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ABSTRACT BOOK

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ABSTRACTS: DOCTORS

Abstract number: 001

PLAN IN CASE OF MASS DISASTERS IN EMERGENCY DEPARTMENT-GENERAL HOSPITAL LESKOVAC

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Introduction: In mass disasters and catastrophes use of prehospital emergency treatment measures is significant: on-site, during transport and in hospital, immediately on admission to hospital in the Emergency Department (ED), because definitive surgical and medical care is not possible in the first hours, especially in circumstances of reduced resources. It is important to perform first aid at the scene, resuscitation, stabilization and other non-surgical medical procedures which may be sufficient for saving lives even in severely injured. Basic procedures and timely implementation of reanimation measures: maintaining the patent airway, controlling the bleeding, administration of intravenous fluids may be enough in the first period to stabilize the victim with severe and life-threatening injuries, before they are definitively treated in hospital. Quality of initial prehospital treatment and timely implementation of emergency medical treatment at the scene, during transport and at admission to the hospital, may affect the chances of injured to survive.

Case report: Emergency Department has its own plan in case of mass disasters and accidents, and personnel are roughly informed of the plans of other organizations involved in the management of the mass disaster (the ambulance service, the police department, the city and region). Our plan is integral part of the plan of the General hospital in case of mass disasters. In order to implement this plan adequately in emergency situations, it is necessary to analyze the daily work activities, equipment and capacity resources. The plan includes data on organizing, operation and description of the procedures to be applied in the event of mass disaster. Medical part in ED is carried out through four main activities:

- Admission of patients
- Triage and retriage of patients
- Medical Treatment
- Emergency medical transport to another medical facility

In the case of mass accidents injured are brought to ED by ambulance, police, private car or otherwise. At the entrance gate of the hospital, patients are directed to the hospital by the security services personnel towards the hospital building and ED, which is located on the ground floor of the hospital building next to entrance. Admission of patients is carried out according to the procedure for admission and procedures for triage of patients in mass disaster. Staff working in shift begins admission, triage and medical treatment of injuries, notify the ED chief of the accident and the foreseeable number of injured and implement the procedure for mass disaster. Team that manages the ED is activated in case of mass disasters and, if necessary, more ED personnel are called which should help in medical treatment. Teams from other departments arrive who are serving according to a specific plan to assist emergency physicians and in a short period of time substantially increases the number of workers involved in the medical treatment of victims of mass disasters in the hospital.

Keywords: Mass accident, plan, hospitals, triage, management, resuscitation

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Abstract number: 002

MEDICAL SUPPORT OF PUBLIC GATHERING WITH INCREASED RISK - CASE REPORT

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Introduction: The situation in sports arenas in Serbia, but also in the rest of the world, shows that before, after and during the competition, sports passion and desire to win sometimes break beyond correct cheering for your team and go into physical clashes, often with severe consequences for safety of people and objects.
Objective: The study is to show that medical support of sport meetings with increased risk is a complex task that requires the involvement of various institutions, cooperation between different departments and organizational units in the management of a large number of injured.
Case: How it was different and what was different in 148th derby which was played on April 25th 2015, between FC Crvena Zvezda - FC Partizan in Belgrade? Derby started 45 minutes late and was played in three half. The first half started with no players on the field and with the duel of Delija on the northern and eastern stands against the police and the gendarmerie. This part of the "game" resulted in injures of a large number of police members, spectators and the stands were demolished. The clashes began before the start of the match around the stadium and continued in the stadium where the fans of two teams exchanged pyrotechnics, chairs, and stones. Three medical teams from the composition of the medical service of the Gendarmerie participated in managing of injured members of the police. The epilogue of the conflict: 35 members of the police and a few fans were injured. "Police responded efficiently and professionally to prevent the conflict, caused by a group of fans in the stadium at the start of the game, which could have caused the cancellation of the match and possible major consequences." (Press release Ministry of Interior, Republic of Serbia)
Conclusion: From the medical point of view of the organizers of sport events it is of great importance to have a significant number of trained medical teams that will adequately and timely manage situation at the scene. For the teams that are involved, teamwork, training, and adequate medical equipment are of paramount importance. Connecting of all departments at the scene and having a plan in such situations is the key to success.
Keywords: sports events, connection, medical managing.

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Abstract number: 003

SNAKE BITE – CLINICAL PRESENTATION, FIRST AID AND TREATMENT

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It is estimated that worldwide 1.2 million people encounter a snake bite each year and it is estimated that several hundred thousand have long-term consequences, and in about 100.000 there is a fatal outcome. By biochemical analysis of snake venoms it was found that they contain many enzymes. Proteolytic digestion ferments lead to extensive necrosis, all toxins have antigen properties and victims usually die in toxic shock leading to disseminated intravascular coagulation. Each snake bite is treated as if it is venomous snake bite. First aid procedures and advanced medical support procedures at the scene will be explained. Anti-viperine serum is not given routinely in all situations of venomous snakes bites. The real indications for anti-viperine serum were early signs of systemic intoxication or rapid expansion of the local swelling with bullous changes. Basic prevention measures for snake bite relating to the enlightenment and education of the population on how to prevent snake bite will be addressed.
Keywords: snake bite, first aid, advanced medical support, anti-viperine serum

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Abstract number: 004

THE INCIDENCE OF SEIZURES DURING HYPOGLYCEMIA IN DIABETIC PATIENTS

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Introduction: Hypoglycemia as a multifactorial syndrome has a number of effects on human health and reduces a quality of life. It is most common in diabetics who are on insulin therapy with uncontrolled glycemia, but also occurs in alcoholics, starvation, pancreatic tumors and disorders of the pituitary gland and adrenal gland and after gastrectomy. Hypoglycemia manifests with dizziness, confusion, fatigue, and headache, improper behavior that might be mistaken for drunkenness, poor concentration, convulsions and coma. Prolonged state of hypoglycemia may cause permanent brain damage. Prevention is of greatest importance for controlling of hypoglycemia and tonic-clonic convulsive seizures. Therapy in these hypoglycemic states is intravenous administration of hypertonic glucose.
Objective: To determine the incidence of seizures during hypoglycemic states and its complications in primary health care settings.
Methodology: This retrospective study examined 145 diabetic patients of both sexes, aged 30-80 years who came for medical examinations in Health center Čukarica, Belgrade in 2015.
Results: The study included 145 diabetic patients with determined hypoglycemia, 34% male and 66% female, aged 30-80 years. Of the total number of examined diabetics only 9 (6.2%) had seizures. Blood glucose level was 2-3mmol/l in 65.5%, 2-1mmol/l in 28.3% and below 1mmol/l in 16.2%. Examined, who had a seizure, sustained injuries in 33.3%, 11.1% had epileptic status, while 88.9% were hospitalized. Of the total number surveyed, 75% received 10% glucose and 2% received 50% glucose intravenously.
Conclusion: Hypoglycemia, as a medical emergency state that can lead to severe convulsions, is very important from a medical point of view. Administering of hypertonic glucose solution solves the current state and prevents development of dangerous complications. However, proper implementation of prevention with patient education to timely recognize the symptoms of hypoglycemia and make regular glucose level controls, follow the guidelines in nutrition and diabetes therapy, will reduce the incidence of this disorder and development of seizures.

Keywords: Convulsions, hypoglycemia, diabetes

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Abstract number: 005

TRAUMATIC DIAPHRAGMATIC HERNIA

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Background: Traumatic diaphragmatic hernia occurs after injury and penetration or during interventions. It occurs most often on the left posterior diaphragm and can go through three stages: acute, latent and obstructive.
Synthesis: In the acute phase, injured may have tachypnea, hypotension, absence of respiratory sound over chest wall or intestinal peristalsis in the chest cavity. If the diagnosis is missed, the patient will slip into a latent phase. It is characterized by occasional visceral herniation with vague abdominal pain after meal, nausea, vomiting and belching. In obstructive stage, there is abdominal pain, distension and vomiting. Incarcerated hernia produces intestinal obstruction and ischemia. Tension viscerothorax indicates an increase in intrapleural pressure caused by a hernia resulting in a shift of the mediastinum to the opposite side leading to compression of the lungs and vena cava. Venous flow is reduced and accompanied by hypotension and hemodynamic collapse.
In the acute phase, chest radiography is the best screening test. When hernia is present in the chest cavity nasogastric tube can be observed. Other findings include elevation of the diaphragm, mediastinal shift, pleural thickening and atelectasis. Computed tomography does not detect small diaphragmatic gaps. Diaphragmatic injury should be suspected always after penetrating injuries of the lower left region of chest or upper abdomen. It

is important to confirm the hernia on the left side, as the spleen will not prevent it as does the liver on the right. Diagnostic peritoneal lavage is used to estimate intra-peritoneal bleeding. Laparoscopy is the best way to discover the small diaphragmatic gaps. It is important to consult a surgeon in the early stages.
Treatment starts with decompression by nasogastric tube and lowering of intra-thoracic pressure. In hypotensive patients and suspected pneumothorax indicated opening thoracostomy is indicated and be done with caution. Physician must check whether the tube is placed in the chest cavity safely of intestines and intra-peritoneal contents. As soon as confirmation of diaphragmatic injury is made, emergency surgical care is indicated.
Key words: traumatic diaphragmatic hernia, stages, diagnosis, treatment

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Abstract number: 006

Q-FEVER IN CITY OF BANJA LUKA IN FIRST THREE MONTHS OF YEAR 2016

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Introduction: Q -fever is an acute disease caused by Coxiella burnetii, and it belongs to a group of anthropozoonosis. The main reservoirs are sheep, cattle and goats that secrete Coxiella by feces, urine and milk, especially during parturition. The incubation period lasts from 9 - 28 days. About half of patients with general symptoms also have atypical pneumonia. Chronic infection can be presented as endocarditis, chronic hepatitis, osteomyelitis, pulmonary fibrosis and chronic vasculitis.
Objective: Insight in epidemiological data and differential diagnosis of febrile state, pneumonia and Q-fever in the city of Banja Luka, in period from 01.01.2016 to 22.03.2016.
Methodology: A retrospective analysis of Emergency Department protocols and protocols of Epidemiology department of Health center Banja Luka.
Results: The number of patients in the given period was 17, of which 15 men and 2 women. According to age most of the patients were 41-50 years old (6) and 31-40 (5) 51-60 (3) 61-70 (3). All patients were referred to Clinic for Infectious Disease, with diagnosis of febrile state and Pneumonia, where further laboratory-serological analysis were conducted and confirmation Q-fever was made.
Conclusion: Emergency Department did not register patients diagnosed with Q fever, while in the Epidemiology department 17 patients had been registered with the disease. The importance of prevention in order to fight the infection is in the scope of veterinary healthcare and education of the population that is in direct contact with animals. Training of healthcare workers to be able to timely recognize acute and chronic Q fever conditions is very important in early detection of this disease.
Keywords: Q-fever, early recognition in Emergency Department, Epidemiology service

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Abstract number: 007

DEHYDRATION AND REHYDRATION OF CHILDREN IN FEBRILE STATES IN ED HEALTH CENTRE BANJA LUKA IN FIRST TREE MONTHS OF YEAR 2015

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Introduction: Dehydration of the lack of water and electrolytes in the body. There are three forms of dehydration: isonatremic, hypernatremic and hyponatremic. Dehydration leads to hypovolemia that reduces MV and BP, which stimulates the hypothalamus and pituitary gland to secrete ACTH and cortisol, disrupt glycemia, causes sympathetic activation with consequent disturbance of homeostatic mechanisms. After compensatory phase, if further loss of fluid continues, decompensated phase starts. The clinical findings we can have are mild, moderate and severe dehydration. Treatment of dehydration is carried out by oral intake and parenteral routes.

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Objective: 1. To examine the number of patients with fever of unknown origin in the Children's Emergency Department of Health centre in the period from 01.01. to 01.04.2015. who had symptoms of dehydration, 2.Choice of treatment 3.Number of children sent to hospital treatment.
Methods: Retrospective analysis of protocols in the Children's emergency department considering patients with diagnosis of febrile state.
Results: From a total of 2271 patients examined, there were 478 children (21.05%) with diagnosis febrile state. Of these, 245 were male (51.26%) and 233 female (48.74%). According to age, most of the children were over 7 years, 161 (33.68%). 123 children (25.73%) had body temperature over 39°C, there were 316 with the body temperature up to 39°C (66.11%), and 39 were with a body temperature up to 37.5°C (8.16%). 216 children had significant laboratory findings, 96 had increased number of segmented leukocytes, indicating to a bacterial infection. Treatment Options: antipyretics (89.54%), antibiotics (37.87%), oral rehydration (89.54%), parenteral rehydration (0.42%), inhalation (3.35%). Of the 478 children 50 were sent to hospital treatment, 21 (4%) to Clinic for Infectious Diseases and 29 (6%) to Pediatric clinic. Other children were taken care of in the Emergency Department.
Conclusion: When examining patients - children with febrile state, it is important to successfully assess the general condition of the child, set accurate diagnosis and administer appropriate therapy. Due to the small number of children treated with parenteral therapy, great importance lies in education of parents in oral rehydration and regulation of body temperature in children. Also in relation to the small number of patients referred for hospital treatment, it reflects the correct choice of treatment in pre-hospital setting.
Key words: febrile state, dehydration, rehydration, choice of therapy

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Abstract number: 008

RESPIRATORY SUPPORT IN PATIENTS WITH POST CARDIAC ARREST SYNDROME

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Introduction: The successful return of spontaneous circulation (ROSC) is only the first step towards achieving the main goal - a complete recovery from cardiac arrest. The term post cardiac arrest syndrome (post CA Sy) consists of a complex of pathophysiological processes which accompany the ischemia of the whole body and subsequently reperfusion during cardiac arrest and after successful resuscitation. Post CA Sy includes post CA brain damage, post CA myocardial dysfunction, systemic ischemia/reperfusion response and persistent precipitating pathology.
Control of oxygenation: While 100% oxygen is used as standard in the initial stage of resuscitation (up to achieving ROSC) animal studies and observational clinical studies indicate the potential harmful effect from oxygen toxicity in further treatment. Patients who had a brief period of cardiac arrest (prompt response to appropriate treatment) and who do not require endotracheal intubation and ventilation, but should be given supplement oxygen by mask if SaO2 <94%. Namely, hypoxemia as well as hypercapnia increase the possibility of reoccurring of cardiac arrest and could lead to secondary brain damage. However, some studies in animals have shown that hyperoxemia early after ROSC causes oxidative stress and damages post-ischemic neurons. One study in animals (dogs) showed that in the first hour after ROSC administration of oxygen at a concentration sufficient to achieve SaO2 of 94-96% is associated with better neurological recovery than the use of 100% oxygen. Multicenter clinical study (included database from intensive care unit in 120 hospitals in the US) which included 6326 patients with out of hospital cardiac arrest also showed that post-resuscitation hyperoxemia (PaO2> 300mmHg) in the first 24 h was associated with a worse outcome compared to normoxemia and even hypoxemia.
Control of ventilation: Consider endotracheal intubation, sedation and controlled ventilation in patients with impaired brain function (Vt 6-8ml/kg, PEEP 4-8cm H2O). Hypocapnia, caused by hyperventilation leads to vasoconstriction, cerebral ischemia and unfavorable neurological outcome. Hyperventilation also increases intrathoracic pressure, with consequent reduction in venous return of blood to the heart, leading to a drop in

cardiac output. In the absence of relevant data from prospective studies (which are underway), it is recommended to provide normocapny with adequate ventilation (monitoring - capnometry, blood gas analysis). In patients with post CA syndrome nasogastric tube should be introduced (reduces the pressure in the stomach after mouth-to-mouth ventilation or balloon-mask ventilation), consider giving bolus doses of neuromuscular blocking agents and the implementation of continuous EEG. If necessary, check the positioning of the tube by radiological chest imaging and detect CPR complications, such as pneumothorax caused by a fractured rib.
Conclusion: It is a great challenge for the physician, particularly in the pre-hospital setting, when he has a patient with post CA Sy, to maintain adequate oxygenation and ventilation, and provide normoxemia and normocapnia and avoid complications in the form of barotrauma, volutrauma of lungs and depression or cardiovascular function.
Keywords: Post CA Sy, oxygenation, ventilation, normoxemia, normocapnia

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Abstract number: 009

THE PREVALENCE OF ARTERIAL HYPERTENSION IN THE EMERGENCY DEPARTMENT PODGORICA IN YEAR 2015

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Introduction: Despite substantial preventive work, easily accessible and adequate antihypertensive therapy, patients with high blood pressure are still common in the outpatient work of physicians in emergency medical services. The prevalence of hypertension is high both in Montenegro and surrounding countries as well as in other parts of Europe. Improper diet, physical inactivity, smoking, alcohol consumption, stress in the everyday life and working environment contribute to the appearance of high values of blood pressure even at a young age.
Objective: The aim of this paper is to show the prevalence of hypertension in Emergency department in Podgorica in 2015.
Materials and methods: The survey was conducted during March 2016, and as material we used written protocols of the Emergency department Podgorica from 2015. In statistical analysis descriptive statistics methods were used.
Results: Of the total number of patients examined in 2015 which was 58.009, of them 5.677 had hypertension, 2.899 men (51.07%) and 2.778 women (48.93%). Arterial hypertension occurs in ages of 20-29 years in 6.25% of men and in 3.1% among women. Between 30-39 years men were 13.11%, and 6.8% of women. Percentage for years 40-49 that had hypertension were 19.39% for men and 15.19% for women. In the age group of 50-59 years the percentage was 22.80% men and 26.46% women. In the group of 60-69 years old the percentage was 22.90% for men and 26.89% women, while at the age of 70 years and more percentage of men were 14.9% and women 21.49%. Research has shown that hypertension occurs in a larger number in men than women, 1.04 times more. The highest percentage of men with measured high values of blood pressure are 60-69 years old, as is in women. In the group aged 20-49 years, the number of men with high values of arterial blood pressure is higher than in women; there are more women in group of 50-69 years, and at the age of 70 and more. Greatest number of patients with high blood pressure was in January 2015, 619 of them (10.90%).
Conclusion: Arterial hypertension and complications as a result of it are a significant factor in morbidity and mortality and they indicate the need for constant preventive work, continuous education of patients and members of their families, and because of this it is inexhaustible topic for the professional public.
Keywords: arterial hypertension, prevalence, Emergency department Podgorica

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Abstract number: 010

IMPORTANCE OF PATIENT'S OBSERVATION IN EMERGENCY MANAGEMENT

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Case report: On 18th of January 2016 emergency medical team gets the vague description of the symptoms of the caller, but since he is the first neighbor of doctors in shift, the call is accepted.
At the scene we find a patient who walks around the room, holding his stomach. He complains of pain in the stomach and hands ("his hands are heavy, languor, it is difficult for him to lift them up"), bloating that lasts most of the morning and from last 30 minutes got worse (while he was cleaning the snow and was bent). He also states that he has "stomach ulcer" and that he had little too much food previous evening. He took Tbl. Espumisan, in order to "relieve the stomach" and "reduce bloating". Patient is a retired medical technician. Now he feels a little better. He says that similar situation occurred and few day ago when he carried some weight to the car, he was unable to bring the load in the car due to the pain in his hands. On examination we determined following: BP 170/110 mmHg ("he never had that high BP"). Heart and lungs: normal. ECG - sinus rhythm, HR 53 / min, with no signs of ischemia and lesions. Peripheral pulses are present, symmetrical, well filled. Abdomen: above the chest, slightly painful on palpation in epigastric region, with no radiation of pain, audible peristalsis which is not accelerated. Neurological examination shows no abnormalities. Glycemia 6.5mmol/L. Patient was transported to the emergency department with following therapy: Amp. Ranisan, Tbl. Aspirin 300mg, Spray Nitrolingual II sl. During observation, patient is intermittently better and worse, but the pain is still present. Repeated ECG recording after 40 minutes showed signs of anterior STEMI. IV line was placed, further therapy: Tbl. Plavix 300mg, Clexane 0.3 ml IV, spray Nitrolingual II sl. Patient was referred for further management to internal ward of ZC Zajecar, where he immediately underwent coronary angiography and pPCI of LAD.
Conclusion: This emphasizes and reminds, especially young doctors, that experts caution (along with medical knowledge, of course) and expecting attitude when in dubious conditions, is very important while establishing diagnosis and treatment of patients, especially in out of hospital settings, where the triage decisions are more difficult than in the hospital. It is always better to wait, keep the patient "on the eye", if the diagnosis is uncertain, until all available diagnostic criteria are utilized. Differential diagnosis is a broad field, and probably not so important in any branch of medicine as it is in emergency medicine.
Keywords: observation, emergency medical service

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Abstract number: 011

ANOMALOUS ORIGIN OF LEFT CORONARY ARTERY FROM THE PULMONARY ARTERY – IMPORTANCE OF ECHOCARDIOGRAPHY IN EARLY DIAGNOSIS AND ADEQUATE SURGICAL TREATMENT

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Anomalous origin of left coronary artery from the pulmonary artery (ALCAPA) is a very rare congenital anomaly. In a normal heart, the left coronary artery emerges from aorta and nourishes the heart with blood that is rich in oxygen. In children with ALCAPA left coronary artery arises from the pulmonary artery and carries deoxygenated blood from the lungs to the heart. If not detect timely the majority of patients die in early childhood from ischemic cardiomyopathy. In 1962, Fontan and Edwards showed 58 post mortem specimens of this anomaly, deceased in early childhood.
We are presenting a female infant aged 7 months, which was examined due to respiratory infection by primary health care. Heart murmur was detected and it was sent to cardiologist. From personal history: the baby full-term newborn, BW 3400gr, BL 52cm, AS 9/10. It is developing normally for the first 5 months. The 6th month of life a

viral infection of the upper respiratory tract developed. Since then it stagnated in weight, occasionally sweats on the forehead during feedings, has no languor, and does not breathe fast.
Objective findings: without clear signs of heart failure, eupnoic, pale, without cyanosis, HF 100 / min, RF 32 / min, SatO2 94%. At the heart apex systolic murmur 3/6 can be heard which propagates toward the axilla. The liver can be palpated 1 cm below the rib cage. Radiographic, TCI> 55%, there are electrocardiographic signs of ischemia and myocardial fibrosis of the lateral wall (deep Q waves in I, aVL and precordial leads in V5 and V6). Echocardiography has shown clear dilatation and hypocontractility of left ventricle EF <30%. Mitral apparatus fibrosis, MR 2/4. Grave fibrosis of the mitral apparatus and the whole heart has prompted suspicion of ALCAPA. From a short parasternal cross-section, anomalous left coronary artery (LCA) origin from the pulmonary artery can be seen. Right coronary artery (RCA) has adequate origin and is dilated. The diagnosis is confirmed with echocardiography as well as with angiography of coronary arteries. Immediately after the diagnosis, cardiac surgery was performed, left coronary artery transfer, with normal postoperative and long-term postoperative course. One year after the surgery there was good general condition. Normal growth and development, BM 12kg and BH 77cm.
Conclusion: ALCAPA is a rare but life-threatening congenital anomaly. The possibility of early echocardiographic diagnosis and improvement of surgical techniques allowed the prognosis of patients with ALCAPA to dramatically improve.
Keywords: left coronary artery, pulmonary artery, myocardial ischemia, dilated cardiomyopathy

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Abstract number: 012

MET AND ASA CLASSIFICATION AS PREDICTORS OF PERIOPERATIVE COMPLICATIONS IN ABDOMINAL SURGERY

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Introduction: According to the revised guidelines of the American College of Cardiologists and the American Heart Association in 2014 for perioperative evaluation of patients who are consequently subjected to non cardio surgery, metabolic equivalent (MET), which is an indicator of functional capacity, is a reliable predictor of perioperative cardiac complications (KVS). According to the American Society of Anesthesiologists, ASA Classification (ASA) is an important predictor of postoperative mortality.
The objective is to examine the possibility of predicting perioperative complications with MET and ASA.
Materials and Methods: The study included 35 patients of both gender aged 30 to 86 years, who had undergone major abdominal surgery in KBC Bežanijska Kosa. The group of patients with complications (SKG) consisted of 11 patients and a control group without complications 24 (KOG). According to anamnestic data in the history chart we have determined MET and ASA classification, and then followed the clinical course of patient until the end of treatment in the hospital and registered the following complications: death, surgical complications (wound infections, anastomosis leak, reintervention) and KVS complications (myocardial infarction, pulmonary edema, ventricular fibrillation, cardiac arrest and complete heart block). Values of ASA were from 1 to 3, a value of MET1 (MET less than 4 indicating bad or unknown functional capacity), 2 (MET value of 4-6, indicating the medium functional capacity) and 3 (for values MET greater than 7 indicating good and excellent functional capacity).
Results: SKG 4 patients had surgical and cardiovascular complications, ASA values were 2,3,3,3, and MET in one patient was 1, while the other three was 2. Isolated surgical complications was found in 5 patients, their values ASA were 1,2,2,2,3, MET in four patients was 2, and in one was 3. Isolated KVS complications was found in 2 patients were ASA values were 2 and 3, and MET was in both 1. Five patients with complications had a fatal outcome, their ASA values were 1,2,3,3,3 and MET 1,1,1,2,2. In the group of patients with postoperative complications MET ($p < .05$) had significantly lower value and ASA had significantly higher value, compared with the control group ($p < 0.05$). The group of patients with postoperative KVS complications had statistically lower MET ($p < 0.05$) and when it comes to predicting a lethal outcome has proved to be a significant predictor.

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Conclusion: To assess the overall risk of postoperative cardiovascular complications after major abdominal surgery MET and ASA classification can be used. None of the classification was a predictor of abdominal complications. The only predictor of postoperative mortality is a poor functional capacity (low MET).

Keywords: preoperative evaluation, operative risk, functional capacity, MET, ASA

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Abstract number: 013

THE IMPORTANCE OF PERFORMING PERCUTANEOUS TRACHEOTOMY (PT) IN PATIENTS ON PROLONGED MECHANICAL VENTILATION (MV) - OUR EXPERIENCE

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Background: Percutaneous tracheostomy is a minimally invasive airway management technique. It began to be applied in 80-ies of the last century when it was performed by ENT surgeons. Today it is a procedure that is performed in the ICU or in the operating room. It can be performed by trained physicians, ENT and most often intensivists and anesthesiologists. The most common indications are prolonged mechanical ventilation, airway protection and improved tracheal-bronchial branch toilet or when it is necessary to overcome airway obstruction. This method avoids the complications of surgical tracheostomy, bleeding, injury of the thyroid gland, esophagus, wound infection around the tracheostomy, narrowing of the trachea, emphysema of soft tissues of the neck and mediastinum, tracheomalacia. Discontinuation of MV is made earlier, risk of aspiration is reduced, as is airway resistance, reduction in dead space and while spontaneous breathing and better oral hygiene.
Objective: is to show the importance of performing PT in critically ill patients on PV in the ICU.
Materials and methods: In a prospective study we have examined critically ill patients in the KBC "Bežanijska Kosa" in ICU II and ICU III in the period from June 2014 to March 2016. Percutaneous tracheostomy had been performed. Patients were between 60-79 years old. On the neck of the patient determine the approximate point at the level of 1-2, or 2-3 tracheal ring, make an incision in the skin of the neck. Fine guided needle enters the trachea. The needle is removed while the thin guidewire remains in the trachea. Over guidewire are introduced corresponding dilators that expand the opening in the neck and trachea to the width of endotreheal cannula. Dilator now can be removed and endotracheal cannula is placed. Is checked the functioning of the cannula is checked, and confirmation of adequate ventilation is made.
Results: The total number of patients was 15. In 14 patients it was elective interventions and in 1 patient the PT was an urgent intervention to secure the airway (Ca of base of the tongue). Length of stay on MV in 8 patients was 21 days, at 3 lasted 18 days and at 3 for 15 days. Prior to intervention of placing PT, patients or relatives have been requested a written consent. Patients underwent basic laboratory (complete blood count, biochemical analysis, coagulation status). In 12 patients PT was performed in the operating room with a prepared set for PT and set to perform surgical tracheostomy. The team was consisted of two anesthesiologist, anesthetist, nurse and surgeon who is trained to perform surgical tracheostomy. In 2 patients, the team was made of two anesthesiologists and nurse anesthetist. In all patients the intervention was performed under general anesthesia with standard monitoring. After the placement PT position was checked by auscultation, aspiration catheter, patient monitoring (pulse oximetry, capnometry), blood gas analysis, X-ray of the lungs. In 1 patient ventilation was impossible, so he was re-intubated (paratreheal introduction of the cannula).
Conclusion: Percutaneous tracheostomy is a simple and effective method for airway management in patients on prolonged MV with a small number of complications. It takes the involvement of a small number of staff and resources so we can say that it is relatively inexpensive method. Training to perform PT is simple.

Keywords: Percutaneous tracheostomy, prolonged mechanical ventilation

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Abstract number: 014

PERIDURAL AND INTRAVENOUS LOCAL ANESTHETICS IN THE TREATMENT OF PAIN IN ACUTE PANCREATITIS

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Introduction: According to the American College of Gastroenterology Atlantic revision criteria (2013), AP is divided into mild, moderately severe and severe form. Intravenous administration of lidocaine is effective for treatment of visceral pain and may improve intestinal function.
The objective is to examine statistically significant difference between intravenous and peridural application of local anesthetics.
Materials and methods: In 10 patients who were admitted to the ICU of our hospital with the form of light and moderately severe AP, in 5 patients we have placed EDK (EDKG), as with the other 5 we applied intravenous lidocaine (LG). Patients in EDKG received 0.125% bupivacaine (Marcaine). Patients in the bolus LG were given a dose of lidocaine 1,5-2mg/kg followed by infusion of lidocaine at a dose 1,5-2mg/kg/h for next 24h. We compared pain intensity based on the VAS scale 1-10, the need to add other analgesic (ketorolac, tramadol), the time to occurrence of peristalsis and time to occurrence of gas. The measurements after admission to the ICU were made every 2h on the first day and the second day every 4h.
Results: In EDK group in three patients we did not add another analgesic. One patient received 30mg of ketorolac and 50mg of tramadol. In one patient, due to inadequate position of the catheter, we continued with classical analgesia. In LG group two patients did not need the additional analgesics, two received 30mg of ketorolac and 50 mg of tramadol. One patient infusion had to be stopped because of side effects of lidocaine. VAS score in the group with EDK was 1.6 ± 2.4 and in the LG group, 1.8 ± 3.1. In EDK group peristalsis could be heard 12.5 ± 7.5 h, and the first gas occurred 22.5 ± 13,5h and in LG group peristalsis occurred 10.7 + - 5,5h and first gas 15.5 ± 6,2h. In one patient from the LG group with moderate form of AP, intravenous lidocaine was repeated in the same manner 14 days after the first administration with the same results. These are the first result of our research which will continue.
Conclusion: In AP of mild and secondary severe forms, the use of EDK and intravenous lidocaine in the treatment of pain, a shorter onset of peristalsis and prevention of ileus had no significant difference. We believe that the use of lidocaine infusion is less invasive and easier to use than the application of EDK.
Keywords: Acute pancreatitis, EDK, infusion of lidocaine

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Abstract number: 015

PRESENTATION OF THE URLA INTERNATIONAL EMERGENCY DISASTER, TRAINING AND SIMULATION CENTAR (URLASIM) MINISTRY OF HEALTH, REPUBLIC OF TURKEY

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Urla Emergency, Disaster, Training and Simulation Center (UrlaSim), which is affiliated to Ministry of Health is within Quarantine Island of Urla, 38 km. distant from Izmir. Urla State Hospital which was built in 1955, the Training and Simulation Center, historical Quarantine building is located on the island. Ministry of Health approved the training center and accommodation facilities to be used as
"International Emergency, Disaster, Training and Simulation Center". There are 20 treaining and education saloons in Urla SIM. We have 40 hotel rooms and 97 beds capacity.
Introduction: Over **10.000** participants attended to certified training pro-grams since 2004 all around the country. These certified training programs are for 112 emergency medical services and National Medical

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Response Teams (NMRT) personnel; and fulfilled at the natural training/practicing areas and training halls of the island. Also international ambulance competitions and emergency medical services symposiums were organized in 2005, 2008 and 2010 years in the island. National and international ambulance teams re-sponded to scenario based cases and evaluated according to their medical interventions. Also several projects, trainings and workshops were conducted with ambulance teams and emergency medical specialists from other countries. General Directorate of the Ministry of Health Emergency Medical Services and Project Administration Support Unit prepared World Bank project in 2012 for UrlaSim. World Bank Authorities approved the project, so simulated and computerized mannequins; software programs that will be used in training programs, will be purchased.**Emergency Medical Services Training Programs:** Basic Life Support Module (5 days); Adult Advance Life Support Course (3 days);Pediatric Advance Life Support Course (4 days); Trauma Life Support Course (4 days); Ambulance Driving Techniques Course (5 days); Neonatal Resuscitation Course (3 days); Ambulance Team Standardization Training (1 day); 112 Command and Control Center Training (2 days); Air Ambulance Basic Training (5 days); Emergency Health Instructor Trainings; First Aid Course (2 days); First Aid Instructor Course (5 days); First Aid Master Instructor Course (5 days) **Disaster Medicine Training Programs:** Medical Incident Command Course (2 days); Hospital Disaster Planning Course (3 days); Disaster Medicine Training (5 days); NMRT* Basic Training (8 days); NMRT Wrecked Area Training (2 days); NMRT Water Rescue Training (2 days); CBRN Training (2 days) ** National Medical Response Team*

2015 National Trainings: Emergency Health Basic Training-Module Number of Training 3 (Participiants 69); Advanced Life Support Course- Number of Training 6 (Participiants 130); Advanced Pediatric Life Support Course-Number of Training 1(Participiants 18); Trauma Life Support Course- Number of Training 12(Participiants 269); Approach on Criminal Cases Course-Number of Training 7(Participiants 292);

2015 International Trainings: Country: Albany (Participiants 64); Benin (Participiants 4); Hungary (Participiants 17); Kirghizia (Participiants 30); Lebanon(Participiants 16); Macedonia (Participiants 45); Mongolia (Participiants 16); Republic of Cote D'Ivoire (Participiants 4). Total number:196.

Conclusions UrlaSim turned out to be a specialized training center for team work, patient safety and scenario based simulated training programs with experienced instructors from 2013. Beginning form 2014 year, it is planned to open; simulated hospital trainings (emergency room, intensive care unit, operation room, sterilization, etc.) in hospital building, emergency and disaster simulation software-assisted trainings, hands-on and tabletop exercises in the island. Protocols were signed with international and domestic universities in order to provide international accreditation for participating health personnel to the future courses.

Keywords: international training, Urlasim

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Abstract number: 016

WHAT TO DO IN THE FIRST HOUR IN PATIENTS WITH ACS ?

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Aim: The aim of this presentation is to determine the first hour implementations of the patients with ACS.

Results: There are three different entities of acute coronary syndrome (ACS) encompassing the acute manifestation of coronary heart disease: ST elevation myocardial infarction (STEMI), non-ST elevation myocardial infarction and unstable angina pectoris (UAP). In first hour after onset of symptoms, out of hospital treatment and initial therapy in emergency department may differ according to resources and local capabilities. Typical symptoms of ACS are radiating chest pain, shortness of breath and sweating. However, 12-lead ECG and cardiac biomarker testing should be part of the initial evaluation of all patients with symptoms cardiac ischaemia. For diagnosing myocardial infarction in the first hours after the onset of symptoms, there should be no delay in release of biomarkers from damaged myocardium. Effective screening techniques of patients with suspected ACS, but with negative ECG and negative cardiac biomarkers are non invasive imaging techniques like CT

angiography, cardiac magnetic resonance, myocardial perfusion imaging, and echocardiography. Also, echocardiography should be routinely available in emergency department for all patients with suspected ACS.
Conclusion: For treatment of ACS one of the therapeutic agents is glyceryl trinitrate. If the systolic blood pressure (SBP) is above 90 mmHg and the patient has ongoing ischaemic chest pain glyceryl trinitrate may be considered. For nitrate-refractory pain morphine is the choice for analgesia and also has calming effects on the patient making sedatives unnecessary. At the same time morphine is a dilator of venous capacitance vessels, it may have benefit in patients with pulmonary congestion. Patients with presumed ACS do not need supplemental oxygen unless they have signs of hypoxia, dyspnoea or heart failure. But if ACS is complicated with cardiac arrest, hypoxia develops therefore during CPR adequate oxygenation is essential. 100% inspired oxygen should be used until arterial blood oxygen saturation is achieved in the range of 94–98%. For inhibition of platelet aggregation, acetylsalicylic acid (ASA) and ADP receptor inhibitors may be used. Oral loading dose of ASA (150 to 300 mg of a non-enteric coated formulation) or 150 mg of an IV preparation should be given as soon as possible to all patients with suspected ACS unless the patient has a known allergy to ASA or has active bleeding. ASA may be given by the first healthcare provider, bystander or by dispatcher assistance according to local protocols. Clopidogrel and prasugrel may be used as ADP receptor inhibitors also. Antithrombins like unfractionated heparin (UFH) which in combination with ASA is used as an adjunct with fibrinolytic therapy or PPCI and is an important part of treatment of unstable angina and STEMI. Also enoxaparin, fondaparinux and bivalirudin are the agents of antithrombins used in ACS. Reperfusion should be initiated as soon as possible using the most appropriate available strategy for patients presenting with STEMI within 12 h of symptom onset. Reperfusion may be implemented with fibrinolysis, with primary percutaneous coronary intervention (PPCI), or a combination of both. Efficacy of reperfusion therapy is profoundly dependent on the time interval from symptom onset to reperfusion. Fibrinolysis is effective specifically in the first 2 to 3 h after symptom onset; PPCI is less time sensitive. As a result, sufficient management of ACS using sufficient drugs and interventions especially in first hour of onset may be life saving.
Keywords: Acute coronary syndrome, ACS treatment

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Abstract number: 017

RESPIRATORY ARREST IN PATIENT WITH COPD AND HEART FAILURE – CASE REPORT

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Case report: A neighbor calls EMS because of the patient R.Ž. 74 years old, who is feeling short of breath, has swollen legs and abdomen for a significant period of time and call was received as a third line of emergency. Patient is sitting in bed, conscious, oriented, dyspnoic, tahypnoic and pale, he is not sweating and has pronounced peripheral cyanosis. He complains of difficult breathing and notes that he has COPD. Examination found following vital parameters: BP 80/50 mmHg; HF about 136 / min; RF 24/min, we were not able to measure SpO2; BT normal. Breathing sound in diminished on both sides and crackles are present at one half of lung. Heart action is arrhythmic, sounds are slightly diminished and fast, murmurs are not heard. Pretibial edema is prominent, there is no signs for ascites. ECG: AFib HR 70-140/min, right heart axis, with no clear signs of ischemia, with a flattened T wave in D3 and aVL. Occasional VES. IV line is placed, ECG monitoring, and O_2 2L / min is adminitred and transport begun to Clinic for cardiology. Amp Aminophylline was prepared and we intend to give it during transport. Upon entering the ambulance patient makes bizarre movements of the arms and face and loses consciousness. He stops breathing. Amp Adrenalin IV is administred, patient is intubated in the first minute ETT No8, O_2 5L / min, ventilation frequency is 10 / min. Chest compression are started. On the monitor it appears to be VT with present pulse which is why we gave amp Amiodarone 150 mg IV bolus. After 3-4 min spontaneously shallow respirations occur. We continued with assisted ventilation and after 3min patient begins to breathe evenly with a frequency of about 12 respirations per minute. Further, patient gets the urge to vomit, do not tolerate the ET tube so we decided to extubate her. The patient begins to react to external stimuli by opening the eyes and after 10 min to calling her by name.

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Conclusion: We believe that the respiratory arrest in this case occurred with the presence of heart failure and respiratory failure, VT is present can be explained by dilated cardiomyopathy that was later confirmed by ultrasound. Quick and adequate response to enable the maintenance of vital parameters is a prerequisite for the performance in the process of resuscitation.

Key words: respiratory arrest, heart failure

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Abstract number: 018

HEADACHE AS A FIRST AND PREDOMINANT NEUROLOGICAL SYMPTOM OF ENCEPHALITIS, CASE REPORT

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Introduction: The headache is the most common neurological symptoms in humans. Encephalitis is a disease in which one of the main symptoms are headache, vomiting, fever, impaired consciousness (80% patients), and focal neurologic signs (1). It most often begins suddenly, is progressive and has a high risk of complications and sequelae (1). In about 75% of cases there are history details of previous respiratory infection, pharyngeal inflammation, enterocolitis, rash viral diseases, lymph nodes swelling (1). Most adults recover without sequelae, which can occur in 3-70% of patients. Mortality occurs in 3-30% of patients (1).Case report: Female 29 years old with no previous medical history was brought into emergency medical service due to loss of consciousness which have lasted 10 minutes, according to eyewitnesses. When she regained consciousness she did not vomit and there was no involuntary urinating or defecation. The patient did not feel tired. Relatives note that in the past 5 days patient complained of headaches that did not subside to painkillers (Ibuprofen). She correlated headaches with the change of weather and seasons shift. She describes pain throughout the whole head and in the form of pressure. She denies other neurological disturbances. She is without increased temperature. On examination, vital signs are normal, (BP, pulse, EKG, Gly, Sat O2). Neurological findings except confusion and incoherent speech remained unremarkable. Meningeal signs were negative. That same evening, she was examined by neurologist who found no disturbances and ordered RO of the cervical spine and EEG, on suspicion of epilepsy. The headaches continued, and 2 days later, before her arrival to genera physician she lost consciousness. She was unconscious for less than 10 min. When she regained consciousness, she vomited and gave the impression that she is sleepy. Neurological examination was normal again. In consultation with the doctor it is decided for her to return home and to come tomorrow for laboratory analysis. In the morning, family members were not able to wake her up. They brought her to EMS. On examination, she reacted to painful stimuli with motor response, did not open her eyes, GCS 4, as for meningeal there was stiff neck. She was taken to neurology and then referred to Clinic for Infectious Diseases, where viral encephalitis was confirmed based on the findings of cerebrospinal fluid. The patient continues to be hospitalized.

Conclusion: Headache as a symptom may be a result of some harmless conditions that do not require treatment, but it can also be the result of conditions that are life threatening. It is vital that we approach even the most harmless forms of headache with greater caution in order to get information from clinical and diagnostic findings as soon as possible and therefore be able to timely help the patient and prevent serious complications that would affect the outcome of the disease itself.

Keywords: headache, loss of consciousness, neurological examination, meningeal signs, encephalitis

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Abstract number: 019

LEFT ANTERIOR FASCICULAR BLOCK PRIOR TO ACUTE MYOCARDIAL INFARCTION- CASE REPORT

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Introduction: Myocardial infarction has characteristic ECG changes that point to developing of this emergency state. On the other side, ECG is often regular or without significant changes in first moments, which often can be misleading.
Objective: Case report of a patient in whom left anterior fascicular block preceded acute myocardial infarction.
Case report: 54 years old patient had myocardial infarction with ST elevation, presides by left anterior fascicular block. During morning hours of the day, patient had mild physical activity when he experienced strong chest pain in front left side. Health center was in near proximity of the event and he was examined in first 5 minutes with ECG print, which with preexisting left anterior fascicular block, showed no ST changes and no conduction disturbances. Patient was diaphoretic, holding to his chest and was extremely fatigued. Blood pressure was normal. Patient was given sublingual nitroglycerine two times and after 10 minutes he was without any discomfort. Patient even wanted to get up and leave, because he had felt good, but he was held for another ECG, which now shoved ST segment elevation of 3-4mm in D2, D3, and aVF leads, with clear ST segment depression in contra-lateral leads. Patient was given acetylsalicylic acid and clopidogrel and he was transported to Clinical center where coronarography shoved occlusion of right coronary artery. Two coronary stents were placed and patient was admitted for further treatment. Apron recovery, in his medical documentation patient found earlier ECG print, from one year before myocardial infarction, which did not show left anterior fascicular block.
Conclusion: In this case, left anterior fascicular block was obviously the firs sign in ECG for AMI of inferior wall, which after short period of time transformed to ST elevation. Typical clinical findings remained dominant sign, and in the cases when ECG is normal or without significant changes, demands caution and observation of the patent.

Keyword: infarction, fascicular block, ECG.

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Abstract number: 020

SUICIDE ATTEMPT BY HANGING – CASE REPORT

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Introduction: According to the World Health Organization million people a year commits suicide. Every 40 seconds a person in the world commit suicide. In Europe, the average 30.000 people commit suicide in a year. Studies have shown that more than 90% of people who committed suicide were suffering from depression or other mental disorders, or was prone to substance abuse. It is prominent that the number of male suicide is greater than in women, and that the number of suicide in our country is the greatest in people with no school completed or uncompleted primary school.
Case report: Man 57 years has tried to commit suicide by hanging. Before EMS medical team arrived, neighbor and patients wife took him off the gallows. The physician notes spontaneous breathing, BP 110 / 70mmHg, GCS 3, pupils were narrow, motor response on stimulation was with decorticate reaction (arm flexion and leg extension), there was no verbal response. Impression of noose around his neck and larynx deformity could be seen. We immobilized his neck at the scene. The hospital he was examined by a neurologist, internist and anesthesiologist. Internist noted that the vital signs were normal. Neurologist, based on decorticate reaction, suspected serious ischemic disturbances. Corticosteroid was given intravenously. The patient was intubated with maximum caution due to deformities of the larynx and transported to neurosurgery. Patient was than extubated

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because was breathing spontaneously. At the ED MSCT of head and neck was done, which showed that there were no change in ischemic brain injuries or cervical spine fractures but is only dislocation of hyoid bone to the left and upward and soft tissue structures were in order. Patient was kept for observation due to the expected brain edema. A few days later he made a full recovery and for further treatment he was sent to psychiatrist.
Conclusion: Is there suicide prevention? Thanks to the profession that we do we are trained to recognize changes in the behavior of our closest. Are we really competent to do that with our patients if we are not their physicians or psychiatrists? Maybe we should raise awareness of our citizens the fact that things like this happen, but that is a topic for some other conferences. It is certainly important that when we have suicide attempt patient, all the procedures set by the protocol in such situations should be performed!
Keywords: suicide attempt, vital signs, decorticate reaction, MSCT of head and neck

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Abstract number: 021

PRIMUM NON NOCERE, THE MOST IMPORTANT ETHICAL PRINCIPLE IN MEDICINE BUT ALSO A NECESSARY GUIDANCE IN CRITICAL SITUATIONS – CASE REPORT

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Introduction: After tightening the penal policy of traffic offenders in our country, the number of victims and injured in traffic accidents is reduced. In the period from 2010 to 2014, that number was an average of 653 persons killed per year, while the number of injured was 18,714 persons per year (1). For the year 2014, 536 persons who were killed, and there were 14,720 injured (1). The death toll for cyclists for that period was 299 (1). We are aware that pedestrians, cyclists and motorcyclists, according to the World Health Organization, are the most vulnerable traffic participants! The right way to act when someone is injured in a car accident is very important! All drivers should know this, and is it really so? We as medical workers all know what “Primum non nocere” means and it is obvious that it is necessary for us to get the rest of the population educated of this matter!
Case report: A woman 59 years, cyclist, was hit by a car in the rear wheel as she pulled to the right. When falling she had hit her head on concrete, parieto-occipital part and immediately lost consciousness. This all happened before the eyes of her son and daughter who ran up, raised her without prior immobilization of the cervical spine and transported to the nearest medical facility. At the health center cervical collar was placed, vital signs were normal, she was spontaneously breathing but she did not regain consciousness. For the transport airway was placed. On her head she had laceration and contusion wounds with no visible signs of the skull bones fracture. At the hospital she was intubated, the wound was sutured and she was referred to neurosurgeon. In the emergency room, MSCT of head and neck was performed, where comminuted fracture of the C2-C4 was seen with foreign object in spinal medulla. The prognosis was negative, with very low survival with quadriplegia. With all resuscitation measures, patient died after 3 days.
Conclusion: From this case we see how important it is that the entire population is educated in providing first aid! We even do not have to focus on the trauma as this case, but to any situation where someone's life or health is in danger! Despite the great desire to help someone it is very important not to cause any harm because of lack of knowledge! That's why it is one of the most important ethical principles of medicine, Primum non nocere (first do no harm, or first not make any damage)! We are obliged raise awareness of the people around us about the importance of first aid procedures, when this situation comes! This is our task and mission!
Keywords: primum non nocere, traffic accidents, head trauma, immobilization of the cervical spine

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Abstract number: 022

NOCTURNAL HYPOGLYCEMIA – CASE REPORT FROM PRACTICE

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The term hypoglycemia is of Greek origin and literally means "drop in blood sugar". Hypoglycemia is the most common acute complication of diabetes which emergency medicine physicians have in the field. In most cases it is without focal neurological and meningeal signs. After treatment with hypertonic glucose it usually resolves to full recovery of consciousness.

Objective: Case report that highlights the importance of rapid response to hypoglycemia case, because prolonged hypoglycemia can sometimes lead to death.

Materials and methods: Case report of a person with hypoglycemia in emergency medical service Vlasotince. The material is protocol review of emergency medical service Vlasotince, protocol number 3896 from 18.03.2016.

Case report: On 18.03.2016. (Protocol No 3896 EMS Vlasotince) after obtaining calls from patients brothers at 05:30h ambulance team was activated in the first minute upon call is received, and was at the scene in five minutes. Patient V.B. 61 years old from Vlasotince otherwise long-term diabetic (over 15 years) on insulin therapy was found in bed, unconscious, with spontaneous breathing and present pulse of the a.carotis. Pupils are dilated medium, slowly reactive. Skin is pale, cold and damp. Hetero anamnesis by brother, we hear that the patient is a long-term diabetic on insuin therapy, that she took evening dose of insulin, and that this morning he could not wake her up for work. He notes that in recent times there were problems with the regulation of blood sugar. Vital parameters: BP 170/80 mmHg, HR 70 / min, RF 18 / min. SpO2 96%, BT 36.8 C, Gly 1.2 mmol / l, ECG sinus rhythm without signs of ischemia. Therapy approach IV line was placed and hypertonic glucose (Sol.Glucosae 50%) and 20 ml + 20 ml + 20ml was given. After that, there was a rapid recovery and re-measured Gly was 6.8 mmol / l. Patient wakes up, answers questions but she is quite confused and says she has such falls in sugar blood levels more often lately. Neurological examination shows no abnormalities and referral to endocrinologist was recommended.

Discussion: Hypoglycemia, occurs when blood sugar levels are too low. It is common in people with diabetes who use insulin, and in some patients who use medications that orally. The lowering of blood sugar levels in patient with diabetes are caused by one of the following:

- Too much insulin administered
- Do not eat enough food
- Too much exercise without snacks
- Waiting too long without a meal
- Drinking too much alcohol

Symptoms of low blood sugar: sweating, trembling, hunger, anxiety. If nothing is done, symptoms become more serious: difficulty in walking, weakness, blurred vision, strange behavior and personality, confusion, loss of consciousness and seizures. Low blood sugar level generally is defined as 3.3 mmol / l or less. Low blood sugar levels during sleep (nocturnal hypoglycemia) can disrupt sleep, but most often is unnoticed. Nocturnal hypoglycemia is a form of unnoticed hypoglycemia. Therefore, if there is night-time hypoglycemia it is harder to notice the symptoms that indicate the need for treatment. Nocturnal hypoglycemia may be difficult to diagnose and can increase the risk of unnoticed hypoglycemia in the next 48-72 hours. We must not forget that hypoglycemic coma can lead to death especially if the period of unconsciousness is prolonged.

Conclusion: In pre-hospital treatment, where the diagnostic abilities are narrow disorder of consciousness should always be considered in several directions, even if the circumstances clearly state the underlying disease. Rapid response of emergency medical team in the treatment of these conditions will always help to preserve life BECAUSE TIME IS LIFE.

Keywords: Hypoglycemia, diabetes, therapy

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EMERGENCY SURGICAL MANAGEMENT OF INJURED WITH FRACTURES OF FEMORAL NECK IN ELDERLY POPULATION

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Fractures of the femoral neck are common in the elderly population, usually as a result of localized or generalized osteoporosis. The smallest, sometimes trivial trauma leads to femoral neck fracture. Osteoporosis is also one of the main reasons these fractures do not heal. Conservative treatment (lying, analgesics, and various immobilizations) often can not prevent the occurrence of local and general complications which lead to high mortality. With surgical treatment occurrence of these complications is reduced, because early surgical treatment in elderly injured population mobilizes them earlier. Proper attitude for injured elderly person is to operate as soon as posible and use the least traumatic procedure - placing partial hip prosthesis (Austin-Moore). Hemiarthroplasty of the fractured femoral neck was done in patients in whom there was a poor general condition, of reduced basic vital function capacity, neurological patients (hemiplegic patients), and patients with pathological fractures as with all older patients. Surgical procedures of this type have not been performed in injured that did not get internist or anesthesiologists consent. During the period 2014-2015 in Vršac General Hospital there were 58 patients with femoral neck fractures that were operated on with hemiarthroplasty (age 61-95). Left hip was dominant (55%) and female gender (72,4%). All were operated within 24-48 hours after injury. Post operative mortality was 5.17% - three operated. This surgery relieves pain, enables quick start of active movement in the hip as well as the early vertical posture and walk with full support.

Keywords: emergency, neck of the femur, fracture

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Abstract number: 024

TREATMENT OF OPEN FRACTURES OF HUMERUS DIAPHYSIS WITH EXTERNAL FIXATION – CASE REPORT

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Fractures of the humeral diaphysis are usually caused by mechanism of direct trauma, when we usually have the transverse fracture, or mechanism or indirect trauma (fall on the outstretched hand or elbow), when most frequently occurs linear or spiral fracture. The sharp bone fragment can puncture the skin and muscles becoming open fracture with underlying potential complications, primarily osteomyelitis or tetanus. Fractures of humerus diaphysis are treated conservatively (eg hanging cast) or surgical (osteosynthesis plate and screws, intramedullary fixation, etc.). Open fractures are lately treated with external fixation. Surgery should be done as soon as possible, if manageable, within 6-8 hours.
Injured patient is a strong man, a 36 year old with an open oblique fracture of the right humerus. He was injured at work falling from a height. Following preoperative antibiotic prophylaxis with AT protection and was operated on under general anesthesia. After primary surgical treatment of wounds, under X-ray (C arch) orthopedic reposition is performed and stabilization with external fixation Mitković with four pins. Fixation device is worn 4 months (until X-ray confirmation of fracture healing). Advantages of this method of treatment are easy treatment of wound, the possibility of early mobilization of the shoulder and elbow and prevention of contractures in the mentioned joints. Removing of fixation device after fracture healing is performed without anesthesia.

Key words: fracture, external fixation, humerus

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Abstract number: 025

WHAT TO DO WITHIN GOLDEN HOUR IN ACUTE ISHEMIC INSULT?

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In emergent neurological conditions the golden hour refers to a time period lasting for one hour or less, during which there is the highest likelihood that prompt medical treatment will prevent disability or death. It is well established that good outcome is greatest if patients receive care within a short period of time after a neurological emergency. But there is also no evidence that someone could conclude that good outcome rates drop off after 60 minutes. Data on golden hour are primarily to show the core principle of rapid intervention in some neurological traumatic or non-traumatic conditions, rather than the narrow meaning of a critical one-hour time. There are several non-traumatic neurological emergency conditions, such as acute cerebrovascular disease, including transitory ischemic attack(s), epileptic seizures and status, acute fulminant inflammatory polyradiculoneuritis, exacerbation or worsening of the neuromuscular diseases, delirium, etc.

