BÁO CÁO CA BỆNH
(Case report)

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BMJ Case Reports 2011; doi:10.1136/bcr.10.2011.5001

Images in...

An incidental finding of a gastric foreign body 25 years after ingestion

Oliver Richard Waters, Tawfique Daneshmend, Tarek Shirazi

BÁO CÁO CA BỆNH

- Kênh trao đổi thông tin
- Giá trị thấp về y học chứng cớ
- Giúp phát hiện các bệnh lý mới

(*Quái thai do thalidomide*)

HÌNH THỨC

1500-2500 từ

Gồm 5 mục:

- Tóm tắt (100-250 từ) đủ 4 mục
- Mở đầu (đặt vấn đề) và mục đích
- Mô tả ca bệnh
- Bàn luận
- Kết luận
- Tài liệu tham khảo: 10-20 tài liệu

PHẦN MỞ ĐẦU

Ngắn gọn, xúc tích, gây ngay sự chú ý cho người đọc

Nêu lên tính mới và giá trị của ca bệnh

Tổng quan tài liệu có liên quan (MEDLINE, EMBASE)

Không quá 3 đoạn văn (paragraphs)

PHẦN BÁO CÁO CA BỆNH

Viết theo diễn tiến thời gian, liên hệ nhân-quả bao gồm tiền sử, triêu chứng, xét nghiệm, chẩn đoán, theo dõi, kết cục.

(*Viết liên tục không gạch đầu dòng)*

Chỉ cung cấp chi tiết vừa đủ và liên quan ca bệnh (lâm sàng, XN..)

Các thông tin về BN (tên họ tắt, tuổi, giới, sắc dân, không cần ghi rõ ngày tháng nhập viện…. .)

PHẦN BÀN LUẬN

- Đặc điểm ca bệnh
- So sánh với các tài liệu
- Kinh nghiệm rút ra (Vd: vệ sinh răng miệng, mổ dẫn lưu sớm, KS tích cực)
- Kết luận.....

BÁO CÁO CA 1

PRACTICE

IN BRIEF

- Death from odontogenic sepsis is rare but still a reality.
- Odontogenic sepsis is the most common cause of Ludwig's angina.
- Ludwig's angina and other cervicofacial infections present more severely in those with underlying systemic disease.
- Early surgical drainage, aggressive intravenous antimicrobial therapy and supportive care are imperative.

VERIFIABLE CPD PAPER

Death from overwhelming odontogenic sepsis: a case report

L. Carter[1] and E. Lowis[2]

A case of fatal Ludwig's angina from an odontogenic origin complicated by chronic lymphocytic leukaemia is presented. This case highlights that death from odontogenic infection is a reality, particularly in those with systemic disease causing immunocompromise. Early surgical intervention, aggressive intravenous antimicrobial therapy and supportive care is imperative.

BÁO CÁO CA 1

INTRODUCTION

Odontogenic infection is the most common cause of Ludwig's angina.[1,2] Mortality associated with Ludwig's angina has reduced with the routine use of antimicrobials as an adjunct to surgical drainage of head and neck tissue spaces. Up to 35% of patients presenting with Ludwig's angina have an underlying systemic disease that may have contributed to immunocompromise.[1]

CASE REPORT

A 67-year-old man presented to Accident and Emergency at Hull Royal Infirmary after emergency transfer from another hospital. He had a three day history of increasing neck swelling and difficulty breathing. His voice was hoarse and his sentences limited due to breathlessness. He reported a sore throat, swelling of his face and tongue but no dental pain. He had a past medical history of angina, nasal polyps and chronic lymphocytic leukaemia.

