Book of abstracts
Cardiovascular diseases

"Fibromuscular dysplasia (FMD): An infrequent cause of Secondary Hypertension"

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Introduction
FMD is an idiopathic, segmentary, non-inflammatory and non-atherosclerotic disease that can produce arterial stenosis, occlusion, aneurysm, dissection, affecting all layers of both small- and medium-calibre arteries.

Case description
59-year-old Female patient with history of Hypothyroidism and dyslipidemia, previously asymptomatic, started with episodes of occipital headache, otalgia, abdominal pain, associated with dyspnea, sweating, palpitations and increased blood pressure (220/110 mmHg), requiring hospital admission due to frequency of episodes. At Internal Medicine ward blood pressure was controlled progressively. Acute phase reactants were negative, no anemia or alteration of autoimmune test (ANCA, Anti-DNA, ANA, complement, Ig, Cryoglobulins) as well as negative microbiology. We rule out other causes of Secondary Hypertension, such as Pheochromocytoma, Hyperaldosteronism or Cardiologic origin. CT scan shows segments of stenosis and dilatation in visceral arteries of medium caliber specifically in celiac, renal and mesenteric territory related with medium size vasculitis vs dysplasia Fibromuscular. No significant renal artery stenosis was detected by Doppler study so revascularization of renal artery was not necessary. During the follow up no autoimmunity alteration was observed. Patient was treated with angiotensin receptor blockers + calcium channel blocker, with adequate blood pressure control and no recurrence of symptoms.

Discussion
Patients with FMD have involvement of the renal arteries approximately 75 to 80 percent of the time as our patient presented. Although involvement of extracranial cerebrovascular arteries have been reported in 75 percent of the time, it was not presented during initial follow up of our patient. The decision of revascularization is reasonable if resistant hypertension or progressive loss of kidney function is presented.
3 years of follow up in patients admitted by stroke and atrial fibrillation diagnosis

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Introduction: Ischemic stroke is largely associated with the presence of atrial fibrillation (AF). Disability and mortality rates are higher in patients with these two disease, independently the time that each occurred. The objective of this study was to evaluate the correlation between the time of atrial fibrillation’s occurrence and mortality rates, in stroke patients.

Methods: In a single-centre retrospective study, patients were admitted for an ischemic stroke between 1 January 2013 - 31 December 2014. All patients admitted by stroke were included, and the presence of AF was determined. After 3 years of hospital discharge, patients were divided in four groups: (i) patients without AF history, (ii) patients with AF before a stroke, (iii) patients admitted by a stroke and had the first AF episode in that moment, and (iv) patients that manifest AF in the follow up. The association between the time of atrial fibrillation’s occurrence and mortality rates, in stroke patients was explored by the Wilcoxon statistical test.

Results: 248 patients were included in the study, in which 190 did not showed AF; 33 with AF previously to the stroke; 16 exhibited the pathology in the emergency room when admitted for a stroke episode; and 9 developed AF during the 3 years after the hospitalization. Statistical analysis didn’t shown significant differences in mortalities between patients with clinical history of AF before stroke, and patients that exhibited AF In the emergency room (p=0.059). However, it was confirmed that AF leads to higher in mortalities rates, especially when compared patients without AF and patient admitted for a stroke with is first episode of AF in that moment, p=0.008.

Conclusion: A manifestation of AF in the moment of admission by a stroke had more mortality rates when compared with patients without AF history. To fully understand if the time of AF detection in stroke patients can be correlate with long-term mortality rates, are needed more data and studies.
A 66-year-old woman with difficult-to-manage hypertension

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INTRODUCTION:

We present the case of a 66-year-old woman with high blood pressure that was difficult to control for years, with no other background of interest. She was on chronic treatment with Doxazosin 12 mg/day and Isosorbide mononitrate 20 mg/12 hours. Previously, she had been treated with Irbesartan, Spironolactone and Bisoprolol.

CASE DESCRIPTION:

The physical examination was normal, except for high blood pressure (systolic 170, diastolic 90). Routine analysis, electrocardiogram, chest x-ray and urinalysis were strictly normal. After several treatment and lifestyle modifications, Internal Medicine derivation was decided for the study of secondary hypertension. A specific analytical testing with aldosterone 527 ng/dl (4 - 31 ng/dl), plasma renin activity 0.1 ng/ml/h (1.9 - 3.7 ng/ml/h) and potassium 3.8 (3.5 - 5 mEq/l) was performed, and a CT of the abdomen was also performed, where a 19 mm left suprarenal nodule, compatible with a probable adenoma, was seen. With all these findings, primary hyperaldosteronism was suspected. The furosemide - erect position tests were performed, resulting positive, and an adrenal catheterization was performed too, where in the left vein, great aldosterone production was observed. Thus, the patient underwent laparoscopic left adrenalectomy.

Subsequently, the biopsy confirmed it was an adrenal cortical adenoma, and the patient was discharged only with Manidipino, that three months later could be removed, and she maintained normal blood pressure without treatment.

DISCUSSION:

The autonomous secretion of aldosterone is the most frequent cause of secondary hypertension, and usually presents with the classic triad: hypertension, hypokalemia and metabolic alkalosis. It is important to suspect this pathology when we have these findings, since its prevalence is 5-10% in hypertensive patients.
A noninvasive subclinical atherosclerosis indicator in primary hypertension: Blood pressure index

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Objectives: Primary hypertension (PH) is the most important reason that may cause major cardiovascular complications all over the world. Hypertension causes early onset of subclinical atherosclerosis in central and peripheral vascular structures due to endothelial dysfunction. In clinical practice, atherosclerotic course can be slowed down when end organ damage (EOD) is detected in subclinical stages and medical and paramedical precautions are performed. In this study, we investigated the importance of the blood pressure index (BPI), defined as the ratio of systolic blood pressure to diastolic blood pressure, to reflect subclinical atherosclerosis. And we aim to conduct a research on the relationship between BPI and carotid intima media thickness (CIMT), left ventricular mass index (LVMI), urinary albumin excretion(UAE) which are the subclinical atherosclerosis markers in hypertensive patients.

Methods: 205 patients, diagnosed PH and elder than 18 years, were included in the study. LVMI, CIMT, and UAE levels were recorded from patients files.

Result: The 24-h BPI, the night-time BPI, and the day-time BPI were found to be associated with LVMI, CIMT, and UAE. 24-h BPI was found to be an independent risk factor for LVMI, CIMT, and UAE in the whole population. 24-h BPI and night and day-time BPI in EOD (+) group were found to be higher than EOD (-) group. In the regression analysis, similar to other subclinical atherosclerosis findings, the 24-h BPI was found to be a risk factor that associated with EOD. When the diagnostic value of these parameters in predicting EOD is reserached, the 24-h BPI and CIMT had similiar diagnostic discrimination. it was found that these two parameters had higher diagnostic discrimination than the UAE and LVMI.

Conclusion: This study is the first resarch that examine the role of BPI in determining subclinical atherosclerosis in PH. As a result, we think that the BPI may be a good predictor that can detect EOD due to PH.
A paradigm shift in home medicine: The high prevalence of heart failure with preserved ejection fraction among home-bound residents

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Background:
The volume of patient encounters in home-bound individuals has recently shown unprecedented growth. The reasons for this are multifactorial but one aspect is the increasing age of these patients. Consequently it is important to identify disease mechanisms in this cohort in order to develop appropriate training for medical providers.

METHODS:
We analyzed data of consecutive patients visited at home due to mobility problems, vision problems, cognitive decline and in some cases, mental health issue in 2017. ICD-10 codes were extracted on all the primary encounter diagnosis from all the visits.

RESULTS:
There were a total of 3,408 patient home encounters during the study period. There were 2,345 ICD-10 codes extracted. Mean age is 81.9 yo, The top ICD by organ system are cardiovascular (n= 1085), endocrine (n=232), respiratory (n=179), renal (n=63), malignancy (n=30).

The top 10 ICD classification includes:

ICD-10: description

1. Heart Failure with preserved systolic function. I5032: Chronic diastolic heart failure. n=239
I11.0: Hypertensive heart disease with heart failure. n=149. Total n=388

2. I11.9: Hypertensive heart disease without heart failure. n= 288

3. E11.xx: Type 2 diabetes mellitus (all types). n=153

4. I48.xx atrial fibrillation. n=137

5. J44.x: Chronic obstructive pulmonary disease. n=90

6. I2510: Atherosclerotic heart disease of native coronary artery. n=88


8. M179: Osteoarthritis. n=47


10. R29.6: Falls. N=30

CONCLUSIONS:
Most home bound medical encounters of older adults were due to cardiovascular related causes mostly from heart failure with preserved ejection fraction. With heart failure being one of the most common causes of hospitalization and readmission in the elderly population today. The present findings clearly emphasize focus
on specialized training in heart failure to providers dedicated to practicing home medicine.
A Patient With Reverse Takotsubo Cardiomyopathy After Laparoscopic Cholecystectomy

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Introduction:
Takotsubo cardiomyopathy (TCM) usually develops secondary to emotional or physical stress and mimics acute coronary syndrome. TCM is usually reversible and classified into 4 subgroups in relation with the involved parts of heart. Apical or classical form is the most common form while other forms which are detected with less frequency are in order: midventricular form, reverse form and focal form. Herein we present a patient who was diagnosed reversed TCM just after laparoscopic cholecystectomy.

Case Description:
A 59 years old female patient was consulted to Cardiology Department with new onset chest pain and dyspnea started just after laparoscopic cholecystectomy. Physical examination was normal except crepitant rales at the lower and middle lung zones. ECG revealed ST segment depression in anterior leads (Fig-1). Her complete blood count, liver and kidney function tests were all normal. Cardiac enzyme follow up was consistent with myocardial infarction. Ejection fraction (EF) was estimated 40% and wall motion abnormalities at the mid-basal segments of posterior, inferior and lateral walls were detected. Chest X-ray was consistent with pulmonary edema. Coronary angiography was performed and all coronary arteries were normal. Patient was diagnosed reverse TCM. Carvedilol, ramipril was prescribed and patient was discharged. One month later near to complete recovery of the wall motion abnormalities and EF was estimated 55%.

Discussion:
TCM develops secondary to physical or emotional stress and usually presents with chest pain, ECG changes and elevated cardiac markers. TCM diagnosis is established with excluding other causes and detecting typical ballooning of the apical segment by echocardiography or ventriculography. In reverse TCM; apical segment is preserved while the mid-basal segments are affected. TCM should be kept in mind in patients with chest pain and apical dyskinesia in conjunction with the presence of stressfull conditions.
INTRODUCTION
As the prevalence of cardiovascular diseases is increasing in the older population, the number of patients requiring implantable cardioverter-defibrillators (ICDs) is significantly higher. Lead-related venous thrombosis is a recognized complication of cardiac implantable electronic device.

CASE DESCRIPTION
A 41 years old male was attended in our emergency department with gradually reddening and swelling of the face. Symptoms started one month before and characteristically worsened with Valsalva maneuver. About his medical past history, he was carrier from 2007 of an implantable cardioverter desfibrillator (ICD) due to a ventricular fibrillation secondary to an hypertrophic miocardiopathy. A Cava superior syndrome was suspected and a supra aortic trunk doppler was performed which was negative; however, the diagnosis was confirmed by performing an angioCT scan; showing an extensive thrombosis which involves the wires of the ICD. Anticoagulation was started and he was referred to a hospital with Cardiovascular Surgery for replacement of the ICD.

DISCUSSION
ICD related thrombosis is a relatively frequent event. Most common affected veins are: axilar and subclavia vein and brachiocephalic trunk, while superior cava vein (SCV) is less frequent involved. Complete obstruction is not frequent also (3-9% of the cases). A few factors are proposed as predictors of thrombosis: two or more wires, hormonal therapy, personal history of venous thrombosis, the presence of temporary wire before implantation, and the use of dual-coil leads. Facial edema or cyanosis are common symptoms but in the most serious cases, pulmonary thromboembolism can be the way of presentation. Gold Standard test for the diagnosis is Angiotac, specially when SCV is suspected to be thrombosed. Anticoagulation should be started, and in case of inestability or extensive thrombi, ICD should be replaced.
Abdominal mass as presentation of huge infra renal abdominal aortic aneurism

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INTRODUCTION: abdominal aortic aneurism is a pathology common in vascular surgery but the form of presentation os this patient and the size of this aneurism is excepcional.

CASO DESCRIPTION: We present the case of a 69 years man with background of type 2 diabetes-nephropathy diabetes, diabetic retinopathy smoker of 20 cigarettes daily, with constitucional syndrome consistent in weigh loss and a huge mesogastric mass that extends to left flank. It was solid and painful. Analytics showed a iron deficiency anemia. We realize TC with a huge infra renal abdominal aortic aneurism with a dimension of 12x10.5x14 cms. With this resoult we derivate to vascular surgery of our Reference Hospital for an emergency intervention. They did a resection of the vessel and put a dacron graft. The evolution was espectacular and the patient could go home in a week. The patient is actually completely recovered.

DISCUSSION: in the natural history of aortic aneurism the growing determinates the evolution to the break. This complication is common in abdominal aneurism. In this patient it grows quickly and affortunately could be operated at time with no complications.
Age, sex and racial differences during cardiac stress testing in Brazilian patients with and without hypertension

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Objective: To investigate age, sex and racial differences in the measures of metabolic equivalent task (MET) scores, heart rate and blood pressure during cardiac stress testing. Methods: A total of 198 patients who attended the Cardiology outpatient facilities at a university hospital in Northeast Brazil were included in this study. Individuals underwent a cardiac stress testing using the Ellestad or Bruce protocols and the measures of MET scores, heart rate at rest, maximum heart rate, systolic/diastolic blood pressure at rest, and systolic/diastolic blood during exercise were obtained. For statistical analysis, the Student t, Pearson’s chi-squared, Kruskal-Wallis and Dunn’s tests, Kendall’s tau b correlation and linear regressions were used. Results: The majority of patients were females (68.2%) and naïve to cardiovascular interventions (88.4%), had brown skin color (34.8%), hypertension (58.6%) and dyslipidemia (53.5%). Age was shown to predict the maximum heart rate (R²=0.25, p< 0.001). Still, males presented with significantly (p=0.002) increased means±SD of MET scores (10.1±2.7) as compared to females (8.8±2.3). A slightly difference (p=0.037) was also observed for systolic blood pressure during exercise between males (187.3±25.0) and females (179.5±21.9). Patients with hypertension had significantly decreased means of MET scores as compared to those without hypertension (p=0.001). Yet, there was no association between sex and hypertension, dyslipidemia or diabetes. Most patients presented without ST-segment alterations or arrhythmia in either exercise or recovery phases in both male and female groups (p >0.05). Additionally, there was a statistically significant difference of the maximum heart rate medians between individuals with black and brown skin color (p=0.036). Conclusion: These findings suggest that MET scores, maximum heart rate and systolic blood pressure during exercise might be affected by age, sex or skin color during cardiac stress testing.
An analysis of the use of sacubitril/valsartan in a cohort of HFrEF patients

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OBJECTIVES
Analyze the characteristics of a cohort treated with sacubitril/valsartan and describe the potential side-effects and biomarker changes.

METHODS
We analyzed 36 patients being treated with sacubitril/valsartan with a mean follow-up of 10 months.

RESULTS
73.5% of the patients were male with a mean age of 72.1 years. Hypertension (85.3%), type II diabetes (67.6%) and dyslipidemia (41.2%) were the commonest comorbidities.

Prior to sacubitril/valsartan, 61.3% patients received ACE inhibitors, 33.3% ARBs, 88.2% β-blockers and 80.6% aldosterone blockers.

The year before the study we registered 13 admissions for acute decompensated HF, reducing to 6 during the follow-up (53% reduction).

Three patients discontinued therapy; one as a result of hypotension, another due to an ulcerative colitis episode coincidental with the start of the treatment, which was notified to the Spanish pharmacovigilance authorities. The third patient stopped the treatment for financial reasons.

While reductions in NT pro-BNP have been described, there were no reports on RDW change (a valid predictor of outcome in HF patients); our study found no statistically significant differences in the RDW values after starting the treatment. We found no statistically significant differences in potassium levels, being significant in the creatinine and GFR analysis.

CONCLUSION
Sacubitril/Valsartan has demonstrated morbidity and mortality reduction in HFrEF patients (PARADIGM-HF Trial). Our study showed low intolerance and side effects incidence; however, further clinical safety experience is required. We did not find any differences in the studied biomarkers levels.

REFERENCE
An Observational Study of Pulmonary Embolism in Pregnancy and Postpartum

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BACKGROUND
Pregnancy is a hypercoagulable state which predisposes to pulmonary embolism (PE).1 It is common to investigate for PE in pregnancy.

METHODS
This is an 11-year observational study of patients who underwent CTPA from 1-1-2007 to 31-12-2017. Data was obtained from electronic patient record systems and presented using descriptive statistics. Pearson’s correlation coefficient was used to find any relationship.

The aim was to establish the rate of PE, timing, and other lung abnormalities on CT pulmonary angiography (CTPA) results performed on pregnant and postpartum women in our hospital.

RESULTS
CTPA scans of 132 pregnant and 97 postpartum women were included. Of these, 3(2.3%) pregnant and 9(9.3%) postpartum women were found positive. 4(1.7%) scans were inconclusive.

Mean age (SD) was 26 (6) in positive group and 28 (6) in negative group.

All D-dimers in the PE group were positive, ranging from 0.71 µg/ml – 13.07 µg/ml.

Gestational age for 3 positive result was within 10-12 weeks. In postpartum, 9 positive result was ranged from 1st – 5th week (Median 1, Interquartile range = 1-3 weeks).

On the negative PE group (n=213), consolidation 35(16.4%), pleural effusion 13(6.1%), atelectasis 16(7.5%), nodule 6(2.8%), emphysema 2(0.9%), and pneumothorax 1(0.5%) were found.

Increasing numbers of CTPA scans were performed with no increment in positive findings (r=0.4).

CONCLUSION
Increasing numbers of CTPA scans performed with weak correlation to positive findings and potential risk of unnecessary radiation.
In our sample, PE is more common in the first trimester of pregnancy and during the first three weeks of postpartum period. Infective lung disease is a common finding in negative PE cases.

REFERENCE
Purulent pericardial effusion is uncommon and can occur by direct spread from a lung infection or haematogenous dissemination. The diagnosis is established by echocardiogram and pericardial fluid analysis. Antibiotic therapy and pericardiocentesis are essential for the treatment.

A 48-year-old male with a history of tobacco smoking, alcoholism, bronchiectasis, pulmonary tuberculosis sequelae, recent hospitalization regarding H. influenzae and S. pneumoniae lung abscess, was admitted due to septic shock. A large pericardial effusion with signs of hemodynamic instability was detected, and pericardiocentesis was performed with aspiration of purulent pericardial fluid (pH 6.704, glucose < 1 mg/dl, total proteins 5.6 g/dL, 98% neutrophils). No agent was identified in the blood cultures or pericardial fluid. Complication of previous lung abscess was considered, and piperacillin/tazobactam and vancomycin were started. During hospitalization, the patient developed acute heart failure with a slight increase in myocardial injury biomarkers and severe global ventricular dysfunction. He was admitted to the cardiac intermediate unit, with clinical and ventricular function recovery, one week later. The hypothesis of myopericarditis became probable, because of the pyogenic pericardial effusion. However, the fast improvement of global ventricular function makes this diagnosis less likely. Cardiac tamponade and loculated pericardial effusion were feared complications, but the outcome was favourable. Antibiotic therapy was administered during six weeks.

It is a case report that usually presents itself in the form of sepsis, with a high incidence of complications. Diagnosis is essential because a comprehensive therapy allows 85% of patients to survive and have a good long-term outcome.
An unexpected case of pericardial effusion secondary to Systemic Sclerosis

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Introduction:
Systemic Sclerosis (SS) is a multiorganic connective tissue disorder characterized by generalized vascular dysfunction and progressive fibrosis of the skin and other organs. The clinical manifestations are heterogeneous and the diagnosis is essentially clinical. The red flags are the Raynaud phenomenon, puffy fingers and positive anti-nuclear antibodies.

Case description:
Man, 76 years old, with a history of multifactorial heart failure, chronic kidney disease and arterial hypertension; sent about 1 year ago for external consultation of Hepatology for anemia, thrombocytopenia and splenomegaly. In the consultation, portal vein thrombosis and Raynaud's phenomenon were diagnosed, which were found to be secondary to SS. At a follow-up, a difference in blood pressure was detected in both upper limbs (>20 mmHg) and he was sent to the emergency department. He performed AngioTC that excluded alterations of the great vessels, however, a massive pericardial effusion was observed, and he was hospitalized for study. During hospitalization, the patient remained asymptomatic and clinically stable. No electrocardiographic changes or biomarkers were observed. He underwent a transthoracic echocardiogram that revealed small/medium volume pericardial effusion without hemodynamic compromise. Other causes of pericardial effusion were excluded, and the etiology was attributed to the already known autoimmune disease.

Discussion:
The risk of premature death is substantially increased in patients Systemic Sclerosis. Active research and early treatment of ES manifestations are determinant to delay the progression of the disease and improve its prognosis.
In fact, a pericardial effusion in SS can be a sign of active or severe disease, sometimes developing rapidly, with hemodynamic compromise, putting the patient's life at risk. However, corticosteroid therapy should be used carefully, taking into account the risk of precipitating a renal sclerodermic crisis.
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Anakinra for recurrent pericarditis: results from a real world European registry (BEAT registry)

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Background
Anakinra, a new promising treatment for recurrent pericarditis (RP) after failure of conventional therapies, has limited data available. Aim of this real-world registry is to evaluate its efficacy and safety.

Methods
Data from all patients receiving anakinra for RP from 3 referral centres for pericardial diseases (BErgamo, Athens, Torino: BEAT registry).

Results
The consecutive patients with refractory RP were 50: mean age 41.5 years, 26 females, mean duration of RP 25 months. The aetiology was idiopathic 94%, systemic inflammatory disease 4%, post-pericardiotomy syndrome 2%. C-reactive protein elevation was present in 98%, pericardial effusion 86%. Baseline therapies before anakinra included NSAIDs in 90%, colchicine in 86%, corticosteroids in 98% of patients. Anakinra mean starting dose was 100mg/day sc, maintained for a mean time of 14 months then tapered in 64% of cases. After a mean follow-up of 28 months, before and after anakinra the mean number of recurrences was 6.0 vs 0.9 (p<0.0001), hospitalizations 2.96 vs 0.16 (p<0.0001). A stable remission without recurrences was recorded in 64% of patients. Corticosteroid use before and after anakinra was 98% vs 44%. Side effects were recorded in 48% of cases (local skin reactions in the injection site 48%, arthralgia 16%, elevation of transaminases 6%, leukopenia 4%). No severe side effects were recorded. Drug withdrawal occurred in 3 cases (6%) for side effects.

Conclusions
Anakinra is a safe and efficacious in a real world population to reduce recurrences and hospitalizations in refractory RP after failure of conventional drugs.
Analysis of risk factors and peculiarities of polymorphism of genes in patients with ischemic damage of organs without the symptoms of stenotic atherosclerosis

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Relevance.
The heart and the brain are interrelated target organs of vascular pathology, which continue to lead in the structure of the causes of mortality in developed countries. It is known that approximately 10-20% of patients undergoing diagnostic coronary angiography in connection with acute or chronic ischemic syndrome, arteries are intact. The key theories are the theory of endothelial dysfunction, caused in most cases by gene polymorphism. Inflammatory damage to the arteries, the impact of neurohumoral factors, as well as the presence of a genetic predisposition. It is assumed that endothelial dysfunction is primarily associated with increased formation of highly active products of peroxidation (free radicals).

Purpose of the study:
To study the prevalence and degree of the main risk factors for the development of atherosclerosis among the study groups. To analyze the polymorphism of the lipid metabolism genes and the genes of regulation of the tone and structure of the vascular wall in a group of patients undergoing myocardial infarction or stroke with angiographically intact arteries, and also to associate the polymorphism of the studied genes. We studied and compare phenotype features and polymorphism of ApoE, MMP1, MMP3, MTHFR, MTRR, NOS3, ACE, FGB, F2 in patients who underwent myocardial infarction or stroke with angiographically intact arteries.

Practical significance:
Analysis of polymorphic variants of cardiovascular genes (ApoE, MMP1, MMP3, MTHFR, MTRR, FGB) can be considered as a prognostic test for assessing the risk of myocardial infarction and stroke in people with a clinical picture of the disease and healthy individuals.
Anthracycline cardiotoxicity: a case report

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Introduction: Several drugs used as anticancer agents are associated with cardiotoxicity. The most common clinical presentation is cardiomyopathy (CMP) leading to chronic heart failure (HF) and the most frequent agents are anthracyclines.

Case description: A 79 years old patient with hypertension, dyslipidemia and atrial fibrillation diagnosed with follicular non-Hodgkin lymphoma with areas of fast-growing diffuse large B-cell lymphoma. Echocardiogram performed prior to initiating therapy showed a slightly increased left atrium, mild pulmonary hypertension and 73% LVEF. She received six R-CHOP cycles (with a cumulative dose of doxorubicin of 550mg/m²). Later admitted in emergency department with dyspnea, orthopnea and decreased effort capacity. Physical examination revealed bilateral pretibial edema, tachycardia and hypotension. Chest radiograph showed bilateral pleural effusion; EKG showed rapid atrial fibrillation; cardiac biomarkers were negative, BNP level was increased. Echocardiogram showed global hypokinesia, moderate to severe aortic and tricuspid dysfunction, moderate pulmonary hypertension and 45% LVEF. Subacute toxic cardiomyopathy secondary to doxorubicin was diagnosed. She received treatment with diuretic, beta blocker and aldosterone receptor antagonist. Clinical improvement and increased functional capacity at discharge time.

Discussion: Patients that underwent cardiotoxic treatment regimens have increased risk of HF. Chemotherapy-induced CMP can present in many ways, either acute, subacute or chronic. The reversibility of cardiac damage depends on the offending agent but all patients should receive appropriate HF treatment and discontinuation of the drug is recommended. The growing use of anticancer agents and the increased life expectancy of cancer patients justifies the need for recognizing, preventing and screening for side-effects, namely cardiomyopathy.
Anthropometric estimation and blood pressure: implication of body roundness index

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Objectives: Traditionally, obesity provides remarkable asset in overall mortality. Following grave concern about management of hypertension, it’s well-established risk factor for CVD such as ischemic heart disease, stroke. Moreover, researchers waded in discussion with flurry of claims to suggest they shared affirmation that abdominal obesity is responsible for development of MetS. Nowadays, we know little about benefits of anthropometry.

Methods: We used clock-time-dependent method narrow-approach for ambulatory BP, body roundness index (BRI), EPOGH (n=300).

Results: The allegations are long overdue; how measurements depict abdominal obesity, anticipate horrid circumstances. In all-embracing theory the integration between obesity and hypertension is determined with refinements which repeatedly made it clear; therefore BRI is affordable, competitive, weird combination of elements designating obesity impact on appreciation of hypertension. This study looks like tip of iceberg, we defined correlation of BRI with SBP, DBP, Hr clinic (r=0.597; r=0.593; r=-0.003), home (r=0.517; r=0.505; r=-0.021), 24-hour (r=0.445; r=0.404; r=-0.104), day (r=0.392; r=0.319; r=-0.165, p=0.004), night (r=0.458; r=0.456; r=0.015), p<0.001. It’s being explained in several studies, especially as being important, for good; BRI forecasts percentage of body fat, puts down roots in pathogeneses of CVD, diabetes, dyslipidemia; predictive abilities of BRI are rather identical than superior compared to BMI, despite the complicity in metabolic breach. Its three predecessors - in particular BMI, WC, WHR - were all approved unanimously as parameters strongly associated with central obesity, MetS. It’s quite an odd task though, adiposity indices showed dominating capacities for detection of hypertriglyceridemia among lipids.

Conclusions: In summary, obvious way forward is through sequential construction of new series of accurate modified parameters of kind now being developed by applying anthropometry.
Aortic Dissection presenting as new onset Atrial Fibrillation

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Aortic dissection (AD) occurs as a result of blood entering the media layer of the aortic wall producing a false lumen with propagation through the aorta and branching arteries. Typically, patients experience an abrupt onset of interscapular pain radiating down the back or the anterior chest depending on the direction of the dissection. There are currently limited reported cases regarding new onset atrial fibrillation (AF) as a presenting sign of AD which poses a diagnostic challenge.

An 80 year-old Caucasian male presented to the emergency department with a complaint of worsening abdominal pain for two days duration without any associated symptoms. Physical examination of the patient was benign except for a palpable abdominal mass that was pulsatile. A CT of the abdomen was obtained and revealed a large saccular aneurysm stationed above the aortic bifurcation and measuring 6.0 x 5.6 cm. Then underwent an Endovascular Aortic Repair (EVAR) that was successful and without intraoperative complications. He was then transferred to the ICU for post-op management and observation. For the first two days, the patient was hemodynamically stable but on day three, he was found to have a new AF with a rapid ventricular rate. Work up revealed no electrolyte abnormalities and a normal echocardiogram. A D-dimer was elevated. This led to a CT angiography which was performed in order to screen for a pulmonary embolism (PE). CT angiography was negative for PE but incidentally captured a combined Stanford A and B AD aneurysm.

This patient did not present with any common clinical feature to suggest the presence of a dissecting thoracic aortic aneurysm. New onset afib is a rather rare presentation of AD indicating possible influence of the aorta and proximal dissection on the etiology of afib. Clinicians should maintain a high index of suspicion for diagnosing aortic dissection in patients with new onset afib, especially in those with a concomitant abdominal aortic aneurysm.
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Arterial stiffness in a high blood pressure unit: a descriptive study

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Objective
To figure out epidemiological and clinical characteristics of patients with arterial stiffness, measured by carotid pulse wave velocity (cPWV).

Methods
An observational study in a cohort of 77 patients of high blood pressure (HBP) and cardiovascular risk (CVR) Unit. Patients were asked about their previous diseases, cardiovascular risk factors, target organ damage, anthropometric measurements (weight, height, waist circumference), the treatment they followed and then they were measured the blood pressure (BP) and cPWV by ultrasound. The statistic study was made with SPSS 19.0

Results
There were 33.8% of males, 96.1% white race. The 87% had essential HBP, 2.6% renovascular hypertension and 7,8% hyperaldosteronism. The 7.8% of patients had white coat hypertension. The average of weight was 78,13Kg, height 162cm and waist circumference 100.31cm. The average of pulse rate was 73.29bpm. The 46.8% had dyslipemia, 24.7% diabetes mellitus, 18.2% were smokers or ex-smokers, 10.4% heart disease, 6.5% cerebrovascular accident, 1.3% peripheral arterial disease and 10.4% obesity hypoventilation syndrome. The 15.6% took acetylsalicylic acid, 53.2% angiotensin receptor II antagonists, 54.5% diuretics, 37.7% calcium antagonists, 23.4% beta-blockers, 18.2% angiotensin-converting enzyme inhibitors, 14.3% mineralcorticoid receptors antagonists 9.1% alfa-blockers, 3.9% vasodilators and 50.6% statins. The 18.4% of patients had resistant arterial hypertension. The average cPWV was 11.88 ± 2m/s and average central BP was 131/77 ± 14.7/9.9 mmHg and peripheral BP of 142/77 ± 15.4/9.8 mmHg.

Conclusions
The most of patients were white females, their anthropometric measurements were higher than expected for their age, sex and height. Half of patients had dyslipemia. The treatments more used were angiotensin receptor II antagonists, diuretics and statins. These data suggest that maybe a global intervention could improve arterial stiffness as target organ damage.
Assessment of pressure overload and variability in relation to age categories in hypertensive patients

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Background: The role of blood pressure variability (BPV) as an additional cardiovascular (CV) risk factor and its relationship to other parameters reflecting BP overload is not well established. It is known that CV risk, BP increases with age. Therefore, we aimed to investigate 24-hour ambulatory BP monitoring (ABPM) derived parameters in different age categories and to compare CV risk.

Methods: We performed ABPM in 97 hypertensive patients, admitted to the hospital for treatment adjustment. Based on their age, patients were classified in middle aged, elderly and very elderly groups. Awake, asleep BP, BP load, BPV, morning surge were compared among groups. BPV was assessed by the formula of average real variability (ARV). Demographic data, and those reflecting CV risk, were collected in a questionnaire.

Results: Highest systolic asleep BP was recorded in the very elderly group 135.7±12.1 vs 132±14.8 vs 129±15.7 mmHg (p=0.04). Systolic BP load was highest in the elderly group (206.8±183.3 mmHgxh), p=0.04. The very elderly patients reached highest values on BP variability (12.27±4.59), p=0.009 as well as in morning surge (22.34± 15.08 mmHg), p=0.033. Positive correlation was found between BPs load and ARV in the elderly group (p=0.04, r²=0.1047, CI: 0.01338 to 0.5770).

Conclusion: The very elderly reached highest variability and asleep systolic BP values, while elderly patients had highest pressure overload. Attention has to be paid for the appropriate selection of antihypertensive medication to improve BPV as well as BP values, pressure overload in order to prevent early target organ damage.
Association of visceral obesity with the parameters of central aortic pressure in patients with arterial hypertension and type 2 diabetes mellitus.

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Objective: To determine the relationship between visceral obesity and the parameters of central aortic pressure in patients with arterial hypertension (AH) and type 2 diabetes mellitus (DM).

Methods: 60 patients (56.7% of male and 43.3% of female) with stage III of AH and DM type 2 age 40-65 years old were included in the study. A standard physical examination, 24-hour monitoring of the parameters of the central aortic pressure, body composition analysis with a percentage of visceral fat, a visceral fat index (VAI), the degree of adipose tissue dysfunction (ATD) were conducted. The data are presented in the form M±SD, where M is the average value, SD is the standard deviation. A correlation analysis by Spearmen was carried out.

Results. The mean visceral fat values were 16.2±3.93%. 0% of patients had a normal level of visceral fat, 26.7% had a high level and 73.3% of patients had a very high level of visceral fat. The mean values of the VAI calculated index were 3.51±1.44. 93.3% of patients had adipose tissue dysfunction, 7.1% of whom had mild dysfunction, 57.2% had moderate dysfunction and 35.7% had severe dysfunction of adipose tissue. 63.3% of patients had an unfavorable daily profile of aortic pressure for systolic aortic blood pressure and 33.3% for diastolic aortic blood pressure (non-dipper, night-peackers). The conducted correlation analysis showed the presence of relationships between the parameters of central aortic pressure and the activity of visceral obesity. High direct associations between VAI and pulse aortic pressure during day and night (r=0.6 and r=0.56, respectively, p<0.05), VAI and augmentation index by day and night (r=0.58 and r=0.52, respectively, p<0.05), as well as ATD and pulse aortic pressure per day (r=0.39, p<0.05) were detected.

Conclusions. The presence associations of visceral obesity with central aortic pressure parameters shows a pathogenetic relationship between visceral obesity and aortic stiffness in patients with AH and DM 2.
Atrial fibrillation (AF) is the most prevalent dysrhythmia, increasing the risk of stroke, among other potentially life-threatening complications.

PURPOSE: to characterize the hospitalized population with AF in an internal medicine team.

METHODS: Retrospective analysis of patients admitted to an Internal Medicine team diagnosed with AF during the year 2016 and 2017.

Clinical information was obtained using the discharge notes and the CHA2DS2-VASc index was calculated based on the European Society of Cardiology Guidelines.

RESULTS: There were 129 cases of AF, 73% of the female gender. The average age was 81+/−9 years. The most frequent co-morbidities in descending order were Essential Hypertension (78%), Diabetes Mellitus type 2 (26%), Cerebrovascular disease (25%), Chronic renal disease (20%), Ischemic heart disease (19%). Patients presented a CHA2DS2-VASc> 1 index in 99% of cases.

CONCLUSION: AF is a very prevalent pathology, especially in the older age groups and often associated with other comorbidities that together may imply a significant increase in mortality. Often hypocoagulation of these patients raises questions because they are patients with pluripathology, a high degree of dependence and therefore often with hemorrhagic risk associated with high hypocoagulation.
Autonomic and cardiorespiratory improvement provided by aerobic training in hemodialysis patient

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Introduction: Studies have shown a high prevalence of autonomic dysfunction in patients undergoing hemodialysis, and this dysfunction is associated with cardiac events such as sudden death, heart failure and myocardial infarction. Aerobic training is an important ally in improving autonomic balance and consequently in heart rate variability (HRV). Objective: To evaluate the cardiovascular alterations of hemodialysis patients after 12 weeks of aerobic training. Materials and methods: 14 patients undergoing dialysis participated in this study, and were allocated to two groups, active (GA) and control (GC) with 7 subjects (4 women and 3 men) each. GA participants underwent an aerobic training protocol with intensity of 60% to 80% of maximal heart rate. The data were tested using the Shapiro-Wilk test, and for group characterization we adopted the paired Student’s t test and the Wilcoxon test for unpaired variables. Statistical analysis between the groups was performed using the two-way ANOVA with post-hoc Student Newman-Keulls. RESULTS: VO₂ value after 12 weeks of intervention was higher in GA, with value from 22.53 ± 2.63 ml.kg.min to 18.23 ± 0.82 ml.kg.min of GC. Regarding the autonomic modulation of GA, the GA showed an improvement in the HF (nu) index from 47.41 ± 15.95 (nu) to 69.35 ± 19.37 (nu) and in the sympatovagal balance with a reduction of 1.20 ± 0.60 to 0.59 ± 0.68, comparing their baseline values and post 12 weeks. Among groups, the GA obtained better values of HRV, the HF index (n.u) and the LF / HF of GA were respectively 69.35 ± 19.37 (n.u); 0.59 ± 0.63 and for GC the values were 43.63 ± 21.07 (n.u.); 2.40 ± 3.13. Conclusion: The aerobic training of moderate intensity, at 12 weeks, provided cardiorespiratory and autonomic improvement in patients undergoing hemodialysis. In addition, the GA obtained better body composition values than the sedentary ones at the end of the study.
Objectives: to review the literature concerning azilsartan use in hypertension and provide a summary of its pharmacological properties.
Methods: A search was conducted on PubMed, using keywords “azilsartan and hypertension”.
Results: Azilsartan produces great affinity for AT1 receptor blockade compared to several other angiotensin II receptor antagonists, including valsartan and olmesartan. This drug has been shown to have pleiotropic cardioprotective effects, independent of its blood pressure lowering effect. Its pharmacokinetic profile permits for use as once-daily oral administration regime, making it a patient compliant therapy. It is efficacious in reducing 24-h mean systolic blood pressure compared to maximum approved dosages of olmesartan or valsartan. Generally is well tolerated, most common adverse effects being headache and dizziness.
Conclusion: Azilsartan is a useful and attractive new option for lowering BP in patients with essential hypertension, particularly for those not able to tolerate other antihypertensive drugs.
Balloon pulmonary angioplasty as an effective method of treatment of patient with pulmonary hypertension

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A 62YOM was admitted to the Department of Cardiology of General Hospital on 1.12.2017 in good general condition.
The patient suffered from shortness of breath on exertion over the past 6 months.
On auscultation heart sounds were clear and regular, there were no murmurs. BP was 145/90 mm Hg. On palpation the pulse was rhythmic. Auscultation of the lungs was normal. Palpation of the abdomen resulted in no pain, no resistance, no abnormal sounds, liver and kidneys was abnormal. No oedema of the legs were observed.
X-ray of the chest did not reveal significant pathologies.
ECG showed SR, HR 78 /min, normal heart axial deviation, QRS 90 ms, PQ 162 ms. Echocardiography showed enlarged left and right atrium, right ventricle, mild mitral valve regurgitation. Left ventricular diastolic dysfunction was observed. The aortic valve was thickened and calcified, without a significant gradient. Moderate tricuspid regurgitation allowed estimation of a systolic pulmonary pressure of 78 mmHg. Vena cava inferior was normal.
Right heart catheterization showed: PA 57/27/38, RA 12/10/8; RV 64/8/8, PCWP 17/14/10, CO 5,17 l/min, thus confirming chronic thromboembolic pulmonary hypertension.
CT showed a pulmonary artery diameter of 32 mm, diameters of right and left pulmonary arteries were 23 and 26 mm respectively. there was no mosaic perfusion. No visible thrombotic material.
PAG illustrated bilateral perfusion defects, webs, bands and occlusions.
Blood tests revealed anemia and elevation of NT-pro-BNP to 147 pg/mL.
The patient was treated with enalapril 5 mg (x1/day) and enoxoparin natrium 60 mg (x2/day).
The pulmonary hypertension board who reviewed the case decided that the patient was no good candidate for pulmonary endarterectomy (PEA). Therefore, the patient was scheduled for balloon pulmonary angioplasty (BPA) and was pre-treated with riociguat.
Several BPA session are planned to normalize pulmonary artery pressures and improve saturations.
Blood cardiac biomarkers and its relationship with heart failure pathophysiology

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Objective: To assess the contribution of possible cardiac biomarkers in pathophysiology involved in P with HF.

Methods: The sample consisted of 139 P with HF, with median age of 82 years (mean age 79.4±11.4); 79 F(56.8%) and 60 M(43.2%). In HF P with preserved or decreased EF (EF<50%) were evaluated cardiac biomarkers Galectin-3, ST2/IL-33R,Pro-ADM by ELISAs (R&D Systems). Statistical methods were Mann-Whitney U test, and Spearman correlations. Statistical significance: P<0.05.

Results: Elevated RDW, erythrocytes, NT-ProBNP and slightly higher ST2/IL-33R levels were found in M in relation to F gender (P<0.05). The NT-ProBNP was directly correlated with ST2/IL-33R (r=0.35, P=0.047), urea (r=0.60, P<0.001), creatinine (r=0.64, P<0.001) and inversely GFR (r=-0.54, P<0.001) and hemoglobin (r=-0.26, P=0.023). Galectin-3 was directly correlated with urea (r=0.39; P=0.009), creatinine (r=0.46, P=0.002), platelets (r=0.45, P=0.002) and inversely with GFR (r=-0.40 P=0.006).

The ST2/IL-33R was inversely correlated with serum iron (r=-0.38, P=0.010), transferrin saturation (r=-0.33, P=0.029), erythrocyte enzyme – methaemoglobin reductase (r=-0.82, P=0.042) and directly correlated with an erythrocyte enzyme – acid phosphate (r=0.83, P=0.04). 58 P (57.4%) had HFPEF (EF≥50%), while 43 (42.6%) had HFREF (EF<50%). The levels of NT-ProBNP, Galectin-3 and ACP1 were higher for HFREF P (P<0.05). For P with HFREF, some correlations maintained the same profile mentioned, namely, NT-ProBNP versus urea; NT-ProBNP versus GFR; Galectin-3 versus creatinine; Galectin-3 versus GFR.

Only for HFREF P, the Pro-ADM biomarker revealed to be directly correlated with GFR (r=0.40, P=0.050), and inversely correlated with urea (r=-0.50, P=0.011), creatinine (r=-0.47, P=0.018) and RDW (r=-0.40, P=0.048).

Conclusions: Further studies will be needed, nevertheless, our results pointed to the possible involvement of the cardiac biomarkers above mentioned in the pathophysiology of HF P and prognosis.
Goal: to study hypertension reaction features during cardiopulmonary exercise testing (CPET) in intellectually working men with stress induced episodic high blood pressure (BP).

Methods: 43 patients (pats) with periodic episodes of high BP due to high level of stress were included (all men, 44 ± 3.4 years old), 65% non-systemically took hepatensive therapy. Risk factors: smoking had 88%, high cholesterol level 93%, glucose intolerance 42%, family history of high BP 8%. All pats had normal BMI and no signs of visceral fat and target organ damage. CPET was done for optimal training regime appointment. Baseline BP was 132± 2.6 mm Hg, most of the pats had low tolerance level (load 6.8±0.5 MET). All patients demonstrated hypertensive reaction (HR) during test, and that was the reason for test stop. While 70% of pats demonstrated systolic BP 220 mm Hg at respiratory compensation point (RCP) and RER 1.17 ± 0.02, 30% of pats demonstrated it earlier than RCP and RER 0.85± 0.06. All pats got recommendations with optimal physical and pulse regime for training. All the patients had 3 ± 1 aerobic training per week for 45 ± 10.7 min

Results: in 6 months all the patients demonstrated increase in physical tolerance (ΔVO2 5.1 ±1.3 ml/kg/min). Patients with HR at RCP showed significantly lower baseline BP (123.7± 3.8mm Hg vs 130.2 ± 4.1 mm Hg in other patients, p <0.05), only 14% demonstrated HR during CPET vs 89% in other patients, p <0.05 and mentioned less hypertension episodes during 6 months (8 ± 3 episodes vs 24 ± 2, p <0.05). 96% pats of this group demonstrated higher level of physical tolerance (load 9.6 ± 0.4 MET vs 7.9± 1.1 MET , p <0.05). Also, they didn't show abnormalities in glucose intolerance test.

Conclusion: hypertension reaction at RCP during CPET in intellectually working man with stress induced episodic high BP can be a predictor of great benefit in life style modification, cardiac risk lowering and arterial hypertension appearance and progression.
Introduction: Central retinal artery occlusion (CRAO) and branch retinal artery occlusion (BRAO) are rare events (1 to 10 cases in 100,000, or less), most often found in men aged 60 to 65 years. Ipsilateral carotid artery atherosclerosis is the most common cause, and hypertension, smoking and diabetes are the most common comorbidities.

Case description: We present a 59-year-old Caucasian male with previous smoking habits (40 pack-year), dyslipidaemia, diverticulosis, chronic gastritis and a right inguinal hernia, for which he refused surgical treatment. He was admitted to the Emergency Department for sudden loss of vision in the right eye, since that morning. His neurological examination showed nothing else of interest. After funduscopy examination, he was diagnosed with inferior BRAO and admitted to an Internal Medicine ward for further exams and cardiovascular risk factor management. 24 hours after admission, he developed sudden left-sided paresis, with ipsilateral complete facial hemiparesis, conjugated eye deviation, homonymous hemianopsia and Babinski sign, totalling 13 points on the National Institutes of Health Stroke Scale (NIHSS). A contrasted head CT scan showed the presence of a thrombus in the right distal common carotid artery. Fibrinolysis with alteplase (0.9 mg/Kg) was immediately undertaken, and the patient was transferred to a tertiary centre for mechanical thrombectomy.

Discussion: While rare, BRAO and CRAO are important clinical entities that require immediate attention. A detailed medical history may provide vital information to help with etiological identification, so that prompt treatment may prevent long-term sequelae and further vascular occlusion.
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Broken brain, broken heart.

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Introduction
Cardiac tumors are rare entities, occurring in 0.001-0.3% of the autopsies. Papillary fibroelastomas (PF) contributes to <10% of them, but is the most common valve tumor, particularly in the aortic valve.

Case description
The authors present a 34-year-old man, with a history of smoking and occasional cannabinoid use, who went to the emergency department for weakness of the right upper limb associated with drowsiness. At physical examination, he presented global aphasia, homonymous hemianopsia, hemiparesis and positive Babinski sign on the right side. The CT scan showed signs of ischemia in the territory of the anterior and left cerebral artery. In the emergency room, he experimented an episode of self-limited atrial fibrillation. The patient was refused for thrombectomy and he underwent thrombolysis without clinical improvement. 14 hours after, the patient went to coma due to intracerebral hemorrhage with need of descompressive craniectomy. Four days later, CT scan revealed new cerebral embolism in the territory of the left posterior cerebral artery. Thus, transthoracic echocardiography was performed, which identified an irregular spherical, pediculated and mobile mass with a maximum of 10 mm in diameter, located at the auricular face of the anterior mitral leaflet, without other changes. The patient had a transesophageal echocardiogram that confirmed the presence of the same structure. A possibility of cerebral embolization by PF was admitted. The patient was transferred to the Cardiothoracic Surgery. The anatomopathological result confirmed the diagnosis. Currently, the patient is in rehabilitation and without recurrence of embolic phenomena.

Discussion
Although histologically benign, the PF can manifest as catastrophically as in this case. Surgical excision should be taken as an option in symptomatic patients and asymptomatic patients with masses greater than 1 cm, particularly if located on the left side of the heart.
Brugada Syndrome triggered by Legionella Pneumonia

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Introduction
Brugada syndrome (SB) is a rare entity characterized by ST segment elevation greater than 0.2 mV in more than one lead from V1-V3 (type 1 morphology), associated with the risk of cardiac sudden death (CSD). SB pattern may be present spontaneously or be induced by febrile or vagotonic states or by the administration of antagonists of the sodium channels.

Case description
We report the case of a 63-year-old man with family history of early CSD who resorted to emergency service for fever and asthenia with 4 days of evolution. He was febrile (38° C) and with crackles in the lower 2/3 of the left lung. His analysis revealed elevation of inflammatory parameters, type 1 respiratory failure and a positive urinary antigen for Legionella pneumophila. On chest x-ray and thoracic CT was visualized an hipotransparency in the superior lobe of the left lung. The electrocardiogram (ECG) showed sinus rhythm with Brugada type 1 pattern (in hyperpyrexia), which was previously unknown. The patient started antibiotherapy with levofloxicin and was admitted in the intermediate care unit, were the patient had normalization of Brugada pattern in apirexia. For arrhythmic risk stratification, electrophysiological study was held, in which it was induced a polymorphic self-limited ventricular tachycardia associated with syncope. Therefore, an implantable cardioverter defibrillator (ICD) was implanted for prevention of CSD. The genetic test was negative. The patient is in close follow-up in the Cardiology department and it has been identified an episode of ventricular fibrillation treated properly with a ICD shock.

Discussion
This case illustrates the importance of the performance of an ECG in the febrile state, which may be the trigger for the development of life-threatening diseases, such as the SB. The authors support that all patients admitted must do an ECG for future memory. This case also highlights the importance of implementation of ICD in high arrhythmic risk patients.
CA-125, a biomarker in acute-decompensated heart failure for obese patients. Preliminary study.

Prof. Dr. Th. Burghele Hospital, Bucharest, Romania

Background: It is well known that the NT-proBNP in obese subjects is much lower than in normal weight subjects, making difficult to interpret it. In current practice the patients are frequently obese. In these conditions, a new biomarker, not influenced by weight, could be useful in acute-decompensated heart failure (ADHF).

Aim: To determine CA-125 changes in obese and normal weight patients with ADHF.

Method: The study group included 110 patients (mean age 72±10 years, 63% men) with ADHF caused by ischemic cardiomyopathy. The subjects were clinically, ecocardiographically and biologically (NT-proBNP, CA-125) evaluated.

Results: The mean BMI was 27.6±5.8 kg/m² and 35 (33%) subjects were obese. CA-125 at admission was 53±33 U/mL and decreased at discharge to 34±17 U/mL, without any difference between males and females.

There was a significant difference between NT-proBNP at admission in obese versus normoponderal patients (3207±1432 pg/mL versus 4457±2737 pg/mL (p=0.02)), which was maintained at discharge (1711±816 pg/mL versus 2674±1475 pg/mL (p=0.03)). In the same time, the CA-125 did not show statistically significant differences between obese and normoponderal subjects at admission (56±29 U/mL versus 51±20 U/mL (p=0.63)) and discharge (36±20 U/mL versus 33±16 U/mL (p=0.56)).

Conclusions: CA-125 could be an useful biomarker in monitoring the obese patients with ADHF, better than NT-proBNP.
CA-125, a biomarker in acute-decompensated heart failure. Preliminary study.

Prof. Dr. Th. Burghele Hospital, Bucharest, Romania

Background: CA-125 is a tumor antigen expressed on the surface of ovarian cells, used to monitor the treatment of ovarian cancer (normal upper limit is 35U/mL), but it seems to have a role as biomarker in heart failure (HF).

Aim: To determine CA-125 changes in acute-decompensated HF (ADHF) patients.

Method: The study group included 110 patients (mean age 72±10 years, 63% men) with ADHF caused by ischemic cardiomyopathy. The subjects were clinically, ecocardiographically and biologically (NT-proBNP, CRP, serum uric acid (sUA), CA-125) evaluated.

Results: CA-125 at admission was 53±33 U/mL and decreased at discharge to 34±17 U/mL, without any difference between males and females.

The mean level of CA-125 was significantly higher in patients with pleural effusion: 63±25 U/mL versus 43±19 U/mL (p=0.02).

In the same time, the mean level of CA-125 was significantly higher for subjects with reduced ejection fraction and with elevated left ventricular filling pressures versus for subjects with preserved ejection fraction and normal left ventricular filling pressures: 57±21 U/mL versus 35±20 U/mL (p=0.013), respectively 61±24 U/mL versus 37±18 U/mL (p=0.005).

The CA-125 was correlated with LVEF (R=-0.221, p=0.02), with NT-proBNP (R=0.371, p<0.001), with the inflammation marker - CRP (R=0.284, p=0.003) and oxidative stress marker - sUA (R=0.234, p=0.015).

Conclusions: The wide availability of CA-125, its relatively low cost, its correlation with known prognostic factors in HF and the additional information provided make it a valuable biomarker that can be used in monitoring ADHF patients.
Cardiac arrhythmias in young people and the assessment of superoxid-dismutase as oxidative stress biomarker

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Introduction: Oxidative stress may be involved in the pathogenesis, often multifactorial, of cardiac arrhythmias diagnosed in young patients. Superoxide-dismutase (SOD), as enzyme involved in the generation of oxidative stress, is important in its argumentation.

Aim: To investigate the enzymatic oxidative stress level through a biomarker represented by SOD in non-lesional arrhythmic cardiac pathology in young people.

Patients and Methods: The study was conducted on 80 young subjects (2 groups), with an average age of 33 years old, selected as follows: group I, consisting of patients with clinical and electrocardiographic (ECG) diagnosed arrhythmias; group II, healthy subjects, as controls. Other pathologies associated with arrhythmias, on clinical and paraclinical explorations basis, were excluded. Serum SOD value was determined in all 80 subjects. The obtained data were statistically processed.

Results: The mean SOD value in patients with arrhythmias was 104.63 U / mL, recording a 61.92% decrease against mean SOD value of 168.97 U / mL, in healthy subjects. The enzyme deficiency was 38.08% in the arrhythmias group, recording also some differences depending on arrhythmia type. Thus, the deficit was, as follows: of 48% in atrial fibrillation, 45% in sinus bradycardia, 44% in atrial flutter, 36% in ventricular extrasystolic arrhythmia, 35% in atrial extravaascular arrhythmia, 34% in combined arrhythmias, 29% in paroxysmal supraventricular tachycardia and 26% in sinus tachycardia.

Conclusions: 1. Determination of SOD can represent an oxidative stress biomarker, important in the pathogenetic and therapeutic orientation of arrhythmias in young people.
   2. SOD deficiency was 38% in patients with arrhythmias and was observed in all types of arrhythmias, with values between 48 and 29%.
   3. The expression of oxidative stress, with the increase of free oxygen radicals by lowering SOD, can thus be monitored since early stages, as well as in evolution.
Cardiac Tamponade as the first symptom of lung cancer

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Introduction: Cardiac tamponade is a common emergency problem, but it is rarely to be the first symptom of cancer. This work presents a patient in whom cardiac tamponade was the first symptom of lung cancer.

Case report: A 62-year-old male, smoker (40 pack-year), was admitted to hospital due to progressive symptoms of dyspnea and productive cough for a week. Examination revealed low arterial blood pressure, muffled heart sounds, sinus tachycardia and elevated jugular venous pressure. Bed side echocardiogram showed fluid in the pericardium and signs of life-threatening cardiac tamponade. The patient underwent pericardial puncture and additional imaging examinations. Lung adenocarcinoma was recognized as the underlying disease. Due to pleural effusion and its recurrence, thoracoscopic talc pleurodesis was performed. And systemic chemotherapy was introduced.

Discussion: Cardiac tamponade requires always an emerging treatment. However, after solve the emergency situation it’s mandatory investigate the subjacent etiology. In this case the analise of pericardial effusion and the additional imaging examinations were essential to achieve the underlying disease and begin the subsequent treatment.
Cardiovascular diseases
A-2184

Cardioembolic complication after delayed diagnosis of renal infarction.

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INTRODUCTION
We present a case of a cardioembolic ischemic stroke after delay in the diagnosis and treatment of a previous renal infarction.
CASE DESCRIPTION
A 72-year-old woman with no relevant medical history who initially consulted at the Emergency Department due to pain in the right flank of acute onset accompanied by nausea, vomiting and hematuric urine. Despite presenting a mild worsening in renal function (creatinine 1.38 mg/dl) discharge to home was decided with clinical judgment of right renal colic.
Three days later she consulted again due to fluent aphasia and acute facial palsy. A computed tomography angiography with occlusion of left middle cerebral artery and an electrocardiogram with atrial fibrillation, previously unknown, were performed. After intra-arterial fibrinolysis with good results, she was admitted in the Stroke Unit, completing the etiological study with an echocardiogram and a supra-aortic trunks ultrasound within normality. In the admission analysis renal function persisted deteriorated (creatinine 1.98 mg/dl, together with LDH of 890 U/L), so before the suspicion of renal infarction an abdominal ultrasound with intravenous contrast was performed. It confirmed an avascular area in the cortical of right kidney with the rest of the parenchyma adequately perfused. Subsequently a renal scintigraphy was performed which showed complete annulment of the right kidney function. After resolution of neurological symptoms and partial improvement of renal function, hospital discharge was decided. Currently she continues follow-up in outpatient clinics maintaining stable renal function. New abdominal ultrasound with contrast was performed without changes.
DISCUSSION
Renal infarction is a pathology of infrequent diagnosis but should be kept in mind when evaluating a patient with the triad of embolism risk factor, compatible clinical symptoms and elevated serum LDH. Its correct diagnosis and treatment can prevent later thromboembolic complications.
Cardiovascular diseases
A-1186

Cardiovascular comorbidity as a risk factor of the progression of chronic obstructive pulmonary disease

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Objectives
The aim of the study is the analysis of risk factors, influencing on the progression of chronic obstructive pulmonary disease.

Methods
259 patients with chronic obstructive pulmonary disease (COPD) I and III stages, mean age 54.3±11.7 and the duration of the disease 10.1±5.7 were enrolled in the trial. Patients were divided into 2 groups: I group (n=119) – with III stage of disease, II group (n=140) – COPD with I stage. 30 healthy were involved in control group. The risk factors of progression, including markers of inflammation, HHS, of COPD were determined with the use of regressive and correlative analyses.

Results
The level of markers of systemic inflammation in serum of patients with COPD: TNF-alpha (RR 3.25; p=0.05); IL-8 (RR 2.1; p=0.03); hs-CRP (RR 3.52, p=0.01), HHS>5.0 mM/l (RR 2.14; p=0.03) and long-term treatment with glucocorticoids (RR 2.45; p=0.01) in combination with traditional risk factors (long course of the disease (RR 2.3; p=0.01), age (RR 1.65; p=0.03), smoking (RR1.65; p=0.05), and also obesity (RR2.45; p=0.01), early menopause (RR 3.52; p=0.001), hereditary respiratory predisposition (RR 3.05; p=0.01), and also coexisting cardiovascular pathology (CAD, AH) (RR 6.3; p=0.01) increase the risk of COPD progression several times.

Conclusion
According to the results of this trial, unmodified risk factors such as hereditary predisposition, early menopause, long course of the diseases and mainly coexisting cardiovascular pathology and HHS contribute significantly on progression of COPD. The relative risk increases with increasing of concentration of markers of systemic inflammation (TNF-alpha, IL-8 and hs-CRP), that correlate with clinical manifestations of COPD: cough, shortness of breath on VAS in mm.
Aortic dissection is a potentially fatal medical condition. It is estimated that affects 5 to 30 people / million, especially men in the 60-80 age group. The most important risk factors are uncontrolled hypertension (AHT) and atherosclerosis. A 30-year-old male patient with a history of hypertension for about 2 years without established therapy. He was referred to the Emergency Department for chest pain with abdominal irradiation and decreased muscle strength of the right lower limb (MID). At entry into the ED (SU) with PAS 300 mmHg and absence of right femoral pulse. AngioTC TAP revealed a dissection of the aorta with involvement of the left subclavian artery, celiac trunk, superior mesenteric artery, left renal artery and inferior mesenteric artery, originating in the true lumen, right renal artery equally with dissection blade and involvement that extends until along the iliac arteries. Transferred to the Vascular Surgery Unit where he was firstly operated for ischemia of the MID and later underwent cardiac surgery. In the immediate postoperative period, he suffered a cardiopulmonary arrest and eventually died on the 4th day. The histology of the surgical part of the aortic ring has documented minor morphological changes but can be classified into atherosclerosis.

Atherosclerosis is a reality present in every day of clinical practice and the control of risk factors is the only way to change its progression. This case is evidence that structural changes arise from young ages and reinforces the importance of primary health care and specialty consultations to control and follow up these patients so that fatal situations like this do not happen.
Cardiovascular diseases
A-1230

Cardiovascular risk factors and other pathologies related to cardiopathy patients admitted in the internal medicine service of a private hospital

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Objectives: To evaluate the patients admitted to our Internal Medicine service with heart disease and related pathologies.

Methods: Patients with hospitalization date from 1/1/2017 to 1/31/2017 were included. In case of more than one hospitalization, it was analyzed just the first admission. The variables analyzed were sex, age, hypertension, diabetes, dyslipidemia, anemia and renal failure during admission, base cardiopathy, reason for admission, final diagnosis at discharge and hospital stay. The data was analyzed using SPSS.

Results: 47 patients were analyzed, 59.6% were men and 40.4% were women. The mean age was 69 years. The average stay was 8.3 days and 4 patients (8.5%) died during the hospitalization. The main reason for admission was dyspnea (29.8%). 21.3% of patients presented acute heart failure, most of them were due to respiratory infection (70%). More than half of the patients were hypertensive (61.7%), 31.9% diabetic and 38.3% dyslipidemic. During the admission 48.9% had anemia (hemoglobin less than 11g/dl) and in 31.9% of the cases the renal function was deteriorated.

Almost half of patients(48.9%) had underlying heart disease (ischemic or heart failure). Regarding patients who had structural heart disease, 58.6% were hypertensive, 73.3% were diabetic, 61.1% had some type of dyslipidemia. Furthermore, 56.5% of the patients with heart disease presented anemia and 66.6% had acute renal failure during the admission.

Conclusion: When cardiopathy patients are hospitalized in addition to control the usual risk factors is important to consider hemoglobin level as well as renal function as part of optimization of clinical management and to avoid further complications.
Cardiovascular diseases
A-2259

Cardiovascular risk factors, metabolic syndrome and cardiovascular outcomes in a Latin-american cohort

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Introduction: Cardiovascular diseases are the main cause of mortality in the world. In 2016, cardiovascular diseases produced 17.6 million deaths worldwide and this number may increase to 25 million by 2030.

Methods: Prospective cohort conducted in patients aged between 15 to 64 years. Standardized measurements of cardiovascular risk factors were made in 2001, 2007 and 2013. The presence of cardiovascular disease was identified as a composite outcome defined by the presence acute coronary syndrome and/or cerebrovascular disease. Univariate analysis was performed to describe the distribution of these cardiovascular risk factors according to metabolic syndrome definition proposed by World Health Organization (WHO), Adult Panel Treatment III (ATPIII) and International Diabetes Federation (IDF).

Results: In 2001, 2432 participants were included. 67% were women. The average age was 36 years. The prevalence of high blood pressure was 15.5% for ATPIII and IDF and 8.4% for WHO. The prevalence of dyslipidemia was 87.8% for ATPIII and IDF and 60% for WHO. The prevalence of metabolic syndrome according to the WHO, ATPIII and IDF definitions was 5.2%, 6.9%, and 11.4% in 2001, 11.8%, 9.5% and 17% in 2007 and 24%, 17.3% and 29% in 2013 respectively. The primary outcome was identified in 2.4% of the study population.

Conclusion: There is variability in the prevalence of metabolic syndrome according to each of the different definitions used, being higher when using the definition proposed by the IDF, probably due to the cut-off point used to define obesity.
Cerebral amyloid angiopathy (CAA) refers to the deposition of B- amyloid in the media and adventitia of small and mid-sized arteries of the cerebral cortex and leptomeninges. Although CAA is usually asymptomatic, it is an important cause of primary lobar intracerebral hemorrhage in the elderly; the superficial locations contrast to the deep locations characteristic of hypertensive hemorrhage. The authors report a case of 81 years old man with history of hypertension and ischemic stroke admitted at our hospital for sudden onset of dysarthria. The blood pressure was normal. Computed tomography scan revealed cortical-subcortical hemorrhage and the MR multiple micro hemorrhages suggestive of AAC. In the diagnostic work-up of this patient was detected atrial fibrillation and ablation was successful done. As a result of embolic risk of atrial fibrillation, chronic oral anticoagulation is recommended. However, such therapy in this patient is not safe because is associated with a serious increased risk of bleeding. Potential alternative to anticoagulation in this case was catheter ablation to reduce the risk of stroke.
Objectives: The aim of this study is to access the value of CH2Ds2-VASc score in predicting cerebrovascular events in the presence or absence of atrial fibrillation (AF).

Methods: Observational retrospective study, with information collected from the clinical process (ALERT and SClinico). Data were analysed using Microsoft Excel®. The population studied (n=490) was composed by patients with cerebrovascular disease admitted in a Central Hospital during 2017. They were categorized considering the type of cerebrovascular disease (haemorrhagic, ischemic or transient) and analysed those who had a score ≥2.

Results: The profile found was 73.5 years (+ -13) and the male gender was the most prevalent. The longest time of hospitalization for hemorrhagic stroke (8.34 days) and transient ischemic attack was the lowest (3.1 days). The majority of the patients had ischemic stroke (n = 315), 72.6% without AF (n = 227) presented a high score. Considering hemorrhagic stroke 47.5% (n = 72) without AF with a score ≥2. Although we have 30% of AF in all groups, only 8% of patients undergo anticoagulation therapy. Mortality was higher in hemorrhagic stroke 25% (n = 27), and the prevalence of hemorrhagic stroke was higher (25%), hypertension (65.7%), previous cerebrovascular accident (23.4%) and diabetes.

Conclusion: The association between higher scores and cerebrovascular disease with atrial fibrillation is well established. The predictable value of this score without atrial fibrillation is supported by our study and information for future research into optimal risk stratification and therapy guidelines.
Chagasic cardiomyopathy: a relatively common cause of heart failure in Spain due to migratory phenomena

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INTRODUCTION
The notable increase in immigration from Latin-American countries to Spain during the last years, particularly people from Bolivia, has converted Chagas disease (American trypanosomiasis) into a public health problem in Spain.

CASE REPORT
A 55 years old male from Bolivia, who have been in Spain for one year, went to the emergency department for presenting 7 days progressive increase of dyspnea with orthopnea and paroxysmal nocturnal dyspnea that incapacitated him for working. He didn’t report fever or any other symptomatology. On examination, a mitral diastolic murmur, a third noise and bilateral crackles from both apexes attracted attention. The chest radiograph showed a pattern of bilateral interstitial edema in butterfly wings compatible with heart failure. The echocardiogram revealed a dilated cardiomyopathy with an ejection fraction of 20%. EKG showed nonspecific repolarization alterations and occasional bigeminisms without arriving to provoke ventricular tachycardia. Upon suspicion of infectious origin of the process, PCR was requested for Trypanosoma cruzi being positive and IgG serology, also positive, which confirmed the chronicity of it. On the other hand, the patient reported vague abdominal pain and constipation, what was the manifestation of a megacolon that was confirmed radiologically. Upon suspicion of infectious origin of the process, PCR was requested for Trypanosoma cruzi being positive and IgG serology, also positive, which confirmed the chronicity of it. On the other hand, the patient reported vague abdominal pain and constipation, what was the manifestation of a megacolon that was confirmed radiologically. With the diagnosis of chronic Chagas disease with myocardial and colonic involvement, treatment was started with diuretics, ACEIs and carvedilol, presenting a good clinical evolution and being asymptomatic 24 hours after admission. The megacolon was solved with diet with fibers and laxatives. At present, the patient is awaiting assessment for cardiac transplantation and it’s being treated with benznidazole (antiparasitary).

DISCUSSION
In our case, a frequent pathology in Internal Medicine Services like heart failure, is explained by dilated cardiomyopathy caused by chronic Chagas disease. Therefore, it’s important to pay attention to migratory phenomena in anamnesis.
Cardiovascular diseases
A-1820

Chest pain and extrasystoles as Cardiac Sarcoidosis manifestations a Case Report

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Introduction

A 50-year-old male from the Dominican Republic with episodes of angina, with no other symptoms, was admitted to our hospital emergency department. He had a previous history of hypertension, type II diabetes with secondary retinopathy, activity-limiting polyarthralgia and abundant extrasystoles in treatment with β-blockers. Upon arrival to the hospital, the chest pain had disappeared and the patient was asymptomatic.

Case description

Physical examination was completely normal. The patient underwent a cardiac stress test and a myocardial perfusion scan, that were negative for ischemia, but the latter showed a reduced ejection fraction. A cardiac MRI was performed revealing a non-ischemic dilated myocardioopathy and multiple enlarged mediastinal and hilar lymph nodes, that had high uptake in a posterior PET-SCAN. The biopsy of the nodes was positive for non-caseating granulomas. The final diagnosis was Cardiac Sarcoidosis (CS), and subsequently, treatment with corticosteroids was started, with an improvement of the symptomatology.

Discussion

Clinically manifest cardiac involvement occurs in perhaps 5% of patients with sarcoidosis. Conduction abnormalities, ventricular arrhythmias, and heart failure being the most common manifestations. Although some studies suggest that CS is becoming more prevalent others argue that this is likely due to improvements in imaging techniques (especially MRI and PET-SCAN), with the first imaging guidelines being published recently.

References

Aim: to estimate the prevalence of the obstructive sleep apnea syndrome (OSA) in patients with chronic rheumatic heart disease (RHD) and its effect on the course of the disease.

Material and methods: the study included 165 patients with acquired mitral stenosis who underwent risk assessment of OSA, snoring and daytime drowsiness. Cardiac respiratory monitoring was performed to detect OSA. In assessing the functional class of chronic heart failure (CHF), a 6-minute walk test was used.

Results: according to cardiorespiratory monitoring, patients were divided into 4 groups: with a normal value of the apnea/hypopnea index (AHI) - 14.5%; mild degree of OSA (AHI 5-14) - 58.1%; moderate degree of OSAS (AHI 15-29) - 16.3%; a severe degree of OSA (AHI 30 or more) - 10.9%. Patients without OSA had significantly lower 6-minute walk test results - 226.21±22.2 meters, referring to III FC of CHF, and patients with OSAS had II FC of CHF. At the same time, all patients in the non-OSA group had atrial fibrillation (AF) and a significantly smaller area of the mitral orifice-1.17±0.07 cm². In groups with OSA, there were significantly higher values of the Epworth Sleepiness Scale compared with those without OSA (4.0±0.66). Dyspnea in the VAS in patients without OSA was higher - 53.0 ± 5.3 mm, but the data were unreliable. Holter monitoring showed a significantly higher frequency of 2 second pauses in the background of AF and a larger number of ventricular extrasystoles in groups of patients with OSAS.

Conclusion: patients with RHD there is a high prevalence of OSA - 85.5%. At the stage of CHF transition in patients with RHD from II FC to III FC, the frequency of OSA decreases. OSA does not affect the quality of life, the severity of anxiety and depression in patients with RHD, which may be due to the effect of CHF on these indicators. The presence of OSA in patients with RHD affects the slowing of atrio-ventricular conduction and an increase in the number of ventricular extrasystoles.
Comparison of the prognostic role of Q waves and inverted T waves in the presenting ECG of STEMI patients

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Objectives: Both Q waves and T-wave inversion (TWI) in the presenting ECG are associated with a progressed stage of myocardial infarction possibly with less potential for myocardial salvage with reperfusion therapy in ST-elevation myocardial infarction (STEMI). Combining the diagnostic information from the Q- and T-wave analyses could improve the prognostic work-up in STEMI patients.

Methods: We sought to determine the prognostic impact of Q waves and TWI on patient outcome in STEMI. We formed four groups according to the presence of Q waves and/or TWI. We studied 627 all-comers with STEMI derived from two patient cohorts.

Results: The patients with both Q waves and TWI had highest 30-day and 1-year mortality. Q waves predicted higher 30-day mortality than TWI, while one-year mortality was similar between these two groups. Highest peak troponin level was found in the patients with Q waves and positive T waves.

Conclusions: Q waves and TWI predict adverse outcome, especially if both Q waves and TWI are present. Q waves predict larger infarcts and higher early mortality than TWI. Extending ECG analysis to include Q waves and inverted T waves in STEMI patients provides a useful tool for risk stratification.
Complicating the complication: iatrogenic pneumothorax worsened by inadvertent reversal of a Heimlich valve

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Introduction
Iatrogenic pneumothorax is a well-documented complication of CT guided lung biopsy, with treatment sometimes involving tube thoracostomy. We present a case of a patient with a post-CT-guided lung biopsy pneumothorax complicated further by subsequent inadvertent reversal of a Heimlich valve.

Case description
A 73-year-old lady with a 40-pack-year smoking history underwent an elective CT-guided lung biopsy of a right upper lobe lesion, and a subsequent post-biopsy plain radiograph showed a moderate right pneumothorax with right upper lobe pulmonary haemorrhage, which was treated by tube thoracostomy via an ambulatory Portex® drain and Heimlich valve, and with initial radiography confirming reduction in pneumothorax size. Subsequent chest radiography the following day demonstrated new extensive subcutaneous emphysema of the right chest wall extending into the neck, with an increase in pneumothorax size. Inspection of the drainage system revealed reversal of the Heimlich valve direction. When this was correctly repositioned, the radiographic findings improved.

Discussion
The Heimlich valve is a small plastic device housing a flutter valve, which, when attached to a tube thoracostomy, allows unidirectional flow of air from a pneumothorax. Valve malfunction and reversal have been associated with both tension pneumothoraces and one reported fatality. We discuss recent published literature on Heimlich valve use and associated complications, with the aim of raising awareness about patient safety issues associated with improper use of the device, as well as the importance of meticulous inspection of the drainage system when unexpected complications arise.

References
Deep vein thrombosis of unusual seat and pregnancy

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Introduction
Venous thromboembolism is a common clinical situation that causes morbidity and mortality that is still too high. DVT of unusual seat includ evenous thrombosis of the upper limbs, thrombosis cellars, digestive and cerebral. The aim of this work is to specify the epidemiological characteristics of unusual seat DVT and its prevalence during pregnancy.

Patients and method:
This is a retrospective study including 33 patients followed for TVP with unusual seat over a period of 10 years between 2007 and 2017.

Results:
The average of the patients was 45.2. The risk factors found were respectively :age (42.4%), obesity (42.4%), tobacco (30%), bedrest (24.2%), interventions surgical and postpartum (6.1%) and pregnancy (3%).

Conclusion:
The knowledge of risk factors for deep vein thrombosis is essential for any clinician, whether transient (bed rest, surgery, immobilization plastered ...) or permanent (age, cancer, thrombophilia ...).
Cardiovascular diseases
A-1792

Descriptive study of the characteristics according to the age of the patients with implantation of a cardiac electrostimulation device

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OBJETIVES
To analyze the differences of the patients that require implantation of an implantable cardioverter defibrillator (ICD) depending on the age.

METHODS
Patients with ICD implantation were collected from 2007-2016. They were classified into three groups: ≤40 years, 41-65 years and >65 years. Demographic data, cardiovascular risk factors and comorbidities were collected, data on heart disease with, monitoring data and mortality per year. The SPSS package was used for the statistical analysis. For the comparison of qualitative variables, the X2 test was used and ANOVA test for quantitative variables.

RESULTS
6.5% of patients were ≤40 years old, 46.7% between 41 and 65 and 45.6% >65 years old. 91 DAIIs were implanted. Men predominated (66.7%, 81% and 76.2%, p=0.664). HBP was more frequent among the older group (76.2%, p=0.008) and dyslipidemia in the intermediate age group (61.9%, p=0.013). The structural pathology that led to the indication of ICD in the group of younger patients was non-ischemic cardiomyopathy (33%), in the older groups ischemic heart disease (51.2% and 50%, p=0.001). They had NYHA II-III 33.3%, 37.2% and 66.3% respectively (p=0.025). There were no differences in the need for replacement, time elapsed and reason for it. 4 deaths were recorded within the older group (p=0.209). In the intermediate group more arrhythmic events were recorded (59.5%, p 0.483). Discharges were observed in 16.7%, 12.8% and 18.9% respectively (p=0.766). The adequacy of the therapy did not differ between groups (p=0.188), the discharges tended to be more appropriate in the older group (0%, 60% and 85.7% respectively).

CONCLUSION
When we analyzed patients according to age, we only found that those over 65 years of age suffered HTA more frequently and had a worse functional class. There are also differences between the structural pathology, with ischemic heart disease being the most frequent in the older age groups, and non-ischemic cardiomyopathy in the youngest.
Cardiovascular diseases
A-1790

**Descriptive study of the characteristics of patients according to the type of indication of cardiac electrostimulation devices**

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**OBJECTIVES**
To analyze the differences between patients implanted with an implantable cardioverter defibrillator (ICD) as primary prevention vs secondary prevention.

**METHODS**
Retrospective study of patients with implantation of ICD from 2007 to 2016. The sample was divided into two groups according to the indication of ICD, primary or secondary. Demographic data, cardiovascular risk factors, comorbidities, type of heart disease and the reason for the implant were collected. The evolution of patients was analyzed, including mortality one year after implantation, need for replacement and adequacy of therapy. The SPSS package was used for the statistical analysis. The qualitative variables were compared with the X2 test and the quantitative variables with the Student’s t test.

**RESULTS**
91 ICD implantation was performed, 56 for primary prevention and 35 for secondary prevention. The mean age in both groups was 62 ± 1.8 years in the first group and 62 ± 2.4 years in the second group (p=0.901). In the secondary prevention group, there was a higher percentage of hypertensive, diabetic, dyslipidemic patients, chronic obstructive pulmonary disease and renal failure than in the primary prevention group. No difference was found in the history of sudden family death (p=0.641). In both groups, ischemic heart disease predominated (p=0.439). Patients in the first group had a higher percentage of depressed ejection fraction (75% vs 42% p=0.003). No differences were found in the need for device replacement (p=0.268). Discharges were more frequent in the secondary prevention group (23% vs 11%). The adequacy of the therapy was greater in the primary prevention group (83% vs 57%), without significant differences.

**CONCLUSION**
We have not found significant differences between the patients to whom an ICD is implanted for primary prevention versus secondary prevention, with the exception of the ejection fraction that is more frequently depressed in those with indication for primary prevention.
Cardiovascular diseases
A-1796

Descriptive study of the characteristics of patients with ischemic heart disease who need implantation of a cardiac electrostimulation device

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OBJECTIVES
To study the characteristics and evolution of patients with previous ischemic cardiopathy (IC) requiring implantation of an automatic implantable fibrillator (ICD).

METHODS
Retrospective study of patients with IC and ICD implantation between 2007-2016. We collected demographic data, personal history, comorbidity and coronary angiography, systolic function and the reason for the implant. The evolution, need for device replacement and mortality per year were analyzed. The SPSS package was used for the statistical analysis. Quantitative variables are expressed as mean ± standard deviation if they followed a normal distribution or as a median ± interquartile range if they did not follow it. The qualitative variables are described with their percentages.

RESULTS
29 DAI’s were implanted. 93% men. Average age 65 ± 9 years. 74.4% HBP, 51.2% diabetes, 60.5% dyslipidemia, 19% non-smokers. In 27.5%, coronary angiography showed 3 affected vessels, 35% two vessels, 30% a single vessel, 5% three vessels and trunk. The most responsible vessel was AD (22,5%). The most frequent revascularization procedure was stent colocation (60%). The ejection fraction was depressed in 76.7%. The ICD was implanted as primary prevention in 55.8% and secondary prevention in 44.2%. In 42,1%, arrhythmic events were recorded, the most frequent arrhythmia was non-sustained ventricular tachycardia. In 10,5% some discharge was observed, being appropriate 50% of the time. 16,3% required device replacement, mean time of 50 ± 15 months. The cause of the change was "ERI" in 57,1% and infection in 42,9%. One year after implantation, 97% of the patients were alive.

CONCLUSION
ICD reduces mortality in patients with IC due to the effect of the treatment of sudden death due to ventricular arrhythmias. In our study, 10,5% of the patients required discharge therapy once the device was implanted, thus being able to avoid death and other complications related to the appearance of malignant arrhythmias.
Detection of Asymptomatic Atrial Fibrillation after a Stroke

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OBJECTIVE
Evaluate the percentage of AF after a stroke in an asymptomatic patient detected through 24 hours holter. Determine the number of patients who receive anticoagulant treatment after a stroke. Evaluate if there is any difference in risk factors and echocardiographic parameters between patients with AF detected by 24 hours holter and patients without.

METHODS
Observational retrospective study. We selected all patients who were in the neurology unit from January 2016 to April 2017. We excluded those with a previous AF. A total of 164 patients had had a stroke during this time but 6 were excluded because of a previous AF. The characteristics of our patients are: men 59.5%, high blood pressure 63.9%, dyslipemia 71.44.9%, previous stroke 17.1%, diabetes ellitus 37.3%, AI dilatada 17.7%, anticoagulation at discharge 22.4%, depressed ejection fraction 7%, Mitral valvulopathy 12.7%.

RESULTS
The mean age of our patients was 66.4. The percentage of AF detected by 24 hours holter was 15.8% (25 patients). All of them were discharged with an oral anticoagulant. A total of 31 patients (39.6%) some of them without an AF were discharged with an oral anticoagulant. (The majority of them because of ejection fraction severely depressed or because of embolic profil of the stroke). We didn’t find differences in risk factor or echocardiographic parameters between patients with AF or without it. Among the patients with AF, 6 of them had had a TIA and 19 had had an hemispheric stroke. None of the patients with a lacunar stroke had a AF.

CONCLUSION
The Stroke is an important health issue leading to significant morbidity and mortality so it is really important to prevent a new stroke. AF is likely the cause for many strokes but goes undetected due to the asymptomatic and intermittent nature of the disease. In our study we conclude that 24 hours monitoring holter is important for the detection of atrial fibrillation and for the starting of anticoagulant treatment in order to avoid new events.
Purpose: To evaluate the significance of clinical symptoms and risk factors in the diagnosis of pulmonary embolism with a small volume of pulmonary lesions.

Methods: A comparative study was carried out to assess the importance of clinical, laboratory and instrumental parameters in 463 patients with suspected pulmonary embolism, randomized into 2 groups. The first group consisted of 228 patients with pulmonary embolism with thrombotic occlusion in an average of 2.9±2.4 segmental arteries that correspond to not a massive volume of damage. There were 121 men, 107 women. The median age was 56.1±15.5 years. The second group consisted of 235 patients with excluded pulmonary embolism. There were 130 men, 105 women. The median age was 62.4±14.23 years.

Results: It was found that in patients of the first group the main symptoms of pulmonary embolism are presented statistically significantly less frequently than in patients of the second group: hypotension less than 90/60 was 0.4% and 6% (p<0.01), syncope - 1.5% and 7.7% (p<0.01), tachycardia over 100 beats per minute - 0.8% and 22.1% (p<0.01), dyspnea - 14% and 33.6% (p<0.01) respectively.

The most significant risk factors for pulmonary embolism were - physical inactivity, oral contraceptives: 21.7% and 11.1% (p<0.01), 4.3% and 0.4% (p<0.01) respectively.

Conclusion. In the diagnosis of pulmonary embolism with small volume of pulmonary lesions is not established none of the symptoms that would help to differentiate this disease from others. Suspected pulmonary embolism in these cases can help the presence of predisposing factors: physical inactivity or oral contraceptives.
Differences in morphological structure of diaphragm and mussels of low extremities in patients with chronic heart failure

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Purpose: To study the morphological features of diaphragm versus skeletal muscles in patients with different classes of HF and the role of respiratory muscles (RM) disorders in ventilation abnormalities in patients with HF.

Materials: 32 diaphragm autopsies (14 male, 16 female) with different lethal outcomes (8 MI, 9 stroke, 5 pulmonary embolism, 10 pneumonia) were taken in 1 hour after death. Patients were selected from the research database of patients with NYHA I-IV class HF. Patients with CAD, arterial hypertension and NYHA I-IV class HF with stable standard doses of drug therapy. Methods: percentage composition of muscle (MT), connective (CT), adipose tissue (AT), collagen and number of fibroblasts cells (FC) were studied in diaphragm and low limb skeletal muscle autopsies. Results of functional status (vital capacity, forced vital capacity were taken from research database. Spirometry was done during dynamic examination no longer then within 3 months of lethal outcome date. Results: Patients with NYHA I HF had 97% of MT, 1% CT, 2% AT, 8 FC in diaphragm vs 98% of MT, 1% CT, 1% AT, 2 FC in low limb, p>0.05. Patients with NYHA II HF had 91% of MT, 2% CT, 7% AT, 8 FC vs 95% of MT, 2% CT, 3% AT, 6 FC. Patients with NYHA III HF had 79% of MT, 13% CT, 8% AT, 21 FC vs 90% of MT, 4% CT, 6% AT, 9 FC, p<0.05. Patients with NYHA IV HF had 62% of MT, 20% CT, 18% AT, 35 FC vs 75% of MT, 10% CT, 15% AT, 17 FC. Collagen content in CT in diaphragm– 2% in patients with NYHA I, 5% in NYHA II, 8% in NYHA III, 15% in NYHA IV. Conclusion: The diaphragm undergoes structural changes with the increase in functional class of HF – connective tissue, collagen and adipose tissue is growing while muscle tissue is decreasing and this process starts earlier then in skeletal muscles of low limb. Respiratory functional disorders directly correlate with the products of inflammation process – the high content of collagen, fibroblasts and connective tissue.
Diseases of the circulatory system - a retrospective study in an Internal Medicine Service

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Objectives: The main objectives of this retrospective study are to characterize the major diseases of the circulatory system that mostly affect the patients hospitalized in an internal medicine service in the north of Portugal.

Methods: It was realized a consult of the clinical process of 135 hospitalized patients in the second half of 2017.

Results: Of the total number of patients observed (n = 135), 98 (72.5%) were Hypertensive, being the most frequent secondary diagnosis of patients admitted to the Internal Medicine Department. The great majority were always in control during hospitalization. Very close to Hypertension, Cardiopathy arises, most of the time, patients with Chronic Heart Failure (n = 88), and the largest sample of these patients does not have their disease studied and stratified. Of the 78 patients diagnosed with Atrial Fibrillation, 27 were hypocoagulated, remaining warfarin, the oral anticoagulant mostly used (n = 16; 60%). Rivaroxaban is the most commonly used DOAC (n=7; 26%).

Conclusion: The diseases of the circulatory system are an important morbidity factor for hospitalized patients, often conditioning hospitalization times. The authors intend to alert for their control and optimization in hospitalization.
Disseminated intravascular coagulation secondary to thoracic and abdominal aortic aneurysms

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Disseminated intravascular coagulation (DIC) is an acquired syndrome characterized by the dysregulated activation of coagulation and fibrinolysis, without a specific location, originating thrombotic and hemorrhagic phenomena and multiple organ dysfunction. It may progress in an acute, potentially fatal form or in a chronic, clinically silent form. The most frequent underlying conditions are sepsis, trauma and obstetric complications.

An 87-years old man was admitted to the hospital because of petechiae and easy bruising that had developed over the last 2 weeks. He had a personal history of recurrent pulmonary embolism for which he had received a vena cava filter and chronic anti-coagulation. Apart from petechiae and hematomas, he had no remarkable findings on observation. Blood tests showed thrombocytopenia (18x10^9/L), prolonged prothrombin and partial thromboplastin times, hypofibrinogenemia and high fibrin degradation products, compatible with the diagnosis of DIC. For etiologic investigation he performed a thoracic and abdominal computerized tomography, which revealed an aneurysm of the ascending aorta and another of the infrarenal aorta with 44 and 51mm, respectively. The complementary study did not detect any underlying neoplastic or infectious condition. The patient underwent endovascular aneurysm repair with placement of thoracic and abdominal vascular prosthesis. However, after the procedure he maintained features of DIC with uncontrolled bleeding, which culminated in his death.

DIC is a rare complication of aortic aneurysms, with a high mortality rate. It is potentially reversible if the underlying cause is treated. This clinical case shows the complexity and difficulty in the therapeutic approach of DIC.
INTRODUCTION: Given the progressive application of echocardiography in the bedside of the patient:

OBJECTIVE: Our objective was to observe the clinical-pathological characteristics of the patients who were asked for an echocardiogram during their hospitalization, according to a medical specialist in Internal Medicine (IM). In this poster we analyze what other tests were requested in these patients.

MATERIAL AND METHODS: Observational study of prospective cohorts. Sample 200 patients. Who an echocardiography was requested during their hospitalization.

RESULTS: 51% were women. The average age is 73.4 years, with 62.5% between 70-89 years old.

93.4% had a chest (C) x-ray versus 14.7% that was performed on the abdomen (A). A total of 131 CT scans were performed, 25 C, 38 A and 30 of the skull. 14 magnetic resonances were made. 23.5% of patients were asked for an abdominal ultrasound.

In the extended thoracic study (CT, MRI, PET and V/Q range); 62.5% of the patients, the only cardio-thoracic imaging test performed (excluding X-rays) was echocardiography.

If we analyze these data according to the reason for requesting echocardiography: heart failure was the main reason with 38.4% of requests, followed by 14.6% for dyspnea of uncertain origin; 8.6% was requested as a study of febrile syndrome without focus.

CONCLUSIONS: Echocardiography, despite being a simple test, has great specificity, so frequently in more than half of the cases (62.5%) it was not necessary to perform other imaging tests to establish the definitive diagnosis of our patients.

This test was requested mainly in patients admitted to heart failure and dyspnea o. And the complementary test performed in those cases in which another imaging test was needed was the CT.
Do we handle cardiac insufficiency in the palliative patient?

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OBJECTIVES

To describe palliative heart failure patients population comparing its management to an acute patient plant.

METHOD

Patients admitted in 2015-2016 with diagnosis at discharge of heart failure are included. The variables were: demographic characteristics, comorbidities, treatment at discharge, Barthel scale, Charlson scale and type of heart failure (according to ejection fraction).

RESULTS

Sample of 113 patients (61% women). The age average was 83 years. The most frequent comorbidity was HBP (80%). Sixty percent of palliative patients had a moderate-severe dependence (Barthel <60), compared to 40% of the acute ones (p = 0.001). 97% of patients had high comorbidity (Charlson), compared to 74% of the control group (p = 0.02). In 43% of palliative patients, there was no guide echocardiography, compared to 1% in the control group. 22% of acute patients had heart failure with a reduced ejection fraction, compared to 2% of the palliative group. At discharge, both groups had loop diuretics (80%) with p = 0.65. 83% of palliative patients did not present a mineralocorticoid receptor antagonist (p = 0.056). 49% of palliative patients did not present an ACEI (p = 0.135). Beta-blockers were present in 33% of the palliative agents and in 64% of the acute ones (p = 0.002).

CONCLUSION

Comorbidity and dependence are higher in the palliative care units. The absence of echocardiography leads to ignorance of structural heart disease or ventricular dysfunction. Treatments that are beneficial in heart failure are rarely used in this palliative population.
Does peritoneal ultrafiltration play a safe role in patients with refractory congestive heart failure?

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Objectives
The aim of our study is to analyze if the implementation of peritoneal ultrafiltration (UF) in patients with refractory congestive heart failure (RCHF) involve any adverse event.

Methods
Observational prospective study of patients diagnosed with RCHF undergoing peritoneal UF. All patients fulfilled inclusion criteria for the Peritoneal Dialysis (PD) program. 12 months of follow-up was performed in 15 patients, in this period we analyze the incidence of adverse events as well as survival. The overall incidence rate of peritonitis should not exceed 0.5 episodes / year in international Society for Peritoneal Dialysis.

Statistics: categorical variables are presented as frecuency values and compared by chisquare test and continuous variables are presented as mean±standar deviation (SD).

Results
Fifteen patients were followed up for 12 months with a mean age of 66.2 years. Most of them were men (Male n = 11). No patient died during the follow-up. During this period, one patient had 2 episodes of aseptic peritonitis that required hospitalization and another patient had a single episode of bacterial peritonitis. Other patient had 2 episodes of catheter obstruction due to entrapment of the omentum. The Incidence Rate of peritonitis was 0.11 episodes / year. The total incidence rate of adverse events were 0.17 episodes / year.

Conclusion
Peritoneal UF plays a safe role for the treatment of patients diagnosed with refractory congestive heart failure.
Dysphagia lusoria – A rare cause of dysphagia

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Introduction: Dysphagia lusoria is an impairment of one’s swallowing ability caused by an aberrant right subclavian artery.

Case description: 85 year-old-female was admitted with hematuria and intravesical expansive solid tumor suggesting malignancy. The patient also reported having suffered from an esophageal dysphagia to solid food for several years. Laboratory results showed Hb: 8.4 g/dL, MCV: 73.1 fl, MCHC: 31.0 g/dL, WBCs: 11230/μL, Neutrophils: 91.7%, Platelets: 307000/μL; Tumor biopsy disclosed a papillary urothelial neoplasm of low malignant potential (PUNLMP). Body CT scan didn’t show any metastasis, but was able to identify a retro-esophageal path of the right subclavian artery.

Discussion: Lusoria artery, also known as aberrant right subclavian artery (ARSA) is a rare anatomical variation (0.5-2% incidence), that may be associated with chronic low dysphagia, as seen in this case.
Cardiovascular diseases
A-1496

Effects of inhibitors of Sodium-Glucose Cotransporters type 2 (i-SGLT2) on Heart Failure Episodes: Analysis of a Monographic Diabetes Reference Record.

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Introduction: Heart failure is the most frequent cardiovascular complication of type 2 diabetes. Some hypoglycaemic medications (sulfonylureas, glitazones, saxagliptin, ...) can potentially increase the risk of heart failure (measured with hospitalization for heart failure), and others seem to be neutral in that regard. Recently we have a new therapeutic group that can reduce the risk of heart failure (i-SGLT2).

Material and method: We collected a retrospective cohort using the databases of the Diabetes Monographic Consultation of the Gutierrez Ortega Hospital. The population comprised adults over the age of 18 who received regular care in our clinic during the last 18 months and were treated with oral hypoglycaemic agents at least during that time. Patients taking oral hypoglycaemic agents and having a serum creatinine <1.5 mg/dL were followed from the start of randomization until a decompensated heart failure event or cardiovascular death. Acute decompensated heart failure was defined as an event if it was the primary reason for hospitalization. We performed an additional analysis of the subgroup of patients with a history of heart failure. Among 346 patients with oral hypoglycemic agents, 81 were users of i-SGLT2 (43 with canagliflozin, 26 with dapagliflozin and 12 with empagliflozin). Average age was 67 years, 7% of patients had a history of heart failure and 18% had cardiovascular disease; the median of HbA1c was 7.2% (6.3, 8.1) at the beginning of randomization.

Results: There were 7 (8.64%) versus 33 (13.41%) heart failure hospitalizations or cardiovascular deaths among iSGLT2 versus no iSGLT2, respectively (86.4 versus 134.1 events per 1000 person-years), adjusted hazard ratio [aHR]: 0.68 (95% CI). Results were consistent by history of heart failure.

Conclusions: Patients using i-SGLT2 had a lower risk for decompensated heart failure or cardiovascular death. This observation confirms that therapy with i-SGLT2 is preferred to other.
Endothelial dysfunction in patients with arterial hypertension in combination with obesity and / or type 2 diabetes mellitus: the role of systemic inflammation.

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Objectives: to study the role of systemic inflammation in the progression of endothelial dysfunction in patients with arterial hypertension (AH) in combination with obesity and / or type 2 diabetes mellitus (DM).

Methods: 90 patients stage II-III of AH age from 45 to 65 years old were divided into 3 groups. Group 1 was represented by patients with "isolated" AH, group 2 was represented by patients with AH in combination with obesity, group 3 was represented by patients with AH and type 2 DM. A standard physical examination was performed, laboratory markers of systemic inflammation, endothelial dysfunction and fibrosis were determined.

Results. The concentration of C-reactive protein (CRP) was statistically significantly higher in patients with AH and type 2 DM than in those with AH and obesity and those with "isolated" AH (7,92 [4,77; 16,15] vs 4,77 [4,53; 5,43] and 7,92 [4,77; 16,15] vs 2,98 [0,65; 7,19] mg/l, respectively). The level of endothelin-1 (ET-1) in the serum increased from 1 to 3 group, achieving significant differences between all studied groups. The concentration of type 4 collagen in the serum was statistically significantly higher in patients with AH and type 2 DM than in patients with AH and obesity and "isolated" AH (5,67 [3,58; 9,20] vs 2,94 [2,57; 8,45], 5,67 [3,58; 9,20] vs 2,63 [2,23; 7,28] ng/ml). Highly reliable relationships between the concentration of CRP and the level of ET-1 (r=0.51), between ET-1 and duration of type 2 DM (r=0.58), body mass index (r=0.35), smoking (r=0.54), between the concentration of type 4 collagen and the duration of type 2 DM (r=0.36) were found.

Conclusions. The obtained data testify a significant role of systemic inflammation in the progression of endothelial dysfunction in patients with AH in combination with obesity and / or type 2 DM.
Etiological descriptive study of cardiac insufficiency in patients with novo cardiac insufficiency that develop diabetes mellitus type 2 in its evolution

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OBJECTIVES:
The aim of the study is to know the etiological factors of heart failure (HF) in newly-developed HF patients who develop diabetes mellitus type 2 (DM2) in their evolution

METHODS:
From a cohort of 1519 patients with new diagnosis of HF and type 2 diabetes mellitus, the etiological factors of newly heart failure diagnostic were described, distinguishing between ischemic, hypertensive, valvular, ischemic-hypertensive and other etiologies. The results were analyzed based on the characteristics of a descriptive study.

RESULTS:
A total of 1519 patients were analyzed. Etiology: Ischemic (angina or AMI) 779 (51.3%), HTA 653 (43%), Valvular 91 (6%), Ischemic-HTA 1103 (75%), Other 33 (2.1%).

CONCLUSION:
In the patients diagnosed with new HF and developing type 2 diabetes mellitus, the most relevant etiological factor is the ischemic etiology combined with hypertension; being the ischemic etiology the most prevalent, in contradistinction to the valvular etiology or other causes. These results agree with the ones described in the literature, with the peculiarity that they were patients with first episode of HF and subsequent development of DM2.
The ischemic-hypertensive etiology is the most prevalent cause in PC with the novo HF that subsequently develop DM2 in its evolution. The internist integral handling in this type of patients is pretty important. A clinical management focuses on the adequate cardiovascular risk factors control (dyslipidemia, hypertension, ...), either at the primary and secondary prevention level.
Evaluation of Cardiovascular Risk Factors in a HIV-Positive Population over 26 years

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Objectives: The HIV patient is at increased cardiovascular risk due to the virus itself, chronic inflammation and the effects of drug treatment. We analyse the main cardiovascular risk factors before and after starting antiretroviral therapy (ART).

Methodology: Observational, analytical, retrospective study of 149 HIV+ patients in follow-up consultations of Infectious Diseases between January 1992 and December 2017, using the clinical history and statistical package SPSS 24.0 as a tool.

Results: The majority of the population studied was male (72%), with an average age of 50.34 ± 0.752 years and an average age at diagnosis of HIV of 35 ± 0.830 years. The average CD4 nadir is 229.31 cells/mm3 ± 13.56 and 4.4% have LV > 20 copies/ml, the rest being undetectable. 100% receive ART, 46% receive protease inhibitors (14% Cobicistat-enhanced and 7% Ritonavir-enhanced) and 21.3% receive integrase inhibitors. Prior to the introduction of ART: 74.2% had a smoking habit, 26.4% alcoholism, 18% cocaine use, 2.5% high blood pressure, 3.8% diabetes, 1.3% total cholesterol > 200 mg/dL and 1% obesity. After the introduction of ART: 53.3% had a smoking habit, 6% alcoholism, 20.7% high blood pressure, 14% diabetes, 52% total cholesterol > 200 mg/dL, 82% HDL cholesterol < 40 mg/dL and 29.3% metabolic syndrome. An increase in cardiovascular risk is observed with a "very high risk" SCORE of 0.5% before ART and 41.3% after ART (p< 0.001). The main variables associated with a risk >10% are male gender at >50 years, smoking, lower CD4 nadir, increased LDL after ART and statistically significant protease inhibitor therapy (p < 0.05). 4.6% had suffered a cardiovascular event, with a predominance of ischaemic heart disease (57.14%).

Conclusions: Prevention strategies are necessary, with special emphasis on the importance of primary prevention for the control of cardiovascular risk factors in the HIV population.
Evolution of heart rate in patients with OSAS and atrial fibrillation treated with CPAP

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Background. Obstructive sleep apnea syndrome (OSAS) is commonly found in patients with cardiovascular disease, the prevalence of atrial fibrillation in patient diagnosed with moderate or severe OSAS being 3%. The pathophysiological mechanisms involved are intermittent hypoxia and stimulation of the sympathetic nervous system. The study objectives was the assessment of heart rate in patients with OSAS and atrial fibrillation treated with CPAP.

Materials and methods. Prospective, interventional study, involving 20 patients with atrial fibrillation and OSAS, divided into 2 groups. Group A included 10 patients treated with beta blockers and CPAP, in group B were enrolled 10 patients treated only with pharmacological therapy. They were monitored at 3 and 6 months after inclusion. For statistical analysis were used SPSS versions 23 and Microsoft Excel 2016.

Results. In group A at inclusion, mean heart rate was 101.2 beats / minute, and in group B mean heart rate of 89.57 beats / minute. At 3 months of enrollment in group A, mean heart rate was 78.33 beats / minute, and in group B 77 beats / minute. At 6 months in group A mean heart rate is 82 beats / min, and in group B is 95 beats / min.

Conclusions. These results could support the idea that heart rate decreases in patients with atrial fibrillation and OSAS who have used CPAP for 6 months, but the small number of patients prevents us from extrapolating this statement, and requires further research.
Experience in cardiac electrostimulation in a tertiary hospital

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OBJECTIVES
To study the characteristics of the patients who were implanted with an implantable cardioverter defibrillator (ICD).

METHODS
Retrospective study of patients who required an ICD from 2007-2016. Demographic data, cardiovascular risk factors, comorbidities, type of heart disease and the reason for the implant were collected. The evolution of patients, mortality per year, need for replacement and adequacy of therapy were analyzed. For the statistical analysis the SPSS package was used. The variables are expressed as percentages, means or medians.

RESULTS
91 patients required ICD implantation. The mean age was 62±3 years, 78% males. 37% with diabetes, 62% hypertension, 50% dyslipidemia and 21% obesity. 16% with chronic obstructive pulmonary disease and 10% renal insufficiency. The most common cause of ICD implantation was systolic dysfunction secondary to ischemic heart disease (47%). 62% had depressed ejection fraction (<30%). The indication of the device was made as primary prevention in 61% patients and secondary prevention in 38%. In 18% of cases it was necessary to change the device, mean time of 55±8 months. In 68% of patients due to entry into the elective replacement period, pocket infection being the second most important cause. The mean time of follow-up was 72±8 months. Arrhythmic events were recorded in 54% of the patients, with the most frequent arrhythmia being non-sustained ventricular tachycardia. In 15% discharges were observed being appropriate in 69% of the cases. One year after implantation, 95% of the patients were alive.

CONCLUSION
The ICD has become one of the main therapeutic options in patients with malignant ventricular arrhythmias, sudden cardiac death or high risk of developing them. The most frequent indication for ICD in our patients was systolic dysfunction secondary to ischemic heart disease. In 10% of patients, appropriate discharges were registered, thus avoiding the consequences triggered by the malignant arrhythmia.
Cardiovascular diseases
A-1927

Fatal events caused by hypertrophic cardiomyopathy from 2015 to 2017 in Latvia

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Objectives: to collect and analyse the autopsy data of hypertrophic cardiomyopathy (HCM) cases in Latvia and to get an insight of the spread of the disease and its demographic characteristic.

Background: HCM is a genetic disease that is often inherited autosomal dominant way. In most cases the disease is asymptomatic. Sudden death is often the first clinical manifestation of the disease.

Methods: analysis of autopsy conclusions for the period from 1 January 2015 to 31 December 2017 carried out in State Centre for Forensic Medical Examination.

Results: analysis revealed 42 cases of HCM with no prior known cardiac or other diseases, 32 were males (76.2%) and 10 females (23.8%), mean age was 43.73 ± 11.44 years. In 20 cases (47.6%) death occurred in hospital, in 17 cases (40.4%) - at home, in 5 cases the place of death was not specified. Mean heart weight was 533.87 ± 105.62 grams (g), mean left ventricular (LV) weight was 178.93 ± 43.12 g, mean septum weight was 138.1 ± 44.58 g, mean LV wall thickness was 22.7 ± 2.5 millimeters (mm). Positive relation was detected between the age and LV weight (r=0,566), the age and septum weight (r=0,427), the age and heart weight (r=0,533), all statistically significant (p≤0,05).

Conclusions: undiagnosed HCM as a cause of sudden death is more common finding in autopsies of young and pre-middle age males. Mean results of heart anatomical features are significantly higher than in normal population and fit in range for HCM. Their positive relation with age represent possible progressive myocardium thickening in HCM. These cases should be dealt with in depth and at least first degree relatives should be offered additional examinations and genetic screening for the detection of a possible disease, this practice should be implemented in routine.
The aim of the study was to study the pathogenetic features of idiopathic heart rhythm disorders (HRD) in women in different periods of pregnancy. Materials and methods. 105 women were enrolled in the study, 84 of them were pregnant: 43 patients with HRDs during pregnancy, mean age 29.93 ± 2.32 years, and 41 women without HRDs (28.7 ± 2, 14 years). The control group consisted of women (n = 21), non-pregnant, without HRDs (28.53 ± 3.11 years). Women in all groups were evaluated for the activity of the sympathoadrenal system (SS) for the level of adrenoreception of erythrocyte membranes (β-ARM), evaluation of the structural and functional parameters of the left heart with the help of echocardiographic (EchoCG) studies. The evaluation of the diastolic function was carried out using the recording of high-amplitude reflected motion signals (HRMS). In order to confirm the presence of diastolic dysfunction the morphofunctional diastolic index (MFDI) was tested by the formula: MFDI = LA / Ea, where LA is the diameter of the left atrium, and Ea is the peak value of Ea HRMS. Results. Women with idiopathic HRDs in both II and III trimesters showed a higher level of β-ARM. In 100% of cases, women with HRDs had hyperadrenergic type of adrenoreactivity (β-APM more than 40.0 conventional units). In pregnant women with idiopathic HRD in the III trimester there were observed an increase in the indexed size of LA, indexed terminal diastolic volume (ICDD), left ventricular myocardial mass index LVMI), LV remodeling according to the type of eccentric hypertrophy of myocardium in 34.8% of cases. Reliable correlation between the level of β-APM and the parameters characterizing the diastolic function of the LV (MFDI, the magnitude of the Ea peak HRMS), as well as between the values of the circadian index and LVMI, MFDI in pregnant women with idiopathic HRD is revealed, which indicates the influence of hypersympathicotonia on the structural-functional remodeling of the left heart.
Objective: To establish a correlation between the FRAX score and 10-year estimated Atherosclerotic Cardiovascular Disease Risk (ASCVD) in asymptomatic males compared to females.

Methods: Cross-sectional study in Mexico City in asymptomatic outpatients. ASCVD was calculated using the American College of Cardiology/American Heart Association formula (2013-ACC/AHA); densitometry was performed using a Hologic-Discovery device. We used current accepted cutoff points for: high ASCVD ≥7.5%, FRAX for major osteoporotic fractures (MOF) ≥10% and hip fracture (HF) ≥3% and adjustments for trabecular bone score (TBS). Results: 213 patients from January 2017 to March 2018. 46.7% were men. Men were older (68.5±9.9 vs. 58.2±11.7, p<0.001), had more hypertension (39.4 vs. 19.5%, p<0.01), diabetes (17.2 vs. 6.2%, p=0.01) a higher mean 2013 ACC/AHA and FRAX-HF [24.9 % (CI 95%, 22-27) vs. 8% (5.8-10.2), p<0.01] and [1.1 (95% CI, 0.56-1.6) vs. 0.4% (0.29-0.53), p<0.01]. Smoking status, alcohol consumption, dyslipidemia were similar between the groups. 8% of women and 4% of men had a prior fracture. ASCVD risk and FRAX-MOF had a higher correlation for females than for males [(Pearson’s r=0.54, p<0.01) vs. (r=0.16, p=0.11), respectively] that increased when adjusted for TBS [(r=0.56, p<0.01) vs. (r=0.36, p=0.02), respectively]. The discriminating capability of total FRAX-MOF for a previous fracture was similar for females vs. males ((AUC=0.8 (95%CI, 0.7-0.9) vs. (0.68, 0.47-0.89), p=0.2), respectively). FRAX-MOF adjusted for TBS showed a discriminating capacity for patients with both a previous fracture and high ASCVD and was similar between females and males [(AUC=0.92, 95% CI 0.8-0.98) vs. (0.9, 0.7-1), p=0.8]

Conclusions: Stronger ASCVD risk scores correlate with higher FRAX scores. The correlation is stronger in females than in males. It increases when adjusting for TBS, particularly in males. Microarchitecture of the bone may be affected in male subjects with high ASCVD risk.
Functional class of clinical presentation in patients with de novo heart failure who develop diabetes mellitus type 2 in its evolution. Descriptive study in a specialty hospital

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OBJETIVES
We want to know the clinical presentation of the novo heart failure (HF) in patients who develop type 2 diabetes mellitus in their evolution.

METHODS
Of a cohort with first diagnosis of HF patients (6561), those with diabetes mellitus type 2 were excluded at the time of the episode (1247) and those who developed diabetes mellitus type 2 were selected (1519). The studied variables were: vascular congestion presence, crackles presence, and NYHA functional class.

RESULTS
Finally, 1519 patients were analyzed, presenting: vascular congestion 641 (42.2%), crackles 709 (46.7%), Functional Class NYHA I 289 (19%), II 656 (43.2%), III 410 (27.4%), IV 158 (10.4%).

CONCLUSION
The most prevalent clinical form of HF in patients who progressed to develop type 2 diabetes mellitus was the crackles presence and the NYHA II functional class (followed by NYHA III, I and IV). NYHA type II functional class was the most prevalent in patients with the novo heart failure who developed type 2 diabetes mellitus in their evolution, as well as the auscultation of crackles such as signs in the exploration of this type of patient.
Heart failure and chylous ascites: an uncommon cause of a rare condition

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INTRODUCTION:
Chylous ascites is a rare form of ascites characterized by high triglyceride content. Heart failure is a rare cause of this condition.

CASE DESCRIPTION:
65 years old male patient, obese, with known hypertension, dyslipidemia, type 2 diabetes mellitus, stage III chronic kidney disease and ischemic heart failure (HF), with severe left ventricular dysfunction (LVEF 23%). He went to the emergency department complaining of a 2 weeks history of aggravated dyspnoea, orthopnoea and anasarca. No signs or symptoms of infection. EKG showed no alterations suggestive of acute myocardial ischemia or signs of ventricular arrhythmias. No rise of high-sensitivity cardiac troponin or inflammatory markers. Evacuation paracentesis was performed for respiratory relief, with drainage of turbid yellowish fluid with albuminocytogenic gradient of 13 g/dl, cytology: 220 Cels/dl and Leuk: 193/dl and triglyceride level of 209 mg/dl. Thoracoabdominopelvic CT showed no signs of obstruction of the lymphatic system. Immunophenotyping of ascitic fluid was normal and both PCR of and cultural examination for M. tuberculosis were negative. Citology was also negative for malignant cells. No history of trauma or abdominal surgery. Echocardiogram showed worsening of left ventricular dysfunction (LVEF: 17%) and de novo right ventricular dysfunction. It was admitted heart failure progression, and without another cause, assumed chylous ascites of cardiac etiology. Resolution of chylous ascites after restriction of long chain fatty acids, and improvement of symptoms after intensification of diuretic therapy were observed.

DISCUSSION: The incidence of chylous ascites is unknown. Most of the described cases of chylous ascites of cardiac etiology are related to constrictive pericarditis, which has a good prognosis after pericardiectomy. There are few reported cases associated with HF, characterized by severe impaired ventricular function and worse prognosis.
Heart failure challenges in the 21st century

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Objectives: Heart failure (HF) is an important cause of morbidity, mortality and a burden to the healthcare system. We investigated patient’s characteristics associated with readmission in our hospital.

Methods: Retrospective data were collected to characterize patients over 85 years of age readmitted in the Internal Medicine ward due to decompensated HF, from January 1st 2011 to December 31st 2016.

Results: 128 patients were included in the analysis, the majority with ages between 85 and 90 (73%); 67% were female; 96% were on diuretics. The average number of readmissions was 3. At least 75% died following decompensated HF, 18% at the first readmission. Approximately 60% of patients were readmitted within the 30 days of discharge. Hypertension, atrial fibrillation (AF) and renal disease were the main comorbidities. 80% had diastolic HF (dHF), mostly hypertensive (92%). dHF patients had more comorbidities (6 on average) - arterial hypertension (97%), AF (73%), anemia (70%) - and more than 1 readmission (76%). On the other hand, systolic HF (sHF) patients were less dependent (36%), had lower therapeutic compliance (12%), and had higher prevalence of renal disease (80%) and diabetes (48%).

With regard to gender, men had a higher prevalence of hypertension (86%), sHF (28%) and hypertensive HF (78%); women had higher prevalence of AF (76%), obesity (41%), cerebrovascular disease (36%), dHF (83%) and valvular HF (27%).

The main cause of decompensation was infection (respiratory-81%; urinary-16%); the influence of hypertension, hypothyroidism and tachyarrhythmia was more representative in dHF patients.

Conclusion: Readmissions in elderly patients due to decompensated HF are mainly due to non-cardiac causes. Beyond the management of cardiovascular risk factors, it is also important to prevent infections in these patients.
Heart Failure, myocarditis and viral infection - What is the relation?

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Introduction: Myocarditis defines a state of inflammatory disease of the heart muscle. It may be classified as acute, subacute or chronic, with focal or diffuse involvement of the myocardium. In symptomatic patients, the cardiac presentation is often that of acute heart failure.

Case description: 59-year-old male, previously healthy, presented to the emergency department with complaints of bloodborne cough, lower limb (LL) edema, easy fatigue, orthopnea and fever, over the previous week. He reported influenza-like illness 3 weeks before. On observation he was feverish and with edema of both LL. Pulmonary auscultation evidenced scattered wheezing, and crackles in the lower third of both lungs fields. Chest radiography showed bilateral heterogeneous hypotransparency. A mild respiratory alkalosis was seen in the arterial blood gas exam. Analytically with lymphopenia, thrombocytopenia, altered liver function tests and increased cardiac markers and brain natriuretic peptides, compatible with myocarditis. He was hospitalized and an echocardiogram was performed, revealing dilated cardiomyopathy, with severe depression of the systolic function and diffuse hypocontractility. On the second day of hospitalization, marked clinical deterioration was observed, with increasing acute phase markers, radiological aggravation and type I respiratory failure, refractory to noninvasive ventilation. Invasive mechanical ventilation and admission in the intensive care unit were needed. Serology for H1N1 virus was positive and oseltamivir therapy was initiated.

Discussion: Viral etiology is frequent in the context of myocarditis and has a significant clinical impact. Therefore, the authors consider it should be taken into account in the etiological investigation of these patients.
Hemorrhagic Stroke in an Internal Medicine Ward – clinical features and functional impact

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Background: Hemorrhagic stroke is associated with significant morbidity, mortality and need for extensive multidisciplinary care. Our objective is the characterization of the population admitted to our ward with diagnosis of hemorrhagic stroke in a period of 5 years.

Methods: Retrospective study, based on the electronic health record of all the patients admitted with hemorrhagic stroke between January 2012 and December 2017.

Results: A total of 120 patients were admitted, 65.8% were male, average 71.9 years old. 94 patients were transferred from the emergency department, 16 from the Intensive Care Unit and 10 from Cerebrovascular Unit. Most of the patients had >2 associated risk factors, hypertension being the most prevalent (80.8%), 18 had atrial fibrillation (only 50% under proper anticoagulation, even though all scored >1 on CHA2DS2-VASc). 38 were taking antiplatelet medication, half without clear indication. Average length of stay - 15.4 days; infectious complications occurring in 53 patients (64.2% respiratory tract infections). 8 patients were submitted to decompressive craniectomy. 84.2% scored < 2 on modified Rankin Scale before the event, with predictably worse scores after the event (17% >3 points; 29.5% >4; 17% >5). Mortality during hospital stay was 25% (n=30); 26 went to a continued care facility. 17 patients were discharged under antiplatelet/anticoagulant agents.

Conclusion: Hemorrhagic stroke is associated with a prolonged length of in-hospital stay, a significant rate of nosocomial infections and a greatly increased morbidity and mortality. Most of the patients had modifiable risk factors, namely hypertension with some taking antiplatelet agents without clear indication.
Cardiovascular diseases
A-1329

Hemorrhagic stroke – A year in review

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Introduction: The cerebral hemorrhage is the second most common cause of stroke. Statistics refer an annual average of 16 to 33 cases per 100,000 persons. There are multiple causes associated with hemorrhagic stroke (HS), being the principal ones the arterial hypertension, amyloid angiopathy or vascular malformation.

Objective: To study the etiology, location, risk factors and outcome of patients admitted for HS in one year.

Methods: Retrospective study regarding admitted patients for HS at the Neurology and Internal Medicine Department of Pedro Hispano Hospital.

Results: The study, performed between December 2016 and December 2017, included a total of 75 patients, all of them admitted for HS at the Neurology and Internal Medicine Department. A total of 43 patients (57%) were males, with an average age of 73.6 years. In 59 cases (79%), the hemorrhagic main lesion was localized in a supratentorial structure; In those patients, only 26 cases (44%) were localized at cortical level being the remain 33 cases (56%) hemorrhagic lesions in deep structures. Regarding cerebrovascular risk factors, the most common were arterial hypertension in 68 cases (91%), followed by dyslipidemia in 51 cases (68%). This fact is observed at the emergency department admission as 51 patients (68%) presented a hypertensive hemodynamic status (>140/90mmHg). The hemorrhagic stroke patient was accompanied by a Pre-hospital emergency physician in only 29 cases (39%). The “mRankin score” at admission was situated at 1.82, being at the moment of patient discharge from the hospital calculated at 3.51. The admission average time was 16.6 days with a global mortality was situated at 16% (12 cases).

Conclusions: The HS remains an important cause of morbimortality around the globe. The patient’s prognosis depends on the location, volume of the lesion but also the compression of adjacent structures. Although the authors present a mortality of only 16%, worldwide mortality is situated in 35 to 52%.
Hoarseness unravelling a mycotic aortic aneurysm: a surprising diagnosis

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Introduction: Mycotic aneurysms are degeneration of the arterial walls in result of infection due to bacteremia or other septic embolization. They are associated with significant morbidity and mortality.

Case Description: The authors present the case of a 77 years old man with a 2 months duration anorexia, weight loss, and, 15 days prior to admission, dysphonia and selective liquid dysphagia. Of note, he was an insulin treated diabetic and there was a previous hospital admission in the context of a E. coli bacteremia attributed to acute prostatitis (treated with amoxicillin and clavulanic acid for 21 days). On physical examination low grade fever, a holossystolic left sternal murmur (not previously described), hoarseness and liquid dysphagia were noted. Lab workup revealed elevation of inflammatory parameters. Urgent videolaryngoscopy showed a left vocal cord paralysis. Chest X-ray showed mediastinal enlargement not present in previous radiograms. Thoracic CT scan unravelled an irregular saccular aneurysm and densified periaortic tissues, suggestive of a mycotic aortic arch aneurysm. Transthoracic echocardiogram was normal and syphilis was excluded. No microrganisms were detected in hemocultures, although urine culture isolated a multisensitive E. Coli. Prompt treatment was initiated with vancomycine and metronidazole and transfer to a cardiothoracic center for surgical debridement and vascular reconstruction.

Discussion: Mycotic aneurysms may often be misleading during the early stages, resulting in misdiagnosis and delay in treatment. In this case, presenting features of dysphonia, dysphagia, wasting and mediastinal enlargement prompted a differential diagnosis of a neoplastic or a neurological cause. Unravelling a treatable, high morbidity, infectious cause was surely surprising.
Idiopathic Jugular Thrombosis: A case report

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Introduction
Venous thrombosis of the neck and upper extremities is a rare entity and represents less of 5% of the total of venous thrombosis. Risk factors included the presence of intravascular devices, trauma, infection in ENT area, drug or oral contraceptives use or hypercoagulability state like the presence of malignancy.

Case description
We report a case of a 37-year-old female with history of high blood pressure and obesity. She reported left side neck pain and fever in the last seven days. At physical examination we observed cervical swelling with inflammatory signs and an indurated adenopathy. In blood test we only observed an elevated C reactive protein level. An ultrasound was performed and was found a thrombosis in the proximal area of left internal jugular vein and multiple adenopathies. We completed the study with fine needle aspiration and a CT but them did not add any relevant information. Blood test was extended with an autoimmunity and a thrombophilia test that result negative. We started the treatment initially with low molecular weight heparin and subsequently with oral anticoagulant therapy. After six months of treatment the clot had disappeared in the US and the patient was asymptomatic.

Discussion
The finding of idiopathic jugular thrombosis is unusual, but in absence of risk factors we have to take into consideration. Usually appears like a laterocervical mass associated to inflammatory signs and fever. Diagnosis is confirmed with cervical ultrasound or CT scanner. The main risk of this disease is fragmentation and progression to pulmonary embolism (present in 5% of cases), for that reason is very important early anticoagulation.
Idiopathic Pulmonary Arterial Hypertension

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INTRODUCTION

Idiopathic pulmonary artery hypertension (IPAH) is a progressive disease that affects the precapillary pulmonary vasculature. The pulmonary artery pressure is persistently above 25mmHg. If left untreated, IPAH results in increasing backward pressure, right heart failure and death. Older patients usually have a poor prognosis due to comorbidities and a diminished response to therapy.

CASE DESCRIPTION

A 79 year old male, with prior history of coronary heart disease, heart failure with preserved ejection fraction and type 2 Diabetes mellitus presented to the emergency department with shortness of breath. On admission, his blood pressure and heart rate were normal, but his peripheral arterial oxygen saturation was 81%. Arterial blood gas analysis revealed hypoxemic respiratory failure (pO2/FiO2=220). Echocardiography demonstrated a pulmonary artery systolic pressure of 100mmHg, flattening of the interventricular septum, right ventricular hypertrophy and pulmonary and tricuspid regurgitation. HIV testing was negative. Rheumatoid factor, antineutrophil cytoplasmic and antinuclear antibodies were normal. There was no exposure to drugs known to induce pulmonary arterial hypertension. Abdominal ultrasound showed no signs of hepatic disease. Right heart catheterization revealed a mean pulmonary artery pressure of 36mmHg, a pulmonary wedge pressure of 10mmHg and a pulmonary vascular resistance of 6.75uWood. Vasoreactivity test was negative. The patient was started on sildenafil 10mg tid, which he did not tolerate, and ambrisentan 5mg id. He was discharged 32 days after admission, on ambrisentan 5mg id and continuous oxygen therapy. Although his symptoms improved over the next 6 months (WHO functional class II), the patient was readmitted 9 months later due to pneumonia and died.

DISCUSSION

IPAH can be a progressive fatal disease, even with appropriate treatment. Factors associated with poor prognosis include older age, male gender and functional class III or IV.
Impact of a previous heart ischemic event in the mortality of an acute ischemic stroke

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Introduction: Heart failure and others cardiologic events, such as myocardial infarction, are associated with an increased risk of stroke, reduction of individual capacity of adaptability, and can also predispose patients to other pathologies. Therefore, it is assumed that a previous cardiologic historical can be associated with a worse prognose, resulting in some cases in mortalities

Methods: In a single-centre retrospective study, patients were admitted with an ischemic stroke between 1 January 2013 - 31 December 2014. Only patients diagnosed with stroke and with a well-documented medical history were admitted in this study. Previous ischemic events was defined as a myocardial infarction with or without ST elevation, and the association between a previous heart attack and the outcome after admission was explored with the chi-square statistical test.

Results: 362 patients were included in this study. 52/362 possess a previous history of myocardial infarction, with 76 ± 12 years old, 43% of them male, 89% with arterial hypertension, 54% with dyslipidemia and 35% with diabetes mellitus type 2. The group without myocardial history is constituted by patients with 74 ± 12.5 years old, 53% male, 84% with arterial hypertension, 43% with dyslipidemia and 43% with diabetes mellitus type 2. Both groups were compared by mortality rates in admission for a primary ischemic stroke to understand if ischemic infarction was an independent predictor factor on the outcome of these patients (p=0.061).

Conclusion: In our study, patients admitted with a primary stroke with ischemic myocardial infarction’s history didn’t lead to higher mortalities, allowing us to conclude that patient mortalities are directly influenced by cardiac ischemic events. Although, ischemic myocardial events can influence the patient recovery, long-term clinical events, and others. To fully understand the relation between these two pathologies, and how can influence each other is required more data and studies.
Cardiovascular diseases
A-1436

Impact of intensive treatment of High blood pressure in patients with arterial stiffness

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Objective
To figure out epidemiological and clinical characteristics of patients with arterial stiffness, measured by carotid pulse wave velocity (cPWV) and measure its variation after a year of intensive treatment of high blood pressure (HBP).

Methods
An observational study in a cohort of 77 patients of high blood pressure (HBP) and Cardiovascular Risk Unit. Patients were asked about their previous diseases, cardiovascular risk factors (CVRF), target organ damage, anthropometric measurements the treatment they followed. They were measured the blood pressure (BP) and cPWV by ultrasound. After a year of treatment the anthropometric measurements, cPWV and BP (central and peripheral) were measured again. The statistic study was made with SPSS 19.0. Statistically significant results if p < 0.05.

Results
There were 33.8% of males, 96.1% white race. The 87% had essential HBP. The average of weight was 78.13Kg, height 162cm and waist circumference 100.31cm. The 15.6% took acetylsalicylic acid, 53.2% angiotensin receptor II antagonists, 54.5% diuretics, 37.7% calcium antagonists, 23.4% beta-blockers, 18.2% angiotensin-converting enzyme inhibitors, 14.3% mineralcorticoid receptors antagonists, 9.1% alpha-blockers, and 50.6% statins. The average cPWV was 12.08 ± 2.21m/s and after of a year of treatment it was 9.55 ± 2.18m/s (p<0.05). The average central systolic BP lowered from 131.44 ± 15.81mmHg to 120.51 ± 17.79mmHg (p<0.05). The weight lowered from 78.67 ± 16.01 to 77.67 ± 8.94 Kg (p<0.05).

Conclusions
An intensive treatment of CVRF and optimising antihypertensive treatment show a decrease of cPWV, best tensional control and reduction of weight. We are considering new studies to clarify what are the specific steps to lower cPWV and its role in global morbimortality in these patients.
Increased plasma omentin-1 levels are associated with peripheral artery disease in type 2 diabetic patients

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Objectives
Peripheral artery disease (PAD) represents an important public health problem. Type 2 diabetes mellitus is one of the major risk factors of atherosclerosis, and in particular of PAD. It appears necessary the search for early biomarkers of PAD in diabetic patients. In the last years, attention has been focused on adipokines, cytokines produced and secreted by visceral adipose tissue, related to the development of atherosclerotic disease. In particular, studies have documented a possible role of omentin-1 (the primary human plasma isoform) and a correlation of its serum levels with cardiovascular diseases. However, a clear link between circulating omentin-1 and PAD in diabetic patients has not yet been established.
The aim of this study was to investigate the potential role of omentin-1 on PAD in type 2 diabetic patients.

Methods
In this retrospective observational study, we analyzed omentin-1 serum level by ELISA analysis in 50 type 2 diabetic patients with (n = 25) or without (n = 25) PAD at Fontaine’s stage II, III, or IV. Diagnosis of PAD was performed in accordance with the criteria established by the Ad Hoc Committee on Reporting Standards of the Society for Vascular Surgery and the International Society for Cardiovascular Surgery.

Results
We found that omentin-1 median serum levels were significantly higher in diabetic patients with PAD than in diabetic controls [10.6 vs 6.5 pg/mL, p < 0.001].

Conclusion
Our results suggest that omentin-1 could be associated with presence of PAD in type 2 diabetic patients. However, further studies should be performed on a larger number of patients in order to confirm these results and to consider omentin-1 as a new biomarker of PAD in patients with type 2 diabetes.
Increased sortilin levels are associated with peripheral arterial disease (PAD) in type 2 diabetic patients

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Background
Peripheral arterial disease (PAD), is a major health problem. In genome-wide association studies, the genetic locus 1p13.3 has emerged as an independent predictor of the lifetime risk of major cardiovascular events. The minor allele on 1p13.3 is linked to higher levels of circulating cholesterol and higher cardiovascular risk. This locus is located on a non-coding region which acts as a promoter for SORT1, a gene which encodes a 95-kDa intracellular protein known as sortilin. Soluble sortilin is released by different cell types and higher levels have been found in patients with established coronary artery disease and diabetes mellitus. However, a clear link between circulating sortilin and PAD in diabetic patients has not yet been established.

Aims
The object of this study was to investigate the potential role of sortilin on PAD in type 2 diabetic patients.

Methods
In this retrospective observational study, we analyzed sortilin serum level by ELISA analysis in 42 type 2 diabetic statin free patients with (n = 21) or without PAD (n = 21) at Fontaine’s stage II, III, or IV. Diagnosis of PAD was performed in accordance with the criteria established by the Ad Hoc Committee on Reporting Standards of the Society for Vascular Surgery and the International Society for Cardiovascular Surgery.

Results
We found that sortilin median serum levels was significantly higher in diabetic patients with PAD than in diabetic controls [1.2 (0.2-3) pg/mL and 0.54 (0.052-0.88), P < 0.01].

Conclusions
We have found, for the first time, that sortilin could be associated with presence of PAD in type 2 diabetic patients. Since the sortilin plasma levels could be influenced by statin therapy, in this preliminary study we studied only statin-free patients. However, further studies should be performed on a larger number of patients in order to stratify the effect of therapy on this potentially new biomarker of PAD in patients with type 2 diabetes.
Infarctus Mésentérique Secondaire à Une Thrombose Porte Du Post-partum A Propos d’un cas.

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Introduction
L’infarctus mésentérique est une urgence vitale: chirurgicale le plus souvent, son incidence et en augmentation et évaluée à 1/1000 - 1/200 hospitalisations pour douleurs abdominales. C’est une entité grave avec une mortalité de l’ordre de 50 à 95 % (selon l’étiologie).

Sa physiopathologie découle de l’hypo perfusion tissulaire compensée (extraction en O2) et l’ischémie mésentérique aggravée par les lésions de reperfusion.

But
La Thrombose veineuse représente 10% des étiologies et qui serait en rapport avec un foyer infectieux intra abdominale, l’hypercoagulabilité vasculaire quelques soit l’origine et les syndromes myéloprolifératifs.

La grossesse, la contraception hormonale ainsi que le post-partum (en particulier post-césarienne) et l’immobilisation sont des facteurs favorisants.

Matériel et méthode
Nous rapportons dans ce travail un cas d’infarctus veineux entéro-mésentérique par thrombose étendu du tronc porte diagnostiqué à J12 post-césarienne chez une femme de 31 ans sans antécédents particuliers.

Résultat
Le diagnostic a été retenu sur les données de l’imagerie (échographie et TDM abdomino-pelvien) devant un tableau d’abdomen chirurgical.

Une résection du grêle nécrosé avec double stomie a été réalisée et les suites opératoires étaient favorables sous héparinothérapie à dose curative.

Conclusion
Nous discutons à partir de ce travail et à la lumière des de la littérature le mécanisme physiopathologique de cette entité anatomique et en particulier le rôle de la grossesse, le post-partum (notamment le post-césarienne); ainsi que les principes de prise en charge thérapeutique de cette pathologie.
Infectious (non mycotic) aneurysm in a immunocompromised patient: a case report

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INTRODUCTION
Infectious aneurysms have a high morbidity and mortality. Diagnosis is based on clinical presentation, positive blood cultures and imaging with angio-CT.

CASE REPORT
An 81-years-old woman with history of Diabetes and chronic treatment with corticosteroids and Golimumab for Rheumatoid Arthritis, was admitted in Internal Medicine with fever and confusion. Due to her age, the patient was initially empirically treated with Ceftriaxone, Ampicillin, Vancomycin and Acyclovir upon suspicious of CNS infection, remaining asymptomatic but with persistent PCR elevation (>350). Later, she developed a similar episode associated to intense abdominal pain, so a CT-scan was performed showing the existence of ruptured saccular infrarenal aneurysm. Antibiotic therapy was changed to Imipenem and Daptomycin and patient had an emergency intervention, implanting an endovascular prothesis by femoral access. S. aureus was isolated in blood cultures so after 15 days of intravenous treatment she was discharged with oral Linezolid for 6 months, being completely recovered. A transesophageal ecocardiogram was performed, excluding endocarditis as the cause of bacteremia.

DISCUSSION
S. aureus is one of the most frequent organisms related to infectious aneurysm although it is only isolated in 50-85% of the blood cultures. Probably in our case immunosupression (Diabetes and Rheumatoid arthritis treatment) was one of the the predisposing factors.
We should underline endovascular techniques without removing infected tissue with prolonged antibiotic therapy is an option in patients at high surgical risk or hemodinamic inestability.
Influence and diagnostic utility of echocardiography for the internist in the VSCARDIO study cohort

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INTRODUCTION: Given the progressive application of echocardiography in the bedside of the patient:

MATERIAL AND METHODS: Prospective observational cohort study of patients attended by the M. Internal service to whom an echocardiogram was requested during their hospitalization between February 2017 and February 20178 A systematic review of the clinical history was carried out investigating the reason for income, the request for the test and the diagnosis at discharge.

RESULTS: N=200 patients. Average age of 73.4 years, 94.5% being older than 50 years and 62.5% being between 70-89 years. 49% male.

The main reasons for admission: 31% for dyspnea of probable cardiac origin, being the 2nd reason (13.7%) for respiratory infection; 12.7% due to general deterioration; 6.6% due to fever without a focus.

In these patients, the reason for requesting echocardiography was 38.4% congestive heart failure, 14.6% due to dyspnea of uncertain origin at the time of the request; 8.6% were requested for febrile syndrome without a focus.

Up to 50% of the main diagnoses at discharge were distributed between two syndromes: congestive heart failure (24.5%) and respiratory infection (23%). Other diagnoses include, thromboembolic disease (6.6) and neoplastic disease (3.5%). The remaining 25.6% were other isolated diagnoses. We analyzed in greater depth the diagnostic yield of echocardiography in patients with suspected heart failure (71): 17.2% had a depressed left ventricular ejection fraction (LVEF), 6.3% were not severe, and 9.4% were severe.

In patients discharged with CHF as the main diagnosis (44), 25% had a depressed LVEF.

CONCLUSIONS: Our descriptive analysis highlights the wide diagnostic diversity faced by the internist in his usual practice. Clinical ultrasound should be considered as another tool, applicable in multiple scenarios and being determinant on many occasions to reach the final diagnosis.
Cardiovascular diseases
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Influence of calcium channel blockers on iron deficiency and quality of life in patients with heart failure

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Objectives The etiology of anemia associated with heart failure is not fully understood but could be involved multiple mechanisms including iron and erythropoetin deficiency, inflammation, and a few classes of drugs used in heart failure treatment: beta blockers, angiotensin converting enzyme inhibitors and digoxin. The presence of iron deficiency in patients with heart failure is associated with poor quality of life. This study intended to assess the impact of the drugs used for heart failure on iron deficiency.

Methods We evaluated prospectively 128 patients consecutively hospitalized and diagnosed with heart failure and iron deficiency (ferritin <100μg/l or 100-300μg/l with transferrin saturation<20%). The patients with any past medical history, or new diagnosed diseases possible related to anemia were excluded. Results From the study group, 28.12% of the patients were treated with calcium channel blockers. Hemoglobin (p=0.018), hematocrit (p=0.003) and iron (p=0.038) were significantly lower in patients receiving calcium channel blockers treatment. Quality of life assessed by the Kansas City Cardiomyopathy Questionnaire (p=0.01) and 6 minute walking test (p=0.02) was significantly higher in subjects treated with calcium channels blockers.

Conclusion Our data suggest that treatment with calcium channel blockers can lead to iron deficiency. In this context, we expected that quality of life to be impaired. The presence of a better quality of life on this group of patients could emphases the general beneficial effect of this class of drugs, despite the negative effect on functional iron levels.
Inter-dose effectiveness of proprotein convertase subtilisin kexin 9 inhibitors (PCSK9)

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OBJECTIVES:
We sought to study whether LDLc reduction is uniform throughout the interdose period of an iPCSK9.

METHODOLOGY:
A retrospective, descriptive study. Patients who started iPCSK9 treatment were included from March-2016 to November-2017, evaluating the lipid profile 12 weeks after. Patients were grouped according to the time of analytical extraction on days 0-3, 4-6, 7-9, 10-12, and from day 13 onwards (group 1, 2, 3, 4 and 5 respectively).

RESULTS:
N=79. 27.9% treated with Alirocumab (17.7% with the 75mg/tom doses and 10.2% with 150mg/tom) and 72.1% with Evolocumab 140mg/tom.

Similar frequency in all groups (group 1 (18.9%), 2 (20.8%), 3 (26.4%), 5 (24.5%)), except from the group 4, with a lower percentage (9.4%).

40% of those who performed analytical control in the first 3 days were in LDL-C goal, 90.9% in days 4-6 days, 66.7% in 7-9 days, 50% in 10-12 days and 46.2% of those who performed the extraction from day 13 onwards.

LDLc levels were reduced by -51.2% from baseline in group 1, -74.6% in group 2, -54.2% in both groups 3 and 4, and -43.6% in group 5.

Alirocumab presents a similar curve with 75% of patients in target between days 4-7. Evolocumab, with higher n, presents a high percentage (75-100%) of objective accomplished between days 4-9. Descending to 40-50% in the rest of cases.

Alirocumab 75mg presents a similar curve, with a greater reduction of 84.1% in group 2, as it happens with the 150mg dose, with a reduction of 60.2%. Similarly, when it comes to Evolocumab 140 mg, we observed a decrease in LDLc levels of 49.7% from baseline in the 0-3 period, which rises to 74% in group 2, and progressively decreases to 46% from the 13th.

CONCLUSIONS:
In our study, despite its limitations, we observed that the lipid-lowering efficacy of iPCSK9 varies in the interdose period, occurring a greater LDLc reduction 4-6 days after the administration of the drug, with a subsequently decrease of its effectiveness; hence the importance of drug administration every 15 days.
Interrelation between myocardial structure and daily monitoring of arterial stiffness (DMAS) in patients with rheumatoid arthritis (RA)

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Objective: to study the relationship myocardial structural and DMAS in RA patients with hypertension (HP).

Subjects and methods. DMAS was measured in 50 female patients with RA and HP (mean age 57.2 ± 6.4 years; mean duration of RA 11.2±9.3years; mean duration of HP – 8.7±4.2; DAS28 – 4.9±1.2; mean duration of RA treatment 6.3±5.4years). Exclusion criteria were smoking, diabetes mellitus, symptomatic HP, associated clinical conditions of HP.

An index of arterial stiffness (ASI100), an ambulatory ASI (AASI), an aortic pulse wave velocity (PWVao100), augmentation index (Aix75), dP/dt max were measured by using the BPlab with technology Vasotens (Russia). Echocardiography performed 26 RA with HP patients.

Results. The increase of PWVao100 observed at 80% hypertensive RA patients, 44% women has increased Aix 75. The pathological AASI was registered in 12% RA patients, 14% patients has high risk ischemic heart diseases (ASI 100).

Almost every third patient has the increase of left ventricular (LV) myocardium mass index, 8% RA patients has hypertrophy of the posterior wall of the LV, 12% has hypertrophy of the interventricular septum. The increase of left atrium (LA) was registered in 10 (40%) hypertensive RA patients. Diastolic dysfunction was found in 80% patients.

RA patients had association between the thickness of the posterior wall of the LV, the thickness of the interventricular septum and PWVao100 (r=0.51 and r=0.52, p<0.01). Value of LA correlated with dP/dtmax (r=0.44, p=0.04), end-diastolic volume correlated with Aix75 (r=0.48, p=0.02). The ASI100 correlated with the degree of mitral and tricuspid regurgitation (r=0.59 and r=0.49, p<0.05).

Conclusions: The association DMAS and myocardial structural demonstrates that daily arterial stiffness can be predictor of remodeling left ventricle of heart in patients with RA and hypertension.
The relationship between central nervous system disorders and hemodynamic changes has been clarified. In intracranial hypertension, the explanation consists in the activation of a self-regulation system to ensure cerebral perfusion, causing an increase in blood pressure and reactive bradycardia.

A 78 year old woman, with history of arterial hypertension and chronic obstructive pulmonary disease, presented to the emergency department because of asthenia and headaches. Her sister said that the patient had fallen in the previous day. Objectively, Glasgow 15, hypertensive (152/88 mmHg) and bradycardic (42bpm). Although she had not neurological deficits, the patient was slower than usual in the execution of simple orders and with persistent sinus bradycardia on the electrocardiogram. Those signs raised greater concern and, after excluded drug consumption and ionogram/cardiac markers alterations, patient went to brain CT that showed massive chronic subdural hematoma with recent intralesional hemorrhage in the left cerebral convexity, marked midline deviation, left uncus hernia and obliteration of the basal cisterns. Also present recent subarachnoid hemorrhage and subdirectory hemorrhagic infestation adjacent to the tent and sickle.

Contacted Neurosurgery that indicated the transfer of the patient to surgical drainage. The patient was discharged days after, without deficits and normalized cardiac rate and blood pressure.

Even though it was not initially identified as a complication of the neurological situation, bradycardia became crucial in recognizing the need for a higher level of care although the remaining clinic was innocent. Thus, clinical instinct, detailed anamnesis and physical examination play a valuable role in the search for less obvious causes for low heart rate.
Is anemia a predisposing mortality factor for patients with stroke history?

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Introduction: Anemia is commonly found in acute stroke, however any association between anemia and stroke outcomes are registry. Anemia is associated with higher mortality rates in different conditions, so it is logical to assume that this disease can induce a poor outcome in stroke patients by acting not just in the stroke but also interacting with other comorbidities. This study aimed to understand if anemia in the admission by a stroke have a long-term influence in mortality.

Methods: In a single-centre retrospective study, patients were admitted for an ischemic stroke between 1 January 2013-31 December 2014. All the patients admitted by stroke were tested by anemia. Anemia was defined as less than 12g/dL in female patients and less than 13 g/dL in male patients. A presence of anemia in the admission of this patient was compared with their vital status 3 years after the stroke. The relationship between the anemia in the admission by a stroke and a long-term mortality rates were explored by T-square statistical test.

Results: 142 patients are included in the study. Of them, 33 have anemia, with a median age of 75.18 ± 8.76 years old, 57.8% of them female, 87.9% with arterial hypertension, 57.6% with dyslipidemia, 57.6% with diabetes mellitus type II and 42.4% with chronic renal disease. The group without anemia (109 patients) had 68.34 ± 12.25 years old, 45.9% of them female, 83.5% with arterial hypertension, 49.5% with dyslipidemia, 37.6% with diabetes mellitus type II and 15.6% with chronic renal disease. The presence of anemia in admission by a stroke wasn’t associated to a higher mortality rates in long-term (p = 0.131).

Conclusions: Even anemia is associated with multiple comorbidities, and caused recurrent hospital admission, doesn’t seem to be associated with higher mortality rates in stroke patients to a long-term period. However more data and studies are necessary to recognize the importance of anemia in stroke patients.
Is D vitamine insufficiency associated with asymptomatic organ damage in patients with primary hypertension?

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Objectives: High blood pressure causes subclinical endothelial damage and followed by organ disfunctions. In the light of studies conducted to prevent endothelial damage, Vitamin D receptor is demonstrated in cardiovascular system, and also in endothelial and vascular smooth muscle cells. Therefore, in this thesis we aim to conduct a research on the relationship between asymptomatic organ damage (AOD); carotis intima media thickness (CIMT), left ventricular mass index (LVMI), 24-hour urinary albumin and protein excretion(UPE) parameters and vitamin D.

Methods: 207 patients which are older than 18, regularly controlled by the clinic and do not have any chronical disease other than esential hypertension, are included to this study. The blood pressure of the patients were measured with sphygmomanometer, LVMI was measured with echocardiography and CIMT was measured with carotis doppler USG. Moreover, Vitamin D level, 24-hour urinary albumin and UPE were investigated in the laboratory.

Result: We found AOD in the 51,2 % of the patients. In the group that have AOD, UPE-LVMI-CIMT is observed with the highest percentage 29,2 %, while UPE-LVMI is observed with the lowest percentage 6,6% and UPE-CIMT is observed only 7,5 % of the patients. In our study, we have determined a negative correlation between AOD and vitamin D level in hypertensive patients. The AOD level is the lowest in the patients that have normal levels of Vitamin D, while it is highest in the patients that have serious lack of vitamin D. We have determined that 1 unit decrease in Vitamin D causes an 1.115 times increase in AOD risk using logistic regression analysis. Thanks to the ROC analys, we have found out that CIMT has the highest diagnostic power in terms of AOD.

Conclusion: We have demonstrated the relationship between vitamin D deficiency which is thought to contribute to endothelial damage in recent years and AOD.
Is hospitalization time by stroke related with different mortality rates after discharge?

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Introduction: Prolonged hospital admission consume a substantial health-care resources and is related to high mortality rates. In general, a stroke implies an etiological exam, and the admission’s time for such events can be influenced by stroke etiology and other comorbidities. Since the long-term mortalities outcome isn’t well defined, the objective of this study is to define the long-term mortality outcome after discharge. Methods: In a single-centre retrospective study, patients were admitted for an ischemic stroke between 1 January 2013-31 December 2014. All the patients admitted by stroke were selected for the study, and their hospitalization time was divided in 3 groups: (i) short-term (less than 15 days), (ii) medium-term (between 15 and 30 days) and (iii) long-term (more than 30 days). Their vital status were evaluated 3 years after. The relationship between the hospitalization time and mortalities were explored by the Wilcoxon statistical test. Results: The short-term group of hospitalization had 71±13 years old, 46% of them female, 85% with arterial hypertension, 45% with dyslipidemia and 41% with diabetes mellitus type II. Regarding the medium-term admission, patients had 73±12 years old, 46% of them female, 83% with arterial hypertension, 49% with dyslipidemia and 42% with diabetes mellitus type II. Finally, the long-term admission group had 75±10 years old, 67% female, 91% with arterial hypertension, 43% with dyslipidemia, 48% diabetes mellitus type II. The admission time seems to be associated with higher mortalities, and between the short-term group and a long-term group were found significant differences in mortalities (p=0.021). Conclusion: The long-term group hospital admission was associated with a worst outcome in a long-term follow up of patients admitted by stroke. However, the patients in this group could had more severe comorbidities, leading to an extended period of hospitalization, and therefore being associated with higher mortalities.
Is there a relationship between vitamin D levels and ejection fraction in patients with heart failure? Descriptive study in a third level hospital

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OBJECTIVES:
The aim of our study is describing the relationship between vitamin D levels and ejection fraction in patients with heart failure in a third level hospital.

METHODS:
Observational, descriptive and retrospective study of 58 patients who attended internal medicine consultations of the San Carlos Clinical Hospital (Madrid, Spain) from 2015 to 2016 with the diagnosis of heart failure. Vitamin D and parathyroid hormone(PTH) levels were determined and their relationship with the left ventricular ejection fraction (LVEF) was evaluated. The dates were analyzed with the SPSS.

RESULTS
58 patients were included in the study; 36 women (62%). Mean age 80(± 8). 21 patients (36%) had a depressed LVEF and only 2 of them had LVEF less than 25%. The mean level of PTH was 95pg/ml(±43) and those of 25(OH)D were 22 ng/ml (±14). 31 patients had a deficit of 25(OH)D (53.4%) and the values were only normal in 10 patients (17.5%). If we relate the values of Vitamin D with the presence of systolic dysfunction, 14 of the 21 patients had 25(OH)D values below 30 ng/ml (p= 0.06).

CONCLUSION:
There is agreement between our results and other studies in the finding of low levels of vitamin D in a high percentage of patients with heart failure. In our study we find more than half of patients with heart failure with systolic dysfunction presented hypovitaminosis D. Although our results are not statistically significant, it is posible that more studies are needed to demostrate the effects that vitamin D deficiency
Knowledge Assessment of Cardiovascular Diseases among Pakistani Population.

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Background:
Cardiovascular diseases are the leading cause of death worldwide. The most interesting feature of cardiovascular diseases is that they can be prevented. Majority of the risk factors are controllable including hypertension, dyslipidemia, obesity, diabetes, smoking, stress and sedentary lifestyle etc.

Objective:
We aim to assess knowledge, awareness, perception of cardiovascular diseases and risk factors among people living in rural areas of Pakistan. We also aim to evaluate the level of prevention of cardiovascular diseases as a result of awareness and knowledge.

Method:
The study was conducted in peripheral areas of Lahore, Pakistan during the year 2016. A structured questionnaire was established that targeted 350 population >20 years. Informed consent was obtained and questionnaire were filled. The data was analysed using SPSS 16.0.

Results:
Only 26% of the participants agreed that cardiovascular diseases are the most leading causes of mortality. Knowledge regarding cause, risk factors and complications was found inadequate. There was identified lack of health promoting behaviours and practices among the subjects. Practices regarding diet and lifestyle were also found unsatisfactory. Awareness of risk factors was present in 110(31%) of targeted population. On risk assessment scale, 62% were found at high risk and 38% at low risk of developing cardiovascular diseases.

Conclusion:
It has been concluded that a significant number of people had little or now awareness regarding the cardiovascular diseases and its complications. We can surely lessen the morbidity and mortality by primary prevention followed by early detection of the diseases and early interventions. The proportion of individuals found high risk and low risk should be screened regularly. We should prevent CVD though outreach programs and mass media.
Losartan is one of the angiotensin II receptor antagonist drugs for which some cases, although very rare, of hepatotoxicity (<0.1%) have been described. This is mainly hepatocellular although cholestasis and mixed patterns have also been described less frequently. The mechanism is not fully understood and the reaction may appear days or months after contact. The normalization of hepatic enzymology occurs 2-4 months after its suspension.

A 66-year-old male patient was recruited to the ED for 8 days of asthenia, nausea, a feeling of non-specific discomfort, coluria and increased abdominal volume. The objective examination emphasized sclerotic and icteric skin. Laboratory with hepatic cytocholasease standard (AST 2522 U / L, ALT 3603 U / L, GGT 375 U / L, FA 184 U / L, LDH 846), hyperbilirubinemia of 5.28 mg / dl and thrombocytopenia (101,000 platelets). Acute liver failure of etiology to be cleared and admitted to the Medical Service was admitted.

Of the personal history it is emphasized arterial hypertension medicated since 3 weeks with Losartan and hospitalization for toxic hepatitis to calcitrin, about 4 years before. At the time other etiologies (infectious, autoimmune, ethanolic, hereditary) were excluded, and therapy with Losartan was also emphasized at that time.

Clinical and laboratory improvement were observed during hospitalization and the case was discussed with the Gastroenterology team, who considered the hypothesis of drug-induced autoimmune hepatitis despite the fact that the autoimmunity study was negative.

The patient started corticosteroid therapy with a good response, currently being treated with prednisolone 2.5 mg daily. He was subjected to a Fibroscan showed an F3-F4 which requires reevaluation.

Toxic hepatitis to Losartan is rare but there are some cases described in the literature. After this second event and if there is a drug common to both, this will be responsible for the process of hepatitis in this patient.
Malignant syncope in a patient with right ventricular dysfunction: an evidence-based patient-centered case report

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Introduction. Syncope is a frequent medical problem and a great cause for concern regarding the risk of sudden death. A number of institutional protocols include sensitive methods to filter high-risk patients and to guide further work-up, once prognosis of cardiogenic syncope is consistently worse. We present a case of malignant syncope associated with acute right ventricular (RV) dysfunction attributed to arrhythmogenic RV dysplasia (ARVD) and review the literature for evidence-based decision making.

Case description. Man, 39 years, previously healthy, experienced sudden collapse after intense verbal conflict, resulting in significant trauma. Upon admission, monomorphic ventricular tachycardia (VT) with left bundle branch block morphology was promptly reverted. Electrocardiogram on sinus rhythm was unspecific and troponin, elevated. Coronary angiography was normal and multi-slice CT discarded pulmonary embolism. Echocardiogram revealed a hypertrophied left ventricle with normal Strain and severe RV systolic dysfunction. Cardiac MR showed significant global RV dysfunction without remodeling or fibrosis. Family history was poor. Sinus bradycardia precluded beta-blockage. Imaging studies were repeated later and showed only slight improvement in RV function, which motivated the implantation of an automatic cardioverter-defibrillator (ICD) given the probable diagnosis of ARVD. The patient was discharged asymptomatic.

Discussion. ARVD is an inherited disease associated with increased risk of sudden death. Incomplete penetrance and limited phenotypic expression contribute to underestimated prevalence. Its diagnosis relies on clinical factors, genetic data, electrocardiographic abnormalities and ventricular function and structure. ICD therapy appears to be safe and effective to treat VT in this context, but data on survival is limited.
INTRODUCTION: The Mesenteric panniculitis was first described by M. Jura in 1927, and is characterized by a chronic inflammation of mesenteric fat. The mesenteric panniculitis is an idiopathic disease that has been associated with cancer based on radiology studies (computed tomography scan and Magnetic resonance imaging). However, the histological confirmation is the goldstandard for diagnosis.

CASE DESCRIPTION: A previously healthy 74-year-old woman was admitted with vespertine fever, tremors, shivers and loss of appetite within previous month. Blood tests revealed an elevated C reactive protein of 150mg/L and a white cell count of 19.6 (neutrophils 16.6) x 106/mL. The white cell count normalized after admition but ferritin and C-reactive protein remained elevated. Serologies for infection were negative. Blood cultures grew no organisms. Colonoscopy showed no changes. CT scan showed signs of mesenteric panniculitis with 9 cm and mesenteric mesenteric lymph node enlargement with 6-7mm. PET-scan revealed an elevation of glucose uptake at the inferior celiac-mesenteric space up to the pre-renal right space. Histology tissue from mesenterium revealed chronic inflammation.

DISCUSSION: Upon histological confirmation we began treatment with prednisolone 1mg/kg with improvement of the clinical symptoms and blood tests. We replaced it with azathioprine after 1month to prevent the adverse effects of glucocorticoids. After 9 months of therapy, the patient remains asymptomatic and the CT scan shows a mesenteric lymph node with normal size.
Objectives: Psoriasis is considered a chronic inflammatory disease with numerous associated co-morbidities and a higher prevalence of metabolic syndrome and cardiovascular risk factors. To analyse cardiovascular risk factors and metabolic syndrome in patients with psoriasis and their relationship with increased severity.

Methodology: Observational, analytical, retrospective study of 13 psoriasis patients with metabolic syndrome, in follow-up consultations of Dermatology-Internal between November 2017 and March 2018, using the clinical history and statistical package SPSS 24.0 as a tool.

Results: The population studied was mostly male (92.3%), with an average age of 53.31 ± 3.003 years, a predominance of plaque and scalp psoriasis (69.2%) and a BSA >5% in 69.2%, PASI 7-15 in 38.4% and DLQI 5-15 in 38.4%. 94.1% meet the criteria of metabolic syndrome according to IDF and 100% according to ATPIII. Regarding cardiovascular risk factors, 53.84% are overweight and 46.16% are obese, 61.5% have HDL < 50 mg/dL and 69.2% have LDL > 100 mg/dL, 61.5% have high blood pressure, 23.1% have diabetes, 46.2% have a family history of coronary heart disease, 23.1% are active smokers and 53.8% are ex-smokers. The severity of psoriasis is statistically related to metabolic syndrome (p=0.001), increased cardiovascular risk (p=0.035) and smoking (p=0.015). The factors that are associated with a greater effect on quality of life are years of psoriasis progression (p=0.001), body mass index (p=0.032) and topical treatment (p=0.035). 84.6% have a SCORE 5-10% with a high cardiovascular risk.

Conclusions: We advocate a multidisciplinary approach to patients with psoriasis given its association with the metabolic syndrome and its direct relationship with its severity, recommending the systematic search for this syndrome in a population at high cardiovascular risk.
Mitral valve prolapse – results of long-term follow-up and treatment

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Objective: results of prospective long-term follow-up, development of tactics of management and treatment of patients with mitral valve prolapse taking into account clinical, phenotypic, psychological characteristics, functional state of cardiovascular system.

Methods: the study involved 31 patients with PMK: 18 men (mean age 39.4±0.9) and 13 women (mean age 38.9±1.1), with pronounced phenotypic disorders. Patients received magnesium orotate at a dose of 1500 mg per day (97.4 mg elemental Mg) during the entire observation period (15 years) 2 times a year (course duration 3 months). All patients underwent clinical examination, morphological examination of biopsy specimens of the skin, the magnesium content in hair, the levels of total cortisol, the endogenous opioid system and the immune interferon system, psychological examination and evaluation of the quality of life by self-assessment of surveyed on the scale of VAS (Visual Analog Scale) and DISS (Disability Scale).

Results: after magnesium orotate was taken, the General condition improved. After therapy, the number of patients with cardialgia decreased more than 3 times. Significantly reduced the severity of vascular disorders and hemorrhagic syndrome. Significantly decreased the depth of prolapse and mitral regurgitation, decrease in the maximum systolic and diastolic blood PRESSURE. Self-assessment of patients significantly improved, there was an improvement in all three DISS scales.

Conclusions: magnesium orotate is effective in patients with PMK: the General condition of patients improves, reduces the frequency and severity of all clinical syndromes and symptoms. The depth of the prolapse of the mitral valve, the degree of mitral regurgitation, the left atrium is reduced, reduced average and maximum heart rate, the number of episodes of tachycardia, duration of the interval QTc, frequency of paroxysmal supraventricular tachycardia, supraventricular and ventricular extrasystole, increased quality of life.
Mondor's disease.

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Background
Mondor's disease (MD) is a poorly defined entity. It comprises any form of superficial venous thrombosis (SVT) that appear in unlikely locations, such as the penis or the mammary veins.

Method
We present three cases of MD in a third level hospital.

Results
A 39-year-old male came to the emergency room (ER) complaining of pain on his left upper abdominal quadrant. An abdominal ultrasound was performed and a SVT of the left mammary vein was noticed. He received enoxaparin at prophylactic dose for 6 weeks, with a good outcome.

A 37-year-old male complaining of chest pain arrived to the ER. He presented a tender, indurated lesion on his left hemithorax. He was sent to the outpatient clinic, where prophylactic bemiparin was prescribed. The outcome after 6 weeks of treatment was good.

A 48-year-old male consulted with the Urologist because of an indurated lesion on his penis. An ultrasound was performed showing thrombosis of the dorsal vein of the penis. The patient claimed to have engaged in sexual intercourse 48 hours prior to the onset of the clinic. Acetylsalicylic acid was initiated. Evolution was good.

Conclusion
These cases evidence different presentations of Mondor's disease. Several treatment options have been suggested, but there is not a defined course of action. Most cases resolve within 2 months. Long term anticoagulation has not been shown to decrease the duration of the symptoms. Awareness of MD could avoid misdiagnosis and performance of unnecessary complementary tests.
Mortality in patients suffering from atrial fibrillation in two surgical units

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OBJECTIVES
To analyze the mortality rate (M) in patients with atrial fibrillation (AF) who undergo some medical
decompensation during an admission to Orthopedic Surgery and Traumatology (OST) and Vascular Surgery
(VS).

MATERIAL AND METHODS
Descriptive analysis of patients admitted to OST and VS who suffered some type of medical
decompensation that needed to notify a team (T) of Internal Medicine and Cardiology. Patients with AF,
known or unknown, and their M were analyzed.

RESULTS
From June 2008 to November 2014, 1486 consultations were carried out from OST to T for various medical
decompensations that occurred in their patients. AF was detected in 56, corresponding to 3.77% of the
decompensated patients. Their M was 7.14% (4 patients), with the M of the decompensated 10.3%.
From January 2011 to November 2014, 173 consultations were carried out from VS to T for various medical
decompensations that occurred in their admitted patients. AF was detected in 8, which corresponds to 5.78%
of the decompensated. Their M was 75% (6 patients), being the M of the decompensated 16.76%. We want
to indicate that the 6 patients who died had diabetes and hypertension.

CONCLUSIONS
There is a low rate of AF in patients admitted to OST, as the prevalence in the decompensated group is even
lower than the total prevalence in our environment (4.4%). In addition, patients with AF who suffer some
medical decompensation during an admission to OST have lower M than that of the decompensated
subgroup. These data seem to suggest that there is no relevant association between the history of controlled
and uncontrolled AF and M in this type of patients.

VS admissions have a very high M, much higher than that of the decompensated subgroup. These data
could suggest as a priority an early and strict control of patients in VS with controlled or uncontrolled AF, and
other vascular risk factors, which could be beneficial in terms of decreased M.
Mortality in patients suffering from high blood pressure in two surgical units

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Objectives:
To analyze the mortality rate (M) in patients with known HBP who suffered some medical decompensation during an admission to Orthopedic Surgery and Traumatology (OST) and Vascular Surgery (VS).

Material and methods:
Descriptive analysis of patients admitted to OST and VS who suffered some type of medical decompensation that needed to notify a team (T) of Internal Medicine and Cardiology. We analyze the patients with known hypertension and their M.

Results:
From June 2008 to December 2014, 1486 consultations were sent to T regarding patients admitted to the OST area who had suffered some type of medical decompensation during admission. 976 (65.7%) had a documented history of hypertension. Their M was 11.17% (109 patients), with M of the decompensated group being 10.3%.

From February 2011 to December 2014, 173 consultations were sent to T regarding patients admitted to the VS area who had suffered any medical decompensation during admission. 139 (80.34%) had a documented history of hypertension. Its M was 15.1% (21 patients), with the M of the decompensated patients being 16.76%.

Conclusions:
2 out of 3 patients suffering from medical decompensation during admission to OST had a history of hypertension. These patients, with or without decompensation, present a slightly higher M than the overall M of decompensated patients in this area.

4 out of 5 patients suffering from medical decompensation during a VS admission had a history of hypertension. In spite of this very high prevalence, patients with a history of hypertension, with or without decompensation, present a slightly lower M than the global number of decompensated patients in this area. An early evaluation of BP and strict monitoring of patients with concomitant vascular disease who undergo some medical decompensation in OST and VS, by Cardiology or Internal Medicine could be beneficial in terms of morbidity and mortality.
Cardiovascular diseases
A-2171

Multiple localized arterial disease

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Introduction: Demonstration that atherosclerosis represents a systemic disease which simultaneously affects multiple vascular territories, but with a significant different progression stage.

Case description: We describe a 56 year-old female patient case with multiple cardiac risk factors. At the first medical evaluation she presented suggestive symptoms for aortic dissection associated with claudication pain in the lower limb. Clinical examination reveals significant blood pressure asymmetry, systolic heart murmur on the left carotid and subclavian artery, as well as, the pulse absence on the left radial artery and bilateral femoral arteries. The first electrocardiogram and echocardiography reveals normal values and biological a moderately high value of blood glucose and lipid profile. The thoraco-abdominal angio-CT exam infirm the first diagnostic hypothesis and objectifies the quasi-complete left subclavian artery thrombosis, the quasi-complete infrarenal abdominal aorta thrombosis extended to the common iliac arteries and also the tight inferior mesenteric artery stenosis. Doppler ultrasound of carotid artery and lower limb arterial spindles reveal diffuse atherosclerotic lesion with high significance on the left subclavian artery with vertebral theft syndrom aspect. The surgical resolution of the main lesion was imposed so the patient was directed to the Cardiovascular Surgery Clinic where the aorto-bifemoral by-pass was performed with Dacron prosthesis.

Discussion: The presence of multivascular atherosclerotic disease on a female patient with atypical symptoms and fortuitous diagnosis of the main lesion has been directed to proceed an urgent surgical treatment.
Neopterin and beta-2-microglobulin: modest significance in peripheral artery disease diagnosis.

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Objectives: The study aims to evaluate the use of Neopterin and beta-2-microglobulin (b-2-MG) for early detection of peripheral artery disease (PAD) comparing with “classic” biomarkers: C-reactive protein (CRP), fibrinogen and D-dimers.

Methods: A total of 139 patients with PAD were consecutively enrolled. The prospective study evaluated the associations of plasma levels of inflammatory biomarkers (Neopterin, b-2MG, CRP, fibrinogen and D-dimers) and the PAD Leriche-Fontaine staging.

Results: No significant associations were found between Neopterin, b-2-MG and PAD stages, and neither the combination of two and three biomarkers. Only 4 plasma biomarkers tested in combination (Neopterin, CRP, fibrinogen and D-dimer) showed on ANOVA significant mean differences in terminal PAD stage (p<0.0001). AUCs received by ROC analysis reflect that utilization of 4 biomarkers together indicated a satisfactory early diagnosis prediction in the 4th PAD stage (AUC 0.835, p<0.0001).

Conclusion: Neopterin and beta-2-microglobulin have modest significance in peripheral artery disease diagnosis, even in combination with other “classic” biomarkers. This study shows the value of multimarker testing in terminal PAD stage, but always using well certified inflammatory tests (CRP) that proofs significant diagnosis importance, in relation with the clinical and imagistical arguments.
Non-coronary sinus of Valsalva aneurysm rupture simulating acute endocarditis in adolescent patient: A case report

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Introduction: Congenital aneurysm of the sinus of Valsalva is a rare entity whose clinical manifestations usually occurs in adolescents and young adults. It can be asymptomatic for a long period and then debuting with varying degrees of heart failure or sudden death.

Case report: A 17 years old man with no relevant medical history. He was admitted to the emergency department for a two months clinical evolution characterized by cough with hemoptysis, chest pain, fever and dyspnea associated with impaired functional class, lower limb edema, orthopnea and ascites. An initial echocardiogram performed, reports a vegetation and tricuspid regurgitation, been diagnosed infective endocarditis, however, a new echocardiogram evidenced a non-coronary sinus of valsalva aneurysm fistulized to right atrium, whose echogenicity simulated vegetation and tricuspid regurgitation. A surgical procedure to close the fistula was performed, with subsequent development of left-right shunt in the implant, reason why is rehospitalized with defect correction and subsequent improvement of the heart failure.

Discussion: It’s estimated that congenital aneurysm of the sinus of Valsalva corresponds to 0.09% of all congenital heart disease. The most common origin is the right sinus of Valsalva (76.7%), followed by the non-coronary sinus, while in most of the cases the rupture is in the right ventricle (69-90%) being less common to the right atrium (10%). In this case, an ultrasound image interpreted as endocardial vegetation led to a misdiagnosis, a finding that should be considered in the echocardiographic study and differential diagnosis in patients with novo heart failure.
Introduction: Non-bacterial thrombotic endocarditis (NBTE) is characterized by presence of vegetations in
the heart valves, composed of fibrin and platelet aggregates. These lesions represent the corollary of several
types of aggressions secondary to different pathologies, namely hypercoagulable states, cancer, as well as
autoimmune pathologies.
Case description: Authors described a case of an 83-year old female with history of rheumatoid arthritis (RA),
hospitalized for urinary tract infection with decompensation of chronic kidney disease and heart failure.
During hospitalization, she performed an echocardiogram (transthoracic and transesophageal (TE)) that
reveal a vegetation adhered to the posterior leaflet of the mitral valve. Infective endocarditis (IE) was
suspected and empirical antibiotic therapy initiated. When TE echocardiography was repeated, she
maintained the same vegetation and appear to have another one.
A study was then performed showing the presence of increased rheumatoid factor (26 IU / mL) and the
presence of the A1298C mutation in homozygosity in the MTHFR gene. Other laboratory tests were normal,
autoimmune screening negative and infection excluded. In this context NBTE was suspected and
hypcoagulation incited. After two months, TE echocardiogram was repeated, showing disappearance of the
vegetation's.
Discussion: NBTE is an uncommon condition, often underdiagnosed, and is often found during an autopsy.
RA is a systemic autoimmune disease that may be associated with an increased risk of thromboembolism. In
the case presented, the fact that the patient remained without fever, together with the maintenance of the
echocardiographic findings after antibiotic treatment, and the exclusion of any infectious process suggest
strong evidence for the NBTE diagnosis.
To our best knowledge, this is the fifth case described of NBTE in an RA patient, the second with mitral valve
attainment and the first whose diagnosis was made before a thromboembolic event.
OBJECTIVES
To analyze the prevalence of atrial fibrillation (AF) in patients admitted to Vascular Surgery (VS) Unit and to assess if its presence influences the average hospital stay (AS).

MATERIAL AND METHODS
Descriptive analysis of patients admitted to VS who suffered any medical decompensation that needed to be notified to a team (T) of Internal Medicine and Cardiology. Patients with known or unknown AF and their AS were analyzed.

RESULTS
From June 2008 to December 2014, 173 consultations were sent from VS to T for medical decompensations in patients admitted in their unit. Only 1 of the consultations corresponded to uncontrolled AF. After the evaluation of all 173 patients, AF was detected in 8, which corresponded to 5.78% of the decompensated patients. Their average stay was 21.6 days, with the AS of the overall group of decompensated 20.2 and the total AS of the Unit 12.1 days.

CONCLUSIONS
There is a significant rate of AF in patients admitted to the VS, since the prevalence in the decompensated group is greater than the prevalence in our geographical area (4.4%). Patients with AF have a much higher AS than the overall one in the Unit, and slightly higher than that of the decompensated subgroup. These data, together with previous studies in which we concluded AS of hypertensive patients in surgical areas was 14.15%, could suggest that an early evaluation of patients in VS, with controlled or uncontrolled AF, and other vascular risk factors, could be beneficial in terms of reducing the AS.
Cardiovascular diseases
A-1000

Patientes with atrial fibrilation admitted to Orthopaedic Surgery have a much higher average hospital stay than the rest in the unit

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OBJECTIVES
To analyze the prevalence of atrial fibrillation (AF) in patients admitted to Orthopedic Surgery and Traumatology (OST) Unit and to assess whether its presence affects the average hospital stay (AS).

MATERIAL AND METHODS
Descriptive analysis of patients admitted to OST who suffered some any medical decompensation that needed to be notified to a team (T) of Internal Medicine and Cardiology. Patients with known or unknown AF and their AS are analyzed.

RESULTS
From June 2008 to December 2014, 1486 consultations were sent from OST to T due to various medical decompensations that occurred in hospitalized patients. 39 of consultations corresponded to uncontrolled AF. After the evaluation of all 1486 patients, AF was detected in 56, corresponding to 3.77% of decompensated patients. Their average stay was 14.1 days, with the AS of overall decompensated patients being 14.01 and the total AS of the unit being 8.03.

CONCLUSIONS
There is a low rate of AF in patients admitted to OST, since the prevalence in the decompensated group is even lower than the total prevalence in our geographical area (4.4%). However, patients with AF have an AS that is much higher than the one of overall unit, and slightly higher than that of the decompensated subgroup. These data, together with previous studies in which we concluded AS in hypertensive patients in surgical areas was 14.15%, could suggest that an early evaluation of patients with controlled or uncontrolled AF and other vascular risk factors, could be beneficial in terms of reducing the AS.
Patiromer multimorbidity patients with heart failure and hyperkalemia

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Background
Patiromer is a potassium chelator indicated for patients with hyperkalemia in treatment with angiotensin-converting-enzyme inhibitors (ACEi) so that these patients can maintain or reach the doses recommended by the clinical guidelines. In addition, it is indicated for the maintenance phase, where currently there is no alternative treatment.

The objective of the present study is to evaluate the tolerance and effectiveness of a multimorbidity patients with heart failure (HF).

Methods
Observational and descriptive study. Multimorbidity patients with HF and hyperkalemia in follow-up by the Chronic-Pluripathological Unit of the Complejo Hospitalario de Navarra.

Informed consent was required for compassionate use for not being commercialized in our country.

Results
Four patients with an average age of 83 years were included, 75% being male. All had HF, 50% HF with reduced ejection fraction, and advanced chronic kidney disease (CKD) (CKD-EPI 28 ml/min/1.73 m2). 50% of patients received treatment with ACEi and the other 50% received Sacubitril-Valsartan (angiotensin II receptor blocker neprilysin inhibitor-ARNI). 25% were receiving treatment with an mineralocorticoid receptor antagonist (MRA).

All patients had received regular treatment with calcium polystyrene sulfonate. Potassium levels prior to the start of treatment with Patiromer were 5.7 mEq/L; after treatment the levels were 4.4 mEq/L. In addition, the treatment with Patiromer was much better tolerated than the treatment with calcium polystyrene sulfonate.

Conclusions
Patiromer is a well-tolerated and effective drug for the treatment of hyperkalemia in patients with HF and CKD who require drugs with ACEi or ARNI or MRA.
Pericardial Effusions in Pulmonary Arterial Hypertension - What therapeutic approach?

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Introduction
Pulmonary arterial hypertension (PAH) is a severe condition that culminates in right heart failure (HF), and the presence of ventricular dysfunction and pericardial effusion are associated with increased morbimortality. Despite the negative impact on the prognosis, this clinical entity, of unknown incidence and multifactorial pathogenesis, presents a nonspecific clinical and controversial approach.

Case description
An 85-year-old male patient (history of pulmonary thromboembolism, severe PAH, HF NYHA class III/IV, paroxysmal AF and CKD stage 3b) went to emergency department with polypnea, generalized cyanosis and productive cough with respiratory failure. Of the etiological investigation carried out, we highlight an echocardiogram that showed 'severe tricuspid regurgitation, severe PAH (PSAP> 100mmHg) and pericardial effusion with 24mm. After exclusion of neoplastic, infectious or autoimmune causes, we assumed that the most likely etiology was dysfunction of RV secondary to severe PAH. During hospitalization, the patient maintained venous congestion and hypotensive profile, although without paradoxical pulse or hypophonesis of cardiac sounds. Due to the clinical stability and comorbidities, a conservative strategy (diuretic reinforcement) was adopted, with progressive resolution of the effusion (initially large and later with small/medium volume). At discharge, the patient was hemodynamically stable.

Discussion
The complexity is evident on pericardial effusion secondary to PAH. Indeed, the classic signs of cardiac tamponade/bulky effusion (Beck triad and paradoxical pulse) may be absent in these cases or present in PAH without effusion. The therapeutic approach is controversial, being that the ideal therapy for effusions of medium volume (1-2 cm) is still not established, with a high risk of cardiocirculatory collapse after pericardiocentesis. This case aims the importance of knowing the etiology of the effusion before defining the therapeutic strategy.
Objective
To evaluate the quality of life and functional class of patients included in the Peritoneal Dialysis (PD) program. The changes in the Left Ventricular Ejection Fraction (LVEF), the glomerular filtration rate (GFR) and the systolic blood pressure (SBP) at the follow-up year were secondarily analyzed.

Methods
N: 15 patients with a diagnosis of RCC in the peritoneal dialysis (PD) program and were evaluated at one year of follow-up. All of them fulfilled the inclusion criteria for PD. Quality of life was assessed using the SF-36 questionnaire (Short Form-36) and the functional class according to the New York Heart Association (NYHA) classification. Once included, the Tenckhoff catheter was placed and the usual technique of maturation was carried out for two weeks. Subsequently, they underwent icodextrin alone or with dextrose according to the degree of renal failure. Three patients were excluded for exitus prior to the beginning of the technique (cardiologic causes) and one due to mechanical problems.

Results
The results were analyzed in the 15 patients before starting PD and one year after PD. 73.3% were men with a mean age of 66.2 years. An improvement in quality of life was observed (mean score 28 ± 2 vs 58 ± 1) and grade of functional class (according to NYHA II 20% and IV 80% vs II 100%). There was no worsening of the analyzed values secondarily: Left Ventricular Ejection Fraction (LVEF) (mean value 31.6 ± 14.4 vs. 41.2 ± 10.4%) Glomerular filtration rate (GFR) (37.4 ± 18.8 vs 40.6 ± 34 ml / min / 1.73m2) Systolic blood pressure (SBP) (108 vs. 109 mmHg).

Conclusion
Peritoneal ultrafiltration improves quality of life and degree of functional capacity in patients with RCC. There was a reduction in hospital readmissions, no worsening of LVEF, GFR or BP.
Pilot study to compare Conventional Hospitalization (CH) and Home Hospitalization (HH) in Chronic Heart Failure (CHF)

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BACKGROUND
Multiple studies suggest chronic heart failure is safely manage at home with telemonitoring systems or admitted in Home Care Units. So far, no studies select the cluster of patients eligible for this.

METHODS
In order to build two similar groups we selected 10 patients who fulfilled criteria to be admitted on HH, that finally refused to be admitted on HH, and entered CH. We compared them with 10 patients admitted on HH. We confronted their basal characteristics and then we followed them up during 30 days to see re-admission and mortality rates due to the episode.

RESULTS
We found no differences in the base-line parameters of the two groups. 2 patients were admitted for CHF during this period in the CH group and 1 in the HH group. 1 patient died during the first admission in the CH group and no-one in the HH group.

CONCLUSION
As the two groups are comparable, we can assess the outcomes observed easily. It is soon to declare that CH has negative implications in selected patients but further studies are need in this direction. This pilot study encourages us to carry on with a bigger one.
Portal vein thrombosis, thinking outside the box: a case report

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INTRODUCTION:
Portal vein thrombosis (PVT) is a relatively common complication in patients with liver cirrhosis, but might also occur in absence of an overt liver disease. Several causes, local or systemic, play an important role in pathogenesis. Clinical examination, laboratory investigations and imaging help provide a quick diagnosis, as prompt treatment greatly affects patient’s outcome.

CASE DESCRIPTION:
Female, 43 years old, presented with abdominal distension and pain to the superior quadrants for one month. No relevant history.Computed tomography scan revealed portal vein cavernomatous transformation with portal hypertension and varices in splenic hilium, small gastric territory, left gastric vein in topography to the inferior esophagic and superior mesenteric. Discret splenomegaly. Also thrombosis in portal vein, splenic vein and portal-mesenteric confluent. Hypocoagulation was initiated. No qualitative or quantitative changes in blood count or peripheral smear. Thrombophilia study negative, highlighting JAK2 V617F mutation positivity. Bone marrow biopsy featured morphological changes suggesting myeloproliferative syndrome. Hydroxyurea was initiated, hypocoagulation maintained. Currently, at two years of treatment, she presents clinical and laboratorial stability, without signs of progression of the disorder.

DISCUSSION:
With this case we want to highlight the importance of recognition and perception of thrombosis characteristics, as those can be indicative of major diagnosis as myeloproliferative syndromes in need of an adapted approach. The location of thrombosis in unusual sites constitutes a challenge to the diagnostic and therapeutic planning for patients. Thrombophilia study protocols should therefore include searching for JAK2 mutations in cases of splenic thrombosis.
Predicting atrial fibrillation in type 2 diabetes mellitus patients

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Type 2 diabetes mellitus (DM) is a risk factor for atrial fibrillation (AF). Among patients (pts) with AF, DM pts have an even bigger risk of thromboembolic (TE) events. Given the clinical heterogeneity in these pts, it might be useful to know AF predictors to ensure an early diagnosis.

Objectives: determine AF prevalence and predictors in DM pts.

Methods: retrospective analysis of a random sample of Diabetes Hospital Clinic pts. This included demographic, clinical and laboratory parameters, as well as determination of AF prevalence, CHA2DS2VASc score and antithrombotic therapy.

Results: One hundred and twenty pts were selected, 52.5% were female and 47.5% male, mean age 68.5±10.3 years. DM diagnosis had been established for 17.4±9.7 years. The majority already had microvascular complications (c) (71.7%), nephropathy being the most frequent (52.5%), and less than half (40%) had known macrovascular c, mainly coronary artery disease (CAD) (25.8%). As for cardiovascular risk estimation, 75.8% were very-high risk pts and the rest only high risk.

The majority had Haemoglobin A1C levels>7% (71.7%) and was treated with insulin (78.3%); 55% were under metformin therapy. Most of them were also under angiotensin-converting enzyme i/angiotensin receptor blocker (86.7%) and statin (80%) drugs.

There was a 13.3% AF prevalence, with high TE risk (CHA2DS2VASc 6.1±1.3); anticoagulation was prescribed to the majority of the pts with AF (75%) and direct oral anticoagulants were chosen in 75% of cases. There was a statistically significant association between AF and older age (AF 74.9±9.6 vs No AF 67.5±10.1 years, p=0.007), and also macrovascular c (p=0.005), namely CAD (p<0.001, OR=9.2, 95% CI 2.9-29.6). On multivariate analysis, an independent association was only seen between CAD and AF (p=0.001).

Conclusion: These results show the clinical diversity of the DM patient population, enlightening the need to actively screen for AF in elderly pts with macrovascular c and, particularly, CAD.
Cardiovascular diseases
A-2328

Predicting perioperative performance in complex pluripathological patients

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Objectives
Due to improvement in surgical and anesthetic procedures, older and more complex patients undergo surgical treatment. Hip fractures account for a significant disease burden in elderly population. The rise of this activity urges to identify these patients with the aim to enhance disease prevention, chronic disease management, and perioperative treatment. For that matter, orthopedic-hospitalist comanagement (OHC) service was established at our hospital to manage hip fracture patients. Our objective was to assess the most prevalent comorbidities and complexity at admission in this population with the aim to develop tailored health-care strategies.

Methods
We retrospectively identified a sample of 111 patients aged \( \geq 65 \) years who underwent surgical repair of hip fractures in our hospital over a year period between January 2017 and December 2017. General data (age range, sex, Charlson Comorbidity Index (CCI), pluripathology and polyparmacy status were collected from charts of every patient during the hospital stay. The study was approved by the Hospital Research Ethical committee.

Results
Age 65-74 yr.: 13: (11.7%), 75-84 yr.: 50 (45%), 85-94 yr.: 35 (31.5%) > 95 yr.: 13 (11.7%). Male accounted for 21.6%. Pluripathology: 47.7%. The most prevalent conditions were stroke, dementia and motoneuron disease: 40, 5%, cardiovascular disease: 37.8%, moderate to severe chronic renal disease and anemia/malignancy: 20.7%. CCI < 5: 26%, 5-9 > 72%, >9: 1.8%. Polyparmacy: 52.25%

Conclusions
Hip fractures are a public health problem worldwide and related to elderly suffering from chronic complex disease. The most important principle in limiting the possibility of perioperative complications is prevention by means of correct identification.
Cardiovascular diseases
A-1818

Pulmonary and Arterial Thrombosis as presentation of Essential Thrombocythaemia.

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Introduction: Essential Thrombocythemia (ET) is a myeloproliferative disorder may include manifestations of arterial or venous thrombosis and/or haemorrhage, but many patients are asymptomatic. Mutation JAK 2 and splenomegaly are present in 50-60% cases. Case description: 76-years-old female with history of hypertension and glaucoma presented at emergency with dyspnea, chest and right leg pain. Physical exam: painful palpation of right abdominal quadrant, rubor and right leg edema, periphery pulses presents. Blood test: hemogram: thrombocytosis (597000L), normal kidney and liver function, negative cardiac biomarkers and D-dimer >44.0g/ml. Gasometry: no respiratory insufficiency. Thorax-abdominal angiography computer tomography: bilateral pulmonary embolism (PE), thrombus in thoracic-abdominal aorta and bifurcation and iliac, thrombosis of superficial femoral artery; splenomegaly; complex process that include fat mesenteric, sigmoid and small intestine, impossible to exclude neoplasm. She was admitted due to PE and start anticoagulation. Blood tests: hemogram with thrombocytosis; protein electrophoresis, kidney, liver, iron and thyroid functions normal; autoimmunity, viral and tumour tests were negative; increase of reticulocytes, LDH, uric acid and ferritin. Mutation JAK2 positive. Right limb venous ultrasound: deep vein thrombosis. Colonoscopy: exclude neoplasm, diverticulitis. Abdominal magnetic resonance: splenomegaly, inflammatory complex diverticulitis process; assumed abscess intra-abdominal due to diverticulitis and started large spectre antibiotics with good clinic and image response. Discussed case with Vascular Surgery and Hematology, assumed ET according 2016 World Health Organization diagnostic criteria and added antiaggregation to anticoagulation and follow up. Discussion: It was assumed that the etiology of PE and arterial thrombosis was ET due to the persistent thrombocytosis, splenomegaly, positive mutation JAK 2 and exclusion of other diagnosis.
Pulmonary arterial hypertension and secondary right ventricular insufficiency in hyperthyroidism

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Introduction:

Pulmonary Arterial Hypertension (PAH) occurs idiopathically or as a result of other pathologies. The relation between hyperthyroidism and PAH has been approached with an increasing frequency implying that thyroid's function should be contemplated at the investigation of patients with PAH.

Case report:

A 53 year old female was admitted to the hospital with dyspnea for six months, heart palpitations and lower limb edema. Physical examination showed signs of systemic congestion, tremor of the upper limbs, augmented and asymmetric thyroid. Cardiac auscultation with second sound split, systolic heart murmur in tricuspid focus of 3 + / 6 + and irregular pulse. Ascitic abdomen and symmetrical lower limb edema. Ascitic fluid analysis revealed 1.2 serum-ascites albumin gradient. The laboratory's analysis exposed T4: 7.7 ng/dl, TSH: 0.0011mUI/ ml and Anti TPO: 529.8 U/ml. Electrocardiogram with atrial fibrillation. Transthoracic echo-cardiogram with pulmonary artery systolic pressure(PASP) estimated at 60 mmHg, right hand heart dilatation, moderate right hand ventricular dysfunction, severe tricuspid regurgitation, left hand cavities of the normal size, and preserved left hand ventricular function with 66% of ejection fraction. It was started the therapy using the methimazole, diuretic, and oral anticoagulation and the patient presented progressive clinical improvements. Three months later of thyroid function control, she came back to sinus rhythm, with reversion of right heart dysfunction.

Conclusion:

Cardiovascular involvement associated with hyperthyroidism is common, although the association of right heart failure with preserved left ventricular function is rare. The possibility of reversion of cardiac abnormalities after restoration of a state of euthyroidism is already well documented in the literature, highlighting the importance of considering this diagnosis in order to institute early treatment and avoid the progression to advanced heart failure.
Venous thromboembolism (VTE) can present as the first manifestation of an occult cancer. A 51-year-old woman presented with one week history of dyspnoea and left chest pain. Had previous history of excised Gartner’s cyst, weight loss >10% in 3 months and in the last month developed multiple pruriginous, eritematous arciform lesions throughout her body with no resolution with corticoids and antihistaminics. On observation was afebrile, tachycardic and hypoxemic. Initial studies revealed microcytic, hypochromic anaemia, relative eosinophilia and elevated D-dimers. Chest computed tomography showed extensive bilateral pulmonary embolism. Treatment dose of enoxaparin was started. Further studies showed elevated LDH, β2-microglobulin, CA-15.3, CA-125 and a peak at the gamma region electrophoresis but without monoclonal bands. Increase in eosinophil count with preserved morphology was seen on bone marrow smear and biopsy. Skin biopsy identified eosinophil infiltrate. On magnetic resonance multiple pelvic lymphadenopathy and a nodule comprising vaginal anterior wall with urethral involvement were detected. Vaginal mucosal biopsy was inconclusive. Pelvic lymph node biopsy revealed metastatic adenocarcinoma cells, with morphology suggestive of gynaecological origin. Human papillomavirus was negative. Further sub-urethral biopsies were positive for clear cell carcinoma of gynaecological origin, immunostaining for Prostatic antigen was negative. Treatment was started with Cisplatin + Gemcitabine. Between 4-10% of patients with VTE will have underlying cancer and those that are diagnosed with cancer will have a lower survival rate. Elevated eosinophil counts can be present in a variety of diseases, including cancer of different origins. Although unspecific, can give a diagnostic clue of an underlying malignancy. This case highlights a diagnosis of a rare metastatic gynaecological cancer, with a challenging anatomical and histological characterization.
Purulent pleuropericarditis in a 31-year old woman caused by Streptococcus pyogenes

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Introduction
Sepsis from an underlying purulent pleuropericarditis is an infrequent diagnosis, especially in adults. Through applying urgent pericardiocentesis and administering early antibiotic treatment, further complications can be prevented such as cardiac tamponade.

Case description
A 31-year old woman, with a history of leukemia and allogenic allogenic bone marrow transplantation, was admitted to the emergency ward because of thoracic pain, fevers and dyspnea.

An urgent focus assessed transthoracic echocardiography (FATE) was performed, confirming the presence of 20mm circumferential pericardial fluid. Antibiotic therapy was started immediately after the removal of pericardial fluid for culture, which grew positive for Streptococcus pyogenes. She recovered fully after pericardiocenteses, pleurocentesis and antibiotic therapy.

Discussion
Key to finding the diagnosis were a clinical suspicion raised by present signs and performing urgent echocardiography. The pericardial effusion was detected by echocardiography by three different emergency ward physicians, with different level of skills.

Pleuropericarditis caused by streptococcus pyogenes can result in rapidly increasing pericardial effusion. Echocardiography is instrumental in the diagnostic work-up for this unusual and serious disease entity, preferably as part of the bedside skills of the emergency physician.

References
Recurrent bilateral deep venous thrombosis after surgical resection of inferior vena cava.

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Introduction
Inferior vena cava (IVC) leiomyosarcoma is an extremely rare tumor, and barely three hundred cases have been reported in the literature.

Case description
A 71-year-old patient was diagnosed with retroperitoneal leiomyosarcoma of the IVC. Infrarenal IVC was surgically removed. During the procedure, venous flow seemed to be adequate through collateral veins, and surgeons considered there was no need for a prosthesis. Enoxaparin 40 mg daily was initiated.

Five days after surgery, the patient complained of right lower limb (RLL) edema and pain. Doppler ultrasound showed deep vein thrombosis (DVT) of the RLL affecting iliac, femoral and popliteal veins. Treatment was switched to enoxaparin 80 mg bid.

Five days later, the patient complained of edema and pain on his left lower limb (LLL). Doppler ultrasound showed a distal DVT. DVT recurrence was related to recent surgery and subsequent immobilization, as well as the lack of drainage through the IVC, which entailed an important venous ectasia. The patient was discharged with tinzaparin 14000 UI daily.

Nineteen days later, the patient was admitted again with a volume increase in LLL. Doppler ultrasound exhibited a progression of the thrombosis on that limb. CT confirmed thrombosis of the ilio-pheural-popliteal axis in both lower limbs. The dose of tinzaparin was increased up to 16000 UI.

Two months later the patient presented a good clinical evolution. Anticoagulation was then switched to acenocoumarol.

Discussion
IVC resection increases risk of DVT. Further research is needed to establish a course of treatment for these patients.
Relationship between arterial hypertension and retinal venous occlusion

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Background: Retinal venous occlusion (RVO) is the second cause of retinal vascular disease. It is a consequence of vascular risk factors and aging.

Objectives: Analyze the prevalence of arterial hypertension (AHT), the value of systolic blood pressure (SBP) and the value of diastolic blood pressure (DBP) in subjects with RVO and in the control group.

Methods: we recruit prospectively 240 patients with retinal venous occlusion who were referred to the Internal Medicine clinic between December 2008 and November 2016 and 232 subjects in control group. Clinical and demographic variables were analyzed (age, gender, type of RVO, AHT, SBP, DBP).

Results: The presence of arterial hypertension was significantly higher in patients with RVO than in control group (72,1% vs 50%, p<0,0001). This patients also had higher values of SBP (148 ± 22 vs 138 ± 18, p<0,0001) and DBP (83 ± 10 vs 77 ± 10, p<0,.0001). There were no differences between the type of retinal venous occlusion. In 24% of patients with hypertension the diagnosis was made after presenting retinal venous occlusion. Ambulatory blood pressure monitoring was made in only nine patients with RVO. Six of this patients was non-dippers.

Conclusion: Arterial hypertension is very prevalent in patients with retinal venous occlusion. The diagnosis and treatment of the same one is established frequently from the retinal venous occlusion, which is going to have repercussion in the treatment.
Relationship between monocyte/HDL-cholesterol ratio and urinary protein excretion in primary hypertension patients with reverse dipper pattern

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Background: Ambulatory blood pressure measurements (ABPM) are confronted with different clinical patterns due to diurnal changes. Rise of blood pressure at night is known as reverse dipper whereas it is expected to decrease at night physiologically. The monocyte/HDL cholesterol ratio (MHR) is considered as a marker of inflammation and oxidative stress. In our study, we planned to investigate the relationship between MHR and urinary protein excretion in a reverse-dipper (RDHT) patient group.

Methods: 24 hour ambulatory blood pressures of 195 primary hypertension patients were measured. We examined the monocyte HDL cholesterol ratio (MHR) and 24 h urine protein excretion in patients with reverse dipper hypertension (RDHT).

Results: In our study, urinary protein excretion which is a predictive indicator of target organ damage in patients with RDHT was found to be higher than other groups. Furthermore, MHR, an oxidative stress and inflammation marker, was found higher in this patient group. Stepwise regression analysis revealed that MHR was an independent predictor of urinary protein excretion in the group of reverse dipper hypertension.

Conclusion: In RDHT patients, except for normal physiology, high nighttime BP measurements have a negative effect on all systems. Oxidative stress and inflammation are thought to play a role in this process in terms of target organ damage.
Remote effects of the repeated forearm ischemia and reperfusion on mechanical properties of the arterial pressure waveforms on the contralateral arm in healthy people

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Objectives: Repeated episodes of ischemia and reperfusion (I&R) applied to one organ may trigger protection against ischemia in other organs - this phenomenon is called as the remote ischemic preconditioning (RIPC).

We aimed to study the effects of repeated episodes of forearm I&R on one site on different features of arterial pressure waveforms on the contralateral arm in healthy people.

Methods: 86 healthy volunteers (22+/−1,9 years) were resting in a sitting position. Finger arterial pressure waveform was recorded continuously and non-invasively (Portapres 2, FMS, The Netherlands) during 100-second rest, then 100-second forearm ischemia of the contralateral forearm (caused by inflation of the brachial arm with the pressure 60 mmHg over personal systolic blood pressure), and 100-second reperfusion. The recordings were then repeated twice, each time the ischemia was started 10-minutes after the onset of the preceding reperfusion. With the pulse contour analysis, we measured mean blood pressure (MBP), arterial compliance (Compl), distensibility (Dist), and total peripheral resistance (TPR). Two-way ANOVA was applied for testing the effects of I&R as one factor and preconditioning (3 repetitions of I&R) as another factor. Results are presented as mean +/- standard deviation.

Results: There were no significant effects of I&R on the studied features of arterial pressure waveforms (the first factor). However, the repetitions of I&R (i.e., the preconditioning as the second factor) induced significant reductions in MBP (p<0.001) and TPR (p=0.001), and increases in Compl (p=0.007) and Dist (p=0.001). Pairwise comparisons showed that the significant differences were present as early as during the second I&R and further improved after the third I&R.

Conclusion: RIPC induces significant vascular changes in healthy individuals. RIPC reduces blood pressure and vascular resistance and improves arterial compliance and distensibility on the contralateral arm.
Objective: To assess renal dysfunction in patients with acute myocardial infarction (AMI). Material and methods. In 28 patients with AMI, urine albumin and alpha-1-microglobulin levels, albumin-creatinine and alpha-1-microglobulin -creatinine ratios in a single morning urine sample, serum creatinine were detected after percutaneous coronary intervention (PCI) and before discharge from hospital. Results. 28 patients were examined: 20 (71.4%) men, the age of patients was 58.8±6.1 years. 5 (18.9%) patients developed acute kidney injury (AKI), 3 of them were diagnosed with the first stage AKI, 2 - the second stage according to KDIGO classification. AKI was resolved by the time of discharge from the hospital in all patients. The median of urinary albumin-creatinine ratio was 418 mg/g [238; 1356] after PCI, 451 mg/g [120; 560] before hospital discharge. The increase in the value of urinary albumin-creatinine ratio (over 30 mg/g) was observed in all patients with AMI after PCI and before hospital discharge, and the ratio was over 300 mg/g in 20 (71.4%) patients. The median of urinary alpha-1-microglobulin-creatinine ratio was 192 mg/g [100; 338] after PCI, 236 mg/g [116; 439] before hospital discharge. The urinary alpha-1-microglobulin-creatinine ratio over 20 mg/g was detected in all the examined patients after PCI and before hospital discharge. A correlation was found between the values of urinary albumin-creatinine and alpha-1-microglobulin-creatinine ratios after PCI ($\beta = 0.82$, p<0.05). Conclusions. Myocardial infarction was complicated by the development of acute kidney injury in every fifth patient. An increase in urinary excretion of albumin and alpha-1-microglobulin was detected in patients with acute myocardial infarction. The presence of a correlation between the values of the urinary albumin-creatinine and alpha-1-microglobulin-creatinine ratios may indicate the tubular origin of albuminuria in patients with acute myocardial infarction.
Response of the iPCSK9 in real life conditions

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INTRODUCTION AND OBJECTIVES: iPCSK9 has shown to reduce LDLc levels by more than 50% and
other atherogenic lipids, as well as a modest increase of HDLc.
We aim to analyze the indications, efficacy and safety in patients in whom iPCSK9 are prescribed.

METHODOLOGY: A retrospective, descriptive study. Patients who started iPCSK9 treatment were included
from March-2016 to November-2017. The lipid profile and adverse effects were evaluated 12 weeks after.

RESULTS: N=79. Mean age 59.23±7.8 years. 63.3% males. 50.6% hypertensive, 32.9% diabetic, 16%
smokers and 44.3% ex-smokers. 77.2% of iPCSK9 prescribed by Cardiologists, 10.1% in the lipids unit,
8.9% by Nephrologists and 3.8% by Endocrinologists. The main indication was secondary
prevention (59.1%). 70.5% for not achieving LDLc goal despite optimal lipid-lowering therapy. 29.5% due to
intolerance to statins (31.8% with documented increase transaminases, 18.2% myopathy and CK increase,
myalgias without CK increase 22.7% and CK and transaminases increase 18.2%). 72.1%(57) treated with
Evolocumab 140mg/tom, 17.7% Alirocumab 75mg/tom and 10.2% Alirocumab 150mg/tom. Mean baseline
LDLc was 146.35±68.41mg/dl and 12 weeks later 64.73±41.8mg/dl (p=0.001). We observed a reduction in
total Cholesterol of 37.7% (p=0.007), of 24.2% (p=0.28) in Triglycerides. HDLc levels didn’t change (p=0.85).
A very slight increase in transaminase and CK was observed, not statistically significant. 61.8% were
targeted for LDLc at 12 weeks. Regarding adverse effects, 3 patients reported myalgias, gingival bleeding and
diarrhea respectively.

CONCLUSIONS: Secondary prevention in ischemic heart disease is the main indication for iPCSK9 in our
center. According to our initial experience, iPCSK9 reduces LDLc more than 50%, leading a large
percentage of patients to reach the lipid target by safety way.
Retrospective study in patients with heart failure and reduced and mid range ejection fraction in Infanta Elena Hospital since January 2017

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Objectives: To describe the clinical and prognostic characteristics of patients with heart failure and mid range ejection fraction (HFmEF) admitted to the Internal Medicine Service of Infanta Elena Hospital (IEH). To compare their characteristics with patients with Heart Failure and Reduced Ejection Fraction (HFrEF) of that same year to see if their characteristics are similar: Number of admissions, visits to the Emergency Department, degree of dependence and comorbidities.

Methods: A total of 39 hospitalized patients in Internal Medicine Service at IEH in 2017 with HFmEF and HFrEF were enrolled and retrospectively studied in the present study. Area: HIE (Huelva). Regional Hospital of 2nd level that covers the districts Huelva-Costa and Condado-Campiña. It has 70 beds of Internal Medicine, with an assistance activity of 3000 admissions per year. Inclusion criteria: LVEF 40%-50%; LVEF<40%; New York Heart Association (NYHA)II-III; Admission in Internal Medicine in 2017; Echocardiography performed in 2017. Exclusion criteria: Age younger than 18 years.

Results: A total of 39 patients admitted to the Internal Medicine Service during 2017 (33 with HFmEF and 6 patients with HFrEF) were collected. The analysis of age, days and number of admissions, visits to the emergency Department, hemoglobin, lymphocytes, albumin, cretinine, glycated hemoglobin, PCR, Barthel and Connut did not show significant differences. However, significant differences were found in the functional class, number of drugs and cholesterol values, which were higher in patients with HFmEF group; Natriuretic peptide (ProBNP) values and PROFUND scale were higher in HFrEF.

Conclusion: It is observed that patients with HFmEF have more diabetes, atrial fibrillation, comorbidities and a higher drug consumption and cholesterol levels than those with HFrEF, but a better functional class. However, both groups show a high prevalence of ischemic disease, which means that could be considered the same identity.
Objective: To describe the clinical and prognostic characteristics of patients with heart failure (HF) and mid-range left ventricular ejection fraction (LVEF)(40%-50%) (HFmFE) admitted to the Internal Medicine (IM) Service of Infanta Elena Hospital.

Methods: A total of 33 hospitalized patients in Internal Medicine Service at Infanta Elena Hospital in 2017 with HFmEF were enrolled and retrospectively studied in the present study. Area: Hospital Infanta Elena (Huelva). Regional Hospital of 2nd level that covers the districts Huelva-Costa and Condado-Campiña. It has 70 beds of IM, with an assistance activity of 3000 admissions per year. Inclusion criteria: FEVI 40% -50%; New York Heart Association (NYHA) II-III; Admission in Internal Medicine in 2017; Echocardiography performed in 2017. Exclusion criteria: Age younger than 18 years.

Results: A total of 33 patients admitted to the Internal Medicine Service were collected during 2017 with an age of 79 years (median), 57.6% men and 42.4% women. The majority of the patients showed dependence, with a median in the Barthel scale (85 points) and Profund scale (3 points). Related to comorbidities, it is observed that 84.8% suffer from arterial hypertension, 66.7% atrial fibrillation, 60.6% dyslipidemia, 57.6% diabetes, and 39.4% ischemic events. Patients take a median of 10.64 drugs per day: beta-blockers (90.9%), Furosemide (72.7%) and angiotensin-converting enzyme inhibitors (63.3%). Only 57.6% receive full treatment for heart failure. 66.7% consulted in the emergency department after admission for the following 3 months, 48.5% for HF. 39.4% were admitted for this reason. 12.1% died during the admission or follow-up of the study (from the admission to March 2018). Conclusion: Our patients with HFmFE have the same prevalence of coronary events and number of hospitalizations as those described in the literature for patients with reduced LVFE and comorbidity and quality of life similar to patients with preserved LVEF.
Reverse Dipper Blood Pressure Pattern in Normotensive Individuals and Its Clinical Importance

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Background: Our purpose in this study is to investigate reverse dipper blood pressure levels and its clinical importance in patients who applied to our clinic with hypertensive symptoms and were found to be normotensive according to 24h ambulatory blood pressure measurement (24h-ABPM).

Methods: Individuals over the age of 18 who applied to our clinic between January 2015 – January 2017 with hypertensive symptoms and whose 24h, nocturnal, and daytime blood pressure values were within normal limits according to 24h-ABPM were included in the study.

Results: The study population consisted of 393 patients in total, 13.5% with reverse dipper, 33.6% non-dipper, 44.3% dipper, and 8.7% extreme dipper. The reverse dipper group had higher mean white blood cell (WBC), mean low density lipoprotein (LDL), median c-reactive protein (CRP), and median 24h urine protein excretion levels and lower median high density lipoprotein level compared to other groups. In the reverse dipper group, 24h urine protein excretion level was positively correlated with 24h systolic blood pressure (r= 0.522; p< 0.001), 24h diastolic blood pressure (DBP) (r= 0.635; p< 0.001), nocturnal DBP (r= 0.313; p= 0.022), WBC level (r= 0.491; p< 0.001), monocyte level (r= 0.453; p= 0.001), total cholesterol (r= 0.448; p= 0.001), LDL (r= 0.378; p= 0.005), CRP level (r= 0.673; p< 0.001), creatinine level (r= 0.379; p= 0.005).

Conclusion: It is considerably common to observe significantly high rates of reverse dipper pattern of blood pressure in normotensive patients. More importantly, subclinical atherosclerosis signs may be observed to be significantly high in these patients.
Right Heart Failure: Paracentesis or Sacubitril-Valsartan. New medical horizons.

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INTRODUCTION:
Sacubitril-Valsartán is a complex of the neprilysin inhibitor and the angiotensin receptor blocker, which in the PARADIGM-HF study showed reduce hospital admissions for acute decompensated heart failure and mortality in those patients with symptomatic chronic heart failure with reduced ejection fraction. We want to Know if this drug also could be a good option to treat patients with preserved ejection fraction.

CASE DESCRIPTION:
A 73-year-old woman, with personal history of long duration arterial hypertension, hypercholesterolemia, diabetes, Chronic Obliterative arteriopathy, Chronic Kidney disease, permanent atrial fibrillation anticoagulated with acenocumarol and usually followed up by Cardiology due to Chronic isquemic Cardiopathy with 50% residual left ventricular ejection fraction, right ventricular function preserved and high probability of pulmonary Hypertension.

Our patient, was kept in III Functional class with frequently right heart failure decompenation, overriding ascites despite optimal Therapy with Beta Blockers, inhibitor enzyme angiotensin-converting and diuretics. Throughout the process, the patient disallowed the proposals of peritoneal dialysis technique and she preferred monthly therapeutic paracentesis like symptomatic treatment.

Although she didn’t show left ventricular dysfunction, it is decided to start sacubitril-valsartan therapy due to conventional treatment poor results.

It is obtained a spectacular response, not being necessary more paracentesis and keeping without changes the blood pressure and kidney function.

DISCUSSION:
In that case, patient with particular right-sided Heart failure with data of systemic congestion regardless the value of the preserved ejection fraction (HFpEF), evinces another possible patient profile who could acquire advantages of neprilysine and angiotensin associated inhibition. However, long-term clinical trial are needed in order to confirm them.
Risk factors in developing cardiogenic shock in acute myocardial infarction.

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Objectives: Determine the incidence rate of cardiogenic shock (CGS), possible risk factors and clinical outcomes in patients with acute myocardial infarctions (MI).

Background: CGS, as a complication, occurs in 5-10% of patients hospitalised with MI. It is important to assess the risk factors that might contribute to the development of shock and affect the clinical outcome.

Methods: Analysis of Paul Stradins Clinical University Hospital archives, from January 1st 2015, till January 1st 2016, were performed, identifying patients hospitalised with ACS with STE or without STE (NSTE), as well with CGS. Patients were divided in two groups. In group I patients did not develop CGS and in group II - developed CGS.

Results: The study included 803 patients, group I - 695 (86.56%), group II - 108 (13.44%) patients. In patients older than 65, CGS developed not only more often (p 0.0001), but also positively correlated with clinical outcome was observed (p= 0.0001). Average myocardium injury and heart failure markers values were higher in group II when hospitalised (Troponin I; p 0.002, CK-MB mass; p 0.009, BNP; p 0.001) in comparison with group I; moreover, they have positive correlation with CGS development. To patients in group II the level of BNP has a positive correlation with clinical outcome (p= 0.04). In comparison with group I, patients in group II more often had frontal MI (57.4% vs 45.8%) this positively correlates with the development of CGS (p = 0.03). Patients in group II statistically more frequently had exitus letalis (61.1 vs 3.5%; p = 0.001)

Conclusions: Patients older than 65 have positive correlation with CGS development. Myocardial injury (Tn, CK-MB) marker and BNP correlate with development of CGS. BNP level positively correlates with the clinical outcome. MI frontal localisation is more often associated with the development of CGS. Mortality rate is still high for patients with CGS.
Risk of arterial hypertension in general population with family stress in Russia/Siberia: gender features. WHO epidemiological program Monica-psychosocial

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Objective: to determine gender differences in the effect of family stress on the risk of arterial hypertension (AH) in an open population of 25-64 years in Russia / Siberia.

Methods: Within the framework of the III screening of WHO’s MONICA-psychosocial program, a random sample of general population aged of 25-64 years was examined in Novosibirsk in 1994 (men: n = 657, 44.3 ± 0.4 years, response - 82.1%, women: n = 689, 45.4 ± 0.4 years, response - 72.5%). The screening survey program included: registration of socio-demographic data, determination of stress in the family. During the 16-year period, 229 new-onset AH cases in women and 46 cases in men were detected.