To provide streamlining of prehospital management in neurological conditions we would like to show the importance of a "golden our" in stroke management, as well as in an epileptic status. It is well known that thrombolysis with alteplase administered within a narrow therapeutic window provides an effective therapy for acute ischemic stroke (the principle of »Time is Brain«). However, mainly because of prehospital delay, despite the prolongation of the time window, patients often arrive too late for such treatment (1 – 11 % of patients with stroke obtain thrombolytic treatment). So, it is of utmost importance to perform good public awareness campaigns on stroke signs, as well as educating prehospital medical teams to implement emergency protocols, such as Stroke Code and for proper triaging. The prehospital stroke rescue chain must be optimized so that more than a small minority of patients can profit from time-sensitive acute stroke therapy. All cerebrovascular patients are to be treated in prehospital settings this way - as candidates for thrombolysis. When we approach the stroke patient we need to perform a quick neurological status, blood sugar and blood pressure determination and, if time permits, record 12-channel ECG. In case of elevated blood pressure, we need to reduce it to the level below 185/110 mmHg, with e.g. urapidil, labetalol, etc., and give, if necessary in case of pain, adequate analgesia. If, according to Glasgow Coma Scale, the sum is 8 or less, we need to secure airway. Transportation is with all emergency signs to the nearest hospital; that is able to treat stroke patients. A prenotification is an important measure in stroke prehospital management. The incidence of cerebrovascular diseases in Slovenia is around 200 patients/100.000 population, 85 % having ischemic stroke. Between January 1st, 2003 and December 31st, 2014, 1215 patients, admitted to hospitals in Slovenia, included in Safe Implementation of Treatment in Stroke Register, were treated with thrombolysis (3 % of all ischemic stroke patients). Within first 60 minutes, meaning golden hour, only 45 (3.7 %) patients received alteplase. Due to low number, statistical analysis, comparing outcomes between group, treated within 1-3 hours (or 1-4.5 hours, according to changed guidelines) and group, treated within golden hour, cannot be done reliably. We will show some outcome details.

So, first conclusion could be that ultra-early brain salvage in stroke patients will someday surely reduce the tremendous burden of disability and death due to stroke.

Key words: stroke, thrombolysis

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INVOLUNTARY HOSPITALIZATION – EXPERIENCE FROM EMERGENCY MEDICAL SERVICE ZAJEČAR

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Introduction: The process of involuntary hospitalization is justified and allowed only in cases when a person is not able to consider the consequences of his actions or to control his behavior, that is, when potentially dangerous to themselves and / or the environment. Otherwise, it is the illegal limitation of patients' freedom and the legal consequences that may arise from that are concerning the team members who are involved in this kind of intervention. Therefore, a good diagnostic assessment of physician at the scene of immediate danger to the patient and / or the environment is necessary, and the decision for involuntary (forced) hospitalization. Also, cooperation and good team skill is of crucial importance for the success of these interventions. Police assistance is often necessary due to physical managing of agitated / aggressive patients.Objective: Getting to know the laws and regulations of involuntary hospitalization and emphasizing the importance of that knowledge by emergency medical teams, as well as any health care professional who comes into contact with similar cases.
Materials and methods: A retrospective analysis of emergency protocols of Emergency medical service Zaječar in the period 01.01-31.12.2015. Search criteria were referral to a psychiatrist for any reason. In particular, referrals for hospitalization were noted, which were done with the assistance of the police and / or hospitalization carried out without the consent of the patient (all specifically noted in the protocols).
Results and Discussion: In observed period emergency service intervened 4123 times. Of the total number of patients, 178 patients were referred to the department of psychiatry. Involuntary hospitalization was conducted in 69 cases and police assistance was requested in 42 cases
The most often, procedure of involuntary hospitalization was in patients diagnosed as F20-F29 and F40-F49.
One of the major problems was brought by the Public Health Bill, which is the version from 1992 (Sl. Glasnik RS, no. 17/1992), in Article 44 has formulation: "When psychiatry specialist or neuro-psychiatrist specialist estimate that the nature of mental illnesses in such that patient can endanger his life or the life of other persons or property, he may be referred to hospital treatment ...". The same bill in 2005 (Sl. Glasnik RS , no. 107/2005) in the same Article (44) states:" If a physician or psychiatry specialist or neuro-psychiatrist specialist estimate that the nature of mental illnesses in such that patient can endanger his life or the life of other persons or property, he may be referred to hospital treatment ... ". So, the legislator has made problem with a specialist (psychiatric or neuropsychiatric) returned to the level of general practitioners or physicians of any specialty (which comes in contact with such patients and who is not a psychiatrist or neuro-psychiatrist), obligation but also the responsibility of solving this problem.
Personnel of emergency medical service is a relatively often (and certainly much more often than those who do not work in EMS) in contact with these issues in the field. Fast and efficient management is definitely needed, but there are several factors that complicate the decision and the actual course of intervention.
From a legal standpoint involuntary hospitalization is deprivation of liberty. Before the physician (doctor of medicine, neuro-psychiatrist, psychiatrist or other physician specialty) faced with the involuntary hospitalization are numerous dilemmas (professional, legal, ethical, social) which, each for itself, but also together, carry a high level of responsibility for making decisions in such a delicate situations.
Conclusion: The use of involuntary hospitalization, either as a short-term procedure (removal of the mentally ill from society as dangerous), either as a long-term method of control of the mentally ill who have committed a criminal offense (mentally ill sentenced to prison customized treatment), either as an ad hoc techniques of "treatment" of agitated patient, will constantly require fresh expertise, sociological, psychiatric and legal review, not only because of the basic contradictions (punished but incompetent), but because of the violence that is increasingly present in society and it is not in connection with the mental disorder of the offender.

Keywords: Involuntary hospitalization, emergency medical service

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Abstract number: 027

ACUTE CORONARY SYNDROME – IT CAN BE THIS WAY!

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Introduction: Acute coronary syndrome (ACS) encompasses three entities with the same pathological mechanism, which basically is narrowing with the consequent partial or complete obstruction and requires urgent medical treatment. These are: acute myocardial infarction with ST-segment elevation (STEMI), acute myocardial infarction without ST segment elevation (NSTEMI) and unstable angina pectoris (UAP). When ACS is present with typical symptoms, the diagnosis is made in accordance with the finding on the ECG. Diagnosis becomes more difficult when symptoms do not clearly point to coronary artery disease and when the ECG has a vague and atypical ECG signs.

Case report: On 16.12.2015. at 17:00 emergency medical team was sent to the call of the second line of urgency for the patient Ž.O. 53 years old due to suffocation after inhaling substance for cleaning bathrooms. Medical team was on site after 4 min, finds patient on the bed in the sitting position, normal color of the skin and visible mucous membranes, moderately tachypnoic and who did not give the impression of severely ill patient. The whole house smelled of Domestos, to which we clearly point to an existing problem. We immediately opened the windows, and then she said she was better. Patient states that she had worked for more than one hour indoors with Domestos, that she has well-regulated Diabetes Mellitus (DM). On physical examination: BP 160 / 90mmHg; HR 65 / min; RF20 / min, Gly 7.2 mmol / L; SpO2 we have not been able to measure. Heart: the rhythm was regular, audible tones without pathological sounds. Lungs, vesicular breathing is present on both sides. Given that we expect to find changes in the respiratory sound and that patient is diabetic routine ECG is done. On ECG: sin rhythm, normal heart axis, ST segment elevation, D1 and aVL of 1mm -1,5mm, as well as V1-V3 and ST depression of 1-2mm in D2, D3 and aVF. IV line was placed, monitoring is attached and 0_2 4L / min. Th ASA 300 mg PO. Patient was transported to the Clinic for cardiology with the referral Dg: ACS. During transport she starts to complain of chest pain and nausea. Working diagnosis of cardiologist at the admission was: Vasospastic Angina (Prinzmetal), but later lab analysis confirmed increase in Troponin T and the patient was underwent pPCI.

Conclusion: The correct assessment of onerous that patient complains belongs doctors in primary care because they are the first link in the care of patients with ACS

Key words: acute coronary syndrome, non-specific ailments

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Abstract number: 028

INFLUENCE OF PRE-HOSPITAL MANAGEMENT OF INJURED PATIENTS ON TREATMENT OUTCOME IN INTENSIVE CARE UNIT OF EMERGENCY DEPARTMENT CLINICAL CENTER VOJVODINA - ONE YEAR EXPERIENCE

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Background: Trauma is the leading cause of death in population aged 1 to 44 years. Recommendations related to pre-hospital management of injured patients emphasize the importance of faster transport to referent trauma center, where the patient is adequately and definitively treated.

Objective: The objective of this study was based on the characteristics of injured patients and treatment measures taken prior to admission to Emergency Center of Clinical Center of Vojvodina (CCV), to identify factors associated with mortality in order to improve the treatment of these patients and indicate possible measures that could contribute to better outcome of treatment.

Materials and Methods: The study included 209 trauma patients whose treatment continued after initial resuscitation in the intensive care unit of Emergency Center, Clinical Center of Vojvodina. Data were analyzed retrospectively. For statistical analysis we used SPSS 20, 0software. Categorical variables were analyzed using the

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chi-square test, while non-categorical variables were analyzed by Mann-Whitney test. The results were marked as statistically significant if p <, 05.
Results: Patients who have had unfavorable outcome were significantly older than patients whose outcome was favorable (49.4 ± 18.5 vs. 14.7 ± 63, p <.05). Patients who had signs of hemorrhagic shock, respiratory failure, gcs≤8 had statistically significant worse outcome (p <0.05). Secured airway at admission to the emergency department of CCV showed better outcome, while the test did not differ in terms of outcomes in relation to whether emergency venous received from regional institutions and a greater percentage of patients initially managed by emergency services (p <0.05) .
Conclusion: Although there is still no sufficient evidence of the importance of airway management and venous lines before patient admission to referent trauma center, our results show the benefit of implementing these procedures if long time for transport is expected to referent trauma center and if the medical staff is adequately trained to perform these procedures.
Keywords: trauma; intensive care unit; mortality

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Abstract number: 029

SHOCK OF UNKNOWN ORIGIN

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Introduction: Shock is urgent condition. At first glance it is difficult to determine the cause. Entering into a vicious circle and with development of metabolic acidosis, we are often helpless and lose the patient if we do not discover the cause timely. Therefore, of great importance is in rapid diagnostics and wide range of ideas.
Case report: Patient D.M. 69 years old from Zaječar. On 04.12.2016., at about 16:20, emergency medical service receives a call about a sudden loss of consciousness and poor general condition of the patient. Until then he did not treat any medical condition, cared for by guardians and is deaf. At the scene we get information on sudden chest pain and loss of consciousness. Clinical findings show that the patient is pale, hypotensive, and there are confluent red stains from the navel and along the entire lower extremity. ECG is normal. Suspected of development of allergies and threatening anaphylactic shock with the resulting therapy the patient is transferred to internal department of HC Zaječar. During transport he developed paraplegia. Upon admission, the only finding is distended stomach. Patient denies pain. In laboratory findings we observed the development of metabolic acidosis Ph 7.19, the enormous increase in LDH, enzymes AST, ALT. Other laboratory parameters were within normal limits. Patient is still conscious, but changes on the skin get character of purpura. Ultrasound and radiography of abdomen did not show pathological changes. Working diagnosis in consultation with surgeons and neurologists ranged from electrolyte imbalance, aortic aneurysm, and mesenteric artery thrombosis to deep vein thrombosis of large venous vessels. CT and Doppler of blood vessels of the patient could not be done and in 18 hours patient becomes comatose with abnormal heart rhythm that was stabilized. CT is performed where he a large retroperitoneal cystic formations and distended bowel are seen. After that the patient has a cardiac arrest and dies. Autopsy showed only cyst in the pancreas that had necrotic content and there was a suspicion that it compressed large vessels. The cyst was confluent with part of the mesentery, spleen and adrenal gland. The cause of paraplegia and skin changes remained unclear.
Conclusion: In unclear emergency situations, urgent diagnosis is crucial to discovering the causes and especially in shock conditions. Knowledge, ideas and rapid diagnosis could in these cases prevent the lethal outcome.
Key words: lack of rapid diagnostics

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Abstract number: 030

COMPARISON OF TWO NUMERIC SCORING SYSTEMS, MPM AND SOFA, IN PREDICTING MORTALITY IN PATIENTS WITH SEPSIS

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Introduction: Recurring numerical scoring systems, Mortality Prediction Model - MPM and SOFA – Sequential Organ Failure Assessment - SOFA score are two most commonly used scoring systems for assessing organ dysfunction in patients with sepsis in the Intensive Care Unit.
Objective: The objective of this study was to compare the predictive power of the mortality scales in the evaluation of hospital mortality in patients with sepsis.
Methodology: The study was conducted as a one-year trial in ICU of tertiary level. Prognostic ability of MPM II and SOFA was estimated as area surface under the curve (AUROC). AUROC is used for comparison of the initial score, after 48, 72 hours and the maximum and minimum of numeric system.
Results: From a total of 111, 71 (63.9%) had fatal outcome. AUROC of predicted mortality on admission was 0.80 ± 0.05 for MPM II and 0.86 ± 0.04 for SOFA. AUROC 48h for MPM II was 0.83 ± 0.04 and 0.75 ± 0.06 SOFA. The maximum value of the score was a better predictor of mortality than anticipated admission ($p < .01$) for MPM II 0.79 ± 0.04 and 0.84 ± 0.03 SOFA. Finally AUROC SOFA was 0.78 ± 0.04 and 0.68 ± 0.05, $p < 0.01$).
Conclusion: A numerical scoring systems, MPM II and SOFA were statistically significant for predicting hospital mortality in patients with sepsis. The maximum score is important for the assessment of survival in relation to the admission, which especially applies to SOFA.
Keywords: MPM, SOFA, sepsis

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Abstract number: 031

LIVEDO RETICULARIS – CASE REPORT

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Introduction: Livedo reticularis (LR) is the change in the skin to form a net by which it was named, and can occur as a sign of underlying vascular disease. It is most common in the lower extremities and in severe cases may occur on the trunk and arms. The pathophysiology of these changes is in the microvasculature of the skin because deoxygenation or venous dilatation of venous bed.
Case report: On 08.04.2016 in emergency medical service Niš comes a boy, 14 years old, accompanied by his parents, who were visibly worried. They note that they suddenly noticed the boy's left leg has changed in color and has become somewhat "brownish". While the emergency physician encounters with a wide range of different symptoms and signs of diseases, such descriptions is not often heard. They say they have noticed a change about an hour ago, and boy and his parents claim that changes appeared for the first time and during that day. Family and personal history is negative. He denies recent infection, heavy exercise and exposure to new substances. He denies that he has pain or any other sensation. On examination, patient is normal skeletal structure corresponding to his age. There are dark web-like changes on the outside part of the left lower leg and thigh. At touch it does not subside and it is not painful. The skin temperature is normal and the leg is not swollen. Whole skin is examined and we found that the change is only localized in this area. We performed a complete physiological examination that he was within normal limits. Pulses are present and regular. Laboratory and blood test results remained within normal limits. Surgeon was consulted (in EMS Nis), who found no acute surgical disease. He was referred to rheumatologist with the Dg Vasculitis, Livedo reticulars. Further examinations showed that there is underlying APS.
Discussion: The decrease in perfusion arterioles is the predominant reason for the emergence of deoxygenation. Reduction the flow through arterioles can be caused many reasons: vasospasm, inflammation, hyper viscosity,

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thromboembolism. Physiological spasm of arterioles causes reversible discoloration in the skin areas while other mechanisms leading to pathological changes in the skin and development liviedo racemoza. Deoxygenation can also be caused by increased resistance of the venous flow that occurs at high multisegmental deep vein thrombosis. Venous dilatation can also occur due to hypoxia or dysfunction of the autonomic nervous system. Histopathology in LR shows endotheliitis and obliterating endarteritis without evidence of real vasculitis. In addition to being the most common manifestation of the skin in patients with antiphospholipid syndrome (APS), LR occurs in combination with autoimmune diseases such as systemic lupus erythematosus (SLE), systemic sclerosis, celiac disease and systemic vasculitis (polyarteritis nodosa, and cryoglobulinemia). Greater incidence of stroke is noted in patients with LR in the absence of other vascular risk factors. (described in Sneddon syndrome). LR may be the first manifestation of APS in 40% of patients, of whom one third will develop multisystem thrombosis in the course of the disease, stressing the importance of diagnosing APS in all cases with LR. Joint appearance of LR with valvular heart disease, stroke, and migraine is important to be noticed. LR should be an early predictor of recurrent thrombosis in patients with APS.
Conclusion: Seemingly harmless signs may be a prelude to a serious illness. The task of EMS physician is to take development of all symptoms seriously and consider all options for the adequate reaction and referral to further examination.
Key words: Livedo reticularis, Antiphospholipid Syndrome

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Abstract number: 032

ACUTE RESPIRATORY INFECTIONS AS EMERGENCY CONDITIONS IN CHILDREN IN EMS BERANE AND ANDRIJEVICA IN YEAR 2015

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Background: Acute respiratory infections in infants and young children account for about 20% of all medical examinations in pediatric emergency room of EMS. Inflammation of the epiglottis, laryngitis (croup) and laryngotracheobronhiolitis are diseases that are mainly present in children younger than 5 years and are often emergency conditions which we encounter. Important predisposing factor that precedes the inflammation of the upper respiratory tract are viruses (Parainfluenza, Influenza A and B, RSV), bacteria (Haemoflus inf.), allergic causes, as well as psychological factors. They are characterized by the most common triad of symptoms: inspiratory stridor and dyspnea, hoarseness and coughing (barking dog). This disease have special characteristics because of the anatomic structure of the respiratory tract of children, because they airways narrower and shorter. Active marked narrowing of the muscles in infections are easily developed because of good mucous membranes vascularisation. Due to an underdeveloped immune system, children are more vulnerable and susceptible to respiratory infection pathogens.
Objective: To determine the performance of emergency management in prevalence of these diseases in relation to the overall morbidity and ratio of male and female population affected.
Materials and methods: We used a retrospective analysis of protocols EMS Berane and Andrijevica for period January - December 2015.
Results: During 2015 in EMS Berane and Andrijevica 12.434 patients were examined by a physician on duty, which is a pretty big number if we know that Berane municipality, according to the last census from year 2011, has 33 970 inhabitants and municipality Andrijevica 5 071. Of these, a total of 3 720 had symptoms, what makes (30%) of the total number of examined. Of this number, 3236 patients (87%) were male and 484 (13%) were female children. We have started our therapeutic measures with following combination of medication (dexamethasone 0.6 ml / kg), inhalation steroids (pulmicort, Becotide) and adequate hydration. In 74% of cases, we had a good outcome, while in about 26% of patients had to be referred to pediatrician for further treatment.
Key words: acute respiratory infections as emergency condition in children.

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Abstract number: 033

LYMPHOMAS IN CHILDREN – CASE REPORT

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Introduction: Lymphomas account for 10-12% of all malignant diseases of childhood with an annual incidence of 15 per million children under 14 years. They are on third place in incidence behind acute leukemia and brain tumors. There are two categories of lymphoma: Hodgkin and Non Hodgkin. NHL is 6-7% of all malignancies in children in Europe and the United States. Etiology of NHL is not exactly determined. Chemical agents, viral infection, ionizing radiation, immunity disorder are the factors that are associated with the onset of the disease.
Today classification of NHL divides it into four main types:
1. Burkitt lymphoma
2. Diffuse large B-cell lymphoma
3. Lymphoblastic lymphoma
4. Anaplastic large cell lymphoma
Burkitt lymphoma is characterized morphologically uniform malignant cells with a round nucleus, prominent basophilic nucleolus and cytoplasm.
Case report: Burkitt lymphoma in boy aged four years. A boy aged 4, medium-developed musculo-skeletal appearance complains of constipation, difficulties in defecation, occasional blood in the toilet and toilet paper and stools at 4 days. On palpation of abdomen it is soft and not reactive, not distended, liver and spleen are within the normal range. Child is, due to repeated complaints, referred gastroenterologist in Podgorica and then for further diagnosis and treatment to The Institute for Medical Care of Mother and Child, Beograd (IMD). After completion of the laboratory, and radiographic and PH findings in IMD was concluded that boy has a B-cell non Hodgkin lymphoma - Lymfoma Burkitt, with primary localization in the abdomen. Cytostatic treatment lasted three months per protocol A EOP LNH-B 97 for R4 risk group. Gastroenterologist introduced therapy with Macrogolaxan 2x1 / 2 bags, Panthenol cream 2x daily, diet for constipation. Lab. analysis: Hgb 122 g / l; RBC 4.24; WBC 2.5; Plt 698; Urine b.o. Coagulation: PT 11.7s; INR 0.99; Aptt 32,9s; Fibrinogen 2.4; Gly 4,27mmol / l; urea 1.2 mmol / l; creatinine 48; CO2 19; K 4,5; 142; Cl 103; Mg 0.89; SGOT 96; SGPT 121; Bilirubin total 8.8mcmol / l; Bilirubin direct 4.5mcmol / l; Uric acids 250mcmol / l; LDH 618IJ / L.
Conclusion: The child is after completing cytostatic treatment sent home in good general condition, afebrile, with normal physical findings and with recommendation to receive therapy from a gastroenterologist. He is using Syrup Bactrim 240mg / 5ml 2x 6 ml three consecutive days of the week with the purpose of prophylaxis of Pneumocystis c. He needs regular control at IMD Beograd.

Keywords: lymphoma in children, Burkitt's lymphoma, a Case

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Abstract number: 034

CARDIAC ARREST IN YOUNG PERSON – PREHOSPITAL MANAGEMENT AND COOPERATION WITH CLOSEST MEDICAL FACILITY WITH HIGHER LEVEL OF HEALTH CARE – CASE REPORT

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Sudden cardiac death (SCD) is defined as the natural death caused by heart disease, which is manifested by a loss of consciousness occurring within one hour of the start of the acute changes in the function of the cardiovascular system (CVS). SCD can occur in a person with known heart disease or as the first event in a person with unknown heart disease. It is believed that the incidence of SCD is 0.1 - 0.2% in a year.
Case report: Patient AB (29 years old) was presented to the emergency department, a medical team of Cetinje, on 09.02.2016. at 11:10 AM. The dispatcher received information that the younger man fell ill and that he lost consciousness and has breathing difficulties. Medical team arrives after 3 minutes and sees the patient half-sitting position, unconscious, cyanotic, with occasional agonal breaths (one every 8-10 seconds). There is absence of

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foreign body in the airways, chest rising, respiratory sound and heart action, as well as the absence of pulse over the carotid artery. Pupils discreetly mydriatic, equal, do not react to light. Dg: Cardiac arrest
Patient is lowered to the floor, head is tilted back and measures of cardiopulmonary resuscitation (CPR) are started with chest compressions, balloon-mask ventilation and IV line is placed. After about 1 minute, carotid pulse is established, which is lost after 10 seconds. We continued with CPR, when after about 2 minutes we reestablished carotid and filiform radial pulse. Cyanosis starts to recede. The decision to transport the patient was made, from the first floor of the building down the stairs down patient was carried to the ambulance. While mowing the patient to the ambulance, we established the communication with the nearest hospital, informed them of the case and initiated gathering of their specialists team (internist and anesthesiologist team).
During this activities, we got hetheroanamnesis of patient complaining of heart palpitations and irregular heartbeat about a minute before losing consciousness, that during the day he was sitting in the office, that he had no health problems, do not use alcohol, cigarettes nor psychoactive substances. Family history of SCD and CVD is negative. In ambulance we re-verify presence of carotid pulse, occasional agonal breaths and cyanosis persist. CPR is continued with adrenaline 1 mg intravenously. After 2 minutes, we arrive at the nearest general hospital, where the monitor shows ventricular fibrillation (VF). Patient was intubated, defibrillated and CPR was continued under the protocol for VF. In the future course patient established sinus rhythm three times, which altered to VF after half a minute.
After 50 minutes of CPR (10 minutes pre-hospital and 40 minutes in hospital), patient has a stable sinus rhythm. After a few hours he was transported to the regional center - CCM, where he was fully assessed and discharged with implanted cardioverter defibrillator. During the examination-in CCM, structural or functional abnormality of CVS could not be proven.
Post resuscitation period continued without rhythm disturbances and disorders of consciousness. About a month after the incident, patient had problems with short-term memory. To date, the patient feels good, denies the complaints, has no problems with short-term memory and returned to his regular life activities.
Conclusion: This case has shown that timely and adequate pre-hospital management and communication with the nearest health centers is a very important link in the chain of survival.
Key words: cardiac arrest, young person, pre-hospital management, communication with the hospital

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Abstract number: 035

AORTIC DISSECTION

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Introduction: Acute aortic dissection, "the most common of catastrophic processes that affect the aorta," is a serious condition that requires immediate medical and surgical management. The force of pulsatile blood flow under great pressure breaks the intima of the aorta, which then expands in media. The initial intimal tears usually occur just above the valve (2 - 4 cm behind the ostium of the coronary artery) or distal to the left subclavian artery. Pulsed extravasation of blood into the wall leads to progressive separation of the intima, usually in the distal direction. The resulting false lumen occupies, in general, at least ½ of the volume and pressure of true lumen. Places where the flow of blood from the false lumen penetrates through the valve intimacy back into the true lumen are often numerous. The outer layers of the false lumen, consisting only of the adventitia and part of media are weakened; therefore, lead to progressive dilatation. Part of the wall adjacent to the initial intimal tear is usually the weakest point and ruptures.
Materials and Methods: DeBakey classification of aortic dissection describes three distinct types: DeBakey Type I the affected parts are ascendant, arch and descending thoracic segment; dissection is often extends into the abdominal aorta. DeBakey Type II also originates from ascending part, but ends just proximal to the origin of the innominate. DeBacky Type III is further divided into two subtypes: type IIIA, which begins just distal to the left subclavia and ends above the diaphragm; type IIIB, which begins at the same point, but extends into the abdominal aorta.

Conclusion and ideas: Because the symptoms of acute dissection may be masked by numerous other emergencies, one of the most important factors in the diagnosis of aortic dissection should be a high degree of clinical suspicion. Aortic dissection may be presented with various clinical features: syncope, anuria, chest pain, pulse deficit, abdominal pain, back pain or acute congestive heart failure. In one third of patients with acute aortic dissection other diagnose was determined.

Key words: Aorta, dissection, hypertension.

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Abstract number: 036

THE IMPORTANCE OF EARLY APPLICATION OF BLS BY EYEWITNESSES - CASE REPORT

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Introduction: Early initiation of basic life support 2-4 times increases the chances of survival. If the rescuer is trained he will perform standard cardiopulmonary resuscitation (CPR) - a combination of compressions and ventilations. In case of no experience, EMS dispatcher gives instructions for CPR performed only by chest compression while waiting for the arrival of professional assistance.

Objective: Point out the fact that if in cases of sudden cardiac arrest CPR is immediately initiated by eyewitness, survival increases.

Materials and Methods: A retrospective case report using data from the protocol of department who had participated in the diagnosis and treatment of the patient.

Case report: Dispatch of EMS Pirot after receiving a call of "fallen man who is not breathing", sends the medical team to that address. At the scene team arrives after 5 minutes and there they find colleague nurse who had already started CPR to a man age 64. The patient is unconscious, is not breathing and is without a palpable carotid pulse. On the defibrillator monitor we had ventricular fibrillation. We proceed to cardiopulmonary resuscitation using algorithm for schockable rhythms. The patient was intubated, delivered a total of three DC shock, given 1mg adrenaline and 300mg of amiodarone. Then we verified the systolic rhythm with a frequency of 90 / min and patient starts to breathe spontaneously 7 / minute. Transported to General Hospital Pirot. During examination he has a brief periods of respiratory arrest, and after stabilization is referred to a coronary care unit. After two hours he regains consciousness, oriented in time, place and personalities, denies any complains and neurological examination shows no abnormalities. There is only memory loss for period of previous event and he said that he remembered that he fainted in the bathroom. Ultrasound of heart shows enlarged LV with reduced global contractile function, EF 30%, septal wall in the entire length is thinned and akinetic. With therapy at the Internal Medicine Ward he is stabilized after 15 days referred to coronary angiography, which showed no change. LAD narrowed 60% below significant D1 branches. LCx not change. RCA is without changes, dominant. There was indication for implantation of ICD, which was done a month after coronary angiography. Patient, with the recommended medications feels good, has no complaints and returnes to daily life activities.

Discussion: Sudden cardiac arrest is the leading cause of mortality in the world. Return of spontaneous circulation in patients who experienced sudden cardiac arrest and survival to hospital admissions depend on the immediate CPR measures. Most patients, after a time interval for which medical team gets to them , and in our service it is average 8 minutes, if CPR is not initiated, are found with unschockable rhythms (asystole or pulseless electrical activity), which is the reason of unsuccessful return of spontaneous circulation in patients with sudden cardiac arrest. In this case, eyewitness began CPR before the arrival of the EMS team, patient is found in scockable rhythm (ventricular fibrillation), which has contributed significantly to the outcome of CPR and resuscitation of the patient without any subsequent sequels.

Conclusion: The largest number of acute cardiac arrest happens at home, so it is necessary to educate the population for early recognition of sudden cardiac arrest by eyewitnesses, adequate calling of number 194 and the providing of basic life support until medical team arrives.

Key words: acute cardiac arrest, cardiopulmonary resuscitation.

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GOLDEN HOUR IN EPI STATUS SOLVING

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Epileptic status, both, in generalized tonic-clonic and subtle (non-convulsive) must be treated aggressively. Maintenance of vital signs, including respiratory function, is of major importance. Any indication of respiratory insufficiency airway should be secured. Early treatment measures must be performed and the emergency physician should not wait for laboratory tests before giving the patient an antiepileptic drug, except for blood glucose level. The same protocol should be followed regardless of whether the patient is already taking antiepileptic drugs, since we can assume that the patient might be noncompliant because this is the most common cause of epileptic status in patients with known epilepsy. Latest guidelines for the treatment of epileptic status provide a time- dependent treatment algorithm that includes some phases. If the seizure fails to stop within 4-5 minutes or if the patient is continuing to seize at the time of prehospital team arrival, prompt administration of anticonvulsants may be necessary. Establish intravenous access, ideally in a large vein. Intravenous administration is the preferred route for anticonvulsant administration because it allows therapeutic levels to be attained more rapidly. In the stabilization phase (0-30 minutes), standard first-aid for seizures should be initiated. In the initial therapy phase, an i.v. benzodiazepine (midazolam (2.5-5 mg), lorazepam (0.1 mg/kg), or diazepam (0.15 mg/kg)) is recommended as initial therapy. In the decompensated phase (30 minutes or more), options include iv levetiracetam (loading dose of 1500-2000 mg), fenitoin (18-20 mg/kg) or fosphenytoin (15-20 mg/kg) or valproic acid if available in the country. If none of these is available, phenobarbital (15 mg/kg) is a reasonable alternative. In the prolonged refractory phase, if there is more than 40 minutes of seizure activity, we should consider repeating second-line therapy or anesthetic doses of thiopental (3–5 mg/kg bolus, then 3–5 mg/kg/hour, titrated to effect), midazolam (0.1–0.2 mg/kg bolus, then 0.05–0.5 mg/kg/hour) titrated to effect, pentobarbital, or propofol (1–2 mg/kg bolus, then 2–10 mg/kg/hour, titrated to effect). In case we expect status due to alcohol withdrawal, administer 100 mg of thiamine. In some settings where drug intoxication might be likely, consider also adding naloxone at 0.4-2.0 mg.
Conclusiones: All efforts in epileptic status management are to be done to stop convulsions; however, this is not as clear in case of non-convulsive epileptic status. Sometimes, benzodiazepine injection could stop the non-convulsive status, but more often, we will need appropriate electroencephalographic monitoring to see the status and the success of the therapy.

Keywords: epi status, urgent treatment

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Abstract number: 038

WHAT TO DO AFTER ACUTE MYOCARDIAL INFARCTION IN WOMEN?

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Symptoms of ischemic heart disease, especially acute myocardial infarction, often remain not recognized by patients, sometimes even from the medical staff, until some of the complications occur, especially in women who have long considered protected by hormonal status.
The study included 252 patients with acute myocardial infarction in the territory of Novi Sad treated from 15.09 to 15. 12. 2015 in the Institute of Cardiovascular Diseases. The average age of patients studied was 64.3. Among the studied patients, 80 were women (31.75%), average age 67.4 years, and 172 (68.25%) men, mean age 62.8 years.
In woman there are usually four risk factors (RF) (obesity, physical inactivity, hypertension and smoking), and in men six RF (hypertension, obesity, smoking, hyperlipoproteinemia, reduced physical activity and genetics).

Extensiveness of these risk factors was higher in the studied women, and duration, and women were rarely motivated to correct risk factors before disease occurs. "Jung's" variable, as an indicator of mortality risk calculated at the admission is 0.0283, which indicates an increased risk of death and unfavorable outcome. The value of these variables in the examined women was 0.0260, and 0.0294 for men, indicating a greater risk in the studied women, as well as a less favorable course of the disease, greater disability, mortality and complications with a slightly higher age in tested women.
Hence the great importance of secondary prevention measures should be in examined women in order to reduce the recurrence of disease, its progression of complications and mortality.
Key words: acute myocardial infarction, women, risk factors, prevention

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Abstract number: 039

CHANGES IN THE ECG AS A GUIDE IN THE DIAGNOSIS OF SYNDROME OF INADEQUATE SECRETION OF ANTIDIURETIC HORMONE (SIADH) - CASE REPORT

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Introduction: Antidiuretic hormone (ADH) is a hormone that is secreted by the pituitary gland (from posterior pituitary lobe), located at the base of the brain. Its primary role in water reabsorption in the renal tubules and correction of osmotic balance in the body, it participates in the regulation of pressure by exercising vasoconstriction (narrowing) of arterioles, so this hormone is also called vasopressin. Syndrome of inappropriate secretion of antidiuretic hormone, or Schwartz-Batter's syndrome is the most common cause of reduced sodium levels in the blood. Causes: After infection of brain structure and brain membranes (abscess, menignitis and encephalitis), after skull injuries, bleeding within the skull, with the inflammatory lung diseases, the use of certain medications for systemic diseases (polyarteritis nodosa, temporal arteritis, sarcoidosis) and also in the presence of a tumors that secrete vasopressin. Males are affected in the same number as the females, a syndrome can occur at any age. Symptoms and signs of inadequate secretion of antidiuretic hormone (ADH) syndrome is largely associated with low levels of sodium in the blood (hyponatremia) and non-specific are: fatigue and lethargy, loss of appetite, nausea and vomiting, headache, blurred vision, disorientation, irritability or apathy, muscle cramps, which alternate with muscle weakness, in the worst cases there may be to the development of coma, possible edema, but not to a great extent, patients reported weight gain (at the expense of retained water), urine volume is very small. The diagnosis is hard to determine based on the difficult history with clinical and objective review, due to the large number of non-specific symptoms, and on the basis of laboratory analyzes - reduced sodium levels in the blood (hyponatremia), measurement of plasma osmolality, urine osmolality measurement, antidiuretic hormone levels in the blood. The scanner (CT) and magnetic resonance imaging of the head and the body are used to find the cause of the secretion of large amounts of antidiuretic hormone (ADH secreting tumors) and identify some possible changes in hypophysis. Therapy for syndrome involves correcting sodium levels in the blood which is achieved by infusion hyperosmolar sodium solution. Also in patients with severe symptoms, reduced fluid intake is recommended until normalization of sodium levels in the blood. Be sure to treat the underlying disease, surgical treatment is indicated in antidiuretic hormone secreting tumors, in the presence of an infection using antibiotics or antifungal medications, and in the presence of systemic diseases using of corticosteroids. Take into consideration use of diuretics (medication that increase urination) - such as furosemide (Lasix), and drugs that are antagonist to antidiuretic hormone.
Objective: To point to the possibility of recognizing electrolyte abnormalities based on the ECG, as well as to the need for a mini-laboratory in the EMS and GH, so that patient can be sent timely to hospital after quick and accurate insight into the patient plasma electrolytes.
Methods: analysis of electronic and written protocols UP General hospital Šabac Protocol HC Šabac.
Case report: Man aged about 6o comes to EMS physician because of fatigue, headaches, nausea and instability with referral Dg: Instabilitas et vertigo R42. Languor et lassitude R53. Physical findings BP = 115/75 mmHg, ECG shows nodal rhythm with HR around 12o / min, QRS is widened by type of left bundle branch block, high

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pointed T waves, medical history does not give information about previous heart disease, which awakens suspicion of electrolyte and acid-base balance disorder. Blood sample is taken for gas analysis and the results were hyponatremia (121 mmol / l, hyperkalemia 5.7 mmol / l hypochloremia 89 mmol / l; pH 7.20; Bicarbonate 20 mmol / l; BE-8 mmol / L; osmolality: 287mosm / l; glucose 7.8 mmol / l ; Ca-2 mmol / L; hemoglobin 114 g / L; Htc: 0.46l. Patient is referred to the Internal Department of GH Šabac with Dg: Hyperkalemia, Metabolic Acisosis, susp ABI. Laboratory analysis (urea, creatinine) taken in the meantime excluded ABI as the cause of this condition. During hospitalization brain CT scan is performed, which showed pituitary tumor. Lethal outcome occurred on the 8th day of hospitalization.
Conclusion: Patients presented with unclear and vague complaints should have ECG because shape of the QRS complex, arrhythmias and conduction disturbances could lead diagnosis in the right direction and with timely diagnosis and prompt start of treatment. All emergency services should have mini-laboratories with the option for blood gas analysis.
Keywords: hypophysis, ADH, hyponatremia, hyperkalemia, ECG

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Abstract number: 040

THE IMPORTANCE OF PHYSICAL EXAMINATION IN THE DIFFERENTIAL DIAGNOSIS OF ACUTE APPENDICITIS IN PRE-HOSPITAL SETTING – CASE REPORT

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Introduction: Appendicitis is one of the most common surgical entities in young adults. The clinical presentation depends on the anatomical localization and because there is often atypical anatomical accommodation there is atypical clinical presentation. As a result, complications are very frequent complications, among which peroration stands out. Detailed history and physical examination in the pre-hospital setting are very important in the differential diagnosis.
Objective: To present the case which shows the importance of a well-taken history, physical examination and timely transport in bringing possibility of complications of underlying disease to a minimum?
Materials and methods: Case report of a young person with a perforated appendix. Source of the data is review of the EMS Podgorica protocol.
Case report: Emergency medical service was addressed by a young person who complains of severe abdominal pain accompanied by malaise, vomiting, liquid stools and fever. Problems persist for 24 hours. From anamnesis we learned that it started with high fever (38 ° C) and nausea, then a slight pain in the stomach. The pain went down to the lower abdomen and was party localized around the navel. Patient 4 times vomited content without a tinge of blood and she had 3 stools. When examined, patient is in forced supine position, the radial pulse is rhythmic, well-filled (HR 80 / min), rapid breathing (RF 20 / min), BP 115 / 75mmhg. While examining the abdomen, patients complain of intense pain in the right lower quadrant. Active muscular defense of anterior abdominal wall, Rovsing sign is positive. Venous cannula was placed, Hartmann's solution of 500 ml was given and the patient was transported in a half-sitting position to surgeon in the ER CC of Montenegro with referral dg: Abdomen acutum, Appendicitis acuta perforativa susp. During transport, patient complains that pain is intensifying. Skin is pale, sweaty, "facies abdominalis", radial pulse was poorly filled (HR 110 / min), shallow and rapid breathing (RF 25 / min) BP: 65/40 mmHg, abdomen was tence, with muscular defense. In ED patient was admitted and she went to surgery. She was discharged home after 3 days of stable vital parameters. The diagnosis at discharge was Appendicitis acuta gangraenosa perforativa.
Key words: physical examination, appendicitis, pre-hospital physician work

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Abstract number: 041

VIOLENCE IN KRUŠEVAC FOR THE PERIOD 2010 TO 2014.

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Violence (derives from the word "force") is any behavior that directly, intimately and actually endangers the physical and mental integrity of the passive subject. It represents global, worldwide problem that occurs regardless of age, race, religion, educational and socio-economic status and geographical area and constitutes of a grave violation of fundamental human rights, which has caused the international community to adopt numerous acts of combating and eliminating this phenomenon. Domestic violence includes physical, sexual, psychological and economic violence mostly against women, children and the not-so-rare and men. Violence against children within the family and outside it, as a special form – bullying, and inappropriate behavior at sporting events - instead of fair play cheer expressed rampage. Electronic violence and abuse - although of great help informational modern technologies are powerful tools of violence. The role of the Health Centre in the area of violence is medical managing for victims, informing the Police, and Social services and conducting special protocol made under the decision of the Ministry of Health of the Republic of Serbia, 2010.
Objective: To raise awareness about the importance of violence as a global problem and finding preventive activities both for reduction and eradication of it.
In 5-year period in the Emergency medical service, there were 2197 people and 221 children of both sexes who have experienced some form of violence. The eldest was 94 years old and the youngest is one year and the highest numbers were in 21 to 34 years old. After examination they were referred to specialists, most of them to surgery, ENT and orthopedics. For each victim Police in Kruševac was informed and all children were presented the Team of the Health center and Social services were notified or School administration. Perpetrators were reported as unknown or known people (spouse, partner, son, police officer). Most common were assaults using knife or fist. Some victims report violence reoccurring and some appear in the role of both victim and perpetrator. There were 7 adults and one 6-year-old girl who had a fatal outcome.
By the nature of our work, our primary role in providing health care and notification of appropriate institutions which are with their ministries signed a binding protocol, and on society as a whole is to find mechanisms to prevent any form of violence.
Key words: violence, victim, bully, help form, protocol

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Abstract number: 042

PENETRATING INJURIES TO THE THORAX - CASE REPORT

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Thoracic injuries are the second most common cause of mortality after head injury and the most sensitive brain tissue. They can be penetrating where because of pleural layers injuries there is communication with the exterior environment, with the accompanying risk of infection haemopneumothorax and non penetrating injuries which are, for the patient, with better outcome, and for a physician easier management. Given the size and contents of the chest, great caution is required in diagnostic and therapeutic approach to the injured patient. Only on the basis of clinical parameters folowing syndrome should be thought about - respiratory failure, hypovolemia, cardiac tamponade - that require immediate surgical intervention without losing precious time for additional diagnostic procedures. During transport of such a patients, continuous monitoring is required and announcement to the receiving facility should be made.
Objective: To show the importance of adequate management and the importance of first aid training of team members of Kruševac Police force.
Case report: During shift on 17.08.2015. at 23:30 we received a call from a member of the Police team Kruševac (they were notified first and arrived at the scene) that on the sidewalk in front of the Music School lies a young

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Roma with bloody t-shirt with stab wounds to the chest and that they put pressure on the wounds. Medical team goes out in the first minute and after 4 minutes arrives at the scene where we see injured young man lying down on the left side, two officers with the gloves using a shirt to put pressure on the wound on the back of the chest and at abdomen in the front. The place is poorly lit, so the patient is brought to the ambulance, put on oxygen and on detailed examination we found other wound, a cut or under the chin, back side of the neck and partially severed earlobe. Due to moisture skin we decide to use digital compression to stop the bleeding in addition to the oxygen and make rapid transport of unfortunate young man to surgery. The police officer helps with calling emergency service to notify surgery of our arrival. At surgery they insist on putting young man to the table, and after the moving hiss sound could be heard. Overlooking the closed water tap we could not find the source of the sound, disturbed young man turns to the table so that the sound occasionally fades. By lifting the gauze from the wound on the thorax we got a confirmation on the nature of the sound (open pneumothorax) and speed up nurses and one older nurse makes decision to move the patient to the shock ward which is accepted by surgeon on site. The next day, the injured young man was transferred to a tertiary level. After ten days, the same young man comes in our emergency medical service because pain in my stomach when made further examination with his consent .

First aid from members of the Kruševac Police team, adequate hemostasis and urgent successful surgery to the injured young man secured a second chance for all the joys of life and the rescuers immense content of professional work. The remark was made by duty anesthesiologist about the non existence of venous line. In this situation, my decision was to make a proper hemostasis with 4 arms and quick transport. For venous line we had no free hands. For this dilemma, dear colleague Milan anesthesiologist asured us with contemporary explanations that fast and cold infusions in shocked patients can make more harm than good, even though I did not know that then, the adequacy of my decision was confirmed.

Employees of the Police department had first aid course on many occasions, so in this case, the knowledge was applied (precise call to the site, digital hemostasis, informing of our arrival to surgey).

Keywords: first aid, adequate hemostasis, rapid transport, open pneumothorax.

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Abstract number: 043

CASE REPORT OF THE PATIENT WITH RUPTURE OF THE SPLEEN

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Introduction: The spleen is the most commonly injured abdominal organ from non-penetrating injuries. Its location and anatomic features are primarily responsible for its susceptibility to injury from external forces. The etiology of traumatic rupture of the spleen include automobile accidents, fall from a height or on level ground, blows and kicks, gunshot wounds and others.

Objective: Case report patients with rupture of the spleen.

Materials and methods: Descriptive data display. Data source: the book of calls, the protocol of the Emergency department Niš, medical report and hospital discharge letters from the Clinical Center of Niš.

Case report: EM team had call to a village 35 km away from Nish for a patient who fell from a tractor 4 hours ago. The patient said that he have had accident, after that he came home and went to rest. He woke up an hour ago, and since then he had lost consciousness three times. He denied any abdominal pain. On examination he was alert and orientated, pale, with Glasgow coma scale score of 15/15. Vital parameters: BP 80/60mmHg, HR~100min, RF12, SaO298%, Gly 6,3mmol/L, TT36,5C. During the examination he was without symptoms. At physical examination: Heart-action rhythmical, clear tones, without heart murmurs. ECG-normal. Over lungs normal respiratory sound. Neurological examination –normal. Abdomen was in the level of the chest, on superficial palpation gravely painful. Below the left rib cage he had bruise, 1x2 cm in size. Liver and spleen are not palpable. Pulses of a.femoralis are equal. He was diagnosed as suspected rupture of the spleen. Two IV lines were placed, patient received Sol.NaCL 0,9% 500ml and Sol. Ringer 500ml. Patient was then transported to Surgery Clinic where he underwent surgery.

Discussion: Although protected under the bony ribcage, the spleen remains amongst the most vulnerable organ sustaining injury from abdominal trauma cases in all age groups. It is a fragile and highly vascular organ holding 25% of the body's lymphoid tissue and has both hematological and immunological functions.
Conclusion: Abdominal trauma is one of the commonest causes of mortality and morbidity during the first four decades of life and third commonest cause of death overall. The spleen is the most commonly injured organ after blunt abdominal trauma (40-55%). The clinical presentation of splenic injury is highly diverse. Most patients are presented acutely with symptoms of hemodynamic instability or acute abdominal signs attributed to hemoperitoneum. Hypotension in a patient with a suspected splenic injury is a grave sign and a surgical emergency. A physical exam may be the only test done to diagnose a ruptured spleen.
Key words: Rupture of the spleen, hypotension.

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Abstract number: 044

SUBARACHNOID HEMORRHAGE (SAH): A CASE REPORT

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Introduction: Subarachnoid hemorrhage (SAH) is the presence of blood in the subarachnoid space of extracerebral, between thin meninges, and is significant because within it are the large brain arteries. SAH can be post traumatic and spontaneous. The most common reason for the occurrence of spontaneous bleeding in this area is the rupture of cerebral artery aneurysm.
Objective: To show the importance of suspected intracranial hemorrhage in pre-hospital setting, based on history, clinical presentation and examination.
Method: Case report of a man, who developed subarachnoid hemorrhage with relatively mild symptoms as well as the management that were taken pre-hospital.
Case report: In the morning we received a call from a man 46 years old who complained of headache that began during the night, stating that "he had a little too much food ". He said that he has a high fever, that he had vomited several times and that he feels tired and has high blood pressure. He had previous migraine pain but never such a headache. He believed that he "caught the virus" and seeks advice. Medical team went to see a patient where we found a patient who is pale, slightly confused, lying on the bed, holding his head. Blood pressure was 195/115 mmHg, with no neurological deficit but with slightly stiff neck in anteflexion position, BT 37.6 C. Patient was placed in a half-sitting position, analgesic administered iv, Kaptopril 25 mg tablet to be chewed, and under the suspicion of subarachnoid hemorrhage transported to neurology ward where a diagnosis of SAH is confirmed and patient was later referred to the tertiary health facility.
Conclusion: Headache, fever and high blood pressure as well as general symptoms are common findings in the work of the emergency physician. Also, patients often do not want intervention of physicians, believing that the situation is not serious seeking only advice to help themselves, but insisting on detailed history is extremely important. In the presented case of an emergency condition was suspected on the basis of anamnesis and reinforced by clinical examination and finding of typical sign of SAH (stiff neck).
Key words: subarachnoid hemorrhage, headache, vomiting

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Abstract number: 045

DIFFICULT ENDOTRACHEAL INTUBATION, SCORES AND CAUSES

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Endotracheal intubation is a basic resuscitation procedure in hospital and pre hospital settings. It is performed whenever there is, for some reason, a compromised movement of the chest and the normal process of respiration

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is in question. Respiratory arrest may be a result of some diseases (such as cardiac arrest, coma of any origin, poisoning) or direct damage to the respiratory tract, for example in trauma (injury of the face, oropharynx, larynx, trachea, chest). Basic equipment for endotracheal intubation are: laryngoscope, endotracheal tube, fittings (tube connectors and Ambu balloon), a complete Ambu set (face mask and balloon), 20 ml syringe for cuff inflation, suction unit, the metal tube guide wire, Magill s curved forceps. In order to assess the performance of endotracheal intubation is necessary to identify patients who are candidates for difficult intubation. In order to detect these patients, numerous scores and screening tests are developed for predicting difficult intubation. The best known and most widely used screening tests are Mallampaty score and Wilson's score, as well as the assessment of the airway in emergency situations LEMON procedure. Despite this, difficult intubations are present and in about 1% of cases. Difficult intubation occurs most often when the manipulation with laryngoscope handle is not possible in patients with short necks and obese, when there is congenital reduced possibility of opening the mouth, decreased neck mobility, reduced mobility of the temporomandibular joint, where there is edema, fibrosis and lesions of tongue, pharynx and larynx, when there are anatomical variations and congenital malformations of the oral cavity, pharynx, larynx and structures of the head, neck and chest.

Key words: endotracheal intubation, difficult intubation, screening tests, laryngoscope, airway.

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Abstract number: 046

HOW TO SURVIVE MYOCARDIAL RUPTURE AFTER MYOCARDIAL INFARCTION

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A 65 year old woman was admitted to hospital because of dispnea and chest pain. She had known coronary three vessel disease without coronary artery bypass surgery. In the coronary care unit, the ECG showed complete left bundle branch block and subacute myocardial infarction (creatine kinase 3903 U/l) was diagnosed. Because of the time delay, no thrombolysis was given but the patient received tirofiban and heparin until the next day when coronary angiography was performed. All bypasses were open and all major native vessels occluded, so coronary angioplasty was not feasible. Four days later, while taking a shower on the ward, the patient suddenly experienced a severe pain in her left flank. Left heart failure developed (no new creatine phosphokinase rise occurred). Cardiac magnetic rezonance showed myocardial rupture (maximal diameter of entry 10 mm) of the hypokinetic inferolateral wall with effusion contained by the pericardium (pseudoaneurysm formation) as shown: A, apical long axis view showing rupture site of the inferolateral wall with pericardial effusion (PE, pericardial effusion; AO, aorta; LA, left atrium; LV, left ventricle); B, colour Doppler flow image showing blood flow from the left ventricle through the rupture site into the pseudoaneurysm or pericardial effusion, respectively; C, immediately after intravenous contrast injection, the left ventricular cavity is filled with contrast; D, within one minute after contrast injection, contrast enhancement is seen within the pericardial effusion. Cardiac surgery was refused by the patient. After seven days the echocardiographic findings were unchanged. Twelve days later the patient went home. Myocardial rupture is a known fatal complication of myocardial infarction occurring especially in women, elderly patients and in first or inferior myocardial infarction. Left ventricular pseudoaneurysms form when myocardial rupture is contained by adherent pericardium or scar tissue. Free intrapericardial rupture usually results in cardiac tamponade and death. Because of this patient's previous bypass surgery there were pericardial adhesions and so the rupture was contained, which enabled pseudoaneurysm formation and thus survival.

Key words: rupture, myocardial infarction, MRI

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Abstract number: 047

INITIAL CT EXAM AS A PREDICTOR OF ENDOCRANIAL TRAUMA OUTCOME

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Endocranial injuries are a common cause of hospitalization of patients and are associated with significant long-term morbidity and mortality. Assessment of incidence of endocranial injuries varies widely depending on the region and is usually limited to cases that have resulted in examination in emergency department and range around 700 per 100,000, of which about 14% are treated in hospitals, and 2% of cases resulted in death. In developed countries the largest part of trauma is result of traffic accidents.
Endocranial trauma are according to severity divided into mild, moderate and severe based on the GCS (Glasgow coma scale) and the additional criteria that increase the accuracy of classification. These are the duration of loss of consciousness, altered mental status and post-traumatic amnesia, results of examination by computed tomography (CT) and AIS (Abbreviated Injury Scale) for head and neck.
Initial CT scan is indicated in severe and moderate head injuries while in mild it is not a routine practice indication unless there are one or more risk factors that indicate a potentially significant mild trauma present. The presence of radiation as an adverse effect of CT examinations requires adequate selection of patients even in emergency conditions.
Computed tomography as a diagnostic modality is characterized by wide availability, scanning speed and compatibility with medical devices for the maintenance of vital functions which are all very important in emergency conditions. CT examination is essential in detecting lesions that require urgent neurosurgery intervention, as well as those that require in-hospital observation and treatment. CT scan has a high sensitivity for the detection of the effect of mass, fractures and acute hemorrhage and to assess the size and configuration of fluid spaces.
The first goal of CT exam of patient with a head injury is to detect the existence of hemorrhage. Intracranial hemorrhage can act as expansive lesion with mass effect and edema leading to hydrocephalus, herniation and significantly affect the management of patient and outcome. In this paper we describe CT presentation of different types of intra- and extra-axial bleeding: epidural, subdural, subarachnoid, intraventricular and intraparenchymal. At the initial CT examination good predictors of outcome were volume of subdural hemorrhage and displacement of midsagittal structures, besides that presence of certain types of intracranial hemorrhage reduces the predictive value of GCS. It should be noted that early CT scan within 3 hours of injury may underestimate the extent of the trauma, and often control CT examinations are indicated and important indicators of the outcome are the presence of post-traumatic hydrocephalus, the location and the presence of gliosis. CT examination allows detection of contusion foci, although it has low sensitivity for the detection of small lesions and non-hemorrhagic contusions and diffuses axonal injury (DAI).
Keywords: CT, endocranial trauma

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Abstract number: 048

SUCCESSFUL MANAGEMENT OF VENTRICULAR FIBRILLATION IN OUT OF HOSPITAL SETTING BY EMERGENCY MEDICAL TEAM IN NOVI PAZAR

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Emergency medical team was on a call where patient was declared deceased. We were informed that, in the house next door, there is a brother of deceased who fell ill. At the scene we find a person without consciousness, pulse and spontaneous respirations. We immediately started CPR, chest compressions and balloon-mask ventilation 30:2 and IV line was placed. After that, on defibrillator monitor (DEF), ventricular fibrillation (VF) was seen, patient was defibrillated with 180J (biphasic defibrillator) and CPR continued with chest compressions and ventilation. One ampoule of Adrenalin IV was given. Again on monitor there was VF present and defibrillation

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with 180J was done. After that, the patient made one spontaneous breath take and at the monitor there was tachyarrhythmia with frequency of 130-150 / min. Patient was transferred to ambulance, where he received Amiodarone 300mg IV and oxygen through a mask 7l / min. During transport the patient regains consciousness, starts breathing spontaneously and has palpable carotid pulse. He was transported to the coronary unit of Department of internal diseases in Novi Pazar, where the ECG verified acute myocardial infarction of anterior wall. After ten days the patient was discharged from the internal department ward in stable health condition.

