OPEN BOOK PELVİS YARALANMASI; OLGU SUNUMU

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ÖZET

Acil servise pelvik travması ile gelen hastanın hemodinamik olarak stabilitesi belirlenmeli, mortalite ve morbilidite açısından risk oluşturacak yaralanmalar uygun ve hızlı bir şekilde değerlendirilmelidir. Ciddi pelvis yaralanmaları multidisipliner yaklaşım gerektirir ve genellikle multisistem travmaları ile birlikte görülür. Şiddetli pelvik travmalarında hemoraji en önemli ölüm nedenidir. Risk altında hastalar acil hekimi tarafından hızlıca tanımlanmalı ve vakit kaybetmeden ilk müdahaleye başlanıp ilgili branşlarca ileri tetkik ve tedavi başlanmalıdır.

Anahtar Kelimeler: Pelvik travması, hemoraji, Open book pelvik kırıkları

ABSTRACT

The hemodynamic stability of the patient who comes to the emergency department with pelvic trauma should be determined, and injuries that may pose a risk in terms of mortality and morbidity should be evaluated appropriately and quickly. Serious pelvic injuries require a multidisciplinary approach and are often seen with multisystem traumas. Hemorrhage is the most important cause of death in severe pelvic trauma. Patients at risk should be identified quickly by the emergency physician, and the first intervention should be started without wasting time, and further examination and treatment should be started by the relevant branches.

Keywords: *Pelvic trauma, hemorrhage, Open book pelvic fractures*

GİRİŞ

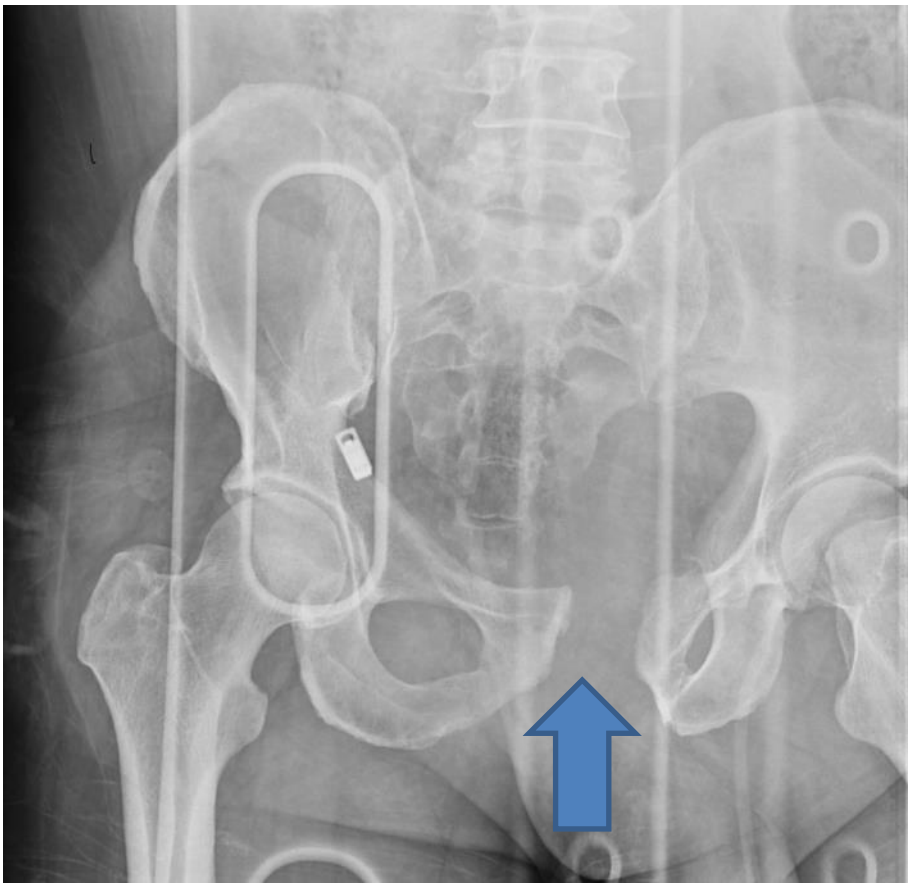
Pelvis ilium, ischium, pubis, sakrum ve koksiks'in birleşmesi ile oluşur. Vücut ağırlığının taşınmasını sağlayan kas ve önemli vasküler yapıları için koruma görevi görür. Pelvis gövde ve alt ekstemite arasında vasküler, nörolojik yapılar için hayati önem taşımaktadır. Şiddetli pelvik travmalarında hemoraji en önemli ölüm nedenidir (1). Gastrointestinal ve genitoüriner organ pelvis kemiği içerisinde korunur. Bu nedenle pelvisin en önemli görevleri koruma, destekleme ve kan dolaşım sistemidir (2).