Results: In an open population of 25-64 years the level of high family stress was higher in men (31.5%) than women (20.9%). Risk of hypertension was higher in men HR=2.24 experiencing stressful situations in the family compared to women HR=1.35 over 16-year of follow-up. Taking into account social parameters and age risk of hypertension also remained higher in men HR=1.9 than in women HR=1.37. The highest risk of hypertension was observed in divorced HR=12.7 and widowed men HR=10.6 and also in women aged 45-54 years experiencing stressful situations in the family HR=2.86 (p for all < 0.05).

Conclusion: Stress at home is more common in men than in women. Risk of hypertension in presence of stress at home is higher in men.
Role of multi-marker analysis in acute heart failure and overlapping pathologies: a prospective study

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BACKGROUND
In emergency settings, clinical manifestations of acute heart failure are often misinterpreted due to the presence of comorbidities, mainly respiratory pathologies, chronic administration of cardiovascular medication (e.g. diuretics) and reduced specificity for cardiovascular symptoms. Existing data sustain the utility of a multimarker analysis in enhancing the diagnosis and cardiovascular risk stratification abilities of natriuretic peptides in acute patients.

AIM: To evaluate the diagnosis value of a multimarker panel in patients with suspected acute heart failure presenting with atypical clinical manifestations or overlapped pathologies.

METHODS: 100 adult patients consecutively presenting to the Emergency Room with acute onset or exacerbation of dyspnea were included. Exclusion criteria consisted in active neoplasias and documented fibrotic diseases. Seric determinations of three biomarkers (NT-proBNP, galectin-3 and cystatin C) were performed at admission using validated laboratory methods. The patients were further divided into 3 groups: cardiac etiology group, non-cardiac etiology group and mixed etiology group. All possible etiologies of acute heart failure were accepted.

RESULTS: In the group of patients deceased of cardiovascular causes (5%), only NT-proBNP and galectin-3 were proven to have statistically significant superiority ($p=0.007$, respectively $p=0.023$). All three biomarkers showed significant correlation with the cardiac etiology of the clinical manifestations (NT-proBNP $p=0.000$, cystatin C $p=0.002$, galectin-3 $p=0.032$).

CONCLUSIONS: Our findings sustain the utility of multimarker analysis in atypical presentations of acute heart failure, having direct consequences in establishing a prompt diagnosis and, additionally, identifying patients with an increased cardiovascular risk requiring intensive care treatment.

We have no conflict of interest to declare.
Sistemic embolic events in patient with MTHFR C677T polymorphism and a patent foramen ovale

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Introduction
The association between hyperhomocysteinemia and the development of cardiovascular diseases, thereby implicating it as a risk factor for atherosclerosis and thrombosis, is demonstrated in several studies. On the other hand, a patent foramen ovale (PFO) has been linked to many clinical conditions, the most important being ischemic strokes of undetermined cause.

Case description
We present a 53-year-old Caucasian female, with hypothyroidism and cholelithiasis that presented with an abdominal pain in the lower quadrants and biliary vomiting for three hours. At observation, she was conscious, dehydrated, with stable vitals, normal cardiac and pulmonary auscultation and pain with palpation of the hypogastric region, without peritoneal irritation. There were no laboratory alterations, but the abdominal CT revealed a low captation of contrast in the parietal small bowel and edema of the peripheral fat that was assumed as a possible mesenteric ischemia. She was hospitalized for monitoring and began anticoagulation therapy with low-molecular-weight heparin. The pain resolved progressively. Another CT was performed two days later and revealed a cortical defect in the right kidney, suggesting a renal ischemia. The patient remained asymptomatic and was transferred to the Internal Medicine service to investigate a possible systemic embolic disease of unknown origin. The study revealed the patient had a MTHFR 677T mutation with detection of the C677T polymorphism in heterozygosity with high levels of homocysteine and a PFO with 2mm.

Discussion
A C677T polymorphism in heterozygosity or a PFO of 2mm alone might not be enough to explain a systemic embolic disease, but in this patient, the co-existence of both might explain the renal and mesenteric ischemia. The co-existence of more than one pro-thrombotic factor is not uncommon and its identification is fundamental to avoid unfavorable outcomes.
Spontaneous bilateral vertebral artery dissection causing stroke in a young woman

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INTRODUCTION
Cervical artery dissections are a rare cause of stroke (1-2%), predominantly affecting carotid arteries, and to a much lesser extent the vertebral arteries. In younger patients (<45 years), the contribution of dissection to stroke etiology is higher, causing 20% of all strokes.

CASE DESCRIPTION
A 27-year-old woman, with known history of Hashimoto thyroiditis, migraine and use of oral contraceptives, was admitted to the emergency department with sudden gait imbalance. There was no history of recent trauma, no relevant personal or familiar history, and no substance abuse. On admission, she had a left hemihyposthesia but no ataxia (NIHSS 1). CT and CTA were unremarkable. MRI showed small acute ischemic lesions on the left pons and right cerebellar hemisphere. She started IV-tPA after 3h30 of symptom onset. Two hours later, her neurological status worsened (NIHSS 11) but repeated CT showed no new lesions or hemorrhagic transformation. Doppler sonography showed occlusion of the right vertebral artery and a cerebral angiography was performed, disclosing dissection of both vertebral arteries on its V3 segments with severe stenosis of the V3/V4 right junction and an endoluminal thrombus in the left V3 segment without significant stenosis. The patient was started on anticoagulation (dabigatran) and discharged from hospital with no major neurological deficits (NIHSS 0). At three-month follow-up, she was asymptomatic. Doppler sonography and MRI-angiography showed both vertebral arteries were patent and no new ischemic lesions were observed. Anticoagulation was withheld.

DISCUSSION
Spontaneous vertebral artery dissection is a rare cause of stroke, especially when bilateral, but should be considered in younger patients, even with a normal CTA at admission. MRI and angiography might play an important role in such instances. Treatment remains controversial but favorable outcomes are to be expected when early diagnosis is made and adequate therapeutic options are considered.
Stroke is a major cause of morbidity and mortality in Portugal. In ischaemic stroke, fibrinolysis is the indicated treatment within 4.5 hours after symptom onset. In eligible patients with large vessel occlusion within 24h of symptom onset, mechanical thrombectomy should be considered. Since a regional hospital does not have the ability to perform acute phase therapy, the patients who benefit from it are transferred to a central hospital.

Objectives: To revise the information of the patients who were transferred from a regional hospital to a central hospital stroke code to be submitted to acute phase therapy.

Methods: Retrospective analysis of the clinical information of the patients transferred from the emergency department of a regional hospital to a central hospital stroke code between September 2016 and August 2017.

Results: During the period of the study, 71 patients were transferred to the reference center to be submitted to acute phase therapy. Fifty seven percent were male and the mean age was 69 years. From the patients who were transferred, 13 were submitted to fibrinolysis, 6 were submitted to thrombectomy and 8 were submitted to both procedures. From the 44 who did not receive therapy, in 14 the diagnosis of ischaemic stroke was not confirmed, 10 presented with minor neurologic deficit, 8 presented extensive regions of hypoattenuation in the computed tomography which contraindicated therapy, 7 were admitted after the recommended time limit to start the therapy and 5 patients were excluded because they presented with complete reversion of the neurologic deficit.

Conclusion: The time elapsed since the onset of the symptoms is decisive in the decision to start ischaemic stroke acute phase therapy. It is fundamental to optimize protocols in order to expedite patient referral and improve the clinical evaluation in hospital admission, since more than half of the patients form this study did not be benefited from the transference to the stroke code team.
Stroke in young adult - Blame the hormonal contraceptives?

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Stroke in young adults are uncommon however it represents an important economic impact as the victims can be disabled and that contributes to a decrease in the number of years of productive life. Highly prevalent modifiable risk factors for stroke in young adults are dyslipidemia, smoking and hypertension.

We report the case of a 23-year-old woman that is taking a hormonal contraceptive for the last 5 years and didn't have any other risk factor. Her grandfather died young, at age of 28, due to a stroke. She was previously healthy but she was diagnosed with a stroke after she had a sudden decrease of strength and sensibility on the right side of her body while she was working.

She underwent an extensive workup, including echocardiogram, cardiac monitoring for paroxysmal atrial fibrillation, lipid panel, lupus anticoagulant, anticardiolipin antibodies, antinuclear antibodies, antithrombin-3, B-2 glycoprotein, protein C and S, all the complements viral diseases, GAD-1 antibodies and Fabry disease and all of them were negative for a potential case of stroke. The only positive findings were a heterozygous mutation for the genes MTHFR677T (encodes an enzyme involved in breaking down the amino acid homocysteine) and PAI-1 5G/4G (endothelial plasminogen activator inhibitor).

Some studies considers the evidence for stroke risk associated with use of currently available oral contraceptives. Since all the common tests were negative for a potential cause of stroke, hormonal contraception and the genetic mutations together could contribute for the ischemic stroke in this young patient.
Introduction:

Tetanus is a rare infectious disease in developed countries, with Clostridium tetani as its etiologic agent. The clinic is not due to the tissue invasion by the bacteria, but to the neurotoxin it produces, atetanospasmin.

In the particular case of Portugal, there are less than 10 cases per year since 2003.

The diagnosis of tetanus is clinical, based on semiology and history. Laboratory tests have a very limited role, especially in cases of typical presentation.

Clinical case:

A 69-year-old woman, self-employed, with a National Vaccination Plan to be updated.

Admitted to the Emergency Department after having been found at home unconscious. She presented a 3-day evolution described as "dysarthria, deviation of the labial commissure, associated with headache, dysphagia and paresthesias at the level of the limbs". In the neurological examination: marked cervical hyperextension, moderate dysarthria, muscular rigidity and marked spasticity at the level of the 4 limbs with repetitive contractions, with exuberant trismus and intense sweating.

In the objective examination, a traumatic lesion was detected in the right hand thumb, with purulent exudate.

Objective Cardiorespiratory arrest in asystole due to probable hypoxia secondary to marked trismus, with spontaneous recovery.

She was admitted to the Intensive Care Unit (ICU) with the diagnosis of tetanus.

Discussion:

The case presented in the XXI century is interesting because of the rarity of this pathology in developed countries, due to the need for a correct action, which requires a high index of suspicion. Early diagnosis is essential, given the frequent need for ICU admission.
Surgery outcomes in mechanical complications of acute myocardial infarction

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Aims: characterize a group of patients who underwent cardiac surgery (CS) due to mechanical complications (MC) in the context of AMI and evaluate its outcomes.

Methods: retrospective analysis; patients admitted with mechanical AMI related complications underwent CS, in a single center (January 2007 - October 2017). Results: N=25 (64% male; median of 71 years); heart surgery due to: rupture of the interventricular septum (n=17; 68%), mitral valve regurgitation (MRV) (n=4; 16%), rupture of the free wall of the left ventricle (n=3; 12%) and right ventricle (n=1; 4%). All patients had MVR (only 4 patients had grade III or IV MR and underwent CS). The most frequent mechanisms of MVR were restriction of closure of the posterior leaflet (40%), rupture of tendinous chords (20%) and papillary muscle rupture (12%). All patients were hypertensive and dyslipidemic, The most common co-morbidity was heart failure (n=7; 28%); the median ejection fraction of left ventricle was 40%; peripheral arterial disease was present in 24% of patients, and severe renal disease in 20% (creatinine clearance <30 ml / min/1.73 m2). At admission 52% of patients were in Killip class ≥ 3, and about 26% of patients had severe impairment of right ventricular function. Anterior wall was affected in 44% of cases, the inferior in 32%, and the inferior-lateral wall in 20%. The culprit artery was the right coronary artery in 48%, and the anterior descending artery in 40%. Twenty one patients (84%) were submitted to PCI (65% in the first 12h of admission). There were 11 deaths during hospitalization (mortality rate 44%). Conclusion: low percentage of surgeries due to post AMI-MC in a center with important surgical activity (n=850/year) and primary PCI available occurred; a high in-hospital mortality rate (44%) in patients with severe clinical presentation (Killip class ≥ 3) and severe systolic ventricular dysfunction, was observed.
Swinging heart presentation of metastatic lung cancer

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Introduction:
The “swinging heart” sign as a manifestation of cardiac tamponade mandates for emergent pericardiocentesis. We report a case where this was the presentation of lung cancer in a patient with other plausible causes of polyserositis.

Case description:
A 60-year-old male with history of coronary disease and atypical mycobacteriosis was admitted to the emergency department with complaints of thoracic discomfort and dyspnea that had been aggravating during the previous week.
On admission the patient was hemodynamically stable. Chest x-ray revealed enlarged cardiac silhouette and pleural effusion. The transthoracic echocardiogram identified large pericardial effusion with the “swinging heart” sign, and thus furosemide and nitrate were initiated, with ensuing clinical deterioration into cardiogenic shock. An emergent pericardiocentesis was performed with drainage of more than 800ml of pericardial fluid with hemodynamical recovery. The patient was then admitted in the Intermediate Care Unit.
The diagnostic workup revealed pleural effusion, pericardial effusion and ascites, an area of ground-glass opacity with consolidation whose etiology was unclear, and one axillary adenopathy. The pleural effusion had transudate characteristics. The patient’s blood tests for mycobacterial DNA were negative. A biopsy of the axillary adenopathy was performed and revealed cells of pulmonary adenocarcinoma.

Discussion:
Metastatic pericardial effusion is not uncommon in lung cancer. However, presenting with a malignant cardiac tamponade is considered a rare presentation. Immediate pericardiocentesis is mandatory and life-saving. This case also presents other diagnostic challenges, in relation to the patient’s history of mycobacteriosis.
Symptomatic cardiovascular disease in a cohort of patients with HIV infection

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Objectives: The cardiovascular etiology is one of the main HIV-not associated mortality causes. The aim of this study is to analyze the prevalence and characteristics of cardiovascular disease (CVD) in a cohort of patients with HIV infection.

Methods: Retrospective observational study of patients with HIV infection followed up in consultation of our hospital until January 2016. Patients who had presented a CVD were included and clinical presentation, cardiovascular risk factors, toxic consumption and parameters related to HIV infection were evaluated.

Results: 650 patients with HIV infection were included. 43 (6.6%) had suffered a CVD, 90% males with 56-year median age. Clinical presentation was ischemic heart disease in 17 patients (40.5%), ischemic stroke in 16 (38%) and peripheral arterial disease in 15 (35.7%). Patients presented 2,1 average risk factors, being smoking the most frequent (85% of patients, in 16% it was the only predisposing factor); followed by HBP (52.4%), dyslipidemia (40.5%) and DM (21%). Two patients met metabolic syndrome criteria. 35% were former drug users (1 cocaine user). Regarding HIV infection, the time elapsed since the diagnosis was 264 months. 32% presented an opportunistic infection defining AIDS, with a CD4 nadir of 226 /mm3. 76% were in treatment with protease inhibitors (PI), with an average of 84 months of exposure.

Conclusions: The prevalence of symptomatic CVD in our series is high. Smoking and the use of IP are frequent risk factors in our population. The control of these factors, both modifiable, is important to reduce the incidence of CVD in these patients.
Cardiovascular diseases
A-1640

Tachycardia mediated cardiomyopathy

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Introduction:
Arrhythmias can cause or exacerbate an acute heart failure in patients with previous cardiac pathology. However, persistent tachycardia (either supraventricular or ventricular) or frequent ectopic activity can also originate a dilated cardiomyopathy in a previously healthy patient. This mechanism is poorly understood.

Case description:
The case presented is of a 59-year-old male, without cardiovascular risk factors, with recent normal routine cardiac exams. He went to the emergency department after one week of exertional dyspnea, orthopnea and paroxysmal nocturnal dyspnea. He also referred episodic palpitations. There were no stressful events. He denied alcohol abuse or drug use. On the initial evaluation an auricular fibrillation (AF) with rapid ventricular response (RVR), 120-130bpm, was discovered. He had seriated normal measurements of troponin. An echocardiogram revealed a dilated cardiomyopathy with severe biventricular dysfunction, without left ventricular hypertrophy. He was admitted to study the etiology of a dilated cardiomyopathy. Analytically, he had normal exams including ionogram and thyroid function. He was submitted to cardiac catheterization that excluded coronary disease. A cardiac magnetic resonance excluded active inflammation in the context of a myocarditis. The diagnosis of Tachycardia mediated cardiomyopathy (TMC) was reached. A chemical cardioversion was successfully performed. He improved clinically with ACE inhibitor, beta blocker, aldosterone antagonist and diuretic. After being discharge the patient had 2 more episodes of tachyarrhythmia that needed electrical cardioversion. Six months later his echocardiogram had normalized.

Discussion:
TMC can be reversible with the resolution of the arrhythmia, although the increased risk of sudden death persists. The authors present this case to highlight the consequence of a late treatment of an AF with RVR, which is a very frequent disease in the emergency department.
INTRODUCTION
Takayasu arteritis is a vasculitis of large vessels that mainly affects the aorta and its main branches. It is a rare disease in Europe with about 1 to 3 cases per year per million inhabitants. The clinical manifestations are extremely variable depending on the affected vascular portions and type of injury.

CLINICAL CASE
A 53-year-old female, active smoker, grade 1 obesity, dyslipidemia and arterial hypertension. She went to the emergency room with a 2-week course of fever, fatigue, headache, photophobia, neck pain and paraesthesia of the left upper limb. At observation, without asymmetries of the pulses or of the arterial pressure of the 4 limbs, intermittent claudication or arterial blows.

Analytically, it presented leukocytosis with neutrophilia and increased sedimentation rate and C-reactive protein. Lumbar puncture was performed without alterations in the cyto-chemical analysis. The autoimmune and infectious analytical study was all negative. She also performed cranioencephalic computed tomography (CT), which revealed no alterations and echocardiogram showing good systolic function and a slightly hypertrophied ventricular septum.

She performed a CT scan of the body that revealed the arteriopathy of large vessels, involving different segments of the thoracic and abdominal aorta and some of its branches, compatible with the diagnosis of Takayasu Arteritis type V. She started systemic corticosteroid therapy with good clinical and laboratory response.

DISCUSSION
The present clinical case evidences the non-specificity and insidious progression of Takayasu's Arteritis symptoms. The need for high clinical suspicion is stressed for this entity to be diagnosed early, before the emergence of irreversible complications.
Takayasu's disease and pregnancy: two cases and review of the literature

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Introduction
Takayasu’s Arteritis (TA) is a chronic, inflammatory, progressive, idiopathic disease that causes narrowing, occlusion, and aneurysms of systemic and pulmonary arteries affecting especially the aorta and its branches. During pregnancy, one should pay special attention to these patients. Due to the manifold cardiovascular complications that can occur in the course of the disease, management of pregnancies in TA patients is a challenge for the obstetrician, the anesthesist and the cardiologist

Case report
We report the case of a 37-year-old patient, who had Takayasu’s disease with a history of fetal death in utero, diagnosed during her previous pregnancy with a tension asymmetry. Her new pregnancy was complicated by preeclampsia associated with intrauterine growth retardation.
Second case was a 32 yr old female patient, G2P1 at 14 weeks period of gestation. She gives no history of high blood pressure during her last pregnancy. On examination, upper limb peripheral pulsations were not felt and blood pressure was not recordable in both upper limbs Her new pregnancy was complicated by preeclampsia associated fetal death in utero.

Discussion
Based on our observation, we recommend that patients with TA should have a medical screening prior to conception. During pregnancy their blood pressure should be strictly controlled and the mode of delivery should be planned for a favorable maternal and fetal outcome
Takotsubo's cardiomyopathy and Neoplastic disease – a case report

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Introduction:
Takotsubo's cardiomyopathy is characterized by transient ventricular dysfunction, usually associated with stress situations. The correlation with cancer has been studied but still needs to be confirmed.

Case description:
We present the case of a 64 year-old woman, with history of chronic obstructive pulmonary disease, hypothyroidism and breast cancer in the past. The patient was referred to the ER with dyspnoea and precordialgia. Upon evaluation with decreased vesicular murmur on the right and sinus tachycardia. Laboratory with TnT-hs elevation (275 ng/L). Chest X-ray with right pleural effusion and electrocardiogram with ST segment elevation in V3-V6 leads. A thoracocentesis was performed, draining pleural fluid with exudate characteristics. Echocardiogram revealed hypokinesia of the apical segments, hyperkinesia of the basal segments and decreased ejection fraction; coronary angiography revealed a lesion in the middle segment of the anterior descending artery, and ventriculography with a suggestive pattern of Takotsubo cardiomyopathy. She was admitted for etiological investigation, having performed: cervico-thoraco-abdomino-pelvic CT-scan, that showed right pleural effusion, pleural thickening and heterogeneous consolidation of probable neoplastic etiology. She underwent thoracoscopy and pleurodesis, with pleural biopsy suggestive of breast carcinoma metastasis. The diagnosis of pleural and pulmonary recurrence of breast neoplasia, with Takotsubo's cardiomyopathy interpreted as a clinical presentation in this context, was assumed. The patient started chemotherapy and was discharged with follow-up in oncology.

Discussion:
The authors intend to emphasize the importance of Takotsubo cardiomyopathy as a possible presentation of a neoplasm, considered as a possible paraneoplastic syndrome or resulting from the metabolic stress inherent to this pathology.
The Impact of 48-Hour Ambulatory Measurements on Antihypertensive Drug Prescriptions at Outpatient Clinic

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Background. Arterial hypertension is important risk factor for cardiovascular morbidity and mortality in patients with chronic kidney disease (CKD), therefore an appropriate measurement and treatments of increased blood pressure is crucial for patients’ quality assessment. 48-hour ambulatory blood pressure measurement (ABPM) is a useful, noninvasive tool for the evaluation of blood pressure status of patients. In our study we aimed to define the impact of 48-hour ABPM on antihypertensive drug prescriptions in CKD patients.

Methods. We retrospectively examined the data of 38 patients with 48-hour ABPM performed at our outpatient clinic. Basic demographic data, comorbidities, concomitant medications prior and after the 48-hour ABPM were recorded. SPSS statistical software was used for statistical analysis.

Results. We included 38 patients (20 female, 18 male), average age was 56.5 ± 17 years. Mean blood pressure was 138.7 ± 19.3 mmHg/81.5 ± 12.5 mmHg (on day 1) and 136.6 ± 18.8 mmHg/80.1 ± 12.5 mmHg (on day 2). Two thirds (29/38) of patients were non-dippers (less than 10% decrease of blood pressure in 48-hour measurements), 24% (9/38) were dippers (more than 10% decrease in blood pressure in 48-hour measurements). Before the measurement, 38 patients had altogether 73 antihypertensive drugs and after the measurement 125 antihypertensive drugs. The dippers took 15 drugs before the measurement and 23 after the measurement. The non-dippers took 55 drugs before the measurement and 88 after the measurement. The difference in drug prescribing number between both groups of patients (before and after 48-hour ABPM) was statistically significant (p < 0.0005).

Conclusion. The results of our study show that 48-hour ABPM has an important impact on antihypertensive drug prescription regime.
The level of adiponectin and leptin in heart failure patients with preserved ejection fraction in combination with obesity

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Aim. To study the level of adipocytokines - leptin and adiponectin in heart failure (HF) patients with preserved ejection fraction in combination with obesity. Patients and methods. The study included 92 HF patients with preserved ejection fraction in the age from 40 to 70 years old. Patients were divided into three groups, comparable in age, sex, smoking frequency, duration of heart failure, systolic and diastolic blood pressure, depending on the body mass index (BMI): normal weight, overweight, obesity. The level of adiponectin, leptin, lipid metabolism parameters, structural and functional parameters of the heart were determined. Clinical examination with analysis of the body composition calculation of BMI, measurement of waist circumference (WC) and waist-to-hip ratio were performed. Results. A significant decrease in the level of adiponectin in CH patients in combination with obesity was found 8.9 [3.8; 15.7] ng/ml compared with CH patients and normal body weight of 22.3 [10.3; 26.4] ng/ml, p<0.05. The leptin level was higher in CH patients in combination with overweight and obesity in comparison with patients with normal weight, p<0.05. In CH patients in combination with obesity, a significant inverse relationship of adiponectin with BMI (r=-0.278), with WC and waist-to-hip ratio (r=-0.348), and visceral fat (r=-0.382) was revealed. The statistically significant correlation of leptin and adiponectin with the parameters of fat metabolism (leptin-cholesterol r=0.248, p<0.05, leptin-triglycerides r=0.326, p<0.05, leptin index of atherogenicity r=0.348, p<0.05, adiponectin-cholesterol r=-0.292, p<0.05, adiponectin-high density lipoproteins r=0.224, p<0.05, adiponectin-atherogenicity index r=-0.264, p<0.05) was revealed. Conclusions. In CH patients with a preserved ejection fraction in combination with overweight and obesity, adiponectin level decreased and leptin level increased, and relationships with abdominal obesity and fat metabolism were established.
The results of the Russian Research Program on the Diagnosis and Treatment of Patients with Familial Hypercholesterolemia in Stavropol region

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The aim: to assess the possibility of timely detection of familial hypercholesterolemia (FH) and effectiveness of therapeutic and diagnostic measures in severe hypercholesterolemia.

In the period of 2013-2016 102 patients with a total cholesterol (TC) level ≥7.5 mmol/l and/or a low-density lipoprotein (LDL) cholesterol ≥4.9 mmol/l were included in the Stavropol regional center of the National Multicenter Register of FH. The simple examination based on modified Dutch lipid clinics criteria was carried out. Data on the clinical status and risk factors of the atherosclerosis, blood lipid parameters, echocardiography, duplex scanning of brachiocephalic arteries and treatment was recorded in the electronic medical system.

Results. Blood lipids mean levels were TC 9.6±2.5 mmol/l, LDL cholesterol 6.8±2.4 mmol/l, lipoprotein (a) 39±56 mg/dl. Elevated lipoprotein (a) (>30 mg/dl) was detected in 31% of cases. In the presence of the severe primary hypercholesterolemia, the probability of detection of FH reached 22%. The frequency of lipid-lowering therapy did not exceed 21%; the target level of LDL cholesterol was reached extremely rarely.

For timely diagnosis and treatment, increasing FH awareness, the data was used for creating the National Society for Atherosclerosis recommendations on the diagnosis and treatment of FH and methodological recommendations on the organization of medical care for patients with FH.

Conclusion. Family hypercholesterolemia in Stavropol region is characterized by high prevalence, untimely identification, low awareness, poor adherence to lipid-lowering therapy with an extremely rare achievement of LDL cholesterol target level.
The Visceral Adiposity Index Predicts The Presence Of Cardiovascular Risk Factors In Asymptomatic Patients With A Normal Body Mass Index: The Metabolically Obese Normal Weight Patient.

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OBJECTIVE: To compare the capability of novel adiposity indexes: visceral adiposity index (VAI), lipid accumulation product (LAP) and waist circumference-triglyceride index (WTI) to discriminate metabolically obese normal weight (MONW) patients in Mexican population.

METHODS: Cross-sectional study in asymptomatic outpatients with a body mass index (BMI) < 25 kg/m2. MONW was defined using available Wildman criteria (≥2: blood pressure >130/85 mmHg, fasting triglycerides (TG) ≥ 150 mg/dL HDL <40 in men, <50 mg/dL in women, impaired fasting glucose ≥100 mg/dL, C-reactive protein ≥0.1 mg/dL) the LAP, WTI, VAI scores, were calculated using the pre-established formulas with waist circumference and fasting TG. Diagnostic yield was calculated with areas under the curve (AUC), we performed logistic regression analysis to calculate Odds Ratios (OR).

RESULTS: 642 subjects were included, 20.4% were MONW. MONW patients were older (50.8±12.9 vs. 42±10.4, p<0.01), male (61.1% vs. 42.9%, p<0.01), had higher mean waist-to-hip ratio (WHR) (0.88±0.07 vs. 0.83±0.07, p<0.01), more prediabetics (32.8% vs.6.5%,p<0.01), diabetics (6.1% vs. 0.6%, p<0.01) and a higher mean Framingham risk score for coronary heart disease (7.3±6.6, 2.4 ±2.0, p<0.01). Mean LAP, WTI and VAI scores were higher in the MONW (88 ±58 vs. 43±28, <0.01), (360±226 vs. 192±104), p<0.001), (7.0±5.0 vs. 3.2±2.2, p<0.01), respectively. Better performance for discriminating MONW was observed using VAI and WTI, compared with LAP and WHR (AUC of 0.80 (CI 95% 0.76-0.85), 0.78 (CI 95% 0.73-0.83) vs. 0.77 (CI 95% 0.73-0.82) and 0.67 (CI 95% 0.62-0.72), p<0.01, respectively. A cut-off point of VAI≥ 3.7 was an independent risk factor for MONWP with an OR=7.6 (95% CI 4.5-12.4,p<0.01)

CONCLUSION: Available formulas may be useful for discriminating metabolic abnormalities in patients with normal BMI who could otherwise be classified as healthy. A positive value should prompt a more extensive cardiovascular risk assessment.
Cardiovascular diseases
A-1877

Total in-hospital mortality rate of st-segment elevation myocardial infarction after the implantation of 24 hours of primary PCI in our cath lab

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Background and purpose
Primary percutaneous coronary intervention (PCI) is now established as the reference treatment for the management of ST segment elevation acute myocardial infarction (STEMI). The aim of this study is to determine the influence of 24 hours of primary PCI in total in-hospital mortality of STEMI in our patients.

Methods
Observational retrospective study was done to analyze the data of 1269 consecutive patients included in the ARIAM-Andalucía Registry from our Coronary Intensive Care Unit (CICU) with STEMI diagnosis from 1st January 2005 to 31th December 2016. Patients were divided in two groups according to primary PCI implantation on 2012;
Group 1 comprises those patients included in our registry from 1st January 2005 to 31st December 2011 (n=690).
Group 2 comprises those patients included in our registry from 1st January 2012 to 31st December 2016 (n=579).

Results
Baseline characteristics of both groups were similar in male sex (80,12% vs 81,35%) and mean age (60,32% vs 61,18%) while differences were observed in reperfusion therapy (PCI 31% vs 72,8% Trombolysis 40,6% vs 21%).
Total in-hospital mortality rate of STEMI was significantly higher in the first group (6.8% vs 5.4% p value = 0.0424).

Conclusions
24 hours primary PCI implantation achieved statistically significant reduction of total in-hospital mortality rate of STEMI.

Non conflicts of interest to declare.
Transplanting the hypertension away: an unusual cause of grade III pulmonary hypertension

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Introduction
Pulmonary hypertension is a heterogeneous disease that has a varied aetiology. The European Society of Cardiology (ESC) / European Respiratory Society (ERS) classify Grade III pulmonary hypertension as being due to underlying lung disease and chronic hypoxia. We present a case of pulmonary hypertension in a patient with surfactant deficiency type 2, who underwent successful lung transplantation and improvement of symptoms.

Case
A 33-year-old lady with an established diagnosis of surfactant deficiency type 2, was admitted with clinical features of acute decompensated cardiac failure. Transthoracic echocardiography showed right ventricular (RV) dilatation with reduced systolic function, RV thrombus, and inter-ventricular septal flattening with severe tricuspid regurgitation and elevated estimated pulmonary arterial pressures. Using the ESC/ERS algorithm, the patient was diagnosed and treated as having Group III pulmonary hypertension. Tissue characterisation by cardiac magnetic resonance (CMR) imaging showed subsequent resolution of the RV thrombus following anticoagulation. She progressed to have successful bilateral lung transplantation with marked improvement of symptoms.

Discussion
Surfactant dysfunction and associated disorders arise from mutations in genes encoding for normal function and metabolism of surfactant. They manifest more commonly as acute lung disease in neonates, and rarely as interstitial lung diseases in children and young adults. We discuss the mechanisms of grade III pulmonary hypertension and how adherence to the ESC/ERS guidelines led to a good outcome in a district general hospital’s encounter with an orphan disease.

References
Myocarditis, an inflammatory process of the heart muscle, can be found in a number of systemic diseases (autoimmune, infectious, toxic and others), although more than half of the reported cases are classified as idiopathic. It usually manifests in an unspecific way, with chest pain, palpitations, fatigue or tachycardia. In worst cases, signs and symptoms of heart failure can be present. Negative T waves, atioventricular block and/or recent onset arrhythmia on electrocardiogram (ECG), elevated troponin levels and an abnormally thick ventricular wall can contribute to diagnosis, but a definitive diagnosis will only be attained by endomyocardial biopsy.

The authors report the case of a 56 year-old woman with known hypertension, hypothyroidism and polyarthralgia, presenting with chest pain, elevated troponin levels and a slight ST depression on ECG, with negative T waves from V1 to V4. She was submitted to cardiac catheterization and ventriculography, as well as magnetic resonance imaging, which revealed a normal heart structure. The chest pain and troponin elevation were constant. On lab tests there was a positive serology (1/1280) indicating recent Rickettsia conorii exposure, and the patient was started on doxiciclin. The source of exposure was never identified, and after prolonged antibiotic therapy the patient maintained intermittent chest pain, elevated troponin levels and joint pain on her hands and hips. She was then treated with low-dose corticosteroids and antidepressants, with clinical benefit.

The authors discuss the relevance of heterophilic antibodies in recurrent chest pain and their possible association with autoimmune diseases and post-infectious syndromes.
Objectives: This study was to assess the relationship between the compliance to treatment and the affecting factors in hypertension patients.

Methods: In this descriptive study, socio-demographic, affecting factors and compliance to treatment were assessed using a questionnaire form and Hypertension Compliance Assessment Scale in 187 patients with hypertension who applied at a research and application hospital in a city in Turkey between 6th March 2017-31th December 2017. The data was analyzed using descriptive statistics (percentage, mean, standard deviation), t test, one-way ANOVA and pearson correlation.

Results: The mean age was 60.67±11.48 years and 66.3% of the patients were female. The mean score for Hypertension Compliance Assessment Scale was 5.56±2.27. There were no significant relationships between compliance score and age, gender, marital status, drugs of number, duration of hypertension.

Conclusions: Based on these results, regular training and information regarding compliance must be provided to patients.
Underdosage of Oral Anticoagulants (OACS) as a Risk Factor for Cerebrovascular Accidents in Atrial Fibrillation Patients Taking OACS

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Background: Patients with atrial fibrillation (AF) are at high risk of cerebrovascular accidents (CVA) and mortality. Anticoagulants (ACs) reduce the risk of CVA and thromboembolic events. The recommended AC drugs belong to two main groups - Vitamin K antagonists and the new ACs (NOACs). Physicians occasionally prescribe an underdose of the medicines. Studies have shown that inappropriate underdosing of ACs does not protect from CVA. This study examined whether there is a relationship between the dosage of the AC drugs and hospitalization due to CVA in AF patients taking AC therapy.

Methods: Retrospective (case-control) study on patients treated with ACs for AF and hospitalized in the internal medicine departments of Emek medical center, Afula, between 2013 and 2016. The study group consisted of patients hospitalized for CVA and Transient Ischemic Attacks (TIA) and the control group included patients who were hospitalized for other reasons, and corresponded, in terms of ages and risk level, to the development of CVA. Data on each patient was extracted in order to calculate the risk of ischemic attacks and of bleeding. We determined whether the dosage of AC therapy prescribed for each patient was optimal or not, and whether there were more patients in the research group who were treated with an inappropriate underdose of ACs in comparison to the control group.

Results: The study group consisted of 156 patients and the control group of 294 patients, 54% of the patients who participated in the study were not prescribed the recommended dosages of ACs. We found no statistically significant differences between the two groups upon examination of the connection between the inappropriate low dose of ACs and hospitalization following CVA/TIA.

Conclusions: Most of the patients with AF hospitalized in the internal medicine departments are treated with a lower dose of ACs than recommended. No connection has been found between the low dose and hospitalization following a CVA.
Usefulness of abdominal ultrasound to establish the definitive diagnosis in de VSCABD study cohort

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OBJECTIVE: Observe the clinical-pathological characteristics of the patients who were asked for an abdominal ultrasound. We focus our attention on the reason for which they were admitted, the reason for requesting that abdominal ultrasound and the influence of the results on the diagnosis at discharge.

MATERIAL AND METHODS: Prospective observational study of cohorts of a randomized sample of patients attended by the M. Internal service to whom an abdominal ultrasound was requested during their hospitalization between Feb’17 and Feb’18.

RESULTS: N=190 patients. Average age 69.07 years (18-97 years), with 68.9% of the sample older than 60 years. 50.5% women.

The reason for admission was, 20.2% Febrile syndrome, 14.4% dyspnea of cardiac origin, 11.7% general state deterioration, 10.6% vomiting/diarrhea, 8.5% increase in the perimeter of one limb.

The reasons for the request of the ultrasound were analyzed, grouping them by clinical syndromes, obtaining that 25.3% for abdominal pain (22% with suspicion of urinary origin), 21.6% for the study of febrile syndrome, 9.5% by alterations in transaminases, 3.7% by sensation of mass at abdominal palpation.

The most prevalent diagnoses at discharge were: 13.2% left with the diagnosis of respiratory infection, 9.5% urinary infection, 8.9% thromboembolic disease as well as CHF, 6.8% were exitus.

It is striking that the main reason for requesting an abdominal ultrasound is a diagnosis of respiratory infection, if we analyze the reason for requesting these ultrasounds, the pain accounted for 40% of the cases and the fever itself by 16%, other reasons were: cytolysis, cytolysis, constitutional syndrome, acute renal failure or sensation of mass at abdominal.

CONCLUSIONS: As can be seen in this descriptive analysis, the heterogeneity of pathologies faced by the internist is very broad and the usefulness of ultrasound covers all these scenarios, helping in multiple situations to modify the diagnostic presumption towards the final diagnosis.
VCARDIO study: Is there an agreement between echocardiography performed by an echocardiographer and echocardiography performed by an internist?

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OBJECTIVES
To compare the data obtained in an echocardiography performed in the image laboratory of the Cardiology service against echocardiography performed by an internist after a basic instruction with a pocket device (dual Vscan)

METHODS
Echocardioscopy was performed at the bed in +/- 24 hours compared to gold standard ultrasound in 200 first patients in VSCARDIO study

RESULTS
Average age 73.4 years (16-92 years). 51% women
The agreement obtained between a internist (using a pocket sized ultrasound) and the echocardiographist in the imaging laboratory was good (k>0.61) for the presence of structural alteration, ejection fraction VI, wall VI, pulmonary hypertension, mitral, aortic and tricuspid valvulopathy, RV dysfunction, aortic root and pericardial effusion. Being very good (k>0.81) in the detection of metallic valvulopathy and the IVC diameter

The specificity was >90% for the VI ejection fraction, the characteristics of the LV wall, mitral, aortic and tricuspid valve disease, RV dysfunction, IVC diameter, aortic root and pericardial effusion

Obtaining a sensitivity>90% in the presence of structural alteration, the VI ejection fraction, the absence of valve disease, the presence of valvular prosthesis; as well as the diameter VD

Obtaining, likewise, a J of Youden ≥0.6 in all categories with the exception of double aortic injury and mitral insufficiency

In relation to the predictive values, a NPV>0.8 was obtained in all parameters measured except for tricuspid insufficiency. As well as a PPV>0.8 in structural alteration, TPH, ventricular wall, atrial dilation, absence of mitral and aortic valve disease; mitral and tricuspid insufficiency, IVC diameter and aortic root

CONCLUSIONS
Echocardiography provides very positive results where we observed that rapid learning is possible and at the cost of relatively few tests; where, in return, the holistic view of the patient that an internist should have and improve their performance both in speed and accuracy could be completed
Venous Thrombosis: Can vitiligo be a risk factor?

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A 58-year-old male was admitted to the Emergency Department with abdominal and left flank pain. The patient has only vitiligo for 7 years. The vital signs were stable and the physical examination was unremarkable except for left upper quadrant tenderness with deep palpation and disseminated depigmented patches on skin (vitiligo). Apart from vitiligo, no signs of autoimmune disorders were present. The platelet count was 404,000/µL. No renal function or hepatic function abnormality and no electrolyte abnormality were reported. Abdominal magnetic resonance imaging (MRI) scan, revealed splenic vein thrombosis with splenic infarction, thrombosis in hepatic veins and the portal vein also. The patient had no personal or family history suggestive of thrombophilia. Workups for the etiology of venous thrombosis included testing for hereditary thrombophilia (F5 Leiden mutation and F2 prothrombin mutation, protein C, protein S), antinuclear antibody (ANA), antiphospholipid syndrome (anti-beta2 microglobulin, anti-cardiolipin), and Janus kinase 2 (JAK2) V617F gene mutation, but all of the tests failed to reveal any abnormalities. Malignancy was important for differential diagnosis. We performed an abdominal and thoracic computed tomography (CT) scan to search for the cause of the venous thrombosis, but the scan did not reveal any evidence of malignancy. We performed endoscopy and colonoscopy also. There were no pathological finding other than internal hemorid in anal canal. The Prostate Specific Antigen (PSA) was 0,08 ng/mL (normal values: 0,01-0,5). There was no clinical suspicion for infection. Brucella markers and tuberculosis markers were negative. We eliminated Behçet’s syndrome with the absence of oral and genital ulcers and negative result of the Pathergy test. We eliminated Sarkoidosis also. We didn’t clarify the etiology of thrombosis in our patient. In our opinion the vitiligo can be a possible cause of venous thrombosis.
Cardiovascular diseases
A-1316

Which is the best technique to evaluate congestion in outpatients with chronic heart failure? Comparison between inferior vena cava ultrasound, lung ultrasound, body bioelectric impedance analysis and natriuretic peptides.

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Introduction: Heart failure (HF) is an important healthcare problem. Knowing volume status in outpatients with chronic HF to adjust treatment and to avoid decompensations is a challenge. The aim of this study is comparing the usefulness of inferior vena cava (IVC) ultrasound, lung ultrasound, bioelectrical impedance analysis (BIA) and natriuretic peptides in the follow-up of outpatients with chronic HF.

Methods: prospective cohort study. Ninety nine patients with chronic HF were included consecutively as they attended scheduled medical visits. The different techniques were performed on the day of the clinic visit, and the result was hidden from the patients and the responsible medical team. Follow-up time was 1 year. Outcome events checked were a combination of death or hospitalization due to HF.

Results: Thirty six patients (36.4%) died or were hospitalized for HF. They had a significantly lower IVC collapse, and a greater number of lung B-lines and higher NTproBNP levels compared to patients who remained stable. There were no differences in the BIA parameters. After multivariable analysis, cut-off points of IVC collapse <30%, number of pulmonary B lines greater than 5, and NTproBNP levels greater than 2000 pg/ml were associated with increased risk of HF death or admission. NTproBNP had the best area under the curve. An algorithm is proposed to classify patients into low or high risk taking into account values of maximum sensitivity (potential screening) and maximum specificity. This algorithm allows to classify patients reaching a sensitivity of 81.3% (CI 64.7-91.1) with a specificity of 68% (CI 55.5-79.0).

Conclusion: evaluation of congestion in outpatients with chronic HF may be based on NTproBNP, IVC ultrasound or lung ultrasound; they are useful in identifying patients at high risk of hospitalization or death due to HF. The study of body BIA is less useful in these patients.
INTRODUCTION
We present a case of herpes simplex virus (HSV) meningoencephalitis in which the diagnosis and treatment were delayed for a few days and the evolution of the patient one year after the episode.

CASE DESCRIPTION
A 62-year-old male with no relevant medical history consulted for headache, vomiting and acute confusional state of one week of evolution. He had already consulted the previous day at a private clinic where he was discharged with a cranial computed tomography without acute alterations. At our emergency department he had fever, he was diagnosed of respiratory infection and he was admitted to the Internal Medicine Service to complete the study of acute confusional state.

He was reevaluated three days later, when he had developed progressive deterioration of the level of consciousness. Then a lumbar puncture was performed and treatment with ceftriaxone, vancomycin, ampicilin and acyclovir was started. The next day the diagnosis of meningoencephalitis caused by HSV was confirmed after polymerase chain reaction was positive for HSV in cerebrospinal fluid and he completed treatment with intravenous acyclovir for 21 days while he presented progressive improvement of the level of consciousness and cognitive functions.

The study was completed with a brain magnetic resonance imaging that showed involvement of the left temporal lobe with extension to the hippocampus, insular region and both frontobasal regions, as well as amygdala of the right hippocampus.

One year after the episode the patient presents cognitive and behavioral disorder with memory impairment, disinhibition and irritability.

DISCUSSION
In our patient the diagnosis was delayed one week from the beginning of symptoms and four days from the first consult in emergencies. Early onset of treatment is the most important factor in the prognosis of HSV encephalitis, so there should always be a high clinical suspicion in patients with acute confusional state to rule it out or start the right treatment.
CSF leaks are a well-documented indication for extended vaccination in individuals less than 65 years to reduce the risk of invasive pneumococcal disease. The indication for vaccination of neurosurgical/neurotrauma patients, whether a leak was previously corrected, is not so widely recognized. We present a case of a 60 year old man that presented to the emergency department with sudden generalized tonic-clonic seizures. He had a history of attempted suicide with a firearm 12 years prior, resulting in a metal bullet that remained deeply lodged in the parietal region, neurosurgery to correct a CSF leak shortly after and epilepsy treated with phenytoin. Even though the patient had infra-therapeutic levels of phenytoin on admission and a “normal” head CT scan, progressive deterioration of consciousness, along with fever, prompted a lumbar puncture with criteria for bacterial meningitis. Empirical antibiotics and dexamethasone were started. CSF gram and culture later confirmed S. pneumoniae. The persistence of fever 10 days after admission motivated a new head CT scan which now showed multiple frontal abscesses. Antibiotic therapy was prolonged to 4 weeks, with serial CT scans showing regression and disappearance of the abscesses. Shortly after discharge the patient was vaccinated with Pn13 and 8 weeks later with Pn23. A neurosurgical evaluation confirmed the recurrence of a CSF leak that was once again corrected. This case raises the discussion for the need to vaccinate patients even after correction of CSF leaks, when other risk factors for invasive pneumococcal disease are present (such as persistent neurotrauma from a firearm).
A case report of zoonosis

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Brucellosis is a zoonotic infection transmitted by animals to humans. Most cases are the result of occupational exposure to infected fluid animals, but infections can also occur from ingesting contaminated dairy products. Brucellosis is one of the most widespread zoonoses worldwide and is a serious, debilitating and sometimes chronic disease that can affect a variety of organs. Osteoarticular presentation is the most common and dermatologic manifestations occur in 10 percent of patients.

The authors report a case of a 44 years old man with the previous diagnosis of anquilosante espondilitis admitted at our hospital with insidious onset of fever, weight loss and polyarthralgia. On physical examination he presents with maculopapular eruptions. He had a ingested unpasteurized cheese. The exhaustive diagnostic approach excluded a noninfectious cause. Blood cultures were negative and a presumptive diagnosis of Brucellosis with osteoarticular and dermatologic envolvement was made, by demonstrating elevated titers of specific serum antibodies. He was treated with doxycycline and rifampin for 6 weeks, with symptoms resolution.

Brucellosis has high morbidity both for humans and animals; it is an important cause of economic loss and a public health problem in many developing countries. The diagnosis of Brucellosis should be considered in an individual with otherwise unexplained fever and nonspecific complaints who has a possible source of exposure.
A challenge for the internist doctor: complexity and multipathology of patients infected by multiresistant Acinetobacter baumannii

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INTRODUCTION
Multiresistant Acinetobacter baumannii is recognized as one of the most difficult gram-negative bacilli to control and treat, because of the increased incidence and spectrum of resistance to antibiotics that has occurred in recent years causing outbreaks of intrahospital infection.

METHODS
Descriptive and prospective study in which all patients with multiresistant A. baumannii isolation admitted to the “Hospital General Universitario Reina Sofia de Murcia” from December 2016 to May 2017 were consecutively collected. In this analysis, those patients were included who the physician were considered as infection and not as colonization. The epidemiological, clinical, mortality and associated factors of these patients are described.

RESULTS
Of 40 patients with multiresistant A. baumannii isolation who entered the study period, 24 patients considered as infected were included. The median age was 79.50 years (RIC 66.50-84.00) with a male prevalence of 67%. 91.2% presented comorbidity with a Charlson’s index median of 2.46 (RIC 1.5-4). The most common associated comorbidity was arterial hypertension (79.2%), secondly ischemic heart disease (58.3%) and third, the presence of preceding neoplasia (50%). Median hospital stay was 30.50 days (RIC 12.75-55.8), with a re-entry rate of 75%, death of 54.2% and mortality attributable to infection of 12.5 %. The most frequent colonization risk factors were: the previous use of antibiotics (75%) and the previous stay in ICU (33.33%). 66% of patients suffered one or more complications, and the most frequent was decompensated heart failure (20.83%).

CONCLUSION
Patients infected by multiresistant A. baumannii in our study are elderly and with a very high comorbidity, this influences the high percentage of global deaths, readmissions and prolonged duration of hospital stay. This infection has become a challenge for the internist doctor due to its complexity and the multipathology presented by infected patients.
Infectious diseases
A-1643

A complicated case of Influenza B

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Introduction: Influenza infection is an acute respiratory illness caused by influenza A or B virus. Symptoms involving the upper/inferior respiratory tract are present, along with signs of systemic compromise. Although it may be debilitating in the acute phase, usually it is a self-limiting infection; however, in high risk populations, it is associated with increase of morbidity and mortality – complicated influenza.

Case Report: We presented a case of infection with influenza B complicated by toxic shock syndrome and secondary pneumonia in a healthy young adult. A 26-year-old adult male presented with a viral infection 13 hours after symptom onset. It was initially observed in another institution and later in the emergency service of our hospital. On admission, the patient showed a flushed oropharynx, edema of the tonsillar pillars and bilateral purulent exudate and cutaneous rash. Sepsis was assumed with the probable source being a viral tonsillitis with 11 SOFA (Sepsis-related organ failure assessment score) criteria and he was transferred to Intensive Care Unit. In the complementary study, the presence of Influenza B virus was confirmed. Complications presented were toxic shock syndrome, fulfilling all the clinical criteria, without identification of another agent; secondary pneumonia and ICD (Disseminated Intravascular Coagulation). Following clinical stability of the patient, he was transferred back to his local hospital to continue care. During hospitalisation, the patient recovered well following the therapy and support measures instituted.

Discussion: Although infection by influenza virus is self-limiting and not complicated in low risk cases, it is important to recognize situations with complicated infection despite the absence of risk criteria. Toxic shock syndrome is commonly associated with Staphylococcus aureus or Streptococcus infections, but there are cases described in the literature associated with influenza infections.
A forgotten cause of peripheral neuropathy: LEPRA

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Introduction:
Developing countries have the possibility of having forgotten and rare diseases in other latitudes; however, it is not common to find an infectious disease such as Leprosy as a cause of peripheral neuropathy. Reason for which a multidisciplinary approach was required to perform the diagnosis.

A 40-year-old patient attended in the neurology outpatient clinic with an appearance of chronic indurated lesions predominantly in the lower limbs and at the level of the tendons of the hands, which were accompanied by symptoms of weakness, paresthesias and dysesthesias. Multiple inconclusive studies, with evidence of anesthesia in areas of lesions, electromyography with diagnosis of advanced chronic sensory-motor peripheral polyneuropathy type.
It required nerve biopsy to confirm LEPRA, considering a case of paucibacillary LEPRA with good response to management, reversal of lesions, without new progressions of neuropathy.

Discussion:
In our country, leprosy is a neglected disease, however, it has mandatory care protocols, and the use of nerve biopsy as part of the diagnosis is not frequent. The evolution of this disease fulfills the chronic, disabling and non-reversible course expected by the definition of the disease, however there are other causes more frequent of dermatological lesions than the infectious diseases caused by mycobacterium leprae, which made the diagnosis difficult and in this case the follow-up that should include the family as part of its integral management, characteristic of the internist.
A holistic approach to managing patients with chronic wounds

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When dealing with patients with chronic wounds, we often tend to treat the hole in the patient disregarding the needs of the whole patient. Assessing the patient as a whole – in regards of his diagnoses, needs, ability and pathology – with often multiple co-morbidities, allows us to centre the patient and create a circle of care addressing all his/her issues and limitations including his setting in the professional and private life. Directing advice from the physician and caregiver unilaterally, takes all initiative and motivation from the patient. Instead we should empower the patient while in a circle of care to request and direct us to integrate the much needed help and care into his individual setting in life. Thereby he/she can overcome limitations that have often prevented successful healing in the past. We want to elaborate this with the example of a patient with diabetes mellitus and hypertension – in combination the number 1 predictor for poor prognosis in any cardio-vascular outcome trial – What can be offered, what should happen and how to initiate tissue repair by changing a maintenance wound into a healable one.
A protocol for previous vesical probe removal on urine infections impact and days of catheter maintenance

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OBJECTIVES
To analyze the impact of a protocol for the early removal of bladder catheter in the incidence of catheter-associated urinary tract infections and its duration.

METHOD
A random sample of patients admitted to an Internal Medicine unit during 2016 is included, excluding less than 24 hours income. The incidence rate of catheter-associated infections and the days of catheter use are compared to the study group (catheter removal protocol) and its control (usual practice).

RESULTS
From 423 patients, 137 were carriers of bladder catheter upon admission. They were mostly women (62%) with an age average of 85 years. The most frequent comorbidity was hypertension (80%). No differences were observed between both plants in relation to the population basal characteristics nor related to the risk factors for urinary tract infections development. The rate of infection associated with the catheter was 78% in the study group and 87% in the control group, p = 0.22. Catheter days average in the study group was 8 days and 6 days in the control group, p = 0.19.

CONCLUSION
A protocol for early removal of bladder catheter use did not have a positive impact on the duration nor in catheter-associated infections in our population.
A rare bacteria in the pleural fluid – an unrecognized Lemierre’s Syndrome?

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Introduction: Fusobacterium species infections are rare and classically associated with Lemierre's Syndrome. Rarely, infection by this agent can be seen without the full syndrome presentation.

Case description: A 71-year-old woman had been recently hospitalised for an acute heart failure with associated pleural effusion, pericardial effusion and mediastinal adenopathies. Following a good clinical response to heart failure treatment she was discharged and scheduled for outpatient follow-up. She then presented again in the emergency department with cough, dyspnea and fever. Her physical examination was unremarkable. Her blood workup had leucocytosis (14 000/uL) and elevated CRP (107 mg/L). She underwent a chest CT that detected a thick-walled collection with 10 cm diameter on the lower right thorax compatible with an empyema. A chest tube was placed and purulent pleural liquid was sent for microbiologic analysis. The patient was kept on Piperacillin and Tazobactam for 4 weeks with favourable clinical response. The control chest CT showed marked empyema reduction. The microbiology laboratory identified a multi-susceptible Fusobacterium and a Peptostreptococcus micros. Epstein-Barr testing was negative for recent infection.

Discussion: The objective of this case report is to discuss a rare cause of infection that is becoming more frequent. Fusobacterium was considered part of normal human flora, but that is under dispute, and person-to-person transmission is a concern. It is able to infect younger population groups, and infectious mononucleosis has been postulated as a facilitating co-infection. Empirical antimicrobials aren't 100% effective on treating infections by these anaerobic bacilli.
A Rare Cause of Infectious Endocarditis in a Native Valve

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INTRODUCTION: Endocarditis mortality rates suffered a significant reduction due to faster diagnosis and better therapeutic options. However, the clinician should be aware of its frequent subtle presentation and that a thorough clinical rationale is essential for diagnosis.

CLINICAL CASE: 80-years-old female, with history of moderate aortic stenosis, was brought to emergency department by sudden postprandial vomiting, generalized ostearticular complaints and febrile peak. She also referred progressive asthenia and dyspnea, in the last month. On admission she was febrile, hypotensive, tachycardic and peripheral oximetry of 90%; panfocal cardiac systolic murmur grade III/VI and pulmonary basal crepitations. Septic shock diagnosis of unknown etiology was considered and empiric antibiotic was initiated after septic screening. Analytically with discrete leukocytosis and RCP elevation. Transthoracic echocardiogram showed a calcified aortic valve, not excluding endocarditis. Blood cultures were positive for Streptococcus dysgalactiae and a transesophageal echocardiogram was performed revealing an aortic valve vegetation and another one in left atrium. Assumed septic shock due to infectious endocarditis by Streptococcus dysgalactiae, she started vancomycin. Despite the initial clinical improvement, after 6 weeks of treatment, vegetations were still present on imaging and aortic regurgitation became severe. Surgical intervention was postponed due to patient's comorbidities and clinical worsening.

CONCLUSION: Infectious endocarditis by S. dysgalactiae although extremely rare is associated with an increased risk of local complications. So, when a patient declines, a meticulous evaluation is mandatory to avoid missing potentially reversible causes of the decline. Nevertheless, invasive treatment approaches must be carefully considered and planned in order to assure the best therapeutic options to the patient.
A severe and fatal case of meningitis by Pasteurella multocida

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Introduction: Pasteurella multocida can be found at the upper respiratory tract flora of many domestic and wild animals. Human infections frequently result of animal bite or licking, but infection without a bite history was associated with severe comorbidity or immunocompromising condition, often with more severe disease.

Case description: A 72 year old woman recurred to emergency department with epigastralgia and vomiting since that day, also referring asthenia, neck and low back pain, edema and pain in both legs with functional limitation with 1 week evolution. She had history of arterial hypertension, ischemic cardiomyopathy with previous angioplasty and pre-dyalsis chronic kidney disease. At examination patient was febrile, prostrated and had edema of the legs without inflammatory signs. Blood tests showed elevation of inflammatory parameters and d-dimer, acute kidney injury and metabolic acidosis.

Piperacillin/tazobactam was initiated and she stayed in observation. The next day she was confused, agitated, without meningism or other neurologic signs. Cranial CT scan excludes acute alterations and the CSF analysis showed 864 WBC/mm³ with predominance of polymorphonuclear, 311mg/dl of proteins and 6mg/dl of glucose. Treatment was changed for vancomycin, ceftriaxone and ampicillin. The microbiological study of CSF was negative; however, blood cultures were positive for Pasteurella multocida. At home, she had a cat but no history of bite or scratch. The clinical status of the patient worsened, evolving with bradycardia and cardiac arrest. She was transfered to the intensive care unit after cardiopulmonary resuscitation but died weeks later after a new septic intercurrence.

Discussion: Pasteurella multocida was not identified in CSF but the analysis was highly suggestive of bacterial meningitis and bacteremia was confirmed. Although this bacteria usually causes mild infection in healthy patients, in this case the comorbidities dictated the poor prognosis.
Acute Pyelonephritis is an infection of the renal parenchyma, which is based on a presumptive diagnosis but the definitive one is realized by the urine culture. The initial image is indicated in specific situations. Supportive care and antibiotic therapy should be instituted as early as possible, being the criteria of hospitalization weighted according to the clinical severity.

To characterize hospitalizations for acute pyelonephritis in an Internal Medicine service, based on the current clinical guidelines.

A retrospective descriptive study of a cohort of admitted patients from January 2015 to December 2016 was done by consultation of the clinical computer process using SClinico. We selected all the patients with acute pyelonephritis diagnosis.

Of the 4164 patients hospitalized in the 2 years, 2.3% (n=94) had a diagnosis of acute pyelonephritis, with a mean age of 51 years; 84% were women. The hospitalization time ranged from 1 to 34 days, with an average of 8 days. Regarding risk factors identified, 19% were diabetic, 47% had previous kidney disease and one patient was on the 11th day of puerperium. The majority of the patients underwent imaging on admission (n=86) and 89 patients had urine culture, with agent isolation in 55%. The most frequent etiological agent was Escherichia coli. Blood cultures were performed in 66 patients, with isolation of at least one agent in 24%. 93 patients were empirically medicated, 59% with ceftriaxone. At the time of discharge, most patients were directed to the General Physician.

The authors concluded that the analysis of this retrospective study is in accordance with the literature data regarding the at-risk population, the established empirical therapy and the isolated agent in the urine culture. The same did not occur with the initial image examination, which is indicated in a restricted group of patients. Considering the hospitalization criteria, it was not possible to draw any conclusion through the accessed medical records.
Abdominal lymph nodes tuberculosis: does radiological monitoring modify the duration of treatment?

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Background:
Abdominal lymph nodes tuberculosis is not uncommon in our country. At least, 6 months treatment is recommended. The aim of this study is to describe the clinical, radiological and therapeutic features of Abdominal lymph nodes tuberculosis and to specify the impact of radiological monitoring on the duration of treatment.

Methods:
This was a retrospective study conducted from 2013 to 2017. Diagnosis of Abdominal lymph nodes tuberculosis was based on histological findings.

Results:
There were 21 patients of mean age 33 years and most were women (66, 7%). Predominant clinical presentations are: alteration of general condition (66, 7%), fever (66, 7%), night sweats (66, 7%) and abdominal pain (61, 9%). Tuberculin skin test, when realized, was positive in 33, 3% of cases. Diagnostic surgery was realized in 14 cases (66, 7%). The diagnosis was histological in 19 cases (90, 5%). CT scan of the abdomen revealed intra-abdominal lymph nodes in all cases. All patients were treated with quadruple therapy during 2 months, followed by dual therapy during at least 7 months. Four patients were lost to Follow-Up and two patients did not complete the treatment yet. Among the 15 patients that completed treatment, it was necessary to prolong the treatment more than 9 months in 10 cases (66, 6%) since CT scan showed evolutive lymph nodes. The median duration of treatment was 11(9-24) months.

Conclusion:
According to this study, CT scan control prolong significantly the total duration of anti-tuberculosis treatment.
Abdominal tuberculosis particularities in an endemic area

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Background:
Abdominal tuberculosis is an uncommon condition, with a lack of reports in the most recent years. Our aim is to update knowledge on Abdominal tuberculosis especially about the epidemiology and diagnosis.

Methods:
This was a retrospective study conducted from 2013 to 2017. Diagnosis of Abdominal tuberculosis was based on histological evidence or on clinical and radiologic features with favorable outcomes under specific treatment.

Results:
There were 35 patients of median age 33 years and most were women (68, 6%). The most frequent sites of Abdominal tuberculosis were peritoneal in 26 cases and lymph nodes in 21 cases. Predominant clinical presentations were: abdominal pain (68, 8%), fever (65, 7%) and night sweats (57%). Tuberculin skin test and IGRA test were positive respectively in 52% and 16% of cases. CT scan of the abdomen revealed ascites in 65, 7% of cases, lymph nodes in 57% of cases and thickened peritoneum in 25, 7% of cases. Peritoneal tap was realized in 25, 7% of cases, but, acid-fast bacilli were not seen on smear or culture. Diagnostic surgery was realized in 26 cases. The diagnosis was confirmed by histology in 32 cases. Management was based on conventional antitubercular therapy with a mean duration of 11, 5 months. Corticotherapy was received in 5 cases. Six patients were lost to Follow-Up. All the remaining patients were cured.

Conclusion:
Laparoscopy was very useful for the diagnosis of Abdominal tuberculosis. Due to early diagnosis, and the availability of adequate therapy, complications and mortality are significantly reduced.
Abiotrophia defectiva: a portuguese heart valve near you

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Abiotrophia defectiva is a common organism that lives in the gut and oral cavity of healthy individuals. Until recently, these bacteria had not been described and recognized as a gram positive microorganism belonging to the group of nutritionally variant streptococci – NVS. Some factors like oral/dental manipulation, immunosuppression and the presence of prosthetic heart valves (90% of endocarditis caused by NVS occur in individuals with prior heart disease) contribute to facilitate bacterial entrance into blood circulation. This agent is associated with higher morbidity and mortality (17%) than other types of streptococci (12%), even under adequate antibiotic treatment. Therefore, the authors believe this case to be important because it shows the vital importance of correct microbiological identification as a prognostic and therapeutic indicator. This case report is about a 74 year old woman admitted to the hospital for infective endocarditis by A. defectiva, successfully treated with biologic aortic valve replacement and 6 weeks of antibiotic therapy (ampicillin plus gentamicin).

A. defectiva is a recent but known cause of infective endocarditis, associated to a high mortality and complication rate. As such, its cultural identification is essential to a correct treatment and a premature surgical intervention, factors that can improve prognosis. This microorganism should not be overlooked, given is pathogenic potential, even in the absence of clinical instability, as described earlier. Finally, the authors consider that this case, despite being and isolated and rare case report, is important because it reinforces the significance of correctly identifying microorganisms in culture, as the benefits of narrowed antibiotic therapy and early recognition of warning signs that contribute to a better prognosis and a lower mortality rate.
Mycobacterium avium complex (MAC) is the bacillus most implicated in human mycobacterial lung infection following mycobacterium tuberculosis. It is a pathogen that mainly affects immunocompromised or underlying lung disease patients.

Man, 69 years old, history of smoking (smoking load greater than 100 pack-year), chronic obstructive pulmonary disease, mild obstructive ventilatory syndrome, pulmonary emphysema and previous recent hospitalization for community-acquired pneumonia with clinical improvement after ceftriaxone and azithromycin cycle. After discharge, MAC was isolated in culture of sputum. He returned to the emergency department two months after first hospitalization for the same clinical complaints, specifically long-standing resting dyspnea associated with pleuritic thoracalgia, non-productive cough, and nocturnal hypersudoresis. He was admitted in Internal Medicine department for pneumonia and empirically medicated with macrolide and antibacterials, namely Azithromycin, Rifampicin and Etambutol. He presented clinical and analytical improvement, 6 negative bacilloscopies in the microbiological examination of sputum and was discharged at the 8th day of hospitalization oriented to Internal Medicine consultation.

The clinical spectrum of infection by MAC is varied; however, pulmonary fibrocavity, a body mass index below 18.5 kg/m2 and anemia are independent negative prognostic factors, and the implementation of early treatment should not be postponed after laboratory confirmation of infection.

The authors present iconography.

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The varicella zoster virus belongs to the Herpes virus family, producing varicella during childhood, meanwhile the re-infection in adults presents with Zoster’s characteristics skin lesions. Rarely, the VZV can produce neurological disorders. We describe here the case of a patient presenting with cerebellar ataxia in the context of a Zoster with otic affection.

A 79 year-old male, with medical record of ischemic cardiopathy, atrial fibrillation, type 2 diabetes mellitus and a recent previous admission because of a Pneumococcal pneumonia. Three days after being discharged from the Hospital, the patient begins to suffer from walking instability, with no associated temperature. He also describes the presence of swelling in the left auricular pavilion. In the Physical examination the presence of cerebellar ataxia stood out, accompanied by bilateral dismetria of the lower extremities and dorsal skin lesions, all of them in different developing stages, as well as great edema, erythema, suppuration and peripheral blisters round the external auditory canal (Ramsay Hunt Syndrome).

Due to the suspicion of VZV cerebellitis, a serology was performed, which showed a positive IgG (>4000), compatible with reactivation of the virus. The CF showed 31 leukocytes (100% MNC), a glucose of 100 and 70 protein mg/dl.

After 14 days of treatment with IV acyclovir, the patient showed a significant improvement of the symptoms, although a certain degree of non-disabling ataxia remained.

He was given appointment after 3 more months, when it was verified that the completely asymptomatic. The VZ could produce symptoms compatible with meningoencephalitis in individuals with a compromised immune system. The diagnosis does not usually pose a problem, especially if the patient present the typical skin lesions, which allow the specialist to run the specific tests, as well as initiate the specific treatment, resulting this in a decreased rate of deaths and in long and severe physical damages.
Acute Hepatic Failure and Hepatitis E virus - a case report

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Introduction: Hepatitis E virus (HEV) infection is an increasing and underdiagnosed cause of acute hepatitis, which, although usually self-limiting, can cause fulminant hepatic failure. Although anti-HEV IgM appears early in the phase symptomatic, variable diagnostic sensitivity (less than 40%) has been found.

Case description: A 43-year-old non-pregnant woman with arterial hypertension who had been receiving azilsartan for 3 months, was admitted for asthenia, nausea, diarrhea, jaundice and coluria with a 4-day evolution, with reference to possible contact with rats. She presented AST and ALT> 20x upper limit of normal (LSN) and total bilirubin (TB) 27mg /dL. During hospitalization, there was a rise in TB (maximum 33mg /dL) and coagulopathy, requiring hospitalization in intermediate care unity. Negativity of HAV, HBV, HCV, HIV, Herpes, Leptospira and Coxiella virus, and negative serum HEV RNA, negative autoimmunity. Liver biopsy suggestive of toxic cause, it remains to explain an immunopathic component. Admission of 34 days with favorable clinical and analytical evolution, although delayed. One month after she was asymptomatic with normalization of all laboratory parameters. Results of serum samples sent to the external laboratory revealed anti-HEV IgM and IgG positive.

Discussion: Despite the high sensitivity of VHE RNA 2-6 weeks after infection and its persistence detectable for 2-4 weeks, the delay in the diagnostic suspicion as well as an incubation period (15-60 days) may have an impact on its analytical evidence. This case shows the importance of the detailed clinical history, emphasizing the difficult diagnostic approach of a severe and potentially fatal hepatitis.
Introduction: Chickenpox is an infectious exanthematous of childhood and its incidence in adults (2%) has been increasing, showing a greater severity and being seronegative in about 7% of the cases. This work describes 3 different cases.

Case description 1: Man, 36 years old, without history of varicella, vaccinated, presented with 2 days of flu-like syndrome with loss of consciousness and paresthesias. Discharged of emergency department service with respiratory infection diagnosis, returns 1 day later for typical skin rash. For ataxia, bilateral diplopia and neck stiffness, lumbar puncture was performed and CSF examination by PCR for VZV DNA was positive;

Case 2: Pregnant at 29 weeks gestation, hospitalized for pruritic papular lesions on the back and lower limbs, son with chickenpox diagnosed 1 day ago, showing a progression of the dermatological picture. She made 4 days of acyclovir and was referred for specific obstetric consultation. Case 3: Male, 50 years old, childhood varicella, 2 days of fever general malaise, exuberant vesicular and papular pruritic rash, with onset in the abdomen and diffuse diffusion to the face, back and limbs. Oropharynx with 2 macules on the palate. Chest X-ray normal, collected vesicular fluid and PCR for VZV DNA was positive. Started acyclovir and was discharged with valacyclovir.

Discussion: These three cases illustrate the diversity of varicella presentations in adults, with inherent risks and main complications, highlighting the essential role of surveillance and support measures in the prognostic impact of this disease in the less usual age group.
Adverse events in patients admitted for community acquired pneumonia.

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Introduction: Community-acquired pneumonia (CAP) is one of the most frequent causes of hospital admission. The presence of comorbidities contributes to a higher length of hospital stay and to a higher rate of adverse events during CAP hospitalization. We aimed to evaluate the occurrence of significant adverse events in patients admitted to our department with CAP.

Methods: a retrospective cohort study was conducted. All patients admitted for CAP to our department in 12 consecutive months were included. Demographic and clinical data were collected. We defined the composite outcome (CO) of death, admission to intensive care unit (ICU), myocardial infarction (MI), stroke and respiratory reinfection. Statistical analysis was performed with Stata®.

Results: 140 patients were admitted with a median age of 75 years [IQR: 63,84] and similar gender distribution. In twenty-nine patients (21%) a CO was verified. Patients who developed a CO were older (median age 84 vs. 74 years; p=0.198) and had a higher prevalence of heart failure (HF) (52% vs. 31%; p=0.048), chronic kidney disease (21 vs. 13%; p=0.369) and diabetes (17% vs. 14%; p=0.564). The prevalence of hypertension was similar (34 vs. 32%; p=0.828). Unexpectedly this group of patients had less prevalence of known pulmonary disease (7% vs. 22%; p=0.058). The distribution of the CO in patients with HF was: 10 pulmonary reinfection, 6 deaths, 5 MI, 4 stroke and 1 admission to ICU. Patients with CO had a higher length of hospitalization (12 vs. 8 days; p=0.002).

Conclusion: in our cohort patients with heart failure were at risk for the occurrence of adverse events when admitted for CAP. Other comorbidities were not associated with adverse events. Despite being older, a significant association between age and our CO was not shown. Patients with adverse events during hospitalization had a higher length of hospital stay.
Afebrile and blood culture-negative Infective Endocarditis: a challenging diagnosis

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INTRODUCTION: Infective Endocarditis (IE) has an important clinical and etiopathogenic heterogeneity and the etiological agent identification is essential to select the appropriate antibiotic therapy (AB). Elderly or immunocompromised patients can have an atypical presentation and 30% of IE cases have negative blood cultures (BC) constituting a diagnostic and therapeutic challenge.

CASE DESCRIPTION: A 79-year-old woman, living in Lisbon, with a biological prosthetic aortic valve, presented with 3 months of fatigue, dyspnea and weight loss, without fever. Blood analyzes presented anemia, without inflammatory parameters elevation. Transthoracic (TTE) and transesophageal echocardiography revealed moderate periprosthetic leakage and vegetation in the aortic ventricular cusp. She was admitted with the diagnosis of subacute IE and started empirical AB with Ampicillin, Flucloxacillin and Gentamicin. She maintained afebrile, without agent isolation in serial BC. Assuming blood culture-negative IE (BCNIE), serologies were collected for Brucella, Coxiella burnetii, Bartonella, Mycoplasma, Legionella and fungi research. The reassessment TTE revealed dysfunction of the prosthetic aortic valve with severe regurgitation and posterior mitral leaflet vegetation with moderate regurgitation. Due to the progression of IE with ongoing serologies, a sporadic rural epidemiological context was established and Doxycycline, Hydroxychloroquine and Vancomycin was started. Due to patient’s instability and frailty was multidisciplinary considered no surgery criteria and the patient died. Coxiella burnetii’s serology confirmed diagnosis of subacute/chronic IE by this agent.

DISCUSSION: The case intends to alert to diagnostic and therapeutic challenge of BCNIE cases and describes a very atypical presentation in an elderly woman with sporadic rural context who presented a subacute EI caused by Coxiella burnetii infection, with indolent onset and rapid final progression despite appropriate therapy.
An half-open door between the thyroid and the liver?

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Objectives: Thyroid hormones help in regulating the basal functioning of all cells, including hepatocytes. The binding between the two organs also exists because thyroid hormones are metabolized by the liver and regulates its endocrine effects. There are still a number of systemic diseases and coincident symptoms that seem to bind both organs. Several studies have been carried out to better understand this connection.

Methods: Retrospective study of records of the first consultation of the year of patients with Chronic Liver Disease (CLD) followed throughout 2017 in one of the specialized consultations in CLD of a Portuguese tertiary hospital.

Results: Total sample consisted of 89 patients, 53.9% men and mean age 59.4 years. Of these 16 (18%) had functional thyroid pathology (15 hypothyroidism and 1 hyperthyroidism), with similar mean ages but most females (75%). Regarding the etiologies of CLD in this group, in 4 it was alcoholic (25% vs. 29.2% in the general sample), 3 primary biliary cirrhosis (18.8% vs. 4.5%), 2 autoimmune hepatitis (12.5% vs. 4.5%), 2 non-alcoholic fatty liver (12.5% vs. 15.7%) and 2 viral (12.5% vs. 7.9%). Focusing severity scales, in those with thyroid diseases, Child-Pugh Score was not A only on one occasion (6.3%) vs. 14.6% in general group; mean MELD Score was 8.4 in the total sample but 7.7 in those with thyroid disorders. In this group, 31.3% had another imminently autoimmune pathology.

Conclusion: The known data suggest some association between CLD pathogenesis and functional thyroid disorders, and more comprehensive studies are needed to demonstrate this.
Analysis of sepsis cases attended in a third level hospital. Evaluation of the application of measures aimed to decrease mortality

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Objectives: Sepsis is one of the main causes of death among hospitalized patients. In the latest International Sepsis Consensus (Sepsis-3) developing hospital programs to improve sepsis care was recommended. The aim of this study is to analyze the characteristics of the sepsis cases identified in our hospital prior to implement an educational program on sepsis, to describe the factors associated with mortality and the level of compliment of the measures aimed at reducing it.

Methods: descriptive, prospective and observational study of the sepsis cases diagnosed by the Internal Medicine guard team in emergency department and hospitalization units during a 3-months period. Sepsis was diagnosed according the Sepsis-3 criteria. We analyzed the characteristics of patients, the SOFA and quick SOFA (qSOFA) scores and we developed a multivariant analysis of mortality associated factors. Statistical analysis SPSS-18.0 was used.

Results: 38 patients were included, with 70-year median age and Charlson Morbidity Index of 5.3 points. SOFA score median punctuation was 5.5. Every patient fulfilled at least one point in qSOFA score. The most frequent source of infection was respiratory (44%) followed by urinary source. Blood cultures were collected in the 95% of cases but early collected cultures and early antibiotic therapy (1st hour) were achieved in only 43%. 12 patients died (32%) being the SOFA-qSOFA scores and the age mortality associated factors.

Conclusions: mortality rate is high between patients with sepsis in our hospital. Although the small sample, this study confirms that an educational program on early identification ant treatment of sepsis is needed between health professionals.
Infectious diseases
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Antibiotic Treatment at II. Internal Department SZU FNsP F.D. Roosevelta in Banska Bystrica

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Background: Increased use of antibiotics has led to rapid emergence of resistant bacteria and is becoming one of the most alarming problems of internal medicine worldwide. One of possible approaches to tackling this issue is the Antibiotic Stewardship (ATB – St).

Goal: To set the stage for phase II. of ATB – St.

Objective: To assess the determinants of ATB choice, prescription patterns, outcomes of microbiological examination, duration of treatment and therapeutic effect.

Methods: Retrospective analysis of clinical and laboratory data. Inclusion criteria: hospitalized patients at II. Internal department between January 2015 and December 2015. Exclusion criteria: none

Results: Data from 313 patients. Recorded variables: Empirical ATB: 64%. Prescribed ATB: quinolons 31%, pip/tazo 22%, carbapenems 20%, glycopeptides 12%. Cultures: positive 57%, negative 23%, non-available 20%. Agents: Gram-positive (35%): Staphyloccocus aureus* 43%, Enterococcus species*33%, Streptococcus viridians 9%; Gram-negative (65%): Escherichia coli* 34%, Klebsiella pneumonia*33%, Pseudomonas aeruginosa*16%. Median duration of antibiotic therapy: 12 days. Resistance (*) to: pip/tazo 30%, quinolons 29%, carbapenems 13%.

Conclusion: Prevalence of prescribed ATB and resistance of isolated pathogens are consistent with data from other internal departments. One in five patients hadn’t had properly collected samples for laboratory test. Duration of therapy had been longer than recommendations in guidelines.

*Resistant bacteria
Arterial thrombosis of a mycotic aneurysm due to Salmonella enteritidis

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Introduction
Mycotic aneurysms due to Salmonella enteritidis is an unfrequent complication of acute gastroenteritis and has been associated with contaminated food ingestion.

Case report
A 57-year-old male patient was admitted in emergency room because of paresthesias and difficulty walking of 48 hours of evolution. Previous days had presented an acute gastroenteritis after egg intake, consisting of vomiting, diarrhea, fever and general malaise.

A physical examination highlighted peripheral hypoperfusion in both lower limbs with livedo reticularis up to the pelvis. Laboratory studies showed creatinin 2.45 mg/dl, pH 7.15, pCO2 44 mm Hg and lactate 10.1 mg/dl. CTscan showed aneurysmal dilatation and complete thrombosis of the abdominal aorta infrarenally.

He was urgently intervened by aortofemoral bypass.

Salmonella enteritidis was isolated in blood cultures 5 days after admission and completed 14 days with 2g of ceftriaxone in addition to anticoagulation with enoxaparin 60 mg twice perday and acenocumarol later. A Positron Emission Tomography and a scintigraphy with marked leukocytes were performed because of persistent fever and finally ruled out infection at vascular prosthesis.

Discussion
We present the case of an acute gastroenteritis by Salmonella complicated with complete arterial thrombosis of an infrarenally aortic aneurysm not previously known. In our knowledge it is the first case of arterial thrombosis associated with aneurysm infected with Salmonella. It is also remarkable the association with food infection by egg intake.
Aspergillus fumigatus infection – a risk of immunessuppression

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Aspergillosis is a fungal infection by Aspergillus, in which the clinical manifestations of the disease are determined by the host's immune response. It can present itself in the allergic form (Allergic pulmonary aspergillosis), invasive form (invasive pulmonary aspergillosis) or semi-invasive (chronic pulmonary aspergillosis - CPA, with or without aspergilloma), and finally as Aspergillus induced asthma. CPA is a rare form, but probably underestimated.

We introduce a 70 year old male, splenectomized for hypersplenism secondary to hepatic cirrhosis, with a history of treated pulmonary tuberculosis, with bronchiectasis and cavitations as scars. He presented with an 8 month history of weight loss, hemoptysis and dyspnea. He was first admitted in the medical department after respiratory failure, rise of inflammation markers and the presence of pulmonary consolidation in the lower left region. He started antibiotics, but later had a Aspergillus fumigatus isolated in the sputum sample, confirmed with the identification of IgG. These results, combined with the presence of an extensive cavity in the lower area of the left lung for more than 6 months, raised the suspicion of CPA with presumptive aspergilloma. The patient started Voriconazole 200 milligrams twice a day, for 6 months with excellent clinical, laboratory and imaging response.

The authors present this case because of its rarity, allowing to highlight one of the risks of chronic pulmonary structural disease. It is fundamental to remember this entity, so that we can conduct the diagnostic study, start the correct treatment and exclude complications.
Atypical mycobacteria - 29 cases analysis of infection and colonization from 2013 to 2017

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Objectives: Analysis of Nontuberculous mycobacteria (NTM) associated with active pulmonary infection in hospitalized patients in a five year span.

Methods: Retrospective analysis of consecutive patients with pulmonary infection by NTM according to the diagnostic criteria of the Infectious Disease Society of America, between 2013 and 2017. Risk factors, clinical manifestations, imaging findings, empirical and directed treatment were analyzed.

Results: Of 29 cases with NTM cultural isolation, 13 were considered active pulmonary infections. The remaining 16 were colonization or contamination. The 13 cases of NTM infection corresponded to patients with a mean age of 48.2 years, only one female. The most frequent risk factors were smoking in 53.8% of patients and human immunodeficiency virus (HIV) infection in 46.2% of the patients, with mean CD4 + T cells of 71.3 cells/μL and viral load of 430,605 copies/mL. 66.7% were not on antiretroviral therapy. The disease manifested with cough and expectoration in 83.6% of the cases. In the radiologic imaging studies, 79.6% had pulmonary cavitations. Sputum acid-fast bacilli (AFB) smear was positive in 53.8%, with a higher prevalence of Mycobacterium avium spp. and Mycobacterium xenopi (23.1% each). Empirical treatment with isoniazid, rifampicin, pyrazinamide and ethambutol (HRZE) was initiated in 38.5% cases, followed by R, E and clarithromycin in 23.1%.

Conclusion: Pulmonary infection by NTM resembles clinical and radiologically to tuberculosis, and as such, be treated at baseline, erroneously with first-line antituberculous agents (HRZE). Diagnostic suspicion should be increased in patients with immunodepression states, such as HIV infection and risk factors for chronic pulmonary disease, such as smoking. Although most cultural NTM isolations were considered colonization/contamination, this study highlights the importance of diagnosis and surveillance of established therapy based only on positive bacilloscopy.
Atypical Presentation, Cryptococcal Meningitis in Immunocompetent Patients. Review of two cases

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INTRODUCTION: Cryptococcus infections occur globally and in a wide variety of hosts, ranging from severely immunosuppressed to phenotypically “normal” immune systems. Recent emergence of Cryptococcus gattii in otherwise non-immunocompromised individuals emphasizes the importance in differentiating infection in HIV- and non–HIV-infected patients in hopes of better understanding the clinical features and outcomes.1

CASE DESCRIPTION: Two cases of a 29 yo masculine and a 56 yo female with past medical history of diabetes and poor adherence to treatment. They presented to the ER with tonic–clonic seizures. Initial evaluation: postictal phase, no neurological focalization nor meningismus, stupor state of consciousness and stable vital signs. Routine laboratories were remarkable but elevated neutrophils and HIV negative. CT scans without ischemic, hemorrhage, or occupational lesions. Lumbar puncture with opening pressure of 225 (female) and 210 (male) mmH2O, Indian ink and cryptococcal latex agglutination were positive. HIV test was negative with undetectable viral load. HBV, HCV, VDRL, and TORCH negative. Amphotericin B lipid complex (5mg/kg) IV was the induction therapy. After 1 week, the female died of epilepticus status. The male patient after three weeks of induction, consolidation with fluconazole (8 mg/kg/day) was initiated and finished at home.

DISCUSSION: We present cases of atypical cryptococcal meningitis in otherwise, healthy patients. The management was similar but with different closures. There aren’t any specific guidelines to determine what to do with these cases. The management is transpolated from HIV-uninfected host.

Autoimmune Thyroiditis at the Patients with Chronic Hepatitis C

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We can talk about a true viral hepatitis C syndrome including hepatic and extrahepatic manifestations. HVC antigens act as chronic stimuli of the immune system of the host by favoring triggering of autoimmunity. Autoimmune thyroiditis is one of the most common manifestations of this type. Considering that is relatively feasible (no invasive methods, expensive determinations are required) to investigate the thyroid gland, we start from the idea that all patients with hepatic C virus should be examined and monitored regularly for a possible autoimmune thyroid disease. C virus can infect thyroid cells, and the thyroid serves as an extrahepatic viral replication reservoir, contributing to the persistence of viral infection, triggering autoimmune thyroiditis. The study (trials) of the patients with viral hepatitis C, from The Emergency Constanta County Hospital (Romania), starting with 01.2016 until now, confirmed the connection between the two pathologies. Anti-TSH antibodies, anti-thyroglobulin antibodies (anti-TG), anti-thyroid peroxidase (anti-TPO) (antimicrosomal), TSH and T4 have been considered. In addition, it has been shown that interferon treatment (IFN alpha) is an increased risk factor in triggering autoimmune thyroiditis. The results show that anti-thyroid peroxidase antibodies are found in the serum of most patients with autoimmune thyroiditis and viral hepatitis C. The presence of autoantibodies does not involve active tissue destruction, and the anti-peroxidase antibody titer correlates with lymphocyte infiltration of the thyroid gland.
Bacteriological survey of diabetic foot infections in Porto

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INTRODUCTION: An epidemiological survey of diabetic foot infections took place in Centro Hospitalar do Porto, stratifying the bacterial profile of the diabetic foot infections in hospitalized patients.

METHODS: A transversal observational retrospective study at the Centro Hospitalar do Porto between 2012 and 2013. The Microbiological products from clinically infected foot ulcers of patients with diabetes mellitus were collected by aspirates, biopses or swabs using the Levine method.

RESULTS: Eighty-five patients in 2012 and eighty-six patients in 2013 were enrolled in this study, 100 microbial isolates were cultured in 2013 and 104 microbial isolates were cultured in 2012. In the clinical samples collected from patients undergoing antibiotic regimens, less than 5% exhibited resistance to broad spectrum antibiotics in use.

DISCUSSION: The incidence of Methicillin-resistant Staphylococcus Aureus (MRSA) organisms increased from 8% to 11% in one year. The probability of multidrug-resistant agents increases with prior oral antibiotics, specially fluoroquinolones. The incidence of MRSA-resistant organisms to clindamycin is also of special concern, given its ambulatory use at the community. Clinicians ought to avoid fluoroquinolones and consider the use of empirical anti-MRSA therapy that should be guided by the microbiological resistance pattern at the community.
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A-1237

Bilateral non-granulomatous total uveitis revealing acute septicemic brucellosis

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Introduction: Brucellosis is a highly contagious infection that is still endemic in several countries. The septicemic forms are characterized by a polymorphic clinical presentation and a systemic damage presenting sometimes a real diagnostic challenge. The revealing ocular manifestations are unusual. We report one.

Case description: A 43-year-old woman with no medical history, hospitalized for a sudden and bilateral decrease of visual acuity with eye pain and fever. Ophthalmological examination concluded to a bilateral non-granulomatous panuveitis. The somatic examination noted a fever at 39 °C and a moderate and painless hepatosplenomegaly. Biology showed a marked inflammatory syndrome with neutrophilic leukocytosis at 18 000/mm3. Screening for immunological diseases, tuberculosis, connective tissue diseases, systemic granulomatosis and hematological malignancies was negative. Wright's serologic test was positive at 1/320. The Rose Bengal test was also positive confirming the diagnosis of brucellosis. With Rifampicin-Doxycycline, the evolution was favorable with recovery of the visual acuity and normalization of ophthalmologic check-up at two months.

Discussion: Ocular lesions during brucellosis are rare: 3.35% and the revealing forms remain exceptional: 0.83%. Panuveitis are associated with the worst visual prognosis. Brucellosis should therefore be mentioned in the presence of recurrent uveitis or uveitis having a poor response to corticosteroid therapy, particularly in an endemic country.
Introduction: Brucellosis and tuberculosis are two granulomatous diseases caused by intracellular bacteria. The simultaneous occurrence of both infections is rare, with very few cases reported in the literature.

Case description: We describe the case of a 52-year-old man, worker in a slaughterhouse, with a history of alcohol abuse, that presented to Emergency Department for a week lasting abdominal pain, of progressive worsening. The clinical examination revealed fever and painful abdomen, without lymph nodes. The laboratory workup revealed leukopenia with mild neutropenia, thrombocytopenia (51,000 platelets/μL) and hyperamylasemia of 1750 U/L (normal <100). Abdominal ultrasound showed homogenous hepatomegaly without splenomegaly. He was hospitalized with a probable diagnosis of acute pancreatitis. Despite progressive improvement of the condition and afebrile in the first 5 days of hospitalization, fever recurred on day 6, with no clinical evidence of an infectious outbreak. An abdominal CT was performed, which excluded complications of pancreatitis. A study for fever without focus was initiated, with chest CT scan revealing inflammatory changes in the upper lobe of the right lung and positive serology for Brucella, confirmed later by two blood cultures that isolated Brucella melitensis.

He was treated with gentamicin 5mg/kg/day (7 days) and doxycycline 100mg 12/12h (7 weeks), with favorable response. In addition, a bronchoalveolar lavage (BAL) was performed and the patient was reassessed after 6 weeks, with a positive a BAL culture for multisensitive Mycobacterium tuberculosis. The patient initiated treatment with rifampicin, isoniazid and pyrazinamide for 9 months.

Discussion: In this case, it was not possible to objectify a clear organ involvement by brucella infection. The authors question if whether the elevation of pancreatic enzymes could correspond to organ involvement. The epidemiological context was a key piece for the differential diagnosis.
OBJECTIVE: To analyze the distribution of Candida species that produce candidemias and their resistance to antifungals in the last three years

MATERIAL AND METHODS: Retrospective observational study. January’15 - December’17. The blood cultures were processed in the BacT / ALERT system (bioMerieux), the strains were identified with the YST card of the Vitek 2 system, the antifungal sensitivity was determined by the semi-automated system VITEK-2 (bioMérieux SA). Sensitivity results (CMI) to antifungals are performed by microdilution with AST-YSO7 cards. EUCAST standards are followed.

RESULTS: 31 samples positive for Candida spp were isolated in blood. 61.52 years (30-87). 20M/11W. 81.5% (22) had risk factors for candida infection

35.5% of the isolates corresponded to Candida albicans, and 65.5% to other Candida spp (C. tropicalis 32.3%, C. parapsilosis 12.9%, C. glabrata 12.9%, C. metasilopsis 3.2%, C. lusitanie 3.2%).

No isolates resistant to Amphotericin B (MIC 0.6) or Voriconazole (MIC 0.14) were found, all were sensitive to Fluconazole(MIC 1.34) except for a single case; and to 5-Fluocitosin (MIC 1.12), except C. lusitanie. All isolates were sensitive to echinocandins except C. tropicalis.

Empirical treatment with Caspofungin was prescribed in the majority of cases (45%). There were 50% of patients in whom treatment was de-escalated and 75% of them were de-escalated to fluconazole monotherapy.

As a directed treatment, Fluconazole was used in 58% of the cases, given its high sensitivity.

38.7% received advice from the PROA group, with a difference in the percentage of deaths at 15 days, 25% vs 55.6% in the non-advised. Likewise, If we take into account the final outcome, 25% vs 77.8%.

CONCLUSIONS: C. Albicans and C. tropicalis was the most common. Amphotericin B and Voriconazole have the best percentages of sensitivity to all species. Also, Fluconazole has a good sensitivity against Candida albicans and Candida tropicalis. PROA counseling supposes a decrease in mortality.
Carbapenemase-producing Enterobacteriaceae: a descriptive study.

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Background: Carbapenemase-producing Enterobacteriaceae (CPE) are carbapenem-hydrolyzing beta-lactamases that confer resistance to a broad spectrum of beta-lactam substrates.

In Europe, and specifically in Spain, OXA48 CPE are the most frequent.

Antibiotic options to treatment of infection due to OXA48 CPE are limited.

Methods: cohort of patients admitted to the Hospital Universitario Marqués de Valdecilla (Spain) during 2017, diagnosed with OXA48 CPE infections in the Internal Medicine Department.

Results: 18 patients were registered: 13 women. Mean age 80+/-13 years. 10 patients come from their home and 8 from old people’s home. Mean hospital stays 14+/-8 days. The medical history more important were: diabetes 39%, indwelling urethral catheter 33%, chronic kidney disease 17%, immunosuppressive therapy 11%, urethral catheter replacement 11%, COPD 6%, solid organ transplant 6% and glucocorticoid therapy 6%. No patients underwent endoscopies or abdominal surgeries the previous month.

Microorganisms isolated were: Klebsiella pneumoniae OXA48 56%, Klebsiella oxytica OXA48 17% and other CPE (E. Cloacae BLEE, E. Coli AmpC, E. Coli BLEE, SARM) 27%. 56% had had previous infections by the same microorganism.

95% rectal swabs was collected: 50% positives. 28% patients needed isolation after hospital discharge.

The main infections were: Urinary tract infections 39%, pneumonia 22%, respiratory infections 17%, bacteremia 11% and peritonitis 6%.

The average duration of treatment 9+/-5 days. The antibiotics used were: piperacillin-tazobactam (50%), meropenem (11%) and combination antibiotic therapy (22%).

After hospital discharge: 17% went home, 39% chronic hospital and 11% nursing home. 2 patients re-entered and 3 died.

Conclusions: OXA48 CPE may produce a broad spectrum of infections that are typically associated with high mortality (our study 11%). Increase the mean stay 14+/-8 days (Internal Medicine Department Mean stays during 2017 11+/-1 days). Therapeutic options for infections caused by CPE are usually very limited.
Infectious diseases
A-1967

Cardiac surgery for infective endocarditis (IE) - characteristics of patients.

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Aims: characterization of a population of patients undergoing cardiac surgery due to IE.

Methods: Retrospective, descriptive study; patients with IE who underwent cardiac surgery in a single center (between January 2006 and October 2017). Results: N=145 patients (72.4% males; median age of 72 years). 83% were hypertensive, 66.9% dyslipidemic, 33.0% diabetic, 35.2% had a history of previous valve surgery and 3.4% patients had a history of prior IE. Native valve was involved in 67.6%, prosthesis in 32.4% (22.1% biological, 10.3% mechanical). Aortic valve was the most affected (64.1%) followed by mitral valve (53.1%); tricuspid valve was affected alone in 0.7%. Microbiological agents were isolated in 89 patients (61.4%); staphylococcus (31%), streptococcus (13.1%) and enterococcus (10.3%). Thirty percent of cases were associated with provision health-care, 69% were community-acquired and 0.7% with iv drug use. Emergent (within 24 h) surgery was performed in 29 patients (20%), urgent surgery (first week) in 108 patients (74.5%) and elective surgery in 8 patients (5.5%). The main surgical indications were heart failure (57.9%), large vegetation (20%), systemic embolization (17.2%), prosthetic dysfunction (15.2%), large abscesses (9.7%). The main surgical complications were acute kidney injury, atrioventricular block, atrial fibrillation, sepsis and respiratory failure. Post-surgery dialysis was required in 24.8% of patients and the need for definitive pacemaker implantation in 12.4% of patients. During hospitalization, a total of 19 patients (13.1%) died. Conclusions: The most frequent microorganism isolated was Staphylococcus; the native aortic valve was the most affected and the biological prosthetic valves were more frequently involved. Urgent surgery was the most performed (main reason being heart failure, followed by the presence of large vegetations). Acute kidney injury and atrioventricular block were the most frequent complications.
Carotid artery dissection is a rare event that cause ischemic stroke, more frequently in the fifth decade of life. Internal carotid artery dissection can be caused by: systemic vasculitis (large vessel, medium vessel, ANCA-associated, immune complex), or vasculitis mimics (systemic infection, malignancy, vascular trauma, vaso-occlusive processes, fibromuscular dysplasia or connective tissue diseases). If the dissection is symptomatic, the annual incidence is 2.5-3 per 100 000, but if it is as a result of blunt injuries is less than 1-3%.

Syphilis is a very common infectious disease caused by Treponema pallidum, and it is generally transmitted through sexual contact. It remains prevalent in many developing countries (southern Asia and sub-saharan Africa). There are three stages in progression of syphilis: primary, secondary and tertiary. The last stage is classified into another three types: neurosyphilis, cardiovascular syphilis and gummatous syphilis.

We reported a case of 56-year-old man with ischemic stroke and radiological evidence of internal carotid artery dissection presumably due to syphilitic inflammation. He was a smoker with hypertension, dyslipidemia and he went to Angola for a one month. Screening blood test (IgG and IgM) revealed Treponema pallidum IgG, VDRL and TPHA positive, but Treponema pallidum IgM was negative. In cerebro-spinal fluid (CSF), VDRL test and IgM were negative. CSF culture was negative.

As cervical artery dissection is one of the most common causes of stroke in a young, otherwise healthy population, it is important for physicians to recognize the vasculitis appearance of arterial dissection on advanced imaging techniques to avoid overdiagnosis and to prevent the recurrence of carotid artery dissections.
Introduction: Pott's disease, also known as tuberculous spondylitis, is the most common form of skeleton tuberculous accounting for 35% of extra-pulmonary tuberculous cases. The inferior thoracic and superior lumbar regions are most frequently affected.

Case Description: The authors present a case of a 66 year old man with a history of diabetes, hypertension, dyslipidemia and spine pathology known since 2012, with three surgical interventions. The patient's experiences of lower back pain since the last surgery prompted several visits to the emergency department. In one of his visits, computed assisted tomography of the spine was performed and scanning documented lesions in spines of D8-D9 compatible with spondylitis. Workup of the case revealed positive Interferon Gamma Release Assay (IGRA) and an inconclusive biopsy of the spine. Spinal tuberculosis was hypothesized and the patient was treated with antituberculostatics, with improvement in clinical and analytical presentations. In a follow up consultation, the patient was asymptomatic. The results of the biopsy culture were negative, however the clinicians assumed the response to the antituberculous therapy as therapeutic proof thus maintaining the diagnosis and treatment.

Conclusion: Tuberculous is a prevalent disease in several countries. The complications and the outcome of the disease are severe, therefore it is important for every clinician to be aware of the different forms of presentation and the initial approach.
Central nervous system tuberculosis – a presumptive diagnosis

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Central nervous system tuberculosis (TB) is one of the rarest forms of infection by Mycobacterium tuberculosis, reaching 1% of all forms of TB with a high mortality even under correct treatment. The imaging and laboratory findings are unspecific and the detection methods have low sensitivity, which makes the clinical suspicion the key for the diagnosis.

Male patient, age 52, with chronic pulmonary disease, smoker, history of untreated latent TB and recent contact with a person with active TB. He presented with a migraine and nausea. He was decumbente, feverish and had meningism. The laboratory tests found a C reactive protein of 5mg/L and 14510/uL Leucocytes. The CT scan excluded an intracranial lesion and other complications. The lumbar puncture revealed an elevated number of proteins (102mg/dL), glucose consumption and 3864 cels/uL with predominant mononuclear cells. At this point, we assumed a bacterial menigitis and started empirical treatment with Ceftriaxone 2gr twice/day and Ampicilin 2gr six times/day. The patient kept a low response, with recurrent fever and persistente migraine. The MRI excluded complications. Because of the lack of response we held several lumbar punctures, all of which had high number of proteins (99 to 225mg/dL), glucose consumption and the presence of nucleated cells, even after 18 days of antibiotics. So, by adding a positive interferon gamma release assay, a history of weigh loss and hypersudorese, recent contact with TB and the absence of response to the antibiotics, we decided to start a 2 month course of 4 tuberculostatic agentes, with posterior simplification with a double scheme for 9 more months. After 10 days, we began to see a clinical and laboratory response.

TB is a major worldwide public health problem, with a greater proportion of extrapulmonary manifestations presenting in developed countries. It is up to the medical team to identify the risk factor for this infection, so that an appropriate treatment can be started.
**Cerebral toxoplasmosis in a severely immunocompromised patient – a case of success**

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**INTRODUCTION:** Toxoplasmosis is caused by an intracellular protozoan (Toxoplasma gondii) and is the most common CNS infection in patients with human immunodeficiency syndrome.

**CASE DESCRIPTION:** Male patient with 44 years old with HIV and HCV infection, noncompliant and with history of heroin active consumption. In the Emergency Department he presented impaired gait, dysarthria and left hyposthesia and hemiparesis. On the blood tests performed there were 3900 leucocytes and 1300 lymphocytes per microliter. The brain CT documented bilateral subcortical oedematous areas, more expressive on the parietal and right temporo-parietal zones, along with a hypodensity in the right thalamus. During the hospitalization, the patient also presented a depression of the consciousness. On the analytic tests: 56 CD4+ per microliter, Toxoplasma gondii PCR positive on the liquor, pneumocystis jirovecii positive on the sputum culture. On the imaging studies: multiple expansive intra-axial lesions with vasogenic oedema, suggesting toxoplasmosis on the brain MR; bilateral areas of consolidation and inflammatory densification, more expressive in the right upper lobe with a tree in bud pattern suggesting an infectious process with endobronchial dissemination on the chest CT.

This patient was submitted to the treatment with cotrimoxazole and anti-retroviral therapy. He had a favourable evolution which made possible the discharge from hospital with follow-up in extern consult.

**DISCUSSION:** It is important to maintain the follow-up and viral charge monitoring in HIV patients. Prophylaxis should be implemented CD4+ counts are above 100 cells per microliter in patients with IgG positive for Toxoplasma gondii.
Cervical HPV infection in peri- and postmenopausal women at a reference center in Northeast Brazil

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Although the occurrence of cervical HPV infection in peri- and postmenopausal women remains widely controversial, this population has been targeted by screening programs for cervical cancer. Objectives: To investigate the occurrence of cervical HPV infection among peri- and postmenopausal women. Methods: A cross-sectional study was carried out and included a total of 70 women, aged 35-65 years (mean age: 51.1 ± 8.4), who attended outpatient clinics of a public research hospital in São Luís, Brazil, in the period from 2015 to 2017. A questionnaire was applied to the participants regarding sociodemographic, behavioral and clinical variables. After completing the questionnaire, patients underwent the collection of endocervical material for identification and genotyping of HPV DNA using polymerase chain reaction (PCR) assay, followed by collection of material for oncotic cytology. Results: The prevalence of positive HPV-DNA was 40%, being HPV 16 the most prevalent subtype (28.6%) and women aged 51-65 the most affected age group. Nevertheless, there was no statistically significant association between age and HPV-DNA status (p = 0.10). Women either positive or negative for HPV DNA showed similar characteristics regarding number of partners, condom use, smoking status, and history of sexually transmitted infections. Most non-infected women (59.5%) reported having a fixed partner, and this was shown to be a protective factor for HPV infection (p = 0.02; prevalence ratio = 0.50). Conclusion: Even though a high prevalence of high-risk HPV was found in postmenopausal women, age was not associated with the occurrence of cervical HPV infection.
Infectious diseases
A-1634

Chagas disease: The traveling heart

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We present the case of a 47-year-old woman natural from Bolivia, currently living in Spain, with a family history of sudden death. She had no cardiovascular risk factors, but suffered from subclinical hypothyroidism. She was diagnosed in 2006 of Chagas disease and developed bradycardia due to sick sinus syndrome so a DDDR pacemaker was implanted (Lorenzo Guirao Hospital, Lorca).
She suffered from an episode of NSVT in 2014 which required adjustment of medical treatment (Morales Meseguer Hospital, Murcia). In 2015, an episode of TV finally needed a pacemaker upgraded from DDDR to bicameral DAI.
She was studied in the Tropical Medicine Unit initiating treatment that she later abandoned due to an allergic reaction. No formal protocol studies were performed for Chagas disease due to the unattendance of the patient to appointments.
She moved to France due to work reasons and presented a new episode of VT due to withdrawal of the medication. When she returned, she went to a private hospital due to a decrease in her functional capacity, and was referred to our hospital (Reina Sofia Hospital, Murcia) where she finally completed a full study and was treated adequately, although it was too late.
The difficulty in the management of this patient was to reconstruct the clinical history with four different hospital clinical reports. The follow-up was ineffective, not being able to complete imaging studies of her illness, and therefore she did not have a proper treatment. This led to Chagas’ cardiomiopathy with poor response to treatment.
The aim of the study is to assess the serological diagnosis of HCV infection in blood donors category, during the period 2014 – 2017, in Blood Transfusion Center, Bihor county Romania.

During the mentioned period of time, were evaluated certain parameters specific for a blood transfusion center, such as: total number of blood donors, the gender and age distribution according to blood donors’ category, the number of reactive blood samples for HCV, the configuration of serological markers and diagnosis. The information was collected, using the internal records from annual activity reports, laboratory work sheets and documents from the screening tests (ELISA) done in Transfusion Center, and the laboratory tests results (ELISA, Immunoblot and PCR) from the Reference Central Laboratory, Bucharest.

Along the studied period, were 52 reactive blood samples in screening tests (ELISA combo Ag/Ab HCV). 46 cases were represented by first donors, 2 were occasional and 4, regular donors; 11 were females and 41 males, knowing that the gender ratio is 1:4, from an average of 7,500 blood donors yearly. From 52 reactive samples, only 30 were confirmed by Immunoblot, for serological diagnosis, 22 being interpreted as indeterminate or reactive in a single screening test.

The transfusion safety, is covered from HCV point of view, by performing for each blood donation an ELISA combo test; even about 0.1733% from tested blood samples were reactive, the serological diagnosis was confirmed only in 57.6% by Immunoblot; anyway, all the blood donors, with reactivity are permanent withdrawn from blood donation, for patient safety.
Infectious diseases
A-1077

Characteristics of invasive pneumococcal disease and epidemiology in a tertiary level hospital

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Objectives: To describe the characteristics, morbidity and mortality of patients in whom St. Pneumoniae was isolated in blood and/or biological fluids.

Material and methods: Retrospective and descriptive study was conducted from April 2015 to December 2017 in which all strains of S. pneumoniae isolated from blood cultures or sterile fluids were studied. The identification was made by the sensitivity test to Optoquine.

Results: A total of 27 positive samples were obtained from St. Pneumoniae. 21 were adults, and 6 patients were of pediatric age, with median ages of 63 and 4 years.

37% of the isolates were in patients admitted to the intensive care unit, followed by Internal Medicine, Pneumology and Pediatrics (11% each). Of the 27 cases of ENI, 24 (88.9%) were of community origin. More than half of the cases (55.6%) presented pneumonia as a clinical manifestation, followed by meningitis (22.2%) and peritonitis (18.5%).

The patients presented an average Charlson index of 2.96; 40.7% of patients were immunocompromised. Diabetes mellitus was the 1st cause of cellular immunodeficiency, occurring in up to 81.8% of patients. Analytically, an average leukocytosis of 16,907 cells/uL (88.2% PMN) and a CRP of 246 mg/L was highlighted; with a mean glomerular filtration rate of 66 mL/min (CKD-EPI).

All the strains were serotyped, finding 14 different serotypes, the most frequent being 3 (18.5%). These were isolated mainly in blood cultures (70.4%), followed by CSF where it was isolated in 22.2%, and in two patients in both samples. The remaining isolates were in peritoneal fluid (11.1%) and pleural fluid (3.7%).

Conclusions: The ENI presents a manifest severity, not only because of the diversity of germs (14 serotypes in 27 samples) and the high mortality (up to 44%) that this condition presents; but because of the complexity that encompasses these patients, with a high morbidity (33% of patients required admission to the ICU) and a high percentage of immunocompromised patients (40.7%).
Characterization and Diagnostic Reflection of the Influenza in the Epidemic Period of 2018

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Objectives:

To characterize the population that carried out the diagnostic's study of influenza in a Central Hospital during the month of January, 2018.

The following variables were analyzed: age, gender, analytical alterations (leukogram, platelets, procalcitonin, reactive protein C (pCr)), hospitalization time and mortality.

Methods:

Retrospective observational study with clinical data collection (ALERT and SClinico) and data processing in Microsoft Excel®.

A total of 406 patients were included in the Xpert FLU Kit (GeneXpert®) and 301 were selected, aged ≥18 years.

Results: 58.1% of the patients were female and the mean age was 69.7 years. 43.5% of the Flu results were positive: 20.6% A, of which 44.4% were H1N1 and 79.4% were Influenza B). At the analytical level, 63.6% of the patients had no changes in leukocytes at admission (62.8% had neutrophilia and 65.1% relative lymphopenia) and 46.5% had thrombocytopenia. The mean hospitalization time was 7.1 days and the mortality rate was 0.0024%.

Conclusion: The majority of the cases occurred in people with more advanced age and with analytical alterations. This study allowed to evaluate the diagnostic approach of influenza and to establish a profile of the patient with influenza, allowing to guide the use of this diagnostic test and the positivity involved a large number of hospitalizations in isolation that merit reflection on the hospital, clinical and economic management.
Infectious diseases
A-2233

Citomegalovirus Gastroenteritis in Common Variable Immunodeficiency

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Common variable immunodeficiency (CVI) is a primary immunodeficiency characterized by the inability of B lymphocytes to differentiate into plasmocytes, capable of producing the various immunoglobulin isotypes. This disease is associated with a wide variety of clinical manifestations, namely: recurrent infections; chronic lung disease; gastrointestinal disease and autoimmune diseases. CVI is the primary immunodeficiency, in which gastrointestinal complaints are more frequent.

Clinical case: A 52-year-old female with CVI diagnosed 13 years ago, with bronchiectasis, hepatosplenomegaly and malabsorption syndrome (usually with 3-4 liquid bowel movements each day), under monthly treatment with EV immunoglobulins. She was hospitalized for worsening of the habitual pattern of diarrhea and epigastric pain aggravated by feeding, with two months of evolution.

Upper digestive endoscopy showed several superficial and white base gastric ulcers, whose biopsy was positive to Cytomegalovirus (CMV), using protein chain reaction.

Severe hypocalcemia, hypokalemia and hypomagnesaemia were also identified. Furthermore, she presented very low A immunoglobulin (<7 mg/dl). The most common infectious causes were excluded. Therefore, the worsening of diarrhea was considered like CMV gastrointestinal infection. The patient was treated with an antiviral regimen of ganciclovir for 3 weeks, followed by vanciclovir for a total of 6 weeks, with clinical and analytical improvement. She maintained follow-up by Internal Medicine.

CMV gastroenteritis is a rare cause of diarrhea, but should be considered in patients with severe clinical symptoms of gastrointestinal disease, severe immunosuppression and suggestive endoscopic signs (scattered superficial ulcers or esophagus, stomach and colon erosions or deep and necrotic ulcerations in the colon).
INTRODUCTION: Cytomegalovirus (CMV) infection in immunocompetent patients is rare and is usually asymptomatic. However, its presentation can be recognized as a mononucleosid syndrome (MS), with manifestations ranging from mild symptoms to life-threatening conditions. CASE DESCRIPTION: A 55-year-old woman with type 2 diabetes, hypertension and autoimmune hypothyroidism was admitted due to disproportionate fatigue, asthenia, food/watery vomiting, non-selective anorexia and fever for the last two months. Her blood tests revealed: relative and absolute lymphocytosis (with hyperbasophilic lymphocytes), erythrocyte sedimentation rate 94 mm/h, C-reactive protein 6.4 mg/dL, acute renal injury (AKI) AKIN III (creatinine 5.3 mg/dL, urea 117 mg/dL), cytocholestatis without hyperbilirubinemia. Ultrasonography showed homogenous hepatosplenomegaly and normodimensioned kidneys, with increased parenchyma echogenicity. Further etiological investigation showed positive IgM and IgG for CMV (viral load not detected). The remaining viral and bacterial serologies were negative. Autoimmune, neoplastic and primary immunodeficiencies were also excluded. Even though, she was diagnosed with a monoclonal gammopathy of indeterminate significance IgG. CMV MS associated with AKI was admitted. She recovered under supportive treatment. During follow-up, CMV IgM turned negative. DISCUSSION: CMV infection represents 7% of MS. Although rare, AKI should be considered as a possible complication of CMV infection even in immunocompetent patients.
Community-acquired necrotizing pneumonia caused by E coli: a rare cause

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Introduction: the differential diagnosis of cavitary lung lesions is a clinical challenge. It is mandatory to correlate the imagining findings with clinic context, disease and personal history to establish the most likely differential diagnoses and to guide the subsequent management of these lesions.

Case description: we present a 62-year male with history of rheumatoid arthritis in treatment with prednisone, controlled large granular lymphocyte syndrome and pernicious anemia due to gastrectomy for carcinoid tumor years ago. He was admitted in the emergency department with one-month evolution of fever, productive cough with hemoptoic sputum, asthenia, hyporexia and 5 kg of weight-loss. Pulmonary auscultation revealed scattered roncus and analysis only revealed CRP 46,1 mg/dL. Chest X-ray showed right upper lobe cavitary lesion compatible with necrotizing pneumonia. Pulmonary tuberculosis was suspected as the first possibility in the differential diagnosis. Consecutive sputum samples did not show any acid fast bacilli, the sputum cultures and blood cultures were negative. A posterior bronchial alveolar lavage (BAL) established a definitive microbiological diagnosis: Escherichia coli infection. According to the antibiogram report, he was treated with intravenous antibiotics followed by long term oral treatment with satisfactory evolution.

Discussion: necrotizing pneumonia is a community-acquired pneumonia complication. The organisms generally implicated are Staphylococcus aureus and few gram-negative bacteria. E. coli pneumonia is relatively rare but there is a reported rise incidence, especially in patients with underlying conditions like chronic corticosteroids-treatment. It is important to consider a wide range of entities in immunodeficient patients and obtaining respiratory samples turn out to be very helpful in certain diagnosis.
Complicated urinary tract infection with myoclonus and neurological deterioration.

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68-year-old patient with one kidney, history of anxious-depressive syndrome and lumbar disc herniation, under treatment with antidepressants, vildagliptin, glycazide and atorvastatin. Admitted in the Emergency Department due to vertigo with diarrhea and hypotension previously. Three days later, there is decreased strength in the lower limbs, tendency to sleep, disorientation, stuttering and tremors. Highlights TAC skull, abdominal ultrasound and lumbar puncture were normal. Blood test with glucose 228 mg/dl, renal failure with plasmatic creatinine 2.15 mg/dl and potassium 4.2 mmol/dl. Acute phase reactants increased C reactive protein 83 mg/dl and procalcitonin 1.9 mg/dl with normal blood count. Infection data in urinalysis. During the hospitalization he begins with maintained hyperthermia, hypoxemia, persistent myoclonus and stupor. The Brain MRI was normal. Escherichia coli grew up in blood cultures and antibiotic treatment was initiated, adjusted to renal failure, without neurological response. Because of autonomic and neurological symptoms, serotonergic syndrome was suspected, contact was made with psychiatry that adjusted the treatment. At 72h the patient present clinical neurological improvement, disappearing myoclonus and returned to baseline in 4-5 days. Serotonin syndrome is a group of symptoms that may occur following use of certain serotonergic medications or drugs. The degree of symptoms can range from mild to severe. Symptoms include high body temperature, agitation, increased reflexes, tremor, sweating, dilated pupils, and diarrhea. The symptoms are classically described with a triad: changes in mental state, autonomic hyperactivity and neuromuscular abnormalities. Sometimes it cause death. It is frequent due to the indiscriminate use of antidepressants. For this reason, it must be kept in mind in the differential diagnoses in those patients who take them and come with atypical symptoms.
Cryptococcal meningitis in HIV-infected patients – a retrospective single center analysis through the time

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Objectives: Cryptococcosis is an invasive mycosis caused by Cryptococcus neoformans, a major opportunistic pathogen. In human immunodeficiency virus (HIV) infected patients the widespread use of antiretroviral therapy (ART) lowered the incidence of this infection. The modest burden of patients with cryptococcal disease is related with newly diagnosed HIV infection and non-adherent patients. This work aims to characterize the HIV patients diagnosed with cryptococcal meningitis (CM) in our center in the late 6 years and compare the results with previous data.

Methods: Retrospective and descriptive study of patients diagnosed with CM in our center between the years of 2012 and 2017 regarding demographic features, HIV status, intracranial pressure (ICP), treatment and outcome. Analysis and comparison of these results with data from 1998 to 2004.

Results: In this 6-year period, there were 13 cases of CM in HIV patients registered in our center. They were all males with a median age of 49 years. HIV infection was newly diagnosed in 62% of the cases. CD4 count was < 50/µL in 54% of cases and 50-200/µL in 23%. ICP was evaluated in 11 patients and was >25 cmH2O in 64% of them. All patients were treated with 1st line antifungal schemes. Mortality rate was 46%; most of the deaths occurred in a premature phase (1st 15 days after diagnosis).

Conclusion: Comparing with data from 1998 to 2004, the median age was higher (49 vs. 38 years), as was the rate of inaugural HIV diagnosis (62 vs. 43%). Mortality rate was superior in recent years (46% vs. 29%), which was probably related with diagnosis of HIV infection in advanced immunosuppressive stages, associated opportunistic diseases and other comorbidities. An aggressive approach, with combination of antifungal therapy and ICP control, is essential to optimize prognosis of this condition. This study alerts that late HIV diagnosis is still an issue with potentially fatal outcomes and highlights the importance of early screening.
Cryptococcal meningitis in immunocompetent patient: a case report

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Introduction:
Cryptococcal meningitis is one of the most important human immunodeficiency virus (HIV)-related opportunistic infections. However, it can occur in immune competent patients. Despite the antimicrobial drugs and modern imaging techniques, morbimortality remain high. Delay in diagnosis is related to a poor outcome, including various degrees of neurological sequelae.

Case Description:
A 47-year-old man, ecotourism guide, was admitted at the hospital with an 8-week history of headache, fever, fatigue and new onset (6 days) altered mental status and diplopia. He presented signs of intracranial hypertension (headache, papilledema and a sixth nerve palsy) and had no stiff neck or focal neurological deficits. He was negative for HIV.
Magnetic Resonance Imaging revealed a hyperintensity in the subarachnoid space from certain sulci in the frontal lobe and a subtle increase in intensity in the right head of caudate nucleus and anterior part of the right putamen, at the T2-weighted images.
The cerebrospinal fluid analysis showed a clear appearance, an opening pressure of 42 cmH2O, WBC count of 85 cells/mm³, glucose level of 43 mg/dL and protein level of 79 mg/dL. The India ink and latex agglutination antigen detection identified Cryptococcus neoformans.
The treatment with amphotericin B and fluconazole was started (flucytosine is not easily available in Brazil) associated with serial lumbar punctures to relieve the symptoms. Despite the clinical improvement, he had a bilateral and parcial hearing loss as a sequelae.

Discussion:
Although CM is related with immunosupression, immune competent patients are also susceptible. In this case, an HIV-negative patient was infected, exposed by his work in Brazil. As an HIV-negative person, he received a late diagnosis.
CM must be considering as differential diagnosis in immune competent patients to avoid complications by applying the plans of care for minimizing sequelae and maximizing functional recovery.
With the growing number of transplanted patients and the emerging immunosuppressant therapies there has been an increase in the number of patients with complex clinical situations in relation either with side effects of their drugs or with the risk of opportunistic infections.

We bring you the case of a 49 year old man, with a history of coinfection with hepatitis B and D that had been submitted to a kidney transplant more than 10 years ago.

The patient presented to his regular follow up consult with a history of weight loss, fatigue, mild fever and headaches that had been evolving over 2 weeks.

He was admitted for a full physical exam and complementary exams.

On a first approach no evident signs of infection, blood work showed an undetectable viral load of Hepatitis B virus, and a slight degradation of the renal function with a increase of plasma creatinine 1.5fold.

Due to the sustained complaints of headache besides blood cultures, a lumbar puncture was done with culture of cerebrospinal fluid.

After 2 weeks of admission both blood and cerebrospinal cultures came back positive for Cryptococcus neoformans.

Adequate treatment was initiated with amphotericin B in combination with flucytosine.

Despite adequate treatment patient showed increase in uremia and plasma creatinine and a decrease in urine output, at this point he restarted dialysis and flucytosine was stopped.

At 2 weeks of treatment the patient showed evidence of hemathological disfunction with thrombocytopenia, with evidence of mucosal and puncture sight bleeding. At this point an hepatitis D viral load was collected.

The patient rapidly progressed with mental impairment and need of major transfusional support.

This case is relevant not only due to the number of immunosuppressed patients we face but also the importance of knowing that opportunistic infections and the chronic ones can interact and produce a worst outcome for the patient. In this case remembering Hepatitis B/D infection was of substantial importance.
Cryptogenic organizing pneumonia as cause of nonresolving pneumonia

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Introduction: slow or incomplete resolution of pneumonia despite treatment is a common clinical problem, and there are a variety of reasons. It is necessary to correlate the clinical history with the imaging findings to guide the adequate supplementary tests to get the correct diagnosis.

Case description: we present a 62-year male with history of dyspnoea, dry cough and fever with vesper predominance of 20 days of evolution. He had received several cycles of antibiotic therapy (Amoxicillin-Clavulanic, Levofloxacin, Azithromycin) without clinical, analytical or radiological improvement, being appreciated on chest-X-ray an infiltrated in ground glass in the left lower lobe. We decided to continue studies with tomography computerized and bronchoscopy to obtain microbiological tests. The same infiltrate was observed in the tomography computerized, and all the microbiological studies were negative: sputum culture, blood culture, bronchoalveolar-lavage culture, bacilloscopes, Löwenstein-Jensen culture, Nocardia culture, Actinomycyes culture, Streptococcus pneumoniae and Legionella antigen, serologies (Mycoplasma, VIH, Coxiella burnetii, Rickettsia, Yersinia) and galactomannan antigen test. In view of the clinical and analytical worsening as well as the persistent negativity of the studies carried out, it was decided to complete the study with open surgical biopsy. The results of pathological anatomy offered the definitive diagnosis: cryptogenic organizing pneumonia. Treatment with corticosteroids was started with excellent clinical response.

Discussion: a slow-resolving pneumonia may be a consequence of underdiagnosed pathogens or complications of initial pneumonia (for example, empyema or lung abscess). However, we must not forget more infrequent causes that are not solved with antibiotherapy such as neoplasia, vasculitis, interstitial lung diseases or even pharmacological origin.
Infectious diseases
A-1609

Device-associated endovascular infections - the need for tenacity in clinical approach

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Introduction: Infective endocarditis (IE) and device-associated endovascular infections (DAEI) incidence is
increasing, along with population aging, intensive contact with health care, and expansion of heterologous
material use. Keeping in mind their severity and associated morbidity and mortality, it is imperative to keep a
high level of clinical suspicion and to optimize the available diagnostic tools for an adequate and timely
treatment.

Case Description: An independent 81-year-old male with symptomatic bradycardia controlled by pacemaker
(PM) searches medical care with a 1-day history of fever, interscapular pain without pleuritic, mechanical or
tear features, poorly productive cough and anorexia. Physical examination was normal; leucocytes
17,650/uL, C-reactive protein 172 mg/L and D-dimers 1.05 ng/L. Angio-CT excluded pulmonary
thromboembolism. Ceftriaxone was started after collecting blood cultures (BC), which were positive in <24
hours for methicillin-sensitive Staphylococcus aureus (MSSA). Echocardiogram showed no signs of
endocarditis and abdominal and cerebral imaging had no evidence of embolization. Still, given the high
clinical suspicion of pacemaker-associated IE, antibiotic treatment was switched to Flucloxacillin
plusGentamicin and, after BC turned negative, Rifampin was also added. PET-CT revealed hypermetabolism
of soft tissues next to the PM probe, near the exit zone of the generator. PM was removed and probes were
positive for MSSA. He completed 4 more weeks of Flucloxacillin and had no relapse.

Discussion: DAEI is often difficult to document. Even without inequivocal lesions or endocardial
inflammation, our patient's PM probes were infected. This case aims to warn for the need for tenacity in the
diagnosis and therapeutics of DAEI.
**Diagnosis of Atypical Mycobacterial and Fungal Coinfection**

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**Introduction**

We present the case of a 74 year-old female hospitalized for further study of chest computer tomography (CT) scan compatible with mycobacterial infection.

**Case Description**

A 74 year-old female with previous history of idiopathic thrombocytopenia and an episode of acute pancreatitis hospitalized because of a chest CT scan in which bronchiectasias, nodules and cavitations, compatible with mycobacterial infection were observed. The CT scan was done for further study of a possible solitary pulmonary nodule observed in a previous chest radiography which was done due to a persistent cold. At the moment of the study, the patient was completely asymptomatic, but she had presented symptoms of two respiratory tract infections in the last year. The physical examination was normal. Biochemistry and hematologic parameters did not show any alteration, with the exception of the already known thrombocytopenia. Immunological studies did not reveal any cellular or humoral immunity deficiency. Microbiological tests results were negative for human immunodeficiency virus and hepatitis virus serologies, interferon-gamma release assay and treponemal screening test. Three sputum cultures were collected without evidence of acid alcohol resistant bacillus in the auramine stain and negative culture after 6 weeks of incubation. A bronchoalveolar lavage was done and the culture was positive for filamentous fungus Scedosporium apiospermum and Mycobacterium Avium Complex (MAC). As the patient was completely asymptomatic, the decision was close follow up without treatment of the mycobacterial infection. The patient received treatment with voriconazol for the fungal infection.

**Discussion**

MAC lung infection is more common in male adults with underlying lung disease, but there is also other clinical presentation in elderly women without known lung disease or immune alteration. Scedosporium apiospermum infection was probably favoured by MAC infection.
Infectious diseases
A-2066

Diagnostic challenges of extrapulmonary tuberculosis: a case report

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Extrapulmonary tuberculosis (EPTB) refers to disease outside the lung, which by nature often poses real challenge for clinicians, resulting frequently in delayed diagnosis and therapy. The present study describes the presentation and diagnostic management of one patient with EPTB, aiming to highlight the necessity of considering this entity in any differential diagnosis process, especially in endemic regions. Case description: An 18-years-old, non smoker female, without any previous medical history, was referred to our clinic from a Gynecology ward, where she was admitted with diffuse abdominal pain and malaise caused by newly onset ascites. She underwent exploratory laparoscopy due to the suspicion of ovarian tumor based on abnormal abdominal ultrasound. Routine blood tests were in normal range, HIV serology was negative. Tissue sampling was performed from the peritoneum with bacteriologic confirmation of M.tuberculosis, histological examination described multiple granuloma with epitheloid macrophages, Langhans giant cells and lymphocytes. We administered initial intensive–phase anti-tuberculous therapy with successful results so far. Discussions: TB infection remains a threat in endemic regions and can appear in patients without visible risk factors or immune depression. One of the challenges in diagnosing EPTB is caused by the necessity for surgical methods in order to obtain samples. Furthermore, such samples are often paucibacillary, hence the necessity of histological examination. Our patient presented intense positivity at direct microscopic examination (2+), with characteristic histological findings as well. Peritoneal TB infection is often caused by seeding from abdominal lymph nodes or from salpingo-oophoritis due to diminished or inefficient local immune mechanisms. Prolonged physical over-exertion with a primary genital infection might have led to the development of this particular case.
INTRODUCTION: Central nervous system tuberculosis (CNSTB) is a rare but a serious manifestation of secondary tuberculosis. It may be manifesting as meningitis, encephalitis or tuberculomas, affecting mainly immunosuppressed patients. The clinical manifestations include focal neurological signs or symptoms with minimal systemic involvement. The anti-tuberculous drugs are essential for successful recovery. CASE REPORT: A 71-year-old man with a history of hypertension, was admitted to the emergency room for an insidious 4-month history of dizziness and neck pain with mechanical characteristics, with progressive worsen. In the last 2 months he reported an intense holocranial headache and the appearance of right facial paresis associated with an decreased left leg strength. He was hemodynamically stable and had no fever. The neurological examination emphasized right central facial paralysis and an unstable gait with left imbalance but with negative romberg. The laboratory study was normal. Brain-CT was normal and cerebral MRI described hyperintensities in T2 in the left cerebellar peduncle and protuberance suggesting an granulomatous process. Cerebrospinal fluid (CSF) had a mononuclear pleocytosis, a proteinorraquia associated with low glucose levels. The capsular antigens of CSF, direct test and PCR for mycobacterium tuberculosis were negative. The diagnosis was compatible with meningitis tuberculous, for hence he has treated with pyrazinamide, isoniazid, rifampicin, ethambutol and pyridoxine. At 4 month treatment he had a slight neurological improvement and the cerebral lesions documented in MRI recede. DISCUSSION: The authors report this case, because of the rarity of clinical manifestations in a patient with unknown immunosuppressed risk factors. Because of a protean of unspecified clinical and radiologic findings, the early CNSTB diagnosis is fundamental in reducing morbidity and mortality.
Dorsal pyogenic spondylodiscitis- an uncommon case

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Spondylodiscitis is an infectious process that affects the intervertebral disc and contiguous vertebral bodies, epidural space and paravertebral soft tissues. The low incidence, insidious evolution and lack of specificity of the symptoms make diagnosis difficult.

The authors present the case of a 65-year-old male, with history of small cell carcinoma of the lung, chronic alcoholism and chronic obstructive pulmonary disease. Recent appendectomy complicated by Extended spectrum beta-lactamase producing Escherichia coli (E. coli ESBL +).

Admitted for dorsalgia with irradiation to the anterior hemithorax, inflammatory characteristics evolving over two months. No fever, weight loss or other organ symptom. Pain on compression of the spinous processes D3 to D7. No neurological deficits. Analytically, discrete thrombocytosis and C-reactive protein of 3.95 mg/dL.

Computed tomography scan (CT scan) of the dorsal spine revealed changes of infectious nature involving D4-D5 intersomatic disc and D4 and D5 vertebrae - probable spondylodiscitis. Bilateral D4-D5 foraminal stenosis, presenting space conflict with the foraminal segment of the D4 roots.

CT-guided biopsy was inconclusive. Due to symptomatic persistence, characteristics of the lesion and after a multidisciplinary discussion, combined antibacillary medication was started, without improvement. On the 20th day of hospitalization, decompression surgery and posterior fixation was performed. Culture study revealed the presence of E. coli ESBL +, beginning meropenem and gentamicin (2 weeks), with a clear improvement of symptoms, continuing outpatient therapy with ertapenem for 1 month.

Spondylodiscitis is an unusual entity, but its incidence is increasing, so a high level of caution is necessary, especially in patients without fever or infection parameters. If diagnosed in a timely manner, the success rate is 80%.
**Empirical antimicrobial therapy in patient with haematological malignancies and febrile neutropenia.**

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**BACKGROUND:**
The recent publication of the How Long study opens the debate on continuation of the empirical antimicrobial therapy (EAT) in haematological patients with febrile neutropenia until neutrophile recovery or withdrawal after 72 h or more of apyrexia plus clinical recovery.

**METHODS:**
Episodes of febrile neutropenia in patients of our hospital with haematological malignancies were assessed for retrospective analysis. Between October 1, 2015 and 31 August, 2017, 98 episodes of febrile neutropenia in 63 patients were chosen for analysis.

We analyzed epidemiological features, haematological malignancies, neutrophil count at the time of febrile neutropenia episode, EAT employed, microbiological diagnosis and antimicrobial resistances.

**RESULTS:**
Gram-negative bacteria were the main etiology (63.44%), primarily *E. coli* (24%) and *K. pneumoniae* (10%). Only 4% were BLEE and/or AmpC.
Among Gram-positive bacteria (36.54%), *S. aureus* stood out with 5%, none meticillin-resistant. There were only 7% positive blood cultures for *Pseudomonas*, mostly sensitive to Ceftazidime, Cefepime and Piperacillin-Tazobactam. The EAT was correct in 81% of the cases and in the majority of cases was not withdrawn after the arrival of the antibiogram, continuing until the recovery of the neutrophil count.

**CONCLUSIONS:**
In our hospital area, most cases of analyzed bacteremia in patients with haematological malignancies and severe neutropenia were due to Gram-negative bacteria, in a high percentage without resistance mechanisms (96%). However, EAT must always include broad-spectrum antibiotics if risk factor are detected, without being necessary to cover MRSA.
Encephalitis associated with antibodies anti NMDA: 3 cases report

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INTRODUCTION

Encephalitis due to anti-NMDAR antibodies usually occurs in young women and children. It can be confused with viral encephalitis or psychiatric processes. 50% of cases can be associated with malignant neoplasms.

CASE DESCRIPTION

Three cases were identified in the years 2016 and 2017, all women, with an average age of 31 years. Only one had a history of neurological pathology, (multiple sclerosis). Two of them started with a psychotic picture and one with an epileptic crisis. All of them presented psychomotor agitation with a need of sedation. After other causes were rejected, IgG GluN1 antibodies were requested against NMDAR, being diagnose. They were treated with five boluses of Methylprednisolone and five sessions of Plasmapheresis, using fresh plasma as an exchange fluid. One patient required treatment with Cyclophosphamide and Rituximab due to poor outcome, dying from secondary sepsis to colonic perforation.

DISCUSSION

Encephalitis mediated by anti-NMDAR antibodies is related to antibodies against the N-methyl-D-aspartate receptor. The average age of onset is 23 years, women predominantly. It consists of several phases. The prodromal phase simulates a viral picture. Psychotic symptoms or agitation that worsen up to catatonic pictures or Dysautonimia can occur in the psychiatric phase. In the recovery phase, an executive dysfunction and impulsivity disorders may remain. The diagnosis is based on the clinical and presence in CSF of IgG antibodies directed against NMDAR subunit GluN1. Treatment consists of 1g / day of Methylprednisolone for 5 successive days of Immunoglobulins (400 mg / Kg / day) or Plasmapheresis. In case of not responding, it is necessary to evaluate Rituximab or Cyclophosphamide.
Endocarditis caused by Neisseria Mucosa, commensal...or not?


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INTRODUCTION
Neisseria Mucosa is frequently found as a saprophyte in the upper respiratory tract. Its isolation in blood cultures has been related to endocarditis and meningitis.

CASE DESCRIPTION
A 77-year-old woman with history of arterial hypertension, dyslipidemia, revascularized ischemic heart disease, atrial fibrillation and implantation of biological aortic valve. She went to our hospital due to gait instability, disorientation and fever. Physical examination showed heart murmur in the aortic focus. Lab tests showed leukocytosis, elevated acute phase reactants and overdosage of Acenocoumarol. A cranial computerized tomography and angiography was performed, showing subarachnoid hemorrhage with aneurysm of the right middle cerebral artery. After 48 hours the described aneurysm has dissapered. In blood cultures grew Neisseria Mucosa. A transesophageal echocardiogram showed a vegetative image in the aortic valve prosthesis and a cavitated abscess at the level of the mitroaortic junction. A thoraco-abdominal computed tomography and positron emission tomography was performed, showing splenic infarcts with thrombus image in the splenic artery. She went under surgery for the implantation of aortic homograft. During surgery, cavitated abscess under the aortic annulus and degeneration of the biological prosthesis was observed. Samples of valvular tissue were taken, with Polymerase chain reaction positive for Neisseria mucosa. After the intervention, the patient evolves favorable with intravenous Ceftriaxone until completing 6 weeks of treatment.

DISCUSSION
We present a case of infectious endocarditis due to Neisseria mucosa in a non-immunosuppressed patient, with late involvement on aortic prostheses, with the appearance of cerebral mycotic aneurysm and splenic embolisms. There are few cases of endocarditis caused by Neisseria mucosa described in the literature with high incidence of systemic embolisms and mycotic aneurysms in relation to endocarditis of other etiologies.
Endocarditis for *Corynebacterium minutissimum*

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**INTRODUCTION**

*Corynebacterium minutissimum* is the cause of erythrasma, however, there have been some cases of infections in other locations despite its low infectivity.

**CASE DESCRIPTION**

A 79 year-old hypertensive man with mechanical mitral prosthesis from 2014, with permanent atrial fibrillation, severe pulmonary hypertension and stage III chronic kidney disease. In chronic treatment with furosemide, bisoprolol, omeprazole, sildenafil, acenocoumarol, darbepoetin alfa and ferrous sulfate.

He underwent right total nephrectomy for whole cell carcinoma and suffers from bacteremia due to *E. faecalis*, ruling out endocarditis due to lack of criteria. After one month, he returns due to fever and a collection in a surgical bed, making it impossible to drain.

Six months later, consultation for dyspnea of minimal effort of 2-3 days of evolution. Physical examination: afebrile and hemodynamically stable. Arrhythmic cardiac tones with metallic click by mitral prosthesis, decrease of pulmonary vesicular murmur and rest without pathological findings. Three days later, he presented fever of 38.5°C and a systolic murmur in mitral focus not previously present, so blood culture were taken and empirical antibiotic treatment was started with ceftriaxone. *Corynebacterium minutissimum* grows in blood culture only sensitive to tetracycline and vancomycin, so the antibiotic plan is adjusted and echocardiography is requested when endocarditis is suspected. The transesophageal echocardiogram shows vegetations in the mitral and tricuspid valve. The patient presents periprosthetic mitral and tricuspid endocarditis due to *Corynebacterium minutissimum*. After receiving antibiotherapy for 6 weeks, blood cultures are repeated and negative and no vegetations are found in subsequent echocardiographic controls.

**DISCUSSION**

The genus *Corynebacterium* can be a challenge for the microbiologist because these bacteria can be considered contaminants. They are rare causes of bacterial endocarditis.
Enterococcus gallinarum causing native valve endocarditis

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Introduction: Enterococcal endocarditis is usually a disease affecting older patients, the most frequent source of infection being the gastrointestinal or genitourinary tracts; it frequently involves the aortic valve and tends to produce heart failure. The most common species causing human infections are E. faecalis and E. faecium; the other species are rarely encountered in human clinical specimens.

Case description: A 77-year-old women hospitalized with 1-week history of progressive dyspnea, orthopnea, cough and lower limb edema. History of arterial hypertension.

The laboratory examination revealed PCR 5.86 mg / dl, without leukocytosis, K + 3.1 mmol / L, BNP 1790. A chest X-ray showed pulmonar venous congestion and cardiomegaly.

On the first day, the patient required mechanical ventilation because of heart failure. A transthoracic echocardiogram showed moderate to severe aortic and mitral regurgitation and vegetations with valvular destruction. The combination vancomycin and gentamicin was started for presumably infective endocarditis.

Because an E. gallinarum was isolated from two blood cultures, gentamicin was switched to ampicillin.

Discussion: E. gallinarum endocarditis is rare. To our knowledge, this is the first report in our country. E. gallinarum are intrinsically resistant to vancomycin. Antibiotic susceptibility patterns indicate that most isolates are penicillin and ampicillin-susceptible. Clinicians need to be alerted to the possibility that vancomycin may not be effective against E. gallinarum, despite in vitro results that indicate vancomycin susceptibility.
Enterococcus hirae, an unusual pathogen in humans, causing bacteriemic urinary tract infection in a patient with ureterosigmoid anastomosis

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Introduction
E. hirae is known to cause infections in animals (these species were identified for the first time in young chickens) but is rarely isolated from human clinical samples. In the present report, we describe the case of an 85 year old woman with an ureterosigmoid anastomosis performed more than 30 years ago with a bacteriemic urinary tract infection caused by this microorganism.

Case description
Woman of 85 years old without drug allergies, hypertension and chronic interstitial cystitis that required cystectomy and ureterosigmoid anastomosis more than 30 years ago, having countless episodes of urinary infection since then (requiring admission to ICU in 2009).

Independent for basic activities of daily life. She came to the hospital with fever of up to 39°С since 2 days ago that did not yield to antipyretics with chills and myalgias, and deterioration of the general state. She has not had lumbalgia or dysuria.

At thorough physical examination she has acceptable general condition, well hydrated, abdominal palpation and normal renal percussion, without edema or exanthemas. An urgent analysis with blood cultures was requested, isolating E. hirae.

Discussion
After studying the case and taking into account the peculiarities of the patient, a series of anatomoclinical relationships can be established that may have led the patient to suffer multiple infections, most likely due on previous occasions by this same human exceptional pathogen.
Infectious diseases
A-1805

Enteroinvasive colitis in a patient with immunodeficiency and thymoma

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Introduction: the association of thymoma and immunodeficiency (hypogammaglobulinemia, low B-cell count and/or cellular immunodeficiency) is known as Good’s Syndrome (GS). Diarrhea appears in 50% of the patients with GS, but the identification of enteric microorganisms is rare. The literature review shows three previous cases of infection by Campylobacter jejuni in GS. Clinical case: An 87-year-old woman with frequent respiratory infections and a thymoma diagnosed ten years before, was attended because a 3-week watery and bloody diarrhea. Dehydration and diffuse abdominal pain were observed. Laboratory: hemoglobin 11.8 mg/dL; leukocyte count 6.3x10⁹/l (67% neutrophils); platelet 221x10⁹/l; ESR 22 mm/hour; total proteins 24 g/L; albumin 24 g/L; α1-globulin 0.63 g/L; α1-globulin 0.82 g/L; β-globulin 0.39 g/L; IgA 0.22 g/L; IgG < 2 g/L; IgM < 0.25 g/L; Coagulation: normal; lymphocyte subpopulations: CD4+ T 392 cells/mm³ (28%); CD8+ T 896 cells/mm³ (64%); CD3+ T cells 92%; CD4+/CD8+ ratio 0.43. Mantoux test negative. Thyroid hormones: normal. Thorax scanner: mass in the anterior mediastinum (16x6 cm), with vascular displacement and a bilateral pleural effusion. Parasites in stools: negative. Campylobacter jejuni was identified in stools by conventional tests. Good’s syndrome was stabilized and treatment with intravenous immunoglobulins (IVIG) (0.5 g/Kg) and ciprofloxacin (400 mg/12 h iv) was started. The patient recovered five days later. Treatment with IVIG has continued every three weeks. Prophylactic cotrimoxazol is administered to prevent opportunistic infections. One year later IgG values are normal and no infections have been observed. Discussion: GS is a rare entity with unknown pathogenesis mostly diagnosed in the fourth decade of life. Respiratory infections by encapsulated bacteria are the most frequent infections. In our patient, the resection of the thymoma was not indicated because her age and the high surgical risk.
Infectious diseases
A-1082

Epidemiological and microbiological characteristics of candidemia in a tertiary hospital

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OBJECTIVE: To describe the characteristics and morbidity and mortality of patients in whom Candida spp. in blood in a tertiary hospital.

MATERIAL AND METHODS: Retrospective observational study. Jan´15 - Dec´17. Epidemiological data were collected. A single incident per episode and patient has been detected. The blood cultures were processed in the BacT / ALERT system (bioMérieux), the strains were identified with the YST card of the Vitek 2 system.

RESULTS: 31 samples for Candida spp were isolated. An average age of 61.52 years (30-87). 20 men (64.5%) and 11 women (35.5%). The distribution of episodes by Service was: General Surgery (22.6%), Intensive Care (16.1%), Internal Medicine (16.1%), Oncology (9.7%), Nephrology (9.7%), Digestive System (6.5%) and Vascular Surgery (6.5%). 29 (93.5%) were of nosocomial origin.

81.5% (22) of the patients had risk factors for candida infection. Among them, 96.8% had ever been manipulations of some kind (76% had a central catheter, 80% had a bladder catheter, and 53% had parenteral nutrition). Likewise, 44.4% were immunosuppressed patients. Being 25.9% (7) diabetics, and 33.3% IRC.

Analytically, at the time when candidemia was detected, an average leukocytosis of 14535 cells / uL with 95% PMN and a CRP of 190 mg / L; with a creatinine of 2.6, which implied an average glomerular filtration rate of 65 ml / min.

All the strains were typed, finding 6 different species, being the most frequent C. Albicans (35.5%) and C. Tropicalis (32.3%). All of them isolated in blood cultures.

61.3% of patients died, of which 73.7% did so within the first 15 days.

Conclusions: Candidemia presents a manifest drop, not only due to the diversity of germs (6 species/31 samples) and the high mortality (up to 61.3%) that this condition presents; but because of the complexity that encompasses these patients, with high morbidity (16.1% of patients required admission to the ICU) and a higher percentage of immunocompromised patients (44.4%)
Tuberculosis (TB) is one of the most prevalent infections in the world. It is caused by the bacterium Mycobacterium tuberculosis. TB lymphadenitis is one of the most frequent presentations of extrapulmonary TB, caused by a reactivation of disease at a site seeded hematogenously during primary tuberculosis infection. Extrapulmonary TB is more common among immunocompromised patients, including those with HIV infection. In developed countries, most cases of TB lymphadenitis occur among adult immigrants from TB endemic countries.

A 30-year-old man from Peru without previous medical history was admitted in an Internal Medicine unit presenting a month length epigastric abdominal pain, with weight loss, asthenia and anorexia. He referred the week before admission shivers and profuse nocturnal sweating. Given the clinical suspicion, a Quantiferon test was performed to rule out TB, with a positive result. Afterwards, a full-body CT scan demonstrated multiple necrotic lymph node conglomerates (located both supra-mediastinic, hilum, retroesternal- and infradiaphragmatic – mesenteric, retroperitoneal, perihepatic, perisplenic, peripancreatic- ). A bronchofibroscopy-guided biopsy from a hilium lymph node was deemed inconclusive. A fine needle puncture aspiration assessment (PAAF) of an epigastric lymph node was obtained, with microbiological and molecular (polymerase chain reaction) isolation of Mycobacterium tuberculosis. HIV screening was negative.

It is necessary to establish a proper differential diagnosis for lymphadenitis that includes malignancy and infectious diseases. Diagnosis is made through a lymph node biopsy (microbiologic, histopathological and molecular examination) and the gold standard diagnostic test is the culture for mycobacteria. Treatment consists of following a multidrug antimycobacterial therapy for six months.
Extended-spectrum beta-lactamases-producing enterobacteria in patients with urinary sepsis in internal medicine.

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Objective
To describe the frequency of extended-spectrum beta-lactamases-producing (EBSL) enterobacteria isolations in microbiological samples from patients with urinary sepsis admitted to the Internal Medicine Department of the University Hospital of Salamanca.

Methods
A prospective observational study of all episodes of urinary sepsis (Sepsis-3 criteria) was conducted in the Internal Medicine Department from April 2016 to March 2017. Epidemiological, clinical and microbiological data were recorded. Sepsis related cultures were obtained from one day before, until 3 days after the moment sepsis was identified. We received a funding from the Spanish Society of Internal Medicine to develop the Project (‘Ayudas a la investigación FEMI para jóvenes investigadores’ program)

Results
We included 184 cases of urinary sepsis, 94 of them were men (51%) and 164 (93%) were older than 65 years. Sixty-seven (35%) had a Charlson Comorbidity Index equal or higher than 3 and 36 (36%) had an indwelling urinary catheter at the moment of sepsis detection. A total of 355 sepsis related cultures were analysed. Of them, 177 were urinary samples, 104 (59%) were positive; enterobacteria were isolated in 85 (82%) and among them 11 (13%) were ESBL-producing enterobacteria (9 Escherichia coli and 2 Klebsiella pneumoniae). Thirteen percent of E.coli (9/67) and 33% of K.pneumoniae (2/6) were positive for ESBL in urinary cultures. Regarding sepsis related blood cultures, 55 of 178 (31%) were positive, enterobacteria were isolated in 43 of them (78%) and 10 (23%) were ESBL-producing enterobacteria (9 E.coli, and 1 K.pneumoniae). Thirty percent of E.coli were positive for ESBL in blood cultures.

Conclusion
In our sample of older and highly comorbid patients with urinary sepsis, the isolation of ESBL producing enterobacteria is frequent. Appropriate antibiotic administration in sepsis is usually delayed. A proper suspicion of ESBL-producing microorganisms is essential to offer the best empirical treatment.
Extrapulmonary tuberculosis: a case of atypical muscle involvement

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Introduction
Extrapulmonary tuberculosis, due to its multiplicity of symptoms, is often a difficult diagnosis to establish and may be confused with other granulomatous diseases.

Case Description
In mid-2011, a 36-year-old man presented with nodular erythematous lesions on the anterior compartment of both legs compatible with erythema nodosum. The etiological study, which included total colonoscopy and immunological study, was negative. One year on, he develops intense muscle pain in the calf region, accompanied by edema/induration, which quickly becomes incapacitating and resistant to anti-inflammatory drugs. Angiotensin converting enzyme (ACE) was slightly elevated (56U/L N <52U/L) with normal CPK and myoglobin. MRI showed interstitial edema of the gastrocnemius and chest CT showed calcified nodulariform images (smaller than 1cm) in the retrocaval, carina and right perihilar space compatible with residual granulomatous lesions. The condition was labeled as probable sarcoidosis and corticotherapy was started with transient symptomatic improvement and normalization of ACE, however, recurrence of complaints under corticotherapy was observed. PET showed spots of hyperfixation in the cervical lymph nodes and gastrocnemius muscles. Biopsy of one of these lymph nodes showed granulomatous lymphadenitis with isolation of Mycobacterium tuberculosis.

He started treatment with anti-TB agents with complete resolution of complaints and normalization of MRI changes.

Discussion
This case describes a ganglionar tuberculosis with atypical muscle involvement. We highlight the difficulty in establishing the initial diagnosis of tuberculosis, confirmed by cervical lymph node biopsy and muscle involvement, in this case translating as symmetrical myopathy of the gastrocnemius, which, to the best of our knowledge, is not described in the literature as being associated with tuberculosis.
Extrapulmonary tuberculosis: a diagnostic challenge

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Introduction
Tuberculosis remains a serious public health issue. The diagnosis of extrapulmonary tuberculosis is a major challenge and a high level of suspicion at the outset is not always enough to obtain a quick diagnosis.

Case Description
A 59-year-old male was evaluated for retrosternal pain, fatigue, persistent dry cough and fever. Laboratory tests were negative for HCV and HBV, Wright and tuberculin skin test. Chest CT revealed multiple thoracic lymphadenopathies, with biopsy excluding the presence of granulomas or lymphoproliferative disease. Bronchofibroscopy and bronchoalveolar lavage were inconclusives. Mycobacterium tuberculosis (MTB) screening (direct, culture and DNA by PCR) in bronchial aspirate and biopsy specimens was negative. The diagnosis of sarcoidosis was assumed. He remained without therapy, presenting symptoms intermittently. CT was repeated at 14 months: increased dimensions of the thoracic lymphadenopathies; abdominal adenomegalies and a right adrenal nodule de novo. Adrenalectomy was performed with histology showing tuberculoid granulomas and positive MTB DNA screening. Tuberculin skin test was repeated and was positive. Favorable outcome after treatment with anti-TB drugs.

Discussion
Extrapulmonary tuberculosis can affect any organ, with nonspecific clinical manifestations. Adrenal involvement is very rare.
In the case described, negative direct, culture, and MTB DNA testing by PCR in samples collected by bronchofibroscopy led to early consideration of the diagnosis of sarcoidosis, reviewed later after positive MTB DNA screening in adrenal nodule, concluding definitively by tuberculosis. In samples extracted by invasive methods, DNA screening by PCR is an asset and should be considered in a systematic way.
Factors associated with very high HIV viral load in the Spanish VACH Cohort

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Background
With nowadays-available antiretroviral therapy, most HIV-infected patients are properly controlled, but a percentage of subjects still exist with that objective unachieved and at risk of progression of HIV disease. We aim to determine the prevalence of very high HIV viral load and factors associated with it in a large cohort.

Methods
Cross-sectional multicenter study, carried out in January 2016 with data of the VACH Cohort, a registry participated by 23 hospitals from most regions of Spain. The prevalence of very high HIV viral load, defined as HIV RNA ≥ 100,000 copies per ml, is documented from all participants. The possible associated of that viral load with sociodemographic and clinical variables is assessed with a multivariable logistic regression analysis.

Results
A total of 30,843 adult patients are included, 23,682 (76.78 %) are male, and mean and standard deviation of age of all participants is 43.68 ± 10.52 years; 12,677 (41.10 %) are current smokers, 16,057 (52.06 %) are hepatitis C co-infected and 1,775 (5.75 %) have a very high viral load, as defined for the study. In the multivariable analysis, an association in found between very high HIV viral load and all the following variables: lower body mass index, lower number of visits carried out during follow up, lower last available CD4 cell count, higher highest available HIV RNA, higher number of modalities of treatment received during follow-up, HIV risk factor other than sexual, occurrence of death during follow-up, non-adherence to treatment, hepatitis C coinfection, being a smoker, and pertaining to groups A1 or A2 of the CDC groups classification on enrollment to the cohort, P < 0.001 in all cases.

Conclusions
Very high HIV viral load is still present in a small but significant percentage of patients. The condition is associated with HIV risk factor other than sexual, hepatitis C coinfection, and being a current smoker, among other factors.
Focal Myositis of the sternocleidomastoid muscle, a rare cause of neck mass

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INTRODUCTION
Focal myositis is a rare idiopathic pseudotumor that mostly occurs in the extremities in adults. Very rarely, it may affect one of the neck muscles and present as a neck lump.

CASE DESCRIPTION
A 60-year-old Morocaan man was hospitalized by a 6-days of a left neck mass, tenderness, torticollis and throat pain without fever or any symptoms. He had past B hepatitis; his medical-family history was no significant. Physical examination showed a healthy-appearing man with stable vital signs; the left sternocleidomastoid muscle was tender, firm and indurated. The overlying skin was erythematous. Otorhinolaringeous examination were normal, also general one. A routine laboratory evaluation revealed 20,700/mm³ leucocytes (82.1% neutrophils), c-reactive-protein and sedimentation rate were elevated. TSH and autoimmunity were normal. Mantoux and HIV, HCV and syphilis serologies were negatives. A CT-body-scan was performed, revealing a homogeneous mass consistent with an enlarged, inflamed sternocleidomastoid muscle. The surrounding structures were not involved. No other alterations were revealed. Empirical treatment with intravenous anti-inflammatory and antibiotic therapy with Amoxicillin/Clavulanic-acid were initiated with clinical improvement. For this reason, we did not decide to perform a biopsy and make a close follow-up. The mass had completely disappeared in 2 weeks.

DISCUSSION
Focal myositis is a benign distinct clinicopathological entity described by Heffner in 1977. It is an unusual, but important possibility in the differential diagnosis of any neck mass. On imaging, the condition is hard to distinguish from lymphadenopathy or malignancy. In cases of insufficient response to empirical antibiotic therapy, focal myositis should be considered.
Fever is one of the most frequent reasons for going to the Emergency Department (ED). This is particularly true in individuals with infection with HIV, sometimes with a difficult etiological investigation. We present the case of a female patient, 35 years old, leukodermic who comes to the ED in October of 2017 for toxidermia and fever with a 3 week evolution. Patient had a diagnosis of HIV infection and was under antiretroviral therapy since September of 2017. By toxidermia was altered, with good response.

She was admitted to the Internal Medicine Department for etiological study. Analytically with inflammatory parameters increased and radiologically with a nodular formation in the right lung field. Eight blood cultures and a urine culture were collected with no agent isolation. Thoracic CT showed right para-hilar nodular lesion and hepatic nodules compatible with secondary lesions. Antibiotic therapy was initiated, requiring several therapeutic regimens during hospitalization for lack of clinical and analytical response.

Abdominal CT scans identified nodular images in the hepatic parenchyma with target enhancement, translating lesions, probably of secondary origin. Two bronchofibroscopies were performed with negative bacteriological and mycobacterial bronchial secretions. Lymph node aspiration cytology and bronchial biopsies were negative. A liver biopsy was performed with a slight nonspecific lymphocytic infiltrate. Due to an inconclusive diagnosis, transbronchial aspiration with endobronchial ultrasound was performed with echogenic aspects cytological and histochemical findings in necrotizing granulomatous lymphadenitis. Patient began therapy with good clinical and analytical response.

The diagnosis of lymph node tuberculosis is a challenge. A high level of suspicion and a adequate diagnostic means are necessary to obtain the definitive diagnosis. The absence of agent isolation and inconclusive histological examination imply a delay in the therapeutic institution.
From foot to brain by the heart - About clinical case of infective endocarditis

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Introduction: Infective endocarditis (IE) is an infection of the intracardiac structures resulting from the proliferation of microorganisms in the endothelium of the heart. Ischemic stroke is one of the most serious complications of IE, responsible for a high morbidity and mortality rate in developed countries. Cerebral embolism affects more than 40% of patients with IE.

Case description: The authors present a man, 60 years old. History of type 2 diabetes, alcoholic habits in the past, Ex-smoker. Admitted in the surgery ward due to infection of the right foot to corynebacterium striatum, evolution with respiratory, cardiovascular and neurologic failure, needing for support organ measures, admitted in ICU. He underwent cranioencephalic CT scan "hypodense lesion in the right parietal region, with some fine points after contrast enhancement, possibly corresponding to vascular structures, which could be subacute, vascular-infectious lesion" For clarification of the origin of these embolic focus, an echocardiography was performed, showing a massive vegetation of the auricular face of the mitral (20 mm greater diameter). Blood cultures were positive for corynebacterium striatum. Initiated antibiotic therapy with vancomycin, gentamicin and isoniazid, without resolution of the septic system. Cardiac surgery was performed and the valve and vegetation exerted. Referred to Cardiac surgery and a mechanical prosthesis implantation was performed. The clinical situation favored ventilatory and vasopressor discontinuation and recovery of the basal neurological state of the patient. Control Cranioencephalic CT scan revealed evolving embolic strokes for chronicity.

Discussion: In presence of infection/sepsis the possibility of elimination of the focus is crucial for treating the patient. In the case of IE surgical treatment is the best option. The role of echocardiography is extremely important, allowing the early detection of IE and the search for unexplained septic embolism.
Fulminant necrotizing fasciitis due to Streptococcus Group A (beta-hemolyticus)

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Necrotizing fasciitis (NF) is a devastating soft tissue infection characterized by rapidly progressive tissue necrosis. Its diagnosis and treatment are challenging. A 42 year old woman, medicated with prednisone due to recent history of laryngitis, who presented with intense generalized myalgia and decreased muscle strength. She was afebrile, no skin lesions, had pain upon palpation of the limbs and hypotonic tetraparesis. Blood tests showed elevated inflammatory and muscle markers, acute kidney injury and compensated metabolic acidosis. Admitted to intensive care unit with signs of shock. Fluid challenge was given, cultures were taken and ceftriaxone started. On initial assessment by the surgical team, compartmental syndrome was discarded. After a few hours developed multiple erythematous scaly lesions with violaceous blisters and generalized oedema, low peripheral perfusion with patent arterial pulses and anuria with the need of renal replacement therapy. Blood cultures stained positive for Gram+ cocci. Due to the fulminant presentation, antibiotic was changed for vancomycin, clindamycin and benzylpenicillin. Toxic shock syndrome was suspected. After administering immunoglobulin, a transient improvement was noted. 48 hours after starting therapy, patient maintained clinical deterioration (peak CK 68455 UI/L). An exploratory limb fasciotomy was performed which revealed irreversible muscle necrosis of the various muscle groups. Amputation was not an option due to the necrosis extension. Even though was on multiorganic support, the patient died a few hours after surgery. Definitive cultural results showed Group A Streptococcus (GAS) isolates. NF is a rare and potentially fatal surgical emergency. A prompt diagnosis and treatment with intravenous antibiotics and aggressive surgical debridement is critical. GAS can cause various infections with a range of different presentations. This case illustrates a fulminant presentation of a type II NF refractory to treatment.
Gangrena Fournier - a rare condition

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Introduction: Fournier gangrene is a polymicrobial infection from the genital or perianal region. With a rapid evolution and high morbidity and mortality, it is characterized by obliterating endarteritis, ischemia and thrombosis of the subcutaneous vessels that result in necrosis of the skin and adjacent subcutaneous cellular tissue.

Case description: Male, 82 years old, antecedent of benign prostatic hyperplasia, hospitalized for acute pyelonephritis, with multiorgan dysfunction, under antibiotic and treatment support. On the second day of admission to the ward, on physical examination, scrotal edema with erythema and necrosis plaques - Fournier's Gangrene. The abdominopelvic tomography documented moderate prostatic enlargement and millimetric periprostatic gas bubbles.

Discussion: In this type of complication, treatment with antibiotics, drainage and surgical cleaning is the first therapeutic option. After resolution of the acute condition, patients should be observed by Plastic Surgery.
Granulicatella - A Rare Cause of Endocarditis

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Introduction
Infective endocarditis (IE) is a condition that remains associated with high mortality and morbidity. Granulicatella adiacens (G. adiacens) is a gram-positive cocci previously considered as part of the group of nutritionally variable streptococci, with rare cases described in the literature of IE caused by this bacterium.

Case description
A 82-year-old patient with severe mitral regurgitation caused by a myxomatous valve and aortic regurgitation presented with intermittent fever, anorexia, weight loss, dizziness, and fatigue with 7 months of evolution. Transesophageal echocardiogram revealed vegetations on the posterior leaflet of the mitral valve. In blood cultures a fastidious and unusual bacteria was isolated, later identified by biochemical testing with molecular confirmation, the G. adiacens. A infective endocarditis (IE) due to G. adiacens was diagnosed. Treatment was started with ampicillin and gentamycin for 6 and 4 weeks, respectively. Mechanical replacement of the valve was required 6 weeks after initiation of antibiotic therapy due to failure of treatment and worsening of the heart condition. After surgery, the patient completed antibiotic therapy for 4 weeks with ampicillin. In the follow-up the patient presented a favorable evolution.

Discussion
IE caused by G. adiacens carries greater morbidity and mortality than IE caused by other streptococci. The reported case explains the typical characteristics described in the literature of IE caused by G. adiacens: slow and indolent course, large vegetations, difficulty in isolating bacteria in blood cultures, higher rates of embolic complications, congestive heart failure, lack of bacteriological resolution, relapse and increase in the rate of surgical interventions. This case is relevant once it highlights the diagnostic perseverance that these cases imply, but also due to the sharing of effective treatments in a rare pathology with few cases described in the literature.
Guidelines accomplishment regarding pneumonia on admitted patients above 80 years old

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BACKGROUND
Although several guidelines have stated the rules to manage patients with pneumonia, clinical practice differs throughout internists. Regarding elderly patients, differences increase.

METHODS
We performed a retrospective study during 3 months including consecutively all patients admitted for pneumonia in an internal medicine department. Demographic details, laboratory parameters and treatment features were recorded. We collected the performance of blood tests, blood cultures, arterial blood gases and antigenuria at admission; and the choice of antibiotic, the use of non-invasive ventilation, fluids, steroids, length of stay and mortality. We conducted a search in Pubmed and Medline using the key words: "pneumonia", "elderly", "guidelines".

RESULTS
Initially, 102 patients were included in the study from which 3 declined to participate. 99 subjects in total, 52 females and a mean age of 85 years old. Blood tests were performed in 12,12%, arterial blood gases in 15,15%, pneumococcus an legionella antigen in urine in 4,04%. Quinolones were used on a third of patients, cephalosporin in 9% and the rest received amoxicillin. Non-invasive ventilation was not used on any subject. Fluids were given in 38% and steroids used in 47%. Length of stay was 12,78 days and we registered 11 deaths.

CONCLUSION
As we did not assess the clinical features of our sample it is not easy to say whether our approach was correct. What we can state is that on our group, guidelines were not accurately accomplished due to the low rate of blood cultures, arterial blood gasses and antigenuria performed.
Guillain-Barré Syndrome and Hepatitis C: a possible association?

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Introduction: Guillain-Barré syndrome (GBS) is an acute monophasic illness causing a rapidly progressive polyradiculoneuropathy with ascending weakness or paralysis. GBS is thought to result from an immune response to a preceding infection or from a triggering event such as immunization. Hepatitis C virus (HCV) is frequently associated with immune-mediated diseases, but GBS is only anecdotally reported, usually in the axonal form.

Case description: A 35-year-old man with history of intravenous drug use was admitted in the medical ward complaining of paresthesias in both hands and feet, generalized myalgia, progressive ascending weakness of all four limbs and gait unsteadiness, starting in the previous week. He denied sensory or sphincter complaints, recent infection or vaccination. Neurological examination disclosed symmetric tetraparesis accompanied by depressed deep tendon reflexes, without cranial nerve changes. Blood workup showed mild hepatic cytolysis (AST 120 U/L; ALT 195 U/L) and a positive HCV antibody and elevated viral load. Autoimmunity panel was negative. Cerebrospinal fluid analysis revealed albuminocytologic dissociation (protein content 1.81 g/L; cell count 4/μL). Electromyography showed an axonal and demyelinating polyradiculoneuropathy suggestive of GBS. Treatment with intravenous immunoglobulin was performed during 5 days. All neurological symptoms disappeared within 2 weeks and transaminases were later on shown to fluctuate.

Discussion: Although a causal relationship between HCV and GBS could not be completely ascertained in this patient, HCV may be the trigger of this immune radiculoneuropathy. The authors suggest that liver biochemistry profiles and HCV testing be done in all patients with GBS to further elucidate a possible disease association.
Leprosy is a major chronic infectious granulomatous disease caused by Mycobacterium leprae, which is widespread in developed nations, but in countries where debris development is a public health problem.

CASE report: The authors present a clinical case of a 39-year-old melanodermic man with no relevant pathological history. Begins about 8 months weight loss (more than 10% of SCT), unquantified febrile sensation, dermatological lesions and general malaise, with a history of several hospitalizations without improvement, appealed to the emergency service of the CSE. The emaciated observation, with amyotrophies of the upper and lower limbs, very marked left ulnar claw (preacher's hand), less intense right, infiltrated the nasal pyramid and small nodules in the auricle, palpatating thickened and painful nerve nerves as well as left auricular. Loss of pain and tenderness in the upper and lower limbs. Complementary exams include hypochromic microcytic anemia with hemoglobin 5.8g/dl, renal inficcion with LRA, HIV negative. Histological examination of the skin confirmed the diagnosis of Hansen's disease. Initiated directed therapy with rifampicin, clofacimine and dapsone, with favorable result, maintaining an outpatient follow-up.

CONCLUSION: Despite being a disease in irradiation, according to the WHO, after an exhaustive diagnosis, hansen disease was concluded, with a happy ending after specific therapy.
Hematogenous methicillin-resistant staphylococcus aureus spondylodiscitis

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Introduction: hematogenous methicillin-resistant S aureus (MRSA) spondylodiscitis is a devastating condition with high morbidity and mortality.
Case description: 89 years old male with type 2 diabetes mellitus, hypertension, ischemic heart disease, hypothyroidism and benign prostatic hyperplasia. He was admitted in our hospital referring fever, lumbar pain and urinary frequency. He was febrile with 38.9ºC, dehydrated, disoriented, with painful lumbar spine palpation, presented phimosis and balanitis. Without meningeal signs or heart murmurs. Laboratory showed elevation of inflammatory parameters with leukocytosis 13270, neutrophilia 84%, C reactive protein 6.8mg/dL, urinalysis with 500 leukocytes and positive nitrites. Renal and pelvic ultrasound showed prostate enlargement and heterogeneous structure, PSA 25ug/L. He was medicated with ceftriaxone. In urine and blood cultures was isolated a MRSA sensitive to vancomycin and cotrimoxazole. Antibiotic was switched to vancomycin. Systematic study of metastatic focus of infection in the heart, bone, joints, lung, liver, kidney and brain was done. Spine magnetic resonance was suggestive of spondylodiscitis, with thickness of prevertebral soft tissues and abscesses inside psoas muscle. Abdominal, renal and pelvic ultrasound and brain computerized tomography were negative Spondylodiscitis caused by MRSA from hematogenous dissemination with main source of sepsis in genitourinary tract (urinary infection/balanitis/prostatitis) was hypothesized. The patient died 1 month later after suffering a stroke and a nosocomial infection by Klebsiella pneumoniae carbapenemase producing.
Discussion: in this patient with MRSA bacteremia, the systematic study of septic focalizations made possible the diagnosis of spondylodiscitis. The advanced age, the MRSA infection and the long hospitalization, enhanced the risk of fatal outcome.
Hepatic abscess by fish spine

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INTRODUCTION: The accidental ingestion of a foreign body is not exceptional, less than 1% of the patients with foreign body ingestion develop complications such as perforations of the gastrointestinal tract. More exceptional still is that the foreign body migrates to the liver causing a liver abscess.

DESCRIPTION: A 72-year-old patient with a personal history of vasculitis with antineutrophil cytoplasmic antibodies (ANCA) and myeloperoxidase (MPO) positive with glomerulonephritis diagnosed by renal biopsy and treated with corticosteroids and then with azathioprine. Clinical picture for 40 days of sudden diarrheal descent of liquid feces without other pathological products, without sensation of tenesmus, including nocturnal pain with epigastrium, several episodes of vomiting and progressive fatigue with anorexia. Four days prior to admission, he presented with a fever of 38 degrees, preceded by chills with a reduced level of consciousness preceded by a preschoolar episode. Positive blood culture for Staphylococcus and Streptococcus sensitive to antibiotics with ceftriaxone and fosfomycin. Abdominopelvic CT: hepatic LOE already known in segment II compatible with hepatic abscess with two confluent collections of 1.5 cm. Linear image of more density of 3 cm related to these lesions that starts from the region of the antrum and reaches the ligament through the liver. Compatible with foreign body (fishbone, bird bone). Impossibility of abscess drainage through percutaneous punctures. Consulted with surgery that indicate conservative management.

DISCUSSION: Hepatic abscess secondary to penetration by a foreign body embedded in the liver is exceptional. The majority of patients present nonspecific symptoms such as anorexia, vomiting, weight loss with leukocytosis and alterations in liver function. Ultrasound and CT are the most sensitive imaging tests for the location of foreign bodies in solid organs.
Higher mortality among dependent patients who were hospitalized for influenza-like illness in 2016-2017 influenza season: Results of a prospective study from Turkey

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Introduction: Influenza can affect patients with chronic diseases as well as otherwise healthy people. In particular, elderly people may be at increased risk for worse outcomes.

Methods: A prospective, epidemiological study was conducted in accordance with the core protocol of Global Influenza Hospital Surveillance Network. The investigators screened and identified all patients hospitalized in the previous 24-48 hours or overnight in the predefined wards or emergency room. Fieldwork started on December 13, 2016 and ended on April 15, 2017. Two swabs per patient were obtained for Influenza A and B. The functional dependency was evaluated by using Barthel Index (BI).

Results: A total of 549 patients ≥18 years of age were screened and 171 patients were enrolled, of whom 112 (65.5%) were ≥65 years of age. Elderly group had more comorbidities and most common comorbidity was cardiovascular diseases. Influenza vaccination rate was only 15.2% in elderly group. Sixty-six (38.6%) patients were positive for influenza and 37 (56.1%) of these were elderly. Nearly one-third of the elderly patients were admitted to the intensive care unit, whereas 13.4% of all elderly patients died in the hospital. While 1 (2.1%) of the patients in the independent group (BI: 100) died, 6 (35.3%) of the patients in the total or severe dependence group (BIs60) died in that particular hospitalization period.

Conclusion: The ratio of patients who were discharged from the hospital was inversely proportional with increasing dependency. Healthy aging might have an impact on the outcomes of severe influenza like illness requiring hospitalization.

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HIV/HCV Coinfection - A Retrospective Study

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Objectives
To characterize the patients followed in consult in an Immunodeficiency Unit with coinfection of human immunodeficiency virus and hepatitis C virus (HIV/HCV) who were treated for Hepatitis C between 2015 and 2017.

Methods
Retrospective and descriptive analysis of coinfected patients. In this group, the value of HCV viral load, genotype, elastography result, treatment schedule, sustained viral response at 12 weeks (SVR12), the percentage of patients experienced in treatment and the number of reinfections were analyzed. The data was collected by consulting patients' clinical files and analyzed through Excel, Microsoft.

Results
In total, 59 patients completed treatment between 2015 and 2017. The mean age of the patients treated was 47.6 years. Approximately, 83% were male, 34% were in advanced stages of fibrosis (F3-F4 according to the METAVIR score) and 75% presented with genotype 1. Most patients were naïve for treatment of hepatitis C and only 13.6% were previously experienced.

The most commonly used treatment regimen was sofosbuvir and ledipasvir in 81.3% of the cases. Among the treated patients, only 3 did not reach SVR12 and only one of these was due to therapeutic failure. Between the other two patients, one presented SVR at the 24th week after treatment and another was did not comply with treatment correctly.

Of the treated patients, 2 later presented reinfection with a different genotype. The SVR12 rate stood at 94.9%.

Conclusion
The World Health Organization estimates that there are currently 36.7 million people living with HIV. Of these, 2.3 million (6.7%) are also infected with HCV. Among HIV and HCV coinfected patients, the progression to cirrhosis is faster than in monoinfected and there is also a concern about the choice of antiretroviral therapy because of possible liver toxicity. Nowadays, with the new hepatitis C treatment regimens it is possible to reach cure rates of 95%, as verified in this study.
Infectious diseases
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Hospital admissions for community-acquired pneumonia at an Internal Medicine Department.

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Background: Community-acquired pneumonia (CAP) is one of the most frequent causes of hospital admission. The use of severity scores for pneumonia is recommended to help clinicians decide when to admit patients. The current recommended empiric antibiotic regimen is a combination of a beta-lactam and a macrolide. We aimed to study if patients admitted to an internal medicine department had criteria to be admitted based on severity scores and what antibiotics were used.

Methods: Retrospective cohort study that included all CAP patients admitted to an internal medicine department. Patients included were admitted in 12 consecutive months. Demographic, clinical, antibiotic and microbiology data were collected and the CURB-65 and Pneumonia Severity Index (PSI) were calculated.

Results: From 236 patients admitted for pneumonia, 140 had CAP. Median age was 75 years [63,84], gender distribution was identical (51% female). Time to discharge was 10 ± 6.7 days. According to CURB-65 115 (82%) patients had criteria for admission and according to PSI 118 patients (84%). One hundred and fourteen (82%) patients were started on amoxicillin/clavulanic acid or ceftriaxone and a macrolide. In 12 patients empiric therapy was escalated to broad-spectrum antibiotics due to non-response to empiric therapy. The median antibiotic duration was 8 days. Mortality rate was 5% and 3.6% of patients were admitted to an Intensive Care Unit.

Conclusions: Most of the patients admitted had severity score criteria for admission. Most patients were started on adequate empiric therapy according to current recommendations. Mortality was similar to described in previous studies.
Introduction: Type II Diabetes has been suggested as a potential manifestation of C hepatitis, affecting the response to treatment and the prognosis. The risk increases with the duration of exposure to infection. The hepatitis C treatment has changed with the introduction of direct action antivirals. The combination Ledipasvir/Sofosbuvir has proven to cure with good tolerance. However, some cases have described an association between changes in insulin sensitivity and this treatment.

Case description: Man, 52 years old, caucasian, electrician. Clinical priors of dyslipidemia and COPD, some alcoholic and smoking habits. The patient had increased serum ferritin, at examination presented a BMI of 28 Kg/m2 and cutaneous lesions compatible with cutaneous porphyria. The study revealed an increased ferritin (1482.9 ng/mL), C hepatitis (genotype 4), heterozygote mutations for C282Y, increased urinary porphyrins, no signs of hepatic cytolysis or cirrhosis. Attempted treatment with Peg-INF and ribavirin without therapeutic response. For lack of therapeutic options began phlebotomies plan with normalization of ferritin and improvement of the viral load. When the new treatments appeared, he was treated with Sofosbuvir/Ledipasvir with negative viral load and excretion of urinary porphyrins improved. During the treatment developed hyperglycemia and at the end of the treatment presented criteria of type 2 DM, with Hb A1c of 8.4% (which had not before), in probable context of iatrogenesis by Sofosbuvir + Ledipasvir.

Discussion: Hepatitis C is one of the main causes of chronic liver disease and the main cause of liver transplant. The new treatments have a demonstrated benefit in prognosis and quality of life. However, despite their benefit, some adverse effects may arise, such as type II DM induced by these drugs, described in obese patients. Good control of the blood glucose levels and Hb 1Ac before, during and after treatment allow to intervene early in the control of this pathology.
Infectious diseases
A-2187

Iatrogeny: a case of spondylodiscitis due to Staphylococcus caprae

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Spondylodiscitis are rare infections of the spine, which may include a component of osteomyelitis, discitis and spondylitis. Its diagnosis may be delayed by the high rate of back pain in the general population and the lack of specificity of the findings. The route of infection is mostly hematogenous and may occur due to iatrogeny.

The authors present 86-year-old man with history of ischemic heart disease, valvular heart disease (in the context of aortic stenosis), arterial systemic hypertension, atrial fibrillation, cerebrovascular disease with sequelar left hemiparesis and stage 3 chronic kidney disease. He was hospitalized due to anemia. During hospitalization, he started complaining of worsened lower back and left lower limb pain, gait abnormality. There was an increase in leukocytosis e C reactive protein. Blood and urine cultures, chest x-ray, computed tomography and magnetic resonance image were performed to rule out infectious etiologies and to better characterize the pain. A Staphylococcus caprae was isolated and the study of the spine documented an infectious spondylodiscitis in L5-S1, with epidural and discal component at L2-L3 level. Infectious endocarditis was excluded with echocardiography. Antibiotic treatment was initiated with ceftriaxone and rifampicine and there was progressive improvement of pain and motor function. Retrospectively, there was probable origin in a phlebitis associated with a peripheral venous catheter.

Staphylococcus caprae is a gram positive agent traditionally associated with mastitis in goats. Most cases in humans occur in nosocomial context, mainly around the implanted devices. This case aims to highlight the need for high clinical suspicion for the diagnosis of spondylodiscitis and for the need to establish safety and hygiene procedures in order to minimize nosocomial occurrences and infections.
Infectious diseases
A-1253

Imported Malaria in Spain: A case report.

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Introduction:
We report a case of Plasmodium falciparum malaria in the south of Spain in a Spanish man with Mali origin who reported a recent travel to his country.

Case description:
A 42-year-old visited the Emergency Department for one-week history of headache, weakness and arthromyalgia together with a dysthermia feeling that he attributes to respiratory infection.
The patient had no past medical history. He had spent two weeks in Mali, on his return to Spain he begins with shivering and sweating. He also refers abdominal pain and liquid diarrheic stools.
At physical examination the patient was hemodynamically stable on presentation. His blood pressure was 100/55 mmHg and heart rate was 99 bpm and a normal oxygen saturation, febrile. Findings of chest, cardiovascular and abdominal examination were unremarkable.
Blood test demonstrated low leukocyte and erythrocyte counts and thrombocytopenia. A peripheral smear was done that showed red blood cells contain forms consistent with P. falciparum infection with a parasitemia level of 2%. P. falciparum antigen was detected and subsequently confirmed by PCR.

Discussion:
Malaria remains a major place among the endemic tropical diseases causing 1 million deaths globally every year. When we have a suspicion of imported malaria, the diagnosis is always urgent. Diagnostic tests for malaria should be requested from any patient with fever from an endemic area.
The symptoms and signs are not specific. The most frequently detected are fever, headache and arthromyalgia. Malaria is a life-threatening disease, and any patient can show signs and symptoms of seriousness at a certain time.
In the currently case, the availability of an rapid diagnostic tests for malaria in the Emergency Department prevented a dangerous delay in hospitalization. This is especially important for rural emergency departments with limited local access to hematology services.
Infectious diseases
A-1169

Incidence and consequences of bacterial infections in patients with decompensated chronic liver disease – cirrhosis.

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Background: Over the last ten years, the overall mortality due to the consequences of liver cirrhosis has increased significantly and this is a continuous trend; in Slovakia it ranks 5th among all causes of mortality and Slovakia ranks 4th in Europe in this parameter. The mortality is greatly affected by infections.

Methods: Retrospective analysis of data in patients with ACLD hospitalized at HEGITO between July 2014 and September 2016.

Results: The study population included a total of 400 observed patients; inclusion criteria were satisfied by 354 patients; 95 patients (27%) had a confirmed infection complication. The occurrence of infections was as follows: urinary infections, spontaneous bacterial peritonitis and infections of respiratory tract. Approximately 49% of bacterial infections were healthcare associated, 35% nosocomial and 15% are community acquired. The most common type of microorganism isolated were Enterococci and K.Pneumoniae. The mortality during hospitalization was 17.9% in the population of patients with infection.(p=0.001).

Conclusion: Microbial infections represent a major problem in patients with ACLD. Early diagnosis and treatment of infection is pivotal in the management of patients with decompensated cirrhosis.
Infective endocarditis by the HACEK group mimicking lupus in a young woman: an evidence-based case report

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Introduction. Infected myxomas are rare and diagnosis is challenging, as features from uninfected tumors may overlap. Infection impacts negatively on prognosis and data regarding operative complications are limited. Herein we report a case of an infected mitral valve myxoma and review the literature to determine its epidemiology.

Case description. Female, 33 years, history of fever, headache and breathlessness, was admitted with hepatosplenomegaly, hemolytic anemia, thrombocytopenia, acute kidney injury with subnephrotic proteinuria and respiratory distress secondary to alveolar hemorrhage. She presented antinuclear antibodies 1/80 with a fine pointed pattern and mosquito-borne diseases were ruled out. However, infective endocarditis by Haemophilus species was evidenced, with a giant mass involving both mitral leaflets causing severe regurgitation by flail and perforation. She was transferred to our tertiary center for valve surgery. AngioMRI scan showed a mycotic aneurism of the left middle cerebral artery that underwent embolization. Splenic embolism was treated conservatively. After biological mitral valve replacement with extensive resection, aortic regurgitation developed, secondary to damage of the mitroaortic intervalvular fibrosa and the non-coronary aortic cusp. Histopathologic analysis indicated an infected myxoma and she was discharged asymptomatic upon completion of antibiotics.

Discussion. Myxomas are rarely found in the mitral valve and their infection is even less frequent in this position, accounting for only six reported cases in the literature. Exceedingly high incidence of embolic events and the occurrence of immune-mediated phenomena mimicking vasculitis are associated with high morbidity, which makes prompt echocardiogram, antibiotic therapy and surgery key to better outcomes. Our case fulfills criteria for the definitive diagnosis of an infected myxoma and it appears to be the third caused by the HACEK group.
Infectious diseases
A-2067

Infectious Endocarditis beyond major DUKE criteria

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INTRODUCTION
Infectious endocarditis (IE) is a severe disease, where a successful outcome is highly dependent on a prompt diagnosis and treatment. The diagnosis is established based on modified DUKE criteria. When major criteria are not present, the physician should actively search for minor criteria and a careful physical examination could be the key for the diagnosis.

CASE DESCRIPTION
A 78-year-old man with history of prior aortic valve (AoV) replacement with biological prosthesis presented to the emergency department with fever and a new onset grade 3/6 mitral murmur. The transesophageal echocardiography revealed an 8mm movable mass attached to the AoV. Empiric antibiotherapy with ampicillin, gentamicin and flucloxacillin was initiated for suspected IE. The blood cultures became negative. At the 7th day of hospitalization, some erythematous-purpuric macules appeared in both legs and the biopsy revealed lesions of neutrophilic vasculitis. This was compatible with Janeway lesions, therefore achieving definitive diagnosis of IE, according to modified DUKE criteria (1 major + 3 minor).

Despite the prompt treatment, this case had an unfavorable outcome. The patient developed complications such as perivalvular abscess, pseudoaneurism with periprosthetic leakage and eventually died at the 57th day of hospitalization.

DISCUSSION
Janeway lesions are one of the stigmata of IE. They are irregular, erythematous, flat, painless macules that mainly appear on the palms and soles and are very rare in clinical practice. They represent one of the minor DUKE criteria and in this case, were the key for establishing the diagnosis, since the patient’s blood cultures were negative. Whenever there’s a suspicion of IE one must start antibiotic therapy as soon as possible, as well as performing a thorough physical examination in search of the minor criteria that could establish the diagnosis.
Infectious Endocarditis: take two

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Infectious endocarditis (IE) is a disease with high morbidity. Despite diagnostic and therapeutic advances, it continues to be associated with elevated mortality and severe complications. The authors present the case of a 31 year old woman with a history of rheumatic cardiopathy; with mechanical mitral and aortic prosthetic valves, tricuspid ring, with subsequent cardiac heart failure. Lithiasic cholecystitis, treated conservatively.

Recent hospitalization for fever of unknown origin, with isolation of Salmonella non-tiphy, treated with Ceftriaxone for 20 days. Transthoracic echocardiogram (TTE) at the time showed no signs of vegetations. Rehospitalized one month later for fever, chills and vomiting for 5 days, with isolation of the same Salmonella spp. Underwent transesophageal echocardiography (TEE) that revealed a 6.4mm image next to the mitral ring, suggestive of a vegetation. Completed 43 days of directed antibiotherapy with Ceftriaxone, with negative control hemocultures (HC).

Cholecystectomy in order to reduce future risk of bacteriemia was postponed due to new onset of fever and chills. HC isolated, once again, Salmonella, initiating treatment with ceftazidime, with a TEE revealing a 12mm vegetation on the mitral prosthesis, without surgical indication according to Cardiology. Within a week of antibiotic therapy, the patient suffered an ischemic stroke, with a small inner "spot sign". Considering the stroke with hemorrhagic transformation, she now had indication for mitral prosthesis surgery, after a one month vigilance period.

In the meantime, a cholecystectomy was performed, new HC (after 41 days of ceftazidime) were negative and further ETE showed reduction in the dimensions of the mitral vegetation.

IE is associated with various complications, such as cardiologic, neurologic, renal and pulmonary lesions. Salmonella has the ability to adhere to the altered endothelium, thereby increasing the risk of endocarditis, myocarditis and pericarditis.
Infective Endocarditis after Dental Extraction revealed by Spondylodiscitis

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INTRODUCTION The pathogenesis of spondylodiscitis is mainly of haematogenous origin from a distant site and is influenced by various predisposing factors. It has recently been shown that infective endocarditis can be a common cause of spondylodiscitis. Its combination is potentially fatal and diagnose is often delayed.

CASE DESCRIPTION Autonomous 75-year-old male, with recent dental extraction, admitted with a 4-week history of lumbar pain and weight loss, with presence of motor deficit on neurologic examination. Blood analysis revealed elevation of inflammatory markers. Spondylodiscitis of L5-S1 vertebras was suggested by lumbar computed tomography and then confirmed by magnetic resonance imaging. Empirical large-spectrum antimicrobial therapy was initiated, but in the first 72 hours the patient developed congestive heart failure and presented a systolic murmur. Transthoracic echocardiogram revealed severe aortic stenosis and posterior mitral leaflet prolapse with regurgitation, suggesting endocarditis. Despite therapy adjustment, the evolution was unfavourable, developing acute respiratory failure. Transesophageal echocardiogram showed severe mitral insufficiency and ventricular pseudoaneurysm, confirming mitral valve endocarditis. Cerebral and abdominal embolization were excluded, and emergent aortic and mitral valve replacement were performed. Blood cultures taken in the admission isolated Peptostreptococcus micros, completing a total of 6 weeks of antimicrobial therapy with good results. The patient also initiated anticoagulation and physiatric therapy.

DISCUSSION This case of bacterial endocarditis which initially manifested as lumbar spondylodiscitis shows that this association should always be considered, independently of the primary diagnosis, aiming to prevent possible complications. The presence of bacteraemia supports the haematogenous dissemination of, in this case, Streptococcus as the infection agent, possibly related with the recent dental procedure.
Infective endocarditis after transcatheter aortic valve implantation: a case report

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INTRODUCTION: Transcatheter aortic valve implantation (TAVI) represents a paradigm shift in the treatment of aortic stenosis in high-risk patients. Although safer than conventional surgery, some risks are the same, such as infective endocarditis (IE). Because of their comorbidities, patients submitted to TAVI have a higher risk of infection and a higher probability of atypical presentation of IE, hindering its diagnosis.

CASE DESCRIPTION: We describe the case of an 83-year-old female, with type 2 diabetes, atrial fibrillation, stage 3 chronic kidney disease and history of TAVI for 10 months. Over this period she had multiple infectious complications, including one hospitalization for Streptococcus mitis bacteraemia and two other for urinary tract infections without bacterial growth. She was admitted for dyspnoea at rest and fever. In the physical examination she was pale, feverish, and auscultation revealed a grade III/VI holosystolic murmur and bilateral inspiratory rales in the lower lung fields. Empiric antibiotherapy was initiated with vancomycin, gentamicin and rifampicin. Transesophageal echocardiogram (TEE) revealed a small vegetation in the aortic prosthesis and blood cultures were negative. Due to her high-risk profile, surgical treatment was ruled out. After 42 days of treatment, TEE was repeated, and the vegetation had resolved.

CONCLUSION: Post-TAVI IE is a rare complication of the procedure, with an incidence of 0.3-2.1% after the first year. A high level of suspicion for this entity is crucial for its diagnosis. Nonetheless, treatment of post-TAVI IE is still a challenge because of the scarce experience.
Infective endocarditis – What are the odds?

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INTRODUCTION
Infective endocarditis (IE) is a challenging diagnosis: it is suspected in the presence of fever and cardiac risk factors and it is established by clinical, microbiology and echocardiographic data.

CASE DESCRIPTION
Woman, 66 years old, with rheumatic heart failure, submitted to replacement of aortic valve in 2008 (mechanical) and mitral valve in 2017, having pacemaker (PM) since 2002 but recovering own rhythm in 2017. Assintomatic Crohn’s disease (CD) under azathioprine and mesalazine. She was hospitalized due to sepsis with acute hypoxemic respiratory failure (AHRF). Echocardiograms (echo) showed no vegetations and 2 sets of aerobic blood cultures (BC) were negative. She was discharged after 14 days of piperacillin-tazobactam and vancomycin for nosocomial pneumonia. She was readmitted 36h later with fever, dyspnea and AHRF. New BC were negative and echo showed no vegetations (despite difficulties in full characterization of tricuspid valve). Thorax CT angiography had no signs of embolism but a right sided moderate pleural effusion (transudate after thoracocentesis). Abdominopelvic CT suggested CD activity (not confirmed by colonoscopy biopsies) without signs of embolization. Cardiac and full body PET scan was normal. Despite these results, persistence of fever and inflammatory markers led to IE as the possible diagnosis and the beginning of empiric antibiotherapy with vancomycin, gentamicin and rifampicin. After 2 weeks, gentamicin was suspended with recrudescence of fever. By this time, Pseudomonas aeruginosa was isolated from new BC and thorax CT revealed septic embolus in the lung. Ceftazidime and amikacin were started and she was submitted to PM extraction. Microbiologic analysis of PM was negative. She was discharged home after 6 weeks of antibiotherapy with resolution of clinical and laboratory signs.

DISCUSSION
In spite of successive negative imaging, the diagnosis of IE must be pursued in any patient with unexplained fever in the presence of PM.
Introduction

Emphysematous pyelonephritis is a necrotizing kidney infection consisting of the accumulation of gas in the kidney tissue, most commonly caused by Gram negative and anaerobic bacteria. Predisposing factors are: diabetes mellitus, end stage renal disease, immunosuppression, urinary tract obstruction.

Case description

A 67-year-old woman with a history of diabetes mellitus type 2 for 20 years, was admitted in our clinic for pollakiuria and dysuria. The clinical exam showed no pathological findings. Laboratory results identified a mild inflammatory syndrome (neutrophilic leukocytosis, erythrocyte sedimentation rate 70 mm/h, C-reactive protein 10 mg/dL), azotate retention (creatinine 1.70 mg/dL, urea 90 mg/dL), hyperglycemia (300 mg/dL, HbA1c 10%), leukocyturia, hematuria. The urine culture was positive for *Escherichia coli*.

Under antibiotherapy with ceftriaxone and ciprofloxacin, clinical and biological status got worse and patient became febrile. We performed an abdominopelvic computed tomography (CT) scan with contrast revealed emphysematous pyelonephritis, this being the underlying factor for poorly controlled diabetes mellitus. Antibiotherapy was switched accordingly to meropenem and metronidazole. Percutaneous nephrostomy and JJ stent was performed without improvement. Radical nephrectomy was chosen as a last resort treatment. The anatomopathological examination showed macroscopic and microscopic aspects of acute suppurative pyelonephritis.

Postoperative evolution was favorable with clinical improvement, better glicemic control and a significant decrease of the inflammatory syndrome.

Discussion

Emphysematous pyelonephritis is associated with high mortality if not identified early. The abdominopelvic CT scan with contrast medium allows the detection of gas bubbles or abscess. Emergency nephrectomy may be a therapeutic option.
Infectious diseases
A-1365

Influence of Hepatitis C treatment on CD4/CD8 ratio in HIV patients

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INTRODUCTION
The CD4 / CD8 ratio is a good biomarker for immune activation and inflammation in HIV-treated patients. Has been proposed that Hepatitis C virus coinfection contributes to inflammation and chronic immunoactivation in HIV patients. Therefore, the objective of this study is to assess if the eradication of HCV reduces this inflammation and the immune response in patients coinfected with HIV.

MATERIALS AND METHODS
All of HIV patients of our institution with undetectable HIV viral load and sustained viral response after HCV treatment, were included. To assess Immunoactivation, we used the CD4/CD8 ratio that was measured before and at three, six and twelve months after hepatitis treatment. Relation to sex, severity of liver fibrosis, scheme of ART and the type of HCV treatment was investigated. We used the non-parametric Wilcoxon T-test for differences of means of paired groups.

RESULTS
191 patients were included (78% males, average age, 48.3 years) with an average of 26 months with CV < 40 copies/ml. The ART were 30.4% with PIs, 34.6% with NNRTIs and 26.6% with INSTIs. The distribution of HCV genotypes was 46.6% 1a; 17.3% 1b, 17.3% 3; 15.2% 4 and 1.0% 2. Peginterferon therapies were used in 26.1% and DAA in 73.3%. The degree of fibrosis was F0-1 16.2%, F2 17.3%, F3 18.8% and F4 37.7%. The median CD4/CD8 ratio prior to HCV treatment was 0.70 (IQR 0.50 to 1.13) and there were no significant changes in this figure after 3 months (median 0.73; IQR 0.52 to 1.04; p > 0.20), 6 months (median 0.69; IQR 0.50 to 1.07; p > 0.20) and 12 months (median 0.69; IQR 0.52 to 1.12; p > 0.20) of treatment. The sex, type of HCV treatment, severity of the fibrosis and the scheme of TAR did not have influence on these results.

CONCLUSION
The eradication of HCV in patients with HIV infection does not change the CD4/CD8 ratio, suggesting that the treatment of hepatitis C does not decrease the degree of Immunoactivation and inflammation in these patients.
Infective endocarditis (IE) is a serious disease with significant morbidity and mortality; In-hospital mortality ranges from 15-30%.

The objective of this study was to identify the factors that predict in-hospital mortality in a group of patients with IE undergoing cardiac surgery.

Methods: Retrospective, unicentric study including all IE patients undergoing cardiac surgery between January 2006 and October 2017. Patients with IE were identified according to the ICD9 classification, and their diagnosis was confirmed in agreement with modified Duke criteria. The characteristics of the non-survivors patients were compared with those who survived for a set of demographic, clinical and imagiologic parameters, as well as for the causes of endocarditis, affected valves, and isolated microorganisms.

Results: A total of 145 patients (72.4% male) were included, with a median age of 72 years. Non-survivors patients showed a significantly lower pre-surgical left ventricular ejection fraction [median 48% (interquartile range 11) versus 56% (interquartile range 17); p = 0.027)], as well as a higher frequency of preoperative atrial fibrillation (31.6% versus 11.1% p= 0.027).

Sepsis in the pre and postoperative period, the need to perform emergency surgery in the first 24 hours (compared to urgent or elective surgery), the presence of severe valve regurgitation associated with previous cardiogenic shock or the presence of tamponade as a postoperative complication, were also associated with a significantly higher mortality.

CONCLUSIONS: In patients hospitalized for IE and undergoing cardiac surgery, significant predictors of mortality included lower left ventricular ejection fraction, presence of atrial fibrillation, sepsis in the pre and postoperative period, the need for emergent surgery and the presence of tamponade as a postoperative complication. These results may help identify patients at greater risk of in-hospital mortality, although additional studies are needed.
Infectious diseases
A-2060

Invasive aspergillosis, 10-year analysis of ICU patients

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Background: Aspergillus in the environment is frequent and its spores are permanently inhaled. The most important factor for the appearance of invasive aspergillosis is host defense capacity loss in the immune system, occurring mainly in immunocompromised patients. More recently, risk factors have been identified in immunocompetent patients, such as chronic obstructive pulmonary disease (COPD).

Retrospective analysis of patients admitted to the Intensive Care Unit (ICU) with diagnosis of invasive aspergillosis between 2009 and 2018, and clinical presentation, risk factors and mortality were evaluated.

RESULTS: We identified 28 patients with typical risk factors associated with the onset of invasive aspergillosis: 9 patients under high-dose corticosteroid therapy (32.1%), 4 patients with active neoplasia and undergoing chemotherapy (14.3%), only one of them for haematological neoplasia, two patients with HIV infection (7.2%). Of the remaining risk factors presented: 11 patients with COPD (39.3%) and 14 diabetic patients. In half of the patients the isolated agent was Aspergillus fumigatus, and the most common form of isolation was the cultural examination of bronchial secretions obtained by endotracheal aspiration (n=15, 53.5%). Pulmonary aspergillosis was identified in 25 patients, followed by cerebral aspergillosis and cutaneous aspergillosis. The first line therapy was voriconazole in 20 patients (71.4%), followed by amphotericin B in 3 patients (10.7%). At admission, mean severity indexes were APACHE 31 (expected mortality 73.3%) and SAPS II - 58 (mortality 64.0%). Intra-ICU mortality was 64.3%.

Conclusions: Invasive aspergillosis is a disease with high mortality and patients presenting some degree of immunosuppression. There was also a high percentage of patients (64.3%) in whom no classical factor was identified. Therefore, there must be a high index of clinical suspicion for the early identification and treatment of the infection.
Kaposi’s sarcoma is a malignant neoplasm of the vascular endothelium that is multifocal in origin involving the skin and other organs, herpes type 8. We present the case of a 33 years old man, with fever, weight loss of 8kg, cough with purulent expectoration and tiredness, with a 4month evolution, in the context of pulmonary tuberculosis, who was under 1st line tuberculostatic therapy for 1 month. Due to the persistence of fatigue and the appearance of generalized edema, he go to the emergency department. On admission he presented with skin pallor, emaciated, with generalized oedema. Oropharynx without changes. Diminished respiratory murmur. Hepatomegaly and splenomegaly grade 1. Analytically with Hb 8g/dL normocytic anemia, HIV 1 positive, viral 864716 cp/mL, CD4 55cell/ul, albumin 1.97g/dL, AST32.4 U/L, ALT21.1U/L, sedimentation rate of 100 mm in the 1st hour. Serology for viral hepatitis B and C and VDRL negative. Chest X ray with interstitial pattern in the middle lobe and micronodular pattern in the apex of the left lung field, condensation in the lower right lobe. Abdominal ultrasonography with mild hepatomegaly and splenomegaly. Transthoracic echocardiogram with slight pericardial effusion. He was hospitalized with the following: HIV 1 stage 3C, pulmonary and extrapulmonary tuberculosis, normocytic anemia. Maintained tuberculostatic therapy and started corticotherapy due to pericardial involvement. Developed hepatic cytolysis and stasis, secondary to tuberculostatic therapy, and aggravation of the anemia worsening requiring transfusional support. Iron, total iron binding capacity and transferrin were normal and ferritin elevated. B12vitamin and folic acid were normal. Underwent upper digestive endoscopy which revealed changes compatible with esophageal candidiasis and visceral Kaposi’s sarcoma, which were confirmed by anatomopathological examination. Kaposi’s sarcoma is reported as the initial manifestation of the AIDS syndrome in approximately 30% of cases.
Knowledge, attitude and motivation of health care workers towards influenza vaccination

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Objectives

Healthcare workers (HCWs) are considered a target group for yearly vaccination against influenza, as they are often in close contact with sick people. In practice, vaccination coverage among HCWs is low; in Belgium, it is estimated to be around 52%. A better understanding of the processes behind a positive attitude towards vaccination might help guiding campaigns to increase vaccination coverage. This study aims at generating insight on knowledge, attitude and motivation towards influenza vaccination among HCWs at the Universitair Ziekenhuis Brussel (UZB).

Methods

A qualitative study was performed among HCWS of the UZB, a tertiary teaching hospital. All HCWs received an invitation to participate to an online survey. HCW was defined as all people working in the hospital who might encounter patients directly or indirectly. The survey evaluated not only the personal attitude towards influenza vaccination, but also the motivation to accept or refuse vaccination and the knowledge about influenza.

Results

More knowledgeable HCWs tend to get vaccinated more commonly. This is especially true for HCWs with excellent knowledge on the topic compared to participants with average knowledge (78.30% vs. 60.90%, p = 0.00319). Furthermore, the decision to get vaccinated is influenced by how the disease is perceived: HCWs agreeing with ‘influenza is a serious illness’ show a significantly higher vaccination rate (70% vs. 58%, p = 0.0043) than those denying the seriousness.

Conclusions

Increasing the knowledge on influenza and influenza vaccine may lead to higher vaccination rates among HCWs. Vaccination campaigns in hospitals might therefore be more successful when coupled to specific educational programs.
Latent late Syphilis. About a case.

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INTRODUCTION: Latent syphilis refers to the period in which a patient is infected with Treponema pallidum (as shown by serological tests) but has no symptoms.

DESCRIPTION: A 68-year-old man with a history of four glasses of wine per day, pancreaticoduodenectomy secondary to pancreatitis of enolic origin and last year's admission for abdominal sepsis secondary to liver abscesses. It is native to Morocco and resides between Tangier and Marbella, last trip to Tangier two days ago. He has a weight loss of 5Kg in about a year, with asthenia and anorexia for a month, but these days he has intensified. No stable relationship. Consistent constipation, constipated habit, but refers to dark-looking stools without pathological products. No abdominal pain, clear urine without coluria. A single episode of food vomit. Febrile sensation not thermometrated, with shivering without night sweating. No chest pain, eupneic. Without referring trips to the tropics and denies contact with animals, he refers not to live in the countryside. No other accompanying symptomatology, without presenting skin lesions. During admission, complementary tests are requested, including positive serology for LUES, which is why he performs a lumbar puncture that confirms the diagnosis.

DISCUSSION: It is important to differentiate between early and late latent syphilis to understand the risk of transmission to others. Patients with late latent disease are not considered infectious for their recent sexual contacts, since they do not have lesions that can transmit the disease. In contrast, patients with early latent syphilis may have transmitted treponema pallidum to their sexual partners through lesions that were recently active, but are no longer present. The differentiation of late latent disease also has implications for treatment.
Legionnaires disease: descriptive study in a tertiary hospital.

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Objectives: to describe Legionnaires disease in a tertiary hospital.

Methods: cohort of patients admitted to the Hospital Universitario Marqués de Valdecilla (Spain) between 2012-2017, diagnosed with Legionnaires disease. Epidemiological and clinical characteristics, diagnostic tests, treatment performed and outcome were analyzed.

Results: 75 patients were registered: 42 men. Mean age 65 +/- 15 years. 70 community-pneumonia: 6 spa, 1 air conditioning. 5 associated with health care: 4 hospital home-care-unit, 1 old people’s home. Mean hospital stays 11 +/- 11 days. Immunosuppression causes: smokers 31%, diabetes mellitus 23%, malignancies 7%, glucocorticoid therapy 8%, liver disease 8%, transplant 3%, chemotherapy 1%, HIV 1%. Symptoms: fever 77%, weakness 43%, respiratory failure 20%, encephalopathy 19%, myalgias 28%, arthralgias 19%, diarrhea 12%. Analytical aspects: elevated transaminases 27%, renal failure 28%, sodium 132 +/- 3, CRP 24.19 +/- 7.13. All antigenuria were positive except three. 74 patients had radiological pneumonia: unilateral 84%, bilateral 15%. 7 had co-infection by other microorganism. 8 needed mechanical ventilation. 64 received Levofloxacin and 10 dual therapy: Levofloxacin + macrolide. The average duration of treatment 12 +/- 4 days. 21 admitted to ICU and risk factor: positive serologies RR 22.79*, pneumonia RR 8.36*, renal failure RR 5.56* and respiratory failure RR 4.05*. Mortality rate was 4% and prognostic factor: mechanical ventilation RR 25.79*, co-infection RR 12.14*, dual therapy RR 8.70*, ICU admission RR 8.04*, pneumonia RR 6.76* and encephalopathy RR 4.74*.

Conclusion: Legionnaires disease is a more severe pneumonia than others etiologies. It’s necessary an early initiation of antibiotic therapy. The mortality increases in immunocompromised patients or who present with severe illness at the onset of therapy and needed ICU admission. Although the number of exitus in our series was low, patients who required mechanical ventilation, presented co-infection, encephalopathy, pneumonia, received dual therapy and ICU admission died more frequently. *p<0.05
INTRODUCTION:
La dépression immunitaire expose le dialysé chronique aux infections notamment la tuberculose. La réponse au traitement et la survie du dialysé sont étroitement liées à la précocité de la mise en route des antituberculeux. Toutefois, ce traitement n’est pas dénué d’effets indésirables.

MÉTHODES:
Etude rétrospective sur 10 ans incluant les malades dialysés traités pour tuberculose. L’objectif est de préciser les effets indésirables du traitement anti tuberculeux.

RESULTATS:
Il s’agit de 53 malades atteints de tuberculose évolutive en dialyse. Tous les malades avaient reçu une chimiothérapie antituberculeuse. 23 malades (43,4%) avaient développé des effets indésirables secondaires à ce traitement.

22 malades étaient en hémodialyse et un en dialyse péritonéale.
Un bilan pré thérapeutique était réalisé dans tous les cas. Le bilan hépatique était normal, le taux moyen d’albumine, d’hémoglobine et de globules blancs était respectivement de 30 g/l ; 7,5 g/dl et 7587 éléments.
Le traitement était basé sur une quadrithérapie (isoniazide, pyrazoline, rifampicine et éthambutol) dans 52,2% des cas et une trithérapie (isoniazide, pyrazoline et rifampicine) dans 47,8%. La durée totale du traitement était en moyenne de 234,27 jours.
17% des malades avaient présenté une intolérance digestive. Une cytolysée était observée chez 5 patients, compliquée d’une insuffisance hépatocellulaire et de décès dans un cas. Une réaction cutanée était notée chez 6 patients dont 2 cas de toxidermie sévère. Une atteinte hématologique était survenue chez 2 malades. Un patient avait développé une névrite optique rétrobulbaire.
Les médicaments incriminés étaient l’isoniazide et la rifampicine dans 88,2% des cas, la piazoline dans 95% des cas et l’ethambutol dans 63% des cas.

CONCLUSION:
Les effets indésirables des antituberculeux sont fréquents et imprévisibles. Un contrôle rapproché et ciblé est recommandé pour pouvoir les déterminer à temps et prévenir les formes graves.
Listeria Meningitis in Immunocompetent - A Case Report

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INTRODUCTION: Listeriosis is a rare disease caused by Listeria monocytogenes and is associated with high rates of mortality and unfavorable outcome. The risk group are pregnant woman, the elderly and immunocompromised individuals.

CASE DESCRIPTION: 78-years-old caucasian man, in holidays in our country with uncomplicated essential hypertension and atrial fibrillation treated with apixaban, bisoprolol, propanolol and sinvastatin, that come to hospital with 24h of fever, nausea and vomiting with innocent blood tests and Xray. 24h later was admitted in ITU with fever, altered consciousness and neck stiffness. GCS8 (O4,V1,M3) with peripheral hiporreflexia. RCP extension at right / flexion at left side. Leucocytes 17.6x10³/uL, N 91%, platelets 131x10³/uL, CRP 195mg/dl, glucose 103mg/dl, with no disfunction organ, VDRL, HIV, HBV, HCV negative, CT brain normal. MRI presents 2 restriction focus at lateral ventricles compatible with infectious process. No hydrocephalus. Treatment was begun with ceftriaxone and acyclovir after taking blood cultures that showed at 3th day Listeria monocytogenes. Therapeutic was changed to ampicillin and gentamicin during 21 days. First lumbar puncture (delayed because apixaban treatment): CSF yellow, turbid, low pressure, 267 cells/mm³ (85% lymphocytes), glucose 53mg/dl, protein 399mg/dl, Gram stain positive for bacteria, culture negative. Despite the normalization of proteinorraquia and cellularity patient maintain severe neurological sequelae with very low cognitive function. On 30th day of admission his clinical status deteriorate: CSF-normal, CT brain-acute hydrocephalus. An external ventricular catheter was inserted.

