3. Uluslararası Acil Tıp ve Aile Hekimliği SEMPOZYUMU

29 Kasım - 02 Aralık 2018
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Dr. Yunsur ÇEVİK
Dr. Zeynep ÇAKIR

29 Kasım 2018 Perşembe Salon A

Saat	Konu ve Konuşmacılar
14.00 - 16.00	OTELE GİRİŞ
16.00 - 19.00	**Açılış Konuşmaları** **Kuzey Kıbrıs Türk Cumhuriyeti – Azerbaycan Cumhuriyeti - Türkiye Cumhuriyeti Acil Tıp ve Aile Hekimliği Çalıştayı** **Prof. Dr. Başar CANDER** Acil Tıp Uzmanları Derneği Başkanı, Kanuni Sultan Süleyman Eğitim ve Araştırma Hastanesi Acil Tıp Kliniği Eğitim Sorumlusu **Dr. Hakan UZUN** Trabzon Aile Hekimleri Derneği Başkanı Aile Hekimleri Dernekleri Federasyonu Genel Sekreteri **Dr. Vusale YAŞAR** Azerbaycan Cumhuriyeti **Prof. Dr. Turan SET** Karadeniz Teknik Üniversitesi Tıp Fakültesi Aile Hekimliği Anabilim Dalı Başkanı **Yavuz ATEŞ** T.C Sağlık Bakanlığı Halk Sağlığı Genel Müdürlüğü Bütçe ve Projeler Dairesi Başkanı **Av. Halil ŞEN** T.C Sağlık Bakanlığı Halk Sağlığı Genel Müdürlüğü Daire Başkanı Kuzey Kıbrıs Türk Cumhuriyeti Sağlık Bakanlığı Yetkilileri **Kuzey Kıbrıs Türk Cumhuriyeti Sağlık Bakanlığı Yetkilileri**
19.00 - 22.00	AKŞAM YEMEĞİ

30 Kasım 2018 Cuma Salon A

Saat	Oturum Başkanı	Konu ve Konuşmacılar
09.00 - 10.30	**AÇILIŞ KONUŞMALARI** **Prof. Dr. Başar CANDER** Acil Tıp Uzmanları Derneği Başkanı, Kanuni Sultan Süleyman Eğitim ve Araştırma Hastanesi Acil Tıp Kliniği Eğitim Sorumlusu **Dr. Hakan UZUN** Trabzon Aile Hekimleri Derneği Başkanı Aile Hekimleri Dernekleri Federasyonu Genel Sekreteri **Dr. Vusale YAŞAR** Azerbaycan Cumhuriyeti **Kuzey Kıbrıs Türk Cumhuriyeti Sağlık Bakanlığı Yetkilileri** **Av. Halil ŞEN** T.C Sağlık Bakanlığı Halk Sağlığı Genel Müdürlüğü Daire Başkanı	
10.30 - 11.00	ARA	
11.00 - 12.00	**Prof. Dr. Başar CANDER**	**Acil Servis ve Öncesi** Dr. Öğr. Üyesi Ersin ŞİMŞEK Dr. Öğr. Üyesi Semih KORKUT
12.00 - 13.00	**Dr. Teona VARSAMİLADZE** **Dr. Burhan YILMAZ**	**Akılcı İlaç Kullanımı** Prof. Dr. Turan SET
13.00 - 14.00	ÖĞLE YEMEĞİ	
14.00 - 15.00	**Prof. Dr. Başar CANDER**	Temel Yaşam Destek Kursu (Teorik Bilgi)
15.00 - 15.30		**UYDU SEMPOZYUMU** imuneksFarma **Boğaz Ağrısında Yeni Yaklaşımlar** Dr. Eren ÇAĞLIYOR
15.30 - 16.00	ARA	
16.00 - 17.00	**Prof. Dr. Mehmet GÜL**	İleri Kardiyak Yaşam Desteği ve Defibrilatör Kullanımı Kursu (Teorik Bilgi)
19.00 - 22.00	AKŞAM YEMEĞİ	

30 Kasım 2018 Cuma Salon B

Saat	Oturum Başkanı	Konu ve Konuşmacılar
15.30 - 16.30		**Göç ve Enfeksiyon Oturumu - Salon B**

15.30 - 15.50	Dr. Burhan YILMAZ Dr. Nezaket İSMAYİLOVA	**Su Çiçeği** Dr. Öğr. Üyesi Cüneyt ARDIÇ
15.50 - 16.10		**Kızamık** Dr. Öğr. Üyesi Cüneyt ARDIÇ
16.10 - 16.30		**Tüberküloz** Dr. Öğr. Üyesi Cüneyt ARDIÇ
16.30 - 17.00		**Hepatit B ve Hepatit C** Dr. Vusale YAŞAR Dr. Aydan SEVİZADE
17.00 - 17.30		**Akne Tedavisi** Dr. Narmin AKBAROVA Nihal ADAĞ
17.30 - 18.30	**Prof. Dr. Hakan OĞUZTÜRK**	**Sözlü Bildiriler**
19.00 - 21.00	AKŞAM YEMEĞİ	

1 Aralık 2018 Cumartesi Salon A

Saat	Oturum Başkanı	Konu ve Konuşmacılar
09.00 - 10.20	**Prof. Dr. Hakan OĞUZTÜRK** **Dr. Abdo KHOURY**	**Kardiyak Aciller Oturumu**
09.00 - 09.20		**Hipertansif Acillerde Tedavi Protokolleri** Prof. Dr. Sadiye YOLCU
09.20 - 09.50		**Ölümcül Göğüs Ağrıları ve Acil Yaklaşımlar** Doç. Dr. İsa KILIÇASLAN
09.50 - 10.10		**Ölümcül EKG Tanıları** Dr. Öğr. Üyesi Burak KATİPOĞLU
10.10 - 10.20	ARA	
10.20 - 11.20	**Dr. Öğr. Üyesi Ersin ŞİMŞEK** **Doç. Dr. Şükrü GÜRBÜZ**	**Solunum Acilleri Oturumu**
10.20 - 10.40		**Astım-KOAH Ataklarında Tanı Tedavi** Prof. Dr. Polat DURUKAN
10.40 - 11.00		**Pulmoner Emboli** Dr. Öğr. Üyesi A. Osman KOÇAK
11.00 - 11.20		**Pnomonili Hastaya Yaklaşım** Uzm. Dr. İlker AKBAŞ
11.20 - 11.30	ARA	
11.30 - 12.30	**Doç. Dr. İsmail Okan YILDIRIM** **Doç. Dr. Abdelouahab BELLOU**	**Travmatik Aciller Oturumu**
11.30 - 11.50		**Genel Travma Hastasına Yaklaşım** Dr. Öğr. Üyesi Semih KORKUT
11.50 - 12.10		**Baş Boyun Travmasına Yaklaşım** Doç. Dr. Yahya Kemal GÜNAYDIN
12.10 - 12.30		**Ekstremite Travmalarında Gözden Kaçanlar** Dr. Öğr. Üyesi Ali DUMAN
12.30 - 14.00	ÖĞLE YEMEĞİ	
14.00 - 15.00	**Prof. Dr. Behçet AL**	**Dahili Aciller Oturumu**

14.00 - 14.20		**Anafilaksi** Doç. Dr. Şükrü GÜRBÜZ
14.20 - 14.40		**Sepsis-2018** Doç. Dr. Mehmet OKUMUŞ
14.40 - 15.00		**Zehirlenmelerde Hayat Kurtarıcı Antidotlar** Prof. Dr. Yunsur ÇEVİK
15.00 - 15.30	ARA	
15.30 - 16.30	**Prof. Dr. Yunsur ÇEVİK** **Dr. Öğr. Üyesi Emel ERKUŞ SİRKECİ**	**Adli Aciller Oturumu**
15.30 - 15.50		**Hasta ve Yakınları ile İletişim** Prof. Dr. Behçet AL
15.50 - 16.10		**Malpraktis** Doç. Dr. Ayhan AKÖZ
16.10 - 16.30		**Sağlıkta Şiddet** Uzm. Dr. Kerem Dost BİLMEZ
19.00 - 22.00	AKŞAM YEMEĞİ	

1 Aralık 2018 Cumartesi Salon B

KURS - PRATİK		
14.00 - 15.00	**Prof. Dr. Başar CANDER**	**KURS** **Temel Yaşam Destek Kursu**
15.00 - 15.30	ARA	
15.30 -17.00	**Prof. Dr. Mehmet GÜL**	**KURS** **İleri Kardiyak Yaşam Desteği ve Defibrilatör Kullanımı Kursu**
17.00 - 18.00	**Dr. Öğr. Üyesi Ali DUMAN**	**Sözlü Bildiriler**
19.00 - 22.00	AKŞAM YEMEĞİ	

2 Aralık 2018 Pazar Salon A

Saat	**Aile Hekimliğinde Hukuksal Sorunlar**	
08.30 - 11.00	**Yavuz ATEŞ**	**Aile Hekimliğinde Hukuksal Sorunlar ve Çözümleri** Dr. Hakan UZUN Av. Halil ŞEN
11.00 - 12.00	**KAPANIŞ KONUŞMASI**	
12.00	**OTELDEN ÇIKIŞ**	

POSTER BİLDİRİLER

POSTER 1

CHARACTERİSTİCS OF PATİENTS HOSPİTALİZED TO CARDİOVASCULAR SURGERY DEPARTMENT FROM EMERGENCY SERVİCE

Sema Avcı[1], Bulut Demirel[2], Zarife Selvan[3], Elif Burcu Garda[4]

[1]Amasya University Sabuncuoğlu Şerefeddin Research and Training Hospital, Department of Emergency Medicine, Amasya.

[2]Ankara Çubuk Halil Şıvgın State Hospital, Department of Emergency Medicine, Ankara.

[3]*Kars Harakani State Hospital, Department of Emergency Medicine, Kars.*

[4]*Yakın Doğu University, Department of Emergency Medicine, Kıbrıs.*

ABSTRACT

Introduction: Emergency service is the area where patients are first evaluated. Relevant physicians are consulted in emergency services. The aim of this study is evaluation of the patients hospitalized by cardiovascular surgery from emergency service.

Method: This retrospective study was conducted in a state hospital between the dates 01.01.2012-01.09.2017. The records of patients hospitalized by cardiovascular surgery from emergency service were reached. The demographic features, hospitalization diagnosis, complication rates, comorbidities, duration of emergency service, complete blood count and bleeding parameters, hospitalization duration and outcomes of patients were evaluated.

Results: Records of 146 patients from the automation system were evaluated retrospectively, 88 (62%) of the 142 patients included in the study were male. The most common (39.4%) cause of hospitalization was deep vein thrombosis. 92.3% of the hospitalized patients were discharged with cure. Six patients were referred to an advanced center, one patient refused treatment and four patients died. The most common concomitant disease was hypertension.

Discussion: Doctors working in emergency service, should throughly evaluate the clinical characteristics of patients before the Cardiovascular Surgery consultation.

Keywords: Emergency service; surgery; hospitalization; consultation.

POSTER 2

KUMADİN KULLANAN EVDE SAĞLIK HASTALARINDA INR DÜZEYLERİNİN DEĞERLENDİRİLMESİ

Oğuzer Usta[1], Cüneyt Ardıç[1]

[1]*RTEÜ Tıp Fakültesi Aile Hekimliği AD., Rize*

Amaç

Varfarin sodyum evde bakım hastalarında yaygın kullanılan pıhtılaşmayı önleyen, venöz ve arteriyel tromboemboli riskini yüksek etkinlikte azaltan kumarol türevi bir oral antikoagülandır. Varfarin tedavisinin kontrol ve takibinde INR (international normalized ratio) değeri kullanılır. Hedef INR

değerinin; mekanik protez mitral kapağı olan hastalarda 2,5-3,5 mekanik protez aort kapağı olan hastalarda 2,0-3,0 atriyal fibrilasyon, pulmoner emboli, derin ven trombozlu hastalarda 2,0-3,0 arasında tutulması önerilmektedir. Bu çalışma hastanemiz evde sağlık hizmetlerine kayıtlı varfarin kullanan hastalarda hedef INR düzeylerine ulaşma oranının değerlendirilmesi amacıyla yapılmıştır.

Yöntem

Çalışmamız Recep Tayyip Erdoğan Üniversitesi Evde Bakım Hizmetlerine'ne kayıtlı varfarin kullanan hastalarda Temmuz-Eylül 2018 tarihleri arasında yürütüldü. Çalışma grubunu bu hastalardan düzenli INR kontrolü yapılmış toplam 76 hasta oluşturdu. Literatür bilgilerinin ışığında oluşturulan değerlendirme formunda sosyo-demografik özellikler, INR değeri bilgileri yer aldı. Katılımcılar hedef INR düzeyinde olanlar ve olmayanlar olarak gruplandırıldı.

Bulgular

Olguların yaş ortalaması 79,8 (min. 38,maks. 93) idi. Hastaların 66'sı (%86) kadındı.

INR'si 2-3 arası normal değer referans aralığında olan hasta sayısı 20 (%26) idi. Hastaların 40 (%52) tanesinin INR değeri normalin altındayken 16 (%21) tanesi normalin üstündeydi. 2 hastanın INR değerin kritik değer olan 5'in üzerindeydi.

Sonuç

Varfarin tromboembolik olayların tedavisinde endike olup, sıklıkla kullanılan oral antikoagülandır. Dar terapotik doz aralığı nedeniyle dikkatli kullanılmalıdır. Hemorajik ve tromboembolik komplikasyonları nedeniyle düzenli ve sık takibi yapılmalıdır.

Çalışma sonuçlarına göre, bireyde var olan hastalıklar ve varfarin-ilaç etkileşimi hakkında bireylerin bilgilendirilmesi gerektiği görülmektedir. Johnson ve arkadaşlarının (2010) çalışmalarında da benzer şekilde varfarin eğitimi ile ilaca uyumun arttığı saptanmış, bunda hemşirelik danışmanlığı ve eğitim programlarının önemi vurgulanmıştır.

Çalışmalarda varfarin kullanımında eğitimin önemli olduğu belirtilmektedir. Bu sonuçla eğitimin artmasıyla varfarin ilişkili komplikasyonların azalacağı ve buna bağlı olarak da maliyetin azalacağı vurgulanmıştır. Tüm bu sonuçlar, hastalara verilen eğitimin önemini ve gerekliliğini açıkça göstermektedir.

Kumadin kullanan, yatağa bağımlı ve hastaneye ulaşması zor hastalarda INR takibi kritik öneme sahiptir. Aile hekimleri bu takibin yapılmasında önemli bir yere sahiptir.

POSTER 3

PORCELAİN GALLBLADDER PERFORATİON

Huda Almadhoun [1] , Fatma Sarı Doğan [1] , Nurhayat Başkaya [1] , Semih Korkut [1] , Avni Uygar Seyhan [1]

[1] Emergency department, Kartal dr. Lütfi Kırdar Training and Research Hospital, Sağlik Bilimleri University, Istanbul, Turkey.

ABSTRACT

Introduction :
Porcelain gallbladder is a rare medical condition that results from extensive calcification of the gallbladder walls. It's an entity that usually presents asymptomatically in elderly patients with non specific signs and symptoms.
Case Presentation :
We reported a case of 82 year old female patient with a 20 years history of hypertension, diabetes mellitus, chronic heart failure and chronic kidney failure who was presented with non specific signs and symptoms of sepsis and was diagnosed incidentally to have perforated porcelain gallbladder
Conclusion :
Porcelain gallbladder usually present as chronic cholecystitis and upon perforation can cause severe signs of sepsis that requires extensive medical and surgical management.

INTRODUCTION

Porcelain gallbladder is an uncommon clinical entity. Recognizing the clinical and imaging characteristic of this condition is important because of the high frequency of adenocarcinoma in porcelain gallbladder. It's characterized by the presence of brittle calcified gallbladder. The term "Porcelain" has been used to emphasize the blue discoloration and the brittle consistency of the gallbladder wall at surgery . Porcelain gallbladder rarely manifest as acute condition and is most likely to be present as chronic cholecystitis.

CASE REPORT

82 year old female patient with a history of 20 years of hypertension, diabetes mellitus, chronic heart failure and chronic kidney failure presented to our emergency department with a 3 days history of vomiting, weakens and lethargy. Her vital signs were stable at time of examination. Abdominal examination showed mild abdominal discomfort at the right upper quadrant without defense or rebound tenderness and Murphy sign was negative. The remaining of her clinical examination didn't show any other abnormality other than dry mouth and mucous membranes that was secondary to her continuous vomiting. Performed blood tests showed lactate level of 6 mmol/L CRP of 327 mg/l and a WBC of 15.000/µL. Contrast enhanced computed tomography CT scan revealed a large perforated

porcelain gallbladder. Extensive empirical antibiotic therapy was started immediately. The patient was admitted to the Intensive care unit and had undergone surgical cholecystectomy few days later on

.

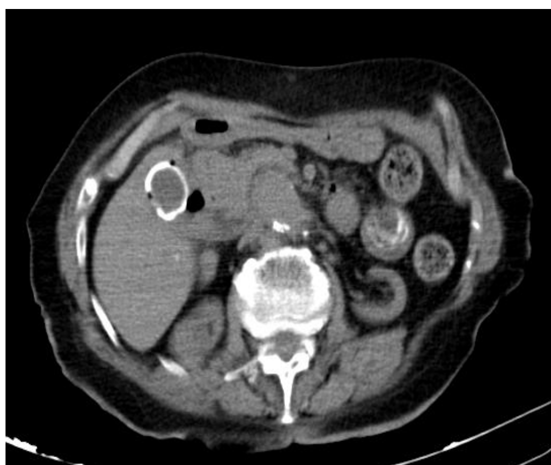
DİSCUSSİON

Evaluation of elderly patients remains to be difficult due to the co-morbidities and the nonspecific symptoms and signs that this age group present with. Patients with porcelain gallbladder are usually asymptomatic, which adds to the difficulty of diagnosing this condition. Porcelain gallbladder presents as chronic cholecystitis. It should be noticed that once diagnosed it has to be resected surgically even if asymptomatic due to the high risk of adenocarcinoma that it carries. If presented acutely it can lead to serious complications such as sepsis and bilious peritonitis. Sometimes its difficult to distinguish porcelain gallbladder from entirely filled cholelithiasis by ultrasonography and the differential diagnosis can be made only by abdominal radiography.

CONCLUSİON

Patient with porcelain gallbladder are not usually considered to have a high risk of acute cholecystitis but the risk of perforation and sepsis should be kept in mind. Elderly patients presenting with unexplained signs of sepsis should be examined thoroughly and with the aid of nowadays radiological techniques the correct diagnosis and the appropriate therapy should be started as soon as possible.

Abdominal CT Scan



POSTER 4

COEXİSTENCE OF DRUG USE WİTH SPLEEN LASERS

Serkan Dogan, Ertuğrul Ak, Bensu Bulut, Ramiz Yazıcı, Büsra Bildik, Basar Cander
University of Health Sciences, Kanuni Sultan Suleyman Research and Training Hospital, Department of Emergency Medicine, Istanbul,Turkey

Introduction

Substance abuse is one of the leading social problems in our country and in the world. The patients who admited to the emergency department with various complaints as a result of substance abuse, such

as loss of consciousness, seizures, confusion and so on. clinical conditions are encountered. These patients experience minor or major traumas secondary to loss of consciousness. In this poster presentation, we wanted to mention the case of splenic laceration due to suspected trauma mechanism after substance abuse.

The Case
A 21-year-old male patient who lost consciousness after substance abuse was brought to the emergency department with Ambulance 112. The patient had no history of disease or drug use, and his vital signs were stable. On physical examination, no additional pathology was found except for blurred consciousness. During the follow-up in the emergency room, the patient was conscious, complaining of abdominal pain and side pain. Bedside ultrasound was performed. Widespread fluid in hepatorenal junction (Morrison) and spleen parenchyma irregularities were found by ultrasound (Figure 1). The patient underwent contrast-enhanced abdominal computed tomography (CT). In the CT, a 12 cm, the biggest one, hemorrhagic fluid in the pelvic region and a 61-mm-thick subcapsular hematoma in the anterior of the spleen were observed.(Figure2). The patient did not have any pathological findings in his vital signs; but, the first hemoglobin value of the patient was 13.3 g/dl and the control hemoglobin value was 7.7 g/dl. The patient was then given 2 units of erythrocyte suspension. The patient, who was consulted with general surgery, was hospitalized for further examination and treatment.

Result
Traumas that develop secondary to blurred consciousness due to substance abuse can be seen with mortal clinics. The case of splenic laceration in our case is an example; we, emergency physicians, should always be careful for such situations.

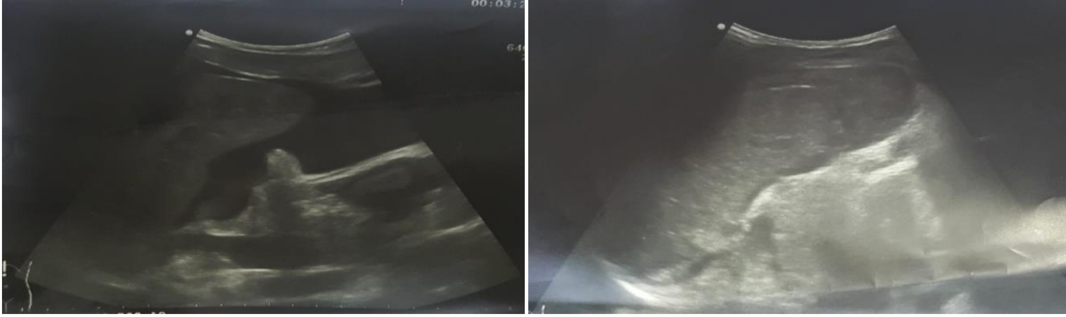


Figure 1

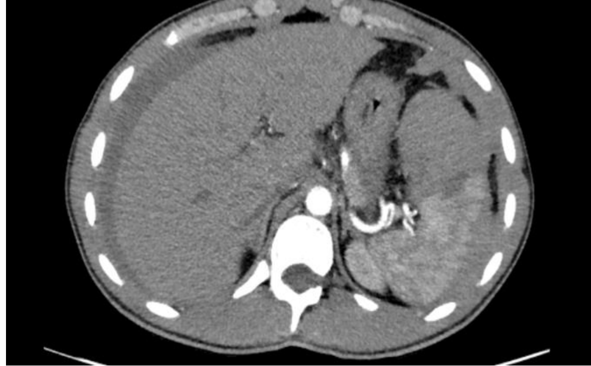


Figure 2

POSTER 5

SEPTIC PULMONARY EMBOLISM CAUSED BY CELLULITIS

Rabia Birsen Tapkan, Ertuğrul Ak, Büşra Bildik, Ramiz Yazıcı, Serkan Dogan, Başar Cander
University of Health Sciences, Kanuni Sultan Suleyman Research and Training Hospital, Department of Emergency Medicine, Istanbul,Turkey

Introduction

Septic pulmonary embolism is characterized by fever, shortness of breath, pulmonary infiltration and one of the rare clinical conditions. This disease is hard to diagnose due to the absence of specific symptoms and laboratory tests. Pathophysiologically, the thrombus containing the microorganisms that settle into the fibrin in the primary focus of infection is in the pulmonary artery. The causes such as tricuspid valve bacterial endocarditis, thrombophlebitis, osteomyelitis, soft tissue infections are among the risk factors. In this poster presentation, we wanted to mention about septic pulmonary embolism caused by cellulite.