Keywords: KPR, ventricular fibrillation, defibrillation.

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Abstract number: 049

STATUS ASTHMATICUS IN PRE-HOSPITAL SETTING EMS CETINJE – CASE REPORT

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Introduction: Asthma is a chronic inflammatory infection of the lower respiratory tract. The main sign of this disease is wheezing in the chest with of expectoration of small amount of viscous mucus. The cause of the attack is a spasm of bronchioles, which is sometimes accompanied by edema and hypersecretion of mucus. Basic disturbance in asthma attack is reduced passage of air through the narrow bronchioles.
Objective: To show how important is timely diagnosis based on physical findings, given appropriate treatment to alleviate symptoms and transported to hospital for further treatment.
Materials and methods: A case report of patient based on medical calls and logbook HMP Cetinje.
Case report: In the afternoon hours medical team receives a call from the wife who explains that half an hour before the call, her husband complained of difficult breathing and that he has "lack of air". Patient's wife said that her husband has asthma and that she gave him a bronchodilator which is his regular therapy, but his condition persistently deteriorates. Now he can hardly breathe, speaks in short sentences and that his lips are bluish. Medical team arrives at the patient site. There we see a man, age 52, sitting, sweating, frightened, with torso leaning forward, holding his hands to the edge of the bed. To the question "of what is the disease he treates?" answers in intermittent sentence because of shortness of breath. Heteroanamnesis gives us data of asthmatic patients (diagnosed with asthma 15 years ago) who regularly uses the therapy and go for check-ups. For the past 3 years he did not have acute asthmatic attacks. Physical examination: Patient is conscious, oriented, subfebrile, dyspneic, with livid lips and periphery, tachypneic, with tachycardia, occupies a forced position using auxiliary respiratory muscles. Further physical examination BP 100/60 mmHg, EKG: sinus rhythm, HR 125 / min, turned axis to the right. Lungs: respiratory rate 27 / min. Auscultation: Breathing sound is attenuated with prolonged exhalation. SatO2 72%. We gave oxygen trough mask (5 l / min), inhalation of β2 agonists (Berodual) venous line was placed, amp. Aminophillin i.v. and amp. LemodSolu 80 mg i.v. Patient was transported to GH in Cetinje. During transport vital parameters improved and patient was brought to the general hospital with stabile vital parameters for further treatment and diagnostics.
Conclusion: Status asthmaticus - extended asthmatic attack that lasts more than 24 hours and not to subside to adequate therapy with bronchodilators. This is a life-threatening condition and requires a rapid response of emergency medical service. Symptoms of acute asthma attacks of are shortness of breath, difficult speech, cyanosis of the lips and visible mucous membranes, tachycardia, tachypnea, rapid pulse, confusion. Status asthmaticus is a serious condition that, if not timely diagnosed, leads to coma and death.

Key words: Asthma, status asthmaticus

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Abstract number: 050

ABDOMINAL PAIN - DIFFERENTIAL DIAGNOSTIC DILEMMA IN PATIENT ON REHABILITATION AFTER STROKE-CASE REPORT

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Introduction: Rehabilitation of conditions following stroke involve the use of a complex individual and dosed physical treatment in order to achieve reduction in subjective symptoms, improvement in functional state of the musculoskeletal system and achieve a greater level of independence in activities of daily living. During rehabilitation treatment is necessary to continuously monitor the condition of patient. Comorbidities can sometimes be a cause for termination of rehabilitation. Differential diagnosis of abdominal pain in pre-hospital phase can be very difficult, partly because of the lack of suitable diagnostic procedures.
Objective: To highlight the importance of abdominal pain and differential diagnostic dilemma as a reason for the termination of the rehabilitation, as well as the importance of non-invasive diagnostic procedures in the diagnosis.
Materials and methods: Data obtained by anamnesis, heteroanamnesis and available medical documentation (medical history, discharge letters). Method case report presentation.
Results: March 2016, patient BM 77 years old, visited the Institute Dr Simo Milosevic in Igalo because of the condition after ischemic stroke. In period from 01.18. to 01.26.2016. he was hospitalized at the Clinic of Neurology, Clinical Center of Montenegro in Podgorica due to the weakness of the left half of the body and with prior occurrence of dizziness and loss of consciousness. CT scan revealed the existence of the zone of slightly hypodense parenchyma right occipitoparietal, which by the characteristics could imply initial signs of acute ischemia, with slightly impressed lateral ventricle on the same side. Neurological – weakness of pyramidal type of deficit left. During hospitalization ultrasound of abdomen was performed – Infrarenal abdominal aortic aneurysm, diameter 40 mm, other findings normal. From history: hypertension, myocardial infarction 20 years ago, quadruple coronary artery bypass 12 years ago, dyslipidemia. At the patient admission: weakness with pyramidal type of deficit, medium right hemiparesis.
Dosed individually adjusted physical therapy was done. During his stay he was regularly monitored by an internist. On 27.03.2016. during evening hours, he complained of pain in his right lower back. On 28.03.2016. early in the morning he vomited once, fluid content without traces of blood. He complained of pain in his right lower back and under the right rib cage. Febrile up to 39 C. Urine and stool were normal color. Objectively: HD compensated, eupneic, dry skin, skin and visible mucous membranes properly vascularised. Breathing sound is normal. Heart action is rhythmic, HR 75 / min with quieter tones. BP 80/50 mmHg at 10 AM. Abdomen is below the level of the thorax, soft on palpation, painful to touch in the upper right quadrant. Right renal region is sensitive to percussion. ECG: no significant dynamics in relation to one at admission. In laboratory studies we can be seen leukocytosis with a predominance of granulocytes, elevated kidney, liver and inflammatory parameters. Despite the prescribed therapy, hypotension persists with subjective problems. Because of hemodynamic instability, anemia, hypotension, increase in value of inflammatory and liver parameters, along with fever and a history of previous abdominal aortic aneurysms (Infrarenal segment), the patient was referred to the department of surgery, GH Meljine for further diagnosis and treatment, where he was admitted.
Conclusion: Although the clinical presentation did not absolutely indicate a ruptured abdominal aortic aneurysm resulting in hemodynamic instability, with anemia and increase in the value of the liver and inflammatory parameters were the reasons for the termination of the rehabilitation treatment and referral to an appropriate facility for further evaluation and treatment.

Key words: abdominal pain, aneurysm, rehabilitation

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CONTINUITY IN MANAGEMENT OF PATIENT WITH NEGATIVE OUTCOME – CASE REPORT

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Introduction: Managing of patients in circumstances where we do not have enough medical history and scarce heteroanamnesis data, presents an additional challenge for any pre-hospital emergency medical team. Clinical presentation and examination of the patient must provide sufficient information for proper diagnostic evaluation and the lowest differential diagnostic dilemma.
Objective: To present a case of continuity in the management of a patient who is in a public place in circumstances where it is impossible to take an adequate medical history and heteroanamnesis, during transport and after admission to the emergency center.
Case report: On 20.04.2016. emergency medical team of Emergency medical service receives a call for a person injured by a fall from a bike in the city traffic roundabout. The dispatcher sends available medical team. Our team was closer to the site and takes over a patient. On the site we find middle-aged man lying on the asphalt of roundabout inner lane in the immediate vicinity of the bike. While approaching the patient we see that he is in a lateral position, conscious, with no visible major bleeding or deformity in the body. Passers-by who happened to be there, say that he was not hit by a vehicle but that he fell from the bike and then had something that they describe as a seizure ("shaking up the entire body and urinated"). Manual immobilization of cervical spine was placed. Airway is estimated as patent, patient is breathing and pulse over a. radialis is normaly filled with the HR of about 100 / min. We were not able to establish adequate communication with the patient but he does provide scant information about himself and says that he does not suffer from epilepsy. Maintaining the principles of immobilization, patient was transported on a stretcher in the prone position. During transport, there is a worsening of the neurological status and the patient becomes agitated. General examination of the body shows no signs of visible injury except abrasions on the back of the left hand. Vital parameters obtained until the arrival to the Emergency Center, Clinical Center Nis were as follows: BP 110 / 70mmHg, HR 100 / min, RF 14 / min, Gly 5,7mmol / L. Auscultation of heart: heart rate is rhythmic, tones are clear without murmurs. Thorax is symmetrical and mutually respiratory mobile with normal breathing sound present on both sides. Abdomen is in the level of the chest, soft but extremely painful sensitivity to palpation diffusely. 16G IV line is placed and manual immobilization of the cervical spine is maintained. A few minutes after arrival at the EC CC Niš, the patient stops breathing, briefly vented with mask and balloon and then endotracheal itubation is performed with 7,5mm tube. Soon after the patient loses the pulse over the large blood vessels when chest compression is initiated and ECG registered asystole. Resuscitation measures which were continued by a team at EC did not have a positive outcome. Given that it is the patient who died within 24 hours from the moment of admission to the hospital, an autopsy of the body was ordered to determine the cause of death.
Conclusion: Timely identification of vitally endangered and hemodynamic unstable patient and adequate management is imperative toward positive outcome.

Keywords: history, clinical picture, continuity, CPR

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Abstract number: 052

POLYMORPH SYMPTOMATOLOGY IN THE CLINICAL PRESENTATION OF STEMI AIM

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Introduction: AMI represents ischemic heart disease, which occurs as a result of a sudden and complete disruption of circulation in one of the coronary arteries, leading to myocardial ischemia and necrosis. In a typical clinical presentation dominant symptom is angina pain accompanied by pallor, anxiety and cold sweating.
Material and methods: A case based on the logbook of protocols from EMS Podgorica with a subsequent review of the medical history of the patient's from coronary unit CC Montenegro.

Case report: On 10.01.2016 around 17h, dispatching center of Podgorica receives emergency call from a 50 year old man. He complains of losing of consciousness, voluminous liquid stool and extreme fatigue. Upon arrival of medical team to given address we find that man is conscious, with pale skin, not cyanotic, adynamic and in a passive lying position. Heteroanamnestic data tells us that he briefly lost consciousness when he left the bathroom (the patient does not recall the event), after which he had voluminous liquid stool and now felt extreme fatigue. There are no other complaints. In personal history he has high blood pressure for past few years, former professional athletes and is a smoker. Family history is positive for ischemic heart disease.
Physical examination - BP 85/50 mmHg, Sa02: 89%. Heart: heart action is rhythmic, without murmur. ECG: sin. rhythm; HR about 50 / min; ST segment elevation in D2, D3, AVF, V3 neg T in V1, V2, V5 and V6. Based on the findings, the diagnosis of STEMI AIM pars inferioris and the patient is prepared for rapid transport. Intravenous lines is placed immediately with administration of Sol. Hartman, nasal catheter with oxygen 10l / min and tbl Andol tbl 300mg S.L. After transport, the patient is referred to the coronary intensive care unit of CC Montenegro.
Subsequent data - Echocardiogram: LV reduced in global systolic function, hypo to akinetic septum and inferior wall. EF is 37%. Coronarography: Selective coronarography reviled single vessel disease dominant RCA with proximal occlusion. Laboratory findings (10-11.01.'16): 0,084-9.60 troponin, CK: 84-2452, LDH: 191-768, AST: 40-286, UH: 3.07 Trigl 1.21. With adequate preparation he underwent PCI and stent was implanted in the RCA.
Conclusion: Atypical clinical presentation may complicate the diagnosis of AMI in the pre-hospital setting, as well as the importance of a well collected anamnesis, physical findings with the timely transport of the patient to the nearest emergency center.
Keywords: atypical clinical presentation, pre-hospital work, emergency medical service

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Abstract number: 053

LACERATION OF SPLEEN IN TRAFFIC ACCIDENTS TRAUMA

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Introduction: In addition to the injuries of musculoskeletal system, traffic accidents are very common cause of internal injuries that can be inflicted by blunt objects or penetrating trauma. Spleen capsule lesions accompanied with hematoma or laceration are very common.
Objective: To show all the mechanisms of injury leading to lesions of the spleen and the modalities and management in certain specific cases.
Materials and methods: This study is based on the data of 54 patients hospitalized at the Department of Emergency surgery KCS Emergency Center. These were different conditions that led to heavy bleeding in the abdominal cavity, various lacerations of parenchymal organs and hollow organs.
Results: For the period of one year and review of patient data we were able to observe-what are the mechanisms that most commonly led to lesions of the spleen and its capsule, what were the conditions of patients and management options.
Conclusion: In this paper we present our experience and knowledge that we have.
Keywords: spleen injuries, traffic trauma

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Abstract number: 054

LAPAROSCOPY IN EMERGENCY CONDITIONS FOR QUICK EVALUATION AND DECISION OF THE SCOPE OF SURGERY

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Introduction: Very often, while working in the ED, we are faced with the need for rapid evaluation, diagnosis in resolving of life-threatening conditions. Our goal is to show through this paper ways of rapid diagnostics that leads us to a decision on the manner and mode of management of the conditions after gathering information by abdominal laparoscopy.
Objective: To point to the causes and possible mechanisms of origin and try to find a causal link of developing of this condition.
Materials and methods: This study is based on patient data of 28 patients hospitalized at the Departments of emergency surgery of Emergency Department CCS. These are different conditions that led to heavy bleeding in the abdomen, various lacerations of parenchymal organs and hollow organs.
Results: For the period of one year and according to patient data, we were able to observe how laparoscopy helped us in solving conditions that were put upon us as a task. How much is this method used in such conditions in our setting, and in the view of our experience, what were the findings we came upon.
Conclusion: The sample of patients was small, but sufficient stimulus for further research in this direction, with the desire to bring closer to our experiences acquired in our daily work.
Keywords: laparoscopy, estimation of scope of surgery

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Abstract number: 055

MANIFESTATION OF CONDITION IN FRACTURE OF PROCESS OF LOWER JAW

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Introduction: In conditions of trauma of facial bones and jaw, a special place has a fracture of the process of mandibula. They are not so often but they have their place in trauma of facial bones. Very often a projection of these fractures throughout the diagnostics does not give us enough insight into the manifestation of the condition which patients express through a subjective feeling and the experience of trauma.
Objective: Through the work we want to show and point out that certain importance fractures of the process of mandibula have. Angle in the newly created position, caused by trauma, result that patients have specific manifestations of condition seen as parenthesis to anesthesia in the area of distribution of n.alveolaris inferior on that side, secretion of saliva through the skin and so on.
Materials and Methods: This study is based on patient data of 13 patients that were diagnostically evaluated in the Emergency radiology department.
Results: The results show our conclusions in evaluating patient data of given number of patients that are in this patient material.
Conclusion: In this paper we present our experience and findings, diagnostic methods and conclusions that were imposed on us.
Keywords: manifestation of lower jaw fracture

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Abstract number: 056

CONTROVERSY IN EMERGENCY RADIOLOGY THROUGH VARIOUS DIAGNOSTIC METHODS

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Introduction: Very often in practice we meet with the need for rapid diagnosis of conditions that are caused by various forms of trauma, injuries inflicted by suicidal attempts and diseases. Radiology diagnostic methods should be paramount in providing an indication for condition that requires quick reaction of physicians who will be managing the patient. Very often these are post-resuscitation patients.
Objective: Through this paper we want to show and highlight the controversies that may arise in daily work, especially if we take into account a large number of diagnostic examinations.
Materials and Methods: This study is based on patient data of 790 patients who underwent diagnostics in Emergency department of radiology.
Results: The results show our conclusions evaluating patient material data and the controversy that occurred in this patient material.
Conclusion: In this paper we present our experience and findings, diagnostic methods and conclusions that were imposed on us.
Key words: emergency radiology, diagnostic methods

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Abstract number: 057

SKIN DEFECTS OVER THE SKIN SURFACE WHICH REQUIRE DEFECT CLOSURE WITH PLANNED GRAFTS

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Introduction: Skin carcinomatosis of larger diameter is often predominantly basocelular form, which affects large areas and results in defects after tumor ablation requiring adequate surgical reconstructive solutions to overlap newly created defect and establish a new continuity of skin.
Objective: Through this paper we want to present some of our solutions for reconstruction after tumor ablation, planning of reconstructive surgery which was carried out, the method of designing the solution in particular cases.
Materials and methods: This study is based on patient data of 12 patients who were hospitalized at the Department of Emergency surgery CCS Emergency Center. These were different conditions of tumor formations in different parts of the body, different diameters of skin involvement both in surface and in depth.
Results: The results show our management practices, gender distribution, early and late postoperative sequelae and modes of their management.
Conclusion: In this paper we present our experience and findings.
Keywords: planned grafts, skin defects

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THE PLACE AND ROLE OF LOCAL SKIN GRAFT

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Introduction: Very often in practice we meet with small reconstructive surgery on skin areas that are affected by certain forms of tumor formations that require excision and management of newly defect.
Objective: Through this paper we want to present some of our solutions for reconstruction after tumor ablation with local skin grafts that are simple to apply and provide after adequate planning effective cosmetic outcome.
Materials and methods: This study is based on patient data of 36 patients who were hospitalized at the Emergency Department of Emergency surgery clinic CCS. Modalities, planning of management and the results of the definitive patient appearance after removing changes.
Results: showing our management practices, gender distribution and results.
Conclusion: In this paper we present our experience and findings.
Key words: local skin graft

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Abstract number: 059

MASSIVE INTRA-ABDOMINAL BLEEDING IN AMBULANCE SETTINGS

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Introduction: It is not often that we, during shifts in emergency center, come upon abundant and heavy abdominal bleeding of various etiologies. Most often it is consequence of rupture of large blood vessels, lesions of parenchymal organs, etc.
Objective: To show all the mechanisms leading to lesions and the modalities and means of managing the specific cases.
Materials and methods: This study is based on patient data of 11 patients hospitalized at the Department of emergency surgery Emergency Center, CCS. These are different conditions that led to heavy intra-abdominal bleeding.
Results: Show our way of management of emergency conditions and show some of the solutions in the given moment that we have followed.
Conclusion: In this paper we present our experience and findings.
Key words: massive abdominal bleeding

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Abstract number: 060

OCLUSIVE CONDITIONS IN ABDOMEN

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Introduction: The number of patients after the sixth decade that comes to Emergency Center and most often with the need for urgent management are the patients with occlusive problems.
Objective: To show all the mechanisms leading to occlusive symptoms, number of patients, gender distribution, as well as the modalities of surgical treatment of this category of patients.
Materials and methods: This study is based on patient data of 46 patients who were hospitalized at the Department of Emergency surgery Emergency Center CCS. These are different conditions that led to occlusive abdominal complaints.

Results: showing our management practices, gender distribution, early and late postoperative sequelae and resolution procedures.
Conclusion: In this paper we present our experience and findings.
Keywords: abdomen, occlusive conditions

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Abstract number: 061

TRAUMATIC CRANIAL INJURIES ACCOMPANIED WITH COMA AND MANIFESTED PULMONARY CONDITION

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Introduction: The knowledge about the relation between the states of consciousness among traumatized with head and brain injury and changes in the lungs date from ancient times. Experiment on animals was described and files dates from 1874. The first clinical announcement dates from 1918, on the presence of pulmonary edema in these conditions, in which these changes occurred immediately after the event.
Objective: To overview the causes and possible mechanisms of origin and try to find a causal link occurrence of this condition.
Materials and methods: This study is based on patient data of 23 patients hospitalized in the neurosurgical intensive care unit. In the available literature we find- "shown as a serious form of neurogenic changes in pulmonary hemodynamic parameters." In such patients, we have set the task of measuring intracranial pressure, place and role of ventilation and perfusion ratio, the importance of cerebral and arterial hypoxia.
Results: For the period of one year and patient data we were able to observe-in the genesis of these changes is increased ICP or cerebral hypoxia has a causal meaning. The assumption implies that pulmonary changes are caused by sympathoadrenergic mechanism, where arterial hypoxia has a significant impact in the disorder of ventilation and perfusion ratio. We can say that it follows that severity of head and brain injury is in a direct relation to the level of arterial hypoxia.
Conclusion: The sample of patients was small, but sufficient for further research in this direction. Laboratory studies could not be conducted for a long time in these patients because of the shortness of life of these patients. But our desire was to point out that such trauma condition of patients deserves studying this kind of problem in order to find of some new procedures for their management.
Keywords: head injuries, pulmonary changes

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Abstract number: 062

THE ROLE OF RESPIRATORY FUNCTION IN SEVERE CRANIOCEREBRAL INJURIES

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Introduction: For long time it has been observed that there is a link between severe craniocerebral injuries and respiratory problems. Very often these conditions led to the lethal outcome, because it was noted that in such patients after a head injury has occurred, respiratory arrest happened rather than heart insufficiency, and from available literature, it is believed that the brain can survive if respiration is timely supported.
Objective: The idea of this paper was to point out and show that if we timely take notice of importance of respiratory failure in cranial trauma, we can make impact in reduction of mortality in patients with this type of trauma.

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Materials and methods: This study is based on a hospital data of patients in the neurosurgical intensive care unit. Confusion in mental condition, disorientation and loss of consciousness are pre-terminal conditions of respiratory insufficiency. Very often in near post-trauma period, hypoxia significantly affects the speed and quality of recovery of craniocerebral injuries. The idea was to find what would be the response to reduced level of consciousness as an indicator and an indication for additional respiratory support. We have faced the same issue with our patients in the immediate posttraumatic period. Importance of timely control of hypoxia will be presented in conducted clinical course of patients with this type of trauma.
Results: For the period of one year and patient data from 60 patients we were able to spot-reduced mortality in patients with head injuries after artificial ventilation with moderate hyperventilation was applied, considering that provides better oxygenation of the brain, reduces intracranial pressure, corrects intracerebral acidosis and significantly increases perfusion of the injured brain. If we bear in mind that the brain represents only 2% of the body weight of an adult, and it has about 20% of the total body oxygen consumption, that is an enormous metabolic demand. When the consumption falls in injured brain below 2.5 ml O2 per 100 g of tissue per minute, mental changes occur, and below 2.0 ml there is coma. That's why we were able to detect early subclinical respiratory problems with blood gas analysis.
Conclusion: By focusing on timely correction of blood desaturation, pulmonary insufficiency, was less frequent as the immediate cause of death in craniocerebral injuries.
Keywords: respiratory function, head injury

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Abstract number: 063

BULLET IN THE NECK

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Introduction: Accidental injuries of head and neck region in recent years have important place in trauma of these areas. Clinical examination and early diagnosis are important as the main guides in the general approach of managing patients in this type of injuries. If we take into account the fact of importance of structures that are in the topography of this area, as well as the possibility of their lesions with manifest heavy bleeding, the task is all the greater.
Objective: The study included 13 patients from the Department of Emergency neurosurgery KCS in Belgrade, who required urgent and immediate surgical care. Display practice and management algorithms of patients with this type of injury and the requirements that we encountered during managing these conditions.
Materials and methods: Usually these are wounds caused by sharp and / or blunt objects, and consequently the way in which they occurred, leaves us with the task that imposes the manner of their management. Bearing in mind the fact we have created through our practice, that trajectory of the bullet through the soft tissues of the neck in particular have their migratory movements for several centimeters. Selectivity and decision for non-surgical management of certain pattern of injuries will determine our algorithm of actions and procedures in their management. Given the characteristics of trauma, elapsed time and current condition of patient, decisions must be made quickly in order to win the race against time for the general well-being and health of the patient.
Results: The possibility that certain vital structures are injured is potentially very high, therefore it is very important for us to timely perform proper diagnostic procedures, MSC and CT angiography, in order to provide us with sufficient data for determining surgical management. To what extent can we rely solely on clinical examination without the diagnostic data only in those situations where there is a significant hemorrhage that threatens patient of developing hemorrhagic shock, and the surgical approach and the management leads to

timely resolution. The actual plans of practice will depend not only on the particular patient with such injury, but also of the available staff and technical resources of provider facility.
Conclusion: The structures at risk in such neck injuries are primarily airways, vascular structure-primarily the main blood vessels, the esophagus, vertebral column including the spinal cord, the lower cranial nerves and brachial branches. The thoracic duct is in danger, in particular in the wound positioned on the left side of the neck. We wanted to point out the specifics of such injuries, management mode and diagnostics. Noting that timely action in the final result has the quality of life of these patients.
Keywords: neck injuries, treatment decisions

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Abstract number: 064

FRACTURES OF NASAL BONES

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Nasal bone is the most prominent facial bone, the most often injured facial bone (40- 50%). Fracture of nasal bone can be isolated or combined with other facial bone fractures. Fractures may be complete or incomplete, with or without dislocation, open or closed. They are more common in men than in women, and the etiological factors generally are violence, followed by traffic accidents, sport and falls. Of the diagnostic methods roentgenography of facial massif or less often computed tomography. Patients complain of pain, bleeding from the nose and difficulty breathing through the nose. The clinical presentation is dominated by the edema with hematoma, variously expressed deformity of the nose, bleeding from the nose of various volume, pathological mobility of bone fragments and crepitus (if it is a complete fracture). The treatment of nasal bones should be done as soon as possible, but in complete fractures, it is necessary do reposition the nasal bones, which is usually carried out in local anesthesia. Reposition should be carried out within 3 to 5 days. Inadequate and untimely treatment leads to poor aesthetic and functional results, accompanied by frequent complications.
Key words: fracture of the nasal bone, patients, treatment

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BITE WOUND ON THE NECK

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One of the most common wounds on the face and neck are bite wounds that can result from the bite of animals (mostly dogs -80%), although not uncommon are bite wounds caused by humans. Bite wounds are particularly frequent in children. The most common bacteria that can be found in bite wound are aerobic and anaerobic oral flora of the attacker and aerobes from the skin of the victim.
Case report of female patient, 34 years old, with infection of bite wound on the neck due to dog bites. Patient came for examination 30 hours after receiving injuries with swelling and redness of the skin with signs of fluctuation, pain and high fever (38.2 ° C). The laboratory there is leukocytosis (15 x10^9), CRP-19. Immediately after admission, wound was surgically treated, incision of the wound was made with drainage and antibiotic

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therapy ordered with debridement and analgesic. In patients after daily dressing changes to the said therapy has been a complete rehabilitation of the infection, after which the wound suture and properly healed.
Management of bite wounds of face and neck is specific in relation to other parts of the body. Due to good perfusion complications are rare, they can be life threatening. Patient should be regularly checked, so that in case of complications, timely surgical treatment of the wound could be done and adequate therapy included.
Keywords: Bite wounds, infection, treatment

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Abstract number: 066

QUALITY OF LIFE AFTER FRACTURES OF FACIAL BONES AND JAW

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Introduction: In patients with a fracture of some of the facial bones quality of life is often a lower after the fracture, as well as some form of psychological morbidity. In studies related to this topic is mentioned the presence of specific psychosocial factors such as depression, anxiety, changes in the perception of your own body looks after maxillofacial surgery (MFS), low self-esteem and poor social relationships. For many authors there is tendency to measure outcomes of treatment of patients in MFS facing the patient, assessing the patient's needs and perspective of a comprehensive, clear, rational qualitative way. This method of treatment would include measures of socio-psychological problems as well as physical handicap. Such measures should be able to monitor the progress of treatment and to facilitate decision-making regarding surgery, potential legal cases and psychological care.
Surgical treatments on the face and lip regions are associated with specific and strong fear. According to some studies, in 30% of patients immediately after maxillofacial fractures and after surgical procedure, there are clearly expressed psychological morbidity (anxiety and depression).
Objective: To show the types of injuries and methods of treatment. The extent of the resulting trauma required is an appropriate surgical approach and method of treatment.
Materials and methods: The study included 24 patients who had trauma in the area of facial massif, with great destruction and consequent postoperative sequelae-deformities that were created after a long period of time. Clinical presentation was divers depending on the type of trauma, injury and the extent of lesion structure.
Results: The paper is exclusively based on the management of conditions and assessment of the quality of life of patients after the trauma and the recovery period after the treatment. Through a survey conducted in patients, their attitude and thinking and how they see their condition. And we present some of our new solutions in solving consequences and making their quality of life better.
Conclusion: We will present algorithms of actions and procedures in the management of such trauma, methods of diagnosis and optimal treatment solutions that we are through practice proved most useful. Conceptual solutions have primarily been oriented in order to avoid or reduce to a minimum the early and late complications, and thus improve the quality of life of patients in the start of management after encountering trauma.
Keywords: fractures of facial bones, quality of life

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Abstract number: 067

SURGICAL TREATMENT AND OUTCOME OF COMPLEX BRACHIAL PLEXUS ELEMENTS IN CIVILIAN CUNSHOT INJURIES-SINGLE CENTER EXPIRIENCE

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Introduction: Gunshot injuries to the brachial plexus are the second most common mechanism of the brachial plexus injuries accounting about 25%, and occur in both, civilian and war practice.
They represent a specific problem and considered to be the most serious injuries of the peripheral nervous system.
Nerve elements could be damaged by direct impact of the shell fragments, or due to shock waves and cavitation effects causing their compression and stretching. This is cause of the nerve structures being damaged outside of the path of the projectile and at longer nerve segment.
Also there are a number of different combinations of elements of the brachial plexus damage both by the degree of severity, and by extension of damage.
There is often a limited possibility of surgical treatment, especially in case of damage spinal roots.
Objective: Functional recovery is very long with unpredictable and often adverse outcome because of the long path of regeneration of nerve fibers and time-dependent reduction of Schvann tubules.
The purpose of this study is to analyse characteristics of these injuries and possibilities for functional recovery following their surgical treatment
Material and Methods: Retrospective analisis of surgical treatment and outcome of complex brachial plexus elements in civilian gunshot injuries.
This series consist of 32 patients with complex brachial plexus elements gunshot injuries who were operated between January 2003 and January 2013 because of gunshot injuries to the brachial plexus. The age of the patients ranged from 15 to 54 years.Total brachial plexus palsy was presented initially in 20 patients, upper palsy in 2 patients, and partial functional loss in 10 patients. Injuries were located supraclavicularly in 9 patients and infraclavicularly in 23 patients. According to the location of injury, preoperativne clinical and electrodiagnostical studies, we found injuries to 101 nerve elements (individual components of the complex brachial plexus). The majority of lesions 75 were found at the origin of the individual nerves from the cords or at their first several centimeters.The remaining 15 of 101 brachial plexus elements were damaged at the spinal nerve to trunk level and 11 of 101 elements at the division to cord level. Intraoperatively, complete loss of continuity was found in 25 nerve elements, partial loss of continuity in 14 nerve element, neuroma in continuity in 45 nerve elements and external scarring without nerve injury in 17 nerve elements.
Surgical procedures were performed in a period from 3 weeks to 12 months following injury, with average of 3 months. Majority 26 of 32 patients were operated in a period up to 6 months.
Surgical procedures were performed according to intraoperativne findings. Exploration and external neurolysis was performed to 18 nerve elements, interfascicular neurolysis to 45 nerve elements, split repair(nerve grafting in cases with endoneurial fibrosis, intrafascicular neuroma or interruption of same fascisles) to13 nerve elements, nerve grafting to 23 nerve elements and nerve transfer to 2 nerve elements.
Results: Results were analysed in all 32 cases with follow/up period over 24 months. Motor function was classified in six grades, from M0 to M5 using the widely accepted Highet's clinical scale. Sensory function was classified in five grades from S0 to S4 according to Millesi.Finnally Results were classified in three groups (good, fair and bad) according to the functional priorities in in brachial plexus surgery. Good and fair results were estimated as useful functional recovery.
Nerve grafting including split repair of nerve elements gave 19 good results, 11 fair results and 4 bad results. Neurolysis (external and interfascicular) gave 43 good results, 12 fair results and 6 bad results. Combination of procedures performed on complex brachial plexus elents gave 4 good results and 2 fair results.

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Neurolysis gave good resultis in 3 lesions of lateral cord, 1 lesions of medial cord, 1 lesion of posterior cord, 8 lesions of musculocutaneus, 7 lesions of lateral root of medianus, 3 lesions of median root of medianus, 2 lesions of ulnaris,11 lesions of axillaris, and 7 lesions of radialis.
Neurolsis gave fair results in 1 lesion of medial cord, 2 lesions of lateral root of medianus, 2 lesions of medial root of medianus, 2 lesions of ulnaris, 1 lesion of axillaris and 4 lesions of radialis
Neurolysis gave bad results in 1 lesion of C8-T1 to/or lower trunk, 3 lesions of ulnaris and 2 lesions of radialis.
Nerve grafting gave good results in 2 lesions of C5-C6 to/or uppesr trunk, 1 lesion of C5-C6-C7 to/or upper and middle trunk, 1 lesion of lateral cord, 2 lesions of posterior cord, 6 lesions of musculocutaneus, 3 lesions of lateral root of medianus, 2 lesions of axillaris and 2 lesions of radialis
Nerve grafting gave fair results in 2 lesions of C5-C6-C7 to/or upper and middle trunk, 1 lesion of lateral cord, 3 lesions of leteral root of medianus, 3 lesions of medial root of medianus, 1 lesion of axillaris and 1 lesion of radialis.
Nerve grafting gave bad results in 1 lesion of lateral root of medianus, 2 lesions of medial root of medianus and 1 lesion of radialis.
Combination of neurolysis and nerve grafting gave good results in 2 lesions of C5-C6 or/to upper trunk and 2 lesions of C5-C6-C7 to/or upper and middle trunk, fair results in 1 lesion of C5-C6 to/or upper tunk and 1 lesion of C5-C6-C7 to/or upper and middle trunk and no bad results.
Conclusion: Our experience with gunshot injuries to brachial plexus is specific (if we compared it with other studies) because higher incidence of total brachial plexus palsy and higher incidence of lesions with complete loss of continuity.
We are able to conclude that gunshot injuries to brachial plexus very rarely recover spontaneously; surgery is indicated if there is functional loss in distribution of one or more nerve element persisting at least 3 months. Surgery delayed for more than one year is not justifiable. Useful recovery may be obtained in over 90% of neurolysed cases and nerve grafting is successful in repair of injuries to the C5 and C6 spinal nerves, upper trunk, lateral and posterior cord, their nerve outflows and possibly median nerve.
Key words: Brachial plexus, gunshot injury, nerve repair, neurolysis, nerve grafting, nerve transfer

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Abstract number: 068

SCHOOL CHILDREN AND ADOLESCENTS IN EMERGENCY MEDICAL SERVICE OF BIJELJINA HEALTH CENTRE DURING YEAR 2015

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Introduction: The emergency medical service is running continuously for 24 hours in 12 hour shifts. One team consists of two physicians, four nurses and technicians, of which one is dispatcher and two ambulance drivers. Each team has a shift supervisor who is responsible for the functioning of emergency medical service team. At least one more physician with experience of more than 2 years in emergency medicine is present with the team during working hours. Health Center Bijeljina has 11 ambulance teams and provides services for about 150,000 people, of whom about 10,000 are children 7-18 years old. After receiving the call, shift manager refers medical team to the scene. All calls are recorded, and sound recordings are kept for at least one year.
Objective: The aim is to show the frequency of providing emergency medical services to school children and adolescents in the city of Bijeljina, in the Emergency Department or in the field when assistance is provided out of the Health Center Bijeljina in 2015.
Method: A retrospective and statistical analysis was performed of receiving calls log book and logbook in the Emergency Department of the Health Center Bijeljina in the period from 01.01. - 31.12.2015. We analyzed the gender and age structure, diagnosis, time and place of intervention.
Results: During 2015, EMS teams have performed 5,548 emergency interventions for children aged 7-18 years, of which 5,189 were at the center and 359 in the field. Total number of emergencies in 2015 was 29,596, out of which 18.75% were interventions provided for children aged 7-18 years. The gender structure shows that the

emergencies occur more frequently in boys 3,259 than in girls 2,289. The most urgent interventions were for children 14-15 years old or 13.43%, followed by the 10-11 years 11.58% and for the age of 5-6 years, 8.35%. If we consider the time of day when the interventions had occurred, it was most often in the period from 8:00 – 16:00. Analyzing the diagnoses we found that the highest percentage represented injuries and that was in 3,150 cases, which accounted for 56.78% of all interventions. The greatest number of injuries was accidental injuries (falls, cuts, bites, etc.). The number of patients with poisoning in 2015 was 256, of which alcohol poisoning were most often 76.53%. There were no children in coma and intoxication with psychoactive substances was the cause of 1% of interventions in school children and adolescents. There were 28 children who were transported to the relevant hospital for observation or treatment.

Conclusion: All team members of the emergency are trained and familiar with the procedures for triage of patients and algorithms for prehospital management of emergencies, the procedure for performing CPR in adults and children and procedures for the transport of patients to hospitals and other institutions. Giving instructions till emergency team arrives is the first link in management of patient, regardless of age. Continuous training and renewal of knowledge and skills is also important, as well as training of new employees in the management of injured patients. States with impaired consciousness, severe trauma in childhood, poisoning, suicides and suicide attempts require readiness of EMS team whose primary objective is to preserve the life of a child.

Key words: adolescents, injury, poisoning

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Abstract number: 069

INTESTINAL OBSTRUCTION CAUSED BY TUMOR OF RECTOSIGMOID PART OF THE COLON-WHAT TO DO?

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Objective: To determine the appropriate method (Hartmann's procedure vs. bipolar colostomy) for managing of intestinal obstruction caused by malignant tumors of rectosigmoid segment of the colon. Monitor the occurrence of surgical and nonsurgical complications and the need for blood transfusion and treatment outcome.

Method: The study included a total of 120 patients, who underwent surgery in two different techniques, the method of bipolar colostomy and Hartmann's procedure. All subjects were randomized into four corresponding groups, according to age and ASA score. We examined the incidence of surgical and nonsurgical complications and the need for blood transfusion of and its volume. Also, outcome it was observed as in-hospital mortality (survival).

Results: The study did not show statistically significant difference in the occurrence of surgical and nonsurgical complications in patients operated with two techniques ($p > 0.05$). In addition, there was no significant difference in survival in relation to applied surgical strategy ($p > 0.05$). In terms of treatment outcomes, it was noted that impact on mortality have nonsurgical complications, as well as high levels of ASA score ($p < 0.05$). The occurrence of surgical complications also has an impact on survival (increased hospital mortality, $p < 0.05$, Mantel-Cox test).

Conclusion: Both procedures are safe enough, with almost equal treatment outcomes and complication rate. Neither of these two methods is in this sense does not impose as superior to another. However, in the case of significant intestinal distension is technically more appropriate method was bipolar colostomy. Bipolar colostomy compared to Hartmann's procedure has the advantage in the fact that after the creation of bipolar colostomy problem of intestinal distension is solved and that on definitive surgical procedure there is better oncological access. The down side is certainly the need for second surgery, for which not all patients could be prepared in such a short period of time, so Hartmann's procedure with removal of the tumor seems like oncology acceptable solution. Hartmann's procedure is more suitable for older patients (> 60 years), with values ASA score

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>3. With this procedure (with high ligation of lymphovascular pedicle) the effect of removing the tumor in the first surgery is achived. Bipolar colostomy followed by definitive surgery after a maximum of two weeks is imposed as a procedure that is acceptable for younger, healthier patients, which may be ready for a new surgery in a shorter time interval. Bipolar colostomy has its place with extremely unstable patients with high levels of ASA score in order to manage emergency intestinal decompression.

Keywords: obstruction, tumor, solution

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Abstract number: 070

SOME PATIENTS STAY ENIGMA

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Introduction: In everyday activities of emergency medical services (EMS), there are patients who, because of the short time and the scarce pre-hospital diagnostic, are not clear in terms of diagnosis and are treated as syndromes.

Objective: To present a patient who after several-day stay at the clinic and diagnostics, modern medicine has failed to explain the initial symptoms and the clinical presentation.

Case report: Medical team received a call of second line of urgency at 14:48 for a patient who had sudden breathing difficulty and physician answering the call reception considered possible pulmonary edema, given that he got information from family that he does not have COPD, and treats hypertension. Assessment in the direction of edema was reinforced by the fact that physician receiving call heard the patient. Medical team arrives at 15:54. They see a patient S.R. 73 year, lying, who is conscious, oriented, extremely pale, sweating, dyspnoic, tachypnoic, with audible respirations, stating that it all started suddenly in the last half hour. He has no other complains and in personal history, 15 years as he had stroke, with residual discrete right hemiparesis. Vital parameters: BP 100/60 mmHg; HR 60 / min, RR 22 / min; SpO2-not detectable; Gly 8 mmol / l. Lungs: prolonged expiration, shortened inspiration, weakened vesicular breathing, diffuse polyphonic lower tones on both sides, basal to height of half scapula wet sound. Heart: rhythmical, clear tones, without murmur. Abdomen: normal. Neurological: Sequela of previous CVI. ECG: sin rhythm, narrow QRS, without changes in the ST segment and T wave. Intra venous line is placed, including O_2 7 L / min; Amp. Lasix No II is administered. While transferring patient from a bed to the chair patient loses consciousness, is breathing spontaneously, loses the pulse on a.radialis but has it over carotid artery, and after obtaining defibrillator we see only fastening of HR to 80 / min, other remained unchanged. Infusion with amp Dopamin 50mg in 300ml 0.9% NaCl is started. We began our transport to cardiology. During transport and haemodinamically still unstable, breathing becomes irregular, slow, with occasional apnea, which is why we started assisted ventilation placing airway and mask balloon. On the admission at cardiology clinics and during the examination, patient makes one deep breath and then continues with regular breaths 14 / min. ECG remained regular BP 90/50 mmHg. Lungs: normal. EHO of heart normal and due to the present state of coma, patient is transported to neurology clinic where he was hospitalized. After review of documentation we find that following diagnostic procedures have been made: CT (chronic lesions microischemic supratentorial), color Doppler of blood vessels of the neck (ICA fibrocalcific plaques, left, 1,8mm thickness, on right side has character of ulcerated plaque; AV: Right has smaller diameters, left normal) EEG: regular; MSCT of blood vessels in the neck (on left carotid bulb 45% stenosis). The patient regained consciousness on the first day after admission, with no new neurological events. During his hospitalisation he was treated with antiedematous, rehydration, vasoactive, polyvitamin, antiplatelet and antihypertensive therapy and nephrology therapy. Diagnosis at discharge: Synkope, St post Shock, Stenosis ICA l.sin, Sequelae infarctus cerebri, Sy Parkinson, HTA, HBI.

Keywords: enigma, hemodynamic instability.

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AMI – CASE REPORT

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Introduction: The clinical definition of acute myocardial infarction (AMI) requires a combination of typical history and electrocardiographic (ECG) changes, biochemical findings and techniques that indicate the reduction or loss of perfusion or abnormalities in contractility in left ventricle (LV), which is an indirect sign of myocardial necrosis. According to current guidelines, we have diagnosis of acute myocardial infarction when patient has typical ischemic symptoms and ST-elevation on ECG. Most of these patients have an increase in biomarkers after typical ischemic pain started. According to WHO data, 12 million lives are lost annually due to cardiovascular diseases, making them responsible for 50% of total mortality. 50% of patients die due to acute myocardial infarction (AMI), before they come to hospital, while in hospitalized with AMI mortality rate is 5-10%. In the US each year 330 000 patients are hospitalized due to myocardial infarction with ST elevation (STEMI) and 24 milion people wit myocardial infarction without ST-segment elevation (NSTEMI). AIM is the most common cause of death in the Western world and the World Health Organization predicts that this trend will remain until 2020. In Podgorica, the city which has 170 000 inhabitants, 150 - 275 patients are hospitalized each year with STEMI with hospital mortality of 5-8%.
Objective: The timely diagnosis based on physical examination and initial treatment and quick decisions on further appropriate hospital treatment.
Material and Methods: Case report of patient based on medical examination and logbook EC CC Montenegro.
Case report: 49 year old man was brought to EC by EMS team due to sudden onset of chest pain accompanied by nausea, vomiting, shortness of breath, weakness and profuse sweating. We found that the symptoms began one hour before, while lying home he had severe pain behind the sternum which had as clenching character which spreaded to both hands and to the stomach and was accompanied by nausea, sweating, general weakness and malaise. He notes that on one occasion vomited profusely stomach contents without traces of blood and mucus and after few minutes felt well but the pain began to intensify after a few minutes. He has no other complaints by systems. He has been a smoker, occasionally consumed alcohol, has hypertension for the past 8 years (irregular therapy), knows of elevated blood lipids but does not take medication. He noted that two years ago he had arrhythmia, was examined by a cardiologist and received therapy Presolol a 50 mg x 2 ¼ which he occasionally used – does not have medical records. He denies other diseases, injuries and surgeries. Family history is positive for CVD diseases. Physical examination: conscious, oriented, communicative, dyspnoea, very pale, covered with cold, sticky sweat, pulse 115 / minute; grave hypotension, BP: 70/50 mmHg. Lungs: respiratory sound weakened, with discrete left basal crackles. Heart: heart rate rhythmic, quieter tones, without murmur. ECG at admission to the EC: sinus rhythm, frequency of 115 / minute, ST elevation in II, III, AVF with a negative T from V2 to V6. Two venous lines were immediately placed two, complete lab. Analysis were made including cardio-specific enzyme, sol. 0.9% NaCl and 500 ml, oxygen therapy was administered through nasal catheter 4 l / minute and Aspirin tablets and 300 mg was given p.o., marketed urinary catheter was placed and patient was immediately transported to the coronary care unit for further diagnosis and treatment.

Keywords: AIM

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Abstract number: 072

ACUTE PUMONARY EDEMA – CASE REPORT

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Introduction: Acute pulmonary edema is urgent and life-threatening condition, which is caused by the accumulation of extra vascular fluid in the alveoli due to elevated pulmonary capillary pressure or disturbed

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permeability of alveolar capillary membrane. Therefore, the described condition requires emergency management.
Case report: Emergency medical team of health center received a call from relatives of patient 65 years old and due to shortness of breath, choking with the appearance of foam at the mouth and anxiety. Upon arrival, we find a patient who is agitated in the sitting position, which audibly and shallow breathing, coughing and coughing up frothy content, with cyanotic lips and distended neck veins. Auscultatory findings of the lungs shows crackles and diminished respiration on both sides, BP 190 / 105mmhg, ECG: sin.rit.HR 105 / min, ST-T normal. After examination immediate therapy was ordered Furosemide 40 mg IV, NTG tbl. sublingual, intravenous lines placed and medical team was called to transport the patient to the ED. After admission to the ED BP was 165 / 100mmHg, Sat O_2 80% and therapy is continued with Furosemide 40 mg iv, iv morphine, oxygen therapy with oxygen mask and O2 flow 6l / min until reduction of symptoms and improvement of parameters BP 140 / 80mmHg and SAT O_2 92%. Hospitalization was indicated due to previously diagnose and treatment for heart failure and hypertension.
Conclusion: In case of acute pulmonary edema timely response, adequate therapy and rapid transport to tertiary institutions is essential to the survival of the patient.
Keywords: shortness of breath, cough, distension of neck veins

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Abstract number: 073

ANAPHYLAXIS AFTER INDUCTION OF ANESTHESIA IN THE FIVE-YEAR CHILD-CASE REPORT

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Introduction: Anaphylactic reactions as a complications of inducing anesthesia, occurs is around 3%, although it is believed that the percentage might be higher because many are not recorded and reported. All anaphylactic reactions to anesthetics, analgesics and miorelaxants occur in different forms: from skin changes to fatal anaphylactic and anaphylactoid reactions.
Objective: To present a patient who developed anaphylactic reaction to the introduction of anesthesia.
Case report: Child M.Đ. 5 years and 2 months old, height 118cm, 20kg, comes with one parent for elective tonsillectomy and adenoidectomy. The first examination in anesthesia department, child is healthy, without accompanying comorbidity, pediatrician and ENT specialist gave their approval for surgery. Laboratory tests were in the reference values for given age. Father denies allergies to food and medicine. It was its first surgery. Two days after admission of child who was accompanied by his father it comes to surgery ward. Preoperative preparation: amp. midazolam 5mg IM, amp. atropine 0.4 IM; 20G IV line placed. After 30 minutes, child was brought to the operating room, conscious, indifferent, not crying. Standard monitoring is placed(ECG, SpO2, NIBP). Child breathes oxygen through a mask for 3 minutes and SpO2 is 100%. Introduction to anesthesia started with thiopentone and alfentanil (per kg / BM) and relaxant - leptosukcin. Intubated with No. 5 tube on the first attempt. BP 103 / 58mmHg, HR 112 / min, SpO2 100%. Immediately after intubation we spotted bronchospasm, started therapy with aminophylline per kg / BM, methylprednisolone per kg / BM and O2 6L / min. Instead of improving, in the next 10min condition worsens, tidal volume declined, balloon had more resistance, SpO2 76%, HR 160 / min. Auscultation finding in a deterioration, drop in BP, the loss of the radial pulse, and by aspiration of tube foaming content is obtained.amp. adrenalin IV was administered, continued O2 ventilation and after a short period of time followed by resolution of bronchospasm and regulation of all vital parameters. After 60 min, the child was safely extubated, spontaneously breathing through oxygen a mask 6L / min and 100% SpO2 is achieved. BP 95/50 mmHg, HR 120 / min. Observation in intensive care unit for the next 6 hours and for the next two days child was monitored in the department of ENT. In discharge letter, the child is referred to the Military Medical Academy because of suspicion of allergy to one of the three drugs that were given. Allergy to thiopentone was confirmed.

Conclusion: Quickly identify anaphylactic reactions and accurate and timely therapy are the key to success. It should be always approached with caution and be prepared for developing emergency condition and its solution, especially when it is the first general anesthesia.

Keywords: thiopentone, complications after induction in anesthesia, anaphylaxis

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Abstract number: 074

ETHICAL FRAMEWORK OF THE EMERGENCY MEDICAL SERVICES (EMS) IN MASS ACCIDENTS AND DISASTERS

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Introduction: Effective planning in the process of management in disasters requires that individuals at all levels of the health system (public and private) accept and act on certain ethical and professional principles. The greatest responsibility is on government departments, primarily in the process before, during and after disasters.
Objective: To describe the elements of an ethical framework for the functioning of the EMS in mass accidents and disasters.
Data source and selection of materials: Retrospective analysis of literature with settings: mass disasters, catastrophes, ethics, responsibility, ambulance. Search is done through: PubMed, Medline and electronic journals available through KoBSON as well litrature available in the library of the Faculty of Medicine.
Results of synthesis: Ethical framework of behavior in the case of mass disasters should also apply to the conduct of participants at each level in the management, starting with those who work at the state level to the individuals who work in the field. The basic elements of ethical behavior in mass accidents and disasters are:

- honesty
- duty to care for patients
- obligation to manage resources
- transparency
- consistency
- proportionality
- responsibility

Each of these entities will be considered in the work. Honesty: In mass accidents and disasters not everyone should get the same treatment, but there should be no difference in treatment in the same group. The decision to make differences in treatment must be based on clear community objectives that were set before an accident happens. Example (when there are limited resources in the vaccine, the decision of the community that priority for vaccination should have persons exposed to a greatest possibility of infection, such as rescuers in the process of relief). There are examples of some communities who decided that in such situations, priority depends on the age or that persons who are in prison or with the pre-existing diseases or severe disabilities have no priority. Religious, cultural or language differences should not be the basis for the decision. The duty to provide care: The staff at EMS is trained to care primarily about individuals and not the population. Reduced resources lead to a reduction in the types and methods of treatment. In these events, triage should not be taken by the same person responsible for the direct treatment of individuals. Staff working in the process of care, also has their families. Rescuers, who have minor children, have a duty to primarily take care of them and after they provide for their loved ones, will they be able to carry out their professional duties. In the planning process this should be also addressed and bring ethical and legal frame to it. Obligation to manage resources: Health facilities, physicians and other health professionals have an obligation to manage scarce resources. The disaster itself, by definition, creates scarcity, since demand outweighs the need. The goal - the preservation of life, requires that professionals accept the responsibility to plan and use resources wisely. As the scarcity in the process of disasters increase, resource management will require more difficult decisions. Transparency: refers to the determination of the values and priorities. Public involvement, public debate, revision of policy based on dialogue and facts, as well as

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the responsibility for the implementation of agreed plans in the process before the disaster can be a key for the process management in the moments of disaster and its aftermath. Finally, transparency can be seen in the fact that all are engaged in the process of decision-making: health care facilities, politicians, ethicists, religious leaders, lawyers and public opinion. Consistency: Treatment of similar groups in a similar or equal manner is one of the ways to promote justice. It should be avoided that patients in different hospitals in the same affected area receive very different levels of care. Proportionality: this term refers to events in society that accompany such a disaster for example moving, evacuation, closing schools or quarantine. This should be proportionate to the scale of the disaster. Accountability: Relations with the fact that every member in the process of management knows their level of responsibility and act in accordance with it. Responsibility of rescuer in time of disaster should be assessed in the period before the disaster. Medical professionals need to get from the community a clear framework of their responsibilities and scope of operation and be prepared through adequate training. If there are no such guidelines, clear and responsible action can not be expected from them.
Conclusion: The ethical frameworks allow physicians to adequately and without a doubt use limited resources to provide the necessary and available therapy for patients who will most likely benefit from it. Also, do not allow physicians to simply ignore professional standards and acts, without ethical standards and accountability.
Keywords: ethical framework, disaster, emergency medical service

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Abstract number: 075

AGRESSIVE PATIENT – CASE REPORT

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Introduction: When a person is potentially dangerous to himself and / or surrounding, the decision is on EMS physician to assess patient's involuntary hospitalization. This situation is associated with illicit restriction of the freedom of the patient and the legal consequences that may arise from that and concerns team members who are this kind of intervention, medical team and the police force team. Cooperation and communication of medical and police teams is crucial to the success of these interventions. Physical restraining of agitated / aggressive patients can lead to their injuries which can have serious legal consequences.
Objective: Case report of managing and involuntary hospitalization of aggressive person.
Case report: EMS team received a call of the second line of urgency for intoxicated person who has slit his wrists, and is threatening to jump from the eighth floor. Police team has been called to assist the medical team and arrives at the same time at a given address and enters the apartment. We find a man M.P. 38 years, who while celebrating his birthday, drank considerable amount of alcohol, had a fight with his girlfriend and tried to kill himself. The patient is heavyset osteo-muscular build, well developed, visibly intoxicated, on the forearms are visible large injuries caused by sharp object and which are bleeding. The cuts are 8-10cm in size, with flat edges and start from the wrist. Patient is trying to get to the terrace and other three persons are holding him while he resists and hits them uncontrollable. On the face of his girlfriend we can see injuries. All of them are very upset. Two policemen stand between the patient and the terrace door and try to start a conversation in order to calm him down. He is shouting that he will first kill his girlfriend and then himself and that no one can prevent it. He becomes aggressive towards physician and the police. The physician decides that the patient is involuntary hospitalized because he shows extreme aggression towards himself and others. Three police officers try to restrain him, when he became even more aggressive and begins to attack all standing around. Putting restraining means (handcuffs) on injured arm is postponed (in order to avoid further injury) until he tried to take weapon from the police officer. At that moment intervention police unit arrived, which has been called, and a decision on putting the handcuffs is made. The patient is with great reluctance (6 police officers) is brought to the hallway of the building, where he tried to break away and jump over the fence. Patient is put on the floor and physician decides to give him the Amp Dormicum 15 mg IM (estimated weight was more than 100 kg. dosing 0.15 mg / kg). Within 2min patient calms down, starts to cooperate and willingly enters the elevator and then into the

ambulance. Patient was referred to EC with police assistance, with Dg: Vulnus scissum region antebrahii bill, Tentamen Suicidi, Aethilismus.
Discussion: Midazolam in these situations may be applied by experienced physician, with adequate equipment in case there is need for managing and support of cardiopulmonary function. Severe cardiorespiratory adverse reactions may occur with the isolated use of midazolam, namely: respiratory depression, apnea, respiratory arrest and / or cardiac arrest. Alcohol increases the sedative effect of midazolam and this decision was made with full readiness to intubate the patient in case of respiratory depression or respiratory arrest.
Keywords: sedation, aggressive, intoxicated persons

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ABSTRACTS: NURSES

Abstract number: 001

PSVT IN YOUNG POPULATION – CASE REPORT

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Introduction: PSVT (paroxysmal supraventricular tachycardia) is atrial arrhythmia and represents sudden onset of rapid heartbeat. Most often it happens due to the existence of two functional paths in AV node, where circular movement of electrical impulses occurs. PSVT starts suddenly in the form of irregular heartbeat, may last several minutes, several hours or even days. When in people without heart damage, except the feeling of heart palpitations, usually there are no significant symptoms. In patients with structural damage of the heart (myocarditis, coronary heart disease, hypertension, congenital and acquired heart defects), longer duration of the attacks can cause deterioration of cardiac function and myocardial ischemia. PSVT is easily detected on the ECG, heart rate changes are always present and clear. HR is from 140 to 250 / min, in ECG there are characteristic changes (negative retrograde P waves in leads D2, D3, AVF, or P waves could not be recognized). Symptoms that accompany heart rhythm disorder are numerous, depending on the age and hemodynamic condition: palpitations, shortness of breath, angina pain, fatigue, tinnitus, nausea. Conversion of PSVT in young people is performed by stimulation of the vagus (inducing vomiting), Valsava maneuver (carotid massage). If there is no effect, the drug of choice is verapamil . Also, the attack can be stopped by using beta-blockers and other anti-arrhythmic drugs (amiodarone). Persistent and frequent PSVT, which disturbs the quality of life of patients should be treated radically with ablation in hospital settings.
The objective is to show the role of emergency medical system in managing PSVT, where abnormal rhythm in a patient is being converted in pre-hospital settings.
Materials and Methods: A retrospective analysis of available written documentation of Emergency Department in Nis.
Case report: On 02.02.2016., around 2PM, patient A.I. age 16, enters pediatric section of emergency department, accompanied by his mother, with complains of palpitation, visibly pale, frightened and feeling exhausted. Allegedly this is not happening for the first time, she had similar attacks 7-8 times in the last year and that she is on continuous treatment with propranolol. Pediatric examination found patient to be hypotensive (BP-90/60 mmHg), tachycardiac (HR-220/min), the RF-19/min and SPO2-99%. After ECG (normal axis, P wave is not visible, narrow QRS, without signs of ischemia), she was admitted for observation and monitoring. IV line was placed and solution of NaCl 0.9% 500ml was administered. An attempt was made to stimulate vagal nerve by inducing vomiting and Valsalva maneuver. This was the first attempt of conversion to normal rhythm. As

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Valsalva maneuver did not give effect after 7-8 min, we decided to administer amp. Verapamil, fractionated. After administration of one half of ampoule, heart rate begins to fall, which was registered on the monitor and by ECG. We continued with giving verapamil, and after a whole ampoule HR falls to 140/min. In the same minute the girl enters the sinus rhythm. Again ECG recording shows: sinus rhythm, HR-90/min, with no signs of ischemia, the RF-15/min, BP 110/70mmHg. Diagnosis: I47, PSVT.
Conclusion: In our patients we determined that she is on continuous treatment with propranolol, which she did not take regularly, as confirmed on the given day, and come to the conclusion that was the reason of her frequent attacks of PSVT. In this case, conversion of frequency while observation of this patient, verapamil shoed to be efficient. However, such attacks are unpredictable and definitely affect and disrupt the quality of life of young people. Most of these attacks emergency department manages in observational, so that the patient does not have to be hospitalized and can return the same day to normal life activities.
Keywords: PSVT, conversion, sinus rhythm.