DISCUSSION: We emphasizes importance of covering empirically for Listeria in all bacterial meningitis, either with negative cultures to avoid severe neurological sequelae.
Liver abscess caused by fishbone

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Introduction: The liver abscess is a pathology uncommon in patients without backgrounds. Even more infrequent is the existence of a foreign body as a cause of it. The most common are the trorns of fish in countries with high consumption of fish. The strange associated germ and the virulence of the picture require special mention.

Case description: 52-year-old male with no history except pyorrhea with extraction of multiple teeth before admission. Admission for epigastric pain and 40 degree fever for four days. Analytics with hypertransaminaseia, RCP 21, 14,000 leukocytes, prothrombin activity 58%, thrombocytopenia 38000, creatinine 2.1. Hypotension 50/30 requiring admission to the ICU for vasoactive intensive fluid therapy. Was treated with imipenem. TAC of the abdomen is performed with a heterogeneous collection of 9x8 cms in hepatic segment III, tuck gastric greater curvature.

Blood culture and culture of percutaneous aspiration was positive to gemella morbillorum. Gastric ulcer and neoplasm were ruled out. A percutaneous drain is placed. Control TC showed a reduction of the lesion to less than 2 cms.

He was released from the hospital with 21 days of treatment. Return 7 days after discharge with fever, increased liver access and appearance of two satellite minor accesses. Intervened by laparotomy and fishbone removal completing a month of antibiotics with clavulanic amoxicillin and metronidazole without new readmissions.

Discussion: liver abscess is rare in occidental society with incidences of 11.8 in male y 9.7 en femail per million. The mortality is high (26.95 at the 30 days of diagnostic). The most common germs is E. coli, klebsiella pneumoniea, bacteroides, enterococcus, streptococcus and staphylococcus. The liver accesses associated to foreign body ingestion are very rare only 60 cases described and only 10 cases described by gemella morbillorum and anyone associated to a foreign body. His presence oblige to rule out endocarditis, gastrointestinal ulcer and neoplasm.
Ludwig Angina – A story of Tonsilar abcess with fasciitis and mediastinitis

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Introduction - Ludwig's angina is an infection of the submandibular, sublingual and submaxillary spaces. It's an aggressive, rapidly spreading cellulitis, potentially leading to airway obstruction, requiring careful monitoring and rapid intervention to prevent asphyxia and aspiration pneumonia.

Case Description – Man, 60 years old, autonomous, previously suffering from Rheumatoid Arthritis, Osteoarthritis, benign prostatic hyperplasia, and allergic to amoxicillin and clavulanic acid, presenting at the ER with fever, odynophagia and bilateral swelling of the neck, having been treated with benzilpenicilin. GCS 15, without dyspnea. On ORL evaluation he was placed under ceftriaxone and clindamycin therapy. The initial analytic evaluation was slightly abnormal, with a C reactive protein of 3,4. Neck and chest CT revealed gas bubbles in the anterior and posterior mediastinum, extending to the base of the neck, traducing necrotizing fasciitis, probable starting point at the left tonsil (abcess), as well as right tracheal deviation and airway narrowing.

He is then transferred to a reference hospital, after airway is secured with an endotracheal tube, there being submitted to exploratory neck and chest surgery.

After 37 days in intensive care underantibiotherapy, ventilatory and vasopressor support, achieving post-surgery clinical stability, he is transferred back for continued care.

Discussion - Airway compromise is a complication of Ludwig's angina, requiring urgent evaluation. Mediastinitis is a rare complication resulting from spread to the parapharyngeal space and from there to the retropharyngeal space and superior mediastinum. With systemic antibiotics and aggressive surgical intervention, the mortality rate for Ludwig's angina has declined drastically from 0 to 4%.
Introduction - Lung abscess is defined as necrosis of the pulmonary tissue and formation of cavities containing necrotic debris or fluid caused by microbial infection. Multiple, and small abscesses can be referred as “necrotizing pneumonia” or “lung gangrene”. Despite being manifestations of a similar pathologic process. Failure to recognize and treat lung abscess leads to poor clinical outcome.

Case Description – Man, 71 years old, institutionalized, dependant in everyday care, suffering from hypertension, Diabetes which led to right leg amputation, left hemiparesis from past stroke. Arrives at the ER with high fever, dyspnea and dessaturation, aggravating in the last week. Analytical investigation revealed neutrophilia and c-reactive protein of 7.92. Cultures were all negative. X-ray identified a pleural effusion, exsudate, steril and chest CT clarified a right organized collection of fluid noticing hydroaereal level suggesting an abscess. Several failed attempts of abscess drenage required a CT guided drenage.

Discussion – The prognosis is generally favorable. Over 90% of lung abscesses are cured with medical management alone, Host factors associated with a poor prognosis include advanced age, debilitation, malnutrition, immunosuppression, malignancy, and duration of symptoms greater than 8 weeks. The mortality rate for patients with underlying immunocompromised status or bronchial obstruction who develop lung abscess may be as high as 75%. Aerobic organisms, frequently hospital acquired, are associated with poor outcomes. The overall mortality rate of lung abscesses caused by mixed gram-positive and gram-negative bacteria are approximately 20%
Infectious diseases
A-1390

Lyme aortitis

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Introduction
Lyme disease is caused by Borrelia burgdorferi, transmitted by the tick Ixodes ricinus bite. The presentation is variable and multisystemic. The symptoms of infectious aortitis are nonspecific, making early diagnosis difficult.

Case Description
A healthy 72-year-old man, portuguese caucasian, with contact with hunting dogs. Appealed to emergency with sudden precordial pain with irritation to the back. Presented with hypotension, cold extremities and cyanosis. Acute Coronary Syndrome was excluded. Angio CT Thorax: diffuse parietal thickening of the arch and descending thoracic aorta. Transesophageal Echocardiogram: dilatation of root and proximal ascending aorta and complex atheromatosis of the thoracic aorta. The patient was admitted to the hospital. Initiated vespertine fever. He had a two-tiered testing positive for Borrelia burgdorferi. Was excluded other infections and immune diseases. The diagnosis of Lyme vasculitis of thoracic aorta was made. Antibiotic therapy was started with doxycycline 1 mg/kg/day. He presented resolution of the symptoms and inflammatory parameters. A control Angio CT revealed dissection of the thoracic aorta and Transesophageal Echocardiogram and Catheterization revealed a Stanford type A and a 34mm of false lumen. A surgery with placement of a prosthesis was performed. At follow up 2 months after surgery, the patient is asymptomatic.

Discussion
At the moment, there are no cases reported to Lyme vasculitis, hence the importance of this case. The early diagnosis and treatment (medical and surgical) is fundamental to reduce mortality. In this case, despite the presence of factors of worse prognosis, the resolution was favorable.
Lymphadenopathy in elderly patient – A case of tuberculosis lymphadenitis

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Introduction: Tuberculosis remains in the 21st century as one of the most prevalent conditions worldwide, with high mortality in some countries. Disease presentation as lymph node tuberculosis is the most frequent form of extrapulmonary presentation. Chronical evolution, especially in elderly patients, renders the diagnosis more difficult, since the presence of lymphadenopathies are generally associated to other diseases in this population.

Case description: A 81 years old man, with past medical history of hyperkeratotic Bowen's disease and terminal renal disease (in hemodialysis), reports multiple, persistent cervical and axillary lymphadenopathies for the past 3 years, asthenia, anorexia and progressive cachexia, for the past year, which was confirmed by physical examination. He also presents a localized edema in a left upper limb (without relation to arterio-venous fistula in that limb) and in the lower limb. He had hypercalcemia and a cervical and thoracic CT scan confirmed the existence of multiple adenomegalies, both in deep and superficial territories, but no organ enlargement or space-occupying lesions. An aspiration biopsy of a cervical adenopathy was performed, revealing lymphocytes and BAAR within necrotic debris. The diagnosis of lymphadenopathy tuberculosis was made, and treatment with rifampicin, isoniazid and pyrazinamide started, however without success, as the patient's condition continued to decay.

Discussion: This case aims to call for the attention to an underdiagnosed, insidiously progressive and lethal pathology, otherwise with good prognosis if treated. The prevalence of tuberculosis is higher in hemodialysis patients, probably due to reactivation. In elderly people, considering as differential diagnose with lymphadenopathies, even with absence of history of bacillary exposure, the diagnose can lead to effective therapy and favorable outcome.
MAC infection in an immunocompetent patient

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Introduction: Atypical mycobacteriosis occurs only in a minority and is usually due to predisposing factors such as structural lung disease or immunosuppression.

Case description: The authors report the case of a 64-year-old woman, with arterial hypertension, valvulopathy with a mechanical mitral valve and chronic sinusitis. She was admitted to the ER with fever, night sweats, loss of 7% of total body weight and asthenia for the last 3 months. During this period, she was treated with 4 different beta-lactam antibiotics assuming respiratory infections, with only partial response. On physical exam, she was underweight (BMI 17 kg/m²) and had a mitral systolic murmur. Blood analysis showed CRP 249.7mg/L, ESR 106 mm/h and euvoletic hyponatremia. Chest X-ray presented nodular infiltrates. Serologies were negative for syphilis, HCV and HIV with previous contact with HBV. ANA, ANCA and ENA were negative. Blood cultures were negative in 3 different timings. Infective endocarditis was excluded. Thoraco-abdomino-pelvic CT revealed multiple micronodular lesions, with tree-in-bud pattern associated with coalescent nodules, with peripheral distribution. Sputum culture isolated Enterobacter cloacae complex and it was started Piperacillin/tazobactam, with clinical improvement. Lung biopsy showed a pattern suggestive of organizing pneumonia (OP). The patient was then started on systemic glucocorticoids for cryptogenic OP (COP). Weeks later, bronchial washing samples were positive for Mycobacterium intracellulare (MAC), being assumed an OP secondary to MAC infection. It was started antimycobacterial therapy.

Discussion: OP may be associated with several conditions, namely respiratory infections, drugs, connective tissue diseases... When no association is found, it is termed COP. The distinction is crucial, since the management of secondary OP requires treatment of the underlying disease or potential avoidance of the trigger, as COP, typically, presents good response to corticotherapy.
Malaria in a private hospital

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Objectives: Malaria is an endemic disease in central and south America, southeastern Asia, Africa and Oceania. In Western non-endemic countries many cases are imported and increasing in numbers, due to the growth of migrants from endemic areas and more travelers going to endemic areas who do not make prophylaxis properly. The authors describe their clinical experience on patients diagnosed with Malaria admitted in the hospital ward, in order to characterize the behavior and expression of imported Malaria in Portugal.

Methods: Descriptive and retrospective study, reviewing the clinical process of all patients diagnosed with Malaria between 2012 and 2017, including initial symptoms, diagnostics tests, epidemiology, treatment and outcome.

Results: 14 cases had moderate to severe Malaria, average age 39 years, most were males (86%), returning from Angola (71%), none took chemical prophylaxis prescribed. Initial symptoms were fever, vomiting, diarrhea. All were infected with Plasmodium falciparum, median parasitemia of 8%. About 28% of patients had criteria of severe Malaria and needed ICU care (severe anemia, SARS, acute renal failure); 42% received atovaquone+proguanil and doxicicline; 60% of those treated with quinine presented toxicity symptoms. None died.

Conclusion: The close relation between Portugal and African countries endemic to Malaria makes it important for Internal Medicine doctors to keep in mind this serious disease. Although some cases evolve to rapid severe organ failure forcing supportive measures, the early diagnosis and treatment allowed a final favorable outcome for all patients.
Mediastinitis and pleural empyema following retropharyngeal abscess: was it predictable?

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Introduction: Retropharyngeal abscess’s incidence has lowered since the widespread use of antibiotics. However, mortality remains high due to associated complications, mainly in low immunity patients. Case Description: a 49-year-old man, with medical background of rheumatoid arthritis on methotrexate and corticoids, was admitted in the ER with a two-day history of fever, sore throat and dysphagia. Laryngoscopy revealed swollen posterior pharyngeal mucosa till the epiglottic fold with bulging of vallecula and piriform sinus. Cervical CT confirmed retropharyngeal abscess leading to surgical drainage and admission in the intensive care unit under amoxicillln-clavulanate plus clindamycin. Significant clinical improvement followed, and he was extubated the day after. On the subsequent day, he reported intense back pain, respiratory failure developed and inflammatory markers raised. A thoracic and abdominal CT scan was performed revealing cervical soft tissue gas and mediastinitis with left septate pleural effusion – ultrasound guided pigtail catheter was use to drain and wash a foul-smelling empyema. Cultures yielding Prevotella, Gemella morbillorum and coagulase negative Staphylococcus led to adjustment to metronidazole plus ceftriaxone. The patient improved and follow up CT scan showed mediastinitis resolution and residual pleural effusion. Discussion: In the reported case, full diagnosis remained obscure until complete clinical picture evolved, raising awareness that once established retropharyngeal diagnosis serious potential complications must be anticipated, since retropharyngeal space may serve as a conduit between the neck and the mediastinum, which is fortunately rare. CT scan is indicated following clinical suspicion and as a follow-up modality. Early direct antibiotic therapy must be yield taking in consideration anaerobic predominance as etiologic organisms.
INTRODUCTION: Staphylococcus aureus infections are becoming more frequent. Most cases present an infection of skin and soft tissue, and the most invasive forms observed are osteoarticular and pleuropulmonary infections. Meningitis is a rare manifestation of Staphylococcus aureus infections. We describe an unusual case of methicillin resistant Staphylococcus aureus (MRSA) infection.

CASE DESCRIPTION: A 52-year-old man, active consumer of inhaled cocaine and intravenous heroin. Diagnosed of HIV infection for more than 15 years, in active treatment, with good virological and immunological control. Coinfected by HCV.
He presents fever without clear infectious etiology, of several days of evolution, together with mild abdominal pain, episodes of diarrhea and pain in the left hip. Hospitalization was decided with diagnosis of sepsis due to probable enteral focus; antibiotics were indicated. A cranial TC, echocardiogram, pelvic resonance, x-rays were performed, all normal. Blood cultures and cerebrospinal fluid culture were positive for MRSA. Sepsis with meningitis by MRSA was diagnosed. Antibiotic treatment was adapted and evolved satisfactorily.

DISCUSSION: MRSA is a relatively uncommon but serious disease. Although most cases are nosocomial infections appearing in neurosurgical patients, spontaneous meningitis may present to community-onset infection in patients with severe comorbidities requiring frequent contact with the health care system.
In most cases, the mechanism by which meningeal infection occurs would be haematogenous spread from distant infectious foci, such as osteomyelitis, arthritis, pneumonia or endocarditis, discarded in the case of our patient described. Although sometimes it arises from a local extension to the subarachnoid space. The diagnosis of the infection is made by isolating the germ in organic liquids (blood and cerebrospinal fluid). Most patients have a favorable response to vancomycin. MRSA meningitis is associated with a high mortality.
Infectious diseases
A-2263

Microbiological pattern in a Portuguese Population

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Objectives
In an inpatient setting, early and appropriate empirical antibiotic therapy directly influences the prognosis of the patient. Nevertheless, the microbiological data are fundamental in the possibility of reducing the number and the spectrum of the antibiotics, limiting the duration of their use and being also determinant in the monitoring of bacterial resistance standards. The objective of this study was to evaluate the spectrum of microorganisms detected in cultural examinations in a group of patients in the Internal Medicine department.

Methods
This is a retrospective observational study, through consultation of the computer clinical process, in a public Portuguese hospital. We studied the patients admitted to an internal medicine ward with discharge between July 1, 2017 to December 31, 2017.

Results
We admitted 507 patients, and 272 cultural examinations were carried out, with only 35% isolated microorganisms. Of these, 20 positive blood cultures, 76 positive urine cultures, 6 positive sputum cultures, and 4 positive coprocultures were found. The most frequently isolated agent in blood culture was Escherichia coli (40%). In urine, the most frequent agent was Escherichia coli (63%), 19% are producers of extended-spectrum beta-lactamases. In urine culture, also isolated Klebsiella pneumoniae (13%) and Proteus mirabilis (7%). In sputum it was observed a higher frequency of Pseudomonas aeruginosa (50%). As for coprocultures, Clostridium difficile positive antigen was detected in 4 patients.

Conclusion
The low profitability of the collection of cultural exams and the impact on therapeutics need an exhaustive reflection in the clinical practice, given the importance that the microbiological isolation has in the therapeutic adequacy.
Infectious diseases
A-2142

Microbiological Profile Retrospective Analysis of a Central Hospital Internal Medicine Unit

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BACKGROUND: World is heading towards a post antibiotic era, in which common infections can become lethal again. The indiscriminate use of wide spectrum antibiotics is causing a higher rate of virulent microorganisms. The need to know each Hospital ward epidemiology is mandatory to accurately decide an empiric treatment and optimize antimicrobial selection.

OBJECTIVES: Study the incidence, species distribution and antibiotic profile of an Internal Medicine Unit (IMU) patients of a central hospital, between January 2015 and December 2017.

METHODS: Retrospective analysis of all IMU admitted patient microbiological cultures. For the identification and antibiotic profile of the microorganisms, Vitek MS® and Vitek2® (Biomerieux) were used.

RESULTS: 1452 samples from 695 patients (average age, 80,8 years old; 57,3% females) were collected. Studied samples: 561 (38,6%) urines; 423 (29,1%) bronchial secretions; 313 (21,5%) blood cultures; 97 (6,8%) wounds exudates; 58 (4,0%) others. S. aureus was the leading cause of bloodstream infection (20,5%) which 83,7% were MRSA followed by E. coli (3;8%); K. pneumoniae (2,8%); E. faecalis (2,8%); E. faecium (2,3%). On remaining samples, K. pneumoniae was identified in 13,8%; 38,4% were carbapenemase producers mostly from urines followed by P. aeruginosa (10%) where 4,8% were only colistin susceptible and A baumanii (7,4%).

CONCLUSIONS: These results highlight the urgent need of coordinate efforts to improve quality of antibiotic prescription and thereby patient clinical outcomes. Regular surveillance of antimicrobial resistance must be effectively implemented in order to early identify emerging problems, decreasing unnecessary antimicrobial use and thus halting antimicrobial resistance.
Mortality rate of patients infected by HIV in Portuguese District Hospital 2011-2017

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Objectives: Characterize the causes of death in patients infected with HIV who died in the period 2011-2017 in our hospital.

Methods: A retrospective study of patients based in demographic variables related to the staging in diagnosis and evolution, HAART, coinfection, alcoholism, chronic liver disease (CLD) and death circumstances.

Results: There were 40 deaths, 80% in males; median age 46.5 years (33-81); risk factors: 17 - drug addiction, 20 – heterosexual transmission. At the moment of the first medical contact, the most frequent CDC stages were A2 and C3, 12 patients (30%) each; 16 (40%) had a CD4 count <200 / mm3, 9 <50 / mm3. The AIDS stage was reached in 62.5% of patients, and the most frequent AIDS-defining illnesses was pneumocystosis (PPc). Half the sample had coinfection, especially HCV (47.5%); 60% had alcoholism; 42.5% had CLD; 34 (85%) had previous admissions.

At the time of death, 67.5% of patients were on antiretroviral therapy (ART), 40% on viral suppression; at least 20 had CD4 <200 / mm3. Regarding the causes of death: 8 (20%) were due to complications of CLD, 7 (17.5%) due to opportunistic infection (OI), mainly toxoplasmosis and PPc; 6 (15%) due to progression of neoplastic disease (1, S. Kaposi; 1, NHL; 4, another); 15 (37.5%) due to other causes, mostly severe septic conditions. Thirty - three patients (82.5%), 70% in inpatient care - median of 12.5 days (1-177) - and 12.5% in the emergency department died in the hospital. Six deaths occurred in intensive care units.

Conclusions: There is a high OI representation in the mortality of HIV-infected patients, as well as significant complications of CLD and respiratory sepsis. These results reflect the high rate of patients with late presentation, insufficient adhesion to HAART, and high prevalence of viral coinfection and alcoholism.
**Multifocal pyomyositis, septic arthritis, osteomyelitis, pneumonia, empyema and bacteremia due to CA-MRSA in a male adult with hemophilia, treated with combination of daptomycin and vancomycin**

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Introduction: Pyomyositis is an uncommon skeletal muscle infection, usually caused by Staphylococcus aureus. Sepsis and metastatic abscesses are often described.

Case description: A 47-years-old man with hemophilia presented due to muscle pain and fever up to 40oC. Symptoms had begun after a dog bite at the right calf. He had dyspnea, bilateral thigh and calf pain and inability to walk. Gradually, arms and neck were affected. Acute phase response markers were elevated. Chest radiograph revealed pleural effusion and multiple infiltrates. Vancomycin, ceftriaxone and clindamycin were administered. After 48 hours, blood cultures grew MRSA (PVL+). CT scans revealed empyema, multiple bilateral lung nodules and large abscess affecting the chest wall. Leg MRI revealed abscesses with enhancement after contrast administration and findings suggestive of septic arthritis and osteomyelitis of the left ankle. Pus aspiration from all sites showed the same MRSA. Vancomycin and daptomycin were given. Drainage of the empyema and multiple surgical incisions and debridement were performed. After seven weeks of daptomycin and four weeks of vancomycin, he was discharged with co-trimoxazole and rifampicin for 16 weeks. He is cured with no signs or symptoms of relapse after 2 years.

Discussion: Other medication was ruled out due to adverse events (tigecycline, clindamycin). Linezolid was considered potentially harmful in this patient with thrombocytopenia, hemophilia and the need of multiple surgical interventions and long target duration of treatment. In the era of individualized treatment with no evidence of antagonism between daptomycin and vancomycin, this combination was used in this difficult to treat patient.
Multiple brain abscesses in an immunocompetent patient

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INTRODUCTION: The S. anginosus group is one of the main producers of abscesses of the central nervous system (CNS) due to contiguity or bacteremia.
DESCRIPTION: Man of 21 years, antecedents of bronchial asthma, that attends to urgencies for having presented loss of consciousness in the previous hours. It refers cefalea holocraneal of 1 month of evolution that prevents him sleep, with fotosensibilidad, rinorrea purulenta and fever of several weeks of evolution and has been diagnosed of sinusitis by otorrinolaringologo. Has been in treatment with 2 cycles of antibiotic (cefditoren 200 mg / 12 hours during 10 days), corticoides intranasales and descongestivos without improvement. To the exploration finds with general discomfort, been of consciousness conservado. No signs of neurological focus, negative meningeal signs. Pain to the palpation of region of frontal breasts. Analítica: Polimerase chain reaction (PCR) 1.60 mg/dl. Leucocitosis 17490 with polymorphonuclear 15.110. Renal and hepatic function normal. Red series, platelets and coagulalation normal. Computed tomografic (CT) Cranial: first suspicion of encefalitis with accesses in parenchyma encephalic, in frontal zone, secondary to sinusitis with destruction of the back wall of both frontal breasts. Magnetic resonance imagine (MRI) Cranial: various frontal brain abscesses in vicinity to the frontal ventricle. It contacts with Neurocirugia and realises craniectomía with drainage of abscesos cerebral frontal bilateral, with crop of absceso positive for Streptococcus anginosus, realising tto antibiotic with ceftriaxone and metronidazole during 8 months given the persistence of brain lesions.
DISCUBSSION: CNS infections caused by S. anginosus are potentially fatal. Imaging with CT or MRI should be performed to evaluate collections that require drainage. Immediate surgical intervention for abscess drainage and timely initiation of appropriate antimicrobial therapy are essential.
Multiple liver abscesses caused by Streptococcus intermedius in an immuno-competent patient.

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INTRODUCTION
Streptococcus intermedius is a member of the "Streptococcus anginosus group", frequently found in the human oral cavity. Although rare, Streptococcus intermedius has been reported to cause liver and brain abscesses and infective endocarditis.

CASE DESCRIPTION
A 74 year old male, with prior history of hypertension and dyslipidemia, presented to the emergency department with a 3-day history of malaise and fever (up to 39°C), without abdominal pain. No history of prior infection, intravenous drug abuse, or travelling was reported. On admission, the patient was febrile and presented multiple oral cavities. Laboratory data revealed elevated white blood cell count and C-reactive protein, as well as affected liver function. HIV testing was negative. His abdominal ultrasonography demonstrated an enlarged liver, showing signs of hepatic steatosis and multiple hypoechoic lesions and computed tomography showed numerous enclosed low density masses. Empirically intravenous ceftriaxone and metronidazole were started till isolation of Streptococcus intermedius in blood cultures. Infective endocarditis was ruled out by transthoracic echocardiography. Under antimicrobial treatment and removal of the suspected causative focus by extracting the infected teeth, the infection parameters dropped while repeated ultrasonography demonstrated regression of the liver lesions. The patient was discharged after completion of 6 weeks of intravenous ceftriaxone.

DISCUSSION
The Streptococcus anginosus group of bacteria are low-virulence commensals of the gastrointestinal tracts of humans and may spread to the blood in individuals with poor oral hygiene. This may lead to infections such as brain and liver abscesses. This case illustrates the potential danger associated with untreated dental infections.
Mycobacterium avium complex (MAC) is a non-tuberculous mycobacterium that exists in the environment and can be acquired by ingestion or inhalation of aerosols from soil, water or biofilms. The disease can manifest itself in several ways, with pulmonary disease being the most common presentation.

Case report: Female, 28 years old, veterinary nurse, was referred to the internal medicine consultation due to marked asthenia, associated with erythema nodosum. Patient with normal physical examination, with exception of erythema nodosum. Analytically, the patient had a slightly elevated sedimentation rate, normal angiotensin-converting enzyme, negative immunological study and negative viral serologies. In the etiological investigation, bilateral mediastinal adenomegalies were detected on thorax computed tomography, and bronchofibroscopy was performed to exclude sarcoidosis. Bronchial lavage showed a high CD4 / CD8 ratio and microbiological culture of bronchial lavage and aspirate with growth of MAC. She underwent mediastinal lymph node biopsy guided by echoendoscopy, which did not show granulomas. She initiated treatment for MAC infection, with a clear improvement in complaints of asthenia and no recurrence of erythema nodosum. Because the possibility of sarcoidosis cannot be discarded and the risk of recurrence of MAC disease is elevated, the patient maintains follow-up and vigilance at internal medicine consultation. The prevalence of MAC-related lung disease has been increasing. Environmental factors, increased virulence, and host susceptibility seem to be related. Pulmonary symptoms associated with imaging pulmonary alterations and positive sputum or bronchial lavage cultures are consistent with MAC lung disease.
Mycobacterium xenopi - a possible and unexpected etiologic agent of Cavitary Pulmonary Disease

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Introduction: Over the last two decades the advancement of microbiology techniques has allowed the identification of nontuberculous mycobacteria (NTM) in the respiratory tract, leading to a better understanding of its clinical significance in the etiology of pulmonary pathology. Within the approximately 160 known NTM species, Mycobacterium xenopi is one of the species most frequently associated with lung disease.

Case Description: A 48-year-old man with symptoms of poorly productive cough, asthenia, and night sweats during four weeks. On admission, no relevant clinical findings were identified. Radiographic imaging showed a pulmonary cavitation on the right lung's upper lobe posterior segment, measuring 5.8x3 centimeters and cylindrical bronchiectasis in the middle lobe and basal segments. Sputum acid-fast bacilli (AFB) smear positivity lead to patient's hospitalization in a respiratory isolation unit and antituberculous treatment with isoniazid, rifampicin, pyrazinamide and ethambutol was initiated. Several sputum AFB smear were performed but only the initial sample was positive. Nucleic acid amplification (NAA) testing for M. tuberculosis complex (MTC) was negative. Bronchofibroscopy with bronchoalveolar lavage was performed with negative AFB smear and MTC NAA testing. There was clinical improvement and the patient was discharged under antituberculous treatment. Mycobacterial cultures were positive for Mycobacterium xenopi, and therapy was adjusted.

Discussion: Even with clinical history and radiologic findings suspicious for Mycobacterium tuberculosis infection, the correct identification of the mycobacteria is fundamental both due to the need to initiate appropriate treatment and the consequences of possible erroneous reports in Public Health. In particular, Mycobacterium xenopi assumes great importance given its association with chronic pulmonary pathology, including bronchiectasis.
Mycoplasma pneumonia associated with hemolytic anemia: case report

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The most frequent clinical presentation of Mycoplasma pneumonia (MP) is respiratory tract infections. The extra pulmonary manifestations are uncommon and hematological complications may include autoimmune hemolytic anemia (AIHA). Cold agglutinins have been implicated in the etiology of the hemolysis.

The authors present a case report of a 61 years old woman with history of alcoholic liver disease admitted to our hospital for relevant fatigue. On physical examination the body temperature was 36ºC, she was tachycardic, had jaundice and normal chest examination. Blood count showed severe anemia, depressed haptoglobin and elevated lactate dehydrogenase and bilirubins. Direct Coombs and cold agglutinin IgM tests were strongly positive, which diagnosed cold agglutinin disease. A bone marrow aspiration and computed tomography rule out the possibility of an underlying hematological malignancy. MP IgM antibody was positive. She was treated with clarithromycin during 10 days, with symptoms resolution and hemoglobin increase.

We highlight a case of MP infection presenting as severe hemolytic anemia. In the presence of positive Coombs test MP infection was suspected and diagnosis was confirmed. Even in the absence of clinical evidence of pneumonia, MP may be the cause of severe anemia.
Mycotic Thoracic Aortic Aneurysm Due to Streptococcus Agalactiae: A Case Report

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Introduction
A mycotic aneurysm (MA) is the destruction of a vessel wall leading to dilatation of an artery caused by infection. Group B Streptococcus is an extremely rare cause. We report a case of infectious aortitis due to GBS complicated with MA of the thoracic aorta.

Case description
We describe an 87-year-old male with a 14-day history of malaise, chills, vomiting and fever. Previous diagnoses included hypertension and chronic kidney disease. At admission, he had 147/80 blood pressure, 61 b/min, and 37 ºC, with bibasilar crackles and a painless and soft abdomen. Laboratory revealed an elevated C-reactive protein; normocytic anemia and leucocytosis. Chest and abdomen CT was suggestive of infectious aortitis. Blood cultures were positive to a penicillin-susceptible Streptococcus agalactiae, starting intravenous Ceftriaxone. Transoesophageal echocardiogram showed a mitral-aortic intervalvular fibrosa thickening with an incipient abscess, although due to the patient’s age and good response to antibiotic, surgery was refused. After 6 weeks of parenteral antibiotics, evolution was favourable with disappearance of mitroaortic abscess.

Discussion
GBS causing an aortic MA is exceedingly rare. We reviewed the literature on cases of GBS-associated aortic thoracic and abdominal aneurysms reported from 1989 to 2017, finding eight cases. With a low rate of disease occurrence and poor sensitivity and specificity of signs and symptoms, diagnose can be challenging and it is frequently delayed. Treatment includes surgery in combination with antimicrobial therapy, although we suggest that in the absence of complications, in elderly patients medical therapy alone could be an option.
Human respiratory viruses infection like influenza infection most commonly affects the upper and lower respiratory tracts, but can involve also extrapulmonary sites, including the myocardium. We report a case of a previously diabetic adult diagnosed with pneumonia complicated with myocarditis caused by viral infection. The patient was male, 37 years old, and presented in the emergency department on March this year, with fever, pleuritic chest pain, dry cough and shortness of breath of 7 days duration. Chest X-ray and CT-scan findings depicted bilateral infiltrates and consolidations compatible with severe atypical pneumonia and bilateral pleural effusion and the test for Influenza like H1N1 in nasopharyngeal secretions was unavailable. Because of elevated cardiac enzymes and abnormal electrocardiograph (ECG), myocarditis was suspected, but not confirmed by Cardiac Magnetic Resonance (CMR) or biopsy. We concluded that myocarditis of various severity is an unusual and potentially fatal complication of some viral infection like influenza and high level of clinical suspicion is essential for timely diagnosis and treatment.
Neck tumor: a case of syphilitic tonsillitis

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Introduction. Syphilis is a sexually transmitted disease caused by Treponema pallidum. After the first stage of infection, bacteria disseminate causing multisystemic manifestations. This article presents an unusual case that mimicked head and neck lymphoproliferative disease.

Case description. Male, 16 years old, searched medical assistance due to a cervical tumor. Previously healthy, he noted the appearance of a painless submandibular node on the left that slowly increased in size throughout the past year, followed by weight loss, fever, pain to swallow, nasalized voice and satellite nodes. He had risky sexual behavior, smoked cigarettes and consumed alcohol. At admission, a hard deeply-adhered submandibular mass could be perceived at both sides along with bilateral ulcerated tonsillitis, a tongue ulcer, generalized lymphadenomegaly and papular rash. Inflammatory markers were elevated. Computed tomography revealed bilateral submandibular and neck lymphadenomegaly compressing adjacent structures. Lymph node biopsy revealed follicular and parafollicular lymphoid hyperplasia with capsular fibrosis. Infectious screening was negative, except for VDRL, which was positive at 1:1024. The diagnosis of secondary syphilis was presumed and two days after the first dose of benzathine penicillin all lesions dramatically involuted. The patient was discharged after the second dose of penicillin and remained asymptomatic at follow-up.

Discussion. Syphilis is a reemerging and neglected disease that impacts people at vulnerable conditions. It may evolve unnoticed and mimic other disorders. Therefore, syphilis screening is mandatory due to its long latent course, disabling complications and psychosocial stigma.
Necrotizing fasciitis after extravascular injection of illicit drugs.

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INTRODUCTION: Necrotizing fasciitis is a surgical diagnosis characterized by the friability of the superficial fascia, the water gray exudate and a notable absence of pus.

DESCRIPTION: A 42-year-old patient with a personal history of politoxicomania. Chronic hepatitis C virus infection, infectious endocarditis admitted to the emergency room due to an infectious process after injection of methadone diluted in water that could be contaminated, complicated by rhabdomyolysis and acute renal parenchymal failure, as well as soft tissue infection of the lower left limb from the region Inguinal, swollen aspect, very painful with flectenas and crepitus to the touch and vinous lesions in reticular distribution. Peripheral pulses present and symmetrical.

Venous Doppler ultrasound was performed, ruling out deep vein thrombosis. Assessed by the vascular surgery service that suspected arterial involvement, but ruled out revascularization.

Antibiotic therapy with piperacillin / tazobactam and clindamycin adjusted to renal dose, vasodilator with prostaglandins and prophylactic low molecular weight heparin is initiated.

Given the severity of the infection, acute renal failure and high suspicion of necrotizing fasciitis is admitted to Intensive Care for resuscitative measures of septic shock and the performance of lateral and medial fasciotomies in thigh and lateral and medial leg by service of traumatology with muscle necrosis of the lateral and external component, samples are taken for culture, resulting in positive for clostridium septicum.

DISCUSSION: Although C. septicum causes infections in patients with gastrointestinal entry portals such as adenocarcinoma or in those with congenital or cyclic neutropenia. It is important to note that they can develop after traumatic injuries and surgical procedures or injection of illicit drugs as in the case of our patient.
INTRODUCTION
Necrotizing Pneumonia (NPn) is a severe and rare complication of community acquired pneumonia, characterized by lung tissue necrosis and cavitation. Its development depends on the virulence of the pathogen and the host's defense mechanisms. Risk factors include smoking, alcoholism, advanced age, Diabetes mellitus and chronic pulmonary and hepatic disease. Staphylococcus aureus is among the most frequent pathogens. Usually it responds to intensive medical treatment, except when there are associated complications such as hemoptysis, abscess, gangrene or empyema.

CASE DESCRIPTION
Female, 68 years old, with hypertensive chronic kidney disease and hypothyroidism, with no known structural pulmonary disease, admitted to the hospital with asthma exacerbation. At the 8th day of hospitalization the patient developed high fever with productive cough, ronchi and wheezing at pulmonary auscultation, worsening of respiratory failure and elevation of inflammatory parameters without de novo infiltrates on chest x-ray. Blood cultures where collected and Piperacillin/Tazobactam was started empirically. Methicillin-sensitive Staphylococcus aureus (MSSA) was isolated. Because the clinical condition was maintained after 3 days and the respiratory sounds became diminished at right lung auscultation, the patient was submitted to a chest computer tomography which showed multiple abscessed cavitations in the right lung, the biggest being subpleural with an air-fluid level. Antibiotic therapy was escalated to linezolid and clindamycin and endocarditis and septic embolization to other organs were excluded. There was clinical, analytical and radiological improvement, with hospital discharge and outpatient follow-up.

DISCUSSION
We present this case of NPn by MSSA with rapid clinical and radiological evolution because it developed in a patient without evident skin lesions as entrance doors, there were no known immunosuppression factors and the treatment was exclusively medical.
Neurological Clinic In Context Of Acute HIV Infection

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INTRODUCTION:
Acute HIV infection is estimated to be symptomatic in 80% of the cases, however neurological clinic, except cephalgia, is varied and infrequent. Because of this, differential diagnosis of this entity is complex.

CASE DESCRIPTION:
Case was reported of a 62 year-old female without relevant conditions. She was admitted at charge of Digestive Service for suspected acute pancreatitis due to minimal elevated amilasa values associated to stomachache, diarrhea, temperature and neurological focality (cerebellar ataxia, inestability, dismetry and dysarthria). Following advices of our Hospital Neurologists, were realized many complementary studies: cranium CT and MRI scanner, blood cultures, viral serologies, blood test (biochemistry and hemogram) and cerebrospinal fluid RCP and cultures.
After four days, her doctor was warned of positive HIV serology by Microbiologist. At the same time high viral load results were detected and antiretroviral treatment for HIV was initiated. It brought about important improvements in this patient, disappearing her symptoms.

DISCUSSION:
Despite neurological clinic is not very frecuent in context of acute HIV, we must consider these manifestations in the differential diagnosis and request viral serologies in the case of we could not explain the symptoms.
Neurological focality in HIV patient after hepatitis C virus treatment

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INTRODUCTION
A 50-year-old HIV male (with adequate immunological and virological control) and a hepatitis C virus (HCV) who, within a few months of beginning treatment for HCV, experienced neurological deterioration with severe visual acuity deficit, language impairment, left hemiparesis and instability when walking.

CASE DESCRIPTION
A 50-year-old HIV male (with adequate immunological and virological control). Concomitantly, he was diagnosed with coinfection with hepatitis C virus (HCV) (genotype 3A), decided to start treatment with Sofosbuvir and Ribavirina for 12 weeks with curative criteria.
A few months after starting treatment for HCV, he experienced neurological deterioration with severe deficit of visual acuity, language impairment, left hemiparesis and unsteadiness when walking.
An analytical study was requested in which there was undetectable HIV viral load with stabilization of the CD4 figure (in 418/ul) without other added alterations.
Computed tomography (CT) and cranial magnetic resonance, which demonstrated compatible findings as the first possibility with progressive multifocal leukoencephalopathy.
Lumbar puncture was performed, resulting positive for JC virus in cerebrospinal fluid.

DISCUSSION
Progressive multifocal leukoencephalopathy (PML) is a demyelinating disease caused by the reactivation of the papovirus JC. It is very ubiquitous in the healthy population (60% of the adult population) and is generally associated with some immunodeficiency.
In Spain it represents 3% of focal encephalopathies and has been described as a diagnostic criterion for AIDS, affecting 1-8% of said patients. Although it is associated with patients with some immunodeficiency, there are described cases of PML with CD4> 200 (as in our case), with an increasingly frequent association in this group with HCV co-infection and occasionally with interferon or ribavirin. In general, it has a poor short-term prognosis.
Non-diagnosed diabetes as a predisposing factor for Mucor infection

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INTRODUCTION
Invasive fungal infection has become a major problem given the increasing number of susceptible patients, whose particular situation, along with the difficulty for early diagnosis and absence of effective treatment, lead to high mortality.

CASE DESCRIPTION
An apparently immunocompetent 82-year-old male with hypertension, dyslipidemia and a history of dilated cardiomyopathy was admitted for community-acquired pneumonia. Antibiotic therapy with ceftriaxone and clarithromycin was initiated and he required corticosteroid therapy for bronchospasm. During admission, he reported periorbital headache and pain on palpation of the left malar and supraciliary region, presenting leukocytosis and increased acute phase reactants. A complete occupation of the left frontal sinus, ipsilateral ethmoidal cells and maxillary sinuses by hypodense and homogeneous material was observed in CT-scan. Given the lack of improvement despite treatment with levofloxacin, exudate from the nasal meatus was obtained, where filamentous fungi and wide non-septate hyphae were observed with KOH preparation. Upon suspicion of mucormycosis, amphotericin B and caspofungin were initiated and endoscopic sinus surgery was performed. The presence of Aspergillus and Rhizopus was confirmed in resected bone tissue. As one of the most common causes of immunosuppression in invasive fungal infections, type 2 diabetes mellitus was diagnosed (HbA1C 7.5%).

DISCUSSION
Invasive fungal infection usually affects immunosuppressed patients (hematologic malignancies, solid organ transplantation or immunosuppressive therapy). In this case we want to highlight the diagnosis of diabetes in a patient with fungal rhinosinusitis infection that required systemic corticosteroids, which are two predisposing factors for this infection, despite not having presented metabolic acidosis.
Listeriosis is a disease that despite being described in immunocompetent patients, mainly affects some groups at risk such as pregnant, elderly, newborn and immunosuppressed patients.

We present the case of a 66-year-old man with a history of non-hypocoagulated paroxysmal atrial fibrillation who is brought to the Emergency Department for an acute confusional state with about 6 hours of evolution and aphasia. On objective examination, the patient was febrile (atrial temperature 38.2°C), disoriented, with horizontal nystagmus, with flaccid paresis of the lower limbs but with muscular strength preserved in the upper limbs.

Computed tomography scan of the head had no acute changes. A lumbar puncture was later performed and showed marked pleocytosis, with a predominance of polymorphonuclear cells, high proteins level and glucose consumption. Treatment with antibiotics and steroids was initiated. Listeria Monocytogenes was isolated in cerebrospinal fluid culture.

During hospitalization, the patient presented episodes of atrial fibrillation with rapid ventricular response and hypocoagulation was started.

On the 17th day, the patient presented a pain on the inside of the right thigh with a hemoglobin drop of about 4g / dl in 3 days. The abdominopelvic computed tomography scan revealed a right psoas hematoma of 9.8x8 cm and a 4.2 cm hypervascular nodule in the left kidney, compatible with renal neoplasm.

In conclusion, we present a case of a patient who is admitted by listeriosis in apparently an immunocompetent individual, who due to an intercurrence is detected a early onset cancer.
Introduction: ocular syphilis may occur as early as 6 weeks after transmission and may manifest in a spectrum of ways, with the most common finding being panuveitis. Syphilitic uveitis can be associated with neurosyphilis.

Case description: a 77-year-old man was admitted to hospital with a history of diffuse chest pain, dyspnea and explained mental and physical numbness for 6 months. He had hypertension and was an ex-smoker. Physical examination was unremarkable except for the increased respiratory rate. Laboratory tests revealed elevated inflammatory parameters. Chest x-ray showed diffuse bilateral reticular infiltrate and the chest CT revealed extensive, bilateral areas of ground glass opacities, predominantly in superior an inferior lobules and regions of crazy-paving pattern. Levofoxacin was started with partial improvement. He had a history of hospitalization one month before with panuveitis which etiology study was inconclusive. Viral PCR studies from the vitreous humour were negative, but treponema pallidum wasn’t searched at that time. We took the opportunity of the admission to search for syphilis. Serum VDRL (1/32) and TPPA (1/5120) were positive and HIV test was negative. A lumbar puncture was performed which showed a positive titer of VDRL (1/8). Neurosyphilis and ocular syphilis were assumed and penicillin G was initiated. Although the chest CT changes were not compatible of pulmonary syphilis, there was a complete respiratory response with penicillin. Unfortunately, no improvement of the visual acuity was achieved.

Discussion: Ocular syphilis can be challenging to diagnose therefore increased awareness in all clinicians can lead to improved care for patients.
One dose vancomycin does not fit all – lessons learnt from a PK/PD study

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Objectives: Routine therapeutic monitoring of vancomycin is recommended throughout the treatment course in order to optimize drug exposure. The aim of our study was to evaluate the frequency of optimal vancomycin dosing with regard to the pharmacokinetic/pharmacodynamic (PK/PD) parameters and to identify covariates enabling to predict optimal initial dosage regimen.

Patients and Methods: A retrospective analysis of vancomycin plasma levels determined during a 5-year period in patients treated with i.v. vancomycin in University Hospital Olomouc was performed. Haemodialysed patients were excluded. Pharmacokinetic modelling using MWPharm ++ software was performed to assess individual PK/PD indices.

Results: A total of 1458 vancomycin concentrations obtained in 382 patients were included. Initial vancomycin dosing of 1 g twice daily was prescribed to 62.9 % of patients, but it would be considered as optimal initial dosage regimen only in 30.8 % patients. Pharmacokinetic simulations showed suboptimal and supratherapeutic concentrations in 22.8 % and 37.9 % of monitoring events, respectively. Dosing adjustment based solely on vancomycin pre-dose concentrations failed to accurately estimate drug exposure in 35 % of monitoring events. Patients' age, sex, height and renal functions were significant covariates in the PK model, but creatinine clearance was clearly the most important one to predict over- and underdosing.

Conclusion: Optimal initial vancomycin dosing still remains challenging in clinical practice. Simple nomograms with creatinine clearance could improve vancomycin prescribing.

Disclosure of Interest: None declared.

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INTRODUCTION
Visceral leishmaniasis, also known as kala-azar, is a disease primarily caused by Leishmania donovani and L. infantum that is transmitted by sandflies. Many leishmaniasis infections are asymptomatic, reflecting the ability of the host immune system to control the parasite. Visceral leishmaniasis causes irregular fever, hepatosplenomegaly, pancytopenia and polyclonal hypergammaglobulinemia, with high mortality in untreated patients.

CLINICAL CASE
A 77-year-old man with type 2 diabetes under oral antidiabetics and rheumatoid arthritis under methotrexate, without other antecedents, was admitted with asthenia, anorexia, fever and loss of 10 kg in the last month. The observation was emaciated, pale, with splenomegaly and without adenomegalias or other alterations in the objective examination. 
Analyses showed Hb 8.2 g/dL, Neutrophils 2x10^3/μl, and 90x10^3/μl platelets with no other relevant alterations. 
Abdominal ultrasound showed enlarged spleen (17cm longitudinal axis) with no other changes.
In the myelogram, extra and intracellular forms of leishmania were observed, a condition compatible with visceral leishmaniasis with medullary infiltration.
Liposomal amphotericin B was started with good clinical and laboratory evolution.

DISCUSSION
This case demonstrates the importance of a good clinical history in an immunodepressed patient taking into account the location (Mediterranean) and the importance of timely treatment.
Parvovirus induced thrombocytopenia-case report

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Introduction: Immune thrombocytopenic purpura is an acquired thrombocytopenia caused by autoantibodies against platelet antigens. ITP can develop in the context of other disorders (secondary ITP). Some cases of ITP are associated with preceding viral infections or less commonly bacterial infections. Antibodies against viral antigens may cross-react with normal platelet antigens.

Case description: A 30 year old previously healthy man admitted to emergency room with skin rashes. He had no chronic disease and any drug use. One week before he admitted to hospital he had had an upper respiratory flu like infection. After that his body rashes appeared. During this period he did not have used any drugs. At presentation the patient did not have bleeding or any active symptom. He had skin rashes in all extremities. Blood samples revealed 5000/microL platelets, 15.6 mg/dL hemoglobin, 6800/microL white blood cells. Pseudothrombocytopenia was excluded with peripheral blood smear. Kidney functions were in normal range in admission. LDH was a near the upper limit (292u/L). Liver enzymes were in normal range. In follow-up, the patient had epistaxis. He was replaced with one unit of platelet suspension. Platelet count did not increase enough after platelet replacement. We excluded other possible causes of thrombocytopenia. Many of viral and bacterial antigens runned including HIV, HCV, HBV, EBV, CMV, Herpes virus, Helicobacter pylori, Toxoplasma, ParvovirusB19, Brucella. Only Parvovirus B19 IgM resulted positive among them. Then we administrated intravenous immunoglobulin (IVIG) treatment with 1mg/kg/day dose for two days. After IVIG treatment platelets increased to 40000/microL in two days. His skin rashes disappeared in three days after IVIG treatment. Platelet counts increased spontaneously and reached normal range in about one week.

Discussion: Parvovirus B19 is a rare cause of thrombocytopenia especially for non immunosuppressed adult patients.
Pericardial effusion as a form of presentation of *Chlamydia trachomatis* infection

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INTRODUCTION: Pericardial effusion may occur as a primary pericardial disease or secondary to systemic diseases. *Chlamydia trachomatis* infections are among the less frequent infectious causes, being a rare cause nowadays.

CASE DESCRIPTION: A 50-year-old male was referred to an Internal Medicine appointment for etiological investigation of a pericardial effusion. He had history of coronary heart disease and acute pericarditis with circumferential pericardial effusion, without constrictive physiology. An initial etiologic study was requested for the most common infectious, metabolic, neoplastic and autoimmune causes. A chest computed tomography was also performed and revealed regular enhancement of the pericardium suggesting infectious pericarditis. Throughout the follow-up he presented new complaints of terminal dysuria with urinary urgency, denying other symptoms or signs including fever. The physical examination was normal. Serological tests for *Chlamydia trachomatis* were requested, showing IgG << 5.00 AU / mL (negative < 9 AU / mL) and IgA 7.19 (positive > 6 AU / mL). He performed urine DNA testing for the germ before taking azithromycin 1g in a single dose, which was found to be positive. No pericardiocentesis was performed given the absence of hemodynamic compromise and resolution of effusion on a control echocardiogram 2 months after treatment. The control serology tests (IgM) were also negative. Thus, we consider the infection was effectively treated.

DISCUSSION: Pericardial effusion is an established risk factor for bacterial pericarditis, which is infrequent in the adult population. The identification of the causative agent allowed rapid diagnosis and treatment, avoiding deadly outcome that is always verified in the untreated infectious causes.
**Peritoneal tuberculosis : analysis of 26 cases in Tunisia**

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**Background:**
Peritoneal tuberculosis is an uncommon site of extrapulmonary tuberculosis. The diagnosis is often difficult. The aim of this study is to describe clinical, radiological, biological and therapeutic features.

**Methods:**
This was a retrospective study that included all cases of Peritoneal tuberculosis hospitalized in the department of Infectious Diseases between 2013 and 2017.

**Results:**
26 patients were included. The mean age was 32.5 years and most were women (73%). Predominant clinical presentations were: alteration of the general state (80.8%), abdominal pain (73%), fever (69%) and night sweats (53.8%). Peritoneal tuberculosis is revealed by a surgical emergency in 3 cases. Physical examination found ascites in 13 cases (50%). Tuberculin skin test and IGRA test were positive respectively in 34.6% and 3.8% of cases. CT scan of the abdomen revealed ascites in 84.6% of cases, lymph nodes in 50% of cases, thickened peritoneum in 34.6% of cases and omental cake in 11.5% of cases. Peritoneal tap was realized in 34.6% of cases: proteins are > 30g/l and lymphocyte cells predominate, but, acid-fast bacilli are not seen on smear or culture. An abdominal surgery with peritoneal biopsy was performed in 23 cases (88.4%). The mean duration of treatment was 12 months. Five patients were lost to Follow-Up. All the remaining patients were cured.

**Conclusion:**
Diagnosing Peritoneal tuberculosis is a challenge for clinicians. Coelioscopy with peritoneal biopsies still remains the method of choice to establish a definite diagnosis of Peritoneal tuberculosis.
Peritoneal tuberculosis: an evidence-based case report

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Introduction: Tuberculosis is an infectious disease caused by Mycobacterium tuberculosis and is highly prevalent in underdeveloped countries. The lungs are the main affected organs, but rarer extrapulmonary forms may manifest. This paper reports an unusual case of peritoneal tuberculosis and aims at enquiring the diagnostic work-up based on evidence.

Case description: Male, 47 years old, resident of Rio de Janeiro, a month before consultation referred weight loss and night sweats followed by increased abdominal volume and pain. Ascites and abdominal tenderness were noticeable. CT scan of the abdomen revealed massive ascites and peritoneal thickening with diffuse uptake of contrast. Paracentesis demonstrated an exudative effusion with serum-ascitis albumin gradient lower than 1.1 and a negative cytology for neoplastic cells. There was no evidence of pulmonary or liver disease. Videolaparoscopy was performed, which demonstrated thickened peritoneum, studding of peritoneum with multiple tubercles and adhesions. Biopsy showed caseating granulomas compatible with the diagnosis of peritoneal tuberculosis. Ascitic fluid culture later proved to be positive for tuberculosis. Treatment with RHZE was initiated leading to clinical remission at follow-up.

Discussion: Peritoneal tuberculosis comprises 5% of all cases of tuberculosis. It may mimic other pathologies and its diagnosis is challenging. Though laparoscopic peritoneal biopsy is the gold standard, CT and serum-ascitis albumin gradient are helpful in the diagnostic workup and it’s been reported that adenosine deaminase of the ascitic fluid has high sensitivity and specificity. The timely recognition of such condition is mandatory as a reemerging disease in high-income countries due to immigrant populations.
Persistant fever in 16 year-old man

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Introduction
Sarcoidosis is a granulomatous disease of unknown origin. It usually affects young adults, mainly women, and it can affect any organ. A pediatric diagnosis of this entity is rare and can imitate a lymphoproliferative disorder.

Case description
A 16th year old man with a history of diabetes mellitus was admitted to hospital because of extend fever, ruled out previously infectious diseases and other causes. The complementary exams showed a minimal elevation of transaminasas and the abdomen ultrasound revealed a splenomegaly. For that reason a PET-TC was made and showed superior and inferior diaphragmatic adenopathies as well as increased activity in PET-TC in spleen (nodules), liver and bone marrow, suggesting lymphoproliferative disorder. In a lymph node biopsy were seen epithelioid granulomas and to confirm the diagnosis because of implication therapeutic options, a spleen biopsy revealed the same histophatoly. With all of this results the patient was diagnosed of sarcoidosis stage 1 with systemic affection (bone marrow, lymph nodes, liver and spleen). The patient received steroids improving clinically and even in imaged, although some increased activity in spleen remains in last PET-TC.

Discussion
Spleen sarcoidosis is rare and it has a variable incidence (from 6.7 to 77%). Usually it is asymptomatic although some patients have splenomegaly or cytopenias. There are no available data about its prognosis and treatment. In some studies, spleen sarcoidosis can be a worse prognostic factor of sarcoidosis.
Persistent Bacillus cereus bacteremia in an immunocompetent patient: a challenging enemy

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Introduction
Bacillus cereus is an aerobic to facultative anaerobic, Gram-variable bacilli found readily in soil and near fresh and marine water beds. Herein, we present an interesting case of persistent B. cereus bacteremia in an immunocompetent patient, in order to emphasize the importance of recognizing B. cereus as a potentially serious human pathogen even in an immunocompetent host with need of early combination therapy.

Case description
An 85-year old Caucasian woman, with a history of chronic renal failure, was admitted to our clinic due to fever, progressively worsening of generalized edema, oliguria and hypotension. B. cereus was isolated from 3 blood cultures and empiric antibiotic treatment (ciprofloxacin and vancomycin) was initiated. Hemodialysis was performed once daily initially and then every other day. A week later, the central venous catheter was changed due to persistent bacteremia, and clindamycin was added. Transthoracic and transesophageal echocardiogram were performed, excluding endocarditis and a full body CT scan did not confirm an abscess. A 99mTc LeukoScan showed pericardial positive uptake. Due to persistent bacteremia 20 days later, the antibiotic treatment was changed to an IV-initiated gentamycin/meropenem/vancomycin combination. 3 days later, the blood cultures were negative and the patient showed significant clinical response.

Discussion
Until identified as a clinically significant pathogen, B. cereus was often thought to be a contaminant of blood cultures. Most clinically significant cases of bacteremia are usually associated with an immunocompromised host, the presence of foreign bodies or both.
Pneumococcal bacteremia in adult patient: Vaccines, serotypes and antibiotic sensitivity.

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Objectives:
The objectives of this study were to analyze the distribution of isolated serotypes in patients with Invasive pneumococcal disease (IPD), their antibiotic sensitivity and their relationship with vaccines in isolated pneumococcal strains in a tertiary hospital.

Material and methods:
Retrospective and descriptive study of IPD in patients hospitalized from April 2015 to December 2017. The antibiotic sensitivities were determined by E-test according to the EUCAST 2017 cut-off point.

Results:
Of the total sample, 48.1% of the patients were vaccinated, and of these 76.9% with the 13-valent vaccine, 38.5% with the 23-valent vaccine, having three patients (23.1%) who received both vaccines. We typed 14 serotypes (3, 6C, 7B, 8, 10A, 11A, 12F, 15A, 19A, 21, 22F, 24F, 33F and 35B), of which the most prevalent were 3, 8 and 12F. (18.5%, 11.1% and 11.1%, respectively). Of the 10 vaccinated patients, only 3 (11.1%) were protected against the serotype that caused the infection and of the 16 patients not vaccinated prior to the episode, only 3 of them (18.5%) were vaccinated after the event. 37% of the isolates showed some kind of resistance; 22.2% being resistant to penicillin, tetracycline and erythromycin with an average MIC of 0.025, 37.3 and 128 (the cut-off point (COP) being 0.06, 11 and 0.25, respectively); in four patients resistance to amoxicillin was found with 3.2% (pc 0.5). Three patients presented resistance to cefotaxime with an average MIC of 1.3, with a COP of 0.5. No resistances were found for chloramphenicol, levofloxacin and vancomycin. 37% received advice from the PROA group, with a difference in the percentage of death at 15 days, with 10% in the cases assessed, compared to 30% in those not advised.

Conclusions:
- The most frequent serotypes were 3, 8 and 12F.
- There is a resistance of 22.2% to penicillins in our series, not finding resistance to quinolones.
- The advice by PROA implies a reduction in mortality.
Infectious diseases
A-1672

Pneumonia by Varicela Zoster

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Abstract

Introduction

Chickenpox is an exanthematous disease caused by the varicella-zoster virus. Varicella pneumonia complicated by acute respiratory distress syndrome is very rare in adults and it is associated with high morbidity and mortality. Early treatment with Aciclovir could reduce the mortality associated with that respiratory complication.

Case description

Below we report a case of acute respiratory distress secondary to varicella-zoster pneumonia. 15-year-old woman consults for tachypnea, not productive cough and intermittent fever, general discomfort, with cutaneous injuries vesículo - papulares widespread, some of purulent content pruriginosas. Since a week ago several relatives and friends of the same age, presented cutaneous compatible injuries with varicela.

Discussion

Patient not vaccinated, with vaccines according to the official calendar. without pathological background and with relatives and friends with presumed varicella (epidemiological outbreak?).

Key words: PNEUMONIA, VARICELLA ZOSTER SYNDROME OF RESPIRATORY DISTRESS IN ADULTS (ARDS), ACYCLOVIR.

Private Clinic of Carmen. Zárate. Province of Buenos Aires. Argentina
Pneumonia due to Influenza A

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INTRODUCTION
Pneumonia is the most common complication of the influenza virus. Viral primary pneumonia occurs most commonly on at-risk patients.

Typically, pneumonia due to influenza A presents itself radiologically as a reticular or reticulonodular pattern, bilateral, at times, concomitantly, with consolidation area(s).

CASE REPORT
A case is presented of a 61-year-old man, living in a prison establishment, diabetic, with antecedents of alcoholism in the past, who resorts to the Emergency Room due to dyspnea, productive cough with mucous secretions, asthenia, anorexia with unquantified ponderal loss and fever. His clinical condition had a week of evolution.

During examination he was tachypnoeic, sweaty and feverish. Pulmonary auscultation there were audible crepitant and disperse bilateral rhonchi. Analytically, there was a clear leucocytosis (>200000/uL) and neutrophilia (>20000/uL) as well as an increase in the RCP (reactive C protein) values, which were 34.64mg/dL. Radiologically, a nodular pattern was visible dispersed through the pulmonary fields.

After clinical, analytical and radiological evaluation, an extensive bilateral pneumonia was objectified, associated with an Influenza A infection and severe partial respiratory failure, in need of supplemental oxygen.

He was admitted to the Unit of Infectious Diseases, having undergone therapy with Piperacillin + Tazobactam and Azithromycin for 14 and 8 days, respectively. Due to the Influenza A, he initiated treatment with Oseltamivir.

DISCUSSION
The influenza virus causes necrosis of the respiratory epithelium predisposing it, therefore, to secondary bacterial infections. In the present case, it was essential to treat the laboratory-confirmed influenza, as well as secondary bacterial infections. The hospital admission was vital in this case due to the severe respiratory failure presented by the patient.
Pott's disease - about a clinical case

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Introduction: Pott's disease or tuberculous spondylodiscitis is a rare disease caused by Mycobacterium tuberculosis affecting the lower thoracic and lumbar regions of the spine.

Case description: We report the case of a 79-year-old woman that was admitted to our emergency department with low back pain associated with fever, with some weeks of evolution. MRI of the spine documented an extensive infectious process, with starting point in spondylodiscitis, involving the vertebral bodies L3, L4 and L5 with a massive collection with extension to the psoas muscle. Biopsy of the abscess with isolation of Mycobacterium tuberculosis in the culture. Targeted therapy was initiated with gradual improvement of the pain.

Discussion: The authors intend to alert to the rarity and indolent nature of this entity. Also, to the early institution of treatment to minimize sequels.
Profile of patients with latent tuberculosis comorbidities in HIV infection the last 15 years.

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Objective: Characterization of patients with HIV infection and latent tuberculosis (TL) followed in an Angolan hospital

Method: Retrospective analysis of the processes of patients with HIV and LT infection from 01/01/2003 to 12/31/2017. Process identification was provided by hospital.

Results: LT was diagnosed in 49 patients, being evaluated 46 patients (3 patients without transfer / death registries), 35 men (M) and 11 women (W).

The ages ranged from 20 to 71 years, with an overall mean age of 37.5, with 37.9 for M and 36.2 for W. They had work activity 71.3% and 28.3% were unemployed. The detection method used was contact screening 10.9%, passive screening 2.2%, screening of other groups 82.6%, and no information 4.3%. The mantoux test was less than 10 mm in 19.6%, 10-20 mm in 67.4%, 21-30 mm in 10.9%, and 2.2% without information (WI). Only 17.4% had positive IGRA, 2.2% negative and 80.4% had no evidence. The vaccine scar was present in 87% and in 13% W. Chest x-ray was normal 91.3% M and 8.7% W. In addition to HIV infection, the other co-morbidities include hepatitis C (HCV) 30.4%, asthma 6.5%, COPD 4.3%, liver disease 2.2%. The risk factors were intravenous drugs 60.1%, other drugs 60.1%, imprisonment 21.7%, alcohol dependence 15.2%, smoking 11%, community residence 8%, homelessness 2.1% and unidentified 26%. Angolan nationality 95% and 5% Portuguese; 100% were treated with isoniazid: with treatment completed 36 patients, interruption or abandonment 10, transfer / emigration / death 3.

Conclusions: The highest number of patients diagnosed was sent by the hospitals to the CDP according to the protocol, and it occurred in the male sex. The mantoux test determined the diagnosis of LT in 100%, 74% had a risk factor for tuberculosis. There was a high prevalence of HIV and HCV co-infection in LT patients; therapy with isoniazid was effective.
Pulmonary aspergilloma - a case report

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Introduction: Aspergilloma is an uncommon infection usually with invasion of lung cavities. Clinical manifestations of aspergillosis include allergic bronchopulmonary and chronic necrotizing pulmonary disease, aspergilloma, and invasive infections. The diagnosis of pulmonary aspergillosis should be based on classical images, positive serology test, or culture isolation of Aspergillus from respiratory tract. Case report: 40 years old woman, with no relevant personal history, presented with acute fever without localizing infection focus, namely without respiratory complaints. At admission she was febrile, with no other relevant changes. Analytically excluded malaria or arbovirose, without leukocytosis / neutrophilia, c-reactive protein 5.7mg / dl, sedimentation rate 9mm / 1st hour. Chest x ray showed a radiopaque image with well-defined contours in the apex of the left lung. Thorax CT scan showed heterogeneous cavitary lesion compatible with aspergilloma and areas of condensation in the lower left lobe compatible with acute inflammatory / infectious process. Admitted with community acquired and aspergilloma. Immunosuppression was excluded, cultural exams were negative. She was treated with antibacterial drugs (amoxicillin–clavulanate and clarithromycin) and itraconazole with improvement. Discussion: Pulmonary aspergilloma is relatively rare pulmonary infectious diseases. Chest imaging may provide some clues as to how to diagnose this clinical condition, but a definitive diagnosis often relies on a pathological examination of the infected tissue. The treatment of pulmonary aspergillosis is typically with anti-fungal agents, and while the management of aspergilloma is often through surgical resection, it can also be treated medically.
Introduction
In the differential diagnosis of pulmonary abscess, it is important to consider infectious and non-infectious etiologies, including neoplasms.

Case description
Male, 62 years old. History of smoking and alcoholism. Left posterior thoracalgia, exertional dyspnea and cough with mucopurulent expectoration, for one month. No constitutional symptoms or epidemiological context. At the physically examination emaciated, with fever, decreased respiratory sounds at the left base and rhonchi at pulmonary auscultation. No respiratory failure. Analytically anemia and elevated systemic inflammatory parameters. Imagologically a nodular area in the left inferior pulmonary lobe, with heterogeneous content and cavitation, with hydroaenal level; consolidation of the adjacent parenchyma. On suspicion of lung abscess, started antibiotic therapy with ceftriaxone and clindamycin. HIV serology negative. No microbiological isolation – hemocultures negative; bacteriological, acid-fast bacilli and mycobacteriological of bronchial secretions and bronchoalveolar lavage negative. Bronchofibroscopy revealed a tumoral mass. Bronchial biopsy compatible with squamous cell carcinoma. In the imaging revaluation, increased dimensions of the lung lesion and paravertebral mass, with significant destruction of the D8 body. Thus, squamous cell lung carcinoma, with extension to the posterior thoracic wall and vertebral bone involvement. Undergoing vertebral arthrodesis and proposed for palliative chemotherapy.

Discussion
The patient has a history of smoking, the main risk factor for lung cancer. Lung cancer, especially squamous type, may present as a cavitated lesion, mimicking other causes. Bronchoscopy is not mandatory in all cases of suspected abscess. It is recommended in those with atypical presentation or therapeutic failure. In this case was essential for a definitive diagnosis, with therapeutic and prognostic implications.
Infectious diseases
A-1518

Pulmonary cavitation’s: not always pulmonary tuberculosis

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Introduction:
Several benign pulmonary diseases can simulate a pulmonary neoplasia in its clinical and radiological presentation, with a strong emotional impact on the patient and implicating the need for rapid diagnosis, not always possible.

Case reports:
A 75-year-old man, worked in glass industry. Ex-smoker (60UMA). Personal history of pulmonary tuberculosis at 6 years of age. Cough with hemoptoic sputum for 2 months and dyspnea for exertion, but no other respiratory symptoms, namely night sweats, weight loss, weakness, asthenia. At the physical examination, digital clubbing was noted, but no adenopathy and a normal pulmonary auscultation. Thoracic CT scan revealing lesions cavitated in the LSE, suspected of Mycobacterium tuberculosis infection; smear microscopy was negative (2x). Bronchofibroscopy showed reduction of the caliber and hypervascularization of left B1 + 2, and a bronchial biopsy was performed. Without microbiological and mycobacterial isolates in bronchial aspirate and bronchoalveolar lavage. The anatomopathological result revealed an epidermoid carcinoma. PET-CT suggesting malignant neoplastic infiltration and intense glycolytic hypermetabolism in 3 spinal / bone lesions. Assumed, a stage IVb (T4N0M1c), with PDL-1 expression in 39.8% of the cells. Decided in Oncological Pneumology Group Consultation of cerebral RT, followed by palliative QT.

Discussion:
Tuberculosis is one of the pulmonary pathologies that can simulate a lung neoplasm. Although the cavitated lesions are imaginary presentations of lung neoplasia, there is a wide range of pathologies with which it is necessary to make the differential diagnosis, and it is sometimes a great challenge to establish the definitive diagnosis quickly.
Pulmonary Cryptococcosis in an immunocompetent patient - a case report

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Introduction: cryptococcosis is caused by Cryptococcus gattii and C. neoformans, and is rare in immunocompetent individuals. Clinical manifestations vary from asymptomatic nodular disease to severe acute respiratory distress syndrome. The most common radiological presentation consists of single or multiple nodules, with or without cavitation, mainly in immunocompromised patients. Case report: 45 year old man, smoker, admitted with subacute cough, chest pain, fever, weight loss, fatigue, anorexia and asthenia. He presented without respiratory distress, febrile, respiratory murmur diminished on the right lung. Analytically: RPC 45.9 mg/dl, HIV negative. Thorax CT scan: condensation foci in the upper, middle and lower stages, sequential hyperdensities and sequelae, suggestive of a specific inflammatory / infectious process. Tuberculostatic and antibacterial drugs were empirically initiated. Bronchofibroscopy with bronchoalveolar lavage was performed. Cytological examination revealed numerous fungal structures consistent with cryptococcus. Fluconazole was immediately initiated with improvement. Discussion: one third of immunocompetent patients with cryptococcosis are asymptomatic. The main manifestations are respiratory and constitutional. Radiological changes are infiltrate (62%), nodules (38%), mass (19%), cavitary lesion (14%), pleural effusion (3%). CT scan aids in differential diagnosis and in invasive diagnostic programming. The differentiation between cryptococcosis and tuberculosis in countries with a high prevalence is crucial to a successful management of the patient. The diagnosis can be made by direct observation of the fungus in the expectoration, bronchoalveolar lavage, cerebrospinal fluid and in the histological sections, being confirmed by the culture of fungi. Fluconazole has been the initial treatment described. Amphotericin B is reserved for cases of without response to fluconazole, severely ill and in the central nervous system involvement.
Introduction: Tuberculosis (TB), caused by the bacterium Mycobacterium tuberculosis, is a serious public health problem, can lead to death and is transmitted from person to person. To be correctly identified, is necessary to know the available diagnostic methods, their advantages and limitations. With a correct and fast diagnosis, the patient can quickly start the treatment and heal completely. Pulmonary TB complications may include hemoptysis, pneumothorax, bronchiectasis, extensive lung destruction, malignancy, and chronic pulmonary aspergillosis.

Case description: 74-year-old woman with easy fatigue, constitutional syndrome to be clarified and anemia. No relevant changes on the objective clinical examination, namely dyspnea, coughing or sputtering. Chest radiograph: small left nodular opacity. Angio CT thorax: bilateral pulmonary parenchymal nodules compatible with primary lesion with signs of interstitial spread, not excluding secondarily from unknown primary lesion. She performed several imaging tests to study possible neoplasia lesions that were negatives. Tumor markers and serologies were negatives. Bronchofibroscopy without visible neoplasia lesion. Blood cultures, bronchoalveolar lavage (BAL) and neoplasia cells in the bronchial aspirate (AB) were negatives. Repeats CT thorax: multiple bilateral micronodular infiltrates suggesting bronchial superinfection. IGRA positive. Collect gastric aspirate (3 samples) with positive Ziehl Neelsen. Start treatment. Later, Middlebrook's results of AB were positive and Ziehl Neelsen without bacilli in the sample.

Discussion: The diagnosis of pulmonary TB should always be present in the constitutional syndrome to be clarified. Alerting that gastric lavage is a form of TB diagnosis and may be of value, especially in patients without sputum or cough.
Introduction: Tuberculosis remains one of the major public health challenges. Despite being a preventable and curable disease, this epidemic is far from being under control. In Europe, more than 250,000 cases are diagnosed each year. Pulmonary tuberculosis is the most common form of disease and must be considered in all patients with risk factors. Case report: A 45 years old man, diagnosed with pulmonary emphysema due to alpha-1 antitrypsin deficiency, presented with productive cough, low fever and weight loss for the past 2 months. Previous contact with tuberculosis or immunosuppressive therapy was not reported and HIV serology was negative. The clinical examination was normal. The laboratory results showed C-reactive protein 105.9 g/l without leukocytosis. Chest X-ray revealed 3 cavitated lesions with hydroareal levels on the right upper lobe. Sputum samples were collected and the patient was hospitalized with isolation measures. Chest CT revealed bilateral pulmonary emphysema with multiple bulla on the right upper lobe and multiple centrilobular nodules which formed larger masses of cavitated and necrotic appearance with hydroareal levels - the bigger one with 8cm on the right upper lobe. After 24h the sputum examination was positive for acid-resistant bacilli and later the nucleic acid amplification test was positive for Mycobacterium Tuberculosis. Treatment was initiated with isoniazid, rifampicin, pyrazinamide and ethambutol. Discussion: Tuberculosis should be suspected in patients with risk factors - HIV infection, immunosuppressive therapy and previous contact with tuberculosis. Pulmonary emphysema due to the alpha-1 antitrypsin deficiency in the alveolar tissue might be a favorable condition for the pathophysiology of pulmonary tuberculosis. More studies are needed to determine the risk of pulmonary tuberculosis in a patient with alpha-1 antitrypsin deficiency.
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Introduction: The infective suppurative thrombosis of the portal vein, or pylephlebitis, is a condition that can complicate any intraabdominal or pelvic infection. Its association with splenic abscess has been rarely reported in the literature. Since clinical manifestations are unspecific, the diagnosis of both conditions can be a diagnostic challenge.

Case description: A 77 year old man with previous history of diabetes mellitus type 2 and Parkinson’s disease presented to emergency department with fever, chills and dyspnea since the day before, without significant signs on examination. Three weeks before he was treated for an urinary tract infection caused by *Escherichia coli*. Blood tests showed leucocytosis, raised CRP, d-dimers, aminotransferases and GGT, hypoxemia and hypocapnia. Contrast-enhanced CT scan revealed splenic and portal veins thrombosis with hypodense splenic areas suggesting infarction and left pleural effusion. He started treatment with enoxaparin and piperacillin/tazobactam, with good clinical response. Blood cultures were positive for *Escherichia coli*, with no focus identified and infective endocarditis was excluded. After discharge, episodes of fever and chills recurred and left pleural effusion persisted, with abdominal MRI showing a splenic abscess. Metronidazole and meropenem were given for about 6 weeks and CT guided percutaneous drainage performed, but pleural effusion and abscess image persisted, so he underwent splenectomy.

Discussion: After the accidental finding of pylephlebitis, the main difficulty of this case was to reach the splenic abscess diagnose, since the first imaging studies didn’t clarify the scenario. In our opinion, colonization of splenic infarctions was the most probable cause of the splenic abscess. The failure of less invasive treatment measures left no option but to remove the spleen.
INTRODUCTION: Pyomyositis is an acute infection of the skeletal muscle. Staphylococcus aureus is the etiological agent isolated in 75-90% of cases. Several risk factors have been identified, such as diabetes, neoplasms, autoimmune diseases, HIV infection, surgery and previous trauma. 

CASE DESCRIPTION: A 65-year-old woman with a history of type 2 diabetes mellitus and rheumatoid arthritis on treatment with Tocilizumab. Consultation for left thigh pain of 5 days evolution with inability to walk. No fever. No traumatism.

The scan was afebrile. Carrier of right subclavian reservoir without superficial local complications. It presented swelling and filling from the left thigh with pain on palpation, without erythema or local heat.

In the analysis, 17510 leukocytes with 80% neutrophils (14000), PCR 0.7 mg / L, VSG 1st Hour 7 mm. MRI showed pyomyositis of the thigh muscles without collections. Staphylococcus aureus methicillin susceptible was isolated in the sterile microbiological sample. The blood cultures were negative.

Treatment with cloxacillin was started. He presented local worsening, with MR that showed extensive collection in left thigh musculature. Debridement and surgical drainage were performed, cloxacillin was continued for 2 weeks and linezolid for 4 more weeks, with resolution of the table.

DISCUSSION: Pyomyositis is an entity that may initially manifest little symptomatic and with a low elevation of acute phase reactants in patients with autoimmune diseases, diabetes mellitus and other forms of immunosuppression such as pharmacological. The therapeutic management involved not only antibiotic treatment, but the concomitant surgical treatment.
**Pyomyositis: A tropical disease?**

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Introduction: Pyomyositis is an acute bacterial infection of the skeletal muscle characterized by localized abscess formation. Although classically considered a tropical infection, this entity shouldn’t be disregarded in non-tropical regions since its most common predisposing factors and causative bacteria are also prevalent in temperate areas.

Case description: A 79-year-old man presented with pain in the left leg, movement limitation, confusion and fever over 2 days. He denied trauma or heavy exercise, but he was on warfarin. The lateral aspect of his left leg showed erythema, without edema and the laboratory tests indicated rhabdomyolysis. A CT-scan revealed a hematoma extending from the tibial tuberosity to the middle third of the tibia and edematous infiltration and densification of subcutaneous cellular tissue. Thus, cellulitis of the leg was recognized, and amoxicillin/clavulanate was initiated. After 7 days the fever recurred and the leg was edematous and painful, so antibiotherapy was switched to piperacillin/tazobactam. A second CT-scan revealed hematic infiltration laterally to the lower third of the anterior tibial muscle and hallux extensor muscles in resolution and pyomyositis on the peroneal muscles in the upper third of the left leg. After the escalation of the antibiotherapy, the fever subsided and the symptoms resolved completely after 15 days.

Discussion: The development of the infection, in this case, was probably related to the hematoma, providing in the muscle bed favorable bacterial growth conditions. The absence of risk factors should not exclude the possibility of pyomyositis. This case serves as an example of a pyomyositis in a non-tropical region.
Hepatitis C virus (HCV) infection is a global health problem. The treatments that have been used in the past have limited efficacy that did not surpass an average of 50% of success rate. With the introduction of new drugs called direct-acting antiviral agents (DAA) the response rate has changed significantly.

Our objective was: A) to compare the response rate of DAAs in real life (in different genotypes) with the response rate obtained in clinical trials and cohorts. B) To compare the response rate in monoinfected patients with HIV co-infected patients under the same conditions.

We obtained a sample of 143 patients, 57 mono-infected (39.9%) and 86 HIV co-infected patients (60.1%) who went to the Hospital Virgen de las Nieves Granada infectious diseases service (or medical consult). We collected data concerning their HCV genotype, degree of fibrosis before the treatment and sustained virologic response after 12 weeks (SVR12). We obtained 93.2% SVR12 in 137 patients. The SVR in monoinfected and co-infected patients was 94.7% and 93% respectively.

In conclusion, DAA treatments in HCV in real life achieved the same results as clinical trials, in both groups HIV-infected or seronegative patients. These results are the same when compared with published cohorts of mono-infected such as COSMOS, POSITRON, VALENCE, PHOTON 2, or HIV-infected ALLY-2, ION-4 or BALANCE.
Recurrent hemoptysis and an invasive pulmonary aspergillosis

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We present the case of a 21-year-old male from the Democratic Republic of the Congo, resident in a reception center in Spain for 4 months, with no medical history of interest. He was admitted to the Emergency Department for multiple episodes of life-threatening hemoptysis that had required two episodes of bronchial artery embolization and admission to the Intensive Care Unit. The serologies (HIV, HAV, HBV, HCV, syphilis, Histoplasma capsulatum, Coccidioides immitis, Cryptococcus) were negative as well as the malaria test. Study for immunodeficiencies was negative. Thoracic CT was performed showing bilateral pleuroapical thickening with volume loss and thick-walled air cavities and bronchiectasias suggesting changes related to tuberculosis without ruling out invasive aspergillosis. The antigenuria for A. fumigatus resulted to be positive and the culture of micobacteria was negative. Bronchoscopy was performed with biopsy compatible with bronchial and pulmonary necrotizing aspergillosis. Treatment with voriconazole was initiated during at least 3 months, with an adequate tolerance. Given the recurrence of hemoptysis, a programmed left upper lobectomy was performed.

Invasive pulmonary aspergillosis is a severe disease, whose most common form of presentation include respiratory tract infection with poor response to antibiotics. Pulmonary aspergillosis is the cavitary form. Up to 15% of the cases debut with hemoptysis. The delay on the diagnosis and the lack of suspicion is one of the main causes of morbidity and mortality of this disease. The definitive diagnosis require histological confirmation. When the patient clinical status is severe, empiric treatment should be considered.
Relationship between concentration of C Reactive Protein and procalcitonin with mortality in patients with sepsis.

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BACKGROUND

The aim of the study was to evaluate the association of C-reactive protein (CRP) and procalcitonin concentration and 14-day mortality in a cohort of patients with sepsis.

METHODS

We conducted a prospective study of all episodes of sepsis detected in our department (April 2016-December 2017). Epidemiological and clinical variables and 14-day mortality were collected. For the analysis, the sample was divided according to the tertiles of CRP and procalcitonin distribution. The cut-off points for CRP were <7.45 mg/dl (lower tertile), 7.46 - 18.62 mg/dl (medium tertile) and ≥18.63 mg/dl (upper tertile). The cut-off points for procalcitonin were <0.49 ng/ml (lower tertile), 0.50 – 3.18 ng/ml (medium tertile) and ≥3.19 ng/ml (upper tertile). We analyzed the relationship of CRP and procalcitonin with 14-day mortality. P for the trend (Ptrend) <0.05 was considered statistically significant. We received a funding from the Spanish Society of Internal Medicine to develop the project (‘Ayudas a la investigación FEMI para jóvenes investigadores’ program).

RESULTS

The sample included 392 patients, with a mean age of 81 years (SD 13) and 243 men (62%). Fifty-nine (15%) patients died at day 14. The mean CRP at admission was 17 mg/dL (13) and the mean procalcitonin at admission was 9 ng/mL (19). The mortality frequency in the 1st to 3rd CRP at admission tertiles was 11 (10%), 17 (13%) and 31 (20%), respectively (Pt = 0.02). The relationship of the procalcitonin tertiles and the 14-day-mortality did not reach statistical significance. Mortality in the 1st tertile was 17 (13%), 20 (16%) in the 2nd and 22 (17%) in the 3rd (Pt = 0.36).

CONCLUSIONS

In this study, it is noteworthy that the concentration of CRP is related to 14-day-mortality in patients with sepsis, nevertheless, this is not demonstrated in the case of procalcitonin. It would be necessary to confirm these findings in prospective studies designed for this purpose and a larger sample size.
Infectious diseases
A-2175

Relationship between changes in the concentration of C-Reactive Protein with 14-day-mortality in patients with sepsis between changes in the concentration of C-Reactive Protein with mortality at day 14 in patients with sepsis

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BACKGROUND
The aim of the study was to evaluate the association between changes in C-reactive protein (CRP) concentration and 14-day mortality in a cohort of patients with sepsis.

METHODS
We conducted a prospective study of all episodes of sepsis detected in our department (April 2016-December 2017). Patients with registered CRP values on the day of admission and 3 days after were included. We analyzed the relationship of ΔCRP with 14 days-mortality, so the sample was divided into three groups according to the ΔCRP: a) decrease > 5 mg/dL, b) stable with variation of ± 5mg / dL, and c) increase > 5 mg/dL. The first group was considered as a reference for estimating the relative risk (RR) and its 95% confidence interval (95% CI). P for the trend (Ptrend) < 0.05 was considered statistically significant. We received a funding from the Spanish Society of Internal Medicine to develop the project (‘Ayudas a la investigación FEMI para jóvenes investigadores’ program).

RESULTS
The sample included 231 patients, with a mean age of 79 years (SD 15) and 126 men (55%). Twenty-eight (12%) patients died at day 14. Regarding the kinetics of CRP, in 81 patients the CRP decreased, in 99 patients, it remained stable and in 51 patients, it increased. The 14 days-mortality was 6 (7%), 11 (11%) and 11 (22%) respectively (Ptrend=0.02). The RR of mortality was 1.5 (95% CI 0.5-3.8) in the group that maintained a stable CRP, and 2.9 (95% CI 1.1-7.3) in the group that increased the CRP > 5 mg/dL.

CONCLUSIONS
In this study, we show that an increase of ≥5 mg/dL in CRP level with respect to the first day is associated with three times increase in the risk of mortality.
Respiratory infections in the Internal Medicine Department - a retrospective study.

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Objectives: Respiratory infections (RI) are a common cause of admission to the emergency department, often requiring hospitalization and may occur during the course of the emergency. The objective of this study is to characterize the hospitalization of a patient with a diagnosis of RI at discharge of the Internal Medicine Service.

Methods: Analysis of the clinical processes of the target population with appropriate statistical analysis and scale application.

Results: There were included 139 patient with diagnosis of respirartory infections. Mean age was 79.5 years and 54.4% were women. 32.5% of the respiratory infections were classified as Pneumonia. 11.2% were classified as acquired in the Hospital. The average duration of hospitalization was 8 days. Only 7% of the patients required long term oxygen therapy and an etiological agent was identified in only 6.3%. The most prevalent etiological agent was Klebsiella pneumoniae in the sputum. The most frequent empiric antibiotic scheme was ceftriaxone and clarithromicin (23.4%).

Conclusion: Respiratory infections continue to be the main reason for admission to internal medicine services. The authos also highlights the low prevalence of etiologic agent identification.
Infectious diseases
A-2294

Revisiting tuberculosis risk factors

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Introduction: The incidence of tuberculosis (TB) have been decreasing in developed countries. However, population aging and multiple comorbidities conferring low-immunity states, as in diabetes mellitus, severe kidney disease, low body weight, hepatic liver disease, organ transplants and medical treatment such as corticosteroids and other immunosuppressive drugs, may play a role in the overall incidence of tuberculosis in developed countries. Case Report: A 81-year-old male with medical history of type 2 diabetes mellitus, chronic alcoholic liver disease and arterial hypertension, was admitted with 1 week history of markedly anorexia and asthenia. On admission, he had decreased left breath sounds and thoracic CT showed a left-sided large volume pleural effusion with atelectasis of the lower upper lobes. The differential diagnosis included both infectious and malignant diseases, the first being more probable since the relative rapid onset of the patient's symptoms. Over the hospital course, the patient underwent two thoracenteses, which demonstrated a lymphocytic exudative effusion high adenosine aminase (ADA) value of 107 UI/L (normal range for pleural effusion < 45 UI/L). Pleural biopsy showed granulomatous changes. Cultural and direct exams were negative. Giving high ADA level, a lymphocytic pleural effusion and granulomatous reaction, the patient was started on RIPE therapy for treatment of presumptive TB with symptom improvement.

Discussion: TB is a major global health concern with increasing atypical presentations, where late diagnosis comprises significant morbidity and mortality. The incidence of TB in Portugal has decreased 40% over the last 10 years, currently with an incidence of 17.7/100 000 people, remaining higher than Europe's incidence of 11.4/100 000 people. However, when analysing risk factors such as advanced age, diabetes and chronic liver disease incidence, has shown by our patient, one can understand this results.
Rifaximin on Treatment of Clostridium Infection Recurrence

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Introduction: Clostridium difficile infection (CDI) is a frequent cause of nosocomial infections, increasing the morbidity and mortality in hospitalized patients. Its clinical manifestations can range from mild diarrhea to toxic megacolon, bowel perforation, septic shock and death. The prevalence and severity of CDI have increased. CDI recurrence may occur after 1st line antibiotic therapy in about 8% of patients.

Case description: An 88-years-old woman, with hypertension and diabetes was hospitalized for pneumonia and treated with amoxicillin/clavulanic acid and clarithromycin. The patient was re-admitted with diarrhea and abdominal pain and was diagnosed with mild CDI, performing a ten-day course of metronidazole with favourable evolution. Nine days after discharge, the patient shown recurrence of gastrointestinal symptoms and initiated vancomycin for severe CDI. Pre-discharge colonoscopy revealed colonic diverticulosis. Readmitted after six days with abdominal pain, watery diarrhea and vomiting. Objectively feverish, hypotensive and dehydrated. On complete blood count, there was increased inflammatory parameters and renal dysfunction. Clostridium difficile (CD) toxin test was positive on stool. It was associated rifaximin to vancomycin to treat the second recurrence of CDI. Clinical and biochemical improvement was observed and CD test toxin control was negative. Was no recurrence three months after discharge.

Discussion: After resolution of CDI with standard antibiotic therapy, recurrence can occur between 12-25%, increasing to over 65% if multiple recurrences are observed. Treatment of recurrent CDI remains challenging. Rifaximin demonstrated efficacy against CD without significantly altering the gastrointestinal flora and with low resistance rates. Positive results are reported with the combination of vancomycin and rifaximin.
Risk Factors associated with Metabolic Syndrome in an HIV Population

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Objectives: HIV patients often develop a general disorder of lipid and fat metabolism, carbohydrates and vascular control mechanisms. To analyse the main factors associated with the metabolic syndrome in an HIV+ population.

Methodology: Observational, analytical, retrospective study of 149 HIV+ patients in follow-up consultations of Infectious Diseases between January 1992 and December 2017, using the clinical history and statistical package SPSS 24.0 as a tool.

Results: In the population studied, 72% were men, with an average age of 50.34 ± 0.752 years and a predominance of the age range [36 - 55 years]: 68%. The most frequent mode of transmission is sexual (44.7% heterosexual) followed by parenteral (37.1% IDUs). The majority of patients belong to the C3 category (28.3%) with 64.2% of them diagnosed with AIDS. 100% receive ART, 46% with protease inhibitors and 21.3% with integrase inhibitors. 82% have HDL<40 mg/dl cholesterol, 29.3% hypertriglyceridemia, 20.7% hypertension, 14% diabetes, 23.3% obesity and 24.7% central obesity. The prevalence of metabolic syndrome by ATPIII criteria is 23.4% (95% CI 18.1%-28.7%) and by IDF criteria 29.3% (95% CI 23.43%-35.20%). Factors independently associated with an increased risk of developing metabolic syndrome are age (≥ 40 -59 years) (OR = 3.37, 95% CI 1.37 – 8.47, p = 0.412), CD4 < 200 cells/mm3 (OR = 3.062, 95% CI 0.532-11.542, p = 0.028), BMI>25 (OR = 1.85, 95% CI 0.876-3.81, p = 0,113) and the use of protease inhibitors (OR = 1,062, 95% CI 1.014-1,103; p = 0.037)

Conclusion: We suggest regular monitoring of HIV patients under anti-retroviral therapy for metabolic abnormalities, as proper diagnosis and treatment of the metabolic syndrome would result in a decrease in the incidence of coronary heart disease in a population at risk.
Infectious diseases
A-2480

**S. pneumoniae spondylodiscitis: an inaugural manifestation of HIV infection**

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Invasive pneumococcal disease (IPD) is an important cause of morbidity and mortality among HIV-infected patients. It can occur at any stage of HIV-infection, including as a inaugural manifestation of it.

A 46-year-old black man was admitted to hospital with a 48-hour history of fever, cervical pain radiating to right upper limb and right hand paresthesias. On physical examination, he was febrile, had oral thrush and had pain at palpation of cervical and dorsal spinous processes. Laboratory tests revealed haemoglobin: 10.4 g/dL, normal total white cell count and absolute lymphocyte count (confirmar que eram normais), monocytosis (1110 cells/μL) and elevated erythrocyte sedimentation rate (120 mm) and C reactive protein (14.1 mg/dL). Cervical magnetic resonance findings showed C5-7 spondylodiscitis and anterior paravertebral abscess. Blood cultures were positive for Streptococcus pneumoniae. Chest computed tomography scan excluded pneumonia and transthoracic echocardiogram showed no vegetations. ELISA and Western blot for HIV1 were positive. HIV RNA viral load was 132 873 copies/mL and CD4 lymphocyte count was 600 cells/μL. The patient was treated with benzathine penicillin G and, subsequently, with amoxicillin (8 weeks), with regression of the referred symptoms and imaging improvement with significant reduction of paravertebral abscess. Simultaneously anti-retroviral therapy was started.

HIV infection is the most common (24.1%) underlying condition in adults with IPD (24.1%). Increased risk for IPD is due to impaired host humoral and cellular immune response, with progressive loss of specific functional antibodies. IPD typically presents as meningitis and pneumonia. Endocarditis, peritonitis, arthritis and osteomyelitis are less common manifestations. There are limited data on osteoarticular involvement. The case here presented is rare and emphasizes the lack of correlation between HIV infection stage and pneumococcal osteoarticular infection.
Scimitar syndrome; Pneumonia and 2:1 AV block

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Introduction - Scimitar, or pulmonary venolobar, syndrome is a rare congenital cardiovascular defect that includes a hypoplastic right pulmonary artery and right lung, which leads to displacement of cardiac structures into the right hemithorax, anomalous systemic arterial supply to the right lung, and a curved anomalous right pulmonary vein that drains into the inferior vena cava resembling the curved Middle Eastern sword “scimitar.”

Case Description – Woman, 82 years, partially autonomous; with Heart failure; Chronic Obstructive Pulmonary Disease with asthma component; anomalous drainage of right hypoplastic lung with drainage of pulmonary veins to the inferior vena cava - Scimitar syndrome; arrives to ER with dyspnea, cough, face edema. Initial evaluation with systolic murmur in right hemithorax and ronchi in pulmonary auscultation; symptomatic bradycardia with cardiac frequency 42 bpm; oxygen saturation in ambient air 87%. Thorax X ray: cardiomegaly and hipotransparency of right inferior lobe. Analytics with C reactive protein 9,96 mg/dl. Electrocardiogram: second-degree atrioventricular block 2:1 AV block. Diagnostic hypothesis: Pneumonia and decompensate heart failure. Treatment with antibiotics during 7 days then she was transferred to other unit to implant pacemaker. The infectious component evolved in a favorable pattern; Pacemaker implantation with frequencies above 60 bpm without complications. Discharge with follow up in 2 months.

Discussion - This syndrome has varied presentations, from an asymptomatic state to severe pulmonary hypertension and/or heart failure. Disease in adults commonly presents with recurrent pulmonary infections or exertional dyspnea and in this group usually presentation is benign.
Scrofuloderma – A rare presentation of Tuberculosis

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Introduction: Cutaneous tuberculosis (CTB) is a rare disease, which represents 1-1.5% of all extra-pulmonary tuberculosis (TB) cases. Scrofuloderma results from endogenous TB source and is one of the most common forms of CTB infection. It is caused by contiguous spread of infection from an underlying structure, most commonly from a lymph node, bone, joint or the epididymis. These lesions are most commonly seen in the neck region, but chest, axillae and groin can also be afflicted.

Case Description: A 69-year man presented in the emergency department with a right supraclavicular indurated nodule, which led to subsequent ulcer formation associated with purulent discharge, dating back to more than 1 month earlier. The patient reported substantial weight loss in the last year, without fever. Examination revealed the aforeknown ulcerated lesion surrounded by an indurated area with nontender adenopathies. The cervical and thoracic computed tomography revealed a right supraclavicular abscess with multiple loci and mediastinic adenopathies. Laboratory parameters revealed chronic disease anemia, high ESR (99 mm/h) and maximum PCR of 11.4 mg/dL. HIV testing was negative. On microbiological analysis of the biopsy, Mycobacterium tuberculosis PCR was positive and M. tuberculosis complex grew on Bactec medium, susceptible to all the first line anti-TB drugs. The patient started first-line tuberculostatic drugs, followed by clinical recovery. Blood, sputum and bronchoalveolar lavage cultures revealed no bacterial growth.

Discussion: Regardless of the HIV epidemic, CTB remains a rare diagnosis. Added to its clinical polymorphism, it can be an easily misdiagnosed entity. Therefore, it is important to have a high index of suspicion, so that an earlier diagnosis can be reached and TB drugs started as soon as possible.
Infectious diseases
A-1709

Seizures, Epstein-Barr Virus Encephalitis: Case report

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Introduction: Many neurologic manifestations of Epstein-Barr virus (EBV) infection have been documented, including encephalitis, aseptic meningitis, transverse myelitis, and Guillain-Barre syndrome. The diagnosis of EBV acute encephalitis (AE) is made by changes in titers of EBV specific antibodies and magnetic resonance imaging (MRI) findings. EBV AE can occur in the immunosuppressed as well as in primary infection of a healthy individual.

Case Description: An 74-years-old man with a history of dyslipidemia attended to the emergency department with three episodes of generalized tonic-clonic seizures with spontaneous recovery. On physical and neurologic examination presented with no relevant changes. Laboratory study showed leukocytosis and neutrophilia, CPR 0.07mg/dl. Brain CT scan revealed no lesions. Cerebrospinal fluid (CSF) was hematic, with protein concentration of 5.8mg/dL, normal glucose and some leukocytes. Due to the number of erythrocytes, it was impossible to performed a cell count. Subsequently, serologic testing was compatible with acute EBV infection. No immunosuppression was found. EBV on CSF was positive. Brain MRI hyperintense in T2 in the white region of the semioval centers and periventricular seat. Assuming seizures in the context of EBV AE. Initiated empiric treatment acyclovir, without recurrence of seizures and hospital discharge after 14 days.

Discussion: The clinical manifestations in AE is variable, sometimes may present as convulsive seizures. EBV infection should be considered when lesions are localized to the basal ganglia and documented with serologic tests. EBV encephalitis is rare, occurring in less than 1% of cases, with a self-limiting nature and few sequelae.
Infectious diseases
A-1781

Sepsis of biliary origin and pylephlebitis: a rare and fatal complication.

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INTRODUCTION

Pylephlebitis is a rare and severe complication of intrabdominal infectious processes, characterized by septic thrombophlebitis of the portal vein tree.

CASE DESCRIPTION

A 87-year-old woman with past medical history of hypertension, diabetic type II, hyperthyroid and paroxysmal atrial fibrillation (AF), presented to the emergency department with general non-specific malaise and confusion for two days without other symptoms even fever. Due to poor clinical evolution it was decided to cover with empiric broad-spectrum antibiotic, vancomycin and meropenem, with the need to rule out three possible foci: neurological (confusion), urinary (pathological urinary sediment) and/or abdominal (clinical ultrasound with cholelithiasis without cholangitis).

In addition, endocarditis was ruled out and a new abdominal ultrasound was repeated due to persistence of abnormal liver chemistries even though the patient did not manifest abdominal symptoms. Distended gallbladder with multiple cholelithiasis, choledocholithiasis, perihpatic collections and pylephlebitis with thrombus in the anterior branch of the right portal vein was evidenced. A study with computed tomography (CT) confirmed these findings.

After a targeted therapy with broad spectrum antibiotics (piperacillin-tazobactam) for four weeks, and two more weeks with ciprofloxacin and metronidazole, and keeping previous anticoagulation due to AF, our patient presented a satisfactory evolution and survived.

DISCUSSION

Pylephlebitis is a major diagnostic challenge requiring CT with contrast for confirmation. It implies a high mortality rate without early treatment, where the role of anticoagulation is subject to discussion. Our case was presented as a pylephlebitis due to biliary origin, where a systematic review of the proofs gave us the clue.
INTRODUCTION: The infection of the joints of the chest wall is infrequent and therefore causes uncommon chest pain. When septic arthritis (SA) occurs, the sternoclavicular joint is usually affected and is usually associated with a history of intravenous drug abuse, a distant infectious focus, diabetes and rheumatoid arthritis, although it can also occur in patients without them. The most frequent germ in patients with drug abuse is Pseudomonas aeruginosa and without a history of Staphylococcus aureus.

DESCRIPTION: A 72-year-old patient with a personal history of Diabetes Mellitus, chronic bronchitis and arterial hypertension, presented with cough and yellowish sputum for a month without dyspnea. Thoracic pain at the level of sternoclavicular joint, which has progressively increased in intensity, with swelling of the area and fever of 39.5 degrees. Computed tomography of the thorax and abdomen: Sternoclavicular joint with elongated collection that affects the left sternocleidomastoid muscle. Thoracoabdominal subcutaneous fatty tissue edema and mediastinal extension. Positive culture for cloxacillin-sensitive Staphylococcus aureus that is maintained for 18 days in addition to surgical drainage of the abscess. Transthoracic echocardiography not suggestive of endocarditis was performed during admission and the control blood cultures were negative, without observing images of septic metastases at other levels.

DISCUSSION: The most frequent complications are abscesses in the surrounding area that are usually associated with mediastinitis, a situation that occurred in our patient as well as myositis. In addition to antibiotic treatment, it requires surgical debridement, prolonged hospital stay and physiotherapy due to residual functional limitation. The sternoclavicular joint is poorly vascularized, so antibiotic treatment is usually prolonged.
Infectious diseases
A-1387

Septic Cardiomyopathy in a patient with pneumococcal pneumonia

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INTRODUCTION: Septic cardiomyopathy is a potential complication of septic shock, defined as an acute global dysfunction of the left ventricle (LV), in the set of septic shock, which is always reversible.

CASE DESCRIPTION: A 55-year-old man, with hypertension and diabetes, attended the emergency room (ER) due to a 2-day history of dyspnea, wheeze, backache and cough, without fever. At admission, he had arterial pressure 86/46 mmHg, oxygen saturation 79%, lactates 3.15mmol/L. Chest X-ray revealed an extensive opacity in the right hemithorax. Ceftriaxone, azithromycin and fluids were started, but there was significant clinical worsening, with evolution to septic shock, multiple organ dysfunction and the need for vasopressor and ventilatory support. Streptococcus pneumoniae was isolated on blood cultures and bronchial secretions. The echocardiogram showed LV light dysfunction, with progression to severe dysfunction and global hypocontractility on the 4th day. There were no electrocardiographic changes suggestive of ischemia, notwithstanding a high-sensitivity troponin (hsTn) 101.835ng/L. In the following days, there was a progressive recovery of general condition and organic dysfunctions, with progressive decrease of hsTn and an improvement of LV ejection fraction to 40% at discharge, on the 21th day. Cardiac magnetic ressonance imaging (cMRI) on the 23th day revealed edema and late enhancement, suggestive of inflammation. Echocardiogram at 8 months showed LV ejection fraction of 60%, with no contractility changes.

DISCUSSION: Although the initial presentation suggested myocardial infarction, the subsequent evolution with cardiac function recovery, absence of segmentar contractility abnormalities and the cMRI pattern fit in the septic cardiomyopathy diagnosis.
Septic sternoclavicular arthritis - pulmonary and mediastinal extension

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Introduction:
Sternoclavicular septic arthritis is a rare infection, accounting for approximately 1% of septic arthritis.

Case description:
A 59-year-old male presented a two-week history of progressive, painful swelling of the right clavicle and fever. He complained of fatigue and dry cough. He denied any history of trauma or intravenous drug abuse. A physical examination revealed a soft and warm erythematous fluctuating mass was found overlying the right proximal clavicle, immediately lateral to the sternoclavicular joint. Analytically, inflammatory parameters were elevated (RCP 320). A CT scan of the chest showed necrotizing infection of soft tissues right chest wall with sternoclavicular, with retrosternal extension into the superior mediastinum and pulmonary apex. Blood cultures were obtained (isolation methicillin-sensitive Staphylococcus aureus MSSA) and treatment with intravenous piperacillin/tazobactam and vancomycin was immediately started. There were no signs of endocarditis on echocardiography. Bronchoscopy did not reveal endobronchial changes and bronchial aspirate isolated MSSA. Aspirated joint fluid and blood cultures were negative. His condition did not improve and started empirical AB with cefazolin and vancomycin. After discussion with Thoracic Surgery, there was no indication for surgery, and so antibiotic therapy with flucloxacillin at high doses was initiated. Percutaneous drainage guided by ultrasound of the swelling in the dependence of the right sternoclavicular joint (microbiological was negative), with posterior drainage and surgical debridement. Maintained AB for an extended time (80 days) with slow but favourable evolution.

Discussion:
Based on this case, we discuss the difficulty of diagnosing this pathology, and the consequences of delayed treatment in terms of life-threatening features of this infection and therapeutic option.
Objectives: To assess the available evidences on indication and duration of antibiotic treatment in Urinary Tract Infections (UTIs).

Methods: A systematic literature search was performed to identify all systematic reviews and guidelines in UTIs assessing the optimal duration of antibiotic therapy. We compared the recommendations of the three most cited and recent guidelines. Moreover, a meta-analysis of non-duplicate data from RCTs described in enrolled systematic reviews was performed together with a trial sequential analysis to identify the need for further studies.

Results: We enrolled 4 systematic reviews on cystitis and 2 on pyelonephritis. Both the enrolled meta-analyses on pyelonephritis and the meta-analysis we performed on 10 non-duplicate RCTs showed non-significant difference in rate of clinical failure (OR 0.87, 95% CI [0.62-1.23]) and microbiological failure (OR 1.07, 95% CI [0.81-1.41]) between short (7 days) and long (>7 days) antibiotic treatment courses. As for cystitis, the enrolled meta-analyses and our meta-analyses showed significant higher rate of microbiological failure at long term follow-up in short course antibiotic therapy (=3 days) compared with long course group (5-10 days) when using the same antibiotic (OR 1.48, 95% CI [1.20-1.83]). No significant difference among short and long courses groups was recorded for clinical failure at short and long term follow-up and short-term microbiological failure. The trial sequential analysis suggests that there is no need of other studies. Selected guidelines suggest considering shorter course, with low grade of evidence.

Conclusions: Short course antibiotic treatment seems to be as effective as longer courses for both microbiological and clinical success for pyelonephritis. For cystitis short course antibiotic treatment is not associated with higher rate of symptomatic and microbiological failure than longer courses, except for long-term microbiological failure.
Skin and Soft Tissue infections by Carbapenemase-Producing Enterobacteriaceae (CPE)

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Background: CPE are a public health problem because they are very resistant to antibiotics. CPE can infect skin and soft tissues needing broad spectrum antibiotics.

Methods: We analyzed all the cases of CPE affecting skin and soft tissue between 2015 and 2017 in a tertiary hospital.

Results: There were 7 cases (total number of infections): 5 occurred in men; average age was 77.7 years (min 70; max 89); mRankin score was 1-2 in 3 patients and 3-5 in 4 patients. The Charlson score had an average result of 7. Other diseases in this patients: 3 had pulmonary disease, 2 had chronic kidney disease and 6 had diabetes. Most of them had medical devices: urinary catheter was the most common (in 5). About the infection: 3 had infected sacrum ulcer, 2 had infected wound in a leg with peripheral arterial disease, 1 had wound in diabetic foot and 1 had deep infection of the surgical site. The diagnosis was made with pus cultura (in 4), exudate cultura (in 2) and skin biopsy (in 1); we had an isolated Klebsiella pneumoniae KPC+ in 5 cases and Escherichia Coli KPC+ in 2. Treatment have been made with an association of at least 2 antibiotics: 4 patients was prescribed fosfomycin, 3 tigecycline, 3 amikacin, 2 gentamicin, 1 colistin and 1 meropenem; the treatment lasted an average of 14 days. At the end 2 patients died and 5 patient were cured.

Conclusion: In our hospital we found few cases of CPE in skin and soft tissue infections. Besides that we had a high mortality rate (28.6%). It is essential to isolate this patients to avoid that CPE becomes pandemic, with increasing mortality and increasing antibiotic resistance.
Smoking is associated with higher chemerin serum levels in HIV infected-patients

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Background
Chemerin, also known as retinoic acid receptor (RAR) responder protein 2, is associated with normal skin function, but recent data also suggest that it may have a role as a mediator of inflammation, and there is an increasing interest on the molecule, as a potential line to develop new therapies for inflammatory conditions. Studies on chemerin are almost nil; therefore, we designed this project with the aim of increasing knowledge in that field.

Method
Cross-sectional study carried out throughout 2017 in the HIV outpatient clinic and the biochemistry department of a tertiary level hospital. The following variables were included: age, gender, number of cigarettes smoked per day, systolic blood pressure, diastolic blood pressure, heart rate, antecedent of cardiovascular disease or not, type of antiretroviral treatment (dolutegravir based, elvitegravir based, protease inhibitor based, nonnucleoside analogue based, or other type), CD4 cell count, HIV RNA undetectable or not, and fasting serum total cholesterol, HDL cholesterol, glucose, and chemerin (Human RARRES2, TIG2, ELISA Kit - Thermo Fisher Scientific). A multicenter linear regression analysis was carried out using the automatic linear modeling provided by SPSS version 22, with chemerin as dependent variable. Bivariables analyses were also carried out as needed.

Results
A total of 242 patients were included; their age was 45 ± 8 years; 180 of them (74 %) were male. The multivariable analysis showed an association of number of cigarettes smoked per day with chemerin level (P < 0.001) (Figure) and a trend towards and association of dolutegravir based treatment with higher chemerin level (P < 0.089). A bivariable analysis, showed a mild to moderate positive correlation between number of cigarettes smoked per day and chemerin level (Pearson 0.217, P = 0.001).

Conclusion
Chemerin serum level was positively correlated with the number of cigarettes smoked per day, in HIV-infected patients.
Introduction
Infectious spondylodiscitis is a rare diagnosis, often difficult to establish, by its insidious presentation. MRI is an added value in the early stages, aiding the diagnosis at this step. The authors describe two cases of pneumococcal spondylodiscitis complicated by an epidural abscess.

Case description
A 70-year-old woman, evaluated for acute dorsalgia and right foot pain, accompanied by inflammatory signs of the tibiotalar joint. No fever. Laboratory tests showed increased markers of systemic inflammation. MRI of the spine showed small posterior epidural collection (D7-D9), consistent with infectious process with the starting point being the posterior joint. MRI of the right foot revealed diffuse edema and signs of ankle synovitis. Streptococcus pneumoniae was isolated from blood cultures.

A 49-year-old man was evaluated for fever, severe cervicalgia and acute onset of tetraparesis with increased systemic inflammation markers. Cervical MRI showed C5 spondylodiscitis with spinal cord compression by an infectious intracanal collection with extension of C5 to C6. Urgent decompression surgery was performed, with resolution of the deficits. Streptococcus pneumoniae was isolated from the epidural collection.

Discussion
Spondylodiscitis should be suspected in the presence of back pain and constitutional symptoms. After establishing the diagnosis, the active demand of the agent responsible for the infection is essential, allowing the pathogen directed treatment that conditions the therapeutic success. In the cases described, the isolation of Streptococcus pneumonia allowed the antibiotic treatment according to the antimicrobial susceptibility testing, with favorable outcome.
Infectious diseases
A-1916

Stercoral Colitis as a Rare Cause of Cytomegalovirus Infection

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Introduction:
Cytomegalovirus (CMV) seroprevalence in general population ranges from 45% to 100%. Although CMV infection can cause severe complications in immunocompromised patients, gastrointestinal-CMV infection rarely occur in immunocompetent patients.

Case Description:
A 73-year-old male with a past of Parkinson’s Disease appeared at the emergency department with fever, black vomit and diarrhea for 3 days. Physical examination revealed abdomen bloating and pain without abdominal guarding. Blood tests showed leukocytosis, neutrophilia, CRP 19mg/dL, urea 153mg/dL, creatinine 2.3mg/dL, arterial gasometry normal. A large fecal mass in the rectum with colonic distention was evident in the abdominal x-ray.

In CT scan it was clear an image suggestive of pneumonia in the left lower lobe and fecal impaction in the recto-sigmoid colon (10cm), with thickening of the colonic wall and pericolonic fat stranding. Given the suspicion of stercoral colitis, enemas and empiric piperacillin/tazobactam were initiated; manual disimpaction was unsuccessful. On the 4th day, abdominal radiograph showed resolution of the previous fecal mass. Coprocultures and Clostridium difficile identification stool test were negative, colonoscopy revealed mucosal ulceration with signs of regeneration, which suggested subacute ischemic colitis, histopathology was compatible with CMV-colitis.

Discussion:
The exact mechanism of the pathogenesis of CMV-colitis remains to be determined. Pre-existing ischemic colitis may help to create a favourable environment for CMV leading to local immunosuppression. In our patient the inflammation caused by increased intraluminal pressure in the colon may have been the starting point for the CMV-infection.
CMV-disease is probably still underestimated and this case highlights the importance of CMV-colitis suspicion in immunocompetent patients.
Infectious diseases
A-1225

Still the burden of opportunistic infections

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Introduction
Toxoplasmosis, caused by the parasite *Toxoplasma gondii*, is the most common central nervous system infection in patients with acquired immunodeficiency syndrome (AIDS) who do not undergo prophylaxis.

Case description
A 36-year-old female patient with AIDS and history of cytomegalovirus (CMV) pneumonia with poor adherence to antiretroviral therapy is referred to the Emergency Department due to sudden bilateral decrease of visual acuity. Analytically, she had C-reactive protein of 43 mg/L, HIV-1 viral load of 1.688.456 c/μL and CD4+ 88 cells/μL.

A diagnostic of CMV retinitis is admitted, restarting ganciclovir. Serologically, patient had IgM negative for *Toxoplasma gondii* with IgG positivity. There was a positive result in the search of serum CMV DNA. During the first days of hospitalization, the patient complained of headache and a head CT scan was required and the result showed no alterations. She presented continuous degradation of her general state and fever without evident focus, initiating broad spectrum antibiotic therapy. Lumbar puncture was performed with no alterations and without bacterial isolation. Cranioencephalic MRI revealed "multiple intra-axial expansive lesions compatible with opportunistic infectious lesions/brain abscesses" and a diagnosis of cerebral toxoplasmosis was reached.

Treatment was initiated with sulfadiazine and pyrimethamine. In control imaging, there was a marked decrease in lesion size.

Discussion
In immunocompromised patients, especially in those with AIDS, toxoplasmosis causes opportunistic disease usually when CD4+ levels are under 100 cells/μL.

The most common presentation is encephalitis with headache and fever. The diagnosis is made by the presence of compatible clinical syndrome, IgG antibody positivity and imaging confirmation.

We present a case where a high level of suspicion was necessary for this diagnosis since the initial CT did not show lesions.
**Streptococcus agalactiae Meningitis**

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**INTRODUCTION**

Streptococcus agalactiae (S. agalactiae) is a common gram positive commensal of the gastrointestinal and genitourinary tracts. In older diabetic patients, S. agalactiae is usually implicated in soft tissues infection and it is increasingly being recognized as a cause of bacteremia.

**CASE DESCRIPTION**

A 92 year old female, with prior history of type 2 Diabetes mellitus presented to the emergency department in coma and apparent signs of infection of the right hallux, despite recent treatment with ciprofloxacin. No headache or vomiting were reported. On admission, she was febrile and the Glasgow coma scale was 9. She had no focal neurological deficits nor meningeal signs. Laboratory data revealed elevated inflammatory markers. Her head CT scan presented a left anterior temporal cortico-subcortical hypodensity. Thoracic X ray and abdominal ultrasound were normal. The electroencephalography demonstrated no epileptiform activity though it showed severe dysfunction in the left brain. Examination of the cerebrospinal fluid revealed 57 cells/uL; 30 polymorphonuclear cells/uL, 500 red blood cells/uL, glucose 204mg/dL (serum glucose= 300mg/dL), and protein concentration 1.49g/L. She was started on intravenous antibiotics: ceftriaxone 2g bid and ampicillin 2g 4/4h for 3 days till isolation of S. agalactiae in blood culture results. Right foot X ray did not support the hypothesis of osteomylelitis and transthoracic echocardiography did not support endocarditis. Cerebral MRI confirmed the left temporal lesion and suggested cerebritis. There was neurological recovery and the patient was hospital-discharged after completion of 21 days of intravenous penicillin 2000 U 6/6h.

**DISCUSSION**

Infection by S agalactiae is considered severe when there is bacteremia, endocarditis or meningitis. Although rare, meningitis due to S agalactiae has a high mortality rate, especially in elderly patients with multiple comorbidities.
Introduction: S. bovis accounts for about 10% of the causes of endocarditis. At the same time it has a strong association with lesions in the colon, from carcinoma, premalignant lesions, adenomas or polyps.

Case description: We present the case of a 77 years old male, with history of hypertension, diabetes mellitus type II, atrial fibrillation and recent diagnosis of adenocarcinoma of the rectum, in a study performed by the Primary Care Physician. Interned in the Internal Medicine service for community acquired pneumonia with an associated hypoxemic respiratory insufficiency. Given the favorable clinical response and good general condition, the patient was discharged after 3 days, completing antibiotic therapy with levofloxacin at home and directed to general surgery consultation (coloproctology). Three days after discharge, Streptococcus bovis (S. Bovis) was identified in previously collected blood cultures. The patient was called for medical reassessment. Asymptomatic, without complaints of fever, dyspnea, chest pain, easy fatigue or peripheral edema. Cardiac auscultation presented a new systolic murmur, grade III / VI, audible throughout the precordium, more evident in the mitral focus. The patient was re-hospitalized and performed a transesophageal echocardiogram: "(...) on the aortic face of the right conorian sigmoid presence of a" mass "of about 7 mm, mobile, probably corresponding to a vegetation. Mitral valve remodeling with leaflet thickening and holosystolic prolapse of the anterior leaflet with cord rupture. " Initiated antibiotic therapy with ceftriaxone and gentamicin, in a 4 and 2 week schedule, respectively. It was referenced for consultations of Oncological group to, in collaboration with Cardiology, to define the best therapeutic strategy.

Conclusion: With this case, the authors intend to reinforce the importance of endocarditis screening and a possible intestinal neoplasm, even in asymptomatic patients, in the presence of S. bovis bacteremia.
Streptococcus gallolyticus and abdominal tumors

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Streptococcus gallolyticus (S. gallolyticus) bacteremia is an important cause of endocarditis, and the identification of this species should lead to the search for indolent gastrointestinal (GI) malignancies, as the gut has proven to be the most probable gate of entry. Established since the 1970’s, this association has been in 25 to 80% of patients with S. gallolyticus bacteremia, but conditions such as chronic liver disease have also been reported as a predisposing factor.

The authors present the case of a 75 year-old woman with a history of hypothyroidism, heart failure and total hysterectomy as treatment for ovarian cancer. Ten years later, several metastases were identified, leading to a partial pneumonectomy, total splenectomy and peritoneum nodule excisions, as well as adjuvant chemotherapy with tamoxifen. Recently she was admitted with complaints of respiratory tract infection, while all blood cultures revealed a S. gallolyticus bacteremia. A computed tomography (CT) scan revealed a pelvic mass in contact with the sigmoid colon. Colonoscopy described a subocclusive mass with normal mucosa appearance 35cm away from the anus, suggesting extrinsic compression. The colonoscopy biopsy revealed a normal intestinal mucosa. Further data led to the conclusion that the pelvic mass represented a focal relapse of the ovarian cancer.

The absence of an obvious portal of entry for S. gallolyticus in this case, as well as the anatomical site involved, with no apparent disruption of the GI wall, made the authors consider the intraabdominal malignancies with GI wall contact as a possible predisposing factor for bacteremia, S. gallolyticus bacteremia in particular, leading to believe that colonoscopy alone should not rule out a neoplastic disease in S. gallolyticus bacteremia patients.
The microbial flora in the medicine ward- 1 year study

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Introduction: Infections are one of the main causes of morbidity and mortality in hospitalization. The knowledge of our microbial flora is one of the best tools in the prevention and therapeutic approach.

Methods: The authors evaluated the microbial flora in the hospitalization of medicine in the year 2017.

Results: We identified 503 bacteria (90.96%) and 50 fungi (9.04%) were isolated from the 553 aseptic urine (UC), with the most frequent agent being Escherichia coli (E. coli) 34.36%, followed by Klebsiella pneumoniae (K. pneumoniae) 21.52% and Candida albicans respectively. Of the 140 blood cultures, 139 bacteria were isolated, Staphylococcus epidermidis being the most frequent (25%) followed by Staphylococcus aureus (21.43%), of these strains 43.33% were methicillin resistant (MRSA) and 1 fungus. From purulent exudate we identified 81 bacteria and 1 fungus. Of the 112 bronchial secretions (either by expectoration or bronchial aspirate) 93 were positive, Pseudomonas aeruginosa 28.88% were the most frequent, followed by Staphylococcus aureus (23.66%) of these 68.18% MRSA and 19 fungi. Vaginal exudate was the site where more fungi were isolated when compared to bacteria. In feces (N = 5) only isolated Campylobacter spp. Only 1 positive result of cerebrospinal fluid (Staphylococcus hominis), ascitic fluid (Proteus mirabilis) and synovial fluid (Burkholderia pseudomallei).

In general, E. coli was the most frequent bacteria (N = 181) followed by K. pneumoniae (N = 164) and Pseudomonas aeruginosa (N = 72). Candida albicans isolated fungi was the most frequent agent (N = 54) followed by Candida glabrata (N = 6) and Candida tropicalis (N = 5). UC was the most frequent site of bacterial and fungal isolation.

Conclusion: With the delay of the isolation of the cultural results, the knowledge of the microbial flora in our work place is of extreme importance so that effective empirical antibiotic can be realized early.
Infectious diseases
A-1788

Toxoplasmosis induced by routine immunosuppressive regimens

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Introduction: Opportunistic infections cause severe morbidity and mortality in autoimmune patients under immunosuppressive therapy. Toxoplasmosis is a well-known opportunistic disease in HIV-induced T-cell deficiency. Reactivation of latent Toxoplasma gondii by therapeutic immunosuppression is less well defined.

Case description: A 45-year-old male, with primary antiphospholipid syndrome (APS) with refractory immune thrombocytopenia was admitted due to tonic-clonic seizures. Physical examination was remarkable for a central right facial paralysis. His blood tests were normal except for thrombocytopenia. Brain MRI revealed multiple supratentorial expansive lesions with T2 hyperintensity with contrast enhancement and vasogenic edema. Lumbar puncture revealed pleocytosis (12.3 cells/mm³ with no cell predominance) and was positive for T. gondii RNA. All the other viral infections were excluded. In spite of being under immunosuppressive therapy in the last four years, no alterations were found on peripheral blood T and B cell frequencies. During the first two years of APS diagnosis he was under high dose corticosteroids, plus azathioprine, and was also treated with rituximab. During the two past years he was under low dose prednisolone with stable platelet count and no bleeding. The patient was started on pyrimethamine/sulfadiazine plus levetiracetam with clinical improvement and imaging resolution after 8 months.

Discussion: T and NK cell function are critical to maintain T. gondii latency and to effectively control active infection. It is well known that therapeutic immunosuppression disrupts multiple immune pathways. However, severe impairment of immune function may be kept unnoticed. This case highlights that therapeutic immunosuppressive regimens may significantly impair T cell function leading to opportunistic toxoplasmosis infection.
Tropical Piomiosite by intense physical activity

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Introduction: Tropical Piomisite (TP) is an infectious pathology caused most of the times by Staphylococcus aureus, forming deep muscle abscess or in various muscle groups. The risk factors are disseminated infections, immunodeficiency, trauma and intense physical activity.

Case Description: A.S, male, 51 years old, resident of Rio de Janeiro, beach hawker, presenting intermittent fever for more than 20 days, and intense pain in the inguinal region with progressive worsening of the pain and the blemish.

To the exam: Icteric 1+/4+, atypical abdomen, inferior members with paraparesis without edema, internal rotation, semiflexed, intense pain to immobilization.

Exams: 38800 leukocytes, PCR 8,5 cultures and serologies negative, Computed Tomography (CT) with contrast pelvis to abdomen - significant thickening of the left iliac muscle (L), non-capturing areas in the contrast medium in the psoas muscle. Ultrasonography of Psoas with hypoechoic areas in iliac musculature, with greater collection in left iliac muscle (2,5x2,0cm). Lymph node enlargement in the inguinal region.

Initiated Oxacillin, without significant laboratory improvement after 10 days. On the 16th day without clinical and laboratory improvement, the surgical approach of the abscess was chosen and the antibiotic scheme for Meropenem and Vancomycin was extended. Thus, it later evolved with clinical and laboratory improvement. Cultures of abscess fluid with growth of S. aureus MRSA. He was discharged after 10 days with improvement of pain and blemish.

Conclusion: In Brazil, there’s too little data on Tropical Piomisite. Skeletal musculature is usually resistant to bacterial infection but studies have shown that this tissue when previously damaged is susceptible to infection. The patient presented muscle stress due to work activity as a precipitating factor, and was then diagnosed with TP. The surgical treatment associated with antibiotic therapy proved to be extremely effective.
Tuberculose extra pulmonaire chez le dialysé

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INTRODUCTION : L’incidence de la tuberculose (TBC) est en nette augmentation. Toutefois le diagnostic de la tuberculose extra pulmonaire reste difficile et sous-estimé notamment chez les malades en hémodialyse ou en dialyse péritonéale.

MÉTHODES : Étude rétrospective réalisée sur une période de 10 ans incluant les malades dialysés et suivis pour tuberculose. Ce travail permet d’étudier les différentes localisations extra pulmonaires chez cette population.

RÉSULTATS : Il s’agit de 53 malades atteints de TBC dont 43 soit 81,11% présentaient une tbc extra pulmonaires. La moyenne d’âge de ce sous-groupe était de 50,8 ans avec un sexe ratio de 0,79. 40% des patients était tabagiques, 93 % diabétiques et 58% hypertendus. 85,7% étaient en hémodialyse et 14,3% en dialyse péritonéale. Il s’agissait d’une TBC monofocale chez 23 patients, bifocale chez 15 patients et multifocale chez 5 patients. Neuf patients avaient à la fois une tuberculose pulmonaire et extra pulmonaire. Les organes atteints étaient : les sërées (la plèvre dans 25,9% des cas, le péricarde dans 25,6% des cas et le péritoine dans 25,6% des cas), les ganglions dans 27,9% des cas, l’appareil urogénital dans 27,9% des cas, les organes hématopoïétiques dans 7% des cas et l’os dans 11,6% des cas. Le diagnostic positif de la TBC extra pulmonaire était retenu sur des critères bactériologiques dans 30,2% des cas, histologiques dans 11,6% et sur des éléments de présomption chez 58,13%.

Nous avons trouvé une relation statistiquement significative entre l’hémodialyse et la susceptibilité de localisations extra pulmonaires de la TBC (p=0,05 [1,039 ; 1,419] OR=1,214).

CONCLUSION : La TBC extra pulmonaire chez le dialysé est souvent sous diagnostiquée du fait de la fréquence des localisations inhabituelles et la non spécificité de la symptomatologie mais il faut toujours l’évoquer et essayer de la confirmer par la multiplication des prélèvements.
Tuberculosis – a differential diagnosis to consider

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Introduction: The global incidence of tuberculosis appears to be declining slowly, but it remains an important health problem in many parts of the world and in many population groups. Poverty, human immunodeficiency virus (HIV) co-infection and drug resistance are major factors in the enduring global epidemic.

Case description: We present a 63-year-old homeless Caucasian male with active smoking habits (15 pack-year), chronic alcohol abuse and psoriasis, who presented with 2 month-history of pleuritic chest pain, cough with scarce purulent sputum and subjective weight loss. Objectively, he presented with malnourishment, hypotension, and persistent horizontal nystagmus; the cardiac and pulmonary auscultation was normal. Laboratory findings revealed anaemia, hyponatraemia hypoalbuminemia and an elevated C-reactive protein (CRP). The chest radiography revealed an extensive hypotransparency of the left lung and multiple nodules in the right lung. To exclude the presence of metastatic disease a thoracic, abdominal and pelvic contrasted CT scan was obtained, which showed multiple large cavities in both lungs, mainly in the superior lobes, with thickened interlobular septa and evidence of infectious condensation. Direct sputum smear microscopy was positive for Mycobacterium tuberculosis. A four-drug antituberculous regimen was initiated, pending drug-resistance testing being undertaken at a reference laboratory.

Discussion: Despite its declining incidence, tuberculosis remains an important differential diagnosis in many parts of the world, and clinical awareness and suspicion is an important step towards making the correct diagnosis and initiating proper treatment.
**Tuberculosis: The (un) usual suspect**

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**Introduction:** The differential diagnosis in a fever of unknown origin includes the infectious, immunological and neoplastic causes. In order to accomplish that it is important to take into account the pattern of fever and associated symptoms, pathological background, epidemiological context and a detailed objective examination. Complementary examination results are often nonspecific.

**Case description:** 76-year-old male with history of depressive and post-traumatic stress disorder. He was admitted in our infirmary to study a fever of unknown origin. Apart from headache and global malaise during febrile peaks (predominantly in the evening), the patient was asymptomatic. Analytically, we found an anemia compatible with an inflammatory state and elevation of inflammatory parameters. The septic screening was sterile. Virology markers were negative, echocardiogram was normal and the myelogram, endoscopic study and autoimmunity markers had no alterations. He performed PET scan without abnormally increased catchment areas. Finally we performed a liver biopsy that only came with nonspecific reactive changes. During the investigation period, the patient maintained evening febrile peaks, without symptomatology suggestive of associated infection. After all this study, the patient started antimicrobial therapy for tuberculosis and in 48h was in apirexia that maintained afterwards, sustainably.

**Discussion:** In several recent WHO reports, Portugal is considered the Western European Country with the highest prevalence of tuberculosis. Diagnostic suspicion in a fever of unkown origin, although the diagnosis is of exclusion, must always be present.
INTRODUCTION: Bursitis trocanterea by Mycobacterium tuberculosis is an infrequent entity that usually affects immunocompromised patients. It usually manifests insidiously, making diagnosis difficult and delaying treatment.

CASE DESCRIPTION: A 86-year-old woman with a history of left trochanteric infectious bursitis who had been operated on for a year with conventional negative bacterial cultures. Previously, he reported swelling and pain of inflammatory characteristics in the left peritroarthreatic area with limitation for ambulation in the 3 months of evolution. Consultation for cutaneous fistula at scar level of 3 weeks of evolution and fever. On examination, spontaneous purulent drainage was observed by fistula, with normal exploration remains. The complementary tests show: 24,000 leukocytes with left deviation and PCR 210 mg / L. Negative blood cultures. Quantiferon: positive 4.45 IU / mL. Normal chest x-ray. MRI shows thickening of the pertrocanterea musculature, with abscess and accompanying bone infection. Surgery was performed with bone samples taken for microbiological study that were negative for conventional bacterial cultures and positive for mycobacterium tuberculosis PCR. With these results, antibiotic treatment was started with rifampicin, isoniazid and pyrazinamide and ethambutol during the first two months, continuing with rifampicin and isoniazid until completing 9 months with good clinical radiological evolution.

DISCUSSION: Mycobacterium tuberculosis infection of the joint pouches of the gluteus maximus is uncommon; its clinical presentation is not very florid and of long evolution. These two facts make the diagnosis difficult and commonly these processes are labeled "nonspecific" and, therefore, poorly treated at the time of the first consultation. Diagnosis is usually made in advanced stages due to the presence of cold abscesses and fistulas. Sometimes, the surgical approach is required to arrive at a diagnosis of certainty.
Tuberculous lymphadenitis in a low prevalence country: Changes in clinical profile and potential diagnosis role of PCR in urine.

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OBJECTIVES: In recent years, there has been a significant decline in pulmonary tuberculosis with a relative increase of extrapulmonary cases. Tuberculous lymphadenitis (TBL) is the most common form of extrapulmonary tuberculosis. Gold standard diagnostic test for TBL is a culture positive specimen obtained by fine needle aspiration or biopsy. These tests involve invasive procedures and could delay several weeks to yield results, being this approach not always suitable to be performed in clinical practice. Hence, we evaluate the diagnosis accuracy of urine PCR and we describe epidemiological and clinical data of patients with TBL.

METHODS: All TBL cases diagnosed at a Spanish tertiary hospital between 1995 and 2016 were evaluated. Likelihood ratio, sensitivity, specificity and predictive values of 16S-rRNA amplification by PCR on urine were evaluated comparing with a reference method of positive culture performed on FNA specimens.

RESULTS: 1356 TB cases were diagnosed during the study period, 252 (19%) of them were classified as TBL. 65 (26%) patients were non-native residents, with different baseline characteristics compared with Spanish population, being a younger population with fewer associated comorbidities and clinical profile (HIV, HCV, pulmonary involvement, fever and chronic liver disease). Specimen culture was performed in 36 out of 43 patients that underwent urine PCR analysis. Culture-positive outcome resulted in 24 patients (9.5%), 9 of them with positive urine PCR. Positive likelihood ratio was 4.50 (95%; IC 0.2-4.96), sensitivity 37.5% (95%; IC 18.3-56), specificity 92% (95%; IC 76-100) and positive predictive value 90% (95%; IC 71-100).

CONCLUSION:
- TBL has increasingly been diagnosed in non-native residents, with a different clinical profile and less systemic clinical involvement of TBL.
- Urine PCR could be a useful marker of TBL diagnosis as a combination with other tests given its high positive likelihood ratio, specificity, lower invasivity and being a less time-consuming test.
**INTRODUCTION**

Tuberculous myopericarditis is an important complication of tuberculosis, with higher prevalence in immunocompromised population. HIV-infected-patients can develop a wider spectrum of cardiac and vascular manifestations. Cardiomyopathy in association with HIV infection still under study.

**CASE DESCRIPTION**

38-year-old man from Equatorial Guinea, with a history of untreated HIV infection came to the ER with dyspnea, with acute pulmonary edema. He referred two-month duration fever, weakness and dyspnea. The chest x-ray and echocardiography showed a severe pericardial effusion. A pericardiocentesis was performed, obtaining 1.4 liters of hematic fluid with exudate characteristics. The PCR and culture of pericardial fluid were positive for Mycobacterium tuberculosis. Levels of troponin T and NT-proBNP were of 300 ng/L and 15179 ng/L respectively. The HIV viral load was of 457,400 copies/mL and CD4+ count was of 294 cells/mL. Echocardiogram showed persistent severe left ventricular systolic dysfunction (15%) with left ventricular dilatation, suggesting HIV-related-cardiomyopathy. Tuberculosis was dismissed in other levels. He received antiretroviral therapy for HIV and rifampicin, isoniazid, ethambutol and pyrazinamide for M. tuberculosis. Prednisone (1mg/Kg) was also administrated. 3 months after starting treatment normalization of LVEF and ventricular dilatation was observed.

**DISCUSSION**

Tuberculosis is responsible of 70% of severe pericardial effusion in developing countries, but only 4% in developed countries. Tuberculous pericarditis has high mortality (between 17 and 40%). The most sensitive test for diagnosis is the pericardial biopsy. It is difficult to discern between myopericarditis due to M. tuberculosis and HIV-related-cardiomyopathy, both happening in patients with low CD4+ counts. Treatment for tuberculous pericarditis does not differ from other forms of tuberculosis. Both, antiretroviral and tuberculostatic treatment can reverse myocardial damage.
Typhlitis as a complication of influenza in a patient with advanced HIV infection

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Introduction
Typhlitis, or inflammation of the cecum, is a severe condition that usually affects patients receiving chemotherapy for cancer, but it can also affect patients with other immunodeficiencies.
We report a case of typhlitis that occurred in a patient with advanced poorly uncontrolled HIV infection as a complication of influenza infection, an association that had not been previously reported.

Case description
A 50-year-old woman presented with upper respiratory symptoms and diarrhea.
Her past medical record included parenteral drug use, tricuspid endocarditis, HIV-infection, hepatitis C virus infection, visceral leishmaniosis, vaginal and perianal papillomatosis, ectopic pregnancy, and inadequate adherence to medical visits and prescribed treatment.
She was thin and pale, but otherwise healthy. Temperature was 37.7 °C. The abdomen was diffusely tender and a five-centimeter splenomegaly was felt.
Analyses showed mild anemia and hypoalbuminemia. CD4 cell count was 121 per µL, HIV-RNA 363 copies per mL, hepatitis C genotype 1-a, and hepatitis C viral load 5,000,000 IU per mL. PCR of nasopharyngeal exudate was positive for influenza A virus.
An abdominal ultrasound exam disclosed marked thickening and inflammation of the cecum and surrounding fat tissue. Transient elastography gave a result of 5.6 kPa of liver elasticity.
With oseltamivir, imipenem and symptomatic treatment she completely recovered. Antiretroviral treatment, as well as Pneumocystis jirovecii prophylaxis was instituted. Hepatitis C treatment was programmed for the next months.

Discussion
In a review of the literature with PubMed, using the search profile “typhlitis AND influenza”, we have found no other cases of typhlitis as a complication of influenza. Probably, in our case, HIV infectious played some role in the development of typhlitis; a few cases of such association were reported in the early years of the HIV epidemic (Jumper C et al. Typhlitis and HIV. Ann Intern Med 1992; 117: 698.)
Use of high-flow nasal oxygen therapy as a respiratory support in an immunocompromised patient with Pneumocystis jirovecii pneumonia

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High-flow nasal cannula oxygen therapy (HFNC) is an alternative to conventional oxygen therapy systems. In selected patients, HNFC may prevent endotracheal intubation (ETI) and invasive mechanical ventilation (IMV). Selection of the ideal candidate patient for this oxygen delivery system is still a challenge. A 50-year-old woman, with personal history of active smoking, presented with fever, productive cough and dyspnea with one month of evolution, with no response to previous therapy. The patient also reported complaints of asthenia, night sweats and weight loss in the last three months. At admission, was febrile, polypneic, SpO2 82% (in room air) and with inspiratory rales on the lower 2/3 on pulmonary auscultation. Blood testing showed mild elevated inflammatory markers (with lymphopenia) and lactic dehydrogenase, acute hypoxemic respiratory failure in arterial blood gas (ratio PaO2/FiO2 135). Chest x-ray revealed interstitial infiltrates bilaterally. Cultures were taken and ceftriaxone and clarithromycin started. An infection by human immunodeficiency virus (HIV) diagnosis was made at admission. Pneumocystis jirovecii pneumonia was suspected and trimethoprim-sulfamethoxazole and prednisolone were associated. On 2nd day of hospitalization, due to persistent signs of respiratory distress (PaO2/FiO2 64) with high concentration mask, the patient was connected to HFNC. Improvement of the respiratory pattern and correction of respiratory insufficiency were observed with the need of lower FiO2. On 5th day, she was disconnect from HFNC to venturi mask with 60% FiO2. Posteriorly respiratory insufficiency resolved. Cultural results were negative. Bronchoalveolar lavage (performed under antibiotic therapy) was negative for PCJ. The present case demonstrates a successful use of HFNC in an immunosuppressed patient with severe acute respiratory insufficiency. This system avoided ETI and IMV, avoiding the potential complications associated with this ventilatory support.
Infectious diseases  
A-1386

Ventriculitis acute meningitis by streptococcus pneumoniae

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INTRODUCTION: Ventriculitis can occur due to different circumstances such as ventricular shunts, external ventricular drains, intrathecal infusion pumps, deep brain stimulation, neurosurgery or cranial trauma. In our case none of them was given.

DESCRIPTION: A 70-year-old patient with a personal history of multiple myeloma who came to the emergency room due to arterial hypertension, severe headache with vomiting and fever of three days of evolution associated with progressive deterioration of the level of consciousness until presenting Glasgow of 9 points. Computed cranial tomography with minimal amount of hematoma content in the most declining region of the lateral ventricles that make up a liquid-liquid level, but before the worsening re-evaluates and decides new image test and lumbar puncture for suspicion of central nervous system infection confirming the diagnosis: 4419 polymorphonuclear cells 92% with glucose consumption and hyperproteinorraquia with pneumococcal antigen and positive blood culture for pneumococcus. In the slow neurological clinical evolution, magnetic resonance was performed with contrast, showing bilateral occupation of occipital horns of the two lateral ventricles and another lesion that is situated on the bottom of the right silvian recess, with a laminar appearance. Considering the existence of a ventriculitis in the first place. Performing treatment with third generation cephalosporin for 3 weeks.

DISCUSSION: The neurological complications of pneumococcal meningitis can be frequent despite treatment with antibiotic, dexamethasone and intensive neurological observation. It has an 18-30% mortality and 50% of the survivors have neurological sequelae of hearing loss and neurological deficits. The most serious complications are cerebro-vascular. Pyogenic ventriculitis is rare and the clinical course of the disease is still unknown.
Visceral Leishmaniasis – Casuistic of an Endemic Portuguese Region

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Background: Visceral leishmaniasis (VL) is a rare clinical condition transmitted by sandflies and the dog is the main reservoir. Algarve is considered an endemic portuguese region for human VL.
Methods: Retrospective study that included patients with confirmed diagnosis of VL admitted on Internal Medicine department of Algarve’s University Hospital Centre between 2010 and 2016. The aim of this study is to determine the prevalence and characterize the VL in the Eastern Algarve population.
Results: Five cases of VL were hospitalized between 2010 and 2016, all male with median age of 59 years old, confirmed by the presence of amastigotes in the myelogram or by myeloculture. All of them lived in urban areas, and two cases occurred in the same year and location. The daily contact with dogs occurred in 40% of cases and 60% of patients were HIV positive. The mean time from onset of the clinic to the diagnosis was about 3 months and the most prevalent symptoms were: fever (100%); weight loss (80%); asthenia (80%) and abdominal pain (80%). Hepatosplenomegaly was present in 80% and edema in 20%. Blood tests revealed pancytopenia in all the patients, being severe pancytopenia observed in only 40%. An analytical pattern of cholestasis and hepatic cytolysis was identified in 60% and 20%, respectively. Hypergammaglobulinemia was identified in all cases and hypoalbuminemia in 20%. The mean hospitalization required was 33 days under treatment with amphotericin B. After 6 months of follow-up, 3 of the patients recovered from splenomegaly and 4 from pancytopenia.
Conclusion: The present case series has special importance because Algarve is an endemic region of VL in Portugal. The data collected between 2010 and 2016 occurred in about 0.71 case per year. Fever and pancytopenia were hallmarks being the immunocompromised group the most affected.
Introduction: Active tuberculosis may present with typical radiologic findings: upper lobe infiltrates and cavities that must be considered with clinical manifestations and epidemiologic factors. However other conditions may present with similar radiologic findings including a very frequent one: community-acquired pneumonia.

Case description: A 69 year old man was admitted at the emergency department for low grade fever, dry cough, fatigue and weight loss (not quantified) in the previous month. At the emergency department he had a normal physical exam. The CRP was 90 mg/L and leucocytes 11000/microL. A computed tomography revealed multiple foci of consolidations with peribronchovascular distribution in the upper lobe of the right lung, an image of cavitation next to the adjacent pleura and prominent centrimetic right hilar lymph nodes. Pulmonary tuberculosis was suspected and proper specimens (sputum and bronchoalveolar lavage) were obtained.

Empiric treatment with amoxicillin-clavulanate and azithromycin to community-acquired pneumonia was initiated and after seven days of treatment the symptoms completely resolved. Acid-fast bacilli smear and mycobacterial culture of the specimens obtained were negative; no infectious agent was identified. The computed tomography was repeated 8 weeks after and showed no infiltrates, cavitation or nodules in both lungs.

Discussion: In this situation, pulmonary tuberculosis was highly probable given the typical radiologic findings and indolent symptoms in a relatively high-prevalent area of the infection. Community acquired pneumonia may resemble tuberculosis at presentation, especially if caused by Staphylococcus aureus, gram negative or anaerobic bacteria, and empiric treatment to the first should be considered before definitive diagnosis is obtained.
INTRODUCTION:
Infectious Spondylodiscitis is an infectious process that strikes the intervertebral disc and the adjacent vertebral bodies. Its low incidence, the insidious course and the high prevalence of low back pain in the population make it difficult to diagnose it early.

CLINICAL CASE:
A 62-year-old woman, with no relevant personal history, applied to the emergency room for mechanical low back pain, with anterior irradiation to the left, with a progressive installation that lasted 1 year and was incapacitating. Analytically without leukocytosis, but with C reactive protein of 50mg/dL and Sedimentation Rate of 120mm/1h. Lumbar Magnetic Resonance showed dipping and cortical discontinuity of the lower D11 and D12 upper platforms with somatic edema and disc hypersignal that suggest the diagnosis of spondylodiscitis of etiology to be clarified. Since she did not have criteria for urgent surgical intervention and due to the worsening of the clinical condition and the impossibility of biopsy in a desirable time, she initiated empirical antibiotic therapy with Vancomycin and Ceftriaxone. However, due to the poor response to the established therapy and due to the presence of the findings, a tuberculous etiology was suggested. After multiple complementary examinations all negative, Mantoux test proved to be doubtful and the IGRA test was Positive. Due to the suspicion of tuberculous etiology, she started a classic antitubercular regimen with Isoniazid, Pyrazinamide, Rifampicin and Etambutol, with clear clinical and laboratory improvement.

DISCUSSION:
Due to the poor response to antibiotic therapy and improvement with antitubercular therapy it can be concluded that it was Spondylodiscite of tuberculous etiology.
Infectious diseases
A-2337

When clinical suspicion becomes the cornerstone of diagnosis: a rare case of brain abscess

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Introduction: Central nervous system tuberculosis can present with brain lesions with a broad range of differential diagnosis. Therefore high degree of suspicion is vital, particularly when infection is limited to the brain.

Case description: A 58 year old man with chronic alcohol abuse and a history of treated pulmonary tuberculosis was admitted to the hospital for left arm clonic movements, left hemiparesis and low grade fever. Physical exam showed no other abnormalities. The CRP was 15 mg/L without leukocytosis. Head Computed Tomography and Magnetic Resonance revealed an expansive lesion in frontal brain parenchyma with 1,5 centimeters with peripheral edema suggesting brain abscess. Empiric treatment with ceftriaxone and metronidazole was initiated.

Two weeks into treatment, Magnetic Resonance showed no regression of brain lesion. Concurrently, an extensive study was undertaken excluding neoplasia and atypical infective causes (no agent was isolated in blood, bronchoalvelolar lavage or cerebrospinal fluid and serologies for HIV, Borrelia burgdorferi and Taenia Solium were negative).

Given the radiologic findings, patient’s medical history and a positive IGRA test, treatment with isoniazid, ethambutol, rifampicin and pyrazinamide was started. After four weeks of treatment, neurologic symptoms completely resolved and Magnetic Resonance revealed significant regression of abscess.

Discussion: In this case, presumptive diagnosis of tuberculous brain abscess was made based on clinical, epidemiologic and radiologic features as well as response to treatment. In this rare condition, presence of Mycobacterium Tuberculosis is not expected in cerebrospinal fluid but in pus drained from the abscess. This diagnostic step was not taken due to therapy's favorable outcome.
INTRODUCTION: Whipple's disease is a rare infectious disease caused by Tropheryma whippelii with clinical manifestations. This infection can simulate chronic inflammatory rheumatism.

DESCRIPTION: A 59-year-old patient with a personal history of spondyloarthropathy due to ankylosing spondylitis in bamboo cane, pulmonary fibrosis and asbestosis with mixed pulmonary hypertension (asbestosis and ankylosing spondylitis) under treatment with etanecet. He presents fever of unknown origin and polyadenopathic symptoms (thoracoabdominal, peritoneal and mesenteric). After performing multiple complementary tests with three non-conclusive computed tomography (CT) biopsies and an open laparotomy, the diagnosis by needle aspiration with CT-guided lymph node needle is from Whipple's disease. Antibiotic therapy was started with ceftriaxone for 14 days and then septrim, which has to be replaced by doxycycline by toxic epidermal necrolysis with suspected Johnson Johnson syndrome. After treatment with bosentan 125mg / 12 hours for six months, pulmonary hypertension disappeared, confirmed with echocardiography and pressure measurement in pulmonary artery, reason for which drug withdrawal was decided.

DISCUSSION: Whipple's disease should be suspected in all patients diagnosed with chronic inflammatory rheumatism, partially controlled or not controlled by treatment with alpha blockers of tumor necrosis factor, whose condition worsens after treatment.
“Invasive Pulmonary Aspergillosis and Virus Herpes Simplex type 1 respiratory tract infection in a severe COPD patient: A coexisting infection to be aware of”

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Introduction: The incidence of invasive pulmonary aspergillosis (IPA) in severe chronic obstructive pulmonary disease (COPD) patients has increased due to the development of more sensible and specific criteria. The role of herpes simplex virus type 1 (HSV-1) in respiratory tract infections as a pathogen, bystander or poor prognosis factor has not been clarified. Nevertheless, some cases of IPA an HSV-1 co-infection have been described.

Case description: A 79-year old male with severe COPD, multiple recent hospitalizations and long high dose corticoids and antibiotics intake, presented with dyspnoea, respiratory failure and parenchymal infiltrate in thorax X-ray. The response to corticoids and two courses of broad spectrum antibiotics was unfavourable. In bronchial aspirate samples, A. fumigatus was identified both by culture and histologic examination. Visible cytophatic effects and immunohistochemical profile compatible with HSV-1 were also confirmed. Therapy with Voriconazole, Liposomal B Amphotericin and Acyclovir was initiated. The patient and family refused non-invasive mechanical ventilation. Despite treatment the patient showed no improvement and died 16 days after admission.

Discussion: The patient was diagnosed of probable IPA using Bulpa criteria and VHS-1 pneumonia by cytodiagnosis. Although similar case reports in the literature are scarce, it is possible that IPA and HSV-1 co-infection is an underdiagnosed condition and should be considered in severely ill COPD and immunocompromised patients not responding to standard pattern.
Diabetic Mastopathy: A Rare Case of in a Young Type 1 Diabetic Patient

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Introduction: Diabetic mastopathy compose of < %1 of all breast benign diseases. It is characterized by a dense fibrous stromal proliferation of breast tissue. The differentiation of these lesions from malignant ones using radiological imaging and clinical findings are extremely difficult. Histopathological examination is an obligation for definitive diagnosis. We present the case of a 33 years old woman with type 1 diabetes with a mass at left breast.

Case Description: 33-years-old female patient known history of diabetes mellitus type 1 was using a continuous insülin infusion in the following order : 0.8 u/h and 4.5u/7.5u/9u with meals for the diabetes. Breast ultrasonography (USG) was performed when the patient noticed a mass in her left breast and reported as : ‘no solid lesions were identified in both breasts. In the left breast a few cysts less than 5 mm in size were noticed ’. It was evaluated as BRADS 2. An USG guided core biopsy was performed with the following findings : lobulitis, ductitis and lymphomononuclear cell infiltration.

Discussion: The inflammatory and immunological reactions to exogenous insulin and advanced glycosylated end-products are thought to be responsible for the pathogenic mechanism of the diabetic mastopathy. The accumulated extracellular matrix products which cause neoantigen presentations are thought to act a role in B-cell proliferation and autoantibodies secretion. The important findings in USG examinations are solid lesions, distortion of breast tissues, hypoechoic nodules and posterior acoustic shadows. Both of USG and magnetic resonance imaging (MRI) can not provide sufficient clues to differentiate diabetic mastopathy from malignant lesions. Tru-cut biopsy is essential to diagnose. The characteristic findings of pathological examinations are lymphocytic lobulitis, ductitis, fibrosis, vasculitis and lymphoid nodules. Excisional biopsy is not recommended because of high rate of recurrence.
A body shape index and body roundness index: relationship between new anthropometric adiposity indices and carotid atherosclerosis

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Objectives. A Body Shape Index (ABSI) and Body Roundness Index (BRI) are new anthropometric adiposity indices recently proposed in order to overcome the limits of traditional obesity markers. They have shown to correlate with adipose abdominal tissue better than BMI and to predict the onset of diabetes and the risk of premature death.

Little is known about the influence of ABSI and BRI on subclinical vascular damage.

The study was aimed to assess the relationship between ABSI and BRI with carotid atherosclerosis.

Methods. 468 patients with hypertension (30-80 years old) were enrolled; adiposity indices were calculated (BMI, WC, ABSI, BRI) and carotid ultrasonographic examination was performed to detect atherosclerotic damage (IMT or atherosclerotic plaque). Population was divided in tertiles based on BMI (<25; 25-30; ≥30 kg/m2).

Results. Subjects with higher BMI showed a higher BRI and ABSI than subjects with lower BMI (p<0.001). The percentage of subjects with BMI ≥ 30 kg/m2 was higher in the group with greater IMT than in that one with IMT≤0.90 mm (p<0.001), whereas BMI did not differ in subjects with carotid plaques compared to those without them.

BRI, but not ABSI, was higher in subjects with IMT >0.90 mm than those with a lower IMT (p<0.001), whereas patients with carotid plaques showed higher values of ABSI (p=0.001), as well as of BRI (p=0.003). Linear regression analysis disclosed significant correlation of IMT with ABSI, BRI and BMI (all p<0.001). In the multivariate analysis BMI independently correlated with cIMT (p=0.011), and similar results were obtained with BRI (p=0.015). ABSI did not show any independent association with cIMT. However, ABSI, neither BRI nor BMI, was strongly associated with carotid plaques in multiple logistic regression analysis after taking into a count the effect of multiple potential confounding factors.

Conclusions. ABSI may be proposed as a better correlate of carotid atherosclerosis than the traditional measures of adiposity.
A case of Cushing Syndrome diagnosed by pathological fractures in a young woman

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INTRODUCTION

Cushing syndrome (CS) is an endocrine disease with multiple etiologies and is characterized by a constellation of clinical manifestations that result from hypercortisolism. Diagnosis is based on medical history, physical examination and laboratory tests.

CASE DESCRIPTION

A 42-year-old female was referred in December 2016 to Internal Medicine for ilium and isquiopubian partially consolidated fractures (MRI) and osteopenia (DEXA), performed by inguinal pain since the last year. She presented hypertension (Valsartan/Hidroclorotiazida), mild renal colics, oligomenorrhea and weight gain evolving over 2 years. No alcohol drinking-smoking history or other drug intake; family history was no significant. The physical exam revealed a moon face, a moderated hirsutism, a buffalo neck and an abdominal obesity. Blood pressure was 142/98mmHg. Biochemical analysis revealed high levels of free-urine cortisol and an altered serum cortisol circadian rhythm. A low dose dexamethasone suppression test returned negative. ACTH was low. An abdominal CT-scan revealed a right solid heterogeneous adrenal mass of 3,2x2,2cm, compatible with adenoma in MRI. The diagnosis of ACTH-independent CS due to right adrenal adenoma was established. Calcium and D-vitamin supplements were ruled. She was referred to Surgery. Laparoscopic right adrenalectomy was performed in November 2017. Hydrocortisone was initiated; the suppression of the hypothalamic-pituitary-adrenal axis is still shown.

DISCUSSION

The diagnosis of CS is often delayed because it is frequently masked by its overlap with common medical problems. Test for secondary hypertension and osteoporosis should be performed in young patients, especially women. Bone loss is more frequent in CS caused by adrenal tumors.
A Case Of Excessive Thirst

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Introduction: Psychogenic polydipsia, or primary polydipsia, is a rare condition characterized by the compulsive ingestion of water (over 3L/day), in the absence of organic or pharmacological disorders, often associated with psychiatric illness.

Case description: The authors present the clinical case of an 45-year- old man, with history of depression and recent social isolation. The patient was referred to an Internal Medicine consult due to excessive intake of water (8L/day). At presentation, he says that when he doesn’t drink, he has burning sensation and feels widespread body heat, especially in the face and holocranial headache. He refers fetid and dark colored urine and the only way to relief these symptoms is drinking large amounts of water (ingestion of 0.5L after urinating). At physical examination, including neurologic exam, no significant alterations were found. Analytically he presented with hyponatremia (125 mmol/L), decreased urinary osmolarity (232 mOsm/kg) with a normal vasopressin value and preserved renal function.

He was admitted for water restriction control. The urinary output went from 5300cc to 2000cc, with a daily intake of 2500cc, with normalization of sodium levels and urinary osmolarity.

Patient was treated with clonazapine and referred to a Psychiatry consult, with favorable medical evolution and symptomatic relief.

Discussion:
In the description of this case, there was no abnormality of vasopressin and renal function, suggesting a central origin disorder called psychogenic polydipsia. This diagnosis was confirmed by the improvement of sodium levels and urinary osmolarity after water restriction and treatment with psychoactive drugs.
Acromegaly is a rare hormonal disorder that results from persistent hypersecretion of growth hormone, which in turn stimulates the hepatic production of insulin-like growth factor-1 (IGF-1). It has a slow evolution and the average age at diagnosis is 40 years for men and 45 years for women. The diagnosis is made by clinical suspicion in individuals with macrognathia, enlargement of the feet and hands and risk of developing arterial hypertension, cardiovascular disease, among other conditions; and testing for IGF-1. Once its elevation has been confirmed, a brain Magnetic Resonance Image (MRI) should be performed, knowing that the pituitary adenoma is the most common cause of acromegaly. The treatment depends on the symptomatology of the patient and should be instituted as early as possible.

The authors describe a case of a 72-year-old woman, autonomous, cognitively intact, with no history of diseases, who was referred to the Emergency Department for hypertensive crisis. The patient complained about progressive worsening asthenia with about 1 year of evolution, dyspnea on exertion and episodes of sweating and growth of hands, feet and face since menopause. On objective examination, she had disproportionate face, hands and feet, macrognathia, tooth spacing, abdominal obesity; she was hypertensive and with signs of bilateral pulmonary stasis. The chest X-ray performed had an increased cardiothoracic index, the electrocardiogram had criteria for left ventricular hypertrophy, and the transthoracic echocardiogram was compatible with dilated cardiomyopathy with a left ventricular ejection fraction of 30%. The IGF-1 assay was high and brain MRI showed a pituitary macroadenoma. Neurosurgery consultation was requested at the referral hospital.

Pituitary adenoma is the most common cause of acromegaly. This syndrome has typical phenotypic characteristics and may complicate with cardiovascular disease, arterial hypertension or other associated conditions and should be treated early.
A Case Report of Refractory Gout: Efficacy of High-Dose Anti-IL1r Treatment

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Introduction
Gout is an inflammatory disease characterized by the deposition of monosodium urate (MSU) crystals in joints and other tissues that allows immediate unequivocal diagnosis. Hyperuricaemia is part of the metabolic syndrome.

Case Report
A 49 years male patient, with morbid obesity, on onset incapacitating polyarthritis of small and large joints, with 1 month of evolution. On evaluation, asymmetric nodular arthritis, compatible with gout tophus. Serum workout showed hyperuricaemia (13.4 mg/dL). Colchicine (1mg per day) was started. Two month later, worsening of the symptoms, with the same polyarthritis pattern, with ongoing treatment. Since the lack of response and the possible overlap with Rheumatoid Arthritis (RA), corticotherapy (deflazacort 15 mg per day) and allopurinol, were started.

No remission was achieved. Prednisolone 1 mg/Kg/day was initiated, with no response.

Anti-IL1r antagonist (Anakinra) 100 mg/day and rasburicase were started, maintaining corticotherapy in the lower dose tolerated (20 mg per day).

Although maintaining outbreaks, a gradual increase Anakinra dosage to 200 mg per day led to a total remission.

Discussion
Intraarticular SF sampling, allowing a definitive diagnosis of gout.

The most appropriate drugs for gout treatment are traditional anti-inflammatory substances, and innovative drugs, such as the biological drugs acting as IL-1 inhibitors, in patients with inadequate response to standard drugs.

As we know, patients with hyperuricaemia and/or gout should be carefully assessed for the presence of metabolic syndrome. Our subject was poorly responsive to drugs that reduce uric acid levels, which can partially explain the refractory symptomatology, and the necessity of high intensity treatments. Hence, the patient was proposed to bariatric surgery.

Anakinra is a widely studied drug, approved in Rheumatoid Arthritis, effective controlling symptoms and preventing outbreaks. This case demonstrates the efficacy of the drug in a case of gout.
Introduction:
It is frequent for female athletes to experience anemia, with ferropenic anemia (FA) as the most frequent presentation. It is usually reversible with nutrition or supplementary oral iron. Menstruation and intense physical activity are important factors for losing iron. Some vegetables, coffee and specially tea reduce the absorption of iron up to 65% because of high concentration of Thanatos.

Case description:
45-year-old woman, athlete of middle-distance race, training 4 hours daily. FA diagnosed over 15 years, more symptomatic in the last two. Presented to the GP with fatigue and severe menorrhagia. Bloods revealed FA with haemoglobin 8.9g/L; Iron 17ug/dL; Ferritin 6ng/mL; Transferrin 356mg/dL; Vit.B12 476pmol/L; Reticulocytes 51%. Genital, hysteroscopic, endoscopic examinations and fecal occult blood test showed no significant changes. Patient started supplementation with iron p.o. without resolution. After changing to carboxymaltose I.V., improvements of haemoglobin values and symptomatology were important but dermatological pigmentation was observed as an adverse reaction. After talking to her husband it was found out her hydration consisted mainly of green tea (3-4L/daily). Nutrition changes were suggested and after a 3-month follow-up the patient was asymptomatic just with iron p.o.

Conclusion:
Iron is absorbed in duodenum and superior part of jejunum and the daily recommended dose is 17.0–18.9mg/day in adult women. A diet rich in animal meat and vitamin C supplementation increases the intake of iron. A case of multifactorial ferropenic anemia is presented, with a clear improvement in the patient quality of life by detailed clinical history and lifestyle changes.
Acceptance of Injection for the Treatment of Elevated Low-Density Lipoprotein Cholesterol with Alirocumab: An Analysis of the ODYSSEY DM-INSULIN Study


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Background: In ODYSSEY DM-INSULIN (NCT02585778), alirocumab significantly reduced low-density lipoprotein cholesterol (LDL-C) versus placebo over 24 weeks among insulin-treated individuals with type 1 or 2 diabetes, who had baseline LDL-C \(\geq 1.8\) mmol/L despite maximally tolerated statin therapy. Alirocumab, or matching placebo, was self-injected subcutaneously (prefilled pen) every 2 weeks. Given the paucity of data on injection acceptance with proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors, we measured this attribute among DM-INSULIN participants.

Methods: Trial participants (491/517 of those randomised) completed a validated patient-reported outcome (Injection-Treatment Acceptance Questionnaire; I-TAQ) to assess acceptance of subcutaneous injection. I-TAQ includes 22 questions in four domains (perceived efficacy, side-effect acceptance, injection self-efficacy, and injection convenience), and gives a total score measuring overall acceptance. Scores range on a 0–100 scale, with higher scores indicating higher acceptance. Score changes were calculated from baseline (Week [W] 8) to W24; differences between alirocumab and placebo were assessed by Mann-Whitney test.

Results: Baseline scores indicated a high level of acceptance, with mean (SD) acceptance scores of 80.48 (11.32) and 80.27 (11.67) for placebo and alirocumab, respectively. Change from baseline to W24 was +1.31 (12.52) and +2.29 (10.56) for placebo and alirocumab, respectively (P=0.42). No differences in individual domain scores were observed between treatment arms at baseline and at W24. Notably, acceptance of side-effects scores was high at baseline and remained high at W24: 96.7 (9.4) and 97.4 (7.7) for placebo and alirocumab, respectively.

Conclusion: Results indicate a high level of acceptance of injection. Acceptance of side effects and confidence in injection ability were similar between treatment arms.

Endocrine and metabolic disorders
A-1538
Acquired chylomicronemia-induced acute pancreatitis

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Introduction:
Pancreatitis is an acute inflammatory response of the pancreas characterized by abdominal pain and elevated pancreatic enzymes. A serum triglyceride level of more than 2000 mg/dl is a rare, but well-known identifiable risk factor. Herein we present a case of an alcoholic patient presenting with acquired chylomicronemia-induced acute pancreatitis.

Case description
A 48-year old Greek man, with a history of chronic consumption of ethyl alcohol (>50g/d), was admitted to our clinic due to progressively worsening of abdominal pain for the last 24 hours and two episodes of vomiting. Similar signs have been reported in the recent past. Blood chemistry revealed severely elevated TGs (Tg=3500 mg/dl) and transaminasemia. Hepatomegaly and fatty liver disease were found in the upper abdomen ultrasound, whereas the CT scan findings were compatible with chronic pancreatitis (calcification of the pancreatic duct). Fenofibrate 145mg/d and ω3 fatty acids were initiated along with standard pancreatitis treatment. The patient showed outstanding clinical and laboratory response and was discharged after six days of hospitalization.

Discussion
The clinical course and routine management of hypertriglyceridemia-induced pancreatitis is similar to other causes. A thorough family history is important, as is the identification of secondary causes of hypertriglyceridemia. The mainstay of therapy includes dietary restriction of fatty meal. Alcoholism itself effectuates acquired hypertriglyceridemia, since it causes an increase in the synthesis of triglycerides (TGs) and TG-rich lipoproteins in the liver, while it stimulates lipolysis in fatty tissue resulting in a larger supply of fatty acids to the liver.
Introduction
Thyrotoxic periodic paralysis (TPP) is a sporadic form of hypokalemic paralysis. We discuss a case of a 39-year-old man who presented with acute, marked muscle weakness.

Case description
A 39-year-old Albanian prisoner was admitted to the hospital due to severe muscular weakness, experienced suddenly during his morning rise. The neurological examination revealed non-spatric tetraparesis, proximal muscle weakness and absence of deep tendon reflexes without sensory disturbances. Laboratory findings revealed serious hypokalemia (K+:1.5mmol/L) with ECG alterations. There was strong suspicion of TPP, confirmed with thyroid hormones analysis (TSH<0.008U/mL). He immediately received intravenous potassium administration under intensive ECG monitoring, followed by propranolol and methimazole, and symptoms were restored. The thyroid ultrasound revealed multinodular goitre.

Discussion
TPP is characterized by acute paralysis and severe hypokalemia with thyrotoxicosis. Hypokalemia results from intracellular potassium movement, via thyroid hormone stimulation of the Na+/K+-ATPase, rather than from depletion of whole-body K+ reserves. TPP has an incidence of 2% in patients with thyrotoxicosis of any etiology, and is more prevalent in Asians. Precipitating factors are strenuous exercise, stress, steroids and high-carbohydrate diet. TPP should be distinguished from familial forms of periodic paralysis with identical neurological status. The lack of family history, male gender, onset during 2nd-4th decade and signs of thyrotoxicosis help diagnose TPP. Treatment includes prevention of intracellular K+ shift with non-selective b-blockers, K+ restoration, and correction of thyrotoxicosis.

Episodes of TPP can be lethal. Acute management is critical to avoid dangerous arrhythmias. Achieving euthyroid function restores TPP, therefore high clinical suspicion is mandatory for early thyroid testing.
Acute pituitary apoplexy after hypocoagulation for an acute pulmonary thromboembolism

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Introduction:
Pituitary apoplexy is a rare, life-threatening syndrome caused by acute pituitary hemorrhage or pituitary infarction, usually in an adenoma on the pituitary gland; it can occur acutely, with headache, neuro-ophthalmological symptoms and death, or sub-acutely with evolution from days to weeks.

Case description:
A 65-year-old woman with dyslipidemia, obesity, and degenerative osteoarticular disease, was admitted into the emergency department for dyspnoea and chest pain. She was diagnosed with acute pulmonary thromboembolism at intermediate risk of mortality and started hypocoagulation (with enoxaparin). On the 5th day of hospitalization she presented with severe headache and right third nerve palsy. The brain MRI revealed pituitary haemorrhage, grafted in a previously unknown macroadenoma. She was evaluated by Neurosurgery - no emergent surgery was needed, but hypocoagulation was stopped and a filter insertion on vena cava was done. After serial evaluations proving stability of hemorrhagic lesion, hypocoagulation was reintroduced. She developed hypopituitarism symptoms, due the injury to the anterior pituitary, and supplementation with levothyroxine and hydrocortisone was started. Polyuria and polydipsia also occurred and raised the suspicion of central diabetes insipidus; therefore initiation of desmopressin improved symptoms. She was later discharged and revaluated in ophthalmology, neurosurgery and endocrinology consultations.

Discussion:
Pituitary apoplexy is a potentially fatal neuroendocrine emergency that requires immediate therapy. This entity must always be considered as a differential diagnosis in a patient who presents with sudden, intense headache and neuro-ophthalmologic symptoms. A multidisciplinary approach, as described in this case, is essential to guarantee the proper treatment and follow-up.
Adropin influence on nephropathy development in hypertensive patients associated with diabetes mellitus 2 type

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Association of arterial hypertension (AH) and type 2 diabetes mellitus (2TDM) often aggravates the prognosis and lead to rapid development of diabetic nephropathy (DN). There are many factors involved in the pathogenesis of DN, but among basic are endothelial and inflammatory ones. We studied serum adropin and soluble Inter-Cellular Adhesion Molecule 1 (sICAM-1) influence on DN development in essential hypertensive patients with 2TDM.

METHODS. Enrolled patients number 180, were randomly divided into 2 groups: the first control group without DN (n=91) and the second one with DN (n=89). DN criteria established according increased urinary albumin excretion (UAE) >20mg/24h. We measured serum creatinine (Scr), blood urea nitrogen (BUN). ELISA was performed to test serum sICAM-1 levels and serum adropin levels. The correlation of Adropin and ICAM-1 with renal function and inflammatory factors was analyzed.

RESULTS. DN group showed statistically increased Scr and BUN levels, and elevated IL-6, IL-1β, and hs-CRP secretion (P<0.05). Compared with controls, adropin was statistically decreased in the DN group (1.87 ± 0.63 ng/ml vs 2.76 ± 0.75 ng/ml, P<0.05). A moderate negative correlation was detected UAE with adropin levels (p < 0.01). Logistic regression showed adropin (p = 0.043) and sICAM (p = 0.059) were independently associated with DN.

CONCLUSIONS. Adropin and ICAM-1 suggested as an important players in DN development through involving in inflammation and renal function. These markers can be possibly used in DN diagnosis and open a new therapeutic opportunities.
Altered mental status: when sodium is the culprit.

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Introduction:
Hyponatremia is the most common electrolyte disturbance in hospitalized patients and can represent a diagnostic challenge.

Case description:
76-year-old man with a history of: long standing hyponatremia (120-130mEq/L since 2009); hypertension; atrial fibrillation; type 2 diabetes; hypothyroidism.

He presented with symptoms of confusion and decreased state of consciousness 2 days after discharge from a surgical ward (right hemicolectomy for colon carcinoma). At the emergency department he had fever, hypoxemia, generalized spasticity, and responded only to painful stimulus. White blood cell count was 20.88×10⁹/L, and serum sodium 121mEq/L. Brain CT showed cortical atrophy; thorax CT showed inferior right lobe pneumonia. He was treated with piperacillin/tazobactam with resolution of the pneumonia.

Initial study revealed a hypotonic hyponatremia with plasma osmolality 225mOsmol/kg and urinary sodium 99mEq/L. It was assumed a diagnosis of Inappropriate ADH secretion, but there was no improvement with diuretic therapy, water restriction and high sodium intake. On admission to our ward he was awake but minimally responsive, bedridden, with marked spasticity, and fed by nasogastric tube. Further testing showed normal blood cortisol and ACTH with undetectable urinary cortisol. The diagnosis of adrenal insufficiency was considered and he was started on hydrocortisone (30mg id). There ensued a progressive normalization of sodium levels and cognitive function, and a reduction of spasticity; at the time of discharge he was able to walk and feed himself unaided.

Discussion:
Adrenal insufficiency should always be considered in long standing hyponatremia. It is possible that the stress induced by surgery and infection precipitated the clinical deterioration.
Asymptomatic endogenous hyperinsulinism

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INTRODUCTION
Hypoglycemia is rare in seemingly well patients without drug-treated diabetes mellitus. In general, the occurrence of hypoglycemia warrants evaluation and management only when the Whipple’s triad is documented.

CASE DESCRIPTION
Woman, 78 years old, with aluminium pneumoconiosis, multiple bronchiectasis and a recent acute pulmonary thromboembolism. She was medicated with apixaban and inhaled umeclidinium bromide/vilanterol. There was no history of alcohol abuse. She was hospitalized due to infected bronchiectasis and acute hypoxemic respiratory failure and successfully treated with piperacilin-tazobactam. During hospitalization, she had multiple asymptomatic fasting hypoglycemia values (minimum of 21mg/dl) as measured by a glucometer and confirmed in venous blood samples. Endogenous hyperinsulinism was confirmed: plasma glucose of 40mg/dl, C-peptide of 4.99ng/mL and insulin 4.84uU/mL. Thyroid function tests were normal and 8am cortisol was 16.3ug/dl. Insulin antibodies were negatives. Abdominal CT did not show any pancreatic abnormality. Endoscopic pancreatic ultrasound, somatostatin receptor scintigraphy and pancreatic MRI were also normal. Selective pancreatic arterial calcium stimulation revealed a more than twofold increase in hepatic venous insulin levels over baseline after injection of calcium gluconate in the splenic artery, localizing the hyperselection to the body/tail of pancreas. Based in the lack of precise anatomical location and the comorbidities of the patient, a conservative approach was decided. Diazoxide was initiated at a 50mg bid dose, no further hypoglycemic events were documented.

DISCUSSION
In this case, the Whipple’s triad was not documented, however the hypoglycemic episodes were frequent enough and the glucose values low enough to warrant investigation. Despite tumor excision being potentially curative, medical treatment is possible and some patients may be good candidates to a conservative approach.
Autonomous thyroid nodule & Abscesses by SARM. A strange relationship.

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Introduction
Autonomous thyroid nodules (ATN) are the result of focal/diffuse hyperplasia of the thyroid follicular cells, which become independent of TSH regulation. More common in women.

Staphylococcus aureus (SA) is part of the usual flora, being present in the skin and oropharynx and is one of the main causes of nosocomial infections. The main risk groups are diabetic, neutropenic and patients with prostheses. The treatment of choice for Staphylococcus Aureus Meticilin Sensible (SAMS) is Cloxacillin. In cases of methicillin resistant (MRSA), Vancomycin is the choisen.

Case description
A 41yo woman, with no personal history of relief or medication, came to the hospital for a cutaneous abscess in the right buttock and drainage with purulent contents. Microbiological collection and antibiotic intake at home.

The review in consulte of surgery aimed the appearance of lesions of the same characteristics in other points of the buttock. The culture was positive for MRSA (Sensible to Vancomycin and Teicoplanin). Initiated targeted antibiotic therapy with lesion regression.

A month later she recurs to the urgency due to an abscess in the right thigh. Microbiological culture, positive again for MRSA with same characteristics. She was given antibiotics again and was referred to Internal Medicine. These events were repeated for another 2 months, with several subcutaneous nodules at different locations in the body.

Later we found a nodule in the left lobe of the thyroid, associated with TSH decreased. She was diagnosed as having an ATN by scintigraphy, She did hemithyroidectomy and substitutive therapy.

At present it maintains good control of the thyroid profile, with no skin lesions.

Discussion
The interest in this case is the diagnosis of cutaneous MRSA infection, an uncommon cause of cutaneous abscess, in a very probable context of immunosuppression associated with ATN. The "cure" of ATN implied the "end" of the appearance of new abscesses.
Endocrine and metabolic disorders
A-2421

Beta-cell glucotoxicity related to dapagliflozin induced euglicemic diabetic ketoacidosis – A case report

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INTRODUCTION
Sodium-glucose co-transporter-2 inhibitors (SGLT2i) are a novel class of oral antihyperglycemic agents known by its effective glycemic control. However, they have been associated to significant adverse effects, such as euglycemic diabetic ketoacidosis (EDKA).

CASE DESCRIPTION
This is a case of a 74 year-old woman with a 10-year history of diabetes mellitus (DM) (last HbA1c of 8.7%), medicated with metformin, sitagliptin, gliclazide and dapagliflozin, admitted to the ER complaining of generalized myalgias and abdominal discomfort for 5 days. She appeared lethargic, normotensive and afebrile with diffuse abdominal discomfort and no signs of peritoneal irritation. Diagnostic work-up revealed a high anion-gap metabolic acidosis (serum HCO₃⁻ of 14.5 mmol/L) with ketonemia, blood glucose of 230 mg/dl, glycosuria, ketonuria and bacteriuria. After 8 hours of hospital admission she developed fever, hypotension with high serum CRP levels. She was diagnosed with EDKA related to dapagliflozin use and urosepsis and then transferred to ICU for further medical care. During admission, the ongoing investigation showed unmeasured C peptide and negativity for islet cells and glutamic acid decarboxylase antibodies. Given the glycemic improvement after the treatment, a restoration of serum levels of C peptide was noticed, consistent with beta-cell glucotoxicity.

DISCUSSION
EDKA secondary to SGLT2i use is a rare, but life-threatening condition and recent data have shown an increased number of reports on this matter. The use of SGLT2i is on the rise, so it is important for clinicians to report cases of adverse events, so that additional insight can improve their safe use.
Bilateral optic neuropathy revealing type 1 diabetes mellitus

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Introduction: Optic nerve involvement is exceptional in diabetes mellitus with an estimated frequency of 1.58%. It is largely dominated by ischemic neuropathy and optic atrophy, while retrobulbar optic neuritis (RBON) remains exceptional and unusual. We report a bilateral and simultaneous RBON inaugural of type 1 diabetes mellitus.

Case description: A 29-year-old man with no medical history was explored for bilateral and sudden decrease in visual acuity. The somatic examination was without abnormalities. The ophthalmological examination noted a visual acuity at 4/10 on the left eye and 7/10 on the right eye and a normal eye fundus. Ophthalmologic explorations concluded to a bilateral RBON. The etiological investigation of this RBON was negative. The pre-corticosteroid check-up showed fasting glycemia at 1.80 g/l, postprandial at 3.2 g/l and HbA1c at 8%. Anti-GAD and anti-ICA antibodies were positive confirming type 1 diabetes. The patient was put on intensive insulin therapy normalizing his fasting and postprandial glycemia. The outcome was favorable with gradual improvement in vision parallel to the equilibration of blood sugar level. Ophthalmologic check-up at one month noted visual acuity at 7/10 on the left eye and 8/10 on the right eye. At 3 months visual acuity was 10/10 on both sides; eye fundus, visual field and visual evoked potential test were normal.

Discussion: To the best of our knowledge, bilateral RBON associated with a chronic imbalance of type 1 diabetes mellitus was previously reported only once in the literature. Our observation is distinguished by the male sex, the bilateral and simultaneous involvement, and its inaugural character of the disease.
Biological age may predict the metabolic risk in general population.

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Background: Metabolic syndrome (MS) is a cluster of metabolic abnormalities, which increase with age. Biological age (BA) determined by physiology reflects the functional state of the body. The aim of the present study was to evaluate the development of MS in terms of biological aging.

Methods: A consecutive series of asymptomatic subjects aged ≥30 years who underwent routine check-ups were enrolled. Clinical profiles such as physical, biochemical, and hormonal parameters for calculating BA were collected. BAs were calculated using the MEDIAGETM Biological Age Measurement System.

Results: A total of 2,677 subjects were investigated. The mean chronological age (CA) was 46.0 years and the mean BA was 44.7 years. MS was diagnosed in 216 subjects (8.1%). The prevalence of MS increased with increasing BA (P < 0.001). Especially, the gradient of prevalence of MS in BA was higher than that in CA. When the subjects were divided into two groups based on an age gap between BA and CA, Biologically older group (BA-CA ≥0) and biologically younger group (BA-CA <0), the incidence of MS in the biologically older group was significantly higher than in the biologically younger group (P < 0.001). When the subjects were categorized into quartiles according to age gap between BA and CA, the prevalence of MS increased with increasing quartiles of age gap between BA and CA (P < 0.001).

Conclusion: Development of MS is affected by biological aging process. Therefore, measurement of BA may help to estimate the risk of MS among the general population.
Cardiovascular system damage in patients with Metabolic syndrome

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Objectives: to investigate the condition of the coronary vessels in patients with acute coronary syndrome on the background of MS. Methods: Cross-sectional retrospective study of 412 clinical cases was conducted at the cardiology units of the Central Clinical Hospital, Almaty, Kazakhstan. The study involved patients with CHD on the background of MS. Inclusion criteria were obesity or overweight (body mass index (BMI) greater than 25 kg / m², dyslipidemia, an increase in triglyceride levels, hypertension, and violations of carbohydrate metabolism and diabetes mellitus type 2. ECG and coronary angiography were applied to investigate CA morphology. Results: All patients with ACS underwent coronary angiography, further separated into 3 groups according to their BMI (normal, overweight and obese). The majority of the patients (331 people or 78.8%) admitted with ACS were either overweight or obese. Amongst men, overweight and obese represented 63.6% and 58.7% respectively, amongst women there were 36.4% and 41.3% respectively. The average age of all patients ranged from 61.7 ± 9.5 to 63.9 ± 10.3 years. An average duration of the CHD in the overweight or obese patients was 7.6 ± 7.4 and 5.9 ± 6.0 respectively. Low level of HDL was observed in 60.9% of women and in 44% of men. Carbohydrate metabolism changes were in more than a half of the patients (54.8%). The CA data showed that, in 71% of the overweight patients there were hemodynamically significant morphological lesions of CA. 17.2% of the patients had single-vessel lesions, 30.9% had two-vessels lesions and 23.5% had three-vessels lesions. The most common lesions were in the anterior interventricular branch and the right CA, 54.5% and 40.9% respectively. Conclusion: coronary angiography showed that MS was associated with pronounced morphological changes of the heart vessels. Clinical, laboratory and instrumental examinations of the overweight/obese individuals showed that MS severely affects heart vessels.
Endocrine and metabolic disorders
A-1322

Care of the patient with Diabetic Arteriopathy

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Introduction: Diabetes mellitus (DM) is a chronic disease with great impact on patients' quality of life. In 2015, the estimated prevalence of Diabetes in the Portuguese population aged 20 to 79 years was 13.3%. Arterial disease in large and medium-sized arteries is currently responsible for 80% of deaths in type 2 diabetic patients.

This situation does not always have clinical expression and usually when the patient has complaints are the presence of intermittent claudication.

According to studies, diabetic arteriopathy in patients without DM is 7%

DM with peripheral circulatory disorders represents 24% of hospitalizations in Portugal.

Case Description: The authors present a case of a 62-year-old male smoker of 25 UMA. Accompanied in the Diabetes Day Hospital since the inaugural diagnosis of Type 2 DM secondary to chronic alcoholic Pancreatitis. He has a good glycemic control with glycosylated hemoglobin of 6.9%. After 3 years of diagnosis, the patient started with pain at the level of the calcaneus and complaints of intermittent claudication for 50-100 m distance, becoming incapacitated for activities of daily living. He did not have complaints at rest. Lower limb arterial Doppler revealed in the distal third of the superficial femoral artery a lumen occlusion by an atheromatous plaque and the presence of several atherosclerotic plaques in the popliteal artery, one of which characterized by marked stenosis compatible with hemodynamic significance.

The patient was directed for evaluation by Vascular Surgery speciality and submitted to angiography, approaching the left femoral artery with repermeabilization of arteries with significant stenosis.

Discussion: This case demonstrates the importance of keeping the vascular and neuropathic alterations of these patients under surveillance, as well as exploring the clinical complaints in each contact with these patients.
Endocrine and metabolic disorders
A-1894

Case report of hereditary hemorrhagic telangiectasia and primary hyperparathyroidism.

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Introduction:
The diagnosis of hereditary hemorrhagic telangiectasia (HHT) is definite if 3 of the following criteria are present, possible or suspected if 2 are present and unlikely if fewer than 2 are present:
• Epistaxis.
• Telangiectasias
• Visceral lesions: gastrointestinal, pulmonary, hepatic, cerebral and spinal)
• Family history: a first-degree relative with HHT.

Case presentation:
She is 81 years lady, well-known case of HHT. She was found to have hypercalcemia on a routine checkup. Her hypercalcemia was proved to be caused by primary hyperparathyroidism. Patient’s blood tests showed hypercalcemia (serum levels of corrected calcium was 2.8 mmol/L), hypophosphatemia (phosphorus of 0.75 mmol/L respectively), high levels of parathyroid hormone (16 pmol/L) and hypercalciuria. However, she did not have any symptoms of hypercalcemia. Total proteins and albumin levels were normal as well as her vitamin D, thyroid hormones and other electrolytes were also normal. A neck ultrasound was performed, showing no notable pathologies.

Conclusion and discussion:
Here we present a case of primary hyperparathyroidism in a patient of HHT. No definite association between HHT and endocrinial disorder was confirmed before. However, a case report described the occurrence of hypoparathyroidism and HHT (1). Another case of Hashimoto thyroiditis and HHT was reported in 2006 (2).

References:
Chemerin correlation with heart dyssynchrony in patients with hypertension combined with diabetes mellitus 2 type

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Background. Chemerin is strongly associated with markers of inflammation and components of the metabolic syndrome in hypertensive subjects and is independently associated with hypertension. The aim of this study was to estimate the correlations between chemerin, heart dyssynchrony (HD), end diastolic volume (EDV) and end-diastolic dimension (EDD), LV mass, hsCRP in patients with diabetes mellitus type 2 (T2DM) and hypertension.

Methods. The study included 61 patients with EH II stages combined with 2TDM at the age of 49-59 years. The level of hs-C-reactive protein (hsCRP), in serum, chemerin were measured with commercially available sandwich (ELISA) according to the manufacturer’s instructions. Diagnosis of myocardial dissynchrony and determination of morphofunctional parameters of cardiac function were performed by echocardiography on the Philips Sonos 7 500 ultrasound system.

Results. Under statistical analyses we estimated significant correlations of chemerin (p<0,05) with the next indices: systolic blood pressure (SBP) -0,316 (Pearson correlation coefficient); diastolic blood pressure (DBP) - 0,272; LV end diastolic volume - 0,269; LV end-diastolic dimension - 0,287; body mass index - 0,789; LA diameter - 0,361; LV mass - 0,217; APEI (Aortic Pre-ejection Interval) - 0,329; IVMD (Inter Ventricular Mechanical Delay). - 0,248; IVRT (Isovolumic relaxation time) -0,714; hs-CRP - 0,215; the rest of correlations didn’t get significant values. The most prominent positive relationship of chemerin were detected with BMI (strong positive), LA diameter, APEI, SBP (moderate positive). And strong negative relation between chemerin and IVRT was measured.

Conclusions. Chemerin possibly can be marker for HD development.
Clinical difficulties in the assessment of an encephalopathic patient: Myxedema coma versus Hashimoto encephalopathy

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INTRODUCTION
Encephalopathy can represent a clinical dilemma. Thyroid disorders should not be forgotten when assessing a patient with altered mental status.

CASE DESCRIPTION
Woman, 71 years old, with hypertension, dyslipidemia and type 2 diabetes mellitus medicated with metformin and nebivolol. She presented with a sudden onset of disorientation, slow speech, sleepiness and unsteady walk after cold exposure the day before. She had no focal alteration to neurological exam, but she presented sinus bradycardia (~37bpm) and hypothermia (<33°C), blood pressure 146/50mmHg. Blood gas analysis: pH 7.33, pCO2 44.7, pO2 108, bicarbonate 24.4, sodium 130, lactate 2.22. Cerebral CT scan: normal. The hepatic panel, urea, creatinin, calcium and ammonia were normal. Vitamin B12<83pg/ml. Thyroid function test showed subclinical hypothyroidism: TSH 27.22uUI/mL and normal free T4 0.87ng/mL (0.7-1.48). During observation she suffered a generalized tonic-clonic seizure and was treated as a myxedema coma: levothyroxine and hydrocortisone IV, supportive care and IM hidroxicobalamin supplementation. Lumbar punction: increased protein levels, electroencephalography (EEG) showed diffuse cerebral dysfunction. Adrenal insufficiency was excluded by the ACTH stimulation test and hydrocortisone was suspended. Anti-thyroperoxidase, anti- parietal cells and intrinsic factor antibodies were positive. Thyroid ultrasound: heterogeneous structure. Cerebral MRI was normal and repeated EEG (corticoids suspended for 2 days) although improved continued to show diffuse encephalopathy.

DISCUSSION
There are only anecdotal reports of myxedema coma in patients with subclinical hypothyroidism. Hashimoto encephalopathy is a rare syndrome associated with Hashimoto thyroiditis; it is corticoid responsive and represents an exclusion diagnosis. The definite diagnosis in this particular case is not settled; perhaps follow-up might provide the answer.
Correlation between recurrent resistant hypertension and primary aldosteronism- Secondary hypertension in a young patient After solitary adrenalectomy

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INTRODUCTION
Primary aldosteronism is considered one of the most common cases of secondary hypertension and treatment-resistant hypertension. We discuss a 34-year old male with a second-degree arterial hypertension (mean readings 170/110mmHg) 6 months after adrenalectomy.

CASE DESCRIPTION
A 34-year old man with BMI 31kg/m² was admitted in our department due to hypertensive peaks, without other pathological signs in the physical examination, basic laboratory tests, ECG and cardiac ultrasound. Secondary hypertension diagnostic workup was decided and he started treatment with two neutral antihypertensive agents.

Specific hormonal profile revealed plasma aldosterone (PA) level 237.9 pg/ml and Plasma Renin Activity (PRA) 0.23ng/ml/h, resulting in a pathological plasma aldosterone/plasma renin activity (PA/PRA) ratio. The saline suppression test revealed PRA of 0.02 ng/ml/h and high PA level of 20.29 pg/ml. The serum levels of dehydroepiandrosterone sulfate, adrenocorticotropin, and cortisol were normal. The suprarenal MRI illustrated a 46.3x31 mm left adrenal adenoma and contralateral adrenal hyperplasia. Total andrenalectomy was performed.

After a normotensive period of 6 months the patient presented with a recurrence of resistant hypertension. The new PRA was 0.44 ng/ml/h and PA levels 381 pg/ml which remained high after saline suppression test (163pg/ml). The MRI illustrated left adrenal adenoma of 11mm-and the constant right adrenal hyperplasia. The patient was treated initially 200mg eplerenone/ day and subsequently 100 mg/day resulting in mean blood pressure 135/90mmHg without hyperkalemia.

DISCUSSION
In young patients presenting with adrenal adenomas and concurrent pathological hormonal profile, surgery is probably required, without excluding new hormonal control for secondary hypertension in case of hypertension recurrence.
Cost-Effectiveness of FINDRISK-based horizontal screening for IFG and DM2

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Objectives: Diabetes is an ongoing global epidemic, with increased prevalence associated with obesity and sedentary lifestyle. The aim of this study was to collect data on diabetes prevalence in a country with no national diabetes registry.

Methods: The study consisted of home visits during a 3-month period (October-December 2017) in a combination of urban and rural settlements representative of the general population. In total, 2100 adults aging 18 years or older were interviewed using the validated translation of the FINDRISK questionnaire and fasting glucose measurements. OGTT curves were ordered for undiagnosed cases with high FINDRISK scores or glucose measurements consistent with IFG (100-125 mg/dl).

Results: Total participation rate was 80%, with a mean duration of each session of 7.8 minutes (standard deviation 1.2). Final results indicated 183 individuals with diagnosed diabetes plus 36 individuals with new diagnosis of diabetes based on high fasting glucose > 126 mg/dl or random glucose > 200 mg/dl plus typical symptoms. In addition, 16 more individuals were newly diagnosed with diabetes after OGTT results. In total, the study yield of new cases was 52/2100 interviews, or one new case for every 40 screening tests performed.

Conclusion: Despite increased diabetes awareness, a significant proportion of diabetic patients remain undiagnosed to this date. A horizontal screening policy for all adults may be justified to reveal still undiagnosed asymptomatic individuals in this population.
Dapagliflozin-associated euglycemic diabetic ketoacidosis in the ICU

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INTRODUCTION: Sodium-glucose cotransporter 2 (SGLT-2) inhibitors are one of the most recently approved antihyperglycemic drugs in the treatment of type 2 diabetes mellitus (T2DM). They’ve been associated with euglycemic ketoacidosis (euDKA) defined as ketoacidosis with glycemia < 300mg/dL, with a few cases being reported yearly. It's usually described in patients with type 1 DM, reduced carbohydrate intake and low insulin dosage. In patients with T2DM the SGLT-2 inhibitors inhibit glucose reabsorption, promote glycosuria and lower plasma glucose, leading to deceptively low blood glucose levels in the presence of increased ketogenesis.

CASE DESCRIPTION: A 51 year-old woman with T2DM recently medicated with insulin and dapagliflozin, was admitted in the Emergency Room (ER) with malaise and incoercible vomits. She was sleepy, dehydrated and with abdominal discomfort. The blood tests revealed leukocytosis, hyperglycemia of 294mg/dL and ketonemia of 7.4mmol/L. Arterial blood gases showed metabolic acidemia. The presumed diagnosis was euDKA and she was started on IV insulin and hydration, with scarce results and worsening of the acidemia. She was then admitted in the Intensive Care Unit under IV hydration and insulin perfusion, with steady improvement. After thorough investigation there was no other identifiable cause of DKA. Following clinical and gasometrical improvement, she switched to insulin bolus and was discharged.

DISCUSSION: EuDKA seems to be a common adverse event of SGLT-2 inhibitors. The fact that it occurs with relatively normal glycemia values can delay the diagnosis, thus the need to instruct the patients to look for signs of deterioration, and alert physicians on the importance of close monitoring patients. In this case it’s also important to clarify the initial diagnosis, since sometimes latent autoimmune diabetes of adults can be diagnosed incorrectly as T2DM, affecting the following therapeutic approach and rising potentially fatal complications.
Descriptive study of patients who are treated with teriparatide in a third level hospital

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Background:
Teriparatide is an anabolic agent which acts directly stimulating bone formation and improving bone mass quantity and quality.

Material and methods:
Descriptive and retrospective study of patients who were treated with Teriparatide from 2008 to 2016 in Bone Metabolism Unit of Hospital Universitario Marqués de Valdecilla

Results:
- Teriparatide was used in 128 patients with a mean age of 72 years. Majority of whom were females, only 11% males.
- The average Body Mass Index (BMI) was 26.45. The average age of menopause was 48.
- In respect of results of bone density prior to the treatment were (statistical average): T score at total hip -2.03, T score at lumbar spine -2.6 and T score at femoral neck -2.25.
- The average time of treatment with Teriparatide was 17 month.
- Only 40 of 128 patients were checked through densitometry (one year after onset of treatment) (statistical average): T score at total hipo -1.96, T score at lumbar spine -2 and T score at femoral neck -2.02. There are no statistically significant results comparing data by age group (cut off age 75 years) (p 0.2 at lumbar spine, p 0.3 at femoral neck and 0.7 at total hip) or by gender.
- 14% of patients had family history of osteoporosis and 13% had been treated with corticoids for at least three month.
- Previously to the treatment with Teriparatida, 65% of patients had recieved other treatment (50% Alendronate)
- After end of treatment three patients suffered fractures.
- 43% of patients affirmed that they had felt less lumbar pain with Teriparatide.
- 45% of patients who recieved treatment with Teriparatide have subsequently been treated with Denosumab.

Conclusion:
Teriparatide in our hospital is a very important alternative to treat osteoporosis, and it is become more popular in the last years.
Patients who were controlated by densitometry had T score improvement.
Descriptive study of the epidemiological, clinical and diagnostic characteristics of patients diagnosed with sepsis at the Rafael Méndez Hospital

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OBJECTIVES

To analyze the epidemiological, clinical and diagnostic characteristics of patients diagnosed with sepsis during 2014 in the Internal Medicine service of our hospital.

METHODS

Retrospective descriptive study of patients diagnosed with sepsis during 2014 (92 patients). We collected the following variables: age, gender, multi-pathological, systolic blood pressure, heart rate, creatinine, INR, total bilirubin, platelets, C-reactive protein, semiquantitative procalcitonin, arterial pH, arterial lactate, volume of fluid during the first hour of care, death, admission to the ICU and use of vasoactive drugs.

RESULTS

The average of the variables were: age: 72.7 years, systolic blood pressure: 107 mmHg, heart rate: 96 bpm, creatinine: 2.3 mg/dL, INR: 1.5, total bilirubin: 1.07 mg/dL, platelets: 199000/mm3, C-reactive protein: 194 mg/L, semiquantitative procalcitonin: 7.13 ng/mL, arterial pH: 7.35, arterial lactate: 3.3 mmol/L, volume of fluid during the first hour of attention: 452 ml.

56% were women and 26.6% were multi-pathological. 36.2% died. Admission in ICU 22.3%. 38.3% required the use of vasoactive drugs. 81.9% presented community infection and 18.1% infection associated with health care.

Mortality has been associated with a statistically significant relationship with age (p<0.001), use of vasoactive drugs (p<0.001), INR (p<0.01), semiquantitative procalcitonin (p<0.05) and arterial lactate (p<0.03). Age correlates inversely with a statistically significant relationship with C-reactive protein (p<0.002) and admission to the ICU (p<0.01).

CONCLUSION

Age correlates with a statistically significant relationship with mortality and inversely with C-reactive protein. Mortality has been associated with a statistically significant relationship with semiquantitative procalcitonin and arterial lactate.
Descriptive study of the microbiological and antimicrobial characteristics of patients diagnosed with sepsis at the Rafael Méndez Hospital

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OBJECTIVES

To analyze the microbiological and antimicrobial characteristics of patients diagnosed with sepsis during 2014 in the Internal Medicine service of our hospital.

METHODS

Retrospective descriptive study of patients diagnosed with sepsis during 2014 (92 patients). We collected the following variables: age, death, primary infection focus, associated organic dysfunctions, surgical intervention to control the focus, isolated microorganisms, antimicrobial agents used in the initial regimen, culture used and percentage of isolation in culture.

RESULTS

According to the primary infection focus, we found according to frequency: urinary (35.2%), respiratory (23.4%), septic, abdominal and other shock. Associated organic dysfunctions found according to frequency: acute renal failure (58.5%), respiratory distress (29.8%), hepatic involvement, cardiac dysfunction, DIC and encephalopathy. Surgical intervention was performed in 12.8% to control the focus, with cholecystectomy being the most frequent (25% of the total).

Most frequent microorganisms isolated: E. coli (22%), K. pneumoniae (9%), S. pneumoniae (8%), Candida (7%), E. faecalis (6%). Most frequent antimicrobials used in initial regimen: ceftriaxone (30%), Fluoroquinolones (15%), carbapenems (14%), piperacillin-tazobactam (8%), clarithromycin (6%).

Microbiological isolation was found in 42.7% of total crops and by type of culture: blood cultures: in 32.5% of them, urine cultures: 42.2%, sputum cultures: 68.4%, cultures of exudate: 63.2%, biological liquid cultures: 38.5%.

Mortality is associated with a statistically significant relationship with respiratory distress (p<0.02) and septic shock (p<0.01). Age correlates inversely with a statistically significant relationship with obtaining blood cultures (p<0.02).

CONCLUSION

The most frequently isolated microorganism is E. coli followed by K. pneumoniae and S. pneumoniae. The most frequently used antibiotic is ceftriaxone followed by fluoroquinolones and carbapenems.
Diabetes and the hidden foe

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Introduction:
There is a complex connection between diabetes mellitus (DM) and pancreatic carcinoma (PC) and it has been target of many studies, some of each suggest that while DM is a risk factor for developing PC, this last one can be the cause of diabetes as a paraneoplastic syndrome.

Case description:
The authors present a case of a 72 years old female diagnosed with type 2 diabetes two weeks ago, and started on metformin. She had also hypertension and dyslipidaemia. The patient was admitted in the emergency room (ER) complaining of polyuria, polydipsia and weight loss of 10 kilograms in the last two months. She had uncontrolled glycaemic values (475 mg/dL), ketonemia and ketonuria. Laboratory evaluation reported leucocytosis, elevated c reactive protein and aminotransferase levels, with normal range bilirubin levels. An abdominal CT was performed, showing a 36mm heterogenous mass in pancreatic cephalad region and multiple nodular liver lesions. A liver ultrasound-guided biopsy, confirmed the diagnosis of a primary pancreatic adenocarcinoma. There was a rapid deterioration with progressive obstructive jaundice, for each was submitted to a ERCP with prosthetic permeabilization of the main biliary duct and then referred to palliative care.

Discussion:
In diabetic patients with optimized therapy and still uncontrolled glycaemic values, the exclusion of other pancreatic diseases is of the most importance. Although some studies verify a connection between DM and PC, its understanding remains unclear and in the need for further study.
Diabetes complications or another diagnosis? A case report

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Introduction
Screening for diabetes complications should be a routine part of diabetes care at any age with the need of understanding etiologies that may present as complications.

Case Report
A nineteen-year-old male with type 1 diabetes has complained of decreased visual activity and worsening of his polydipsia and polyuria. He was diagnosed with type 1 diabetes at the age of thirteen and had an excellent metabolic control.

Physical examination showed bilateral mild optic nerve atrophy. Laboratory testing showed Hemoglobin A1C of 7.2% and negative urine micro albumin.

The possibility of diabetes complications affecting the eyes and kidneys was considered, although it was unlikely due to the good metabolic control and relatively short duration of the disease. Ophthalmology consultation confirmed the bilateral optic nerve atrophy without any diabetic retinopathy. This prompted consideration of Wolfram (DIDMOAD) Syndrome that consists of Diabetes Insipidus, Diabetes Mellitus, Optic Nerve Atrophy and Deafness.

Laboratory work up confirmed the diagnosis of Diabetes Insipidus. Genetic testing showed a mutation in the WFS1 gene confirming the diagnosis of WS type 1.

Discussion:
Wolfram syndrome (WFS: DIDMOAD) is an autosomal recessive neuro-endocrine degenerative disorder. Many cases of WFS may remain misdiagnosed as type 1 diabetes mellitus with associated complications. Diabetes mellitus is typically the first symptom, usually diagnosed in childhood requiring insulin therapy. Optic atrophy is often the next symptom to appear, with loss of color and peripheral vision. Approximately 70 percent of people with Wolfram syndrome have diabetes insipidus.

When multiple organ involvement is seen in young patients with diabetes, certain syndromes should be considered including Wolfram syndrome or mitochondrial disorders, this should not be mixed up with diabetes complications.
Diabetes Mellitus And Colorectal Cancer: Is There Any Relationship?

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Objectives: Type 2 Diabetes mellitus (DM2) and cancer are common diseases. Recent studies suggest that there is an increased risk of colorectal cancer (CRC) among DM2 patients. The association between DM2 and some cancers may be due to shared risk factors. The study aim is to assess the prevalence of DM2 among patients with CRC and to compare cancer patients with DM2 with non-diabetic cancer patients.

Methods: Retrospective analysis of all patients diagnosed with colorectal adenocarcinoma (CRA) or relapsed CRA, during one year. The association between DM2 and CRC was estimated using SPSS 22.0.

Results: 88 patients with CRA were included, mainly male (55.7%) with a median age of 72 years [39-89]. Among these 18 patients (20.5%) had DM2, with an average glycosylated hemoglobin of 6.1%. Among DM2 patients, 86.0% were treated with oral antidiabetic agents, 7.7% with insulin and 7.0% with both. Diabetic patients were diagnosed at earlier stages of CRA (50.0% in stage II), with similar initial performance status. They required a larger number of postponements of chemotherapy cycles and reduction of cytostatics doses. The overall survival rates at 3, 9 and 12 months were lower in the DM2 group. There were no statistically significant differences.

Conclusion: These results suggest that CRC incidence is higher in DM2 patients. It remains unclear whether the association between DM and cancer is direct, whether DM is a marker of underlying biologic factors that alter cancer risk. Diet and exercise reduce risk and improve outcomes of DM2 and some forms of cancer.
Efficacy on metabolic parameters, mGFR and safety from the administration of IDegLira in a real-life setting in poorly controlled patients with Type 2 Diabetes Mellitus.

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Background: IDegLira is a combination of Insulin Degludec (IDeg) and Liraglutide (Lira). The aim of the study was the investigation of clinical outcomes in a real-world population with long-standing, poorly controlled Type 2 Diabetes Mellitus (T2DM) after switching from oral drugs, GLP-1RA or/and insulin to IDegLira.

Methods: The study was a prospective, open-label, single-center observational follow-up of 35 patients (42.9% men, mean age 63.9±9.7 years, mean duration of DM 15.8±8.5 years). All patients before IDegLira were on treatment with metformin, DPP-4Inh., sulfonylureas, SGLT-2Inh., GLP-1 RAs or/and insulin. After the initiation and additionally to IDegLira, all patients were on metformin and in few cases on fast insulin analogs. Patients were on treatment with IDegLira for at least 3 months. Information about glycemic control, IDegLira dose, weight, mGFR and blood pressure, along with any adverse events was collected from medical records and patient reports during clinical visits.

Results (initial vs final): Mean HbA1C improved (8.9±1.6% vs 7.3±0.7%, p<0.001) with concomitant weight loss (97.4±18.4 vs 94.4±18.4 kg, p<0.001). With the use of IDegLira, there was a decrease in mean systolic (135.6±19.4 vs 130.7±16.4 mmHg, p<0.05), but not in mean diastolic pressure. Mean dose of IDegLira was 35.9±13.8 U/24h. MGFR did not change significantly (74.7±17.4 vs 72.6±22.8 ml/min/1.73m2). There were no episodes of severe hypoglycemia during treatment with IDegLira.

Conclusion: Switching to IDegLira, mostly from regimens using insulin in conjunction with oral antidiabetics in a real-world population of patients with T2DM resulted in improved glycemic control with a reduction in systolic blood pressure and weight loss.
Endocrine and metabolic disorders
A-1466

Extreme hypertriglyceridemia, is abstinence the answer? A case report and review of the literature

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Hypertriglyceridemia develops due to the impairment of the lipoprotein metabolism, either as a hereditary dysfunction; as a secondary manifestation of an underlying pathology; or the consequence of the use of certain drugs. Nonetheless, extreme hypertriglyceridemia (>10,000 mg/dL) is rare to find.

We report the case of a 44yo. man, BMI of 32.5, with type 2 diabetes mellitus and dyslipidemia, but no family history of dyslipidemia. He had a high soda and alcohol (169 g/day) intake. He was on metformin, sitagliptin and simvastatin.

He was admitted to the Emergency Department, with a 4-week history of abdominal pain, steatorrhea, vomiting. He showed jaundice, but an unremarkable physical examination. His lab results revealed AST, ALT and GGT of 383, 198 and 926 mg/dL, respectively, with total bilirubin of 3.9 mg/dL, hyponatremia of 117 mg/dL, slightly elevated prothrombin time, and normal glucose, protein C reactive, amylase and lipase. At macroscopic examination, the serum was extremely lipemic, triglycerides (TG) of 12,549 mg/dL and total cholesterol (TC) of 956 mg/dL. Thyroid function was normal, HIV, HCV and B were negative, and no proteinuria was found. A CT scan showed hepatomegaly with diffuse steatosis.

A diagnosis of alcoholic hepatitis was made (Maddrey score of 23.2) and the patient was admitted to the wards: nil per os, IV hydration, insulin therapy and alcohol-abstinence prophylaxis, with careful monitoring in case of worsening or development of pancreatitis.

At day 6, after introduction of low-fat diet, TG of 250 mg/dL and TC of 449 mg/dL, the patient was discharged with the same antidiabetic agents, and an ACE-inhibitor for hypertension diagnosed during his stay. 1 week later, lab studies showed total resolution of hepatitis with TG 91 mg/dL and TC of 247 mg/dL.

To our knowledge this is one of the few cases of alcoholic hepatitis presenting with such an extreme hypertriglyceridemia. Even so, a conservative strategy showed excellent results.
Feasibility Study of a remotely delivered, tailored eHealth behavioural change intervention in Type 2 Diabetes Mellitus.

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Effective and affordable interventions are needed to treat type II diabetes (T2D). In-person behavioural counseling focusing on diet and physical activity are accepted therapies for T2D, but are costly and labour-intensive. eHealth technologies, offer novel cost-effective approaches to intervention delivery for T2D.

Objective: To determine the efficacy of ‘RediCare 8’, an 8 week eHealth intervention in a self-selecting sample of people diagnosed with T2D.

Methods: 50 self-selecting adults with T2D were recruited online (age: M= 57, SD= 6.49, weight, M= 100.43, SD= 20.94, body mass index: M= 34.11, SD= 6.41, kg/m2; 32% women). Participants entered dietary intake, physical activity and body weight daily to ‘MyFitnessPal’. Educational content regarding behaviour change was delivered by email to participants bi-weekly. Health coaches remotely monitored participant progress via a web-based platform. They provided behaviour counseling and tailored feedback to participants remotely by telephone or via an asynchronous video recorded review.

Results: 39 participants completed the intervention (22% attrition). HbA1c % mean reduction was .86 %, p < .001. 59% of participants achieved HbA1c <6.5%. Mean body weight reduction = 6 kg (p< .001). 61% (24/39) participants attained clinically significant weight loss ( >5% weight reduction). statistically significant reductions were noted in BMI, Waist circumference, waist to height ratio, Systolic blood pressure, Diastolic blood pressure, resting heart rate, medication requirement and three lipid parameters (all P<.05).

Conclusions: An eHealth Program was highly effective in significantly improving glycaemic control, weight and medications, in addition to important clinical outcome parameters in adults with T2D.
Fever and pleural effusion as debut of pheochromocytoma

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Introduction:

Pheochromocytomas are a neuroendocrine tumors that predominantly presents with hypertension, palpitations, headache and sweating due to excessive catecholamine excretion. Pheochromocytoma multisystem crisis (PMC) includes multiple organ failure, severe blood pressure variability and high fever.