The Case

A 31-year-old male patient was admitted to emergency medicine department with fever,shortness of breath and complaining of bloody sputum for 3 days. It was learnt that the complaints of the patient who had no history of known disease and usage of drug had begun 13 days ago. On his physical examination, his right leg was edematous and inflamed; Spo2: 94% (in room air) and respiratory sounds were bilaterally reduced. The other system examinations were natural and the ECG was normal sinus rhythm. C-reaktive protein (CRP) was 203 mg\L and WBC was 21.37 10^3/µL in his laboratory tests. Superficial tissue ultrasonography (USG) was performed to the right leg. Cellulitis was detected in USG. In thorax computerized tomography, the patient had pleural effusion in the right hemithorax up to 3 cm and in the left hemithorax up to 5 cm and had scattered nodules showing multiple cavitation in both lungs(Picture 1). The patient was diagnosed with septic embolism caused by cellulitis. The consultation of department of pulmonary diseases was requested and the patient was admitted to the intensive care unit for further examination and treatment.

Conclusion

We should consider septic embolism in the prediagnosis of patients who are admitted to emergency department with shortness of breath when a focus of infection such as soft tissue infection is detected.

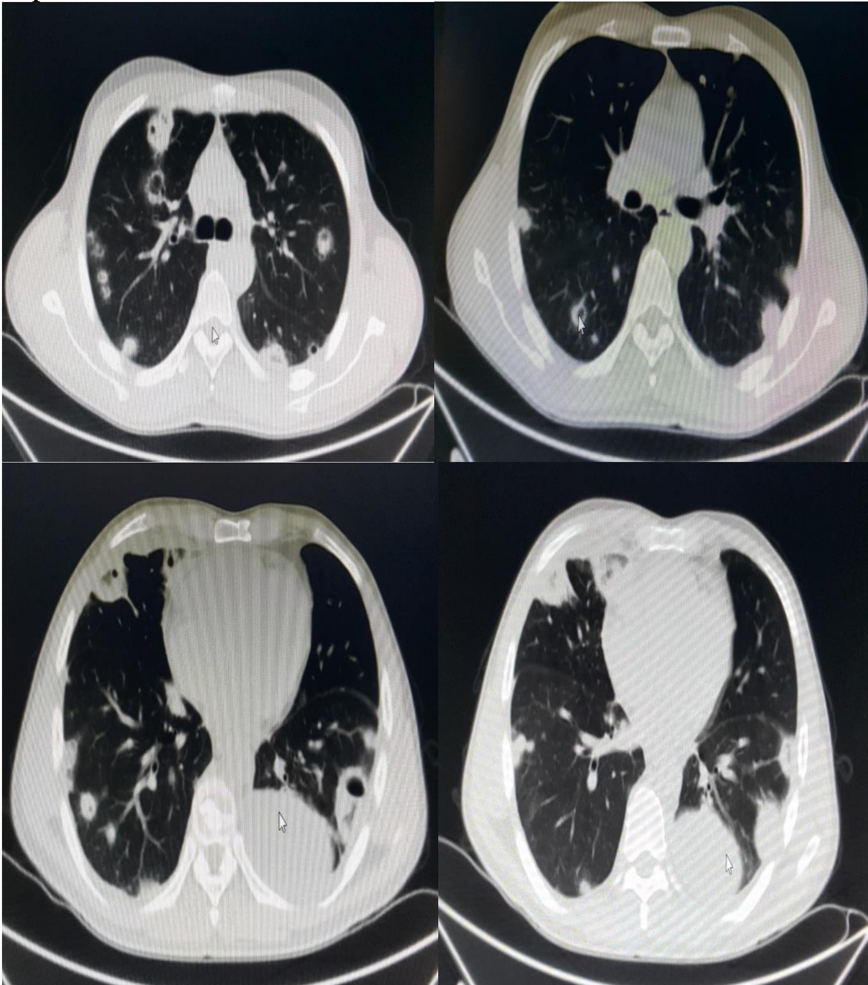


Figure 1

POSTER 6

AORTIC DISSECTION PRESENTED WITH ACUTE CORONARY SYNDROME CLINIC

DR. TURGUT DOLANBAY (BINGOL STATE HOSPITAL EMERGENCY SERVICE)
DR. İLKER AKBAŞ (BİNGÖL STATE HOSPITAL EMERGENCY SERVICE)

INTRODUCTION: Aortic dissection is the filling of the blood into the aortic wall as a result of tearing in the aorta. We present a case of aortic dissection in a patient with presenting inferior myocardial infarction.

CASE: A 87-year-old woman was admitted to the emergency department with chest pain, shortness of breath and blood spitting. The patient had 140/80 mmHg blood pressure, %99 saturation, 90 pulse, 37C fever and 15/min respiratory rate. The lung sounds were normal. ECG revealed a ST segment elevation in inferior leads and ST segment depression in v1 2 3 4, d 1 and avL Ecocardiography was performed and a flap view on the aorta was seen. The thorax tomography of the patient revealed aortic dissection including the hypodense filling defect of the thrombus except the aortic segment, extending from the aortic level to the bilateral main iliac arteries. At the bifurcation level of the main pulmonary artery, there are hypodense appearances in the filling defect that cause a decrease in the calibration (secondary to dissection). The patient was consulted to cardiology and cardiovascular surgery and was admitted to cardiovascular surgery.

CONCLUSION: Although typical myocardial infarction with ECG findings is rare in patients, bedside ECO for aortic dissection excision and if suspicion CT angio monitoring may be lifesaving.

POSTER 7

ECTOPIC PREGNANCY PESENTED WITH DYSMENORRHEA: A CASE REPORT

DR. TURGUT DOLANBAY (BINGOL STATE HOSPITAL EMERGENCY SERVICE)
DR. MUHAMMET MUSTAFA TÜRK (FIRAT UNIVERSITY EMERGENCY SERVICE)
DR. İLKER AKBAŞ (BİNGÖL STATE HOSPITAL EMERGENCY SERVICE)
DR. OKAN ÇAKIR (BİNGÖL STATE HOSPITAL EMERGENCY SERVICE)

INTRODUCTION: Ectopic pregnancy occurs when the ovum is located in the genital tract, outside the uterine cavity. It is the most important cause of pregnancy-related deaths in the first trimester of pregnancy.

CASE: A 28-year-old woman presented to the emergency department with severe abdominal pain. On physical examination, she had tenderness and rebound on the left lower quadrant of the abdomen. The patient was in the menstruation period also. The patient's B-hcg level was 1500 mlU/ml. The abdomen USG was performed and the patient was diagnosed with ectopic pregnancy and left ovarian cyst rupture. Patient was consultated to gynecology department and hospitalized.
CONCLUSION: Ectopic pregnancy is most common in the clinic with pelvic pain and vaginal bleeding. It should be kept in mind that ectopic pregnancy may be present in patients presenting with dysmenorrhea.

SÖZEL BİLDİRİLER

SÖZEL 1

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A RARE CAUSE OF RECURRENT SYNCOPE

Introduction

Syncope is one of the most frequent causes of emergency department visits. Patients with syncope should be evaluated thoroughly both in terms of neurological and cardiac disorders. Despite the availability of so many sophisticated tests to find out the underlying cause, taking a good history still remains as the main pillar of diagnosis. In this case, we present a patient who came to the emergency department because of recurrent syncopal episodes over the last two months.

Case

A 60-year-old woman with myasthenia gravis (MG) for five years came to emergency department because of increasing frequency of fainting and complete loss of consciousness over the last two months. These episodes got worse and some days she fainted five times in a single day. Her past medical history also included a thymectomy operation four years ago. The initial physical examination which included a thorough neurological evaluation was unremarkable. Her blood tests, brain magnetic resonance imaging, and electrocardiogram were also within normal limits. Her medication was pyridostigmine 180 mg/daily. When questioned further for syncopal episodes, it was found out that she had no prodromal symptoms and most importantly she lost her consciousness even while lying down. This feature prompted for a possible cardiac cause and she was admitted to the hospital where she developed complete atrioventricular block leading to syncope which required temporary venous pacing. Based on consultation with neurologists, pyridostigmine was discontinued but intermittent A-V block persisted and eventually, the patient received a permanent pacemaker. She was discharged one week later in a stable condition.

Conclusion

Patients with MG may have a tendency for syncopal episodes due to cardiac causes. There are two possible mechanisms for this. Either the disease itself may attack the myocardium or the conduction system leading to atrioventricular block of varying degrees or pyridostigmine which is the main drug used for MG may itself cause significant sinoatrial or atrioventricular block due to its muscarinic side effects and cause long asystole and heart block. Therefore, when emergency physicians encounter syncopal episodes in these patients, they should be aware of this potential cardiac cause and have a low threshold for prolonged rhythm monitoring and early hospital admission.

Keywords
Syncope, myasthenia gravis, atrioventricular block

SÖZEL 2

SPONTANEOUS HAEMOPNEUMOTHORAX: TWO CASES PRESENTATİON

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Introduction
Accumulation of air and blood in the pleural space is termed as spontaneous haemopneumothorax (SHP). Bleeding in most cases results from torn small vessels and shearing of the adhesions between the parietal and the visceral pleura. Its incidence is in the 1-12% range in spontaneous pneumothroax cases (1); and has been found to be more prevalent in in the right lung and in male patients (2). Treatment approaches include tube thoracostomy, video assisted thorascopic surgery (VATS) and throracotomy.

Case 1: The 55-year- old male patient consulted the hospital emergency service with shortness of breath and right sided chest pain. The patient did not have a history of lung disease or trauma. Physical examination showed that breathing sounds had decreased in the right hemithorax with dullness in the costophrenic sinus. Arterial blood pressure was 110/75mmHg. His PT,PTT and INR levels were within normal limits; haemoglobin and haematocrit values were 11.4 gr/dl and 33.2%. respectively. Posteroanterior (PA) lung radiography (Figure 1) revealed penumothorax involving 50% of the hemithorax with fluid filling the costophrenic sinus.
Tube thoracostomy was performed and 200 cc effusate was drained . The patient was transferred to the thoracic surgery clinic. Control PA radiography showed expanded lungs and general haematoma formation in the right hemithorax (Figure 2) . Surgery was decided when the control haemogram values of haemoglobin and haematocrit were 8 gr/dl and 23.8 %, respectively. The patient was entubated with double lumen intubation tube and right lateral thoracotomy was performed under general anaesthesia. The generalised haematoma was drained and lung parenchyma and parietal pleura were explored for the bleeding site. A bullous area of small nodules was determined in the apical segment of the right lung. An adhesion of 1-2 cm diameter with a bleeding point at its counter site on the parieteal pleura on the thorax wall was discovered (Figure 3). It was ligated and wedge resected with the surrounding apical segment tissue (Figure 4). The patient was replaced intraoperatively and postoperatively with 4 units of erythrocyte suspension and 2 units of freshly frozen plasma. Post operative radiography showed expanded lungs (Figure 5). After a 2-day observation period, the 100cc/day serohaemorrhagic drainage procedure was stopped and haemoglobin was found elevated to 9.5 gr/dl. Upon subsidence of complaints and establisment of haemodynamic stability, the chest drainage tube was removed and the patient was discharged.

Case 2: The 19-year old male patient consulted the emergency service with shortness of breath and left sided chest pain. A history of lung disease and trauma was eliminated. His physical examination indicated reduced breathing sounds in the left hemithorax. Near total spontaneous pneumothorax was determined in the left lung by PA radiography (Figure 6). Left tube thoracotomy was performed. Arterial blood pressure as 115/65 mmHg. Haemeogram was normal. During the 6-hour postoperative observation 800 cc of blood was collected from the chest drainage tube. Cold sweating , arterial blood pressure of 85/60mmHg and 120/min pulse was determined. To prevent haemorrhagic shock the chest drainage tube was clamped. And replacement therapy with erythrocyte suspension and 0.9% NaCl was started. A generalised haematoma was discoveredin the left hemithorax by PA (Figure 7) and decision was taken for emergency surgery. Left thoracotomy showed generalised haematoma which was drained and the left lung was explored for bleeding foci. A bullous area of 3-4 cm diameter was discovered onthe left lobe apical segment with an aberrant vasculation on the bulla and this region was removed by wedge resection. Postoperatively, the patient's clinical symptoms improved when his chest drain was removed (Figure 8) and discharged with appointment to be controlled 10 days later. Three months later the patient consulted us with right total spontaneous pneumothorax (Figure 9). This time VATS was performed and the bullous area on the upper lobe apical segment was removed

by wedge resection . When air drainage ceased during the control observations, his chest drainage tube was removed and the patient was discharged.

Discussion

SHP is diagnosed with the accumulation of blood in excess of 400 cc in the pleural space (3). In the relevant literature it is a rarely reported pathology that was first described in 1828 during an autopsy performed by by Laennec(4). SHP aetiology does not involve a history of trauma. Underlying rare causes include haemophilia, congenital cyctic adenoid malformation, Marfan syndrome, Ehler Danloss syndrome, sarcoidosis, systemic lupus erythematosus and congenital afibrinogenemia (5). Hsu et al have denoted 3 mechanisms as responsible for the haemorrhages leading to SHP (6). Primary cause was given as the shearing and tearing of the adhesions between the parietal ve visceral pleura ; secondary cause was the rupture of vascular bulla under the lung parechyma, and the third cause was the tearing of the congenital aberrant vasculature in and around the lung apices and cupolas.

In the first case reported here, haemorrhage was due to disrupted adhesion between the paretal and visceral pleura and to the ruptured apical bulla. In the second case, haemorhage was caused by rupturing of an aberrant blood vessel in the apical bullous area.

In general, patients arrive at hospital emergency services with dyspnea, chest pain and hypovolemic shock. The two cases reported here involved lateral chest pain and dyspnea. SHP should be suspected in patients presenting with sudden chest pain and dyspnea without a history of chest trauma and after visualising penumothorax line and fluid accumuılaion by PA radiography. Definitve diagnosis is made after removing blood and air from the chest by thoracentesis or tube thoracotomy. Air and fluid line detection by PA radiographical imaging cannot necessarily be diagnosed with SHP. PA radiaography of delayed spontaneous pneumothorax cases, with fluid diffusing to the thoracal space from the parietal pleura, can give the impression of SHP.

Treatment of SHP involves surgical procedures including thoracostomy, VATS and thoracotomy (7). There are published reports recommending VATS on gounds of being less invasive with less complaint of postoperative pain and shorter hospital stay as compared to thoracotomy (8). In both of the cases presented here we performed right lateral thoracotomy. The grounds for these decisions were occurrance of haemorrhagic shock in one case and detection of genralised heamatoma requiring complete evacuation in the other case.

Conclusion

SHP should come to mind with sudden onset chest pain and dyspnea without a history of chest trauma and observing pleural fluid and pneumothorax by PA radiography. Thoracentesis carried out before tube thoracostomy ascertains the diagnosis of SHP. It should be remembered, however, that haemothorax can develop in cases of spontaneous pneumothorax without radiologicial evidence for air-fluid level by RA radiography. Therefore, we believe that patients with spontaneous pneumothorax should be intervened with as early as possible and followed up closely.

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SÖZEL 3

BİLATERAL ACUTE BACTERİAL PAROTİTİS

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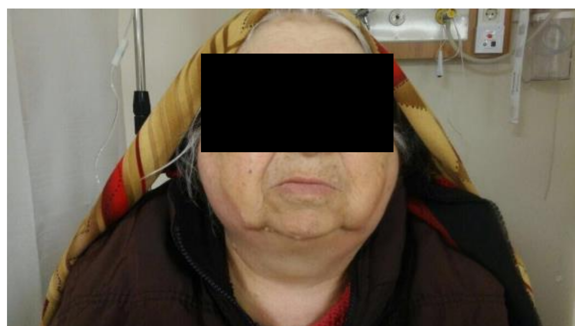
Introduction: Bilateral parotid enlargement pathologies have a wide differential diagnosis which encompasses infectious, neoplastic, autoimmune, metabolic, and iatrogenic etiologies with different algorithms. The infectious causes include viral mumps, HIV, acute suppurative parotitis, tuberculosis, and bilateral parotid abscess.

Case: A 79 year old obese female patient presented to emergency department due to painful enlargement of both lower jaw regions. She claimed that the swelling and pain started bilaterally two days ago and increased with time. She was diabetic for over 25 years. There were tenderness, redness and swelling on both sides of parotid glands in the physical examination. Leucocyte count was 12.600/mm^3 and blood amylase level was 1656 U/L with normal lipase levels. Ultrasonographic evaluation revealed diffuse hypertrophy of parotid glands without any localized pathology or any stone formation. She was admitted to internal medicine ward and the ampiric antibiotic treatment was started until the culture sample resulted with vancomycin and metronidazole. The blood culture result represented S.Hominis and the ampiric treatment was replaced by tigecycline.

Conclusion: History and physical exam findings such as disease onset, pain, and nodularity are key elements in the algorithm to quickly narrow the differential diagnosis of bilateral parotid enlargement. Viral mumps and HIV are bilateral more than half of the time whereas the rest are less likely to be bilateral.

Keywords: bilateral parotid enlargement, acute bacterial parotitis.



SÖZEL 4

DİNİTROFENOL

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Introduction: Dinitrophenol is a highly toxic substance widely used in dyes, developers, drugs, indicators, insecticides, and in the preservation of wood. It was used as an oral weight control drug in the 1930s, because it clearly increased the body's basal metabolic rate, but was soon banned for this purpose by the Food and Drug Administration (FDA) because of serious adverse effects such as hyperthermia, cataracts, and even death. It has been gaining popularity among bodybuilders for rapid weight loss with it's illegal online sale.

Case: A 20 year old male presented to emergency department with nausea, vomitting, palpitation and dispnea. He was a bit lethargic. In the physical examination, there was no abdominal tenderness, no cardiovascular or respiratory signs. His vitals were in normal range. But during his first hour of emergency follow-up, he became hypotensive (Blood pressure: 100/65 mmHg) and tachycardic (Heart rate:125/min). His lethargic status deepened. He denied any drug usage. No needle tracks were observed. Toxicology screen was negative. He claimed that he used a weight loss supplement for the

first time on that day which he didn't know the brand name. His relatives brought the drug. It was calculated that he consumed 400 mg of DNP in 8 hours. Despite the supportive treatment, he he developed asystole and cardiac arrest at 8. hour of admission.

Conclusion: DNP is a widely available substance on the internet used for weight loss. It frequently causes toxicity and death even at the proposed recommended doses.

Keywords: Dinitrophenol, intoxication, weight loss supplement, death.

SÖZEL 5

PARADOXİCAL EMBOLİSM AS A CAUSE OF STROKE İN A YOUNG PATİENT

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Background

Stroke is still a leading cause of mortality and morbidity all over the world. Embolic stroke of undetermined source (ESUS) is a intriguing topic, especially in young population. Ischemic strokes with cryptogenic origin are thought to be responsible for approximately 25% of all ischemic strokes. One of the cryptogenic stroke source is patent foramen ovale (PFO).

Case

A 38-year old male patient admitted to the emergency department with vertigo lasting almost 2 days. No pathology was seen during his physical examination. On neurological examination, patient was noted to be alert, awake, and oriented without any lateralized motor deficit. His pupils were isochoric and reactive to light and accommodation, but bilateral horizontal nistagmus was seen during eye movement. His vitals were stable with blood pressure: 130/90 mmHg, heart rate: 80/min, fever: 37.2°C. His medical history revealed that he had admitted to a neurology outpatient clinic due to vertigous symptoms 3 months ago. During his evaluation, cranial magnetic resonance imaging (MRI) was reported as normal. After the neurology consultation, the patient was sent to cranial computerized tomography (CT), firstly. Chronic infart zones were detected. Thereupon MRI was planned. Acute ischemic involvement with multiple microemboli appearance was observed on MRI. The cardiology consultation was requested due to the possibility of a cardiac originated etiology. Echocardiography was performed. Patent ductus ovale was detected.

Conclusion

PFO is present in almost 40% of cryptogenic stroke patients (1). The foramen ovale is a hole that exists in the wall located between the left and right atrium, which should be disappeared during infantile period but it does not close in approximately 25% of the general population. Most of the PFO patients are asymptomatic in spite of ongoing shunting. But in the presence of PFO, a clot in the venous circulation may travel across the PFO with shunting and lead to arterial occlusion (paradoxical embolism). Large case-control studies showed an association between PFO and cryptogenic stroke, especially in patients younger than 55 years of age (2).

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SÖZEL 6

CAN THE EMERGENCY PHYSICIANS PREDICT THE MORTALITY OF ELDERLY PATIENTS WITH HYPOGLYCEMIA?

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ABSTRACT

Object: The aim of this study to evaluate of elderly patients' mortality admitted to emergency room with hypoglycemia.

Material and method: 111 elderly patients admitted to emergency service with hypoglycemia were evaluated retrospectively. The complete blood count parameters, electrolytes, glucose, urea, admission time to emergency room, comorbidities, 15-days mortality, three-month mortality and one-year mortality were revised. SPSS 20.0 for Windows were used for analysing of parameters.

