ANNUAL SCIENTIFIC MEETING

‘MASTERING THE ART OF CHALLENGING DIAGNOSES, MINIMIZING MISSES’

9th - 12th NOVEMBER 2017

Universiti Teknologi MARA
Sungai Buloh Campus
Selangor

SOUVENIR PROGRAMME & ABSTRACT BOOK
Welcome Message 2 - 3
Organising Committee 4
Pre-Congress Workshops 5
Opening Ceremony on 11th November 2017 (Saturday) 6
Housemen Teaching: Intro to Acute Care and Housemanship Survival 7 - 8
Daily Programme
  • 11th November 2017 (Saturday) 9 - 11
  • 12th November 2017 (Sunday) 12 - 13
Floor Plan & Trade Exhibition 14
Abstracts
  • Speakers 15 - 18
  • Oral Presentations 19 - 24
  • Poster Presentations 25 - 41
A very warm welcome to all to our Annual Scientific Meeting with the theme ‘Mastering the Art of Challenging Diagnoses, Minimizing Misses. As doctors, our main responsibility is making the correct diagnosis. As internal medicine specialists or physicians this responsibility is further enhanced in hospital medicine - basically we are ‘the diagnosticians’. The ensuing management is usually standard. On the other hand, wrong or delayed or missed diagnosis leads to morbidity and mortality. Hence, we should get it right, the first time. The first physician seeing the patient should ensure that happens; avoiding unnecessary multiple referrals before a diagnosis is made. Thus, in the process of diagnosing we should - ‘Do It Once and Do It Well’.

In keeping with the theme, you would notice that many of the sessions in the conference are symptom or problem based. There is even one dealing with the significance of AVR elevation! Attend all sessions and clear your doubts. Make it interactive.

Not forgetting our future, we have a separate but nevertheless a very good session tailor made for house officers. For the pre-congress sessions, we have MRCP PACES Tutorial & Mock Exams and echocardiography course - for beginners & another transoesophageal echocardiography for those who wish to advance. As we wish to support innovations in health care systems and research in medical sciences that makes a difference to patients, we are introducing an ‘Innovation Award’. For young physicians, there is indeed a plenary for future career pathway.

Last year our meeting was in a hotel. This year, considering the economic situation but nevertheless wishing to keep to our tradition of bringing high quality CME to as many as possible (without taxing the pharma industry too much - as that would indirectly affect drug cost), we are having it in a university campus with very good facilities. The College is very grateful to UiTM and its lecturers for joining forces with us to make this meeting a reality. We continue to receive support from MOHE for which we are always thankful.

The College of Physicians as being a part of Academy of Medicine, Malaysia is very much committed to maintenance of high standards of specialist care to our patients in our beloved country. We are, together with other stakeholders, involved in the curriculum development, criteria for specialist recognition, nomination to NSR, training of new specialists and providing relevant CME. We would like to urge all physicians whether generalists or subspecialists in MOH or in universities or in the private practise to join us to have your voice heard in the above issues.

To all conference participants, please give us your constructive feedback to make this annual scientific meeting - your first choice.

**Dr G R Letchuman Ramanathan**  
President  
College of Physicians, Academy of Medicine of Malaysia
On behalf of the organizing team, it gives me great pleasure to welcome each and everyone of you to the Annual Scientific Meeting of the College of Physicians, Academy of Medicine of Malaysia. The theme for this year’s meeting is ‘Mastering the Art of Challenging Diagnoses, Minimizing Misses’.

Medicine is not only a science; it is also an art. It does not consist of compounding pills and plasters; it deals with the very processes of life, which must be understood before they may be guided (Paracelcus).

Aspiring future doctors and specialists in Malaysia require a tactful approach. Standard of care is paramount and innovation is the key to advancement in this sacred field. Technological advancement may sometimes lead to complacency and over reliance. As Medicine is not simply just science, one would also need to be equipped with necessary knowledge in mastering the art of challenging diagnoses, whilst minimizing misses.

The programme outline for this year’s meeting has been tailored to cater these needs. We have a concurrent session on Saturday for the housemen, introducing them into acute care and survival skills during the challenging houseman years. We hope this will spur their interest further to explore more during the course of their medical careers.

The scientific team, led by Associate Professor Dr Sazzli Kassim, has come up with interesting line up of topics involving prominent speakers in the country. I am sure that you will gain valuable knowledge and benefits from attending this important meeting.

At this juncture, I would like to express my gratitude to the council members of College of Physicians, led by the President, Dr G R Letchuman, for placing the trust in my team to organize this important event. To all members of Organizing and Scientific Committees and team from Faculty of Medicine, Universiti Teknologi MARA, millions of thanks for your cooperation in making this event a success.

I hope you will have a fruitful meeting and bring home valuable knowledge and skills to improve patient care in your day-to-day practice.

Dr Ahmad Izuanuddin Ismail
Organising Chairman
PPUiTM
Organising Chairmen
Professor Dr Hj Mohd Shahrir *(PPUKM)*
Dr Ahmad Izuanuddin Ismail *(PPUitm)*

Scientific Committee
Associate Professor Dr Sazzli Shahlan Kassim *(Chairman)*
  Dr Rosnida Mohd Noh
  Dr Muhammad Yazli Yuhana
  Dr Diana Katiman
  Dr Nurhidayati Muhd Sharif

Echo Course
Dr Effarezan Abdul Rahman
Dr Khairul Shafiq Ibrahim

BLS Course
Dr Abdul Halim Sanib
Dr Izzat Ismail

PACES Course
Dr Nicholas Chua Yul Chye
Dr Shafira Mohamad Sha

Housemen Teaching
Dr Julina Md Noor
Dr Muhammad Iqbal Abdul Hafidz
Dr Rizmy Najme Khir
PRE-Congress Workshops

9th November 2017 (Thursday)
Pre-Congress Workshop 1
Echo Course for Beginners
Venue: UiTM Sungai Buloh

Pre-Congress Workshop 2
MRCP MasterPACES Mock Tutorial and Exams
Venue: UiTM Selayang

10th November 2017 (Friday)
Pre-Congress Workshop 3
Transoesophageal (TOE) Echo Course
Venue: UiTM Sungai Buloh
OPENING CEREMONY PROGRAMME

11th November 2017 (Saturday)
Venue: Dewan Kuliah 1

0945 - 1115 Opening Ceremony

0945 Arrivial Guests

0950 Arrivial of VIP

0955 Arrivial of Yang Berhormat Datuk Dr Noor Hisham bin Abdullah, Director-General of Health Malaysia

1000 National Athem

1005 Welcome speech by Organising Chairman
   Dr Ahmad Izuanuddin Ismail

1010 Speech by the President of the College of Physicians, Academy of Medicine of Malaysia
   Dr Letchuman Ramanathan

1015 Speech by Director-General of Health Malaysia
   Yang Berhormat Datuk Dr Noor Hisham bin Abdullah

1025 Launching “Mastering the Art of Challenging Diagnosis, Minimizing Misses” Annual Scientific Meeting 2017

1040 Lifetime Achievement Award to Tan Sri Dato’ Dr Abu Bakar bin Suleiman

1115 Press Conference
11th November 2017 (Saturday)

0730 - 0800  REGISTRATION

0810 - 0830  Welcome Note  
Dr Muhammad Iqbal Abdul Hafidz

Session 1

0830 - 0850  Who is the Critically Ill Patient?  
Dr Juita Bt Hassan

0850 - 0910  Between High Flow Mask and Intubation  
Dr Zawiah Kassim

0910 - 0930  Cardiac Biomarkers: Interpretation and Utilization  
Dr Rizmy Najme Khir

0930 - 0950  Ultrasound in Shock  
Dr Julina Md Noor

0950 - 1100  Opening Ceremony  
Auditorium 1

1100 - 1115  BREAK

1115 - 1235  Session 2  
Clinical Skills Lab
Technology in CPR
• Lucas
• Autopulse  
Dr Izzat Ismail

Difficult X-Ray Interpretation  
Dr Mohammad Hanafiah Kreah

Advance Airway Management  
Dr Mohd Amin Mohd Mokhtar

Basic Non-Invasive and Invasive Ventilation  
Associate Professor Dr Vineya Rai
11th November 2017 (Saturday)

Session 3

1400 - 1420  What to Expect During Housemanship
Professor Dr Hj Shahrir Mohamed Said

1420 - 1505  Forum: Approach to:
• Medicine
  Professor Dr Hj Shahrir Mohamed Said
• Paediatrics
  Dr Anis Siham Zainal Abidin
• A&E Postings
  Dr Julina Mohd Noor

1505 - 1550  Forum: Approach to:
• Surgery
  Dr Zeti Rahayu Abd Karim
• Orthopaedics
  Dr Mohd Reza Mohd Aridz
• Obstetrics and Gynaecology
  Dr Bahiyah Abdullah

1550 - 1610  BREAK

1610 - 1640  Save Your $ Now Before the Summons Arrive: A Brief Overview
Dr Letchuman Ramanathan

1650 - 1720  After Houseman: What’s Next?
Professor Dato’ Dr Adeeba Kamarulzaman

1720 - 1735  Q & A Session
Dr Letchuman Ramanathan / Professor Dato’ Dr Adeeba Kamarulzaman

1735 - 1755  Close and Certificate Collection
11th November 2017 (Saturday)

0730 - 0800  REGISTRATION

GASTROENTEROLOGY
Auditorium 1
Chairperson: Dr Bahariah Khalid

0800 - 0820  A Practical Approach in the Assessment of NAFLD [PAGE 15]
Associate Professor Dr Chan Wah Kheong

0820 - 0840  When Liver Fails Out of the Blue
Dr Tan Soek Siam

0840 - 0900  Different Faces of IBD [PAGE 15]
Associate Professor Dr Raja Affendi Raja Ali

0900 - 0930  BREAK

0930 - 1000  Plenary 1
Rheumatology: New Challenges
Professor Dr Hj Mohd Shahrir Mohamed Said

1000 - 1100  Opening Ceremony

RESPIRATORY
Auditorium 1
Chairperson: Dr Mohd Ariff Bin Mohd Zim

1100 - 1120  Persistent Breathlessness in COPD, What the Interventionalist Sees and Does [PAGE 16]
Dr Jamalul Azizi Abdul Rahaman