Case description:

A 79 year old woman with a history of hypertension. She consulted due to 5 days history of fever, dry cough, dyspnea, and left hemithorax pain. Physical examination revealed blood pressure of 150/100 mmHg and temperature of 38°C. ECG showed atrial fibrillation, heart rate 130 bpm, and the chest radiography revealed left pleural effuse. Laboratory work-up showed leukocytosis, acute phase reactants increase and renal failure. Body-CT demonstrated a left adrenal mass of 5x5cm. Urinary noradrenaline concentration was raised and I-MIBG confirmed the diagnosis. Postoperatively she remained free of symptoms.

Discussion:

Although PMC is relatively rare, clinicians should focus on early diagnosis as delay in initiating the appropriate treatment can lead to mortality.
OBJECTIVES: Thyroid nodules are relatively frequent findings whether detected physically or incidentally in complementary diagnostic exams. Its clinical importance lies in the fact that exclusion of malignant lesion is necessary. Our goal was to compare the results obtained in fine needle aspiration biopsy (FNAB) of the thyroid requested in an Internal Medicine consultation with the ultrasound characteristics of the nodule that led to its requisition.

METHODS: A retrospective study of a patient population of an Internal Medicine consultation was carried out, through the analysis and survey of the respective clinical processes of all patients between January 1st and December 31st of 2017 that were submitted to a FNAB of thyroid nodules.

RESULTS: During the analyzed period, 54 FNAB of the thyroid were requested, 5 of which were not performed and were excluded from this analysis. From the cytological point of view, 3 FNAB showed to be compatible with malignant tumors, 6 corresponding to follicular lesion of undetermined significance (FLUS). The main criteria for the requisition of FNAB of thyroid nodules was the size of the nodule > 10mm accompanied by at least one ultrasound characteristic of suspected malignancy.

CONCLUSION: The results obtained through the analysis of this population are in accordance with the literature. The majority of the nodules were benign and the malignancy rate of this sample was low (~ 6%). The nodule size, solid appearance and hypoechogenicity were the main factors for FNAB. However it was not possible to determine their significant relationship with the malignancy of the nodules. Nevertheless, the risk of malignancy should not be underestimated.
Fitobezoar secondary to diabetic gastroparesis dissolved with Coca-Cola®

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Introduction
The dissolvent property of the Coca-Cola® is related to its active component, the phosphoric acid, coupled with its bicarbonate content, with mucolytic action, and the CO2. There are few publications describing the use of Coca-Cola® to treat bezoars, being in some cases successful after failure of endoscopic fragmentation or dissolution by an enzymatic drug.

Case presentation
A 40-year-old woman was admitted due to abdominal pain, located in the epigastrium and left iliac fossa, for about 3 days of evolution; non-irradiated and fluctuating throughout the day, unrelated to meals or other triggers. Two days ago she presented fever of up to 39°C, later afebrile. No changes in intestinal habit (constipated), although she commented about nausea with an isolated episode of vomiting and abdominal distension. Gastroscopy detected findings compatible with a phytobezoar, most likely secondary to gastroparesis. We started medical treatment with prokinetics and CocaCola®, confirming its subsequent resolution with a new endoscopy.

Discussion
Although there is no consensus about the treatment of bezoars, if endoscopic fragmentation it is not efficient, substances capable of enzymatic degradation, or CocaCola®, should be used, being our experience with the latter very positive. If conservative treatment fails or complications develop, the bezoar should be approached surgically, ideally by laparoscopy.
Frequency of Obesity in Women Screening for Breast Cancer by Electro Impedance Mammography (MEIK).

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Breast cancer is the second highest cause of cancer-related death, and breast cancer mortality has increased in recent years. Current research indicates that body composition increases the risk of recurrence and decreases survival. An increase in Body Mass Index is associated with major grade breast cancer and luminal B breast cancer, mainly in postmenopausal women. Obesity is associated with increased mortality among women with hormone receptor-positive breast cancer, which may be as a result of increased steroid hormone levels. Obesity contributes to a higher aromatization of body fat and this increases circulating hormone levels.

Many studies have focused on establishing an association between obesity and breast cancer. In this study, we evaluated the correlation between frequency of obesity and the BIRADS (Breast Image Reporting and Data System) diagnosis by electroimpedance, as well as the distribution of the conductivity in breast tissue.

Results: We included 503 female patients who had breast cancer screening by electro impedance (MEIK), during the period from January to April 2018. The mean age was (50.14±9.90) years, weight (71.07±13.61) kg, height (156.46 ± 6.67) cm, BMI was 29.14 ± 10.24, body fat 37.46 ± 6.94, muscle 41.50 ± 5.17, water 44.49 ± 18.12, visceral fat 8.75 ± 3.43 and bone 2.23 ± 0.26. In 109 (19.3%) women normal weight was observed, with overweight 176 (31.2%), with Obesity: 195 women (34.5%), grade 1: 130 (23%), Obesity grade 2: 48 (8.5%) and Obesity type 3: 17 (3%). The average of the difference in the distribution of conductivity between mammary glands was 10.15 ± 5.18, the conductivity in left breast: 0.48 ± 0.13, and right: 0.49 ± 0.13. The distribution of the BIRADS diagnosis was 1 (3.36%), 2 (37.52%), 3 (7.6%) and 4 (2.65%), 4 cases with histopathological diagnosis of mammary carcinoma (0.79%) with a BMI of 35.51.

Conclusions: 34.5% of the studied population presents obesity, showed (0.79%) for mammary carcinoma found have Obesity type 2.
INTRODUCTION: Hypopituitarism is defined as the total or partial loss of anterior and posterior pituitary gland function that is caused by pituitary or hypothalamic disorders. Its clinical manifestations vary, depending on the affected hormonal axis and speed of installation.

CLINICAL CASE: 48 year old female, with history of necrotizing pneumonia requiring multiple antibiotics and hospital admission in the previous year. Excluded aspergillosis and pulmonary tuberculosis. Immunological study was normal. She was sent to our consultation due to mild anemia and hyponatremia.

At the first appointment, she complained about fatigue to exertion and severe asthenia with several years of evolution. No alterations found on physical examination besides a BMI of 17.1 kg/m2. On blood analyses, a hypoproliferative anemia (Hgb: 10 g/dl), mildly hypochromic and microcytic, without iron deficiency. Renal function and serum sodium concentration were normal. De novo, identified central hypothyroidism (TSH: 3.23 uIU/ml and free T4: 0.63 ng/dl). Requested study of the hypothalamic/pituitary axis and an immunological pannel. Highlighting results: a not measurable IGF1, low cortisol (2.3 ug/dl) with normal ACTH (10.7 ng/L), low FSH and LH with serum estradiol compatible with menopause, and normal Prolactin levels. Immunological study was negative. She started hydrocortisone supplementation and, 7 days later, levothyroxine supplementation. Her cerebral MRI documented adenohypophysis apoplexy – she had no previous history of bleeding, trauma or radiation. Six months after suplementation, improvement of complaints and weight gain. Resolution of anemia, microcytosis and hypochromia.

DISCUSSION: The speed of installation of hormonal deficits and their severity determine the clinical manifestations of hypopituitarism. Slow and progressive installation usually results in nonspecific clinical manifestations that lead to impaired quality of life and make it difficult to diagnose.
Background: It has been demonstrated in various studies that, as a result of chronic inflammations and fluctuations in level of thyroid hormones that increase due to auto-inflammation during the phase of subclinical hypothyroidism in Hashimoto’s Thyroiditis, a tendency for atherosclerosis occurs in cardiovascular system. Therefore we aimed to examine level of homocysteine and its association with auto-antibodies in patients diagnosed with subclinical hypothyroidism.

Methods: A total of 90 participant were included in the study with 48 patients, older than 18 years of age, who were diagnosed with subclinical hypothyroidism due to newly-diagnosed Hashimoto’s Thyroiditis, and 42 healthy volunteers without any known diseases.

Results: In our study, the levels of homocysteine (9.6 µmol/L vs 5.5 µmol/L; p< 0.001), hs - CRP (2.4 mg/L vs 0.9 mg/L; p< 0.001) and LDL - cholesterol (respectively: 115.9 ± 32.7 mg/dl vs 100.3 ± 23.9 mg/dl, p= 0.008) were higher in the group of autoimmune subclinical hypothyroidism than in the healthy control group, whereas the level of HDL – cholesterol (respectively: 51.2±12.7 mg/dl vs 58.8±15.2 mg/dl; p= 0.008) was lower in our study group. There was a positive correlation between homocysteine level and hs – CRP (r= 0.312, p= 0.027), anti – TPO (r= 0.505, p< 0.001) and anti – Tg (r= 0.318, p= 0.031) levels in the subclinical hypothyroid group. Regression analysis showed that HDL - cholesterol, hs - CRP and homocysteine levels were independent risk factors for subclinical hypothyroidism.

Conclusion: High levels of homocysteine and hs - CRP in autoimmune subclinical hypothyroidism group, which have been shown to be closely related to the pathophysiology of atherosclerotic diseases in these findings, and these parameters as independent risk factors for autoimmune subclinical hypothyroidism; suggesting that autoimmune subclinical hypothyroidism may be closely associated with atherosclerotic diseases.
Hypercalcemic parathyroid crisis as a rare manifestation of primary hyperparathyroidism.

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Primary hyperparathyroidism is a common disease that usually follows an indolent course. The authors report an uncommon case of primary hyperparathyroidism which presented as a hypercalcemic crisis. A 46-year-old female patient was admitted with a three-week history of nausea and vomiting, followed by hypertension and acute renal failure. She had been recently diagnosed with type 2 diabetes and medicated with anti-diabetic drugs. There was no history of any other type of medication, like lithium. The blood tests showed calcium of 17.4 mg/dL, ionized calcium of 2.14 mmol/L, phosphorous of 2.4 mg/dL, uric acid of 11.8 mg/dL, PTHi of 596 pg/mL and 25(OH)D of 3.2 pg/mL, with normal TSH, T4 and T3. Urinary calcium was 619 mg in a 24-hour sample. The thyroid ultrasound showed a solid node in the posterior and inferior border of the thyroid's left lobe, measuring 27 x 14 x 12 mm. The final diagnosis was made by aspiration cytology that revealed a parathyroid adenoma, with a negative result in sestamibi scan. After intense intravenous hydration and diuretics, and the administration of pamidronic acid, the levels of calcium and subsequent complications began to normalize. The patient was then subjected to a left inferior parathyroidectomy, recovering to normal metabolic and hormonal levels.

Primary hyperparathyroidism is frequently asymptomatic, allowing the disease to develop for several years before the diagnosis. Hypercalcemic parathyroid crisis is a rare course of parathyroid adenomas, requiring urgent medical treatment and a subsequent surgical approach.
Introduction: the differential diagnosis of hypercortisolism is a clinical challenge. It is necessary to perform multiple analytical tests to reach the most probable etiological origin, in order to avoid more invasive tests on the patient.

Case description: we present a 64-year old female who was admitted to our Unit with an exacerbation of chronic obstructive pulmonary disease. It was observed that she had a tendency to hard-to-control arterial hypertension, hypopotassaemia in spite of potassium supplements and hyperglycaemia. It was excluded the treatment with corticosteroids, reason why endogenous hypercortisolism was suspected, being confirmed by the determination of high levels in 24-hour free urinary cortisol and non-suppression in the overnight 1 mg dexamethasone suppression. High levels of ACTH indicated ACTH-dependent Cushing’s syndrome. To establish the origin we perform a dexamethasone suppression test with higher concentrations (8 mg) which non-suppression result indicated an ectopic ACTH-secretion, so it was necessary to complete the study with computerized tomography. We identified a nodular image of 1.5x2 cm in the left lower lobe, and the Octreoscan showed a pathological uptake establishing the diagnosis of Cushing’s syndrome by ectopic secretion of ACTH by bronchial carcinoid tumor. Open surgery was dismissed because of the comorbidities and the medical treatment was performed with Ketoconazole, Metyrapone and Octreotide while stereotactic body radiation took effect.

Discussion: Cushing’s syndrome by ectopic secretion of ACTH by bronchial carcinoid tumor is a rare cause of hypercortisolism, although there are some cases reported there are not enough to establish the most correct treatment algorithms. In patients who are not candidates for surgery, stereotactic radiotherapy is becoming a curative option, which needs further studies to clarify its real role.
Hyperglycemia by alcoholic ketoacidosis mimicking diabetic ketoacidosis – a case report.

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Introduction: Chronic alcoholism is an occasionally unrecognised cause of ketoacidosis. Most patients with alcoholic ketoacidosis present with normal or low glucose, but hyperglycemia may also prevail. This can lead to misdiagnosis of diabetes ketoacidosis, therefore, inappropriate treatment with insulin.

Case description: 54 yo man presented to our emergency department (ER) with 2-day history of abdominal pain, vomiting and shortness of breath. His past medical history included chronic alcoholism and pancreatitis. He had been discharged just one week prior after a supervised alcohol withdrawal. He reported that soon after discharge he had started to drink large amounts of vodka and beer. On admission, his vital signs were within normal limits. Blood gas analysis was significant for metabolic acidosis with an elevated lactate 5.9mmol/l. Serum alcohol 1.4 °%, random blood glucose 25 mmol/l, and there was mild ketonuria present. A CT abdomen showing no evidence of intestinal ischemia. As the triad for diabetes ketoacidosis was fulfilled, intravenous insulin and aggressive fluid repletion was initiated in the ER. Subsequently, several facts led to the rejection of diabetic ketoacidosis as working hypothesis: his past medical was unremarkable with respect to diabetes mellitus, HbA1c 5.5%, serum glucose levels and pH had rapidly normalized, he did not require any further insulin treatment. With his recent history of recent binge drinking a diagnosis of alcoholic ketoacidosis was finally made. The patient was treated with antiemetic, analgesics and intravenous fluids, and recovered immediately. His glucose levels remained within the normal range during the rest of the hospital admission.

Discussion: Alcoholic ketoacidosis is an important differential diagnosis of a ketoacidosis and may be confused with diabetic ketoacidosis. Both, diabetic and alcoholic ketoacidosis can present with vomiting and abdominal pain, and elevated lactate levels are observed in both condition.
Hyperparathyroidism - a case report

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Introduction
Parathyroid glands are responsible for maintaining extracellular calcium levels within stable limits. Excess production of PTH results in elevated levels of serum calcium. The symptoms commonly include asthenia, decreased intestinal motility, electrocardiographic abnormalities and nephrocalcinosis. Although unusually, the clinical presentation may include neurologic disturbances, and it is crucial to do a quick diagnosis.

Case description
Patient of male gender, aged 70, presented to the emergency room with marked asthenia, dizziness, sweating associated with difficulty in walking and obstipation. Medical history of the patient is significant for renal lithiasis and chronic obstipation. At admission he had a heart rate of 40 bpm, blood pressure 110/60 mmhg; normal body temperature. Laboratory tests revealed the following significant abnormalities: normocytic anemia, with a slight creatinine elevation of 1.2 mg/dl, a corrected calcium of 13.12 mg/dl, ionized calcium 1.87 mmol / L, serum phosphate 0.52 mmol / L, urinary calcium 13.16 mmol / 24 hours and PTHi 285 ng / L. Normal thyroid function and vitamin D. Cranial CT scan revealed a calcified meningioma, and the neck CT revealed a heterogeneous thyroid gland with a nodular formation at the level of the lower left lobe. The parathyroid cintigraphy showed a focus of hypercaptation of 99mTc-Sestamibi, on the lower left pole of the thyroid. Osteodensitometry revealed an evident loss of bone mass equivalent to a condition of osteoporosis. The patient was treated with a scheme of hydration and furosemide, and then with zoledronic acid, with a great response. Subsequently, the parathyroidectomy was performed and the histology of the surgical piece was compatible with oxyphilic adenoma of the parathyroid.

Discussion
The clinical case aims to demonstrate the importance of the ability of the internist to thinking beyond the usual. Hypercalcemia if not adequately treated could be a potentially fatal condition.
INTRODUCTION: Although Paget's bone disease may be an incidental finding in radiographic examination or biochemical tests, up to 40% of patients who come to medical attention have bone pain. Patients with Paget's disease who present pain should be carefully evaluated for causes other than increased metabolic activity, such as nerve compression syndromes, pseudofractures, secondary osteoarthritis, or other musculoskeletal condition.

DESCRIPTION: A 33-year-old woman with a history of dyslipidemia, L5 sacralization, odontogenic tumor removal and caesarean section, attended the Internal Medicine department as a result of emergencies due to left coxalgia and right heel pain due to mechanical characteristics after accidental fall related to the syndrome. pyramidal. Magnetic resonance of the lumbar spine performed two months ago within normality. No joint pain at other levels. No photosensitivity, dryness, oral-genital sores, uveitis, Raynaud or other data of collagen diseases. Presenting autoimmunity including anti-CCP and negative HLAB27, non-significant VSG. Negative serology Hypercalcemia 15.6 mg / dl stands out. Bone scintigraphy was performed, highlighting pathological hyperfixation with blastic features in the right sacroiliac, sternoclavicular joint, coxofemoral, superior region of both tibias and left heel. Rear arch of 9th and 10th right rib. Intense hyperfijation in the calotte, suggestive of frontal hyperostosis. Parathyroid scintigraphy compatible with hyperplasia / adenoma of the left inferior parathyroid and ectopic parathyroid. Multiple thoracic lytic lesions were observed in chest CT.

DISCUSSION: Given that the patient suffers from hyperpathyroidism and Paget's disease, the differential diagnosis would be between brown tumor in the context of hyperparathyroidism, polyostotic fibrous bone dysplasia (assess if it could be in the context of the Mc Albright syndrome), Paget's disease.
Hyperthyroidism as a Cause of Intractable Diarrhea

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Introduction: Diarrhea is a common gastrointestinal manifestation. It has diverse causes, due to a local aggression or as manifestation of a systemic entity. Infectious or non-infectious causes, such as inflammatory bowel disease, neoplasias, thyrotoxicoses, medications, among others, may be involved in its etiopathogenesis. Hyperthyroidism may occur with digestive symptoms, such as secretory diarrhea or steatorrhea.

Case Description: An 82-years-old woman with hypertension and dyslipidemia, presented to the Emergency Department with diffuse colic abdominal pain, postprandial vomiting, aqueous diarrhea, asthenia and weight loss of 4 kg in the last two months. On physical examination, the patient presented dehydrated, with painful abdomen in the upper quadrants and hypotensive. Laboratory study revealed elevation of inflammatory markers, renal dysfunction and hypokalemia. Metabolic acidosis was found in blood gas test. Abdominal CT scan showed mesenteric panniculitis. Numerous laboratory and imaging studies and endoscopic examinations failed to disclose the cause of the diarrhea. Antibiotics and other empiric medications failed to control the problem. No other symptoms of hyperthyroidism were reported, but when the endocrinopathy was suspected (TSH 0.03uUI/mL, free T4 1.9ng/dL and TRABS 1.0U/L), the patient begun the treatment. The diarrhea was promptly controlled by treatment with thiamazole and propranolol. Hyperthyroidism was assumed to be the cause of diarrhea.

Discussion: The effects of thyroid hormone on the adrenergic system lead to an intestinal hypersecretory state and/or hypermotility, associating with diarrhea and intestinal malabsorption. This clinical case demonstrates the importance of considering hyperthyroidism in the differential diagnosis of chronic diarrhea of unknown cause.
Hypothyroidism in the course of systemic vasculitis.

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Introduction: Thyroid involvement is exceptionally studied during systemic angiitis despite hypotheses of a non-hazardous association between the two conditions.

Methods: Retrospective study (2000 and 2014) carried out at the Internal Medicine Department of the Military Hospital of Gabes, to identify among adults ≥18 years of age with symptomatic primary hypothyroidism those with associated systemic vasculitis.

Results: Of 200 hypothyroid patients, 8 had associated vasculitis, or 4%. This vasculitis was of Behçet's disease type: n = 4, Horton's disease: n = 3 and Takayasu's disease: n = 1. By comparing this group with the rest of the hypothyroid, there were significantly more associated autoimmune/dys-immune pathologies (50% vs 25%, p = 0.02), significantly more familial self-immunity 50% vs 16%, p = 0.03), a net male predominance: sex ratio of 1.7 vs 0.15, p = 0.01, significantly more antithyroid auto-antibody positive: 75% vs 87%, p = 0.03 both anti-TPO (75% vs 46.87%, p = 0.03) and anti-Tg (62.5% vs 40.6%, p = 0.04), Significantly more Hashimoto's thyroiditis at the origin of hypothyroidism: 75% vs 46.87%, p = 0.03 and a lower dose of prescribed levothyroxine: 106.25 μg / d Vs 125.7 μg / J, p = 0.04. Clinically, there were no significant differences between the two groups on the basis of the mean value of the Billewicz-Zulewski scale grouping the clinical signs of hypothyroidism and the relative frequencies of the different symptoms separately.

Discussion: Our results as well as those of the literature confirm the association between hypothyroidism and systemic vasculitis. This hypothyroidism may result either from specific thyroid involvement by angiitis (thyroid vasculitis) or most often from associated autoimmune thyroiditis. In favor of this association we retain a genetically predisposing terrain, a common autoimmune signature and arterial thyroid hypervascularization, making it a preferred target during systemic angiitis.
Impact of Maternal Overweight during Pregnancy – An Observational Retrospective Study in a Tertiary Maternity

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Background: Maternal overweight is an increasing problem that has an impact on pregnancy outcomes and medical complications that can accompany or appear during the gestation.

Objectives: Understand the impact of maternal obesity and weight excess on pregnancy outcomes and medical complications during pregnancy in a population of pregnant women.

Methods: We performed a retrospective observational study of pregnant women with a body mass index (BMI) ≥ 25 that were referred to nutritional counseling during 2015-2016 in a tertiary care center.

Results: 351 pregnant women were included, with an average age of 32.6 years old, 11.7% were above the age of 40 yrs. 47.6% were overweight (BMI≥ 25), 32.5% class 1 obesity, 12.3% class 2 and 7.7% class 3 obesity. There were 24 multifetal pregnancies. Gestational Diabetes had a prevalence of 30.4% and 11.2% were at increased risk of Diabetes after reclassification. However, 10.5% didn't undergo reclassification. 15.1% had chronic arterial hypertension and 11.1% had pregnancy-induced hypertension, with a total prevalence of preeclampsia of 3.7%, 12.5% of preterm birth, cesarean delivery in 37%. Interestingly, 20% of newborns were small for gestation age (P< 10) and 2% large for gestational age (P >90). There were 5 late miscarriages, 2 fetal deaths, 3 neonatal deaths, 5 chorioamnionitis and 3 postpartum haemorrhage needing transfusion support. 34.2% of the women were under prophylaxis with acetylsalicylic acid and 11.7% with enoxaparin.

Conclusions: It is important to access a close follow up of these women in order to control their comorbidities, prevent complications and therefore minimize maternal and neonatal morbility. Special programs are needed.
Impact of pre-surgical weight loss on weight evolution in short and medium terms after bariatric surgery

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Introduction: Bariatric surgery has revolutionized morbid obesity therapy for its proven efficacy in long-term sustained weight reduction. Adherence to the dietary plan and physical exercise nevertheless maintain a decisive role in the clinical approach of the obese patient.

Objectives: To analyze the impact of preoperative weight behavior on weight evolution in the short and medium terms after bariatric surgery.

Methods: We retrospectively analyzed a sample of 54 patients using electronic clinical process. We evaluated the existence of a correlation among the weight difference between first visit and the day of surgery and the weight evolution after the procedure (at the first, second and fifth years). Ensuring normal distribution criteria were met, correlation tests were performed using the Pearson correlation coefficient, for a 95% confidence interval.

Results: The mean age of the sample was 42.6±10.7 years (85.2% female). The mean weight at the time of surgery was 119.02±20.35 Kg, corresponding to an average body mass index of 45.18±5.66 Kg/m2. Of the 54 patients, 72.2% did a restrictive surgery (sleeve gastrectomy) and 27.8% underwent malabsorptive surgery (gastric bypass or duodenal switch). The analysis of the correlation coefficients shows that in the restrictive surgery group, there was a statistically significant positive correlation between the value of weight lost before surgery and the weight lost in the first year after surgery (r=0.525, p=0.001), which did not occur in the second year (r=0.334, p=0.055) nor the fifth year (r=0.145, p=0.384).

In the malabsorptive surgery group there was no statistically significant correlation at any time.

Conclusions: The weight loss verified between the first visit to a multidisciplinary Morbid Obesity Medicina Center (doctor, nurse, nutritionist) and the day of surgery, analyzed as a marker of adherence to non-pharmacological obesity therapy, does not seem to have an impact on the outcome of follow-up in the medium term.
Insulinoma and Multiple Myeloma - From Suspicion to Diagnosis

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Introduction: Insulinoma is an endocrine tumor of the pancreas which is originated in beta cells of Langerhans. It secretes insulin autonomously what causes hypoglycemia. It’s a rare entity with an incidence of 4/1,000,000 inhabitants per year. Multiple myeloma is characterized by monoclonal proliferation of plasma cells in the bone marrow with an incidence of 4/100,000 inhabitants per year.

Case description: A 69-year-old woman with a history of persistent hypoglycemia was brought to our emergency room with symptomatic hypoglycemia – at home with capillary glycemia of 16 mg/dL. She was hemodynamically stable upon arrival. The exams revealed acute renal injury (urea 182.4mg/dL creatinine 4.39mg/dL) with metabolic acidemia and macrocytic anemia. At hospitalization the patient maintained symptomatic hypoglycemia coinciding with high insulin levels (>70mU/L), always requiring perfusion of glucose serum. The renal ultrasound and upper abdominal CT showed no alterations. On the other hand pancreatic endoscopy showed a paracentimetric nodule in the body-tail transition of the pancreas whose histological examination allowed the diagnosis of insulinoma. Simultaneously medulogram and bone biopsy were performed to clarify anemia, renal dysfunction and electrophoretic proteinogram with monoclonal peak (31.6g/dL). These exams allowed the diagnosis of IgG/Kappa multiple myeloma and our patient started chemotherapy. Due to worsening of the renal function she was transferred to a central hospital for urgent dialysis and orientation for distal pancreatectomy. Currently the patient is being followed up by Hematology and Endocrinology. She’s clinically stable with chemotherapy and without new episodes of hypoglycemia.

Discussion: The clinical evaluation of a patient should be made systematically problem by problem in order to allow an overall clinical diagnosis that, as in the present case, corresponds to more than one nosological clinical entity with multidisciplinary approaches.
Primary hyperparathyroidism consists of a deregulated parathyroid hormone (PTH) production, which leads to an altered calcium homeostasis. It is a common endocrine disorder mostly detected in routine blood tests in the asymptomatic phase. However, presentation can be atypical and include a vast spectrum of clinical manifestations.

We describe the case of a 67-year old female patient, with known bipolar disorder, who presented with muscle weakness, asthenia, polydipsia, nausea, obstipation, anorexia with weight loss, mental confusion and behavioural changes. On blood testing she had severe hypercalcemia and high PTH levels; cervical ultrasound imaging showed changes compatible with parathyroid adenoma. The patient was treated with zoledronic acid followed by parathyroidectomy, with gradual resolution of the symptoms and blood test abnormalities.

The authors wish to discuss this case due to the atypical presentation of this pathology, associated with a varied symptomatology.
Lactic acidosis due to linezolid used in a diabetic foot

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Introduction: Linezolid is one of the antibiotics indicated in osteomyelitis occurring in patients with diabetic foot. It can be used for up to 6 weeks according to the published guidelines. Linezolid has many side effects; even though it is rare, metabolic acidosis is one of them.

Case description: We present the case of a 62 years old man, admitted to the internal medicine ward with osteomyelitis in a diabetic foot. Because of a Methicillin-Resistant Staphylococcus Aureus (MRSA) isolated from his foot, we initiated vancomycin associated with other antibiotics. The patient developed a cutaneous reaction to vancomycin so we changed it to linezolid. When he was completing 47 day of linezolid he developed dyspnea, signs of respiratory distress and abdominal pain; vital signs were well, including arterial pressure, oxygen saturation and heart rate. We performed some complementary diagnostic tests, including an arterial blood gas analysis that showed pH 7.32 and lactates 8.7 mmol/L. We excluded other causes of lactic acidosis including sepsis, hypovolemia, cardiac failure or diabetic ketoacidosis and assumed a lactic acidosis due to a prolonged treatment with linezolid. This antibiotic was substituted and the patient slowly recovered clinically and analytically.

Discussion: Lactic acidosis due to linezolid is a rare but dangerous adverse reaction. This antibiotic should only be used in prolonged therapy if there are no other options. In this case we had a patient with a MRSA isolated in an osteomyelitis that initiated vancomycin and developed a cutaneous adverse reaction, so we needed to use linezolid instead. It is important to do a careful follow-up of this patients being aware of this adverse reactions.
Metabolic Encephalopathy, It is Indapamide Fault

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Introduction: metabolic encephalopathy arises as a consequence of overall alteration of biochemical function of the brain. The aetiology can be very variable, with overlapping clinical manifestations, hence the relevance of the clinical history for orientation and adequate therapy.

Case description: authors describe the clinical case of a 71-year-old woman with history of dyslipidemia (medicated with simvastatin) admitted to hospital for metabolic encephalopathy. It was pointed out that ten days before she had been medicated with indapamide for arterial hypertension. Since then, she complaints of headache, nausea and vomiting, then she develop confusion and agitation and was referred to emergency department. Physical examination showed psychomotor agitation and inability to maintain attention. She had no focal motor deficits, but had a stiff neck, was dehydrated, anicteric and had fever (38.1°C). Analytically presented with severe hyponatremia (Na-110 mmol/L); elevation of myoglobin (3493ng/ml) and total CK (26200 U/L). Renal, hepatic, CBC, and C-reactive protein function were within normal range. She underwent CT and brain magnetic resonance imaging and lumbar puncture, which were normal. The etiological study excluded hypovitaminosis, viral and bacterial infection, hypo / hyperthyroidism, and autoimmune disease. Since admission, indapamide and simvastatin had been discontinued and with these measures she present resolution of symptoms.

Discussion: This clinical case highlights the importance of "tight" monitoring of patients receiving indapamide. A systematic review in 2015 showed that the time from the start of the thiazide diuretic to the presentation with hyponatraemia is short, suggesting that the practice of performing a single investigation of serum biochemistry 7-14 days after initiation of thiazide is insufficient. Also, patients have to be subjected to a battery of tests so that the diagnosis can be made.
Metabolic Syndrome and other comorbidities are associated with increased risk of hospitalization for acute hepatitis in patients with previous exposure to over-the-counter analgesics

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Background: Hepatic injury and subsequent hepatic failure due to non-intentional overdose of over-the-counter (OTC) analgesics has affected patients for decades. Epidemiological studies related to hospitalization due to the hepatotoxicity of OTC analgesics are increasing. We aimed to determine comorbidities associated with hospitalization related to acute hepatitis due to OTC analgesics.

Methods: We included eight hospitalized women (mean age 73.4±6.7 years) with a diagnosis of toxic hepatitis after we excluded viral and other causes of hepatobiliary diseases, i.e. autoimmune, alcohol, cholelithiasis. We defined toxic hepatitis as a 28-days exposure-to-drug window before onset of hepatotoxicity and a 90-days wash-out period for recovery of transaminases elevation. Data on gender, age, admission, discharge diagnoses, and prescription information were recorded.

Results: The most common comorbid diseases before admission were osteoporosis (88.9%), chronic kidney disease (CKD) (75%), anemia (87.5%), diabetes (50.0%), hypertension (62.5%), and hyperlipidemia (12.5%). Acute cholestatic liver damage was present in 66.7%, hepatocellular in 11.1%, and mixed in 11.1% of patients. There was a significant association between the presence of toxic hepatitis and hypertension (beta=0.395, p=0.003), diabetes (beta=0.316, p=0.001), hyperlipidemia (beta=0.125, p<0.001), metabolic syndrome (beta=0.250, p=0.001), hypothyroidism (beta=0.125, p<0.001), CKD (beta=0.189, p=0.005), and anemia (beta=0.125, p=0.025). We didn’t find any association with age, gender, obesity, hyperthyroidism, and osteoporosis.

Conclusion: Metabolic syndrome, and its components, thyroid diseases, renal failure, and anemia appear to increase the risk of hospitalization for acute hepatitis due to OTC analgesics. Our study was limited to the more severe cases resulting in hospitalization, which may result in underestimation of hepatotoxicity with milder manifestations.
Microvascular disease in poorly controlled diabetes mellitus with rapid glycemic control - a case of diabetic muscle infarction

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**Introduction:** Spontaneous diabetic muscle myonecrosis is a rare microangiopathic complication associated with poorly controlled diabetes mellitus. Rigorous glycemic control has become the standard approach to diabetes care but unintended consequences include the development of microvascular complications related to the rapidity of glycemic improvement.

**Case description:** We describe a case of a 40-year-old African male with a 5-year history of uncontrolled diabetes mellitus with multiple microvascular complications, having recently initiated insulin treatment with a rapid decline in glycosylated haemoglobin (HbA1c) concentration. The patient presented with a sudden onset of right thigh pain and swelling not associated with trauma. On admission he had a swollen right thigh, elevated creatine kinase of 1639 U/L and C reactive protein of 25mg/dL. A presumptive diagnosis of pyomyositis was made and the patient was treated with intravenous antibiotics with no improvement. Diabetic muscle infarction was then considered. Magnetic resonance imaging of the affected thigh revealed increased volume and heterogeneity of the adductor, vastus and sartorius muscles associated with perifascial and perimuscular edema and multiple areas of increased contrast caption compatible with muscle infarction. Muscle biopsy was obtained revealing inflammatory infiltrate and areas of skeletal muscle necrosis. These findings were confirmatory of the diagnosis of diabetic muscle infarction and supportive care was initiated with significant improvement.

**Discussion:** As with retinopathy and neuropathy deterioration that have been described as secondary to aggressive glycemic control we hypothesized that muscle myonecrosis was consequent to rapid HbA1c normalization. Intensive insulin treatment inducing a rapid HbA1c decline should prompt vigilance and caution, particularly in patients with long-term and uncontrolled diabetes, regarding the risk of microvascular disease complications.
Mortality in patients suffering from diabetes in two surgical units

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Goals:
To analyze the mortality rate (M) in patients with DM who undergo some medical decompensation during an admission to Orthopedic Surgery and Traumatology (OST) and Vascular Surgery (VS).

Material and methods:
Descriptive analysis of patients admitted to OST and VS who suffered some type of medical decompensation that needed to notify an team (T) of Internal Medicine and Cardiology. We analyze the patients with known DM and their M.

Results:
From June 2008 to December 2014, 1486 consultations were sent to T regarding patients admitted to the OST area who had undergone some type of medical decompensation during admission. Of these patients, 437 (29.4%) had a documented history of DM. Their M was 11.21% (49 patients), with the M of the decompensated 10.3%.

From February 2011 to December 2014, 173 consultations to T were carried out regarding patients admitted to the VS area who had suffered any medical decompensation during admission. Of these patients, 94 (49.1%) had a documented history of DM. Its M was 23.4% (22 patients), with the M of the decompensated patients being 16.76%.

Conclusions:
DM is a cause of medical decompensation in 8.3% of patients admitted to OST. One in four known diabetics had abnormal blood glucose levels. Patients with a history of DM, decompensated or not, present a slightly higher M than the global number of decompensated patients in this area.

DM is a single cause of medical decompensation in 4.6% of patients admitted to the VS. However, associated with decompensation of other vascular risk factors, one out of four known diabetics had abnormal blood glucose levels. Patients with a history of DM, decompensated or not, present a M that is much higher than the overall M of decompensated patients in this area.

We suggest that an early assessment of glycemia and strict monitoring of diabetic patients suffering from some medical decompensation could be beneficial in terms of morbidity and mortality.
Endocrine and metabolic disorders
A-2303

Multiple Sides of an Autoimmune Land: A Clinical Report

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Introduction: Polyglandular Autoimmune Syndromes (PAS) are characterized by the presence of autoimmune endocrine and non-endocrine disorders. PAS type 3 gathers autoimmune thyroiditis and other autoimmune disorders that should not affect the adrenal cortex. Early diagnosis is difficult because of the long latency of clinical signs and symptoms, but it’s crucial because it may prevent potentially fatal consequences.

Case Description: A 65-year-old woman presented in the internal medicine outpatient clinic with xerostomia, xerophthalmia, polyarthralgia, paresthesia of both hands, diarrhea, recurrent genital and oral ulcers. Previous medical history included autoimmune thyroiditis; pulmonary, renal, genital and lymph node tuberculosis. She had a positive Schirmer Test. Some laboratory tests were performed: Hb=13,7g/dL, TSH=1,95µUI/ml (0,38-5,33), FT4=9,8pmol/L (7,9-14,4), positive anti-thyroid peroxidase, anti-thyroglobulin and anti-gastric parietal cell antibodies, vitamin B12=151pg/mL (180-914). Gastric biopsies were also performed: chronic gastritis, body inflammation with mild atrophy and intestinal metaplasia without dysplasia in less than 5% of glandular component. From clinical and laboratorial findings we can assume PAS type 3.

The patient was given vitamin B12 supplementation and is currently on follow-up because of the 40-50% risk of new autoimmune disorders.

Discussion: Regarding this patient, autoimmunity shows multiple sides, being a rare association. A greater clinical suspicion is needed for an early diagnosis that will imply adequate treatment and follow-up and eventually a better prognosis.
Introduction
Myxedema coma is a medical emergency, in which its clinical course is dependent on diagnosis and early therapy. In the elderly patient, due to their clinical conditions and potential complications, this diagnosis may require a higher diagnostic suspicion and requires a complex approach.

Case description
A 95-year-old male, cognitively intact, admitted with a clinical course of adynamia, psycho-motor lentification with a progressive decreased of muscle strength with a month of evolution. At admission, the patient was arreactive, hypothermic (T 33°C), hypotensive (BP 48/36 mmHg) with generalized edema. Acidemia (pH 7.13) and sinus bradycardia (heart rate 37 bpm) were detected and a chest X-ray showed bilateral pleural effusion. It was started heating measures and fluidotherapy. Hypothyroidism (TSH: 7.05 μUI / ml, FT4: <0.64 ng / dL) was noted in the study, and immediately initiated levothyroxine. The immunological study was negative, thyroid ultrasonography revealed an enlarged gland and echocardiogram showed a slight pericardial effusion. In the first 2 weeks, despite hemodynamic recovery as well as renal function, he maintained confusional state and time and space disorientation, with full recovery of cognitive functions at third week.

Discussion
This case illustrates the more serious spectrum of hypothyroidism with multi-organic failure, highlighting the central role of the rapid diagnosis, clinical and therapeutic approach with impact on the prognosis. It emphasizes the importance of the recognition of the reversible causes of coma, regardless the age of the patient.
INTRODUCTION

Myxedema coma is a rare and serious complication in the hypothyroid patient, predominantly in older women, triggering by multiple causes.

CASE DESCRIPTION

A 85-year-old woman with a history of arterial hypertension, atrial fibrillation, heart failure and hypothyroidism secondary to thyroidectomy. Last admission in traumatology due to hip fracture after accidental fall; during the postoperative period the patient suffered NSTE-ACS. At discharge, levofloxacin was prescribed for bronchitis.

One month later, she went to the Emergency Department due to deterioration of general condition, hyporexia and nonspecific abdominal pain with constipation. Fluid and corticosteroids therapy was initiated due to hypotension and suspicious of adrenal insufficiency.

During her admission she had rapidly progressive with maintained hypotension and decreased level of consciousness. In analytics, TSH was 29.03 mIU per liter (0.5 - 4.5 mIU per liter) and free T4 thyroxine (FT4) was 0.4 ng per deciliter (0.6 - 1.4 ng per deciliter). Her daughter reported that the caregiver had given levofloxacin instead of levothyroxine (L-thyroxine) by mistake.

She presented refractory shock to volume expansion that required dopamine perfusion, which was discontinued because of angina. After ruling out main causes of shock (cultures, ecocardioscopy, thoracoabdominal and cranial scanner, etc.), intravenous FT4 was started with progressive improvement in the following 24 hours. Ensuing treatment of multiple ion alterations, she was discharged home.

DISCUSSION

Myxedema coma is a life-threatening condition, where mechanisms to maintain homeostasis fail. It is important to suspect it in hypothyroid patients with shock of unknown cause. Treatment requires corticosteroids and FT4 (even triiodothyronine) intravenous.
Endocrine and metabolic disorders
A-1880

Myxedema coma: treatment and support measures

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Introduction
Myxedema coma is a medical emergency. It has a mortality of 30-40%. The diagnosis is based on the clinic, and you should not wait for the hormonal results to start the treatment.

Description of the case
75 year old woman Dyslipidemia in treatment. Breast cancer operated on 20 years ago with mastectomy. Her family reports that it has been slowly progressive deterioration for months, more evident in the last two weeks. The morning before going to the emergency, the patient can not get out of bed. Upon reaching the hospital, severe hypotension, bradycardia and deterioration of the level of consciousness were observed. In the first analysis we see a hyponatremia of 126mg / dl, pCO2 89 mmHg. Increase GOT, GPT, CPK and LDH In hemogram, leukopenia and lymphopenia. TSH 55 mg / dl.
Intensive care is advised to assess the patient.
On arrival at the ICU, NIMV is started, requiring IOT with minimal sedation. The patient recovers ions and renal function in 48 hours.
From the first 24 hours, treatment with IV levothyroxine with hydrocortisone at high doses and subsequently T3 by nasogastric tube is established. In 5 days the patient has recovered neurologically completely. It remains with IOT connected to mechanical ventilation with surgical tracheotomy. Difficult withdrawal of ventilatory support.

Conclusion
Administer T4, T3 and hydrocortisone (with initial loading dose). Transfer to the oral route when the clinical condition allows it and hydrocortisone withdraw when associated adrenal insufficiency is ruled out. The support measures are fundamental, especially in the first hours since they mark the patient's prognosis.
Myxedematous coma: a clinical case nowadays rarely found outside textbooks

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INTRODUCTION
Myxedematous coma is a rare life-threatening condition, caused by a long-standing severe hypothyroidism. The clinical features must raise suspicion, which should be rapidly confirmed, and direct treatment initiated immediately.

CASE DESCRIPTION
72-year-old woman, with no regular medical follow-up or any prescribed medication, presented to the emergency department with general discomfort and altered level of consciousness. She was lethargic, with hypothermia, hypotension, bradycardia, bradypnea, respiratory acidosis, in anasarca, and with classical semiology of hypothyroidism: thinning of the eyebrows, alopecia, lips, facial and periorbital edema, cutaneous xerosis, macroglossia, hoarseness, obesity. Hypothyroidism was confirmed, and treatment with intravenous levothyroxine, corticosteroids and vasopressors were initiated immediately.

She was transferred to ICU, where she stayed for 10 days. Treatment with levothyroxine and corticosteroids was upheld during all inpatient stay. Initially she needed external heating, diuretic infusion, vasopressors for 5 days, and noninvasive ventilation for 7 days. The patient progressively got better, with clinical stability, although she maintained fluctuation of consciousness, and thus she was transferred to Internal Medicine ward, at 11th day of inpatient stay. There, she maintained the same state of consciousness and difficult control of thyroid function. Afterward she developed type II respiratory failure, needing to restart noninvasive ventilation.

At 17th day, she was found on cardiorespiratory arrest, which was not reverted with advanced life support.

DISCUSSION
Diagnosis and treatment of hypothyroidism in its mild stages can successfully avoid the progression to this severe and nowadays rare condition. Even though immediately suspected and rapidly confirmed, along with replacement and supportive treatment, it ended up with a fatal outcome, corroborating the high rates of morbimortality of this entity.
Neck Circumference: More an efficient tool for metabolic syndrome in hypertension patients

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Introduction: Some studies suggest the potential use of neck circumference (CP) as an anthropometric measure to estimate cardiometabolic risk and its independent association with insulin resistance and diabetes.

Objective: To verify if the circumference of the neck is an anthropometric measure capable of tracking and confirming the cardiometabolic risk related to the diagnosis of metabolic syndrome.

Methodology: The data collection was performed on the days of hypertension league service in the period of 7 months from January 2017 to July 2017, with the participation of 60 patients, both sexes with a mean age of 62.6 +/- 11.7 years, enrolled in the hypertension league with mean time of hypertension of 15.8 +/- 8.8 years. The data were cataloged and analyzed in a graphpad statistical program using the Shapiro-Wilk tests, unpaired t test, Mann-Whitney test (p <0.05) and the Pearson and Spearman correlations.

Results: The mean values of body mass index (BMI) for men (25.2 +/- 3.56) and women (27.3 +/- 4.7), neck circumference (CP) for men (37.1 +/- 3 cm) and women (33.1 +/- 2.49 cm) and waist circumference (WC) for men (95.3 +/- 0.69 cm) and women (91.3 +/- 9.61 cm), were above the values recommended mainly for individuals with arterial hypertension. When we analyzed the circumference of the neck, it was found that in women the neck circumference was higher in those with MS (32 +/- 2.8 cm 33.8 +/- 2.5cm p = 0.02). It was also verified (r = 0.46 p = 0.001 for females) and (r = 0.67 p = 0.04 for males) and with the index of body mass (0.73 p = 0.02 for females) and (r = 0.40 p = 0.01 for males), In women the neck circumference showed high area under the curve in the ROC analysis (0.688 confidence interval 0.526 to 0.850 p = 0.03)

Conclusion: Neck circumference has been shown in this group of patients to be an anthropometric marker useful in ratifying the metabolic syndrome and may possibly be used as another tool to screen this condition in similar populations.
Nutritional status of patients admitted to an Internal Medicine department: comparison between diabetic and non-diabetic patients

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Objectives:
The aim of this study was to analyze and compare the nutritional status and clinical evolution of diabetic and non-diabetic patients admitted to an Internal Medicine department.

Methods:
A prospective cross-sectional study was carried out through the analysis of clinical, anthropometric and laboratory data of patients hospitalized in an Internal Medicine department. Only patients who signed informed consent were included. Statistical analysis was performed using Excel V16.9 and BM SPSS V23.0.

Results:
Sample of 95 patients, divided into diabetics (group 1) and non-diabetics (group 2). Group 1 included 32 patients (62.5% women, mean age 84.3 years) with mean BMI of 21.2 kg/m² and group 2 63 patients (58.7% men, mean age 78.3 years) with an average BMI of 22.5 kg/m². Group 1 had a higher number of comorbidities (Charlson index 3.41 vs 2.38), as well as higher modified Katz index (3.9 vs 3.4) and also higher proportion of malnourished patients (40.6% vs. 33.3%). Mortality rate was significantly lower in group 1 (3.1% vs 15.9%).

Conclusion:
Authors conclude that diabetic patients are older, have higher number of comorbidities, are more dependent among daily activities and have higher incidence on malnutrition. However, mortality rate was lower in comparison with non-diabetic patients. This may be explained by the close monitoring and follow up protocols instituted in our diabetic population.
Objectives
Previous studies have suggested an obesity survival paradox in patients with peripheral artery disease (PAD). We investigated the influence of obesity and underweight on adverse in-hospital outcomes in PAD.

Methods
Patients diagnosed with PAD based on ICD-code I70.2 of the German nationwide database were stratified for obesity, underweight and a reference group with normal-weight/over-weight and compared regarding adverse in-hospital outcomes.

Results
Between 01/2005-12/2015, 5,611,484 inpatients (64.8% males) were diagnosed with PAD; of those, 8.9% were coded with obesity and 0.3% with underweight.

Obese patients were younger (70 (IQR 63/76) vs. 73 (66/80) years, P<0.001), more frequently female (36.7% vs. 35.1%, P<0.001), had less often cancer (4.9% vs. 7.9%, P<0.001) and were less often treated by major amputation (2.6% vs. 3.2%, P<0.001) compared to the reference group.

Overall, 277,876 (5.0%) patients died in-hospital. Obese patients showed lower mortality (3.2% vs. 5.1%, P<0.001) compared to the reference group and reduced risk of in-hospital mortality (OR, 0.617 [0.607-0.627], P<0.001). This “obesity paradox” was demonstrated in obesity classes I (OR, 0.475 [0.461-0.490], P<0.001), II (OR, 0.580 [0.557-0.605], P<0.001), and III (OR, 0.895 [0.857-0.934], P<0.001) and was independent of age, gender and comorbidities.

Underweight patients revealed higher in-hospital mortality (6.0% vs. 5.1%, P<0.001) compared to the reference group (OR, 1.179 [1.106-1.257], P<0.001) and showed higher prevalence of cancer (22.0% vs. 7.9%, P<0.001).

Conclusions
Obesity is associated with lower in-hospital mortality in PAD patients relative to those with normal-weight/over-weight. This obesity survival paradox was independent of age, gender and comorbidities and observed for all obesity classes.
Introduction
Pheochromocytomas are tumors that secrete catecholamines. They usually appear between 40 and 50 years and most are expected. The characteristic symptoms are headache, tachycardia, sweating. The diagnosis depends on the level of suspicion and is based on the measurement of metanephrines in urine and/or plasma with subsequent confirmation with imaging test.

Description of the case
44 year old man Smoker habitual. Hypertension since 2013, with hypertensive crisis, headache and palpitations with sweating. Type 2 diabetes mellitus treated with insulin since 2013.
He goes to the emergency room for abdominal pain and vomiting, very affected by pain but stable HD. In analytical FRA (Cr 2.1), elevation troponins and CPK (3.22 and 327) were observed. Abdominal ultrasound revealed a solid right adrenal lesion confirmed by abdominal CT, an image suggestive of hematoma. The patient begins with hypotension and is admitted to intensive care.
Due to the suspicion of pheochromocytoma due to radiological and clinical images of the patient, metanephrines are requested in 24-hour urine and in plasma, which appear elevated.
He is in charge of internal medicine, performing a CT scan of the abdomen, with adrenal mass image without specific pheochromocytoma characteristics. Gammagraphy was performed with MIBG with I-123, and the mass was suggestive of pheochromocytoma.
Treatment is started with alpha and beta-blockers. At discharge the patient is maintained with stable TA and HR pending intervention that is scheduled by Urology two months later to stabilize the possible associated hematoma.

Conclusion
Clinical suspicion is fundamental due to the variability of symptoms. They should consider in some cases the genetic study. Alpha-adrenergic blockade should be performed 10-14 days before surgery (phenoxybenzamine) with beta-adrenergic blockade 2-3 days before surgery (propranolol). Calcium antagonists and methyrosine may be included.
Poor compliance with diabetes follow up in the primary care setting

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Objectives: Despite global WHO campaigning, there is still no uniform approach regarding disease screening, early diagnosis or preventive measures. The BIRO / EUBIROD project and NICE have proposed standardized documentation and follow up protocols. The aim of this study was to determine the degree of compliance with diabetes management protocols in the community.

Materials and methods: The study consisted of home visits during a 3-month period (October-December 2017) in a combination of urban and rural settlements representative of the general population. The study was approved by the institutional and the national bioethics committee, the Personal Data Protection Commissioner and the Ministry of Health Research Committee prior to its application.

Results: Total participation rate was 80%, with a mean duration of each session of 7.8 minutes (standard deviation 1.2). Final results indicated 183 individuals with diagnosed diabetes out of 2100 interviewed. Thus total prevalence of diabetes was 235/2100 (11.2%) of which 52/235 cases (22.1%) were undiagnosed prior to the study. Of the known diabetic patients, less than half had achieved the goal for glucosylated hemoglobin level (6-7%), whereas only 70% had had a renal function assessment over the last year. In the case of diabetic foot / podiatric assessment, professional nutritionist consultation and annual fundoscopy all rates were extremely lower than the recommended goal.

Conclusion: Despite increased diabetes awareness, early detection of complications is hindered by the poor application of existing algorithms and the poor compliance to screening recommendations.
Prevalence and risk factors for peripheral neuropathic pain in patients with newly diagnosed dyslipidemia

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Objectives: Dyslipidemia is a major permissive-factor for the development of peripheral-neuropathy. Evidence suggest that other factors are involved in its pathogenesis and clinical-phenotype. Prevalence and risk-factors for peripheral-neuropathic-pain (PNP) in patients with newly-diagnosed-dyslipidemia are not known.

Methods: We included 85 subjects (44 women/41 men, 60.6±10.3 years), without diabetes/known macrovascular-disease. Diagnosis of dyslipidemia was 1 month. The Hellenic/Score (HS) was used for the evaluation of cardiovascular-disease-risk. The Dutch/Lipid/Clinic/Network criteria were used for the assessment of familial-hypercholesterolemia. Assessment of PNP included evaluation of somatic-neuropathy using the Neuropathic/Symptom/Score (NSS). Severity of PNP was quantified by the Neuropathy/Disability/Score (NDS).

Results: Prevalence of PNP was 40.0% (34 patients). Multivariate-logistic-regression-analysis, demonstrated that the odds of PNP increased with height [4.04 (1.63-6.56), p=0.003], depression [2.91 (1.55-6.72), p=0.009], ankle-brachial-pressure-index (ABPI) [1.55 (2.91-6.72), p=0.001], total-cholesterol [1.06 (1.02-1.11), p=0.002], LDL-cholesterol [1.04 (1.00-1.08), p=0.02], and antiplatelet-medication (no) [1.01 (1.00-1.79), p=0.04]. These variables explained 67% of PNP. Patients with increased HS exhibited increased prevalence of PNP (p=0.005). In addition, multivariate-linear-regression-analysis demonstrated that increased NDS was significantly and independently associated with total-cholesterol (beta=0.40, p<0.001), LDL-cholesterol (beta=0.26, p=0.002), and smoking (beta=0.19, p=0.04).

Conclusion: PNP is common at the time of diagnosis of dyslipidemia, and is associated with somatometric-parameters, smoking, ABPI, increased total-cholesterol, LDL-cholesterol, and depression. These risk-factors are also associated with the severity of PNP. Increased cardiovascular-disease risk was associated with increased prevalence of PNP in the studied subjects.
prevalence of diabetes in a random day of internal medicine service

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Objective: To characterize patients with diabetes at an Internal Medicine service at a central hospital on a random day in 2014 (January 6, 2014). Method: Cross-sectional study based on consultation of the clinical files of patients hospitalized at the Medical Service Internal.

Results: 61 patients were hospitalized and 23 patients with Diabetes mellitus (36.00%) were enrolled, all being type 2, 60.87% were female, and 39.13% were female male, with a mean age of 80.49 years, residing mainly at home (78.26%). The main cause of hospitalization was, according to ICD 10, respiratory diseases (52.17%), being 50% community-acquired pneumonia and 50% pneumonia associated with health care. Regarding the type of anti-diabetic therapy at home, the majority of them performed insulin (55%), followed by biguanides (45%), IDPP4 (27%), sulfanilureas (23%), and arcabose (5%). Within insulins, most used biphasic action analogues (33%). Regarding HbA1, 30.43% presented values between 7-9%. With regard to comorbidities and vascular complications, the majority presented macrovascular complications (30.43%), being most peripheral arterial disease. Regarding the insulin regimen to be performed at admission, the majority of patients presented a rapid isopic insulin regimen (56.52%).

Conclusion: It is concluded that a significant percentage of patients presented Diabetes mellitus, this result is not surprising given the prevalence of this pathology in our population. Regarding the HbA1c values, these present a satisfactory value, consistent with the glycemic targets that are expected for an elderly population with multiple pathologies of long duration and with multiple complications. Regarding the anti-diabetic therapy performed prior to hospitalization, it is with satisfaction that most have been insulinized. At admission, most patients have fixed insulin regimens as opposed to sliding scale regimens.
Primary Adrenal Insufficiency Due to a Hypercoagulable State

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Introduction
We present a case when a man with Eosinophilic granulomatosis with polyangiitis (EGPA) presents with bilateral adrenal hemorrhages, presumably secondary to a hypercoagulable state leading ultimately to AI.

Case Description
Patient is a 59-year-old male with a past medical history of EGPA, cellulitis, and colon resection for polyps who presented to the emergency department with dyspnea. A month prior to this admission the patient had presented with abdominal pain after two weeks of failed outpatient cellulitis treatment with antibiotics. An abdominal CT at that time showed bilateral adrenal masses. During this admission his CBC revealed 47% eosinophils and chest x-ray showed pulmonary infiltrates. A CT scan of the chest revealed a pulmonary embolism with infarctions noted. Incidentally noted on the scan were bilateral 3-4 centimeter adrenal gland masses that were seen on the abdominal CT the previous admission. During the hospital course his “cellulitis” was biopsied and revealed eosinophilic angitis with granulomas. The patient was treated with steroids. The patient’s pulmonary embolism was treated with anticoagulation. Over the course of next few months the patient’s steroids were decremented and symptoms of fatigue began to insidiously occur. The fatigue only improved when he was started on high dosing of hydrocortisone. We performed a three day cosyntropin test (CST). We found the cortisol and aldosterone to remain decreased, confirming our diagnosis of primary AI. The patient had been admitted again at a later date for shortness of breath, and a CT chest showed resolution of the bilateral adrenal masses. Presumptively the hypercoagulable state and subsequent adrenal infarctions was due to the inflammatory response from his eosinophilic vasculitis.

Conclusion
This highlights the importance of proper evaluation of AI in someone with a hypercoagulable state and the use of formal CST to evaluate the etiology of fatigue.
Pseudomyxoma peritonei a rare cause of ascites

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Pseudomyxoma peritonei is rare tumor that presents insidious evolution and is characterized by mucinous ascites or implants in the peritoneal cavity. The origin of this tumor is frequently the appendix or the ovaries. It has an indolent course but may recur over months to years. Annual incidence is estimated at 1/1,000,000 with female predominance.

The authors report a case of a 91 years-old woman with intermittent diarrhea, loss of appetite and increase of the abdominal volume during the last three months. The clinical and imagological evaluation revealed ascites.

Ascitic fluid was gelatinous, cytological examinations was positive to neoplastic cells but with immunohistochemical inconclusive. The risk of Ovarian Malignancy Algorithm (ROMA) was 67.5% and therefore at high risk for ovarian tumor. Exploratory laparotomy for definite diagnosis would have been necessary but the patient didn’t present clinical condition for surgery and after multidisciplinary discussion a conservative treatment was the option. With this case we show a rare cause of ascites and that the diagnosis of pseudomyxoma peritonei is difficult because laboratory and radiology results are frequently nondiagnostic.
Relationship among body mass index, bone mineral density and vitamin D levels in postmenopausal women

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Obesity has been considered beneficial for bone health because of the positive biomechanical effect of weight on bone formation. However recent studies suggest that higher levels of fat mass may be risk factors for osteoporosis and fragility fractures. Similarities between obesity and osteoporosis have been identified suggesting a common pathophysiological pathway that supports the hypothesis that osteoporosis can be considered as bone tissue obesity.

Objectives
Analyze relationship among BMI, vitamin D levels and bone mineral density (BMD) in patients with postmenopausal osteoporosis.

Methods
Cross-sectional retrospective study, including postmenopausal patients with osteoporosis. Age, weight, height, BMI, BMD, T-score in the femoral neck (CF) and in the lumbar spine (CL) were collected. Pearson's coefficient of correlation were used.

Results
164 postmenopausal women [mean age 67.5 years [47-92] were included. The mean BMI was 25.2 [17.7-41.3], 2.44% BMI < 18.5, 50% between 18.5 and 24.9, 37.8% between 25-29.9 and 9.7% > 30. The average Vitamin D levels were 22.91 [4-71]. The mean BMD in CF was 0.61 [0.35 and 1.01] and T-score CF -2.6 [0] and -5.2. In CL the mean BMD was 0.81 [0.019 and 1.39] and T-score -2.41 SD [0 and -5.3]. The correlation coefficients between BMI and BMD were in CF +0.27 and in CL of +0.18; between IMC and vitamin D was -0.12. In the analysis by BMI subgroups, the correlation between BMD and BMI was -0.44, 0.11, 0.10, 0.42, while the BMD BM was -0.68, 0.08, 0.01, 0.39 respectively.

Conclusions
The results of the study show a weak positive correlation between BMI and BMD. In the analysis by subgroups of BMI, it is observed that association between BMD and BMI is higher in extreme values of BMI, being negative in lower values and positive in the higher ones. In terms of BMI and vitamin D it is observed that they are inversely related, as previously described in other studies. Data suggest that extreme BMI values have an impact on BMD and bone metabolism.
Endocrine and metabolic disorders
A-1961

Respiratory failure and hyponatremia - obscure but real relation?

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Introduction: Hyponatremia (hNa) is typically observed in the final stages of chronic obstructive pulmonary disease (COPD). In hospitalized patients, hNa is commonly caused by syndrome of inappropriate antidiuretic hormone secretion (SIADH), raising to 30% incidence. There are several causes for SIADH, most due to malignancy, mainly small-cell lung carcinoma.

Case description: A 58-year old male presented to the emergency department with symptoms of confusion, unsteadiness, headaches and worsening of usual dyspnea, with no history of fluid loss. He had a previous history of 30-pack year smoking, COPD and respiratory failure, already under oxygen therapy and non-invasive ventilation, solely medicated with 4-daily nebulized ipratropium bromide and salbutamol. He had polypnea, tachycardia and very low periphery oxygen saturation. Further physical examination was unremarkable. Laboratory results revealed hNa of 122mmol/L, low serum osmolality, blood urea nitrogen and serum uric acid concentration, normal serum creatinine, acid-base and potassium balance. Common causes of hNa were excluded, such as medication, pain, respiratory infection, hypothyroidism, adrenal insufficiency and HIV infection. The urinalysis revealed elevation of osmolality and sodium concentration. A head-thorax-abdomen computed tomography showed no sign of malignancy or central nervous system disease. Therefore, the working diagnosis was SIADH, possibly secondary to respiratory failure or idiopathic. He was placed on fluid restriction and furosemide, which serum sodium normalization in 8 days.

Discussion: although already described, the mechanism of SIADH in respiratory failure is still unclear. It probably shares features with other pulmonary diseases that can cause hNa such as asthma, cystic fibrosis, pneumonia and COPD. Nevertheless, in a COPD patient, hNa should get proper attention and SIADH etiology, including malignant causes, such as lung carcinoma, should be investigated.
Safety and efficacy of insulin degludec in patients with Type 1 Diabetes Mellitus after one year of treatment.

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Background: Insulin degludec is a long-acting basal insulin analogue, with a duration of action up to 42 hours. The aim of the study was the evaluation of the safety and efficacy of insulin degludec in patients with Type 1 Diabetes Mellitus (T1DM).

Methods: We studied 31 patients with T1DM (61.3% males, mean age 45.5±17.6 years), who were switched to insulin degludec, after at least 2 years of treatment with another basal insulin. Patients were followed up for 1 year after switching to insulin degludec.

Results: Patients were previously treated with insulin glargine (77.4%) or detemir (22.6%). During the 24 months prior to the switch to insulin degludec, 29 patients (93.5%) experienced at least 1 non-severe hypoglycemic episode (mean 12.7±3.7 episodes, among which 4.6±1.9 during the night). During the 12 months after the switch to insulin degludec, 4 patients (12.9%) experienced a non-severe hypoglycemic episode (1, 2, 1 and 3 episodes respectively, among which none occurred during the night). At the time of switch to insulin degludec, HbA1C and plasma glucose levels were 7.0±0.6% and 130±15 mg/dl respectively (p<0.001 for both comparisons). During treatment with insulin degludec, there was no change observed regarding body weight, dose of insulin degludec in comparison with the previously administered insulin and prandial insulin.

Conclusion: In patients with T1DM, the switch from other basal insulins to insulin degludec reduces the risk of hypoglycemia and improves glycemic control, along with no body weight gain and without a need of increasing insulin doses.
State of plasma coagulation in patients with hypertensive disease in combination with obesity and non-alcoholic fatty liver disease

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Significant contributions to the mortality rate in patients with non-alcoholic fatty liver disease (NAFLD) have risk factors such as obesity, high blood pressure, hyperglycemia, and hypercholesterolemia. The most common causes of death in this patient cohort are myocardial infarction and ischemic stroke, as a result of thrombogenic changes in blood.

Objective: To improve the early diagnosis of thrombophilic blood changes in patients with hypertension (HT) and NAFLD by determining the state of plasma hemostasis.

Methods: 74 patients were studied (41 men and 33 women). The average patient age was 58.7 ± 4.1 years. Patients were divided into three groups: I - 30 patients with hypertension and without NAFLD, II - 26 hypertensive patients with NAFLD, III group – 12 patients with NAFLD without HT. The control group consisted of 15 healthy subjects matched for age and sex. State of plasma hemostasis was evaluated coagulation tests based on highly specific snake poisons to achieve the goal.

Results: In the performing of a lebetox test, which reflects the process of blood coagulation activation by the external pathway, the time of clot formation in patients with HT significantly decreased by 21% (p<0.001), and prolonged time in the NAFLD group by 37% (p<0.05) and the NAFLD+HT group by 58% (p<0.05). According to the ancistronic test, the shortening time of thrombus formation in the NAFLD group was detected by 13% (p<0.05) and by 16% (p<0.01) in the NAFLD+HT group compared to control group. The HT group according to the ancistronic test did not differ from the control group.

Conclusion: The activation of the external pathway of blood coagulation is faster in patients with HT, but in the case of joining NAFLD, and in patients with isolated NAFLD, this process is significantly slowed down. Considering that factor X is formed in the liver, it may be possible that the presence of NAFLD violates the synthesis of this factor.
Subclinical hypothyroidism and hyperinsulinemia in a patient with a metabolic syndrome

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Introduction: The metabolic syndrome is a cluster of at least three of the following five conditions: high blood pressure > 130/85 mmHg or already existing therapy, fasting glicemia > 6.1 mmol / L or already existing therapy, serum triglycerides > 1.7 mmol / l, serum HDL<1 mmol / l (men) / < 1.3 mmol / l (women) and waist circumference > 102 in men /> 88 cm in women. Thyroid dysfunction, particularly subclinical hypothyroidism, is common among patients with metabolic syndrome, associated with certain of its components (waist circumference and HDL cholesterol) due to related underlying mechanism of insulin resistance (altered insulin secretion and lipid levels)

Case Report: Female patient, 60 years old calls for consultations due to unregulated values of arterial tension (TA). At the examination TA 160/100 mmHg, ECG without signs of acute heart failure, normal auscultatory finding. Physical finding: height 168 cm, body weight 97 kg, BMI 34.4 (obesitas). Waist circumference 93 cm. On the neck acanthosis nigricans. Laboratory analyzes: TC 6.0 mmol/l, LDL 4.1 mmol/l, HDL 1.0 mmol/l, TG 2.2 mmol/l, TSH 10.4 mU/l, fT4 13.4 pmol/l, ATPO < 10, insulinemia 30.1. Started treatment with Tabl. Levothyroxine 50 mcg 1 x 1 and Tabl. Metformin 500 mg 2x1. Prescribed antihypertensive therapy and hygiene-dietary regime

Discussion: Follow-up after 2 months: TA 135/85 mmHg. BW 92 kg. TSH 5.0, insulinemia 18. There is a significant association between metabolic syndrome and hypothyroidism. It is advisable a routine examination of thyroid status and insulinemia in patients diagnosed with metabolic syndrome.
The complex diagnosis of AL amyloidosis following a splenic rupture

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Introduction:
Spontaneous splenic rupture is rare and possibly life-threatening with multiple etiologies including neoplastic, infectious or inflammatory disorders. Only 3.8% are caused by amyloidotic disorders.

Case description:
We present the case of a 58-year-old man, with irrelevant medical history, that presented to the emergency department with a 1-day-long abdominal pain. He had a hemorrhagic shock due to a spontaneous splenic rupture, revealed in an abdominal CT scan. The CT scan also showed a hepatomegaly. On admission, his blood analysis showed a coagulopathy and elevation cholestastic enzymes. He was submitted to a total splenectomy. The persistence of coagulopathy with a hepatomegaly motivated an internal medicine evaluation for liver disease. The initial workup did not reveal the etiology of the hepatic involvement. On a broader investigation a urinalysis revealed proteinuria. The subsequent exams unveiled a nephrotic syndrome with a splenic thrombosis causing its rupture. The association of liver disease and nephrotic syndrome raised the suspicion of an amyloidosis. The spleen histology was revised but was negative for amyloidosis. An abdominal fat biopsy also revealed negative for amyloidosis. The coagulopathy led to the choice of a transjugular liver biopsy over a kidney biopsy, and this confirmed the diagnosis of amyloidosis. With the following study, the final diagnosis was a primary AL (kappa) amyloidosis with hematologic, coagulopathic, renal, hepatic, soft tissue and thyroid involvement.

Discussion:
Amyloidosis is characterized by the deposition of proteins in a beta-pleated sheet structure that lead to organ dysfunction. In AL amyloidosis there is a deposition of monoclonal immunoglobulin light chains. The clinical presentation differs depending on the affected organs and thus the diagnosis is usually difficult. The prognosis varies, according to the severity of organ involvement, mainly the heart. An early diagnosis is crucial.
The effect of combined hypolipidemic therapy at lipoprotein (a) and lipoprotein-associated phospholipase A2 levels in diabetes mellitus type 2

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The aim of study estimate the effect of combined lipid-lowering therapy at lipoprotein (a) (Lp(a)) and lipoprotein-associated phospholipase A2 (Lp-PLA2) at patients with type 2 diabetes.

Methods:
In study was 68 patients with type 2 diabetes without lipid-lowering therapy randomized on three comparable groups. The patients of the first group (18) received the simvastatin (40 mg daily), 26 persons of the second group received the combined lipid-lowering therapy with simvastatin (40 mg daily) and ezetimibe (10 mg daily). In 24 patients of third group lipid-lowering therapy was not performed due to refusal of patients. The lipid panel, level of Lp(a) and Lp-PLA2 was determined.

Results:
It was marked the decrease in level of the total cholesterol, LDL-cholesterol, triglycerides, atherogenic index and insignificant increase in level of high density lipoproteins cholesterol. The marked decrease of low density lipoproteins cholesterol from 4.42±0.27 to 3.01±0.23 mmol/l at combined therapy in compare with from 3.58±0.29 to 3.14±0.16 mmol/l on statin only was determined. The level of triglycerides decreased by 15.4% at simvastatin therapy in compare with 30.6% on combined therapy. Lp(a) increased from 22.27±2.96 to 24.31±2.34 mg/dl in the patients without hypolipidemic therapy. In patients with simvastatin only Lp(a) decreased from 22.69±2.08 to 17.37±1.81 mg/dl as well as in the group with combined therapy (22.38±2.07 to 17.10±1.83 mg/dl). The level of Lp-PLA2 was not changed in control group without hypolipidemic therapy and decreased from 148.53±10.76 to 135.66±9.74 ng/ml at patients treated with simvastatin as well as in case of the combined therapy (from 141.23±10.38 to 120.78±9.29 ng/ml). All reported changes was statistically significant (p<0.001).

Conclusion:
Mono and combined lipid-lowering therapy in addition to hypolipidemic effect decreased the level of new risk faktorslipoprotein (a) and lipoprotein-associated phospholipase A2 in patients with type 2 diabetes.
The efficacy of the sequential treatment for Helicobacter Pylori eradication in patients with type 2 diabetes mellitus

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Objectives: Assessment of the efficacy and safety of sequential therapy for HP eradication as a first-line therapy.

Methods: This retrospective study was performed on 88 patients with HP infection. The A group was consist of 39 patients with type 2 diabetes mellitus (DM) and B group contained 49 nondiabetic patients. The first-line therapy for HP eradication was: conventional triple therapy (10 days of pantoprazole, 2x20 mg/day, amoxicillin 2x1000 mg/day and clarithromycin 2x500 mg/day) in 57 cases and sequential therapy (5 days of pantoprazole and amoxicillin followed by 5 days of pantoprazole, clarithromycin and metronidazole) in 31 cases. We monitored glycosylated hemoglobin (HbA1c) values and BMI during the treatment and one year after HP eradication.

Results: The therapeutic option for the sequential treatment for HP eradication was present in both groups: 18 cases (46.16%) in patients with type 2 DM and 25 cases (51.02%) in nondiabetic patients. The eradication rate was lower in patients with type 2 DM (76.93%) comparative with nondiabetic patients (91.84%). In patients with type 2 DM the sequential therapy was more effective than conventional triple therapy: eradication rate was 83.34%, (15 cases) after sequential therapy and 71.43% after standard therapy. In nondiabetic patients the HP eradication rate was similar in both treatments: 91.6% in standard treatment versus 92.1% in sequential therapy. The monitoring of BMI show a significantly increased of mean value of BMI in diabetic patients at 6 months (22.8+3.2 kg/sqm versus 21.3+2.9 kg/sqm at baseline) and 12 months (23.9+3.8 kg/sqm) after HP eradication. The incidences of adverse effects was reduced in both groups: abdominal pain (5 cases), nausea and/or vomiting (6 cases), diarrhea (3 cases).

Conclusion: The sequential therapy for HP eradication was more effective and safe in patients with type 2 DM comparative with standard treatment. HP eradication was associated with increased of BMI in diabetic patients.
The evaluation of thyroid function tests in patients with gestational diabetes mellitus

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Objective: The incidence of thyroid disorders in patients with gestational diabetes is controversial. The aim of this study was to investigate thyroid function tests in patients with gestational Diabetes Mellitus (GDM).

Method: Thirty patients with GDM without known thyroid disorder (mean age = 31.1 ±1.9 years) were enrolled in the study. Demographic characteristics, thyroid function tests such as Thyroid Stimulating Hormone (TSH), Free Triiodo Thyronine (FT3), and Free Thyroxine (FT4), Anti TPO Ab and other biochemical tests were evaluated, retrospectively.

Results: Mean levels of TSH, FT3, and FT4 were found to be 1.9±1.1 µIU/mL (normal range: 0.35-5.5 µIU/mL), 3.0±1.1 pg/mL (normal range: 2.3-4.2 pg/mL); 1.1±0.8 ng/dL (normal range: 0.93-1.7 ng/dL), respectively. Thyroid dysfunction was detected in 7/30 (23.3%) of patients. 57.1% (4/7) of patients with thyroid dysfunction had positive titer of Anti TPO Ab. Among patients with thyroid dysfunction, 4 (57.1%) had subclinical hypothyroidism (TSH > 3 µIU/mL and normal FT4) and 3 (43.9%) had clinical hypothyroidism (TSH > 3 µIU/mL and FT4 < 0.93 ng/dL).

Conclusion: Thyroid dysfunction is a common endocrine disorder in patients with GDM. All patients should be evaluated for thyroid disorders.
INTRODUCTION: Type 2 Diabetes (DM2) is the 21st century pandemic. DM2 is a major cause of premature mortality and morbidity worldwide. It’s estimated that 13.3% of the Portuguese population is diabetic, of which only 7.5% are diagnosed. In Portugal, the number of diabetic patients hospitalized per year exceeds 160,000.

OBJECTIVES: Characterization of the profile and therapeutic approach of patients with DM2 admitted to a medical nursery.

METHODS: Retrospective, observational and cross-sectional study, which included all inpatients with the diagnosis of DM2 during the month of November 2017. Data was collected through consultation of clinical files and analysed with Microsoft Excel 2016.

RESULTS: Over the 152 hospitalizations, 32.9% of patients (n=50) had DM2 (3 were inaugural diagnoses). The mean age was 76.9 ± 11.3 years and 52.0% were males. The main reason for admission were infectious intercurrences (58.0%) and strokes (18.0%). Only 3 hospitalizations were due to hyperglycaemic hyperosmolarity. The mean hospital stay was 11.6 days and hospital mortality 16.1%. From the analysis of the therapeutic approach it was found that 24.0% (n=12) of the patients presented pre-prandial capillary glycemia higher than 200mg/dL. Regarding in-hospital therapy, none of the patients were under oral antidiabetic agents, 36.0% (n=18) had prescribed intermediate-acting insulin, and the remaining patients with the fast-acting insulin slimming scale. As for the glycaemic control only 42.0% (n=21) had HbA1c requested, which mean value was 7.9%. The registry of target organ complications was verified in 42% of cases, and nephropathy was predominant. At the time of discharge 36 patients maintained previous medication and the rate of insulinization was 32.0%.

CONCLUSION: Hospital admission may be an opportunity for optimization of diabetic patients, but it is often underused. It’s essential to increase awareness among professionals of this aspect to improve outcomes in type 2 diabetic patients.
The profile of the patients with stroke and diabetes in 2017

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Objective: The purpose of this study is to characterize the risk and profile of diabetic patients with stroke and compare with non-diabetic patients.

Method: Retrospective observational study, collecting clinical information from clinical process (ALERT and SClinico) and data processing in Microsoft Excel®. The sample (n = 498) corresponds to the patients who suffered a stroke in 2017 and were hospitalized in a stroke unit in a Central Hospital. The risk profile and the stroke profile were analyzed by dividing the sample according to the type of stroke and the presence/absence of Diabetes mellitus.

Results: Diabetic patients (n = 123) presented with ischemic stroke (69.7%), had a profile with tendency to dyslipidemia (40%), glycemia > 140mg/dl (66.4%) and arterial hypertension (>140/90mmHg). 19.4% aren’t treated for diabetes. The mortality rate in this group was 10.3% versus 11.4% in non-diabetic patients and the mortality rate in this group with glycemia >140mg/dl was 7.3% versus 2.7% in non-diabetic patients. Considering non-diabetics, ischemic stroke was present in 64.4%, showing a profile with dyslipidemia, hypertension and atrial fibrillation.

Conclusion: Diabetic and non-diabetic patients presented no difference between ischemic stroke and dyslipidemia. The glycemia >140mg/dl in the event is a possible prognostic indicator.
The relationship between chronic stress level and metabolic/cardiovascular disease risk factors in professional musicians

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Objectives: Present study aimed to reveal the relation between chronic stress level and physical abnormalities of professional musicians.

Method: 46 musicians (25 females, 21 males; 28 string, 14 wind, 4 drum musicians; age $\bar{x}=45$, $\sigma=6$) participated. Musicians were examined by internal diseases specialist and clinical psychologist. Biochemical laboratory tests and Recent Life Events Scale to reveal chronic stress levels were run. Independent samples t-tests with dependent variables body-mass index, insulin resistance, total/HDL cholesterol ratio, insulin resistance, fasting blood glucose level; with independent variables age, gender were conducted. 1x3 one-way between subjects ANOVA (stress level, 3 levels: low, moderate, high) for fasting blood glucose level was run.

Results: The significant results revealed that total/HDL cholesterol ratio was different for gender group ($t(42) = -2.276$, $p=0.028$, CI 95%[-1.28, -.077]). Males had higher total/HDL cholesterol ratio ($\bar{x}=3.63$, $\sigma=1.21$) than females ($\bar{x}=2.96$, $\sigma=0.74$). Musicians with different stress levels were found to have significantly different level of fasting blood glucose ($F(2,26)=3.709$, $p=0.038$). Musicians with moderate level of chronic stress had higher fasting blood glucose level ($\bar{x}=93.2$, $\sigma=7.32$) than high level of stress ($\bar{x}=85.5$, $\sigma=6.42$).

Conclusion: Male musicians have greater risk of cardiovascular diseases since higher total/HDL cholesterol ratio level is a predictor (Rosenson and Durrington, 2017). It could be expected to have high level of fasting blood glucose levels but according to Cognitive Appraisal Theory (Lazarus and Folkman, 1984) high level of chronic stress ends up with physical and psychological adaptation. Thus musicians with higher level of chronic stress had lower levels of fasting blood glucose.
The relationship between insulin and levels of liver enzymes in patients with metabolic syndrome

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OBJECTIVE: Therefore; the aim of the study was to evaluated the relationships between insulin and levels of four liver enzymes such as aspartate aminotransferase (AST), alanine transferase (ALT)), gamma glutamyl transpeptidase (GGT) and alkaline phosphatase (ALP) in patients with metabolic syndrome (MS).

METHODS
One hundred patients had MS and 100 patients without MS as control were included in the study. Metabolic syndrome was diagnosed according to the National Cholesterol Education Program Adult Treatment Panel III criteria.

RESULTS: The mean age of patients had MS was 59.0±6.0 years (age range of 20– 80 years). And also, it was found to be 51.9±7.0 years (age range of 20– 80 years) in control. 69 of the 100 patients had MS (69%) showed 1 to more abnormal liver enzymes. The levels of the 4 liver enzymes were all higher in the group with MS than in the group without MS (all P < 0.05). With the increase of the number of elevated MS components the serum levels of ALT, AST, and GGT were elevated accordingly. Mean levels of HOMA were found to be 3.4±0.3 and 2.0±0.8 in patients with MS and without MS, respectively. Multivariate regression analysis showed that, among the above-mentioned variables, only HOMA-IR and was independently correlated with both ALT and GGT.

CONCLUSION:
Most patients with MS have abnormal liver enzymes. And also, the percentage of high ALT and GGT in patients with insulin resistance.

Key words: liver enzyme, metabolic syndrome
The role of Diabetes type 2 in patients with Cancer diseases

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Objective: The risk of several types of cancer is increased in type 2 diabetes mellitus. We were studied role of diabetes type 2 in patients with cancer diseases. We studied 74 patients with different cancer diseases. 36 female and 38 male. age 42-80 year. Patients were divided in two groups. First group were patients who had diabetes type 2 before cancer was diagnosed. Second group were patients who developed diabetes type 2 after diagnosed by cancer.

Results: 52 patients have developed cancer diseases after diabetes type 2, 22 patients developed diabetes type 2 after cancer disorders.

Conclusion: Diabetes type 2 patients more commonly develop cancer disorders, then patients who have cancer diseases and after this develop diabetes type 2. Diabetes type 2 is high risk factor for cancer development.
Atrial fibrillation is the most frequent chronic arrhythmia, affecting 1-2% of the population. Often, due to its paroxysmal potential, it may be underdiagnosed and undertreated. The authors present the case of a 50-year-old patient from Sao Tome who was visiting Portugal, with a history of hypertension, type 2 diabetes and anxiety. Several episodes of palpitations and atypical anterior thoracalgia over the past years, without diagnosis to date. Admitted to the emergency room for palpitations, fatigue after moderate exertion and anterior thoracalgia (located with one finger and increased with digital pressure), without irradiation, nausea, vomiting, lipothymia. Without orthopnea, cough, fever, urinary or intestinal complaints. Reference to episodes of agoraphobia. The patient was anxious, uncooperative, dehydrated, with discrete crackling at the right base. Apyretic, hypertensive, with a heart rate of 140 beats per minute, with arrhythmic heart sounds. Electrocardiogram showed atrial fibrillation with a rapid ventricular response of 138, which was controlled with 5 mg of bisoprolol. Analytically, microcytic, hypochromic anemia, without elevation of acute phase parameters, negative cardiac biomarkers. Thyroid stimulating hormone (TSH) <0.01 mU/L, with free thyroxine level (FT4) of 43.8 ng/dl.

She began methimazole, with good tolerance and results. After one month, the patient was asymptomatic, calmer and more cooperative, with TSH <0.01, FT4 19, Free Triiodothyronine (FT3) 5.6, microsomal anti-peroxidase antibody 609 and anti-TSH receptor antibody 4.53, confirming the presumptive diagnosis of Graves disease.

Patients with hyperthyroidism may suffer from a wide range of symptoms, including anxiety, palpitations, irritability, heat intolerance, muscle weakness, among others. Patients often resort to emergency services with similar symptoms, so we mustn't forget this etiology during the diagnostic process.
Thyrotoxic Hypokalemic Periodic Paralysls:A Case Report

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Introduction: Thyrotoxic Hypokalemic Periodic Paralysis (THPP) is an entity characterized by thyrotoxicosis, hypokalemia, and acute proximal muscle weakness. It is a manifestation of paralysis dependent on increase in Na+ /K+ ATPase activity due to cathecolamine discharge secondary to hyperthyroidism.

Case Description: A 35-year-old male patient consulted our emergency service with weakness in his legs, and inability to walk. The patient was evaluated by neurology department, any significant finding was not detected in cerebral, and spinal imaging studie. His blood tests revealed the presence of hypokalemia so he was brought into clinic of internal medicine for further examination. Physical examination findings of the patient were as follows: TA: 120/70 mmHg, pulse rate: 90/min, rhytmic; body temperature: 36.9°C; respiratory rate, 16/min; open consciousness; complete cooperation; agitation because of his complaints of weakness; sweaty skin, and natural skin color. Thyroid gland manifested stage 1 b goiter. Muscle strengths were 4/5, and 5/5 for proximal and distal parts of upper, and 3/5, and 5/5 for proximal, and distal parts of lower extremities, respectively. Negative Babinsky reflexes were negative, and bilateral DTRs decreased. Following additional tests were requested. TSH: 0.01Uu/mL; ST3: 45 pmol/L; ST4: 57pmol/L; Anti-TPO 194IU/ML; TSH receptor-blocking antibody, 27IU/L. Thyroid US, and scanning results were consistent with Graves disease. His initial potassium level was 2.1mmol/L. Potassium replacement was initiated. At third hour of the treatment complaints of the patient regressed, and at 5. hour he could walk. After he received a total of 80 mEq/L KCl, his KCl level was measured as 4.5 mmol/L. When thyroid function test results were obtained, the patient started on daily doses of 30 mg methimazole, and 80 mg propranolol treatment. Discussion: Early diagnosis, and rapid treatment in THPP is life-saving. We are presenting this case because of its rarity.
Introduction: It is well known that patients with malignancy are in a hypercoagulable state, having much higher venous thromboembolism risk which is aggravated by chemotherapy (CT). The association between cancer and thrombosis was first described in the 19th century by Armand Trousseau and is known since then as the Trousseau's syndrome (TS). The development of TS enhances morbidity and mortality.

Case description: The patient was an autonomous 56 years aged male; with former smoking habits, medicated arterial hypertension and dyslipidemia and diagnosis of advanced lung cancer, submitted to chemical pleurodesis of pleural effusion (PE), that started CT with carboplatin, pemetrexed and pamidronate the week before and was admitted to the emergency department with 8-hour evolution complaints of sudden onset dysarthria, headache, pain and plegia of the left arm. On physical examination he had bilateral pupillary miosis, ocular motricity limitation and in the upper left limb: palour of the hand, cianosis of the finger tips, impalpable radial pulse and diminished muscular strength. The complementary study showed cerebellar hypodensities in cerebral tomography; sinus rhythm with right-bundle block in electrocardiography; left radial artery ischemia in ecodoppler and right PE on chest x-ray. He was admitted to the ward with diagnosis of ischemic stroke and acute left radial arterial ischemia interpreted as TS on non-fractionated heparin. Days later he developed acute respiratory failure caused by volumous bilateral hemothorax. Despite the multidisciplinary approach, the patient died during hospitalization.

Discussion: This case report intends to alert for the risk of developing TS and to highlight the possible complications of the treatment. The application of more sophisticated methods of thrombotic risk prediction, evaluation of risk versus benefit of antithrombotic prophylaxis and its eventual initiation is essential for improving the outcome of this patients.
Endocrine and metabolic disorders
A-1300

Uncommon nephropathy associated to Hashimoto’s thyroiditis

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Introduction: The association between Linear IgA nephropathy and autoimmune thyroiditis is exceptional and its mechanisms are too controversial. We report one.

Case description: patient aged 38 with no notable medical history was hospitalized for generalized edema of renal type and lasting for one week. Physical examination was unremarkable, apart from the white swelling, soft, painless, sloping and keeping the bucket. The simple biology concluded that a pure nephrotic syndrome. Renal ultrasound was normal. Renal biopsy done showed mesangial deposits of IgA compatible with the diagnosis of Linear IgA nephropathy. The family investigation was negative, as well as looking for another systemic disease or underlying connectivity. The TSH thyroid function tests showed a 15 μUI/ml. Cervical ultrasound objectifying one aspect of thyroiditis and the search for anti thyroglobulin and thyroid peroxidase antibodies strongly came back positive, confirming the diagnosis of Hashimoto’s thyroiditis. Systemic corticosteroids as well as hormone replacement therapy were established with a favorable outcome.

Discussion: The combination of a genuine autoimmune thyroiditis a primitive glomerulonephritis, especially linear IgA nephropathy is exceptional. However, it deserves to be known by the clinician and thyroid function tests is justified before any primitive Linear IgA nephropathy.
OBJECTIVES
To analyze the prevalence of episodes of diabetic decompensation in patients admitted in Orthopedic Surgery and Traumatology (OST) area.

MATERIAL AND METHODS
Descriptive analysis of patients admitted to OST Service who presented abnormally high or decreased blood glucose levels according to the criterion of the Orthopedic Surgeon who performed the consultation.

RESULTS
From June 2008 to December 2014, 1486 consultations were sent to Internal Medicine or Cardiology, regarding patients admitted to the OST area who had suffered any medical decompensation during admission. 437 (29.4%) had a documented history of DM. The reason for consultation was poorly controlled DM in 124 patients (8.3%), with 111 patients (89.5%) presenting hyperglycemia and 13 (10.5%) presenting hypoglycemia. Since the consultations were made by the Orthopedic Surgeon who requested it, after the initial evaluation of all these patients, the diagnosis of poorly controlled DM was only considered in 108 patients (7.4% of the total decompensated patients), since the rest, despite presenting glycemia above 125 on fasting, were considered controlled taking into account their particular clinical situation. This implies an actual decompensation of 24.7% of patients with known DM.

CONCLUSIONS
DM is a cause of medical decompensation in 8.3% of patients admitted to OST. One in four known diabetics had abnormal blood glucose levels. In previous studies we concluded that approximately one in six known hypertensive patients is decompensated during admission to surgical areas. An early evaluation of blood glucose and blood pressure performed by Cardiology or Internal Medicine could be beneficial in terms of morbidity.
OBJECTIVES
To analyze the prevalence of diabetic decompensation in patients admitted to Vascular Surgery and Angiology (VS) area.

MATERIAL AND METHODS
Descriptive analysis of patients admitted to VS who presented abnormally high or decreased blood glucose levels according to the criteria of the Vascular Surgeon who performed the consultation.

RESULTS
From June 2008 to December 2014, 173 consultations were sent to Internal Medicine or Cardiology regarding patients admitted to VS area who suffered any medical decompensation during admission. Of these patients, 94 (49.1%) had a documented history of DM. The main consultation was poorly controlled DM in 8 patients (4.6%) of whom had hyperglycemia 4 (50%) and hypoglycemia, 4 (50%) and control of vascular risk factors in 18 (10.4%). After analysis of all patients, 22 (12.7%) were diagnosed as decompensated DM in the discharge report. This implies a real decompensation of 23.4% of patients with known DM.

CONCLUSIONS
DM is a single cause of medical decompensation in 4.6% of patients admitted to VS. Associated with decompensation of other vascular risk factors, one out of four known diabetics had abnormal blood glucose levels. Together with previous studies we concluded that approximately one in six known hypertensive patients decompensated during admission to surgical areas. An early evaluation of DM and blood pressure performed by Cardiology or Internal Medicine could be beneficial in terms of morbidity and hospital stay, since previous studies associate the diabetic uncontrol in patients admitted to VS to an average stay 9 days superior compared to non-diabetics.
Unusual presentation of Acromegaly.

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Case description:
38 years gentleman presented with DKA as the first presentation of his diabetes. His HbA1c was 12%. On exam, he showed features of Acromegaly and normal BMI. His Growth hormone and IGF-1 were very high confirming the diagnosis of Acromegaly. His Anti GAD and Anti Islet cell antibodies are negative. MRI dedicated pituitary showed pituitary macroadenoma. Treatment of his DKA was difficult. He was discharged on insulin.

Later, the patient was seen in the endocrine clinic. Insulin dose was reduced gradually till completely stopped due to recurrent hypos. He also mentioned marked improvement of his Acromegaly symptoms. GTT showed appropriate Growth hormone response and his maximum blood sugar was 7.5 mol/L. also his IGF-1 became normal. After the disappearance of his symptoms and normalization of his blood sugar, Growth hormone and IGF 1, the patient was scheduled for another MRI pituitary which showed cystic changes and marked reduction of his pituitary adenoma size.

Further, follow up, revealed persistent remission of his diabetes (his HbA1c is 5.4%) and Acromegaly.

• Conclusion and Discussion:
1- DKA could be the first presentation of diabetes and Acromegaly.
2- Secondary diabetes should be considered in any new onset diabetes especially if with an atypical presentation (our patient MBI was not typical of type 2, his age and antibodies were not typical of type 1). We recommend general physical examination and act upon the findings.
3- Apart from steroid induced hyperglycemia, there are no guidelines to manage secondary diabetes including Acromegaly.
Use Glucagon-like peptide-1 in multimorbidity patients

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Objectives
Glucagon-like peptide-1 (GLP-1) based therapies affect glucose control through several mechanisms, including enhancement of glucose-dependent insulin secretion, slowed gastric emptying, and reduction of postprandial glucagon and of food intake. These agents do not usually cause hypoglycemia in the absence of therapies that otherwise cause hypoglycemia.

The objective of the present study is to evaluate the GLP1 effectiveness in a Chronic-multimorbidity patients.

Methods
Observational study. Multimorbidity patients in follow-up by the Chronic-Multimorbidity Unit of the Complejo Hospitalario de Navarra. August 2016 to May 2018.

For data analysis student t-test for paired samples we were performed. All analyzes were performed using SPSS version 20.

Results
A total of 27 patients (11/16) with an average age of 73 years. The comorbidity index measured by the Charlson index was around 7 points. 93% of the patients received treatment with Dulaglutide, the most dose used was 1.5 mg/week (96%); Liraglutide was used in the remaining percentage (7%), with the dose used being 1.2 mg/day. The average treatment time was 309 days (SD 180 days).

There was a significant decrease in weight and HbA1c values after treatment (101 vs 96 kg, t = 2.79, 95CI 0.98-6.58, P = 0.01 and 8.62% vs 7.73%, 95CI 0.43-1.68, P = 0.002, respectively). Only two patients had to be suspended (1 gastroparesis, 1 mild pancreatitis).

Conclusion
In our population, this type of drugs is well tolerated and produces a significant improvement in glycemic control and weight.
Endocrine and metabolic disorders
A-1451

Vaspin and clusterin role in pathogenesis of diabetes mellitus in obesity. Peculiarities of dyshidria

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Objective: To study vaspin and clusterin contents in circulatory blood on the degree of adipose tissue accumulation, blood insulin level. Peculiarities of accumulation of water in the body in the patients with obesity by bioimpedance method according to the evidence of different body sectors. Material and methods: 361 individuals aged (45.08±14.43) year were examined. Four groups were distinguished: group I – the patients with excess body weight (n=117), group II – I grade obesity (n=109), group III – II grade obesity (n=69); comparison group included those with normal body mass (n=66). Body content was studied with complex set "Diamant-AIS-IRGT". Results: The quantity of total water in the body in the individuals with normal body mass (comparison group) is in average of (36.06±6.73) L, in those with excess body mass, I and II grade obesity are of (41.74±6.64), (43.16±6.40), (51.96±7.64) L, correspondingly, (p<0.001). Differences in the degree of accumulation of extracellular and intracellular fluid were established as well with increasing body mass. Revealed that vaspin blood level correlates positively with adipose body mass – correlation level – r=0.5582, (p<0.001). Vaspin blood contents correlation on the level of insulinemia and HOMA index was established: positive correlations at level, respectively, r=0.7944, (p<0.001) and r=0.7720, (p<0.001) were registered between them. Vaspin blood level correlates positively with clusterin blood level, as well (r=0.871, p<0.001). Conclusion: To determine excess body weight and various grades obesity, it is necessary to assess specifics of distribution of different body sectors, including dyshidria. Vaspin and clusterin influence in pathogenesis of diabetes mellitus at obesity was proved. Results confirm interference between adipose tissue accumulation, changes in its endocrine function, decreased body tissues insulin sensitivity and eventual development of diabetes mellitus.
INTRODUCTION: Vitamin D intoxication has been documented in adults taking more than 60,000 IU per day, and cases of hypervitaminosis D due to errors in the manufacture, formulation or prescription of vitamin D. The most frequent symptoms are confusion, polyuria, polydipsia, anorexia, vomiting, abdominal pain and muscle weakness. Chronic intoxication can cause nephrocalcinosis, and bone demineralization. This is an unfrequent entity in adults.

CASE DESCRIPTION: 93-year-old woman with arterial hypertension, aortic stenosis, CKD, hyperthyroidism due to multinodular goiter with endo-thoracic extension, primary hyperparathyroidism due to parathyroid adenoma treated with zoledronic and cinacalcet due to rejection of surgery in follow-up due to endocrinology. He went to the emergency room for diffuse abdominal pain of one week of evolution with hyporexia and sickness. Without another clinic added or fever. On physical examination: dry oral mucosa, systolic aortic murmur, and diffuse abdominal pain on palpation without peritonism. Analytically it presents kidney failure, normal sodium, low potassium, Andrés magnesium, calcium 14.2. Treatment with intensive fluid therapy, Furosemide 20 mg/6 h, Methylprednisolone 20 mg/8 h, Calcitonin 100 IU/12 h, Cinacalcet 30 mg/24 h, potassium and magnesium. In control biochemistry has calcemia of 11.3.

Finally, enter in internal medicine. Requestion, 3 months before went to review in endocrinology consultation and adjust their usual treatment adding calcifediol 0.266 mg per week, but the patient has a mistake and she takes 1 ampoule daily from that moment. In the intake profile, normalized ionic 1.09 mM, total intact PTH 103 pg/ml, 25-OH-Vitamin D 100 ng/ml. With these results and the anamnesis, she is diagnosed with hypercalcemia due to Vitamin D poisoning.

At 48 hours, she's asymptomatic with ionic normalization at discharge.

DISCUSSION: At this case, we see the importance of a good anamnesis to elucidate the etiology, checking in this case the correct take or not of your medication.
When a Heart Failure is in reality an autoimmune endocrinological disease because of a hyperfunctional gland

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Introduction: Thyroid storm is a rare condition, a medical emergency requiring an emergent diagnosis and treatment. With high mortality (10-30%), may leave irreversible sequels. The diagnosis is based on the presence of life-threatening symptoms such as fever, cardiovascular dysfunction, altered state of consciousness and laboratory abnormalities: decreased thyroid stimulating hormone (TSH), increased free thyroxine (T4L) and / or increased free triiodothyronine (T3L).

Case description: The authors present the case of a 63-year-old man, with a history of schizophrenia, benign hypertrophy of prostate and moderate ethanolic habits. He goes to the emergency department for dyspnea, easy tiredness and weight loss of 10 kg in the last year. At the objective clinical examination: agitated, hypotensive, apyretic, dyspneic, tachycardic, with bibasal fervor in pulmonary auscultation. Analytically: unmeasured TSH and impaired hepatic tests. Chest radiograph: bilateral pleural effusion, especially on the right. Echocardiogram: Severe systolic function compromise, with a Ejection Fraction <30% and pericardial effusion. Interned in the context of severe and instituted therapeutic heart failure. Subsequently: T4t 18.2, T3t 243.8, T4L 4.5, T3L 10.6. Ac Anti-thioglobulin < 1, Ac Anti-peroxidase >17, TRABs 15.7. Thyroid ultrasound: heterogeneous, multinodular structure; Right lobe with 4 nodules of 5 mm, 1 nodule of 10 mm and 1 nodule of 18 mm; Left lobe with 2 nodules of 23 and 28 mm. This patient scored 55 points on Score45. He presented with Graves’ Disease in Thyroid Storm, was medicated with B-blocker, Tionamide and Corticoid, with good clinical and laboratory evolution. We requested Thyroid scintigraphy and external consultations of Internal Medicine and Cardiology.

Discussion: In short, sick with fever, tachycardia, symptoms of multiorgan failure, we must equate the diagnostic hypothesis of a thyroid storm and act accordingly, even before thyroid hormone tests.
"Moscow" Systematising classification of multifocal lesions of the mucous membrane of the gastrointestinal tract (GIT) with nonsteroidal anti-inflammatory (NSAIDs) and antithrombotic (ATP) drugs

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Objective: to introduce the systematizing classification of multifocal gastrointestinal lesions against the NSAIDs and ATPs treatment convenient for practical use. Materials and methods. To develop the classification, we used our own experience and data from PubMed, Cochrane Library, MDConsult, DynaMed, Google Scholar. Results. The developed classification is a "formula" in the form of alphanumeric characters and subsequent cascade, which includes stratification of the risk of recurrence of bleeding and thromboembolism. The general scale includes: the title of the GIT part - E (esophagus), G (gaster), D (duodenum), I (intestine), C (colon); endoscopy data: 0 - no change, I - "reddned lesions"; II - ulcers; III - bleeding tumors and polyps; ? - no examination of the GIT; type of bleeding in the lesion focus: a - ongoing, b - recent bleeding illness. Examples of a common scale: E0G0D0I0C0 or E0G0DII?CIIIb Clarifying scale includes: severity of blood loss (Rockall): A0 - no bleeding, A1 - mild bleeding, A2 - medium severity of blood loss, A3 - severe blood loss, A4 - relapse bleeding; level of risk of thromboembolic complications: T1 - low, T2 - intermediate, T3 - high.

Examples of the formula are the extended (refining) scale: EIА0Т3 or CIяа A3. The HAS-BLED and CHA2DS2-VASc scales are generally accepted for the stratification of bleeding and thromboembolic risks. They have the similar maximum scoring value 9, which allows determining the bigger risk zone in correction purpose.

Conclusion. The developed classification refers to the model of medicine "Three P": personified, preventive and predictive. Where a simple formula takes into account a significant number of gender, functional and clinical-laboratory indicators. The use of the "Moscow classification" refers to the decision-support system for managing patients with complex comorbid pathology.
**Introduction**: Herbal medicines are commonly used, as alternative or traditional medicines. *Boldo* is a tree growing in South American Andes mountains and is traditionally used for symptomatic treatment of dyspepsia, mild gastrointestinal spasmodic disorders and painful joints. However, the number of reported cases of possible hepatotoxicity is increasing.

**Case Description**: An 87-years-old male, with hypertension and polymyalgia rheumatica, has been admitted to the hospital with asthenia, anorexia and jaundice. Laboratory tests showed increase serum levels of liver enzymes after repeated consumption of *Peumus boldo* leaves infusion for a month. Abdominal CT scan and RMI reveal no changes, except a known inespecific subcapsular cyst in the upper posterior margin of the right lobe about 4cm large and other small cysts smaller than 4mm in both liver lobes. Viral hepatitis serology was negative.

After exclusion of common causes of hepatobiliary pathology, *boldo*-induced hepatotoxicity was considered probable. Interruption of its ingestion led to complete clinical and laboratory recovery.

**Discussion**: *Peumus boldo* leaves infusion can be hepatotoxic and may be the cause of otherwise unexplained jaundice or abnormal values of liver enzymes, particularly in elderly patients.
Antibiotic Prophylaxis in Patients with Upper Gastrointestinal Hemorrhage Secondary to Esophageal Varices

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OBJECTIVE
Compare rebleeding events and infections in patients with antibiotic prophylaxis vs. non antimicrobial in patients with variceal hemorrhage.

METHODOLOGY
Quasi experimental, prospective and analytical study. Patients admitted to the General Hospital of Diseases diagnosed with upper gastrointestinal bleeding secondary to esophageal varices were included. A simple randomization between antibiotic prophylaxis and the control group was carried out.

The analysis was made with the statistical software PSPP-2007. Categorical variables were presented in frequencies and percentage, and analyzed by Chi square of homogeneity. Normality of the numerical variables was checked by Kolmogorov-Smirnov. Numerical data were shown with measures of central tendency, and were compared by t Student of independent samples.

At the relational level, a bivariate analysis was carried out, which later became explanatory with the multivariate analysis. Next, a logistic regression was applied at the predictive level and this prediction was weighted with R squared by Cox and Snell and Nagelkerke. A statistically significant p was considered when the value was <0.05.

RESULTS
We included 33 patients; 12 (36.4%) women and 21 (63.6%) men; with an average age of 53.85 years (SD 8.12); 72.7% were Child C; and the main cause of chronic liver disease was alcoholism (69.7%). After simple randomization 51.5% were distributed with antibiotic prophylaxis and the rest without antimicrobial. Among the complications, 21.2% had rebleed and 27.3% were infected (9.1% spontaneous peritonitis and 18.2% other types of infections). The total mortality was 21.2%.

After the multivariate analysis there was no difference between bleeding, infection and mortality events among the groups studied.

CONCLUSIONS
Despite the fact that according to this comparison there is no difference in rebleeding events and infections, prophylaxis is still valid, and studies with greater statistical power to change this recommendation are lacking.
Prevalence and clinical characteristics of autochthonous acute hepatitis E among acute non-A, non-B, non-C acute hepatitis in central Greece

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Objectives:
Hepatitis E virus (HEV) is the leading cause of acute hepatitis in the developing world. In developed countries HEV occurs sporadically, but its incidence is steadily increasing. Our aim was to investigate the prevalence and clinical characteristics of acute HEV infections in patients with acute non-A/B/C hepatitis in central Greece.

Methods:
All patients (n=15) with acute hepatitis of unknown cause referred to our center in 2015-2017 were tested for anti-HEV-IgM antibodies (Wantai diagnostics, China) and HEV-RNA (FTD Hepatitis E RNA kit). Stored (-80°C) samples of acute autoimmune hepatitis patients (AIH; 2000-2015; n=50) were also tested as disease controls. In all sera, liver autoimmune serology was performed.

Results:
12/65 (18.5%) patients diagnosed with acute HEV [median HEV-RNA 10.37x10^4 (387-39.7x10^5) IU/ml]; 1/50 (2%) of AIH and 11/15 (73%) of acute non-A/B/C hepatitis patients. HEV-patients were older compared to those without (p=0.009), predominately men [11/12(91.6%) vs. 17/53(32%); p=0.001] with significantly higher ALT and γ-GT, but lower IgG levels (p<0.05). All HEV-patients had high titers of smooth muscle anti-F-actin antibodies, but none antinuclear antibodies. Liver biopsies (performed in 5 HEV-patients) revealed histologic features compatible with AIH. HEV genotyping was performed in 3 patients: 2 had genotype 3f and one 3i, compatible with the genotypes of the wild-boars of the region.

Conclusion:
One fifth of the patients with acute non-A/B/C hepatitis had autochthonous HEV infection with features of AIH. Therefore, a careful diagnostic work-up excluding HEV should be carried out in all acute hepatitis cases before a definite AIH diagnosis is made.
A case of age-related isolated esophageal varices

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We discussed a case in which we detected isolated esophageal varices during further investigations performed for investigating etiology of iron deficiency and which we thought to result from age-related vascular insufficiency. 79-year-old male patient admitted to our clinic with complaints of shortness of breath and abdominal distention. It was learned that these complaints were persisting for a long period of time and he had severe effort dyspnea with slight exercises. There was no characteristic in his past history other than transient ischemic attack. In physical examination, vital signs were stable, mild venous distention in head-neck region was present. In cardiovascular system examination, s1+, s2+ s4+ and 2/6-degree murmur were present. Respiratory system examination was natural. Other system examinations were normal. In the performed laboratory tests, there was no abnormal finding other than a hemoglobin level of 9.6 g/dL. Low hemoglobin level was observed to be consistent with microcytic anemia and iron-deficiency anemia (transferrin saturation: 15). In the endoscopic examination performed for iron-deficiency anemia, 3 column ¼-degree varices were detected in distal edge of esophagus, and no lesion was detected in other parts of the gastrointestinal system. In the portal, hepatic and splenic vein doppler ultrasonographic examinations performed for esophageal varices, vascular structures were determined to be normal. Hepatic parenchyma was determined to be normal. In the magnetic resonance venography of these regions, these vascular structures and the superior vena cava were determined to be normal. In the computed tomography performed for thymoma, chronic fibrosing mediastinitis and mediastinal tumors, no pathology was detected. The isolated esophageal gastric varices the patient had was thought to be due to age-related insufficiency of vascular structures. The patient was put on a treatment for heart failure and we call him for routine controls.
**A case of Diphyllobothrium nihonkaiense infection identified by capsule endoscopy**

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**Introduction**
Diphyllobothrium nihonkaiense is morphologically similar to but genetically distinct from Diphyllobothrium latum, and is the second most common causative agent of diphyllobothriosis in humans. Most cases have been reported from Japan, and also reported in Taiwan, China, Russia, France, Switzerland, and New Zealand. Additionally, Diphyllobothrium nihonkaiense was found in the musculature of wild pink salmon in North America in 2013.

**Case description**
A 28-year-old man with an acute history of abdominal pain and exertion of tape-like structure presented to our emergency department. His vital signs were normal. There was no history of fever, night sweat, rebound tenderness, or weight loss. He had no previous significant medical problems, and denied any recent travel outside Japan. However, he also reported that he regularly ate raw salmon sushi. Capsule endoscopy showed that a whitish-yellow tapeworm was found in the small intestine. Stool examination revealed segments of a polypide and eggs, subsequently identified as Diphyllobothrium nihonkaiense. He was treated with a single dose of oral praziquantel.

**Discussion**
Adult tapeworms can achieve a length of more than 10m in the small intestine. Despite the large size of the tapeworms, gastrointestinal symptoms of diphyllobothriosis can be absent or mild, including abdominal discomfort, watery diarrhea, and abdominal pain. Capsule endoscopy is a safe and less invasive procedure to make a definitively diagnosis of the Diphyllobothrium nihonkaiense infection, and is useful to determine the indication of an additional vermifuge treatment.
**A case of dysphagia: connecting the dots**

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**INTRODUCTION**  
Dysphagia is usually first approached as symptom from a gastrointestinal (GI) disorder, although a neuromuscular or oropharyngeal ailment may also be the cause of this complaint. In this case, the role of the internist in connecting the dots between the different medical areas is an example of how important it is to have an all-inclusive approach in order to achieve a diagnosis.

**CASE DESCRIPTION**  
A 63-year-old man was admitted to our ward in the context of probable aspiration pneumonia. For the past 7 years he suffered from upper dysphagia, with difficult swallowing and occasional nasal reflux. At first, the dysphagia was mainly for solids, but now it also affected liquids. He reported losing around 40 kilograms (kg) in this period, from 82 kg to 42 kg. He denied gastroesophageal reflux or dyspepsia. Medication included paroxetine, amilsupride and alprazolam, which he hadn't been taking for some time. Since the beginning the patient tried to deny his symptoms and spent 3 years without being examined. In 2014, he was consulted by an internist. An upper GI endoscopy showed no evidence of any lesions. The patient was discussed with Gastroenterology and a functional disorder was assumed. In 2016 he was submitted to a dynamic swallowing study, which revealed paradoxical contraction of the cricopharyngeal muscle. Due to this finding, he was seen by two different specialties, ENT and Neurology. ENT found salivary stasis on both pyriform sinuses. Neurology, due to rigidity in his limbs, asked for a brain magnetic resonance which showed no evidence of Parkinson disease. A DaTscan was suggested. The patient was only submitted to it during this hospitalization.

**DISCUSSION**  
The DaTscan was negative for parkinsonian syndromes. An upper GI videoendoscopy was obtained, showing salivary stasis in the hypopharynx, with difficulty passing through the cricopharyngeal muscle. Based on these findings, a rare cause of dysphagia was assumed: primary cricopharyngeal dysfunction.
A Rare Case of Esophagopericardial Fistula

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Introduction: Esophagopericardial fistula is uncommon and rarely a complication of esophageal neoplasia. It has a benign etiology in 80% of cases. Predisposing factors are the localization of the neoplasia in the anterior wall and previous radiotherapy.

Description: A 76-year-old man with cardiovascular risk, non-smoker, recent diagnosis of squamous cell carcinoma of the esophagus with cerebral metastasis and with a esophageal prosthesis, under palliative chemotherapy. He also had a family history of oesophageal neoplasia. Admitted by sudden onset of cervicalgia with interscapular irradiation. On hospital admission, he was hypotensive with hypoxemia and hyperlactacidemia. Electrocardiogram showed a new atrial flutter. AngioTC excluded aortic dissection and pulmonary thromboembolism, showing a large hydropneumopericardium. It also showed pulmonary nodules suggestive of metastasis and laminar atelectasis. During hospitalization an esophagopericardial fistula was assumed, with no further studies. It was adopted a symptomatic treatment, taking into account the rapid progression of the disease. Unfavorable evolution with death on the 2nd day of hospitalization.

Conclusion: Esophagopericardial fistula is a rarely reported life-threatening complication. The presence of cardiac arrhythmias suggests ventricular fistula. The diagnosis must be as quick as possible due to the risk of purulent pericarditis and cardiac tamponade. Nevertheless, it has a bad prognosis with poor survival rate in the first month.
**A Rare Cause of Acute Pancreatitis: Mesenteric Panniculitis**

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**Introduction:** Mesenteric panniculitis is characterized by nonspecific inflammation, fat necrosis and fibrosis in mesenteric fat. It is a rare occurrence with a prevalence of 0.6% to 2.5% and usually seen in adults (23-87 years, mean age 60). Despite of both sexes can be affected, males are seen more often (twofold). Although etiology is not clearly known, there are many diseases associated with it. The clinic is often asymptomatic but when symptomatic, mostly present in the form of abdominal pain and palpable mass. Diagnosis is usually made by abdominal computed tomography (CT) and magnetic resonance imaging (MRI) without the need for biopsy.

**Case Description:** A 75-year-old woman with a 15-year history of diabetes mellitus was admitted to our hospital complaining of abdominal pain, nausea and vomiting. A laboratory investigation showed Amylase: 1573U/L, Lipase: 4130U/L, AST: 334U/L, ALT: 256U/L. Abdominal CT yielded soft tissue densities of 54x34 mm surrounding the superior mesenteric artery (SMA) and vein (SMV) in the inferior compartment of the pancreas. MRI showed that gallbladder and bile ducts are natural appearance, heterogeneous signal changes that suggest panniculitis. The patient's oral intake stopped and followed by intravenous fluid support. When abdominal pain improved, oral intake was opened.

**Discussion:** MP is a non-specific fibroinflammatory disease that affects mesenteric fatty tissue, first described by Jura in 1942. Abdominal CT is the best diagnostic method for diagnosis and CT findings are characteristic. There is no standardized treatment for MP, often followed without treatment. In the medical treatment, corticosteroids, Colchicine, Azathiopurine, Thalidomide, Cyclophosphamide, Tamoxifen, Progesterone, Pentoxifylline have been tried. Consequently, there may be many different causes as well as the gastroenterological system; cirrhosis, cholelithiasis, jaundice, pancreatitis, peptic ulcer, celiac disease and retroperitoneal fibrosis.

As a very rare cause of acute pancreatitis, MP was detected in our case.
A rare presentation of acute pancreatitis

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Introduction: Acute pancreatitis (PA) is one of the most frequent conditions in emergency department. In the last years, the incidence of this disease has been increasing, however mortality not changes, depending on the stages’ severity.

Case Description: A 59 years old female, with a medical history of breast cancer, active rheumatoid arthritis (RA) and asthma presents with epigastric abdominal pain, vomiting and fever for the past 24 hours. She had started leflunomide for RA 5 months before and since then she had gone several times to the emergency department with intermittent fever and abdominal pain, which she related to the use of the new drug. Blood analysis and abdominal ultrasound were, nevertheless, unremarkable. In the current admission, she had high inflammatory markers, but normal amylase and lipase, and normal liver function. The abdominal TC was compatible with alitiasic acute pancreatitis (Ranson 1 at admission and 0 at 48 hours; Apache II score 6). Further diagnostic work-up was positive for eosinophilia, and high levels of IgG4, but negative for autoimmune antibodies. Leflunomide discontinuation was followed by a favorable outcome and no recurrence, with a recommendation to performed MRI one month later.

Discussion: There are several drugs well known to be related to pancreatitis but there is scarce knowledge about leflunomide. The onset of symptoms, laboratory and imaging evidence of pancreas inflammation, with a latency period (variable in drug-induced PA) of the drug intake raise the hypothesis of drug-induced pancreatitis. Although, IgG4 elevation is one criteria for autoimmune and IgG4 pancreatitis, the patient improved without corticosteroid therapy and didn't have any other organs involved. Additionally, RA, is also associated to higher incidence of acute pancreatitis. So, it's possible that in this case, more than one cause is responsible for the disease occurrence.
A surprising cause of ascites in a patient with deep venous thrombosis

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Introduction. Accumulation of ascites fluid can have different causes, like tuberculosis, kidney or thyroid disorders, pancreatitis, primary causes being liver cirrhosis, heart failure or cancer. Also, the presence of ascites in a patient who develop a profound deep venous thrombosis represent a diagnostic challenge.

Case description. We present the case of a 59 years man, included in gastroenterological evidence with toxic liver cirrhosis, portal hypertension and ascites, from July 2017. In October 2017, he was admitted in our clinic for an episode of deep vein thrombosis and progressive volume enlargement of the abdomen. Laboratory data did not reveal any liver disorders, endoscopy did not detect esophageal varices, abdominal ultrasound showed normal liver, spleen and portal vein, but high volume of non-homogeneously ascites fluid. Ascites fluid had low serum-ascites albumin gradient, low glucose, very high LDH, and reaccumulated fast after paracentesis. Abdominal CT showed important peritoneal implants and in oncologic surgery department, diagnostic laparoscopy and biopsy certified well differentiated peritoneal malignant mesothelioma.

Discussion. Although it is widely accepted that cirrhosis associates hypocoagulation state, studies show an increased probability of an acute thrombotic event. The presence of large amount of ascites and fast reaccumulation after paracentesis raised the suspicion of another possible etiology of both venous thrombosis and ascitic syndrome. Peritoneal malignant mesothelioma has a low incidence and outlines a polymorphic and non-characteristic clinical picture, often leads to diagnostic errors and delayed initiation of therapeutic strategies, being extremely aggressive in evolution.
Introduction: Hepatitis C infection is the leading cause of chronic hepatitis, cirrhosis and HCC (Hepatocellular carcinoma). Acute infection may occur 7 to 8 weeks after contact but only a small percentage of acute infections are symptomatic. After acute infection, the patient's chance of turning chronically infected is 85-90%, and the probability of spontaneous remission is only 15%.

Case Report: We presented a case of acute hepatitis C infection in a young adult, 32 years old, who came to our hospital's emergency department. He had history of 4 days of prodromal symptoms, with pruritus, jaundice and choluria. He also showed high alcoholic intake for a period of 12 years, with recent abstinence. In the physical examination, was evident the jaundice and the liver was palpable about 8 cm below the rib cage, of a hard but painless consistency. Analytically, he had bicytopenia, with alterations in the markers of liver function, with elevation of total and direct billirubins. In the infectious serologies, positive HCV test and confirmatory test, with RNA viral load 163 IU/mL. The presence of chronic liver disease of probable alcoholic etiology with acute HCV hepatitis was assumed.

We opted for delaying the initiation of acute-phase therapy by performing only supportive therapy. In the recovery phase, the constitutional symptoms disappeared, with sclerotic jaundice remaining and normalization of liver function values. The patient was referred for liver transplantation.

Discussion: The presence of symptoms in HCV infection shows a vigorous and broad immune response in early infection. There is a surprisingly high rate of hepatitis C infection in patients with alcohol abuse, even in the absence of other risk factors. HCV can accelerate liver injury in patients with marked habits. Hepatitis C is responsible for 40% of cases of chronic liver disease and is the primary indication for liver transplantation.
Acute Liver Failure - Diagnosis Challenger

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INTRODUCTION: Acute liver failure is an uncommon but dramatic clinical syndrome of abrupt loss of liver function in patient with previously healthy liver. The most prominent causes encompass a wide variety of drugs, toxic, viral, metabolic, vascular and autoimmune insults, but in many cases, the cause remains unknown.

CASE REPORT: 27-years-old caucasian female, previously healthy, pharmaceutical worker, with daily intake of protein supplement. 45 days before this episode had a muscle breakage at gym and was treated with etoricoxib 60mg and ciclobenzaprine 10mg during 2 weeks followed by amoxicillin/clavulanate 8 days. 20 days after the treatment, was admitted into hospital presenting malaise, fatigue, nausea, diarrhea and epigastric and right hypochondrium abdominal pain with 2 days of evolution. The patient denied previously history of fever, cough or other symptoms, ingestion of mushrooms, alcohol or drugs intake. At admission time we remark temperature 37.5°C, hemodinamically stable, GSC15, sclera jaundice, painful examination of abdomen at epigastric level but without signs of peritoneal irritation. No palpable hepatosplenomegaly. Hb 14.4g/dL, leucocytes 4.8x10^3/uL, neutrophils 67%, platelets 188x10^3/uL, CRP 21mg/dL, INR 1.56; Bil total 3.5mg/dL, Bil direct 2.9mg/dL, GOT 980U/L, GPT 1852mg/dL, LDH 326U/L, PA 95U/L, GGT 208U/L, amilase, calcium and renal function normal. From the subsequent assessment we register normal abdominal ultrasound, negative viral serologies, urine and blood cultures. Despite the supportive treatment, the patient presents deterioration of liver function and higher INR until the 8th day, when gradually begun to normalize until the discharged from hospital.

DISCUSSION: Timely diagnosis is critical because of rapid deterioration with high mortality rate.
Acute liver failure in probable Autoimmune Hepatitis - Primary Biliary Cirrhosis overlap syndrome

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Introduction
Prognosis of acute liver failure depends on etiology, since this severe condition can threaten the patient's life if directed therapy is not initiated promptly. Hepatitis due to an autoimmune mechanism is rare, usually with an insidious presentation; the acute or even fulminant forms are uncommon. We present a very unusual case of acute hepatitis due to autoimmune hepatitis-primary biliary cirrhosis (AIH-PBC) overlap syndrome.

Case Description
The authors present the case of a 33-year-old male, previously healthy, with no exposure to drugs, alcohol or dietary supplements, admitted for a 5-day history of asthenia, lipothyrm, abdominal discomfort, jaundice, choluria, acholia and vomiting. Relevant findings on examination were jaundice of sclera and skin. Blood workup showed thrombocytopenia, coagulopathy, elevated liver enzymes, alkaline phosphatase and immunoglobulin G, and direct hyperbilirubinemia. Imaging studies only showed homogeneous hepatosplenomegaly. Infectious serological tests and tumoral markers were negative. The patient deteriorated under support therapy, presenting with haemorrhagic dyscrasia, encephalopathy and further elevation of liver enzymes and bilirubin. At this point, the autoimmune study was found positive for anti-nuclear (ANA) and anti-mitochondrial antibodies (AMA), namely anti-M2-3E and anti-M2; thus, an autoimmune hepatitis with acute liver failure was assumed. Then, the patient started immunosuppressants (corticosteroids and azathioprine), with significant improvement. After discharge, he remained stable under this therapy.

Discussion
Clarifying the etiology of acute liver failure is essential, since it ensures effective therapy, with clear prognostic implications. This is a particularly interesting and peculiar case due to the acute presentation of a probable AIH-PBC overlap syndrome.
Gastrointestinal and liver diseases
A-1995

Acute necrohemorrhagic pancreatitis - surgery or conservative treatment?

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Introduction: In severe pancreatitis there is pancreatic necrosis, it appears in 10-20% of patients, with mortality between 40-70%. Related to etiology and age, it is higher in patients over 50 years older. 5% of acute pancreatitis (AP) die from shock during the first week. Acute necrohemorrhagic pancreatitis (ANHP) represents the most severe variant, with variable clinical features, from abdominal discomfort without systemic repercussions to multiple organ failure and death. Treatment involves several questions: antibiotic therapy, type of diet and the management of infected necrosis.

Case description: 77 years old female, a history of type 2 diabetes mellitus, rheumatoid arthritis, hypertension, dyslipidemia and anemia of chronic disease. She went to the emergency department with vomiting, diarrhea and diffuse abdominal pain. Analytically: increased inflammatory parameters, creatinine 1.9 mg/dL, hyperbilirubinemia (total 7.22, direct 4.52), increased alkaline phosphatase, GGT, AST, ALT, amylase and LDH. Abdominal ultrasound: pancreatic edema suggesting AP, with thin peripancreatic and perihepatic fluid thin liquid sheet. Computed tomography (CT): ANHP. Discussed the case with the Gastroenterology that opined to maintain surveillance by CT, antibiotic therapy, without indication for surgical intervention if no clinical aggravation or obstruction. Repeated serial CTs and despite presenting severity criteria remained hemodynamically stable, without SIRS criteria. She developed clinical, laboratory and imagiological well, been discharged for external consultation of internal medicine.

Discussion: In the ANHP study, later surgery has the advantage of allowing better delineation of the area of necrosis or liquefaction of the same, resulting in the formation of a pancreatic abscess, the resolution is easier and can be treated by percutaneous drainage. Early intervention is associated with increased mortality and unnecessary procedures.
An unusual cause of chronic diarrhea and weight loss. Bibliographic review and case reports.

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1. OBJECTIVES
Bibliographic review about diagnostic and therapeutic management of olmesartan-related chronic diarrhea. Reporting of actual cases from our Hospital.

2. METHODS
A review of scientific evidence about diarrhea related to treatment with olmesartan was conducted, following Haynes 6S hierarchy. Additionally, our Hospital data-base was accessed to retrieve diagnosis in discharging reports of diarrhea/malabsorption syndrome related to olmesartan or others angiotensin II receptor blockers (ARBs).

3. RESULTS
In 2013, FDA reported olmesartan-associated sprue-like syndrome very similar to celiac disease, characterized by villous atrophy in intestinal biopsy (98%), intraepithelial lymphocytes (65%) and negative antibodies for celiac disease (100%); genetic study for celiac disease was also negative. A French nationwide observational cohort study (Basson M, et al. Gut 2016) observed increased risk of hospitalisation for intestinal malabsorption syndrome in patients receiving olmesartan. This relative risk increased with treatment duration. Such risk was not found for other ARBs.

Three cases were found in our hospital within a period of 2 years: 2 females and 1 male, median age 68, all receiving olmesartan for several years. The clinical presentation was similar: severe diarrhea associating acute kidney injury. A study was conducted, discarding celiac sprue, yet findings in duodenal biopsy were consistent with celiac disease. Resolution of symptoms was observed after cessation of olmesartan. Restitution of mucosal indemnity was confirmed in two cases.

4. CONCLUSION
Olmesartan should be included in the differential diagnosis of chronic diarrhea. A basic study discarding celiac disease may be sufficient for diagnosis if clinical improvement is evident after olmesartan cessation, thus avoiding invasive tests.
An unusual cause of chronic diarrhea: Plastron appendicitis

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Introduction: Plastron appendicitis is an abscess formation that occurs when the appendix is surrounded by the omentum following perforation of acute appendicitis [1]. The cases usually present with abdominal pain, nausea, vomiting, and abdominal mass. Chronic diarrhea due to plastron appendicitis is a very rare clinical condition. A limited number of cases were mentioned in the literature. In this case report, a case who applied with chronic diarrhea and intermittent abdominal pain and diagnosed as plastron appendicitis is discussed.

Case description: A 63-year-old male patient was admitted to our clinic with diarrhea and intermittent abdominal pain for 3 months. The patient had mucoid-runny diarrhea 3-4 times a day. He had visceral pain at periumbilical region relieving with diarrhea. On physical examination; fever was 36 °C, pulse was 82/min, arterial blood pressure was 130/80 mmHg. He had abdominal distention, increased bowel sounds and ileocecal tenderness with deep palpation. Abnormal laboratory findings were white blood cell: 14,000/uL, C-reactive protein: 185 mg/L, erythrocyte sedimentation rate:60 mm/h. Celiac markers were negative. Many leukocytes were seen in the stool microscopy. No parasitic organism was identified. In stool culture, no specific microorganism was detected. Inflammation of intestinal loops, omental inflammatory thickening and 7x5x4 cm fluid collection in pericaecal area were observed on ultrasonography. Abdominal computed tomography revealed a hyperdense area of 12x16 mm in heterogeneous structure within the anterior mesenteric fat tissue at the ileocecal valve level. It was found to be compatible with plastron appendicitis. The patient was hydrated. He was started on empiric cefixime 1x100 mg metronidazole 3x500 mg. Elective appendectomy operation was performed 6 weeks later.

Discussion: Plastron appendicitis should be kept in mind as a differential diagnosis during investigating the causes of chronic diarrhea.
**Introduction**
Ascites results from accumulation of fluid in the peritoneal cavity. Its most common cause is portal hypertension resulting from hepatic cirrhosis, but it can be caused by malignancy or heart failure.

**Case description**
A 79-year-old female is referred to the Emergency Department for an increase in abdominal volume during the last 3 weeks. Patient has a history of right-sided heart failure with cardiac ascites. At the entrance ultrasound she presented with "loculated ascites in all quadrants". Cardiology discarded ascites of cardiac origin.

She was admitted to Internal Medicine for the etiological study of the ascites. Diagnostic paracentesis was attempted with drainage of serohematic contents in small quantity. Abdominal ultrasound "without signs of ascites, massive mucinous tumor". A thoraco-abdomino-pelvic computed tomography (CT) scan reported "hypodense mass of rounded morphology in the uterus" and "bulky amount of non-pure hypodense fluid containing spontaneously hyperdensed areas with a non-typical distribution of peritoneal fluid".

A case discussion with General Surgery and Gynecology placed the diagnostic hypothesis of peritoneal pseudomyxoma.

Patient underwent exploratory laparotomy that noted an "absence of ascites" and a "giant tumor of uncertain origin that extended from the pelvis to the epigastrium with various adhesions to the abdominal wall". Histological diagnosis did not present malignancy characteristics.

**Discussion**
Peritoneal pseudomyxoma is a unique condition characterized by diffuse collections of gelatinous material in the abdomen and pelvic region. We present a case in which, although there was no histological confirmation, the diagnostic process was not the one expected in a patient hospitalized for etiological study of ascites with a history of heart failure.
Autoimmune hepatitis in an elderly Portuguese population

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Autoimmune hepatitis is a chronic, inflammatory liver disease characterized by the presence of autoantibodies, elevated levels of immunoglobulin G and specific histological features. In Europe, it has an incidence of 0.9-2/100,000 inhabitants per year. Usually, it presents a fluctuating and heterogeneous trajectory, with a wide variability of clinical manifestations. The AIH approach is a diagnostic and therapeutical challenge. The treatment aims biochemical and histological remission in order to prevent the progression of liver disease.

Objectives: to performed an epidemiologic investigation to describe the incidence and prevalence of AIH in a defined population. It was also investigated the clinical, laboratory profile and histological findings in the time of diagnosis and evaluated treatment approach and side effects.

Methods: Patients with AIH attending the hepatology consult in a period from 2009-2016. This Hospital serves a defined population of 137,000 inhabitants.

Results: During a 7 year period, a total of 12 patients were diagnosed of AIH. There was observed different disease presentation forms (58% with nonspecific symptoms, 75% with impaired hepatic function in a routine laboratory study, 8% with encephalopathy and 8% with fulminant hepatitis. The mean age of diagnosis was 58.1 years. The mean annual incidence was 1.9. The point prevalence per 100,000 was 15.8. All patients had impaired hepatic function. One patient underwent a liver transplant. All patients underwent liver biopsy. Clinical and biochemical remission were observed in 10 patients. The most common side effects of treatment were corticoid-induced diabetes and leukopenia.

Conclusion: These epidemiologic data can be useful to evaluate the demographics aspects of a population of AIH in comparison with the literature. It also allows the medical time to assess the liver behavior in this particular entity as well the number of liver transplantations required due to autoimmune liver disease.
INTRODUCTION
Acute pancreatitis (AP) is characterized by the onset of parenchymal and peripankreatic fat necrosis. Gallstones and alcohol abuse are the most common causes of AP. Drugs are responsible for 0.1%-2% of acute pancreatitis cases. In this case we present a patient with AP after azathioprine treatment for Takayasu Arteritis.

CASE REPORT
A 50-year-old woman who had type 2 diabetes mellitus and Takayasu Arteritis presented to emergency department with a history of central abdominal pain and vomiting. Her current medications were metformin, azathioprine, metoprolol, apixaban. The azathioprine treatment was started 15 days before for Takayasu arteritis. Her initial white cell count was 8800/µL, an amylase level was 166u/L, and a lipase level was 160u/L. A recent lipid profile was normal and her corrected calcium level was 9 mg/dL. The diagnosis was confirmed by abdominal ultrasound and abdominal CT. Her abdominal CT showed no evidence of gallstones. She was abstinent of alcohol, had a normal serum calcium level and had no family history of pancreatitis or hyperlipidemia, moreover no history of trauma. After exclusion of other causes we diagnosed acute pancreatitis secondary to azathioprine. Standard acute pancreatitis treatment was administered.

Azathioprine medication was discontinued. Her amylase level decreased and symptoms relieved.

DISCUSSION
Pancreatitis is a serious condition and has a significant morbidity and mortality. Drug induced pancreatitis can be diagnosed by exclusion of other causes. It has generally a milder clinical presentation than other causes. The recovery of pancreatitis after drug discontinuation could confirm the diagnosis. In this case; we discontinued azathioprine and observed that clinical progression began to regressing. We concluded that acute pancreatitis can be considered a side effect of the azathioprine treatment.
INTRODUCTION
Autoimmune hepatitis and sclerosing cholangitis are disorders with a non-clearly defined pathogenesis and highly variable clinical presentation, which chronic liver and biliary inflammation caused by immunologic phenomena are the core feature. The overlap between these two disorders is known as rare, even though underdiagnosed. Despite a few descriptions in literature of these overlap syndromes, there are still no guidelines for its management.

CASE DESCRIPTION
We present a case of type I AIH and SC overlap in a 57-year-old female patient, who was admitted to the ER with recent noticeable jaundice with rapid worsening, choluria and acholic stools, and a 2-month history of nausea and vomiting. Diagnostic workup revealed liver transaminases with hepatic cytolysis pattern (AST 1026IU/L; ALT 882IU/L), markedly elevated total bilirubin (23mg/dL), mostly unconjugated (18mg/dl). Viral hepatitis and acute biliary obstruction were excluded. Toxic hepatitis was considered a low probability diagnosis. Autoimmune study revealed positive antinuclear, anti-smooth muscle and F-actin antibodies, leading to the initial diagnose of type 1 AIH. Mild persistent cholestasis markers leaded to further investigation with MRCP, which revealed intrahepatic bile ducts’ stenosis with rosary sign pattern, highly favorable to the diagnosis of SC. ERCP was performed and excluded cholangiocarcinoma, and placement of biliary prostheses was perfomed. The patient showed clinical and analytical improvement with concomitant course of corticorticotherapy and ursodeoxycholic acid.

DISCUSSION
The overlap between AIH and SC is extremely rare. The management of the case was very challenging, facing the absence of standardized recommendations. Diagnostic approach and treatment is detailed and discussed in the setting of best evidence available, but high clinical suspicion and individually guided management is essential.
Celiac disease - late onset with normal macroscopic aspect of duodenum

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Introduction:
Celiac disease is a chronic, multiple- organ, autoimmune disease affecting small intestine in genetically predisposed children and adults, induced by gluten .Clinical presentation varies widely, the incidence increased over the last 20 years and onset may be any time in life.

Case description
We present the case of a 62 years old woman, admitted in the internal medicine department for anorexia, weakness and weight loss (7 kg in 3 months). Personal history - Hypertension - treated and a recent depression with no medication; 2 normal births.
At physical examination - BMI was 18,5, pale- dry skin, positive Chwostek sign . Investigations- for the weight loss - blood tests, abdominal ultrasound, gastroscopy ( normal macroscopic aspect), colonoscopy, chest X-ray, gynecologic exam, tumoral and viral markers, etc. were normal, except: mild normochromic, normocytic anemia, low sideremia and normal folate- vit B12 levels, hypocalcemia, slightly elevated transaminases and alkaline phosphatase. We continued for malabsorption and autoimmune diseases and found very high levels of Anti-tissue transglutaminase IgA and anti- endomysium antibodies. We insisted to the gastroenterologist to repeat gastroscopy, she took biopsy from the "normal" D2 and the result was - celiac disease, MARSH grade 3A (lymphocytic infiltrate, crypt hyperplasia, partial villous atrophy).

Discussions and conclusion
We must consider celiac disease as a possible diagnosis of malabsorption and weight loss even at an 62 years old patient with an untreated depression and a first normal endoscopy. As association we found autoimmune hepatitis .
Patient must be followed up for the risk of intestinal lymphoma and esophageal cancer.
Introduction: Hodgkin’s lymphoma is a common malignancy with a high cure potential and a bimodal distribution, afflicting more men, aged between 20-40 and over 55 years. Presenting clinically with painless lymphadenopathy, mostly cervical, fever, night sweats and unexplained weight loss, being diarrhea a rare symptom.

Case description: Male, 36 years, mechanic. No history of smoking, drinking or recent travel was reported. The patient presented with 6 months diarrhea, with 5/6 dejections per day, without blood or mucous, and an unexplained weight loss of 12kg in 2 months. At examination, supraclavicular lymphadenopathy and cutaneous xerosis were noted.

Laboratory studies showed an increased SV and CRP (100mm/1ªh and 153 mg/L), augmented ferritin as well as an important hypergamaglobulinemia.

CT scan showed multiple mediastinal and supraclavicular lymph nodes, hepatosplenomegaly and left para-aortic lymphadenopathy. The endoscopic study with biopsies was normal.

The diagnosis was reached by excisional biopsy of a supraclavicular lymph node which revealed Hodgkin’s lymphoma, mixed cellularity type.

The patient has completed five courses of chemotherapy with ABVD, with remission of the symptoms.

Discussion: Diarrhea is a common symptom, often underestimated, with multiple etiologies, infectious (one of its major contributors), metabolic, auto-immune and malignant. In this case, the aggressive clinical presentation might be explained by the exuberance of the pro-inflammatory status. Therefore, it is important to investigate and exclude possible treatable causes of diarrhea, including the more unusual ones.
Chronic pelvic pain associated to irritable bowel syndrome, a new perspective

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Introduction Chronic pelvic pain (CPP) is often reported in female patients with irritable bowel syndrome (IBS). The aim of this study was to explore some insights of these two functional pain conditions, sometimes associated.

Patients and Methods 40 female patients, age under 45 years, with confirmed IBS (Rome III), joined this pilot study, being assigned into 2 groups based upon the presence of CPP (EAU, 2014): 20 patients CPP negative vs. 20 patients CPP positive. A lot of diseases and conditions were ruled out. Patients undertook a thoroughly clinical examination, with the assessment of concurrent pains: fibromyalgia (FM), headaches (MIDAS-migraine disability assessment), temporo-mandibular joint disorder (TMJD) and anxiety (GAD).

Symptoms relevant for CPP: urinary urge, cystalgia and dyspareunia were scored using a scale ranging from 0=absent to 6=very severe. Biochemical works up: blood, urine (biochemistry, cytology, microbiology), stool exams including microbiology with semiquantitative assessment of dysbiosis (DB): 0=absent, 1=mild, 2=medium, 3=severe, were run. Digestive and bladder endoscopies, abdominal and pelvic ultrasound and CT were also performed.

Results: TMJD (p=0.06) and headaches (MIDAS; p=0.07) were often present in CPP positive patients. However, DB (p=0.0001), FM (p=0.0001) and anxiety (GAD; p=0.03) were significantly present and at higher range of severity in CPP positive group. DB was positively good correlated to CPP symptoms: urinary urge (r=0.53), dyspareunia (r=0.48) and cystalgia (r=0.41).

Conclusions: Female patients with CPP associated to IBS experienced significantly higher rates of FM and anxiety, along with significant intestinal microbiota alterations. In these patients DB was good correlated to urinary urge, dyspareunia and cystalgia.
Colonic pseudo-obstruction in the very old - a serious problem

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Introduction:
Old age and some neurologic conditions make our elderly often bedridden and dependent on neuroleptic medication. In these patients obstipation is frequent. Its most serious form is pseudo-obstruction - also known as Olgivie's syndrome.

Case description:
An 88-year-old patient with severe Parkinson's disease and dementia was admitted to the Internal Medicine department. He was totally dependent on others, bedridden and institutionalized. His medication was levodopa/carbidopa in high dosages.
He was admitted due to severe hypokalemia (K+ 2.6 mmol/L) and severe diarrhea. His abdomen was very distended with tympanitic sounds on percussion. We performed an abdominal x-ray that showed severe colonic distension with no signs of obstruction.
GI decompression was done with nasogastric intubation and rectal tube placement. There was significant improvement.
Electrolytes were corrected and his medication was adjusted with dosage tapering.

Discussion:
Olgivie's syndrome is characterized by acute colonic dilatation without intestinal obstruction. It is very frequent in institutionalized patients with multiple co-morbidities, especially with severe neurological diseases.
Hyperbilirubinemia, whatever its cause, is presented at physical examination as jaundice, for bilirubinemia values ≥3mg/dL. Jaundice was first described by William Osler as being the yellow coloration of the skin and conjunctivae. However, the first place where it can be observed has been the subject of discussion between the sclera and the conjunctiva, considering the physical and structural characteristics of these two layers and the affinity of bilirubin for each of them. Through this clinical case we propose a reflection about the term "conjunctival icterus".

A 54-years-old female, hospitalized in an intensive care unit during 5 months for severe acute pancreatitis with maintained hyperbilirubinemia (total bilirubin= 6mg/dL, direct= 4mg/dL), hypoalbuminemia (1.8g/dL) with consequent generalized edema.

Figure 1 shows asymmetric conjunctival edema (chemosis) accumulated at the left ocular ends due to left lateral decubitus for a few hours following the alternation of decubitus. This edema (transudate) is constituted in the integrity of the fibrous layer of the conjunctiva lamina propria, since it is in this layer that there is abundance of blood vessels. This innermost layer of the conjunctiva is a mesh of collagen and elastin fibers for which bilirubin has large electrostatic affinity. The sclera, although rich in elastin fibers in the innermost layers, has a sparse vascularity, mostly at the expense of the conjunctival vessels and its outermost conjunctival layer (episclera).

In this image the yellow coloration of the conjunctival chemosis is observed, while the sclera remains white in the free edema areas. This demonstrates the consistency of the term "conjunctival icterus" rather than focusing the sclera as the site of bilirubin deposition. It is even more true in jaundice of recent evolution, since penetration of bilirubin into the innermost layers of the sclera is less likely given its poor vascularity.
Descriptive study of acute pancreatitis in a tertiary hospital in the last year

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Objectives: Acute pancreatitis is one of the most frequent causes of hospital admission due to digestive disease. The aim of this hospital-based study was to define the epidemiological and clinical characteristics including the microbial agents, therapeutic options and antimicrobial agents, and severity of patients with acute pancreatitis.

Methods: Retrospective descriptive analysis of patients with diagnosis at discharge of acute pancreatitis in the last year, from January to June, 2017, in our hospital.

Results: The study group consisted of 77 patients, 45% males and 55% females, age range 28-93 years (mean 68 ± 16 years). The underlying causes were: lithiasis 58%, tobacco 33%, alcohol 27%, obesity 22%, diabetes 16%, hypertriglyceridemia 20%, post-ERCP 10%. 15 patients (20%) had a history of previous pancreatitis and 11 patients (15%) re-entered during this period. 17 patients (22%) had sepsis criteria and 5 patients (7%) required admission to the intensive care unit (ICU). 5 patients (7%) died. Necrotizing pancreatitis appeared only in 3 patients (4%). 6 patients (8%) had associated bacteremia, mostly due to Gram-positive bacteria 4%, Gram-negative bacteria 2.6% and Candida albicans 1.3%. There was a microbiological isolation in 5.2% of the pancreatic drainages: 2.6% Gram-negative, 1.3% C.albicans and 1.3% polymicrobial. Antibiotic treatment was prescribed in 39%, with an average of 9 ± 13 days, meropenem 22%, piperacillin-tazobactam 16%, amoxicillin-clavulanic acid 9%, cephalosporins 6%, and fluconazole 4%.

Conclusion: The most frequent cause of acute pancreatitis is lithiasis. The majority associated comorbidities and had mild pancreatitis. A small percentage had criteria for sepsis and needed admission to ICU. Mortality is low and few necrotizing pancreatitis were registered. The most used antibiotic is meropenem and antifungal, fluconazole. These conclusions are similar to the rest of the series published in the literature.
INTRODUCTION
The posterior circulation cerebrovascular stroke syndromes are probably the most challenging ones, specially when presenting with few and more uncommon symptoms.

CASE DESCRIPTION
A 82-year-old male, with history of arterial hypertension, dyslipidemia and perypheral vertigo, presented in his primary care doctor appointment with vertigo, gait disturbance and vomiting being diagnosed with perypheral vertigo exacerbation. These symptoms improved but hiccups started after a few days. He went for 3 times to the immediate care (IC) being discharged with clorpromazine titration after a normal thoracoabdominal CT scan and otolaryngologist evaluation. For its persistence he was admitted at the Internal Medicine IC and on clinical examination he had unstable gait, mild dysphonia and dysmetria. A central cause was then suspected, he was submitted to a head CT scan that didn’t show acute lesions, but the head MRI and its angiography confirmed a bulbar ischaemic stroke with an occluded right intracranial vertebral artery. He had clinical improvement except for the hiccups with the need to further titrate the clorpromazine dosage, add baclofen and haloperidol. He had a good outcome, with a gradual treatment decalation until the lowest possible dose of baclofen alone.

DISCUSSION
Hiccups are relatively uncommon in the bulbar stroke and can be easily disregarded at first. It also can be difficult to treat, leadind to complications and a negative impact on a patient quality life. His past history of a perypheral vertigo contributed to a delay in the diagnosis, so this case aims to adress the significance of a thorough evaluation, having always in mind the rarer but also more serious differential diagnosis.
Dysphagia - a case report

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Dysphagia is the difficulty in initiating swallowing, or the feeling of food retained, somehow, during passage from the mouth to the stomach. It may be of obstructive cause, due to neuromuscular disease or other.

CASE Report: The authors present a clinical case of a 32-year-old male, melanodermic, student and with no personal history. The patient is referred for dysphagia to progressive aggravating solids with 6 months of evolution, accompanied by loss weight of 8 kg and hyperpigmented spots on the tongue. He still complained of an unquantified feverish feeling intermittently in the last month. The observation shows poor general condition, cutaneous-mucosal pallor and exuberant nodular lesions on the tongue. Without adenopathies. No other gastrointestinal complaints and other organs or systems. Of the complementary exams, microcytic and hypochromic anemia (Hb 8.9g / dl); positive HIV serology with high viral load; CD4 low. EDA with nodular mucosal infiltrate at pharynx, glottis and arytenoids; infiltrative gastropathy of the body. Thoracic and abdominal CT revealed bilaterally dispersed alveolar micro-nodular lesions and hepatic splenomegaly. He also performed BFO that showed reddish spots and infiltrated by nodular lesion at the glottic, epiglottis and arytenoid region. Histopathological examination confirmed the diagnosis of visceral Kaposi. Initiated therapy with antiretroviral, Cotrimoxazole, Omeprazole and Paclitaxel® with satisfactory evolution. After 6 months, significant lesion reduction and infection control.

CONCLUSION. After a diagnostic, the conclusion was that of visceral Kaposi's sarcoma, an infrequent and atypical form of presentation in patients with HIV infection. Improvement was observed with the therapy instituted.
Eosinophilic gastroenteritis

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Introduction and case description
A 79 year old woman hypertensive and dyslipidemic was admitted at the hospital due to constitutional syndrome and postprandial epigastralgia irradiated towards the right hypochondrium. The analytics showed leukocytosis with neutrophilia, PCR 661 g/dl, albumin 1.9 g/dl, total proteins 4.8 g/dl and normal transaminases, GGT, AF and bilirubin levels. A broad serology was negative as well as coproculture, Clostridium difficile toxin, celiac disease screening and ANAs and ANCAs. The abdominal TC revealed dilatation of the duodenal bulb with fluid inside and in small bowel loops without free fluid. Esophagogyastroduodenoscopy (EGD) showed multiple gastroduodenal ulcers and there where noticed ulcerations in the right colon by colonoscopy. Biopsies reported regenerative mucosa not compatible with ischemia, inflammatory bowel disease or cytomegalovirus infection. Parenteral nutrition and treatment with PPIs are maintained without improvement. According to findings in complementary tests not concordant with the clinical and patient evolution, new EGD was performed and now, biopsy revealed an erythematous duodenopathy with chronic inflammation rich in eosinophils. Oral corticosteroid was started with excellent response.

Discussion
Our patient met diagnostic criteria for eosinophilic gastroenteritis (EGE) described by Klein et al: gastrointestinal symptoms, histological demonstration of eosinophilic infiltration in one or more divisions of the gastrointestinal tract, absence of infestation by parasites and exclusion of other differential diagnoses. The EGE is an infrequent entity of unknown etiology. It affects any age group. Diagnosis is not easy because clinical non-specificity and wide differential diagnosis that includes: inflammatory bowel disease, vasculitis, celiac disease and neoplasms.
Episcleritis and Pyoderma Gangrenosum: extra-intestinal manifestations as initial presentation of Crohn's Disease.

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Introduction:

Crohn's Disease is a systemic inflammatory condition characterized by transmural, focal and asymmetric involvement of any portion of the digestive tube, with preponderance of the ileum, colon and perianal area. Clinical presentation may occur with extraintestinal manifestations.

Case report:

A 31-year-old male patient, without previous comorbidities, admitted at the hospital with a history of fever, hypoxia and liquid diarrhea with blood and mucus in the last 12 days. Hyperemia appeared in the left eye 2 days after the onset of the condition, without purulent discharge, pruritus or visual acuity reduction. He also presented vesicular lesions in the lower right limb that evolved for ulceration. Physical examination showed conjunctival hyperemia in the left eye. Cardiac and respiratory auscultation unaltered, and right lower limb with medial malleolar ulcer of poorly defined contours, dirty bottom and granulations. Ophthalmic evaluation identified episcleritis in the affected eye. The skin wounds suggested pyoderma gangrenosum, confirmed by biopsy later on. Both the HIV serologic testing an the rheumatologic markers were negative. Colonoscopy revealed stenosis that prevented the progression of the device after 20cm, with edematous and ulcerated regions interspersed by areas of mucosa with no alterations. The colon biopsy has indicated inflammatory cellular infiltrate and destruction of the intestinal crypt architecture, sugesting Chron's Disease. It was started a pulse therapy with methylprednisolone, followed by maintenance with prednisone 60mg / day and mesalamine 4g / day. After therapy, the patient evolved with improvement of diarrhea and remission of the ocular and dermatological lesion, being discharged for outpatient follow-up.

Conclusion:

The incidence of Crohn's Disease is increasing worldwide, what turns essential the knowledge of it's manifestations in order to aid in diagnosis and management, providing a better quality of life to the patients.
Introduction. Infective endocarditis portends dismal prognosis, especially when surgery becomes necessary in the most ill patient. Acute liver failure as a consequence of valve dysfunction and sepsis is poorly reported, though it represents a major limitation to cardiopulmonary bypass and evidence on alternate salvage therapies is lacking. Herein we report a case that portrays such complexity and review the literature.

Case description. 34-year-old woman with rheumatic disease underwent biological mitral replacement in January, 2018. She developed breathlessness, coughing and fever, which prompted oral antibiotics and later rehospitalization as abdominal pain, diarrhea and vomiting ensued. Stable, presented thrombocytopenia and impaired liver and kidney function. Hepatotoxic drugs were withdrawn and echocardiogram showed severe prosthetic dysfunction related to a vegetation 4x6mm. Within 48h, hepatic encephalopathy evolved with multi-organ dysfunction. Doppler fluxometry demonstrated reversed hepatopetal pulsatile flow. Heart surgery was unfeasible. Despite broad-spectrum antibiotics, negative water balance and inotropes, the patient died.

Discussion. Cardiac events are the major precipitant for ischemic hepatitis, which rarely leads to acute liver failure. Early echocardiogram and portal Doppler fluxometry are key to the recognition of cardiohepatic syndrome and most cases respond to hemodynamic support. However, in the case of acute endocarditis urgent valve surgery may be the sole intervention to restore hemodynamics and eliminate septic foci. Mortality rates are exceedingly high and dyscrasia may preclude extracorporeal circulation. We found only one case comparable to ours involving a native mitral valve in which the patient underwent simultaneous liver transplantation and heart surgery. Heparin-coated cardiopulmonary bypass systems, dilutional ultrafiltration during bypass and percutaneous procedures have been reported in other scenarios.
A 82-year-old man was admitted to our hospital because of a large subepithelial tumor of the stomach, which was incidentally found on an endoscopy for a routine checkup. Physical examination results were unremarkable. On endoscopic examination, a large, dumbbell shaped, and hard subepithelial tumor was seen on the anterior wall side of low body of the stomach. The tumor showed a well-demarcated smooth border without any erosions and ulcerations. An abdominal pelvic CT demonstrated a large subepithelial tumor without regional lymphadenopathy. EUS showed a 4.5 cm sized, multiseptated hypoechoic mass in the submucosal layer. Initial EUS-FNB specimen showed monotonous lymphoid cell aggregation with CD20 positive. Immunohistochemical stain of CD20 showed that these lymphoid cells originated from B cells. However, there is no mucosal layer in this specimen and lymphoepithelial lesions can not be confirmed, although diffuse lymphocytic infiltration findings support the possibility of mucosa-associated lymphoid tissue lymphoma (MALToma). Bite-on-bite re-biopsy was performed for histologic examination including mucosal layer. Results of a histopathologic examination of the tumor showed diffuse lymphocytic infiltrations with suspicious lymphoepithelial lesions. Immunohistochemical stain of cytokeratin also showed suspicious lymphoepithelial lesions. And the monoclonality of the lymphoid cells was proved by the IgH gene rearrangement analysis. Histologically, many H. pylori were also observed in the luminal side. Finally, the patient was diagnosed as having a H. pylori–positive extranodal marginal zone B-cell lymphoma (MALToma) (stage EI1; Ann Arbor classification of extranodal lymphoma, modified by Musshoff) and then underwent H. pylori eradication. The successful eradication was confirmed 6 weeks later. However, the follow-up endoscopic examination until 6 months after H. pylori eradication showed no interval changes. Therefore, he is currently undergoing radiation therapy.
Gastrointestinal and liver diseases
A-1061

Gastrointestinal Bleeding (GIB) in an Internal Medical Department of a Third Level Hospital: Descriptive Study.

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OBJECTIVES: describe the patients admitted with diagnosis of GIB with anticoagulan, antiaggregant or both therapies.

METHODS: descriptive, cross-sectional and retrospective observational study of patients admitted to IMD with diagnosis of GIB at the HUMV during 2016.

RESULTS: n=73, 45 women, mean age 81(41-97). Charlson scale 6.5(1-13).
Medical antecedents: hypertension79%, atrial fibrillation-AF42% [CHADsVASc2 4,8(3-8), HAS-BLEED 3,3(1-6)], peptic ulcer38%, diabetes mellitus32%, dementia25%, heart failure17%, CKD, cerebrovascular disease, COPD, Ischemic heart disease, solid tumors.
Receiving anticoagulan46%, antiaggregant36%[Aspirin(30%), Clopidogrel(3%), dual-antiplatelet-therapy(3%)] or both drugs12%.
The main causes to receive these treatments: AF26%, stroke8%, pulmonary embolism8%, deep venous thrombosis4%.
The anticoagulants used: vitamin K antagonists-VKA24%, direct oral anticoagulants-DOAC11%, low molecular weight heparin7%, unfractionated heparin4%.
Analytically: hemoglobin 8,5 g/dl(2.8-15.7), prothrombin time 66% (6-100), serum creatinine 1,4mg/dl(0,4-7,1).
Receive blood transfusion 53(79%): 20 antiaggregant, 13 VKA, 8 both drugs, 7 DOAC, 2 dual-antiplatelet-therapy, 3 without treatment.
Receive vitamin K 11(14,5%).
Died 9(12%): 6 adequacy of the therapeutic effort, 3 therapeutic failure.

CONCLUSION: GIB is a frequent complication, with a high mortality rate within the studied population. Have a high comorbidity index, highlighting AF and cardiovascular risk factors, both indications to receive anticoagulant and/or antiaggregant therapy.
The results confirm that in both groups the incidence of GIB was similar.
The aging of the population and the increase in cardiovascular diseases prevalence could lead to the use of double or triple therapy, with the risk of hemorrhagic complications, so that individualization is necessary.
Most of our patients were anticoagulated with VKA, so more study is needed to assess the true incidence of GIB complications with the DOAC.
Hepcidin in morbidly obese women with nonalcoholic fatty liver disease

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OBJECTIVES: Non-alcoholic fatty liver disease (NAFLD) is the most common cause of chronic liver disease in Western countries. Both iron and lipid metabolism seem to be involved in its pathogenesis. We aimed to assess the relationship between levels of hepcidin in plasma and the presence of NAFLD in morbidly obese (MO) patients, and to investigate the association between the hepatic expression of the main iron and lipid metabolism-related genes.

METHODS: Enzyme-linked immunosorbent assay was used to measure plasma hepcidin levels in 49 normal-weight control women, 23 MO women with normal liver (NL) histology and 46 MO women with NAFLD. The mRNA expression of hepcidin, the main iron metabolism-related genes, and the main lipid-metabolism genes was quantified by qRT-PCR in liver biopsies from members of the MO group undergoing bariatric surgery.

RESULTS: Our cohort of 118 women was classified according to the body mass index and hepatic histology into normal-weight, morbidly obese with normal liver histology, and morbidly obese with NAFLD. Circulating hepcidin levels were significantly greater in MO than in normal-weight control women. However, there were no significant differences between MO women with NL and those with NAFLD. In addition, plasma hepcidin concentrations positively correlated with the hepatic expression of hepcidin and the biochemical parameters of iron status (ferritin, transferrin saturation and iron levels), and negatively with transferrin levels. PCR analysis showed increased expression of hepcidin, FPN1, TfR1 and TfR2 in the liver of MO NAFLD women compared to those with NL. Moreover, a positive association of hepatic hepcidin mRNA expression and the iron metabolism-related genes was found with some key genes involved in the lipid metabolism.

CONCLUSION: Circulating hepcidin levels are associated with obesity but not with NAFLD. However, the expression seems to play a role in regulating lipid metabolism pathways in liver.
INTRODUCTION
Esophagitis caused by herpes simple virus (HSV) is often documented during immunosuppression and is rare in immunocompetent. It usually presents typical triad consisting on acute odynophagia, chest pain and fever. Diagnosis is usually made endoscopically and typical findings are multiple ulcerating lesions (1 to 2 cm) with whitish exudates in the middistal esophagus. Histological findings of Cowdry type A intranuclear inclusions and multinucleated giant cells are typical. Finally specific diagnostic procedures are neccessary as virus culture, immuno-histochemistry, electron microscopy and in situ hybridation of viral DNA.

METHODS
We analyzed retrospectively patients with herpetic esophagitis from 2006-2016 in a tertiary hospital (Hospital General Universitario Gregorio Marañón, Madrid) and we only found two immunocompetent patients with confirmed diagnosis.

RESULTS
We found two cases of 41 and 27-year-old without any risk factor (Structural and functional esophageal anomalies, stress, contact with people infected with HSV or previous antibiotic therapy). Principal symptoms were dysphagia, fever, and malaise. One of them also presented odynophagia and chest pain, the other one debuted as syncope. Initial diagnosis was made by esophagoscopy (finding multiple confluent ulcers) and confirmation in both was made by virus culture. First patient was treated with Aciclovir while second patient was treated with Famciclovir. None of them had recurrences or complications after first episode.

CONCLUSION
Herpetic esophagitis in immunocompetent is a rare entity that must be suspected initially in young patients with acute odinophagia, chest pain and fever. Initial diagnosis is made endoscopically. Early treatment with Aciclovir decreases risk of complications.
Gastrointestinal and liver diseases
A-1030

How do comorbidities influence the abdominal ultrasound window in the VSCABD study cohort?

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INTRODUCTION: Given the progressive increase in the importance of the use of clinical ultrasound in internal medicine.

OBJECTIVE: To analyze the clinical-pathological characteristics of the patients who were asked for an abdominal ultrasound in Internal Medicine (IM). We focused our attention on the different comorbidities that patients presented and tried to establish which of them predispose to a worse echographic window.

MATERIAL AND METHODS: An observational study of prospective cohorts. Sample of 190 patients who had been assessed by IM was selected and an abdominal ultrasound was requested during their hospitalization between Feb17 and Feb18.

RESULTS: 50.5% were women. Average age: 69.07 years, with 68.9% > 60 years. 19.2% were sick who had life as an armchair/bed-bed. 64 % of the patients had been previously hospitalized (last year).
Cardiovascular Risk Factors: 58,7% had hypertension, 39,7% DM, 28.9% dyslipidemia and 24,2% had heart failure, having suffered 6,4% coronary disease. 14,6% were recognized as smokers, and 18,1% were ex-smokers.
Respiratory pathology: 11,1% COPD and 5,9% asthma, 1 patient shared both. 12,5% were smokers and 47,8% had been smokers. 51,6% of them presented acute respiratory failure and required oxygen therapy during admission.

If we analyze the predisposition to a worse echographic window according to the different variables studied, we did not obtain a statistically significant association for any variable. Although, some variables [acute respiratory failure (p=0.79) and obesity (p=0.150)] are close to this significance and possibly the increase of the sample would increase this significance.

CONCLUSIONS:
Cardiovascular risk factors are the most frequent comorbidities in our sample, highlighting hypertension and DM as the most prevalent
A correlation could not be established between the comorbidities studied and the worst echographic window, although acute respiratory failure and obesity seem to be close to significance.
Introduction: Dysphagia is a subjective symptom that affects a large part of the population over 65 years. It has the potential to result in more severe consequences such as aspiration pneumonitis or malnutrition states. Numerous causes are known, which can be grouped into mechanical (intrinsic or extrinsic) lesions, motility disorders or as a manifestation of a systemic disease. About 15-18% of patients have functional dysphagia, with no established cause.

Case description: A 78-year-old woman is referred to the emergency department for dysphagia for solids, intermittent, with a feeling of food stagnation content at the level of the sternal furcula. She was discharged with dietary measures. By persistence of symptoms returned to the ED. She denied significant weight loss. On physical examination the patient did not shown any significant changes. In the thoracic X-ray, there was ectasia of the aortic arch. Later, she underwent thoracic angioCT scan, which revealed dilation of the proximal 2/3 of the esophagus conditioned by the presence of a pronounced tortuosity of the descending aorta in the transition from the middle third to the lower third of the esophagus with extrinsic compression phenomena. The patient started symptomatic treatment, with improvement of the complaints.

Discussion: Because dysphagia is a symptom of underling disease it can be associated with varied diagnoses. This case remind us that all entities should be counted for it.
Hyperhomocysteinemia and thrombosis in cirrhotic patients

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The liver plays a key role in the metabolism of homocysteine. Hyperhomocysteinemia is a common condition in hepatic cirrhosis and an independent risk factor for thrombosis. Portal vein thrombosis is a potentially fatal complication.

The authors present the case of a 67-year-old male patient, self-employed, with a past medical history of obesity, hypertension, heavy alcoholic habits and no therapeutic compliance. The patient went to the emergency department complaining of abdominal pain and hematochezia with 3 days of evolution. On physical examination the patient presented with grade 2 ascites. Blood tests demonstrated leukocytosis (16.9g/L), thrombocytopenia (52000/L) and cytocholestase. Abdominal computed tomography (CT) revealed partial portal vein thrombosis and complete superior mesenteric vein thrombosis, signs of intestinal vascular suffering and findings consistent with chronic liver disease. Laboratory testing for prothrombotic states revealed hyperhomocysteinemia (21.9umol/L). Serologic and immunological tests were negative. Upper gastrointestinal endoscopy demonstrated portal hypertensive gastropathy. The patient was diagnosed with portal and mesenteric vein thrombosis due to alcoholic cirrhosis (Child-Pugh A5) associated with hyperhomocysteinemia. The patient was treated with enoxaparin for 6 months, folic acid, vitamin B6 and B12 (vitamins throughout lifespan), lactulose, perindopril and amlodipine and alcohol withdrawal. The patient presented clinical and analytical improvement, with permeable spleno-portal vein and no signs of portal vein or mesenteric vein thrombosis accordingly to abdominal CT.

In cirrhotic patients with portal vein thrombosis, the presence of hyperhomocysteinemia should be considered. Portal vein and/or mesenteric vein thrombosis are rare entities that require prompt diagnosis and treatment, based on clinical findings, underlying disease, the extent of thrombosis and comorbidities of the patient.
Hyperprolactinemia as a marker of disease activity in a patient with primary Sjögren’s syndrome: a case report

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Introduction

Prolactin has an important role in the innate and adaptative immune response, and hyperprolactinemia has been described in autoimmune diseases such as primary Sjögren’s syndrome (pSS). We report the case of a 35-year-old woman with pSS whose levels of prolactin correlated disease’s activity, hypothesizing a potential role as a marker of pSS’ activity.

Case description

A 35-year-old woman with pSS treated with prednisone and rituximab was admitted for sharp and diffuse abdominal pain with asthenia and alternating non bloody diarrhea/constipation. After an initial extensive clinical and paraclinical evaluation excluding other etiologies, her symptoms were attributed to pSS. During the course of her hospitalization, she presented a rapid elevation in liver tests and C-reactive protein levels, associated with pancytopenia and agranulocytosis. A complete workout looking for infectious disease was performed as well as a bone marrow biopsy that showed neither infectious nor infiltrative process. A PET scan did not show evidence of a Sjögren’s associated lymphoma, but an anterior hypophysitis was incidentally discovered. Pituitary magnetic resonance imaging demonstrated a T1 hyperintensity of the anterior pituitary, without evidence of adenoma. Laboratory hormonal findings showed hyperprolactinemia in a symptomatic patient with a new galactorrhea. The follow up showed a rapid and spontaneous resolution of symptoms, prolactin levels, liver tests and blood count results. The pancytopenia, hyperprolactinemia, hepatitis as well as the abdominal pain were attributed to pSS.

Discussion

There is inconsistent data regarding the correlation between hyperprolactinemia and autoimmune diseases’ activity. Prolactin up-regulates Th2 cytokines and INF-γ. INF-γ induces leukopenia in pSS patients. Our patient’s PSS activity correlated prolactin levels. We hypothesize that prolactin could be a marker of the disease activity in a subset of patients with pSS.
A 47-year-old woman was admitted in our hospital for investigation of recurrent ascites with a 10 months evolution.
Habits: alcohol consumed in social context.
Routine lab tests were normal except GGT 153U/L; alkaline phosphatase 150 U/L.
Further investigation:
Ascitic fluid: SAAG >1.1g/dL (3 evacuatory paracentesis); negative for aerobic and anaerobic bacteria, negative for fungus, negative for neoplastic cells, Ziehl-Neelsen negative.
Anti-HIV 1/2; HBsAg; HBcAg; Anti-HBe; Anti-HBc IgM; Anti-HCV negative, Anti-CMV IgG positive and anti-CMV IgM negative, Treponema pallidum antibodies not reactive. Epstein Barr antibodies (AB) IgG positive and IgM negative, anti-EBNA1 antibodies not reactive.
The following antibodies were negative: anti-DS-DNA Ab; ANA screening (SSA, SSB, SM, RNP, SM, HS70, JO1); AMA Ab, Anti-smooth muscle Ab, MPO+C-ANCA.
Ceruloplasmin levels 33mg/dL, ACE 11U/L, alfa-fetoprotein 7.7ng/ml, alfa 1-antitrypsin 196mg/dL
CEA 1.1ng/ml; CA 125: 395U/ml; CA 19.9: 31.2 U/ml
Lysosomal lipase deficiency negative
Imaging investigation:
-Thoracic-Abdominal-Pelvic CT scan: pulmonary system normal. Small mass of the left ovary.
-Abdominal and pelvic ultrasound: small left ovarian mass
-PET: small mass on the left ovary.
-ERCP: without alterations
-Abdominal MRI, MR Colangiography: discrete hepatomegaly. Diffuse ductopenia suggesting vanishing duct syndrome
Biopsies: 3 hepatic biopsies- idiopathic non cirrhotic portal hypertension
She was submitted to a laparotomy exploration that ruled out intestinal tuberculosis.
Diagnosis: Idiopathic Non-cirrhotic Portal Hypertension.
The patient is on spironolactone and furosemide, waiting for TIPS in the pre hepatic transplantation phase.
The diagnosis of Idiopathic Portal Hypertension implies a thorough investigation, has a reserved prognostic and is dependent on liver transplantation. The prognosis is reserved and dependent on the response to TIPS and liver transplantation.
Implication of liver enzymes on incident cardiovascular diseases and mortality: A nationwide population-based cohort study

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OBJECTIVES
Although liver enzymes, such as γ-glutamyltransferase (GGT), alanine aminotransferase (ALT), and aspartate aminotransferase (AST), have recently been suggested as risk factors for cardiovascular diseases (CVD), impact on mortality after myocardial infarction (MI) or ischemic stroke (IS) was not previously examined.

METHODS
Using a population-based, nationwide cohort database, we explored the implication of GGT and aminotransferases on the development of CVD and all-cause mortality during a median 9.1 years of follow-up.

RESULTS
Among 16,624,006 Korean adults, both GGT and aminotransferases exhibited a positive relationship with MI, IS, and mortality in a multivariate adjusted model. The adjusted HR of MI was 1.10 (95% CI, 1.07-1.10) in the highest quartile of ALT and 1.05 (95% CI, 1.04-1.06) in the highest quartile of AST compared to their lowest quartile counterparts, respectively. A much stronger relationship between GGT and MI was found, with adjusted HR of 1.27 (95% CI, 1.26-1.29). For IS and all-cause mortality, a similar association with ALT, AST, and GGT was observed, and GGT was the strongest risk indicator (IS: HR, 1.36; 95% CI, 1.34-1.37; Mortality: HR, 1.64; 95% CI, 1.63-1.66). ALT and AST showed U-shaped associations with mortality, whereas GGT showed a positive linear relationship with mortality. The risk of 1-year mortality after MI or IS was significantly higher in the highest quartile of GGT compared to the lowest quartile (HR, 1.46; 95% CI, 1.40-1.52). The implication of GGT on MI, IS, and mortality persisted regardless of traditional cardiovascular risk parameters.

CONCLUSION
This study demonstrated the unique pattern of association of ALT, AST, and GGT with the development of CVD and all-cause mortality in the Korean population. In particular, GGT showed the most robust linear relationship with mortality before and after cardiovascular events independent of risk factors.
Infective Endocarditis and Colorectal Cancer - not to forget

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Introduction
Infective Endocarditis is a relatively common disease in the inpatient’s department. The authors present this case report since its diagnosis lead to the suspicion of undiagnosed cancer.

Case description
A 83 years old man with past medical history of arterial hypertension, type 2 diabetes, status post TB infection, is admitted due to neck pain that started the week before admission. Since there were elevated inflammatory markers there was suspicion of spondylodiscitis. Both CT and MRI scan were performed that excluded this hypothesis - he had uncodiscartrosis C5-7 with radicular compromise and bilateral stenosis in C7. He was started on NSAIDs with clinical improvement but maintained elevation of inflammatory/infectious markers.

He developed a heart murmur that was not present on admission - systolic III/VI audible over the entire precordium. A transthoracic and transesophageal echocardiogram was performed that showed severe mitral regurgitation and a 6mm vegetation in the aortic valve. Endocarditis was diagnosed and he was started on penicillin and gentamycin with a decrease of inflammatory markers.

In two sets of blood cultures, there was growth of Streptococcus gallolyticus. There is known association of this bacteria with colorectal cancer so total colonoscopy was performed, the exam confirmed high grade dysplasia of multiple adenomas.

Due to social conditions the patient couldn't be discharged and developed nosocomial pneumonia with rapid deterioration of is clinical status. He died 48h after.

Discussion
This case was challenging due to the association of endocarditis by S.gallolyticus with colorectal neoplasia. Colorectal cancer is diagnosed in 16-32% of patients with S. gallolyticus bacteriemia, so it is mandatory to exclude cancer.
Iron overload and alcoholism: Results from an alcohol consultation of an internal medicine service

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Objective: To evaluate the relationship between the ferrokinetic parameters and the alcohol intake in patients of a specific alcohol consultation.

Methods: We collected iron metabolism parameters and grams of alcohol of every patient one week prior to the first medical visit to the alcohol consultation. Quantitative variable were expressed as means ± SD. Spearman's rank correlation coefficient (rS) was used for the comparison of quantitative variables. A p value < 0.05 was established as statistically significant. We used the program SPSS v20 for the data processing.

Results: Data from 32 patients were analyze, 62% male with a median age of 32 ± 11 year-old. Regarding iron parameters, median ferritin levels were 467,6 ± 480,7 ug/L, iron saturation index (ISI) 41 ± 25,6 % and transferrin levels 207,8 ± 82 ug/L. The median of daily alcohol consumption was 387 ± 225 grams of alcohol. Transferrin values had a strong inverse association with the grams of alcohol rS - 0.91 (p = 0.706). Ferritin and ISI correlated positively with the grams of alcohol (rS= 0,32 and 0,39 respectively)

Conclusion: Patients with alcoholic liver disease frequently exhibit increased body iron stores. Although it would be necessary a larger sample size to achieve statistical significance, in our study the amount of daily alcohol intake tends to correlate strongly and inversely proportionally with the transferrin levels while ferritin levels tend to increase linearly with daily alcohol consumption. Better understanding of the effects of alcohol in iron metabolism is needed and it may help to propose preventive measures.
Introduction: Helicobacter pylori (H. pylori) has a well-known interaction with the immune system and a consequent downregulation of the immune response that makes it an ideal trigger of autoimmune phenomena.

Case Description: Female, 72 years old, referred to systemic autoimmune diseases appointment due to back pain of mechanical characteristics with a positive analytical profile of autoimmunity. She had personal history of osteoarthrosis, thrombocytopenia, subclinical hypothyroidism and high blood pressure. She was medicated with enalapril 10mg, amlodipine 5mg, gabapentin 300mg 3id and tapentadol 50mg. The first analytical evaluation revealed aggravated thrombocytopenia of $56 \times 10^9/L$ with no other abnormalities in the blood count and coagulation, a normal thyroid and renal function. Regarding autoimmunity there was positive ANAs 1/160 with granular pattern and ENA screen with anti-RNP. The remaining study was negative, including thyroid’s autoantibodies. The HIV, Hepatitis (B and C) and syphilis serologies were negative. The abdominal and thyroid ultrasounds had no significant alterations, the high endoscopy showed a gastric polyp and the biopsies revealed chronic gastritis and H. pylori positivity. Eradication was performed with amoxicillin 1000 mg 2id + clarithromycin 500mg 2id + pantoprazole 40 mg id with a posterior negative respiratory test. Two months after eradication, there was a complete normalization of the autoimmunity pattern, persisting a thrombocytopenia in recovery ($>100 \times 10^9/L$).

Discussion: Strong associations of H. pylori and thrombocytopenia are found in the literature. The role of H. pylori in the majority of autoimmune diseases remains controversial, praising this case as there was full clinical and analytical recovery after eradication.

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Objectives: the liver is a filter of the organism, when it fails a multisystemic affectation occurs in which the liver function is initially impaired severely (INR> 1,5 or prothrombin activity less than 50%), in association with hepatocellular necrosis. There are different classifications of liver failure according to duration (hyperacute, acute, subacute and chronic) or etiology, the most frequent causes being infectious, followed by toxic and infiltrative or autoimmune diseases. Since the causes of liver failure can be of multiple origins, global management is important.

Methods: an observational and retrospective study was carried out through the analysis of medical records of patients over 14 years admitted with a diagnosis of liver failure at the University Hospital of Valladolid years 2013 thru 2017. The following parameters were analyzed: sex, age, admission Service, reason for assessment, acute renal failure at admission, etiology, destination at discharge.

Results: 193 patients with the diagnosis of liver failure were analyzed, 65.3% were men. The average age of the patients analyzed was 58 years, with a higher incidence in their 60s, with 22.28%. 42% of patients were admitted in the Digestive Service followed by 30% in Internal Medicine. The main reason for initial assessment was jaundice in 26% of those analyzed, followed by fever in 14%. In 28% of cases analyzed there was acute renal failure with MDRD <60 mg / dL at admission. The most frequent etiology was toxic in 29.5% of the cases, followed by the infectious one in 17.1%. A biopsy was performed on 15 (7.8%) patients to determine the etiology of the process. 30% of the individuals in our series died and five required a liver transplant.

Conclusion: higher percentage of patients diagnosed with hepatic failure due to pharmacological toxicity. High incidence of renal failure from the beginning of the process. Jaundice was the most frequent clinical manifestation. High percentage of deaths.
Liver fibrosis modifications assessed by transient elastography in patients with sustained viral response after treatment of hepatitis C virus in monoinfected (HCV) and coinfected patients HIV/HCV

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It has been reported that HCV-infected patients with a significant fibrosis status can show a decrease of fibrosis after reaching sustained virological response (SVR), after receiving interferon and ribavirin therapy. To evaluate the variation of fibrosis, assessed by transient elastometry (FibroScan) after eradication of HCV, in patients who received a PEG-interferon and ribavirin therapy and patients treated with direct-action agents (DAA); and to establish any existing associations between fibrosis variation and previous fibrosis status in mono-infected (HCV) as well as co-infected (HCV/HIV) patients.

Methods: Prospective observational study, including 62 patients whose fibrosis was measured previously and subsequently to therapy.

Results: Of the 62 subjects, 45.2 % of them showed a decrease of fibrosis, with an average decrease of 9.45.7 kPa and 45.2% of patients reduced, at least, one Metavir stage. According to pre-treatment fibrosis, 62.5% of F2, 60% of F3 and 40.7% of F4 decrease in stage. We did not found a clear association between pre-treatment fibrosis stage and decrease of fibrosis (p=0.774) and neither was an association with HIV co-infection (p=0.389).
Malnutrition in a patient with history of biliopancreatic diversion with duodenal switch and celiac disease

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Introduction
Bariatric surgery is the most effective kind of treatment for morbid obesity. Among the several options, Biliopancreatic Diversion with Duodenal Switch (BPD/DS) is a procedure with two components: restrictive and malabsorptive. This surgery provides a greater weight loss; however, it also has a greater risk of protein, vitamin and mineral deficiencies.

Case description
A 41 year-old female, with personal history of morbid obesity, was submitted to gastric banding in 2005, which was removed in 2010 due to lack of results. In 2011, the patient was submitted to BPD/DS. After that, she had recurrent episodes of symptomatic sideropenic anaemia, that demanded intravenous iron supplementation. In 2015, the patient presented complaints of asthenia, diarrhoea and peripheral oedema. The following study revealed positive anti-gliadin IgA antibody and gastrointestinal biopsies suggestive of celiac disease. The symptoms improved after implementing a gluten-free diet, which confirmed the diagnosis. In January 2017 and March and April 2018, the patient was hospitalised with symptoms of oedema, malaise and weakness. Laboratorial findings included hypoalbuminemia (January 2017), hypoalbuminemia and sideropenic anaemia (March 2018) and hypoalbuminemia, pancytopenia, vitamin D deficiency and hypolipidemia (April 2018). During the last hospitalisation, it was decided to undergo surgery to increase gastrointestinal absorption area, which was expected to decrease nutrient deficiency.

Discussion
Celiac disease is a common cause of malabsorption of multiple nutrients. It is relevant that patients considered to undergo malabsorptive surgery are screened for malabsorption diseases before intervention, in order to diminish the risk of nutrient deficiencies and conditions associated to those.
Managent of diabetes in the pluripatological patient

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OBJECTIVES
Describing a population of diabetic patients who are admitted in Internal Medicine, by analyzing the treatment changes.

METHODS
Descriptive study that includes diabetics admitted during 2014, excluding patients who died during admission. Variables included were age, sex, creatinine at admission, glycosylated Hb (at admission and three months before) and treatment (at admission and discharge). The insulins were classified as basal, bolobasal, and mixtures. A glycosylated Hb of 7.5% was considered an acceptable control.

RESULTS
From 1003 episodes, the first 179 subjects were included. 49% were men and 51% were women. The average age was 76 years. 54% had kidney failure. 50% of patients had good control of their diabetes. Metformin was the most commonly used drug in admission, presented in 51% of the subjects, with a reduction of up to 42% in discharge. Repaglinide and insulins increased in the prescription. In 41% of the subjects with control, there was modification at discharge, being 20% in the case of the group with good control. Decrease of metformin in the group of poorly controlled patients, well controlled or without glycosylated Hb available.

CONCLUSION
Prevalence of renal failure conditions the treatment of diabetes. A high percentage of patients presents high basal-bolus therapy, the relevance of this cause should be assessed is due to the profile of the patient with multiple pathologies, with risk of hypoglycaemia and unstable intake.
Mesenteric panniculitis presenting with pleural eosinophilic effusion

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Introduction:
Mesenteric panniculitis is an idiopathic chronic inflammation of the mesentery’s adipose tissue which presents frequently with abdominal pain, vomiting and distention. Rarely, it is associated with pleural effusion. There are several designations for this condition and diagnosis is challenging with multiple clinical presentations. Specific findings in computed tomography (CT) helps the diagnosis and prognosis is frequently benign.

Case description:
A thirty-eight-year-old woman presented with epigastric and lower thoracic pain associated with anorexia and asthenia and other signs and symptoms. She had personal history of auto-immune thyroiditis and no use of medication. The physical examination was compatible with pleural effusion and mild ascites. Blood analysis identified anaemia (Hb 10.5 g/dL) and elevated C reactive protein. Thorax x-ray showed signs of bilateral pleural effusion. Thoracentesis identified an eosinophilic exudate and CT showed ascites with moderated volume and abdominal fat nodules with suspicion of malignancy. The initial study focused on a pulmonary cause but there were no other findings and antibiotics were initiated without clinical improvement. No malignancies were found. At this time, corticosteroids were prescribed with significant clinical improvement. CT images were reviewed there was a positive evolution after corticosteroids were initiated which helped to the final diagnosis of mesenteric panniculitis.

Discussion:
Pleural effusion was rarely associated with mesenteric panniculitis, a possible mechanism to this is a diaphragmatic defect that allows fluid leakage to the pleural space. To our knowledge there are very few reports about the characteristics of the pleural effusion associated with mesenteric panniculitis.
Morphological consequences for noncapsular lymphoid tissue in the case of malignancy of gastro-esophageal reflux disease (Barrett's esophagus)

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The research focus. To study lymphoid noncapsular formations of the mucous membrane of the Barrett's esophagus.

The research methods and materials used. Biopsies of Barrett’s esophagus were used in 19 patients. The material was fixed in neutral formalin, the thickness of the cut was 7-8 micrometer, staining: Hematoxylin-Eosin. Histological studies and photomicrographs were performed using a "Leica" microscope.

Results.
a) Postcapillary venules (High endothelial venules) are the precursors of lymphoid formation in the esophageal mucosa.
b) The alteration goes along the gastric and intestinal type.
c) The formation of a noncapsular lymphoid tissue not peculiar to the esophagus (gut-associated lymphoid tissue).
d) In metaplasia, the esophagus becomes a lymphoepithelial organ in the colonic and intestinal type.

Conclusions. In the discussion of the obtained material, it can be said that intraepithelial leukocyte appears in the epithelium of Barrett’s esophagus, its own plate is infiltrated with lymphocytes and follicles are formed. Lymphocytes penetrate the postcapillary venules (insert) through the wall, which recirculates the lymphocytes. From all that has been said, it can be assumed that the lymphoid apparatus in the Barrett's esophagus is included in the lymphopoiesis system and functions as its component part.
INTRODUCTION: The systemic disease related to immunoglobulin G4 (IgG4-RD) is a syndrome of unknown etiology, which occurs more frequently in middle-aged and older men.

DESCRIPTION: A 35-year-old patient with a history of appendicectomy as his only personal history several years ago. He went to the Internal Medicine department, which was referred from the Emergency Department for pain in the right long iliac fossa (presentation in the form of a crisis) accompanied by diarrheic stools without pathological products. Nausea with isolated bilious vomiting. Generalized arthromyalgia. Athermal sensation without thermometrated fever. The patient has gone to his primary care physician multiple times for the same reason with diagnosis of Acute Gastroenteritis (GEA).

It has been evaluated by Digestive performing study of food allergies, 3 colonoscopies, oral endoscopy, Echoendoscopy and abdominal computerized tomography all normal. It presents levels of Ig g4> 150 in addition to having suffered from a pancreatitis of autoimmune origin, according to what it refers to.


Ileocolonoscopy: no macroscopic findings. Pathological anatomy of colonic biopsies compatible with Ig G4 related disease.

Treatment with corticoids is started with a clear response.

DISCUSSION: Most patients respond initially to treatment with glucocorticoids, but relapses are common after the interruption of treatment. The possibility of an increased risk of malignancy in patients with IgG4-DR requires further study.
Not just another abdominal pain

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Introduction:
Crohn’s disease is a not-fully explained medical condition with heterogenous symptoms, as abdominal pain, weight loss and chronic diarrhoea, which may raise a suspicion of this disease, specially among youth.

Case description:
The authors present a case of a 31-years-old male, smoker, with unremarkable medical past history. The patient was admitted in the emergency room (ER) complaining of diffuse abdominal pain, nausea and vomiting with acute onset. He had leucocytosis with neutrophilia. Abdominal CT showed diffusely distended small intestine, ileal wall thickening and enlarged lymph nodes, compatible with terminal ileitis. Stool cultures and serum viral antibodies (Hepatic B Virus, Hepatic C virus and HIV) were negative. There was a positivity for saccharomyces cerevisiae IgA and faecal calprotectin (542 µg/g). Colonoscopy showed cecum oedema and serpentiginous mucosal ulceration of terminal ileus, without further findings. Biopsy of these lesions revealed chronic colitis with inflammatory activity, compatible with inflammatory bowel disease – Crohn’s disease. He was started on corticosteroids therapy (1 mg/kg/day prednisolone) with global clinical improvement and was discharged. The patient was followed in Internal Medicine consult where he was started on immunomodulation therapy with azathioprine (2mg/kg/day).

Discussion:
Correlation between clinical examination, laboratory, imaging and endoscopic studies are of the most importance in diagnosing this condition as there isn’t an isolated gold standard study. Clinical suspicion remains the first and only factor that dictates the study and further diagnosis of Crohn’s disease.
Introduction: Paracetamol is one of the most used drugs worldwide. It is safe at recommended doses but in high-risk populations or overdose may cause hepatotoxicity.

Case description: A 20-year old male was admitted in the emergency department 1.5 hours after voluntary ingestion of 8 to 12 grams of paracetamol. He was asymptomatic and hemodynamically stable. Gastric lavage, decontamination with activated charcoal and 21-hour protocol of acetylcysteine were performed. His initial liver function tests revealed total bilirubin to be 2.8mg/dL with the unconjugated fraction as 1.9mg/dL; International Normalized Ratio was 1.2; no other alterations. On the second day he developed jaundice and total bilirubin levels due to unconjugated fraction significantly increased, with maximal rise 72 hours after (14.53 mg/dL and 14.06 mg/dL, respectively); there were no other changes in the liver enzyme levels nor coagulopathy. Given the finding of isolated indirect hyperbilirubinemia, which is not a typical pattern of paracetamol toxicity, it was hypothesized that there was a Gilbert syndrome aggravated by the ingestion of paracetamol. The genetic study confirmed a homozygous mutation in the UDP-glucuronosyltransferase gene (UGT1A1). The patient was discharged on day 4. His follow was uneventful.

Discussion: There is no clear evidence of increased paracetamol toxicity in patients with Gilbert syndrome. However the therapeutic dose required may be substantially lower due to lower hepatic glucuronidation capacity. So it is important taking into account the implication of relative deficiency of glucuronyl transferase on metabolism and excretion of several drugs, including paracetamol.
Past history of hepatocellular carcinoma is an independent risk factor of treatment failure in the patients with chronic hepatitis C virus infection on direct-acting antivirals treatment.

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Background/Aims: Direct Acting Antivirals (DAAs) against HCV can achieved nearly 100% of sustained virological response (SVR) even in not only elderly patients but also cirrhosis patients, as well as the patients who have had the past history of hepatocellular carcinoma (HCC). In this study, we investigated the clinical features of the patients with the past history of HCC in DAAs therapy and the clinical influences of HCC past history on treatment outcome of DAAs.

Methods: A retrospective cohort study was conducted on HCV patients who were treated with DAAs at our institution or affiliation hospitals in Nagano prefecture between April 2015 and October 2017. Clinical features and treatment outcomes were analyzed.

Results: Of the enrolled 838 patients, 370 were male and 468 were female with a median age of 69 years. Of all, 759 (90.6%) had no history of HCC, HCC (-) group, while 79 (9.4%) had previous history of HCC, HCC (+) group. The frequency of male patients in HCC (+) and HCC (-) were 60.8% and 42.4%, respectively (P=0.006). There were significant differences between HCC (+) and HCC (-) group, such as platelets counts (115 vs. 152 x 10⁹ /L, P<0.001), and baseline AFP (9.9 vs. 4.5 ng/ml, P<0.001), as well as established fibrosis markers of APRI (1.1 vs. 0.7, P=0.009) and FIB-4 Index (4.7 vs. 3.0, P< 0.001), M2BPGi (3.80 vs. 1.78, P< 0.001), Autotaxin (1.91 vs. 1.50, P<0.001). Overall SVR rate was 94.8% with a significant difference between HCC (+) and HCC (-) (87.4 vs. 95.5%, P=0.001). A multivariate analysis proved that the past history of HCC is independently associated with SVR rate (Odd ratio: 4.58, 95% CI: 1.12-18.60, P=0.033).

Conclusions: The patients with past history of HCC showed disease progression. Moreover, the past history of HCC at the initiation of HCV DAAs therapy is significantly associated with DAAs treatment outcome. Therefore, DAAs treatment for HCV should be induced as early stage as possible, specifically before complication of HCC.
Plasmapheresis in acute liver failure: a case report

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INTRODUCTION
Plasmapheresis was first used successfully in 1959 and since then it has become widely available. Today it is a treatment option in several conditions, including those with extremely high bilirubinemia. Scientific evidence for its use in this situation is scarce and most case reports refer to pediatric patients.

CASE DESCRIPTION
38-year-old man, recently diagnosed with stage IV B Hodgkin’s Lymphoma with liver, bone marrow and lymph node infiltration, who was admitted to intensive care unit (ICU) for septic shock with renal and neurological dysfunction.

After admission, the patient was started on broad spectrum antibiotics (no microbiological isolates) as well as respiratory, circulatory and renal support.

During his stay in the ICU, disease progression led to medullary aplasia due to bone marrow infiltration and the patient needed multiple red blood cell and platelet transfusions, along with treatment with granulocyte colony-stimulation factor. Sepsis coupled with hepatic infiltration caused severe liver dysfunction with cholestasis, hypoalbuminemia and coagulopathy. Worsening hyperbilirubinemia, with hepatic encephalopathy, lead to the decision to start the patient on plasmapheresis. Three sessions on alternate days were performed with significant reductions in bilirubinemia and improvement of neurological status, thus allowing the patient to be discharged to the Hematology ward where he was started on second line chemotherapy.

DISCUSSION
Despite the lack of robust evidence supporting the use of plasmapheresis, there is a growing body of literature supporting its use in the treatment of severe liver dysfunction with hyperbilirubinemia and encephalopathy. This case illustrates its successful use and supports the need for further research of plasmapheresis in these situations.
Predisposing risk factors and clinical characteristics of liver cirrhosis in patients with Latent Autoimmune Diabetes in Adults

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Background: Type2 and Type1 diabetes-mellitus are associated with increased risk of liver-cirrhosis. There are no data regarding liver-cirrhosis in patients with Latent Autoimmune Diabetes in Adults (LADA). We examined predisposing factors, prevalence, and clinical-characteristics of liver-cirrhosis in LADA.

Methods: We included 16 patients with LADA (12 men/4 women, 48.7±3.9 years). Follow-up was 6 years. Diagnosis of LADA was made according to the guidelines of the American/Diabetes/Association. Diagnosis of liver-cirrhosis was based on clinical, blood-test analysis, and endoscopic-criteria following the recommendations of the European/Association of Gastroenterology/Hepatology.

Results: Class A liver-cirrhosis, according to the Child-Pugh score, presented in 8 patients (50.0%). Liver-cirrhosis was positively related with central-obesity (p=0.04), worse glycemic control (p=0.02), longer duration of diabetes (>10 years) (p=0.04), presence of cardiac autonomic neuropathy (CAN) (p=0.02), severity of CAN (p=0.04), hyperlipidemia (p=0.05), and renal dysfunction (p=0.02). Liver-cirrhosis was negatively associated with age of diabetes diagnosis (p=0.005), whereas it was positively related with presence of anemia (p=0.04), lower absolute neutrophils number (p=0.02), lower lymphocytes (p=0.05), and monocytes (p=0.05), thrombocytopenia (p=0.05), prolongation of prothrombin-time (p=0.03), INR (p=0.03), and increased total-bilirubin levels (p=0.01). Multivariate-linear-regression analysis, after adjustment for age, and gender, demonstrated that the odds of liver-cirrhosis increased with: longer diabetes duration [1.41 (1.05-1.80), p=0.03], presence of CAN [1.42 (1.04-1.94), p=0.04], severity of CAN [1.60 (1.03-1.24), p=0.02], and lower neutrophils number [1.34 (1.00-1.80), p=0.05]. These variables explained 33% of liver-cirrhosis in the studied patients.

Conclusion: Class A liver-cirrhosis is common in LADA, and is correlated with duration of diabetes, and diabetic complications.
Prevalence of auto immune diseases in patients with coeliac disease

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Background: Patients with coeliac disease (CD) are at high risk of having autoimmune disorders. The aim of this study was to determine the prevalence of the more frequent auto immune diseases (AID) in patients with CD.

Methods: 28 patients with proven CD aged upper 14 years were screened for autoimmune thyroiditis (AIT), type 1 diabetes (T1D) and other AID. Screening was performed by completing a questionnaire which included demographic and medical history information and clinical examination data. All patients were subjected to thyroid biochemical and hormonal examination (thyroid stimulating hormone and free thyroxine), thyroid serological tests (thyroglobulin and thyroid peroxidase antibodies).

Results: An evaluation of 28 patients with mean age 36.39 years (Range: 18-66) and male female ratio at 1/6, revealed 16 patients with AID (57.14%). AIT was the more frequent one with 10 patients (35.71%). Of these 10 cases, 5 patients had subclinical hypothyroidism, 1 had Grave’s disease and the other 4 patients were considered to have Hashimoto’s disease. T1D was found in 2 cases (7.14%). Other AID were found at similar frequency (1 case each one), such as Scleroderma, lupus, autoimmune hepatitis, primary biliary cirrhosis, Crohn’s disease, dermatitis herpetiformis...
5 patients were previously diagnosed for AID, while 7 patients developed associated auto immune disorders later. Synchronous diagnosis of AID and CD was made in 4 cases.

Conclusion:
Current data shows an increased prevalence of AID among patients with CD. Thus, screening for AID especially for AIT in this population is recommended.
We present the case of a 68-year-old woman with no cardiovascular risk factors nor a history of drinking nor smoking. She suffered from dyspepsia and presented increased transaminases in relation to antiinflammatory drugs which she took for sciatica, but then normalized after discontinuation of these drugs. Her family history includes: mother with an unspecified cardiac arrhythmia and a daughter in follow-up due to an autoimmune liver disease.

She is referred to our hospital by her local GP because of a 3-week history of limb edema, increased abdominal perimeter, jaundice, choluria, acholia and elevated serum levels of bilirubin and transaminases. Also, she presented an episode of diarrhea and hematemesis. She denied fever, but had been shivering on occasions throughout the past month. She also suffered from tiredness, had a loss of appetite and weight loss (approximately 2 kg in 1 month). She denied consumption NSAIDs or herbal products or other drugs other than Omeprazole and paracetamol.

During her admission she presented coagulation alterations and refractory low hepatic function; finally, prior to taking a biopsy, corticoid treatment was started with clinical and analytical improvement of the patient.
Proton Bomb Inhibitors (PBI) as a rare cause of pancreatitis

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Introduction: PBI are safe drugs. Acute pancreatitis by PBI is exceptional. We present the fourth case of pancreatitis due to omeprazol.

Case description: A 68 year-old abstemious man, with a well-controlled hypertriglyceridemia treated with gemfibrozil and three episodes of acalculous pancreatitis in the last year, was attended because a new episode of epigastralgia and vomits. No other medical history was related. The patient was treated with omeprazol (20 mg/24 h) from 25 days before, and he refered that in the last year, every time he was treated with omeprazol epigastralgia appeared, and symptoms disappeared as retired. Clinical examination: epigastric pain. Laboratory: amylase 2217 U/I; RCP 21,3 g/L. Hemogram, coagulation, ions, bilirubin, GGT, alkaline phosphatase, lipids, proteinogram and autoimmunity: normal. Abdominal scanner: Aumented pancreas, with homogeneous enhancing and peripancreatic fluid. ERCP: normal. Repeated acalculous pancreatitis was diagnosed and analgesia and absolute diet were initiated. Omeprazol was replaced with ranitdin. A few days later, recovery was observed and the patient have not suffer new events after two years without omeprazol.

Discussion: Diagnosis of drug-induced pancreatitis is difficult and other causes must be ruled out. Symtoms and hyperamylasemia should coincide with the drug administration. Recent works refer until 120 drugs as potential causes of pancreatitis, and categorise them in classes (Ia, Ib, II, III y IV) in descending order of probability. Omeprazol is included in the class Ib (at least one decribed case with a positive rechallenge).
Proton Pump Inhibitor Overuse in Internal Medicine Department

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Objectives
Proton pump inhibitors (PPI) are indicated in the prevention of peptic ulcer disease (PUD), particularly in those receiving nonsteroidal anti-inflammatory drug (NSAID) and in a few gastrointestinal disorders. However, they are widely used in chronic disease and multiple comorbidities patients, despite their possible association with increased intestinal infection and magnesium malabsorption.

Methods
We conducted an observational cross-sectional study to evaluated predictors of PPI prescription in an internal medicine department. Data was collected regarding previous and current PPI prescription, indications for PPI and concomitant medication.

Results
Seventy-eight admission were considered with a mean age of 77 years. Fourty-five patients (58%) were under PPI prior to admission, and 93% of these maintain the prescription during hospital stay. A total of 68 patient (57%) were prescribed PPI during hospital stay. Only eight patients (10%) had history of either PUD or gastroesophageal reflux disease. Twenty-six (38%) were under NSAID, including aspirin. Only a total of 29 of the 68 PPI inpatients were considered under correct prescription. Predictor of PPI prescription were chronic kidney disease, anticoagulation, corticosteroids, stroke and previous stay in intensive care unit.

Conclusion
PPI are over prescribed in our internal medicine department. Discontinuation of PPI in some of the patients would be recommended. Guidelines for prevention of upper gastrointestinal bleeding in hospitalized non-ICU patients might be useful for better use of PPI.
Gastrointestinal and liver diseases
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**Pyoderma gangrenosum in patient with ulcerative rectocolitis treated with infliximab and corticotherapy: case report**

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**INTRODUCTION:**
Pyoderma gangrenosum (PG) is a rare chronic neutrophilic dermatosis, which is an exclusion diagnosis. The lesion is characterized by hemorrhagic pustules and painful, multiple vesicopustules that develops into destructive ulcers. It is estimated an incidence of 3 to 10 cases per million people per year.

**CASE DESCRIPTION:**
A 52-year-old woman, diagnosed with ulcerative retocolitis (UR) in remission using mesalazine 5 g/day and azathioprine 150 mg/day was admitted at the hospital with a painful ulcerated lesion with areas of necrosis in the right calf of approximately one month. Initially, the lesion was nodular, erythematous, painful and evolved to an ulcer with necrotic center, raised violaceous borders and hemorrhagic areas.

Cultures of secretion and tissue and excisional biopsy were collected. The wound secretion culture isolated multisensitive Staphylococcus aureus and the wound tissue fragment culture, Corynebacterium sp. non-diphtheric and coagulase-negative Staphylococcus. Anatomopathological analysis revealed acute neutrophilic dermatitis.

As there was no improvement after the antibiotic therapy and other hypotheses were excluded, PG was diagnosed and started prednisone 1 mg/kg/day for ten days and three doses of infliximab with a fifteen-day interval. Patient evolved with clinical improvement, reducing pain and injury after infliximab.

**DISCUSSION:**
PG is an uncommon neutrophilic disease, usually, an exclusion diagnosis. However, when associated with inflammatory diseases, its diagnosis must be considered earlier, since there is a high association between both conditions. Therapeutic includes antibiotic regimens (to treat associated infections), corticosteroids, immunosuppressants and immunomodulators. The efficacy of infliximab in inflammatory conditions has been established, but its use in PG has been reported in few cases. Although there are no protocols, this case suggests that infliximab is an effective treatment for PG associated with UR.
关系 HLA-DQA1 和十二指肠溃疡穿孔之间的关系

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背景：十二指肠溃疡疾病受环境因素以及遗传因素影响。一些 HLA-DQA1 基因位点在幽门螺杆菌感染和十二指肠溃疡疾病中比例较高。我们描述十二指肠穿孔，即十二指肠溃疡最重要并发症，与 HLA-DQA1 之间的关系。

方法：本研究包括 100 例患者（30 例对照组，30 例十二指肠溃疡，40 例十二指肠溃疡穿孔）。标准组织活检或尿素酶呼气试验用于幽门螺杆菌诊断。采血使用乙二醇四乙酸二钠（EDTA）管。血清样本和血样用于 HLA-DQA1，分别保存于 -20° 和 -80°。

结果：聚合 HLA-DQA1 0101 位点在穿孔组显著较高（P=0.002，P<0.01）。穿孔组胃蛋白酶水平显著高于溃疡组（P=0.001）和正常组（P=0.001）。溃疡组胃蛋白酶水平也显著高于正常组（P=0.001）。

结论：具有 HLA-DQA1*0101 等位基因的患者有十二指肠溃疡穿孔的遗传倾向。
Seronegative Enteropathy – a diagnostic challenge

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Introduction: severe chronic diarrhoea and weight loss in the setting of intestinal villous atrophy and inflammatory infiltrates with negative celiac serologies (sprue-like enteropathy) is a diagnostic challenge with a broad differential diagnosis including autoimmune and drug-induced enteropathies, malignancies, infections, post-infectious enteropathy, and immunodeficient disorders. Case report: a 80-year-old woman with a past medical history of hypertension on olmesartan and hydrochlorothiazide, presented a 3-month history of intense asthenia, anorexia, weight loss and diarrhoea. She had already been treated with antiparasitic, antibiotic and probiotics without symptomatic relief. Also, she had performed esophagogastroduodenoscopy that was normal. On admission, there were volume depletion, hypotension, hypokalemia and acute renal insufficiency. She was admitted for supportive treatment and etiologic study. Hypotensive drugs were suspended with resolution of the clinical symptoms. The abdomino-pelvic computerized tomography was normal, stool culture was unremarkable and lab study revealed a normal IgA and negative tissue transglutaminase IgA. Colonoscopy with biopsies showed chronic inflammation with reactive epithelial changes and prominent lymphocytosis. Assuming the diagnosis of Olmesartan-induced enteropathy, this drug was discontinued and she started on lisinopril. At the 3 month follow-up the patient remained asymptomatic. Conclusion: olmesartan-induced enteropathy clinical presentation, with diarrhoea, weight loss, and nausea, mimics celiac disease. As in this disease, the pathologic findings are villous atrophy and increased intraepithelial lymphocytes, differing by seronegative findings. Physicians who face sprue-like enteropathies, should include this entity in the differential diagnosis, since replacing olmesartan with an alternative antihypertensive drug can simplify the diagnostic workup and provide both clinical and histologic improvement.
Severe coagulopathy due to celiac disease

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INTRODUCTION
Celiac disease is an autoimmune disorder, in which the common manifestations are gastrointestinal symptoms. The prevalence in Europe and USA is about 1%. The interest about extraintestinal symptoms increased in the last years. With all that, a few cases of coagulopathy were reported. This is a case report of celiac disease manifested through severe coagulopathy.

CASE DESCRIPTION
We report a case of a 40 year old man who presented himself in emergency department for multiple spontaneous ecchymosis, swelling and tenseness to the legs over the last 12 hours. He had been prescribed NSAID for renal colic 3 days before presentation.

Clinical exam revealed pale teguments and mucosa, ecchymosis and hematomas to the right forearm, left and right leg.

Laboratory results showed abnormalities of both coagulation pathways. Platelets were normal. Hemoglobin level decreased until 5g/dl. The patient presented also dyselectrolitemia and hypoproteinemia associated with inflammatory syndrome.

We excluded the acute promyelocytic leukemia, hemophilia and a possible organophosphate poisoning.

The CT scan showed intestinal walls thickened due to possible hematomas at this level.

We performed an esophagogastrroduodenoscopy that revealed a typical pattern for celiac disease. The level of antitransglutaminase IG A antibody was increased. Diagnosis was confirmed by histopathological exam.

The clinical and biological evolution of the patient was favorable, after we started the free gluten diet and specific substituted therapy.

DISCUSSION
Spontaneous muscular hematomas represents a very rare manifestation of celiac disease, in this particular case revealed by the consumption of NSAIDs medication.
Sigmoidal Adenocarcinoma as a Late Complication of Ureterosigmoidostomy

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Introduction
We highlight a case of a 45-year-old male with congenital bladder extrophy who underwent ureterosigmoidostomy and developed late-stage adenocarcinoma at the site of the ureterosigmoid stoma causing outflow obstruction and acute kidney injury.

Case description
The patient had congenital bladder extrophy that required surgical reconstruction and ureterosigmoidostomy, at the age of 4 months. At age 20 he suffered from acute ascending pyelonephritis that lead to right-sided nephrectomy. In the subsequent decades he had no further complications and his medical history is insignificant otherwise. In spring 2017, while being evaluated at the urological department, he complained about haematochaezia which was underestimated and thus attributed to haemorrhoidal disease. In November 2017, he was admitted to the emergency department with nausea, vomiting and lower abdominal pain. At the time of admittance, he was found to have acute kidney injury due to hydronephrosis that required haemodialysis. Colonoscopy showed a neoplasm at the site of the ureterosigmoidostomy and a biopsy confirmed poorly-differentiated adenocarcinoma. In January 2018, intestinal resection showed invasive growth and spread. The patient was referred to palliative care.

Discussion
The patient suffered from two of the most common late complications of ureterosigmoidostomy, kidney injury and aggressive malignancy. Due to the high oncological risk this procedure is rarely considered nowadays. However, in patients who had undergone this surgical manipulation, colonoscopy screening should always be mandatory to prevent these predictable sequelae.
Somnolence and back pain at ulcerative colitis patient

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Introduction
The new therapies like monoclonal antibody allow the treatment and control of steroid-refractory and steroid-dependent ulcerative colitis but not without risks.

Case description
A 45 years old male with ulcerative colitis, treated with vedolizumab for over 1 year, consult at Emergency Service by back pain irradiated to L3 dermatome since 5 days and delirium, headache and somnolence at the last 12 hours.
Presented ailed erythematous papules rash at back and left leg over the L3 dermatome.
Blood and urinary test, EKG, thorax x-rays, cranial and abdominal CT were normal.
Meningitis or viral encephalitis was suspected. The biochemical and cytological characteristics of cerebrospinal fluid (CSF) were 359 polymorphonuclear leukocytes, protein 115 mg/dl and glucose 73 mg/dl. This findings suggested the diagnosis of Menigitis-Encephalitis Varicella-zoster virus (VZV) reactivated in immunosuppressed patient, confirmed by CSF PCR. Intravenous Aciclovir during 10 days was the treatment.

Discussion
Herpes zoster is a reactivation of endogenous latent VZV infection within the sensory ganglia. Clinical manifestations of herpes zoster are rash and acute neuritis, but there is an atypical pain syndromes without rash.
Vedolizumab is a recombinant humanized, anti-alpha-4-beta-7 integrin monoclonal antibody effective in remission of ulcerative colitis. This immunosuppression drug allowed VZV extended centrally, resulting patient meningeal inflammation and clinical meningitis (0,5%).
Another risk factors for zoster encephalitis include cranial or cervical dermatome involvement, two or more prior episodes of zoster and disseminated herpes zoster.
Stevens-Johnson Syndrome with Chronic Liver Injury and Vanishing Bile Duct Syndrome as a Result of Antibiotic Therapy

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INTRODUCTION
We describe a case report about a 82 year old woman with history of tramadol and tetrazepam intolerance. She suffer of high blood pressure, type 2 diabetes, dyslipidemia and moderate Alzheimer's disease.

CASE DESCRIPTION
She complained of diarrhoea without abdominal pain, daily nausea and vomiting. About 48 hours before she had started taking colchicine.

In the Hospital Emergency Room she was diagnosed with urinary tract infection and acute renal failure secondary to dehydration, so she was told to take fluids and trimethoprim-sulfamethoxazole.

