant (p <0.001). When the heart rate was >99 beats/min, sensitivity was 100%, and specificity was 84.37%. Conclusion: In our study, elevated heart rate and prolonged hospital stay were risk factors for mortality. The shock index had the highest predictive ability for mortality. Our study serves as a guide for ED physicians who conduct the initial evaluation of patients with proximal femur fractures.
ROC Curve for Shock Index in Predicting Mortality



Keywords: Proximal Femoral Fractures, Mortality, Risk Factors

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Ref No: 9166
A hematological and hepatological approach: a rare and unexpected diagnosis of a pancytopenia case with portal vein thrombosis
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[1]Department of Emergency Medicine, Konya City Hospital, Türkiye
Introduction and Purpose: Portal vein thrombosis (PVT) refers to the partial or occlusion of any part of the portal vein. The most common underlying mechanisms contributing to PVT development include hypercoagulopathy, which is frequently observed in patients with liver cirrhosis, malignancy, acquired prothrombotic disorders, or inflammatory conditions. The estimated overall prevalence of PVT is low (approximately 1%); however, studies have shown that patients with cirrhosis or underlying malignancies are at increased risk, with some studies reporting PVT prevalence in this population ranging between 10% and 26%.
Materials and Methods: A 42-year-old male patient presented to the emergency department with a complaint of scrotal swelling and was referred to our clinic because of anemia. Upon physical examination, widespread ascites was detected in the abdomen. Laboratory tests revealed a hemoglobin (HGB): 5.5 g/dL, platelet count (PLT): 108 × 10^3/μL, and white blood cell count (WBC): 3.84 × 10^3/μL, leading to hospitalization for further investigation of pancytopenia. Abdominal ultrasonography performed during hospitalization revealed the following: "The main portal vein measured 16 mm. Findings consistent with chronic thrombosis with cavernous transformation were observed in the right and left portal vein branches." The patient was subsequently evaluated for gastroenterological treatment.
Results and Conclusion: Pancytopenia is defined as a reduction in all three blood cell lines and may present with symptoms related to anemia, leukopenia, or thrombocytopenia; however, it can also be asymptomatic. It is not a disease in itself but rather a finding associated with an underlying pathological process affecting the bone marrow or peripheral blood cell lines. This case highlights that hematological evaluation alone may not always be sufficient.
Keywords: Portal vein thrombosis, Pancytopenia, Anemia

Ref No: 9167

A Retrospective Analysis of Factors Associated with Mortality in Patients Undergoing Emergency Hemodialysis

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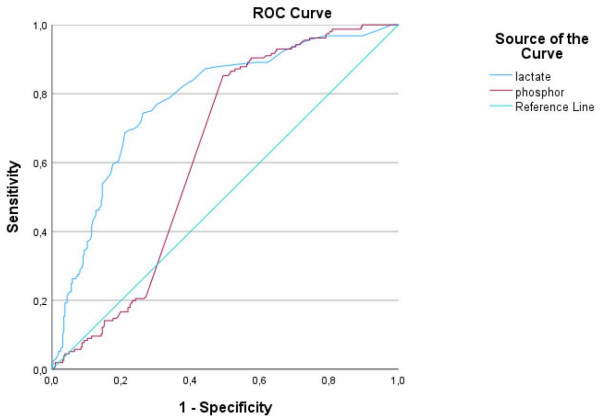
[2]Izmir Bozyaka Training and Research Hospital, Department of Emergency Medicine

Introduction and Purpose: Kidney failure, whether acute or chronic, is a major cause of mortality. For patients initiating hemodialysis due to end-stage renal disease, the first three months following the initial hemodialysis session present the highest risk of mortality. Predicting and preventing mortality in this critical patient group, who are dialyzed within the first 24 hours of emergency department admission, is of great importance. This study aims to determine the mortality rate and potential factors affecting mortality in patients admitted to the emergency department and requiring urgent hemodialysis within the first 24 hours due to renal failure.

Materials and Methods: This retrospective, cross-sectional study included patients over the age of 18 who were admitted to the emergency department and underwent hemodialysis within the first 24 hours between 2017 and 2023. Patients under 18, routine hemodialysis patients, those with a history of renal transplantation, and others meeting exclusion criteria were not included in the study. The demographic characteristics, level of consciousness, urine output, comorbidities, etiology of acute kidney injury, and laboratory tests of the included cases were recorded. Seven-day and 28-day mortality rates were calculated.

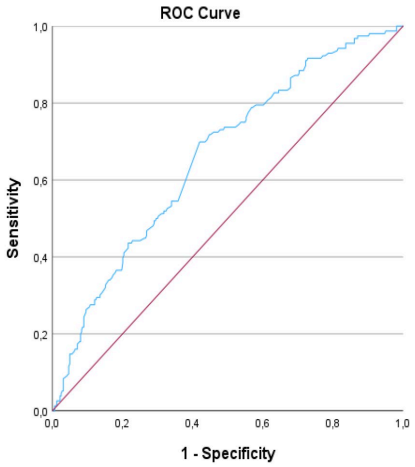
Results and Conclusion: A total of 480 cases were included in the study. Seven-day mortality was identified in 156(32.5%) out of 480 cases, and 28-day mortality in 202(42.1%) out of 480 cases. Of the cases, 56.9% were male and the median age of the entire group was calculated as 73.0[62.0;81.0] years. The mean age of deceased patients was higher than that of survivors for both seven-day and 28-day mortality (p=0.003, p<0.001). Anuria (p<0.001 for both) and the need for inotropic therapy (p<0.001 for both) were significantly associated with seven-day and 28-day mortality. Additionally, a low GCS score (p<0.001 for both), low albumin levels (p<0.001 for both), high potassium (p=0.025, p<0.001), CRP (p<0.001 for both), lactate (p<0.001 for both), and phosphorus (p<0.001,p=0.017) were significant for seven-day and 28-day mortality. Among patients who underwent emergency hemodialysis within the first 24 hours following admission to the emergency department, seven-day mortality was found to be 32.5%, and 28-day mortality 42.1%. The factors most strongly associated with mortality were anuria, high lactate levels, low albumin levels, and high phosphorus levels.

Seven-Day Mortality - Lactate and Phosphorus



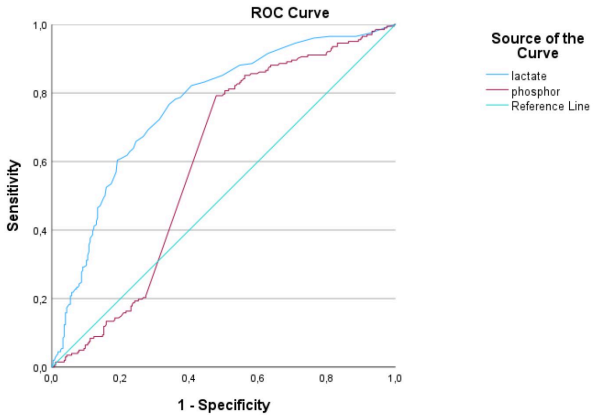
ROC Analysis of Lactate and Phosphorus Values Predicting Seven-Day Mortality

Seven-Day Mortality -Albumin

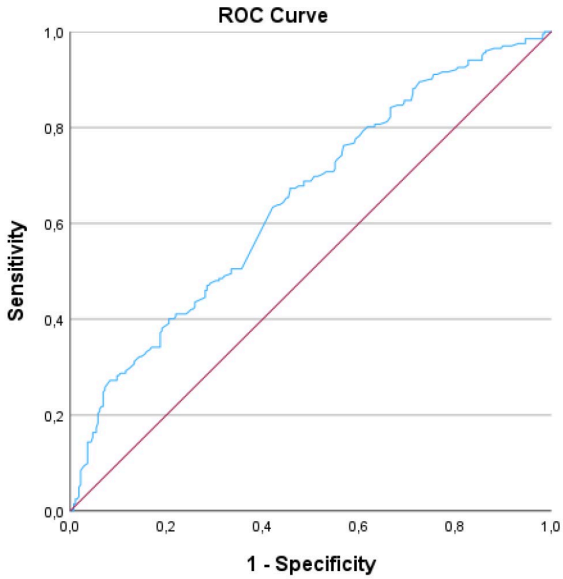


ROC Analysis of Albumin Value Predicting Seven-Day Mortality

28 Day Mortality- Lactate and Phosphorus



ROC Analysis of Lactate and Phosphorus Values Predicting Twenty-Eight-Day Mortality
28 Day Mortality-Albumin



ROC Analysis of Albumin Value Predicting Twenty-Eight-Day Mortality
Keywords: Acute kidney injury, Emergency hemodialysis, Anuria

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Ref No: 9212
Concurrent ischemic stroke and st-elevation myocardial infarction: a lethal confluence in stroke-heart syndrome – case report and clinical implications
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[2]Kırşehir Ahi Evran University, Faculty of Medicine, Emergency Medicine Department
Introduction and Purpose: This case report aims to highlight the clinical complexities and high mortality associated with Stroke-Heart Syndrome (SHS) by presenting an elderly patient with concurrent acute ischemic stroke (AIS) and ST-elevation myocardial infarction (STEMI). The report underscores the necessity of integrated cardiac and neurological monitoring to mitigate adverse outcomes in SHS, emphasizing its pathophysiological and therapeutic challenges.
Materials and Methods: An 83-year-old female with diabetes, hypertension, and prior ischemic stroke presented with syncope. Initial evaluation included Glasgow Coma Scale (GCS) scoring, hemodynamic monitoring, 12-lead electrocardiography (ECG), and emergent neuroimaging (non-contrast brain CT and diffusion-weighted MRI). Cardiac assessment involved serial high-sensitivity troponin measurements, CK-MB analysis, and coronary angiography. Management followed the 2019 AHA/ASA guidelines for dual evaluation of cerebral and coronary ischemia.
Results and Conclusion: The patient exhibited severe neurological impairment (GCS 6), requiring immediate intubation. ECG demonstrated ST-segment elevation in inferior leads, ST depression in lateral leads, and T-wave inversions in V4-6, diagnostic of STEMI. Neuroimaging revealed a left middle cerebral artery (MCA) infarction without hemorrhage. Laboratory results showed markedly elevated cardiac biomarkers: troponin (3583 pg/mL) and CK-MB (121 ng/mL). Coronary angiography confirmed total occlusion of the left

anterior descending artery (LAD), necessitating revascularization. Despite aggressive intervention, the patient developed multisystem organ failure and expired on day 7. The clinical trajectory aligned with SHS mechanisms, including catecholamine surge-induced myocardial stunning, autonomic dysregulation, and systemic inflammation, compounded by pre-existing comorbidities.This fatal case underscores the prognostic gravity of SHS, particularly when AIS coincides with STEMI. Early dual-pathway evaluation for cerebral and coronary ischemia, guided by current guidelines, is critical. However, therapeutic trade-offs, such as bleeding risks from anticoagulants during coronary interventions, complicate management. The case reinforces the imperative for vigilant cardiac monitoring in AIS patients, especially those with comorbidities, to address the bidirectional cerebrovascular-cardiac interplay inherent to SHS.

Keywords: stroke-heart syndrome, acute ischemic stroke, st-elevation myocardial infarction

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Ref No: 9299

Sepsis Due To A Liver Abscess In A Patient With Lung Cancer Presenting With Hypoglycemia

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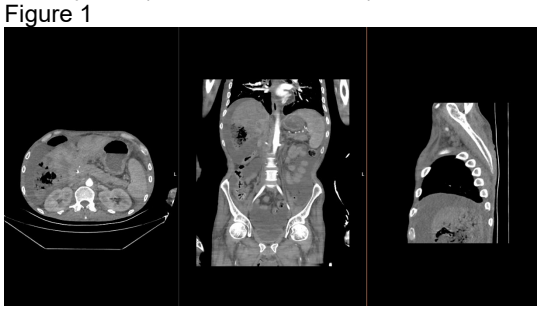
[1]Düzce University

Introduction and Purpose: Sepsis is a critical condition with high morbidity and mortality, especially in immunocompromised individuals such as cancer patients. Prompt recognition and treatment are essential for improving outcomes. We present a case of a patient with lung cancer who presented to the emergency department (ED) with altered mental status and was ultimately diagnosed with sepsis due to a liver abscess. This case highlights the diagnostic challenges and importance of early imaging in atypical presentations.

Materials and Methods: A patient with a known diagnosis of lung cancer who had completed four cycles of chemotherapy, the last administered approximately one month earlier, was brought to the ED with acute impairment of consciousness. On initial evaluation, the patient's blood glucose was 24 mg/dL, blood pressure was 90/55 mmHg, body temperature was 36°C, and oxygen saturation was 98% on room air. Following the administration of 100 cc intravenous 20% dextrose, the patient regained consciousness. Physical examination revealed abdominal distension, with tenderness and guarding localized to the right upper and middle quadrants. Initial laboratory results showed elevated inflammatory markers and liver enzymes (CRP: 106 mg/L, AST: 1126 IU/L, ALT: 262 IU/L), coagulopathy (INR: 2.36), hyperbilirubinemia (total bilirubin: 4.36 mg/dL, direct: 4.10 mg/dL), anemia (Hb: 8.8 g/dL), thrombocytopenia (platelets: 57,000/µL), and leukocytosis (WBC: 10.24 x10³/µL).

Figure 1



Results and Conclusion: Given the abnormal liver function tests and abdominal findings, an urgent contrast-enhanced abdominal CT scan was performed. Imaging revealed gas-containing lesions in liver segments 5 and 6, with a subcapsular, irregularly bordered hypodense area suggestive of a liver abscess (Figure 1). Consultations were obtained from general surgery, internal medicine, and infectious diseases departments. Despite initial stabilization, the patient's respiratory status deteriorated, requiring elective intubation. Broad-spectrum antibiotics were initiated, and the patient was admitted to the intensive care unit for close monitoring and treatment. This case underlines the importance of considering intra-abdominal sources of infection in sepsis, especially in patients with malignancy and atypical initial presentations such as hypoglycemia.

Keywords: Sepsis, liver abscess, hypoglycemia

Ref No: 9430

The Relationship Between Stress Hyperglycemia Ratio and Prognosis in Patients Diagnosed with Ischemic Stroke in the Emergency Department: A Retrospective Cross-Sectional Study

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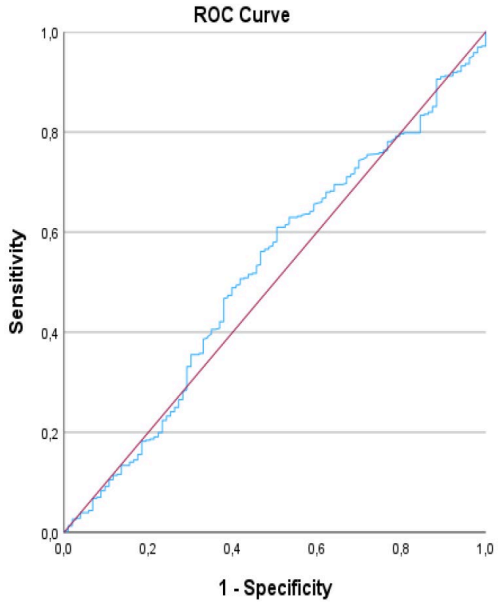
[1]Dokuz Eylül University School of Medicine, Department of Emergency Medicine

Introduction and Purpose: Acute ischemic stroke is one of the diseases that cause mortality and morbidity. Abnormal glucose regulation, a hallmark of diabetes, is observed in approximately two-thirds of individuals experiencing acute stroke. Stress hyperglycemia is defined as a transient increase in blood glucose levels in response to inflammation and neurohormonal imbalances. It has been suggested that a high stress hyperglycemia ratio(SHR) may serve as an indicator for predicting adverse clinical outcomes after a stroke. This study aims to evaluate the relationship between SHR and prognosis in ischemic stroke patients and to assess its impact on patient outcomes.

Materials and Methods: This retrospective cross-sectional study included patients aged 18 years and older who presented to the Emergency Department of Dokuz Eyþl University Hospital between 2022-2024 with a diagnosis of acute ischemic stroke. Patients younger than 18 years, those with hemorrhagic stroke, transient ischemic attacks, those whose clinical outcomes could not be followed, and those with incomplete medical records were excluded. The demographic characteristics, admission blood glucose levels, comorbidities, NIHSS scores at admission, treatments administered, clinical outcomes, and laboratory findings of the included patients were recorded. SHR was calculated using admission blood glucose and HbA1C levels. The relationship between SHR and prognosis was assessed using the modified Rankin Scale(mRS).

Results and Conclusion: A total of 559 cases were included in the study. Among them, 306(54.7%) were male, with a median age of 73.0 years (63.0;80.0). Of the cases, 103(18.4%) had a good outcome, while 456(81.6%) had a poor outcome. The difference in SHR values between the good and poor outcome groups was not statistically significant (p=0.518). Multivariate logistic regression analysis showed that a 1-unit increase in SHR resulted in an average increase of 0.156 units in mRS, but this was not statistically significant. According to propensity score analysis, the wide confidence interval of SHR suggests that the analysis results may be variable and that the impact of SHR is difficult to determine definitively. SHR has low performance in predicting poor outcomes and does not provide a clinically significant distinction. It was determined that the SHR score is not associated with clinical outcomes and is not significant in predicting poor outcomes.
SHR-Poor Prognosis



SHR-Poor prognosis ROC Curve
Keywords: Acute Ischemic Stroke, Stress Hyperglycemia Ratio, Modified Rankin Scale

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Ref No: 9441
Atrial Fibrillation Complicated by Spleen Infarction Due to Suboptimal Anticoagulation with Aspirin
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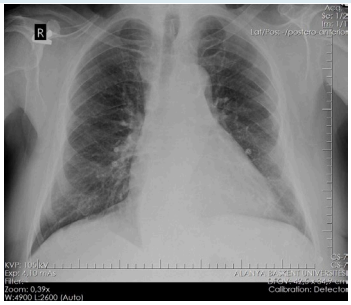
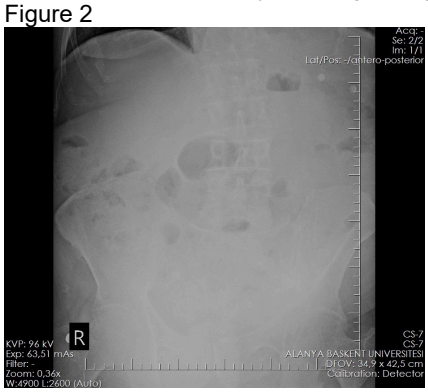
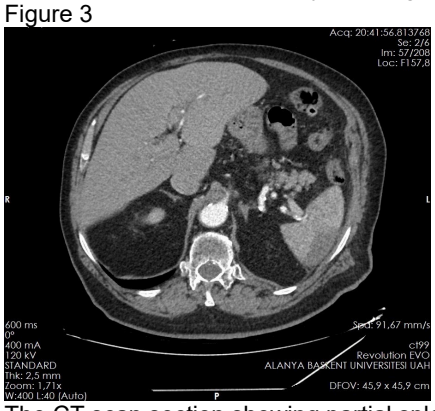
Introduction and Purpose: Atrial fibrillation (AF) is a significant risk factor for thromboembolic events, particularly in the elderly. The CHA DS VASc score is a widely used tool to assess thromboembolic risk in AF patients and guide anticoagulation therapy decisions. However, aspirin's role in stroke prevention for AF patients has diminished over time, as recent studies show limited efficacy in reducing thromboembolic risk. Aspirin is now reserved for low-risk patients (CHA DS VASc ≤ 1), as this case highlights its limitations in preventing thromboembolic complications in high-risk atrial fibrillation.
Materials and Methods: An 81-year-old male presented with a three-day history of severe left-sided abdominal pain, different from his usual chronic constipation. His medical history included hypertension, BPH, type 2 diabetes and atrial fibrillation. He had been under regular cardiac follow-up, with his last check-up two months ago. His regular medications consisted of diltiazem, amlodipine, metformin, dutasteride, and acetylsalicylic acid. There were no additional gastrointestinal or urinary symptoms. On examination, the patient was haemodynamically stable with no abdominal tenderness. This absence of peritoneal signs, despite patient's own expression significant pain, raised concern for ischemia-related aetiologies, prompting us for further evaluation. Initial laboratory investigations, including a comprehensive biochemistry panel and measurement of amylase and lipase, were unremarkable. The only significant finding was a mildly elevated C-reactive protein (CRP) level of 59.9 mg/dL. The emergency electrocardiogram (ECG) was consistent with atrial fibrillation, while troponin-I level was within the normal limit. Abdominal and chest X-rays showed no significant findings. Given the patient's disproportionate pain and inconclusive initial investigations, a contrast-enhanced abdominal CT was ordered, which confirmed a diagnosis of splenic infarction. Early consultation with the on-call surgical and cardiology teams was conducted, and the anaesthesia team subsequently accepted the patient for admission to ICU. Anticoagulation, antihypertensive, and antiarrhythmic therapies were promptly initiated. After stabilisation, anticoagulation therapy was switched to rivaroxaban 20 mg daily for long-term management.
Figure 1



The patient's chest X-ray showing no significant pathologies
Figure 2



The patient's abdominal X-ray showing no significant pathologies
Figure 3



The CT scan section showing partial splenic infarction

Results and Conclusion: This case highlights the limitations of aspirin monotherapy in preventing thromboembolic events in atrial fibrillation, especially in high-risk patients. Evidence suggests aspirin provides minimal stroke risk reduction and may contribute to embolic complications. It underscores the need for guideline-directed anticoagulation therapy for optimal stroke prevention and patient outcomes.

Keywords: Aspirin, Atrial Fibrillation, Splenic Infarction

Ref No: 9483

EVALUATION OF GDF-15 BIOMARKER AND HEAVY METAL LEVELS IN ACUTE ISCHEMIC STROKE CASES

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Introduction and Purpose: Ischemic stroke is a significant public health issue that requires rapid diagnosis and treatment due to its high mortality and morbidity rates. However, no widely accepted biochemical marker has been established for stroke diagnosis. Growth differentiation factor-15 (GDF-15), also known as macrophage inhibitory cytokine-1, is a distinct member of the transforming growth factor-β superfamily. Plasma concentrations of GDF-15 increase in pathological conditions and are associated with hypoxia, inflammation, oxidative stress, and oncogene activation. It has been found that serum GDF-15 levels can predict atherosclerotic events and are linked to tissue regeneration in cardiac damage. Imbalances in heavy metal levels can affect body homeostasis and biological processes, contributing to the development of various diseases, including ischemic stroke. In this study, we aimed to investigate the relationship between GDF-15 levels and heavy metal concentrations in patients with acute ischemic stroke and to evaluate whether GDF-15 can be used as a prognostic biomarker in acute ischemic stroke.
Materials and Methods: The study included a total of 128 participants, consisting of 64 ischemic stroke patients (patient group) and 64

healthy volunteers (control group). Blood levels of 10 heavy metals were measured using inductively coupled plasma mass spectrometry. Serum GDF-15 levels were measured using an enzyme-linked immunosorbent assay (ELISA) kit (Elabscience, USA).
Results and Conclusion: There was no significant difference between patients and controls in terms of age, sex, and comorbidities. GDF-15 levels were significantly higher in the acute ischemic stroke group compared to the control group ($p<0.001$). Heavy metal analysis revealed that lead (Pb) and mercury (Hg) levels were significantly elevated in the stroke group compared to the control group. A positive correlation was observed between NIHSS score, GDF-15 levels, and Pb levels. Additionally, GDF-15 levels varied according to sex, age, and stroke etiology. In conclusion, this study demonstrates that GDF-15 levels are significantly elevated in ischemic stroke patients and increase with age. It highlights the potential role of certain heavy metal levels in stroke pathogenesis. Furthermore, our study emphasizes that patients with higher NIHSS scores also have increased GDF-15 levels, suggesting that this parameter could be an important biomarker for stroke severity.
Keywords: Acute Ischemic Stroke, GDF-15, Heavy Metals

Ref No: 9498
From vision loss to death: the dark side of methanol intoxication
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Introduction and Purpose: Methanol is a colorless and toxic alcohol obtained by distilling wood. It is used in industry as a chemical solvent. Methanol poisoning usually occurs due to the consumption of illegally produced alcoholic beverages, but can also be accidental or intentional. Methanol is metabolized in the body by the enzyme alcohol dehydrogenase to formaldehyde and formic acid, leading to metabolic acidosis, retinal damage, and optic nerve damage. Symptoms appear within 12-24 hours and initially appear as visual disturbances, abdominal pain and headache. If left untreated, methanol poisoning can lead to blindness, coma, and death.
Materials and Methods: Our patient was admitted to the emergency room with blurred vision 36 hours after alcohol consumption. Methanol poisoning was suspected, and the Glasgow Coma Scale (GCS) score was E4M6V5, blood pressure was 110/70 mmHg, pulse was 85 bpm, and temperature was 36.5°C. Venous blood gas analysis showed pH: 7.10, PCO2: 24 mmHg, PO2: 52 mmHg, HCO3: 12 mmol/L, lactate: 1.8 mmol/L, and a base deficit of -20.5, indicating high anion gap metabolic acidosis. The ethanol level was <10 mg/dl. Central imaging revealed no pathology, but the patient developed respiratory arrest during follow-up, was intubated, and was admitted to the intensive care unit. Bicarbonate replacement and ethanol treatment was started, and vasopressor support was provided. The patient remained hypotensive despite hemodialysis and died 12 hours after admission to the intensive care unit.
Results and Conclusion: Methanol is a common cause of fatal poisoning in our country due to its easy accessibility and use in counterfeit alcoholic beverages. Physicians should consider methanol intoxication in patients with altered consciousness, unexplained high anion gap metabolic acidosis, and a history of alcohol intake. Rapid and effective treatment significantly reduces morbidity and mortality.
Keywords: Methyl alcohol, Poisoning, Metabolic Acidosis

Ref No: 9564
Hidden Threats of Motor Vehicle Accidents: First Rib Fractures
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Introduction and Purpose: First rib fractures are relatively rare compared to other rib fractures due to the rib's well-protected anatomical position in the upper thoracic cavity. These fractures are typically associated with high-energy trauma and may accompany multisystem injuries, including subclavian artery and aortic damage. Given their association with significant morbidity and mortality, early diagnosis and proper management of first rib fractures are essential. In this case report, we present an isolated traumatic first rib fracture without any major thoracic organ injury, aiming to emphasize its clinical importance.
Materials and Methods: A 56-year-old male was brought to our Emergency Department with ambulance following a motorcycle accident. Upon arrival, his vital signs were stable, and he was conscious, oriented, and cooperative. The patient reported severe pain in the left shoulder region. Physical examination revealed a 3x2 cm area of dermabrasion on the forehead and restricted range of motion in the left shoulder joint. Emergency imaging identified bilateral pulmonary contusions and non-displaced anterior and posterior fractures of the left first rib, without any other pathological findings. The patient was evaluated by the thoracic surgery team, admitted for observation, and subsequently discharged from the emergency department
Results and Conclusion: The anatomical location of the first rib provides substantial protection and stability, making its fracture a critical indicator of high-impact trauma. Most first rib fractures are linked to motor vehicle accidents and are often accompanied by intrathoracic injuries such as pulmonary contusion, pneumothorax, or hemothorax. Although rare, first rib fractures may signal the presence of severe thoracic and extrathoracic injuries. Due to the overlapping structures in this region, these fractures are often difficult to detect on plain radiographs. Therefore, computed tomography (CT) remains the most sensitive and specific imaging modality for identifying first rib fractures. Emergency physicians must recognize the potential severity of first rib fractures. A multidisciplinary approach, including early diagnosis, appropriate management, and close monitoring—especially in an intensive care setting when necessary—can significantly reduce the risk of complications and mortality
Keywords: First rib fracture, Isolated injury, Motorcycle Accident

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Ref No: 9596
Can the blood urea nitrogen-to-hemoglobin ratio be used to predict the diagnosis and prognosis of upper gastrointestinal bleeding?
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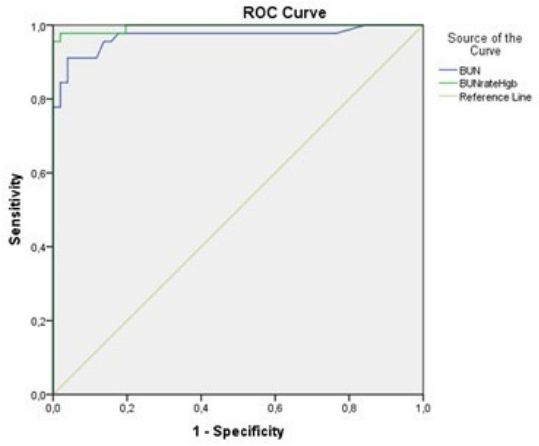
Introduction and Purpose: Upper gastrointestinal bleeding (UGIB) is defined as hemorrhage originating from anywhere between the esophagus and the ligament of Treitz. Although endoscopy is a definitive diagnostic and therapeutic method, there is a need for easily calculated parameters that support the diagnosis, especially for emergency physicians. We aimed to examine the ability of the blood urea nitrogen (BUN)-to-hemoglobin (Hgb) ratio to predict the diagnosis and prognosis of patients admitted to the emergency department (ED) due to UGIB.

Materials and Methods: In this study, the data of UGIB patients who presented to the ED of a tertiary health institution during a 6-month period between July and December 2024 were evaluated retrospectively. Patients who presented at the UGIB clinic and underwent esophagogastroscopy were included in the study. Age, sex, bleeding foci, intensive care unit (ICU) admission and patient mortality were evaluated. In addition, the BUN and Hgb values were measured, and the BUN/Hbg ratios calculated from these data were compared with those of the control group.

Results and Conclusion: Of the 45 patients who applied with UGIB, 32 (71%) were male. The median age of the patients was determined to be 72 years (range 23–93 years). The most common focus observed via endoscopy was the bulbus in 23 patients (51%). 21 of the patients (47%) were treated in the ICU. The median hospital stay was 3 days (range 1–27) days. While 3 patients died during hospitalization, 5 patients died within 1 month after bleeding. The BUN/Hgb ratio did not significantly predict in-hospital mortality or 1-month mortality (P values: 0.18 and 0.25, respectively), but it significantly predicted ICU admission (P=0.03). When the BUN, Hgb and BUN/Hgb values of the control group and the patient group were compared, the values of the patient group were significantly different (p<0.001). When these values were examined with the ROC curve, the AUCs were 0.931, 0.877 and 0.986, respectively (Figure-1). In conclusion, although the use of the BUN/Hgb ratio at the time of first admission in patients admitted to the ED due to UGIB is insufficient for predicting mortality, it can be helpful in diagnosing UGIB and determining the indications for the ICU.

Figure-1



Receiver-operating characteristic curve for BUN and BUN/Hgb ratio in the diagnosis of UGIB

Keywords: Emergency department, Intensive care unit, Mortality

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Ref No: 9630

Deep Neck Infection: A Case Report

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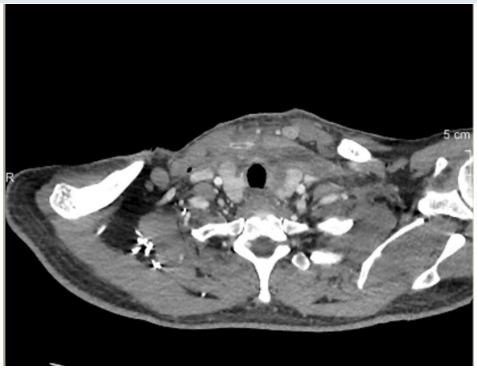
Introduction and Purpose: Deep neck infections (DNI) are potentially life-threatening bacterial infections involving the deep cervical fascial spaces. Owing to the complex anatomy of the neck and the proximity of vital structures, these infections can rapidly progress and cause severe complications, including airway obstruction, vascular involvement, mediastinitis, and sepsis. The etiology is often polymicrobial, typically involving a combination of aerobic and anaerobic organisms. DNIs are most commonly secondary to upper respiratory tract infections, odontogenic infections, cervical trauma, or postoperative complications.

Materials and Methods: This case report describes a 51-year-old male patient with no known chronic illness who presented to the emergency department with complaints of neck swelling and difficulty swallowing. The patient had a history of upper respiratory tract infection three days prior to admission. Physical examination revealed restricted mouth opening, right-sided oropharyngeal fullness, cervical tenderness, erythema, limited range of motion on the right side of the neck, and torticollis. Laboratory investigations demonstrated leukocytosis (WBC: 26.32 ×10³/μL), neutrophilia (24.23 ×10³/μL), and a significantly elevated C-reactive protein level (CRP: 266.88 mg/L). Contrast-enhanced computed tomography (CT) of the neck and thorax revealed a deep neck infection extending through multiple cervical levels, including areas adjacent to the carotid sheath and the thyroid gland, with soft tissue inflammation and gas locules, but without a well-formed abscess or vascular thrombosis. The patient was diagnosed with DNI and admitted to the otorhinolaryngology (ENT) department for inpatient treatment.

Picture 1



Results and Conclusion: This case highlights the diagnostic challenges and importance of early recognition of DNI. Clinical suspicion, supported by physical examination and inflammatory markers, should prompt advanced imaging studies to evaluate the extent and complications. Management requires a multidisciplinary approach, with broad-spectrum intravenous antibiotics as the initial step. Surgical intervention may be necessary if abscess formation or airway compromise is present. Early diagnosis and coordinated care significantly improve patient outcomes. This case underscores the critical need for awareness among clinicians, especially when evaluating patients with recent infections and developing neck symptoms.

Keywords: Deep Neck Infections, Bacterial Infection, Otorhinolaryngology

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Ref No: 9653

Retained foreign body not detected by imaging methods

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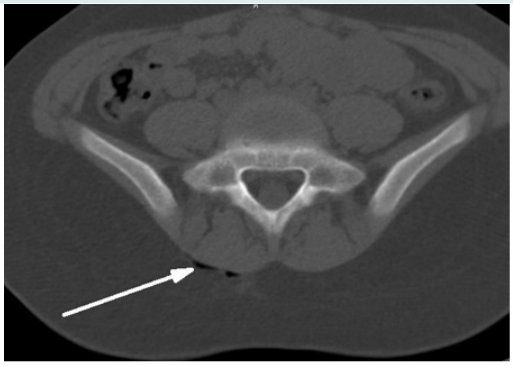
Introduction and Purpose: Introduction: In this case presentation, we aimed to present a case of a retained foreign body in the gluteal region of a male child that was overlooked in imaging methods.

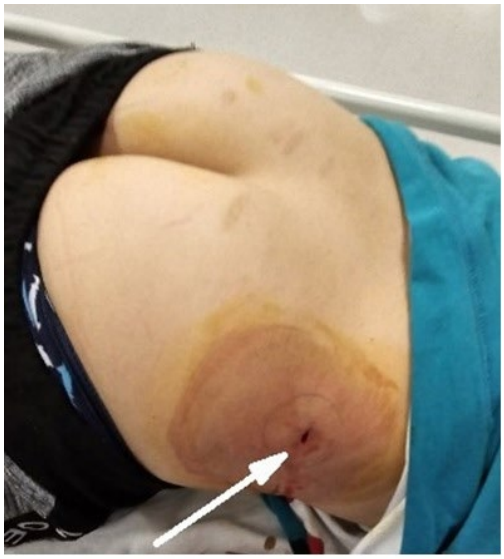
Materials and Methods: Case report: An 11-year-old male child was brought to the emergency department by his family after reporting that a splinter had entered his left inner hip area while sliding on a slanted board they had placed to play. A lesion was detected on the left inner hip area, where the patient indicated pain, potentially corresponding to the point of entry. However, no foreign object or hardness was felt upon examination. A superficial ultrasound (US) examination was performed, and no pathology was found in the lesion site or the surrounding area. As the patient's severe pain persisted, a pelvic computed tomography (CT) scan was conducted. The pelvic CT scan revealed air densities in the region of the skin lesion, but no other pathology was identified. Later, due to the continuation of the patient’s complaints, the area was done repeat physical examination along the air densities starting from the skin lesion. During this examination, a hardness was detected under the skin on the upper outer side of the right hip, at the end of the tract originating from the skin lesion. An incision was made at the site of the palpable hardness. Upon finding a foreign object, the child was made consultation to the pediatric surgery department. The foreign body, measuring approximately 35x0.8 cm, was then removed in a procedure performed by the pediatric surgery team.

In the initial examination, the area where the patient reported pain, which was considered as the possible entry site, was identified

The pelvic CT scan revealed air densities in the region of the skin lesion



The incision made over the area with hardness during the examination



Removed foreign body

Results and Conclusion: Conclusion: In cases of retained foreign body, although imaging methods such as US and CT are important for diagnosis, it should be remembered that in rare cases where imaging methods are not helpful, a thorough history and physical examination remain the most effective approach.
Keywords: Computed tomography, retained foreign body, ultrasound

Ref No: 9675

A CASE OF HYPERLIPIDEMIA DEVELOPING PULMONARY EMBOLISM DURING PLASMAPHERESIS

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Introduction and Purpose: Venous thromboembolism (VTE), clinically manifesting as deep vein thrombosis (DVT) or pulmonary embolism (PE), is the third most common acute cardiovascular syndrome worldwide after myocardial infarction and stroke. In cases of resistant hypercholesterolemia, plasmapheresis may be employed as a therapeutic modality. However, reports regarding the risk of thrombosis during plasmapheresis are limited. İn this article, we present a case of pulmonary embolism that developed during plasmapheresis in a patient with hyperlipidemia.

Materials and Methods: A 56-year-old female patient was referred to the emergency department by the cardiology department after pulmonary embolism was detected on coronary computed tomography angiography (CTA). One month earlier, she had been hospitalized in the endocrinology department due to hyperlipidemia. During hospitalization, therapeutic plasmapheresis was planned using 10 units of fresh frozen plasma. According to the patient's history, a brief episode of syncope occurred during the sixth unit of the plasmapheresis session, leading to the termination of the procedure. Subsequently, a coronary CTA was performed by the cardiology team. Twenty days later, the patient returned to the outpatient clinic for the evaluation of the CTA results, which revealed a pulmonary embolism involving the left main pulmonary artery (Figure 1). The patient was asymptomatic at the time of admission at emergency department. Her past medical history included diabetes mellitus, hypertension and hypercholesterolemia. Vital signs were stable. Laboratory results revealed blood glucose of 306 mg/dL with normal other parameters.A repeat pulmonary CTA was requested, which showed; "A filling defect consistent with an embolism allowing flow is noted in the left main pulmonary artery.' (Figure 2). Compared to the previous imaging, signs of recanalization were evident. The patient was subsequently admitted to the chest diseases service for further management and follow-up.

Figure 1: Pulmonary CTA following plasmapheresis

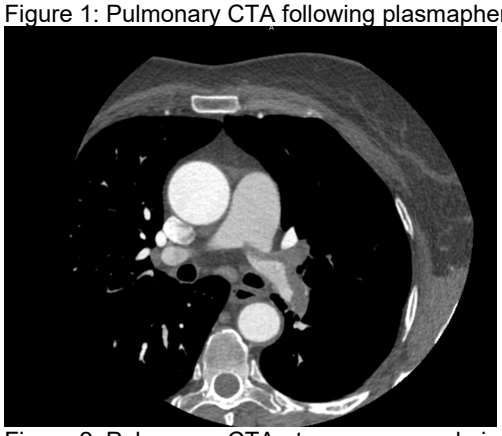
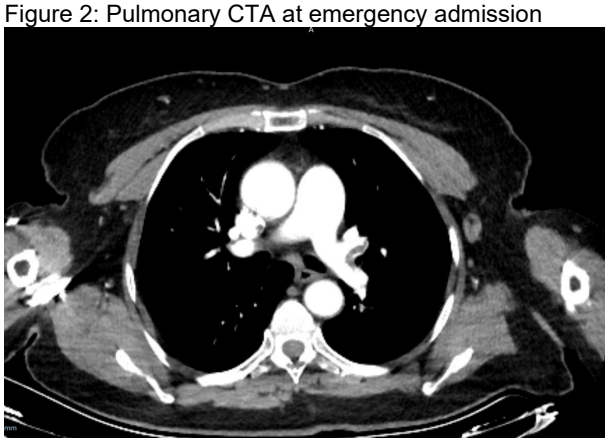


Figure 2: Pulmonary CTA at emergency admission



Results and Conclusion: Hyperlipidemia may lead to acute thrombotic events by promoting atherosclerosis and hypercoagulability. Although there is limited evidence in the literature supporting thrombosis, clinicians should be vigilant for new symptoms in patients receiving blood product transfusions.In patients with hyperlipidemia, the development of syncope during or after plasmapheresis may suggest pulmonary embolism. A thorough anamnesis and appropriate additional investigations are critical for timely diagnosis and management.

Keywords: Pulmonary Embolism, Hypercholesterolemia, Plasmapheresis

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Ref No: 9696

The Prognostic Role of Bilirubin and Lactate in Acute Kidney Injury

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Introduction and Purpose: Acute kidney injury (AKI) is a clinical syndrome characterized by a rapid decline in renal excretory function, decreased glomerular filtration rate, and increased serum creatinine levels, leading to high morbidity and mortality rates. Serum total bilirubin concentrations are known to be associated with AKI development and clinical outcomes. Elevated total serum bilirubin levels can lead to direct toxic effects on renal tubules by reducing arterial pulse pressure and intraglomerular pressure. A serum total bilirubin level above 2.0 mg/dL has been associated with a 16.4% incidence of AKI, and previous studies have identified high bilirubin levels as a significant risk factor for AKI development.

Materials and Methods: This retrospective study was conducted in the emergency department between 01.01.2021 and 30.06.2022. Ethical approval was obtained before initiating the study. The diagnosis of acute kidney injury was made according to the AKIN staging criteria. Routine blood samples taken in the emergency department, including complete blood count and biochemistry (BUN, creatinine, AST, ALT, total bilirubin), as well as blood gas analysis, were evaluated. The patients' discharge status, ward admission, intensive care unit (ICU) admission, hospital length of stay, dialysis requirement, and survival outcomes were assessed.

Results and Conclusion: A total of 324 patients were included in the study. The mean age of the patients was 68.6 ± 14.3 years, with 44.1% (143) being female and 55.9% (181) male. The tables analyzed the relationship between biochemical parameters and prognosis in patients with AKI. AST and total bilirubin levels were significantly higher in the deceased group compared to the surviving group (p=0.001, p=0.015). The markedly higher lactate levels in the deceased group (p<0.001) suggest that tissue hypoxia and metabolic dysfunction are associated with poor AKI prognosis. The data of discharged patients, ward-admitted patients, and ICU-admitted patients were compared. AST and total bilirubin levels were higher in the ICU group (p=0.001 and p=0.032), indicating disease severity. Additionally, significant differences in lactate, pH, and HCO3 levels (p<0.001) suggest that metabolic acidosis is more pronounced in critically ill patients. In conclusion, elevated AST, total bilirubin, and lactate levels may serve as indicators of poor prognosis in AKI (Figure 1).

Figure 1. Acute Kidney Injury and Laboratory Results

Parameter	Discharge (Min-Max)	Service Admission (Min-Max)	Intensive Care (Min-Max)	p value
AST	18 (8-244)	20 (5-2722)	24 (3-617)	0,001
ALT	16 (6-318)	17 (4-2111)	17 (6-712)	0,371
Total Bilirubin	0,6 (0,1-3,3)	0,5 (0,1-14,6)	0,8 (0,2-24)	0,032
Lactate	1,2 (0,4-4,5)	1,4 (0,1-13,5)	2,6 (0,3-19,2)	<0,001
pH	7,37 (7,18-7,56)	7,36 (7,02-7,56)	7,28 (6,85-7,47)	<0,001
HCO3	21 (13-31)	20 (3-45)	16 (4-28)	<0,001

Keywords: Acute kidney injury, bilirubin, emergency department

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Ref No: 9731

Diffuse Subendocardial Ischemia Secondary to Disulfiram-Ethanol Reaction: A Case Report

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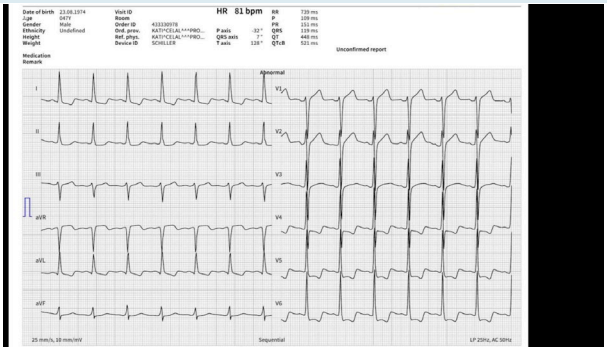
Introduction and Purpose: Disulfiram is widely used in alcohol dependence management due to its deterrent effect mediated by acetaldehyde accumulation following ethanol ingestion. The resulting disulfiram-ethanol reaction (DER) typically presents as flushing, hypotension, and gastrointestinal symptoms. Although considered generally safe, severe cardiovascular complications such as transient myocardial ischemia are rarely reported. We present a unique case illustrating diffuse subendocardial ischemia secondary to DER without underlying coronary disease.

Materials and Methods: A 47-year-old male without prior cardiovascular disease presented after consuming approximately 5 grams of disulfiram and alcohol simultaneously. He initially exhibited somnolence (GCS 14) without hemodynamic instability. Laboratory evaluation showed elevated troponin I (0.143 ng/mL, normal <0.04 ng/mL) and ethanol (124 mg/dL). ECG demonstrated widespread ST-segment depression, indicative of subendocardial ischemia. Echocardiography revealed preserved ejection fraction (65%) without regional wall motion abnormalities. Cardiology evaluation excluded acute coronary syndrome, attributing findings to secondary toxic-metabolic effects. Supportive care resulted in spontaneous clinical and electrocardiographic improvement. Psychiatric evaluation diagnosed adjustment disorder with depressive features, initiating SSRI therapy. The patient was discharged on day two with recommendations for cardiology and psychiatric follow-up.

Electrocardiogram (ECG) demonstrating diffuse subendocardial ischemia following disulfiram-ethanol interaction



The presented 12-lead resting ECG shows sinus rhythm with a heart rate of 81 beats per minute. Notably, there are diffuse horizontal ST-segment depressions prominently seen in leads V3 to V6 and inferior leads (II, III, aVF), consistent with widespread subendocardial ischemia. These ECG abnormalities are suggestive of a transient myocardial ischemic event secondary to a disulfiram-ethanol reaction (DER). Despite significant electrocardiographic changes, the patient exhibited preserved left ventricular function (EF 65%) without regional wall motion abnormalities on echocardiography. The ischemic changes resolved spontaneously following supportive medical treatment, correlating with the transient and reversible nature of DER-associated subendocardial ischemia.

Results and Conclusion: Cardiac complications during DER, though uncommon, include potentially severe outcomes such as transient ischemia and arrhythmia. The pathophysiology is likely related to hemodynamic alterations, including vasodilation and hypotension, resulting in myocardial oxygen supply-demand mismatch, particularly affecting vulnerable subendocardial regions. Literature review underscores careful patient selection, emphasizing that cardiac risks must be considered when initiating disulfiram therapy. This case uniquely contributes to clinical awareness by explicitly linking DER with diffuse subendocardial ischemia, emphasizing the importance of differential diagnosis in acute coronary syndrome mimics. Physicians must remain vigilant regarding rare but clinically significant cardiovascular complications of DER. Prompt recognition, multidisciplinary management, and patient education on disulfiram-associated risks are essential to minimize adverse outcomes. This case reinforces the need for cautious prescribing practices and multidisciplinary follow-up strategies in patients receiving disulfiram.

Keywords: Disulfiram, Myocardial Ischemia, Alcohol Deterrents

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Ref No: 9752

The Diagnostic Value of BUN/Albumin and BUN/Creatinine Ratios in Patients with Gastrointestinal Bleeding Presenting to the Emergency Department

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Introduction and Purpose: This study aimed to investigate the diagnostic value of blood urea nitrogen-to-albumin (B/A) and blood urea nitrogen-to-creatinine (B/Cr) ratios in predicting in-hospital mortality, active bleeding, and differentiating gastrointestinal bleeding (GIB) types in patients presenting to the emergency department (ED).

Materials and Methods: This retrospective study was conducted in a tertiary care hospital between June 1, 2019, and June 30, 2024. Patients over 18 years old diagnosed with GIB and undergoing endoscopy/colonoscopy were included. Demographic, laboratory, and clinical outcomes were analyzed. The B/A and B/Cr ratios were calculated and evaluated for their prognostic significance using ROC curve analysis.

Results and Conclusion: A total of 864 patients were included. Active bleeding was observed in 16.3%, and in-hospital mortality occurred in 7.1% of patients. The threshold values for mortality prediction were determined as 10.15 for the B/A ratio and 28.53 for the B/Cr ratio. The B/A ratio showed high prognostic value for mortality (AUC: 0.822) and active bleeding (AUC: 0.720), while the B/Cr ratio was particularly effective in differentiating upper GIB. The findings suggest that B/A and B/Cr ratios may provide useful prognostic information in GIB patients. The B/A ratio appears to be particularly relevant for predicting mortality and active bleeding, while the B/Cr ratio could assist in distinguishing upper GIB.

Keywords: Gastrointestinal bleeding, Blood urea nitrogen/albumin ratio, Blood urea nitrogen/creatinine ratio

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Ref No: 9762

Right adrenal hemorrhage masquerading as nephrolithiasis: a case of atypical presentation and diagnostic challenges

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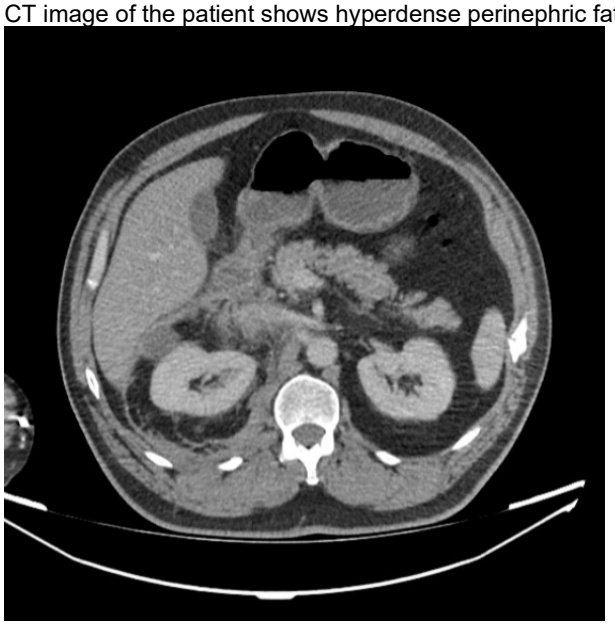
Introduction and Purpose: Adrenal hemorrhage, a rare yet life-threatening condition, arises from traumatic or spontaneous etiologies. Spontaneous adrenal hemorrhage (SAH) is particularly challenging due to nonspecific symptoms and frequent absence of classic risk factors, often leading to misdiagnosis. This report aims to describe an atypical case of right adrenal hemorrhage initially misdiagnosed as nephrolithiasis, emphasizing the diagnostic pitfalls and the critical role of imaging in identifying this condition.

Materials and Methods: A 42-year-old male with no prior medical history presented to the emergency department with colicky abdominal and flank pain. Initial evaluation, including laboratory tests and urinalysis, showed no abnormalities except mild leukocytosis (13.99 × 10^3/μL) and elevated C-reactive protein (20.4 mg/L). After analgesic therapy failed to alleviate symptoms, a non-contrast abdominal computed tomography (CT) scan was performed.

Results and Conclusion: CT imaging (Figure 1) revealed hyperdense perinephric fat stranding consistent with right adrenal

hemorrhage, despite stable hemoglobin (11.5 g/dL) and absence of adrenal insufficiency. The patient was managed conservatively with analgesia and monitoring, leading to symptom resolution and discharge on day six. This case highlights the diagnostic complexity of SAH, particularly when lacking traditional risk factors or hemodynamic instability. The overlap of symptoms with nephrolithiasis underscores the necessity of high-resolution imaging in equivocal presentations. Furthermore, stable hemoglobin levels and localized hemorrhage challenge the conventional association of SAH with overt bleeding, broadening the clinical spectrum of this condition. Clinicians should maintain a high index of suspicion for adrenal hemorrhage in patients with unexplained flank pain, even in the absence of classic indicators. Future research is warranted to identify biomarkers for early diagnosis and risk stratification in atypical cases.

CT image of the patient shows hyperdense perinephric fat stranding consistent with right adrenal hemorrhage



Keywords: adrenal hemorrhage, nephrolithiasis, computed tomography

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Ref No: 9822

Seasonal and Monthly Evaluation of Patients Admitted to the Coronary Intensive Care Unit from the Emergency Department: A One-Year Retrospective Study

Cemre Akdoğan[1], Nurbanu Akdoğan[1], Erinç Barçın[1], Alican Ünal[1], Büşra Bildik[1], Şeref Emre Atiş[2], Bora Çekmen[1]
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Introduction and Purpose: Cardiovascular emergencies remain a leading cause of morbidity and mortality, with possible time-related variations influencing patient characteristics, diagnoses, hospital stay durations, and outcomes. This study aimed to evaluate patients admitted to the Coronary Intensive Care Unit (CICU) from the Emergency Department over one year, focusing on seasonal and monthly variations in demographics, diagnoses, hospital length of stay, and mortality.

Materials and Methods: A retrospective observational study was conducted on 851 patients admitted to the CICU between 01.01.2024-31.12.2024. Data were collected on age, sex, comorbidities (hypertension, diabetes mellitus, coronary artery disease, chronic renal failure, etc.), diagnosis type (STEMI, NSTEMI, UA, HF, etc.), mortality, time that patients were admitted, and lengths of hospital and ICU stays. Patients with incomplete data and those transferred to other institutions, for whom mortality outcomes could not be confirmed, were excluded from the analysis.

Results and Conclusion: The study population included 61.6% males and 38.4% females, with a median age of 68 years. The most frequent diagnoses were NSTEMI (44.7%) and STEMI (28.4%). Seasonal distribution showed the highest number of admissions in autumn (26.6%) and the lowest in spring (22.6%). While diagnostic categories did not significantly differ by season (p=0.072), hospital length of stay varied significantly (p=0.009). The median length of stay was longest in autumn (4 days; IQR: 3–7.75) and shortest in spring (4 days; IQR: 2–7). Similarly, ICU stay duration was significantly different across seasons (p=0.015), with autumn again having the longest median ICU stay (2 days; IQR: 1–4). Mortality was observed in 5.2% of patients, with no statistically significant variation across seasons (p=0.852) or months (p=0.875). Median hospital stays did not vary notably across months, although October and November had higher upper ranges (75th percentile: 9 days). No significant monthly or seasonal differences were found in gender distribution (p>0.05), nor in mortality or diagnosis frequencies by month (p>0.05).This study demonstrates significant ICU lengths of stay among CICU patients, particularly longer stays in autumn, despite stable mortality and diagnosis rates. Recognizing these patterns may assist hospital resource planning and patient management strategies across different seasons.

Keywords: season, length of stay, intensive care

Ref No: 9837

intracranial hemorrhage

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Introduction and Purpose: Intracranial hemorrhage (ICH) is a critical condition that can cause significant morbidity and mortality in the emergency department. It can occur due to traumatic or non-traumatic etiologies. Common causes of non-traumatic ICH include hypertension, aneurysms, arteriovenous malformations (AVMs), and coagulopathies. In young adults presenting with syncope, ICH should be considered in the differential diagnosis. This case report discusses the evaluation and management of a 30-year-old male patient diagnosed with intracranial hemorrhage following a syncopal episode.
Materials and Methods: A 30-year-old male patient presented to the emergency department with a sudden loss of consciousness and syncope. The patient reported that he had not experienced any trauma at the time of the incident, the loss of consciousness was brief, and he recovered spontaneously. He denied any prior headache, visual disturbances, or neurological deficits. His medical history was unremarkable for hypertension, diabetes, or known coagulation disorders. There was no family history of cerebrovascular disease.On physical examination, the patient was alert, cooperative, and in stable condition. His vital signs were normal, and a neurological examination revealed no pathological reflexes. Laboratory tests, electrocardiography, and cardiac enzymes were within normal limits. However, given the possibility of a neurological cause for the syncope, brain imaging was performed.A CT scan of the brain revealed intracranial hemorrhage. Further evaluation with brain MRI and cerebral angiography was conducted, but no structural vascular pathology was identified. The patient was evaluated by neurology and neurosurgery specialists and was admitted to the intensive care unit for close monitoring.
Results and Conclusion: Syncope has a broad differential diagnosis and requires a multidisciplinary approach in the emergency setting. Although intracranial hemorrhage is rare in young patients, it can have serious consequences. This case highlights the importance of neurological evaluation and early imaging in patients presenting with syncope. Furthermore, in non-traumatic brain hemorrhages, underlying vascular anomalies, coagulopathies, and systemic diseases should always be investigated.
Keywords: Intracranial hemorrhage, syncope

Ref No: 9845
Black and White Cloud Physician In The Emergency Department; Are They Myth?
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Introduction and Purpose: In clinical practice, physicians are often informally labeled as either a "Black Cloud" or a "White Cloud." The term "Black Cloud" refers to physicians who are perceived to have busier shifts and encounter more complex cases, whereas "White Cloud" is used for those whose shifts are considered to involve fewer or simpler cases. This study aimed to evaluate the impact of physicians labeled as "Black Cloud" and "White Cloud" on the workload and case profile of emergency department (ED) shifts.
Materials and Methods: This study included 22 physicians who had been working in the emergency department of Karabük Training and Research Hospital for at least six months. Participating physicians were asked to identify colleagues, including themselves, whom they perceived as "unlucky" in terms of shift intensity. Based on the number of votes received, the four physicians with the highest votes were categorized as "Black Clouds," and the four with the lowest as "White Clouds." The study analyzed a 5-month period (October 1, 2024 – February 28, 2025) using the official shift schedule. Shifts staffed by White Cloud physicians were defined as “White Days,” those staffed by Black Cloud physicians as “Black Days,” and shifts that included both as “Gray Days.” These days were compared in terms of the total number of patients, the number of red triage (code red) cases, hospital admissions, traffic accident-related admissions, and patient mortality. Group comparisons were conducted using the Kruskal–Wallis test.
Results and Conclusion: No statistically significant difference was observed in the total number of patients among White Days, Gray Days, and Black Days ($p = 0.429$). Similarly, no significant differences were found between groups regarding the number of red triage cases, hospitalizations, intensive care unit admissions, resuscitation cases, traffic accident admissions, or patient deaths ($p = 0.269$, $p = 0.357$, $p = 0.841$, $p = 0.578$, $p = 0.315$, and $p = 0.157$, respectively) (Table 1).These findings suggest that the perception of physicians as "Black Clouds" or "White Clouds" does not objectively influence emergency department case dynamics. The results indicate that such labels may reflect subjective bias rather than evidence-based differences in shift workload.
Keywords: Emergency Medicine, White Cloud, Black Cloud

Ref No: 9847
The Role of Peripheral Perfusion Index in Predicting Biphasic Reactions in Anaphylaxis Patients
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Introduction and Purpose: Anaphylaxis is a rapidly onset, life-threatening hypersensitivity reaction, and in some patients, a biphasic reaction may develop following initial treatment. This study aims to investigate the prognostic value of the peripheral perfusion index (PPI) in predicting biphasic reactions among patients presenting to the emergency department with anaphylaxis.
Materials and Methods: The study is prospective and single-centered. A total of 104 patients aged 18 years and older, diagnosed with anaphylaxis in the emergency department, were included. PPI values, along with other vital signs, were measured at 0, 10, 20, and 30 minutes, as well as after symptom resolution. All patients were observed for a minimum of 6 hours to monitor for the development of biphasic reactions.
Results and Conclusion: The median PPI value at the 0-minute mark was 2.20 (IQR, 1.52-3.67), while the median PPI value after symptom resolution was 4.20 (IQR, 3.10-6.35). A biphasic reaction occurred in 10.6% of patients. Among patients who developed a biphasic reaction, PPI values at 0, 10, 20, and 30 minutes were significantly lower compared to those who did not ($p<0.05$). In ROC analysis, a PPI cutoff of ≤2.17 for predicting biphasic reactions yielded 57% sensitivity and 91% specificity (AUC=0.753). PPI may serve as an accessible and cost-effective test in emergency departments for continuous monitoring of patients diagnosed with anaphylaxis, allowing for assessment of treatment response, early detection of biphasic reactions, and risk evaluation.

Keywords: Anaphylaxis, Peripheral Perfusion Index, Biphasic Reaction

Ref No: 9880

Can the Wells Score Predict Severity in Confirmed Pulmonary Embolism? A Retrospective Study Based on PESI and sPESI Classification

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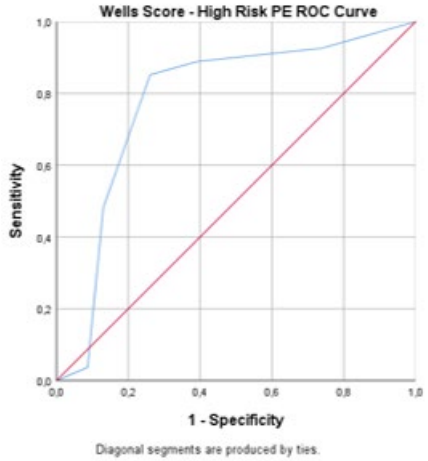
Introduction and Purpose: Pulmonary embolism (PE) is a potentially life-threatening condition that requires prompt diagnosis and effective risk stratification. While the Wells score is widely used to assess the clinical probability of PE, its prognostic utility remains uncertain. This study aims to evaluate the relationship between the Wells score and pulmonary embolism severity as defined by the Pulmonary Embolism Severity Index (PESI) and simplified PESI (sPESI) classifications.

Materials and Methods: This retrospective observational study was conducted at the Emergency Department of Ondokuz Mayıs University Faculty of Medicine, Türkiye, and included adult patients diagnosed with PE via computed tomography pulmonary angiography (CTPA) between January 1, 2021 and January 1, 2024. Patients with incomplete data or non-thrombotic PE were excluded. The Wells score, PESI, and sPESI were calculated retrospectively at admission. Patients were stratified into low (Class I–II), intermediate (Class III), and high-risk (Class IV–V) categories based on PESI scores. The Wells score was compared across groups using the Kruskal-Wallis test, followed by Dunn's post hoc test. The relationship between Wells and PESI scores was evaluated using Spearman correlation analysis. A receiver operating characteristic (ROC) analysis was performed to assess the discriminatory ability of the Wells score in predicting high-risk PE.

Results and Conclusion: Median Wells scores were significantly different across PESI risk groups ($p = 0.001$). A moderate positive correlation was observed between Wells and PESI scores ($r = 0.519$, $p < 0.001$). The ROC analysis yielded an AUC of 0.780 (95% CI: 0.638–0.922) for predicting high-risk PE, with a cut-off value of ≤2.5 offering 85.2% sensitivity and 73.9% specificity. Although originally designed as a diagnostic tool, the Wells score may provide insight into PE severity. Its moderate correlation with established severity indices supports its potential role in early prognostic stratification. These findings highlight the clinical relevance of incorporating the Wells score into broader risk assessment frameworks, especially in emergency settings where immediate decisions are critical. However, further prospective studies are warranted to confirm its prognostic value.

Receiver Operating Characteristic (ROC) Curve for Wells Score in Identifying High-Risk Pulmonary Embolism



. The area under the ROC curve (AUC) was calculated as 0.780 (95% CI: 0.638–0.922), indicating good discriminatory ability. A Wells score cut-off value of ≤2.5 was found to yield a sensitivity of 85.2% and a specificity of 73.9% for predicting high-risk PE. These findings suggest that the Wells score, although originally developed for estimating PE probability, may also provide useful prognostic information in identifying patients at greater clinical risk .

Comparison of Wells Scores According to PESI-Based Pulmonary Embolism Risk Groups

	Low Risk	Intermediate Risk	High Risk	Test Statistic	p*
Wells Score	1.0 (0.0-4.0)a	2.0 (0.0-5.0)a,b	3.0 (0.0-5.0)b	14.601	0.001

Median Wells scores were 1.0 (0.0–4.0), 2.0 (0.0–5.0), and 3.0 (0.0–5.0) for the low-, intermediate-, and high-risk groups, respectively. The Kruskal-Wallis test indicated a statistically significant difference between groups ($p = 0.001$). Post hoc analysis using the Dunn test revealed that the Wells score was significantly higher in the high-risk group compared to the low-risk group. However, no statistically significant difference was observed between the intermediate group and either of the other groups. These findings suggest that as PE

severity increases according to PESI classification, the Wells score also tends to increase, indicating a potential relationship between clinical probability and disease severity (Table 1).

Correlation Between Wells Score and PESI Score

		Wells Score	PESI Score
Wells Score	r	1,000	
	p		
PESI Score	r	0,519	1,000
	p	***<0,001****	

Table 2 presents the results of Spearman correlation analysis between Wells and PESI scores. A statistically significant moderate positive correlation was found between the two scores ($r = 0.519$, $p < 0.001$). This correlation implies that patients with higher Wells scores, which reflect a greater pre-test probability of pulmonary embolism, also tend to have higher PESI scores, which reflect greater clinical severity and mortality risk. This finding supports the hypothesis that the Wells score may carry prognostic value beyond diagnostic estimation alone.

Diagnostic Performance of the Wells Score in Predicting High-Risk Pulmonary Embolism

	Wells Score
Cut Off	≤2.5
AUC (%95CI)	0.780 (0.638-0.922)
Sensitivity	85.2 %
Specificity	73.9 %
p value	***0.001***

Table 3 summarizes the results of the ROC curve analysis evaluating the performance of the Wells score in predicting high-risk pulmonary embolism as defined by PESI Class IV–V. The area under the ROC curve (AUC) was calculated as 0.780 (95% CI: 0.638–0.922), indicating good discriminatory ability. A Wells score cut-off value of ≤2.5 was found to yield a sensitivity of 85.2% and a specificity of 73.9% for predicting high-risk PE. These findings suggest that the Wells score, although originally developed for estimating PE probability, may also provide useful prognostic information in identifying patients at greater clinical risk.

Keywords: Pulmonary Embolism, Prognosis, Risk Assessment

Ref No: 9923

Analysis of Patients Diagnosed with Acute Stroke in the Emergency Department

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Introduction and Purpose: According to the WHO definition, stroke is a sudden onset of clinical findings and symptoms due to focal or global impairment of cerebral functions that last 24 hours or longer or result in death, and there is no other identifiable cause that could explain this condition. Studies have shown that approximately 795,000 strokes occur each year in the United States and that the prevalence of stroke tends to increase with age. Studies have shown that on average one person has a stroke every second and that on average one person loses their life due to stroke every 4 minutes. This study investigated the relationship between the presence of AF in the history of stroke cases in our clinic and the medications they used.

Materials and Methods: The median age of the 302 patients included in the study was 72 (IQRs: 62-79, min: 30 max: 97) years. 52.3% of the patients were male. 11.9% of the patients had a history of atrial fibrillation, while 32.1% of the patients had a history of antiplatelet or anticoagulant agent use. 14.2% of the patients were using acetylsalicylic acid, 7.3% were using clopidogrel, and 10.6% were using oral anticoagulant agents. The rate of admission to the intensive care unit (ICU) was 43.4%, while the in-hospital mortality rate was 14.2% (Table 1). When examined in terms of ICU admission, there were statistically significant differences in terms of age, gender and presence of atrial fibrillation (p values 0.008, 0.027 and 0.008, respectively). Accordingly, patients admitted to the intensive care unit were older. In addition, female patients were admitted to the ICU at a higher rate than male patients (55% vs. 45%) (Table 2). When examined in terms of in-hospital mortality, it was determined that the patients who died were older than those who survived (75 vs. 71 years), but it was not statistically significant (p= 0.146). When in-hospital mortality was examined in terms of the antiplatelet,

antiaggregant or anticoagulant agents used by the patients, a statistically significant difference was obtained (p= 0.012)(Table 2).

Table 1. Demographic data of patients

	n	%
Age, median, IQR, years	72	62- 79 (min:30, max:97)
Female	144	47,7
Male	158	52,3
Atrial fibrillation	36	11,9
Anticoagulant/antiplatelet use	97	32,1
Acetylsalicylic acid	43	14,2
Clopidogrel	22	7,3
Warfarin	19	6,3
Rivoroxaban	8	2,6
Apixaban	5	1,7
Emergency department outcome		
ICU admission	131	43,4
Service hospitalization	171	56,6
Hospital outcome		
Recovery without sequelae	194	64,2
Recovery with sequelae	64	21,2
Mortality	43	14,2

Ref No: 9931

Investigating the Therapeutic Potential of Facet Injections for Lower Back Pain

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Introduction and Purpose: One of the leading causes of disability in the globe is lower back pain. Affected patients experience diminished quality of life, frequent hospital visits, and long-term reliance on oral pain medications. This raises the total burden on healthcare services in addition to decreasing worker productivity. Both patients with a history of lumbar surgery and those without are affected. This study aimed to evaluate whether facet joint injections can improve patients' quality of life while reducing healthcare burden.

Materials and Methods: A total of 23 patients participated in this study. A modified Oswestry Disability Index (ODI) questionnaire was completed by all patients prior to the injection and one month afterward. In addition to the standard scale, a body diagram was used to document the precise location of pain, while data regarding monthly emergency department/outpatient clinic visits and pain relief medication usage were collected. Patient selection was based on a combination of MRI findings, detailed pain descriptions, and clinical examination results. Under fluoroscopic guidance, a 22-gauge needle was advanced to make contact with the superior articular facet capsule. A mixture of betamethasone and bupivacaine was then injected into the joint capsule and surrounding tissues.

Results and Conclusion: One month post-procedure, there was a significant reduction in ODI scores from a mean of 63.22 ± 16.25 to 16.00 ± 15.29 ($p < 0.001$). Prior to the injection, patients required pain relief medications 3–4 times per week while the need for these medications was effectively eliminated after injection ($p < 0.001$). Additionally, while hospital visits for lower back pain averaged 1–3 per month pre-treatment, the frequency of visits approached zero after the procedure ($p < 0.001$). Patients also reported a shift in pain intensity from severe–very severe before the injection to mild–very mild ($p < 0.001$). According to these findings, facet joint injections effectively relieve pain while improving function, which lowers the overall cost of healthcare. With proper patient selection, this technique offers a viable therapeutic option for managing persistent lower back pain and lays the foundation for future long-term studies.

Fig 1

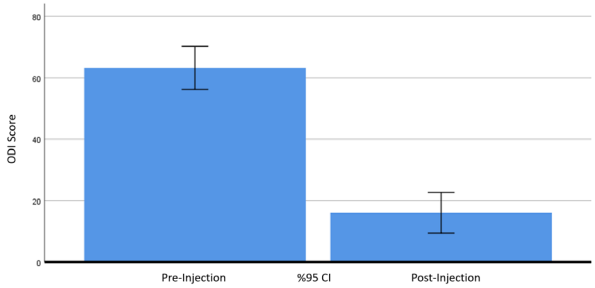

Fig.1: ODI score markedly decreased one month after injection.

Fig 2

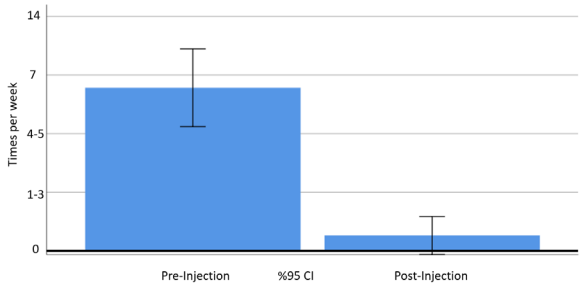

Fig.2: Number of drugs used per week for lower back pain markedly decreased one month after injection.

Fig 3

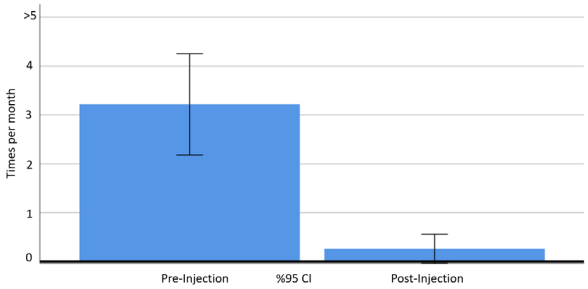

Fig.3: Outpatient/emergency service visits per month markedly decreased one month after injection.