Yüksek enerjili pelvis yaralanmalarının %25'ini Open book pelvik kırıkları oluşturur. Genellikle multisistem travma ile birlikte görülür. Open book pelvik kırıkları ya da açık kitap kırığı aynı zamanda anterior-posterior kompresyon kırığı olarak da adlandırılır. Pelvisi ön-arka yönde şiddetli kuvvet sonrası gerçekler. Şiddetli kuvvete maruziyet sonrası simfizis pubis genişler, aynı bir kitap gibi açılır. Bu açılma ya da genişleme ile birlikte sakral bağlar ve sakroiliak bağlar dahil tüm destekleyici bağ, kas ve vasküler grupları bozulabilir. Bununla birlikte hastanın hemorojik riski artar (3).

Bu vakada künt travma sonrası simfizis pubiste genişleme ve psoas kas etrafına kanaması olan bir hastanın durumu ele alınmıştır.

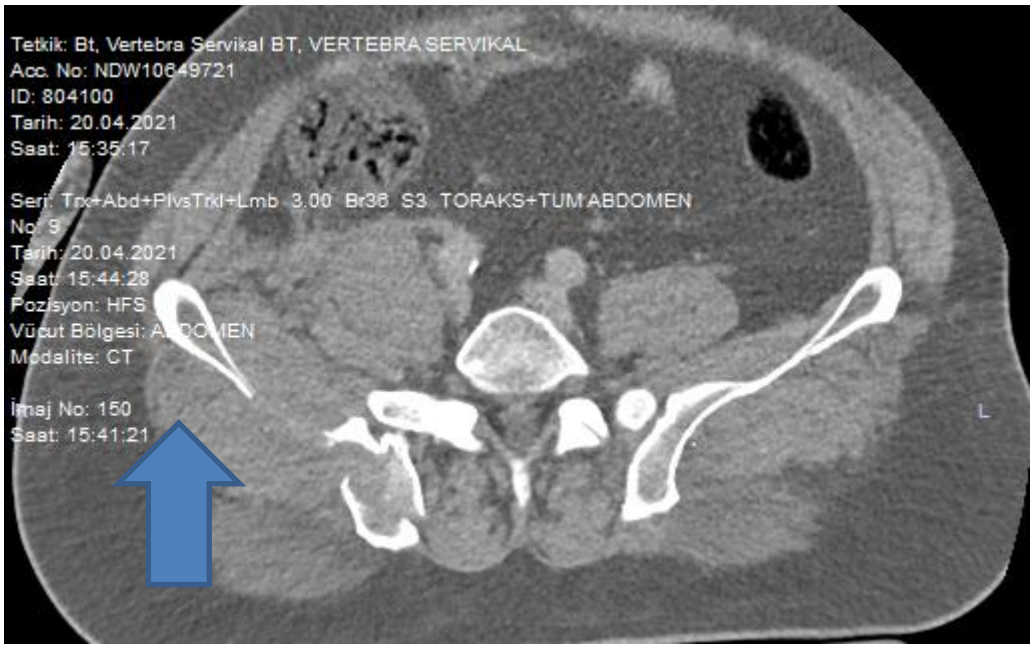
VAKA TAKDİMİ

60 yaşındaki erkek hasta künt travma sonrası acil servise getirildi. Hastanın bilinci açık, oryante ve koopere idi. Hastanın vitallerinde tansiyon 110/70 mmHg, nabız 110/dk, hava odasında oksijen satürasyonu 98 ve ateş 36.7°C olarak ölçüldü. Fizik muayenesinde sağ lumber flank alanda dermaabrazyonu ve ele gelen hematomu vardı. Ayrıca sağ iliak alanda daha fazla olmak üzere pelviste şiddetli ağrısı mevcuttu. Hastanın pelvis alanında ciddi ağrı ve taşikardik olması nedeniyle, pelvik volümü azaltma amacıyla çarşaf bağlama ile pelvis sabitlendi. İlk olarak acil servisin içinde yer alan röntgen odasında hızlıca pelvik grafiler elde edildi. Simfizis pubisdeki ciddi genişleme ve sağ iliak kanatta parçalı deprese fraktür mevcuttu. Açık kitap kırığı olarak da bilinen bu yaralanmanın tanısı konduğunda ortopedi hekimine konsülte edildi.



Şekil 1. Simfizis Pubis'deki genişleme (Open Book pelvis fraktürü)

Yüksek enerjili künt travmada oluşabilecek intraabdominal hasarı görmek için hastanın tüm batın tomografileri istendi. Hastanın mevcut haliyle solid organ hasarı izlenemedi. Fakat sağ iliopsoasta kalınlaşma ve dansite artımı izlendi. Ayrıca S1 vertebra düzeyinde kortikal düzensizlik izlendi. Bu durum yüksek enerji sonrası posterior S1 ligamentlerin hasarını akla getirdi. Ayrıca bu görüntüler sonrasında hastamızda akut hemoraji olduğunu karar verildi. Hastamız acil ameliyata alındı.



Şekil 1. Sağ iliak kanat fraktürü ve sağ iliopsoas'da kalınlaşma (hemoraji)

SONUÇ-TARTIŞMA

Bilindiği üzere major pelvik yaralanmalarda hemoraji en önemli ölüm nedenidir. Pelvik kırıklarına bağlı kanamalar presakral ve lumbar pleksuslarından, iliak veya femoral arterlerden veya direkt kırık alanından kaynaklanabilir (4). Risk altındaki hastalar hızlı bir şekilde tanımlanmalıdır.