Results: The mean±SD/n(%) values of patients were written in this order; age (76,2±6,6), female (63.1%), male 41 (36.9%), glucose (mg/dL) (37,5±10), blood urea nitrogen (mg/dL) (63,5±47,8), creatinine (1,72±1,33), sodium (141,5±26,9), potassium (4,56±1,03), calcium 8,55±1,17, hemoglobin (mg/dL) (11,9±2,3), hematocrit (36,9±7,6), platelets-10*3 223,5±100, mean platelet volume 8,5±1,7, RDW 16,37±2,88, neutrophile count 7,4±4,6, lymphoycte count 2,2±2. The most frequent admission time of patients was between 20.00-24.00 hours (25,2%). The leading comorbidities were diabetes mellitus and hypertension. 59.5% of patients were discharged to emergency room. One-year mortality and three-month mortality was higher were patients hospitalized intensive care unit (p=0,001). 15-days mortality was higher in patients with coronary artery disease (p=0,0017).

Conclusion: In admission, hospitalization of patients in intensive care unit and having coronary artery disease are risk factors for hypoglycemic elderly patients.

Conflict on interest: None declared.

SÖZEL 7

ANALYSIS OF PATIENTS WITH COPD ADMITTED TO EMERGENCY ROOM

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ABSTRACT

Object: The aim of this study to evaluate of patients with Chronic Obstructive Pulmonary Disease (COPD) exacerbation admitted to emergency room.

Material and method: 94 patients who admitted to emergency service with exacerbation of COPD were evaluated. The complete blood count parameters, electrolytes, glucose, urea, lactat, Forced Expiratory

Volume 1(FEV 1) % were recorded. In echocardiography, ejection fraction (EF) % of patients were calculated. SPSS 20.0 for Windows were used for analysing of parameters.

Results: The mean values of patients were written in this order; age (68.67±8.99), FEV 1 % (34.25±12.22), glucose (94±34.1), blood urea nitrogen (43.08±17.65), C- reactive protein (4.37±1.49), creatinin (1.05±1.14), calcium (8.84±0.56), sodium (137±13.35), RDW (16.41±2.94), lactat (1.42±0.75), platelet-10*3 (230±68.1), lymphoycte count (1.93±1.63), neutrophil count (6.52±3.07), Platelet Crit (0.20±0.059) and White Blood Cell-10*3 (9.14±3.48). The mean EF % of patients was 65.59±5.35 (min 49.40- max 75). There was no relation between age- EF% (p =0.453) and FEV 1 %- EF % (p= 0.427). The relationship between C-reactive protein and lactat was no statistically meaning (p=0.557).

Conclusion: The more scientific studies are needed in the future including control groups of patients with COPD.

Conflict on interest: None declared.

SÖZEL 8

RETROSTERNAL GOITER: A METHOD OF CLASSIFICATION BY COMPUTED TOMOGRAPHY FINDINGS

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ABSTRACT

Introduction: The incidence of retrosternal goiter (RSG), which is a thyroid gland disease, can be defined by different classification between 2% and 26% of all thyroidectomized patients. Our aim is to classify RSG cases in a number of different ways, which we have detected in computed tomography (CT) imaging of the thorax.

Material and method: In this retrospective study, 4334 thorax CT images with or without contrasts of the patients referred to the Pulmonary Medicine Policlinic were retrospectively scanned and 176 patients were included in the study. The age, sex, diagnostic codes, retrosternal extension of the thyroid gland (aortic upper arch, aortic reaching arch and aortic inferior arch), extension type (prevascular, paratracheal retrovascular and retrotracheal), extension amount (mm) (<50% and 50%<) of patients were assessed.

Findings: 43.75% of the patients (n=77) were male, 56.25% (n=99) were female and the mean age was 65.9 ± 11.4 years. The most common diagnosis in patients with RSG was Chronic Obstructive Pulmonary Disease (COPD) (52.3%). 39 (22.2%) of the patients had associated nodule, 16 (9.1%) had accompanying tracheal pressure and one patient had nodule and tracheal pressure. The incidence of RSG among patients was 4.15%. Anatomical classification was made with thorax CT findings of the patients. 27.3% of the patients had gland right lobe and 28.9% of the left lobe >50% extended below the thoracic entry. Left thyroid gland's (90.3%) retrosternal extension and aortic arch spread (91.2%) were more. When classified according to the trachea, the left lobe's paratracheal and retrovascular extension (50.9%) was more. Extension amounts were similar for both thyroid lobes.

Result: In patients who have retrosternal goiter, goiter spread can be defined with multiple classification with thorax CT.

SÖZEL 9

BEHCET'S DİSEASE WİTH PULMONARY EMBOLİSM: TWO CASES PRESENTATİON

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Introduction

Behçet's disease is a rare, chronic relapsing and remitting vasculitis of unknown aetiology. It has the capacity to affect almost all organ systems because of its potential to involve both arteries and veins of all sizes, The aetiology remains unknown, but a combination of genetic and environmental factors may play a role. The HLA-B51 genetic marker is found in around 60% of BD patients (1).

Case 1

A 38 years old male patient presented to the emergency room with complaints of cough and dyspnea over 7 days. In history, it was learned that he has been followed 5 years with the diagnosis of Behcet's disease and he still had treatment with azathioprine and methylprednisolone daily.

A physical examination indicated the following:; blood pressure, 130/80mmHg; pulse rate, 105 beats/minute and a respiratory rate of 25 breaths/min. Blood oxygen saturation level measured by pulse oximetry was 88%. A pulmonary physical examination revealed rales at the right lung. Laboratory test results were as follows: CRP: 136mg/L, wbc: 14000/mm3, d-dimer: 3.01 ng/ML troponin:0 µg/l. Echocardiogram was normal.

A contrast enhanced CT pulmonary angiography (CTPA) scan showed contrast enhancement in pulmonary arteries suggesting pulmonary embolism (PE), pleural effusion, and consolidation in the right lung (Figure 1). Treatment was started with a low molecular weight heparin (LMWH) called as enoxaparin sodium 2 x 6000 IU subcutaneously and imipenem IV.Then lung ventilation and perfusion scintigraphic interpretation was reported as low probability of PE. So diagnosis of PE was excluded and LMWH therapy started to be given at the prophylactic dose. Cyclosporine added to current Behcet's treatment that he was still receiving. Clinical and radiological improvement was seen with this therapy.

Case 2

A 48 years old male patient admitted to emergency department because of dyspnea, chest pain and fewer. In history, it was learned that he has been followed with the diagnosis of Behcet's disease (BD) and he still had treatment with prednisolone and cyclophosphamide.

A physical examination indicated the following: blood pressure, 110/80mmHg; pulse rate, 110 beats/minute and a respiratory rate of 28 breaths/min. Blood oxygen saturation level measured by pulse oximetry was 87%. There were some rales auscultated in both lungs on physical examination.

A contrast enhanced CT pulmonary angiography (CTPA) demostrated filling defects in the main pulmonary artery suggesting PE (Figure 2). A LMWH therapy was started with a diagnosis of PE. Echocardiographic findings were normal. Bilateral lower extremity venous doppler usg examination was normal.

The patient was consulted a rheumatologist. Activation of BD was considered in the patient and methylprednisolone 250mg IV per day was added to therapy. Clinical, laboratory and radiological improvement was seen with this therapy.

Discussion

Behçet's disease typically manifests as mucocutaneous disease with orogenital ulcers and skin lesions (2); however, involvement of the musculoskeletal system, eye, nervous system, gastrointestinal tract, vascular beds, urogenital tract and cardio-pulmonary system can lead to significant morbidity and mortality.

BD occurs worldwide but clusters are found mainly along the 'silk road' with highest prevalence in Turkey (approximately 80–370 cases per 100,000) Japan and Iran, and lower prevalence in North American and Northern European populations(3,4,5).While the commonest age group affected is those aged 20–40 years, BD is also seen in children and older patients.The disease is usually severe in young adult men(6).

Vascular BD is unique in affecting both arterial and venous vascular system of all sizes and is a major cause of morbidity and mortality. The arterial disease is less prevalent than venous disease. Arterial lesions resulting from inflammation cause aneurysm, ulcerations, thrombosis and stenosis, whereas, the venous disease mainly manifests as venous thrombosis and thrombophlebitis (7). The thrombus is usually tightly adherent to the vessel wall and may not embolise.A combined pharmacological and non-pharmacological approach to management is essential, as for any chronic disease. With the absence of large randomised controlled clinical trials to evaluate the effects of various interventions in BD, treatment is driven by recommendations of expert bodies like EULAR, with consensus statements (8)

The arterial aneurysm requires strong immunosuppressants. Intravenous steroids (three pulses of 1,000 mg methylprednisolone) followed by oral steroids and cyclophosphamide are used to rapidly control the disease. Oral DMDs (azathioprine) can be used 6 months after induction with cyclophosphamide. Alternatively, TNF inhibitors can be used in place of cyclophosphamide. Expert opinion is divided on the treatment of deep venous thrombosis and cerebral venous sinus thrombosis: some experts recommend anticoagulation, while others believe that effective immunosuppression is key (8).A 2015 observational study did not show any favourable effect from the addition of anticoagulation to immunosuppresion on the relapse rates of vascular events in BD (9). In our cases aggressive immunosuppressive therapy was needed for treating pulmonary complications of BD, some studies suggested that immunosuppressive therapy might control or even revert the prothrombotic state seen in Behcet’s disease (10,11). However, anticoagulation may be indicated in the presence of another pro-thrombotic condition (e.g. Protein C and S resistance, Factor V Leiden) but, again, coexisting arterial aneurysms must be excluded. Stenotic arterial lesions require stenting to help re-establish perfusion. Pulmonary aneurysms can be coiled and bleeding vessels embolised. Bronchial artery embolisation is frequently required as it is the commonest cause of bleeding and haemoptysis

In conclusion, for treating pulmonary complications of BD, we strongly recommend intense immunosuppression, which is required to reduce the stimulus for thrombosis .

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Figure 1. A Pulmonary embolism , pleural effusion, and consolidation in the right lung

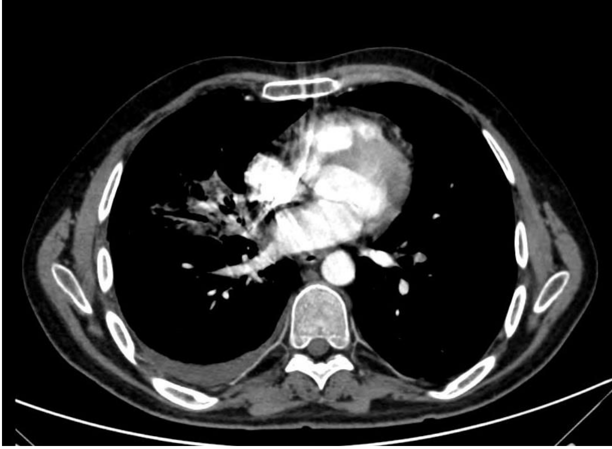
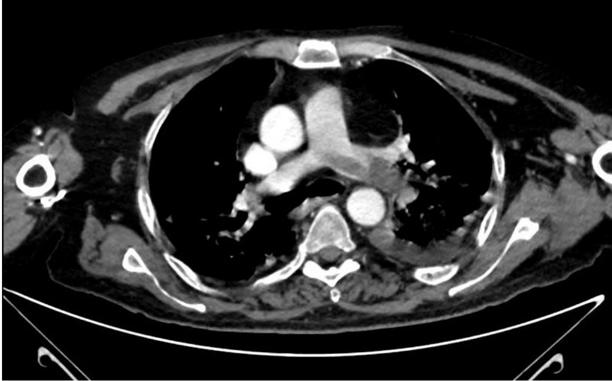


Figure 2. The filling defects in the main left pulmonary artery



SÖZEL 10

A RARE CAUSE OF REFRACTORY ABDOMİNAL PAİN AND NEW-ONSET ASCİTES: BUDD CHİARİ SYNDROME

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Introduction

In patients presenting with abdominal pain and ascites, possible underlying etiologies such as renal, cardiac and liver failure should be investigated. In particular, the addition of ascites to refractory abdominal pain should alert the physician for acute vascular pathologies that cause portal hypertension. In this case report, we present Budd Chiari syndrome caused by multiple hepatic vein thrombosis in a patient with Behçet's disease who presented with abdominal pain, ascites and acute liver failure.

Case

A 32-year-old woman presented with a 10-day history of abdominal pain, abdominal distention, jaundice, and 5 kg weight loss in two weeks. Her medical history revealed colchicine use for 1 year due to Behçet's disease. In physical examination marked ascites, jaundice and hepatomegaly were noted. Ascites analysis turned out to be transudate. Doppler ultrasonography revealed hepatomegaly, ascites, periportal edema and thrombosis in hepatic veins and high resistance flow in the hepatic artery. Abdominal computed tomography showed minimal flow in left hepatic vein and total obstruction in other hepatic veins. Thrombosis of hepatic veins was also confirmed by endosonography. The patient was started on anticoagulant therapy and later referred to rheumatology.

Conclusion

Generally, Budd Chiari syndrome occurs when there is an underlying disease that creates a tendency to thrombosis. The most common causes are either hereditary or acquired thrombophilic diseases, Behçet's disease being responsible for only 5% of all cases. Budd Chiari syndrome should be considered in patients who have rapidly developing ascites, right upper quadrant pain, hepatomegaly and portal hypertension, especially if there is a tendency to thrombosis. The diagnosis is based on the demonstration of thrombosis and obstruction in hepatic veins either by doppler ultrasonography or computed tomography. Treatment options range from anticoagulation to porto-systemic shunting and liver transplantation. Therefore, early diagnosis and treatment is very important for prognosis.

Keywords

ascites, Budd Chiari Syndrome, hepatic vein thrombosis, portal hypertension

SÖZEL 11

A RARE CASE OF SERTRALİNE SİDE EFFECT

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Introduction
Increased prescription of antidepressants leads to more frequent side effects. Dermatologic lesions are the side effects observed in the skin. Acute generalized exanthematous pustulosis and Steven Johnson syndrome due to sertraline, which is a frequently prescribed antidepressant, have been reported. In this case, we aimed to present a case of urticaria due to sertraline.

Case
A 27-year-old male patient with no history of allergy was admitted to our clinic with complaints of itching and redness for several days. In his medical history, it was learned that fluoxetine, which was used by the patient due to anxiety, was stopped by his doctor a week ago and sertraline was started. The patient did not have the difficulty of swallowing, respiratory distress, and anaphylaxis. On physical examination, there were pruritic and papular rashes in the abdominal region. The patient was treated with dexamethasone and pheniramine with an allergic reaction diagnosis due to sertraline. After the medication patient’s complaints regressed and the patient was discharged with suggestions.

Conclusion
It is known that psychiatric diseases and dermatological problems can be seen together. Also, dermatological symptoms may be observed due to antidepressant drugs used in the treatment of mental disorders. Emergency physician should be prepared against these side effects.
Key words: Antidepressant, sertraline, urticaria.

SÖZEL 12

CLİNİCAL PROFİLE OF ECTOPİC PREGNANCY: A SİNGLE-TERTİARY CENTER EXPERİENCE

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Introduction:
Ectopic pregnancy(EP) is the implantation of the embryo anywhere other than the uterine lining of the endometrium. The incidence of EP ranges from 0.25% to 2% of all pregnancies. In 95% of EPs, fertilized ovum implants in the fallopian tube, but rarely in other sites like ovaries, cervix, prior cesarean scar, spleen, omentum and other parts of the abdomen. Signs and symptoms classically

include amenorrhea, abdominal pain, and vaginal bleeding. A ruptured EP can cause life-threatening hemorrhage in the abdominal cavity resulting with in increased heart rate, low blood pressure or hypovolemic shock. The death rate is about 1 per 2000 EPs. Early diagnosis of EP isn't easy but it allows life-saving and non-surgical medical treatments such as methotrexate.

The aim of this study was to highlight the clinical profile of EP patients and to examine treatment modalities in a tertiary center.

Materials and Methods:
In this retrospective study, 62 cases with the diagnosis of EP treated in our gynecology unit between January 2017 and Agust 2018 has been carried out. Age, gravidity, gestational age, clinical presenting features, mode of treatment, and type of surgical procedure were recorded.

Results:
The incidence of EP was 4.57 per 1000 (62/1630) deliveries. Among all patients, 40 cases (64.5 %) were diagnosed from our outpatient clinic while 22 cases (35.5%) were consulted by the emergency department. 51 cases (82.25%) were from urban areas and 11 cases (17.75%) were from rural areas. Majority of the patients (30.6%) belonged to 31-36 years age group. 56.4% of the women were multiparous. The classical triad of amenorrhea, vaginal bleeding, and abdominal pain was seen in 64 % of the study population. The mean of gestational age at the time of presentation was 6.32±1.17 week. 12 patients (19.3%) presented with ruptured EP and were operated within 24 hours, and the remaining were kept under observation till further diagnosis. After confirming the diagnosis, laparoscopic management was performed in 26 (41.9%) patients. In this surgical groups, salpingectomy was performed 22 (35.4% of total) and salpingostomy was performed in 4 (6.5% of total) patients. 43.5% of the patients received medical treatment with methotrexate. Three cesarean scar pregnancy were treated by curettage. Six EP cases resolved with complete tubal abortion. No mortality was observed.

Discussion:
EP is one of the most common gynecological emergencies with significant maternal morbidity and mortality. Despite the advances in diagnostic methods and management, EP is an important health problem that endangers the mother's life. Therefore, both gynecologists and emergency physicians should be aware of the differential diagnosis in patients with pelvic pain and menstrual irregularity. Early diagnosis makes the medical management and conservative surgery feasible. This may have a significant impact on the fertility and mortality rates of EP patients.

Keywords: Ectopic pregnancy, emergency, methotrexate, salpingectomy

SÖZEL 13

ARE WE LATE İN RECOGNİZİNG LUNG CANCER?

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Introduction

Lung cancer is the leading cause of cancer deaths worldwide. Early diagnosis of lung cancer is the fundamental factor on its prognosis. Family physicians or other primary care providers who first encounter these patients have an important role in this respect. Our aim in this study is evaluating the stage of newly diagnosed lung cancer patients in 18F fluorodeoxyglucose positron emission tomography/computed tomography (18F-FDG PET/CT) scan.
Methods
Among the patients who admitted to the PET/CT unit of the nuclear medicine department with the diagnosis of lung cancer, between November 2017-August 2018, 100 patients were included in this study. Demographic and clinical characteristics and PET CT findings of them were re-evaluated retrospectively. Staging was performed according to TNM 8th edition. Stage 3B and above was accepted as advanced stage according to TNM 8. Obtained data were analyzed using SPSS version 20.
Results
A total of 100 patients were included in this study; 89% of them were male and the mean age was 66.07 ±10.97 years (min 33-max 89). 55 patients were aged ≥65 years (elderly group). 83% of newly diagnosed lung cancer patients was evaluated to be in advanced stage, and only 17% of them was in early stage. When evaluating according to age groups and gender, advanced stage patients’ rate was predominant at both categories. There was no statistically significant difference in the distribution of stage in the elderly and young group or between male and female groups. The most common distant organ metastasis was the surrenal Gland (20%), bone (14%) and abdominal lymph node (11%), respectively. The rate of patients according to the stages is given in the Table 1.
Table 1.

Stage	1A	1B	2A	2B	3A	3B	3C	4A	4B	Total
Rate (%)	-	3	3	3	8	20	12	19	32	100

Conclusion
This study showed that most of the patients diagnosed with lung cancer were in advanced stage at the time of the diagnosed. There is a need to develop screening strategies for early diagnosis of lung cancer in the high-risk group of patients presenting to primary health care.
Keywords: Primary care, lung cancer diagnosis, early, late.

SÖZEL 14

SİMÜLASYONA DAYALI YENİ NESİL SAĞLIK EĞİTİMİNDE ÜLKELERARASI İŞBİRLİĞİ GİRİŞİMLERİ: GÜRCİSTAN ve TİFLİSTE OKUYAN TIP ÖĞRENCİLERİNDEN RECEP TAYYİP ERDOĞAN ÜNİVERSİTESİ KLİNİK SİMÜLASYON EĞİTİM MERKEZİ (RSİM) HAKKINDA İLK İZLENİMLER

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AMAÇ

Günümüzde sağlık sistemine maliyeti, hasta güvenliği, etik ve yasal yaptırımlar, sağlık güvenliğinin sağlanması ve standardize edilmiş eğitim ve değerlendirme ortamlarını sunma fırsatının zorlaşması nedeniyle simüle ortamlarda eğitim son yıllarda öne çıkmaktadır. Türk Dil Kurumu sözlüğünde,''benzetim'', "öğrence" olarak tanımlanan simülasyonun tıp eğitiminde kullanımının öğrenci (hastaya zarar vermeme, tekrarlama, hatalarından öğrenme vs); hasta (hasta güvenliği, hasta merkezli yaklaşım); eğitim ve eğiticiler (öğrenci performansının değerlendirilmesinde standartizasyon, temel ve ileri düzey beceri eğitimlerinin yükselmesi, becerilerin sınıflardan gerçek ortamlara transferinin cesaretlendirilmesi gibi) ve kurum (prestij, eğitimin ve hizmetin kalitesinin artması, malpraktisin azalması vs) açısından birçok faydaları vardır.Ancak farklı eğitim ortamları ve araçları gerektirdiğinden hem pahalı hem planlama ve uygulama süreci açısından zaman alıcıdır. Öğrencilerine iyi hekimlik uygulamaları kazandırmak amacıyla kısa adı ®SİM olan Recep Tayyip Erdoğan Üniversitesi Tıp Fakültesi Klinik Simülasyon Eğitim Merkezi fakültemiz dekanlık binasında yaklaşık 2000 metrekarelik alanda kurulmuştur. Acil, yoğun bakım, ameliyathane, doğumhane, standart hasta odası, Objektif Yapılandırılmış Klinik Sınav (Objective Structured Clinical Examination-OSCE) odaları, evde sağlık hizmetleri odası, temel beceri laboratuvarı, debrifing odaları, destek alanları (depo, teknik alan vs) olan ve ambulans da bulundurularak fiziki yapılandırılması tamamlanmış olan evde sağlık hizmetleri odasında mezuniyet öncesi hekimlere gerçeğe en yakın ortamda eğitim imkanı sunulmaktadır. Bu merkezde mezuniyet öncesi ve sonrası eğitimler ile meslekleraras işbirliği eğitimleri/kursları düşünülerek eğitim programları hazırlanması amaçlanmaktadır. Bu bağlamda bölgemizdeki komşu ülke ve şehirlerle ortak eğitim planları yapılmaya başlanmıştır. Gürcistan Kutaisi Akaki Testereli Devlet Üniversitesi Tıp Fakültesi ve Tiflis Tıp Üniversitesinden ziyarete gelen öğrencilere simülasyona dayalı eğitim sistemi hakkında bilgi vererek, sonraki eğitim programlarının planlanmasına ışık tutması düşünülerek ilk izlenimlerine dair görüşlerin alınması amaçlanmştır.

