CASE PRESENTATION

Presented by:
SANDY WILLIAM
SARA ADIL
SARA MATTI

Supervised by:
Dr.Jassim Muhammed Taib
Name: س. س. د.
Age: 40 years old
Sex: female
Occupation: teacher
Address: Mosul/Mosul Al-Jadida quarter
Religion: muslim
DOA: 6/11/2013
DOE: 13/11/2013
CHIEF COMPLAINT AND ITS DURATION:

fainting attacks 3 days before admission.
The history of this patient who is 40 years old and not known to have any chronic medical illness and who was emotionally unwell one week before, began 3 days before admission with 3 attacks of loss of consciousness of same duration about 2-5 minutes, sudden in onset, with no complaint before it, the patient turned pale with upward staring of her eyes, frothy secretion in the mouth, no abnormal body movement, no urinary incontinence with spontaneous recovery.
no weakness of limbs but she did not remember the attack and then she return normal. No associated chest pain, palpitation, ankle swelling.

Another attack occurred at the same day in the evening at home, and 3\textsuperscript{rd} one occurred the next day at the street which was just the same.
The patient decided to consult an outpatient clinic for evaluation of her condition and her doctor decided to transfer her to ER where she had another attack _the same as the previous attacks_ but with urinary incontinence as well, so they transferred her to the neurological unit on suspicion to have epilepsy.
At the neurological unit the patient developed sudden onset of severe shortness of breath and bluish discoloration of her body followed by loss of consciousness and abnormal body movement, so she was resuscitated, then transferred to CCU and put on monitoring which showed an abnormality, the patient was reverted to normal by electrical shock. Next two days, more than 100 times of the same preceding attacks were developed and the patient was resuscitated each time with the same way.
CNS : apart from her fainting attacks, the patient did not have any complaint.

GIT : good appetite, 5 years history of self induced vomiting, 3 times daily, after each meal by 10 minutes. No change in weight, no change in bowel motion.

Genito-urinary : apart from oligomenorrhea nothing was remarkable.

Respiratory, MSK, Skin : unremarkable.
PAST MEDICAL HISTORY

No previous similar condition
No chronic illness: DM, HT ...etc
No history of CVS disease: IHD, Rheumatic fever...
PAST SURGICAL HISTORY: negative
FAMILY HISTORY: no similar condition in the family, no history of HT, DM, IHD, nor sudden death.
DRUG HISTORY: no use of drugs, no drug allergy.
SOCIO-ECONOMIC: Married, 2 daughters and one son, good socio-economic state, good water supply and sewerage disposal, not smoker nor alcoholic.
GENERAL EXAMINATION

Young aged female, conscious, alert, sitting comfortably in bed, not dyspneic, good body built, no abnormal facies. Pale, not cyanosed, not jaundiced, no raised JVP, no goiter, no hand signs or nail changes, no leg edema, normal peripheral pulses.

VITAL SIGNS:

Temperature → 37 C
RR → 15 breath/min
PR → 68 bpm, regular, good volume, no special character, the vessel wall is just palpable.
BP → 130/80 mmHg
CVS:
Inspection ➔ no chest deformity, no scar, no precordial pulsation.
Palpation ➔ the apex was just present in the 5th intercostal space, no palpable thrill or heave.
Auscultation ➔ normal S1, S2.
No added sounds.
The local examination regarding CNS and other systems was quite normal.
D .DX ??
DDX:

- Epilepsy
- Cardiac arrest
- Stokes-Adams syndrome (arrhythmia, MI,....)
INVESTIGATIONS
LAB investigations:

