ECHO SESSION CASE PRESENTATION

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Case Presentation

PC- loss of consciousness X1/7

HPC - 39/F with hypertension x 6yrs on bisoprolol 5mg twice a day, a referral from Masaka RRH with 1/7 h/o sudden LOC, preceded by sudden onset of severe generalized headache, 6 episodes of nonprojectile vomiting, neck swellings, progressive weight loss, increased sweating, palpitations, insomnia, easy fatigability & palpitations x 1/12 progressive hearing impairment (Lt>>Rt), blurring of vision(Lt>>Rt), heat intolerance for the last 3 years

Primary Survey (Emergency Assessment and Management)

A	Airway	Patent, threatened by reduced levels of consciousness	Maintain patent airway, positioning
B	Breathing	Not in distress, clear chest, RR 16/min, SPO2 98% on RA	Continuous monitoring
C	Circulation	BP 160/119 PR 96/min regular full volume, warm peripheries, cap refil <2sec	IV access Blood samples for lab investigations

Primary Survey (Emergency Assessment and Management)

D	**Disability**	**Semi-conscious GCS 11/15 (E4M5V2) restless in bed Neck soft, PEARL left CN VII, palsy**	**Recovery position Pass urethral catheter Urgent Brain CT scan (non-contrasted) Insert NGT**
E	Exposure	Axillary temperature was 36.6˚C No life-threatening injuries	Continue monitoring

Secondary Survey (Head-to-toe examination)

G/E - FGC, no jaundice, no pallor, no finger clubbing, no cyanosis, no edema, well hydrated with cervical lymphadenopathy

CVS -96bpm, regular, full vol, symmetrical, synchronous, BP160/119mmHg; Normoactive precordium, apex beat in 5th ICS, MCL; HS I+II+0

R/S - 19cycles/min, Normal chest shape, moves symmetrically with respiration; Vesicular breath sounds, no added sounds

Secondary Survey (Head-to-toe examination)

P/A - Normal fullness, moves with respiration, Pfannenstiel incision scar; non-tender, no palpable enlarged organs

ENT -good oral hygiene, no nose or ear discharge or pain

CNS –Restless in bed, semi-conscious GCS 11/15(E4M5V2), neck soft, kernig's and brudzinski negative. PEARL 3mm diameter, Left lateral gaze palsy. Facial asymmetry with deviation to the right side, Left sided tongue atrophy with loss of papillae

SAMPLE History

S	**Sign & Symptom**	**Progressive symptoms over the past 3yrs with H/o progressive hearing and visual impairment, weight loss, facial asymmetry, insomnia, excessive sweating, palpitations and bilateral neck swellings.** **On admission –sudden LOC and vomiting.**	
A	Allergies	No known drug or food allergies	
M	Medication	Amlodipine 10mg x 4/12 Bisoprolol 5mg X 2/12 Paracetamol 1g TDS X 1/52	

SAMPLE History

P	**Past Medical History** **Past Surgical History** **FSH**	**Hypertensive (poorly controlled) on treatment for the past 4/12, second admission in 2024** **No history of surgery, blood transfusions or trauma** **P9, amenorrhea for past 3 years, married, has both parents still alive, no familial illnesses, No alcohol/smoking Hx**	
L	Last meal/LNMP	Last meal was 6hrs prior to admission	
E	Events	Patient was observed to have acutely lost consciousness, fell to the ground got no convulsions, started vomiting about 15mins after the fall.	

Problem List

- Reduced LOC
- Hypertensive emergency
- Neck swellings
- Vomiting

Investigations

TEST	RESULT
Head and neck CT-scan	features of bilateral avidly enhancing masses arising in the carotid spaces(Lt>Rt) at the point of bifurcation of the common carotid artery with associated marked temporal bone/petrous apex/inner ear infiltration(L>Rt), note is also made of left optic chiasm infiltration, bilateral complete post obstructive chronic mastoiditis, conclusion: bilateral glomus jugulare
Brain MRI and MR-angiography	cervical portion of the right is partially encased by a mass in the right jugular fossa with encasement more than 180, cervical, PETROUS and lateral segments of the ICA completely encased by the jugular fossa mass with angle of contact up to 360, cavernous segment of ICA is displaced by the mass with angle of contact up to 360
Neck USS	Bilateral echo complex masses reported, normal thyroid gland
Thyroid Function tests	TSH 3.28(Normal) T.4 – 13.50(Normal) T3 – 3.81 (NORMAL)

Investigations

cbc	**Hb11.4g/dl, MCV 64.2(LOW) MCH 19.6pg(LOW) Haematocrit 37% PLT 567/L WBC 10.90, NEU 89.1% LYM 4.6%, MON 6.0%**
LFT	Serum total bilirubin 0.3mg/dl(normal), serum direct bilirubin 0.1(normal) ALT 68U/L (high) AST89U/L(X2.8 the upper limit of normal), ALP, Total protein and albumin were normal
RFT	Urea 10mg/dl, creatinine 0.51mg/dl, sodium and potassium were both normal
TFT	TSH 3.28(Normal) T.4 – 13.50(Normal) T3 – 3.81 (NORMAL)

Management

- Iv labetalol 20mg STAT
- IV mannitol 20g 6hrly
- Iv paracetamol 1g TDS
- Continue anti hypertensive medication
- Tab Doxazocin 4mg OD
- IV Dexamethasone 16mg stat

Supportive management

- HOB at 30
- Catheterize and do Fluid balance
- Regular turning in bed
- monitor Bp and RBS regularly
- NGT Feeding; 3 hourly

Follow-up and Disposition Plan

- Patient after 1day of management on Emergency ward had regained full consciousness, but still had fluctuating high blood pressure recordings.

- Admitted to neurosurgery ward for further evaluation and review by neuro surgeons
- urine metaneprines test results pending, nuclear medicine studies also pending

Thank you