YÖNTEM

Fakültemiz klinik simülasyon eğitim merkezi (RSİM) Gürcistan Kutaisi Akaki Testereli Devlet Üniversitesi Tıp Fakültesi ve Tiflis Tıp Üniversitesinden gelen 26 öğrenci ve danışmanları tarafından ilgiyle gezildi. Gezi ve tanıtım sonrası öğrencilere RSİM hakkında görüşlerini belirtmeleri amacıyla anket yapıldı. Aslında bu çalışmada veriler, gözlem ve görüşme tekniklerive anket bir arada kullanılarak toplanmıştır.

BULGULAR

Gürcistan'dan 15 ve Tiflis'ten 11 öğrencinin katıldığı RSİM tanıtım gezisinde öğrencilerin hepsi kız öğrencilerden oluşuyordu. En çok %39 oranı ile 3.sınıf öğrencileri çoğunluğu oluştururken, onu %18 oranı ile 2. ve 6.sınıf öğrencileri takip ediyordu. En az ise %7 oranı ile 7.sınıf öğrencileri vardı. Öğrencilerin %70 'i simülasyona dayalı eğitim aldığını belirtirken, %30'u almadığını belirtmişlerdir. RSİM nin gerçek hastane içerisinde gibi hissettirdiğini sorduğumuzda %48'i katılıyorum derken, %52'si kesinlikle katılıyorum diyerek öğrencilerin hepsi olumlu cevap vermiştir. Simülatör, manken, maket ve simüle hasta ile yapacağım girişimlerde ortam hasta odasındaymışım gibi hissetmemi sağladı diyenlerin oranı ise %96 idi. Simülasyona dayalı eğitimin eksiklikleri görüp düzeltme konusunda etkin bir eğitim yöntemi olduğunu söyleyenlerin oranı %52 ile kesinlikle katılıyorum iken, %48 ile katılıyorum olmuştur.Simülasyona dayalı sınavın objektif sınav olup olmadığı konusunda %11'i ''fikrim yok ''derken %89'u objektif sınav olduğunu düşünmüşlerdir.Yine aynı şekilde standardize eğitim sağladığını düşünenlerin oranı %78 iken, kararsızım diyenlerin oranı %22 olmuştur. Öğretim üyesinin önünde her aşamanın izlenmesinden rahatsızlık duyacağını söyleyenlerin oranı %48 iken, %42'si bu düşünceye katılmadığını ve %10'u kararsız olduğunu aktarmıştır. Yine simülasyona dayalı eğitimde senaryo ile anemnez almak rahatsız hissetmeme neden olur diyenlerin oranı %15 iken, %30'u kararsız, %55'i ise bu fikre katılmadığını belirtmişlerdir. Simulasyona dayalı eğitimde hasta hekim iletişimi için gereken becerileri kullanacağını söyleyenlerin oranı %84 iken, %4'ü kararsız ve %12'si kullanmayacağını belirtmişlerdir. Simülatör, manken, maket ve simüle hasta yerine gerçek hasta ile sınava girmeyi tercih edeceğini söyleyenlerin oranı %33 iken, kararsızlar %11 ve gerçek hasta ile sınava girmeyi tercih etmeyeceğini söyleyenlerin oranı %56 olmuştur.Hasta güvenliği ve çalışan güvenliği açısından iyi bir eğitim modellemesi olduğunu düşünenlerin oranının sırasıyla %96 ve %100 olduğu görülmüştür. Böyle bir eğitim ortamından geçince kendinizi yetkin bir birinci basamak hekimi olarak görürmüsünüz sorusuna %89'u evet cevabını vermiştir.RSİM'de eğitim imkanları olsa sırayla en çok CPR (%29) ve cerrahi girişimler (%23), klinik konular (%19), doğum (%10), enjeksiyon (%10), yenidoğan (%6) ve uygulamaları olarak dikkat çekmiştir.

SONUÇ : Son yıllarda sağlık alanında artan öğrenci kontenjanları, yükselen değer olan hasta güvenliği kavramı ve doktor, hastane ve diğer sağlık çalışanlarının yanlış sağlık uygulamaları olarak bilinen malpraktis davaları sağlık eğitiminde simülasyon uygulamalarının yaygınlaşmasını zorunlu hale getirmiştir. Ülkemizde devlet tıp fakültelerinde çok az bulunan hatta afiliye tıp fakültesi olarak ilk ve tek olan bu merkezde hem ülkemizde hem Gürcistan, Tiflis gibi komşu ülkeler başta olmak üzere uluslararası arenada tıp eğitimine yön veren bir merkez olmayı hedeflemekteyiz.

SÖZEL 15

ATYPİCAL İLİAC ARTERY DİSSECTİON: A CASE REPORT

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Abstract
Introduction, Aim: Iliac artery aneurisms are generally observed associated with abdominal aortic aneurisms. Iliac artery dissection happens to be one of the rarely encountered cases and very few cases have been reported in literature. We aimed to present a patient with both iliac artery aneurisms associated with left iliac artery dissection in this study.

Case: A male, 34-year old patient applied to emergency service with complaints of abdominal pain and paresthesia in his left leg. There was no pain or loss of strength in the left leg of the patient, but there existed a numbness described by himself. The brain BT of the patient was considered as normal but his abdominal ultrasonography was reported as "an aneurismal dilatation in both iliac artery at bifurcation level on a nearly 3 cm-segment, reaching up to 3 cm at the widest section and a mural thrombus reaching up to 70 % stenosis within the vein lumen were observed". Thereon, the patient went through a BT-angiogram and as a result, an image compatible with dissection was observed in the left iliac artery together with aneurismal dilatation + mural thrombus in both iliac arteries. The patient was hospitalized in the intensive care section of cardiovascular surgery clinic.
Conclusion: In regards to the patients who apply to emergency services with complaints of abdominal pain, numbness in extremities, acute abdomen or neurologic symptoms atypically seen like loss of strength; we should also keep in mind aortic dissection and/or iliac artery dissection among our preliminary diagnoses.
Keywords: Abdominal pain, numbness in extremities, iliac artery dissection

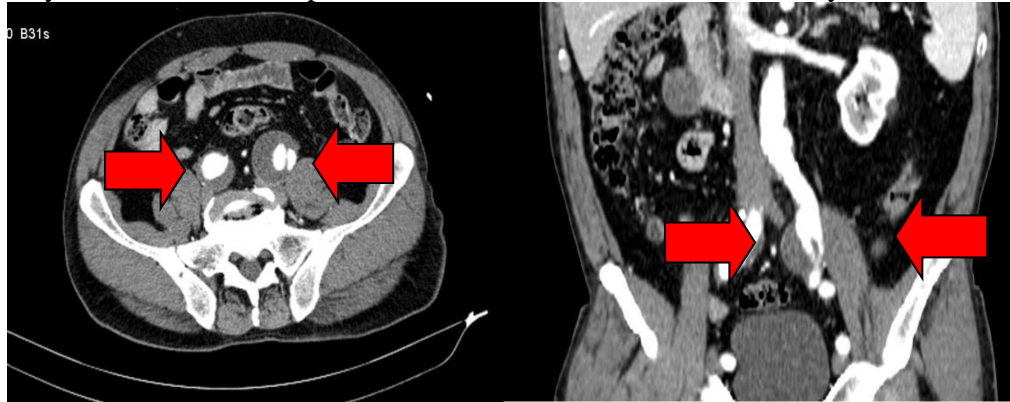

Figure-1: Image of BT-angiogram compatible with aneurismal dilatation in both iliac arteries, mural thrombus and dissection in the left iliac artery

SÖZEL 16

A RARE CAUSE OF CHEST PAİN: SPONTANEOUS PNEUMOMEDİASTİNUM

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Abstract
Spontaneous pneumomediastinum is defined as the presence of air in the mediastinum and is a rare clinical condition. In our emergency department, the case presented with acute-onset chest pain and feeling of tightness in the throat. Our purpose of presenting the case is, spontaneous pneumomediastinum should be considered in the differential diagnosis of acute chest pain.

Case Report

A 16-year-old female patient presented with a sudden onset of chest pain and a feeling of throat tightness that started 1 hour ago. The patient stated that chest pain increased with breathing. The past history and family history revealed nothing of note. Her vital signs were measured as following: blood pressure:110/70 mmHg, pulse:104/min, respiration:20/min, fever:36.7°C, sPO2:90%. Subcutaneous emphysema and crepitus were detected in the neck and bilateral chest wall superior lateral level. The heart sounds and breathing sounds were normal. The patient's cardiac markers were normal. The patient had a postero-anterior chest X-ray (CXR) on which free air in the neck, upper part and on the right side of the chest wall was observed. The free air was extending from upper zone to the lower zone and showed a linear band appearance following mediastinal centric contour. As this abnormal CXR finding was observed, a thorax computed tomography (CT) scan was ordered for further investigation. In mediastinum, free-air was visualized which extends into the neck and bilaterally superior thoracic aperture (Figure 1).
Following a consultation with thoracic surgery department, the patient was hospitalized. The patient underwent fiber-optic bronchoscopy. The bronchoscopy revealed normal anatomy of the larynx and trachea, both of which were patent. The patient had a nasal oxygen therapy of 2 liters per min and also, she was confined to bed rest. The patient did not develop any complications during hospital stay. After a week, the patient was recovered completely and she was discharged.

Discussion
Pneumomediastinum is the mediastinal presence of the air and it can be categorized as spontaneous (SPM) or traumatic. SPM develops through leaks through small alveolar ruptures to the surrounding bronchovascular sheath or less commonly as a result of the perforation of the respiratory or digestive viscera (1). It was first described by Hamman in 1939 (2). SPM is a rare clinical condition, generally affects young males. SPM is usually asymptomatic, even if some symptoms develop they are self-limited in most cases, and in 30% of these cases, etiology is not identified. Patients with SPM show following sign and symptoms: sudden onset of chest pain, dyspnea, cyanosis, distended neck veins, dysphagia, odynophagia, dysphonia, fever and hypotension. Air can travel under the skin to the neck and face to cause subcutaneous emphysema (3). Diagnosis can be made by posteroanterior and lateral chest radiography, thorax CT, bronchoscopy. Esophagus passage graphy can be performed if esophageal perforation is suspected. Treatment should be based on a rapid diagnosis and surgical intervention if necessary (4). Uncomplicated conditions, as in our case, usually regresses within 48 hours, if dyspnea is present 100% nasal oxygen therapy and if mediastinitis as a complication occurs antibiotherapy should be planned.

Conclusion
Although spontaneous pneumomediastinum is a rare clinical condition, it is important to consider differential diagnosis of the patients presenting to the emergency room with the acute chest pain.

Keywords: Pneumomediastinum, chest pain, emergency department

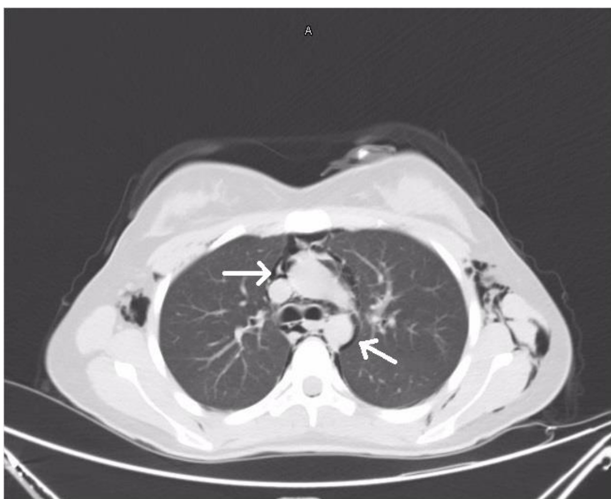

Figure 1

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SÖZEL 17

PRİMARY ANAPLASTİC LARGE CELL LYMPHOMA OF THE LUNG: A CASE REPORT

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Introduction
Anaplastic large cell lymphoma (ALCL) is a rare non-Hodgkin, T-cell lymphoma, representing only 2-3% of all lymphoid neoplasm's in adults according to World Health Organization (WHO) (1). CD30 antigen-positive, large neoplastic cells characterize ALCL (1). According to the current WHO classification, there are two variants: ALCL, ALK (anaplastic lymphoma kinase)-positive (ALCL, ALK+) and ALCL, ALK-negative (ALCL, ALK-), which have many similar features (1).

Case
A 50 years old smoking male patient admitted to emergency clinic with complaints of cough, sputum, weakness, and weight loss. He was a teacher. He had no disease other than hypertension. He has smoked for 15 years but hasn't smoked for the last 20 years. In history, it was learned that he had been followed-up for 1 year in various clinics with diagnoses like pneumonia and bronchitis. A physical examination was normal.
Abnormal laboratory test results were as follows: White blood cell count: 11100/mm3, platelet count: 454000/mm3 (normal:100-400000/mm3), C-Reactive Protein: 61 mg/L (normal is< 5 mg/L), erythrocyte sedimentation rate: 79 mm/hour (normal: 5-25 mm/hour).
Chest X ray chest x-ray showed prominent bronchovascular markings (Figure 1). Thorax CT showed mass lesion in lower lobe of right lung, and mediastinal lymphadenopathy (Figure 2).

F-18 FDG positron emission tomography (PET) revealed standard uptake value (SUV) of 5.4 for mass lesion that was 3.6 cm in size in lower lobe of right lung, SUV of 29.1 for paratracheal, precarinal, subcarinal, paraesophageal conglomerate lymphadenopathy in mediastinum, and SUV of 30 for conglomerate lymphadenopathy that was extending from the right cervical region to the right supraclavicular region (Figure 3). Also PET showed SUV of 32.9 for lymph node located in gastrohepatic area and SUV of 20.2 for lymph node near the right lobe of thyroid gland (Figure 3).
Fine needle aspiration biopsy of right cervical lymph node was not diagnostic. Then fiberoptic bronchoscopy (FOB) was performed. It showed that main carina, right and left main bronchi were infiltrated by the tumor and bronchoscope could not be passed beyond the both main bronchi because of that (Figure 4). Biopsy of tumor with FOB yielded CD30(+) anaplastic large cell lymphoma (Figure 4). Chemotherapy with cyclophosphamide, doxorubicin, vincristine, prednisolone (CHOP) was started.

Discussion

ALCL is a highly aggressive T cell lymphoma that requires aggressive treatment, particularly in case of anaplastic lymphoma kinase (ALK) down regulation (3). Clinical presentation frequently involves both nodal and extranodal sites, including (in decreasing order of frequency) skin, bone, soft tissue, lung, and liver (4). The lung variant of ALCL is a rare entity that usually presents with mediastinal lymphadenopathy.

Among extranodal presentations, extremely rare ALCL cases have been reported to present with respiratory complaints and later a bronchial mass was found.
Xu X who reviewed all reported 9 cases ALCL with bronchial involvement in the English literature and found that the initial bronchial involvement of ALCL was associated with some interesting clinicopathologic features: 1) There is a female predominance, in contrast to male predominance in the general ALCL group; 2) Majority of the patients are less than 18 year-old; 3) The patients uniformly present with obstructive symptoms of respiratory tract and usually develop respiratory failure; 4) The primary neoplasm is in the bronchus or the trachea; 5) At the initial presentation, majority of the cases have only localized disease (2).
One retrospective study described the computed tomography findings in multiple cases of primary 4 Case Reports in Radiology and secondary pulmonary lymphoma which included consolidation, ground-glass opacification, air-bronchograms, lymphadenopathy, CT-halo sign, lung nodules, reticular opacities, and pleural effusions (5). Also complete atelectasis can be seen because of endobronchial mass (6). In the majority of pulmonary non-Hodgkin lymphoma cases, patients presented with a combination of multiple CT findings. The most common combination of findings in

primary and secondary non-Hodgkin's lymphoma included consolidation with air bronchogram, ground-glass opacities, and lymphadenopathy. In our case, lymphadenopathy and mass was found on the chest CT.

There is no standardized treatment for ALCL of the lung; however, current first-line therapy includes anthracycline-based regimen, such as CHOP (7,8). We started that therapy too.

Conclusion

It is extremely rare for ALCL to initially present with respiratory symptoms. But physicians should keep ALCL in their mind for differential diagnosis.

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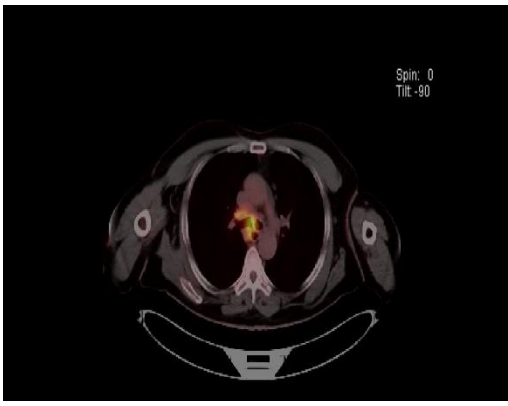

Figure 1: Conglomerate lymphadenopathy region in PET

SÖZEL 18

OUR 10 YEARS OF EXPERİENCE İN CASES WİTH TESTİCULAR TORSİON

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Aim: Testicular torsion is an urological emergency which can be described as the twisting of the spermatic cord causing impairment in the blood supply of the testis which may lead to testicular necrosis. In this study we aimed to evaluate the clinical data on our emergency application records with testicular torsion.

Material and Methods: Data of fifty patients who applied to urology clinic due to testicular torsion between April 2008 and April 2018 were evaluated. The evaluation criteria were age, complaint, duration and localisation of the torsion, diagnostic tool, surgical observations and the method of treatment.

Results: Mean age of the 50 patients was 23.54 ±11.8 (1-51) years. Affected testis was left in 25 and right in 25 of the patients. There was no case with bilateral testicular torsion. Mean time period between the onset of the complaints and the application to the hospital was 15 (2-72) hours. All of the patients complained about scrotal pain, testicular swelling and hardness. Nine of them also described mild abdominal pain. All patients were diagnosed with physical examination and the diagnosis was verified with scrotal doppler ultrasound. Torsion was corrected manually by 8 of the patients (4 left, 4 right). By 21 of the patients testicular blood supply was regained after surgical detorsion (9 left, 12 right). Testicular fixation was performed by all patients with regained testicular blood supply. By all of the patients undergoing detorsion and testicular fixation, sufficient blood supply was observed with doppler ultrasound after the procedure. By the 21 patients disseminated haemorrhagia and infarkt was

observed and orchiectomy was performed because of no blood circulation in the testicular tissue after detorsion (12 left, 9 right). All of the orchidectomy specimens revealed haemorrhagic infarct after pathological examination.

Conclusion: Testicular torsion is the most important pathology in the differential diagnosis of acute scrotum because of its potential for testicular necrosis. Therefore it should be distinguished from other scrotal pathologies by all the diagnostic methods necessary and urgent intervention should be performed in order to prevent organ loss.

SÖZEL 19

EVALUATİON OF THE EFFİCACY OF LOSARTAN ON THE BASİS OF THE PATHOPHYSİOLOGY OF ISCHEMİC PRİAPİSM

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Aim: Priapism is described as the extended unpreferred erection status without any sexual stimulus. There are three types of priapism which are classified as ischemic, non ischemic and recurrent priapism depending on the blood flow of the penile artery. Ischemic priapism is a urological emergency which requires urgent and appropriate approach. In this study we aimed to investigate the effect of losartan an Angiotensin 1 receptor blocker on the apoptosis index in the penile tissue on the base of a ischemic priapism in a rat model.

Material and Methods: Fourty-eight adult Sprague-Dawley rats were divided into 8 equal groups. Group 1 was the control (shame) group. Penises of the rats in the Group 1 were resected without generating priapism. In Group 2; priapism was generated and penile resection was performed after 4 hours. In Group 3; priapism was generated and afterwards losartan in 15 mg/kg dose was administrated intraperitoneally. Penile resection was performed after 4 hours. In Group 4; priapism was obtained and resolved after 4 hours and penile resection was performed after 8 hours. In Group 5; priapism was obtained, losartan in 15mg/kg dose was administered, then priapism was corrected in the fourth hour and penile resection was performed after 8 hours. In Group 6; priapism was obtained and corrected in the fourth hour. After the correction losartan in a dose of 15 mg/kg was administered and penile resection was performed. In Group 7; Losartan in a dose of 15mg/kg was administered for 3 days before priapism. Then priapism was obtained and penile resection was performed after 4 hours. In

Group 8; ; Losartan in a dose of 15mg/kg was administered for 3 days before priapism. Then priapism was obtained and corrected after 4 hours. Penile resection was performed after 8 hours.
Vacuum constriction method was used in all rats for obtaining erection and priapism was generated by maintaining it. Apopitosis index was evaluated by using the Tunel method in the cavernous tissue samples of all groups.

Results: When comparing Group 3 and 7 with Group 2, it was observed that apoptotic index was decreased significantly, When comparing Group 2 with the ischemia reperfusion groups (Group 4,5,6 and 8) there was a decrease in the apoptotic index. Comparison of the ischemia perfusion groups between each other, losartan administered groups (Group 5,6 and 8) showed a significant lower apoptosis index compared to Group 4. In Group 6, where losartan is administered in the late phase, apoptotic index was higher than in Group 5 and 8 which was significant.
Conclusion: In this study it is detected that losartan administration in the early phase of priapism is reducing the apoptotic index statistically significantly when compared to the control group. Therefore preventing of the occurence of apopitosis during priapism with losartan may promise a future treatment option for the the protection of the erectile function.

SÖZEL 20

CARDİAC TAMPONADE IN THE EMERGENCY DEPARTMENT: AS A FİRST SYMPTOM OF SYSTEMİC LUPUS ERYTHEMATOSUS

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SBÜ Antalya Eğitim ve Araştırma Hastanesi, Kardiyoloji Departmanı

A 50-year-old woman admitted to emergency department with a compliant of ever-increasing shortness of breath for 5 days. Her medical history was unremarkable except hypertension. On examination, blood pressure was 88/54 mmHg, pulse rate was 128 per minute and body temperature was 36.5°C. Jugular venous distension was obvious. Furthermore, there was rash on her face. Respiratory examination revealed right sided crackles and and decreased breath sound at the base of right lung field. Laboratory investigations revealed anaemia with low platelet count (91.000/mm3). ESR was 49 mm/h and CRP was 11 mg/dl. Moreover, creatinine level was 1.98mg/dl.
Electrocardiogram showed low voltage. Echocardiogram confirmed features of cardiac tamponade that was a large circumferential effusion with early diastolic right ventricle collapse. Emergency

pericardiocentesis with subxiphoid approach was then performed and 500 ml of pericardial fluid was drained. After pericardiocentesis, her symptoms' resolved.
Her serum was strongly positive for antinuclear antibody as well as positive anti-double stranded DNA antibody. Serum complement levels were low. Pericardial fluid was exudative in nature. Pericardial fluid cytology showed cells of an inflammatory response with no microorganism identified by Gram stain or Ziehl-Neelsen stain. PCR for tuberculosis was negative. There was no evidence of malignant cells.