But a few days after that, she came back complaining of widespread rush and weight loss of 5 kg.

Physical examination showed 38ºC of temperature, disorientation and abdominal discomfort. A widespread rush without respect of palms or soles was confirmed.

The blood test showed a not anuric acute renal failure, an elevation of acute phase reactants and a bilirubin and transaminases elevation.

A thoraco-abdomino-pelvic-CT scan was made, showing a thickening of the gallbladder wall with a normal biliary tract, so an acute cholecystitis with dermatotoxic reaction was suspected. Surgeon general was called, who opted to conservative therapy with antibiotics.

About 72 hours after, skin lesions progressed to epidermolysis bullosa and a positive Nikolsky’s sign.

A diagnosis of TMP-SMT toxicity with Stevens-Johnson syndrome was made. Therapy with corticosteroids and Flebogamma during 5 days was made, getting a clinical and analytical stabilization resulting in a chronic liver failure.

DISCUSSION
The pattern of injury of this pathological entity is typically cholestatic or mixed and can be complicated and prolonged. As with other sulfonamides, TMP-SMZ has been linked to cases of hepatocellular injury that can be severe and lead to acute liver failure. Severe cholestatic injury may be prolonged and rare cases of chronic liver injury with vanishing bile duct syndrome have been reported.
The diagnostic value of platelet indices in the gastrointestinal system bleeding, the bleeding severity and the prognostic site

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Background: Early identification and determination of risk and severity of gastrointestinal system (GIS) bleeding and prediction of prognosis of this clinical problem with high diagnostic and treatment costs is very important. Therefore; determination of diagnosis of the GIS bleeding, bleeding severity and prognosis is requires low-cost, easily accessible and non-invasive methods. We aimed to find out the significance of platelet indices which satisfy the above mentioned criteria and also be routinely assessed with a complete blood count, in determination of the diagnosis of GIS bleeding, bleeding severity and prognosis.

Methods: This study retrospectively evaluated patients who were admitted to the hospital automation system with the diagnosis code 'Gastrointestinal System Bleeding' between March-2014 and February-2017.

Results: The GIS bleeding patients consisted of 331 (66.2%) men and 169 (33.8%) women. Increase in PLT, PCT, MPV and PDW was detected in patients with GIS bleeding compared with control group. In the first week; PLT, PCT, MPV, PDW results of the patients were significantly decreased compared to the reference results at hospital admission. The health checks made after the 1. month of admission showed that there was a dramatic decrease in platelet indices and also there were no significant changes in other parameters compared to the results of the 1. week. Significant strong relevance was found between bleeding severity and presence of chronic liver disease, coagulopathy, elevated platelet indices. It was found that poor prognosis is associated with advanced age, female gender, presence of comorbidity, high levels of PLT, PCT, MPV, PDW. Independent predictors of GIS bleeding, bleeding severity and prognosis were PLT, PCT, MPV and PDW.

Conclusion: The findings of our study suggest that platelet indices may be used both in the diagnosis of GIS bleeding and in the prediction of the bleeding severity and prognosis.
The link between gut inflammation and articular manifestations in inflammatory bowel diseases

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Objectives: The purpose of this study was to analyze the frequency of articular manifestations and to highlight the correlations with the main characteristics of inflammatory bowel disease (IBD).

Material and methods: We performed a prospective study that included 517 patients with IBD (Crohn Disease - CD, ulcerative colitis - UC or undifferentiated colitis - NC) diagnosed between 1975 and 2016 in the N-E region of Romania. The patients were extracted from the national database (IBD Prospect). UC cases predominated compared to CD cases (n=368 vs n=135). Only 10 patients were diagnosed with NC. In the study group, 51 cases with IBD and EIM were identified, having a prevalence of 9.9%.

Results: Musculoskeletal manifestations were the most common EIM (n=38, 74.5%, p =0.001). Peripheral involvement - arthritis (n = 26; 68.42%) predominated, followed by axial damage - sacroiliitis/ankylosing spondylitis (SI/AS) (n =12; 31.58%) (p =0.001). Patients with CD had a 3.48-fold greater risk of developing joint manifestations (p <0.001, OR=3.478; 95% CI 1.779-6.801). In both CD and UC patients, arthritis cases were the most frequent observed (68.42% vs. 31.58%). Patients with CD had a 5-fold higher risk of developing arthritis (p<0.001, OR=5.009, 95% CI 2.21-11.34). Neither CD, nor UC patients, had a confirmed risk of developing SI/AS (p=0.468, OR=1.565, 95% CI 0.463-5.293 for CD) (p= 0.586, OR=0.714, 95% CI 0.211-2.413 for UC). Cases of arthritis and CD (n=16) mainly correlated with the colonic localization of inflammation (n=7, p=0.723) followed by ileo-colonic form of CD (n=7, p=0.321). Patients with arthritis and UC (n=10) initially correlated with pancolitis (n=5, p=0.072, OR=3.023, 95% CI 0.855-10.690) then with proctitis (n =3, p=0.392) and left colitis (n=2, p=0.024, OR=0.196, 95% CI 0.041-0.938).

Conclusion: Articular manifestations were the most frequent EIM in IBD. CD represents the phenotype of IBD which has a higher incidence for EIM.
The role of genetic polymorphisms of interleukins in alcoholic liver disease

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Purpose: To assess the role of genetic polymorphisms of cytokin (IL-6, IL-8, TNF-α) in progression of alcoholic liver disease and identify associations of interleukin polymorphisms with their concentrations.

Methods: One hundred seventy-nine patients, alcohol abusers [129 male, median age 50±10.9 years, median term of alcohol abuse 15.1±9.4 years] were included. Alcoholic liver disease was verified in 153 patients (86.4%), including 66 patients (37.3%) with alcoholic hepatitis, 27 patients (15.3%) with acute alcoholic hepatitis, 60 patients (33.8%) – with alcoholic cirrhosis. The remaining 26 alcohol abusers (13.6%) without liver disease formed the control group. The serum concentrations of pro-inflammatory cytokines (IL-6, IL-8, TNF-α), and interleukin genetic polymorphisms (IL-6 C174G (rs1800795), IL-8 A352G (rs4073), TNF-α rs G4682A (rs1800629)) were analyzed.

Results: CC genotype of IL-6 and TT genotype of IL-8 showed strong associations with the presence of ALD, being diagnosed more frequently than in controls (22% vs 8.5%, (p=0.03) и 33.8% vs 16.6%, (p<0.007), respectively). In acute alcoholic hepatitis patients with CC genotype of IL-6 had significantly increased serum level of this cytokine in comparison to GG homozygotes. There were no other significant correlations between genotype and serum level of cytokins. There was no association between genetic polymorphisms TNF-α and the presence of ALD and there was no relationship between the genetic polymorphisms of TNF-α and its serum concentrations.

Conclusion: Genotype CC of IL-6 and genotype TT of IL-8 may be associated with development of ALD, but do not affect on the severity of liver damage. There were no associations between genetic polymorphisms of pro-inflammatory cytokines and serum concentration in patients with ALD, except for the genotype CC in comparison with genotype GG in acute alcoholic liver hepatitis.
The role of the gastrostomy tube to ensure adequate nutrition in advanced dementia with dysphagia - about the clinical report

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Introduction: Dementia is a progressive and irreversible disease, with a high incidence in the elderly population. The nutritional status of these patients is controversial due an amount of issues like refusal to eat, dysphagia and risk of aspiration, inadequate food intake. The Percutaneous Endoscopic gastrostomy (PEG) is a preventive measure of respiratory infections by aspiration and a means of maintaining the nutritional status and adequate hydration.

Description of the case: We report the case of 84-year-old man, totally dependent for daily life activities in Alzheimer’s dementia context in advanced stage (stage 7 of The Global Deterioration Scale for Assessment of Primary Degenerative Dementia). Patient had been several admissions for respiratory infection in last years (the medical team had the clinical suspicion of bronchial aspiration as the cause of recurrent infections). In the last hospitalization the patient was progressively parlous, malnourished with hypoproteinemia and hypoalbuminemia. During the hospitalization it was documented dysphagia and high risk of aspiration. It was decided to suspend oral feeding and start feeding by PEG. Currently patient has better nutritional status (with total protein and albumin levels are normal) and no new admissions for respiratory infection.

Discussion: The above clinical case illustrates one of the most common realities in medical wards and the power dilemma oral versus feeding by device. In the literature there is no consensus or guiding guidelines on this subject, only recommendations of some societies in favour of feeding by mouth, by changing the food consistency, use of preferred foods and calorie supplements.
The role of the PLR – NLR combination in the prediction of the presence of helicobacter pylori and its associated complications

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Background/Aims: The aim of this study to investigate the role of the platelet-to-lymphocyte ratio (PLR) – neutrophil-to-lymphocyte ratio (NLR) combination, in the prediction of the presence of helicobacter pylori (HP) and its associated complications to the gastrointestinal system.

Methods: 1289 patients who applied to our clinics with complaints of pain, dyspepsia, heartburn and postprandial bloating, and who underwent esophagogastroduodenoscopy and biopsy for HP were included in the study.

Results: The ratio of patients with moderate and severe chronic gastritis was higher in the HP (+) group than the HP (-) group. The ratio of patients with level 1-3 atrophy and intestinal metaplasia was higher in the HP (+) group. Compared to the HP (-) group, the HP (+) had a higher mean platelet, neutrophil, PLR, and NLR levels, as well as a lower mean lymphocyte level. The ratio of HP (+) patients was higher in the high-risk group compared to the low- and medium-risk groups. The HP invasion stage, the intestinal metaplasia level, and the ratio of patients with atrophy level “3” were higher in the high-risk group compared to the low- and medium-risk groups. Regression analysis showed that the PLR-NLR combination was an independent risk factor for both HP presence and moderate and severe chronic gastritis.

Conclusion: We found the PLR-NLR combination to be a good predictor of HP presence and gastrointestinal complications associated with HP. We believe that the PLR-NLR combination will be a great convenience for clinicians as an easy-to-use, easily accessible, and inexpensive index.
The usual suspects – a case of toxic hepatitis with multiple confounding factors

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Introduction: Toxic hepatitis is an inflammation of the liver caused by chemicals, including drugs, industrial solvents, pollutants and teas. Although different drugs are often associated with different patterns of liver tests abnormalities and systemic manifestations, this is not specific.

Case report: A 72-year-old woman presented to the emergency with jaundice, choluria and acholia during the last week. She also complains of pruritus, anorexia and weight loss. She was previously medicated with pantoprazole (for a gastric ulcer), sulfasalazine (for chronic diarrhea) and Ginkgo Biloba. Two months ago, she was prescribed 6 days of azithromycin for a respiratory tract infection. She drinks various natural teas that she prepares with leaves she catches in the wild, namely anise tea, gorse flower tea and lemon balm tea, among others. She does not drink alcohol. Sulfasalazine, pantoprazole and natural teas were suspended on admission. Liver tests were abnormal, showing a cholestatic pattern. Both abdominal ultrasound and CT scan were normal and did not show any biliary tract dilatation. There was no evidence of chronic or recent infection by hepatotropic virus and autoimmunity study was negative. An endoscopy was performed, which showed no gastric ulcer. Liver biopsy was suggestive of toxic hepatitis.

Patient was discharged after marked improvement of liver tests, with clear indication to avoid azithromycin, sulfasalazine and natural teas.

Conclusion: A diagnosis of toxic hepatitis may sometimes not be accompanied by a definite culprit agent. This should never delay the main therapeutic measure, which consists of suspending any potential aggressors.
Objectives: The aim of this study was to investigate two predictive scores (Computed Tomography Severity Index - CTSI and Bedside Index of Severity in Acute Pancreatitis - BISAP scores) for early detection of patients in a higher risk of pancreatic necrosis (PN), as one of the most severe local complications of the acute pancreatitis (AP).

Materials and methods: Patients with the diagnosis of AP, 187 of them, were included in the study. In the period of almost four years (January 2014 to November 2017), data of all patients were collected prospectively. The BISAP score is calculated within the first 24 hours of hospital admission, while the CTSI is calculated within the first 72 hours of admission to the hospital. The collected data were compared with the corresponding statistical analyzes.

Results: Of all 187 patients, 176 patients (94.1%) had a positive outcome. The severe form of the disease was present in 23 patients (12.3%). PN had 36 (19.8%) patients. Out of total number 112 (59.9%) patients had AP billiard origin. There were 118 males (63.1%). Higher value of BISAP scores and CTSI were present in patients with diagnosed pancreatic necrosis, which is a highly significant statistical difference (p < 0.001).

CTSI had sensitivity 80.6% and specificity 93.8% for PN (cut-off 4), and AUC for PN predicted by CTSI was 0.961 (95% confidence interval(CI), 0.936 - 0.985). BISAP score had sensitivity 55.6% and specificity 85.4% for PN (cut-off 3) and AUC for PN predicted by BISAP score was 0.738 (95% (CI), 0.64 - 0.836). Positive and negative predictive value for CTSI was 0.957 and 0.912, respectively, and for BISAP was 0.476 and 0.890.

The AUC derived were further compared using the De Long test, and high statistical significance was obtained in predicting patients with PN in favor of CSI (Z statistic 4.324, P < 0.0001).

Conclusions: The study suggests that, in everyday practice, CTSI should be used for early detection of patients who have a higher risk of developing PN.
Tigecycline is a broad-spectrum antimicrobial agent that is classically used to treat infections with resistant microorganisms. We present a very rare case of acute hepatic failure following administration of Tigecycline.

A 75-year-old female with recurrent UTIs presented with general weakness and fatigue secondary to a complicated UTI with right sided nephrolithiasis. Initial labs showed leukocytosis and acute kidney injury with normal liver function. Tigecycline was initiated after reviewing prior urine cultures and susceptibilities which grew vancomycin resistant enterococci. Upon receiving the first dose of Tigecycline, follow up labs showed new elevations in AST and ALT. All home medications that were hepatotoxic were initially discontinued including statin and fluconazole. Despite this, liver function test continued to worsen and she developed a coagulopathy with an INR of 5.1. Clinically, she developed ascites and grade 2 hepatic encephalopathy. A comprehensive viral hepatitis panel was negative and liver ultrasound with Doppler was normal. Acetaminophen, salicylate and ethanol levels were all negative. Due to development of acute liver failure, all remaining medications were discontinued and the patient was given N-acetyl-cysteine since she was not a transplant candidate due to underlying comorbidities. After discontinuing Tigecycline, liver function immediately began to recover with resolution of encephalopathy and coagulopathy.

The use of broad spectrum antibiotics is commonly used as initial therapy for early infections with undetermined or resistant pathogens. This patient developed acute liver failure shortly after receiving the first dose of Tigecycline for a complicated UTI. Her signs and laboratory results met the criteria for a diagnosis of acute liver failure, after all common causes were excluded. Although a rare side effect, clinicians should use Tigecycline with caution and monitor patients for development of liver dysfunction.
Toxic hepatitis with sequential and concomitant exposure to potential offending drugs

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Introduction
Drug-induced liver injury (DILI) is one of the causes of hepatocellular damage with high levels of aminotransferases, along with acute viral and ischemic hepatitis.

Case description
63 year old woman with atrial flutter, hypertensive and ischemic heart disease and chronic heart failure (NYHA class III), recently hospitalized for urinary infection and heart failure decompensation with atrial flutter with rapid ventricular response despite therapy with beta-blockers at maximum dose. Empiric antibiotic therapy with meropenem was initiated, based on the antimicrobial susceptibility testing of a previous urinary isolation, and verapamil was introduced for frequency control. The urine culture was positive for a multisensitive Klebsiella pneumoniae strain. The patient was discharged medicated with verapamil and amoxicillin / clavulanic acid (the latter for only 4 days, to complete the antibiotic cycle previously initiated with meropenem for 6 days). She returned to the emergency department 6 days later for fatigue, nausea, vomiting and pain in the right hypochondrium. Laboratory testing showed a hepatocellular pattern of injury (AST and ALT 50x upper limit of normal) and PT prolongation. She was hospitalized and verapamil was discontinued. Other causes of acute liver injury, as acute viral ans ischemic hepatitis were appropriately excluded and drug-induced liver injury was left as the probable cause. Discontinuing of verapamil (antibiotics had already been stopped) led to near normalization of liver enzymes within 1 week.

Discussion
DILI cases with concomitant or sequential drug exposure are challenging as it may not be possible to differentiate between offending drugs. Based on the pattern of injury, verapamil or amoxicillin clavulanate appear to be the most probable culprit medications. Determining which are allowed to be administered in this particular patient in the future is difficult.
Transforming growth factor beta-1 (TGFβ-1) and brain atrophy in alcoholism

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Background: There is uncertainty regarding the role of TGFβ-1 on adult brain. Serum levels of TGFβ-1 were decreased in Alzheimer disease (AD), but not in healthy seniors. Others described increased TGFβ-1 in cerebrospinal fluid in patients with AD and Parkinson disease, but normal ones in amyotrophic lateral sclerosis. The relation between TGF beta and brain atrophy in alcoholics has not been described. Methods: 75 alcoholic patients aged 59.09 ± 11.56 years, drinkers of 180 g etanol daily for > 10 years and 34 age and sex-matched controls, underwent a brain CT scan, on which several indices were calculated, and routine laboratory evaluation and determination of TGFβ-1, IL-6, TNF-α, IL-4, interferon-γ and C-reactive protein (CRP). Results: Serum TGFβ-1 levels were higher in alcoholics, and directly related (i.e., the higher the TGFβ-1 levels the greater brain atrophy) with bicaudate index (r=0.27, p=0.023), cella index (r=0.23, p=0.047), and ventricular index (r=0.24, p=0.040), and, in a nearly significant way, with bifrontal index (r=0.22, p=0.067); By multivariate analysis, besides Evans and bifrontal index, both age (in the first place) and TGFβ-1 (in the second place) were independently related with the CT indices. TGFβ-1 was inversely correlated with IL-6 (p=-0.39; p=0.001), IL-4 (p=-0.30; p=0.017), and interferon gamma (p=-0.27; p=0.031), but not with TNF-α (p=-0.02) or CRP (p=-0.22, 0.06>p>0.05). Conclusions: TGFβ-1 is increased in alcoholics, and, similarly to what is described AD and other neurodegenerative conditions, it is related to CT-assessed intensity of brain atrophy.
INTRODUCTION: Gastrointestinal neuroendocrine tumors (GI-NET) are rare neoplasms. However, the incidence of GI-NETS has been increasing in recent years.

DESCRIPTION: A 66-year-old woman with a history of chronic gastritis, osteoarthritis and osteoporosis, who began a study more than ten months ago due to self-limited metrorrhagia on two occasions. It is studied by gynecology without finding findings of interest and further study by urology for possible gross hematuria. Computed tomography (CT) is requested, where mesenteric solid mass adjacent to the junction of the second and third portion of the duodenum is visible. First possibility, so that it enters the digestive service that repeats CT with tumor growth, oral endoscopy without alterations, a percutaneous biopsy guided by ultrasound is performed and a corresponding pathology anatomy is obtained with a low-grade neuroendocrine tumor (carcinoid) with a grammographic study of Somatostatin receptors showing pathological uptake of the tracer (lesion of somatostatin receptors) in the duodenum being operated on by right hemicolectomy.

DISCUSSION: The differential diagnosis of duodenal neuroendocrine tumors (D-NET) includes hyperplasia of Brunner's gland, heterotopic gastric mucosa, adenomas, adenocarcinomas, gastrointestinal stromal tumors, lymphoid hyperplasia, metastatic tumors, neurofibromas and schwannomas. Gastroduodenal endoscopy and direct tissue biopsy is the most common diagnostic method of D-NET. However, it is possible that the endoscopic biopsy does not always include tumor tissue due to the location of the tumor within the deep mucosal layer or submucosa. There is a significant increase in the reported incidence of G-NET and D-NET. The treatment of D-NETs is based on the size of the tumor, the location, the histological grade, the stage and the type of tumor.
Usefulness of autotaxin as a non-invasive biomarker to estimate chronic liver disease status

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Background/Aims: Autotaxin (ATX) has been found to be associated with liver fibrosis. We investigated the relationship of serum ATX level with disease stage in patients with chronic liver disease.

Methods: Serum ATX values were evaluated in 1,015 patients (45% male, median age: 57 years, chronic hepatitis C; CHC, 584, chronic hepatitis B; CHB: 101, primary biliary cholangitis; PBC: 128, non-alcoholic fatty liver disease; NAFLD: 202), all of whom having undergone liver biopsy, along with 160 healthy controls for comparisons of clinical parameters.

Results: Median age was significantly lower in CHB (46 years) than in others (CHC: 58, P<0.001). The proportion of male patients was significantly less for PBC (16%) than for other groups (CHC: 50%, CHB: 61%, NAFLD: 64%, P<0.001). The median ATX concentration of patients was significantly higher than that in controls (1.13 vs. 0.76 mg/L, P<0.001). ATX in female patients and controls (1.32 and 0.82 mg/L) was significantly higher than that in male patients and controls (1.00 and 0.70 mg/L) (P<0.001). Among liver diseases, ATX values for CHC and CHB (1.39 and 1.22 mg/L, respectively) were significantly higher than those of PBC and NAFLD (0.97 and 0.86 mg/L). Significant correlations were present between ATX and fibrosis stage for each liver disease (CHC: \textit{r}=0.72, CHB: \textit{r}=0.46, P<0.001). ATX showed significant correlations with such established liver fibrosis markers as M2BPGi and APRI for each liver disease (P<0.001). ATX was significantly decreased after achievement of a sustained virological response in CHC but was not after one year of treatment with nucleot(s)ide analogs for CHB (P=0.43) or ursodeoxycholic acid for PBC (P=0.07).

Conclusions: Serum ATX values appear to be useful for assessing disease stage and prognosis in chronic liver disease. As gender and etiology differences exist, further studies are needed to clarify the clinical significance of ATX.
Value of abdominal ultrasound in the definitive diagnosis in Internal Medicine patients in the VSCABD study cohort

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OBJECTIVE: Our objective was to observe the clinical-pathological characteristics of the patients who were asked for an abdominal ultrasound during their hospitalization, according to an Internal Medicine doctor. In this poster we analyze what other tests were requested in these patients.

MATERIAL AND METHODS: Observational study of prospective cohorts. Sample of 190 patients. Who an abdominal ultrasound was requested during their hospitalization.

RESULTS: Of the total sample, 50.5% were women. The average age was 69.07 years (18-97 years), with 68.9% of patients older than 60 years.

77.9% had a chest (C) X-ray versus 24.2% that was performed on the abdomen (A). A total of 94 CT, 40 (C), 38 (A) and 16 skull were performed. 12 magnetic resonances were made. 13.2% underwent colonoscopy and 8.9% under gastroscopy.

In the extended abdominal study (CT, MRI, PET); In 77.8% of the patients, the only abdominal imaging test performed (excluding radiographs) was abdominal ultrasound.

If we analyzed these data according to the reason for requesting abdominal ultrasound: 53% of these were divided into pain (25.3%), fever (21.6%), constitutional syndrome (11.6%) and transaminases increase (10%).

CONCLUSIONS: After this analysis, we can observe that ultrasound is conclusive evidence in a large percentage of cases, having been the only abdominal image test in 77.8% of the patients studied.

This test was requested mainly in patients admitted for pain and fever. The most frequent complementary test in those cases in which another imaging test was needed was CT.

While it is true that in certain pathologies, its usefulness lies in being able to discard a wide range of pathology, allowing the diagnosis to be oriented to other locations, where more specific tests are necessary.
VSCABD study: Concordance between standard abdominal ultrasound performed by radiologist and pocket size ultrasound performed by an internist after basic training

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OBJECTIVES
Compare the data obtained in an ultrasound done by an internist with a pocket device (dual Vscan) in front of an ultrasound scanned in the Radiology Service.

METHODS
Ultrasonography examination was performed at the bedside in +/- 24h compared to standard ultrasound in 190 first patients in the VSCABD study. The following variables were evaluated: hepatomegaly, Space Occupying Lesions of Liver (SOL), echogenicity, gallbladder status, renal size, cysts and hydronephrosis; Splenomegaly and the presence of ascites.

RESULTS
The concordance obtained between the researcher (using a size pocket ultrasound) and the radiologist was good (k>0.6) for the gallbladder, splenomegaly, normal size and megalia of both kidneys, the presence of renal cysts and hydronephrosis; and moderate (k>0.4) for the rest of the variables.

The specificity was >90% for all the parameters evaluated, except for the normal renal size. Being the sensitivity obtained >70% except for hepatomegaly, SOL, echogenicity, renal atrophy and ascites.

In relation to the predictive values a NPV >80% was obtained in all the variables studied except in the normal size of the left kidney (0.7). Achieving a PPV> 80% in all these variables except for the presence of hepatomegaly, hepatic loes, echogenicity and/or increased biliary tract, left renal atrophy or right renal masses.

A Youden index >0.5 was obtained in all the variables, except (0.4) hepatomegaly, the presence of SOL, bile duct alteration and right renal atrophy.

In the sample there is a very low prevalence of disease and therefore, asymmetry between the observed characters; this directly affects the Kappa index, which is why we can explain such high and positive values of specificity and negative predictive value with a limited kappa.

CONCLUSION
In light of these results we can affirm that rapid learning is possible and at the cost of relatively few tests; where, in return, the holistic vision of the patient that an internist should have could be completed.
What is Hiding an Ascite?

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Ascite is a sign that results from the accumulation of fluid at the peritoneum. There are numerous causes of ascites. The authors intend to bring a clinical case in which the first manifestation of the disease was the appearance of ascites.

Female teacher 34-year-old, with no known medical history or history of hospitalization. He went to the emergency department for 3 months of evolution characterized by gradual increase in abdominal volume, weight loss of about 10 kg, anorexia, postprandial infarction, diarrhea without mucus, blood or pus, and unquantified febrile sensation. She went to the emergency with good general condition, vigil, oriented, stained, hydrated, apyrético, eupneica in ambient air. Cardiopulmonary auscultation without changes. Distended abdomen accuses of medium volume ascites. Lower limbs without edema or signs of venous thrombosis. From the initial investigation highlight for rx thoracic: pleural effusion on the left and abdominal ultrasound revealed: Ascitic fluid on the supra mesocolic floor. Interned in the medical service due to ascites of undetermined etiology. During the internally she was always clinically and hemodynamically stable. HIV serotypes and negative hepatitis, ceruplasmin 49.5 mg / dL, autoantibodies (AMA, ASMA, LKM and APCA negative), Ca 19.9 11.6 U / L, Ca 125 62.5 U / L. She made diagnostic paracentesis: Citrus yellow ascitic liquid, proteins 8.5 g / dl, glucose 18 mg / dl, LDH 834 U / L, albumin 3.8, predominance of lymphocytes (59%), with a total of 2517 cells / ul, serosal ,1. Cultural examination of negative ascitic fluid. PCR for Mycobacterium tuberculosis positive. CT scan Pelvic abscess without changes. CONCLUSIONS: This is a case of extra pulmonary tuberculosis and the ascites associated with pleural effusion are presented.
Young male with prolonged diarrhea

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38-year-old man without personal history of interest, live in urban environment, non-hygienized food consumer. Admitted Internal Medicine departed for diarrhea of 3 months, which began after a 101 km race. Referring about 13 depositions/day, liquid and associated with abdominal cramping pain, without fever but with weight loss of about 5 kg.

Physical examination without data of interest, with painful noises in lower hemiabdomen, more accused in left iliac fossa without defense.

In the first 24 hours of admission, the patient began with severe abdominal pain, an urgent abdominal CT scan was performed, showing marked thickening of the walls of the descending colon, sigmoid and rectum, with inflammatory changes in the adjacent fat, in relation to segmental colitis of inflammatory or infectious etiology as the most probable diagnoses and small amount of pericolonic fluid in both Droplets and pelvis. Corticosteroid treatment and antibiotic with metronidazole with suspected inflammatory bowel disease were empirically initiated.

The blood count, coagulation, hepatorenal function and ionogram were normal. Tumor markers, serology of HIV, HBV and CMV, rotavirus and adenovirus, ANA and ANCA and the study of thrombophilia were negative. Stool culture and study of parasites were negative. Elevation acute phase reactants (ESR 28 mm/hour, PCR 53 mg/dl).

Colonoscopy was performed, 8-10 cm from the thickened and unstructured mucous anal margin of dark violet color with fibrin areas on its surface that extend up to about 35 cm from which normal mucosa is seen. Biopsies and samples were taken for culture, that showed a chronic inflammatory process with intense lamina fibrosis and presence of capillary thrombi. Immunohistochemistry is performed for negative CMV, but finally, the CMV-PCR was positive in colon biopsy.

Diagnosis of probable ischemic colitis with CMV superinfection, treatment with valganciclovir 900mg/12 hours for 21 days, with adequate but incomplete and slow response.
Zollinger-Ellison Syndrome Associated with Gastrinoma: Case Report and Literature Review.

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Introduction
Gastrinomas are functionally active pancreatic neuroendocrine tumors (NETs) characterized by the excessive secretion of gastrin leading to an increased gastric acid production. The primary determinants of survival for patients with gastrinomas are the size of the primary tumor and the occurrence of tumor metastasis in the local lymph nodes or liver.

Case presentation
We present a case of a 60-year-old Caucasian man with multiple cardiovascular risk factors (obese, hypertensive, dyslipidemia, diabetic), presented in our hospital with abdominal bloating and pain, nausea, vomiting, diarrhea and weight loss of 6 kg over 4 months.

The EKG excludes a possible myocardic infarction but the endoscopy shows multiple ulcerations in the stomach and duodenum raising suspicion of Crohn disease, Sd. Zollinger Ellison, or a viral pathology. Several other paraclinic tests such as CT scans, ecoendoscopy with fine needle aspiration, gastrin determination are performed in order to exclude these diseases and the results came positive for Sd. Zollinger Ellison due to pancreatic gastrinoma.

He declines initially the surgical intervention and comes back a year later with worsening symptoms. The surgeon finds multiple metastases in the liver, and multiple adenopathies near the aorta and celiac trunk. Despite the maximum treatment of vital functions, he develops MSOF and dies.

Discussion
Gastrinomas are rare neuroendocrine neoplasms and 60 to 90% of them are malignant and can metastasize to regional lymph nodes and the liver.

In this case, although the patient was diagnosed in an early stage of disease, because he refused surgery based on the amelioration of symptoms and some personal issues, sadly he developed a rapidly malignant and metastatic transformation and despite our efforts even in the advanced stage he came we could not save him.
A case of an ACTH producing tumor presenting with multiple gastrointestinal perforations.

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Introduction
This case report highlights the risk of bowel perforation in patients with Cushing’s syndrome presenting with abdominal pain.

Case description
A 61-year-old woman arrived at the emergency room with rapidly progressing abdominal pain suddenly started from 4 hours prior to admission. Over the prior 6 months, she reported constipation, malaise, weight loss, nail hyperpigmentation, and hirsutism. She had a history of rheumatoid arthritis treated with methylprednisolone 1.5 mg daily. She had been smoking 2 packs per day.

On examination, she had obvious cushingoid features and her vital signs were within normal limits. Her abdomen was non-distended but tender in the lower abdomen with rebound tenderness suggesting peritonism.

Laboratory results showed leukopenia (3400 /mcL) and severe hypokalemia (1.6 mEq/L). Enhanced CT scan demonstrated a duodenal perforation and mediastinal lymphadenopathy.

She underwent right colectomy, duodenoileostomy, and sigmoid colectomy to manage the perforation. On further investigation including serum ACTH 804.2pg/ml, cortisol 110mcg/L, no suppression of cortisol level after 1mg of dexamethasone, and positive ACTH staining from a cervical lymph node biopsy, she was diagnosed with ACTH-producing small cell lung cancer.

Discussion
Cushing’s syndrome has various clinical presentations. The risk of intestinal perforation is increased in these patients due to atrophy of the intestinal epithelium Chronic steroid use suppresses inflammation and can, therefore, mask symptoms leading to a diagnostic delay. In this case, the intestinal perforation itself was made easily but this distracted us from the patient’s Cushing’s syndrome and lung carcinoma.

Thus, clinicians should consider this possibility in patients taking steroids presenting with acute abdomen.
A Rare Cause of Chest Pain Mimicking Acute Coronary Syndrome

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Introduction: Amyloidosis is a rare disease which occurs in 8/1000000 people. It is characterized by deposition of amyloid protein in one or more organs which includes the kidneys, gastrointestinal tract, respiratory organs and heart – this is the reason why although inherently a haematological disorder it is relevant to all specialities of internal medicine.

Case description: A 61-year-old female presents to the cardiac unit with chest tightness, progressive dyspnoea and weakness. Objective examination reveals leg oedema. Patient is hemodynamically stable, ECG shows SR; HR – 76/min and first-degree AV block. There are pathologic Q waves in the anterior wall of the left ventricle and in the inferior wall scar formation is seen – a pseudo infarction pattern.

Echocardiography shows a 55% EF, dilatation of the right atrium and right ventricle, moderate hypertrophy of the left ventricle. Third-degree TR and first-degree MR.

Due to presumed acute coronary syndrome, a coronography is carried out but reveals no hemodynamically significant stenosis.

Next, a cardiac MRI is performed, the results of which leads the team to suspect amyloidosis. Finally, an endomyocardial biopsy is taken and histology confirms cardiac amyloid light-chain (lambda) amyloidosis.

Discussion: Amyloidosis has high mortality, however, lifesaving treatment is available for these patients if diagnosed in a timely manner. This case report demonstrates how the unspecific symptoms of amyloid heart disease appears and highlights that physicians must keep in mind the possibility of rare disease.
A Spanish tourist with Paget-Schroetter syndrome (PSS) induced by backcountry snowboarding.

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Paget-Schroetter syndrome (PSS) is characterized by deep vein thrombosis (DVT) in the arm due to the combination of a thoracic outlet anatomical abnormality and vigorous exercise of the affected limb. Complications of PSS include pulmonary embolism and residual venous obstruction, and recent expert opinion suggests that early invasive therapy is superior to anticoagulation. We report a case of a snowboarder who developed PSS at a remote resort in Hokkaido, Japan.

A 30-year-old male presented with a 2-day history of left arm pain, which he first noticed upon awakening. He had been back-country snowboarding, hiking several mountains using ski poles. He was otherwise medically well on no regular medications. Physical examination showed tenderness, and distention of the superficial veins of his left arm. Imaging revealed thrombosis in his left subclavian vein. A thrombophilia screen was normal. A diagnosis of PSS was made based on the characteristic history, and after exclusion of other causes. Since catheter-directed therapy was unavailable in our area, we initiated anticoagulation with unfractionated heparin and transferred the patient to a tertiary hospital in Ibaraki, Japan for definitive treatment. He then underwent catheter-directed removal of the thrombus. Unfortunately, after thrombus removal, he had persistent anatomical compression of his left subclavian vein due to thoracic outlet obstruction, and returned to Spain to undergo a decompression operation.

We believe this patient developed PSS due to a combination of the cold weather, compression from his backpack, and excessive upper body physical activity. It illustrates the importance of early diagnosis and aggressive treatment to prevent subsequent complications. This syndrome should be considered in upper limb DVT of young athletes.
Acute confusional syndrome in elderly patients admitted by acute medical pathology

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Objectives
To determine the prevalence and characteristics of acute confusional syndrome (ACS) in patients hospitalized in Internal Medicine.

Methods
Observational study of retrospective cohorts (patients with and without ACS). Are included patients > 65 years with acute medical pathology, from the Unit of Internal Medicine of the University Hospital of Valme in January in 2017. Are excluded patients with terminal chronic disease, agony or coma and whose reason for admission was ACS.

Results
We studied a population of 269 patients. A total of 38 patients (14.1%) presented ACS. The mean age of these patients was 83 years. The average hospital stay was 9 days. Most of patients with ACS had not study (80.6%), had family support (86.1%), they did not consume toxics (89.5%), they have associated comorbidity (97.4%) and a moderate or severe dependence for the basic activities (68.4%), 34.2% had strokes and 42.1% had dementia. 65.8% took psychopharmaceuticals prior to admission. The most frequent pathology of admission were cardiological (26.3%) and infectious (26.3%). 5.3% died. The hyperactive type of ACS was 86.8% and predominantly night, 84.2% had a duration of 1-3 days. Only in 45.7% was considered in the clinical trial at discharge.

Conclusion
The prevalence of ACS in our population is similar to described in the literature. Most of patients had not study, had family support, they did not consume toxics, they had associated comorbidity and a moderate or severe dependence as well as a history of dementia and ictus. Only half of ACS was considered in the clinical trial at discharge.
Acute lung edema - Not always cardiogenic!

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Introduction: Thiazide-type diuretics are widely used in the treatment of essential hypertension. Hydrochlorothiazide may, however, trigger acute pulmonary edema as a rare but potentially life-threatening allergic, ideosyncratic reaction.

Case description: Hydrochlorothiazide (12.5 mg) was associated to the usual medication (valsartan 80mg) of a 72 years old man, with maintained hypertension and ankles edema. He had hypersensitivity to angiotensin-converting enzyme inhibitors, amoxicillin and clarithromycin. Thirty minutes after the first tablet, he started nausea, vomiting, severe dyspnea and facial flushing. At the hospital ED he was apyretic, hypotensive, bradycardic and tachypneic, with cracles at both lung bases, and a SpO2 of 70%. Arterial blood gas chemistry revealed type I respiratory failure (PaO2 38mmHg) and hyperlactacidemia (21 mg/dL). He developed leucopenia, thrombocytopenia, tryptase elevation (15.9 μg/L) as common in anaphylactic reactions, and acute renal injury AKIN 1. Chest radiograph revealed a bilateral interstitial lung pattern, aspect compatible with the imagiologic diagnosis of acute pulmonary edema. Maintaining a severe refractory respiratory failure, he was admitted to a Respiratory Intensive Care Unit (RICU), requiring aminergic support and mechanical ventilation at 48 hours. Infection was excluded and an echocardiogram revealed preserved left ventricular function. Corticosteroid therapy led to a rapid clinical improvement with progressive resolution of the radiological changes, allowing a ventilatory weaning at the 4th RICU day.

Discussion: It is crucial to early recognize this rare but life-threatening possible allergic reaction to thiazide-type diuretics, in order to immediately stop the drug intake and to prevent any unthoughtful reinitiation of a similar treatment.
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Acute pancreatitis in the elderly

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Introduction: According to the diagnostic criteria of the International Association of Pancreatology, patients who present with two of the following three manifestations are diagnosed as having acute pancreatitis: characteristic upper abdominal pain, elevated levels of pancreatic enzymes and findings of ultrasound, computed tomography or magnetic resonance imaging. Detection of elevated levels of blood pancreatic enzymes is crucial in the diagnosis of acute pancreatitis. Measurement of blood lipase is recommended, because it is reported to be superior to all other pancreatic enzymes in terms of sensitivity and specificity. Acute pancreatitis in the elderly is commonly of gallstone etiology and more likely to have an atypical clinical presentation, making recognition more difficult.

Case description: 79 years old male with hypertension, dyslipidemia, gout, ischemic heart disease, heart failure class III NYHA was admitted with congestive heart failure decompensated by possible respiratory infection. Upper abdominal atypical pain was reported, leukocytosis 20410x10^9/L, neutrophils 90%, C reactive protein 47mg/dL, amylase 210U/L, lipase 207U/L, LDH 900U/L, normal bilirubins and corrected calcium 6.4 mg/dL. Abdomen was tender in epigastric area. Abdominal computed tomography showed heterogenous enlarged pancreas, undefined contours, hypocaptation of the contrast, peripancreatic exudates, pleural effusion, distended gallbladder with sludge. The diagnosis of pancreatitis secondary to calculous cholecystitis Ranson 3 was made. He had gradual improvement with conservative treatment and was oriented for elective cholecystectomy.

Discussion: In this case the pain was atypical and only a high degree of suspicion allowed to establish the diagnosis by mild increases in amylase and lipase and by imaging. Diagnosis on time minimized complications.
INTRODUCTION: The world health organization estimates that every year in the world occur one million serious intoxications by pesticidas and two million suicidal attempts of which the organofosforados are the managers of almost 80%.

DESCRIPTION: A 61-year-old woman came to the emergency department, activating a stroke code after being found two hours earlier by her family members in bed with extreme weakness, difficulty speaking, sweating and sleepy.

Personal history of depressive disorder from stable years without previous autolytic attempts. Physical examination highlights drowsiness with Glasgow Scale 14/15. NISH scale 1-2. Miotic pupils little reactive to light and accommodation. Blood pressure A 170 / 90. Heart rate 115 bpm. E. Neurological: claudication of the four extremities and dysarthria. Stroke code is deactivated and analytical, chest x-ray, electrocardiogram (ECG), computed tomography (CT) cranial and toxic in urine are requested with the following analytical results:

- Hemogram: Leukocytes 16,810 with neutrophils 86.60%. Lymphocytes 10.60%. Monocytes 2.60% red series and rest of normal analytic.
- Cranial CT scan: normal. Negative urine toxicity. The patient worsens at the respiratory and neurological level with respiratory distress so the family and the patient are questioned confessing to having ingested 20-30 cc of an insecticide product for ants (48% Clorpirifox). The patient was admitted to the intensive care unit with ventilatory and cardiovascular support, as well as treatment for the elimination of the toxic and antidotes.

DISCUSSION: Emphasize the importance of the initial medical approach and the clinical suspicion of the consumption of these substances that compromise the life of patients if they do not act early.
Cardiac Tamponed as an initial manifestation of Systemic Lupus Erythematosus: Case report

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Introduction:
Systemic lupus erythematosus (SLE) is an autoimmune disease with a broad spectrum manifestations, marked by periods of remission and exacerbation. There is a major incidence in african american women in reproductive age. Although pericarditis is an usual manifestation of SLE, cardiac tamponed is rare, especially as initial presentation.

Case Description:
A 19 years old african american woman was admitted with a 30-day history of progressive dyspnea with dry cough. There was no history of fever, arthralgia or other sympthoms. The physical exam showed tachycardia, elevateded blood pressure (190 x 120 mmHg), muffled heart sounds, distended jugular veins, tachypnea and systemic edema.
Chest radiograph revealed increased heart area and right pleural effusion, echocardiogram revealed severe pericardial effusion and concentric left ventricular hypertrophy and echocardiographic signs of cardiac tamponade. Pericardiocentesis was performed, with 1 litre serosanguinolent liquid withdrawal followed by important clinical improvement. After laboratory results, the diagnosis of SLE was made after 4 of the 11 criteria proposed by the American College of Rheumatology: Positive anti-nuclear factor with fine dot pattern and native anti-DNA antibody, proteinuria (634,2 mg / 24 hours) and serositis (pericardial and pleural effusion).
Treatment was started with pulse corticosteroid therapy using methylprednisolone for 3 days followed by 60mg/day prednisone maintenance dose associated with 400mg/day hydroxychloroquine. The patient evolved with significant clinical improvement and no recidive of the cardiac tamponed.

Discussion:
Pericarditis is a well known manifestation of SLE, however, the occurrence of cardiac tamponed as initial presentation is rare. We found similar case reports in literature, emphasizing the importance to consider this condition as a differential diagnosis in patients who have pericarditis and/or cardiac tamponed with signs of reumatologic diseases.
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Coma - A rare cause

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Coma has multiple etiologies from secondary to structural lesions of the nervous system to very diverse systemic causes, with hypercalcemic crisis being a rare cause. The hypercalcemic crisis is uncommon, most often associated with primary hyperparathyroidism or malignancy, but may present as its initial manifestation. We present the case of a 71-year-old female patient with a history of type 2 diabetes mellitus and depression. One week prior to admission, the patient started with asthenia and adynamia attributed to the acute exacerbation of the psychiatric illness that conditioned the therapeutic adjustment without improvement. It evolved with increase of drowsiness, disorientation and behavioral changes. In the emergency room, rapid cognitive decline was seen, with a Glasgow Score of 8. The analytical study demonstrated anemia, acute renal injury, severe hypercalcaemia and elevated PTHi. The diagnosis of primary hyperparathyroidism was assumed. Vigorous hydration and administration of intravenous bisphosphonate (pamidronate) were performed with improvement of the condition. Ultrasound of the neck showed well defined hypoechoic nodular formation adjacent to the lower pole of the right thyroid lobe. The scintigraphy with sestamibi identified a hypercaptive lesion with inferior pole location of the right lobe of the thyroid, better characterized by CT-Thorax. After excision of the lesion, rapid normalization of PTHi was observed. The histological diagnosis of the surgical specimen was of parathyroid adenoma. The hypercalcemic crisis is a rare presentation of a functioning parathyroid adenoma, an endocrine emergency that has a high potential for cure if treated in a timely manner.
Comprasion of Energy Consumption Measured by Metabolic Monitor and Standard Equations in Intensive Care Patients

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Objectives: Multiple equations exist for predicting resting energy expenditure, but these equations may not estimate accurate energy requirements at critically ill patients. Although indirect calorimetric examination is gold standard, 24 hour measurement might cause some difficulties. We aimed to compare 2, 6 and 12 hours indirect calorimetric examinations and predicted formulas against 24 hours indirect calorimetric examination at medical ICU patients.

Material and Methods: 131 entubated patients were included to this study. Energy expenditure at 2nd, 6th, 12th and 24th hours measured by indirect calorimetry were recorded. Energy expenditure at 2nd, 6th, and 12th hours were compared on a percentage basis with the energy expenditure at 24th hour. The values within %80 and %110 were considered adequate. Harris Benedict, Owen, Mifflin St. Joir 1990, Ireton Jones 1992, Ireton Jones 1997, Ireton Jones Obesity, Penn-State 1998, Penn State 2003, Penn State 2010, Swinamer 1990, Brandi 1999, Faisy 2003 and Schofield equations were used both to estimate energy expenditure with actual and ideal body weight. Both these calculations and corrected values with 1.3 or 1.6 were compared with 24th hour energy expenditure.

Results: Mean energy expenditure at 24th hour was 2078 ± 794 kcal/day. There was correlation between 24th hour energy expenditure and the other hours. Although all predictive equations were correlated with indirect calorimetry, Bland Altman plot showed wide agreement limits. Mifflin, Ireton Jones 1997 or Swinamer formulas corrected with 1.3 and Penn State 2003, Penn State 2010, Brandi, Ireton Jones 1992 or Schofield formulas without any correction were more reliable.

Conclusion: Indirect calorimetry should be used in critically ill patients to continue accurate nutrition. Most reliable predictive equation decided by clinicians can be used to start nutrition therapy. 24th hour values can be used in maintenance therapy in the following period.
Coronary dissection - An uncommon cause of chest pain

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Spontaneous coronary artery dissection (SCAD) is a non-traumatic and non-iatrogenic separation of the coronary arterial wall and is a rare cause of acute myocardial infarction. It is more common in younger patients and in women. The underlying mechanism is not yet fully understood, but an intimal tear or bleeding of vasa vasorum with intramedial hemorrhage has been proposed.

The authors present the case of a 62 years old female patient, admitted to the emergency department for chest pain with 2 hours of evolution. No previous medical. At admission, hemodynamically stable with an EKG revealing sinus rhythm (72bpm) with left bundle branch block. Analytics revealed high sensibility Troponins I máx 1067 ng/L. The patient was sent to the hemodynamic room for a primary percutaneous coronary intervention (PCI) that showed anterior descendent artery (ADA) distally occluded with suspected dissection. The patient was admitted to the Cardiology Intensive Care Unit in Killip I stage with 38% left ventricular ejection fraction and apical akinesia. Next day, new episode of pain without relief despite medical therapy, with troponin reaching 14.300ng/L. A new emergency PCI was performed revealing new ischemic event with progression of the diffuse spontaneous ADA dissection, impossible to intervene percutaneously but also without favorable surgical approach by the cardio-thoracic surgical team. The option was made to suspend anticoagulation (enoxaparin), maintaining the double platelet antiaggregant strategy. The patient remained in the Cardiology ward without new events and was finally discharged from the hospital 3 weeks after admission.

In most SCAD patients, conservative therapy is the preferred strategy after the diagnosis is secured. However, the optimal management is uncertain. A wide range of approaches, including conservative management, emergency revascularization PCI or coronary artery bypass grafting (CABG) and cardiac transplantation have been reported.
Descriptive study on the application of the PaP-score scale in our hospital

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OBJETIVES:
In palliative care, the estimation of the prognosis is a factor of great importance to be able to provide information to patients and relatives, and to establish appropriate diagnostic and therapeutic plans. For this, we can pass on scales as the PaP-score, recommended after review realized for the European Association of Palliative Care.

The objective of this study is evaluate the application of this scale in our group of patientes.

METHODS:
It is a descriptive study in which they analyzed the histories of 102 patients with advanced oncology disease in whom the applied the PaP-score scale of inclusion in a program of palliative home care during 2017.

The application of PaP-Score classified the patients in three groups in function of their 30-day survival probability.

RESULTS:
Of the 102 revised histories, 41 patients (40.2%) were classified in the group A (30-day survival probability >70%). In this group 39 (95.12%) died after 30 days and only 2 (4.88%) died before 30 days.

41 patients (40.2) were classified in the group B (30-day survival probability between 30-70%). Of them, 14 (34.14%) died before 30 days and 27 (65.86%) died after 30 days. 20 patients (19.6%) were classified in the group C (30-day survival probability <30%). Of them 189 (90%) died before 30 days and only 2 (10%) survived more than one month.

CONCLUSIONS:
We confirm in our study that PaP-score is a useful tool, that helps to predict the survival, mostly in the patients classified in the groups A and C, and helps us to take diagnostic or therapeutics decisions and to make a therapeutic strategy according to the needs of the patients.
Do-Not-Attempt-Cardiopulmonary-Resuscitation practices in acute care for older adults – a qualitative study

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Background:
Older adults are more likely to receive Do-not-attempt-cardiopulmonary-resuscitation (DNACRP) orders when they are admitted to hospitals compared to younger patients, yet little is known of the impact these orders have on the every day care of older patients.

Objectives:
To understand staff perceptions on issues surrounding current DNACPR practices involving older adults in the acute setting, and elicit the influences of DNACPR decisions on care for older adults.

Design:
A qualitative approach was used. Semi-structured interviews were conducted with 15 health professionals from multiple disciplines, working in geriatric medicine wards, in a district general National Health Service (NHS) hospital in the United Kingdom (UK).

Results: All participants supported the use of DNACPR orders in older adults but agree on the unintended repercussions to care beyond what the order stipulates. Four key themes have been identified surrounding DNACPR practices in older adults including: complex decision-making, challenging discussions, staff's reflections of its impact on care and its benefits to geriatric medicine.

Conclusion:
Hospital DNACPR practices in older adults can be variable with DNACPR decisions having unintended negative influences to care. Nevertheless, staff in geriatric medicine strongly support its use in older adults which staff felt led to a more holistic care with discussions often used as platforms for conversations on wider aspects of care. Perhaps incorporating DNACPR decisions into formal care plans, and increasing staff education on resuscitation policies may help standardize practices and remedy its negative influence on care.
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Epicardial fat necrosis: a rare and benign cause of chest pain

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Introduction: Epicardial fat necrosis is a rare clinical condition and it should be considered in the differential diagnosis of chest pain. The etiology is unknown, but the prognosis is good with it being a self-limited disease. In general, the presenting symptom is left-sided chest pain with pleuritical characteristics in a previously healthy individual with an associated juxtacardiac mass seen in chest radiography. The CT or MRI may confirm the correct diagnosis.

Case description: We present the case of a previously healthy 50-year-old man admitted in the emergency department for intense chest pain located in the lower left part of the chest anteriorly, worsened by deep inspiration and with at least 10 hours of duration. The pain was sudden and there were no similar episodes before. On physical examination, the patient was very symptomatic, with tachypnea (29 cpm), tachycardia (HR: 110 bpm) and diaphoresis. Otherwise, the physical examination was normal. The electrocardiogram showed sinus tachycardia, without ischemic changes. Results of blood studies, arterial blood gas, and the chest radiograph were normal. Thoracic CT showed an ovoid encapsulated mediastinal (epipericardial) fatty lesion in the left cardio-phrenic angle with soft tissue rim and intrinsic and surrounding soft tissue stranding, without pleural effusion, typical of epicardial fat necrosis. During hospitalization, the patient remained stable under analgesic therapy and was discharged home with symptomatic relief medication. The thoracic CT was repeated showing a reduction in the size of the paracardiac lesion.

Discussion: Epicardial fat necrosis is a significant clinical condition. At admission, these patients can mimic emergent conditions, such as pulmonary embolism or acute coronary syndrome. Our goal is to raise awareness of clinicians and radiologists to this condition in order to manage it properly in emergency departments. A clinical diagnosis and symptomatic care are sufficient in most instances.
Evaluation of B-type natriuretic peptide as prognostic marker in patients with pneumonia: An observational study

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Background: Pneumonia is the leading cause of death due to infection among the elderly in developed countries. We validated the usefulness of B-type natriuretic peptide (BNP) as a prognostic marker for pneumonia.

Methods: We carried out an observational study at Kanazawa Medical University Himi Municipal Hospital. We enrolled patients admitted between 1 January 2012 and 31 October 2016 with diagnoses of community-acquired pneumonia (CAP), non-CAP composed of aspiration pneumonia (AP) and healthcare-associated pneumonia (HCAP) whose BNP levels had been determined within the first 24 hours of admission. After enrollment, we collected baseline, demographic, clinical and laboratory characteristics, and outcome data. We followed all patients until discharge. Primary outcome was defined as 30-day death. We applied univariate and multivariable Cox-regression analysis to each parameter to identify predictors of death for all included cases, CAP, and non-CAP.

Results: Of 543 subjects included in the study, 205 were diagnosed with CAP and 338 with non-CAP. In the univariate analysis of the 543, mean BNP levels were associated with death (p = 0.0000); and in the multivariate analysis, BNP remained an independent predictor of mortality (cut-off points 220 pg/mL, hazard ratio (HR) 1.99, 95 % confidence interval (CI) 1.16-3.4, p = 0.01). A similar situation was found in univariate analysis of CAP and non-CAP (p = 0.0008, 0.0000, respectively), and in multivariable Cox-regression analysis of non-CAP (HR 2.27, 95 % CI 1.3-3.95, p = 0.004).

Conclusion: BNP level may be a useful single prognostic marker for AP or HCAP.

References:
Factors associated with warfarin overdose and its complications in 1019 cases hospitalized in Emergency Internal Medicine

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Background: We planned this study to investigate factors associated with warfarin overdose (WOD), WOD associated bleeding and factors affecting bleeding, and mortality in WOD cases and factors affecting mortality.

Methods: The study population consisted of 1019 patients in total, 360 patients (35.3%) with an INR below 5, 487 patients (47.8%) with an INR between 5-10, and 172 patients (16.9%) with an INR of 10 or above. Demographic, clinical, and laboratory findings of the patients were obtained from the Real Life Data Provision Center and Hospital Information Management System.

Results: Admittance in winter (OR= 1.468; p= 0.012), INR: 5-10 (OR= 2.302; p< 0.001), INR ≥ 10 (OR= 9.451; p< 0.001), and antiplatelet use alongside warfarin (OR= 1.618; p= 0.008) were found to be independent risk factors for bleeding in our study. The mean age (p< 0.001), median ratio of primary hypertension cases (p= 0.006), ratio of INR ≥ 10 patients (p= 0.010), ratio of patients who had received antiplatelet treatment (p= 0.031), and ratio of patients with bleeding (p< 0.001) were higher among patients who died compared to those who survived. The cutoff value for INR in predicting bleeding was found to be >6 with 81.9% sensitivity and 70.6% specificity.

Conclusion: Factors associated with WOD, WOD associated bleeding and factors affecting bleeding, and mortality in WOD cases and factors affecting mortality were investigated comprehensively for the first time with this study.
Introduction:
Myasthenia Gravis is an autoimmune disease mediated by post-synaptic antibodies to nicotinic acetylcholine receptors or muscle-specific tyrosine kinase, which causes morphological and physiological changes in neuromuscular junction.
Objectives: We intend to emphasize the importance of an adequate differential diagnosis and the immediate establishment of targeted therapy in the context of urgency.

Case description: We present the clinical case of a 61 year old woman. Of her personal antecedents we emphasize mixed dyslipidemia and essential hypertension. She applied to the Emergency Department complaining of left palpebral ptosis, diplopia, dysphonia, dysphagia and asthenia with onset. She denied another symptoms or fever. At physical examination we noticed symmetrical and normal osteotendinous reflexes and a positive ice pack test.

Discussion: There were no analytical alterations and type II urine was normal. Arterial blood sample did not reveal respiratory insufficiency and the chest X-ray was normal. The electrocardiogram presented sinus rhythm. The crainoencephalic computerized tomography (CT) had no recent lesions. Based on suspicion of myasthenic syndrome, the patient promptly started pyridostigmine and was admitted for study. Subsequently the anti-cholinesterase receptor and electromyography were performed and the diagnosis of Myasthenia Gravis was confirmed. In this context, she was treated with immunoglobulins. A thoracic CT was also performed to exclude thymoma.

Conclusion: Myasthenia Gravis is a relatively rare diagnosis. It usually presents with fluctuating generalized muscular weakness and asymmetrical palpebral ptose with diplopia. Following the clinic of suspicion, adequate therapy is crucial. The remission of the disease still the ultimate goal.
Guillain-Barré Syndrome: an important consideration at emergency department

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Introduction: Guillain-Barré Syndrome (GBS) is an immune-mediated peripheral neuropathy characterized by rapidly progressive symmetrical ascending weakness and sensory loss. The cardinal clinical features of GBS are progressive, fairly symmetric muscle weakness and absent or depressed deep tendon reflexes.

Case description: We introduce a case of a 63-year-old woman, with numbness and paresthesias in the lower extremities. She was seen three weeks ago complaining about generalized myalgias, sore throat and cough and was treated with amoxicillin. A week later she noticed numbness and tingling in her feet, progressively ascending, bilateral lower extremity weakness, gait issues, dysphonia and dysphagia. About six weeks ago, she had been vaccinated against influenza. On admission, she was afebrile with stable vital signs. On neurological examination, she presented low elevation of the palate, normal tongue protrusion, dysphagia for liquids and disartrodysphonia, Her motor strength in hip flexors, quadriceps, and hamstrings were 4/5 bilaterally; dorsiflexors and plantar flexors were 3/5 bilaterally. Sensation was intact on upper extremities but diminished on lower extremities and abdomen. Her gait was ataxic with osteotendinous arreflexia and plantar flexion bilaterally. The laboratory tests did not reveal any infectious process. The lumbar puncture revealed protein count of 32 mg/dL with no cells and glucose of 75 mg/dL. The diagnosis of GBS was suspected and we promptly started therapy with immunoglobulins.

Discussion: GBS should be considered in the differential diagnosis for patients presenting to emergency department with lower extremity numbness and antecedent history of upper respiratory infection or gastroenteritis.
High Dosage of Corticosteroid Therapy in Toxic Encephalopathy: A Case Report

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Introduction
Typhoid fever is a common disease in tropical countries, while in Europe it is relatively rare. However, there were 914 cases of typhoid fever that reported in 27 Europe countries in 2014. Typhoid encephalopathy is one of fatal neurological complications of typhoid fever. Unfortunately, there is no definite therapy for typhoid encephalopathy.

Case Description
A 45 years old woman had been developed an acute onset of high fever and diarrhea since 10 days before she admitted to our hospital. On physical examination, we found that her blood pressure was 90/60 mmHg, heart rate was 100 /minute, respiratory rate was 30/minute and temperature was 39\degree C. Laboratory examination showed platelet 65.000/µL and anti-salmonella typhi IgM was positive.
She was treated with ceftriaxone 3 gr/ 24 hours. On the second day of hospital admission, her GCS (Glasgow Coma Scale) score was deteriorating to 8. There were no signs of an intracranial problem. The patient's family refused to have Brain-CT Scan performed on her. After dexamethasone 1 mg/kg IV every 8 hours was given, the patient regains consciousness rapidly that her GCS score was improved from 8 to 15 in three days.

Discussion
We report this clinical case to show the role of dexamethasone therapy for typhoid encephalopathy. There is a hypothesis that suggests that dexamethasone may reduce inflammatory process and cerebellar edema which caused by typhoid toxin. Lakhotia et.al revealed that mean time for resolution in toxic encephalopathy is 19.3 (11-30) days, while in our patient mean time for resolution was only three days. We presumed that dexamethasone may have a role in improvement of typhoid encephalopathy.

Reference:
INTRODUCTION: Acute spontaneous subdural hematomas are rare but they can course with a prompt and progressive neurologic decline, making the early diagnose so important. Its incidence has been increasing, and they are usually associated with anticoagulant therapy, or vascular malformations.

CASE DESCRIPTION: 65 years-old female, medicated with dabigatran 110mg twice/day for atrial fibrillation, changed medication due to minor surgery to 200 mg once/day of low molecular weight heparin (LMWH) instead of the prescribed 100mg once/day.

She came to the emergency department with a sudden cervicalgia, with slight limitation in the movements of the spine that evolved to tetraplegia, anesthesia and urinary retention in just four hours. The complete blood count, coagulation screen, head computed tomography and lumbar puncture, presented no relevant changes.

Medicated with 200mg of hydrocortisone, the patient showed a clinical improvement, yet maintaining right hemiparesis, hypoesthesia below D5 and muscular spasms. After a magnetic resonance (MRI) it was documented an acute epidural hematoma with mass effect. Evaluated by neurosurgery and submitted to conservative treatment, patient progressively improved, having discharge without neurological deficits.

DISCUSSION: In the presence of sudden rachialgia with neurological impairment, subdural cervical hematoma should always be equated. Considered as neurosurgical urgency, conservative treatment can be a plausible choice in patients with spontaneous improvement of neurological deficits or coagulopathy.
Importance of acute renal failure in development of contrast-induced nephropathy in patients for whom emergency coronary angiography was performed

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Objective: In this study, we aimed to examine incidence and clinical outcome of contrast-induced nephropathy (CIN) in patients who had acute renal failure and for whom coronary angioplasty was performed due to pre-diagnosis of acute coronary syndrome.

Material and Method: 138 patients (49 females (35.5%) and 89 males (64.5%) with acute renal failure for whom acute coronary syndrome was suspected between the dates January 2014 and December 2017 were retrospectively included in this study. Diagnosis of CIN was made by an increase of 25% or 0.5 mg/dL in basal creatinine levels 24-48 hours after the procedure and in case where this situation could not be explained by any other cause.

Results: Mean age of the patients was 69.6±13.2 years. In 59.4% (n:82) of the patients, diabetes was present. Distribution of blood groups of the patients by the majority was as: A+ (39.9%), O+ (25.4%), B+ (14.5%), O- (8.7%), AB+ (7.2%), A- (2.2%) and B- (2.2%). Median duration of hospital stay of the patients was 5 days. Of the acute renal failure patients, 89.1% (n:123) was determined to have contrast exposure for once, 6.5% (n:9) for twice and 3.6% (n:6) for three times. Ratio of patients that developed CIN among acute renal failure patients was 1.4% (n:2). Remission was observed in these 2 patients that developed CIN. Both of the patients that developed CIN had been diagnosed with diabetes and had blood group 0.

Conclusion: According to the data of our study, we can say that acute renal failure is not a strong risk factor for development of CIN. Conduction of additional analysis is required in order to say whether blood group is associated with development of CIN. There was not sufficient number of patients that developed CIN for this analysis. Therefore, we may speculate that risk for developing CIN is higher in blood group 0.
Incidence and clinical outcome of development of contrast-induced nephropathy in patients for whom emergency coronary angiography

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Aim: We aimed to examine incidence and clinical outcome of contrast-induced nephropathy (CIN) in patients for whom acute coronary syndrome was suspected in the emergency department and emergency coronary angiography was performed

Method: Clinical, demographical and laboratory findings of 7253 patients who admitted to emergency department and for whom emergency coronary angiography was performed due to acute coronary syndrome between the dates January 2014 and December 2017 were examined retrospectively. Of these patients; 4224 were excluded from the study as they did not have kidney function test (KFT) results after contrast material exposure. 3064 patients were included in the study. Diagnosis of CIN was made by an increase of 25% or 0.5 mg/dL in creatinine levels after contrast material exposure and lack of any cause that may explain this impairment in KFT.

Results: Of 3064 patients; 2535 had normal baseline KFT, 138 were determined to have acute renal failure (ARF) and 391 were determined to have chronic kidney disease (CKD). In whole population, 2.5% (n:77) were determined to have CIN after the procedure. It was determined that KFT of 62 of the patients that developed CIN were regressed up to baseline values and it progressed in 15 of them. Mean age, median duration of hospital stay and ratio of patients with CKD were higher in patients that developed CIN compared to those did not. Ratio of developing CIN was determined to be higher in the CKD patients group compared to the ARF group and the group with normal baseline KFT (%10.2, %2, %1.4, respectively; p<0.001). Rate of remission after CIN was determined to be 100% in the ARF group, 88.6% in the group with normal baseline KFT and 72.5% in the CKD group.

Conclusion: CIN was determined to be lower than expected in patients for whom emergency angiography was performed due to acute coronary syndrome,
Intraaortic balloon pump counterpulsation in critical patients – 3 years in review

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The intraaortic balloon pump (IABP) is the most widely used circulatory assist device. Its inflation and deflation have two main hemodynamic (HD) effects: The blood flow is displaced to the proximal aorta by inflation during diastole and aortic volume (and thus afterload) is reduced during systole. The IABP is a temporary but efficient measure in patients with HD compromise as is cases of acute coronary syndrome (ACS), low cardiac output and as a bridge for CABG.

Objectives: To identify the main indications, complications and average usage time of the IABP at the Cardiology Critical Care Unit at São João Hospital.

Methods: Retrospective study including all the patients selected for IABP in the last three years.

Results: The retrospective study included patients subject to IABP between January 2015 and December 2017, in a total of 43 cases. 35 patients (81.4%) were males and the average age was 65.8 years. The youngest patient was 41 years old and the oldest 86. Regarding the etiologies, 53.4% (n=23) of patients had acute myocardial infarction (AMI) with ST segment elevation; 39.5% (n=17) AMI without ST segment elevation and only in 6.9% (n=3) unstable refractory angina. In the group admitted for AMI, 47.6% (n=20) evolved in Killip IV stage – Cardiogenic shock. Regarding the formal indications for IABP, to highlight patients (n=15) with unstable refractory angina besides optimized medical therapeutics, HD instability (n=20), "bridge" for CABG in HD risk patient (n=19), mechanical complications (n=2) and as an ECMO support (n=2). During the study period were registered 12 complications, the most important ones being fever after IABP (n=4), local hemorrhage (n=2) and cardiac arrest (n=3). The global mortality was situated in 20% (n=9) and the average days of IABP per patient was 3.81.

Conclusion: Intraaortic balloon pump (IABP) is widely used although potentially life-threatening complications could occur including: limb ischemia; vascular laceration and major hemorrhage.
Malignant Hyperthermia in an 18-year-old army recruit with no previous medical history: case report and policy implications

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Introduction: Heatstroke remains to this date a major concern due to its rapid onset and progression, which can result in non-reversible permanent disability to a previously healthy individual. Despite some well-established risk factors, cases have also been reported concerning individuals with no significant medical history and no clear causative agent. In military occupations or activities which demand prolonged exposure to heat heatstroke is therefore significant consideration, requiring early warning and preventive policies.

Case description: We hereby report a case of a young military recruit that developed heatstroke within a week from entering compulsory military service. Despite the existence of preventive and early diagnosis policies, the patient was transferred to the emergency services having already developed the full range of heatstroke multi-organ decompensation. Despite a prolonged ICU hospitalization and rehabilitation process in a center of excellence, severe cognitive, motor and speech disability has been established. Discussion: This case illustrates the need for both generalized application of prevention policies against heat–related adverse health events as well as increase of the capacity for immediate treatment onset on site for military personnel serving in high risk areas.
Medical decompensations in patients urgently admitted in 2 Surgical areas

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OBJECTIVES
To analyze the % of patients admitted urgently and in Orthopedic Surgery and Traumatology (OST) and Vascular Surgery (VS) who present some medical decompensation that needs to notify an Internal Medicine and Cardiology team (T) dedicated to the control of medical pathologies in surgical units, taking into account the age of the patients.

MATERIAL AND METHOD
Descriptive analysis of % of patients admitted urgently and scheduled in OST and VS that presented medical decompensations, according to age groups.

RESULTS
From June 2008 to November 2014, 1486 consultations were sent from OST and 173 from VS to T, on patients with medical decompensations. 135 (9%) corresponded to scheduled admissions and 1351 (91%) to urgent admissions.

About the decompensated urgent admissions, 48% were over 80 years old. Their decompensation rates are summarized in Table 1.

From January 2011 to November 2014, 173 consultations from VS to T were sent about patients with medical decompensations. 13 (7.5%) corresponded to scheduled admissions and 160 (92.5%) to urgent admissions.

About the decompensated urgent admissions, 30.62% were over 80 years old. Their decompensation rates are summarized in Table 1.

CONCLUSIONS
Over 40% of all patients older than 84 years admitted urgently to OST, without taking into account any other variable, suffered some type of relevant medical decompensation. The early evaluation of this subgroup of patients by Internal Medicine and/or Cardiology could be beneficial in terms of morbidity and hospital stay. Otherwise, in VS the data do not seem to suggest that age over 80 years old can be a predictor of decompensation in patients admitted urgently to VS, since only about 15% of this subgroup, without considering any other variable, suffered some type of decompensation. In the absence of further studies, an early evaluation of all this subgroup of patients by Internal Medicine and/or Cardiology does not seem interesting in cost-benefit terms.
Mortality associated with urinary retention and catheter insertion in diabetic older adults admitted to the Internal Medicine department

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Background: Urinary retention (UR) and catheter insertion are common in older adults admitted to Internal Medicine departments. Diabetic older adults are particularly at risk for UR due to higher incidence of bladder atony, urinary tract infection, and polyuria. We sought to study if catheter insertion in this population is associated with higher long-term mortality.

Methods: Included were all (n=160) diabetic older adults (age >65 years) admitted to all Internal Medicine departments in a tertiary medical center during two years, in whom urinary catheter was inserted due to UR - defined as symptomatic post-void residual urinary volume of 150 ml or more. Excluded were 21 (13.1%) patients who died during hospitalization or within 30 days of admission. Cox regression analysis was used to study if urinary catheter not removed at discharge was associated with 1-year mortality independent of age and chronic co-morbidities.

Results: The final cohort included 139 diabetic older adults: mean age 80.3±7.0 years; 83 (59.7%) males. Most patients (n=92; 66.1%) were discharged with a urinary catheter, and compared with patients discharged without a urinary catheter, they had higher 1-year mortality rates (48.9% vs. 19.1%; HR 4.04; 95%CI 1.75-9.30; p=0.001). Cox regression analysis showed that 1-year mortality was associated with being discharged from hospitalization with a urinary catheter (HR 2.55; 95%CI 1.21-5.37; p=0.014) independent of age and chronic co-morbidities.

Conclusion: UR and catheter insertion in diabetic older adults admitted to Internal Medicine departments is associated with higher 1-year mortality rates if the catheter is not removed at discharge.
Organophosphate poisoning - the reality of a Polyvalent Intensive Care Unit

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Background: Pesticide poisonings are a concern in many countries. Organophosphates (OGPs) are one of the greatest threats to human health. The objectives of this study are characterize a population admitted for OGP intoxication and determine predictive factors of poor prognosis.

Methods: A retrospective cohort study of 50 patients admitted to a Polyvalent Intensive Care Unit (PICU) of a Portuguese central hospital between 2006 and 2016. The study evaluated: gender, age, provenance, month of admission, name and type of toxic, clinical admission, cholinesterase assay, prior intoxication, psychiatric illness, intoxication-hospital time, hospital-PICU time, admission Glasgow Coma scale, mechanical ventilation time, total hospitalization time, SOFA in the first 24 hours/maximum, APACHE, SAPS II, presence of intermediate syndrome and mortality at hospital discharge.

Results: Most patients (76%) were male, mean age was 49.72 years (±17.9) and 68% of them were admitted to the Emergency Department. The months in which there were more admissions were October and November (14%). Chlorpyrifos was the most common toxic (52%) and 82% of patients had a history of previous intoxication. Muscarinic symptoms prevailed (54%). The hospital time-PICU ≥2h correlated significantly with absence of previous intoxication, patients aged ≥50 years, total hospitalization time ≥10 days, and higher SOFA. Younger patients (< 50 years) achieved more favourable outcomes at various levels. The prevalence of the intermediate syndrome was 12% and the mortality rate was 6%, with prevalence in patients > 50 years of age (p=0.048).

Conclusion: Timely intervention, adequate patient allocation and maintenance of appropriate follow-up care are the pillars in approaching the intoxicated patient, reflecting the prognosis.
Platelet count upon acute hospital admission to internal medicine wards in adults and its association with mortality: an asymmetric U-shaped curve.

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Background: Platelet have pleiotropic effects and may influence the prognosis of medical conditions. The objective of this study was to assess the prevalence of thrombocytopenia and thrombocytosis upon acute hospitalization in internal medicine wards and to assess the association between the platelet count and mortality in this population.

Methods: We included all adults (>15 years old) in the North and Central Denmark Regions at their first acute admission to an internal medicine ward during 2006-2012 and categorized these patients according to their platelet count measurements within +/- 24 hours of admission. We assessed the association between platelet count and in-hospital, 30-day, 90-day and 365-day mortality by logistic and cubic spline regression models adjusted for age, sex, comorbidities, admission to intensive care unit, hemoglobin level and leukocyte count.

Results: Among the 274,148 patients, 6.8% had thrombocytopenia and 7.8% thrombocytosis. Both thrombocytopenia and thrombocytosis prevalence increased with older age and the presence of cancer. The association between platelet count and mortality depicted an asymmetric U-shaped curve. For 30-day mortality, the ORs were 3.92 (95%CI: 3.31-4.65), 3.07 (95% CI: 2.72-3.45) and 1.64 (95% CI: 1.52-1.77) for severe (<50 x 10^9/L), moderate (50-99 x 10^9/L) and mild thrombocytopenia (100-149 x 10^9/L), respectively, and 1.32 (95% CI: 1.23-1.42) and 1.48 (95% CI: 1.28-1.52) for mild (401-499 x 10^9/L) and severe (≥500 x 10^9/L) thrombocytosis. A similar pattern was observed for in-hospital, 90-day and 365-day mortality.

Conclusions: Abnormal platelet count upon acute hospital admission in internal medicine wards is frequent and is a marker of mortality.
Platelet distribution width: a novel prognostic marker in an internal medicine ward

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Background: Platelet distribution width (PDW) has demonstrated clinical significance in populations with specific disorders; its prognostic significance in internal medicine wards has not been investigated.

Methods: Demographic, clinical and laboratory data were collected prospectively for 1036 internal medicine inpatients. The primary outcome was 90-day mortality, secondary outcomes were: treatment with mechanical ventilation, prolonged hospital stay, in-hospital death and all-cause mortality following discharge. Data were assessed according to PDW values on admission \( \leq 16.7\% \) (group A) and \( >16.7\% \) (group B).

Results: Compared to group A patients (n=273), group B patients (n=763) were more likely to be older, admitted for cardio-cerebrovascular disorder, to present with comorbidities, to be mechanically ventilated (\( p=0.02 \)), to have prolonged hospital stay (\( p=0.01 \)) and to die during the current hospitalization (\( p=0.01 \)). The respective 90-day and total (median follow-up of 5 months) mortality rates were significantly higher in group B (13.2\% and 16.3\%) than in group A (6.6\% and 9.5\%), \( p<0.01 \) for all comparisons. On multivariate analysis, none of the in-hospital outcomes were associated with higher PDW on admission. However, higher PDW values on admission (using the cut-off of 16.7\% and for each 1\% increment) strongly predicted 90-day mortality: relative risks (RR) 1.58 and 1.49; 95\% confidence intervals (CI) 0.89\textsuperscript{–}2.78 and 1.06\textsuperscript{–}2.09, respectively. Moreover, every 1\% increment of PDW on admission was a powerful predictor of shortened survival (RR 1.26, 95\% CI 0.97\textsuperscript{–}1.64).

Conclusion: Higher PDW values on admission to internal medicine wards are associated with a more severe clinical profile and predict poor short-term survival.
Prognostic Impact of Anemia in Patients with Acute Heart Failure

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Objectives: To evaluate the prognostic impact of the mean value of Hb on the admission of patients (D) with acute cardiac insufficiency (ACE) in terms of cardiovascular mortality.

Methods: Retrospective study of 333 D admitted by ICA consecutively between February 2010 and September 2016 in a cardiac intensive care unit. The sample was divided into 2 groups: group 1 (G1) who died during hospitalization and group 2 (G2) who survived. The main objective of the study was to evaluate whether the mean value of Hb at admission in the 2 groups had a prognostic impact on cardiovascular mortality in patients with AHF.

Results: The sample had a mean age of 68 ± 14 years and a predominance of the male gender (78%). In 28% of the D the etiology was ischemic. The mean LVEF was 33 ± 12%. Mortality occurred in 40% of patients. At admission the groups presented similar clinical and analytical characteristics: majority with congestive HF (G1 100% vs G2 91%) and NT-proBNP values (G1 13270 ± 10513pg / nL vs G2 13895 ± 16897pg / nL). The etiology was ischemic in 28% of the D of the G1, in 30% of the D of the G2. Regarding therapeutics, intravenous diuretics in the majority of groups (G1 72% vs G2 62%); use of levosimendan predominantly in G1 D (G1 76% vs G2 52%); noradrenaline / dobutamine (G1 24% vs G2 14%). Noninvasive ventilation was used in 52% of G1 D in 41% of G2.

G1 patients had a mean Hb on admission of 10.2 g / dl and the G2 patients had 12.6 g / dl. In our sample, we observed that the mean value of Hb at admission to G1 was lower, but did not show a prognostic impact on cardiovascular mortality (p = 0.15).

Conclusions: According to the literature we found a high percentage of mortality in these patients. We found that the mean value of Hb on admission has no impact on the mortality of these patients.
Prognostic Impact of Hemoconcentration in Patients with Acute Heart Failure

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Objectives: To evaluate the prognostic impact of Hemococoncentration in patients (D) with acute cardiac insufficiency (AHF).

Methods: Retrospective study of 333 D admitted by ICA consecutively between February 2010 and September 2016 in a cardiac intensive care unit. Hemoconcentration was defined as hematocrit > 35%. According to this value, the initial sample was divided into two groups - Group 1 (G1) with Hematocrit (> 35% mm / L) and group G2 (G2) ≤35%. We evaluated the prognostic impact of hemoconcentration in terms of readmission for AHF and mortality.

Results: The sample had a mean age of 68 ± 14 years and a predominance of the male gender (78%). In 28% of the D the etiology was ischemic. The mean LVEF was 33 ± 12%. ICA re-hospitalization occurred in 38% and mortality was 40%.

Hyponatremia was identified in 45% of the D.

At admission the groups presented similar clinical and analytical characteristics: majority with congestive HF (G1 100% vs G2 91%) and NT-proBNP values (G1 13270 ± 10513pg / nL vs G2 13895 ± 16897pg / nL). The etiology was ischemic in 28% of the D of the G1, in 30% of the D of the G2. Regarding therapeutics, intravenous diuretics in the majority of groups (G1 72% vs G2 62%); use of levosimendan predominantly in G1 D (G1 76% vs G2 52%); noradrenaline / dobutamine (G1 24% vs G2 14%). Noninvasive ventilation was used in 52% of G1 D in 41% of G2.

We found that patients with hematocrit higher than 35% (G1) did not present statistically significant differences regarding the number of ICA rehospitalizations (p = 0.72), nor of in-hospital mortality (p = 0.21), or during follow-up at 12 months (p = 0.20).

Conclusions: According to the literature we found a high percentage of readmissions and mortality in HF patients. We found that hemoconcentration on admission did not have a prognostic impact in patients with AHF.
Prognostic Impact of Hyponatremia in Patients With Acute Heart Failure

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Objectives
To assess the prognostic impact of Hyponatremia in patients (D) with acute cardiac insufficiency (ACF).

Methods
Retrospective study of 333 D admitted by ICA consecutively between February 2010 and September 2016 in a cardiac intensive care unit. Hyponatremia was defined as sodium <135 mmol / L. According to this value, the initial sample was divided into two groups - Group 1 (G1) with hyponatremia (<135 mmol / L) and group G2 (G2) without hyponatremia (135 mmol / L). We evaluated the prognostic impact of hyponatremia in terms of readmission for AHF and mortality.

Results
The sample had a mean age of 68 ± 14 years and a predominance of males (78%). In 28% of the D the etiology was ischemic. The mean LVEF was 33 ± 12%. ICA re-hospitalization occurred in 38% and mortality was 40%.

Hyponatremia was identified in 45% of the D.

At admission the groups presented similar clinical and analytical characteristics: majority with congestive HF (G1 100% vs G2 91%) and NT-proBNP values (G1 13270 ± 10513pg / nL vs G2 13895 ± 16897pg / nL). The etiology was ischemic in 28% of the D of the G1, in 30% of the D of the G2. Regarding therapeutics, intravenous diuretics in the majority of groups (G1 72% vs G2 62%); use of levosimendan predominantly in G1 D (G1 76% vs G2 52%); noradrenaline / dobutamine (G1 24% vs G2 14%). Noninvasive ventilation was used in 52% of G1 D in 41% of G2.

We found that patients with hyponatremia at admission had a worse prognosis-a greater number of rehospitalizations due to AHF (p = 0.05), higher in-hospital mortality (p = 0.05), and also a higher mortality during follow-up at 12 months <0.001).

Conclusion
According to the literature, we found a high percentage of readmissions and mortality in HF patients. We found that admission hyponatremia has a prognostic impact and should be carefully evaluated and corrected in all patients with AAI.
Pulmonary embolism in young women.

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Introduction: Pulmonary embolism (PE) is a common acute cardiovascular disorder with variable and non-specific clinical presentation, of multifactorial cause, with considerable mortality. The pregnancy is one of the particular cause determined by hypercoagulable state, associated with increase of thrombotic and thromboembolic events, whose diagnosis and treatment are limited by the physiological status.

Case description: We describe the case of a healthy, smoking, 18-year-old woman, without usual medication. She was admitted to Emergency Department for shortness of breath, cough and hemoptysis for 3 days and pleuritic chest pain. She was already medicated 2 days ago with empiric antibiotic therapy for respiratory infection. On admission, physical examination revealed normal blood pressure, tachycardia 103 and mild hypoxic of blood arterial gasometry. Laboratory findings identified leukocytosis and neutrophilia of 88%, Protein C reactive High Sensitivity 17 mg/dL, D-Dimers 2855. We suspected the presence of PE (Well’s score + 2.5p.), confirmed after chest Computed Tomography Angiography (CTA) where was identified intraluminal filling defect in the right lower lobe of the pulmonary artery with presence of the pleura-based consolidation, little pleural effusion, with the presence of laminar thrombus of the inferior vena cava. After the abdominal-pelvic CTA, was confirmed the laminar parietal thrombus of 100x4 mm of the inferior vena cava, with an unexpected finding of the intrauterine fetus, estimated pregnancy of 14 weeks. We initiated hypocoagulation with low-molecular-weight heparin. Prothrombotic study performed (lupus anticoagulant, anticardiolipin antibodies, factor V Leiden, prothrombin 20210A, antithrombin, protein C and S)- negative.

Discussion: The diagnosis of pulmonary embolism should be suspected in patients with compatible signs and symptoms. It should be discarded the presence of pregnancy in all women at fertile age, even in an urgent and emerging context.
Several hypomagnesaemia is a cause of seizures frequently unrecognized. Renal, gastrointestinal or pharmacological causes for hypomagnesaemia should be considered and precipitating factors corrected if possible.

A 70-year-old male with stage 3 CKD and adenocarcinoma of the rectum, treated with neoadjuvant QT and RT, followed by retosigmoidectomy and protective ileostomy, three years ago. Diarrheal occurred in the early postoperative period, and he was hospitalized for AKI in CKD and seizure due to hypomagnesemia. Recently, when definitive colostomy was performed, segmental enterectomy was required. While undergoing oral magnesium replacement, he was hospitalized again due to generalized seizures. He reported frequent episodes of involuntary muscular contractions of the limbs and increased stool volume with weeks of evolution, observed in clinical examination. EEG and cerebral CT excluded central neurological lesion. Laboratory tests revealed severe hypomagnesemia and mild hypocalcaemia, decreased urinary excretion of these ions and normal urinary osmolarity; PTH increased, but lower than baseline and normal serum phosphorus; normal levels of sodium, potassium, aldosterone and renin; poor stool digestion; negative in search for Clostridium Difficile and parasitological. After correction of electrolytic disorders, PTH increased to usual values (elevated by CKD).

The increased stool volume in patients submitted to multiple intestinal surgeries and local RT, associated with an adequate renal response, suggests that hypomagnesemia is secondary to gastrointestinal losses. A hypoparathyroidism secondary to hypomagnesaemia is observed, due to a decrease in the synthesis or resistance to the action of PTH. He was discharged with loperamide and oral magnesium (1.5g tid), without recurrence of seizures.
Relation between elevated troponin levels and adverse outcomes in patients with acute heart failure

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Background: Troponin levels are often elevated in patients with acute decompensated heart failure. The clinical significance of this elevation is still unclear. The purpose of this study was to review the association between elevated cardiac troponin levels and adverse events in hospitalized patients with acute decompensated heart failure.

Methods: A retrospective cohort study was performed including patients admitted for acute heart failure to our hospital in 6 consecutive month. We excluded patients with decompensated heart failure due to myocardial infarction. Demographic and clinical data were analyzed. Patients who did not have a measurement of troponin at admission were excluded. High troponin I levels were defined as >0.1 ng/mL according to our local assay cut-off. Statistical analysis was performed with Stata®.

Results: 253 patients were included with a median age of 78 years (IQR: 71, 85) and a predominance of male patients (54%). Overall 107 patients (42.3%) had a high troponin I level. Patients with high troponin were older, more likely to have a history of hypertension and less likely to have a pacemaker. The in-hospital mortality was significantly higher in patients with high troponin (13.1% vs. 4.8%, p=0.018). The adjusted hazard ratio for mortality in patients with high troponin was 3.43 (95% confidence interval 1.27 – 9.30).

Conclusion: As suggested by previous literature, elevated troponin levels are associated with higher in-hospital mortality in patients with acute heart failure. This can help us develop clinical prediction scores in order to identify patients at risk for adverse short-term outcomes.
Acute internal medicine
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Retrospective analysis of erythrocyte concentrates transfusion in the Emergency Department of a District Hospital

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Objectives:
The goal of this work was to analyze and describe the epidemiological characteristics of the erythrocyte concentrate (EC) requests within a period of 6 months (second half of 2017) with a view to the elaboration of a transfusion orientation protocol for implementation in the Emergency Department.

Methods:
Retrospective and statistical analysis of clinical processes of patients undergoing EC transfusion of in the Emergency Department of the District Hospital studied.

Results:
We analyzed a total of 111 transfusion episodes, corresponding to 86 patients (43 women and 43 men) with a mean age of 76.74 years (maximum of 94 and minimum of 39). On average, patients had a hemoglobin value of 6.77 g/dl (maximum of 11.7 and a minimum of 2.2 g/dl). The unit average needed was two per transfusion episode. We found a great variability in the application of the EC transfusion, which was often associated with individual clinical practice rather than patient specific characteristics, conditioned by the need for rapid action. The aim of this therapy was mostly symptomatic improvement.

Conclusion:
The EC transfusion is required when the physiological mechanisms of adaptation fail or are insufficient to compensate for the decrease of hemoglobin levels. However, it has a high monetary cost and is dependent on the existence of donors. In recent years there has been a decrease in the number of donors in Portugal and this trend has been observed throughout the world, which makes the blood a valuable but limited resource.
Thus, it is important to regularize its use through a protocol.
In this series, it was verified that in the emergency department, the decision to transfuse is quite subjective, based on factors difficult to standardize such as quickness of clinical setting, the patients past history, the severity of the clinical picture and the need for surgical intervention, making it difficult to establish a transfusion protocol.
Septic Cavernous Sinus Thrombosis Probably Precipitated by Snorting Amphetamine

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Septic cavernous sinus thrombosis is a rare disease with serious complications and uncertainties about treatment. We report a case of hereditary thrombophilia and septic cavernous sinus thrombosis probably precipitated by snorting amphetamine and complicated by persistent ophthalmoplegia.
Objectives: We conducted a systematic review of secondary studies (systematic reviews and guidelines) to verify which evidence is available on the appropriate duration of antibiotic treatment in Community Acquired Pneumonia (CAP) and Healthcare Associated Pneumonia (HAP).

Methods: A systematic search of the literature was performed to identify all systematic reviews and guidelines that addressed the duration of antibiotic therapy and switch from venous to oral treatment in CAP or HAP. The recommendations of the three most cited and recent guidelines on the topic of interest were compared. Moreover, a meta-analysis of non-duplicate data from RCTs described in enrolled systematic reviews was performed together with a trial sequential analysis to identify the need for further studies.

Results: Two systematic reviews on antibiotic duration in CAP for a total of 15 RCTs and 2764 patients were enrolled in our study. Meta-analysis of non-duplicate RCTs showed non-significant difference in rate of treatment failure between short (< =7 days) and long (>7 days) antibiotic treatment course: OR 1.05 (95% CI, 0.79-1.40). The trial sequential analysis suggests that there is no need of other studies on this topic since further data would not affect current evidence or become clinically relevant. Selected guidelines suggest to consider shorter course, with low grade of evidence and without citing the already published systematic reviews. No systematic reviews on antibiotic duration were found for HAP. Moreover, no study for oral switch was found neither for CAP nor for HAP.

Conclusions: Antibiotic treatment of CAP for seven or less days is not associated with a higher rate of treatment failure than longer courses and should thus be taken in consideration. Guidelines should upgrade their recommendations on this topic.
Significance of hyperferritinemia in hospitalized patients

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Background: the aim of this study was to describe the epidemiological particularities of hospitalized patients with hyperferritinemia higher than 2000 ng/ml, and calculate the H score to evaluate the probability of MAS.

Patients and methods: Retrospective review of patients admitted from 2015 to 2017. Ferritin levels were compared to different diagnoses and laboratory values.

Results: 77 patients (44 men and 31 women) were identified. Median age was 66 years old (extremes 4 and 94 yrs). 20 patients had hematological malignancy, 15 septic shock, 14 chronic renal disease, 11 macrophage activation syndrome, 3 hepato-cellular disease, 7 polytransfusion, 6 sickle cell disease, 2 auto-inflammatory disease, and 1 auto-immune hemolytic anemia. Patients had high temperature in 42 cases (56%), adenomegalia in 22 cases (29.3%), splenomegalia in 18 cases (24%), and hepatomegalia in 8 cases (10.7%). The average rate of hemoglobin was 8 g/dl +/- 2.13, white cells 6160 /mm3 +/- 5540, neutrophils 5255/mm3 +/- 4442, platelets 139 G/L +/- 121, ferritin level 11091 ng/ml (1441 to 193370 ng/L), triglyceride 1.30 g/L, fibrinogen 4 g/L, AST 70 UI/L (7-15000 UI/L), and ALT 45 UI/L (10-2941 UI/L). Marrow aspiration showed hemophagocytosis in 10 cases (13.3%). The median rate of H score was 124 (standard deviation 73). The probability of having MAS was superior to 90% in 13 cases (17.3%) and superior to 75% in 17 cases (22.6%) MAS, hemophagocytosis, and mortality rate were significantly correlated with ferritin level superior to 6000 (p<0.01). Mortality was estimated at 22%. Early age at diagnosis, high temperature, cytopenia, high AST, H score, and mortality rate were significantly correlated in patients with ferritin levels superior to 6000.

Conclusion: this study has showed that high ferritin levels are correlated with the highest H score and mortality rate. In situations of high ferritin levels, we suggest the use of H score to guide the physician to evoke the diagnosis of MAS.
Spontaneous fracture of the sternum: a differential diagnosis of thoracic pain

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Spontaneous sternum fracture is a relatively rare condition. Physicians need to be aware of other non-cardiac, non-pulmonary and non-traumatic causes of chest pain.

A 74-years-old male with Non Small Cell Lung Carcinoma (NSCLC), with bone metastasis (sternum, lumbar and iliac spine). After coughing he developed severe chest pain in the sternal region associated with progressive worsening of dyspnea, and difficulty in eliminating secretions, so he turned to the Emergency Department. At admission he was polyneic with supraclavicular drawing, and global respiratory insufficiency. Chest X-ray was normal. Computed tomography (CT) of the chest revealed pathological fracture of the sternum body. Sternal fracture was treated conservatively in collaboration with the Palliative Care team achieving satisfactory control of pain after the introduction of opioids, corticosteroids and nonsteroidal anti-inflammatory drugs (NSAIDs). He was discharged with good symptomatic control.

Lung cancer is the third most frequent cause of bone metastasis being found in 30 to 40% of these patients. This type of metastasis increases morbidity, loss of functional capacity and quality of life. In the NPCLC the most common sites of metastasis are the spine (50%), ribs (27.1%), iliac (10%), sacrum (7.1%), femur (5.7%) and sternum (2.7%). Bone metastasis causes painful complaints of variable intensity which seems to be related to osteoclastic activity. Osteoclastic activity causes greater bone fragility and may lead to pathological fractures with minimal effort which is a marker of worse prognosis. The diagnosis is made by sternal X-Ray and/or chest CT. Treatment is multidisciplinary, and local radiotherapy may be required. For pain management NSAIDs appear to be effective as do opioid analgesics and corticosteroids.
The presentation, prevalence, etiology, treatment option and clinical outcome of severe hypercalcemic patients in emergency room

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Aim: We identified the presentation, prevalence, etiology and treatment regimens of patients presenting with severe hypercalcemia in order to examine the relationship with mortality.

Method: A total of 261 cases were included in the study, 94 cases with severe hypercalcemia and 167 cases with moderate hypercalcemia. Patients with a mean serum calcium level over 15 mg/dL were considered severe hypercalcemia.

Result: It was found that 49.8% of the patients were referred with neurological symptoms, 39.1% with gastrointestinal symptoms, 32.2% with renal symptoms, 17.2% with cardiovascular system symptoms and 45.2% with musculoskeletal symptoms. The prevalence of severe hypercalcemia in the emergency department was found to be 0.01%. In patients with hypercalcemia, the frequency of severe hypercalcemia was found to be 0.7%. In the etiology of severe hypercalcemia, malignancy was first seen. Patients with severe hypercalcemia had higher hospitalization, intensive care need and mortality rate. 93.5% of patients were isotonic, 62.8% diuretic, 2.7% calcitonin, 18.4% bisphosphonate and 7%, 7 received glucocorticoid therapy, and 16% received hemodialysis. We found the need for bisphosphonates and hemodialysis more because serious hypercalcemia required urgent and effective treatment. There was no difference between treatment regimens and mortality. After treatment, the duration of calcium recovery ranged from 2 to 504 hours with a median of 48 hours. Patients with severe hypercalcemia had a longer duration of calcium recovery. There was no difference in recurrence in patients with severe hypercalcemia and moderate hypercalcemia. There was correlation between calcium levels and mortality; patients with severe hypercalcemia had 2.32 times more mortality risk than those with moderate hypercalcemia.

Conclusion: The relationship between severe hypercalcemia presentation, prevalence, etiology, treatment choices and mortality was first examined extensively in this study.
Unilateral mydriasis after direct accidental visual contact with the plant of the genus Datura. Report of a case

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INTRODUCTION
Mydriasis is a frequent cause of emergency care. The differential diagnosis can be broad. It may be due to ophthalmological, neurological or pharmacological causes.

CASE DESCRIPTION
A 39-years-old male, taxi driver by profession, without allergies to drugs or toxic habits. No diseases of interest. He went to the hospital emergency room due to unilateral mydriasis and blurred vision in the left eye. No other symptoms.

He was admitted to study. The physical examination highlighted a unilateral midriasis of the left eye that reacts to light and accommodation and a slight blurred vision. The rest of the neurological examination was normal. The blood pressure was in the range. Urgent analysis was performed with normal parameters, CT and cranial angioTAC, it was normal. At 48 hours he was asymptomatic, the blurred vision and mydriasis of the left eye had disappeared.

In the interrogation, the patient reported that the previous day and that morning they had been working in the field removing herbs among which he identified the Angel’s trumpet (plant of the Datura genus). The patient remembered rubbing his left eye while working.

DISCUSSION
This report describes a case of unilateral mydriasis of sudden onset caused by the accidental instillation into the eye of the parasympatolytic alkaloids of Angel’s trumpet (plant of the genus Datura). These symptoms are typical of the effects of scopolamine or atropine on the eye after topical instillation.

It is important to make a correct anamnesis to rule out prior contact with toxins as a cause of the clinical picture. In our case, after the normalization of the tests carried out, the interrogation and the evolution of the patient gave us the key to the diagnosis.

Accidental poisonings have been described by contact with this plant, described in the literature with the suggestive name of “gardener mydriasis” as in our case described.
INTRODUCTION:
Malignant neuroleptic syndrome is characterized by symptoms such as hyperthermia, stiffness and altered level of consciousness. It occurs secondary to the use of antipsychotic drugs regardless of their previous use or dose, or by the withdrawal of dopaminergic drugs. The diagnosis is difficult because there are no specific complementary tests that confirm it. This syndrome can be fatal and the mortality 20% if treatment is not implemented promptly. Sometimes it requires admission to an intensive care unit.

CASE DESCRIPTION:
A 25 year old patient with a deep autistic spectrum disorder is admitted to psychiatry for psychomotor agitation. She begins with a fever of 39.6°C for four days after admission and significant muscle rigidity. During its first 48 hours of admission, she was treated with haloperidol because of the agitation. Since admission treated with antibiotics due to tooth infection. In urgent analysis, CP elevation was observed (up to 30000) with no acute phase reactants plus renal function deterioration.

Treatment with dantrolene is started after blood and urine culture extractions. Despite of start of dantrolene during 15 days, the fever remains and it’s not until a few days later that bromocriptine is added to treat the fever. Within the 48 hours after the start of Bromocriptine, the fever disappears. The patient was discharged from the hospital after 7 days without fever, maintaining a progressively decreasing dose of bromocriptine for 2 months at home, until totally finishing the treatment.

DISCUSSION: At present there is little clinical referente experience when we talk about malignant neuroleptic syndrome. It would be convenient to launch new studies in this area, involving the options of treatment of this syndrome and above all in the specific use of dantrolene and/or bromocriptine and the patient’s diverse responses to them.
Utility of Neutrophil-Lymphocyte Ratio, Platelet-Lymphocyte Ratio and Mean Platelet Volume as diagnostic and prognostic markers in patients with Liver abscess in a Tertiary Care Center in India

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Objective: To study the potential role of NLR, PLR and MPV as diagnostic and prognostic markers in patients with liver abscess. Methods: We have conducted the present study by screening 2,08,486 patients who have got admitted during the period January 2013- June 2017 as in patients in AIMS, Kochi. The data collected were analyzed for Neutrophil-Lymphocyte Ratio, Platelet-Lymphocyte Ratio and Mean Platelet Volume. Inclusion criteria was patients of all age group with liver abscess USG/CT proven. Exclusion criteria: All cases other than liver abscess. The data was collected and analyzed on windows excel Results: Male preponderance was seen 66 cases and female were only 15, mean age was 54 years. Eight Mortality were reported among the study population. The incidence of liver abscess was highest in coastal areas. NLR and PLR were highly significant with p- value 0 and 0.001 respectively and comparable to CRP with a p-value 0 but MPV with p-value 0.65 was not statistically significant to be used as diagnostic marker. Conclusion. From our study, we conclude that NLR, PLR are better cost-effective predictor and prognostic markers of liver diseases compared to CRP. These ratios can be used at the primary health care level as it can be derived from a simple peripheral smear. This will aid in early identification and management of liver abscess even in rural areas of developing country like India.
Utility of Neutrophil-Lymphocyte Ratio, Platelet-Lymphocyte Ratio, Mean Platelet Volume – Platelet Count Ratio as diagnostic and prognostic markers in patients with Hepatocellular carcinoma, Prostate carcinoma, Stomach carcinoma, Aplastic Anemia

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Objective: To study the potential role of NLR, PLR and MPV-Platelet ratio as diagnostic and prognostic markers in patients with HCC, Prostate cancer, Stomach cancer, Aplastic anemia. Methods: We have conducted the present study by screening 2,08,486 patients who have got admitted during the period January 2013- June 2017 as in patients in AIMS, Kochi. The data collected were analyzed for Neutrophil-Lymphocyte Ratio, Platelet-Lymphocyte Ratio and MPV-Platelet ratio. Inclusion criteria: Patients admitted with a diagnosis of HCC, prostate cancer, stomach cancer and aplastic anemia irrespective of the age and gender. Exclusion criteria: Patients with multiple malignancies, presence of secondary infection, any source of sepsis. SPSS tool was used for statistically analysis. Results: Cost effective predictive and prognostic biomarkers: identified in the study are- NLR for Liver Cancer, Prostate cancer and Stomach cancer, PLR for Prostate & Stomach cancer, MPV/Plate ratio can be used in addition to NLR in Liver Cancer. These ratios were not significant in aplastic anemia. Conclusion. From our study, we conclude that NLR, PLR are better cost-effective predictor and prognostic markers of HCC, Prostate cancer, and Stomach cancer. These ratios can be used at the primary health care level as it can be derived from a simple CBC/Peripheral smear. Early identification of Carcinoma is possible using these potential markers along with the respective clinical presentations and symptoms. These ratios will reduce the financial burden on the patients from rural and low socio-economic background and will aid in better management of the disease process.
White lung - What does it hide?

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Introduction: A white lung is present in situations in which the lung is unable to expand, conditioning the non-apposition of the visceral pleura and the parietal pleural. The impossibility of total lung expansion may be secondary to multiple pathological processes.

Case description: 83-year-old male with a history of chronic obstructive pulmonary disease (unconfirmed). He presented himself at the emergency department because of prostration and self-limiting hemoptysis. On objective examination he was febrile and with a gross vesicular murmur and prolonged expiratory time on pulmonary auscultation. In the arterial blood gas he had arterial oxygen saturation of 91% and hyperlactacidemia. Analytically there was an elevation of the acute phase markers (APM) and radiologically a hypotransparency limited to the right pulmonary apex. He was admitted to the Internal Medicine ward and empiric amoxicillin/clavulanic acid was initiated. On the third day of hospitalization, he presented heterogeneous hypotransparency of the entire right pulmonary field on the chest radiograph and maintained an elevation of the APM, which led to antibiotic scaling. On the eighth day, there was a marked radiological aggravation, with white lung on the right and retraction of the mediastinum on the same side. Diagnostic and evacuating thoracentesis was performed. The chest computed tomography revealed a massive infiltrative right lung lesion, involving the upper lobe with obstructive pneumonitis of the remaining pulmonary parenchyma.

Discussion: The incidence of lung cancer has increased worldwide, and the authors believe it should be taken into account in the etiological investigation of patients presenting with white lung.
“Battle” of the SIRS and qSOFA: a retrospective study of their predictive power in an emergency department

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Background: Sepsis is a life-threatening organ dysfunction caused by a dysregulated host response to infection. Its high morbidity and mortality have prompted the creation of treatment bundles and diagnostic criteria. In 2016 a new definition was proposed with new diagnostic criteria. We aim to assess the prognostic value of SIRS and qSOFA in the E.D. in patients later admitted to the ward.

Methods: Retrospective analysis of charts of patients admitted to an Internal Medicine Ward between 1/1/2014 to 31/12/2017 with the diagnosis of Sepsis, Severe Sepsis and Septic Shock.

Results: Of the 50 patients admitted, 32 had sepsis, 12 severe sepsis and 6 septic shock. The most common source was urinary (n=24) followed by respiratory (n=22). Inpatient mortality was 64% and 11% 6 months after discharge. The average SIRS was 2.02 and qSOFA was 1.58. The sensitivity for diagnosing sepsis was higher for SIRS, 62%, and 56% for qSOFA. When evaluating their relationship with mortality, qSOFA had no significance (Pearson Chi square test p=0.451), while SIRS had statistical significance (Pearson Chi square test p=0.035) but the mortality decreased with the rise in SIRS criteria. The relationship between SIRS and qSOFA and the length of hospital stay had no significance (ANOVA SIRS p=0.567 and qSOFA p=0.056).

Conclusion: This study shows that qSOFA and SIRS have limitations of their predictive value but the latter has a higher sensitivity with the risk of overdiagnosis and unnecessary tests. More studies need to be conducted in the E.D. to adopt a single score.
"Myocardial infarction as debut of Giant Cell Arteritis (GCA)"


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Introduction
Patients with GCA have a higher risk of developing cardiovascular disease. Among its manifestations, Acute Myocardial Infarction (AMI) is infrequent appearing in less than 5% of cases.

Case description
81-year-old female patient with previous history of DM, High blood pressure, dyslipidemia, with recent hospital admission due to Acute Coronary Syndrome without ST Elevation, with implantation of two drug-eluting stent, and subacute thrombosis of the stent a month later, despite double antiplatelet therapy, was admitted at Internal Medicine ward due to Heart Failure, headache, jaw claudication, and constitutional symptoms. Patient presented with an Hb 9.3 g/dl, marked elevation of ESR (89 mm/h, findings seen previous to AMI), autoimmunity was negative. CT scan reported homogenous mural thickening of the thoracoabdominal aorta and its branches as well as iliac and supraaortic divisions suggesting large vessel vasculitis. We rule out other possible diagnostics (oncologic, infectious, etc). Temporal Artery Biopsy could not be performed because patient was on double antithrombotic therapy. Patient was treated with oral corticosteroid, with subsequent clinical and analytical improvement observed in the follow up.

Discussion
GCA is the most common form of systemic vasculitis in adults. Arteriosclerotic origin is the most common cause of the AMI, however, the accompanying symptoms, the analytical alterations and thoracic aortic branches involvement suggested a systemic manifestation of GCA. Recently several data have been published associating an increased risk of cardiovascular disease among these patients, which would have important implications in their clinical management and prognosis.
22 years old male with fever. A rare cause of hemophagocytic syndrome.

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INTRODUCTION
Hemophagocytic lymphohistiocytosis (HLH) is a rare but potentially fatal disease of normal but overactive histiocytes and lymphocytes. It should be suspected in case of prolonged fever and infections, mainly Herpes virus infections, should be excluded as the most common cause of HLH. Rheumatologic diseases are itself an important cause of HLH, however Secondary HLH in patients with systemic lupus erythematosus (SLE) is uncommon, with an estimated prevalence of 0.9–4.6%.

CASE DESCRIPTION
A 22 years old patient recently diagnosed of systemic lupus erythematosus (SLE), was attended in our emergency department with a history of fever of 10 days and acute kidney failure. Kidney biopsy showed membranous lupus nephropathy and cyclophosphamide was started. Fever did not dissappear while he was hospitalized and anemia, thrombocytopenia, hyponatremia and hyperferritinemia appeared in consecutive blood test. Liver enlargement was also found in abdominal ultrasound. Hemophagocytic lymphohistiocytosis (HLH) was suspected and bone marrow biopsy showed hemophagocytosis phenomena in 45% of macrophages, with a 99% probability of having HLH according to Faradet Score. Different triggers of the disease were exclude, so HLH were considered secondary to SLE.

DISCUSSION
Hemophagocytic lymphohistiocytosis should be suspected in case of fever, spleen and liver enlargement and laboratory criteria such as anemia, thrombocytopenia, hypertriglyceridemia and hypofibrinogenemia. A ferritin value of >10,000 mg/L has been reported to have 90% sensitivity and 96% specificity in defining the presence of HLH. Usually it is possible to show hemophagocytosis in the bone narrow but it is not necessary for the diagnosis. Faradet Score calculate the probability of having the disease but all diagnostic criteria may not be present at the same time. Triggers of the disease should be actively searched, specially infections, but rheumatologic diseases are itself an important cause of HLH.
A case of spotted bone disease

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Introduction: Osteopikilosis (OPK) is a benign condition that presents with multiple sclerotic bone lesions and is also called “spotted bone disease”. Majority of the cases diagnosed incidentally because mostly it’s asymptomatic. However in some cases bone pain can be present. The radiologic findings of the disease can mimic multiple disorders such as metastasis, mastocytosis and bone dysplasias.

Case description: An 18-year-old male with no prior diagnosis was admitted to our Internal Medicine Department with low back pain. His blood tests were in normal range. Pelvis AP X-ray revealed multiple sclerotic spots in bilateral iliac wings, femur heads and necks. A thoracoabdominal CT showed sclerotic bone lesions in thoracic, lumbar and sacral vertabrae, both coxae and femurs. Tc-99 Scintigraphy revealed enhanced focal Tc-99 uptake in left greater trochanter and right sacroiliac joint. Biopsy was taken from the lesion located in the left femoral head and reported as “normal bone tissue”. Considering that X-rays and CT images were typical, the patient was diagnosed with osteopikilosis. NSAIDs prescribed for the back pain and patient was discharged.

Discussion: Osteopikilosis is a rare and benign disease which can be seen as a familial phenomenon or sporadically. Diagnosis is generally made with imaging studies and exclusion of other possible diseases. However in the research process many radiological and invasive tests can be done. In these patients more conservative approach could be preferable. On the other hand it is important to investigate just enough and not miss important diseases such as malignancies.
A case of brachial plexopathy diagnosed after carpal syndrome surgery

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Introduction: Neoplastic invasion of the brachial plexus, a rare cause of brachial plexopathy, can mimic symptoms of many common upper limb neuropathies. Therefore, its diagnosis can be missed easily. We report a case of neoplastic brachial plexopathy (NBP) that was detected after Carpal Syndrome surgery.

Case description:
A 70-year-old woman with history of invasive breast cancer treated with simple mastectomy and axillary clearance in 1991 without sign of recurrence. Was admitted to our hospital because oedema in the left upper limb and pain in wrist and hand, after Carpal Syndrome surgery one month early. The exploration revealed global paresis in the hand without radicular origin. Electrodagnostic testing (EMG) led the conclusion of generalized diffuse plexopathy. Cervical and left braquial plexus magnetic resonance imaging (MRI) revealed a infiltrating and thickening the fat that surrounds the axillary vessels. Finally, a fine needle puncture aspiration was performed, confirming the suspected diagnosis of recurrence of breast cancer upon axillary soft tissue. The patient was referred to the oncology department for treatment after surgical rejection.

Discussion: Neoplastic plexopathy is more common in patients with a previous history of malignant disease. The most common causes are Pancoast tumour, breast carcinoma and Lymphoma. Brachial plexopathy-associated breast cancer can occur by radiation injury or metastatic spread of the tumor. This plexopathy can be detected by MRI and fluorodeoxyglucose positron-emission tomography (PET). On the other hand, metastasis of breast cancer is often detected through a long-term course and difficult to diagnose.
A case of extrathoracic lymph nodes sarcoidosis.

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Introduction: Lymph nodes sarcoidosis without pulmonary involvement is a non-frequent entity, with few published cases. Case description: We present a 79-year old women, referred to an internal medicine appointment for unilateral axillary lymphadenopathies investigation, previously identified in a screening mammography without suspected lesions, and monoclonal gammopathy (MG). Outpatient imaging tests include a CT scan with identification of left axillary lymphadenopaties and no pulmonary involvement or mediastinal adenopathies. Percutaneous lymph node biopsy revealed the presence of epithelioid granulomas and the patient being electively hospitalized for investigation. She presented history of anorexia, weight loss, weakness, night sweats and inflammatory polyarthralgia. The laboratory evaluation revealed elevated erythrocyte sedimentation rate and angiotensin-converting enzyme levels, transitory leukopenia and monoclonal band for IgG and kappa chains. There was no evidence of secondary bone involvement or acute arthritis in bone scintigraphy. The CD4+/CD8+ ratio in bronchoalveolar lavage was increased. A gallium scintigraphy and a positron emission tomography revealed presence of inflammatory activity only in left axillary region, however it was not possible to clarify the underlying etiology. Lymphadenectomy was performed and the histologic exam revealed the presence of non-necrotizing sarcoid granulomas. With the absence of symptoms or imaging suggesting pulmonary involvement, the diagnosis of lymph nodes sarcoidosis was made and a low-dose corticosteroid was initiated. A MG investigation revealed monoclonal gammopathy of undetermined significance, being the patient checked in a hematology consult, with indication for corticotherapy maintenance. The results showed no adenopathies and a significant improvement in the patient’s condition. Discussion: The authors point out the unusual presentation of the disease only with extrathoracic lymph node involvement.
A Case of Systemic Lupus Erythematosus Presenting with Retinitis

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Introduction: Systemic Lupus Erythematosus (SLE) may involve one or several organ systems; additional manifestations may occur. Severity of SLE varies from mild and intermittent to severe and fulminant. In the United States, systemic lupus erythematosus is reported to be more common in women. Retinitis as a presentation in SLE is uncommon.

Case Description: A 41-year-old Turkish lady with no medical history, presented with weight loss and fatigue. Investigation revealed pancitopenia and splenomegaly. On examination she was found to have blood pressure 100/60 mmHg, pulse 120/min, respirations 20/min, temperature 39°C. She appears alert, oriented and cooperative. Lungs are clear to auscultation and percussion bilaterally, crackles heard in the lung bases bilaterally. The abdomen is symmetrical without distention; bowel sounds are normal in quality and intensity in all areas. She had splenomegaly which was palpable from the costal margin. Pedal edema is noted. Skin examination revealed hyperpigmented lesions. Oral ulcer, alopecia and skin rash were not detected. Viral markers, i.e. anti-HCV antibody, HBsAg, HIV were negative. Serological tests for toxoplasma, herpes and tuberculosis were negative. CMV IgM was positive. She started developing blurring of vision of both eyes. Ophthalmological check up and angiography showed retinitis. CT scan of brain was done, it was within normal limit. Following this, serological studies of antinuclear antibody (titre 1:3200), anti-double stranded DNA antibody and antiribosomal P protein antibody were done which were strongly positive. Complement C3 and C4 level were decreased. (C3: 42 mg/dl (90-180 mg/dl), C4: 4 mg/dl (10-40 mg/dl)). Steroid and hydroxychloroquine treatment was administered at the beginning of the therapy.

Discussion: This case demonstrates a patient who presented with newly diagnosed SLE with retinitis. We are presenting this case because of its rarity.
A complication after beginning biological treatment

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The biological therapy is important in the context of autoimmune diseases, however, it is essential to assess the individual risk of infections or other complications arising from the state of immunosuppression that underlies this treatment.

We present the case of a man, 49 years old, with Crohn's disease, A2 L1 B3 (classification of Montreal), treated with Azathioprine since 2012 and after a clinical worsening started Infliximab in 2016. In 2013, Interferon-γ release assays was negative.

The patient was admitted to the Emergency Room with symptoms of dry cough, dyspnea with the duration of 1 month. In association, he had anorexia, weight loss and nocturnal hyperhidrosis. A normal cardiac auscultation. Pulmonary auscultation – reduced breath sounds in the lower third of the right hemithorax, increased vocal transmission, without other adventitious sounds.

Chest x-ray showed pleural effusion of medium volume on the right. Diagnostic thoracentesis compatible with infected exudate with predominance of mononuclear cells. He was hospitalized for research and suspended Infliximab.

During hospitalization, a pleural biopsy and Interferon-γ release assays were performed. The anatomopathological report compatible with granulomatous pleuritis. Ziehl-Neelsen stain was negative. Interferon-γ release assays were positive. Pleural effusion resolution occurred within 9 months of treatment with antituberculosis medication.

In conclusion, it is a case that reinforces the importance of continuously assessing the risk of developing infections, especially Mycobacterium tuberculosis, in all patients proposed to start treatment with biological agents.
Introduction: Ankylosing Spondylitis is a chronic inflammatory disease involving axial skeleton and sacroiliac joint, beginning in the 2nd or 3rd decades of life, being less frequent after the age of 40 years. Sacroiliitis has progressive and ascending involvement of the spine with progressive evolution to ankylosis. There is a genetic predisposition linked to HLA-B27.

Clinical Case: The authors presented a case of a 72 year old man, with follow up in consult since 2013 due to anemia refractory to treatment. The etiological investigation excluded of autoimmunity. During the follow-up period, he started, in 2016, complaints of pain in the lumbosacral region, with inflammatory characteristics. Complaints intensified, with a clear limitation of mobility, with no other associated symptomatology. The study of autoimmunity showed positivity for Anti-Nuclear Antibodies (ANA), Anti-SS-A (Ro) Antibody and HLA B27. The CT imaging found bilateral grade III sacroiliitis and bony bridges were present, joining multiple compatible vertebral bodies "bamboo column". Filling the radiological criteria and two clinical criteria, the definitive diagnosis of Ankylosing Spondylitis was established. For symptomatic relief, he used non-steroidal anti-inflammatory drugs (NSAIDs), with partial relief, and was encouraged to practice physical activity, in order to improve his functional capacity and consequently life quality.

Discussion: Since Ankylosing Spondylitis is a relatively common pathology, the importance of its recognition is emphasized, even in unusual age groups, after exclusion of other etiologies.
A Rare Case Of Necrotizing Fasciitis: Diclofenac Injection

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Introduction: We report herein a fatal case of progressive necrotizing fasciitis and rhabdomyolysis cause of acute kidney injury after intramuscular diclofenac injection.

Case description: A 37 year old man presented to emergency services fatigue, nause, vomiting, pain and swelling in his right leg. He received intramuscular injection of diclofenac in his right leg 2 days ago. On admission his vital signs as follows: blood pressure 90/60 mm/Hg, heart rate 96, body temperature 37°C, respiratory rate 18. Physical examination was remarkable for severe right leg tenderness, swelling and pain. Laboratory analysis showed white blood cell count 46000/mm³, platelet count 42000/mm³, serum creatinine 5.05 mmol/L, serum creatinin kinase 3815 U/L. Urinalysis revealed myoglobinuria. The patient was resuscitated with intravenous fluids. Urine output decreased and in short time his body temperature rising to 39°C. We initiated empirically meropenem and daptomycin antibiotherapy after taking samples for blood and urine cultures. Superficial ultrasonography and computed tomography scan revealed air bubbles and microabscesses among muscles of thigh. Patient general condition had rapidly deteriorated. At this circumstances he had gone hemodialysis 2 hours. Then surgical debridement had done immediately, samples were sent for tissue culture, he entubeted and followed up in intensive care unit. Blood culture and urine culture was negative but tissue culture grew streptococcus viridans. After surgical debridement, patient general condition went on critical. He was in septic shock and surgical team decided to amputate his leg. Although surgery was attempted the patient was extremely poor general condition and he went into respiratory arrest and died after 5 days following intramuscular injection.

Discussion: With this case report we point to a rare complication of intramuscular injections. Necrotizing fasciitis is often initially misdiagnosed as a more benign soft-tissue infection.
A rare case of shoulder pain

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Introduction: The Pancoast syndrome (PS) usually results from apical pulmonary neoplasms with destruction of the nervous brachial and cervical plexus. Clinically the patients present with ipsilateral muscle atrophy, vascular edema and unfrequently with Horner Syndrome (Ptosis, miosis, hemianhydroades and enophtalmia).

Case: The authors present the case of a 63 years old male gender patient. Without known previous medical history, but with professional exposure to paints, diluents and other chemicals. The patient was admitted at the emergency department with 48 hours of evolution of a right shoulder pain, lack of strength, cough and paresthesia in the right arm and hand. He also complained about weigh loss (~12Kgs in 3 months). At the physical exam, to highlight right arm hemiparesia (grade 3/5) and ipsilateral Horner Syndrome with evident ptosis and enohtalmia. At this point and to exclude ischemic cerebral event, the patient was submitted to a cerebral CT-Scan that did not present relevant results; Also, a thorax X-Ray was performed showing a “10cm diameter neoplastic lesion at the posterior segment of the right upper lobe with invasion of the adjacent vertebral bodies and medullar canal”. The patient was admitted to the Internal Medicine war and was submitted to a biopsy that confirmed the diagnosis of Pancoast Tumor. The case was then discussed in a multidisciplinary meeting, but the dimension of the neoplastic lesion did not allow for the surgical team to intervene. At this moment the option was to admit the patient at oncology and palliative care ward.

Discussion: The Pancoast Tumors are rare but usually very aggressive and the patients present globally a poor prognosis. Nevertheless, the prognosis depends greatly on the clinical presentation and time of development until detection. The presence of Horner Syndrome, mediastinal lymph node involvement and vertebral invasion are related with worse prognosis. The life expectancy at 5 years is 15 to 56% of patients.
A rare cause of abdominal pain: Fibromuscular dysplasia.

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Introduction
Fibromuscular dysplasia (FMD) is a non-inflammatory arterial disease that predominantly affects women. The arterial manifestations may include beading, stenosis, aneurysm, dissection, or tortuosity. We report the case of a 50-year-old man presenting with acute abdominal who had multifocal FMD complicated with renal infarct.

Clinical case:
A 50-year-old man without past medical history was referred to our hospital for acute abdominal pain. Physical examination showed a blood pressure of 160/80 mmHg on both arms and regular pulse rate of 88bpm. He was febrile and urine dipstick was negative. Abdominal palpation showed diffuse pain accentuated on the right flank. Routine laboratory tests were normal. D-Dimers, C-reactive protein and LDH levels were elevated. Abdominal angio-CT scan showed irregular stenosis of celiac artery, dissection of the hepatic artery and of the left common femoral artery, and right arterial renal stenosis with extended renal parenchymal hypodensity. Immunological investigations ruled out the hypothesis of systemic vasculitis and connective tissue disease. The exhaustive constitutional thrombophilic parameters were normal. HBV, HCV, HIV, and rickettsial serology were negative. There were no phenotypic abnormalities for collagenosis diseases. Our working diagnosis was renal ischemia caused by multifocal arterial fibromuscular dysplasia of the visceral arteries. Systematic head and neck CT angiography revealed right vertebral arterial stenosis and saccular aneurysm of the left vertebral artery. Transient opioid prescription managed the symptoms. The patient was on calcium channel blockers for arterial hypertension, and started to take oral anticoagulation for three months, and aspirin all his life. The patient was discharged from the hospital and had no symptoms left.

Discussion: patients with FMD should undergo one-time cross-sectional imaging from head to pelvis.
Alveolar hemorrhage: a vasculitic emergency as an inaugural manifestation

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Introduction: Granulomatosis with polyangiitis (GPA) is characterized by granulomatous inflammation of vessels of airways and kidneys with vasculitis and necrosis. Often a differentiated care unit is required for organ support.

Case Report: A 70-year-old woman who uses the emergency department due to progressive worsening dyspnea, with 48 hours of evolution. The initial diagnostic investigation showed severe hypoxemic respiratory failure, acute anemia, acute kidney injury, nephrotic proteinuria and elevated inflammatory parameters. Thoracic radiography showed diffuse bilateral alveolar infiltrates. She was admitted to the intermediate care unit with progressive respiratory deterioration complicated by hemoptysis, requiring invasive ventilatory support. Of the remaining study: anti-neutrophil cytoplasmic antibodies (ANCA) with myeloperoxidase (MPO) positive, anti glomerular basement membrane, cryoglobulins, serologies of hepatitis and human immunodeficiency virus negative. CT scan showed nodular infiltrates and ground glass areas and bronchoalveolar lavage confirmed the presence of alveolar hemorrhage with neutrophilic alveolitis, without eosinophilia.

The clinical diagnosis of GPA was assumed and immunosuppressive therapy with methylprednisolone and cyclophosphamide pulses and simultaneous plasmapheresis were started. Although the initial improvement, complete remission was not achieved despite treatment with rituximab and there was a fatal outcome.

Discussion and conclusion: The case describes a vasculitis associated with ANCA, specifically GPA with MPO specificity. Although most ANCA positive patients produce a pattern proteinase 3 specificity, pulmonary involvement with pulmonary infiltrates and ground glass is in favor of GPA over microscopic polyangiitis. Alveolar hemorrhage is a medical emergency that is usually an indicator of poor prognosis. The case describe a clear example of the impact of these factors and the complexity of the management of these patients.

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INTRODUCTION: Sarcoidosis, a multisystem granulomatous disorder, sometimes manifests as a neuro-ophthalmic subtype. Optic neuropathy occurs in approximately 5% of patients with sarcoidosis and may be the initial manifestation.

DESCRIPTION: A 69-year-old patient with a personal history of hypercholesterolemia, hypertension and peripheral left facial paralysis (two) with mild motor sequelae. He presented episode of amaurosis fugax of the left eye, with normal ophthalmological evaluation, the following month he presented a new episode of amaurosis fugax in the right eye, assessed by ophthalmology that aimed to recover vision in the right eye, but atrophy of the left optic nerve. The remarkable results of the study are, VSG 85/99. Nonspecific monoclonal band, global decrease in Ig. Protein C / S, ACA, altered Ab2GLP1. Acellular cerebrospinal fluid. Normal serology Cranial magnetic resonancia chronic ischemic lesions. Angioresonancia with 60% stenosis and left carotid artery origin. Doppler ultrasonography trunks and transtoracic echocardiography without relevant findings of pulmonary hypertension or cardiac amyloidosis. Thoracoabdominal computed tomography bilateral axillary adenopathies and bilateral pulmonary calcified granulomas. Magnetic resonance of normal sacroiliac. In view of the clinical suspicion of neuro-ophthalmic sarcoidosis and the clinical stability of the patient, the study by Internal Medicine consultation was completed, where the result of the transbronchial biopsy showed a granulomatous non-caseificant lesion that led to the diagnosis of sarcoidosis and therefore, neurosarcoidosis.

DISCUSSION: Sarcoidosis with neuro-ophthalmic subtype can pose a diagnostic challenge, especially when ocular symptoms appear before systemic involvement, since the clinical picture may be nonspecific and standard laboratory and systemic imaging investigations may be negative.
Amyloidosis AA and Rheumatoid arthritis

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INTRODUCTION
Amyloidosis is a clinical disorder caused by deposition of amyloid that alter the normal function of kidneys and/or other tissues.
Systemic amyloidosis can be classified as primary or secondary with evidence of coexisting previous chronic inflammatory disorders (rheumatoid arthritis, ankylosing spondylitis, crohn disease), chronic microbial infections (tuberculosis, chronic bronchiectasis) or neoplasms (renal cell carcinoma, Hodgkin disease).

CASE DESCRIPTION
We thereby present a case of 51-years-old female patient with a history of 23-years of rheumatoid arthritis intermittent treated with DMARDS and NSAIDs who referred with lower-extremity edema.
Physical examination: pale skin, lower-extremity edema, livedo reticularis, symmetric polyarthritis, joint deformity in hands and feet.
Laboratory tests: proteinuria 9,3g/24h, hypoproteinemia, hypoalbuminemia, dyslipidemia, serum creatinine=1,97 mg/dl (eGFR=28ml/min/1,73m2), normocytic normochromic anemia, anti-CCP=361 UI/ml.
Abdominal ultrasonography: reduced kidneys size 89/45mm.
There were no clinical signs and laboratory findings suggestive of any other type of infectious disease or neoplasm.
Minor salivary gland biopsy (Congo red staining) confirmed the presence of amyloidosis.
There was a improvement in clinical and biological status after initiation of anti-inflammatory(anti-TNF) and nephroprotective (antiproteinuric,hypolipemiant) treatment.

DISCUSSION
Up to 5% of patients with rheumatoid arthritis can develop amyloidosis that usually presents as nephrotic syndrome or proteinuria. Renal impairment may progress to ESRD.
A biopsy of potentially affected organ should be performed (subcutaneous abdominal fat tissue aspiration, rectal mucosa and submucosa biopsy, minor salivary gland biopsy). Congo red staining technique is the gold standard for histological diagnosis of amyloidosis.
Earlier diagnosis of amyloidosis AA leads to better treatment, with an increased chance of recovery.
An Interesting case of Proteus Mirabilis causing Spondylodiscitis

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Infected spondylodiscitis often results in local or haematogenous spread into the intervertebral disc and surrounding structures often resulting in sepsis. Proteus Mirabilis is a common bacteria that is frequently seen in the setting of Urosepsis. However, it is seldom documented as a causative agent of spondylodiscitis.

An 84 year old male, nursing home resident with poor premorbid status was recently admitted for 2 day history of fever associated with shortness of breath, chesty cough. He was febrile and tachypneic while in ED, and was noted to be drowsy. On clinical examination, he was noted to have bilateral lower zone crepitations. The labs revealed raised inflammatory markers of total white cell 21, C-reactive protein 52. Chest x-ray showed bilateral consolidative changes in both lower zones, suggestive of ongoing infection. Subsequently, blood cultures were positive for proteus mirabilis bacteremia and he was started on IV Tazocin. On tracing of his previous medical records, it was noted that he had recently been hospitalized for proteous bacteremia secondary to urinary track infection. CT Abdomen Pevis scan had features suggestive of T9 spondylodiscitis, and pyelonephritis. His antibiotics were eventually de-escalated to IV Cefatriaxone and further oralised to PO Ciprofloxacin, completing 14 days of antibiotics.
Background. Anemia is most common hematological disorder in patients with rheumatic diseases. However, the prevalence and characteristics of anemic syndrome in patients with spondyloarthritis (SpA) are not well established. Therefore, we evaluated specifics of anemia and the relationship between anemia and clinical and laboratory values of the disease.

Material and methods. Hemogram, iron metabolism, C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR) were evaluated in 110 patients with SpA. Anemia was defined using the World Health Organization criteria. Associations between hemoglobin level and Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Ankylosing Spondylitis Disease Activity Score (ASDAS) with CRP, Bath Ankylosing Spondylitis Functional Index (BASFI), laboratory values of systemic inflammatory activity were determined.

Results. Anemia was found in 39.1% of patients with SpA, 88.4% of them had mild anemia. Anemia of chronic disease (ACD) and iron deficiency anemia (IDA) was found in 70.3% patients. The inverse relationship between the concentration of hemoglobin and ESR, the level of CRP are revealed ($r=-0.50$ and $r=-0.33$, $p<0.05$, respectively). The decrease in hemoglobin level did not depend on the increase of BASDAI and BASFI scores, but depended on the increase composite index ASDAS-CRP ($p<0.05$).

Conclusion. More than one third of patients (39.1%) were anemic, 70.3% of them had a combination of ACD and IDA. The association between hemoglobin level and ESR, the level of CRP are determined. The relationship between inflammation and anemia is a clinical reflection of the pathophysiological mechanisms.
Ankylosing Spondylitis, immunosuppressive therapy and intestinal Tuberculosis– Case Report

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INTRODUCTION:
Tuberculosis (TB) has become a resurgent global problem with increasing numbers of immunocompromised patients, not only because of human immunodeficiency virus (HIV) but also because of immunosuppressive therapy (IMT).

CASE REPORT:
A 23 years old man was admitted at hospital with 20-day history of fever, cough, night sweats, weight loss and diffuse abdominal pain. He was negative for HIV and had history of ankylosing spondylitis, in use of methotrexate and adalimumabe (ADA). Computed tomography (CT) of the chest demonstrated pleural effusion and sputum Acid-Fast Bacilli (AFB) smear was negative. Abdomen CT revealed ascitis, peritoneal enhancement and terminal ileum thickening producing parcial lumen stenosis. Ascitic fluid analysis revealed increased levels of adenosine deaminase activity ( 113 U/L). Patient was treated with ethambutol, rifampicin, pyrazinamide, and isoniazid. Despite improvement, he evolved with intestinal subocclusion that was responsive to clinical treatment. A Histopathologic diagnostic for intestinal TB was not realized due to suboclusion

DISCUSSION:
Although benefits of IMT has changed history of patients with ankylosing spondylitis, it has also raised the risk of TB reactivation, since TNF-a plays essential role in controlling TB-granuloma formation. Approximately 60% of TB cases related to anti TNF-a are extrapulmonary. In this case, even with the lack of histopathological confirmation, the fact that the patient lives in Brazil, 20th country in total number of TB cases, and exhibited symptons, radiological and laboratorial findings compatible with Intestinal and Peritonial TB allowed us to make a presumptive diagnosis and start treatment. Therefore, TB should always be a differential diagnosis in patients on IMT that develop infectious complications. Furthermore, physicians should evaluate patients for Latent TB Infection before starting ADA therapy.
Antisintetasa syndrome. about a case.

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INTRODUCTION: This syndrome is characterized by myositis with prominent pathological changes in the periphery of fascicles and perimissial connective tissue, interstitial lung disease, arthritis, Raynaud's phenomenon, fever and mechanic's hands. The anti-Jo-1 antibody, the most commercially available, accounts for 75% of all antisynthetic agents associated with the antisynthetase syndrome.

DESCRIPTION: A 41-year-old patient who started a study in Internal Medicine for symmetric inflammatory joints of small joints (distal interphalangeal of both hands, metacarpophalangeal, carpal and tarsal), without clear associated arthritis, together with asthenia and facial skin lesions, suggestive of malar erythema. In analytics, antinuclear antibodies (AN) were highlighted in the cut-off titre, total extractable nuclear antibodies negative, normal creatine kinase, and negative rheumatoid factor. In the case of suspected indefinite autoimmune systemic pathology, treatment with prednisone was started with improvement Clinical. Se dermatolgo is derived for removal of melanoma and in the subsequent review is detected clinical proximal myopathy of the scapular / pelvic belts. AN positive, antiJo1positive. Creatine kinase >4.000 U/L. Muscle magnetic resonance compatible with inflammatory myopathy (dermatomyositis). Electromyogram compatible with polymyositis. Muscle biopsy of the quadriceps muscle compatible with sdme antisintetasa in the context of cutaneous neoplasia. Treatment with steroid boluses and posterior immunoglobulins begins with a good response to treatment.

DISCUSSION: It is known that 15 to 25% of patients with dermatomyositis have had previous cancer or have concurrent cancer, or cancer will develop in them. However there does not seem to be a correlation between dermatomyositis and a specific cancer type.
Antisynthetase syndrome and the new aminoacyl-tRNA synthetase antibodies: beyond anti-Jo1 antibodies

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OBJECTIVES
Assessment antisynthetase syndrome (ASS) after determination of aminoacyl-tRNA synthetase (ARS) antibodies available (anti-PL-12, anti-Jo-1, anti-PL-7, anti-OJ and anti-EJ) at a referral centre.

METHODS
Observational with study 9 ASS patients. Statistical analysis: IBM SPSS Statistics 22 software.

RESULTS
Most were male patients (66.7%). Median age was 65.5 years old (quartile interval [51-3]). The most common manifestations were interstitial lung disease [ILD] (88.9%), myositis (77.8%), Raynaud’s phenomenon (77.8%), mechanic’s hands (66.7%), arthritis (44.4%) and skin involvement (22.2%).

Only 1 patient tested negative for ANA (11.1%). Synthetase-like cytoplasmic immunofluorescence pattern was the most frequent by far (66.7%), followed by fine-spleckled cytoplasmic, nucleolar and homogenous patterns, with 1 case for each one.

Even though fulfilling clinical criteria, one patient tested negative for ARS antibodies (the patient tested positive for anti-Ku antibodies). Anti-Ro52 antibodies, which are associated with a poorer prognosis, especially regarding ILD, were positive in 77.8% of patients (RR for ILD of 1.2, CI 95% 0.839-1.716, p=1.000). This antibody was negative only in 1 of the patients with ILD.

ARS detected: anti-PL7 (44.4%), anti-Jo1 (33.3%). Anti-OJ and anti-PL-12 were positive only once, anti-EJ was always negative. Three patients tested positive simultaneously for 2 ARS.

Therapy: 100% of patients were on steroids, 55.6% methotrexate, 44.4% intravenous immunoglobulins and 22.2% azathioprine. One patient received rituximab, another one cyclosporine and another one cyclophosphamide. Patients were on a median of 2 different medications (interquartile range [2-3]).

Cases of neoplasm detected: one MGUS and one urotelial carcinoma.

CONCLUSIONS
Determination of ARS antibodies different from anti-Jo1 has allowed a better characterization of ASS, thus allowing the diagnosis of patients who fulfilled clinical criteria but tested negative for anti-Jo1 antibodies.
Introduction: Juvenile gangrenous vasculitis of the scrotum (JGVS) is a rare entity of unknown etiology. His association with Behçet’s disease (BD) is, to our knowledge, never reported.

Case description: 23-year-old Tunisian male with BD for five years was hospitalized for intense scrotal pain occurring after a bronchial syndrome and associated with mucocutaneous and articular manifestations of BD. Scrotal examination noted multiple, necrotic, sometimes confluent and very painful lesions. Biology noted a marked inflammatory syndrome and histological examination of this scrotal lesions concluded to a JGVS. Etiological investigations for this JGVS were negative. Final diagnosis was a cutaneous and articular attacks of BD associated with a concomitant JGVS. The patient was treated with ofloxacin, colchicine and oral glucosteroids with a gradual and complete healing of scrotal lesions after four weeks.

Discussion: Our case is to our knowledge the first illustrating the association of JGVS to the BD. Several common characteristics between these two vasculitis evoke a non hazardous link: the elementary lesion of vasculitis, the predominance of the male sex and geographical distribution. The JGVS could corresponded to a particular expression of BD.
Autoimmune hepatitis (AIH) is a chronic disease with a higher incidence in women aged 40-50 years old. Heterogeneity is a hallmark of AIH. The diagnosis is obtained by serology and histology. AIH was the first liver disease with an effective cortico-therapy treatment. It may be associated with other liver conditions, such as primary biliary cirrhosis (PBC), Drug-Induced Liver Injury (DILI), alcoholic or non-alcoholic steatohepatitis or viral hepatitis.

The authors present the case of a 61-year-old female patient with no relevant past medical history. The patient went to the emergency department complaining of abdominal pain, loss of appetite and dark yellow urine with 3 days of evolution and a recent history of ingestion of itraconazole and anti-inflammatories. On physical examination the patient had jaundice. Blood tests showed liver dysfunction and coagulopathy. Abdominal US, abdominal CT and abdominal MRI did not show any changes. HBV, HCV, HEV, HIV, CMV, EBV, HSV, VZV, Brucellosis and Rickettsioses were excluded. Lipid profile, vitamin D and iron kinetics were normal. Seropositive results for anti-nuclear antibodies, anti-centromere antibodies, anti-mitochondrial M2 antibodies, atypical anti-neutrophil cytoplasmic antibodies and slightly increased IgA. Anti-smooth muscle antibodies, anti-liver kidney microsomal antibodies, anti-soluble liver antigen antibodies, anti-actin antibodies, anti-liver cytosolic 1 were all negative. Liver biopsy showed evidence of interface hepatitis. The diagnostic of AIH type 1 (simplified score: 5 points) and DILI was made. The patient was treated with 5 days acetylcysteine, followed by prednisolone 1mg/kg/day and azathioprine. Due to strong diagnostic probability of overlap syndrome of PBC and AIH she also started ursodeoxycholic acid. The patient presented clinical and analytical improvements until a complete resolution.

The diagnosis of AIH remains a challenge. Adequate treatment improve the chances of survival and quality of life.
Autoimmunity or Something else?

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Introduction: Behcet's Disease (BD) is a type of vasculitis that affects a range of blood vessels. It is characterized by recurrent oral aphthous ulcers and other systemic manifestations. One of the systems affected by BD is the central nervous system (CNS), presenting manifestations in 10% of the cases.

Case Description: The authors present a case of a 49-year-old woman followed in outpatient appointment for BD. Clinically she presented with recurrent oral aphthous. In the diagnostic exams, she had an anti-lupus anticoagulant and anti-nuclear antibody positive, as well as HLA-B50 and HLAB51 in heterozygosity. Of previous known history she has a carotid stenosis superior to 70%, without surgical indication, treated medically. After two episodes of amaurosis of the right eye, without ocular pain, she was send to Ophthalmology observation, no changes were detected. She later visited the emergency department for amaurosis of the right eye with about 24 hours of evolution. She was seen by the ophthalmologist again and examination revealed edema of the ocular disc and the macula with foveal cherry red spot. She underwent cranoencephalic magnetic resonance imaging (MRI), which showed small areas of T2-weighted, FLAIR and PD and iso-intense areas in T1 compatible with BD and MRI of the orbits that showed discrete narrowing of the right optic nerve at the level of the optical hole. The clinicians assumed that the amaurosis was due to an ischemic event associated with two risk factors, Neuro-Behcet's disease and vascular atherosclerosis. She had a progressive clinical improvement with local ocular treatment.

Conclusion: Although rare, CNS complications by BD are multiple and with a broad spectrum of severity, depending on the affected brain area. The association of multiple pathologies in one patient is common. Studies show no evidence of an increased incidence of atherosclerosis in BD patients, so risk factors management is important in these patients.
Autonomy Level Of The Elderly With Osteoarthritis

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Objectives: This study aims to descriptively evaluate the autonomy levels of the elderly with osteoarthritis.

Methods: The population of the study is composed of the people with osteoarthritis who consulted the Physiotherapy and Orthopedics Clinic of a Research and Application Hospital in a city center between January 25, 2017 and June 23, 2017. The sample of the study involved 147 patients who volunteered to take part in the study by giving their written and oral consent. In the study, information form for the elderly (age, gender, duration of the illness etc.), visual comparison scale and autonomy measurement system were used to collect data. The data was analyzed using descriptive statistics (percentage, mean, standard deviation), t test, one-way anova and logistic regression.

RESULTS: A significant, moderate negative relationship was observed between the age variable, the sub-dimension of the scale and the autonomy measurement system scores (p<0.001). When the autonomy level of the patients with osteoarthritis was evaluated, it was seen that the participants in the 65-74 age group had 1.28 times better autonomy levels compared to those in the 75 and above age group (p<0.05). The study revealed a significant, weak negative relationship between the duration of the illness and daily activities, mental functions and autonomy measurement system score averages (p<0.001).

CONCLUSION: It was found that the elderly with osteoarthritis had lower levels of autonomy and being single, low education level, advanced age, and increased duration of illness affect the level of autonomy.
Behcet's disease and total inferior vena cava thrombosis. A case report

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Introduction
A 36-year-old, from Senegal, was visited in the emergency department, with a week-long abdominal pain and scrotal and lower extremities edema. He had been diagnosed half a year earlier of Budd-Chiari syndrome, for which he was receiving treatment with acenocoumarol.

Case description
Upon physical examination, the patient had painful scrotal ulcers. He also confirmed episodes of oral ulcers during the previous year. The ulcers cytology and sexual transmitted diseases tests were all negative. Given the ulcer and thrombosis episodes, a skin prick test showed a positive pathergy reaction.
A thoraco-abdominal CT scan was performed revealing hepatomegaly secondary to complete IVC thrombosis. Sodium heparin was started followed by immunosuppressive therapy with corticosteroids and cyclophosphamide with a favorable evolution of the symptomatology. During follow-up treatment with acenocoumarol was restored, completing the treatment with 6 cycles of cyclophosphamide, ciclosporin and lowering corticosteroids doses. A second CT scan two months later, showed partial resolution of the VCI thrombosis.

Discussion
Our patient fulfilled 3 of 5 Behçet’s disease criteria established by International Study Group for Behçet’s Disease (2006). While in some studies the average delay of the inferior vena cava thrombosis was around 4.5 years, there have been cases of it was the thrombosis what revealed the disease. Early treatment with anticoagulation, high dose prednisone, and intravenous cyclophosphamide is the treatment of choice.

Reference
Introduction: Iatrogenic anti-neutrophil cytoplasm antibodies (ANCA)-associated vasculitis are uncommon. Many cases of small vessel vasculitis induced by anti-thyroid drugs (ATD), mainly Propylthiouracil (PTU), have been reported. We present a case of ANCA-associated vasculitis related to another ATD: Benzythiouracil (BTU).

Case description: A 84-year-old man with a 4-year history of multinodular goiter with hyperthyroidism, was treated with BTU. He presented an acute syndrome with fever, epigastriac pain and important abdomen distension. Lactate and Lipase serum tests were normal. Plasma TSH was 0.32 mUI/L (N: 0.27-4.2). Abdomen scan showed a distal thrombosis of splenic artery with splenic infarction. We excluded hypothesis of associated embolic etiology: atrial fibrillation, left atrial myxoma, intraventricular thrombus and artery aneurysm. The laboratory explorations of a possible prothrombotic state (complete blood account, hemostasis tests, activated protein C resistance, factor V Leiden, protein C, S, anti-thrombin III), were normal. Dosage of antinuclear antibodies (ANA) and anti-phospholipid antibodies (APL) were negative. However, p-ANCA with antimyeloperoxidase (MPO) specificity were positive: 120.6 CU (N < 20.0). We didn’t find other systemic manifestations (cutaneous, pulmonary or neurologic) of vasculitis, except a non specific kidney failure stage 3A, without hematuria or proteinuria. BTU was discontinued without steroids or immune modulating drugs. Subsequently symptoms disappeared progressively and titers of ANCA fell till normalization 4 months after the cessation of BTU.

Discussion: Many patients, treated with ATD, present positive titers of MPO-ANCA, without clinical manifestations, the mechanism of this anomaly remains to be elucidated, some studies suggest the possibility of an autoimmune reaction initiated by drug bioactivation mediated by neutrophil-derived MPO. The present observation is particular because the involved drug was BTU and clinical signs and symptoms were unusual.
Calciphylaxis, a rare etiology of leg ulcers. Review of 6 cases in a secondary care hospital.

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BACKGROUND
Leg ulcers are frequent in Internal Medicine Services, increase hospital length of stay and worsen prognosis of patients. 90% are due to arterial disease, venous insufficiency or neropathy. Remaining 10% are due to other causes such as calciphylaxis which consist of calcification of dermal arterioles leading to skin necrosis. It is associated with end-stage renal disease (ESRD), hypertension, Diabetes Mellitus (DM) and treatment with Vitamin K antagonists. Conventional radiography and biopsy lead to diagnosis. Treatment consist of sodium thiosulfate, cardiovascular risk factors control (CVRF) and surgery.

OBJECTIVES
Analyze cases of calciphylaxis, patient profile, their approach and management, so improving our knowledge about this disease, would change the prognosis of patients.

METHODS
Retrospective study of diagnosed cases of calciphylaxis in our Hospital between 2007-2017. Evaluated variables were age, hypertension, DM2, obesity, Vitamin K antagonists, ESRD, autoimmunity tests, diagnostic tests, treatment and recurrences.

RESULTS
Six cases were identified, with an age range of 73-87 years. All were white women with hypertension. 83% were diabetic, 70% obese and 65% had ESRD. 67% were treated with Vitamin K antagonists, only in two cases were withdrawn. 67% had autoimmunity study, which was negative in all cases. The diagnosis was confirmed by biopsy. All needed surgical treatment. Sodium thiosulfate was used just in two cases. 83% presented a recurrence.

CONCLUSION
Consider calciphylaxis as a cause of poor outcome leg ulcers, in patients with mentioned risk factors, even in the absence of ESRD. Conventional radiography is of great help for diagnosis when calciphylaxis is suspected.
Introduction: the association between Behçet's disease (BD) and malignancy is exceptionally reported. This association represents a real diagnostic challenge, dominates the prognosis and suggests a significant carcinogenic potential of the disease.

Methods: Through a retrospective study completed by a review of the literature we attempted to clarify the pathogenesis of this association.

Results: we collected four cases of malignant neoplasms in our 50 patients followed for BD: prevalence of 8%. It was lung cancer (N = 1), colon cancer (N = 1), breast cancer (N = 1) and liver cancer (N = 1) occurring in three men and one woman (sex ratio 3/1 ) with a mean age of 41.25 ± 12.21 years and an average delay of occurring over the BD at 17.25 ± 2.5 years. Comparing subjects with cancer to those having the BD without malignancy showed no significant difference concerning the epidemiological, clinical, therapeutic and evolutionary aspects.

The literature review showed 209 cases of malignancies in 206 patients with BD: 44% solid cancers and 56% hematological malignancies.

Conclusion: These results suggest that the association between BD and cancer is far from being a simple chance. The pathogenesis of this association is not yet fully elucidated. This oncogenesis includes chronic inflammation, hypercytokinemia, underlying vasculitis, immune dysfunction and some medications used to treat BD.

Therefore, clinical and biological special monitoring is warranted in patients with BD to detect degeneration at the appropriate time.
Cardiac tamponade secondary to CREST syndrome - a case report


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Introduction
An 82-year-old woman with previous history of hypertension, CKD, atrial fibrillation, left pleural effusion (with no malignant or infectious exudative characteristics), oropharyngeal dysphagia, Raynaud’s phenomenon and bronchial hyperreactivity, was admitted for worsening dyspnea, requiring three pillows nightly to sleep and palpitations. Upon admission she had early hemodynamic instability signs.

Case description
On physical examination, she had skin hyperpigmentation, dehydration, sclerodactyly, and calcinosis cutis of the phalanges. Cardiac sounds were arrhythmic, with no murmurs. Jugular venous distention was positive and the abdominojugular test was present. Bilateral crackles and inferior left lung hypophonesis could be heard.

An emergency echocardiography was performed, revealing a severe pericardial effusion with hemodynamic compromise signs, confirmed by a thoracic-abdominal CT scan, that also showed bilateral pleural effusion. The patient underwent a US-guided pericardiocentesis, with 700mL of blood-stained fluid drained over the first hour (for a total of 1.15L over 48h).

Laboratory tests showed no abnormalities except for positive Anti-nuclear antibodies, with negative Anti-centromere and Anti-Scl70 antibodies. Fluid cultures were negative.

The final diagnosis was CREST syndrome with massive secondary pericardial effusion. Immunosuppressive therapy with corticosteroids was started (Prednisone 30mg/day).

Discussion
CREST syndrome is a multisystem connective tissue disorder; our patient fulfilled 4 of the 2004 proposed diagnostic criteria, and had an EULAR/ACR score of 18. Massive pericardial effusion as a complication of CREST syndrome has been previously described, being a rare clinical presentation. If it leads to cardiac tamponade the outcome is poor, therefore early drainage is advised.

References
Cauda Equina Syndrome and Dural Ectasia: rare complication of Ankylosing Spondylitis

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INTRODUCTION:
Cauda equina syndrome (CES) is a rare but well-recognized complication of long-standing Ankylosing Spondylitis (AS) that presents with slowly progressive neurological symptoms involving the bowel, bladder and lower limbs.

CASE DESCRIPTION:
A 66-year-old female patient with AS diagnosed more than 30 years, with complete ankylosis of the rachis and very emaciated, was presenting neurological alterations with about 2 years of evolution: paresthesia, hyperesthesia, dysesthesia; decreased sensitivity and strength in the lower limbs hindering gait; and decreased perineal sensitivity as well as sphincter dysfunction (bladder and anal). Imaging studies revealed severe spinal cord injuries between L1 and L4: dural ectasia with posterior arch molding; central canal occupied by a large arachnoid cyst with repercussion on adjacent structures (medullary cone and nerve roots of the cauda were posteriorly deviated) and myelofibrosis. Adhesive arachnoiditis with myelo-radicular lesion was admitted. Despite the obvious neurological deterioration, we chose conservative medical treatment, because the patient didn’t meet clinical stability criteria for surgical intervention.

DISCUSSION:
The authors present this case because of its rarity, clinical exuberance and imaging alterations. The etiopathogenesis of this syndrome remains unclear and treatment remains controversial, no truly effective therapy is currently known.
Challenge in the diagnosis of Rheumatoid Arthritis in the elderly - a Case Report

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Introduction:
Rheumatoid arthritis (RA) is a systemic inflammatory autoimmune disease, characterized by peripheral polyarthritis, that may have extra-articular involvement. At the geriatric age, diagnosis can be a challenge due to preexisting pathologies, and it’s essential to value the signs or symptoms that may be suggestive of RA.

Case Description:
We present a case of an 85-year-old woman, with a history of hypothyroidism, arterial hypertension, dyslipidemia and osteoarticular disease admitted as degenerative, hospitalized to clarify anemia and enlargement of inguinal and iliac lymph nodes. She reported worsening of joint pain with 1 year of evolution, especially in the cervical spine, upper and lower limbs, with functional limitation, morning stiffness, worsening in the evening and with exertion, besides anorexia and weight loss. Computed tomography showed small supraclavicular, axillary and inguinal adenopathy. Analytically: microcytic / hypochromic anemia, elevated ferritin, sedimentation rate 95 mm, C-reactive protein elevated; anti-nuclear and anti-CCP positive antibodies, rheumatoid factor negative. Radiologically with marked band osteopenia, signs of osteoarthrosis predominantly in the hands and feet. Admitting the clinical picture in the context of RA, we initiated treatment hydroxychloroquine 200mg and prednisolone 10mg. It evolved with resolution of the constitutional symptoms and anemia and frank improvement of inflammatory parameters and joint pain complaints.

Discussion:
In this case, we have a patient with previous osteoarticular pathology, with aggravated pain, followed by constitutional syndrome and adenopathy, improved after starting therapy, favoring the diagnosis of RA with potential systemic involvement. It’s important to maintain a high degree of suspicion in the evaluation of patients in the geriatric age, where the clinical presentation of RA can be confused with normal aging abnormalities or other more common diseases in the elderly.
Introduction: Limited case reports of colchicine-induced rhabdomyolysis have been published. This report discusses a case of colchicine-induced rhabdomyolysis in a patient with acute renal failure and elevated liver function tests.

Case Description: A 88-year-old man was admitted to the hospital due to persistent diarrhea, vomiting, and diffuse weakness. Past medical history included hypertension, cerebrovascular occlusion and gout. Approximately one month prior to admission, he had been started on colchicine and. Physical examination revealed dry and pale skin. His pulse rate were 65 beats/minute and blood pressure were 130/85 mm Hg. Laboratory workup showed elevated serum creatinine of 2.74 mg/dL and blood urea nitrogen of 141 mg/dL, elevated serum ALT concentration of 131 IU/L, AST concentration of 155 IU/L, and direct bilirubin of 0.16 mg/dL, elevated serum creatine kinase (CK) of 5050 IU/L and CK-MB of 99 IU/L but with normal Troponin-I. Electrolytes including sodium 138 mmol/L, potassium 3.6 mmol/ L were within normal limits. His urine was bloody in appearance and urine analysis showed blood reaction with dipstick test, but there were no erythrocytes on microscopic examination. Ultrasound scan of the kidneys was normal. Rhabdomyolysis was diagnosed on clinical and biochemical grounds. Neurophysiologic study showed a pattern of severe myopathy with axonal sensorimotor neuropathy. Intravenous infusion with normal saline 2500 mL per day was administrated. Thereafter, progressive normalization of CK and renal function results were observed. In view of his clinical presentations of elevated CK, impaired renal function and proximal weakness, colchicine was thought to be the causative factor for rhabdomyolysis. He was discharged home with instructions to continue his clinical follow-up with his primary care physician within two weeks.

Discussion: Our report emphasize that a rare but serious and potentially life threatening neuromuscular adverse efect of colchicine.
Descriptive analysis of patients characteristics with autoantibodies related to Systemic Esclerosis

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OBJECTIVES
To evaluate the presence of autoantibodies anti-CENP and anti-Scl70 as a diagnostic and prognostic test

METHOD
A sample of 70 individual with specific SSc autoantibodies were attended at the outpatients' clinic of Puerta del Mar University Hospital during the period January 2012 - December 2017.

Patients were distributed into three groups: Systemic Sclerosis (SSc), pre-Scleroderma (pre-SSc) y sine-scleroderma (ssSSc)

Sensitivity (S), specificity (Sp), positive predictive value (PPV) and negative predictive value (NPV) of anti-CENP and anti-Scl70 were calculated. The association between these autoantibodies and clinical features was correlated in those patients who meet the diagnostic criteria of SSc (n=27).

RESULTS
70 were included (14.3% male and 85.7% female, age of 62.8 ± 1.7). 58 patients were anti-CENP positive (82.9%) and 12 anti-Scl70 positive (17.1%).

Ab anti-CENP: S=74.1%, Sp=11.6%, PPV=34.5% y NPV=41.7%.
Ab anti-Scl70: S=25.9%, Sp=88.4%, PPV=58.3% y NPV=65.5%.

Digital ulcers were present in 9% of patients anti-CENP positive, while they were present in all patients anti-Scl 70 positive (p<0.05, χ²). Pulmonary manifestations were present in 54% of those patients anti-CENP positive, and appears in all patients anti-Scl70 positive (p<0.05, χ²).

DISCUSSION
Clinical manifestation most common were Raynaud phenomenon. 60% of patients had lung involvement and 25% cardiac affection. Anti-Scl70 showed good values of specificity but PPV and NPV values were low. The presence in serum of anti-Scl70 were significantly associated with pulmonary affection, digital ulcers. Anti-CENP positive was associated with limited type of SSc, being considered as a marker of good prognosis.
INTRODUCTION
The Metabolic Syndrome is a set of biochemical, clinical and metabolic factors that increase risk of suffering a cardiovascular disease or diabetes mellitus type 2.

CASE REPORT
A 30 years man consulted for joint pain and nocturnal slight fever of 15 days of evolution. He refers similar symptoms for 5 years, so he’s medicated with diclofenac and dexamethasone. Personal history: denies DM and arterial hypertension. Social drinker. Family history: father with same symptoms. BP 140/80, HR 90 /min, RR 18/min, T 37°C. Anthropometric measurements: 122 kg, 1.87 m, BMI 34.9, abdominal circumference 124 cm, waist/hip index 1.1. Globular abdomen with a lot of adipose and violet striae. It’s soft, depressible, not painful, hepatic border 12 cm from right costal margin. Joints: knees, ankles, elbows, wrists, proximal phalanges of hands and feet with swelling, flushing and pain. On these joints are raised inflammatory nodules with whitish secretion. Skin: Acanthosis nigricans on axillas. We could diagnose of gouty attack, obesity grade 2 and medicated Cushing. Leukocytes 14, 100, hemoglobin 12.6, platelets 367,000, GSV 10, RCP 1.1, blood glucose 110, urea 42, creatinine 0.90, uric acid 10.7, total cholesterol 194, HDL 40, LDL 113, 3, VLDL 15, triglycerides 76, GOT 57, GPT 58, albumin 3. Urine: uricosuria 1525.75 mg/24h, clearance 102 ml/min, protein 212.5 mg/24h. To confirm the diagnosis of gout, one of the tophi is punctured and monomorphic urate crystals are observed. AUS: hepatomegaly with severe diffuse steatosis, regular contour and heterogeneous parenchyma. ECC: mild concentric hypertrophy of the left ventricle. The patient’s discharged with hygienic dietetic measures, EICA, metformin, antithrombotic, atorvastatin, analgesics and a progressive reduction of steroids.

DISCUSSION
We always have to actively look for metabolic syndrome even if the reason of admission apparently isn’t related to it. In our case, the patient’s admitted due to a gouty attack that finally leads to the diagnosis of advanced metabolic syndrome.
Different presentation of Mixed connective tissue disease.

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Mixed connective tissue disease, MCTD, is an autoimmune disease characterized by the presence of high blood levels of anti-U1 ribonucleoprotein (U1-RNP). We present two patients with different forms of presentation of MCTD.

The first case is a 78-year-old woman with chronic diarrhea of 6 months with lower limb disability, retroesternal pain, asthenia and palpitations. Blood test with hypokalemia and severe hypomagnesemia, acute renal failure, normocytic normocytic anemia, high ESR, total protein deficit, albumin and vitamin D. ECG with supraventricular paroxysmal tachycardia in relation to severe hypokalemia. Chest radiography, ultrasound and abdominal MRI, colonoscopy, echocardiogram and octreoscan were normal. The autoimmunity study revealed ANA positive with mottled pattern, Ac AntiRNP, Ac AntiSM and Anti SS-A/Ro positive. Recover renal function and correct metabolic disorders, start oral corticosteroid treatment with striking clinical improvement, finding a real asymptomatic date. The second case is a 48-year-old male with abdominal pain, acute diarrhea, and acute renal failure requiring renal replacement therapy. Personal history of diffuse systemic scleroderma of recent diagnosis by skin biopsy. Blood analysis hemoglobin 10.1g/dl, hematocrit 30%, leukocytes 13200/dl, platelets 84000/dl. Urea 291 mg/dl, creatinine 8.51mg/dl, total protein 4.2g/dl, albumin 2.5g/dl, LDH 982U/L, haptoglobin 108md/dl, ADAMTS negative. Negative immunological study. Systematic urine and sediment proteins 500 mg/dl, erythrocytes 2010/ul, ratio Alb/Cr 333mg/g. Abdominal ultrasound with kidneys with a discrete increase in cortical echogenicity, although with preservation of cortico-medullary differentiation. Echocardiogram shows severe global chronic pericardial effusion with mild tamponade data.

Both cases are interesting because of presentation, and remember that corticosteroids should be used with great caution in scleroderma crisis.
Differential diagnosis of cutaneous lesions in a patient with sarcoidosis

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Introduction
Cutaneous sarcoidosis is known as a “great imitator” because of the vast morphologies it can assume, making differential diagnosis with multiple pathologies.

Case description
The case we present is about a 51-year-old man with a thoracic tomography suggesting the diagnosis of sarcoidosis and a pulmonary micro-biopsy supporting it.
He presents with multiple erythematous, scaly, annular lesions on the back of his hands and forearms that resemble the annular granuloma and whose histology was not enlightening, leaving the doubt - annular granuloma or sarcoidosis? It is uncertain if sarcoidosis and annular granuloma have different etiopathogenesis, since in both there is histiocytic mononuclear infiltrate and, as described in several cases in the literature, with concomitant presentation. These skin lesions were refractory to high-dose of corticosteroids, to hydroxychloroquine, methotrexate, but with some, though little, improvement with minocycline.
Four months later of minocycline use, grayish, confluent and flat lesions appeared in the lower limbs whose biopsy was conducive to capillaritis. Due to the possibility of being secondary to the use of minocycline the drug was suspended but with insignificant improvement.

Discussion
This case, profusely illustrated with skin lesions photographs and their histopathological correspondents, aims to show the diversity of cutaneous lesions that can be found in patients with sarcoidosis.
Differential diagnosis of endocarditis in a patient with systemic lupus erythematosus

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Libman-Sacks endocarditis (LSE) (nonbacterial thrombotic endocarditis) is a characteristic cardiac manifestation of systemic lupus erythematosus (SLE) and also occur in association with primary or secondary antiphospholipid syndrome (APLS).

41 year old woman with SLE and APLS was admitted to hospital with complaints about headache, weakness for 2 weeks, febrility, watery stools and vomiting 3 times a day for 2 days. Methylprednisolone 8mg qd was used. Laboratory findings: leukocytes 11.9x10^3/L, thrombocytes 60x10^3/L, erythrocyte sedimentation rate (ESR) 31mm/h, C-reactive protein (CRP) 222mg/l. Blood culture was positive for Salmonella enteritidis. Transthoracic echocardiography (TTE) revealed 5–7mm mobile vegetations on mitral valve (MV) leaflets. After 4 weeks with antibacterial therapy in repeated TTE no vegetations were noted. In a month she was hospitalized again with complaints about weakness, arthralgies, mialgies, skin rash, stools 3-4 times a day. Analysis showed leukocytes 12.8x10^3/L, erythrocyte sedimentation rate (ESR) 28mm/h, CRP 9.1mg/l. Blood culture repeatedly was negative. No pathogenic enterobacteriaceae in stool culture was found. In TTE 2 mobile vegetations (8mm; 3mm) on MV were observed. Although vegetations on the MV were considered as LSE, because of the previous infection and ongoing complains about frequent stool – it was found not to be safe to intensificate immunosuppressive therapy, but also no indications for antibacterial therapy were found.

Infective endocarditis is not unusual in patients with LSE because of patients’ immunosuppressive state. Differential diagnosis is mandatory, but not easy to make. In the present case, first hospitalization represented S.enteritidis sepsis and endocarditis (verrucous, but probably combined with secondary infective endocarditis). After antibacterial treatment inflammation markers were normalized, but attention has to be payed to the clinical signs and careful long term observation.
Effects of Anastrozole On Vasoreactivity In A Patient With IPAH

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Introduction:
Idiopathic pulmonary arterial hypertension (IPAH) is a progressive disease and has fatal outcomes without treatment. Females are more affected than males and it is suggestable that estrogen may play a role in the pathogenesis. Aromatase inhibitors can be protective from IPAH with the mechanism of reducing estrogen levels. Herein we present a woman with IPAH and clinical deterioration after anastrozole treatment.

Case Description:
A 45 years old female patient with (IPAH) admitted to our hospital due to a mass lesion at left breast. Her medical history revealed that she had been diagnosed IPAH 12 years ago and she had been under treatment with nifedipin due to positive vasoreactivity. Preoperative right heart catheterization (RHC) was done and vasoreactivity was positive with estimated baseline mean pulmonary aterial pressure (mPAP) 33 mmHg. Lumpectomy was performed and grade 3 invasive ductal carcinoma was detected. Surgical margins were intact and complementary mastectomy was performed. Hormone receptors were positive so tamoxifen was started. Two months later she suffered from ovarian cyst rupture and sent to total abdominal hysterecemy and bilateral salpingo oophorectomy. Tamoxifen was switched to anastrozole and six months later she admitted with increased exertional dyspnea and worsened functional capacity. Echocardiography revealed increased sPAP (70 mmHg). RHC was repeated and mPAP was 43 mmHg but vasoreactivity was negative. Nifedipin was stopped and bosentan was started. Her exertional dyspnea was relieved and functional capacity was ameliorated.

Discussion:
IPAH is a progressive disease and vasoreactivity can be detected in a small portion of patients. Vasoreactivity is important due to being indicator of responsibility of the patient to calcium channel blockers (CCB). Although anastrozole may be protective for PAH by reducing estrogen levels, it can change the response of pulmonary vascular beds to CCB treatment.
Effects of Far-Infrared & Terahertz Onnetsu Therapy on Rheumatoid Arthritis and Various Cancers

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Onnetsu means comfortable heat. Dr Kazuko Onnetsu Therapy invented by Dr. Kazuko Tatsumura-Hillyer emits from a special ceramic;
1) Precise 8-10μ of vibration of Infrared SunRay.
2) Vibration of Terahertz, and
3) various degrees of heat.
When Onnetsuki is slid over the skin, healthy areas are comfortable, but IF deep tissue is cold, unhealthy or degenerated, “hot spot” is detected by the temperature sensation reported from the patient. Dr Kazuko’s Onnetsu Therapy is both a diagnostic and therapeutic. When this hot spot is effectively treated with Far-Infrared, Terahertz & Heat, Dr Kazuko Onnetsu Therapy, the hot sensation subsides and the Disease conditions improve. Dr. Kazuko’s protocol must be followed.

Dr Kazuko Onnetsu Therapy is based on four historical and scientific facts.
1. NASA's finding regarding Far-Infrared vibration from Sun light 8-10μ only. Also, added is the specific Terahertz vibration: Healing vibration
2. Traditional Japanese Concept of the significance of Body Temperature; Raising Cold Temperature.
3. Immunology Theory by Dr. Toru Abo, balancing autonomic nervous system to improve condition of white cells; Raising Immunity.
4. Promoting four flows of Energy through acupuncture technique: blood, body fluid, Oxygen, Ki(Chi)

Dr. Kazuko has taught her Onnetsu Therapy to MDs and health practitioners over the past decades all over the world: are practicing it in the hospitals and clinics. Clinical Trials have shown improvements on cases (including but not limited to) as arthritis, asthma, various cancers, diabetes, tuberculosis and various painful conditions. Clinical studies from Cuba and Peru will be presented.
Eosinophilic fasciitis in an autoimmune unity

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Background
Eosinophilic fasciitis (EF) was described in 1974 by Shulman, as a rare fibrosing connective tissue disease of unknown etiology, characterized by eosinophilia, hypergammaglobulinemia, and progressive thickening of the fascia over the extremities and trunk. An undetermined trigger is thought to lead to the degranulation of eosinophils that interact with fibroblasts and express fibrogenic cytokines including the transforming factor of tumor growth a and b and interleukins 1 and 6.

Methods
Retrospective, longitudinal, descriptive study of a population of a central hospital. All patients diagnosed with FE in a hospital unit were admitted to the study since 2005 until 2018.

Results
A total of 7 patients diagnosed with EF were analyzed. The median age of the population at the time of diagnosis was 56 years and 57% of the patients were women. At the time of the study, patients had an average of 11 years of disease progression. All patients had elevated peripheral eosinophilia, sedimentation rate, c-reactive protein, and only 1 patient with hypergammaglobulinemia. All patients had edema and cutaneous thickening of the limbs, 57% constitutional symptoms and 57% inflammatory arthritis with joint contracture. No patient had visceral attainment, Raynaud's phenomenon and distal finger reaching. Prednisolone (PDN) therapy was initiated in all patients, and in 5 patients the association of PDN with methotrexate (MTX) was performed. In only 1 patient was required triple therapy of PDN, MTX and cyclosporine. No patient underwent therapy with psoralen and ultraviolet A.

At the time of this publication, only 1 patient maintains active disease, and initiated tocilizumab.

Conclusion
Recent studies show a more favorable response of the association of PDN and MTX, than PDN alone, which is in agreement with this study. Considering the rarity of the disease, more long-term studies are needed regarding etiopathogenesis, progression, recurrence of FE and new effective therapies.
Introduction
Eosinophilic fasciitis is a rare disorder of unknown etiology. Its initial diagnosis is clinical and connective tissue diseases that can simulate a similar disease must be ruled out. Once the treatment has begun, we must look for a possible triggering cause.

Description of the case
A 54 year-old man without known allergies. No history of previous illness or current toxic habits. He goes to his primary care doctor for edema in lower limbs of two weeks of evolution. The day before the appearance of edema the patient does intense physical exercise. It is referred to your referral hospital where it is entered for study and treatment. Analytical, cardiac ultrasound, abdominal ultrasound and chest x-ray are performed without alterations. A diagnosis of probable nephrotic syndrome was made, by albumin of 200 mg in 24 hours and treatment was started with Furosemide 40mg / 24h.
It is derived to Nephrology consultations. The analytical has normalized, edema persists in MMII, although they have improved. The patient is admitted to continue the study.
In analytical elevated eosinophils with induration of the skin of anterior leg region.
On admission, biopsy of the affected area is performed by the surgeons. The study was completed with a CT scan of toral-abdomen, serology and laboratory tests with tumor markers, all normal tests. A high number of eosinophils persists and treatment with Prednisone 80mg / day is started. The result of the biopsy confirms the diagnosis of nonspecific chronic fascitis. The diagnosis of eosinophilic fasciitis is therefore confirmed.
There is improvement of the symptoms from the beginning of the treatment

Conclusion
It is fundamental for the correct diagnosis to make a complete clinical history. Initial clinical suspicion and differential diagnosis is basic in our specialty due to the appearance of similar symptoms in many diseases. In addition, the response to treatment helps us confirm it.
Eosinophilic fasciitis, exuberant presentation

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Introduction
Eosinophilic fasciitis (EF) was described in 1974 by Shulman as a rare fibrosing disease. The pathogenesis is not well understood. Eosinophils degranulate and induce tissue damage, resulting in fibrosis by extracellular accumulation in the matrix. Several studies have indicated that eosinophils interact with fibroblasts and express fibrogenic cytokines, including tumor necrosis factor α and β, interleukin (IL) -1 and IL-6.

Case description
A 61-year-old woman with a medical history of diabetes mellitus, hypertension and right nephrectomy in 2004 due to complications of recurrent pyelonephritis. Referred to autoimmune diseases consultation for a 7-month history of fatigue, exuberant cutaneous thickening of the abdomen and legs, weight loss and pain of both tibio-tarsus, with functional limitation. She developed extension of skin thickening to the thighs and forearms with Groove sign. Laboratory findings showed eosinophilia and elevated inflammatory parameters. A full-thickness skin biopsy confirmed the diagnosis of EF. She had a poor clinical response to high-dose systemic corticosteroid therapy and methotrexate, and tocilizumab therapy was initiated.

Discussion
EF is a rare disease and its diagnosis requires a high level of clinical suspicion and may be difficult for the differential diagnoses to be considered. Frequent analytical findings include peripheral eosinophilia, which may be transient, elevated sedimentation rate and CRP and polyclonal hypergammaglobulinemia. In most cases, the diagnosis is confirmed by skin biopsy.

The standard initial treatment option is systemic corticosteroid therapy, but in some cases the introduction of an immunosuppressive drug is essential. There are some recent studies showing the efficacy of a therapy targeting IL-6 cytokine, tocilizumab, in EF refractory to steroids and other immunosuppressive drugs.
Erythema Multiforme- a challenging case report

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Introduction: Erythema multiforme (EM) as a self-limited mucocutaneous hypersensitivity reaction may arise in the context of infection, reaction to drugs or immunological diseases, representing a challenging diagnosis.

Case description: The patient is a 29-year-old man, previously healthy and without usual medication, admitted after a period of about one week of fever (T- 39ºC), odynophagia and arthralgia, in the last 2 days associated with periorbital swelling and rash with limb onset and proximal progression to trunk and back. Self medicated with antihistamine. He presented objective erythema with target lesions, characteristic of EM in limbs, chest and back. On day 3, he had vesicular lesions on the palate and a sample for molecular study was collected. Remaining laboratory tests negative for HIV, CMV, rubella, varicella, hepatitis B and C, syphilis, chlamydia, mumps, toxoplasmosis, EBV, blood cultures, as well as autoimmune studies. Based on the clinical findings, he completed 5 days of intravenous acyclovir, being discharged with symptomatic and analytical improvement. A week later he presented new characteristic lesions as well as arthralgia. Herpes simplex virus (HSV) DNA type 1 in vesicular lesions was positive. The patient was medicated with valacyclovir.

Discussion: HSV infection is one of the most frequently associated with EM, which is usually self-limited but with recurrence described in 20-25% of cases, requiring prolonged therapy and development of more effective recurrence prevention protocols. This clinical case illustrates by its diversity of clinical manifestations, the complexity of diagnosis that defies internal medicine in its constant holistic approach of the patient.
Erythema nodosum post tonsillitis, a rare etiology in adults.

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Erythema nodosum (EN) is the most common clinicopathological variety of panniculitis. It is considered a delayed cell hypersensitivity reaction, triggered by diverse antigenic stimuli. Although idiopathic in many cases, EN can be the first sign of a systemic disease and, therefore, it is important to reach a correct diagnosis to establish a specific etiological treatment.

In Portugal, the processes more frequently associated to EN in children are streptococcal infections. In adults, the most common causes are drugs, sarcoidosis, autoimmune diseases and inflammatory bowel diseases.

The authors describe a case of a 33-year-old woman with a throat infection three weeks before, treated by her family doctor with amoxicillin and clavulanic acid, when the treatment ended, pain in the lower limbs developed with palpable painful edema and nodules, she had been medicated with indomethacin and had not improved so she went to the emergency department, she complained of intense pain in her legs, she was without fever and hemodynamically stable. An analytical study was conducted that revealed an increase in acute phase reactants and a very high TASO.

Considering the clinical history, post streptococcal infection erythema nodosum was assumed, in spite of not being so frequent in adults.

Potassium iodide may be recommended in case of persistent lesions that do not respond to initial treatment. The mechanism of action of potassium iodide on EN is unknown probably, induce the release of mast cell heparin and heparin suppresses delayed hypersensitivity reactions. The patient was treated with good evolution, regression of the nodules and clinical improvement.

The diagnosis of EN is histological, the access to biopsies in our small hospital is very limited, based on the clinical history, exploration and analytical study, it was reached a diagnostic suspicion being treated successfully.
Fever of unknown origin: PFAPA Syndrome

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Introduction

Fever is one of the most frequent signs that our patients present with. The multitude of causes that can produce it make its differential diagnosis one of the most complex we have to face in our daily practice.

Case description

A 31-year-old male without any known drug allergies. Ex-smoker for 1 year. Periodontal disease with reported extractions and proper antibiotic prophylaxis done with them have been carried out. He is admitted to the ER for episodes of intermittent fever in the last year. It appears with periodicity every 4-5 weeks. He also suffers from the appearance of painless oral sores that resolve without leaving a scar, non-inflammatory arthromyalgia and reactive laterocervical adenopathies. No septic focal point is shown. The fever lasts 4-5 days and vanishes with or without batches of empirical antibiotics. Only a slight rise in ESR and CRP (maximum of 4-5 mg / dl) is observed in the general state and in multiple analyzes. After a detailed study, neoplasia, infections (including endocarditis and zoonosis) and classical systemic autoimmune diseases are ruled out. The clinical periodicity, plus the good general state inter-period, the laboratory results and all the negative studies, make as a very likely possibility the diagnosis of an autoinflammatory pathology (the PFAPA syndrome), classically described during the pediatric age, but with an extensive collected documentation in young people also. A trial of steroids during the fever periods was performed (a single dose of prednisone 60mg at the onset of fever). This resulting an excellent response, and confirming the suspected diagnosis, self-limiting both fever and the rest of the clinic.

Discussion

The detailed study of a patient presenting with fever is essential in order to reach a proper final diagnosis, avoiding to limit ourselves to the classic and most common syndrome that produces it.
Fever, headache, temporal artery tenderness, an elevated ESR and a Giant Cell Arteritis Diagnosis: a case report

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Introduction: Giant cell arteritis (GCA) is a systemic vasculitis, of unknown cause, that predominantly involves the temporal arteries (TA) and mainly affects patients >50 years. It is very commonly associated with a raised erythrocyte sedimentation rate (ESR), usually >50mm/h, and can result in a wide variety of systemic, neurologic, and ophthalmologic complications. Temporal artery biopsy (TAB) remains the gold standard diagnostic test.

Case description: A 62-year-old man was admitted to the hospital for anorexia, fever, myalgia, night sweat and weight loss for 7 days and frontoparietal headache, fotofobia and behavioral changes for 3 days without localizing symptoms of infection. On physical examination, there were no focal neurological deficits or meningism, however, he had TA tenderness. Blood tests showed normochromic normocytic anemia, an increased ERS (100mm/h) and C-reactive protein (314.4mg/L). A toracoabdominal pelvic computed tomography and lumbar puncture were performed with no significant abnormalities. Given the clinical presentation it was placed the hypothesis of GCA, and therefore it was initiated 60mg of prednisolone with symptomatic relief within 24 hours. He also initiated bisphosphonates, calcium and vitamin D supplements and proton pump inhibitor. The TAB revealed “discrete inflammatory lymphocytic infiltrate, located predominantly in the adventitia and in the intima, accompanied by rupture of the internal elastic membrane and marked thickening of the intima” corroborating the clinical hypothesis. After discharge keeps followed-up in medicine department.

Discussion: GCA should be considered in the differential diagnosis of a new-onset headache and an elevated ESR in patients >50 years. Corticosteroids are the mainstay of therapy, however, in steroid-resistant cases, cyclosporine, azathioprine, or methotrexate may be used. Prompt treatment may prevent blindness and other ischemic sequelae. Long-term follow-up is required to detect late recurrences.
INTRODUCTION: Optic neuritis is an inflammatory demyelinating condition that causes acute visual loss, usually unilateral. There’s a close association between this entity and the diagnosis of multiple sclerosis: optic neuritis is present in 15 to 20% of patients at the time of diagnosis of multiple sclerosis and occurs at some point of the evolution of the disease in about 50%.

CASE DESCRIPTION: Young male of 19 years old with previous history of asthma and allergic rhinitis, came to the Emergency Department because of decrease visual acuity of the left eye with a week of evolution. At this point there was no alterations on physical examination, blood tests and brain CT with contrast. He was admitted for complementary study and treatment. There was symptomatic improvement with pulses of methylprednisolone. On the brain RM was detected a hypersignal on the left optic fibers after the optic chiasm and focal lesions of probable inflammatory nature along the justacortical, subcortical and periventricular white matter of both hemispheres, and corpus callosum. Oligoclonal bands on liquor and evoked potentials were positive.

DISCUSSION: The majority of the patients with multiple sclerosis have a relapsing – remission course. The first symptoms typically appear in young adults like optic neuritis or other symptoms of spinal cord or brainstem impairment (relapsing symptoms) followed by their remission. Only a small number of patients develop a progressive form of the disease in which some neurologic deficits became persistent (secondary progressive form) or are present since the presentation (primary progressive form).
Generalized lymphadenopathy in a patient with ankylosing spondylitis and diabetes mellitus on TNF inhibitors - what could it be?

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Introduction. TNF inhibitors are important agents in refractory cases of ankylosing spondylitis and association with diabetes mellitus increases the risk of immunosuppression. Generalized lymphadenopathy in a patient with both diseases raises the suspicion of lymphoproliferation, opportunistic infection, malignancy and represents a challenge for clinician. But what if a medical incident could show you the diagnostic?

Case presentation: We present the case of a 47 years old man with a 25 years smoking history, diabetes mellitus and ankylosing spondylitis (AS) on TNF inhibitors for 8 years. He attended our clinic with significant weight loss (20 kg), fever and productive cough, symptoms that occurred 2 months before. Physical exam revealed cachexia and fine crackles on the basis of the lungs, without peripheral adenopathy. The blood tests showed leukopenia with neutropenia and lymphopenia, moderate inflammatory markers and high level of LDH. Thoracic and abdominal CT scans demonstrated moderate hepatosplenomegaly, and enlarged infra and supradiaphragmatic lymph nodes. Lung and lymph node biopsy provided confusing results: large cell lymphoma and nonspecific interstitial pneumonia. Doing a quick check for glycemia a nurse received needle stick injury. Postexposure measures protocols were applied and both patient and nurse referred to infectious disease specialist. After almost 1 month the patient deceased.

Discussions: Assessment of the immunosuppression status even from the beginning of the biologic treatment should be carefully performed, particularly if it is associated with other immunosuppression conditions.
Giant Cell Arteritis Presenting as Middle Cerebral Artery Stenosis

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Introduction: Giant cell arteritis (GCA) is the most common large vessel vasculitis in patients over 50 years old. GCA is usually recognized based on extracranial arterial involvement with constitutional symptoms. Stroke is an unusual presenting feature of GCA.

Case description: We report a 77-year old male with diabetes and hypertension who presented with repetitive ischemic strokes due to severe stenosis of middle cerebral artery, despite high dose aspirin and statin. Brain MRI and LCR analysis ruled out other small vessel vasculitis. Lack of left temporal artery pulse together with the ultrasound evidence of inflammatory halo in this vessel suggested GCA, which was further confirmed by left temporal artery biopsy. Although, the patient's history was unremarkable for usual GCA symptoms, his blood tests revealed a highly increased erythrocyte sedimentation rate.

Discussion: This case shows that GCA may present with isolated intracranial stenosis, even in patients with cardiovascular risk factors and no GCA-associated constitutional symptoms.
How far to go in the screening of malignancy in Dermatomyositis patients?

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Introduction

Dermatomyositis (DM) is an idiopathic inflammatory myopathy with cutaneous findings & proximal myopathy. Its association with malignancies is well known. Adenocarcinomas of the cervix, lung, ovaries, pancreas, bladder & stomach account for approximately 70 percent of the cancers associated with inflammatory myopathies [1].

Case description

We report the case of 61-year-old woman who presented with rash, myopathy & generalized weakness over three weeks. Patient’s history included hemorrhoids, dyslipidemia & previous smoking history. Patient was managed as DM on the basis of examination & biochemistry findings. Further investigations were done including antibodies & CT Abdomen, pelvis and thorax to rule out malignancy. CT did not reveal any underlying malignancy. Colonoscopy was done due to proctalgia & constipation which revealed adenocarcinoma of the colon.

Conclusions

There is no definitive data suggesting one screening method over another & practices vary among clinicians. Positron emission tomography (PET)) has been used for the detection of malignancy, but few studies have examined its role in screening for malignancy in patients with DM [2-3] Further study is needed to determine whether FDG-PET/CT has a role in screening among patients with DM instead of multiple tests e.g. negative CT. As it may not be always that the tumor is related to gastrointestinal tract as in our case.

1) www.uptodate.com / malignancy-in-DM-PM /abstract
Impact of gender on expression of systemic lupus

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Objective:
Lupus erythematosus is autoimmune disease of unknown cause that involves multiple systems. It affects with preference young women of childbearing age and according to different reports only 4–22% of the lupus population is male.
The aim of this study was to identify the clinical and biological characteristics of lupus disease in men with lupus and compare them to women to investigate the impact of gender on lupus expression.

Methods:
In this retrospective study we analyzed medical records of 81 patients, hospitalized at the Constantine University Hospital Internal Medicine Service between January 2012 and June 2017, ten of whom were male. Seventy-eight percent of patients met the revised American College of Rheumatology (ACR) classification criteria for systemic lupus erythematosus.

Results:
Ten of 81 patients (12.34%) with systemic lupus were men; The male to female ratio was 1/9. Mean age at disease onset was 37.3 years (range 11-81) in men compared with 32.54 years (range 16-66) in women. The main clinical manifestation at disease onset for both male and female patients was arthritis, Additionally nephritis was most common initial manifestations in men(30%)
During the course of disease, The prevalence of mucocutaneous symptoms and hematologic involvements was similar in both sexes, male patients had significantly higher prevalence of discoid lupus lesions. there is also a predominance of thromboembolic events and renal involvement with a high frequency of severe impairment including renal failure that has been present in 50% of male patients

Conclusion:
Our serie confirmed the presence of certain clinical and progressive characteristics related to the gender of patients
It highlights the severity of the disease in humans with a high prevalence of kidney damage. Research is justified in order to clarify these differences in pathogenesis and clinical expression and to allow the development of management strategies adapted to each group of patients.
Improving the management of patients with rheumatoid arthritis using the Internet portal.

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Objectives: Maximally quickly identify the exacerbation of the disease and timely strengthen the therapy, for more rapid achievement of remission or low disease activity. Methods: The authors created an interactive web portal for self-monitoring of RA activity. The patient management model using this method is that a patient conducts a monthly self-evaluation of the disease activity and transmits this information to his treating doctor in a remote manner via the web portal. In case of worsening and in the absence of any dynamics, according to the patient, he was invited to the center, where this information was verified by a doctor. Currently, 30 women with RA, age 57 (38; 71), who completed the 6-month treatment period, are included in the study. 20 women included in the control group, average age 60.5 (40; 77). Initially, all patients were trained by a rheumatologist to carry out a self-assessment of tender and swollen joints according to the original author’s technique “Structured curriculum for teaching RA patients self-monitoring of disease activity”.

Results: During 6 months, there was a positive dynamics of the course of the disease, the activity of the RA by DAS 28 decreased. Initially, 5 patients (16.7%) had high DAS activity, 24 - moderate (80%), 1 - low (3.3%). After 6 months of treatment 8 patients (26.7%) had low activity, 22 (73.3%) achieved remission. The mean value of the DAS 28 index at the time of inclusion was 3.99 (2.46; 5.78) and after 6 months of management 2.175 (0.79; 4.31), a statistically significant decrease (Wilcoxon T-test = 5). Most patients - 10 (33.3%) achieved remission by 3 months of the research, 5 (16.7%) achieved low disease activity. Analysis of clinical and laboratory parameters did not reveal statistically significant deviations.

Conclusions: The 6-month period of patient management via the “web portal for self-monitoring of rheumatoid arthritis activity” proved the possibility of achieving remission and low disease activity in all patients.
Improvement of the skin sclerosis and arthritis in patient with systemic sclerosis treated with tocilizumab monotherapy: Case presentation

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Introduction: Joint involvement is possible in systemic sclerosis (SSc) and up to one third patients can have clinical signs of synovitis or tenosynovitis. Treatment is not standardized and polyarthritis is often refractory to cDMARDS.

Case description: A 78 years old woman affected with limited SSc had been followed at the outpatient clinic for 7 years. At first admission, she showed skin sclerosis confined to hands and face, telangectasias, and Raynaud's phenomenon. She was ANA positive with positive anti-topoisomerase I (anti-ScL 70) and present early SSc pattern at nailfold capillaroscopy. During that period, she was treated with MTX, also she was getting low dose of oral Prednisolone, in the first a few years. During that period there was no damage to the visceral organs, but skin and articular manifestations were not well controlled.

In January 2016, patient was admitted to the Rheumatology department with worsening skin sclerosis, digital tip ulcers and polyarthritis of hands. There were no other visceral organ involvement. In the next 12 months patient received Tocilizumab at 8mg/kg once a month. Disease activity was assessed every month clinically and by laboratory tests. From baseline, after 6 months and after 12 months therapy, there were improvement in: mRSS (baseline-32, 6th months-22, 12th months-14), number of digital ulcers (B.-7, 6th m.- 1, 12th m.-0), no progression in capilaroscopy pattern, mean RP frequency per day in last 7 days (B.-7.3, 6th m.-3.2, 12th m.-4.6), DAS 28/ESR (B.-5.4, 6th m.-4.1, 12th m.-3.0), HAQ-DI Score (B.-1.7, 6th m.-1.6, 12th m.-1.1) and FACIT-Fatigue Score (0-52) (B.-12, 6th m.-18, 12th m.-21). At baseline dose of oral Prednisolone was 20mg/daily, and after 12 months patient was without glucocorticoids and without joint worsening.

Discussion: There is not many trials of biologic agents for skin sclerosis in SS. We showed the case with clinical and satisfactory clinical and laboratory response on tocilizumab therapy.
Inflammatory pseudotumors in Behçet's disease.

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Introduction: non specific inflammatory pseudotumors (NSIPT) are exceptionally reported with Behçet’s disease (MB) and represent a real diagnostic and therapeutic challenge. The main differential diagnosis of these PTINS arises with cancers; this diagnostic level is more difficult than BD already present a significant carcinogenic risk.

Methods: Through a review of the literature we attempted to clarify the pathogenesis of this association as well as diagnostic and therapeutic problems it poses.

Results: We found 43 cases of NSIPT associated with BD. Localization was neurological: N = 30, Cardiac: N = 6, orbital: N = 5, ileal: N = 1 and renal N = 1. Neurological NSIPT were central and intra parenchymal in 100% of cases. Cardiac NSIPT were located in the right ventricle: N = 5/6 and depends on the inter-ventricular septum: N = 1/6. The orbital involvement was unilateral in all cases and consisted of an isolated myositis of extra ocular muscles in 4/5. The epidemiological characteristics showed a male predominance and high occurrence in adults. Clinical features showed a single tumor: 87% of cases and multiple 13%, and variable development timeline compared to the underlying disease: revealing: 31% of cases, inaugural: 24% and occurring during the evolution the BD: 45%.

Conclusion: these results suggest a non-hazardous association; especially because of the rarity of these conditions in the general population, significantly different epidemiological characteristics of those conventionally observed for NSIPT and a different distribution of locations within the organs and tissues. The common pathogenic mechanisms in these two conditions enhancing the causation are immune dysregulation, reactive inflammation, and vasculitis.
Intestinal Toxicity of Methotrexate - a Personal Experience

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Introduction: Methotrexate (MTX), a folic acid antagonist is a very useful drug in various autoimmune inflammatory diseases (notably rheumatoid arthritis and lupus). Even though is considered a relative safety medication if not monitored properly it can lead to severe side effects.

Case presentation: I was diagnosed with systemic lupus erythematosus (SLE) in 2012 (mostly cutaneous and articular involvement) and have tried various disease - modifying antirheumatic drugs (DMARDs) such as: Hydroxychloroquine (HQ), Azathioprine (AZT) and a human monoclonal antibody that inhibits B-cell activating factor (BAFF) – Belimumab alongside with glucocorticoids (GS). HQ and AZT were stopped after developing sting-like cutaneous sensation and low WBCs, respectively, and switch to MTX 10mg once weekly, due to high activity. After two weeks of self - administration alongside with folic acid supplementation and low doses of GS , I experienced constipation followed by rectal tenesmus and bloody stools after taking laxatives. The MTX was administered for a total of 12 weeks. The colonoscopy revealed anterior anal fissure. The Quality of Life (QoL) was worsening, being unable to sit and experienced pain at bowel movement. Finally, after discussing with my rheumatologist, I decided to stop the Methotrexate and within one week I went back to normal.

Conclusion: MTX is associated with intestinal injury assigned to inflammation and oxidative stress. Adverse effects should be taken seriously and the patient should get in contact with the prescribing doctor as soon as possible, in order to create the best plan before their quality of life is severely impacted.

References:
Introduction
Lung cancer is the most frequent neoplasm among men and, in women, it is the third with the highest incidence, after breast cancer.

Case Description
Man, 33 years-old, no known diseases, smoker (15 pack-years), presents with weight loss (5 kg in 2 months), right shoulder pain and dorsalgia. He was evaluated by the general practitioner, and had a spine computed tomography (CT) performed, which revealed an osteolytic lesion of D11 vertebra, and was referred to the hospital. Upon examination, no alterations were identified, but the thorax radiograph showed a hypotransparent image in the right upper lobe, with ill defined contours. Considering the probability of lung neoplasia (primary vs. secondary), he underwent: bronchofibroscopy (total occlusion of right upper lobar bronchus), magnetic resonance imaging of the column (secondary deposits in D11, D12 and T1 vertebrae and 4th right costal arch), bone scintigraphy (hyperfixation in D11 and D12 vertebrae and 4th right costal arch) and thoraco-abdomino-pelvic CT (heterogeneous mass of spiculated contours in the right upper lobe, multiple mediastinic adenopathies, bone lesions of vertebra D11, right shoulder blade and 4th and 7th right costal arches and hypodense nodular areas in the kidneys). Laboratory findings with CYFRA 21-1 6.8 ng/mL. Lung biopsy revealed high-grade neuroendocrine carcinoma.
He underwent vertebroplasty and started chemotherapy with cisplatin and etoposide.
The disease progressed, with the patient deceased 8 months after diagnosis.

Discussion
Lung neoplasm is the one with the highest mortality in men and frequently presents in an advanced form at the time of the initial diagnosis.
Kikuchi-Fujimoto disease associated to connectivitis

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Introduction: Kikuchi-Fujimoto’s disease (KFD) or histiocytic necrotizing lymphadenitis is a rare clinicopathological entity of unknown etiology that primarily affects young Asian women. The association of this disease with dys-immune systemic disease is rare. We report two cases.

Case description
Observation 1: 28 year old woman, having systemic lupus erythematosus (SLE) with cutaneous, hematologic, and renal complication, who developed six years after cervical and axillary febrile lymphadenopathy. A lymph node biopsy showed histological and Immunohistochemical aspects suggesting KFD.
Observation 2: 30 year old woman, without medical history was hospitalized for febrile superficial polylymphadenopathy. Etiological investigation was negative. Lymph node biopsy confirmed the diagnosis of KFD. Two years later primary Sjogren's syndrome was diagnosed in this patient.
Favorable evolution was noted in both cases after 1-2 months.

Discussion: KFD is a very rare histological diagnosis. Underlying autoimmune conditions are rarely reported; particularly the association with primary Sjogren's syndrome is exceptional. These associations represent a real diagnostic challenge and they deserve to be known by physicians.
INTRODUCTION: Cutaneous vasculitis affects the small and medium vessels of the skin and subcutaneous tissue, but not the internal organs. It can present with purpura or petechiae. The diagnosis requires biopsy. Treatment depends on the etiology and extension of the disease. Any primary or secondary vasculitis can affect the skin, including those due to systemic disease.

CASE DESCRIPTION: 66 year-old woman with a history of hypoacusis, hemorrhoids and uterine fibromyoma. No known regular medication. She was admitted in the ER with a cutaneous circular pruriginous erythematous rash with a 2-hour evolution. Initially in the lower limbs and later in the upper limbs, lumbar and abdominal region. She was apyretic, hemodynamically stable, skin with papulous and pruriginous lesions with an erythematic central point, evolving to coalescing petechial lesions, with cranial progression, but sparing the face, scalp, torso, palms and plants. Laboratory tests: leukopenia with 60% of lymphocytes. She underwent a skin biopsy and the diagnostic hypothesis was erythematous cutaneous and pruriginous rash of unknown etiology (probable vasculitis). During the hospital stay she was started on corticotherapy (prednisolone 1mg/kg/day) with a favorable evolution, no new skin lesions and progressive resolution of the ones already present. Of the laboratory study, viral serologies negative, immunologic study, tumor markers and blood cultures negative. After discharge, follow-up in consult with full resolution of the skin lesions, allowing for slow taper off corticosteroids. The skin biopsy later revealed leukocytoclastic vasculitis.

CONCLUSION: In cutaneous vasculitis cases we should exclude the obvious clinical causes of systemic vasculitis. The biopsy helps the diagnosis. The authors present the case with photographic documentation of the skin lesions.
Introduction: Lupus myelitis is a rare and little known complication of lupic disease: 1 à 2% of cases. It is characterized by gravity and very poor prognosis. Longitudinal and inaugural forms are exceptional.

Case description: 32-year-old patient without significant medical history, was hospitalized for exploration of a sudden motor weakness of both lower limbs occurring in a fever. Clinical and biological and radiological investigations allowed to retain the diagnosis of systemic lupus erythematosus with hematologic, renal, and neurological-type transverse myelitis longitudinal type. The search for anti phospholipid antibodies was negative. Anti cytoplasm of peripheral-type neutrophils antibodies (p-ANCA) were positive by immunofluorescence and anti myeloperoxidase specificity (MPO) in ELISA.

Conclusion: Our case is distinguished by its longitudinal topography, its inaugural nature of the disease and its association with the presence of p-ANCA type of autoantibody suggesting a micro spinal vasculitis ANCA-dependent to its origin.
Maladie de behcet et grossesse a propos de douze cas et revue de la litterature

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INTRODUCTION :
La maladie de Behcet est une maladie systémique associant des ulcérations buccales et génitales et une atteinte oculaire d’évolution chronique en poussée.

BUT :
Etudier le pronostic de la grossesse au cours de la maladie de Behcet, son influence sur la l’évolution de celle –ci et les modalités thérapeutiques de cette pathologie chez la femme enceinte

MATERIEL ET METHODE :
Il s’agit d’une étude rétrospective colligée au service de gynécologie obstétrique à la maternité de Monastir sur une période de 04 ans allant du 1 er janvier 2013 au 30 décembre 2017.
Au cours de cette période nous avons colligé 12 patientes enceintes et atteintes de la maladie de Behcet.

RESULTAT :
L’âge moyen était 30 ans avec des extrêmes de 22 et 35 ans.
L’évolution moyenne de la maladie était de 06 ans avec des extrêmes de 1 et 15 ans.
08 femmes étaient en rémission et 02 en poussé nécessitant la corticothérapie : une en bolus et l’autre per os.
L’âge moyen de la grossesse est de 37,5 semaines d’aménorrhée avec des extrêmes de 36 et 40 semaines d’aménorrhée et 03 jours.
02 accouchements sur 04 étaient programmés.
Le poids de naissance moyen était de 3105 gramme avec des extrêmes allant de 2750 à 3950 grammes.
Dans le post partum on n’a pas noté de cas de poussée de la maladie ou d’accident thrombo emboliques.

CONCLUSION :
La maladie de Bechct ayant une répercussion sur la vascularisation systémique et donc sur les échanges vasculaires materno- foetal est pourvoyouse d’un taux important de morbidité maternelle et foetale. Une surveillance rigoureuse pendant la grossesse, l’accouchement et en post partum aussi bien de la mère que de foetus s’avère fondamentale nécessitant une approche multi disciplinaire intéressant aussi bien l’obstétricien que l’interniste et le néonatalogiste.
Malignant neoplasm risk in a Rheumatoid Arthritis cohort: a retrospective study

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Introduction: It’s known that the risk of neoplasms is increased in rheumatic patients, especially in Rheumatoid Arthritis (RA), SLE and inflammatory myopathies. Although the relationship between neoplasms has been studied, we still don’t know all the mechanisms.

Objectives: To determine whether the incidence of neoplasm is increased in RA-patients compared to a matched comparison cohort and to identify risk for any individual malignancy in RA.

Material and methods: 243 RA patients, fulfilling 1987 RA ACR criteria and a comparison matched cohort, were evaluated retrospectively for cancer occurrence. Data were collected through medical record review.

Results: 243 RA patients were enrolled. 148 RA patients had rheumatoid factor (RF) positive; 120 anti-citrullinated peptide (anti-ccp) positive. Erosions were present in 106. The prevalence of neoplasms was similar in RA and non-RA groups (p=0.8). In RA patients, correlation was found between male sex and absence of RF and neoplasm (p=0.04 and p=0.049). No correlation was found between neoplasm and anti CCP presence or erosions (p=0.3 and p=0.51). The risk of neoplasms in RA-patients wasn’t associated with DMARD’s. No differences were found between the type of tumor in RA patients vs non-RA, except for colon cancer, more prevalent in RA patients (p=0.03). Only 21 non-RA patients vs 19 RA patients were smokers and for so, it wasn’t possible to establish any correlations.

Conclusion: We found a higher prevalence of colon cancer in RA patients whoever, the increased risk for lung cancer and lymphoma often reported, was not found. Male sex and the absence of RF are responsible for an increased risk. Our limitations: small sample, predominately Caucasian. Further studies are needed to investigate this theme.
Managing a difficult case of rheumatoid arthritis: an integrated, patient-centred approach

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Introduction: Rheumatoid arthritis (RA) is a debilitating disease with serious physical, emotional and economic consequences that afflicts about 1% of the world’s adult population. Despite the new biological therapies, managing this complex disease can still be a challenge for the physician.

Case presentation: We present the case of a 70 years old female patient, who first came to our clinic 4 years ago. She was known with seropositive RA and received conventional and biologic DMARD in maximal dose for more than 10 years. Lately, she became unresponsive at TNF Alpha inhibitor so she stopped the treatment. At the moment of admission in our clinic she needed a frame in order to walk and complained of pain and tumefactions in: shoulders, small articulations of hand and feet and morning stiffness of 3-4 hours. Her DAS28 (CRP) was extremely high (7.02).

Besides the optimal investigations and medication therapy she was referred to a patient support group where, under the supervision of a psychotherapist and rheumatologist she underwent person-centered therapy. Slowly, her mental state began to improve, she accepted the recommended medication and followed a personalized rehabilitation program. Over the last years she improved so much that the weekly dose of Methotrexate was slowly reduced, being now 5mg/week. The patient is currently pain free and her DAS28 CRP is 1,15.

Discussions: Psychological distress, including depression and anxiety is common among patients with RA and has a significant impact on response to therapy. Optimal care of patients with RA should consist of an integrated approach that includes both pharmacologic and nonpharmacologic therapies.
Microscopic Polyangeitis - Clinical Evolution of a Patient

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Introduction: Microscopic polyangeitis (MPA) is a systemic vasculitis of small vessels that presents typically positive perinuclear cytoplasmic anti-neutrophil antibody (pANCA) and the definitive diagnosis is based on tissue biopsy. Treatment consists of immunosuppression with glucocorticoids and cyclophosphamide.

Case description: Man, 77 years, history of Dyslipidemia. Observed in our hospital for macroscopic hematuria, associated with asthenia, myalgia, weight loss, progressive dyspnea and paraparesis with 2 months of evolution.

Analytically, presented with normocytic/normochromic anemia, leucocytosis, thrombocytosis, elevated C-reactive protein, plasma creatinine increased and pANCA positive (546 U/mL).

Thus, started corticoid pulse, follow by glucocorticoids and cyclophosphamide. Although the treatment instituted, presented unfavorable evolution with tetraparesis aggravation and acute abdomen in context of rupture of the gastroepiploic artery. After phase of greater clinical stability, had a new complication of the disease, at the 15th day of hospitalization presents Diffuse Alveolar Hemorrhage, therefore initiating plasmapheresis as life-saving therapy. At day 18, Thrombotic Microangiopathy. Patient maintained unfavorable evolution under optimized therapy, eventually passing away on the 32nd day of hospitalization. Impossibility of renal biopsy due to progressive clinical worsening and hemodynamic instability.

Discussion: MPA is a systemic necrotizing vasculitis with significant renal and pulmonary manifestations. During the evaluation of the case, placed hypothesis of a Polyarteritis Nodosa (PAN), however despite the involvement of medium vessels, the pANCA positive strongly argues against PAN and in favor of the ANCA-associated vasculitis. Larger arteries may be involved in the MPA. Diagnosis can be challenging, relies on the physician drawing together elements of the patient’s clinical history and symptoms with diagnostic testing - tissue biopsy and autoantibody.
Microscopic polyangiitis in an elderly patient- an interdisciplinary management

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Introduction
Microscopic polyangiitis is a multisystem autoimmune pathology characterized by necrotic inflammation of non-granulomatous small vessels without immune deposits. Its commonly associated with renal, pulmonary, cutaneous manifestations and anti-neutrophil cytoplasmic autoantibodies with specificity for myeloperoxidase (MPO-ANCA) with high levels.

Case description
A 77-year-old woman was admitted in our clinic for hemoptysis, severe dyspnea, abdominal discomfort, vomiting and skin rashes. Her medical, surgical and families histories were unremarkable. The clinical exam showed fever, coarse crackles on both pulmonary areas, hemodynamic stable, urine output <0.5 mL/kg/hour for 12 hours. Maculopapular rash was observed on the chest, upper limbs and livedo reticularis on the lower limbs. Laboratory results identified inflammatory syndrome, impaired kidney function (creatinine 7 mg/dl, urea=110 mg/dl), normochromic, normocytic anemia, urinary protein excretion 1,46 g/24 hours and microscopic hematuria. MPO-ANCA titer was 538 U/L(normal range<7U/L). Chest X-ray and computed tomography scan revealed diffuse infiltrates in both lung fields, suggesting alveolar hemorrhage. Renal ultrasonography was normal, while anatomopathological examination the majority of glomeruli presents "crescents", without immune deposits. Skin biopsy showed leukocytoclastic vasculitis of the small vessels with neutrophilic infiltrates. Microscopic polyangiitis was diagnosed based on clinical, laboratory and histological findings. The patient was treated with prednisolone, cyclophosphamide, plasmapheresis, resulting in improvement in lung, renal function and skin lesions.

Discussion
Vasculitis still poses a challenge to internists, nephrologists and dermatologists, and skin damage may be one of the symptoms of autoimmune disease. Interdisciplinary management has led to successful judgment of this clinical case.
Mixed connective tissue disease - Diagnostic and Therapeutic Challenge

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Introduction: Mixed connective tissue disease (MCTD) due to its spectrum of manifestations and diagnostic peculiarity that does not obey universal criteria requires continuous follow-up. On the other hand, the therapeutic adaptation to the individual characteristics of the patient and different presentations remains a constant challenge considering the risks inherent to corticotherapy. Case description: 30-year-old woman, with onset of symptoms at 20-years-old (Raynaud's phenomenon and hand edema). Several medical recurrences due to asthenia, arthralgia, myalgia and headache, carrying out several studies aimed at inconclusive autoimmunity, being medicated with courses of corticotherapy with improvement. Admission at 25-years-old due to suspicion of pericarditis. At 30-years-old, aggravation of complaints and episode of atrite being followed at hospital level. Capillaroscopy showed a pattern of capillary alterations similar to systemic sclerosis. Negativity of Rheumatoid Factor and anti CCP, remained under radiological surveillance. Due to dyspnea for small efforts without respiratory failure, spirometry and Thoracic CT were performed with high resolution without alterations. No evidence of pulmonary hypertension on echocardiography. Autoimmune study revealed anti-ribonucleoprotein U1 (RNP) antibodies (titer = 1: 1600). Also noteworthy were thrombocytopenia and anti - phospholipid AC - positivity. Although complaints of constant myalgia with maintenance of increased muscle enzymes, electromyography without alterations. Therapeutic response only to corticosteroid therapy. Discussion: This case illustrates the complexity of the MCTD approach and the requirement of continuous follow-up, during which it may be diagnosed another autoimmune disease. Morbidity is high and is mainly associated with general and musculoskeletal manifestations, as well as prolonged corticosteroid therapy.
Monoclonal gammopathy of undetermined significance in a Central Hospital

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Objectives
Characterize patients with the diagnosis of Monoclonal gammopathy of undetermined significance (MGUS) in a central hospital to determine disease progression (DP).

Methods
Retrospective discretionary study of patients with the diagnosis of MGUS from 2013 to 2017, using the corresponding codes from the disease classification ICD-9 and ICD-10 with an evaluation of demographic and clinical variables with posterior descriptive analysis.

Results
There were identified 221 cases with 81 excluded. From the 140 selected, 53% were women. The mean age was 67. In this sample, 90% of MGUS were detected by routine blood tests or through a follow-up of another unrelated clinical situation, with 15% having nonhematologic malignancy prior or after MGUS diagnosis. From all MGUS diagnosed, 66% were IgG type, 29% non-IgG type and 5% without mention of the type. Kappa light chain was present in 56% and Lambda light chain in 39%, with 5% not having the chain type on record. Of all selected cases, 19% had DP (n=27): 63% to multiple myeloma (MM), 30% to smoldering multiple myeloma and 7% to Waldenström macroglobulinemia. The mean time of DP was 2.7 years (ranging from 1 month to 8 years). Predictors of progression (serum monoclonal protein level $\geq 1.5$ g/dL, non-IgG MGUS, abnormal serum free light chain ratio) were found in 43% of all cases: 44% with one and 4% with two. Mortality was 12%: 53% died before DP and 47% (n=8) died 1.1 years after DP (50% by MM or its complications).