Anterior superior iliak spinaya önden gelen kuvvetler sonucu açık kitap kırığı olarak da bilinene pelvis kırıkları oluşabilir. Bu yaralanma yüksek enerjili künt pelvis travmalardan sonra meydana gelir. Bu tür yaralanmalar farklı mekanizmalarla da oluşabilir. En sık görünen nedeni pelvik halkayı öne doğru bozan bir ön-arka sıkıştırma kuvvetidir (5).

Unutulmamalıdır ki, travmatik pelvik fraktürlerinde nörolojik hasar, genitoüriner ve gastointestinal yaralanmalar eşlik edebilir (6). Hızlı yapılan ilk müdahaleler hastayı ileride yaşayacağı komplikasyonlardan koruyabilir. Ayrıca acil servis hekimi radyolojik tetkiklerde gördüğü bulguları iyi analiz edebilmesi hasta için hayat kurtarıcıdır.

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A CASE OF PNEUMOMEDIASTINUM AFTER HITTING A BALL WITH THE CHEST

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INTRODUCTION

Chest pain is one of the most common and complicated complaints amongst emergency service admissions. It is a symptom rather than a diagnosis. Many medical conditions can cause chest pain, and the true underlying cause must be elucidated before it can be adequately treated.

Among all the trauma cases, thoracic trauma is the third most common after head-neck and extremity trauma. Blunt trauma constitutes 10% of thoracic traumas. Rib fractures, pneumothorax, hemothorax, pneumomediastinum, lung contusion are some clinical conditiıons that can arise after the trauma of the thorax.

Pneumomediastinum is defined as the presence of air in the mediastinum and it can occur spontaneously, iatrogenic or due to trauma.

A case of pneumothorax with accompanying pneumomediastinum developed after blunt thorax trauma who had the complaint of chest pain is being presented in this case report.

CASE

A 27-year-old male was admitted to the Emergency Room with complaints of chest pain and shortness of breath. His mean arterial pressure was 120/70 mmHg, his SpO_2 was 97% and his temperature was 36.7 ^{o}C. He was oriented and cooperative. Decreased lung sounds were heard on the left hemithorax with auscultation. The patient's medical history was unremarkable except for the history of smoking a pack of cigarettes a day for the last 3 years. His ECG recording was in normal sinüs rhythm. It was learned from the anamnesis of the patient that a ball hit his chest during a football match one week before the admission and that he had chest pain and respiratory distress that gradually increased since then.

Computed Tomography image of the thorax had an appearance compatible with pneumothorax in the left lung as well as diffuse images of air at the anterior mediastinum. (Figure1)

Tube thoracostomy was applied under emergency conditions and was admitted to the Department of Thoracic Surgery for follow-up and treatment. After 7 days of service follow-up, the patient whose thorax tube was removed was discharged with full recovery.

CONCLUSION

Traumatic pneumothorax and pneumomediastinum should be kept in mind in patients admitted to the emergency department with the complaint of chest pain who also has a history of minor chest trauma.

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Figure 1: Pneumothorax in the left lung, pneumomediastinum in the anterior mediastinum, subcutaneous emphysema on thorax CT

A CASE OF SPLENIC INFARCTION

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INTRODUCTION

Splenic infarct is a rare pathology of the spleen which is most commonly observed as a complication of another disease.[1,2] More than one-third of splenic infarct cases are those with atrial fibrillation and atrial thrombus.[1] There are also hematologic, vascular, anatomical and other causes[1], which are present in the medical literature as case reports. [2]

A case of splenic infarct which is diagnosed after admission to the emergency room with symptoms mimicking renal colic and exacerbation of peptic ulcer is being presented in this case report.

CASE PRESENTATION

A 59-year-old male patient with unremarkable medical history was admitted to our Emergency Room (ER) with the complaint of pain in the epigastric area and left flank. He has recurrent ER admissions in the last ten days with the same complaints. During the physical examination, he was conscious, cooperative and oriented, his arterial pressure was 90/60 mmHg, heart rate was 110 beats per minute and he had moderate general condition. During the auscultation, there were no pathological breathing sounds at the lung, there was no murmur or pathological sound heard at the heart while S1 and S2 were present. There was pain with palpation on the abdomen especially on the upper left quadrant and epigastric areas. He had costovertebral angle tenderness on his left. Sinus tachycardia was present on the ECG. Renal colic and acute exacerbation of peptic ulcer were the early diagnoses. There was no alleviation of symptoms after symptomatic therapy. Blood analysis is as following: CRP; 247, WBC; 22000, Neutrophil; 19300, D-Dimer; 480 together with unremarkable urinalysis. There was no pathology detected on bedside ultrasound. In the IV contrast-enhanced Abdominal Tomography of the patient; there was an approximately 42x41x35 mm sized hypodense area in the upper pole of the spleen which was non-enhancing, peripheral wedge-shaped and significant in terms of infarction. (Figure 1).

The patient, who was hospitalized in the General Surgery Department with the diagnosis of splenic infarct, was taken to the emergency operation. The patient, who underwent total splenectomy, was discharged with recommendations after 4 days of service follow-up.