Fig 4

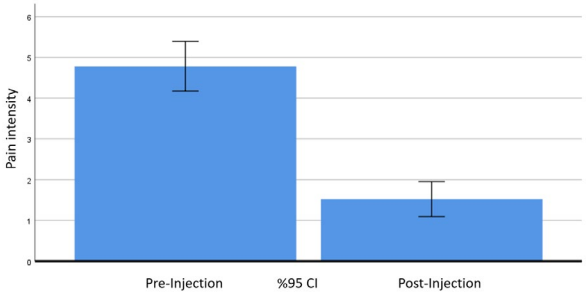

Fig.4: Pain intensity markedly decreased from severe/very severe to mild/very mild one month after injection.

Keywords: Facet joint injections, Lower back pain, Oswestry Disability Index

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Ref No: 9941

Amniotic Fluid Embolism: A Case of Catastrophic Maternal Collapse and Review of Current Pathophysiological Understanding

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[2]King Faisal General Hospital Al Ahsaa

Introduction and Purpose: Amniotic fluid embolism (AFE), characterized by the abrupt entry of amniotic debris into the maternal pulmonary circulation, represents a rare but devastating obstetric emergency. This syndrome, often manifesting as cardiovascular collapse, presents a significant clinical challenge due to its unpredictable nature and poorly understood aetiology. Recent evidence suggests a pathophysiological mechanism akin to anaphylaxis, rather than a purely embolic event, prompting the adoption of the term "anaphylactoid syndrome of pregnancy." This case report details the management of a patient experiencing AFE during a cesarean

section, highlighting the critical need for rapid recognition and aggressive intervention.
Materials and Methods: A 45-year-old gravida 4 para 5 patient at 39 weeks gestation was admitted for labour induction. Following the artificial rupture of membranes, fetal distress necessitated an emergency cesarean section under general anaesthesia. Intraoperatively, the patient suffered two episodes of cardiac arrest. Postoperatively, persistent haemorrhage mandated a total abdominal hysterectomy. Despite this, coagulopathy ensued, treated by haematology with cryoprecipitate and recombinant factor VIIa, consistent with disseminated intravascular coagulation (DIC). A subsequent third cardiac arrest occurred, culminating in a transfer to the intensive care unit (ICU) in a critically unstable hemodynamic state, requiring vasopressor support. The patient ultimately succumbed to the complications despite intensive multidisciplinary management.
Results and Conclusion: AFE is associated with a high maternal mortality rate, ranging from 10-16% globally, and a fetal mortality rate exceeding 30%. Complications, including pulmonary oedema, intractable seizures, DIC, and cardiac arrest, necessitate prompt and aggressive management to improve survival. This case underscores the importance of heightened clinical awareness and rapid response by nurses and clinicians. The shift towards an anaphylactoid model of AFE pathophysiology necessitates further research to refine diagnostic and therapeutic protocols, ultimately aiming to improve maternal outcomes in this catastrophic obstetric complication.
Keywords: amniotic fluid embolism, anaphylactoid syndrome of pregnancy, obstetric emergency

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Ref No: 9960
Yamagichu Syndrome
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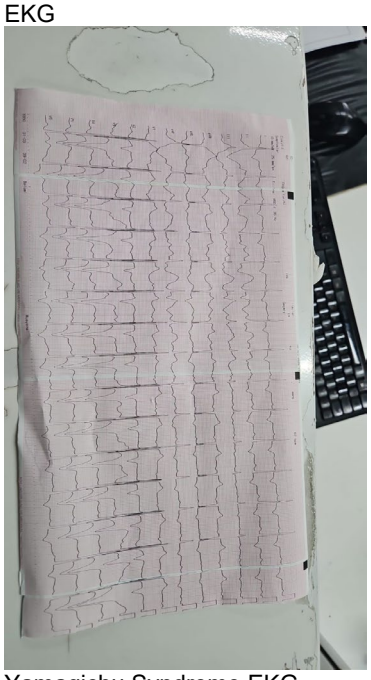
Introduction and Purpose: Hypertrophic Cardiomyopathy (HCM) is an autosomal dominant inherited disease caused by mutations in one of the nine genes that code for myocardial sarcomeric proteins. Apical Hypertrophic Cardiomyopathy (ApiHCM) is a relatively rare form of hypertrophic cardiomyopathy characterized primarily by apical involvement. It accounts for 25% of HCM cases in Japan and 1-2% of cases outside of Japan.
Materials and Methods: A 59-year-old patient presented to our emergency department with complaints of non-cardiac chest pain. The patient had a previous history of CABG. There were no notable findings in the physical examination. The patient's vital signs were stable, but the ECG showed widespread T-wave negativity, depressions, and possible elevation in AVR. Due to the patient's history and the possible elevation observed in the ECG (Image 1), the patient was referred to cardiology. The cardiology consultant performed an echocardiogram and diagnosed the patient with apical hypertrophic cardiomyopathy. No wall motion abnormalities were detected, and the ECG changes were attributed to this condition.
EKG



Yamagichu Syndrome EKG
Results and Conclusion: Yamagichu syndrome is a rare form of HCM, which should be considered, especially in patients who have previously exhibited early repolarization in anterolateral leads.
Keywords: Apical HCM, Yamagichu Syndrome

Ref No: 9965
One CT, One Chance.
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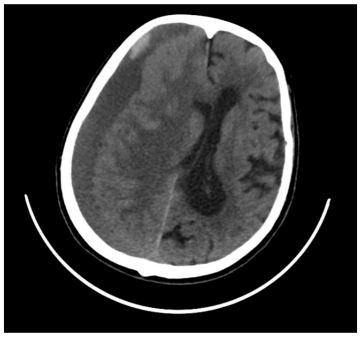
[2]Emergency Medicine Service, Muğla Training and Research Hospital

Introduction and Purpose: Introduction and Purpose: Spontaneous acute-on-chronic subdural hematoma (SDH) in elderly patients without a history of trauma is rare but potentially life-threatening, especially in those on antiplatelet therapy. Early clinical suspicion and timely imaging are crucial. This case illustrates the emergency recognition and management of a rapidly deteriorating patient diagnosed on a single CT scan.

Materials and Methods: Case: An 87-year-old female presented to the emergency department with dizziness, nausea, vomiting, and generalized weakness for three days. She had experienced transient slurred speech earlier that morning, which resolved spontaneously. Her medical history included hypertension, atrial fibrillation, heart failure, prior ischemic stroke, and left hip arthroplasty. She was on clopidogrel 75 mg daily, restarted two months prior following temporary cessation.On initial evaluation, vital signs were stable. Neurologic examination revealed no focal deficits and a GCS score of 15. While under observation, the patient acutely deteriorated within one hour, developing dysarthria, left upper extremity dystonic movements, and a GCS decline to 9 (E3M4V2). Blood pressure acutely rose to 200/100 mmHg. A single non-contrast cranial CT demonstrated a right-sided crescentic subdural collection with mixed density, consistent with acute-on-chronic SDH. There was mass effect with right lateral ventricle effacement and a midline shift to the left. Hyperdense areas in the frontal lobe suggested subacute hemorrhagic components. Neurosurgical consultation was obtained emergently. ED management included intravenous mannitol, dexamethasone, levetiracetam, ceftriaxone, and preparation of blood products. The patient underwent urgent burr-hole evacuation and was transferred to the intensive care unit postoperatively. Her neurologic status improved over the following days.

CT image



This non-contrast axial CT image of the brain reveals a left-sided subdural hematoma.

Results and Conclusion: Results and Conclusion: This case illustrates a dramatic neurological collapse due to a spontaneous acute-on-chronic subdural hematoma in an elderly woman on clopidogrel, diagnosed on a single CT following a rapid clinical change. In the absence of trauma, such presentations can easily be missed. Emergency physicians must remain alert to subtle red flags and act decisively. Early imaging, appropriate neuroprotective measures, and timely surgical intervention were critical in altering the trajectory of this patient's outcome. This case reinforces the need for aggressive evaluation of neurologic changes in elderly, anticoagulated patients—where one opportunity for diagnosis may be all that exists.

Keywords: Acute-on-Chronic, Subdural Hematoma, Clopidogrel

A Rare Case: Brain Abscess Presenting to the Emergency Department with Drowsiness

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Introduction:

Brain abscess is a rare diagnosis in patients presenting to the emergency department with nonspecific symptoms such as headache, altered consciousness, and drowsiness. It is a local bacterial infection of the brain parenchyma surrounded by a central purulent infection, potentially requiring urgent neurosurgical intervention. Neurological imaging is crucial for diagnosis. As in our case, contrast-enhanced MRI studies, which can be confused with acute ischemic infarction, facilitate definitive diagnosis.

Case Report:

A 65-year-old male presented with a 3-day history of headache and excessive but easily arousable sleepiness. His medical history included coronary artery disease, hypertension, and hyperlipidemia. He had no history of antibiotic use in the last 2 months, no diagnosed dental infection, or dental intervention. He reported a recent upper respiratory tract infection that resolved without medication about a month prior.

On emergency admission, his vital signs were normal except for elevated blood pressure. His ECG showed no signs of acute ischemia. Neurological examination revealed suspicious neck stiffness and mild right hemiparesis. Blood tests showed elevated inflammatory markers (WBC 21,250 mg/dL, CRP 19.60 mg/dL, ESR 46). Brain CT and MRI diffusion imaging were performed to rule out intracranial ischemic and hemorrhagic pathologies.

MRI DWI showed a lesion with restricted diffusion, corresponding to findings on FLAIR and CT, with no signal change on SWI, extending from the medial right temporal lobe to the posterior lateral ventricle. Contrast-enhanced cranial MRI was performed due to the difficulty in differentiating the space-occupying lesion as a mass or abscess. He received analgesic treatment and 2 grams of ceftriaxone IV in the emergency department. His blood pressure was reduced to 165/80 and stabilized. Neurology, infectious disease, and neurosurgery consultations were obtained. He was scheduled for hospitalization for abscess drainage, further examination, and treatment by neurosurgery.

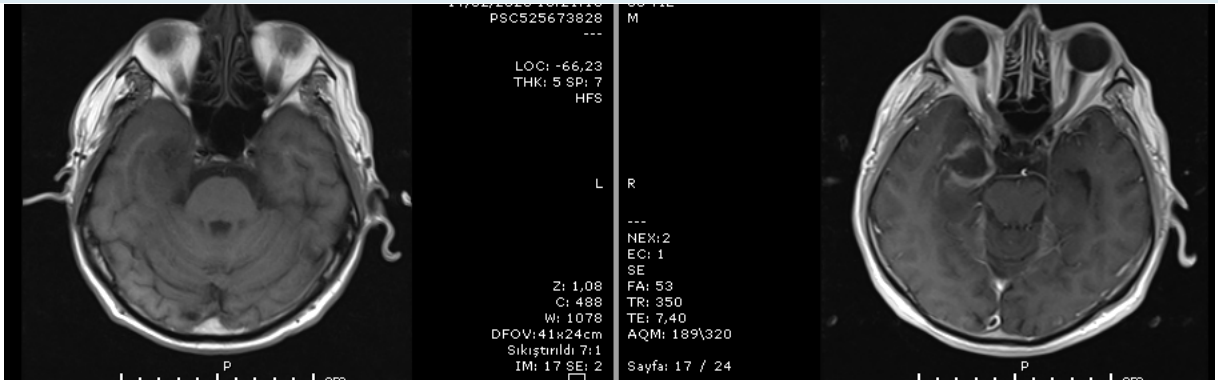

Figure: Peripheral contrast enhancement is observed in the area where the brain abscess is located.

Discussion:

This case highlights a rare presentation of brain abscess and a challenging clinical scenario. Brain abscess should be considered in patients presenting with atypical symptoms like drowsiness. Contrast-enhanced MRI is essential for differentiating brain abscess from other pathologies and for definitive diagnosis

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Ileus and HALP Score: Clinical Significance and Relationship

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Introduction

Ileus is the cessation or slowing of normal intestinal movement, caused by either mechanical obstruction or functional disorders. The HALP score combines hemoglobin, albumin, lymphocyte, and platelet levels to assess nutritional and inflammatory status. The score is helpful in risk assessment, treatment decisions, and prognosis prediction but should not be used alone for diagnosis and must be considered alongside other clinical findings.

Materials and Methods

This study analyzed the HALP scores of ileus patients to explore gender differences. Blood samples were used to measure hemoglobin, albumin, lymphocyte, and platelet levels. Demographic data, including age and gender, were recorded.

Results

This study analyzed gender differences in the HALP score and its components (hemoglobin, albumin, lymphocytes, platelets) in ileus patients. The average age of women was 62.84 ± 13.04 years, and for men, it was 59.77 ± 19.09 years (P = 0.458). Women had a lower average HALP score (24.76 vs. 28.07; P = 0.490). Hemoglobin levels were significantly lower in women (11.11 vs. 12.56 mg/dl; P = 0.002), potentially contributing to the lower HALP score and worse prognosis. Platelet counts were higher in women (307.66 vs. 245.90; P = 0.053), nearing statistical significance. Albumin and lymphocyte levels showed no significant gender differences (P = 0.115 and P = 0.336, respectively). Although women had slightly higher average age, it did not significantly affect the HALP score (P = 0.458). Overall, the findings suggest that lower hemoglobin levels in women may indicate poorer prognosis, although further research with larger sample sizes is needed.

POSTER PRESENTATIONS

Ref No: 1074
Vena Cava Superior Syndrome
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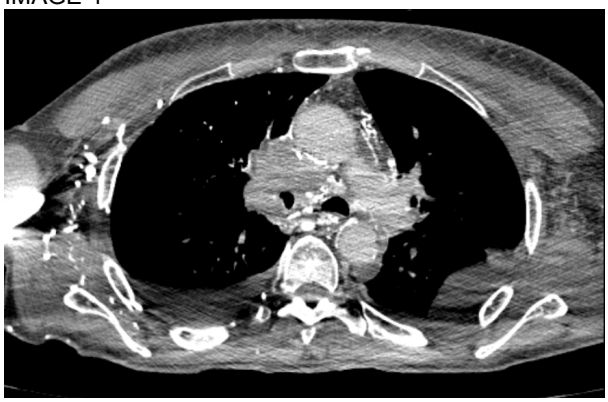
[1]Atatürk Üniversitesi Tıp Fakültesi Acil Tıp Anabilim Dalı
Introduction and Purpose: Superior vena cava syndrome (SVCS) is a clinical condition that occurs due to the obstruction of the superior vena cava, commonly caused by tumors or thrombosis. This syndrome is most frequently associated with malignancies and presents with symptoms such as facial, neck, and upper extremity swelling, dyspnea, and venous congestion. In this case report, we describe the evaluation of a patient who presented with post-cough facial and upper extremity swelling and dyspnea and was found to have a mass compressing the superior vena cava on imaging.
Materials and Methods: An 82-year-old male patient with no known comorbidities presented with swelling in the face, neck, and upper extremities, along with dyspnea, which worsened with coughing. Upon arrival, he was normotensive, and his oxygen saturation was 83%. Physical examination revealed angioedema-like swelling in the face, neck, and upper extremities, uvular edema, and prominent venous distension in the neck and thoracic wall.Contrast-enhanced thoracic computed tomography (CT) showed a mass compressing the superior vena cava (İMAGE-1). The patient was admitted to the pulmonary diseases department with a diagnosis of SVCS for further malignancy evaluation and management.
İMAGE-1

Results and Conclusion: Superior vena cava syndrome can often be the initial manifestation of an underlying malignancy and requires prompt diagnosis and management. This case highlights the importance of considering SVCS in patients presenting with significant upper body edema and venous congestion. Early diagnosis, identification of the underlying etiology, and appropriate treatment are crucial in improving disease prognosis and patient outcomes.
Keywords: ANJİOEDEMA, VENA CAVA SUPERİOR SYNDROME

Ref No: 1153
Necrotizing fasciitis in the anal area
alparslan altun[1], sultan tuna akgöl gür[1]
[1]Necrotizing fasciitis in the anal area
Introduction and Purpose: Necrotizing fasciitis is a disease characterized by rapidly spreading necrosis of soft tissues and fascia and can be fulminant if not treated appropriately. Although many bacteria are causative agents (Group A streptococcus, Clostridium perfringens, Bacteroides fragilis), Group A streptococcus is the most common agent. The most common sites are perineum and inguinal regions.
Materials and Methods: A 80 year old male patient presented with complaints of anal pain and constipation for 5 day. He was diagnosed with DM. Vitals were bp: 155/80 sat: 94 hr: 76 fever: 37.2. Rectal touch examination revealed tenderness and induration in the anal area. In blood tests, wbc was high in neutrophil dominance and crp was elevated. There was also a minimal increase in creatinine values. In imaging, it was determined as 'In CT interpretation, there are increases in density and air densities in the perianal region and an 8 CM sized loculation extending into the abdomen along the left endopelvic fascia along the left endopelvic fascia into the left anterolateral of the bladder and air densities in it'. The patient was consulted to the general surgery clinic. He was hospitalized with a diagnosis of necrotizing fasciitis by general surgery.
Results and Conclusion: Early diagnosis is the most important factor in the treatment of necrotizing fasciitis. The diagnosis is mainly based on clinical findings. In fact, the most important thing is the suspicion of necrotizing fasciitis by the physician evaluating the patient. As in this patient, early detection and treatment of necrotizing fasciitis, especially in elderly patients, is of life-saving importance.
Keywords: Necrotizing fasciitis, fulminant, air densities

Ref No: 1170
Subclavian artery thrombosis presenting with upper extremity ischemia and acute stroke
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[1]Pamukkale University
Introduction and Purpose: Subclavian artery thrombosis is an uncommon but serious vascular emergency that can lead to acute upper limb ischemia and cerebrovascular complications. Due to its often nonspecific presentation, early recognition is critical for preventing permanent neurological deficits and limb loss.

Materials and Methods: A 46-year-old male with a history of diabetes mellitus presented to the emergency department complaining of right arm pain and coldness that began two days prior and had worsened significantly in the past 4–5 hours. He denied any chest pain, dyspnea, nausea, or vomiting.On initial examination, blood pressure measured 112/65 mmHg in the left arm, while no measurable pressure could be obtained in the right arm. Vital signs were otherwise stable: oxygen saturation 99%, pulse rate 89 bpm, temperature 36.2°C, respiratory rate 19/min. Breath sounds were equal and clear bilaterally. Abdominal examination was unremarkable. On extremity exam, pulses were absent in the right upper limb, though muscle strength and neurological function were intact.ECG showed normal sinus rhythm with no ischemic changes. Bedside echocardiography revealed no structural abnormalities. Doppler ultrasonography showed findings suspicious for thrombus in the right subclavian artery. A computed yomography angiogram confirmed a 3.5 cm thrombus extending from the distal right subclavian artery to the axillary artery. Additionally, occlusion at the bifurcation of the right common carotid artery and absent contrast in the right internal carotid artery were noted.While awaiting vascular surgery consultation, the patient developed right-sided facial asymmetry. Urgent diffusion-weighted MRI confirmed an acute ischemic stroke involving the right MCA territory. Intravenous thrombolysis with alteplase (0.9 mg/kg) was administered, and the patient was admitted to the intensive care unit. Follow-up imaging showed resolution of the subclavian thrombus.
Results and Conclusion: This case illustrates the importance of prompt evaluation of acute upper extremity ischemia, particularly in patients at risk for vascular events. Subclavian artery thrombosis may be a harbinger of more extensive cerebrovascular pathology, and early recognition is essential for guiding effective, multidisciplinary management.
Keywords: subclavian artery thrombosis, upper limb ischemia, acute ischemic stroke

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Ref No: 1208
FEMUR FRACTURE
ABDULLAH SÜHA AKÇA[1], AYÇA ÇALBAY[1]
[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP ANABİLİM DALI
Introduction and Purpose: Postictal trauma is common in patients with epilepsy, particularly in individuals with motor dysfunction, necessitating careful evaluation for possible fractures. In this case, a 22-year-old male patient with a known history of epilepsy and cerebral palsy presented to the emergency department with complaints of swelling and pain in the left leg following a seizure. Based on physical examination and imaging findings, a femoral fracture was diagnosed, and an appropriate orthopedic and intensive care management plan was initiated.
Materials and Methods: A 22-year-old male patient with a known diagnosis of epilepsy and cerebral palsy was admitted to the emergency department due to a seizure, followed by pain and swelling in the left leg. On arrival, his vital signs were stable. Neurological examination was suboptimal due to underlying cognitive impairment. Physical examination revealed deformity and significant tenderness in the proximal left femur, while distal pulses were palpable. Radiographic imaging confirmed a displaced fracture of the femoral shaft. The patient was evaluated by the orthopedic team, who decided on closed reduction. Following the procedure, he was admitted to the intensive care unit for pain and hematoma monitoring.
Results and Conclusion: Seizure-related fractures due to falls or sudden muscle contractions can contribute to significant morbidity, particularly in patients with impaired motor and cognitive functions. In this case, a displaced femoral shaft fracture occurred following a seizure, requiring prompt orthopedic intervention. The decision for intensive care unit admission was made to closely monitor postoperative pain and hematoma development. This case highlights the importance of thorough postictal trauma assessment in epilepsy patients and emphasizes the need for a multidisciplinary approach in managing such complications.
Keywords: FEMUR FRACTURE

Ref No: 1248
Silent threat: mesenteric ischemia in a patient with melena
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[1]Pamukkale University
Introduction and Purpose: Melena, or black tarry stools, is a critical indicator of gastrointestinal (GI) bleeding that requires prompt evaluation. Although it is most commonly associated with upper GI sources, other less frequent but serious causes should not be overlooked. This case details a patient initially suspected of upper GI bleeding who was ultimately diagnosed with mesenteric ischemia.
Materials and Methods: A 72-year-old male with a medical history of hypertension and type 2 diabetes mellitus presented to the emergency department with complaints of melena, generalized weakness, and dizziness. On arrival, he was hypotensive (90/60 mmHg) and tachycardic (120 bpm), with mild disorientation. Physical examination revealed conjunctival pallor, cold extremities, weak peripheral pulses, and diffuse abdominal tenderness without signs of peritoneal irritation.Laboratory investigations showed severe anemia (hemoglobin: 7.8 g/dL, hematocrit: 25%) and leukocytosis (white blood cell count: 14,800/mm^3). Elevated lactate levels (3.5 mmol/L) were suggestive of tissue hypoperfusion, and elevated creatinine (1.8 mg/dL) indicated possible prerenal azotemia due to hypovolemia. The patient was promptly resuscitated with intravenous fluids and received two units of packed red blood cells.Given the initial suspicion of an upper GI bleed, gastroenterology was consulted. Nasogastric aspiration revealed no evidence of fresh blood. Upper GI endoscopy was unremarkable, showing no ulcers or active bleeding sources. However, colonoscopy revealed mucosal pallor, submucosal hemorrhages, and linear ulcerations localized to the descending colon and splenic flexure—findings consistent with ischemic colitis.Despite transfusion and supportive measures, the patient's condition deteriorated, marked by persistent abdominal pain and a rising lactate level. These findings raised concern for evolving mesenteric ischemia, prompting an urgent surgical consultation.
Results and Conclusion: This case underscores the importance of considering mesenteric ischemia in the differential diagnosis of patients presenting with GI bleeding, especially when typical bleeding sources are not identified on endoscopy. Ischemic colitis may be an early manifestation, but clinical deterioration, ongoing abdominal pain, hemodynamic instability, and metabolic derangement—such as elevated lactate—should raise suspicion for more severe ischemic processes. Early recognition and multidisciplinary collaboration are

vital to improving patient outcomes in such high-risk scenarios.
Keywords: gastrointestinal bleeding, melena, mesenteric ischemia

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Ref No: 1255
INFERIOR MYOCARDIAL INFARCTION PRESENTING WITH DIARRHEA
MERT DURMAZ[1], YAĞMUR KOCA[1], SEVİLAY VURAL[1], MİKAİL KUŞDOĞAN[1], EMRE GÖKÇEN[1], LEVENT ALBAYRAK[1]
[1]YOZGAT , BOZOK ÜNİVERSİTESİ MEDİCAL FACULTY
Introduction and Purpose: Inferior myocardial infarction (MI) is typically associated with occlusion of the right coronary artery (RCA), and less commonly the left circumflex artery. On ECG, it is characterized by ST-segment elevation in leads II, III, and aVF. Right ventricular and posterior wall involvement may also be present.Patients often present with chest pain, sweating, nausea, and hypotension. Although inferior MI generally has a lower mortality rate than anterior MI, it can be complicated by atrioventricular block, bradycardia, and right ventricular dysfunction.
Materials and Methods: A 60-year-old female was brought to the emergency department via EMS due to one day of diarrhea, occurring approximately 7 times. She also reported a brief episode of chest pain the day before.Past medical history included diabetes, hypertension, and hyperlipidemia. Vital signs: BP 110/79 mmHg, Temp 36.5°C, HR 102 bpm, SpO 95%. On physical exam, epigastric tenderness and occasional nausea were noted.Due to her chronic conditions and prior chest pain, an ECG was performed and labs were drawn. ECG findings were consistent with inferior MI. Cardiology was consulted, and the patient was admitted to the coronary ICU for emergency angiography.Lab results:Troponin T: 1243 ng/LTroponin I: 17 ng/mLAngiography findings:LMCA: NormalLAD: Proximal 40–50% stenosis, distal 90–99% (narrow)CX: 30% stenosisRCA: Dominant, proximal 30% stenosisVentriculography: Not specifiedDiagnosis: Coronary Artery Disease – Inferior STEMI
Intervention: Primary PCI to RCA
Results and Conclusion: Inferior MI, though often less severe than anterior MI, can still lead to serious complications such as bradycardia, AV block, and right heart failure. Early recognition, appropriate treatment, and rapid intervention are essential to reduce mortality and morbidity.
Keywords: Inferior myocardial infarction (MI), dıarrhea

Ref No: 1328
ACUTE PANCREATITIS
ALİ KERİM ÖZPOLAT[1], ZEYNEP ÇAKIR[1]
[1]ACUTE PANCREATITIS
Introduction and Purpose: Acute Pancreatitis is an inflammatory condition of the pancreas that can lead to local damage, systemic inflammatory response syndrome and organ failure. Acute pancreatitis is the most common gastrointestinal disease requiring hospitalization. Patients with acute pancreatitis often experience abdominal pain, nausea and vomiting, which negatively impacts quality of life. The most common causes of AP are gallstones and alcohol, which together account for 80% of cases; the remainder of cases are due to less common causes, including drug reactions, pancreatic hard and cystic malignancies, and hypertriglyceridemia.
Materials and Methods: A 75-year-old woman presented with complaints of abdominal pain and 1 episode of vomiting for about 24 hours. Her vital signs were normal on admission (Pulse: 85 SPO2: 95 TA: 125/85 FEVER: 36.7). The patient had no known comorbidities and had previously undergone cholecystectomy surgery.Physical examination revealed tenderness in the right upper quadrant, epigastric region and left upper quadrant of the abdomen. Lung sounds were normal and external examinations were unremarkable. In the tests taken from the patient, HGB: 13.5, WBC: 7130 AMYLASE: 429 , GGT: 406 , ALP: 284 , AST: 288, ALT: 360 , LDH: 415 , DIRECT BILIRUBIN: 0.2 , TOTAL BILIRUBIN: 1.2 , were obtained. CT scan of the patient's abdomen was performed: No gallbladder was observed (operated), choledochal diameter was measured as 15 mm and it ends by being examined distally. Contamination was observed in the surrounding fatty planes of the pancreas and Pancreatitis? It was reported as pancreatitis. The patient was consulted to internal medicine and hospitalized in gastroenterology service.
Results and Conclusion: The most common cause of acute pancreatitis is gallstones. Other etiologic causes in this patient with a history of cholecystectomy include alcohol, hypertriglyceridemia, hypercalcemia, drug-related, OI, hereditary/genetic, anatomical anomalies and idioptic acute pancreatitis. The diagnosis is made if acute epigastric pain in the lower back is accompanied by a 3-fold increase in serum amylase or lipase levels and/or one of the imaging findings. The patient is hospitalized for treatment and follow-up. Fluid therapy is the cornerstone of FP treatment. If persistent organ failure (>48 hours) is present, the patient should be followed up in intensive care unit.
Keywords: PANCREATITIS, ABDOMINAL PAIN, CHOLECYSTECTOMY

Ref No: 1357
A case of disseminated intravascular coagulation in the emergency department
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Introduction and Purpose: Disseminated intravascular coagulation (DIC) is a complex syndrome marked by systemic activation of the coagulation cascade, leading to both thrombotic and hemorrhagic complications. Intravascular fibrin deposition causes occlusion of small and medium-sized vessels, potentially resulting in impaired organ perfusion and multiorgan failure. Simultaneously, consumption of clotting factors and platelets may lead to severe bleeding.Cutaneous manifestations are seen in approximately two-thirds of DIC cases and range from petechiae and ecchymoses to ischemic skin necrosis and hemorrhagic bullae. In some cases, these lesions can progress to symmetric peripheral gangrene. DIC is typically secondary to an underlying condition such as infection, hematologic malignancy, or solid organ cancer. This report presents a case of DIC in a patient with a known uterine malignancy.

Materials and Methods: A patient with a history of uterine malignancy presented to the emergency department with ecchymosis on both toes (Figure 1). Arterial and venous Doppler ultrasonography of the lower extremities showed no evidence of vascular occlusion.Laboratory tests revealed a platelet count of 10 K/μL, D-dimer level of 35.2 mg/dL, fibrinogen of 99.3 mg/dL, prothrombin time (PTZ) of 25 seconds, and a calculated DIC score of 10. Based on these findings, and in the context of an underlying malignancy and possible infection, a diagnosis of DIC was made in consultation with the hematology team.The patient received supportive therapy, including transfusion of 2 units of platelets, 2×5 units of cryoprecipitate, and 1×3 units of fresh frozen plasma. Broad-spectrum antibiotic therapy with piperacillin–tazobactam was initiated due to suspicion of infection. Following transfusions, the platelet count increased to 67 K/μL. The patient was subsequently admitted to the Internal Medicine Intensive Care Unit for ongoing management.
Results and Conclusion: This case highlights the importance of considering DIC in the differential diagnosis of patients with known malignancy who present to the emergency department with signs of bleeding and coagulation abnormalities. Early recognition and prompt treatment of DIC are essential to reduce morbidity and improve outcomes.
Keywords: disseminated intravascular coagulation, malignancy, hemorrhagic complications

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Ref No: 1364
A case report of perimyocarditis
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[1]Pamukkale University
Introduction and Purpose: Perimyocarditis is an inflammatory condition in which pericarditis, myocarditis, and sometimes endocardial involvement occur simultaneously. It typically presents with chest pain and tachycardia. Early diagnosis and treatment are crucial to prevent complications.
Materials and Methods: A 25-year-old male patient with no known chronic diseases presented with a 5-day history of progressively worsening, constrictive chest pain. He described the pain as persistent, unaltered by exertion, and present even at rest, with occasional radiation to the back. The pain worsened with breathing. On physical examination, tachycardia was noted, and breath sounds were normal. Blood pressure was within normal limits, and the ECG revealed widespread ST segment elevations along with tachycardia. Laboratory results showed elevated troponin, CK-MB, and erythrocyte sedimentation rate (ESR). An echocardiogram performed by the cardiology team revealed vegetations. The patient was admitted to the coronary intensive care unit for observation with a preliminary diagnosis of perimyocarditis.
Results and Conclusion: Perimyocarditis can be associated with viral infections, autoimmune diseases, or bacterial infections. In the differential diagnosis of myocardial infarction with widespread ST segment elevation, caution is required. Treatment is generally supportive and tailored according to the underlying cause. In young patients presenting with chest pain and tachycardia, perimyocarditis should be considered, and prompt diagnosis with appropriate treatment is essential.
Keywords: chest pain, tachycardia, perimyocarditis

Ref No: 1368
A BULLET AFFAİR
NİSA MINDIZ[1], MUHAMMED CENGİZHAN DURMUŞ[1], MERVE BULUT[1], ERDAL TEKİN[1]
[1]ATATURK UNIVERSITY DEPARTMENT OF EMERGENCY MEDICINE
Introduction and Purpose: Traumatic brain injury refers to brain damage caused by sudden and severe impact to the head, such as hitting an object (e.g., car window, radiator, concrete) or by an object penetrating the skull and damaging brain tissue (e.g., bullets). In developed countries, head trauma is one of the leading causes of mortality and morbidity in the population over the age of 45. Half of patients with severe head trauma die at the scene or within the first minutes or hours. Only 40-50% of survivors of severe head trauma recover without sequelae.
Materials and Methods: A 29-year-old male patient was brought to our facility after a self-inflicted gunshot wound to the head. Upon arrival, the patient's Glasgow Coma Scale (GCS) was 10, non-orientated and non-cooperative. The patient had a gunshot entrance wound in the left frontotemporal region and an exit wound in the right frontotemporal region. Pupils were anisocoric, and there was periorbital ecchymosis bilaterally. Imaging revealed fractures in the bilateral frontal sinus walls, multiple fractures in the bilateral orbital walls, fractures in the frontal and parietal bones, and fractures in the bilateral maxillary sinuses. The patient also had subarachnoid hemorrhage (SAH) extending from the frontal to parietal regions, along with epidural and subdural hemorrhage, and pneumocephalus. The patient was urgently taken to surgery after being evaluated by the neurosurgery department.
PHOTO 1

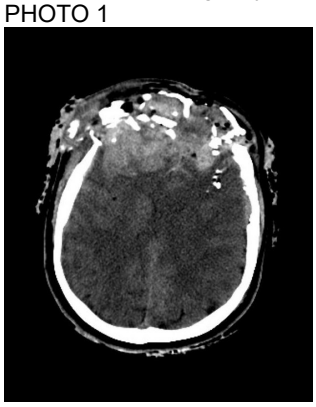
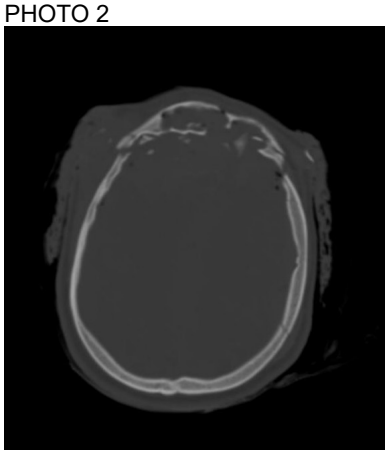


PHOTO 2



Results and Conclusion: A well-performed non-contrast brain CT scan can easily diagnose intracranial hemorrhages (intra-cerebral, epidural, subdural), brain herniation, brain edema, traumatic brain infarction, facial or skull base fractures, pneumocephalus, and foreign bodies within the skull. In the emergency department, rapid assessment of patients with severe head trauma should be conducted, and if necessary, antibiotic therapy and tetanus vaccination should be administered. Imaging studies should be promptly performed, and consultations with relevant departments should follow.

Keywords: INTRACRANIAL HEMORRHAGES, TRAUMATIC BRAIN INJURY, BULLET

Ref No: 1410

A rare stroke case: Heubner's artery occlusion

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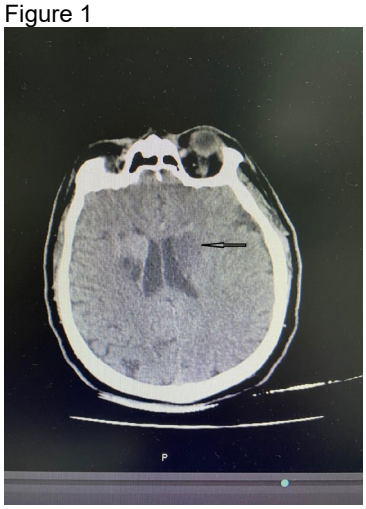
Introduction and Purpose: Heubner’s artery, also known as the medial striate artery, is an important structure in cerebral vascular anatomy. It plays a crucial role in supplying blood to the basal ganglia, particularly the anterior portions of the caudate nucleus and putamen, the anterior limb of the internal capsule, and the superior parts of the hypothalamus.

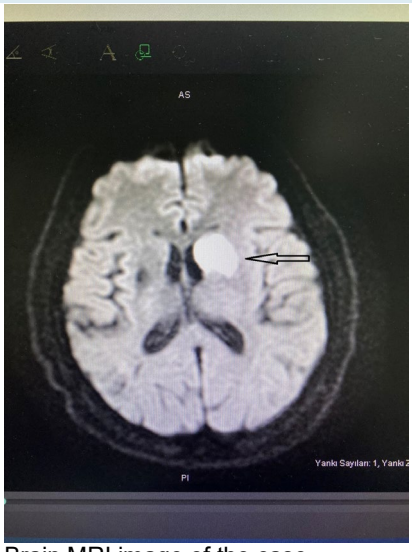
Materials and Methods: A 50-year-old male patient was brought to the emergency department by his relatives due to complaints of meaningless speech and gait disturbances that had developed over the past few days. The patient had no known medical history but had a history of chronic alcohol dependence.Vital Signs;Blood Pressure: 145/88 mmH,SpO □ 98%,Temperature: 36.4°C,Blood Glucose: 158 mg/dL,Heart Rate: 74 bpm,Glasgow Coma Scale (GCS): 13,Physical Examination;General condition: Moderate,Consciousness: Alert, cooperative, but disoriented,Pupils: Isocoric, light reflex present (+/+),Neck stiffness: Absent,Speech: Mild dysarthria,Motor strength: 4/5 in the right upper and lower extremities,Other system examinations: Unremarkable,Cardiac Evaluation,ECG: Normal sinus rhythm, no ST-T changes.Echocardiography: Normal ejection fraction, no valvular pathology, no intracardiac thrombus detectedMedical History,No known comorbidities,History of chronic alcohol dependenceImaging FindingsBrain CT: hypodense area at the level of the left basal ganglia (Figure1)Diffusion-weighted Brain MRI: Infarction observed in the left Heubner’s artery territory and left basal ganglia, confirmed with ADC correlation (Figure 2-3).The patient was admitted to the neurology intensive care unit for further evaluation and treatment. A neurovascular council consultation was planned.

Figure 1

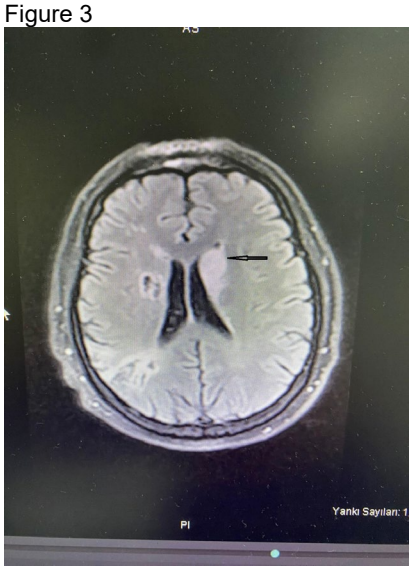


Brain CT image of the case

Figure 2



Brain MRI image of the case
Figure 3



Brain MRI image of the case

Results and Conclusion: Heubner's recurrent artery is a branch of the anterior cerebral artery (ACA) that supplies the head of the caudate nucleus and the anterior limb of the internal capsule. This artery is not present in all individuals; about 25% of people have a single Heubner's artery, while others may have multiple branches.Infarction of Heubner's artery can lead to brachiofacial hemiparesis due to ischemia in the anterior limb of the internal capsule.More proximal occlusions of the artery may result in spastic paraplegia and contralateral sensory deficits.Additional symptoms may include urinary incontinence and gait apraxia.Occlusive damage to Heubner's artery can also manifest with contralateral grasp reflex abnormalities and frontal lobe dysfunction.When the infarction affects the left hemisphere, patients may develop transcortical motor aphasia or contralateral gaze preference, with or without aphasia.

Keywords: Emergency department, Heubner's artery, anterior cerebral artery

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Ref No: 1432

FROM RHEUMATOID ARTHRITIS TO CARDIAC EFFUSION

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Introduction and Purpose: Common causes of pericardial effusion include viral or idiopathic pericarditis, malignancy, uremia, trauma, and radiation therapy. Less commonly, drug reactions and autoimmune diseases may also be responsible. Pericardial effusions are often asymptomatic. In patients with underlying conditions such as cancer or renal failure, symptoms like fever, cough, chest pain, or dyspnea should raise suspicion for effusion. In this case, we aim to raise awareness of pericardial effusion as a rare complication of rheumatoid arthritis.

Materials and Methods: A 42-year-old male presented with shortness of breath and chest pain, ongoing for two weeks and worsening over the past few days. His medical history included rheumatoid arthritis, COPD, and a recent diagnosis of pericardial effusion one week prior. Vital signs were: temperature 36.9°C, blood pressure 80/50 mmHg, heart rate 98 bpm, oxygen saturation 90%. ECG showed

normal sinus rhythm.On physical examination, lung auscultation revealed rales; heart sounds were muffled without additional murmurs. No other significant findings were noted. Bedside echocardiography showed pericardial effusion: 18 mm near the lateral wall, 19 mm posteriorly, and 10 mm near the right heart chambers, without evidence of tamponade.Lab results showed WBC 25.99×10³/mm³, CRP 9.77 mg/dL, creatinine 1.50 mg/dL, and D-dimer 1.40 µg/mL. Consultations with internal medicine, infectious diseases, pulmonology, and cardiology suggested that a flare of rheumatoid arthritis exacerbated the effusion. The patient was admitted to the cardiology ICU for close monitoring.

Results and Conclusion: Although systemic autoimmune diseases are less frequently encountered in emergency settings, their potential to cause or worsen pericardial involvement should not be overlooked. Patients with autoimmune conditions and coexisting respiratory or cardiac symptoms require detailed evaluation and workup

Keywords: pericardial effusion, pericarditis, rheumatoıd arthrıtıs

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Ref No: 1531

ELBOW DISLOCATION CAN OCCUR IN ADULTS TOO

Erhan Şahin[1], Ayça Çalbay[1]

[1]Atatürk Üniversitesi

Introduction and Purpose: Elbow dislocations can be either complete or partial and generally occur following a trauma such as a fall or accident. In a complete dislocation, the joint surfaces are fully separated, while in a partial dislocation, the joint surfaces are only partially separated. A partial dislocation is also known as a subluxation. Elbow dislocations are not common but typically occur when a person falls onto an outstretched hand. When the hand hits the ground, the force is transmitted to the elbow, often accompanied by a rotational movement. This can displace and rotate the elbow out of its socket. A complex dislocation can cause severe bone and ligament injuries. In the most severe cases, blood vessels and nerves passing through the elbow can be damaged. If this occurs, there is a risk of losing the arm. In patients with connective tissue disorders and high joint mobility, even minor trauma can cause such subluxations.

Materials and Methods: A 32-year-old male patient presented with elbow pain after falling onto his left hand from a height of one meter. The patient had no known comorbidities, and his vital signs were within normal limits. On systemic examination, there was restricted range of motion, a deformity, and tenderness over the olecranon region of the left elbow. The neurovascular examination was normal. A direct radiograph revealed an elbow dislocation, and the patient was referred to orthopedics. Under sedation, reduction was performed, and the post-reduction neurovascular examination was normal. A CT scan showed a millimetric bone fragment within the joint. The patient was discharged with symptomatic treatment and recommended follow-up with orthopedics.

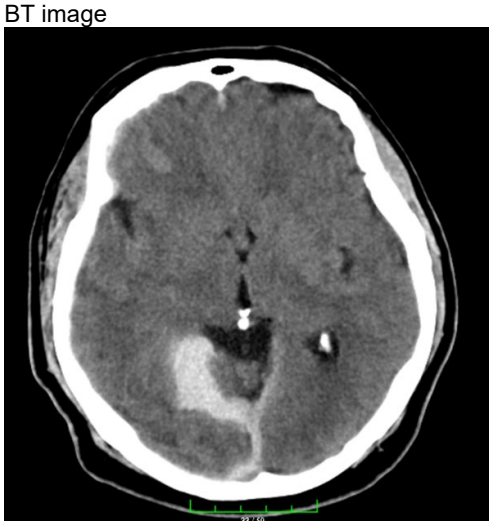
Results and Conclusion: In adults, elbow dislocations resulting from direct or indirect trauma should be diagnosed promptly and treated under the supervision of specialists due to the complex ligament structures and neurovascular proximity involved. This case highlights the importance of raising awareness about this rare type of dislocation in the emergency department and emphasizing the necessity of advanced imaging for proper management.

image1

image2

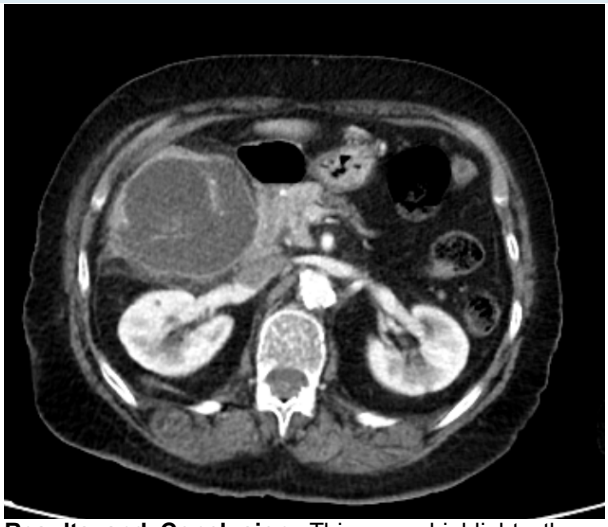
Keywords: ELBOW DISLOCATION

Ref No: 1618
Subarachnoid Hemorrhage
Berk ORAL[1], Ayça ÇALBAY[1]
[1]Atatürk University
Introduction and Purpose: Subarachnoid hemorrhage (SAH) is a pathological condition in which blood spreads into the subarachnoid space. Traumatic subarachnoid hemorrhage, on the other hand, refers to the situation where blood is distributed into the subarachnoid space due to the rupture of intracranial arteries and bridge veins following trauma or diffusion from cortical contusions.
Materials and Methods: A 60-year-old male patient when he hit the back of his head, after he slipped and fall three days before, presented to emergency department . The patient complained of sweating and nausea but had not vomited. There were no signs of any lesions on his head, and his Glasgow Coma Scale (GCS) score was 15. Neurological examination was normal. No fractures were seen on the radiograph. Despite symptomatic treatment, nausea persisted, so a brain CT was requested. The CT scan revealed an intracerebral hemorrhage (ICH) and subarachnoid hemorrhage (SAH) in the right temporal region. The patient was consulted to the neurosurgery department and was admitted to the intensive care unit for surgery.
Results and Conclusion: Neurological examination of trauma patients can be normal. However, for patients with persistent symptoms, advanced imaging should be performed. Non-contrast CT is the first step in diagnosing SAH. CT has high sensitivity within the first three days after symptoms appear. It is also crucial for identifying pathologies that may require urgent surgical intervention, such as local intracerebral hemorrhage or hydrocephalus after aneurysm rupture.
BT image



Keywords: head trauma, Subarachnoid hemorrhage

Ref No: 1727
Gallbladder Perforation in an 80-Year-Old Female
ŞAFAK ÇOMURLU[1], ZEYNEP ÇAKIR[1]
[1]ATATURK UNIVERSITY
Introduction and Purpose: Abdominal pain in elderly patients can be a symptom of various gastrointestinal and abdominal pathologies. Gallbladder diseases, in particular, pose significant clinical challenges in elderly individuals. Gallbladder perforation, a condition characterized by the disruption of the gallbladder wall integrity, is a severe complication that requires urgent surgical intervention. In this case, an 80-year-old female patient presented with right upper quadrant pain and vomiting, and diagnostic findings were consistent with gallbladder pathology.
Materials and Methods: An 80-year-old female patient arrived at the emergency department with complaints of severe abdominal pain and tenderness in the right upper quadrant. The pain had persisted for a week but had worsened significantly on the day of presentation, accompanied by vomiting. On physical examination, guarding was detected in the right upper quadrant, and the patient exhibited tenderness to palpation. Laboratory findings revealed leukocytosis and elevated C-reactive protein (CRP) levels, suggesting inflammation and a possible infection.Abdominal computed tomography (CT) showed an enlarged gallbladder measuring approximately 74×80 mm. Irregularities in the gallbladder wall and findings suggestive of perforation were noted, raising suspicion of gallbladder rupture. Additionally, cystic duct dilation up to 21 mm and perfusion abnormalities in the liver parenchyma were observed. These findings indicated a possible biliary obstruction and hepatic perfusion disturbances secondary to gallbladder perforation.Gallbladder perforation is commonly associated with gallstone disease or severe cholecystitis. In elderly patients, such complications are more frequent and often present with a more complex clinical course. Gallbladder perforation can lead to bile leakage, intra-abdominal infection, and peritonitis.In elderly patients, preoperative antibiotic therapy is essential to control sepsis before surgical intervention. Due to the potential for reduced tolerance to anesthesia and surgery, a multidisciplinary approach is necessary in the management of these patients. Gallbladder perforation is a surgical emergency, and delayed treatment can lead to severe complications, including mortality.
Gallbladder Perforation



Results and Conclusion: This case highlights the complex clinical presentation of gallbladder perforation in elderly patients and emphasizes the need for urgent intervention. Early diagnosis, appropriate antibiotic therapy, and timely surgical management can significantly improve patient outcomes. In elderly individuals, the clinical manifestations of gallbladder disease are often atypical, making careful evaluation and early intervention critical for survival.

Keywords: Gallbladder, Perforation

Ref No: 1778

Inferior glenohumeral dislocation (luxatio erecta humeri): a case presentation

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[1]Nigde training and research hospital

Introduction and Purpose: The shoulder joint is the joint where dislocations occur most frequently. Multi-directional mobility of the shoulder joint, its anatomic structure and frequent exposition to traumas result in the more frequent occurrence of dislocations. Inferior dislocation (luxatio erecta), with an occurrence rate of 0.5% among all shoulder dislocations, on the other hand, is a traumatic case that is observed quite rarely, which generally occurs during hyperabduction type trauma of the arm. In such cases, it is usually observed that the inferior capsule of the joint is torn. The current study presents case of inferior dislocation of the glenohumeral joint that were treated with closed reduction.

Materials and Methods: A 45-year-old male patient presented to our emergency department with complaints of severe pain in his right shoulder and inability to lower his arm after a traffic accident in November 2024. During the physical examination of the patient, it was determined that the patient's right hand was elevated at head level and the elbow was flexed. Palpation revealed fullness in the axilla. No neurological or vascular injuries were detected. The radiological evaluation revealed that the humeral head was dislocated inferior. The radiograph showed that the humeral joint was dislocated inferiorly. Closed reduction was achieved under intravenous sedation and analgesia with traction of the humeral head in the same direction as the humerus, outward and upward, and traction of an assistant inthe opposite direction. It was checked again for neurological and vascular injuries. In the control radiograph, it was seen that the anatomical relationship of the joint was provided. A Velpeau bandage was applied for three weeks for immobilization. Orthopedic outpatient clinic control was recommended.

Figure 1

Figure 2

Figure 3

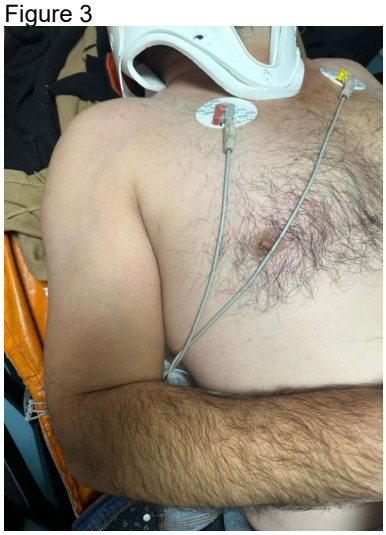


Figure 4

Results and Conclusion: Result and ConclusionIn cases of inferior dislocation of the shoulder, neurovascular compression injuries are usually found as a complication, but they often heal after reduction. Cases of axillary artery injuries and axillary vein thrombosis have been presented in the literature. Vascular injuries develop more frequently in patients with luxatio erecta compared to anterior, posterior, and upward dislocations of the shoulder. The treatment for inferior shoulder dislocation is traction under sedation and analgesia and closed reduction with traction applied in the opposite direction.

Keywords: Luxatio erecta, shoulder dislocation, traffic accident

Ref No: 1814
Spontaneous İliopsoas Haematoma Due To Warfarin Overdose: A Case Report
Ayşegül Uygur[1], Çiğdem Sarı Yıldızhan[1]
[1]Yalvaç State Hospital
Introduction and Purpose: Iliopsoas hematoma (IPH) is a rare but serious complication in patients on anticoagulant therapy, with causes including trauma, coagulopathy, vasculitis, and retroperitoneal tumors. Anticoagulant therapy, especially warfarin, heparin, and DOACs, is the most common cause in non-traumatic cases. Diagnosis can be delayed due to the retroperitoneal location and lack of specific symptoms. Severe pain in the groin and abdomen, along with clinical signs, should raise suspicion. Ultrasonography may not fully assess the retroperitoneal space, making contrast-enhanced CT the most reliable imaging method for diagnosis.
Materials and Methods: A 52-year-old male patient, on long-term warfarin therapy following mechanical mitral valve replacement (MVR), presented to the emergency department with epistaxis. Initial evaluation showed stable vital signs, with no pathological findings other than epistaxis. Laboratory results were within normal limits: hemoglobin 14.3 g/dL, hematocrit 43.7%, MCV 95.4 fL, platelets 193,000/mm³. However, the patient's INR was 10. The warfarin dose was skipped for 1 day, and 2.5 mg intravenous vitamin K was administered per cardiology recommendations. Since there were no active bleeding or significant complaints, the patient was discharged with instructions for INR follow-up the next day.Approximately 6 hours after initial discharge, a 52-year-old male patient on warfarin therapy presented again with new-onset left groin pain. Initial evaluation showed stable vital signs, with tenderness in the left lower abdomen but no rebound tenderness. Laboratory results revealed a decrease in hemoglobin from 14 g/dL to 11 g/dL, while INR decreased from 10 to 4. A contrast-enhanced abdominal CT scan identified a left iliopsoas muscle hematoma. The patient was given fresh frozen plasma, and consecutive hemogram monitoring and vital sign follow-up were initiated. After consultation with general surgery, the patient was admitted, showing no significant decrease of hemoglobin, maintaining hemodynamic stability, and avoiding surgical intervention. Warfarin therapy was adjusted, and the patient was discharged with resolution of the hematoma.
Results and Conclusion: This case highlights that focusing solely on INR values is inadequate for managing warfarin-related bleeding. Early consideration of retroperitoneal hematoma in patients on anticoagulants and prompt imaging can reduce mortality and morbidity by preventing diagnostic delays.
Keywords: emergency medicine, anticoagulation complication, iliopsoas haematoma

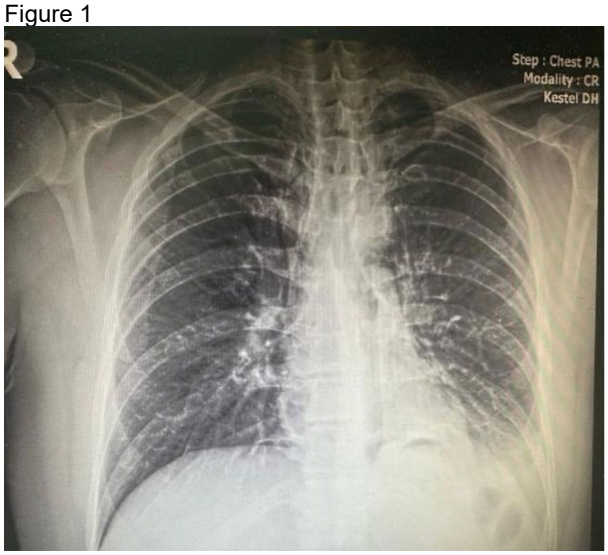
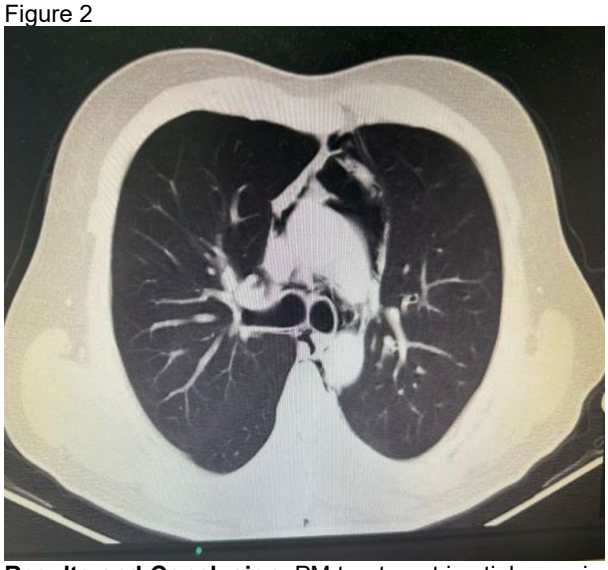
Ref No: 1903
Pneumomediastinum
Dursun Mafis[1], Yesim Isler[1], Halil Kaya[1], Melih Yüksel[1], Mehmet Oguzhan Ay[1]
[1]University of Health Sciences Turkey, Bursa Yuksek Ihtisas Training and Research Hospital, Department of Emergency Medicine, Bursa
Introduction and Purpose: Pneumomediastinum (PM), first described by Rene Laennec in 1819 after trauma, was later described by Hamman in 1839 as spontaneous. It is a rare, generally benign and self-limiting condition. Its pathogenesis is responsible for the passage of air into the interstitial space and mediastinum as a result of ruptures in the respiratory or digestive tracts when intrathoracic pressure increases. In severe cases, it can lead to complications such as pneumothorax, tension pneumothorax or pneumopericardium, leading to airway obstruction and decreased venous return to the heart, and life-threatening shock conditions.
Materials and Methods: A 36-year-old male patient was admitted to the emergency department with complaints of cough, fever and shortness of breath for 1 week and had severe chest pain for 1 day. Known: COPD patient. Physical examination: GCS: 15 Auscultation revealed decreased breath sounds in the lower zones of the left lung, bilateral wheezing and a crackling sound synchronized with the apex beat of the heart. Vital signs: Fever: 36.3 C°, Pulse: 114/Min, Blood Pressure: 70/40 Mm/Hg, Respiratory Rate: 25, SpO2: 83, Blood Pressure: 149 mg/dl Laboratory tests were normal. After examination, the patient was diagnosed with Pneumomediastinum pneumothorax and left lung lower lobe pneumonia (Figure 1-2). After 1 week of triple antibiotic and symptomatic treatment in the thoracic surgery department, his condition improved. He was discharged with the recommendation of outpatient clinic control.
Figure 1


Figure 2



Results and Conclusion: PM treatment is etiology-oriented, if necessary, surgical intervention should be planned and cases diagnosed with PM should be kept under surveillance for an average of 24-36 hours. Patients' complaints usually improve quickly and cases that become clinically stable can be discharged.

Keywords: dyspnea, chest pain, pneumomediastinum

Ref No: 1933

Do The Criteria Know Everything?

Murat Kurtulmuş[1], Fatma Tortum[1]

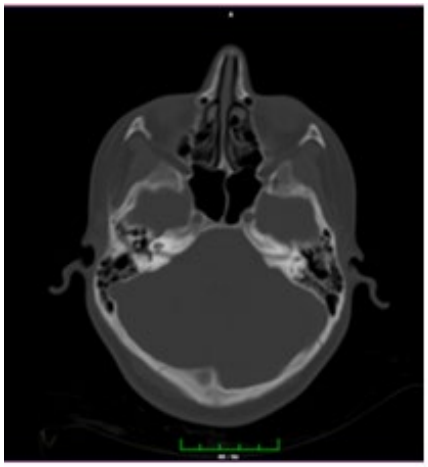
[1]Atatürk Üniversitesi

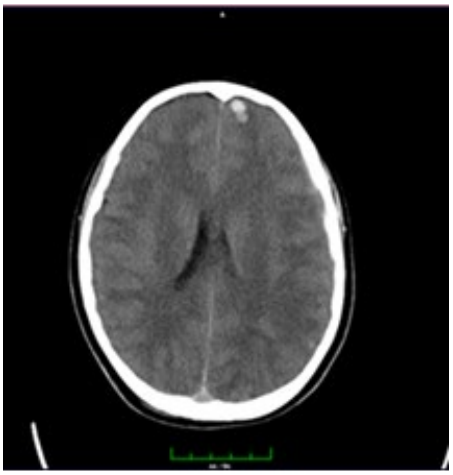
Introduction and Purpose: The Pecarn criteria are guidelines used to help clinicians decide whether a CT (computed tomography) scan is necessary for children with minor head trauma, particularly to assess the risk of clinically significant brain injury. In children over 2 years of age, the Pecarn criteria generally do not recommend a CT scan for isolated, one-time vomiting.

Materials and Methods: Case: A 12-year-old female presented to the emergency department after falling from the same level and sustaining a head injury. She had vomited once but had no other complaints. She has no underlying medical conditions, is not on any medications, and has no active issues. The patient reported pain in the right occipital region. Her Glasgow Coma Scale (GCS) score was 15. Blood pressure is 110/70 mmHg, oxygen saturation is 97%, and pulse rate is 89 bpm. The patient exhibited an apathetic gaze, so a decision was made to perform a CT scan. A CT scan revealed a fracture in the right occipital region, along with a counter-coup lesion in the left frontal region. The patient was subsequently admitted to the neurosurgery service.

Results and Conclusion: Conclusion: While CT scans are not routinely recommended in some cases, clinical judgment based on the physician’s experience and careful evaluation can be crucial. In this case, the decision to perform a CT scan helped identify potentially life-threatening injuries that might have otherwise gone undetected.

ct





ct

Keywords: trauma, ct, pecarn

Ref No: 1939
Foreign body aspiration in an elderly patient: a critical airway emergency
Tuba Nur Vural[1], Mert Ozen[1], Alten Oskay[1], Atakan Yilmaz[1], Murat Seyit[1], Ibrahim Turkcuer[1]
[1]Pamukkale University
Introduction and Purpose: Foreign body aspiration (FBA) is a potentially life-threatening condition, particularly in elderly individuals and patients with neurological disorders. Prompt recognition and intervention are crucial to prevent severe respiratory compromise. This case highlights the diagnostic and therapeutic approach to FBA in an elderly patient with multiple comorbidities.
Materials and Methods: An 82-year-old male nursing home resident with a history of ischemic stroke, hypertension, epilepsy, and dementia was brought to the emergency department by EMS after experiencing respiratory distress and loss of consciousness during breakfast. On initial evaluation by nursing home staff, he was pulseless, and cardiopulmonary resuscitation (CPR) was initiated. After approximately five minutes, return of spontaneous circulation (ROSC) was achieved prior to hospital arrival. He was intubated in the field, with a Glasgow Coma Score of 3 upon presentation.Upon admission, the patient had palpable peripheral pulses, fingertip oxygen saturation of 100%, blood pressure of 154/83 mmHg, heart rate of 98 bpm, and body temperature of 36.4°C. Auscultation revealed diffuse rales on both lung fields. ECG showed sinus tachycardia without ischemic changes. Transthoracic echocardiography was unremarkable, with no evidence of tamponade, right heart strain, or significant wall motion abnormalities.Arterial blood gas analysis revealed a pH of 7.18, pCO □ of 61 mmHg, pO □ of 75 mmHg, HCO □□ of 22.5 mmol/L, and lactate of 2.28 mmol/L. With a working diagnosis of aspiration pneumonia, thoracic computed tomography was performed, revealing an 8×8 mm hyperdense foreign body at the distal right intermediate bronchus, causing total obstruction of the lower lobe and near-complete obstruction of the middle lobe bronchus.Thoracic surgery was consulted. Multiple millimetric food particles and an olive pit were removed from the main bronchi via aspiration, restoring airway patency. The patient was subsequently admitted to the intensive care unit.
Results and Conclusion: FBA should always be considered in elderly or in patients with altered mental status. This case underscores the importance of early imaging, clinical suspicion, and multidisciplinary collaboration for timely diagnosis and definitive management.
Keywords: foreign body aspiration, elderly, emergency airway

Ref No: 1962
Case presentation: spontaneous pneumothorax
Saffet Guler[1], Alten Oskay[1], Mert Ozen[1], Murat Seyit[1], Atakan Yilmaz[1], Ibrahim Turkcuer[1]
[1]Pamukkale University
Introduction and Purpose: Spontaneous pneumothorax is a condition commonly observed in young, asthenic males, particularly those with a history of smoking. It occurs commonly due to the presence of subpleural blebs or bullae that can rupture, leading to the accumulation of air in the pleural space and subsequent lung collapse. Prompt recognition and management are crucial to prevent complications and ensure optimal patient outcomes.
Materials and Methods: Spontaneous pneumothorax is a condition commonly observed in young, asthenic males, particularly those with a history of smoking. It occurs commonly due to the presence of subpleural blebs or bullae that can rupture, leading to the accumulation of air in the pleural space and subsequent lung collapse. Prompt recognition and management are crucial to prevent complications and ensure optimal patient outcomes.
Results and Conclusion: Spontaneous pneumothorax is commonly seen in young individuals with a history of smoking. Management depends on the size of the pneumothorax and the severity of symptoms. Initially, the patient was treated with oxygen therapy and closely monitored. As the patient's symptoms worsened, the possibility of placing a chest tube was considered, and further treatment options were discussed. The patient was also informed of the increased risk of recurrence of pneumothorax due to his prior smoking history.Spontaneous pneumothorax is a condition frequently observed in young, smoking individuals and can lead to severe respiratory complications. In this case, the patient’s smoking history may have contributed to the development of pneumothorax, even after cessation. Early diagnosis and appropriate treatment are critical to ensuring lung re-expansion. The patient's condition continues to be closely monitored, with an individualized treatment plan in place.
Keywords: chest pain, lung collapse, spontaneous pneumothorax

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Ref No: 2045
Mesenteric panniculitis; radiological and clinical evaluation of 15 patients
Yusuf TANRIKULU[1], Gökhan YILMAZ[2], Süleyman KARGIN[3], Ramazan Saygın KERİMOĞLU[3], Ceren ŞEN TANRIKULU[4]
[1]Baskent University, Faculty of Medicine, Department of General Surgery, Konya, Türkiye
[2]Medipol University, Faculty of Medicine, Department of General Surgery, İstanbul, Türkiye
[3]Health Science University, Konya City Hospital, Department of General Surgery, Konya, Türkiye
[4]Health Science University, Konya City Hospital, Department of Emergency Medicine, Konya, Türkiye
Introduction and Purpose: Mesenteric Panniculitis (MP) is a fibrotic, non-neoplastic inflammatory disease. MP can induce gastrointestinal and systemic symptoms such as abdominal discomfort, nausea, vomiting, diarrhea, weight loss, and fever. It has been reported that 20-25% of patients require hospitalization after admission, while no pathology is discovered in 35-40% of them despite the tests performed; the pain usually resolves spontaneously and is classified as nonspecific abdominal pain. The goal of our study was to compare the clinical findings, laboratory, and imaging results of 15 individuals.
Materials and Methods: Patients who were followed up on and treated for mesenteric panniculitis in a tertiary university hospital's general surgery clinic. A total of 2361 patient CT scans were evaluated, and archive records were used to compile data for 15 patients with mesenteric panniculitis. The patients' demographics, complaints, hospitalization requirements, therapy methods, laboratory, and radiographic characteristics were all analyzed

Results and Conclusion: Abdominal pain was the most common complaint among the patients (80%). This was followed by nausea, vomiting (40%), chest pain (33%), and diarrhea (7%). Fat halo sign was seen in 8 patients due to mesenteric vascular involvement. In 5 patients, an image consistent with mesenteric adenitis greater than 10 mm was found. Four patients exhibited a pseudo capsule appearance, and two had a mesenteric mass pushing on the intestinal loops. Mesenteric panniculitis is a disease that should be considered in the differential diagnosis of patients who present to the emergency department with abdominal pain, as it will ensure that the patient receives the appropriate treatment and reduce the high rate of patients discharged with the diagnosis of non-specific abdominal pain.

Demographic characteristics of patients

Table 1. Demographic characteristics of patients

Gender (Male/Female)	6 (40%) / 9 (60%)
Mean age (years)	66.40 ± 13.20
Complaints	
Abdominal pain	12 (80%)
Chest pain	5 (33%)
Nausea-vomiting	6 (40%)
Diarrhea	1 (7%)
Fever	3 (20%)
Weakness	3 (20 %)
Asymptomatic	1 (7%)
Comorbid disease	
Diabetes mellitus	2 (13%)
Hypertension	2 (13%)
None	13 (74%)
Previous Surgery	
Appedectomy	4(26%)
Cholecystectomy	2 (13%)
Hospitalization	7 (47%)
Surgical treatment	2 (13%)
Length of stay (days)	1.67 ± 1.76

Table 1

Laboratory results of patients

Table 2. Laboratory results of patients

WBC (x1000/L)	11.85 ± 4.57
CRP (mg/L)	56.09 ± 14.68
NLR	5.34 ± 5.16
MPV (fL)	8.60 ± 1.71
Hg (g/dL)	14.15 ± 1.35
Urea (mg/dL)	37.07 ± 8.40
Creatinin (mg/dL)	0.94 ± 0.18
Glucose (mg/dL)	131.67 ± 27.93
ALT (U/L)	25.27 ± 15.61
AST (U/L)	23.93 ± 11.68

WBC; white blood cell, CRP; C-reactive protein, NLR; neutrophil lymphocyte ratio, MPV; mean platelet volume, Hg; hemoglobin, ALT: alanine aminotransferase, AST; aspartate aminotransferase

Table 2

Keywords: Abdominal pain, acute abdomen, mesenteric panniculitis

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Ref No: 2106

A rare case of ST-elevation myocardial infarction (STEMI) following trabectedin treatment

İlter Düzgün[1], Melih Yüksel[1], Mehmet Oğuzhan Ay[1], Yeşim İşler[1], Halil Kaya[1]

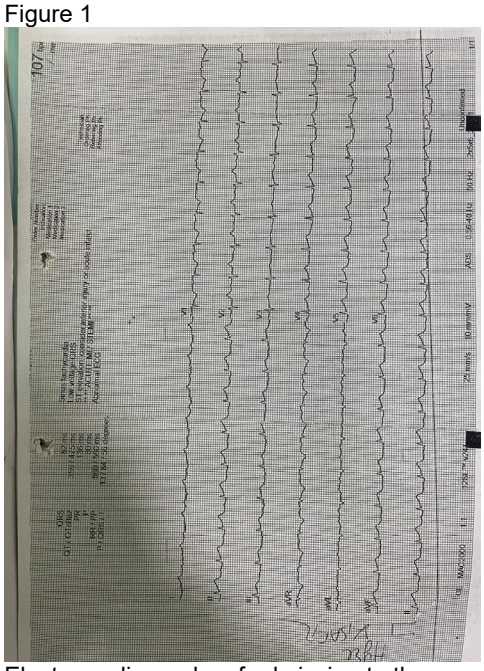
[1]University of Health Sciences, Bursa Yuksek Ihtisas Training and Research Hospital, Department of Emergency Medicine, Bursa /Türkiye

Introduction and Purpose: Although anticancer treatments significantly improve the quality of life and survival of oncology patients, their adverse effects on cardiac health remain a critical concern. This case report aims to emphasize the importance of chemotherapy agents' side effects in patients undergoing chemotherapy.