CBC, ESR, FBS: normal

RFT

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>Reference Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.Urea</td>
<td>5.2 mmol/L</td>
<td>3.3-7.5 mmol/L</td>
</tr>
<tr>
<td>S.Creatinine</td>
<td>4 mmol/L</td>
<td>Up to 124 mmol/L</td>
</tr>
<tr>
<td>S.Sodium</td>
<td>133 mmol/L</td>
<td>135-145 mmol/L</td>
</tr>
<tr>
<td>Test</td>
<td>Normal Value</td>
<td>Test</td>
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<tr>
<td>------------------</td>
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</tr>
<tr>
<td>Blood Sugar (F)</td>
<td>3.6-6.1 mmol/L</td>
<td>S. Uric Acid</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F (155-357 µmol/L)</td>
</tr>
<tr>
<td>Blood Sugar (R)</td>
<td>up to 7.8 mmol/L</td>
<td>S. Total Bilirubin</td>
</tr>
<tr>
<td>Blood Urea</td>
<td>3.3-7.5 mmol/L</td>
<td>(Neonates premature 3.54) &lt;=285 µmol/L</td>
</tr>
<tr>
<td>S. Creatinine</td>
<td>M (62-115 µmol/L)</td>
<td>(Neonates 3.54) &lt;=285 µmol/L</td>
</tr>
<tr>
<td></td>
<td>F (53-97 µmol/L)</td>
<td></td>
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<tr>
<td></td>
<td>Child (2-12m)</td>
<td>S. Bilirubin (Direct)</td>
</tr>
<tr>
<td></td>
<td>14.34-34.9 µmol/L</td>
<td>S. Bilirubin (Indirect)</td>
</tr>
<tr>
<td>S. Sodium</td>
<td>136-185 mmol/L</td>
<td>S. Alkaline Phosphatase</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F (35-104 U/L)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2-12 Y.) &lt;=300</td>
</tr>
<tr>
<td>S. Potassium</td>
<td>3.5-5.3 mmol/L</td>
<td>S. A.L.T. (G.P.T)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F (Up to 31 U/L)</td>
</tr>
<tr>
<td>S. Chloride</td>
<td>95-165 mmol/L</td>
<td>S. A.S.T. (G.O.T)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F (Up to 32 U/L)</td>
</tr>
<tr>
<td>S. Calcium</td>
<td>2.1-2.6 mmol/L</td>
<td>S. L.D.H</td>
</tr>
<tr>
<td>Ionized Ca</td>
<td>1.0-1.3 mmol/L</td>
<td></td>
</tr>
<tr>
<td>S. Phosphorus</td>
<td>0.8-1.6 mmol/L</td>
<td></td>
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<tr>
<td>S. Magnesium</td>
<td>0.7-1.1 mmol/L</td>
<td>S. C.K</td>
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<tr>
<td></td>
<td></td>
<td>F (24-170 U/L)</td>
</tr>
<tr>
<td>S. Cholesterol</td>
<td>&lt;=5.2 mmol/L</td>
<td>S. Amylase P.A.M.Y</td>
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<td></td>
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<tr>
<td>S. Triglycerides</td>
<td>&lt;=2.3 mmol/L</td>
<td>S. Acid Phosphatase Prostatic</td>
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<tr>
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</tr>
<tr>
<td>S. HDL</td>
<td>&lt;=1 mmol/L Low</td>
<td>S. Iron</td>
</tr>
<tr>
<td></td>
<td>&gt;=1.5 mmol/L High</td>
<td></td>
</tr>
<tr>
<td>S. LDL</td>
<td>&lt;=2.59 mmol/L</td>
<td>T.I.B.C</td>
</tr>
<tr>
<td>Optimal Border line</td>
<td>(3.37-4.21 mmol/L) High</td>
<td></td>
</tr>
<tr>
<td>S. LDL</td>
<td>(4.15-4.9 mmol/L)</td>
<td></td>
</tr>
<tr>
<td>S. VLDL</td>
<td>&lt;=0.53 mmol/L</td>
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</tr>
<tr>
<td>S. Total Protein</td>
<td>60-80 g/L</td>
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<tr>
<td>S. Albumin</td>
<td>36-52 g/L</td>
<td></td>
</tr>
<tr>
<td>S. Globulin</td>
<td>24-37 g/L</td>
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<tr>
<td>A/G Ratio</td>
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Date: 8/1/2013
Cardiac Enzymes

**Patient name:**

**Age:**

**Sex:**

**Ward:**

**Clinical Presentation:**

**Cardiac Enzyme Report**

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
<th>Comment</th>
</tr>
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<tbody>
<tr>
<td>Troponin</td>
<td></td>
<td><strong>Negative</strong></td>
</tr>
<tr>
<td>Myoglobin</td>
<td></td>
<td></td>
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<tr>
<td>CK-MB</td>
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</tbody>
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8/11/2017
Echocardiogram: normal.
ECG: during attack
ECG: between attacks
The main treatment for V.F are: CPR & DC.
TREATMENT AND FOLLOW-UP

<table>
<thead>
<tr>
<th>Date</th>
<th>Treatment</th>
<th>Follow-Up</th>
<th>Diet</th>
</tr>
</thead>
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</tbody>
</table>

is continuing to have VF despite of amiodarone.