1120 - 1140  TB or Not TB
Professor Dato’ Dr Abdul Razak Muttalif

1140 - 1200  The Patient with the Stiff Lung
Professor Dr Roslina Abdul Manap

1200 - 1230  Plenary 2
Dr Kalaiarasu M Peariasamy
### ANNUAL SCIENTIFIC MEETING

**11th November 2017 (Saturday)**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Location</th>
</tr>
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</table>
| 1230 - 1330 | SYMPOSIUM 1  
Heart Failure, Mortality and Hospital Readmissions - What Happens After ACEi / ARB?  
Professor Dato’ Dr Wan Azman Wan Ahmad | Auditorium 1       |
| 1230 - 1315 | SYMPOSIUM 2  
Dual Bronchodilators: Are They All the Same?  
Dr Manuel Hector U Silos | Auditorium 1       |
| 1315 - 1415 | LUNCH | | |
| 1415 - 1555 | ID / HAEMATOLOGY  
Chairperson: Dr Goh Kim Yen  
Febrile Neutropenia  
Dr Mohd Haris Fadzillah B Abd Rahman  
Acute Febrile Illness with Thrombocytopenia in Peninsular Malaysia  
Dr Muhamad Yazli Bin Yuhana  
The Patient with Fever and Headache  
Dr Alwi Bin Muhd Besari | Auditorium 1       |
| 1515 - 1615 | NEPHROLOGY  
Chairperson: Datuk Dr Paras Doshi  
Between The Heart & The Kidney  
Professor Dr Goh Bak Leong  
Demystifying RPGN  
Dr Rosnawati Yahya  
Proteinuria in Pregnancy [PAGE 16]  
Associate Professor Dr Lim Soo Kun  
Update Career Pathways  
Professor Dato’ Dr Adeeba Kamarulzaman | Auditorium 1       |
11th November 2017 (Saturday)

DERMATOLOGY / GERIATRICS /
PALLIATIVE MEDICINE
Chairperson: Dr Mohd Noh Idris

1635 - 1705  Systemic Contact Dermatitis  
Dr Tarita Bt Taib

1705 - 1725  “Doctor, How Long Does He Have?”  
Dr Richard Lim Boon Leong

1725 - 1745  Down Memory Lane [PAGE 17]  
Dr Tan Maw Pin

1745 - 1800  BREAK

END OF DAY 1
12th November 2017 (Sunday)

NEUROLOGY  
Chairperson: Dr Letchuman Ramanathan  

0830 - 0850  Seizures, It is Not Always Epilepsy [PAGE 17]  
Professor Dato’ Dr Raymond Azman Ali  

0850 - 0910  Shake It Off, Recognising and Treating Movement Disorders [PAGE 18]  
Dr Ooi Phaik Yee  

0910 - 0930  The Stroke and The Stroke Mimics  
Professor Dr Hj Hamidon Hj Basri  

0930 - 1000  BREAK

CARDIOLOGY  
Chairperson: Dr Sia Koon Ket  

1000 - 1020  AVR Elevation; STEMI or NSTEMI?  
Dr Asri Rangga bin Abdullah Ramaiah  

1020 - 1040  The Patient with Low BP; Is it Cardiogenic Shock? [PAGE 18]  
Professor Dato’ Dr Wan Azman Wan Ahmad  

1040 - 1100  Not All Breathless Patients Have Poor LV Function  
Associate Professor Dr Sazzli Shahlan Kassim

ENDOCRINOLOGY  
Chairperson: Col Dr Syed Edi Sazali Syed Haidzir  

1100 - 1120  Hyper & Hypocortisolism  
Dr Azraai Nasruddin  

1120 - 1140  Hypoglycaemia Syndromes, Challenges and Dilemma  
Associate Professor Dr Rohana Abdul Ghani  

1140 - 1200  Secrets in Endocrine Hypertension  
Professor Dr Norlela Sukor
12th November 2017 (Sunday)

1200 - 1230
PLENARY 4
Shaping the Future of Clinical Research in Malaysia
*Dr Akhmal Yusof*

1230 - 1330
LUNCH SYMPOSIUM 3
Salford Lung Study: Effectiveness of Relvar on Asthma Control in Everyday Clinical Practice
*Dr Manuel Hector U Silos*

1330 - 1400
CLOSING
ANNOUNCEMENT OF WINNERS
### Booth No. & Company

<table>
<thead>
<tr>
<th>Booth No</th>
<th>Company</th>
</tr>
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<tbody>
<tr>
<td>6</td>
<td>Inova Pharmaceuticals (S) Pte Ltd</td>
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<td>7</td>
<td>Clinical Research Malaysia (CRM)</td>
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<td>9 - 12</td>
<td>GlaxoSmithKline (GSK) Pharmaceutical Sdn Bhd</td>
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<td>14 &amp; 15</td>
<td>Novartis Corporation (M) Sdn Bhd</td>
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<td>16</td>
<td>Sanofi - Aventis Sdn Bhd</td>
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Non-alcoholic fatty liver disease (NAFLD) is characterized by the excessive accumulation of fat in the liver that is due to over-nutrition. It is closely associated with central obesity, insulin resistance, glucose intolerance, atherogenic dyslipidemia and arterial hypertension, and is considered the liver manifestation of the metabolic syndrome. Non-alcoholic steatohepatitis (NASH), the more severe form of NAFLD, can progress to fibrosis, cirrhosis and hepatocellular carcinoma. Patients with NASH, especially advanced fibrosis, are the ones at increased risk of liver-related mortality. Given the high prevalence of NAFLD, the relatively low but significant proportion of NASH patients, the marked difference in prognosis of the different histological types, and the evolving landscape of therapeutic options, it is important that NAFLD patients be carefully assessed for the severity of their liver disease so that appropriate management decisions can be made. An accurate diagnosis of NASH and advanced fibrosis can only be made by histopathological examination of a liver biopsy specimen, but the procedure is invasive and should not be applied to all NAFLD patients. Some currently available non-invasive methods can be easily used for the assessment of the severity of liver disease in NAFLD patients and can guide us in the management of these patients.

Inflammatory bowel disease (IBD) either ulcerative colitis (UC) or Crohn disease (CD) has become a global disease since the turn of the century, with incidence stabilizing in the Western countries, but increasing steadily in the Asia pacific region including Malaysia. The aetio-pathogenesis of IBD is complex and it’s involved the interactions of certain genome with gut microbiome, immunological dysfunction coupled with many environmental (exposome) triggers including ‘westernization’ will lead to IBD. The patterns of IBD incidence observed in Malaysia are comparable in certain aspects to those observed in the West, but due to their ‘different and challenging faces’, making it difficult for clinicians to diagnose and manage the rising cases of IBD. Majority of patients with CD have involvement of the terminal ileum and/or right colon mimicking ileo-caecal tuberculosis and upper gastro-intestinal or duodenal CD manifests as seemingly refractory peptic ulcer disease. Due to the nonspecific gastrointestinal and extra-intestinal manifestations of IBD, several other diagnoses which range from infectious colitis to early neoplastic changes must be considered before establishing a diagnosis of UC or CD, particularly in the absence of typical endoscopic findings and in patients at higher risk for other diagnoses. There should be a consistent ‘cross talk’ between clinicians managing IBD with other IBD-related specialists as the management of IBD rely heavily on multi-disciplinary team and also involved personalized medicine.
Emphysema is a progressive chronic disease that afflicted approximately 3 million people in the United States in 2001. The intermediate term benefit of lung volume reduction surgery (LVRS) in the management of end-stage emphysema has been defined in selected group of patients. LVRS has been shown to improve survival in a subset of patients with upper lobe emphysema and low baseline exercise tolerance albeit at a high cost.

The National Emphysema Treatment Trial (NETT) investigated the efficacy and cost effectiveness of LVRS which was compared with standard medical therapy. Analysis of the NETT showed that patients with very low FEV1 (< 20% of predicted) and a homogenous pattern of emphysema or DLco of < 20% predicted were at high risk of death after LVRS. Even with a successful LVRS, patients often have to stay in the ICU and may have prolonged air leak. Given all these limitations, many severe emphysema patients are not candidates for LVRS.

The concept of removing hypoventilated and non-functional areas of the lung and the favourable results of the NETT have led to the development of various bronchoscopic techniques to provide an alternative means of achieving the results of LVRS. These bronchoscopic techniques are performed by interventional pulmonologists.

Different approaches of bronchoscopic lung volume reduction have been described including endobronchial valves, thermal vapour ablation and coils. Endobronchial valve is the most studied of these devices. The one-way valve is intended to prevent air from entering the most emphysemaatous segment while allowing air to exit distal to the valve. In theory, this will result in atelectasis of the isolated emphysematous lung segment, mimicking the results of LVRS but with less morbidity and mortality.

Pregnancy is a physiological condition that causes a number of changes in renal physiology and anatomy. Changes in hormones level contributes to increase in plasma circulating volume and thus glomerular blood flow and glomerular filtration. The glomerular filtration peaks towards the end of first trimester. Slight increase in proteinuria is considered physiological in pregnancy because of all these changes in renal blood flow.

Nevertheless, increase in proteinuria of more than 300mg per day is abnormal and should be investigated. There are many conditions that can cause proteinuria during pregnancy. The most classical is the clinical dilemma in differentiating pre-eclampsia from a flare in lupus nephritis when a pregnant lupus patient develops significant proteinuria. The accurate differentiation is essential as the following management differs based on the underlying cause.

The speaker will use a case-based approach to discuss few important issues in managing proteinuria during pregnancy. Among those include methods of proteinuria assessment during pregnancy, differential diagnosis, key investigations to differentiate clinically important conditions and further management. The speaker hopes to make this session an interactive one to enhance learning and understanding of this important topic.
An epileptic seizure can be defined as an intermittent, stereotyped disturbance of consciousness, behaviour, emotion, motor function, perception or sensation that on clinical grounds results from cortical neuronal discharge. Epilepsy is a neurological disorder characterised by two or more epileptic seizures occurring more than 24 hours apart. Vasovagal attacks occur in the presence of a clear precipitating factor such as pain, emotional stress and crowded areas. They are usually preceded by light-headedness, nausea, ringing in the ear and the vision “going black”. Various epileptiform clinical phenomena (e.g. tonic spasms, myoclonic jerks and automatism) may accompany vasovagal attacks and simulate epileptic seizures. Cardiac syncope is also commonly associated with myoclonic jerks. The diagnosis of psychogenic non-epileptic seizures is now facilitated by video-EEG monitoring. The attacks are seldom stereotyped and are modified according to the relevance or importance of the audience. There is usually no or little post-ictal confusion and drowsiness. Urinary incontinence and self-injury, including tongue biting do not exclude the diagnosis. Tics and other movement disorders may also mimic epileptic seizures. Focal seizures with or without loss of awareness, on the other hand, may mimic pseudoseizures. A good history obtained from a reliable eyewitness is the cornerstone to the diagnosis of epileptic seizures.
Low blood pressure or hypotension as long as a person does not experience symptoms, is not a problem. It becomes a medical concern if a person is symptomatic and if the hypotension is severe enough that it can lead to shock. Shock is a clinical syndrome resulting from the hypoperfusion of the tissues. Regardless of the underlying cause, this hypoperfusion leads to the failure to meet tissues’ nutritional and oxygen needs, causing cellular dysfunction. This leads to the production and release of inflammatory mediators that will further jeopardize perfusion through changes in the vasculature. The results of these changes are organ failure and death if treatment is not timely applied.