Conclusion
These results are similar to those found in literature except for the predominance of women. Predictors of progression may have a significant role in determining which patients with MGUS should have a closer follow-up, although this study did not incorporate the abnormal serum free light chain ratio. No light chain MGUS were detected, explained by the selection bias, which is the major limitation of this study. Therefore, these results may underestimate the true prevalence of MGUS and its progression.
Neoplasia of tendinous sheaths

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Introduction: Osteomyoarticular pain is unspecific and common symptoms of several pathologies. It is important, as in any pathology, to perform a clinical history and an exhaustive diagnostic procedure to identify the cause and therapeutic orientation.

Case report: Male 26-year-old patient with no known pathological history who started generalized osteoarticular pain for more than 3 months with greater intensity in the frontal and back of the hands, concomitantly noted nodular lesions on the back of the hand, inflammation in the interphalangeal joints of the hands and knees. From the exams performed, it was emphasized for the elevation of inflammatory parameters, chest Rx, thoracic and abdominal CT without any relevant alterations, left and right hand with fluid distension of the cuffed tendons suggestive of tenosynovitis, Biopsy of the nodular lesions (back of the hand) showed histological findings compatible with giant cell tumor of the tendon sheaths of diffuse type. In a joint follow-up with rheumatology and oncology, he started therapy with imatinib 400mg daily for 3 months and subsequent reevaluation.

CONCLUSION: The Giant Cell Tumor of the Tendinous Sheaths is a tumors benign of histiocytes associated with multinucleated giant cells, assuming circumscribed or polygonal forms. The etiology is not yet fully known. It is most commonly found on the hands and feet, and more rarely described in the ankles and knees. Since excision completes the treatment of choice avoiding relapses.
Neuropsychiatric manifestations of Systemic Lupus Erythematosus

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Introduction: Neuropsychiatric symptoms are reported in nearly half of lupus patients. However, a psychiatric disturbance due to CNS lupus is a diagnosis of exclusion.

Case Description A 32 year-old female with a two months diagnosis of SLE with cutaneous, musculoskeletal, hematologic and renal involvement (class III focal lupus nephritis), previously treated with methylprednisolone bolus and currently with lisinopril, hydroxychloroquine and prednisolone 0.5mg/Kg/day, presents for a follow-up appointment where she exhibited a sudden change in behavior with disorientation, irritability, inappropriate speech, mental slowing and frequent crying spells. She had no past personal or family history of psychiatric illness.

Mental status examination revealed agitation, labile mood, poor attention span, misinterpretation of her surroundings and short-term memory difficulty. Blood analysis showed anemia, raised ESR, no electrolyte/metabolic derangements or complement consumption, negative CRP, normal renal function and urinalysis, positive SLE specific immune-biomarkers and antiphospholipid antibodies, negative antiribosomal P antibody. CSF fluid cell count, chemistry and microbiologic analysis were normal as were the brain MRI and EEG.

A diagnosis of psychotic disorder (steroid induced versus neurologic involvement by SLE) was considered. Risperidone, tianeptine, lorazepam and aspirin were prescribed. Prednisolone was reduced to 20mg/day. Due to the renal involvement, the patient had already been proposed for MMF treatment but, given a possible lupus cerebritis, CYC was considered. MMF was started to avoid CYC ovarian toxicity. The attempted psycho-pharmacotherapeutic intervention was successful.

Conclusion: This case highlights how complex the distinction between organic and functional causes of SLE neuropsychiatric symptoms is, and how difficult it is to ascertain its etiology since both the disease and its treatment (steroids) may be responsible for these manifestations.
New Diagnosis of Sjögren's Syndrome Presenting with Acute Pancreatitis Clinic: Case Report

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Introduction: A chronic autoimmune inflammatory disease characterized by the infiltration of exocrine glands predominantly by CD4 T lymphocytes, resulting in Sjögren's syndrome, dry eye and dry mouth. Sjögren's syndrome can keep the entire gastrointestinal tract at different levels. Pancreatic involvement often results in acute or chronic pancreatitis. Following the case of pancreatitis, Sjögren's syndrome presented the case we had diagnosed.

Case: A 53-year-old woman presented with epigastric abdominal pain. His physical examination was normal except for epigastric tenderness. In laboratory evaluation; Amylase: 2673 u/L(28-100), Creatinine: 0.6 mg/dL(0.5-1.2), ALT/AST: 231/267 u/L(0-40), Wbc: 10 109/L(4-10), Hbg 12.5 gr/dl(12-16), Plt 245 109/L(100-400), Triglyceride 178 mg/dl(0-200). Hepatitis serology was negative. Abdominal USG and abdominal CT were evaluated as normal. The patient was hospitalized with pancreatitis. Electrocardiogram and chest X-ray were normal. She did not use alcohol. Intravenous hydration started. At 2 weeks, all biochemical parameters were monitored in the normal range. It was observed that her frequently drank water, because of the patient had frequent dry mouths in her follow-ups. Plasma fasting glucose was 89 mg/dL (70-110) and HbA1c was 5.5%. Schirmer test was positive (4 mm / 5 min in both eyes). Anti-Ro/SSA, anti-La/SS-B antibody positives, Anti-CCP and RF negative. Salivary gland biopsy was evaluated as compatible with Sjögren's syndrome. The patient was diagnosed with primary Sjögren's syndrome and medical treatment was arranged.

In conclusion, Primary Sjögren's syndrome is an autoimmune inflammatory disease with different clinical manifestations. It should be considered that pancreatitis may develop when abdominal pain is present in patients with Sjögren's syndrome. Sjögren's syndrome should also be considered in differential diagnosis in patients presenting with pancreatitis.
Introduction: Non-uremic calciphylaxis has been increasingly recognized and affects patients with preserved renal function. It is commonly described in primary hyperparathyroidism and more rarely in patients with autoimmune diseases, alcoholic liver disease and malignant neoplasies. Mönckeberg medial calcific sclerosis refers to a calcification of the medial artery layer mostly found in muscular arteries of the extremities and occasionally in visceral arteries.

Case description: a 51-year-old woman was admitted to the hospital with the suspicion of cellulitis of the right lower limb in association to a chronic ulcer that was being under wound care. She was obese and had hypertension and rheumatoid arthritis diagnosed at age of 20, controlled with low dose corticotherapy. She started antibiotics with resolution of the cellulitis. For better knowledge of the etiology of the ulcer a biopsy was made that revealed calciphylaxis. Laboratory tests revealed normal creatinine, calcium and phosphorus levels and a discrete elevation of the parathyroid hormone (99.5pg/ml). Corticotherapy at high doses was implemented with partial improvement of the non-healing wound and she was discharged. One month later the left femoral pulse was not palpable and the ankle-brachial index was >1.5. A lower limb arteriography was performed and showed bilateral, widespread vascular calcifications involving femoral, popliteal and tibial arteries. The left leg had to be amputated and shortly after the right one, too.

Discussion: individuals with rheumatoid arthritis are at increased risk for premature atherosclerosis and can have early-onset diffuse calcification. Yet to date, there are only few case reports of these disease associations.
Otologic symptoms as first manifestation of Wegener’s Granulomatosis - A case report

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INTRODUCTION
Granulomatosis with polyangiitis (GPA), also known as Wegener’s granulomatosis, is a systemic vasculitic disease affecting small vessels associated with necrotizing granulomas.

CASE DESCRIPTION
We present a 47 year-old non-smoker and previously healthy male, admitted at the ER complaining of a 3-month history of fever, anorexia, weight loss, episodes of serous medial otitis and left supraciliary headache. He was previously treated with antibiotics, but showed no improvement. Last month, he noticed dyspnoea, hemoptoic cough and progressive hypoacusia. At the hospital, chest radiograph revealed a middle lobe opacity, blood tests showed leukocytosis with high serum CRP levels and negative microbiologic screening, including tuberculosis. During admission, his thoracic-CT scan revealed cavitated lesions in the lung (medium lobe and superior segment of the right inferior lobe). His first bronchofibroscopy had no specific cytologic and histologic findings. Given the suspicion of cavitated pneumonia, he was treated with piperacillin/tazobactam and co-trimoxazole, with no improvement 1 week later. At that time, he developed eosinophilia, ESR of 95mm/h and presented a high serum titre of ANCA-c and anti-MPO antibodies. His second bronchofibroscopy and histopathological exam found necrotic granulomas and Langhans giant cells, suggestive of GPA. He began treatment with prednisolone 1mg/kg/day and rituximab with subsequent clinical improvement.

DISCUSSION
This case highlights the challenging diagnostic approach to GPA with otologic symptoms being unusually present at an early stage of the disease (they usually present during clinical course in up to 60% of cases). If untreated, GPA is a rapidly progressive disease with 82% mortality within a year.
Overlapping features between polymyositis and systemic sclerosis: a multidisciplinary approach

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Polymiositis (PM) is a subacute auto-immune myopathy. Rare as a single entity it is more often associated with other connective tissue diseases like systemic sclerosis (SSc). SSc-PM overlap syndromes may have a heterogeneous clinical presentation and are frequently misdiagnosed.

A 29-year-old black woman presented with a 2-month history of fever, myalgias, proximal upper and lower limbs muscle weakness and dyspnoea that had developed gradually. On physical examination she presented salt-and-pepper neckline skin appearance, puffy hands and feet and diffuse skin thickening. Blood tests showed a 6-fold creatine kinase elevation and positive-Polymyositis-Scleromyositis (PM-Scl75) and anti-Sjögren's-syndrome A (SSA) antibodies. Electromyography revealed myopathic changes and muscle biopsy showed inflammatory changes and muscle biopsy showed inflammatory infiltrate. Nail fold capillaroscopy revealed frequent haemorrhages. Findings on high-resolution thoracic computed tomography were compatible with interstitial lung disease and pulmonary function tests showed a restrictive pattern with respiratory muscles involvement (maximum inspired pressure 30%) and 30% reduction for diffusing capacity of the lung for carbon monoxide. Pulmonary hypertension was excluded by transthoracic echocardiography. The patient received intravenous immunoglobulin (2g/Kg per day divided over 3 days) and then was started on prednisolone and mycophenolate with progressive clinical improvement. After functional recovery corticoid was tapered. The patient is being closely monitored.

This case illustrates the importance of recognizing SSc-PM overlap syndromes. Pulmonary fibrosis and cardiac disease are major causes of morbidity and mortality. Disease awareness and early recognition of pulmonary and cardiac involvement will permit earlier adequate therapeutic intervention and disease course modification, contributing to quality of life improvement and increased survival.
Paraneoplastic erythema nodosum, rare entity not to be ignored: à propos a case

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Introduction: We report a case of paraneoplastic erythema nodosum (EN) associated with huge umbilical metastatic nodule simulating an umbilical hernia due to a subacute onset upper gut cancer.

Case description: 63-year-old patient admitted for asthenia & weight loss with concomitant painful huge EN of 4 limbs.

His past history: myocardial infarction & chronic alcoholism.

Biology: altered hepatic function tests, major hypoalbuminemia & elevated C-reactive protein (46mg/l). The angiotensin converting enzyme was elevated (87U/l).

CA.19.9 antigen was elevated.


Biopsy of umbilical lesion: highly undifferentiated adenocarcinoma.

CK7 +, CK20- compatible with upper gut or biliopancreatic origin.


We concluded to an upper gut adenocarcinoma.

EN required high doses steroid therapy

Chemotherapy was started.

The patient until then still receiving chemotherapy (after 16 months of diagnosis) with partial regression of the tumoral syndrome and total disappearance of EN and the umbilical metastasis.

Discussion: The paraneoplastic EN are quite rare and even rarer those associated with umbilical metastasis which are always secondary to adenocarcinoma most often of digestive origin (gastric cancer 21%), or gynecological origin (34% ovarian cancers, then 12% endometrial and 5% cervical cancers), which are of poor prognosis.

This paraneoplastic erythema nodosa responds rapidly to corticosteroids + chemotherapy.

Thoracoabdominopelvic CT scan is recommended in front of diffuse & bulky erythema nodosa to search for an underlying neoplastic cause.
Pauci-imune vasculitis - the importance of early diagnosis

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Objectives: Retrospectively characterize pauci-immune vasculitis patients followed between May 2014 and December 2015.

Methods: Consultation of pauci-immune vasculitis patient records in the period. Results are expressed as percentage, mean and standard deviation.

Results: Vasculitic processes frequently affect the kidney, namely granulomatosis with polyangiitis, microscopic polyangiitis, eosinophilic granulomatosis with polyangiitis and idiopathic crescentic glomerulonephritis, show none/low immune deposits to immunofluorescence microscopy and are frequently associated with neutrophil cytoplasmic antibodies (ANCA).

12 patients were evaluated: 67% female and 33% male, mean age 54.2±13 years. The initial clinical presentation was: involvement limited to kidney (n=2), renal and pulmonary (n=8), renal and cutaneous (n=1), renal and gastrointestinal (n=1). All had constitutional symptoms, anemia and renal dysfunction. The mean serum creatinine level was 4.3±2.5 mg/dl. 7 had proteinuria < 1 g/24h, 3 between 1-3.5 g/24h and 2 patients >3.5 g/24h.

8 patients were anti-MPO positive, 2 anti-PR3 positive, 1 negative for both markers and 1 anti-GBM and anti-MPO positive. 10 patients underwent renal biopsy: 8 had glomerular crescents under light microscopy. All were treated with corticosteroids and cyclophosphamide. 2 underwent plasmapheresis and 2 started hemodialysis.

During the follow-up period (16±13 months), none manifested disease’s reactivation; 1 patient progressed to terminal chronic kidney disease and none died. There were 2 infectious complications (pneumonias) during the follow-up.

Conclusions: Female and pulmonary-renal involvement are more prevalent at the initial clinical presentation. Only 2 patients required hemodialysis and plasmapheresis in the acute phase. To date no mortality, no disease related complications and a low ratio of treatment-related complications.

Therefore, early diagnosis of pauci-immune vasculitis and adequate immunosuppressive therapy is fundamental.
Pernicious anaemia and Behçet’s disease

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Introduction: Behcet's disease is a chronic and relapsing inflammatory disease with systemic involvement with various in habitual reported associations. Our objective is to report two cases of association of pernicious anemia to Behçet's disease in the young.

Case description: We report two male patients aged of 26 and 33 years respectively. They had Behçet's disease since the age of 20 for the first and 26 for the second. They presented at the routine control review a macrocytic anemia: hemoglobin at 9 g/dl with MCV at 115 μ3 for the first and 10.9 g/dl with MCV at 104 μ3 for the second. The diagnosis of pernicious anemia was confirmed in both cases by a low level of vitamin B12, a megaloblastosis with asynchronism of nucleo-cytoplasmic maturation on myelogram, and positive anti intrinsic factor and anti parietal cell antibodies.

Under intramuscular B12-vitamin therapy, outcome was favorable in both cases.

Discussion: To our knowledge, this is the first publication of such an association. The occurrence of pernicious anemia in Behçet's disease reinforces the hypothesis suggesting an autoimmune origin of this vasculitis.
Rheumatology + musculoskeletal disorders
A-1656

Polyarteritis Nodosa: an exceptional first manifestation

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Introduction: Splenic infarction is mainly caused by haematological malignancies and different thromboembolic diseases. Polyarteritis nodosa (PAN) is an exceptional cause. We present a case of PAN with a massive splenic infarction as the first manifestation.

Case description: A 37 year-old woman with smoking, hypertension, diabetes and HBV Carrier, consulted because abdominal pain and fever. She also referred weight loss, myalgia, astenia and parestesia in hands and feet. Clinical examination: pain in left hypochondrium. Blood analysis: 18200 leukocytes (68%N); 1103000 platelets; fibrinogen 561; ESS 120 mm/h; RCP 11.4; ions, liver biology, ferrokinetics, ACE, ANAs, ANCAs, rheumatoid factor, proteinogram: negatives. Serology: Ag HBVs positive; HIV, herpesviridiae, lues and toxoplasma: negative. Thrombophilia study: negative. JAK 2 mutation: negative. Abdominal ultrasounds: Spleen size 12.6 cm and hypoecogenic space occupying lesions. Abdominal CT angiogram: celiac artery stop from the origen of the splenic and hepatic arteries. Abdominal RMI: Splenomegaly and stop in splenic artery Echocardiogram: normal. Bone Marrox: normal. The patient was treated with anticoagulants and corticoids. Surgery was dismissed.

Discussion: PAN is a necrotizing vasculitis that can affect many organs. The American College of Rheumatology stablished ten diagnosis criteria in 1990 (at least three must be present), with a sensibility/specificity of 82/86%. Four of them were presented in our case: weight los, mialgia, positive serology for HBV and mesenteric thrombosis. Vasculitis are a rare cause of splenic infarction, specially PAN, but it is necessary to think about them as a posible differential diagnosis.
Polymyalgia Rheumatica: a diagnostic challenge.

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Introduction: Polymyalgia rheumatica (PR) is a common chronic inflammatory condition from unknown etiology, many times misdiagnosed since is a diagnosis of exclusion and through the inexistence of specific diagnostic exams. Corticotherapy (CT) is considered the treatment of choice and a rapid response to low-dose corticosteroids is considered pathognomonic. Case description: We present a case of a 75-year-old woman, with history of primary hyperparathyroidism, conditioning hypercalcemia and generalized bone pain (submitted to parathyroidectomy), type 2 diabetes, chronic kidney disease (CKD) and anemia. The patient was followed in the internal medicine consultation and ended up being electively admitted at the hospital for presenting a deterioration of health, worsening anemia and low back pain with compromised mobility and disability to perform daily activities, associated to a lytic thoracic vertebra lesion in bone scintigraphy. In admission the patient revealed pain in the lumbar spine, pelvic and shoulder girdle. The blood tests revealed normocytic normochromic anemia requiring a transfusion support, high levels of erythrocyte sedimentation rate (ESR) and parathyroid hormone, abnormalities that have been assumed in a CKD context, having the patient initialized treatment with folic acid and erythropoiesis stimulating agents. The CT scanning of the spine showed the existence of multiple fractures in the bones and serious spinal stenosis, without surgical indication. After neoplastic and infection causes excluded and having pain symptoms involving the pelvic and shoulder girdle, aggravated anemia and persistent high level of ESR, PR was accepted as a hypothesis and a low-dose corticosteroids was initiated, resulting in an improvement in blood test and clinic results. Discussion: This case shows the difficulty that is involved in PR diagnosis, being necessary a large degree of clinical suspicion in the presence of symptoms common to multiple diseases.
Objective:
The purpose of this study is to evaluate the impact of SLE on pregnancy and pregnancy outcomes on maternal morbidity in lupus patients.

Patients and methods:
A retrospective study of 8 pregnancies in 5 patients with diagnosed SLE before or during pregnancy during a period of 4 years. The epidemiological, clinical and evolutionary characteristics of each patient were collected on a pre-established form. Information on lupus disease and the progress of pregnancy has been obtained from hospital records.

Results:
The mean age was 28.5 years. In 2 cases, LES was cutaneous, articular and hematologic. 2 cases of histologically proven renal failure and 1 case of neurolupus were noted. 1 patient had an antiphospholipid syndrome associated with LES.
The mean duration of progression of SLE before pregnancy was 4.2 years. In 3 cases pregnancy was revealing of SLE.
2 patients were in flush at the time of conception with an average SLEI of 7.75.
3 pregnancies occurred in 2 patients on prednisone, the average dose was 10.6 mg. In 2 pregnancies, patients were on synthetic antimalarial drugs (APS) before pregnancy. In one pregnancy, the patient was on both APS and prednisone. One patient received no treatment at the time of diagnosis of pregnancy. The patient with SAPL received preventive treatment with low molecular weight heparin (LMWH) in a single pregnancy without associated aspirin.
the LES became active during the pregnancy in 1 case and in the postabortum in the other case.
4 pregnancies were complicated by preeclampsia and 2 with gestational diabetes. 2 early abortions occurred in patients with quiescent lupus.
Among live births, 1 neonatal death with congenital BVA was observed

Conclusion:
Pregnancy in a lupus woman should be considered a high-risk situation and therefore requires special monitoring. Controlling the disease before and during pregnancy remains the best guarantee of pregnancy without problem.
Primary Sjögren syndrome and autoimmune thyroiditis

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Primary Sjögren syndrome is a systemic autoimmune disease characterized by salivary and lacrimal exocrinopathy in association with antinuclear anticodies (ANA) and anti-SSA/SSB. However, endocrine manifestations may also occur, namely thyroid autoimmune disease. The aim of our work was to assess the frequency of autoimmune thyroid disease in a population with primary Sjögren syndrome, in relation autoantibody profiles.

We conducted a retrospective clinical analysis of patients with primary Sjögren syndrome followed at our internal medicine department. Patients were characterized according demographic data, Sjögren extra-glandular manifestations, presence of thyroid disease and auto antibody titers.

The population of this study consisted of 50 patients aged 60 ± 14 years with primary Sjögren syndrome, being the great part of them women (92%). Median disease time since diagnosis was 4 years (1-26). Nine patients (18%) presented severe extra-glandular manifestations, from which 3 had central nervous system involvement, 3 had pulmonary disease associated with Sjögren syndrome, 2 had tubulointerstitial nephritis and 1 had lymphoma. About 78% of patients had positive ANA titers, and 48% had either positive anti-SSA and/or anti-SSB. In our population the frequency of autoimmune thyroid disease was of 18% (9 patients). All of them had Hashimoto thyroiditis: 44% (4) had either hypothyroidism or were euthyroid; the remaining patient (11%) had hyperthyroidism. With didn’t identify other thyroid autoimmune diseases (such as Graves disease), Most patients with Sjögren syndrome and Hashimoto thyroiditis (8 out of 9 patients) had positive ANA titers.

In our population of patients with primary Sjögren syndrome, the prevalence of autoimmune thyroiditis was of 18%, therefore justifying a systemic thyroid evaluation in Sjögren syndrome patients. Patients with both autoimmune thyroiditis and primary Sjögren syndrome had in their majority positive ANA titers.
Prise en charge des grossesses en cas de syndrome des anticorps antiphospholipide

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INTRODUCTION :
Le syndrome des antiphospholipides (SAPL), individualisé dans les années 80, est une pathologie auto-immune du sujet jeune associant des manifestations cliniques principalement à type de thromboses veineuses et artérielles récidivantes et/ou de complications obstétricales variées à répétition. Il peut être isolé, le SAPL est alors défini comme étant primaire ou bien il est associé à un lupus érythémateux systémique (LES) ou à une autre maladie auto-immune, dans ce cas il est secondaire.

MATERIELS ET METHODES :
Nous avons mené une étude rétrospective descriptive sur une période de 5 ans et qui a porté sur 34 femmes avec SAPL dont 11 cas confirmés par le bilan immunologique.

Résultats :
L’âge moyen des patientes présentant le syndrome d’anticorps anti phospholipides (SAPL) est de 32 ans avec des extrêmes allant de 21 à 44 ans. La gestité moyenne des malades est de 4,5 pour une parité de 1,7. Toutes nos patientes ont bénéficié d’un bilan immunologique. Nous avons noté que le résultat du bilan était positif dans 11 cas soit 32% et normal dans 23 cas soit 68%.

Pour le Traitement prophylactique
- Aspéthic dans 100% des cas à dose de 100mg par jour du début de la grossesse jusqu’à 34SA
- LOVENOX 40 dans 33 cas à dose de 40mg par jour jusqu’à la veille de l’accouchement

Parmi les 34 gestantes APL diagnostiquées et mises sous traitement prophylactique et suivies dans le service, il y a 26 grossesses qui sont arrivées à terme soit 76,5%. Nous avons enregistré 7 cas de prématurité et 1 cas de MFIU. Le poids foetal moyen à la naissance est de 2511,5 g avec les extrêmes allant de 1100 et 3870 g.

CONCLUSION :
L’association grossesse et SAPL est une situation à haut risque pour le foetus et la mère nécessitant une prise en charge pluridisciplinaire.
Pulmonary hypertension and interstitial lung findings in Neurofibromatosis type 1.

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INTRODUCTION: Pulmonary hypertension (PH) is a rare complication of Neurofibromatosis type 1 (NF1). The authors present a case of pre-capillary PH in a patient with NF1 and interstitial lung findings.

CASE DESCRIPTION: A 68 year-old non-smoker female presented a progressive effort dyspnea for one year. Main findings from the initial study included: hypoxemia (pO2: 55mmHg); centrilobular ground-glass micronodules on thoracic high-resolution computed tomography (HRCT); a moderate defect in diffusion lung capacity for carbon monoxide (DLCO: 44%); 97% monocytes/macrophages in bronchoalveolar lavage; inconclusive transthoracic biopsy. In parallel to the study of dyspnea, NF1 diagnosis was made and confirmed by genetic study. Meanwhile, clinical worsening with cor pulmonale was documented. The patient underwent right heart catheterization with vasodilatation test that confirmed pre-capillary PH (PAPm: 41mmHg, PCWP: 9mmHg, PVR: 13.4UWood, CI= 2.39L/min/m2), which could fit in group 5 (secondary to NF1), however there were doubts about the coexistence of an interstitial lung disease (ILD). For that reason, surgical lung biopsy was performed, revealing not only vasculopathy findings, but also an accumulation of macrophages along the bronchovascular bundles and alveolar spaces, with type II pneumocyte hyperplasia. Interstitial findings could correspond to a respiratory bronchiolitis (RB-ILD), however there was no history of smoke exposure; the possibility of NF1-related ILD was also hypothesized. The patient was transferred to a PH treatment center, however combined sequential therapy was ineffective and death occurred 18 months later.

DISCUSSION: Patients with NF1 and PH usually have a dismal prognosis, with limited impact of specific therapy. The existence of an NF1-related ILD has been suggested, with reports of pulmonary cysts and ground-glass centrilobular nodules, even in non-smokers. Contrary to our case, most of those reports lack evidence from lung biopsy and HRCT.
RDW as a marker of disease activity in systemic lupus erythematosus

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Objectives
Red cell distribution width (RDW) is a routine laboratorial marker reflecting variation in erythrocyte size. Despite being developed to study anemia, recently it is being used as a potential marker of systemic inflammation, particularly in immuno-mediated diseases. Previous studies concluded that RDW was higher in systemic lupus erythematosus (SLE) patients when compared to a healthy population¹.

The aim of this study was to investigate the association between RDW and disease activity of SLE.

Methods
Transversal retrospective study including all patients with a definitive diagnosis of SLE (SLICC criteria) followed at our SLE clinic in 2017. Disease activity was evaluated using SLEDAI-2K score. Data was analyzed using STATA software. RDW was stratified as terciles (< 12.7; 12.7-13.8; >13.8) and was analysed in relation with SLEDAI-2K.

Results
Ninety-two patients were included, 91% were female and the mean age was 47±15.5 years. The mean RDW was 13.4 ± 1.2% and the mean SLEDAI-2K score was 2.1 ± 2.6.

The plotted analysis of the association between RDW and SLEDAI-2K showed that there was a tendency towards a linear association, but not statistically significant (correlation test: p=0.161). There was no difference between the SLEDAI-2K values in each tercile of RDW (p=0.240), but patients with RDW <12.7% were significantly associated with lower disease activity as per SLEDAI-2K value (p=0.023).

Conclusion
Lower values of RDW were associated with lower SLEDAI-2K values in our cohort. RDW is an inexpensive test that could potentially be used as a negative predictor for disease activity in SLE. Further studies should be conducted with larger samples and with patients with higher disease activity.

References:
Recidival Polycondritis

Cataldi Amatriain Roberto, Franco Amaro, Alberto Arena, María José Rota, Lorena Baez and Matias Ottaviani.

ABSTRACT
Introduction
Recurrent polycondritis is an inflammatory disease of unknown etiology and autoimmune base, rare, characterized by recurrent inflammatory lesions, which affect the cartilaginous structures, the cardiovascular system and the sense organs. It has a similar distribution in both sexes, appearing mainly in the fifth decade of life, and it is often associated with other systemic, hematological and endocrine autoimmune diseases. Chondritis of the auricular and nasal pavilion, arthropathies and ocular involvement are the most common clinical manifestations.
Case description
61-year-old man consults for asthenia, adynamia, abulia, irritability, hyporexia, loss of weight, fever, generalized tremor and postural inestability. Also painful and erythematous swelling of both auricular pavilion. A case is described below of a patient with polycondritis who has an important improvement after treatment with steroid.
Discussion Frequently the diagnosis is based mainly on the clinical picture, since there is no specific laboratory parameter or immunological marker. The treatment of choice is steroid therapy, although in many cases they require immunosuppressants as second-line medication.
Key words: RECIDIVAL POLYCONDritis
Private Clinic of Carmen. Zárate. Province of Buenos Aires. Argentina
Retro-peritoneal fibrosis and abdominal aortitis of Horton

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Introduction
Retro-peritoneal fibrosis (FRP) is a rare disease, characterized by the presence of fibro-inflammatory tissue that often forms around the infrarenal portion of the abdominal aorta and iliac arteries, the relationship between retro-peritoneal fibrosis and Horton's aortitis remains ambiguous, is it an association or a secondary condition to inflammatory aortitis?

Observation:
63-year-old patient following our level for abdominal aortitis of Horton for 4 years, treated with corticosteroids for 18 months, stabilized.
During the routine imaging examination, an abdominal mass was objectified 4 cm around the abdominal aorta and both iliac arteries. After a thorough interrogation the patient reports abdominal pain but bearable. Inflammatory assessment made positive return and the IGg4 assay was normal, the scanned-guided cytoprotomy confirms the notion of retro-peritoneal fibrosis, treatment with corticosteroids and methotrexate for cortisonic sparing was undertaken with a good response and regression of the mass.
This fibrosis may be secondary to abdominal aortitis as it may be associated as a separate entity to vasculitis.

Conclusion:
The follow-up by imaging in the Horton aortitis remains a good means of surveillance, thanks to the control retro-peritoneal fibrosis was discovered fortuitously and treated.
Retrobulbar optic neuritis.

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INTRODUCTION: Optic neuritis is a condition that involves primary inflammation of the optic nerve. It may be associated with a variety of systemic autoimmune disorders, but the most common form, acute demyelinating optic neuritis, is best known for its association with multiple sclerosis.

DESCRIPTION: A 23-year-old man with no personal history of interest, assessed in the emergency room for ocular pain. He entered the study due to a week of episodes of paresthesias in the leg and left hand associated with left eye pain as well as visual alteration by that eye. For two days he has felt stinging pain in his right eye, but without visual alteration.

Normal ophthalmologic examination. Transparent liquid lumbar puncture is performed in rock water: normal biochemistry, negative microbiology, negative autoimmunity and serology. Visual evoked potentials are performed against monocular stimulation of the eyes, with slight involvement of both visual pathways in the fibers of central vision, predominantly demyelinating. Cranial, cervical and dorsal magnetic resonance without demyelinating lesions. After starting treatment with boluses of methylprednisolone for five days, he presented a spectacular initial response, disappearing neurological symptoms and recovering completely the vision of the left eye.

Oligoclonal bands in serum and cerebrospinal fluid are requested for multiple sclerosis screening.

DISCUSSION: Acute demyelinating optic neuritis is the characteristic form of presentation (ie, the first clinical demyelinating event) in 15 to 20 percent of patients with multiple sclerosis, and occurs at some time during the course of the disease in the 50 percent of patients. The high risk of multiple sclerosis associated with optic neuritis, combined with data from clinical trials demonstrating a reduction of this risk with early therapy in selected patients, underscores the importance of accurate diagnosis and treatment.
Rhabdomyolysis diagnosed in the department of Internal Medicine

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Objectives: Rhabdomyolysis is the destruction of muscle fibers with the transfer of toxines to the systemic circulation. It is usually characterized by hyperkalemia, metabolic acidosis and acute kidney failure. With this study we want to know the casuistry of rhabdomyolysis and to characterize the presence of risk factors.

Methods: All cases of diagnosed rhabdomyolysis in our hospital in the last five years were retrospectively reviewed. Epidemiological and analytical data were collected. Results: We found 27 cases of diagnosed acute rhabdomyolysis in our database, most of them attended in the Internal Medicine Department (52%) and in the Critical Care Unit (33%). 23 cases were men; average age 61 ± 21 years; average admission 14 ± 14 days. The main risk factors observed were: alcohol consumption 6, drugs of abuse 2, myotoxicity due to drugs 5, immobility 11, direct muscle injury 14, hypothermia 3, intense muscular activity 7, infections 21, sepsis 9. Symptoms and signs: fever 13; dehydration 16 and hypotension 14. Median CPK was 5140 UI/L. 29% of the patients presented arrythmia. Kidney failure was evidenced in 19 cases and haemodialysis was needed in 3 cases, hepatic failure in 5 cases. Eight patients died during the admission (30%). Conclusions: These data let us to assert that in our area rhabdomyolysis concerns mainly young men, specially because direct muscle injury, immobility and, lesser, because drugs and alcohol. The most frequent clinical sign was dehydration and reversible kidney failure. This so high mortality rate obtained was related with non-reversible kidney failure, in agree with other studies. Finally, is important to remember that rhabdomyolysis is a serious complication in immobilism and traumatisms, whose prognosis is determined by the prevention and the aggressive treatment of the kidney failure.
Rheumatic fever in the adult – a case report

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Introduction:
Rheumatic fever is a late complication of infection with group A Streptococcus, and may have an atypical clinical presentation, especially in adults.

Case description:
We present the clinical case of a 30 year-old man without previous illnesses. The patient was referred to the emergency department with myalgia, migratory polyarthralgia, fever, right calf pain, with decreased muscle strength, 72h after onset. Upon evaluation, with right hemiparesis. Laboratory findings with elevation of inflammatory markers (C-reactive protein 5.85mg/dL, ESR 48mm). A cranial CT-scan was performed, which showed no alterations, an electromyogram that exclude peripheral nerve injury, and a lumbar puncture, without changes, and negative serology in the CSF.
At the 2nd day of hospitalization, patient maintains fever and subcutaneous nodules in the lower limbs, whose histopathology confirmed erythema nodosum, associated with migratory polyarthralgia and erythema marginatum of the upper and lower limbs. Laboratory evolution with inflammatory markers and troponin elevation, without chest pain and without electrocardiogram or echocardiogram changes. The complementary etiological investigation revealed: infectious serology, blood cultures, autoimmunity study, all negative; anti-streptolysin O titer of 363 IU/ mL. The diagnosis of rheumatic fever was assumed, fulfilling clinical and laboratory criteria, and antibiotic therapy was started with penicillin, followed by clinical and laboratory improvement. The patient was discharged with follow-up in internal medicine.

Discussion:
The authors intend to emphasize the importance of considering the diagnosis of rheumatic fever in patients without concomitant or previous acute tonsillitis, with absence of carditis, and with cutaneous alterations and polyarthritis as the inaugural clinical presentation.
Rheumatoid Arthritis Mimicking Diabetic Neuropathy: A Case Report

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Introduction: Rheumatoid arthritis (RA) is a symmetric, inflammatory, peripheral polyarthritis of unknown etiology. It typically leads to deformity through the stretching of tendons and ligaments and destruction of joints through the erosion of cartilage and bone. Diabetes mellitus (DM) is a chronic disease caused by deficiency in production or the ineffectiveness of the insulin produced. DM has many complications. The most common complication is neuropathy. Clinic neuropathy may present with a wide variety of symptoms, such as pain, paresthesias and muscle weakness. These symptoms may mimic and overlap those of arthritis and it is difficult to distinguish peripheral neuropathy symptoms from arthritis symptoms.

Case Description: 62-year-old man with a 20-year history of DM that using intensive insulin therapy was admitted to our hospital complaining of paresthesias in his hands and feet, pain and weakness in his legs for about 2 months. α-lipoic acid treatment was started considering diabetic neuropathy but when the complaints were not improved, he came back. Swelling in the joints and limited range of motions were observed. A laboratory investigation showed sedimentation 43 mm/h, RF 210 U/ml, anti-CCP IgG >200 U/ml. RA was diagnosed, prednisolone and methotrexate were started. After 1 month of follow-up, the clinic was significantly improved.

Discussion: RA is a systemic inflammatory disease that mainly affects the joints. It has a worldwide distribution with an estimated prevalence of 1 to 2%. Both incidence and prevalence of RA are two to three times greater in women than men. Although the main manifestations involve the joints, RA also has extraartricular manifestations and clinical neuropathy occurs in 0.5% to 85%. Consequently, neuropathic symptoms mimic the symptoms of arthritis and it is difficult to distinguish between them. Rheumatologic diseases should also be considered if patients with DM, such as in our case, are admitted with neuropathic symptoms and not responded to standard therapy.
**Rheumatology + musculoskeletal disorders**
A-2100

**Rheumatoid arthritis: twist of a story**

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**INTRODUCTION:**
Rheumatoid arthritis (RA) is a chronic, autoimmune and systemic disease. The central pathophysiology is based on inflammation and destruction of synovial joints. However, extra-articular involvement can occur and is considered a marker of severity.

**CASE DESCRIPTION:**
A 68-years-old female with 10 years of evolution of RA treated with sulfasalazine and corticosteroid (CT) therapy in low doses. The relevant antecedents were the mitral valve replacement with mechanical prosthesis in 2000 and atrial fibrillation anticoagulated.

The patient had 2 hospitalizations in April and May 2017 for spontaneous hematomas. In the course of the 2nd hospitalization she began to feel exertional dyspnea with progressive worsening, without infectious cause. The presumption of extra-articular involvement was further supported by the chest computed tomography which revealed a pleural thickening and signs of pulmonary hypertension (PH) confirmed in the transthoracic echocardiography. Therefore, CT’s doses were increased and the start of mycophenolate mofetil (MF) was programed.

In June 2017 the patient was once again hospitalized due to rest dyspnea during consultation. This symptoms only improved after the start of MF and the increase of CT’s doses. This hospitalization was marked by various complications, which included 2 episodes of nosocomial pneumonia and a huge spontaneous hematoma of the left thigh whith hypovolemic shock and compartmental syndrome resolved after surgical drainage. The patient was discharged with oxygenotherapy and is currently in a program of rehabilitation.

**DISCUSSION:**
Thus, we have a patient with RA with articular symptoms and sudden pulmonary and vascular involvement, in the form of pleural disease and PH. The singularity of this case is increased by the fact that PH is rare in RA and pleural disease is, generally, subclinical and more prevalent in male. In sum, this case demonstrates the importance of awareness even in patients with long-term illness.
Role of Positron-emission tomography (PET) in confirming large vessel vasculitis.

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Introduction
Systemic vasculitis can be a challenging diagnosis despite initial suspicion when non-specific symptoms are accompanied by apparently normal radiological investigations.

Case Description
A 59-year old woman presented with malaise and weight loss. Accompanying symptoms included throat discomfort and night sweats. The patient recalled flu-like symptoms in the preceding week. She reported hypertension, Raynaud’s, depression and a chest pain admission 2 years prior. Despite having widespread electrocardiographic T-wave inversions and high troponins coronary angiogram was normal. Examination showed only a goiter. Initial investigations revealed a normocytic anemia with hemoglobin of 7.7g/dL. Renal and liver biochemistry was normal. Inflammatory markers were raised with an ESR 120 and CRP 216. A vasculitis screen including ANA, RF and ANCA were negative. CT imaging of thorax, abdomen and pelvis, along with GI endoscopy were inconclusive. Echo showed reduced right ventricular function. A bone marrow biopsy demonstrated reactive features. Finally, the patient had a diagnostic PET-CT which showed diffuse FDG uptake (SUVmax 3.9) in the wall of all large blood vessels from the iliacs, aorta to the proximal subclavian and carotid vessels confirming large vessel vasculitis. The patient responded to glucocorticoids and was switched to tocilizumab for maintenance therapy.

Discussion
FDG-PET CT is increasingly diagnosing large vessel vasculitis with good specificity and sensitivity. Most diagnostic pathways for atypical chest pain ends with a normal coronary angiogram. Our case strengthens a role for functional imaging in the context of constitutional symptoms and non-diagnostic investigations. [1]

1) http://dx.doi.org/10.1136/annrheumdis-2017-212649
Introduction: RS3PE (remitting seronegative symmetrical synovitis with pitting edema) syndrome, is characterized by symmetric polyarthritis with synovitis in fingers with pitting edema in the dorsum of the hands and/or feet.

Case 1 description: An 84-year-old man, with smoking, dyslipidemia and prostatism, was attended because pain and tumefaction in hands and feet, anorexia and weight loss. Physical examination: pain in hands, metacarpophalangeal joints and feet, with pitting edema. Temporal arteries: normal. Blood analysis: hemoglobin 12.6 mg/dl; ESS 83 mm/h; total proteins 5.4 mg/dl; CRP 9.8 mg/dl; PSA, ANA and rheumatoid factor normal. Abdominal and thoracic RMI: hepatic simple cyst and a 5 cm aortic aneurism. Osseous gammagraphy: normal. RS3PE was suggested and treatment with deflazacort was initiated (30 mg/day, initially). Clinical improvement was observed in three days. Two years later treatment with prednisone (5 mg/day) continues, and no neoplasms have appeared.

Case 2 description: A 81-year-old man, with smoking, hypertension and non-metastatic prostate cancer diagnosed five years before, treated with androgen blockade, refered pain and tumefaction in hands and feet. Physical examination: pain in hands and feet, with pitting edema. Temporal arteries: normal. Blood analysis: hemoglobin 11.4 mg/dl; ESS 102 mm/h; CRP 20.4 mg/dl; PSA 55; ANA and rheumatoid factor were normal. Osseous gammagraphy: normal. The patient was treated with deflazacort 30 mg/day (descending doses). Thirteen months later, improvement is kept and the patient continues with prednisone 5 mg/day.

Conclusions: we must remember that, specially in older patients with pain and edema in hands and/or feet, this syndrome should be consider.
Sarcopenia, frailty and osteoporosis in Spanish adult men and women: the Camargo cohort study.

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Background:
Sarcopenia and frailty are disorders associated with an increased mortality and morbidity. Our aim was to estimate the prevalence of these conditions in community-dwelling postmenopausal women and adult men of our area (Cantabria, Spain).

Material and methods
We studied 807 patients (198 men and 609 women) aged over 50 years included in a population-based study (the Camargo cohort). Sarcopenia was defined using DXA (Hologic DQR 2000) analysis for muscle mass assessment according to EWGSOP. We also examined frailty by Fried’s definition.

Results
The mean (SD) age of participants was 717 years. The prevalence of severe sarcopenia reached 0.5% in men and 1.6% in women, whereas sarcopenia was observed in 15% of men and 7.5% of women (p< 0.002). Presarcopenia was observed in 19% of men but only in 2.3% of women (p< 0.001). Most of the subjects (82%) had no sarcopenia 82%. This figure was higher in women (65% men vs. 88% women; p< 0.0001). The prevalence of frailty was lower in men than in women (6% vs. 14%; p=0.004), but pre-frailty was similar in both sexes (79% and 75% woman).

Conclusions:
Most of the subjects studied do not present sarcopenia or frailty. The prevalence of presarcopenia was also low. However, most of the participants fulfilled pre-frailty criteria. There were differences between both sexes in the prevalence of sarcopenia, presarcopenia, no sarcopenia, and frailty.

Supported by a grant from the Instituto de Salud Carlos III (PI15/00521), that included FEDER funds from the EU.
INTRODUCTION:
Scleroderma is an autoimmune disease that involves a deep interaction between immuno-inflammatory, vascular and fibrotic processes. Being this a disease of the repair of connective tissue leads to complications in multiple organs and systems. Its etiology and triggering events are unknown and there are considerable variations in its early manifestations and in the progression of the disease.

CLINICAL CASE:
A 47-year-old man, smoker, with no relevant personal history, appealed to the Emergency Room for dyspnea, malaise, fatigue to small efforts and polyarthralgias with 8 months of evolution. He presented sudden dyspnea with the need for supplemental oxygen and in the arterial blood analysis there was hypoxemia and hypocapnia, increased D-dimers (1947 ng/mL) and an electrocardiogram with S1Q3T3 pattern.

On objective examination, the patient was skinny and had a scleroderma facies with limiting mouth opening, Raynaud's phenomenon, sclerodactyly, and digital ulcers. He had hardened skin and with depigmented areas in the body and polyarthrits with inflammatory signs more exacerbated in the right hand and knee. In Angio CT, TEP was not confirmed, but revealed adenomegaly, cardiomegaly, esophageal and pulmonary alterations. In the very suggestive clinic of Pulmonary Thromboembolism, we used Ventilator-Perfusion Scintigraphy that demonstrated pulmonary thromboembolism with different types of evolution. Due to the clinical changes characteristic of Scleroderma, the immunity demonstrated by Ac. ANA, Ac. Anti-SSA, Ac. Anti-SSB and Ac. anti-SLC70 positive, without other relief changes.

DISCUSSION:
We report a case of chronic pulmonary thromboembolism associated with severe pulmonary hypertension secondary to scleroderma.
Scleroderma complicated with severe respiratory failure during pregnancy

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Introduction
Systemic sclerosis (SSc) is a connective tissue disease that usually affects women. It was thought that there was a prohibitive risk of fatal complications in the pregnancies. The obstetric risk will depend on the subtype and clinical stage of the disease, and severity of the internal organ involvement during the pregnancy. We report the case of a patient with a history of adrenal insufficiency and systemic sclerosis, who presented at 29 weeks with chronic restrictive respiratory failure and severe thrombocytopenia.

Case report
A 39 year-old-woman, with a history of adrenal insufficiency, developed 5 years ago a thickened skin affecting hands, telangiectasia and Raynaud’s phenomenon. She was diagnosed as SSc and treated with colchicine, but she has stopped treatment for 2 years and has been lost view. She presented at 29 SA with progressive dyspnea (NYHA IV) and hemoptysis. On clinical examination, she had a polypnea, bilateral cracking rails with 82% oxygen saturation requiring high-concentration masking. Chest X-ray shows cardiomegaly with bilateral basal opacities in favor of pulmonary fibrosis. Among other things, in biology, the patient had severe thrombocytopenia at 15000 and anemia. Obstetrically, pregnancy was progressive with intra uterine growth retardation and oligoamnios without fetal malformations. The patient received 3 cures of immunoglobulins and she was put under cortef 1cp*2/day. The evolution was favorable with the ascension of the platelet figures to 100000/mm3. In front of the respiratory insufficiency, the general anesthesia was against indicated and a elective caesarean section was performed under spinal anesthesia at 34 th week of pregnancy.

Conclusion
The Systemic sclerosis has long been considered a formal counter-indication to procreation. Currently, concepts are changing: pregnancy during SS is now possible, in the absence of serious visceral impairment, but at risk. Pregnancy management should be multidisciplinary.
Secondary amyloidosis and Sjögren's syndrome - an uncommon association.

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Introduction: Secondary amyloidosis (SAA) is a complication of chronic inflammatory and infectious diseases but the association with Sjögren’s syndrome (SS) is rare. There are only few case reports in the literature of this association.

Case description: the authors describe a 70-year-old women with SS diagnosed 20 years before with usual interstitial pneumonia and chronic interstitial nephritis. She was admitted to the hospital with pneumonia and an exacerbation of her chronic renal dysfunction. During the first days at the hospital she experienced respiratory and renal deterioration and developed a hypercloremic metabolic acidosis. Blood analysis identified elevated inflammatory parameters (PCR 73 mg/dl and ESR 140 mm/h) and hyperkalemia and in urine examination we discovered subnephrotic proteinuria and a reduced transtubular potassium gradient consistent with type 4 renal tubular acidosis. For better clarification of the etiology we ruled out the lymphoma with an extensive physical examination and thoraco-abdomino-pelvien scanner. The possibility of cryoglobulinemia was excluded with normal complement and negativity for cryoglobulins. Renal ultrasound showed reduced sized kidneys, not suitable for biopsy. Therefore, we performed an abdominal fat and rectal biopsy that identified AA amyloid and confirmed the diagnosis of secondary amyloidosis. Corticotherapy (0.5mg/Kg/day) was initiated with renal function improvement. As corticoid sparing agent rituximab was initiated.

Discussion: amyloidosis secondary to Sjögren’s syndrome is very rare and the case reports described at literature refer to nodular amyloidosis, localized to the dermis or lungs. There is only one report of secondary amyloidosis nephrotic syndrome related to Sjögren’s syndrome.
Severe toxidermia complicating systemic corticosteroid therapy during a primary Sjögren's syndrome.

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Introduction: Corticosteroid-induced toxidermies remain exceptional and represent a real diagnostic challenge since these drugs are major anti-allergic agents. We report an observation of severe toxidermia secondary to systemic corticosteroids.

Case description: 24-year-old woman diagnosed with primary Sjögren's syndrome complicated by severe glomerular nephropathy prompting full systemic corticosteroid therapy (1 mg/kg/day). The evolution was marked by the appearance after one week of diffuse and pruriginous maculopapular rash evolving rapidly to exfoliation of the whole body in thick layers giving the appearance of acquired ichthyosis. Para-clinical investigations, specialized dermatological exam and pharmacovigilance survey concluded to a prednisone (cortancyl®)-induced toxidermia. Therapeutic management was to make a rapid decrease until the discontinuation of prednisone, symptomatic cutaneous treatment and switching to prednisolone (solupred®). The evolution was marked by the clear improvement of the cutaneous lesions.

Discussion: Allergic accidents due to corticosteroids are rare and unusual given the anti-inflammatory, anti-lymphocytic and immunosuppressive actions of these drugs, making them the treatment of choice for allergies. Our observation is characterized by an underlying dys-immune disorder that may play a role in triggering this allergic reaction.
Severity of anxiety and depression depending on the characteristics of the pain syndrome in women with rheumatoid arthritis (RA)

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The purpose of the study is valuation severity of anxiety and depression depending of the characteristics of the pain syndrome among women with rheumatoid arthritis (RA).

Subjects and methods. The study included 76 women with RA (age 54.1 ± 11.1 years, duration of RA - 8 [4; 14] years, DAS28 - 5.12 [4.38; 5.77]). Valuation of the severity of anxiety and depression was carried with using HADS. The severity of pain was determined by VAS. Detection of the neuropathic component of pain (NCP) was carried with using the DN4 questionnaire. Decompensated diabetes mellitus, uncontrolled arterial hypertension, exacerbation of chronic diseases, severe radiculopathy, aseptic necrosis of large joints there are exclusion criteria of study. Statistical processing was performed using STATISTICA 10.0.

Results. Clinically expressed anxiety was detected in 15 (20%) patients, depression - in 11 (15%); subclinically expressed anxiety - in 18 (24%), depression - in 18 (24%) patients.

Severe pain in the VAS was noted by 29 (38%) patients, moderate - 35 (46%), low - in 12 (16%) patients.

NCP was identified in 38 patients.

The relationship between NCP and the severity of anxiety (r = 0.3, p <0.05), depression (r = 0.36, p <0.05) were observed. The level of anxiety in women with NCP (8.5 [6; 12]) was significantly higher than in patients without NCP (6.5 [4; 9]) (p = 0.01). The severity of depression in women with NCP was 7.55 [5; 10], in patients without NCP - 5.55 [3; 7] (p = 0.005).

Conclusions. Clinically expressed anxiety and depression affects observed in every fifth patient with RA, subclinical anxiety and depression revealed in 25% of patients with RA. In the majority of patients (84%) the pain was moderate or severe, half of the patients had signs of neuropathic pain.

The relationship between the severity of anxiety and depression with pain severity and the presence of neuropathic pain are revealed.
Shortness of Breath: An Insidious Presentation of Cardiac Amyloidosis

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Introduction: Dyspnea is a common initial complaint in the generalist’s office. We present a case of cardiac amyloidosis presenting as isolated dyspnea in an elderly man.

Case Description: An 84-year-old man presented to cardiology clinic for one year of progressive dyspnea on exertion without other associated symptoms. Exam revealed blood pressure 161/78, heart rate 75 bpm at rest, and 96% oxygen saturation on room air. After walking 10 feet on flat ground, he became tachycardia to 102 bpm and maintained oxygen saturation at 93%. A chest x-ray demonstrated AV pacemaker and mild cardiomegaly. ECG was consistent with dual chamber pacemaker. Transthoracic echocardiogram showed left ventricular ejection fraction of 60 % and thickened left ventricular walls. Left and right coronary angiogram revealed patent saphenous vein grafts.

Technetium Pyrophosphate (PYP) scan was obtained to evaluate for possible transthyretin (TTR) amyloidosis given patient’s advanced age and thickened left ventricular myocardium. PYP scan showed increased uptake in the left ventricular myocardium, which is consistent with a diagnosis of TTR cardiac amyloidosis. Furosemide was started for management of volume status. He is currently exploring long term treatment options, including doxycycline /tauroursodeoxycholic acid (TUDCA).

Discussion: Wild type transthyretin cardiac amyloidosis is responsible for sporadic cardiac amyloidosis in the elderly. Also termed “senile amyloidosis,” it affects 25-36% of patients older than 80 years. Presenting symptoms include heart failure, angina, and arrhythmias. While amyloid deposition on histopathology is the gold standard, PYP scan has been shown to have 97% sensitivity and 100% specificity for TTR amyloidosis in some studies. Treatment is currently focused on management of heart failure symptoms, but there are investigational drugs that target TTR production and degradation under study.
Syndrome of CREST with progression to systemic sclerosis with pulmonary involvement.
Treatment with cyclophosphamide.

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Introduction
Localized sclerosis is a rare autoimmune disorder that requires monitoring especially in young patients. This disease can progress and cause compromises of vital organs. The response to the immunosuppressive treatment is a fundamental pillar and at the same time it is very different according to the system and type of patient.

Description of the case

The patient presents progressive dyspnea with cough without expectoration that is treated ambulatory with corticosteroids and antibiotics. There is no improvement. It is entered to perform tests and iv treatment. CT of the thorax was performed in which interstitial involvement with alveolitis and fibrosis was observed, probably in relation to systemic involvement of his systemic sclerosis. It is treated with contriciones at high doses without presenting memory with a significant pulmonary restriction. The patient had previously needed to enter for multiple respiratory infections.

It was decided to start immunosuppressive treatment with cyclophosphamide. The patient is treated with boluses every 4 weeks for 6 months. Posterior control CT is performed with excellent improvement. Revision consultations are made with persistence of memory after years of treatment.

Conclusion
It is important to consider immunosuppressive treatment in autoimmune disorders. The response to treatment can be spectacular, achieving the remission of symptoms in some cases.
**Systemic lupus erythematosus manifestation as a part of type 3 autoimmune polyglandular syndrome**

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**Introduction.** Type 3 autoimmune polyglandular syndrome (APS-3) is defined by the presence of an autoimmune thyroid disease and another autoimmune illness, excluding Addison’s disease. The epidemiology of APS-3 is unknown. We present a case of systemic lupus erythematosus (SLE) manifestation as a part of APS-3.

**Case report.** A 29-year-old woman with a history of T1DM and autoimmune hypothyroidism receiving insulin and levothyroxine was brought to the therapeutic department with fever, hand joint pain, progressive fatigue, Raynaud’s phenomenon, alopecia. Prominent livedo reticularis was detected on physical examination. Laboratory findings showed autoimmune hemolytic anemia (Hb 93 g/L), leukopenia (2.9x10⁹/L), lymphopenia(0.8x10⁹/L), increased ESR(72 mm/h), mild cytolysis (ALT 70 E/L, AST 83 E/l), elevated creatinine (109μmol/l), decreased eGFRCKD EPI — 59 ml/min/1.73m²; 24-h proteinuria was 558 mg. Low levels of C3 and C4 components of complement and high titters of antinuclear (1: 5120), anti-dsDNA (>240 U/ml) and all antiphospholipid antibodies were revealed. Abdominal MRI showed hepatomegaly and focal nodular hyperplasia of the liver. The patient was diagnosed SLE with high activity (SELENA-SLEDAI 16 points) and immunological signs of secondary antiphospholipid (AP) syndrome. Standard combination therapy including 40 mg of prednisolone was administered.

**Discussion.** Combination of 3 autoimmune diseases fulfilled the criteria of 3D type APS and raised several diagnostic (origin of liver and kidney damage) and therapeutic issues. Persistent proteinuria was regarded as a result of diabetic nephropathy, lupus nephritis and AP syndrome and liver lesions—as a sign of SLE and AP syndrome. Administration of steroids has led to deterioration of diabetes that required increased doses of insulin (30->68 U/day) without achievement of the control. The case shows a rare combination of 3 autoimmune diseases, where each influenced the course and the treatment of another.
Systemic Lupus Erythematos /Polymyositis Overlap Syndrome: a rare condition

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Introduction: Systemic lupus erythematosus (SLE) is a multisystemic chronic autoimmune disease. Muscle and lung involvement is common. However, myositis is rare and Overlap Syndrome (OS) should be considered in this situation. Acute pneumonitis is a rare pulmonary complication, but highly fatal.

Case description: An African-American 52-year-old woman, with SLE for 14 years, controlled with hydroxychloroquine, presented with a month history of fever, dyspnea, dry cough, myo-arthritis and night sweating. On examination, she had tachypnea, crackles and wheezing on pulmonary auscultation, peripheral edema and proximal muscle weakness. Arterial blood gas test revealed hypoxemia and the laboratory findings included elevated white blood count, serum muscle enzymes (creatine kinase and aldolase) and C-reactive Protein. Chest radiography showed a bilateral lower lung infiltrate. Antiviral coverage and empiric antibiotic was started and escalated to large spectrum. Pneumococcal and Legionella Urinary Antigens, hemocultures and atypical microorganism serologies were negative. After 10-days without clinical resolution, patient underwent a bronchofibroscopy that showed inflammatory signals and an electromyography suggestive of myositis. It was decided to suspend antibiotics and start Prednisone and Cyclophosphamide. After 24 hours, fever disappeared and patient presented a clinical, laboratory and radiologic improvement.

The Immunological panel revealed positivity to anti-JO1, anti-SSA and anti-PM-Scl-75, but no hypocomplementemia. Muscle biopsy was compatible with Dermatomyositis/Polymyositis. We assume Systemic Lupus Erythematos/Polyomyositis Overlap Syndrome with Acute Pneumonitis associated.

Discussion: The OS presents as two or more connective tissue disorders in the same patient. Few SLE patients have Dermatomyositis/Polyomyositis OS. Immunological data is important to differential diagnosis. Treatment is challenging and includes glucocorticoids and immunosuppressive agents.
Takayasu Arteritis Presenting as Multiple Vessel Embolic Stroke

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Introduction: Takayasu arteritis (TA) is a rare form of granulomatous vasculitis of large and medium sized arteries most commonly affecting women in their second and third decade. In males usually, TA starts later in life and is associated with a more extended artery involvement and ascending aorta aneurisms.

Case description: We report a case of a 23-year old healthy African male who presented with multiple vessel embolic ischemic strokes. Carotid ultrasound and Angio-TC showed concentric thickening of aorta and its main branches walls, with an ascending aorta aneurism with intramural thrombus, and left subclavian artery and right renal artery stenosis. Cardiac ultrasound revealed an aortic insufficiency. Blood tests were only remarkable for increased erythrocyte sedimentation rate. IGRA (T-Spot) test was positive, suggesting latent tuberculosis (TB). Although, large vessel vasculitis may be secondary to TB, TA was more likely based on angiographic pattern observed.

Discussion: Our case suggests that TA should be considered in young patients with multiple vessel ischemic strokes. Additionally, this case highlights the importance of angiographic pattern in distinguishing large vessel vasculitis from tuberculosis and TA origins.
Objectives: This study was conducted to evaluate the effect of aromatherapy massage on knee pain and functional status in subjects with osteoarthritis. Methods: The study was designed as a non-randomized interventional study. The study was carried out on patients who referred to the outpatient clinics of the Department of Orthopedics, Physiotherapy and Rehabilitation at Bozok University Research and Application Hospital, and were diagnosed with osteoarthritis. A total number of 95 patients were included in the study, and of those, 33 were allocated to aromatherapy massage group, 30 were allocated to conventional massage group, and 32 were allocated to the control group. The study data were collected using the Patient Identification Form, visual analogue scale, the Western Ontario and McMaster University Osteoarthritis Index. Repeated measures analysis of variance test was used to analyze the outcomes in the aromatherapy, conventional massage and control groups, according to the weeks of follow-up. Bonferroni test was used for further analysis.

Results: Baseline mean visual analogue scale score and the Western Ontario and McMaster University Osteoarthritis Index were not significantly different between the groups (p > .05). Visual analogue scale (rest-activity) scores and the scores in the Western Ontario and McMaster University Osteoarthritis Index in the aromatherapy massage group were lower, and the difference compared to the control group was statistically significant (p < .001).

Conclusion: Aromatherapy massage performed in patients with osteoarthritis reduced knee pain scores, decreased morning stiffness, and improved physical functioning status. Thus, as long as specific training is provided for aromatherapy massage, aromatherapy can be recommended for routine use in physical therapy units, hospitals and homes.
The value of follow-up in autoimmune disease

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Introduction: Axial spondyloarthritis is a potentially disabling inflammatory arthritis of the spine, usually presenting as chronic back pain, but it may be related with numerous nonarticular features. Patients frequently carry the gene for human leukocyte antigen HLA-B27, and those with active inflammatory disease often have evidence of an elevated acute phase response.

Case description: We report the case of a 44-year-old woman sent to a consultation after an episode of autoimmune hemolytic anemia with warm antibodies associated with secondary organizational pneumonia (secondary OP). ANA, ANCA and anti-ds-DNA were negative, positive HLA-B27 antigen, positive Coombs test, normal complement system, negative cryoglobulins, normal immunoglobulins and electrophoresis. The patient started corticotherapy presenting good clinical and analytical response with resolution of anemia and secondary OP. Posteriorly with inflammatory low back pain of insidious onset for more than three months. Positive sacroiliac joint test. Performed MRI showed bilateral sacroiliitis. Therefore, the diagnosis of ankylosing spondylitis was made. The patient initiated NSAID with partial improvement, with recurrence of pain after switch by 3 different NSAIDs so there was performed an infiltration of the left sacroiliac joint with clear improvement.

Discussion: The inflammatory feature of the pain as well the rigidity and limitation of joint mobility, associated with typical analytical and radiological findings, including sacroiliitis, allowed to establish the diagnosis. The available scales allow us to assess the degree of disease activity and to consider the best therapeutic option. Early diagnosis and treatment improve the prognosis of patients by increasing their social and work autonomy. Several diseases share similar genetic backgrounds, as reflected by study of loci within the major histocompatibility complex and some genetic defects seem to predispose patients to more than one autoimmune disease.
Thrombotic Thrombocytopenic Purpura and Antiphospholipid Syndrome - The Diagnostic Duality

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Introduction: Thrombotic thrombocytopenic purpura (TTP) and antiphospholipid syndrome (APS), particularly in its catastrophic form, are possible etiologies for multiple thromboembolic phenomena.

Case-description: A 39-year-old woman with a history of polycystic ovaries was observed for hematemesis. The patient had fever, and during observation she developed expression aphasia, right central facial paresis and paresis of the homolateral half-body. Blood test showed an hemolytic anemia (Hb 5.7 g / dL), with schizocytes, severe thrombocytopenia, an increased aPTT and serum creatinine of 1.4 mg / dL. Brain CT angiography showed bilateral subacute phase hypodensities, and subocclusive endoluminal thrombi on the left M2 / M3, as well as chronic ischemic lesions. With the suspicion of TTP, anti-ADAMTS 13 antibody was requested which was positive and ADAMTS 13 activity was 0.UI / ml. Acetylsalicylic acid, corticotherapy were started and plasmapheresis was performed with clinical and analytical improvement. Days later there was worsening of previous neurological deficits, with brain-MRI evidencing new ischemic infarctions. Since antiphospholipid antibodies were positive, the patient was anticoagulated with the assumption of concomitant APS. Neurological deficits improved, and no new events were documented. The patient maintained plasmapheresis (total of 11 sessions) due to instability of platelets count, LDH and presence of schizocytes. Posteriorly, antiphospholipid immunology was repeated and remained positive, confirming the aforementioned diagnosis.

Conclusion: TTP is a primary thrombotic microangiopathy caused by the severe deficiency of ADAMTS13 and APS is an autoimmune acquired thrombophilia. The differential diagnosis between these two entities is challenging and a coexistence of both is rare, but this case illustrates this possibility.
Tocilizumab in recurrent acute anterior uveitis in a patient with rheumatoid arthritis

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Introduction: classically in our hospital we treat recurrent acute anterior uveitis in patient with rheumatoid arthritis with adalimumab, we present the case of a patient that does not respond to treatment in which we deal with tocilizumab.

Case description: 53 year-old woman with rheumatoid arthritis since 1984. She started with arthritis in both hands and she did not tolerate methotrexate nor leflunomide by hypertransaminasemia. 10 years after the diagnosis she presented her first acute anterior uveitis and she started treatment with etanercept 50/week and cyclosporin 100 mg/dayly. But she continues with 8/10 uvietis buds/year. We changed the treatment to prednisona + adalimumab 40/14 days and in the next 4 years, she was without symptoms. Then two years ago she started again with recurrent acute anterior uveitis and symptomatic arthritis with VSG 74/94, RCP 5. We decided to change the treatment to tocilizumab/week. Since then the patient is completely asintomatic. VSG 6/11. PCR 0.02.

DISCUSSION: in this patient adalimumab did not control the symptoms and tocilizumab does. If we reviewed the literature there is not many cases with this pathology treated with this drug and in our experience is so effective in this cases.
Rheumatology + musculoskeletal disorders
A-1310

Unusual case of Rituximab-induced Cardiomyopathy

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Introduction: Rituximab is an anti-CD20 monoclonal antibody initially used to treat non-Hodgkin’s lymphoma with recent widespread use for autoimmune disease, such as granulomatosis with polyangiitis. Known side-effects of the medication includes infusion reactions such as those that are cardiac related, being acute angina or arrhythmia. We are presenting an atypical case of delayed reaction in form of non-ischemic cardiomyopathy secondary to rituximab infusion.

Case:
Patient is a 47 year old man with a history of end stage renal disease secondary to granulomatosis with polyangiitis presenting with complaints of worsening shortness of breath and bilateral lower leg swelling. He completed a course of rituximab infusion 1 week prior to hospitalization. On examination, chest auscultation revealed bibasilar crackles followed by chest x ray showing cardiomegaly, pulmonary congestion, as well as bilateral pleural effusion. Subsequently, echocardiogram showed reduced ejection fraction (EF) of 30-35%, global hypokinesis, and moderately dilated left ventricle. Echocardiogram 5 months ago showed normal left ventricular systolic function with EF of 55-60%. Cardiac catheterization findings showed patent coronary arteries. All other workup for secondary causes of non-ischemic cardiomyopathy were found negative (i.e. endocrine, hematologic, infectious, etc.).

Discussion:
There are four reported cases of non-ischemic cardiomyopathy after rituximab infusion for treating non-Hodgkin’s lymphoma. This is the first case reported for rituximab-induced cardiomyopathy in a receiving the infusion for GPA.

This case highlights the significance of rituximab and its potential fatal side effects. Majority of known side effects from the medication are immediate, but more awareness is needed as it can cause delayed reaction such as this patient who presented 1 week later. Precautions should be noted and care taken during administration especially in patients who are at higher risk of cardiomyopathy.
Unusual cause of low back pain in systemic lupus erythematosus

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Introduction: The inferior vena cava thrombosis (IVCT) is rare even in thrombotic high-risk conditions as systemic lupus erythematosus (SLE). We report an original case of IVCT revealed by acute and analgesic treatment-resistant low back pain in a young woman with SLE.

Case description: 20-years-old patient having SLE with type IV lupus nephritis diagnosed sine one month, reported during hospitalization for the second cyclophosphamide pulses a low back pain of sudden onset and evolving continuously for several days. Physical exam, basic biology investigations and conventional radiological studies were without abnormalities. The lack of improvement with analgesic treatment required the realization of a lumbar CT-scan objectifying partial thrombosis of the inferior vena cava. The investigation looking for a primitive thrombophilia was negative.

Under effective anticoagulation with heparin relayed by anti-vitamin K in addition to systemic corticosteroids and immunosuppressive therapy, the outcome was favorable with disappearance of low back pain after a month, disappearance of the inferior vena cava thrombus at CT-scan control after three months, and no thrombotic recurrence for ten years now.

Discussion: IVCT must remain to consider as a possible diagnosis for any unexplained or not improved acute back pain; particularly in young and high thrombotic risk people as those with SLE.
Multiple myeloma is a pathology with a broad spectrum of clinical presentation, ranging from anemia, bone pain, pathological fracture, renal failure, susceptibility to infections and hypercalcemia.

Clinical case
Patient of female gender, aged 61 years old, went to the emergency department with a subacute installation of asthenia, easy tiredness, low back pain and difficulty in walking. She had a medical history of osteoporosis and a vertebral fracture in D12, L1 and L3 after a car accident about 3 months before. Usually medicated with cholecalciferol, iron, various non-steroidal anti-inflammatory drugs and vitamin complexes.

Laboratory tests revealed a microcytic and hypochromic anemia with hemoglobin of 8 g / dl, urea of 9.4 mmol / L, creatinine 1.09 mg / dl.

A tomography of the dorsal and lumbar spine was performed, showing collapse of the vertebral body, pedicle and transverse process of L3 with loss of bone density and expansion with soft tissue density that compresses the central canal.

During hospitalization, an etiological study was performed and revealed: sedimentation velocity 119 mm; alkaline phosphatase 162 U / L; negative tumor markers; albumin 23 g / L; Protein electrophoresis with gamma fraction 73 g / L and immunoelectrophoresis with presence of monoclonal band in IgG and of two bands in the Kappa light chains. B2-microglobulin 11.90 mg / L; IgG 6744 mg / dL; IgA 64 mg / dL; IgM 15 mg / dL; Kappa light chains 9100 mg / dl; Kappa / lambda ratio 87.5.

The patient had a rapid worsening of renal function, and it was transferred to the Hematology care in a reference hospital, with the diagnosis of Multiple Myeloma.

Discussion
This case evidences the importance of the etiological study of the patient with vertebral fracture, because the symptoms of Multiple Myeloma are non-specific. In this case although there is a diagnosis of osteoporosis and a traumatic lesion, the patient’s complaints were previous to the accident.

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INTRODUCTION: fractures without any history of significant trauma are not uncommon, but a red flag should pop up and further evaluation performed, excluding secondary causes.

CASE DESCRIPTION: a 71-year-old caucasian woman, with past medical history of type 2 diabetes mellitus, hypertension and hypothyroidism after total thyroidectomy 40 years ago, presented to our emergency department with a 3-day history of aggravated lumbar pain and new-onset strong right brachial pain.

Anamnesis revealed further details: 2 months earlier the patient underwent total left hip replacement surgery after a non-traumatic hip fracture. Also, the patient had several constitutional symptoms: asthenia, anorexia and significant weight loss in the last 4 months – 15 Kg, approximately 20% of total body weight. Pain control and diagnostic workup were started and the patient admitted to our Internal Medicine department.

Physical examination raised the hypothesis of humeral fracture (promptly stabilized), confirmed by radiography – a mid humeral diaphyseal fracture was identified, suggestive of a pathological nature. Laboratory analysis revealed normocytic, normochromic anaemia and hyperproteinemia.

Thoraco-abdomino-pelvic CT scan showed multiple rib fractures, lumbar fractures of L5 and S1 vertebrae and a left sacral wing fracture. Serum protein electrophoresis identified a beta-globulin monoclonal spike. Serum IgA and Kappa chains were elevated. Medular biopsy identified a plasmocytic population CD38/CD138 positive and a final diagnostic of Multiple Myeloma was made. Treatment with dexamethasone and intravenous bisphosphonate followed by Bortezomib, Melphalan, and Prednisone was started, along with radiotherapy for pain control.

CONCLUSION: non-traumatic fractures in patient without significant risk factors, regardless of sex, demand for further evaluation besides initial fracture stabilization. In this particular case, important morbidity could have been avoided with an earlier diagnostic.
INTRODUCTION
We describe a case report about a 66-year-old woman with history of high uric acid level, a primary mucinous adenocarcinoma of the lung and a heart transplant 3 years before treated with prednisone and tacrolimus.

CASE DESCRIPTION
The patient went to the Hospital Emergency Room because of a low-grade fever and signs of asymmetrical arthritis of distal joints that was thought to be related to gouty arthritis, so she was discharged with anti-inflammatory drugs.

Two months later, she came back with an increased number of distal joints affected, fever and diarrhoea. Examination shows very painful oral and genital ulcers, pustules in the neckline and scalp and intertrigo candidiasis.

Differential diagnosis include crystalline arthritis, neutrophilic dermatosis, infectious disease and autoimmune disease.

Infectious disease was descarted with the negative results of serology and microbiologocal check.

Colonoscopy shows inflammatory polyps and multiple ulcers along the entire colon.
A pathergy skin test was positive.
And finally, the positivity of the immunological study with HLA-B51 was decisive for the diagnosis of Behcet’s disease.

DISCUSSION
Very often diagnosis of autoimmune diseases can be very complex in the context of patients with immunodeficiency, reason why opportunistic infectious pathology must be dismissed.
A case of synchronous malignant neoplasias

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INTRODUCTION: The incidence of malignant neoplasias has increased in recent years, with tumors of colon and prostate being among the most common in males. Although the majority of these occur in isolation, it is estimated that 1.2 to 3.5% of patients with a malignant neoplasia will develop a new synchronous lesion in another organ during the diagnostic or treatment period.

CASE DESCRIPTION: Male, 75 years, with past medical history of high blood pressure, type 2 diabetes, prostatic benign hyperplasia, psoriasis and cigarette smoking (50 pack-year). Was admitted to A&E due to asthenia, anorexia, fatigue, unintentional weight loss of 5kg, dark stools and straining to urinate; no previous cancer screening. Blood testing showed microcytic/hypochromic anemia (Hb 8.4g/dL); PSA > 100; beta-2 microglobulin 3.15; CA19-9, CEA, AFP and squamous cell carcinoma antigen within normal range. Chest x-ray showed several nodular formations (cannonball metastases-like). CT scan of thorax, abdomen and pelvis was performed – it showed 1) pulmonary metastases and multiple sclerotic lesions in the skeleton; 2) probable hepatic metastases; 3) tumoral lesion in colonic hepatic flexure and 4) prostatic neoplasia with bladder invasion. Colonoscopy revealed a stenosing carcinoma of colon. Management consisted of palliative hormonal therapy (prostatic neoplasia) and palliative surgery (colonic tumor - right hemicolectomy).

DISCUSSION: this case report reflects on the fact that an increase in life expectancy may amplify the risk of neoplasias (including synchronous ones); it alerts also to the importance of a good clinical history and to the unspecificity of tumor markers; finally it reinforces the role of local screening programs.
A case report of advanced Gastric Cancer after a potentially curative resection

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Gastric neoplasms are the second cause of cancer-related deaths in the world, most of them being adenocarcinomas. Surgery is the only curative option in tumors that don’t meet the criteria for endoscopic treatment. Prognosis depends on the degree of visceral wall penetration, ganglionar involvement and neurovascular invasion. 5-year survival rate is 25-30% in patients after complete resection.

We present a case of an 89-year-old man with previous history of hypertension, obesity, paroxysmal AF (under vitamin K antagonists), stage 3 CKD and gastric adenocarcinoma of the great curvature, submitted to partial gastrectomy 2 years before, with no signs of disease progression. He was admitted to the emergency department after an isolated episode of hematochezia. The patient also mentioned fatigue and worsening of his clinical state. He was recently treated with amoxicillin-clavulanate for a urinary tract infection. Laboratorial exams revealed a low haemoglobin concentration and an INR value above the target level.

The patient was admitted to the Internal Medicine department, suspended vitamin K antagonists and performed a red cell transfusion. He started empiric antibiotic therapy with ceftriaxone, but had to escalate to meropenem due to sepsis, most likely because of the urinary tract infection. During hospitalization, the patient developed anuria and uremic encephalopathy, for which dialysis was required. Abdominal ultrasound and CT scan revealed bilateral hydronephrosis due to extensive latero-aortic and great gastric curvature adenopathies, probably secondary to a recurrence of the previous gastric neoplasia.

The patient performed unilateral percutaneous nephrostomy without any improvement. With no other treatment options, he underwent palliative care measures. He died 39 days after admission to the hospital.

This case highlights the high mortality associated with gastric neoplasms, even in the cases of resectable tumors.
A dramatic case of tumor lysis syndrome

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Introduction:
The tumor lysis syndrome is an oncological emergency due to a massive destruction of tumor cells, leading to hyperuricemia, hyperkalemia, hyperphosphatemia and hypocalcemia. This can cause kidney failure, arrhythmias, seizures and eventually multiorgan failure and death. It is more frequent with hematologic cancers and the cornerstone for its management is prevention.

Case description:
The authors present a 78-year-old female that went to the emergency department because of a one-week-long dry cough, progressive dyspnea and wheezing. She also complained of asthenia, anorexia, loss of 12kg and hyperhidrosis without fever for 2 months. There were multiple palpable adenopathy on the physical examination. The blood analysis revealed hyperlactacidemia, elevated lactate dehydrogenase, normal renal function, hyperuricemia, normokalemia, normocalcemia and normophosphatemia. A thoracic CT scan showed multiple cervical, axillary and mediastinal lymphadenopathy. The patient was admitted to study the etiology of the lymphadenopathies, medicated with IV hydration, sodium bicarbonate and allopurinol. An abdominal CT scan showed generalized lymphadenopathy with some coalescing, forming a nodal mass. She was submitted to a myelogram plus bone marrow biopsy. While awaiting an excisional biopsy of a lymphadenopathy, she became anuric, followed by an acute pulmonary edema and developed hyperphosphatemia, hypocalcemia and hyperkalemia. Emergent dialysis was started due to a tumor lysis syndrome. The patient continued to worsen, with rising hyperuricemia and lactate dehydrogenase, hemodynamic instability and died on the fifth day of admission. Afterwards, the bone marrow immunophenotyping revealed a diffuse large B cell lymphoma.

Discussion:
In this case, the extension of the disease would be sufficient to induce a tumor lysis syndrome spontaneously, however a possible cause for the sudden worsening could be the administration of corticoids.
A patient diagnosed with POEMS syndrome with atypical presentation

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Introduction: POEMS syndrome is a paraneoplastic syndrome due to an underlying plasma cell neoplasm. The major criteria for the syndrome are polyradiculoneuropathy, clonal plasma cell disorder (PCD), sclerotic bone lesions, elevated vascular endothelial growth factor and the presence of Castleman disease. Minor features include organomegaly, endocrinopathy, characteristic skin changes, papilledema, extravascular volume overload and thrombocytosis. Autologous Stem Cell Transplantation (ASCT) might be potential approach of choice in patients that are eligible. In this paper we reported that a patient which was treated with VAD (Vincristine, Doxorubicin, Dexamethasone 40mg) and ASCT and improved; although the bone marrow biopsy did not observe a plasma cell clone.

Case description: 41 years old Caucasian female patient admitted to the hospital with the loss of sense in her hands and skin hyperpigmentation for 6 months. Electromyography (EMG) was reported as demyelination and secondary axonal sensorimotor polyneuropathy. Abdominal USG confirmed the hepatosplenomegaly. In laboratory test revealed that hypothyroidism. Immunfixatiton electrophoresis and protein electrophoresis revealed that there was IgA lambda monoclonal gammopathy and beta gamma monoclonal band respectively. Bone marrow aspiration and biopsy revealed as normal with normal percentaged of plasma cells. She was diagnosed with POEMS syndrome because of she had neuropathy, monoclonal gammopathy, endocrinopathy, organomegaly and skin changes and treated with VAD and performed ASCT with highdose melphalan. ASCT was succesfully performed and the patient recovered quickly. Now she is under follow up and she is very well.

Discussion: POEMS syndrome is a rare paraneoplastic plasmacell disorder. ASCT might be potential approach of choice in patients that are eligible. As an exception to our case; although the patient had normal plasma cells in the bone marrow biopsy, she responded to the ASCT.
A rare case of osteolytic lesions in middle age

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Introduction
Multiple myeloma is characterized by malignant proliferation of plasma cells. The mean age at diagnosis is 70 years old and bone pain is a common manifestation, observed in more than 50%.

Case description
Male, 45 years old presenting with low back pain for 6 months, irradiation to the left lower limb and improvement with analgesia. In addition, night sweats, anorexia and weight loss of 10 pounds. Lumbar resonance imaging with an osteolytic lesion involving the vertebral body of L5 with extension to the epidural and foraminal space of L5-S1 on the left. Admitted to the hospital to study of lytic bone lesion. Analytically normocytic normochromic anemia (9.4g/dL), no renal failure or hypercalcemia. Thoraco-abdomino-pelvic CT confirmed multiple lytic lesions in the dorso-lumbar rachis, no evidence of primary neoplasia. Total PSA and beta-HCG normal. Increased lactic dehydrogenase and Beta 2-microglobulin. Serum protein electrophoresis without monoclonality. Serum and urinary Kappa (K) free light chain very high and evidence of monoclonal band of K light chain in the serum and urine immunofixation. Full bone imaging with diffuse impairment of vertebral bodies, ribs, and skull. Bone marrow with clonal plasma cell infiltration higher than 10%. Therefore, the diagnosis of light chain myeloma was obtained, having been proposed chemotherapy followed by autologous hematopoietic transplantation.

Discussion
Only 20% of myeloma just have light chain secretion, detected through its free portion and serum/urine immunofixation. This has a heterogeneous prognosis influenced by multiple factors including features of the plasma cell clone and patient specificities such as age, comorbidities and functional status.
Acute Kidney Injury revealing a disseminated prostatic cancer

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Introduction: Prostatic adenocarcinoma is the most common neoplasm in men, with a high mortality. The presence of metastasis is a source of major morbidity and usually present at local lymph nodes and bones. Acute kidney injury (AKI) can be the initial presentation. Case description: 52-year-old man, previously healthy, presented at emergency due to reduction in urine output, complaints of urinary frequency, urgency and nocturia; physical exam with enlargement of left supraclavicular lymph node (SLN), inguinal adenopathies (ADP), vesical globe, nodular stony left testicle and anal exam with stony prostate. Blood tests: AKI stage 3, polyclonal increase of immunoglobulins G-M, PSA 2464.0 ng/ml; viral serology and other tumour markers were negative; microscopic hematuria; thorax-abdominal-pelvic computer tomography: mediastinal ADP, SLN, bilateral ureteral hydronephrosis by retroperitoneal ADP with inguinal extending and prostatic hypertrophy. Upper endoscopy was normal; prostate ultrasound: heterogeneous prostate increase and left epididymis thickening. SLN biopsy: prostatic adenocarcinoma metastasis; prostate biopsy: invasive acinar adenocarcinoma, gleason 8(4+4), peri-neural invasion; bone scintigraphy: hyperactivity on right orbital, maxillary, left parietal and L3-L5. The initial treatment discussed with Urology was androgen blockage and internal urinary derivation. At Urology-Oncology Meeting was decided surgical castration (right total+left subalbugineal orchiectomy) and docetaxel (protocol CHAARTED). Histologic testicular parenchyma: prostatic adenocarcinoma metastasis. After 6 months of surgery and 6 cycles of docetaxel, he was asymptomatic with regression of ADP and PSA of 3.4 ng/ml. Discussion: this case describe the atypical presentation of prostatic cancer with AKI and SLN, testicular, orbital and maxillary metastasis. The initial PSA response, imagiologic and clinical improvement with androgen blockage and docetaxel cycles are predictors of good prognosis.
Adrenal angiosarcoma, a rare disease

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The adrenal glands are frequently observed on computed tomography (CT) scan of the abdomen and on most chest CT scan. Adrenal masses are often referred to as an “adrenal incidentaloma”, an adrenal mass discovered incidentally on cross-sectional imaging exam. Most of these masses are benign adenomas. However, angiosarcomas are extremely rare and have a poor prognosis.

Case description: a 74-year-old man came to our Emergency Department complaining of hemoptoic cough. The patient had a previous history of unprovoked pulmonary embolism, still under anticoagulation and a large non-functioning adrenal mass incidentally found on the CT pulmonary angiography, which had been surgical removed very recently, along with the ipsilateral kidney. Initial chest CT revealed bilateral infracentimetric hypervascular nodular lesions suggestive of pulmonary metastasis. After a multidisciplinary team approach, the anatomopathological result of the excised adrenal gland was compatible with adrenal epithelioid angiosarcoma with immunohistochemical staining positivity for vascular markers (CD31, CD34, factor VIII) and keratin markers (CAM5.2 and AE1/AE3). Unfortunately, the patient suffered a fatal massive hemoptysis.

Adrenal angiosarcoma is a rare malignant neoplasm and a diagnostic challenge for clinicians and pathologists. The pulmonary embolism was admitted as a paraneoplastic syndrome and the lung lesions as metastasis, whereas in angiosarcoma, pulmonary involvement usually is secondary.
Introduction: Brain tumors originate in different cells of the central nervous system (CNS) or in systemic neoplastic cells that metastasize to the CNS. The signs and symptoms may be caused by compression of adjacent structures or by increased intra-cranial pressure. High-grade gliomas are malignant and rapidly progressive brain tumors.

Case description: 49-year-old female, previously healthy. She was taken to a primary health care facility after an inaugural partial sensory-motor (sensory predominance) seizure, from the fingers of the right hand to the right hemiface. She was medicated with clopidogrel. Six days after this event, she returned to that facility due to maintenance of the symptoms. Ten days after the initial episode, she went to the emergency department of a central hospital complaining of dizziness and decreased sensibility in the right upper limb and face. Neurological examination showed a decrease in muscle strength in the right upper limb (grade 3+/5). A cranieoencephalic computed tomography scan revealed a "left, cystic-necrotic lesion of aggressive characteristics and significant perilesional cerebral edema compatible with glioblastoma". She was admitted to the Neurosurgery department for treatment of cerebral edema, diagnostic brain magnetic resonance imaging and surgical planning. The examination of the brain tissue excised during the surgery revealed it to be a glioblastoma multiforme (grade IV).

Discussion: Symptoms caused by high-grade gliomas usually develop over days to weeks and, at an early stage, may mimic other pathologies. Therefore, the authors believe they should be taken into account when evaluating patients with neurological complaints.
Ampulla of Vater Adenocarcinoma: a rare form of cancer

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CASE DESCRIPTION: 69 years old male with history of microcytic anemia, resorted to the emergency room with epigastralgia over the last 15 days. During the previous week patient reported constipation and coffee ground vomiting. Patient also complained of asthenia, loss of weight (11kg) and bile vomiting, over the last two to three months. Upper GI endoscopy revealed reflux esophagitis type B and duodenal ulcer. Abdominal and pelvic ultrasound revealed slight Wirsung duct dilatation with no apparent cause. Observable gastric distension with liquid and aerial contents. At the emergency room patient presented with hypotension, peripheral saturation of 88%, pain in the epigastric regions and diminished hydro-aerial murmurs. Analytically it was found microcytic anemia, hypokalemia, hyponatremia, acute renal lesion without hyperbilirubinemia. Blood gases showed metabolic alkalosis and hypoxemia. On the ward patient maintained nausea and bile vomiting despite having a nasogastric tube draining freely. Evaluation was requested to the Gastrology Specialists who conducted an upper GI endoscopy and found an obstructive duodenal lesion with likely origin in the Ampulla of Vater. Further testing by magnetic resonance cholangiopancreatography showed primary malignant obstruction on the third portion of the duodenum, adenomyomatosis of the gall bladder, hyperplasia on Vater’s Ampulla and right pleural effusion. Hystological examination revealed high grade dysplasia/adenocarcinoma of Vater’s Ampulla. Patient was submitted to surgery and started chemotherapy.

DISCUSSION: Roughly one third of patients presents with occult blood in stools and chronic microcytic anemia. Frequent non specific symptoms like abdominal pain (45%), severe nausea and vomiting are present in this case. With surgical treatment the five-year survival rate for this cases is around 50%.
An almost fatal drug interaction between capecitabine and brivudin in a patient with metastatic breast cancer and a recent Varicella-Zoster virus infection

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Introduction: Drug interactions are sometimes severe and may even have fatal results, if overlooked. The physician in charge should be extremely careful when prescribing new drugs and always consider the effect that they will have on the patient’s health when combined with the drugs that the patient is already receiving. This seems to be the case with capecitabine and its serious interaction with soribudine and its analogues, such as brivudin, resulting in maximizing the adverse effects of capecitabine due to the inhibition of dihydropyrimidine dehydrogenase and occasionally having a fatal outcome.

Case Description: We present a 65-year-old female with metastatic breast cancer, who underwent a recent Varicella-Zoster virus infection. Upon her visit to the family doctor she was correctly diagnosed, but erroneously commenced on brivudin, while on capecitabine treatment. After developing a rash and a severe inflammation of her oral mucosa and since she became unable to swallow, she was admitted to our department for further management. The patient had developed oryphangeal and esophangeal mycositis and candidiasis and she was put on parenteral nutrition and intravenous fluconazole. Capecitabine was discontinued and the patient was also transfused, since she exhibited medullar aplasia. After being successfully treated for various hospital-acquired infections, she was successfully discharged on day 26 and was once again referred to her oncologist.

Discussion: In order to avoid fatal mistakes every physician needs to acknowledge the importance of alertness while prescribing drugs and the necessity of effective and constant communication between the patient and his main physician.
An interesting case of metastatic renal carcinoma presented as an inflammatory sternal mass

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Introduction: An inflammation of the sternum may be benign, but sometimes it can indicate various types of metastatic cancer. Rarely, renal cell carcinoma can present itself with bone metastases located in the sternum. An accurate diagnosis can be achieved through the histological examination of a sternal biopsy and thus ensure that the patient receives the appropriate treatment.

Case Description: We present the case of an 84-year-old female who was admitted to our department due to an enlarged mass of the sternum with signs of inflammation, which did not seem to improve with oral antibiotics. Initially, a chest MRI was performed that showed a sternal metastasis and a bone metastasis to the T7 vertebra. The MRI scan also revealed a mass of the right kidney, which was further examined with an additional abdominal CT scan. An isotope bone scan corroborated the findings of the sternal and spinal metastases and eventually a sternal biopsy was performed. In view of the fact that the histopathology analysis revealed metastatic renal clear cell carcinoma, the patient was referred to an oncologist for further management.

Discussion: In cases of sternal inflammation the physician should always consider the possibility of a metastatic carcinoma and try to minimize the patient’s discomfort at all costs. Even when it is not possible for the patient to receive the appropriate treatment due to age restrictions or due to his lack of consensus, it is important to help him retain his quality of life to an acceptable level.
An interesting case of metastatic squamous cell carcinoma of the tonsil in a 65-year-old patient with fever and cervical lymphadenopathy

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Introduction: Cervical lymphadenopathy may be the primary presentation of various diseases such as malignancies, infections, autoimmune disorders or may even be iatrogenic. As far as tonsillar carcinomas are concerned, cervical lymphadenopathy is not an uncommon occurrence. It can, however, trouble the physician at first, especially when accompanied by fever and elevated inflammatory markers and thus delay an accurate diagnosis.

Case description: The present study reports a case of a 65-year-old male who was admitted to our department due to low-grade fever and a mass on the left side of his neck with signs of inflammation. A neck CT scan revealed enlarged lymph nodes. The patient was initially commenced on empirical antimicrobial treatment with intravenous ampicillin-sulbactam, which resulted in the shrinkage of the mass. The blood cultures as well as the cultures taken from the mass yielded negative results and since the patient remained afebrile, he was discharged with instructions to continue receiving oral antibiotics and to perform a cervical MRI scan. He was re-evaluated one week later with the results of the magnetic resonance imaging that additionally revealed an enlargement of the left tonsil and he was referred for an ultrasound-guided fine needle aspiration (FNA) cytology. Since the result revealed a metastatic squamous cell carcinoma the patient was also referred to a head and neck specialist for further management.

Discussion: In cases of cervical lymphadenopathy due to tonsillar carcinoma an FNA cytology of the involved lymph nodes can accelerate the diagnostic process and subsequently the initiation of the appropriate treatment.
Introduction: Wilson Disease (WD) is an inherited disorder of the copper metabolism, resulting in copper accumulation mainly in the liver and the brain. Clinical presentation includes hepatic disease and/or neuropsychiatric symptoms. Hepatocellular Carcinoma (HCC) is a rare complication of WD.

Clinical Case: 63 years old male, with history of hepatic WD diagnosed at 47 years old. Two years after diagnosis, the patient abandoned follow-up and therapy with D-penicillamine. No history of viral hepatitis or alcohol abuse.

At admission, the patient complained of abdominal pain, malaise and high fever for the past 3 days. He had a tender hepatomegaly but no ascites, oedema or jaundice. Laboratory results showed an elevation of CRP, leucocytosis and hepatic cholestasis and cytology. Abdominal ultrasound suggested a cirrhotic liver with abscesses and the patient began empiric antibiotics with good clinical and laboratory responses. Blood cultures were repeatedly negative. Abdominal CT (with IV contrast) confirmed a cirrhotic liver with several nodules, several cysts and abscesses. Among many heterogeneous lesions, one outstanding voluminous nodule, measuring 9cm, raised the suspicion of HCC. A triphasic CT scan showed arterial hypervascularity and venous phase washout in the voluminous lesion as well as in two others. A CT-guided liver biopsy confirmed the diagnosis of multicentric HCC. The patient was sent to a reference center.

Discussion: We report a rare case of multicentric HCC in an untreated patient with cirrhotic-WD. van Meer et al. (2015) reported an annual HCC risk of 0.09% in WD and 0.14% for cirrhotic-WD. When adequately treated, WD patients have similar survival to the general population (Bruha et al. 2011). Although both cirrhosis and HCC had been associated with pyogenic liver abscess (Mølle I. et al. 2000; Wen-Kuan et al. 2014), liver abscesses had never been related with WD – another atypical feature of the case.
An old fashion cannon ball metastases

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Introduction
Cannon ball metastases refer to large, well circumscribed, round pulmonary metastases that appear like cannon balls. Cannon ball pulmonary metastases are typically seen in the patients with choriocarcinoma or renal cell carcinoma. Rarely, pulmonary metastases with the same appearance may be secondary from prostate cancer, synovial sarcoma, endometrial carcinoma or hepatocellular carcinoma.

Case description
We report the case of a 50 years old man, with diagnosis of epidermoid carcinoma of the larynx with local invasion, previously submitted to total laryngectomy with bilateral cervical ganglionic emptying and adjuvant radiotherapy in April 2017. He resorted to the emergency service in September 2017 with pleuritic chest pain associated with dyspnea and cough. He performed a chest x-ray which revealed diffuse nodularidades suggestive of a “cannon ball metastases” default. The Computerized Tomography showed multiple bilateral pulmonary masses, some with cavitations, suggestive of metastases, the largest with 85x48 mm of dimensions. Bronchofibroscopy revealed endobronchic tumors and its histology confirmed the diagnosis of epidermoid carcinoma. The patient was oriented to revaluation on oncology consultation.

Discussion
Multiple pulmonary nodules on the chest X-ray have multiple causes, including, metastases (cannon ball secondaries), various infections, immunological diseases and arteriovenous malformations. Pulmonary metastasis is seen in 20-54% of the extrathoracic malignancies. Lungs are the second most frequent site of metastases from extrathoracic malignancies. Most of the time, the presence of cannon ball metastases indicates an advance stage of malignancy, such as the present case. This case illustrates the fast evolution of this pattern and its exuberance rarely seen nowadays.
Ascites as the Presenting Symptom of Multiple Myeloma

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Multiple myeloma is a clonal proliferation of malignant plasma cells bone marrow. It is accounted for 13 % of hematological malignancies and 2 % of all malignancies worldwide. It may present with many different manifestations such as anemia, bone tenderness, bone pain, weakness, bone fractures, kidney damage, hypercalcemia, nerve damage, skin lesions, enlarged tongue and infections. Ascites is a rare complication of multiple myeloma. In this report, we studied a case of multiple myeloma with ascites and candida esophagitis being the main presenting feature. An 80-year-old man without any chronic disease appealed to the hospital with weakness, weight loss (10 kilograms in four weeks) and difficulty during swallowing. The patient had progressive abdominal distention and peripheral edema just a month before the presentation. Multiple myeloma was suspected based on anemia, and hyperglobulinemia, in addition to symptoms of weight loss and possible immunosuppressive condition. Protein electrophoresis were performed and monoclonal gammopathy were detected. Immunofixation electrophoresis revealed IgG kappa pattern. An assay for serum free light chain showed increased kappa light chains (5.79 g/dL; reference interval, 1.7-3.7 g/dL) and decreased lambda light chains (0.7 g/dL; reference interval, 0.9-2.1 g/dL); the kappa / lambda ratio was 8.1.

The results of bone marrow biopsy revealed 20% plasma cells. Therefore, a diagnosis of multiple myeloma was demonstrated. Beta-2-microglobulin level were detected 4.35 mg/L. X-ray skeletal series had no lytic lesions. Computed tomography of the abdomen was performed to assess the extramedullary hematopoiesis. There were no sign of extramedullary hematopoiesis. After diagnosis chemotherapy was started (Bortezomib, dexamethasone, and zoledronic acid). After four cycles of treatment, there was a major improvement in hemoglobin levels and globulin levels. There was a marked decrease in the abdominal ascites.
Assessing a patient for Liver Transplant and a non diagnosed Malignant Peritoneal Mesothelioma: a Case Report

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Alcoholic liver disease (ALD) is the first commonest indication for liver transplantation in Portugal. It’s very important to assess a patient for liver transplant making sure there is no contraindication to go forward. Authors present a 59 year old male with a background of cirrhosis due to ALD that was being assessed for liver transplant. With a MELD of 9 the main indication was refractory ascites. Ascitic fluid analyses always showed signs of portal hypertension but with elevated LDH (372 U/L), elevated proteins (4.31 g/dL) and low glucose. Before going for transplant, tuberculosis and cancer were excluded with complementary diagnostic exams. Transplant was performed with another patient on the background in case the surgeons saw any signs of neoplasia. Patient was discharged 4 weeks later with standard immunosuppression, a normal graft and the explant had only signs of cirrhosis. Two months later developed a cellulitis of the abdominal wall and antibiotics were given with no signs of improvement. He was admitted with persistence of the cellulitis and an internal jugular thrombosis. Anticoagulation was started and a mini laparotomy was done to retrieve tissue from the peritoneum and the abdominal wall. Pathological anatomy showed intravascular dissemination of an epithelial neoplasia with immunohistochemistry favoring the diagnose of mesothelioma. Two months later patient died due to acute kidney injury complications.

This case report shows the importance of questioning all the abnormalities that are found doing a liver transplant assessment, as the patients start immunosuppression, the evolution of undercovered diseases is exponential.
Atypical Lung Carcinoid Tumour: Unusual Origin Of Brain Metastases

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Introduction
Metastases are the most frequent intracranial space-occupying lesions in adults. Cerebral metastasis of an atypical lung carcinoid tumour is an extremely rare finding.

Case description
A 74 years-old male with rapid progressive dementia, schizoaffective disorder, dyslipidaemia, obstructive sleep apnoea syndrome and drug-induced parkinsonism was brought to the Emergency Department with disorientation. He denied any symptom but the physical examination revealed slight dysmetria and a hyperpigmented lumbar skin lesion. The brain CT showed two space-occupying lesions with haemorrhagic signs and cerebral oedema. The blood test was normal, except for PSA 4.88µg/L and a positive faecal occult blood test. The body CT revealed a centimetric nodular lesion in the right lower lobe suggestive of metastasis and the PET/CT showed activity in the lung and the cutaneous lesion. The biopsy of the skin lesion had no signs of malignancy. In the colonoscopy a polyp was removed, with mild atypia. After this procedure, he suffered a pneumoperitoneum that led to his death. The necropsy diagnosed an atypical lung carcinoid tumour with brain metastases.

Discussion
Although carcinoid tumours have an indolent course, they tend to metastasize. The incidence of brain metastases is 1.5 to 5%, with worse prognosis than those with extracranial metastases. Most patients have either a primary carcinoid lung tumour or carcinoid lung metastases at the time of the cerebral metastases diagnosis. Neurologic symptoms from brain metastases are exceptionally rare as the first manifestation of carcinoid tumours. In our case, the presence of dementia possibly masked the patient's symptoms, delaying the diagnosis.
Atypical presentation of chylous ascites and dermatomyositis in an infiltrative rectosigmoid cancer: a case report

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Introduction: Approximately 95% of colorectal cancers are adenocarcinomas being the second most common type in women. Paraneoplastic syndrome is uncommon in this type of cancer.

Case description: Woman, 76 years, presented to the Emergency Department with acute obstructive pyelonephritis. The obstruction was caused by severe peritoneal effusion with areas of peritoneal focal thickening with apparent diffuse densification, suggestive of peritoneal carcinomatosis, discovered in Uro-CT scan. As for the physical exam, she had violaceous desquamative erythema in areas of solar exposure that was biopsied, revealing a paucicellular liquenoid infiltrate with basal duplication, suggestive of dermatomyositis. The patient underwent a diagnostic paracentesis which showed milky peritoneal fluid, hypertriglyceridemia and a serum-ascites albumin gradient of 0.6, with no neoplastic cells in the cytological examination. Anatomopathology was suggestive but not diagnostic of carcinoma. Cell-block and immunohistochemical tissue staining was performed, with abundant reactive mesotelial cells immunomarked for Ber Ep4 and TTF1. Colonoscopy had abnormal mucosa with irregular borders and an infiltrative appearance that occupied one third of the lumen, 20cm from the anal border. Biopsies revealed an infiltrative rectosigmoid adenocarcinoma that stained positive for CK7. 18F-FDG PET/CT revealed hypercaptation in the rectosigmoid area with metastasis in the abdominopelvic and inferior laterocervical and suprascapular ganglia. The patient was discharged to the oncology department for palliative care and died 5 months after diagnosis.

Discussion: This is an atypical presentation of a common carcinoma which delayed the diagnosis, with no influence in the final prognosis. Atypical presentations such as dermatomyositis are associated with a higher mortality rate.
Bilateral proptosis as the initial manifestation of malignancy


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INTRODUCTION
Proptosis, unilateral or bilateral, is a frequent indication for medical evaluation. Ophthalmological involvement in lymphoma is rare.

CASE DESCRIPTION
A 58-year-old Spanish man was hospitalized by a 3-month history of painless bilateral proptosis and weight loss of 6 Kg without other ophthalmologic and systemic symptoms. His medical-family history was no significant; he did not take medications. Ophthalmologic examination revealed marked bilateral proptosis with conjunctival edema, visual acuity was normal in both eyes and no afferent pupillary defect was noted. Extraocular motility was reduced in both eyes, intraocular pressures were normal. General physical examination was normal. No hematologic abnormalities were found. TSH and T4, ECA and autoimmunity (ANAs, ANCAs, AntiTSI) were normal. Mantoux was 20 mm and HIV, HCV and HBV serologies were negatives. A CT-body-scan was performed, revealing bilateral proptosis with extraconal orbital symmetric masses of 4.5x3cm which compressed lateral rectus muscles and demonstrate uniform intense gadolinium enhancement in MRI. TC-scan also shown bilateral peripheric pulmonary infiltrates, mild hepatosplenomegaly, a pelvic retroperitoneal mass of 4.1x2.3cm and multiple infradiaphragmatic lymphadenopathies. An orbital mass biopsy was performed, revealing MALT cell lymphoma. He was referred to Haematology. A bone marrow biopsy confirmed the diagnosis. Chemotherapy with CHOP and rituximab and, also Isoniazid, were initiated. He is in follow-up, with radiologic improvement after 3 cycles.

DISCUSSION
The diagnosis of MALT lymphoma is anatomopathological and immunohistochemical. Orbital involvement is found most often in advanced stages of the disease. Treatment has improved with the use of rituximab.
Bone metastasis: a diagnostic challenge

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Introduction
Low back pain is a frequent symptom and most of the cases are self-limited. When there is no response to initial treatment, underlying systemic pathologies should be considered.

Case description
Female, 61 years old and updated cancer screening tests. Low back pain for 6 months, no response to treatment and progressive functional limitation. No focal neurological signs on physical examination. Lumbar CT revealed extensive bone destruction of the lumbar spine suggestive of secondary invasion and thoraco-abdomino-pelvic CT with lytic lesions in the right clavicle, illium and sacro as well as nodular lesions in the lungs and liver suggestive of secondary foci. Admitted by multiple lytic bone, pulmonary and hepatic metastasis of unknown origin. Serum and urine immunofixation without monoclonality, normal light chain assay; thyroid, breast and gynecological ultrasonography and gastrointestinal endoscopy without lesions. Once the primary neoplasm was still unknown, a biopsy of clavicular bone was performed and showed a solid and acinar carcinoma with immunohistochemistry compatible with breast origin. A new breast imaging was performed and disclosed a suspicious right axillary adenopathy and a densification area in the upper external quadrant of the right breast. Biopsy compatible with HER2 positive breast carcinoma. Thus, stage IV breast cancer at diagnosis, being proposed for palliative chemotherapy. Lumbar resonance revealed spinal cord compression and she was submitted also to radiotherapy.

Discussion
Bone metastasis are related with high morbidity due to disabling pain and risk of fractures and spinal cord compression. The search for primary neoplasm is a challenge for a targeted therapy in these patients.
Brain tumour, the eternal doubt: primary versus secondary?

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Introduction: Primary tumours of the central nervous system (CNS) have a low incidence in adults, while brain metastases account for more than half of the brain tumours in this age group. Clinical manifestations are diverse depending on the site of the invaded brain. Treatment and prognosis are dependent on the histology of these tumours.

Description of the case: A 74-year-old woman hospitalized for the study of brain lesions suggestive of neoplasia. The patient presented a clinic with a 2-week evolution of behavioural changes (adynamia, emotional lability, apathy and mnesic alterations) associated with intense bilateral frontal headaches. Documented at the objective examination: bradifrenia, poor speech, inattention, signs of frontal (palmomentonian on the left and bilateral grasping), some neglect of the left hemibody and ideomotor apraxia in the left limbs. During hospitalization, the patient maintained the same clinical manifestations with increasing adynma and apathy. She performed nuclear magnetic resonance imaging (MRI) that showed several intracranial lesions (at the level of the corpus callosum and cortico-subcortical and periventricular regions of right predominance) suggestive of primary cerebral neoplasm (glioma), and it was not possible to exclude brain metastases. The study for primary systemic neoplasm as well as cerebrospinal fluid cytology was negative. Stereotactic biopsy showed glioblastoma multiforme.

Discussion: The study of brain tumours in the older population almost always involves the exclusion of primary systemic neoplasm. Although imaging techniques often provide information suggesting a specific histology, biopsy remains essential for the diagnosis and therapeutic orientation of primary CNS tumours. This clinical case is intended to highlight this fact.
Cancer of unknown primary origin, where should we go?

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Introduction: Cancer of unknown primary origin (CUP) is responsible for 4-5% of cases of neoplasia. Despite extensive clinical, laboratory and radiological investigation, primitive tumor remains largely unknown - 70% adenocarcinomas.

Case description: A 56-year-old woman with bilateral omalgia with one year of evolution, hospitalized for prostration and right upper limb paresis (grade 3/5). CT-CE showed “supratentorial and one infratentorial intra-axial lesions, calcifications, cystic and vasogenic edema”. CT-TAP: lytic and blast bone lesions of the shoulder blades, clavicle, ribs and iliac. Initiated dexamethasone and screening for CUP: normal mammography, mammary ultrasound and endovaginal ultrasound; endoscopy and colonoscopy without significant changes. Tumor markers: CEA 78.3ng/ml, CA19.9 254U/ml, CA15.33U/ml, CA125228U/ml, CYFRA-21 12.3ng/ml, NSE 32.1ng/ml. She was submitted to iliac bone biopsy with inconclusive histology and surgical bone biopsy of the clavicle lesion that showed a mucous producing adenocarcinoma (pulmonary vs. pancreatic neoplasia or biliary tract by immunohistochemical study). PET-scan was compatible with cerebral, osteomedullary and muscular malignancy adjacent to the left iliac and showed focal hypermetabolism in the area of pleural effusion/thickening in the lower lobe of the left lung. Bronchofibroscopy with cytological examination and broncoalveolar lavage fluid were negative for neoplastic cells but with a reduction of the left inferior lobar bronchus caliber. After multidisciplinary discussion, she started holocranial radiotherapy and treatment for probable primitive lung cancer.

Discussion: The investigation of metastatic CUP is time consuming, which delays treatment. It is necessary to perform invasive techniques to obtain the definitive histological diagnosis. When this is not possible, it should be treated according to the most probable etiology, as in this case.
Cancer cells have an increased need for cholesterol, which is required for cell membrane integrity. Cholesterol accumulation has been described in various malignancies including breast cancer. Cholesterol has also been known to be the precursor of estrogen and vitamin D, both of which play a key role in the histology of breast cancer. Thus, depleting the cholesterol levels in cancer cells is a proposed innovative strategy to treat cancer. Therefore, novel cholesterol-depleting compounds are currently being investigated. KS-01 is a cyclic amylose oligomer composed of glucose units. It solubilizes the cholesterol and is proven to be toxicologically benign in humans. This led us to hypothesize that it might deplete cholesterol from cancer cells and may prove to be a clinically useful compound. Our work provides preliminary experimental evidences to support this hypothesis. We identified the potency of KS-01 in vitro against two breast cancer cell lines: MCF-7 (Estrogen positive, ER+), MDA-MB-231(Estrogen negative, ER-) and compared the results against two normal cell lines: MRC-5 (Normal Human Lung Fibroblasts) and HEK-293 (Normal human embryonic kidney cells) using cytotoxic, apoptosis, protein expression and cholesterol based assays. KS-01 treatment reduced intracellular cholesterol resulting in significant breast cancer cell growth inhibition through apoptosis. The results hold true for both ER+ and ER-. These data suggest that KS-01 can prevent cholesterol accumulation in breast cancer cells and is a promising new anticancer agent. We are currently testing our hypothesis in vivo to validate our in vitro results.

N.B: We have submitted the preliminary data to WITS ENTERPRISE (University’s internal patenting agency); therefore the chemical name has been kept classified. Once we get our in vivo data, the compound would be patented for its mechanism of action in Breast cancer.
Depression and anxiety as the main symptom of pancreatic cancer

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INTRODUCTION
In pancreatic cancer, there is a high rate of depression and anxiety. Almost every time, during the use of the medication, however, some report show the presence of episodes of depression before diagnosis, suggesting the presence of prodromal depression.

CASE DESCRIPTION
A 70-year-old woman with anxious-depressive syndrome and diffuse abdominal pain of 4 months evolution. A digestive study of colonoscopy and endoscopy has been done with normal results. She is diagnosed with depressive syndrome in follow-up due to Psychiatry and treatment with antidepressants and anxiolytics without improvement. The patient had never needed treatment for anxiety or depression and the family denies triggers of that state of mind.


Supplementary tests:
- Abdominal CT: Pancreatic head tumor that includes arterial vessels. Stage III (T4N0M0).
- Pathological anatomy: infiltrating ductal adenocarcinoma of the pancreas.

Evolution: The case is raised in the Digestive Tumors committee, as it is an unresectable neoplasia, treatment with radiotherapy and chemotherapy with Capecitabine and Gemtabicina-Abraxane is decided.

DISCUSSION
In clinical practice is common for depressive illness to be associated with medical pathology, which is a symptom to consider in patients such as our case, with no depressive history or triggers. To date, many hypotheses about the etiology of depression in pancreatic cancer have been stipulated, based on the fact that the pathophysiology of depression in pancreatic cancer results from the biological changes that are induced by the presence of the tumor itself.
Diffuse hepatic metastasization as presentation of pancreatic neuroendocrine neoplasm: a case report

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INTRODUCTION: Pancreatic neuroendocrine neoplasms are a rare group of tumours that originate in the endocrine tissues of the pancreas. Although the typical presentation is related to hormone production, some patients present with symptoms associated with advanced disease and metastasization.

CASE REPORT: A 43-year old female with family history of lung cancer (father and uncle) and breast cancer (aunt) was admitted referring nausea, abdominal tenderness, bloating sensation and loss of 4kg in the last month. Computerized tomography (CT) of the abdomen revealed multiple and coalescent neoformative hepatic lesions, the largest with 13cm of diameter. In the CT there was also a 6cm lesion in the tail of the pancreas, referred as the probable primary lesion. The biopsy of one of the hepatic lesions revealed a neuroendocrine neoplasm and the diagnosis of non-functional pancreatic neuroendocrine neoplasm was assumed. A few days after the biopsy, the patient passed away.

CONCLUSION: Although rare, pancreatic neuroendocrine neoplasms should be considered in the differential diagnosis of pancreatic masses, mainly in young patients. This group of neoplasms has a better prognosis than pancreatic adenocarcinoma when the diagnosis is promptly made. The non-functional form of presentation entails a delay in the diagnosis, which can lead to hepatic metastasization and a worst prognosis, as seen in this case.
Doxorrubicina liposomal as a treatment in epidemic kaposi sarcoma.

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INTRODUCTION: Kaposi’s sarcoma is a vascular neoplasm caused by human herpesvirus 8 (HHV-8) that affects the surfaces of the skin and mucosa. There are several types: classic, endemic (African), associated with immunosuppression (iatrogenic) and epidemic (associated with Human Immunodeficiency Virus (HIV)).

DESCRIPTION: A 47-year-old patient with a personal history of HIV stage C3 (Kaposi’s sarcoma) over 30 years of evolution with voluntary withdrawal of HAART 3 years ago, never drug addiction via parenteral and gender dysphoria intervened years ago. It presents a progressive worsening of the general condition for a month and a half with the appearance of red wine-colored skin lesions in the form of macules and violet-brown to reddish-brown plaques along the lines of tension of the skin, associated with significant weight loss and dysphagia to solids and liquids. It presents severe CD4 17 immunosuppression (CD4 / CD8 0.01). In oral endoscopy, gastric and duodenal lesions compatible with Kaposi’s sarcoma were observed. It was decided jointly with oncology to initiate chemotherapy treatment with liposomal Doxorubicin for the treatment of epidemic Kaposi’s sarcoma (associated with HIV).

DISCUSSION: Of the different treatment of epidemic Kaposi sarcoma associated with HIV, it can be affirmed with a level of evidence 2 (medium level) that: The topical 0.1% alitretinoin gel seems to reduce the size of the lesion in the treatment of sarcoma of Cutaneous Kaposi in adults with HIV infection who also receive HAART, human chorionic gonadotropin (hCG) as an intraliesional injection, pegylated liposomal doxorubicin combined with HAART seems to be more effective than HAART alone, pegylated liposomal doxorubicin appears to be more effective than the bleomycin / vincristine regimens and that Paclitaxel may be as effective as pegylated liposomal doxorubicin for survival and tumor response.
Esophageal invasion by lung cancer

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Introduction
Invasion of the esophageal wall with primary pulmonary carcinoma is an uncommon occurrence. Diagnostic techniques, such as chest X-rays and CT scans, are important in diagnosing the lesions.

Case description
A 61-year-old man with a history of tagging and alcoholism. He went to the emergency department for weight loss, dysphagia, dry cough and loss of 8 kilos with a month of evolution. At admission: afebrile, auscultation: vesicular murmur with fine crackling noises. It had leukocytosis (23,100 / mm3), C-reactive protein 31.16 mg / L. Chest X-ray: image with right-side hydroaereal level (Figure 1). Computed tomography of the thorax: Large cavitary lesion in the right lung, apical region of the lower lobe, 75x40x70mm, with hydroaereal level and peripheral contrast uptake Adjacent densification that extends to the main homolateral bronchus Nodular areas in depolished glass in the right upper lobe and middle lobe, with a centrilobular distribution pattern, these aspects are more accentuated in the lower right lobe, with poorly defined areas of consolidation tending to confluence.some nonspecific mediastinal ganglionic images. A cavitary lesion contacts the right side of the esophagus. In the region near the cardia and without cleavage plane with the gastric fund, is there a nodular area with 35x35mm, adenopathic conglomerate. (Figure 2).

Discussion
The patient underwent empirical antibiotic therapy with ceftriaxone and metronidazole, aimed at abscessed lung infection. High digestive endoscopy, with biopsy, revealed well differentiated squamous keratinizing carcinoma, confirming the diagnosis of squamous neoplasia of the abscessed lung with invasion of the esophagus. It is intended to alert to the possibility that we are facing a neoplasia with advanced invasion to another organ, detectable with a chest radiograph with nonspecific alterations
Fournier's gangrene in oncological patients

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Introduction: Fournier's gangrene is a rapidly progressive necrotizing fascitis that affects the genital, perineal and perianal regions due to infectious etiology. Diabetes mellitus, chronic alcoholism and immunosuppression states, such as neoplasia, are important triggers. Its poor prognosis is associated to the septic clinic, the locally advanced state of the disease and possible distant spread in the form of metastasis.

Results: We present a 3-cases serie of male patients who presented oncological pathology and were in chemotherapy treatment. One of them suffered localized rectal carcinoma, another suffered metastatic colon carcinoma and the third suffered advanced bladder carcinoma. They were admitted with septic shock secondary to Fournier gangrene, requiring broad-spectrum antibiotic therapy (two were treated with meropenem and one with piperacillin-tazobactam and linezolid) and urgent surgery with debridement and surgical drainage. A left orchiectomy for testicular infeasibility was needed in one of these patients. Subsequently, it was necessary to perform new surgical debridements in all patients, up to 3 times, to achieve control of the infectious process. One of them died due to complications derived from his oncological process and the other two patients were discharged, being able to continue with chemotherapy treatment after the resolution of the condition.

Conclusions: It is essential to carry out an early diagnosis and initiate without delay the hemodynamic, antibiotic and surgical debridement treatment, since it is a process with high mortality that increases in immunocompromised patients due to neoplastic processes and chemotherapy treatments.
From acute bronchitis to laryngeal cancer

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INTRODUCTION: The larynx is one of the most important organs of the cervical region, being fundamental in the speech, respiration and swallowing. The tumors in that region cause impact in those three functions, especially speech. Laryngeal cancer represents 25% of the malignant neoplasms in the head and neck region and 2% of all malignant neoplasms. About two thirds of those tumors appear on the real vocal folds and one third on the supraglottic larynx (above the vocal folds).

CASE DESCRIPTION: A 74 year-old man with a history of stroke, chronic kidney disease, dementia, lower limb amputation was admitted in the ER for dyspnea, fever and productive cough with several weeks. He was already medicated with moxifloxacine without benefit, having evolved with wheezes and stridor. He presented with altered mental status, fever, tachypnea and low oxygen saturation, respiratory secretions and ronchi and wheezes at auscultation. The blood tests showed anemia, leukocytosis and neutrophilia, elevated CRP and hyperkalemia. Arterial blood gases with respiratory acidosis. Chest radiograph showed no alterations. He was admitted in the Ward with the diagnosis of acute bronchitis. He evolved with dysphonia and stridor, without benefit from the medication started. He performed an upper endoscopy which revealed mucosal edema and irregular area suggestive of atypia. Neck CT suggestive of laryngeal cancer. He was referred to Otorhinolaryngology.

DISCUSSION: The authors intend to highlight the importance of differential diagnosis, attending to the signs and symptoms common to a lot of pathologies with a different approach and prognosis, and that the admission diagnosis is not always the same as the discharge diagnosis.
From vomits and food intolerance to the diagnosis of small cells lung carcinoma

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INTRODUCTION: Small cells lung carcinoma is distinguished from non-small cells lung carcinoma by its high proliferation index and the early development of metastases (particularly liver, suprarenal glands, bone, spinal cord and brain).

CASE DESCRIPTION: Man, 61 years old, with previous history of ischemic stroke, pulmonary chronic obstructive pulmonary disease, heart failure, alcoholic and smoking habits.

The patient came to the Emergency Department because of alimentary vomits with several weeks of evolution. There was a cytocholestease pattern on the blood tests that were performed and in the abdominopelvic CT were documented three large hypodense focal lesions, a retroperitoneal adenopathy, one hypodense lesion on the right adrenal gland and several areas of rarefaction on the bone.

We performed a hepatic biopsy of the lesion that concluded a hepatic metastasis of a small cell lung carcinoma. On a brain CT were documented two intra-axial hyperdense expansive lesions located on the cerebellar hemispheres with a halo of vasogenic oedema causing compression over the IV ventricle and dilation of the supratentorial ventricular system and thus hydrocephalus. On the chest CT there was diffuse centro-lobular emphysema and a nodular opacity on the left upper lobe.

The diagnostic of a small cells lung carcinoma in the IV stage was possible and the palliative treatment was started.

DISCUSSION: Approximately 70% of the patients diagnosed with of small cells lung carcinoma have disseminated disease at the time of the diagnosis and the presentation symptoms can be very diversified.
Glioblastoma IDH1 wild-type: from autonomy to dependency

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Introduction: Glioblastoma (GB) is the commonest and most aggressive primary malignant brain tumour. Clinical presentation can be similar to other neurological diseases, such as stroke. It is classified according to neuropathological and molecular features by the WHO 2016 classification, and includes isocitrate dehydrogenase (IDH) mutational status. Importantly, glioblastoma IDH wild-type is associated with worse prognosis. Case description: 59 years old male; autonomous; history of hypertension, diabetes mellitus and dyslipidaemia; on medication. Presented at emergency room with left facial paresis and hypoesthesia, left arm weakness 4+/5 and nocturnal disorientation. Complementary exams: brain computer tomography (CT) with right frontal space occupying lesion with edema; thorax-abdomen-pelvic CT normal; tumour markers negative; blood tests, electrocardiography and chest radiography were normal; magnetic resonance (MRI) revealed brain tumour from glial series. He started treatment with dexamethasone until surgery. Submitted to tumoral removal with right frontal craniotomy using intracerebral mapping. Post operatory with maintenance of left arm hemiparesis 4+/5; neuropathology revealed Glioblastoma IDH1 wild-type (grade IV WHO), and was oriented to radiotherapy and chemotherapy (temozolamide) according to Stupp protocol. During the 3 months of follow up, he developed loss of autonomy, confusion and seizures, that conditioned his rapid institutionalization; new brain MRI revealed recurrence and progression of GB. Discussion: GB IDH1 wild-type is an aggressive tumor and median survival is 15 months, though evolution among patients is highly heterogeneous. Patient quality of life and functional status must be privileged; including assertive seizure treatment and symptom control upon inoperable recurrences.
Hydropneumopericardium a rare complication of esophageal tumor

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Introduction
Esophagopericardial fistula is an unusual but life-threatening finding whose etiology includes some benign conditions but also trauma and malignant esophageal disease.

Case description
We report the clinical case of a 77-year-old man diagnosed, 10 months earlier, with epidermoid carcinoma of the middle esophagus presenting with involvement of the left main bronchus and descending thoracic aorta. Later he was diagnosed with brain metastases and because of aphagia an esophageal prosthesis was inserted.
He was admitted to the emergency department because of a sudden interscapular pain, during a meal, with shoulder irradiation, with no other associated symptomatology. On admission, the patient was hypotensive, with no tensional differential between the limbs and with arrhythmic heart sounds. He had hyperlactacidemia and an atrial flutter. On suspicion of aortic dissection he underwent thoracic CT angiography, which revealed the presence of air and fluid in the pericardial space in the context of esophageal perforation due to tumor invasion. As a patient with poor functional status and terminal cancer, priority was given to comfort measures, culminating with death within 24 hours.

Discussion
Hydropneumopericardium secondary to esophageal tumor is a very rare complication and carries an ominous prognosis. A high level of suspicion is needed to make the diagnosis because clinical manifestations can be very unspecific. Successful management of an esophagopericardial fistula should include surgical closure of the fistula, pericardial drainage and antibiotic therapy. In this case, due to the documented disseminated malignancy and poor patient status, conservative management was preferred.
Objectives: Vitamin B12 deficiency is common among Turkish population. An important aspect of management is determining the underlying cause because the need for additional testing, the duration of therapy, and the route of administration may differ depending on the underlying cause. The most common causes of Vitamin B12 deficiency is pernicious anemia (PA). PA is associated with an increased risk of gastrointestinal cancer. Findings from small studies about the association between the other causes of vitamin B12 deficiency and cancer are conflicting. There are insufficient data to support routine surveillance following an initial screening in the absence of symptoms for cancer based on the diagnosis of vitamin B12 deficiency. We investigated the malignancy rates in vitamin B12 deficient patients.

Methods: We retrospectively analyzed patients who had serum vitamin B12 levels lower than 300 pg/ml in 2007 and recorded any type of malignancy diagnosed in 10-year period.

Results: In 2007, there were 456 patients with low B12 levels in our general Internal Medicine Clinic and we sampled 331 patients of those whose data can be reached. Median age was 46 (15-80) years at the time of diagnosis and 251 of the patients (75.8 %) were female. Median B12 levels were 218 (87-300) pg/ml, mean hemoglobin was 13.3 ± 1.8 g/dl, median mean corpuscular volume (MCV) was 86.1 (55-102) fL. Up to the end of 2017, any malignancy was diagnosed in 34 (10.3 %) of 168 patients who had vitamin B12 deficiency. There was no correlation between vitamin B12 levels and MCV levels. In regression analysis, we could not find any relationship between vitamin B12 levels and malignancy.

Conclusion: Vitamin B12 deficiency is a common problem in Turkey. we could not show any relationship between vitamin B12 levels and malignancy in this retrospective study but well-designed prospective further analysis is required to investigate any possible relationship between vitamin B12 levels and malignancy.
Maternal thyroid papillary carcinoma associated with pregnancy: About a case

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Introduction
Thyroid cancers are rare and represent 1% of malignant tumors, when pregnancy is associated with breast cancer, the situation is complicated and multidisciplinary care is required.

Observation:
46-year-old patient referred to our level for clinical, biological and ultrasound monitoring of total thyroidectomy following thyroid cancer. One month before, the patient was diagnosed with thyroid cancer and treated two weeks after surgery. During the interview, we noted the absence of contraception during this period and a delay in menstruation.
The BHCG and the obstetrical ultrasound confirm a pregnancy of 12 weeks of amenorrhea. Clinically the patient was in good general condition, she did not need additional sessions of irathérapie and after a multidisciplinary collegial decision, the pregnancy was maintained. Our behavior was to provide psychological support and answers to his fears about the condition of the fetus. Strict clinical, biological and ultrasound surveillance was done in our patient, marked by a good evolution of the pregnancy during the first and second trimester, in the third trimester the patient makes the HTA pregnancy and the fetus knows disorders of the rhythm cardiac, the patient was hospitalized in the department of high-risk pregnancies at the maternity hospital, the hypertension was stabilized, at 40 weeks of pregnancy, unfortunately the patient had complications during her delivery with loss of the fetus.

Conclusion:
Very few studies have explored the impact of a diagnosis of maternal thyroid cancer during pregnancy on the woman and mother-child interactions during pregnancy and postpartum.
The management of thyroid cancer, pregnancy and the child depend on the prognostic and progressive factors of maternal neoplasia, the early diagnosis and must be transversal and multidisciplinary.
Multiple primary tumors- a diagnosis to keep in mind

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Introduction: Integrating multiple semiologic elements into a single diagnostic hypothesis is a common routine in the clinician’s mindset. However, coexisting different disorders, such as multiple primary tumors, may challenge this way of thinking.

Case description: A 58 year-old male with active smoking habits (approximately 40 pack years) was admitted to the ward. He reported a 2 month history of progressive left parotid gland swelling, early satiety, dyspnea to progressively minimal exertion and 7 kg weight loss. On physical examination, a 5 cm elastic mass was observed in the left parotid gland. The mass was well defined, non-tender and closely adherent to surrounding tissues. ORL observation revealed no further findings. The patient had neither adenopathies nor hepatosplenomegaly. Laboratory results showed Hb: 7,5 g/dL, Ht: 26,1%; MCV: 71,9 fl, reticulocytes: 2,9%; WBCs: 12520/μL, Neutrophils: 8640/μL, Platelets: 414000/μL, ESR 118 mm, CRP 0.460 mg/dL, BUN 46 mg/dL, creatinine 0.9 mg/dL, LDH 141 U/L, iron 18.2 ug/dL, ferritin 8.3 ug/L, TIBC 459 ug/dL, transferrin saturation 4%. Cervical CT scan identified two left parotid heterogeneous nodules. Upper tract endoscopy revealed a vegetative ulcerated lesion that extended from the cardia to the lesser curvature of the stomach. Histologic examination of the gastric samples unveiled an intestinal type moderately-differentiated gastric adenocarcinoma. Aspiration needle biopsy of the parotid gland disclosed a Warthin’s tumor (WT) with lymphocytic predominance and excluded monoclonal features.

Discussion: WT is a rare entity associated with tobacco smoking. Though majorly benign, 10% of cases undergo malignant transformation. Up until now there is no known correlation between this type of tumor and gastric carcinoma. Epidemiologic studies concluded that multiple primary tumors have a 2-17% prevalence, thus underlining the importance of this hypothesis in this particular clinical case.
Neoplastic ascites - An unidentified adenocarcinoma

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Introduction: Ascites is of neoplastic origin in 7% of cases. When neoplastic ascites is not associated with peritoneal carcinomatosis it might be difficult to reach a definitive diagnosis.

Case description: A 61-year-old man came to the emergency department complaining of diffuse, colicky, abdominal pain. In the previous week he reported dyspnea for moderate intensity activities. He was a former smoker and consumed around 90 grams of alcohol a day. At physical examination a dilated abdomen was noted, barely depressible and painless. No masses or organs where palpable. The patient underwent a chest, abdominal and pelvic CT which identified: 1. Bilateral pulmonary thromboembolism; 2. Two nodular areas on the right hepatic lobe (16 and 24 mm); 3. Large volume ascites; 4. Densification of the greater omentum, suggesting peritoneal carcinomatosis. Ascitic fluid was obtained and its biochemical and cellular count analysis had no particular features. SAAG was 0.3. Upper and lower digestive tract endoscopy, PET scan and three different cytologic examinations of ascitic fluid were inconclusive. A MR didn't identify the nodular lesions previously reported in the abdominal CT. A blood workup showed an elevated CA 19,9 (160 U/mL). The patient underwent laparoscopy for greater omentum and hepatic ligament biopsy. The pathologic examination of these biopsies revealed an adenocarcinoma of unknown origin. Chemotherapy with cisplatin and fluorouracil was initiated. The patient died 8 months after presentation.

Discussion: A definitive diagnosis wasn't achieved in this case. When true peritoneal carcinomatosis is present, the sensibility of cytologic examination of ascitic fluid can reach 97%.
Occult neoplasia and venous thrombosis

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Background
Unprovoked events of venous thromboembolism (VTE) are often associated to occult neoplasia (4-10%, according to different studies). The objective of this study is to evaluate whether the performance of abdominal ultrasound and biomarkers in a cohort of patients with unprovoked VTE is useful for the diagnosis of occult neoplasia.

Method
The study was performed in an outpatient VTE clinic of a third level hospital in Madrid. Consecutive patients with diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) or repeated superficial venous thrombosis (SVT) were included in the study. Abdominal ultrasound and biomarkers were performed in all patients, and they were followed up for at least 12 months. A descriptive analysis was performed with SPSS (version 23).

Results
118 patients were included in the study (50.4% male) with an average age of 70. VTE event was isolated DVT (55.95%), isolated PE (33.8%), DVT + PE (9.3%) and repeated SVT (0.95%). Average follow-up was 13 months (387 days). During follow-up, diagnosis of cancer was made in 4 patients (3 new events and 1 recurrence of previous cancer). Diagnosis of cancer was achieved after breast X-ray (1), pulmonary CT (1), upper endoscopy (1) and abdominal MRI (1). Abdominal ultrasound and biomarkers did not lead to the diagnosis of occult neoplasia in any patient. As a consequence of abdominal ultrasound findings, 12 additional tests were performed in 7 patients.

Conclusion
Abdominal ultrasound and biomarkers were not useful for the diagnosis of occult neoplasia in patients with unprovoked VTE. Abdominal ultrasound led to the performance of unnecessary additional tests in some cases.
Rare subtype of Peritoneal mesotheloma with very poor prognosis associated symptoms

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Introduction:
Mesotheliomas most commonly arise from the pleura, although only 10% arise from the peritoneum. We are presenting rare subtype of peritoneal mesotheliomas that is acting very aggressively and has poor prognosis. By reviewing literature only 3 cases were reported about this type of Mesotheliomas.

Case presentation:
A 75-year-old male presented with abdominal distention. Initial CT of the abdomen revealed multiple mesenteric/intra-abdominal masses with two large masses; one above the left adrenal gland measuring 5.5 x 4.0 cm and other above distal stomach measuring 2.0 x 2.2 cm. CT-guided biopsy of the left adrenal lesion showed Desmoplastic Mesothelioma. Occupational he was exposed to asbestos from working in insulation and served 4 years in the air force

Patient was not a candidate for surgical intervention, so the plan was to start chemotherapy. After 2 weeks, he presented with significant increase in abdominal distention, hyperkalemia and AKI. Subsequent CT of the abdomen/pelvis revealed the development of small amount of ascites around the liver and in the pelvis, as well as the two large masses rapidly increasing in size (left adrenal gland measuring increased from 5.5 x 4.0 cm to 6.5×5.0 and other above distal stomach measuring increased from 2.0 x 2.2 cm. to 5.5×4.0). Chest X-ray did not reveal any suspicion for pleural mesothelioma. The patient received one dose of chemotherapy (Alimta), but his symptoms continued to get worse and developed renal failure with uremia. The patient decided to hospice treatment and stop the medical treatment

Discussion
On review of literature we found two other cases with the same diagnosis. All 3 cases presented similarly with abdominal distension and pain. Also all cases had metastasis to the liver. Our case was different from the other two cases in that he had exposure to asbestos while the other two cases didn’t
On review of the literature, four cases were found, with a mean survival of 6.5-month after diagnosis.
Retrospective study of multiple neoplasms including malignant lymphoma

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[Introduction] A treatment outcome of malignant lymphoma (ML) improved. Opportunities having the second malignant tumor increased after treatment. So we examined multiple neoplasms including the ML.

[methods] In the case that hematologic malignancy was diagnosed in our hospital by 1988 from 2017. We intended for multiple neoplasms 329 cases including hematological malignancy. We reviewed 182 multiple neoplasms including the ML. All patients were followed up until death or until December 2017. Survival was measured from the diagnosis of multiple cancer to time of death or last contact. Definition of the multiple neoplasms was in compliance with Warren & Gates. Also we determined the synchronous type and metachronous type in accordance with the definition of Moertel. So we reviewed and reported about age, gender, kind of hematologic malignancy, type of co-exist malignancies, and the cause of death.

[Result] All cases are 182 cases, consist of male 113 cases, female 69 cases, median age was 70 years, synchronous type 46 cases, metachronous type 136 cases. Double neoplasms 155 cases, triple neoplasms 25 cases, quadruple neoplasms 2 cases. The contents of ML were an non-Hodgkin’s lymphoma (NHL) 175 case, Hodgkin’s lymphoma (HL) 7 cases. Merger malignant disorder of malignant lymphoma is as follows. gastric cancer 45 cases, colon cancer 29 cases, lung cancer 30 cases, prostate cancer 13 cases, esophageal cancer 8 cases, and other 584 cases (including 23 diagnosis). About the cause of death, the death cases were 90 cases, 48 cases deied from ML, 42 cases others reasons. Median survival time, synchronous type was 13M, metachronous type was 15M, The fatal case within one year was 21 cases (60%) in synchronous type, 53 cases (41%) in metachronous type.

[Conclusions] Synchronous type tends with many fatal cases within one year. It must be necessary to investigate co-exist another malignancies before starting therapy.
Risk factors associated with HCC recurrence and occurrence of after achieving SVR: towards the control of HCC

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Background/Aims: Direct-acting antiviral (DAA) treatment can achieve a high sustained virological response (SVR) rate in patients with hepatitis C virus (HCV) infection. However, there still exist cases of hepatocellular carcinoma after SVR achievement (HCC+). The aim of this study was to uncover the factors associated with HCC+.

Methods: A total of 987 patients (434 men, median age: 70 years) who were treated with DAAs (DCV/ASV: 328, LDV/SOF: 304, OBV/PTV/r: 45, EBV+GRZ: 70, and SOF+RBV: 240) were enrolled for comparisons of clinical features between HCC+ and HCC- groups.

Results: Of the 987 patients, 35 (3.5%) were HCC+ and 952 (96.5%) were HCC-. Eighty-one (8.2%) had past history of HCC, therefore, 14 were occurrence and 21 were recurrence of HCC. The SVR rate in HCC+ was significantly lower than HCC- (80% vs. 96%, p<0.001). The rate of past history of HCC was significantly higher for HCC+ (60% vs. 6%, p<0.001). There also were significant differences between the HCC+ and HCC- groups for platelet count (113,000 vs. 150,000 /L, p<0.001), baseline AFP (13.9 vs. 4.2 ng/mL, p<0.001), baseline albumin (3.7 vs. 4.1 g/dL, p<0.001), baseline ALT (45 vs. 36 U/L, p=0.03), ATX (1.64 vs. 1.54 mg/L, p=0.03) and M2BPGi (3.2 vs. 1.8 C.O.I, p=0.001). Multivariate analysis revealed that past history of HCC (HR: 16.3, 95% CI: 7.3-36.5, p< 0.001), age > 70 years old (HR: 2.7, 95% CI: 1.1-6.7, p=0.03) and AFP > 10 ng/mL (HR: 2.4, 95% CI: 1.0-5.6, p=0.04) were independently associated with HCC after SVR. Sub-analysis also elucidated that independent risk factors of occurrence and recurrence were AFP > 10 ng/mL (HR: 6.2, 95% CI: 1.9-20.0, p=0.002) and SVR failure (HR: 5.7, 95% CI: 1.1-28.7), and SVR failure (HR: 5.3, 95% CI: 1.1-25.3, p=0.03), respectively.

Conclusion: HCV eradication should be initiated as early as possible, specifically before complicating HCC. Moreover, Patients exhibiting strong HCC risk factors require vigilant surveillance even after achieving an SVR.
Schwartz-Bartter syndrome - paraneoplastic manifestation of bronchopulmonary cancer

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Introduction.
Schwartz-Bartter Syndrome is translated clinically by water intoxication tableau, associating eating disorders (anorexia, nausea, vomiting) with neuropsychiatric manifestations (euphoria, aggressiveness, mental confusion). Full seizures may then complete the clinical tableau, when plasma sodium drops drastically (<120mmol/l). This syndrome is caused by inappropriate paraneoplastic ADH secretion (SIADH). The main SIADH-associated malignancy is small-cell bronchopulmonary cancer.

Case description
An 63 year-old patient is hospitalized for balance disorders, muscle weakness and nausea, onset dating a week before, with progressive development. Usual tests show low serum sodium levels. With 18 days before, patient had shown repeated vomiting and loose stools for several days, which were remitted as a result of therapy for Helicobacter pylori. During hospitalization, despite administration of sodium chloride 5.85%, serum sodium levels continued to be low (below 125mmol/L), and plasma osmolality levels increased (above 1300mOsm/kg). Chest CT with contrast and bronchoscopy conduced to diagnosis of bronchopulmonary neoplasm with secondary lymph node metastases.

Discussions
The syndrome of inappropriate ADH secretion (SIADH) is suggested by hyponatremia, low serum osmolality and high urine osmolality, or continued excretion of urine sodium, in the absence of other causes of hyponatremia. The main SIADH-associated malignancy is small-cell lung carcinoma (75% cases; the other 25% are non-small cell lung cancer, pancreatic cancer, thymomas).
Solitary and bilateral choroïdal metastasis revealing breast cancer

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Introduction: Breast cancer is complicated by intraocular metastases in 8-10% of cases and these metastases occur most often in patients already known with cancer. Revealing forms are exceptional as well as bilateral involvement. We report an original case characterized by bilateral and solitary (without other visceral or bone secondary locations) choroïdal metastasis revealing breast neoplasia.

Case description: 38 years old patient with no notable medical history presented to a progressive decrease in visual acuity of the right eye lasting for two weeks and suddenly worsened in the last two days. Ophthalmologic examination showed a large detachment of the right retina with retinal infiltrates in both sides. The oculo-orbital ultrasound exam showed the presence of bilateral choroïdal echogenic, well circumscribed, and homogeneous tissular formations. The exploration was completed by oculo-orbital MRI confirming the same findings. Research of the primitive objectified left breast carcinoma. Reviewing other possible metastases was negative. The patient was assigned to radiotherapy but the evolution was unfavorable with worsening of visual impairment and persistence of choroïdal metastases on ultrasound control after one month.

Discussion: An ophthalmologic evaluation with fundus exam may be indicated in the staging of breast neoplasm. In other hand, breast examination should be systematic to the discovery of a choroïdal secondary tumor.
Spontaneous tumor syndrome.

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Introduction: the tumor lysis syndrome (TLS) it’s a rare complication of the chemotherapeutic treatment, but spontaneous cases have been described in patients with hematologic malignancies. It is associated with a massive tumor lysis characterized by hyperkalemia, hyperphosphatemia, hypocalcemia, hyperuricemia and acute renal injury.

Case description: a 43-year-old man was admitted to our hospital with malaise, myalgia and generalized arthralgia. He was obese, a light smoker and was medicated for dyslipidemia. On examination, he had a firm and fixed 4cm axillary adenopathy. Blood analysis identified bicytopenia (anemia and thrombocytopenia), an acute renal injury and elevated inflammatory parameters. During the first day his clinical condition deteriorated and was admitted to the intensive care unit with septic shock with multiorgan dysfunction. At that time the renal function worsened and had to initiate dialysis. Subsequently he developed the metabolic constellation of TLS (hyperuricemia, hyperkalemia, hyperphosphatemia, hypocalcemia and urinary uric acid crystals). We performed an HIV test that was positive and a thoraco-abdomino-pelvien scanner that was normal except for a unique adenopathy at the axillary region with suspicious characteristics. The adenopathy was biopsied and confirmed the diagnostic of Burkitt lymphoma. Hydration, allopurinol, anti-retroviral treatment and a pre-chemotherapy with cyclophosphamide and metilprednisone was initiated with good response and rapid resolution of the multiorgan dysfunctions.

Discussion: the findings of the laboratory features of TLS, should prompt the search for an underlying malignancy. TLS is potentially fatal, thus it’s imperative that clinicians recognize laboratory and clinical findings that suggest the diagnosis and initiate quick and appropriate treatment.
Stroke patients and cancer

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Objectives: To characterize the population with acute ischemic stroke (AIS) of undetermined etiology and observe the presence during or after stroke of cancer as possible pro-coagulant/thrombotic state. Evaluate any relation with recurrence of stroke.

Methods: Retrospective study including patients with stroke of undetermined etiology admitted in the stroke Unit between January of 2015 and January of 2017, aged above 18 years. Clinical data retrieved from databases and analyzed by excel.

Results: A total of 203 patients were included, majority men (51%), with a median age of 75 year (50-92). Most patients had hypertension (76%), followed by hypercholesterolemia (57%), diabetes (27%) and vasculopathy (22%). At the time of AIS 6% had active cancer, of which 38% lung adenocarcinoma, followed by prostatic cancer, with a rate of stroke recurrence of 15%. There were nine cases (4%) of new diagnosis of cancer, mainly adenocarcinoma (55%) of lung, breast, prostate and pancreas. The recurrence of AIS in this last group was 22% vs 6% in non-cancer patients.

Conclusion: Although the limitation of a small sample, there was still an important percentage of patients with AIS of unknown cause that had or were diagnosed with cancer within 1 year (11%). Cancer group appeared to have higher recurrence rate of AIS when compared with non-cancer group. No statistic significance was achieved and further studies must be performed in the area of stroke and cancer patients.
Symptomatic hyponatremia as an initial presentation for small-cell lung cancer

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Introduction: Small-cell lung cancer (SCLC) is frequently associated with paraneoplastic syndromes (PNS), including the syndrome of inappropriate antidiuretic hormone secretion (SIADH), which is characterized by hypotonic hyponatremia (hypoNa) and caused by ectopic secretion of the antidiuretic hormone. Although hypoNa may show in the initial presentation of SCLC, it doesn't correlate with the neoplasm staging or prognosis.

Case description: Male truck driver, aged 49, former smoker of 37 pack-year and quarry worker, with history of anxiety and medicated arterial hypertension. He was admitted to the emergency department for the second time in 3 days, with one week duration complaints of nausea, vomit, headache and dizziness. Beside anxiety he had an unremarkable physical exam. Laboratory results showed a hypoNa of 108mmol/L, without other alterations. An outpatient laboratory analysis from the previous month revealed a sodium level of 117mmol/L. Despite a normal chest x-ray, chest computed tomography showed left paratracheal conglomerating adenopathy, with mass effect on the main left bronchus. The following in-patient study excluded other differential diagnoses for hypoNa. Indirect signs of tumor in the left upper bronchus were found in bronchofibroscopy with confirmation of SCLC in the biopsy and paraneoplastic SIADH was diagnosed.

During hospitalization, treatment was focused on symptomatic improvement with gradual rise on sodium levels after fluid restriction and diuretics. The patient was assymptomatic on discharge, but maintaining hypoNa of 114mmol/L. Out-patient antineoplastic treatment was provided with a rise on sodium levels.

Discussion: In this case, symptomatic hypoNa figured as the initial presentation of SCLC. The authors want to highlight the importance of pursuing the cause of hypoNa, in the possibility of diagnosing a PNS; to show the interesting and complex relationship between SCLC and SIADH and the effect on sodium level in response to treatment.
Synchronous lung and renal tumours: a rare association

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INTRODUCTION:
Patients with cancer may present with more than one primary lesion - multiple primary cancers (MPC), although this is a rare condition. These are called synchronous if diagnosed at the same time or within six months.

CASE DESCRIPTION:
74-year-old male, admitted due to 1 hour evolution dizziness and left visual impairment. Smoker with history of hypertension. During the initial observation, sudden onset of left hemiparesis, left homonymous hemianopsia and neglect. A computed tomography (CT) scan showed a right parietal subcortical lesion with surrounding edema. Treatment with dexamethasone and levetiracetam was started and the patient was admitted to the Internal Medicine ward and an exhaustive study was performed. The magnetic resonance imaging (MRI) confirmed the presence of a secondary lesion; a thoracic-abdominal-pelvic CT showed a spicule nodule in the right lower lobe of the lung and a left kidney mass. After a CT-guided biopsy of both lesions, two primary cancers were confirmed: an acinar adenocarcinoma of lung and a clear cell renal cell carcinoma. The patient has initiated radiosurgery targeted to the cerebral lesion and is waiting for Oncology decision regarding the therapeutic approach of the two cancers.

DISCUSSION:
The coexistence of lung and renal cancer is particularly uncommon. MPC cases are complex, presenting clinically important diagnostic, prognostic and therapeutic challenges, which differ from those present in patients with a single primary tumor. The increased incidence of MPC is a real challenge to the clinicians and clinical attention should be made to avoid misdiagnosis.
T lymphoma after treatment with biological therapy

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Introduction:
Psoriasis is an inflammatory and chronic disease of the skin and joints, with a prevalence between 1-2\% of the population. It has been demonstrated that those patients have a higher risk of developing malignant tumors, existing a direct relationship between the severity of the disease and the risk of tumors. This risk is related to the immunological nature of the disease and to the immunosuppressive treatments used.

Case description:
We present the case of a 29-year-old woman with a personal history of extensive vulgar psoriasis and depressive symptoms, under treatment with Adalimumab, Rivotril and Desvenlafaxine. The patient consulted for back pain after traffic accident, so MRI was performed resulting in herniated discs at the cervical and dorsal levels, without root compromise, and analgesics were prescribed. After several months in treatment, the pain persists and even worsened, so a new MRI is performed, showing lesions of different intensity in different vertebral bodies, iliac blade and multiple retroperitoneal adenopathies. The patient was admitted to Internal Medicine, where soft and rolling supraclavicular adenopathies were palpated. After performing a biopsy, pathologists established: positive tumor cellularity for T-lymphoid markers and negative for B-lymphoid markers with positive EBV PCR, giving the diagnosis of peripheral N-Hodgkin's T-cell lymphoma. The patient initiated chemotherapy with ECHOP scheme, currently in complete clinical and radiological remission after 8 cycles.

Discussion:
The high levels of inflammation maintained over time, added to the overactivity of LT for a long time, with cytokine production, can trigger a dominant clone that causes a lymphoma.
The curious evolution and unusual imaging presentation of a pulmonary adenocarcinoma: challenges posed in the interpretation of thoracic CT.

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Introduction: The appearance of lung neoplasms, especially adenocarcinomas, in areas of lung scarring is well documented in the literature. On the other hand, neoplasms may themselves mimic sequelar lesions, confusing the clinician in the diagnosis.

Case description: 74-year-old male, former smoker, with past history of COPD, emphysema and Pulmonary Tuberculosis in 2006, was referred to the Pulmonology consultation in 2016 for aggravated dyspnea. The functional study revealed a severe obstructive ventilatory defect with a positive bronchodilation test. In thoracic computed tomography (CT), a partial-solid nodular lesion with 46x37mm of diameter was visualized in the left upper lobe. Reviewing the clinical process, the image already existed in 2008, presenting at that time 22x21mm of diameter. The entire lesion has grown over the time, with a significant increase in the solid component, at the periphery. At the latest CT, the solid component presented spiculated margins and the lesion extended to the hilar zone. Bacteriological, mycobacteriological and mycological exams of the sputum were negative, as well as serum precipitins and RAST for Aspergillus fumigatus. IgE levels were in normal range. Bronchofibroscopy did not show macroscopic abnormalities and the microbiological examination of bronchial lavage was negative, however, in the cytology, cellular atypia was found. A transthoracic biopsy was performed and anatomopathological study revealed a pulmonary adenocarcinoma (stage IIIA/cT3N1M0). The patient had no respiratory functional conditions for surgery, so chemoradiotherapy was proposed.

Conclusion: The relevance of the presented case goes beyond its uncommon imaging presentation and evolution over time. The valorization of both the dimensional increase and the modification of the lesion’s characteristics over time allowed to raise the clinical suspicion, motivating the study with biopsy.
The importance of image examination in early diagnosis: case report of a renal cell carcinoma

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Introduction: Renal cell carcinoma (RCC) represents 2-3% of all cancers, with a higher incidence in the West and ages between 60-70 years, more common in men. Etiologic factors: smoking, obesity and antihypertensives drugs. The asymptomatic ones are smaller, of lower stage than the symptomatic ones. Clinically: macroscopic hematuria, palpable mass, varicocele and bilateral lower limb edema. Paraneoplastic symptoms (hypertension, weight loss, fever, neuromyopathy, anemia, elevated sedimentation rate (ESR), abnormal hepatic function) are observed in 20-30% of cases.

Case description: 66-year-old female, autonomous, type 2 diabetic, hypertensive and with recurrent urinary infections (UTI), who went to the emergency department with pain in the right flank, vaginal burning and hematuria. Medicated and discharged. She returns after 1 month, presenting transfixive pain in the dorsolumbar region with extension to lower limb, associated with paresthesia. Abdominal and renal ultrasound raised the suspicion of right kidney cancer. Laboratory: normocytic normochromic anemia, ESR 85 mm/h, UTI to Escherichia coli initiating ciprofloxacin according to laboratory. Computed tomography (CT) of the spine revealed bone metastasis in D8, D9, D12, L3, L5, S1 and S2 confirmed by Bone Scintigraphy. Abdominal pelvic CT: 45 mm right kidney nodule - neoplastic lesion, lytic lesions in the left costal graft and right shoulder blade. Magnetic resonance: confirms bone metastization. Subjected to right total nephrectomy. Histological study confirmed RCC, grade 3 of Fhruman, pT1. Started radiotherapy.

Discussion: More than 50% of the RCC’s are accidentally diagnosed. The classic triad of flank pain, hematuria and palpable abdominal mass is rarely detected, therefore the importance of ultrasound and CT for the early detection of RCC.
The risk of development hepatocellular carcinoma in obese patients with chronic alcohol consumption and long history of C virus infection

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Objectives: We evaluated the effect of association between chronic alcohol consumption, obesity and hepatitis C virus (HCV) infection on risk of develop hepatocellular carcinoma (HCC).
Methods: We studied 88 patients with chronic HCV infection: 59 heavy alcohol drinkers (over 80g ethanol/day for more 10 years) and 29 non-alcoholic patients. The alcoholic patients were divided in two groups: obese patients (A group, 37 cases, BMI>32 kg/sqm) and normoponderal patients (B group, 22 cases). The C group contained 29 non-alcoholic patients in the last 5 years.
Results: At baseline, the mean value of alcohol consumption was: 116.25 g/day in the A group and 124.72 g/day in the B group. After 6 and 12 months, the mean value of AST/ALT ratio was <1 in the A and B groups and between 1 and 1.3 in C group. This level of AST/ALT ratio was maintained for whole period and wasn’t observed differences between normoponderal and obese patients. Sub-unitary AST/ALT ratio was correlated with the presence of histological active hepatitis and exclusively with the presence of the C virus infection. After 12 months, the steatosis was most frequent in the A group (89.19%), B group (68.19%) and C group (55.18%). At 24 and 36 months, the steatosis grade was significantly higher in the A group. The score of fibrosis was more severe in patients with HCV chronic infection and alcohol intake. The incidence of cirrhosis after 3 years was increased in patients who associated obesity with alcohol: 37.83% in the A group, 27.28% in the B group and 17.25% in C group. HCC was developed in 5 cases in the A group, 3 cases in B group and only one case in C group. The association between presence of C virus and alcohol abuse, in patients which developed HCC, was correlated with tumour dimensions, BMI, but no correlation with AFP.
Conclusion: In obese patients, association of the HCV infection with alcohol abuse was correlated with the high steatosis grade and severe fibrosis.
Thymic carcinoma is a rare tumor located on the anterior mediastinum. This neoplasm can be associated with other paraneoplastic syndromes, such as haematological, collagen, autoimmune and endocrine disorders. Myastenia gravis is the most frequent autoimmune disorder associated with benign thymoma.

The authors report the case of a 79 year-old female with hypertension and dyslipidaemia, presenting with cough, dyspnea and unquantified weight loss. Lab tests revealed a normal blood cell count, normal renal function, TSH of 0.00 μUI/L, free T4 of 217.7 nmol/L. The computed tomography scan revealed a cervical mass with 6 x 3.6 x 3.6 cm suggestive of thymic carcinoma, in close contact with the aorta and left pulmonary artery, as well as liver and lung secondary lesions, with no secondary brain lesions. Thyroid ultrasound revealed multinodular goiter. An open surgical biopsy confirmed the diagnosis. Myastenia Gravis was ruled out.

The rarity of malignant thymic carcinomas makes it difficult to find significant associations with other diseases. We report this case in order to raise awareness to the possible similar associated diseases regarding thymoma and thymic carcinoma, as well as the possible immune-mediated process involved in those associations.
Man, 78-years-old, living in Brazil, staying in Portugal in tourism, autonomous. History of Diabetes Mellitus, Hypertension, Chronic Kidney Disease (CRD) (Basal Pcreatinine 2.5mg / dL); Right partial nephrectomy; Transureteral resection of the bladder in 2011; renal biopsy of 2016 with inconclusive result. He went to the Hospital of Braga due to dyspnea for minor exertion, orthopnea and edema of the lower limbs. No palpitations or chest pain, no other complaints. He was not taking other medication except their usual. Pulmonary auscultation had bilateral stasis. Blood analysis showed creatinine 6.3mg/dL; urea 181mg/dL; B-type natriuretic peptide (PBNP) 18858pg/mL; proteinuria 5.88g/24hours. No other changes, especially ionic. Although the whole picture is compatible with an acute renal injury in patients with CKD, of a not fully understood etiology, without functional recovery, possibly in the cardiorenal context, monoclonal gammopathy, autoimmune and viral causes were excluded. It was evaluated by Urology and performed a renal biopsy which demonstrated the presence of tumor recurrence, although the last one did not in any way indicate that this would happen. This was a case of CKD with sustained and rapid deterioration in a hypertensive patient with known nephrotic proteinuria caused by tumor recurrence. He began peritoneal dialysis, recovering the quality of life and autonomy of his daily and leisure activities. This case aims to sensitize clinicians to the use of peritoneal dialysis over hemodialysis, especially in younger patients or even if they are not, presenting a level of autonomy and social interaction that can be maintained even with the implications that the technique can lead to.
Two associated tumors, one rarity

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Introduction: Renal and colorectal tumors are very frequent, occupying the third and sixth place, respectively; although, their simultaneous presentation is rare. The incidence of synchronicity varies from <0.1% to 5% and asymptomatic renal tumors are found in 0.03 to 0.5% of colorectal cancers.

Case Report: The authors present a case of a 72 year old man, with a personal history of chronic alcoholism and previous intestinal subocclusion, hospitalized for portal vein thrombosis. A thoraco-abdomino-pelvic CT scan showed “full thrombosis of the left portal vein, a solid hypercapitating nodule in the left kidney with 2.7 cm, suggestive of neoformative lesion and concentric parietal thickening of the colon at the splenic angle”. He had a colonoscopy that confirmed a stenosing lesion at the splenic angle, a sessile polyp in the proximal descending colon, and two polyps in the distal and right sigmoid. He was submitted to colectomy and nephrectomy at the same operative time. Histology was compatible with adenocarcinoma (pT3pN1b) and clear cell renal carcinoma (pT1a).

Conclusion: Venous thrombosis is a common event in cancer patients, associated with an unfavorable prognosis. The occurrence of these two neoplasms simultaneously is more frequent in elderly age. The association of adenocarcinoma and multiple polyps is questioned as a risk factor for a second cancer and may serve as an alert for this situation.
Introduction: Merkel's carcinoma is a rare and aggressive neuroendocrine tumor of the skin with rapidly progressive evolution. The vast majority occurs in older people, and it has a high rate of relapse and metastization, frequently with a fatal prognosis.

Case Description: Man, 86 years old, independent and without relevant medical history. He was referred to the emergency department for edema and pain of the right lower limb with ten days of evolution, associated with decreased diuresis and erythematous plaque in the right buttock. On observation, he presented edema and warmth of the right lower limb and an erythematous, firm and non-painful lesion on the right buttock. Blood exams showed acute kidney injury without acid-base changes. An abdominal CT was performed and revealed right retroperitoneal and inguinal adenomegalies, a mass in the region of the iliac vessels with ureter-hydronephrosis and a mass in the homolateral wall of the bladder. Patient was hospitalized for study, and undergone surgical excision of the inguinal mass, cutaneous biopsy of the right buttock lesion and cystoscopy. During hospitalization, the edema progressed with consequent incapacity to walk, worsening of the hydronephrosis and kidney injury with a decrease in diuresis. Two weeks later, the anatomopathological exams of the cutaneous biopsy demonstrates a small cell cutaneous neuroendocrine carcinoma, Merkel carcinoma. This case was discussed at a multidisciplinary meeting, where it was decided that given the advanced stage and aggressiveness of the disease, the patient only has indication for palliative measures, having died two weeks after.

Discussion: This case is one of several, in which the primary neoplasm it is not the expected one, being distinguished by the fact that it is a rare, severe and aggressive cutaneous cancer, and whose presentation was not valued by the patient, what made it impossible the early diagnosis and a greater offer of treatments.
Cancer is a known risk factor for deep venous thrombosis (DVT) which may be an early indicator of an undiagnosed cancer. Currently, it is controversial whether patients with unprovoked DVT should be investigated for underlying cancer.

A 55 year old man was admitted with hypochromic microcytic anemia (haemoglobin 3.9g/dL) and a 5 month asthenia. He had no blood losses, fever or other complaints. He had a history 3 months before of a DVT and was medicated with apixaban. He suspended it by his own initiative after 1 month because he attributed the asthenia to this medication. Blood transfusion of 1 unit of red cell concentrate was done and intravenous iron was initiated.

Laboratory results showed no other cytopenias, a normal renal function, LDH 118 U/L, a negative direct antiglobulin test and severe iron deficiency (ferritin 1ng/mL). Blood smear showed anisocytosis, hypochromic and microcytic erythrocytes. Computed tomography scan of thorax, abdomen and pelvis was normal. Video capsule endoscopy was ordered, but it took several weeks to schedule. The patient haemoglobin was normalized with iron therapy, and started low weight heparin, remaining clinically stable and able to resume his usual exercise activities. The video capsule endoscopy revealed a submucosal jejunal lesion, and its biopsy showed a malignant neoplasm. The patient was submitted to a jejunal enterectomy, and a stenosing neoplasm was found.

Secondary anemia due to small intestine cancer is rare (5% of gastrointestinal bleedings), being even less common in this location (1%). The diagnosis is difficult and delayed due to the rareness of these lesions and the non-specific clinic presentation.

The authors stand out the association of DVT and neoplasm, rare in small intestine neoplasms and the fact that symptomatic anemia in a patient taking anticoagulant therapy led to an early diagnosis.
Weight Variability in a Colombian Breast Cancer Retrospective Cohort.

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Background: Breast cancer is the most prevalent malignancy in Colombian women. Weight changes before, during and after the treatment of breast cancer have been related to different outcomes but there is no evidence coming from this Latin American country. We present a descriptive study nested in a retrospective cohort (ONCOCITOS study) that pretends to describe the trend of weight in women with breast cancer during treatment in a local oncology unit registry.

Methods: analyze collected retrospective clinical and sociodemographic data from the records of 575 consecutive patients between 2010 and 2015.

Results: Five hundred an seventy-five women with breast cancer patients were processed, the mean age was 55 years. They were classified as luminal A (39%) followed by Basal-Like (23%) and HER 2/neu + subtype (10%). At the first visit, 31,3% was in the state I, 35% was in state III and almost 10% had metastatic disease. During the surveillance, the distribution in each of those groups changes to 1%, 24,1%, and 21%, respectively. The annual mortality rate was calculated at approximately 5%. Subanalysis of the main study (10% of the total sample), shows that 33,3% of patients were obese at the beginning of treatment. All recurrent disease cases had lost weight in the first year of follow up, and they tended to recover weight in the second year when were found all metastatic cases predominantly affecting bone.

Conclusion: It was found an important change in the cancer staging in this cohort during the surveillance. For the moment there seems to be a trend in weight changes in patients with metastatic disease. This hypothesis is being considered in the main analysis from which this interim data was presented and its expected to conclude in 2019 spring. With the expectative of validating the introduction of cheap and simple metabolic recommendations like weight loss in the breast cancer patient follow up to improve outcomes.
A case of Paroxysmal Nocturnal Hemoglobinuria

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Paroxysmal nocturnal hemoglobinuria (PNH) is a rare acquired clonal hematopoietic stem cell disorder that results in abnormal sensitivity of the red blood cell membrane to lysis by complement. The cellular abnormality is caused by a somatic mutation in a totipotent hematopoietic stem cell. Classically, patients report episodic hemoglobinuria resulting in reddish-brown urine. Besides anemia, these patients are prone to thrombosis and this is the primary cause of death. As this is a hematopoietic stem cell disorder, PNH may appear de novo or arise in the setting of aplastic anemia or myelodysplasia with possible progression to acute myeloid leukemia.

We present a 21-years old man admitted with the complaint of progressive mild fatigue, which began several months ago with no other symptoms. He had no significant past medical history. Physical examination on admission showed no remarkable findings. Blood test showed pancytopenia (anemia with macrocytosis), reticulocytosis and elevated serum lactate dehydrogenase (LDH) with no other abnormalities verified (levels of bilirubin and hepatic function tests were normal, as were results of renal-function tests). Haptoglobin was undetectable. Coombs test was negative and blood smear was normal. The bone marrow showed generalized hypoplasia. Flow cytometry of blood demonstrated deficiency of CD55 and CD59 which confirmed the diagnosis of PNH. The patient already started treatment with eculizumab with improvement on quality of life and reduction on hemolysis, fatigue and transfusion requirements.

Many patients with PNH have mild disease not requiring treatment. In severe cases and those occurring in the setting of myelodysplasia or previous aplastic anemia, allogeneic hematopoietic stem cell transplantation may prove curative. In patients with severe hemolysis or thrombosis the treatment with eculizumab is warranted.

Despite the remarkable progress in our understanding of this disorder, treatment has remained largely supportive.
A case of plasma cell type Castleman’s disease with sustained fever and arthralgia

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Introduction
Castleman’s disease (CD) is multicentric, characterized by fever with chills, anemia, generalized lymphadenopathy and hepatosplenomegaly, and a more aggressive clinical course presentation. This report describes the diagnosis of plasma cell (PC) type CD presenting as stained fever and arthralgia.

Case Presentation
A 69-year-old man reported shoulder pain and numbness malaise from one year and six months prior. He visited our hospital when he became aware of fever. His body temperature (BT) was 38.1°C. Multiple superficial lymph nodes were palpable in the neck, axilla, and groin area. Swelling and pain were found in the joints of the two hands, wrist joints, and both shoulders. Laboratory findings were WBC 11,800/μl, Hb 10.4 g/dl, Plt 387000/μl, CRP 9.43 mg/dl, antinuclear antibody 40 fold, P/C ANCA negative, IgG 3202 mg/dl, and IgG4 154 mg/dl. No abnormal finding was obtained from imaging examination. Lymph node biopsy was performed, revealing follicular cells with large germinal centers and sheet-like proliferation of mature plasma cells positive for IgG and expressed kappa and lambda light chains. No neoplastic proliferation was found. From the IgG4/IgG staining ratio of 5.3% (high power field), we inferred that IgG4-related disease was negative. Serum soluble interleukin(IL)-2 receptors 1190 u/ml and IL-6 801 pg/ml were high. We diagnosed plasma cell (PC) type (CD). From steroid hormone therapy (methylpredonin 500 mg/day), an antipyretic effect was obtained with improvement of joint symptoms by steroid administration, which was decreased gradually. The patient remains under observation with PSL 5 mg today.

Discussion
PC-CD often shows signs of chronic inflammation such as fever, elevated erythrocyte sedimentation, weight loss, and systemic lymph node swelling with arthralgia.
A case of solitary plasmocytoma of axis complicated by obstructive hydrocephalus.

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INTRODUCTION
Plasmocytoma is a proliferative disease of plasma-cells, usually located in the axial skeleton seldom causing medullary compression.

CASE DESCRIPTION
An 84 – year – old man, with a medical history of aortic biologic valve prosthesis and recent atraumatic severe neck pain, was admitted to the ER with high fever, stupor, lower limb palsy and no signs of meningeal irritation. Furthermore, the patient was recently treated with antibiotics for a bacteremia caused by Enterococcus Faecalis. A brain CT scan showed a mild dilatation of the ventricles and a pathologic fracture of the epistropheus with a dislocation of its dens. An antibiotic therapy was started to treat a definite diagnosis of endocarditis. During the second week of hospitalization, the patient’s mental status worsened. An MRI confirmed a progressive enlargement of the ventricles. Unfortunately, the patient passed away, due to hypovolemic shock. An autopsy revealed a massive gastric haemorrhage, as the final cause of death, likely caused by Cushing ulcer, strongly associated with elevated intracranial pressure. Moreover, the microscopic analysis showed that the cervical fracture was caused by a plasmocytoma.

DISCUSSION
This case illustrates difficulties that clinicians meet in the diagnostic process. High fever, hemocultures and the prosthetic valve suggested a bacterial endocarditis, possibly complicated by secondary spondylodiscitis. This scenario did neither perfectly match the laboratory findings, nor the clinical course. The suspect of a solitary bone plasmocytoma is usually based on clinical symptoms and a compatible imaging finding, but the diagnosis remains histologic.
A case of Thrombotic Thrombocytopenic Purpura (PTT): the unpredictable clinical developments

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Introduction:
PTT (also known as Moschcowitz disease) is an infrequent disease related to the severe deficiency of ADAMTS-13, the specific Von Willebrand Factor (vWF) cleave protease. The lack of enzymatic activity forms platelet-rich microthrombi that can embolize and occlude arterioles. In most cases, the mechanism of deficiency is the result of acquired autoantibodies against ADAMTS-13.

Case Description:
A 36-year-old man was admitted to our hospital with some small purpuric lesions at the root of his limbs. He also complained of headache and fever for several days. Blood tests showed low platelets (17000/μL) and anemia (Hb 9.1g/dL), with increased total bilirubin (1.7mg/dl) and LDH (690U/L), the haptoglobin was indosable; all signs are consistent with a hemolytic etiology. Serum creatinine was increased (1.25 mg/dl). The peripheral blood smear highlighted the presence of schistocytes. Thus in strong suspicion that it could be a PTT, we have performed the therapeutic plasma-exchange (TPE) procedure. A few hours after TPE the patient showed confusion, seizures and prolonged loss of consciousness requiring orotracheal intubation. Instrumental control tests did not reveal ischemic or hemorrhagic evidence at encephalic level. In the following days the platelets have increased and we have witnessed a recovery of the patient’s state of mind. Then suddenly, after seven days of TPE there was a new fall in platelet count values, in addition the indexes of hemolysis were significantly raised. We have detected a high titre of inhibitory antibodies of ADAMTS-13 and an enzymatic activity < 5%.

Discussion:
Acute TTP episodes are medical emergencies: despite the therapeutic and resuscitation measures taken, the immediate outcome might not be predictable. Although TPE remains the cornerstone of the treatment, the addiction of Rituximab in the recurrences of thrombocytopenia, appears to be associated with a better prognosis and with a reduction in long-term relapses.
Introduction: The association of pernicious anemia (PA) with multiple myeloma (MM), still characterized as unusual, is a true diagnostic and therapeutic challenge for the clinician and underlines the particular carcinogenicity of pernicious anemia. We report a case.

Case description: Tunisian patient aged 75 years with no medical history, was admitted to our clinic for evaluation of a bicytopenia: anemia 7.8g / dl with macrocytosis (MCV=109μ3) and thrombocytopenia 58,000 / mm3. The diagnosis of PA was selected (positive anti intrinsic factor antibodies, chronic atrophic gastritis and vitamin B12 plasma collapsed) and the patient put under Vitamins B12 intramuscularly at a dose of 1000μg / d. Erythrocyte count control after ten days of vitamin therapy did not show reticulocyte crisis. The myelogram was then performed objectifying, next to signs of pernicious anemia significant plasma cell infiltration estimated 55% made of dystrophic plasma cells. The plasma protein electrophoresis, urine tests and radiological assessment had concluded at MM IgG kappa stage IIIA associated with the PA and the patient was transferred to hematology therapeutic management adapted.

Discussion: As rare as it is, this association deserves to be known saw its therapeutic and prognostic implications. The search for a monoclonal immunoglobulin seems useful prior to initiation of treatment with vitamin B12 during a pernicious anemia.
A rare case of an afebrile patient with pancytopenia and hepatosplenomegaly: a diagnostic challenge

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Introduction

Leishmaniasis is a vector-borne zoonosis with variable clinical presentations. We present an interesting case of visceral leishmaniasis (VL) in an afebrile patient with rheumatoid arthritis presenting with hepatosplenomegaly and pancytopenia.

Case description

A 73-year old Caucasian man, with a history of rheumatoid arthritis under current medication with methotrexate (10mg per week) and adalimumab for the last 3 years, was admitted to our clinic due to progressive worsening of fatigue, weight loss and abdominal tension for the last 5 months. He was recently diagnosed as an outpatient patient with pancytopenia. He was afebrile and physical examination was unremarkable apart from hepatosplenomegaly. Blood chemistry revealed pancytopenia, hypergammaglobulinaemia and elevated inflammation markers. During the first day of hospitalization the patient had two febrile waves up to 38.8°C. The blood and urine cultures did not isolate any pathogen. The patient's tests for HIV, HBV and HCV were negative. No signs of portal hypertension were found, while liver transient elastography revealed no signs of cirrhosis. A bone marrow biopsy was performed with several intracellular and extracellular Leishmania parasites visualized directly in Giemsa-stained bone-marrow aspirate. Anti-K39 antibody was positive and the title of anti-Leishmania antibodies was 1/3.200. The patient was started on liposomal amphotericin B for five days. One month after his discharge, he is asymptomatic with normal blood count.

Discussion

Visceral, cutaneous and mucocutaneous types of leishmaniasis can emerge, depending on the Leishmania species and immune responses of the host. Atypical presentation of VL in a nonendemic area is always a diagnostic challenge.
A rare case of autoimmune hemolytic anemia

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INTRODUCTION:
Autoimmune hemolytic anemia is an acquired disorder characterized by immunologic destruction of red blood cells (RBCs) mediated by autoantibodies. The cold type is the least common, accounting for 30% of all cases.
Cold hemagglutinin disease (CHAD) is characterized by the presence of clinical symptoms triggered by low temperatures, hemolytic anemia, and antibodies directed to antigens on the RBCs surface.
CASE DESCRIPTION
A 43-year-old man presented with dyspnea, palpitations, jaundice and mucocutaneous paleness. Blood tests confirmed hemolytic anemia (HA) with hemoglobin (Hb) of 4.2 g/dL, increased reticulocyte count, low serum haptoglobin and elevated bilirubins. The blood smear was also compatible with HA and the direct antiglobulin test was highly positive for IgG.
Treatment for CHAD was initiated with a metilprednisolone pulse but Hb decreased to 3.1 g/dL. After an emergency blood transfusion, treatment resumed with 4 additional metilprednisolone pulses and prednisolone 1 mg/kg/day.
The patient denied previous drug consumption, blood transfusions, recent travels and other relevant epidemiological context. Additional study, including screening for cancer, infectious and other autoimmune disorders was negative with the exception of a positive IgG and IgM for Herpes Simplex Virus 1 (HSV1).
The patient showed favorable response to treatment with remission of all symptoms and an Hb of 12 g/dL. He was discharged 30 days after hospital admission with a tapering dose of steroids, folic acid and gastric protection.
DISCUSSION
CHAD is a rare entity with an incidence of one case per million people per year. Usually it is caused by IgM autoantibodies, but in this case it was positive for IgG antibodies, which occurs in approximately 25% of all cases.
Systemic autoimmune disorders, viral and mycoplasma infections and lymphoproliferative disorders must be excluded. In this case, serum IgG and IgM for HSV1 were positive – a possible trigger for secondary CHAD.
A rare cause of anemia

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Introduction: Secondary hemolytic anemia to carbidopa-levodopa intake is a rare side effect, with only few cases described in literature. Less frequently, non-hemolytic anemia cases were found. This case reports a non-hemolytic anemia secondary to carbidopa-levodopa intake.

Case description: An 87-year-old woman with a history of previous uncontrolled Parkinson's disease medicated with primidone initiated carbidopa-levodopa. Initially, she presented an 11.9 g/dL hemoglobin (Hb). A month later, the patient presented to the Emergency Department (ED) with a symptomatic normocytic normocromic anemia (Hb 5.9 g/dL), with no bleeding history. No abnormalities were found on upper digestive tract endoscopy and red blood cell transfusion was performed. The next month, the patient returned to the ED with symptomatic anemia. She was admitted to undergo further diagnostic testing. It was found to be an hypoproliferative anemia, with leucopenia (2500/uL), and a slight folic acid deficit. Neither iron deficiency nor hemolysis criteria were found. Colonoscopy was normal. The hypothesis of secondary anemia due to carbidopa-levodopa toxicity was considered, and it was suspended. At the time of discharge, the patient’s white blood count had normalized, and red blood cell count significantly improved (Hb 8.2g/dL). Four months after suspension, the patient presented an Hb of 11.3 g/dL.

Discussion: This case reports the strict association between carbidopa-levodopa therapy and a secondary hypoproliferative non-hemolytic anemia, after excluding other causes of anemia, with complete resolution after treatment suspension. Although this is a rare association, it should be kept in mind after exclusion of more frequent causes of anemia.
A Rare Cause of Asymptomatic Hypereosinophilia: Fasciola Hepatica

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Introduction: Fasciola hepatica (FH) is a zoonotic liver trematode and is frequently observed in temperate climate subtropical regions. People take fasciola metacercariaes by eating uncooked freshwater vegetables. As it may be asymptomatic, it may be seen in abdominal pain, nausea, vomiting, weight loss. FH serological tests are positive in all patients. Hypereosinophilia and IgE elevation are expected in laboratory. The imaging methods help diagnose.

Case Description: A 58-year-old woman without medical history was admitted to our hospital pruritus only when she is stressed. A laboratory investigation showed leukocytosis (13400/μl), eosinophil (4180/μl). Eosinophil was detected in 15% of the peripheral spread. IgE: 3920IU/ml. Allergen food and inhalant panel was negative. Stool microscopy and culture were normal. PDGFR-α, β genes were studied and no mutation was detected. Abdominal Computed Tomography (CT) was performed. There were geographically patterned, multicentric, reaching the largest diameter of 4 cm, silky limited, hypodense areas of liver left lobe that suggested parasitic infection and we sent FH IgG that was 1/2560. Two doses of 10 mg/kg triclabendazole were given for 1 week. At 6 months follow-up, improvement in FH IgG titer and clinic was observed.

Discussion: FH is zoonotic and parasitic infestation. Multiple nodular lesions similar to the microabscesses and the geographical appearance on CT and magnetic resonance imaging are the most important findings. Triclabendazole 10 mg/kg single dose 2-4 weeks later again 2 days triclabendazole 10 mg/kg used in medical treatment.

Consequently, FH is a rare parasitic disease. Clinical presentation may be asymptomatic but may be noisy, such as abdominal pain, weight loss, pulmonary infiltrate with ascites, ascites, bile duct obstruction, bilateral obstruction, ascending cholangitis, acute pancreatitis, ascites, hepatic subcapsular hemorrhage.

Therefore, FH should be kept in mind in every patient who has hypereosinophilia in their asymptomatic investigations.
AA amyloidosis associated with Non-Hodgkin Lymphoma

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INTRODUCTION: AA amyloidosis is a disorder characterized by the extracellular tissue deposition of fibrils that are composed of fragments of and/or intact serum amyloid apolipoprotein A. AA amyloidosis may complicate any chronic inflammatory condition, including rheumatoid arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, inflammatory bowel disease, familial periodic fever syndromes, chronic infections, and certain neoplasms. Furthermore, HIV infection is associated with increased risk of Non-Hodgkin lymphoma.

CASE DESCRIPTION. A 45 year-old caucasian man, diagnosed in 1999 with HIV infection and HVC infection, presents at the hospital with peripheral oedema, epigastric pain and asthenia. Blood tests revealed moderate leukocytosis with elevated C-reactive protein and acute kidney injury with a BUN of 140µmol/L and a creatinin of 5mg/dL. Urine tests revealed proteinuria of 4.2g/dL, without hematuria and leukocytosis. Patient need to start hemodialysis 4 weeks after the start of nephritic syndrome, and remained on it, without regression to a normal kidney function. The patient had a reasonable immunological state with a CD4 count of 620cells/mm³. Upper endoscopy showed a nodular pattern at the duodenon that were biopsed and revealed AA deposition. CT-scan revealed lombo-aortic adenopathies.

DISCUSSION: HIV infection is a multisystemic disease that has been associated with non-hodgkin lymphoma (NHL). This case represents a nephrotic syndrome with AA amyloid deposition subsequent to NHL. This case highlights the importance of recognizing and addressing HIV as a multi-systemic disease. It also reinforces the possibility of AA amyloidosis as a secondary manifestation of NHL with a quick pass to hemodyalisis.
ABDOMINAL RECTUS SHEATH HEMATOMA An increasingly frequent diagnosis of iatrogeny by Low Molecular Weight Heparin

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Well-known adverse effects of Low Molecular Weight Heparin (LMWH) include gastrointestinal, intracranial and retroperitoneal haemorrhage and thrombocytopenia. Abdominal sheath hematoma is a rare complication that may be spontaneous or associated with trauma/anticoagulation. The casuistry is limited but suggests an association with therapeutic doses of LMWH, especially among "medical", elderly females. Case report: a 77-year-old woman went to the emergency room for lipotimia. She reported generalized abdominal pain in the previous days. Also, she recently had acute tracheobronchitis, with frequent coughing. Medicated with warfarin due to recent tricuspid valve bioprosthesis implantation, her anticoagulation therapy had been altered 5 days prior to enoxaparin because she had a knee arthroplasty scheduled. The examination identified a tense abdomen and tenderness on hypogastric palpation. Analytically: Hemoglobin 6 g/dl and acute renal injury. Computed tomography showed an extensive hematoma of the left rectus abdominis (10x23cm). Anticoagulation was discontinued. Due to hemodynamic instability, the patient was admitted to intermediate care unit and transfused with red cells. After 4 days she was transferred to the ward where clinical, analytical and imagiologic evolution continued to be favourable. Abdominal rectus sheath hematomas can mimic several acute abdominal pathologies. Most are treated conservatively while invasive approaches are reserved for hematoma progression or hemodynamic instability despite adequate resuscitation. Although most hematomas are self-limited, they can have significant morbidity with a mortality rate of 4%. In the anticoagulated patient, mortality is higher (25%) due to larger hematomas and advanced age/more comorbidities, making high clinical index of suspicion of the utmost importance.
Abdominal Splenosis Mimicking a Colon Tumor

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Introduction: Splenosis is one type of ectopic splenic tissue. It is an acquired condition and is defined as autoimplantation one or more focal deposits of splenic tissue in various compartments of the body after spleen trauma or splenectomy. Although it is not an uncommon disease, it is often misdiagnosed as malignant tumors what can lead patients through unnecessary operations with high morbility.

Case Description: We report a case of a 57-year-old male patient with past history of a splenectomy due to trauma at 21 years of age. He went to the Urology first consultation for benign prostate hyperplasia and there the medical doctor performed a digital rectal exam and noticed a mass with approximately six centimeters, above the anal margin. To enlighten this mass the patient made an abdominal and pelvic CT that described a mass between the bladder and without a cleavage plane with the rectosigmoid junction wall. At this time it was thought that the mass was an intestinal tumor. A colonoscopy was performed and it was normal. Therefore the patient underwent a MRI that referred that considering the patient's past history it should be consider splenosis as the etiology. To confirm this finding it was made a scintigraphy with (99m) TC labelled heat-denatured erythrocyte that showed multiple sites of erythrocytes abnormal accumulation in the left side that was compatible with ectopic splenic tissue.

Discussion: Splenosis is a benign finding and is the greatest importance to distinguish this condition from more sinister pathology. Like proved in our case, it is a very difficult diagnosis and sometimes the correct one is only made after surgery.
Acquired hyperpigmentation in pernicious anemia

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Objective: The Biermer’s anemia may sometimes have a pseudo-addisonian form with digestive manifestations, weight loss, hypotension and melanoderma. The exact mechanism of hyperpigmentation in pernicious anemia is still unclear. The aim of this study is to describe this skin involvement during pernicious anemia. Methods: Retrospective and descriptive study was done in the Internal Medicine department of Fattouma Bourguiba University Hospital in Monastir (Tunisia) from 2008 to 2017, including 66 patients diagnosed with pernicious anemia. Acquired melanoderma was found in 8 patients (12.1%). Results: The study includes 4 women and 4 men. Mean age was 53.88 years ± 19.73. Hyperpigmentation was diagnosed at the same time with pernicious anemia (100%). On examination, all patients presented significant weight loss, along with epigastralgia (62.3%), dyspnea (37.5%), and sensitive/motor manifestations (26.3%). Melanoderma was whether diffuse (50%) or localized (50%): in the face, hands and flexion areas. Other skin and mucosal manifestations were noted: Hunter glossitis (n = 3), hair loss (n = 2), brittle nails (n = 1), and perleche (n = 1). Anaemia was severe (mean Hb was 6.4 g/dl). Mean level of vitamin B12 was 86,73 pmol/l. Both intrinsic factor and anti-parietal cell antibodies were positive in (37.5%). Hyperpigmentation was related to adrenal deficiency in 3 cases. Conclusion: Acquired hyperpigmentation, although suggestive of Addison disease, is not unusual during pernicious anemia, and it may sometimes be revealing. Its discovery should encourage the clinician to detect this anemia at an early stage, to avoid its complications especially neurological ones.
Introduction: Iron deficiency anemia is a great burden due to both nutritional and infectious etiologies in African settings. Parasitic diseases lead to both extracorporeal iron loss and anemia of inflammation. Case report: a 67 years old women, with hypertensive heart disease and iron deficiency anemia due to digestive hemorrhage, admitted due to aggravation of the anemia (Hb 5.9 g/dl). The upper digestive endoscopy revealed gastropathy of the antrum, erythematous duodenitis and multiple parasites on the intestinal and duodenal histology compatible with gastroduodenitis associated with parasitic infection. She received blood transfusion, intravenous iron and albendazole. Analytically on the time of discharge: Hb - 9.2gr / dl.

Discussion: the causes of anemia in the developing world are multifactorial and include nutritional deficiencies, extra-corporeal blood loss, higher prevalence of hemoglobinopathies, and inflammation. Soil-transmitted helminths (STH), are very common in our environment. The development of hookworm-related iron deficiency anemia depends on the level of an individual’s iron stores, the intensity of infection, and the infecting species. Blood loss is caused predominantly by parasite release of coagulases, causing ongoing blood loss in the stool, rather than actual blood consumption by the parasite. The association between hookworm infection intensity and increasing age has serious implications for women. Iron-deficiency anemia resulting from chronic intestinal blood loss due to hookworm infection often causes long-term morbidity.
An infectious cause of autoimmune hemolytic anemia in an elderly patient with urinary bladder cancer: could there be a hidden relationship?

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Introduction: Cold agglutinin-induced anemia has already been known to be associated with solid tumors, while it is considered a rare complication of Mycoplasma pneumoniae infection. Herein we present an interesting case with known bladder cancer, who developed autoimmune hemolytic anemia.

Case description: An 81-year old Greek man, with recently diagnosed metastatic urinary bladder cancer, was admitted to our clinic due to progressively worsening fatigue. He was afebrile and laboratory studies confirmed the presence of cold agglutinin-associated anemia (Hb=4 mg/dl) and positive direct Coombs test, while serological tests revealed acute Mycoplasma pn. infection and elevated inflammatory markers. The patient received multiple red blood cell transfusions and corticosteroids, as well as antibiotic treatment with azithromycin for five days and showed significant clinical response.

Discussion: Although subclinical cold agglutinin-induced anemia in the setting of Mycoplasma pneumoniae infection is well defined, only few cases of anemia requiring transfusion have been reported. Mycoplasma infection has been also associated with prostate cancer development, implying that prolonged infection may confer to the malignant transformation of the benign prostate cells. However, this is the first case presented with an association between urinary bladder cancer and Mycoplasma infection so far.
Hematology
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An unusual cause of agranulocytosis

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Introduction: Agranulocytosis is a rare side effect of antithyroid drugs, appearing only in 0.35% of patients. It mainly affects individuals over 40 years of age and usually appears within the first 90 days after starting treatment. This is a dose-dependent phenomenon, is ten times less frequent in subjects at low doses (below 15mg/day).

Case report: The authors present a case of an 82 years old woman diagnosed with primary hyperthyroidism, medicated in the 150 days before went to the emergency service with 30 mg of thiamazole daily. At the admission she presented a clinical condition characterized by odynophagia and progressive dysphagia; on objective examination, lesions compatible with candidiasis were found on the hard palate; analytically highlight neutropenia (approximately 100 neutrophils/L). She was hospitalized for diagnostic and therapeutic guidance. Thiamazole was suspended and initiated GCSF (granulocyte colony stimulating factors - Filgastrim®), intravenous antifungal and analgesic control. The hospitalization lasted for 21 days, with symptomatic and analytical improvement, with resolution of oral lesions.

Conclusion: Currently there is no cost/benefit in monitoring the count of granulocytes in individuals receiving antithyroid therapy. Treatment with GCSF factors did not alter the high morbimortality rate associated with these cases, contributing only to a shorten hospitalization time. The previous diagnosis of infectious processes are rarely recognized in these situations, witch contribute to a unknown mechanism.
Angioimmunoblastic T-cell lymphoma: the diagnostic challenges of a case of autoimmune hemolytic anemia

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Introduction: Angioimmunoblastic T-cell lymphoma (AITL) is a rare form of non-Hodgkin lymphoma that arises from follicular T-helper cells. It has an intricate relationship to Epstein-Barr virus (EBV); some data suggest it may play a role in the pathogenesis of the disease. AITL may relate with immune phenomena. Warm autoimmune hemolytic anemia (AIHA) is an uncommon initial presentation of this disorder.

Case description: A 72-year-old male presented with a 3-month history of recurrent fever, asthenia, anorexia and weight loss, associated with dyspnea and peripheral edema in the last week. At examination, he was pale and anasaric, with cervical, axillary and inguinal enlarged lymph nodes. Laboratory tests showed anemia (7.9 g/dL) with 19% reticulocytes, lactate dehydrogenase >600 U/L, low haptoglobin and positive direct and indirect antiglobulin tests, which was consistent with AIHA. A monoclonal gammopathy IgG/kappa was present. Tomography revealed peripheral, mediastinal and retroperitoneal lymphadenopathies, hepatosplenomegaly and bilateral pleural effusion. An axillary lymph node biopsy showed morphologic and immunophenotypic features of AITL, with associated proliferation of immunoblastic B cells CD30+ with active EBV infection. Bone marrow was normocellular, with a myeloid:erythroid ratio of 3:1 and absence of atypical lymphocytes. Diagnosis of AITL stage IV was made, with prognostic features of high risk (age >60, performance status >2, extranodal disease and B symptoms). Patient was started on steroid therapy (prednisolone 1 mg/Kg) with improvement of AIHA, and later on chemotherapy (cyclophosphamide, doxorubicin, vincristine and prednisone).

Discussion: In this report, we present a case of AITL which presented as AIHA. This disorder has an aggressive behavior with a poor 5-year survival; although complete remission can be attained, relapse is frequent. Early diagnosis and addition of novel agents to standard chemotherapy may reduce primary refractory disease.
Introduction and case description
A 73-year-old male hypertensive was admitted to the hospital due to dyspnea, inter-scapular pain and edemas in lower limbs that did not improve with diuretics. Examination manifested rhythmic heart tones with bi basal lung crackles, no palpable lymphadenopathies and no fever. The electrocardiogram showed right branch block. The first analytic indicated thrombocytopenia, mild renal insufficiency, high LDH and natriuretic peptide levels. Chest x-ray showed right pleural effusion. Echocardiography was not executed because of poor acoustic window. Coronary angiography was performed. Right coronary artery was revascularized without clinical improvement. A CT was made due to the pleural effusion which showed a right atrium mass invading paracardiac fat, pericardium and right ventricle. Additionally, an osteolytic lesion in the ninth right rib was observed. Cardiac MRI indicated myocardial and pericardial invasion. The biopsy of costal lesion showed diffuse large cell non-germinal center lymphoma. PET confirms stage IV-B.

Discussion
The cardiac involvement by lymphomas is not exceptional but the onset with cardiological symptomatology is very rare. Echocardiography establishes a suspicion of a cardiac tumor. CT and MRI will establish the morphology and extension. The prognosis is ominous since cardiac involvement usually refers to advanced stages of aggressive lymphomas subtypes.
Autoimmune Hemolytic Anemia (AIHA) can occur by two distinct mechanisms: presence of direct antibodies against red blood cells (RBCs) or antibodies with affinity for a molecule culminating in erythrocyte destruction/damage. AIHA is slightly more common in women and it is particularly more frequent in middle-aged individuals or elderly. Left untreated, the mortality rate of this condition reaches 10%. Its initial presentation is usually abrupt and dramatic.

We present a case of a 67-year-old woman with previous diagnosis of hypertension, chronic gastritis, vertigo and depressive disorder. She was admitted to the emergency department with complaints of fatigue, anorexia and gastric and chest discomfort with progressive worsening since the beginning of these symptoms 1 month before. The patient denied weight loss, night sweats, nausea or vomiting, and genitourinary symptoms. She had no fever, jaundice or itching. The patient was found to have a severe anemia (with a haemoglobin of 6.9 g/dL). Electrocardiogram showed no signs of ischemia and her chest X-ray had no abnormal features. The thoracoabdominal CT scan was unremarkable. Other procedures (bronchofibroscopy, upper and lower GI endoscopies) revealed no pathologic features.

From our extended etiologic study, we highlight a positive direct Coombs test and significantly increased reticulocyte count. In terms of immunological study, complement factors C3 and C4, ANAS, rheumatoid factor and anti-CCP were negative.

The patient started in-hospital corticosteroid therapy with a delayed but sustained response. Currently, the patient has stabilized her hemoglobin concentrations by controlling immune-mediated hemolysis. The next step consists of steroid withdrawal.

With this case report the authors intended to demonstrate the difficulty of exclusion of malignant pathology in these cases, in order to initiate the so needed corticosteroid therapy.
Axillo-subclavian vein thrombosis and Thoracic Outlet Syndrome: A case of Paget-Schroetter Syndrome

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Introduction: Upper extremity deep vein thrombosis (UEDVT) is an uncommon condition, representing only 1 to 4% of all deep vein thrombosis (DVT). Thoracic Outlet Syndrome (TOS) describes the spectrum of UEDVT resulting from compression of neurovascular structures passing through the thoracic outlet. TOS encompass three main subtypes, of which the axillo-subclavian effort-induced vein thrombosis, also known by Paget-Schroetter Syndrome (PSS), accounts for 20% of all UEDVT. This syndrome is more commonly seen in young, active and healthy patients with a male to female ratio of 2:1.

Case Description: A 27-year-old woman, previously healthy, presented with sudden onset of pain, swelling and limitation of movement of the left arm during heavy upper extremity exercise. The patient reported a past history of Raynaud phenomenon and paresthesia of the left hand fingers. History of oral contraceptive use was known. Examination demonstrated an edematous, warm and red-coloured left arm with visible collateral circulation starting from the upper left anterior chest wall and shoulder. The ultrasound revealed acute DVT of the left subclavian and axillary veins. The DVT was confirmed by computed tomography angiogram of neck and chest, which revealed a diminished left costo-clavicular space resulting in venous compression. Treatment with low-molecular-weight heparin was initiated promptly, followed by gradual clinical recovery. The left Adson, Wright and upper arm Tinel tests were positive. Thorough thrombophilia and autoimmunity studies were negative. Nailfold capillaroscopy revealed long-lasting secondary Raynaud Syndrome. The patient was evaluated by Thoracic and Vascular Surgery Consults and awaits for decompression surgery while on anticoagulant treatment.

Discussion: Nonetheless the rarity of PSS, this diagnosis should be kept in mind when an UEDVT occur, especially in young, active and previously healthy subjects, with no other evident risk factors for DVT.
Bone marrow aplasia in a patient with cutaneous porphyria.

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Introduction:

The aplasia is a disorder characterized by a syndrome of medullar insufficiency, presenting bone marrow's hypocellularity. It can be acquired, but on most cases is from congenital etiology. Porphyria derives from enzymatic deficiency in heme synthesis and have varied clinical forms and manifestations.

Case report:

A 29 years-old man, brown, drug user, presents since his childhood skin bullous lesions, non-pruritic, with bloody contents, no scars. The lesions had intermittent character, getting worse after sun exposure and alcoholic libations. He presented his teeth in poor state of conservation and evolved with fever, gingivorrhagia and weight loss and the hemogram attested pancytopenia. He was submitted to skin biopsy and the histopathologically was compatible with porphyria, besides positive urine porphyrin screening and bone marrow biopsy with hypocellular material for the age, exhibiting about 5% of cellularity with rare erythroid elements and granulocytes compatible with aplasia of bone marrow. It was researched several causes of medullary aplasia, such as viral infections, autoimmune mechanisms, and clonal and genetic disorders and all of them were negative. Patient presented several episodes of febrile neutropenia and bleeding, necessitating multiple blood transfusions and antimicrobial schedules. At the time, his sisters were evaluated as possible donors of bone marrow, without compatibility. Then, he was subscribed in International Bank of Bone Marrow (REREME) and got clinical and transfusion support. He evolved with febrile neutropenia, unresponsive antibiotic therapy, resulting in death.

Conclusion:

The reported case shows a complex situation, which two rare diseases (Plastic Anemia and Porphyria Cutanea Tarda) developed concomitantly, leading to the discussion of therapy of two diagnoses without correlation and evidence in the literature of similar cases.
CASE SERIES. Acute splachnic vein thrombosis in patients without cirrhosis or malignancies.

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Acute splachnic vein thrombosis (ASVT) is defined as a thrombosis of the major vessels of the abdomen, with symptoms for less than 60 days and no cavernomatosis or portal hypertension. It’s clinical spectrum goes from an asymptomatic patient to acute abdominal pain with intestinal ischemia when mesenteric circulation is affected. It is often associated with cirrhosis and malignancy. We present a case series of ASVT without these predisposing factors to drive attention on this challenging diagnosis.

OBJECTIVES: Describe the clinical findings, time until diagnosis and causes.

METHODS: observational, descriptive and retrospective. We select patients from the Internal Medicine inpatient unit from our hospital between 07/2017 and 04/2018 with ASVT diagnosis at discharge and review their medical charts. Inclusion criteria: less than 60 days of symptoms, diagnosis by abdominal CT with IV contrast or angiography. Exclusion criteria: cirrhosis and malignancies.

RESULTS: We found 4 cases. Median age 34 (range 19-46), female/male 1:1. The average time to consult was 11,5 days. The median time from admission until diagnosis was 14 days. Abdominal pain was the cardinal symptom described as generalized and of high intensity. Two patients had fever, nausea or vomit. The most frequent test findings were hyperbilirubinemia, splenomegaly and ascites. The location of thrombosis was: superior mesenteric vein (n=2), portal vein (n=2, one extended to mesenteric and splenic veins). One from three patients with mesenteric compromise, had intestinal ischemia and required resective surgery. All patients were assessed for thrombotic risk factors. We found a case associated with oral contraception, one pylephlebitis, an heterozygous prothrombin gene mutation and a case of undetermined cause. All cases were discharged with anticoagulation treatment; two required antibiotics.

CONCLUSIONS: ASVT is an heterogeneous disease that should be suspected even in the absence of cirrhosis and malignancies.
Case-by-case Analysis of Red Cell Concentrate Transfusion in Hospitalized Patients in a Districtal Hospital

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Objectives
The main goal of this work was to analyse the requests for red cell concentrate transfusion in a six-month period in order to make a protocol guiding transfusions in the studied hospital.

Methods
Retrospective study of patient files submitted to red cell concentrate transfusion in the 4 areas of admission of the studied hospital.

Results
171 episodes of red cell concentrate transfusion were analysed, corresponding to 110 patients, 60 women and 50 men, mean age of 76.94 years (maximum of 96 and minimum of 17). The mean value of haemoglobin was 7.45 g/dL (maximum of 13.6 and minimum of 4.4). The patients admitted in the Internal Medicine Service were responsible for 85.45% of all red cell transfusions, followed by the Orthopedics with 39.09%, then by the General Surgery with 30.90%, and finally by the Pediatrics with no transfusions registered (0%). The clinical reasons that motivated transfusions differed between the different hospital specialties. The number of units transfused depended on the etiology of anaemia and on how suddenly it started. On average, it was transfused 1 unit of red cell per episode of transfusion, in order to increase haemoglobin to greater than 9 g/dl. It was not always possible to evaluate the transfusion profitability because there was no further blood tests. No adverse reactions were documented in the studied period.

Conclusion
It is a well-known fact that transfusion therapy is fundamental to the treatment of patients with many severe diseases. Nowadays, in many hospitals, therapy with red cell transfusion is commonly used, so it is necessary to establish a protocol that rules the use of transfusions, given its shortage and high costs. Other than that, this therapy should be used in a responsible way, as it can be harmful to patients. Drawing up guidelines is crucial to standardize decisions and contributes to good clinical practice, always taking into account a patient-centred approach.
Casuistry of Platelet Concentrate Pool transfusion in an Hospital

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The objective of this study was to analyze and describe the epidemiological characteristics of platelet transfusion requests in a period of 6 months (second half of 2017), and to elaborate a transfusion orientation protocol for implementation in the Districtal Hospital studied.

Retrospective and statistical analysis of the clinical processes in electronic format of patients undergoing platelet concentrate pool (PCP) transfusion at the District Hospital studied.

The clinical charts of 6 patients were analyzed, for a total of 15 platelet transfusion episodes, 1 female and 5 male, mean age 67.67 years (maximum 91 and minimum 49). On average, patients had a platelet value of 28,735/mm3 (maximum of 65,000 and a minimum of 1,000) and hemoglobin of 9.81g/dL. In 2 episodes there was a need for PCP support associated with erythrocyte concentrate. In a significant number of episodes transfusion of PCP did not meet criteria. No post-transfusion control was performed in 1 patient, and in the remaining there was 100% profitability. The motives for transfusion were mostly to prevention of bleeding.

The transfusion of Platelet Concentrate Pool can be life-saving in certain clinical situations in thrombocytopenic patients. There are limited alternatives to PCP transfusion for the acute treatment of thrombocytopenia associated with bleeding. The decision to transfuse is an act of medical responsibility and should be based on the clinical and laboratory evaluation of the patient.

The criteria for blood products transfusion are vast, so it is essential to develop a protocol for easy consultation and guidance.
Cauda equina syndrome as a rare form of presentation of diffuse large B-cell non-Hodgkin lymphoma.

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The involvement of the spinal cord and cauda equina is a rare clinical expression in non-Hodgkin lymphomas. The authors report a case with this particular initial presentation of the disease. A 78-year-old male patient was admitted complaining of paraparesis for two days. He had a history of diabetes, hypertension and dyslipidemia, and was appropriately medicated. We determined a grade 3 paraparesis (grade 2 hip flexion, grade 3 knee flexion, grade 3 knee extension and grade 1 dorsiflexion of the feet), reduced protopathic and epicritic sensitivity up to upper thigh (maintaining epicritic sensitivity below the knees), reduced patellar and Achilles reflexes and absent plantar reflex in both lower limbs. CT scan and MRI showed a prevertebral large soft tissue mass at the level of L5, invading the vertebral body bone marrow from L5-S2, the foramina, spinal canal and epidural space, resulting in collapse of the dural sac and compression of the cauda equina’s roots from L4-S2, without compressing the conus medullaris between L2-L3. There was no destruction of the vertebrae associated. The biopsy of this mass revealed a diffuse large B-cell non-Hodgkin lymphoma of germinal center, positive for CD20, CD79a, bcl-2 e CD10 and negative for CD3, CD5 e cyclin D1.

Spinal cord compression as a first symptom of non-Hodgkin lymphomas is extremely rare (0.1 to 3.3%) and cauda equina syndrome is rarer. It can occur in the context of meningeal infiltration, intravascular lymphomas or as a result of an extrinsic soft tissue mass, as in the present case.
Cerebral hemorrhage as final outcome of a patient with anemia and chronic myeloproliferative syndrome.

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Introduction: We describe the management of acute anemia in a patient with hematological chronic diseases.
Case report: A 74-year-old man, with a history of hypertension, hyperthyroidism, heart failure functional class I NYHA, atrial fibrillation, lumbar spondylolisthesis, splenectomy after traffic accident. He was followed-up by hematology due to hereditary spherocytosis in treatment with oral iron and epo, and myeloproliferative syndrome chronic. He consults for asthenia, increased of dyspnea, abdominal cramping pain and constipation.
At physical examination: blood pressure 135/75 mmHg, Oxygen saturation 92%. Normal cardiopulmonary auscultation. Blood tests: normocytic normocytic profile anemia Hb 4.8 g/dl, urea 58 mg/dl, creatinine 1.3 m/dl, CRP 27 mg/L. Pancolonoscopy were performed and normal, fecal occult blood test was also negative, and abdominal ultrasound reported only chronic pyelonephritis. During admission, the patient suffers cardiorespiratory arrest and is admitted to the ICU. Thoracic x-ray is performed revealing pneumonia with right lung atelectasis. The evolution was unfavorable with hemodynamic instability refractory to vasoactive. A cranial CT scan was performed due to neurological deterioration, with right cerebellar hemorrhage opened to the IV ventricle with hydrocephalus and finally the patient died.
Discussion: However, due to the acute presentation and the value of hemoglobin, in addition to abdominal discomfort, the first thing to assess is a digestive bleeding, which was initially ruled out, although abdominal tac should have been performed and if this was negative then video capsule. Through the study of anemia, other deficiency were ruled out, but a bone marrow biopsy sample was not taken to assess the possible progression of the known myeloproliferative syndrome. We cannot establish chronological relationship between anemia and cerebral hemorrhage since he previously had no neurological focality and anticoagulation was suspended.
Chylothorax in a patient with chronic lymphocytic leukemia: Case Report and Literature Review

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Introduction
Chylothorax represents an accumulation of lymphatic fluid in the pleural space secondary to leakage or impaired drainage from the thoracic duct or one of its main tributaries. It may result from traumatic, non-traumatic causes, but there are also idiopathic forms. Treatment of chylothorax is controversial and depends on both its cause and symptoms. The approach may range from conservative treatment to elective surgery.

Case description
We present a case of bilateral chylothorax in a female patient with chronic lymphocytic leukemia (CLL) and recent pacemaker implantation and we intend to discuss etiology, possible pathogenesis in our case along with diagnostic options and treatment modalities. Diagnosis was confirmed based on the milky appearance and composition of the fluid, chest x-ray and CT scans results.

Discussion
The cause of chylothorax in the reported patient is difficult to establish, because there was no obvious mediastinal mass effect, which could have disrupted or compressed the thoracic duct. We hypothesized that the chylothorax could have been due to the presence of an extremely large number of abnormal lymphocytes in lymphatic fluid due to chronic lymphocytic leukemia, which might have caused sludging in the lymphatic system, resulting in the pseudo obstruction of the lymphatics draining the pleura and subsequent chylothorax.
Because the patient showed pleural effusion on the chest x-ray previous to the pacemaker implantation we decided to exclude the possibility of a traumatic chylothorax.

Conclusion
In patients with chronic lymphocytic leukemia who present with a new pleural effusion, chylothorax should be suspected and pleural fluid TG levels should be checked due to sludging of lymph.
Classical Hodgkin Lymphoma presenting as a hard-to-treat AutoImmune Hemolytic Anemia

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INTRODUCTION
AutoImmune Hemolytic Anemia (AIHA) is characterized by the presence of autoantibodies that attach erythrocytes leading to their destruction. It can be idiopathic or secondary to other conditions, more rarely Hodgkin Lymphoma (HL).

CASE DESCRIPTION
A previous healthy 80-year-old man, was admitted with wasting syndrome for the past month and abdominal pain. Physical examination: skin pallor, icteric sclera, no fever, palpable lymphadenopathies or hepatosplenomegaly. Laboratory findings: haemoglobin (Hb) 4.2g/dL with reticulocytosis, indirect bilirubin 3.0mg/dL, lactate dehydrogenase 756U/L, 4+ positive direct antiglobulin test for IgG and C3d, low haptoglobin, peripheral blood smear with only red blood cells (RBC) agglutination. We could not show/exclude the presence of a concomitant auto-IgM hemolysis.

He received 2 units of RBC after methylprednisolone pulse, and began treatment with prednisolone 1mg/Kg/day without clinical improvement, lowering Hb values to 3.8g/dL. Later began IV immunoglobulin achieving a stable RBC count.
Further studies ruled out the presence of monoclonal gammopathy, infection disease including M. pneumoniae, occult digestive disease, and paroxysmal nocturnal haemoglobinuria. Bone marrow evaluation was normal. Cold haemagglutination test had high thermal amplitude, titre 1:8192 at 4ºC against papainized adult O cells, and 1:1024 at 37ºC. A tomography scan revealed multiple mediastinic lymphadenopathy proven to be classical HL on anatomopathologic/immunohistochemistry evaluation. PET scan confirmed high metabolic disease above the diaphragm-Ann Arbor stage II-B. The patient then started chemotherapy with clinical and hematological improvement.

DISCUSSION
This case highlights the importance of understanding the underlying disease behind a hard-to-treat AIH, presumably caused by mixed cold- and warm-active antibodies, as the patient only showed clinical and analytical improvement with the modulation of his immune system with chemotherapy.
Clinical case - Extensive thrombosis

Elevated levels of factor VIII can be found in about 11% of the adult population. The relationship between factor VIII and venous thromboembolism is well documented, however the problem in clinical practice is timing for its measurement, since it may be elevated in acute phase reactions, and a basal value can be obtained only after several months. We present the case of a 70-year-old woman with pulmonary thromboembolism for six years, currently non-smoker and non-anticoagulated. Observed by clinical condition with 3 days of evolution of epigastralgia aggravated in ventral decubitus, without defense or organomegaly. Analytically, hyperbilirubinemia and elevation of inflammatory parameters. Abdominal ultrasound revealed portal vein thrombosis confirmed by CT angiography, which also showed extension of most of the splenic vein and superior mesenteric vein. Initiated anticoagulation with enoxaparin with switch to warfarin. Study with high FVIII, without occult neoplasia. Favorable clinical evolution with 2-month control-Tc angiography with exuberant portal-systemic collateral pathways (sappey veins and portal cavernomatosis) and superior mesenteric recanalization. Elevated levels of factor VIII are also a risk factor for recurrence of thrombotic events, with about 30% occurring within two years after discontinuation of anticoagulation. The time course of anticoagulation that an individual with elevated levels of factor VIII should do is not yet well established. The present case serves to alert the need for further studies given its important additive factor for the recurrence of thromboses.
primary adrenal lymphoma is a rare disease. The clinical presentation of PAL includes major general symptoms, often associated with abdominal pain. Only half of the patients with bilateral masses were screened for adrenal insufficiency.