Mg infusion, the VF occurring every 5-10 minutes.

Since 8:30 am, she received more than
30 DC shock 200-360 Jules.

After each attack of VF she hear multiple ventricular ectopics on monitor.

At 6:20 am — VF occurred A she is needed to have 3 DC shocks 200, 200, 360 Jules.

At 6:30 am — VF A 2 DC 360 Joles was given

- BP 130/80

At 11:00 am she continuing to have VF every 5 minutes,

she received more than 100 DC in 10 hrs duration.

- 7/11/2013

مان لکه ی دخیل ۲۰۰ و ۳۶۰ جول

بعد از هر حمله VF او چندین بیانیه قلبیventricular از سطح یافت.

در ۶:۲۰ صبح — VF افتاد که باید ۳ DC شکل ۲۰۰، ۲۰۰، ۳۶۰ جول را بگیرد.

در ۶:۳۰ صبح — VF تحت ۲ DC ۳۶۰ جول داده شد.

- BP ۱۳۰/۸۰

در ۱۱:۰۰ صبح او به پیچیدن خود ادامه داد و هر ۵ دقیقه

او بیش از ۱۰۰ DC در ۱۰ ساعت و ۰ دقیقه دریافت کرد.
Treatment before knowing cause of VF
Oxygen on need.
GTN on need.
Morphine on need.
Metoprolol tab 50 mg 1 X 2
isosorbide dinitrate tab 10 mg 1 X 2
Atrovastatin 20 mg 1X1 at night
Clopidogrel tab 75 mg 1 X1
Enoxaparin vial 6000 U SC X 2
Aspirin
amiodarone
Treatment after identification of the cause

Potassium ampule in 500 cc ?? during 2 hours  X 4

Normal saline 1 X 4
40 g
SILVERDIN
CREAM 1%
10 mg/g
Silver Sulfadiazine
TREATMENT OF VESCICULOUS URTICARIA
40 g
SILVERDIN
CREAM 1%
10 mg/g
Silver Sulfadiazine
TREATMENT OF WOUNDS AND BURNS
Bulimia nervosa complicated by hypokalemia....
Bulimia is a serious, potentially life-threatening eating disorder, that can be categorized in two types:

Purging bulimia.

Non-purging bulimia.
• **Diagnostic criteria:**
  
  • Recurrent bouts of binge eating.
  • Lack of self-control over eating.
  • Self-induced vomiting, purgation or dieting after eating.
  • Weight maintained within normal limits.

• Sometimes people purge after eating only a small snack or a normal-size meal.
Patients with bulimia nervosa may experience the following symptoms and complications:

**General** - Dizziness, palpitations

**Gastrointestinal symptoms** - Pharyngeal irritation, abdominal pain, bloody vomiting, constipation.

**Pulmonary symptoms** - Uncommonly, aspiration pneumonia

**Menstrual irregularity.**

**Electrolyte disturbance:** hypokalemia occurs in patients with bulimia that may predispose to cardiac arrhythmias.

Bulimia nervosa should be suspected in patients who have unexplained hypokalemia and metabolic alkalosis in the presence of risk factors.
Physical findings may include the following:
Bilateral parotid enlargement
Dental damage
Russell sign
Non-pharmacological Rx:
Cognitive-behavioural therapy.

Pharmacological Rx:
Fluoxetine (Prozac)
Normal potassium level (3.5-5.2) mmol/L

When K is <3.5 mmol/L → hypokalemia

Causes:

- Decrease intake.
- Shift into cells: alkalosis, insulin, B2 agonist, hypokalemic periodic paralysis.
- Excessive K losses: GIT….RENAL
• Ventricular fibrillation is the most serious cardiac rhythm disturbance, occurs when parts of the ventricles depolarize repeatedly in an erratic, uncoordinated manner, which may lead to cardiac arrest.
Causes may include:
• CAD
• Electrolyte disturbance.
• Hypothermia.
• Drugs.
• Drowning.
• Defibrillation is the only effective treatment for ventricular fibrillation, and will restore cardiac output in more than 80% of patients if delivered immediately.

• Shock-resistant ventricular fibrillation which is persisting after three defibrillation attempts, intravenous anti-arrhythmic agent as amiodarone is acceptable, safe, and useful.
THANK YOU