According to the underlying cause, there are different types of shock, which have similar presentations. It is important to determine the underlying cause so that right treatment can be instituted. Cardiogenic shock is a clinical condition, defined as a state of systemic hypoperfusion originated in cardiac failure, in the presence of adequate intravascular volume, typically followed by hypotension, which leads to insufficient ability to meet oxygen and nutrient demands of organs and other peripheral tissues. In most studies, it is defined as a state in which systolic blood pressure is persistently < 90 mm Hg or < 80 mm Hg, for longer than 1 hour, with adequate or elevated left and right ventricular filling pressures that does not respond to isolated fluid administration.

The clinical presentation of shock is usually the result of a complexity of processes, such as the sympathetic and endocrine responses to hypoperfusion, along with manifestations of organ failure. The differential diagnosis of shock sometime can be challenging as some components of each type may be combined in a single patients. This lecture will discussed the differential diagnosis of cardiogenic shock, their similarities and differences in term of clinical presentation and hemodynamics.
FP 01  FIXED COMMON DOSAGE RADIOIODINETHERAPY FOR THYROTOXICOSIS: A SENSIBLE TREATMENT OPTION AND ITS OUTCOME
Ahmad Zaid Zanial1, Mahayuddin Abdul Manap2, Fadzilah Hamzah3
1 Nuclear Medicine Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia
2 Advanced Medical and Dental Institute, Universiti Sains Malaysia, Pulau Pinang, Malaysia
3 Nuclear Medicine Department, Hospital Pulau Pinang, Pulau Pinang, Malaysia

FP 02  REAL LIFE EXPERIENCES WITH PRACTICES IN SOFT TISSUE INFILTRATIONS AND INTRA-ARTICULAR INJECTIONS (ReLEP-Star)
CK Cheah, HL Tan, KH Lee, SH Chua, N Mohd Noor, BA DSouza, SC Gun
Department of Medicine, Hospital Tuanku Ja’afar Seremban, Negeri Sembilan, Malaysia

FP 03  CLINICAL OUTCOMES OF LEVOSIMENDAN USE IN LOW EJECTION FRACTION CARDIAC PATIENTS: A META-ANALYSIS OF RANDOMISED CLINICAL TRIALS
KT Ng1, XL Chan2, WK Tan1, CY Wang1
1 University of Malaya, Kuala Lumpur, Malaysia
2 University of Bristol, United Kingdom

FP 04  CONTINUOUS INFUSION VERSUS INTERMITTENT BOLUS INJECTION OF FUROSEMIDE IN CRITICALLY ILL PATIENTS: A SYSTEMATIC REVIEW AND META-ANALYSIS
KT Ng1, A Velayit2, DKY Kho1, A Mohd Ismail1, M Mansor1
1 University of Malaya, Kuala Lumpur, Malaysia
2 International Medical University, Kuala Lumpur, Malaysia
3 Monash University Malaysia, Malaysia

FP 05  WATCHFUL WAITING VERSUS PROSTATECTOMY FOR LOCALISED PROSTATE CANCER: A META-ANALYSIS OF RANDOMISED CLINICAL TRIALS
KT Ng1, PE Kwok2, WY Teoh3
1 University of Malaya, Kuala Lumpur, Malaysia
2 International Medical University, Kuala Lumpur, Malaysia
3 University of Liverpool, United Kingdom

FP 06  DON’T UNDERESTIMATE ME, I AM MORE THAN WHAT YOU SEE : AVR ST-ELEVATION IN PULMONARY EMBOLISM
Wei Ven Chin1, Wen Ji Kang2, Siew Gar Ng3
1 Internal Medicine Department, Sarawak General Hospital, Sarawak, Malaysia
2 Emergency Department, Sarawak General Hospital, Sarawak, Malaysia
3 Emergency Department, Hospital Kajang, Selangor, Malaysia

FP 07  CHOLESTEROL EFFLUX CAPACITY IN YOUNG ACUTE CORONARY SYNDROME IN MALAYSIA
Nicholas Chua1, Rizmy Najme Khir1, Raja Ezman1, Noorlizah Wendy1, Johan Rizwal1, Zubin Othman1, Kamal Arshad1, Effa Abdul Rahman1, Lim Chiao Wen1, Hafisyatul Aiza1, Thuhairah Rahman1, Sazzli Kasim1
1 Cardiology Department, UiTM Sungai Buloh, Selangor, Malaysia
2 Pathology Department, UiTM Sungai Buloh, Selangor, Malaysia

FP 08  CHRONIC KIDNEY DISEASE STAGE 2 SHOULD BE CONSIDERED HIGH RISK INDIVIDUALS FOR PRIMARY PREVENTION
AB Md Radzi, SS Kasim
Universiti Teknologi MARA, Selangor, Malaysia

FP 09  EVALUATION OF LEFT ATRIAL FUNCTION IN PHYSIOLOGICAL AND PATHOLOGICAL PROCESS
Faculty of Medicine, UiTM Sungai Buloh, Malaysia
FIXED COMMON DOSAGE RADIOIODINE THERAPY FOR THYROTOXICOSIS: A SENSIBLE TREATMENT OPTION AND ITS OUTCOME
Ahmad Zaid Zanial1, Mahayuddin Abdul Manap2, Fadzilah Hamzah3
1Nuclear Medicine Department, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia
2Advanced Medical and Dental Institute, Universiti Sains Malaysia, Pulau Pinang, Malaysia
3Nuclear Medicine Department, Hospital Pulau Pinang, Pulau Pinang, Malaysia

INTRODUCTION
Radioiodine therapy is one of treatment options available for thyrotoxicosis. Although several methods in calculating appropriate radioiodine activity to be administered have been proposed previously, no clear advantages could be proven in using adjusted dosage over fixed dosage. Generally prescribed dosage for benign thyroid disorders is <30 millicurie.

OBJECTIVES
We aimed to determine the outcome following fixed common dosage of 15 millicurie radioiodine therapy among our thyrotoxicosis patients and factors associated with euthyroid outcome.

METHODOLOGY
Thyrotoxicosis patients, regardless of aetiologies, undergoing first-time radioiodine therapy and achieved pre-therapy urinary iodine level <50 μg/L after minimum of 1 week dietary restriction and preparation were recruited in this prospective study (n=49). Majority were middle aged females with small to moderate sized goitre. Anti-thyroid drugs consumption was stopped for at least a week prior to therapy with fixed 15 millicurie radioiodine. Patients being monitored and treatment outcomes (i.e. persistent hyperthyroidism, euthyroid status or hypothyroidism supplemented with thyroxine) were determined at 9th month follow-up. Collected data were then analysed.

RESULTS
Majority of patients (88%) achieved favourable outcome (euthyroid, n=26 and hypothyroidism, n=17). None developed any major therapy complication. No significant association between age, gender, goitre classification, duration of illness and urinary iodine level with therapy outcome. However, patients with optimised pre-treatment level of free thyroxine hormones, fT4 (values within normal range) were associated with euthyroid status at 9th month follow-up (p<0.05). Multiple logistic regression analysis revealed that optimised baseline fT4 was the only factor associated with attaining euthyroid status (OR 0.06, 95% CI 0.040-0.865, p<0.05).

CONCLUSION
Fixed common dosage of 15 millicurie radioiodine therapy could well be utilised for thyrotoxicosis treatment. Majority of our patients achieved favourable outcome at 9th month follow-up with no reported major complications. Optimised pre-treatment fT4 level was significantly associated with euthyroid status post therapy.

INTRODUCTION
Soft tissue infiltrations and intra-articular injections are becoming increasingly popular in pain management amongst patients with rheumatology disorders.

OBJECTIVE
We assessed the clinical efficacy of these bedside procedures based on patient reported outcomes.

METHODOLOGY
The study was conducted at Hospital Tuanku Ja’afar Seremban from January to April 2017 at the clinic as well as in-patient setting. Baseline and immediate post procedure pain and functional status were scored by patients using a 10-points Likert Scale and they were followed up prospectively at 6 weeks and 12 weeks post procedure. Statistical analysis performed with SPSS version 23.0.

RESULTS
111 patients were recruited, with 75% of the cohort were female. 58 patients (52.3%) underwent intra-articular injection, 28 patients (25.2%) had intra-lesional injection and remaining 25 patients (22.5%) received hydro-dissection. Approximately 75% of the procedures were ultrasound-guided. Majority of the patients had rheumatoid arthritis, 48.6%. Mean pain score at baseline was 5.96 (95%CI: 5.55-6.38). This reduced immediately to 2.57 (95%CI: 2.17-2.97) and 2.57 (95%CI: 2.08-3.06) at 12 weeks post procedure. The reduction in mean pain score was significant, p=0.005. The functional score at baseline was 3.72 (95% CI: 3.30-4.15). Significant increment in functional score was seen only at 6 weeks post procedure (mean at 5.26,95%CI: 4.79-5.02) and sustained even at 12 weeks (mean at 5.49,95%CI: 5.72-5.96), p=0.005 respectively. Six patients (5.4%) experienced worsening of the musculo-skeletal pain. None of the patients developed infection related to the procedures.

CONCLUSION
Soft tissue infiltrations and intra-articular injections are effective and safe in pain management and functional rehabilitation among rheumatology patients.
CLINICAL OUTCOMES OF LEVOSIMENDAN USE IN LOW EJECTION FRACTION CARDIAC PATIENTS: A META-ANALYSIS OF RANDOMISED CLINICAL TRIALS

KT Ng1, XL Chan2, WK Tan2, CY Wang1
1University of Malaya, Kuala Lumpur, Malaysia
2University of Bristol, United Kingdom

OBJECTIVES
Low ejection fraction (≤50%) is known to be associated with high morbidity and mortality in cardiac surgery. Levosimendan is believed to provide cardioprotection and inodilatation to improve haemodynamics in these patients, but recent trials have reported conflicting findings. The primary aims of this review were to examine the clinical outcomes of levosimendan in patients undergoing cardiac surgery with low ejection fraction.