DISCUSSION AND CONCLUSION

The presence of well-circumscribed, non-enhancing, hypodense area on IV contrast-enhanced abdominal tomography is diagnostic at a rate of 75% for splenic infarct. [1,2,3,4] Splenic infarct is a rare,

silent clinical condition that is difficult to diagnose and can be confused with other diagnoses unless there is clinical suspicion. It is most commonly caused by thromboembolism or other hematologic diseases.

In our case, the clinical presentation was resembling renal colic and acute exacerbation of peptic ulcer in a way to mislead the physician. However, the patient's complaints did not get any better despite the treatment and his general condition was not good, which warned the clinician to review the pre-diagnosis and led to further examination. The patient was diagnosed with splenic infarct after IV contrast-enhanced abdominal tomography, which is in accordance with the literature. While conservative treatment is sufficient in the early period, surgical intervention may be required in complicated cases such as ours.

Key-Words: splenic ischemia, epigastric pain, flank pain, infarct

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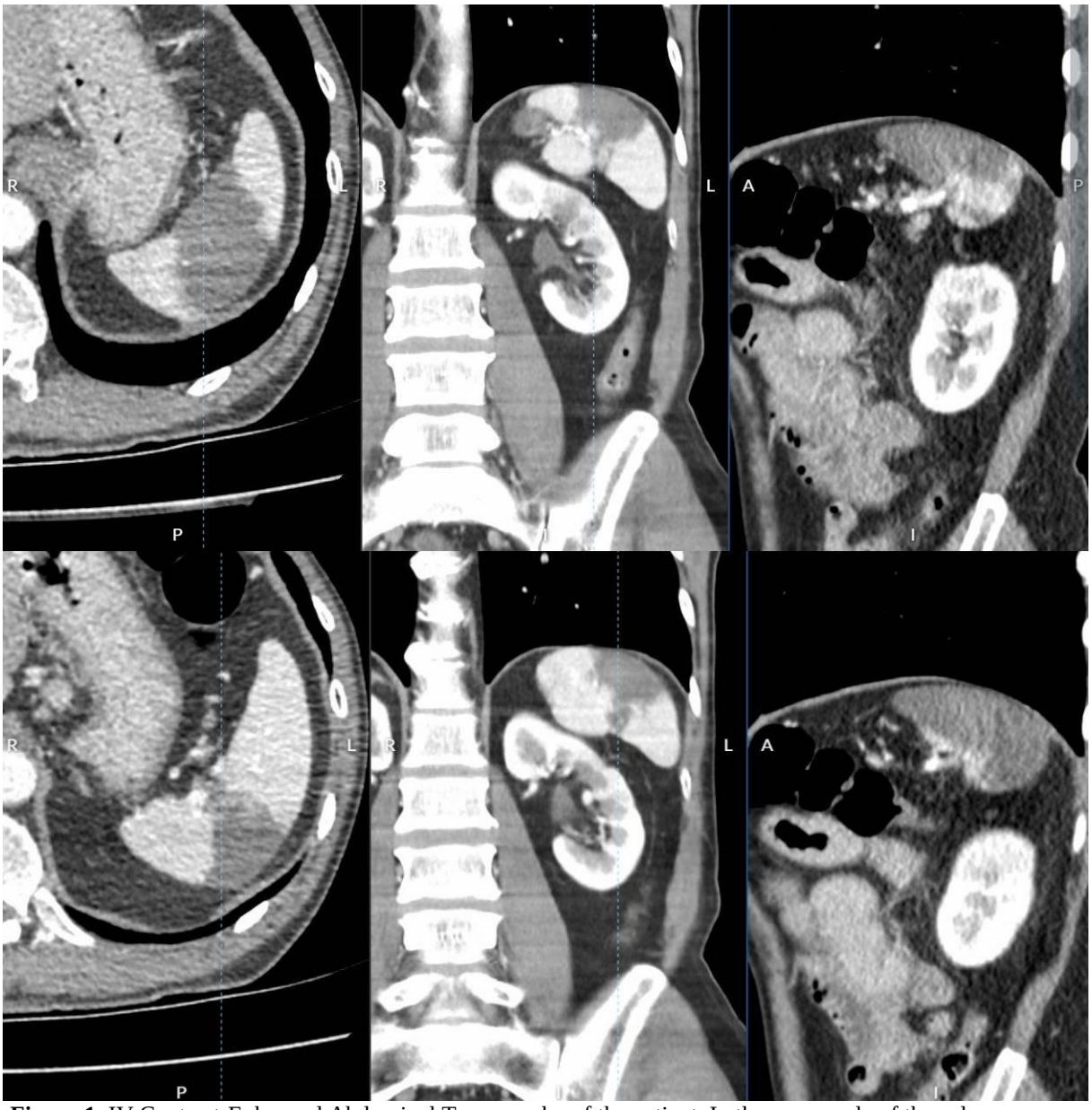

Figure 1. IV Contrast-Enhanced Abdominal Tomography of the patient. In the upper pole of the spleen, an approximately 42x41x35 mm sized non-enhancing hypodense area wedge-fit to the periphery which is significant in terms of infarction.

