epiglottitis, and primarily sublingual and submandibular swelling. A size 6 cuffed oral endotracheal tube (ETT) was passed over the scope but the cuff was not inflated (fig 1B). The patient experienced no chest pain or ECG changes during intubation, and systolic blood pressure remained between 120 and 135 mmHg.

Over night on in the intensive care unit, the patient received dexamethasone and minimal sedation. His ETT cuff remained deflated and he breathed spontaneously with continuous positive air pressure at 10 cm H₂O. Upon review in the morning, the haematoma was stable and the patient was able to talk around his ETT. He was therefore extubated uneventfully.

DISCUSSION

Of the few reported cases of haemorrhage into the subcutaneous neck tissues post-thrombolysis, none were linked with tenecteplase. The ASSENT-2 study¹ compared the efficacy and safety of tenecteplase to the more commonly used alteplase. The findings were that the 30 day mortality rates were almost identical (6.18% for tenecteplase and 6.15% for alteplase) but that there were fewer non-cerebral bleeding complications following tenecteplase (26.43% v 28.95%, $p=0.0003$). As with any thrombolytic agent, caution is advised with its administration following trauma. Overenthusiastic jaw thrust can lead to soft tissue trauma and even result in jaw dislocation.

Of the five other documented cases, three required endotracheal intubation.²⁻⁴ Two of these cases were not associated with any trauma,^{2,3} but the other cases were associated with a preceding localised trauma. The trauma was very specific in two cases; tongue biting resulting in lingual haematoma⁵ and laceration with Magill's forceps leading to uvular haematoma.⁶ The tenuous history of trauma in our case and its cautionary significance for thrombolysis would only be picked up upon if actively sought. If a history of this nature is elicited, while not contraindicating thrombolysis, it should lead to subsequent close observation of the patient (on the high dependency/intensive care unit).

How and when do you manage the airway in these patients? Causing stress, pain, and tachycardia on the background of a recent MI is obviously undesirable. Further bleeding due to a traumatic intubation secondary to distorted anatomy could lead to total airway obstruction. In our case, a nasal intubation would have been preferable, but the risk of bleeding and possible laryngospasm favoured the oral route. We decided to intervene and protect the airway pre-emptively rather than risk further compromise and have to carry out a physiologically stressful and dangerous intubation later. In such cases, an experienced surgeon who is able to perform a surgical tracheostomy should be readily available in the event of a failed intubation. The intubation itself should be carried out by an anaesthetist who is experienced in difficult airway techniques.

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IMAGES IN EMERGENCY MEDICINE

Cocaine induced non-ST-elevation myocardial infarction: an uncommon electrocardiographic presentation

The incidence of myocardial infarction in cocaine associated chest pain is approximately 6%.¹ The most common cocaine induced electrocardiogram changes are non-specific ST segment changes, ST segment elevation, T wave inversion, and QT interval prolongation.

A young man was brought to the emergency department after having taken intranasal cocaine. He was agitated, tachycardic, hypertensive, and complaining of substernal, pressure-like chest pain. The electrocardiogram showed sinus tachycardia and a large magnitude ST segment depression in all leads except aVL and V2, and ST segment elevation in leads aVR and V1 (fig 1). Treatment with nitroglycerin infusion and aspirin was initiated, the chest pain resolved, and the electrocardiogram normalised. Cardiac enzymes showed a typical rise and fall curve. A two-dimensional echocardiogram, performed after the chest pain had subsided, showed normal left ventricular systolic function

with no segmental wall motion abnormalities. The patient refused cardiac catheterisation and left the hospital against medical advice.

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Figure 1 Electrocardiogram showed large magnitude ST segment depression in all leads except aVL and V2, and ST segment elevation in leads aVR and V1.

Emergency casebook

Please visit the *Emergency Medicine Journal* website (www.emjonline.com) for links to the full text of these emergency casebooks.