METHODOLOGY
All randomised clinical trials were systematically searched in MEDLINE, EMBASE, PubMed and the Cochrane Database of Systematic Reviews from their inception till August 2017. Observational studies, case reports, case series and non-systematic reviews were excluded.

RESULTS
Fourteen trials were eligible (n=2,555) for inclusion in the data synthesis. In comparison to placebo group, levosimendan cohort was associated with a significant reduction in mortality (13 studies, ρ=0.009, I²=32%; FEM:RD -0.03; 95%CI -0.05, -0.01) and duration of ventilation (ρ=0.002, I²=92%; REM:MD -6.26; 95%CI -10.23, -2.29), which corresponded with lesser incidence of low cardiac output syndrome (ρ<0.01, I²=0%; FEM:RD -0.08; 95%CI -0.12, -0.04) and mechanical support from cardiac assist devices (ρ=0.01, I²=84%; REM:RD -0.06; 95%CI -0.11, -0.01). Subgroup analyses showed these benefits were confined mainly to patients with severely low ejection fraction <30% and those who received levosimendan pre-operatively. No significant differences were noted in the prevention of post-operative supraventricular arrhythmias, duration of intensive care unit and hospital stay.

DISCUSSION AND CONCLUSION(S)
In summary, the use of levosimendan resulted in a significant reduction in mortality, duration of ventilation, incidence of low cardiac output syndrome and mechanical cardiac assist devices. These benefits were mainly seen in patients with severely low ejection fraction <30% and those who received levosimendan pre-operatively.

CONTINUOUS INFUSION VERSUS INTERMITTENT BOLUS INJECTION OF FUROSEMIDE IN CRITICALLY ILL PATIENTS: A SYSTEMATIC REVIEW AND META-ANALYSIS

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OBJECTIVE
Fluid overload is a common phenomenon seen in intensive care units. However, there is no general consensus on whether continuous or bolus furosemide is safer or more effective in these haemodynamically unstable patients. The aims of this meta-analysis were to examine the clinical outcomes of continuous versus bolus furosemide in critically-ill population.

METHODOLOGY
All randomised clinical trials, observational studies and case-control studies were systematically searched in MEDLINE, EMBASE, PubMed and the Cochrane Database of Systematic Reviews from their inception till June 2017. Case reports, case series and non-systematic reviews that involved children were excluded.

RESULTS
Nine studies (n=464) were eligible in the data synthesis. Both continuous and bolus furosemide resulted in no difference in all-cause mortality (seven studies; n=396; I²=0%; FEM:OR 1.15 [95%CI 0.67,1.96]; ρ=0.64). Continuous furosemide was associated with significant greater total urine output (n=132; I²=70%; REM:OR 811.19 [95%CI 99.84,1522.53]; ρ=0.03), but longer length of hospital stay (n=290; I²=40%; FEM:OR 2.84 [95%CI 1.74,3.94]; ρ<0.01) in comparison to bolus group. No statistical significance was found in the changes of creatinine and eGFR between both groups.

DISCUSSION AND CONCLUSION(S)
In this meta-analysis, continuous furosemide had greater diuretic effect in total urine output as compared with the bolus arm, neither of them had any differences in mortality and changes of electrolytes. However, a large adequately powered randomised clinical trial is required to answer this knowledge gap.
WATCHFUL WAITING VERSUS PROSTATECTOMY FOR LOCALISED PROSTATE CANCER: A META-ANALYSIS OF RANDOMISED CLINICAL TRIALS

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OBJECTIVES
The management of localised prostate cancer remains unclear in the literature. Recent published randomised controlled trials on follow-up data of nearly 20 years have reported conflicting findings in all-cause mortality and prostate-cancer related mortality. The aims of this meta-analysis were to examine the clinical outcomes of watchful waiting versus prostatectomy for localised prostate cancer.

METHODOLOGY
All randomised clinical trials were systematically searched in MEDLINE, EMBASE, PubMed and the Cochrane Database of Systematic Reviews from their inception till August 2017. Observational studies, case reports, case series and non-systematic reviews were excluded. All the included RCTs were assessed for risk of bias using the Cochrane Collaboration Risk of Bias Assessment Tool.

RESULTS
Three trials were eligible (n=1,568) for inclusion in the data synthesis. Prostatectomy cohort was associated with a significant reduction in all-cause mortality (2 studies; p=0.02, I2=59%; REM:OR 1.51; 95%CI 1.07, 2.12) and prostate cancer-related mortality (2 studies; p<0.01, I2=0%; FEM:OR 1.73; 95%CI 1.29, 2.32) as compared with watchful waiting arm. There was no significant difference in the incidence of erectile dysfunction (2 studies; p=0.27, I2=90%; REM:OR 0.57; 95%CI 0.21, 1.54). Prostatectomy had significantly higher incidence of urinary incontinence (2 studies; p<0.01, I2=65%; REM:OR 0.31; 95%CI 0.16, 0.58) in comparison to watchful waiting group.

DISCUSSION AND CONCLUSION(S)
In summary, prostatectomy resulted in a significant reduction in all-cause mortality and prostate cancer-related mortality, but had higher incidence of urinary incontinence in comparison to watchful waiting, but neither of them had any significance in the incidence of erectile dysfunction.

DON’T UNDERESTIMATE ME, I AM MORE THAN WHAT YOU SEE : AVR ST-ELEVATION IN PULMONARY EMBOLISM

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INTRODUCTION
ST-elevation in lead avR (STEavR) is gaining a huge attention over the past decade with association to severe acute coronary syndrome (ACS), e.g. left main coronary artery occlusion. In fact, this once forgotten lead can tell us more, as massive pulmonary embolism (PE) can present with the similar electrocardiography (ECG) findings.

CASE PRESENTATION
55 year-old lady with right closed lateral malleolus fracture came for follow-up. However, she fainted in the hospital washroom. Upon attending, she was drowsy. Heart rate = 130bpm, blood pressure = 60/52mmHg, SPO2 = 68% under room air and respiratory rate = 40 breath/min. ECG noted ST-elevation in lead avR and V1, ST depression in leads I, V4-V6. Bedside echocardiography showed right ventricle dilatation with positive McConnell’s sign. Computed tomography pulmonary angiogram showed bilateral pulmonary artery embolism. Creatine Kinase-MB is within range. In view of hemodynamic instability, thrombolytic therapy was given. Subsequently, patient’s condition improved. Repeated ECG showed resolved ST-segment changes and echocardiography showed normal right ventricle size.

DISCUSSION
It is increasingly recognized that STEavR in ECG is an alarming finding for severe ACS. But considering our patient’s prolonged immobilization status and echocardiography findings, PE was highly possible. According to multiple studies, STEavR is a common finding in PE but was generally ignored. It reveals right ventricular injury and the diffuse ST depressions were related to diffuse subendocardial ischemia. PE is a life-threatening condition with rapid clinical deterioration that might mimic ACS during presentation. In some studies, the presence of STEavR is predictive of hemodynamic instability and poor outcome. Therefore, prompt recognition improves survival. Can we differentiate PE from ACS base on ECG findings? Presence of the terminal S-wave in lead 1 and terminal R-wave in lead III may point towards PE.

CONCLUSION
In conclusion, high index of suspicion for severe ACS and massive PE is needed when encountered with a STEaVR in electrocardiography.
BACKGROUND
We hypothesized that the capacity of HDL to accept cholesterol from macrophages, via cholesterol efflux capacity (CEC) would serve as a predictor of atherosclerotic disease.

OBJECTIVE
Compare CEC of young ACS to a healthy control cohort.

MATERIALS & METHODS
This was a prospective, single center pilot study that was carried out at Universiti Teknologi MARA Malaysia. All subjects were below 40 years old. Blood serum were taken and analyzed with CEC assay kit (cell-based, ab196985) using fluorescently-labelled cholesterol and THP-1 macrophage cell line.

RESULTS
15 young ACS and 20 healthy control subjects were recruited. The mean age was 35.3±3.6 and 29.9±2.7. Young ACS cardiovascular risk assessment revealed 87% smokers and 67% undiagnosed dyslipidemia. Young ACS had mean fasting glucose level of 7.0±1.5 mmol/L, and serum creatinine 88.7±13.4 µmol/L. Lipid profile revealed mean total cholesterol of 5.40±1.18 mmol/L, HDL of 0.99±0.23 mmol/L, and LDL of 3.53±1.02 mmol/L. Mean HDL healthy cohort was 1.48±0.75 mmol/L. Abnormal CIMT was 86% in young ACS and 35% in healthy control. Mean CEC in the young ACS and control were significantly different at 17.9±1.5% and 26.3±1.1% (p<0.005).

CONCLUSION
Young ACS have abnormal CIMT, low HDL and impaired HDL function.

OBJECTIVE
We aimed to study the presence of arterial stiffness using pulse wave velocity (PWV) in patients with CKD stage 2 of younger-age population.

BACKGROUND
Arterial damage in chronic kidney disease (CKD) is characterized by aortic stiffness. This is seen in elderly patients with advanced CKD. Patients with CKD stages 3 and above are considered high risk for cardiovascular disease with two-fold higher cardiovascular mortality rate when compared with patients with normal renal function. The association between arterial stiffness and early CKD is not well established.

METHODS
Patients below the age of 55 years with CKD stage 2 and normal renal function were recruited. Demographic details, co-morbidity, risk factors, medications as well as blood investigations were collected. Arterial stiffness was determined using carotid-femoral (aortic) PWV. Results were analysed using SPSS version 22.0.

RESULTS
39 patients with CKD stage 2 and 39 control patients were recruited. The mean age of CKD patients was 46 years ± 5.7. Patients with CKD stage 2 had a significant higher mean PWV (7.5 m/s ± 1.5) compared to controls (5.7 m/s ± 1.1) (p<0.001, 95% CI -2.45,-1.21). Diabetics patients had higher mean PWV (7.8 m/s ± 1.7) compared to non-diabetics (7.3 m/s ± 1.3) (p=0.34, 95% CI -1.50, 0.53). Multiple linear regression analysis revealed pulse pressure as the independent predictor of abnormal PWV (r²=0.568, p=0.006).

CONCLUSIONS
Arterial stiffness as assessed by PWV occurs early in the young CKD stage 2 patients.
EVALUATION OF LEFT ATRIAL FUNCTION IN PHYSIOLOGICAL AND PATHOLOGICAL PROCESS

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BACKGROUND/INTRODUCTION
Recognition of left atrial (LA) remodeling is important, as it has been shown to be a predictor of adverse cardiovascular outcomes. However, the adaptive remodeling can occur in response to either physiological or pathological response. Little is known on the parameters to differentiate between these two distinct processes.

