

POSTER SESSION

PS-1

DISCOID LUPUS ERYTHEMATOSUS LESION AS THE MOST COMMON MANIFESTATION OF SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Discoid lupus erythematosus (DLE) is the most common form of Chronic Cutaneous Lupus erythematosus (CCLE). Approximately 5% of the patients presenting with DLE subsequently develop Systemic Lupus Erythematosus (SLE). Although clinical characteristics of DLE have been well described, diagnosing DLE is a challenge without the aid of proper examination. This case report focuses on early diagnosis of DLE, preventing development of SLE.

Case: 16-year-old female with pruritic erythematous plaque on her face one week prior consultation to the dermatovenereology department of Sumber Waras hospital. We followed the patient's signs and symptoms from the very beginning, conducted local skin examination followed by dermoscopy to have a better visual understanding of the symptoms and performed Laboratory test for ANA and Anti-dsDNA to help us screen the possibility of an upcoming SLE.

Discussion: Lesion initially started as erythematous plaque on forehead and spread to both cheeks and conchal bowl. There was no mucosal involvement. Patient complained about joint pain on the knee and metatarsophalangeal, developing along the

rash. Dermoscopy shows telangiectasia and hyperpigmented plaque. Laboratory test for ANA and Anti-dsDNA were ordered and the results were 335 IU/ml and 12 IU/ml, respectively. The patient was then administered hydroxychloroquine, loratadin, and flucinolone acetonide as the treatment and referred to pediatric department for further examination.

Conclusion: Dermoscopy results showing telangiectasia and hyperpigmented lesions certainly confirm our diagnosis of DLE and laboratory examination showed an increase in ANA and Anti-dsDNA level. This result might support our hypothesis that DLE could be considered as the cutaneous precursor of SLE, supported by its practicality and accuracy, dermoscopy is an important diagnostic tool, to confirm the power of DLE in predicting the occurrence of SLE, further studies with bigger sample must be done.

Keywords: DLE, SLE, dermoscopy, erythematous plaque

PS- 2

COMPARISON OF QUALITY OF LIFE ON PRECLINICAL AND CLINICAL MEDICAL STUDENTS IN UNIVERSITAS PELITA HARAPAN

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Background: Medical students learn to attend to the quality of life of patients during the course of their education. However, their own quality of life may decrease in medical school. Few studies found significant difference of quality of life between preclinical and clinical students, others found otherwise as there was improvement in medical education curriculum. The aim of this study was to assess the quality of life of medical students in preclinical and

clinical education, and to explore their influencing factors. The hypothesis of this study was students in preclinical education have higher quality of life compared to clerkship students.

Materials and methods: A cross-sectional study was conducted in February and March 2018. The study population was composed of 389 medical students in preclinical and clinical education at Universitas Pelita Harapan. WHOQOL-BREF instrument was used to assess the quality of life of preclinical and clinical students. Results were analyzed by SPSS 22 using Mann – Whitney U and Kruskal – Wallis.

Results: Based on the statistical review, preclinical students have better quality of life in physical, psychological and environment domains than clinical students (p value = 0.000; 0.000; 0.000). The result shows a significant decrease in quality of life in physical, psychological and environmental domains during the transition phase from pre-clinic to clinic (p value = 0.000; 0.001; 0.004). Moreover, result shows significant relationship between better quality of life in physical, psychological and social domains, and students who have parent working as doctor (p value = 0.017; 0.043; 0.038), also that longer sleep duration (p value = 0,000; 0,000; 0,014; 0.000) and routine exercise 2 to 3 times per week (p value = 0.000; 0.000; 0.002; 0.018) increase the quality of life in all domains.

Conclusion: This study shows significant difference of quality of life on preclinical and clinical students, particularly during the year of transition phase from pre-clinic to clinic.

Keywords: *quality of life, medical students, preclinic, clinic*

PS-3

DRY EYES DIFFERENCES AMONG CONTACT LENSES WEARERS, GLASSES WEARERS, AND EMMETROPES ON MEDICAL STUDENTS

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Background: Dry eyes is a syndrome in which a person eyes doesn't have enough amount of tears to lubricate the eyes. Study suggest that 25% of patient who comes to ophthalmologist complain about dry eyes. Worldwide statistic suggests around 7.4% until 33.7% people has ever experienced dry eyes. One of the risk factor of dry eyes is the use of refractory modalities such as contact lenses and glasses. The use of refractory modalities causing a higher rate of tear film evaporation compares to those who did not use any refractory modalities. The aim of this study to compare dry eyes among contact lenses wearers, glasses wearers, and clinical emmetropes.

Materials and methods: The sample which are medical students requires to fill DEQ-5 questionnaire. The questionnaires will determine whether the sample has dry eyes or not. The data then being evaluated and analyzed to find the relation between dry eyes on contact lenses wearer, glasses wearer and emmetropes eyes.

Results: The results of DEQ-5 questionnaire shows that 4 from 23 (17.39%) emmetropes respondents have dry eyes, 15 from 23 (62.22%) glasses wearers respondents have dry eyes, and 17 from 23 (73.91%) contact lenses wearers have dry eyes. The results of ANOVA analytical test shows that p-value= 0.000

Conclusion: There is a significance in dry eyes differences among contact lenses wearers, glasses wearers, and emmetropes.

Keywords: dry eyes, contact lenses, glasses, emetropie, DEQ-5

PS-4

CURRICULAR STRATEGY TO IMPROVE THE CAREER CHOICE OF SURGICAL DISCIPLINE AMONG MEDICAL STUDENTS

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Background: We present the findings from a study to assess the difference in perception and preference for surgical discipline between two cohorts of medical students. The purpose of the study was to evaluate the difference in perception, and preference of surgical discipline among freshmen and those that were midway in their medical school training program as well as to evaluate if there were any particular type of learners who preferred surgery.

Materials and methods: Two cohorts one freshmen and the other mid-way in medical school training were selected. The freshmen were given a questionnaire to evaluate their perception of surgical discipline as well as the type of learning they find most useful. The second cohort was administered a questionnaire with the same elements with additional responses to indicate the reason for their choice.

Results: In this study there is a significant increase in the proportion of both male and female medical students who has preference for surgical disciplines as they progressed in their training in medical school. The predominant learning type among those who preferred surgical discipline was those who used visual, kinesthetic as well as auditory learning.

Conclusion: It is our contention that increasing the visual and kinesthetic content of medical school curriculum will significantly

enhance the choice of surgical discipline among medical students.

Keywords: Curricular Strategy, Surgical Discipline, Medical Student

PS-5

CASE REPORT: PILOMATRICOMA ON DELTOID AREA MIMICKING EPIDERMOID CYST

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Background: Pilomatricoma is an uncommon benign skin tumor, typically grown from hair follicle matrix with a very low incidence, recurrence, and frequently displaying a bluish-red discoloration. Epidermoid cyst is the most common benign skin tumor which in some cases has the blue colored appearance.

Thus, pilomatricoma is frequently misdiagnosed and not usually considered as differential diagnoses on benign neoplasms of the skin. This article emphasizes a clinical case of a patient who had pilomatricoma in right deltoid area and its histopathologic features

Case report: 7 years old boy indicated by blue colored lump on his right deltoid area since 3 months ago. His mother admitted about non tender, and mobile lump. No symptoms of cough, fever or malaise before admission. Clinical examination revealed an non tender blue colored mass, mobile, soft consistency with smooth surface and the diameter measured approximately one centimeter. The first diagnosed was epidermoid cyst, then it removed along with the capsule by surgery. Histological examination revealed pilomatricoma.

Conclusion: Because of the difficulty of making a correct diagnosis of this lesions when using clinical examinations, we concluded that histopathologic feature

considered as the gold standard to reduce the misdiagnosis.