Materials and Methods: A 42-year-old female patient with a known history of hypertension and diabetes had been diagnosed with a High-Grade Malignant Mesenchymal Tumor (Epithelioid Leiomyosarcoma). She presented to the emergency department (ED) with complaints of nausea, vomiting, loss of appetite, and intermittent cough five days after receiving chemotherapy (trabectedin).Vital Signs:•Respiratory rate:20 breaths/min•Oxygen saturation:90%•Blood pressure:117/75 mmHg•Heart rate:100beats/min•Body temperature:36.5°CGlasgow coma score was 15, general condition was moderate and respiratory sounds were bilaterally coarsened.Medical History:•Previous Total abdominal hysterectomy + bilateral salpingo-oophorectomy + pelvic and para-aortic lymphadenectomy + omentectomy•20 pack-year smoking history (ex-smoker)•No alcohol or substance useElectrocardiography (ECG):

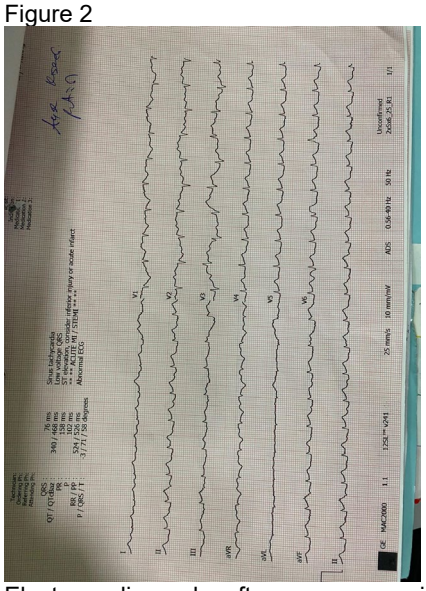
Demonstrated inferoposterior STEMI (Figure 1). Emergency Coronary Angiography (CAG) identified a plaque-containing lesion in the RCA, while the CX and LAD were normal. Acute coronary syndrome was ruled out. Pulmonary embolism was also excluded via CT pulmonary angiography. However, in the third ECG taken after CAG, ST-segment elevation persisted (Figure2). Echocardiogram:•Ejection fraction(EF): 20% (Severe global hypokinesia)(Note: One month prior, outpatient ECHO reported an EF of 60%.)İntensive Care Unit(ICU) Laboratory Follow-up:•Troponin(ng/L): 9900→20,000→40,000•B-type natriuretic peptide(pg/mL): 600→900→2000•White blood cell count(cells/μL):2870→700•Hemoglobin(g/dL):9.8→9.1•Platelet count(cells/μL):49,000→50,000•Neutrophil count(cells/μL):1960It was considered that the patient developed ST elevation myocarditis, heart failure and pancytopenia secondary to the cardiotoxic chemotherapy agent. Despite optimal supportive measures in the ICU, her condition progressively deteriorated. She ultimately suffered cardiac arrest and passed-away on the 10th day of admission.

Figure 1



Electrocardiography of admission to the emergency department

Figure 2



Electrocardiography after coronary angiography

Results and Conclusion: The incidence of cardiovascular adverse effects during trabectedin treatment has been reported as approximately 3.4%, including myocarditis, heart failure, and other cardiovascular complications. In the ED, patients should not be evaluated solely based on typical symptoms; instead, a comprehensive clinical approach that considers all systemic findings is essential.

Keywords: ST-elevation myocardial infarction, emergency department, chemotherapy

Ref No: 2157

Our eyes that see and our ears that hear are our examination.

ÖMER TURALİOĞLU[1], FATMA TORTUM[1]

[1]Atatürk University Faculty of Medicine Department of Emergency Medicine

Introduction and Purpose: A 60-year-old male patient was brought to us due to assault. Upon arrival, his general condition was poor, and he had already undergone endotracheal intubation. The emergency service teams reported that he had arrested four times. His blood pressure was around 70/50 mmHg.

Materials and Methods: On examination, extensive subcutaneous emphysema, diffuse rales, and rhonchi in lung sounds were noted. His Glasgow Coma Score (GCS) was 3. All necessary emergency interventions were promptly performed in the emergency department resuscitation room.Imaging studies revealed a sacral fracture, fractures in the superior and inferior pubic rami, and an anterior wall fracture of the left acetabulum. Therefore, an orthopedic consultation was requested.Intra-abdominal bleeding and bowel perforation were detected, necessitating a general surgery consultation.Multiple rib fractures, hemopneumothorax, extensive emphysema, pulmonary contusion, and a displaced sternum fracture were identified, prompting a thoracic surgery consultation. A tube thoracostomy was performed on the left lung, draining 400 cc of hemorrhagic fluid.

image 1

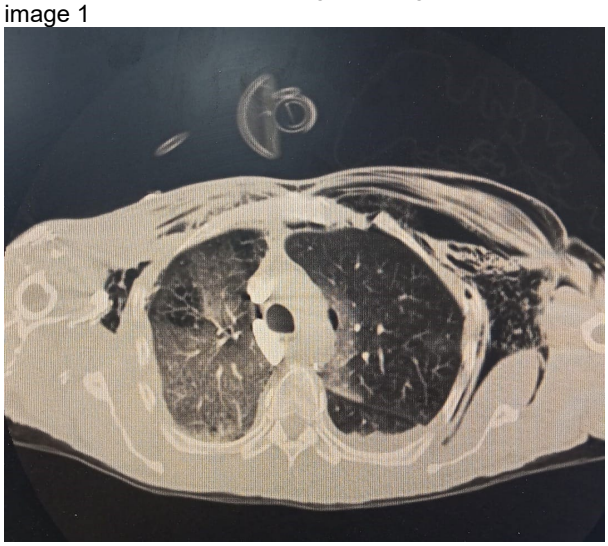


image 2

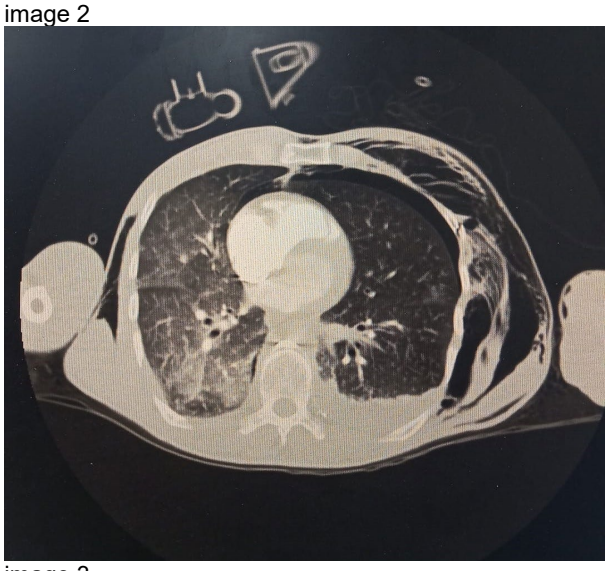


image 3

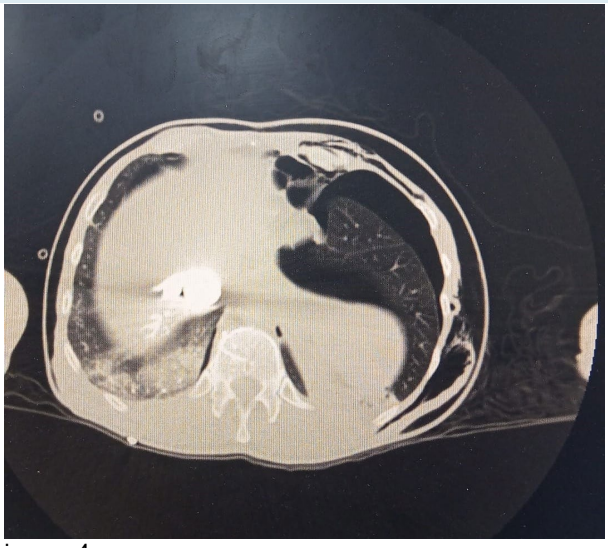


image 4

Results and Conclusion: This case reinforced the importance of being extremely meticulous when examining patients presenting to the emergency department with multiple traumas. We once again understood the necessity of conducting a thorough, systemic examination of the entire body. Had we failed to recognize the signs of pneumothorax, extensive subcutaneous emphysema, pelvic fractures, and other pathologies during our examination, any delay in medical intervention could have cost the patient their chance of survival.

Keywords: assault, arrest, trauma

Ref No: 2165

The Bleeding Sheath Knows How to Cover Itself: Rectus Sheath Hematoma

Mehmet Ulutürk[1]

[1]**Burdur State Hospital**

Introduction and Purpose: Rectus sheath hematoma (RSH) results from the rupture of the inferior or superior epigastric artery, often due to trauma or spontaneously. It commonly presents with nonspecific symptoms like abdominal pain, leading to underdiagnosis. Risk factors include anticoagulant therapy, severe coughing, hypertension, advanced age, and prior abdominal surgeries. First-line treatment is conservative management (CM), involving fluid resuscitation, blood transfusion, anticoagulation reversal, and bed rest. If CM fails, surgical intervention or embolization may be needed.

Materials and Methods: An 86-year-old female with a history of heart failure and arrhythmia presented to the emergency department with abdominal pain. She was on furosemide, rivaroxaban, nebivolol, and digoxin. Upon admission, her blood pressure was 105/64 mmHg, oxygen saturation 92%, temperature 36.2°C, and heart rate 100 bpm. Physical examination revealed bilateral lower thoracic rales and a 6x5 cm tender swelling in the right lower abdomen near the umbilicus. Laboratory results showed hemoglobin 16.32 g/dL, platelets 239,600 K/uL, white blood cells 7,947 K/uL, creatinine 0.92 mg/dL, and INR 5.38. Contrast-enhanced abdominal CT revealed a 5 cm rectus sheath hematoma with active extravasation. The patient was admitted for treatment and monitored by general surgery. Abdominal ultrasound confirmed a 65x34 mm hypoechoic lesion within the rectus muscle, consistent with an intramuscular hematoma. Treatment included 1 unit of fresh frozen plasma, symptomatic management for nausea and vomiting, and intravenous hydration. Following cardiology adjustments, the patient was discharged two days later.

Axial view of rectus sheath hematoma on CT

Axial view of rectus sheath hematoma
Sagittal view of rectus sheath hematoma

Sagittal view of rectus sheath hematoma on CT

Results and Conclusion: RSH is a medical emergency requiring prompt evaluation and management. The decision between conservative or invasive treatment depends on the physician's judgment. Early diagnosis and intervention are key to ensuring rapid recovery and preventing complications.

Keywords: Rectus Sheath Hematoma, Anticoagulan Therapy

Ref No: 2229

COINCIDENTAL CAROTIS COMMUNIS DYSEXION

Şamil Emin Yalçın[1], Sultan Tuna Akgöl Gür[1], Alparslan Altun[1]
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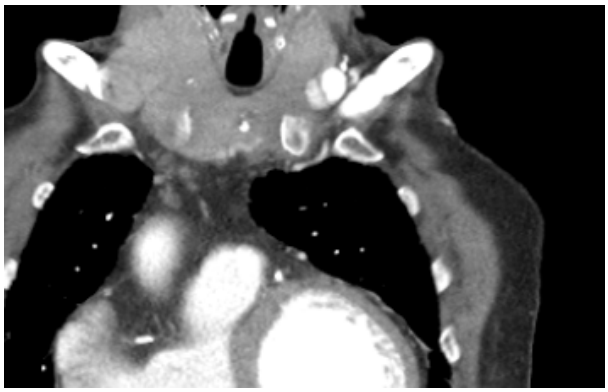
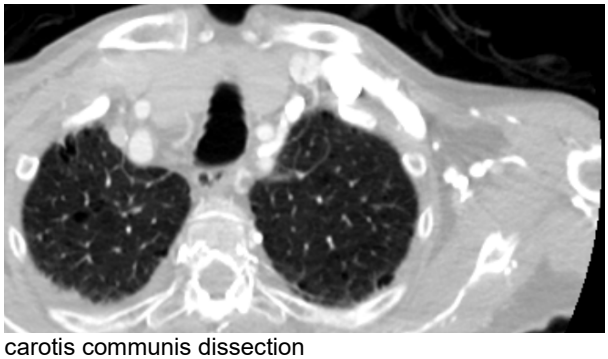
Introduction and Purpose: Dissection is the rupture of the intima of an artery, resulting in the formation of 2 lumens, one of which is a false lumen. If there is a vessel leaving the false lumen, the flow of this artery is lost. Infarcts are observed in the areas it supplies.

Materials and Methods: An 83 y male patient was admitted with chest pain and shortness of breath. He had known diagnoses of kah, af, angio-stent and bph. His vitals were mean nb: 115, sat:88 ta: 86/58, temperature: 36.7. There were no acute pathologic examination findings. Blood tests revealed elevated d-dimer and trop. Angiographic CT scan showed left carotid communis dissection. The dissection did not extend to the external and internal carotid junction[1]. The patient was evaluated by cardiovascular surgery and neurology and discharged with a follow-up recommendation.

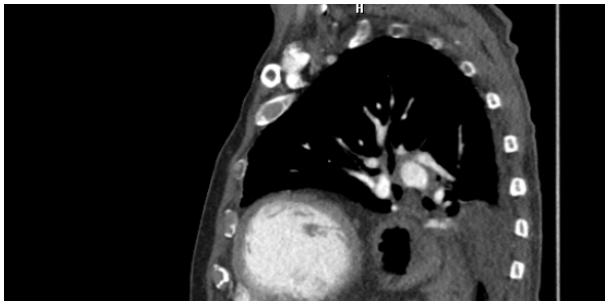
carotis communis dissection



carotis communis dissection



carotis communis dissection



Results and Conclusion: Our patient had stabbing pain from chest to back and shortness of breath. He had no acute pathologic examination findings. Because he was hypoxic, tachycardic and hypotensive, trop and d-dimer tests were elevated and imaging was performed. Although we primarily look for pulmonary embolism and aortic dissection, we should keep in mind that we should look at the whole imaging picture.

Keywords: carotis communis, dissection

Ref No: 2279

The Importance of Differential Diagnosis

Fazilet Gucuko[1], Atakan Yilmaz[1], Murat Seyit[1], Mert Ozen[1], Alten Oskay[1], Ibrahim Turkcuer[1]
[1]Pamukkale University, Department of Emergency Medicine, Denizli, Turkey

Introduction and Purpose: Acute retinal artery occlusion is an ophthalmic emergency that presents with painless, unilateral, sudden vision loss or visual field loss. The occlusion can occur in the ophthalmic artery, central retinal artery or its branches, and the cilioretinal

artery. It is more commonly seen in elderly male patients with cardiovascular disease. Although age-related differences are observed in its etiology, embolic and thrombotic conditions are considered the primary causes. History and ophthalmologic examination are often sufficient for diagnosis; however, imaging methods are used for diagnosis and follow-up.
Materials and Methods: A 64-year-old female patient with no known medical history experienced a sudden sensation of a curtain descending over her left eye four hours before presentation, followed by painless, complete vision loss in the same eye. While waiting in line, her vision loss partially improved, but she still reported blurred vision. Alongside this complaint, she experienced headaches, dizziness, nausea, and vomiting four times.On physical examination, her neurological and abdominal examinations were normal. Her pupillary response was +/+, direct and indirect light reflexes were +/+, and pupils were isocoric. Visual acuity was found to be decreased. The patient was initially evaluated for stroke. Brain CT and diffusion MRI findings were normal, vital signs were stable, ECG showed normal sinus rhythm with no pathological findings, and blood tests were within normal limits.Following symptomatic treatment, her systemic symptoms improved, but her vision loss persisted. The patient was referred to the ophthalmology department. She was admitted to the ophthalmology unit, diagnosed with retinal artery occlusion, and started on hyperbaric oxygen therapy. Further investigations were planned to determine the underlying etiology.
Results and Conclusion: The purpose of presenting this case is to emphasize that when systemic symptoms accompany localized findings, diagnoses based solely on localized symptoms should not be prioritized. In our case, despite the presence of systemic symptoms alongside sudden vision loss, the primary systemic causes were ruled out before identifying the actual ophthalmic problem. The process of reaching a differential diagnosis took time and led to a delay in treatment.
Keywords: Acute arterial occlusion, retinal artery, physical examination

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Ref No: 2297
Emergency approach to subdural bleeding
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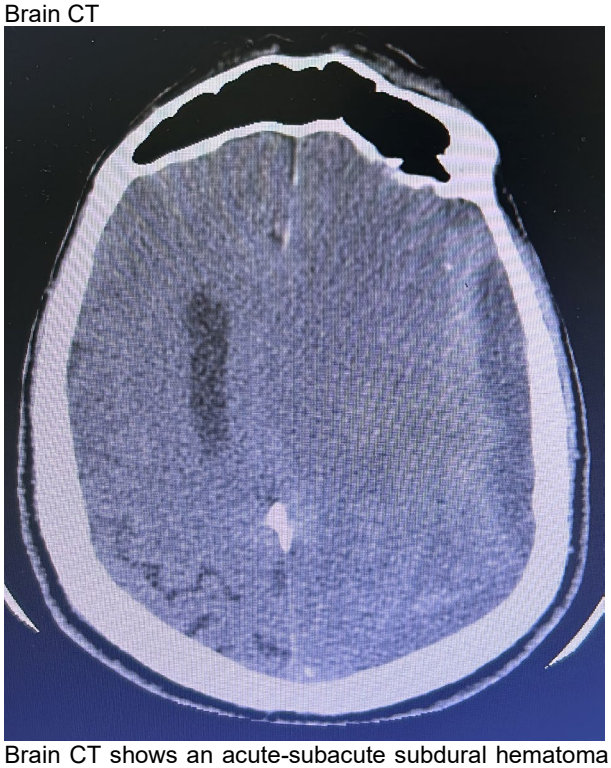
[2]BOLVADİN STATE HOSPİTAL
[3]AFYONKARAHİSAR HEALTH SCIENCES UNIVERSITY HOSPITAL
Introduction and Purpose: Emergency approach to subdural bleeding. 68-year-old male patient with no comorbidities and no history of surgery. He was brought to the emergency room on the 112 call with a complaint of syncope.
Materials and Methods: Vitals: Blood pressure: 128/75 mmHg, Pulse: 69 beats/minute, respiratory rate: 25 breaths/minute. Fever: 36.6. SpO2: 95.Physical Examination: GCS 14. There is a tendency to sleep. There is a headache. Extremity movements are natural.
Brain CT



Brain CT shows an acute-subacute subdural hematoma measuring 31 mm at its thickest point in the left cerebellar convexity. The left lateral ventricle appears compressed and there is a slight shift to the right in the midline.
Results and Conclusion: The patient was diagnosed with acute subdural and underwent emergency surgery. His treatment continued in the ward on the 3rd postoperative day.
Keywords: Acute, Subdural, Syncope

Ref No: 2370

Neurofilament Light Chain as a Biomarker for Neurological Prognosis in Post-Cardiac Arrest Patients

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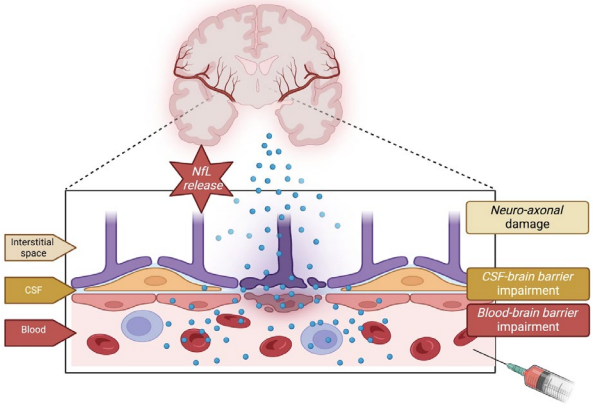
[1]LUXMED Group, Warsaw, Poland
[2]International European University, Kyiv, Ukraine
[3]Bezmialem Vakif University, Fatih, Istanbul, Turkey
[4]The John Paul II Catholic University of Lublin, Lublin, Poland

Introduction and Purpose: Out-of-hospital cardiac arrest (OHCA) is a major public health concern with low survival rates despite advances in care. Neurological outcomes after return of spontaneous circulation (ROSC) vary widely. Accurate early prediction of prognosis remains difficult. Neurofilament light chain (NFL), a structural protein in myelinated axons, is released into the bloodstream following axonal injury, particularly in hypoxic-ischemic brain injury (HIBI; Fig. 1). Studies have investigated NFL levels as a potential biomarker for neurological prognosis in OHCA patients, assessing its correlation with outcomes at different post-ROSC time points.

Fig. 1. Neurofilament light chain mechanism of action



Materials and Methods: This meta-analysis was conducted following PRISMA guidelines. A comprehensive search was performed across PubMed, Embase, Scopus, and Web of Science databases to identify studies evaluating neurofilament light chain (NFL) as a prognostic biomarker in patients after out-of-hospital cardiac arrest (OHCA). Keywords included “neurofilament light chain,” “NFL,” “cardiac arrest,” “OHCA,” and “neurological outcome.” Eligible studies included observational or interventional research that reported NFL measurements at defined time points post-ROSC and correlated them with neurological outcomes. Data extraction focused on NFL concentrations, measurement timing, and outcome definitions.

Results and Conclusion: Immediately after ROSC, NFL levels were low in both groups, averaging 26.24 ± 31.41 pg/mL in patients with good outcomes and 37.45 ± 32.54 pg/mL in those with poor outcomes (p=0.20; Fig. 2). By 24 hours, NFL levels rose sharply in the poor outcome group (1710.37 ± 3344.64 pg/mL) but remained low in the good outcome group (43.43 ± 47.83 pg/mL; p<0.001). This gap widened at 48 hours (4581.38 ± 10767.13 vs. 56.68 ± 64.75 pg/mL; p<0.001) and persisted at 72 hours (3947.71 ± 7155.10 vs. 60.79 ± 62.74 pg/mL; p<0.001; Fig. 3). These results demonstrate a clear and progressive increase in NFL concentrations in patients with poor neurological outcomes, with the most pronounced differences emerging from 24 hours onward.

Fig. 2. Pooled analysis of NfL concentration among patients with good and poor neurological outcome

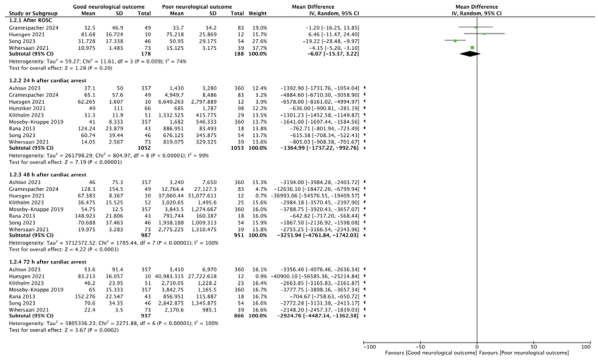
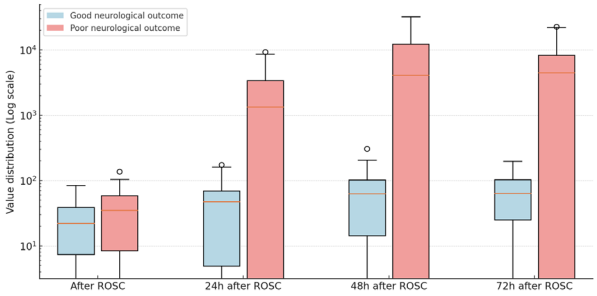


Fig. 3. Mean NfL concentration among good and poor neurological outcome groups



Keywords: neurofilament light chain, cardiac arrest, neurological status

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Ref No: 2450

GIS PERFORATION

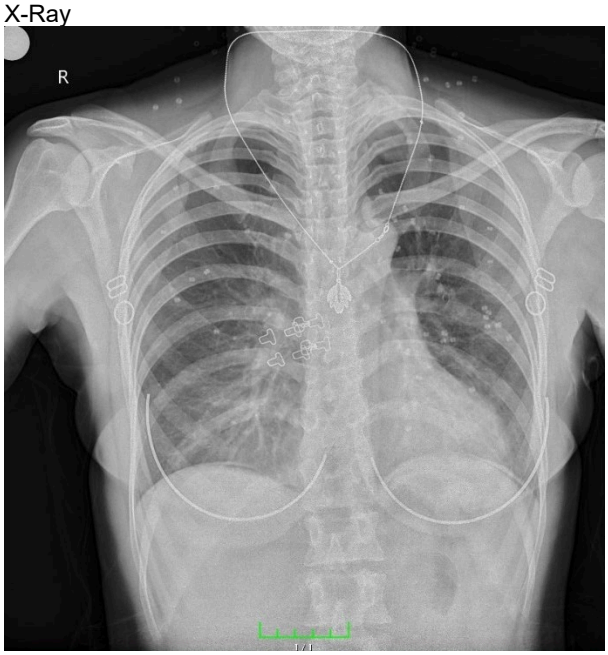
Dr. Alara Nergiz Soslu[1], Assoc. Prof. Dr. Ali Gür[1]

[1]Ataturk University Faculty of Medicine, Department of Emergency Medicine

Introduction and Purpose: The diagnosis of gastrointestinal system perforation can be made by the history taken from the patient or by the collection of free air or fluid seen on diagnostic imaging performed while investigating abdominal pain. Iatrogenic causes, blunt or penetrating trauma, mesenteric ischemia, ileus, neoplasms, foreign body aspiration, medications, appendicitis, peptic ulcer can be considered mostly in the etiology of perforation. Peptic ulcer is the most common cause of gastric and duedonal perforation. The incidence of perforation in peptic ulcer patients is between 3 and 6.5 per 100,000. Perforation of the stomach and duedonum often requires surgical intervention (open or laparoscopic). For this reason, rapid surgical consultation is necessary due to the risk of intra-abdominal contamination in patients suspected of perforation.

Materials and Methods: A 42-year-old female patient was admitted to the ER with the complaint of abdominal pain and nausea that had been going on for several hours. Her vitals were unremarkable. The patient had known gastritis.There was no recent history of NSAID use. There was no history of an abdominal operation. During the physical examination of the patient, there was abdominal tenderness. During routine diagnosting imaging, free air was observed under the diaphragm in the X-ray. Contrast-enhanced abdominal CT was interpreted as "Free air densities were observed at the linea alba level and perihepatic area on the anterior abdominal wall (perforation?)" The patient was admitted to the General Surgery clinic.

X-Ray



x-ray

Results and Conclusion: Perforation should be kept in mind even if there is no history of intra-abdominal surgery in patients followed up with a preliminary diagnosis of acute abdominal pain. GIS perforation, which does not require any specific blood test and can mostly be diagnosed with x-ray, requires rapid diagnosis and early surgical consultation, as it can cause intra-abdominal contamination and sepsis in the advanced stages.

Keywords: gastrointestinal system perforation, acute abdomen

Ref No: 2536

A Complex Case of Seizure, Trauma, and Multisystem Injury

ÖMER TURALİOĞLU[1], FATMA TORTUM[1]

[1]Atatürk University Faculty of Medicine Department of Emergency Medicine

Introduction and Purpose: A 31-year-old female patient, known to have epilepsy and hyperthyroidism, was brought to our facility after experiencing a seizure at home, followed by a suspected fall. This resulted in a deterioration of her general condition and a decreased Glasgow Coma Score (GCS). She was intubated prior to transport. Upon arrival, her GCS was measured at 3.

Materials and Methods: On examination, bilateral breath sounds were normal, and no differences in the diameters of the lower extremities were noted. However, widespread subcutaneous emphysema was present. Pupillary light reflexes were intact bilaterally, both directly and indirectly.Imaging revealed an aneurysmal dilation at the level of the left internal carotid artery, associated with a subarachnoid hemorrhage. Neurology and neurosurgery consultations were requested. Additionally, bilateral pneumothorax, widespread subcutaneous emphysema, massive pneumomediastinum, and left lung pulmonary contusion were detected, leading to a thoracic surgery consultation. An abdominal perforation was also noted, prompting a general surgery consultation. The patient was subsequently transferred to the anesthesia and intensive care unit for further management.

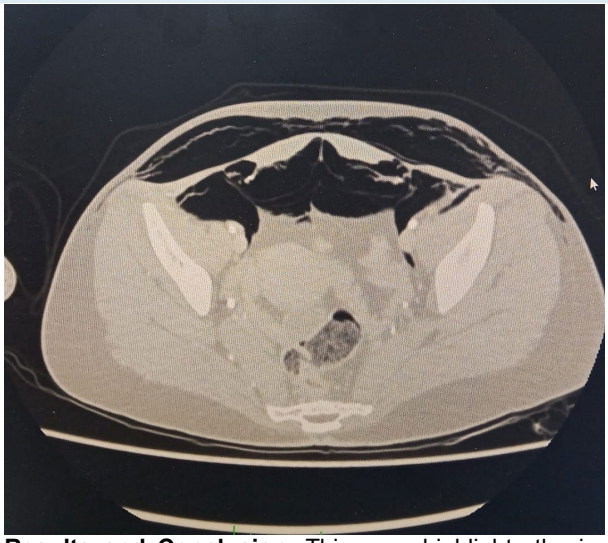
İMAGE 1

İMAGE 2

İMAGE 3

İMAGE 4

İMAGE 4



Results and Conclusion: This case highlights the importance of not only focusing on the effects of the seizure in critically ill and unconscious epilepsy patients. An altered mental state following a seizure should not be solely attributed to the seizure itself. Secondary trauma must always be considered. This emphasizes the need for a thorough and cautious approach in patient evaluation and history-taking to ensure proper management.

Keywords: Epilepsy, Subarachnoid Hemorrhage, TRAUMA

Ref No: 2564

Doronicum Caucasicum Ingestion: A Case of Plant-Induced Toxicity

Mehmet Ulutürk[1], Sebahat Ulusan[1]

[1]Burdur State Hospital, Emergency Medicine Department

Introduction and Purpose: Doronicum caucasicum (Leopard's Bane) is a perennial herbaceous plant from the Asteraceae family, recognized for its bright yellow flower heads. It features alternate leaves, basal ones with long petioles and 3–4 cauline leaves with short or absent petioles. The scape bears glandular or sparse hairs and a single capitulum, with lanceolate involucral bracts and unbranched trichomes distally. All parts of the plant are toxic, and accidental ingestion can lead to systemic poisoning, requiring prompt medical attention.

Materials and Methods: A 53-year-old male presented to the emergency department via ambulance following accidental ingestion of Doronicum species (leopard's bane), with confusion and hallucination-like symptoms. Initial vital signs were stable: blood pressure: 136/86 mmHg, oxygen saturation: 94% in room air, heat rate: 102 bpm, body temperature: 36.5 °C, and blood glucose level: 111 mg/dL. Poison control consultation advised against gastric lavage and activated charcoal. On examination, the patient was alert, cooperative, and oriented, with bilateral mydriasis. 2 L/min oxygen was administered via nasal cannula, and 2 mg neostigmine was given twice at 10-minute intervals. Laboratory findings were unremarkable. The patient was admitted to a tertiary ICU for close monitoring of renal and hepatic functions. After clinical improvement, he was transferred to the internal medicine ward for mobilization and oral intake evaluation, and subsequently discharged without complications, with outpatient follow-up advised.

Results and Conclusion: Doronicum caucasicum (Leopard's Bane) is a toxic plant found in regions near our locality; however, there is limited literature addressing its clinical management. This case provides a rare and instructive example of emergency response to D. caucasicum poisoning. To our knowledge, it is among the first to document both presentation and treatment. Given the plant's accessibility and toxic potential, public education and awareness efforts are essential to prevent accidental ingestion and to facilitate timely medical intervention.

Keywords: Leopard bane, Doronicum caucasicum, Toxicology

Ref No: 2599

Electrolyte Imbalances

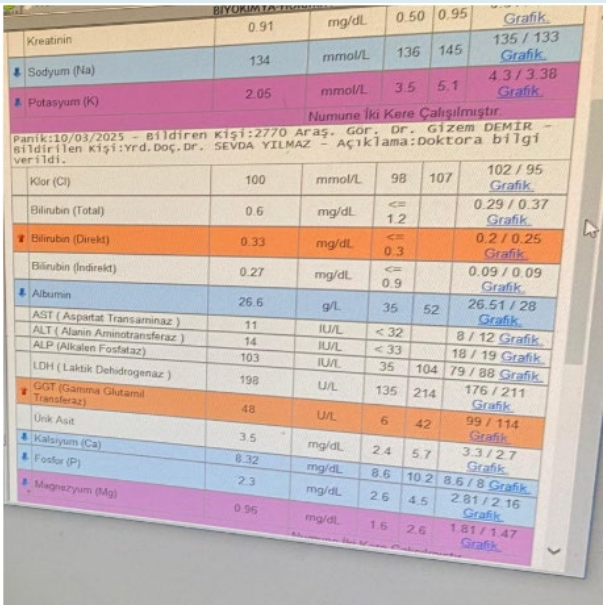
Mustafa Erkam Dut[1], Atakan Yilmaz[1], Murat Seyit[1], Mert Ozen[1], Alten Oskay[1], Ibrahim Turkcuer[1]

[1]Pamukkale University, Department of Emergency Medicine, Denizli, Turkey

Introduction and Purpose: A 41-year-old female patient presented to the emergency department with complaints of weakness and diarrhea. She had a history of mesenteric ischemia surgery three years ago, followed by two bowel resections due to ileus. On examination, no significant pathology was detected, but a blood gas analysis revealed hypokalemia (low potassium levels).

Materials and Methods: Given the hypokalemia, an electrocardiogram (ECG) was performed, which showed a normal sinus rhythm. Potassium replacement therapy was initiated, but follow-up blood tests showed persistent low potassium levels. A comprehensive biochemical analysis was conducted, revealing concurrent hypomagnesemia (low magnesium levels). After magnesium replacement therapy, the patient's electrolyte levels stabilized, and she was discharged from the emergency department with appropriate recommendations.

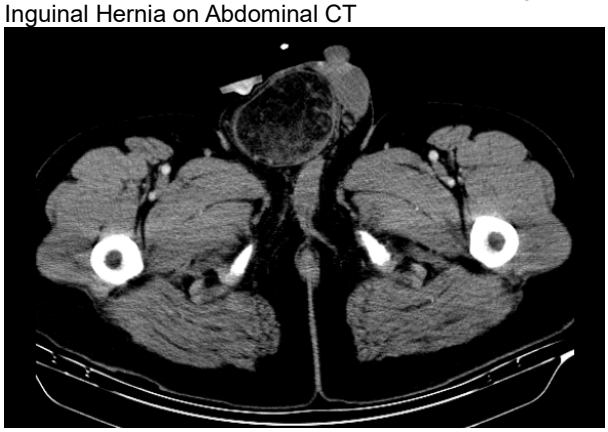
Blood Tests



Kreatinin	0.91	mg/dL	0.50	0.95	Grafik
Sodyum (Na)	134	mmol/L	136	145	135 / 133 Grafik
Potasyum (K)	2.05	mmol/L	3.5	5.1	4.3 / 3.38 Grafik
Numune İki Kere Çalışılmıştır.					
Panik:10/03/2025 - Bildiren Kişi:2770 Araş. Gör. Dr. Gizem DEMİR - Bildirilen Kişi:Yrd.Doç.Dr. SEVDA YILMAZ - Açıklama:Doktora bilgi verildi.					
Klor (Cl)	100	mmol/L	98	107	102 / 95 Grafik
Bilirubin (Total)	0.6	mg/dL	<= 1.2		0.29 / 0.37 Grafik
Bilirubin (Direkt)	0.33	mg/dL	<= 0.3		0.2 / 0.25 Grafik
Bilirubin (Indirekt)	0.27	mg/dL	<= 0.9		0.09 / 0.09 Grafik
Albumin	26.6	g/L	35	52	26.51 / 28 Grafik
AST (Aspartat Transaminaz)	11	IU/L	< 32		8 / 12 Grafik
ALT (Alanin Aminotransferaz)	14	IU/L	< 33		18 / 19 Grafik
ALP (Alkalen Fosfataz)	103	IU/L	35	104	79 / 88 Grafik
LDH (Laktik Dehidrogenaz)	198	U/L	135	214	176 / 211 Grafik
GGT (Gamma Glutamil Transferaz)	48	U/L	6	42	99 / 114 Grafik
Ürik Asit	3.5	mg/dL	2.4	5.7	3.3 / 2.7 Grafik
Kalsiyum (Ca)	8.32	mg/dL	8.6	10.2	8.6 / 8 Grafik
Fosfor (P)	2.3	mg/dL	2.6	4.5	2.81 / 2.16 Grafik
Magnezyum (Mg)	0.96	mg/dL	1.6	2.6	1.81 / 1.47 Grafik

Results and Conclusion: The purpose of presenting this case is to emphasize that patients with a history of bowel resection and diarrhea may be prone to electrolyte imbalances. Additionally, in cases where hypokalemia does not improve with potassium replacement, the possibility of concurrent magnesium deficiency should always be considered.
Keywords: Bowel resection, diarrhea, electrolyte imbalances

Ref No: 2600
Pain in the Hole: Inguinal Hernias
Mehmet Ulutürk[1]
[1]**Burdur State Hospital**
Introduction and Purpose: The term inguinal hernia encompasses direct inguinal, indirect inguinal, and femoral hernias, classified based on their position relative to the inguinal triangle. A direct inguinal hernia arises medial to the inferior epigastric vessels from the posterior wall of the inguinal canal, whereas an indirect inguinal hernia originates lateral to these vessels at the internal inguinal ring. A femoral hernia is located inferior to the inguinal ligament and medial to the femoral vessels. Clinically, inguinal hernias often present with progressive groin swelling and may be associated with pain or discomfort, although one-third of cases remain asymptomatic. Pain, if present, is typically described as a dull ache, pulling, or burning sensation, which may worsen as the hernia enlarges. Severe pain may indicate incarceration, necessitating emergency intervention. Asymptomatic cases are frequently identified incidentally during physical examination. Herein we present a case of inguinal hernia.
Materials and Methods: A 52-year-old male presented to the emergency department with right groin pain and a 5-year history of inguinal hernia, with no comorbidities. Vital signs were stable: blood pressure 135/80 mmHg, respiratory rate 16/min, temperature 36.3°C, and SpO 98% on room air. Physical examination revealed an 8×8 cm irreducible, non-discolored swelling in the right inguinal region. Laboratory tests showed leukocytes 9373 K/uL, hemoglobin 18.44 g/dL, and INR 1.13. Contrast-enhanced abdominal CT revealed a large pelvic adipose tissue herniation in the right inguinal canal. General surgery consultation was obtained, and the patient underwent surgery. Intraoperatively, a 5 cm posterior inguinal wall defect with an expanded internal ring was identified, containing a 45 cm ileal segment and a 6×6 cm omental mass, both with minimal edema but no pathology. The herniated structures were reduced, and the defect was repaired. The patient was discharged on postoperative day 2 with outpatient follow-up recommendations.
Inguinal Hernia on Abdominal CT



Contrast enhanced abdominal CT shows an inguinal hernia

Results and Conclusion: All inguinal hernia patients should be referred to general surgery due to the risk of strangulation or incarceration. While watchful waiting is a safe initial approach for asymptomatic or minimally symptomatic cases, most patients require surgery within 10 years due to progressive pain or functional limitations. Surgical repair is a safe and effective treatment, Postoperative pain may occur in some cases.

Keywords: Inguinal hernias, strangulation, surgical repair

Ref No: 2625

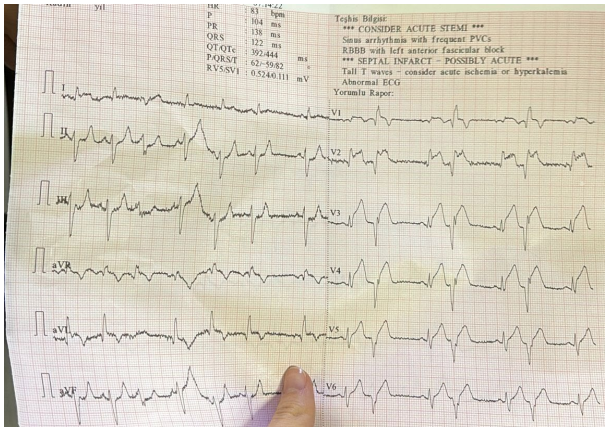
Urgent approach to STEMI

YASİN BÜLBÜLOĞLU[1], MEHMET SOYUGÜZEL[2], ŞERİFE ÖZDİNÇ[3]
[1]ŞANLIURFA BALIKLIGÖL DEVLET HASTANESİ
[2]BOLVADIN STATE HOSPITAL
[3]AFYONKARAHİSAR HEALTH SCIENCES UNIVERSITY HOSPITALİTY

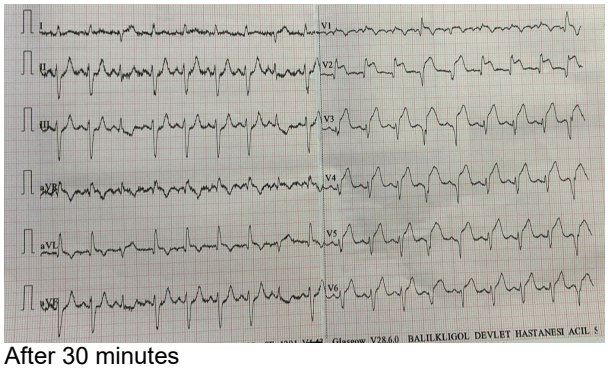
Introduction and Purpose: Urgent approach to STEMI. A 51-year-old male patient with no comorbidities came as an outpatient with the complaint of abdominal pain. He has no previous angiography history. He does not have DM.

Materials and Methods: Vitals: Blood pressure 132/85 mm Hg. Pulse: 74 beats/minute. Respiratory rate: 28 breaths/minute. Fever: 36.5. SpO2: 95.Physical examination: The abdomen is comfortable. GCS: 15. No chest pain.

first ECG



control ECG



After 30 minutes

Results and Conclusion: The patient diagnosed with STEMI was administered 300mg aspirin orally and then referred to an advanced center for PCI. MI may not present to the emergency room with chest pain. MI should also be considered in patients presenting with abdominal pain.

Keywords: Occlusion, PCI, STEMI

Ref No: 2656

Not Every Rash İs Urticarial: A Case Of Erythema Multiforme

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[1]Pamukkale University

Introduction and Purpose: Erythema multiforme is a rare skin condition that often arises as a hypersensitivity reaction to infections, medications, or other triggers. It is characterized by red, target-shaped lesions that typically appear symmetrically on the body.

Materials and Methods: A 42-year-old woman presented to the emergency department (ED) with pruritic, erythematous lesions on the palmar surface of both hands (Figure). According to the patient, systemic and topical antihistamine treatment had been initiated at another hospital for these lesions. A detailed medical history revealed that the lesions had developed following the use of antibiotics and nonsteroidal anti-inflammatory drugs (NSAIDs) prescribed for a viral upper respiratory tract infection that had started approximately 10 days earlier.Due to the presence of target-like lesions on the patient's hands and a history consistent with erythema multiforme, a

dermatology consultation was requested. Following evaluation, the dermatology team initiated clinical follow-up and steroid treatment.
Red, target-shaped lesions on the palmar surface of both hands

Results and Conclusion: The aim of presenting this case is to highlight the importance of recognizing erythema multiforme, which can be a precursor to life-threatening conditions such as Stevens-Johnson syndrome or toxic epidermal necrolysis. A thorough medical history is crucial in patients presenting to Eds with skin rashes to ensure accurate diagnosis and appropriate management.
Keywords: erythema multiforme, Stevens-Johnson Syndrome, Toxic Epidermal Necrolysis

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Ref No: 2692
Non-Ketotic Hyperosmolar State
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Introduction and Purpose: Diabetes mellitus is a chronic disease caused by insulin production deficiency due to congenital or acquired factors, or by insulin resistance. One of its most important acute complications is the hyperosmolar hyperglycemic state.
Materials and Methods: A 75-year-old female patient presented to Pamukkale University emergency department with a three-day history of reduced oral intake, general deterioration, and altered mental status. Known chronic conditions: hypertension (HT), diabetes mellitus (DM) Initial vital signs:BP: 130/80 mmHgSpO □ 90%HR: 95 bpm Temperature: 36.8°C Physical examination:GCS: 9 (E3 M5 V1)General condition poor, confused consciousness.Disoriented to time, place, and person; uncooperative.Thoracic and abdominal examinations: unremarkable.Laboratory results:WBC: 9 CRP: 10 Glucose: 520 mg/dL No acidosis on blood gas analysis. Bicarbonate levels: normalUrine ketones: negative Imaging studies: no pathological findings. The patient received initial treatment in the emergency department and was consulted with endocrinology under the preliminary diagnosis of non-ketotic hyperosmolar state. Due to general condition deterioration, ICU admission was indicated and the patient was transferred to internal medicine intensive care.
Results and Conclusion: In elderly patients with known diabetes mellitus who present to the emergency department with altered mental status and general deterioration, non-ketotic hyperosmolar state due to dehydration should be considered. Once diagnosed, fluid deficit should be calculated and treatment should be initiated promptly in the emergency setting.
Keywords: Altered mental status, non-ketotic hyperosmolar state

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Ref No: 2764
A RARE CASE OF ZIPPER INGESTİNG
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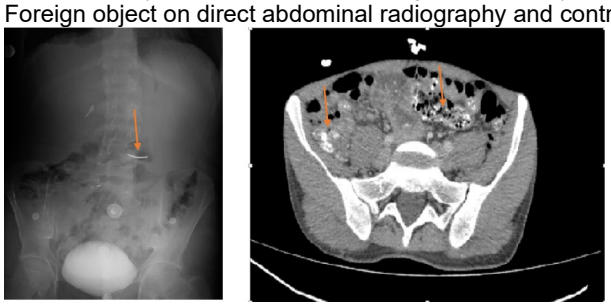
[1]Afyonkarahisar Health Sciences University Faculty of Medicine Department of Emergency Medicine
Introduction and Purpose: Foreign object ingestion is frequently observed in childhood. It is very difficult for doctors to diagnose and treat. It usually occurs accidentally. In adults, it is more associated with the elderly population, alcohol and substance addictions, desire for self-harm, secondary gains and psychiatric disorders. Prisons have a high incidence of these cases. While 80% of patients spontaneously extract the foreign object, 20% require endoscopy/colonoscopy. Only 1% require surgical intervention.
Materials and Methods: CASE REPORT: A 31-year-old male patient presented to the emergency department with severe abdominal pain. It was learned that the patient had no known disease and drug use and had been imprisoned 1 day ago. He stated that he smoked

cigarettes, did not use alcohol and drugs. Abdominal examination revealed no findings except diffuse tenderness in all quadrants. Vital signs were as follows: blood pressure 120/70 mmHg, pulse 83/min, respiratory rate 16/min. An intravenous line was opened and crystalloid fluid infusion was started. In blood tests no significant pathology was detected. Abdominal CT was planned after a foreign object was observed in the standing direct abdominal radiography. A detailed anamnesis was obtained after abdominal CT showed multiple punctate foreign objects. In his history, he stated that he swallowed a long zipper with the zipper slider with suicidal intent. The patient stated that she had no previous suicidal attempt and was not receiving psychiatric treatment. The patient was consulted to the general surgery clinic. The patient was hospitalized in the general surgery clinic for follow-up and treatment. The patient was treated conservatively in the ward and discharged after 2 days.

Foreign object on direct abdominal radiography and contrast-enhanced lower abdominal CT axial section



Results and Conclusion: A thorough anamnesis and careful physical examination are very important in patients presenting to emergency departments with abdominal pain. Imaging should not be avoided if necessary. Zipper ingestion has been reported mostly in the form of swallowing a zipper slider. A case of swallowing a long zipper complete with its slider has not been reported before. This patient is a rare case of foreign object ingestion.

Keywords: zipper, foreign object, ingestion

Ref No: 2825

Yamagichu Syndrome

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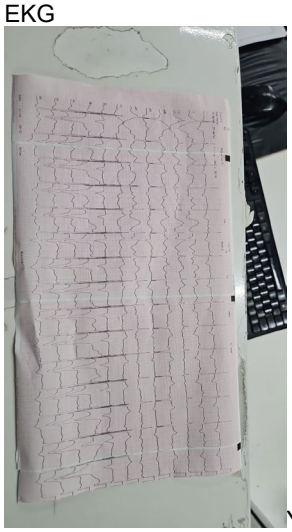
[1]Ataturk University

Introduction and Purpose: Hypertrophic Cardiomyopathy (HCM) is an autosomal dominant inherited disease caused by mutations in one of the nine genes that code for myocardial sarcomeric proteins. Apical Hypertrophic Cardiomyopathy (ApiHCM) is a relatively rare form of hypertrophic cardiomyopathy characterized primarily by apical involvement. It accounts for 25% of HCM cases in Japan and 1-2% of cases outside of Japan.

Materials and Methods: A 59-year-old patient presented to our emergency department with complaints of non-cardiac chest pain. The patient had a previous history of CABG. There were no notable findings in the physical examination. The patient's vital signs were stable, but the ECG showed widespread T-wave negativity, depressions, and possible elevation in AVR. Due to the patient's history and the possible elevation observed in the ECG (Image 1), the patient was referred to cardiology. The cardiology consultant performed an echocardiogram and diagnosed the patient with apical hypertrophic cardiomyopathy. No wall motion abnormalities were detected, and the ECG changes were attributed to this condition.

EKG



Yamagichu Syndrome EKG

Results and Conclusion: Yamagichu syndrome is a rare form of HCM, which should be considered, especially in patients who have previously exhibited early repolarization in anterolateral leads.

Keywords: Yamagichu Syndrome, Apical HCM

Ref No: 2830

Infective endocarditis in a pregnant patient presenting to the emergency department with chest pain and dyspnea

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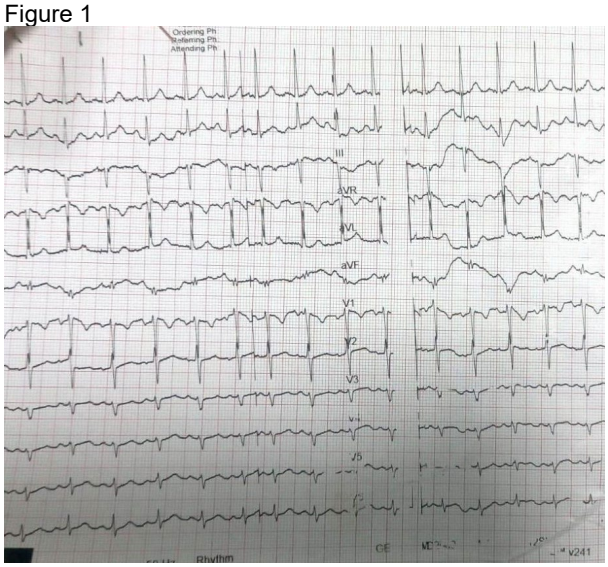
Introduction and Purpose: Infective endocarditis is a rare but potentially life-threatening condition associated with significant morbidity and mortality. Recent studies have reported an incidence of two cases per million in pregnant women. The primary risk factors include rheumatologic valvular disease, intravenous drug use, and prosthetic heart valves. Recent studies indicate that pregnant women with a history of intravenous drug use constitute the predominant group. Maternal mortality rate ranges between 5% and 11%.

Materials and Methods: A 35-year-old female patient presented to the emergency department with complaints of retrosternal chest pain and dyspnea that had begun two weeks prior. The patient was at 24 weeks and 6 days of gestation.Her medical history revealed no known chronic illnesses or regular medication use. Vital signs were as follows: blood pressure 110/80 mmHg, heart rate 125 bpm, body temperature 36.1°C, and SpO□ 98%.On physical examination, breath sounds were normal and equally audible bilaterally. There were no findings indicative of deep vein thrombosis in the lower extremities. No significant findings were noted in other systemic examinations. ECG revealed sinus tachycardia (Figure 1).Lower extremity venous Doppler ultrasonography showed no evidence of deep vein thrombosis. Laboratory results revealed a troponin level of 80 (0-15,6), while routine complete blood count and biochemistry tests were within normal limits.Echocardiography demonstrated a 1.7 × 1.5 cm vegetation on the aortic valve (Figure 2). Further investigations revealed an elevated C-reactive protein (CRP) level and growth of Staphylococcus epidermidis in blood cultures.The patient was admitted to the coronary intensive care unit. Intravenous daptomycin, ceftriaxone, and steroid therapy were initiated. Following inpatient monitoring, the patient was discharged and is currently being followed up with low-molecular-weight heparin and warfarin.

Figure 1



The Sinus Tachycardia Observed On The Patient's Electrocardiogram (ECG)

Figure 2

The Aortic Valve Vegetation, Indicated By The Black Arrow In The Patient's Echocardiogram

Results and Conclusion: Chest pain is a common presentation in the emergency department, with a wide range of differential

diagnoses. These conditions can lead to significant morbidity and mortality if not promptly recognized and managed.Although infective endocarditis is rare in pregnant patients, especially those with risk factors, it should be considered as a differential diagnosis. Early recognition and appropriate management are crucial to prevent adverse maternal and fetal outcomes.

Keywords: Infective endocarditis, chest pain, emergency department

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Ref No: 2880

A case report of pancreatitis

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[1]Pamukkale University

Introduction and Purpose: Acute pancreatitis is a condition with multiple etiologies, characterized by epigastric pain, nausea, and vomiting. Early diagnosis and appropriate management are essential to prevent complications and improve patient outcomes.

Materials and Methods: A 78-year-old woman with a known history of hypertension presented to the Emergency Department with complaints of epigastric pain, nausea, and vomiting persisting for the past 15 days. She described worsening epigastric pain, particularly after meals, which was non-radiating, accompanied by nausea and intermittent vomiting.On presentation, the patient's vital signs were stable. Physical examination revealed tenderness localized to the epigastric region. Laboratory tests showed significantly elevated amylase and lipase levels (1000 U/L). Electrocardiography (ECG) demonstrated normal sinus rhythm, and abdominal imaging findings were consistent with acute interstitial edematous pancreatitis. The patient was admitted to the Gastroenterology Department, where intravenous fluids, analgesics, and supportive therapy were initiated.

Results and Conclusion: The most common causes of acute pancreatitis are gallstones and alcohol consumption. Diagnosis is based on clinical presentation, elevated amylase/lipase levels, and imaging findings. Early fluid resuscitation and symptomatic management can significantly improve disease outcomes. In patients presenting with epigastric pain, nausea, and vomiting, pancreatitis should be considered in the differential diagnosis, and early intervention should be prioritized.

Keywords: vomiting, acute pancreatitis, epigastric pain

Ref No: 2908

Unmasking the Silent Threat: The Critical Role of Imaging in MCA Infarction Diagnosis

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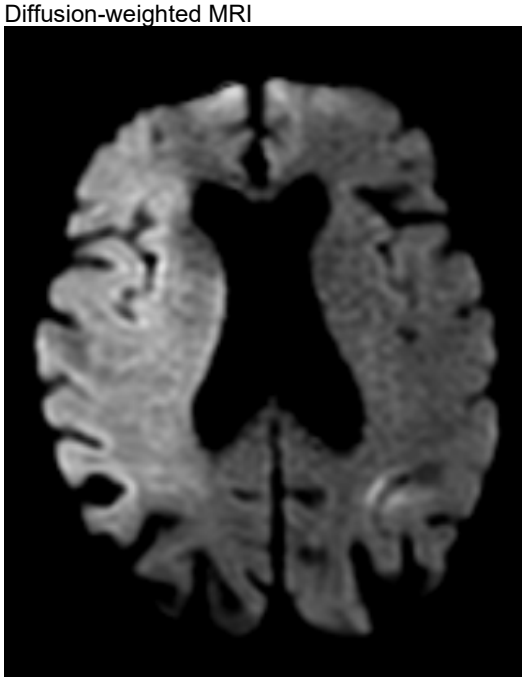
Introduction and Purpose: Middle cerebral artery (MCA) stroke manifests with diverse neurological deficits, including contralateral weakness, sensory loss, facial asymmetry, and dysarthria. Space-occupying edema is the leading cause of mortality within the first week, typically appearing between days two and four but sometimes progressing within 24 hours. When the entire MCA territory is affected, it is termed "malignant MCA infarction," with an annual incidence of 10–20 per 100,000 and a higher prevalence in females. Prognosis is poor, with mortality rates reaching 80%. Imaging plays a crucial role in early diagnosis and management, aiding in timely intervention.

Materials and Methods: A 94-year-old female patient was brought to our emergency department by ambulance with complaints of speech impairment and weakness in the left upper and lower extremities, which had started approximately 1.5 to 2 hours prior. It was learned that she had been immobile for the past 2–3 years due to advanced age and was on regular acetylsalicylic acid therapy. Upon arrival, her vital signs were as follows: blood pressure, 140/90 mmHg; oxygen saturation, 94% on room air; heart rate, 110 bpm; and body temperature, 36°C. Electrocardiography revealed atrial fibrillation. Neurological examination showed the absence of meaningful verbal responses, spontaneous rightward gaze deviation, left-sided hemiplegia, and flattening of the left nasolabial fold. Other systemic examinations were unremarkable. Imaging studies were performed, revealing no pathological findings on non-contrast brain computed tomography (CT). However, diffusion-weighted magnetic resonance imaging (MRI) demonstrated a large infarct area in the right middle cerebral artery (MCA) territory, with corresponding signal changes on the apparent diffusion coefficient (ADC) sequence. Given the patient's immobility and after discussing the risk-benefit ratio with family members, thrombolytic therapy was deemed inappropriate, and the patient was admitted to the intensive care unit for antiplatelet therapy and further monitoring. On the fourth day of hospitalization, the patient's clinical condition deteriorated, necessitating endotracheal intubation. However, she subsequently experienced cardiac arrest and passed away.

CT head scan image in early phase of symptoms

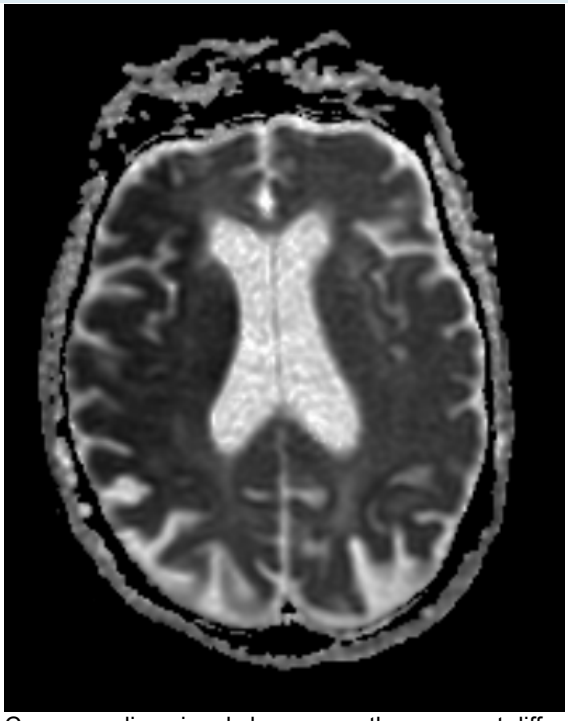
CT head scan image demonstrating right 'hyperdense middle cerebral artery (MCA) sign

Diffusion-weighted MRI



Diffusion-weighted magnetic resonance imaging (MRI) demonstrating a large infarct area in the right middle cerebral artery (MCA) territory

ADC sequence



Corresponding signal changes on the apparent diffusion coefficient (ADC) sequence
CT head scan after 48 hours

Repeat imaging 48 hours later shows established right MCA infarct with extensive oedema and compression on right lateral ventricle

Results and Conclusion: Large MCA infarctions are commonly encountered in emergency departments and are identified through imaging modalities. Early diagnosis via imaging and appropriate management are essential aspects of neurological emergencies that emergency physicians must be familiar with.

Keywords: Acute stroke, middle cerebral artery, imaging

Ref No: 3017

Chiliaditi Syndrome

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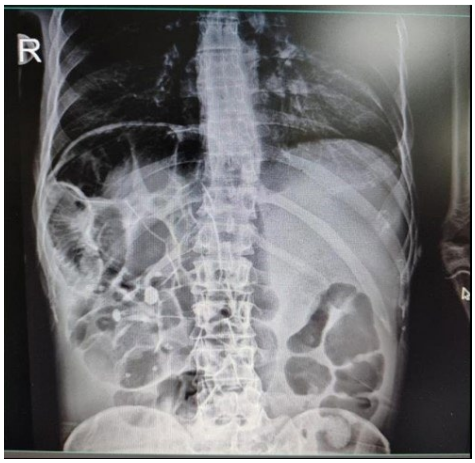
[1]University of Health Sciences Turkey, Bursa Yuksek Ihtisas Training and Research Hospital, Department of Emergency Medicine, Bursa

Introduction and Purpose: Chiliaditi syndrome is a condition where the colon and small intestine are displaced between the right diaphragm and the liver. It was first described by Demetrius Chiliaditi as the “hepatodiaphragmatic interposition” of the colon or small intestine. The frequency of occurrence increases with age. While most cases are asymptomatic, some may present with acute, chronic, or recurrent symptoms related to the digestive or respiratory systems. If the condition is asymptomatic, it is referred to as the Chiliaditi sign, whereas when symptoms are present, it is called Chiliaditi syndrome.

Materials and Methods: A 40-year-old male patient with a known history of coronary artery disease presented to the emergency department. He had undergone angiography twice but had no stents. He also had a history of substance use. He was admitted to the emergency department with complaints of severe abdominal pain, nausea, vomiting, and difficulty breathing. Upon arrival, his vital signs were: Blood Pressure: 150/80 mmHg, heart rate: 78 bpm, SpO2: 98%, temperature: 36.2°C. Physical examination revealed tenderness in the epigastric region and the right upper quadrant, along with guarding and rebound tenderness. The abdomen was distended. Laboratory results: WBC: 18.4 × 10^9/L, CRP: 56 mg/dL, Renal and liver function tests: Normal A chest X-ray was performed Picture 1). In the emergency department, a nasogastric (NG) tube was inserted, and approximately 3000-3500 cc of fluid was decompressed. An oral and intravenous contrast-enhanced CT scan was performed. The CT report indicated that loops of the colon were located anterior to the liver, leading to a diagnosis of Chiliaditi syndrome (Picture 2). The patient was admitted to the general surgery department. He was treated with antibiotics and monitored with dietary adjustments. After 10 days, he was discharged.

Picture 1



Picture 2

Results and Conclusion: The treatment of Chiliaditi syndrome may be either conservative or surgical. Conservative management includes bed rest, nasogastric decompression, high-fiber diets, enemas, and laxatives. If symptoms persist despite conservative treatment, surgical intervention may be required. Cases in the literature have reported surgical procedures such as colectomy (partial or total removal of the colon) and colopexy (surgical fixation of the colon to the abdominal wall) due to volvulus, incarceration, perforation, or acute abdomen.

Keywords: Chiliaditi syndrome

Ref No: 3021

THE LUMBALGİA

AHMET HASAN TAŞCİ[1], ERDAL TEKİN[1]

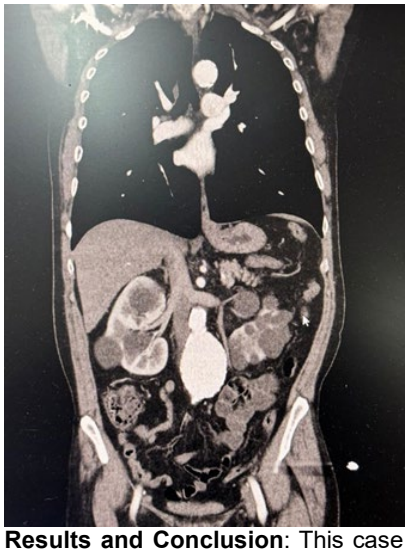
[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP ANABİLİM DALI

Introduction and Purpose: Low back pain is a common complaint among patients presenting to the emergency department, with an etiology ranging from musculoskeletal disorders to visceral pathologies. In patients with a known history of lumbar disc herniation, atypical pain characteristics may obscure underlying serious vascular conditions. This case report discusses the diagnostic and management process of a 58-year-old male patient who presented with low back pain and was subsequently diagnosed with a large abdominal aortic aneurysm (AAA).

Materials and Methods: A 58-year-old male patient presented to the emergency department with complaints of low back pain. He had a known history of lumbar disc herniation. Upon admission, his general condition was moderate, and his vital signs were stable. Physical examination revealed a positive left Lasegue test. The patient described his pain as different from his usual symptoms. A lumbar X-ray showed an image consistent with a chronic abdominal aortic aneurysm (IMAGE-1), characterized by calcified arterial walls. A contrast-enhanced CT angiography revealed a fusiform abdominal aortic aneurysm measuring 72 mm at its widest point, extending from the infrarenal level to the iliac bifurcation (IMAGE-2). The patient was urgently referred to the cardiovascular surgery department, and surgical intervention was planned.

IMAGE-1

IMAGE-2



Results and Conclusion: This case highlights the importance of considering vascular causes in the differential diagnosis of low back pain. Imaging studies identified a 72 mm fusiform abdominal aortic aneurysm, necessitating urgent cardiovascular surgical intervention. This report underscores the necessity of thorough evaluation in high-risk patients, emphasizing that low back pain may not always be musculoskeletal in origin. Early recognition of life-threatening conditions such as AAA is crucial for preventing catastrophic complications and improving patient outcomes.

Keywords: ABDOMİNAL AORTİC ANEURYSM, BACK PAİN, LUMBALGİA

Ref No: 3109
Pregnant Patient Presenting with Chest Pain
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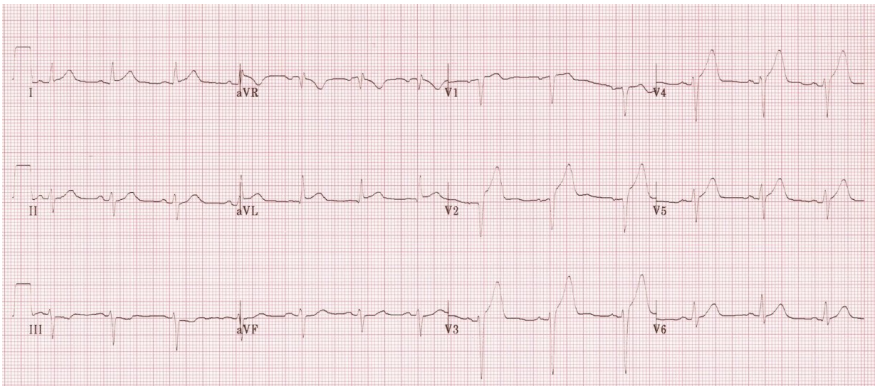
[1]Erzurum Atatürk Universiy Emergency medicine department
Introduction and Purpose: Cardiovascular diseases are a leading cause of maternal mortality in developed countries. In pregnant women, congenital heart diseases are more common than acquired ones. However, acquired conditions such as aortic dissection, peripartum cardiomyopathy, and acute coronary syndrome (ACS) are associated with higher maternal mortality. The risk of ACS is three to four times higher during pregnancy. Advanced maternal age, diabetes, hypertension, and obesity are significant risk factors, increasing the likelihood of myocardial infarction (MI) during pregnancy.
Materials and Methods: A 32-year-old woman at 34 weeks of gestation with a history of diabetes presented with chest pain persisting for one hour. The pain was pressure-like, non-radiating, and not affected by movement. Her vital signs were as follows: blood pressure 126/68 mmHg, oxygen saturation 96%, pulse 82 bpm, and temperature 36.8°C. On physical examination, lung sounds were normal, both hemithoraces moved symmetrically with respiration, and heart sounds were rhythmic with no murmurs or additional sounds. Systemic examination was unremarkable.Electrocardiography (ECG) revealed widespread anterolateral ST-segment elevation, suggestive of myocardial infarction. Echocardiography showed an ejection fraction (EF) of 30-35%, and the patient was admitted to the cardiology department for urgent coronary angiography.
Photo-1



Results and Conclusion: Acute myocardial infarction (AMI) can present with varied symptoms across different patient populations. In pregnant women presenting with acute chest pain, particularly those with comorbidities, MI should be considered in the differential diagnosis and promptly evaluated to ensure timely intervention.
Keywords: Pregnant, acute coronary syndrome, anterolateral ST-segment myocardial infarction

Ref No: 3182
DİABETİC EMERGENCİES
ABDULLAH SÜHA AKÇA[1], AYÇA ÇALBAY[1]
[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP ANABİLİM DALI
Introduction and Purpose: Diabetic ketoacidosis (DKA) and hyperosmolar hyperglycemic state (HHS) are acute complications that can arise in diabetic patients and require urgent intervention. DKA is characterized by insulin deficiency and elevated glucagon levels, leading to increased lipolysis and ketone production, while HHS typically presents with high blood glucose levels and hyperosmolarity. Clinical signs such as acetone breath, Kussmaul respiration, and elevated blood glucose are prominent in these cases. This case report discusses the clinical process of a patient diagnosed with diabetic ketoacidosis and hyperosmolar state following investigation of shortness of breath and general malaise.
Materials and Methods: A 34-year-old female patient with no known comorbidities presented to the emergency department with complaints of shortness of breath and general deterioration in her condition. Upon arrival, her general condition was poor, Glasgow Coma Scale (GCS) was 13, vital signs were stable with a blood pressure within normal limits, pulse rate was 117, and oxygen saturation was 88%. On examination, there was a noticeable acetone odor and Kussmaul respiration. Her fingertip blood glucose level was 782 mg/dL, and arterial blood gas analysis revealed a pH of 7.09 and bicarbonate (HCO3) of 12 mmol/L. Urine tests confirmed 3+ ketones. Serum osmolality was calculated at 318 mOsm/kg. The patient was diagnosed with diabetic ketoacidosis and hyperosmolar state and was admitted to the intensive care unit for further management.
Results and Conclusion: This case emphasizes the importance of recognizing diabetic ketoacidosis and hyperosmolar hyperglycemic state in the emergency setting. Early diagnosis, appropriate fluid therapy, and insulin management play a crucial role in improving patient survival and preventing complications. Patients presenting with clinical signs suggestive of ketoacidosis or hyperosmolarity require thorough evaluation to ensure prompt treatment.
Keywords: DİABETES, KETOACİDOSİS

Ref No: 3184

Comparison of a Novel Chest Compression Technique with the Two-Finger Method in Infant Cardiopulmonary Resuscitation: Pilot Data

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[2]Department of Emergency Medicine, Medical University of Warsaw, Warsaw, Poland
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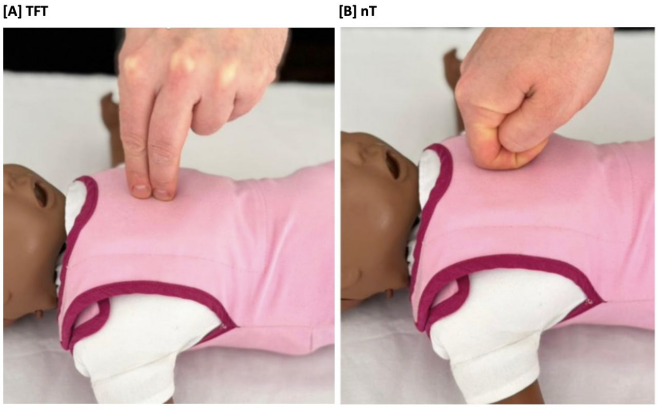
Introduction and Purpose: Achieving effective cardiopulmonary resuscitation (CPR) in infants requires high-quality chest compressions, but the ideal method for single-rescuer situations remains uncertain. While the two-finger technique (TFT) is commonly employed, it has been linked to insufficient compression depth and heightened rescuer fatigue. This study investigates a newly proposed technique (nT) as a potential alternative, with the goal of improving both compression effectiveness and reducing rescuer fatigue (Fig. 1).

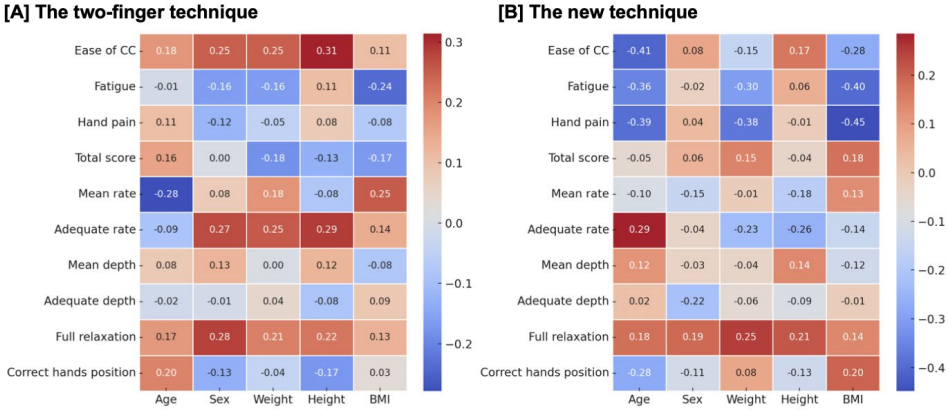
Fig. 1. Chest compression techniques used in study protocol



Materials and Methods: This randomized crossover study aimed to evaluate the effectiveness of the two-finger technique (TFT) and the novel technique (nT) in a simulated infant CPR scenario. Medical students, who had received training in neonatal and infant resuscitation, performed both techniques under controlled conditions using a high-fidelity neonatal simulator. Key CPR performance indicators, along with levels of rescuer fatigue and hand pain, were objectively assessed and compared between the two methods.