PURPOSE
We aim to describe and assess differences in parameters related to LA function in 3 groups of population at risk of LA remodeling; professional athletes, recreational sportsman and patients with cardiomyopathy

METHODS
This was a descriptive single centre cross-sectional study comparing LA function in male professional athletes, recreational sportsman and subjects with cardiomyopathy by 2D transthoracic echocardiography. Maximum, minimum and pre-A volumes were obtained by manual calculation. Values representing LA reservoir, conduit and pump function were expressed as LA total emptying, passive emptying and active emptying fraction respectively. Global longitudinal LA strain (GLS) was also calculated using conventional software.

RESULTS
There were 23 professional athletes, 20 recreational sportsman and 27 subjects with cardiomyopathy in this cohort. Their mean age were 23±1.9 years, 26±2.1, 35±2.4 years respectively. Athletes and cardiomyopathy subjects have a significantly larger LA volume index compared to recreational sportsman (38.1±11.1ml/m², 25.6±7.7 ml/m² and 28.89±12.9 ml/m² respectively). Cardiomyopathy subjects had a significant lower LA reservoir capacity (mean LA total emptying fraction of 0.38±0.1, 0.57±0.1 and 0.59±0.8 respectively, p<0.01) lower conduit function (mean LA passive emptying fraction of 0.2±0.1, 0.5±0.3, 0.4±0.2 respectively, p=0.001), lower pump function (mean LA active emptying fraction 0.2±0.1, 0.30±0.1 and 0.32±0.2 respectively, p=0.02) and lower LA global longitudinal strain (mean 9.8±6.7, 23.9±12.1, 27.8±14.6, p<0.001). When compared professional to recreational sportsman, no significant difference between the three phasics of LA function and GLS. Of these parameters, GLS is the best discriminatory factor between physiological and pathological LA remodeling. (GLS sensitivity: 86%, specificity 97%, AUC curve: 0.8, p<0.001).

CONCLUSION
LA remodeling occurs differently in response to exercise and diseases. GLS LA outperforms current conventional parameters as a discriminatory factor for physiological versus pathological LA remodeling.
POSTER PRESENTATIONS

PP 01 SCINTIGRAPHIC EVALUATION OF CHRONIC LOWER LIMB SWELLING AND FEATURES OF LYMPHOEDEMA
Ahmad Zaid Zanial, Noor Azilah Ahmad Tajudin
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PP 02 A CASE OF CATASTROPHIC BLEEDING IN A PATIENT WITH GROUP A BETA-HEMOLYTIC STREPTOCOCCAL BACTEREMIA: ATYPICAL SITE FOR MYCOTIC ANEURYSM AND ACQUIRED DYSFIBRINOGENEMIA
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PP 03 A RARE CAUSE OF ACUTE KIDNEY INJURY: PRIMARY RENAL LYMPHOMA (PRL) IN A PATIENT WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV)
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2Nephrology Unit, Department of Medicine, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia
3Department of Pathology, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

PP 04 BRUCELLOSIS-INDUCED AUTOIMMUNE HEMOLYTIC ANAEMIA (AIHA) - A CASE REPORT
Woh Wei Mak1, Adrian Mark Masnammany2
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2Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan, Malaysia

PP 05 GALLOPING INTO A CAVITY OF CONUNDRUM: RHODOCOCCUS EQUI PRESENTING AS CAVITARY PNEUMONIA IN AN HIV PATIENT - A MIMIC’S IMITATOR
S Prakash, KS Chiew, W Syazween Lyana, N Rizal, KK Sia
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PP 06 CLINICAL AUDIT AND STRATEGIES TO REDUCE THE INCIDENCE OF THROMBOPHLEBITIS IN Dengue Patients
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PP 07 EARLY REFERRAL STRATEGIES IN SPONDYLOARTHRITIS - FOSTERING VIGILANCE, FORTIFYING COHERENCE
KH Lee, CK Cheah, N Mohd Noor, BA D’Souza, SC Gun
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PP 08 SICK SINUS SYNDROME IN DERMATOMYOSITIS: A CASE REPORT
Wee Fang Yap, Ruhaila Binti Abdul Rahim, Suryati MY
Hospital Sultanah Aminah, Johor Bahru, Johor, Malaysia

PP 09 PREVALENCE OF OBESITY AND SCREENING FOR DIABETES
Edmund Yu Wei Chang
Hospital Taiping, Perak, Malaysia

PP 10 DEMOGRAPHIC FEATURES OF STROKE PATIENTS (n=170) IN HOSPITAL SULTAN HAJI AHMAD SHAH (HoSHAS) TEMERLOH, PAHANG, MALAYSIA
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2Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan, Malaysia

PP 11 THE INTERPLAY BETWEEN STEATOSIS AND CHRONIC HEPATITIS B INFECTION ON LIVER FIBROSIS
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POSTER PRESENTATIONS

PP 12  PREVALENCE OF TARGET ORGAN DAMAGE AND PREDICTORS OF RESISTANT HYPERTENSION IN PHYSICIAN CLINIC: A LOCAL CROSS SECTIONAL STUDY
TG Wong, M Monniaty
Hospital Raja Perempuan Zainab II, Kota Bharu Kelantan, Malaysia

PP 13  FACTORS PREDICTING MORTALITY IN PATIENTS WITH ACUTE MYOCARDIAL INFARCTION (AMI) (n=580)
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²Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan, Malaysia

PP 14  INTRAVENOUS RITUXIMAB IN SEVERE REFRACTORY PRIMARY FOCAL SEGMENTAL GLOMERULOSCLEROSIS: A CASE REPORT AND LITERATURE REVIEW
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PP 15  ACUTE KIDNEY INJURY DURING FASTING MONTH IN A PATIENT WITH MODERATE CKD
CL Looi, WK Cheah, Christopher KS Chan
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PP 16  THE TIMI RISK SCORING FOR ACUTE CORONARY SYNDROME PATIENTS MANAGED IN HOSPITAL PUTRAJAYA - A RETROSPECTIVE REVIEW
Iskandar Mirza bin Amran, Muhammad Irfan bin Mohd Sallehhudin, Noor Shairah bt Mat Barhan,
Aribah binti Alias, Nor Shuhaile Shahril
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PP 17  THE ATYPICAL PRESENTATION OF GOUTY TOPHI - A CASE SERIES
Heamawathy, Shukur A, S Sharifudin
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PP 18  DENGUE FORECAST IN ASSOCIATION WITH CLIMATE CHANGE
SL Ee, CH Ong, Albert I L Anthony
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PP 19  ERYSEPelas VS NECROTISING FASCIITIS - A DILEMMA
Kavinkumar S, Shukur A, Sharifuddin S
Orthopedic Department, Hospital Teluk Intan, Perak, Malaysia

PP 20  A CASE REPORT OF HEREDITARY HEMORRHAGIC TELANGIECTASIA
TG Wong
Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan, Malaysia

PP 21  “TENNIS RACKET” SIGN IN PULMONARY TUBERCULOSIS
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²Monash University Malaysia, Subang Jaya, Selangor, Malaysia

PP 22  EFFICACY OF EMPAGLIFLOZIN IN RAMADHAN
FZ Mohamed Shah, SF Wan Mohd Hatta, R Abdul Razak, R Abdul Ghani
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PP 23  PARTIAL ADRENAL SUPPRESSION FOLLOWING PROLONGED DEPO-PROVERA USE: A CASE REPORT
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Faculty of Medicine, Universiti Teknologi MARA, Sungai Buloh, Selangor, Malaysia
POSTER PRESENTATIONS

PP 24  GLYCEMIC STATUS AMONG PATIENTS WITH RECENT EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)
Khairil Khuzaini Zulkifli, Fatimah Zaherah Mohamed Shah, Rohana Abdul Ghani
Faculty of Medicine, Universiti Teknologi MARA, Sungai Buloh, Selangor, Malaysia

PP 25  HIGH GLYCAEMATED HEMOGLOBIN PREDICTS NON-ALCOHOLIC FATTY LIVER DISEASE AMONG DIABETIC PATIENTS WITH CORONARY ARTERY DISEASE IN MALAYSIA
Fatimah Zaherah Mohamed Shah, Nurazam Omar, Sh Faradilla WM Hatta, Marymol Koshi, Sazzli Sahlan Kasim, Rohana Abdul Ghani
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PP 26  OPTIMIZING CLINIC WAITING TIME - A NOVEL MODULE INCORPORATING FUN AND KNOWLEDGE IN THE WAITING ROOM
Fatimah Zaherah Mohamed Shah, Sh Faradilla WM Hatta, Rohaya Abdul Razak, Rohana Abdul Ghani
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PP 27  DENGUE INFECTION WITH SECONDARY HEMOPHAGOCYTIC HISTIOLYMPHOCYTOSIS (HLH): OUR EXPERIENCE IN AMPANG HOSPITAL
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INTRODUCTION
Lymphoedema is a chronic disease due to lymphatic drainage abnormality in the affected extremities causing limb swelling. Although rarely being requested and performed, scintigraphic evaluation of lymphatic system or lymphoscintigraphy is a relatively simple functional nuclear medicine test.

OBJECTIVE
Aim of this study was to ascertain clinical characteristics of patients referred for lower limb lymphoscintigraphy, their scan findings and presence of lymphoedema.

METHODOLOGY
Retrospective study involving lymphoscintigraphy cases referred to Nuclear Medicine Department, HKL over 3 years period (2014-2017). Patients with chronic leg swelling (unilateral limb, n=5 and bilateral limbs, n=2) who underwent lymphoscintigraphy were included. All patients received 0.5 millicurie of Technetium-99m nanocolloid radiotracer injections at first and second web-spaces of each foot (totaling 2 millicurie). They underwent 15 minutes of dynamic imaging followed by delayed whole body scanning. Relevant information comprising clinical parameters and scan findings obtained from database records were compiled and analysed.

RESULTS
Majority were females (5/7) with mean age of 48 years. Duration of chronic lower limb swelling was between 1-4 years. Moreover 3 patients were previously treated for cellulitis. All patients in this study demonstrated abnormal scan findings in the affected limbs, suggestive of lymphoedema. Dynamic and delayed images of 2 patients with unilateral swollen limb showed no significant radiotracer progression associated with non-visualisation of inguinal nodes. Whereas, remaining 5 patients (unilateral limb, n=3 and bilateral limbs, n=2) revealed radiotracer accumulation in inguinal nodes at delayed images. Only 1 patient demonstrated popliteal nodes which were seen at the swollen limb. Majority of affected limbs (7/9) showed dermal back flow.