Keywords: pilomatricoma, epidermoid cyst, benign skin tumor, histopathologic

PS-6

ATRIAL FIBRILLATION AWARENESS AMONG FIRST YEAR MEDICAL STUDENTS IN INDONESIA

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Background: Atrial fibrillation (AF) a global wide issue due to cardiac arrhythmia, a common matter in Indonesia. Due to irregular contractions (fibrillation) blood in the atrium is not pumped maximally to the ventricle. Although AF is usually asymptomatic, common features such as chest pain, heart attack, shortness of breath and in rare cases sudden syncope occurs, the increased risk for stroke. Therefore, early detection of AF detection will be very useful for tracking stroke especially for those with risk factors: advanced age, high blood pressure, underlying heart disease, athletes with supraventricular tachycardia (SVT). The aim of this study to find out the knowledge of first year medical student about heart health associated with Atrial Fibrillation.

Materials and methods: Cross sectional design study with randomized control trial has been done. The questionnaire which consist of pre-test, review and post-test, 27 questions general knowledge of heart health associated with Atrial Fibrillation was distributed to first year medical student who have not yet passed the cardiology block. With the cut-off of 10 to determine high-low of the participants knowledge. Data was analyzed using Wilcoxon, Chi-Square statistical method.

Results: From 135 participants median age 18 (16-21) years old, 66.7% female and 33.3% male students. 79.3% have heard about

irregular heart rhythm. 85,2% of the participants know how to check their own pulse. In total, 54% of students have advanced knowledge, 32.6% beginner (low score in pre-test, higher score in post test), 11.9% low knowledge, 1.5% answered randomly (high score in pre-test, low score in post-test). Wilcoxon test showed difference between pre-test and post-test, signifies the post-test was valuable.

Conclusions: Most students have heard about heart rhythm disturbances and known the technique to check pulses. Increase of results in post-test showed pre-test has a significant positive correlation between student's knowledge.

Keywords: Atrial Fibrillation, knowledge

PS-7

QUALITY OF LIFE IN INDONESIAN BREAST CANCER PATIENTS

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Background: Breast cancer is reported to have the highest incidence rate for women in Indonesia. From having the cancer itself to receiving treatment, the quality of life for these patients are quite unfavorable because of having effects at physical and psychological. The aim of this study is to assess the quality of life in breast cancer patients receiving chemotherapy treatment in Indonesia.

Materials and methods: A cross-sectional design study using the EORTC QLQ-C30 version 3.0 questionnaire was used to assess quality of life in breast cancer patients in Siloam Karawaci General Hospital in Tangerang, Banten. In this questionnaire consisting of 28 questions with scale of 1-4 and 2 questions with scale of 1-7. The questionnaire assessed functional aspect, symptoms and quality of life of breast cancer patients. An exclusion criteria for this research

are the breast cancer patients with distant metastasis and those who have underwent chemotherapy more than three times. The results were analyzed using SPSS version 24.0 and presented using descriptive statistics.

Results: From the 19 breast cancer patients with an average age of 46.33 (SD=9.48) (28-65), the median score obtained for Physical functioning is 80 (0-100) , Role functioning 83.33 (50-100), Emotional functioning 91.67 (25-100), cognitive functional 100 (33.33-100), Social functioning 83.33 (0-100). Mean scores for Functional scale is 81.56 (SD=15.54) (45-100). Fatigue 51.46 (SD=32.33) (0-100), Nausea and vomiting 16.67 (0-100), Appetite loss 33.33 (0-100), Pain 16.67 (0-83.33). On the other hand, median scores for Dyspnoea, Insomnia, Constipation, Diarrhea and Financial difficulties each have an average score of 0 (0-100). Median score for Symptom scale is 26.54 (0-79.63). Mean score for quality of life is 65.35 (SD=21.38) (25-100)

Conclusion: The Conclusion we got from this study is that patients with breast cancer have good function, minimal side effects, and good quality of life.

Keywords: Breast Cancer, Quality of Life

PS- 8

CASE REPORT: HUMAN GRANULOCYTTIC ANAPLASMOSIS CAUSING FEVER IN PAROXYSMAL NOCTURNAL HEMOGLOBINURIA

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Background: Human Granulocytic Anaplasmosis (HGA), a tick-borne illness caused by *Anaplasma phagocytophilum*, can present as a nonspecific febrile illness with leukopenia and thrombocytopenia. Laboratory findings of Paroxysmal nocturnal hemoglobinuria (PNH) overlap with that of HGA making the diagnosis challenging.

Case: A 70-year-old Caucasian man, with PNH, presented with a 10-day history of generalized fatigue, fever, night sweats and dark-colored urine. He played golf frequently and lived in Parkville, Maryland with no recent travel history or knowledge of tick bite. Physical examination was unremarkable with no evidence of any rash. CBC revealed anemia, leukocytosis with monocytosis and lymphopenia, and thrombocytopenia. A 2-fold increase of AST was found on initial chemistry. He was admitted for PNH crisis, transfused with pRBC, and started on empiric piperacillin-tazobactam injection and vancomycin. Despite those broad-spectrum antibiotics, fever persisted. Subsequent CBC revealed pancytopenia with a severe neutropenia. Infectious disease specialist was consulted, doxycycline was added, and workup for atypical infection was pursued. Sepsis workup including *M. tuberculosis* QuantiFERON, Babesia, Lyme, and West Nile virus were negative. Initial titers for *Ehrlichia chaffeensis* was <1:64 and titers for *Anaplasma phagocytophilum* was 1:128. Bone marrow biopsy was negative for aplastic anemia. He was treated with doxycycline for 21 days and was discharged afebrile with resolution of symptoms. Repeat titers for *Ehrlichia* and *Anaplasma*, 3 weeks post-infection revealed 1:512 and 1:1024 respectively. Three months post-infection, the titers for *Anaplasma* remained high 1:512 while the titers for *Ehrlichia* was <1:64.

Conclusion: HGA as a cause of nonspecific febrile illness in PNH needs to be considered especially in endemic places even without any known history of tick bite. Appropriate workup should be pursued as HGA in PNH can mimic aplastic crisis. The bacteria are transmitted by *Ixodes sp.* and rarely, through blood transfusion. The gold standard for diagnosis of HGA would be at least 4-fold increase in antibody titers measured by an indirect immunofluorescent-antibody assay (IFA) which was present in this patient.

Keywords: human granulocytic anaplasmosis, paroxysmal nocturnal hemoglobinuria, tick-borne disease, pancytopenia, prolonged fever.

PS-9

RELATION BETWEEN BREAKFAST WITH DYSPEPSIA IN PRECLINICAL AND CLINICAL STUDENTS AT THE FACULTY OF MEDICINE UNIVERSITAS PELITA HARAPAN

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Background: The Ministry of Health of the Republic of Indonesia placed dyspepsia in 15th out of 50 diseases with the largest inpatients in Indonesia. Previous research concluded that breakfast can be a factor of dyspepsia. Medical students are known to have a busy schedule and often skip breakfast. Therefore, researcher is interested to find out the relationship between breakfast with dyspepsia in preclinical students and clinical students at the faculty of medicine Universitas Pelita Harapan. The aim of this study to reveal the relation between breakfast with dyspepsia in preclinical and clinical students at the faculty of medicine Universitas Pelita Harapan.

Materials and methods: This study is an analytical study conducted by cross sectional design. The sample is determined by unpaired categoric comparative analytic design. Researchers will interview and retrieve the required data from the medical records of patients and checking the blood sugar level of patients stating willing to be the object of research. The researcher uses breakfast questionnaire and Short – Form Leeds Dyspepsia Questionnaire to assess the subject that is willing to be a part of the study. Result of the collected data is inserted at a table and tested using Chi square method.

Result: The result from 174 respondents shows that student's status ($p=1$) and breakfast ($p=0.245$) don't have a significant relation with dyspepsia. Student's status also doesn't have a relation with breakfast ($p=0.331$).