Acute appendicitis: emergency presentation and computed tomography appearances

► Acute epiploic appendicitis is an uncommon cause of abdominal pain. It is caused by torsion of an epiploic appendage or spontaneous venous thrombosis of a draining appendageal vein. The diagnosis of this condition primarily relies on cross-sectional imaging and is made most often after computed tomography. Clinically, it is most often mistaken for acute diverticulitis. Approximately 7.1% of patients investigated to exclude sigmoid diverticulitis have imaging findings of primary epiploic appendicitis.

▲ Subramaniam R. Acute appendicitis: emergency presentation and computed tomography appearances. *Emerg Med J* 2006;23:e53. <http://emjonline.com/cgi/content/full/23/10/e353> doi: 10.1136/emj.2005.033704.

Traumatic diaphragmatic herniation presenting as a delayed tension faecopneumothorax

► We report an unusual case of delayed presentation of a tension faecopneumothorax after traumatic injury to the diaphragm 5 years previously. This article highlights Three important clinical lessons including: (a) for suspected tension pneumothorax, if a significant quantity of serous fluid is drained in addition to air, think of a communication with the peritoneal cavity; (b) spontaneous tension pneumothorax is an extreme rarity and other causes should be kept in mind; and (c) in the presence of a tension pneumothorax and diaphragmatic hernia, the sac visceral contents may be completely reduced and mask the hernia.

▲ Ramdass MJ, Kamal S, Paice A, et al. Traumatic diaphragmatic herniation presenting as a delayed tension faecopneumothorax. *Emerg Med J* 2006;23:e54. <http://emjonline.com/cgi/content/full/23/10/e354> doi: 10.1136/emj.2006.039438.

Jejunal transection after blunt abdominal trauma: a report of two cases

► Small bowel injuries are uncommon after blunt abdominal trauma, and are usually due to high energy deceleration injury, frequently in relation to motor vehicle accidents. We report two cases of jejunal transection in two young male patients that occurred following direct blows to the periumbilical region of the abdomen. Both patients underwent laparotomy where transection of the jejunum was found. The injuries found were anatomically quite similar. Based on the types of injury pattern found, the presentations were quite subtle. We review the literature examining this topic and we advocate that clinicians maintain a high level of suspicion when dealing with similar presentations.

▲ Sandiford NA, Sutcliffe RP, Khawaja HT. Jejunal transection after blunt abdominal trauma: a report of two cases. *Emerg Med J* 2006;23:e55. <http://emjonline.com/cgi/content/full/23/10/e355> doi: 10.1136/emj.2006.38604.

A novel method of intravascular temperature modulation to treat severe hypothermia

► An 81-year-old male patient with hypertension, urosepsis, congestive heart failure and chronic renal insufficiency was admitted with profound hypothermia (rectal temperature 27.9°C). He was bradycardiac and presented with a first degree AV block and hyperkalemia. After being intubated and pan-cultured, the patient was treated for hyperkalemia, evidenced by a serum potassium of 7.6 mmol/l. Due to the severity of the hypothermia, and the availability of an intravascular temperature modulation catheter, the decision was made to attempt to rewarm the patient with a device normally utilised to maintain normothermia or hypothermia in neurological or cardiac arrest patients. An ICYT™ catheter (manufactured by Alsios Corporation, Irvine, CA) was placed via the femoral vein, and intravascular warming was initiated with goal temperature set at 37.5°C. The patient was warmed to goal temperature at a steady rate within 12 hours after admission, at a rate of 0.74°C per hour. The patient did not experience cardiovascular afterdrop, and normal sinus rhythm resumed 90 min after rewarming was initiated. The patient was successfully extubated 2 days after admission.

▲ Willekes T, Naunheim R, Lasater M. A novel method of intravascular temperature modulation to treat severe hypothermia. *Emerg Med J* 2006;23:e56. <http://emjonline.com/cgi/content/full/23/10/e356> doi: 10.1136/emj.2006.035360.