The diagnosis of SLE was established based on the positive clinical and immunological findings (Figure 1). The patient was started high dose prednisolone along with non-steroidal anti-inflammatory drugs and hydroxychloroquine. Pericarditis is very common in SLE and has been shown to occur up to 60% of patients but cardiac tamponade is truly rare both as the initial manifestation and throughout the disease course.

Physicians must consider SLE as the differential diagnosis of cardiac tamponade and perform convenient tests to diagnose connective tissue diseases. Because immunesuppressive treatment is the mainstay therapy of connective tissue disorders, it should be diagnosed correctly. Thus, recurrence of pericardial effusion or even pericardial tamponade could be prevented.

SÖZEL 21

THE EVALUATİON OF THE REAL-TİME TELERADİOLOGY CONSULTATİON SYSTEM İN EMERGENCY DEPARTMENT

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Background: Teleradiology involves the transmission of all radiological images to a radiologist in a remote location to ensure the accurate diagnosis. Although various teleradiology systems exist, there is not a fully accepted real-time interactive teleradiology system yet. In this study, we analyzed "the teleradiology consultation system which includes a real-time and instant messaging program (Skype®)" established in an emergency department.

Methods: The consultations requested from teleradiology system implemented in the emergency department of a Medical Faculty Training and Research Hospital were evaluated between January 2018 and June 2018 retrospectively.

Results: A total of 18284 teleconsultations was included in the study. The mean age of the patients required teleconsultation was 40.6 ± 24.8 years (range: 0-109 years) and 10.069 (55.1%) were male.

17079 (93.4%) Computed tomographies (CT) were consulted. The majority of CT scans were cranial CT (n=7113, 41.7%) and upper-lower abdominal CT (n=5436, 31.8%). 1205 MRI (6.6%) were consulted. The majority of MRI were diffusion MRI (n=975, 80.9%) and vertebral MRI (n=76, 6.3%). The mean evaluation time of radiological imaging was 66.3 minutes.

In 7238 (39.6%) of all consultations, a problem or a demand were reported via interactive communication by radiologists or emergency physicians. They are as follows; desire to speed up delayed reports (33%, n = 2388), problems related to radiological images (32%, n = 2316); demand for correction of delay problems from health system technician (11.6%, n = 839), incomplete reporting (6.6%, n = 477), demand for acceleration of reports of critical patients (6.4%, n = 463), request for re-evaluation of radiological images (5.2%) (n = 376), the demand for additional clinical information of the radiology doctor (2%, n = 144), asking radiology doctor the statements in the report or to request for disclosure of findings (1.1%, n = 78), the other reasons (2%, n = 144). All of these problems were answered with real-time interviews and all problems were solved.

Conclusion: The teleradiology system is important in health institutions where there is no 7/24 radiologist. This study showed that the establishment of a teleradiology consultation system integrated with a messaging service (Skype®) in the emergency department may be useful and may provide the real-time and immediate resolution of the occurring problems.

SÖZEL 22

CEREBRAL SEPTİC EMBOLİSM SECONDARY TO İNFECTİVE ENDOCARDİTİS

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ABSTRACT

Introduction :
Cerebral brain embolism results from fragmentations of cardiac vegetations or from deeply seated infection in the blood streams that migrates to the central nervous system vessels occluding them, causing Infarcts and other neurological complication.

Case Presentation :
We reported a case of 57 year old male patient with a history of hypertension, Diabetes mellitus and chronic kidney failure who presented to the emergency department complaining of fever and was diagnosed with infected dialysis catheter that caused infective endocarditis and consequently septic brain embolism

Conclusion :
Septic brain embolism continues to affects a wide range of critically ill patient despite the development of modern clinical approaches .

INTRODUCTION
Septic embolism includes a wide range of clinical presentations and considerations. It could be completely asymptomatic and manifests only as incidental finding to devastating cardiovascular and cerebral events. Among the immediate complications is the vascular occlusion of the downstream vascular tree and the resultants destructive sequel such as cerebral, bowl, spleen, pulmonary and myocardial infarction. The late complications may include mycotic aneurysm and abscesses.

CASE REPORT

57 year old male patient with 10 years history of hypertension, diabetes mellitus and chronic kidney failure presented to our emergency department complaining of fever and malaise.The patient undergoes regular hemodialysis via internal jugular vein dialysis catheter. Upon medical examination his Glasgow coma scale was 14 (E4M6V4) but he wasn't oriented or cooperative.His vital signs were a body temperature of 38.8 C , blood pressure of 160/50 mmHg, a heart rate of 130/minute and Spo2 90%. ECG showed sinus tachycardia. Upon auscultation pansystolic murmur (4/6) was heard at the heart apex. Neurological examination showed paralysis of his right upper and left lower extremities. The inserted internal jugular vein catheter was clearly inflamed and areas of redness and swelling around it was noticed. Emergent cardiac echo was performed which shows a normal ejection fracture but 1.1 x 1.2 cm vegetation on the mitral valve was noticed. Diffusion brain MR showed multiple septic emboli in both cerebral hemispheres.Obtained blood cultures resulted in the growth of gram negative pseudomonas aeruginosa. The patient was admitted into the intensive care unit.

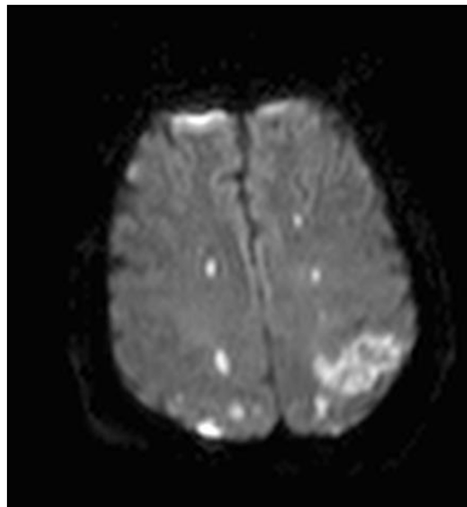
DİSCUSSİON

Bacterial infective endocarditis and central venous catheter infections are the most frequent conditions that are associated with septic embolism.Infective endocarditis carries a very high complication rate. Cerebral septic embolism usually results from dislodgment of cardiac vegetations which is followed by vessels occlusions, ischemia and infarction.Cerebral arteries occlusions accounts for 40-50% of central nervous system complications of infective endocarditis. Other complications includes cerebral hemorrhage, meningitis, brain embolism and mycotic aneurysm. Timely and appropriate antibiotic therapy is the major factor affecting the outcome results.

CONCLUSİON

Cerebral septic embolism should be considered in critically ill patients who are presented with neurological symptoms and are susceptible to bacterial infections. Prompt identification of the underlying infectious source and immediate antibiotic therapy are critical to successful management. Awareness is still needed in our hospitals for the risk factors, clinical presentation and management of cerebral septic embolism.

BRAİN Diffusion MR



SÖZEL 23

RENAL INFARCTİON

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ABSTRACT

Introduction :
Renal infarction is an easily under diagnosed medical condition due to it's non specific presentations that mimics renal colics or pyelonephritis.

Case Presentation :
We reported a case of 76 year old male patient with 10 years history of hypertension and without any other cardiovascular or hyper-coagulable conditions who was presented to the emergency department with right side flank and was diagnosed with right renal infarction

Conclusion :
Renal infarction is a rare condition but it's clinical outcomes can be devastating on renal function. A high level of suspicion is needed to diagnose this medical entity and an appropriate and timely management results in excellent prognosis

INTRODUCTION
Renal infarct is a rare medical condition that carries a high risk of morbidity due to it's difficult and delayed diagnosis.The cause of renal infarction includes either an embolic or thrombotic event.The diagnosis of this condition should be suspected in patient with flank or abdominal pain that is unexplainable. Renal infarction usually affects elderly patients and the main differential diagnosis includes pyelonephritis lymphoma or metastases.

CASE REPORT
76 year old male patient with a 20 years history of hypertension presented to our emergency department with right flank plain. His pain on a scale of 10 was 7, he was distressed and in severe discomfort. His vital signs was body temperature of 37.1 C, blood pressure of 140/70 mmHg, heart rate of 90 beat/minute and Spo2 of 97%. ECG showed normal sinus rhythm. Abdominal examination showed significant right costo-vertebral angle tenderness. The remaining of his physical examination was unremarkable. Symptomatic treatment was started to alleviate his pain. Blood test and urine analysis were obtained and both of them were totally normal. A normal urine analysis raised our suspicion of renal infarction and abdominal CT scan with contrast was obtained that showed right renal artery embolism and abdominal aorta aneurysm with mural thrombus. Anticoagulant therapy was started and the patient was transferred to an appropriate vascular surgery unit for possible embolectomy.

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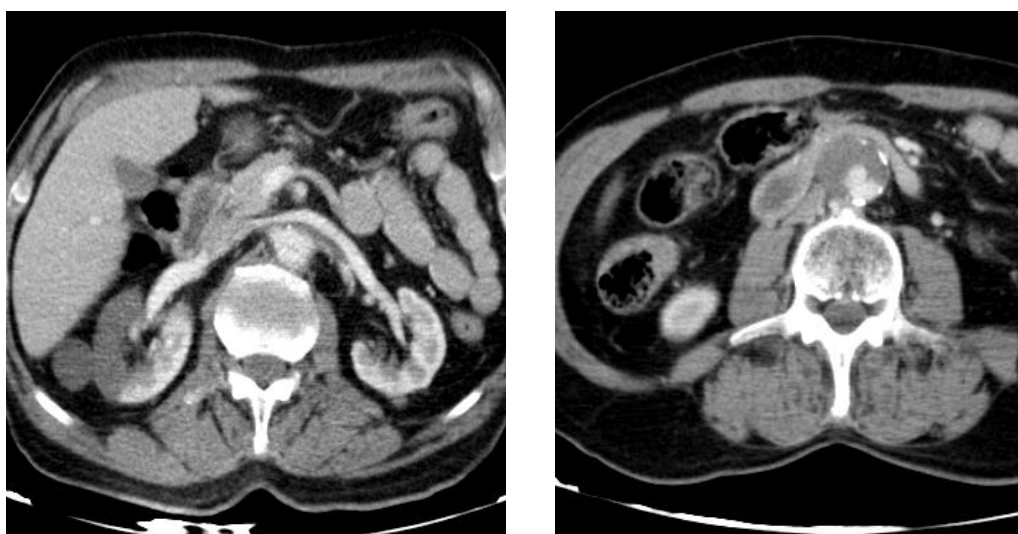
DİSCUSSİON

Renal infarction has still remained an under diagnosed medical condition that should be diagnosed rapidly and promptly for the high risk of permanent renal function failure that it may causes. Risk factors for renal infarction include atrial fibrillation, pulmonary embolism and valvular heart disease. The source of thrombus usually results in the heart or aorta, but also in situ renal artery embolism can occur. In our case report it was so surprising that the patient didn't had any predisposing risk factors for renal infarction. Patients with renal infarction usually present with acute onset of flank pain associated with nausea and vomiting and this typically mimics nephrolithiasis presentation. Treatment options includes thrombolysis, thrombectomy with or without angioplasty.

CONCLUSİON

Renal infarction should be considered in the differential diagnosis of nephrolithiasis and pyelonephritis.A high level of suspicion is mandatory for the diagnosis of renal infarction. Early diagnosis and rapid anticoagulation therapy is the key for rapid renal recovery.

Abdominal CT Scan



SÖZEL 24

HYPOKALEMİC PERİODİC PARALYSİS: A CASE REPORT

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Objective: Hypokalemic periodic paralysis (HPP) is a rare disease characterized by intermittent attacks of muscle weakness occurring at irregular intervals and accompanied by episodic hypokalemia. During the attacks due to the shift of potassium into muscle cells, the serum potassium level is low but it is normal between attacks. There are generally some precipitating factors such as stress, high carbonhydrate food consumption, cold, resting after strenuous exercise, drugs (such as glucocorticosteroids), insulin and diuretics, preceding infections, and pregnancy. The most common

causes of HPP are familial periodic paralysis (FPP), thyro-toxic periodic paralysis (TPP) and sporadic periodic paralysis (SPP). In order to get attention to this rare disease, we hereby present a 28-year-old male patient admitted to our emergency department who had suddenly developed muscle weakness in his upper and lower extremities.

Case: A 28 year-old male patient with no significant past medical history presented to the emergency room with sudden onset paralysis. The patient awoke in the morning unable to move his lower extremites (flaccid paralysis), with extreme weakness of his upper extremities after a strenous exercise the previous evening. At presentation, his blood pressure was 100/70 mmHg and his heart rate was 86 beats/min. He demonstrated flaccid symmetrical proximal
and distal weakness of the arms and legs (power: legs 1/5, arms 3/5). Sensation was intact but deep tendon reflexes were depressed bilaterally (grade 1/4). The patient stated that, he had undergone similar episodes, beginning after midnight, which resolved spontaneously within a few hours. No similar weakness or other remarkable diseases in the family was reported. Except for a potassium level of 1.9 (3.5-5.2 mmol/L) routine chemistry, liver enzymes, thyroid functioning tests and complete blood count were normal. Electrocardiogram showed a complete atrioventricular block. Treatment was started with intravenous administration of potassium chloride at 10 mmol/h and oral potassium chloride at 40 mmol every 8 h. The patient recovered full muscle strength within three hours of treatment. And an electrocardiogram after one hour of treatment revealed a sinüs rhythm at 78 beats/min. The patient was diagnosed with Hypokalemic Periodic Paralysis and admitted to the internal medicine department.

Conclusion: It is important to consider Hypokalemic Periodic Paralysis when seeing a patient with sudden onset weakness or paralysis, without significant risk factors for stroke and no history or evidence of other diseases. Failure of diagnose can be fatal, but rapid correction of hypokalemia can resolve the symptoms quickly and completely.

SÖZEL 25

OPİOİD ANALGESİCS MUST USE COUTİOUSLY

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ABSTRACT

Introduction: Narcotic (opioid) analgesics are not treated with non-steroidal anti-inflammatory drugs and relieves pain. Opioids are seen as oral, dermal, intravenous, intramuscular and nasal. Opioids are safe and effective analgesics in appropriate medical uses. Although they contain significant toxicity at high doses, they are sometimes treated with high mortality potential drugs. It is also possible to reverse its effects when diagnosed with narcotic intoxication. In this case presentation our aim is to take care of narcotic drugs and to draw attention to the signs of toxicity.

Case Report: A 65-year-old male patient was admitted to our emergency department with 112 emergency ambulances due to deterioration in his breathing and not responding to the morning.When he was come ,his general condition was bad, unconscious, the patient who is in the stupor position responding to the painful stimulus; blood pressure: 60/40 mm/Hg, pulse: 160/min, fever: 35, peripheral oxygen saturation 60%, and fingertip blood glucose: 110 mg/dl. In his story It was learned that Lung Ca and worsening the condition of the patient with diffuse metastasis in the body after he had a night sleep state. In physical examination, rough rales in both lungs and bilateral myositis in pupils when the patient's history is deepened ,it was learned that the previous day fentanyl-containing transdermal drug was started because of widespread body pain. The patient was suspected to have opioid overdose with spontaneous breathing after Naloxone was administered three times with a dose of 0.2 mg iv by 2 min. in a total dose of 0.6 mg, and vital signs were stabilized.
Results: After the patient was followed in the intensive care unit for 24 hours, he was discharged with pain relief polyclinic control.

Conclusion: Narcotic drugs should be used with caution in elderly patients with additional diseases such as cancer. Patients should be told about the use of drugs and their side effects. Physicians should not ignore narcotic toxicity and naloxane use in patients with unconsciousness, respiratory depression and myositis.

SÖZEL 26

RETROSPECTIVE ANALYSIS OF CARBONMONOXIDE CASES APPLIED TO OUR EMERGENCY SERVICE

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INTRODUCTION:
The term hyperbaric means high pressure. Generally, if the medical use of high pressure is known in our recent history, the first records of this treatment are based on the 17th century. In 1984, in Turkey hyperbaric medicine activities were started in GATA Haydarpaşa Hospital. Essentially, it is a treatment method that is administered by breathing 100% oxygen intermittently to patients fully pressurized in a pressure chamber. Hyperbaric oxygen therapy, which has accelerated wound healing, has antitoxicity effects and is used in many areas, is frequently used to remove toxic effects of carbon monoxide especially in our own hospital. In this report, we aimed to analyze the hyperbaric oxygen therapy of patients with carbon monoxide intoxication.

MATERIAL AND METHOD:
The patients who were admitted to our emergency department between 01.09.2017 and 31.12.2017 were diagnosed with carbon monoxide intoxication and were screened through the hospital information management system. A total of 65 patients were found. The gender, admission complaints, cause of poisoning and whether they received hyperbaric oxygen therapy were examined.

RESULTS:
Of the 65 patients in total, 40 were female (61.5%) and 25 (38.5%) had male sex. Of the patients, 30 had headache (46.1%), 17 had fainting (26.1%), 9 had nausea and vomiting (13.8%), and 5 had

dizziness (7.7%), 4 had fatigue(6,3%). The reason of poisoning was stove smoke in 49 patients (% 75,4). Other reasons include exposure to tandoor smoke, exposure to shisha and exposure to fire smoke (24.6%). While 35 of the patients were receiving hyperbaric oxygen therapy (53.8%), the remaining 30 patients were followed with normobaric treatment (46.2%).

CONCLUSION:
Hyperbaric oxygen therapy has been used in the treatment of many diseases from past to present and the number of centers in our country is increasing day by day. We also wanted to talk about the use of hyperbaric oxygen therapy in carbon monoxide intoxications which we need most in our emergency department.

SÖZEL 27

A RETROSPECTİVE ANALYSİS OF ORAL MUCOSA PATHOLOGİES: A SİNGLE-CENTER TRİAL

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Aim: Oral cancer is the sixth most common cancer worldwide however a wide range of diseases may affect the oral mucosa. We aim to determine the prevalence of the oral mucosal pathologies in our patient series and discuss the final diagnosis in relation to sex, age and subsite distribution.

Patients and Methods: This was a cross sectional descriptive study, including 288 patients with oral mucosal pathologies, diagnosed at Baskent University Konya Hospital between January 2002 and December 2014. Data were retrieved from archives of pathology laboratory, retrospectively. A commercially available statistical package (SPSS17.0) was used for descriptive statistical analysis.

Results: The results showed that benign epithelial proliferations and reactive pathologies were the most frequently diagnosed lesion, accounting for 22.7% of the total number of patients. Among this reactive pathologies, squamous papillomas were the most common (n: 31; 9,9%), followed by fibroepithelial polyps (n:24;7,7%) and irritation fibromas (n:16; 5,1%). Oral mucosal dermatoses were the second common benign lesions, accounting for 21,8% (n:63) of all cases. Of the 288 oral mucosal pathologies 15,3% (n:44) were malignant and 17,7% (n:51) were precancerous. Squamous cell carcinoma were comprised of 95,5% of all the malignant lesions. Premalignant lesions were with the following distribution: squamous cell hyperplasia (n:47; 16%), moderate dysplasia (n:2; 0,7%) and lichenoid dysplasia (n:2; 0,7%). Lip was the most frequently involved site for squamous cell carcinoma. The male to female ratio was almost equal in both sex for premalignant lesions however there was slight male predominance for squamous cell carcinoma ($p>0.1$). Squamous cell carcinoma was commonly seen in the older age group compared to benign and precancerous lesions.

Conclusion: The similar clinical appearance of oral mucosal pathologies in a very wide spectrum is a compelling element for clinicians in the process of diagnosis. Especially in malignant lesions early diagnosis may be life saving. Therefore, it is important to reveal our own series about these pathologies. This study, by demonstrating distribution of histopathologically classified lesions according to some clinical features such as location, age and gender, will guide and facilitate the clinical diagnosis.

Keywords: Oral mucosa, cancer, pathology

SÖZEL 28

A RARE CAUSE OF ACUTE ABDOMİNAL PAİN İN POSTMENOPAUSAL WOMEN: SUBACUTE ADNEXAL TORSİON MİMİCKİNG OVARİAN TUMOR

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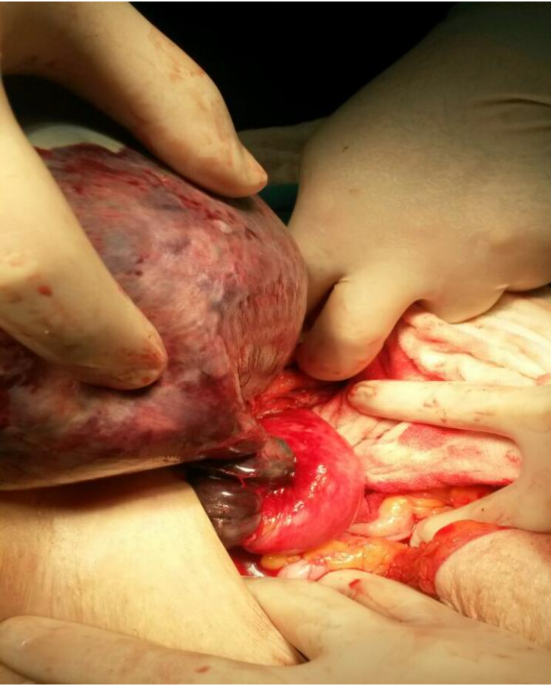
Aim:
Adnexal torsion constitutes 3% of all gynecological emergencies (1). It is frequently seen in the reproductive age with acute onset symptoms. Adnexal torsion is a rare cause of lower abdominal pain in the postmenopausal period. In this case report, an adnexial torsion case was operated with subacute preinclusion in the postmenopausal period and preliminary diagnosis of ovarian malignancy was discussed.