Conclusion: There is no relation between breakfast with dyspepsia between preclinical and clinical students at the faculty of medicine Universitas Pelita Harapan.

Keywords: *dyspepsia, breakfast, preclinical and clinical medical students*

PS-10

THE EFFICACY OF MOISTURIZERS CONTAINING CERAMIDE IN INCREASING SKIN HYDRATION LEVEL IN MEDICAL STUDENTS OF TARUMANAGARA UNIVERSITY

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Background: Skin hydration (SH) is determined by Natural Moisturizing Factors (NMF), sebum, and hydromicroscopic mixtures of urea, amino acids, and other components. Skin hydration can be measured on the stratum corneum of epidermal layer. Dryness of the skin will occur if the amount of NMF decreases. Moisturizers containing ceramide is also known to have emollient effects, preventing loss of water from the skin surface. The purpose of this study is to evaluate the efficacy of moisturizers containing ceramide to increase SH level.

Materials and methods: This is an experimental observational study with prospective cohort design. The subjects are 30 medical students of Tarumanagara University with dry skin. They were given moisturizers containing ceramide twice a day on their right forearm as intervention for three weeks. Left forearm was set as negative control. The level of SH on the left and right forearms then measured using corneometer before and after routine moisturizers application. The results were analyzed using paired t-test by percentage of SH on both intervention and control groups.

Results: All of the subjects showed increased SH in the intervention forearm. After one week of moisturizers application, the level of SH was significantly increased.

Conclusion: The moisturizers contained ceramide have the effect of increasing SH

level. There were no side effects reported in this study.

Keywords: *Skin hydration (SH), Natural Moisturizing Factor (NMF), Ceramide, Emollient, Corneometer*

PS-11

A CASE OF SEROUS CYSTADENOFIBROMA WITH TORSION

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Background: Ovarian torsion is one of the most common gynecologic emergencies which can affect women of all ages, particularly women of reproductive age. The primary risk factor for ovarian torsion is the presence of an ovarian mass. Ovarian torsion requires prompt diagnosis and treatment by surgery to preserve ovarian function and to prevent life-threatening complications.

Case: We present a case of a 47-year-old woman who presented to the emergency department with severe left lower abdominal pain. Further investigation using transabdominal ultrasound revealed a cystic pelvic mass, suggesting ovarian torsion. The patient underwent exploratory laparotomy and the diagnosis of ovarian torsion was confirmed. Considering that the patient is approaching menopausal age and her wish to undergo sterilization procedure, a left-sided salpingo-oophorectomy was performed. Histopathological examination revealed the mass to be a cystadenofibroma of the serous type.

Conclusion: Ovarian masses, particularly benign tumors larger than 5 cm, is the most important risk factor of ovarian torsion. Serous cystadenofibroma is a rare type of such benign tumors. The mainstay of treatment in ovarian torsion is surgery, which includes ovarian conservation with detorsion, and salpingo-oophorectomy. The choice of treatment ultimately depends on the menopausal status of the patient, the viability of the torted ovary, and the suspicion for malignancy. Salpingo-

oophorectomy is a reasonable treatment of choice in older women who have completed childbearing to completely remove the risk of re-torsion.

Keywords: *cystadenofibroma, ovarian cyst, ovarian neoplasm, ovarian torsion, salpingo-oophorectomy, serous cystadenofibroma, torsion*

PS-12

CASE REPORT : DANDY WALKER MALFORMATION WITH POLYDACTYLY AND NEUROFIBROMATOSIS TYPE 1 IN 6-MONTH-OLD FEMALE

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Background: Dandy-Walker Malformation was first mentioned by Sutton in 1887, but labelled as dandy walker disease in 1954. This is congenital malformation that affects cerebellum development, happens to one in every thirty thousand births, and only very few of them were associated with genetic abnormalities, such as neurofibromatosis. This malformation is characterized by the hypoplasia of the vermis, cystic dilatation of the fourth ventricle, and enlargement of the posterior fossa. It is clinically shown by hydrocephalus and other neurological symptoms in first year of life.

Case: We report a case from pediatric policlinic of a 6-month-old female patient with hydrocephalus since birth, postaxial polydactyly, and numbers of cafe-au-lait spots on the trunk and lower extremities, with most of them measured 0,5 to 1 cm in diameter are found. These found together with low set ears, broad nasal bridge, and depressed nasal bridge. Developmental delay was found, but neurological examination is still within normal limit. CT scan results in Dandy Walker Malformation. Parents denied any family history of neurological and genetic problem, including hydrocephalus, seizure, or dandy walker malformation. Patient was then

referred to neurosurgery department for VP shunt insertion.

Conclusion : Polydactyly and other axial problem shown together with DWM suggested as the *Pierquin Syndrome*, which all patients have normal karyotype. Patients with this syndrome reported to have large head, dolichocephalic, frontal bossing, low set ears, small palpebral fissures, chorioretinal atrophy, posterior embryotoxin, broad nasal bridge, depressed nasal bridge, fleshy tumors of the tongue, cardiac and genitourinary problems, postaxial polydactyly, and neurologic problem consistent with DWM. Even though not all shown in our patient, still Pierquin syndrome has to be in the differential diagnosis. Beside that, five or more Cafe-au-lait spots that found in younger children of at least 0,5 cm in diameter, could diagnosed as NF1, in the absence of cutaneous neurofibromas. Initial operative management of this patient would be VP Shunt and patient will also referred for other conservative management involving the physiotherapy, occupational, speech, and specialized education therapy. The main purpose of therapy is to improve speech and language ability and reduce fall risk.

Keywords : *Dandy-Walker Malformation, polydactyly, neurofibromatosis*

PS-13

FIRST METHOTREXATE THERAPY OF UNRUPTURED TUBAL PREGNANCY IN SILOAM GENERAL HOSPITAL: A CASE REPORT

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Background: Ectopic pregnancy is a term in which the implantation of fertilized egg occurs outside the endometrial lining of uterine. Ectopic pregnancy can happen in cervical (<1%) caesarean scar (<1%), intraligamentous or abdominal (1%), ovarian (3%) and the biggest incidence is tubal pregnancy (95%). There are some complications of tubal pregnancy such as tubal rupture, tubal

abortion, or resolution failure. Surgery is the most common treatment in ectopic pregnancy, however, medical therapy, using methotrexate can be used as the modality of treatment in some certain cases.

Case: This is the case of 33 years old primigravid with unruptured tubal pregnancy that underwent medical therapy using methotrexate treatment. The course of treatment and final result was uneventful. This is the first medical therapy that has been performed at Siloam General Hospital Karawaci-Tangerang.

Conclusion: Methotrexate therapy is safe and can be used in case of unruptured ectopic pregnancy with certain prerequisites. Conservative management using methotrexate is recommended and should be considered when emergency surgery is not needed.

Keywords: *Ectopic pregnancy, tubal pregnancy, methotrexate, conservative management, unruptured ectopic pregnancy*

PS- 14

ATRIAL FIBRILLATION IN PATIENT WITH CORONARY ARTERY DISEASE POST PRIMARY PCI

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Background: Heart disease is predicted as the leading cause of death in the world, with coronary artery disease as the major culprit. It is estimated that 17.3 million deaths happened each year due to cardiovascular disease, in which 42.3% caused by coronary artery disease and 38.3% caused by stroke. Patients with coronary artery disease and atrial fibrillation have increased risk of thrombosis. Comorbidity such as chronic heart failure could complicate treatment, especially on acute condition.

Case: Hence, we present a 55 year-old woman who came to the ED with palpitations and shortness of breath. She has experienced the same symptoms for the last 5 months. She also

complained of fatigue for the last two months. Typical or atypical chest pain were denied by the patient. The patient went through primary PCI one month ago due to STEMI inferoposterior. The patient admitted she discontinued the medication days ago. The laboratory examination showed elevated platelet count (544.000) and high ESR 44 mm/h. Electrocardiography showed atrial fibrillation with rapid ventricular response, right bundle branch block, and old posterior infarct (Q pathologic wave). From the X-ray it can be seen that the patient has cardiomegaly and lung oedema. **Conclusion:** The patient was treated with antiarrhythmic drugs and was prescribed dual antiplatelet therapy and beta-blocker for daily basis.