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Abstract number: 002

WHEN YOU ARE ON THE RIGHT PLACE, AT THE RIGHT TIME AND YOU KNOW WHAT TO DO!

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Introduction: Injuries of thorax are responsible for about 20-25% of deaths caused by trauma and in 25-50% of cases of other deaths. Treatment of injured patient is a dynamic process that consists of identification and assessment of severity of injury in the first place, appropriate therapeutic and procedural measures that would enable the conditions for further forms of treatment.
Objective: To describe the case of managing injured patient where circumstances in which the accident occurred, led to the most appropriate treatment in the first 5 minutes of the injury.
Case report: At the beginning of the shift and after checking of the equipment, ED medical team heads for the substation to start with regular work. At the intersection, while waiting at traffic lights, we witnessed the traffic accident where a bus, wile trying to turn, hits motorcycle driver. The medical team reaction was instant, physician and nurse take protective devices and run out of the car while the driver remained in ambulance to report the event to dispatch. We find that the patient is away from the bus about 3m, a motorcycle for approximately 5m. The patient lies on his right side, unconscious, he is breathing but with difficulties and has a visible bleeding on the face. In the first contact with the patient, all members start certain procedures in accordance with their responsibility. Physician maintains the control of the cervical spine and simultaneously evaluates the respiratory frequency, whether there is a need for the aspiration of the contents of the oral cavity. When lifting the lower jaw, the doctor noted that there are multiple fractures of the mandible and a numerous cuts on his face and neck, which bleed profusely. The nurse dresses the wounds on the neck and places two IV lines, and we restrained from setting cervical collar because of inability to control bleeding. Ambulance driver had already brought ferno and stretcher and prepared them for transport. At that point, medical team was approached by the person who presents himself as an anesthesiologist and offers assistance. Given that the physician knew a colleague, she handed over the control of cervical spine to him, and then was able to do a complete initial assessment of patient, according to the ABCDE system. At step B -Breathing she notes that there was a deformity of the right side of the chest wall, decreased mobility, and impaired breathing sound. Other parameters were fine. Patient was placed on the ferno while maintaining the spinal column in a line. Secondary survey was performed in the ambulance, checking of vital parameters and fluid resuscitation begun with the analgesic. During transport of the patient, he regained consciousness, gave information about himself, he has no recollection of the event and is partly confused while answering questions. Referral diagnosis: Accidents, VLC regio colli lat son et faciei multiplex, Fract.costae thoracalis lat sin, Pneumothorax lat sin.

Conclusion: Regardless of the severity of the injuries of the chest wall, most injured can be helped if the injury is identified timely, and most importantly fast identification of life-threatening injuries trough teamwork and appropriate medical treatment provided.

Keywords: pre-hospital treatment of injured persons

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Abstract number: 003

PRE-HOSPITAL APPROACH TO INTOXICATION WITH DIFFERENT TYPES OF PSYCHOACTIVE SUBSTANCES

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The problem of substance abuse and behavioral disorder due to psychoactive substances (PAS) in our country in recent years gained epidemic proportions. The number of new cases is unfortunately in constant rise and all studies indicate that the age limit moves towards younger age, and age 11 years is mentioned as the first time coming into contact with psychoactive substances. According to research by the United Nations done in 1990, 180 million people around the world have used drugs, of which about 4 million children aged 13-15 years. Psychoactive substances are classified into three major groups, depending on their effects on the brain and nervous system:

- depressants - alcohol, sedatives and opiates have effect on the brain as to cause sleepiness, global slowing of psychomotor activity, relaxation, a sense of calm, and also lower the activity of vital centers controlling heart work and breathing.
- stimulants - cocaine, crack, amphetamines, ecstasy, cannabis, have a stimulating effect on psychomotor activity, give sense of increased power, happiness, self-esteem, a sense of being without fatigue, lack of fear, accelerate heart rate and increase blood pressure.
- Hallucinogens - LSD, mescaline, peyote and different synthetic products, lead to a state of altered perception with the appearance of hallucinations, altered perception of time, space, and altered perception of self and surroundings.

There are four pathological forms of drug use:

1. Acute intoxication with psychoactive substances (PAS)
2. Problem (risky) taking of PAS
3. Harmful use of PAS (abuse), and
4. Dependency syndrome as continuous or episodic use of PAS (dipsomania)

Acute intoxication is a transient condition that occurs after taking psychoactive substances, when there is a change in mental behavior, with changes of consciousness (commonly seen as increased alertness or drowsiness - depending on which drug is in question), changed process of thoughts and sometimes the appearance of hallucinations. It also changes the mood and may cause euphoria, but also the sense of fear or panic attacks, with cannabis, for example. The behavior is also changing from hyperactive and accelerated, with lots of movement and exaggerated expression of emotions to slow, lethargic, where the person appears drowsy and distracted. The duration of these changes is different and depends on the type of used substances (for example, acute heroin intoxication lasts up to 8 hours, but intoxication with marijuana 3-5 hours). In case of intake of excessive doses of substances that can lead to death, we are talking about overdose.

In most cases of poisoning, the causative agent is known, and the only problem for the Emergency services medical team is to determine whether the degree of intoxication requires more than first aid and initial emergency management. However, sometimes patient history is not reliable. The exact amount of toxin (in this case psychoactive substances) that the patient took/absorbed is likely to be unknown, but the medical team should be able to assess what is the possible maximum amount that the patient could have taken/absorbed. Information of Known minimal lethal doses may serve as useful indicators of relative risk which the patient has. Lethal doses may be in a wide range. If the amount of taken toxin/PAS is estimated at level that could lead to death, vigorous treatment measures must be initiated at once.

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Key words: Intoxication, pre-hospital approach, ambulance

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Abstract number: 004

TRIAGE IN DISPATCHER CENTER OF EMERGENCY DEPARTMENT

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Introduction: Word dispatcher comes from the English language and preferably means a person who distributes, processes, delivers. The name itself, medical dispatching service, gives us an explanation of its purpose. Medical dispatching service is a special service within the healthcare structure, which may function as part of Emergency department or a part of the emergency medical services.
Objective: The main role of the medical dispatch service is to retrieve the call of an accident, which requires the intervention of medical services in the field, setting priorities after receiving calls and activation of appropriate medical team, with respect to the nature and location of the event.
Material and methods: The analysis and insight into relevant literature.
Discussion: Organization of dispatching centers in the Republic of Serbia is heterogeneous. A unique phone number is 194 but in smaller centers there are other numbers. Due to the lack of protocols, most emergency department relies on the experience of personnel in call centers and use internally accepted sets of questions. A small number uses existing formal protocols for triage while receiving a call. Recently, in Emergency department (ED) in Niš, nurses with high school education and university education are working on receiving a call. ED in Nis there is no official protocol for triage of incoming calls but we use internally accepted sets of questions, where it is emphasized that only a doctor can "reject" a call.
Conclusion: The majority of emergency departments today is obliged to strive to achieve standards to make shorter response time to emergency calls. For adequate recognition of the degree of urgency and the timely activation of the medical teams for emergency calls, it is necessary to make clear triage protocols that make it possible.
Keywords: 194, triage, dispatcher

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Abstract number: 005

ATTITUDE OF ADOLESCENTS TOWARD PSYCHOACTIVE SUBSTANCES

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On 5th of January this year, we had a 15 year old patient with a superficial head injury and under the influence of alcohol. He was conscious and agitated and during examination and observation his state of consciousness deteriorated and he was sent to ED, injury skull and IC bleeding was eliminated and he was referred to CC Montenegro because of alcohol poisoning. This was the reason why we did a survey in his school on the attitude of adolescents towards addiction diseases and to see in what age these phenomena happens.
During this survey we used the following methodology: We have interviewed a total of 147 students in a secondary school in Berane ages 15 and 16. 42 responses were dismissed, while we analyzed 105 responses, of which 79 (75.23%) were boys and 26 (24.77%) girls.
Results: 37 students (35.23%) have tried cigarettes of which 8 (21.63%) were girls and 29 (78.37%) boys. There were 7 (18.91%) actively smoking 1 (14.38%) female and 6 (82.35%) male, occasional smoking 6 (16.21%), 2 male (33.33%) and 4 female (82 75%) students. The average age of first contact with cigarettes was 12.5 years. 70 students (66.66%) tried alcoholic beverages of which 59(84.28%) male and 11 (15.29%) female students. The average age of first contact with alcohol is 13.6 years. Of 70 students who tried alcoholic beverages 4 (3.8%) drink often and 35 occasionally (50%) of which 30 (85.71%) are mail, and 5 (14, 29%) female. Drugs have been tried by

4 students (3.88%), the three boys had consumed only marijuana and one had hashish also. The average age of the encounter with the drug was 14.8 years. 11 students responded that they had information that someone in their company from school was using illicit drugs (11.5%)
Conclusion and discussion: The results of our survey show that boys are more prone to the consumption of tobacco and psychoactive substances than girls. A larger number of children and adolescents had tried alcohol than cigarettes 66.66% vs. 35.23%. We witness daily campaign against cigarettes, drug trafficking is prohibited by law but fight against alcoholism is insignificant, although we are aware that alcohol endangers health and leads to behavioral and personality disorder. We believe that responsible institutions should seriously undertake a campaign against alcoholism
Keywords: psychoactive substances, alcohol, cigarettes, adolescent.

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Abstract number: 006

ACUTE MIOCARDIAL INFARCION IN ROMA POPULATION, HOW TO FOCUSE PREVENTION?

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Health of Roma population is often poorer than that of general population, and this disparity is still the subject of numerous studies. Most of the papers relate to the anthropometric and genetic research, infectious diseases or reproductive health. There are few published papers on characteristics of non-communicable diseases, especially ischemic heart disease with a focus on acute myocardial infarction. Roma population often have less access to health facilities, and have special needs, bearing in mind the conditions of life, level of education and specific sociological ethnic characteristics.
The research included the Roma who were treated for acute myocardial infarction from 1.01 to 31. 12. 2015, risk factors were analyzed and their extensiveness as well as specific risk factors, clinical presentation and "Jung variable" as an indicator of mortality risk calculated on admission. Measures of secondary prevention are planned and adapted to patient individually.
On control examinations, month after hospitalization symptoms, clinical status and risk factors, complications of disease were analyzed.

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Abstract number: 007

GPS IN EMERGENCY MEDICAL SYSTEM

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Introduction: Global Positioning System - GPS is currently the only fully functional Global Navigation Satellite System (Eng. Global Navigation Satellite System - GNSS). GPS was developed in 1973. by the US Department of Defense named NAVSTAR GPS and system was declared fully operational on 17. 07.1995. In the beginning it was used only for military purposes but later was made available for free to everyone, as a public good. Annual maintenance costs are about 750 million US dollars.
Data source and selection of materials: Retrospective analysis of literature with settings: GPS, EMS, medical use of GPS. Search is done through: PubMed, Medline and electronic journals available through KoBSON as well as available literature.
The results of the synthesis: GPS system consists of three components (segments): the space segment, control segment on the ground and user segments. The space segment, which consists of at least 24 satellites, is the heart of the system. Satellites are in so called "high orbit" about 20,000 miles above Earth's surface. Operating at such a high altitude allows the signals to cover a larger area. The satellites are arranged in their orbits in that way so a

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GPS receiver on earth can always receive signals from at least four of them. The control component consists of satellite tracking stations, control stations and ground antennas. User components make GPS receivers on Earth. Receivers can be standalone devices or components incorporated into other devices, such as mobile phone, watches, new generation cameras. In medicine, especially in emergency medicine GPS system has an important role when combining with other information technologies becomes more complex and its role gains importance. Basic GPS functions in EMS: Locating the patient; Impact on reaction time; Mileage; Time spent on the road; Improvement to the "PAD" and similar systems.

GPS helps in street search, especially in unfamiliar, rural areas and significantly reduces the number of traveled kilometers, time spent on the road and in 72% of cases set location is found more quickly in comparison with standard equipment. In emergency medical system it has been proven that the use of GPS in 94% of cases meets eight-minute interval for calls first line of urgency. In this way, GPS shortens the reaction. Without GPS desired eight-minute interval is between 34% and 62%.

Keywords: GPS, use in EMS

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Abstract number: 008

POSITIONING OF PATIENT HEAD DURING ENDOTRACHEAL INTUBATION

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Introduction: The main goal of positioning the head during intubation is to achieve a straight line from the incisors to the larynx. This path has three axes (oral, pharyngeal, laryngeal). Maintaining adequate position is achieved by moving the patient's head and neck, which in the conditions of operating room is achieved by raising the head about 10 cm, while the shoulders remain on the table. This position aligns the pharyngeal and laryngeal axis. This is the so-called "sniffing position." This position implies that the earlobe-level is inline with shoulders front line.

Data source and selection of materials: Retrospective analysis of literature with settings: Positioning, endotracheal intubation. Search is done through: PubMed, Medline and electronic journals available through KoBSON as well as available literature.

Results of synthesis: Once the head is placed in the optimal position, additional moving and tilting of head aligns al axes. In the operating room, you can nearly always have an extra pair of hands for positioning, as almost never in pre-hospital setting. Many attempts can upset physician who tried to carry out this procedure and it is easy for him to lose the true sense of the patient's head position. Often the laryngoscope is used as lever and than possible soft tissue injuries and injuries to the tooth can happen. By placing folded towels, sheets under the patient's head favorable position can be achieved with slightly head tilt. This material can often be unavailable, or you can use anything that is found in your surroundings.

The headrest, in the form of bagels with a hole in the middle in which the head is placed was often used, but can be misleading that the head is in a good position, also prevents tilting of head. If you intend to use such aid should confirm that ear lobe is in the level with chest line.

Assistant`s hand can also be helpful and is available immediately.

If the patient is obese, the width of the chest wall and the breast may interfere with laryngoscopy and visualization. By forming the ramp with placing of folded sheet under the shoulders, with the aim of aligning the ear canal with the sternum, often improves the ability to open the mouth and see larynx.

Conclusion: The positioning of the head when placing the endotracheal tube is one of the ways to facilitate and enable intubation. Often this task belongs to the nearest physician's assistant - nurse / medical technician and their role is of the greatest importance.

Keywords: positioning, endotracheal intubation

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Abstract number: 009

COMPLICATIONS OF VARICELLA IN CHILDREN

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Introduction: Varicella in unvaccinated populations occurs most often in children aged 1-6 years. Persons older than 14 years account for 10% of all cases. About Varicella (chickenpox) is usually thought of as a mild viral disease from which children recover easily and without major complications. However, chickenpox is not completely benign, even today. The mortality rate in the general population is 6.7 cases per 100,000 inhabitants. A significant number of cases are associated with serious complications including pneumonia and encephalitis.
Data source and selection of materials: Retrospective analysis of literature with settings: varicella, complications, consequences, risk factors. Search is done through: PubMed, Medline and electronic journals available through KoBSON as well as available literature.
Results of synthesis: Varicella Zoster virus belongs to a DNA group, a subgroup of Alphaherpesvirus. It enters through conjunctiva and upper respiratory mucosa. Incubation time is 10-21 days. Viral replication occurs in the regional lymph nodes in the next 2-4 days and 4-6 days later, the virus spreads to reticuloendothelial cells. The patient is contagious 1-2 days before the rash appears and until crust formation. Infection of the central nervous system is also happening at this moment. Some children are more at risk from of developing severe disease with complications, even with lethal outcome. Children with increased risk are: 1: In the first month of life, especially if the mother is seronegative; 2: Treatment with high doses of corticosteroids (1-2 mg / kg / d prednisolone) over the past 2 weeks. Even short term therapy in these doses immediately before or during the incubation period can cause serious or fatal chickenpox; 3: Malignancy: All children with malignancy and in particular with leukemia. Nearly 30% of patients who are immunocompromised and who have leukemia have a severe form of chickenpox and 7% died. 4: Diseases of immune system (HIV, congenital or acquired immunodeficiency disease). Data show that 1:50 children have complications. The most common are pneumonia and encephalitis, and both are associated with high mortality. Viral pneumonia is one of the most serious complications, which are more common in older children. Respiratory symptoms appear 3-4 days after rash. Symptoms of secondary bacterial infections can be identified within the first 3-4 days. Skin lesions provide door for entry of bacteria; rapidly spreading cellulitis, sepsis. The most common agents responsible are group A streptococci and Staphylococcus aureus. In addition to toxic shock syndrome, streptococcus can cause necrotizing fasciitis, osteomyelitis, pyomyositis, gangrene, subgaleal abscess, arthritis, and meningitis. The most common neurological complication, with an incidence of 1 case per 4,000 patients, is postinfectious acute cerebellar ataxia which has a sudden onset, occurs 2-3 weeks after the start of chickenpox. Manifestation can vary from mild instability of incompetence to stand and walk, with accompanying incoordination, dysarthria, complaints were prominent at the beginning and gradually subside. Sensorium is preserved, even when the ataxia is profound. It can take as long as two months. The prognosis for patients with ataxia is good, but some children may have residual ataxia. Encephalitis occurs in 1.7 patients per 100,000 cases in otherwise healthy children aged 1-14 years. The disease is manifested during the acute phase of the chickenpox few days after the appearance of rash. Lethargy, drowsiness, confusion, and convulsive seizures can quickly move towards a deep coma. This serious complication has a mortality rate of 5-20%. Other neurological complications include aseptic meningitis, myelitis (Sy Guillain-Bare) poliradiculitis and encephalitis. About 5% of children develop otitis media caused by the usual pathogens. Severe hepatitis with clinical manifestations is rare in otherwise healthy children and development is independent of severity of changes on the skin and systemic manifestations. Not detecting occult complications and infection and can lead to serious illness and even death.

Keywords: varicella, complications.

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DRUGI MEĐUNARODNI KONGRES
DRUŠTVA LEKARA URGENTNE MEDICINE SRBIJE
NIŠ, 2016.

ZBORNIK SAŽETAKA

SAŽECI: DOKTORI

Broj apstrakta: 001

PLAN ZA SLUČAJ MASOVNE NESREĆE U SLUŽBI URGENTNE MEDICINE OPŠTE BOLNICE LESKOVAC

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OPŠTA BOLNICA LESKOVAC, SLUŽBA ZA PRIJEM I ZBRINJAVANJE URGENTNIH STANJA, SRBIJA

Uvod: U masovnim nesrećama i katastrofama značajna je primena urgentnih mera lečenja prehospitalno: na licu mesta, u toku transporta i hospitalno, odmah na prijemu u bolnicu u Službi urgentne medicine (SUM), jer definitivno hiruško i medicinsko zbrinjavanje nije moguće u prvim satima, naročito u okolnostima smanjenih resursa. Važno je da samopomoć, prva pomoć na mestu događaja, reanimacija, stabilizacija i druge neoperativne medicinske procedure mogu biti dovoljne za spašavanje života čak i za teško povređenog. Opšte procedure i blagovremena primena reanimacionih mera: održavanje prohodnosti disajnog puta, zaustavljanje krvarenja, davanje tečnosti, intravenska nadoknada tečnosti, mogu za izvesno vreme stabilizovati žrtvu sa teškim i po život opasnim povredama, pre nego što se one definitivno medicinski zbrinu u bolnici. Kvalitet početnog prehospitalnog zbrinjavanja i pravovremena primena urgentnih mera lečenja na mestu događaja, u toku transporta i na prijemu u bolnicu može uticati na šanse povređenih ili obolelih za preživljavanje.
Prikaz: Služba za prijem i zbrinjavanje urgentnih stanja bolnice (SUM) ima svoj plan za slučaj masovnih nesreća i akcidentalnih situacija, i u grubim crtama upošljenici su upoznati sa planovima drugih organizacija koje učestvuju u zbrinjavanju u masovnim nesrećama (služba hitne pomoći, službe policije, grada i regiona). Plan službe je deo plana Opšte bolnice za slučaj masovnih nesreća. Da bi plan aktivnosti u vanrednim situacijama bio ostvarljiv neophodno je da se analiziraju svakodnevne radne aktivnosti, opremljenost i prostorna mogućnost u službi.
Plan obuhvata način organizovanja, način rada i opis procedura koje se primenjuju u slučaju masovnih nesreća. Medicinski deo u službi se odvija kroz tri osnovne aktivnosti:

1. Prijem pacijenata
2. Trijaža i retrijaža pacijenata
3. Medicinski tretman
4. Urgentni medicinski transport u drugu zdravstvenu ustanovu

U slučaju masovne nesreće povređeni se u SUM bolnice dovoze kolima hitne pomoći, policije, privatnim kolima ili na drugi način. Na ulazu kroz bolničku kapiju prijem pacijenata u bolnicu se od strane osoblja službe obezbeđenja usmerava ka bolničkoj zgradi i SUM koja se nalazi u prizemlju bolničke zgrade pored ulaza. Prijem pacijenata se vrši po proceduri za prijem a primenjuje se procedura za trijažu pacijenata u masovnim nesrećama. Osoblje koje radi u smeni SUM započinje prijem, trijažu i medicinski tretman povređenih, obaveštava načelnika službe o nesreći i očekovanom broju povređenih i postupa po proceduri za masovne nesreće. Aktivira se Tim za rukovođenje u službi za slučaj masovnih nesreća i po potrebi vrši pozivanje upošljenika službe koji bi trebali da pomognu u medicinskom tretmanu. Dolazak timova iz ostalih službi, koji su planom službi određeni kao ispomoć službi urgentne medicine, za kratak vremenski period značajno se povećava broj medicinskih radnika u bolnici koji učestvuju u medicinskom tretmanu žrtava masovne nesreće.

Ključne reči: Masovna nesreća, plan, bolnica, trijaža, zbrinjavanje, reanimacija

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Broj apstrakta: 002

SANITETSKO OBEZBEĐENJE JAVNOG SKUPA POVEĆANOG RIZIKA-PRIKAZ SLUČAJA

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Uvod: Stanje na sportskim borilištima u Srbiji, ali i u ostalom delu sveta, pokazuje da pre, posle i za vreme takmičenja, sportska strast i želja za pobedom nekada probijaju okvire korektnog navijanja za svoj tim i prelaze u fizičke obračune, neretko sa velikim posledicama po bezbednost ljudi i objekata.
Cilj: rada je da pokažemo da sanitetsko obezbeđenje sportskih skupova povećanog rizika predstavlja složen zadatak koji zahteva angažovanje različitih institucija, saradnju između različitih resora i organizacionih jedinica u zbrinjavanju većeg broj povređenih.
Prikaz slučaja: Po čemu i da li se razlikovao 148. po redu od ostalih derbija koja je odigran dana 25. 04. 2015. godine između FK Crvena Zvezda – Partizan u Beogradu? Derbi je počeo sa 45 minuta zakašnjenja i odigran je u tri poluvremena. Prvo poluvreme je proteklo bez igrača na terenu a započeo je megdanom Delija na severnoj i istočnoj tribini protiv policije i žandarmerije. U tom delu „utakmice“ povređen je veliki broj pripadnika MUP-a, gledalaca i došlo je do demoliranja tribina. Sukobi su počeli pre početka utakmice oko stadiona a nastavljeni su na stadionu gde su navijači dva tima razmenjivali pirotehnička srestva, stolice i kamenice. U zbrinjavanju povređenih pripadnika MUP-a učestvovale su i tri medicinske ekipe iz sastava sanitetske službe Žandarmerije. Epilog sukoba: lakše su povređena 35 pripadnika MUP-a i nekoliko navijača. „Policija je efikasno i profesionalno reagovala i sprečila da sukob, koji je grupa navijača izazvala na stadionu na samom početku utakmice, dovela do otkazivanja utakmice i mogućih većih posledica“(saopstenje MUP-a Srbije).
Zaključak: Sa medicinskog aspekta za organizatora sportskog takmičenja najvažnije je da ima veći broj obučenih medicinskih ekipa koje će pravilno i pravovremeno da ukažu prvu pomoć na licu mesta. Za ekipe koje ukazuju pomoć važan je timski rad, obučenost i posedovanje odgovarajuće medicinske opreme. Povezivanje svih službi na terenu i potojanje plana zbrinjavanja u ovakvim situacijama je ključ uspeha.
Ključne reči: sportski skup, povezivanje, zbrinjavanje

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Broj apstrakta: 003

ZMIJSKI UJED - KLINIČKA SLIKA, PRVA POMOĆ I LEČENJE

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Procenjuje se da širom sveta 1.2 miliona ljudi doživi ujed zmija svake godine i procenjuje se da nekoliko stotina hiljada imaju dugotrajne sekvele a da nakon ujeda zmije kod oko 100.000 dođe do fatalnog ishoda. Biohemijskom analizom zmijskih otrova utvrđeno je da oni sadrže mnogobrojne enzime.
Proteolitički fermenti digestije dovode do opsežnih nekroza, svi toksini imaju antigena svojstva a žrtve ujeda najčešće umiru u toksičnom šoku koji dovodi do diseminovane intravaskularne koagulacije. Svaki ujed zmije se tretira kao ujed otrovnice. U toku predavanja biće objašnjena procedura kod prve pomoći na terenu i stručne medicinske pomoći na terenu. Antiviperini serum ne daje se rutinski kod svih ujeda zmija otrovnica. Prave indikacije za primenu antiviperinum seruma su rani znaci sistemske intoksikacije ili rapidno širenje lokalnog otoka sa buloznim promenama.
Ključne reči: Zmijski ujed, prva pomoć, stručna medicinska pomoć, antiviperinum serum

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Broj apstrakta: 004

UČESTALOST EPILEPTIČNIH NAPADA U TOKU HIPOGIKEMIJE KOD DIJABETIČARA

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Uvod: Hipoglikemija kao multifaktorijalni sindrom ima brojne posledice na zdravlje ljudi i umanjuje kvalitet života. Najčešće se javlja kod dijabetičara koji su na insulinskoj terapiji uz neregulisanu glikemiju, ali se javlja i kod alkoholičara, gladovanja, tumora pankreasa, poremećaja rada hipofize i nadbubrežne žlezde kao i posle gastrektomije. Hipoglikemija se manifestuje vrtoglavicom, konfuzijom, umorom, glavoboljom, neprilićnim ponašanjem koje se može pogrešno shvatiti pijanstvom, slabom koncentracijom, napadima konvulzije i komom. Prolongirana hipoglikemija može trajno oštetiti mozak. Najvažnija je prevencija u sprečavanju razvoja hipoglikemije i nastajanja toničko kloničkih konvulzivnih napada. Terapija se u urgentnim hipoglikemijskim stanjima sprovodi administracijm hipertone glukoze intravenski.
Cilj rada; Utvrditi učestalost javljanja konvulzivnih napada u toku hipoglikemije i njihovih komplikacija u okviru primarne zdravstvene zaštite.
Metodologija: Retrospektivnom studijom ispitano je 145 dijabetičara oba pola, starosti od 30-80 godina koji su dolazili na lekarske preglede u DZ Čukarica u Beogradu u toku 2015. godine.
Rezultati: Ispitano je 145 dijabetičara sa utvrđenim stanjem hipoglikemije, 34% muškog i 66% ženskog pola, starosti od 30-80 godina. Od ukupnog broja ispitanih epileptični napad je imalo 9 (6.2%) dijabetičara. Nivo glikemije 2-3mmol/l je imalo 65.5%, 2-1mmol/l 28.3%, a ispod 1mmol/l 16.2%. Ispitanici koji su imali epileptični napad su zadobili povrede u 33.3%, 11.1% je imalo epileptični status, dok je 88.9% hospitalizovano. Od ukupno ispitanih 75% je primilo 10% glukozu, a 2% 50% glukozu intravenski.
Zaključak: Hipoglikemija kao urgentno stanje koje može da dovede do teških konvulzija je veoma značajna sa medicinskog aspekta. Davanjem hipertonog rastvora glukoze rešava se trenutno stanje i sprečava razvoj opasnih komplikacija. Međutim, pravilno sprovođenje prevencije uz edukaciju pacijenta da pravovremeno prepoznaju znake hipoglikemije i sprovedu kontrolu glikemije, prate smernice u ishrani i terapiji dijabetesa smanjiće učestalost ovog poremećaja i razvoj konvulzija
Ključne reči: Konvulzije, hipoglikemija, dijabetes

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Broj apstrakta: 005

TRAUMATSKA DIJAFRAGMALNA HERNIJA

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Uvod: Traumatska dijafragmalna hernija nastaje poslije povreda i penetracija ili tokom intervencija. Najčešće se javlja na lijevoj posteriornoj dijafragmi i može proći kroz tri faze: akutnu, latentnu i opstruktivnu.
Sinteza pregleda: U akutnoj fazi povređeni mogu da imaju tahipneju, hipotenziju, odsustvo disajnog šuma u grudima ili prisutnu crijevnu peristaltiku u predjelu grudnog koša. Ako se dijagnoza propusti, pacijent će skliznuti u latentnu fazu. Ona se karakteriše povremenim visceralnim hernijacijama sa nejasnim bolom u stomaku poslije jela, mučninom, povraćanjem i podrigivanjem. Ako hernija ide u opstruktivnu fazu, prisutan je abdominalni bol, rastezanje i povraćanje. Inkarcerirana kila stvara crijevnu opstrukciju i ishemiju. Tenzioni viscera toraks ukazuje na povećanje intrapleuralnog pritiska uzrokovanog hernijom što rezultira pomjeranjem medijastinuma na suprotnu stranu sa kompresijom pluća i vene kave. Venski dotok je smanjen i praćen hipotenzijom i hemodinamskim kolapsom. U akutnoj fazi, radiografija grudnog koša predstavlja najbolji skrining test. Kod prisutne hernije u grudima može da se uoči nazogastrična sonda. Ostali nalazi obuhvataju elevaciju dijafragme, pomjeranje medijastinuma, pleuralno zadebljanje i atelektazu. Kompjuterizovana tomografija ne detektuje male dijafragmalne rascjepe. Na povredu dijafragme treba sumnjati uvijek nakon penetrantne povrede lijevog donjeg predjela grudi ili gornjeg abdomena. Važno je potvrditi herniju lijeve strane, pošto je slezina neće spriječiti kao što to čini jetra na desnoj. Dijagnostičkom peritonealnom lavažom procjenjuje

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se intraperitonealno krvarenje. Laparoskopija je najbolji način za otkrivanje malih dijafragmalnih rascjepa. Bitno je konsultovati hirurga u ranoj fazi promjena.
Liječenje počinje dekompresijom nazogastričnom sondom i ublažavanjem intratorakalnog pritiska. Kod hipotenzivnih pacijenata i sumnje na pneumotoraks indikovano je otvaranje torakostome koju treba uraditi veoma pažljivo. Ljekar obavezno provjerava da li je cijev plasirana u šupljinu grudnog koša bezbjedno po crijeva i intraperitonealni sadržaj. Čim se potvrdi povreda dijafragme indikovano je hitno hirurško zbrinjavanje.
Ključne reči: traumatska dijafragmalna hernija, faze, dijagnostika, liječenje

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Broj apstrakta: 006

POJAVA Q-GROZNICE U GRADU BANJA LUKA U PRVOM TRIMESTRU 2016.GODINE

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Uvod: Q-groznica je akutno oboljenje koje izaziva Coxiella burneti i spada u grupu antropozoonoza. Osnovni rezervoari su ovce, goveda i koze koje izlučuju koksijelu stolicom, mokraćom i mlijekom, naročito tokom okota. Inkubacija traje od 9 – 28 dana. Oko polovine bolesnika uz opšte simptome, ima atipičnu pneumoniju. Hronična infekcija može se prezentovati kao endokarditis, hronični hepatitis, osteomijelitis, fibroza pluća i hronični vaskulitis.
Cilj rada: uvid u epidemiološke podatke i diferencijalna dijagnoza status febrilisa, pneumonija i Q-groznice u gradu Banja Luka, od 01.01.2016. do 22.03.2016.god.
Metodologija: Retrospektivna analiza protokola SHMP i HES službe JZU DZ Banja Luka.
Rezultati: Broj oboljelih u navedenom periodu je 17, od toga muških 15, ženskih 2. Po dobnoj strukturi dominiraju pacijenti starosti 41-50god (6), 31-40 (5), 51-60 (3), 61-70 (3). Svi oboljeli su upućeni pod dg. St. febrilis, Pneumonia na Infektivnu kliniku UBKC BL, gde je provedena laboratorijsko-serološka obrada i potvrđeno da se radi Q-groznici.
Zaključak : U SHMP nije bilo registrovanih pacijenata sa dijagnozom Q-groznice , dok je u HES službi bilo 17 registrovanih pacijenata sa ovim oboljenjem. Značaj prevencije infekcije u cilju suzbijanja infekcije je u domenu veterinarske zdravstvene zaštite i edukacije stanovništva koje je u neposrednom kontaktu sa stokom. Edukacija zdravstvenih radnika sa osvrtom na rano prepoznavanje akutnih i hroničnih parametara Q groznice ima veliki značaj u ranom prepoznavanju ove bolesti.
Ključne reči: Q-groznica, rano prepoznavanje u SHMP, HES

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Broj apstrakta: 007

DEHIDRATACIJA I REHIDRATACIJA KOD DJECE SA FEBRILNIM STANJEM U SHMP JZU DZ BANJA LUKA U PRVOM TRIMESTRU 2015.

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SLUŽBA HITNE MEDICINSKE POMOĆI SA EDUKATIVNIM CENTROM JZU DZ BANJA LUKA, REPUBLIKA SRPSKA

Uvod: Dehidratacija predstavlja nedostatak vode i elektrolita u organizmu. Postoje tri oblika dehidratacije: izonatrijemijska, hipernatrijemijska i hiponatrijemijska. Dehidratacija dovodi do hipovolemije koja smanjuje MV i TA, što stimuliše hipotalamus i hipofizu da luče ACTH i kortizol što remeti glikemiju, izaziva aktivaciju simpatikusa sa posljedičnim poremećajem homeostatskih mehanizama. Nakon kompenzatorne faze, ako se tečnost i dalje gubi, nastupa dekompenzatorna faza. U kliničkoj slici razlikujemo blagu, umjerenu i tešku dehidrataciju. Liječenje dehidratacije se provodi oralnim i parenteralnim putem.

Cilj rada: 1. Ispitati broj pacijenata sa febrilnim stanjem u Dječijoj ambulanti SHMP u periodu od 01.01.-01.04.2015.god., koji su imali simptome dehidratacije, 2. Izbor tretmana 3. Broj djece upućene na hospitalni tretman.
Metodologija: Retrospektivnom analizom protokola u Dječijoj ambulanti uzeti su u obzir pacijenti pod dg. St. Febrilis.
Rezultati: od ukupno pregledanih 2271 pacijenata, pod dg. St febrilis, bilo je 478 djece (21,05%). Od toga 245 muškog pola (51.26%) i 233 ženskog pola (48,74%). Po dobnoj strukturi najviše djece je bilo preko 7 godina, 161 (33,68%). Parametar tjelesne temperature preko 39°C imalo je 123 djece (25,73%), 316 je bilo sa temperaturom do 39°C (66,11%), a 39 je bilo sa temperaturom do 37,5°C(8,16%). 216 djece je imalo patološki nalaz laboratorije, 96 je imalo povećan broj segementiranih leukocita, što ukazuje na bakterijsku infekciju. Izbor terapije: antipiretici (89,54%), antibiotici (37,87%), oralna rehidratacija (89,54%), parenteralna rehidratacija (0,42%), inhalacije (3,35%). Od 478 djece na bolničko liječenje je upućeno 50, od toga na Infektivnu kliniku 21(4%), a na Pedijatriju 29(6%). Ostala djeca su zbrinuta u SHMP.
Zaključak: Pri pregledu pacijenata – djece sa febrilnim stanjem, važno je uspješno procijeniti opšte stanje djeteta, postaviti tačnu dijagnozu i primjeniti odgovarajući tretman. S obzirom da je mali broj djece parenteralno tretiran, veliku važnost je imala edukovanost roditelja u peroralnoj rehidrataciji i regulisanju tjelesne temperature kod djece. Također u odnosu na mali broj pacijenata upućenih na bolničko liječenja do značaja dolazi pravilan izbor tretmana na prehospitalnom nivou.
Ključne reči: febrilno stanje, dehidratacija, rehidratacija, izbor terapije

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RESPIRATORNA POTPORA PACIJENTA SA POST CARDIAC ARREST SINDROMOM

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Uvod: Uspešan povratak spontane cirkulacije (ROSC) je samo prvi korak ka postizanju osnovnog cilja – kompletnom oporavku od srčanog zastoja. Termin post cardiac arrest sindrom (post CA Sy) obuhvata kompleksne patofiziološke procese koji prate ishemiju celog tela i sledstvenu reperfuziju za vreme srčanog zastoja i posle uspešne resuscitacije. Post CA Sy obuhvata post CA oštećenje mozga, post CA miokardnu disfunkciju, sistemsku ishemiju/reperfuzioni odgovor i perzistentnu precipitirajuću patologiju.
Kontrola oksigenacije: Iako se 100% kiseonik koristi standardno u početnoj fazi resuscitacije (do postizanja ROSC-a) i studije na životinjama i opservacione kliničke studije ukazuju na potencijalnu štetu od toksičnosti kiseonika u daljem lečenju. Pacijenti koji su imali kratak period srčanog zastoja (promptno reagovali na odgovarajući tretman) ne zahtevaju endotrahealnu intubaciju i ventilaciju, ali treba im dati kiseonik na masku ako je SaO2 <94%. Naime, i hipoksemija i hiperkapnija uvećavaju mogućnost ponovnog srčanog zastoja i mogu dovesti do sekundarnog oštećenja mozga. Međutim, neke studije na životinjama su pokazale da hiperoksemija rano posle ROSC-a uzrokuje oksidativni stres i oštećuje postishemične neurone. Jedna studija na životinjama (psima) je pokazala da u prvom času posle ROSC-a primena kiseonika u koncentraciji dovoljnoj da se postigne SaO2 94-96% povezana sa povoljnijim neurološkim oporavkom nego primena 100% kiseonika. Multicentrična klinička studija (obuhvatala je baze podataka jedinica intenzivnog lečenja 120 bolnica u SAD) koja je uključila 6326 pacijenata sa vanbolničkim srčanim zastojem je takođe pokazala da post-resuscitaciona hiperoksemija (PaO2>300mmHg) u prva 24 h je udružena sa lošijim ishodom u poređenju sa normoksemijom i čak hipoksemijom.
Kontrola ventilacije: Razmotriti endotrahealnu intubaciju, sedaciju i kontrolisanu ventilaciju kod pacijenata sa smanjenom moždanom funkcijom (Vt 6-8ml/kg, PEEP 4-8cm H2O). Hipokapnija, uzrokovana hiperventilacijom dovodi do vazokonstrikcije, cerebralne ishemije i nepovoljnijeg neurološkog ishoda. Hiperventilacija, takođe, povećava intratorakalni pritisak, sa sledstvenim smanjenjem vraćanja venske krvi u srce, što dovodi do pada minutnog volumena srca. U nedostatku podataka iz relevantnih prospektivnih studija (koje su u toku), preporuka je obezbediti adekvatnom ventilacijom normokapniju (monitoring – kapnometrija, gasne

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analize). Kod pacijenata sa post CA sindromom potrebno je dalje uvesti nazogastričnu sondu (smanjuje se pritisak u želucu posle ventilacije usta na usta ili balon-maska ventilacije), razmotriti davanje bolus doza neuromuskularnih blokatora i sprovođenje kontinuirane EEG. Po potrebi, proveriti položaj tubusa rendgengrafijom grudnog koša i detektovati komplikacije CPR-a, kao što je pneumotoraks izazvan prelomom rebara.
Zaključak: Veliki je izazov pred lekarom, naročito u prehospitalnim uslovima, da kod pacijenata sa post CA Sy, adekvatnom oksigenacijom i ventilacijom obezbedi normoksemiju i normokapniju i izbegne komplikacije u vidu barotraume i volutraume pluća ili depresije kardiovaskularne funkcije.
Ključne reči: Post CA Sy, oksigenacija, ventilacija, normoksemija, normokapnija

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PREVALENCIJA ARTERIJSKE HIPERTENZIJE U ZAVODU ZA HITNU MEDICINSKU POMOĆ PODGORICA U 2015.GOD.

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Uvod: Uprkos značajnom preventivnom radu, lako dostupnoj i adekvatnoj antihipertenzivnoj terapiji, pacijenti sa visokim vrijednostima arterijskog krvnog pritiska i dalje su česti u ambulantnom radu ljekara za hitnu medicinsku pomoć.
Prevalencija arterijske hipertenzije visoka je kako u Crnoj Gori tako i u zemljama regiona i ostatka Evrope. Nepravilna ishrana, fizička neaktivnost, pušenje, konzumacija alkohola, stres u životnom i radnom okruženju doprinose pojavi visokih vrijednosti arterijskog pritiska i u mlađoj životnoj dobi.
Cilj ovog rada je prikazivanje prevalencije arterijske hipertenzije u ambulanti Zavoda za hitnu medicinsku pomoć u Podgorici u 2015. godini.
Materijal i metode: Istraživanje je sprovedeno tokom mjeseca marta 2016. godine, a kao materijal korišteni su ambulantni protokoli Zavoda za hitnu medicinsku pomoć Podgorica iz 2015. godine. U statističkoj obradi podataka korištene su metode deskriptivne statistike.
Rezultati: Od ukupnog broja pregledanih pacijenata u 2015. godini kojih je bilo 58009, njih 5677 je sa arterijskom hipertenzijom i to 2899 muškaraca (51,07%) i 2778 žena (48,93%). Arterijska hipertenzija se pojavljuje u uzrastu od 20-29 godine i to u 6,25% slučajeva kod muškaraca i 3,1% kod žena. U periodu od 30-39 godina procenat muškaraca je 13,11%, a žena 6,8%. Procenat arterijske hipertenzije u dobi od 40-49 godina je kod muškaraca 19,39%, a kod žena 15,19%. U starosnoj kategoriji od 50-59 godina procenat je 22,80% kod muškaraca, odnosno 26,46% kod žena. U periodu od 60-69 godina procenat je 22,90% kod muškaraca, a 26,89% kod žena, dok je u dobi od 70 i više godina procenat muškaraca 14,9% , a žena 21,49%. Istraživanje je pokazalo da se arterijska hipertenzija javlja u većem broju kod muškaraca u odnosu na žene i to za 1,04 puta. Najveći procenat muškaraca sa izmjerenim vrijednostima visokog krvnog pritiska je u periodu od 60-69 godina, kao i kod žena. U dobi od 20-49 godina broj muškaraca sa visokim vrijednostima arterijskog krvnog pritiska veći je u odnosu na žene; žena je više u periodu od 50-69, kao i u dobi od 70 i više godina. Najveći broj pacijenata sa visokim vrijednostima arterijskog krvnog pritiska javio se u mjesecu januaru 2015. godine i to njih 619 (10,90%).
Zaključak: Arterijska hipertenzija i komplikacije kao i njene posljedice, značajan su faktor morbiditeta i mortaliteta zbog čega ukazuju na potrebu neprekidnog preventivnog rada, stalne edukacije pacijenata i članova njihove poroodice, a zbog svega navedenog neiscrpna je tema za stručnu javnost.
Ključne reči: arterijska hipertenzija, prevalencija, Zavod za hitnu medicinsku pomoć Podgorica

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ZNAČAJ OPSERVACIJE U URGENTNOM ZBRINJAVANJU PACIJENATA

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Prikaz slučaja: 18.01.2016. ekipa HMP dobija sa nejasnim opisom tegoba od strane pozivaoca, ali pošto se radi o prvom komšiji lekara u smeni, poziv je prihvaćen..
Na licu mesta zatičemo pacijenta koji šeta po sobi i drži se za stomak. Od tegoba navodi bol u stomaku i rukama („teške su mu ruke, malaksale, teško mu je da ih podigne“), nadimanje koje traje skoro celo jutro, a od pre 30 minuta je postalo malo jače (dok je čistio sneg i saginjao se). Takođe, navodi da ima „čir na želucu“i da je prethodne večeri preterao sa jelom. Na svoju ruku je uzeo tbl.Espumisan, kako bi malo „rasteretio želudac“ i „smanjio nadimanje“. Inače, pacijent je medicinski tehničar u penziji. Malo se bolje sada oseća.Navodi da mu se slična situacija desila i prenekoliko dana kad je nosio teret do kola, kada nije mogao da unese teret u kola zbog bolova u rukama. Objektivnim pregledom utvrđuje se sledeće:TA 170/110 („nikada nije imao toliki pritisak“). Cor et pulmo: b.o. EKG – sinusni ritam, HR 53/min, bez znakova ishemije i lezije. Periferni pulsevi prisutni, simetrični, dobro punjeni.Abdomen: iznad nivoa grudnog koša, palpatorno lako bolno osetljiv u epigastrijumu, tegoba se ne širi, peristaltika čujna, nije ubrzana. Neurološki nalaz uredan. Glikemija 6.5mmol/l. Pacijent transportovan do službe HMP, uz terapiju: amp. Ranisan, tbl. Aspirin 300mg, sprej Nitrolingual SL.U toku trajanja opservacije pacijentu je čas bolje čas gore, ali tegoba je i dalje prisutna. Na ponovljenom EKG zapisu, nakon 40 minuta uočavaju se znaci prednjeg STEMI. Plasirana IV kanila, ordinirana terapija: Plavix 300mg, Clexane 0,3ml iv, sprej Nitrolingual II slPacijent je upućen na dalje zbrinjavanje na interno odeljenje ZC Zaječar, gde mu je odmah urađena koronarografija i urađena pPCI na LAD.
Zaključak: Ovim naglašavamo i podsećamo, pre svega mlade lekare, da je stručni oprez (uz medicinsko znanje, naravno) i ekspektativan stav kod nejasnih stanja, veoma bitan pri postavljanju dijagnoze i tretmanu pacijenata, naročio na terenu, gde je trijažna odluka mnogo teža nego u ambulanti. Uvek je bolje sačekati, držati pacijenta „na oku”, sve dok je dijagnoza nesigurna, dok se ne iscrpu svi dostupni dijagnostički kriterijumi. Diferencijalna dijagnoza je široko polje, i verovatno ni u jednoj grani medicine nema toliki značaj kao u urgentnoj medicini.
Ključne reči: opservacija, hitna pomoć

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ANOMALNI IZLAZAK LEVE KORONARNE ARTERIJE IZ PLUĆNE ARTERIJE – ZNAČAJ EHOKARDIOGRAFIJE ZA RANU DIJAGNOZU I ADEKVATAN HIRURŠKI TRETMAN

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Anomalni izlazak glavnog stabla leve koronarne arterije iz plućne arterije (ALCAPA) je veoma retka kongenitalna anomalija. U normalnom srcu leva koronarna arterija izlazi iz aorte i ishranjuje srce krvlju koja je bogata kiseonikom. Kod dece sa ALCAPA leva koronarna arterija polazi iz plućne arterije i nosi neoksigenisanu krv iz pluća u srce. Ukoliko se na vreme ne otkrije većina pacijenata umre u najranijem detinjstvu od ishemijske kardiomiopatije. Fontan i Edvards su 1962 godine prikazali 58 postmortem uzoraka ove mane umrlih u ranom detinjstvu. Prikazujemo žensko odojče uzrasta 7 meseci koje je zbog respiratorne infekcije pregledano u primarnoj zdravstvenoj zaštiti. Tada je otkriven šum na srcu, pa je upućeno dečijem kardiologu. Iz lične anamneze: beba je rođena u terminu, PT 3400gr, PT 52cm, AS 9/10. Dobro je napredovala prvih 5 meseci. U šestom mesecu života dobila je virusnu infekciju gornjih respiratornih puteva. Od tada stagnira u težini, povremeno se oznoji po čelu u toku podoja, ne zamara se, ne diše ubrzano. Objektivno: bez jasnih znakova srčane slabosti, eupnoična, bleda, bez cijanoze, SF 100/min, BR 32/min, SatO2 94%. Na vrhu srca čuje se sistolni šum 3/6, propagira se ka aksili. Jetra se pipa 1 cm ispod rebarnog luka. Radiografski, TCI>55%, Elektrokardiografski postoje znaci ishemije i fibroze lateralnog zida miokarda. (dubok Q talas u I odvodu, aVL i

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prekordijalnim odvodima u V5 i V6). Ehokardiografski je prikazana jasna dilatacija i hipokontraktilnost leve komore EF<30%. Mitralni aparat je fibrozno izmenjen, MR 2/4. Izrazita fibroza mitralnog aparata kao i srca u celini podstakla je sumnju da se radi o ALCAPI. Iz kratkog parasternalnog preseka prikazano je anomalno izlaziše leve koronarne arterije (LCA) iz stabla plućne arterije. Desna koronarna arterija (DCA) je urednog izlazišta, dilatirana. Dijagnoza je osim ehokardiografski, potvrđena i angiografijom koronarnih arterija. Odmah po postavljanju dijagnoze učinjena kardiohirurška intervencija po tipu transfera leve koronarne arterije sa urednim operativnim i dugoročnim postoperativnim tokom. Godinu dana nakon operacije dobrog opšteg stanja. Urednog rasta i razvoja, TT 12kg TV 77cm.
Zaključak: ALCAPA je retka, ali životno ugrožavajuća kongenitalna anomalija. Mogućnost rane ehokardiografske dijagnoze i usavršavanje hirurških tehnika omogućilo je da se prognoza pacijenata sa ALCAPA dramatično poboljša.
Ključne reči: leva koronarna arterija, plućna arterija, ishemija miokarda, dilatativna kardiomiopatija

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MET I ASA KLASIFIKACIJE KAO PREDIKTORI PERIOPERATIVNIH KOMPLIKACIJA U ABDOMINALNOJ HIRURGIJI

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Uvod: Prema revidiranim preporukama Američkog koledža kardiologa i Američkog udruženja kardiologa za 2014. god za perioperativnu evaluaciju pacijenta koji se podvrgava nekardiohirurškoj operaciji metabolički ekvivalent (MET) koji je pokazatelj funkcionalnog kapaciteta je pouzdan prediktor perioperativnih srčanih komplikacija (KVS). Prema Američkom udruženju Anesteziologa ASA klasifikacija (ASA) je važan prediktor postoperativnog mortaliteta.
Cilj rada je da se ispita mogućnost predviđanja perioperativnih komplikacija uz pomoć MET i ASA.
Materijal i metod: U studiju je uključeno 35 pacijenata oba pola starosti od 30god do 86 god koji su se podvrgli velikim abdominalnim operacijama u KBC Bežanijska kosa. Grupu pacijenata sa komplikacijama (SKG) činilo je 11 pacijenata, a kontrolnu grupu bez komplikacija 24 (KOG). Određivali smo na osnovu anamnestičkih podataka u istoriji bolesti MET i ASA klasifikaciju, a zatim pratili klinički tok pacijenta do završetka lečenja u bolnici i registrovali sledeće komplikacije: smrt, hirurške komplikacije (infekcija rane, popuštanje anastomoze, reintervencije) i KVS komplikacije (infarkt miokarda, edem pluća, ventrikularna fibrilacija, srčani zastoj i kompletan srčani blok). Vrednosti ASA ispitanika bile su od 1 do 3, a vrednosti MET 1 (za MET manji od 4 što označava slab ili nepoznat funkcionalni kapacitet), 2 (za vrednosti MET od 4-6 što ukazuje na srednji funkcionalni kapacitet) i 3 (za vrednosti MET veće od 7 što ukazuje na dobar i odličan funkcionalni kapacitet).
Rezultati: U SKG 4 pacijenta je imalo hirurške i KVS komplikacije, vrednosti ASA bile su 2,3,3,3, a MET je kod jednog pacijenta bio 1, dok je kod ostala tri bio 2. Samo hirurške komplikacije je imalo 5 pacijenata, njihove vrednosti ASA bile su 1,2,2,2,3, MET je kod četiri pacijenta bio 2, dok kod jednog 3. Samo KVS komplikacije je imalo 2 pacijenta, vrednosti ASA su bile su 2 i 3, a MET je kod oba bio 1. Čak 5 pacijenata sa komplikacijama je imalo smrtni ishod, njihove ASA vrednosti bili su 1,2,3,3,3, a MET 1,1,1,2,2. U grupi pacijenata sa postoperativnim komplikacijama statistički značajno je bila niža vrednost MET ($p<.05$), a značajno viša vrednost ASA u odnosu na kontrolnu grupu ($p<0.05$). U grupi pacijenata sa postoperativnim KVS komplikacijama statistički je bila niža vrednost MET ($p<0.05$), kada pitanju predviđanje letalnog ishoda, pokazao se kao značajan predictor.
Zaključak: Za procenu ukupnog rizika za postoperativne i kardiovaskularne komplikacije nakon velikih abdominalnih operacija mogu se koristiti ASA i MET klasifikacije. Nijedna od klasifikacija nije bila prediktor abdominalnih komplikacija. Jedini prediktor postoperativnog mortaliteta je je loš funkcionalni kapacitet (nizak MET).
Ključne reči: preoperativna evalucija, operativni rizik, funkcionalni kapacitet, MET, ASA

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ZNAČAJ IZVOĐENJA PERKUTANE TRAHEOSTOMIJE (PT) KOD PACIJENATA NA PRODUŽENOJ MEHANIČKOJ VENTILACIJI (MV)-NAŠA ISKUSTVA

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Uvod: Perkutna traheostomija predstavlja minimalno invazivnu tehniku obezbeđivanja disajnog puta. Počela je da se primenjuje 80-ih godina prošlog veka kada su je izvodili ORL hirurzi. Danas je to procedura koja se izvodi u JIL-a ili u operacionoj sali. Mogu je izvoditi obučeni lekari, otorinolaringolozi a najčešće intenzivisti i anesteziolozi. Najčešće indikacije su produžena mehanička ventilacija, zaštita vazdušnog puta i toaleta traheo-bronhijalnog stabla ili kada treba premostiti opstrukciju disajnog puta. Ovim načinom se izbegavaju komplikacije hirurške traheostomije, krvavljenje, povrede štitne žlezde, jednjaka, infekcije rane oko traheostome, suženje dušnika, emfizem mekih tkiva vrata i sredogruđa, traheomalacija. Brže je odvajanje od MV, smanjen rizik od aspiracija, smanjenje otpora u disajnim putevima, smanjenje mrtvog prostora i rada pri spontanom disanju, bolja je higijena usne duplje.
Cilj ovog rada je da prikažemo značaj izvođenja PT kod kritično obolelih pacijenata na PV u JIL.
Materijal i metode: U prospektivnoj studiji pratili smo kritično obolele pacijente kojima je u KBC "Bežanisjka Kosa" na odeljenjima JIL II i JIL III u periodu od juna 2014. do marta 2016 god. izvedena perkutana traheostoma. Pacijenti su bili starosne dobi od 60-79god. Na vratu bolesnika odrede se orijentacione tačke u visini 1-2, ili 2-3 trahealnog prstena, učini se mali rez na koži vrata. Tankom iglom se vodičem ulazi u traheju. Igla se vadi dok tanki vodič ostaje u traheji. Preko vodiča se uvode odgovarajući dilatatori koji proširuju otvor u vratu i traheji do širine endotrehealne kanile. Skida se dilatator i plasira endotrahealna kanila. Vrši se provera funkcionisanja kanile, odnosno da li je adekvatna ventiliacija
Rezultati: Ukupan broj pacijenata je bio 15. Kod 14 pacijenata je urađena elektivna intervencija a kod 1 pacijenta je PT urađena kao urgentna intervencija za obezbeđenje disajnog puta (Ca baze jezika). Dužina boravka na MV je kod 8 pacijenata bila 21 dan, kod 3-18 dana i kod 3-15 dana. Pre plasirana PT od pacijenata ili rodbine je zatražen pismeni pristanak za intervenciju. Pacijentima je urađena osnovna laboratorija (krvna slika, biohemija, koagulacioni status). Kod 12 pacijenta PT je urađena u operacionoj sali sa pripremljenim setom za PT i setom za izvođenje hirurške traheostomije. Ekipu su činila dva anesteziologa, anestetičar, instrumentarka i hirurg koji je obučen za izvođenje hirurške traheostomije. Kod 2 pacijenata ekipa je bila u sastavu dva anesteziologa, anestetičar i instrumentarka. Kod svih pacijenata intervencija je urađena u opštoj anesteziji uz standardni monitoring. Nakon plasiranja PT proverena je pozicija i prolaznost PT auskultatorno, aspiracionim kateterom, monitoringom pacijenata (pulsna okimetrija, kapnometrija), gasne analize, RTG pluća. Kod 1 pacijenata je ventilacija bila nemoguća pa je on ponovo intubiran (paratrehealno uvođenje kanile)
Zaključak: Perkutana traheostomija je jednostavna i efikasna metoda za obezbeđivanje disajnog puta kod pacijenata na produženoj MV sa malim brojem komplikacija. Potrebno je angažovanje malog broja zaposlenih i sredstava, pa možemo reći da je relativno jeftina metoda. Obuka za izvođenje PT je jednostavna.
Ključne reči: Perkutna traheostomija, produžena mehanička ventilacija

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PERIDURALNA I INTRAVENSKA PRIMENA LOKALNIH ANESTETIKA U TERAPIJI BOLA KOD AKUTNOG PANKREATITISA

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Uvod: Prema revidiranim Atlantskim kriterijumima iz 2013 god American College of Gastroenterology deli se na blagu, srednju i tešku formu AP. Intravensko davanje lidokaina je efikasno za tretirenje visceralnog bola a moze poboljšati i crevnu funkciju.
Cilj rada je da se ispita statistički značajna razlika izmedju intravenske i periduralne primene lokalnih anestetika.
Materijali metode: Kod 10 pacijenta koji su primljeni u JIL naše bolnice sa formom lakog i srednje teškog AP, kod 5 pacijenta plasirali smo EDK (EDKG), kod drugih 5 smo intravenski primenjivali lidokain (LG). Pacijenti u EDKG su dobijali 0,125% bupivacaine (Marcain). Pacijenti u LG dobijali su bolus dozu lidokaina 1,5-2mg/kg a zatim se nastavljalo sa infuzijom lidokaina u dozi 1,5-2mg/kg/h naredna 24h. Uporedjivali smo jačinu bola na osnovu VAS skale 1-10, potrebu za dodavanje drugih analgetika (ketrolak, tramadol), vreme do pojave peristaltike, vreme do pojave gasova. Merenja smo vršili prvog dana na 2h a drugog dana na 4h po prijemu u JIL.
Rezultati: U EDK grupi kod tri pacijenta nismo dodavali drugi analgetik. Jedan pacijent je dobio 30mg ketrolaka i 50mg tramadola. Kod jednog pacijenta zbog neadekvatne pozicije katetera nastavilo se sa klasičnom analgezijom. U LG grupi dva pacijenta nisu imala potrebe za dodavanjem analgetika, dva su dobila po 30mg ketrolaka i po 50 mg tramadola. Kod jednog pacijenta infuzija je morala biti prekinuta zbog neželjenih efekata lidokaina. VAS skor u grupi sa EDK-om je bio 1,6±2,4 a u LG grupi 1,8±3,1. U EDK grupi peristaltika se čula 12,5± 7,5h, a prvi gasovi su se javili 22,5±13,5h a u LG grupi peristaltika se čula 10,7+- 5,5h a prvi gasovi 15,5±6,2h Kod jednog pacijenta iz LG grupe sa srednje teškom formom AP, intravensko davanje lidokaina je ponovljeno na isti način 14 dana nakon prvog davanja sa istim rezultatima.Ovo su prvi rezultat našeg istraživanja koje se nastavlja.
Zaključak: Kod AP lake i srednje teške forme, primena EDK i intravenskog lidokaina u tretmanu bola, bržeg uspostavljanja peristaltike i prevencije ileusa nije bilo značajne razlike. Smatramo da je upotreba infuzije lidokaina manje invanzivna i jednostavnija za upotrebu od primene EDK-a.