FATAL COMPLICATION OF FRONTAL SINUSITIS; POTT'S PUFFY TUMOR

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Keyword: Frontal Sinusitis, Complication, Pott's Puffy Tumor, Functional Endoscopic Sinus Surgery

INTRODUCTION

Pott's Puffy Tumor (PPT) is a rare clinical entity characterized by subperiosteal abscess accompanied by osteomyelitis due to frontal sinusitis. This condition is usually not diagnosed at the beginning and can easily be mistaken for neoplasms, skin and soft tissue infections. This condition is usually observed in adolescents and is therefore considered rare in adults**(1).** Due to the widespread use of antibiotics, it is rarely seen in developed societies**(2)**. In this case report, a 19-year-old male patient who was admitted to the emergency service with a complaint of swelling and headache on his forehead for the past month and was diagnosed with PPT due to complicated frontal sinusitis is described.

CASE REPORT

A 19-year-old male patient was admitted to the emergency service of the Kanuni Sultan Süleyman Training and Research Hospital with headache, swelling of the forehead and fever. Since the patient did not speak Turkish, anamnesis was taken by an interpreter. The patient had a recurrent headache for 4 months. Purulent nasal discharge has been added to this for the last 2 months. For the last month, swelling has developed on his forehead and there was a slight discharge from the swelling on the left. Sick Syrian refugee. He lived in unhealthy environments for about 1 year. She applied to the emergency department 2 months ago with headache and was treated for sinusitis. He could not take his medication for economic reasons. The patient has no known history of head injury or surgery. The patient applied to the emergency department with the increase in headache and fever.

In the physical examination of the patient, he was conscious, oriented and cooperative. Neurological examination of the patient was normal. The patient had an area of 3.5x3.5cm in the midline of the forehead and a 3x3cm area of soft consistency at the right eyebrow level. The lesion on the left eyebrow was more raised than the skin and there was crusting in the middle part **(Figure 1).**

There was WBC and CRP elevation in the laboratory tests of the patient. Sinusitis was detected in the left maxillary sinus and frontal sinus in the Brain Computed Tomography (BCT) of the patient. An abscess formation, which eroded the anterior wall of the frontal sinus, causing swelling in the forehead, also eroding the posterior wall of the frontal sinus and opening to the brain was detected (**Figure 2-3**).

After the first treatment of the patient, a consultation was made with a Neurosurgeon and an Otolaryngologist. The patient examination and treatment for the purpose of the Republic of Turkey Ministry of Health Istanbul Provincial Health Directorate was referred to the Istanbul Bağcılar Training and Research Hospital. Abscess drainage was performed with Functional Endoscopic Sinus Surgery (FESS) by the Otolaryngology deparment**.** Consulted with Neurosurgery. Neurosurgery did not consider additional surgery because the dura mater was intact. Antibiotic treatment was given to the patient (amoxicillin + clavulanic acid). The patient was called for control 3 months later. It was observed that the abscess did not recur.

DISCUSSION

PPT is a frontal osteomyelitis that accompanies the subperiosteal abscess in the frontal bone, and this "swollen" lesion occurs when the inflation erodes the outer border of the frontal bone. While osteomyelitis secondary to sinusitis often develops in the maxilla in the first years of life, it often develops in the frontal bone in older children and adolescents. It is a rare complication in the adult age group. A systematic review of literature in 2020 reported 128 cases of PPT identified in adults **(3)**.

Life-threatening complications can be seen in the event of delay in the diagnosis of PPT or inadequate antibiotic and surgical treatments. Among these complications, periorbital cellulitis, subperiosteal abscess and fistulization to the skin occur when the infection progresses towards the outer wall of the frontal bone. Skin fistulas, on the other hand, develop from the frontal region or the orbital region because the anterior wall and base of the frontal sinus are not resistant to infections. If the infection erodes the posterior wall of the frontal sinus, it can cause epidural, subdural or intracranial abscesses, meningitis, empyema, and cerebritis. If the infection is carried back with diploic veins, septic thrombophlebitis may develop and as a result sagittal sinus vein thrombosis can be seen **(4)**.

In our patient, PPT secondary to frontal sinusitis was detected. In our patient, the frontal sinus posterior wall was eroded and the abscess was opened into the intracrenal space. In the early diagnosis of this clinical condition, it is very important to choose the radiological imaging methods correctly and to perform them on time. Computed Tomography is the most preferred imaging method because of its good visualization of bone tissue and lesions. Computed tomography was preferred as the imaging method in our patient who presented with the complaint of swelling in the frontal region after sinusitis, and radiological images consistent with clinical suspicion were observed. Abscess drainage was done with FESS, an up-to-date technique performed by the Otolaryngology department **(5).**

CONCLUSION

In conclusion, Pott’s puffy tumor is a sign of a potentially life-threatening infection of the frontal sinus, which may be accompanied by intracranial invasion. PPT should be kept in mind in the differential diagnosis of patients with poor socio-cultural level who present with swelling in the forehead.

