In this study, we present a case of Myasthenia Gravis associated with thymoma. The patient's clinical course, diagnostic approach, and treatment process will be discussed in detail.

Case

A 46-year-old male patient presented to the emergency department with complaints of slurred speech, throat burning, itching, and difficulty swallowing for the past 15 days. The patient has no known chronic medical history and is not on regular medication. On physical examination, Glasgow Coma Score (GCS) was 15, blood pressure was 110/80 mmHg, heart rate was 86 beats per minute, respiratory rate was 18 breaths per minute, axillary temperature was 36.2°C, and blood glucose level was 106 mg/dL. Electrocardiogram (ECG) showed sinus rhythm. Neurological examination revealed the patient was alert, cooperative, and oriented, with slurred but meaningful speech. Pupils were equal and reactive to light (direct and indirect reflexes ++/++), with no nystagmus. Muscle strength in both upper and lower extremities was 5/5 bilaterally. Cerebellar tests were bilateral and coordinated, and deep tendon reflexes (DTR) were normal bilaterally. Oropharyngeal examination was normal, and no palpable masses or lymph nodes were detected.

The patient had previously been evaluated with a suspected cerebrovascular event (CVE) diagnosis, but no acute pathology was found. He was referred from an outside facility for further evaluation. Routine laboratory tests were ordered, and to rule out acute cranial pathologies, a brain CT and diffusion MRI were performed. The brain CT report indicated "no intracranial hemorrhage." Diffusion MRI showed no acute diffusion restriction. Laboratory results revealed no significant abnormalities.

The differential diagnosis included viral upper respiratory tract infections, cranial nerve palsies, oropharyngeal masses, vocal cord paralysis, and Myasthenia Gravis. Consequently, a neck CT and thoracic CT were requested. The thoracic CT report noted "A 39x23 mm soft tissue density nodule in the anterior mediastinum, potentially indicative of lymphoma or thymoma." Thymoma-associated Myasthenia Gravis was suspected. Consultation with neurology and thoracic surgery was obtained for further evaluation and treatment. The patient did not require emergency admission; however, a follow-up in the outpatient clinic was recommended for further diagnostic evaluation and treatment. The Acetylcholine Receptor Antibody (AchR) level was 9.212 (negative <0.25, borderline 0.25–0.4). In the outpatient follow-up, intravenous immunoglobulin (IVIG) therapy was initiated, and a total thymectomy was planned. The patient's symptoms improved with IVIG treatment, and no active symptoms were observed post-surgery.

Conclusion

Myasthenia Gravis is an autoimmune neuromuscular disorder characterized by muscle weakness and fatigue. The diagnosis of this disease is based on clinical findings, electrophysiological tests, and antibody screening. Pathological changes in the thymus, particularly thymoma, are an important factor in the disease's etiology. In this case, we discussed a patient diagnosed with Myasthenia Gravis associated with thymoma, and the clinical course, diagnostic approach, and treatment strategies have been detailed. The patient initially presented with slurred speech, dysphagia, and oropharyngeal symptoms, and following further investigations, a diagnosis of Myasthenia Gravis associated with thymoma was confirmed. The patient responded well to treatment.

This case highlights the rare but significant association between Myasthenia Gravis and thymoma. Early diagnosis and appropriate treatment can significantly improve patients' quality of life. IVIG therapy and thymectomy are effective management strategies, and the improvement in the patient's symptoms demonstrates the success of these treatments. In the differential diagnosis of Myasthenia Gravis, early and careful neurological evaluation, along with comprehensive diagnostic testing, plays a crucial role in increasing diagnostic accuracy and guiding treatment decisions.

This case further emphasizes the importance of timely diagnosis and the application of appropriate treatment protocols in controlling the symptoms of Myasthenia Gravis and improving patient outcomes.

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5274

A case of necrotising fasciitis after intramuscular injection

Abdülaziz Doğan[1], Ali Küçükosmanoğlu[1], Ayla Mollaoğlu[1], Yasin Yıldız[1], Mehmet Gül[1]

[1]Department of Emergency Medicine, Konya City Hospital, Türkiye

Introductıon

Necrotising fasciitis (NF) is a serious life-threatening soft tissue infection characterised by rapidly spreading necrosis and infection affecting subcutaneous tissue and fascia (1). Infection may usually occur after trauma, surgical interventions or microtraumas (2). Intramuscular injection is a rare but serious condition that may be the trigger of such infections (3). The rapidly progressive nature of NF makes early diagnosis and treatment mandatory, because delay in the diagnosis of the disease may increase morbidity and mortality rates. In the literature, broad-spectrum antibiotherapy and aggressive surgical debridement are recommended in the treatment of such cases. Although streptococcal toxic shock syndrome (STSS) has similar symptoms with NF, it progresses with hypotension, systemic toxicity and multiple organ failure as a distinctive feature, which may complicate the treatment process (4).