Ključne reči: Acutni pancreatitis, EDK, infuzija lidokaina

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PREDSTAVLJANJE MEĐUNARODNOG URLA SIMULACIONOG CENTRA MINISTARSTVA ZDRAVLJA REPUBLIKE TURSKE ZA TRENING IZ OBLASTI URGENTNE MEDICINE I ZBRINJAVANJA U MASOVNIM NESREĆAMA

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Uvod: Urla centar za simulaciju i trening iz oblasti urgentne medicine i oblasti zbrinavanja u masovnim nesrećama (UrlaSim), osnovan je od strane Ministarstva zdravlja na ostrvu Urla, 38km udaljenom od Izmira. Državna Bolnica Urla sagrađena je 1955, Trening i Simulacini Centar, istorijska zgrada karantina je takođe locirana na ostrvu. Ministarstvo zdravlja je dozvolilo formiranje centra za trening kao i prostora za smeštaj polaznika treninga na ostrvu pod nazivom "Internacionalni centar za urgentnu medicinu, medicinu katastrofe, trening i simulacioni centar-URLA SIM". U ovom centru postoje 20 sala za trening i edukaciju kao i 40 hotelskih soba sa 97 kreveta.
Sinteza podataka: Preko 10.000 polaznika iz cele zemlje je pohađalo akreditovane treninge i programe počev od 2004 god. Ovi sertifikovani treninzi su pre svega namenjeni za osoblje hitne medicinske službe 112 i Nacionalnog medicinskog tima za urgentni odgovor (NMRT) i održavaju se u prirodnom i realnom okruženju kao i salama za

trening na samom ostrvu. U 2005, 2008 i 2010 na ostrvu je održano i međunarodno takmičenje hitnih medicinskih službi. Nacionalni i internacionalni timovi hitne pomoći su ocenjivani prilikom rešavanja kliničkih scenarija. Takođe nekoliko projekata, treninga i radionica su sprovedena uz učešće specijalista urgentne medicine iz drugih zemalja. Generalni Direktorat Ministarstva Zdravlja, Hitnih pomoći i projekat za administrativnu pomoć pripremili su projekat i konkurisali kod Svetske banke u 2012 za izgradnju UrlaSim centra. Svetska Banka je odobrila kredit, tako da su fantomi i simulacioni progremi i sva potrebna oprema kupljena novcem od tog projekta. Emergency Medical Services Training Programi: Basic Life Support Module (5 days); Adult Advance Life Support Course (3 dana); Pediatric Advance Life Support Course (4 dana); Trauma Life Support Course (4 dana); Ambulance Driving Techniques Course (5 dana); Neonatal Resuscitation Course (3 dana); Ambulance Team Standardization Training (1 dana); 112 Command and Control Center Training (2 dana); Air Ambulance Basic Training (5 dana); Emergency Health Instructor Trainings; First Aid Course (2 dana); First Aid Instructor Course (5 dana); First Aid Master Instructor Course (5 dana) Disaster Medicine Trening Programi: Medical Incident Command Course (2 dana); Hospital Disaster Planning Course (3 dana); Disaster Medicine Training (5 dana); NMRT* Basic Training (8 dana); NMRT Wrecked Area Training (2 dana); NMRT Water Rescue Training (2 dana); CBRN Training (2 dana).
2015 Nacionalni Treninzi: Kurs hitnih stanja-broj treninga 3 (69 polaznika); Advanced Life Support Course-broj treninga 6 (130 polaznika); Advanced Pediatric Life Support Course-broj treninga 1(18 polaznika); Trauma Life Support Course-broj treninga 12 (269 polaznika); Approach on Criminal Cases Course-broj treninga 7 (292 polaznika)
2015 Internacionalni Treninzi: Države: Albanija (64 polaznika); Benin (4 polaznika); Mađarska (17 polaznika); Kirghizia (30 polaznika); Liban (16 polaznika); Makedonija (45 polaznika); Mongolija (16 polaznika); Republika Obala Slonovače (4 polaznika). Ukupan broj:196.
Zaključak: UrlaSim je postao specijalizovani trening centar za timski rad, sigurnost pacijenta, kao i za simulacione programe zasnovane na scenarijima koji vode iskusni instruktori počev od 2013 god. Počev od 2014, planira se otvaranje centra sa simulacijom u bolničkim uslovima (urgentni prijem, jedinica intenzivne nege, operaciona sala, sterilizacija, i sl.) U bolničkoj zgradi smešten je software za simulaciju koji olakšava terninge i to kako manuelne tako i kabinetske treninge. Protokoli su potpisani sa domoćim i međunarodnim univerzitetima u cilju sprovođenja međunarodnih i nacionalnih kurseva zdravstvenog osoblja.
Ključne reči: internacionalni trening, Urlasim

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ŠTA URADITI U PRVOM SATU KOD PACIJENATA SA AKUTNIM KORONARNIM SINDROMOM (AKS)?

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Cilj je odrediti osnovne postupke i medicinski tretman u prvom satu kod pacijenata sa AKS
Rezultati: Postoje tri različita entiteta akutnog koronarnog sindroma (ACS) koja obuhvataju akutni manifestaciju koronarne bolesti srca: infarkt miokarda sa ST elevacijom (STEMI), infarkt miokarda bez ST elevacije i nestabilna angina pektoris (NAP). U prvom satu nakon pojave simptoma, prehospitalni tretman i inicijalne terapije na urgentnom prijemu mogu da se razlikuju prema resursima i lokalnim mogućnostima. Tipični simptomi za AKS su bol u grudima, otežano disanje i znojenje. EKG i biomarkeri treba da budu deo početne procene svih pacijenata sa simptomima srčane ishemije. Da bi se postavila dijagnoza infarkta miokarda u prvim satima nakon pojave simptoma, nije potrebna potvrda u porastu biomarkera iz oštećenog miokarda. Efikasne tehnike za procenu bolesnika sa sumnjom na AKS, a negativnim EKG i negativnim srčanim biomarkerima su neinvazivne tehnike: CT angiografija, magnetne rezonanca srca, perfuzione tehnike i ehokardiografija. Ehokardiografija bi trebalo da bude rutinski dostupna u prijemnim odeljenjima za sve pacijente sa sumnjom na AKS.

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Zaključak: Za lečenje AKS jedan od terapeutskih agenasa je gliceril trinitrat. Ako je sistolni krvni pritisak (SBP) iznad 90 mmHg i pacijent ima ishemijski bol u grudima moze se upotrebiti nitroglicerin. Za bol koji se ne smanjuje uz nitroglicerin, morfijum je izbor za analgeziju, koji ima i umirujuće dejstvo na pacijenta čime je dodavanja sedativa nepotrebno. Istovremeno morfijum je dilatator venskih kapilara pa će koristi kod pacijenata sa plućnom kongestijom. Pacijentima sa simnjom na AKS ne treba dodatni kiseonik, osim ako imaju znake hipoksije, otežano disanje ili znake srčane insuficijencije. Ali, ako se AKS razvija u srčani zastoj, hipoksija koja se razvija tokom KPR je veoma bitna te je adekvatna oksigenacija je od suštinskog značaja. Kiseonik (100%) treba koristiti do postizanja saturacija arterijske krvi u rasponu od 94-98%. Za inhibiciju agregacije trombocita, mogu se koristiti acetilsalicilna kiselina (ASA) i inhibitori receptora agregacije trombocita. Oralna doza ASA (150 do 300 mg neobloženi oblik) ili 150 mg IV treba dati što je pre moguće za sve pacijente sa sumnjom AKS. ASA može dati prvi lekar, laik ili sam pacijent koji će biti savetovan od strane dispečera hitne medicinske pomoći u skladu sa lokalnim protokolima. Clopidogrel i Prasugrel mogu koristiti kao inhibitori ADP receptora takođe. Antithrombini poput nefrakcioniranog heparina (UFH) koji se u kombinaciji sa ASA koristi u sadejstvu sa fibrinolitičkom terapijom ili PPCI i važan su deo lečenja nestabilne angine i STEMI. Enoxaparin, fondaparin i bivalirudin su nosioci antithrombinske terapije koja se koriste u AKS. Reperfuzija treba da se primeni što je pre moguće, korišćenjem najpogodnije raspoložive strategije za pacijente sa STEMI u roku od 12 časova od pojave simptoma. Reperfuzija se može postići primenom fibrinolize, primarnom perkutanom koronarnom intervencijom (PPCI), ili kombinacijom oba. Efikasnost reperfuzije zavisiće od vremenskog intervala od pojave simptoma do reperfuzije. Fibrinoliza je efikasna posebno u prvih 2 do 3 časa posle pojave simptoma; efikasnost PPCI je manje vremenski zavisna. U tretmanu AKS korišćenje odgovarajućih lekova i pravovremna intervencija pogotovo u prvom satu od početka simptoma može biti po život spašavajuća.

Ključne reči: Akutni koronarni sindrom, pristup

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RESPIRATORNI ARREST KOD PACIJENTA SA HOBP I SRČANOM INSUFICIJENCIJOM-PRIKAZ SLUČAJA

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Prikaz slučaja: Komšija poziva HMP zbog pacijenta R.Ž. starog 74 god., zbog osećaja gušenja, otoka na nogama i stomaku koje traju duže vreme, poziv primljen kao treći red hitnosti. Pacijent zatečen na krevetu, u sedećem položaju, svestan, orjentisan, dispničan, tahipničan, bled, nije preznojen, sa izraženom perifernom cijanozom. Žali se na gušenje i navodi da se leči od HOBP. Pri pregledu nalazimo sledeće vitalne parametre: TA 80/50mmHg; SF oko 136/min; RF 24 SpO_2 nismo bili u mogućnosti da izmerimo; norm TT. Disanje obostano oslabljeno, do polovine plućnih polja prisutni pukoti. Nad srcem, akcija aritmična, nešto tiši i brzi srčani tonovi, šumove ne čujem. Pretibijalni otoci izraženi, znakovi za ascit se ne vide. Na ECG-u: AF sa odgovorom komora 70-140, desna srčana osovina, bez znakova jasne ishemije, sa aplatiranim T talasima u D3 i aVL. Prisutne retke VES. Postavljena IV linija, ecg monitoring, i uključen O_2 2L/min Započet transport do Klinike za kardiologiju. Pripremljena amp Amynophillin koju smo nameravali da damo u toku transporta. Odmah po ulasku u auto pacijent pravi bizarne pokrete ruku i lica, gubi svest. Prestaje da diše. Data amp Adrenalin IV, intubiran u prvom minutu ETT No8, O_2 sa protokom 5L/min, ventiliran frekvencom 10/min. Započeta kompresija grudnog koša. Na monitoru se pojavljuje VT sa pulsom zbog čega je data amp Amiodaron 150 mg u sporom IV bolusu Posle 3-4 min javljaju se plitke spontane respiracije. Nastavlja se sa asistiranom ventilacijom, za 3min pacijent počinje ujednačeno da diše sa frekvencom od oko 12 respiracija u min. U daljem toku pacijent dobija nagon na povraćanje, ne toleriše tubus pa se odlučujemo da ga ekstubiramo. Pacijent počinje da reaguje na grube draži otvaranjem očiju i kroz 10 min i na poziv po imenu.

Zaključak: Smatramo da se respiratorni arrest u ovom slučaju javio na terenu prisutne srčane insuficijencije i respiratorne insuficijencije, prisutna VT se može objasniti dilatativnom kardiomiopatijom kako je kasnije

potvrđeno UZ nalazom. Brza i adekvatna reakcija da se omogući održavanje vitalnih parametara je preduslov uspešnosti postupka reanimacije.

Ključne reči: respiratorni arrest, srčana insuficijencija

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GLAVOBOLJA KAO PRVI I PREDOMINANTNI NEUROLOŠKI SIMPTOM ENCEFALITISA, PRIKAZ SLUČAJA

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Uvod: Glavobolja je jedan od najčešćih neuroloških simptoma kod ljudi. Encefalitis je oboljenje čiji je jedan od osnovnih simptoma glavobolja, povraćanje, povišena temperatura, poremećaj svesti (80% obolelih), i fokalni neurološki znaci. Najčešće počinje naglo, ima progresivan tok i visok rizik za pojavu komplikacija i posledica. U približno 75% slučajeva u anamnezi postoje podaci o prethodnoj respiratornoj infekciji, upali ždrela, enterokolitisu, osipnoj virusnoj bolesti, otoku limfnih čvorova. Većina odraslih se oporavi bez posledica, sekvele se javljaju kod 3-70% obolelih. Smrtnost se dešava kod 3-30% obolelih.
Prikaz slučaja: Devojka starosti 29 godina bez prethodne medicinske istorije dovežena u službu HMP zbog gubitka svesti za koji pratnja tvrdi da je trajao 10 min. Kada je došla svesti nije bilo povraćanja, bezvoljnog umokravanja ili defekacije. Pacijentkinja nije osećala umor. Pratnja navodi da pacijentkinja unazad 5 dana ima glavobolje koje popuštaju na analgetike (Ibuprofen). Glavobolje je povezala sa promenom vremenskih prilika i smenom godišnjeg doba. Navodi da je bol u celoj glavi i u vidu pritiska. Druge neurološke tegobe negira. Bez povišene temperature. Na pregledu, vitalni znaci uredni, (TA, puls, EKG, Glu, Sat O_2). U neurološkom nalazu, osim konfuznosti i nepovezanog pričanja ostalo bez osobenosti. Meningealni znaci su bili negativni. Isto veče pregledana od strane neurologa koji je konstatovao uredan nalaz i tražio da se uradi RTG vratne kičme i EEG, zbog sumnje na epilepsiju. Glavobolje su se nastavile, a 2 dana kasnije pre dolaska kod izabranog lekara pacijentkinja je ponovo izgubila svest. Bez svesti je bila kraće od 10 min. Kad je postala svesna, povratila je i na samom pregledu je odavala utisak da je pospana. Neurološki nalaz je ponovo bio uredan. U konsultaciji sa lekarom odlučeno da se vrati kući i da sutra dođe i uradi laboratorijske analize. Ujutru, ukućani nisu uspeli da je probude. Dovezli su je u HMP. Na pregledu, reagovala samo na grube draži motornim odgovorom, nije otvarala oči, GSK 4, od meningealnih znakova ustanovljen je ukočen vrat, odvežena na neurologiju a potom sprovedena na infektologiju gde je potvrđen virusni encefalitis na osnovu nalaza likvora. Pacijentkinja je i dalje hospitalizovana.
Zaključak: Glavobolja kao simptom može biti posledica nekih bezazlenih stanja koja ne zahtevaju lečenje ali isto tako može biti posledica stanja koja su opasna po život. Vrlo je bitno da i najbezazlenijim formama glavobolje pristupimo sa većom opreznošću, kako bismo neke stvari iz kliničke slike i dijagnostičkih nalaza što pre prepoznali pa samim tim i pre pomogli pacijentu i sprečili nastanak ozbiljnih komplikacija koje bi uticale na sam ishod bolesti.

Ključne reči: glavobolja, gubitak svesti, neurološki nalaz, meningealni znaci, encefalitis

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PREDNJE LEVI HEMIBLOK KAO PRETHODNIK AKUTNOG INFARKTA MIOKARDA, PRIKAZ SLUČAJA

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Uvod: Infarkt miokarda ima karakteristične EKG znake koji ukazuju na pojavu ovog urgentnog stanja. Sa druge strane, često je EKG normalan ili pokazuje neke nespecifične znake u prvim trenucima, što često može da zavara lekara.
Cilj rada: prikaz slučaja pacijenata kod koga je prednje levi hemiblok bio prethodnik akutnog infarkta.
Prikaz slučaja: Pacijent star 54 god, koji je imao infarkt miokarda sa ST elevacijom, čemu je prethodila pojava prednjeg levog hemibloka.
Pacijent je tokom prepodneva obavljao lakši fizički posao i osetio jak bol u grudima, sa prednje leve strane. Obzirom da se zdravstvena institucija nalazila u neposrednoj blizini, za 5 min je pregledan i urađen je EKG zapis, koji osim postojanja prednjeg levog hemibloka, nije imao ST promene, niti poremećaj ritma. Pacijent je bio orošen hladnim znojem, držao se za grudi i bio izuzetno malaksao. Krvni pritisak je bio normalan. Pacijentu je u dva navrata dat nitroglicerin pod jezik i nakon 10 min tegobe su se u potpunosti povukle. Pacijent je čak izrazio nameru da ustane i ode, jer se osećao dobro, ali je ipak zadržan i ponovljen je EKG, koji je sada jasno imao elevaciju ST segmenta u D2, D3 i aVF od 3-4mm, sa jasnom ST depresijom u suprotnim odvodima. Pacijentu su dati acetilsalicilna kiselina i klopidogrel i transportovan je u Klinički centar gde je koronarografija pokazala okluziju desne koronarne arterije. Ugrađena su dva stenta i pacijent je zadržan na daljem lečenju. Nakon oporavka, pacijent je u svojoj medicinskoj dokumentaciji pronašao svoj EKG, urađen na sistematskom pregledu godinu dana pre infarkta na kome nije postojao prednji levi hemiblok.
Zaključak: U ovom slučaju je prednje levi hemiblok očigledno je bio prvi znak na EKG za AIM donjeg zida, koji je nakon kraćeg veemana prešao u ST elevaciju. Tipična klinička slika ostaje dominantan znak, a u slučajevima kada je EKG normalan ili nekarakterističan, zahteva oprez i opservaciju pacijenta.
Ključne reči: infarkt, hemiblok, EKG

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POKUŠAJ SAMOUBISTVA VEŠANJEM, PRIKAZ SLUČAJA

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Uvod: Prema podacima Svetske zdravstvene organizacije milion ljudi godišnje sebi oduzme život. Svakih 40 sekundi u svetu neka osoba izvrši samoubistvo. U Evropi u proseku samoubistvo izvrši oko 30 000 ljudi godišnje. Istraživanja su pokazala da je više od 90% osoba koje su izvršile samoubistvo bolovalo od depresije ili nekog drugog mentalnog poremećaja, ili je bilo sklono zloupotrebi psihoaktivnih supstanci. Upadljivo je da je broj muških samoubica veći nego ženskih, kao i da je broj samoubica u našoj zemlji najveći kod osoba bez završene škole ili sa nedovršenom osnovnom školom.
Prikaz slučaja: Muškarac 57 godina je pokušao da izvrši samoubistvo vešanjem. Dok je stigla služba HMP, komšija i žena su ga skinuli sa vešala. Lekar konstatuje spontano disanje, TA 110/70mmHg, GSK 3, zenice su bile uske, na grube draži je reagovao dekortikacijom (fleksijom ruku i ekstenzijom nogu), nije bilo verbalnog odgovora. Vidljiv je bio trag omče oko vrata i deformitet grkljana. Na licu mesta mu je imobilisan vrat. U bolnici pregledan od strane neurologa, interniste i anesteziologa. Internista je konstatovao da su vitalni znaci uredni. Neurolog je na osnovu dekortikacionog reagovanja konstatovao ozbiljne ishemijske promene. Od terapije dat kortikosteroid intravenski. Pacijent je intubiran uz maksimalnu pažnju zbog deformiteta grkljana i transportovan na neurohirurgiju. Izvučen tubus jer je pacijent spontano disao. Na Urgentnom centru urađen MSCT glave i vrata, koji pokazuje da nema ishemijskih promena mozga, niti preloma vratne kičme već je samo prisutna

dislokacije hioidne kosti ulevo i naviše, mekotkivne strukture su bile uredne. Pacijent ostavljen na posmatranju zbog očekivanog edema mozga. Posle nekoliko dana se potpuno oporavio i na dalje lečenje je bio upućen nadležnom psihijatru.
Zaključak: Da li postoji prevencija samoubistva? Zahvaljujući struci kojom se bavimo osposobljeni smo da prepoznamo promene u ponašanju naših najbližih. Da li smo to stvarno u stanju kod naših pacijenata a da nismo njihovi lekari, psihijatri? Možda bi trebalo među građanstvom više podizati svest o tome da se ovakve stvari dešavaju, ali to je tema za neke druge kongrese. Svakako je bitno da kada već dođe do pokušaja samoubistva ispoštujemo sve procedure koje određuje protokol u takvim situacijama!
Ključne reči: pokušaj samoubistva, vitalni znaci, dekortikaciono reagovanje, MSCT glave i vrata

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PRIMUM NON NOCERE, NAJZNAČAJNIJE ETIČKO NAČELO MEDICINE ALI I NEOPHODNA VODILJA U KRITIČNIM SITUACIJAMA, PRIKAZ SLUČAJA

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Uvod: Nakon pooštravanja kaznene politike prestupnika u saobraćaju u našoj zemlji, broj žrtava i povređenih u saobraćajnim nezgodama je smanjen. U periodu od 2010. do 2014. godine taj broj je prosečno iznosio 653 poginula lica godišnje, dok je broj povređenih iznosio 18714 lica godišnje. Za 2014. godinu je iznosio 536 lica koji su poginuli, a bilo je 14720 povređenih. Broj poginulih biciklista za taj period bio je 299. Svesni smo toga da su pešaci, biciklisti i motociklisti prema Svetskoj zdravstvenoj organizaciji najranjivije kategorije učesnika u saobraćaju! Kako na pravi način postupati kada je neko povređen u saobraćajnoj nezgodi je vrlo značajno! Bar svi vozači bi trebalo to da znaju, a da li je to zaista tako? Svi, kao medicinski radnici znamo šta znači, Primum non nocere, očigledno da sa time treba da upoznamo i ostatak populacije!
Prikaz slučaja: Žena starosti 59 godina, vozač bicikla, udarena od strane automobila u zadnji točak dok je skretala udesno. Prilikom pada, glavom je udarila u beton, parijetookcipitalno i momentalno je izgubila svest. Sve se desilo na očigled njenog sina i ćerke koji su pritrčali, podigli je bez prethodne imobilizacije vratne kičme kako bi je transportovali u najbližu zdravstvenu ustanovu. U domu zdravlja je stavljena Šanc kragna, vitalni znaci su bili uredni, spontano je disala ali nije dolazila svesti. Za transport je stavljen airway. Na glavi je ustanovljena lacerokontuzna rana parijetookcipitalno bez vidljivih znakova preloma kostiju lobanje. U bolnici je intubirana, rana ušivena i upućena neurohirurgu. U urgentnom centru urađen MSCT glave i vrata gde je ustanovljen kominutivni prelom C2-C4 sa zabadanjem fragmenata u medulu spinalis. Prognoze su bile loše, uz vrlo malo moguće preživljavanje sa kvadriplegijom. Pored terapije održavanja života, pacijentkinja je posle 3 dana preminula.
Zaključak: Iz ovog prikaza slučaja vidimo koliko je važno da celokupna populacija bude edukovana u smislu prve pomoći! Čak se ne moramo ni usredsrediti na traumu o kojoj se ovde radi, koliko na bilo koju situaciju u kojoj je nečiji život ili zdravlje ugroženo! Bez obzira na veliku želju da se nekome pomogne, jako je bitno i iz neznanja mu ne naškoditi! Zato i jeste jedan od najznačajnijih etičkih načela medicine, Primum non nocere (Prvo ne škoditi, ili Prvo ne učiniti štetu)! Dužni smo da podižemo svest ljudi oko nas o važnosti poštovanja procedura prve pomoći kada su ovakve situacije u pitanju! To je naš zadatak i misija!
Ključne reči: primum non nocere, saobraćajna nezgoda, povreda glave, imobilizacija vratne kičme

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NOĆNA HIPOGLIKEMIJA - PRIKAZ SLUČAJA IZ PRAKSE

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Termin hipoglikemija je grčkog porekla i doslovno znači „pad šećera u krvi". Hipoglikemija je najčešća akutna komplikacija šećerne bolesti, s kojom se lekari hitne pomoći sreću na terenu. U najvećem broju slučajeva nije praćena fokalnim neurološkim znakovima i znacima meningealnog nadražaja. Nakon terapije hipertonom glukozom uobičajeno dolazi do potpunog oporavka svesti.

Cilj rada: prikazom slučaja ukazati na značaj brzog reagovanja na slučaj hipoglikemije, jer produžena hipoglikemija nekad može dovesti i do smrti.

Materijal i metod rada: metod rada je prikaz slučaja jedne osobe sa hipoglikemijom, pacijenta Službe hitne medicinske pomoći Vlasotince.

Materijal za izradu rada korišćen je material iz protokola pregleda SHMP Vlasotince.

Prikaz slučaja: dana 18.03.2016. godine (br.protokola 3896 SHMP Vlasotince) nakon dobijenog poziva od brata pacijentkinje V.B. u 05:30 ekipa hitne pomoći kreće u prvoj minuti od prijema poziva i dolazi na lice mesta za pet minuta. Pacijentkinju V.B., staru 61 godinu iz Vlasotinca inače dugogodišnjeg dijabetičara (preko 15 godina) na insulinskoj terapiji, zatičemo u krevetu bez svesti, spontanog disanja uz prisutstvo pulsa nad karotidnom arterijama. Zenice su srednje dilatirane i sporo reaktivne. Koža je bleda, hladna i vlažna. Heteroanamnestički od brata pacijentkinje saznajemo da je dugogodišnji dijabetičar na insulinskoj terapiji, da je uzela večernju dozu insulina i da jutros nije mogao da je probudi za posao. Napominje da u poslednje vreme ima problema sa regulacijom nivoa šećera. Vitalni parametri: TA 170/80 mmHg, SF 70/min, RF 18/min. SpO2 96%, tt 36,8 C , ŠUK 1,2 mmol/l, EKG sinusni ritam bez znakova za ishemiju.

Terapijski pristup: plasirana je braunila i pristupilo se davanju hipertone glukoze (Sol.Glucosae 50%) i to 20 ml + 20 ml + 20ml. Nakon date terapije došlo je do brzog oporavka i ponovo izmereni šuk je 6,8 mmol/l. Pacijentkinja se budi, odgovara na pitanja ali je dosta konfuzna i kaže da joj se ovakvi padovi nivoa šećera sve češće događaju. Neurološki nalaz uredan, data preporuka za pregled endokrinologa.

Diskusija: Hipoglikemija, javlja se kada su nivoi šećera u krvi previše niski. Često se javlja kod osoba sa dijabetesom koje koriste insulin i kod nekih pacijenata koji koriste lekove koji se unose oralno. Nivo pada šećera u krvi kada pacijent oboleo od dijabetesa uradi nešto od sledećeg:

- unese previše insuina
- ne unese dovoljno hrane
- previše vežba bez užine
- čeka suviše dugo bez obroka
- pije previše alkohola

Simptomi niskog šećera u krvi: znojenje, drhtanje, osećaj gladi, osećaj anksioznosti. Ako ništa ne preduzme simptomi će postati ozbiljniji i to: otežan hod, slabost, zamućen vid, čudno ponašanje i promena ličnosti, zbunjenost, gubitak svesti i napadi. Nizak nivo šećera u krvi generalno se definiše količinom od 3,3 mmol/l ili manje.

Nizak nivo šećera u krvi tokom sna (noćna hipoglikemija) može da poremeti san, ali najčešće se ne primeti. Noćna hipoglikemija je oblik neprimećene hipoglikemije, zato, ako pacijent ima noćnu hipoglikemiju teže primeti simptome koji upozoravaju za potrebu za terapijom. Noćna hipoglikemija može da bude teška za dijagnozu i može da poveća rizik od neprimetne hipoglikemije u sledećih 48-72 sata. Ne smemo smetnuti s uma da hipoglikemijska koma može dovesti i do smrti naročito ako je dug period bez svesti.

Zaključak: u prehospitalnom tretmanu, gde su sužene dijagnostičke mere, poremećaj stanja svesti treba uvek razmatrati u više pravaca, i ako okolnosti jasno navode na osnovnu bolest. Brza reakcija hitne pomoći u tretmanu ovakvih stanja uvek će pomoći da se sačuva život JER VREME JE ŽIVOT.

Ključne reči: Hipoglikemija, šećerna bolest, terapija

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Broj apstrakta: 023

URGENTNO HIRURŠKO ZBRINJAVANJE POVREĐENIH SA PRELOMOM VRATA BUTNE KOSTI KOD GERIJATRIJSKE POPULACIJE

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Prelomi vrata butne kosti su česti u starijoj populaciji, najčešće kao posledica lokalizovane ili generalizovane osteoporoze. I najmanja, nekada i trivijalna trauma dovodi do preloma vrata butne kosti. Osteoporoza je, takodje, jedan od glavnih razloga nezarastanja ovih preloma.
Konzervativno lečenje/ležanje, analgetici, razne imobilizacije/često ne mogu da spreče pojavu lokalnih i opštih komplikacija što dovodi do velikog mortaliteta.
Operativnim lečenjem, se pojava ovih komplikacija u velikom broju izbegava jer je potrebno da se ranim operativnim lečenjem se starija povređena osoba i rano mobiliše. Stav je da se starija povređena osoba što pre operiše na najmanje traumatičan način-ugradnjom parcijalne proteze /Austin-Moor/.
Ugradnja parcijalne proteze kod preloma vrata butne kosti je rađena kod pacijenata kod kojih je postojalo loše opšte stanje-umanjen kapacitet osnovnih vitalnih funkcija, kod neuroloških bolesnika/hemiplegičara/, kod pacijenata sa patološkim prelomom kao i kod svih starijih pacijenata. Operacije ovog tipa nisu rađene kod povređenih koji nisu dobili internističku ili anesteziološku saglasnost.
U analiziranom periodu od 2014-2015 god. u OB Vršac je operisano 58 pacijenata sa prelomom vrata butne kosti kod kojih je ugrađena parcijalna proteza/starost 61-95 god./. Dominirao je levi kuk /55%/ a dominirale su žene /72,4%/
Svi su operisani u roku od 24-48 sati nakon povređivanja. Post operativni mortalitet je bio 5,17%-troje operisanih.
Ovom operacijom se otklanja bol, omogućava se brzo započinjanje aktivnih pokreta u kuku kao i rano dizanje i hod sa punim osloncem.

Ključne reči: urgentno, vrat butne kosti, prelom

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LEČENJE OTVORENIH PRELOMA DIJAFIZE HUMERUSA SPOLJAŠNJOM FIKSACIJOM-PRIKAZ SLUČAJA

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Prelomi dijafize humerusa obično nastaju mehanizmom direktne traume i tada se radi, najčešće, o poprečnim prelomima ili mehanizmom indirektne traume/pad na lakat ili ispruženu ruku/ tada najčešće nastaju kosi ili spiralni prelomi. Oštar koštani okrajak može da probije mišiće i kožu i da time postane otvoreni noseći sa sobom potencijalne komplikacije, pre svega, osteomijelitis ili tetanus.
Prelomi dijafize humerusa se leče konzervativno/viseći gips npr./ ili operativno/osteosinteza pločom i šrafovima, intramedularna fiksacija itd/
Otvoreni prelomi se, u poslednje vreme, najčešće leče spoljašnjim fiksatorom. Operaciju treba uraditi što ranije, ako je moguće, unutar 6-8 sati.
Povređeni je snažan muškarac, star 36 godina sa otvorenim kosim prelomom desnog humerusa. Prelom je zadobio na radnom mestu padom sa visine. Nakon preoperativne pripreme uz antibiotsku profilaksu i AT zaštitu operisan je u opštoj anesteziji. Nakon primarne hirurške obrade rane, pod rentgenom/C luk/ uradi se ortopedska repozicija i stabilizacija spoljašnjim fiksatorom po Mitkoviću sa 4 klina. Fiksator je nošen 4 meseca/do rentgenološkog zarastanja preloma/.

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Prednosti ovakvog načina lečenja su: lako negovanje rane, mogućnost rane mobilizacije u ramenu i laktu i spečavanje kontraktura u pomenutim zglobovima. Odstranjivanje fiksatora nakon sanacije preloma se vrši bez anestezije

Ključne reči: prelom, spoljasnji fiksator, humerus

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Broj apstrakta: 025

ŠTA JE POTREBNO URADITI U PRVOM SATU U AKUTNOM MOŽDANOM UDARU?

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U hitnim neurološkim stanjima zlatni sat se odnosi na period u trajanju od jednog sata ili manje, tokom kojih je najveća verovatnoća da će brz medicinski tretman smanjiti invaliditet ili sprečiti smrt. Poznato je da je dobar ishod najveći, ako pacijenti dobiju adekvatan tretman u kratkom vremenskom periodu, posle akutnog neurološkog događaja. Ali takođe, nema dokaza na osnovu kojih može da se zaključi da dobar ishod opada ako se deluje posle 60-og min. Podaci o zlatnim satu imaju za cilj, da pre svega, pokažu temeljni princip brze intervencije u nekim neurološkim traumatskim ili netraumatskim stanjima, a ne u užem smislu kritičnom trenutku od jednog sata. Postoji nekoliko netraumatskih neurološka stanja, poput akutne cerebrovaskularne bolesti, uključujući i tranzitorni ishemijski atak, epileptični napad i status, akutne fulminantni inflamatorni poliradikuloneuritis, egzacerbacija ili pogoršanje neuromišićnih bolesti, delirijuma i sl. Kako bi poboljšali prehospitalni tretman kod pacijenata sa akutnim neurološkim oboljenjima želimo da ukažemo na značaj "zlatnog sata" u lečenju moždanog udara. Poznato je da tromboliza alteplazom, administrirana u adekvatnom terapijskom “prozoru,” obezbeđuje efikasnu terapiju akutnog ishemičnog moždanog udara (princip »Time is Brain«). Međutim, uglavnom zbog prehospitalnog kašnjenja, bez obzira na produženje terapijskog prozora, pacijenti često stižu prekasno za takav tretman (svega 1-11% pacijenata sa moždanim udarom dobije trombolitičku tretman). Od izuzetnog značaja je dobra javna kampanja, za upoznavanje populacije sa simptoma moždanog udara. Edukacija timova hitne medicinske pomoći za sprovođenje protokola, kao što je “Stroke Code” i pravilna trijaža pacijenata su drugi elementi sa uspešno lečenje pacijenata sa akutnim moždanim udarom.

Lanac spašavanja mora biti poboljšan tako da veći broj pacijenata, može imati koristi od terapije moždanog udara koja je vremenski uslovljena. Svi cerebrovaskularni bolesnici u prehospitalnom periodu treba da se posmatraju kao kandidati za trombolizu. Pri pregledu pacijenta, lekar HMP treba da uradi brz neurološki status, odredi nivo šećera u krvi i vrednost krvnog pritiska i EKG. Povišeni krvni pritisak, se smanjuje na nivo ispod 185/110 mmHg, i za to se koristi urapidil, labetalol itd, a u slučaju bola, adekvatna analgezija. Ako je Glasgov Coma Scale 8 ili manje, moramo osigurati disajne puteve. Brz transport (sa najavom) u najbližu bolnicu u kojoj je moguće adekvatno lečiti moždani udar.

Učestalost cerebrovaskularnih bolesti u Sloveniji je oko 200 pacijenata /100.000 stanovnika, 85% ima ishemični moždani udar. Između 1. januara 2003. i 31. decembra 2014. godine, 1215 pacijenata, koje je primljeno u bolnice u Sloveniji, uključeno je u “Safe Implementation of Treatment in Stroke Register”, 3 % od svih ishemijskih moždanih udara je tretirano trombolizom. U prvih 60 minuta, što znači zlatni sat, samo 45 (3,7%) pacijenata je primalo alteplazu. Zbog malog broja, statističke analize se ne mogu uraditi pouzdano, između grupe, tretirane u roku od 1-3 sati (1-4.5 sata, u skladu sa izmenjenim smernicama) i grupe, tretirane u zlatnom satu. Mi ćemo pokazati neke detalje ishoda. Dakle, prvi zaključak može biti da ultra – rano spašavanje mozga kod pacijenata sa moždanim udarom, jednog dana može smanjiti ogroman teret invaliditeta i smrti usled moždanog udara.

Ključne reči: šlog, tromboliza

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PRINUDNA HOSPITALIZACIJA-ISKUSTVA SHMP ZAJEČAR

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SLUŽBA HITNE MEDICINSKE POMOĆI ZAJEČAR, SRBIJA

Uvod: Postupak prinudne hospitalizacije opravdan je i dozvoljen samo u slučajevima kada osoba nije sposobna da sagleda posledice svojih postupaka niti da kontroliše svoje ponašanje, odnosno kada je potencijalno opasna po sebe i/ili po okolinu. U protivnom, reč je o nedozvoljenom ograničavanju slobode pacijenta i pravnim posledicama koje mogu iz toga da proisteknu a tiču se članova tima koji obavlja ovakvu intervenciju. Zbog toga je neophodna dobra dijagnostička procena lekara na terenu o neposrednoj opasnosti za pacijenta i/ili okolinu i odluka o prisilnoj (prinudnoj) hospitalizaciji. Takođe, dobra saradnja i uvežbanost tima je od presudnog značaja za uspeh ovakve intervencije. Neretko je neophodna i asistencija policije zbog fizičkog savladavanja agitiranih/agresivnih pacijenata.
Cilj rada: Upoznavanje sa zakonskom regulativom postupka prinudne hospitalizacije i naglašavanje važnosti poznavanja iste u radu kako osoblja hitne pomoći, tako i svakog zdravstvenog radnika koji dolazi u dodir sa sličnim slučajevima.
Materijal i metodologija: Retrospektivna analiza urgentnih protokola Službe hitne medicinske pomoći Zaječar za period 01.01-31.12.2015. Kriterijum za pretragu bio je uput za psihijatriju iz bilo kog razloga. Posebno je beležen uput za hospitalizaciju koji se realizuje uz asistenciju policije i/ili je hospitalizacija sprovedena bez pristanka pacijenta (sve je posebno naznačeno u protokolima)
Rezultati i diskusija: Za posmatrani period služba hitne medicinske pomoći intervenisala je 4123 puta na terenu. Od ukupnog broja pacijenata 178 pacijenata upućeno je na odeljenje psihijatrije. Prinudna hospitalizacija sprovedena je u 69 slučajeva a asistencija policije zatražena je u 42 slučaja.
Najčešće je postupak prinudne hospitalizacije sprovođen kod pacijenata sa fijagnozom F20-F29 a zatim F40-F49.
Jedan od većih problema doneo je Zakon o zdravstvenoj zaštiti, koji je u verziji iz 1992. (Sl. glasnik RS br. 17/1992) u članu 44 doneo formulaciju: "Kada specijalista psihijatar, odnosno specijalista neuropsihijatar proceni da je priroda duševne bolesti kod bolesnika takva da može da ugrozi život bolesnika ili život drugih lica ili imovinu, može ga uputiti na bolničko lečenje...". Isti zakon 2005. godine (Sl. glasnik RS", br. 107/2005) u istom članu (44) navodi: "Ako doktor medicine, odnosno specijalista psihijatar, odnosno specijalista neuropsihijatar proceni da je priroda duševne bolesti kod bolesnika takva da može da ugrozi život bolesnika ili život drugih lica ili imovinu, može ga uputiti na bolničko lečenje...". Dakle, zakonodavac je problem sa specijalističkog (psihijatrijskog ili neuropsihijatrijskog) vratio na nivo lekara opšte medicine ili lekara bilo koje specijalnosti (koji dolazi u kontakt sa ovakvim pacijentima, a pritom nije ni psihijatar ni neuropsihijatar) obavezu, ali i odgovornost u rešavanju ovakvih problema.
Osoblje službi hitnih pomoći je relativno često (a svakako neuporedivo češće u odnosu na one koji ne rade u HMP) u kontaktu sa ovom problematikom na terenu. Brza i efikasna pomoć je svakako neophodna, no postoji više faktora koji otežavaju odluku i sam način izvođenja intervencije.
S pravnog stanovišta prinudna hospitalizacija je lišavanje slobode. Pred lekarom (doktorom medicine, neuropsihijatrom, psihijatrom ili lekarom druge specijalnosti) suočenim sa prisilnom hospitalizacijom stoje brojne dileme (stučne, pravne, etičke, socijalne) koje, svaka za sebe, ali i zajedno, nose visok nivo odgovornosti pri donošenju odluke u ovako delikatnim situacijama.
Zaključak: Primena prinudne hospitalizacije, bilo kao kratkoročni postupak (uklanjanje duševnog bolesnika iz društva kao opasnog), bilo kao dugoročni način kontrole nad duševno obolelim koji su izvršili krivično delo (osuđeni duševni bolesnik na zatvorskoj meri lečenja), bilo kao ad hoc tehnika"tretmana" uznemirenog pacijenta, stalno će zahtevati sveža stručna, sociološka, psihijatrijska i pravna preispitivanja, ne samo zbog osnovne protivrečnosti (kažnjen a neuračunljiv), nego zbog nasilja koje je sve prisutnije u društvu a nije ni u kakvoj vezi sa psihičkim poremećajem učinioca.

Ključne reči: Prinudna hospitalizacija, hitna pomoć

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AKUTNI KORONARNI SINDROM - MOŽE I OVAKO!