The initial care needs to be codified and should include endocrinology examination in patients with bilateral adrenal masses and/or symptoms of adrenal insufficiency. FDG-PET appears to be more discriminating than a CT scan and was an efficient examination to reveal extra-adrenal locations.

Diagnosis can be established with the help of biopsy and histological examination.

The European Society of Endocrinology recommends imaging studies and hormonal assessment for bilateral adrenal masses first.

Primary adrenal lymphoma is a typically highly aggressivemalignancy, most cases are usually diffuse large B-cell lymphomas and bilateral involvement is frequently observed. Age, tumour size, adrenal insufficiency, lactate dehydrogenase level, and performance status of the patient can significantly influence prognosis.

Diagnosis can be established with the help of biopsy and histological examination. The European Society of Endocrinology recommends imaging studies and hormonal assessment for bilateral adrenal masses first. This because there are many differential diagnoses ranging from metastases from a different primary lymphomas or bilateral pheochromocytoma.

Although our experience suggests that a rituximab-containing regimen with intrathecal methotrexate is effective, larger studies should ideally be carried out to validate this treatment modality.

Learning Points
Commonly bilateral adrenal masses are usually due to metastases from malignant tumours arising from lungs, breast, or colon.
Clinical, etiological and scalable spectrum of thrombocytopenia in a Tunisian monocentric cohort

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Introduction: Thrombocytopenia represents a genuine diagnostic and therapeutic emergency. The aim of our study was to evaluate the global picture of thrombocytopenia. Method: Retrospective and descriptive study at the internal medicine department of CHU Fattouma Bourguiba Monastir from 2008 to 2017 was conducted. 131 patients with thrombocytopenia as defined as platelet rate <150000 elt/mm\(^3\) were included. Thrombocytopenia was classified according to its depth as mild (100000-150000 elt/mm\(^3\)), medium (50000-100000 elt/mm\(^3\)), deep (20000-50000 elt/mm\(^3\)) and very deep (<20000 elt/mm\(^3\)). Clinical and biological were analyzed. Results: The study includes 80 women and 51 men (sex ratio H/F 0.63). Mean age was 42.51 years ± 19.73. Thrombocytopenia was incidentally discovered in 26.7%. Revealed by haemorrhagic syndrome in 52.7%. Revealed by thrombocytopenic purpura (34.78%), gingivorrhage (23.18%), epistaxis (15.94%) and gross and hematuria (14.49%). The average haemorrhagic score (Khellaf) was 2.84 ± 3.53. Thrombocytopenia was mild (23.7%), mean (31.3%), deep (16.8%) and very deep (26.7%). Thrombocytopenia was either isolated (29.5%) or associated with another cytopenia (43.5%). Peripheral origin was seen in 82 patients (62.6%) and central one was in 49 patients (37.4%). Peripheral thrombocytopenia was due to autoimmune diseases in 38 patients (46.34%): Systemic lupus (20 cases), antiphospholipid syndrome (13 cases) and Sjogren syndrome (5 cases). Hypersplenism (5 cases), drug-induced thrombocytopenia: heparin (6 cases). Immune thrombocytopenic purpura was retained in 21 patients (25.60%). Central thrombocytopenia was dominated by haemopathies in 24 patients (48.97%): mostly myelodysplastic syndrome (8 cases) and multiple myeloma (5 cases). High-dose cortico-steroid was used in 48.1%, platelet pellets’ transfusion (32.1%), immunoglobulins (25.2%). Conclusion: Thrombocytopenia presented particularly in women probably explained by the frequency of autoimmune diseases.
Cryoglobulinemia Essential: report case

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Introduction: Cryoglobulinemia is a systemic inflammatory syndrome that usually involves small and medium vessel vasculitis due to the deposition of immune complexes containing cryoglobulins, which are immunoglobulins (Ig) that precipitate at temperatures below 37 °C and dissolve on heating. This article presents a case of critical vasculitis in a patient who developed nephrotic syndrome, ulcerated and purple skin lesions in limbs.

Case description: Woman, 44-year-old, searched medical assistance with nephrotic syndrome, ulcerated and purple lesions on limbs. She performed kidney-function tests that showed progressive increased in creatinine levels, as well as positive rheumatoid factor and decreased complement levels. Skin biopsy demonstrated leukocytoclastic vasculitis and kidney biopsy a pattern of membranoproliferative glomerulonephritis. The serum levels of cryoglobulins was high. Blood tests for HIV, HCV, HBV and syphilis were negatives. The others tests against autoimmune diseases were negatives. The diagnosis of essential cryoglobulinemia was presumed and due to progressive worsening of renal function was started methylprednisolone in high doses and cyclophosphamide started. Patient progresses with improvement in kidney-function and resolution of skin lesions.

Discussion: Cryoglobulinemia is called idiopathic or essential (<10%) when it is not associated with the underlying and secondary disease like malignant tumors, infections and autoimmune diseases. Because it is a rare disease, it must be properly researched and treated according to its evolution, in a more aggressive or less aggressive way.
Deficit anemia and main etiologies in the elderly

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Introduction
Anemia of the elderly is a common condition that significantly affects the quality of life and the cognitive and physiological functions of patients. The aim of this study is to determine the etiologies of deficiency anemias in the elderly.

Patients and method:
This is a retrospective study of 146 patients who was greater than or equal to 65 years, during a 7-year period (January 2006 to December 2012).

Results:
10.2% of women over the age of 65 are anemic. Digestive blood loss was the most common etiology (68.6%): gastroduodenal ulcers and gastritis were the most common causes 25.5 and 15.7% respectively. The causes of digestive bleeding were multiple in 15.3% of patients. The frequency of digestive cancers was 11.7%.

Conclusion:
Anemia is the most common hematologic problem in geriatrics. All data in the literature agree on the increase in the prevalence of anemia with age and especially after 65 years.
Determination of the titre of inhibitor antibodies with using the obtained of factor VIII in vitro

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Background: We created a new method to obtain purified preparation of the highly active virus-safety blood coagulation factor VIII (FVIII) using Diasorb-aminopropil matrix with active dyes as ligands and studied its biochemical properties. One of the important properties is the use of a concentrate with a diagnostic purpose for the detection of inhibitory antibodies.

Aims: to explore the use of obtained purified sample FVIII for detecting inhibitory antibodies.

Materials and Methods: citrated venous blood was collected from patients with severe haemophilia A, deficiency standard plasmas «Siemens Healthcare Diagnostics Products GmbH» and «Helena Biosciences Europe» (a model of severe hemophilia without an inhibitor), «Immunate» Baxter (plasma derivate concentrate, control), obtained factor concentrate (experiment).

The titre of inhibitors was calculated in Malm Inhibitor Units (MIU)/mL (corresponds to 3,3 BIU (Bethesda Inhibitor Units). The principle of this test is based on the properties of the inhibitor in the process of incubation with concentrate of FVIII to reduce its activity.

Results. A study of the application of the obtained purified FVIII sample to detect inhibitory antibodies was conducted. A direct correlation between the be method of Bethesda and the Malmo was established (r=+0,89). When determining the inhibitory antibodies with the use of the Immunate and the obtained concentrate of FVIII, the data obtained do not differ significantly (P≥0,05).

Conclusion: The obtained data demonstrates suitability of using the obtained concentrate of FVIII as a diagnostic tool for the detection of inhibitor antibodies in patients. This technique allows choosing the optimal concentrate for the substitution therapy of patients with hemophilia A with inhibitor.
Diagnosis of multiple myeloma and microcytic lung cancer in patient with pemphigus.

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Introduction: The paraneoplastic pemphigus is an autoimmune bullous disease associated to a hidden or previously diagnosed neoplasm, with well-defined clinical, histological and immunological manifestations. Case report: A 63-year-old male smoker with a history of hypertension, bone marrow aplasia followed up by hematology under treatment with cyclosporin and magnesium. He was also been studied for a lung mass in left upper lobe with core needle biopsy reported chronic inflammatory pneumopathy. He comes for the appearance of ulcerated purple-like skin lesions on the back and hands from the last week. At physical examination: pulmonary auscultation with hypoventilation left hemithorax. Oxigen saturation 94%. Purpura skin lesions and blisters in the back of hands and in the lower back.

Blood tests: Hb 6.6 g/dl, leukocytes 3840/ul (82% neutrophils), platelets 52000/mm3. Creatinine 1.5 mg/dl, Na 129 mmol/l, PCR 7 mg/dl. Proteinogram: monoclonal band in gamma region. Ig G 8315 mg/dL, low levels of C3 and C4. Free kappa/lambda ratio 12, free kappa chain immunofixation 755 mg/dl, kappa chains in urine 105 mg/L. Bronchoscopy: endobronchial neoplasm in the apical-posterior segment of the left tree (lung small cell carcinoma). Aspirated bone marrow: multiple myeloma. Cutaneous biopsy: nonspecific inflammatory infiltrate.

Discussion: Simultaneously to the study of the lung mass (do not forget that he smoked), was the study of the skin lesions which switched on the alarm after the discovery of the monoclonal peak in the proteinogram. Although the definitive diagnosis was provided by the anatomo-pathological study, despite this was not the case for cutaneous lesions, and its etiology was attributed to a paraneoplastic component of multiple myeloma, whose diagnosis was simultaneous with pulmonary neoplasia, which also became no possible choice curative therapy of the first one.
Adenopathies are enlarged lymph nodes with multiple etiologies.

Female, 65 years, history of systemic lupus erythematosus and breast neoplasm in complete remission. She went to the emergency department (ED) for abdominal pain, fever and weight loss. At admission she presented anemia, leukopenia, increased systemic inflammatory parameters and evidence of hepatomegaly, millimetric hepatic granulomas, moderate splenomegaly, heterogeneous spleen texture with multiple hypodense nodules.

During hospitalization, she remained feverish, with no alterations to the objective examination. She underwent neoplastic, inflammatory, infectious and toxic etiology screening. She performed tomography to the skull and neuroaxis, viral serologies, autoimmunity, blood cultures, myelogram, immunophenotyping and myeloculture, endoscopic studies, bronchofibroscopy with bronchoalveolar lavage, mammography, mammary and thyroid ultrasound, hepatic biopsy and IGRA without alterations. She was observed by gynecologist and otorhinolaryngologist without changes. Thoracic CT was performed with evidence of multiple adenomegaly homogeneous paratracheal, subcarinal and pulmonary threads apparent of sarcoidosis; abdominal magnetic resonance imaging with hepatomegaly and splenomegaly and nonspecific retroperitoneal adenopathies; abdominal ultrasound with spleen of prominent dimensions, heterogeneous with hypoechoic pericymetric images; gallium scintigraphy with increased uptake in pulmonary hilar regions suggestive of eventual sarcoidosis. Collaboration request for General Surgery for elective splenectomy for diagnostic purposes. Histologic result of spleen compatible with splenic involvement due to lymphoproliferative malignancy - classic Hodgkin's lymphoma. Oriented to oncology consultation.

Adenopathies are a clinical challenge given the multiplicity of differential diagnoses, with very different treatment and prognostic implications.
Introduction:
Diffuse alveolar hemorrhage (DAH) occurs due to disruption of the alveolar-capillary basement membrane. Most patients present with fever, dyspnea, cough and sudden onset of hemoptysis, though it can be absent in one-third of cases. Acute chest syndrome (ACS) is defined as a new pulmonary infiltrate on chest radiograph accompanied by fever and/or respiratory findings.

Clinical Case:
A 37-year-old Guinean male, with history of sickle cell trait, type 2 diabetes mellitus and hypertension was admitted in the emergency department complaining of sudden onset of pleuritic chest pain, cough and dyspnea. He denied fever and hemoptysis. Physical examination was normal. Chest radiograph revealed bilateral para-cardiac alveolar infiltrates. Angio-computerized tomography (CT) excluded pulmonary thromboembolism and revealed dispersed ground glass opacities. Routine blood investigations showed haemoglobin of 14.7 g/dL, normal renal function (Creatinine 0.91 mg/dL) and low C Reactive Protein (2.13 mg/dL). Autoimmune, infectious and mitral valve diseases were excluded. Angiotensin conversion enzyme was normal. DLCO was increased (113%). Bronchoscopy was performed, with bronchial biopsies being negative for neoplastic causes or sarcoidosis. Bronchoalveolar lavage revealed 86% of macrophages with 56% of Hemosiderin-laden macrophages, confirming DAH. Both cytologic and microbiologic analyses were negative. Sickle cell trait was confirmed with an HbS concentration of 36.8% and heterozygosity for mutation c.20A>T. The symptoms disappeared with supportive care. We admitted the diagnosis of DAH secondary to an ACS. The patient remains in clinical vigilance without any further symptoms.

Conclusion:
Sickle-cell trait has been characterized as a benign condition. However ACS can develop, with secondary diffuse alveolar haemorrhage. Early diagnosis and supportive treatment can improve the outcome in these patients and prevent further pulmonary damage.
Diffuse large B-cell lymphoma leading to HIV infection diagnosis

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Introduction:
Non-Hodgkin lymphomas (NHL) in HIV-infected persons are very aggressive, however, with the advent of highly active antiretroviral therapy (HAARTT) their outcome resembles the one observed in non-HIV-infected patients.

Case description:
73yo male, with chronic bronchitis and atrial fibrillation, was admitted with one-week history of abdominal discomfort, constipation and 14% weight loss in 4 months. Physical examination revealed left inguinal and cervical adenopathies, and an abdominal mass on the left inferior quadrant proved to be a 89x67x131mm retroperitoneal mass after performing an abdominal computed tomography (CT) scan.
Laboratory results showed lymphopenia 0.96x10^9/L and high lactate dehydrogenase and β2-microglobulin. HIV-1 serology test was positive. Absolute CD4 lymphocyte count and HIV viral load were 141 cells/µL and 16015 copies/mL, respectively. HIV resistance testing was negligible. Ultrasound evaluation of cervical and inguinal contents confirmed lymphadenopathies. The patient underwent excisional inguinal lymph node biopsy which diagnosed Anaplastic Variant of Diffuse Large B-Cell Lymphoma. In order to stage the disease, the patient did thoracic and pelvic CT scan and bone marrow evaluation, which concluded a stage III-B Ann Arbor, International Prognostic Index 3, ARL-IPI 7. A lumbar puncture proved to be negative for the presence of clonal cells. He then started immunochemotherapy and HAARTT. He’s now on cycle 3, showing improvement of CD4 lymphocyte count and lowering adenopathies.

Discussion:
The prognosis of HIV-infected patients with NHL depends primarily on the degree of immunodeficiency at the time of diagnosis. The control of HIV infection and improvement of immune system with HAARTT provides the opportunity to perform full-dose immunochemotherapy.
Effectiveness outcomes at 30 days in 30 patients with venous thromboembolism. "EFEXEMB" Study: comparative analysis using Cochran's parametric Q test for continuous variables.

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Background and purpose of the study: The "EFEXEMB" study - an acrostic arising from "EFicacy outcomes in 30 cancEr patients in treatment with rivaroXaban for acute vEnous thromboeMBolism", enrolled 30 patients with venous thromboembolism in the 2015-2017 period. The "EFEXEMB" study has the following objectives: to verify any relationship between the values of Recurrent VTE and VTE-related death; and to verify the statistical significance detected by applying the Cochran Q parametric test.

Materials and methods: For the calculation of the $\chi^2$ apply the following formula: $\chi^2 = (K-1) [(kx) - y^2] / (Ky) z$

$= 20.95$. Where "k" refers to the three variables considered, and "x" refers to the total of the squares of the 3 variables considered. "y" indicates the total number of clinical conditions. "y^2" refers to the square of the total clinical conditions. "z" indicates the total of the squares of the clinical condition. The relative value (RV) of $\chi^2$ obtained is 60 with Degrees of Freedom (DF) = 2. The critical value (CV) of $\chi^2$ for $p = 0.001$ is 13.816.

Results: The Cochran Q test shows how the clinical situation "N" (No recurrent VTE) detected for all patients is not due to chance, but takes a high statistical significance, as the relative value (RV) of $\chi^2$ obtained is 60 with Degrees of Freedom (DF) = 2 and the critical value (CV) of $\chi^2$ for $p = 0.001$ is 13.816. The differences of choice are, therefore, highly significant with $p < 0.001$.

Conclusions: The data from the "EFEXEMB" study show in the follow-up at 30 days highly significant outcomes of effectiveness.
Essential thrombocytemia in woman with headache

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Introduction: Essential Thrombocytosis is a disease characterized by a pathological increase in the number of platelets, which occurs as a result of a clonal proliferation of the progenitor cells of platelets called megakaryocytes in the bone marrow. It is considered a chronic myeloproliferative syndrome. The most frequent clinical manifestations are vascular complications, with alterations of the microcirculation or of thrombotic or hemorrhagic type. Although it is usual for patients to suffer no symptoms, the most common are headache, weakness or dizziness. Treatment objectives are normalize the platelet count, reduce the frequency of thrombotic and hemorrhagic complications, minimize the risk of acute transformation and myelofibrotic evolution and improve the quality of life.

Case report: 67-year-old woman with background of hypertension and atrial fibrillation treated with atenolol, hydrochlorothiazide and dabigatran. She comes because of sudden headache accompanied by malaise and presyncope. Physical examination was normal. Blood test: Hb 12 g/dL, 10600/mcL leukocytes, 102800/mm³ platelets, LDH 1543 IU/L, RCP 0.5 mg/L. Liver and renal function test were normal. B12 vitamine>2000 pg/ml. Bone marrow biopsy: moderately hypercellular, very striking megakaryocytic hyperplasia, absence of fibrosis, compatible with essential thrombocythemia. JAK2 mutation positive. MRI of the skull: changes related to multi-infarct leukoencephalopathy.

Discussion: in the differential diagnosis of thrombocytosis we must investigate, initially reactive origin (infection, acute inflammatory process either pancreatitis or neoplasms), on the other hand hematological disorders as myeloproliferative type (polycythemia vera, essential thrombocythemia such as the current patient) or in cases of hemolytic anemia, iron deficiency or other deficiency states. Furthermore, under suspicion of this entity we must consider a bone marrow biopsy to confirm it.
Evaluation of bleeding events with enoxaparin

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Objectives: Enoxaparin is frequently used for the treatment and prevention of thromboembolic events. Despite its low hemorrhagic potential, it is not free of risk particularly if overdosed, at advanced ages, renal insufficiency or concomitant use of other drugs that affect hemostasis. The aim of this study was to describe dosing practices and identify potential risk factors for bleeding in patients who received treatment with enoxaparin.

Methods: All patients admitted to the Internal Medicine Service in 2016 and 2017 who developed major bleedings while taking enoxaparin 1 mg/kg were retrospectively evaluated. Enoxaparin dosing practices and factors that might influence the safety of enoxaparin administration were documented and analyzed.

Results: Fifteen patients taking enoxaparin developed major bleeding events. Thirteen (87%) were hypocoagulated prior to hospital admission: 4 with warfarin and 9 with non-vitamin K antagonist oral anticoagulants (NOAC). Three patients taking warfarin had therapeutic International Normalized Ratios when they started enoxaparin while 4 initiated enoxaparin before the time of the next scheduled dose of NOAC, leading to overdose of anticoagulants. Eight patients (53%) did not have body weight documentation to guide enoxaparin dosing and 4 received a dose that was lower than the recommended in this context. However, 5 patients (33%) received a dose that was 50% higher of the recommended 1mg/kg due to severe renal impairment, with the potential for bioaccumulation. There were 3 deaths attributable to hematomas and 2 due to hospital infectious complications. The increased patients age (67% over 75 years) was also identified as a potential risk for bleeding.

Conclusion: In this clinical practice assessment, the prescription of enoxaparin was suboptimal with the potential to increase bleeding complications. Coadministered anticoagulants, renal impairment and age could confer an increased bleeding risk.
Felty’s Syndrome - a rare febrile neutropenia

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Introduction:
Felty’s Syndrome (FS) occurs rarely in a severe subset of seropositive Rheumatoid Arthritis (RA) patients, with neutropenia and splenomegaly. Its prognosis is poor due to the higher incidence of severe infection, with up to 36% 5-year mortality. Neutropenia is multifactorial including increased neutrophil sequestration secondary to splenomegaly, peripheral destruction of neutrophils and bone marrow failure.

Case Description:
A 53-year-old Caucasian female with AR diagnosed 12 years before and previously on Methotrexate (MTX), developed neutropenia (<2000/mm³) identified 8 years later, with a continuous neutrophil (N) count decrease, but no recurrent infection. One month prior to her hospital admission, she was referred to hematology with N< 500/mm³. Her myelogram and bone marrow biopsy with flow cytometric immunophenotyping revealed a neutrophil maturation arrest, with no blasts or signs of myelodysplastic syndrome. The patient presented to the hospital ER with sudden onset of fever (>38,5ºC), without symptoms, being her physical exam unremarkable. Her white blood cell count was 2.610/mm³ (N=450/mm³), and there was a high C-reactive protein (2,81mg/dL). Abdominal ultrasound revealed splenomegaly (130mm). Admitted to the ward, broad spectrum antibiotics and granulocyte colony-stimulating factor (G-CSF) were initiated (Blood/urine cultures negative). Fever disappeared and N count improved, making possible to stop G-CSF. She was discharged after 22 days, with MTX re-introduced. Six months afterwards she maintained mild neutropenia with no infections and no G-CSF need.

Discussion:
FS should be considered in long standing AR patients presenting with neutropenia. MTX is recommended for long term management along with antibiotics once infection is suspected.
Introduction: Hodgkin’s lymphoma (HL) is a B cell solid tumour responsible for approximately 11% of all lymphomas. Today, 80% to 90% of patients achieve remission and can be considered cured.

Case description: A 68-year-old woman with a diagnosis of Sweet’s Syndrome five years before presented in the emergency department reporting fever in the preceding week and a confusional state, initially with brief periods of spatial disorientation, aggravated in the 48 hours before admission. The physical examination revealed an enlarged cervical node and an excisional biopsy was obtained. The blood workup showed elevated transaminase, alkaline phosphatase, gamma-glutamyl transferase and C-reactive protein levels. The CSF had no abnormalities. A contrast enhanced chest, abdominal and pelvic CT revealed mediastinal adenopathies. A complete immunological and infectious panel was negative. A transthoracic echocardiography was unremarkable. Pathological examination of hepatic biopsy samples revealed an unspecific inflammatory pattern. A MRCP identified peri-celiac adenopathies. A PET-CT scan demonstrated high mediastinal, hepatic and peri-celiac activity. After an initial period of stability the patient developed an acute renal insufficiency with need for dialysis treatment. The diagnosis was obtained by pathological examination of the cervical node biopsy, defining the disease as a mixed cellularity HL. Classified stage IV B. IPS Score: 5 (high risk). The patient initiated salvage chemotherapy with ABVD, but wasn’t able to tolerate the treatment modality.

Discussion: The objective of this case report is to discuss an aggressive Hodgkin’s lymphoma with a largely inconclusive diagnostic workup, while awaiting a cervical node biopsy results.
Spinal cord spontaneous hematoma (SCH) is an unusual condition which cause rapid and irreversible neurologic impairment. The incidence reported is 1 case for 100,000 persons/year and represents 0.3 - 0.9% of all the spinal cord lesions. The main causes implicated in SCH are traumatic ones or related to spinal procedures such as lumbar puncture or epidural anesthesia. In fewer cases, vascular malformations, clotting disorders, inflammatory and infectious myelitis may be involved.

The authors present the case of a 69 years old patient, admitted to the emergency department with epigastric pain with 6 hours of evolution and cervical acute pain with lumbar irradiation. Known previous medical history of mitral prosthetic valve, anticoagulated with Warfarin.

During physical examination, the patient was found to be mildly anxious due to the pain, with arterial blood pressure (BP) of 160/70 mmHg and no relevant differential BP between arms and legs. There wasn’t any neurological impairment at this time, but the pain remained despite drug induced analgesia. The electrocardiogram and cardiac enzymes were normal. The transthoracic echocardiogram was negative for valvular prosthetic disfunction or abnormalities of myocardial contraction. The analytical study revealed 15.9 g/dL of hemoglobin (13.6-18.0 g/dL), 189.000 platelets (140.000-440.000 U/L) and INR of 3.20. The Aortic CT Scan excluded aortic dissection.

Four hours after admission, the patient presented a posterior thoracic severe pain and began to develop mild motor and sensory deficits in his lower extremities. Within 30min the patient was paraparetic. He was at this time rushed to the CT-Scan for a medullar contrast scan revealing a C5-D2 medullar haematoma. At this point an emergency transfer to a Neurocritical care facility for a decompressive laminectomy was decided. After 2 months of physical rehabilitation the patient had only a minimal recovery, maintaining high level of dependence in basic life activities.
Hemagocytic lymphohistiocytosis, case report and literature review.

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Abstract:

Introduction:
Haemophagocytic lymphohistiocytosis (HLH) is a rare syndrome described as an uncontrolled rapid progressive immune hyperactivation, associated with a high mortality. HLH can either be a primary inherited familial disorder or caused by a secondary acquired infectious or neoplastic trigger. The disease is characterized by a large spectrum of different clinical presentations with nonspecific signs and symptoms including fever, splenomegaly, bi- or tri-cytopenia, hypertriglycerides and elevated ferritin. These same clinical features could be found in other conditions such as sepsis, autoimmune disorders, hematologic and solid neoplastic diseases. Despite difficulty to recognize HLH, early treatment is imperative to reduce mortality.

Case description:
A 75-year old male patient known with a 2-month history of multiple myeloma was admitted with fever secondary to an invasive aspergillosis. A HLH was suspected as he developed an acute respiratory distress accompanied with elevated ferritin (>10,000ng/ml), anemia, thrombocytopenia and an increased inflammatory blood level. The patient passed away 2 weeks after diagnose despite control of infectious focus and the initiation of high doses dexamethasone.

Discussion:
In this article, we took the opportunity of a case report to review the literature. We emphasise on the optimal diagnostic approach but also the difficulties often encountered when treating a patient with HLH.
Background: Hemophagocytic syndrome (HPS) is a rare and life-threatening disease. The aim of this study was to report clinical and biological features, outcome characteristics, and underlying pathology of patients with HAS.

Patients and methods: A retrospective study of patients with hemophagocytic syndromes admitted in Marc Jacquet’s hospital from 2015 to 2017.

Results: 11 patients were concerned: 9 men and 2 women. Mean age was 55 years (extremes 26 and 86 years). Etiological investigations showed malignant hemopathy in 7 cases, solid tumors in 2 cases, HIV and tuberculosis in one case each. Fever was present in all cases, polyadenomegaly in 6 cases, splenomegaly in 4 cases, and hepatomegaly in one case. Hemoglobin rate was 6 g/dl, white blood cells 3532/mm³, platelets 57349/mm³, fibrinogen 2.68 g/l, AST 3921 UI, and ALT 466. HPS was associated with a ferritin level superior to 6000 in 91% of cases. Marrow aspiration showed hemophagocytosis in 81.8% of cases. The H score for HPS was 273 (extremes 205 and 292). The probability of HPS was estimated at 99% (extremes 91 and 99.9%). The mortality rate at 1 month was 81.8%.

Conclusion: Hemophagocytic syndrome is a rare and life-threatening disease. Pejorative prognosis requires an early therapy with etiological treatment.
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Hodgkin Lymphoma Post-Chemotherapy – Regarding a Clinical Case

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Introduction
Chemotherapy can be associated with multiple long-term complications, such as secondary neoplasms, heart failure or endocrine dysfunction. Development of secondary neoplasms is most commonly described in patients treated with alkylating agents or topoisomerase II inhibitors.

Case description
Male, 74 years-old diagnosed with Diffuse Large B cell lymphoma, stage IVB, in June 2013, treated until November 2013 with 8 cycles of Rituximab, Cyclophosphamide, Mitoxantrone, Vincristine and Prednisone with complete response, afterwards only under clinical surveillance. In May 2017, he presented with purulent sputum cough, with night predominance, anorexia and weight loss of 10% over the last 3 months. He was initially prescribed Levofloxacin 500mg/day without improvement. Analytically he had normocytic and normochromic anemia, leukocytosis with neutrophilia, Sedimentation Rate of 134mm and C Reactive Protein 119.09mg/L. He was admitted to our ward for etiological study. He completed 8 days of Piperacilin-Tazobactam, with improvement of respiratory function, but fever persisted. Additionally, he developed a supraclavicular adenopathy and a pleural effusion (exsudate and lymphocytes predominance). Body-CT revealed supra and infra-diaphragmatic adenopathies, compatible with relapsing lymphoproliferative disease. An excision of the rith supraclavicular adenopathy was performed with the neuropathological study revealing a Classic Hodgkin Lymphoma, stage IVB. He was started on Vinblastine-monotherapy, but due to associated complications he was switched to Procarbazine and Chlorambucil.

Discussion
This case highlights the importance of long-term follow-up of patients with a history of neoplastic diseases that are submitted to chemotherapy and the importance of histological confirmation in cases suspected of relapse of disease, given the increased likelihood of different tumors.
Hyperviscosity in a patient with POEMS syndrome

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Introduction: POEMS (Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal protein and Skin changes) syndrome is a rare disease that demands a high index of suspicion for the diagnosis.

Case description: Here is presented the case of a 68-year-old patient, first brought to Emergency Department in the context of repeated episodes of loss of consciousness, sometimes preceded by dizziness and partial and sudden loss of vision, with quick spontaneous recovery, along the previous month. There was mention of fatigue and weight loss over the previous year, with episodes of nausea and vomiting. Moreover, he referred a long date mechanical knee pain with recent escalation. At physical examination, he presented multiple recently appeared telangiectasias on the trunk.

From the study made there were identified: multiple bilateral ischemic strokes and a demyelinating motor and sensitive polyneuropathy that caused progressive loss of autonomy; a monoclonal IgA/Lambda gammopathy with vestigial M protein; thrombocytosis; hypothyroidism; multiple osteoblastic vertebral and pelvic lesions; and serum hyperviscosity. One of the sclerotic lesions was biopsied presenting alterations compatible with plasma cell dyscrasia with lambda light chain restriction.

Considering all the findings, the patient was diagnosed with POEMS syndrome with associated hyperviscosity, causing overwhelming central nervous system involvement that made him unfit for curative treatment.

Discussion: Although central nervous system involvement is a common feature of this syndrome, its presentation with hyperviscosity is not previously described and may explain such devastating evolution.
Cavernous sinus thrombosis is a rare, life-threatening condition in which a blood clot blocks a vein that is responsible for carrying blood from the face and head back to the heart. The cause of cavernous sinus thrombosis is usually an infection but other factors as genetic mutations or autoimmune diseases may play a role.

We introduced the case of a 50-year-old woman, previously healthy, who was taken to the emergency department after an inaugural and generalized seizure. The patient had stable vital signs, a normal neurological examination, and no changes in analysis or physical examination were detected. It was decided to perform a cerebral CT that revealed signs of left lateral venous sinus thrombosis and possible subarachnoid hemorrhage in the temporal region on the same side. Since we were dealing with a thrombosis, the treatment should go through hypocoagulation and study of the cause, but would not the hemorrhage be a major contraindication?

Subarachnoid hemorrhage in these cases is probably due to raised venous pressure of draining venous tributaries so, once the cause is treated the bleeding should also resolve. Therefore, venous sinus thrombosis associated to subarachnoid hemorrhage the only indication for hypocoagulation despite the presence of bleeding.
Introduction: Disseminated intravascular coagulation (DIC) is a syndrome diagnosed by laboratory tests in an appropriate clinical setting. The mainstay of therapy relies in the treatment of the triggering condition and individualised supportive treatment.

Case: A 82 years old man, known for past endovascular abdominal aortic aneurysm repair, was referred at the hospital by his general physician for a new isolated thrombocytopenia. He had no complaint and physical examination revealed hematomas on both flanks and purpura on the legs. Laboratory results showed severe thrombocytopenia (14G/l, ref. 150-350G/L), low fibrinogen (1.2g/l, ref. 1.8-4 g/L), elevated D-dimers (19184μg/l ref. <500 μg/l) and normal aPTT (35s ref. 25-36s). An extensive search for a triggering condition of suspected DIC was unrevealing. CT-scan angiography excluded any complication of the endoprothesis and ultrasonography excluded a popliteal aneurysm; PET-CT did not find evidence for a neoplastic process; autoimmune and viral tests were negative. DIC of unknown origin with an hyperfibrinolytic state was diagnosed. An empiric treatment of heparin and tranexamic acid was initiated with a favourable outcome. Eight months later, the patient had no sign of an underlying disease and underwent hip surgery without complication.

Discussion: Treatment of DIC consists in treating the condition triggering coagulation activation. In our case, none could be found. Little evidence from RCTs exist for the treatment of DIC and recommendation are based on experts’ opinions. Heparin treatment is proposed with addition of tranexamic acid in case of hyperfibrinolytic state. Our case shows a good long term outcome under this therapy.
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Idiopathic Trombocytopenic Purpura After The Treatment Of Cervix Carcinoma

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AIM: We present a case with cervical carcinoma who developed idiopathic trombocytopenic purpura (ITP).
CASE: In December 2017, a 45-year-old woman was diagnosed with stage 2B cervix carcinoma. She received concomitant chemoradiotherapy treatment with weekly cisplatin. The first blood count parameters at the time of diagnosis in oncology outpatient clinic were normal ranges. Hemoglobin (Hb) of 11.3 g/dL, white blood cell count (WBC) of 7.9 x 10⁹/L, platelet count of 467 x 10⁹/L. Three months after she completed 6 cycles of weekly cisplatin chemotherapy and definitive radiotherapy, she presented with petechiae on her legs. Platelet count of 4 x 10⁹/L was found in complete blood count. Biochemistry tests and coagulopathy parameters were normal. Peripheral blood smear showed thrombocytopenia. The patient never used drugs that cause thrombocytopenia. Hepatosplenomegaly was absent on physical examination. Transfusion of apheresis platelet was failed to increase platelet level. We considered bone marrow infiltration with primary cervical carcinoma cells but bone marrow examination showed no evidence of malignant infiltration. We diagnosed ITP and applied 1 mg/kg/day methylprednisolone intravenously for 3 weeks and 1 gr/kg/day immunoglobulin for 2 days in a week. After this treatment platelet count increased to normal range and remained stable at levels over 150 x 10⁹/L.

DISCUSSION: ITP is an autoantibody-mediated thrombocytopenic disorder in which accelerated destruction of platelets occurs and platelet production may also be impaired by these antibodies. The common causes of immunologic thrombocytopenia are viral infection, drugs, chronic autoimmune disorders. Also, oncology literature shows various solid tumors reported with ITP.
Immune Thrombocytopenia With Severe Hemorrhagic Complication

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INTRODUCTION
Immune Thrombocytopenia (IT) in adults is a frequent hematologic disorder, with higher incidence in men over 70 years. It usually presents with a chronic course and even in cases of serious thrombocytopenia (less than 10,000 - 20,000 platelets/μL), severe hemorrhage is rare. Treatment is indicated if platelet count is less than 30,000 platelets/μL even in the absence of hemorrhage.

CASE DESCRIPTION
Man, 79 years old, with arterial hypertension and dyslipidemia enters the Emergency Department with hemorrhage and hemorrhagic blisters on the gums and petechiae on the lower limbs. The initial analytical study showed 1,000 platelets/μL, hence it was started prednisolone 1mg/kg and intravenous immunoglobulin (IVIG) 400 mg/kg for 5 days. The complementary study only revealed positive antithyroid antibodies, but without alterations in thyroid function. There was no improvement in platelet count, and there was even clinical worsening with spontaneous hyphema in the left eye. In this context, platelet transfusion was administered. Since the patient was Rh (D) positive, a single dose of anti-Rh0 (D) immunoglobulin was administered, and a 24-hour increase in platelet count was observed and complete response was achieved in one week, which remains to date.

DISCUSSION
Most cases of IT present less severe manifestations and produce good response to initial treatment with corticosteroids and IVIG. However, there are more severe and unresponsive to first-line therapy cases and splenectomy may be necessary. In the present case, the patient had a favorable evolution without the need of splenectomy, since he was a candidate for anti-D immunoglobulin and had a good response.
Immune thrombocytopenic purpura (ITP) is an acquired disorder characterized by immune-mediated destruction of platelets and inhibition of their release from megakaryocytes. It may be idiopathic or secondary, if associated with underlying causes (such as autoimmune or infectious diseases, drugs). ITP is a diagnosis of exclusion, clinically presenting as mucocutaneous lesions, GI or menstrual heavy bleeding, or, rarely, as lethal CNS bleeding.

We present the case of a 52-year-old woman with previous history of depressive disorder, degenerative osteoarticular disease and multiple sclerosis (treated with B-interferon for about 17 yrs). The patient presented to the Emergency department with multiple hematomas all over her body that started about 2 months before. The patient had lost 6 kg in 6 months. She had no overt blood loss, joint pain, morning stiffness or recent infectious disease. She also mentioned the introduction of gabapentin and naproxen for pain relief, 2 months before. These drugs were discontinued in order to exclude drug-induced thrombocytopenia. Since late adverse reactions with thrombocytopenia are reported with the use of B-interferon, the patient also discontinued this drug.

Laboratorial results showed severe thrombocytopenia (platelet count ~25 x 10^9/L). Biochemical tests and peripheral blood smear were unremarkable. Thoracoabdominal CT scan was performed to rule out neoplastic disease.

The patient maintained fluctuating platelet count (the lowest record count was 16 x 10^9/L). It is important to mention that the patient remained asymptomatic during the hospitalization. The diagnosis of immune thrombocytopenic purpura was then accepted and the patient began treatment with corticosteroids. She had a progressive increase in platelet counts and restarted gabapentin and naproxen, while maintaining alternative treatment for MS. Finally, slow steroid withdrawal was carried out and the patient managed to achieve stable platelet counts and no symptoms.
Immune thrombocytopenic purpura (ITP) is an isolated thrombocytopenia with normal medullar function in the absence of other causes for the anomaly. There are two forms of presentation – acute, common in children and usually of spontaneous resolution after 2 months; and chronic which persists after 6 months and is more common in adults, reaching 66 people/million/year.

We introduce a woman, age 28, without recent introduction of medicine, herbal products or vaccines. She presented to the emergency department with petechial lesions in the lower limbs, bruising and epistaxis. In the blood work she had thrombocytopenia of 16000/uL, without anemia ou other anomalies in the leucocyte formula. The results for Parvovirus, Epstein-Barr, Cytomegalovirus, B hepatitis, C hepatitis and HIV 1/2 were negative. The auto-immune study with anti-platelet antibodies, ANAs and antiphospholipid syndrome antibodies, was negative. The abdominal ultrasound showed a normal spleen. She started dexamethasone 40 milligrams/day for 4 days, reaching a value of 150000/uL. After 10 days she relapsed with 13000/uL platelets and new symptoms, requiring a new course of 40 milligrams of dexamethasone for 4 more days with a partial response up to 73000/uL. After 72 hours, another relapse was found, having begun prednisolone 1 milligram/kilogram/day, with a response only after 7 days. Despite all the tries, she kept platelet levels below 100000/uL, which promoted the introduction of 60 milligrams of immunoglobulin with a more satisfying response.

This case highlights the importance of the individualized therapy of ITP, being steroids the main choice. An individual approach may lead to a new strategy, with the start of immunoglobulin or other immune suppressors, like Rituximab.
Important but rare complication of Nodular sclerosing Hodgkin’s lymphoma

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Introduction: Hodgkin lymphoma is a rare B-cell malignant neoplasm. It is more frequent in men, with greater incidence in young adults and in people older than 60 years. Typically presents as painless lymphadenopathy, which is frequently cervical or supraclavicular. More than 50% of patients have a mediastinal mass.

Description: A 36 year old man, smoker, with history of drug abuse and a psychiatric disorder. Admitted to study of a cervical mass detected on ambulatory. He only complained of disphonia. On hospital admission, he had a painful, hard, immobile, well defined right cervical mass with 4 cm of extension. He also had 3 centimeters left superior clavicular adenopathy. Complementary studies revealed normocytic /normochromic anemia, leukocytosis, reactive C protein 50mg /L and LDH over 3 times the normal. Tomography (TC) showed a mass 18x9x8 cm with left midline mediastinum deviation, reduction of 70% caliber of trachea, involving supra aortic trunk and with absence right subclavian flow. He started anticoagulation to prevent thrombotic events and systemic glucocorticoid with mass reduction on TC.

Histology showed a Classic, nodular sclerosis type of Hodgkin lymphoma. He was discharged with indication to complete staging and chemotherapy.

Conclusion: The initial treatment is based on the histologic characteristics of the disease. Nodular sclerosing Hodgkin’s lymphoma commonly presents with a mediastinal mass, but it rarely compresses or invades mediastinal structures. The recognition of tracheal involvement in Hodgkin’s lymphoma is important due to the risk of life-threatening airway compression, especially in those poorly symptomatic, as our patient.
Internal jugular vein thrombosis: a rare vascular entity

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Introduction
Inner jugular vein (IJV) thrombosis is a rare vascular entity Herein, we present an interesting and rare case of a female patient with malignancy- associated IJV thrombosis.

Case description
A 60 -year old female patient, was admitted to our clinic due to headaches and left cervical inflammation with concomitant progressively worsening swelling for the last 10 days. Physical examination revealed low grade fever and left sided neck swelling along the anterior border of sternocleidomastoid muscle with no abnormality on otoscopic examination of the ear. Blood chemistry revealed mild anemia, hypergammaglobulinaemia, elevated inflammation markers and d-dimers. Diagnosis of left IJV was established after ultrasound examination of the cervical area. Low molecular weight heparin twice daily was initiated along with ampicillin/sulbactam IV as well as analgesia, with poor clinical response though. The patient underwent a full body CT scan, where a mass was detected by the left sternocleidomastoid muscle in contact with the inner jugular vein forming a clot in it. She underwent fine needle aspiration of the cervical mass, the histological examination of which revealed a mesenchymal -type neoplasm. The patient was referred to an Oncology Unit and was discharged.

Discussion
IJV is usually secondary to intravenous drug abuse, central venous catheterization, deep head-neck infections or trauma. Associated malignancies are uncommon and not well documented in the etiology of IJV thrombosis.
Iron deficiency and red cell indices in patients with heart failure

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Objectives: To assess implications of iron deficiency in red cell indices and cardiac biomarkers in P with HF

Methods: 55 P with HF, with mean age of 79.5±10.9; 28 F (54.9%) and 23 M (45.1%). HF P were classified based on measurement of the LVEF into HFrEF<40%, HFmrEF40-40% and HFpEF 50%. ID was considered for HF P with serum ferritin<100 mg/L or ferritin between 100-299 mg/L and transferrin saturation<20%. ST2/IL-33R was measured by ELISA (R&D Systems). Transmembrane reductase (TMR) (mmol/l/cell/h) was determined in the erythrocyte by spectrophotometric method. Blood count and iron-related parameters were determined by standard methods. Statistical methods: Mann-Whitney U test, Spearman correlations and ANCOVA. Statistical significance: p<0.05.

Results: ID of HF P was near 60%. Almost the majority of P presented a HFpEF (46.8%) (HFrEF 29.8% and HFmrEF 23.4%), being M more presented within HFrEF group (M 64.3% vs F 35.7%, P<0.001). The HF P with ID in relation to P without ID, presented lower values of MGV (ID 88.9±1.4 vs no-ID 93.1±1.7, P=0.050) and higher values of an erythrocyte enzyme - TMR (ID 2.4±0.2 vs no-ID 2.0±0.3, P=0.067). MGV was directly correlated with levels of ferritin (r=0.49, P<0.001) and TS (r=0.44, P=0.001) and inversely correlated with TMR (r=-0.32, P=0.040). For other marker for ID diagnosis in HF P, the TS was also inversely correlated with a cardiac biomarker ST2/IL-33R (r=-0.30, P=0.044). Considering HF P with ID, the previous associations mentioned were also true for the following correlations: MGV directly correlated with levels of ferritin (r=0.53, P=0.03) and TS (r=0.64, P<0.0001); ferritin levels directly correlated with ST2/IL-33R (r=0.50, P=0.008). The analysis of covariance showed significant effect of ST2/IL-33R levels on ferritin levels (F=2.1, P=0.033), controlling for age, haemoglobin and MGV.

Conclusions: The presence of ID is a real scenario in HF. The implication of this co-factor is reflected in some red cell indices, which possibly worsen prognosis.
Large B cell Lymphoma - a chylothorax presentation and management

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Introduction:

Chylothorax is a rare disorder characterised by augmented triglycerides in the pleural fluid, caused by disruption of the thoracic duct, mainly due to traumatic causes.

Case description:

Male, 69 years, caucasian, construction worker, with priors of hypertension, dyslipidemia and former light smoker, unstable angina and gastroesophageal reflux, presented with pleuritic pain, dyspnoea and unexplained weight loss (10% of total body weight in 9 months). He was oriented to Pneumology consultation. The symptomology worsened, orthopnea and spumous cough emerged. On a CT scan, a bilateral pleural effusion was documented as well as a right paravertebral mass. Electively thoracentesis, bronchofibroscopy and biopsy were performed but without conclusive results.

The patient was admitted for worsening dyspnoea. On admission CT scan revealed bilateral pleural effusion, a para-aortic mass with 3 cm and multiple splenic abscesses, the largest measuring 2cm. Thoracentesis performed had the characteristics of chylothorax.

A thoracic drain was inserted on the right and afterwards on the left side.

Parenteral nutrition and octreotide were started and talc pleurodesis was later performed due to substantial pleural drainages.

Immunology and serologic studies performed were negative, except for an increased ESR.

First CT-guided biopsy was inconclusive, on the second attempt the diagnosis was reached: large B cell lymphoma.

The patient was started on chemotherapy with R-CHOP, with impressive clinical improvement and resolution of respiratory insufficiency.

Discussion:

This was an interesting case of a difficult diagnosis and management of a chylothorax, with emergence of possible complications and possible treatments.
Late Diagnosis of Erythropoietic Protoporphyria

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Introduction: Erythropoietic protoporphyria (EPP) is a rare disease which occurs in 1-9/1000000 people. EPP is an inherited disorder of heme biosynthesis caused by decreased activity of the enzyme ferrochelatase, which catalyzes the insertion of iron into protoporphyrin. It causes dermatological, neurological, psychiatric, hepatological and gastrointestinal symptoms and is therefore relevant to a broad spectrum of specialties.

Case description: 54-year-old female gardener whose notable symptoms begin at age 12 but no medical assistance is ever sought. Peripheral neuropathy and photosensitivity skin rash that presents as painful, pruritic, oedematous, erythematous skin after sunlight exposure. Sunlight brings on spells of diarrhoea, abdominal pain, dizziness and headache, therefore she takes extensive measures for complete sun protection.

In family history – grandfather died at 60 after years spent sectioned in a psychiatric hospital. The patient seeks medical help for the first time in 2012 aged 48 when a new symptom of arthralgia appears and her laboratory results show increased ALAT and ASAT at 700 IU/ml. Infectious diseases are excluded. Years of investigation looking for an aetiology follow.

In 2016 patient is found positive for increased urinary coproporphyrin. The patient is then referred to an internist specialized in rare diseases. Serum, plasma, and erythrocyte protoporphyrin levels are found to be increased - consistent with a diagnosis of erythropoietic protoporphyria.

Discussion: This case demonstrates the complex process of diagnosing rare disease - in this patient suffering for years without medical intervention, a diagnosis of EPP was important not only to improve current quality of life but also to evade future complications of the disorder such as burns and fatal liver damage.
Malignant mesothelioma, a diagnostic challenge

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Introduction: sometimes is very difficult to come to a diagnosis despite the multiple diagnostic tests made to a patient. This is the case we presents.

Case description: 71 year old male, former smoker, beer drinker (500 ml daily), with ischemic heart disease (stent placement in 2000). Home treatment: dyslipidemic drugs, antihypertensive drugs and aspirin.

Patient admitted due to increased abdominal circumference of three months of evolution. No fever, no weight loss, no abdominal pain, without any symptom added.

Abdominal ultrasound showed massive ascites, liver smooth surface without portal hypertension.

Ascites cytology showed 2688 leukocytes with 51% polymorphonuclear, glucose 57, 2000 red blood cells. ADA 30. No tumor cells. Compatible with inflammatory exudate

Thoracoabdominal CT abundant amount of ascitic fluid. Benign prostatic hypertrophy.

Colonoscopy: diverticula in colon.

Endoscopy: uncomplicated hiatal hernia.

Echocardiogram: left ventricular hypertrophy with preserved systolic function.

PET-CT SCAN: hypermetabolic adenopathies superior mesenteric artery probably reactive. Abundant amount of peritoneal fluid without hypermetabolic focal deposits.


Discussion: in some cases reach the diagnosis is tremendously complicated. Some tumor require multiple test to reach a diagnosis. In this patient only the diagnostic laparoscoph help in the diagnostic. In some patients we need to do this intervention and sometimes it is very difficult get it.
INTRODUCTION: Extranodal marginal zone lymphoma (EMZL) is a kind of non-Hodgkin lymphoma that has its origin in post-germinal center memory B cells with the capacity to differentiate into marginal zone cells and plasma cells. Medium age of onset is 65 years old, affecting more frequently female, caucasian patients. It is clinically a form of indolent non-Hodgkin lymphoma and most patients are asymptomatic. When there are symptoms, these are often non-specific and related to the organs involved.

CLINICAL CASE: 66 years old male, history of extra nodal Marginal NHL, diagnosed in 2012, followed in the Hematology outpatient clinic, with poor therapeutic compliance. In 2016 there was worsening of adenopathies, renal function and the appearance of leukocytoclastic vasculitis lesions on the lower extremities. In 2017 the patient presented to the emergency department with worsening of these lesions. He had symptomatic pleural effusion and hypochromic/microcytic anemia, refusing transfusion for religious motives. For these reasons the patient was admitted at the internal medicine ward. A bone marrow aspiration and pleural biopsy was performed and revealed lymphoma infiltration. A body computed tomography revealed multiple adenopathies above and below the diaphragm. He was discharged on 40mg of prednisolone, which he stopped after a month. A week later there was further clinical worsening and he was proposed to start chemotherapy with R-CVP, however the patient didn’t appear at the first hematology appointment and initiated chemotherapy later than initially planned. There was one more hospital admission because of worsened pleural effusion, but currently the patient is following chemotherapy cycles in the outpatient clinic.

DISCUSSION: The evolution of this patient shows that despite of the indolent character of EMZL, bad treatment compliance allowed for the multisystemic progression of the disease, with need for aggressive cytostatic therapy.
Hematology
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Masked lymphoma

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Introduction: Non-Hodgkin's lymphoma (NHL) is the most frequent neoplasia of the hematopoietic system, however it has a very wide variability in morphology, immunology and clinical, ranging from indolent presentations to very aggressive forms. Its correct approach is not infrequently controversial, even using the latest diagnostic tools.

Case description: We present the case of a 79-year-old man, former smoker, with severe aortic stenosis, who appeal to the Emergency Department for low back pain and was diagnosed with renal colic. The performed image showed a nodule in the right adrenal gland, left renal vein thrombosis and a large mass in the lower lobe of the left lung. He was hospitalized. No relevant complaints. Blood tests with normocytic normochromic anemia, increased lactic dehydrogenase, negative viral serologies, immunoelectrophoresis of proteins with monoclonal IgG lambda peak, and normal PSA. In the abdominal CT, right adrenal nodule and right peri-renal mass were confirmed. PET scan shows activity in this region and in a small left pulmonary nodule, with no uptake in the largest pulmonary mass. It was performed a biopsy of the capturing lung lesion that showed inflammatory characteristics, biopsy of the major mass was suggestive of hamartoma. Endoscopy studies discarded any change. It was decided to approach peri-renal mass by ultrasound-guided biopsy, and the anatomopathological diagnosis of a marginal zone lymphoma with plasmacytic differentiation was made. Non-secreting adrenal nodule. The patient was referred to Hemato-Oncology.

Discussion: We present this case as a reflection to the diagnosis of this entity, masked in this case as an initial hypothesis of metastatic lung neoplasm to the adrenal, emphasizing the importance of the extended study and histological characterization for a correct diagnosis following improvement of its prognosis.
Multiple Myeloma Aggressive Presentation

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Introduction: Monoclonal gammopathy of undetermined significance (MGUS) is an asymptomatic plasma cell dyscrasia relatively common over the age of 50 with an average multiple myeloma progression risk of 1% per year in the case of non-IgM MGUS. Multiple myeloma with biclonal gammopathy is rare and accounting about 1-2%. Case Report: A 56 year old man with past medical history of MGUS - IgA/Kappa known for 4 years, with annual follow up, presented with severe sudden onset pain in the lumbar region. He was seen in the ER and medicated with anti-inflammatory and analgesic drugs. An ambulatory CT scan was performed showing a lumbar fracture at L1 and osteolytic lesion of L3. Three days after he recurred to the ER with symptoms of nausea, anorexia and asthenia. Laboratory investigation revealed acute renal lesion with 3,6 mg/dl of serum creatinine and anaemia with 8.9 gr/dL haemoglobin. Calcium level was 8,9 mg/dL, phosphorous: 8,2 mg/dl, urinary free light chains were elevated, serologies for HCV, HBV and HIV were negative. Bone biopsy revealed clone bone marrow plasma cells >90%. Salivary gland biopsy exclude amyloidosis. Renal insufficiency progression led to haemodialytic treatment. Multiple myeloma diagnosis was made and the patient was transferred to the Oncology department to initiate treatment. Discussion: Renal failure in multiple myeloma, often associated with immunoglobulins, especially free light (kappa and lambda) chain deposition, is commonly seen in elderly patients, comprising poor prognosis. The incidence of pathological fracture of dorsal spine as presenting feature of multiple myeloma in older group is 5% while in young patient is extremely rare. Our patient presented with acute renal failure and vertebral fracture, which is an aggressive mode of presentation.
Multiple myeloma as an extra-pulmonary cause of Pancoast syndrome

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Introduction: Pancoast syndrome (PS) is characterized by shoulder, arm and armpit pain; muscle atrophy, weakness and oedema of the upper limb. It is an early manifestation of a Pancoast tumor (PT) - a superior sulcus tumor that due to its lung apex peripheral location, invades the surrounding structures. PT represent 3-5% of all lung cancers, mostly of non small cells. Rarely PS can be caused by an extra-pulmonary tumor.

Case description: A prior healthy 74 years old female, with history of treated lung tuberculosis, presented to the emergency with one month complaints of gradual worsening, high intensity pain of the right arm and shoulder, with irradiation to the armpit, paraesthesia of the right cubital nerve territory and lack of grasping force in the right hand. She referred weight loss and anorexia in the past 3 months.
Physical exam revealed right sided ptosis and miosis, paresis and muscular atrophy of the hand, sensory loss on the cubital nerve territory and a supraclavicular enlarged lymph node. Chest x-ray had a right lung apex round and regular opacity. A right apical mass invading the first rib, muscles, brachial plexus and neck vertebrae, with possible liver and spleen metastasis was found on computed tomography (CT). She was admitted with suspected diagnosis of PT causing PS. Pet-CT confirmed CT lesions and also signs of bone and mediastinum metastasis. Citology of trans-thoracic needle biopsy revealed plasmacytoma (PM). The final diagnosis was multiple myeloma (MM). Pain control was achieved with medication. MM treatment was started but she died shortly after.

Conclusion: MM cells are rarely found in extra-medullary (EM) sites, due to EM plasmacytoma or EM dissemination of MM.
PS caused by extra-pulmonary tumor is rare, and caused by EM MM is much more infrequent. This case reveals the extraordinary importance of cytology in the setting of the definitive diagnosis and therefore definitive treatment, as rare entities can occur.
Introduction: Renal insufficiency exists in 20-35% of patients with multiple myeloma at diagnosis, but considering the evolution of the disease may be 50%. The degree of initial attainment varies and in the presentation of the disease is mostly moderate, with creatinine levels <4 mg / dl, and the condition may even be reversed. The presence of renal insufficiency at diagnosis is associated with a large tumor burden and the majority of these patients are at an advanced stage of the disease.

Case description: 49-year-old woman with no medical history. Admitted in our ER with abdominal pain, biliary vomiting and decreased diuresis. From the analysis that we runned out, it was important the Hb 7.6 (normocytic and normochromic), creatinine 19 g/dl, and metabolic acidosis with severe acidemia. She had a reno-vesical and abdominal image, excluding obstruction cause. Faced with low urine output despite the fluid challenge, she was admitted in the ICU where continuous venous venous hediafiltration was required. After stabilization, she was admitted in our infirmary for an etiological study of this exacerbated renal dysfunction. In urine 24h, proteinuria of 985 mg/24h was detected. In view of the inconclusiveness of the rest of the study, it was decided to advance to renal biopsy. The histology established the diagnosis of myeloma kidney.

Discussion: The worth of this clinical report is related with its atypical clinical presentation. Multiple myeloma is the second most common hematologic neoplasm, but it appears more often in men in their 70s.
Nodal Marginal Lymphoma: A Rare and Difficult Diagnosis

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Nodal marginal lymphoma accounts for 1% of all Non Hodgkin Lymphomas. In 75% of cases, it is already diagnosed as a disseminated disease, and in 33% of cases, there is also bone marrow (BM) involvement. Clinical course is slow and patients often respond to combination chemotherapy, although remissions are not long lasting. The 5-year survival rate is about 60%.

We present the case of a 69-year-old man, with the diagnosis of pulmonary tuberculosis 6 months before (with complete treatment). He was admitted to the emergency department with complaints of night sweats, weight loss (15kg in 6 months) and fever. On physical examination he had a remarkable hepatosplenomegaly. Abdominal CT scan revealed hepatosplenomegaly and lateral-aortic and aorto-cava retroperitoneal adenopathies. Chest CT scan showed dispersed inflammatory nodular infiltrates, without pleural effusion. Direct sputum exam, bronchoalveolar lavage and aspirate were negative for mycobacteria. BM PCR for detection of M. tuberculosis was negative. Peripheral blood smear had no abnormal features. Bone biopsy and myelogram with immunophenotyping revealed 1% of cells suggestive of marginal zone lymphoma. Infectious disease was also ruled out. Due to persistent and worsening symptoms, he underwent diagnostic splenectomy. Histological examination only revealed granulomas without evidence of lymphoproliferative disease. After this procedure, clinical improvement and remission of B symptoms were reported.

4 months later, the symptoms returned and new inguinal lymph nodes were noticed. The histologic examination of an excised node revealed marginal zone B cell lymphoma features with plasmacytic differentiation. The patient was then transferred to the Hematology department and started R-CHOP chemotherapy with positive treatment response.

With this case report the authors intended to demonstrate the difficulty to establish a diagnosis in a patient with all clinical features but no laboratory/imaging findings.
Non-Hodgkin anaplastic lymphoma: A case of incredible mass growth

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Introduction:
Anaplastic large-cell lymphomas account for 2% of all lymphomas. It presents typically in young or 50-60 years-old patients with rapid growth. Usually remission occurs with great overall survival, with aggressive chemotherapy (CT) CHOP protocol (Cyclophosphamide, doxorubicin, vincristine, prednisolone).

Case description:
61-year-old man with a history of medicated hypertension. Visited the Emergency Department with complaints of 2 tumefactions growing rapidly during the last 9 months, with pain and ulcerative lesions. The first, in the axillary right region measuring 13x20x8cm, adherent to subcutaneous tissue and a smaller one located in the right anterior thoracic region, both of them with differential diagnosis in the thorax CT of multiple abscessed lesions vs lymphoproliferative disease. The lesions were drained surgically and biopsies were collected. Infection was excluded as the patient did not present with fever and blood cultures and serologies were negative. Histology revealed a non-Hodgkin anaplastic large-cell lymphoma (CD4+; CD2-; CD3-; CD5-; CD7-; CD20-; TiA-1++; GranzimaB+; CD30+; CD25+; ALK-; EBER-).

The masses growth within the next 2 weeks was evident macroscopically. A multidisciplinary decision team in Lisbon’s IPO (Portuguese Oncology Institute) was requested. Patient underwent haemostatic radiotherapy followed by CHOP protocol with amazing results, shrinkage of the masses and drainage of necrotic exudate. In the present-day patient is feeling well, with great response to treatment, awaiting 3rd cycle of CT.

Discussion:
We expect to raise awareness with this clinical case as it shows a rare condition and had an aggressive growth presentation. The differential diagnosis between neoplastic and abscessed lesion was challenging.
Orbital plasmacytoma - an uncommon presentation of advanced multiple myeloma

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Secondary plasmacytomas are present in 13% of multiple myeloma (MM) patients, half of them at the diagnosis. Less than 5% MM are non-secretory. The orbital location is uncommon and only a minority of orbital tumors are plasmacytomas.

Case: man, 71 years-old, presenting with right proptosis, retro-ocular pain and epistaxis for 4 weeks. The ophthalmologic exam revealed proptosis, visual acuity 2/10 and overdraft limitation, without papilledema. He had scattered ecchymosis. Thoracic and abdominal exam were normal, without adenopathies. He initiated antimicrobial therapy, considering bacterial or fungal systemic infection, without improvement. Blood tests disclosed severe normocytic normochromic anaemia, severe thrombocytopenia, prothrombin 27%, normal ESR, increased serum creatinine, C-RP 15 mg/dl and LDH 10 ULN. Calcium was normal. Flow cytometry with immunophenotyping exhibited 9.4% of plasma cells with intracytoplasmic clonal k-chain. G immunoglobulin and λ-chain were decreased with normal k/λ ratio, and increased beta-2 microglobulin. Plasma and urine immunofixation was normal. Orbital CT: retro-orbital superomedial tumor with bone destruction and filling of the ethmoidal sinus. Histology was consistent with plasmacytoma. Bone biopsy confirmed a MM. The patient ended up deceasing in two weeks.

Discussion: MM represents 10% of the total of hematologic tumors, 7% with plasmacytoma at the diagnosis. They are frequent on the axial region, with orbital tumors rarely reported and more frequently in the temporal region. Proptosis is the most common signal, as well as ptosis and reduced visual acuity. However, orbital pain (the main symptom presented in this case) is less frequent. Less than 5% MM are non-secretory, most of them have hypergammaglobulinemia.

Plasmacytoma location, uncommon topography, symptom particularities, and monoclonality absence led to a diagnostic challenge of advanced and fatal malignant tumor.

(Bonavolontà G.,2013; Varettoni M.,2010; Burkat CN.,2009)
Painful lymphadenopathies in a dialysis patient: a diagnostic challenge

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Introduction: The lymph node form is the most frequent extrapulmonary presentation of tuberculosis, occurring in about 5% of the immunocompetent population. The association between the occurrence of tuberculosis and chronic kidney disease (CKD) has been established and there is a greater risk in dialysis and transplant patients, due to immunosuppressive status.

Case description: The present case refers to a 45-year-old man with a history of CKD on hemodialysis and meningeal tuberculosis. The patient was admitted in the emergency department due to right axillary and supraclavicular painful swellings, night sweats and fever lasting for a week. At the physical examination, there was no inflammatory signs in his arteriovenous fistula of the left arm, but it was evidenced painful supraclavicular and axillary adenopathies, well defined, non-adherent and without other inflammatory signs. No more adenopathies were palpable. Blood analyses only revealed elevation of inflammatory markers, so cultures were collected and empirical antibiotics was started. Chest X-ray and computed tomography showed no relevant changes. Ultrasound of adenopathies revealed hypoechoic lesions with evidence of vascularization. Purulent aspiration biopsy was performed with a negative microbiological result. After excisional biopsy of the axillary adenopathy, the histological analysis revealed necrotizing granulomatous lymphadenitis. Cultures and DNA were positive for Mycobacterium tuberculosis. The present case refers to lymph node tuberculosis in patients with CKD, representing the second episode of active tuberculosis.

Discussion: In this case will be discussed the increased susceptibility to Tuberculosis in patients with CKD, especially in advanced stages, due to its immunosuppressive condition.
Paraneoplastic Sclerodermiform Syndrome

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Introduction
Within sclerodermiform squares it is important to know that etiologies secondary to other primary disorders exist. The treatment to solve the sclerosis or to improve it is to solve the primary disorder that produces it. Among the etiologies to rule out are primary neoplasms that can give a paraneoplastic syndrome that produces sclerosis of different degrees.

Description of the case
A 75-year-old woman with arterial hypertension who requires multiple drugs for proper control and hypothyroidism in substitution treatment with good control. Presents a progressive induration of the skin that begins in legs and forearms. There are no signs or symptoms of connective tissue in the interview. Upon arrival at the hospital, a biopsy of the affected skin region is performed. Treatment is started with prednisone at 30mg / day, with minimal improvement later. Ultrasound of the heart is requested to rule out pulmonary hypertension, which is normal. In Doppler ultrasound of the legs there is no associated deep vein thrombosis. Abdominal appearance of the right renal mass and left suprarenal mass were observed on abdominal CT scan.
It is consulted with urology that programs surgical intervention in 4 weeks. Previously, plasma and urine analyzes of metanephrines are performed to rule out the existence of pheochromocytoma due to the adrenal image.
In a previous revision to the surgery, the induration has improved with the treatment with corticoids. After the intervention the symptoms progressively improve until they resolve in around 3 months.

Conclusion
Before any systemic picture we must take into account the secondary etiology. For the treatment of these, the primary etiology must be treated. Despite this, the response to treatment is very variable and is not always complete.
Peripheral Blood Smear - a key to diagnosing a new mutation of Hereditary Xerocytosis

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Introduction
Hereditary xerocytosis is a rare disorder linked to haemolytic anaemia and iron overload. The problem lies in a primary defect on a cation transporter, that leads to low intracellular concentration of Na+ and K+ resulting in a dehydrated erythrocyte. In the following case study, we will be describing a patient with this disorder.

Case description
Female patient, 50 years old, presents with a long clinical history of sideropenic anaemia during childhood and pregnancy, haven undergone multiple oral iron treatments. There is no family history of blood related disorders. The patient was sent to our consultation with the provisional diagnosis of haemochromatosis due to high concentrations of ferritin found in her blood work.

The hepatic magnetic resonance imaging showed severe iron overload, however, the genetic study for HFE gene mutations was negative. Xerocytes in the blood smear led to PIEZO1 evaluation which came back negative. GARDOS channel genes evaluation was requested and a mutation, not previously described in the literature for xerocytosis, was discovered.

The patient relies on periodic phlebotomies to manage iron overload, with good tolerance.

Discussion
To diagnose the cause of anaemia in a pre-menopausal woman can pose a challenge to the physician. Multiple aetiologies should and must be considered. A detailed clinical history is essential to unravel the cause. A simple blood smear can also be key in diagnosing. In this case, a high suspicion for hereditary xerocytosis led to the discovery of a new mutation for the disease, allowing for suitable control of the complications of hemosiderosis.
Pernicious Anemia: A Broad Spectrum Syndrome

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Introduction: There are several causes of vitamin B12 deficiency, including pernicious anemia, decreased intake, malabsorption and genetic disorders.

Case description:
Case 1: 74-year-old man admitted on the emergency department due to repeated lipothymias. Admission electrocardiogram was normal but analytical study revealed: macrocytic anemia (hemoglobin (HB) 7.1 g/dL, mean corpuscular volume (VCM) 136 fL, Red Cell Distribution Width 10.2, reticulocites 15x109). Further workup: elevated lactate dehydrogenase (LDH 1657 U/L), iron and folic acid levels normal and severe vitamin B12 deficiency (79 pg/mL). The peripheral blood smear showed macrocytosis and anisocytosis. Abdominal computed tomography and colonoscopy were normal. Upper digestive endoscopy revealed antral erythema and severe atrophy of the gastric fundus. Anti-intrinsic factor antibodies were positive while anti-parietal cell antibodies were negative.

Case 2: 44-year-old male with recurrent lipothymias. Admitted in the Internal Medicine department because of pancytopenia presenting macrocytic anemia with HB 5.1g/dL, VCM 97.9 fL, LDH 4852 U/L, normal iron levels but vitamin B12 and folic acid deficiency (50 pg/mL and 2.9 ng/mL). Peripheral blood smear: macrocytosis and anisocytosis. Bone marrow aspiration: megaloblastic anemia. Abdominal ultrasonography was normal. Upper digestive endoscopy: chronic atrophic gastritis. Anti-intrinsic factor antibodies were negative and anti-parietal cell antibodies were positive.

Both patients were transfused with 2 units of red blood cells and initiated cyanocobalamin therapy for pernicious anemia with symptomatic resolution and analytical recovery.

Discussion: The diagnosis of pernicious anemia requires a combination of laboratory tests that include the determination of vitamin B12, metabolites and / or antibodies. With these 2 cases the authors intend to alert to its different forms of presentation and the need for adequate supplementation.
Objectives: Analysis of Thrombotic Microangiopathy (TMA) cases that underwent plasmapheresis in a six years time span in an intensive care unit (ICU).

Methods: Retrospective analysis of consecutive patients with TMA undergoing plasmapheresis between 2013 and 2018. ICU admission severity index, reason for admission, clinical manifestations, microangiopathic hemolytic anemia, thrombocytopenia, ADAMTS13’s activity (ADisintegrin And Metalloprotease with a ThromboSpondin type1 motif, member13) and anti-ADAMTS13 antibodies (abs) in TTP patients, organ damage, plasmapheresis sessions per patient and efficacy, complementary therapies and mortality, were analyzed.

Results: Out of 26 patients who underwent plasmapheresis, 9 had TMA, 8 with Thrombotic thrombocytopenic purpura (TTP) and 1 Hemolytic-Uremic Syndrome, mean age of 39.9 years, 6 were women. ICU admission severity index: APACHE II 16.3, risk 24.84%; SAPS3 58, risk 32.82%. The main ICU admission reason was hemolytic anemia (89%). Neurological symptoms were present in 67% of the patients as initial clinical manifestation in which 44% had transient ischemic stroke. Pre-plasmapheresis were registered average (avg) values of hemoglobin of 6.27 g/dl (minimum of 3.9mg/dl), avg platelets 24,033x10^9/L (minimum 6x10^9/L), avg LDH 1718.4U/L. Among TTP cases, avg ADAMTS13 activity of 31% (minimum 0%) and avg anti-ADAMTS13 abs of 75.11 U/ml. Acute renal injury was observed in 67% of the patients. During ICU hospitalization, 89% had cerebrovascular thrombotic events. An average of 5.3 plasmapheresis sessions per patient was performed. In 78% cases corticosteroids were associated. Only in refractory TTP was administered rituximab and cyclophosphamide.

Conclusion: Among patients with TMA requiring ICU admission, plasmapheresis is a safe and effective treatment with great impact in in-hospital survival and should be started early as well as the workup to distinguish the TMA syndromes ensuring a more effective approach.
Primary adrenal failure and central nervous system lesion: a rare case report of Non Hodgkin's lymphoma

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Introduction The endocrine system's involvement in extra nodal non-Hodgkin lymphomas is rare. The prognostic depends on involvement of other organs such as the central nervous system. Case description We report a case of an 71 years old man presenting with a history of nausea, vomiting, lethargy, weight loss and fever a month long. Physical exam at admission showed hypotension, normoglycemia and no evidence of palpable lymphadenopathy or abdomen mass. Laboratory workout revealed hemoglobin 8,8 g/dL (12 - 15), sodium 125 nmol/L (136 - 145). CT scan showed occupant injury ependymal space in central nervous system. Abdominal CT scan disclosed bilateral adrenal masses, in the left gland with 5 cm and in the right with 4 cm of greatest diameter. At biochemistry analysis ACTH 49,8 pg/mL (< 46), serum cortisol 10,9 g/dL (5 - 25), plasma aldosterone< 1,1 ng/dL (1 - 16), DHEA-S < 15 g/dL (35 – 430), urine cortisol 8,7 g/24-hours (20 - 90) and urine metanephrines 13 g/24-hours(< 350). Primary adrenal failure was confirmed with a high-dose ACTH stimulation test and 20 mg/day of hydrocortisone was administered to maintain adrenal function. CT guided needle biopsy of right gland was performed, and histology revealed a non-Hodgkin diffuse large B-cell lymphoma. Discussion: In 70% of the cases of primary non-Hodgkin adrenal lymphoma both glands are affected. CNS involvement is a bad prognostic sign. First clinical manifestation might be adrenal failure. High degree of suspicion is needed in order to obtain an accurate and fast diagnosis.
Primary Effusion Lymphoma (PEL) in a non-HIV patient. A case report.

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INTRODUCTION
An 89-year-old male with a previous history of left ACA stroke secondary to atrial fibrillation the year prior to the admission, benign prostatic hyperplasia, and chronic iron-deficiency anemia, presented initially to the emergency department with dyspnea, cough, and progressive lower extremities edema.

CASE PRESENTATION
The initial physical examination, was compatible with acute decompensated heart failure, with jugular vein distention, positive abdominojugular test and arrhythmic heart sounds. However, the lower left lung auscultation revealed absent breath sounds.
A chest x-ray was performed revealing a left hemithorax white-out. A thoracocentesis was performed (after reversing the effect of the anticoagulation of the atrial fibrillation), with hematic exudate fluid drainage. Due to continuous worsening condition, the thoracocentesis was repeated with a total drainage of 500 mL.
The cytology of the liquid revealed a large amount of malignant cells with little cytoplasm and markedly positive HHV-8 nuclei compatible with a Primary Effusion Lymphoma (PEL).

DISCUSSION
Primary effusion lymphoma is one of the least common of the AIDS-related lymphomas. Although most cases occur in HIV-infected patients, this lesion can occur in the absence of HIV infection¹, most often in patients with other causes of immunocompromise. Human herpesvirus 8 appears to play a role in the pathogenesis, and the presence of HHV-8 in the nuclei of the malignant cells is a key diagnostic criterion. Primary effusion lymphoma has a poor prognosis, even after treatment with chemotherapy.

REFERENCE
Pulmonary Langerhans cell histiocytosis

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Introduction: Diffuse pulmonary cysts are uncommon presentations in clinical practice, which are part of the spectrum of manifestations of diseases such as lymphangioleiomyomatosis, pulmonary Langerhans cell histiocytosis, lymphocytic interstitial pneumonia.

Case report: 56-year-old black woman, with a clinical history of sickle cell, splenectomy, former smoker, admitted with mild dyspnoea, cough, chest pain, fever, myoarthralgia and headache. Analytically: hemoglobin 7.9 g/dl, Leucocytes 19,600, Neutrophils 85%, ProteinCReactive 25,9, HIV negative. Antigenuria as well as blood culture were positive for pneumococcus. Chest X-ray revealed a heterogeneous bibasal opacity, more evident to the left with interstitial component. Tomography showed "small areas of heterogeneous reticulomicronodular opacity at the basal segments of apparent inflammatory / infectious nature, several cystic lesions of different sizes, bilaterally distributed, these findings are suggestive of Langerhans cell histiocytosis/Lymphangioleiomyomatosis without excluding Lymphocytic Interstitial Pneumonia. The bronchoalveolar lavage showed a differential cell count with predominance of macrophages, bacteriological examination was negative. Distal lung biopsies revealed PLCH. Initiated antibiotic therapy with ceftriaxone with improvement.

Discussion: PLCH is predominantly diagnosed during the third or fourth decade of life and has no predominance in sex. About 90-100% of patients have a history of smoking. The PLCH presentation is pleomorphic and 25% of the patients are asymptomatic or poorly symptomatic. The presentation includes diffuse pulmonary involvement, dry cough and exertional dyspnea that may be associated with nonspecific constitutional manifestations, such as asthenia, fever, night sweats and weight loss. Spontaneous pneumothorax occurs in 10-20% of cases. The definitive diagnosis requires biopsy with identification of granulomas of Langerhans cells.
Refractory chronic Immune Thrombocytopenic Purpura: a case report

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Treatment of Immune Thrombocytopenic Purpura (ITP) treatment is based on drugs that decrease the uptake of platelets by phagocytic system or increase platelet production. The current treatment of choice in patients without severe thrombocytopenia or active hemorrhage is corticosteroid therapy (usually prednisolone 1mg/kg/day). In non-responsive patients or in severe cases, the combined use of intravenous immunoglobulin G (IgG) or Anti-RhD immunoglobulin with corticosteroids is recommended. Rituximab is also effective in the treatment of refractory ITP. Splenectomy is still an option, but less used nowadays. We present the case of a 49-year-old man with severe thrombocytopenia. The patient presented with hemorrhagic blisters in the oral cavity and dispersed petechiae. He also referred episodes of nosebleed. He denied drug or herbal product abuse or unprotected sexual activity. Thoracoabdominal CT scan had no pathological features. The complete blood count, reveals a low platelet count (7x10^9/L). Viral serologies were negative. Immune study was negative. Endoscopic studies revealed no abnormal features.

Assuming the diagnosis of ITP, the patient started high dose dexamethasone in a 4-day pulse. On the second day of hospitalization, the patient presented with macroscopic hematuria and decrease in hemoglobin concentration; platelet count was still bellow 10x10^9/L. Due to the lack of response to corticosteroids, we switched to IV immunoglobulin G (1mg/kg for 2 days). After this approach, the patient still had severe thrombocytopenia and ended up restarting daily steroids, with a slow increase in platelet counts (25x10^9/L after one week of treatment). The patient is currently in steroid withdrawal, without bleeding complaints and with a normal platelet count (200 x 10^9/L platelets).

Treatment of most patients with chronic ITP is fairly straightforward. However, this case highlights the difficult management of patients refractory to corticosteroids.
Retrospective study of erythrocyte concentrate transfusion in a Day Hospital

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The objective of this study was to analyze and describe the epidemiological characteristics of erythrocyte concentrate (EC) in a 6-month period (second half of 2017) in the day hospital, and to elaborate a transfusion orientation protocol for implementation in the studied hospital.

Retrospective and statistical analysis of the electronic clinical chart of patients undergoing EC transfusion at the day hospital of the districtal hospital at study.

A total of 121 transfusion episodes were analyzed, corresponding to 26 patients (12 females and 14 males), with a mean age of 71.8 years (maximum of 93 and minimum of 42). Each patient had on average 4 episodes of transfusion in this period (maximum 32 and minimum 1). On average, patients had a hemoglobin value of 7.42 g/dL (maximum of 9.2 and minimum of 4.8). The average units administered was 1 per episode. Post-transfusion control was rarely performed, making it difficult to assess the cost-effectiveness of transfusion. Almost all patients were found to be patients with anemia related to an oncological disease, many undergoing chemotherapy and, in this context, requiring regular transfusional support secondary to the disease itself and/or to the ongoing therapy.

Patients in need of frequent care, such as those requiring transfusional support, are referred to the Day Hospital because of their unstable base pathology, comorbidities and other ongoing therapies. In this context, the criteria for transfusion are often carried out according to an individual intervention plan. Nevertheless, a restrictive attitude is desirable given the number of episodes associated with each patient, in order to alleviate the side effects of EC transfusions and to alert to the existence of alternative supportive therapeutic.
Salmonella typhimurium in a patient with chronic alcoholic liver disease

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Introduction: Salmonella enterica subsp. enterica serovar typhimurium is a Gram-negative mostly present in the mammalian gastrointestinal tract. It is one of the few emerging invasive strains of non-Typhoidal Salmonella that causes diarrhea and bacteraemia, by food borne transmission. Affects specially patients with prior antimicrobial or immunosuppressive therapy, gastric acid suppression, malignancy, diabetes, HIV infection, pernicious anaemia, malaria, sickle cell disease, schistosomiasis. In USA 3 multidrug-resistant strains (resistant to ≥5 antibiotics) accounted for 74% of isolates. Mortality can achieve 21%.

Case description: 63 years old male, with chronic alcoholic liver disease (drinking 200g of alcohol per day), started complaints of nausea, emesis and watery diarrhea without mucus or blood, followed by a skin rash, 3 days after a lunch in restaurant. He denied fever, ingestion of non-potable water, other cases in his family and friends. He was dehydrated, apyretic, TA 75-48mmHg, pulse 94/minute, thoracic skin rash. Laboratory: hemoconcentration (Hb 16g/dL, Htc 47%), leukocytes 10 300x10^9/L, neutrophils 73%, C-reactive protein 7.1mg/dL, acute renal lesion (urea 64mg/dL, creatinine 2.38mg/dL), glomerular filtration rate 28mL/min/1.73m2, sodium 133mEq/L, potassium 2.9mEq/L. Anti HIV1 and 2 negative. Blood cultures sterile. Widal negative. Stool culture revealed Salmonella typhimurium producing extended spectrum beta-lactamasis, only susceptible to meropenem and cotrimoxazole, being medicated with the last one.

Discussion: alcohol has been mentioned in literature as having a protective effect for Salmonella gastroenteritis. However, chronic alcohol consumption and subsequent chronic alcoholic liver disease, may weaken host resistance to Salmonella typhimurium. Patients with gastroenteritis of possible Salmonella etiology and that need hospitalization, should be medicated with antibiotics after stool culture with caution of possible antimicrobial resistance.
Severe thrombocytopenia induced by Epstein Barr Virus

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Introduction

Infection caused by EBV virus is common in children and adolescents. Usually it is either asymptomatic or manifested by severe fatigue and respiratory symptoms - infectious mononucleosis. It usually has a benign course but can manifest itself in more severe ways. Severe thrombocytopenia is a rare complication.

Case description:

A 19-year-old girl was admitted due to severe thrombocytopenia (1000/uL). She had severe metrorrhagia that had started 72h before admission, generalized petechiae, and hematomas in the upper lip and palate. There was no fever and no upper respiratory symptoms. Besides the low platelet count, she had 10% activated lymphocytes, 3% monocytes, hepatic enzyme elevation and positive monotest. A bone marrow sample was drawn that showed megakaryocytosis. She had a negative autoimmune study and negative antiplatelet antibodies. There was no vitB12 or folate deficiency. There were positive EBV serology and positive viral load. She was started on corticosteroids and immunoglobulin with the recovery of normal platelet count.

Most infectious mononucleosis patients have a benign disease but some may have serious complications. Thrombocytopenia occurs in 25-50% of cases but is very rarely severe. Our patient had no classical symptoms (fever, enlarged lymph nodes or sore throat) so diagnosis was made by investigation of a serious complication.
Splenic Marginal Zone lymphoma in a 64-year-old male with hemochromatosis

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Introduction:
Hereditary Hemochromatosis is characterized, most commonly, by the presence of mutations on the HFE gene, leading to increased intestinal iron absorption, iron overload and tissue damage. Splenic marginal zone lymphoma (SMZL) constitutes <1% of all non-Hodgkin lymphomas, and typically presents with splenomegaly, lymphocytosis and cytopenias.

Case description:
64yo male, with assumed alcoholic liver cirrhosis, was admitted with acute-onset dyspnea and weight loss. Physical examination: melanoderma and inspiratory crackles; without organomegaly. Laboratory findings: Haemoglobin 12.6g/dL, mean corpuscular volume 103fL, neutrophils 1.43x10⁹/L, platelet count 38x10⁹/L, aspartate aminotransferase 77U/L, alanine aminotransferase 115U/L, normal vitamin B12/folic acid/thyroid function/lactate dehydrogenase, ferritin 2373 ng/mL, transferrin saturation 127.7%, and right pleural effusion. Diagnostic thoracocentesis: exudate with 2360 cells/µL (lymphocytes’ predominance). Thoraco-abdomino-pelvic computed tomography scan revealed splenomegaly. A bone marrow evaluation confirmed the presence of SMZL. Given the clinical/laboratory evidence of iron overload, genetic testing for HFE mutations was performed, which revealed homozygosity for C282Y mutation. He’s about to start phlebotomies and he’s on watchful waiting for SMZL.

Discussion:
Although serum ferritin and transferrin saturation may be increased in alcoholic liver disease, if one of them is high, additional testing for hemochromatosis is recommended. Control of serum ferritin levels is essential in this patient, in order to prevent exacerbation of his hepatic cirrhosis and appearance of complications due to iron overload, namely, hepatocellular carcinoma and heart failure. Despite hepatic cirrhosis is a frequent cause of splenomegaly and cytopenias, hematologic malignancies should not be overlooked particularly in such a patient with unexplained weight loss.
Spontaneous hematoma of the abdominal wall, a rare but potentially fatal situation

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Introduction: The spontaneous hematoma of the abdominal wall is a rare but serious and emergent situation. We report the case of a patient with a spontaneous hematoma who had an unfavorable outcome despite its early recognition.

Case description: A 80-year-old female with hypertensive heart disease had been recently admitted because of congestive heart failure and was discharged on subcutaneous enoxaparin because of newly diagnosis of atrial fibrillation. After 1 week the patient was admitted to the emergency room with sudden onset of right abdominal pain after severe coughing. She was stable at the admission and had a painful mass in the right abdominal flank. The blood work showed anemia (hemoglobin 7.4g/dl) and the abdominal CT-scan revealed 2 extensive hematomas with active bleeding and rupture of the superior epigastric artery. The patient developed hemorrhagic shock, which required blood transfusion and embolization of the bleeding artery. After the procedure noradrenaline was initiated but the condition deteriorated and the patient died.

Discussion: The spontaneous hematoma of the abdominal wall is rare and often due to the rupture of the epigastric artery. It occurs mostly in anticoagulated patients and in the presence of precipitants that increase the tension of the abdominal wall being cough the most common. It can simulate an acute abdomen as there is peritoneal irritation because of the blood. The treatment is conservative, however surgery is required in the setting of active bleeding and hemodynamic instability. Early diagnosis is key but in 4% of patients hypovolemic shock will lead to death.
INTRODUCTION
We present a case report about a 74 year old woman from Switzerland, who lives in Spain since her husband was retired, so we only have her medical history for 10 years. She is Witness of Jehovah, so she refuses any hemoderivative treatment. Her only son lives in Switzerland. Her medical history consist in high blood pressure, a cured hepatitis B and clinical depression evolutioned to a dysthmic disorder after the death of her husband two years before.

CASE DESCRIPTION
The patient was admitted for weight-loss study, jaundice and abdominal pain, with intermittent diarrhea and rectal bleeding.
Blood test showed 7.8 mg/dL of haemoglobin (N/N), hypogammaglobulinemia with moderate elevation of erythrocyte sedimentation rate, total and indirect bilirubin, reticulocytes and ferritin. Direct Coombs test was negative. Tumoral markers, autoimmunity and infectious serology were also negatives, except anti-HBc. Faecal occult blood testing was positive.
EKG showed atrial fibrillation with rapid ventricular response.
Intestinal ischemia was ruled out as CT angiography was made, showing moderate pleural effusion and ascites, periportal swelling, intrahepatic bile duct slightly dilated, mild homogeneous splenomegaly and atrophic pancreas with dilation of the main pancreatic duct.
Anemia study was completed with 3% of anisopoikilocytosis, spherocytes ane ekinocytes, 1% schistocytes and moderate polychromasia. Lysis in glycerol were 26 seconds. Haemolysis with glucose-6-phosphate dehydrogenase was elevated. And finally, a flow cytometric with eosin-5’maleimide, showing a 23% of decrease in erythrocytes. A diagnose of hereditary spherocytosis (HS) was made.

DISCUSSION
Between 50 and 60% of patients with autosomal dominant HE has the clinic form called typical hereditary espherocytosis, so a genetic study of the family is required. The main treatment would be splenectomy and blood transfusions, both options were refused by the patient.
Systemic Senile Amyloidosis

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Amyloidosis is a disease caused by extracellular tissue deposition of insoluble polymeric protein fibrils, with a beta-pleated sheet configuration. Systemic senile amyloidosis (SSA) is caused by a non-mutated form of transthyretin, which presents primarily as a restrictive cardiomyopathy. A 77-year-old male sent to the internal medicine consultation to study infiltrative cardiomyopathy. Personal history of hypertension, type 2 diabetes mellitus, dyslipidemia and sinus node disease, with pacemaker implantation needed. He had dyspnea for moderate exertion and orthopnea. Physical examination showed a systolic murmur, inspiratory crackles and bilateral peripheral edema, with no further changes. Analytically, PBNP was elevated, viral serologies were negative and inflammatory parameters were negative. The electrocardiogram presented sinus rhythm, with heart rate of 79 bpm and low voltage. Cardiac magnetic resonance imaging showed marked left ventricular hypertrophy, global hypokinesis and suggested infiltrative myocardial disease.

The presence of amyloid substance was confirmed by a salivary gland biopsy. There was no increase in serum or urine light chains, excluding primary amyloidosis. He had no history of chronic inflammatory or infectious disease, so secondary amyloidosis was discarded. Patient had no history of familial amyloidosis or presence of peripheral polyneuropathy. Therefore, cardiomyopathy was considered in the context of SSA. With the population ageing, senile systemic amyloidosis will be a growing problem, so the medical community should be alert to this disease. In patients with heart failure, with left ventricular hypertrophy with low voltage criteria on the ECG, the diagnosis should be considered. In addition, it is crucial to identify the type of amyloidosis, since the treatment and prognosis are different.
INTRODUCTION: T-Cell/Histiocyte-Rich Large B-Cell Lymphoma (THRLBCL) is an uncommon morphologic variant of Diffuse Large B-Cell Lymphoma, with a distinct clinical profile: frequent involvement of liver, spleen and bone marrow.

Primary Epstein Barr Virus (EBV) infection is a common human infection, exhibiting fever, pharyngitis and lymphadenopathy; fulminant manifestation of EBV is a rare occurrence.


Analytically: Hb 9.6 gr/dL, platelets 67x109/L; ESR 100 mm/1sth; normal CRP; hyperuricemia 9.4 mg/dL; normal lactate dehydrogenase; β2-microglobulin 10100 µg/L; EBV screening positive for recent infection.

Cervical lymph node biopsy: a) histology/immunohistochemistry suggested THRLBCL, not being able to rule out EBV infection; b) immunophenotyping showed infiltration of polyclonal B-cells suggestive of a strong reactive process. In spite of all the findings suggesting a fulminant EBV infection, we performed a bone marrow study suggesting a reactive process and facial lesions biopses which could not rule out herpes virus infection. Finally, it was performed immunoglobulin gene rearrangement status of B-cells confirming the clonal nature of the disease. She was staged as Ann-Arbor III-B and started immunochemotherapy+therapeuthic aciclovir. She is now on cycle 4 with good clinical/analytical response.

DISCUSSION: This case highlights the importance of pursuing all diagnostic considerations. In this patient suspected to have EBV infection, timely diagnosis of lymphoma was determining to the initiation of immunochemotherapy and subsequent clinical/analytical improvement.
Tetrapararesia by leptomeningeal dissemination in lymphoma non-hodgkin diffuse of large cells.

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INTRODUCTION: Central nervous system (CNS) involvement is an infrequent but often fatal complication of aggressive B-cell lymphomas. It occurs mainly as a leptomeningeal disease with cerebrospinal fluid (CSF) involvement.

DESCRIPTION: A 53-year-old patient with a personal history of giant cell B-cell lymphoma on chemotherapy every 3 weeks (last 3 weeks ago). For 3 weeks he has noticed progressive weakness in the lower limbs, especially in the left one (possibly out of the past, although he attributed the asthenia to the effect of chemotherapy) with difficulty in the last days for the standing, coming to fall several times. In addition to plantar paresthesias and left predominant hands. Four days ago he noticed left and oppressive punctured orbital pain at the temples and at the left parietal level. Without vomiting. Since its admission progressively worsening motor, language, difficulty in chewing and anorexia. Tetraparesis, global areflexia and hyperesthesia. Important lower back pain and lower limbs that respects sleep and that does not yield with analgesics and needs major opioids. In medullary magnetic resonance: marked leptomeningeal uptake in medullary cone and the roots of the horse's tail. A study of cerebrospinal fluid (CSF) with pathological clear liquid was performed, obtaining 124 cells, 95% mononuclear, hyperprotenorraquia and glucose consumption, being a negative microbiological study. Onconeuronal and negative antiganglioside antibodies. In the second flow cytometry, the presence of CSF infiltration by clonal B lymphocytes was observed.

DISCUSSION: CSF flow cytometry (FCM) is significantly more sensitive than cytology for the detection of CSF involvement by aggressive B-cell lymphoma and indicates the presence of CSF in a large proportion of untreated patients with clinical risk of disease of the central nervous system.
The ghosts behind deep venous thrombosis at young age

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Introduction: The main causes that lead to the development of a pulmonary embolism are obesity, contraceptive pills, venous insufficiency of the lower limbs, smoking, heart failure and thrombophilia. However, the possibility of embolism manifesting as a paraneoplastic syndrome is always there to be excluded.

Case description: 33-year-old female, obese and under oral contraception. She was admitted in our ER because of pain and edema of the right leg with irradiation to the sole of the foot. Asymptomatic from the respiratory, cardiac, genitourinary or gastrointestinal point of view. Firstly Vascular Colleagues observed the patient and confirmed deep venous thrombosis, then sent her to us for pulmonary thromboembolism exclusion. In angio thoracic CT, besides the confirmation of the diagnostic hypothesis, it was also possible to visualize superior cuts of some hepatic segments with multiple hypodense and hypovascular lesions compatible with metastases. At the colonoscopy was possible to diagnose a colon stenosing carcinoma. Despite the therapeutics instituted, she died in a few months.

Discussion: This case is useful to emphasize that deep venous thrombosis imposes the exclusion of pulmonary thromboembolism. If it is present, the neoplastic cause screening should be performed even in the presence of a young patient with a confounder factor (anticonceptive oral and obesity).
Objectives: Idiopathic thrombocytopenic purpura (ITP) is an autoimmune disorder characterized by platelet destruction leading to decreased platelet count and an increased risk of bleeding. Recent studies suggested pulsed high-dose dexamethasone given at a dose 40 mg/day to a 4-day course treatment as an alternative corticosteroid to reduce the duration and the adverse effect of corticosteroid therapy. In this randomized controlled clinical trial our aim was to compare the efficacy and the relapse free survival time of 3 therapy cycles of HD-DXM versus conventional treatment with PDN for untreated adult patients with ITP.

Method: This was a monocenter, randomized, controlled, clinical trial approved by ethics committee on medical research in Isfahan University of Medical Sciences (IUMS) and also registered in clinical trial.gov (NCT02914054). Eligible patients were randomly assigned to either enroll conventional Prednisone therapy or pulses of high dose Dexamethasone (HD-DXM) treatment. In HD-DXM arm, DXM was administered intravenously at 40 mg in 500cc normal saline (0.9% saline) during 1 hour for consecutive 4 days and then stopped. This cycle was repeated in 14 days interval to receive 3 cycles of treatment.

Results: 36 cases were given high dose Dexamethasone another 36 cases were given prednisone as control group. The following results were obtained: (1) at the end of the 3rd cycle, the overall response rate was higher in the HD-DXM group than in the prednisone group; (2) the relapse rate of the HD-DXM group was lower than the control group after 12 months discontinuation; (3) Adverse effect of corticosteroid therapy was less than the control group (p value<0.05).

Conclusion: Treatment with 3 cycles of HD-DXM pulses is an effective method for untreated ITP patients with less adverse effect of corticosteroid in comparison with conventional prednisone therapy.
INTRODUCTION: Thrombocytopenic thrombotic purpura is a thrombotic microangiopathy with onset in adulthood or childhood. The pathophysiology is heterogeneous and can be congenital or acquired. ADAMTS13 function or interveniens on its pathway are affected.

CLINICAL CASE: Female, 45 years old, without prior history of illness or medication, admitted with a sudden state of confusion, disorientation and mutism. No physical or neurological findings, except fever.

Lab results showed anaemia and thrombocytopenia. 2 units of erythrocyte concentrate, and a pool of platelets were administered.

CT scan and Lumbar Puncture showed no relevant changes. Cultures, serologies, and auto-immunity parameters were negative. C3 and C4 within the normal range.

Myelogram showed “erythroid and megakaryocytic hyperplasia, suggestive of haemolytic anaemia and auto-immune thrombocytopenia without bizarre cells”.

Platelet level decreased to the lowest of 5 000. Symptoms led to an ICU transfer. Corticotherapy and 4 sessions of Plasmapheresis were performed.

Blood work revealed: ADAMTS13 activity below 10%. Negative for ADAMTS13 antigens or antibodies. Clinically stable, the patient was discharged with corticotherapy.

DISCUSSION: Clinical features lead us to consider auto-immune, infectious or neoplastic causes. Antibiotics and corticoids played no part on initial improvement. Due to lowering platelet levels and depressed consciousness, plasmapheresis was performed resulting in stabilization. Despite the age of the patient, the lab results pointed to a congenital cause.

ADAMTS13 levels are known to correlate with the time of symptoms onset. Usually, in adulthood infections or pregnancy work as triggers. The influence of one session of plasmapheresis on blood sample results is still under our investigation.
Vitamin B12 Deficiency: An Unexpected Diagnosis in Pancytopenia

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Introduction: Vitamin B12 is an essential element in erythropoiesis, and its deficiency should be questioned when macrocytic erythrocytes are present with or without anaemia, pancytopenia or unexplained neurological signs or symptoms.

Case description: Authors described a case of a 61 years old female, with history of neuroendocrine tumour submitted to subtotal gastrectomy in December 2013. On March 2014 she was observed for progressive asthenia, anorexia and lower limb oedema and petechiae in the last 8 days. Analytically she presented leukopenia (1200 μl); thrombocytopenia (23,000) and macrocytic anaemia (3.4g/dl) without reticulocytosis. VitaminB12 and haptoglobin were decreased, LDH increased and coombs negative. Folic acid, iron kinetics, liver enzymes, bilirubin’s, and protein electrophoresis were normal. She transfused 2 units of red globes and was admitted for study. After review of the clinical process we verified the existence of atrophic gastritis in surgical specimen histology. High endoscopy exclude recurrence of disease. Abdominal echography showed mild splenomegaly and medium volume ascites. Blood smear, myelogram and bone biopsy were compatible with megaloblastic anaemia. She starts vitamin B12 supplementation. In the following months she presenting normalization of hemoglobin and leukocyte values, disappearance of ascites and oedema. Currently, maintain follow up for mild thrombocytopenia.

Discussion: Pancytopenia, when present, should lead to the exclusion of other diagnoses such as myelodysplastic syndrome (MDS), acute myeloid leukaemia or aplastic anaemia. This case highlight the contribution of the vitamin B12 deficit to the clinic presented. It is interesting that gastrectomy was not the etiologic factor but a probable precipitating factor of the clinical picture.
Vitamin D levels correlate with iron load and glycemic intolerance in thalassemia major

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Objectives: Bone health is a significant consideration for people with thalassemia. Vitamin D is a major modifiable determinant of bone health that is very frequently below desirable levels in this population. Moreover, it can be associated with other complications, including glycemic intolerance and iron overload. The aim of this study is to evaluate the correlation between vitamin D, ferritin and insulin resistance in patients with thalassemia.

Methods: 75 patients with thalassemia major submitted to weekly transfusions were included in a cross-sectional study following approval by the National Bioethics Committee. Patients were evaluated in terms of anthropometric indexes (weight, height, BMI), disease duration, vitamin D, PTH, HbA1c%, fasting glucose and insulin levels and HOMA index.

Results: In total, 75 patients were included, of which 33 (44%) male and 42 (56%) female. Mean age was 38.59 years (SD: 7.8 years). Mean vitamin D value was 31.11 (SD:10.73), with individuals (42.67%) below the threshold of 30. Using the Pearson r correlation coefficient, vitamin D serum values were weakly negatively correlated at a statistically significant (p<0.05) degree to serum ferritin (r=-0.2187), PTH (r=-0.239) and HOMA index (r=-0.216). Contrary to this finding, no significant correlation to fasting glucose or HBA1C% values could be detected.

Conclusion: Vitamin D levels remain below the therapeutic goal for the vast majority of patients with thalassemia. Vitamin D levels are also associated with lower ferritin and higher insulin production and may therefore imply better compliance and less progression of thalassemia-related complications.
Scleromyxedema – A Rare Systemic Disease

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Introduction: Scleromyxedema is a rare, chronic and systemic disease of unknown etiology, that affects adults between 30-70 years of age, with no gender preference. The disease is characterized by a generalized papular eruption and sclerodermoid induration, with histopathologic features of mucin deposition and fibroblast proliferation and in most cases is associated with a monoclonal gammopathy.

Case description: A 43-year-old previously healthy man presents with a 1-year history of painless nose and ear edema and erythema, with no other symptoms. He had been diagnosed of Relapsing Polychondritis after laboratory studies revealed normal inflammatory markers, and was started on systemic corticosteroids and methotrexate without improvement. Physical examination revealed deep furrows of the glabella, skin thickening of the ears, multiple 1-3mm diameter firm papules in the limbs, and “Shar-Pei sign” in the thighs. Lab tests showed an IgG Kappa monoclonal gammopathy and normal thyroid tests. Skin biopsy revealed mucin deposition and fibroblast proliferation. The diagnosis of scleromyxedema was made and the patient was started on intravenous immunoglobulin and thalidomide, with a partial response after 2 months. Therapy with immunoglobulin was kept and thalidomide was reduced due to side effects.

Discussion: Scleromyxedema, as well as relapsing polychondritis, can involve the ear and nose. Key features of scleromyxedema include absence of pain and involvement of the ear lobe, as seen in this case.
A common disease as manifestation of a rare disease

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Introduction: Hypogammaglobulinemia is a rare primary immunodeficiency disease. Some defects on the immune system can increase the likelihood of an infection, as well as other pathologies.

Case Description: Female, 56 years old, medical history of gastroesophageal reflux disease, was admitted with fever and myalgias with 3 days of evolution. Blood work as performed, revealing highly elevated inflammatory parameters. Chest radiography suggesting a community acquired pneumonia. The patient remained without the need of oxygen and otherwise asymptomatic, but due to the analytic inflammatory response and fever, empirical antibiotic therapy was initiated. In addition, the patient had also prior history of multiple infections, such as urinary tract infections several times a year, the flue, gastroenteritis and an infection by Herpes Zoster Virus, with regular reactivations in lumbar region, including during the hospitalization. A protein electrophoresis was performed, revealing a hypogammaglobulinemia, as well as a serum immunoglobulin quantification, that exposed a IgG deficiency in all IgG subclasses. Due to a favorable evolution, the patient was discharged after 10 days of antibiotic therapy.

Discussion: The presence of markedly elevated inflammatory parameters in the absence of significant clinical manifestations and organic compromise, led us to consider other pathologies. A disorder of the immune system can cause multiple symptoms and signs. Viral infections and lower/upper respiratory infections are common primary manifestations. Thus, in patients with history of recurrent infections, it is important to take into consideration a primary disease as the cause of the infection, leading to a reduction of the morbidity and mortality associated with multiple treatments.
**INTRODUCTION:**
Bullous pemphigoid (BP) is an autoimmune subepithelial blistering disease that most commonly arises in older adults. This is an uncommon disorder with rates of 4 to 22 cases per million individuals per year and some retrospective studies suggest that its incidence may be increasing.

**CASE DESCRIPTION**
An 84-year-old woman with prior history of stroke, presented with pruriginous tense blisters on the arms, trunk, axillary and inguinal folds, without mucosal involvement. Initial blood tests were normal except for an eosinophilia of 1200/uL.

Treatment was initiated with oral prednisolone 0.5 mg/kg and topical steroids for a suspected BP. A lesional skin biopsy from the edge of an intact blister confirmed the clinical diagnosis. Additional study, including screening for cancer, infectious and other autoimmune disorders were all negative.

The patient was discharged 22 days after hospital admission with remission of all lesions and a tapering dose of steroids.

**DISCUSSION**
Steroids are the first line therapy for this disease and despite they are rapidly effective, this is a chronic disorder characterized by exacerbations and remissions over the course of months to years.

Although the mechanisms that lead to BP are not fully understood, it is believed that autoantibody-mediated damage to epithelial basement membrane is a key factor. Associations between BP and neurological disorders as dementia, Parkinson's disease, or stroke as the case of this patient, have been reported. However further studies are necessary to fully understand the pathogenesis and the relationship between these disorders.
Rosai-Dorfman disease (RDD) is a rare histiocytosis of unknown origin. Usually presents with massive bilateral cervical adenopathy but may present with lymph node involvement in other sites and extranodal involvement of at least one site is frequent.

We present the case of a 71 years old woman admitted with two weeks evolution of polyarthralgias, fever and in the last two days nausea. She presented polyarthritis and laboratory findings were increased inflammatory parameters and erythrocyte sedimentation rate (ESR), anemia, very high ferritin and polyclonal gammopathy on serum protein electrophoresis. Her diagnostic workup was negative for infectious and rheumatic diseases. Computed tomography showed multiple mediastinal adenopathies. To exclude a myeloproliferative syndrome bone marrow smear and biopsy were performed showing hypercellular marrow and emperipolesis. She also performed colonoscopy, upper endoscopy, bronchofibroscopy, bronchial cytology and broncho-alveolar lavage, all normal. At last the endobronchial ultrasound revealed reduction of the adenopathys comparing with the CT and the histologic exam revealed sinus histiocytosis with the amount of material being too small to immunohistochemical examination. During the 6 weeks workup she maintained fever, polyarthritis and elevated inflammatory parameters which began to resolve spontaneously in the last days.

The presence of massive lymphadenopathy with sinus histiocytosis, fever, increased inflammatory parameters, ESR and polyclonal gammopathy with spontaneous remission and an exhaustive workup without other cause led to the presumptive diagnosis of RDD.
A rare cause of abdominal pain and fever

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Introduction: A periampullary duodenal diverticulum compressing the distal common bile duct resulting in obstructive jaundice, without gallstones or another cause to direct hyperbilirubinemia, is called Lemmel syndrome.

Case description: An 89-year-old male was admitted to the emergency department with a one-day history of fever and chills; the patient referred intermittent abdominal pain in the upper right quadrant during the last month, worsened in the last three days. He was hemodynamically stable but febrile, had scleral icterus and abdominal right upper quadrant tenderness. Laboratory findings revealed a total bilirubin of 5.1 mg/dL (direct fraction: 2.9mg/dL), serum aspartate aminotransferase: 171U/L, alanine aminotransferase: 243U/L, alkaline phosphatase: 236U/L, γ-glutamyl transferase: 374U/L and C-reactive protein: 13.2mg/dL. Complete blood count was normal. Abdominal ultrasonography showed no evidence of choledocholithiasis or dilation of biliary and main pancreatic ducts. The patient was admitted to the internal medicine ward with suspected acute cholangitis and started on antibiotic. Abdominal computed tomography scan showed a duodenal diverticulum of the second portion of duodenum (2ndPD) and dilation of biliary tree, without evidence of pancreatic lesions. All microbiologic studies and serologic tests were negative. The patient completed 7 days of antibiotic therapy, with clinical and laboratorial improvement. Later, a magnetic resonance cholangiopancreatography showed discrete dilation of the intrahepatic bile ducts and a 2,5 cm diverticulum on the 2ndPD, without cholelithiasis or choledocholithiasis.

Discussion: Lemmel syndrome is a rare and benign cause of obstructive jaundice. High index of suspicion is important to establish an accurate diagnosis since it can mimic a malignant neoplasm.
A rare cause of dyspnea

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Introduction

The pseudocyst of pancreas is a complication of acute or chronic pancreatitis. By breaking the pancreatic duct into retroperitoneum, pancreatic fluid can migrate into the mediastinum via esophageal or aortic hiatus, generating symptoms by compressing adjacent structures: dysphagia, dyspnoea, chest pain.

Case description

A 57 years old male, chronically consuming ethanol, with pulmonary tuberculosis, in the 3rd-month of treatment was submitted for a cardiologic evaluation because of dyspnea and atypical precordial pain, unjustified by the good evolution of pulmonary disease. Echocardiography and the general ultrasound scan showed a voluminous pancreatic pseudocyst migrating into mediastinum, which was compressing the heart. Toracoabdominal CT confirmed the diagnosis. As a particularity our patient had no history of acute or chronic pancreatitis. Percutaneous drainage of the cyst was successfully performed; control at one month, 3 and 6 months showing changes of chronic pancreatitis, without recurrence of the cyst.

Disscution

The pancreas pseudocyst migrated to mediastinum is a rare complication of chronic pancreatitis. It can cause minor thoracic symptoms. For the accuracy of the diagnosis and the setting of the treatment strategy, a multimodal imaging approach is needed in which the ultrasound exam has a leading role. The accurate diagnosis is important for this unusual and potentially life threatening presentation of a common complication of pancreatitis. Physicians should be aware of atypical presentations and treatment options available for such mediastinal extension of a pseudocyst.
A story Spontaneous calyceal rupture when the ureter Bursts

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Introduction - Rupture of the urinary collecting system with perirenal and retroperitoneal extravasation of the urine is an unusual condition that is typically caused by ureteral-obstructing calculi.

Case Description – Man 40 years, without pathologic background presents in the ER with pain in the left flank with irradiation to the left iliac fossa ; positive kidney percussion test, complaints of oliguria . He was treated with analgesic and maintained the symptoms . A CT scan was preformed: "Moderate proximal pelvic and ureteral dilation to the left, visualizing a radiodense calculus in the proximal third of this ureter with 5mm of greater axis. Moderate liquid infiltration of the perirenal fat coexists, with signs of extravasation of contrast in the excretory phase of the study for the latter last space, translating rupture of this excretory tree". Patient was transferred to Urology and submitted to surgery and JJ stent placing.

Discussion: The clinical manifestation of spontaneous urinary extravasation is diverse, ranging from mild flank discomfort to unremitting abdominal pain such as acute abdomen. Spontaneous calyceal rupture should always be considered in the differential diagnosis of a patient presenting with complex symptoms after renal colic. CT scanning, can make the differential diagnosis of acute abdomen, obtain more accurate information about the location and the size of the urinoma and assessing progression. Stenting of the ureter is a treatment method for calyceal rupture with upper ureteral and ureteropelvic junction stones. As the first therapeutic step, a low pressure system should be established.
Introduction
Osler’s triad which reunites pneumonia, meningitis and endocarditis is a rare syndrome nowadays and in spite of the progress in medicine, the mortality is still high.

Case description
A 62 y/o man, had presented in March 2017 pulmonary sepsis and secondary infections – meningitis, arthritis, and had received extensive antibiotic treatment for three weeks. He was readmitted two weeks later for persistent fever and the intensive antibiotherapy was resumed. During the next three months the patient was subjected multiple times to transthoracic echocardiography (TTE) which revealed moderate aortic stenosis, without evident vegetations. A month prior to the admission in our Clinic, the patient complained of shortness of breath and a tumoral formation in the pericardium at a TTE exam was observed. During his stay in our department in July 2017, he was diagnosed with severe aortic stenosis, moderate aortic regurgitation and a heterogeneous formation in the pericardium which was compressing the right cavities and the suspicion of previous infective endocarditis (IE) on bicuspid aortic valve was raised. The TEE examination confirmed the aortic bicuspidy and revealed a cystic formation in the pericardium and an image suggestive of drained aortic root abscess. The chest CT confirmed the fluid nature of the tumor, and the patient was subjected to cardiac surgery for ascending aortic reconstruction, aortic valve replacement and drainage of the pericardial formation – Streptococcus mitis was isolated in the pus.

Discussion
Probably the patient had had IE with secondary infections – meningitis and pneumonia which dominated the clinical picture, thus delaying the diagnosis.
INTRODUCTION - Beriberi is probably much more common than previously recognized in the developed country. This must be considered a differential in patients presenting with hyperdynamic circulation. There are many clinical complexity involved in the diagnosis and management of thiamine deficiency. Early suspicion and initiation of therapy is crucial especially with the increasing number of migrant workers in modern communities. CASE DESCRIPTION-A 23-year-old Myanmar domestic worker presented with acute dyspnoea and marked lower limb oedema to our local hospital in Singapore. Clinical examination revealed tachycardia and respiratory distress with pulsatile neck veins. A chest X-ray showed cardiomegaly with pulmonary congestion. Initial impression was high output cardiac failure and was admitted under cardiovascular service. Diuretic therapy was initiated. Laboratory tests reported no proteinuria; normal serum levels of urea and creatinine. The haemoglobin levels, thyroid function test and cardiac enzymes were within normal range. An echocardiogram showed reduced left ventricular (LV) function, enlarged right ventricle with dilated pulmonary arteries. She continued to deteriorate and required higher oxygen demands. Referral was made to internal medicine service. Further questioning revealed numbness on both lower limbs and reduced oral intake. In view of her dietary history and acute presentation, therapeutic trial of thiamine replacement was given. Clinical response of the treatment was immediate with recovery of cardiac function on repeated echocardiogram. DISCUSSION—The diagnosis of beriberi secondary to thiamine deficiency is not straightforward due to its nonspecific symptoms, signs and diagnostic tools. Therefore, a constellation of findings including history, physical examinations, and cardiac imaging modalities should form the basis of early diagnosis. In which trial of therapy will significantly change the outcome by initiation of appropriate treatment.
Dandy-Walker syndrome: case report in an adult

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Introduction: Dandy-walker syndrome is a rare congenital malformation that involves the cerebellum and the fourth ventricle. It has a range of symptoms that normally manifest in early childhood. The diagnosis is reached by prenatal ultrasound and after birth by magnetic resonance imaging.

Clinical Case: The authors present the case of a 72 year old man with a history of dementia, depressive syndrome and mild cognitive impairment. He was brought to the emergency department (ED) when he was found lying on the floor unconscious/conscious by his wife. Initial observation at the ED showed that he was confused and not cooperative although no focal signs were found. Computed assisted tomography of the brain was performed and demonstrated a hypoplastic cerebellum malformation, Dandy-walker type, revealing a communication of the IV ventricle with a retrocerebellum cyst, without supratentorial hydrocephalous. The patient’s neurological state improved gradually during the observation period. He was discharged from the hospital, with a neurology consultation scheduled.

Conclusion: Although rare, some cases of Dandy-Walker syndrome in adults have been described worldwide. Knowledge of this pathology is important because not only asymptomatic presentations have been a challenge but also difficult medical access and lack of diagnostic tools in certain countries lead to a later diagnosis in life.
Eosinophilic Ascites: a Rare Presentation of Eosinophilic Gastroenteritis.

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Introduction
Eosinophilic gastroenteritis (EGE) is an uncommon disease of unknown etiology reported in both adult and pediatric age groups. Here we report the case of a 17-year-old female patient who presented to us with ascites and abdominal pain with peripheral eosinophilia, and diagnosed as EGE.

Case presentation
We report the case of a 17-year-old woman, without past history, presented with diffuse abdominal pain, nausea, abdominal distension, and moderate ascites of two weeks' duration. Other physical and clinical examination showed recent shortness of breath. Thoraco-abdomino-pelvic CT scan showed the presence of ascites and diffuse thickening of small bowel wall. There were neither lymph nodes nor spleen enlargements. Laboratory test results revealed essential peripheral blood eosinophilia, elevated serum Ig E, and marked increase of eosinophils in the abdominal fluid. Bone marrow biopsy confirmed isolated eosinophilic hyperplasia. The immunophenotypage of medullar lymphocytes was normal. The screenings of the mutations of FIP1L1 PDGFRA and PDGFRB genes and JAK2 V617 were negative. Upper and lower endoscopy showed duodenitis. Systematic biopsy revealed eosinophilic colic infiltration. Treatment with oral corticosteroids normalized laboratory tests results, the ascites resolved immediately, and the patient recovered from her symptoms.

Conclusion:
EGE is a rare entity and it should be kept in mind in patients of unexplained ascites. The absence of primary myeloid and lymphoid malignancies, coupled with marked increase of fluid eosinophilia, eosinophilic tissue infiltration, and immediate response to treatment with oral steroids, confirm the diagnosis of EGE.
Introduction:
Hereditary hemochromatosis (HH) is a genetic disease, associated with mutations in the HFE gene, the most common mutations are C282Y and H63D. An abnormal absorption of intestinal iron occurs with the consequent excessive accumulation of the same in the organism, causing tissue injury and dysfunction of several organs, frequently leading to cirrhosis of the liver.

Case description:
The authors present the case of a 74-year-old caucasian man, who was referred to the emergency department for jaundice with 8 days of evolution, coluria, asthenia, anorexia, and joint pain. Examination show cutaneous hyperpigmentation. Analytically mixed hyperbilirubinemia at the expense of indirect hepatic cytocholasease pattern. Elevated tumor markers for which a study of the digestive tract was requested which was inconclusive. Iron kinetics were requested which revealed elevated iron, very high ferritin and transferrin saturation of 119%. Study of negative autoimmunity. The diagnostic hypothesis of HH was established, and hepatic biopsy was performed, which revealed aspects compatible with chronic hepatitis in the cirrhosis phase and moderate iron deposition (siderosis grade II / IV). The genetic study for detection of HFE gene mutations revealed heterozygosity for H63D mutation. After initiation of periodic hematophores, the clinical and analytical response was favorable.

Discussion:
The major strategy in relation to HH is early diagnosis, which requires a high level of suspicion and is fundamentally based on the study of iron metabolism, genotype and hepatic biopsy, as well as the timely institution of adequate therapy.
Kawasaki disease in an Adult Female from Iran

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Introduction: Kawasaki disease is an acute necrotizing vasulitis of small-to-medium sized vessels affecting predominantly children younger than 5 year-old, but it occurs rarely in adults. Although its rarity and broad differential diagnosis it should be considered in adults with clinical features of the disease as previous studies from other regions reported typical and atypical manifestations of Kawasaki disease in adults.

Case description: A 23-year-old woman was referred to Al-zahrah Hospital, a main referring medical center in Isfahan in the center of Iran because of prolonged fever and arthralgia began 1 week before admission in March 2017. She reported a 1 week of fever with arthralgia and general malaise. During several outpatient visit oral and parenteral antibiotics such as co-amoxiclavunate, ampicilline and azithromycine was prescribed for her but her fever did not abate and general condition deteriorated. On physical examination, the patient’s temperature was 39.7 °C. She had bilateral non-purulent conjunctivitis and strawberry tongue. She had hyperemia and desquamation on both palms but only hyperemia on soles. After 10 days from onset of fever desquamation of soles began.

Discussion: Kontopoulou et al had described Kawasaki disease in adults with geographic distribution. According to this review only 100 cases of adult Kawasaki disease had been described until 2015 and never reported in the literature from Iran yet. There is no specific test for its diagnosis and due to its rarity diagnostic criteria in adults has not been established. The diagnostic criteria for Kawasaki disease was reported since 1967 for children. It is defined complete when 4 of the 5 principal features are fulfilled despite of at least 5 days of fever and is defined incomplete when clinical features do not fulfill the criteria but based on coronary abnormalities the diagnosis is established.
INTRODUCTION: Osteonecrosis (ON) is a disease usually occurring in a younger population, with potentially devastating consequences. It can have many causes, both traumatic and non-traumatic. The femoral head is the most commonly affected site, with other bones being affected far less frequently.

CASE DESCRIPTION: A 54-year-old woman, active smoker and with coronary artery disease, breast cancer under hormone therapy with anastrozole, and a recent prolonged hospital stay due to pneumonia and meningitis without isolated agent, complicated with cerebral abscess, with need for high dose corticosteroids, developed pain and inflammatory signs in the right foot, with difficulty walking. She reported no previous history of trauma. Her initial imaging exams were inconclusive but magnetic resonance imaging showed multiple ON lesions in distal tibia, talus, calcaneus, navicular, first metatarsal and cuneiforms. Computed tomography angiography found bilateral areas of arterial occlusion in both inferior extremities. Additional study revealed no other contributing diseases. As such, the ON was attributed to the added effects of smoking, steroid therapy, peripheral artery disease and, eventually, anastrozole medication. The patient was treated with statins, anticoagulation and symptomatic analgesia and has no surgical indication. Hyperbaric oxygen therapy will be considered in case of refractory symptoms.

DISCUSSION: The pathophysiology of nontraumatic ON is believed to be related to the death of cellular bone components due to vascular compromise; therefore it is more common in bones with less abundant blood supply. The ankle and foot are rare anatomical sites of ON, and it is especially rare for several bones to be involved. The authors would like to highlight the importance of being aware of this entity, which, although rare, can cause significant morbidity.
Neurologic complications of Rendu-Osler-Weber disease

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Introduction: Hereditary Haemorrhagic Telangiectasia (HHT), also known as Rendu-Osler-Weber disease, is a rare disorder affecting the vasculature of several organs. Telangiectasias and arteriovenous malformations (AVMs) are its hallmark features.

Case description: A 47-year-old woman with family history of HHT presented with symptoms consistent with stroke, confirmed as an ischemic event of the posterior inferior cerebellar artery and right vertebral artery dissection on MRI. She had no evident cerebrovascular risk factors, but had a history of epistaxis. A pulmonary CT showed bilateral AVMs and thus the diagnosis of HHT was assumed. She recovered completely. One year later she presented with fever, headache, nausea, vomiting and left homonymous hemianopsia. A MRI showed frontal and occipital cerebral abscesses. She was treated with antibiotics and surgical drainage, recovering completely. To prevent further complications, the pulmonary AVMs were managed with percutaneous embolization and segmental pneumectomy. The genetic study confirmed HHT with a genetic variant on ENG gene, not described in literature. The patient had no further complications.

Discussion: Acute ischemic stroke is often the first manifestation of HHF; these patients are generally young and with no evident risk factors for cerebrovascular disease. Cerebral abscesses are a recognized complication of pulmonary AVMs, therefore, prophylactic antibiotics and early management of AVMs should be considered in all patients with HHT. With this case, we aim to highlight the neurologic complications of this disease and the importance of the early management of the AVMs.
Neurological signs in an immunocompromised patient

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Introduction
Brain abscesses are a rare complication that may occur in patients immunocompromised. They can present non-specific symptoms, that could delay the diagnosis and treatment.

Case description
An 84-year-old male went to the Emergency Department with confusion, hallucinations, and a progressive decline of general status in a few months. Had been medicated with prednisolone 60 mg/day during the previous three months due to a diagnosis of giant cell arteritis. He presented at admission prostrated, with dysarthria, dysphagia, right hemiparesis, fever and respiratory infection signs. Blood analysis showed increased inflammatory parameters, with a sedimentation rate of 105 mm/h and no relevant alterations in thoracic radiography, suggesting a respiratory infection that lead to the administration of ceftriaxone 2gr/day. Latter a head computed tomography (CT) showed multiple supra and infratentorial lesions suggestive of cerebral abscesses, confirmed by magnetic resonance imaging (MRI). Empirical antibiotherapy with ceftriaxone, vancomycin, metronidazole and cotrimoxazole at meningeal doses was initiated. No agent was identified on lumbar puncture, multiple blood cultures, thoracic, abdominal and pelvic CT and transthoracic echocardiogram. The patient presented a gradual clinical improvement. The case was discussed with the neurosurgery that decided not to perform a brain biopsy, due to the age of patient and clinical improvement, and was maintained empiric antibiotherapy for six weeks. The MRI repeated at four weeks showed a clear decrease in number and size of lesions. The patient had discharge just with dysarthria, dysphagia and imbalance. After two months the clinical and imagiological improvement is sustained.

Discussion: It's important to keep in mind the early clinical suspicion of brain abscesses, specially in patients undergoing prolonged corticosteroid therapy.
Rare Leukemia associated with an even rarer disease (KIMURA's disease): about an observation

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Introduction:
Kimura's disease or eosinophilic lymphogranuloma is very rare chronic inflammatory disease of unknown etiology.
The association of KIMURA with leukemia and autoimmunity has never been described before. We report a case.

Case description:
70-year-old patient with a history of hypertension consulted in 2014, for a mandibular lymphadenopathy, right parotid swelling and cutaneous infiltrated rash.
Surgical biopsies and skin biopsies confirmed Kimura's disease (angiofollicular hyperplasia with eosinophilia, affecting all ganglia examined, tumor masses and skin lesions).
Biology: Hemogram showed monocytosis >2500 / mm3 with no other anomaly except moderate transient eosinophilia. High C-reactive protein. Presence of anticardiolipin antibodies + significant anti-beta 2 GP1 antibody + antinuclear antibodies. Bone marrow biopsy: marked medullary hyperplasia of granulocytes compatible with inflammatory origin.

Corticosteroid was started since 2014 with primary prophylaxis by antiplatelets.
The outcome being initially very favorable under high doses then recurrence once corticosteroids less than 20 mg/day, which required introduction of MYCOPHENOLATE MOFETIL (MMF) since 2015, with excellent results and total disappearance of monocytosis for 2 years.
Reappearance of monocytosis 2300/mm3 at the end of 2016.
A new Bone marrow aspirate showed a chronic myelomonocytic leukemia of type LMMC-1. The karyotype was normal. Since then, MMF was discontinued with the continuation of corticosteroids alone (15-20 mg/day).
Discussion:
KIMURA's disease is rare in Caucasians. The associated autoimmunity &/or hematological malignancy had never been reported before. Is it a complication of KIMURA or secondary to MMF? This requires the collection of other similar cases in order to establish a cause/effect.
Rare diseases
A-1675

Recurring Hypopotasemic Paralisis: a Strange Channelopathies

Cataldi Amatriain Roberto, Franco Amaro, Adel Escobar García, Lucas Dolcemelo, Matías Ottaviani and Lorena Baez.

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Introduction
Among the transient neurological syndromes the recurrent hypopotasemic paralysis is a prototype of neurological symptomatology which appears not much frequently. This pathology is characterized by severe muscular events with variations of potassium blood. There are genetic changes that codify ion channels and they produce the symptomatology that the patients show. There is a dominating autosomic transmission.

Case description
Three cases, two men and one woman adults. Both men consulted for recurrent tetraparesia among other symptoms, and the woman for muscular weakness repeated. In the three we find hypopotasemia coincidental with the symptoms and with the replacement of potassium disappearance of the symptoms.

Discussion
The clinical parameters are specified for the diagnosis and they are validated with the personal assistance of three patients with that pathology. The main substantial treatment is predominant substitute.

Key words: hypopotasemic, tetraparesia, muscular weakness.

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Subacute chorea - Probable Sydenham’s chorea

Introduction: There are several etiologic causes for chorea, such as hereditary neurodegenerative diseases, cerebral structural damage associated with autoimmune diseases (Sydenham chorea - SC, systemic lupus erythematosus among others), metabolic disorders or toxic / drug cause.

Description of the case: We report the case of a 24-year-old woman, a history of recurrent otitis about 5 per year, psychiatric problems (anxiety / depression). Negative family history for neurodegenerative and hereditary diseases. The patient was admitted by generalized chorea without dystonia. The patient had a clinic of 3 months of evolution of choreic movements with progressive aggravation that interfered with the activities of daily life, without other symptoms. The patient initiated haloperidol and benzodiazepine with symptomatic improvement. An exhaustive study with a metabolic, infectious (serological viral, syphilis, blood cultures); endocrinological, immunological screening; peripheral blood smear; nuclear magnetic resonance of the brain; chest X-ray; abdominal ultrasound were: normal or negative. Anti-streptolysin O antibodies (TASO) were slightly elevated. Trans thoracic echocardiogram with suggestive alterations of rheumatic carditis. Observed by otolaryngology without changes to otoscopy. Therefore, the probable diagnosis of Sydenham’s chorea (due to repetitive otitis, echocardiogram changes and increased TASO) was assumed.

Discussion: SC is a movement disorder characterized by chorea, emotional lability and hypotonia. It is more common in children and adolescents, but it also occurs in adulthood. Symptoms usually begin between 1-8 months after the onset of rheumatic fever. Chorea is a common manifestation of rheumatic fever as demonstrated in the clinical case described above.
Transthyretin amyloidosis (ATTR): A case report

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Introduction:
Transthyretin amyloidosis (ATTR) is the least frequent type of amyloidosis, with two variants: the hereditary form and the wild-type or senile form.

Case description:
Female 67 years old, with no personal or family history of interest. In April 2017, she began with a progressive pain pattern in lower limbs of burning characteristic, allodynia, paresthesias and motor weakness in both lower extremities, requiring a walker. The neurological examination showed a postural guarding. And to the superficial touch, burning pain arose. EMG revealed signs consistent with chronic sensory-motor, axonal polyneuropathy, of moderate-intensity in lower and upper extremities. Metabolic, immune and imaging studies to rule out possible causes were negative.

Suspecting amyloid polyneuropathy, left sural nerve biopsy was performed, but the histopathological study was negative. With these data, immunoglobulins and corticosteroids were started to treat a possible chronic inflammatory demyelinating polyneuropathy (CIDP), with discrete (but not maintained) improvement.

In November 2017 she was hospitalized again due to cardiac decompensation, with a normal transthoracic echocardiogram. In February 2018 she was readmitted due to worsening of her polyneuropathy and heart failure. On this occasion, proteinuria in nephrotic range was observed. A new TTE evidenced moderate-severe systolic dysfunction. Given these findings suspected systemic amyloidosis is reawakened, performing a lumbar puncture (with increased protein without cellularity present) and biopsies of subcutaneous fat, rectal, renal and myocardial; this last one showed to be positive for ATTR. Unfortunately, the patient presented progressive clinical worsening requiring sedoanalgesia, finally dying.

Discussion:
Although it is more possible that our case is a wild-type (since she does not have a family history), the atypical clinical manifestation requires confirmation and/or genetic exclusion.
Urinary 2,8-Dihydroxyadenine Excretion in Patients with APRT Deficiency, Heterozygous Family Members and Healthy Subjects

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Objectives: Adenine phosphoribosyltransferase (APRT) deficiency is a rare disorder of adenine metabolism resulting in renal excretion of the poorly soluble 2,8-dihydroxyadenine (DHA), leading to kidney stones and chronic kidney disease. We recently developed a high-throughput ultra-performance liquid chromatography – electrospray tandem mass spectrometry (UPLC-MS/MS) assay for measurement of DHA in urine samples. The purpose of this study was to assess the urinary DHA excretion in patients with APRT deficiency, heterozygotes and healthy subjects.

Methods: Data from 19 patients in the APRT Deficiency Registry of the Rare Kidney Stone Consortium, 4 heterozygotes and 10 healthy volunteers, not taking medications affecting the metabolism or excretion of purines, were included in the analysis. DHA excretion was measured in timed urine collections and first random void urine samples and expressed as mg/24 hrs or DHA-to-creatinine (DHA/Cr) ratio. The detection limit of urinary DHA was 100 ng/mL. Wilcoxon-Mann-Whitney test was used to compare the urinary DHA/Cr ratio between the 3 groups.

Results: The median DHA excretion measured in 28 timed urine collections from 19 patients with APRT deficiency was 138.1 (63.8-291.5) mg/24 hrs. The DHA/Cr ratio in the morning void urine samples was 13.1 (3.8-37.2) mg/mmol. The DHA concentration was below the detection limit in the urine samples from 4 heterozygotes and 10 healthy individuals (p=.000).

Conclusions: Urinary DHA excretion was marked but variable in all patients with APRT deficiency, while it was undetectable in heterozygotes and healthy subjects. This highly sensitive and specific urinary DHA assay facilitates the diagnosis and pharmacologic treatment of APRT deficiency.
Vascular Chorea – An unusual presentation

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Introduction - Chorea may occur as a symptom of acute stroke; it may be manageable or progressive. Patients with vascular-related chorea typically present with an acute or subacute onset of this symptom on one side of the body (hemichorea), contralateral to the lesion. Cerebrovascular disease is the most common cause of sporadic chorea. Lesions are most frequently found in the thalamus and lentiform nucleus.

Case Description – Man, 92 years old, institutionalized, hygiene-dependant, cognitively able suffering from residual paquipleuritis, dementia, chronic anemia and Dupuytren contracture. Arrives at the ER on 22/01 with right hemibody large amplitude involuntary circular movements with superior limb predominance that had been progressing for 48h. Otherwise asymptomatic. Analytical investigation of no significance, but left parietal focal hypodense area on Brain CT imaging of probable ischemic etiology. Admitting an ischemic chorea, a 75% stenosis of the left internal carotid was found. Given age and comorbidities, vascular surgery was discarded, proceeding only with medical treatment. Antichoreic drugs allowed for symptomatic relief.

Discussion – The long-term prognosis is determined by the prognosis of the acute stroke and not by the severity of the chorea itself. Symptomatic treatment with antichoreic drugs may be necessary in the acute phase. Surgery is rarely indicated to treat vascular chorea.
Von Hippel-Lindau disease is a cancer syndrome associated with a germline mutation of the VHL tumour suppressor gene on the short arm of chromosome 3 that is inherited as a highly penetrant autosomal dominant trait. Affected individuals are at risk of developing various benign and malignant tumours of the central nervous system, kidneys, adrenal glands, pancreas, and reproductive adnexal organs. We present the case of a 26-year-old female with no relevant personal or family history referenced by neurosurgery for etiological investigation of hemangioblastoma of the posterior fossa. A genetic diagnosis of Von Hippel Lindau Disease (VHL gene mutation: c.470C>T (p.Thr157Ile)) was confirmed. During the follow-up vigilance in Internal Medicine, she developed cervical pain complaints with irradiation to the left upper limb, associated with a slight motor deficit. No headache/vomiting or changes in cranial nerves. Magnetic resonance imaging (MRI) identified a second hemangioblastoma in the C5-C6 plane with a cystic component extending from C2 to D1. The patient was subjected to surgery with complete removal of the cervical hemangioblastoma and drainage of the cystic cavities adjacent to the lesion. Because of the complexities associated with management of the various types of tumours in this disease, treatment and vigilance is multidisciplinary. Comprehensive serial screening and routine scheduled follow-up are essential for proper care. This patient undergoes ophthalmology evaluation, catecholamine dosing and abdominal ultrasound/ MRI annually and brain/spine MRI and audiometry every 6 months.
"Old but gold"

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Introduction: The CHADS² score estimates the risk of stroke in patients with atrial fibrillation, as well as allows to decide on the introduction of anticoagulant or antiaggregant therapy. The HAS-BLED score evaluates the risk of bleeding in patients with atrial fibrillation under prophylactic anticoagulant therapy. However, the decision to hypocoagulate or suspend hypocoagulation in a patient does not always come down to the application of these scores.

Case description: A 101-year-old Franciscan monk, cognitively preserved. History of arterial hypertension, ischemic heart disease, atrial fibrillation, pacemaker device, hypocoagulated with rivaroxaban and anti-aggregate with acetylsalicylic acid. Interned in the Internal Medicine department for a heart failure descompensation caused by anemia, in the context of acute upper gastrointestinal bleeding with gastric ulcer starting point. He performed endoscopic treatment and transfusion of red blood cells, with gradual recovery of the hemoglobin value from 7.8 to 9.6 g / dl, without further blood loss. Given the patient's hemorrhagic risk, we decided to suspend oral hypocoagulation, maintaining acetylsalicylic acid 100mg and pantoprazole 40mg twice daily for 1 month. Three weeks after hospital discharge, the patient went to the emergency department for focal neurological deficits, namely left paresis of brachial predominance. Cerebral computed tomography (CT) revealed a "frontal and temporal corticosubcortical hypodense area on the right, reflecting acute infarction in the territory of the middle cerebral artery." He was hospitalized for 3 days, presenting progressive clinical improvement and near total recovery of the initial deficits.

Conclusion: In many cases there is no right or wrong way to decide to start or suspend hypocoagulation. It is up to the physician to weigh risks and benefits and make a decision in the hope that it will be the best for the patient, whatever his or her age.
80 year-old man with left ventricular diastolic dysfunction to study

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INTRODUCTION

This patient is in a Cardiology study at the time of entering Internal Medicine due to left ventricular diastolic dysfunction with echocardiography and cardio-resonance findings of infiltrative disease with late gadolinium reality of the left ventricle (suspicion of cardiac amyloidosis) with negative endomyelial biopsy for amyloidosis.

CASE DESCRIPTION

An 80 year-old man, allergic to quinolones and macrolides, chronic macrocytic anemia, chronic prostatitis and permanent atrial fibrillation. He went to the emergency department for left hemicranial contusion after accidental fall with left deviation of the mouth and inability to close the right eye. He has presented the previous days expectoration, lower limb edema and right costal pain.

On examination, jugular ingurgitation, arrhythmic heart sounds without murmurs, hypophysis in both lung bases predominantly in the right base, edema with fovea in the lower limbs and positive Bell sign in the right eye. The rest of the exploration without findings.

The differential diagnosis of the patient: secondary amyloidosis, Fabry disease, mitochondrial cardiomyopathy and restrictive cardiomyopathy (sarcoidosis, hemochromatosis, etc.). He presents angiotensin-converting enzyme: 34 mcg/l, normal protein and normal ferritin. Amyloidosis is the main diagnostic suspicion, so a rectal mucosa biopsy is requested.

He presents a torpid evolution, hospitalization in the ICU and dies within a few days. The pathology report reports AA (secondary) amyloidosis with Congo red staining.

DISCUSSION

The most common underlying disorders associated with AA amyloidosis include rheumatoid arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, inflammatory bowel disease, etc. The inflammation of unknown etiology seems to be responsible for a growing proportion.
Antithrombotic therapy in geriatric patients with atrial fibrillation

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Objectives: In geriatric patients, many factors modify the risks associated with both atrial fibrillation and anticoagulant therapy. The aim of our study was to evaluate the indications of antithrombotic therapy with respect to the drug and dosage selection.

Methods: All patients with atrial fibrillation hospitalised in Geriatric department in University Hospital Olomouc between October 2017 and March 2018 were included. Selection of the antithrombotic agent and its dosage and patients’ demographic and clinical characteristics (age, weight, renal parameters, functional status, co-medication, CHADS-VASc and HAS-BLED scores) at the discharge were analysed.

Results: A total of 138 patients were included, which represented 37.6% of all hospitalised patients. Direct oral anticoagulant (DOAC) was indicated in 23.91% of patients, mostly by a neurologist. With the exception of 9 patients, DOACs were used in the reduced dose, which was consistent with SPC recommendations. Low-molecular-weight heparin (LMWH) was chosen as a temporary strategy in patients transferred to the long-term nursing care beds (40), in patients indicated for early invasive procedures (7) and for home care (13). Vitamin K antagonist (warfarin) was used in 10 patients, mainly in chronic users with no recent alterations of thrombotic and/or bleeding risks. Due to significant comorbidity, patient’s functional status and risk/benefit ratio, antiplatelet therapy was preferred in 24 patients. In 9 patients no antithrombotic therapy was indicated.

Conclusion: DOACs prevailed over coumarines, but LMWH still represents a common treatment strategy. Aspirin is often indicated in fragile patients with an uncertain prognosis.

Disclosure of Interest: None declared.

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Elderly people sometimes have difficulty expressing and explaining complaints, so too often clinicians tend to say they are “confused”. The “confusion” can be the result of physical limitations to word articulation, poor vocabulary, previous conditions (aphasia, dementia) or other in other cases, delirium...

CLINICAL CASE: 81 year-old woman, with hypertension, dyslipidaemia, obesity, epilepsy, depression, heart failure and hypothyroidism. She was found fallen on the floor of her bedroom by domiciliary care, with “nonsense” speech, assumed as dysarthria. She was unable to move her right arm. Major head, cervical thoracic and abdominal trauma were excluded. Head CT scan showed no acute ischemic or haemorrhagic lesions. The right arm paralysis and the “confusion” were interpreted as manifestations of acute stroke. She didn’t have any speech problems at the ER (real problem was lack of teeth). In the internal medicine ward, she had paralysis of right arm with pain on active and passive mobilization of the shoulder, features of local articular and/or periarticular disease. Shoulder X ray excluded fracture but showed subluxation. Electromyography revealed right brachial plexus partial lesion. Shoulder MRI showed complete rupture of the hood with myotendinous retraction, exuberant subacromial-deltoid bursitis and surrounding soft tissue oedema.

She was treated with oral steroids for 2 weeks and started on a physical rehabilitation program with physiatry surveillance. She was discharged with partial recovery of function and was kept on rehabilitation program.

DISCUSSION: Limb paralysis is commonly the basis of the clinical diagnosis of stroke. When dealing with patients with cardiovascular risk factors and acute limb paralysis, it is important to be open-minded. Several disorders presenting with an acute neurological can imitate stroke, including traumatic muscular lesions. Can be difficult to find signs and symptoms in confused patients.
A one-year review of medical complications in an Orthogeriatric Unit

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INTRODUCTION: Geriatrics and Internal Medicine roles following orthopedic surgery have been well established with positive impact in both morbidity and mortality. In this study we aim to share our experience in a Portuguese orthogeriatric unit.

METHODS: A longitudinal retrospective study (sociodemographic, medical history and intercurrences) was made to all 117 patients admitted to our unit, during 2017, following surgery due to femur transtrochanteric fracture.

RESULTS: Patients’ age ranged from 65 to 98 years old, with a mean of 84.21±7.26 years. Eighty nine patients were female. Median Katz index was “B”, mean modified Rankin was 2.25±1.2 and Barthel 75±2.9. A total of 198 complications were observed. About 35% of patients had only 1 recognized complication, 46% had 2 and 20% had 3 or more, averaging 1.7 per patient. Acute anemia was the most frequent complication, in 45%. Infections were the second most common, affecting 35%. Urinary tract infections were the most common location (46%), followed by respiratory infections (44%) and surgical site infections (5%). Cardiovascular complications were observed in 15% of patients, like exacerbated chronic heart failure (33%), uncontrolled ventricular frequency in chronic auricular fibrillation (22%), hypertension urgencies (22%), hypotension (11%) and even cardiorespiratory arrest (11%). Acute kidney injury was observed in 11% of all patients, electrolyte disorders in 10%, delirium in 10%, vitamin D deficiency in 8%, hyperglycemia in 5%, hemorrhagic complications in 4% and thrombotic in 2%. Mortality rate was 1.7% (N=2).

CONCLUSION: The complications in orthogeriatric patients often arise not just from the surgical procedure itself but due to exacerbation of previous chronic diseases and the state of frailty that frequently accompanies aging. Most of these patients are complex and therefore the recognition and treatment of them should be achieved with aid of an internist in order to improve quality of treatment.
Antihyperglycemic deprescription in an internal medicine ward

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Background: Mean life expectancy is increasing worldwide due to scientific developments and better disease prevention and treatment. Polypharmacy is an important worldwide known health public problem.

Methods: This was an observational, longitudinal, retrospective and descriptive study in a public Portuguese hospital. Polypharmacy was defined as the current use of five or more different medicines. A total of 838 consecutive patients were admitted to an internal medicine ward between January and July 2017. All patients aged under 65 years old, or who died before discharge, where excluded. We examined whether patients were taking antihyperglycemic (AH).

Results: A total of 483 patients were included in our study. We evaluated a total of 80 patients (17%) which were taking AH, and mean age was 79±8 years. Polypharmacy was present in 72% and 76% patients in hospital admission and discharge, respectively.

We found in 61 patients who were on risk or potential risk of hypoglycemia: 20 patients were taking insulin therapy, 12 patients were taking sulphonylureas, 10 had dementia, 8 had chronic kidney disease, 6 had possible drug interactions and 10 had low average life expectancy and frailty risk.

Conclusions: Polypharmacy might be a serious public health problem concerning medicine costs and indirect costs from drug-related morbidity. Decreasing polypharmacy and avoiding inappropriate medicines is a common goal of care in older people. Physicians should set individualized A1C and blood glucose targets to decrease drug related hypoglycemia risk. Multidisciplinary team effort to do a regular prescription reconciliation and review is the gold rule to identify and reduce drug-related problems.
Applicability of Barthel Index in a Portuguese Population

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Objectives
Hospital admission constitute a vulnerability to the establishment of some degree of dependence. One of the instruments most commonly used in research and clinical practice to assess functional capacity of the patient is the Barthel Index (IB), validated in the Portuguese population. The IB assesses the functional potential of the individual to perform ten basic activities of daily living. This study aims to characterize the IB at the date of hospital admission and clinical discharge in a population of patients admitted to an Internal Medicine service.

Methods
This is a retrospective observational study, through consultation of the computer clinical process in a public Portuguese hospital. We studied the patients admitted to an internal medicine ward with discharge between October 1, 2017 and December 31, 2017.

Results
We admitted 350 patients, predominantly male (54% vs 46%), mean age of 67.6 years, with an average of 5.7 secondary diagnoses. Barthel index (hospital admission versus clinical discharge): independent (27% versus 37%), mild dependency (28% versus 20%), moderate dependence (16% versus 14%), severe dependence (10% % versus 8%) and total dependence (19% versus 21%). There is a homogeneity between the degree of dependence at the time of admission and discharge: patients admitted with an independent and mild dependency (55%) were similar at hospital discharge (57%). The same happens, when we group the patients with severe and total dependency (29% versus 29%).

Conclusion
These data suggest a balance on patient dependence degree at hospital admission and discharge. There are several factors that may contribute to this fact, although the multidisciplinary work with physical medicine and rehabilitation team, the early patient ambulation and the short duration of the hospitalization should be emphasized.
Association Between Functional Status and Mortality

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Objectives: We aim to correlate functional status in hospitalized patients with readmissions and mortality. A sub-analysis was performed considering both in-hospital and after discharge mortality rate.

Methods: A prospective, observational study was performed during four months in a internal medicine ward. Functional status was assessed using the Eastern Cooperative Oncology Group (ECOG) Scale, the Karnofsky Scale and the Charlson Comorbidity Index (CCI). The in-hospital mortality and the mortality in the six months after discharge were registered.

Results: Among 384 patients, seventy four were readmissions. The mean age was 78.53±13.74 years, with 50% of the patients being female. A total of 138 patients lived in nursing homes. The ECOG mean was 3.13±0.83, while the Karnofsky mean was 35.81±15.49, with the CCI being 7.07±2.62. The global mortality rate was 32.3%, with 26% of the patients dying in-hospital, while the remaining deceased within the next six months. The deceased patients were older and had worse outcomes in the ECOG, Karnofsky Scale and CCI scales (p<0.05). There was a positive correlation between death and readmission (p<0.05), as well as between death and living in a nursing home (p<0.05). The discharged patients who died had worse performance scales (p<0.05).

Conclusion: The functional status in the internal medicine ward was correlated with mortality. Performance status can be used as a tool to manage human and material resources and to help in medical decisions.
Choosing Wisely Germany – Recommendations for General Internal Medicine and Emergency Room Management for Geriatric Inpatients

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Objective:
The Choosing Wisely Committee of the German Society of Internal Medicine (DGIM) decided in 2016 also to develop recommendations for general internal medicine and the emergency room (ER). The German Society of Geriatrics (DGG) and the German Society of Gerontology and Geriatrics (DGGG) take part in this initiative.

Methods:
Based on the Choosing Wisely recommendations of international societies an expert group of the DGG and the DGGG proved and developed recommendations on over- and underuse for general internal medicine and the ER. The here presented recommendations are not yet (April 2018) finally consented by the DGIM Committee.

Results:
The geriatric recommendations for general internal medicine are: 1. Treatment goals using HbA1c in older diabetic patients over 75 years should be orientated at the functional status. 2. Older inpatients should receive an early mobilization regime during the hospital stay. The geriatric recommendations for the ER are: 1. Indwelling urinary catheters should not be used in the ER for stable patients for urinary volume assessment who are able to urinate. 2. Older inpatients > 75 years in the ER should be screened for the need of geriatric co-care.

Conclusion:
Geriatric medicine contribute with recommendations to general inpatients care as well as ER management addressing special needs of older persons.
Choosing Wisely Germany – The Developmental Process for Recommendations in Geriatric Medicine in Germany

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Objective:
The German Society of Internal Medicine (DGIM) established in 2015 a Choosing Wisely Committee with its specialities to develop and consent recommendations on over- and underuse in Germany. The German Society of Geriatrics (DGG) and the German Society of Gerontology and Geriatrics (DGGG) take part in this initiative.

Methods:
Based on the Choosing Wisely recommendations of international societies an expert group of the DGG and the DGGG proved and developed recommendations on over- and underuse as part of the campaign. In a multi-step approach a membership survey about this recommendations were performed, the results re-analyzed and again prioritized by the expert group. The recommendations were finally discussed by the DGIM Choosing Wisely Committee. Please note that in contrast to the US campaign the DGIM initiative address primary physicians and not the conversation between physicians and patients. The results of the German initiative were first presented at the DGIM meeting April 2016.

Results:
The DGG and DGGG identified 5 recommendations on over- and underuse in Germany which was consented within the Choosing Wisely working group and presented in two posters at this meeting (Choosing Wisely Germany – TOP 5 Recommendations on Overuse in Geriatric Medicine in Germany and Choosing Wisely Germany – TOP 5 Recommendations on Underuse in Geriatric Medicine in Germany).

Conclusion:
In a combined approach using first an expert group for development, second a membership survey for comments and further proposals, and third again the expert group for assessment and prioritization we are able to identify serious areas of over- and underuse in older patients in Germany.
Choosing Wisely Germany – TOP 5 Recommendations on Overuse in Geriatric Medicine in Germany

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Objectives:
The German Society for Geriatrics (DGG) together with the German Society of Gerontology and Geriatrics (DGGG) identified 5 recommendations on overuse and consented them with the Choosing Wisely Committee of the German Society of Internal Medicine (DGIM).

Methods:
We used a multi-step process within the gerontological and geriatric societies: 1. consensus group for development in the societies, 2. membership survey for discussion, and 3. consensus group for evaluation and ranking.

Results:
The top 5 identified recommendations on overuse are: 1. Don’t prescribe a new drug without conducting a drug regime review. 2. Don’t recommend percutaneous feeding tubes in patients with advanced dementia. 3. Don’t use neuroleptics for behavioral or psychological symptoms of dementia (BPSD) in persons with dementia without an assessment for an underlying cause of the behaviour. 4. Don’t recommend screening for breast, colorectal, prostate or lung cancer without considering life expectancy and the risks of testing, overdiagnosis and overtreatment. 5. Don’t use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium.

Conclusion:
Through a multi-step process we identified serious areas of overuse in older patients in Germany and developed recommendations to change physician behaviour.
Choosing Wisely Germany – TOP 5 Recommendations on Underuse in Geriatric Medicine in Germany

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Objectives:
The German Society for Geriatrics (DGG) together with the German Society of Gerontology and Geriatrics (DGGG) identified 5 recommendations on underuse and consented them with the Choosing Wisely Committee of the German Society of Internal Medicine (DGIM).

Methods:
We used a multi-step process within the gerontological and geriatric societies: 1. consensus group for development in the societies, 2. membership survey for discussion, and 3. consensus group for evaluation and ranking.

Results:
The top 5 identified recommendations on underuse are: 1. Decision making about diagnostic and therapeutic procedures should depend on a functional assessment and not on chronological age. 2. Falls and risk for falling should be recognized in diagnostic and interventional procedures. 3. Malnutrition in older persons should be recognized in diagnostic and interventional procedures. 4. Depression in higher age should be treated primary by psychotherapeutic interventions in non-severe and combined psychotherapeutic and drug intervention in severe cases. 5. Osteoporosis as a disease of older persons should be recognized in diagnostic and interventional procedures.

Conclusion:
Through a multi-step process we identified serious areas of underuse in older patients in Germany and developed recommendations to change physician behaviour.
Co-morbidities in hospitalized elderly patients

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OBJECTIVE: Determine the causes of hospitalization in older patients. Determine the most frequent co-morbidities and the prior performance status hospitalization of the older patients.

INTRODUCTION: Elderly patients are define as those over 65 years of age. In the majority of cases these population have poor performance status and other co-morbidities and they are treated with multiple medications.

METHODS: This is a retrospective study of 65 years older patients who were hospitalized between January and December of 2016. Demographics, number of co-morbidities, days of hospitalization and prior performance status were evaluated for each patient.

RESULTS: The sample included 303 patients, average age 83 years only 85 of them were daily activities independent. 49 patients have an urinary catheter and 35 have a nasogastric tube. There were a significant predominance of co-morbidities such as hypertension, atrial fibrillation, diabetes and dyslipidemia. The most prevalent causes of hospitalization were respiratory diseases and genitourinary diseases. The majority of cases were pneumonias, cystitis or pyelonephritis.

CONCLUSION: Elderly people have many morbidities that can be associated with higher time of hospitalization. The infectious disease is the most prevalent cause of hospitalization.
Comorbidity associated with mortality in the elderly patient with pneumonia

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OBJECTIVE:
To analyse the pathologic conditions associated with the patient older than 65 years who is admitted in a hospital with pneumonia.

METHODS:
A prospective observational cohort study was conducted which included all patients older than 65 years who were admitted in the Department of Internal Medicine with pneumonia and who had not been hospitalized in the previous month. All previous medical records of the patient were collected at the time of admission. During the hospitalization, different clinical and analytical variables were collected. In addition, different scales of functional evaluation were obtained from the patient. After discharge, follow-up was carried out in the first month, at six months and a year, evaluating readmissions and mortality.

RESULTS:
348 patients were included in the study, with no significant difference in gender (166 men, 47.7%). The mean age was 86.47 (SD 6.41) coinciding with the median (87.08). 224 patients (64.74%) came from a private home, with 113 (32.66%) coming from a nursing home. The main associated comorbidities with mortality during inpatient pneumonia care were: ischemic heart disease (OR 5.23; 95%CI 2.70 – 10.12), congestive heart failure (OR 4.84; 95%CI 2.93 – 7.99), dementia (OR 2.77; 95%CI 1.72 – 4.78), non-metastatic neoplasia (OR 3.32; 95%CI 1.92 – 5.76) and creatinine clearance rate <30ml/min/1.73m2 (OR 1.87; 95%CI 1.10 – 3.19). Other comorbidities such as cerebrovascular disease, chronic lung disease, diabetes mellitus, metastatic neoplasia, peptic ulcer and chronic liver disease did not reach statistical significance for mortality. As for the Charlson index, 35 patients had 0 points, 279 had between 1 and 6 points and 87 had between 7 and 12 points.

CONCLUSION:
Patients older than 65 years who were admitted for pneumonia, mostly came from a private home and presented a relevant associated co-morbidity that could condition the prognosis and the high mortality rate (106, 30.90%) observed in our cohort.
Background: European population is aging and an increasing number of people live with frailty and die with multiple chronic diseases. In Portugal geriatrics is not a specialty, so when elderly patients are hospitalized, they are follow by Internal Medicine doctors.

Objective: To know the overall health status of the elderly patients admitted to Internal Medicine care; assess therapeutic suitability; build a service protocol to establish a plan of care more appropriate to this patient’s needs.

Methods: This study was divided into three phases: in the first phase, a pilot study was carried out (in one ward with 30 beds) and Comprehensive Geriatric Assessment of Portuguese Society of Internal Medicine (IM) was applied. Subsequently, a prospective study is being carried out, including all old patients (65 or more years) admitted to IM service, on March 2, 2018. In the third phase, predicted to June 2018, we will discuss this results at a service meeting, and carry out a protocol.

Results (pilot study): Twenty-seven patients aged 73-93 years (mean 81) were included. More than 1/3 had total dependence on basic daily living activities and about 1/2 presented palliative care criteria. Most patients were polymedicated, had at least one drug included in Beers criteria. During hospitalization three patients suffered a fall, three develop ulcers and three delirium.

Conclusion: Currently patient admitted to IM care are older, had pluripathology, are polymedicated, and mostly frail. By knowing health status, it will be possible to establish a therapeutic and following plan more coordinated and integrated, aiming to recovery or maintenance of functional capacity.
Cross-Sectional Analysis of Blood Glucose Levels and Cognition in Geriatric Inpatients

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Objectives:
Diabetes mellitus affecting increasingly ageing persons, alters micro- and macrocirculation and foster arteriosclerosis, which play a role in accelerating ageing and cognitive decline. Diabetes nowadays is recognized as a metabolic and vascular risk factor for cognitive decline including Alzheimer’s and vascular dementia.

Methods:
Geriatric inpatients were tested in a prospective, cross-sectional design for cognition using the Mini Mental Status Examination (MMSE, range 0-30 points, higher results indicating better cognitive function) and blood sugar day profiles. In accordance to guidelines we used following cut-offs: normal fasting blood glucose (NFG) < 100 mg%, impaired fasting blood glucose 100-125 mg%, and elevated fasting blood glucose (EFG) ≥ 126 mg%. Pearson’s correlation and Student’s t-test were used for statistical calculations, p values were set to 0.05 or lower for significance.

Results:
We examined 478 consecutive geriatric inpatients with a mean age of 78.89±8.06 years. NFG (mean 91±6.8 mg%) were detected in 171, IFG (mean 110.7±7.3 mg%) in 208, and EFG (mean 153.1±38.9 mg%) in 99 patients. Cognitive testing with MMSE revealed mean scores of 22.93±5.45 points (m 23.25±5.54, w 22.71±5.39, p=0.28). Total MMSE scores and subscores revealed no correlation with fasting blood glucose levels. Pearson’s r for MMSE total was 0.0578. In stratified groups for NFG, IFG, EFG including stratification for sex we found no significant correlation too.

Conclusion:
In a cross-sectional analysis of geriatric inpatients we revealed no correlation between fasting blood glucose levels including stratification for NFG, IFG, and EFG and cognitive testing using the MMSE.
Geriatrics
A-1989

Descriptive study of the influence of rehabilitation treatment in Alzheimer’s disease at the Rafael Méndez Hospital (Lorca, Spain)

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OBJECTIVES

Study the degree of compliance in our Health Area of the main requests made by the association ALZ (Alzheimer) Lorca to our health service.

METHODS

Retrospective descriptive study of 59 patients: 34 patients non affiliated with ALZ Lorca and 25 affiliated patients. Both groups are being followed up in Neurology at our hospital due to Alzheimer’s disease. The investigators do not know whether the patient belongs to the association or not. Neurology consultation reports were reviewed between 2013 and 2016, analyzing the following data: age, gender, time between revisions, time of revision after new treatment, GDS (Global Deterioration Scale), MMSE (Mini Mental State Examination) and stage of disease. Subsequently, a telephone survey was conducted to the patient or family member asking if they know the association and how, if they use their services and if they go to a different center.

RESULTS

The average of the variables were the following: Age: 80 years, 78% women, time between reviews: 8.5 months, time for check-up after new treatment: 8.6 months, GDS: 5, MMSE: 18, stage: 1, 85 (1-3). 53% know the association: 11% through a neurologist, 15% through another specialist, 11% through a relative and 63% through other channels. 45% of patients in our sample have used the association (42% of those are affiliated to the association). 15% go to a different association. There were no statistically significant differences between the group of associates and those not associated with ALZ Lorca in any of the variables studied (p <0.05).

CONCLUSION

There were no statistically significant differences between the group of affiliates and those not affiliated with ALZ Lorca.
Dysphagia as a risk factor of mortality in the elderly patient with pneumonia

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OBJECTIVE:
To analyse the influence of dysphagia at the time of admission as a risk factor for death in the patient over 65 years of age with pneumonia.

METHODS:
A prospective observational cohort study was conducted which included all patients older than 65 years who were admitted in the Department of Internal Medicine with pneumonia and who had not been hospitalized in the previous month. At the time of hospital admission, the presence of dysphagia in the patient was evaluated as a possible risk factor for developing pneumonia. Patient follow-up was performed during hospitalization and satisfactory resolution of pneumonia or death was recorded. The influence of dysphagia on the probability of patient death was compared by logistic regression.

RESULTS:
308 patients were included in the study, with no significant difference in gender (142 men, 46.1%). The age mean was 86.51 (SD 6.33) coinciding with the median (87.04). 129 patients (41.88%) had dysphagia before admission for pneumonia, of which 54 (41.86%) died during hospitalization. Overall mortality rate during admission was 29.87%. The relative risk of dying from pneumonia presenting dysphagia prior to admission was 1.97 (95% CI 1.39 to 2.79) (p = 0.0001).

CONCLUSION:
The presence of dysphagia prior to hospital admission and as a possible cause of pneumonia in the patient over 65 years of age determines an increased risk of death during hospitalization of 1.97, this result being statistically significant.
Elderly population deprescription in an internal medicine ward

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Background: Polypharmacy is often observed in elderly patients and is associated with an increased risk of adverse drug reactions, side effects and interactions.

Methods: This was an observational, longitudinal, retrospective and descriptive study in a public Portuguese hospital. Polypharmacy was defined as the current use of five or more different medicines. A total of 838 consecutive patients were admitted to an internal medicine ward between January and July 2017. All patients aged under 65 years old, or who died before discharge, were excluded.

Results: A total of 483 patients were included in our study. Mean age was 79.2±8.0 years, and 42% were male. Median length of stay was 11.3 (7.5-16.9) days. Patients' medications were reviewed from medical database at hospital admission and discharge according to chart deprescribing.org criteria. We examined whether patients were taking proton pump inhibitor (PPI). PPI was the most commonly prescribed drugs at both hospital admission and discharge. The PPI was also the most common inappropriate prescription at discharge (17.2%).

Conclusions: This study demonstrated a low use of inappropriate medicine (11.2% -17.2%) in older people discharged from a hospital, according to other studies. Our study shows that polypharmacy is present in more than 70% of elderly admitted patients. Nevertheless, drug inappropriateness rate was not significantly affected by polypharmacy at both admission and discharge, being overall lower than published data.
Factors related to the development of acute confusional syndrome in elderly patients admitted by acute medical pathology.

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Objectives
To identify the factors related to the development of acute confusional syndrome (ACS).

Methods
Observational study of retrospective cohorts (patients with and without ACS). Are included patients > 65 years with acute medical pathology, from the Unit of Internal Medicine of the University Hospital of Valme in January in 2017. Are excluded patients with terminal chronic disease, agony or coma and whose reason for admission was ACS.

Results
We studied a population of 269 patients. A total of 38 patients (14.1%) presented ACS. Patients with couples (12%), with family support (13.7%), institutionalized (33.3%), with enolytic habit (8.3%), with 3 or more associated diseases (15.1%), with severe or total dependence (23.8%) or infectious cause as pathology of admission (24.4%) more frequently developed ACS, although without statistical significance. Of the patients with stroke, 28.3% developed ACS versus 11.2% who did not have it (p<0.005), OR 3.12 (1.45-6.7). Of the patients with dementia, 34.8% developed ACS compared to 9.9% who did not have it (p<0.005), OR 4.8 (2.3-10.3). 20.8% of patients with mild dementia and 50% of patients with moderate/severe dementia presented ACS.

Conclusions
Patients with a history of stroke have 3 times more risk of ACS than those who have not had a stroke. Patients with dementia have 5 times more risk of ACS than those without dementia. The rest of factors (marital status, family support, consumption of toxics, associated comorbidity, degree of dependence and pathology of admission) are not significantly associated with the development of ACS.
Frailty index (LFI) in Patients with Advanced chronic liver disease (ACLD). First results of study : Frailty- Hegito 7 (FH-7)

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Background: ACLD patients have accelerated biological aging and frailty which lead to complicated prolonged recovery, high costs and increased mortality. Already existing prognostic score systems such as Child-Pugh and MELD do not fully reflect these facts. Diagnosing frailty could improve prognostic stratification of patients with ACLD.

Objective: To determine prevalence and prognostic value of LFI in hospitalized ACLD patients.

Methods: Prospective study. Median follow-up time 90 days. Inclusion criteria: admission with acute or chronic decompensation of ACLD, informed consent. Exclusion criteria: malignity except HCC in Milan criteria, withdrawal of informed consent. Interval of FH7: 1.6.-31.12.2017. Collected variables: age, sex, ACLD etiology, MELD, Child-Pugh, LFI by Lai (grip strength, chair stands and balance). Based on LFI results, cohort was divided to 3 subgroups: robust, pre-frail and frail (by calculator http://liverfrailtyindex.ucsf.edu).

Results: 126 patients were enrolled, 37% were women, median age was 55,2 years. Etiology of ACLD: ALD- 68%, ALD+NASH- 8%, autoimmune syndromes (PBC,PSC,AIH)- 8%, hepatitis B and C- 4%, NASH- 3%, others - 9%. Median MELD - 17, Child-Pugh- 9. Robust, pre-frail, and frail were 4 patients (3%), 59 patients (47%), and 63 patients (50%), respectively. Prevalence of frailty in patients deceased and alive at day 30 was 94% and 43%, resp. (p=0,0001). Presence of frailty diagnosed by LFI increased 30-day mortality with OR 4,59 (95% CI: 2,18- 9,65; p = 0.0001), independently of MELD.

Conclusion: In real-life clinical practice, LFI has been easy to measure, uncovered high prevalence of frailty in ACLD patients, and added independent prognostic value to/over MELD.
Frailty inpatient in a tertiary hospital

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Background: There is general agreement that frailty affects 20–50% of older hospitalized patients. Frail older patients are particularly susceptible to the adverse consequences of an acute care stay.

Aim: detect frailty in acute care and outcomes

Methods: A longitudinal retrospective study was conducted among patients who were admitted to a tertiary hospital over a period of 12 months. We used clinical frailty scale (CFS) to stratify frailty. We used binary logistic regressions to evaluate the impact internal medicine in the hospitalizations, adjusted for age, multimorbidity and hospital mortality. We considered a 95% confidence interval, and tests with a p-value <0.05 were considered to be statistically significant.

Results: The records of 10656 patients, ½ of hospitalization episodes, were reviewed. There were 54.1% females and median age of 66 years. The age group ≥65 years was 53.2%, and with age ≥75 was 33%. Chronic morbidities were present in 87.7% of the patients, whereas 73.4% had multimorbidity. Internal medicine (IM) accounted for 17.4% of the episodes, whereas 45.5% were frailty and account 10% total frailty. Inpatient frailty accounted for 22% of the total episodes had OR= 6.98 for hospital mortality, OR= 6.31 for multimorbidity and OR= 5.77 for internal medicine.

Conclusion: Our study reported that frailty was an independent predictor of multimorbidity or hospital mortality. And, is associated an internal medicine inpatient.

Impact: Frailty is a geriatric condition characterized by an increased vulnerability to external stressors. Internal Medicine today is heavily committed to integrative care, and the practitioner must be able to collate different pathologies and manage patients as a whole without fragmentation of care. This is especially true of the frailty patients.
Geriatric reality in the majority of the Portuguese households

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The present case aims to reflect the reality of the geriatric support that is given in the large majority of Portuguese households, in which the poor ratio of auxiliaries / patients and the lack of investment in the training of these professionals leads into a serious impairment of the clinical stability and quality of life of these patients.

We report the case of a 71-year-old male, polymedicated and with multiple comorbidities, including chronic stage 4 renal disease and polytraumatic sequelae with limitation of lower limb strength. He went to emergency room because he fell.

In the emergency room, he rejected food and became more prostrated. During the complementary examinations he acquires an aspiration pneumonitis and acute chronic renal disease. He was hospitalized and he carried out treatment directed to the pneumonitis and reinforcement of the hydration that allowed the return of the renal function to the basal of the patient. During the hospitalization it was verified that the patient needed some support to the feeding which had to be carried out gradually to avoid episodes of choking. With bilateral support, he began to walk and walk around the infirmary. At the time of discharge, a patient that was confined to the bed, comes to say good morning to the office of the Medical Team.

With this case, the authors wanted to emphasize the need of investment in training and increase the number of qualified professionals in the institutions that care for the elderly, especially those who require more care and time for them, since the contribution they gave to society throughout a life, gives them the right to dignity until the last of their days of life. It is unacceptable that in many cases it is compacted by the fact that the elderly are a burden, so topics like this should be brought into the discussion.
How best to predict the outcome of the very elderly admitted to internal medicine wards?

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Objectives: Elderly people constitute the majority of patients admitted to internal medicine wards, presenting with chronic/acute multimorbidities, disability, frailty, family discomfort-tiredness, and social isolation. It is, therefore, important to decide early if prognostic complications are to be expected, and whether an entry into an institutional facility will be needed after discharge.

Methods: Data from 56 patients more than 75 years old (from 80 consecutive patients hospitalized during a 3 months period) were analysed using the ‘Cumulative Illness Rating Scale for Geriatrics’ (CIRSG) – grading patients’ problems in 14 organ systems, and determining a total score (CIRS-TS) and a severity index (SI). The frailty of these patients was also graded using the Clinical Frailty Scale (CFS). Correlation coefficients, and both linear and logistic regression relating the 4 indexes and scales with the length of stay (LOS) and the patients’ outcomes (discharge to own house/nursing home or to an institution of long-term hospitalization/death) were used.

Results: The highest correlation with LOS and outcome success was found with the CFS (0.29 and 0.44 respectively), followed by CIRS-TS (0.21 and 0.15). When adjusting a linear regression model, the only scale that could explain LOS was CFS (β=1.64, p<0.05). When modelling the outcome success, CFS was the only significant predictor (β=1.13, p<0.01).

Conclusion: In the very elderly admitted to an internal medicine ward, it is useful to evaluate the severity of their systems affections through the combination of different scales with prominence to CFS which seems to be more associated to LOS and patients’ outcomes.
How do we deal with the elderly and the vulnerable patients?

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Very old patients (≥80 years-old) and fragile patients are becoming more common in the internal medicine departments, demanding a multimodal approach of biological and psychosocial issues.

Objectives: Characterization of very old and fragile patients admitted to internal medicine departments, as well as the diagnostic and treatment approaches.

Methods: Descriptive study that included patients ≥80 years-old or with a Clinical Frailty Scale (CFS) ≥4 admitted to an internal medicine department over the period of 15 weeks. Data was taken from electronic medical records and analyzed with Excell®. CFS was used at admission and at discharge.

Results: A total of 121 patients were included, 45% were very old and 66% were at least vulnerable according to the CFS, accounting for 84 patients. Of these, 30% were autonomous at admission. 94% had at least 1 cardiovascular risk factor, 25% had established cerebrovascular disease, 27% had chronic respiratory pathology and 17% oncologic pathology. Hypertension (86%), dyslipidemia (48%) and diabetes mellitus (38%) were the most common comorbidities. 33% had been admitted to the hospital in the past 6 months. Respiratory tract infection (24%), stroke (20%), urinary tract infection (11%) and decompensated heart failure (11%) were the most frequent diagnosis. 10% were submitted to invasive procedures, which sometimes increased significantly the duration of hospitalization. The most common intercurrences were hospital-acquired infections and delirium. 63% were polymedicated at admission, with no significant reduction of the number of drugs prescribed at the time of discharge. At discharge, only 19% were autonomous.

Conclusion: Very old and vulnerable inpatients are each time more common, requiring adjustments on the approach taken by medical and nursing teams. However, there is still an exhausting diagnostic and therapeutic investment that seems to have little benefit to these patients and might even worsen their performance status.
Hypothermia in elderly

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Introduction:
Hypothermia is defined by body temperature <35ºC. It presents several predisposing factors: caloric intake, physical activity, comorbidities (endocrine, neurological, cardiovascular, infections), falls or drugs.

Case description:
The authors report a clinical case of a woman, 86 years old, referred to the emergency department for prostration, dysarthria and fall. At examination Hypothermia (29ºC), bradycardia (+ -30 / min), hypotensive and with generalized edema. Lab results elevation of inflammatory parameters, anemia and thrombocytopenia, acute renal injury, metabolic acidemia and hyperlactacidemia. X-ray with pulmonary stasis and brain CT without changes. Thyroid function revealed hypothyroidism. Presented periods of alternation between junctional rhythm and atrial fibrillation with slow ventricular response, no response to tachycardic drugs, in need to temporary pacemaker (PM) and was admitted to the intensive care unit. After heating measures and initiation of therapy with levothyroxine resolution of the bradycardia and PM was removed after 36h. Complementary study: echocardiogram was normal, holter 24h atrioventricular block 1st degree. The patient was discharged with salbutamol 4mg. Scheduled medical consultation for study of thyroid function.

Hypothermia particularly affects the elderly. With aging there is progressive loss of thermoregulatory capacity, increased vasoconstriction and associated comorbidities. Hypothyroidism is one of the causes that causes hypothermia. Hypothermia may have serious clinical repercussions as was reported in the clinical case (symptomatic bradycardia and signs of severity and need for provisional PM implantation).

Discussion:
With aging population and vigorous winters, we must adopt measures to prevent this cases of hipothermia in order to avoid complications.
Immunodeficient 76 year-old woman with pneumonitis

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INTRODUCTION

Lung disease is a common complication in immunodeficient patients. It constitutes an increasingly frequent challenge given the rise of the immunodeficient population.

CASE DESCRIPTION

A 76 year-old woman, allergic to streptomycin, hypertense, dyslipidemic, followed up by Rheumatology for suspicion of temporal arteritis (receiving corticosteroid therapy for 2 years and methotrexate for a month).

She was hospitalized for rest dyspnea accompanied by fever, chills and a cough with whitish expectoration. She had been transferred from another hospital where she had been hospitalized for pneumonia of the right lower lobe. He has received levofloxacin and cefotaxime. In the physical examination, there is fever (37.2°C), oxygen saturation with reservoir of 92%, acrocyanosis, dry crackles in both apex and in the right middle. Antibiotic treatment with meropenem is established, the dose of corticosteroid therapy is increased and oxygen therapy is implemented with reservoir. Methotrexate is suspended.

In the chest CT scan a possible viral origin is reported versus Pneumocystis versus acute interstitial pneumonia. Acute/subacute pneumonitis due to methotrexate is described. It is not recommended to perform bronchofibroscopy due to respiratory instability. Given the good clinical evolution with steroids and the high suspicion that methotrexate is the cause of her clinical case, septic shock of respiratory origin and diffuse pneumonitis due to methotrexate are diagnosed.

DISCUSSION

Methotrexate pulmonary toxicity is developed more frequently after chronic treatment but it may occur after the short-term administration at high doses as in this clinical case.
Inpatients with Multiple Chronic Medical Conditions (MCMC) in a Tertiary Portuguese Hospital

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Background: The increasing number of acute admissions to tertiary hospitals over the past few years demands significant process redesign. The ageing population, improved survival rate of patients with multiple chronic medical conditions (MCMC) and increased patient and internist expectations may all contribute to the burgeoning number of complex medical admissions.

Aim: Identify inpatients with MCMC in a tertiary hospital.

Methods: A longitudinal retrospective study was conducted among patients who were admitted to a tertiary hospital over a period of 12 months. We defined MCMC when the patient has \( \geq 3 \) comorbidities and indices Katz > 1. Polypharmacy (Pphy) was defined as \( \geq 5 \) medicines. We used binary logistic regressions to evaluate the impact internal medicine in the hospitalizations, adjusted for age, MCMC and polypharmacy. We considered a 95% confidence interval, and tests with a p-value < 0.05 were considered to be statistically significant.

Results: The records of 10656 patients, \( \frac{1}{2} \) of hospitalization episodes, were reviewed. There were 54.1% females and median age of 66 years. The age group \( \geq 65 \) years was 53.2%, and with age \( \geq 75 \) was 33%. The indices Katz > 1 were 26.8% and patient with \( \geq 3 \) comorbidities were 58.6% that counts 23.3% with MCMC. Internal medicine (IM) accounted for 17.5% of the episodes, and OR for MCMC in this population was 4.74; Pphy=1.65 and age group \( \geq 65 \) years=2.49.

Conclusion: In this study, hospitalized patients were elderly, with multicomorbidities and \( \frac{1}{4} \) had MCMC. Internal medicine is of great need for these patients, especially with the elderly patients with multipathology who fill hospitals. These patients often do not need cutting-edge technology, but they thrive and enhance an astute medical analysis along with a holistic approach to their problems and needs.
Polypharmacotherapy in the Internal Medicine Department: experience of a referral emergency hospital

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Background: As the average lifespan has increased worldwide, so has the global burden of disease, with many patients admitted to the hospital with multiple comorbidities. In this context, polypharmacotherapy has become serious concern nowadays, as multiple illnesses require distinct medications and may lead to harmful drug-to-drug interactions.

Objectives: to investigate the frequency of polypharmacotherapy in the Internal Medicine Department and to evaluate the number of drugs prescribed at discharge and the percentage of drug-drug or food-drug interactions.

Methods: We conducted a retrospective, observational study of patients admitted to the Internal Medicine Department, between January 1st, 2018 – February 1st, 2018. Patients were identified by a database search of diagnostic codes of discharge diagnoses. Patient characteristics and medical prescriptions were retrieved from medical records.

Results: We included 229 patients (50.22% male, 49.78% female, mean age 67.74±13.61 years, range 22-94 years) in our study. The number of comorbidities per-patient was 8.82±3.56 and the number of prescribed drugs at discharge was 6.51±2.78 per-patient. The number of drug-to-drug interactions was 6.26±5.89 per-patient, with 85.15% (195 patients) of the study group being at risk for at least one potentially harmful interaction. 71 patients (31.00%) had major drug-to-drug interactions (0.44±0.77 per-patient). 188 patients (82.10%) had moderate drug-to-drug interactions (4.68±4.70 per-patient). 127 patients (55.46%) had minor drug-to-drug interactions (1.20±1.59 per-patient). 207 patients (90.39%) had food-to-drug interactions (2.46±1.46 per-patient).

Conclusions: Polypharmacotherapy is a relevant problem in the Internal Medicine Department, due to the high number of potentially harmful drug-drug or food-drug interactions. A strategy to evaluate the number of discharge medications and to reduce the interactions between drugs is essential for the safety of patients.
Pulmonary Embolism in the 9th and 10th Decades of Life

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Introduction
Venous thromboembolism (VT) is the 3rd most frequent form of cardiovascular disease, with increasing incidence with age (estimated 1/100/year in the elderly). Older age is considered one of the most relevant risk factor for VT. However, this disease is not well studied in patients over 80 years.

Objectives
To characterize a population of patients over 80 years old, admitted with pulmonary embolism (PE) between 2012-2017.

Methods
Retrospective study with descriptive data analysis.

Results
We included 277 patients (n=277), mean age 84.9 (±3.6) years, 66.1% were female. Functional assessment according to Katz index, showed a predominance of moderate dependence and complete independence. Mean life expectancy at 10 years, according to Charlson Comorbidity Index, was 2.0% (mean index 6.38 [±/2.01]). The median of the duration of admission was 12 days (interval 1-62). The majority of the events occurred in outpatients (67.9%), and the remaining 32.1% in inpatients. About half (52.7%) of the events were considered idiopathic and the rest were provoked (minor-11.2%, major-24.5%, persistent-11.6%). The PE severity, determined by the Pulmonary Embolism Severity Index, was very high - class V in 51.3% of cases. The initial treatment strategy was anticoagulation in 95.7% of cases, thrombolysis in 2.2% and 2.2% did not receive any kind of antithrombotic treatment. At discharge, only 76.2% were anticoagulated (33.9% vitamin K antagonists; 32.9% direct oral anticoagulants; 9.4% low molecular weight heparin). In-hospital mortality for PE was 15.2%; haemorrhagic events were described in 10.5% of cases; and recurrence of PE at 1 year was 3.1%.

Conclusion
Description of this high thrombotic and haemorrhagic risk population is essential to define better treatment strategies, namely, weighing risk/benefit of antithrombotic therapeutics.
Sexuality in the Elderly - Literature Review

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Background: According to the World Health Organization between 2000 and 2050 the proportion of people over 60 years will double in the World. Thus, all aspects of the elderly should be taken into account with sexuality being no exception. However this topic lacks scientifically studied information.

Objectives: Increase information on a controversial topic, for revealing the real importance of sexuality in the elderly, mainly for its quality of life and health care.

Methods: Literature search and review.

Results: The sexual activity decreases with age, but for approximately half of the individuals in this group, sexuality remains an important aspect. An active sex life is beneficial. Many seniors have sexual dysfunction but do not address the issue with their doctors, nor healthcare professionals question patients about this aspect. Many factors contribute to the decrease of sexual activity, from health to social reasons. Health professionals should know how to manage issues related to sexuality affecting their elderly patients. More research is needed for a better understanding of sexuality in the 3rd age.

Conclusion: Sexuality is an impotant issue for the elderly. It’s necessary to increase training and information in this area to provide better health care for this population group.

Keywords: Sexuality; elderly population; Healthcare professionals.
Geriatrics
A-2008

Sickness of the elders in the youngest

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Adult latent autoimmune diabetes (ALAD) is an autoimmune disease (AID) characterized by the progressive destruction of pancreatic islets with subsequent insulin deficiency. Occurs in 2-12% of individuals with type 2 diabetes with a mean age of 40 years. Its diagnosis is based on Fourlanos criteria: age less than 50 at diagnosis, presence of acute symptoms, body mass index (BMI) <25kg/m², personal or familiar history of other AID, no need for insulin in the first six months after diagnosis and positive antibodies identified in type 1 Diabetes. In these patients glutamic acid decarboxylase antibodies (GADA) are usually present and are characteristic - 90% of positivity.

Clinical presentation of at least two of these features has a sensitivity of 90% and a specificity of 71% in the identification of patients with ALAD.

A 24 year old woman, with history of obesity grade 2 (BMI 39.2 kg/m²) and no personal or familiar history of AID, was diagnosed with type 1 Diabetes in May 2017 at the Health Center and medicated with oral Antidiabetics.

Applied to the emergency department in January 2018 for hyperglycemia of 350mg/dl, polyphagia, polydipsia, polyuria and HbA1C 10.8%.

Was hospitalized and started basal insulin Glargine and preprandial Glulisine with suspension of oral antidiabetics and with control of glicemia.

Laboratory tests revealed Peptide C 0.87 μg/L and GADA 44.4U/ml.

Despite the patient's age, high BMI, lack of personal and familiar history of other AIDs, the presence of anti-GAD and the need for insulin about 6 months after diagnosis leads to the diagnosis of LADA.

Even in patients who may not fit the profile it is always important to consider more unusual forms of the disease by the early need for insulin and the association with other AIDs and a more accurate management of the disease.
Use of psychotropic drugs in acute confusional syndrome in elderly patients admitted for acute medical conditions

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Objectives
Relationship between the number of psychotropic drugs at admission, during hospitalization and discharge in patients with acute confusional syndrome (ACS) during admission.

Methods
Observational study of retrospective cohorts. Are included patients > 65 years with acute medical pathology, during the admission presented ACS, from the Unit of Internal Medicine of the University Hospital of Valme in January 2017. Are excluded patients with terminal disease and whose reason for admission was ACS.

Results
A total of 38 patients presented ACS. Patients without psychotropic drugs at admission were 34.2% and during admission, 7.9%. Patients with 3-4 psychotropics at admission were 5.3% and during admission 36.8%. During admission, the rate of patients without psychotropic drugs decreased 26% and those who took 3-4 psychotropics drugs increased 31% (p=0.004).

Patients without psychotropics during admission were 7.9% and at discharge 31.6%. Patients with 3-4 psychotropics during admission were 36.8% and at discharge 10.5%. At discharge, the rate of patients without psychotropic drugs increases 24% and decreases 26% those who take 3-4 psychotropic drugs (p=0.004).

The rate of taking psychotropic at admission and discharge was similar. Increases the prescription rate at discharge of 3-4 psychotropics 5% (p=0.369).

Conclusions
During admission, the prescription of psychotropics increases 3-4 drugs with respect to at admission. Therefore, patients get worse from confusional state during admission.
At discharge, there are more patients without psychotropics compared to during admission, and the prescription of psychotropics decreases (3-4). Therefore, patients improve confusional symptoms at discharge.
There were no differences between the number of psychotropics at admission and discharge.
A Mass In The Left Hemithorax Related With An Accidental Fall... Or Not

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INTRODUCTION
We present a case report about a 75 year old man, who lives in a rural area, with personal history of high blood pressure, type 2 diabetes mellitus, enlarged prostate and ex-smoker.

CASE DESCRIPTION
The patient goes to the hospital emergency department complaining of less than 12 hours history of dyspnea, left shoulder and hemithorax pain. About 4 months before, he suffered an accidental fall from his own heights, with traumatism in his left shoulder and the emergence of a tumor in the lower ribs of his left hemithorax, that his family doctor treated with common painkillers with improvement of symptoms. Physical examination only showed a left painful shoulder, without inflammatory signs, and an immobile and painful stone parasternal mass of 3 cm in diameter. Lymph node enlargements were no found.
Complementary tests show a normal blood test with biochemistry with proteinogram, full blood count, clotting test and tumor markers. Thoracic X-ray were also normal. D-dimer test was found moderately elevated, so an AngioCT was performed and a pulmonary embolism was ruled out, but it shows a 5 cm left parasternal mass, some ipsilateral lymph nodes enlargements and osteolytic lesions in breastbone. With those findings a full TC-scanner was performed, showing osteolytic lesions in both posterosuperior iliac spines as a large tumor mass (9x5 cm in the left and 3x2 cm in the right side).And finally, the histology of a core needle biopsy revealed a diffuse large B-Cell lymphoma (DLCL).

DISCUSSION
In this case report we can see the importance of physical examination and don’t forget than rare (light) manifestation of aggressive diseases are possible. The DLCL is the most common subtype of non-Hodgkin’s lymphoma. It is aggressive and its incidence rises with age.
Activated charcoal aspiration and progression to chronic pulmonary lesion

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Introduction
Activated charcoal is recommended for acute oral intoxication. Although it is considered an inert substance, pulmonary aspiration of activated charcoal is associated with lung injury.

Case description
51 year old caucasian woman with major depressive syndrome and previous drug-related suicide attempts, admitted to the emergency department for prostration after presumed drug overdose. On admission, she presented a depressed level of consciousness, hypotension and tachycardia. Activated charcoal was administered through a nasogastric tube, complicated by vomiting with aspiration. She was intubated, invasive mechanical ventilation was initiated and transferred to the Intensive Care Unit. The diagnosis of acute respiratory distress syndrome was made, managed with ventilatory support, repetitive toilet bronchoscopy and antibiotic therapy. She weaned off ventilation by the 29th day and was discharged by the 39th day of hospitalization. Readmitted one week later for resting dyspnoea and cough with grayish sputum, elevated inflammatory parameters and disperse infiltrates on chest x-ray. Nosocomial pneumonia was diagnosed and broad spectrum antibiotics were initiated. Chest CT showed multifocal parenchymal densification, bronchoscopy revealed diffuse mucosal inflammation and bronchoalveolar lavage showed dark pigment fragments. Blood, sputum and bronchoalveolar lavage cultures were negative. Symptomatic improvement occurred after initiating systemic corticosteroid therapy. She was discharged with supplemental oxygen therapy and integrated an out-patient respiratory rehabilitation programme.

Discussion
Case reports and rat models suggest that pulmonary injury following aspiration of activated charcoal may progress to chronic histopathological changes and chronic pulmonary disease. Regarding this patient, it is not yet known whether the use of corticoids at a relatively early stage of inflammation will prevent progression to chronic disease.
Acute Pulmonary Embolism – an approach in an Intermediate Unit

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Objectives: Acute Pulmonary Embolism (PE) is the most serious clinical presentation of Venous Thromboembolism (VTE). PE presentation is diverse and its management relies on risk stratification. The aim of this work was to characterize PE patients admitted in an Intermediate Unit (IU) and assess their prognosis.

Methods: Retrospective analysis of the data concerning patients admitted in an IU between 1/1/2017 to 31/12/2017.

Results: Of 177 patients admitted 10 had PE; most were admitted from the emergency department. The main risk factors for VTE were cancer (N=4), use of corticosteroids (N=3) and immobilization (N=3). All the diagnosis were made using Angio-CT; 5 patients had echocardiogram performed in the acute phase and of those 3 had right ventricular enlargement. Half the patients had a PESI score class V classification and the rest were in class III and IV. According to European Cardiology Society guidelines all patients had an intermediate high risk of early mortality. The majority of patients (N=8) were treated with low molecular weight heparin. Only 1 patient received fibrinolysis with Alteplase. Six months after discharge 4 patients were dead and the rest were on oral anticoagulants.

Conclusion: Management of PE patients can be challenging. Risk stratification plays a key role in identifying the best suitable candidates for IU admission in order to provide the best management of complications and, therefore, the best chance for survival.
Respiratory diseases
A-1256

Atypical Pneumonia - case report

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Introduction:
Community-acquired pneumonia is a frequent medical condition seen in the Internal Medicine department. Atypical agents may sometimes be responsible for this condition and can lead to severe infection.

Case description:
A 92-year-old man, institutionalized is admitted due to sepsis secondary to respiratory infection. He had been on amoxicillin-clavulanic acid with no response. His x-ray showed bilateral heterogeneous consolidation. He was started on piperacillin-tazobactam without response. On the 6th day of admission, there was a positive serology for Chlamydia pneumoniae, so azithromycin is started. The patient progressed in respiratory failure and died a few days after.

Discussion:
Pneumonia due to C. pneumoniae is mostly mild or asymptomatic. It is rarely severe and refractory to treatment. Our patient was very old and fragile so it was tragic. In literature, there are reports of outbreaks in institutionalized patients, with severe outcomes.
Biliopleural Fistula as a rare complication

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Introduction: Biliopleural fistula is a rare complication, difficult to diagnose and with a wide clinical spectrum where the pathognomonic symptom is the presence of bile in the pleural effusion. One of its various aetiologies is iatrogenic, both in open laparoscopy cholecystectomy. Morbidity and mortality is high and can be minimized with early diagnosis and treatment.

Case description: We present an 89 year old patient with a history of hypertension, dyslipemia and cholelithiasis by laparoscopic cholecystectomy. At the sixth postoperative month he presented pleuritic pain in his right side, dyspnea and asthenia which developed over two months. In the examination, the decrease in vesicular murmur and right basal dullness was observed. The chest x-ray showed a right pleural encapsulated effusion that required placement of a pleural drainage tube with abundant biliopurulent debit (Bilirubin LP/Bilirubin serum > 1) and antibiotic therapy (piperacillin-tazobactam). E was isolated in the pleural fluid culture. Coli. The patient recovered well and was discharged after 14 days with antibiotic therapy. Six months after discharge, he came back to the same clinic twice, again requiring a drainage tube and antibiotic treatment for bilious empyema. A thoraco-abdominal CT scan was performed with a posterior segment collection of the IOL extending through the posterior portion of the right diaphragm and into the abdominal cavity, contacting the liver and right perirenal fat, confirming the suspected biliopleural fistula. The patient again made a good recovery following conservative treatment, without needing invasive treatment with ERCP and/or surgery.

Discussion: The history of cholecystectomy, biliary empyema and CT results confirm the suspicion of biliopleural fistula, where a conservative approach with chest drainage tube and antibiotics has been shown to be successful in up to 60% of cases.
Cardiac remodeling, subclinical atherosclerosis and inflammation in early stage COPD, a longitudinal study

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OBJECTIVES: To assess cardiovascular (CV) organ damage in mild-moderate COPD with regard to Left Ventricular Mass (LVM), Ankle-Brachial Index (ABI) and to evaluate the association with inflammatory markers and lung function decline over the time.

METHODS: 33 mild-moderate COPD outpatients (mean age 66.9 ± 6.6 yrs) were age-, sex- and smoking habit- matched with 37 non-COPD controls. A clinical evaluation, blood sampling and functional tests (spirometry, echocardiography, ABI measurement) were performed at baseline and after a mean follow-up of 49.7±6.9 months (with a minimum of 40 months).

RESULTS: In COPD, compared to non-COPD controls, we found a similar prevalence of hypertension, dyslipidemia and diabetes. Baseline LVM was significantly increased (97.26±32.33 g/m² and 81.70±17.71 g/m², respectively, p<0.02), with a 33% prevalence of LV hypertrophy, while ABI was decreased (p<0.01) although still in the normal range. Systemic markers of inflammation (high-sensitive C-reactive protein, hs-CRP, white blood cells WBC) were significantly higher both at baseline and follow-up (p< 0.05 both). Moreover, we found a negative association between WBC and lung function decline in COPD patients (r=-0.386; p=0.027) and a similar association with a baseline hs-CRP level > 2mg/L r=-0.677; p=0.003).

CONCLUSIONS: Cardiac remodeling and subclinical atherosclerosis are present in mild-moderate COPD patients with a good control of CV risk factors. This may be related to a persistent low-grade inflammation which is also associated to the COPD faster lung function decline, being systemic inflammation a possible link between early cardiovascular damage and the airway obstructive disease even at the early stage of COPD.
Clinical characteristics in patients with pulmonary embolism and deep vein thrombosis.

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OBJECTIVES
To describe the clinical characteristics, risk factors, co-morbidities and thrombofilia testing in patients with venous thromboembolism (VTE).

METHODS
We used the RIETE database to assess the clinical characteristics. All analyses were completed with the Statistical Package for Social Sciences (SPSS) program version 21.0.

RESULTS
Of 70,119 patients enrolled in RIETE until September 2017, 35,824 were aged ≥25 years with acute pulmonary embolism (PE). Of these, 16,810 (47%) were male. The mean age was 68±16 years. The outpatients were 23,800 (68%).
In this group, the main risk factor was unprovoked (46%), followed by cancer (23%), immobility ≥4 days (22%), prior VTE (15%), surgery (12%), hormonal therapy (4.5%), prolonged travel (2.5%) and pregnancy or puerperium (0.80%).
The co-morbidities registered were chronic lung disease (14%), chronic heart failure (9.2%) and recent major bleeding (2.4%). The 40% of patients have CrCl levels <60 mL/min and 33% anemia. The thrombophilia test was done in 18% of patients. The 9.1% had prothrombin mutation, 8.5% antiphospholipid syndrome and 7.9% factor V Leiden.
There were 32,809 patients aged ≥25 years with acute deep vein thrombosis (DVT). Of these, 16,907 (52%) were male (p <0.001). The most frequent initial presentation was lower-limb DVT in 30,124 (92%).
In this group, the main risk factor was unprovoked (44%), followed by cancer (24%), immobility ≥4 days (23%) or prior VTE (16%).The co-morbidities registered were chronic lung disease (8.6%), chronic heart failure (4.5%) and recent major bleeding (2.1%).The 33% of patients have CrCl levels <60 mL/min and 36% anemia. The thrombophilia test was done in 21% of patients. The 14% had factor V Leiden, 9.4% had prothrombin mutation and 7.6% antiphospholipid syndrome.

CONCLUSION
There were more women in PE group. Cancer is the main risk factor after unprovoked in both groups. The factor V Leiden was more often found in DVT group and prothrombin mutation in PE group.
Clinical features of hospitalized patients with deep venous thrombosis and pulmonary embolism in an Internal Medicine Department

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Venous thromboembolism (VTE) is a significant cause of morbidity and mortality in hospitalized patients. The aim of this study was to evaluate the incidence and characteristics of patients presenting with deep vein thrombosis (DVT) or pulmonary embolism (PE) in an Internal Medicine setting.

Methods
A retrospective chart review was performed with patients admitted to Internal Medicine wards at a tertiary hospital in Madrid (Spain) between January 2000 and March 2018. We analyzed 291 patients.

Results
Mean age was 76 years (range 20-98), 53% women. Among the patients, 147 (50%) had DVT, 220 (75%) PE, and 76 (26%) both. Regarding predisposing factors for VTE, 62 (21%) of patients had heart failure, 86 (27%) acute infectious disease, and 100 (34%) cancer. The most common cancer was lung cancer, followed by cancer of unknown origin. The most frequent infections were respiratory, followed by urinary tract infections. Diagnostic CT scans were conducted in 65% of patients, and ventilation/perfusion scan in 30%. Among VTE patients, 17% of the VTE were diagnosed in the emergency department and 79% in the Internal Medicine department. Only 139 (48%) patients had typical VTE symptoms (dyspnea, pleuritic chest pain, leg swelling, hypotension, and syncope). Mortality rate was 13.7% (40 patients); 16 (40%) PE, 13 (32%) PE with DVT, and 10 (25%) had only DVT. Mortality among DVT patients was 10/147 (6.8%), among PE patients was 16/220 (7.3%) and 13/76 (17%) in patients with both conditions. The mortality rate associated with heart failure, infectious diseases and cancer was 4/62 (6%), 9 (10%) and 13 (13%) respectively.

Conclusions
There is a high incidence of thromboembolic disease in patients hospitalized for an acute illness such as heart failure or infection; the mortality rate in these processes is also high. A high proportion of patients had unspecified symptoms. Many patients are likely to remain undiagnosed, and a lower extremity Doppler ultrasonography on admission might be considered in this population.
Background: Sarcoidosis is a diffuse granulomatous disease. The preferential affection remains mediastino-thoracic. We report 4 cases where sarcoidosis was manifested exclusively in skin of the head and neck area.

Methods: Case N°1: 26 year old male patient of African origin, consulted for a huge swelling of the vertex appeared few months before. Past history irrelevant. This swelling was considered initially as hematoma because a history of trauma.
Case N°2: 21 year old female, consulted for diffuse purplish lesions of nose, cheeks and ears.
Case N°3: 50 year old female, consulted for facial cellulitis with mandibular lymphadenopathy and fever.
Case N°4: 35 year old male consulted for an exclusive nodule of the forehead.

Biology: Mild lymphopenia in 3 patients. Angiotensin-converting enzyme was elevated in cases 2 and 4. Bacterial, viral & rickettsial serologies were negative. C-reactive protein was high (case 3). Surgical scalp biopsy case 1: gigantocellular granulomatosis without caseous necrosis. Mycobacteria were negative. Cutaneous biopsy in cases 2 & 4: sarcoidosis granuloma. Accessory salivary gland biopsy (case 2 & 3): Sarcoidosis granuloma. Thoracoabdominopelvic CT scan: negative in case 2, 3 & 4.

Results: Case 1: HYDROXYCHLOROQUINE was started with spectacular outcome on the reduction of the swelling. Due to weight loss + dyspnea, a CT scan found stage III pulmonary sarcoidosis. Corticotherapy was started with excellent outcome without pulmonary/cutaneous recurrence.
Case 2 and 3: HYDROXYCHLOROQUINE was initiated + short course corticosteroids due to painful lesions, without recurrence after the end of treatment.
Patient N°4: Spontaneous disappearance of the nodule.

Conclusion
Exclusive cutaneous sarcoidosis of head and neck don't have a systemic extension in most cases, nevertheless, a thoracoabdominal CT scan should be performed as a routine as soon as sarcoidosis is confirmed. Treatment with HYDROXYCHLOROQUINE has its place in cutaneous sarcoidosis and could be a good alternative to corticosteroids.
In real clinical practice, doctors are more likely to meet with patients who have several pathological processes, especially in patients of the older age group. It is established that comorbidity is an independent risk factor for adverse outcome and significantly affects the prognosis of the disease and life. The aim of our study was evaluated frequently of comorbidities in patients with COPD.

We performed retrospective analysis history of 125 patients with COPD (mean age 54.93 ± 0.63 yrs). We studied all comorbidity diseases in patients with COPD and performed analysis of the Charlson Comorbidity Index (CCI) with W.H. Hall modification. COPD was diagnosed according GOLD criteria. 39.2% was with COPD A-B stage and 60.8% was with COPD C-D stage.

Results. Patients with COPD had 3.49 ± 0.22 chronic comorbidity condition. Cardiovascular diseases are most frequently comorbidities in pts with COPD (MI had 11.2% pts, angina pectoris 13.6%, arterial hypertension 59.2% and heart failure 20.0% pts). CCI was 2.82 ± 0.14 in patients with COPD. CCI in patients with COPD I-II stages was 2.40 ± 0.19 and in pts with COPD III-IV stages was 3.11 ± 0.18 (p<0.01). In group of COPD patients we noted correlations between CCI and age (r=0.76, p<0.001), duration of disease (r=0.48, p<0.01), smoking intensity (r=0.47, p<0.01), SaO2 (r=-0.47, p<0.01) and 6-min. test result (r=-0.38, p<0.05). Also we noted association between CCI and systemic inflammation (leucocytes (r=0.19, p<0.05) and ESR (r=0.25, p<0.05) and Systemic Coronary Risk Evaluation (r=0.54, p<0.001).

Conclusion. Comorbidities are frequently in patients with COPD. Early detection of comorbidity diseases in patients with COPD is important and should be considered carefully when initiating therapy.
Comparison of arterial stiffness based on results of one-time measurement and 24-hour monitoring in males with chronic obstructive pulmonary disease

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Objective. Comparison of on-time measurement and diurnal monitoring (DM) parameters of arterial stiffness (AS) in patients with chronic obstructive pulmonary disease (COPD).

Methods. 148 men suffering from COPD were examined. Mean age – 61.3±7.5 years, duration of COPD 7.3±4.8 years. All patients underwent DMAS, one-time stiffness measurement by non-invasive arteriography. To evaluate AS aortic pulse wave velocity (aPWV), augmentation index (AI) were used.

Results. Average aPWV in COPD patients according to one-time measurement is 10.4±2.4 m/s, according to DM median diurnal aPWV is 11.6±1.9 m/s (p<0.01), daily average – 11.8±1.9 m/s (p<0.01). Out of 148 patients with COPD, the increase of aPWV more than 10 m/s was registered in 87 patients according to one-time measurement, in 119 patients according to DM in 24 hours (80.4%, p<0.01), in 120 patients according to DM in daytime (81.1%, p<0.01), in 117 patients – in night-time hours (79.1%, p<0.01). Out of 61 COPD patients with normal aPWV casual measurement registered its increase to more than 10 m/s according to 24-hour and daytime DM in 72.1% of patients. AI increase of more than -10% was registered in 41.3% of patients according to one-time measurement, and according to DM, in 60.3% of patients during 24-hour period (p< 0.01), in 49.2% of patients during daytime (p >0.05), in 65.9% of patients during night-time hours (p<0.01). Out of 74 COPD patients with normal AI according to casual measurement its increase of more than -10% according to DMAS was registered in 34 patients (45.9%) within a 24-hour period, in 27 patients (36.5%) during daytime, in 39 patients (52.7%) during night-time hours.

Conclusion. In COPD patients, average aPWV and AI according to DMAS surpass the same indices according to one-time measurement. More than half of all patients with normal AS parameters according to one-time measurement had pathological indices according to DM, which may indicate that DMAS is more informative.
Introduction: Congenital lobar emphysema is a rare developmental anomaly of the lower respiratory tract that is characterized by hyperinflation of one or more of the pulmonar lobes.

Case description: Male, 38-years-old. History of asthma and allergic rhinitis; obese and active smoker. Hodgkin lymphoma diagnosed 4 years ago, underwent chemotherapy and radiotherapy, currently under surveillance and no evidence of disease. Referenced to present on chest CT isolated panlobular emphysema, restricted the right lower lobe. Also presented mediastinal adenopathies, compatible with lifoproliferativa disease. At the time of examination he had good general condition without respiratory or constitutional symptoms. Physical examination showed slight decrease in breath sounds in the lower 1/3 of the right hemithorax. Laboratory tests showed increased total IgE and RAST-IgE positive (herbs and grasses). Functional respiratory examination revealed mild obstruction with response to inhaled bronchodilator. Chest radiography showed hypertransparency in the lower 1/3 of the right lung, with distension of the affected lobe and contralateral mediastinal shift. It was asked TC with contrast which ruled out pulmonary sequestration, vascular aetiology, as well as the presence of nodules, lymphadenopathy or areas of consolidation. Bronchoscopy without significant changes. Patient is currently without respiratory symptoms. The authors opted for conservative treatment.

Discussion: The description of this case report is intended to alert to a rare congenital anomaly that while most cases are diagnosed at birth may go unnoticed in less symptomatic patients and should be considered as a differential diagnosis in adults with emphysema restricted to one or more lung lobes.
Cor pulmonale due to Trapped Lung: A Case Report

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INTRODUCTION: Chronic lung disease and circulation disorders are possible causes of cor pulmonale. In patients who remain symptomatic despite medical treatment, further investigation may be warranted.

CASE DESCRIPTION: A 37-year-old woman presenting with 2-month history of exertional dyspnea and productive cough was initially managed as a case of heart failure and discharged with minimal improvement. She consulted our institution for second opinion. Work-ups showed hypercarbia and hypoxemia, with ECG and echocardiogram findings of right chamber enlargement; akinesia in the mid-apical free wall; moderate pulmonary hypertension; increase in pulmonary vascular resistance and PCWP suggestive of pulmonary vascular disease. She was hooked to oxygen support and started on Bosentan with some improvement. Coronary angiography was normal. Pulmonary angiography and hemodynamic study showed no filling defect and presence of calcified pleural plaque. High resolution chest CT scan showed findings which may relate to chronic pulmonary thromboembolism or small airway disease, with concomitant infectious/inflammatory process. She was then started on LMWH. Further work-ups for infectious process and connective tissue disease were negative. She was referred to TCVS. Open decortication of right lung was done which showed dense fibrous adhesions with calcifications from pleura to the ribs and chest wall. Biopsy was negative for TB and malignancy. Post-operatively, she had clinical improvement.

DISCUSSION: Trapped lung is characterized by inability of the lung to expand and fill the thoracic cavity due to a restricting fibrous visceral pleural peel. History may reveal asbestos exposure among other chemicals, or tuberculosis and pleural effusion. Diagnosis is made from radiologic findings and a history of a predisposing cause. Our patient presented with shortness of breath; she has a history of tuberculosis and recurrent pleural effusion. Decortication is the only available treatment for fibrothorax.
Respiratory diseases
A-2268

Description of findings of dysphagia in a population with a diagnosis of chronic obstructive pulmonary disease in an intermediate city of Colombia during 2017

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Objective
To evaluate the findings related to dysphagia by means of clinical and paraclinical tests in a population with a diagnosis of chronic obstructive pulmonary disease (COPD) in Bucaramanga

Methods:
Patients were selected (54) with spirometry diagnosis of COPD.
All patients were asked to apply the Eating Assessment Tool (EAT-10) for dysphagia and the application of fibroendoscopy of swallowing.

Neurological etiology of dysphagia or patients with previous known dysphagia were excluded.
Clinical and paraclinical variables were tabulated and statistical adjustment was made in order to evaluate trend measures.

Results:
A total of 54 patients entered the study to complete the sample. The median age was 70 years, 53.4% of the sample were women, 70% were rural. 1 out of 3 patients admitted had EAT 10 scale greater than 3 and 31% had a value greater than 5.

Clinical findings in 70% of the sample had to diagnose dysphagia or risk of bronchoaspiracion. Of the total population with dysphagia, 86% was for fluids.

More than 70% of the dysphagia events were in the population between 65 and 84 years old.

Conclusion:
Currently published studies of the same line of research had biases in the classification of cases (COPD without having spirometric tests for its diagnosis) and difficulty in not performing imaging tests when defining dysphagia. The present study does not present such limitations.

The results show that a large part of the population (33%) presented symptomatic with clinical tests and 86% of the dysphagia were for fluids that allows to see a dysphagia in the initial phases.

The systematic evaluation of swallowing in a population with lung disease is not indicated, however swallowing disorders have been described as a source of possible exacerbations of lung disease that may worsen their baseline status and increase the cost overruns and clinical deterioration of the person.
Diagnosis of amyloid lung nodule by surgical biopsy - simulating lung cancer

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Introduction: Amyloidosis is caused by proteins deposited as insoluble blades that interfere with the functioning of organs. Each precursor protein induces a differentiated spectrum of organ involvement, and different manifestations of disease in the lung. Amyloid deposits can occur in systemic or organ-limited forms. The manifestations of lung disease range from nodules to diffuse septal and alveolar deposition, simulating malignancy, and/or diffuse alveolar damage.

Case description: Male, 63 years-old. History of hypertension and ischemic stroke. Former smoker. In 2009, in context of hospitalization due to stroke, was requested a chest X-ray, which showed a nodular image in the right lung. Without respiratory or constitutional symptoms. Physical examination was normal. Pulmonary-CT showed a 3.5 cm nodule in the anterior segment of the right upper lobe with regular, homogeneous contours, which contacted pleura. Bronchofibroscopy was normal. Transthoracic aspirative biopsy revealing necrotic material and rare hyperchromatic nucleus cells, likely neoplastic in nature. PET-Scan presenting intense avidity for FDG. Laboratory study, electrocardiogram and respiratory function tests without alterations. A surgical biopsy of the nodule revealed amyloid substance. Negative for malignancy. Patient remains asymptomatic until the present.

Discussion: This case report intends to describe a rare entity: Localized amyloid nodular disease. In contrast to systemic disease, the monoclonal proteins that make up the localized amyloid deposits arise from a small number of plasma cells around the lesion. The monoclonal light chains do not circulate or deposit outside the target organ. Published data concerning the prognosis and treatment of localized amyloidosis are scarce. Nodular disease may progress slowly, with increasing size or number of lesions, but usually has no impact on lung function or gas exchange of the lung nor on survival of the patient.
Diagnostic efficacy of the new qualitative heart type fatty acids binding protein test in patients with suspected acute coronary syndromes

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Objective: Early diagnosis of myocardial infarction (MI) improves its outcomes. We compared the diagnostic efficacy of the point-of-care test for heart type fatty acids binding protein (hFABP) with high sensitive troponin I (hsTnI) in patients with suspected acute coronary syndromes (ACS).