Results and Conclusion: The study involved 30 participants. For the compression performance parameters, the novel technique demonstrated notable differences. Although the ease of chest compression was significantly higher for the TFT, the nT technique was associated with significantly lower rescuer fatigue and hand pain (both $p < 0.001$; Tab. 1). The correlation analysis revealed distinct patterns between the two chest compression techniques (Fig. 2). In TFT, height correlated positively with the ease of compression ($r = 0.31$) and the proportion of adequate compressions ($r = 0.29$), while BMI was positively associated with compression rate ($r = 0.25$). In contrast, in nT, age and BMI showed negative correlations with the ease of compression ($r = -0.41$ and $r = -0.28$), fatigue ($r = -0.36$ and $r = -0.40$), and hand pain ($r = -0.39$ and $r = -0.45$), suggesting greater difficulty, discomfort, and fatigue for older individuals and those with higher BMI. Summarizing, this study demonstrates that the novel chest compression technique (nT) offers notable advantages over the conventional two-finger technique (TFT) in infant cardiopulmonary resuscitation. While the TFT was rated as easier to perform, the nT technique significantly reduced rescuer fatigue and hand pain, which are crucial factors in maintaining high-quality compressions during prolonged resuscitation efforts.

Fig 2. Correlation heat maps of physical indices with chest compression parameters



Keywords: infant, cardiopulmonary resuscitation, chest compression

Ref No: 3227

From traffıc accıdent to coronary ınsetıve care

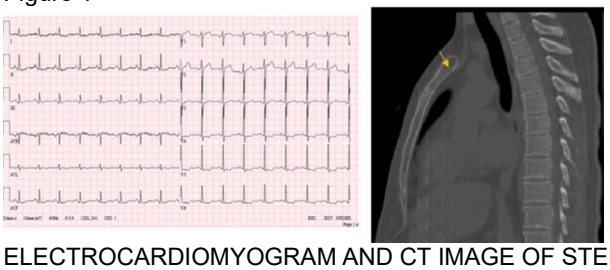
Gamze Ergöl[1], Tansu Akpınar[1], Hülya Sevil[1]

[1]Afyonkarahisar Sağlık Bilimleri Üniversitesi Hastanesi

Introduction and Purpose: Blunt cardiac injury (BCI) is clinically silent. Dysrhythmia, cardiac wall motion abnormalities, cardiogenic shock, cardiac wall rupture may be seen in blunt cardiac trauma. The most common form is “cardiac contusion”. The lack of an accepted gold standard for the test makes the diagnosis of cardiac contusion difficult.

Materials and Methods: A 44-year-old male patient was brought to the emergency department due to a vehicular traffic accident. We learned that the patient hit the anterior thoracic wall to the steering wheel. The patient had no examination findings other than sternal tenderness and chest pain. He had no known disease and was not taking any medication. CT scan of the thorax revealed a fracture in the manibrium sterni posterior to the sternum. Electrocardiomyogram was performed and sinus tachycardia was observed. Blood samples taken 2 hours apart showed a 5-fold increase in troponin (hs-Troponin T - 0.020 ng/Ml; 0.102 ng/Ml). As cardiac markers were elevated, the patient had a sternal fracture and active chest pain, we consulted cardiology with a prediagnosis of “traumatic cardiac contusion”. Bedside echocardiography showed no pathology. The patient was admitted to the coronary intensive care unit for follow-up.

Fıgure 1



ELECTROCARDIOMYOGRAM AND CT IMAGE OF STERNUM FRACTURE

Results and Conclusion: Cardiac contusion is often associated with concurrent injuries. These can be injuries to the head, chest, abdomen or spine. In our case, the injury was accompanied by a sternal fracture. Cardiac contusion should be considered in patients with blunt thoracic trauma.

Keywords: Cardiac kontusion, Trauma

Ref No: 3244

Mechanical Ileus Due to Polycystic Kidney Disease: A Case Report

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[1]Manisa Celal Bayar University, Faculty of Medicine, Department of Emergency Medicine, Manisa, Turkey

Introduction and Purpose: Polycystic kidney disease is an inherited disorder, transmitted in an autosomal dominant or recessive pattern, characterized by renal cysts and cyst formation in the liver and other organs. Patients with this disease may present to the emergency department with renal failure, hypertension, liver cysts, and gastrointestinal complications. Although gastrointestinal complications are rare, they can lead to bowel obstruction. In our case, a patient with polycystic kidney disease developed mechanical ileus, and the clinical course was detailed. (1,2)

Materials and Methods: Our study involved a 65-year-old male patient with a known history of polycystic kidney disease and end-stage renal disease,undergoing weekly hemodialysis. The patient presented with a one-week history of colicky abdominal pain, nausea,vomiting,and minimal stool passage.Physical examination revealed abdominal distension and generalized tenderness,while guarding and rebound tenderness were absent.Rectal examination showed normal stool consistency with minor traces,followed by stool passage.Laboratory findings were as follows: White blood cell 15.26 x10^9/L, Hemoglobin 7.8 g/dL, C-Reactive Protein 15.43 mg/L, Creatinine: 9.45 mg/dL, Urea: 120 mg/dL, Sodium: 133 mEq/L, Potassium: 4.4 mEq/L.Abdominal CT revealed multiple cysts in both kidneys,the largest measuring 7 cm in diameter.Additionally, multiple hypodense lesions up to 3.5 cm were detected in liver segment 3,along with small bowel dilatation and air-fluid levels.Mesenteric fat heterogeneity and free fluid accumulation were observed,and the transverse and left colon appeared collapsed.

Results and Conclusion: The patient was managed conservatively with nasogastric tube placement. Fluid-electrolyte balance was maintained,and supportive treatment was provided.During follow-up,continued passage of gas and stool was observed, eliminating the need for surgical intervention.The patient's clinical condition improved, and discharge was planned.Considering the risk of mechanical ileus in PKD patients,careful monitoring is essential.This case highlights the importance of recognizing gastrointestinal complications in patients with PKD(3,4).Polycystic kidney disease can lead to both renal and extrarenal complications. In this case, mechanical ileus developed due to PKD,a rare but significant complication.Diagnosis and treatment should involve both clinical assessment and radiological evaluation.The patient responded well to conservative treatment and was discharged without requiring surgical intervention.Patients with polycystic kidney disease should be monitored for potential gastrointestinal complications, including mechanical ileus.

Keywords: Polycystic Kidney Disease, Mechanical Ileus, Mesenteric Heterogeneity

Ref No: 3269
Sibling two malignant diagnosis: pulmonary embolism + deep vein thrombosis
Dilara Dikici[1], Alten Oskay[1], Mert Ozen[1], Atakan Yilmaz[1], Murat Seyit[1], Ibrahim Turkcuer[1]
[1]Pamukkale University
Introduction and Purpose: Pulmonary embolism (PE) and deep vein thrombosis (DVT) are two serious medical conditions that are often interrelated. DVT is characterized by the formation of blood clots in the deep veins, primarily in the lower extremities, while PE occurs when these clots travel through the bloodstream and obstruct pulmonary circulation, leading to a life-threatening condition. The strong connection between these diseases lies in the fact that DVT is the most common cause of PE, emphasizing the importance of early diagnosis and intervention.
Materials and Methods: A 55-year-old male academic lecturer was brought to the emergency department (ED) by emergency medical services following an episode of syncope during a lecture. Upon arrival, the patient was conscious, oriented, and cooperative. His general condition was stable, with vital signs within normal limits. Physical examination revealed no significant abnormalities apart from back pain. His medical history included chronic hypertension (HT) and lumbar hernia.Initial laboratory investigations did not indicate any active pathology. However, during emergency room observation, the patient developed swelling and pain in his right leg. Subsequent ultrasonographic evaluation confirmed the presence of DVT in the right lower extremity. Given the high risk of pulmonary embolism, thoracic computed tomography (CT) angiography was performed. Imaging confirmed the presence of pulmonary embolism in the right lung.Following the diagnosis of DVT and PE, a multidisciplinary approach was adopted. Given the segmental involvement of the lung, a treatment plan was formulated in consultation with pulmonology and cardiovascular surgery specialists. The patient was initiated on an appropriate fibrinolytic regimen and was considered for an interventional procedure by the cardiovascular surgery team. Consequently, he was admitted to the ward for close monitoring and further management.
Results and Conclusion: This case highlights that DVT and PE can present with sudden and potentially severe symptoms, such as syncope. Early recognition, prompt imaging, and timely intervention are crucial in preventing life-threatening complications. Raising awareness and educating healthcare professionals on the importance of early detection and management strategies can significantly improve patient outcomes.
Keywords: deep vein thrombosis, pulmonary embolism, syncope

Ref No: 3274
Foreign Body In Trachea
Yusuf Burak Eker[1], Muhammed Cengizhan Durmuş[1], Erdal Tekin[1]
[1]Atatürk Üniversitesi Acil Tıp Anabilim Dalı
Introduction and Purpose: Foreign bodies in the respiratory tract can partially or completely obstruct the passage of airways. Removing the foreign body can lead to a dramatic relief in the patient's clinical condition.
Materials and Methods: A 40-year-old female patient presented to the emergency department with sudden throat pain while attempting to speak, forgetting that she had a needle in her mouth while tying her headscarf. The patient's vital signs were normal, and a lateral X-ray taken at an external facility showed a foreign body in the epiglottis (Figure 1). The X-rays were repeated upon referral to our department, and it was determined from the anterior-posterior (AP) X-ray that the foreign body was not in the epiglottis but rather on the patient's headscarf (Figure 2).
figure 1

figure 2

Results and Conclusion: In cases involving foreign body investigation, X-rays should be taken in at least two directions to accurately determine the location of the foreign body.
Keywords: Foreign body in trachea, 2 view chest X-ray

Ref No: 3278
The Unstable Hip: Hip Prosthesis Dislocation
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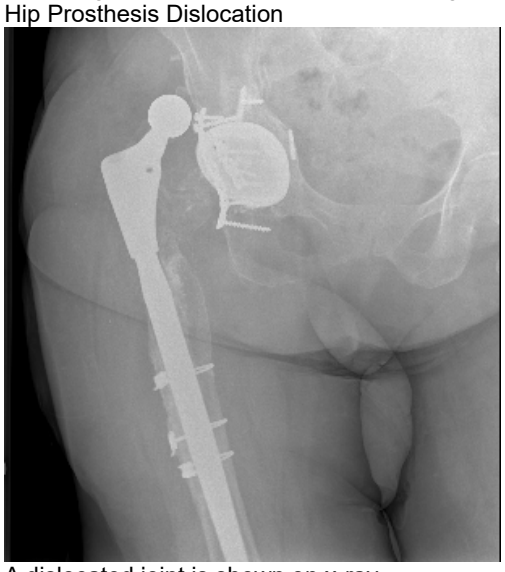
[1]**Burdur State Hospital**
Introduction and Purpose: Total hip arthroplasty (THA) is a standard treatment for chronic hip disorders, including degenerative diseases, avascular necrosis, and trauma. Despite its benefits, dislocation remains a common complication, occurring in 1.4% to 5.0% of primary procedures, with recurrence rates reaching 25% after revision surgery.Dislocation, resulting from the prosthetic head's loss of contact with the acetabulum, may occur due to mechanical stress or extreme joint positioning. It can lead to soft tissue damage, joint instability, periprosthetic fractures, and bone loss, increasing the risk of recurrence. Additional complications such as avulsion fractures, fibrosis, and heterotopic ossification further compromise joint function and long-term outcomes.
Materials and Methods: An 83-year-old female patient presented to the emergency department via ambulance with a complaint of right hip pain persisting for one day. Due to her existing dementia and reliance on a walker for ambulation, it was reported that she frequently experienced falls at home, with the most recent incident occurring the previous day due to loss of balance. Her medical history included diabetes mellitus and hypertension. Additionally, she had undergone surgery for a right femoral fracture five years prior and had a revision surgery four months ago due to femoral prosthesis dislocation.Upon arrival, the patient's vital signs were stable. Physical examination revealed tenderness in the right hip. Consequently, pelvic and right femur radiographs were obtained, which revealed prosthetic bone dislocation. The patient was consulted with the orthopedic department, and surgical intervention was performed. Following the procedure, she was discharged on postoperative day one.
Hip Prosthesis Dislocation



A dislocated joint is shown on x-ray

Results and Conclusion: Hip prosthesis dislocations are commonly encountered in emergency departments. Effective postoperative management, including the reinforcement of proper locomotor habits, patient education on implant stability, and the implementation of appropriate preventive strategies, plays a crucial role in reducing the risk of dislocation. Additionally, minimizing risk factors and addressing comorbid conditions that may contribute to further injuries are essential in preventing this complication.
Keywords: Total Hip Arthroplasty, Hip Prosthesis Dislocations, Trauma

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Ref No: 3288
Pyelonephritis
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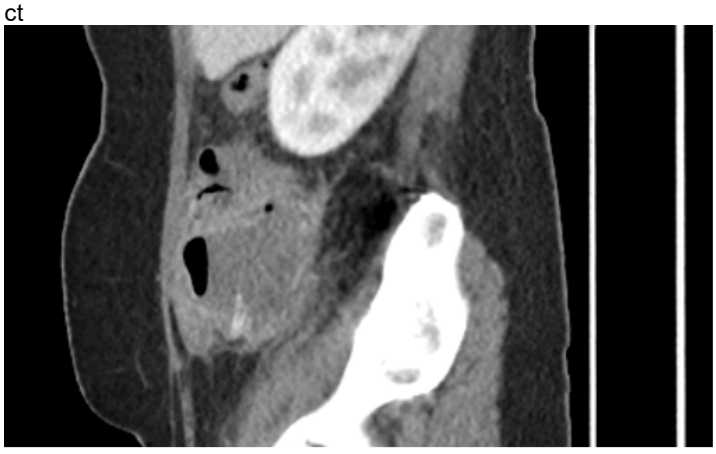
Introduction and Purpose: Pyelonephritis is an infection of the upper urinary tract, which can present more severely, particularly in diabetic patients. Early diagnosis and treatment are crucial in patients pretenting with fever, flank pain, and urinary symptoms.
Materials and Methods: Patient is 65-year-old male with the medical history of diagnosis of diabetes mellitus (DM)His complaints are right flank pain, burning sensation during urination, and feverThe patient presented with a 2-day history of fever, chills, right flank pain, and burning sensation while urinating.His vital signs are mild tachycardia and fever present and, his abdominal examination pointed out that he has right cosvertebral angle tenderness. His blood tests have shown elevated infectious parameters (high CRP and leukocytes) also urine test has shown significant leukocyturia.His abdominal CT findings were consistent with pyelonephritis.The patient was started on intravenous antibiotic therapy and was admitted to the infectious diseases department for monitoring.
Results and Conclusion: Pyelonephritis can lead to serious complications, especially in elderly and diabetic patients. Clinical signs, laboratory tests, and imaging are essential in the diagnosis. Early antibiotic treatment can prevent complications.In patients presenting with fever, flank pain, and urinary complaints, pyelonephritis should be considered. Early treatment should be planned, particularly for patients with risk factors.
Keywords: Fever, Pyelonephritis

Ref No: 3310
Appendicitis İn A Patient With Appendectomy
Alparslan Altun[1], Sultan Tuna Akgöl Gür[1]
[1]atatürk Üniversitesi Acil Tıp Ana Bilim Dalı
Introduction and Purpose: Residual appendicitis remaining after surgical operation is a rare condition associated with appendicitis. It is defined as re-inflammation of residual appendicitis tissue after acute appendicitis operation. Clinically, it presents as acute abdominal pain.
Materials and Methods: A 40-year-old woman presented with abdominal pain. She complained of right lower quadrant pain for 2 days. The patient has a history of appendectomy. No other known disease history. Vitals bp: 123/76 sat: 96 hr: 82 temperature: 36.7. On examination, there was deficiency and rebound in the right lower quadrant. In blood tests, wbc was observed as high crp with neutrophil dominance. On imaging, fatty tissue contamination was observed in the periocecal area and right paracolic area. The differential diagnosis of these appearances in the case with a history of appendectomy includes cecal diverticulitis and stump appendicitis.' It was determined as follows. The patient was consulted to general surgery clinic. He was hospitalized with the diagnosis of stump appendicitis by general surgery.
ct



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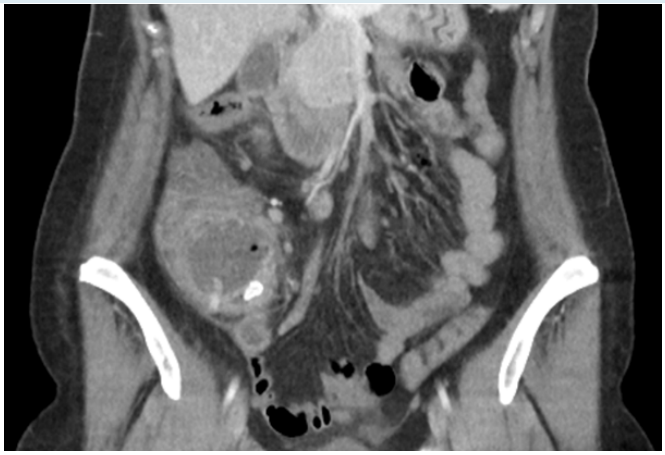


Results and Conclusion: Even if there is a history of appendectomy, the patient with elevated infective parameters and acute abdomen in the right lower quadrant should be proceeded until acute abdomen is ruled out again. As a matter of fact, stump appendicitis was detected in this patient even though it is rare.

Keywords: appendicitis, abdominal pain, stump appendicitis

Ref No: 3424

Subdural Hematoma in a 75-Year-Old Male

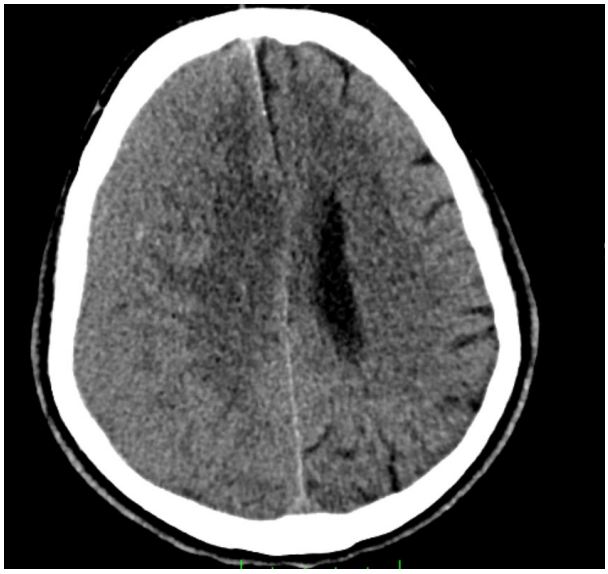
ŞAFAK ÇOMURLU[1], ZEYNEP ÇAKIR[1]

[1]ATATURK UNIVERSITY

Introduction and Purpose: A sensation of falling in elderly individuals may indicate an underlying neurological problem and can be associated with various pathologies. Subdural hematoma is characterized by blood accumulation in the subdural space and can develop either traumatically or spontaneously. In elderly patients, subdural hematomas are often caused by minor trauma or spontaneous bleeding. This case report presents the clinical presentation, diagnostic process, and treatment approaches for a patient diagnosed with subdural hematoma.

Materials and Methods: A 75-year-old male patient presented to the emergency department with complaints of weakness and a sensation of falling forward while walking. He had a history of hypertension (HT) but no prior surgical history. Neurological examination was unremarkable, with no signs of ataxia, abnormal cerebellar tests, or anisocoria. The patient did not report any recent trauma but experienced a persistent sensation of falling forward, which required further investigation.Blood tests showed no abnormalities. Subsequently, brain computed tomography (CT) imaging was performed, revealing an increase in subdural space thickness of up to 15 mm on the right hemisphere, consistent with a subacute subdural hematoma. Additionally, the supratentorial scans showed compression of the right lateral ventricle and a midline shift of approximately 10 mm from left to right.In this patient, the hematoma was classified as subacute. Subacute subdural hematomas generally develop within 1–2 weeks after bleeding and present with symptoms such as headache, balance disturbances, and focal neurological deficits. The patient's sensation of falling could be attributed to vestibular and motor control dysfunction caused by the hematoma.

subdural



Results and Conclusion: This case highlights the importance of recognizing atypical symptoms of subdural hematoma in elderly patients and the critical role of early diagnosis. Subdural hematomas, especially in the subacute phase, may manifest with symptoms such as headache, balance impairment, and a sensation of falling. Thorough neurological examination and imaging are essential for proper evaluation. Early diagnosis and intervention can improve patient outcomes. In elderly individuals, subdural hematoma risk should be assessed considering factors such as hypertension and minor trauma.
Keywords: SUBDURAL HEMATOMA

Ref No: 3481
Post-Endovasculer Procedure Complications
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[1]ATATÜRK UNIVERSITY EMERGENCY MEDICINE
Introduction and Purpose: Elderly patients frequently undergo clinical evaluations due to cardiovascular diseases and their associated complications. Endovascular procedures used in the treatment of atherosclerotic diseases may lead to certain complications. In this case, a 75-year-old male patient presented with complaints of increased temperature, pain, and fever in the right inguinal region. The patient had a medical history of diabetes mellitus and hypertension . Imaging studies revealed the presence of previously placed stents in the right femoral artery and right iliac artery . This case aims to discuss the potential complications following endovascular procedures and their management.
Materials and Methods: Upon arrival at the emergency department, the patient reported pain, localized warmth, and fever. A physical examination revealed tenderness and increased temperature in the right inguinal region. His body temperature was recorded at 38.2°C. Laboratory findings indicated elevated C-reactive protein levels, raising suspicion of infection, prompting further imaging studies.Ultrasound (USG) and computed tomography scans confirmed the presence of previously placed stents in the right AFA and YFA. Additionally, a 43×53 mm localized collection with hemorrhagic density was detected in the medial aspect of the thigh, adjacent to the stent within the muscle layers. This finding raised suspicion of an abscess. Moreover, thickening and increased density in the subcutaneous tissue were observed. A consultation with cardiovascular surgery was requested, and appropriate treatment was initiated. Among these, infections, hematomas, and abscesses are common. Infections are typically associated with implanted stents and can pose a significant threat, particularly in immunocompromised patients. Hematomas and abscesses often develop as a result of bleeding and infection-related processes. The localized hemorrhagic collection observed in this case was strongly indicative of an abscess. Therefore, patients undergoing endovascular interventions require close postoperative monitoring to identify and manage potential complications promptly.
abscess

Results and Conclusion: This case underscores the importance of recognizing and managing complications following stent placement. In patients with risk factors such as DM and HT, infections and hematomas should be considered as potential post-procedural complications. Early diagnosis, appropriate treatment, and vigilant follow-up play a crucial role in managing these conditions effectively. A multidisciplinary approach and timely intervention by cardiovascular specialists are essential in ensuring optimal patient outcomes.
Keywords: abscess, hematoma

Ref No: 3502
Bursting the Bubble: A Case of Ovarian Cyst Rupture Gone Unattended
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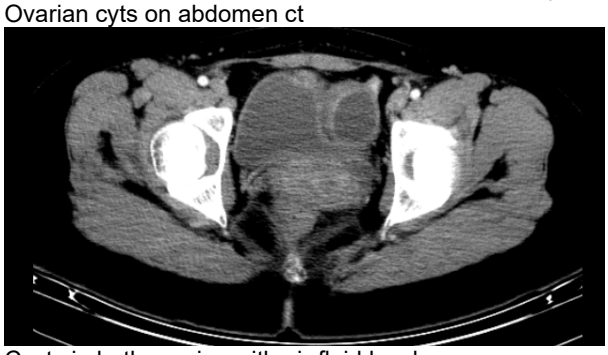
[1]Burdur State Hospital
Introduction and Purpose: Ovarian cyst rupture is a common cause of emergency department visits among reproductive-aged women presenting with acute abdominal pain. Symptoms often include sudden severe pain, nausea, vomiting, lightheadedness, or weakness. In hemorrhagic ovarian cyst (HOC) rupture, blood and fluid may accumulate in the abdominal and pelvic cavities, posing risks such as hemoperitoneum, organ hypoperfusion, and sepsis. Severe cases may require laparoscopic intervention for hemostasis or cyst removal, along with fluid resuscitation and blood transfusion if needed. While often a self-limiting physiological process, complications like hemorrhage or torsion may necessitate surgery. Ovarian cyst rupture can involve both functional (e.g., follicular, corpus luteum) and non-functional cysts (e.g., teratoma, endometrioma, cystadenoma), with diagnosis primarily based on clinical history, especially during the luteal phase, and supported by imaging when necessary.
Materials and Methods: A 19-year-old female presented to the emergency department with abdominal pain. She had no significant medical or family history. Vital signs were stable, but physical examination revealed tenderness and guarding in both lower quadrants. Laboratory results showed leukocytosis (18,170 K/uL), a hemoglobin level of 14.4 g/dL (later decreasing to 13.1 g/dL), and a negative

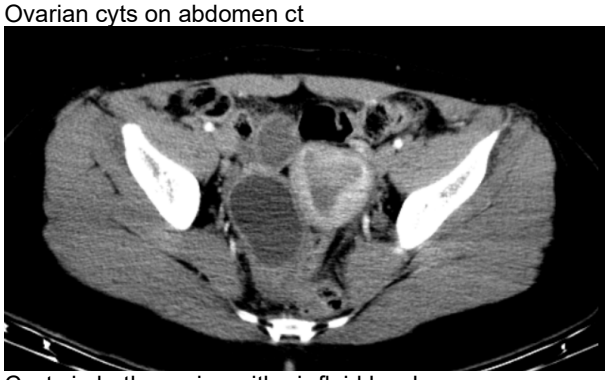
beta-hCG. Urinalysis indicated mild hematuria and pyuria. Contrast-enhanced abdominal CT revealed bilateral ovarian cysts with air-fluid levels, raising suspicion of ovarian cyst rupture. The patient was consulted with gynecology and admitted for further management. However, she later refused treatment and voluntarily left the hospital.

Ovarian cyts on abdomen ct



Cysts in both ovaries with air-fluid levels

Ovarian cyts on abdomen ct



Cysts in both ovaries with air-fluid levels

Results and Conclusion: Ruptured ovarian cysts, whether functional or non-functional, remain a common cause of acute abdominal pain leading women to seek care in the emergency department. Management strategies range from conservative treatment to surgical intervention, with the latter being necessary in cases complicated by hemoperitoneum or ovarian torsion.

Keywords: Ovarian cyst rupture, Abdominal pain, Gynecologic emergencies

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Ref No: 3593

Utilizing the emergency department as a training hub for non-medical personnel. A win-win situation.

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[1]Emergency Department of Nikaia General Hospital, Nikaia, Greece

Introduction and Purpose: The emergency department (ED), beyond its crucial role in providing acute care alsoserves as a training hub for healthcare personnel. Due to its fast-paced and diverseenvironment, the ED offers a unique opportunity for multidisciplinary training,making it an attractive training point for non-Emergency healthcare professionals.At Nikaia Hospital Emergency Department we have created practical trainingprograms for recipients of various professional backgrounds.

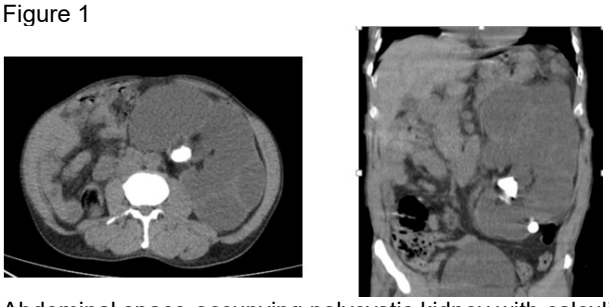
Materials and Methods: At Nikaia Hospital Emergency Department we have created practical trainingprograms for recipients of various professional backgrounds.•Trauma management for the Greek army field medics•Basic resuscitation and first aid for Police first responders•Basic resuscitation and first aid for NGO first aid teams•Practical skills maintenance for both state and private EMS personnel•Triage training for healthcare professionals from other Greek ED's•Advanced resuscitation skills for anesthesiologists in training•ED operations for managing directors of Greek ED'sThe experience and pioneering spirit of the Emergency Department of Nikaia GeneralHospital, Greece, and its active involvement in education for many years make it anattractive training point.Although the training process adds a significant burden on Nikaia ED staff thebenefits of becoming a training hub are many for the staff involved in training.•They further develop their non-technical skills.•They develop skills in adult education.•They are motivated to attend ERC and ATLS instructor courses•It helps prevent burnout through diversification.•It helps expose the ED to new ideas and improvement suggestions.•It supports overwhelmed staff.

Results and Conclusion: The emergency department benefits by serving as a multidisciplinary training hub bydeveloping unique features, by motivating excellence in essential clinical and non-technical skills, and by being constantly exposed to new ideas.To become an effective training hub, the ED must have experienced faculty, state-of-the-art equipment, a culture of continuous learning, and up-to-date trainingpossibilities.

Keywords:

Ref No: 3744
Severe Acute Kidney İnjury İn Ultra-Marathon Runner: Risk Factor Review İn Endurance Athletes
Safiya Khan[1]
[1]**St Luke's General Hospital**
Introduction and Purpose: Acute kidney injury (AKI) is a common and sometimes serious complication in ultra-marathoners. The increasing popularity of ultra-endurance events has brought attention to the medical risks associated with prolonged physical exertion, especially in extreme environmental conditions. This report highlights a case of severe AKI in a healthy endurance athlete and explores contributing risk factors including exertional rhabdomyolysis, dehydration, NSAID use, heat stress, and exertional heat stroke.
Materials and Methods: We present the case of a healthy male in his early 30s who developed AKI following participation in an ultra-marathon. He presented to the emergency department one week post-race with non-specific symptoms, including abdominal pain, vomiting, lethargy, and bilateral lower limb oedema. Laboratory investigations confirmed stage 3 AKI as per KDIGO guidelines, warranting initiation of continuous renal replacement therapy (CRRT). His clinical course was complicated by hypertension and progressive fluid overload, both of which resolved with careful management of fluid balance. The patient made a full recovery, with renal function returning to baseline within two weeks.
Results and Conclusion: This case underscores the complex interplay of risk factors involved in the development of severe AKI in endurance athletes. While most cases resolve with conservative management, early recognition of high-risk individuals and timely intervention are critical to preventing complications such as the need for dialysis. Post-race monitoring protocols may be beneficial in identifying delayed presentations of AKI and improving outcomes in ultra-endurance athletes.
Keywords: acute kidney injury, ultra-marathon, renal replacement therapy

Ref No: 3808
LARGE KIDNEY WITH STONES
Tansu AKPINAR[1]
[1]**Tansu AKPINAR**
[2]**Gamze ERGÖL**
[3]**Hülya SEVİL**
Introduction and Purpose: Polycystic kidney disease (PKD) are progressive cysts that form in the kidneys and cause loss of function. They can be found in all age groups from fetal period to adulthood. PKD is detected in screenings due to family history, during the investigation of symptoms and, as in our case, in USG/ CT/ MR examinations performed for any reason.
Materials and Methods: A 62-year-old male patient presented to the emergency department with left ankle pain after a traffic accident (TA). There were no physical examination findings other than left ankle pain and dislocation. Thorax/abdominal CT scan and extremity X-RAY were performed for TA. X-RAY showed left tibiotalar dislocation and bimalleol fracture. Orthopedics clinic was consulted. Dislocation reduction was performed and splint was applied. CT scan of the abdomen revealed a polycystic, atrophic, nonfunctioning kidney with calculi covering most of the abdomen. Blood results of the patient; Urea. - 79.6 mg/dL, Bun - 37.2 mg/dL, Creatinine - 2.11 mg/dL. Blood pressure was 135/80. The patient who had no known chronic disease or regular medication was consulted to the urology clinic. Urgent operation was not considered by urology. The patient was admitted to the orthopedics clinic for elective operation.
Figure 1



Abdominal space-occupying polycystic kidney with calculi
Results and Conclusion: In PKD, hypertension is usually the first symptom and renal failure develops later in life. PKD should be investigated in patients with family history or symptoms (hematuria, renal colic, nephroiliasis, hypertension, etc.). It may also be seen incidentally as in our patient.
Keywords: Polycystic kidney disease, Nephrolithiasis, Atrophic kidney

Ref No: 3863
Tracheal Stenosis Following Endotracheal Intubation: A Case Report
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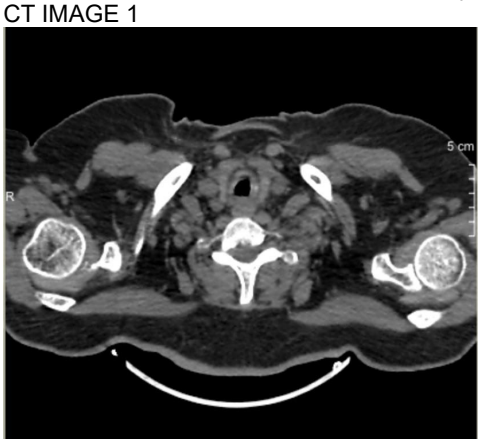
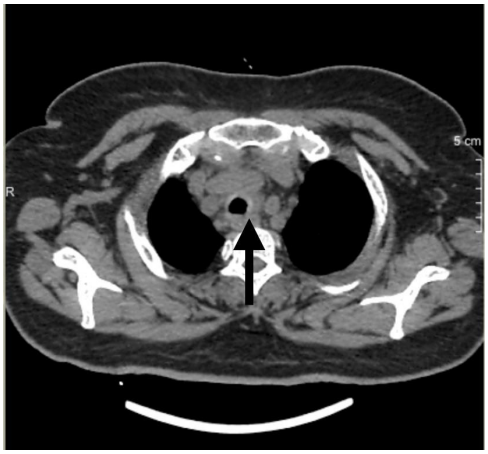
[1]**Department of Emergency Medicine, Faculty of Medicine, Ondokuz Mayıs University, Samsun, Türkiye**
Introduction and Purpose: Tracheal stenosis refers to the narrowing of the tracheal lumen, often leading to respiratory compromise. One of the most common causes is prolonged endotracheal intubation, known as post-intubation tracheal stenosis (PITS). It typically develops due to mucosal ischemia caused by cuff pressure, leading to inflammation and fibrosis. Patients may present days to weeks after extubation with progressive dyspnea or stridor. Early diagnosis is crucial to prevent morbidity.
Materials and Methods: A 56-year-old female with a history of hypertension, diabetes mellitus, chronic kidney disease, and coronary

artery disease presented to the emergency department with a two-month history of progressive shortness of breath, which had acutely worsened. Medical history revealed that she had been intubated 56 days earlier following an acute myocardial infarction and ischemic cerebrovascular event, requiring intensive care admission.Upon presentation, the patient was alert, oriented, and hemodynamically stable. Physical examination revealed audible stridor and coarse breath sounds bilaterally. Vital signs were within normal limits. Laboratory findings included creatinine 3.19 mg/dL, hemoglobin 11 g/dL, CRP 7 mg/dL, and elevated troponin levels (1072 → 962 ng/mL). Chest and neck computed tomography (CT) demonstrated a 28 mm segment of tracheal narrowing at the thoracic inlet, with a minimal luminal diameter of 7 mm, thickening of tracheal walls, and peritracheal soft tissue changes suggestive of fibrosis. Additionally, obliteration of the fat plane between the trachea and esophagus indicated ongoing inflammation.Consultations were obtained from pulmonology, thoracic surgery, cardiology, and otorhinolaryngology. The patient was diagnosed with post-intubation tracheal stenosis and was scheduled for tracheal dilatation by thoracic surgery. The procedure was performed without complications.

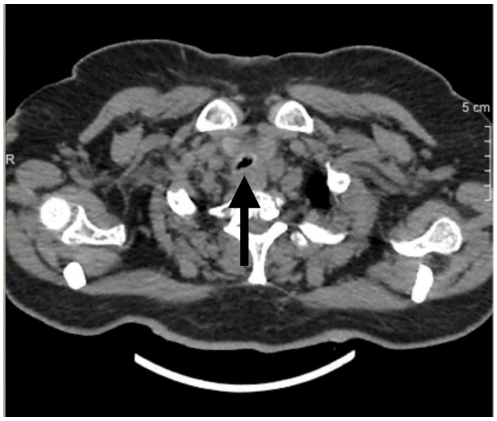
CT IMAGE 1



CT IMAGE 2



CT IMAGE 3



Results and Conclusion: PITS is a notable complication, particularly in ICU patients requiring prolonged ventilation. Risk factors include intubation duration, comorbidities, and mucosal fragility. CT plays a key role in diagnosis by providing detailed anatomical visualization. In this case, early imaging enabled timely detection and led to successful endoscopic tracheal dilatation by thoracic

surgery. This case highlights the need to consider PITS in patients with recent intubation presenting with unexplained dyspnea. Prompt imaging, early intervention, and multidisciplinary care can significantly improve outcomes. Though tracheal dilatation is effective, close follow-up is essential due to recurrence risk.

Keywords: Post-Intubation Tracheal Stenosis, Dyspnea, Stridor

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Ref No: 3864

Bedside Ultrasound And Rapid Diagnosis

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Introduction and Purpose: The purpose of presenting this case is to emphasize the role of bedside ultrasound in the rapid diagnosis of patients presenting to the emergency department with syncope and trauma.

Materials and Methods: A 33-year-old female patient presented to the emergency department two days ago with complaints of vaginal bleeding. She was a 33 weeks and 2 days pregnant patient under follow-up for known placenta previa (G6P2A3). The patient had been admitted to the obstetrics and gynecology service two days prior and was discharged after evaluation. Following her discharge, she experienced a syncopal episode at home, leading to a fall from the same level. She was brought to our emergency department via EMS (112) in a hypotensive and tachycardic state.On arrival, the patient's blood pressure was 74/47 mmHg, and her heart rate was 117 bpm. According to the patient's history, she reported falling on her abdomen. A bedside ultrasound was immediately performed, revealing intrauterine fluid elements. Given these findings, the patient was urgently consulted with the obstetrics and gynecology department and transferred to the delivery room.In the delivery room, the patient underwent an emergency operation. A live baby was delivered via a supraumbilical and infraumbilical midline incision. General surgery was involved intraoperatively. During the procedure, widespread hemorrhagic fluid was observed in the abdomen, but no additional splenic or hepatic bleeding was detected. The patient was transferred to the intensive care unit postoperatively. The newborn was delivered alive, and after an ICU stay, the mother was transferred to the obstetrics and gynecology service. Both the mother and baby were eventually discharged in good condition.

Results and Conclusion: Bedside ultrasound can be a critical tool in emergency settings to expedite decision-making and improve patient outcomes.

Keywords: Placenta previa, Pregnant trauma, Bedside ultrasound

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Ref No: 3914

Evaluation of Anaphylaxis Patients Admitted to the Emergency Department

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Introduction and Purpose: Anaphylaxis is a potentially life-threatening, multisystem allergic reaction that can cause airway, respiratory, or circulatory collapse. It requires rapid evaluation, diagnosis, and treatment. In this study, we aimed to increase awareness of anaphylaxis by evaluating anaphylaxis patients who presented to the emergency department and to help patients and physicians approach anaphylaxis.

Materials and Methods: This retrospective study included patients aged 18 and over who presented with anaphylaxis between 01.01.2018 and 31.12.2022 at Bezmialem Vakıf University Medical Faculty Hospital. We excluded those under 18, without a diagnosis of anaphylaxis, or with incomplete data. Patients received intramuscular (IM) or intravenous (IV) epinephrine. Key factors such as symptoms, comorbidities, and treatment outcomes were assessed. Anaphylaxis was diagnosed according to the National Institute of Allergy and Infectious Disease 2021 guideline. Epinephrine was started intramuscularly in patients, and infusion epinephrine treatment was started in patients who did not respond to IM adrenaline.

Results and Conclusion: In the emergency department, prompt diagnosis and immediate treatment of anaphylaxis are critical. Initial treatment with intramuscular adrenaline should be followed by an infusion in cases where the first two doses are insufficient, as the continuous, titratable delivery offers a more stable hemodynamic response. Notably, patients with neurological symptoms are more likely to require IV infusion, and those receiving IV treatment frequently have comorbidities—an important risk factor for anaphylaxis. Delayed epinephrine administration has been associated with an increased risk of biphasic reactions and poorer outcomes, as evidenced by longer times to treatment in patients with biphasic reactions and fatal cases. These findings underscore the necessity of early intervention, vigilant patient assessment, and the use of personal epinephrine in at-risk individuals. Of the 77 patients studied, 9 required IV epinephrine treatment. More than half of the patients were started on epinephrine within 1 hour of exposure to the allergen. And the only person who was arrested had more than 1 hour to reach epinephrine treatment. When diagnosing anaphylaxis, we should not hesitate to start adrenaline and switch to IV infusion, and we should get the patient to the necessary care and treatment as soon as possible.

Keywords: Anaphylaxis, Emergency, Biphasic reactions

Ref No: 3923

Non-acute appendicitis patient presenting with right lower quadrant pain

alparslan altun[1], sultan tuna akgöl gür[1]

[1]Non-acute appendicitis patient presenting with right lower quadrant pain

Introduction and Purpose: Acute abdomen refers to sudden, severe abdominal pain. In most cases it is a medical emergency requiring immediate and specific diagnosis. In some cases it requires immediate surgical intervention.

Materials and Methods: A 25 year old male patient presented with abdominal pain that started 4 hours ago. The patient had no known medical history. Vitals bp: 125/75 sat: 97 hr: 87/min fever: 36.8. On examination, deficiency rebound in the right lower quadrant was detected. No obvious abnormality was found in blood tests. The imaging examination was reported as 'A SPACE-COVERING LESION

WITH AN AVERAGE DENSITY OF 70 HU WITH AN AVERAGE DENSITY OF 70 HU WAS TRACKED IN THE LEFT UPPER QUADRITOR OF THE ABITTIN NO SPECIFIC CONTRASTING WAS TRACKED IN THE LEFT UPPER QUADRITOR OF THE ABITTIN, WITH AN APPROXIMATELY 4 * 7* 10 CM SIZE, SURROUNDED BY VASCULAR STRUCTURES THROUGH WHICH DIRSTING WAS TRACKED IN THE FATTY PLANS'. After general surgery consultation, surgical operation was planned to determine the nature of the lesion.

Results and Conclusion: Physical examination is one of the most important steps in the detection of acute abdomen. Acute abdominal pathologies usually indicate pathologies related to the abdominal region examined, but rarely, as in this patient, the abdominal pathology may belong to a region other than the focus of the examination.

Keywords: Acute abdomen, immediate surgical intervention

Ref No: 4148

Successful Thrombolysis During Cardiopulmonary Resuscitation İn Massive Pulmonary Embolism: A Case Report

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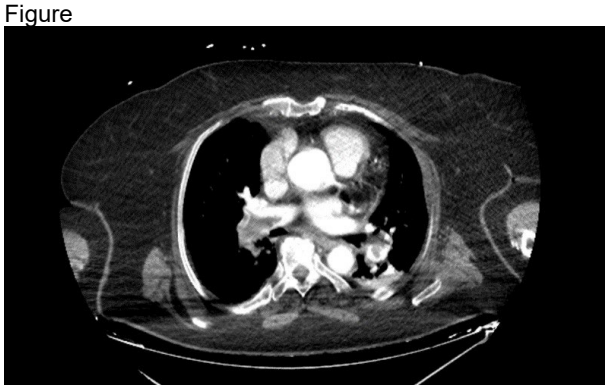
Introduction and Purpose: Massive pulmonary embolism (PE) is a life-threatening emergency with high mortality rates, especially when complicated by cardiac arrest. Thrombolytic therapy during cardiopulmonary resuscitation (CPR) remains controversial but may be lifesaving in cases with confirmed or strongly suspected PE.

Materials and Methods: A 77-year-old female with a history of hypertension and obesity presented after experiencing sudden-onset dyspnea that woke her from sleep. Upon ambulance arrival, she lost consciousness and suffered cardiac arrest. Emergency medical services initiated CPR and endotracheal intubation. On arrival to the emergency department (ED), the patient had been in cardiac arrest for 15 minutes with only epinephrine administered. History revealed three months of reduced mobility due to obesity, becoming essentially bed-bound.Given the presentation of sudden dyspnea followed by syncope and arrest, massive PE was suspected. Point-of-care echocardiography during ongoing CPR revealed right ventricular dilation and interventricular septal flattening ("D-sign"), consistent with right ventricular strain. The decision was made to administer intravenous alteplase 50 mg during CPR. Return of spontaneous circulation was achieved 10 minutes after thrombolytic administration.Post-resuscitation ECG showed rapid atrial fibrillation with right bundle branch block. Laboratory studies revealed elevated troponin (initial: 86 ng/L; repeat: 304 ng/L; reference <14 ng/L), severe metabolic and respiratory acidosis (pH: 6.76, lactate: 12.11 mmol/L), and hypoxemia (PO□ 55.3 mmHg). Imaging studies confirmed the presence of massive PE. The patient was stabilized on vasopressor support and transferred to intensive care.This case highlights the importance of considering PE in cardiac arrest patients with appropriate risk factors and demonstrates the potential benefit of thrombolysis during CPR when PE is strongly suspected. Point-of-care echocardiography provided crucial diagnostic information that guided immediate therapeutic intervention, leading to successful resuscitation despite prolonged cardiac arrest.

Figure



Massive Pulmonary Embolism

Results and Conclusion: Early recognition and aggressive management of suspected massive PE, including thrombolysis during CPR, may improve outcomes in selected patients. Point-of-care ultrasound is invaluable in guiding this time-critical decision-making process.

Keywords: Massive pulmonary embolism, Point-of-care ultrasound, Thrombolysis

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Ref No: 4173

PERIPHERAL FACIAL PARALYSIS:

ALİ KERİM ÖZPOLAT[1], ZEYNEP ÇAKIR[1]

[1]PERIPHERAL FACIAL PARALYSIS

Introduction and Purpose: Peripheral facial paralysis is the most common cranial neuropathy. Any damage to the motor nucleus in the brain stem, starting from the motor nucleus to the most distal neuromuscular junction, can cause peripheral facial paralysis. Involvement of the facial nerve in the periphery results in unilateral facial paralysis. Symptoms include paresis of facial muscles, hyperacusis (overhearing), decreased tear and saliva secretion, and decreased taste sensation in the 2/3 front part of the tongue.

Materials and Methods: An 80-year-old woman presented with complaints of pain behind her left ear that started about 48 hours ago and inability to close her eyes and decreased lip movements on the left side of her face for 48 hours. Vital signs were normal on admission (Pulse: 88 SPO2: 93 TA: 123/85 FEVER: 36.5). The patient had known diagnoses of DM and hypertension. In the physical examination, there was drooping of the eyebrow on the left side of the face, inability to close the eyelid completely, fading in the nasolabial groove and drooping of the lip edge on the affected side. In the tests obtained from the patient, HGB: 13.5, WBC: 12.680,

there was no feature in other blood tests. Brain CT and Diffusion MR imaging were performed, there was no acute pathological feature. The patient was consulted to the Otorhinolaryngology clinic in this condition, hospitalization was given to the ENT service and continuation of treatment was planned.

Results and Conclusion: The clinician should decide whether inpatient or outpatient treatment should be arranged in consultation with the relevant clinics, taking into account the patient's other known chronic disorders when organizing treatment in patients with a prediagnosis of peripheral facial paralysis. Treatment consists of two main forms of treatment started at the same time. The first is eye protection, which is organized as artificial tear drops during the day, vaseline eye ointment and eye closure at night, and anti-inflammatory treatment should be started with 60-80 mg/day prednisone. Depending on the clinical condition of the patient, antiviral therapies can also be started in addition to the current treatment.

Keywords: FASCIAL PARESIS, PARESIS, STEROID THERAPY

Ref No: 4259

THE MOST FATAL CHEST PAIN

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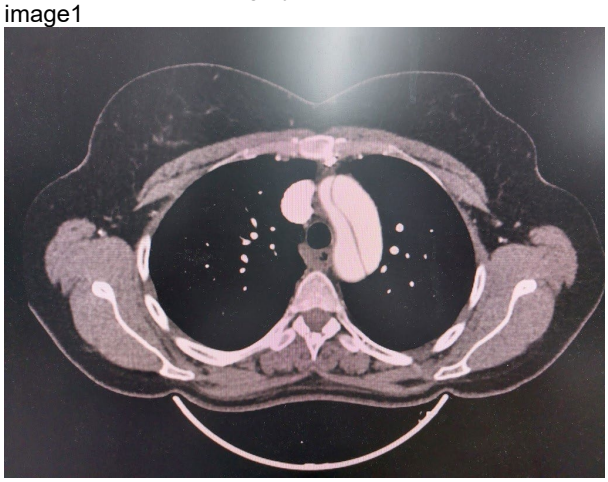
Introduction and Purpose: Acute aortic dissection is a vascular disease that is difficult to diagnose, and even when diagnosed, it has a very high in-hospital mortality rate. It is defined as the tearing between the intima and media layers of the aortic wall, resulting in the separation of the intima layer in the direction of blood flow, extending distally. Death from aortic dissection may occur due to rupture of the proximal dissection into the pericardium, which accelerates cardiac tamponade, bleeding into the pleural cavity, dissection into the aortic valve ring leading to severe aortic insufficiency, or occlusion of the coronary artery ostium causing a myocardial infarction.

Materials and Methods: A 55-year-old male patient with a known history of aortic valve replacement and ongoing anticoagulation therapy with Coumadin presented to our emergency department with sudden-onset, tearing chest pain followed by accompanying back and lumbar pain. His vital signs were as follows: right arm blood pressure: 140/85, left arm blood pressure: 100/60, pulse: 96/min, oxygen saturation: 96% (room air), and temperature: 36.7°C. During examination, the pulses in all four extremities were palpable and equal, and other systemic examinations were unremarkable. The patient's Aortic Dissection Detection Risk Score (ADD-RS) was found to be high. A contrast-enhanced tomography performed urgently confirmed aortic dissection, and the patient was promptly operated on by the cardiovascular surgery team.

Results and Conclusion: Due to the high mortality risk, a high level of suspicion is crucial in identifying patients with acute aortic dissection in order to avoid missed or delayed diagnoses. In cases of chest pain with risk factors that predispose to aortic dissection, such as prior aortic surgery or valve replacement, aortic dissection should be one of our primary differential diagnoses.

image1



Keywords: aortic dissection, CHEST PAIN

Ref No: 4261

TRAUMATIC EYE

MUHAMMED CENGİZHAN DURMUŞ[1], ALPARSLAN ALTUN[1], SULTAN TUNA AKGÖL GÜR[1]

[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP

Introduction and Purpose: Ocular trauma is a significant cause of visual impairment and a common reason for emergency department (ED) visits. High-energy explosive-related eye injuries can result in either open or closed globe injuries, often necessitating urgent surgical intervention. This case report presents the evaluation and management of a young female patient who sustained a severe ocular injury following a firework explosion.

Materials and Methods: A 17-year-old female patient presented to the emergency department with complaints of bleeding from the left eye following a firework explosion. On physical examination, total conjunctival hyperemia and hyphema were observed in the left eye, consistent with a penetrating globe injury (image1). Given the high suspicion of an open globe injury, the patient was urgently consulted with the ophthalmology department. Due to the severity of the ocular trauma, the patient was admitted for emergency surgical intervention.

image 1

Results and Conclusion: Open globe injuries caused by high-energy trauma require prompt evaluation and immediate surgical management to prevent vision loss. In this case, the rapid assessment and referral to the ophthalmology department played a crucial role in optimizing the patient's prognosis. Early diagnosis, appropriate surgical intervention, and postoperative monitoring are key factors in determining visual outcomes. Preventive measures, including raising awareness regarding the dangers of handling explosive materials, are essential to reducing the incidence of such injuries, particularly in young individuals.
Keywords: TRAUMA, RED EYE

Ref No: 4287
Amyand's hernia with appendicitis
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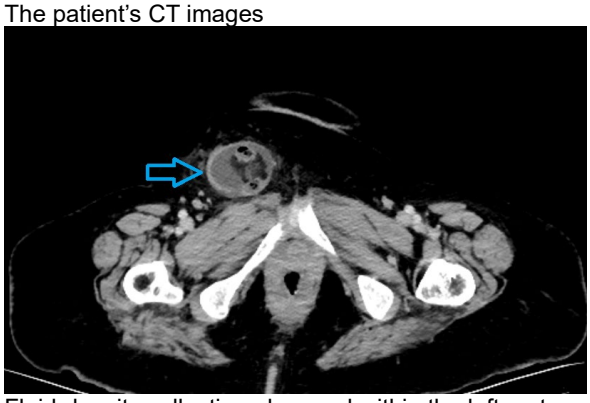
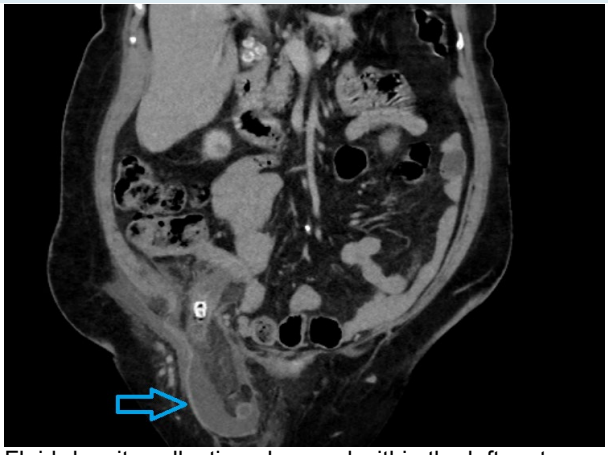
[1]Kütahya Sağlık Bilimleri Üniversitesi
Introduction and Purpose: Hernia is the abnormal protrusion of an organ or tissue from its containing cavity. A non-reducible hernia is termed an incarcerated hernia. This report presents a rare case of an incarcerated appendix within a right inguinal hernia, also known as Amyand's hernia (AH). This case aims to raise awareness of this rare medical condition in emergency service.
Materials and Methods: Case Presentation A 76-year-old female patient presented to our emergency department with complaints of pain and swelling in the right lower quadrant for the past few days.Medical history:The patient has a history of diabetes mellitus, hypertension, and heart failure.The patient has no history of intra-abdominal surgery. She has no known allergies, and there are no significant findings in her family history.Vital signs: Heart rate: 87 bpm, Oxygen saturation: 92%, Temperature: 36.8°C, Blood pressure: 125/79 mmHg.Physical examination:A firm, irreducible inguinal hernia was detected in the right lower quadrant. The abdomen was soft, with no guarding or rebound tenderness.Laboratory findings:WBC: 24.84 × 10^9/L, Neutrophil percentage: 86.9%, Hemoglobin: 10.7 g/dL, CRP: 170 mg/L, No other laboratory abnormalities were noted.Due to elevated acute-phase reactants and leukocytosis, IV Flagyl 500 mg was initiated, oral intake was stopped, and 0.9% saline infusion was started at 100 cc/hour.Since the patient's creatinine levels were within normal limits, a contrast-enhanced abdominal CT scan was performed.CT findings: The appendix was observed within the right inguinal canal, with an increased diameter of approximately 13 mm and surrounding heterogeneous fat stranding. There was linear density increase and heterogeneity in the pericecal fat tissue in the right lower quadrant.Following the CT findings, the general surgery department was consulted, and the patient underwent laparoscopic appendectomy. Postoperatively, the patient was started on analgesia and antibiotic therapy and was discharged after follow-up.
The patient's CT images



Fluid-density collection observed within the left rectus muscle, consistent with intramuscular hematoma
The patient's CT images



Fluid-density collection observed within the left rectus muscle, consistent with intramuscular hematoma

Results and Conclusion: Amyand's hernia is a very rare surgical condition, affecting 1% of all inguinal hernia cases. What makes our case interesting is the inflammation of the appendix inside the Amyand hernia sac. Early diagnosis and surgery can prevent long-term complications.It is a condition that should always be kept in mind in patients with a hernia for early diagnosis and intervention in the emergency department.

Keywords: amyands hernia, surgical case reports, symptomatic hernia

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Ref No: 4333

Hidden Danger in a Knee Injury: Hematoma Diagnosis in a 9-Year-Old Girl

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[1]Atatürk University, Department of Emergency Medicine

Introduction and Purpose: IntroductionTraumas in childhood are often related to falls that occur during sports activities or play. Evaluating such traumas is crucial for making an early diagnosis and managing the treatment process effectively. Bone and soft tissue injuries, particularly in the lower extremities, are commonly observed. In this case presentation, we report a 9-year-old female patient who presented with a suspected femoral distal hematoma after falling on both knees.

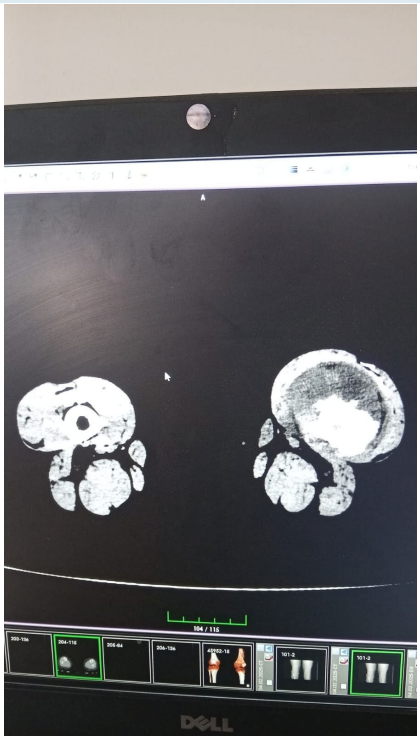
Materials and Methods: A 9-year-old female patient presented to our clinic 3 days after falling on both knees, complaining of pain. The patient's general condition was stable, with intact consciousness and normal respiratory findings. Neurological examination revealed no pathological findings. On physical examination, tenderness was noted over the left knee, but no signs of cellulitis (such as redness or increased warmth) were observed. Swelling, firmness, and severe tenderness were found at the distal femoral level, specifically at the quadriceps muscle.Radiological evaluations revealed radio-opaque findings in the bone surrounding tissues. Ultrasonography showed a 33x18 cm heterogeneous, loculated area with no internal flow in color Doppler ultrasonography, which was considered consistent with a hematoma. Computed tomography also showed findings compatible with a hematoma in the muscle planes.

image 1

İMAGE 2

İMAGE 3

İMAGE 4



Results and Conclusion: This case highlights the importance of identifying soft tissue hematomas in lower extremity trauma and the significance of timely diagnosis in facilitating treatment. Imaging techniques such as ultrasonography and computed tomography play a vital role in evaluating soft tissue injuries.
Keywords: Hematoma, Trauma, Knee

Ref No: 4470
Aneurysm rupture
Erdem Zeki KARABULUT[1], Zeynep ÇAKIR[1], Muhammed Cengizhan DURMUŞ[1]
[1]Ataturk University
Introduction and Purpose: Aneurysm rupture is a challenging diagnosis when no prior aneurysm diagnosis exists. Aneurysm ruptures can occur in various locations and are life-threatening conditions.
Materials and Methods: A 58-year-old female patient presented to our emergency department with complaints of fainting and left-sided flank pain. She reported a history of similar recurrent visits to the emergency department with these complaints, as well as a history of nephrolithiasis. The patient had a known diagnosis of hypertension, for which she was taking an ACE inhibitor. On physical examination, the abdomen was soft, and there was left costovertebral angle tenderness. Vital signs were stable, and urinalysis revealed minimal hematuria. Creatinine, BUN, liver function tests, and white blood cell count were within normal limits, and there were no abnormalities in gas or stool output. Blood gas analysis showed a lactate level of 4.3, with no other significant findings. A spiral CT was requested for central imaging and to confirm possible nephrolithiasis. Despite the administration of opioid analgesia for the patient's agitation, there was no relief. The central imaging did not show any significant findings, but the spiral CT scan did not reveal any stones. However, there were findings consistent with an aneurysm or possible aneurysm rupture, prompting a contrast-enhanced CT. The patient was diagnosed with a ruptured abdominal aortic aneurysm at the renal level, and an urgent consultation was made with the Cardiovascular Surgery team, after which the patient was taken to surgery.
Results and Conclusion: In patients with severe kidney pain, unrelieved pain, and elevated lactate levels in blood gas, aneurysm rupture should be considered as a possible diagnosis.
Keywords: Aneurysm rupture, Flank pain

Ref No: 4471
Acute mesenteric ischemia
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Introduction and Purpose: Acute mesenteric ischemia is a condition that is difficult to diagnose and usually presents with unexplained abdominal pain. The most crucial part of diagnosing acute mesenteric ischemia is to suspect it when presented with such symptoms.
Materials and Methods: A 60-year-old male patient presented to our emergency department with intermittent abdominal pain and constipation. He reported that these symptoms had recurred previously, and he had been relieved with symptomatic treatment and enemas. The patient has gas and stool passage but expresses difficulty. He has a known history of atrial fibrillation and hypertension, and he takes beta-blockers and anticoagulants. On physical examination, there was widespread tenderness in the abdomen, but no signs of guarding or rebound tenderness. His vital signs were stable, and his creatinine, BUN, liver function tests, and white blood cell

count were normal. The only abnormal finding on his arterial blood gas was a lactate level of 3.2. There were no signs of perforation or air-fluid levels on the plain abdominal X-ray. Due to the patient's recurrent visits, comorbidities, and the persistence of his symptoms, further investigations were performed in our emergency department. A CT scan of the abdomen showed possible mesenteric ischemia at the level of the abdominal aorta. The patient was admitted to the General Surgery department and underwent surgery.
Results and Conclusion: Acute mesenteric ischemia should be considered, especially in elderly patients with comorbidities and recurrent visits due to unexplained abdominal pain.
Keywords: Acute Mesenteric Ischemia, Abdominal Pain, Constipation

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Ref No: 4512
A Neurologıcal Cause Of Dyspnea
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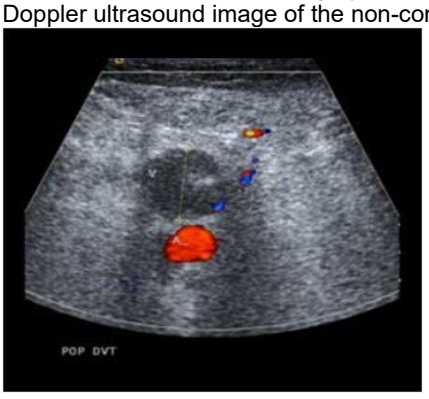
[1]Afyonkarahisar Health Sciences University
Introduction and Purpose: Myasthenia graves (MG) is an autoimmune disease caused by autoantibodies against the acetylcholine receptor at the neuromuscular junction, leading to fatigue and skeletal muscle weakness. Extraocular muscle weakness with diplopia is present in 90% of MG patients. The most important diagnostic test is the detection of serum antibodies against acetylcholine receptors, which are positive in 90% of patients with generalized MG.
Materials and Methods: A 72-year-old woman presented to the emergency department with dyspnea and dysphagia. She had diabetes, hypertension and asthma. Her neurologic and respiratory examinations were normal. Her vitals showed only low saturation. The patient underwent thorax CT. No pathologic findings were detected in CT scan results and blood samples. The patient's dyspnea and apnea attacks did not resolve and we consulted pulmonology and otolaryngology. Flexible endoscopy revealed right vocal cord paralysis. The patient developed ptosis in the following hours. When we deepened the anamnesis of the patient, we learned that he had complaints of dysphagia, hoarseness, inability to hold his head upright, drooping of the left eyelid and weakness for 3 days. No pathology was found in central imaging of the patient. We consulted the patient to neurology with a prediagnosis of MG. Pyridostigmine was administered by neurology. The patient's symptoms improved after administration. We hospitalized the patient in the neurology ward with the diagnosis of MG.
Results and Conclusion: MG may have a mortal course with dyspnea and is diagnosed especially at young ages. Although the etiology of respiratory failure is very wide, dysphagia in the anamnesis and ptosis on inspection have been helpful in the diagnosis and treatment of MG.
Keywords: Myasthenia graves, Ptosis, Dyspnea

Ref No: 4525
Deep Vein Thrombosis
Egenur Yilmaz[1], Alten Oskay[1], Mert Ozen[1], Murat Seyit[1], Atakan Yilmaz[1], Ibrahim Turkcuer[1]
[1]Pamukkale University
Introduction and Purpose: Deep vein thrombosis (DVT) is a serious condition that commonly presents with symptoms such as pain, swelling, and tenderness in the lower extremities. However, these symptoms can overlap with various other medical conditions, necessitating a comprehensive differential diagnosis. A thorough medical history and clinical evaluation are essential to accurately diagnose DVT and determine the most appropriate treatment plan.
Materials and Methods: An 85-year-old female patient presented with swelling in her right leg for one day. The patient had a history of pulmonary embolism in 2021, three coronary angiographies five years ago, and a pacemaker insertion two months prior due to AV block. Her vital signs were stable, and further questioning revealed complaints of orthopnea and right leg pain.Physical examination showed decreased breath sounds bilaterally at the bases with bibasilar fine rales. Additionally, pretibial edema was noted, graded as +3 on the right and +1 on the left. Given the clinical findings consistent with venous congestion, a detailed anamnesis was performed, revealing that the normally present leg swelling had increased unilaterally within one day, raising suspicion for DVT.A Doppler ultrasound was performed, revealing a hyperechoic thrombus in the distal femoral and external iliac veins of the right lower extremity (Figure). Venous collaterals were also observed at the popliteal vein level. With the diagnosis of thrombosis in the right popliteal vein, the patient's Wells score was calculated as 6, and a computed tomography pulmonary angiogram showed no filling defects consistent with embolism. A cardiovascular surgery consultation was obtained, and anticoagulant therapy was initiated. The patient was discharged with a follow-up plan in the cardiovascular surgery clinic.
Doppler ultrasound image of the non-compressible distal femoral vein of the right lower extremity



Results and Conclusion: This case highlights the importance of a detailed anamnesis and clinical evaluation in diagnosing DVT. Heart failure, lymphedema, cellulitis are among differential diagnosis. The identification of unilateral leg swelling and confirmatory imaging led to the diagnosis of DVT. This case report underscores the necessity of careful patient assessment to ensure an accurate diagnosis and appropriate treatment.

Keywords: deep vein thrombosis, medical history, physical examination

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Ref No: 4535

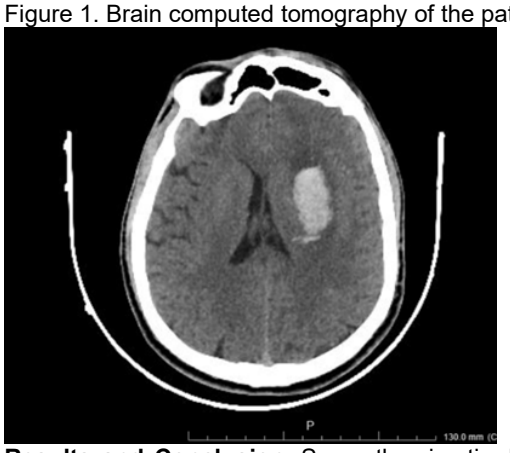
Substance use and intraparenchymal hemorrhage: a case report

Mert Can Yilmaz[1], Mert Ozen[1], Atakan Yilmaz[1], Alten Oskay[1], Murat Seyit[1], Ibrahim Turkcuer[1]
[1]Pamukkale University

Introduction and Purpose: Substance use is a well-established risk factor for cerebrovascular events. Illicit drugs can precipitate intraparenchymal hemorrhage (IPH) through both direct neurotoxic effects and acute hemodynamic disturbances. Sudden blood pressure surges, particularly in the context of chronic substance use, can lead to spontaneous cerebral bleeding. This report presents a case of hypertensive basal ganglia hemorrhage in a young male following drug use.

Materials and Methods: A 41-year-old male with no documented medical history but known regular illicit drug use presented to the emergency department with acute onset of speech disturbance, right-sided weakness, urinary incontinence, and transient loss of consciousness. The patient reported drug use the day before admission.On arrival, vital signs were as follows: blood pressure 170/80 mmHg, heart rate 110 bpm, respiratory rate 20 breaths/min, and body temperature 36.7°C. Neurological examination revealed a Glasgow Coma Scale (GCS) score of 12, with 3/5 muscle strength in the right upper and lower extremities and 5/5 in the left. Pupils were isocoric with preserved light reflexes bilaterally. Other systemic findings were within normal limits.Non-contrast cranial computed tomography (CT) demonstrated a 4×2×4.5 cm hyperdense hematoma in the left basal ganglia, surrounded by hypodense edema. A mild midline shift to the right and compression of the left lateral ventricle were noted (Figure 1).The working diagnosis was hypertensive basal ganglia hemorrhage secondary to substance-induced blood pressure elevation. Neurosurgery, and neurology teams were consulted. Emergency surgical intervention was not indicated. The patient was admitted to the intensive care unit for close monitoring and supportive care.

Figure 1. Brain computed tomography of the patient



Results and Conclusion: Sympathomimetic drugs such as cocaine and amphetamines are known to cause hypertensive crises that can result in IPH. This case emphasizes the importance of early neuroimaging, detailed substance use history, and interdisciplinary collaboration. In young patients with acute neurological deficits, substance-related hemorrhage should be a differential consideration. Timely diagnosis and intensive care support are essential to optimizing outcomes.

Keywords: intraparenchymal hemorrhage, substance use, hypertension

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Ref No: 4544

Penetrating Trauma and the Unpredictability of Injury Patterns: A Case of Stabbing with Atypical Findings

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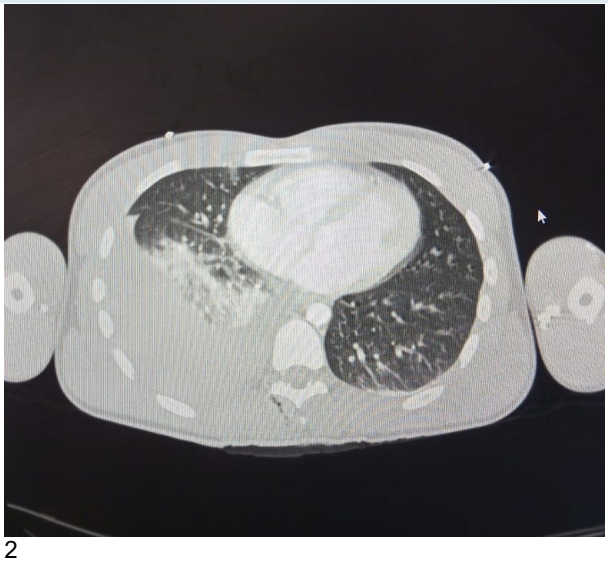
[1]Atatürk University Faculty of Medicine Department of Emergency Medicine

Introduction and Purpose: A 32-year-old male patient was brought to the emergency department by ambulance due to a stabbing injury. On initial assessment, his Glasgow Coma Scale (GCS) score was 15, blood pressure was 90/50 mmHg, and oxygen saturation was 88%. Due to alcohol intoxication, full communication could not be established. Physical examination revealed a 2 cm laceration at the thoracic level, in the left paravertebral region. Due to his deteriorated general condition, the patient was evaluated in the resuscitation room of the emergency department, and emergency tests and treatment were planned.

Materials and Methods: On lung auscultation, contrary to expectations, while pathological sounds were anticipated in the left hemithorax, diminished breath sounds and diffuse coarseness were detected in the right lung. This finding was unexpected during the initial inspection and warranted further radiological evaluation. Imaging studies revealed a right thoracic transverse process fracture and right-sided hemothorax.

1



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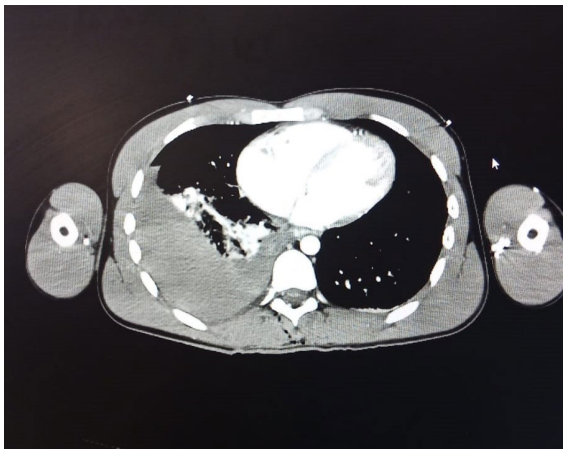


3

Results and Conclusion: This case teaches us that the expected findings in a patient's examination and imaging may differ from the actual results. It highlights the importance of gaining more experience and being prepared for unexpected outcomes in clinical practice.As seen in this case, in penetrating injuries caused by sharp objects, it is often impossible to predict the exact trajectory of the penetrating object. Therefore, it is crucial to consider potential pathologies involving all organ structures in the affected region.