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Uvod: Akutni koronarni sistem (AKS) obuhvata tri entiteta sa istim patološkim mehanizmom, gde se u osnovi nalazi suženje sa posledičnom delimičnom ili potpunom opstrukcijom i zahteva hitan medicinski tretman. To su: akutni infarkt sa ST elevacijom (STEMI), akutni infarkt bez ST elevacije, (NSTEMI) i nestabilna angina pektoris (NAP). Kada se AKS prezentuje sa tipičnim simptomima, dijagnoza se postavlja u skladu sa nalazom na EKG. Dijagnostika postaje otežana kada simptomi ne ukazuju jasno na koronarnu bolest kao i kada EKG ima nejasne i netipične EKG znake.
Prikaz slučaja: Dana 16.12.2015. u 17:00 ekipa HMP upućena na poziv drugog reda hitnosti kod pacijentkinje Ž.O. stare 53 god zbog gušenja, nakon udahnutog sredstva za čišćenje kupatila. Ekipa HMP na licu mesta nakon 4 min zatiče pacijentkinju na krevetu u sedećem položaju, normalne prebojenosti kože i vidljivih sluzokoža, umereno tahipnoična, ne odaje odaje utisak teškog pacijenta. U celoj kući se oseća Domestos, koji nas jasno upućuje na postojeći problem. Odmah otvaramo prozore, nakon čega ona kaže da joj je lakše. Pacijentkinja navodi da je više od jednog sata radila u zatvorenom prostoru sa Domestosom, boluje Diabetes Mellitusa (DM), koji dobro reguliše. U fizikalnom nalazu: TA 160/90mmHg; SF 65/min; RF 20/min, ŠUK 7,2 mmol/L; SpO_2 nismo bili u mogućnosti da izmerimo. Nad srcem: ritam pravilan, tonovi čujni bez patološkog šuma. Nad plućima, obostrano prisutno vezikularno disanje. S obzirom da smo očekivali promene u disajnom šumu-kojih nije bilo a da je pacijent dijabetičar radi se rutinski EKG. Na EKG: sin ritam, normalna srčana osovinima, elevacia STsegmenta, D1 i avL od 1mm -1,5mm, kao i od V1-V3, i ST depresiju od 1-2mm u D_2, D_3 i aV_F. Pacijentkinji je plasirana braunila, postavljena na monitor i dat 0_2 4L/min. Ordinirana th ASA 300mg PO. Pacijentkinja transportovana do klinike za kardiologiju sa uputnom Dg: AKS. U toku transporta počinje da se žali na bol u grudima i mučninu. Radna dijagnoza kardiologa na prijemu je bila: Angina vasospastica (Prinzmetal), ali je kasnijim lab analizama potvrđen porast Troponina T i pacijentkinji je urađen pPCI
Zaključak: Pravilna procena tegoba na koje se pacijent žali pripada lekarima u primarnom zdravstvu jer su oni prva karika u zbrinjavanju pacijenata sa AKS
Ključne reči: akutni koronarni sindrom, nespecifiče tegobe

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UTICAJ PREHOSPITALNOG ZBRINJAVANJA TRAUMATIZOVANIH PACIJENATA NA ISHOD LEČENJA U JEDINICI INTENZIVNOG LEČENJA URGENTNOG CENTRA KLINIČKOG CENTRA VOJVODINE- JEDNOGODIŠNJE ISKUSTVO

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KLINIČKI CENTAR VOJVODINE, URGENTNI CENTAR, NOVI SAD, SRBIJA

Uvod: Trauma predstavlja vodeći uzrok smrti u popilaciji u uzrastu od 1 do 44 godine. Preporuke koje se odnose na prehospitalno zbrinjavanje traumatizovanih pacijenata ističu značaj što bržeg transporta u referntni trauma centar, gde će se pacijent adekvatno i definitivno zbrinuti.
Cilj ove studije je bio da se na osnovu karakteristika traumatizovanih pacijenata i mera lečenja preduzetih pre prijema u Urgentni centar Kliničkog centra Vojvodine (KCV) identifikuju faktori udruženi sa mortalitetom kako bi se unapredilo lečenje tih bolesnika i ukazalo na eventualne mere koje mogu doprineti boljem ishodu lečenja.
Materijal i metode: U studiju je bilo uključeno 209 traumatizovanih pacijenata čije je lečenje nakon inicijalne resuscitacije nastavljeno u jedinici intenzivnog lečenja Urgentnog centra Kliničkog centra Vojvodine. Podaci su analizirani retrospektivno. Za statističku obradu podataka korišćen je SPSS 20,0 softver. Kategorijalne varijable su analizirane pomoću Hi-kvadrat testa, dok su nekategorijalne varijable analizirane Man-Vitnijevim testom. Rezultati su označeni kao statistički značajni ukoliko je p<,05.
Rezultati: Bolesnici koji su imali nepovoljan ishod lečenja su statistički značajno bili stariji u odnosu na bolesnike

čiji je ishod lečenja bio povoljan (49,4±18,5 vs. 63±14,7, p<,05), pacijenti koji su imali znake hemoragijskog šoka, respiratorne insuficijencije, GCS≤8 statistički značajno gori ishod lečenja (p<0,05). Pacijenti sa obezbeđenim disajnim putem i venskom linijom pre prijema u urgentni centar je imao bolji ishod, dok se ispitivani nisu razlikovali smislu ishoda odnosu na to da li su primljeni iz regionalnih ustanova i pacijenata inicijalno zbrinutih od strane službe hitne pomoći (p<0,05).
Zaključak: Iako još uvek ne postoje dovoljni dokazi o značaju obezbeđivanja disajnog i venskog puta pre prijema bolesnika u referentni trauma centar, naši rezultati ukazuju na benefit sprovođenja ovih mera ukoliko se očekuje duži transport do refernentog trauma centra i ukoliko je medicinsko osoblje adekvatno osposobljeno za izvođenje ovih procedura.
Ključne reči: trauma; jedinice intenzivnog lečenja; smrtnost

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ŠOK NEPOZNATOG POREKLA

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Uvod: Šok predstavlja urgentno stanje. Na prvi pogled teško je uočiti uzrok. Ulazeći u začarani krug i razvitkom metaboličke acidoze često smo nemoćni i gubimo pacijenta ako na vreme ne otkrijemo uzrok. Zbog toga su od izuzetnog značaja brza dijagnostika i široka paleta ideja.
Prikaz slučaja: Pacijent D.M. starosne dobi 69 godina iz Zaječara. Dana 12.04.2016. godine oko 16 h i 20 min. SHMP dobija poziv o naglom gubitku svesti i lošem opštem stanju pacijenta. Do tada se ni od čega nije lečio, čuvan od strane staratelja i gluvonem. Na terenu dobijamo podatke da se pacijent požalio na iznenadni bol u grudima, gubitku svesti. Kliničkim nalazim uviđa se bledilo pacijenta, hipotenzija i crvene konfluentne mrlje od pupka duž čitavih donjih ekstremiteta. EKG je bio uredan. Sumnjom na razvitak alergije i pretećeg anafilaktičkog šoka uz dobijenu terapiju pacijent se prebacuje na interno odeljenje ZC Zaječar. U toku transporta se kod pacijenta razvija paraplegija. Po prijemu, jedini nalaz jeste distendiran trbuh. Pacijent negira bol. U labaratorijskim nalazima uočava se razvitak metaboličke acidoze PH 7,19, enormni porast LDH, enzima AST, ALT. Ostali laboratorijski parametri bili su u granicama normale. Pacijent još uvek svestan, ali promene na koži dobijaju karakter purpure. Ultrazvučno i nativnim snimkom abdomena nisu uočene patološke promene. Radna dijagnoza uz konsultaciju hirurga i neurologa kretala se od elektrolitnog dizbalansa, aneurizme aorte, tromboze mezenteričke arterije do duboke venske tromboze velikih venskih sudova. Zbog nemogućnosti rađenja skenera i doplera krvnih sudova pacijent za 18 sati ulazi u komatozno stanje sa poremećajem srčanog ritma koje se u jednom trenutku stabilizuje. Tada se radi CT gde se uočava retroperitonealno velika cistična formacija kao i distendirana creva. Nakon toga pacijent ulazi u srčani zastoj i umire. Obdukcijom je jedino pronađena cista pankreasa unutar koje je bio nekrotični sadržaj pod sumnjom da je vršila kompresiju velikih krvnih sudova. Cista je unutar sebe konfluirala, nekroza je zahvaila deo mezenterijuma, slezine i nadbrubežne žlezde. Uzrok paraplegije i promene na koži ostale su nejasne.
Zaključak: U hitnim nejasnim stanjima urgentna dijagnostika je od presudnog značaja za otkrivanje uzroka naročitno kod šoknog stanja. Znanje, ideje i brza dijagnostika mogu u ovakvim situacijama sprečiti letalan ishod.
Ključne reči: nedostatak brze dijagnostike

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POREĐENJE DVA NUMERIČKA BODOVNA SISTEMA, MPM I SOFA, U PROCENI MORTALITETA KOD PACIJENATA U SEPSI

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Uvod: Ponavljajući numeričko bodovni sistemi, Model verovatnoće mortaliteta – MPM i SOFA – skor sepsom udružene organske slabosti su dva najčešće korišćena bodovna sistema za procenu organske disfunkcije kod septičnih pacijenata u Jedinici intenzivnog lečenja.
CIlj ovog rada je da uporedi skale mortaliteta i prediktivnu moć u proceni bolničkog mortaliteta kod pacijenata obolelih od sepse.
Metodologija: Studija je sprovedena kao jednogodišnje ispitivanje u JIL tercijalnog nivoa. Prognostička sposobnost MPM II i SOFE procenjena je površinom ispod krivulje (AUROC). AUROC je korišćen radi komparacije inicijalnog skora, nakon 48, 72 sata i maksimalnog i minimalnog bodovnog numeričkog sistema.
Rezultati: Od ukupno 111 ispitanika, smrtnim ishodom je završilo 71 (63,9%). AUROC predviđenog mortalitea na prijemu je bio 0.80±0.05 za MPM II i 0.86±0.04 za SOFA. AUROC 48h za MPM II je bio 0.83±0.04 i za SOFA 0,75±0,06. Maksimalna vrednost skora je bio bolji prediktor predviđenog mortaliteta od prijemnog ($p<.01$), za mpm ii 0.79±0.04 i 0.84±0.03 sofa. Konačni auroc sofa je bio 0.78±0.04 a 0.68±0.05, $p<0.01$).
Zaključak: Numeričko bodovni sistemi, MPM II i SOFA statistički su značajni za predviđanje intrahospitalnog mortaliteta kod pacijenata sa sepsom. Maksimalni skor je značajniji za procenu preživljavanja u odnosu na prijemni, što se naročito odnosi na SOFA.
Ključne reči: MPM, SOFA, Sepsa

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LIVEDO RETIKULARIS-PRIKAZ SLUČAJA

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Uvod: Livedo reticulars (LR) je promena na koži u obliku mreže po čemu je i dobila ime i može se javiti kao znak osnovne vaskularne bolesti. Najčešće se javlja na donjim ekstremitetima a u težim slučajevima može se javiti na trupu i rukama. U patofiziologiji ove promene su u mikrovaskulaturi kože, nastaje zbog ili deoksigenacije ili venodilatacije venskog korita.
Prikaz slučaja: Dana 08.04.2016 u ambulantu ZHMP Niš dolazi, dečak star 14 god u pratnji roditelja, koji su vidno zabrinuti. Navode da su iznenada primetili da je dečakova leva noga promenila boju i postala nekako "braonkasta". Iako se lekar hitne pomoći susreće sa širokim spektrom različitih simptoma i znakova bolesti, ovakvi opisi se ne čuju često. Navode da su primetili pre sat vremena promenu, ali i dečak i roditelji trvde da se promene javlja prvi put i da se sigurno pojavila u toku dana. Porodična i lična anamneza negativne. Negira skore infekcije, teži rad i izlaganje novim supstancama. Negira bolove niti bilo kakve druge senzacije. Pri pregledu pacijent normalne osteomuskularne građe koja odgovara uzrastu. Prisutne, tamnije mrežolike promene na spoljašnjoj strani leve butane i potkolenice. Na dodir se ne povlače i nisu bolne. Koža je normalne temperature i nije otečena. Pregledana cela koža i ustanovljeno je da je promena lokalizovana samo na tom području. Urađen kompletan fiziološki pregled koji je bio u granicama normale. Pulsevi prisutni i regularni. Radi se laboratorija i KKS ostaje u granicama normale. Konsultovan i hirurg (u ZHMP Niš) koji nije našao akutno hirurško oboljenje. Upućen reumatologu sa Dg Vasculitis, Livedo reticulars. Dalja ispitivanja su pokazala da u osnovi postoji antifosfolipidni sindrom (AFS).
Diskusija: Smanjenje perfuzije u arteriolama je predominantni razlog za pojavu deoksigenacije. Smanjenje protoka kroz arteriole može nastati iz više razloga: vazospazma, inflamacije, hiperviskoznosti, tromboembolije. Fiziološki spazam arteriola pruzrokuje reverzibilnu promenu boje u delovima kože dok ostali mehanizmi dovode

do patoloških promena na koži i razvoja Livido Racemoza. Deoksigenacija takođe može biti izazvana povećanim otporom u venskom toku koja nastaje kod velike multisegmentalne duboke venske tromboze. Venodilatacija može takođe nastati i zbog hipoxksije ili disfunkcije autonomnog nervnog sistema. Histopatologija kod LR pokazuje endotheliitis i obliterišući endarteritis bez dokaza o pravom vaskulitisu. Pored toga što je najčešća manifestacija kože kod pacijenata sa (AFS), LR se javlja i u kombinaciji sa autoimunim bolestima kao što su sistemski lupus eritematozus (SLE), sistemske skleroze, celijakija i sistemski vaskulitis (poliarteritis nodosa, i krioglobulinemija). Uočena je i veća učestalost moždanog udara kod pacijenata sa LR u odsustvu drugih faktora vaskularnog rizika. (opisan u Sneddon sindromu). LR može biti prva manifestacija AFS u 40% pacijenata, od koga će jedna trećina razviti multisistemsku trombozu u toku bolesti, ukazujući na značaj dijagnostikovanja AFS u svim slučajevima sa LR. Značajano je postojanje i udruženog pojavljivanja LR sa oboljenjima srčanih zalistaka, šloga i migrena. LR bi trebao biti rani prediktor za rekurentne tromboze kod pacijenta sa AFS.
Zaključak: Naizgled bezazlene tegobe mogu biti uvod u ozbiljne bolesti. Zadatak lekara HMP, da ozbiljno shvati i razmotri sve mogućnosti za razvoj određenih simptoma, adekvatno odreaguje i uputi na dalje ispitivanje.
Ključne reči: Livedo Retikularis, Antifosfolipidni sindrom

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AKUTNE RESPIRATORNE INFEKCIJE KAO URGENTNA STANJA KOD DJECE U AMBULANTI HMP BERANE I ANDRIJEVICA ZA 2015. GOD.

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Uvod: Akutne respiratorne infekcije kod odojčadi i male djece obuhvataju oko 20% ljekarskih pregleda u ambulantama hitne pomoći. Zapaljenje epiglotisa, laryngitis (krup) i laringo traheobronhiolitis su oboljenja koja su uglavnom prisutna kod djece mlađe od 5 godina i predstavljaju često urgentno stanje sa kojima se susrećemo u ambulantama hitne pomoći. Važan predisponirajući faktor koji neposredno prethodi inflamaciji gornjih respiratornih puteva su virusi (parainfluenca, influenca A i B, RSV), bakterije (Haemofilus inf.), alergijski uzročnici, kao i psihološki faktor. Karakteriše ih najčešći trijas simptoma: inspiratorni stridor ili dispneja, promuklost i kašalj (lavež psa). Ova oboljenja imaju posebne karakteristike zbog anatomske građe respiratornih organa djece, jer su disajni putevi uži i kraći. Aktivno veće suženje muskulature pri infekcijama se lako razvija jer je sluzokoža bolje vaskularizovana. Zbog nedovoljno razvijenog imuniteta, djeca su osetljivija i prijemčljivija uzročnicima respiratornih infekcija.
Cilj rada: Ispitivanje uspešnosti hitnog terapijskog zbrinjavanja i učestalosti ovih oboljenja u odnosu na ukupni morbiditet kao i medjusobni odnos muške i ženske populacije u oboljevanju.
Metod i materijali: U toku pisanja ovog rada koristili smo retrospektivnu analizu protokola HMP Berane i Andrijevica za period januar – decembar 2015 godine.
Rezultati rada: U toku 2015 u jedinicama HMP Berane i Andrijevica je pregledano od strane dežurnih ljekara 12 434 pacijenta, što je dosta veliki broj ako znamo da Beranska opština po poslednjem popisu iz 2011 god. broji 33 970 stanovnika,a opština Andrijevica 5 071.Od toga njih ukupno 3 720 je imalo ove simptome sto čini (30%) od ukupnog broje pregleda. Od ovog broja pacijenata 3236 (87%) su muška dijeca a 484 (13%) su ženska dijeca. Mi smo terapijski tretman pacijenta započinjali sledećom kombinacijom medikamenata (dexametazon 0,6 ml/kg), inhalacija steroidima (pulmicort, becotide), adekvatna hidratacija. U 74% slučajeva smo imali odličan uspjeh, dok oko 26 % smo poslali na dalji terapijski tretman pedijatru.
Ključne reči: akutne respiratorne infekcije kao urgentna stanja kod djece

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LIMFOMI KOD DJECE-PRIKAZ SLUČAJA

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Uvod: Limfomi čine 10-12% svih malignih oboljenja dječje dobi s godišnjom incidencom 15 na milion djece do 14 godina starosti. Nalaze se na trećem mjestu po učestalosti, iza akutnih leukemija i tumora mozga. Postoje dvije kategorije limfoma: Hodgin i Non Hodgin.
NHL čine 6-7 % svih malignih oboljenja dječje dobi u Evropi i SAD. Etiološki uzrok NHL nije tačno utvrdjen. Hemijski agensi, virusne infekcije, jonizirajuće zračenje, poremećaj imuniteta su faktori koji se dovode u vezu sa nastankom oboljenja.
Danas je prihvaćena podjela NHL na četiri glavna tipa:
1. Burkit limfom
2. Difuzni velikoćelijski B limfom
3. Limfoblastični limfom
4. Anaplastični velikoćelijski limfom
Burkit limfom karakterišu morfološki uniformne maligne ćelije sa okruglim jedrom, prominentnim bazofilnim jedarcima i bazofilnom citoplazmom.
Prikaz slučaja: Burkit limfom kod dječaka uzrasta četiri godine.
Dječak uzrasta 4 godine, srednje razvijene osteomuskularne gradje dolazi zbog konstipacije, ima otežanu defekaciju, povremeno krv na šolji i toalet papiru, stolice na 4 dana. Palpatorno abdomen mekan i neosjetljiv, nije distendiran, jetra i slezina u fiziološkim granicama. Dijete je zbog ponavljanih tegoba upućeno gastroenterologu u Podgorici a potom na dalju dijagnostiku i liječenje u IMD Beograd. Nakon sprovedenog laboratorijskog, radiografskog i Ph nalaza u IMD zaključeno je da se kod dječaka radi o B ćelijskom non Hodgin limfomu-Lymfoma Burkit, sa primarnom lokalizacijom u abdomenu. Citostatsko liječenje je trajalo tri mjeseca po protokolu A EOP LNH-B 97 za R4 rizičnu grupu. Gastroenterolog uvodi terapiju Macrogolaxanom 2x1/2kesice, Pantenol krem 2x dnevno, antikonstipacijska ishrana. Lab.analize: HGB 122 g/l; Er 4.24; Le 2.5; Tr 698; urin b.o. Koagulacioni skrining: PT 11.7s; INR 0.99; Aptt 32,9s; Fibrinogen 2.4; GLYC 4,27mmol/l; urea 1.2mmol/l; kreatinin 48; CO2 19; K 4,5; Na 142; Cl 103; Mg 0.89; SGOT 96; SGPT121; Bilirubin ukupni 8.8mcmol/l; Bilirubin direktni 4.5mcmol/l; Mokracna kisjelina 250mcmol/l; LDH 618IJ/L .
Zaključak: Dijete je nakon kompletnog citostatskog liječenja otpušteno kući dobrog opšteg stanja, afebrilno, urednog fizikalnog nalaza sa savjetom da dobija terapiju od gastroenterologa. Da uzima Bactrim sirup 240mg/5ml 2x 6ml tri uzastopna dana u nedelji s ciljem profilakse Pneumocistis c. Neophodne su redovne kontrole u IMD Beograd.
Ključne reči: limfomi kod djece, Burkit limfom, prikaz slučaja

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IZNENADNA SRČANA SMRT KOD MLADE OSOBE – PREHOSPITALNI TRETMAN I USKLAĐENOST SA NAJBLIŽIM CENTRIMA NA VIŠIM NIVOIMA ZDRAVSTVENE ZAŠTITE – PRIKAZ SLUČAJA

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Iznenadna srčana smrt (ISS) se definiše kao prirodna smrt čiji je uzrok srčano oboljenje, a koja se manifestuje gubitkom svijesti nastalim unutar jednog sata od početka akutnih promjena u funkciji kardiovaskularnog sistema (KVS). ISS može nastupiti kod osobe koja ima poznatu srčanu bolest ili kao prvi događaj bez prethodno poznate srčane bolesti. Smatra se da je incidenca ISS 0.1 – 0.2 % godišnje.
Prikaz slučaja: Pacijent A.B. (29 godina) je prezentovan službi hitne pomoći, jedinica Cetinje, 09.02.2016.g. u 11:10 prije podne. Dispečer dobija informaciju da je mlađem muškarcu pozlilo, da je izgubio svijest i da otežano

diše. Ekipa HMP dolazi nakon 3 minuta i zatiče pacijenta postavljenog u polusjedećem položaju, bez svijesti, cijanotičan, sa povremenim agonalnim udisajima (na 8-10 sekundi). Ne verifikujem strano tijelo u disajnim putevima, odizanje grudnog koša, disajni šum, akciju srca, kao ni puls nad karotidama. Zjenice diskretno midrijatične, jednake, ne reaguju na svjetlost. Dg: Cardiac arrest
Pacijent se spušta na pod, zabaci se glava i primjenjuju se mjere kardiopulmonalne reanimacije (KPR): kompresija grudnog koša, ventilacija maska-balonom, postavlja se venska linija. Nakon oko 1 minuta, uspostavlja se karotidni puls, koji se gubi nakon 10-ak sekundi. Nastavljaju se mjere KPR-a, kada se nakon oko 2 minuta opet uspostavlja karotidni, i filiforman radijalni puls. Cijanoza počinje da se povlači. Donosi se odluka o transportu, prenosi se na transportno sredstvo i, sa prvog sprata zgrade, stepenicama spušta do vozila HMP. Prilikom prenošenja pacijenta do vozila, uspostavlja se komunikacija sa najbližom bolnicom, obavještava se o slučaju i inicira okupljanje ekipe specijalista (anesteziološki i internistički tim).
Tokom obavljanja gore navedenih aktivnosti, dobijamo heteroanamnestičke podatke da se pacijent žalio na lupanje i preskakanje srca oko minut prije gubitka svijesti, da je tokom dana sjedio u kancelariji, da ranije nije imao zdravstvenih problema, nije korisnik alkohola, cigareta niti psihoaktivnih supstanci. Negativna je i porodična anamneza na ISS i oboljenja KVS-a.
U vozilu se ponovo ne verifikuje karotidni puls, povremeni agonalni udisaji i dalje prisutni, kao i cijanoza. Nastavljene su mjere KPR i dat 1 mg Adrenalina intravenski. Nakon 2 minuta stižemo u najbližu Opštu bolnicu, gdje monitor pokazuje ventrikularnu fibrilaciju (VF). Pacijent biva intubiran, defibriliran i nastavljaju se mjere KPR po protokolu za VF. U narednom toku, pacijentu se tri puta uspostavio sinusni ritam, koji bi prelazio u VF nakon oko pola minuta.
Nakon 50 minuta mjera KPR-a (10 minuta prehospitalno i 40 minuta hospitalno), pacijent ulazi u stabilni sinusni ritam.
Nakon par sati prevezen je u regionalni centar – KCCG, gdje je kompletno obrađen i otpušten kući sa ugrađenim kardioverter defibrilatorom. Tokom ispitivanja u KCCG-u nisu dokazane strukturne niti funkcionalne abnormalnosti KVS-a.
Postreanimacioni tok je prošao bez poremećaja ritma i poremećaja svijesti. Oko mjesec dana nakon događaja, pacijent je imao problema sa kratkoročnom memorijom. Do danas, pacijent se osjeća dobro, negira tegobe, nema problema sa kratkoročnom memorijom i vratio se redovnim životnim aktivnostima.
Zaključak: Ovaj slučaj je pokazao da su pravovremena i adekvatna prehospitalna njega i usklađenost sa najbližim zdravstvenim centrima veoma važne karike u lancu preživljavanja.
Ključne reči: iznenadna srčana smrt, mlada osoba, prehospitalni tretman, komunikacija sa bolnicom.

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DISEKCIJA AORTE

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Uvod: Akutna disekcija aorte, "najčešći od katastrofalnih procesa koji pogađaju aortu", je ozbiljno stanje koje traži neodložno medicinsko i hiruško zbrinjavanje. Silina pulsativnog protoka krvi pod velikim pritiskom, cepa intimu aorte, što se dalje širi u mediju. Početni rascep intime obično nastaje tik iznad valvule (2 - 4 cm iza ušća koronarnih arterija) ili distalno od leve potključne arterije. Pulsirajuća ekstravazacija krvi u zid vodi progresivnom odvajanju intime, najčešće u distalnom smeru. Posledični lažni kanal zauzima, uopšte uzev, najmanje ½ obima i pritiska pravi lumen. Povratna mesta, gde tok krvi iz lažnog lumena probija kroz zalistak intime nazad u pravi lumen, su često višestruka. Spoljni slojevi lažnog kanala, sastavljeni samo od adventicije i dela medije, su oslabljeni; s toga, dolazi do progresivne dilatacije. Deo zida u susedstvu inicijalnog rascepa intime je najslabija tačka i najčešće ruptuira.
Materijali i Metode
DeBakeyjeva podela disekcija aorte opisuje 3 posebna tipa: DeBakeyjevom tipu I zahvaćeni su ascendentni deo, lučni i descendentni torakalni segment; disekcija se često proteže u abdominalnu aortu

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DeBakey tip II takođe polazi iz ascendentnog dela, ali završava tik proksimalno od ishodišta anonime
Tip III po DeBakeyju se dalje deli u 2 podtipa:
-tip IIIA, koji počinje tik distalno od leve supklavije i završava se iznad dijafragme
-tip IIIB, koji počinje u istoj tački, ali se proteže u abdominalnu aortu.
Zaključak i ideje
Zbog toga što simptomi akutne disekcije mogu biti prikriveni mnogobrojnim drugim hitnim stanjima, jedan od najvažnijih faktora u dijagnostici aortne disekcije mora biti visok stepen kliničke sumnje. Aortna disekcija se može prezentovati raznolikom kliničkom slikom: sinkopa, anurija, bol u grudima, deficit pulsa, bol u trbuhu, bol u leđima ili kao akutna kongestivna srčana insuficijencija. Kod trećine bolesnika sa akutnom aortnom disekcijom postavljena je druga dijagnoza.
Ključne reči: Aorta, disekcija, hipertenzija

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ZNAČAJ RANE PRIMENE MERA OSNOVNE ŽIVOTNE POTPORE OD STRANE OČEVIDACA - PRIKAZ SLUČAJA

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Uvod: Rani početak mera osnovne životne potpore 2-4 puta povećava šanse za preživljavanje, ako je spasilac uvežban izvodi standardnu kardiopulmonalnu reanimaciju (KPR)-kombinaciju kompresije i ventilacije. U slučaju da nema iskustva, dispečer HMP mu daje instrukcije da KPR izvodi samo kompresijom grudnog koša dok čeka dolazak profesionalne pomoći.
Cilj rada: Ukazivanje na činjenicu da ukoliko se kod iznenadnog srčanog zastoja odmah preduzmu mere KPR od strane očevica, preživljavanje se povećava.
Materijal i metode: Retrospektivni prikaz slučaja korišćenjem podataka iz protokola službi koje su imale učešće u dijagnostici i lečenju pacijenta.
Prikaz slučaja: Dispečer SHMP Pirot po prijemu poziva „pao čovek i ne diše„ upućuje ekipu na datu adresu. Na mesto događaja ekipa stiže nakon 5 min.„i tamo zatiče kolegu medicinskog tehničara koji je već započeo KPR muškarcu, starosti 64 godine. Pacijent je bez svesti i disanja, palpabilnog karotidnog pulsa. Ubrzo je na monitoru defibrilatora verifikovana je ventrikularna fibrilacija. Pristupa se kardio pulmonalnoj reanimaciji po algoritmu za šokabilne ritmove. Pacijent je intubiran, isporučeno je ukupno tri DC šoka, dato 1mg adrenalina i 300 mg Amiodarona. Nakon toga verifikuje se sistolni ritam sa frekvencom od 90/min, pacijent počinje spontano da diše 7/minuti. Transportuje se na odeljelje za prijem urgentnih stanja Opšte bolnice Pirot. Tokom pregleda na kratko pravi respiratorne areste, a nakon stabilizacije se prevodi u Koronarnu jedinicu. Posle dva sata dolazi svesti, orjentisan je u vremenu, prostoru i prema ličnostima, negira bilo kakve tegobe, neurološki nalaz uredan. Ima jedino period nesećanja za protekli događaj, navodi da se seća da se onesvestio u kupatilu. Urađen je EHO srca koji pokazuje LK uvećanih dimenzija, smanjene globalne kontraktilne funkcije EF 30%, septum celom dužinom istanjen, akinetičan. Ordiniranom terapijom na Internom odeljenju se stabilizuje, nakon 15 dana upućuje na koronarografiju, gde se nalazi da je stablo bez promena. LAD sužena 60% ispod odstupa značajne D1 grane. LCx je bez promena. RCA je bez promena, dominantna. Indikovana je implantacija ICD-a, što je i urađeno mesec dana nakon koronarografije. Pacijent uz ordiniranu medikamentoznu terapiju se oseća dobro, nema nikakvih tegoba i vratio se svakodnevnim životnim aktivnostima.
Diskusija: Iznenadni srčani zastoj predstavlja vodeći uzrok mortaliteta u svetu. Povratak spontane cirkulacije kod pacijenata koji su doživeli iznenadni srčani zastoj i preživljavanje do prijemne ambulante hospitalne ustanove zavisi od odmah preduzetih mera KPR. Većina pacijenata se nakon vremenskog intervala za koji stigne ekipa HMP a koji u našoj službi u proseku iznosi 8 minuta, ako se ne preduzmu mere KPR, zatekne u nešokabilnom ritmu (asistoliji ili bespulsnoj električnoj aktivnosti) koji je razlog manje uspešnosti povratka spontane cirkulacije kod pacijenata sa iznenadnim srčanim zastojem. U ovom slučaju je očevidac započeo KPR pre dolaska ekipe

HMP, pacijent je zatečen u šokabilnom ritmu (ventrikularnoj fibrilaciji) što je znatno doprinelo uspešnosti KPR i oživljavanju pacijenta bez ikakvih kasnijih sekvela.
Zaključak: Najveći broj akutnih zastoja srca dešava u kućnim uslovima, zato je neophodna edukacija stanovništva za rano prepoznavanje iznenadnog srčanog zastoja od strane očevidaca, adekvatno pozivanje broja 194 i pružanje mera osnovne životne potpore do stizanja ekipe hitne medicinske pomoći.
Ključne reči: akutni srčani zastoj, kardiopulmonalna reanimacija

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ZLATNI SAT U REŠAVANJU EPI STATUSA

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Epileptični status, kako generalizovani toničko-klonični tako i atipični (ne konvulzivni) se moraju tretirati agresivno. Održavanje vitalnih parametara, uključujući respiratornu funkciju, je od velikog značaja. Svaki, i najmanji znak respiratorne insuficijencije, treba rano tretirati a taj postupak pripada lekaru HMP. Laboratorijske testove ne treba čekati (osim ŠUK-a), nego što pre dati pacijentu antiepileptički lek.
Isti protokol treba poštovati, bez obzira na to da li je pacijent već uzima antiepileptike ili ne, jer možemo pretpostaviti da pacijent nije pod odgovarajućom terapijom, s obzirom da je to najčešći uzrok epileptičnih stanja kod pacijenata sa poznatom epilepsijom. Najnovije smernice za lečenje epileptičnog statusa sadrže algoritam u fazama (zavisno od vremena početka epi napada i vremena početka terapije). Ako se napad ne uspe da zaustaviti u 4-5 minuta ili ako pacijent i dalje ima napad, na terenu, brza primena antikonvulzivima može biti neophodna. Prehospitalni tretman uključuje: postavljanje intravenske linije, idealno u veću venu. Intravenska primena je poželjan put za administraciju antikonvulzivnih lekova jer dozvoljava da se terapijski nivo brže postigne. U fazi stabilizacije (0-30 minuta), treba započeti standardnu terapiju za epi napade. U početnoj fazi terapije, i.v. se ordiniraju benzodiazepini: midazolam (2.5-5 mg), lorazepam (0.1 mg/kg) ili diazepam (0,15 mg/kg). Oni se preporučuju kao inicijalna terapija. U dekompenzovanoj fazi (30 minuta ili više od početka napada), može se razmišljati o intravenskom ordiniranju levetiracetama (doze od 1500-2000 mg), fenitoina (18-20 mg/kg) ili fosfenitoina (15-20 mg/kg) ili valproinske kiseline ukoliko su dostupni. Ako nijedan od ovih lekova nije dostupan, fenobarbital (15 mg/kg) je razumna alternativa. U produženoj fazi (refraktarnoj fazi) ukoliko napadi postoje više od 40 minuta, treba uzeti u obzir ponavljanje terapije druge linije ili uvođenje u anesteziju ordiniranjem Tiopentala (3-5 mg/kg bolus, a zatim 3-5 mg/kg /h, uz titriraciju), midazolam (0.1-0.2 mg/kg bolus, a zatim 0.05-0.5 mg/kg/h), pentobarbitalom ili propofolom (1-2 mg/kg bolus onda 2-10 mg/kg/h). U slučaju da je status izazvan upotrebom alkohola, administrirati 100 mg tiamina. U nekim slučajevima u kojima se sumnja na trovanje lekovima, razmislite o dodavanju naloksona 0,4-2,0 mg.
Zaključak: svi napori treba da se usmere u zaustavljanju epi statusa. Međutim, slučaju nekonvulzivnog epileptičkog statusa, preporuke nisu tako jasne. Ponekad bi amp benzodiazepina mogla zaustaviti nekonvulzivni status, ali češće, nam je potreban odgovarajući elektroencefalografski monitoring kako bi se video status i uspeh terapije.
Ključne reči: epi status, hitan tretman

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ŠTA POSLE AKUTNOG INFARKTA MIOKARDA KOD ŽENA?

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Simptomi ishemijske bolesti srca, posebno akutnog infarkta miokarda; često ostaju neprepoznati od strane pacijenata, ponekad i od medicinskog osoblja, dok se ne javi neka od komplikacija, posebno kod žena koje su dugo vremena smatrane zaštićenim hormonskim statusom.
Ispitivanjem je obuhvaćeno 252 bolesnika sa akutnim infarktom miokarda sa teritorije grada Novog Sada lečenih od 15. 09 do 15. 12. 2015 u Institutu za kardiovaskularne bolesti Vojvodine. Prosečna starost ispitivanih bolesnika je 64,3 godine. Među ispitivanim bolesnicima je bilo 80 žena (31,75%) prosečne starosti 67,4 godine i 172 (68,25%) muškaraca prosečne starosti 62,8 godina.
Kod žena je najčešće prisutno četiri faktora rizika (FR)/gojaznost, smanjena fizička aktivnost, hipertenzija i pušenje/, a kod muškaraca šest FR/ hipertenzija, gojaznost, pušenje hiperlipoproteinemija, smanjena fizička aktivnost i nasleđe/. Ekstenzivnost navedenih faktora rizika je bila veća u ispitivanih žena kao i dužina trajanja. Žene su bile ređe motivisane za korekciju faktora rizika pre nastanka oboljenja. "Jungova" varijabla, kao pokazatelj rizika mortaliteta izračunata pri prijemu je: 0,0283 što ukazuje na povećani rizik od smrtnog ishoda kao i nepovoljnu prognozu oboljenja. Vrednosti ove varijable kod ispitivanih žena je 0,0260, a kod muškaraca 0,0294, što ukazuje na veći rizik u ispitivanih žena, kao i nepovoljniji tok bolesti, veću invalidnost, smrtnost i komplikacije uz neznatno veću životnu dob ispitivanih žena.
Otuda izuzetan značaj mera sekundarne prevencije treba u ispitivanih žena u cilju smanjenja recidiva bolesti, njene progresije komplikacija i letalnog ishoda.
Ključne reči: akutni infarkt miokarda, žene faktori rizika, prevencija

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PROMENE U EKG-U KAO PUTOKAZ U POSTAVLJANJU DIJAGNOZE SINDROMA NEADEKVATNE SEKRECIJE ANTIDIURETSKOG HORMONA-(SIADH)- PRIKAZ SLUČAJA

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Uvod: Antidiuretski hormon (ADH) je hormon koji se luči u hipofizi (iz zadnjeg režnja hipofize), žlezdi smeštenoj na bazi mozga. Njegova primarna uloga je u reapsorpciji vode u tubulima bubrega i korigovanje osmotskog balansa u organizmu, učestvuje u regulisanju pritiska, tako što vrši konstrikciju (sužavanje) arteriola, pa se ovaj hormon naziva i vazopresin. Sindrom neadekvatne sekrecije antidiuretskog hormona, ili Schwartz-Batter sindrom je najčešći uzrok sniženog nivoa natrijuma u krvi. Uzroci: nakon infekcija moždanih struktura i moždanih opni (apsces, menignitis i encefalitis), nakon povreda lobanje, kod krvarenja unutar lobanje, kod zapaljenskih oboljenja pluća, kod upotrebe određenih lekova, kod sistemskih bolesti (poliarteritis nodosa, temporalni arteritis, sarkoidoza, i kod postojanja tumora koji luči ovaj antidiuretski hormon. Osobe muškog pola oboljevaju u istom broju kao i osobe ženskog pola, a sindrom se može pojaviti u bilo kom životnom dobu. Simptomi i znaci sindroma neadekvatne sekrecije antidiuretskog hormona (ADH) u velikoj meri su povezani sa niskim nivoom natrijuma u krvi (hiponatrijemija) i nespecifični su: malaksalost i pospanost, gubitak apetita, mučnina i povraćanje, glavobolja, zamućen vid, dezorijentacija, iritabilnost, ili apatija, mišićni grčevi koji se smenjuju sa mišićnom slabošću, u najgorem slučaju, može doći do razvoja kome, moguća je pojava otoka, ali ne u velikoj meri, pacijenti prijavljuju porast telesne težine (na račun zadržane vode), količina izmokrenog urina je veoma mala. Dijagnoza se teško postavlja na osnovu anamneze sa kliničkom slikom i objektivnog pregleda, zbog velikog broja nespecifičnih simptoma, se postavlja na osnovu laboratorijskih analiza – snižen nivo natrijuma u krvi (hiponatrijemija), merenje osmolarnosti plazme, merenje osmolarnosti urina, nivoa antidiuretskog hormona u krvi. Skener (kompjuterizovana tomografija) i nuklearna magnetna rezonanca glave i tela se

primenjuju kako bi se pronašao uzrok lučenje velikih količina antidiuretskog hormona (tumori koji luče ADH) i ustanovile eventualne promene na hipofizi.Terapija ovog sindroma podrazumeva korigovanja nivoa natrijuma u krvi što se postiže infuzijama hiperosmolarnih rastvora natrijuma.Takođe, kod pacijenata sa izraženim simptomima, preporučuje se uzdržavanje unosa tečnosti do normalizacije nivoa natrijuma u krvi. Obavezno je lečenje osnovne bolesti, odnosno hirurško lečenje je indikovano kod postajanja tumora koji luče andidiuretski hormon, kod postojanja infekcija koriste se antibiotici, ili antimikotici, a kod postojanja sistemskih oboljenja koriste se kortikosteroidi. Dolazi u obzir i primena diuretika (lekovi koji pospešuju izmokravanje) – poput furosemida (Lasix) i lekova koji su antagnosti antidiuretskom hormonu.
Cilj rada: ukazati na mogućnost prepoznavanja poremećaja elektrolita na osnovu EKG-a, kao in a potrebu postojanja mini-laboratorija u Službama HMP i UP OB , kako bi se brzim i tačnim uvidom u elektrolite plazme pacijent pravovremeno uputio na bolničko lečenje.
Metod rada: analiza elektronskog i pisanog protokola UP OB šabac protokola DZ Šabac.
Prikaz slučaja: Muškarac starosti oko 6o god javlja se lekaru UP zbog malaksalosti, glavobolje, mučnine i nestabilnosti sa uputnom Dg: Instabilitas et vertigo R42. Languor et lassitude R53. Fizikalnim nalazom TA=115/75 mmHg, EKG nodalni ritam sf oko 12o/min QRS proširen po tipu bloka leve grane, visoki zašiljeni T talasi, anamnestički ne daje podatak o ranijim srčanim oboljenjima, što budi sumnji na pormećaj elktrolita i acidobazne ravnoteže. Uzima se krv za gasne analize i rezultat govori u prilog hiponatreiemije (121 mmoL/l, hiperkaliemije 5,7 mmol/l hipohloremije 89 mmol/l; pH krvi-7,20; Bikarbonati-20 mmol/l; BE-8 mmol//L; osmolalnost: 287mosm/l; glikemija 7,8 mmol/l; Ca-2 mmol/L; Hgb:114 g/L; Htc:0.46l. Pacijent se upućuje na Interno odeljenje OB Šabac po DG: Hiperkaliemia, Acidosis metabolica, susp ABI. U medjuvremenu uzete laboratorijske analize (urea, kreatinin) isključuju ABI kao uzrok ovog stanja. U toku hospitalizacije radi se CT endokranijuma koji govori u prilog tumora hipofize. Smrtni ishod je nastupio 8 dana od hospitalizacije.
Zaključak: pacijentima treba raditi EKG u slučaju nejasnih i neodređenih tegoba jer se na osnovu oblika QRS kompleksa, poremećaja ritma i sprovođenja može usmeriti dijagnostikovanje u pravom smeru čime se pravovremenom dijagnostikom može i pravovremeno započeti lečenje. Sve urgentne službe treba da poseduju mini laboratorije sa opcijom gasnih analiza krvi.
Ključne reči: hipofiza, ADH, hiponatremia, hiperkaliemia, EKG

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ZNAČAJ FIZIKALNOG PREGLEDA U DIFERENCIJALNOJ DIJAGNOSTICI AKUTNOG APENDICITISA U PREHOSPITALNIM USLOVIMA - PRIKAZ SLUČAJA

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Uvod: Upala slijepog crijeva je jedan od najčešćih hiruških entiteta kod mladih osoba. Klinička slika zavisi od anatomske lokalizacije pa zbog često atipičnog anatomskog smještaja ima i atipičnu kliničku sliku. Kao rezultat toga veoma su česte komplikacije, među kojima se izdvaja perforacija. Detaljna anamneza i fizikalni pregled u prehospitalnim uslovima vrlo su značajni u postavljanju diferencijalne dijagnoze.
Cilj rada je da se prikazom slučaja pokaže značaj dobro uzete anamneze, fizikalnog pregleda i blagovremenog transporta koji mogućnost komplikacija primarnog oboljenja svode na minimum.
Materijal i metod rada: Kao izvor podataka korišten je protokol terenskuh pregleda ZZHMP Podgorica.
Prikaz slučaja: Hitnoj pomoći je upućen poziv od strane mlade osobe koja se žali na jak bol u trbuhu, praćen malaksalošću, povraćanjem, tečnim stolicama i povišenom tjelesnom temperaturom. Tegobe perzistiraju 24 časa. Iz anamneze saznajemo da se prvo javila povišena tjelesna temperatura (38°C), mučnina, a onda blagi bol u predjelu želuca. Bol se spustio u niže partije trbuha i lokalizovao se oko pupka. Pacijentkinja je 4 puta povratila sadržaj bez primjesa krvi i imala 3 tečne stolice. Prilikom pregleda, pacijentkinja zauzima prinudan ležeći položaj, radijalni puls je ritmičan, dobro punjen (fr 80/min), disanje ubrzano (fr20/min), TA: 115/75mmHg. Pri pregledu abdomena pacijentkinja se žali na intezivan bol u desnom donjem kvadrantu. Prisutan mišićni defans

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prednjeg trbušnog zida, Rowsingov znak pozitivan. Plasirana je venska braunila, uključen Hartmanov rastvor 500ml i pacijentkinja je transportovana u polusjedećem položaju hirurgu u UC KCCG sa uputnom dg: Abdomen acutum, Appendicitis acuta perforativa susp. U toku transporta pacijentkinja se žali na intenziviranje bolova. Koža je blijeda, oznojena, prisutan "facies abdominalis", radijalni puls ubrzan, slabo punjen (fr 110/min), disanje plitko, ubrzano (fr 25/min) TA: 65/40mmHg, abdomen tvrd, sa defansom. U UC pacijentkinja je zadržana i hitno operisana. Otpuštena na kućno liječenje nakon 3 dana stabilnih vitalnih parametara. Dijagnoza na otpustu Appendicitis acuta gangraenosa perforativa.

Ključne reči: fizikalni pregled, apendicitis, rad ljekara na terenu

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NASILJE U KRUŠEVCU ZA PERIOD 2010.-2014.

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Nasilje (dolazi od reči "sila") je svaka delatnost kojom se neposredno, blisko i stvarno ugrožava integritet pasivnog subjekta. Predstavlja globalan, svetski problem koji se dešava bez obzira na starosnu dob, rasu, veru, obrazovni i socioekonomski status i geografsko područje i predstavlja grubo kršenje osnovnih ljudskih prava, što je uticalo na međunarodnu zajednicu da usvoji brojna akta za suzbijanje i eliminaciju ovog fenomena. Nasilje u porodici podrazumeva, fizičko, seksualno, psihološko i ekonomsko nasilje najčešće nad ženama, decom a ne tako retko i nad muškarcima. Nasilje nad decom u porodici i van nje kao poseban oblik-vršnjačko nasilje. Nedolično ponašanje na sportskim priredbama-umesto ferplej navijanja-izraženo divljanje. Elektronsko nasilje i zlostavljanje – iako od velike pomoći savremene informacione tehnologije su moćna sredstva nasilja. Uloga Doma zdravlja u oblasti nasilja je zdravstveno zbrinjavanje žrtve, obaveštavanje PU te CSR i vođenje posebnog protokola po odluci Ministarstva zdravlja Republike Srbije iz 2010.
Cilj rada je podizanje svesti o važnosti nasilja kao globalnog problema i iznalaženju preventivnih aktivnosti kako za smanjenjem tako za iskorenjavanjem.
Rezultati: U petogodišnjem periodu u SHMP se javilo 2197 osoba i 221 dete oba pola koji su doživeli neki oblik nasilja. Najstariji je imao 94 god. a najmlađi godinu dana. Najveći broj je bio starosti između 21-34god. Po pregledu upućivani su na specijalističke preglede, najviše na hirurgiju, ORL i ortopediju. Za svaku žrtvu je obaveštena PU Kruševac a sva deca prezentovana timu Doma zdravlja, obavešten CSR ili ŠU Kruševac. Izvršioci su okarakterisani koa nepoznate osobe ili poznate osobe (supružnik, partner, sin, policajac). Način izvršenja najčešće nožem ili pesnicom. Pojedine žrtve prijavljuju ponovo nasilje, a pojedini se pojavljuju i u ulozi žrtve i nasilnika. Sa smrtnim ishodom bilo je 7 odraslih osoba i jedna šestogodišnja devojčica.
Zaključak: po prirodi posla naša prvenstvena uloga je u pružanju zdravstvene zaštite i obaveštavanju odgovarajućih ustanova koja su sa svojim ministarstvima potpisala obavezujuće a na društvu u celini je da pronađe mehanizme za sprečavanje bilo kog nasilja.

Ključne reči: nasilje, žrtva, nasilnik, oblik pomoći, protokol

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PENETRANTNE POVREDE TORAKSA-PRIKAZ SLUČAJA

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Torakalne povrede su na drugom mestu po mortalitetu, posle povreda glave i najosetljivijeg moždanog tkiva. Mogu biti penetrantne, gde usled lezije listova pleure postoji komunikacija sa spoljašnjom sredinom sa sledstvenom opasnošću od hemopneumotoraxa, te infekcije. Povrede toraxa bogu biti i nepenetrantne, što je po pacijenta bolji prognostički ishod a za doktora olakšica u zbrinjavanju. Imajući uvidu veličinu i sadržaj grudnog

koša, on iziskuje veliku opreznost u dijagnostičkom i terapeutskom pristupu povređenom pacijentu. Samo na osnovu kliničkih prametara treba odmah izdvojiti sindrome: respiratorne insuficijencije, hipovolemije, tamponade srca- koji iziskuju hitnu hirurško intervenciju ne gubeći dragoceno vremena dodatne dijagnostičke procedure. Tokom transporta takvih pacijenata neophodan je kontinuirani monitoring i najava instituciji u koju se pacijent transportuje.
Cilj rada je da se kaže na značaj kako adekvatnog zbrinjavanja tako i na značaj obuke iz prve pomoći članova ekipe PU Kruševac.
Prikaz slučaja: U noćnoj smeni 17.08.2015. u 23:30 primili smo pozivod člana ekipe PU Kruševac (prva obaveštena i prva stigla na mesto događaja) da na trotoaru ispred Muzičke škole leži mladić, romske nacionalnosti, krvave majice sa ubodnim ranama na grudnom košu i da vrše pritisak na te rane. Ekipa izlazi u prvom minutu i za 4 min stiže na mesto događaja, gde zatiče uznemirenog mladića u ležećem položaju na levom boku, dvojicu policajaca koji vrše pritisak na rane pozadi na grudnom košu i napred na trbuhu. Mesto je slabo osvetljeno, pacijenta unosimo u sanitet, gde je priključen na kiseonik a detaljnom inspekcijom nalazimo i druge rane: posekoinu ispod brade, po vratu pozadi, delimično odsečenu ušnu školjku. Zbog vlažne kože odlučujem da digitalnom kompresijom zaustavimo krvarenje i brzim transportom predamo nesrećnog mladića hirurgu. Policajac još pomaže i najavljuje dolazak na hirurgiju. Na klinici, insistiraju da momak pređe na sto te po premeštanju postaje čujno šištanje. Pogledom na zatvorenu česmu ne nalazim izvor zvuka, a uznemireni mladić se okreće po stolu pa se taj zvuk povremeno gubi. Podizanjem gaze sa rana na toraxu, dobijam potvrdu o prirodi zvuka (otvoreni pneumothorax) i ubrzavam dežurne sestre, te starija donosi odluku da se momak smesti u šok što prihvata i prispeli hirurg. Sutradan je povređeni mladić prebačen na kliniku tercijalnog nivoa. Nakon desetak dana isti mladić se javlja u našu službu zbog bolova u stomaku kada su uz njegov pristanak načinjeni snimci.
Zaključak: pružena prva pomoć od članova ekipe PU , adekvatna hemostaza i neodložna hirurška intervencija su povređenom mladiću obezbedila drugu šansu za sve radosti življenja a spasiocima neizmerno zadovoljstvo profesionalnim radom. Mada, postojala je opaska dežurnog anesteziologa o nepostojanju venskog puta. U toj situaciji moja odluka je bila da imamo adekvatnu hemostazu sa 4 ruke i brz transport. Za venski put nismo imali slobodne ruke. Za ovu enigmu pobrinuo se Milan, mladi kolega anesteziolog i savremena objašnjenja da brze i hladne infuzije šokiranom pacijentu donose više štete nego koristi iako to tada nisam znala, potvrđena je ispravnost moje odluke.
Ključne reči: prva pomoć, adekvatna hemostaza, brz transport, otvoreni pneumothorax

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PRIKAZ PACIJENTA SA RUPTUROM SLEZINE-PRIKAZ SLUČAJA

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Uvod: Slezina je najčešce povređeni organ kod nepenetrantnih povreda. Njena lokalizacija i anatomska struktura su najodgovorniji za njenu osetljivost na dejstvo spoljašnje sile. Najčešća etiologija rupture slezine uključuje saobraćajne nesreće, pad sa visine na ravnu podlogu, udarac, rane nanesene vatrenim oružijem.
Cilj: Prikaz pacijenta sa rupturom slezine.
Materijal i metod rada: Deskriptivni prikaz podataka. Izvor podataka: knjiga poziva, protokol Zavoda za hitnu medicinsku pomoć Niš, lekarski izveštaj i otpusna lista Klinike za hirurgiju KC Niš
Prikaz slučaja: Ekipa je pozvana u selo udaljeno 35 km od Niša zbog pacijenta koji je pre 4 sata pao sa traktora. Pacijent navodi da je pao sa traktora koji se prevrnuo, kako nije bio povređen otišao je kući i legao da se odmori. Probudio se pre sat vremena i od tada je tri puta izgubio svest. Negira bol u stomaku. Na pregledu svestan, orjentisan, blede prebojenosti kože i vidljivih sluzokoža, Glazgov koma skor 15/15. Vitalni parametri: TA80/60mmHg, SF~ 100min, RF12; $SaO_2$98%, ŠUK 6,3mmol/L; TT36,5C. U toku pregleda bez tegoba. U fizikalnom nalazu-Srčana akcija ritmična, tonovi jasni, šumova nema. EKG-b.o. Nad plućima normalan disajni šum. Neurološki nalaz uredan. Trbuh ispod ravni grudnog koša, na prednjem trbušnom zidu ispod levog rebarnog luka modrica veličine 1x2 cm. Abdomen palpatorno mek, bolno neosetljiv na površnu i duboku

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palpaciju. Jetra i slezina se ne palpiraju. Peristaltika čujna. Pulsevi nad a.femoralis su jednaki. Postavljena radna dijagnoza Accidens, Ruptura lienalis in obs. Postavljene dve IV linije, priključen na kiseonik, dat Sol.NaCl 0,9% 500ml, Sol. Ringeri 500 ml. U toku transporta pacijent stabilan TA 110/70. Pacijent transportovan do Hirurgije KC Niš, gde je operisan.
Diskusija: Pored toga što je zaštićen grudnim košem, slezina je među najugroženijim abdominalnim organima u slučaju trauma kod svih starosnih grupa. To je veoma osetljiv, vaskularni organ koji sadrzi 25% limfnog tkiva tela i ima važnu hematološku i imunološku funkciju.
Zaključak: Abdominalna trauma je jedan od najčešćih uzroka morbiditeta i mortaliteta tokom prve četiri decenije života i treći najčešći uzrok smrti u celini. Slezina je najčešće povređeni organ kod tupih abdominalnih povreda (40-55%). Klinička prezentacija povrede slezine je veoma različita. Većina pacijenata imaju oskudne simptome hemodinamske nestabilnosti. Hipotenzija kod pacijenata sa sumnjom na povredu slezine je ozbiljan znak i zahteva urgentnu dalju dijagnostiku. Fizikalni pregled je nekada najvažniji i jedini test u postavljanju sumnje dijagnoze rupture slezine.
Ključne reči: Ruptura slezine, hipotenzija.

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Broj apstrakta: 044

SUBARAHNOIDALNA HEMORAGIJA (SAH) PRIKAZ SLUČAJA

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Uvod. Subarahnoidalna hemoragija (SAH) predstavlja prisustvo krvi u subarahnoidalnom prostoru koji se nalazi ekstracerebralno, između tankih moždanih ovojnica, a značajan je jer se unutar njega nalaze velike moždane arterije. SAH može biti posttraumatska i spontana. Najčešći razlog nastanka spontanog krvarenja u ovom prostoru je ruptura aneurizme cerebralne arterije.
Cilj rada. Prikazati značaj prehospitalno postavljene sumnje na intrakranijalno krvarenje na osnovu anamneze, kliničke slike i pregleda.
Metod. Prikazaćemo slučaj muškarca kod koga je došlo do razvoja subarahnoidalne hemoragije sa relativno blagom simptomatologijom kao i mere preduzete prehospitalno
Prikaz slučaja. U jutarnjim satima primljen poziv od strane muškarca starosti 46 god. koji se žalio na glavobolju koja je počela u toku noći, navodeći da je "malo preterao sa hranom". Navodi povišenu temperaturu, da je povraćao nekoliko puta, da je malaksao i da ima visok pritisak. Ranije imao migrenozne tegobe ali nikada takvu glavobolju. Smatra da ga je “zakačio virus” i traži savet. Ekipa izlazi na teren gde zatičemo pacijenta koji je bleđeg aspekta, blago konfuzan, leži na krevetu i drži se za glavu. Objektivno, krvni pritisak 195/115 mmHg, bez neurološkog deficita ali blago ukočenog vrata pri antefleksiji, telesna temperatura 37,6 C. Pacijent postavljen u polusedeći položaj, ordiniran analgetik i.v, data tableta kaptopril 25mg da sažvaće i pod sumnjom na subarahnoidalnu hemoragiju transportovan na odeljenje neurologije gde je dijagnostički potvrdjena SAH a pacijent kasnije zbrinut u tercijarnoj zdravstvenoj ustanovi.
Zaključak. Glavobolja, povišena temperatura i povišen krvni pritisak kao opšti simptomi česti su u radu lekara hitne službe. Takođe pacijenti često ne žele intervenciju lekara već smatrajući da je stanje bezazleno traže savet kao bi se sami izlečili ali insistranje na detaljnijoj anamnezi je izuzetno važno.U prikazanom slučaju na hitno stanje posumnjalo se na osnovu anamnestičkih podataka a sumnja dodatno pojačana kliničkim pregledom i nalazom tipičnog znaka za SAH (ukočen vrat).
Ključne reči: subarahnoidalna hemoragija, glavobolja, povraćanje

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Endotrahealna intubacija je osnovna reanimaciona mera u bolničkim i terenskim uslovima. Izvodi se uvek kada su iz nekih razloga kompromitovani pokreti grudnog koša i normalan proces respiracije doveden u pitanje. Zastoji u disanju mogu biti posledica nekog oboljenja (kao što su srčani zastoj, koma bilo kog porekla, trovanje) ili direktnog oštećenja disajnih puteva, npr. kod traume (oštećenja lica, orofarinksa, larinksa, traheje, grudnog koša). Osnovnu opremu za endotrahealnu intubaciju čine: laringoskop, endotrahealni tubus, priključci (konektori tubusa i Ambu balona), kompletan Ambu set (maska za lice i balon), špric od 20 ml za naduvavanje kafa, aparat za aspiraciju, metalni vodič za tubus, Magill -ov zakrivljeni forceps. Da bi procenili uspešnost endotrahealne intubacije potrebno identifikovati bolesnike koji su kandidati za otežanu intubaciju. U svrhu otkrivanja takvih bolesnika kreirani su brojni skrining testovi i skale za predviđanje otežane intubacije. Najpoznatiji i najčešće korišćeni skrining testovi su Malampatijeva skala i Vilsonova skala, kao i procena disajnog puta u hitnim stanjima LEMON postupkom. I pored toga je prisutna otežana intubacija i njen procenat je oko 1%. Otežana intubacija nastaje najčešće kada manipulacija drškom laringoskopa nije moguća kod bolesnika sa kratkim vratom i gojaznih, kada postoji kongenitalno smanjena mogućnost otvaranja usta, smanjena pokretljivost vrata, smanjena pokretljivost temporomandibularnog zgloba, kada postoji edemi, fibroze i lezije jezika, farinksa i larinksa, kada postoje anatomske varijacije i kongenitalne malformacije usne duplje, farinksa, larinksa i strukture glave, vrata i grudnog koša.

Ključne reči: endotrahealna intubacija, otežana intubacija, skrining testovi, laringoskop, disajni put.

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KAKO PREŽIVETI RUPTURU POSLE INFARKTA MIOKARDA?

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Žena stara 65 god je primljena na kliniku za kardiologiju zbog dispneje i bola u grudima. U anamnezi su postojali podaci o trosudovnoj koronarnoj bolesti srca i urađenoj hirurškoj intervenciji. Na ECG-u je viđen kompletni blok leve grane a kreatinin kinaza je bila 3903 U/l te je dijagnostifikovan NSTEMI. Zbog kašnjenja, tromboliza nije urađena, ali je pacijentkinja primala tirofiban i heparin do sledećeg dana kada je urađena koronarna angiografija. Svi graftovi su bili prohodni i svi veliki krvni sudovi zatvoreni, te nije bilo potrebe za koronarnom angioplastikom. Četiri dana kasnije, tokom tuširanja na odeljenju pacijentkinja je iznenada osetila jak bol u desnoj slabini. Ubrzo se razvija popuštanje levog srca (bez porasta creatine phosphokinase). Magnetna rezonanca je pokazala rupturu srca (maximalni dijameter je 10mm) na hipokinetičnom infolateralnom zidu sa efuzijom u perikardu (forma - pseudoaneursme): A: uzdužni apikalni presek pokazuje mesto rupture na inferolaterlanom zidu sa perikardnom infuzijom (PE- perikardna efuzija; AO, aorta; LA, leva pretkomora; LV, leva komora); B: Color Doppler pokazuje protok krvi iz leve komore kroz mesto rupture u pseudoaneuriumu odnosno perikardnu efuziju; C: odmah posle injekcije kontrasta, šupljina leve komore se puni kontrastom, D: u okviru jedne minute posle injekcije kontrasta, se vidi u perikarnoj efuziji. Pacijentkinja je odbila hiruršku intervenciju. Sedam dana kasnije, echocardiografski nalaz je neizmenjen. Dvanaest dana kasnije pacijentkinja je otpuštena. Ruptura miokarda je poznata kao fatalna komplikacija infarkta miokarda, javlja se posebno kod žena, starijih osoba, na prednjem i donjem zidu miokarda. Pseudoaneurizma leve komore formirala se kada je ruptura miokarda zadržana priraslicama ili ožiljnim tkivom na perikardu. Slobodne intraperikardijalne rupture se uobičajno završavaju tamponadom i smrću pacijenta. Zbog prethodne bypass operacije, postojale su perikardne priraslice što je omogućilo formiranje pseudoaneurizme i preživljavanje pacijenta.