Early diagnosis, appropriate antibiotic treatment and surgical abscess drainage applied in the early period in addition to these treatments are life-saving in PTT.

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Figure 1. A mass-looking lesion on the patient's forehead with a puffy, soft consistency from the skin.

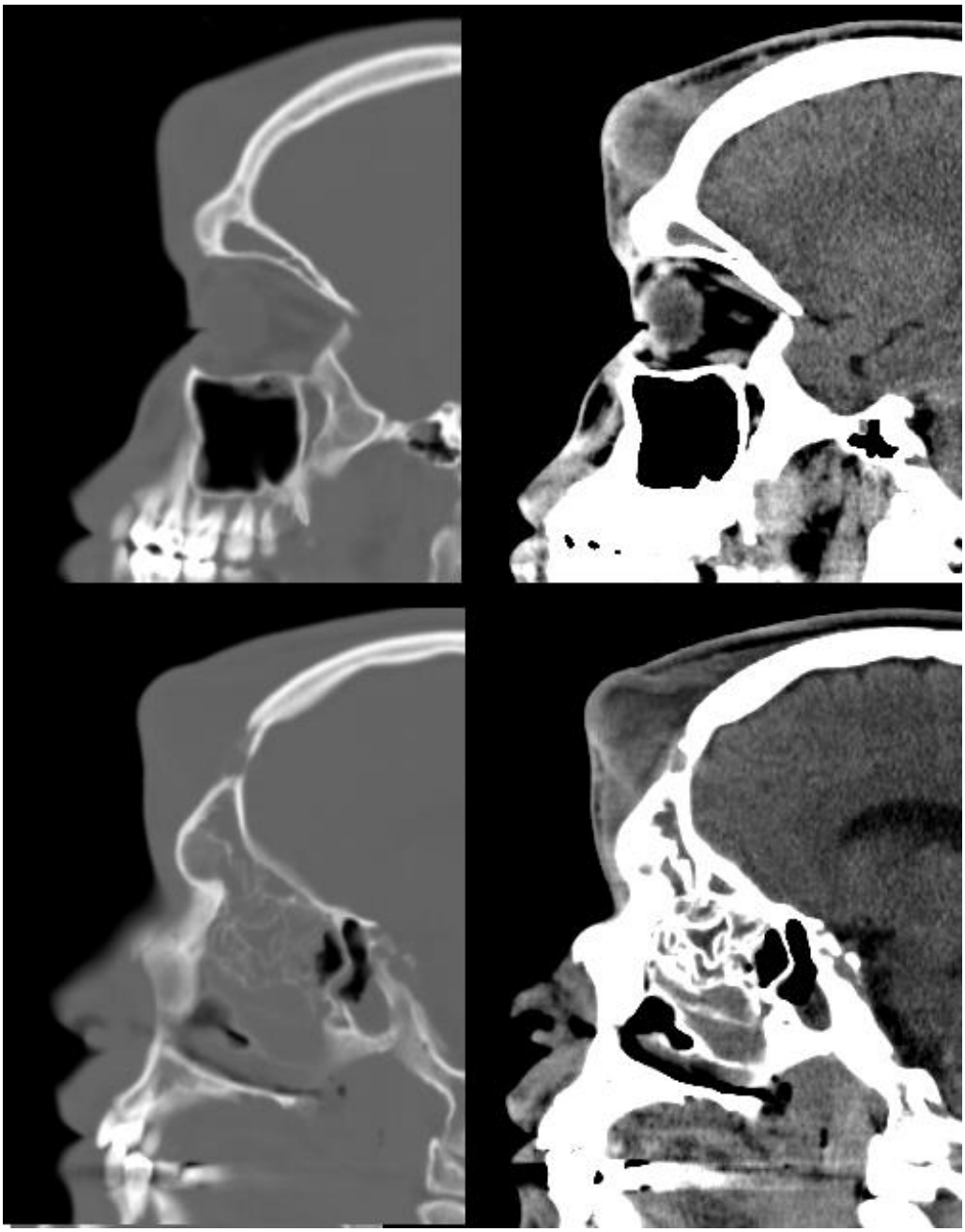

Figure 2. Cranial CT, Sagittal sections, bone and brain window. The appearance of an abscess forming a mass effect on the forehead and under the skin.