Keywords: stabbing, hemothorax, thoracostomy

Ref No: 4555
Hemoroid and Syncope
ABDULLAH SÜHA AKÇA[1], AYÇA ÇALBAY[1]
[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP ANABİLİM DALI
Introduction and Purpose: Falls following presyncope can indicate serious underlying conditions, particularly in elderly patients. In this case, a 70-year-old male patient presented to the emergency department after experiencing a fall while seated due to a presyncopal episode. Given his hemodynamic instability and trauma-related injury, a comprehensive evaluation was conducted to identify potential underlying causes.
Materials and Methods: A 70-year-old male patient was admitted to our emergency department following a fall from a seated position due to a presyncopal episode. On arrival, he was hypotensive and tachycardic, with a Glasgow Coma Scale (GCS) score of 15, oriented, and cooperative. Physical examination revealed a deformity of the left shoulder with the presence of the "epaulet sign" and significant tenderness. Radiological imaging confirmed a left shoulder dislocation.During the etiological evaluation of the presyncopal episode, rectal examination revealed thrombosed external hemorrhoidal masses with active bleeding on digital rectal examination. After a successful closed reduction of the shoulder dislocation, laboratory tests showed a hemoglobin level of 6.7 g/dL, indicating significant anemia. Given the presence of active gastrointestinal bleeding secondary to hemorrhoidal disease and symptomatic anemia, the general surgery department was consulted. The patient received erythrocyte suspension transfusion and was subsequently taken for emergency surgical intervention by the general surgery team.
Results and Conclusion: This case highlights the importance of a thorough assessment of presyncope, particularly in elderly patients, as it can be a manifestation of significant underlying pathology. In this patient, active gastrointestinal bleeding led to symptomatic anemia, which was identified as the probable cause of presyncope. The multidisciplinary approach ensured appropriate management, including shoulder reduction, transfusion therapy, and emergency surgical intervention. Clinicians should maintain a high index of suspicion for potential life-threatening conditions when evaluating presyncope in elderly patients.
Keywords: HEMORRHOIDS, SYNCOPE

Ref No: 4594
A presentation of pontine infarction in an elderly patient with atrial fibrillation
Meryem Kecelioglu[1], Mert Ozen[1], Alten Oskay[1], Atakan Yilmaz[1], Murat Seyit[1], Ibrahim Turkcuer[1]
[1]Pamukkale University
Introduction and Purpose: The pons is the largest component of the brainstem, located distal to the midbrain and proximal to the medulla oblongata. Obstruction of its blood supply, whether acute or chronic, results in pontine infarction, a form of ischemic stroke. Timely diagnosis is critical due to the pons' vital role in autonomic and motor functions.
Materials and Methods: An 80-year-old male presented to the emergency department with complaints of fatigue and decreased oral intake persisting for one month. His medical history included hypertension, diabetes mellitus, and atrial fibrillation. His medications were rivaroxaban and digoxin.On admission, his Glasgow Coma Scale (GCS) score was 15, and his vital signs were within normal limits. Electrocardiography revealed atrial fibrillation with a slow ventricular response (heart rate: 35 bpm) (Figure 1). Intravenous atropine (1 mg) was administered in three doses, raising the heart rate to 45 bpm. Due to persistent bradycardia, a transcutaneous pacemaker was applied. Laboratory results revealed an INR of 1.09 and a digoxin level of 3.9 µg/L, indicating digoxin toxicity.During follow-up, the patient's level of consciousness deteriorated, and his GCS score declined to 12 (E4M6V3). A non-contrast brain computed tomography (CT) scan showed no acute pathology; however, diffusion-weighted magnetic resonance imaging (MRI) (Figure 2-3) revealed acute diffusion restriction in the left pons, consistent with pontine infarction. Neurology consultations were obtained. Subcutaneous enoxaparin (0.6 cc) was initiated, and the patient was transferred to the intensive care unit for close monitoring and further management.
Figure 1. Electrocardiography of the patient, showing atrial fibrillation with a slow ventricular response.

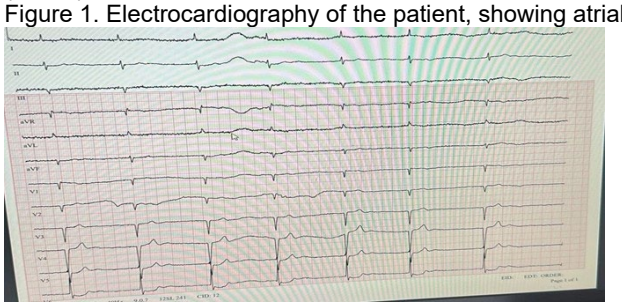


Figure 2. Diffusion-weighted magnetic resonance imaging of the patient

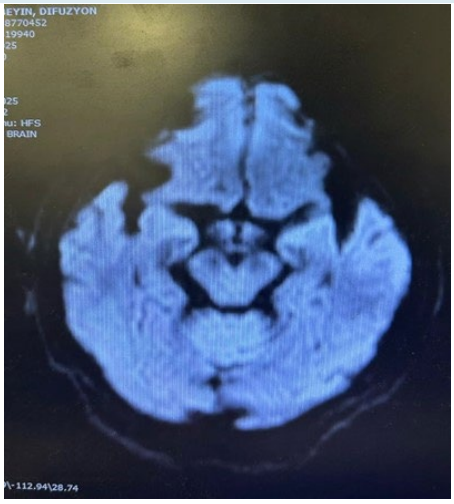
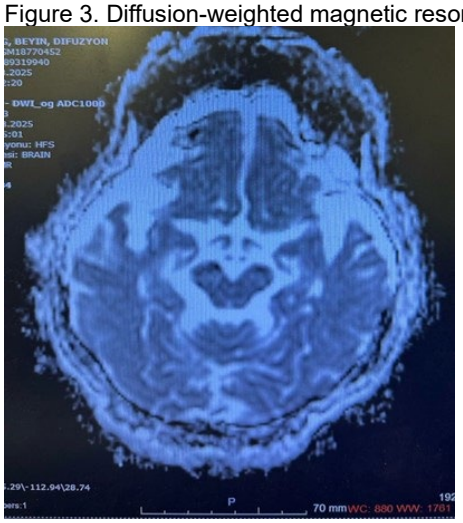


Figure 3. Diffusion-weighted magnetic resonance imaging of the patient



Results and Conclusion: This case underscores the importance of considering pontine infarction in elderly patients with atrial fibrillation and altered mental status, particularly when complicated by bradycardia and possible digoxin toxicity. The presence of acute diffusion restriction on MRI confirmed the diagnosis. Multidisciplinary management, including anticoagulation and intensive monitoring, is essential in improving outcomes in such high-risk patients.

Keywords: pontine infarction, digoxin toxicity, atrial fibrillation with a slow ventricular response

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Ref No: 4678

Look At The Spine

AHMET HASAN TAŞCİ[1], ERDAL TEKİN[1]

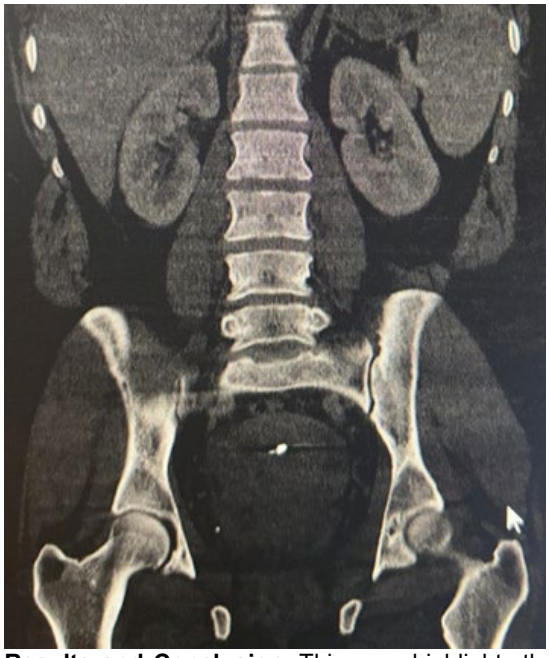
[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP ANABİLİM DALI

Introduction and Purpose: Falls from height are a common cause of trauma-related emergency department visits and can lead to severe musculoskeletal and spinal injuries. The impact force upon landing, particularly on the lower extremities and spine, often results in complex fractures. One such injury pattern, known as the "Don Juan" fracture, typically involves calcaneal fractures along with associated vertebral or lower limb fractures. This case report presents the diagnostic and management process of a 38-year-old female patient who sustained multiple fractures following a fall from a height of 2 meters.

Materials and Methods: A 38-year-old female patient was brought to the emergency department via emergency medical services (EMS) after falling from a height of 2 meters. She had no known comorbidities. Upon arrival, her general condition was moderate, and her vital signs were stable. Physical examination revealed tenderness on palpation at the heel level of the right plantar foot and lateral malleolus. Additionally, tenderness was present over the lumbar vertebrae. No motor or sensory deficits were noted. Imaging studies demonstrated a distal right fibula fracture, a comminuted right calcaneus fracture (IMAGE-1), and an L4-L5 compression fracture(IMAGE-2). The patient was diagnosed with a "Don Juan" fracture and was consulted with neurosurgery and orthopedics. As there was no indication for emergency neurosurgical intervention, the patient was scheduled for orthopedic surgery.

IMAGE-1

IMAGE-2



Results and Conclusion: This case highlights the importance of a thorough clinical and radiological evaluation in patients presenting after falls from height. The presence of a calcaneal fracture should raise suspicion for concomitant spinal injuries, necessitating careful neurological assessment and imaging. In this patient, distal fibular, comminuted calcaneal, and L4-L5 compression fractures were identified, consistent with a "Don Juan" fracture pattern. The patient was managed through a multidisciplinary approach involving neurosurgery and orthopedics, with surgical intervention performed for orthopedic stabilization. This case underscores the need for prompt recognition and appropriate management of high-impact trauma to optimize patient outcomes and prevent long-term complications.

Keywords: DON JUAN, LOVER FRACTURE, ANKLE AND SPİNE FRACTURE

Ref No: 4757

Predictive Value of Circulating Dipeptidyl Peptidase-3 (DPP3) for Mortality in Patients with Sepsis

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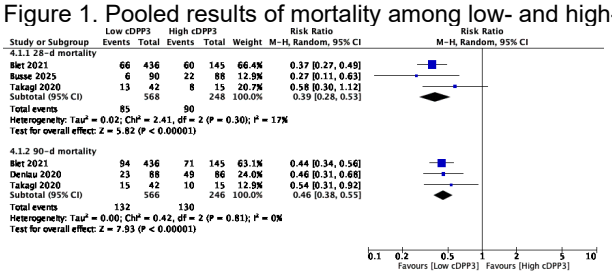
[2]LUXMED Group, Warsaw, Poland

Introduction and Purpose: Sepsis remains a major cause of morbidity and mortality worldwide, challenging the management of critically ill patients. Dipeptidyl peptidase-3 (DPP3), a cytoplasmic enzyme released after cellular injury, degrades cardiovascular mediators and endorphins, influencing hemodynamic stability. Elevated circulating DPP3 (cDPP3) levels in sepsis are associated with organ dysfunction, particularly cardiac and renal impairment. This meta-analysis aims to evaluate the predictive value of circulating dipeptidyl peptidase-3 (cDPP3) levels for mortality in patients with sepsis. By assessing the association between cDPP3 levels and short- and medium-term mortality outcomes, this study seeks to determine the potential role of cDPP3 as a prognostic biomarker to improve risk stratification and clinical decision-making in this high-risk patient population.

Materials and Methods: This meta-analysis was conducted in accordance with PRISMA guidelines. A comprehensive search of PubMed, Embase, and Web of Science was performed to identify studies evaluating the predictive value of circulating DPP3 in relation to mortality in patients with sepsis. Pooled risk ratios (RR) with corresponding 95% confidence intervals (CI) were calculated using a random-effects model to assess the prognostic significance of DPP3.

Results and Conclusion: The meta-analysis, which included four studies meeting the inclusion criteria, demonstrates a significant association between cDPP3 levels and mortality outcomes. Patients with low cDPP3 levels experienced markedly lower 28-day and 90-day mortality rates compared to those with high cDPP3 levels. Specifically, the 28-day mortality rate was significantly reduced in the low cDPP3 group (14.9%) compared to the high cDPP3 group (36.3%), with a relative risk reduction of 61% (RR = 0.39; 95% CI: 0.28–0.53; $p < 0.001$; Figure 1).Similarly, the 90-day mortality rate was substantially lower among patients with low cDPP3 levels (23.3%) compared to those with high cDPP3 levels (52.8%), corresponding to a 54% relative risk reduction (RR = 0.46; 95% CI: 0.38–0.55; $p < 0.001$).These findings suggest that cDPP3 may serve as a valuable prognostic biomarker for short- and medium-term mortality outcomes. The strong association observed highlights the potential utility of cDPP3 in risk stratification and clinical decision-making. Further research is warranted to confirm these results and explore the underlying mechanisms driving the observed relationship.

Figure 1. Pooled results of mortality among low- and high- cDPP3 groups.



Keywords: Circulating dipeptidyl peptidase 3, cDPP3, biomarker

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Ref No: 4781

ASSESSMENT OF THE IMMEDIATE AND LONG-TERM CONSEQUENCES OF CORONAVIRUS INFECTION IN THE PATIENTS WHO HAVE UNDERWENT MYOCARDIAL REVASCULARIZATION, BASED ON THE SPECIAL REGISTER.

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[1]Semey Medical University, Kazakhstan

Introduction and Purpose: Introduction. Coronavirus infection (CVI) is not only a disease of the respiratory system, but also has a systemic effect at the level of the human body as a whole. This disease has a proven association with increased rates of restenosis or rethrombosis of the coronary vessels in individuals suffering from coronary artery disease (CAD). For the most accurate assessment and interpretation of such a relationship, a tool is required in the form of creating a specialized registry that allows the use of patient information for statistical analysis.Aim of the study. Assessment of the immediate and long-term consequences of coronavirus infection in patients with coronary artery disease who have undergone myocardial revascularization, based on the creation of a special register.

Materials and Methods: Materials and methods. The registry database included all patients who underwent repeat myocardial revascularization between March 2020 and May 2023 after suffering from CVI. A total of 504 patients were included in the database, of which 86 showed in-stent thrombosis or restenosis of the coronary artery stent due to previous CVI (main study group), 82 patients with restenosis and stent thrombosis who did not survive coronavirus infection, 164 patients with repeated myocardial revascularization after undergoing CVI and 172 patients with repeated revascularization who did not undergo CVI. This research was funded by the Science Committee of the Ministry of Education and Science of the Republic of Kazakhstan (Grant no. AP19677465).

Results and Conclusion: Results.The main register tabs are:⎪socio-demographic data,⎪main diagnosis and concomitant diseases,⎪information on myocardial revascularization,⎪laboratory data indicating a history of CVI,⎪clinical data, data from instrumental examination of patients,⎪laboratory diagnostic data.Conclusion. Organization of monitoring of the health status of patients with repeated myocardial revascularization is carried out based on the analysis of epidemiological and clinical data, taking into account the dynamics of indicators. The main tool for such monitoring is a specially created register, which includes all the information that interests us.

Keywords: restenosis, coronavirus infection, register

Ref No: 4904

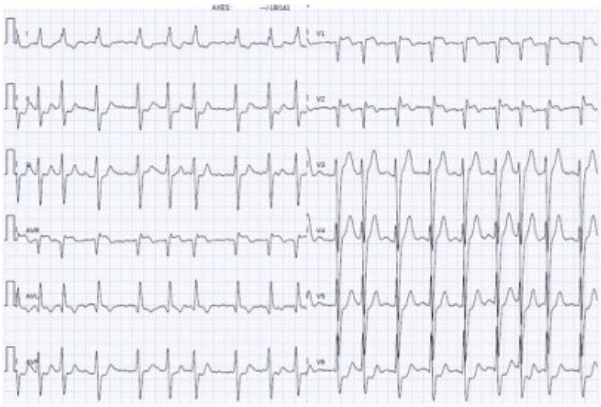
ACUTE MESENTERİC ISCHEMIA MIMICKING ACUTE CORONARY SYNDROME

Kerem Sami KEYF[1], Hüseyin Celal BİLEN[1]
[1]Aksaray Eğitim ve Araştırma Hastanesi

Introduction and Purpose: Acute mesenteric ischemia refers to the sudden onset of small intestinal hypoperfusion, which may be due to decreased or interrupted arterial flow. Ischemia due to acute mesenteric artery occlusion may result from embolic obstruction of the intestinal blood supply, most commonly to the superior mesenteric artery.

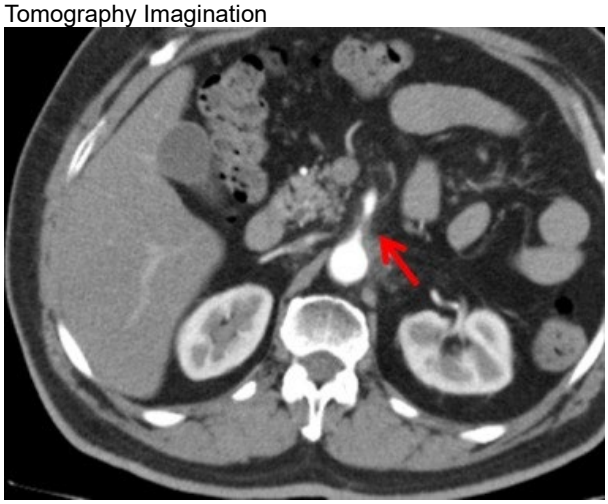
Materials and Methods: A 69-year-old male patient came to the emergency department with pressure-like chest pain that started 30 minutes ago. On his arrival, his GKS was 15, his general condition was moderate-good, and his vital signs were within normal limits. The patient with a history of coronary stent due to coronary artery disease had vena saphenous magna insufficiency and polycythemia vera, and he used beta blockers, diuretics, and aspirin as drugs. On physical examination, the patient's peripheral pulses were open, extremities were sweaty and cold. Abdominal comfortable, defense - rebound - and other system examinations were normal. In the ECG imaging taken from the patient, there were ST elevations in the V1-AVR leads and ST depressions in the D2-D3-AVF segments. Troponin: 6.8 and CK-MB: 43 in blood tests; other blood tests of the patient were normal. The patient was monitored with a defibrilator, 300 mg of ASA was chewed, 600 mg of Clopidogrel was given orally, 0.6 units of Enoxaparin was administered subcutaneously. The cardiologist was consulted and transferred to the Coronary Angiography unit. No finding that would cause ST elevation was detected in the coronary angiography of the patient. The patient was taken for further examination. In the contrast-enhanced abdominal CT, the SMA was observed in an occluded view from the exit. The patient was transferred to the General Surgery department for further assessment and treatment.

EKG



ST elevations in the V1-AVR leads and ST depressions in the D2-D3-AVF segments

Tomography Imagination

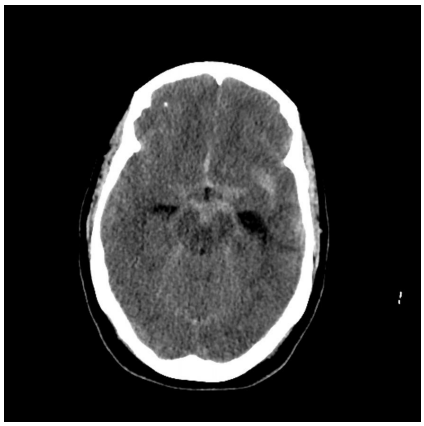


SMA was observed in an occluded view from the exit

Results and Conclusion: As seen in this case, Acute Mesenteric Ischemia does not always present with specific symptoms and findings. It should be kept in mind as a differential diagnosis, especially in patients who are over 65 years old, have comorbid diseases, use multiple drugs, are not mobile enough due to old age, and do not use anticoagulants or antiaggregants despite having risk factors, even if they present with nonspecific symptoms and there are not enough findings in our hands.

Keywords: Mesenteric Ischemia, Chest pain, ST Elevation

Ref No: 4938
Subarachnoid Hemorrhage
YUNUS EMRE EK[1], SULTAN TUNA AKGÖL GÜR[1]
[1]ATATÜRK ÜNİVERSİTESİ ACİL TIP
Introduction and Purpose: Subarachnoid hemorrhage (SAH) is a condition in which blood passes into the cerebrospinal fluid (CSF). It often occurs after aneurysm rupture (85%) and SAH should be managed quickly and accurately. Headache is the most common reason for presentation to the emergency department in SAH.
Materials and Methods: A 60-year-old woman presented to us with syncope following a headache. She had no known disease and her vital signs were unremarkable except for hypertension. Systemic examination revealed no pathology. Central imaging showed diffuse subarachnoid hemorrhage and the patient was consulted to the relevant clinic. The patient's treatment was organized by the relevant clinic.
SAH



Results and Conclusion: Subarachnoid hemorrhage should not be forgotten in patients presenting with severe headache.
Keywords: aneurysm rupture

Ref No: 5040
Acute Abdomen
Yunus Emre Ek[1], Sultan Tuna Akgöl Gür[1]
[1]Atatürk Üniversitesi Acil Tıp
Introduction and Purpose: ACUTE ABDOMEN CAUSES INCLUDE ACUTE APPENDICITIS, ACUTE PANCREATITIS, ACUTE PANCREATITIS, ACUTE CHOLECYSTITIS, ILEUS, PERIENTERITIS, INTRA-ABDOMINAL PERFORATION, ETC., WHICH ARE COMMON CAUSES IN THE EMERGENCY DEPARTMENT.
Materials and Methods: A 39-YEAR-OLD FEMALE PATIENT WAS ADMITTED TO US WITH THE COMPLAINT OF ABDOMINAL PAIN FOR 1 WEEK. THE PATIENT HAD A KNOWN DIAGNOSIS OF CECAL CA CA. THE PATIENT HAD A DEFICIENCY IN THE RIGHT LOWER QUADRANT OF THE ABDOMEN IN THE EXAMINATION OF THE PATIENT WITH STABLE INCOMING VITALS. THE PATIENT WHO HAD INTRA-CELL PERFORATION ON IMAGING WAS CONSULTED TO THE GENERAL SURGERY CLINIC. HER TREATMENT WAS ORGANIZED BY THE RELEVANT CLINIC.
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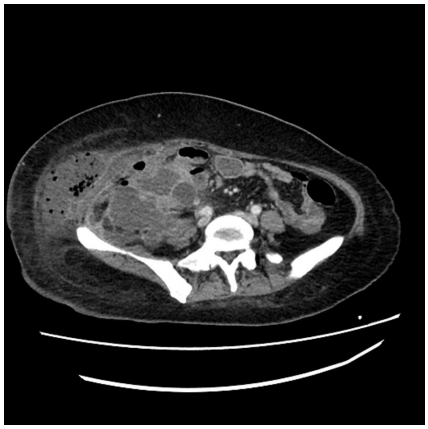


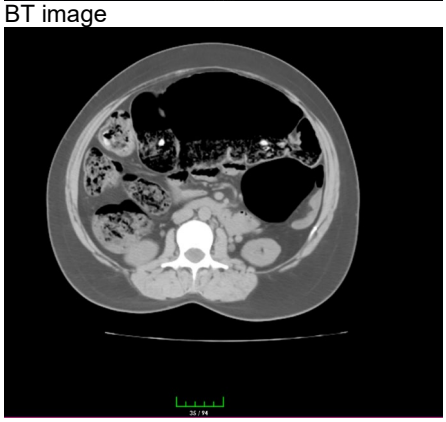
Results and Conclusion: INTRA-ABDOMINAL PERFORATION SHOULD BE KEPT IN MIND IN PATIENTS WHO PRESENT TO THE EMERGENCY DEPARTMENT WITH ABDOMINAL PAIN, HAVE AN ACUTE ABDOMEN ON EXAMINATION, AND HAVE AN INTRA-ABDOMINAL MASS.
Keywords: ACUTE ABDOMEN, ABDOMINAL PAIN

Ref No: 5122
Trimalleolar Fractur
MUHAMMED CENGİZHAN DURMUŞ[1], FATMA TORTUM[1]
[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP
Introduction and Purpose: Mechanical falls can lead to common injuries, particularly in younger individuals. Foot and ankle traumas often occur as a result of sports activities or daily accidents. This case report discusses a 36-year-old woman with no known comorbidities who developed a trimalleolar fracture following a fall. Early diagnosis and appropriate treatment of such injuries are crucial in preventing complications.
Materials and Methods: A 36-year-old female patient with no known medical history presented to the emergency department (ED) with foot and ankle pain after a fall from the same level. Upon admission, her general condition was moderate, with a Glasgow Coma Scale (GCS) score of 15. Vital signs were stable. Physical examination revealed significant swelling and tenderness over both the lateral and medial malleolus of the left ankle. The dorsalis pedis and posterior tibial pulses were palpable, and capillary refill was normal. Neurological examination was within normal limits, though slightly suboptimal. Imaging studies confirmed a trimalleolar fracture of the left ankle(image 1). Following these findings, the patient was referred to orthopedics for consultation, and a decision was made to proceed with surgical intervention.
image 1

Results and Conclusion: Trimalleolar fractures are complex bony injuries that often require surgical intervention. In this case, a timely diagnosis was made based on imaging, and a surgical operation was scheduled following consultation with orthopedic specialists. Early intervention and appropriate management are essential to accelerate recovery and prevent long-term functional impairment. A multidisciplinary approach is key in managing such injuries, ensuring optimal outcomes for patients.
Keywords: fractur, unkle

Ref No: 5169
SEEDS CAN CAUSE ILEUS
Berk ORAL[1], Ayça ÇALBAY[1]
[1]Atatürk University
Introduction and Purpose: Ileus is defined as the inability to pass gut contents, whereas intestinal obstruction refers to the partial or complete blockage of the passage of intestinal contents. The primary focus in ileus is to diagnose strangulation, which requires emergency surgery. Sometimes, this obstruction occurs due to improper nutrition.
Materials and Methods: A 50-year-old female patient presented with complaints of abdominal pain, bloating, and constipation for the past week. Her vital signs were in normal range. On systemic examination, pathologic findings as following: bowel sounds were decreased, and there was generalized abdominal distension. X-ray images suggested ileus, so the patient was referred for a detailed evaluation with a CT scan. The CT scan revealed oval-shaped foreign bodies within the intestinal lumen, causing an increase in bowel diameter and contents. The patient admitted to swallowing seeds, believing it would help her stomach. She was consulted to the general surgery department and admitted for further management.
Results and Conclusion: In patients without a history of surgery and with no abnormalities in laboratory tests that would suggest paralytic ileus, the ingestion of solid objects that can cause ileus should be considered. This should be carefully investigated during the patient's history.
BT image

BT image



Keywords: Ileus, seeds

Ref No: 5185

A guiding algorithm for children with minor head trauma: PECARN

Neslihan Saglam[1], Mert Ozen[1], Alten Oskay[1], Murat Seyit[1], Atakan Yilmaz[1], Ibrahim Turkcuer[1]

[1]Pamukkale University

Introduction and Purpose: Head trauma is a common reason for pediatric presentations to the emergency department (ED). In children under two years of age, clinical evaluation can be challenging due to the presence of open fontanelles and unfused cranial sutures, which may delay the detection of trauma-related neurological findings. This case presentation aims to highlight the importance of the PECARN rules in evaluating children with minor head trauma and a Glasgow Coma Scale (GCS) score of 14–15.

Materials and Methods: A 14-day-old male infant was brought to the ED approximately 30 minutes after falling from his mother's lap, a height of about one meter. On admission, his vital signs were within normal limits for his age. Physical examination revealed a 2 cm hematoma over the left parietal region. Neurological examination was normal; the modified pediatric GCS score was 15, and all four extremities were spontaneously active. According to PECARN criteria for children under two years of age, transfontanel ultrasonography was unremarkable. Due to the presence of a scalp hematoma in parietal region, a cranial computed tomography (CT) scan was performed. Imaging (Figures 1-2) revealed a minimally displaced fracture line in the left parietal bone extending toward the left coronal suture, along with an adjacent cephal hematoma approximately 6.5 mm in thickness. The patient was admitted to the neonatal intensive care unit for observation and discharged after 24 hours.

Figure 1. Head CT image of the patient

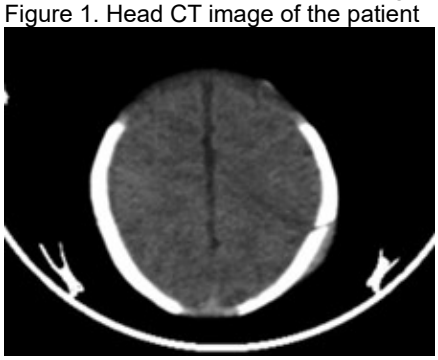
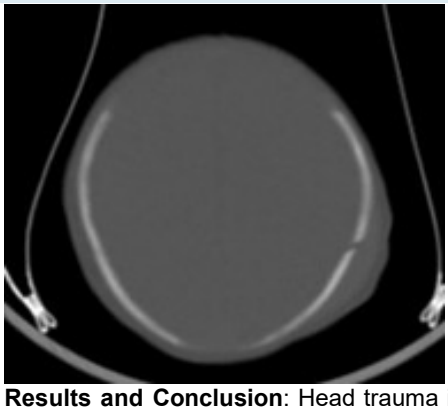


Figure 2. Head CT image of the patient



Results and Conclusion: Head trauma is a significant cause of morbidity and mortality in children, with the highest incidence seen in the 0–4 age group. According to the PECARN algorithm, children under two years of age presenting within 24 hours of a blunt head injury, with a GCS of 14–15 and additional concerning findings should be considered for CT imaging. The decision should be based on a combination of clinical judgment, the presence of single or multiple physical findings, symptom progression, age under 3 months, and parental preference. Children who meet PECARN low-risk criteria are considered to be at a very low risk for clinically important traumatic brain injuries that would require intervention. The PECARN algorithm thus provides a structured, evidence-based approach to minimize unnecessary radiation exposure while ensuring patient safety.

Keywords: head trauma, PECARN, CT scan

Ref No: 5245

Vascular Access in OHCA: Is IO Access a Viable Alternative to IV?

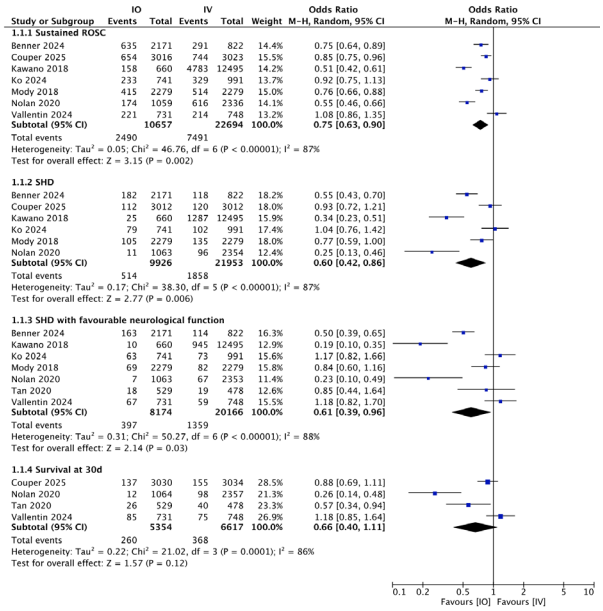
Miroslaw Dabkowski[1], Karol Bielski[2], Michal Pruc[3], Karol Momot[4], Lukasz Szarpak[3]
[1]Polish Society of Disaster Medicine, Warsaw, Poland
[2]Voivodeship Emergency Medical Service, Warsaw, Poland
[3]LUXMED Group, Warsaw, Poland
[4]Medical University of Warsaw, Warsaw, Poland

Introduction and Purpose: Out-of-hospital cardiac arrest (OHCA) remains a major global concern with low survival rates despite resuscitation advances. Effective vascular access is crucial for administering life-saving medications like epinephrine during CPR. Peripheral intravenous (IV) access is the gold standard due to its proven efficacy but can be challenging in patients with poor venous access. Intraosseous (IO) access has emerged as a reliable alternative, offering faster placement in emergencies when IV attempts fail. While IV remains preferred, IO is vital in critical situations where rapid drug delivery is essential.

Materials and Methods: A systematic review and meta-analysis were conducted to compare IO and IV vascular access in OHCA resuscitation. A comprehensive search of PubMed, Embase, Web of Science, and Cochrane Library was performed for randomized controlled trials (RCTs) and observational studies published up to March 2025. Primary outcomes included return of spontaneous circulation (ROSC), survival to hospital admission, and survival to discharge. Data extraction and quality assessment were conducted independently by two reviewers. Pooled odds ratios (OR) with 95% confidence intervals (CI) were calculated using a random-effects model. Heterogeneity was assessed via the I^2 statistic, with values >50% considered significant.

Results and Conclusion: Sustained ROSC was significantly lower in the IO group (23.4%) than in the IV group (33.0%; OR: 0.75; 95%CI: 0.63–0.90; p=0.002; Fig. 1). Survival to hospital discharge (SHD) was also reduced with IO (5.2% vs. 8.5%; OR: 0.60; 95%CI: 0.42–0.86; p=0.006), as was SHD with favorable neurological outcomes (4.9% vs. 6.7%; OR: 0.61; 95%CI: 0.39–0.96; p=0.03). Survival at 30 days showed no significant difference (4.9% vs. 5.6%; OR: 0.66; 95%CI: 0.40–1.11; p=0.12). These results suggest IO access may be less effective than IV in improving key resuscitation outcomes.Our meta-analysis and reviewed studies indicate that intraosseous (IO) access is associated with poorer outcomes compared to intravenous (IV) access in out-of-hospital cardiac arrest (OHCA). IO access was linked to lower rates of sustained ROSC, survival to hospital discharge, and favorable neurological outcomes. However, these findings should be interpreted with caution as IO is typically used when IV access fails or is unfeasible, often in critically ill patients with poorer baseline conditions.

Fig. 1. Forest plot of resuscitation outcomes among IO and IV groups.



Keywords: Cardiopulmonary resuscitation, Intravenous Vascular Access, Intraosseous Vascular Access

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Ref No: 5253

Trauma-Related Hematoma Around a Cardiac Pacemaker: A Case Report

Ahmet Dursun DEMİR[1], Hızır Ufuk AKDEMİR[1]

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Introduction and Purpose: Cardiac pacemaker implantation is a widely accepted therapeutic intervention for symptomatic bradycardia, atrioventricular block, and certain cardiac arrhythmias. Although generally safe, it is an invasive procedure and may be associated with various complications, including infection, device dysfunction, lead fracture, perforation, and hematoma formation. Hematoma is typically seen in the context of anticoagulation, antiplatelet therapy, or surgical manipulation, but may also occur following trauma, particularly in the pacemaker pocket region. While trauma-induced hematomas are rarely reported in the literature, they can result in pain, swelling, risk of infection, and, in some cases, impaired device function.

Materials and Methods: We present the case of a 79-year-old male with a history of hypertension, congestive heart failure (CHF), Alzheimer's disease, and atrial fibrillation (AF), for which he had a VVI-ICD pacemaker. The patient presented to the emergency department with swelling over the pacemaker site. According to his caregiver, the swelling appeared after changing clothes the previous night, accompanied by localized bruising. He was hemodynamically stable on admission. Physical examination revealed extensive ecchymosis and a palpable mass over the left pectoral and upper arm region. Peripheral pulses were intact, with no signs of distal ischemia.ECG revealed AF with a heart rate of 85 bpm, and echocardiography showed a reduced ejection fraction (30%) with global left ventricular hypokinesia. Serial hemoglobin levels showed a mild downward trend (15.1 → 14.3 → 13.9 g/dL). Contrast-enhanced thoracic CT demonstrated a 90×60 mm hematoma located beneath the pectoralis major muscle, adjacent to the pacemaker device, with surrounding soft tissue edema and linear hyperdensities between muscle planes, consistent with post-traumatic bleeding. No signs of vascular injury or active bleeding were detected.The patient was evaluated by cardiology, cardiovascular surgery, and thoracic surgery. Given his clinical stability and absence of device malfunction, conservative management and close monitoring in the cardiology department were recommended.

Results and Conclusion: This case highlights the importance of recognizing trauma-induced hematomas in elderly patients with cardiac devices. Fragile vascular structures, comorbid conditions, and potential anticoagulation use increase the risk. Early identification, imaging, and multidisciplinary collaboration are essential to minimize complications and ensure optimal patient outcomes.

Keywords: Cardiac Pacemaker, Trauma, Hematoma

Ref No: 5302

Guillain-Barré Syndrome: A Case Report

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Introduction and Purpose: Guillain-Barré Syndrome (GBS) is a rare but potentially life-threatening acute inflammatory polyneuropathy of the peripheral nervous system. It is typically triggered by an autoimmune response following infections such as Campylobacter jejuni, cytomegalovirus, or Epstein-Barr virus. Clinically, GBS presents with rapidly progressive symmetrical weakness, areflexia, and sensory disturbances. The underlying pathophysiology involves immune-mediated demyelination or axonal damage, impairing nerve conduction. GBS subtypes include acute inflammatory demyelinating polyneuropathy (AIDP), which is most common in Western countries, and axonal forms like AMAN and AMSAN, more frequently seen in Asia and South America.

Materials and Methods: We present the case of a 54-year-old male with a known history of coronary artery disease, who was admitted to the emergency department with a five-day history of numbness and tingling in the feet, which progressed to the hands and face. The

patient reported a recent upper respiratory infection 15 days prior. Neurological examination revealed glove-and-stocking hypoesthesia without motor deficits. Laboratory tests and neuroimaging were unremarkable. Electromyography (EMG) demonstrated findings consistent with sensorimotor demyelinating polyneuropathy. Based on clinical and EMG findings, the patient was diagnosed with GBS and admitted to the neurology department. Intravenous immunoglobulin (IVIG) therapy was initiated, resulting in significant clinical improvement.

Results and Conclusion: This case illustrates the classical features and diagnostic approach to GBS. Diagnosis is based on clinical presentation, cerebrospinal fluid (CSF) analysis showing albuminocytologic dissociation, and supportive electrophysiological studies. Early initiation of immunomodulatory therapy—IVIG or plasmapheresis—is critical in halting disease progression and enhancing recovery. Supportive care and rehabilitation are essential, especially in cases involving respiratory muscle weakness. Our case emphasizes the importance of early diagnosis and multidisciplinary management in GBS. Prompt treatment can significantly improve outcomes, although some patients may experience long-term neurological deficits. Continued research is necessary to better understand the variable clinical presentations and prognoses associated with this condition.

Keywords: Guillain-Barré Syndrome, Acute Inflammatory Polyneuropathy, Intravenous Immunoglobulin

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Ref No: 5318

Worst Side Of The Diabetes

MUHAMMED CENGİZHAN DURMUŞ[1], FATMA TORTUM[1]
[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP

Introduction and Purpose: Elderly patients presenting to the emergency department (ED) with deteriorated general condition often have underlying chronic diseases and undiagnosed or untreated infectious foci, both of which significantly increase mortality risk. This case report discusses a 68-year-old male patient with a history of diabetes mellitus and hypertension, who developed necrotizing soft tissue infection (NSTI) complicated by sepsis.

Materials and Methods: A 68-year-old male patient with known hypertension and diabetes mellitus presented to the ED with a severely deteriorated general condition. Upon arrival, he was somnolent with a Glasgow Coma Scale (GCS) score of 11. His vital signs indicated tachycardia and hypotension. Physical examination revealed an 8 × 15 cm chronic diabetic ulcer with purulent discharge and a foul anaerobic odor on the plantar surface of his right foot. Crepitus was noted on palpation of the right foot and cruris. Imaging studies demonstrated extensive subcutaneous and muscular gas densities in the foot and lower leg.(image 1) Laboratory results showed a severe metabolic acidosis with a pH of 7.018 and a lactate level of 17 mmol/L. Hematologic findings included leukocytosis (18,500/μL) and an elevated C-reactive protein (CRP) level of 373 mg/L. Gram-negative and Gram-positive bacilli were identified in microscopic examination of wound cultures. Based on clinical and laboratory findings, the patient was diagnosed with gas gangrene and sepsis. Orthopedics and internal medicine specialists were consulted. Despite the recommendation for urgent amputation, the patient refused the procedure and was admitted to the internal medicine intensive care unit for further management.

image 1

Results and Conclusion: Diabetic patients, particularly those with chronic wounds, are at high risk for rapidly progressing necrotizing infections leading to sepsis. Early diagnosis and aggressive medical and surgical interventions are critical for survival. In this case, the patient declined amputation, necessitating intensive medical management. Effective patient and family education regarding prognosis and treatment options is crucial to optimizing outcomes in such high-risk cases.

Keywords: gangren, sepsis

Ref No: 5334

Carbon monoxide (CO) poisoning

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Introduction and Purpose: Carbon monoxide (CO) is the most toxic component in smoke inhalation. It is a colorless, odorless, tasteless and non-irritating gas. It occurs as a result of poor combustion of carbon-based fuels. CO toxicity is a condition characterized by tissue hypoxia due to the decrease in oxygen transport and usage. Patients in a coma should be intubated and respiratory support should be provided.

Materials and Methods: A 56-year-old male patient with known epilepsy was brought by ambulance after a fire and smoke exposure at home. When the patient came to the emergency room, his general condition was poor, Gks: 7 (E1M4V2), light reflexes were bilaterally normal. Respiratory sounds were decreased upon auscultation, BP: 140/81 mmHg, Pulse: 140/min, Temperature: 36.6 SS: 27/min, saturation: 85% under oxygen support and the patient was intubated using accessory respiratory muscles. Extensive smoke exposure was observed on the patient's entire body and nasal and oral mucosa. A 2*2 cm 2-degree burn was observed on the dorsal of the 1st and 2nd fingers of the right hand. In the examinations of the patient, ECG: Sinus tachycardia (140/min). Blood sugar: 220 mg/dl, pH: 7.18- pCO2: 30.6- HCO3: 12.9- Carboxyhemoglobin: 44.1- Troponin: 113-75 (0.-1. Hour) and other laboratory findings of the patient were within normal range. No acute pathology was detected in the patient's central imaging. In thoracic imaging: Scattered millimetric ground glass nodules, centrilobular nodules were observed in bilateral lungs (infective processes?). Postrobazellary more pronounced endobronchial filling defects, focal ground glass areas, consolidation-atelectasis, peribronchial thickness increases were observed in bilateral lower lung lobes (aspiration pneumonia?) and appearances compatible with these were observed. Tetanus prophylaxis was applied. Burn dressing was applied. The patient, who required hyperbaric oxygen and intensive care, was referred to the relevant unit after receiving initial interventions.

Results and Conclusion: Respiratory support and oxygen therapy should be provided to patients who are suspected of having carbon monoxide poisoning due to smoke exposure. It should be clarified whether the patient's clinical condition is only CO poisoning and the health conditions that may occur before and after. Normobaric-hyperbaric oxygen and additional medical treatment requirements should be determined and applied according to the patient's clinical condition.

Keywords: Smoke exposure, Carbon monoxide poisoning, Hyperbaric oxygen

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Ref No: 5338

Traumatıc Aortıc Rupture

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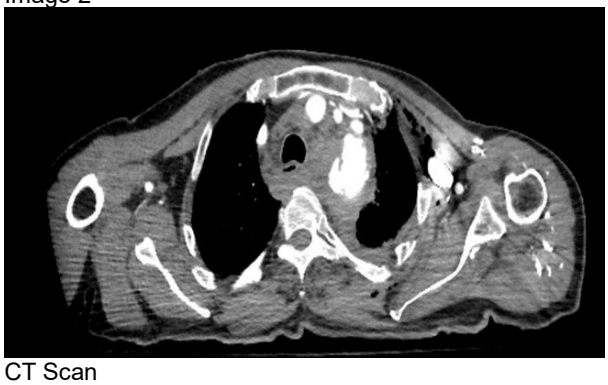
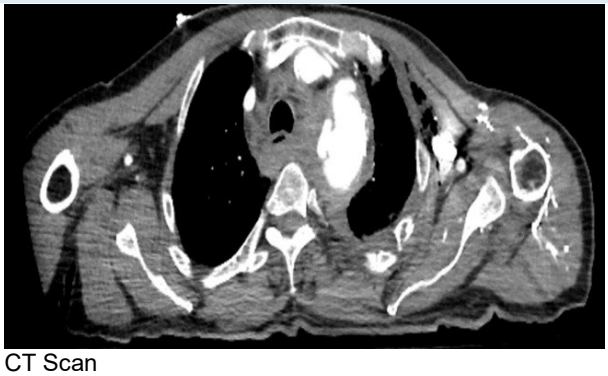
Introduction and Purpose: Blunt aortic injury is the second most common cause of mortality after intracranial hemorrhage among all blunt trauma injuries. Approximately 80% of patients with blunt aortic injury die at the scene. Even in patients who make it to the hospital, mortality is around 46%.

Materials and Methods: An 82-year-old male patient was brought to our hospital after being hit by a vehicle while on foot. According to the information received from the 112 team, the patient had no change in consciousness and his vitals were stable during transportation. On admission to the emergency room, the patient's blood pressure was 110/80 mmHg, saturation was 93% and pulse rate was 75/min. On physical examination, the patient was conscious, oriented, occasionally confused, respiratory sounds were decreased on the left side, there was tenderness in the pelvis, there was an open wound and deformity in the left leg. Blood tests and trauma tomography were ordered. Blood tests showed a hemoglobin value of 8.5 g/dL, lactate 6.46 mmol/L and pH 7.177 in blood gas. After imaging transport, hypotension was noticed and intravenous fluid resuscitation was started. Within a few minutes of follow-up, the patient's consciousness deteriorated and cardiac arrest occurred. CPR was started and the patient was intubated. A central catheter was inserted and 1 unit of erythrocyte suspension was given to the patient with low hemogram. A chest tube was inserted to the patient with hemothorax and pneumothorax. A long leg splint was applied to the patient with open fracture of tibia and fibula. Thoracic tomography showed a high suspicion of aortic rupture distal to the aortic arch and the patient was considered as exitus after no response to CPR for 50 minutes.

İmage 2



CT Scan
İmage 1



CT Scan

Results and Conclusion: In patients presenting with blunt thoracic trauma, blunt aortic injury, a condition with high mortality, should be kept in mind.

Keywords: Aortic Rupture, Blunt Thoracic İnjury

Ref No: 5343.

Subdural Hematoma

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[1]Atatürk Üniversitesi

Introduction and Purpose: Subdural hematoma (SDH) is a type of intracranial hemorrhage characterized by bleeding in the space between the dura mater and the arachnoid membranes surrounding the brain. It can be caused by trauma or occur spontaneously. Hematomas are classified as acute, subacute, or chronic based on the time of onset. Acute is up to 3 days, subacute is between 4 and 20 days, and chronic is 21 days or more. In this study, we aim to present a 72-year-old female patient with chronic subdural hematoma in the falx cerebri, who presented with intermittent weakness in her right leg.

Materials and Methods: A 72-year-old female patient presented to the Emergency Department 15 days after hitting her head against a car window, experiencing intermittent weakness in her right leg. On admission, her general condition was moderate, with a Glasgow Coma Scale (GCS) of 15, heart rate of 86 beats per minute, blood pressure of 142/89 mmHg, and oxygen saturation of 91%. She had a known diagnosis of hypertension. Neurological examination revealed no motor deficits. No findings were noted on the systemic examination. A peripheral intravenous line was established, and blood tests were requested. A non-contrast brain CT scan was performed. The CT scan revealed a chronic subdural hematoma in the falx cerebri (Figure 1). The patient was consulted to the Neurosurgery Department and was admitted to the ward.

Results and Conclusion: The treatment approach may vary depending on the patient's clinical condition, the radiological findings of the hematoma, the patient's age, and the presence of comorbidities. Clinical follow-up of patients with subdural hematoma has shown that in 60% of cases, the hematoma resolves spontaneously. This is thought to be due to the compression effect of intracranial pressure preventing the hematoma from enlarging, as well as the cerebrospinal fluid (CSF) washing and draining the hematoma due to a tear in the arachnoid membrane during trauma. In chronic subdural hematomas, surgery is usually the preferred treatment, and it should be remembered that subdural hematomas can also occur in the falx cerebri.

Figure 1

Keywords: Motor Deficit, Subdural Hematoma

Ref No: 5395

Pulmonary Embolism

MUHAMMED CENGİZHAN DURMUŞ[1], FATMA TORTUM[1]

[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP

Introduction and Purpose: Pulmonary thromboembolism (PTE) is a critical clinical condition requiring urgent intervention, posing significant morbidity and mortality risks, particularly in elderly patients. Orthopedic trauma, prolonged immobilization, and comorbidities are major risk factors for PTE. This case report presents an elderly patient with a recent history of femur fracture and underlying diagnoses of diabetes mellitus (DM) and hypertension (HT), who developed PTE.

Materials and Methods: An 87-year-old female patient was admitted to the emergency department with complaints of chest pain and dyspnea. Her medical history revealed a femur fracture two months prior, along with known diagnoses of DM and HT. Following laboratory tests, arterial blood gas analysis, and imaging studies (image 1,image2), the patient was diagnosed with PTE. She was hospitalized and initiated on anticoagulant therapy.

image1

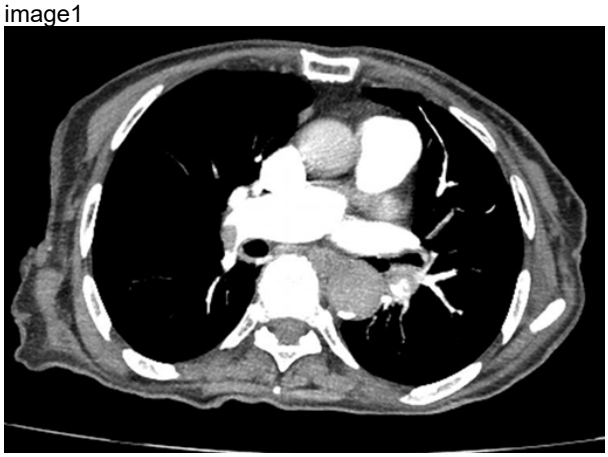
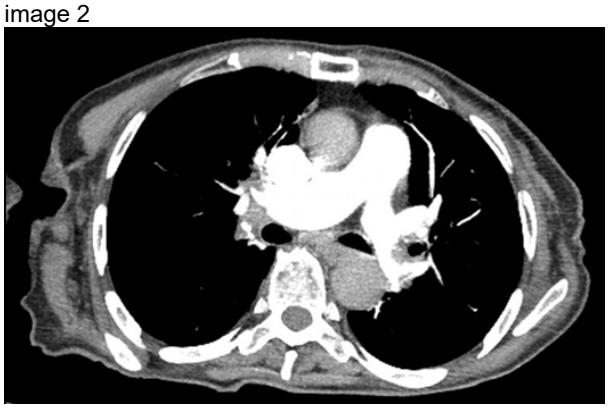


image 2



Results and Conclusion: This case highlights that immobilization and underlying chronic diseases are significant risk factors for PTE in elderly patients. Particularly in patients with a history of orthopedic trauma, clinical suspicion for PTE should remain high, and early diagnosis with appropriate treatment should be prioritized.

Keywords: embolism, pulmonary

Ref No: 5425

TOXIC HEPATITIS

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Introduction and Purpose: Complementary and alternative medicine are various applications that include the use of herbal and nutritional supplements, which have increased in popularity today. It is estimated that there are over 80,000 herbal and nutritional supplements on the market today. It is known that about 1000 of these products lead to toxic hepatitis. So much so that a database has been developed listing these products that cause hepatotoxicity.

Materials and Methods: A 50-year-old male patient is admitted to the ER with complaints of abdominal pain, bloating, chest pain, shortness of breath that persisted for about 24 hours. The patient's vital signs were unremarkable. (Pulse: 82 SPO2: 96 TA:123/91 Fever 36,6) The patient had no known additional illness, no medication that he used regularly. He had a bronchoscopy 3 days ago, PTCA 4 days ago and a history of eating mountain thyme, which he collected from the plateau 1 week ago. During the physical examination, there was tenderness in the upper right quadrant of the abdomen, wheezing was heard. Routine blood tests Hb:13.7 g/dL WBC: 21.73µL PLT: 322µL INR:1.62 aPTT: 29.3sec PT: 20.6sec CRP: 207mg/L AMYLASE:10U/L ALP:142U/L GGT:218U/L AST:941U/L ALT:2180 U/L Total Bilirubin: 13.7g/dL WBC: 21.73µL PLT: 322µL PT:20.6sec CRP:207mg/L ALP:142U/L GGT:218U/L ALT:2180 U/L Total Bilirubin:2180

U/L ALP:142U/L AST:941U/L ALT:2180 U/L Mol: Direct Bilirubin 0.89 mg/dl: 0.18 mg/dl Glucose:410 mg/dl Na:120mmol/L Troponin:18.3 pg/ml. Biliary pathologies were excluded with the diagnostic imaging of the patient. As such, the patient was admitted with a preliminary diagnosis of toxic hepatitis with the Internal medicine clinic consultation.

Results and Conclusion: Patients usually do not accept nutritional supplements and herbal medicines as medicines and do not feel the need to specify them in the medical history. For this reason, it is recommended that the clinician add the use of these products to his questions in line with clinical suspicion when asking the history. Patients should be informed about the side effects and drug interactions that may occur later.

Keywords: alternative medicine, toxic hepatitis

Ref No: 5446

A Disease Difficult to Diagnose in the Emergency Department: Brucellosis

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[1]Department of Emergency Medicine, Faculty of Medicine, Pamukkale University, Denizli, Turkiye

Introduction and Purpose: Brucella, also known as Malta fever or Mediterranean fever, is an infectious disease caused by bacteria. The Brucella species most commonly causing illness in humans include Brucella melitensis, Brucella abortus, Brucella suis, and Brucella canis.

Materials and Methods: A 57-year-old male patient, who is a family physician, reports right upper quadrant abdominal and bilateral flank pain that started last night. He notes that this pain has been intermittent for a long time and is sometimes accompanied by fever. His medical history includes diabetes mellitus, hypothyroidism, lumbar disc herniation, thyroidectomy, and cholecystectomy. Physical examination reveals open pulses in all four extremities, no PTÖ, normal SS, a soft and non-defensive abdomen with no rebound tenderness, and tenderness in the right upper quadrant. Minimal bilateral CVA tenderness (+) is observed, with neurological examination findings normal. Laboratory tests show ALT: 420, AST: 403, and CRP: 80. Abdominal ultrasound and CT are reported as normal. The patient was referred to the rheumatology clinic for further evaluation. The rose Bengal test showed significant elevation, leading to a diagnosis of brucellosis, and doxycycline treatment was initiated. On further investigation, it was discovered that the patient occasionally consumes raw dairy products.

Results and Conclusion: The purpose of presenting this case is to highlight the importance of obtaining a detailed medical history in patients presenting to emergency departments, particularly regarding diseases like brucellosis that can have chronic pathological effects.

Keywords: Brucella, Medical History, Physical Examination

Ref No: 5453

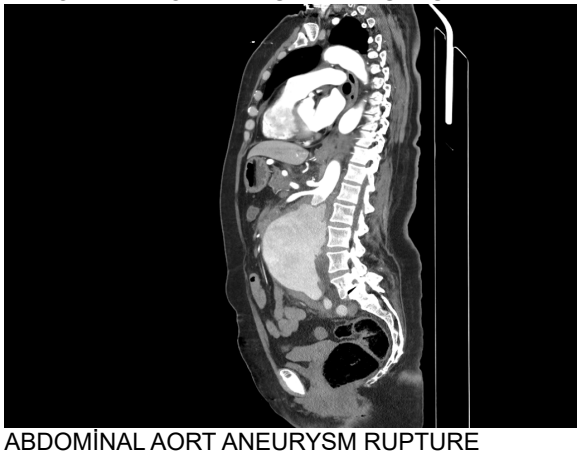
AORTIC ANEURYSM RUPTURE PRESENTING WITH FLANK PAIN

ŞAMİL EMİN YALÇIN[1], Sultan Tuna Akgöl Gür[1], ERDEM ZEKİ KARABULUT[1]
[1]ATATURK UNIVERSITY EMEGENCY DEPARTMENT

Introduction and Purpose: Aortic aneurysm is the formation of a balloon-like sac due to enlargement of the aorta, the main artery that carries blood throughout the body. In case of rupture, it may present with a noisy clinical presentation similar to aortic dissection.

Materials and Methods: A 58-year-old woman with no known medical history. She presented to us with complaints of side pain and inability to breathe due to pain. She said she had severe side pain that started 1 hour ago. Her father had a history of renal and urinary calculi. There is a description of pain in the lower quadrants. Vitals were measured as ta:138/72 sat:96 fever:36 nb: 96 was measured. Examination revealed bilateral costovertebral angle tenderness. There was tenderness and pulsatile palpable mass with superficial palpation at the midline level of the abdomen. Laboratory tests revealed no acute pathology. Rupture of abdominal aortic aneurysm was detected on imaging[1]. She was operated by cardiovascular surgery.

ABDOMİNAL AORT ANEURYSM RUPTURE



ABDOMİNAL AORT ANEURYSM RUPTURE

Results and Conclusion: The patient is being followed up in the intensive care unit after cardiovascular surgery. A detailed physical examination should always be performed. Even if we do not encounter it frequently, as in this patient, conditions that can have fatal consequences even when delayed and that can be diagnosed immediately with simple physical examination should always be kept in mind.

Keywords: ABDOMİNAL AORT, RENAL COLİC, ANEURYSM RUPTURE

Ref No: 5479

EVERY INTERVENTIONAL PROCEDURE CAN LEAD TO COMPLICATIONS

Erhan Şahin[1], Ayça Çalbay[1]

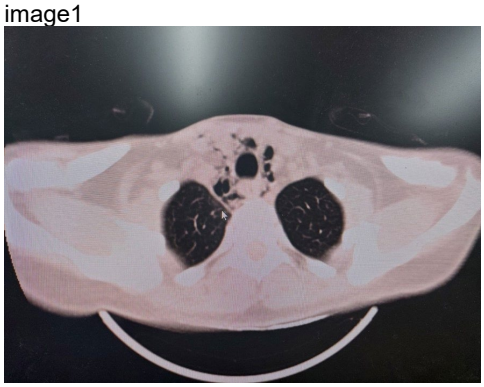
[1]EVERY INTERVENTIONAL PROCEDURE CAN LEAD TO COMPLICATIONS

Introduction and Purpose: Pneumomediastinum, also known as mediastinal emphysema, is defined as the escape of air from the esophagus or airways into the central chest cavity, the mediastinum. The released air may then dissect into neighboring structures such as the cervical subcutaneous tissues, the epidural space, the pericardium, or the peritoneal cavity. Retrosternal chest pain is the most common presenting symptom. Patients may present with dyspnea, dysphagia, a feeling of something stuck in the throat, and hoarseness.

Materials and Methods: A 34-year-old male patient with a known history of hemorrhoids was referred to our facility after developing retrosternal chest pain and dyspnea following the accidental ingestion of 7 Daflon tablets and 3 PPI tablets, which led to an indication for gastric lavage at another center. After the orogastric tube was applied, the symptoms began. Upon examination, his vital signs were within normal limits. No pathology was detected during the systemic examination. Advanced imaging revealed pneumomediastinum, and the patient was transferred to the chest surgery department under oxygen therapy.

Results and Conclusion: Pneumomediastinum can occur spontaneously or secondarily. In our patient, secondary pneumomediastinum developed due to trauma after orogastric lavage. This complication should be considered in patients who have recently undergone such invasive procedures.

image1



Keywords: Pneumomediastinum, Retrosternal chest pain

Ref No: 5491

Subdural Hematoma

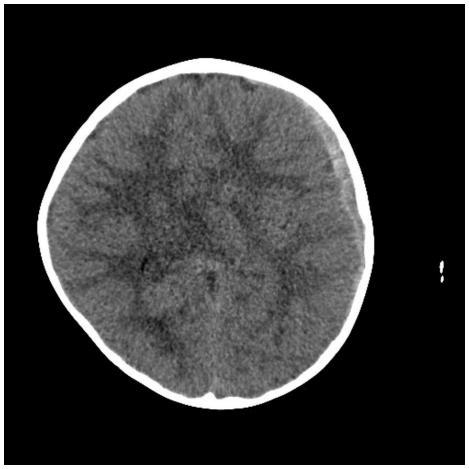
YUNUS EMRE EK[1], SULTAN TUNA AKGÖL GÜR[1]

[1]ATATÜRK ÜNİVERSİTESİ ACİL TIP

Introduction and Purpose: Emergency conditions such as subdural hematoma, epidural hematoma, subarachnoid hemorrhage, intracranial hemorrhage can be detected by non-contrast brain tomography in patients with head trauma.

Materials and Methods: A 2-year-old male patient was admitted to our hospital with head trauma after a mechanical fall at his own level. On presentation, he had vomiting and a tendency to sleep. The imaging revealed subsural hematoma and subarachnoid hemorrhage and the patient was consulted to the relevant clinic. His treatment was organized by the relevant clinic.

subdural



Results and Conclusion: In patients admitted with head trauma, if the GCS score is low, imaging should be performed urgently in terms of intracranial hemorrhage and treatment should be initiated by the relevant clinic.

Keywords: subdural hematoma

Ref No: 5499

Bibliometric Analysis of Studies Published from Türkiye in the Journal Named "Resuscitation"

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Introduction and Purpose: We aimed to examine the publications originating from our country that have been published in the journal named "Resuscitation", to elucidate the position of the emergency medicine field in this context.

Materials and Methods: A total of 68 publications were identified on the website of Scimago Journal & Country Rank due to "Journal Ranking on Emergency Medicine" category. The categories of the studies, year of publication, number of authors, and the specialties and institutions of the corresponding authors were recorded and analyzed using the Jamovi statistical software package.

Results and Conclusion: The average number of publications per year was 2.64 (range: 0-14, SD: 3.16). The most common type was conference abstracts, with 44 publications (64.71%). The most frequent specialty with 41 publications (60.29%) was Anesthesiology and Reanimation, followed by Emergency Medicine (EM) with 10 publications (14.71%). The average number of authors per publication was 4.55 in total and 4.7 for EM. According to the results of the chi-square test, there was no statistically significant relationship found between institutions and publication types ($\chi^2 = 47.2$, $p = 0.08$) and there was a statistically significant relationship found between the specialties of responsible authors and publication types ($\chi^2 = 121.30$, $p < 0.001$).As a result, while 60.29% of the publications examined in our study belong to the Anesthesiology specialty, only 14.71% were authored by emergency medicine specialists. Despite emergency medicine being a relatively newer specialty compared to others, it should play a more prominent role in international publications.

Keywords: Emergency medicine, publication, Resuscitation

Ref No: 5531

Farm Accident

Gülbahar Demir[1], **Erdal Tekin**[1]

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Introduction and Purpose: Vertebral fractures result from trauma, osteoporosis, infection, metastatic or other bone disease, and/or improper axial loading and/or distraction/dislocation. Evaluation includes spinal stability, neurologic deficit, location, degree of bone damage, and associated ligaments. Osteoporosis is the most common precipitating factor for vertebral fractures. Trauma is the second most common cause of vertebral fractures, and motor vehicle accidents are the leading cause of spinal cord injury. Spinal cord injury occurs approximately at the level of the cauda equina, from C1 to L2. Traumatic vertebral fractures are estimated to occur annually, with 50% affecting the thoracolumbar junction. They are more common in males, with a mean age of 30 years.

Materials and Methods: A 22-year-old male patient was brought to the emergency room with a trauma board and neck brace after falling from hay bales while working on a farm and landing on approximately 10-12 bales. On arrival, GKS: 15, oriented and cooperative. Vital signs were natural-stable. Physical examination revealed upper extremity mobile muscle strength of 5/5. Paresthesia was present in bilateral lower extremities, bilateral dorsalis pedis pulses were palpable. The stable patient underwent a whole-body CT scan. L1 vertebral corpus fracture, spondolisthesis and compression of the medulla at this level were seen in the tomography scans. The patient was urgently consulted to the neurosurgery clinic and preparations were made for surgery. He underwent emergency surgery by the neurosurgeon.

Results and Conclusion: The goals of treating vertebral fractures are to restore spinal stability and preserve neurologic function. The thoracic spine, which supports a rigid column, articulates with the more mobile lumbar spine at the thoracolumbar junction (T10–L2), where most fractures occur. A complete examination includes a careful neurologic examination of both the motor and sensory systems. CT scans best define bony detail, while MRI is most effective in defining soft tissue and neurologic structures. In addition to imaging modalities, a thorough neurologic examination is a key element in approaching the patient and ensuring effective treatment. Thoracolumbar vertebral fractures continue to be a significant source of potential morbidity.

Figure 1

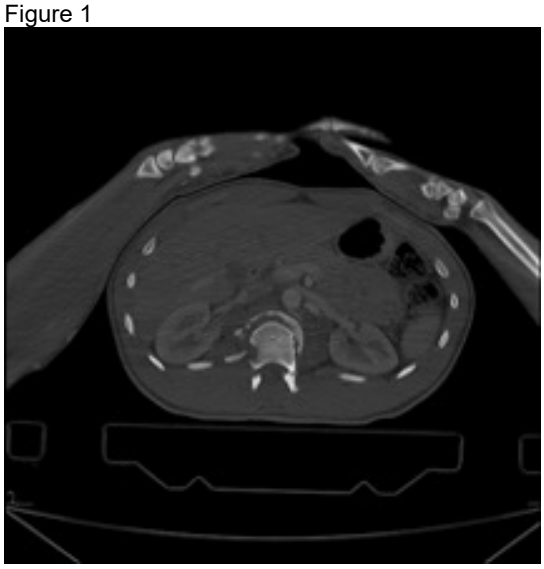

Figure 2

Figure 3

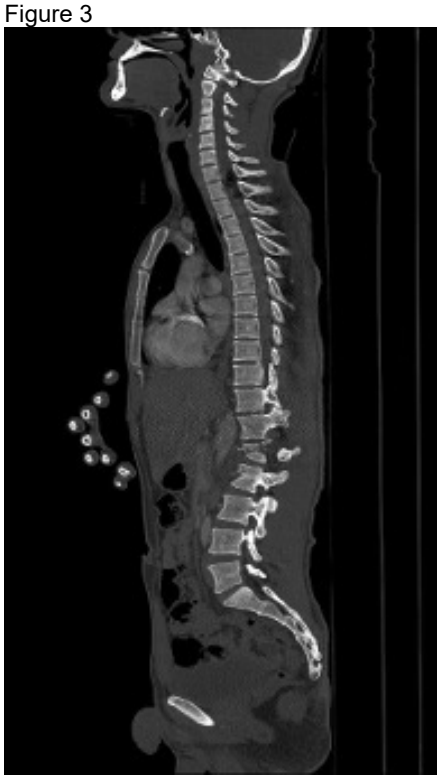

Figure 4

Keywords: Vertebral fracture, falling from height, spondolisthesis

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Ref No: 5539

Consciousness Alteration in an Elderly Patient

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Introduction and Purpose: The number of elderly patients presenting to the emergency department with altered consciousness is increasing day by day. These patients tend to spend more time in the emergency department and undergo more extensive investigations due to their atypical clinical presentations.

Materials and Methods: An 84-year-old female patient with a known history of hypertension experienced a syncopal episode while waiting for her turn to be evaluated in our emergency department. According to information obtained from the patient's relative, she had been fasting that day and felt weak, which prompted them to seek medical attention. Upon arrival, the patient's vital signs were normal, and her Glasgow Coma Scale (GCS) score was 14 (E:4 V:4 M:6). Due to limited orientation and cooperation, the neurological examination was suboptimal.A brain CT and diffusion MRI were performed to investigate the etiology of the syncope, but no abnormalities were detected. However, during follow-up, the patient's condition deteriorated, with her GCS dropping to 9 (E:3 V:1 M:5). Due to the worsening of her general and mental status, she was admitted to the neurology department. The neurology team evaluated the patient primarily for syncope and altered consciousness, suspecting an underlying metabolic or infectious process.The patient had mild elevation in creatinine levels, which was not significant enough to be classified as acute kidney injury (AKI), likely due to prolonged fasting and dehydration. No other significant abnormalities were found in the laboratory results. The patient was closely monitored overnight, and appropriate hydration was provided. By morning, her GCS improved to 15, and she was discharged with recommendations.

Results and Conclusion: The purpose of presenting this case is to emphasize that metabolic changes in elderly patients can easily lead to altered consciousness and deterioration of general condition.

Keywords: Altered consciousness, elderly patient, metabolic disorder

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Ref No: 5548

Reversible cause of cardiac arrest: pulmonary embolism

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Introduction and Purpose: Cardiac arrest is a life-threatening condition characterized by the sudden cessation of cardiac activity. While timely initiation of cardiopulmonary resuscitation (CPR) is crucial, early recognition of potentially reversible underlying causes, particularly pulmonary embolism (PE), is essential. Prompt identification and intervention significantly enhance the patient's survival chances, making rapid and effective management a critical component of the life-saving process in such emergencies.

Materials and Methods: A 65-year-old female patient awoke at 05:00 with complaints shortness of breath. After notifying household

members, an ambulance was called. The patient experienced fainting near the ambulance. Following the initial fainting episode, she suffered a witnessed cardiac arrest, prompting emergency medical teams to initiate CPR immediately. She was intubated and transported to the emergency department (ED) following a 15-minute CPR effort. During return of spontane circulation electrocardiographic (ECG) evaluation revealed a right bundle branch block (RBBB), raising suspicion of pulmonary embolism as the underlying cause of the arrest. However, the patient experienced re-arrest during the follow-up period. Given the clinical suspicion, thrombolytic therapy was promptly initiated. Following thrombolysis, CPR yielded a successful response, leading to the restoration of cardiac rhythm and hemodynamic stabilization. The patient was subsequently admitted to the intensive care unit (ICU) for close monitoring.In the ICU, the patient remained under respiratory support and continuous hemodynamic surveillance. Laboratory tests, imaging studies, and echocardiography confirmed the diagnosis of PE, leading to the initiation of appropriate thrombolytic therapy.

Results and Conclusion: This case highlights that in elderly patients, sudden onset dyspnea, syncope, and cardiac arrest can progress rapidly despite immediate intervention. PE should be a primary consideration in emergency settings, particularly when shortness of breath is accompanied by syncope and ECG findings such as RBBB. The timely administration of thrombolytic therapy, coupled with effective CPR, plays a crucial role in the patient's survival and in mitigating severe complications.This case was selected for presentation due to the critical impact of thrombolytic therapy during CPR and efficacy of it on patient recovery, so the pivotal role of early diagnosis and intervention in patient outcomes. The case underscores the importance of rapid recognition and treatment in achieving successful resuscitation and preventing adverse complications.

Keywords: pulmonary embolism, cardiac arrest, emergency

Ref No: 5582

NOROPATHY COULD BE COVER UP THE PATHOLOGY

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Introduction and Purpose: Diabetic neuropathy is one of the most common neurological complications of diabetes with a high risk of morbidity that affects the quality of life of individuals. Many people with diabetes do not report symptoms or problems associated with diabetic neuropathy. Sometimes because they couldn't relate to diabetes, and sometimes because they didn't feel it...

Materials and Methods: An 80-year-old female patient is came to us after a fall. During the examination, she states that she does not have pain, but feels pain in the cruris while trying to stand up. In the detailed examination, the pulses are evaluated as normal. There are no neurological or muscular deficits found. It is learned from the anamnesis that the patient has a hip prosthesis, and we decided to imaged the entire lower extremity .In the imaging, the patient is found to have a femoral shaft fracture, and the examination is repeated. However, the patient does not describe pain in the fracture area. The patient, consulted by the orthopedics clinic, was admitted for surgery.

Results and Conclusion: Complications such as neuropathy in patients diagnosed with diabetes can cover up the anamnesis and examination. A more comprehensive evaluation is required to avoid missing patients diagnoses.

X-ray

Post op. X-ray

Keywords: Noropathy, fracture

Ref No: 5600

WELLENS SYNDROME: A SILENT WARNING FOR ANTERIOR MI

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Introduction and Purpose: Wellens syndrome is an electrocardiographic finding that suggests a critical proximal left anterior descending (LAD) artery stenosis. It is typically seen in patients with a history of chest pain, and the characteristic T wave changes appear after the pain resolves. First described by Zwaan and Wellens in 1982, it is a strong predictor of anterior myocardial infarction (MI) if left untreated.There are two ECG patterns:Type A: Deep, symmetric T wave inversions in V2-V3Type B: Biphasic T waves in V2-V3, sometimes with isoelectric or mildly elevated ST segmentsEarly recognition is vital to prevent a major cardiac event.