Ključne reči: ruptura, infarkt miokarda, MRI

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INICIJALNI CT PREGLED KAO PREDIKTOR ISHODA ENDOKRANIJALNIH TRAUMA

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Endokranijalne povrede su čest uzrok hospitalizacije pacijenata i povezane su sa značajnim dugotrajnim morbiditetom i mortalitetom. Procena incidence endokranijalnih povreda značajno varira u zavisnosti od regiona i najčešće su ograničene samo na slučajeve koji su rezultirale pregledom u urgentnim centrima i kreću se oko 700 na 100,000 od čega oko 14% biva hospitalizovano, a 2% slučajeva se završi smrtnim ishodom. U razvijenim zemljama najveći udeo imaju traume nastale kao rezultat saobraćajnih nesreća.
Traume endokranijuma se prema težini dele na blage, umerene i teške na osnovu GCS (Glasgow coma scale) i dodatnih kriterijuma koji povećavaju tačnost klasifikacije. To su dužina trajanja gubitka svesti, izmenjen mentalni status i posttraumatske amnezije, rezultati pregleda kompjuterizovanom tomografijom (CT) i AIS (Abreviated Injury Scale) za glavu i vrat.
Inicijalni CT pregled je indikovan kod teških i umerenih povreda glave dok se kod blagih ne indikuje rutinski osim ako nije prisutan jedan ili više faktora rizika koji ukazuju na potencijalno značajnu blagu traumu. Prisustvo radijacije kao neželjenog efekta CT pregleda zahteva odgavarajuću selekciju pacijenata i u uslovima hitnih stanja.
Kompjuterizovanu tomogafiju kao dijagnostički modalitet karakteriše široka dostupnost, brzina skeniranja i kompatibilnost sa medicinskim uređajima za održavanje vitalnih funkcija što je sve vrlo značajno kod urgentnih stanja. CT pregled je esencijalan u otkrivanju lezija koje zahtevaju hitnu neurohirušku intervenciju, kao i onih koje zahtevaju intrahospitalnu opservaciju i terapiju. CT endokranijuma ima veliku senzitivnost za detekciju efekta mase, fraktura i akutne hemoragije kao i za procenu veličine i konfiguracije likvorskih prostora.
Prvi zadatak CT pregleda paijenta sa povredom glave je detektovati postojanje hemoragije. Intrakranijalna hemoragija može delovati kao ekspanivna lezija sa mas efektom i edemom, dovesti do hidrocefalusa, hernijacije i značajno uticati na menadžment pacijenta i ishod lečenja. U radu je opisana CT prezentacija različitih vrsta intra- i ekstraaksijalnih krvarenja: epiduralnog, subduralnog, subarahnoidalnog, intraventrikularnog i intraparenhimskog. Na inicijalnom CT pregledu dobri prediktori ishoda su volumen subduralne hemoragije i deplasman mediosagitalnih struktura, osim toga prisustvo određenih vrsta intrakranijalnih krvarenja umanjuje prediktivnu vrednost GCS. Treba imati u vidu da rani CT pregled unutar 3h od povrede može potceniti obim traume, te se često indikuju i kontrolni CT pregledi gde su važni pokazatelji ishoda prisustvo posttraumatskog hidrocefalusa, mesto i postojanje glioze. CT pregled omogućava detekciju kontuzionih žarišta iako ima malu senzitivnost za detekciju malih i nehemoragičnih kontuzionih lezija i difuzne aksonalne traume (DAI).

Ključne reči: CT, endokranijalna trauma

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USPEŠNO ZBRINJAVANJE VENTRIKULARNE FIBRILACIJE U TERENSKIM USLOVIMA HITNE MEDICINSKE POMOĆI U NOVOM PAZARU

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Ekipa hitne pomoći se nalazila na terenu gde je konstatovana smrt pacijenta.Obaveštavaju nas da je u susednoj kući pozlilo bratu osobe kojoj je konstatovana smrt. Na licu mesta zatičemo osobu bez svest, pulsa i spontanih respiracija. Odmah su započete mere KPCR , masaža srca i ventilacija ambu-balonom 30:2 i otvorena je venska linija. Nakon toga na monitoru defibrilatora (DEF) je verifikovana ventrikularna fibrilacija (VF) te je pacijent defibriliran sa 180J (bifazni defibrilator) i nastavljena KPCR masažom srca i ventilacijom. Data je jedna ampula Adrenalina i.v. Ponovo je na monitoru DEF-a bila prisutna VF, te je pacijent defibriliran sa 180J. Nakon toga pacijent je napravio jednu spontanu insuflaciju vazduha i na monitoru defibrilatora konstatovana je tahiaritmija frekvence 130-150/min. Pacijent je prebačen u terensko vozilo gde mu je data ampula Amiodarona 300mg i.v. i kiseonik preko maske 7l/min. U toku transporta pacijent dolazi svesti, sponatno diše, palpirao se karotidni puls.

Transportovan je u koronarnu jedinicu internog odeljenja u Novom Pazaru gde je elektrokardiografski verifikovan akutni infarkt prednjeg srčanog zida. Nakon deset dana pacijent je otpušten sa internog odeljenja stabilnog zdravstvenog stanja.

Ključne reči: KCPR, ventrikularna fibrilacija, defibrilacija.

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STATUS ASMATHICUS NA TERENU HMP CETINJE-PRIKAZ SLUČAJA

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Uvod: Astma predstavlja hroničnu zapaljensku upalu donjih disajnih puteva. Osnovni znak ove bolesti jeste vizing tj. sviranje u grudima sa iskašljavanjem male količine žilavog ispljuvka. Uzrok napada je spazam bronhiola koji nekad bude praćen edemom i hipersekrecijom mukusa. Osnovni poremećaj u asmatičnom napadu je smanjen prolazak vazduha kroz sužene bronhiole.
Cilj ovog rada je da prikažemo koliko je važno pravovremeno postaviti dijagnozu na osnovu fizikalnog nalaza dati odgovarajuću terapiju u cilju ublažavanja simptoma i transportovati ga na dalje hospitalno liječenje.
Materijal i metode: Prikaz slučaja pacijenta na osnovu ljekarskog poziva i knjige protokola HMP Cetinje.
Prikaz slučaja: U popodnevnim časovima ekipa HMP prima poziv od strane supruge koja objašnjava da je prije pola sata od poziva upućenog HMP njen muž se požalio da otežano diše, da mu „nedostaje vazduha“. Žena navodi da se njen muž liječi od astme, da mu je dala bronhodilatator koja je njegova redovna terapija, ali mu se stanje uporno pogoršava. Sada navodi da jedva diše, da isprekidano govori da su njegova usta pomodrela. Ekipa HMP izlazi na teren. Zatičemo čovjeka, starosti 52 godine, u sjedećem položaju, preznojen, uplašen, trupom nagnutim naprijed pridržavajući se rukama o ivice kreveta. Na pitanje „od čega se liječi?“ odgovara isprekidanim rečenicama zbog kratkoće daha. Heteroanamnesticki dobijamo podatak da se radi o asmatičaru (dijagnostikovana astma prije 15 godina) koji redovno koristi terapiju i ide na kontrolne preglede. Protekle 3 godina nije imao akutne asmatične napade. Fizikalni pregled: Pacijent svijestan, orijentisan, subfebrilan, dispnoičan, usne lividne kao i periferne okrajine, tahipnoičan, tahikardičan, zauzima prinudan položaj koristeći pomoćnu disajnu muskulaturu. U daljem fizikalnom pregledu TA 100/60 mmHg, EKG: sinusni ritam, fr 125/min, skretanje osovine u desno. Pulmo: Broj respiracija 27/min. Auskultatorno: Disajni šum oslabljen, produžen ekspirijum. SatO2 72%. Dajemo kiseonik na masku (5l/min), inhalacija sa b2 agonistima (Berodual) otvaramo venski liniju, amp Aminophillin i.v, amp LemodSolu 80 mg i.v. Pacijenta transportujemo u OB Cetinje. U toku transporta vitalni paramteri se poboljšavaju, pacijent stabilnih vitalnih parametara doveden do bolnice na dalje liječenje i dijagnostiku.
Zaključak: Status asmathicus- produžen asmatični napad koji traje duže od 24 sata i ne smiruje se na adekvatnu terapiju tj bronhodilatatore. To je po život opasno stanje i zahtijeva brzo reagovanje hitne medicinske pomoći. Simptomi akutnog napada astme su nedostatak vazduha, otežan i isprekidan govor, cijanoza usana i vidljivih sluzokoža, tahikardija, tahipneja, ubrzan puls, konfuznost. Status asmathicus je ozbiljno stanje koje ukoliko se ne postavi pravovremena dijagnoza dovodi do kome pa i smrti.

Ključne reči: Astma, status asmathicus

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BOL U ABDOMENU-DIFERCIJALNO DIJAGNOSTIČKE DILEME KOD PACIJENATNA REHABILITACIJI NAKON MOŽDANOG UDARA–PRIKAZ SLUČAJA

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Uvod: Rehabilitacija stanja nakon moždanog udara podrazumeva primenu kompleksnog individualno koncipiranog i doziranog fizikalnog tretmana u cilju postizanja smanjenja subjektivnih tegoba, poboljšanja funkcionalnog stanja lokomotornog sistema i postizanja što većeg stepena nezavisnosti u aktivnostima dnevnog života. Tokom rehabilitacionog tretmana potrebno je permanentno praćenje stanja pacijenta. Komorbiditeti nekada mogu biti razlog za prekid rehabilitacije. Diferencijalna dijagnoza bola u trbuhu u prehospitalnoj fazi može biti jako teška, delom zbog nedostatka odgovarajućih dijagnostičkih procedura.
Cilj rada je da ukaže na značaj bola u abdomenu i diferencijalno dijagnostičkih dilema kao razloga za prekid rehabilitacije, kao i na značaj neinvazivnih dijagnostičkih procedura u postavljanju dijagnoze.
Materijal i metode: Podaci dobijeni autoanamnestički, heteroanamnestički i iz dostupne medicinske dokumentacije(istorija bolesti, otpusne liste). Korišćena metoda prikaza slučaja.
Rezultati: Pacijent B.M. star 77 godina tokom marta 2016. boravio u Institutu Dr Simo Milošević u Igalu zbog stanja nakon ishemijskog moždanog udara. U periodu od 18.01.–26.01.2016. hospitalizovan na Klinici za neurologiju KCCG u Podgorici zbog slabosti leve polovine tela, uz prethodnu pojavu vrtoglavice i gubitka svesti. CT endokranijuma ukazao na postojanje zone lako hipodenznijeg parenhima desno okcipitoparijetalno, koja bi po karakteristikama najviše odgovarala početnim znacima akutne ishemije, uz lako imprimiranu istostranu lateralnu komoru. Neurološki – slabost po piramidnom tipu deficita levo. Tokom hospitalizacije urađen EHO andomena - abdominalna aorta infrarenalno aneurizmatski izmenjena, promera do 40 mm, ostali nalaz b.o. Iz anamneze: hipertenzija, infarkt miokarda pre 20 godina, četvorostruki aortokoronarni by pass pre 12 godina, dislipidemija.
Na prijemu: slabost po piramidnom tipu deficita, srednje duboka levostrana hemipareza.
Sproveden je dozirani individualno prilagođen fizikalni tretman. Tokom boravka redovno praćen od strane interniste.Dana 27.03.2016. u večernjim satima žalio se na bolove u predelu desne slabine. Dana 28.03.2016. u ranim jutarnjim satima povratio jedanput, tečni sadržaj, bez primesa krvi. Žalio se na bol u predelu desne slabine i ispod desnog rebarnog luka. Febrilan do 39 st. Stolica i mokraća uredne prebojenosti. Objektivno: HD kompenzovan, eupnoičan, koža suva, koža i vidljive sluzokože uredno prokrvljene. Nad plućima uredan disajni šum. Srčana akcija ritmična, sf 75/min, tonovi tiši. TA 80/50 mmHg u 10h, Abdomen ispod ravni grudnog koša, palpatorno mek, bolno osetljiv u gornjem desnom kvadrantu. Desna bubrežna loža osetljiva na grubu sukusiju. EKG: bez značajnije dinamike u odnosu na prijem. U laboratorijskim analizama uočava se leukocitoza uz predominaciju granulocita, povišene vrednosti bubrežnih, jetrinih i zapaljenskih parametara. I pored ordinirane terapije perzistira hipotenzija uz izražene subjektivne tegobe. Zbog hemodinamske nestabilnosti, anemije, hipotenzije, porasta vrednosti zapaljenskih i jetrinih parametara, uz febrilnost, kao i prethodni anamnestički podatak o aneurizmi abdominalne aorte(infrarenalni segment), pacijent je upućen na odeljenje hirurgije OB Meljine radi dalje dijagnostike i terapije, gde je i zadržan.
Zaključak: Iako klinička slika nije apsolutno ukazivala na rupturu aneurizme abdominalne aorte, nastala hemodinamska nestabilnost, uz anemiju, porast vrednosti jetrinih i zapaljenskih parametara razlog su za prekid rehabilitacionog tretmana i upućivanje u odgovarajuću ustanovu radi dalje evaluacije i lečenja.

Ključne reči: bol u abdomenu, aneurizma, rehabilitacija

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KONTINUITET U ZBRINJAVANJU PACIJENTA SA NEGATIVNIM ISHODOM – PRIKAZ SLUČAJA

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Uvod: Zbrinjavanje pacijenata u okolnostima kada nemamo dovoljno anamnestičkih i šture heteroanamnestičke podatke, predstavlja dodatni izazov za svaku ekipu hitne medicinske pomoći na terenu. Klinička slika i informacije dobijene pregledom pacijenta moraju biti dovoljni za pravilnu dijagnostičku procenu i što manju diferencijalno dijagnostičku dilemu.
Cilj: Prikaz slučaja kontinuiteta u zbrinjavanju pacijenta koji se nalazi na javnom mestu u okolnostima gde je nemoguće uzeti adekvatne anamnestičke i heteroanamnestičke podatke, tokom transporta i nakon prijema u urgentni centar.
Prikaz slučaja: 20.04.2016. ekipa Zavoda za hitnu medicinsku pomoć dobija poziv za osobu povređenu padom sa bicikla u prometnom gradskom kružnom toku. Dispečer upućuje raspoloživu ekipu. Naša ekipa se prijavljuje kao bliža događaju i preuzima zbrinjavanje pacijenta. Na mestu događaja zatičemo muškarca srednjih godina, koji leži na asfaltu unutrašnje trake kružnog toka a u neposrednoj blizini nalazi se oboren bicikl. Dok prilazimo pacijentu vidimo da je on u bočnom položaju, svestan, nema vidljivih većih krvarenja niti deformiteta na telu. Prolaznici koji su se tu zatekli, navode da nije oboren od strane vozila već da je pao sa bicikle i nakon toga imao nešto sto oni opisuju kao epileptični napad („treso se celim telom i umokrio se“). Postavljena je manuelna imobilizacija vretnog dela kičme. Vazdušni putevi su procenjeni kao prohodni, pacijent samostalno diše i puls nad a. radialis je dobro punjen sa SF približno 100/min. Sa pacijentom nije moguće uspostaviti adekvatnu komunikaciju ali on ipak daje oskudne podatke o sebi i navodi da ne boluje od epilepsije. Uz poštovanje principa imobilizacije, pacijent je transportovan na nosilima u ležećem položaju. Tokom transporta dolazi do produbljenja u neurološkom statusu, pacijent postaje agitiran. Opštim pregledom tela nema viljivih znakova povređivanja sem oguljotine na nadlanici leve šake. Vitalni parametri dobijeni do dolaska u Urgentni centar KC Niš su sledeći: TA 110/70mmHg, SF 100/min, RF 14/min, Gly 5,7mmol/L. Auskultatorni nalaz nad srcem: srčana akcija je ritmična, tonovi su jasni i ne čuju se šumovi. Grudni koš je simetričan i obostrano respiratorno pokretan sa obostrano prisutnim normalnim disajnim zvukom. Abdomen je iznad ravni grudnog koša palpatorno mek ali izuzetno bolno osetljiv na palpaciju difuzno. Postavljena je IV linija 16G i održavana manuelna imobilizacija vratnog dela kičme. Nekoliko minuta po dolasku u UC KC Niš, pacijent prestaje da diše, biva kratko ventiliran maskom i balonom a zatim i intubiran endotrahelnim tubusom 7,5mm. Ubrzo zatim pacijent gubi puls nad velikim krvnim sudovima i kada je otpočeta masaža grudnog koša a na ekg-u registrovana asistolija. Reanimacione mere koje su dalje sprovedene od strane ekipe UC nisu imale pozitivni efekat. Obzirom da se radi o pacijentu koji je preminuo unutar 24h od momenta prijema u bolnicu, naložena je obdukcija tela radi utvrđivanja uzroka smrti.
Zaključak: Pravovremeno prepoznavanje vitalno ugroženog i hemodinamski nestabilnog pacijenta i adekvatno delovanje je imperativ na putu ka pozitivnom ishodu.
Ključne reči: anamneza, klinička slika, kontinuitet, CPR

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POLIMORFNA SIPTOMATOLOGIJA U KLINIČKOJ SLICI STEMI AIM

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Uvod: AIM predstavlja ishemijsku bolest srca koja nastaje kao posledica naglog i potpunog prekida cirkulacije u jednoj od koronarnih arterija, što vodi ka ishemiji i nekrozi miokarda. U tipičnoj kliničkoj slici dominantan simptom čini angiozni bol praćen blijedilom, uznemirenošću pacijenta i hladnim preznojavanjem.
Materijal i metoda rada: Prikaz slučaja na osnovu knjige protokola iz ZZHMP Podgorica uz naknadni uvid u istoriju bolesti pacijenta iz koronarne jedinice KCCG.

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Prikaz slučaja: Dana 10.01.2016. oko 17h, dispečerski centar podgoričke hitne pomoći dobija poziv od pedesetrogodišnjeg muškarca. Kao tegobe navodi gubitak svijesti, obilnu tečnu stolicu i izrazitu malaksalost. Po dolasku terenske ekipe HMP na datu adresu zatičemo svjesnog muškarca, blijede prebojenosti kože, acijanotičnog, adinamičnog, koji zauzima pasivan ležeći položaj. Heteroanamnestički dobijamo podatak da je pri odlasku do kupatila kratko gubio svijest (pacijent ne rekonstruiše događaj), nakon čega je imao obilnu tečnu stolicu i sada osjeća izrazitu malaksalost. Druge tegobe negira. U ličnoj anamnezi. hipertoničar unazad par godina, bivši profesionalni sportista, pušač. Porodična anamneza pozitivna na ishemijsku bolest srca.
U fizikalnom nalazu - TA: 85/50mmHg, Sa02: 89, Cor: srčana radnja ritmična, tonovi tihi i tmuli, bez šuma. EKG: sin.ritam; s.f. oko 50/min; ST elevacija u D2,D3, avF, V3, neg T u V1,V2, V5 I V6. Na osnovu nalaza postavljena uputna dijagnoza STEMI AIM pars inferioris i pacijent se priprema za brz transport.. Odmah se postavlja kontinuirana intravenska linija sa sol Hartmana, nazalni kateter sa kiseoničnom terapijom 10l/min i tbl Andola a 300mg s.l. Nakon transporta pacijent je preveden u intezivnu njegu koronarne jedinice KCCG.
Naknadni podaci - Ehokardiogram: LK redukovane globalne sistolne funkcije, hipo do akinetičan septum i akinetičan inferiorni zid. EF 37%. Koronografija: Selektivnom koronografijom nađena jednosudovna bolest dominantne RCA, sa proksmilanom okluzijom. Laboratorijski nalazi(10-11.01.'16): Troponini 0,084-9.60, CK: 84-2452, LDH: 191-768, AST: 40-286, UH:3.07 TRIGL:1.21 Uz adekvatnu pripremu urađena PCI i implantiran stent na RCA.
Zaključak: Atipična klinička slika može otežati postavljanje dijagnoze AIM u prehospitalnim uslovima, kao i značaj dobro prikupljenih anamnestičkih podataka, fizikalnog nalaza uz blagovremeni transport pacijenta u najbliži Urgentni centar.
Ključne reči: atipična klinička slika, terenski rad, hitna pomoć

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LACERACIJE SLEZINE U STANJIMA SAOBRAĆAJNOG TRAUMATIZMA

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Uvod: Pored povreda koštano-zglobnog sistema na meti saobraćajnog traumatizma su vrlo česte i povrede unutrašnjih organa koje mogu biti nanete tupinom predmeta ili ubodinom.Česte su lezije kapsule slezine praćene hematomom ili laceracijom.
Cilj rada: Kroz rad prikazati koji su to sve mehanizmi doveli do lezija slezine i modalitet i način rešavanja u pojedinim konkretnim slučajevima.
Materijal i metode: Rad je zasnovan na bolesničkom materijalu 54 pacijenata koji je hospitalizovani na odeljenjima Urgentne hirurgije KCS Urgentnog centra. To su različita stanja koja su dovodila do obilnih krvavljenja unutar trbušne duplje, razne laceracije parenhimatoznih organa kao i šupljih organa.
Rezultati: Za vremenski period od godine dana i bolesničkom materijalu mogli smo uočiti-koji su to mehanizmi najčešće dovodili do lezije slezine i njene kapsule, kakva smo stanja zaticali i načini pojedinih rešavanja.
Zaključak: U radu iznosimo naša iskustva i saznanja do kojih smo došli.
Ključne reči: povrede slezine, saobraćajni traumatiam

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PRIMENA LAPAROSKOPIJE U URGENTNIM STANJIMA ZA BRZU EVALUACIJU I ODLUKU OPSEGA OPERATIVNOG ZAHVATA

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Uvod: Vrlo često tokom rada u Urgentnom centru suočeni smo sa potrebom za brzom evaluacijom, dijagnostikom u rešavanju stanja koja su po život opasna. Želja nam je da kroz rad prikažemo načine brze dijagnostike koja nas vodi do odluke o načinu i modalitetu zbrinjavanja stanja nakon informacije dobijene laparaskopijom trbušne duplje.
Cilj rada: Uočiti uzroke i moguće mehanizme nastanka i pokušati naći uzročno-posledičnu vezu nastanka ovog stanja.
Materijal i metode: Rad je zasnovan na bolesničkom materijalu 28 pacijenata koji je hospitalizovani na odeljenjima Urgentne hirurgije KCS Urgentnog centra. To su različita stanja koja su dovodila do obilnih krvavljenja unutar trbušne duplje, razne laceracije parenhimatoznih organa kao i šupljih organa.
Rezultati: Za vremenski period od godine dana i bolesničkom materijalu mogli smo uočiti-koliko nam je laparoskopija pomogla u razrešavanju stanja koje se pred naas postavljalo kao zadatak. Koliko je ovaj metod našao kod nas primenu u takvim stanjima,i kroz prikaz našeg iskustva u radu do kakvih saznanja smo dolazili.
Zaključak: Uzorak pacijenata je mali,ali dovoljan podstrek za dalje izučavanje u ovom pravcu,sa željom da Vam približimo naša iskustva,koja su se sticala u svakodnevnom radu.
Ključne reči: laparoskopija, procena opsega operativnog rada

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MANIFESTNA STANJA KOD PRELOMA ZGOBNOG NASTAVKA DONJE VILICE

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Uvod: U stanjima traumatizma kostiju lica i vilica posebno mesto zauzimaju i prelomi zglobnog nastavka donje vilice.Nisu tako brojni ali imaju svoje mesto u traumatizmu kostiju lica.Vrlo često projekcija ovih preloma kroz sprovedenu dijagnostiku ne pruža nam dovoljan uvid u manifestaciju stanja kod pacijenata izraženu kroz subjektivan osećaj i doživljaj traume.
Cilj rada: Kroz rad želimo da prikažemo i ukažemo da određeni položaji koje zauzimaju prelomi zglobnog nastavka, ugao koji zahvataju u novonastaloj poziciji uslovljenoj traumom uslovljavaju da pacijenti imaju određene manifestacije stanja koji seispoljavaju kao parestezija do anestezije u predelu distributivnog predela n.alveolaris inferiora te stran e,lučenjem pljuvačke preko kože itd.
Materijal i metode: Rad je zasnovan na bolesničkom materijalu 13 pacijenata koje je prošlo kroz dijagnostiku odeljenja urgentne radiologije.
Rezultati: Rezultati prikazuju naše zaključke do kojih smo došli evaluacijom bolesničkog materijala pomenutog broja koje su se javile na ovom bolesničkom materijalu.
Zaključak: U radu iznosimo naša iskustva i saznanja do kojih smo došli, dijagnostičkom obradom i zaključcima koje su nam se nametnuli sami po sebi.
Ključne reči: manifestacije prelom donje vilice

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KONTROVERZE U URGENTNOJ RADIOLOGIJI KROZ RAZLIČITE METODE DIJAGNOSTIKE

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Uvod: Vrlo često kroz praksu susrećemo se sa potrebom brze dijagnostike stanja nastalih kroz različite vidove traumatizma,povrede nanete u suicidnim stanjima kao i oboljenjima.Tu suvereno treba da radiologija sa svojim metodama dijagnostike omogući i ukaže na stanje koje zahteva brzo reagovanje lekara koji će ga zbrinuti.Vrlo često to su pacijenti iz reanimacije.
Cilj rada:Kroz rad želimo da prikažemo i ukažemo na kontraverze koje se mogu pojaviti u svakodnevnom radu,naročito ako se ima u vidu velika brojnost dijagnostičkih pregleda.
Materijal i metode: Rad je zasnovan na bolesničkom materijalu 790 pacijenata koje je prošlo kroz dijagnostiku odeljenja urgentne radiologije.
Rezultati: Rezultati prikazuju naše zaključke do kojih smo došli evaluacijom bolesničkog materijala pomenutog broja i na kontroverze koje su se javile na ovom bolesničkom materijalu.
Zaključak:U radu iznosimo naša iskustva i saznanja do kojih smo došli, dijagnostičkom obradom i zaključcima koje su nam se nametnuli sami po sebi.
Ključne reči: urgentna radiologija, metode dijagnostike

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KOŽNE PROMENE IZNAD RAVNI KOŽE KOJE ZAHTEVAJU ZATVARANJE DEFEKTA PLANIRANIM REŽNJEVIMA

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Uvod: Karcinomatoze kože većeg promera vrlo često je u predominaciji bazocelularna forma koja zahvata velike površine,i tako nastali defekti nakon ablacije tumora zahtevaju i adekvatna hiruška rekonstruktivna rešenja kojim se novonastali defekt prepokriva i uspostavlja novi kontinuitet kožnog pokrivača.
Cilj: Kroz rad želimo da prikažemo neka naša rešenja za rekonstrukcije nakon ablacija tumora, plan rekonstruktivnog zahvata koji je sproveden, način dizajniranja i rešenja za dati slučaj.
Materijal i metode: Rad je zasnovan na bolesničkom materijalu 12 pacijenata koje je hospitalizovano na odeljenjima Urgentne hirurgije KCS Urgentnog centra. To su različita stanja tumoroznih tvorevina na različitim delovima tela, različitog dijametra zahvaćenosti kože kako po površini tako i po dubini.
Rezultati: Rezultati prikazuju naše načine zbrinjavanja, polnu distribuciju, rane i kasne postoperativne sekvele i načine njihovog razrešavanja.
Zaključak: U radu iznosimo naša iskustva i saznanja do kojih smo došli.
Ključne reči: planirani režnjevi, defekti kože

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MESTO I ULOGA LOKALNOG KOŽNOG REŽNJA

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Uvod: Vrlo često kroz praksu susrećemo se sa malim rekonstruktivnim zahvatima na delovima kože koji su zahvaćeni određenim formama tumoroznih tvorevina koje zahtevaju eksciziju i zbrinjavanje novonastalog defekta.

Cilj: Kroz rad želimo da prikažemo neka naša rešenja za rekonstrukcije nakon ablacija tumora, lokalnim režnjevima koji imaju svoju primenu kroz jednostavnost rešenja i dobru isplaniranost daju efektan kozmetski efekat.
Materijal i metode: Rad je zasnovan na bolesničkom materijalu 36 pacijenata koje je hospitalizovano na odeljenjima Urgentne hirurgije KCS Urgentnog centra.Načini i plan zbrinjavanja,kao i rezultati kroz definitivni izgled pacijenta nakon uklanjanja promena.
Rezultati: prikazuju naše načine zbrinjavanja, polnu distribuciju, rane i rezultate.
Zaključak: U radu iznosimo naša iskustva i saznanja do kojih smo došli.
Ključne reči: lokalni kožni režanj

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MASIVNA AMBULANTNA KRVAVLJENJA U TRBUŠNOJ DUPLJI

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Uvod: Ne često tokom dežurstava u Urgentnom centru srećemo se i sa abudantnim i obilnim krvavljenjima u trbušnoj duplji raznih etiologija.To su najčešće posledice ruptura velikih magistralnih krvnih sudova, lezije parenhimatoznih organa itd.
Cilj: Kroz rad prikazati koji su to sve mehanizmi doveli do lezija i modalitet i način rešavanja u pojedinim konkretnim slučajevima
Materijal i metode: Rad je zasnovan na bolesničkom materijalu 11 pacijenata koji je hospitalizovani na odeljenjima Urgentne hirurgije KCS Urgentnog centra. To su različita stanja koja su dovodila do obilnih krvavljenja unutar trbušne duplje.
Rezultati: prikazuju naše načine zbrinjavanja urgentnog stanja i prikaz nekih od rešavanja u datom trenutku kojim smo se rukovodili.
Zaključak: U radu iznosimo naša iskustva i saznanja do kojih smo došli.
Ključne reči: masivna krvanjenja, trbuh

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OKLUZIVNA STANJA U TRBUŠNOJ DUPLJI

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Uvod: Brojnost pacijenata posle šeste decenije koja se javlja u Urgentni centar i naješće sa potrebom urgentnog zbrinjavanja je populacija pacijenata sa okluzivnim tegobama.
Cilj: Kroz rad prikazujemo koji su to sve mehanizmi doveli do okluzivnih tegoba, broj pacijenata, polnu distribuciju kao i modalitet operativnog zbrinjavanja ove kategorije pacijenata.
Materijal i metode: Rad je zasnovan na bolesničkom materijalu 46 pacijenata koje je hospitalizovano na odeljenjima Urgentne hirurgije KCS Urgentnog centra. To su različita stanja koja su dovodila do okluzivnih tegoba unutar trbušne duplje.
Rezultati: prikazuju naše načine zbrinjavanja, polnu distribuciju, rane i kasne postoperativne sekvele i načine njihovog razrešavanja.
Zaključak: U radu iznosimo naša iskustva i saznanja do kojih smo došli.
Ključne reči: trbuh, okluzivna stanja

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TRAUMATSKE POVREDE KRANIJUMA PRAĆENE KOMOM SA MANIFESTNIM STANJEM NA PLUĆIMA

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Uvod: Saznanja o povezanosti stanja svesti kod traumatizovanih sa povredom glave i mozga i povezanosti sa promenama na plućima datiraju od davnina. Opisan je eksperiment na životinjama gde spis o tome datira još iz 1874.godine. A prvo kliničko saopštenje datira iz 1918. godine o pojavi edema pluća kod ovih stanja, pri čemu su te promene nastupile neposredno posle događaja.
Cilj rada: Uočiti uzroke i moguće mehanizme nastanka i pokušati naći uzročno-posledičnu vezu nastanka ovog stanja.
Materijal i metode: Rad je zasnovan na bolesničkom materijalu 23 pacijenata koji je hospitalizovan u intezivnoj neurohirurškoj nezi. U nama dostupnoj literaturnoj bazi nailazimo-"prikazano kao teška forma neurogenih promena hemodinamskih plućnih parametara". Kod takvih pacijenata smo sebi postavili za zadatak merenje intrakranijumskog pritiska, mesto i uloga odnosa ventilacije i perfuzije, značaj cerebralne i arterijske hipoksije.
Rezultati: Za vremenski period od godine dana i bolesničkom materijalu mogli smo uočiti-u genezi tih promena povećani I.C.P. odnosno cerebralna hipoksija ima uzročno značenje. Predpostavka proizilazi da pulomnalne promene nastaju izazvane simpato-adrenergičnim mehanizmom, pri čemu arterijska hipoksija ima velikog učešća u poremećaju odnosa ventilacije i perfuzije. Možemo govoriti da iz tog sledi da je u direktnoj vezi težina traume glave i mozga sa veličinom arterijske hipoksije.
Zaključak: Uzorak pacijenata je mali, ali dovoljan podstrek za dalje istraživanje u ovom pravcu. Laboratorijska istraživanja nisu mogla biti dugo sprovođena kod ovih pacijenata zbog kratkoće života ovih pacijenata. Ali nam je želja bila da ukažemo da i ovakva stanja traumatizovanih pacijenata zaslužuju izučavanja ove vrste problema u svetlu iznalaženja nekih novih postupaka za njihovo razrešenje.
Ključne reči: povrede glave, promene na plućima

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ULOGA RESPIRATORNE FUNKCIJE KOD TEŠKIH KRANIOCEREBRALNIH POVREDA

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Uvod: Odavno je uočena veza između teških kraniocerebralnih povreda i respiratorne problematike. Vrlo često su to stanja koja su vodila u letalni ishod, jer se zapazilo da kod takvih pacijenata nakon povrede glave dolazilo je i nastupao respiratorni arest pre nego kardijalna insuficijencija, a iz nama dostupnih literaturnih podataka smatra se da mozak može preživeti ako se pravovremeno potpomogne respiracija.
Cilj: Ideja u ovom radu je bila da ukažemo i prikažemo da ukoliko se pravovremeno prida značaj respiratornoj insuficijenciji kod povrede endokranijuma, možemo uticati na smanjenje smrtnosti kod onih pacijenata koji dožive ovaj vid traumatizma.
Materijal i metode: Rad je zasnovan na bolesničkom materijalu koji je hospitalizovan u intezivnoj neurohirurškoj nezi. Konfuzno mentalno stanje, dezorjentacija i gubitak svesti su preterminalna stanja respiratorne insuficijencije. Vrlo često u neposrednom postraumatslkom periodu, hipoksija bitno utiče na brzinu i kvalitet oporavljanja kod kraniocerebralnih povreda. Ideja je bila kakav bi odgovor bio na smanjeni nivo svesti kao indikator i indikacija za dodatnu respiratornu potporu. S istom problematikom suočili smo se i mi kod naših bolesnika u neposrednom posttraumatskom periodu.Važnost pravovremenog suzbijanja hipoksije prikazaćemo kroz sproveden klinički tok pacijenata sa ovim vidom traume.

Rezultati: Za vremenski period od godine dana i bolesničkom materijalu od 60 pacijenata mogli smo uočiti-smanjeni mortalitet kod povreda glave, nakon primenjene arteficijalne ventilacije sa umerenom hiperventilacijom, smatrajući da se tako postiže bolja oksigenacija mozga, smanjuje intrakranijalni pritisak, koriguje intercerebralna acidoza i značajno povećava perfuzija ozleđenog mozga. Ako se ima u vidu da mozak predstavlja samo 2% telesne težine odraslog organizma, on troši oko 20% od ukupne količine telesne potrošnje kiseonika, što je ogroman metabolički zahtev. Kada ta potrošnja opadne kod oštećene funkcije mozga ispod 2,5ml O_2 na 100gr tkiva u minuti nastupaju mentalne promene, a ispod 2,0ml nastupa koma. Zato smo gasnim analizama krvi bili u prilici da rano otkrijemo subkliničke respiratorne problematike.
Zaključak: Usmeravanjem pažnje na pravovremenu korekciju desaturacije krvi, plućne insuficijencije, bila je manje zastupljena u neposrednom uzroku smrtnosti kod kraniocerebralnih povreda.
Ključne reči: respiratorna funkcija, povrede glave

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METAK U VRATU

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Uvod: Akcidentne povrede u predeo glave i vrata u poslednje vreme zauzimaju značajno mesto u traumatologiji ovih predela. Od značaja je klinički pregled i pravovremena dijagnostika koji su glavni vodiči u opštem pristupu rešavanja stanja pacijenata sa takvom vrstom povreda. Ako se ima u vidu činjenica bogatstva značajnih struktura koja se nalaze po topografiji u tom predelu, kao i mogućnosti njihove lezije sa manifestnim obilnim krvavljenjem, zadatak je tim i veći.
Cilj:U studiju su uključeno 13 pacijenata sa Odeljenja Urgentne neurohirurgije KCS Beograd,koje je zahtevalo hitnu i neodložnu hirurška pomoć. Prikazati algoritme načina pstupanja i lečenja pacijenata sa takvom vrstom povreda i zahtevima koji su se pred nama stvarali tokom rešavanja nastalih stanja.
Materijal i metode: Obično su to rane koje nastaju oštricom i/ili tupinom te sledstveno načinom na koji su nastale ostavljaju i posledično nam nameću zadatak načina njihovog zbrinjavanja. Imajući u vidu činjenicu koja nam se stvorila kroz praksu da putanja metka kroz meka tkiva vrata naročito imaju svoje migratorne pokrete za po nekoliko santemetara. Selektivnost i opredeljenje za ne-operativni menadžment određeni obrazac povreda usloviće i našu odrednicu i algoritam radnji i postupaka u njihovom zbrinjavanju. S obzirom na karakteristiku nastajanja traume, vreme proteklo od iste kao i trenutnog statusa pacijenta odluke se donose vrlo brzo da bi se dobila trka sa vremenom za opštu dobrobit i zdravlje pacijenta.
Rezultati: Mogućnost da su povređene određene vitalne strukture je potencijalno jako visok, stoga su nam jako značajne pravovremene i valjane dijagnostičke procedure koje uključuju MSC i CT angiografiju, kako bi nam pružilo dovoljno informacija i opredelilo operativno delovanje. U kojoj meri se možemo osloniti samo na klinički pregled bez dijagnostičkih dodataka je samo u onim situacijama kada postoji jako izražena hemoragija koji preti da pacijenta uvede u hemoragijski šok, te hirurški pristup i zbrinjavanje vode brzo u njegovo razrešenje. Stvarni planovi delovanja zavisiće ne samo od određenog pacijenta sa takvom povredom, već i od raspoloživih kadrovskih i stručnih potencijala ustanove koja to može da zbrine.
Zaključak: Strukture u riziku kod ovakvih povreda vrata su prvenstveno disajni putevi, vaskularne structure-prevashodno magistralni krvni sudovi, jednjak, kičmeni stub uključujući i kičmenu moždinu, donji kranijalni neravi i brahijalne grane. Torakalni kanal je takođe u opasnosti naročito u rana pozicioniranih na levoj strani vrata. Radom smo želeli da ukažemo na specifičnosti ovakvih povreda, načina njihovog zbrinjavanja i dijagnostike. Ukazujući da pravovremeno delovanje u krajnjem rezultatu ima kvalitet života takvih pacijenata.

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Ključne reči: povrede vrata, odluke tretmana

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FRAKTURE NOSNIH KOSTIJU

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Nosna kost je kao najisturenija kost lica, najčešće je povređivana kost lica (40- 50%). Frakture nosnih kostiju mogu biti izolovane ili kombinovane sa prelomima drugih kostiju lica. Frakture mogu biti kompletne ili inkopletne, sa ili bez dislokacije, otvorene ili zatvorene.
Češće su kod muškaraca nego kod žena, a od etioloških faktora se najčešće navode nasilje, zatim saobraćajni udesi, sport, pri padu. Od dijagnostičkih metoda se koriste RTG facijalnog masiva ili rađe Kompjuterizovana tomografija. Pacijenti se žale na bolove, krvarenje iz nosa i otežano disanje na nos. U kliničkoj slici dominira otok sa krvnim podlivom, različito izražen deformitet nosa, krvarenje iz nosa u razlititom obimu, patološka pokretljivost koštanih fragmenata i krepitacije (ukoliko se radi o kompletnoj frakturi). Liječenje nosnih kostiju je potrebno sprovesti što prije, a ukoliko se radi o kompletnoj frakturi, potrebno je uraditi repoziciju nosnih kostiju, koja se najčešće sprovodi u lokalnoj anesteziji. Repoziciju treba sprovesti u roku od 3 do 5 dana. Neadekvatno i neblagovremeno liječenje dovodi do loših estetskih i funkcionalnih rezultata, što je praćeno češćim komplikacijama.
Ključne reči: fracture nosnih kostiju, pacijenti, liječenje

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UGRIZNA RANA NA VRATU – PRIKAZ SLUČAJA

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Jedne od najčešćih rana na licu i vratu su ugrizne rane koje mogu nastati usljed ugriza životinja (najčešće psi - 80%), mada nisu rijetke ni ugrizne rane usljed ljudskog ujeda. Ugrizne rane su naročito česte kod djece. Najčešće bakterije koje se mogu naći u ugriznoj rani su aerobi i anaerobi iz oralne flore napadača i aerobi sa kože žrtve.
Prikazujemo slučaj pacijentkinje ženskog pola, 34 godine starosti, sa infekcijom ugrizne rane na vratu usljed ujeda psa. Pacijentkinja se javila na pregled 30 h po dobijanju povrede sa otokom i crvenilom kože sa znacima fluktuacije, bolovima i visokom temperaturom (38,2 °C). U krvoj slici je postojala leukocitoza (15 x10 9), CRP-19. Odmah po prijemu rana je hirurški zbrinuta, učinjena je incizija rane sa drenažom, uključena antibiotska terapija, antitetanusna zaštita i analgetik. Kod pacijentkinje je poslije svakodnevnog previjanja uz navedenu terapiju došlo do potpunog saniranja infekcije, nakon čega je rana suturirana i uredno zarasla.
Liječenje ugriznih rana lica i vrata je specifično u odnosu na ostale dijelove tijela. Zbog dobre prokrvljenosti komplikacije su rijetke, mogu biti opasne za život. Potrebno je pacijenta redovno kontrolisati, kako bi se u slučaju komplikacija moglo blagovremeno hirurški obraditi rana i uključiti adekvatna terapija.
Ključne riječi: ugrizna rana, infekcija, liječenje

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KVALITET ŽIVOTA NAKON PRELOMA KOSTIJU LICA I VILICA

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Uvod: Kod pacijenata sa prelomom nekih od kostiju lica često postoji slabiji kvalitet života poslije preloma, kao i neki od oblika psihološkog morbiditeta. U istraživanjima koji su vezani za ovu temu se pominje prisutnost specifičnih psihosocijalnih faktora kao sto su depresija, anksioznost, promene u doživljaju izgleda vlastitog tijela poslije maksilofacijalne hirurgije (u daljem tekstu:MFH), nisko samopoštovanje i loši društveni odnosi. Kod mnogih autora postoji težnja da se mjere ishoda liječenja pacijenata u MFH budu okrenute ka pacijentu, procijeniti pacijentove potrebe i viđenja na jedan sveobuhvatan, jasan, racionalan kvalitativni način. Ovakav način liječenja bi uključivao mjere socio-psihološkog problema isto kao i fizičkog nedostatka. Ovakve mjere bi trebale da prate napredak tretmana i da omoguće donošenje odluka vezanih za hirurško intervenciju, potencijalne pravne slučajeve i psihološku negu.
Hirurški tretmani u predelu lica i usnog regiona su povezani sa specifičnim i jakim strahom. Prema nekim studijama, kod 30% pacijenata neposredno poslije maksilofacijalne frakture i poslije hirurškog zahvata, postoje jasno izražen psihološki morbiditet (kao npr. anksioznosti i depresija).
Cilj: Kroz ovaj rad želja nam je bila da prikažemo vrste povreda i postupke lečenja istih. Opseg nastalog traumatizma zahtevao je odgovarajući hirurški pristup i način zbrinjavanja.
Materijal i metode: U studiju su uključeno 24 pacijenta koji su imali traumatizam u predelu ličnog masiva,sa velikim razaranjima i posledičnim postoperativnim sekvelama-deformitetima koji su nastajali nakon dužeg vremenskog perioda. Klinička slika je bila raznovrsna u zavisnosti od načina nastajanja traumatizma, opsega povrede i lezija struktura.
Rezultati: Rad je isključivo baziran na rešavanju stanja i proceni kvaliteta života pacijenata nakon nastanka traumatizma i perioda oporavka nakon zbrinjavanja. Kroz sprovedenu anketu pacijentima, njihovim stavom i izgrađenim mišljenjem i kako oni vide svoje stanje. A prikazaćemo neka naša nova rešenja u rešavanju sekvela i popravljanju njihovog kvaliteta života.
Zaključak: Kroz rad izložićemo algoritme radnji i postupaka u zbrinjavanju ovakvog traumatizma, načine dijagnostike i najoptimalnija rešenja zbrinjavanja koja su nam se kroz praksu pokazala kao najcelishodnija.Konceptualna rešenja su prevashodno bila orjentisana sa ciljem da se izbegnu ili svedu na najmanju moguću meru rane i kasne komplikacije, a time unapredi kvalitet života pacijenata već u prvom aktu zbrinjavanja nakon doživljenog traumatizma.
Ključne reči: prlomi kostiju lica, kvalitet života

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KARAKTERISTIKE POVREDA BRAHIJALNOG PLEKSUSA IZAZVANIH VATRENIM ORUŽJEM

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Uvod: Povrede barhijalnog pleksusa vatrenim oružjem predstavljaju drugi najčešći mehanizam povređivanja brahijalnog pleksusa i iznose oko 25%, nastaju kako u ratnim tako i u mirnodopskim uslovima. Predstavljaju poseban problem, s obzirom da su to najozbiljnije povrede perifernog nervnog sistema. Nervi mogu biti povređeni direktno fragmentima metka ili tzv šoknim talasom i kavitacionim efektima koji izazivaju njihovu kompresiju i razvlačenje. Ovo izaziva oštećenje nervnih struktura i dužeg nervnog segmenta sa spoljne strane putanje projektila. Takođe, postoje i različite kombinacije povreda elementa brahijalnog pleksusa, po stepenu

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težine povrede kao i po obimu povrede. Veoma često su limitirane mogućnosti hirurškog tretmana. Funkcionalni oporavak je veoma dugačak i nepredvidljiv, i često sa lošim ishodom, zato što je dug put regeneracije nervnih vlakana i redukcije Schvanovih omotača, koje je i vremenski zavisno.

Cilj ove studije je da se analizira karakteristike ovih povreda, kao i mogućnost za funkcionalni oporavak posle hirurškog tretmana.

Dizajn: Retrospektivna analiza pacijenta sa oštećenjem nerava i ishod operacija.

Material i metode: Naša serija sadrži 32 pacijenta, koja su operisani u periodu između januara 2003 i januara 2013. Starost ovih pacijenta se kretala između 15 to 54 god. Totalna inicijalna paraliza se javila kod 20 pacijenta, gornja paraliza kod 2, a parcijalni funkcionalni gubitak kod 10 pacijenata. Povrede su bile lokalizovane supraklavikularno kod 9 pacijenta a infraklavikularno kod 23 pacijenata. Prema lokaciji povrede, preoperativnim, kliničkim i elektrografskim ispitivanjima našli smo povrede 101 nervnog elementa (individualne komponente kompleksa brahijalnog plexusa). Najveći broj lezija-75 je nađeno na individualnim nervima na samom odvajanju od rogova kičmene moždine ili na prvih nekoliko santimetara. U 15 slučajeva oštećenje spinalnog nerva je na nivou tela a 11 na mestu odvajanja. Intraoperativno, kompletan prekid kontinuiteta je nađen kod 25 nervnih elemenat, parcijalni prekid kod 14, povrede neuroma u kontinuitetu kod 45 i spoljašnji ožiljci bez povrede nerva kod 17. Hirurške procedure su sprovedene u periodu od 3 nedelje do 12 meseci posle povređivanja, prosečno u 3 mesecu. Najveći broj 26 od 32 pacijenata je operisan do 6 meseca. Hirurške procedure su sprovedene u skladu sa intraoperativnim nalazom. Exploracija i externa neuroliza je sprovedena kod 18 nervnih elemenata, interfascikularna neuroliza kod 45, split rekonstrukcija (grafting nerva slučajevima sa i endoneuralnom fibrozom, intrafascikularnim neuromom ili prekidom samog fascikulusa) kod 13 nervnih elementa, grafting nerva kod i 23 nervna elementa i transfer nerva kod 2 nervna elementa.

Rezultati: Analizom svih 32 slučajeva sa periodom praćenja od 24 meseca, motorna funkcija je klasifikovana u 6 stepeni, od M0 to M5 korišćenjem široko prihvaćene Highet's kliničke skale. Senzorna funkcija je klasifikovana u stepene S0 do S4 po Millesi. Finalni rezultat je klasifikovan u 3 grupe (dobra, zadovoljavajuća i loša) zavisno od funkcionalnih proriteta u hirurgiji brahijanog plexusa. Dobra i zadovoljavajuća grupa su procenjene kao koristan funkcionalni oporavak.

Grafting nerva uključujući i split rekonstrukciju nervnih elemenata dalo je 19 dobrih rezultata, 11 zadovoljavajućih i 4 loša. Neuroliza (externa i intrefascikularna) dala je 43 dobrih rezultata, 12 zadovoljavajućih i 6 loših. Kombinacijom procedura izvedenih na kompleksnom brahijalnom plexusu dale su 4 dobra i 2 zadovoljavajuća rezultata.

Neuroliza je dala dobre rezultate kod 3 lezije lateralnog snop, 1 lezije kičmene moždine, 1 lezije posteriornog snopa 8 lezije mišićnokutane, 7 lezije lateralnog snopa medijanusa, 3 lezije medijalnog snopa medijanusa, 2 lezije ulnarisa, 11 lezije axilarisa i 7 lezije radijalisa.

Neuroliza je dala dobre rezultate kod 1 lezije medijalnog snopa, 2 lezije lateralnog medianusa, 2 lezije medijalnog snopa medijanusa, 2 lezije ulnarisa, 1 lezije axilarisa i 4 lezije radijalisa. Neuroliza je dala dobre rezultate 1 lezije C8-T1 i/ili donjeg stabla, 3 lezije ulnarisa i 2 radijalisa.

Nerv grafting dao je dbre rezultate kod 2 lezije C5-C6 i/ili gornjeg stabla, 1 lezija C5-C6-C7 i/ili gornjeg i središnjeg snopa, 1 lezije lateralnog snopa, 2 lezije posteriorng snopa, 6 lezije musculocutaneusa, 3 lezije lateralnog korena medianusa, 2 leszije axillarisa i 2 lezije radialisa.

Grafting nerva dao je zadovoljavajuće rezultate kod 2 lezije C5-C6-C7 i/ili gornjeg i središnjeg stabla, 1 lezije spoljašnjeg snopa, 3 lezije lateralnog korena medijanusa, 3 lezije medijalnog korena medijanusa, 1 lezija axilarisa i 1 lezije radijalisa. Grafting nerva je dao loše rezultate kod 1 lezije lateralnog korena medianusa, 2 lezije medijalnog korena medijanusa i 1 lezije radijalisa. Kombinacija neurolize i graftnga nerva dala je dobre rezultate u 2 lezije C5-C6 i/ili gornjeg stabla i 2 lezije C5-C6-C7 i/ili gornjeg i srednjeg stabla, zadovoljavajuće kod 1 lezije C5-C6 i/ili gornjeg stable i 1 lezije C5-C6-C7 i /ili gornjeg i srednjeg stabla i bez loših rezultata.

Zaključak: Naše iskustvo sa povredama vatrenim oružmen brahijalnog plexusa su specifične (u poređenju sa drugim studijama) zato što je veća incidenca kompletne paralize brahijalnog pleksusa i veća je incidenca lezija sa kompletnim gubitkom kontinuiteta. Možemo da zaključimo da se povrede veoma retko oporavljaju spontano, hirurški tretman je indikovan kada ostoji funkcionalni gubitak u distribuciji jednog ili više nervnih elemenata, koji perzistiraju duže od 3 meseca. Odlaganje hirurške intervencije duže od jedne godine nije opravdana,

koristan oporavak može se dobiti u preko 90 % og slučajeva neurolize i nervnog graftinga je uspešan kod povreda C5 i C6 kičmenih nerava, gornji stabla, bočne i zadnjeg snopa, njihova nervnih grana i verovatno sredine nerva
Ključne reči: Brahijalni pleksus, povrede vatrenim oružjem, rekonstrukcija nerva, neuroliza, nervni graft, transfer nerva

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ŠKOLSKA DJECA I ADOLESCENTI U SLUŽBI HITNE MEDICINSKE POMOĆI DOMA ZDRAVLJA BIJELJINA TOKOM 2015. GODINE

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Uvod: Služba hitne medicinske pomoći radi kontinuirano tokom 24 časa u smjenama po 12 časova. Jedan tim sačinjavaju dva doktora medicine, četiri medicinske sestre-tehničara od kojih je jedan dispečer i dva vozača. Svaki tim ima šefa smjene koji je odgovoran za funkcionisanje tima hitne medicinske pomoći. Najmanje još jedan član tima sa iskustvom od 2 godine rada u urgentnoj medicini je prisutan uz ljekara tima u toku radnog vremena. U Domu zdravlja Bijeljina ima 11 ekipa hitne pomoći, a pruža usluge za oko 150.000 stanovnika, od kojih oko 10.000 čine djeca uzrasta od 7-18 godina. Po prijemu telefonskog poziva, šef smjene upućuje ekipu na mjesto dešavanja. Svi pozivi u službu se snimaju, a tonski zapisi se čuvaju najmanje godinu dana.
Cilj rada je prikazati učestalost pružanja hitne medicinske pomoći školskoj djeci i adolescentima na području Grada Bijeljina, koji su se javili u SHMP ili kojima je pomoć pružena van Doma zdravlja Bijeljina u toku 2015. godine.
Metoda rada: Izvršena je retrospektiva analiza i statistička obrada Knjige prijema poziva, Knjiga protokola u SHMP Doma zdravlja Bijeljina u periodu od 01.01. - 31.12.2015. godine. Analizirana je polna i starosna struktura, dijagnoze, vrijeme i mjesto intervencije.
Rezultati: Tokom 2015. godine ekipe SHMP obavile su 5.548 hitnih intervencija kod djece uzrasta od 7-18 godina od toga 5.189 je bilo u ustanovi i 359 na terenu. Ukupan broj hitnih intervencija u 2015. godini iznosi 29.596, a od toga je 18,75% intervencija pruženih kod djece uzrasta od 7-18 godina.
Polna struktura pokazuje da se hitne intervencije češće javlja kod dječaka 3.259 nego kod djevojčica 2.289. Najviše hitnih intervencija bilo je u starosnoj dobi od 14-15 godina i to 13,43%, zatim u 10-11 godina 11,58% te u dobi 5-6 godina 8,35%. Ako posmatramo doba dana kada je pružana intervencija najčešće je to bilo u periodu od 8.00 – 16,00 časova. Analizom postavljenih dijagnoza saznali smo da su u najvećem procentu 56,78% bile zastupljene povrede i to u 3.150 slučajeva, a što je predstavljalo 56,78 % svih intervencija.
Najčešće broj povreda bile su zadesne povrede (padovi, posjekotine, ujedi i sl.).
Broj pacijenata sa trovanjem u toku 2015. godine bio je 256, a od toga trovanje alkoholom je bilo najčešće 76.53 %. Nije bilo djece u komi a intoksikacija psihoaktivnim supstancama bila uzrok 1% intervencija kod školske djece i adolescenata.
Broj djece koja su prevežena u nadležnu bolnicu zbog opservacije ili nastavka liječenja iznosi je 28.
Zaključak: Svi članovi tima službe hitne medicinske pomoći su obučeni i upoznati sa procedurama za trijažu pacijenata i algoritmima za prehospitalno zbrinjavanje urgentnih stanja, procedurom za izvođenje KPR, kod odraslih i djece i procedurom za transport pacijenata u bolničke i druge ustanove. Davanje instrukcija do dolaska ekipe hitne pomoći predstavlja prvu kariku u u zbrinjavanju pacijenta bez obzira na uzrast. Takođe je važna kontinuirana edukacija i obnova znanja i vještina, kao i obuka novozaposlenih radnika, u zbrinjavanju traumatizovanih pacijenata. Stanja bez svijesti, teške traume u dječijem uzrastu, trovanja, suicidi i pokušaji suicida zahtijevaju spremnost ekipa HMP čiji je primarni cilj sačuvati život djeteta.
Ključne reči: adolescenti, povrede, trovanja

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CREVNA OPSTRUKCIJA UZROKOVANA TUMOROM REKTOSIGMOIDNOG DELA DEBELOG CREVA-ŠTA RADITI?