Keywords: Acute Decompensated Heart Failure, Atrial Fibrillation, Primary PCI, Coronary Artery Disease

PS- 15

TYPE-2 DIABETES MELLITUS PATIENT COMPLICATED WITH KETOSIS

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Background: Condition of elevated ketone concentration in blood with hyperglycemia in patients with diabetes mellitus without acidosis is called diabetic ketosis. Inadequate treatment can make this condition go to ketoacidosis which is an emergency complication of type 1 and 2 diabetes mellitus with characteristic of hyperglycemia, acidosis, high serum ketone, and dehydration. Risk factor of diabetic ketosis include infection, uncontrolled diabetic medication, newly diagnosed diabetes mellitus, and trauma.

Case illustration: Herein, we present the case of a 29 year-old man with type-2 diabetes since 5 year ago, came with symptoms of vomiting > 10 times a day since 3 days before, and fatigue. The patient also had weight loss

for 2 kg in 1 week. There is no depletion of urine volume. Laboratory results shows ketonemia (3 mmol/L), hyperglycemia (Random blood sugar : 307 mg/dL). Blood gas analysis was in normal limit.

Conclusion: The patient was given fluid therapy and insulin, then discharged after 3 days.

Keywords: Ketosis, diabetes mellitus, fluid, acidosis

PS-16

MALIGNANT PLEURAL EFFUSION IN METASTATIC BREAST CANCER

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Abstract: The malignancies responsible for more than 75% of all of pleural effusions in order of frequency are lung, breast, and lymphoma cancer. The treatment for pleural effusion, drainage had been done as initial treatment and pleurodesis sometime can be done

Case Report: A 50 year old woman, with the complaining of shortness of breath. Patient are more comfortable with changing position. Patient's past history revealed that she has been diagnosed with breast cancer in May, 2018 and mastectomy has been done (4 months before admission) and advised to undergo chemotherapy for 8 times. Chest X-ray report revealed opacification of the right thoracic cavity and accumulation of fluid in left lung (meniscus sign), and laboratory liver function showed SGOT 377, SGPT 131.

Conclusion: Patient was first treated for pleural effusion by Water-sealed drainage and then followed by pigtail drainage. The patient died after 6 days of hospitalization, can be thought of respiratory failure due to hypoxemia (fibrotic lung due to metastatic tumor).

Keywords: Pleural effusion, breast cancer, water-sealed drainage, pigtail drainage

PS-17

INTRA ABDOMINAL ABSCESS AS PRECURSOR OF DIABETIC KETOACIDOSIS

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Background: Diabetic ketoacidosis (DKA) was one of the complication of diabetes that might increase the mortality and morbidity. 30-50% of DKAs are caused by infections. Infection caused by intra abdominal abscess increased the insulin demand in the body thus increasing the breakdown of adipose tissue that resulted in ketones.

Case: Hence we presented a case of a 48 years old male who came with pain in his right upper quadrant since 3 weeks prior, characterized as twisting and spread to the whole abdomen. He experienced nausea, dyspnea, bloating, decrease in appetite, and intermittent fever for 2 weeks. He was diagnosed with Diabetes Mellitus for approximately 3 years, uncontrolled blood glucose. No known history of smoking and drinking alcohol. Physical examination showed rhonchi on left upper lobe of the lung, pain with palpation on the whole abdomen especially on the right upper quadrant, positive murphy's sign, positive shifting dullness. Laboratory examination showed normocytic normochromic anaemia, leukocytosis, thrombocytosis, increased ESR, hyperglycemia, ketosis, hyponatremia and hypochloremia. Contrast CT of abdomen showed multiple cholelithiasis with cholecystitis, intra abdominal abscess and bilateral pleural effusion. He was diagnosed with diabetic ketoacidosis with intra abdominal abscess of unknown cause.

Conclusion: He got Insulin therapy, Ceftriaxone, Levofloxacin, and Omeprazole as initial treatment. He was scheduled to undergo laparotomy and thoracocentesis.

Keywords: Intra Abdominal Abscess, Diabetic Ketoacidosis, Infection, Cholecystitis, Cholelithiasis, Pleural Effusion

PS-18

ATRIAL FIBRILLATION WITH RAPID VENTRICULAR RESPONSE, ACUTE KIDNEY INJURY, AND HYPERBILIRUBINEMIA IN MITRAL STENOSIS PATIENT

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Background: Approximately 50% - 70% of patients with symptomatic symptoms of MS have a history of acute rheumatic fever an average of 20 years before symptom onset. Another rarer etiology is endocarditis with extensive vegetation that obstructs valve orifice, and congenital stenosis. Acute and recurrent inflammation due to rheumatic heart disease causes typical pathological features of MS, these include fibrous thickening and calcification of the valve leaves resulting in fusion of valvular commissures, and thickening and shortening of the chordae tendineae.

Case: A 40 year old man came with complaints of shortness of breath that worsened 1 day before entering the hospital. The patient said complaints had existed since 4 months ago. Shortness of breath is felt and aggravated if the patient is engaged in activities. The patient said that while sleeping he used 4 pillows. The patient also said that he had woken up at night because of shortness of breath. The patient complained that his stomach and both legs were swollen since 1 month ago and also decreased urine since 5 days ago. In physical examination the patient had icteric sclera, elevated JVP, positive shifting dullness, and pitting edema over his leg. In laboratory examination showed elevated ureum, creatinine, total bilirubin, direct bilirubin, and indirect bilirubin level. The ECG finding was atrial fibrillation with

rapid ventricular response. The echocardiography showed moderate severe mitral stenosis.

Conclusion: Treatment in this patient includes diuretic, β blockers, and anti-coagulant. Symptoms improve after 5 days of admission, he was hemodynamically stable, and then discharged.

Keywords: *Mitral stenosis, atrial fibrilasi, shortness of breath, edema, acute kidney injury, hyperbilirubinemia*

PS-19

RELATIONSHIP BETWEEN SLEEP DISORDER AND BLOCK'S GRADES AMONG MEDICAL STUDENTS OF BATCH 2015 FACULTY OF MEDICINE UNIVERSITAS PELITA HARAPAN

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Background: The good quality of sleep is there is no sleep disturbance and no sleep problems. The prevalence of sleep disturbance in students is still high enough that leads to decreased concentration of learning and health problems. This can lead to failure to achieve optimal academic achievement because learning becomes impaired. This research is to know sleep disturbance at UPH Medical Faculty student and its relation to learning achievement.

Materials and methods: This research is using cross sectional method and will be conducted on medical student class of 2015 which is undergoing block of Hematology Oncology and was conducted on February to May 2018. This study used questionnaire PSQI (Pittsburgh Sleep Quality Index) and data were analyzed by Chi Square statistic test.

Result: From 125 students of UPH Class of 2015 it is found that most of them have poor sleep quality which is 105 students (84%). The results show a meaningless relationship with *p* value 0,181.

Conclusion: There was no significant relationship between sleep disturbance and block's grades among medical student of batch 2015 Faculty of Medicine UPH.

Keywords : *Sleep disturbance, academic achievement, medical student*

PS-20

ANEMIA DUE TO CHRONIC KIDNEY DISEASE

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Background : Anemia is one of the hematological disorder in which the body has fewer erythrocyte. Anemia can be manifest as a complication of chronic disease. Anemia is one of the most common complication in chronic kidney disease (CKD), because kidney play a major role in erythropoiesis where it secretes erythropoietin, a hormone that generates erythrocyte. In CKD, all of the kidney function deteriorates which causes decreasing erythropoietin production that will lead to anemia.