Materials and Methods: A 63-year-old male with known diabetes, hypertension, and COPD presented to the emergency department with typical chest pain lasting for one week, occurring at rest. On physical exam, heart sounds were rhythmic with no murmur. Blood pressure was 140/85 mmHg.ECG showed biphasic T waves in anterior leads, consistent with a Wellens pattern. Echocardiography revealed an ejection fraction of 40%, anterior hypokinesia, and apical akinesia.Laboratory tests: Troponin I: 10.17, Troponin T: 506.7. The patient was diagnosed with acute coronary syndrome and admitted to the coronary ICU for early invasive intervention.Coronary angiography findings:LMCA: NormalLAD: 90% stenosis at proximal and mid segmentsCX: 30% mid-segment stenosisRCA: 30% proximal stenosisA successful revascularization was performed

Results and Conclusion: Wellens syndrome is a critical ECG finding indicating severe LAD stenosis and a high risk for anterior MI. It presents during a pain-free interval, making it easy to miss. Early identification and urgent intervention are essential. Emergency physicians and cardiologists must be aware of this pattern to ensure timely and life-saving management.

Keywords: Wellens syndrome, anterior MI

Ref No: 5604

Patient Presenting With Unilateral Visual Loss: Amaurosis Fugax

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Introduction and Purpose: Amaurosis fugax (AF) refers to transient vision loss, which can be either monocular or binocular. It most commonly presents as monocular vision loss secondary to ischemia affecting the retina, choroid, or optic nerve. The most frequent cause of AF is ipsilateral carotid artery disease (e.g., internal carotid artery dissection or atherosclerosis) with secondary thromboembolism. However, it can also be a manifestation of vasculitis (e.g., giant cell arteritis). AF may serve as a warning sign of an impending stroke and therefore warrants urgent evaluation. Ischemic AF is considered a form of transient ischemic attack (TIA), typically lasting from seconds to minutes, with complete visual recovery.

Materials and Methods: A 53-year-old male patient presented with a complaint of transient vision loss in the left eye, which had started an hour earlier and lasted for 30 minutes. Upon admission, the patient's vital signs were within normal limits. Neurological examination was unremarkable. Pupils were isocoric with a bilateral light reflex of ++/++. Extraocular movements were normal in all directions, and there was no nystagmus. Motor and sensory functions were intact, with no signs of aphasia or dysarthria. Cerebellar tests were successfully performed, and no ataxia was observed. Emergency laboratory tests revealed no pathological findings. Brain computed tomography (CT) showed no evidence of acute hemorrhage, and diffusion-weighted magnetic resonance imaging (MRI) did not reveal any acute ischemic lesions. The patient was consulted with neurology and ophthalmology. Ophthalmologic evaluation did not indicate any urgent pathological findings. The patient was admitted to the neurology department for further investigation with a preliminary diagnosis of amaurosis fugax

Results and Conclusion: AF presents as transient, unilateral, reversible vision loss. The most common cause is atherosclerosis of the internal carotid artery, but other frequent etiologies include ocular migraine and vasculitis. To exclude the possibility of stroke, immediate brain imaging with CT or MRI should be performed, and the patient should be referred to neurology for further evaluation.
Keywords: visual lose, unilateral

Ref No: 5639
Sinus Venous Thrombosis in Pregnancy:A Critical Threat to Mother and Fetus
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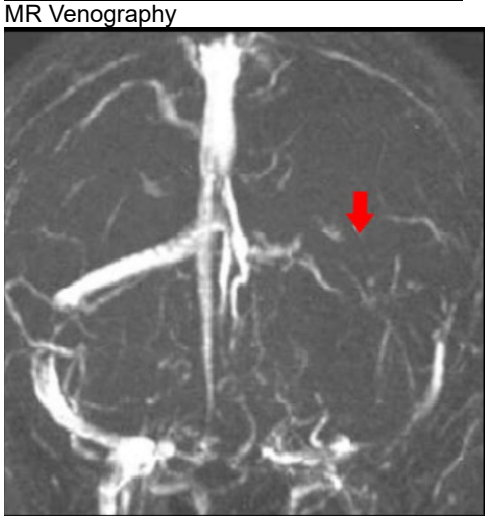
Introduction and Purpose: Cerebral venous sinus thrombosis (CVST) is a rare but life-threatening condition caused by thrombus formation in the cerebral venous sinuses. This thrombosis obstructs cerebral venous drainage, leading to increased intracranial pressure and potentially resulting in cerebral infarction or hemorrhage.
Materials and Methods: A 28-year-old woman, who was 30 weeks pregnant, presented with a three-day history of progressively worsening headache accompanied by nausea and vomiting. She had no additional complaints. The patient reported a recent upper respiratory tract infection. She also stated that her headache was unresponsive to analgesics.On initial evaluation, her consciousness was intact, and her vital signs were within normal limits. Oropharyngeal and respiratory examinations were unremarkable. Neurological examination revealed a muscle strength of 4/5 in the right upper and lower extremities, with no other significant findings. Laboratory investigations were unremarkable.Due to persistent symptoms despite analgesic and hydration therapy, brain magnetic resonance imaging (MRI) and MR venography were performed. Brain MRI (T2-weighted axial sequence) showed hyperintensity in the left transverse sinus, consistent with left transverse sinus thrombosis. MR venography revealed a signal loss in the transverse sinus, indicative of an occlusion. The patient was admitted to the Neurology Department with a preliminary diagnosis of cerebral venous sinus thrombosis.
MR

MR Venography



Results and Conclusion: In pregnant patients presenting with refractory headaches, a thorough neurological examination is essential. Life-threatening conditions such as CVST should always be considered in the differential diagnosis.
Keywords: Pregnancy, headache, cerebral venous sinus thrombosis

Ref No: 5664

A Rare Condition Seen İn The Emergency Department: Guillain-Barré Syndrome

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Introduction and Purpose: Guillain-Barré Syndrome (GBS) is an acute inflammatory demyelinating polyneuropathy characterized by weakness or paralysis, typically symmetric, affecting multiple extremities, and associated with the loss of tendon reflexes. It is often accompanied by elevated cerebrospinal fluid (CSF) protein levels without pleocytosis. Approximately 60% of cases occur following an infection.Weakness develops over hours to days, most commonly affecting the legs, and in some cases, the arms as well. The condition is progressive, reaching its peak severity within 30 days, though in some instances, it can advance rapidly, leading to respiratory involvement within days or even hours. Clinical suspicion is crucial at the time of presentation, as there is no single definitive laboratory test. While elevated CSF protein is a characteristic finding, it typically appears after the second week.

Materials and Methods: A 22-year-old male presented to the Emergency Department (ED) with complaints of nasal discharge, sore throat, and fever that began 10 days prior. His nasal discharge persisted, and he had been experiencing progressive weakness in his lower extremities for the past five days. His medical history was unremarkable.On presentation, the patient was alert and cooperative, with stable vital signs: blood pressure 125/65 mmHg, pulse 80 bpm (regular), temperature 36.6°C, and SpO 98%. Laboratory results showed: leukocytes 6900/µL, CRP 5 mg/L, urea 29 mg/dL, creatinine 1.08 mg/dL, and glucose 97 mg/dL.Physical examination revealed muscle weakness in both legs, with absent deep tendon reflexes in the lower extremities. An electromyography study was performed, and based on the findings, GBS was suspected. The patient was subsequently admitted to the Neurology Department for further evaluation and management.

Results and Conclusion: Patients presenting to the ED with rare conditions like GBS may have nonspecific symptoms, making early diagnosis challenging. In cases where the initial evaluation does not fully explain the clinical picture, maintaining a high index of suspicion and conducting further investigations can be life-saving. Early recognition and timely intervention are crucial in preventing further nerve damage and improving patient outcomes.

Keywords: Guillain-Barré Syndrome, weakness, EMG

Ref No: 5688

APPENDİCİTİS WİTHOUT ABDOMİNAL EXAMİNATİON

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Introduction and Purpose: Appendicitis is the inflammation of the appendix, a 9-10 cm long blind-ended tube that extends from the cecum, which can be obstructed by fecaliths, gallstones, tumors, intestinal parasites, or foreign bodies. The patient may present with abdominal pain, nausea, vomiting, loss of appetite, and a sense of urgency for defecation. Symptoms of appendicitis include diffuse abdominal pain that cannot be localized, loss of appetite, and an urge to defecate. Typically, pain starts around the periumbilical area and later localizes to the right lower quadrant after a few hours. In acute or delayed cases, perforation of the appendix can lead to serious problems such as sepsis. The definitive treatment is surgical.

Materials and Methods: A 29-year-old female patient presented to our clinic with abdominal pain. Her vital signs were stable, and she had no known systemic diseases. On physical examination, there was no rebound tenderness. The patient reported loss of appetite before the onset of abdominal pain, followed by nausea. Initially, she experienced severe pain in the middle of her abdomen, which suddenly stopped before presenting to the hospital. Appendicitis was suspected. Laboratory tests including hemogram, biochemistry, CRP, and abdominal CT were ordered. Blood tests showed WBC: 17 x 10^3/uL, with 68% neutrophil shift to the left. Abdominal CT revealed that the appendix measured 14 mm at its widest point, surrounded by a dirty area and fluid. The patient was diagnosed with acute perforated appendicitis and was taken to emergency surgery by the general surgery team.

Figure 1

Results and Conclusion: Even with intra-abdominal organ perforation, an acute abdomen may not be apparent on physical examination. Therefore, patients should be thoroughly evaluated with detailed anamnesis, laboratory tests, and radiological imaging as a whole.

Keywords: Perforated Appendicitis

Ref No: 5694
Silent Threat:İnfection- Associated Neutropenia
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Introduction and Purpose: Infection-related neutropenia is a condition characterized by a decrease in neutrophil count below normal levels due to an infectious process. Neutrophils are critical components of the immune system, playing a vital role in combating infections.
Materials and Methods: A 60-year-old male patient presented with complaints of fatigue and weakness for one week. His medical history included brain tumor surgery 25 years ago, though he was not receiving any active treatment. Two weeks prior, he had been hospitalized in the Psychiatry Department for psychosis and was discharged one week before his presentation. He had no known chronic illnesses.Upon further anamnesis, the patient reported having a cough for one month, which had worsened over the past week. He had no additional complaints. On admission, his vital signs included an oxygen saturation (SpO □) of 85% and a body temperature of 37.5°C, with no other significant findings. Oropharyngeal examination was unremarkable. Pulmonary auscultation revealed rhonchi and wheezing in the basal lung fields.A chest X-ray demonstrated patchy pneumonic infiltrates. Arterial blood gas analysis showed an oxygen saturation of 85% and a partial oxygen pressure (PaO □) of 47 mmHg. Laboratory tests revealed an elevated C-reactive protein (CRP) level of 177 mg/L. Complete blood count results showed a white blood cell (WBC) count of 0.67 × 10⁹/L and an absolute neutrophil count of 30 cells/μL, with normal hemoglobin and platelet levels. Lymphocyte percentage was increased.Supportive treatment was initiated, and the patient was consulted with the Pulmonology Department for pneumonia and the Internal Medicine Department for neutropenia. Peripheral blood smear analysis revealed atypical lymphocytes, suggesting an infection-related etiology. The Pulmonology team initiated pneumonia treatment, and the patient was admitted to the Internal Medicine Department for further management.
Results and Conclusion: In patients presenting with fatigue and weakness, a thorough evaluation for an infectious focus is essential. Although rare, infections should be recognized as a potential cause of neutropenia.
Keywords: Pneumonia, neutropenia, fatigue

Ref No: 5755
ATTENTıON PREGNANT WOMEN!
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Introduction and Purpose: Pulmonary embolism is a disease with high mortality and morbidity, can recur, sometimes difficult to diagnose, and is preventable. It generally occurs as a complication of deep vein thrombosis . It usually develops when a clot (thrombus) originating from the lower extremity veins travels through the venous system, passes through the right ventricle, and lodges in the pulmonary arteries.
Materials and Methods: A 28-year-old female patient presented with complaints of shortness of breath and back pain. The patient, who had no known systemic diseases, had given birth via cesarean section two days ago. Her oxygen saturation was 87%, pulse 109, and blood pressure 87/60. No pathological lung sounds were heard. There was no difference in the circumference of the lower extremities. The patient's tests were conducted, and troponin was found to be positive. A CT scan was performed, which revealed thrombosis in the bilateral main pulmonary arteries. The patient was consulted with the pulmonology department. After being evaluated as having massive pulmonary thromboembolism, the patient was admitted to the intensive care unit for thrombolytic treatment.
Results and Conclusion: In pregnant patients, increases in fibrinogen, factor V, VII, VIII, X, and von Willebrand factor levels have been observed. This can lead to an increased tendency for thrombosis. In cases with complaints such as chest pain, shortness of breath, and back pain, pulmonary embolism should not be overlooked. Therefore, pregnant and recently postpartum women should be thoroughly examined. These patients should be promptly evaluated and appropriate tests should be conducted for rapid diagnosis and treatment.
Keywords: PULMONARY EMBOLISM, CHEST PAIN, PREGNANT

Ref No: 5832
A Tooth Penetrating the Orbital Region: A Rare Human Bite Case Due to Sports Trauma
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Introduction and Purpose: Traumatic facial injuries are common emergencies during sports activities. In particular, head-to-head collisions may lead to injuries that appear superficial but may conceal deeper pathologies. In this case, a tooth fragment embedded in the orbital region following a collision during an indoor football match presents a rare form of foreign body penetration.
Materials and Methods: A 16-year-old male patient presented to the emergency department with a laceration above his right eyebrow after colliding with an opponent during an indoor football game. Physical examination revealed a 5 cm long, open, fragmented wound with marked surrounding edema. Neurological exam was normal, with equal and reactive pupils (PERRL: +/+), a Glasgow Coma Scale (GCS) score of 15, and no motor-sensory deficits or cranial nerve abnormalities. No facial asymmetry, pathological reflexes, or other traumatic findings were noted. The right orbit was edematous with a 5 cm laceration in the superolateral region. Extraocular movements were intact. Brain and orbital CT imaging showed a hyperdense foreign body within the subcutaneous fat tissue of the right superolateral orbit. Following ophthalmology and plastic surgery consultations, the patient was evaluated in the emergency trauma room. The wound was irrigated with povidone-iodine and saline, then explored, revealing a human tooth as the foreign body, which was successfully removed. The wound was primarily sutured. Tetanus prophylaxis was confirmed, and the patient was discharged with antibiotics and follow-up advice (Figure 1).
Figure 1. Right orbital superolateral hyperdense foreign body

Results and Conclusion: Retained foreign bodies in the orbital region can lead to infections, scarring, and visual impairment, highlighting the need for early diagnosis and treatment. In this case, preserving eye function and successfully removing the foreign body demonstrated the importance of a multidisciplinary approach. Human bite injuries are significant due to their high infection risk and often underestimated severity. Common pathogens in human bites include Eikenella corrodens, Staphylococcus aureus, Streptococcus viridans, and anaerobes like Fusobacterium, Peptostreptococcus, and Prevotella. Bites to sensitive areas such as the face, hands, or genitals, or those with systemic infection or deep tissue involvement, may require hospitalization and coordinated care. Human bites are more contaminated and polymicrobial than animal bites, and even minor injuries should be carefully managed to prevent complications

Keywords: Trauma, Human Bite, Orbital

Ref No: 5843

FATAL CARBON MONOXIDE POISONING

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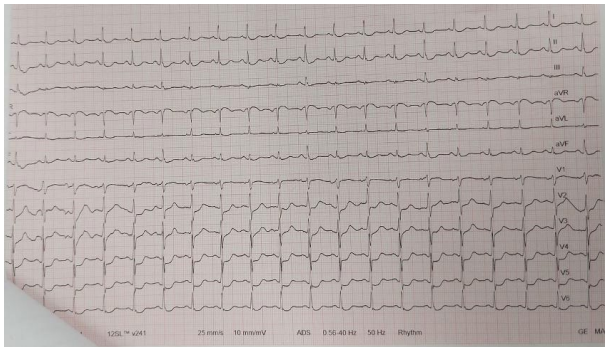
Introduction and Purpose: Carbon monoxide is a poisonous gas that is produced by the incomplete combustion of fuels such as natural gas, gasoline, coal and wood, which contain "carbon" in their structure. CO is a colorless, odorless and non-irritating gas. Carbon monoxide interacts with deoxyhemoglobin and forms carboxyhemoglobin, which has no oxygen-carrying ability. Carbon monoxide has an affinity for hemoglobin that is approximately 200 times greater than oxygen.Headache, dizziness, nausea, vomiting, confusion, chest pain, shortness of breath can be frequently observed in CO poisoning, as well as altered consciousness, syncope, coma and ECG changes, dysrhythmias, and cardiopulmonary arrest. While COHb levels are approximately <1% to 2% in healthy non-smokers, this rate is 4-10% in active smokers. Therefore, we aimed to draw attention to the fact that the diagnosis of CO poisoning can be made by evaluating exposure, appropriate symptoms, and a high COHb level together with our case.

Materials and Methods: A 61-year-old female patient with known asthma was taken by 112 and was unconscious, gks: 3, spo2: 50. When she was brought to our hospital, she had gks: 8 (e3m3v2), intercostal retractions, and abdominal breathing was accompanied. The patient, who had spo2: 79 at 13 lt/min with a mask, was rapidly intubated. There were widespread T negativities in precordial derivations in her ECG. COHb: 52, PH: 7.20, HCO3: 14 Lac: 6.5, d-dimer: 360, trop: 54, no additional features in her blood samples. No urgent pathology was seen in brain CT. In thorax CT, there was a consolidation area with air bronchograms on the left AC base, it was evaluated as pneumonia. A consultation was held with the relevant department for hyperbaric oxygen therapy for CO poisoning.

Picture.1



T wave negativity in inferolateral leads due to carbon monoxide poisoning

Results and Conclusion: CO intoxication is one of the most common toxicities encountered by emergency physicians. It is also the most common cause of poisoning death in the world. Approximately 1,200 deaths per year due to CO exposure have been reported in the United States. CO poisoning continues to be a much more serious threat in developing countries such as ours.Although there is no definitive correlation between COHb levels and clinical severity, significantly high COHb levels of 50% indicate severe poisoning.

Keywords: Unconsciousness, Dyspnea, Carbonmonoxide poisoning

Ref No: 5848

Rectus sheath hematoma

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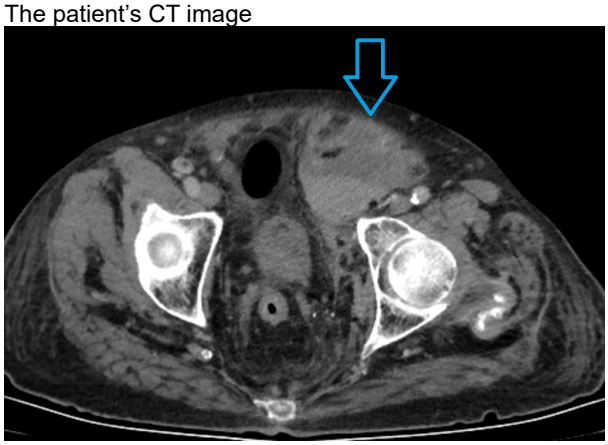
Introduction and Purpose: Rectus sheath hematoma (RSH) is the accumulation of blood within the rectus sheath muscle in the abdomen, resulting from damage to the epigastric arteries or a direct muscle tear. In this case we wanted to emphasize that rectus sheath hematoma is one of the causes of acute abdominal pain and highlight the importance of not overlooking it, especially in trauma patients in the emergency department.

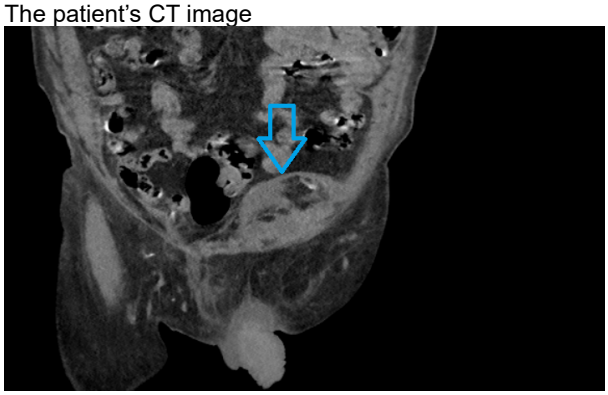
Materials and Methods: Case presentation A 79-year-old male patient presented to our emergency department with abdominal pain after falling on his left lumbar region from his own height last evening.Medical History: Chronic kidney disease, atrial fibrillation, hypertension, and COPD.Vital Signs:Stable, Temperature: 36.5°C, Heart rate: 90 bpm, Blood pressure: 135/84 mmHg. The patient is on dialysis and warfarin therapy. No known drug allergies. No significant family history. Physical Examination: No ecchymosis on inspection. Tenderness in the left lower quadrant on deep palpation. No acute abdomen, guarding, or rebound tenderness. Laboratory Findings: WBC: 11.59 × 10^9/L HGB: 12.5 g/dL Neutrophil percentage: 79.4% Creatinine: 4.94 mg/dL (consistent with patient's baseline) CRP: 83 mg/L BUN: 26.2 mg/dL Urea: 56.1 mg/dL INR: 11.80 APTT: 74.9 seconds Prothrombin Time: 114 seconds Imaging & Initial Management: Abdominal CT scan was performed. Due to elevated INR, the patient received 10 mg of IV vitamin K and IV 60 ml PCC. Ceftriaxone 1g was administered. Paracetamol 1g was given for pain management. CT Report: Fluid-density collection observed within the left rectus muscle, consistent with intramuscular hematoma. An additional 5.5 cm fluid collection was seen inferior to the left rectus muscle. Further Management: Warfarin was stopped until acute bleeding ceased. LMWH was planned to be started once INR fell below 2. Hospital Course & Discharge: Repeat INR (after 3 hours): 1.73 The patient was admitted to the general surgery service. During follow-up, the hematoma regressed, and vital signs remained stable. The patient was discharged with a scheduled outpatient follow-up in the general surgery clinic.

The patient's CT image



Fluid-density collection observed within the left rectus muscle, consistent with intramuscular hematoma

The patient's CT image



Fluid-density collection observed within the left rectus muscle, consistent with intramuscular hematoma

Results and Conclusion: Rectus sheath hematoma is an uncommon condition that can often be managed conservatively. Patients on warfarin presenting with abdominal pain should be evaluated for the possibility of a rectus sheath hematoma.

Keywords: lower abdominal pain, rectus abdominis, rectus sheath hematoma.

Ref No: 5865
ACUTE APPENDICITIS
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[1]ACUTE APPENDICITIS
Introduction and Purpose: Acute appendicitis is one of the most common causes of acute abdomen. Appendectomy is the most common intra-abdominal surgical intervention. In the diagnosis of acute appendicitis, a good anamnesis and a careful and thorough physical examination are very important. In addition, various laboratory and imaging techniques can be used to diagnose acute appendicitis. However, the diagnosis is mainly based on the history and clinical findings.
Materials and Methods: A 24-year-old male patient presented with abdominal pain for approximately 24 hours. His vital signs were normal on presentation (Pulse: 85 SPO2: 95 TA: 125/85 FEVER: 36.7). The patient had no known comorbidities and no history of previous surgery.In the physical examination, there was a defect in the right lower quadrant of the abdomen and there was no feature in the external examinations. HGB: 14.7, WBC: 14.000, neutrophil: 9500 were the other results of the blood tests. There was no feature in other blood tests. Since the appendix could not be visualized in the USG imaging of the patient, abdominal computed tomography imaging was requested: Appendix diameter was measured as 7.5mm and contaminations were observed around it. The patient was consulted to general surgery and hospitalized in the emergency department of general surgery.
Results and Conclusion: In conclusion, patients presenting with abdominal pain constitute a significant proportion of the visits to physicians in the emergency department. Acute appendicitis has an important place among the diseases that may cause abdominal pain. The sine qua non for the diagnosis of acute appendicitis is the patient's history and physical examination. Laboratory and imaging tests are only helpful in the diagnosis. The diagnosis of acute appendicitis cannot be ruled out according to the test results. Recognizing this and paying attention to this in the approach to the patient with abdominal pain will reduce malpractice and legal consequences for physicians and mortality and morbidity for patients as much as possible.
Keywords: ACUTE APPENDICITIS, ABDOMINAL PAIN, DEFENSE SIGN

Ref No: 5893
Osborn Waves: When the Heart Gets Cold, A Warning for Hypothermia
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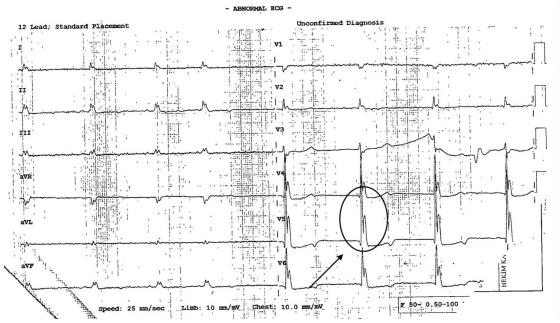
Introduction and Purpose: The Osborn wave, also known as the J wave, is characterized by a dome-shaped deflection or a small secondary R wave (R') following the QRS complex on the electrocardiogram (ECG). This phenomenon is most commonly associated with hypothermia, although it can also occur in conditions such as hypercalcemia, certain drug effects, and intracranial hypertension. The amplitude of the Osborn wave is directly correlated with the severity of hypothermia, making it a valuable diagnostic marker in clinical practice.
Materials and Methods: An 81-year-old male patient, with a Glasgow Coma Scale score of 12 and a general condition disorder, was referred to our institution from a local hospital for intensive care. Upon admission, his vital signs were as follows: blood pressure 50/30 mmHg, oxygen saturation 88% on room air, pulse rate 50 beats/min, body temperature 32°C, and blood glucose level 254 mg/dL. The patient's overall condition was poor, with confusion, disorientation, and non-cooperation noted. Blood work performed at the referring hospital revealed pancytopenia, with a troponin level of 118.49 ng/mL. Electrocardiogram (ECG) findings showed ventricular arrhythmia and the presence of an Osborn wave. Immediate management included the administration of 2000 cc isotonic solution and 5% dextrose at a rate of 11 cc/h. Warm applications were applied to increase body temperature. Abdominal, thoracic, and brain tomography scans did not reveal any acute pathology. The patient was admitted to a tertiary intensive care unit for management of hypernatremia (Na: 179 mEq/L) and pancytopenia (leukocyte: 0.53 x 10^3/µL, hemoglobin: 5.81 g/dL, platelet: 64,000/µL). Unfortunately, despite intensive care efforts, the patient's condition deteriorated, and he passed away seven days later.
Osborn Waves



Twelve-lead ECG obtained in the patient with a core body temperature of 32.0º C. The tracing shows sinus bradycardia, a base-line artifact due to muscle tremors and characteristic Osborn waves
Results and Conclusion: The Osborn wave observed in our patient's ECG played a crucial role in guiding both the diagnosis and treatment. While the Osborn wave is a hallmark finding in hypothermia, it is not pathognomonic. However, it serves as an important diagnostic clue, drawing attention to possible electrolyte imbalances and intracranial pathologies in addition to hypothermia. Hypothermia is a critical condition that requires immediate intervention due to its high associated morbidity and mortality.
Keywords: Osborn wave, hypothermia, pancytopenia

Ref No: 6011
Myocardial İnfarction
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Introduction and Purpose: ST-elevation myocardial infarction (STEMI) is a critical cardiac emergency that, with early diagnosis and rapid reperfusion therapy, can significantly reduce mortality by minimizing myocardial damage.
Materials and Methods: A 58-year-old male presents to the ED with severe chest pain radiating to his left arm and jaw. The pain has lasted 30 minutes, accompanied by cold sweats, nausea, and shortness of breath. He has a history of hypertension and smoking, and reports never having experienced a similar pain before. The patient is anxious and diaphoretic (covered in cold sweat). Skin is cool and pale; pulse is 95 bpm, blood pressure 150/90 mmHg. No murmurs on cardiac auscultation, heart sounds are normal. Palpation of the chest does not reproduce the pain (non-tender chest wall). Lungs are clear bilaterally with no notable abnormalities.Investigations: A 12-lead ECG shows significant ST-segment elevations in the anterior leads V2–V5, consistent with an anterior wall MI. Cardiac enzymes are markedly elevated with a troponin-I of 10 ng/mL (normal < 0.04). CBC and chemistry panel are unremarkable. A screening chest X-ray shows no mediastinal widening (no evidence of aortic dissection) and no signs of pulmonary edema. Acute ST-elevation myocardial infarction (STEMI) of the anterior wall (likely due to occlusion of the left anterior descending artery). Differential: Unstable angina or NSTEMI (acute coronary syndromes without ST elevation), aortic dissection (a critical cause of sudden severe chest pain), pulmonary embolism (considered especially with prominent breathing difficulty), acute pericarditis (can cause diffuse ST elevations), as well as non-cardiac causes such as gastroesophageal reflux disease or costochondritis (musculoskeletal chest pain).
Results and Conclusion: The patient was immediately given antithrombotic therapy including aspirin and heparin, along with morphine and sublingual nitroglycerin for pain relief. The cardiology team performed an urgent primary percutaneous coronary intervention (PCI). Angiography revealed a complete occlusion in the left anterior descending (LAD) artery, which was successfully opened with a stent. The patient was monitored in the ICU, his symptoms resolved and ST elevations subsided. He was discharged after a few days on protective medications (such as a beta-blocker, ACE inhibitor, and statin) with advice on lifestyle modifications and risk factor management.
Keywords: Myocardial infarction

Ref No: 6035
Gallbladder herniation: a rare case
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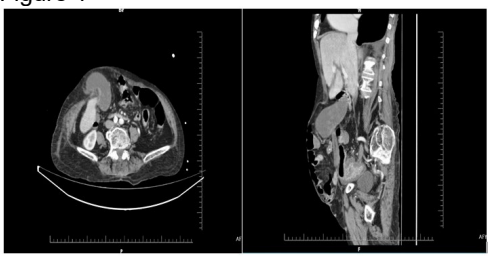
Introduction and Purpose: A hernia is a condition that occurs when an organ or tissue protrudes from its original location. Abdominal hernias result from weaknesses or openings in the abdominal wall, allowing internal organs or intra-abdominal tissues to extend beyond the abdominal wall. This condition often manifests with pain, swelling, and occasionally complications. If left untreated, it may lead to severe health issues. We will present a patient who came to the emergency room with complaints of nausea, constipation and loss of appetite and was diagnosed with a hernia involving the gallbladder.
Materials and Methods: An 87 year old female patient was brought to the emergency department by ambulance due to complaints of nausea, constipation, and loss of appetite persisting for three days. Her general condition was good, and her vital signs were stable. Physical examination revealed a palpable mass in the midline of the abdomen. Deep palpation elicited tenderness, but other systemic examinations were unremarkable. The patient had normal gas and stool discharge. Laboratory tests, including liver, renal function tests, electrolytes, hemogram showed no acute pathology. A standing abdominal X-ray was performed, which did not reveal an ileus-compatible image. Subsequently, an upper abdominal and pelvic contrast-enhanced computed tomography (CT) scan was conducted. Abdominal CT revealed significant herniation of intra-abdominal fatty tissues, segments of the small and large intestines, and the gallbladder through a defect in the umbilical region (Figure 1). The patient was consulted with general surgery, and emergency surgical intervention was not deemed necessary. The patient was prescribed a laxative and discharged.
Figure 1

Contrast-enhanced abdominal CT axial and sagittal sections showed herniation of intra-abdominal fatty tissues, segments of the small and large intestines, and the gallbladder through a defect in the umbilical region
Results and Conclusion: Herniation of intra-abdominal organs occurs when organs or tissues protrude through defects in the abdominal wall, presenting a significant clinical condition. Particularly, situations such as strangulation require urgent surgical intervention. Strangulated hernias can lead to ischemia of the affected organ, resulting in tissue necrosis and peritonitis, which are life-threatening complications. Therefore, early diagnosis and treatment of hernias are of paramount importance. Elderly patients in particular may present to the emergency department with nonspecific complaints and physical examination findings, this often requires the use of imaging studies. Thanks to imaging, pathologies with fatal complications such as hernia can be diagnosed.
Keywords: old patient, computed tomography imaging, gallbladder herniation

Ref No: 6066

DON'T UNDERESTIMATE HICCUPS

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Introduction and Purpose: Atrial fibrillation (AF) is the most common sustained arrhythmia, with a lifetime risk of around 25% after age 40. It can cause complications such as hemodynamic instability, heart failure, and embolic stroke. It is marked by irregular atrial electrical activity. Diagnosis may be challenging due to the absence of P waves and variable heart rate. Sometimes, fibrillatory waves may resemble P waves and lead to misdiagnosis.In this report, we present a case of AF presenting with hiccups.

Materials and Methods: A 64-year-old man presented to the emergency department with persistent hiccups for 3 days. On further questioning, he reported a prior episode of palpitations 5 months earlier, during which he was prescribed Beloc but used it irregularly. He denied current chest pain or palpitations. On examination, he was conscious, cooperative, and hemodynamically stable. Blood pressure was 130/70 mmHg, heart rate 140 bpm, temperature 36.5°C, oxygen saturation 94%.ECG revealed atrial fibrillation with a ventricular rate of 160 bpm. Initial labs were within normal limits. IV Beloc was administered three times under monitoring, but the heart rate did not decrease. Then, IV amiodarone was given, reducing the heart rate to 100 bpm. Cardiac markers and inflammatory parameters were normal. The patient was monitored and later admitted to coronary ICU after cardiology consultation.

Results and Conclusion: Patients with AF may not always present with typical complaints like palpitations or chest pain. Hiccups can be an atypical presentation. Detailed history and early ECG are crucial. Prompt treatment should be guided by the patient's clinical stability.

Keywords: hiccups, atrial fibrilation

Ref No: 6085

IMPORTANCE OF PHYSICAL EXAMINATION

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Introduction and Purpose: Acute aortic dissection is a vascular disease that is difficult to diagnose and has a high in-hospital mortality rate. The aortic wall consists of three layers: the intima, media, and adventitia. A tear between the intima and media layers of the aortic wall leads to the separation of the intima layer in the direction of blood flow distally, which is defined as aortic dissection. The most common presenting symptom in aortic dissection is chest pain, followed by back pain and abdominal pain. The pain typically starts suddenly and is described as sharp, tearing, or ripping. Patients with Type A aortic dissection mostly complain of chest pain, while those with Type B dissection typically report back and abdominal pain.

Materials and Methods: A 65-year-old female patient presented with shortness of breath and chest pain. The patient has a known diagnosis of diabetes and hypertension, and her vital signs upon arrival were stable. On examination, no abnormal lung sounds were detected. Abdominal examination was unremarkable. Peripheral pulses were evaluated, and the left radial pulse was weaker than the right radial pulse. Blood tests were conducted, and a CT scan was performed to investigate aortic dissection. The CT scan revealed a dissection extending from the left subclavian artery to the infrarenal level. The scan was reported as: "Dissection starting from the ascending aorta and continuing to the infrarenal bifurcation level, with intimal flap findings. The dissection also extends from the proximal third of the left subclavian artery toward the right common carotid artery." The patient was referred to the cardiovascular surgery department and admitted for further management.

PHOTO 1

PHOTO 2

Results and Conclusion: Aortic dissection, which has a very high mortality rate, requires rapid diagnosis through a high index of clinical suspicion and the quick use of diagnostic tests. For patients presenting to the emergency department, a detailed medical history and thorough examination are essential for identifying aortic dissection.
Keywords: CHEST PAIN, PULSE DIFFERENCE BETWEEN ARMS, BACK PAIN

Ref No: 6131
Ureteral Perforation as a Complication of Foley Catheterization in the Emergency Department: A Case Report
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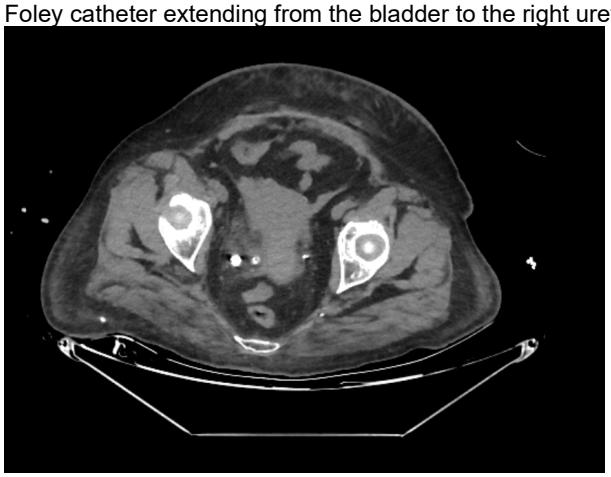
Introduction and Purpose: Ureteral injuries and perforations reflect an underlying pathology such as trauma, urinary stones, obstruction, malignancy, idiopathic retroperitoneal fibrosis, or previous urinary tract surgery. Here, we present a case of ureteral perforation after Foley catheterization without any known underlying pathology.
Materials and Methods: The patient, who was brought to the emergency room due to general condition, had complaints of weakness, palpitations, shortness of breath and blurred vision for a day. The patient's Foley catheter was inserted at an external center and the patient was evaluated as anuric because of the bladder not coming to the bladder. In the abdominal tomography performed on the patient; Hyperdense material compatible with the Foley catheter extending from the bladder to the right ureter. Increased linear densities around the bladder and right ureter, contamination in the perivesical periureteral fatty planes were detected.
Results and Conclusion: There are no characteristic clinical signs of ureteral rupture. In physical examination, patients may experience ipsilateral abdominal pain or costovertebral angle tenderness. In patients undergoing intervention without imaging, the location of the Foley catheter must be confirmed. This situation must be treated promptly, as it can cause serious complications such as ureteral rupture, retroperitoneal abscess formation, and sepsis.
Foley catheter extending from the bladder to the right ureter



Increase in linear densities around the bladder and right ureter, contamination in perivesical – perirectal fatty planes.
Hyperdense Foley catheter material in the ureter

Disruption of ureteral wall integrity

Keywords: Foley Catheterization, Case Report, Ureteral Perforation

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Ref No: 6136

A Case Report Of The İmportance Of Early Nstemi Diagnosis And İntervention İn A Patient Presenting With Atypical Symptoms

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Introduction and Purpose: Chest pain can occur for many reasons. It usually occurs due to benign reasons and the diagnosis of acute coronary syndrome (ACS) should be excluded. In this case report, we will present an ACS patient who presented to the emergency department with atypical symptoms.

Materials and Methods: A 40-year-old male patient presents to the emergency department with complaints of stabbing chest and right arm pain. He has no known disease, has a family history of coronary artery disease, and is a smoker. Physical examination shows no pathological findings, and his vital signs are normal. Electrocardiogram: No significant change, normal sinus rhythm. The first high sensitive troponin (hsTn) taken was 2 times higher than the normal limit. No additional cause was detected that could cause hsTn elevation due to secondary causes. The hsTn taken at the 1st hour was twice as high as the previous one. The patient was diagnosed with ACS and given appropriate medical treatment (antiplatelet, P2Y12 receptor blocker, low molecular weight heparin treatments), and then coronary angiography was planned. Coronary angiography showed 99% thrombosis in the proximal left anterior descending arter and 40% stenosis in the circumflex artery. Percutaneous coronary angioplasty was performed and a drug-eluting stent (DES) was implanted. Afterwards, the patient was admitted to the cardiology service to arrange his medical treatment.

Fig 1

Patient's electrocardiogram: Normal Sinus rhythm

Results and Conclusion: In patients presenting with chest pain, even if the pain is not typical, the diagnosis of acute coronary syndrome should be considered. Additional examination is recommended, especially in patients with risk factors such as family history and smoking. Early diagnosis and treatment in these patients is effective in reducing morbidity and mortality.

Keywords: Atypical symptoms, Chest pain, Emergency department

Ref No: 6139
REFLEX EPILEPSY
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Introduction and Purpose: Epilepsy is a condition that can occur at any age and requires long-term treatment and monitoring, significantly affecting quality of life. The most important diagnostic method for epilepsy, alongside clinical information, is EEG, and EEG should be performed in every patient suspected of having seizures. Seizures can be classified as focal or generalized based on their type. Later, an epilepsy syndrome classification is made based on factors such as lesion presence, family history, age of onset, and types of seizures.
Materials and Methods: A 21-year-old male patient with a known diagnosis of obsessive-compulsive disorder (OCD) was brought to the emergency department after ingesting multiple medications for suicidal intent. He had been using antipsychotics and tricyclic antidepressants due to his psychiatric condition and had taken excessive doses of these medications during the day for suicidal purposes. Upon arrival, his general condition was moderate, with confused consciousness and poor orientation and cooperation. His external system examinations were normal, and vital signs were stable. No abnormalities were found in the lab results, and central imaging was normal. The patient received IV hydration, gastric lavage, and activated charcoal. After consultation with the psychiatry department, the patient was admitted to the emergency intensive care unit for observation and treatment. During follow-up in the intensive care unit, while the patient was being administered activated charcoal, he experienced a generalized tonic-clonic seizure lasting approximately 15 seconds. Three hours after the postictal period, when he was given activated charcoal again, the patient had a second seizure. The neurology department was consulted, and antiepileptic medication was started.
Results and Conclusion: Reflex epilepsy refers to epilepsy syndromes characterized by recurrent seizures triggered by specific sensory stimuli. The primary triggers of reflex seizures include visual, somatosensory, proprioceptive stimuli, music, eating, and hot water. The first notable seizure in our patient occurred during activated charcoal ingestion. When oral intake was withheld, no seizures occurred. The recurrence of seizures after re-administering activated charcoal will be monitored to determine whether this is coincidental or a case of reflex epilepsy
Keywords: Epilepsy, Reflex epilepsy

Ref No: 6208
Twisting the Fate: Can the Twist Score Untangle Testicular Torsion?
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Introduction and Purpose: The TWIST (Testicular Workup for Ischemia and Suspected Torsion) score evaluates testicular torsion risk based on urologic history and physical examination. It includes testicular swelling (2 points), rigidity (2 points), absent cremasteric reflex (1 point), nausea or vomiting (1 point), and high-riding testis (1 point). Patients are stratified into low (0–2 points), intermediate (3–4 points), and high-risk (5–7 points) groups, with recommendations for exclusion, ultrasound, and surgical exploration, respectively.
Materials and Methods: A 20-year-old male presented to the emergency department with a three-day history of scrotal redness and swelling. He had no chronic illnesses, medication use, or significant family history. Physical examination revealed scrotal swelling and firmness, with an otherwise unremarkable systemic evaluation. A TWIST score of 4 prompted scrotal Doppler ultrasonography. Laboratory findings showed leukocytosis (14,410 K/uL) and elevated CRP (11.3 mg/L), with no other abnormalities. Ultrasonography revealed left scrotal edema with a skin thickness of 7 mm, a hypoechoic, heterogeneous testicular parenchyma with absent vascular signals, suggesting testicular torsion. Increased vascularity in another hypoechoic area raised suspicion of epididymitis, while a septated fluid collection measuring up to 9 mm in thickness indicated a possible hydrocele. The patient underwent urgent urological consultation and emergency surgery. A left orchiectomy was performed, and he was discharged on postoperative day 3.
Results and Conclusion: Ultrasound is not required to rule out torsion in low-risk patients. High-risk patients can undergo immediate surgery. The TWIST score can be calculated during the initial assessment before urological consultation to guide radiological evaluation and emergency surgical intervention.
Keywords: Twist score, testicular tortion

Ref No: 6217
Jaw Dislocation İn Elderly Patient
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[1]Jaw Dislocation İn Elderly Patient
Introduction and Purpose: Temporomandibular joint (TMJ) dislocation can be defined as excessive movement of the condyle in the forward direction, crossing the articular eminence, leaving the joint fixed in the open position and not allowing any sliding movement. Especially in elderly patients and patients with poor general condition, overlooking this condition may lead to incorrect prediagnoses.
Materials and Methods: A 80 year old female patient with a history of CVD three months ago was admitted to an external center with complaints of decreased oral intake and deterioration in general condition for 1 year. He was referred to our center due to a cerebrovascular event due to slippage in the mouth. In the anamnesis, it was learned that the work had sequelae on the right side and that he could not speak after a previous IVF. There were known DM and advanced diseases. Vital blood pressure: 165/ 110 hours: 92 hours: 75 Temperature: 36.7 Respiratory rate: 16/min Fingertip blood sugar: 147. Physical examination revealed that the motor power of the right side was 1/5 (according to the previous svo) and the left side was 5/5. On examination of the patient, there was effacement in the right nasolabial sulcus. It was also noticed that he could not keep his mouth shut. No abnormalities were found in blood tests. Magnetic resonance imaging revealed a large encephalomalasic area (secondary to a previous cerebrovascular event) in the right

macular irrigation area. CT imaging revealed temporo mandibular joint exit. No external acute pathology was detected on CT and MR imaging, and the patient was consulted to the maxillofacial surgery clinic. The patient with a reduced jaw was discharged from the jaw surgery clinic.
Results and Conclusion: A good physical examination of the whole body is one of the most important steps in the diagnosis of emergency admissions. Although cerebrovascular events should be ruled out in elderly patients presenting with complaints of impaired general condition and impaired oral intake, a simple condition such as temporo mandibular joint dislocation, which is a much simpler condition compared to cerebrovascular events, can be detected with a good physical examination.
Keywords: elderly patient, cerebrovascular event

Ref No: 6237
Acute Bacterial Meningitis
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Introduction and Purpose: Meningitis is an acute or chronic inflammatory disease of the meninges caused by various microorganisms. Different microorganisms reach the meninges via different routes, leading to pia-arachnoiditis developing in the subarachnoid space
Materials and Methods: A 38-year-old female patient presented to an external emergency department in the morning with a headache. She was discharged after symptomatic treatment provided relief. However, in the evening, she returned with recurrent headache, altered consciousness, and incoherent speech, and was admitted to the Pamukkale University emergency department.No known chronic diseases.No regular medication use .Recent history of upper respiratory tract infection (URTI) Initial vital signs:BP: 130/80 mmHg SpO □ 98% HR: 85 bpm Fever: 36.8°CNo history of surgery, smoking, or alcohol use Physical examination:Patient appeared agitated.Disoriented to time, place, and person, and non-cooperative.Nuchal rigidity present (+).Kernig and Brudzinski signs could not be evaluated.Thoracic and abdominal examinations were normal Laboratory results:WBC: 17.8 CRP: 25 No acidosis on blood gas analysis Coagulation parameters: normal Urinalysis: normal No pathology found in central imaging.Central nervous system infection was suspected and lumbar puncture was performed.The lumbar puncture revealed intense leukocytes and erythrocytes throughout the Thoma slide.Streptococcus pneumoniae was detected in viral panel analysis.The patient was diagnosed with acute bacterial meningitis and admitted to the infectious diseases service.
Results and Conclusion: In emergency patients presenting with fever and altered mental status who also have a history of recent URTI, central nervous system infections must be ruled out
Keywords: Acute bacterial meningitis, streptococcus pneumoniae, nuchal rigidity

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Ref No: 6272
The Hidden Culprit:Acute Pancreatitis as a Seconder Cause of Troponin Elevation
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Introduction and Purpose: Acute pancreatitis is a sudden inflammation of the pancreas. The pancreas is an organ responsible for producing digestive enzymes and hormones such as insulin. In acute pancreatitis, the enzymes produced by the pancreas begin to digest the pancreatic tissue before reaching the intestines, leading to severe inflammation.
Materials and Methods: A 54-year-old female patient presented with complaints of epigastric and abdominal pain radiating to the back, nausea, and vomiting for the past two days. The patient had a known history of angioplasty with stent placement, atrial fibrillation (AF), and heart valve replacement. Upon admission, her vital signs were unremarkable, and no significant blood pressure difference was observed between the arms. The patient's electrocardiogram (ECG) showed atrial fibrillation with no acute pathological findings.On abdominal examination, tenderness was noted in the epigastric region and upper quadrants, but no guarding or rebound tenderness was present. Bilateral costovertebral angle tenderness was negative. Laboratory results revealed the following:Total bilirubin: 2.98 mg/dLDirect bilirubin: 1.82 mg/dLALT: 317 U/LAST: 485 U/LGGT: 251 U/LLDH: 713 U/LALP: 289 U/LAmylase: 2527 U/LLipase: 2380 U/LTroponin: 874 ng/L (with a follow-up level at 1 hour: 948 ng/L)INR: 2.09 (patient on warfarin therapy)Serial ECGs showed no acute ischemic changes. Supportive treatment was initiated. Abdominal computed tomography (CT) demonstrated gallstones and fat stranding around the pancreas and duodenum, leading to a preliminary diagnosis of acute pancreatitis. Given the patient's epigastric pain and elevated troponin levels, a possible non-ST elevation myocardial infarction (NSTEMI) was considered, and cardiology consultation was requested. However, the cardiology team did not find evidence suggestive of acute coronary syndrome (ACS). Consequently, the patient was admitted to the gastroenterology department with a diagnosis of acute pancreatitis.
Results and Conclusion: ACS should always be considered in patients presenting with epigastric pain. In cases of troponin elevation, primary ACS as well as secondary causes of troponin elevation should be evaluated.
Keywords: Acute Pancreatitis, Abdominal Pain, Troponin

Ref No: 6279
Embolism
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Introduction and Purpose: Thromboembolism can present with various clinical manifestations. It may involve transient events such as a transient ischemic attack (TIA) or embolisms that do not resolve without intervention. The clinical presentation varies depending on the location of the thromboembolism. Symptoms may include neurological deficits such as speech impairment and unilateral weakness, cardiopulmonary complaints such as chest pain and shortness of breath, or extremity pain.
Materials and Methods: An 80-year-old female patient presented to our hospital with complaints of numbness and weakness in her left

arm and leg, which had persisted for 30 minutes. On physical examination, she had a 2/5 motor strength loss in her left upper and lower extremities, along with hypoesthesia in the left lower extremity. Imaging studies revealed a lacunar infarct in the right parietal region (Figure 1). Additionally, during the examination, the absence of palpable peripheral pulses in the right lower extremity led to further imaging, which showed no contrast passage in the right popliteal artery (Figure 2).

figure 1

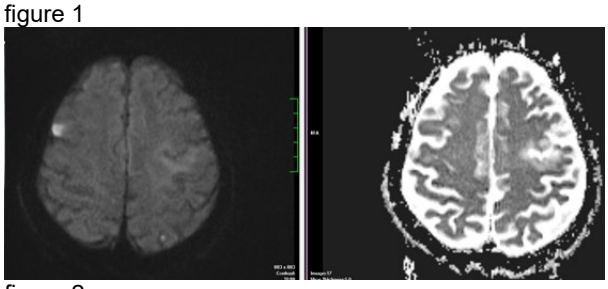
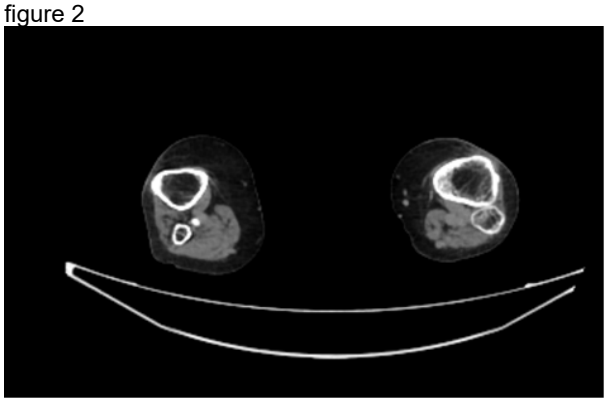


figure 2



Results and Conclusion: Thromboembolism can simultaneously affect multiple regions depending on its source. In patients diagnosed with a single thromboembolic event, thorough examination is crucial to identify potential additional thromboembolic occurrences.

Keywords: Embolism, Cerebrovascular Event

Ref No: 6282

Substance Use And Multiple Organ Dysfunction Syndrome: A Case Report

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Introduction and Purpose: Substance use is associated with a broad spectrum of acute and chronic complications that may result in severe systemic toxicity. Intravenous administration of substances, particularly when performed unsupervised or with unknown drug combinations, can trigger pharmacological toxicity and lead to organ dysfunction. Multiple Organ Dysfunction Syndrome (MODS) is a life-threatening condition characterized by progressive failure of multiple organ systems and carries high morbidity and mortality. This case report describes a patient who developed MODS following intravenous substance administration.

Materials and Methods: A 30-year-old male with no known chronic illnesses presented to the emergency department with complaints of abdominal pain, fatigue, nausea, and vomiting persisting for ten days. His history revealed regular substance use and recent intravenous administration of hydration, analgesics, and antiemetics of unknown composition by a healthcare professional.On admission, the patient was hypotensive (BP 80/40 mmHg), tachycardic (HR 120 bpm), and tachypneic (RR 24/min), with a temperature of 36.7°C. Abdominal examination revealed diffuse tenderness, and neurological assessment showed drowsiness.Laboratory tests indicated acute kidney injury, hyperkalemia, hyponatremia, hyperbilirubinemia, elevated liver enzymes, amylase and lipase levels increased 8–10 times above normal, coagulopathy (prolonged INR, APTT/PT), and marked leukocytosis.Brain computed tomography (CT) revealed no acute pathology. Abdominal CT showed mild pancreatic body and tail thickening with surrounding fat stranding, suggestive of pancreatitis. With a SOFA score of 6, the patient was diagnosed with MODS. Nephrology, infectious diseases, and internal medicine were consulted. A femoral venous catheter was placed in the emergency department, and hemodialysis with ultrafiltration was initiated. Broad-spectrum antibiotics were started, and the patient was transferred to the intensive care unit.

Results and Conclusion: This case illustrates how substance use and intravenous drug administration can precipitate systemic inflammatory response syndrome, acute pancreatitis, renal and hepatic dysfunction, and coagulopathy—culminating in MODS. Early recognition, intensive care, and a multidisciplinary approach are crucial in improving patient outcomes and reducing mortality in such high-risk cases.

Keywords: substance use, multiple organ dysfunction syndrome, systemic inflammatory response syndrome

Ref No: 6289

The hidden killer behind the pain: abdominal aortic dissection

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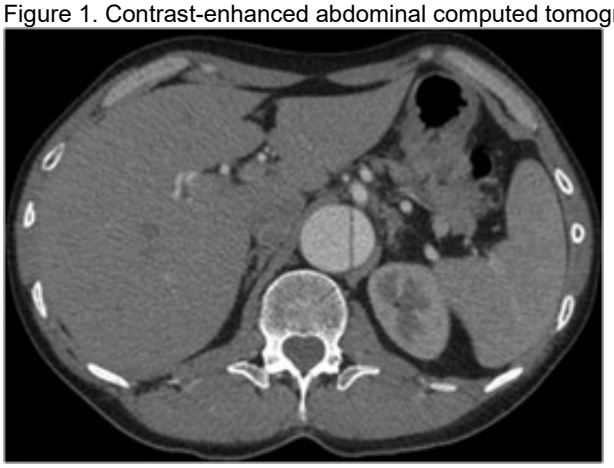
Introduction and Purpose: Abdominal aortic dissection (AAD) is a rare but life-threatening vascular emergency characterized by the intrusion of blood into the media layer of the aortic wall due to an intimal tear. The clinical presentation is often nonspecific, which can complicate timely diagnosis and delay appropriate management.

Materials and Methods: A 58-year-old male presented to the emergency department with sudden-onset, severe abdominal and lower back pain described as tearing in nature. He reported no prior similar episodes. The pain radiated to the lumbar region and was unaffected by changes in position. The patient had hypertension. On arrival, his blood pressure was markedly elevated at 180/110 mmHg.Physical examination revealed a soft abdomen with mild tenderness in the epigastric region upon deep palpation. Peripheral pulses were bilaterally symmetrical, and no motor weakness was observed in the lower extremities. Laboratory results indicated a mildly elevated lactate level.Initially, differential diagnoses included renal colic and musculoskeletal pain. However, given the patient's clinical presentation and hypertensive background, imaging was pursued to assess for aortic pathology. Contrast-enhanced abdominal computed tomography (CT) revealed a dissection of the abdominal aorta (Figure 1). The patient was immediately admitted to the intensive care unit, and emergency surgical intervention was undertaken by Cardiovascular Surgery team. The operation was successful, and the patient was discharged in stable condition following postoperative recovery.

Figure 1. Contrast-enhanced abdominal computed tomography of the patient revealing the dissection of the abdominal aorta



Results and Conclusion: AAD most commonly presents with acute-onset abdominal or lumbar pain. Hypertension remains the primary risk factor contributing to the development of dissection. Due to its overlapping symptoms with other abdominal and musculoskeletal conditions, AAD is frequently misdiagnosed. Therefore, a high index of suspicion and timely imaging—particularly CT angiography—are essential for accurate diagnosis and prompt intervention.AAD is a potentially fatal condition that necessitates early recognition and swift management. Clinicians should maintain a high level of suspicion in patients with risk factors such as hypertension who present with atypical abdominal or back pain. Timely diagnosis is key to improving outcomes and preventing complications.

Keywords: abdominal aortic dissection, abdominal pain, hypertension

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Ref No: 6292

Mad Honey (Grayanotoxin Poisoning)

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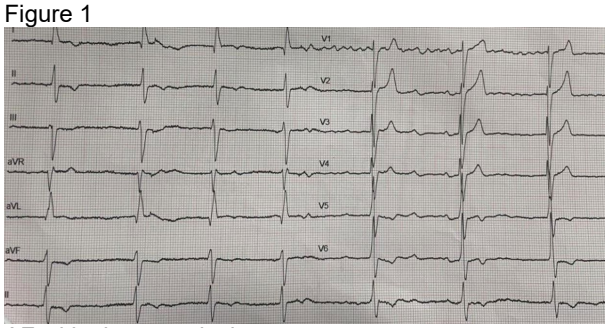
Introduction and Purpose: Mad honey poisoning, occurs not only from honey but also from the boiling or ingestion of the leaves of the Rhododendron plant. The poisoning is caused by the intake of a substance called grayanotoxin, which is present in these plants.Poisoned honey is brown in color and is characterized by delayed crystallization.Clinical Effects: The most common effects are bradyarrhythmias and hypotension with 90%. Sweating, lightheadedness, and changes in consciousness (70%), Syncope (30%) Diplopia and blurred vision (20-80%) Hypersalivation (14%) Gastroenteritis, burning throat, flushing of the skin, blurred vision or temporary blindness, malaria-like fever spells Cholinergic effects on the heart in poisoning with low doses (bradycardia, hypotension) In high doses, epinephrine-related effects (tachycardia, hypertension) come to the fore in the adrenal medulla.Definitive Diagnosis: Chromatography is the most important method; however, because it is not available everywhere, alternative methods are employed. One such method involves searching for pollen in the honey:

Materials and Methods: A 56-year-old male with a history of hypertension and coronary artery bypass grafting (CABG, 2016) presented to our emergency department with complaints of dizziness and weakness. On arrival, his Glasgow Coma Score was 15. Vital Signs: Temperature: 36.6°C Blood Pressure: 80/41 mmHg,Pulse: 37 bpm,SpO□ 100% EKG: AF with slow ventricular response (Figure 1) Physical Examination: On inspection, the patient exhibited an ashen appearance and was sweating. Breath sounds were bilaterally equal and normal. The neurological examination was normal, with no lateralizing signs, no motor deficit, and normal cerebellar tests. The patient's history revealed that he had consumed honey in the morning.Laboratory Results: (Hgb) 14.5 g/dL WBC 7.6 (×10⁹/L) Sodium

(Na) 138 mmol/L Potassium (K) | 3.8 mmol/L Troponin 15 Creatinine (Cre) 1.2 mg/dL Blood Gas Analysis:pH 7.38 HCO □□24 mEq/L Lactate 1.5 mmol/L CO □42 mmHg The patient was admitted to the Coronary Intensive Care Unit with Mad Honey Syndrome. The patient was discharged with recovery after a 3-day hospital stay. He was subjected to periodic cardiology outpatient clinic control for 3 months.

Figure 1



AF with slow ventricular response

Results and Conclusion: Treatment with intravenous (IV) atropine (0.5–2 mg) along with adequate IV fluid therapy resulted in most patients regaining a normal sinus rhythm and normal blood pressure after treatment.

Keywords: Mad Honey

Ref No: 6346

STONE BLOCKING THE DUCT

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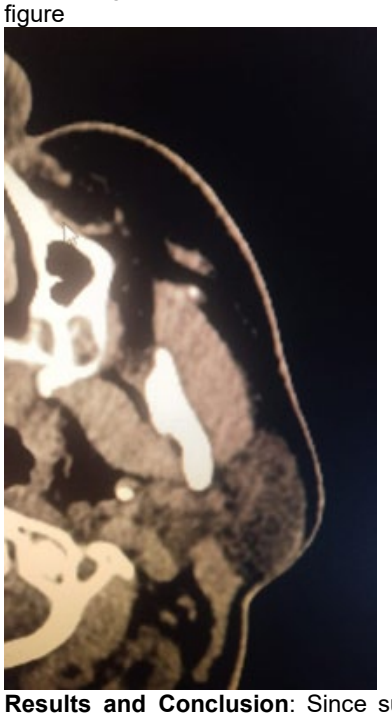
Introduction and Purpose: Acute, localized swelling of the salivary gland is most commonly caused by obstruction, with sialolithiasis (salivary gland stones) being the most frequent etiology. Ductal strictures are also a common cause of obstruction, either alone or in combination with stones. Other common causes of acute, focal gland swelling include bacterial infections and inflammation following external beam radiation. The underlying cause—whether obstruction, bacterial infection, or post-radiation effects—can usually be determined through clinical history and physical examination, and treatment varies accordingly.

Materials and Methods: A 32-year-old male patient presented to our emergency department with complaints of left cheek pain that had persisted for several days, worsening particularly after meals, and swelling that had developed over the past day. The patient denied fever, chills, sweating, or sore throat. His medical history was unremarkable, with no known comorbidities or medication use. Vital signs were within normal limits. On physical examination, tenderness was noted over the left parotid gland. Further history revealed that the symptoms had been recurrent, sometimes accompanied by fever, foul breath, and oral discharge around the right buccal area. Suspecting parotid abscess or ductal stricture, a CT scan was performed, revealing a stone in the left Stensen's duct.

figure



Results and Conclusion: Since suppurative parotitis can spread to the deep fascial spaces of the head and neck, posing a life-threatening risk, initial treatment should be inpatient care. However, in our case, since sialadenitis was not complicated by an abscess,

the patient was managed with nonsteroidal anti-inflammatory drugs (NSAIDs) and educated on the potential progression to abscess formation. Proper outpatient follow-up and patient education are crucial aspects of emergency care in such cases.
Keywords: Sialolithiasis, Stensen's Duct, Suppurative Parotitis

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Ref No: 6379
Todd Paralysis
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[1]ANKARA BİLKENT ŞEHİR HASTANESİ
Introduction and Purpose: Todd's paralysis, also known as Todd's palsy, is a clinical syndrome characterized by the transient focal neurological deficits that occur after a seizure. While it generally presents with temporary unilateral muscle weakness in the postictal period, it can also manifest less commonly as aphasia, hypesthesia, memory loss, and visual disturbances.The cause of Todd's paralysis is a temporary stroke-like condition that arises immediately following a seizure. This condition is associated with a seizure that occurs prior to the clinical manifestation.
Materials and Methods: A 59-year-old male patient was brought to the emergency department by the 112 emergency team after experiencing three seizures one hour prior to admission. According to information from his relatives, he has a known diagnosis of epilepsy and had not been taking his medication regularly. His most recent seizure occurred approximately 3 months ago.Glasgow Coma Score (GCS):15. Blood pressure:150/80 mmHg, Heart rate:86 bpm,Capillary blood glucose:106, ECG:SR. Neurological examination:Conscious, cooperative, oriented, speech dysarthric. Pupils are isocoric, direct/indirect reflexes ++/++.Left NLO (Neglect/Apraxia):Minimal,Left Upper Limb Motor Strength: 3/5,Left Lower Limb Motor Strength:2/5.Medical history:Epilepsy,Diabetes Mellitus.Medications:Keppra,Depakine,Acetylsalicylic acid,Klopidogrel, İnsulin glarjin.An acute cerebrovascular event was suspected based on the patient's presentation. Brain CT and diffusion MRI were ordered. Early neurology consultation was performed. The brain CT:"No intracranial hemorrhage was detected." Diffusion MRI did not show any acute diffusion restriction.Laboratory:pH:7.199, pCO2:37.3, HCO3:14.2, Lactate:9.17, Glucose:106.The EEG revealed focal epileptiform abnormalities originating from the right temporal region.Based on the patient's symptoms, clinical examination and results, an acute ischemic stroke was ruled out.Todd's paralysis was considered as the primary diagnosis.A neurology consultation was conducted for further evaluation and the patient was admitted for follow-up and advanced diagnostic testing.
Results and Conclusion: Todd's paralysis plays a crucial role in the differential diagnosis of patients presenting with acute stroke-like symptoms in the emergency department. Temporary focal neurological deficits that develop during the postictal period may be confused with ischemic stroke.In patients with a history of epilepsy, evaluating adherence to antiepileptic treatment plays a critical role in the differential diagnosis of neurological findings after seizures. Therefore, a comprehensive evaluation of patients with neurological deficits, timely application of advanced diagnostics, and a multidisciplinary approach are essential.
Keywords: Todd's paralysis, Status epilepticus, Postictal temporary neurological deficit

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Ref No: 6420
KIDNEY LACERATION AFTER LOW-ENERGY TRAFFIC ACCIDENT
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Introduction and Purpose: Patients who come to the emergency room after traffic accidents may not show any findings on physical examination due to the shock they experience. Since whole body imaging is generally performed in severe traffic accidents, major injuries are prevented from being missed. In low-energy accidents, diagnoses can be missed due to many conditions such as late examination findings and the patient's high pain threshold. This case shows that there may be serious injuries to internal organs in a low-energy case.
Materials and Methods: A 20-year-old male patient presents to the emergency department with a complaint of left flank pain following a low-energy vehicle traffic accident. On admission, vital signs were stable. Physical examination at the center revealed that the abdomen was comfortable, and the only pathological finding was left costovertebral angle tenderness. The patient had no additional complaints other than left flank pain. He had no complaints of hematuria or dysuria. His urine was pale yellow. Laboratory results showed hemoglobin (Hgb) as 14.5 g/dL (baseline: 15.8 g/dL), and kidney and liver function tests were within normal limits. No acute pathology was detected in the non-contrast abdominal tomography, but a suspicious heterogeneity that could not be distinguished from artifact was observed in the left pararenal area.The patient was discharged after explaining the emergency conditions. The next day, the patient applied to our emergency department with complaints of hematuria. Contrast-enhanced abdominal tomography was performed for the patient who described hematuria and continued costovertebral angle tenderness in terms of abdominal injury.Contrast-enhanced abdominal tomography revealed increased density consistent with widespread hematoma in the left retroperitoneal and perirenal areas and grade 3 renal laceration(Figure 1-2). Urology was consulted and the patient was admitted to the urology department for hematoma, hemoglobin and urine output monitoring.
Figure 1

Appearance compatible with bleeding around the left kidney on contrast-enhanced abdominal tomography(Axial)
Figure 2

Appearance compatible with bleeding around the left kidney on contrast-enhanced abdominal tomography(Sagittal)

Results and Conclusion: This case highlights that non-contrast tomography may be inadequate in the early period after abdominal trauma and the importance of contrast tomography in case of suspicious findings. Contrast tomography plays a critical role in the diagnosis of kidney injuries in patients with hematuria, which may be seen in association with low-energy trauma.

Keywords: kidney injury, traffic accident, low energy

Ref No: 6426

THE ROAD FROM HIP PAIN TO THE OPERATING ROOM

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Introduction and Purpose: Fournier's gangrene is a rapidly progressing necrotizing fasciitis that affects the genital, perineal, and anal regions, and is sometimes life-threatening. Although it is rare, it requires emergency surgical debridement in addition to antibiotic treatment and is a critical condition involving general surgery and urology clinics. The most common causes of the disease are anorectal infections, genitourinary infections (e.g., urinary tract infections), trauma, or local injuries to the perineal and genital skin. Perianal infections (abscesses) are the most common factor and may develop either as a primary infection or secondarily following perianal surgery.

Materials and Methods: A 71-year-old male patient presented with complaints of hip pain. The patient has a known diagnosis of hypertension and has had widespread pain and redness in the anal region for about a week. Upon arrival, the patient's vital signs were stable. On examination, there was widespread redness extending from the anal area toward the scrotum, with crepitus. Blood tests were

ordered, and a CT scan was performed. Antibiotic treatment was initiated in the emergency department. The patient's CT scan was reported as follows: "Changes in the skin, subcutaneous tissue, and fatty layers starting from the scrotal level and extending to the perianal region, with air densities observed between muscle planes. The perianal and perirectal fatty planes appear dirty (suspected Fournier's gangrene?)." The patient was referred to the general surgery department and was admitted to the emergency department for general surgery.

PHOTO 1

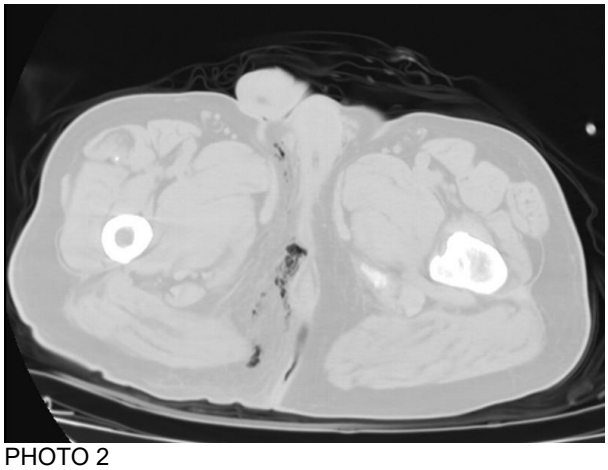

PHOTO 2

Results and Conclusion: In the emergency department, empirical broad-spectrum triple therapy, covering gram-positive, gram-negative, and aerobic organisms, should be initiated. Early surgical intervention is crucial for the prognosis.

Keywords: FOURNIER'S GANGRENE, PERIANAL INFECTIONS, NECROTIZING FASCIITIS

Ref No: 6492

A Case Report Of Pulmonary Embolism

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[1]Pamukkale University

Introduction and Purpose: Pulmonary embolism (PE) is a life-threatening condition resulting from the obstruction of pulmonary arteries by emboli, most commonly originating from deep vein thrombosis (DVT). The clinical presentation of PE can be highly variable, ranging from mild symptoms such as dyspnea to severe manifestations, including syncope and cardiac arrest. Due to its nonspecific symptoms, early diagnosis of PE remains a significant challenge in emergency medicine. This case highlights the importance of comprehensive assessment and prompt diagnostic evaluation in patients presenting with syncope, particularly those with predisposing factors for thromboembolism.

Materials and Methods: A 63-year-old male patient presented to our emergency department (ED) with syncope following by a fall from his level in the bathroom. He did not recall the events following the fall and stated that he regained consciousness in the hospital.On initial examination, the patient exhibited tachycardia, while other vital signs remained within normal limits. His medical history included hypertension and diabetes. Physical examination revealed the presence of a short leg splint on the left foot and a short arm splint on the left hand. The patient reported pain in the left shoulder and head, and an abrasion was noted in the occipital region. Although range of motion in the left shoulder was painful, it was otherwise normal. It was noted that the patient had sustained a left foot fracture due to a fall two weeks prior, necessitating splinting.Electrocardiography (ECG) demonstrated sinus tachycardia. The patient's blood glucose level was 112 mg/dL, and rectal examination revealed no abnormal stool findings. Brain computed tomography (CT) scans did not show any pathological abnormalities. Given the patient's Wells score, which classified him as moderate-risk, a CT angiography with an embolism protocol was performed. The imaging revealed findings consistent with PE in both main pulmonary arteries. Consequently, a consultation with the pulmonology department was requested.Thrombolytic therapy was initiated in the ED. After appropriate monitoring for potential bleeding complications, the patient was admitted to the pulmonology ward for further management.