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Cilj rada: Odrediti adekvatnu metodu (Hartmann-ova procedura vs. bipolarna kolostomija) za rešavanje crevne opstrukcije koja je prouzrokovana zloćudnim tumorima rektosigmoidnog segmenta debelog creva. Pratiti pojavu hirurških i nehirurških komplikacija, kao i potrebu za transfuzijom krvi i ishod lečenja.
Metoda rada: Studijom je obuhvaćeno ukupno 120 ispitanika, koji su operisani dvema različitim tehnikama, metodom bipolarne kolostomije i Hartmann-ovom procedurom. Svi ispitanici su randomizovani u četiri odgovarajuće grupe, shodno godinama života i ASA skoru. Određivana je incidenca hirurških i nehirurških komplikacija, kao i potreba za transfuzijom krvi i njena količina. Takođe, opserviran je i ishod lečenja, odnosno praćen je intrahospitalni mortalitet (preživljavanje).
Rezultati: Ispitivanjem nije dobijena statistički značajna razlika u pojavi hirurških i nehirurških komplikacija kod pacijenata operisanih dvema tehnikama ($p>0.05$). Takođe, nije registrovana statistički značajna razlika u preživljavanju u funkciji primenjene hirurške strategije ($p>0.05$). U pogledu ishoda lečenja, konstatovano je da uticaj na mortalitet ima pojava nehirurških komplikacija, kao i visoke vrednosti ASA skora ($p<0.05$). Pojava hirurških komplikacija takođe ima uticaj na preživljavanje (povišen intrahospitalni mortalitet, $p<0.05$, Mantel-Cox test).
Zaključak: Obe procedure su dovoljno sigurne, sa gotovo jednakim rezultatima lečenja i stopom komplikacija. Nijedna od ove dve metode se u tom smislu ne nameće kao superiorna u odnosu na drugu. Međutim, u slučaju značajne distenzije creva tehnički je primerenija metoda bipolarne kolostome. Bipolarna kolostomija u odnosu na Hartmann-ovu proceduru ima prednost u činjenici da je nakon kreiranja bipolarne kolostome rešen problem crevne distenzije i da se na drugoj definitivnoj hirurškoj proceduri može imati bolji onkološki pristup. Mana je svakako što je neophodna druga hirurška intervencija, za koju ne mogu biti pripremljeni svi pacijenti u tako kratkom vremenskom roku, pa se kod takvih primena Hartmann-ove procedure sa uklanjanjem tumora čini kao onkološki prihvatljivije rešenje. Hartmann-ova procedura je primerenija starijim pacijentima (>60 godina), sa vrednostima ASA skora >3. Ovom procedurom (uz visoko ligiranje limfovaskularnog pedikla) postiže se efekat uklanjanja tumora na prvoj hirurškoj intervenciji. Bipolarna kolostoma praćena definitivnom hirurškom intervencijom nakon maksimalno dve nedelje se nameće kao procedura koja je prihvatljiva za mlađe, zdrave pacijente, koji mogu biti spremni za novu hiruršku intervenciju u kraćem vremenskom intervalu. Bipolarna kolostoma ima i svoje mesto kod izrazito nestabilnih pacijenata, sa visokim vrednostima ASA skora u cilju hitne intestinalne dekompresije.

Ključne reči: opstrukcija, tumor, rešenje

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NEKI PACIJENTI OSTANU ENIGMA

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Uvod. U svakodnevnom radu lekara hitne medicinske pomoći (HMP), postoje pacijenti koji, zbog kratkog vremena i oskudnosti dijagnostičkih sredstava na terenu, nisu jasni u pogledu dijagnoze i tretiraju se kao sindromi.
Cilj nam je da prikažemo pacijenta kod koga i posle višednevnog boravka i dijagnostike na klinici savremena medicina nije uspela da objasni početne simptome i kliničku sliku.

Prikaz slučaja: Ekipa HMP primila poziv drugog reda hitnosti u 14:48 zbog pacijenta koji je dobio naglo gušenje a lekar na prijemu poziva je procenio kao edem pluća, s obzirom da je dobio podatak od porodice, da ne boluje od HOBP, a leči se od hipertenzije. Procena u pravcu edema je bila pojačana činjenicom da je lekar na prijemu poziva i čuo pacijenta. Ekipa kod pacijenta stiže u 15:54. Zatiče, pacijenta S.R. starog 73 god, u ležećem položaju, koji je svestan, orjentisan, izrazito bled, preznojen, dispnoičan, tahipnoičan, sa čujnim disanjem, koji sam navodi da ima se naglo guši poslednjih pola sata. Ostale tegobe negira, a u ličnoj anamnezi je imao pre 15 god moždani udar, sa rezidualnom diskretnom hemiparezom desno. Vitalni parametri: TA 100/60 mmHg; SF 60/min, RF22/min; SpO2-ne očitava; Šuk 8 mmol/l. Pulmo: proužen ekspirijum, skraćen inspirijum, oslabljeno vezikularno disanje, difuzno obaostano polifoni niskotonski tonovi, bazalno do pola skapula vlažni šušnjevi. Cor: akcija srca ritmična, tonovi jasni, baz patološkog šuma. Abdomen: Bo Neurološki: sekvele prethodnog CVI. EKG: sin ritam, uzani QRS, bez promena na ST segmentu i T talasu. Otvara se venski put, uključuje $O_2$7 L/min; ordinira se amp Lasix No II. Pri prenošenju pacijenta s kreveta na kardiološku stolicu, pacijent gubi svest, spontano diše, gubi puls nad a.radijalis, ali ga ima nad a carotis, donešen def i na monitoru samo ubzanje SF na 80/min, ostalo nepromenjeno. Uključuje se inf.sa amp Dopamina 50mg u 300ml NaCl 0,9%. Započinjemo transport ka kardiologiji. U toku transporta i dalje hemidinamski nestabilan, disanje postaje iregularno, sporije, sa povremenim apneama, zbog čega krećemo sa asistiranom ventilacijom uz airway i maska balon. Na prijemnom odeljenju klinike za kardiologiju u toku pregleda, pacijent pravi jedan dubok udah i nakod toga nastavlja da regularno diše 14/min. ECG ostao regularn TA 90/50mmHg. Pulmo: nalaz uredan. EHO srca uredan i zbog prisutnog komatoznog stanja, pacijent se transportuje na kliniku za neurologiju gde je hospitalizovan. Uvidom njegovu dokumentaciju nalazimo da su urađene sledeće dijagnostičke procedure; CT (hronične mikroishemijske lezije supratentirijalno), kolor dopler krvnih sudova vrata (ICA fibrokalcifikovani plakovi, levo debljine 1,8mm, desno uz karakter ulcerisanog plaka, AV:desna manjeg promera, leva b,o.) EEG: uredan; MSCT krvnih sudova vrata (na karotidnom bulbusu levo 45% stenoza). Pacijent vratio svest prvog dana prijema, bez novih neuroloških događaja. Tokom boravka na odeljenju tretiran, antiedematoznom, rehidratacionom, vazoaktivnom, polivitaminskom, antiagregacionom, antihipertenzivnom i nefrološkom terapijom. Dijagnoze na otpustu: Synkopa, St post Shock, Stenosis ICA l.sin, Sequelae infarctus cerebri, Sy Parkinsoni, HTA, HBI.
Zaključak: Prehospitalni tretman ovog pacijenta bio je u pravcu održavanja njegovih vitalnih funkcija i rešavanja hemodinamske nestabilnosti. Prehospitalni klinički tok i fizikalni nalaz su bili nejasni a radne dijagnoze su se kretale od edema pluća, CVI, PTE, shock, anafilaksa, acidoze. Na osnovu medicinske dokumetacije zaključujemo da njegova klinička prezentacija nije u skladu sa dijagnozama na otpustu i da je patofiziološki događaj ostao nejasan.

Ključne reči: enigma, hemodinamska nestabilnost.

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AIM – PRIKAZ SLUČAJA

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Uvod: Klinička definicija akutnog infarkta miokarda (AIM) zahtijeva kombinaciju tipične anamneze i elektrokardiografskih (EKG) promjena, biohemijskih nalaza i tehnika koje ukazuju na redukciju ili gubitak perfuzije ili abnormalnosti u pokretljivosti zidova lijeve komore (LK) koje predstavljaju indirektnu evidenciju nekroze miokarda. Prema sadašnjim vodičima dijagnoza akutni infarkt miokarda se postavlja kada pacijent ima tipične ishemijske simptome i perzistentnu ST-elevaciju na EKG-u.Velika većina ovih pacijenta ima porast biomarkera od pojave tipičnog ishemičnog bola kod pacijenata. Prema podacima SZO, 12 miliona života godišnje izgubi se zbog kardiovaskularnih bolesti, čineći ih odgovornim za 50% ukupne smrtnosti. Od akutnog infarkta miokarda (AIM), prije nego što dođe do bolnice, umre 50% dok kod pacijenata koji se hospitalizuju sa AIM mortalitet iznosi 5-10%. U SAD se godišnje hospitalizuje zbog infarkta miokarda sa STelevacijom (STEMI) 330 000 stanovnika, infarkta miokarda bez ST- elevacije (NSTEMI) l,24 miliona stanovnika. AIM je najčešći uzrok smrti u Zapadnom svijetu i Svjetska zdravstvena organizacija predviđa da će takav trend ostati do 2020.

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god. U Podgorici, gradu koji ima 170 000 stanovnika, hospitalizuje se godišnje kao STEMI 150 - 275 pacijenata sa intrahospitalnim mortalitetom od 5-8%.
Cilj rada :pravovremeno postavljanje dijagnoze na osnovu fizikalnog nalaza i inicijalni tretman i brza odluka o daljem odgovarajućem hospitalnom lijecenju.
Materijal i metode: Prikaz slucaja pacijenta na osnovu ljekarskog pregleda i knjige protokola UC KCCG.
Prikaz slucaja: Muškarac star 49 godina doveden u UC od strane HMP ekipe zbog naglo nastalog bola u grudima praćenim mučninom, povraćanjem, otežanim disanjem, malaksalošću i obilnim znojenjem. Iz anamneze saznajemo da su simptomi počeli sat vremena prije prijema dok je ležao kući sa jakim bolom iza grudne kosti u vidu stezanja koji se širi u obje ruke i prema želucu, praćen je mučninom, preznnojavanjem, opštom slabošću i malaksalošću. Navodi da je u jednom navratu obilno povratio želučani sadržaj bez primjesa krvi i sluzi nakon čega mu je na par minuta bilo lakše ali se bol počeo pojačavati nakon par minuta. Negira ostale tegobe po sistemima. Dugogodišnji je pušač, povremeno konzumira alkohol, hipertenzija unazad 8 godina (neredovno koristi terapiju), zna za povišene masnoće u krvi ali ne uzima terapiju. Navodi da je prije dvije godine imao aritmije , tada pregledan od strane kardiologa i ordinirana terapija Presolol a 50 mg 2 x ¼ koju on povremeno koristi – ne prilaže medicinsku dokumentaciju. Negira ostala ranija oboljenja povrede i operacije. Pozitivna porodična anamneza za KVS oboljenja. Fizikalni nalaz: svjestan, orijentisan, komunikativan, dispnoičan, izrazito blijed, orošen hladnim, ljeplivim znojem, puls 115/minuti; izražena hipotenzija, KP: 70/50 mmHg. pulmo: disajni šum blago oslabljen uz diskretne pukoti lijevo bazalno. Cor: srčana akcija ritmična, tonovi tiši, šum ne čujem. EKG po prijemu u ambulantu UC: sinusni ritam, frekfenca 115/minuti, elevacija ST u II, III, aVf uz negativan T od V2 do V6. Pacijentu odmah postavljene dvije venske linije, uzete kompletne lab.analize uključujući I kardiospecifične enzime, uključen fiziološki rastvor 0,9 % NaCl a 500 ml, uključena oksigenoterapija putem nazalnog katetera 4 l/min, dato per os tbl Aspirin a 300 mg, plasiran urinarni kateter i pacijent odmah transportovan u Koronarnu jedinicu radi dalje dijagnostike i liječenja.
Ključne reči: AIM

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AKUTNI EDEM PLUĆA-PRIKAZ SLUČAJA

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Uvod: Akutni edem pluća predstavlja urgentno i po život opasno stanje, a koje nastaje zbog ekstravaskularnog nakupljanja tečnosti u alveolama zbog povišenog plućnog kapilarnog pritiska ili poremećene propustiljivosti kapilarno-alveolarne membrane. Zbog toga, opisano stanje zahteva hitno zbrinjavanje pacijenata.
Prikaz slučaja: Terenska služba doma zdravlja je dobila poziv od strane rodbine, za pacijenta starosti 65 godina, a zbog otežanog disanja, gušenja sa pojavom pene na ustima i uznemirenosti. Po dolasku, zatičem uznemirenog pacijenta u sedećem položaju, koji čujno i plitko diše, kašlje i iskašljava penušavi sadržaj,sa cijanotičnim usnama i nabreklim venama na vratu. Auskultatorni nalaz nad plućima pokazuje vlažne pukote uz oslabljeno disanje obostrano, TA 190/105mmhg, EKG:sin.rit.fr105/min, ST-T bo. Nakon pregleda je odmah ordinirana terapija Furosemid 40 mg iv, NTG tbl.pod jezik, uspostavljena venska linija i pozvana ekipa za transport pacijenta u Urgentni centar. Po prijemu u UC izmeren TA 165/100mmhg , Sat O2 80% te je nastavljena terapija Furosemidom 40 mg iv, Morfin iv, oksigenoterapija sa kiseoničkom maskom i protokom O2 6l/min sve do smanjenja simptoma i poboljšanja parametara TA 140/80mmhg i SAT O2 92% uz hospitalizaciju pacijenta zbog ranije dijagnostikovane i lečene srčane insuficijencije i hipertenzije.
Zaključak: U slučaju akutnog edema pluća pravovremeno reagovanje, adekvatna terapija i brzi transport do tercijarne ustanove je ključno u preživljavanju pacijenta.
Ključne reči: otežano disanje, kašalj, nabrekle vene na vratu

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ANAFILAKSA NA UVODU U ANESTEZIJU KOD PETOGODIŠNJEG DETETA-PRIKAZ SLUČAJA

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ODSEK ZA ANESTEZIJU, REANIMACIJU I INTENZIVNU TERAPIJU HIRURŠKOG ODELJENJA VOJNE BOLNICE NIŠ, SRBIJA

Uvod: udeo anafilaktične reakcije kao komplikacije uvoda u anesteziju, kreće se oko 3%, mada se smatra da je procenat možda i veći jer se mnoge ne beleže i ne prijavljuju. Sve anafilaktične reakcije na anestetike, analgetike i miorelaksante javljaju se u različitim oblicima: od promena na koži pa do fatalnih anafilaktičkih i anafilaktoidnih reakcija.
Cilj: prikaz pacijenta koji je razvio anfilaktičnu reakciju na uvodu u anesteziju.
Prikaz slučaja: dete M.Đ. staro 5 god i 2 mes, visine 118cm, teška 20kg, dolazi u pratnji jednog roditelja radi elektivne tonzilektomije i adenoidektomije. Na prvom pregledu u anesteziološkoj ambulanti, dete zdravo, bez pratećih komorbiditeta, ima odobrenje pedijatra i ORL specijaliste za operativni zahvat. Laboratorijski testovi u referentnim vrednostima za uzrast. Otac negira alergiju na hranu i lekove. Prvi put se operiše. Dva dana nakon prijema dete u pratnji oca dolazi u operacioni blok. Preoperativna priprema: amp midazolam 5mg IM, amp atropine 0,4 IM; postavljena IV kanila 20G; Nakon 30 min, dete donešeno u operativnu salu, svesno, ravnodušno, ne plače. Postavljen standardni monitoring (EKG, SpO_2, NIBP). Dete diše kiseonik preko maske 3 min i SpO_2 je 100%. Uvod u anesteziju započet tiopentonom i alfentanilom (po kg/TM) i relaksantom – leptosukcinom. Intubirano tubusom br 5 iz prvog pokušaja. TA 103/58mmHg SF 112/min, SpO_2 100%. Odmah nakon intubacije primećen bronhospazam, započeta terapija aminophyllin po kg/TM, metilprednisolonom po kg/TM, O_2 6L/min. Umesto poboljšanja u sledećih 10min stanje se pogoršava, sve manji udisajni volumen, balon sve tvrđi, SpO_2 76%, SF160/min. Auskultatorni nalaz u pogoršanju, dolazi do pada TA, gubitka radijalnog pulsa, aspiracijom tubusa se dobija penušavi sadržaj, dat adrenalin IV, nastavljena ventilacija O_2 i nakon kratkog vremenskog perioda dolazi do popuštanja bronhospazma i popravljanja svih vitalnih parametara. Nakon 60 min, dete extubirano bezbedno, diše spontano preko kiseonične maske 6L/min, postiže se SpO_2 100%. TA 95/50mmHg, SF 120/min. Opservirano u JIN 6 sati a sledeća dva dana dete praćeno na odeljenju ORL. U otpusnom pismu, dete se upućuje na VMA zbog postavljene sumnje na alergiju na neki od tri leka koje je dobilo. Potvrđena alergija na tiopenton.
Zaključak: Brzo prepoznavanje anafilaktične reakcije i tačna i pravovremena terapija su bile ključ uspeha. Potrebno je uvek pristupiti sa oprezom i biti speman na razvoj urgentnog stanja i njegovo rešavanje, pogotovu kada je to prva opšta anestezija.

Ključne reči: tiopenton, komplikacije na uvodu u anesteziju, anafilaksa

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ETIČKI OKVIRI ZA RAD HITNE MEDICINSKE POMOĆI (HMP) U MASOVNIM NESREĆAMA I KATASTROFAMA

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Uvod: Efikasno planiranje u procesu zbrinjavanja u katastrofama zahteva da pojedinci na svim nivoima zdravstvenog sistema (javnog i privatnog sektora) prihvataju i deluju na određenim etičkim i stručnim principima. Najveću odgovornost nose vladina tela, pre svega u procesu pre, u toku i posle katastrofe.
Cilj: Prikazati elemente etičkog okvira za delovanje radnika HMP u masovnim nesrećama i katastrofama.
Izvor podataka i izbor materijala: Retrospektivna analiza literature sa odrednicama: masovne nesreće, katastrofe, etika, odgovornost, hitna pomoć. Pretraživanje je vršeno kroz: PubMed, Medline i elektronske časopise dostupne preko KoBSON-a kao i litratura raspoloživa u biblioteci Medicinskog fakulteta u Nišu.

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Rezultati sinteze: Etički okviri ponašanja u slučaju masovnih nesreća treba da se odnose na ponašanje učesnika na svakom nivou u zbrinjavanju, počev od onih koji rade na državnom nivou pa do individua koji rade na terenu. Osnovni elementi etičkog ponašanja u masovnim nesrećama i katastrofama su:

- poštenje
- dužnost da brinu o pacijentima
- obavezu da upravljaju resursima
- transparentnost
- doslednost
- proporcionalnost
- odgovornost

Svaki od ovih entiteta biće razmatrani u radu. Poštenje: U masovnim nesrećama i katastrofama ne treba svi da dobiju identičan tretman, ali i ne treba da postoje razlike u tretmanu kod istih grupacija. Odluka o postojanju razlike u tretmanima mora da je zasnovana na jasnim ciljevima zajednice koji su postavljeni pre same nesreće. Primer (kada postoje ograničeni resursi u vakcinama, odluka zajednice da prioritet za vakcinisanje imaju osobe koje su izložene većoj mogućnosti infekcije, npr spasioci u procesu zbrinjavanja). Postoje primeri da su neke zajednice donele odluke da u takvim situacijama prioritet zavisi od godina starosti ili npr osobe koje su u zatvoru, sa postojećim teškim bolestima ili invaliditetom nemaju prioritet. Verske, kulturne ili jezičke razlike ne bi smele da budu osnova za donošenje odluke. Dužnost da zbrinjavaju: Osoblje u HMP je edukovano da brine pre svega o individuama a ne o populaciji. Smanjeni resursi dovode do smanjenja vrste i načina lečenja. U ovim događajima, trijažu ne bi trebalo da radi osoba koja je istovremeno zadužena i za direktno lečenje pojedinaca. Osoblje koje radi u procesu zbrinjavanja, takođe ima i svoje porodice. Spasioci koji imaju maloletnu decu, imaju dužnost da se pre svega brinu o njima, tek kada zbrinu svoje najbliže, moći će da izvrše i svoje profesionalne obaveze. U procesu planiranja takođe treba misliti o ovom etičkom momentu i zakonski ga uokviriti. Obavezu da upravljaju resursima: Zdravstvene ustanove, lekari i drugi zdravstveni radnici imaju obavezu da upravljaju oskudnim resursima. Sama katastrofa, po definiciji, stvara oskudnost, pošto potražnja nadjačava potrebu. Cilj-očuvanje života zahteva da profesionalci prihvate i odgovornost da planiraju i koriste resurse mudro. Kako će se oskudnost u procesu katastrofe povećavati, upravljanje resursima će zahtevati i više teških odluka. Transparentnost: se odnosi na određivanje vrednosti i prioriteta. Javni angažman, javna rasprava, revizija politike zasnovane na dijalogu i činjenicama, kao i odgovornost za implementaciju dogovorenih planova u procesu pre katastrofe može biti ključni momenat za sam proces delovanja u katastrofi kao i nakon nje. Konačno, transparentnost se vidi i u tome da u procesu donošenja odluka budu angažovani svi: zdravstvene ustanove, političari, etičari, verski lideri, advokati i javno mnenje.

Doslednost: Lečenje sličnih grupa na sličan ili podjednak način je jedan od načina da se promoviše pravičnost. Trebalo bi izbeći da pacijenti u različitim bolnicama, u istom ugroženom području dobiju veoma različite nivoe nege. Proporcionalnost-ovaj pojam se odnosi na događaje u društvu koji prate katastrofu npr, selidbe, evakuacija, zatvaranja škola, odnosno karantin. Ova opterećenja treba da budu u srazmeri sa razmerama katastrofe. Odgovornost: Odnosi sa na to da svaki član u procesu zbrinjavanja poznaje svoj nivo odgovornosti i da postupa u skladu sa njom. Odgovornost spasioca u vremenu katastrofe mora biti procenjena u periodu pre katastrofe. Medicinski profesionalci moraju od zajednice dobiti jasni okvir, koje su njihove odgovornosti i obim delovanja i biti pripremljeni kroz odgovarajući trening. Ako takvih smernica nema, ne može se ni očekivati njihovo jasno i odgovorno delovanje.

Zaključak: Etički okviri dozvoljavaju lekarima da na pravi način i bez dilema koriste ograničene resurse kako bi se obezbedila potrebna i dostupna terapija za pacijente koji će najvjerovatnije imati koristi. Takođe, ne dozvoljava lekarima da jednostavno ignorišu profesionalne norme i akta bez etičkih standarda i odgovornosti.

Ključne reči: etički okvir, katastrofa, hitna pomoć

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AGRESIVAN PACIJENT – PRIKAZ SLUČAJA

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Uvod: Kada je osoba potencijalno opasna po sebe i/ili po okolinu na lekaru HMP ostaje procena da se pacijent prinudno hospitalizuje. Ova situacija je povezana sa nedozvoljenim ograničavanjem slobode pacijenta i pravnim posledicama koje mogu iz toga da proisteknu a tiču se članova tima koji obavlja ovakvu intervenciju kako medicinskog tima tako i ekipe MUP-a. Saradnja i komunikacija ekipe HMP i ekipe MUP-a je od presudnog značaja za uspeh ovakve intervencije. Fizičko savladavanja agitiranih/agresivnih pacijenata može da dovede do njihovog povređivanja što može da ima i ozbiljne pravne konsekvence.
Cilj: Prikazati slučaj zbrinjavanja i prisilne hospitalizacije agresivne osobe
Prikaz slučaja: Ekipa HMP, je primila poziv drugog reda hitnosti zbog alkoholisane osobe koja je presekla vene, i preti da će skočiti s osmog sprata. Ekipa MUP koja je pozvana za asistenciju medicinskoj ekipi stiže u isto vreme na datu adresu i zajedno ulaze u stan. U stanu zatičemo muškarca M.P. starog 38 god, koji je na proslavi svog rođendana popio veću količinu alkohola, posvađao se sa svojm devojkom i pokušao da se ubije. Pacijent je krupne osteo muskularne gradje, dobro razvijen, alkoholisan vidno, na podlakticama se uočavaju velike povrede nastale oštiim predmetom i koje krvare. Sekotine su veličine 8-10cm, ravnih ivica i polaze od ručja. Pacijent pokušava da dođe do terase ali ga ostale tri osobe zadržavaju pri čemu ih on otimajući se udara nekontrolisano. Na licu njegove devojke vide se povrede. Svi su veoma uznemireni. Dva policajca staju između pacijenta i vrata terase i pokušavaju da započnu razgovor i da ga smire. On više da će da ubije prvo svoju devojku a onda sebe i da to ne može niko da spreči. Postaje agresivan prema lekaru kao i prema policiji. Lekar donosi odluku da se pacijent prislino hospitalizuje jer pokazuje izuzetnu agresivnost prema sebi i drugima. Tri policajca pokušavaju da ga obuzdaju, on postaje još agresivniji i počinje da udara sve oko sebe. Stavljanje prinudnih sredstava (lisica) na povredjene ruke se odlaže (kako ne bi došlo do daljeg povređivanja) sve dok on nije pokušao da otme oružje od policajca. U tom trenutku stiže i interventna jedinica koja je u međuvremenu pozvana i donosi se odluka o stavljanju lisica. Pacijent se uz veliko opiranje (6 policajaca) izvodi u hodnik zgrade, gde on pokušava da se otrgne i skoči preko ograde. Pacijent se obara na pod i lekar donosi odluku da mu da Amp Dormicum 15 mg IM (procenjena težina je bila više od 100kg., dakle 0,15mg/kg). U roku od 2min., pacijent se smiruje, počinje da sarađuje, ulazi voljno u lift, zatim u ambulantna kola. Pacijent u pratnji policije predat UC sa Dg: Vulnus scissum region antebrachii bill, Tentamen Suicidi, Aethylismus.
Diskusija: Midazolam u ovim situacijama sme primeniti lekar s iskustvom, uz adekvatnu opremu u slučaju potrebe za održavanjem i potporom kardiopulmonalne funkcije. Ozbiljne kardio respiratorne nuspojave mogu nastati uz izolovanu upotrebu midazolama, i to: respiratorna depresija, apnea, respiratorni arest i/ili srčani arest. Alkohol izrazito povećava sedativno delovanje midazolama i ovakva odluka je donešena uz potpunu spremnost da se pacijent intubira u slučaju respiratorne depresije ili respiratornog aresta
Epilog: Na klinici za hirurgiju pacijent je potpisao da ne dozvoljava da bude hirurški obrađen. Posle detoksikacije otpušten kući. Član medicinske ekipe je sutradan video pacijenta kako sa svojm devojkom sedi u kafiću, u dobrom raspoloženju.

Ključne reči: sedacija agresivne i alkoholisane osobe

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SAŽECI: MEDICINSKE SESTRE I ZDRAVSTVENI TEHNIČARI

Broj apstrakta: 001

PSVT KOD MLAĐE POPULACIJE-PRIKAZ SLUČAJA

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Uvod: PSVT (paroksizmalna supraventrikularna tahikardia) spada u pretkomorske aritmije i podrazumeva iznenadnu pojavu ubrzanja srčanog ritma. Najčešće nastaje zbog postojanja dva funkcionalna puta u AV čvoru, u kome dolazi do kružnog kretanja električnog impulsa. Napad PSVT nastaje naglo u vidu lupanja srca, može trajati nekoliko minuta, ili više sati pa i dana. Kada se javi kod osoba bez oštećenja srca, osim osećaja lupanja srca obično nema značajnih simptoma. Kod pacijenata sa strukturnim oštećenjem srca (miokarditis, koronarna bolest, arterijska hipertenzija, urođene i stečene srčane mane), duže trajanje napada može uzrokovati pogoršanje srčane funkcije i miokardnu ishemiju. PSVT se lako otkriva na ekg-u, promena srčane frekvence je uvek prisutna i jasna. SF je od 140-250/min, na EKG-u postoje karakteristične promene, (negativni retrogradni p talasi u odvodima D2, D3, AVF, ili se p talasi ne raspoznaju. Simptomi koji prate poremećaj srčanog ritma su brojni u zavisnosti od starosti i hemodinamskog stanja: palpitacije, otežano disanje, anginozni bolovi, malaksalost, zujanje u ušima, mučnina. Konvertovanje PSVT kod mlađih osoba sprovodi se nadražajem vagusa (nadražaj na povraćanje), Valsavin manevar (masaža sinusa karotikusa). Ako nema efekta, lek izbora je Verapamil. Takođe se napad može zaustaviti primenom beta-blokera i drugim antiaritmicima (amiodaron). Uporne i česte PSVT, koje remete kvalitet zivota pacijenta leče se radikalno, ablacijom u bolničkim uslovima.
Cilj rada je da se prikaže uloga hitne medicinske pomoci u zbrinjavanju napada PSVT, gde poremećaj ritme kod pacijenta biva konvertovan u vanbolničkim uslovima.
Materijal i metode: Retrospektivna analiza dostupne dokumetnacije Zavoda za hitnu medicinsku pomoć Niš
PRIKAZ SLUČAJA: Dana 02.02.2016.god. oko 14h, pacijentkinja A.I. starosti 16 godina dolazi u pedijatrijsku ambulantu ZHMP u pratnji majke, zbog jakog lupanja srca, vidno bleda, uplašena, malaksala. Navodi da se napad ne javlja prvi put, da se u poslednjih godinu dana javljao 7-8 puta i da je na kontinuiranoj terapiji propranololom. Pregledom pedijatra biva ustanovljeno da je pacijentkinja hipotenzivna (TA-90/60mmHg), tahikardična(SF-220/min), RF-19/min, SPO2-99%. Nakon urađenog EKG-a (normalne osovine, p talas se ne vidi, uzani QRS, bez znakova ishemije), stavljena je na opservaciju i monitoriranje. Otvorena je jedna i.v.linija, uključen rastvor NaCl 0,9% 500ml. Pokušana je stimulacija vagusa nadražajem na povraćanje i Valsava manevar. Time se pravi prvi pokušaj za konvertovanje u normalni ritam. Kako nakon 7-8min Valsava manevar ne daje efekat, odlučujemo se na amp. Verapamila, frakcionirano. Posle date polovine ampule, srčana frekvenca počinje da pada, što registrujemo na monitoru i EKG zapisu. Nastavljamo sa davanjem Verapamila, i nakon cele ampule SF pada na 140/min. U istoj minuti devojčica ulazi u sinusni ritam. Ponavljamo ekg zapis: sinusni ritam, SF-90/min, bez znakova ishemije, RF-15/min, TA-110/70mmHg. Dijagnoza: I47, PSVT.
Zaključak: Konkretno kod naše pacijentkinje je ustanovljeno da je na kontinuiranoj terapiji propranololom, ali da je neredovno uzima, što je potvrdila kritičnog dana, te dolazimo do zaključka da se zbog toga učestalije javljaju napadi PSVT. U ovom slučaju efikasnost u konvertovanju frekvence na opserviranju pacijentkinje dao je Verapamil. Međutim, ovakvi napadi su nepredvidivi i definitivno utiču i remete kvalitet života mladih. Većinu ovakvih napada ZHMP rešava u opservacionoj ambulanti, tako da se pacijent ne mora hospitalizovati i vraća se istog dana normalnim životnim aktivnostima.

Ključne reči: PSVT, konvertovanje, sinusni ritam.

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Broj apstrakta: 002

KAD SI NA PRAVOM MESTU, U PRAVO VREME I ZNAŠ ŠTA RADIŠ !

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Uvod: Povrede grudnog koša odgovorne su za oko 20–25% smrti zbog traume i učestvuju u 25–50% slučajeva ostalih smrtnih ishoda. Zbrinjavanje povređenih je dinamičan proces koji podrazumeva utvrđivanje i procenu težine povrede i preduzimanje, u prvom redu, odgovarajućih terapijskih i proceduralnih mera da bi se stvorili uslovi za primenu i ostalih vidova lečenja.
Cilj: Prikazati slučaj zbrinjavanja traumatizovane osobe koja je zbog okolnosti u kojima se nesreća desila bila na najadekvatniji način zbrinuta u prva 5 minuta od trenutka povređivanja.
Prikaz slučaja: Ekipa HMP, na početku smene i provere opreme polazi u podstanicu kako bi započela svoj redovan rad. Na raskrsnici, čekajući da se otvori semafor, biva svedok saobraćajnog udesa gde autobus pokušavajući da skrene obara vozača motocikla. Reakcija ekipe HMP je bila istovremena, lekar i sestra uzimaju zaštitna sredstva i istrčavaju iz automobila, dok vozač ostaje da prijavi centrali dogadjaj. Zatičemo pacijenta udaljenog od autobusa otprilike 3m, a motor na otprilike 5m. Pacijent se nalazi na desnom boku, bez svesti, čujnog ali otežanog disanja sa vidljivim krvarenjem u predelu lica. Pri prvom kontaktu s pacijentom, svi članovi započinju određene postupke u skladu sa svojom odgovornošću. Lekar preuzima kontrolu vratne kičme i istovremeno vrši procenu brzine respiratorne frekvence, da li postoji potreba za aspiracijom sadržaja usne duplje. Prilikom podizanja donje vilice lekar uočava da postoji višestruka fraktura mandibule kao i veći broj posekotina po licu, ali i po vratu, koje obilno krvare. Medicinska sestra tamponira rane na vratu i postavlja 2 IV puta, a od postavljanja Šancove kragne se odustaje zbg nemogućnosti kontrole krvarenja. Vozač je već doneo ferno i streč nosila i pripremio ih za transport. U tom trenutku ekipi HMP prilazi osoba koja se predstavlja kao anesteziolog i nudi pomoć. S obzirom da je lekar poznavao kolegu, prepusta mu kontrolu vratnog dela kičme da bi mogao da uradi kompletan inicijalni trauma pregled, po sistemu ABCDE. Na koraku B –Breathing primećuje da postoji deformitet desne strane grudnog koše, smanjena pokretljivost, i oslabljen disajni šum. Ostali parametri su u redu. Pacijent se na ferno nosila postavlja uz pomeranje kičmenog stuba u jednoj liniji. U kolima se radi sekundarni pregled, provera vitalnih parametara i započinje nadoknada tečnosti uz analgetik. U toku transporta dolazi do povratka svesti, pacijent daje podatke o sebi, ne seća se dogadjaja i delimično je konfuzan u odgovorima.
Zaključak: Bez obzira na težinu povreda grudnog koša većini povređenih može se pomoći ako se povrede prepoznaju na vreme i ako se, pre svega, timskim radom obezbedi brzo prepoznavanje povreda opasnih po život i pruži odgovarajuć medicinski tretman.
Ključne reči: prehospitalni tretman povređenih osoba

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Broj apstrakta: 003

PREHOSPITALNI PRISTUP KOD INTOKSIKACJIE RAZLIČITIM VRSTAMA OPOJNIH SUPSTANCI

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Problem bolesti zavisnosti i poremećaja ponašanja uzrokovanih psihoaktivnim supstancama(PAS) u našoj zemlji poslednjih godina dobija razmere epidemije.
Broj novih slučajeva, je na žalost u stalnom porastu a sva istraživanja ukazuju da se uzrasna granica pomera ka sve mlađem uzrastu, pa se pominje uzrasna dob od 11-godina kada se po prvi put dolazi u kontakt sa psihoaktivnom supstancom.
Prema istraživanju Ujedinjenih nacija iz 1990. god, u svetu je oko180 miliona ljudi koristilo drogu, od toga oko 4 miliona dece starosti od 13-15 godina.
Psihoaktivne supstance svrstavaju se u tri velike grupe, zavisno od njihovog dejstva na mozak i nervni sistem:

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- Depresori - alkohol, sedativi i opijati deluju na mozak tako da dovode do pospanosti, globalnog usporavanja psihomotornih aktivnosti, opuštenosti, osećaja smirenosti, a takođe i snižavaju aktivnosti vitalnih centara za rad srca i disanja.
- Stimulansi - kokain, krek, amfetamini, ekstazi, kanabis, deluju stimulativno na psihomotornu aktivnost, daju osećaj povećane snage, sreće, samopouzdanja, osećaj gubitka zamora, odsustva straha, ubrzavaju rad srca, podižu krvni pritisak.
- Halucinogeni - LSD, meskalin, pejotl i različiti sintetski proizvodi, dovode do stanja izmenjenog opažanja sa pojavom halucinacija, promenjenog osećaja za vreme, prostor, kao i promenjenog doživljaja sebe i okoline.

Postoje četiri patološka oblika uzimanja droge:
1. akutna intoksikacija psihoaktivnim supstancama (PAS)
2.problemsko (rizično) uzimanje PAS - narkofilija
3. štetna upotreba PAS (abusus) i
4. sindrom zavisnosti kao kontinuirana ili epizodična upotreba PAS (dipsomanija)

Akutna intoksikacija je prolazno stanje koje se javlja po unošenju psihoaktivnih supstanci, kada dolazi do promena psihičkog funkcionisanja, sa promenama stanja svesti (najčešće se vidja pojačana budnost ili pospanost-zavisno od toga koja je droga u pitanju), izmenjenim misaonim tokom, ponekad pojavom halucinacija. Takođe se menja i raspoloženje, može doći do euforije, ali i straha ili napada panike, kod marihuane na primer. Ponašanje se takođe menja od hiperaktivnog i ubrzanog, sa mnoštvom pokreta i prenaglašenim ispoljavanjem emocija do usporenog, letargičnog, gde osoba deluje pospano i odsutno. Trajanje ovih promena je različito i zavisi od vrste unete supstance (na primer, akutna intoksikacija heroinom traje do 8č, a kod marihuane 3-5č). U slučaju da se uzme prekomerna doza supstance koja može da dovede i do smrtnog ishoda govori se o predoziranju (engl. overdose).

U većini slučajeva trovanja, uzročni agens je poznat i jedini problem za ekipu HMP je da odredi da li je stepen trovanja takav da zahteva više od prve pomoći ili inicijalnog hitnog zbrinjavanja. Međutim, ponekad anamneza nije pouzdana. Tačna količina otrova (u ovom slučaju psihoaktivne supstance) koju je pacijent uzeo/apsorbovao verovatno će biti nepoznata, ali ekipa HMP treba da bude u stanju da proceni kolika je najveća količina koju je pacijent mogao uzeti/apsorbovati. Poznate minimalne smrtne doze mogu biti korisni pokazatelji relativne opasnosti u kojoj se pacijent nalazi. Opseg smrtne doze može biti i veliki. Ako se za procenjenu količinu uzetog otrova/PAS proceni da bi mogla dovesti i do smrtnog ishoda, odmah se mora početi sa energičnim merama lečenja.

Ključne reči: Intoksikacija, prehospitalni pristup, hitna pomoć

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TRIJAŽA U DISPEČERSKOM CENTRU SLUŽBE HITNE MEDICINSKE POMOĆI

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Uvod: Reč dispečer dolazi iz engleskog jezika i prvenstveno označava osobu koja raspoređuje, obrađuje, prenosi. Već sam naziv, medicinska dispečerska služba, pruža nam obrazloženje o toj službi. Medicinska dispečerska služba je posebna služba unutar zdravstvenog sastava, koja može delovati u sklopu određenih zdravstvenih zavoda ili u sklopu hitnih medicinskih službi.

Cilj rada: Glavna uloga medicinske dispečerske službe je preuzimanje poziva o iznenadnom događaju, koji zahteva intervenciju medicinskih službi na terenu, određivanje prioriteta nakon dobijanja poziva i aktiviranje odgovarajućih medicinskih timova, u odnosu na prirodu i lokaciju događaja.

Materijal i metode: Analiza i uvid u stručnu literaturu.

Diskusija: Stanje u organizaciji dispečerskih centara na nivou Republike Srbije je raznoliko. Jedinstveni broj za pozivanje je 194 ali su u manjim centrima u opticaju i drugi brojevi. Zbog nedostatka protokola, najveći broj službi hitne medicinske pomoći se oslanja na iskustvo primaoca poziva i koristi interno prihvaćene setove pitanja. Manji broj ustanova koristi postojeće formalne protokole za trijažu na prijemu poziva. Od nedavno u

ZHMP Niš, medicinske sestre sa srednjom i visokom stručnom spremom rade na prijemu poziva. U ZHMP Niš ne postoji zvanični protokol za trijažu na prijemu poziva ali koristimo interno prihvaćene setove pitanja, gde je naglašeno da samo lekar može odbiti poziv.
Zaključak: Većina službi hitne medicinske pomoći danas je obavezna težiti dostizanju standarda što kraćeg vremena odaziva na urgentne pozive. Radi pravilnog prepoznavanja stepena hitnosti i pravovremene aktivacije medicinske terenske ekipe za urgentne pozive, neophodno je izraditi jasne trijažne protokole koji bi to omogućili.
Ključne reči: 194, trijaža, dispečer

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ODNOS ADOLESCENATA PREMA PSIHOAKTIVNIM SUPSTANCAMA

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05. 01. ove godine smo imali pacijenta sa površinskom povredom glave i u alkoholisanom stanju starog 15 godina. Svestan i agitiran pri pregledu pri opservaciji je stanje svijesti pogoršalo i upućen je u UC, eliminisana je povreda lobanje i IC krvarenje te je upućen u KCCG zbog trovanja alkoholom. To je bio povod da u njegovoj školi napravimo anketu o odnosu adolescenata prema bolestima zavisnosti i da vidimo u kom se uzrastu sreću sa ovim pojavama
Tokom ispitivanja koristili smo sledeću metodologiju: anketirali smo ukupno 147 đaka jedne srednje škole u Beranama uzrasta 15 i 16 godina. 42 odgovora smo odbacili dok smo analizirali 105 odgovora od čega su 79(75,23%) učenici a 26(24,77%) učenice.
Rezultati: Cigarete je probalo 37(35,23%,) đaka od toga su 8(21,63%) učenice i 29(78,37%) učenici. Aktivno puši 7(18,91%), 1(14,38%) učenica i 6(82,35%) učenika, povremeno puši 6(16,21%), 2(33,33%) učenice i 4(82,75%) učenika. Prosječna starost pri prvom kontaktu sa cigaretama je 12,5 godina. Alkoholna pića je probalo 70(66,66%) đaka od toga 59(84,28%) učenika i 11(15,29%) učenica. Prosječna starost pri prvom kontaktu sa alkoholom je 13,6 godina, Od 70 đaka koji su probali alkohol često piju 4(3,8%) a povremeno 35(50%), 30(85,71%) učenika i %(14,29%) učenica. Drogu su probala 4 učenika (3,88%), trojica dječaka je konzumiralo samo marihuanu a jedan i hašiš, prosječna starost prim susretu sa drogom je 14,8 godina. 11 đaka je odgovorilo da ima saznanja da neko u njihovom društvu iz škole koristi narkotike (11,5%)
Zaključak i diskusija: Rezultati naše ankete pokazuju da su dječaci skloniji konzumiranju duvana i psihoaktivnih supstanci nego djevojčice. Veći broj djece adolescenata je probao alkohol 66,66% nego cigarete 35,23%. svedoci smo svakodnevne kampanje protiv cigareta, promet opojnih droga je zakonom zabranjen ali borba protiv alkoholizma je neznatna iako smo svjesni da alkohol ugrožava zdravlje i dovodi do poremećaja ponašanja i ličnosti. Smatramo da odgovorne institucije treba da ozbiljnije povedu kampanju protiv alkoholizma.
Ključne reči: psihoaktivne supstance, alkohol, cigarete, adolescent

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AKUTNI INFARKT MIOKARDA U ROMA, KAO USMERITI PREVENCIJU?

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Zdravlje Roma je često siromašnije od većinskog stanovništva, te je ova nejednakost i dalje predmet brojnih istraživanja Većina radova se odnosi na antropometrijska i genetska istraživanja, zarazne bolesti ili reproduktivno zdravlje. Postoji malo objavljenih radova o karakteristikama nezaraznih bolesti, posebno ishemijske bolesti srca sa akcentom na akutni infakt miokarda. Romi često imaju slabiji pristup zdravstvenim

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ustanovama, i imaju posebne potrebe imajući u vidu uslove života, nivo obrazovanja i specifične sociološko etničke karakteristike.
Ispitivanjem su obuhvaćeni Romi lečeni zbog akutnog infarkta miokarda od 1. 01. do 31. 12. 2015 godine, analizirani su faktori rizika njihova ekstezivnost i kao i specifični faktori rizika, klinička slika u "Jungova varijabla " kao pokazatelj rizika mortaliteta izračunata pri prijemu bolesnika. Mere sekundarne prevencije su isplanirane i prilagodjene pacijentu individualnim pristupom
Na kontrolni pregledima mesec dana nakon hospitalizacije analizirana je siptomatologija, klinički status i faktori rizika , kao i komplikacije oboljenja

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GPS U SLUŽBI HMP

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Uvod: Global Positioning System - GPS je trenutno jedini poptuno funkcionalan globalni satelitski navigacioni sistem (енгл. Global Navigation Satellite System - GNSS). GPS je razvijen 1973god. od strane Ministarstva odbrane SAD pod imenom NAVSTAR GPS a sistem je proglašen potpuno operativnim 17. 07.1995. godine U početku je korišćen isključivo u vojne svrhe da bi kasnije bio besplatno stavljen na raspolaganje svima kao javno dobro. Godišnji troškovi održavanja sistema su oko 750 miliona američkih dolara.
Izvor podataka i izbor materijala. Retrospektivna analiza literature sa odrednicama: GPS, EMS, medical using of GPS. Pretraživanje je vršeno kroz: PubMed, Medline i elektronske časopise dostupne preko KoBSON-a kao i raspoložive literature
Rezultati sinteze. GPS sistem se sastoji od tri komponente (segmenta): svemirskog segmenta, kontrolnog segmenta na zemlji i korisničkog segmenta. Svemirski segment, koji se sastoji od bar 24 satelita je srce sistema. Sateliti su u tzv. "visokoj orbiti" na oko 20.000 kilometara iznad Zemljine površine. Rad na takvoj visini omogućuje da signali prekriju veće područje. Sateliti su tako složeni u orbite da GPS-prijemnik na Zemlji može uvek primati signale sa barem četiri od njih. Kontrolnu komponentu čine stanice za praćenje satelita, kontrolne stanice i zemljišne antene. Korisničku komponenu čine GPS prijemnici na Zemlji. Prijemnici mogu biti samostalni uređaji , ili komponente uključene u druge uređaje, kao npr mobilni telefon, časovnici, foto aparati nove generacije. U medicini a naročito u hitnoj medicinskoj pomoći GPS sistem ima veliku ulogu kada se kombinovanjem sa drugim informatičkim tehnologijama njegova uloga usložnjava i dobija na značaju. Osnovne funkcije GPS u HMP: Lokacija pacijenta; Uticaj na reakciono vreme; Pređena kilometraža; Vreme provedeno na putu; Unapređene funkcije sa “PAD” i sličnim sistemima.
GPS pomaže pri traženju ulica, naročito u nepoznatim, ruralnim predelima i značajno smanjuje broj pređenih kilometara, vreme provedeno na putu i u 72 % slučajeva se brže nađe zadati cilj u poređenju sa standardnom opremom. U hitnoj medicinskoj pomoći je dokazano da upotreba GPS-a u 94% slučajeva ispunjava osmominutni zadati interval za pozive prvog reda hitnosti. Na ovaj način GPS skraćuje reakciono vreme. Bez GPS željeni osmominutni interval se kreće između 34% i 62% .

Ključne reči: GPS, upotreba u HMP

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Broj apstrakta: 008

POZICIONIRANJE GLAVE PACIJENTA PRILIKOM ENDOTRAHEALNE INTUBACIJE

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Uvod: osnovni cilj pozicioniranja glave prilikom intubacije je da se postigne prava linija od sekutića do laringsa. Ovaj put ima tri osovine (oralnu, pharyngealnu, larygealnu).Postizanje adekvatne pozicije postize se pomeranjem pacijentove glave i vrata, sto se u uslovima u operacionoj sali postize podizanjem glave za 10 cm ispod glave, dok ramena ostaju na stolu. Ova pozicija poravnava faringealnu i laringealnu osu. To je tzv"sniffing position."- pozicija njuškanja. Ova pozicija podrazumeva da je ušna školjka u nivou prednje linije ramena.
Izvor podataka i izbor materijala: Retrospektivna analiza literature sa odrednicama: pozicioniranje, endotrahealna intubacija. Pretraživanje je vršeno kroz: PubMed, Medline i elektronske časopise dostupne preko KoBSON-a kao i raspoložive literature.
Rezultati sinteze: Jednom postavljena glava u optimalnu poziciju, dodatnim pomeranjem i zabacivanjem glave sve osovine se dovode u jednu liniju. U operacionoj sali uvek možete da imate dodatni par ruku za poziciju, ta situacija gotovo nikad nije na terenu.Više pokušaja mogu da uznemire doktora koji pokušava da izvede procedure te se lako izgubi pravi osećaj za položaj glave pacijenta. Često se pravi poluga laringoskopom i postoji mogućnost povrede mekih tkiva kao i zuba.Postavljanjem presavijenih peškira, čaršava ispod pacijentove glave može se postići povoljna pozicija uz lako zabacivanje glave. Ovaj materijal često može biti nedostupan, ali se može koristiti bilo šta što se nađe u okolini.
Naslon za glavu, u obliku đevreka sa rupom u sredini u koju se postavlja glava nekada se dosta koristila ali može da prevari da je glava u dobroj poziciji, takođe onemogućava zabacivanje glave Ako nameravate da koristite ovakvu pomoć treba da se proveri da li je ušni kanal u nivou sa grudnim zarezom.
Asistentova ruka takođe može biti od pomoći i odmah je dostupna.
Ako je pacijent gojazan, širina grudnog koša i dojke mogu ometati laringoskopiju i vizuelizaciju. Formiranje rampe postavljanjem savijenog platna pod ramena, sa ciljem usklađivanja ušnog kanala sa grudnom kosti, često poboljšava sposobnost da se otvore usta i vidi larings
Zaključak: Pozicioniranje glave prilikom postavljanja endotrahealnog tubusa je jedan od načina da se olakša i omogući intubacija. Često taj zadatak pripadne najbližem lekarovom saradniku – med.sestri/tehičaru i njegova uloga je od veoma velike važnosti.
Ključne reči: pozicioniranje, endotrahealna intubacija

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KOMPLIKACIJE VARIČELE KOD DECE

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Uvod: Varičele se kod nevakcinisane populacije javlja najčešče kod dece uzrasta 1-6 god. Osobe starije od 14 god. čine 10% od svih slučajeva. O Varičeli (ovčije boginje) se obično misli kao o blagoj virusnoj bolesti od koje se deca oporave lako i bez velikih komplikacija Međutim, varičela nije potpuno benigna ni danas. Stopa letaliteta u opštoj populaciji je 6.7 slučajeva na 100.000 stanovnika. Značajan broj slučajeva su povezani sa komplikacijama a među najozbiljnije su pneumonija i encefalitis.
Izvor podataka i izbor materijala: Retrospektivna analiza literature sa odrednicama: varicella, komplikacije, posledice. Faktori rizika. Pretraživanje je vršeno kroz: PubMed, Medline i elektronske časopise dostupne preko KoBSON-a kao i raspoložive literature.
Rezultati sinteze: Varičela-zoster pripada grupi DNK virusa, podgrupa Alphaherpesvirusa. Ulazi kroz konjuktive i gornju respiratornu sluzokožu. Inkubacije je 10-21 dana. Virusna replikacija odvija u

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regionalnim limfnim čvorovima u narednih 2-4 dana, a 4-6 dana kasnije, virus se širi i na retikuloendotelne ćelije. Pacijent je zarazan 1-2 dana pre pojave osipa do formiranja krusti. Infekcija centralnog nervnog sistema takođe se dešava u ovom trenutku. Pojedina deca su u većem riziku od mogućnosti razvoja teške bolesti sa komplikacijama, pa i letalnim završetkom. Deca sa povećanim rizikom su: 1: U prvom mesecu života, naročito ako je majka seronegativna; 2:Terapija velikim dozama kortikosteroida (1-2mg/kg/d prednizolon) u toku prethodne 2 nedelje. I kratkotrajna terapija u ovim dozama neposredno pre ili tokom perioda inkubacije može izazvati ozbiljne ili fatalne boginje; 3:Malignitet: Sva deca sa malignitetom a posebno sa leukemijom. Skoro 30% pacijenata koji su imunokompromitovani i koji imaju leukemiju imaju težak oblik varičele a 7% umire. 4:Bolesti Imunog sistema (HIV-a, urođena ili stečene imunodeficijentne bolesti). Podaci govore da 1:50 dece ima komplikacije. Najčešće su pneumonija i encephalitis i oba povezana sa visokom stopom smrtnosti. Virusna pneumonija je jedna od najozbiljnijih komplikacija je, koje se češće javlja kod starije dece. Respiratorni simptomi se pojavljuju 3-4 dana nakon osipa. Simptomi sekundarnih bakterijskih infekcija mogu se prepoznati već u prvih 3-4 dana. Kožne lezija obezbeđuju vrata za ulazak bakterija; brzo se širi celulit, sepsa. Prouzrokovači su najčešće streptokoke grupe A i Staphilococcus aureus. Pored sindroma toksičnog šoka, streptokoke mogu izazvati nekrotizirajući fasciitis, osteomijelitis, piomiozitis, gangrenu, subgaleal apsces, artritis, i meningitis. Najčešća neurološka komplikacija, sa incidencom od 1 slučaja po 4000 pacijenata, je Akutna postinfektivna cerebelarna ataksija koja ima iznenadni početak, javlja se 2-3 nedelje nakon početka boginja. Manifestacije može da varira od blage nestabilnosti do nesposobnosti da stoje i hodaju, sa pratećim nekoordinacijom i dizartrijom, tegobe su najjače na početku i postepenim oporavkom. Sensorijum je očuvan, čak i kada je ataksija je duboka. Može trajati i 2 meseca. Prognoza za pacijente sa ataksijom je dobra, ali neka deca mogu imati zaostalu ataksiju. Encefalitis javlja u 1.7 pacijenata na 100.000 slučajeva, kod inače zdrave dece uzrasta 1-14 godina. Bolest se manifestuje tokom akutne faze boginja nekoliko dana nakon pojave ospe. Letargija, pospanost, i zbunjenost i konvulzivne napadi, i mogu brzo napredovati ka dubokoj komi. Ova ozbiljna komplikacija ima stopu smrtnosti za 5-20%. Druge neurološke komplikacije uključuju aseptičnu meningitis, mijelitis (Sy Guillain-Bare), poliradiculitis i meningoencefalitis. Oko 5% dece razviju otitis media, izazvane uobičajnim patogenima. Teški hepatitis sa kliničkim manifestacijama je redak u inače zdrave dece i razvoj je nezavisan od težine promena na koži i sistemskih manifestacija. Neprepoznavanje okultnih infekcija i komplikaija može dovesti do ozbiljnih bolesti pa čak i smrti.

Ključne reči: varicella, komplikacije.

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