Case Illustration : A 88- year old female presented to the Emergency Department with lethargy since 2 days prior. The patient's said that it's hard for her to walk more than 15 steps and doing daily activities because of the lethargy. Aside from the lethargy, the patient's also said that her leg tend to swollen if she sit for about 2 hours. The patient's had a history of hematuria for 3 days 2 years ago. The patient's was diagnosed with hypertension since 2013 and diabetes mellitus since 2004 and well controlled. On physical examination, there is an increase blood pressure (140/80 mmHg) and pitting edema in both of the patient's lower extremities, other than that everything was within normal limit. Laboratory results showed low value of Hb (5.5 g/ dL), erythrocyte (2.01 x 10⁶ μ L), albumin (3.18 g/dL), eGFR (22.0 mL/mnt/1.73

m²), and high value of creatinine (1.98 mg/dL).

Conclusion: The patient was then diagnosed with Chronic Kidney Disease with anemia and given 1,500 cc of Packed Red Cell transfusion.

Keywords : Anemia, Chronic Kidney Disease, Anemia of Chronic Disease, Blood Transfusion

PS-21

ABNORMAL UTERINE BLEEDING DUE TO LEIOMYOMA UTERINE

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Background : Leiomyoma uterine or also known as uterine fibroids are benign growths that develop from the muscle tissue of uterus. The growth can occur inside the uterus, on its outer surface or attached to the lining a stem-like structure. It is thought to be the most common benign tumor of female reproductive organs, with a prevalence of 70 – 80% in women who reach the age of 50.

Case Illustration : A 39-year-old female presented to the Obstetrics and Gynecology outpatient clinic for prolonged menstruation since 1.5 years ago. Within the past year, the patient's menstrual cycle always lasts for more than 15 days each month followed with large amount of blood each day. Aside from the abnormal bleeding, the patient also complained for a mass on the hypogastric region and a painful sensation around the lower abdomen since 3 months ago. Other complaints include lethargy, nausea and loss of appetite. On physical examination, vital signs were within normal limits, but the conjunctiva was anemic. Abdominal examination revealed pain while being palpated and dull on percussion in hypogastric area. A solid, mobile mass with regular margin was also palpated in hypogastric area. The laboratory results showed low value of Hb (4.9 g/dL) and MCV (58.6 fl). Ultrasound examination showed mass suspected to be

leiomyoma uterine of about 10 cm in diameter.

Conclusion: The patient was then diagnosed with Leiomyoma Uterine with anemia and given 750cc of Packed Red Cell transfusion before undergoing total abdominal hysterectomy with bilateral salpingo-oophorectomy.

Keywords : Abnormal Uterine Bleeding, Leiomyoma Uteri, Microcytic Normochromic Anemia, Blood Transfusion

PS-22

LIFE THREATENING ANEMIA

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Background: The prevalence of anemia is growing especially in individuals above the age of 65 years. Anemia itself has myriad of causes, many studies have been investigating between anemia and aging. Recent studies have shown that the most common cause of anemia in older patients include anemia due to nutritional disease, CKD, and chronic inflammation. However, the cause of anemia has remained unexplained in one-third of elderly patients with anemia.

Case Report: A 67 year old man, with no history of hypertension, diabetes, renal disease and other chronic diseases, came to the emergency department due to weakness in his whole body. The patient also complains feeling of breathlessness every time he moves too much, palpitation and dizziness. The patient denies having sudden loss of weight within these past few months, having easily bruised, nosebleeds, blood in the urine and blood in the feces. Furthermore, the patient admits of being hospitalized 4 times these past few months due to anemia. Laboratory examinations showed Hb 4.7, Ht 13.7, MCV 88.4, MCH 30.3, MCHC 34.3, RBC 1.55, Thrombocyte 444.000, Cr 1.40, Na 135, Cl 97 and eGFR 51.6. Stool exams are all within normal limits.

Conclusion: The patient was first treated with blood transfusion, but the cause of the patient's recurrent anemia has not been found. Further investigation is still needed to confirm the cause of anemia in this patient.

Keywords: Anemia, CKD, Hypertension, Diabetes

PS-23

EFFECT OF DIABETES MELLITUS ON SPUTUM SMEAR CONVERSION IN PULMONARY TUBERCULOSIS ON INTENSIVE PHASE OF CATEGORY I THERAPY AT RSU SILOAM LIPPO VILLAGE PERIOD 2015-2017

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Background: Indonesia is the fifth highest country with tuberculosis (TB). The number of deaths caused by TB is far too great considering the fact that tuberculosis can be prevented and treated. In the last few decades, the prevalence of TB and diabetes mellitus (DM) has increased. Diabetics have a 2 to 3 times higher risk of developing tuberculosis. Sputum smear conversion rate is one of the indicators to assess the progress and success of TB control. Factors such as hyperglycemia or diabetes mellitus had been reported to have an effect on sputum smear conversion. The purpose of this study was to determine the effect of diabetes mellitus on sputum smear conversion on intensive phase of category I therapy.

Materials and methods: This study used a qualitative analytical retrospective cross-section that compares the sputum smear conversion of TB patients with and without diabetes mellitus through the patient's medical record data in RSU Siloam Lippo Village period 2015-2017. The obtained data will be analysed by Chi Square test or Fischer test method.

Result: There are a total of 56 subjects. Data shows from 35 subjects experiencing sputum smear non-conversion with 27 of these

subjects (96,4%) have diabetes mellitus. There were 21 patients experiencing sputum smear conversion with 20 (71,4%) of them had no diabetes mellitus. Diabetes mellitus has an effect on sputum smear conversion result at RSU Siloam Lippo Village period 2015-2017 with significant result p-value 0,000

Conclusion: Diabetes mellitus has a significant effect (p = 0,000) on sputum smear conversion in pulmonary tuberculosis on intensive phase of category I therapy at RSU Siloam Lippo Village period 2015-2017.

Keywords: pulmonary tuberculosis, diabetes mellitus, sputum smear conversion test

PS-24

ASCITES MANAGEMENT IN END STAGE LIVER CIRRHOSIS

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Background: Ascites is the most common complication of cirrhosis with approximately 58% of patients will have developed ascites. Management of patients with ascites in end-stage cirrhosis is becoming more common in palliative care.

Case: Hence we present the case of a 35 years old Asian Male, with main complaint of distended abdomen 1 week prior to hospital admission. He experienced fever, bloating, nausea and decrease in appetite, and fatigue for the entire week. He was diagnosed, at the age of 33 years old with Liver Cirrhosis caused by Chronic Hepatitis C infection, with Child-Turcotte-Pugh B. Physical examination showed massive ascites with positive shifting dullness and 98cm for abdomen circumference accompanied by pretibial pitting edema, icteric sclera, pale conjunctiva, jaundice and crackles on both side of the lungs. Laboratory examination showed Anemia microcytic hypochromic, thrombocytopenia, leukocytosis, hypoalbuminemia, hyponatremia, hypokalemia, hypochloremia and decrease of eGFR. Abdomen Ultrasound confirms the

diagnosis of liver cirrhosis and ascites, while Chest X-Ray confirms the suspicion of Pleural Effusion at the right lung pleura. The patient was treated with palliative care and symptomatically, while still considering for invasive diagnostic and treatment procedures such as; large volume paracentesis, pleural puncture, indwelling peritoneal catheters, or Transjugular Intrahepatic Portosystemic Shunt.

Conclusion: Decision making should be influenced by best practices, as well as the patient's goals of care, prognosis, and burden of disease.

Keywords: Ascites, Child-Turcotte-Pugh, Liver Cirrhosis.

PS-25

ACUTE KIDNEY INJURY ON HYPOVOLEMIC ACUTE GASTROENTERITIS

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Background: Acute kidney injury is defined by the abrupt decrease in kidney function (<48h) resulting in retention of urea and other nitrogenous waste products and in the dysregulation of extracellular volume and electrolytes. Multiple studies from 2006 till 2017 shows there is some increase in number of incident of AKI worldwide as well as in southeast Asian population.

