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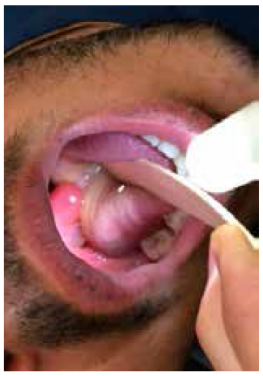
invested. On the third day of follow-up, the patient was discharged with oral antihistamine drug, which completely regressed uvulae edema and ecchymosis near the uvulae.

DISCUSSION: Tables varying from toxic, immunologic and allergic reactions to anaphylaxis and shock can be seen due to bee stings. Anaphylaxis, shock and hypotension are more common, especially due to bee insertions in the head and neck region. Tongue, uvula is rarely exposed to the harmful effects of insects as it is in a closed mouth. However, it should be kept in mind that this rare situation may also lead to life-threatening consequences.

Keywords: Bee, Uvulae, Edema, Sting

Figure 1



PS-393 Trauma emergencies

Occipital condylar fracture

Ataman Köse[1], Fatma Çat[1], Seyran Bozkurt[1], Sermin Tok[2], Giray Altunok[1]

[1] *Mersin University, Faculty of Medicine, Department of Emergency Medicine, Mersin, Turkey*
[2] *Mersin University, Faculty of Medicine, Department of Radiology, Mersin, Turkey*

INTRODUCTION: Occipital condylar fracture (OCF) is a rare condition that cannot be detected in plain films. It is usually diagnosed by computerized tomography (CT). It is generally characterized by neck stem pain and, sometimes, clinical conditions consistent with cranial nerve involvement. Diagnosing OCF in an emergency department requires a high index of suspicion when there exists unexplained neck pain after head and neck trauma. A careful examination of the craniocervical junction can prevent missed diagnoses. In this paper, we report a 32-year-old man with neck and shoulder pain after a motor vehicle accident, who was detected to have occipital condylar fracture.

CASE: A 32-year-old man presented to our emergency department with neck and shoulder pain after a motorcycle accident. His vital signs were stable; he had a GCS of 15; he had full time and place orientation and showed full cooperation. He had tenderness over his left shoulder and cervical region. Apart from upper lip ecchymosis, he had completely normal systemic examination. His neurological examination showed no motor abnormality, deformity, neurological deficit, or loss of strength. A neurological examination was normal. No abnormalities were noted in his laboratory tests. Plain cervical and shoulder films did not reveal any fracture. In line with the algorithm recommended by the Canadian Spinal Rule, a CT was taken, which showed a non-displaced left occipital condylar fracture unaccompanied by brain and cervical atlantooccipital dislocation. The patient was consulted with the neurosurgery department. A shoulder strap was placed for shoulder pain. Having no additional problems, the patient was discharged with the recommendations for using cervical collar and bedrest to stabilize occipital condylar fracture.

CONCLUSION: Patients with OCF may not necessarily have pain. As cervical plain films are inadequate for detecting that fracture, a cervical CT and a careful examination of the craniocervical junction are important for an accurate diagnosis. OCF is typically seen in serious head trauma although it may also be found in patients not having signs of severe trauma or those presenting with shoulder pain. CT examination taken in suspected cases allows a correct diagnosis to be made. Additionally, complying with the spinal trauma imaging rules in asymptomatic patients may prevent missed diagnosis.

Keywords: condylar, emergency, fracture, neck pain

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Archery-Related Hand Injury

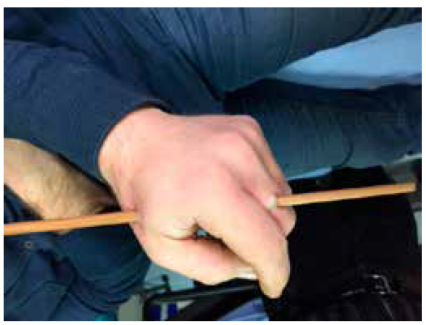
Selim İnan[1], Mehmet Nihat Özüpek[2], Şükrü Yorulmaz[1], Sertaç Güler[1], Cihat Cömert[2], Murat Ongar[1], Sinan Özdemir[1], Mehmet Okumuş[1]

[1] *Ankara Training and Research Hospital*
[2] *Ankara Numune Training and Research Hospital*

There are several common injuries in archery, especially recreational archery when one is learning form for shooting and how to use protective gear. Archery-related injuries of the upper extremities is rarely seen in emergency departments. Acute injuries included arrow laceration of a digital nerve and artery, contusion of forearm and hand skin and subcutaneous tissue, and compression neuropathy of digital nerves from the bowstring. We will report a case of archery injures which was entering the left hand dorsal of the tenor region and leaving the third finger proximal and dorsal region.

A 35 years-old man admitted to emergency department with archery injury of left hand from a broken arrow shaft. This occurred when a wooden arrow broke while he was attempting to shoot it from a compound bow. The arrow, entering the dorsal region of the tenor region and leaving the third finger proximal and dorsal region.On admission his vital signs were within normal values.There was no evidence of active arterial bleeding. There were adequate digital circulation. Sense and two point discrimination examination were normal. Because of the pain motor examination was limited and because of the arrow; slight flexion and extension of the thumb and of the interphalangeal, metacarpophalangeal, and carpometacarpal joints could be elicited. Initial x-rays were without evidence of articular or bony injury. Hand surgeon consultation wanted. Arrow removed by operating surgeon in operating room conditions. After operation motor and sensory functions were intact without evidence of tendon or vascular injury. After 24 hours of intravenous antibiotics the wound dressing was changed. The patient was discharged on oral antibiotics. The outcome, including hand function was good without any functional loss.

Image 1



Archery injures of hand is not a situation we often encounter with emergency services. The patients who come with these injuries should carefully investigate the presence of nerve,bone and vascular injury. Patient should be intervened in the operating room conditions, in order to achieve hemostasis, in case of possible arterial injury.

Keywords: Archery, Arrow, Hand Injury