CONCLUSION
Lower limb lymphoscintigraphy is a valuable tool to evaluate lymphoedema. Our patients had demonstrated suggestive scintigraphic findings of lymphoedema. Future research with larger cohort and correlation with management outcome is recommended.
A RARE CAUSE OF ACUTE KIDNEY INJURY: PRIMARY RENAL LYMPHOMA (PRL) IN A PATIENT WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV)

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We reported a case of primary renal lymphoma presented with non-oliguric acute kidney injury and bilateral kidney infiltrates in a HIV individual. Acute kidney injury (AKI) secondary to lymphoma infiltrates is very rare (less than 1% of haematological malignancy). This is a 37 years old gentleman with underlying human immunodeficiency virus (HIV) disease was on combined anti-retroviral therapy (cART) since diagnosis. He presented to our centre with uraemic symptoms and gross haematuria. Clinically, bilateral kidneys massively enlarged and ballotable. Blood investigations showed hemoglobin of 3.7g/L, urea of 65.6mmol/L, serum creatinine of 1630 micromol/L with hyperkalaemia and metabolic acidosis. An urgent haemodialysis was initiated and he was dependent on regular haemodialysis subsequently. Computed tomography (CT) 4 phase renal showed diffuse non-enhancing hypodense lesion in both renal parenchyma. Diagnosis of diffuse large B cell lymphoma with germinal center type, CD 20 positive, proliferative index 95% was confirmed via renal biopsy and there was no bone marrow infiltrates. Unfortunately, patient succumb prior to initiation of chemotherapy. In conclusion, although PRL is rare, it is still one of the differential diagnosis for consideration when a patient presented with renal mass and AKI. The gold standard of confirmation still renal biopsy histopathological examination together with BMAT and PET-CT for staging of the disease. Currently the standard treatment of PRL is still R-CHOP. Generally, the prognosis of PRL is based on the stage of disease upon diagnosis.

BRUCELLOSIS-INDUCED AUTOIMMUNE HEMOLYTIC ANAEMIA (AIHA) - A CASE REPORT

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OBJECTIVE
Brucellosis is a rare zoonotic infection. Clinical presentations are non-specific with fever being the commonest presenting symptoms. Brucellosis is associated with hemolytic complications, including thrombotic microangiopathy and hemolytic anemia. We describe a patient with brucellosis who presented with Coombs-positive AIHA.

CASE SUMMARY
A previously healthy 31 years old lady, presented with 1 week history of high grade fever and malaise. She had no joint pain, no respiratory tract, gastrointestinal or urinary symptoms. There was no significant family history. Her husband raises cattle, however patient denies direct contact with cattle or ingestion of unpasteurized milk. Clinical examination revealed pallor, jaundice, hepatosplenomegaly but no lymphadenopathy. Examination of other system were unremarkable. Blood investigations revealed Haemoglobin 7.1g/dl (normochromic normocytic), White cells 9.9x10^9/L, Platelets 217x10^9/L. Bilirubin was raised 47.6umol/L with predominantly direct bilirubin 20.8umol/L. LDH is markedly raised at 947U/L. Reticulocytes count 15.6%. Direct Coombs test was positive. ESR > 120mm/hr; CRP 26.63 mg/L. ANA, anti-dsDNA and G6PD screen is negative. Peripheral blood smear showed moderate anisopoikilocytosis, polychromatic cells, microspherocytes with red cells morphology changes suggestive of hemolysis. Ultrasound of the hepatobiliary system confirmed hepatosplenomegaly with no other significant findings. Patient was empirically started on IV ceftriaxone 2g OD for broad-spectrum coverage of sepsis. In view of ongoing immune hemolysis, she was started on T.Prednisolone 1mg/kg which was subsequently tapered within 2 weeks. She required 1 pint packed cell transfusion due to symptomatic anemia. Haemoglobin on discharge was 9g/dL. Brucella Melitensis was isolated from her blood cultures. She was treated with T.Doxycyline 100mg BD and T.Rifampicin 15mg/ kg OD for 6 weeks.

RESULTS
Patient was followed up for 18months, Hb was 10.6g/dl, LDH, bilirubin and reticulocytes normalized. Repeated Coombs test negative. There were no further episodes of relapses or hemolysis.

DISCUSSION AND CONCLUSION(S)
Brucellosis is a rare zoonotic infection that can result in transient immune hemolysis.
INTRODUCTION

The worldwide increased incidence of tuberculosis has instituted pulmonary tuberculosis as an important diagnostic consideration in patients with human immunodeficiency virus (HIV) presenting with lower respiratory tract infection. A positive result on the readily-available Ziehl-Neelsen stain usually leads to the initiation of antituberculous treatment, since tuberculosis may exert a rapid and even fatal clinical progression in HIV coinfection. However, a number of other acid-fast bacteria might be implicated as offending pathogens. This case highlights the importance of broadening the list of pathogens that can account for a positive Ziehl-Neelsen stain in this selected group of patients.

CASE REPORT

This case report describes a HIV infected 15-year-old male on HAART therapy, presented with a three-month history of productive cough, fever and significant weight loss. Chest x-ray noted to have cavitating upper lobe infiltrate resembling infection by mycobacterium. A microscopic examination of the Ziehl-Neelsen sputum showed acid fast bacilli hence was treated as smear positive pulmonary tuberculosis. The patient responded to TB treatment briefly before relapsing with chest x-ray revealed worsening consolidation and more cavities formation. Contrast enhanced Chest CT demonstrated right upper lobe consolidation and multiple collection with peripheral rim enhancement representing abscess formation. One week after admission, blood cultures showed Gram-positive coccoabacillus which identified as Rhodoccocus equi. After aggressive treatment with intravenous vancomycin and erythromycin patient had regression of symptoms.

DISCUSSION

Rhodococcus equi is a rare cause of pulmonary disease, even in patients with HIV, and a positive Ziehl-Neelsen sputum often misleads clinicians to more common organisms such as mycobacteria. A high index of suspicion, broadening the spectrum of optional pathogens, and effective communication between clinicians and microbiologists can ensure an efficient diagnostic and therapeutic approach.
EARLY REFERRAL STRATEGIES IN SPONDYLOARTHRITIS - FOSTERING VIGILANCE, FORTIFYING COHERENCE

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INTRODUCTION
Inflammatory back pain (IBP), hallmarked by ankylosing spondylitis, is a heterogeneous group of rheumatological disorder affecting young adults. Late detection and delayed referral to rheumatology centre lead to unsalvageable joint damage.

OBJECTIVE
To evaluate the level of awareness among primary care providers and establish an integrated chronic back pain (CBP) referral strategy.

METHODOLOGY
Standard teaching slides including an integrated care pathway were introduced at CME sessions conducted district hospitals/health centres. We adopted CBP screening questionnaires from the Assessment of Spondyloarthritis International Society (ASAS). This was coupled with a 10-multiple choice questions assessed pre and post-evaluations, with total scores of 19. Audiences were invited at 6 months post CME to response to online questions. Subsequent referrals for IBP evaluation to our centre were monitored.

RESULTS
Nine CME sessions were held at district hospitals and health centres in Negeri Sembilan in between December 2016 to March 2017. 207 doctors attended the CME sessions. Majority was of less than 5 years in service (46.9%). Pre-test mean score was 11.4 ± 3.14 whereas post-test mean score showed significant improvement of 15.8 ± 2.17, (p=0.001). 120 participants responded to 6 months post-test assessment using the same post-test questionnaire, with mean score of 15.3 ± 2.92. 152 patients were screened at health centres using ASAS screening questionnaires. 4 patients with positive screening test results were referred to our centre within 2 weeks upon presentation.

CONCLUSION
Integrated care pathway and continuous active learning by healthcare providers improve the care of patients affected with CBP.

SICK SINUS SYNDROME IN DERMATOMYOSITIS: A CASE REPORT

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Dermatomyositis is an inflammatory myopathy with characteristic cutaneous findings that occur in children and adults. This systemic disorder most frequently affects skin and muscles but may also affect joints, esophagus, lungs and less commonly heart. Cardiac manifestations include dilated cardiomyopathy, pericarditis, atrioventricular defect, atrial and ventricular arrhythmia. We report here a rare case of dermatomyositis presenting as sick sinus syndrome. A 33 years old man presented with recurrent syncopal attack and was diagnosed with sick sinus syndrome followed by dual chamber pacemaker insertion. Echo showed dilated cardiomyopathy and angiogram demonstrated normal coronary artery. The patient presented with proximal muscle weakness 2 years later and subsequent investigations including muscle biopsy consistent with dermatomyositis. Our case emphasizes the need to exclude an underlying connective tissue disease in young patients presenting with cardiac arrhythmia.
INTRODUCTION
The objectives of this study were to identify the prevalence of overweight and obesity among students from secondary schools and to determine the mean random blood sugar for the overweight and obese students.

METHODOLOGY
A cross-sectional study was done on secondary schools that were scheduled for visit by the School Health Team, Taiping in July 2016 were included. A standardized data collection sheet was used to collect the data. Overweight and obesity were defined based on WHO 2007 reference for BMI-for-age criteria. RBS was checked for overweight and obese students.

RESULT
A total of 184 school students consented and participated. 128 (69.6%) were female and 90 (48.9%) were Malays. The mean weight and height were 56.21 kg and 1.61 m respectively with BMI of 21.49 kg/m². Overall, the prevalence of obese and overweight were 12.5% and 10.9% respectively. No significant difference found among sex and races. RBS readings among overweight and obese students were within normal range with mean of 5.95 (0.67) mmol/l.

DISCUSSION / CONCLUSION
The overall prevalence of overweight and obesity was high among the students. However, there was no prevalence of Type II diabetes mellitus among them.
THE INTERPLAY BETWEEN STEATOSIS AND CHRONIC HEPATITIS B INFECTION ON LIVER FIBROSIS

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INTRODUCTION
Introduction: In recent years, the presence of concomitant Non-Alcoholic Fatty Liver Disease (NAFLD) in patients with Chronic Hepatitis B (CHB) infection increases rapidly, yet the potential interaction between the two most prevalent liver diseases worldwide has not been well established.

OBJECTIVE
This study aims to investigate the relationship between hepatic steatosis, Hepatitis B viral load (HBV VL), alanine aminotransferase (ALT), platelet count and components of the metabolic syndrome with fibrosis stage.