Case: We herein describe the case of a 71 years old woman with acute kidney injury caused by hypovolemic acute gastroenteritis. She came to the emergency department with history of diarrhea and vomiting since 1 day before. She never been diagnosed nor there is no data regarding the condition of her kidney before. On physical examination, sign of dehydration such as dry mucous and decrease skin turgor can be seen in this patient. Hematology investigation showed no sign of infection with WBC $10,27 \times 10^3/\mu\text{L}$ but the

ESR shows there is some inflammation as it appear to be 40mm/hours. Kidney function investigation showed ureum 76 mg/dL, creatinine 3,11 mg/dL and eGFR 19,1 mL/ment/1,73m². Despite she had history of severe diarrhea and vomiting, electrolyte investigation showed no abnormalities. She was then treated with immediate fluid resuscitation, new diatab, and ceftriaxone 2g IV that followed by increase in eGFR and decrease in ureum and creatinine.

Conclusion: She got discharged at the 3rd day as the general appearance back to normal and as a consideration for avoiding more kind of hospital infection.

Keywords: Acute kidney injury, acute gastroenteritis

PS-26

THE AWARENESS AND CURIOSITY ABOUT CPR AND AED ON FIRST YEAR MEDICAL STUDENT

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Background: Cardiovascular disease is one of a leading cause of mortality, in which cardiac arrest is one of them. However, bystander could help by performing cardiopulmonary resuscitation (CPR) and using AED. AED is a lightweight, portable device that delivers electrical shock to stop arrhythmia and prevent sudden cardiac death which can be found in public places or first- response vehicles. This study aims to find out the awareness and curiosity of first year medical student on saving lives with CPR and AED.

Materials and methods: A cross sectional study with randomized controlled trial has been done and the data was collected from first year medical student who have not yet passed the cardiology block, by filling in a questionnaire. The questionnaire consisted of 7 questions about CPR and AED. All the results were presented using descriptive statistics.

Results: 146 respondents were obtained, with median age 18 years old. 67.1% were female

and the rest were male. Only 30.1% aware about CPR while others do not. Furthermore, 11% of the student had received CPR training. 76.7% of the student believe that CPR could save lives, while others do not. Meanwhile, 53.4% aware about AED, while 46.6% of them do not. 20.5% convinced their ability to use AED while 62.3% didn't know and 17.1% were unsure. 6.1% said that AED should be seen at school, 13.4% in mall, 14.5% at the terminal, 15.6% at station, 20.1% at the airport, 30.2% at the hospital. Within their knowledge about AED and CPR, 56.2% would call for help and perform the CPR while 41.8% would only call for help and 2.1% would just pass by, when in emergency situation.

Conclusion: From this study, one can conclude that majority of the first year medical student do not know about CPR as well as AED and have not received any training. Although they admit performing CPR can save lives. According to them, AED must be present in hospitals and half of them would perform CPR in emergency situation. This point out that first year of medical students has low awareness and curiosity about CPR and AED.

Keywords: *Cardiopulmonary Resuscitation, Automated External Defibrillator, Awareness*

PS-27

NON MASSIVE HEMOPTYSIS IN PATIENT WITH TUBERCULOUS PLEURITIS

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Background: The aim of this case report is to reveal a new case of Tuberculosis

Case: Hence we presented a case of a 38 years old female who came to the emergency department with hemoptysis approximately 150 ml of bright red blood 3 hours prior. She experienced cough with green sputum, continuous fever with night sweating since 1

month prior. The patient also felt nausea since 1 day prior, but there is no vomiting. She also experienced fatigue and decrease appetite that leads to weight loss since 1 month prior. She denied headache, loss of consciousness, shortness of breath, chest pain, and other sources of bleeding. The patient's husband is an active smoker for 20 years who smokes approximately 24 cigarettes a day. She denied drug consumption for a long time and family history of any kind of cancer. On physical examination, the patients was hypotensive and had pale conjunctiva. His lungs were clear to auscultation. The remainder of his physical examination was within normal limits. Laboratory examination showed microcytic hypochromic anaemia, leukocytosis, elevated AST, elevated ESR, mild hyponatremia, mild hypokalemia, and hypochloremia. Chest x-ray was obtained and revealed left pleural effusion with widening of right hilum. Acid Fast Bacilli was not found on first, second, and third sputum specimens. Pleural fluid analysis has not been done. She was diagnosed with tuberculous pleuritis with negative AFB, new case.

Conclusion: The patient was treated with Vitamin K, Tranexamic Acid, Ceftriaxone, Codeine, Paracetamol and 4FDC as initial treatment. She was scheduled to come back to outpatient department for follow up next step of management in 2 weeks.

Keywords : *non massive hemoptysis, tuberculous pleuritis, tuberculosis, infection, microcytic hypochromic anaemia*

PS-28

HYPOGLYCEMIA IN DIABETES MELLITUS TYPE II

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Background: Hypoglycemia is most frequent in people with type 1 diabetes, followed by people with type 2 diabetes managed by insulin, and people with type 2 diabetes managed by antihyperglycemic, like sulfonylureas. Hypoglycemia can occur during exercise or fasting, and depressed insulin levels. Hypoglycemia can be severe and result in confusion, coma or seizure. This symptom occurs when glucose drops further, and neuroglycopenic symptoms also occur from the direct effects of hypoglycemia on CNS function. Older adults with diabetes have a disproportionately high number of clinical complications and comorbidities, all of which can be exacerbated and contribute to episodes of hypoglycemia. The goals of treatment for hypoglycemia are to detect and treat a low blood glucose level promptly by using an intervention that provides the fastest rise in blood glucose to a safe level, to eliminate the risk of injury and to relieve symptoms quickly. Over treatment of hypoglycemia should be avoided because it can result in rebound hyperglycemia. The aim of this case report is to know the management of hypoglycemia in diabetes mellitus type 2 patient.

Case: A 66 year old women, with a chief complaint of decrease consciousness. She also experience nausea and vomiting, fatigue, shaking all over body before unconscious. There is loss of appetite complain for three days, and she only eat 3-5 spoon per meal. She recently found out that she has diabetes mellitus type 2 since one weeks ago and treat with unknown oral antihyperglycemic agent. Patient have low random blood glucose level 21 mg/dl. Random blood glucose level become 188 mg/dl after administration of

dextrose 40% intravenous bolus injection. She also receive maintenance dose of intravenous dextrose 10% 500cc for 8 hours and antiemetic.

Conclusion: Treatment in this patient follows hypoglycemia guideline. Symptoms improve after 3 days of admission, she was conscious, hemodynamically stable and then discharged.

Keywords : Hypoglycemia, diabetes mellitus type 2, unconsciousness, treatment diabetes mellitus type 2

PS-29

HEART FAILURE WITH CONGESTIVE LIVER DISEASE

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Background: Moderate or severe right-sided heart failure increases central venous pressure, which is transmitted to the liver via the inferior vena cava and hepatic veins. Chronic congestion leads to atrophy of hepatocytes, distention of sinusoids, and centrilobular fibrosis, which, if severe, progresses to cirrhosis (cardiac cirrhosis). The basis for liver cell death is probably sinusoidal thrombosis that propagates to the central veins and branches of the portal vein, causing ischemia. Most patients are asymptomatic. However, moderate congestion causes right upper quadrant discomfort (due to stretching of the liver capsule) and tender hepatomegaly. Severe congestion leads to massive hepatomegaly and jaundice. Ascites may result from the transmitted central venous hypertension; infrequently, splenomegaly results. With transmitted central venous hypertension, the hepatojugular reflex is present, unlike in hepatic congestion due to Budd-Chiari syndrome. The aim of this case report is to know the characteristics of cardiac cirrhosis

Case Illustration: A 55 year-old man came to the hospital with right upper quadrant pain since 2 weeks before admission. Characteristic

of the pain was intermittent and radiated to epigastric and right lumbar region. He reports that he feels fullness and general weakness especially after walk around 15 meters. He had history of blood transfusion 9 months before admission. The patient is an active smoker with about 20 cigarettes per day since he was 17 years old. On clinical examination vital signs were within normal limits, but a pallor conjunctiva, enlargement of the heart's margin, hepatojugular reflex is present, hepatomegaly 3 fingers below costal arch for the right lobe and 3 fingers below xiphoid process, right hypochondriac region was painful on palpation and dullness on percussion, positive shifting dullness, and peripheral pitting edema. Laboratory findings showed Hb (7.4 g/dL), Ht (24.4%), RBC ($3.58 \times 10^6/\mu\text{L}$), MCV (68.2 fL), MCH (20.7 pg), MCHC (30.3 g/dL), ECG showed old myocardial infarction with LBBB, Radiologic findings showed liver congestive with ascites on ultrasound examination, cardiomegaly with aortic elongation.