On presentation he was tachycardic (heart rate 126 bpm), tachypnoeic (respiratory rate 29/minute), pyrexial (temperature 38.9°C), and normotensive with oxygen saturation of 94% on FiO_2 0.98. He was stridulous and had a large, fluctuant, erythematous swelling of the submental and bilateral submandibular spaces extending from the lower border of mandible to the clavicles. The erythema extended over his anterior chest wall (Fig. 1). He exhibited facial and periorbital oedema and erythema. Intra-oral examination revealed multiple carious and periodontally involved teeth. His tongue and floor of mouth were soft and not enlarged. A provisional diagnosis of submental abscess was made. Chlorpheniramine, intravenous hydrocortisone, benzyl penicillin, metronidazole and coamoxiclav were already given before arrival. Nebulised adrenaline was administered and he proceeded to theatre for surgical incision and drainage.

After an awake fibre-optic endotracheal intubation the neck swelling was incised using three access incisions and the submental and bilateral submandibular and sublingual spaces explored. Three drains were placed and serosanguinous fluid was drained (Fig. 2). Dental caries was evident in both lower second molar teeth and the upper right central incisor tooth which were therefore extracted.

He remained intubated and was transferred to ITU. Blood gases revealed a severe metabolic acidosis. Over the following 24 hours he became hypotensive and required inotropic support with

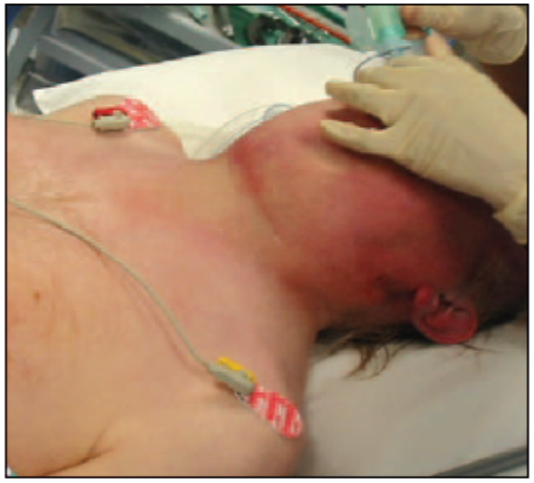

Fig. 1 Neck swelling and chest wall erythema

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BÁO CÁO CA 1

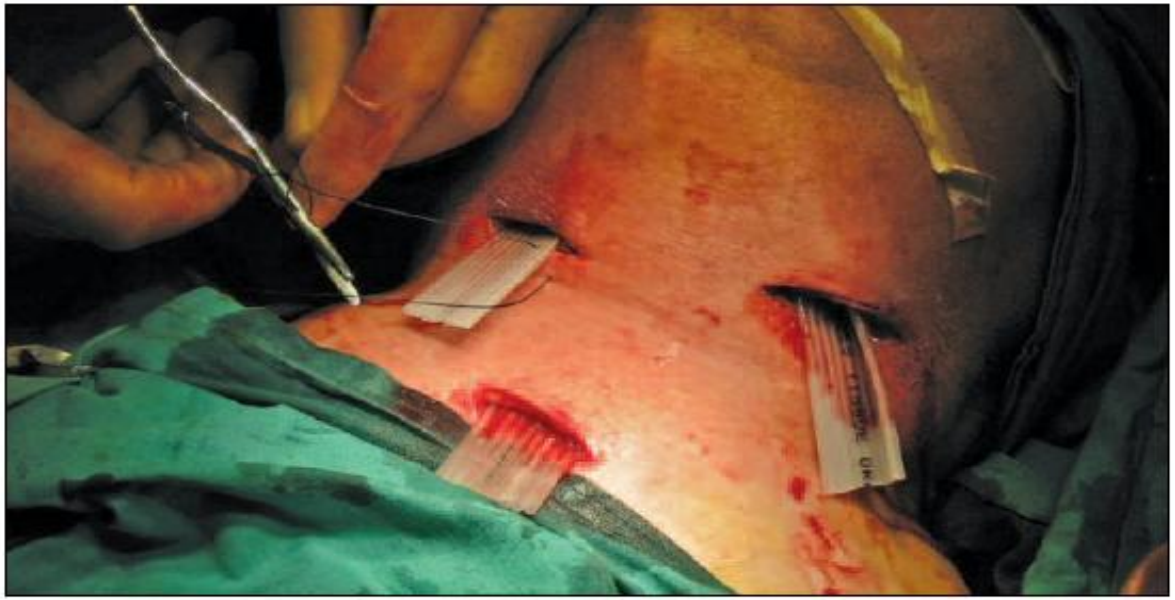

Fig. 2 Access incisions and drains

noradrenaline. The metabolic acidosis worsened despite the ventilatory support, bicarbonate infusions and haemofiltration. As a result of multi-system organ failure he continued to deteriorate and died.

