Case discussion

Dengue Frontier Training

UiTM Selayang Campus

Dr Ong Hang Cheng

23rd Aug 2023

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DATE / TIME	HISTORY / EVENT	INVESTIGATION	MANAGEMENT
5/3/2020 @ 1224H	The patient presented with complaints of persistent vomiting and diarrhoea. At secondary triage - BP : 100 / 69 HR : 109 Temp : 37 .5 DXT : 6.5	-	The patient was triaged to amber zone
5/3/2020 @ 1225H	Amber zone: Dr AA & Dr J (EP Oncall) History from patient • The patient presented to ED with complaints of giddiness and lethargy. • Fever started on Saturday and subsided on Sunday and subsequently no more fever. • Diarrhoea and vomiting for the past 5 days. • Loose stool more than 10 times/day and subsequently 4-5 times / day. • Abdominal discomfort more over epigastric region. • Poor oral intake and only able tolerating fluid. • Recent traveling to Thailand and came back to Malaysia • Saw GP in the afternoon, given 1 pint drip in view of hypotension and referred to hospital		

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DATE / TIME	HISTORY / EVENT	INVESTIGATION	MANAGEMENT
5/3/2020 @1225 H	Physical Examination- Alert, cool peripheries, poor pulse volume. Dehydrated with tongue coated. Tachypneic **BP : 85/54 PR : 120 Tempt : 37.5** DXT : 6.5 Lung : equal air entry P/a : Soft, non tender, flabby abdomen No calf tenderness and unilateral body weakness IMP : **SEPTIC SHOCK SECCONDARY TO POSSIBLE LEPTOSPIROSIS.**	FBC TWC: 12.23 Hb: 19.0 HCT :59.0 PLT : 32 Combo Test **NSI Ag negative** **IgM / IgG Negative** RP/LFT/AST/VBG CXR /ECG Bedside abdomen done at resus (poor window) • Noted minimal bilateral pleural effusion at r4/l4 • Echo cardiac good contractility	• VM60% • Fluid 10 cc/kg (ABW - 100 kg) ~1000cc NS and to reassess back. • Start iv noradrenaline 8mg in 50 cc NS and taper accordingly • IV Rocephine 2 g stat • IV Pantoprazole 40 mg • To insert CBD and strict i/o charting • Uptriage patient to resus • Refer medical • Medical review in resus at 2.15am
5/3/2020 @ 0215h	Medical review in resus IMP: **Septic shock secondary to leptospirosis and TRO acute pancreatitis** Compensated metabolic acidosis with high lactate	Investigation to send: Blood C&S Coagulatuion profile GSH urgent Leptospirosis serology Serum amylase ESR and CRP	• IVD 20 cc/kg as planned • Repeat VBG post fluid bolus • IV rocephine 2 g stat • To update medical with investigation.

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History

- Complained of giddiness and lethargy.
- **Fever subsided**
- Diarrhoea and vomiting for the past 5 days.
- Loose stool > 10 times/day and subsequently 4-5 times / day.
- Epigastrium pain
- Poor oral intake
- Recent travel to Thailand
- Saw GP in the afternoon, given 1 pint drip (hypotension) and referred to hospital

Vitals at TRIAGE:

BP : 100 / 69
HR : 109
Temp : 37 .5
DXT : 6.5

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Physical Examination:

- Alert, cool peripheries, poor pulse volume. Dry coated tongue.
- Tachypneic
- **BP : 85/54 PR : 120 Temp : 37.5**
- CBS : 6.5

No more temperature

- Lung : clear
- Abd: Soft, non tender

FBC
TWC: 12.23, Hb: 19.0, HCT :59.0, PLT : 32

Combo Test: **NSI Ag negative; IgM / IgG Negative**

RP/LFT/AST/VBG
CXR /ECG
} Sent

Bedside USG:
- minimal bilateral pleural effusion
- Echo: cardiac good contractility

IMP : **SEPTIC SHOCK SECCONDARY TO POSSIBLE LEPTOSPIROSIS.**

Do you agree?

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Obese – High Risk

VM60%

Fluid 10 cc/kg (ABW -100 kg) ~1000cc NS and to reassess back.

iv noradrenaline 8mg in 50 cc NS and

IV ceftriaxone 2 g stat
IV Pantoprazole 40 mg

CBD and strict i/o charting

Blood C&S
coag profile
GSH

Leptospira serology

Serum amylase

ESR and CRP

Sent

IMP:
Septic shock secondary to leptospirosis and TRO acute pancreatitis

Compensated metabolic acidosis with high lactate

Dehydration secondary to GI lossess

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Take home message

- RDT: NEG may not be NEG
- Window period

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Thank you

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