Case:
A 84-year-old postmenoposal patient was admitted to our clinic with complaints of lower abdominal quadrant pain, abdominal distention, and constipation. Abdominal distress was observed in the physical examination. Bimanual examination was painful in cervical movements. Ultrasonographic and magnetic resonance evaluation revealed a mass with solid and cystic areas which could not be separated from the uterus originating from the left adnexal area of 120x150 mm diameter. Complete blood count and biochemical measurements were within normal limits in laboratory findings. Laparotomy was planned with a prediagnosis of ovarian malignancy. In the exploration of the abdomen, adnexal torsion with secondary edematous and necrotic structure was observed. It was secondary to the subacute process and formed the adnexal torsion of the left ovary and the tubule which had been rotated twice around itself (Figure 1). It was observed that the mass adducted to sigmid colon and small bowel loops. Since the patient was in postmenopausal period, total abdominal hysterectomy and bilateral salpingo-oopherectomy were performed. The Frozen result is benign. The patient was asymptomatic after the operation.

Discussion:
Ovarian torsion may be seen in the form of tubal and ovarian torsion or isolated tubal torsion. Although it is responsible for few of all gynecological emergencies, it is an important clinical condition with the necessity of urgent operation. The most common complaint is acute pelvic pain, which may be intermittent and continuous, and may be accompanied by vomiting. Fever, tachycardia, rebaund, and adnexal mass may be associated. The diagnosis is based on clinical symptoms, physical examination findings and imaging modalities, but it can be confused with ovarian tumors in advanced age, subacute, as in our case. Necrosis and gangrene transformation in tissues may result in infection or peritonitis, resulting in ovarian or tubal damage in cases of late diagnosis for non-specific features (2). Clinical suspicion is important in diagnosis. Ultrasonographic doppler evaluation is helpful in the diagnosis. Although laparoscopic evaluation and management is the gold standard surgical procedure, laparotomy can be performed in cases of suspicion of malignancy especially in older age group. Detection of adnexin with or without cystectomy is the recommended treatment approach. Complete tissue removal can be performed in cases where the tissue is highly gangrenous and whose fertility is suspected to have malignancy.

Result:
Clinical symptoms and laboratory findings include adnexal torsion, one of the non-specific gynecological emergencies; Although it is often seen at reproductive age, it should be considered in the differential diagnosis of women who presented with subacute symptoms during postmenopausal period and who were pre- sented by imaging methods with similar findings to ovarian malignancy.

Figure 1: Necrosis and torsion adnexes



Keywords: Adnex, torsion, postmenopause, acute abdominal pain

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SÖZEL 29

AN UNUSUAL PRESENTATİON OF SPONTANE GLUTEAL HEMATOMA; DURİNG ANTİCOAGULATİON THERAPY FOR DEEP VEİN THROMBOSİS

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Introduction
Today, anticoagulant agents are widely used for many diseases. Coronary artery diseases, cardiac rhythm and conduction disorders, peripheral arterial diseases, cerebrovascular diseases are some of them

These bleedings can be unusual in body parts

Case report
A 63-year-old male patient was admitted to the emergency department with a complaint of a right foot

He history revealed that he was started on anticoagulant therapy one month ago for venous thrombosis.

It was learned that the patient had pain in her hips and thighs for 1 week in the emergency room application and suddenly ecchymoses developed in the last 2 days.

The patient had no history of trauma. It was learned that he had been suffering from hip pain more than one center for the last 1 week.

Physical examination
Ecchymosis spreading from the gluteal region to the popliteal region

Diameter increase in right leg

Neurovascular system is natural

No pulse deficit

TA :99/58 mmgg

NB :69

FEVER :36,7 °C

You Can't See If You Don't!
You Can't Know If You Don't Ask!

Lab Tests

- INR 15
- HGB 4.1 mg/dL
- Hct: 13%
- Plt: 270.000
- Mcv 95

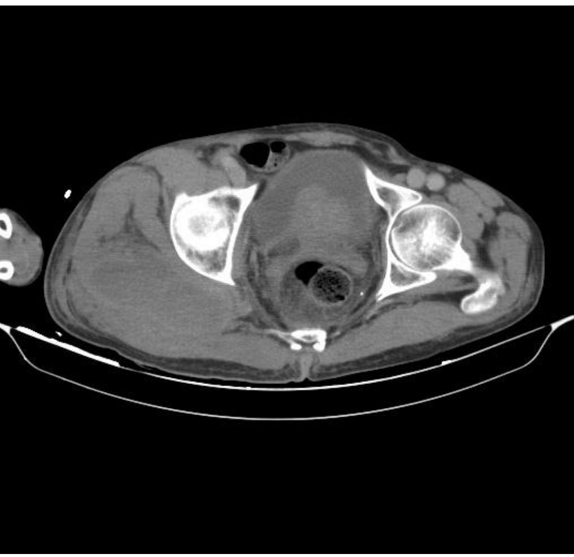
Kreatin 0,65 mg/dl

AST 19 U/L

ALT 16 U/L

Other lab tests natural

Radiology



Background

- When the medications were checked, it was learned that more than one anticoagulant treatment was started for DVT (coumadin 5 mg, pletal 100 mg, aspirin 100 mg).
- In addition, it was learned that he applied to multiple centers with his existing pain but non-specific analgesic (majezik) treatments were arranged on the pain described by the patient

Discussion

In patients with emergency services, such as musculoskeletal pain, which are not of vital importance and with unresponsive complaints, there may be insufficient time for detailed physical examination and diagnosis.

And as in this case, lesions such as ecchymosis, which may be noticed when the patient is peeled, can easily be overlooked.

In addition, it can be thought that pain is mostly caused by thrombosis in patients with a history of chronic DVT

As in our case, gluteal hematoma may cause right leg pain.

The patient who applied to multiple centers with leg pain was thought to be related to DVT and antiplatelet was added to the patient.

Antiinflammatory and anelogic therapy was started in another center.

Only a small group of patients diagnosed with DVT (17% in two large series and 32%) had a real disease.

DVTless symptomatic patients have many different diseases

- Postflebitic syndrome, varices
- Congestive heart failure
- Trauma
- Baker's cyst

- Cellulite
- LYMPHANGITIS
- Inguinal abscesses
- Malignancies causing venous or lymphatic obstruction
- Rheumatoid arthritis
- Contact dermatitis
- Gout
- Erythema nodosum
- Paralysis
- Superficial phlebitis

Some risk factors increase the risk of bleeding in patients using anticoagulants.

Some of those ; Age >75 years, Previous bleeding, cancer, ,Metastatic cancer, Renal failure, Liver failure, Thrombocytopenia, Previous stroke, Diabetes, Anemia, Antiplatelet therapy, Poor anticoagulant control, Comorbidity and reduced functional capacity, Recent surgery, Frequent falls, Alcohol abuse

The most common areas of bleeding are; intracerebellar, gastrointestinal, and genitourinary systems

Increased risk of bleeding due to spontaneous and trauma

Conclusion

A full physical examination may not be performed in the emergency department due to the shortness of examination time and inadequate facilities.

Especially the coumadin, which is a frequent application, and more detailed anamnesis should be taken from geriatric patients.

It should be kept in mind that spontaneous bleeding may develop. Nonspecific musculoskeletal pain diagnosis should be made after detailed investigation.

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SÖZEL 30

AN UNUSAL CASE OF HEALTHY YOUNG FEMALE WİTH ACUTE SVO WİTH UPPER EXTREMİTY EMBOLİ: CASE REPORT

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Introduction: Arterial embolism most common manifestations are strokes and acute lower limb ischemia. Less frequently, emboli target the upper extremities, mesenteric or renal arteries. Treatment involves rapid diagnosis, which may be aided by precise imaging studies and restoration of blood flow. The majority of arterial emboli originate in the left heart where they form secondary to structural or functional abnormalities.Thus clots originating in the heart or the aortic arch can potentially embolise to any arterial branch in the body. Conversely, atherosclerotic plaque formed in more distal arteries such as the carotids are far more likely to embolise to the brain - causing strokes or transient ischemic attacks (TIA's).In this case we will discuss about SVO with upper extremity emboli of young healthy women.

Case: 33 years old women taken with ambulance to emergency service with complaints of left arm weakness, numbness, slurred speech , right eye movement difficulty .Patient claims strong pain in her left arm and also suddenly appeared reddish eruptions in her hand. In her physical examination blood pressure :135/85 mmHg, Heart Rate: 50 /min., Temp:36.7 C , Spo2:100 , RR:18 , neurologic examination shows right internuclear ophthalmoplegia lacking motor deficit , slurred speech.ECG shows bradycardia with extraventricular systoles.Eruptions,which could be related to arterial embolism, inspected in left hand. Left arterial pulses could not be taken. All other physical examination is normal. There was no specific, related disease in family history and personal history of patient. CBC and biochemistry laboratory results were in normal range. Neurology department consultated for further investigation. Cranial MRI showing restricted diffusion in right side of pons, left cingulated gyrus and in thalamus. CT angiography reveals occlusion from the beginning of left vertebral artery and retrograde filling ,also total occlusion seen in basilar artery anterior inferior cerebellar artery orifices distally with contrast filling defect of pontine branches. Upper extremity coloured Doppler USG revealed emboli in the distal end. Patient admitted to ICU for further investigation and trombectomy.

Conclusion: SVO and specially upper extremity emboli is highly rare in young healthy women. However due to high mortality and morbidity rates with late diagnosis of the disease, it is important to consider in any patient with lateralised neurologic symptoms even though it might start only with numbness. Early detection and management of SVO considerably lowers the mortality and morbidity rate and also increases effectiveness of treatment. Emergency physicians should be highly aware of lateralised neurologic symptoms.

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SÖZEL 31

BELL'S PALSY; COULD İT BE THE RESULT OF CENTRAL CEREBRAL PATHOLOGY ? : REPORT OF CASE

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Introduction: Bells palsy is the most common cause of
unilateral facial paralysis. Cranial nerve VII, the facial nerve, supplies
motor innervation to the muscles of expression of the face and scalp,
the stapedius muscle, and taste to the anterior two thirds of the tongue. Herpes simplex virus DNA and antigens play role in etiology of Bell's Palsy. Patient symptoms are usually acute , one sided facial paralysis(facial droop, effacement of wrinkles and forehead burrows inability to completely close the eye) including forehead might be accompanied decrease of taste and hyperacusis .With central pathology forehead is spared and hemiparesis usually accompanied with facial paralysis ,if brainstem is effected findings also include ipsilateral gaze palsy. Usually no imaging or laboratory testing is needed in patients with high suspicion of Bell's palsy unless further studies are required to exclude alternative diagnoses.We aimed to present a case who was admitted to emergency department with headache and Bell's Palsy.

Case:50 years old women attend to emergency service with severe headache,purulant discharge from ear and.she was claiming flu like symptoms a week ago that she had attend to another health center than with increased earache and headache she had ENT examintion 2 days after her antibiotherapy she attended to our clinic with severe headache , purulant discharge from ear and right sided facial numbness and slipping feeling in her lips and neck pain.Physical Examination: When patient smiles, face becomes distorted and lateralizes to left side,Flattening of forehead and nasolabial fold on right sideWhen patient raises eyebrows, right forehead remains flat
Poor eyelid closure on right side.Extreme pain with palpation of mastoid bone.besides these findings other systemic examination was normal.Vital signs: Temp:36.5 C, HR: 95/DK ,Spo2:100 ,BP:120/70 mmHg.CBC shows slightly elevated lökocytosis and slightly elevated CRP.CT scan ordered and in the result on right side of temporal lobe24x14mm hypodens area seen which guided us to suspicion of spread of otitis media to brain tissue.Contrast given Cranial MRI showed pacimeningeal and gyral contrast involvement which is warning to abscess formation.ENT ,Infecitous disease and also neurosurgery consultated for this case. Patient admitted to Infectious disease ward for further antibiotherapy treatment.

Conclusion: Rarely patients with severe headache and also purulent otitis media can lead to mastoiditis and result with brain abscess and Bell's Palsy. Headache that would not respond NSAIDS should lead us to investigation for a central reason for Bell's Palsy.

SÖZEL 32

CASE REPORT: HALLUCİNATİONS DUE TO ANGEL TRUMPET CONSUMPTİON (DATURA STRAMONİUM INTOXİCATİON)

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Introduction:
Delirium,slurred speech and blurred vision can mostly seen in emergency departments. Systematic approach is needed for the proper management of diagnosis and treatment. Delirium can be described as a neuropsychiatric syndrome characterized by impairment of consciousness, orientation, memory, thought, perception and behavioral domains due to direct or indirect physiological or structural changes of brain. Slurred speech and blurred vision may occur as consequences of several systemic diseases, metabolic disorders, toxic effects of drugs or substances, operations, migren seizures and neurological disease. As many psychiatric symptoms and signs such as bizarre behaviors, hallucinations and agitation can be observed in the patient, hallucinations can often be confused with other psychiatric disorders. Datura stramonium(DS) is a plant which can be found in every part of Cyprus and also Turkey.DS is a member of Belladona Alcaloids family it contains hyocyamine, atropine and scopolamine. It may cause anticholinergic symptoms and signs due to its contents . Even tough it can be use for a medical treatment such as asthma , bronchitis, achnes,eczema,hemorroid also there is many misuse and abuse of this plant. Cases of intoxication are important causes of mortality and morbidity among emergency department admissions; however, cases of intoxication due to plants are rare. In our case who was admitted to emergency department with psychiatric and neurologic symptoms and found to be intoxicated with Datura stramonium after detailed history.With this case we aim to increase awareness for use, misuse and abuse of DS.

Case : 28 years old women taken to our emergency service for having hallucinations , slurred speech,blurred vision, diplopia and also increased heart rate. No familial and personal psychiatric and/or epileptic disease history was known.Her physical examination was : Spo2 :100 % , heart rate : 145/dk BP: 110/60 mmHg, temp:37.2 . Pupils mydriatic,otherwise normal neurological examination. Rest of the examination, complete blood count and biochemical parameters were found within normal limits . After having detailed anemnesis , we have learned that she has eaten famous Cypriot food which is rice stuffed squash blossoms but she used angel trumpet flower instead of squash blossoms. Gastric lavage done and charcoal 1 g/kg has given to patient.She was orientated and cooperated but highly agitated and alert.In order to decrease agitations Diazepam 5mg has given to patient parenterally.Hydration done with %0.9 NaCl Saline Solution . Meanwhile anesthesia and internal medicine consultant physicians informed and patient admitted to ICU for close follow up.

Conclusion: In every patient detailed history can be rescuer for MD and also for patient. In this case Angel trumpets was misuse but there can be abuse of this widespread plant. Substance abuse is a common problem in adolescents who deliberately ingest a variety of substances for their mind-altering properties.(3)
Blurred vision , slurred speech and halucinations should be warning asembly for usage of Angel Trumpet. Sometimes what patient ate as a dinner can really matter.

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SÖZEL 33

YOUNG HYPERTENSİVE PATİENT WİTH CONN DİSEASE,FATİGUE CAN BE EMERGENT SYMPTOM.

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Introduction:
One of the reasons of primary HT is Conn's disease,which HT can easily be treated .Conn's syndrome appears with increased secretion of aldosteron from bilateral hyperplasia of adrenal glands or adrenal adenoma.Patient classical sypmtoms is usually HT,hypokalemia,incresed urinary potasium exrection and metabolic alkolosis.(1)With this case we want to emphasize that fatigue can be the only symptom for a real emergent sitiuation;hypokalemia.

Case: 50 year old women attend to emergency service with lately occured diffuse muscle pain ,weakness especially weakness of arms and fatigue.Patient family history was unspecific ,in her history she had hypertension in last 4 years.She is under medication for hypertensin ; amlodipine 10 mg combined with valsartan 160 mg and also bisoprolol 5 mg.She has been determined with hypokalemia 1 year ago but there was no reshearch for etiology.She does not have any history of licorice root usage or any other medical ,herbal medication usage to cause hypokalemia.
In her physical examination ;blood pressure 150/90, pulse:78,rhytmic, respiarory rate :18.Patient was pale ,in her neurological examintaion upper extremity was bilateral 4/5 .Other ohysical examintaion was normal. ECG shows decrease t wave amplitude with U wave appearance . Biochemistry results showed k: 1.5 mg/dL,Ca:8.2 mg/dL(8.4-10.2 mg/dL) AST: 105 U/L (5-34 U/L) creatinine: 0.52 mg/Dl, arterial blood gas result : pH :7.65, pCO2 : 34.7 mmHg ,pO2 : 112 mmHg ,sO2: 97.4 mmHg HCO3: 40.4 mmol /L which shows metabolic alkolosis.After the result internal medicine consultation asked for further treatment and diagnosis.

Conclusion: Between heavy work load in Emergency services sometimes fatigue ca be wrongly estimated in patient with hypertension and muscle weakness .Electrolyte disturbances in hypertensive patients should not be underestimated.

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SÖZEL 34

MECHANICAL STENT RETRIEVER TROMBECTOMY IN ACUTE ISCHEMIC STROKE PATIENT

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BACKGROUND : Stroke is the most common cause of disability and third most common cause of death in Turkey. The aim in these patients is to diagnose stroke, to determine the level of stroke and to decide the reperfusion treatment. Use of IV r-tPA was extended to the first 4.5 hours of acute ischemic stroke treatment. In recent years, endovascular mechanical thrombectomy treatments have been used effectively until the 6th hour after stroke.

CASE PRESENTATION
An 80-year-old male patient presented to the emergency department with hemiplegia recognized 3 hours ago. In the neurological examination of patient NIHSS score was 15. Patient had head CT scan and there was hypodensity at the basal ganglia level compatible with acute infarction. The patient was started with IV r-Tpa 0.9ml/kg. The patient had progressive neurological findings after iv r tPA and the patient was taken to the angio unit for endovascular treatment at the 4.5 th hour. Angiography showed preocclusion of the left internal carotid artery and total occlusion of the left middle cerebral artery. First, the stenotic segment in the internal carotid artery was stented. Then the clot which caused occlusion in the middle cerebral artery was retracted with stent retriever.
Control angiographies showed complete vascularization of the brain parenchyma. The following day, in control head CT the infarct area were the same and did not widen. In the control neurological examination on the third month, the Modified rankin score was 1.

CONCLUSION: IV r-tPA may not be sufficient, especially in patients with internal carotid artery stenosis and long segment thrombosis in the middle cerebral artery. Endovascular mechanical thrombectomy is an effective treatment modality in these patients.

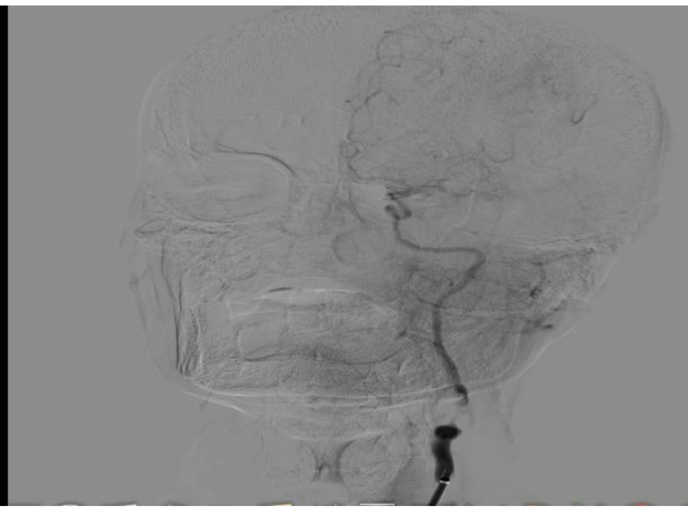

Figure 1: Angiography showed preocclusion of the left internal carotid artery and total occlusion of the left middle cerebral artery

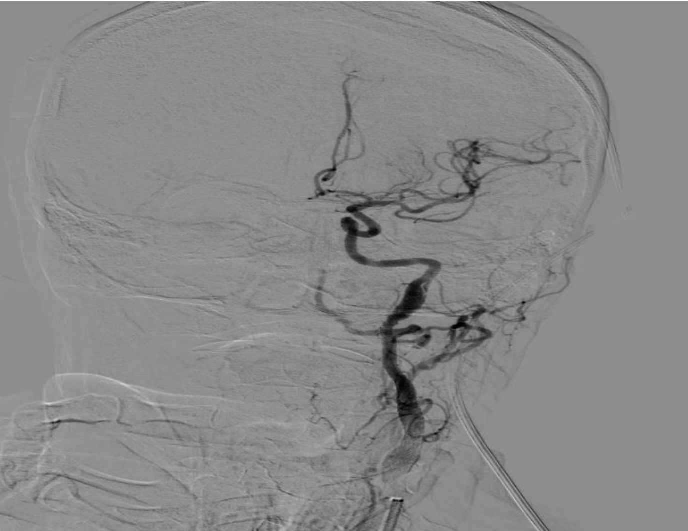

Figure 2. Stenotic segment in the internal carotid artery was stented. Then the clot which caused occlusion in the middle cerebral artery was retracted with stent retriever. Control angiographies showed complete vascularization of the brain parenchyma

SÖZEL 35

WHY MEN?

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Objective
Trauma is a leading cause of death, especially in the 1-44 age group. Penetrating traumas may cause high rates of morbidity and mortality among all these traumas. Penetrating traumas can be identified as stabbing, piercing, piercing-stabbing and firearm injuries. Although penetrating stab wounds are more common, they are less mortal than gunshot wounds. Penetrating traumas continue to be an important cause of morbidity and mortality, which we encounter more frequently in emergency services with increasing violence.Violence is more common in men. The aim of this study is to

investigate the epidemiological and demographic features of penetrating traumas with a multidisciplinary approach, which can significantly decrease mortality and even morbidity.

Method
Between January 2017 and December 2017, 210 patients who presented to the emergency department due to penetrating trauma were reviewed retrospectively. Patient data were obtained from patient files and electronic hospital records in the hospital archive.Patient's age,sex,the manner of application(with an ambulance or etc.),GCS,the mechanism of trauma,traumatic body area,intervention or procedure,requested radiological examination,requested consultations,clinical outcome,length of hospitalization and emergency service cost were recorded in case data form. For statistical analysis, NCSS (Number Cruncher Statistical System) 2007 (Kaysville, Utah, USA) program was used. Significance was evaluated at least $p < 0.05$.