Blood investigations at presentation revealed a white cell count (WCC) of 161.9 x10^9/L which increased to 570.3 x10^9/L over the next 24 hours. A blood film indicated that the high WCC was

aetiology as the cause of death and that impaired immunity associated with the underlying leukaemia/lymphoma was a contributary factor.

DISCUSSION

Death from isolated dental infection is rare.[3] Progression to Ludwig's angina increases the risk of mortality. With routine use of intravenous antimicrobial therapy as an adjunct to surgical incision

chronic lympho-proliferative disorder with features similar to a low grade lymphoma. In the later stages of CLL, infection can become life-threatening and in this case reduced resistance to infection led to a more severe and ultimately fatal presentation of Ludwig's angina. Those with underlying systemic disease are also more likely to have more severe complications.[1,2]

This case highlights the need for regular dental care in patients with underlying systemic disease in order to prevent more severe presentations of potentially life threatening dental sepsis. Unfortunately the majority of these patients are elderly and are less likely to present for regular dental check ups.[4]

This case is also a stark reminder that dental sepsis can still be fatal, particularly in the presence of systemic disease contributing to immunocompromise. Ludwig's angina and other cervicofacial infections present more severely in patients with underlying systemic disease. Therefore early aggressive surgical drainage, adjunctive intravenous antimicrobial therapy and supportive care are prerequisite

BÁO CÁO CA 2

Journal of Medical Case Reports

BioMed Central

Case report

Open Access

Fatal hemolytic anemia associated with metformin: A case report

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Abstract

Introduction: Metformin is a widely prescribed biguanide antidiabetic drug that has been implicated as a cause of hemolytic anemia in three previous case reports. We report a case of rapidly fatal hemolysis that was temporally associated with the initiation of metformin treatment for diabetes. Clinicians need to be aware of this rare but potentially serious side effect of metformin.

Case presentation: A 56-year-old Caucasian man with type 2 diabetes mellitus was started on metformin to improve glycemic control. Shortly afterwards, he developed progressive fatigue, exertional dyspnea, cranberry-colored urine and jaundice. Laboratory studies showed severe hemolysis, with a drop in hemoglobin from 14.7 to 6.6 g/dl over 4 days, markedly elevated lactate

