not available in The Netherlands. The described three patients received high-dose penicillin, NAC, and silibinin in addition to classical supportive treatment, which may account for their full recoveries.

Keywords: amanita phalloides; amatoxin intoxication; ingestion; silibinin; wild mushrooms
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(126) Mass Envenomation by Africanized Bees in a 90-Year-Old Woman

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Introduction: Patients presenting to the ED with a history of insect stings usually show a local reaction of swelling, pain, and erythema at the site of the stinging. In 0.3 to 0.5 percent of stings, an IgE-mediated anaphylactic reaction occurs, possibly after a single sting and can lead to an emergency requiring prompt recognition and treatment. Mass envenomation, sometimes involving hundreds of stings are less common, but can cause severe systemic toxic reactions that also require recognition and initiation of aggressive treatment. The syndrome is difficult to distinguish from systemic allergic reactions and maybe fatal.

Discussion: The patient received more than the mean lethal dose of honeybee venom and did not reach the hospital within the first hour after the stinging incident. Hemodynamic instability, rhabdomyolysis, and acute renal failure developed shortly and proved fatal, despite aggressive treatment at the Intensive Care Unit (ICU). It is unclear whether immediate hemodialysis or plasmapheresis would have saved this patients life, but it remains a treatment option to consider if a patient with a toxic dose of honeybee venom is admitted. The dilution and faster removal of the toxin could prevent a more severe course of the condition. These higher risk patients should be transferred to the hospital without delay and immediately admitted to an ICU to be monitored more closely, so that the first signs of imminent collapse can provoke further action.

Keywords: anaphylactic reaction; envenomation; honeybee venom; IgE-mediated; insect stings; intensive care unit
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(127) Pheochromocytoma: A Rare Cause of Dyspnea and Hypertensive Emergency in the Emergency Department

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Pheochromocytoma rarely is seen in the emergency department (ED), and may present in uncommon ways. A case of pheochromocytoma in a young, severely dyspneic patient is reported in this presentation. A 21-year-old male was brought into the ED with symptoms of sudden-onset dyspnea and hemoptysis. He had experienced cough and headaches for several months. Weight loss was reported, with no night sweating. The patient denied taking medications, drugs and alcohol, or having any allergies. Past medical history included pharyngitis two months earlier, and asthmatic bronchitis.

On examination, the patient was in respiratory distress with O_2 saturation of 60% on room air, and 85% on 15 liters of 100%O_2 non-rebreathing mask. Vitals were: respiratory rate: 24, blood pressure: 235/139, pulse: 125, temperature: 35.4. Lung sounds: bilateral rates; cardiac tachycardia, without murmurs. There were no sweating or extremity abnormalities.

Laboratory results included: Creatinine: 128umol/l; K+:4.1, BUN:3.8mmol/l; LDH:915U/l, lactate:5mmol/l; and respiratory acidosis. Chest x-rays demonstrated diffuse, bilateral pulmonary edema. The electrocardiogram showed sinus tachycardia with LVH; there were no signs of ischemia.

Antihypertensive treatment started and the patient was admitted to the intensive care unit for mechanical ventilation. Differential diagnoses included post-streptococcal glomerulonephritis, renal artery stenosis, pheochromocytoma, and other causes of kidney failure. A swelling of the right adrenal gland (6.5 x 5 x 4 cm) was seen on abdominal ultrasound and magnetic resonance imaging (MRI). Meta-Iodobenzylguanidine (MIBG) testing and SMS testing confirmed the diagnosis of pheochromocytoma. The adrenal tumor was excised surgically.

This report has presented a rare cause of hypertensive crises and highlights the importance of considering the diagnosis of pheochromocytoma in dyspneic patients and in hypertensive emergencies in order to avoid delays in treatment of this potentially life-threatening condition.

Keywords: dyspnea; emergency department; hemoptysis; hypertensive emergency; pheoctromocytoma
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(128) Collaboration between Indonesian and Japanese Emergency Medical Teams during the Sumatra Earthquake in 2004

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Introduction: In February 2004, the earthquake in Papua Province, Indonesia, resulted in severe damage to infrastructure and injuries to residents. Concerning this disaster, Japanese and Indonesian disaster relief teams shared information on management tactics.

Methods: Japan International Cooperation Agency (JICA) dispatched a team of five registered medical personnel and two recorders of the Japanese Disaster Relief Team to Indonesia to hold the joint seminar and exchange information. The JICA team also discussed the possibility of cooperation with Indonesian authorities in the sector of emergency response.

Furthermore, the JICA mission invited Indonesian counterparts to the subsequent meeting involving Japan, Malaysia, and The Philippines. The purpose of the next meeting was to share the output of the seminar and meet with key persons of Japan, Malaysia and The Philippines. On 12 October 2004, the joint seminar between Indonesia and Japan emergency medical teams on emergency medical care in sudden-onset events was held in Jakarta sponsored by JICA. Coordination between Indonesia, Malaysia, and The Philippines via a communication satellite was discussed.

Result: This discussion occurred two months after the Sumatra earthquake. The early medical mission was welcomed in Indonesia and coordinated with Indonesian medical staff.