Case

A 67-year-old male patient with known DM presented to the emergency department with left leg pain that started one day ago. He was discharged after IM injection and no abnormal blood test results. One day later, he presented to the emergency department again with complaints of pain, redness, bruising and swelling extending from the left inguinal region to the ankle after intramuscular injection. On physical examination, it was found that ecchymotic-bullous lesions developed in the affected area and these lesions spread to the perineal region. As a result of biochemistry tests and ultrasonography imaging, necrotising fasciitis was diagnosed. However, the patient's condition deteriorated rapidly before surgical intervention could be performed, and cardiopulmonary arrest developed on the same day during the intensive care unit and the patient died.

Discussion

Necrotising fasciitis is defined as a fatal infection that spreads rapidly and usually develops after trauma (5). The infection causes necrosis in the skin and underlying tissues, which rapidly leads to complications including sepsis, toxic shock and multiorgan failure (6). While most patients have painful, reddened and swollen areas in the early stages of NF, these findings can often be confused with other soft tissue infections. The most critical factor in the diagnosis of NF is the presence of severe pain and swelling and redness disproportionate to the lesions. After the diagnosis is made, broad-spectrum antibiotherapy should be initiated and surgical debridement should be performed (7).

Although streptococcal toxic shock syndrome (STSS) has similar clinical findings to necrotising fasciitis, this syndrome, especially caused by group A beta haemolytic streptococci, leads to a more severe clinical picture. STSS is characterised by sepsis and multiple organ failure, and delayed diagnosis and treatment may significantly increase mortality. Therefore, it is vital to start treatment without differentiating NF and STSS (8). Early diagnosis and rapid surgical interventions increase the chance of survival of patients.

Early debridements, removal of necrotic tissues, antibiotherapy and intensive care support make the treatment of patients more effective. However, the faster the surgical intervention is performed, the more favourable the prognosis of the patients will be. A multidisciplinary approach, early diagnosis and optimisation of the treatment process are of vital importance in the management of such cases (9).

Conclusion

Necrotising fasciitis after intramuscular injection is a rare but potentially fatal complication. Early diagnosis, broad-spectrum antibiotherapy and surgical debridement are important treatment modalities that can improve the prognosis of patients. However, if patients do not respond to treatment, the disease progresses rapidly and complications develop, intensive care support is required. Factors that differentiate it from different clinical pictures such as streptococcal toxic shock syndrome should ensure that the correct treatment is initiated.

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5679

Thromboembolic Complications Associated with the Use of Prothrombin Complex Concentration in Patients Over Sixty Years of Age

İsmail Ataş[1], Mümin Murat Yazıcı[1], Özlem Bilir[1], Gökhan Ersunan[1], Mehmet Altuntaş[1]

[1]Department of Emergency Medicine, Recep Tayyip Erdoğan University Faculty of Medicine, Training and Research Hospital, Rize, Turkey

Introduction

Oral anticoagulants (OACs) are drugs commonly used to reduce the risk, treat and prevent the development of systemic venous thromboembolism (1). Patients are at high risk of bleeding despite using this drug group at therapeutic doses. In the presence of life-threatening bleeding, the most effective and safe treatment to reverse the anticoagulant effect is based on many guideline recommendations (2-4). In reversal of the anticoagulant effect, the use of Quitamine, Fresh Frozen Plasma (TDP) and Prothrombin Complex Concentrate (PCC) is preferred (5-7). However, TDP transfusion may cause adverse effects such as acute lung injury, circulatory system overload and allergic/anaphylactic reaction. PCC, on the other hand, can be used as an effective agent in reversing life-threatening hemorrhages due to its factor 2, 7, 9 and 10 content together with protein C and S without causing these effects. There are publications in the literature indicating that this group of factor Xa inhibitors produce the same effect (8).

Reversal of anticoagulation may cause a number of complications, notably the risk of recurrent thromboembolism. Rapid reversal