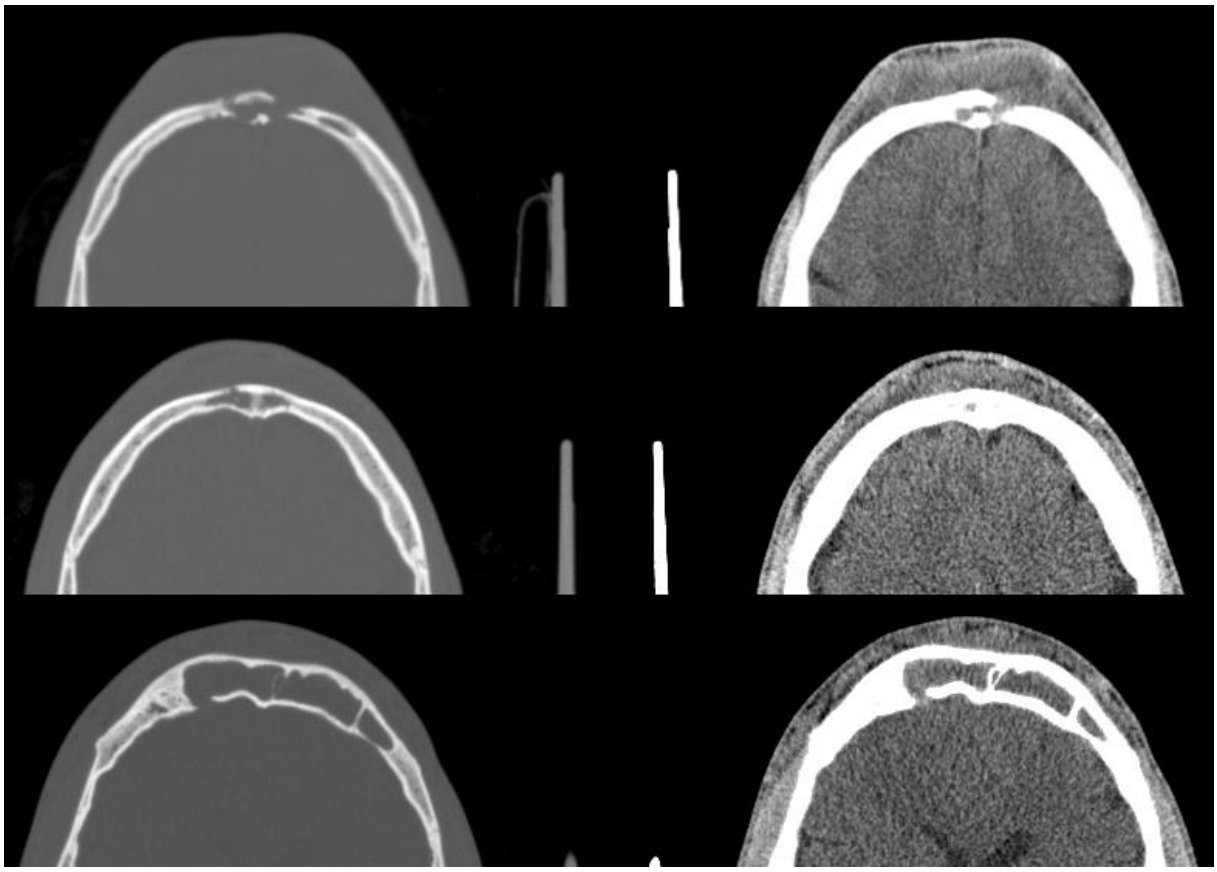

Figure 3. Cranial CT, Transverse section, bone and brain window. There is an abscess that opens under the skin by eroding the frontal sinus anterior wall and opening into the brain by eroding the posterior wall.

GEBELİK KAŞINTILARI SADECE ALERJİK MİDİR?

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ÖZET

İntrahepatik gebelik kolestazı genellikle gebeliğin son trimesterinda ortaya çıkan karaciğer fonksiyonlarında anormallik gösteren gebelik kaşıntısı olarak karşımıza çıkmaktadır. Hem maternal hem de fetal komplikasyonları göz önüne alındığında akılda tutulması gereken bir tablodur. Biz yazımızda acil servise kaşıntı ile başvuran ve gebelik kolestazı düşünülen 29 haftalık bir gebe olgusundan bahsedeceğiz. Acil servise kaşıntı ile başvuran gebe hastalarda intrahepatik gebelik kolestazı acil servis hekimi için gözden kaçmaması gereken bir tanıdır.

Anahtar Kelimeler: Gebelik, Kolestaz, Kaşıntı.

ABSTRACT

Intrahepatic pregnancy cholestasis is usually encountered in the last trimester of pregnancy as pregnancy pruritus with abnormal liver functions. Considering both maternal and fetal complications, it is a table that should be kept in mind. In our article, we will talk about a 29-week pregnant case who presented to the emergency department with itching and was considered to have gestational cholestasis. Intrahepatic pregnancy cholestasis is a diagnosis that should not be overlooked by the emergency room physician in pregnant patients who present to the emergency department with pruritus.

Keywords: *Pregnancy, Cholestasis, Itching.*

GİRİŞ

IGK (İntrahepatik gebelik kolestazı), İlk olarak tekrarlayan gebelik sarılığı olarak tanımlansa da sonraki vakalarda sarılık olsun veya olmasın gebelikte başlayan, doğumdan sonra düzelmesi beklenen altta yatan bir karaciğer hastalığı olmaksızın karaciğer fonksiyonlarında anormallik görülen gebelik kaşıntısı olarak değerlendirilmiştir (1).