Results
A total of 210 patients were included in the study.There were 86.2% men among the patients. Radiological examination was required in 76.2% of the cases. 48.1% of the cases were requested for consultation. The most requested department was orthopedics and traumatology with 51.5%. When the length of stay in the emergency room was examined, it was found that they remained at most 40% for 1-3 hours. Emergency service costs ranged from 15.5 to 6110 TL and the average was found as 386,36 ± 537,66 TL. In men, the cost of emergency service (15,5-6110 (251,2) mean ± 390,30 ± 552,46) was higher than women.The emergency service cost in patients who suffered from gunshot wounds was higher than the patients who suffered from penetrating stab wounds ($p=0{,}023$; $p<0{,}05$). Only 17.1% of the male patients in the emergency room were discharged in the first hour, while the rest remained longer. We analyzed that,patients who came with ambulance(112),hospitalized 6 hours or more($p=0{,}001$; $p<0{,}01$).It was seen that the patients who were came to the emergency service with gunshot wounds hospitalized longer than the other types of trauma patients in the emergency room($p=0{,}006$; $p<0{,}01$). A significant direct correlation was found between the duration of emergency room stay and the application of procedures such as invasive intervention, radiology requests, laboratory requests, consultation($p=0{,}001$; $p<0{,}01$).
Conclusion
Penetrating traumas can be seen in a wide range from a superficial trauma to a fatal trauma. This type of trauma, which occurs especially outside the home and increases with violence, is more common in the male population. As a result, penetrating traumas are frequently encountered in emergency services and with good management,the mortality and morbidity can be reduced in these types of traumas. We believe that more comprehensive multidisciplinary studies in terms of patient population will contribute to emergency service penetrating trauma management planning.

Key Words:Penetrating Trauma, Emergency Service, The lenght of stay in emergency room

SÖZEL 36

ACUTE CORONARY SENDOM AFTER BEE BITE

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DR. İLKER AKBAŞ (BİNGÖL STATE HOSPITAL EMERGENCY SERVICE)

INTRODUCTION: Kounis Syndrome, which is a myocardial ischemia picture accompanying with allergic cases, was first described in 1991. Though not rare, actually, Kounis syndrome is among the less common diseases in literature, and one of the less known and underdiagnosed diseases by clinicians. Real incidence of the disease is not known exactly due to the unreliability in reporting or misdiagnoses. It was first described in 1991 by Kounis and Zarvas. The incidence of the disease was indicated to be between 4.3 and 9.6 per hundred thousand in the retrospective studies. Symptoms and/or findings of systemic allergic response accompanying with the electrocardiographic or

laboratory findings of myocardial ischemia should remind us Kounis Syndrome . However, sometimes Kounis syndrome can also be observed without classical clinical findings of hypersensitivity such as any skin lesion (urticaria, angioedema, mucosal involvement) or hypotension . The diagnosis of the syndrome is made primarily via symptoms and signs, electrocardiographic and laboratory features, echocardiographic and angiographic changes of the patients.
CASE: A 69-year-old male patient was brought to our emergency department with the complaints of persistent chest pain, sweating and nausea starting 10 minutes after bee bite. His ECG revealed ST elevation in lateral leads. Cardiology consultation was requested and the patient was admitted to coronary intensive care unit with the diagnosis of Kounis. The result of the Anjeo LAD plaque cx-rca is normal. After 300 mcG perlinganit infusion, the lesion decreased to 30%. Medical follow-up decision was taken to coronary intensive care unit.
CONCLUSION: Kounis syndrome should be considered in the patient with acute coronary syndrome symptoms due to coronary vasospasm after bee bite.

TAM METİN BİLDİRİLER

TAM METİN 1

VALİDİTY OF SERUM MİCRORNA-93 AND MİCRORNA-191 LEVELS TO REDUCE UNNECESSARY COMPUTED TOMOGRAPHY İN ADULT PATİENTS WİTH MİNOR HEAD TRAUMA

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Keywords: microRNA-93, microRNA-191, minör head trauma, traumatic brain injury, cranial computed tomography

Background

Head trauma is one of the most important causes of mortality and morbidity in developing and developed countries, especially in the young population. Only 40-50% of surviving head trauma patients recover without sequelae. Head trauma constitute of approximately 20% of patients admitted to the emergency department of hospitals (1,2). Although severe head trauma results in disability and death in young individuals, there is more frequent admission to hospitals due to minor head trauma (3).

Indication for the appropriate use of cranial computed tomography (CCT) in patients with minör head trauma (MHT) based on history and physical examination alone remains unclear (4). Recent studies have been reported that 90% of patients with MHT who undergo CCT under the present clinical decision rules have no clinically important brain injuries (5). Actually, many cases with MHT go unnoticed or misdiagnosed, as the current diagnostic tests are neither sensitive nor specific enough to identify traumatic brain injury (TBI) (6,7). Serum concentrations of the various specific microRNAs were recently found to provide useful information in the diagnosis, severity, and prognosis of TBI (8). To date, there have been only a limited number of studies investigated serum microRNAs in MHT patients with TBI.

The purposes of this study were (a) to determine the expression levels of microRNA-93 and microRNA-19 in the sera of adult patients with MHT; (b) to correlate TBI with the initial microRNA-93 and microRNA-191 levels; and (c) to investigate whether the initial serum levels of these miRNAs can predict the presence or absence of intracranial injury for reducing the use of unnecessary CCTs.

Materials and Methods

This study was conducted in accordance with the 1989 Declaration of Helsinki and was approved by the Ethics Committee of Istanbul Haseki Research and Training Hospital (Trial Registration No: 515). The present study was funded by the Health Sciences University Board of Scientific Research Projects (Funding number: 2018/006).

Fifty-nine consecutive adult patients with isolated MHT (Glasgow Coma Scale [GCS], GCS scores of >13) undergoing CCT based on the clinical decision rule of the New Orleans Criteria and 91 age- and sex-matched healthy controls were enrolled in this prospective study. Patients were divided into 2 groups as follows: those without (group 1) and with (group 2) traumatic intracranial or extracranial lesions (e.g., skull fracture, brain swelling, cerebral contusion, intracerebral hematoma) shown on CCT. Patients were also divided into two subgroups based on the presence or absence of traumatic

parenchymal lesions defined as TBI. The serum levels of microRNA-93 and microRNA-191 were assessed in MHT patients and healthy controls using quantitative real-time reverse transcription-PCR. The primary outcome variable was to determine the indication of the need for an initial CCT in patients with MHT and the presence of intracranial lesions in conjuction with serum miRNAs levels.

Results

The mean serum microRNA-93 and microRNA-191 levels were significantly increased in the MHT patients compared with the controls (both comparisons; P<0,001). The mean serum microRNA-93 and microRNA-191 levels between the study groups (groups 1 and 2) were statistically significant (P=0.017 and P=0.001, respectively; Table 1). Of the 79 patients studied, 16 exhibited trauma-relevant intracerebral or extracerebral lesions on the CCT scan (CCT+). With a cut-off limit of 0.15, microRNA-191 had an area under the curve (AUC) value of 0.765 (0.640-0.889), a sensitivity of 68.1%, and a specificity of 68.8% in CCT+ patients (Figure 1).

Compared to MHT patients without TBI, the mean serum microRNA-191 levels were markedly elevated in patients with TBI (0.72±1.64 and -0.56±1.63,respectively; P=0,017). However, microRNA-93 levels levels did not show significant changes in either group of patients (P=0.145; Table 2). With a cut-off limit of 0.069 microRNA-191, TBI+ patients were identified with a sensitivity level of 66.7% and a specificity level of 58.3% (AUC: 0.712, [0.563-0.862]; Figure 2).

Discussion & Conclusions

This study is the first clinical trial to determine whether serum levels of microRNA-93 and microRNA-191 in patients with minor head trauma can predict the presence or absence of intracranial injury for reducing the use of unnecessary CCTs. Minor head trauma accounts for more than 80% of patients admitted to emergency departments due to head trauma. Only a very small group of these patients have intracranial pathology. Because of the large number of patients, performing CCT to all of these patients poses a serious burden on health expenses of countries (9,10). MicroRNAs are important posttranscriptional regulators of complementary mRNA targets and have been implicated in the pathophysiology of acute brain injury (11,12). The human and experimental studies have identified various specific microRNAs as biomarkers in serum/plasma (e.g., miR-425-p, -21, -93, -191 and -499) for possible indicators of the diagnosis, severity, and prognosis of TBI (8,13,14).

In the present study, we found that circulating microRNAs levels increased after MHT and distinguished between those with and those without intracranial or extracranial lesions demonstrable on CCT. The results of this study demonstrate that miRNA-191 expression at a serum level of>0.15 has a high negative predictive value for CCT+ in patients after MHT. MicroRNAs, especially microRNA-191 concentrations in patients with MHT can provide additional information to improve indication of the need for an initial CCT scan. This study is the the first step towards validation of

thresholds for studies integrating microRNAs into a clinical decision rule for MHT to detect ntracranial or extracranial lesions.

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Table 1. Comparison of serum miRNA-93 and miRNA-191 levels according to CCT findings in patients with MHT.

	CCT findings						
	Normal			Abnormal			
	Mean±SD	Min-Maks	Median	Mean±SD	Min-Maks	Median	P*
miRNA-93	1.02±1.92	-2.97-4.53	1.16	-0.30±1.88	-4.67-2.36	0.00	0.017
miRNA-191	0.89±1.57	-2.63-3.46	1.08	-0.71±1.55	-3.31-1.51	-0.83	0.001

*Student's t test.

Figure 1. Receiver operating characteristic (ROC) curve of miRNA-191 expression in the serum of the MHT patients with CCT+ and those with CCT-

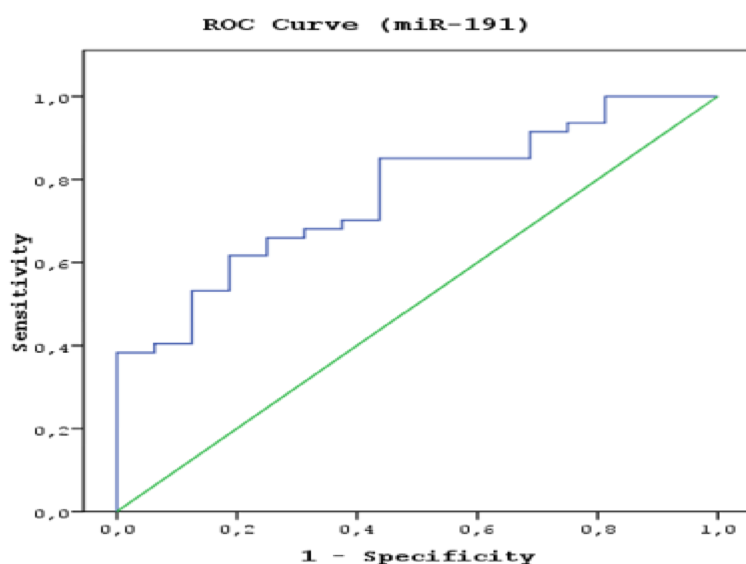
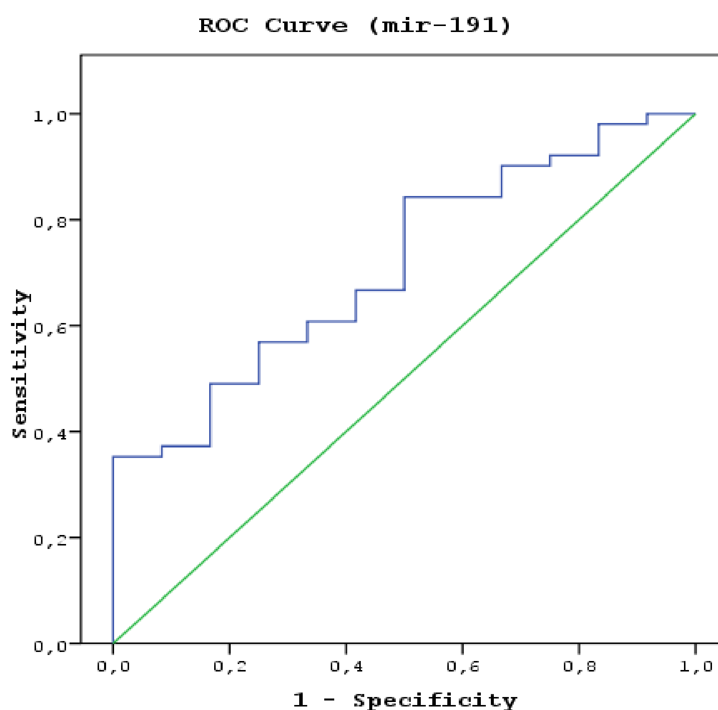


Table 2. Comparison of serum miRNA-93 and miRNA-191 levels in MHT patients with TBI and those without TBI.

	Traumatic brain injury						
	Yes			No			
	Mean±SD	Min-Maks	Median	Mean±SD	Min-Maks	Median	P*
miRNA-93	-0.02±1.27	-1.66-2.36	0.00	0.88±2.05	-4.67-4.53	1.16	0.145
miRNA-191	-0.56±1.63	-3.31-1.51	-0.42	0.72±1.64	-3.12-3.46	1.01	0.017

*Student's t test.

Figure 2. Receiver operating characteristic (ROC) curve of miRNA-191 expression in the serum of the MHT patients with TBI and those without TBI.



TAM METİN 2

SURVİVAL AFTER JUMPİNG FROM THE GOLDEN HORN BRİDGE

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Keywords: Chest trauma, Golden Horn Bridge, suicide, survival, jumping from height

Background

In high-altitude falls, including those related to suicide attempts, mortality varies according to the height of the jump, the rate of the fall, the structure of the ground below, as well as the position of the individual during the jump and upon impact (1). Individuals who unsuccessfully attempt to commit suicide by jumping off a brigde suffer traumatic injuries with potentially significant morbidity (2). The Golden Horn Bridge spans a major urban waterway and the primary inlet of the Bosphorus in Istanbul.

As its English name indicates, the bridge is located on the Golden Horn in Istanbul. It serves as a motorway and has a length of 995 m (3,264 ft), a width of 32 m (105 ft), and a height of 22 m (72 ft) above sea level (3).

Here, we describe the case of a person who jumped from the Golden Horn Bridge but survived, with a better-than-expected, clinically stable condition. The causes underlying her survival are discussed.

Case: A 29-year-old female was brought to our emergency department (ED) by the city ambulance service after she had attemped suicide by jumping from the Golden Horn Bridge, from a height of 22 m above sea level, into the Bosphorus Strait. She had been rescued by fishermen, who brought her to the shore. On admission to the ED, her Glasgow Coma Scale score was 15 and her Injury Severity Score was 14. Injuries to the chest, lumbar region, and left elbow were documented together with minimal abdominal pain. Her X-ray (chest, servical and lomber vertebra, pelvis, and extremity) imaging findings were normal but a cranial computed tomography (CT) scan revealed linear fracture lines on the orbital lateral wall bilaterally. In thoracic CT, fracture of the left fifth rib, left minimal hemothorax, right lung minimal contusion, and minimal hemothorax and atelectasia in the right lower zone were seen (Figure 1). The patient was hospitalized by the chest surgeon for treatment, including thoracic surgery and follow-up. Ten days after thoracic surgery, the general condition of the patient had improved and no complications had developed.

Discussion

Attempts to commit suicide by jumping from a height result in different mortality rates and types of injury, depending on the jumping height. At a height of up to 7 m, the mortality rate is 13–32%, while at heights from 7 to 30 m the rate is 64–81%, and from greater heights (above 30 m) it is 96–100% (4). In a study of suicides from the Bosphorus Bridge, Cetin et al. (5) found that 2 of the 65 individuals who jumped from the bridge between 1986 and 1995 survived, corresponding to a mortality rate of 96.9%. Mortality due to a jump is determined by the height of the bridge, the velocity of the fall, the body's position upon jumping and upon impact, wind speed and direction, clothing, water temperature, and wave conditions (2,5).

Our patient fell onto the lateral aspect of the thorax. Although her position during the jump was unfavorable and the bridge is quite high, she survived, albeit for reasons that are unclear. She attempted suicide in winter, on a cold and windy day. The water temperature of the Golden Horn is low and she was dressed in tight-fitting clothing.

Conclusion

The Golden Horn bridge is 22 m above sea level such that most jumps result in death. In our patient, the absence of major head trauma as well as laryngotracheal, cardiovascular, and major vascular injuries improved her chances of survival.

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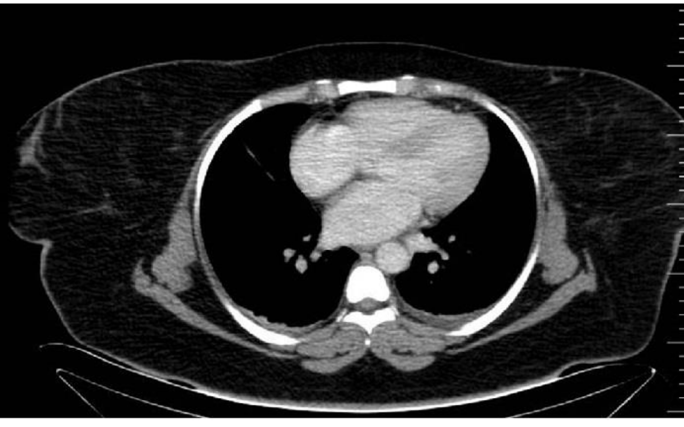
Figure 1. A chest computed tomography shows a left fifth rib fracture, left minimal hemothorax, minimal contusion in the right lung, and minimal hemothorax and atelectasia in the right lower lung zones.



TAM METİN 3

PLASMA OXİDATİVE STRESS PARAMETERS AND PROLİDASE ENZYME ACTİVİTY İN PATİENTS WİTH NON-TRAUMATİC ACUTE ABDOMİNAL PAİN

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Keywords: Non-traumatic acute abdominal pain, prolidase, oxidative stress, TOS, TAS, OSI

ABSTRACT

Inroduction
Acute abdominal pain is one of the most important emergent presentation reasons and all of people live it once at least in their lifetimes. It constitutes 5-10% of all emergency admissions. In genereal, 20-25% of the acute abdominal pain patients are hospitalised into a inpatient clinic and requires emergenct surgery, on the other hand any underlying reason can not be found and pain resolves spontaneously in 35-40% of the patients, this patient group is called nonspesific abdominal pain (NSAP) (1,2).
The ideal management method of patients with abdominal pain presented to the ED is to reach the accurate diagnose and treatment by the shortest time duration and the most effective cost. Aproximately, 10% of the patients with abdominal pain presented to the emergency department can not be diagnosed with a significant disease. Otherwise, just 10% of the diagnosed patients require surgical intervention (3). Because of these reasons, new laboratory markers are warranted for determining in which patients with abdominal pain will require medical treatment or immediate surgical evaluation. Biochemical parameters those can be used alone for diagnosis/differential diagnosis of patients with acute abdominal pain in the ED are unclear and this issue is one of the most important problem for clinicians. Prolidase, alone without other biochemical markers may not provide data to clinicians regarding disease activity. Thus, it has been suggested that prolidase should be evaluated together with other serum biochemical markers (4). In the literature, it has been stated that oxidative/antioxidative status and prolidase might be useful for diagnosis of acute appendicitis which is a widely cause of acute abdominal pain (5-8). It has been well documented that prolidase enzyme activity which is an indicator of collagen turnover, changes in several diseases. An increase in prolidase

activity is observed in diseases such as liver diseases; various tumor types, including breast cancer; renal cell carcinoma and lung cancers; bronchial asthma and acute pancreatitis (9-15). However, comparison of oxidative stress and prolidase in patients with varying causes of abdominal pain has not been established. Thus, in the present study we aimed to investigate the predictive value of plasma prolidase enzyme activity; total oxidant status (TOS); total antioxidant status (TAS); and the oxidative stress index (OSI) plasma prolidase enzyme activity as predictors of early oxidative changes in the differentation of NSAP, medically-treated and surgically treated abdominal pain patients presented to the ED.

Materials and Methods

This study was conducted in accordance with the 1989 Declaration of Helsinki and was approved by the Ethics Committee of Univerity of Harran, Faculty of Medicine, Sanliurfa, Turkey (Trial Registration No: B.30.2.HRÜ.0.20.05.00.050.01.04-70). The present study was funded by the Harran University Board of Scientific Research Projects (Funding number: 13048).

Over a 12-month period (April 2013 through March 2014), the present prospective case-control study enrolled 100 consecutive adult patients (56 females and 44 males; age range: 18–65 years) who were admitted to our tertiary-care university hospital ED with abdominal pain; 100 age- and sex-matched healthy volunteers were also included in this study. One hundred consecutive adult patients with abdominal pain prsented to the ED and 100 age- and sex-matched healthy controls were enrolled in this prospective study. Patients were provided basic trauma life support at presentation and advanced trauma life support if required. After vital functions were monitored, written informed consent was obtained directly from patients after the abdominal pain was controlled by appropiate medications. Furthermore, the healthy volunteers were informed about the study protocol, and written consent was obtained from all participants prior to their participation in the study. Subsequently, the patients with abdominal pain were divided into three groups according to requirement of surgery: surgically-treated patients (STP; group I), medically-treated patients (MTP; group II) and NSAP (group III).

Inclusion criteria were adult patients (≥18 years) with a history of abdominal pain took less than one week. The exclusion criteria were as follows: patients under 18 age, traumatic abdominal pain patients, conditions that may have affected oxidative markers, such as chronic medical disorders (i.e., congestive heart failure, chronic obstructive lung disease, diabetes mellitus, coronary artery disease, peripheral vascular disease, chronic renal failure, stroke, hypertension, active somatic-psyhiatric disease, rheumatic artritis, multiple sclerosis, Parkinson's disease, or malignancy); alcohol use, tobacco use, and/or ecstasy use; being pregnant or exhibiting elevated human chorionic gonadotropin (hCG) levels detected by a quantitative hCG blood test (β-hCG). None of the subjects were taking drugs known to affect lipid or lipoprotein metabolism, and special care was taken to exclude subjects who were taking anabolic drugs, diuretics, vitamins, or other antioxidants (such as vasoactive and beta-blocking agents).

Blood sample collection

Upon admission, venous blood samples of 5 ml were drawn from the antecubital vein of each patient without the use of medications or serum infusion, collected into heparinized tubes, and immediately stored on ice at 4°C. In additon, Venous blood samples of 5 ml from controls were withdrawn, collected into heparinised tubes, and immediately stored on ice at 4°C. Plasma was separated from the blood samples by centrifugation at 4,000 rpm for 5 min, and the plasma samples were stored at –80°C until prolidase enzyme activity; TOS; TAS; and OSI as predictors of early oxidative changes were assessed using a novel automated method.