METHODOLOGY
We recruited 522 consecutive CHB patients with and without antiviral treatments, who had undergone transient elastography in University Malaya Medical Centre (UMMC) from 2013 to 2016. Liver fibrosis and steatosis were assessed by liver stiffness measurement (LSM) and controlled attenuation parameter (CAP). We considered LSM of 7.2 kPa for fibrosis stage F≥2, 9.4 kPa for F≥3 and 12.2 kPa for F4 (cirrhosis) respectively. Mild, moderate and severe steatosis (CAP =1, 2 and 3, respectively) were defined as >248 dB/m, >268 dB/m and >280 dB/m respectively.

RESULTS
Our preliminary analysis showed that when CAP score was stratified, CAP = 1 was positively correlated with HBV VL whilst CAP = 3 was inversely correlated with HBV VL (Figure 1). Cirrhosis was associated with higher ALT and lower platelet count, however, no association between HBV VL and LSM were found. HBV VL was positively correlated with ALT (Figure 2A). Diabetes and fasting blood glucose was associated with higher LSM values. On multivariate analysis, age, ALT, platelet count and CAP score were independently associated with LSM, but not with HBV VL.

CONCLUSION
In patients without antiviral treatment, hepatic steatosis associated with lower hepatitis B viral load suggests the potential effect of NAFLD on Hepatitis B viral replication. The development of liver fibrosis in CHB patients is likely contributed by the inflammatory response induced by NAFLD and the components of metabolic syndrome.

PREVALENCE OF TARGET ORGAN DAMAGE AND PREDICTORS OF RESISTANT HYPERTENSION IN PHYSICIAN CLINIC: A LOCAL CROSS SECTIONAL STUDY

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BACKGROUND & OBJECTIVE
Patient with resistant hypertension (RH) is known to have higher risk of target organ damage (TOD) and development of TOD may render hypertension more difficult to control. This group of patients were frequently referred and managed in tertiary center. This paper examines the prevalence of target organ damage and predictors of RH in physician clinic, Hospital Raja Perempuan Zainab II (HRPZ II), Kota Bharu.

METHODS
We performed a cross sectional epidemiological study which included all patients with RH (n=288) in physician clinic, HRPZ II, from 1st January 2016 till 31st December 2016. Their demographic characteristics, risk factors, antihypertensive drugs and complications were assessed. Resistant hypertension is defined as failure to achieve target blood pressure of <140/90 mmHg while on an appropriate three-drug regimen that includes a diuretic. Associated clinical risk factors were analyzed by logistic regression.

RESULTS
288 patients were included, mean age was 62±10 years old, 67% were women. Median BP was 130/80 mmHg. Metabolic syndrome was present in 64% (CI 95% 61-67), while 50% had diabetes mellitus (CI 95% 45-55). The prevalence of left ventricular hypertrophy (LVH) determined by electrocardiography was 58% (CI 95% 54-62), followed by proteinuria which was found in 47% (CI 95% 44-51) of the patient with RH. 30% (CI 95% 26-34) had history of cerebrovascular accident (CVA).

DISCUSSION AND CONCLUSION
Female sex with metabolic syndrome is the main predictor of resistant hypertension and the prevalence of TOD is high in this group of patient. Hence in managing patients with RH, effective and efficient strategies to manage metabolic syndrome should be implement together with antihypertensive treatment. Early aggressive management of metabolic syndrome helps to reduce the excessive cardiovascular morbidity and mortality in patient with RH.
FACTORS PREDICTING MORTALITY IN PATIENTS WITH ACUTE MYOCARDIAL INFARCTION (AMI) (n=580)

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BACKGROUND
Cardiovascular disease has been the leading cause of morbidity and mortality for more than a decade in Malaysia, accounting for 20-25% of all deaths in public hospitals.

OBJECTIVE
To study factors predicting mortality in pharmacologically managed AMI patients.

METHODOLOGY
Retrospective, cross-sectional study of all patients (n=580) admitted for AMI in Hospital Sultan Haji Ahmad Shah from 2013-2016. Data collected based of electronic medical records and analysed with EpiInfo7 Software.

RESULTS
82.4% patients were males; 17.6% were females. Mean age was 57.2. Mortality rate during admission was 11.2% (65/580) for pharmacologically managed AMI. 80% (52/65) of patients who died had successful thrombolysis. Factors predicting mortality include:

- Acute kidney injury (AKI) (p<0.0001) Mortality rates in patients with AKI was 26.2% (49/187) versus 4.1% (16/393) in those without. 2 out of 3 patients who required hemodialysis died.
- Inotrope (p<0.0001) Mortality rate in patients requiring inotropic support was 41.7% (35/84) versus 6.1% (30/496) in patients without.
- Hypertension (p=0.0003) 48.3% (280/580) patients had underlying hypertension. Mortality rate in patients with hypertension was 16.1% (45/280) versus 6.7% (20/300) in normotensive patients. Age above 65 (p<0.0001) Mortality rate in patients above 65 was 22.5% (40/178) versus 6.2% (25/402) in patients aged below 65. Heart failure with reduced ejection fraction (HFrEF) (p<0.0001) Mean EF was 51.2%. Mortality rates in patients with EF < 40% was 13.7% (16/117) versus 3.2% (12/377) in patients with EF>40%. Chronic kidney disease (CKD) (p=0.5101) 4.3% (25/580) patients had underlying CKD. Mortality rate in patients with CKD was 16% (4/25) versus 11% (61/494) in patients with normal renal function. Diabetes mellitus (DM) (p=0.095) 33.6% (195/580) patients had underlying DM. Mortality rate in patients with DM was 14.4% (28/195) versus 9.6% (37/385) in patients without.

Conclusion
Presence of AKI, inotropic support, hypertension, age above 65 and HFrEF were associated with increased risk of mortality in patients with AMI, while DM and CKD were not statistically significant in this study.

INTRAVENOUS RITUXIMAB IN SEVERE REFRACTORY PRIMARY FOCAL SEGMENTAL GLOMERULOSCLEROSIS: A CASE REPORT AND LITERATURE REVIEW

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Managing primary or even secondary glomerulonephritis remains a challenge to many nephrologists. In primary focal segmental glomerulosclerosis (FSGS) with heavy proteinuria, renin aldosterone system blockade and high dose oral prednisolone is the mainstay of treatment. Other immunosuppressive medications like cyclophosphamide, cyclosporine A and mycophenolate mofetil (MMF) are warranted if a complete remission is not achieved. We illustrate a case of 21 year old gentleman with primary FSGS that was difficult to achieve remission despite on high dose steroid and oral cyclophosphamide. He was also not responsive to a combination of MMF and cyclosporine A (CSA) and even throughout the therapy he developed significant steroid and CSA toxicity. He presented to our center with severe nephrotic syndrome and acute kidney injury requiring acute haemodialysis. Despite re-challenge him again on high dose prednisolone, total of 2.4g of intravenous cyclophosphamide, and MMF, he failed to achieve remission. He was subsequently given intravenous Rituximab 500mg/weekly for 4 doses and able to attained remission for 1 year. He relapsed again and a second course of Rituximab 500mg/weekly for 6 doses were given to attain remission. This case demonstrates the difficulty in managing refractory steroid dependent FSGS and we found that Rituximab is proven beneficial in this case to induce remission.

Keywords:
Refractory Focal Segmental Glomerulosclerosis, Intravenous Rituximab.
ACUTE KIDNEY INJURY DURING FASTING MONTH IN A PATIENT WITH MODERATE CKD
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INTRODUCTION
The month of Ramadan is observed as a holy month where Muslims will fast from dawn to sunset which last from 12-18 hours. Physiological changes were observed in the bodily functions as it adjusts to the changes in the lifestyle and eating habits throughout the day. A small study showed that Ramadan fasting may be injurious to the renal tubules, but only those with CKD. Worsening renal function can be caused by dehydration and accentuated by renin angiotensin aldosterone receptor (RAAS) blocker, diuretics and non-steroidal anti-inflammatory drugs (NSAIDs).

CASE PRESENTATION
We report a case of a 51-year-old Malay lady, with comorbidities of hypertension, diabetes mellitus type II and CKD (eGFR 50.94ml/min/1.73m2) had recurrent admission for acute renal failure for two consecutive years which both episodes occurred during the fasting month of Ramadan. During the first admission, medications reviewed that she was on perindopril 4mg daily, atenolol 50mg daily and hydrochlorothiazide 50mg daily. Renal function improved to baseline following cessation of perindopril and hydrochlorothiazide and adequate hydration. During the second admission, she was noted to be on perindopril 4mg daily and atenolol 50mg daily, and polypharmacy of NSAIDs and dexamethasone for joint pain. She recovered with hydration and cessation of perindopril. For the subsequent year, renal function was stable during fasting without diuretics and RAAS blocker.

DISCUSSION
This is the first case encounter of renal failure in the month of Ramadan in a patient with stable CKD with no obvious acute precipitating factors found. Dehydration can cause volume depletion and the combination of RAAS blocker, diuretics and NSAIDs which reduces renal blood flow predisposed the patient to renal failure.
INTRODUCTION
Gout affects more than 1% of the population depending on the race, sex, and age of the population studied. It is more widespread in men than woman with ratio 20:1 and rarely seen in premenopausal women. Although there is an association of acute gout with hyperuricaemia, however only a fraction of those with hyperuricaemia developed symptoms.

CASES
There are a total of 5 cases in this series.

First case is a 63 years old malay lady with no underlying co-morbid, had left big toe persistant discharge, progressive swelling and huge sclerotic lesions involving ball of a big toe in X-rays.

Second case is a 39 years old malay lady, complained of left knee progressive swelling mimicking sebaceous cyst.

Third case was a 55 year old male with x-rays presentation of irregular and generalized cotton like mass all over his leg.

Fourth case is a 40 year-old indian male, with no underlying co-morbid. He was admitted to ward for typical clinical findings of right septic arthritis. Results of arthrotomy and biopsy confirmed of gout.

Fifth case is a 62 years old man who presented with left elbow charcot arthropathy that was diagnosed as gout after CT and MRI.
ERYSEPELAS VS NECROTISING FASCIITIS - A DILEMMA
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Erysepelas is common but under diagnosed infection that commonly mistaken with life-threatening condition, necrotizing fasciitis. It is important to differentiate this two condition to reduced morbidity to patients. We are presenting a case of haemorrhagic erysepelas that mimic necrotizing fasciitis, that was successfully treated with antibiotics and dressings without any limb morbidity surgical intervention.