Results and Conclusion: This case underscores the importance of thoroughly reviewing prior medical visits and conducting a

comprehensive physical examination to facilitate a rapid and accurate diagnosis in the emergency setting
Keywords: physical examination, pulmonary embolism, syncope

Ref No: 6493
Malaria Following Travel to India: A Case Report
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Introduction and Purpose: Malaria is a potentially life-threatening parasitic disease caused by Plasmodium species and transmitted by Anopheles mosquitoes, predominantly endemic in sub-Saharan Africa, South Asia, and Southeast Asia. India remains one of the major endemic regions, where both Plasmodium vivax and Plasmodium falciparum coexist, complicating diagnostic and therapeutic strategies. In returning travelers, malaria poses a diagnostic challenge due to its non-specific presentation, often mimicking other febrile illnesses. Early identification and management are essential to prevent severe complications, particularly in P. falciparum infections.
Materials and Methods: We report the case of a 20-year-old previously healthy female who presented to the emergency department with a one-week history of persistent fever, intermittent abdominal pain, and nausea. The patient had returned from a six-week stay in rural India three days earlier and reported mosquito bites, as well as similar symptoms in a travel companion. On admission, she was alert, oriented, and hemodynamically stable. Physical examination revealed pigmented maculopapular rashes on the anterior aspects of both tibias. Laboratory evaluation showed leukocytosis (WBC: 11,000/μL), neutrophilia (9,900/μL), anemia (hemoglobin: 7.5 g/dL), and elevated inflammatory markers (CRP: 59 mg/L, procalcitonin: 0.25 μg/L). Abdominal ultrasonography was unremarkable. A rapid diagnostic test for Plasmodium antigens returned positive, confirming the diagnosis of malaria. The patient was referred to the infectious diseases department and admitted for treatment and follow-up.
Results and Conclusion: This case emphasizes the importance of considering malaria in the differential diagnosis of febrile illnesses in patients with a recent travel history to endemic areas. Clinical findings such as rash, systemic symptoms, and laboratory abnormalities should raise suspicion. Rapid diagnostic tests can aid early identification, especially in emergency settings where time-sensitive treatment is critical. Management should be tailored based on the Plasmodium species and disease severity. In addition to antiparasitic therapy (e.g., ACTs or chloroquine-primaquine combinations), supportive care and close monitoring are vital to prevent complications.In conclusion, malaria should be considered early in patients presenting with fever and recent travel to endemic regions. Raising clinical awareness and adhering to updated diagnostic and therapeutic guidelines are key strategies to reduce malaria-related morbidity and mortality in travelers.
Keywords: Malaria, Plasmodium falciparum, Fever

Ref No: 6600
The Importance of Cardiopulmonary Resuscitation"
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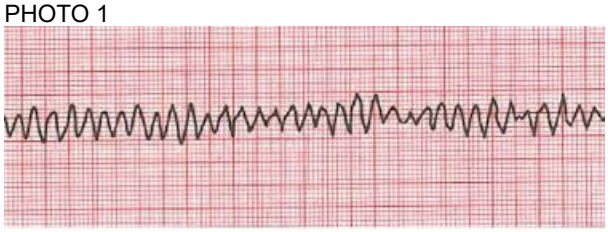
Introduction and Purpose: Ventricular fibrillation is the most critical cardiac arrest rhythm. The ventricles attempt to contract at speeds up to 500 beats per minute. The rapid and irregular electrical activity prevents the ventricles from contracting synchronously, leading to a sudden loss of cardiac output. Without prompt advanced life support, this rhythm is invariably fatal. Prolonged ventricular fibrillation results in a decrease in wave amplitude, transitioning from coarse VF to fine VF and eventually to asystole, due to the depletion of myocardial energy sources.
Materials and Methods: A 66-year-old male patient with a history of hypertension and treatment for prostate cancer 8 years ago presented after sudden convulsions and subsequent loss of consciousness while sitting on a bench in front of his hotel. The ambulance team assessed the patient at the scene, and after being unable to detect a pulse, they initiated CPR. Upon monitoring, the patient's heart rhythm was identified as ventricular fibrillation, and the patient was defibrillated. Upon arrival at our facility, no palpable pulse was detected, and CPR continued. The patient was rapidly monitored, and after assessing the rhythm as ventricular fibrillation again, the patient was defibrillated, and CPR continued. The patient was defibrillated a total of 14 times due to ventricular fibrillation. After approximately 1 hour and 40 minutes of effective CPR, a pulse was detected upon re-evaluation, and the patient was promptly consulted with the cardiology department. An emergency echocardiogram revealed widespread wall motion abnormalities, and the ejection fraction (EF) was assessed as 20%. The patient was quickly taken for coronary angiography.
PHOTO 1



Results and Conclusion: In patients where the heart rhythm cannot be restored, rapid monitoring is crucial In shockable rhythms, the faster defibrillation is administered, the higher the patient's survival rate.
Keywords: DEFIBRILLATION, SHOCKABLE RHYTHMS, VENTRICULAR FIBRILLATION.

Ref No: 6636
Analysis of studies conducted on Artificial Intelligence (AI) in Emergency Services
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Introduction and Purpose: It is observed that the number of articles utilizing artificial intelligence (AI) methods in medicine has increased over the years. AI holds promise in numerous applications within emergency medicine, including the interpretation of diagnostic imaging, predicting patient outcomes, and monitoring vital signs. This study was conducted with the aim of bibliometrically analyzing studies related to AI in emergency medicine (EM) specifically after the year 2020.
Materials and Methods: A search was conducted on Google Scholar. Studies related to AI in emergency services were recorded. The studies were examined in terms of their type, branch, subject, journal, methodology, and results.
Results and Conclusion: Since 2020, five studies related to AI in the emergency department have been identified. One was conducted in 2020, three in 2021, and one in 2022. All three studies in the EM field were published in 2021. All of them were of the review type. In our study, we were able to identify only five works related to AI in emergency services since 2020, a number that we find insufficient. EM, by its very nature, is one of the disciplines that constantly incorporates the latest developments and innovations in the field of medicine. AI should not be excluded from this vision, and more dedicated efforts should be made to explore its applications in emergency services. The limited number of studies highlights the need for increased attention and research dedicated to the use of AI in emergency departments.
Keywords: Emergency Medicine, Publication, Artificial Intelligence.

Ref No: 6686
HOOKAH BOY
ABDULLAH SÜHA AKÇA[1], AYÇA ÇALBAY[1]
[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP ANABİLİM DALI
Introduction and Purpose: Carbon monoxide (CO) poisoning is a potentially life-threatening condition caused by industrial exposure, fires, or inadequate ventilation in enclosed spaces. CO has a high affinity for hemoglobin, reducing oxygen transport capacity and leading to tissue hypoxia. The clinical presentation is often non-specific, including dizziness, nausea, headache, and altered consciousness. This case report discusses the diagnosis and management of CO poisoning in a patient with persistent symptoms unresponsive to symptomatic treatment, whose detailed history revealed chronic exposure to hookah smoke.
Materials and Methods: A 25-year-old male patient with no known comorbidities presented with dizziness and nausea persisting for one week. Despite symptomatic treatment, his complaints did not resolve, prompting further investigation. Upon detailed history-taking, it was discovered that he had recently started working at a hookah café.Arterial blood gas analysis revealed a carboxyhemoglobin (COHb) level of 19%. The patient was immediately started on high-flow oxygen therapy via a non-rebreather mask and admitted to the emergency intensive care unit for further monitoring and treatment.
Results and Conclusion: This case highlights that carbon monoxide poisoning can present with atypical clinical manifestations and that detailed history-taking plays a crucial role in early diagnosis. Risk factors such as prolonged exposure to hookah smoke in poorly ventilated environments may be overlooked, leading to delayed recognition of CO poisoning. Early diagnosis and appropriate treatment are essential in preventing complications and improving patient outcomes.
Keywords: HOOKAH, CO İNTOXİCATİON

Ref No: 6700
Pneumothorax Following a Gunshot Injury
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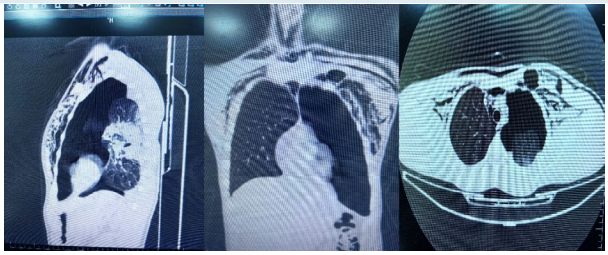
Introduction and Purpose: Gunshot wounds, especially those affecting the thoracic region, can lead to serious morbidity and mortality due to associated complications. One of the most common complications in such cases is pneumothorax, which requires urgent intervention and appropriate treatment approach. Determining the etiology of pneumothorax is very important for rapid and definitive treatment. In this study, we will present you a case that shows that pneumothorax requires close follow-up even after treatment.
Materials and Methods: A 25-year-old male patient was admitted to the emergency room at a different center due to a gunshot wound. A chest tube was inserted into his left lung due to pneumothorax and hemothorax due to the gunshot wound at the external center, which had an entry at the left anterior mid-clavicular line, 5th rib level, and an exit at the left scapular posterior axillary, 6th rib level. The chest tube was removed after the patient's pneumothorax and hemothorax regressed during follow-up. The wounds due to the gunshot were sutured and he was discharged. 2 days after discharge, he applied to the emergency room with complaints of pain and bleeding in the area where the chest tube was inserted. The patient's vital signs were: Blood pressure: 115/70 mmHg, Fever: 36°C, Heart rate: 130 beats/minute, Oxygen saturation: 88%, Respiratory rate: 20 breaths/minute. Physical examination revealed pain in the left thoracic anterior region. On auscultation, there were decreased breath sounds on the left side and widespread crepitation in the left upper extremity. Non-contrast thoracic computed tomography (CT) scan was performed and showed widespread pneumothorax, pneumomediastinum, and subcutaneous emphysema extending to the upper extremities in the left lung (Figure 1-2-3). The patient was admitted to the Department of Thoracic Surgery for consultation and further follow-up and treatment.
Figure 1



Axial, coronal and sagittal views of widespread pneumothorax, subcutaneous emphysema extending to axillary and cervical regions, and pneumomediastinum

Results and Conclusion: This case highlights the significance of long-term complications in patients undergoing surgical intervention following pneumothorax. Early diagnosis and intervention play a critical role in the management of complications and improving patient prognosis. Such cases require a multidisciplinary approach and careful follow-up.

Keywords: pneumothorax, pneumomediastinum, Gunshot Injury

Ref No: 6762

A Diagnosis That Can Be Overlooked: Digoxin Intoxication

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Introduction and Purpose: Digoxin intoxication is a potentially life-threatening condition caused by excessive intake of cardiac glycosides. Early diagnosis and proper treatment are crucial to prevent severe cardiac and systemic complications.

Materials and Methods: An 84-year-old female patient presented to the emergency department with complaints of nausea and vomiting that started today. She also reported a decrease in oral intake for the past week. Vital signs on admission: Blood pressure 137/63 mmHg, temperature 36.8 °C, oxygen saturation 96% on fingertip measurement, heart rate 40 bpm. The patient had a known history of hypertension, atrial fibrillation, and heart failure. Medications used: Beloc, warfarin, digoxin, desal. She had undergone percutaneous coronary angiography four years ago. On physical examination, the patient was conscious, oriented, and cooperative. Neurological examination was unremarkable. Bilateral basal rales were present on lung auscultation. Abdominal examination was normal with no defense or rebound, and bilateral costovertebral angle tenderness was negative. Rectal examination was normal with no stool contamination.Electrocardiography (ECG) showed atrial fibrillation with a slow ventricular response, accompanied by ventricular extrasystoles. Based on these findings, digoxin intoxication was suspected. Laboratory test results: Creatinine 1.56 mg/dL (consistent with baseline), CRP 13.67 mg/L, pH 7.42, INR 1.24, hemoglobin 9.9 g/dL, troponin T: 0-hour 54.6 ng/L, 1-hour 52.9 ng/L, digoxin level 4.22 ug/L (upper limit 1.2 ug/L).The patient with digoxin intoxication was admitted to the cardiology unit. After discharge, she presented again to the emergency department due to a warfarin overdose.

ECG

Results and Conclusion: The purpose of presenting this case is to emphasize that in elderly patients with multiple comorbidities, non-specific symptoms may be attributed to polypharmacy.

Keywords: Digoxin intoxication, polypharmacy, ECG

Ref No: 6829

Acute Appendicitis

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Introduction and Purpose: Early diagnosis and rapid surgical intervention are vital to prevent complications and improve patient prognosis in acute appendicitis.

Materials and Methods: A 22-year-old female patient presents with abdominal pain that has been ongoing for approximately 1 day. The pain initially occurred around the umbilicus, but shifted to the right lower abdomen within a few hours. She describes nausea, vomiting once, and loss of appetite. Her temperature was measured as 37.8°C, and she has no history of similar complaints. The patient's general condition appears moderately unwell, with a slightly elevated fever. Abdominal examination: There is marked defense and rebound in the right lower quadrant. The most severe pain is felt at McBurney's point on deep palpation. Laboratory tests show a leukocyte count of 14,000/mm³ and high CRP, supporting inflammation. The β-hCG pregnancy test performed for differential diagnosis was negative (ectopic pregnancy was ruled out). Contrast-enhanced abdominal CT scan confirmed that the appendix was inflamed and

there was slight fluid accumulation around it, supporting the diagnosis of acute appendicitis.Diagnosis: Acute appendicitis (confirmed by clinical, laboratory and imaging findings).Differential Diagnosis: Other conditions that may cause right lower abdominal pain include mesenteric lymphadenitis (especially in children with viral infection), gastroenteritis (more common, with diffuse abdominal pain and diarrhea), ureteral stones (kidney stones) (pain radiating from the flank tothe groin on the right side, blood in the urine), gynecological pathologies – especially in female patients, ovarian torsion or ruptured ovarian cyst (sudden onset of pain) and pelvic inflammatory disease, as well as ectopic pregnancy.Treatment and Outcome: As soon as the patient was diagnosed, intravenous fluids and broad-spectrum antibiotics were started. The patient was taken to surgery by the general surgery team and an emergency laparoscopic appendectomy was performed. During the surgery, it was observed that the appendix was inflamed and thickened, but there was no perforation or abscess. The patient recovered rapidly in the postoperative period and started taking oral medication. The patient was afebrile and asymptomatic on the second postoperative day and was discharged with appropriate antibiotic therapy and wound care recommendations.

Results and Conclusion: Early diagnosis and rapid surgical intervention are vital to prevent complications and improve patient prognosis.

Keywords: Acute appendicitis, Pain

Ref No: 6848

Necrotizing Fasciitis İn The Anal Area

Alparslan Altun[1]

[1]**Necrotizing Fasciitis İn The Anal Area**

Introduction and Purpose: Necrotizing fasciitis is a disease characterized by rapidly spreading necrosis of soft tissues and fascia and can be fulminant if not treated appropriately. Although many bacteria are causative agents (Group A streptococcus, Clostridium perfringens, Bacteroides fragilis), Group A streptococcus is the most common agent. The most common sites are perineum and inguinal regions.

Materials and Methods: A 80 year old male patient presented with complaints of anal pain and constipation for 5 day. He was diagnosed with DM. Vitals were bp: 155/80 sat: 94 hr: 76 fever: 37.2. Rectal touch examination revealed tenderness and induration in the anal area. In blood tests, wbc was high in neutrophil dominance and crp was elevated. There was also a minimal increase in creatinine values. In imaging, it was determined as 'In CT interpretation, there are increases in density and air densities in the perianal region and an 8 CM sized loculation extending into the abdomen along the left endopelvic fascia along the left endopelvic fascia into the left anterolateral of the bladder and air densities in it'. The patient was consulted to the general surgery clinic. He was hospitalized with a diagnosis of necrotizing fasciitis by general surgery.

Results and Conclusion: Early diagnosis is the most important factor in the treatment of necrotizing fasciitis. The diagnosis is mainly based on clinical findings. In fact, the most important thing is the suspicion of necrotizing fasciitis by the physician evaluating the patient. As in this patient, early detection and treatment of necrotizing fasciitis, especially in elderly patients, is of life-saving importance.

Keywords: Necrotizing fasciitis, air densities, fulminant

Ref No: 6869

SHOULDER DISLOCATION

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Introduction and Purpose: Shoulder dislocation means the separation of the humeral head from the glenoid cavity, and anterior, posterior or inferior discolation may develop. Such injuries necessarily require reduction. Posterior shoulder dislocation is much rarer than anterior. This type of dislocation can typically be seen as a result of trauma to the anterior part of the shoulder. On examination, the forward flattening and the prominence of the posterior shoulder can be felt by palpation. The patient holds his arm in adduction and internal rotation; he cannot perform external rotation.

Materials and Methods: A 13-year-old boy is admitted with a complaint of falling on his left shoulder. During the physical examination, there was limited movement in the left shoulder girdle. Neurovascular examination was unremarkable, pulses were clear, capillary filling was natural. In the diagnostic imaging performed, there was a dislocation of the shoulder posteriorly and free air was seen at the joint site. The patient has consulted to the Orthopedics. After the reduction, which was tried under sedation, the shoulder was reduced, but stability could not be achieved. Due to capsule tear and shoulder instability, surgical intervention was planned and admitted to the Orthopedics service.

Results and Conclusion: AP graphy, which is often preferred in minor traumas in the emergency department, can often be overlooked in posterior shoulder dislocation. For the diagnosis, the bulb finding, rim finding, edge mark and groove line mark can be kept in mind as clues. Therefore, computer tomography may be necessary to determine the exact extent of the injury. Orthopedic consultation is usually required before attempting to reduce posterior shoulder dislocation.

Keywords: shoulder dislocation

Ref No: 7154

Prognostic Role of Growth Differentiation Factor 15 (GDF-15) in Patients After Cardiac Arrest

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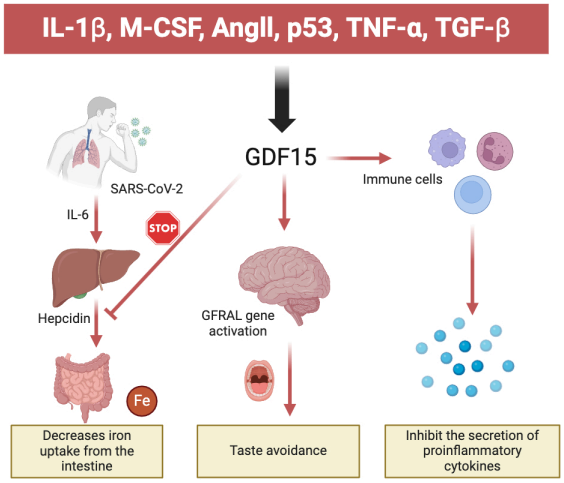
Introduction and Purpose: Patients who survive cardiac arrest encounter considerable obstacles in attaining positive long-term results,

with neurological damage serving as a critical factor in prognosis. Timely identification of individuals predisposed to adverse outcomes is essential for informing clinical decisions and enhancing post-resuscitation treatment. Growth differentiation factor 15 (GDF-15), a cytokine responsive to stress and implicated in inflammatory and reparative mechanisms, has surfaced as a potential biomarker for cardiovascular disease and other severe illnesses (Fig. 1). Recent investigations indicate its usefulness as a prognostic marker post-CA. This meta-analysis seeks to assess the predictive value of GDF-15 in forecasting survival and neurological outcomes in patients following cardiac arrest.

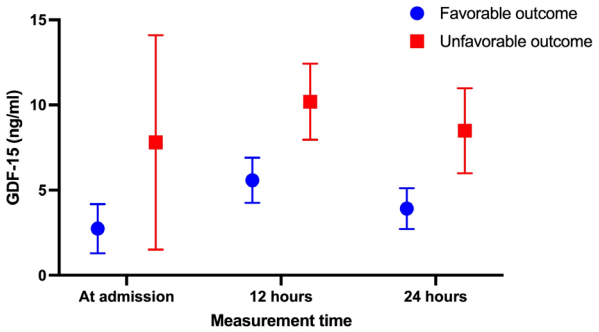
Figure 1. Mechanism of action of GDF15



Materials and Methods: This meta-analysis was conducted in accordance with PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines. A comprehensive literature search was performed across major databases, including PubMed, Web of Science, and Scopus, for studies published up to 12 March 2025.

Results and Conclusion: This meta-analysis included two studies evaluating the prognostic utility of GDF-15 levels in patients following cardiac arrest. The pooled analysis revealed significantly lower GDF-15 concentrations in patients with a favorable neurological outcome at 6 months compared to those with an unfavorable outcome (2.74±1.442 ng/ml vs. 7.806±6.294 ng/ml; mean difference [MD]= -2.52; 95% confidence interval [CI]: -2.87 to -2.16; $p < 0.001$; Figure 2). This pattern persisted in serial measurements, with GDF-15 levels at 12 hours post-cardiac arrest being 5.581±1.332 ng/ml in the favorable outcome group versus 10.194±2.232 ng/ml in the unfavorable outcome group (MD = -4.61; 95% CI: -5.52 to -3.70; $p < 0.001$), and at 24 hours post-cardiac arrest, 3.919±1.204 ng/ml versus 8.489±2.499 ng/ml (MD= -4.57; 95% CI: -5.53 to -3.60; $p < 0.001$). Additionally, GDF-15 levels were markedly lower in survivors compared to deceased patients (1.824±0.312 ng/ml vs. 4.153±1.603 ng/ml; MD = -2.33; 95% CI: -2.77 to -1.89; $p < 0.001$).In conclusion, these results indicate a strong association between lower GDF-15 levels and improved neurological outcomes as well as higher survival rates following cardiac arrest. GDF-15 emerges as a promising biomarker for prognostic stratification in this patient population, offering potential utility in guiding clinical decision-making and risk assessment.

Figure 2. Pooled analysis of GDF-15 as a function of measurement time.



Keywords: Growth differentiation factor 15, GDF -15, cardiac arrest

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Ref No: 7217

Acute Appendicitis in the Geriatric Population: A Case Report

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Introduction and Purpose: Acute appendicitis is one of the most common causes of acute abdomen requiring surgical intervention. Although it predominantly affects younger individuals, its occurrence in the geriatric population is rare and often underrecognized. In patients aged 60 and above, acute appendicitis constitutes only 5–10% of total cases, and this rate drops to approximately 1–2% in individuals over 80 years of age. Diagnosis in this age group poses a significant clinical challenge due to atypical symptomatology,

diminished physiological responses to inflammation, and the frequent presence of comorbidities. Delayed diagnosis increases the risk of complications such as perforation, intra-abdominal abscess, and sepsis, contributing to higher morbidity and mortality rates compared to younger populations.

Materials and Methods: We report the case of a 91-year-old male with a medical history of coronary artery disease and hypertension, who presented to the emergency department with abdominal pain localized to the right lower quadrant, which had started one day prior. On examination, the patient was alert, oriented, and hemodynamically stable. Abdominal tenderness and guarding were noted in the right lower quadrant. Laboratory parameters were within normal limits except for mild inflammatory markers. Initial ultrasonography revealed an enlarged appendix measuring 12 mm in diameter with pericecal fluid accumulation. Further evaluation with contrast-enhanced abdominal computed tomography confirmed the presence of an inflamed appendix measuring 11 mm in diameter, with thickened walls and surrounding fat stranding. No evidence of perforation or abscess was observed. The patient was diagnosed with acute appendicitis and was admitted to the general surgery department, where surgical management was preferred over conservative treatment.

Results and Conclusion: This case highlights the importance of considering acute appendicitis in elderly patients presenting with nonspecific abdominal pain. Early imaging—particularly ultrasonography and CT—plays a pivotal role in diagnosis when clinical findings are subtle. Treatment should be individualized based on overall health status and surgical risk. A multidisciplinary approach and close postoperative monitoring are essential for favorable outcomes. Increased awareness and timely intervention are key factors in improving prognosis in this vulnerable patient population.

Keywords: Acute Appendicitis, Geriatric Population, Abdominal Pain

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Ref No: 7238

Gastrointestinal bleeding in Bardet-Biedl syndrome

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Introduction and Purpose: Laurence Moon Bardet Biedl syndrome (LMBBS) is a rare autosomal recessive genetic disorder with an estimated incidence of 1/160000. It is a syndrome characterized by obesity, mental retardation, polydactyly, hypogonadism and retinitis pigmentosa. It was first described in the literature by 2 ophthalmologists Zachariah Laurence and Robert Moon in 1866. Structural anomalies and dysfunction of the kidneys, diabetes mellitus, insulin resistance, hypertension and liver fibrosis may also be seen in these patients. End-stage renal failure, which develops as a result of progressive deterioration in renal function, is the most common cause of death.

Materials and Methods: A 23-year-old male patient presented with complaints of dark colored stools for 5 days. He has a diagnosis of LMBBS. He receives routine dialysis for chronic renal failure. The last dialysis was 2 days ago and the patient described feeling weak after dialysis. On physical examination, there was no tenderness, defense or rebound on abdominal palpation. melena was observed on digital rectal examination. The patient's hemoglobin was 6 g/dL, hematocrit 18.2%, MCV 85.2 fL, platelets 240000 µL. The patient's oral intake was stopped. Intravenous pantoprazole was administered. intravenous hydration was started and the patient was consulted with Gastroenterology. Endoscopy was performed and upper gastrointestinal (GI) bleeding findings were observed. The patient was then hospitalized in the gastroenterology ward for follow-up and treatment.

Results and Conclusion: In this case report, we reviewed a case presenting with GI bleeding. Various case reports link LMBBS with gastro-esophageal reflux, peptic ulcer disease, non-alcoholic steatohepatitis, hepatic fibrosis, cirrhosis, portal hypertension, bile duct proliferation, dilatation of biliary tract, elevated liver enzymes, primary sclerosing cholangitis, gall stones, Crohn's disease, colonic dysmotility, anal stenosis and Hirschprung's disease.

Keywords: Bardet Biedl syndrome, gastrointestinal bleeding, endoscopy

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Ref No: 7322

Peritonsillar Abscess in a 43-Year-Old Male

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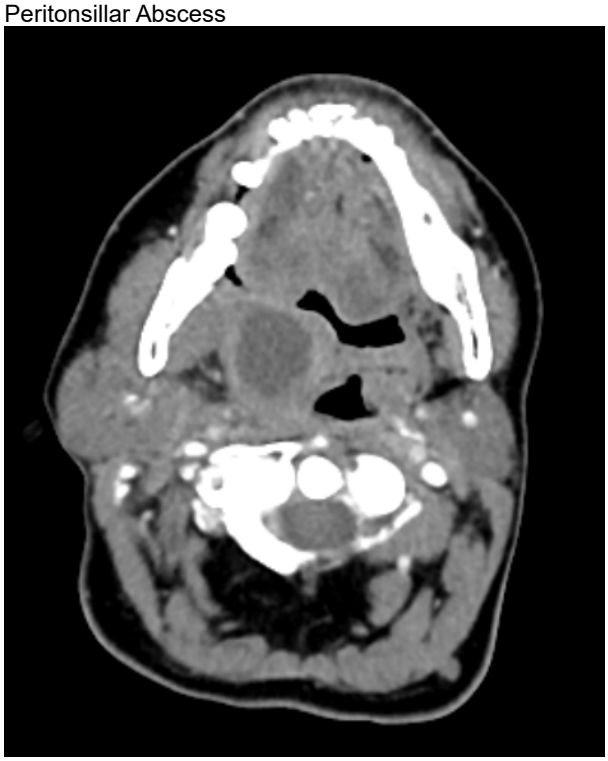
Introduction and Purpose: Peritonsillar abscess is a complication that can develop after acute or chronic tonsillitis. It is commonly seen in young and middle-aged patients and is characterized by the accumulation of pus in the tissues surrounding the tonsils. Peritonsillar abscess presents with symptoms such as severe throat pain, fever, and difficulty swallowing. This case report examines the clinical presentation, diagnosis, and treatment of a patient diagnosed with a peritonsillar abscess.

Materials and Methods: A 43-year-old male patient presented to the emergency department with complaints of sore throat, cough, and fever. The patient had a high fever, throat pain, and swelling. On physical examination, uvular deviation to the left and significant swelling of the right tonsil were observed.Laboratory tests showed significantly elevated CRP and WBC counts, indicating inflammation and infection.CT imaging revealed a 26×28 mm partially thick-walled, peripherally enhancing collection in the right peritonsillar area, consistent with an abscess. This finding strongly suggested the presence of a peritonsillar abscess, leading to the patient's referral to the otolaryngology (ENT) department.Peritonsillar abscess is a bacterial infection that can develop following acute tonsillitis and is most commonly associated with Streptococcus pyogenes. The infection typically begins as tonsillitis and progresses to pus accumulation in the peritonsillar space. Patients frequently present with high fever, sore throat, difficulty swallowing, and fatigue. Physical examination findings often include uvular deviation, swollen tonsils, and pain during swallowing.CT imaging is one of the most important diagnostic tools for peritonsillar abscess, as it helps assess the extent of infection. Once diagnosed, treatment typically consists of antibiotic therapy and, if necessary, surgical drainage.ENT specialists play a crucial role in managing these cases, as some patients may require drainage. Early culture sampling and appropriate antibiotic selection are essential to ensure effective treatment. Initial antibiotic therapy is usually administered intravenously, followed by oral antibiotics based on the patient's clinical response.

Peritonsillar Abscess



Results and Conclusion: This case highlights the importance of clinical findings and imaging in diagnosing peritonsillar abscess. Early diagnosis and treatment are critical in preventing complications and improving patient outcomes. The management of peritonsillar abscess requires a multidisciplinary approach, with early intervention by ENT specialists playing a crucial role in ensuring successful treatment.

Keywords: Peritonsillar Abscess

Ref No: 7348

Nephrolithiasis and Hypoparathyroidism Evaluation as a Cause of Right Side Pain in a Patient Undergoing Thyroidectomy

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Introduction and Purpose: Nephrolithiasis has an increasing prevalence. It is much more common in men than in women. Excessive accumulation of stone-forming substances such as calcium, oxalate and uric acid in the urine and decreased urine volume play a role in its pathophysiology.Hypoparathyroidism is characterized by hypocalcemia and hyperphosphatemia due to parathyroid hormone deficiency. After the surgical procedure, treatment is initiated to prevent hypocalcemia in patients. Treatments are usually vitamin D preparations and supplemental calcium. Therefore, urinary calcium levels should be monitored, adequate fluid intake should be ensured and doses should be adjusted individually.

Materials and Methods: A 53-year-old woman presented to the emergency department with complaints of right flank pain and abdominal pain. The patient had undergone total thyroidectomy three years ago and had missed her endocrinologic follow-up for the last two years. He was being treated for hypothyroidism and had no history of any additional systemic disease. There was also no individual or familial history of nephrolithiasis.On physical examination, right costovertebral angle tenderness and right upper and middle quadrant tenderness were positive. Vital signs were within normal limits. Bedside ultrasonography revealed dilatation in the right renal collecting system and non-contrast abdominal computed tomography (CT) was performed for further investigation. Imaging revealed a hyperdense stone with a diameter of 3x4 mm in the proximal part of the right ureter and an AP diameter of 15 mm in the right renal pelvis.

Results and Conclusion: Concomitant use of vitamin D preparations and calcium supplements may cause nephrolithiasis even in the absence of familial predisposition. In the present case, hypoparathyroidism after thyroidectomy and the lack of follow-up are considered to be predisposing factors in the development of nephrolithiasis.In addition to nephrolithiasis, common diseases such as pyelonephritis, biliary colic and gastrointestinal pathologies are also involved in the etiology of right flank pain. Bedside ultrasonography, as a rapid and effective diagnostic tool, can reduce the need for unnecessary further investigations and play an important role in clinical management. This case highlights the need for long-term endocrinologic follow-up of patients undergoing thyroid surgery and the value of ultrasonography in the diagnosis of nephrolithiasis.

Keywords: Nephrolithiasis, Hypoparathyroidism, Ureteral Stone

Ref No: 7504

Spontaneous Pneumomediastinum: A Rare Cause Of Chest Pain

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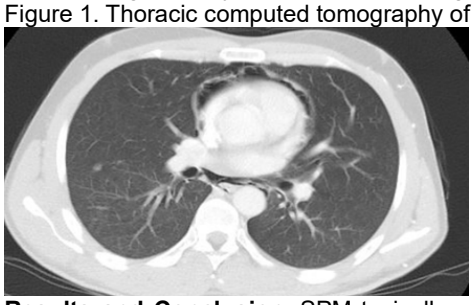
Introduction and Purpose: Spontaneous pneumomediastinum (SPM) is an uncommon clinical entity characterized by the presence of free air within the mediastinum in the absence of trauma or other apparent cause. It predominantly affects young, otherwise healthy individuals. Due to its ability to mimic cardiac chest pain, accurate and prompt diagnosis is essential to avoid mismanagement.

Materials and Methods: A 24-year-old male presented to the emergency department with sudden-onset chest pain accompanied by shortness of breath. The pain was retrosternal in nature, worsened with swallowing, and radiated to the left shoulder. The patient reported no recent physical exertion, trauma, or pre-existing medical conditions. His vital signs were within normal limits.Physical examination revealed subcutaneous crepitus in the cervical region. Lung auscultation was unremarkable, with no adventitious sounds detected. Electrocardiogram (ECG) findings and cardiac enzyme levels were within normal ranges. A chest X-ray suggested subcutaneous emphysema, and subsequent thoracic computed tomography confirmed the presence of mediastinal air (Figure 1), leading to a diagnosis of SPM. The patient received conservative treatment consisting of oxygen therapy and analgesics. His symptoms improved significantly, and he was discharged in stable condition after 48 hours of observation without complications.

Figure 1. Thoracic computed tomography of the patient confirming the presence of mediastinal air



Results and Conclusion: SPM typically results from alveolar rupture, allowing air to track along the bronchovascular sheath into the mediastinum—a mechanism known as the Macklin effect. Common precipitating factors include intense physical exertion, coughing, vomiting, or underlying pulmonary conditions such as asthma. Clinically, SPM may closely resemble acute coronary syndromes, making thorough evaluation critical to prevent unnecessary invasive interventions.SPM is a rare but generally benign condition that can present with symptoms mimicking serious cardiopulmonary pathology. Early recognition through careful clinical examination and appropriate imaging is essential for accurate diagnosis and optimal management, helping to avoid unnecessary diagnostic procedures and interventions.

Keywords: spontaneous pneumomediastinum, chest pain, subcutaneous emphysema

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Ref No: 7568

Pneumonia, Cavitary Lesion

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[1]Atatürk Üniversitesi Acil Tıp Anabilim Dalı

Introduction and Purpose: Respiratory tract infections can vary from simple colds to severe pneumonia and constitute a majority of emergency department visits in Turkey. Patients with pneumonia typically present with symptoms such as productive cough lasting 1-2 days, shortness of breath, fever, fatigue, and decreased oral intake.

Materials and Methods: A 32-year-old male patient presented with a complaint of non-productive cough persisting for a month. Besides known diabetes, the patient had no other underlying conditions, and his overall condition was good with normal vital signs. Lung auscultation revealed rales and rhonchi in the middle-lower zones of both lungs (Figure 1). Advanced imaging was performed for the patient with severe pneumonic involvement, revealing cavitary lesions (Figure 2).

Figure 1

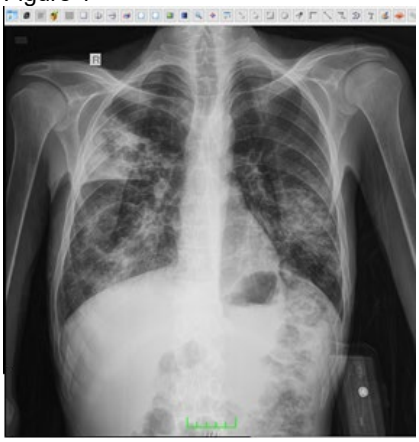
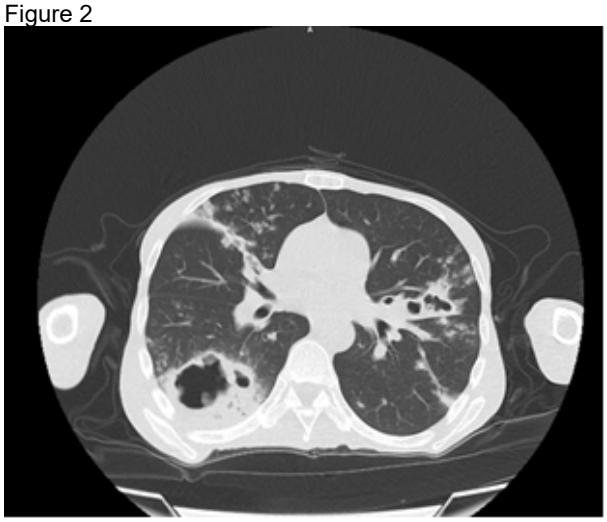


Figure 2



Results and Conclusion: Even though the symptoms in patients presenting to the emergency department might suggest a simple upper respiratory tract infection, it is important not to avoid listening to lung sounds and performing necessary imaging in appropriate cases.

Keywords: Pneumonia, Cavitary lesion

Ref No: 7691

3-2 / 1-2 Rule in Inferior STEMI

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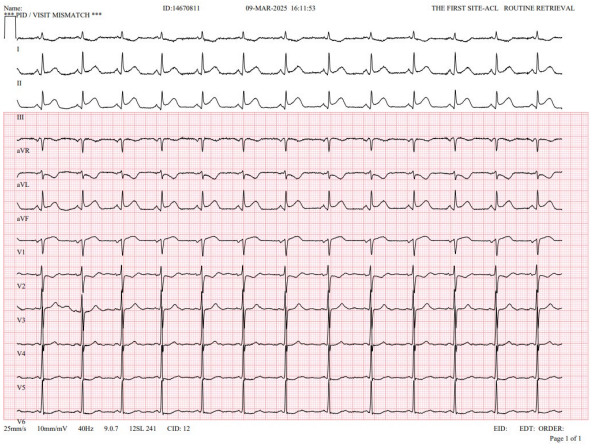
[1]Pamukkale University

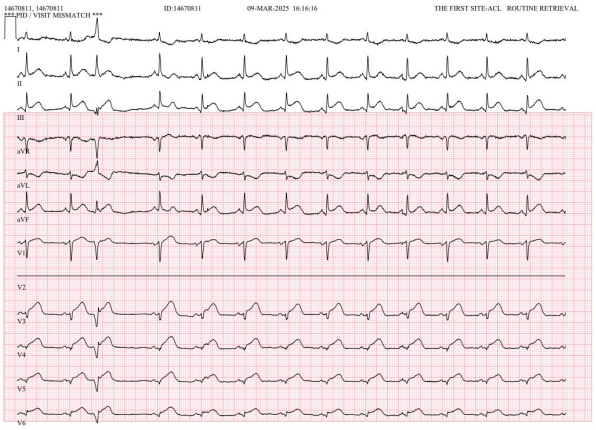
Introduction and Purpose: Right ventricular myocardial infarction (RVMI) is associated with inferior myocardial infarction (MI) in up to 40% of cases, while isolated right ventricular infarction is extremely rare.

Materials and Methods: A 61-year-old male patient presented to the emergency department (ED) with worsening chest pain that had started approximately 2–3 hours earlier. He reported experiencing a stabbing pain accompanied by coughing for the past 2–3 days, which had intensified today. The patient had undergone coronary angiography 8 years ago. He had no known comorbid conditions and was an active smoker.The patient's initial electrocardiogram (ECG) is shown in Figure 1. The ECG was interpreted as showing ST-segment elevation in the inferior leads. Given the findings of DIII > DII and V1 > V2 in terms of ST-segment elevation, a right-sided ECG was performed due to a high suspicion of RVMI. The right-sided ECG, shown in Figure 2, revealed ST-segment elevation in leads V3R, V4R, V5R, and V6R.Based on these findings, the patient was diagnosed with suspected RVMI, and coronary intervention was performed by cardiologists. Total occlusion of the right coronary artery (RCA) was identified, and a stent was placed.

The ECG showing ST-segment elevation in the inferior leads, with the findings of DIII > DII and V1 > V2.



The right-sided ECG showing ST-segment elevation in leads V3R, V4R, V5R, and V6R.



Results and Conclusion: The purpose of presenting this case is to emphasize the importance of recognizing ECG clues indicative of RVMI in patients presenting to the EDs with ECG findings consistent with inferior STEMI. This awareness is crucial for optimizing management and treatment strategies.
Keywords: Acute myocardial infarction, ECG, Right-sided ECG

Ref No: 7716
A Rare Emergency Department Case: Delayed Hemolytic Transfusion Reaction
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[1]Pamukkale University
Introduction and Purpose: Delayed hemolytic transfusion reaction (DHTR) is a rare but potentially serious complication that occurs days to weeks after a blood transfusion. Although frequently underdiagnosed, it can result in significant morbidity. This case emphasizes the importance of early recognition, especially in patients with a recent history of transfusion.
Materials and Methods: A 67-year-old female presented to the emergency department with a progressively worsening rash that began on her lower extremities and spread throughout her body over three days. She also reported shortness of breath and a general decline in her condition over the past 24 hours. Her medical history included thalassemia trait, paraplegia secondary to neurosurgery, and a desmoid tumor. Due to her paraplegia, she was immobile. Four days earlier, she had received two units of erythrocyte suspension (ES) at a hematology outpatient clinic. Additionally, she reported experiencing intermittent fever at home.Upon arrival, she was hypotensive (85/50mmHg), tachycardic (137bpm), and hypoxic (oxygen saturation 78%). She appeared critically ill, with impaired orientation and cooperation. Her Glasgow Coma Scale score was E3M6V4. Bilateral breath sounds were diminished, although there were no rales or rhonchi. The abdominal examination was unremarkable, and there was no pretibial edema.Initial lab tests revealed leukocytosis, elevated creatinine, and increased liver enzymes. C-reactive protein and D-dimer levels were significantly elevated, indicating an ongoing inflammatory response and possible tissue hypoperfusion. Electrocardiogram showed normal sinus rhythm, and thoracoabdominal computed tomography imaging did not reveal any acute pathology. Given the recent transfusion and the patient's clinical deterioration, DHTR was suspected. She was admitted for close monitoring and further treatment. Supportive therapy, including hydration and oxygen supplementation, was initiated. Serial laboratory tests were performed to monitor hemolysis parameters. A multidisciplinary approach, including hematology consultation, was crucial in guiding her management.
Results and Conclusion: This case highlights the importance of considering transfusion reactions in patients with a recent history of blood product administration. DHTR can present with a variety of clinical signs and symptoms, often mimicking other conditions. Prompt recognition and appropriate intervention are critical to preventing severe complications. A high index of suspicion is essential, particularly in patients with risk factors such as hemoglobinopathies or a history of previous transfusions.
Keywords: Delayed hemolytic transfusion reaction, Blood transfusion, Rash

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Ref No: 7783
İs Every Epistaxis İnnocent?
AHMET HASAN TAŞCİ[1], MUHAMMED CENGİZHAN DURMUŞ[1], Erdal Tekin[1]
[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP ANABİLİM DALI
Introduction and Purpose: Introduction:Epistaxis is a common reason for emergency department visits and is often associated with local trauma, hypertension, or coagulopathies. However, persistent and non-traumatic nasal bleeding may indicate an underlying hematologic disorder. This case report presents a young patient with recurrent epistaxis, whose further evaluation led to a preliminary diagnosis of leukemia.
Materials and Methods: Case Presentation:A 19-year-old male patient with no known comorbidities presented to our emergency department with non-traumatic nasal bleeding. Despite applying tamponade at home, the bleeding did not cease. On admission, his general condition was good, and his vital signs were within normal limits and stable. Physical examination revealed postnasal hemorrhagic drainage.Laboratory tests showed an international normalized ratio (INR) of 1.47, leukocyte count of 540/μL, hemoglobin level of 10 g/dL, and a platelet count of 15,000/μL. Given these findings, the patient was admitted to the internal medicine hematology clinic with a preliminary diagnosis of leukemia for further evaluation and management.

Results and Conclusion: Conclusion:This case highlights the importance of considering hematologic disorders in patients with persistent and unexplained epistaxis. Severe thrombocytopenia and associated hematologic abnormalities warrant further investigation to ensure timely diagnosis and treatment. Early recognition and appropriate management can significantly improve patient outcomes and prevent potential complications.

Keywords: EPİSTAXİS, LEUKEMİA

Ref No: 7841

FROM URİNARY TRACT INFECTİON SYMPTOMS TO TUBO-OVARİAN ABSCESS

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Introduction and Purpose: Tubo-ovarian abscess is a condition caused by the inflammation of the fallopian tube and ovary, commonly associated with pelvic inflammatory disease (PID). This abscess develops due to infection and fluid accumulation at the site where the tube and ovary meet. Symptoms generally include pelvic pain, fever, tenderness in the reproductive organs, and sometimes gastrointestinal signs. Early diagnosis is crucial for selecting the correct treatment methods. Tubo-ovarian abscess can sometimes be confused with other conditions, such as urinary tract infections, so proper diagnostic imaging and advanced testing are required.

Materials and Methods: A 69-year-old female patient presented to the emergency department with complaints of burning, stinging during urination, and abdominal pain. The patient had no known systemic diseases. On examination, her blood pressure was 142/84 mmHg, pulse was 87 beats per minute, Spo2 was 95%, and temperature was 37.7°C. On physical examination, voluntary guarding was present, and tenderness was noted in the suprapubic area upon palpation. Laboratory tests showed WBC: 17,000/µL and CRP: 212 mg/L elevated levels. Other laboratory parameters were within normal limits. Despite symptomatic treatment, the abdominal pain did not resolve and worsened. Tenderness continued on palpation. Initial abdominal ultrasonography (USG) did not reveal any acute pathology. Subsequently, abdominal contrast-enhanced computed tomography (CT) was performed, revealing a tubo-ovarian abscess measuring approximately 6x9 mm.

Figure 1

Figure 2

Results and Conclusion: This patient initially presented with common symptoms of urinary tract infection and abdominal pain. However, further investigations and imaging led to the diagnosis of a tubo-ovarian abscess. This case highlights that gynecological pathologies can sometimes be confused with abdominal pain, underscoring the importance of thorough evaluation and appropriate imaging techniques for an accurate diagnosis. The patient was referred to the gynecology department for further management.

Keywords: Tubo-ovarian abscess

Ref No: 7892
Hyperdense MCA on non-contrast brain tomography
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Introduction and Purpose: The hyperdense MCA sign, also known as Gács sign, is a type of hyperdense vessel sign and refers to focal hyperattenuation of the middle cerebral artery (MCA) on non-contrast brain CT and is due to intraluminal thromboembolic material. It is the earliest visible sign of MCA infarction and is seen within 90 minutes after the event. This sign is due to embolic red blood clot arising from the heart or arteries. The high attenuation is predominantly caused by the high globin concentration in the clot. The clot usually lodges in the proximal MCA.
Materials and Methods: An 82-year-old man is found unconscious by his relatives at home in the morning. There is a known history of hypertension and chronic obstructive pulmonary disease. The patient was last seen healthy at night by his relatives. It is not known when the disturbance of consciousness developed. The patient was received by 112 as GCS:6, intubated with midazolam and brought to the emergency department. There was no evidence of trauma on physical examination. There was anisocoria and Babinski reflex positivity on the left. Non-contrast brain CT imaging showed a hyperdense MCA on the right. Diffusion MRI showed wide diffusion limitation in the right frontotemporoparietal lobe. The patient was consulted with neurology, interventional radiology and neurosurgery. Intravenous thrombolytic therapy and mechanical thrombectomy were not considered because a hyperintense lesion was observed in the same region on FLAIR sequence MRI. The patient was interned to the intensive care unit.
Brain CT

Results and Conclusion: The hyperdense vessel sign was first described by Gyula Gács in 1983, a renowned, still active Hungarian neurologist-psychiatrist, who works in Budapest. The sensitivity of this CT sign for embolism is only about 30% but its specificity is about 90%. The dense MCA sign is an early indicator of acute ischemic stroke caused by MCA occlusion. Presence of the dense MCA sign suggests a large clot burden and is associated with more extensive infarction and worse functional outcomes if reperfusion is not achieved.Prompt recognition of the sign improves the chances of favorable recovery by allowing faster intervention.
Keywords: Ischemic stroke, hyperdense MCA, brain CT

Ref No: 7927
Necrotizing Pneumonia: A Case Report
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Introduction and Purpose: Necrotizing pneumonia (NP) is a rare but severe complication of bacterial pneumonia characterized by lung parenchymal necrosis, cavitation, and tissue destruction. It typically arises due to highly virulent or toxin-producing pathogens, including Staphylococcus aureus (especially MRSA), Streptococcus pneumoniae, and Klebsiella pneumoniae. Clinical presentation can include high fever, respiratory distress, hemoptysis, and systemic deterioration. Imaging—especially chest computed tomography (CT)—plays a crucial role in diagnosis, revealing cavitary lesions, consolidation, and air-fluid levels. Early diagnosis and aggressive treatment are essential to reduce the high morbidity and mortality associated with this condition.
Materials and Methods: An 83-year-old female with a history of anemia, hypertension, diabetes, and achalasia presented to the emergency department with generalized weakness. Her past medical history included esophageal perforation and mediastinitis following balloon dilation for achalasia 51 days earlier. On presentation, she was alert, oriented, and hemodynamically stable. Chest auscultation revealed coarse breath sounds and rales in the left lung. Laboratory tests showed leukocytosis (16.9×10^3/μL), neutrophilia (12.9×10^3/μL), anemia (Hb: 6 g/dL), and elevated CRP (116 mg/L). Chest CT revealed a large cavitary lesion in the left lung extending

from the apex to the suprahilar region, with surrounding ground-glass opacities and septal thickening. These findings were consistent with necrotizing pneumonia. The patient was admitted to the pulmonary medicine service and started on broad-spectrum intravenous antibiotics following consultation with pulmonology and infectious disease specialists.

IMAGE 1

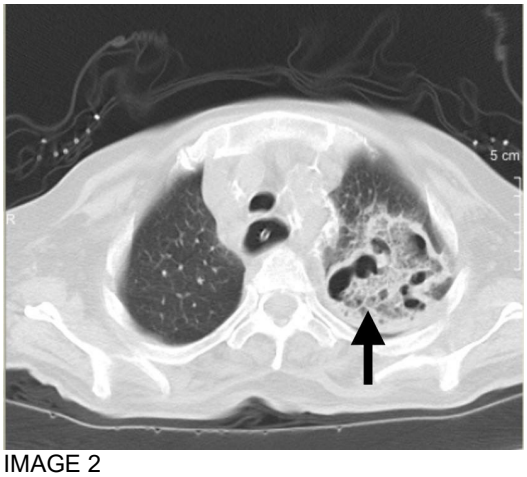

IMAGE 2

Results and Conclusion: This case illustrates that NP can develop in elderly patients with chronic comorbidities and a history of invasive procedures, even when presenting with mild symptoms such as fatigue. The presence of esophageal perforation and prior mediastinitis may have predisposed the patient to pulmonary infection. CT imaging was critical in diagnosing NP and identifying its extent. Early recognition and a multidisciplinary approach—including rapid antibiotic initiation and close monitoring—are essential for improving outcomes. Awareness of this condition is vital, especially in patients with risk factors or prior thoracic complications.

Keywords: Necrotizing Pneumonia, Mediastinitis, Pneumonia

Ref No: 8010

Subarachnoid Hemorrhage

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Introduction and Purpose: Non-traumatic subarachnoid hemorrhage (SAH) most commonly results from the rupture of saccular aneurysms. SAH is typically a devastating event with significant mortality and high morbidity among survivors. In this study, we aim to present a 45-year-old male patient who presented with sudden loss of consciousness due to subarachnoid hemorrhage.

Materials and Methods: A 45-year-old male patient was brought to the Emergency Department by the 112 emergency response team due to sudden onset of confusion. He had no known medical history. On arrival, his Glasgow Coma Scale (GCS) score was 3, blood pressure was 215/125 mmHg, oxygen saturation was 82% (with 2 L/min of oxygen), and heart rate was 76 bpm. The patient was intubated by our team, and a peripheral intravenous line was simultaneously established. Blood tests were requested. A non-contrast brain CT scan and brain CT angiography were performed. The brain CT scan and CT angiography revealed subarachnoid hemorrhage and an aneurysm in the right middle cerebral artery (Figures 1-2). The patient was consulted to the Neurosurgery Department, and a decision for surgery was made, with hospitalization.

Results and Conclusion: SAH is a neurointerventional emergency, and all patients presenting with acute thunderclap headache should be evaluated for SAH. Non-contrast cranial CT should be the first diagnostic test. The sensitivity of CT is very high in the early phase after hemorrhage, but it decreases over time. A sentinel headache is a significant warning sign, but it can still be overlooked in emergency departments. Early diagnosis and treatment are crucial for preventing complications such as rebleeding and vasospasm.

Figure 1

Figure 2

Keywords: Sudden Loss of Consciousness, SAH

Ref No: 8030

WHO SAID THERE'S NOTHING

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[1]ATATÜRK ÜNİVERSİTESİ ACİL TIP

Introduction and Purpose: Posterior malleolus fractures are seen in a considerable number of patients admitted to hospital after rotational ankle injuries. Most of them are associated with trimalleolar fractures. The posterior malleolus is an important structure for rotational stability of the ankle and stability of the synesmosis complex. Therefore, treatment of trimalleolar fractures is important; if not performed appropriately, the prognosis worsens. Posterior malleolus fractures are difficult to diagnose easily due to the wide variety of morphology. A rare consensus on the current approach is that computed tomography (CT) and 3D-CT evaluation are very important in diagnosis and treatment planning.

Materials and Methods: A 26-year-old male patient presented with a complaint of left ankle sprain 2 days ago while descending the stairs. The patient's foot was sprained inward, he had only pain in the first few hours, then he was admitted to an external center due to increasing swelling and although he was splinted there, he was admitted to us because his severe pain continued. On examination, there was diffuse edema, severe tenderness and difficulty in dorsiflexion of the left ankle. Neurovascular examination and all other system examinations were normal. Direct radiographs (Figure 1 - Figure 2) showed no pathology and ankle non-contrast tomography (CT) was performed. The CT scan showed a nondeplaced articular fracture (Figure 3) in the posterior malleolus of the tibia and the patient was consulted to the orthopedic clinic. Treatment was organized by the relevant clinic.

FİGURE 1

FİGURE 2

FİGURE 3

Results and Conclusion: In ankle sprains, if there is severe tenderness, limitation of movement, swelling and edema on physical examination, and if the patient has difficulty stepping on the foot, advanced imaging (CT) is important for early diagnosis and treatment even if there is no pathologic image on direct radiographs.

Keywords: FRACTURE

Ref No: 8064

Conjunctivitis

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Introduction and Purpose: Conjunctivitis is a common clinical condition in patients with complaints of itching, watering and redness in the eye. It is usually a benign and self-limiting condition and can be easily treated. Acute conjunctivitis is divided into infective and non-infective. Bacterial conjunctivitis is more common in children, while viral conjunctivitis is more common in adults.

Materials and Methods: A 42-year-old male patient is admitted to the ER with a complaint of swelling and itching in the eye. There is no known history of additional diseases. The patient's vitals were unremarkable. According to the medical history received, he states that he had an upper respiratory tract infection 7 days ago. In the right eye, hyperemia, edema and periorbital vesicular lesions are observed, prominent on the upper eyelid. Glob's posture and movements are evaluated naturally in all directions. The patient had consulted for eye diseases and dermatology. The patient, who has herpes simplex virus infection considered, is discharged with a prescription and recommended an ophthalmology and dermatology outpatient clinic control.

Conjunctivitis

Conjunctivitis

Results and Conclusion: Ocular HSV is seen in less than 5% of patients, but it can cause of significant morbidity. It can cause conditions such as acute retinal necrosis or keratitis, resulting in vision loss. Therefore, like any acute pathology, it requires early diagnosis. This should be taken into account when approaching conjunctivitis in the emergency department.

Keywords: conjunctivitis, herpes simplex virus

Ref No: 8139
PERITONSILLAR ABSCESS
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[1]PERITONSILLAR ABSCESS
Introduction and Purpose: Peritonsillar abscess is the most common deep infection of the head and neck region in adults and is typically caused by a combination of aerobic and anaerobic bacteria. Symptoms include fever, sore throat and trismus. Ultrasonography and computed tomography scan are useful in confirming the diagnosis. Needle aspiration remains the gold standard for the diagnosis and treatment of peritonsillar abscess. Appropriate antibiotic therapy (including penicillin, clindamycin, cephalosporins or metronidazole) should be initiated after aspiration. In advanced cases, incision and drainage or emergency tonsillectomy may be required.
Materials and Methods: A 45-year-old man presented with a sore throat that had persisted for approximately 24 hours. His vital signs were normal on presentation (Pulse: 85 SPO2: 95 TA: 125/85 FEVER: 36.7). The patient had no known comorbidities. Physical examination revealed good mouth opening, hypertrophic (abscess?) appearance of the right tonsil in the oropharynx, and external examinations were unremarkable. In the tests taken from the patient, HGB: 15.5, WBC: 12.680, CRP: 167, SEDIMENTATION: 71. In the report of the CT imaging of the patient, an increase in the size of both tonsils and heterogeneous appearance was observed (tonsillitis?), 15x9mm peripherally contrasted hypodense area with complicated content was observed in the right tonsil (peritonsillar abscess?). The patient was consulted to the otorhinolaryngology clinic and hospitalized for treatment.
Results and Conclusion: Patients presenting with sore throat, which is a common reason for presentation to the emergency department, should undergo necessary investigations when an abscess is suspected and CT imaging, which is considered the gold standard, should be performed. Treatment of peritonsillar abscess infections includes antibiotic therapy and aspiration or drainage of the loculated abscess, and should be evaluated and treated according to the clinical condition of the patient.
Keywords: PERITONSILLAR ABSCESS, ASPIRATION, DRAINAGE

Ref No: 8190
Pulmonary Embolism (PE)
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Introduction and Purpose: Pulmonary Embolism (PE) is commonly caused by deep vein thrombosis. Pulmonary embolism leads to clinical symptoms such as shortness of breath, back pain, and others.
Materials and Methods: A 20-year-old female patient presented to our emergency department with complaints of throat, back, and side pain, as well as shortness of breath, lasting for one week. The patient had previously visited the hospital a week ago with similar symptoms and was discharged with prescriptions for cystitis and upper respiratory tract infection (URI). The patient has no chronic illnesses or medication use, except for oral contraceptives (OCP) for known PCOS. Upon arrival, her vital signs were as follows: BP: 93/62, O2 saturation: 72%, Pulse: 132, Temperature: 36.8°C. In the physical examination, the only finding was reduced breath sounds in the lung bases. Given the patient's moderate to poor clinical condition, the most likely diagnosis of PE, tachycardia, and OCP use, the patient was immediately evaluated and imaged without waiting for the D-Dimer test. A CT angiogram of the pulmonary arteries revealed pulmonary embolism. The patient was referred to cardiology for echocardiography and to pulmonology for PE management. The patient was admitted for thrombolytic therapy.
Results and Conclusion: Pulmonary embolism should be considered in patients, even young ones, with abnormal vital signs, a history of OCP use, and repeated visits due to shortness of breath.
Keywords: Pulmonary Embolism, Oral Contraceptive, Shortness of Breath

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Ref No: 8211
Complıcatıons Of A Common Dısease Are Also Common
Erhan Şahin[1], Ayça Çalbay[1]
[1]Complıcatıons Of A Common Dısease Are Also Common
Introduction and Purpose: Cholecystitis refers to the inflammation of the gallbladder. Acute cholecystitis primarily occurs as a complication of gallstone disease and typically develops in patients with a history of symptomatic gallstones. Gallbladder perforation occurs in about 10% of cases and is generally seen in patients with delayed diagnosis or those who do not respond to initial treatment. Perforation is often localized and occurs at the fundus of the gallbladder after gangrene development. The resulting pericholecystic abscess can be palpated and imaged in abdominal CT scans. Less commonly, there is free perforation into the peritoneum, which leads to generalized peritonitis and is associated with high mortality.
Materials and Methods: A 52-year-old female patient presents to the emergency department with complaints of abdominal pain. The patient reports that the pain has persisted for a month, localized to the right upper quadrant, increasing after meals and gradually subsiding after a few hours. However, for the past week, the pain has been continuously increasing in severity. Associated symptoms of nausea, vomiting, and fever have been present for one day. The patient has no significant medical history, allergies, or ongoing medication use. Vital signs are within normal limits, except for a temperature of 37.8°C. On systemic examination, tenderness and guarding are noted in the right upper quadrant, and Murphy's sign is positive. In the radiograph, no perforation is identified. However, the patient's WBC count is 23,600 mcg/L (%84 neutrophils). As the pain radiates throughout the abdomen, a contrast-enhanced CT of the upper and lower abdomen reveals edema in the gallbladder wall, along with surrounding infiltration and air densities within the lumen and around the gallbladder, raising suspicion of perforation. The patient is evaluated by the general surgery team and is admitted for surgery
Results and Conclusion: Acute cholecystitis is increasingly common in our society, correlated with the incidental observation of

gallstones. In untreated or late-diagnosed cases of acute cholecystitis, fatal clinical outcomes such as emphysematous cholecystitis and perforated cholecystitis can be observed. In patients with systemic symptoms and a toxic appearance, these differential diagnoses should not be overlooked.

image1

Keywords: cholecystitis, perforation

Ref No: 8230

Hemorrhagic Renal Cysts

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[1]Atatürk University

Introduction and Purpose: Simple renal cysts are common, benign, and usually asymptomatic, typically requiring no treatment. However, over time, these cysts can enlarge, become symptomatic, and develop complications, necessitating intervention. Treatment is only required when a cyst cannot be distinguished from a malignant process or if it causes pelvicaliceal obstruction and/or hypertension.

Materials and Methods: A 46-year-old male patient presented with right flank pain and occasional hematuria. His vital signs were normal. On abdominal examination, there was tenderness in the right upper quadrant. His blood tests were normal. Since the patient did not have active hematuria, a CT scan was performed, which revealed a 18 cm hemorrhagic renal cyst in the right kidney. The patient was referred to the urology department and admitted for surgery.

Results and Conclusion: In patients presenting with hematuria, only considering urolithiasis should not be the approach. Aortic dissection, renal artery infarction, and hemorrhagic renal cysts should also be considered in the differential diagnosis.

BT image

BT image

Keywords: renal cysts

Ref No: 8252
Diagnosis: Ileus
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Introduction and Purpose: Ileus is a clinical condition that occurs when the peristalsis of the small and large intestines is impaired, or when the passage is obstructed due to a mechanical cause. Clinical presentation and symptoms may vary depending on the level of bowel obstruction. The main findings of ileus include abdominal pain, inability to pass gas or stool, nausea, vomiting, loss of appetite, and abdominal distension. Diagnosis is made by taking direct radiographs of patients in an upright or lateral decubitus position. The presence of air-fluid levels or bowel dilation greater than 3 cm at the small intestine level is diagnostic.
Materials and Methods: A 38-year-old male patient with a known diagnosis of Crohn's disease presented to the emergency department with complaints of abdominal pain. The patient reported experiencing frequent episodes of similar attacks. On examination, there was widespread tenderness in the abdomen, particularly in the lower right quadrant, but no guarding or rebound tenderness was observed. Upon further inquiry, the patient reported experiencing diarrhea 4–5 times that day. Additionally, a detailed anamnesis revealed that the patient had constipation and was unable to defecate the previous day.Based on this information, an upright abdominal X-ray was performed, revealing a broad-based air-fluid level. Subsequently, oral contrast was administered, and an abdominal CT scan was obtained. The patient was diagnosed with ileus and referred to the General Surgery department for consultation. He was admitted for treatment and follow-up by the General Surgery team.
X-ray

Results and Conclusion: The main reason for presenting this case is to emphasize the importance of taking a detailed anamnesis. Although the patient's symptoms were similar to previous Crohn's disease flare-ups, leading to a possible misdiagnosis and discharge with treatment, a thorough anamnesis prevented a delay in the correct diagnosis and treatment of the patient's actual condition.
Keywords: Crohn's disease, abdominal pain, ileus

Ref No: 8291

A Rare Case of Aspiration Pneumonia Caused by Aortic Aneurysm Causing Esophageal Compression

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Introduction and Purpose: Aspiration pneumonia is an infection that develops as a result of aspiration of oral or gastric contents into the lower respiratory tract. Predisposing factors include neurologic diseases, altered consciousness, gastroesophageal reflux and mechanical obstruction.Aortic aneurysms are vascular lesions that expand and potentially rupture due to pathologic structural changes in the arterial wall. Thoracic aortic aneurysms account for approximately 25% of all aortic aneurysms and most commonly occur in the descending aortic segment. These lesions can cause clinical symptoms by compressing nearby anatomical structures. In particular, mechanical compression of the trachea, bronchi and esophagus can lead to impaired respiratory function and dysphagia.

Materials and Methods: An 88-year-old woman presented to the emergency department with dyspnea. She had a history of chronic heart failure, diabetes mellitus and hypertension. She was conscious and in moderate general condition. Vital signs were temperature 37.8°C, blood pressure 140/90 mmHg, pulse rate 96/min, respiratory rate 22/min and oxygen saturation 90% in room air. On respiratory system examination, crepitant rales were heard in the basal part of the right lung. Laboratory tests revealed leukocytosis and elevated CRP. Thoracic CT scan showed bronchial filling defects and peribronchial thickening in the right lung consistent with aspiration; aneurysmatic expansion of the descending aorta was detected and this expansion was found to compress the esophagus. As a result of all findings, the patient was diagnosed with aspiration pneumonia and appropriate treatment was organized.

Results and Conclusion: Generally, aortic aneurysms are complicated by rupture, thromboembolic events or airway obstruction, but in this case, esophageal compression leading to aspiration pneumonia is a rare clinical entity. If the aortic aneurysm compresses the esophagus, the patient may develop dysphagia. Impaired coordination of the swallowing action or food entrapment in the esophagus increases the likelihood of food contents escaping into the trachea. As a result, aspiration pneumonia may develop due to esophageal compression. Although cases of aspiration pneumonia due to aortic aneurysm are rarely reported in the literature, it is important to investigate unusual underlying anatomical factors in patients with aspiration pneumonia.

Keywords: Aortic aneurysm, Aspiration pneumonia, Dysphagia

Ref No: 8335

HEMORRHAGIC CVA IS ALSO A RISK FACTOR: HYPERTENSION AND EXERCISE

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[1]Atatürk Üniversitesi

Introduction and Purpose: There are many risk factors for hemorrhagic CVAs (cerebrovascular accidents). Some of them are: Advanced age, hypertension, smoking-alcohol consumption, previous ischemic stroke, vascular malformations (aneurysm, AV mal., cavernous angina), use of anticoagulants or fibrinolytic drugs.

Materials and Methods: 38-year-old male. He applies to the emergency room with the complaint of 'numbness and loss of strength on the right side due to feeding that started during sexual intercourse'. The patient had no known additional comorbidities. His vital signs were: blood pressure: 140/70 mm/Hg, saturation: 97%, pulse: 102 beats/minute. The motor power in the right lower and right upper extremities was 3/5 upon examination. A brain CT (computer tomography) was performed, which revealed an approximately 5x5 mm hemorrhage in the pons.