İGK insidansı, Avrupa'daki gebeliklerin %0.1- 1.5 ve Güney Amerika ülkelerinde özellikle Bolivya veya Şili gibi ülkelerde %9.2-15.6 arasında olduğu görülmüştür. Etyolojide genel olarak etnik köken, yüksek östrojen düzeyleri, antikardiyolipin antikorlar, hepatit C, çoğul gebelikler gibi sebepler suçlansa da genel anlamda çok çeşitli hormonal, çevresel ve genetik faktörler söz konusudur (2,3). İGK teşhis ve klinik izleminde serum safra asidi ölçümü önemlidir ve açlık konsantrasyonunun 10 μmol/L'den yüksek olması ile tanı konulur. Aminotransferaz aktivitesi ve serum safra asitlerinin normalin çok üstünde olduğu vakalar bildirilmiştir (1, 3, 4). Fetal ölüm, fetal distres, erken doğum ve mekonyum aspirasyonu gibi fetal sonuçlar göz önüne alındığında ihmal edilmemesi gereken gebeliğe özgü bir karaciğer hastalığıdır (1,2,3,6).

Biz, yazımızda acil servise kaşıntı ile başvuran İGK olarak değerlendirilen 3.trimester de olan bir gebe olgusunu sunmayı planladık.

VAKA TAKDİMİ

27 yaşında G1P1A0L0 29 hafta olan gebe hasta vücudunda 2-3 gündür yaygın kaşıntı şikayeti ile acil servise başvurdu. Bilinen kronik hastalığı olmayan hastanın yapılan fizik muayenesinde öncelikle acil durumlar ekarte edildi. Glaskow koma skalası 15 olan, oryante-koopere, vital bulgular stabil olan hasta herhangi bir alerjen temasından bahsetmedi. Fizik muayenesinde; uvula ödemi olmayıp, dinlemekle solunum sesleri bilateral solunuma eşit katılmakta olup, ral, ronkus yoktu. Batın muayenesinde hassasiyet olmayıp, defans ve rebond saptanmadı. Anaflaksi ya da anjiyo ödem tablosunda olmayan hastanın acil serviste kaşıntı etyolojisi açısından gebelik kolestazı durumun nüks etme ihtimali düşünülerek kan tetkikleri ve ultrason tetkiki yapıldı.

Yapılan tetkiklerinde ALT:355 AST:328 ALP:226 GGT:33 crp:11 wbc:10 000 olarak saptandı.

MRCP:multiple taş tespit edildi. İHSY normal

Hepatobiliyer USG: safra kesesinde yoğun safra çamuru ve en büyüğü 12 mm çapta olan 5-6 adet kalkül izlendi.

Hepatit paneli: Normal

HDL:30 LDL:122 Total Kolesterol:192 Trigliserit:216 B12:164 Sedimentasyon:53 D.bil:1,81 total:1,91 olarak değerlendirildi.

Hastanın intrahepatik gebelik kolestazı düşünülerek ve dahiliyeye konsülte edildi ve dahiliye tarafından yatış verildi.

Hastaya ursactive (UDCA) 2*2 başlanıldığı ve KCFT değerleri ve semptomlarının gerilediği öğrenildi. Taburculuğunda B12 vitamin replasmanı ve ursactive 2*2 reçete edildiği öğrenildi. Gebelik takibi sonlanan hasta miadında sağlıklı bir bebek sahibi olduğu öğrenildi.

TARTIŞMA

İGK'de en sık ve en rahatsız edici semptom kaşıntı olarak karşımıza çıkmaktadır. Genelde el ayak kısımlarında olması beklense de vücudun her yerinde kaşıntı olabilir ve uykusuzluk gibi yaşam kalitesini bozabilecek durumlara yol açabilir. Her ne kadar semptomlar anne için doğum sonrası düzelmesi beklense de fetal problemler için üzerinde durulması gereken bir konudur (1).

Ldl kolesterol, toplam kolesterol seviyeleri İGK li kadınlarda normalin üst sınırında izlense de bizim vakamızda normal sınırlarda saptanmıştır. Bizim vakamızda olduğu gibi İGK vakalarının yaklaşık %13 ünde safra kesesi taşları olduğu bildirilmiştir ve intrahepatik safra yollarında dilatasyon görülmemiştir (1). İGK bizim vakamızda olduğu gibi genellikle gebeliğin 2, veya 3. Timesterinde başladığı düşünülse de Anastasia ve ark. Bildirdiği vakada ilk trimesterde de karşılaşılabilmektedir (3).

Anne tarafından genellikle iyi tolere edilen UDCA (ursodeoksikolik asit), karaciğer fonksiyon testlerini normale döndürme, kaşıntıyı azaltma konusunda etkilidir ve bizim vakamızda da UDCA kullanımı sonrası hastanın semptomları gerilemiş, karaciğer fonksiyon testleri bazal seviyesine dönmüştür (2,4,5).

Lee ve arkadaşlarının çalışmalarında 2 adet intrauterin fetal ölümle sonuçlanan İGK li gebeliklere rağmen UDCA tedavisi sonrası belirtileri ve KCFT si düzelen gebemizde miadında sağlıklı bir bebek doğumu meydana gelmiştir (6).

SONUÇ

Acil servise kaşıntı şikayeti ile başvuran gebe hastalarda hangi trimester olursa olsun, mevcut sonuçları göz önünde bulundurulduğunda intrahepatik gebelik kolestazı mutlaka ayırıcı tanılar arasında yer almalıdır.

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