A CASE REPORT OF HEREDITARY HEMORRHAGIC TELENGIECTASIA
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We describe a rare case of hereditary hemorrhagic telangiectasia (HHT), also known as Osler-Weber-Rendu disease, in a patient with incidental findings of left lung opacity in chest x ray. HHT is a rare autosomal dominant vascular anomalies characterized by family history, recurrent epitaxis, visceral arteriovenous malformation (AVM) and telangiectasia. The prevalence of HHT is estimated to be 1 in 5000-10,000 people, with extrapolated prevalence of 4704 in Malaysia. A 29 year old young girl with a past history of subarachnoid hemorrhage due to ruptured basilar artery aneurysm, was referred for a persistent left lower zone opacity in her chest x ray. Further history revealed recurrent epitaxis since childhood and clinical examination shows clubbing, cyanosis and telangiectasia over fingers and hard palate. Hemoglobin was 15g% which is elevated for female. CT angiography of thorax show multiple bilateral AVM of the lungs. From these findings, we diagnosed her as definite HHT based on Curacao’s diagnostic criteria, a disease which is rarely reported in Malaysian literature.
Tuberculosis (TB) is a curable infectious disease caused by bacteria Mycobacterium tuberculosis that has predilection to affect the lungs. In year 2015, 10.4 million people around the world were infected with TB with 1.8 million TB-related deaths recorded. The number of TB cases detected annually in Malaysia has been increasing from year 2000 to 2015. The current guidelines for diagnosis of pulmonary TB are based primarily on demonstration of acid-fast bacilli (AFB) on sputum microscopy. However, this test has low sensitivity and typically takes days to weeks causing significant delays in isolating infectious patients. Because of these limitations, the standard chest radiograph is essential in guiding treatment in cases of sputum negativity or inability of patient to produce sputum. "Tennis racket" sign was observed to be associated with higher bacteriological yields in AFB smear, signifying underlying active pulmonary TB. We would like to report a pulmonary TB case involving a 50-year-old gentleman, presented with cough with yellow-greenish sputum, significant weight loss, decreased appetite, and intermittent low-grade fever of three weeks duration. Lung examination revealed reduced chest expansion over the left apex associated with crepitation and bronchial breath sound. A standard chest radiography performed demonstrated a lobulated thick-walled cavity in the upper zone of left hemithorax resembling a tennis racket, a radiological finding also known as the “Tennis racket” sign. AFB smear and culture from early morning samples were subsequently found to be positive for mycobacterium tuberculosis. He was commenced on EHRZ anti-TB regime (EHRZ: Ethambutol 15mg/kg/day, Isoniazid 5mg/kg/day, Rifampicin 10mg/kg/day, Pyrazinamide 20mg/kg/day) and made uneventful recovery upon completion of treatment. Association between “tennis racket” sign and underlying active disease process of Mycobacterium tuberculosis underscores the importance of identifying it on chest x-ray in patients presented with TB, and to provide immediate necessary treatment to halt the progression of the disease.
INTRODUCTION
Depo-Provera, or depot medroxyprogesterone acetate (DMPA), is an effective contraceptive, however side effects such as mood changes, weight gain and increased fracture risk have been reported. We report an interesting case of a lady who developed partial adrenal suppression after taking Depo-Provera for 16 years.

Case summary
A 49-year-old lady on Depo-Provera for 16 years presented with progressive weight gain of 30kg over the period of 10 years, and inability to stop her DMPA. She reported severe lethargy, headaches and mood lability on attempted cessation few years ago, and has been taking it without gynaecologist consult since then. She denies taking any other supplements or traditional medications. Examination revealed an obese lady with body mass index of 47kg/m2, proximal myopathy and Cushingoid features. An early morning cortisol level was low at 140 nmol/L (210-536 nmol/L) with no electrolyte abnormalities and normal thyroid profile, and a short synachten test done 2 months after her last Depo-Provera injection showed inadequate response to synacthen - 0 hour : 156 nmol/L, 30 minutes: 384.9 nmol/L and 60 minutes: 429.7 nmol/L (normal peak level >550 nmol/L). She was started on low dose oral hydrocortisone replacement with gradual cessation of her Depo-Provera.

Conclusion
DMPA exerts a cortisol-like glucocorticoid activity resulting in negative feedback to the hypothalamus and pituitary, leading to low plasma cortisol and ACTH levels. Although adrenal suppression has been reported in high dose DMPA use in cancer patients, its similar effect with contraceptive dose is not widely recognized. This case reports a known side effect occurring at a much lower dose than previously described, and highlights the need for increased awareness of this insidious side effect of Depo-Provera and to avoid unsupervised use of this commonly prescribed medication.
HIGH GLYCATED HEMOGLOBIN PREDICTS NON-ALCOHOLIC FATTY LIVER DISEASE AMONG DIABETIC PATIENTS WITH CORONARY ARTERY DISEASE IN MALAYSIA

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BACKGROUND
Non-Alcoholic Fatty Liver Disease (NAFLD) is associated with increased inflammation and oxidative-stress, whereas carotid intima-media thickness (CIMT) is a screening tool for subclinical atherosclerosis. Impact of HbA1c and other metabolic parameters on the development of NAFLD and CIMT is not well-defined.

OBJECTIVE
To determine the impact of HbA1c on NAFLD, to identify its predictors and assess its effects on CIMT amongst Type 2 Diabetes Mellitus (T2DM) patients with stable coronary artery disease (CAD).

METHODS
Cross-sectional study involving T2DM patients between 18 to 65 years old with established CAD(n=150). Patients with seropositive Hepatitis B or C, and alcohol intake more than 21 units/week for males and 14 units/week for females were excluded. Baseline blood investigations were performed. Participants underwent abdomen ultrasonography for diagnosis of fatty liver. B-mode ultrasonography of both common carotid arteries was also performed, with calculation of the average posterior wall intima media thickness of the right and left common carotid arteries to determine CIMT.

RESULTS
There were 114(76 %) males and 36(24 %) females, with median age 57years(IQR 13) and mean body mass index (BMI) 29.6±15.3kg/m2. The prevalence of NAFLD was 71.3 %(n=107), with higher BMI, waist circumference, blood pressure, HbA1c, LDL-cholesterol and triglyceride in the NAFLD vs non-NAFLD group. Patients with HbA1c>8%, were 2.8 times more likely to have NAFLD compared to those with HbA1c<8%(p=0.032). Patients with NAFLD demonstrated higher CIMT (OR 5.1; 95% CI, 1.9-14.0; p < 0.001), HbA1c (OR 3.1; CI, 1.4-6.5; p=0.003), systolic (OR 3.9; CI, 1.7 – 8.7; p=0.001) and diastolic blood pressures (OR 2.7; CI, 1.3-5.7; p=0.008); and triglyceride level (OR 0.4; CI, 0.3-2.5; p=0.022. Simple linear regression analysis showed that within the NAFLD group, every 1% rise of HbA1c is associated with an increase in CIMT by 0.03 mm (0.009- 0.052 mm, p= 0.006).

CONCLUSION
Among high risk type 2 diabetic patients with proven CAD, poorly controlled diabetes, hypertension and dyslipidemia are all associated with increased likelihood of NAFLD, the main predictor being high HbA1c. It is therefore crucial to incorporate optimal control of glycaemic and other metabolic parameters in patients with NAFLD to minimize their cardiovascular risks.

OPTIMIZING CLINIC WAITING TIME - A NOVEL MODULE INCORPORATING FUN AND KNOWLEDGE IN THE WAITING ROOM

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INTRODUCTION
Increasing diabetes knowledge leads to better adherence to treatment and follow-ups. However, prolonged waiting time could be tiring and may lead to missing appointments.

OBJECTIVE
To design a module that will optimize clinic waiting-time while empowering patients with adequate knowledge for better management of diabetes.

INNOVATION
This program makes full use of waiting time in the Diabetes Clinic, with different modules weekly, held on a rotational basis. During the first and third weeks, patients will be administered knowledge-based quizzes, either on paper or a dedicated computer, where they will answer questions on diabetes, including optimal dietary and lifestyle habits, diabetic complications and knowledge on hypoglycemia. The quizzes will be mainly in pictorial form, and the information is available on posters/flyers in the clinic. This quiz utilizes a special computer software program where the questions will be in the form of games, so patients will enjoy completing the quiz. Prizes will be given for the top scorers every month. During the second week of the month, patients will meet with a diabetic nurse and pharmacist to go through their medications, with reinforcement of proper dose and timing of medications, and insulin injection technique. On the fourth week, the patients will be divided into two groups, one group will meet with the dietitian for reinforcement of healthy diet, and another group will meet with the diabetic educator and rehabilitation physician for diabetic foot care, including updating knowledge on foot care and hygiene, proper foot-ware, with individual feet examination, monofilament testing and ankle-brachial systolic index (ABI) as required.

CONCLUSION
This novel program incorporates fun and active interactions into acquiring proper knowledge on diabetes, which could be translated into optimal attitudes and practices in managing diabetes, with an aim of reducing complications and improving quality of life.
INTRODUCTION AND OBJECTIVE

Hemophagocytic lymphohistiocytosis (HLH) is a syndrome of pathologic extreme immune activation leading to cytokine storm. This can complicate the management of dengue infection. Our objective is to report on the presentation of secondary HLH in a patient with dengue infection and its management.

CASE SUMMARY

We report a case of a 13-year-old lady who was admitted for fever with headache, myalgia, and vomiting. Dengue NS-1 antigen and dengue IgM was found to be positive while Dengue IgG was found to be negative. These suggest a primary dengue infection. Results of real time polymerase chain reaction later revealed patient to be positive and shows a DEN-3 serotype infection. She was clinically uneventful throughout the febrile and critical phases. Initial blood investigations reveal white cell count of 2.0, platelet 126. However, in the recovery phase, her fever persisted and her cell counts remained low with white blood cells of 2.7 and platelet level of 27. Her liver transaminases were also markedly elevated during the recovery phase (AST 1192U/L, ALT 285U/L). Further biochemical investigations revealed hyperferritinemia of 222219µg/L (13-150µg/L), hypertriglyceridemia of 10.7mmol/L (0-2.3mmol/L), and lactate dehydrogenase of 4249U/L (240-480 U/L). A bone marrow aspirate revealed increased numbers of macrophages and haemophagocytic activity. The culture results from the blood, sputum and urine was found to be negative for any pathogens. Hepatitis B surface antigen and Hepatitis C virus antibody was negative. Diagnosis of hemophagocytic lymphohistiocytosis (HLH) secondary to dengue infection was made. A tapering dose of dexamethasone over 2 days was prescribed, which resulted in marked clinical improvement.

CONCLUSION

Secondary HLH can potentially complicate the clinical course of dengue infection with manifestations of persistent fever, worsening hepatitis and poor recovery of cell counts in the recovery phase. Short course corticosteroids can be use to treat secondary HLH which results in marked improvement of patients’ clinical condition.
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