Results

Among the 100 patients included in the present study, the mean age was 39.31 ± 17.66 years (age range: 18–65 years), and 56 (56%) were female. Among the 100 healthy volunteers, the mean age was 37.67 ± 13.77 years (age range: 18–63 years), and 53 (53%) were female. The causes of abdominal pain diagnosed in patients at the ED are summarized in Table 1.

There were no significant differences between the patient and control groups in terms of age (P = 0.837) or sex (P = 0.188). The mean plasma TAS levels were slightly increased in patients with abdominal pain than in controls but this was not significant (1.09 ± 0.21 and 1.05 ± 0.23, respectively;

P = 0.211). Mean plasma OSI values were significantly higher in the patient group than the control group (P = 0.001). Similarly, plasma prolidase enzyme activity, and TOS values were significantly higher in the patient group than the control group (both comparisions, P< 0.001). Table 2 presents comparisons of the patient and control groups in terms of demographic characteristics, plasma prolidase enzyme activity, oxidative stress parameters (TOS and OSI levels), and antioxidant levels (TAS).

When patients were grouped according to the cause of abdominal pain: 33 were surgically-treated patients (STP; group I), 34 were medically-treated patients (MTP; group II) and 33 were NSAP (group III). There were significant differences among the three groups in mean plasma TOS and prolidase levels (between-group comparisons for all three groups, P< 0.001; Table 3). Mean levels of plasma prolidase enzyme activity levels increased in proportion to the cause of abdominal pain, such that the group II had higher levels than the group III (999.80 ± 247.69 and 871.58 ± 128.74 , respectively; Table 3) and the group I, which included patients with the surgically treated, had the highest mean levels (1206.27 ± 242.63; Table 3).

Plasma OSI values were significantly increased (between-group comparisons for all three groups; P=0.001; Table 3), whereas there was no significant difference in TAS levels between patient groups (between-group comparisons for all three groups with TBI compared to those in the controls (P=0.419) (Table 3). Plasma TOS levels were positively correlated with C-reactive protein (CRP) levels (rho = 0.286; P =0.001), although neither of TAS and prolidase levels and OSI values were significantly related to CRP levels.

Table 1. Distrubution of 100 adult patients classified according to the cause of abdominal pain; STP, MTP and NSAP.

Cause of abdomimal pain	STP group I (n=33) n (%)	MTP group II (n=34) n (%)	NSAP Group III (n=33)
Acute appendicitis	6 (18)	-	-
Acute cholecystitis	6 (18)	-	-
Ileus	5 (15)	-	-
Tuba ovarian abscess	2 (6)	-	-
Ovarian torsion	3 (9)	-	-
Gastrointestinal perforation	6 (18)	-	-
Hydatid cyst rupture	1 (3)	-	-
Acute Mesenteric Ischemia	4 (13)	-	-
Acute gastritis	-	6 (17)	-
Hepatosteatosis	-	2 (6)	-
Peptic ulcus	-	4 (12)	-
Urinary tract infection	-	4 (12)	-
Urolithiasis	-	4 (12)	-

Acute gastroenteritis	-	6 (17)	-
Acute diverticulitis	-	2 (6)	
Pelvic inflammatory disease	-	2 (6)	-
Ulcerative colitis	-	4 (12)	-

Note: Data are presented as percentage (%) or n=numbers of patients.
Abbreviations: STP, surgicaly-treated patients; MTP, medically-treated patients; NSAP; nonspesific abdominal pain

Table 2. Demographic data and plasma measures of 100 adult patients with abdominal pain and 100 healthy controls

Characteristics	Control group n=100	Patients with abdominal pain n=100	P-value
Age (years)	37.67 ± 13.77	39.31 ± 17.66	0.837
Gender (female/male)	53/47	56/44	0.188
TAS (mmol Trolox® equiv./L)	1.05 ± 0.23	1.09 ± 0.21	0.211
TOS (μmol H2O2 equiv./L)	25.73 ± 7.59	34.37 ± 10.76	<0.001
OSI (arbitrary units)	2.54 ± 0.90	3.40 ± 2.43	0.001
Prolidase (IU/L)	839.00 ± 148.07	1002.16 ± 268.15	<0.001

Note: Data are presented as means ± SD=standard deviation or n=numbers of patients.

Inter-group comparisons (controls vs. patients) were analysed by chi-square and Mann–Whitney U tests where appropriate.

Abbreviations: STP, surgicaly-treated patients; MTP, medically-treated patients; NSAP; nonspesific abdominal pain; OSI, oxidative stress index; TAS, total antioxidant status; Trolox®, 6-hydroxy-2,5,7,8-tetramethylchroman-2-carboxylic acid; TOS, total oxidant status

Table 3. Comparisons of plasma measures in 100 adult patients classified according to the cause of abdominal pain; STP, MTP and NSAP.

Characteristics	STP group I n=33	MTP group II n=34	NSAP Group III n=33	P-value
TAS (mmol Trolox® equiv./L)	1.09 ± 0.20	1.07 ± 0.25	1.13 ± 0.15	0.419
TOS (µmol H2O2 equiv./L)	41.05 ± 9.74	34.80 ± 10.49	26.94 ± 6.56	<0.001
OSI (arbitrary units)	3.89 ± 3.99	3.84 ± 1.07	2.41 ± 0.64	0.001
Prolidase (IU/L)	1206.27 ± 242.63	999.80 ± 247.69	871.58 ± 128.74	<0.001

Note: Data are presented as means ± SD=standard deviation or n=numbers of patients.
Intra-group comparisons (MIDAS groups) were analysed by the one-way analysis of variance (ANOVA) test.
Abbreviations: STP, surgicaly-treated patients; MTP, medically-treated patients; NSAP; nonspesific abdominal pain; OSI, oxidative stress index; TAS, total antioxidant status; Trolox®, 6-hydroxy-2,5,7,8-tetramethylchroman-2-carboxylic acid; TOS, total oxidant status

Discussion

The present study is the first in vivo clinical trial to simultaneously investigate prolidase enzyme activity and TOS, TAS and OSI in adult patients with varying causes of abdominal pain presented to the ED. In addition, a novel automated measurement method, which has developed by Erel (16,17), was used to assess oxidative and antioxidative status in human plasma.
The present study demonstrated significant changes in prolidase enzyme activity, TOS, levels, and OSI values in patients with abdominal pain compared to the control group. The key findings of the present study are that plasma prolidase enzyme activity, TOS levels, and OSI values as an oxidative stress parameters were significantly higher in the patient group than the control group.
Recent clinical data implicate that increased oxidative stress and decreased antioxidant defenses occur in patients with acute appendicitis (5,6). The role of oxidative stress–induced acute inflammatory responses in pediatric and adult patients with abdominal pain arising from acute appendicitis has been reported in several clinical studies (6,7,18,19). For example, Yılmaz et al. (6) reported significantly high plasma levels of thiobarbituric acid reactive substances (TBARS), an indicator of free radical–

induced oxidative stress, in patients diagnosed with acute appendicitis compared to controls. Also, they observed significantly low plasma thiol groups (SH); which are predictors of antioxidant capacity in patients than controls. In a case control study, conducted by Ozdogan et al. (5) showed that plasma levels of TAS correlates inversely with the extent of acute appendicitis. Consistent with these findings, the present study found that TOS and OSI levels were significantly elevated in patients with varying causes of abdominal pain compared to healthy controls. By contrast, patients with abdominal pain were found to have slightly increased TAS levels than healthy controls, but it was not significant. Taken together, these findings suggest that decreases in the efficacy of the antioxidant response may reflect a severely disturbed oxidant/antioxidant balance in patients with varying causes of abdominal pain, leading to increased oxidative stress. As known, polimorphonuclear leucocysts and macrophages use free oxygen radicals for clearing away the bacterias and cleaning the necrotising tissue (20). In the present study, the levels of TOS as a marker of oxidative stress was positively correlated with CRP levels which is known as a marker of the reactant plasma protein component of the inflammatory response.

Collagen, which constitutes connective tissue structures, plays a critical role in inflammation and wound healing (21). It is believed that prolidase enzyme activity is of great importance during collagen turnover, inflammation, tissue fibrosis and skeletal abnormalities. Prolidase alone without other biochemical markers may not provide data to clinicians regarding disease activity (4). Prolidase enzyme activity changes and oxidative stress parameters have been associated with the development of several diseases in various clinical studies (22-25). For example, Duygu et al. (23) reported significantly high plasma levels of prolidase enzyme and the oxidative stress parameters and low antioxidant levels in patients chronic hepatitis C. Hilali et al. (24) showed that serum prolidase enzyme activity, TOS levels and OSI values were significantly higher in patients with polycystic ovarysyndrome than controls.

Consistent with those findings, the present study found that the mean level of plasma prolidase enzyme activity, TOS levels and OSI values were significantly elevated in patients with abdominal pain compared to healthy controls. Thus, the increase of prolidase activity might be attributable to increased oxidative stress along with ineffective antioxidant defence in patients with varying cause of abdominal pain.

The present study also showed that the highest levels of plasma prolidase enzyme activity, TOS and OSI values increased in proportion to the cause of abdominal pain, such that the STP group, which was composed of patients with the surgically treated, exhibited the highest levels.

In conclusion, these preliminary data indicate that adult patients in the study sample were exposed to potent oxidative stress and that the markers reflected oxidative stress; plasma TOS and OSI levels had prognostic value in patients with varying causes of abdominal pain. Thus, increased plasma prolidase enzyme activity, TOS, and OSI values are more likely reflecting the burden of an unfavorable oxidant/antioxidant balance in patients with non-traumatic abdominal pain. For making a rapid and accurate clinical decision, plasma prolidase enzyme activity, TOS levels, and OSI values, as the biomarkers of oxidative stress might be useful in determining separation of patients with NSAP and those with surgical abdominal pain that requires emergent surgical treatment.

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TAM METİN 4

CONTRAST INDUCED NEPHROPATHY AND ALLERGIC REACTION IN PATIENTS WHO WERE GIVEN INTRAVENOZ CONTRAST MATERIAL IN EMERGENCY DEPARTMENT

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Introduction

In recent years, contrast materials (CM) are widely used in the patients to whom imaging methods are applied for diagnosis and treatment, as a consequence of the increase observed in the utilization of computed tomography (CT) (1). Short term and long term side effects and even death are seen depending on the utilization of iodinated CM. Contrast Induced Nephropathy (CIN) is the most significant side effect of those media (2). Acute allergic reactions are the complications which are known to develop after the utilization of IV CM, and they may cause mild symptoms such as urticaria and itching, or they may result in severe outcomes such as cardiopulmonary arrest and death (3).

After the exposure to CM, an increase of 25% in serum creatinine level in 72 hours according to basal serum creatinine level or precise increase of 0.5 mg/dL or more in serum creatinine is defined as CIN (4). The risk for the development of reaction against CM is higher in the patients having congestive heart failure (CHF) and dehydration, and using nephrotoxic drugs. The patients who have previously suffered from asthma, allergy, hyperthyroidism, or reaction against CM are exposed to the risk of severe reactions related to the utilization of iodinated CM (5). CIN may cause prolongation in the duration of hospital stay, increase in the hospital costs, increase in disability and death rates, or even irremediable end-stage renal failure (6).

In this study, we aimed to research the development of CIN and allergic reactions, the frequency of these diseases, their risk factors, prognosis, mortality and morbidity rates, the interventions made for the prevention of CIN development, and the treatments of allergic reactions.

Material and methods

1463 patients at the age of 16 or older who admitted to the ED between the years of 01 January 2012 to 31 December 2012 and who were given IV contrast medium during CT imaging (iopromide, Ultravist™; 370 - 100 mL flakon Bayer Schering Pharma), were included to the study. The patients who were not hospitalized in any department or who were monitored for less than 48 hours in the emergency department after they were given IVCM (discharge, transfer, voluntary departure),

suffering from chronic kidney disease (CKD) which necessitates dialysis, whose; files cannot be obtained from hospital information system (HIS), creatinine values were not measured at least in two controls in 24th, 48th or 72nd hour before or after CM supply, file information is not complete in HIS and who died in 48 hours after giving contrast material were excluded from the study.

An increase of 25% in serum creatinine level in 72 hours according to basal serum creatinine level or precise increase of 0.5 mg/dL or more in serum creatinine was accepted as CIN in our study (4).

The presence of following criteria was accepted for anaphylaxis (7).

RS: Rhinitis, pharyngeal edema, larynx edema, cough, bronchospasm, dyspnea

CVS: Arrhythmias, collapse, cardiac arrest

Skin: Itching, urticaria, angioedema, rash

GIS: Nausea, vomiting, cramp, diarrhea

Eye: Itching, lacrimation, watering eyes, redness

GUS: Urgent need to urinate, cramps

(RS: Respiratory System, CVS: Cardiovascular System, GIS: Gastrointestinal System,

GUS: Genitourinary System)

GFR (Glomerular Filtration Rate) was calculated in accordance with “Modification of Diet in Renal Disease” equity. The level of failure in renal functions was determined according to RIFLE criteria in consequence of the evaluation of the difference between basal GFRs and the lowest GFRs.

Demographic, clinical and laboratory data of those patients, their clinical conducts and the prophylactic treatments applied to the patients in ED or in the department in which they were hospitalized were scanned in HIS and registered by the researchers.

Statistical analyses

Statistical analyses of the data were carried out with an accuracy rate of 95% in SPSS version 15.0 for Windows. Chi-Square and Fisher’s Exact test were used in categorical data for the comparison of the groups, and statistical analyses of independent sample t test were utilized in continuous data. $P < 0,05$ was accepted as statistically significant value.

Results

CT imaging accompanied with IVCM was applied to 1463 patients in a year. Out of 394 cases included in our study, 159 patients (40.4%) were female while 235 patients (59.6%) were male. Average age of the cases was calculated to be 55,20±19,20. No statistically significant difference was found between female and male patients in terms of CIN development ($p>0,05$). Statistically significant difference was determined between the age groups and the presence of CIN ($p<0,05$). It was seen that the rates of CIN presence increased in parallel with aging. Average age of the cases in which CIN developed was found to be 66,86 ± 16,43 while this average was calculated as 53,99 ± 19,09 in the cases in which CIN did not develop. The average age of CIN-developing cases was recorded to be higher than the

average age of the cases in which CIN development was not seen, which was statistically significant ($p < 0,05$). (Table 1)

When the distribution of CIN development rates were analyzed in the patients with eGFR < 60 ml/min/1.73 m^2 and in the patients with eGFR ≥ 60 ml/min/1.73 m^2 according to 0 hour GFR classification before CM, statistically significant difference was recorded ($p<0,05$). Statistically higher rate of CIN was found in the patients with eGFH < 60 ml/min/1.73 m^2.

It was seen that CIN developed in 37 cases (9.39%) out of 394 cases included in the study. It was observed that the creatinine level of 22 patients (59.4%) suffering from CIN returned to the normal limits, that low clearance developed without the need for hemodialysis in 2 cases (5.4%), and that 13 patients (35.1%) died subsequent to CIN development.

When prophylactic implementations were analyzed after CM application in the ED, statistically significant difference was determined in CIN development rates between the groups according to the distribution of hydration supply rates ($p < 0,05$). Statistically significant difference was not recorded between the groups in terms of N-Acetyl Cysteine (NAC) ($p>0,05$).

It was observed that allergic reactions developed in 13 patients (0.88%) out of 1463 patients to whom IVCM was given. It was determined that 10 of the cases developing allergic reactions were female (76.9%), and 3 of them were male (23.1%).

Within the scope of allergic reactions seen in the patients after IVCM implementation, some reactions developed concomitantly; skin disorders were detected in 12 patients (92.3%), respiratory system (RS) disorders were found in 2 patients (15.4%), and gastrointestinal system (GIS) disorders were observed in 2 patients (15.4%) while cardiovascular system (CVS) disorders were not found in any case.

When the distribution of the treatments administered to the patients developing allergic reactions after IVCM implementation was analyzed, it was found that certain treatments were administered concomitantly, 2 of the patients (15.4%) were in need of O_2 treatment, only fluid therapy was administered to 1 of the patients (7.7%), 12 of other patients (92.3%) received H_1 receptor antagonist treatment, 11 of the patients (84.6%) received H_2 receptor antagonist treatment, steroid therapy was administered to 3 patients (23.1%), and 11 patients (84.6%) were treated with fluid therapy. It was also determined that none of our patients were in need of epinephrine after CM implementation.

Discussion

CIN is a common problem mostly encountered in clinical practices. As a result of the increase observed in the utilization of CMs for diagnosis and treatments in the last 30 years, CIN has become the third most common cause of acute renal failure developing in hospital (8).

CIN rates after contrast-enhanced CT have been found to be between 5% and 13% in the retrospective studies carried out (9). Various studies have shown that CIN frequency varies between 3.1% and 31% (6). CIN frequency may reach 50% in the patients in whom numerous risk factors are seen together

(10). Mitchell et al. reported CIN frequency as 11% in their study in which they analyzed CIN development related to contrast-enhanced CT imaging in out-patients admitted to ED (9). We found CIN frequency as 9.39% in our study. The rates that we obtained by means of our research were similar to the rates recorded in other studies included in the literature.

In the studies carried out, female gender was reported to be a risk factor for CIN development (10). It was determined that high CIN frequency in females were related to advanced age, defects in basal renal functions, and higher prevalence of certain negative findings such as HT and DM in females (11). In our study, on the other hand, statistically significant difference was not found between male and female genders in the cases developing CIN. CIN prevalence increases in parallel with aging. Nevertheless, there is no exact age limit for the increase of CIN risk. An increase of risk was mentioned in the literature for the patients at the age of 60-75. The group over the age of 75 was accepted as a risk factor in numerous scoring systems (10, 12). In our study, it was seen that 70.2% of the cases developing CIN consisted of the patients at or over the age of 60, and it was detected that CIN development increased at statistically significant rate in the patients over the age of 60.

CKD is the most important risk factor for CIN (4). GFR < 60 ml/min increases the risk (13). In this study, CIN development rate decreased as GFR increased, which was compatible with the literature. It was detected that CIN developed at statistically higher rate in the patients with eGFR < 60 ml/min /1.73 m^2. Although basal GFR is found to be favorable, the patients should also be evaluated in terms of other risk factors by taking possible CIN development into account.

The need for dialysis after CIN varies in accordance with the risk factors existing in the patient when the contrast was administered; however, the percentage of this need is generally less than 1% (14). In the study of Nikolsky et al., 3.1% of the patients were in need of dialysis (15). According to another study, urgent need for dialysis was observed in 14% of the patients after CIN development, and 2% of those patients needed hemodialysis in the long run (12). It was reported in the study of Gruberg et al. that the patients were in need of dialysis at the rate of 35% (16). It was determined in our study that CKD developed without any need for hemodialysis in 5.4% of the patients developing CIN and that 5.4% of the patients were dialyzed. It was detected that no patient developing CIN was in need of permanent hemodialysis.

It has been mentioned in the studies that CIN is associated with prolonged duration of hospitalization (4, 17). We determined in our study that the duration of the hospitalization prolonged in the cases developing CIN two times more than the cases not developing CIN, which is similar to other studies.

In the analysis performed by Freeman et al. on 16592 patients, the prevalence of kidney failure necessitating the use of dialysis subsequent to percutaneous coronary procedure was reported to be 0.44%, in 39% of which in-hospital deaths were observed (18). Mortality rate within 30 days was calculated as 16.2% in the patients developing CIN and 1.2% in the cases not developing CIN in the study carried out by Sadeghi et al. on 2082 patients to whom percutaneous coronary procedure was

administered (19). We determined the mortality rate as 35.1% in the cases developing CIN, and 3.4% in the cases not developing CIN in our study. In the research performed by Levy et al., it was reported that only two patients died due to incurable kidney failure subsequent to CIN development, and that other 58 patients died because of the conditions not related to kidney failure such as sepsis, respiratory failure, changes in the state of consciousness and bleeding (17). We determined the mortality rate related to CIN as 2.7% in our study.

In our study, allergic reactions were observed in 13 patients out of 1463 patients after contrast medium were administered in ED. In the study carried out by Cochran et al. in which the rates of allergic reactions were compared after ionic or non-ionic CM implementation, the rate of allergic reactions against ionic CM was calculated to be 6-8% while the rate of allergic reactions against non-ionic CM was found to be 0.2% (20). The rate of allergic reactions after non-ionic CM implementation was determined as 0.6% in the study performed by Wang et al. (21). In our study, it was observed that allergic reactions were developed in 0.88% of 1463 patients after non-ionic CM implementation, which is similar to other studies.

It was reported in a study carried out by Jung et al. that allergic reactions were observed in 62 patients, no treatment was needed in 7 patients, only 1 patient was in need of O_2 therapy, hydration was administered to 10 patients, 1 patient received hydration together with O_2 therapy, H_1 receptor antagonists were injected to 16 patients, 2 patients were given oral antihistaminic, 23 patients received steroid therapy with H_1 receptor antagonists or only steroid therapy, and 2 patients were in need of epinephrine (25). In our study, all patients received treatments, most of which were generally combined treatments. It was recorded that 1 patient received only fluid therapy, and that combined therapies were administered to other patients; accordingly 2 patients were in need of O_2 therapy; 12 patients received the treatment of H_1 receptor antagonists; H_2 receptor antagonists were given to 11 patients; 3 patients received steroid therapy, and 11 patients were treated with fluid therapy. It was observed that none of our patients was in need of epinephrine after CM implementation.

The side effects developing against CM were classified as skin findings, RS symptoms, CVS symptoms, and GIS symptoms in the study performed by Christiansen et al. (23). Skin findings are known to be the most common side effect of CM reactions. It was reported in the study of Mortele et al. that urticarial symptoms were observed in 286 cases out of 545 hypersensitivity reactions observed after CM implementation, itching was seen in 131 cases, 114 patients suffered from rashes, and 7 cases had severe course (24). In our study, on the other hand, numerous allergic reaction symptoms were concomitantly seen in certain cases; skin findings (itching, urticarial, angioedema, rush) were found in 12 patients (92.3%); RS findings were detected in 2 patients (15.4%), and GIS findings were observed in 2 patients (15.4%); no case demonstrated CVS findings. None of the cases resulted in clinical death after the clinical follow-up of the patients.

Conclusion

CIN risk factors should be taken into account in every procedure in which CM is administered to the patient, and necessary preventive procedures should be taken for the patients who are under risk. It should be remembered that CM implementation may trigger allergic reactions it may cause life-threatening situations such as anaphylaxis, these situations prolong the duration of hospitalization and the treatment period, and that they may result in additional costs.

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