Results and Conclusion: CONCLUSION: This patient's presentation demonstrates that exertional events, such as physical strain during sexual intercourse, can contribute to the onset of a hemorrhagic CVAs, regardless of the patient's blood pressure status. The discovery of a hemorrhage in the pons underscores the importance of prompt imaging and intervention in patients presenting with acute neurological symptoms. Exertional activities, particularly those that lead to sudden increases in blood pressure, can potentially induce rupture in vessels that may already be vulnerable due to structural weaknesses or other undiagnosed vascular abnormalities. In this case, the lack of known comorbidities suggests that factors other than hypertension, such as genetic predispositions or undiagnosed vascular malformations, may have contributed to the hemorrhageResults: This case illustrates that exertional activities, even in the absence of traditional risk factors, can potentially lead to hemorrhagic CVA.

brain ct

Keywords: cva, effor, hypertension

Ref No: 8402
Traumatic gastrointestinal perforation in the emergency department
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[1]Pamukkale University
Introduction and Purpose: Gastrointestinal (GI) perforation refers to a full-thickness tear of the intestinal wall. Additionally, partial-thickness bowel tears can progress over time to become full-thickness perforations. Most blunt GI injuries result from motor vehicle accidents, particularly in passengers wearing seatbelts or sitting in the front seat.Trauma patients may present with abdominal pain; however, this symptom is not specific to GI injury. Physical examination findings that may suggest GI injury include abdominal wall ecchymosis, distension, tenderness, or signs of peritoneal irritation, though none are definitive indicators. However, the absence of abdominal pain or tenderness significantly reduces the likelihood of a GI injury requiring surgery.
Materials and Methods: A 23-year-old female patient presented to the emergency department (ED) following a traffic accident while wearing a seatbelt. On initial examination, she exhibited diffuse abdominal tenderness; however, imaging studies did not reveal any acute pathology. Analgesia was administered. Despite pain management, her symptoms persisted, and a repeat examination revealed ongoing diffuse tenderness with newly developed guarding.At the 8-hour follow-up, contrast-enhanced computed tomography revealed free air and a defect at the proximal jejunal loop, confirming a diagnosis of GI perforation. The patient was immediately taken to surgery by the general surgery team.
Results and Conclusion: In trauma patients presenting to the ED, even if initial examinations and imaging do not reveal pathology, continuous monitoring, frequent re-evaluations, and reassessment of suspicious findings are crucial, as early detection can be life-saving.
Keywords: abdominal pain, perforation, blunt trauma

Ref No: 8501
ONLY OLIVES WITHOUT SEEDS ARE SAFE
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[1]Atatürk Üniversitesi
Introduction and Purpose: Bowel obstruction can be either functional or mechanical, and it can be partial or complete. Mechanical large bowel obstruction can be caused by malignant or benign etiologies. Patients with large bowel obstruction may present acutely with sudden abdominal distention and abdominal pain due to sudden lumen obstruction or with subacute or chronic changes in bowel habits over time due to progressive narrowing of the lumen. A longer duration of symptoms and associated symptoms such as unintended weight loss or rectal bleeding may suggest a malignant cause rather than a benign etiology.
Materials and Methods: A 67-year-old patient with no known comorbidities presented to our emergency department with complaints of abdominal pain persisting for a week, a feeling of bloating, nausea, and vomiting. The patient was brought in by the 112 emergency team. Vital signs were within normal limits. On systemic examination, bowel sounds were diminished on abdominal auscultation, and no tenderness was detected on palpation except for widespread distention. In the direct radiograph, large air-fluid levels were detected, and the patient's history was further investigated. It was learned that the patient had swallowed olive seeds in the last month. In the contrast-enhanced abdominal CT scan, in addition to findings compatible with large bowel-type ileus, olive seeds were observed. After NGS was performed, the patient was admitted to the general surgery department.
Results and Conclusion: In patients with ileus who have no comorbidities, no history of previous surgeries, and no electrolyte imbalances that could cause paralytic ileus, it is important to investigate lifestyle changes and dietary habits, along with possible external mechanical pressure from masses or malignancies such as colon or rectal cancer. Furthermore, the ingestion of hard objects, which can cause similar presentations, should also be considered, such as the swallowing of hair, fibers, or objects that may lead to ileus.
image1

Keywords: ileus, olive

Ref No: 8540
Pons Infarcies
Kadir Eryürük[1], Atakan Yilmaz[1], Murat Seyit[1], Mert Ozen[1], Alten Oskay[1], Ibrahim Turkcuer[1]
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Introduction and Purpose: Acute ischaemic stroke is a disease in which early diagnosis and treatment is very important and serious morbidity and mortality can be completely reversed, especially in patients receiving thrombolytic therapy. Anamnesis and physical examination is also a very effective method especially in some inadequacies of current imaging methods.
Materials and Methods: 54 years old male patient. He presented with limitation in eye movements since yesterday. The patient was previously admitted to an external centre where CT and MR imaging were interpreted as normal.The patient was admitted because his complaints did not go away. The patient had no additional complaints other than limitation in eye movements. Vital signs were stable. Neurological examination revealed fixed gaze with limited eye movements. There were no additional neurological examination findings.CT and diffusion MR imaging was planned. The clinical status of the patient was discussed with MR. Thin section imaging was requested in the pons. CT of the patient was normal. MR imaging showed an acute diffusion limiting area in the pons.The patient was hospitalised in neurology ward for clinical follow-up and treatment.
Results and Conclusion: Our aim in presenting this case is to emphasise the necessity of repeating the imaging in case of clinical suspicion, even if the patient has imaging, and the necessity of examining the relevant region with thin section imaging if necessary.
Keywords: CT, MR, pons infarction

No: 8555
Patient Presenting With Face Swelling
ONUR MURAT ATMACA[1], AYÇA ÇALBAY[1]
[1]ATATURK UNİVERSİTY
Introduction and Purpose: An 86-year-old male with a history of chronic obstructive pulmonary disease (COPD) and hypertension presented to the emergency department with worsening dyspnea over the past month. He reported that his shortness of breath, particularly exacerbated at night, was accompanied by facial swelling. These symptoms began one month after the initiation of inhaled medications for COPD. Despite discontinuing the medications, the symptoms did not improve.
Materials and Methods: Upon examination, the patient was alert and oriented, with a Glasgow Coma Scale (GCS) score of 15. His vital signs indicated a blood pressure of 140/80 mmHg, a heart rate of 90 beats per minute, and an oxygen saturation of 82%, demonstrating significant respiratory distress. Physical examination revealed tachypneic breathing, facial and neck edema, and no jugular venous distention. A positive finding of uvula edema was noted, along with widespread wheezing on lung auscultation.Given the clinical presentation, angioedema was suspected, leading to the initiation of corticosteroid therapy with prednisolone. Laboratory tests showed no significant abnormalities. Due to the lack of improvement despite stopping the inhalers, further imaging was warranted. Cervical and thoracic contrast-enhanced CT scans were performed.The cervical CT did not reveal any significant findings; however, the thoracic CT scan identified a 4 cm mass in the mediastinum compressing the superior vena cava (SVC). This finding was consistent with superior vena cava syndrome (SVCS), likely contributing to the patient's respiratory distress and facial edema.
Results and Conclusion: In conclusion, this case highlights the importance of thorough evaluation in elderly patients with respiratory complaints, particularly following medication use. The identification of a mediastinal mass causing SVC syndrome underscores the need for comprehensive imaging in cases with atypical presentations. Prompt recognition and management are crucial to prevent serious complications associated with venous obstruction and respiratory failure.
Keywords: VCSS

Ref No: 8575
An Atypıcal Case: Herpes Zoster Wıth Lumbar Involvement
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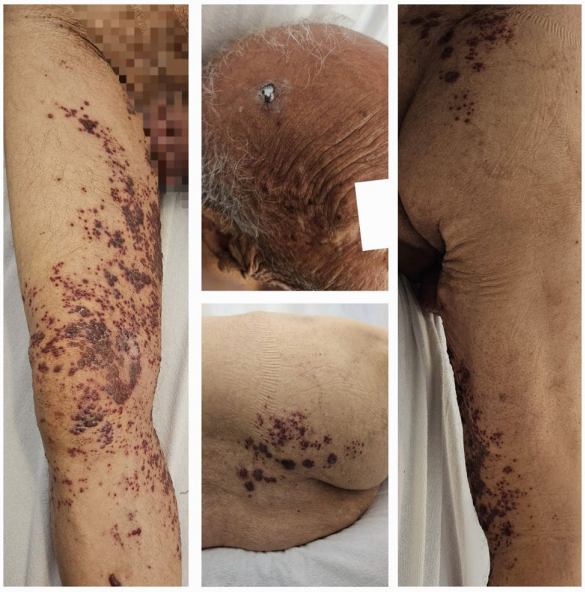
Introduction and Purpose: Herpes zoster, commonly known as shingles, is a viral infection caused by the varicella-zoster virus—the same virus responsible for chickenpox.
Materials and Methods: A 79-year-old male patient was admitted to the emergency department with a head wound. According to the information obtained from the patient's daughter, topical antibiotics had been started for the wound on his head in another hospital. The lesion on his head was ulcerated and black crusted. Upon questioning, it was learned that the lesion was vesicular at first. A full body inspection was performed by protecting the patient's privacy. Physical examination of the patient revealed erythematous, vesicular, occasionally crusted lesions consistent with Herpes zoster in the lumbar region at the L3-L4 level and in the anteromedial thigh of the right lower extremity corresponding to the L3-L4 dermatome. Dermatology consultation was requested for the patient. The patient was interned to the dermatology clinic for treatment and follow-up with a diagnosis of Herpes Zoster (Shingles).
Figure



Erythematous, vesicular, occasionally crusted lesions consistent with Herpes zoster in the lumbar region.
Results and Conclusion: The purpose of presenting this case is to draw attention to the importance of whole body inspection in the systemic examination of geriatric patients presenting to emergency departments.
Keywords: Herpes Zoster, Shingles

Ref No: 8629
The Hidden Danger Behind Abdominal Pain
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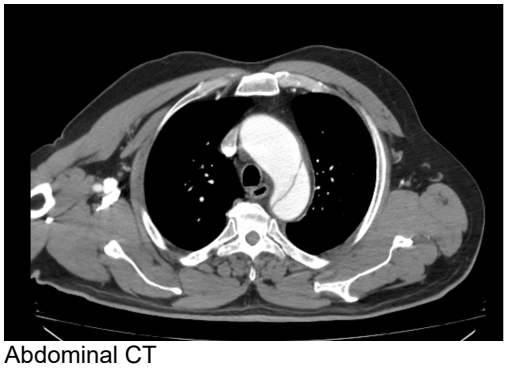
[1]Atatürk Üniversitesi Araştırma Hastanesi
Introduction and Purpose: Aortic dissection is a life-threatening condition caused by a tear in the inner layer of the aorta, allowing blood to enter between the layers of the arterial wall and cause separation.
Materials and Methods: A 57-year-old male patient presented with a three-day history of abdominal pain. He had a known diagnosis of hypertension. The patient had previously sought medical attention twice at external centers for the same complaint, but no significant findings were reported in the conducted evaluations. Due to the persistence of symptoms, he presented to our facility. The patient did not report diarrhea, constipation, nausea, or vomiting.Upon further anamnesis, the patient described his pain as originating from the chest and radiating downward. On initial examination, his vital signs showed a blood pressure of 160/100 mmHg, with no significant difference between both arms. Other vital parameters were within normal limits. Bilateral extremity pulses were palpable and equal. On abdominal examination, tenderness was noted predominantly in the upper quadrants and epigastric region, but no guarding or rebound tenderness was observed. Electrocardiography (ECG) revealed normal sinus rhythm with no acute pathology. Laboratory findings were unremarkable. Chest X-ray showed a prominent aortic arch but no other significant findings.A computed tomography (CT) scan revealed a dissection flap extending from the aortic arch to the right iliac artery. To maintain optimal blood pressure control, an esmolol (Brevibloc) infusion was initiated. The Cardiovascular Surgery department was consulted, and the patient was subsequently admitted for further management.
Toraks CT



Abdominal CT

Results and Conclusion: In patients presenting with abdominal pain, aortic dissection should be considered even in the absence of significant blood pressure differences between arms or agitation. A thorough history, including pain onset and progression, is crucial for the early diagnosis of this potentially fatal condition.
Keywords: Aortic dissection, abdominal pain.

Ref No: 8637
A Rare Case: Brain Abscess Presenting to the Emergency Department with Drowsiness
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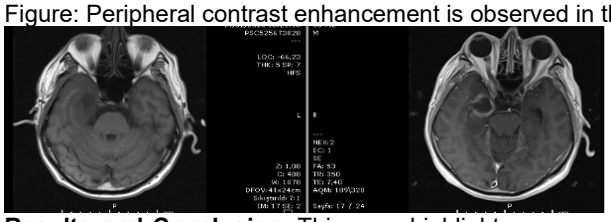
Introduction and Purpose: Brain abscess is a rare diagnosis in patients presenting to the emergency department with nonspecific symptoms such as headache, altered consciousness, and drowsiness. It is a local bacterial infection of the brain parenchyma surrounded by a central purulent infection, potentially requiring urgent neurosurgical intervention. Neurological imaging is crucial for diagnosis. As in our case, contrast-enhanced MRI studies, which can be confused with acute ischemic infarction, facilitate definitive diagnosis.
Materials and Methods: A 65-year-old male presented with a 3-day history of headache and excessive but easily arousable sleepiness. His medical history included coronary artery disease, hypertension, and hyperlipidemia. He had no history of antibiotic use in the last 2 months, no diagnosed dental infection, or dental intervention. He reported a recent upper respiratory tract infection that resolved without medication about a month prior.On emergency admission, his vital signs were normal except for elevated blood pressure. His ECG showed no signs of acute ischemia. Neurological examination revealed suspicious neck stiffness and mild right hemiparesis. Blood tests showed elevated inflammatory markers (WBC 21,250 mg/dL, CRP 19.60 mg/dL, ESR 46). Brain CT and MRI diffusion imaging were performed to rule out intracranial ischemic and hemorrhagic pathologies.MRI DWI showed a lesion with restricted diffusion, corresponding to findings on FLAIR and CT, with no signal change on SWI, extending from the medial right temporal lobe to the posterior lateral ventricle. Contrast-enhanced cranial MRI was performed due to the difficulty in differentiating the space-occupying lesion as a mass or abscess. He received analgesic treatment and 2 grams of ceftriaxone IV in the emergency department. His blood pressure was reduced to 165/80 and stabilized. Neurology, infectious disease, and neurosurgery consultations were obtained. He was scheduled for hospitalization for abscess drainage, further examination, and treatment by neurosurgery.
Figure: Peripheral contrast enhancement is observed in the area where the brain abscess is located



Results and Conclusion: This case highlights a rare presentation of brain abscess and a challenging clinical scenario. Brain abscess should be considered in patients presenting with atypical symptoms like drowsiness. Contrast-enhanced MRI is essential for differentiating brain abscess from other pathologies and for definitive diagnosis.
Keywords: Brain Abscess, Emergency, Diagnosis

Ref No: 8721
Pulmonary embolism
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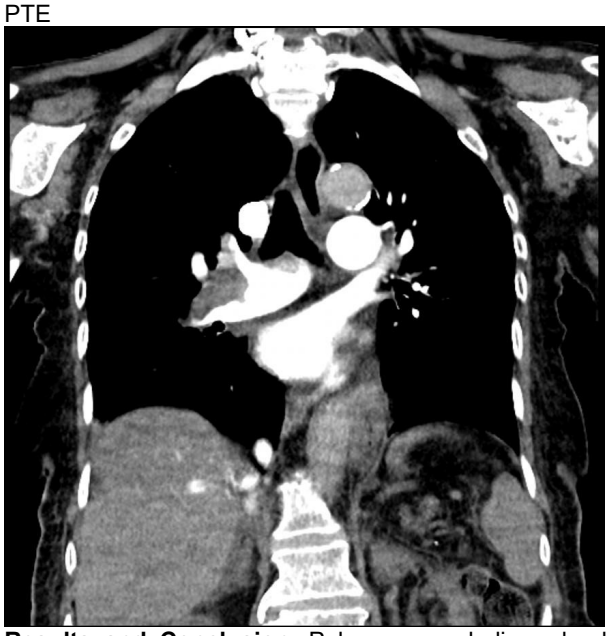
Introduction and Purpose: Pulmonary embolism (PE) is a relatively common cardiovascular emergency. It can cause acute, life-threatening but potentially reversible right ventricular failure due to occlusion of the pulmonary arterial bed. The diagnosis of PE is difficult and may be missed because it does not present with a specific clinical picture.
Materials and Methods: A 75-year-old woman presented to us with sudden dizziness followed by fainting while at home. The patient had a known diagnosis of esophageal ca and had hypotension, tachycardia and hypoxia on admission vitals. There was no pathology on systemic examination, but thoracic imaging revealed bilateral pulmonary embolism. The patient was consulted to the relevant clinic. His treatment was organized by the relevant clinic.

PTE



Results and Conclusion: Pulmonary embolism should be kept in mind in patients presenting to the emergency department with syncope if the vitals and risk status are compatible.
Keywords: Pulmonary embolism, dizziness

Ref No: 8787
Spontaneous Pneumothorax
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Introduction and Purpose: Spontaneous pneumothorax is a condition that typically occurs in young, male smokers. It should be considered in the differential diagnosis of patients presenting with acute chest pain.
Materials and Methods: 20 years old male patient with no history of chronic illness who has been smoking 5 pack-years.Arrived with a chest pain with a stabbing character that started 2 hours ago. The pain is more pronounced on the left side and increases with breathing. Mild shortness of breath is present. Respiratory sounds are reduced on the left side, and hyperresonance is noted on percussion. After ECG performed it has been observed that the patient had a normal sinus rhythm. Chest X-ray depicted a left pneumothorax. The patient underwent tube thoracostomy and was admitted to the thoracic surgery department for further monitoring.
Results and Conclusion: Primary spontaneous pneumothorax is commonly seen in tall, thin, young male smokers. Small pneumothoraxes can be managed conservatively, while large or symptomatic ones require tube thoracostomy. In cases of recurrence, surgery and pleurodesis may be considered.In young male patients presenting with sudden chest pain, pneumothorax should be considered. Early diagnosis and appropriate treatment are essential.
Keywords: Chest pain, Pneumothorax.

Ref No: 8794
Calcaneus and Vertebra Fracture
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Introduction and Purpose: Calcaneus is the widest and most frequently fractured tarsal bone. Calcaneus fractures occur as a result of high-energy traumas such as falling from a height, traffic accidents, and gunshot wounds.
Materials and Methods: A 61-year-old male patient applied to the emergency room after experiencing severe pain in his left foot, inability to step on his foot, and lower back pain after jumping from a height of approximately 1 meter while descending from an olive tree. He has no known history of illness. In the emergency room evaluation of the patient; Vital signs, Fever: 36.4 Pulse 96/min, BP: 120/90, Saturation: 98%. In the physical examination; his general condition is good, Gks: 15, no cervical and thoracic tenderness. Respiratory sounds are normal, no findings in the abdominal examination. There is tenderness in the lumbar region with palpation. There is swelling and tenderness at the level of the medial malleolus of the left foot and tenderness with palpation in the calcaneus. The movements of the left ankle joint were painful and restricted.In the examinations of the patient, a calcaneus fracture and a collapse fracture in the anterior L1 vertebra corpus were detected. The patient was recommended outpatient clinic control with a lumbar brace by the neurosurgery. The patient, whose operation was planned by the orthopedics, was admitted to the orthopedics department.
x-ray 1

X-ray 2

X-ray 3

Results and Conclusion: In cases such as a calcaneus fracture following a fall from a height, the patient should not be focused on a single trauma and a physical examination of the entire system should be performed and relevant tests and treatments should be performed.

Keywords: Calcaneus fracture, Vertebral Fracture

Ref No: 8810

Eye Trauma: When To Request Advanced Examination?

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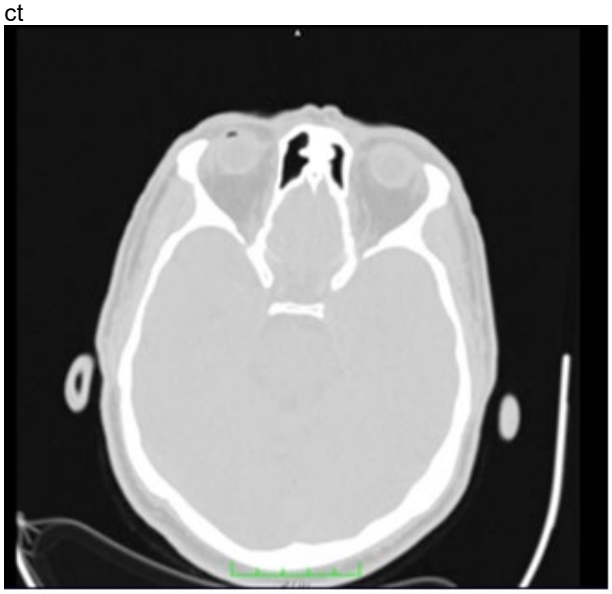
[1]Atatürk Üniversitesi

Introduction and Purpose: Eye trauma is a common presentation in the emergency department, but determining when to request advanced examination is crucial. In this case, we discuss a 75-year-old male patient.

Materials and Methods: Eye trauma is a common presentation in the emergency department, but determining when to request advanced examination is crucial. In this case, we discuss a 75-year-old male patient.

Results and Conclusion: Despite an unremarkable examination, the patient's pain severity raised concern. A CT (Computed Tomography) scan of the orbit was performed, revealing the presence of a foreign body and free air within the eyeball. The patient was immediately referred to ophthalmology for further evaluation and management and was admitted to the ophthalmology ward.In cases of eye trauma, the physical examination may not always reveal the full extent of injury, as was evident in this case. The patient's history and the intensity of pain were key factors that prompted further investigation. It is crucial to carefully assess the patient's symptoms and consider advanced diagnostic tests, even when the physical examination appears normal. Timely consultation with specialists, such as ophthalmology, is essential to ensure proper diagnosis and treatment.

ct



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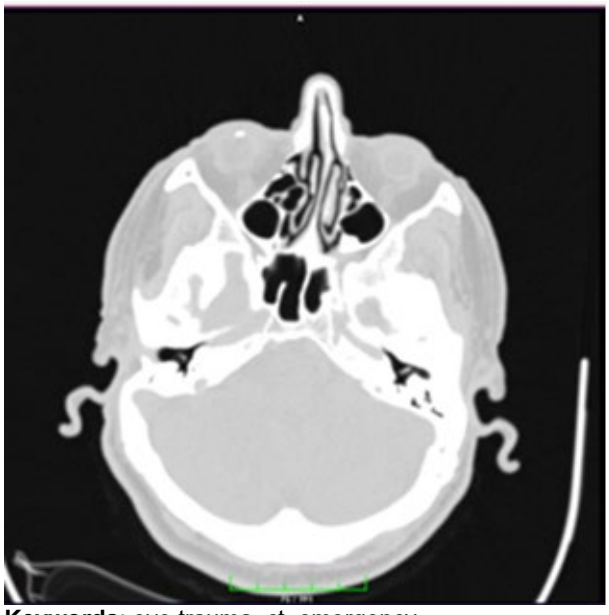

Keywords: eye trauma, ct, emergency

Ref No: 8848

Subarachnoıd Hemorrhage Due To Hypertensıon

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Introduction and Purpose: Subarachnoid hemorrhage is a pathologic condition in which blood is distributed into the subarachnoid space and is a major cause of morbidity and mortality in middle-aged and elderly patients. Subarachnoid hemorrhage can occur as a complication of trauma, aneurysm, vascular malformations, bleeding disorders, brain tumors, anticoagulant therapy and in 20% of cases no cause can be found.

Materials and Methods: A 94-year-old woman with no known history of illness had syncope in the morning after waking up and getting out of bed. She came to consciousness after 10 minutes and was brought to the emergency department by her relatives due to blurred consciousness, slurred speech and slowed reactions. The patient's vital signs were as follows: blood pressure 220/130 mmHg, pulse 74/min, respiratory rate 16/min, temperature 36.6ºC, blood glucose 118 mg/dl. On physical examination, consciousness was stupor, orientation and cooperation were absent, Glasgow Coma Score was calculated as 9 (E2M5V2). Antiplatelet - anticoagulant use is unknown. DLR/IDLR bilaterally negative, corneal reflex on the left (-), corneal reflex on the right (+), anisocoria present, no spontaneous nystagmus, no facial asymmetry. There is no spontaneous movement in the extremities, normal flexor response to pain in the upper extremities and pain avoidance in the lower extremities. The patient underwent brain tomography. On brain tomography; hyperdense hemorrhage areas consistent with SAH filling all sulcal structures at the level of lateral ventricles in bilateral cerebral convexity were observed, hemorrhage area was observed at the level of the genu of the corpus callosum. Large areas of subdural hemorrhage filling all perimesencephalic cisternae and extending around the spinal canal in the foramen magnum in inferior sections were observed. Bilateral cerebral convexity showed erasure of gray-white matter separation secondary to edema superiorly. Cerebral angiography was performed. No aneurysm was observed. Intravenous treatmentfor hypertension was started. The patient was consultedto neurosurgery and admitted to neurosurgery intensivecare unit as in-op.

Bran CT

Bran CT

Results and Conclusion: In patients presenting to the emergency department with altered consciousness, vital signs should be monitored at the time of presentation and a complete systemic examination should be performed. In patients with abnormal findings on neurologic examination, central imaging should be followed up without delay.

Keywords: Hypertension, Subarachnoid Hemorrhage

Ref No: 8865

A Case Report Of Confusion İn An Elderly Patient Presenting With Viral Upper Respiratory Tract İnfection

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Introduction and Purpose: Acutely developing altered consciousness has a wide spectrum of differential diagnosis in patients presenting to the emergency department. Important pathologies such as central nervous system infections, ischemic stroke and sepsis should be considered in the foreground. However, cases of viral upper respiratory tract infection (URTI) that can rarely mimic clinically serious conditions should also be considered in the differential diagnosis. In this case, sudden onset of impaired consciousness and the diagnostic process will be presented.

Materials and Methods: A 78-year-old male patient with a known diagnosis of ischemic stroke. He applied to the emergency room with increasing fever for two days, sore throat, tendency to sleep, and speech disorder. Physical Examination GCS: 15 Conscious, but tendency to sleep. Decreased cooperation. No neck stiffness. Tonsils are hyperemic and hypertrophic. Muscle strength in four extremities is full. Tongue is dry, skin turgor is decreased. Vitals: Fever 38.9 °, blood pressure 110/70 mmHg, oxygen saturation 95, respiratory rate 15/min, pulse 120, Laboratory Findings: WBC: 11.450/µL (Neu: 7050/µL, Lym: 2400/µL) CRP: 40 mg/L Procalcitonin: 1.95 ng/mL, other than that, no acute pathology was observed. No acute pathology was detected in central imaging and thorax CT. EEG and Lumbar Puncture are not compatible with central nervous system infection. The patient was given i.v. hydration, anti-inflammatory, antipyretic, antibiotic treatments. The patient's consciousness improved, his complaints regressed. He was discharged with a diagnosis of viral URTI.

Results and Conclusion: In elderly patients, upper respiratory tract infection and accompanying dehydration may cause simple symptoms such as fever or more severe symptoms such as altered consciousness. However, in these patients, many causes such as

central nervous system infections, sepsis, ischemic or hemorrhagic stroke should be considered. On the one hand, symptomatic treatment should be initiated, and on the other hand, advanced examination and investigation should be continued due to additional causes that may accompany.

Keywords: Confusion, Emergency medicine, Flu

Ref No: 8881

Shoulder dislocation

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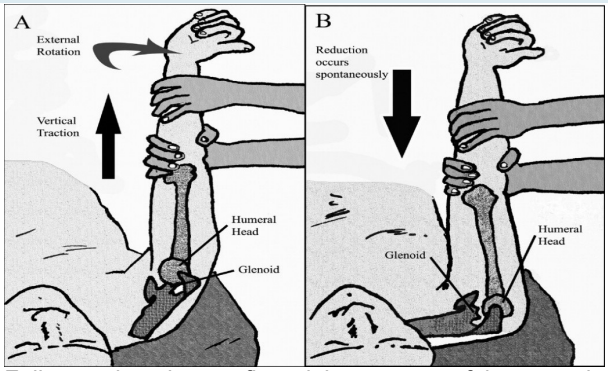
[1]Pamukkale University Hospital

Introduction and Purpose: Traumatic shoulder dislocations are commonly encountered in emergency departments (EDs). Although various treatment methods exist, the most appropriate approach should be selected based on the compatibility between the doctor and the patient. This ensures a safe and effective treatment strategy.

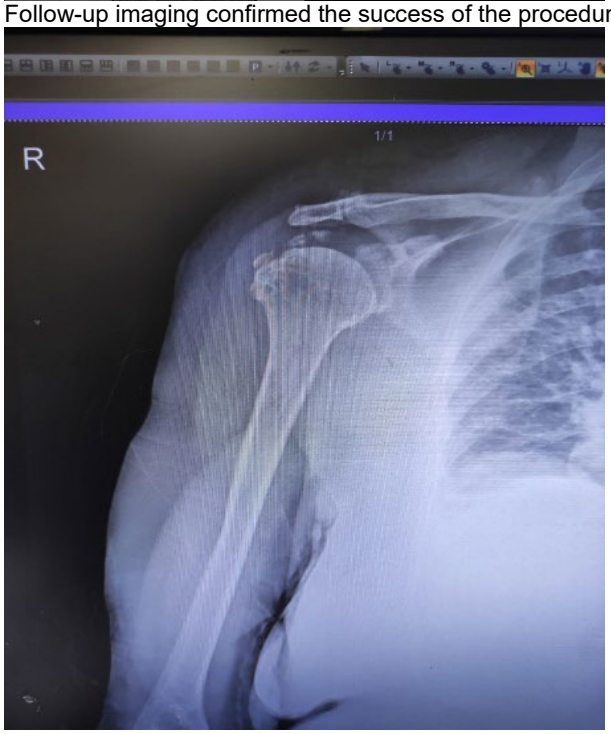
Materials and Methods: A 71-year-old female patient presented to the ED with pain in her right shoulder. She had tripped on a step and fallen from the same level while visiting a health center to obtain a prescription. She reported no additional complaints.Upon presentation, her vital signs were stable. A physical examination revealed normal neurological findings, bilaterally equal and normal breath sounds, and a relaxed abdomen with no signs of guarding or rebound tenderness. An extremity examination demonstrated limited movement in the right shoulder, but distal pulses were intact. Inspection revealed a deformity in the right shoulder, and imaging confirmed an anterior right shoulder dislocation (Figure 1).The procedure was explained step by step, emphasizing the importance of cooperation and communication between the patient and the doctor for optimal execution. The patient was made comfortable, and informed consent was obtained. She was positioned in a supine position, and after intravenous sedation the Spaso technique was used to reduce the shoulder (Figure 2). Follow-up imaging confirmed the success of the procedure (Figure 3). Control neurovascular examination of the extremity was normal.

X ray confirming an anterior right shoulder dislocation.

Description of Spaso technique



Follow-up imaging confirmed the success of the procedure



Results and Conclusion: The purpose of presenting this case is to outline the steps involved in the diagnosis and treatment of shoulder dislocations and to demonstrate the application of the Spaso technique. Additionally, it underscores the importance of patient-doctor collaboration and effective communication throughout the treatment process.
Keywords: physical examination, shoulder dislocation, spaso technique

Ref No: 8947
Not All Back Pain is Mechanical!
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Introduction and Purpose: Aortic dissection is a rupture of the inner wall of the aortic artery due to various causes. Early diagnosis is very important in this disease which needs urgent surgery. In the absence of early diagnosis, it can have very serious mortality. This disease may present with an unusually faint clinic.
Materials and Methods: Patient 48 years old. She took painkillers at DM for low back pain. He applied to us because his pain did not go away. The patient's vitals were stable. General condition was evaluated as good.When the patient was interviewed, he said that his pain was due to herniated disc and he wanted to be discharged when the pain was relieved. When the anamnesis was deepened, it was learnt that the pain had a sudden onset and there was numbness in the right leg.On physical examination, pulse examination of 4 extremities was performed. Right femoral pulse was weaker than the left one and other physical examinations were normal.CT angiography was performed. A dissection flap was seen in the abdominal aorta. The patient was operated by cardiovascular surgeon.
Results and Conclusion: Our aim in presenting this case is to approach each patient impartially. To get information from the patient, relatives, 112 and other physicians, but to remind that it is necessary to evaluate the patient without pursuing the diagnosis.
Keywords: Aortic dissection, anamnesis, pulse

Ref No: 9096

Isolated Superior Mesenteric Artery Dissection: A Case Report

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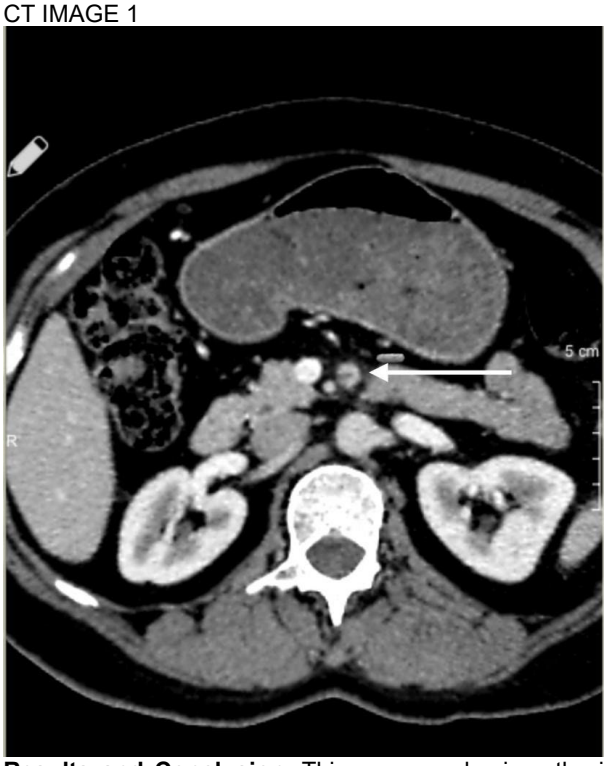
Introduction and Purpose: Isolated superior mesenteric artery dissection (SMA-D) is a rare but increasingly recognized vascular pathology, characterized by a dissection limited to the superior mesenteric artery without involvement of the aorta. While many cases present with acute abdominal pain, others may remain asymptomatic and be diagnosed incidentally during imaging. The increased utilization of high-resolution imaging, particularly contrast-enhanced computed tomography (CT), has contributed to a growing number of reported cases. Risk factors for SMA-D include hypertension, atherosclerosis, connective tissue disorders, trauma, and smoking. If left untreated, SMA-D can lead to life-threatening complications such as mesenteric ischemia, bowel infarction, and perforation.

Materials and Methods: A 43-year-old woman with no known chronic medical conditions presented to the emergency department with a two-day history of localized abdominal pain in the right upper and lower quadrants. She was alert, oriented, and hemodynamically stable. Physical examination revealed abdominal tenderness without rebound or guarding. Laboratory findings were within normal limits. Contrast-enhanced abdominal CT revealed a 4 cm segment of dissection in the SMA just distal to its origin, with a visible intimal flap and contrast opacification of a false lumen. Distal perfusion of the SMA and bowel wall enhancement appeared normal, indicating no signs of ischemia. The diagnosis of isolated SMA dissection was confirmed. Multidisciplinary consultations with cardiovascular surgery, general surgery, and interventional radiology were obtained. Given the absence of ischemia or hemodynamic instability, conservative treatment with anticoagulation and outpatient follow-up was initiated.

CT IMAGE 1



Results and Conclusion: This case emphasizes the importance of including SMA-D in the differential diagnosis of abdominal pain, even in patients without significant comorbidities. Early diagnosis through appropriate imaging and risk stratification allows for the selection of an optimal management strategy. Conservative treatment is effective in hemodynamically stable patients with no signs of intestinal compromise. Long-term follow-up is essential to monitor for progression or late complications. Increased awareness of this rare vascular entity may contribute to earlier detection and improved clinical outcomes.

Keywords: Abdominal Pain, Superior Mesenteric Artery Dissection, Ischemia

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Ref No: 9131

Ankle Inversion Injury with Distal Fibula Fracture and Deltoid Ligament Injury

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Introduction and Purpose: Foot and ankle injuries are common trauma cases encountered during sports activities, traffic accidents, occupational incidents, and daily life. The ankle joint is a strong and stable structure due to the coordinated function of bones, ligaments, and soft tissues. However, because it bears the entire body weight and endures high stress during movement, it is prone to sprains, ligament injuries, fractures, and soft tissue damage. Ankle injuries are generally classified into lateral, medial, and high ankle sprains. The most common type is lateral ligament injury, which occurs due to ankle inversion. Medial ligament injuries are less frequent and usually result from high-energy trauma. Ankle fractures are particularly common in traffic accidents and falls from height, often requiring urgent intervention. The deltoid ligament is the primary stabilizer of the medial side of the ankle joint and may become compromised due

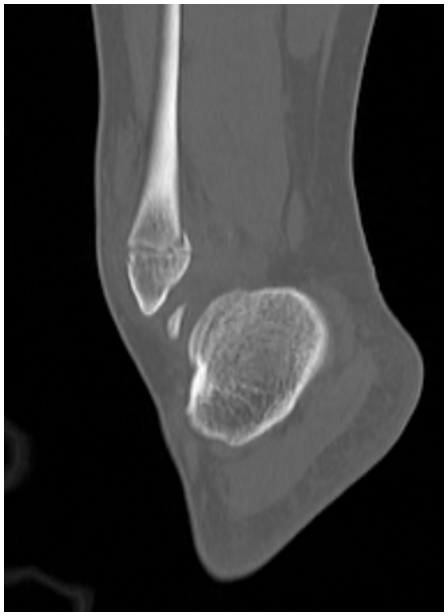
to acute trauma or chronic stress. In acute cases, deltoid ligament insufficiency is often associated with multiple ligament injuries, syndesmotic injuries, or ankle fractures.

Materials and Methods: A 16-year-old male patient presented with an ankle sprain sustained during a wrestling match. Upon history-taking, the trauma was identified as an inversion injury. His vital signs were within normal limits at admission. Physical examination revealed diffuse tenderness and swelling in the ankle. Plain radiography demonstrated a Salter-Harris type III fracture at the distal fibula. The patient was consulted with the orthopedics department, where he was diagnosed with a deltoid ligament injury and subsequently admitted for surgical intervention.

Photo-1

Photo-2

Photo-3



Results and Conclusion: The ankle joint provides both flexibility and durability due to its complex anatomical structure. Despite its high weight-bearing capacity, it remains one of the most frequently injured joints. A thorough analysis of the injury mechanism and affected structures is crucial for accurate diagnosis and appropriate treatment planning.

Keywords: deltoid ligament injury, Salter-Harris type III fracture

Ref No: 9143
COPD EXACERBATION?
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Introduction and Purpose: In cases of hypoventilation, obtaining a detailed medical history and conducting a thorough physical examination are crucial to identifying the underlying etiology and precipitating factors. Arterial blood gas (ABG) analysis should be performed to assess PaCO □, PaO □, and pH levels.
Materials and Methods: A 75-year-old male patient was brought to our emergency department by ambulance (112) due to shortness of breath. He has been diagnosed with COPD for approximately 20 years and is known to be USOT (+). The patient reported experiencing dyspnea, cough, and sputum production for the past two days. He is an ex-smoker with a 30 pack-year history and has been smoke-free for the last 10 years. He presented with a cough and sputum production (white/yellow in color), but no wheezing, hemoptysis, or fever.Vital Signs & Examination Findings:Blood Pressure: 100/80 mmHg Heart Rate: 104 bpmOxygen Saturation (SatO □): 94% (on 2-3 L nasal oxygen) Respiratory Rate: 18 breaths per minute Bilateral decreased breath sounds Pretibial edema: (+/+) Arterial Blood Gas Analysis: pH: 7.28 PCO □ 75 mmHg PO □ 49 mmHg SatO □ 80% HCO □ 35 mmol/LImaging Findings:Thoracic imaging showed no evidence of infiltration, consolidation, or mass in either lung. No pericardial or pleural effusion was detected.Emergency Department Management:The patient was treated with ipratropium bromide (Iprasal) nebulization and Flixair (fluticasone-salmeterol) nebulization in the emergency department. Bilevel Positive Airway Pressure (BiPAP) therapy was initiated (12/6 cmH □O).Follow-Up & Outcome:After two hours of Non-Invasive Mechanical Ventilation (NIMV) therapy, a repeat arterial blood gas (ABG) analysis showed: pH: 7.33 PCO □ 64.7 mmHg PO □ 97.3 mmHg SatO □ 96.4% HCO □ 29.9 mmol/L Since hypercapnia persisted, a pulmonology consultation was requested, and the patient was transferred to the pulmonology department for further management.
Results and Conclusion: Management includes addressing precipitating factors (e.g., infections, bronchospasm) with antibiotics, corticosteroids, and bronchodilators as needed. Oxygen therapy should be administered at an adequate dose to avoid worsening hypercapnia, and the patient should be evaluated for NIMV or mechanical ventilation when necessary. Continuous monitoring is essential, especially in patients with comorbidities such as renal failure, cerebral edema, or cardiovascular diseases, where even mild hypercapnia should be managed promptly.
Keywords: Respiratory failure, Hypercapnia, COPD

Ref No: 9174
The Timeless Digest: The Aging Process of the Gut
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Introduction and Purpose: The aging population and the continuous increase in the elderly percentage havecreated the need to study age-related changes in the human body. A key area of interest is themechanisms of aging and how they affect the occurrence of gastrointestinal disorders. Additionally,the link between gastrointestinal diseases and other chronic conditions, or the regular use ofmedications in the elderly, likely explains why aging itself has limited impact on thepathophysiology of these diseases.The aim of this study was to investigate how much age alone contributes to theoccurrence of gastrointestinal disorders.
Materials and Methods: A quantitative survey was conducted on a random sample of thepopulation regarding gastrointestinal issues in daily life and their correlation with personal medicalhistory. A questionnaire with 33 questions on symptoms, medical history, and demographics wascreated in Greek. The final sample consisted of 319 participants, aged 18 to 100 years. Acomparison was made between individuals over 60 and younger participants to assess the impact ofage on gastrointestinal health.
Results and Conclusion: Age is associated with increased seeking for medical assistance, with older individualsmore likely to visit a doctor for GI symptoms. Age is statistically significantly linked to chronicgastrointestinal diseases, confirming the increased prevalence of these disorders in the elderly. Thepresence of other chronic conditions was not related to the frequency of gastrointestinal complaintsbut was significantly associated with symptom intensity when they occurred. The study confirms acorrelation between the regular use of anti-inflammatory drugs and the incidence of gastrointestinalsymptoms, though not their intensity. Conversely, the intake of aspirin, other antiplatelet agents,and anticoagulants, which are known predisposing factors for gastrointestinal disorders, issignificantly related to symptom intensity but not frequency. No correlation was found between sex,smoking, alcohol use, and the pathogenesis or prevalence of gastrointestinal diseases. Age is an additional factor in the development of gastrointestinal disorders in theelderly. Chronic diseases and regular medication use play key roles in the onset of digestivediseases.
Keywords:

Ref No: 9181
Case presentation: mesenteric ischemia
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Introduction and Purpose: Mesenteric ischemia is a life-threatening condition resulting from reduced blood flow to the intestines, leading to ischemic damage and potential bowel necrosis. It is most commonly seen in female patients with underlying cardiovascular conditions, particularly atrial fibrillation, which predisposes individuals to thromboembolic events. Early diagnosis and intervention are crucial to preventing severe complications and improving patient outcomes.
Materials and Methods: A 60-year-old female patient with a history of atrial fibrillation presented to the emergency department (ED) with a 10-day history of abdominal pain. The pain was particularly aggravated after meals. The patient had a medical history of atrial fibrillation but was not on regular anticoagulation therapy. Mesenteric ischemia was diagnosed upon evaluation.The patient presented

with a 10-day history of abdominal pain. Initially mild, the pain had worsened over the past few days and was more pronounced after eating. The patient also complained of nausea and fatigue. Physical examination revealed mild abdominal tenderness and slight distension, but there was no rebound tenderness or guarding.Laboratory tests showed elevated lactate levels and an increased white blood cell count. Doppler ultrasound and abdominal computed tomography scan revealed significant blockage in the mesenteric artery, and necrosis of small bowel confirming the diagnosis of acute mesenteric ischemia.The patient was stabilized with intravenous fluids and appropriate antibiotics before undergoing emergency surgical intervention. During surgery, the blockage in the mesenteric artery was removed, and necrotic bowel tissue was resected.

Results and Conclusion: Mesenteric ischemia occurs due to reduced blood flow to the intestines, leading to tissue hypoxia. Atrial fibrillation facilitates clot formation, which can cause mesenteric artery occlusion. Early diagnosis is critical for successful treatment.Mesenteric ischemia is a rapidly progressing condition with a high mortality rate. In patients with a history of atrial fibrillation, the lack of anticoagulation therapy can lead to severe complications such as mesenteric artery occlusion. Early surgical intervention successfully preserved the patient's life and prevented bowel necrosis.

Keywords: atrial fibrillation, mesenteric ischemia, acute abdomen

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Ref No: 9235

Horner syndrome

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Introduction and Purpose: Horner syndrome is a clinical condition that occurs due to unilateral damage to the sympathetic nervous system. It is characterized by specific symptoms affecting the eye and facial region. This syndrome can result from involvement of the central nervous system, autonomic nervous system, or vascular structures.The aim of this poster is to raise awareness among clinicians by summarizing the etiology, clinical findings, diagnostic methods, and treatment approaches of Horner syndrome.

Materials and Methods: A 49-year-old male patient presented to the emergency department with right eyelid drooping (Figure 1-2). The patient had a known diagnosis of major depression but no other comorbidities. His vital signs at presentation were as follows: blood pressure 120/80 mmHg, SpO□ 98%, heart rate 110 bpm, and body temperature 36.5°C. Sweating was observed only on the left side of the face. Neurological examination revealed no abnormal findings except for right-sided ptosis. No pathological findings were detected in the patient's central imaging studies or laboratory tests.

Figure 1

Figure 2

Results and Conclusion: Horner syndrome is classified into three main categories: central, preganglionic, and postganglionic. The most common causes include central lesions, lung apex tumors (Pancoast tumor), and vascular pathologies such as carotid artery dissection. Clinically, it manifests with ptosis, miosis, and anhidrosis. Diagnosis is primarily based on clinical findings, but pharmacological tests (such as the cocaine and apraclonidine tests) can support the diagnosis. Additionally, imaging modalities should be utilized to identify the underlying cause.Treatment is directed toward the underlying pathology. Damage to the sympathetic nerve pathways may be irreversible; however, with early diagnosis and appropriate management, the underlying condition can be treated. Therefore, Horner syndrome should be carefully evaluated as a potential indicator of serious neurological and vascular diseases.

Keywords: Emergency department, Horner syndrome, eye

Ref No: 9245

SPONTANEOUS PNEUMODIASTINUM IN A YOUNG PATIENT

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Introduction and Purpose: Pneumomediastinum is defined as the presence of air or another gas in the mediastinum and is also known as mediastinal emphysema. Pneumomediastinum can be categorized as spontaneous (SPM) or traumatic. Some authors distinguish between primary spontan pnömomediastinum (where there is no underlying lung disease that would predispose the person to air leak) and secondary spontan pneeumomediastinum (where there is an underlying airway disease such as cystic fibrosis or asthma). The patient's prognosis and management are guided by the underlying lung disease, if present, rather than the spontaneous pneumomediastinum itself.

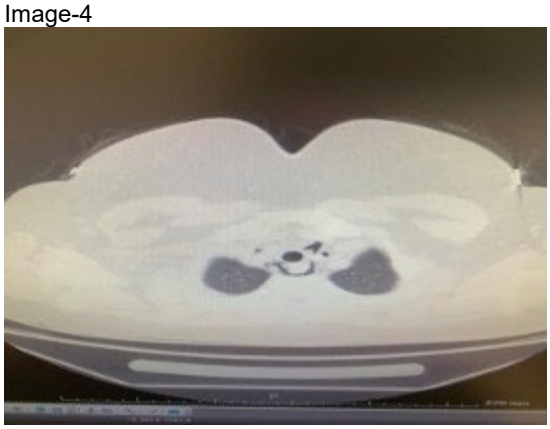
Materials and Methods: A 27-year-old female patient came with chest pain that was independent of effort, started suddenly 1 hour ago, and continued uninterrupted. The patient did not have any additional disease and drug use, cardiac history and history of sudden cardiac death in her family. The patient's vital parameters were within the normal range. On physical examination, Glascow Coma Scale was 15, general condition was good, lung sounds were normal, heart sounds were normal, S1+ S2+, no additional sounds and murmurs were heard. Other system examinations were also normal. Air densities were observed in the mediastinum in an uncontrasted Chest CT of the patient. The patient, who had no history of trauma or surgery, was referred to a Thoracic Surgeon with a preliminary diagnosis: Spontaneous Pneumomediastinum. Vitals were stable, and the general condition was good after 6 hours of observation. The thoracic surgeon did not consider surgery and hospitalisation and recommended outpatient control. Emergencies were explained to the patient, whose complaints did not increase after the observation, and she was discharged with the recommendation of the Thoracic Surgery outpatient clinic control.

Image-1

Image-2

Image-3

Image-4



Results and Conclusion: This case highlights the importance of lung imaging along with cardiac markers in any patient presenting to the emergency department with chest pain who also has stable vital signs and no lung or cardiac sounds. In patients presenting to the emergency department with chest pain, it is important to consider other differential diagnoses, even if they are rare.
Keywords: Pneumomediastinum, Chest Pain, Chest CT

Ref No: 9415
Management of Mogad Disease in Emergency Department
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Introduction and Purpose: Anti-MOG-associated disease (MOGAD) refers to a group of disorders characterized by the presence of antibodies against myelin oligodendrocyte glycoprotein (MOG). Rather than being a singular condition, MOGAD is considered a spectrum of diseases. The onset of MOGAD typically occurs between the ages of 30 and 40; however, cases have been reported in individuals ranging from 18 to 78 years old. MOGAD is notable for its relapsing nature, with recurrence of attacks observed in approximately 60% of patients within the first five years. Notably, a significant proportion of recurrences (40%) occur within the first two years following the initial episode.
Materials and Methods: A 36-year-old female patient with known MOGAD presented to the emergency department with severe pain, weakness, and recurrent attacks. Her vital signs were: blood pressure 126/75 mmHg, oxygen saturation 95% on room air, pulse rate 115 beats/min, and body temperature 36.5°C. She reported severe, stabbing pain in her legs. Initial pain management with 1000 mg of paracetamol and 100 mg of tramadol was ineffective. Subsequently, 10 mg of morphine in 100 cc of isotonic saline was administered, and supplemental oxygen was provided. Gastric protection was ensured with 40 mg of pantoprazole. After pain relief, a physical exam revealed no sensory deficits, but motor weakness (3/5) was noted in the lower extremities. Following a neurology consultation, the patient was admitted for further attack and motor deficit management.
Results and Conclusion: MOGAD is a recently recognized spectrum of disorders that have gained attention in the medical literature. Patients with MOGAD typically experience intense pain during acute exacerbations, often accompanied by a notable loss of strength in the affected extremities. These episodes can significantly impact the quality of life and function of the patients. Given the severity of these attacks, it is crucial for emergency department clinicians to have a thorough understanding of the disease and to implement effective pain management strategies. Timely recognition of the condition and appropriate interventions during exacerbations can help alleviate symptoms, prevent further complications, and ensure optimal patient care in the emergency setting.
Keywords: mogad disease, pain management

Ref No: 9501
A Case Report Of Ovarian Cyst Rupture
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[1]Pamukkale University
Introduction and Purpose: Acute abdominal pain is a common presentation in emergency departments (Eds) and can be caused by a wide range of conditions, from benign to life-threatening pathologies. Among gynecological emergencies, ovarian cyst rupture is a significant yet often overlooked diagnosis. Due to its nonspecific symptoms, it can be misattributed to other conditions, delaying appropriate management. Timely recognition through careful physical examination and imaging is crucial to prevent complications and ensure optimal patient outcomes.
Materials and Methods: A 21-year-old female patient presented to our ED with abdominal pain. She reported experiencing abdominal pain for approximately two days, with a significant increase in intensity about two hours prior to her admission. The patient had no known chronic illnesses. On initial examination, her vital signs were normal. She denied pregnancy. There was no vaginal bleeding, and she did not experience a dysuria. On physical examination, diffuse tenderness and rebound tenderness were present in the bilateral lower quadrants of her abdomen. Costovertebral angle tenderness was negative. No pulsatile mass was detected in the abdomen. The patient's pain did not resolve with analgesia and continued to worsen.Due to persistent examination findings during follow-up, an abdominal CT scan was performed. The CT scan revealed a 3.5 cm heterogeneous cystic lesion in the right ovary, along with hemorrhagic fluid in the perihepatic, perisplenic, paracolic, and pelvic areas. Based on these findings, the patient was diagnosed with an ovarian cyst rupture.Close monitoring of vital signs and hemogram values was conducted. Intravenous normal saline and analgesics were provided. The patient was admitted to the Department of Obstetrics and Gynecology for further monitoring and treatment
Results and Conclusion: The purpose of presenting this case is to emphasize the importance of re-evaluating patients with recurrent ED visits and not being misled by previous diagnoses. This case highlights the critical role of physical examination in making an accurate diagnosis.
Keywords: abdominal pain, cyst rupture, pain

Ref No: 9510
Psoas Muscle Abscess
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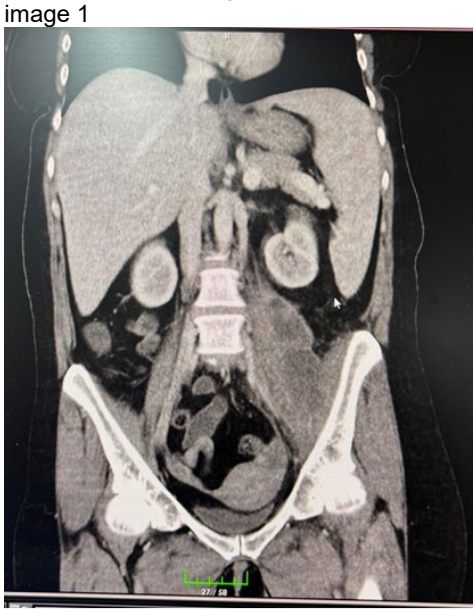
[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ
Introduction and Purpose: Patients presenting to the emergency department (ED) with fever and abdominal pain require a broad differential diagnosis. Intra-abdominal abscesses, though often presenting with nonspecific symptoms, can lead to severe complications if not promptly diagnosed and managed. This case report discusses a previously healthy 57-year-old female patient diagnosed with a psoas abscess.
Materials and Methods: A 57-year-old female patient with no known comorbidities presented to the ED with fever and abdominal pain. On admission, her temperature was 38.8°C, while other vital signs were within normal limits and stable. Physical examination revealed marked tenderness on palpation of the left upper and lower abdominal quadrants.Laboratory results showed leukocytosis (WBC: 16,800/μL) and an elevated C-reactive protein (CRP) level of 308 mg/L. Imaging studies identified a 12 × 7 cm abscess within the left psoas muscle. Based on these findings, the patient was diagnosed with a psoas abscess and was referred to interventional radiology for percutaneous drainage.
image 1

Results and Conclusion: Psoas abscess is a rare but potentially life-threatening condition that can lead to high morbidity if not diagnosed early. It should be considered in the differential diagnosis of patients presenting with fever and abdominal pain, especially

when localized tenderness is present. Imaging modalities play a crucial role in early detection, facilitating timely intervention. In this case, rapid diagnosis allowed for appropriate management via percutaneous drainage. Early intervention is essential in preventing the spread of infection and reducing the risk of complications.

Keywords: PSOAS ABSCESS

Ref No: 9623

Neuron-Specific Enolase as a Predictor of Neurological Outcome After Out-of-Hospital Cardiac Arrest

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[2]The John Paul II Catholic University of Lublin, Lublin, Poland
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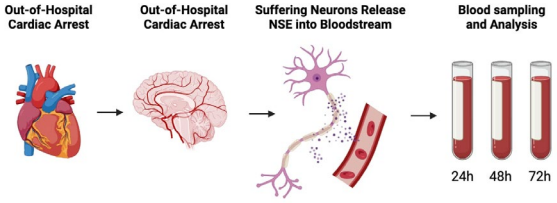
[4]Ankara Etlik City Hospital, Ankara, Turkey

Introduction and Purpose: Out-of-hospital cardiac arrest (OHCA) remains a leading cause of death and long-term neurological disability worldwide. Despite advancements in resuscitation strategies and post-arrest care, the early and reliable prediction of neurological outcomes in comatose survivors continues to pose a significant clinical challenge. Neuron-specific enolase (NSE), a glycolytic enzyme released into the bloodstream following neuronal injury, has emerged as a promising biomarker for neuroprognostication. International guidelines currently endorse NSE as part of a multimodal approach to predicting poor neurological outcomes. In this meta-analysis, we aimed to systematically evaluate the predictive accuracy of NSE for neurological outcomes in adult patients following OHCA.

Materials and Methods: This meta-analysis followed PRISMA 2020 guidelines. We systematically searched PubMed, Embase, Scopus, and Web of Science up to March 2025 for studies reporting serum NSE levels in OHCA adults, with outcomes assessed using the Cerebral Performance Category (CPC) or modified Rankin Scale (mRS). Eligible studies included observational cohorts and clinical trials reporting NSE values by neurological outcome (good vs. poor; Fig. 1). Pooled mean differences (MD) with 95% confidence intervals (CI) were calculated using a random-effects model.

Fig. 1. Neuron-specific enolase role in OHCA



Results and Conclusion: Fifty studies were included in the meta-analysis. Neuron-specific enolase (NSE) levels were significantly lower in patients with good neurological outcomes across all time points. Immediately after return of spontaneous circulation (ROSC), mean NSE levels were 29.75 ± 15.36 µg/L in the good outcome group versus 47.75 ± 36.97 µg/L in the poor outcome group ($p < 0.001$; Fig. 2). At 24 hours, this difference increased substantially (31.02 ± 14.91 µg/L vs. 75.23 ± 52.92 µg/L; $p < 0.001$; Fig. 3). The most pronounced disparities were observed at 48 hours (25.17 ± 13.13 µg/L vs. 118.50 ± 73.80 µg/L; Fig. 4) and 72 hours (25.76 ± 14.03 µg/L vs. 145.80 ± 78.26 µg/L), both with $p < 0.001$ (Fig. 5).These findings confirm that serum NSE levels are strongly associated with neurological outcomes following OHCA, with the highest prognostic accuracy observed at 48 and 72 hours post-ROSC.

Fig. 2. Pooled analysis of NSE concentrations measured after ROSC among good and poor neurological outcome.

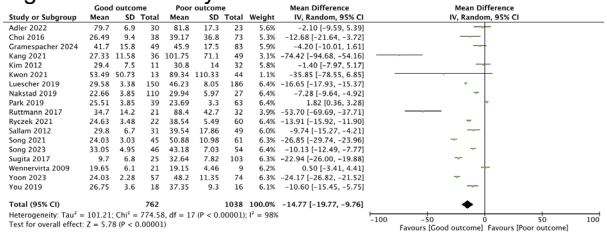


Fig. 3. Pooled analysis of NSE concentrations measured 24h after ROSC among good and poor neurological outcome.

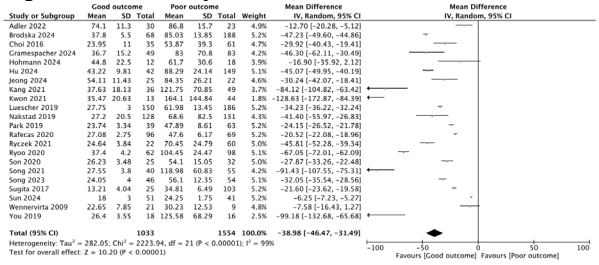


Fig. 4. Pooled analysis of NSE concentrations measured 48h after ROSC among good and poor neurological outcome.

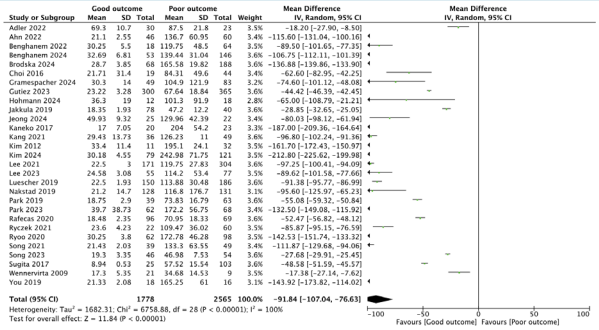
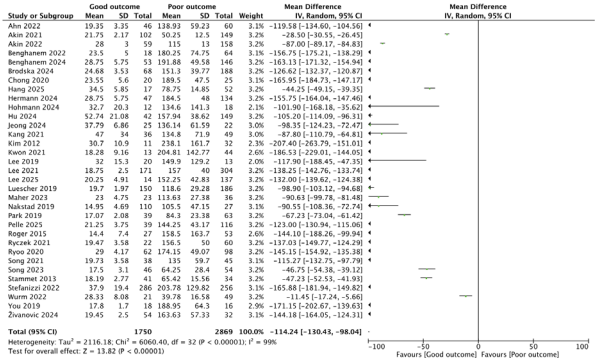


Fig. 5. Pooled analysis of NSE concentrations measured 72h after ROSC among good and poor neurological outcome.



Keywords: Neuron-specific enolase, out-of-hospital cardiac arrest, neurological status

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Ref No: 9643

İLEUS

MERVE BULUT[1], MUHAMMED CENGİZHAN DURMUŞ[1], ERDAL TEKİN[1]

[1]ATATURK UNIVERSITY FACULTY OF MEDICINE

Introduction and Purpose: Bowel obstructions can originate from within the intestine, the intestinal wall itself, or external factors affecting the intestine. Additionally, the causes of ileus vary with age. While congenital anomalies are the most common causes of ileus in the neonatal period, postoperative adhesions, hernias, and malignancies become the primary causes as age increases.

Materials and Methods: A 32-year-old female patient had undergone a cesarean section 20 days ago. She presented with complaints of abdominal pain and vomiting for the past two days. Today, she also experienced diarrhea. On physical examination, diffuse abdominal tenderness was observed, but there was no guarding or rebound tenderness. A direct radiograph showed air-fluid levels. The patient's tests were conducted, and she was consulted with the general surgery clinic.

Results and Conclusion: In patients with a history of intra-abdominal surgery, ileus should always be considered in the differential diagnosis of abdominal pain. Although patients typically present with complaints of an inability to pass gas or stool, diarrhea may also occur due to the emptying of the distal part of the obstruction.

Keywords: DİARRHEA, ABDOMİNAL PAİN, ILEUS

Ref No: 9738

CRIMEAN-CONGO HEMORRHAGIC FEVER (CCHF): A CASE REPORT

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[1]YOZGAT , BOZOK ÜNİVERSİTESİ MEDİCAL FACULTY

Introduction and Purpose: Crimean-Congo Hemorrhagic Fever (CCHF) is a zoonotic viral hemorrhagic disease caused by an RNA virus from the Nairovirus genus. It is primarily transmitted through the bite of Hyalomma ticks or contact with infected animal blood or tissues. Human-to-human transmission via blood, body fluids, or contaminated needles is also possible.CCHF is endemic in regions including Central Asia, Africa, the Middle East, and Eastern Europe, with rural areas in our country frequently reporting cases. The disease typically progresses through four phases:Incubation: Asymptomatic period after tick exposure.Prodromal: Flu-like symptoms such as fever, headache, muscle aches, fatigue, nausea, and vomiting.Hemorrhagic: Signs include petechiae, ecchymosis, epistaxis, hematemesis, and melena.Recovery or Death: Mild cases may resolve spontaneously, while severe cases can lead to multi-organ failure and DIC.

Materials and Methods: A 36-year-old mentally retarded male presented with fever, fatigue, and vomiting. Medical history was limited due to cognitive impairment. No ticks were found on examination, and there were no signs of bleeding. The family reported no tick bites but mentioned that they lived in a rural area with cattle.Vital signs: Temp: 38.2°C, BP: 120/86 mmHg, SpO □ 95%. Lab results showed platelet count: 70,089/mm³, aPTT: 26.8. A 4-panel viral test was negative. Suspecting CCHF, the patient was admitted to the infectious diseases unit. Platelet counts remained between 70–80k during follow-up.

Results and Conclusion: CCHF is a significant public health issue for people in rural areas, especially those involved in animal husbandry. Early diagnosis and supportive care are essential for reducing mortality. Preventive strategies include tick control, personal

protection, and education of at-risk groups. Vaccine development remains a critical goal. Emergency physicians should remain alert, particularly in endemic regions.
Keywords: Crimean-Congo, DIC

Ref No: 9739
Paracetamol İntoxication
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[1]ATATÜRK ÜNİVERSİTESİ TIP FAKÜLTESİ ACİL TIP ANABİLİM DALI
Introduction and Purpose: Paracetamol is a widely used analgesic and antipyretic agent. However, in rare cases, allergic reactions and severe toxic effects may occur in some patients. While paracetamol intoxication is commonly associated with liver damage, allergic reactions related to this drug also present a significant clinical concern. This case report discusses the management and clinical course of a patient who presented with skin rashes, urticaria, and petechial lesions following paracetamol infusion.
Materials and Methods: A 50-year-old woman with no known comorbidities was referred from another center due to skin rashes after paracetamol infusion. The patient has a known allergy to paracetamol. On arrival, her vital signs were stable, and widespread urticarial rashes were observed on her body. No uvular edema was present. Laboratory tests revealed elevated liver function tests, with a platelet count of 57,000/µl and an INR of 1.54. The patient was diagnosed with paracetamol intoxication and treated according to the N-acetylcysteine protocol. Following symptomatic treatment, urticarial plaques regressed, but petechial lesions developed. The patient was admitted to the internal medicine department with a suspected diagnosis of disseminated intravascular coagulation (DIC).
Results and Conclusion: This case highlights that paracetamol can lead to severe complications, including allergic reactions and toxic effects, such as disseminated intravascular coagulation (DIC). Patients suspected of paracetamol allergy or intoxication should be closely monitored, and timely intervention is critical. Early diagnosis and treatment can improve the patient's prognosis and prevent complications. Rapid recognition of such cases in the emergency department and the application of appropriate management strategies are essential.
Keywords: PARACETAMOL

Ref No: 9954
A Case Report İn The Emergency Department: Post-Traumatic Odontoid Process Fracture
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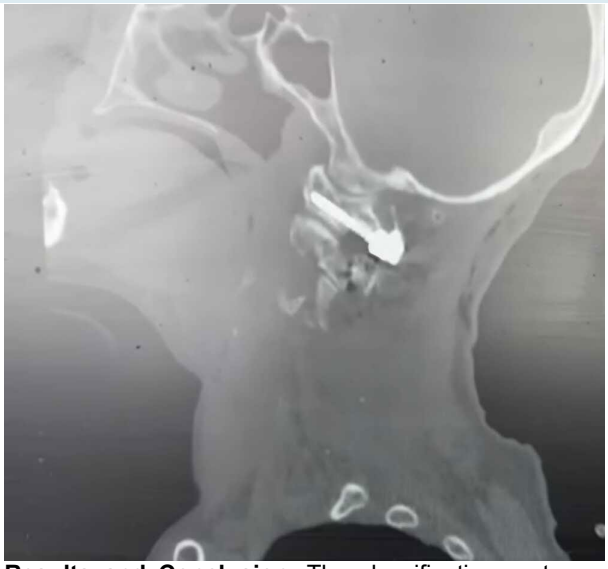
[2]Bartın State Hospital, Emergency Department, Bartın, TURKEY
Introduction and Purpose: While 10% of spinal injuries are traumatic cervical spine injuries, odontoid fractures constitute 10% to 20% of cervical spine fractures in adults. In this case, the initial approach to a patient with an odontoid process fracture in the emergency department, the diagnostic process, treatment, and post-hospitalization status are discussed.
Materials and Methods: A 70-year-old woman fell from a tractor and suffered a blunt blow to her left frontal region, bilateral hemithorax and medulla spinalis level. The patient was brought to the emergency room by 112. In the patient evaluated in the emergency room, except for the lesions mentioned, her neurological examination, ECG, hemogram and blood gas values were normal, while only CRP elevation was present. In the computerized tomography, there was a displaced fracture at the level of the 1st rib, a displaced fracture in the left scapula, and a complete fracture in the spinous processes at the levels of T7, T8, T9, T10 and T11. An odontoid process fracture was noticeable in the patient who did not have neck pain. The patient was operated on accordingly and discharged after being called for check-ups in good health.
figure 1

figure 2



Results and Conclusion: The classification system, which includes type I, type II, and type III fractures of the odontoid process, identifies various presentations based on the location and morphology of the fracture. The primary mechanism of injury involves hyperflexion of the cervical spine, which forces the head and C1 vertebra backward. High-energy injuries usually cause these fractures in young patients, while low-energy impacts are more common in older individuals. Mortality at the time of injury occurs in 25% to 40% of patients. Type II is the most common type of odontoid fracture, accounting for more than 50% of all odontoid fractures. External immobilization and surgery are among the treatment options. In conclusion, odontoid process fracture, which is rarely seen in emergency services, is a condition that should be taken into consideration even though patients do not describe pain, and increasing awareness about this condition will lead to earlier diagnosis, rapid treatment, and prevent permanent sequelae and mortality.Keywords: Odontoid process, external immobilization, fracture

Keywords: Odontoid process, external immobilization, fracture

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Ref No: 9957

HYDATİD CYST PRESENTİNG AFTER A TRAFFİC ACCİDENT

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Introduction and Purpose: Hydatid disease is caused by a parasite called Echinococcus granulosus. The primary source of this parasite is often dogs, where it resides in the small intestine. The disease spreads to humans through eggs excreted in dog feces. Once ingested, the eggs hatch in the intestines, penetrate the intestinal wall, and spread via blood and lymph to organs, predominantly the liver, lungs, and other tissues, where they develop into cysts. In the early stages, when the cysts are small, the disease may remain asymptomatic for many years. However, as the cysts grow, symptoms emerge depending on their size and the pressure they exert on surrounding structures. Cysts are most commonly found in the liver and lungs, though they can rarely affect the spleen, peritoneum, kidneys, bones, eyes, brain, heart, and ovaries. In hepatic involvement, symptoms include pain in the upper right abdomen, nausea, vomiting, itching, and sometimes jaundice. Pulmonary involvement can lead to respiratory distress, cough, hemoptysis, and chest pain.

Materials and Methods: A 16-year-old male patient with no known systemic diseases presented to the emergency department following a traffic accident. On arrival, his general condition was fair, GCS was 15, saturation 93%, pulse 102, blood pressure 131/81 mmHg, and temperature 36.7°C. On physical examination, tenderness was noted in the right upper quadrant of the abdomen. Upon auscultation, reduced breath sounds were detected in the right middle and lower lung fields. The patient was evaluated as having severe trauma and radiological imaging was requested, including abdominal and thoracic CT scans. Radiological findings revealed a 7-8 cm alveolar cyst in the right lung, with evidence of a parasite. The patient was referred to the thoracic surgery department for further management.

Figure 1

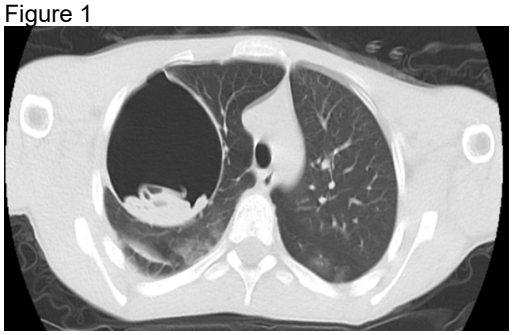
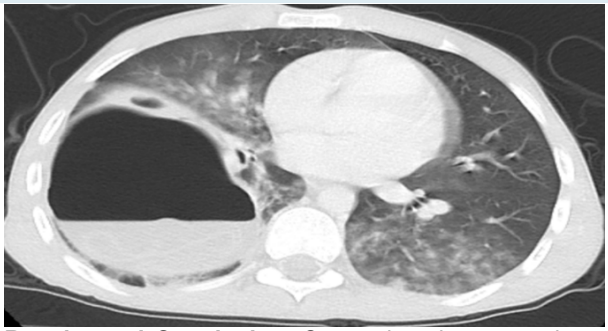


Figure 2



Results and Conclusion: Comprehensive systemic examinations are crucial in patients presenting to the emergency department. In this case, although no pathology was found regarding the trauma, an asymptomatic disease, hydatid cyst, was incidentally detected.
Keywords: Hydatid cyst

Ref No: 9966
A Rare Case: Bilateral Spontaneous Pneumothorax
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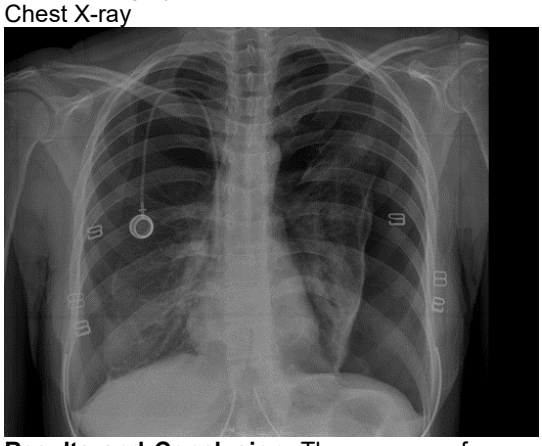
Introduction and Purpose: Pneumothorax is a condition requiring rapid diagnosis and intervention in emergency medicine, leading to lung collapse. Patients typically present with sudden-onset shortness of breath and chest pain, and treatment may involve oxygen support, needle decompression, or chest tube drainage.
Materials and Methods: A 29-year-old female patient presented to the emergency department with a three-day history of shortness of breath. Her complaint was accompanied by severe dry cough. A thoracic computed tomography (CT) scan had been performed at an external center but had not yet been interpreted. Her vital signs on admission were: blood pressure 118/83 mmHg, heart rate 98 bpm, respiratory rate 24, temperature 36.4°C, and oxygen saturation 90%. She was diagnosed with soft tissue sarcoma in 2021 and is not currently receiving active chemotherapy or radiotherapy but is on targeted therapy. In 2023, she underwent cryoablation at an external center. On June 5, 2024, she had a history of spontaneous pneumothorax in the right hemithorax.On physical examination, she was conscious, oriented, and cooperative; neurological examination was normal, and Glasgow Coma Scale was 15. Breath sounds were diminished bilaterally, and the abdomen was soft without defense or rebound tenderness. Due to suspicion of pneumothorax based on physical examination and history, a posteroanterior chest X-ray was performed, revealing bilateral spontaneous pneumothorax. A thoracic surgery consultation was requested, and bilateral tube thoracostomy was performed, after which the patient was admitted to the thoracic surgery department.
Chest X-ray



Results and Conclusion: The purpose of presenting this case is to emphasize that although bilateral spontaneous pneumothorax is rare, it should be considered, especially when underlying conditions (such as soft tissue sarcoma in our case) are present.
Keywords: Pneumothorax, soft tissue sarcoma, spontaneous

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TRANSFUSİON-RELATED ACUTE LUNG INJURY (TRALI)
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Introduction and Purpose: Transfusion-related acute lung injury (TRALI) is a condition characterized by tachypnea, tachycardia, cyanosis, dyspnea, chest pain, and fever, typically occurring within the first 6 hours following the administration of plasma and plasma-rich blood products. In some patients, severe hypotension and acute renal failure accompanied by renal tubular necrosis may also occur. The diagnosis is made if acute lung injury develops within the first 6 hours of transfusion, with no prior lung damage before transfusion, and after excluding other possible causes, such as pneumonia, pulmonary embolism, acute coronary syndrome, pneumothorax, trauma, and anaphylaxis, that could lead to this condition.

Materials and Methods: A 68-year-old female patient presented to the emergency department with complaints of shortness of breath and chest pain for the past 2 hours. She mentioned that she had been followed up for anemia in the Internal Medicine Hematology clinic for about 2 years and received blood transfusions monthly. Today, she had received 2 units of red blood cell transfusion and was discharged after her anemia symptoms improved, with a follow-up recommendation for an outpatient visit. Two hours after going home, she returned to the emergency department with complaints of fever, shortness of breath, and chest pain. Her vital signs were as follows: BP: 115/67 mmHg, Temperature: 37.5°C, Pulse: 110 bpm, RR: 24 breaths/min, SpO2: 89%. An electrocardiogram showed a heart rate of 120 bpm with sinus tachycardia. On lung examination, minimal rales were noted in both lungs. A chest X-ray revealed newly developed widespread bilateral infiltrates (Image 1). After excluding other possible causes and confirming no prior lung injury before transfusion, the patient was diagnosed with TRALI syndrome and admitted to the internal medicine intensive care unit

Figure 1

Results and Conclusion: In conclusion, any patient with a history of blood transfusion who develops respiratory distress, fever, chest pain, and tachycardia within the first 6 hours after transfusion should be suspected of having transfusion-related acute lung injury (TRALI). When diagnosed early, supportive treatments for TRALI yield favorable outcomes.

Keywords: Blood Transfusion