Conclusion: The working diagnosis is heart failure with congestive hepatopathy although the patient still requires further examination such as CT-Scan and echocardiography in order to rule out the differential diagnosis

Keyword: Heart Failure, Congestive Hepatopathy, Ascites, Cardiac Cirrhosis, Anemia

PS-30

CHRONIC IDIOPATHIC THROMBOCYTOPENIC PURPURA (ITP)

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Background: Idiopathic Thrombocytopenic Purpura (ITP) is a clinical hematologic disorder in which there is isolated thrombocytopenia without a clinically apparent cause. It is a condition in, which there is bruising (purpura). The major causes could be immune thrombocytopenia, decreased bone marrow production, and increased splenic sequestration. A normal

platelet count is between 150.000 – 400.000 for any age. A platelet count less than 150.000 is called thrombocytopenia. The clinical presentation may be acute with severe bleeding, or slow development with mild or no symptoms. ITP occurs in 2 to 4/100.000 adults and results in variable bleeding symptoms. The initial laboratory tests are useful including erythrocyte count, leukocyte count, and platelets. The treatment should be avoid drugs that reduce platelet adhesiveness (e.g salicylates, antihistamines, NSAIDs). The aim of this case report is to know the characteristics of Idiopathic Thrombocytopenic Purpura in patient with anemia.

Case Illustration : A 27-year-old female presented to the emergency department for severe fatigue. 2 days prior to presentation she developed diarrhea for 3 times with blood but no mucus. One week prior she was having a petechial spots over the both hands, feet and face. She also had a complaint of gum bleeding accompanying his fatigue and petechial spots. The symptoms occurred especially when she is in a stress state. The patient admitted that she has a past medical history of anemia since one year ago after delivering her second baby. She denied any nausea, vomits, fever, joint pain, hair loss, or any alteration in menstruation. She was diagnosed with Idiopathic Thrombocytopenic Purpura (ITP) since 3 months ago and received a routine transfusion. On physical examination, the patient was conscious, vital signs were normal, conjunctiva anemic, petechial purpuric rashes on both extremities and face. No organomegaly or lymphadenopathy or evidence of chronic liver disease was detectable. The laboratory results showed low value Hb (5.1g/dl), low RBC (1.9×10^6), low platelet count (2.000), increase ESR (120mm/h), MCV (84.2 fl), MCH (26.8), MCHC (31 g/dl). On electrophoresis Hb was remarkable. Abdomen USG showed no evidence of hepatosplenomegaly.

Conclusion: She was then diagnosed with Idiopathic Thrombocytopenic Purpura (ITP) with Normocytic Normochromic Anemia and acute diarrhea without dehydration and has

been treated with Methylprednisolone 2 x 125 mg IV also Packed Red Cell transfusion 750 ml, Fresh Frozen Plasma 1000 ml, TC Apheresis 303 ml, Vitamin K 1x10 mg IV, NaCL 0,95 500 ml/8 hours.

Keywords : *Idiopathic Thrombocytopenic Purpura (ITP), stress state ,Normocytic Normochromic Anemia , routine transfusion.*

PS-31

HYPOKALEMIA, ANEMIA, ORAL CANDIDIASIS, PULMONARY TUBERCULOSIS IN HIV CO-INFECTED PATIENT

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Background: Opportunistic infections can occur more frequently and more severe in patients with HIV. Infection in HIV may lead to alterations in cytokine production with subsequent effects on hematopoiesis, resulting in anemia. In addition, water and electrolyte disorders are bound to happen due to alterations in renal physiology and exposure to infections, inflammations, endocrine disorders further worsen clinical conditions. Combinations of several medications have impact towards homeostatic capability as well. Here we will discuss the clinical disorder and multiple infection treatment of patient with HIV

Case: A 27 year old woman came with the complaint of general weakness. Other symptoms include nausea, loss of appetite, odynophagia, weight loss and persistent cough. Past history revealed that she had been diagnosed with untreated HIV in 2015 and pulmonary tuberculosis in 2017. She had been treated with TB medication however incomplete. On physical examination, the patient was underweight, had pale conjunctiva, oral thrush, and rhonchi on both lungs. Laboratory examination showed normocytic normochromic anemia, leukopenia, increased

ESR, and hypokalemia. Chest x-ray found no radiographic abnormalities.

Conclusion: Patient was first treated for hypokalemia, given antifungal, followed with TB medication. After 6 days, she was clinically stable and thus discharged.

Keywords: *HIV, hypokalemia, opportunistic infection, pulmonary TB, oral candidiasis, anemia*

PS-32

ACUTE RESPIRATORY DISTRESS SYNDROME IN DIABETIC KETOACIDOSIS

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Background: Acute respiratory distress syndrome is a rare but potentially fatal complication of diabetic ketoacidosis which may lead into respiratory failure. Conditions not caused by DKA that can worsen respiratory function under the added stress of DKA include infections of the respiratory system, pre-existing respiratory or neuromuscular disease and miscellaneous other conditions. Thus, early diagnosis and proper treatment are necessary for the prevention of life-threatening complications. This case is presented to discuss a rare case of Acute respiratory distress in patient with Diabetic Ketoacidosis.

Case illustration: A 40 year-old woman with history of uncontrolled type-2 diabetes since 3 years ago, came with history of persistent vomiting and lethargy associated with thirst and polyuria. Her random blood glucose was 500 mg/dl. Clinical examination revealed her to be moderately dehydrated with a tachycardia of 110 beats/min and blood pressure 130/80 mmHg. She was dyspneic with a respiratory rate of 30 breaths/min, the pattern of breathing was characteristic of Kussmaul respiration. Laboratory investigations showed a metabolic acidosis with arterial blood gases pH 7.00, bicarbonate

2.7 mmol/L, base excess -30.4 mmol/l. From the result of her urinalysis, 40 mg/dl of ketone & 1000 mg/dl of glucose were found.

Conclusion: She was admitted to ICU and given mechanical ventilator along with fluid & insulin therapy. After 10 days of admission, her conditions clinically improved thus she may be discharged.

Keywords: ARDS, diabetes mellitus, ICU, ketone, Kussmaul

PS-33

ENTERIC FEVER

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Background: Enteric fever is an infection caused by *Salmonella typhi* (typhoid fever) or *Salmonella paratyphi* (paratyphoid fever). Enteric fever is most prevalent in impoverished areas that are overcrowded with poor access to sanitation where food and water is contaminated by the feces and urine of the infected person. Each year, there are around 22 million cases and 200.000 related deaths worldwide due to *Salmonella typhi*. Diagnosis is made clinically, widal test, and by blood culture. Typhoid fever has a case fatality rate of 10-30% but is reduced to 1-4% in those receiving appropriate therapy. This case will discuss about Enteric Fever and the management of the disease

Case: A 28-year-old woman came to emergency department with history of prolonged fever for the last 9 days. She has step-ladder pattern of fever and have taken paracetamol and did not respond. She also experiences malaise, headache, nausea and vomiting, and abdominal pain. She also has history of appendectomy in 2016. The physical examination revealed coated tongue, tenderness in the right hypochondriac and epigastric region. The liver and spleen were not palpable. On laboratory examination, there are leukocytosis and lymphopenia.