BÁO CÁO CA 3

NHÂN MỘT TRƯỜNG HỢP ĐIỀU TRỊ BỆNH NHÂN NGỘ ĐỘC METHANOL TẠI BVĐKTT AN GIANG

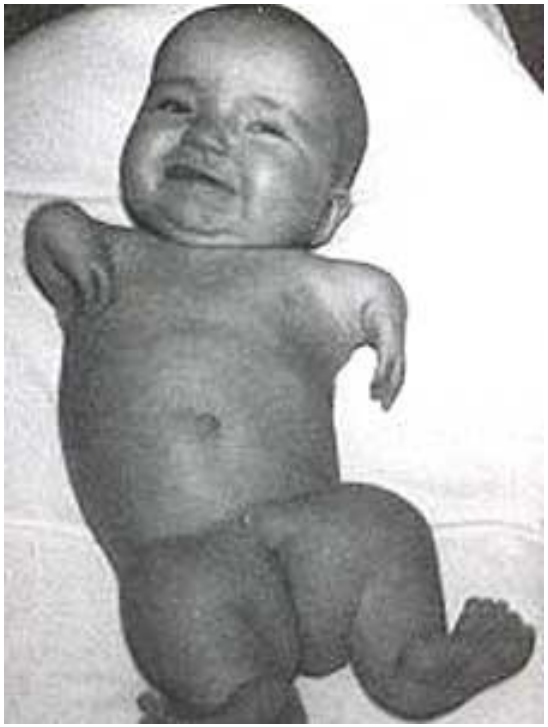
Bs. Huỳnh Trinh Trí

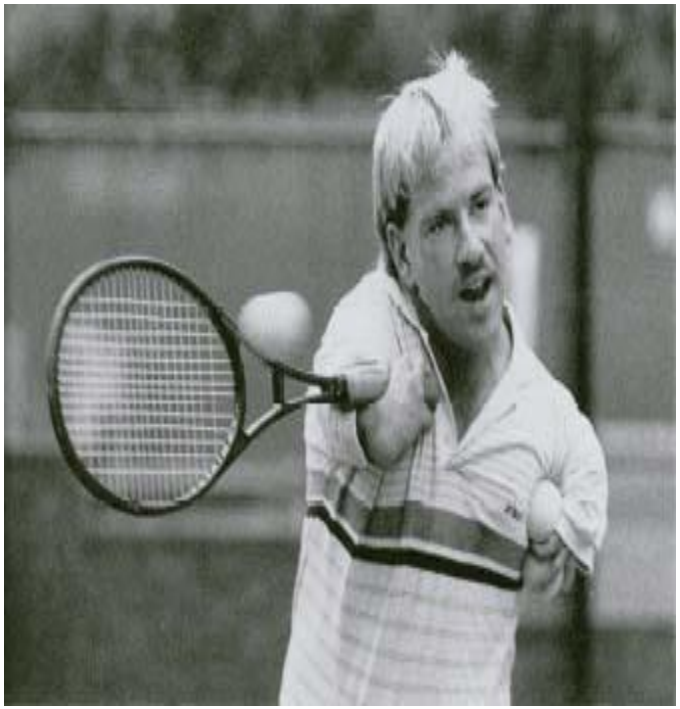
Ngộ độc methanol bằng đường uống thường hiếm, có thể gây rối loạn toan chuyển hóa trầm trọng, mù mắt, rối loạn chức năng thần kinh lâu dài và tử vong.
Sự hiện diện toan chuyển hóa kết hợp với sự gia tăng anion gấp và tăng khoảng trống áp lực thẩm thấu là xét nghiệm quan trọng được tìm thấy.
Chúng tôi báo cáo một trường hợp ngộ độc rượu methanol ở một bệnh nhân 56 tuổi uống rượu thường xuyên, bệnh nhân vào bệnh viện chúng tôi sau 20 giờ uống rượu, triệu chứng đầu tiên là mờ mắt, xét nghiệm lâm sàng toan chuyển hóa nặng với pH máu động mạch : 6,7 và HCO3- 4,5 meq/L. Bệnh nhân được điều trị ngộ độc methanol gồm hồi sức cấp cứu chung, điều chỉnh toan chuyển hóa và lọc máu cố gắng để loại bỏ methanol, acid formic.

Abstract: A case of methanol poisoning was treated at AnGiang Central General Hospital

Methanol ingestion is an uncommon form of poisoning that can cause severe metabolic disturbances, blindness, permanent neurologic dysfunction and death.The presence of metabolic acidosis associated with an increased anion gap and increased osmol gap are important laboratory findings.
We report a case of methanol alcohol poisoning in a 56-year-old chronic alcoholic patient who was presented at our hospital after 20 hours of alcohol drinking. The initial symptom was of blurred vision. The clinical findings of acidosis was very severe with arterial pH values of 6.7 and plasma bicarbonate concentrations of 4,5 meq/liter. The patient was treated with standard supportive care combined with the correction of metabolic acidosis and hemodialysis in an attempt to eliminate both methanol and formic acid from his blood.

THALIDOMIDE AND PHOCOMELIA





Butch Lumpkin