Conclusion: She was then treated with antibiotics, antipyretics, and antiemetics. After 2 days, she was stable and then discharged.

Keywords : enteric fever, typhoid fever, paratyphoid fever, prolonged fever, coated tongue

PS-34

HEART FAILURE AND CARDIORENAL SYNDROME

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Background: Cardio-Renal Syndrome is a renal dysfunction occurring in patients with congestive heart failure. Patients with Cardio-Renal Syndrome often associated with significant morbidity and mortality. The aim of this Case report is to show the correlation of heart failure with Cardiorenal Syndrome

Case Illustration: A 78 years old man presented to the Emergency Department with complaint of shortness of breath worsened 1 day before admitted to the hospital. He also has dyspnea on exertion and orthopnea. He has history of uncontrolled hypertension and chronic kidney disease. On physical examination, bilateral rhonchi was found on auscultation, increased jugular vein pressure was found, and edema were found on both lower extremities. Laboratory results show increased creatinine serum (2.32 mg/dL) and eGFR (25.9) Chest radiography showed cardiomegaly and bilateral pleural effusion. Ultrasound whole abdomen showed bilateral chronic kidney disease and ascites.

Conclusion: He is diagnosed as Cardiorenal Syndrome type 2 and was treated with Furosemide, Aspilet, Lisinopril, and Spironolactone.

Keywords: Heart Failure; Cardiorenal syndrome

PS-35

HYPOKALEMIA IN CHRONIC DIARRHEA PATIENT

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Background: Hypokalemia is the most common electrolyte disorder in clinical practice. It is not a disease but a finding associated with various disease. The prevalence of potassium disorders are very high. Hypokalemia with serum potassium levels of less than 3.6 mEq/ L occurs in 21% of hospitalized patients and 2% to 3% of outpatients. Rapid identification of underlying causes of hypokalemia with appropriate management is still challenging. One cause of hypokalemia is diarrhea. Diarrhea is one of the most common symptoms that takes patients to doctors. These symptoms can interfere with the quality of life, performance, and well being of patients. It is estimated that the prevalence of chronic diarrhea only ranges from 3-5%. This case report will discuss the possible pathology and management of hypokalemia in patient with Diarrhea

Case Illustration : An 18- year- old male patient presented to the emergency department for severe general weakness that worsen since 2 days ago. He describe his weakness started from the legs and ascended towards the body and hands. He developed diarrhea 4 weeks prior to the presentation, which eventually became chronic. The watery stool was not accompanied with mucus or blood. There was no vomit, weight loss, fever, and stomach pain. He also denied eating any raw food, drinking dirty water, being on a diet/fasting, nor taking certain medications including insulin. On physical examination, the patient was compos mentis, vital signs were normal, head to toe examination was unremarkable, there was no evidence of paralysation of the cranial nerves. However, the patients motoric strength on all extremities had full joint

movement against gravitation but could not resist any resistance. The laboratory results showed leukocytosis ($10,68 \times 10^3/uL$) and hypokalemia (1,5 mmol/L). The patients blood glucose level and complete blood count examination was within normal limits.

Conclusion: He was diagnosed with severe hypokalemia due to chronic diarrhea and has been treated with KCL and RL fluids to correct his electrolyte imbalance and was scheduled for a colonoscopy.

Keywords: hypokalemia, chronic diarrhea, weakness.

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WARFARIN-INDUCED SUBDURAL HEMATOMA IN HYPERTHYROID PATIENT WITH ATRIAL FIBRILLATION

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Background: Thyroid dysfunction can cause many organ dysfunctions, some of them are coagulopathy and fibrinolytic dysfunction. Patients with hypothyroidism have higher risk of bleeding, while hyperthyroidism has higher risk of thrombosis. Therefore, anticoagulant has important roles in preventing thromboembolism, especially in hyperthyroid patients with atrial fibrillation. However, the commonly used anticoagulants, warfarin, also increase risk of bleeding especially in patients with poor monitoring and control status. With increasing number of patients with hyperthyroidism, which increased risk of atrial fibrillation and thrombosis, prophylaxis therapy and monitoring are both important subjects to be considered.

Purpose: This case report aims to present the clinical manifestation and management of patient with warfarin induced Subdural Hematoma

Case: Herein, we present the case of a 30-year-old woman with Grave's disease who had subacute subdural hematoma associated with

warfarin-induced coagulopathy, atrial fibrillation, pericardial effusion, and congestive liver disease. She has history of recurrent ischemic stroke in the past 3 months and currently using three milligrams warfarin, once daily, as a prophylaxis for thromboembolism. Came with convulsion as presenting symptoms and INR 7.35. She was then treated with anticonvulsants, antibiotics, diuretics, vitamin K, and transfusion with 600 mL fresh frozen plasma.

Conclusion: After 9 days of admission, she was hemodynamically stable, free of seizure, with hyperbilirubinemia, and then discharged.

Keywords: Warfarin, coagulopathy, subdural hematoma, hyperthyroidism, atrial fibrillation, anticoagulation, pericardial effusion, congestive liver

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HYPERKALEMIA IN PATIENT WITH ACUTE DECOMPENSATED HEART FAILURE WITH PREVIOUS STEMI POST CORONARY ARTERY BYPASS GRAFTING

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Background: Acute decompensated heart failure has become a major health issue with increasing prevalent. Often times, heart failure also followed by hyperkalemia. Among patients hospitalized for any cause, the prevalence of hyperkalemia has been estimated at 1 – 10%, with 2 to 3 time higher in patients with heart failure. Disorders of potassium homeostasis, hyperkalemia particularly, can potentiate even further the elevated risk of arrhythmia in heart failure. Therefore, it is important to adequately and carefully manage the factors that can interfere with potassium levels, and to early treat hyperkalemia.

Purpose: The purpose of this case report is to disclose a case and management of Hyperkalemia in patient with acute

decompensated heart failure with post coronary artery bypass.

Case: A 63-year-old man presented to the emergency department with dyspnea that worsens since 1 week ago. Dyspnea aggravated with activity and lying down. This symptom followed by productive cough with clear sputum. She claims need 3 pillows to sleep at night. Furthermore, the patient experienced decreasing in urine volume in the past 1 week, without changes in drinking volume routine. Moreover, she concede feeling full of the abdomen, which causing decreased in appetite. Additionally, she also admitted there was bilateral edema on her legs. Palpitation, nausea, and vomit are denied. The patient has undergone Coronary Artery Bypass Grafting (CABG) five years ago (2013) when diagnosed as STEMI. On physical examination, the blood pressure slightly increased with other vital signs are within normal limits, increased jugular venous pressure, and positive hepatjugular reflex. Thorax examination revealed decreased tactile fremitus bilaterally, dull on percussion on the base of the thorax, decreased vesicular sound with rhonchi bilateral. On abdominal examination found ascite and on extremity there was pretibial pitting edema bilateral. The laboratory results showed low decreased hemoglobin level (11.0 g/dl) and erythrocyte count (3.93×10^3 /uL), high ESR (67 mm/h), and elevated potassium level (5.4 mmol/L). Electrocardiography showed pathological Q wave on lead III, flattened T wave on lead II, and inverted T wave on lead avL indicated unspecific old myocardial infarct. On chest x-ray it can be seen there was cardiomegaly with elongation and calcification of the aorta.

Conclusion: The patient was treated with diuretic, lipid-lowering agent, anti-platelet, anti-hypertension, and natrium bicarbonate.

Keywords: Hyperkalemia, Acute Decompensated Heart Failure