Methods: 229 patients (mean age 63.3±13.4 y.o.) with suspected ACS and duration of the presentation 1-24 hours were enrolled. Qualitative evaluation of hFABP was estimated at admission in capillary blood by qualitative immunochromatographic test «CARD-INFO» (OFK Cardio, Russia) with diagnostic threshold of 7 ng/mL. HsTnI (Pathfast, Japan) was measured serially thereafter, only the first measurement was used for the determination of diagnostic efficacy. The diagnostic cut-off value for hsTnI assay was 0.02 ng/mL.

Results: Sensitivity of hFABP test at 1-3 hours of MI (n=46) was 56.5% vs 41.3% for hsTnI (p=0.145), 3-6 hours (n=48) – 85.4% vs 66.7% (p=0.032) and 6-24 hours (n=42) – 71.4% vs 81% (p=0.306), respectively. Sensitivity of hFABP test was higher in patients with ST-segment elevation (76.8%, n=95) comparing with non-ST-segment elevation MI (58.5%, n=41). HFABP test specificity was 90.3% vs 94.6% for hsTnI (n=93, p=0.267). HFABP test accuracy was 79%, hsTnI – 75.1% (p=0.434), positive predictive value - 91.5% and 94.5% (p=0.415), negative predictive value – 68.3% and 63.8%, correspondingly (p=0.405). The reasons of the false-positive hFABP test results (n=9) were severe renal impairment (eGFR <45 mL/min/1.73m²), atrial fibrillation, anemia and congestive heart failure.

Conclusion: Qualitative hFABP evaluation is more efficient in diagnosis of MI in the first 6 h since onset of clinical presentations comparing with hsTnI.
Discrimination of Pneumonia Severity Index in a Portuguese Population.

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Background: Community-acquired pneumonia (CAP) is associated with highly variable severity of presentation and mortality. Pneumonia severity scores classify patients based on prognostic factors to help decide which patients should be hospitalized and which patients can be treated as outpatients. One of the most frequently used severity scores is Pneumonia Severity Index (PSI). PSI helps clinicians decide which patients to admit to hospital or to an intensive care unit (ICU). Our objective was to see if PSI has a good discrimination power in our patients admitted for CAP.

Methods: Retrospective cohort study that included all patients with CAP admitted to an internal medicine department throughout 12 consecutive months. Demographic and clinical data were collected and the PSI was calculated. Statistical analysis was performed with Stata®.

Results: We included 140 patients with a median age of 75 years (IQR: 63, 84) and similar gender distribution. The median PSI score was 148 among patients who died and 127 among patients who survived. We found that PSI was associated with death (p=0.034, [0.624,4.733]) and was well calibrated in our cohort (goodness of fit test = 0.27). Although well calibrated, PSI only had reasonable discrimination for survival (AUROC = 66%).

Conclusion: PSI is well calibrated to our population but only has reasonable discriminatory power. Despite being able to identify patients at risk of death, PSI overestimated the absolute risk of death in our cohort. Evaluation of severity scores is important to assess if these are adequate for the population we are treating.
Respiratory diseases
A-1454

Effect of dementia on the survival after a pulmonary embolism

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Background.
There is a nihilistic feeling on treating pulmonary embolism (PE) in patients with dementia.

Patient and methods.
From a registry of PE in our department of Internal Medicine of consecutive patients diagnosed with pulmonary embolism, we extracted all patients with cognitive deterioration, its causes, the Barthel score and physiological parameters and were compared with those with normal cognition.

Results.
A total of 468 patients were admitted with acute PE (median age 76, female 55%), 84 (18%) of them had some form of dementia.
Cognitive impairment was due to Alzheimer disease (47%), vascular dementia 30%, dementia-Parkinson 13%, and other causes 10%.
Patients with dementia were older, the PE was more often provoked, had lower Barthel score, higher thrombotic burden, higher plasma levels of C-reactive protein (p<.001 for each one), higher shock index and more hemorrhagic episodes (p<.05) than patients with PE with normal cognition.
During a median time of follow-up of 32 months, 46(66%) patients with dementia and 97(25%) patients with normal cognition died (p<.001). Death rate during hospitalization was 6% and 3% respectively (p=0.21); one-month mortality was 12% and 3.6% (p<.05) respectively. Death happen a median of 10 months after episode index in patients with dementia and after 17 (p<.05) months in patients with normal cognition.
Survival curves showed an advantage in survival in patients with normal cognition until de 13th month (p<.05). However, the main significant cause of death in patients with dementia was pneumonia (15% vs 2% p<.001).

Conclusion.
Patients with dementia diagnosed with acute pulmonary embolism have a higher risk of death during the first year after an acute pulmonary embolism. However pneumonia continues being the main cause of death in these patients.
Evaluation of the inhalation technique among patients in hospital with COPD

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OBJECTIVES
Inhaled medications are the preferred therapies for patients with COPD. There are some devices used to measure the correct inhalation manoeuvre. Our goal was to assess the entire inhalation manoeuvre and the spirometric flow parameters.

MATERIALS AND METHODS
A descriptive study from November 2016 to April 2018 was performed to analyse the correct handling of an inhalation device. We used the Inhalation Manager ® device and COPD-6 dispositive to measure the expiratory flow parameters in hospitalized patients at a tertiary centre.

RESULTS
During the follow up period, 924 patients were enrolled, 203 of them (22 %) had diagnosis of COPD. The mean age was 77.7 (49-92) years old and 68 (33%) of them were female. Inhalation manoeuvre was performed in 35 (17%) of the patients with COPD, the rest could not be evaluated because of physical disability or non-measurable dispositive among others reasons. 89% smoked more than 20 pack years. 7 patients were active smokers. 20 patients (57%) used a triple therapy with LAMA + LABA + IC. Regarding the spirometric flow parameters, 14 (40%) patients had FEV1 ≥ 50%, 14 (40%) had FEV1 between 50-30% and 6 (20%) had FEV1 ≤ 30% according COPD-6 dispositive. 11 patients (31%) performed an inadequate inhalation manoeuvre, 15 (43%) optimal and 9 (26%) an acceptable technique. Inhalation manoeuvre with PMDI was inadequate in 90% of the cases.

CONCLUSIONS
The use of devices that evaluate objectively the inhalation technique allows us to identify those patients with inadequate inhalation maneuver. This would permit us to optimize the use of the current device or to evaluate the possibility to switch to another one for a better treatment of the disease.
Giant Pulmonary Abscess - Two clinical cases

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Introduction: Pulmonary abscess is defined as a microbial lung infection that results in pulmonary parenchymal necrosis. The authors describe two cases of large pulmonary abscess, diagnosed in an Internal Medicine service.

Case description: Case 1: 52-year-old male, smoker. Complaints of dyspnea and pleuritic chest pain, for the past two months. On examination he was febrile, tachycardic and with decreased vesicular murmur (VM) on the left hemithorax. Chest radiography showed hypotransparency on the left and analytically there was an acute phase markers (APM) elevation. Amoxicillin/clavulanic acid and clarithromycin were initiated but due to the maintenance of complaints and radiological alterations, a thoracic computed tomography (CT) scan was performed, revealing "an extensive pleural effusion on the left, with approximately 17 centimeters". Thoracic drainage was performed and empirical ceftriaxone and clindamycin were initiated, with good clinical response. Case 2: 64-year-old male, smoker. Complaints of productive cough and pleuritic thoracalgia, over the previous 30 days. On examination he was pale and VM was decreased in the left hemithorax. Analytically there was an increase in the APM. CT scan of the chest revealed a voluminous intrapulmonary left thoracic liquid collection, with 16.5 centimeters. Antibiotic therapy with amoxicillin/clavulanic acid was initiated and a thoracic drainage was performed, with significant improvement.

Discussion: Although a large pulmonary abscess (greater than 6 centimeters) is not a very common pathology, the authors believe it should be considered in the diagnostic evaluation of patients with respiratory symptoms of indolent evolution.
Hospitalizations for acute exacerbation of COPD - the Portuguese experience

Hospital de Braga, Braga, Portugal

Objectives:
To evaluated the hospitalizations motivated by acute exacerbation of COPD (AECOPD) in a central university hospital, in the year 2016

Material and methods:
Retrospective analysis of the demographic, analytical and functional characteristics of the patients, as well as related hospitalization data, at the Pneumology Department.

Results:
Of the 113 patients included, 68% (n = 77) were males, with a mean age of 76 years, with most patients having a history of smoking (83.7%). The mean BMI value obtained was 25.1 kg/m2. The mean FEV1 predicted value was 50.18 %. About three-quarters of patients were classified as GOLD class D and 57% were on triple inhalation therapy. Chronic respiratory insufficiency requiring long-term oxygen therapy or noninvasive ventilation was present in 46% of patients. 23% patients (n=26) had a concomitant diagnosis of bronchiectasis.
A total of 55.8% (n=63) had a microbiological sputum, with a positive result in 29.2% of these (n =33), with Haemophilus influenza and Streptococcus pneumoniae being the most frequent agents. Antibiotherapy was prescribed in 90% (n = 102), with an average duration of 18 days and systemic corticosteroid therapy in 77.7% (n = 87). About 39% of the patients (n = 44) had already been hospitalized in the year prior to the study, with 31 patients (27%) hospitalized in the previous 3 months. More than half (n = 70, 62%) had suffered at least 1 AECOPD in that time period. The mean hospitalization time was 11 days. A hospital mortality rate of 7% (n = 8) and 90 days of 10% (n = 11) was calculated. The hospital readmission rate at 90 days was 28% (n = 32).

Discussion:
The identification of COPD patients at high risk of re-hospitalization is of paramount importance in order to improve the quality of health care provided and to reduce associated hospital cost.
Introduction: Dyspnea is a frequent and unspecific symptom which compromises patient's quality of life. It's etiology isn't confined to the cardiopneumological spectrum and a holistic approach plays a pivotal role in addressing these cases.

Case Description: 76-year-old man with a personal history of type 2 diabetes, arterial hypertension, myocardial infarction (1993), haemorrhagic stroke (2006), paroxysmal atrial fibrillation, obesity, heart failure and COPD.

In June 2014 he was admitted at the emergency service (ES) for sudden onset of dyspnea for medium efforts. The physical examination revealed a slight decrease of the vesicular murmur at the left base and oxygen saturation of 94%. He performed a thoracic X-ray, electrocardiogram and blood tests which didn’t show any alteration so he was discharged home. Since the symptoms persisted he performed respiratory function tests that didn’t show any alteration. Three weeks later he was admitted again at the ES due to worsening of the symptomatology. At the physical examination he had arrhythmic cardiac tones, so he performed an electrocardiogram that showed atrial fibrillation with controlled heart rhythm, and an echocardiogram that revealed slight dilation of left heart cavities and mild aortic and mitral regurgitation with normal ejection fraction. He was discharged with increased dose of furosemide, and addition of spironolactone to his regular prescription without clinical improvement. He came back one week later with greater dyspnea and fatigue so we proceeded to revision of chronic therapy. He was taking amiodarone for a long time without thyroid evaluation, so it was requested TSH and free serum T4 that confirmed the diagnosis of iatrogenic hypothyroidism. He was treated with levothyroxine, with gradual dose adjustment and became asymptomatic when a state of euthyroidism was reached.

Discussion: This case demonstrates the importance of a holistic approach which prevents over testing and overmedication.
Imatinib - Unusual iatrogenic Cause of Pleural Effusion

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Introduction: Pleural effusion (PE) is an entity with numerous differential diagnoses requiring a systematized approach. Adverse drug reactions caused by antineoplastic agents are a common form of iatrogenic lung injury. In Bcr-Abl tyrosine kinase inhibitors, in particular Dasatinib, PE is the most common side effect, may be bilateral or unilateral, more often exudative and predominantly lymphocytes. It is more common in patients taking Dasatinib when compared to Imatinib and therefore a possible but infrequent form of presentation in the latter.

Case description: Male, 72 years-old. History of Chronic Myeloid Leukemia in complete remission, hiatal hernia and macrocytic anemia. Chronic medication with Imatinib. He was admitted for progression of the dyspnea pattern with 2 months of evolution. Thoracic Radiography and Computerized Tomography showed a massive bilateral PE. Pulmonary thromboembolism was excluded. He was submitted to diagnostic thoracentesis and pleural biopsy. Pleural fluid with exudative features and microbiological and mycobacteriological study was negative. Cytological examination showed reactive type alteration, lymphocytosis and negative cytology for malignancy. Histological showed discrete inflammatory infiltrate, without granulomas or neoplastic process. Thoracoscopy without relevant changes. Negative blood cultures. Analytical, immunological and virological study without alterations of relief. Echocardiogram with mild depression of left ventricular global systolic function.

Discussion: After exclusion of infectious, neoplastic and autoimmune causes was placed as the most likely diagnosis for persistent exudative effusion chronic medication with Imatinib. Given the risk / benefit of maintaining therapy with Imatinib, and since alternative drugs may have the same iatrogenic effect, it was decided, in a joint decision with Oncology, to maintain the drug.
Intersticial pulmonary disease as a rare cause of presentation

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INTRODUCTION:
Amyloidosis is a disorder caused by misfolding of autologous protein and its extracellular deposition as fibrils, resulting in vital organ dysfunction and eventually death. Pulmonary amyloidosis may be localised of part of systemic amyloidosis. Pulmonary interstitial amyloidosis is symptomatic only if the amyloid deposits severely affect gas exchange alveolar structure, thus resulting in serious respiratory impairment. Localised parenchymal involvement may be present as nodular amyloidosis or as amyloid deposits. Finally, tracheobronchial amyloidosis, which is usually not associated with evident clonal proliferation, may result in airway stenosis.

CASE DESCRIPTION: 74 year old patient with COPD is admitted to pulmonology unit for hemoptysis, he was diagnosed of lund amyloidosis (amiloide AA) in december of 2016, without evidence of systemic amyloidosis, biopsy bone marrow was negative. In 2017 the patient was admitted in Internal Medicine Department with a constitutional syndrome, 20 kg weight loss in three months. Chest-TC Scan was realized finding a big mass in righ upper lobe of right lung with another cavitations of new appearance. A biopsy of this mass eas read congo stain positive. Bone biopsy and cardiac-RMI were also negative. During this admission the patient had syncopes with brain imaging studies and 24-hour heart rate monitoring were negatives. In sputum microbiological study was isolated haemophilus influenzae and the pneumocous antigen in orine was positive. All mycobacterial cultives were negative. The patient received antibioteci treatment and corticoids.

CONCLUSION: amyloidosis of the lower respiratory tract is rare, but may represent a significant clinical problema in either systemic or organ limited amyloidosis. In paricular in systemic AL amyloidosis, pulmonary interstitial involvemet associated with cardiac amyloidosis can contribute to cardiopulmonary failure or even be the major problem in rare cases.
Interstitial lung disease as a form of presentation of allergic bronchopulmonary aspergillosis

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Introduction: Allergic bronchopulmonary aspergillosis (ABPA) is an immunological pulmonary disease resulting from a hypersensitivity to Aspergillus antigens (mainly fumigatus). Immunoallergic reactions type I, II and III are triggered. ABPA occurs predominantly in patients with asthma and cystic fibrosis. We report a case of a 75-year-old non-asthmatic woman with ABPA.

Case description: A 75-year-old woman attended for a persistent dry cough of 3 months without dyspnea. She had a history of hypertension, dyslipidemia and never smoker. Her physical examination was normal except for crackles at the right base, further studies workup with a chest radiography revealed a bilateral interstitial pattern more evident in higher fields. Chest-TC scan: interstitial pathology suggestive of pulmonary fibrosis at onset. Bronchoscopy: acute nonspecific changes of interstitial involvement and alveolar desquamation without granulomas. Elevated IgG antibodies to Aspergillus in serum precipitins.

Discussion: The evolution of the disease depends on the reexposure to the spores of aspergillus, it can manifest clinically with light and moderate pictures, which are usually reversible, but severe reactions and maintained over time can produce fibrosis. The diagnosis of ABPA is based on haematological, radiological and immunological criteria along with the presence of longstanding asthma, and occasionally cystic fibrosis. In ABPA, chest radiography may show parenchymal infiltrates, often in upper lobes, atelectasis, and bronchiectasis. The differential diagnosis must be made with clinical entities that present with similar pulmonary radiological manifestations: heart failure, bronchiectasis and pneumonia, carcinomatous lymphangitis, pulmonary infiltrates in immunosuppressed patients, diffuse pulmonary haemorrhage, lipoid pneumonia and miliary tuberculosis.
Interstitial pneumonia does not specify versus descamativa. About a case.

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INTRODUCTION: Non-specific interstitial pneumonia (NSIP) is a type of idiopathic interstitial pneumonia. NSIP may be idiopathic or be associated with other conditions, such as rheumatoid arthritis, scleroderma, systemic lupus erythematosus, polymyositis, dermatomyositis, inflammatory myopathies and drug-induced lung injury, but no causal link is established.

DESCRIPTION: A 63-year-old woman with a history of morbid obesity, smoking, high blood pressure, hypothyroidism, extabaquism, and anxiety-depressive syndrome who presented with an increase in habitual dyspnea until she had had rest in the last 2 or 3 days associated with dry cough without expectoration, chest discomfort and palpitations. Afebril. No weight loss or lymphadenopathy. Negative history for collagen diseases. Denies feather / goose pillows, nor contact with birds or animals, does not live in the field. Presents <82% basal desaturation that improves with oxygen therapy. Chest radiography shows bilateral interstitial pattern and right pulmonary hilar augmentation that correlates with Computed tomography of the thorax. Negative autoimmunity, high resolution computerized tomography with ground glass pattern and thickening of the interlobular septa, Fibrobronchoscopy with brochoalveolar lavage with 90% macrophage, culture and negative bronchial aspirate. Functional respiratory tests with restrictive pattern, decrease in diffusion of carbon monoxide. Transtoracic echocardiography without pulmonary hypertension. Given the results of tests and clinical the first possibility is that it presents nonspecific Interstitial Pneumonia or desquamative interstitial pneumonia.

DISCUSSION: The prognosis is usually good, with an estimated mortality at 5 years <18% and survival at 74% at 5 years. Patients with NSIP have a better prognosis than patients with idiopathic pulmonary fibrosis. The initial treatment included corticosteroids with or without cytotoxic agents.
Respiratory diseases
A-1782

Intralobar Pulmonary Sequestration supplied by the Left Circumflex Artery – a rare case

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Introduction: Pulmonary sequestration is an uncommon congenital anomaly wherein a portion of non-functioning lung parenchyma is not connected to the pulmonary arterial blood supply. Most pulmonary sequestrations derive their blood supply directly from the aorta or the intercostals vessels.

Case description: 68 year-old male presented in the Emergency Department with 3-day epigastric pain with irradiation to left hemithorax and shoulder, nausea and diziness. Past medical history included arterial hypertension, dyslipidemia, frequent episodes of exertion-related chest pain and a cardiac stress test suggestive of ischemia. The ECG and the cardiac enzymes were suspicious for myocardial infarction and the echocardiogram revealed septal and lower wall hypokinesia with preserved ejection fraction. A CT angiogram was performed to exclude aortic dissection and showed a contrast-enhanced nodular lesion in the left pulmonary lobe, close to the hilum bronchovascular bundle and lung fissure. At coronary catheterization, a branch arising from the left circumflex artery (LCA) supplying an extra-cardiac structure was noted. Angio-MRA confirmed a 41 mm mass in close contact with the left oblique fissure and the mediastinum, compatible with an intralobar pulmonary sequestration with coronary vascularization, namely from the LCA. The patient was referred to Thoracic Surgery for resection and the procedure occurred without any complications. Till today, no recurrence of the previous symptoms was observed.

Conclusion: Arterial supply of PS from the coronary circulation is extremely rare and myocardial ischemia may be the initial and only manifestation of the disease. Surgery is recommended in case of frequent respiratory infections or heart ischemia.
Lung Cancer - characterization of a sample

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Objectives: Lung cancer is the most common tumor in the world and the leading cause of cancer death. The authors intend to characterize a sample of patients with lung cancer.

Methods: Retrospective analysis including patients with lung cancer followed in a Oncological Pneumology Department of a central hospital during 4 months. Demographic, clinical and radiological data were retrospectively assessed.

Results: Diagnosis of lung cancer was obtained in 198 patients, 150 (75.8%) patients were male. The mean age was 69.6±11.6 years. About 77.3% had current or past history of smoking. 62.7% of the diagnoses corresponded to the histological subtype of adenocarcinoma followed by epidermoid subtype (20.7%). At diagnosis 70.7% had a advanced stage. A total of 41.9% (n = 83) were undergoing systemic or target treatment. The remaining were in surveillance phase after radical treatment or in palliative treatment. TKI first-line treatment was initiated, for advanced disease, in 13 patients with EGFR mutation and in 1 patient with ALK translocation. First-line immunotherapy was initiated in 1 patient with PDL-1 expression. Of the total, 20.2% (n = 40) of patients died. The majority of them (n=38;95%) were ad-initium advanced stages and were diagnosed in the last year (n=32;80%).

Conclusion: The treatment of lung cancer has evolved greatly in recent years, with novel therapeutic agent targeting BRAF, EGFR, ALK, and ROS1 and immunotherapy for PDL-1 expression, which has allowed a significant advance in survival and quality of life. The major problem of lung cancer treatment remains the late diagnosis. The authors intend to appeal to clinical suspicion, rapid diagnosis and staging and active research of specific treatment targets.
Lymphocytic interstitial pneumonia (LIP)

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INTRODUCTION: Lymphoid interstitial pneumonia (LIP) is an unusual pathology. It is a non-neoplastic inflammatory respond of the lung to several external stimulus or a systemic disease.

Autoimmune thyroiditis is also associated with lymphocytic interstitial pneumonias as described by Khardori in a review of 4 cases. It is an inflammatory disease that typically affects women over 40 years old. Sometimes, lymphocytic cells can be found in the inflammatory process, probably associated with an autoimmune phase. This includes lymphocytic adrenalitis and lymphocytic interstitial pneumonitis.

CASE DESCRIPTION: 75 years old woman without toxic habits, atrial fibrillation; hypothyroidism; chronic lymphocytic thyroiditis and primary hyperparathyroidism.

Admitted in Internal Medicine department for epigastric pain with colonoscopy and gastroscopy without significant findings. A thoraco-abdominal CT showed multiple nodules in both hemithorax suggestive of metastasic disease, mediastinal lymphadenopathy, thickening of the gastric antrum, pylorus and first duodenal portion. The patient had no respiratory symptoms at that moment or in the previous months. PET/CT: multiple pulmonary nodules with metabolic activity suggestive of metastatic disease.

Finally, a transthoracic biopsy of one nodule was performed. The pathological findings showed diffuse lymphoid hyperplasia, non-clonal rearrangement.

DISCUSSION: The association between lymphocytic interstitial pneumonia and thyroiditis is infrequent. LIP is associated with autoimmune diseases such as Sjögren’s syndrome; rheumatoid arthritis, systemic lupus erythematosus. The most frequent symptoms are cough and dyspnea.

The clinical course varies significantly, from spontaneous resolution without treatment, to progressive respiratory failure and death.

In this particular case, the patient did not present any respiratory symptoms.
Massive subcutaneous emphysema and pneumothorax secondary to minor blunt trauma

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INTRODUCTION Pneumothorax and subcutaneous emphysema are common complications of blunt chest trauma, resulting from spontaneous alveolar wall rupture as a consequence of traumatic disruption of the trachea-bronchial tree. Its treatment and prognosis depend on the extent of the injury and the patient’s clinical presentation. CASE DESCRIPTION Autonomous 81-year-old female with a history of chronic obstructive pulmonary disease (COPD), admitted in the emergency room after a minor blunt dorsal traumatism towards a door at home, presenting dyspnoea and swelling of the face, neck and chest. Initial presentation included respiratory failure with oxygen saturation of 70% in ambient air, pulse rate of 120 beats per minute, blood pressure of 202/128 mmHg and crepitations were detected on palpation of the swollen areas. After clinical stabilization, chest X-ray indicated extensive subcutaneous emphysema and the computed tomography also revealed pneumomediastinum and bilateral pneumothorax associated with rib fractures. After the placement of two chest drains, the emphysema significantly improved, however, bronchoconstriction remained of difficult control. Bronchoscopy ruled out laryngotracheal mucosa rupture, and with optimized medical therapy the patient presented slow but favourable evolution, with progressive improvement of gas exchange and resolution of pneumothorax and subcutaneous emphysema after 10 days. DISCUSSION The interest of this case focuses on the fact that a minor trauma causing rib fracture, associated with the patient’s history of COPD, resulted in pneumothorax that extended through the bronchovascular layers to the mediastinum and further to the vascular sheaths, causing important subcutaneous emphysema. The clinical instability presented in the admission and the consequent COPD exacerbation represented a challenge that required a cautious management and strict surveillance.
Respiratory diseases
A-1615

Melanoma spreads to pleura: a rare clinical picture

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Introduction: Malignant melanoma spreads frequently to different sites (skin and lymphatic nodes (40-50%); lung (20-36%); liver (15-20%); brain (10-18%) and others). Pleural metastasis are rare and there are no case series described, only case reports. We present a case of an unique pleural metastasis in a patient diagnosed of melanoma five years before.

Case description: a 66 year-old man with hypertension and an abdominal melanoma without adenopathies diagnosed five years before, treated with dacarbazine, was attended because dyspnea and asthenia. Clinical examination: Inaudible breath sounds in the right hemithorax. Analysis: hemoglobin 10.1 g/dL; fibrinogen 851 g/dL; R-CP 229. Thorax X-Rays: right-sided pleural effusion. Diagnostic thoracocentesis: Hematic liquid. Thorax and abdominal CT: Moderated right pleural effusion and a heterogeneous pleural implant (55x97x76 mm) in the right base. Videothoracoscopy and biopsies confirmed the metastatic origen of the lesión and treatment with vemurafenib was initiated. The patient died six months later.

Discussion: Melanoma spreads to pleura exceptionally, and in these cases lung is usually affected (70%). When the thoracic cavity is involved, as in our case, only 2% of the cases present pleural effusion. Cytology was negative for malignance, and the diagnosis was made by biopsy of the pleural implant. patient refused. The time elapsed from the diagnosis to the effusion appearence (five years) is not exceptional. It is necessary to remember that pleural metastasis in melanoma are posible, in order to improve the therapeutic strategy and the survival.
Multiple Lung Nodules – A Case Report

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Introduction
Chronic silicosis is a pneumoconiosis caused by inhalation of free silica. It’s the main cause of disability between the occupational lung diseases, estimated to affect one third of miners.

Description
63 years-old male, with known history of arterial hypertension, former smoker and non-stratified lung pathology, presented to the ER with aphasia and right-sided hemiparesis. He was admitted to the hospital with an ischemic stroke/TIA – left medial cerebral artery PACI (NIHSS 1). The patient clinical status developed favorably, with complete resolution of the neurologic deficits (NIHSS 0 when discharged). During the work up, we discovered a symptomatic significative stenosis of the left internal carotid artery (70%) and a right carotid stenosis with hemodynamic repercussion. A bilateral endarterectomy was successfully performed. During his stay, he was also submitted to a chest-CT which showed bilateral multiple lung nodules, compatible with metastatic lung neoplasy; a bronchofibroscopy also confirmed the absence of neoplastic lesions. He was submitted to a lung biopsy, whose histological exam showed a sclero-hyaline nodule, compatible with pneumoconiosis. He was discharged in good clinical condition, although still maintaining exertional dyspnea.

Discussion
Chronic silicosis is a differential diagnosis of multiple lung nodules; frequently the physician needs the histological exam to exclude a neoplasy. It is a cause of restrictive and obstructive limitation. There is no specific therapy; patients must avoid further silica exposure. Silicosis is a risk factor for COPD, lung neoplasy and rheumatic diseases, among other pathologies. It is an important cause of morbility, being associated with early mortality (11 years before the general population).
Necrotizing pneumonia: a rare complication

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Introduction: Necrotizing pneumonia (NP) is a rare and severe complication of community-acquired pneumonia, leading to lung tissue destruction and appearance of necrosis focus. It has different causal agents. Its presentation is variable, ranging from indolent symptoms until rapidly progressive respiratory failure.

Case description: Man, 81 years, history of arterial hypertension, chronic obstructive pulmonary disease and lymphocytic leukemia under QT. Admitted with aggravated dyspnea, episodic chest pain, anorexia and cough with mucous sputum with one week evolution. On physical examination the patient was febrile, tachycardic and tachypneic, pulmonary auscultation with rhonchi and dispersed crackles. He had a type 1 respiratory insufficiency, analytically: neutropenia, acute renal disease, hyponatremia and elevated c-reactive protein. Chest radiography: condensation in the middle of the right lung. He started piperacillin/tazobactam empirically. A multi-sensible S. aureus (MSSA) was isolated in the bacteriological examination of sputum that was sensible to the antibiotic in progress. The blood cultures were sterile. Good initial evolution, but after he finished the antibiotic, clinical worsening occurred and inflammatory parameters raised. Therefore we decided to start linezolide with meropenem. Chest CT scan showed areas of consolidation in the upper lobe of the right lung, partially excavated, that suggested NP. Bacteriological examination of sputum and broncho-alveolar lavage isolated again a MSSA. Good analytical and radiological evolution, having he medical discharge.

Discussion: NP is associated to a higher risk of treatment failure and high mortality. The authors present the case of a immunocompromised patient with a pulmonary infectious process, under early adequate antibiotic therapy, nevertheless clinical decline occurred but was approached on time allowing a favorable outcome. It emphasizes the importance of the MSSA in the NP pathogenesis.
Necrotizing pneumonia: a rare complication.

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Introduction: necrotizing pneumonia is a rare complication of community-acquired pneumonia and characterizes of foci of necrosis in previous areas of consolidation. Many infectious agents can be responsible for developing this condition such as Streptococcus pneumoniae.

Case description: a 57-year-old man was admitted to hospital with dyspnea, dry cough, generalized myalgia and fever (>38°C). He was a heavy smoker and had abused alcohol consumption. The diagnosis of extensive bilateral pneumonia with hypoxemic respiratory insufficiency (ratio PaO2/FiO2 167.5) was made. Ceftriaxone and clarithromycin were started. On the second day of hospital admission his clinical condition deteriorated with the development of respiratory failure with cardiac arrest associated to a hypertensive pneumothorax. He was admitted to the intensive care unit after drainage of the pneumothorax and initiation of mechanic ventilation and he experienced a good response to therapy with time. Bacteriological test revealed Streptococcus pneumoniae sensible to the prescribed antibiotherapy. Subsequently, despite the good outcome, the patient presented radiological and analytical worsening. Therefore a chest CT was performed which revealed: “air bubles at the previous consolidation areas and a voluminous buble at the right lung with approximately 15cm with hydro-aerial level”. He completed 14 days of piperacillin-tazobactam and clindamycin with resolution of the inflammatory parameters and improvement of the lung lesion. He was discharged with clindamycin with total resolution of the lesion.

Discussion: necrotizing pneumonia is a rare complication of community-acquired pneumonia that should be considered in pneumonias with worse outcome. The prompt recognition of this entity is essential towards the good management and treatment.
Nitrofurantoin-induced pulmonary toxicity: A case report

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INTRODUCTION: Nitrofurantoin is an antibacterial agent frequently used in the management of urinary tract infections (UTIs). This antimicrobial drug is generally used for treatment of acute cystitis and for prophylaxis in patients with recurrent UTIs. Rarely, it can produce acute or chronic pulmonary toxicity. Chronic toxicity produces a variable clinical presentation and its radiological presentation requires an exhaustive differential diagnosis within interstitial lung diseases.

CASE DESCRIPTION: A 61-year-old woman, among her personal history, presents repeated urinary tract infections, treated with nitrofurantoin (50 mg/day) for approximately 4 years. She required hospital admission for cough of 2 years of evolution and expectoration in the last nine months. In addition, in the last month she presented progressive dyspnea. Upon examination, chest auscultation revealed bilateral inspiratory crackles. Chest radiograph showed bilateral airspace and interstitial infiltrates. Laboratory studies revealed elevation of liver enzymes without other findings in the rest of the blood test. Chest X-ray revealed a bibasal interstitial pattern and therefore underwent thoracic CT scan showing the same pattern. Spirometry was compatible with restrictive pattern and diffusion with severe. In the 6-minute test the test had to be stopped due to dyspnea and desaturation. It was determined that nitrofurantoin use was the probable cause of the patient's lung injury. Symptomatic improvement was observed shortly after the drug was discontinued.

DISCUSSION: Drug-induced interstitial pneumonitis accounts for approximately 3% of the total DILD. Nitrofurantoin is a cause of lung toxicity. Chronic interstitial pneumonitis due to nitrofurantoin appears after at least 6 months of treatment and presents with cough and dyspnea with absence of fever or obstruction of the airway. The treatment consists of removing the drug and support measures. Clinical improvement is usually rapid.
Respiratory diseases
A-1471

Non cystic–fibrosis cystic bronchiectasis: in respect to an image

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Introduction: The presence of bronchiectasis, abnormal and irreversible bronchial dilatations, with associated bronchic wall destruction, is a common radiological finding, although clinically neglected. When clinically significative, bronchiectasis have an important impact on patients’ quality of life and associated healthcare costs.

Case description: Man, aged 52, former smoker of 25 pack-year, wood worker retired for disease. At the age of 30, he had repeated respiratory infections and was hospitalized for acute respiratory failure. During follow-up in outpatient consult, he developed significant respiratory symptoms, such as persistent cough with abundant expectoration, with important functional limitation and was diagnosed with bilateral disperse cystic and varicose bronchiectasis, chronic obstructive pulmonary disease (COPD), chronic respiratory failure (CRF) and colonization by Pseudomonas aeruginosa and methicillin-resistant Staphylococcus aureus. He had about 1 hospitalization per year for respiratory infection with CRF agudization. Numerous etiologies of bronchiectasis and COPD were excluded, such as cystic-fibrosis, alpha-1 anti-trypsin deficiency, immunological deficiency, allergic bronchopulmonary aspergillosis, primary bronchiolar disorders, inflammatory bowel and connective-tissue diseases, among other. Despite optimized medical treatment, the patient clinical and functional status progressively worsened, with increasing oxygen needs up to 15L/min and prolonged hospitalization. He was proposed for pulmonary transplantation and the procedure succeeded, but the patient died shortly after.

Discussion: Despite being considered an orphan lung disease, it's now known that bronchiectasis are associated with other diseases, namely COPD, with influence on prognosis, morbidity and mortality. Such as in COPD, the evaluation of bronchiectasis severity, with clinical, radiologic and functional staging systems, is essential on the clinical approach of bronchiectasis.
Respiratory diseases
A-1212

Not a single respiratory infection

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Introduction:

Clostridium septicum bacteremia is associated with neoformative processes of the digestive tract (especially colorectal carcinoma) and lymphoproliferative processes.

Case Description:

An 82-year-old man with a personal history of type 2 diabetes mellitus, dyslipidemia and bipolar disorder under treatment with metformin, propanolol, simvastatin, olanzapine and lithium.

He is brought to the Emergency Department due to fever and malaise. After assessment and completion of complementary tests (including blood cultures) is discharged with the diagnosis of respiratory infection and treated oral antibiotic treatment (Moxifloxacin).

48h later, the blood cultures turned positive for Clostridium septicum, so he was admitted in a programmed way in our unit. On admission, the patient was afebrile, with good general condition. Denied weight loss, hyporexia and / or asthenia. There was no pain at any level, including gastric discomfort.

The physical examination was absolutely normal. Antibiotic treatment with Amoxicillin-Clavulanic was instituted and complementary tests were requested. In the analysis, a CRP of 267 mg / L as well as 20200 leukocytes / mm3, with a predominance of neutrophils (18200 / mm3), stood out. Given the findings, gastroscopy was performed to take biopsies, with a positive result for B lymphoproliferative process with MALT lymphoma component. The patient was discharged, pending consultation with the Hematology Department.

Discussion:

The presence of Clostridium septicum bacteremia in a patient should make us suspect in intra-abdominal focus, and given its high connection with malignant processes, its screening is necessary, as has occurred in our case.
Not everything is Pneumonia!

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Introduction: Amiodarone is a widely used antiarrhythmic drug that is associated with an important prevalence of hypothyroidism. Less frequently it is related to cases of hypersensitivity pneumonitis.

Case description: The authors describe the case of an 83-year-old woman with a 2-month history of dyspnea for minor exertion, orthopnea, and lower limb edema. No other symptoms or relevant epidemiological context. History of atrial fibrillation and heart failure (HF) due to ischemic heart disease, chronically medicated with bisoprolol and amiodarone. At admission, the patient presented afebrile and breathing heavily, with low peripheral oxygen saturation. Pulmonary auscultation with decreased vesicular murmur and bibasal crackles. She had symmetrical malleolar edema. From the laboratory results we highlight an hemoglobin of 8.6g/dL (11.5-16.0g/dL), TSH of 11.28μUI/mL (0.34 - 5.60μUI/mL), SR of 36mm (<15mm) and other inflammatory parameters were negative. Gasimetry revealed global respiratory failure. Chest X-ray presented with cardiomegaly and bilateral nodular pulmonary infiltrate. Hemocultures, antigenuria and research of influenza viruses were negative. Thoracic CT-scan showed cardiomegaly and bilateral centro-acinar opacities, in relation to inflammatory process. On suspicion of hypersensitivity pneumonitis to amiodarone, bronchofibroscopy was requested and the patient refused it. After amiodarone suspension and initiation of corticoid therapy, analytical improvement (TSH 3.52 μUI/mL) and respiratory symptoms with radiological resolution of the condition were observed.

Discussion: In the present case, the authors intend to alert some of the side effects of chronic amiodarone use, which, although infrequent, exist and should be considered, remaining a current clinical challenge.
Osteochondroplastic tracheobronchopathy, something more than respiratory infection: a case report

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INTRODUCTION:
Osteochondroplastic tracheobronchopathy (OT) is a rare benign disorder, usually limited to the lower part of the trachea or upper part of the main bronchus, characterized by submucosal calcified sessile, cartilaginous and/or osseous nodules with lumen projection.

CASE DESCRIPTION:
Male, 75 years old, with a history of dyspnea, hemoptoic sputum and left pleuritic pain. Thorax tomography (TT) revealed luminal tracheobronchial micronodularity with a condensation lesion in lower left lobe. Antibiotic therapy was performed. Bronchofiberscopy revealed, immediately below the vocal chords, exuberant polypoid formations of hard consistency over the entire length of the anterior and lateral wall of the trachea extending to both main bronchi, which caused reduction in the caliber of the tracheal lumen, most evident in the lower third. Bronchoalveolar lavage revealed Pseudomonas aeruginosa and bronchial biopsies revealed osteochondral tissue with normal respiratory mucosa, compatible with OT. Control TT verified resolution of the consolidation lesion, with persistence of other clinical findings. Rigid bronchoscopy was performed, including multiple biopsies at different sites, without the need for additional procedures. The anatomopathological study confirmed OT.

DISCUSSION:
OT produces symptoms directly associated with the site and degree of upper airway obstruction. Most common complications include atelectasis and pneumonias. Rigid bronchoscopic procedures or surgical exeresis is restricted to severe obstructions. In this case, besides exuberance and extension of the lesions, atelectasic pneumonia was solved with antibiotic therapy, without the need for more invasive procedures. However, it is of most importance a regular follow up because the occurrence of complications and possible disease progression.
Pancraticopleural fistula: case report and literature review.

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Introduction:
Pleuropulmonary complications of pancreatitis are rather common. However, a pancraticopleural fistula is a rare complication (less than 1%) and can be severe. Detection of high amylase levels and a high protein content in the pleural effusion is characteristic. However, routine determinations of amylase in pleural effusion samples is not recommended. The classic description of a patient with PPF is that of a chronic alcoholic male in his mid-forties, with chronic pancreatitis and shortness of breath.

Case report:
We present the case of a 72 year old male with a clinical history of diabetes and a necrotizing pancreatitis four years earlier.
A retrograde endoscopic cholangiopancreatography was performed due to choledolithiasis. Three months after that, he consulted at the Emergency Room with a chief complaint of dyspnoea that had been increasing for the past three weeks. Upon physical examination, he presented hypoventilation on the left lung. A chest X-ray was performed and showed a massive left pleural effusion. The patient was admitted into the Internal Medicine ward, where a thoracocentesis was performed. A tube thoracostomy was also conducted, with a clear improvement of the pleural effusion. The amylase levels of the fluid were over 9000 U/L. An abdominal computerized tomography (CT) was performed and a peripancreatic collection was demonstrated, with a highly probable fistulisation to the left pleural space. Octreotide treatment was initiate. General Surgery Department performed an open pancreatectomy with splenectomy and cholecystectomy. The patient presented a good clinical evolution.

Discussion:
PPF is a rare condition that can result as a complication of chronic pancreatitis, with an overall mortality of less than 5%. It should be suspected in refractory pleural effusions with high amylase levels, and imaging tests might demonstrate the presence of a fistulous tract.
Pleural effusion: a challenge in the differential diagnosis.

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Introduction and case description
A 89-year-old woman with a history of type-two diabetes and no other significant comorbidities, was admitted to the Emergency Department due to progressive dyspnea. Physical examination revealed bilateral crackles and edema with fovea in lower limbs. Lab test showed a BNP of 566.9 ng/ml (> 500 ng/ml cardiac failure) and respiratory insufficiency. The chest radiograph showed a bilateral pleural effusion, predominantly on the right side. The initial diagnosis of congestive heart failure was made. After five days of diuretic treatment and standard management, pleural effusion persisted, and then a diagnostic thoracocentesis was performed. 870 ml of pleural fluid of serohematic aspect was collected (pH: 6.80, Glucose <5, Liquid PT ratio/ Serum: 0.61, LDH 1842 mg/dL, ADA: 381.4, leukocytes: 13,800, neutrophils: 58.70%, lymphocytes: 39.70%) requiring a drainage tube. Because pleuritic chest pain continued, a CT scan demonstrated a right subacute/chronic pulmonary tromboembolism and significant right pleural effusion. A second thoracentesis was performed confirming a lymphocyte predominant exudate fluid and cytology showed cells compatible with high-grade non-Hodgkin lymphoma.

Discussion
Pleural effusions represent a common problem in daily clinical practice. A substantial number of pleural effusions on the initial diagnostic thoracocentesis could be underdiagnosed or missdiagnosed. Other possible contributing ethiologies may not be suspected from the begining. Some recent reports estimate that the prevalence of multiple cause pleural effusion might be up to 30%⁴. We consider that in elderly patients, a non solving pleural effusion, malignancy should be ruled out. A multidisciplinary approach would be recommended in those complex situations.

Pleuroparenchymal Fibroelastosis – a rare interstitial lung disease

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Introduction: Pleuroparenchymal fibroelastosis (PPFE) is a rare entity characterized by pleural and subpleural parenchymal fibrosis and elastosis mainly in the upper lobes. The etiology and pathophysiology are unknown. We report four cases diagnosed in our hospital.

Case 1 – 47-year-old female, nonsmoker, with first-degree relative with known interstitial lung disease, presented with dyspnea and nonproductive cough within the last year. HRTC revealed apical pleuropulmonary thickening and lower lobe mosaic attenuation pattern; the bronchoalveolar lavage showed lymphocytosis with high CD4+/CD8+ ratio. Surgical biopsy was compatible with PPFE with centrilobular ill-defined epithelioid granulomas, diagnosing concomitant PPFE-Hypersensitivity Pneumonitis and immunosuppressants were started.

Case 2 - 75-year-old female, nonsmoker, with frequent respiratory infections and exertion-related dyspnea. Pulmonary function tests (PFT) revealed severe obstruction and DLCO reduction. HRTC showed apical opacities with bilateral bronchiectasies. Biopsy was compatible with PPFE and hydroxychloroquine and corticosteroids were started.

Case 3 - 71-year-old female, smoker, asymptomatic, with moderately reduced DLCO; HRTC with centrilobular emphysema and bilateral apical pleuroparenchymal thickening suggestive of PPFE, confirmed with biopsy. Patient remained under observation due to minimal disease expression.

Case 4 - 67-year-old female, history of Asthma and Breast Cancer treated with chemoradiation. PFT showed a moderately severe obstruction and HRCT revealed subpleural apical thickening with pleural calcifications. Biopsy was compatible with PPFE. The patient remained under clinical and radiological control.

Discussion: Despite most cases being idiopathic, current data suggests a link with pulmonary infections, genetic and autoimmune mechanisms. There is currently no specific therapy and the prognosis is generally poor.
Respiratory diseases
A-1913

Pneumomediastinum As Rare Complication Of Pneumothorax

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Introduction: Pneumomediastinum is the presence of gas in the mediastinum from the alveolar space or airways. Subcutaneous emphysema, specifically affecting the face, neck, and chest is one of the typical associated signs.

When it is associated with pneumothorax, it may be life-threatening.

Description: This case describes a 70-year-old man, smoker, with history of chronic obstructive pulmonary disease and tuberculosis in the past. Admitted by one day history of retrosternal pain with left dorsal irradiation and dyspnea. On hospital admission he was hemodynamically stable, and there was a decrease in respiratory sounds on the left side of the chest and wheezing. Thoracic radiograph (Rx) showed left pneumothorax. It was placed a thoracic drain, with pulmonary re-expansion and clinical improvement. On the 8th day, he started having signs of respiratory difficulty and hypoxemia. Repeated Rx showing subcutaneous emphysema on cervical, thoracic and abdominal region and limbs. Computed Tomography (Fig. 1) showed pneumomediastinum and right base pneumonia. It required transient invasive ventilation, with favorable evolution. Surgical pleurodesis was proposed.

Conclusion: Pneumomediastinum is rare. Bronchopleural fistula due to persistent pneumothorax is a possible etiology. In 70% of cases, the patient develops subcutaneous emphysema and is usually self-limiting.
Respiratory diseases
A-1254

Pneumonia in the immunocompromised patient

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Introduction:
Immunodepression either due to infection or drug-related makes our patients susceptible to opportunistic infections and usually hard to treat.

Case report:
A 70-year-old man, natural from India is admitted due to severe respiratory infection with hypoxemia. His x-ray shows bilateral infiltrates. He started empirically piperacillin-tazobactam and vancomycin. His bloodwork shows positive HIV test and AIDS criteria (CD4+ 6.1 cel/uL), there was a positive CMV serology with a viral load of 51750.5 copy/mL. Due to severe immunosuppression, he was also started on cotrimoxazol and ganciclovir. There was worsening of his clinical status with severe respiratory failure and need of mechanical ventilation, so he was transferred to the ICU. A bronchofibroscopy is done that confirms isolation of Pneumocystis jiroveci. Unfortunately, he develops refractory septic shock and dies in the ICU.

Discussion:
Even though it's incidence is decreasing, P.jiroveci pneumonia is still one of the most frequent opportunistic infections in the HIV/AIDS population. Prompt treatment and clinical suspicion is needed.
Pulmonary cement embolism after kyphoplasty: a complication to recognize.

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Introduction:
Pulmonary cement embolism is a recognized complication of kyphoplasty, a minimally invasive technique aimed at reducing pain and stabilizing compressive vertebral fractures. Its exact incidence is unknown, varying according to the series between 2-26%. Most cases are asymptomatic, however catastrophic events are described. In cancer patients, the diagnosis is often detected during imaging follow-up.

Case Description:
A 58-year-old non-smoker female was diagnosed in March 2011 with stage IIB EGFR-/ALK- pulmonary adenocarcinoma. Left upper lobectomy was performed, followed by adjuvant chemotherapy with Cisplatin-Vinorelbine. Disease progressed fifteen months later, leading to second-line therapy with Pemetrexed and worsening after the second cycle. Third-line Erlotinib was maintained for 4 years with stability, until progression in June 2016 have led to fourth-line therapy with Nivolumab. In January 2017 persistent low back pain was reported. Computed Tomography (CT) revealed a compressive fracture in L3. Nuclear Magnetic Resonance (MRI) could not exclude metastization, so kyphoplasty was performed with bone biopsy, which eventually excluded malignancy. Patient's clinical status remained unchanged. Control CT three months after surgery showed stable disease, but an embolism involving both pulmonary arteries, right interlobar and right lower lobar arteries was described. The high-density embolic material was related to cement kyphoplasty. Additional major embolic foci were excluded. Therapeutic hypocoagulation with Enoxaparin was performed uneventfully for 3 months, after which CT documented the persistence of endovascular embolic material.

Discussion:
The authors describe a complication to be remembered in patients submitted to vertebral augmentation techniques. A high clinical suspicion is often required for the diagnosis. The natural history, ideal treatment and best prevention strategies still need to be clarified.
INTRODUCTION: Right-sided endocarditis (RSE) is a well-defined clinical entity, rarer than left-sided endocarditis. It is frequently associated with intravenous drug use or presence of medical devices. Tricuspid valve is affected in the majority of cases, and medical treatment is usually sufficient. Surgical treatment is reserved for instances of medical therapy failure or in the presence of large vegetations. Although there’s a high recurrence rate amongst intravenous drug users (IVDU), RSE globally has a good prognosis.

CASE DESCRIPTION: A 70-year old male with history of alcohol abuse was admitted in the emergency room for fever, cough, haemoptysis and loss of 8kg of weight in two months. Chest X-ray revealed two hypodensities, one in the lower right lobe and another in the superior right lobe. Patient rejected hospitalization and went home treated with levofloxacin. Two months after the first episode the patient was admitted with the same symptoms. Amongst other exams, a transthoracic echocardiogram was done, which showed a 20cm vegetation in the tricuspid valve. Microbiological studies revealed Streptococcus mitis and antibiotic therapy was adjusted for penicillin plus gentamicin. In face of an absence of vegetation size reduction, the patient was submitted to surgical approach with a good evolution.

CONCLUSION: RSE is an uncommon disease, corresponding to 5-10% of all infective endocarditis. The most frequent agent is Staphylococcus aureus, although other agents can be isolated. The treatment is frequently medical, with surgical treatment needed when there is a weak response to antibiotics.
Background: The diagnosis of pulmonary embolism (PE) is based on defined algorithms. The etiologic investigations require the research for a prothrombotic state. Patients and methods: A total of 20 patients with PE were enrolled into this retrospective study. The diagnosis of PE was based on clinical and biological arguments (antecedents, dyspnea, hemoptysis, tachycardia, venous thrombosis and high D-dimer level) and was demonstrated with imaging tests (thoracic angio-scan in 16 cases (80%), and scintigraphy in 4(20%).

The risk stratification was performed using the pulmonary embolism severity index (PESI). Results: 13 women (65%) and 7 men (35%) were included, with a mean of age of 52 years (range 21-87 years). The dyspnea was the main symptom, reported in 17 observations (85%). A venous thrombosis was associated in 15 cases (75%). 10 patients (50%) were assigned to PESI class I-II, 7 (35%) to PESI class III and 3 patients (15%) to PESI class IV-V. A favouring risk factor (extended immobilization, pregnancy, post-partum, recent surgery) was noted in 10 cases (50%). The etiologic investigations brought out a defined etiology in 13 cases (65%), it was about: nephrotic syndrome, secondary Antiphospholipid syndrome, malignant neoplasm, vasculitis or a resistance to activated protein C, respectively in 5,4,4,2 and 1 case. All patients were treated with heparin then relay with antivitamin K, the minimal duration of treatment was 6 months. We deplore 2 deaths (10%), one due to the gravity of the PE, the second was a consequence of a hemorrhagic accident due to the treatment. A recurrence occurred in 5 cases (25%). Conclusion: The PE is an affection potentially severe. The prognosis depends on the precocity of the treatment and the diagnosis of the cause.
Respiratory diseases
A-2379

Pulmonary Sarcoidosis: A differential diagnosis to remember

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Introduction
Sarcoidosis is a multi-system granulomatous disease of unknown etiology, characterised by the presence of non caseous granulomas. It affects mostly the lungs but there are extrathoracic manifestations in about 30% of cases. It has an estimated prevalence of 10-20 cases per 100.000 individuals and it usually affects young adults. Half the cases are diagnosed in asymptomatic individuals after an abnormal imaging exam.

Description
Clinical case: Male, 33 years old, operator, caucasian. Former smoker (6 pack-year), with no prior history and no regular medication. On a routine chest X-ray, a hilar bilateral prominence was noted and also multiple bilateral centrimetrical mediastinal adenopathies on CT. The following diagnostic hypotheses were considered: pulmonary sarcoidosis and lymphoma. On his initial evaluation, he showed irritant dry cough of progressive instalation with over an year of evolution, no fever, excess sweating, asthenia or weight loss. From the study carried out: high serum ACE (72 IU/mL) and immunophenotyping on the peripheral blood with increased T cells with NK activity. He repeated a CT (similar to previous one) and undertook an EBUS where several nodes were biopsed, revealing non necrotizing epithelioid granulomas on the anatomopathological examination. Lymphocitic populations of the bronchoalveolar lavage with high CD4/CD8 ratio (5.9). Functional evaluation of the respiratory system with walk test were normal. No suggestive histological alterations of malignancy, infectious (such as tuberculosis) or autoimmune diseases.

Discussion: The sarcoidosis diagnosis requires: exclusion of diseases with similar presentation, sugestive imagiologic study and histologic presence of non caseous granulomas. Thus, assumed Sarcoidosis with bilateral and hilar lymph node involvement. Has been under vigilance for 5 years, with no extra-thoracic involvement or need of medical therapy.
Retrospective analysis on 12 cases of cardiorespiratory arrest in patients with massive pulmonary embolism: CASTEV Study.

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INTRODUCTION: The "CASTEV" study, acrostic deriving from "CArdiac arreST in patiEnts with massiVe pulmonary embolism", enrolled 12 patients with complicated massive pulmonary embolism in the pre-lysis period from January 2008 to December 2017. cardiorespiratory arrest.

PURPOSE OF THE WORK: The "CASTEV" study proposes the following objectives: 1) verify any relationships between the cardiorespiratory arrest and the electrocardiographic presentation rhythm; 2) verify the statistical significance found.

MATERIALS AND METHODS: A comparative analysis was performed for continuous variables with parametric Q test of Cochran to verify if there is a significant relationship between the variables considered: cardiorespiratory arrest during massive pulmonary embolism and electrocardiographic presentation rhythm. For the calculation of the Cochran Test Q the sum of the squared elevated totals is indicated with the following formula: \( X = x_{NS-A}^2 + x_{NS-P}^2 + x_{S}^2 = 144 + 0 + 0 = 144. \)

ANALYSIS OF RESULTS: The Cochran Q test applied to the 12 patients involved in the retrospective analysis, shows how the clinical situation "NS-A" (Non shockable-Asystolia) highlighted in all patients is not attributable to the case but assumes a statistical significance high because the relative value (VR) of \( \chi^2 \) obtained is 144 with Degrees of Freedom (GL) = 2 and the critical value (VC) of \( \chi^2 \) for \( p = 0.001 \) is 13.816. The differences of choice are, therefore, highly significant with \( p <0.001 \).

DISCUSSION: The data obtained in the 12 patients enrolled in the "CASTEV" study show that the rhythm of electrocardiographic presentation is in the course of cardio-respiratory arrest, a non-defibrilla bias and in particular an asystole.

CONCLUSIONS: The "CASTEV" study showed that in the group of 12 patients with massive pulmonary embolism complicated by cardio-respiratory arrest, the electrocardiographic presentation rhythm is a non-shockable rhythm and in particular an asystole.
Respiratory diseases
A-1594

Sleuth - Suspect the unsuspected: the unusual presentation of a lung abscess in an immunocompetent host

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Introduction
Lung abscess is a pulmonary pus collection resulting from an infection, with parenchyma cavities. It occurs in most cases to patients affected by immunodeficiency disorders or dysphagia. Clinical suspicion of lung abscess is higher in patients with underlying conditions and symptoms as cough, fever or night sweats.

Case Description
We present a case of a 49 years old woman, with silent anamnesis and just an unspecified viral syndrome during the previous week, complaining right hemithorax pain not responsive to painkillers and irradiated to the right shoulder and the neck. Apyretic, negative physical examination, bones X-rays and echocardiography. After hospitalisation, develop of fever and increasing inflammation indexes and isolation from a blood culture of S. pneumoniae and shift from empiric ceftriaxone to piperacillin-tazobactam. The chest CT scan showed an image consistent with an infective-abscess disease. No surgical indications after negative cultural and cytological exams. Negative tests for immune-impairments. After 21 days of antibiotic therapy (shift at the discharge to oral moxifloxacin), almost complete resolution of the process at chest CT scan.

Discussion
Although lung abscess is usually suspected in patients with predisposing conditions and typical features, the diagnostic doubt has to be placed also facing cases as this. A hemithorax pain, especially with fever, in a young and otherwise healthy woman in recent history of viral syndromes or respiratory affection, could reveal an underlying lung abscess of great dimensions also with negative first lab tests and chest X-ray.
Suspicous Pulmonary Node: an Harmless Villain

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Introduction: Round atelectasis or Blesovsky's syndrome is a rare form of alveolar collapse that mimics pulmonary neoplasms and results from the rotation of part of the parenchyma on itself. They are more common in men and may occur in association with pleural inflammation resulting from surgeries, infections or trauma. Exposure to mineral dust (asbestos) is the most common etiology.

Case report: Man, 78 years old, retired carpenter, submitted to cardiac revascularization surgery in the past, goes to the Emergency Department for fever, purulent expectoration and dyspnea in the last week. The study reveals elevated inflammatory parameters, respiratory failure and radiography with left pleural effusion of moderate volume. Diagnostic thoracentesis was performed, which was compatible with exudate, with predominance of mononuclear cells and cytology negative for malignant cells. Assumed community acquired pneumonia, having completed ten days of empirical antibiotic therapy with regression of inflammatory parameters. Due to the persistence of radiological alterations, realized Thoracic Computed Tomography that showed a 30 mm rounded mass with pleural adhesiveness, spiculated contours and distortion of the pulmonary vessels (“comet tail signal”). The radiological stability and the accomplishment of multiple biopsies, whose histology was negative for malignancy, indicated the benign behavior of the lesion. The patient remained without respiratory insufficiency, with excellent general condition and without consumptive symptoms.

Discussion: The clinical case shows a rare form of pulmonary collapse often confused with pulmonary neoplasia. A high degree of suspicion is therefore necessary for this entity, since the typical tomographic aspect allows the diagnosis of this benign condition, avoiding invasive diagnostic tests and unnecessary therapeutic procedures. The previous thoracic surgery, professional exposure to mineral dust or previous respiratory infection could be the cause.
Respiratory diseases
A-1677

Swiss cheese lung

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Introduction: The differential diagnosis of pulmonary cavitary disease (PCD) is diverse and can be influenced by host related factors such as immunosuppression. The exclusion of pulmonary tuberculosis (TB) is mandatory.

Case description: A male policeman, aged 46, with alcohol and smoking habits, ischaemic heart disease and chronic lymphocytic leukemia chemotherapy-treated, without evidence of disease for 1 year; was admitted to the emergency department with one week complaints of fever, dyspnea, left pleuritic thoracalgia, anorexia and weakness. On physical examination he was in shock with diminished left lung sounds and disperse crackles on pulmonary auscultation. Hypoxemia with respiratory alkalosis, hyponatremia, liver dysfunction, hypoproteinemia, anemia, elevated C-reactive protein and HIV-negative serology was found on blood tests. Chest x-ray showed a white left lung with visible diffuse heterogeneous infiltrates on the upper left hemithorax and computed tomography revealed extensive parenchymal consolidation and multiple confluent cavitations in the upper lobe and lingula, with the appearance of “swiss cheese”. The direct bacilloscopy of sputum was positive.

He was admitted with severe sepsis by pulmonary cavitary TB in an immunosuppressed patient and initiated treatment with rifampicin (RF), ethambutol (ET), levofloxacin and amikacin with clinical improvement. After normalization of liver function treatment was changed to RF, ET, isoniazid and pyrazinamide, with good tolerance. After discharge he completed the treatment with good evolution.

Discussion: In immunosuppressed patients, several etiologies for PCD are possible, including TB, which requires elevated suspicion index and remains an enormous diagnostic and therapeutic challenge. Lung cavitation in pulmonary TB is associated with greater infectiousness, prolonged mycobacterial negativation time and elevated risk of relapse after initial treatment with development of antibiotic resistances.
Syncope in haemodynamically stable patients with acute pulmonary embolism – Is there a benefit of systemic thrombolysis in these patients?

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Objectives
Syncope in pulmonary embolism (PE) could be the first sign of haemodynamic compromise and is accompanied by high mortality.
We aimed to investigate pathomechanisms of syncope in PE, identify mortality predictors of haemodynamically stable PE patients with syncope (PE+Syncope) and evaluate benefit of systemic thrombolysis.

Methods
Patients (aged ≥18 years) were selected by screening the nationwide sample for PE (ICD-code I26) stratified by syncope. We analysed predictors of both syncope in PE and case-fatality rate as well as benefit of systemic thrombolysis in PE+Syncope.

Results
The nationwide German sample comprised 293,640 inpatients with haemodynamically stable PE (aged ≥18 years) and among them 6,792 (2.3%) PE+Syncope patients (2011-2014). Independent predictors for syncope were age, obesity, renal insufficiency, sick-sinus-syndrome, tachycardia, malfunction of pacemaker or internal-cardiac-defibrillator, right ventricular dysfunction (RVD), vestibular disorders and carotid-sinus-syndrome.
In-hospital mortality rate was lower in PE+Syncope than in PE-Syncope (6.4% vs. 7.6%, P<0.001) with reduced risk for in-hospital death (OR 0.68 [95%CI 0.61-0.75], P<0.001) independent of age and sex. Powerful independent predictors of in-hospital death were cancer and RVD.
PE+Syncope patients were more often treated with systemic thrombolysis (3.1% vs. 2.1%, P<0.001). Systemic thrombolysis was associated with reduced in-hospital mortality in PE+Syncope (1.9% vs. 6.6%, P=0.004) independently of age, right ventricular dysfunction and tachycardia (OR 0.30 [0.11-0.82], P=0.019).

Conclusions
In-hospital mortality was 6.4% in PE patients with syncope. RVD and heart-rhythm-disturbances play key roles in syncope development, whereas RVD and cancer increased case-fatality rate of PE+Syncope. PE+Syncope patients were more often treated with systemic thrombolysis and showed a trend to an improved survival.
COPD is an old pathology with an important associated chronic morbidity. It is also the fourth cause of mortality worldwide. It is frequent that the COPD patient with high morbidity ends up admitted to the Internal Medicine service. Objectives: Our main objective is to know the prevalence, demographic characteristics and diagnosis at discharge of the COPD patients registered in our service. Secondary objectives:
- To know their morbidities.
- To know if there have been changes in the treatment of the COPD.
- Their differences with respect to non-COPD patients.

Methods: Retrospective observational and comparative study performed in Germans Trias i Pujol Hospital of Badalona. We included 618 patients discharged from our Internal Medicine service, registered from May 1st to July 31st, 2017.

We applied the criteria established by the GOLD guidelines for considered a COPD patient. We collected drugs data at admission and discharge according to the WHO, the main diagnosis according to the Classification of Diseases and Related Health Problems, ninth Revision, Diagnostic Relates Group and destination at discharge.

Results: The COPD patients were the majority men (56.13%), the mean age 77.3 years (±13.5) and with a high morbidity (Charlson index 3.6 ±2.1). Only 24.8% changed the treatment at discharge. The comparative study showed that patients with COPD were older (77.5 vs 71.5) (p<0.001) , with more morbidity (Charlson index 3.6 vs 2.9) (p=0.001) and took a greater number of drugs (total drugs in treatment 11.48 vs 7.71) (p<0.001).

On the other hand, we did not find differences in relation to the mean stage.
Among the patients labelled as complex chronic patients (CCP), more than one third are COPD, but compared with the CCP group we did not find differences between both groups.

Conclusions: COPD patients represent a significant percentage of patients admitted to the Internal Medicine service, so we must be up to date with this pathology and associated morbidities.
The Role of Diabetes Mellitus Among Patients With Acute Pulmonary Embolism

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Background. Diabetes mellitus (DM) is a reported risk factor for venous thromboembolism (VTE) (Konstantinides et al., 2014). Patients with DM show higher mortality rates after acute PE (Scherz et al., 2011). However, DM influence on PE has not been fully clarified. The aim of this study was to evaluate the role of DM on the severity and mortality after PE.

Methods. The ongoing prospective cohort study included patients presenting with symptomatic acute PE in a single clinical university hospital from 2014 till 2018. DM status, Pulmonary Embolism Severity Index (PESI) and follow-up data at 90-days and 1-year were assessed. Data analysis was performed using IBM SPSS 23.0.

Results. DM was seen in 16.3% (n=44) of patients, predominantly among females (n=32, 72.5%). Patients with DM had statistically significantly higher PESI values (mean PESI: 103.63 ± standard deviation (SD) 27.89) compared to individuals without DM (mean PESI: 91.43 ± SD 33.48), p=0.014. At 90-day follow-up, patient mortality was 13.4% (n=34). DM was seen in 13.6% (n=30) among survivors vs. in 26.5% (n=9) among non-survivors, p=0.05. At 1-year follow-up, patient mortality was 24.3% (n=44). DM was seen in 12.4% (n=17) among survivors vs. in 25.0% (n=11) among non-survivors, p=0.04. No statistically significant difference was observed between DM, PESI and inpatient stay, p>0.05.

Conclusion. The study showed significantly higher PESI values among patients with DM compared to individuals without DM. Statistically significantly higher mortality at 1-year after PE was observed. DM demonstrated a predisposition on higher mortality at 90-days after PE without reaching statistical significance.
Thrombophilia Testing in Pulmonary Embolism

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Background.
Although thrombophilia status is often used in making decisions in primary or secondary prophylaxis we do not know if there are differences in patients with positive thrombophilic tests.

Patients and methods.
From a registry of pulmonary embolism (PE) in our department of Internal Medicine, we study the thrombophylia causes. The set made included: anticardiolipin antibodies, lupic anticoagulants, Leiden Factor mutation, PT G 20120 A mutation, Protein C and S, mutation of Antithrombin III, VIII factor, plasminogen inhibitor and others. We compared the clinical characteristics (Systolic blood pressure, heart rate, shock index, PaO₂, alveolar difference O₂, NTProBNP, D-Dimer in the index episode and in evolution, Systolic Pressure of pulmonary artery and plasma levels of CRP) of patients in who thrombofilic test was observed compared with those patients without positive tests.

Results
Of 241 patients studied we detect thrombophilia in 103(43%) patients: 35(34%) ACL, 13(13%) ACA, 35(34%) Leiden, 17(16%) PT G20210A(all heterozygous), 4 PC, 6 AT-III, factor VIII 7, others 9. No significant differences as compared with patients without thrombophilia were met in age, gender, central or segmental PE provoked or unprovoked PE, clinical characteristics, the burden of thrombi, mortality, persistency of thrombi and recurrent venous thromboembolism.
We found statistically significant difference in the time of anticoagulation: permanent 58 patients (56%) vs 51 (37 %) without positive tests (P=0.002) and in the level of CRP 32mg/L (IQR67) vs 22 mg/L (IQR 48), (p=0.03).

Conclusion.
The most frequent thrombophilia in our patients was the presence of anti-phospholipid antibodies. Permanent anticoagulation was more frequent in patients with positive tests of thrombophilia showing a higher level of CRP. We did not find differences in the clinical characteristics between both groups.

Methods. 43 males with COPD underwent the examination. Mean age – 61.4±6.0 years, duration of COPD 6.0 [4.0; 10.0] years. The patients are divided into 2 groups: 10 patients with bronchitis phenotype of COPD, 33 patients with emphysematous phenotype. Patients underwent 24-hour AS monitoring. To evaluate AS aortic pulse wave velocity (aPWV), artery stiffness index (ASI), augmentation index (AI) were used.

Results. No significant differences in frequency of occurrence of pathological AS were identified between two groups: increase of median diurnal aPWV was identified in 70% of patients with bronchitis phenotype and in 78.8% of patients with emphysematous phenotype. Increase of AI in a 24-hour period was identified in 40% of bronchitis phenotype patients and 46.4% of emphysematous phenotype patients. Median diurnal and daily average AS indices are changed in both groups: aPWV (11.1±1.5, 11.5±1.9 m/s correspondingly – bronchitis phenotype, 11.0±1.4, 11.1±1.5 m/s correspondingly – emphysematous phenotype), AI (-10.8±14.7, -11.3±14.9% correspondingly – bronchitis phenotype, -12.2±17.3, -14.4±17.2% correspondingly – emphysematous phenotype), ASI (125.0 [122.0;139.0], 122.0 [115.0;144.0] mmHg correspondingly – bronchitis phenotype, 125.0 [115.0;135.0], 126.0 [114.0;132.0] mmHg correspondingly – emphysematous phenotype) are increased. During night-time emphysematous phenotype patients showed a more significant increase in aPVW (11.6±1.2 m/s), AI (-5.1±23.3%) in comparison to bronchitis phenotype patients (10.5±1.2 m/s, p<0.05, -14.4±14.8%, p<0.05 correspondingly).

Conclusion. Abnormalities in elastance of arteries are identified in patients with both COPD phenotypes. AS abnormalities during night-time period are more intense in emphysematous phenotype patients, than in bronchitis phenotype patients.
Uncommon cause of pleural effusion in patient with constitutional syndrome

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INTRODUCCIÓN: Malignant mesothelioma is a rare and insidious neoplasm with a poor prognosis.
CASE DESCRIPTION:A 76 years-old male. He smoked 15 cigarettes per day for 30 years. He worked like a painter since 1976-1986. He had personal history of arterial hypertension, diabetes mellitus type 2. He consulted for progressive dyspnea of three days of evolution with cough and left costal pain. He referred constitutional syndrome with a weight loss of 12 kg at the last two months.
Exploration: On auscultation, he had absence of vesicular murmur at the base of the left hemithorax. Rest of the exploration without relevant findings.
Supplementary tests:
  - Blood test: normal blood count. Biochemistry: glucose: normal, creatinine 0,9 mg/dl, normal ions. Chest x-ray film revealed an pleural efusión on the right side. Computed chest tomography revealed a moderate effusion on left side. Pathological adenopathies in the left mammary artery, prepericardial and ipsilateral phrenic arteries. A mass in the left anterior thoracic wall between the 4th and 5th costal. Thoracentesis showed a sero-hematicoid fluid with exudate characteristics. There was no evidence of malignancy in the cytology of the pleural fluid. A thoracoscopy was performed with pleural and diaphragmatic biopsies. The anatomy pathology was compatible with an epitheloid mesothelioma.
DISCUSSION:The vast majority of MPM occur in patients age 60 years and older, typically presenting decades after an exposure to asbestos with gradually worsening, nonspecific pulmonary symptoms. Clinical suspicion for MPM may arise in the setting of respiratory symptoms in the context of pleural thickening or an effusion on chest imaging and a history of asbestos exposure. Although these features may raise the suspicion of MPM, a biopsy is necessary to confirm the diagnosis.
The prognosis of patients with MPM is poor, with overall survival being on the order of 9 to 17 months after diagnosis. Few patients are cured.
Introduction: Some commonly used drugs are known have lung toxicity, among which nitrofurantoin, amiodarone and carbamazepine. Nitrofurantoin is an antibiotic used in the management of acute cystitis and is associated with interstitial pneumonitis in 1:1000 of exposed people. Identifying lung toxicity is sometimes difficult due to clinical similarities with respiratory tract infections.

Case description: We describe the case of a 86-years-old female who developed interstitial lung disease following chronic use of nitrofurantoin for recurrent cystitis. She presented to the emergency department with a 6 day history of dry cough, dyspnea, wheezing and thoracic back pain. Laboratory studies revealed an elevation of the inflammatory markers. Arterial blood gas analysis showed type 1 respiratory failure. The chest radiograph showed bilateral infiltrates and left costophrenic angle blunting. The patient was diagnosed with pneumonia and was prescribed amoxicillin/clavulanic acid and clarithromycin. As symptoms subsided over the next days, a computed tomographic scan of the thorax was made, showing centroacinar emphysema, a ground glass pattern and intralobular and interlobular septum thickening, suggesting interstitial pneumonitis. The patient also made a bronchofibroscopy that confirmed the diagnosis. The antimicrobial agents were suspended and she started respiratory kinesiotherapy, followed by marked symptomatic improvement. Discussion: Although uncommon, several commonly prescribed drugs can cause iatrogenic disease, like interstitial pneumonitis. This is usually difficult to recognize as it can be easily mistaken as a respiratory infection, so that a high index of suspicion is needed for diagnosis. When this happens is utterly important to discontinue the concerned drug as it is the cornerstone of the treatment.
Respiratory diseases
A-1193

Woman with right pleural effusion

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Introduction
The symptomatic pleural effusion is one of the most frequent clinical signs of our daily practice. The appearance of this requires us to rule out multiple pathologies that produce it, being fundamental the extracted pleural fluid.

Description of the case
A 54 year-old woman without known allergies. No history of previous illness or current toxic habits. She goes to the emergency department because of dyspnea to efforts. Chest X-ray revealed a right plural effusion. A guided thoracentesis is performed, resulting in the extraction of liquid with exudate characteristics according to Light criteria. Analysis and cultures of the pleural fluid are normal, crops of the same. Infectious cause is ruled out. In chest CT, minimal pleural thickening is observed. Mammography, angioTC of the thorax, abdomen CT pelvis and fibrobronchocopy were performed without alterations. Eventually It was decided to perform a pleural biopsy. After that, being the results of the taken samples inconclusive, a videothoracoscopy is advised as next step. The sample is analyzed in pathological anatomy with diagnosis of pleural adenocarcinoma. Thoracentesis was performed with a chest tube with posterior talcage, after discussing the case with pneumolgy, and treatment with oral chemotherapy was started.

Conclusion
In order to arrive at a final diagnosis of a pathology with not very specific clinical signs, the collaboration of different specialists is fundamental. Multidisciplinary management helps the differential diagnosis and improves the response to treatment and the final result.
“False lung tumors”

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Introduction:
Pleuropericardial cysts account for 5 to 10% of all mediastinal tumors. Clinical latency and a benign course are characteristic features. In most cases, computed tomography (CT) confirms the diagnosis. When the cyst is symptomatic or the diagnosis is in doubt, videothoracoscopy offers an alternative to transpleural puncture with evacuation or excision via thoracotomy.

Case description:
A 70-year-old woman, caucasian, non-smoker, with no relevant medical history. No previous history of recurrent respiratory infections and no respiratory symptoms. She was admitted in our hospital for fever (maximum of 38 ºC), exacerbated dyspnea and cough with mucus sputum, for about 3 days. Her physical examination and laboratory findings were unremarkable. Her chest X-ray showed a nodule in the right lower lung field, at the level of the cardiophrenic angle. Her chest CT scan demonstrated in the right paracardiac location inferior to the wire, lenticular configuration image of low density and regular contour measuring 32mm by 13mm, this alteration may correspond to eventual congenital cyst. She was discharged and medicated with antibiotic, resulting in clinical improvement.

At the follow-up appointment, in the reassessment of the CT of the thorax at 6 months, the lesion remained superimposed. However, in order to detect any neoplastic process, PET-CT was performed, in which the lesion was not avid for FDG. At this point, a probable right pleuropericardial cyst was assumed and was discussed with Thoracic Surgery, in order to evaluate the possibility of surgery. Clinical and imaging surveillance was delayed.

Discussion:
Although it is readily admitted that a pleuropericardial cyst in itself is of little pathological importance, the cyst is clinically significant in that it must be clearly differentiated from a large number of other pleural space-occupying masses appearing in the same region which are of particular pathological consideration.
Renal diseases

A case of primary membranous nephropathy

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Introduction: In an aging society with increasing prevalence of heart failure, one must always exclude other etiologies for edema, for example nephrotic syndrome (NS). Membranous nephropathy (MN) is one of the main causes of NS in adults, in its majority (80%) idiopathic, and in a lesser proportion secondary to autoimmune diseases, cancer, viral or bacterial infection. For appropriate management its etiology must be found, and the phospholipase A2 receptor (PLA2R) antibodies play an important role in diagnosing primary MN.

Case description: Men, 77 years old, with a history of hypertension, diabetes, hypercholesterolemia and ulcerative colitis under mesalazine. Presented in the last 2 months with progressive edema in the lower limbs, assumed by is doctor and multiples times in the emergency department to be a case of heart failure, due to age and risk factors. Admitted in the internal medicine ward with anasarca (including periorbital edema) refractory to oral diuretics, being again assumed congestive heart failure and acute kidney disease. Detected in general work up: proteinuria (16.2 g/24 hour), hipoalbuminemia (2mg/dl) and hypercholesterolemia (total cholesterol total 443 mg/dl) kidney echography with slight increase in kidney size; and echocardiogram with good function with no other alterations. He began double blockage of the renin-angiotensin-aldosterone system and optimized endovenous diuretic. Performed renal biopsy compatible with MN. The diagnose of primary MN was made by excluding secondary causes and positive PLA2R antibodies.

Discussion: The importance of this case lies on a basic principle in internal medicine, the differential diagnosis. Moreover, in the benefit of PLA2R antibodies specific in the diagnosis of primary MN and also helpful in monitoring the response to therapy.
A Rare Rapidly Progressive Glomerulonephritis Case Report

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INTRODUCTION:
Vasculitides is group of diseases that damages blood vessels by immunologic or inflammatory mechanism. Anti neutrophil cytoplasmic antibody (ANCA)-associated vasculitis a major cause of rapidly progressive glomerulonephritis (RPGN). It can be seen in all ages but peaks in 50-60 ages. We report ANCA- associated vasculitis with renal involvement in a 74 years-old male patient.

CASE PRESENTATION:
74 years-old male patient, applied for emergency service with lack of appetite, weakness, back pain since two weeks. In application tests blood urea: 272mg/dl(N:17-43), creatinin: 11 mg/dl(0.67-1.17) and there was no metabolic acidosis or hyperkalemia. Transurethral probe were inserted, despite IV fluid replacement he had anuria so the patient underwent hemodialysis. After hemodialysis he had hematuria about 100-500 ml/day about 4 days. There was 2165 mg proteinuria /24h urine sample. He had hemoptysis as thorax CT results compatible with vasculitis. Urgently the patient prepared for renal biopsy. Pathology preliminary report was compatible with crescentic glomerulonephritis. He was taken to plasmapheresis every other day. Mesna and cyclophosphamide treatment administered. Due to these treatments he had respiratory distress and massive hemoptysis. The patient was intubated and after that followed in intensive care unit (ICU). While he was in ICU his autoimmune marker results followed as, anti Ds DNA: weak positive(1+). MPO(P-ANCA):167RU/mL (N:0-19) test was positive and renal needle biopsy resulted as crescentic glomerulonephritis.

DISCUSSION:
In rapidly progressive renal failure, autoimmune causes should be keep in mind. Renal biopsy should be done as soon as possible. In this case report, the patient was applied with non-specific symptoms. Despite this disease is rare, in elderly group the incidence is relatively high and with extrarenal involvement early recognition is vital.
Introduction: Renal involvement in the primary anti-phospholipid antibody syndrome (PAPS) is exceptional and typically results in vascular nephropathy type of vaso-occlusive disease intra-renal vessels. The other kidney diseases are rarer. We report an unusual case of acute interstitial nephritis associated with PAPS.

Case description: Man, 38, with a history of recurrent venous thrombosis of the lower and upper members was admitted for exploration of organic acute renal failure with creatinine at 700 µmol/l and both kidneys of normal size on ultrasound. Biology showed an activated partial thromboplastin time (aPTT) lying (M / T = 2.5), C, S protein, and anti-thrombin III to normal levels, and positive antiphospholipid at significant levels: IgG 38 GPL and IgM 25 MPL. Nuclear antibody were negative. Renal biopsy concluded that acute interstitial nephropathy lesions (NIA) with infiltration of the renal interstitium by cells polymorphic inflammatory vasculitis without images or micro thrombosis. There was no note of suspicious drug taking or nephrolithiasis neither old nor recent urinary tract infection. Under anticoagulants and full dose corticosteroid therapy, the outcome was favorable with a control creatinine at 103 µmol/l after one month.

Conclusion: To our knowledge, the isolated interstitial acute interstitial nephritis tubulointerstitial has not been described in the primary APS. Nephropathy could be a new event enriching the spectrum of renal complications in this syndrome.
Introduction: Rapidly progressive glomerulonephritis (RPGN) is a syndrome characterized by a rapid loss of renal function (RLRF). The RPGN is often associated with C-ANCA vasculitis. The mean age is 50-60 years affecting specially males. Older age and haemodialysis (HD) dependency worsens the chances of survival. Case Report: We report the case of an 81 years old female, with known history of hypertension and chronic osteoarthrosis, admitted with acute kidney disease (AKD) with oliguria, associated with complaints of vomiting and generalized myalgias. There was a consumption of NSAID for chronic pain and a prodromal of gastroenteritis medicated with Trimetropim-sulfametoxazol (TMT-SMT). The physical examination reveals a haemodynamically stable patient with laboratorial analysis revealing a normocytic normochromic anaemia, blood creatinine of 10.7mg/dL (basal 0.8mg/dL), with urea of 202 mg/dL; elevation of muscles enzymes, suggesting rhabdomyolysis (RB). The urine sediment had dysmorphic erythrocytes. It was assumed Acute Interstitial Nephritis due to RB and TMT-SMT. Despite the fluid therapy, the patient remained oliguric and for that reason HD was initiated. The viral serologic, ANA, ENA, Anti-DNA and Ab. Anti GBM were negative. The PR3 and MPO ANCAS were positive. A kidney biopsy was performed diagnosing a Crescentic Pauciimmune Glomerulonephritis. The patient then started prednisolone with great clinical improvement, despite being HD dependent. Conclusion: The authors report this case in order to aware the importance of making a large differential diagnosis in AKD, due to the need of adequate therapy to be started in order to prevent complete RLRF and systemic involvement.
Acute kidney injury prevalence and importance for prognosis in an internal medicine ward

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OBJECTIVES
Acute renal injury (AKI) is a frequent co-diagnosis in Internal Medicine wards (IMW). Its incidence increases in the elderly and, as inpatient population age rises, its importance might grow. A prospective study was developed to describe the early complications after an AKI episode and its impact on patient’s intermediate-term survival.

METHODS
Of all 357 patients hospitalized in an IMW from 01/07 to 10/31/2017, those with no baseline creatinine value (dosing 7-365 days before admission in a routine study) were excluded. A total of 267 patients were included. AKI was defined according to AKIN criteria. Chronic kidney disease (CKD) was defined as an estimated glomerular filtration rate of less than 60 mL/min/1.73m2. The survival curves were obtained using the Kaplan-Meier method, with all-cause mortality being the primary end point.

RESULTS
The most frequent hospitalization motives were respiratory infections (25.8%, n=69), acute heart failure (21.7%, n=58) and urinary infections (13.5%, n=36). The mean age was 73±15 years and 48.3% (n=129) were men. Out of 267 patients, 27.7% (n=74) presented AKI. Of those, 51.4% (n=38) were in AKIN stage 1 and 18.9% (n=14) in stage 3. No statistically significant difference was found between age or sex and AKI. In the AKI group, 90-day mortality was 35.1% (n=26), 20.3% (n=15) had stage progression or present de novo CKD and 6.8% (n=5) developed new AKI. Only 37.8% (n=28) had renal function recovery. There was a significant difference in survival times between the groups (log rank test p <0.001). The Kaplan-Meier survival probability estimates at 90 days were about 0.628 for AKI group and 0.810 for non-AKI group.

CONCLUSION
The results support the importance of AKI, even in an heterogenous ward, not only regarding hospitalization outcome but also intermediate-term survival. Most patients don’t fully recover renal function after AKI, leading us to hypothesize if a post-hospitalization follow-up could improve the outcome.
Acute kidney injury secondary to rhabdomyolysis in case with Gitelman syndrome

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Introduction: Gitelman syndrome is a genetically transmitted tubulopathy. It is characterized with disorder in thiazide-sensitive Na-Cl cotransporter caused by mutation in SLC12A3 gene. Case description: A case diagnosed with Gitelman syndrome and referred with muscular weakness and cramping complaints due to discontinuing potassium replacement in the follow-up is discussed in this case study. The case was diagnosed with rhabdomyolysis and acute kidney injury secondary to hypokalemia upon determination of 2.14 mmol/L potassium, creatine kinase 27.610 U/L and creatinine 3.09 mg/dL in further examination. Therefore, NaCl 100 cc/h isotonic was administered to the patient in addition to oral and intravenous potassium replacement. The dose of given acetazolamide was 2x250 due to presence of severe metabolic alkalosis. Clinical and laboratory findings were fully restored to normal levels one week after the starting of treatment.

Conclusion: As a result, it should be remembered that rhabdomyolysis secondary to severe hypokalemia which induces AKI may develop in GS patients.
Acute renal failure secondary to pelvic organ prolapse.

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Introduction: Genital prolapse is a prevalent condition in postmenopausal and multiparous women. Cystocele without associated uterine prolapse, especially those of large size, may rarely predispose to the presence of hydronephrosis and may cause impaired renal function.

Case description: A 66-year-old woman was admitted to the emergency department for lumbar pain of 24 hours of evolution. His medical history included hypertension and mixed urinary incontinence.

At physical examination, diffuse abdominal pain in both superficial and deep palpation was noticed. Laboratory tests revealed an elevated serum creatinine of 2.7 mg/dL. A point of care ultrasound (POCUS) was performed observing a dilation of the bilateral excretory system, with thinning of the kidney parenchyma suggestive of bilateral hydronephrosis, the bladder could not be adequately visualized. A gynecological examination was performed in which Grade 4 cystocele was observed, easily reduced by manual reduction.

We consulted with the Urology Department that assessed the patient and indicated urinary catheterization. The patient was subsequently reviewed by Urology with good evolution of renal function and successfully underwent surgery.

Discussion: Hydronephrosis is the most serious complication of this pathology and is observed more frequently in those patients who suffer from uterine prolapse. There are few clinical cases documented in the literature in which this complication is associated. Being mostly related to uterine prolapse. According to some published studies, bilateral hydronephrosis can be observed in 3% of cases of genital prolapse.
Renal diseases
A-1262

Arterial hypertension – When the culprit is the kidney!

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Introduction: Arterial hypertension is defined as secondary when it is caused by an identifiable cause. Renovascular disease is an important and potentially correctable cause of secondary hypertension, frequently associated with renal insufficiency and difficult-to-control hypertension, despite optimized pharmacological therapy.

Case description: 75-year-old obese male, with history of diabetes mellitus, arterial hypertension diagnosed 20 years earlier and dyslipidemia. He was referenced to a nephrology consultation due to hypertension and proteinuria (0.5 grams/day). Although under an antihypertensive medication regime of telmisartan, hydrochlorothiazide, lercanidipine and indapamide, his blood pressure values remained high (stage 3 hypertension). For that reason, a study directed to secondary causes of hypertension was performed. The blood tests showed no significant alterations and the echocardiogram concentric hypertrophy of the left ventricle but with good systolic function. A renal artery Doppler ultrasound was also performed and complemented with a computed tomography angiography. This exam showed atherosclerosis of the aorta, a 65% stenosis of the right renal artery and a 56% stenosis of the left renal artery. An attempt at endovascular treatment was performed but it was unsuccessful. Antihypertensive therapy was optimized but blood pressure values remained high, which eventually led to hypertensive nephropathy and, currently, to stage 3 chronic kidney disease.

Discussion: Renal artery stenosis due to atherosclerotic disease is one of the most common causes of renovascular hypertension. The authors believe that it is of great importance to consider this pathology in the etiologic investigation of difficult-to-control hypertension.
C3 Glomerulopathy, is that you?

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Introduction: C3 glomerulopathy comprises rare types of glomerulonephritis that result from abnormal regulation of the alternative complement pathway. Presenting features include proteinuria, hematuria, hypertension and renal failure. Low serum C3 but normal C4 is common. Its most frequent histological feature is glomerular deposition of C3 in the absence of immunoglobulins. There are no randomized trials to inform therapeutic decisions. 36-50% of patients develop end-stage renal disease within 10 years of the diagnosis.

Case description: 62-year-old white female admitted to internal medicine ward due to decompensated heart failure and respiratory infection. In addition to clinical signs of hypervolaemia accompanied by dyspnea, cough and fever, she also presented difficult-to-control hypertension, anemia, active urinary sediment, proteinuria, and a history of progressive decline of renal function. The immunological and virological studies were otherwise normal except for depressed serum C3 level and detection of respiratory syncytial virus, which made post-infectious glomerulonephritis a likely diagnosis. However, 3 months after hospital discharge low C3 levels persisted and the urinary sediment was still active. A C3 glomerulopathy was, then, suspected. For a definitive diagnosis, a renal biopsy was performed. The histological result of the biopsy is not yet available.

Discussion: Differential diagnosis of a C3 glomerulopathy is broad. Decreased serum C3 and normal C4 may help distinguish C3 glomerulopathies from other types of glomerulonephritis. Post-infectious glomerulonephritis is also characterized by this pattern of complement activation and can produce a similar clinical syndrome, but limited (not persistent) in time. Immunofluorescence examination of a kidney biopsy specimen is necessary to make a definitive diagnosis.
Chronic kidney disease as a predispose mortality factor for patient with stroke history?

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Introduction: Chronic kidney disease (CKD) is common and different reports had associated this disease with ischemic brain lesions. Renal disfunction induce higher cardiovascular diseases, what can induce more severe events and premature deaths. Since the relationship between chronic renal disease and long-term mortality in stroke patients wasn’t well-defined, this study aimed to evaluate the possible relationship between these factors.

Methods: In a single-centre retrospective study, patients were admitted for an ischemic stroke between 1 January 2013-31 December 2014. In all the patients was estimated the glomerular filtration rate (GFR), and the chronic kidney disease was defined by a GFR less than 60 ml/min/1.73 m². After 3 years of discharge the vital signs of the patients were analyzed. A relationship between the presence of CKD in the admission by a stroke and a long -term mortalities rates were explored by T-square statistical test.

Results: 142 patients were included in this study. Of them, 31 had CKD, with 72. 61 ± 9.69 years old, 52% of them female, 97% with arterial hypertension, 61% with dyslipidemia, 61.3% with diabetes mellitus type II and 45% with anemia. The group without CKD (111 patients) had 69.18 ± 12.34 years old, 48% of them female, 81% with arterial hypertension, 49% with dyslipidemia, 37% with diabetes mellitus type II and 17% with anemia. Using the statistical analysis, we could observe that the presence of CKD in admission by a stroke wasn’t associated to a higher mortality rates in long-term period (p=0.158).

Conclusion: CKD group had higher percentages of cardiovascular risk factors, however no mortality rates in a long-term period were detected. Even CKD is associated with poor diagnose in multiple pathologies, the impact in mortality wasn’t significant in this study. So, we can assume that this disease don’t influence mortality rates, nevertheless, distinct stages of CKD severity can be associated with different outcomes.
Different renal outcomes in two patients with microscopic polyangiitis. Demonstration of two clinical cases.

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Introduction. Microscopic polyangiitis (MP) is an anti-neutrophil cytoplasmic antibody (ANCA)-associated vasculitis which affects small blood vessels. The most frequent clinical aspect is necrotizing glomerulonephritis. We demonstrate two clinical cases of MP which both manifested with acute renal failure but had different outcomes.

Description of clinical cases. Two patients were admitted to the Pirigov’s first city clinical hospital three weeks apart complaining on lowgrade fever and caught. Chest X-ray showed infiltration in lower parts of the lungs. Both patients were hospitalized with pneumonia. Laboratory tests revealed very high creatinine level which required immediate hemodyalisis in both cases.

The first patient had history of contact with copper vitriol. Taking into account acute renal failure and non-specific changes in lungs the antibiotic and preventive glucocorticoid (GCS) therapy was started immediately. The patient was considered to have ANCA-associated vasculitis or pesticide poisoning. The myeloperoxidase 3 was positive. The patient underwent GCS and cytostatic therapy. Now the creatinine level is slightly increased but hemodyalysis is not needed.

The second patient revealed severe dyspnea. Computer tomography showed infiltration of higher parts of the lungs. T-SPOT.tb test was negative. The myeloperoxidase 3 was positive. This patient underwent GCS and cytostatic therapy after tuberculosis excluding. The creatinine level has decreased, but the patient still needs program hemodialysis.

Discussion. This clinical cases demonstrate importance of early diagnosing of MP to start the «renal safe» therapy as soon as possible. Different renal outcomes are possible depending on time of the treatment start.
Factors associated with contrast-induced nephropathy after emergency coronary angiography in chronic kidney disease patients

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Introduction and Objective: In this study, we aimed to examine the factors associated with contrast-induced nephropathy (CIN) in chronic kidney disease (CKD) patients for whom acute coronary syndrome was suspected and emergency coronary angiography was performed.

Method: 391 CKD patients (149 females (38.1%) and 242 males (61.9%) for whom emergency coronary angiography was performed due to pre-diagnosis of acute coronary syndrome in the emergency department between the dates January 2014 and December 2017 were retrospectively included in the study. Diagnosis of CIN was made by an increase of 25% or 0.5 mg/dL in basal creatinine levels 24-48 hours after the procedure and in case where this situation could not be explained by any other cause.

Results: It was observed that 10.2% of whole population developed CIN. Of the patients that developed CIN; progression was determined in 27.5% and remission in 72.5%. Mean ejection fraction (EF), mean hemoglobin, median high density lipoprotein (HDL) and median glomerular filtration rate (GFR) were determined to be lower in the patients that developed CIN compared to those which did not, and median low density lipoprotein (LDL), median urea and median creatinine were determined to be higher. Ratio of patients with a creatinine value of 2 and more and with a GFR value of 30 and lower were determined to be higher in the patients that developed CIN compared to those which did not. Ratio of those which developed CIN was determined to be higher in stage 4-5 patients compared to the other stages. In the regression analysis hemoglobin (OR=0,63; p=0,002), urea (OR=1,02; p<0,001), GFR≤30 or creatinine≥2 (OR=6,44; p=0,001) and GFR≤30 and creatinine≥2 (OR=29,18; p<0,001) were determined to be potential risk factors that predict CIN.

Conclusion: Low hemoglobin and GFR levels, as well as high creatinine and urea levels were determined to be associated with development of CIN.
Renal diseases
A-1377

First report on the use of extended-release tacrolimus (LCPT) for treatment in primary focal segmental glomerulosclerosis.

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Background
Primary focal segmental glomerulosclerosis (FSGS) is characterized by glomerular injury to podocytes, thought to be caused by circulating permeability factor(s). Among disease-modifying or immunosuppressive agents, off-label tacrolimus is an alternative in case of unresponsiveness or toxicity to glucocorticoids. We report on the off-label first-time use of extended-release MeltDose® tacrolimus (LCPT; Envarsus®, Chiesi) in FSGS.

Case description
After written informed consent was obtained, one female and three male patients with biopsy-proven FSGS and nephrotic syndrome were treated with an ACE-inhibitor, followed by prednisone. Because of intolerance of prednisone in one, and insufficient response in three tacrolimus was started. Three patients were switched from conventional tacrolimus to LCPT after 5, 32 and 38 weeks. One patient started LCPT initially. A target blood trough level of 8-10 ng/ml for the first 3-6 months, and 4-7 ng/ml thereafter was aimed at.

Results
Two patients showed remission (reduction of proteinuria <500 mg/d, no oedema). One patient had partial response (proteinuria <50% from baseline, no oedema). One patient had no response, and tacrolimus was stopped after 4.2 months. Estimated glomerular filtration rate (eGFR; CKD-EPI formula) improved in one patient, and deteriorated in three patients by 26, 12 and 9 %, respectively (difference between diagnosis and last visit). Duration of treatment was 4.2, 7.6, 14.2 and 21.2 months thus far. Treatment with LCPT was feasible in all. Time to response in the three responders was 52, 73 and 244 days. Side effects were within the known range. Tremor under conventional tacrolimus vanished after switch to LCPT in one, and showed no improvement in two.

Conclusion
To the best of our knowledge, this is the first report on once-daily extended release MeltDose® tacrolimus use in patients with FSGS in need of intensified immunosuppression. LCPT therapy is feasible and tolerable. Further studies are needed.
Fructose Intolerance: A Rare Cause of Chronic Kidney Disease

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Introduction: Hereditary fructose intolerance (HFI) is a rare autosomal recessive disorder with an estimated carrier frequency of 1/70 people and a disease prevalence of an estimated 1/20000 people in Europe. HFI is a metabolic disorder caused by the deficiency of the enzyme aldolase B. Typically, patients experience severe hypoglycaemia after ingestion of fructose and sucrose and may suffer long-term consequences due to hepatic and renal injury.

Case description: A 64-year-old male presents to the nephrology unit with progressive chronic kidney disease and uremia. The patient has indications for kidney dialysis, however, refuses life-saving treatment, claiming that he has a sugar allergy. Because all dialysis fluids, both PD and HD, contain glucose, patient insists that dialysis will kill him.

Patient’s allergic symptoms of nausea, emesis, abdominal pain and syncope after ingestion of sugary foods began in childhood. Family history tells of grandfather having the same condition.

A metabolism genetic assay is performed, the results of which leads the team to specifically suspect fructose intolerance. Next, a molecular gene analysis is done - it confirms hereditary fructose intolerance. Having specified which sugar the patient is allergic to, dialysis could be safely initiated.

Discussion: Typically, fructose intolerance is noticed in infancy when fructose and sucrose containing foods are introduced. Patients who survive infancy develop a natural avoidance of sugary foods. However, the necessary level of exclusion is rarely obtained and, thus, leads to hepatic and renal injury later in life. Diagnosis is important not only to improve patients’ current quality of life by fructose elimination but also crucial to avoid fatal complications following inadvertent fructose or sorbitol infusion.

This case reiterates the importance of careful history taking, it also demonstrates the complexity of rare disease diagnosis and management.
**Renal diseases**

A-2114

**Hypertension secondary to ureteropelvic junction obstruction in a 21-year-old**

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Introduction: Secondary causes of hypertension are identified in a small proportion of hypertensive patients. Rarely, hypertension is the presenting symptom of ureteropelvic junction (UPJ) obstruction. Since it's mostly identified and treated in early life, case reports of UPJ obstruction in the adult are rare.

Case description: A 21-year-old man with a history of high blood pressure since he was 15, presented with a non-controlled hypertension of 180/170 mmHg and an unremarkable physical exam. The 24h ambulatory blood pressure monitoring confirmed hypertension with an extreme-dipper profile. Laboratory tests showed an elevation of plasma aldosterone and renin. Ultrasound examination of the kidneys revealed a non-vascularized right kidney with hydronephrosis and without parenchyma, raising the suspicion of UPJ syndrome. Abdominal CT exposed a severe reduction of the right kidney parenchyma with an uncorrected UPJ stenosis and compensatory hypertrophy of the left kidney. Renal dynamic study with 99mTc-DTPA showed a functionally excluded right kidney. He was proposed for a right nephrectomy that successfully treated the patient, but in the meantime, he was initially treated with bisoprolol and then with a combination of amlodipine. The anatomopathological examination revealed chronic pyelonephritis and renal atrophy compatible with junction syndrome. He is currently asymptomatic without any antihypertensive medication.

Discussion: This unusual case aims to highlight the importance of an early study of secondary causes of hypertension in young patients. In young people, asymptomatic unilateral hydronephrosis can lead to renal failure. In this case, the longstanding evolution of the UPJ obstruction caused a complete atrophy of the right kidney with hypertension that was cured by nephrectomy.
IgA nephropathy: several clinical presentations, one disease

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Introduction: IgA nephropathy (IgAN) is characterized by diffuse mesangial deposition of IgA. No clinical pattern is pathognomonic; it could range from asymptomatic haematuria to nephritic/nephrotic syndrome or rapidly progressive IgAN. Authors report the case of 2 patients with different presentations of disease.

Case description: 60 years-old Woman. History of chronic alcoholic liver disease. For a month she presented erythematous lesions and oedema of the lower limbs. By the appearance of hematuria for 3 days, she went to the hospital. Physical examination showed arterial hypertension, lower limb oedema and cutaneous purpuric lesions. Analysis show creatinine (Cr) of 3.1mg/dL and urine had erythrocytes and proteinuria. From the study carried out she presented dysmorphic erythrocytes, increased IgA; ANA 1/160. Given the suspicion of rapidly progressive IgA nephropathy, a renal biopsy was performed and pulses of methylprednisolone follow by prednisolone 1mg/kg initiated.

72 years-old male. History of hypertension, diabetes and tetraparesis (vertebral trauma). Observed for anasarca dyspnoea and uncontrolled hypertension. At admission renal function was normal. Study showed proteinuria (7.6g/24h), hypoalbuminemia and ANA reactive (1/230). Nephrotic syndrome and urinary tract infection were assumed. During the hospitalization he presented worsening of renal function (Cr 4mg/dl). A renal biopsy was carried out and preliminary result showed a membranoproliferative pattern; positive IgA and C3c; acute interstitial nephritis. In this context it was decided to start prednisolone 1mg/kg.

Discussion: This cases highlight the wide range of clinical presentations of IgAN. Also although rare, rapidly progressive IgA Nephropathy is a “renal emergency”. The risk-benefit ratio most strongly favors intensive immunosuppressive therapy, because untreated the patient will rapidly progress to chronic kidney disease.
In the brink of dialysis: the role of steroids on acute interstitial nephritis.

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INTRODUCTION: the role of steroids in the treatment acute interstitial nephritis (AIN) is controversial. Some studies reported better outcomes with steroids versus conservative treatment, but only a small number patients was enrolled in this studies given the low incidence of this entity.

CASE DESCRIPTION: a 62-year-old caucasian woman, with past medical history of hypertension and breast cancer in remission for 10 years, presented to our emergency department with insidious complaints of asthenia, anorexia, foamy urine and halitosis (uremic breath). Laboratory analysis revealed elevated serum creatinine (sCR) and urea – 6,04mg/dL and 145mg/dL, respectively – and non-nephrotic proteinuria. Previous known value of sCR was 0,7mg/dL five months earlier.

Careful anamnesis did not identify recent changes in chronic medication. Physical examination was uneventful. All tested autoimmunity markers and virus were negative. Complement levels, proteinogram, serum immunoglobulins and free light/heavy measurements were all within normal range. Renal biopsy was then performed – no crescents were found, only a diffuse interstitial, inflammatory infiltrate. A diagnosis of AIN was made, although no precipitant cause was identified.

After 8 days of conservative treatment, sCR reached 7,81mg/dL, potassium levels raised and metabolic acidosis was detected. With the patient approaching the need for dialysis, we started methylprednisolone 1mg/kg day. After 6 days, the patient started to recover function. At the time of discharge sCR was already 5,31mg/dL. At 1-month and 2-month follow-up sCR levels were 3,25mg/dL and 1,0mg/dL, respectively. The patient is feeling better and the slowly tapering down of oral steroids is occurring with any adverse events.

CONCLUSION: although controversial, the use of steroids in AIN is a safe therapy choice. The potential benefits surpass the risks and they may prove an option in patients who are not showing any improvements and a conservative approach.
Investigation of the Relationship Between Liver Function Tests and Cardiovascular Risk Factors in Stage 3-5 Predialysis Chronic Kidney Disease

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Introduction and Objective
Chronic kidney disease (CKD) is a syndrome characterized by progressive and irreversible deterioration of renal function. Cardiovascular disease remains the leading cause of morbidity and mortality in patients with CKD. Liver function tests including GGT, ALT and AST are proposed to be emerging markers of cardiovascular disease risk in population-based studies. This study aimed to evaluate the possible relationship between liver function tests and biochemical cardiovascular risk factors in predialysis CKD patients.

Material and Method
A total of 246 adult patients with stage 3-5 CKD-ND were included in the study. Demographics, liver function tests, and biochemical cardiovascular risk parameters were recorded from patients' charts retrospectively. GFR was calculated for each patient using CKD-EPI equation.

Results
Correlation analysis of ALT with biochemical cardiovascular risk factors revealed positive correlations with serum albumin, triglyceride, 25-OH-D and negative correlations with serum creatinine, CRP and PTH. AST was positively correlated with GFR, serum albumin, HDL-C, and 25-OH-D and negatively correlated with serum creatinine, CRP and PTH. GGT was positively correlated with GFR, CRP and triglyceride, and negatively correlated with HDL-C. ALT, AST, and GGT were all positively correlated with GFR. Correlation analysis of biochemical cardiovascular risk factors with GFR revealed positive correlations between serum albumin, triglyceride, 25-OH-D and GFR, and negative correlations between serum creatinine, CRP, PTH and albuminuria. HDL-C did not correlate with GFR. After adjusting for GFR, no correlations were found between liver function tests and biochemical cardiovascular risk factors.

Conclusion
Liver function tests significantly correlated with GFR in stage 3-5 CKD-ND patients. The relationships between liver function tests and biochemical cardiovascular risk factors were significantly influenced by GFR in this patient group.
Lupus nephritis with negative immunological markers: about a clinical case

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INTRODUCTION: Systemic lupus erythematosus (SLE) is an immunologically mediated multisystemic disease with a variety of manifestations. Appearance in patients >60 years is uncommon. Diagnosis is based on association of clinical manifestations and serological changes. Anti-dsDNA antibodies are specific to SLE and important for diagnosis/evaluation of disease activity. It’s recognized the association between anti-dsDNA and lupus nephritis.


DISCUSSION: Membranous Lupus Nephritis (MLN) affects 10-20% of SLE with renal manifestations. Unlike classes III and IV, frequently arises in absence of other clinical/laboratorial manifestations of SLE, making differential diagnosis with Idiopathic Membranous Nephropathy (MIN) difficult. Like MIN, presents with nephrotic syndrome and histological pattern indistinguishable from the idiopathic form. In this case (negative immunological markers), renal biopsy allowed the diagnosis. Uncertain long-term prognosis. Considerable cardiovascular and thromboembolic risks. Risk factors for disease progression aren’t established, making difficult to decide on onset/type of therapy.
Objectives: I will present data on patients with acute kidney injury (AKI), requiring acute hemodialysis in Coastal-carst region of Slovenia in the years 2011-2016.

Method: Analysis of medical data in General hospital Izola, of patients with AKI requiring acute hemodialysis in the years 2011-2016.

Results: In GH Izola, we treated 263 patients (44 per year) with acute hemodialysis. Our incidence is 390 per million inhabitants. The average patient was 71,2 years old. Mortality was 47,6%. Most of the patients had previously known chronic kidney disease (54%). Majority of patients (58,5%) were treated in Intensive care unit (Internal medicine, Surgical ICU, Cardio). The main cause was sepsis (42% patients).

Conclusion: Our incidence of patients requiring acute hemodialysis is comparable to the incidence in the developed world. The patients were old with comorbidities (CKD, diabetes, heart failure). Mortality is also comparable, as the main cause is sepsis, which has high mortality elsewhere in the world.
Peripheral Neuropathy Examination in Hemodialysis Patients

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Objectives: The goal was to detect peripheral neuropathy (PN) in chronic kidney disease (CKD) patients using the Michigan Neuropathy Screening Instrument (MNSI), which had been previously validated in diabetic patients, and to determine any clinical factors contributing to PN.

Methods: In this cross-sectional study, patients with end-stage renal disease receiving hemodialysis maintenance therapy in the Hemodialysis Unit of the Pauls Stradins Clinical University Hospital in Riga, Latvia were evaluated. The MNSI consisted of a questionnaire and physical examination, administered to patients who were able to participate in the study. Patients with diabetes mellitus were excluded. A cut off value of the physical examination MNSI_P score \( \geq 2.5 \) was used to define whether the patient had PN or not.

Results: 61 patients were included in the study. PN was observed in 57.5 % of the patients. The median total MNSI_T score, questionnaire MNSI_Q score and physical exam MNSI_P score were all significantly higher in PN patients (7.5, 4 and 4 with \( p = < .001, p = < .001 \) and \( p = .02 \) respectively) compared to non-PN patients (3, 3 and 0). The median serum urea level was significantly lower in PN patients (25.1 mmol/L, \( p = .008 \)) than non-PN patients (29 mmol/L). There were no strong correlations between the MNSI scores and age, hemodialysis duration, serum creatinine, GFR, urea and calcium levels. The odds of having PN increases 2.9 (95 % CI: 1.5 to 5.6) times with a one point rise in MNSI_T score.

Conclusion: The complication of PN in CKD patients is frequent, but can be asymptomatic. Therefore, the detection of PN by a screening instrument such as the MNSI alone will only detect a fraction of the affected patients. Hemodialysis patients with PN have a lower urea level.
Introduction: Ankylosing spondylitis (AS) is a chronic, multisystemic inflammatory disease primarily involving the spine and the sacroiliac joints. Pulmonary, cardiac and renal involvement is possible, with the last being rare but often associated with a pejorative prognosis. Renal amyloidosis (RA) is the most common nephropathy complicating AS in the adult, with a prevalence of 4-8.6%. Manifestations can be impairment of renal function, proteinuria, hematuria or urinary casts. The diagnosis of RA needs confirmation of tissue amyloid deposition by noninvasive or salivary gland biopsies or by sub-cutaneous fat aspiration. When these techniques fail to provide a proof of amyloid, a renal biopsy is required.

Case description: Male, 53 years old, heavy smoker, followed in auto-immune diseases consultation since 2011, for 1 year complaints of lombalgy. He was diagnosed with AS with low inflammatory activity, prescribed pool physical therapy and occasional non-steroid anti-inflammatory drug (NSAID) for pain relief. The following study revealed: right sided His-bundle heart block in electrocardiogram with normal echocardiogram, discrete bronchiectasias on thorax computed tomography and sustained proteinuria (PU) under 1 gram in the 24 hour urinalysis with normal kidney function. Ultrasound ecography showed normal kidneys. A salivary gland biopsy was performed and revealed amyloid A deposition and Kappa/lambda light chains. RA was diagnosed in 2013. The patient maintains clinical stability, scarce use of NSAID, low erythrocyte sediment rate, negative C reactive protein, normal kidney function and PU under 1 gram/day.

Discussion: In rare cases, patients with severe longstanding AS develop significant extra-articular manifestations such as RA. It is generally revealed by a glomerular nephropathy and has to be histologically proven. The treatment of RA is based mainly on the control of the inflammatory process, which reduces availability of amyloidal protein pre-cursor.
Quality of life assessment in Chronic Renal Failure (CRF) patients via the International Classification of Functioning, disability and health (ICF) questioners.

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Objectives:
ICF was published by World Health Organization providing standardized descriptions of health and disability. The information is categorized into two sections, the first of functioning and disability and the second of contextual factors. The first is consisted of “Body structures & functions” while the second incorporates “Activities and Participation” and “Environmental factors”. CRF consists a public health issue with increasing incidence and prevalence. We assessed the quality of life of CRF patients via ICF questioners.

Methods:
Our study included 200 CRF patients and was conducted in a private hemodialysis center in Greece from October 2017 to February 2018. ICF checklist was used under the permission of Ministry of Labour, Welfare and Social Insurance of Cyprus. Statistical analysis was performed with SPSS.

Results:
171 were undergoing hemodialysis, 15 were under peritoneal dialysis and 14 were transplanted. 135 were males and 65 were females with 51% aged 65-85 years old. In “Body Structures & Functions” component the majority had problems related with sleep, defecation, urination, hypertension, weight management and movement. In “Activities and participation” component 75% terminated their employment and 51% were not financially independent. The majority of patients undergoing dialysis had difficulty in performing housework or socializing while patients under peritoneal dialysis were avoiding transportation. In “Environmental factors” component transplanted and under peritoneal dialysis patients were in great need of their immediate family. Technological advances improved patients’ quality of life.

Conclusions:
CRF patients face daily impairments. Structured ICF questioners CRF oriented should be developed and implemented to improve patients’ quality of life.
Rapidly progressing IgA nephropathy - how to treat?

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Introduction: IgA nephropathy (IgAN) is the most common glomerulonephritis in the Western world and typically presents with a single or recurrent episodes of visible hematuria, usually following an upper respiratory infection, or with mild proteinuria. The rapidly progressing and crescentic subtype is quite uncommon. Case description: A 40-year-old Latin American male with no past medical history presented to the emergency room (ER) with 2 weeks of fatigue, lethargy, shortness of breath, mid sternal exertional chest pain worsened on inspiration, bilateral lower extremity swelling, nausea, and reporting brown emesis 4-5 times/day. He made urine and noted no color changes or dysuria. In the emergency department, examination demonstrated a significant hypertension 194/109 mmHg. Tests showed anemia 8.2/25.3, metabolic acidosis pH 7.22, HCO3 16, PCO2 40, anion gap 18, and BUN/Cr 192/15.1. U/A showed 300 mg/dL of protein and large hemoglobin but no gross hematuria. Echocardiogram and kidney ultrasound were performed. Placement of a dialysis catheter took place for emergent dialysis. Discussion: Despite IgAN is the most common glomerulonephritis in the Western world, a particular rapid progression to ESRD is uncommon (<10%). In this patient, the rapid clinical deterioration and histopathological presence of cellular/fibrous crescents, fibrinoid necrosis, and global sclerosis were suggestive of active glomerular injury in a background of cortical chronic injury. In particular, the treatment of crescentic, rapidly progressive glomerulonephritis in patients with IgAN has not been evaluated in randomized trials.
Rapidly progressive kidney injury: How to treat when you don't know the diagnosis?

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Introduction: Rapidly progressive glomerulonephritis (RPGN) is morphologically characterized by extensive crescent formation and clinically by progression to end-stage renal disease in most untreated patients within a period of weeks to months.

Description of the case: 39-year-old man with five months history of inflammatory polyarthralgias; morning stiffness; weight loss; asthenia and general malaise. One month before admission he had new onset anemia; high sedimentation rate; positive rheumatoid factor; sub nephrotic proteinuria; normal renal function and a normal abdominal ultrasound. At admission he presented with non-oliguric acute kidney injury (creatinine: 15.1 mg/dL), hematoproteinuria. The patient performed treatment with high dose methylprednisolone, cyclophosphamide and plasmapheresis and renal replacement therapy, while waiting for extensive workup. Results for antinuclear antibodies, double-stranded DNA and Cryoglobulinemia (type II) were positive but complement levels were normal. Testing for ANCAs and anti-GBM antibodies and serology of HIV; HBV; HCV were negative. Kidney biopsy showed pauci-immune crescent glomerulonephritis. In spite of the treatment, the patient did not show recovery of the renal function.

Discussion: we assumed the diagnosis of RPGN in relation to autoimmune disease (ANCA-negative vasculitis versus systemic lupus erythematosus). Pauci-immune crescent glomerulonephritis is seldom seen in nephritic lupus. Plasmapheresis was an attempt to prevent progression to end-stage kidney disease, with the assumption that the deposition of immunocomplexes is the pathophysiological mechanism responsible for kidney injury, and this is present in both diagnostic hypotheses. This case illustrates the need for an emergent treatment before a definite diagnosis.
INTRODUCTION: Positive ANCA vasculitis is an increasingly frequent finding in the elderly, as its incidence increases with age, but there is few data on its prognosis and treatment. Some factors such as the degree of renal damage at presentation and the age of the patient seem to influence its evolution.

CASE REPORT: 94 year old woman, partially dependent, with a history of hypertension, was admitted to the Emergency Department for refusal to eat and general fatigue. She had a pneumonia with respiratory insufficiency and acute renal injury (AKI) with Pcr 2.1 mg / dL, so she was hospitalized. Initially there was improvement of the renal function with fluid therapy. Later, she presented with oliguria and progressive worsening of renal function, with hypervolemia. Renal/vesical ultrasound identified bilateral cysts, with no further changes. It was decided to initiate dialysis. The study, including autoimmunity, revealed frankly positive ANA MPO (221.1 IU / mL). Thus, AKI was interpreted in the very likely context of vasculitis by ANCA MPO +. Weighted pros and cons, it was considered that there was no benefit in immunosuppressive therapy given the age and general condition of the patient. Later, she presented progressive deterioration, and the dialytic technique was suspended. The patient died later.

DISCUSSION: The recognition of ANCA positive vasculitis in elderly patients and the quickness of its diagnosis are determining factors in the evolution and prognosis of this pathology. However, in some patients, the challenge of the therapeutic decision for the risks / benefits is placed.
Renal diseases
A-1655

Renal Artery Stenosis – a laborious workup for a straightforward diagnosis

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INTRODUCTION: Arterial hypertension is a common diagnosis. Certain features, such as a sudden rise in blood pressure (BP) or severe, resistant hypertension and end-organ damage, should suggest secondary hypertension.

CASE DESCRIPTION: A seventy-five year old male, smoker, with uncontrolled hypertension and dyslipidaemia, was admitted for acute hypertensive pulmonary oedema with renal dysfunction. Initial study of the cardiac failure showed moderate left ventricular dysfunction without significant coronary disease. Additionally, the renal injury study suggested chronic disease, with morphologically normal and symmetric kidneys; Doppler imaging was inconclusive. Virus serologies, autoimmunity, thyroid function and study for monoclonal gammopathy and amyloidosis where all unremarkable. Further study of both cardiac and renal dysfunctions was hindered by the poor glomerular filtration rate. He maintained high BP, which lead to the introduction of an angiotensin converting enzyme inhibitor (ACEi) and was discharged with stable renal function. On follow-up, worsening serum creatinine prompted repetition of the renal artery Doppler ultrasound, which revealed proximal right renal artery stenosis with haemodynamic repercussion. Medical treatment was optimized and the patient did not require surgery.

DISCUSSION: Renal artery stenosis is a frequent cause of hypertension in older patients with cardiovascular risk factors; worsening renal function after ACEi introduction is an alarm signal. This case is a good example of the exhaustive workup that may be required in some cases, especially in the setting of an acute presentation and absence of kidney asymmetry. It also exemplifies the delicate balance between the need for an accurate diagnosis and the iatrogenic potential of some exams.
Renal artery thrombosis: an infrequent diagnosis

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Introduction: Renal artery thrombosis is a serious, rare and often underdiagnosed entity, given its lack of specificity in clinical presentation. Usually is associated with conditions that increase thromboembolic risk. Case description: The authors report a case of a 59-year-old man with a history of arterial hypertension, dyslipidemia and a smoker with complaints of painful left flank and acute kidney injury. Abdominal Computed tomography angiography (CTA) was performed and revealed thrombus in the proximal segment of the anterior branch of the left renal artery, with a non-perfused area of the cortical parenchyma. Urinary tract infection was ruled out. The patient start on anticoagulation with low molecular weight heparin. From the study of prothrombotic states hyperhomocysteinaemia (27.9umol / L) was highlighted. The patient presented favorable clinical and renal function evolution , currently anticoagulated with warfarin.

Discussion: The clinical presentation of renal infarction is nonspecific, often mimicked by nephrolithiasis or urinary tract infections. Data supporting its diagnosis include elevated analytical inflammatory parameters, increased LDH (serum lactate dehydrogenase), lower back or flank pain, and hematuria. The timing of anticoagulation stills unclear in literature.
Renal function and cardiovascular risk in patients with arterial hypertension and obesity: the role of leptin and adiponectin.

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Objectives: to evaluate the role of laboratory markers of obesity in the progression of chronic kidney disease (CKD) and the development of cardiovascular complications in patients with arterial hypertension (AH) and obesity.

Patients and methods. 120 patients with AH stage II-III age 45-70 years were divided into four comparable in sex, age, frequency of occurrence of smoking, duration of hypertension, the level of office systolic AD (SBP) and diastolic blood pressure (DBP) groups depending on the body mass index (BMI). We performed physical examination, evaluated the renal function, laboratory markers of obesity, analyzed the combined risk of progression of CKD and the development of cardiovascular complications.

Results. There was a significant increase in the level of proteinuria (PU) and albuminuria (AU) among the patients in groups 3 and 4 compared with group 1 (301.3 [138.1;691.0] and 305.7 [139.4;646.9] vs 101.3 [47.9;116.9] mg/g; 91.0 [65.9;273.5] and 119.2 [91.0;291.2 vs 42.2 [41.3;51.1] mg/g, respectively) as well as a statistically significant decrease in the glomerular filtration rate (GFR) in patients of groups 3 and 4 compared with patients in group 1 (63,53,73 and 61,22,71 vs 72 [ 64;98] mL/min/1.73 m2). Serum leptin concentration significantly increased from 1 to 4 group while the concentration of adiponectin significantly decreased from 1 to 4 group. A statistically significant inverse correlation between GFR and leptin concentration (r=-0.42), a direct correlation between the concentration of adiponectin and GFR (r=0.36), the inverse relationship between the concentration of adiponectin and PU (r=0.33), AU (r=0.24) were found.

The conclusion. The revealed reliable correlations between the parameters of renal function and obesity markers testify to the important pathogenetic role of leptin and adiponectin in the development and progression of CKD in patients with AH and obesity.
Renal function impairment among patients with axial spondyloarthritis on the background of long-term therapy with nonsteroidal anti-inflammatory drugs.

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Objectives. The aim of the study was to analyze renal function in patients with axial spondyloarthritis (SpA), taking nonsteroidal anti-inflammatory drugs (NSAIDs) for a long time within 24 months.

Methods. The study included 36 patients with SpAs meeting the criteria of Assessment of Spondyloarthritis international Society, 2009, and constantly taking NSAIDs. Statistical data processing was performed with Statistica 8.0.

Results. In patients with SpAs included in the study, the index of taking NSAIDs ASAS was 75 ± 25, 0%. Average glomerular filtration rate (GFR) by the formula CKD-EPI was 99,5 [96,0; 108,0] ml/min/1.73 m², albuminuria level 24,76 [17,54; 28,43] mg/g, microglobulinuria 25,79 [15,64; 39,06] mg/g. After 12 months of treatment GFR amounted to 101,0 [90,0; 125,5] ml/min/1.73 m² (p ≥ 0,05 relative to the source level), the level of α₁-microglobulin urine has made 27,87 [18,11; 48,45] mg/g (p≥0,05 relative to the source level), slightly increased the level of albuminuria 35,78 [17,11; 64,97] mg/g (p=0.04 relative to baseline). After 24 months of treatment GFR was 107, 0 [93, 0; 125, 0] ml/min/1.73 m², the level of α₁-microglobulin urine was 24,78 [19,87; 34,73] mg/g (p≥0.05), there was an increase in the level of albuminuria to 44,24 [28,46; 85,96] mg/g (p=0.035 compared with the level of albuminuria after 12 months of treatment).

Conclusion. Renal function control is necessary when planning and conducting long-term therapy of NSAIDs, while it is advisable to evaluate not only the speed of glomerular filtration, but also the level of albuminuria as a marker of early kidney damage.
Renal diseases
A-1678

Sind goodpasture

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Renal diseases
A-1469

Unexpected complication of pyelonephritis

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Proteus mirabilis is a common agent of urinary tract infections (UTI). Infective endocarditis (IE) by Proteus mirabilis is rare and a poorly reported disease, with no well-defined effective antibiotic regimen. A woman aged 76 years old with a prior history of heart failure and hypothyroidism admitted for urosepsis with a third generation cephalosporin. She had no previous history of cardiac surgery, valvular heart disease, UTI or even renal lithiasis. On admission presented increased inflammatory parameters and normal renal function, echography excluded obstruction. Blood and urine cultures collected on the day of admission isolated Proteus mirabilis, sensible to the empirical antibiotherapy. She maintained fever and elevated inflammatory parameters, so repeated renal echography that excluded obstruction or abcess. New sets of blood cultures again grew P. mirabilis with the same sensitivity profile as the previous blood isolate, while the urine culture was sterile. At day 7 the physical examination revealed a grade 3 de novo systolic murmur. Transthoracic echocardiogram revealed mitral valve vegetation on the posterior leaflet with 11mm and Transesofagic described an adherent, filiform, moving and complex mass, friable, on the third medium-basal posterior (P2-P3) leaflet of the mitral valve that revealed signs of perforation wich conditioned moderate mitral regurgitation. A 6-week course of antibiotics with penicilin and gentamicin was completed with bacteraemia resolution and analytical good response. She had mitral valvuoplasty surgery, with no intercurrence and good clinical response. Echocardiogram revealed a soft mitral insufficiency. IE of native valve to Proteus mirabilis is very rare. Our patient was admitted for pyelonephritis that evolved to endocarditis with valve perforation despite adequate antimicrobial therapy for the initial known focus of infection. The optimal antimicrobial treatment regimen for P. mirabilis endocarditis is unknown.
Renal diseases
A-2243

Unfrequent cause of acute renal failure in elderly

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Introduction
Glomerular diseases in adults can result from a variety of different pathologies, which can be inherited or acquired, presenting with different grades of severity. Common clinical manifestations are hematuria, proteinuria and rapidly progressive glomerulonephritis. The treatment is usually supportive and directed to the cause.

Case description
The authors report a case of an eighty nine years old female with past medical history of essencial hypertension, dyslipidemia and dementia which came to the emergency room with productive cough, fever and dyspnea in the last two days. At medical observation the patient was hypoxic, hypertensive, febrile, pulmonary auscultation with decreased murmur at base of lungs and wheezes. Chest x-ray was normal and blood tests showed increased inflammatory parameters and acute renal failure. The diagnosis of acute tracheobronchitis was assumed and respiratory virus panel was also requested, which was positive for respiratory syncytial virus. Respiratory symptoms improved progressively but, at the same time, we found accelerated hypertension, progressive deterioration of renal function with oliguria, macroscopic hematuria and nephritic proteinuria. The case was discussed and patient was also observed by Nephrologist and we concluded that this is a post infectious nephritic syndrome secondary to respiratory syncytial virus, with no indication for biopsy nor dialysis. There was complete resolution of renal function with optimization of medical therapy, namely anti-hipertensive medication and fluidotherapy, in 3 months.

Discussion
This case report is of particular interest due to rarity of this pathology in elderly patients as well as etiology, the syncytial respiratory virus, which typically causes nephrotic syndrome in children.
Renal diseases
A-1680

Xanthogranulomatous pyelonephritis: a case report

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INTRODUCTION: Xanthogranulomatous pyelonephritis (XGP) is an uncommon and serious subtype of chronic pyelonephritis. It is characterized by the destructive inflammatory yellow mass and can be associated with Proteus mirabilis, Escherichia coli, Klebsiella, Pseudomonas infections or even mixed organisms. The condition can also be caused by struvite calculus obstruction of the urinary tract. CASE REPORT: A 69-year-old female with a history of recurrent urinary infections, hypertension, heart failure and obesity has admitted at emergency room with clinical manifestations of congestive heart failure associated with bilateral pleural effusion. On examination, she had hemodynamic stability and had no fever. At the physical examination she was congestive with a pronounced costovertebral angle tenderness on the left side. The Initial laboratory evaluation revealed pyuria, but no hematuria or leukocytosis. The uroculture was negative, as well as hemocultures. A contrast-enhanced CT of her abdomen and pelvis revealed a soft tissue density in the pelvis and perirenal space with multiple intrarenal hypodense collections consistent with xanthogranulomatous pyelonephritis, associated with coraliform calculi. She was treated with left nephrectomy. The histology reveals XGP. She had recovery successfully after the intervention.

CONCLUSION: XGP is a rare condition affecting middle-aged women. The diagnosis is suspected in severe illness or recurrent urinary infections, when the imaging assessment describe this condition. Since the image findings may also mimic Wilms tumour, neuroblastoma, clear cell carcinoma, malacoplakia, pyonephrosis or tuberculosis, tissue biopsy to confirm the diagnosis is recommended. Most cases require total nephrectomy. Careful evaluation of patients must be performed in order to help reduce the chances if incorrect diagnosis.
2-in-1: Autoimmune hepatitis - Primary biliary cirrhosis overlap syndrome

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INTRODUCTION: The overlap syndromes of auto-immune hepatitis and primary biliary cirrhosis or primary sclerosing cholangitis are rare entities, in which the patients present with histologic and/or serologic features of both pathologies. Its classification and diagnosis is still controversial and its therapeutic options limited.

CASE DESCRIPTION: A 71 year-old woman, with a history of Parkinson’s disease and abnormal liver function tests since 2002 never fully understood, was admitted in the Emergency Room with weakness, adynamia, weight loss, peripheral edema and increased abdominal volume. The blood tests showed macrocytosis, thrombocytopenia, hyponatremia, severe hypokalemia, elevated liver enzymes and conjugated hyperbilirubinemia. Abdominal US revealed heterogeneous density of the liver, without evidence of nodular lesions, and ascites. She was admitted in the ward with chronic liver disease of unknown etiology complicated with encephalopathy. Of the blood tests performed we point out hypoalbuminemia, hyperammonemia, polyclonal hypergammaglobulinemia, hypocomplementemia, negative viral serologies for HIV and HCV, HBV immunization, and positive ANA (» 640 U/mL), antimitochondrial antibodies (» 220 U/mL) and anti-liver antibodies (AMA-M2, M2-3E, gp210 and LC-1). Upper endoscopy revealed large esophageal varices and portal hypertensive gastropathy. With these results the diagnosis of auto-immune hepatitis and primary biliary cirrhosis overlap syndrome was assumed and the patient started on ursodeoxycholic acid, with benefit. She is currently followed in an Internal Medicine consult.

DISCUSSION: The authors point out that in this case, the long evolution of the disease at the time of diagnosis, already with liver cirrhosis and its complications, reduced our therapeutic options, affecting the prognosis.
A Bleeding Ulcer In The Palate As First Presentation Of Bullous Pemphigoid

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Introduction
Bullous pemphigoid (BP) and mucous membrane pemphigoid are uncommon autoimmune subepithelial blistering disorders that affect skin and mucous and most commonly arise in older adults. The trunk and extremities are typically involved in bullous pemphigoid. European studies document an incidence of 4 to 22 cases per million inhabitants per year.

Case report
The authors present a case of an 85 years old woman, with past history of hypertension, vascular dementia and heart failure, admitted to the emergency room with a bleeding ulcer in the palate. Hemodinamically stable. Blood tests revealed hemoglobin 7 g/dL, with no other changes. 4 months after she developed pruritic skin lesions in lower extremities and trunk that didn't heal with antihistamines and topical therapies. She was again admitted to the emergency room with painful cutaneous blisters in several evolutionary phases in 30% of the body surface. She was hospitalized with suspected bullous pemphigoid and treated with systemic glucocorticoids and analgesia with great clinical response. The identification of increased circulating IgG antibodies against bullous pemphigoid antigen 180 (BP180) and bullous pemphigoid antigen 230 (BP230) supported the diagnosis.

Discussion
The onset of blistering lesions in BP is frequently preceded by a prodromal phase characterized by pruritic inflammatory plaques, that look like eczematous dermatitis or urticaria, and rarely involvement of oral mucous. The treatment of BP should be aimed at decreasing blistering formation and pruritus, promote the healing of blisters, that usually heal without scarring, and improve quality of life with minimally adverse profile. The authors present this case because of its rarity and the insidious and indolent evolution of skin lesions that, many times, may delay diagnosis.
A case of Horton's disease

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Introduction: The authors present a case of Horton disease, or giant cell arteritis, highlighting the importance that an anamnesis and physical examination care may have in establishing a successful diagnosis.

Case description: 84-year-old woman, admitted for left hemicranial headache, photophobia and nausea. Investigations without alterations of relief It was hypothesized to be a paroxysmal hemicranial headache, indicating a therapeutic trial with indomethacin. The patient presented worsening of the condition, with hyperesthesia of the scalp in both temporal regions (more to the left), lameness of the mandible, and fever. From the complementary study, positive biomarkers of inflammation were documented [C-reactive protein = 16 mg / dL and sedimentation rate = 85 mm / h] and normochromic normocytic anemia. Considering the suspicion of giant cell arteritis (GCA), we performed a Doppler echocardiogram of the temporal arteries, which documented a reduction of the left hypoechoic halo and flows, and began systemic corticosteroid therapy. The patient was asymptomatic and asymptomatic. Temporal artery biopsy performed 7 days later confirmed GCA.

Discussion: GCA is a chronic systemic vasculitis of large vessels. The most dreaded complication is visual loss. The diagnosis should be considered in patients> 50 years of age and again headache, sudden visual changes, Polymyalgia Rheumatica, claudication of chewing muscles, unexplained fever, anemia and elevation of biomarkers of inflammation. Despite the value of the Ecodoppler of the temporal arteries, biopsy of the temporal artery is essential to the diagnosis.
Erythema nodosum is the most usual form of panniculitis, an acute, nodular, inflammatory reaction of the subcutaneous adipose tissue, with variable duration. It has multiple etiologies, specifically inflammatory - autoimmune/hypersensitivity, infectious, neoplastic.

A 62-year-old woman with a history of recent upper airway infection, accompanied in Internal Medicine consultation for erythema nodosum etiology. Diagnostic exams were performed to exclude inflammatory, infectious and neoplastic etiologies, such as viral markers, bacterial and viral serologies, IGRA, autoimmunity, thoracoabdominal, pelvic, mammary, thyroid, medullary, and echocardiogram tests without relevant alterations. Assay of anti-streptolysin O positive - 896 (N <200).

She initiated systemic steroid therapy (initially 1 mg/kg/day), followed by a gradual weaning off, with clinical improvement. Awaits upper endoscopy and colonoscopy.

Erythema nodosum is a challenging clinical diagnose given the wide spectrum of different etiologies with different prognosis and orientation.

The authors present iconography.
IgA Nephropathy is an immunological kidney disease caused by deposition of antibodies (IgA) causing progressively inflammation and damage of the renal glomeruli. The diagnosis is clinical, analytical and histological. Early treatment should be implemented in order to prevent progression to renal failure.

A 20-year-old male, with a history of upper airway infection in the previous 4 weeks, went to the emergency department for food vomiting, nausea and generalized abdominal discomfort associated with hematuria within 3 weeks, intermittent and worsened on the day of admission. At admission he had anemia, acute renal damage (serum creatinine of 2.6 mg/dL and Glomerular Filtration Rate (GFR) of 33.6 mL/min/1.73m²) and erythrocyturia, performed abdominopelvic tomography and was admitted to Internal Medicine department.

During hospitalization, he performed a 24-hour urine collection with evidence of proteinuria of 2028 mg, negative serologies, viral markers and autoimmunity. Increased assay of Immunoglobulin A 481 (N 114-457) and Immunoglobulin E 349 (N <87).

He performed an echocardiogram without alterations and renal biopsy on the 5th day compatible with IgA Nephropathy. Patient was discharged on the 8th day of hospitalization with Diltiazem 60 mg, oriented to Internal Medicine consultation.

At the moment, he is medicated with lisinopril 10 mg, asymptomatic, proteinuria of 480 mg/24h and serum creatinine of 1 mg/dL (GFR 95.26 mL/min/1.73m²).

IgA nephropathy is a frequent diagnosis, which should always be considered and confirmed histologically, in order to establish diagnosis and early therapy.
INTRODUCTION: Neutrophils are mature granulocytic cells that defend the body against infection. Neutropenia is defined as an absolute neutrophil count <1500 cells/microL in adults. It is classified as mild (1000-1500 cells/microL), moderate (1000-500 cells/microL) or severe (<500 cells/microL) and the risk of infection is related to its severity and duration. Etiologically can be divided into congenital or acquired. The causes of acquired neutropenia are mostly related to three categories: infectious, pharmacological (direct or immuno-mediated toxicity) or autoimmune. It is important to determine the cause of neutropenia and the associated risk of infection so that the patient can be properly managed.

CASE DESCRIPTION: We present an 83 years old woman with history of heart failure and osteoarticular disease, medicated with vitamin B12, folic acid, iron, furosemide, ramipril and recently with mirtazapine. She recurred to the emergency room (ER) for generalized abdominal pain, vomits and diarrhea starting the previous day, without fever or other associated symptoms. Analyses showed leukopenia (1500 leukocytes, 0% neutrophils), normocytic/normochromic anemia and C-reactive protein 230 mg/L. *Clostridium difficile* toxin and stool cultures were negative. She was treated empirically with ciprofloxacin. During hospitalization developed nosocomial pneumonia and was treated with vancomycin and meropenem. After correction of infectious complications, and no other cause for neutropenia was found, she discontinued mirtazapine which resulted in a gradual recovery of neutrophil count (0> 500> 1900).

DISCUSSION: Studies suggest that, although rarely, mirtazapine may cause agranulocytosis and neutropenia and if so, should be discontinued immediately. Thus, we emphasize the importance of defining neutropenia’s etiology in order to remove causative agents as soon as possible, avoiding consequences that may arise from such toxicity.
Angioedema – a paraneoplastic sign?

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Introduction: Angioedema is present in different pathologies. The mechanism most known is an allergic response to some allergenic (drugs, food) caused by immunoglobulin E-mediated hypersensitivity and can result in an acute urticaria or a more generalized anaphylactic reaction.

Case description: Male, 58 years old, antecedents of hypertension, diabetes mellitus type 2, dislipidemia, obesity, smoker, admitted in our urgency with tongue angioedema, without an identified trigger. The thorax x ray presented with right pleural effusion. The thorax tomography showed a right pleural effusion, nodular thickening of the right pleural base, a right anterior mediastinum- hilar lesion, with a diameter of 41x31mm, confined to the anterior wall of the right upper lobar bronchus. He performed abdominal ultrasound that detected important renal neoformation on the left. The histology of lung biopsy showed a neoplastic process with carcinoma cells of probable neoplastic nature, with immunohistochemistry suggesting primary kidney neoplasia. PET suggested primitive malignant neoplasm of the left kidney, intensely avid for FDG, with regional secondary ganglion involvement, and bilateral right pleural and medullary / bone lung metastasis in D1.

Discussion: Angioedema can be a neoplastic sign and it is important to notice this sign for an early diagnosis and treatment of the subjacent pathology.
Can Immunotherapy Reverse Platinum Resistance?

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Introduction:
Platinum based chemotherapy regimens are cornerstone treatment for non small cell lung cancer. Platinum resistance is defined as disease progression during the treatment or in 6 months following the last chemotherapy regimen. When platinum resistance occur, second line agents should be tried. Herein we present a patient with platinum resistant NSCLC who had great response after a period of atezolizumab treatment.

Case Description:
A 50 year old male patient with locally advanced lung adenocarcinoma was referred to our Medical Oncology department. Surgery (Right lower lobectomy plus lymph node dissection) was performed after radiologically complete response was achieved with 4 cycles of cisplatin, gemcitabine and paclitaxel. Pathological examination was consistent with lung adenocarcinoma and metastatic lymph nodes (7/25). Postoperative IMRT was conformed. After 8 months follow up without treatment, bilateral metastatic lung nodules were detected and 6 cycles of carboplatin plus pemetrexed, 3 cycles of pemetrexed only and 3 cycles of docetaxel were given in sequence due to the progression of disease under the previous chemotherapy regimen. ALK and EGFR mutations were negative. The specimen was evaluated for PD-L 1 expression and atezolizumab was started after the detection of expression and a good response was gained. The disease stayed stable for 1,5 years under atezolizumab treatment till intraabdominal lymph node metastasis detected. Carboplatin plus gemcitabine regimen was restarted and dramatically near to complete response was obtained. He is still in our follow up under weekly gemcitabine without progression.

Discussion:
Immune checkpoint inhibitors have promising effects in many types of cancer but there are not enough data in the literature about the role of reversing platinum resistance. Restarting platinum based regimens can be considered in patients with the history of platinum resistance after immunotherapy.
Characterization of systemic sclerosis patients from a single referral center cohort - 8 year retrospective analysis

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Objectives: To characterize patients with SSc from a single referral center cohort of an internal medicine department.

Methods: Retrospective analysis of patients with SSc, followed between June 2009 and December 2017.

Results: Sixty-seven patients were identified (57 female, 10 male), with a mean age of 56 years and mean disease duration of 9 years. 16 patients had diffuse SSc, 28 limited SSc, 5 mixed connective tissue disease, 8 overlap syndrome, 5 very early SSc and 5 SSc sine scleroderma. 100% were ANA positive, 37% anti-centromere positive, 22% anti-Scl70 positive, 9% anti-RNA polymerase III positive and 7% anti-U1-RNP positive. Cutaneous involvement was limited in 58% and diffuse in 28%. Peripheral vascular involvement was frequent: 94% with Raynaud phenomenon and 30% with digital ulcers. Nail-fold capillaroscopy revealed an early pattern in 16% of the patients, an active pattern in 45% and a late pattern in 30%. 81% of patients had gastrointestinal involvement mainly characterized by oesophageal dysmotility. 40% had interstitial lung disease (ILD) on high resolution thoracic scan (85% non-specific interstitial pneumonia pattern and 15% usual interstitial pneumonia pattern). According to the Wells scoring system for evaluation of ILD in SSc, 63% had a limited disease and 37% an extensive disease. 15% had pulmonary hypertension (according to echocardiographic evaluation of pulmonary artery pressure). 2 patients had a scleroderma renal crise. The preferred immunosuppressor strategies were mycophenolate mofetil (31%) and methotrexate (31%), with biologics being utilized in 13% of patients (7 tocilizumab, 2 rituximab). The most used vasodilator therapies were calcium channel blockers (35%) and endothelin receptors antagonists (22%).

Conclusion: This population is characterized by a high prevalence of vascular involvement and an important pulmonary involvement by ILD. We highlight the significant percentage of patients under biologic therapeutics.
Chronic renal disease secondary to AL amyloidosis.

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Introduction: amyloidosis is a rare disease that frequently affects the kidneys. The most common type of amyloidosis, which is also related to a bad prognosis is called AL amyloidosis and is caused by the deposit of light chains of clonal immunoglobulin produced by plasma cells in the bone marrow. This entity has no cure. However, treatments can help control the signs and symptoms, and limit the production of the amyloid protein.

Case description: 67-year-old woman with a history of hypertension, dyslipidemia, mild mitroaortic insufficiency, hiatus hernia and iron deficiency anemia. She claims of back pain that is not controlled with oral analgesia, attributed to renal colic and concomitant urinary infection. At physical examination to highlight pain on the back palpation. Blood test: Hb 8.8 g/dl, leukocytes 11400/μL, platelets 592000/μL. Glucosa 88 mg/dl, creatinine 2.77 mg/dl, urea 56 mg/dl, sodium 144, potassium 4.1, total proteins 5.4 mg/dl, autoimmunity was negative and normal complement. Urine test with blood and proteins. 24 hour-Urine albumin 5.8 g.
Renal ultrasound shows that Both kidneys are increased in size, cortical hyperechonegicity and light bilateral ectasia of renal pelvis.
Kidney biopsy: diffuse glomerular deposits of amyloid material, apple-green birefringence with polarized light and congo red positive stained amyloid.
Lumbar spine MRI: L4 fracture with crushing of vertebral body.

Discussion: The nephrotic syndrome is caused by different disorders, it can be secondary to tumours, diabetic nephropathy, it also can occur in the context of lupus nephritis, neoplastic infiltration, drugs or even infections (such as streptococcal tonsillitis, hepatitis or mononucleosis). Furthermore, hematological disorders such as multiple myeloma (first suspected in this patient due to bone and kidney pathology) and amyloidosis, less frequent but it was the final etiology.
Chylous ascites as an unusual manifestation of cardiac amyloidosis

Introduction:
Senile systemic amyloidosis is a condition associated with aging, caused by tissue accumulation of wild-type transthyretin. The heart is typically affected and patients develop progressive chronic heart failure. Chylous ascites is a rare form of ascites (< 1%) characterized by a milky-appearing fluid containing high level of triglycerides (>200mg/dL) caused primarily by neoplasms or trauma.

Case Description:
A 76-year-old Caucasian male admitted in August/2015 with signs of heart failure was diagnosed with senile amyloidosis by echocardiography and endomyocardial biopsy (March/2016). His symptoms where initially mild but rapidly progressed to significant exertional dyspnea, fatigue at rest and generalized edema with ascites. Therapeutic paracentesis where often needed since September/2016. The initially clear ascitic fluid changed to a chylous appearance with a triglyceride level of 669mg/dL (November/2017), with no clinical or radiological evidence of neoplasm and no history of trauma. Despite all efforts of therapeutic optimization the patient died of end stage refractory heart failure (January/2018).

Discussion:
In patients with heart failure when ascites is present the fluid is usually a clear transudate. Chylous ascites is rarely seen. It may, however, be formed by two likely mechanisms: an increase in the abdominal lymph production and an ineffective lymphatic drainage, both secondary to high venous pressure. Senile systemic amyloidosis is a slowly progressive disease of the elderly whose incidence is increasing. There’s no specific licensed treatment for this condition which is treated as other forms of heart failure, disease progression is the rule with high short-term morbidity and mortality.
Comprehensive diagnostic approach in autoimmune virus-negative myocarditis: retrospective review of a large monocentric cohort.

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Autoimmune virus-negative myocarditis (AVNM) is an overlooked disease with heterogeneous clinical presentation, from chest pain to cardiogenic shock. Although endomyocardial biopsy (EMB) is the diagnostic gold standard, cardiac magnetic resonance (CMR) has been investigated as non-invasive surrogate and Lake Louise criteria (LLC) for CMR myocarditis have been developed.

Objective. To describe clinical and immunohistochemistry features of AVNM from an Italian monocentric cohort and to investigate the role of CMR for diagnosis.

Methods. 42 patients (45.57±14.9yrs, M:F=1:1) were diagnosed with EMB-proven AVNM from January 2015 to December 2017. CMR was performed to evaluate T2-weighted sequences, short inversion time inversion recovery (STIR) sequences and delayed gadolinium enhancement (LGE).

Results. Holter-ECG tape abnormalities (VEBs, non-sustained ventricular tachycardia) were detected in 47.6%. Serum levels of troponin T and NT-proBNP were increased in 40.5% and 30.9%. At least 1 LLC was present at CMR in 92.5% of patients. LGE resulted in 90% (mainly subepicardial 57.5%, intramural 55%), followed by T2-oedema in 52.5%. STIR abnormalities appeared mainly in lateral (19%), septal and inferior wall (21.4%) of left ventricle, with ejection fraction reduction in 52.5%. 54.8% of EMBs were classified as active myocarditis and 42.3% as chronic; 6.7% had both evidences. 64.3% detected CD3+>7/mm2, 47.6% necrosis, 66.7% oedema, 73.8% fibrosis. Anti-heart antibodies (AHA) and anti-intercalated disks were positive in 50% and 28.6%. CRM oedema significantly correlated with active myocarditis at EMB (11vs4, p=0.027), AHA with pericarditis at CMR (3vs1, p=0.050) and patchy/intramural LGE with rhythm abnormalities at Holter-ECG tape (12vs6, p=0.037).

Conclusion. The investigation of AVMN needs a comprehensive approach, considering significant correlations between CMR, serum-histological features and Holter-ECG tape.
Autoimmune diseases present with varied and broad-ranging cutaneous manifestations.

Female, 46 years old with a history of Cutaneous Lupus Erythematosus/Dermatomyositis, accompanied by Dermatologist in 2012, performed skin biopsy with dermatomyositis compatible result, without follow-up since then. She was referred to the Emergency Department for lesions with a necrotic center in the arms and, currently anterior cervical region around 3 cm, worsened in the last 2 months and associated with erythematous rash dispersed throughout the body and photosensitivity. She performed ultrasonography with the exclusion of abceded collections. She was transferred to Internal Medicine from the hospital of the area of residence, scheduled skin biopsy for the following week that the patient missed and was oriented to Internal Medicine-Autoimmune and Dermatology consultations.

There is a differential diagnosis for each clinical presentation and confirmatory skin biopsy is helpful to ensure appropriate diagnosis and treatment.

The authors present iconography.
CVID Patient With PAH and Successful Treatment With Bosentan

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Introduction:
Common variable immunodeficiency syndrome (CVID) is a severe primary immunodeficiency syndrome characterized with recurrent bacterial infections and organ dysfunctions. Bronchiectasis is a common outcome in CVID patients and group 3 pulmonary hypertension is frequent in these patients. Association of CVID with PAH is a rare condition.

Case Description:
A 22 years old female patient with the history of autoimmune hemolytic anemia (AHA) and CVID presented with exertional dyspnea 8 years ago. Her medical history revealed that she had been diagnosed AHA while she was 1 year old and splenectomy was performed when she was 6 years old. 4 years later, bronchiectasis due to frequent pneumonia episodes was detected, pulmonary lobectomy was done and she was evaluated for immune deficiency. Immunglobuline levels were low and she was diagnosed as CVID. Her complete blood count was normal except mild anemia (Hb:11.4 g/dL) and respiratory function tests were normal. Echocardiography revealed elevated systolic pulmonary artery pressure (sPAP). Rheumatologic evaluation was unremarkable, V/Q scan was normal and she was non reactive for HIV. Right heart catheterization was performed and mean PAP was 40 mmHg with normal wedge pressure (12 mmHg) and increased pulmonary vacular resistance (5.4 WU). Vasoreactivity was negative and bosentan was started. Her functional class improved and respiratory complaints relieved by the time. She is still in our follow up with normal sPAP (30 mmHg) levels assessed by echocardiography.

Discussion:
CVID and PAH combination is a rare clinical condition can have fatal outcomes either this condition is overlooked. There is a case in the literature that successfully treated with iloprost and our case shows that bosentan also can be effective in these patients.
DRESS syndrome to allopurinol, a classic not always straight

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Introduction: Drug reaction with eosinophilia and systemic symptom (DRESS) is a severe adverse drug-induced reaction with a prolonged latency period which is characterized by a variety of clinical manifestations, usually fever, rash, lymphadenopathy, eosinophilia, and a wide range of mild-to-severe systemic presentations. The most frequently implicated drugs are antiepileptics (carbamazepine and phenytoin) as well as allopurinol.

Case description: The authors present the case of a 79-year-old woman, with multiple cardiovascular risk factors (arterial hypertension, dyslipidemia, non-insulinotrated diabetes and hyperuricemia), that was present to our emergency department with facial edema in association with fever (peaks of 38.8 °C), dizziness, asthenia and anorexia with 3 days of evolution. Physical examination was remarkable for fever (38, 5°C) but with no other changes in the examination. Analytically, the PCR was 129 mg/dL; AST 65 mg/dL; ALT 88 mg/dL; FA 513 mg/dL; GGT 792 mg/dL; LDH 304 mg/dL.

Performing a more detailed clinical history, it was found that she had started treatment with allopurinol for her hyperuricemia about 2 months earlier. The hypothesis of being a Syndrome of DRESS was raised, reason why she initiated systemic steroids with total resolution of the symptoms within days.

Discussion: DRESS syndrome is usually underdiagnosed and has a good response to systemic steroids. A good clinical history remains the gold standard of the diagnosis.
INTRODUCTION: IgA Multiple Myeloma (MM) is a highly amyloidogenic rare disorder that comprises 20% of all cases of MM. It is characterized by an immunoglobulin producing plasmocytic dyscrasia that causes osteolytic lesions. Diagnostic suspicion arises from clinical presentation and diagnostic work-up abnormalities.

CASE DESCRIPTION: A 82-year old female with past medical history of hypertension and osteoporosis was sent to an Internal Medicine appointment for one-year evolution of unexplained anorexia, asthenia and nocturnal predominant hypersudoresis of progressive installation. At examination she presented with mucocutaneous pallor, asthenic, emaciated and with bilateral lower limb oedema. Blood tests revealed normocytic normocromic anemia of 7.2 g/dL and hypereosinophilia associated with abnormal morphology on blood smear. Subsequent study revealed serum calcium of 12.8 mg/dL, beta-2 microglobulin of 6.78 mg/L, total serum protein of 10.2 g/dL and total IgA of 55.40 g/dL. Renal function and viral serology were normal. Serum immunoelectrophoresis revealed IgA/Lambda monoclonal gammopathy and myelography revealed erythroid and megakaryocytic marked hypoplasia, with plasmocytic series representing 62% of total cellularity, both compatible with IgA MM. During hospitalization, antalgic therapeutic was carried out and she started zoledronic acid and 4-day dexamethasone cycle, presenting symptomatic control at discharge. She was posteriorly referred to Hematology-oncology appointment for treatment and follow-up.

DISCUSSION: Due to its rarity, the authors intend to highlight the necessity to have a high clinical suspicion, since disease prognosis rely on early diagnosis and disease burden.
IgA vasculitis treatment with rituximab

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BACKGROUND
To assess the effectiveness of rituximab treatment in patients with IgA vasculitis and to analyze the epidemiological, clinical, diagnostic, therapeutic and prognostic characteristics of these patients.

METHODS
We searched for cases in PubMed, Web of Science, Embase and Scopus, selecting articles on IgA vasculitis and their treatment with Rituximab until April 2018. Different clinical variables were analyzed by SPSS.

RESULTS
Thirty-five patients were analyzed: 18 women and 17 men with an average age of 27.9 years and 54.28% more than 18 years at diagnosis. 25 had suffered previous outbreaks before the onset of rituximab, with the presence of recurrent or refractory disease in 85.7%. In the outbreak, 91.4% had skin involvement, 40% joint, 60% digestive and 77% renal. 3 patients suffered mild adverse effects. After treatment, 33 presented clinical improvement and 27 obtained complete remission of the outbreak. There were no recurrences in 82%.

CONCLUSION
1. Our series of 35 patients was predominantly female with an average age of 28 years
2. 54% were more than 18 years old at diagnosis.
3. Most had presented a previous outbreak
4. The predominant symptom of the outbreak was skin involvement.
5. In more than 85%, RTX was started due to recurrent or refractory disease.
6. Adverse effects were scarce and mild.
7. The majority had clinical improvement, complete remission and absence of recurrences.
INTRODUCTION: IgG4-related diseases are a constellation of entities that share a lymphoplasmacytic infiltrate of the organs, enriched in IgG4-positive plasma cells leading to swelling of involved organs in a tumour-like fashion, with a variable degree of fibrosis associated with a typical “storiform” pattern. Most of the times elevated concentration of serum IgG4 is also observed. Many organs can be affected, and it is not rare to have a multiorganic involvement. Manifestations of the disease relate commonly to the involved organ (jaundice for obstructive pancreatic mass or acute kidney injury for retroperitoneal fibrosis with ureter stenosis, for example), so diagnosis is often made after exhaustive investigation.

CASE DESCRIPTION: We describe our experience with three cases that represent the typical findings of IgG4-related disease: a man with auto-immune pancreatitis related to IgG4 associated with pulmonary fibrosis and sclerosing sialadenitis, a man with Ormond’s disease (idiopathic retroperitoneal fibrosis), and a man with pulmonary inflammatory pseudotumours. We also describe a forth case that embodies a rare presentation of this entity: non-resectable intramyocardial IgG4 tumour causing severe heart failure and atrioventricular blockade with the need of pacemaker implementation.

DISCUSSION: Even though ethiopathogeny is not fully understood, it is believed that it may have an autoimmune/allergic background, and treatment with glucocorticoids is usually effective within weeks/months. All four were treated with corticotherapy and other immunossuppressants (rituximab for refractory disease) with reasonable response, and maintain regular follow-up in our ambulatory setting.
Immunoglobulin A vasculitis - a challenging case report

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Introduction: Immunoglobulin A (IgA) vasculitis, formerly called Henoch-Schönlein purpura, is an immune complex vasculitis affecting small vessels with dominant IgA deposits. It’s rare in adults and characterized by the clinical tetrad of non-thrombocytopenic palpable purpura, abdominal pain, arthritis and renal involvement. Case description: We report a case of a 53-year-old male presented with fever and sore throat for 5 days. He was given oral penicillin by his primary care doctor. After a day, he developed an erythematous, non pruritic rash which progressed proximally from both feet to thighs, with arthralgia and swelling of wrist and ankle joints. Examination demonstrated a palpable purpuric eruption over the lower extremities. Tests showed normal renal function. An autoimmune screen was performed: ANA, ENAs, Anti-DNA, ANCs and antiphospholipid antibodies, which were all negative. The patient’s proteinogram showed no alteration and serology for CMV, EB, HCV, HBV and HIV was negative. Chest x-ray was normal. Punch biopsy of involved skin demonstrated leukocytoclastic vasculitis, accompanied by deposition of IgA on vascular walls on direct immunofluorescent staining. He started corticosteroids with improvement. Two months later urinalysis revealed microscopic hematuria and proteinuria. The spot urine protein-creatinine ratio was 3.7. Renal biopsy revealed focal segmental endocapillary proliferation with positive immunofluorescent staining for mesangial IgA. Immunosuppressive treatment was adjusted, with progressive normalisation of renal function. Discussion: Kidney involvement, present in half of patients affected by this disease, only becomes severe in 10% of cases. It is not coincident with skin involvement and may appear later, presenting as isolated haematuria or proteinuria, nephrotic and nephritic syndrome, and even renal failure. Prompt diagnosis and multidisciplinary intervention can lead to appropriate management and mitigate potential complications.
Insulin Allergy: Case Report

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Introduction: Insulin allergy in diabetic patients is a rare condition, approximately 2% and less than one-third of these events have been considered related to the insulin itself. The clinical presentation can range from local symptoms to more severe generalized symptoms. It should be suspected if immediate signs, such as rash, urticaria, angioedema and itching, among others, appears after insulin injection. The confirmation of the diagnosis can, sometimes, be difficult.

Case Description: An 67-years-old man with type 2 diabetes mellitus, treated with insulin detemir once a day and oral antidiabetics. He noticed the appearance of confluent, no pruriginous rash on the thorax and lower limbs after six hours of insulin injection. The symptoms exacerbated with new administration. No other systemic manifestations and no other triggers were verified. Excluded autoimmune diseases with laboratory evaluation and negative viral serologies. Total IgE was high (2434.0UI/mL). Therefore, the insulin detemir was suspended and started H1 antihistamine, which led to a visible regression of the lesions. He began therapy with insulin glargine and after a few days he suspended H1 antihistamine with no recurrence of rash.

Discussion: When insulin allergy is suspected, the medical history has a very important role and it is useful to distinguished the different types of allergic reaction. On this particular case, it was important to exclude other entities for the rash, therefore, the allergic reaction mediated by IgE was assumed. Skin prick testing and assessment of specific IgE should be performed to confirm the diagnosis.
Löfgren's Syndrome

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INTRODUCTION: Löfgren syndrome (LS) is a variant form of acute sarcoidosis, characterized by erythema nodosum, arthralgias/arthritis and bilateral hilar lymphadenopathy. It is present in less than 5-10% of patients and it is usually self-limited in 90% of cases, representing a clinical challenge. CASE DESCRIPTION: A 57-year-old woman, with no prior medical conditions, presented with erythema nodosum, medium/large arthralgias, asthenia and disproportionate fatigue. Biopsy of skin nodules showed non-caseous epithelioid granulomas. Her blood test were remarkable for an elevated erythrocyte sedimentation rate (59 mm/h) and angiotensin converting enzyme (78 U/L). Autoimmune and infectious diseases were excluded. Despite the absence of respiratory symptoms, thorax CT scan revealed multiple mediastinal and hilar adenopathies, as well as bilateral nodules in the pulmonary parenchyma. Bronchoalveolar lavage identified a lymphocytic alveolitis (51% of lymphocytes: 82% CD4 T lymphocytes, 10% CD8 T lymphocytes with a CD4/CD8 ratio > 2.5). LS was assumed, and the patient was treated with a taper regimen of prednisolone (PDN).

DISCUSSION: Dermatological manifestations of sarcoidosis are observed in 25% of cases. They are usually associated with systemic involvement, but in some patients it may be the only form of sarcoidosis. LS should be considered in the differential diagnosis of a patient with erythema nodosum and joint symptoms.
Mixed Connective Tissue Disease and DRESS Syndrome: Autoimmunity flare or hypersensitivity reaction?

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Introduction: Dress Syndrome results from a late hypersensitivity reaction to drugs with the potential to cause multiorganic dysfunction. Despite being rare, it is important to recognize this syndrome as the mortality rate is up to 10%. Case description: A 23 year old woman, with previous background of mixed connective tissue disease (MCTD), chronic medicated with Leflunomide (LFM), Indometacin and from some weeks earlier with associated sulfasalazine (SSZ). She presented to the general practitioner with fever, headache, myalgias and dry cough. Suspecting of infection, the doctor discontinued LFM and SSZ and initiated antibiotic therapy with levofloxacin, then replaced by cefuroxime after an rash. On the 11th day after the beginning of symptoms, she was admitted to the ER with persistent fever and a diffuse maculopapular rash with a superior limbs and dorso predominance, painful cervical adenopaties, normocytic normocromic anemia, eosinophilia, hepatic cytoolestasis and elevated CRP with normal levels of procalcitonin. She was admitted to inpatient treatment with ceftriaxone and doxycyclin for fever of unknown origin. Mycrobiologic studies and infectious serologies were negative, lymphoproliferative diseases were excluded and the autoimmunity panel was ANA positive, therefore antibiotic therapy was interrupted and corticoterapy iniciated. Although the patient responded with defervescence, she suffered from rash worsening and developed acute kidney injury. She was submitted to kidney and skin biopsies which revealed acute interstitial nephritis and toxydermia, respectively. It was then established the diagnosis of DRESS syndrome (RegiSCAR score>5), probably secondary to SSZ. The corticoid dosage was adjusted and a global improvement was witnessed. Discussion: This case-report demonstrates the challenge that diagnosis of DRESS may be, particularly in a patient with MCTD, as the clinical picture raises suspicion of an autoimmune flare.
Mortality in autoimmune diseases: cohort study of an immune-mediated disease unit.

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Background: Autoimmune diseases are associated with an increased mortality rate due to an increased cardiovascular, neoplastic and infectious risk. Since the year 2000 there have been major advances in the treatment of immune diseases but data regarding mortality after these changes in treatment is sparse in the literature. We aimed to study the mortality in a cohort of patients followed at an immune-mediated disease unit.

Methods: Retrospective cohort study that included all patients with an autoimmune diagnosis followed up at an immune-mediated disease unit of an Internal Medicine Department from 2010 to 2017. Demographical, clinical and mortality-related data were collected.

Results: From the 624 patients followed up at UDIMS 54 had died (mortality rate of 9%). The mortality group had a median age of 74 years (vs. 53, p<0.001), female predominance (62%) and 52% of these patients had reported limitations in their daily activities (vs. 11% in survival group, p<0.001). Eighteen had rheumatoid arthritis (34%), 8 had connective tissue diseases (15%) and 8 had systemic sclerosis. Sixty-eight per cent were on corticosteroid therapy, 26% on methotrexate and 20% on biologics. The most frequent co-morbidities were hypertension (66%), hyperlipidaemia (34%) and diabetes mellitus (32%). The causes of death were infection (39%), cardiovascular events (23%) and neoplastic diseases (11%).

Conclusion: Age and limitation in daily activities were associated with death. Rheumatoid arthritis was the most prevalent disease in the mortality group. Most of the patients died from infectious diseases. This characterization is fundamental to reflect on strategies to reduce the mortality rate in patients with autoimmune diseases.
Nephrotic syndrome and leukocytoclastic vasculitis after bone marrow transplantation in non-hodgkin lymphoma.

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Introduction: leukocytoclastic vasculitis (LV) is a term that describes the histological findings of a small vessel vasculitis with a predominant neutrophil infiltrate. When they become inflamed they originate the cutaneous clinical manifestation of the vasculitis, furthermore it can integrate a broad spectrum of diseases characterized by the predominance of cutaneous involvement that associates or not different degree of systemic affectation.

Case report: A 64-year-old male with a history of anaplastic large cell lymphoma treated with chemotherapy and radiotherapy in 2015, chemotherapy in 2017 and autologous bone marrow transplant 6 months ago. He comes due to the appearance of blisters that become ulcerative skin lesions in the lower extremities. At physical examination to highlight rounded ulcers of 1 cm of diameter in different stage of evolution. Blood test: Hb 11 g/dL, 9000/mcL leukocytes, 100000/mm3 platelets, Glucose 90 mg/dl, creatinine 2 mg/dl, urea 49 mg/dl, sodium 140, potassium 4.5, total proteins 6.1 mg/dl, autommunity and cryoglobilins was negative. 24 hour-Urine albumin 8.2 g. Skin biopsy: leukocytoclastic vasculitis.

Discussion: in a patient with lymphoma and immunosuppressed skin lesions we must consider either an infectious origin (e.g. bacteria as Staphylococcus, virus or fungus), or as a side effect by treatments administered. Furthermore in this case we have to take into account a possible complication due to the transplant. Less likely choice are autoimmune diseases such as immune complex formation (cryoglobulinemic vasculitis or Schönlein-Henoch purple), nitaterophil cytoplasmic antibody (ANCA)-associated vasculitis, erythematous systemic lupus, Sjögren síndrome, rheumatoid arthritis. All these entities are a secondary cause of LV, it can by primary as systemic vasculitis or at last idiopathic with unknown origin.

With the use of esteroids (firstly intravenous then by oral way) skin ulcers and renal function got improved.
An 87 year old woman with past medical history of right ureterohydronephrosis with stent placement is sent to the Internal Medicine outpatient department due to weight loss and fatigue, that started months before. A CT scan is done that showed densification of the retroperitoneal tissues that involve the abdominal aorta to the iliac bifurcation. This mass compressed the right ureter leading to ureterohydronephrosis. After a detailed history, the patient reveals she had been previously diagnosed with idiopathic retroperitoneal fibrosis (Ormond's) and that she had abandoned therapy. She is started on corticosteroids with improvement of her condition.

Ormond's disease is a rare illness characterized by the presence of fibrous/inflammatory tissue in the retroperitoneum, that frequently involves the ureters and other abdominal organs. It is idiopathic in 70% of cases. Corticosteroids are 1st line of therapy.

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Eosinophilia constitutes an unusual paraneoplastic sign when related to solid tumors. The authors report on a case of hypereosinophilia in a patient with cervical cancer. A forty-year-old female patient was admitted with fever, dysuria and low back pain, that was maintained for a week. She also mentioned leukorrhea since a few months before. The gynecological examination revealed an irregular, hard, friable mass with necrosis, that was replacing the cervix and invading both the anterior and posterior walls of the vagina. The laboratory tests showed a hemoglobin of 11.2 g/dL, MCV of 87.8 fL, MCHC of 35.5 g/dL, 14570 leukocytes/μL, 9880 neutrophils/μL, 2840 eosinophils/μL and 419000 platelets/μL. The myelogram revealed a normocellular bone marrow, with a normal erythroid:myeloid ratio and a moderate increase of eosinophils (9% of total cellularity). Pelvic ultrasound and magnetic resonance identified a solid and heterogeneous formation in the cervix, with 6.5 x 6 x 6 centimeters, that was biopsied and confirmed the diagnosis of invasive squamous cell carcinoma of the cervix, poorly differentiated, without keratin and positive for p16. After the first administration of cisplatin, the eosinophil counting drastically decreased to 110 cells/μL, clearly suggesting a paraneoplastic nature for the original hypereosinophilia. Paraneoplastic eosinophilia occurs in 10% of lymphomas and 3% of pulmonary neoplasms, but only rarely been reported occasionally in gastro-intestinal, breast, kidney and cervix neoplasms. The production of interleukins 5, 3 and GM-CSF by the tumor is thought to be responsible for this paraneoplastic syndrome.
Patient with polyneuropathy, organomegaly, endocrinopathy, monoclonal gammapathy and skin changes with a peculiar debut

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INTRODUCTION: POEMS syndrome is a rare multisystemic disease that occurs in the setting of a plasm cell dyscrasia.
Some authors have proposed that the presence of 2 major criteria, including a monoclonal plasma-proliferative disorder and polyneuropathy, in addition to the existence of 1 minor criterion, is sufficient for diagnosis.

CASE DESCRIPTION: 60 year old female with a history of 6 years of disabling peripheral neuropathy treated with corticosteroids without improvement. She was admitted into our Hospital with bilateral numbness in the distal lower limbs, followed by a progressive loss of strength. Physical examination revealed hypertrichosis and mild edema of the lower limbs, hepatosplenomegaly and lymphadenopathy with sclerosis on fingers and hands. Neurological examination revealed moderate muscle weakness and mild sensory disturbance of both lower limbs, the Achilles tendon reflex was absent bilaterally. Laboratory testing showed moderate renal failure, PCR 2.2, VDG 30 and elevated levels of ACTH and cortisol. Monoclonal IgG lambda-type protein was detected by immunoelectrophoresis. The results of autoimmune and peripheral neuropathy autoantibodies were negative. Plasma VEGF levels were markedly elevated 609 pg/ml.

Transthoracic echocardiography revealed normal left ventricular volumes and ejection fraction, mild pericardial effusion, severe tricuspid regurgitation, and pulmonary hypertension. Body TC-Scan showed expansive lesion at the posteromedial border of the left iliac crest with periosteal reaction. Electromiography confirmed chronic inflammatory demyelinating polyneuropathy.

CONCLUSION: The findings are consistent with previous reports of bone lesions in patients with POEMS syndrome confirmed by the biopsy of the lesion with an infiltration of plasma cells.
Introduction
In certain people the presence of certain cofactors is necessary for an allergic reaction to food to occur. These cofactors can be physical exercise, drugs, stress or alcohol. For there to be an allergic reaction it is necessary that the patient is allergic to a food and that he ingests it together with the presence of the cofactor.

The detection of IgE against omega-5-gliadin in vitro is used as a diagnostic method in the wheat-dependent exercise-induced anaphylaxis.

Case description
A 50-year-old man goes to the Allergology Department from the Emergency Department. The patient presented repeated episodes of itching after exercising and eating pasta a couple of hours before two years ago. The process ended spontaneously in a few minutes after the shower. A year later, he began to present joint pain, pruritus and hypotension with some other episode of loss of consciousness and loss of toilet training after physical exercise.

The skin prick test with food was clearly positive against wheat. A total and specific IgE study was requested from the Immunology Department. The high values of total IgE: 230 IU / ml, and IgE positive specific to omega-5-gliadin (F416, rTri a19): 3.4 IU / ml stand out.

Discussion
Wheat-dependent exercise-induced anaphylaxis is a specific form of wheat allergy typically induced by exercise after ingestion of wheat products. Wheat omega-5-gliadin is a major allergen associated with this allergy.

From the diagnosis the patient avoids to exercise 4 hours after the ingestion of foods but in spite of it notes dyspepsia after the ingestion of products with gluten.
Introduction: Pyoderma gangrenosum is a neutrophilic dermatose with an average incidence between 40 and 60 years old (1). 50% of cases associated with systemic disease, usually inflammatory bowel disease or rheumatoid arthritis (RA) (2). The ulcerative subtype is characterized by papules, or pustules, predominantly in the lower limbs and trunk, that evolve into painful ulcers with violaceous and undermined borders, necrotic and purulent exudate with variable depth. Major and minor diagnosis criteria are defined (3).

Case description: 64 years old Portuguese male, Caucasian, living in Mozambique, with RA since 2015, with irregular medical follow-up in South Africa. Medicated with methotrexate, plasmoquine and piroxicam. He came to the hospital with a 3 month scenario, of pustules in the lower limbs and trunk, that evolved into painful ulcers of various sizes, up to 10cm, with necrosis and purulent exudate, and with no improvement after oral corticosteroid and amoxiclavulanate. He was hospitalized and performed flucloxacilin for 10 days for Staphylococcus aureus methicillin-sensitive isolated in the lesional exudate, intensified immunosuppression, and daily dressings. 2 skin biopsies were performed, the first one showed “folliculitis with pustule in elimination”, suggesting pyoderma gangrenosum; the second one showed “focal lymphoplasmatic infiltrate and granulation tissue” and “negative immunocomplex research”. He had clinical improvement, was discharged with indication to maintain immunosuppressive therapy, and medical reevaluation.

Discussion: We highlight the relevance of this case due to its rarity. It is intended to emphasize the importance of regular medical follow-up and the intensification of immunosuppression in pyoderma gangrenosum cases associated with autoimmune disease.
Background: Pyoderma gangrenosum (PG) is a neutrophilic dermatosis, presented as an inflammatory ulcerative disorder associated with systemic comorbidities.

Objectives: To describe the association of PG with systemic diseases and cardiovascular risk factors.

Methods: An observational study was performed in a tertiary hospital; 38 PG were collected from January 2000 to February 2018. Seven cases were excluded for imprecise diagnosis. Data was reviewed from clinical charts.

Results: Of 31 patients, 16 (51%) were men. Regarding comorbidities: 22 cases (70.9%) were attributed to known conditions. Inflammatory Bowel Disease (IBD) was the most common; 14 cases (45.1%). Out of the IBD, Ulcerative Colitis (10 out of 14 cases) was the most frequent. 4 (12.9%) patients had rheumatoid arthritis, 3 had cancer (2 solid and 1 lymphocytic leukemia), 2 (6.4%) had psoriasis and 1 patient had primary immunodeficiency. Regarding cardiovascular risk factors: hypertension with a total of 8 patients (25.8%) was the most frequent. Treatment strategies were variable: topical corticosteroids were effective in 4 patients (12.5%), but frequently systemic corticosteroids were administered at high doses (prednisone: 1-2 mg/kg/day). Focusing on the group with comorbidities, 11 patients (50%), were treated with systemic immunosuppressants: 6 with Azathioprine (54.5%), 5 with Infliximab (45.4%), 3 with Methotrexate (27.2%) and 1 case with systemic Cyclosporine (9%). No mortality related was documented.

Conclusions: A case series of PG is presented with analysis of associated medical and demographic data. Comorbidities were found which UC was the most frequent. These patients usually require treatment with conventional systemic immunosuppressants or biologic drugs.
The art and science of allergy records

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OBJECTIVES
In our hospital, the medical information is digitalized since 2012 and included in a program called Mambrino XXI. There is a specific box for drug allergy.
The objective is to review the drug allergy information included in the electronic medical history of the inpatients, and the accuracy of it.

METHODS
A descriptive study was made in the Hospital La Mancha Centro (Alcázar de San Juan, Spain) from October 2017 to March 2018. The recruitment criteria were:
- To be admitted in charge of the internist who was the main collaborator of this study.
- To have a drug allergy record or to suffer a drug adverse reaction during the admission.
The allergy information was directly collected from the inpatients and their family besides of reviewing the medical history.

RESULTS
A total of 39 patients were included, which represents the 24% of the patients assisted for the internist. They were 17 men and 22 women, with the median age of 78.3 (between 24 and 97 years-old) and the average stay of 9.1 days. There were 10 deceased patients. The most frequent allergy was penicillin (36%) followed by pyrazolone (15%) and iodinated contrast (10%).

The information about allergies was not included in Mambrino XXI (the main program for the electronic medical history) in 14 patients (36%). We found mistakes in 9 patients: 5 cases without allergy after reviewing medical history and asked the patients for information, and 4 cases with allergy study and negative result (in which the information was no updated and the alert was still active). All the mistakes were corrected.

CONCLUSION
A systematic anamnesis, the review of the information and the update of the electronic medical history are the key to detect and correct mistakes.
Pernicious anemia (PA), although rare (overall incidence of 120: 100,000 in the United Kingdom), is the most common cause of cyanocobalamin deficiency, affecting mainly European women in their 50s. It is characterized by megaloblastic anemia with severe deficit of intrinsic factor (FI) due to chronic atrophic gastritis. There are signs that alert for deficiencies, such as the association between vitiligo and PA.

This case is a 52-year-old woman, previously healthy, who went to the Emergency Department for complaints of asthenia, fatigue for minor exertion and weight loss of 10 kg in 2 months. At the physical examination, the patient was emaciated, mucocutaneous pallor, icteric sclerosis and vitiligo in the hands. No glossitis, chylous, coluria or sensitivity changes. Laboratory was Hb 4.5g / L, VGM 116fL, thrombocytopenia 113,000, reticulocytes 2.67%, hemolysis criteria with LDH 6061 IU / L, total bilirubin 2.79 mg / dL and direct 0.74 mg / dL, haptoglobin <0.07 g / L, Coombs negative, folic acid 6.4 ng / mL and vitamin B12 <125 pg / mL. The peripheral blood smear showed anisopoiquilocitosis with macrocytosis, polychromasia and hypersegmented nucleus neutrophils and confirmation of anti-parietal and anti-IF cell antibodies. Upper gastrointestinal endoscopy did not show lesions and gastric body biopsies were indicative of chronic gastritis and severe glandular atrophy with extensive pseudopyloric and intestinal metaplasia. The search for Helicobacter pylori was negative. Initiated vitamin B12 intramuscularly, observing an excellent clinical and analytical response, with total regression of the condition. The presentation of this case is related to its rarity and to the importance of considering the diagnosis of deficiency in the etiological study of anemias, potentially serious, that when diagnosed and treated leads to cure.
Introduction
Drug rash with eosinophilia and systemic symptoms (DRESS) is a rare life threatening drug-induced hypersensitivity reaction that includes fever, rash, lymphadenopathy, hypereosinophilia and multivisceral involvement.

Clinical case
A 44 year-old woman was admitted in the emergency department for rash, fever and abdominal pain that began two weeks before. She was medicated with carbamazepine for trigeminal neuralgia one month prior to the admission.
On examination she had fever, pain in the right hypochondrium, hepatomegaly and maculopapular erythematous rash on the limbs and upper trunk.
Laboratory examination showed leucocytosis (15.90x10^9/L), aspartate aminotransferase (AST) 200 UI/L, alanine aminotransferase (ALT) 438 UI/L, lactate dehydrogenase (LDH) 1033 UI/L and C-reactive protein (CRP) 3.28mg/dL. Abdominal ultrasound revealed unspecific changes related with hepatitis.
During hospitalization she developed sacroiliac pain and cervical, axillary and inguinal lymphadenopathies. The study showed ESR 3.0mm, normal iron kinetics, protein electrophoresis, negative autoimmunity, no HBV, HCV, TORCH, treponema pallidum, HIV, Epstein-Barr virus and Rickettsia conorii infections.
An inguinal biopsy of the lymphadenopathies was performed, with reactive paracortical hyperplasia and lymphocyte transformation test had a mild blastic response to carbamazepine.
She started prednisolone 1mg/Kg and after three days she was discharged with mild liver changes, improvement of the rash and lymphadenopathies and no fever. Full regression occurred one month later.

Discussion
DRESS is characterized by a prolonged latency period after drug intake and persists for weeks despite discontinuation of the causative drug. Therefore, the diagnostic process is complex and high suspicion is required.
Abdominal pain as a manifestation of Gitelman Syndrome

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INTRODUCTION

We present the case of a 24-year-old Bolivian male with abdominal pain and hypokalaemia. Gitelman syndrome (GS) is a tubulopathy of autosomal recessive inheritance that must be considered in some settings of hypokalaemia.

CASE DESCRIPTION

A 24-year-old Bolivian male was hospitalized by abdominal pain and hypokalaemia. His medical and family history was not significant. He denied any drug intake. Blood pressure was 110/70 mmHg, physical examination only showed pain in the right iliac fossa. Complementary evaluation revealed hypokalaemia (2.5 mEq/l), hypomagnesaemia (1.4 mEq/l), hypochloraemia (95 mEq/l), metabolic alkalosis with respiratory compensation (pH 7.39; pCO2 55 mmHg; HCO3 34 mmol/l), hypocalciuria (66 mg/24h) and increased urinary excretion of sodium (465.3 mEq/24h), potassium (51.8 mEq/24h) and chloride (478.5 mEq/24h). Potassium transtubular gradient was 8.9. Hormonal test, abdominal-renal ultrasound and electrocardiogram were normal. The diagnosis of GS was suspected. Oral supplementation with magnesium and potassium was initiated. GS was genetically confirmed. The patient was referred to Nephrology.

DISCUSSION

GS is a rare, salt-losing tubulopathy of autosomal recessive inheritance. It must be suspected in asymptomatic or mild late childhood or adult patients with hypokalaemia, metabolic alkalosis, hypomagnesaemia and hypocalciuria. DNA mutation analysis of the SLC12A3 gene (16q13), which encodes the renal thiazide-sensitive sodium-chloride cotransporter present in the epithelial cells of the renal DCT may confirm the diagnosis. The remaining differential diagnoses was Bartter syndrome. GS is usually managed by a liberal salt intake together with oral magnesium and potassium supplements. The use of potassium-sparing diuretics and indomethacin has also been described.
Introduction: Marfan syndrome is a relatively common autosomal dominant disorder (incidence of 1 in 3,000 to 5,000 individuals). The mutations are mostly missense changes of the FBN1 gene (coding for fibrillin) and may also target TGFBR1 and TGFBR2 (encoding transforming growth factor beta) genes. It’s a connective tissue disease with classic ocular, cardiovascular and musculoskeletal attainment.

Case description: The authors present a case of a male patient, 52 years old, referred to the Internal Medicine consultation for the study of probable connective tissue disease. Personal background: arterial hypertension and eight herniorrhaphies (crural and inguinal hernias). In the first consultation we observed marfanoid habitus and the family history on the maternal side: three male generations with the same physiognomic characteristics. Analytical tests didn’t have significant changes and the thoracic computed tomography and echocardiogram both had aortic ectasia. We requested a genetic study where the missense variant c.3148A> G (p.Ser1050Gly) was detected in heterozygosity in the FBN1 gene: a diagnosis of Marfan Syndrome. It awaits genetic and phenotypic characterization of this syndrome.

Conclusion: this is a genetic diagnosis consistent with the Marfan syndrome, with a variant not described in the literature.
Autosomal dominant polycystic kidney disease - A case report

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Introduction: Autosomal dominant polycystic kidney disease (DRPAD) is characterized by the presence of large kidneys and extensive cysts dispersed throughout both kidneys. In some cases, it leads to progressive renal failure due, in part, to the continuous increase of cysts’ size. Total renal volume is the strongest predictor of the development of renal failure. This pathology is associated with several complications, including urinary tract infections. However, hospitalization due to cysts’ infection is less frequent.

Case description: 47-year-old female with a history of DRPAD and cerebral aneurysm clipping at age 30. Family history: sister with DRPAD; mother and maternal aunt with DRPAD in hemodialysis (HD) program. At the age of 29, after hospitalization motivated by infection of a renal cyst, there was a progressive deterioration in her renal function. In subsequent years, she had multiple renal cyst infections (requiring various hospitalizations and percutaneous drainage) and significant worsening of renal function. Renal replacement therapy (HD) was initiated in January 2014, at 44 years of age. Computed tomography of the abdomen and urinary tract revealed "increased volume of both kidneys due to the presence of numerous rounded hypoechoic images, some spontaneously hyperdense due to hemorrhage and some with calcifications; loss of renal parenchyma." In June 2015, on account of recurrent renal cyst infections, surgical nephrectomy was performed. She is currently on the waiting list for kidney transplantation.

Discussion: Complications in ADPKD are directly related to the extent of cystic renal involvement. Therefore, regular follow-up and periodic imaging should be performed.
H syndrome: a new case and new mutation

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H syndrome is a rare autosomal recessive inherited disease with multisystemic signs and symptoms which are composed of hypertrichosis, hearing loss, short height, hypogonadism, heart abnormalities, hepatosplenomegaly and hyperglycemia(1,2). SLC29A3 gene is mutated in affected patients(3).

Case
A 23 year-old girl applied to outpatient clinic with fatigue, tiredness and dyspnea on exertion. Medical history demonstrated that she had joint abnormalities and contracture abnormalities starting after the first year of life, skin lesions appeared about age 4-5, sensorineural hearing loss developed 1-2 years after the skin lesions. The patient was diagnosed type 1 diabetes mellitus at age 15. Physical examination revealed joint contractions of hands and feet. Skin hyperpigmentation and enduration was seen on the trunk and extremities starting from the proximal medial sides of the lower extremities and extending to the abdominal and genital region sparing the knees and elbows.

After the clinical suspicion of H syndrome, genetic analysis was done from peripheral blood sample of the patient. A novel homozygous nonsense mutation leading to a premature stop-codon (p.Y428*) in exon 6 in SLC29A3 gene was detected.

Discussion
We report here a new case and a novel homozygous nonsense mutation in SLC29A3 gene of our patient. To the best of our knowledge, this mutation has not been reported before in H syndrome patients in worldwide (4,5). This data can update the mutation profile and contribute toward improved clinical management and counseling.

References
Genetic disorders
A-1580

It is not always a matter of genes: a case report of an elderly patient with untreated familial hypercholesterolemia

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Introduction:
Familial hypercholesterolemia (FH) is a common genetic disorder, characterized by elevated levels of low density lipoprotein cholesterol (LDL-C) and early cardiovascular manifestations. Herein, we present an interesting case of a man with non-treated FH, who underwent a transient ischemic attack in a quite advanced age.

Case description:
A 84-year old Greek patient, fit enough despite his age, walking daily at least 10km for the last 50 years, with a history of hypertension under medication, was admitted to our clinic due to hypoesthesia of the right upper and lower limb which lasted less than 20 minutes. No findings were revealed from the brain CT scan. Physical examination was unremarkable apart from a systolic murmur in the right carotid artery. Elevated levels of total cholesterol (T-Chol=270mg/dl) and LDL-C=220mg/dl were found. Right carotid artery stenosis (~45%) was found in Doppler ultrasound. Treatment with a high-dose statin (rosuvastatin 20mg/d) and an antiplatelet agent (salospir 100mg) was initiated; the patient was discharged in 5 days.

Discussion
FH is distinguished in the heterozygous form, which is the most common type, and in the homozygous type, which is more rare with a frequency of 1/10^6 and disease manifestations in early childhood. It should not be under-recognized as an entity, since it can lead to lethal complications. The medical community though should always highlight the cardioprotective role of running a healthy life despite the presence of a genetic predisposition.
About Thrombotic Pathology and Sexual Reassignment Surgery

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Sexual reassignment surgery is the procedure in which the sexual and physical characteristics of an individual are altered for the characteristics of the gender with which the individual identifies personally and socially. There are multiple risk factors that must be taken into account in this surgery, namely, chronic viral infections, diabetes, obesity, smoking and hormone supplementation.

Female, 31 years old, former smoker and history of two sexual reassignment surgery for 7 and 2 months, currently under hormonal therapy with oral contraceptive with drospirenone and ethinylestradiol. She was referred to the emergency department (E.D) for edema and pain of the left lower limb within 5 weeks. She reported episode of thoracalgia and sudden dyspnea about 2 months ago, interpreted as respiratory infection and clinically improved after antibiotic therapy. Observed by Vascular Surgery during permanence in the ED, documented femoropopliteal deep vein thrombosis by echo-doppler, already partially recanalized. Observed also by Internal Medicine, documentation of nonspecific inversion of ventricular repolarization of V1-3, performed thoracic angio-tomography with exclusion of pulmonary thromboembolism. She was discharged with indication of mechanical compression by elastic stocking, hypocoagulation during 6 months and was oriented to consultation of Vascular Surgery and previous particular physician to alter hormonal therapy.

Due to the increasing number of sexual reassignment surgeries performed in Portugal, the present case serves to emphasize the importance of clinical suspicion regarding the risk factors and complications associated with surgery.
Epidemiological characteristics of norovirus gastroenteritis related to gender

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Background: Norovirus is responsible for 85% of epidemic gastroenteritis worldwide. We aimed to elucidate epidemiological characteristics in Norovirus gastroenteritis related to gender.

Methods: We included 50 adolescents (30 girls/20 boys, 15.9±0.3 years). We recorded their demographic, clinical characteristics, and dietary habits. Diagnosis was made with the identification of Norovirus with real-time reverse transcription-polymerase chain reaction assays at whole stool specimens obtained within 24-48h of beginning of symptoms.

Results: The boys included in the study weighted more than the girls (p=0.05), had shorter disease duration (≤48h) (p=0.01), presented oftener with fever (p=0.05), and nausea (p=0.04), and had eaten more regularly a fast-food dinner (p=0.04), ready-to-take food/drinks (p=0.001), or sweets (p=0.05), compared with the studied girls. Before beginning of symptoms, boys had drank oftener non-bottled water than girls (p=0.02). Girls had longer disease duration (>48h), oftener hypotension (< 90/60mmHg) (p=0.02), and tachycardia (>100 beats/min) (p=0.01). Before beginning of symptoms, girls had eaten more frequently roast-chicken (p=0.009), fresh-vegetables (p=0.009), and fruits (p=0.05) compared with the boys. There were no gender differences regarding the beginning of symptoms before viral exposure, their severity, and the incidence of vomiting, abdominal pain, diarrhoea, "metallic" taste, or their 24h frequency. There were no significant gender differences regarding consumption of home-made food. There were no differences regarding personal medical history between genders.

Conclusion: The epidemiological characteristics, and therefore the mode of Norovirus transmission are different in relation to gender, as recorded in the present study. Their knowledge may contribute to a better control and prevention of Norovirus gastroenteritis in adolescents worldwide.
European physicians’ awareness of the difference between sex and gender: the IMAGINE survey


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Background: Sex and gender shape health status through dynamic interaction, therefore the integration of sex and gender in research and clinical approach is mandatory and it drives towards a personalized medicine and equality in health care. Methods: to assess the awareness of the Internal Medicine community on sex and gender dimension in approaching clinical and research questions, an online short survey was run among European internists clinicians.

Results: Among 1040 European Internist surveyed, mainly women (57%), young/middle-aged (78%) and practicing in public general medicine service, around one fifth declared that sex and gender are synonymous. Among those who are aware of the difference, a wide discrepancy still exists on what sex and gender concepts incorporate. Sex and gender are recognized as determinants of health mainly in cardiovascular disease (CVD) and autoimmune/rheumatic diseases. Around 80% of survey's respondents are aware of the low participation of women in randomized controlled trials to tests new drugs. More than 60% declared to notice a lack of sex-specific recommendations in clinical guidelines. Europeans Internists will be interested to know more about sex and gender differences CVD, inflammatory bowel disease and cerebrovascular/cognitive diseases. Conclusion: A change in the knowledge of European Internists is ongoing: sex and gender are recognized as crucial drivers of health disease. However, knowledge translation remains a cross-cutting issue that should be mainstreamed across all the career of European Internist to improve the management and clinical outcome of patients.
Gender differences in homocysteine levels, a population-based cross-sectional study

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**Background:** High levels of homocysteine are considered a risk factor for the development of coronary artery disease. The aim of this study was to assess whether there are gender differences for the levels of homocysteine.

**Methods:** Data was collected from medical records of individuals examined at a screening center in Israel between the years 2000-2014. Cross sectional analysis was carried out on 9237 men and 4353 women (32%).

**Results:** Mean (SD) age of the study sample was 48.4 (9.7) and 47.7 (9.7) years for men and women respectively. Average homocysteine levels were 12.6 (5.9) and 9.6 (3.1) μmol/L in men and women respectively (p<0.001). Prevalence of homocysteine levels above 15 μmol/L were significantly higher in men compared to women 15.5 % vs 3.9% respectively (p<0.001). Low levels of vitamin (B12 <200 pmol/L) and low levels of folic acid (<12 nmol/L) were significantly higher in men compared to women 20.4% vs. 16.0 % and 18.5% vs. 10.8% respectively. Compared to women, men had a significant higher odds ratio (95% CI) for homocysteine levels above 15 μmol/L: non adjusted model, 4.5 (3.8-5.3) (P<0.001); adjusted model for age, BMI, low levels of vitamin B12 and folic acid, 4.0 (3.8-4.7) (P<0.001).

**Conclusion:** Gender differences exist for homocysteine levels. This may be another factor contributing to the inequality between men and women with regard to the risk for developing coronary artery disease.
Influence of gender on the relationships between new indices of adiposity and left ventricular mass and hypertrophy in hypertensive patients

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Background. The unfavourable effects of the association of obesity with hypertension on cardiac structure and function have been extensively studied. However, controversy still exists about the influence of gender on the relationship between obesity and left ventricular mass (LVM) and hypertrophy (LVH). Even if body mass index (BMI) and waist circumference (WC) are widely used as anthropometric predictors for cardiovascular diseases (CVD), their validity has been questioned. Recently, Body Shape Index (ABSI) and Body Roundness Index (BRI) were proposed as alternative measures of adiposity that may better reflect health status (1-2).

Our study was aimed to assess the ability of ABSI and BRI in identifying LVH and to determine whether they are superior to BMI and WC. Moreover, the influence of gender on the relationships between all these indices of adiposity and LVM was also evaluated.

Design and method. We enrolled 724 subjects with EH (mean age 45 ± 12 years, 63 % men) without cardiovascular complications. In all subjects the anthropometric indices (weight, height and waist circumference) and the routine biochemical parameters were determined. BMI, ABSI and BRI were calculated. Furthermore, all patients underwent a 24-h blood pressure monitoring and an echocardiogram. LVM was indexed for body surface area (LVMi) and for height2.7 (LVMH2.7).

Results. At univariate analysis, LVMi and LVMH2.7 correlated with ABSI and BRI as well as with the traditional measures of adiposity (all p < 0.05). ROC curves analysis revealed that in overall population and in men BRI has a greater ability to identify LVH defined as LVMH2.7 > 51 g/m2.7 (p < 0.001 vs ABSI and BMI).

Conclusions. Our results seems to suggest that in men, but not in women, the BRI has a greater sensitivity to detect (is more closely associated with) LVH than ABSI and the traditional measured of adiposity.
Lifetime exposure to violence and other life stressors and hair cortisol concentration in women

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Objectives
Our objective was to use a novel marker of the hypothalamic-pituitary-adrenal axis, that is hair cortisol concentration, and measure its association with violence exposure, and other life stressors.

Methods
We explored the association between lifetime exposure to violence and other life stressors and HCC in 470 adult women, 21-86 years, attending the Cancer Detection Clinic in Iceland. Life Stressor Checklist-Revised (LSC-R; 30-items) was used to assess lifetime exposure to violence and other life stressors. HCC was measured with liquid chromatography coupled with tandem mass spectrometry. Multiple imputation was used for missing LSC-R items. We used Poisson and linear regression models and log-transformed HCC.

Results
A total of 197 women (41.9%) had a lifetime history of physical and/or sexual violence. Among the 273 women without lifetime exposure to violence, HCC was not associated with any of the background covariates, including: age (P=0.100), education level (P=0.184), marital status (P=0.769), income (P=0.976), occupation (P=0.093). Neither was HCC associated with these covariates when the entire sample was examined. Stepwise increase in the number of experienced life stressors was associated with higher HCC (P=0.027), with a steeper increase in HCC when specifically examining exposure to different types of violence (P=0.014). Neither age at first violence exposure nor time from last exposure were clearly associated with HCC levels.

Conclusion
Lifetime exposure to life stressors, particularly violence, is associated with increased HCC in a general population of women.
The association between mental health and hypertension among women with and without a lifetime history of violence

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The long-term physical impact of violence against women is under researched. There are indications of cardiovascular ramifications, but the mechanism is unknown. Our objective was to measure the association between violence and cardiovascular risk factors as well as how violence potentially modifies the association between mental health indicators and hypertension.

We explored the association between violence and cardiovascular risk factors and mental health indicators in 509 women, 20-86 years, attending the Cancer Detection Clinic (CDC) in Iceland. We used the Life Stressor Checklist-Revised to measure lifetime exposure to violence and multiple imputation to account for missing values. Anxiety and depression were measured with PHQ9 and GAD7. Obesity was considered as BMI over 30, as measured at the CDC. Hypertension was defined as a blood pressure reading with either systole over 140mmHg or diastole over 90mmHg.

Of 509 women, 209 (41%) reported lifetime history of physical and/or sexual violence. Compared with unexposed women, women with a history of violence were more likely to report symptoms of depression (6.0% vs. 13.9%; PR 2.23; 95% CI: 1.25, 4.09) and anxiety (8.3% vs. 19.6%; PR 2.29; 95% CI: 1.40, 3.82). Overall, exposed women were not more likely to be obese (PR 1.15; 95% CI: 0.82, 1.60) nor exhibit hypertension (PR 0.95; 95% CI: 0.70, 1.27). Yet, among women exposed to violence, presence of depressive symptoms or anxiety was associated with a doubled risk of hypertension (PR 1.94; 95% CI: 1.05, 3.38 and PR 1.84; 95% CI: 1.06, 3.07, respectively) while such risk elevations by mental health symptoms were not noted among women without lifetime exposure to violence (PR 0.71; 95% CI: 0.22, 1.70 and PR 1.01; 95% CI: 0.45, 1.96, respectively).

Violence against adult urban Icelandic women is common with strong implications for mental health. These women may experience a greater risk of developing hypertension – a finding that calls for prospective studies.
Vitamin B12 Deficiency and the Role of Gender – A Cross Sectional Study of a Large Cohort

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Objectives: Vitamin B12 deficiency is associated with hematological, neurological and cardiovascular consequences. Epidemiologic data on these related illnesses indicate gender differences. The current study aimed to examine a possible association between gender and vitamin B12 deficiency.

Methods: A cross-sectional study was designed to examine gender differences in vitamin B12 deficiency amongst a healthy population. Data from healthy individuals aged 18-65, who were provided with a routine medical evaluation during 2000-2014, were retrieved from the medical charts. Individuals with background illnesses, use of medications or nutritional supplements were excluded. Vitamin B12 deficiency was defined by two cutoffs (206 and 140 pmol/L). The multivariate analysis was adjusted for age, BMI, eGFR, hyperhomocysteinemia, folate deficiency, albumin and transferrin saturation. Sensitivity analyses were implemented by excluding individuals with anemia, hyperhomocysteinemia or folate deficiency and by age stratification.

Results: 7,963 individuals met the inclusion criteria. Serum vitamin B12 mean levels were 312.36 and 284.31 pmol/L for women and men, respectively (p<0.001). Deficiency prevalence was greater for men (25.5%) in comparison with women (18.9%), (p<0.001). Men were strongly associated with severe deficiency (adjusted OR 2.26; 95% CI 1.43-3.56).

Conclusions: Amongst the healthy population, men are susceptible to vitamin B12 deficiency. This can be explained by neither diet habits nor estrogen effect. Genetic variations are therefore hypothesized to play a role.
49 year-old man with constitutional symptoms and myalgias

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INTRODUCTION

Unusually excessive exertion, trauma, and viral infections are among the most common causes of myalgia. While many causes are benign and self-limited, myalgia may be the harbinger of disorders associated with significant morbidity.

CASE DESCRIPTION

A 49 year-old male, with diabetes, siblings who died at 4 and 6 years old with severe psychomotor retardation, a diabetic mother and 4 young deceased uncles. He has 3 healthy children. On treatment with metformin.

He was hospitalized for constitutional syndrome with a loss of 12 kg in the last year and myalgias and muscular weakness in all four limbs without difficulty in walking or mobility.

Neurological physical examination: normal superior functions, normal pupils, normal cranial nerves, hypotonia in all muscles, strength 4/5 in all muscles, mild generalized atrophy, no fasciculations, ROT ++ / ++++, negative Babinsky, negative Hoffman and clonus, normal sensitivity and coordination, walking with decreased step amplitude with prolonged fatigability.

In analytics, CK elevation stood out. Thoraco-abdominal CT, echocardiography and brain MRI were completed without pathological findings.

Electromyography was performed, being compatible with myopathy of moderate diffuse degree in chronic stage of evolution with signs of progression in lower limbs. Muscle biopsy showed changes compatible with mitochondrial myopathy affecting the MT-TL1 gene that codes for tRNALeu (UUA/UUG), causing the MELAS syndrome (mitochondrial encephalomyopathy with lactic acidosis and stroke-like episodes). In current treatment with Coenzyme Q10 and morphic derivatives.

DISCUSSION

Given the risk of lactic acidosis in the MELAS syndrome, metformin was withdrawn. There are studies to include arginine and citrulline in the treatment of MELAS, however, controlled trials are needed to establish if arginine and citrulline treatment are beneficial in MELAS patients.
Background & Objective: Delirium in older people in hospital has a mortality rate of 6-18% and a prevalence of 7-16%. Affected patients are 3 times more likely to develop dementia. Symptoms of delirium are often subtle and diagnosis may be missed by clinicians. Screening tools aid early detection and management of delirium. The screening tool 4AT was introduced into Hairmyres Hospital's Acute Medical Receiving Unit (AMRU) 2.5 years ago. Nurses were asked to complete the form as part of the admission document without formal training. We aim to achieve 80% documentation of 4AT in patients over 65 in AMRU within 3 months using Quality Improvement (QI) methodology.

Methods: A driver diagram helped identify primary and secondary drivers along with strategies. Interventions included feedback, positive reinforcement, buzz sessions, a delirium day and fact of the day. Data was collected using opportunity sampling and displayed on a run chart.

Results: The daily percentage of patients with 4AT documented was collected on 28 separate days. The notes of 364 patients were reviewed in total. 40% of patients had a 4AT chart completed prior to intervention. Our 5 interventions resulted in a shift on the run chart using run chart rules. After intervention, 90% of patients had their 4AT chart completed (This represents 7 different days tested).

Conclusion: We have demonstrated that by using QI methodology, we have improved the completion and documentation of 4AT. This can be expected to improve the detection and subsequent management of patients with delirium.
77 year old man with left hemiparesia.

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INTRODUCTION:
-77 year old male Active life.
-Hypertensive, dyslipidemic, not diabetes mellitus.
-Diffuse large-cell lymphoma B (DLBCL) diagnosed in 2009 treated with QT (R-CHOP and intrathecal QT) discharged in 2014.
He came to the emergency room due to a progressive loss of strength in the left side of his body over a period of four days.

CASE DESCRIPTION:
Good general condition. Normal cardiac and pulmonary auscultation. Normal abdomen. Deviation of the labial commissure to the left, normal motor coordination, left hemiparesis with mild motor loss (IV / V).
-Normal analytical, blood smear and biochemistry.
-Serological study (HIV, EBV, CMV, toxoplasma) negative.
-Cranial CT s/c: 1.4 cm nodular lesion in right thalamus compatible with cerebral LOE vs. ischemia.
-Cranial MRS c/c: intraaxial space-occupying lesions, localization in thalamus and right internal capsule (13x11x15 mm, 10x6x15 mm, 6.3x7.5x5.4 mm). Bilateral and symmetric leptomeningeal infiltration.
-Cervico-thoraco-abdominal CT without subjective lesions of lymphoproliferative disease.
-CSF study: normal.
-Cytological study 8% of medium-sized cells with an irregular nucleus that could correspond to blasts.
-CSF immunophenotype: no pathological B cells are observed.
-Brain biopsy: diffuse large B-cell lymphoma.

DIAGNOSIS:
Recurrence of diffuse large B cell lymphoma in the central nervous system.

DISCUSSION:
DLBCL is one of the most frequent types of lymphoma and accounts for approximately 30% of cases of non-Hodgkin lymphoma in our environment.
Incidence of recurrence of DLBCL in CNS of total lymphomas is 5%. Histological types are: Hodgkin's lymphoma (0.6%), indolent lymphoma (3%), mantle lymphoma (22%), diffuse large B-cell lymphoma (5%), mediastinal lymphoma (19%), T-cell lymphoma (5%), angiocentric lymphoma (21%), Burkitt lymphoma (19-33%), lymphoblastic lymphoma (23%).
Relapse can occur simultaneously at the systemic level and in CNS (20%), in CNS followed by systemic progression (30%) and in isolated form in CNS (5%).
A 56 year-old man with sudden and unilateral vision loss

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Introduction: A 56 year-old man with a 3-month sudden and unilateral vision loss, due to an occlusion in the superior branch of the retinal vein in the left eye, was referred from the ophthalmology out-patient clinic to the internal medicine department. Case description: The patient had a history of hypertension, hyperlipidemia, obesity, hyperuricemia and was a heavy smoker. Several tests were carried out, including chemistry panel (with hemoglobin A1C, liver enzymes, C-reactive protein, lipid metabolism, thyroid profile and erythrocyte sedimentation rate), blood count, proteinogram, immunoglobulins, coagulation and Hepatitis B, C and HIV serology. The thrombophilia study (Prot C and S, Antithrombin III, Lupus anticoagulant, antcardiolipin and Anti b2) and genetic study for factor V leiden (Mutation 20210 A) were normal too. Imaging tests, EKG, chest X-ray and echocardiography showed no pathologic results. Discussion: Retinal vein occlusion (RVO) is a common cause of vision loss in older adults, and the second most common retinal vascular disease after diabetic retinopathy. The mechanism producing of RVO is divided into ischemic or non-ischemic (degenerative or inflammatory). RVO is always a manifestation of a systemic illness, which is why an interdisciplinary work-up becomes a key aspect on managing these patients. In our case, after discarding other causes, the ischemic etiology was assumed and Aspirin 100mg 1c/24h and a stricter control of cardiovascular risk factors were established, obtaining positive results. At this point, we wish to emphasize the important role of the internal medicine specialists in the treatment of potentially underlying diseases.
A case of sensory peripheral neuropathy - the importance of differential diagnosis

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Introduction: Peripheral neuropathy has a variety of underlying causes. The diagnosis requires a systematic and holistic approach and careful clinical assessment.

Case report: We describe a case of a 64-year-old woman presenting with progressive imbalance and distal lower extremities paresthesia for 12 months. On hospital admission sensory disturbances included decreased perception of all sensory modalities in the lower extremities and severe sensory ataxia, with no motor symptoms. Neurological examination revealed absent tendon reflexes in the inferior limbs with preserved muscle strength. Nerve conduction studies showed reduced sensory nerve action potentials in sural nerves bilaterally with preserved motor action potentials, compatible with distal axonal sensory neuropathy. Laboratory investigations, including measurement of fasting blood glucose, vitamin B12 and thyroid hormone levels, were normal. Toxic and infectious causes were excluded. A paraneoplastic panel was negative for occult malignancy. Spinal computed tomography revealed an L1 fracture without spinal cord compromise. Spinal magnetic resonance imaging was finally obtained revealing an expansive intradural extramedullary lesion in the lower thoracic region (D10-D11) compressing the lower spinal cord. The diagnosis of spinal meningioma was made and the patient was then submitted to surgical excision with subsequent gradual improvement.

Discussion: Spinal meningiomas represent a minority of all meningiomas but are among the most common intradural tumours. Despite their usual reduced size they can result in important neurologic dysfunction. The majority of patients presents with motor deficits as a result of spinal cord compression. Our case represents an unusual manifestation with only sensory deficits despite significant medullary compromise, thus presenting as a diagnostic challenge. Spine disease must be considered upon evaluation of sensory distal neuropathy.
A decision support tool to select patients for Co-management

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Introduction: Co-management between internists and surgeons is becoming one of the pillars of modern clinical management in large hospitals. Selecting patients to be co-managed is essential. The aim of this study is to create a decision tool using real-world patient data collected in the preoperative period, to support the decision on which patients should have the co-management service offered.

Methods: Data was collected from the electronic clinical health records (EHRs) of patients who had an International Classification of Diseases, 9th edition (ICD–9) code of colorectal surgery during the period between January 2012 and October 2014 in a 200 bed private teaching hospital in Lisbon. Patients with more than one procedure were excluded from the study. From these data the authors investigated the construction of predictive models using Logistic Regression with techniques of multistage and ensemble modelling.

Results: Data contains information from the EHRs of a cohort of 344 patients. Three preoperative variables were identified as being the most predictive of co-management, in multivariable regression analysis. The final model performed well after being internally validated (0.81 AUC, 77% accuracy, 74% sensitivity, 78% specificity, 93% negative predictive value). The results indicate that the decision process can be more objective.

Conclusions: The authors developed a prediction model based on preoperative characteristics, in order to support the decision for the co-management of surgical patients in the postoperative ward setting. The model is a simple bedside decision tool that uses only three numerical variables collected at a pre-anæsthesic clinic.
INTRODUCTION
Fever is a frequent reason for medical consultation and even though in most situations its etiology is obvious, in some cases it can become a challenge.

CASE REPORT
Male, 81 years old, resorted to the Emergency Room due to a clinical status with an evolution of around 15 days, characterized by asthenia, overall discomfort, myalgias, generalized arthralgias, fever with a maximum temperature of 39°C, intense hyperhidrosis and anorexia, with a 4kg ponderal loss over the last month.

In the Emergency Room, he was hemodynamically stable, with no relevant changes in the physical examination. From the analytical evaluation, there was a noticeable increase in the sedimentation rate and Reactive C Protein, with light leucocytosis.

On the first days of admission, he was complainant, continuously reporting discomfort and generalized muscular skeletal pain accompanied by daily fever spikes (38°C-39°C). Moreover, the patient presented with an intermittent pink-purple skin rash, coincident with the fever spikes.

We proceeded with the search for infectious, neoplastic or autoimmune potential, but all those complementary studies turned out negative.

Owing to the fulfilment of several criteria for Still's Disease (fever, splenomegaly, ponderal loss, leucocytosis with neutrophilia, normocytic and normochromic anaemia, increased Reactive C Protein and sedimentation rate, ferritin, fibrinogen and the appearance of the skin rash coincident with fever spikes), that was assumed as the nosological condition in question.

He initiated therapy with corticoids, to which the patient favourably responded with apyrexy following the beginning of the therapy and with no osteoarticular complaints, with follow up in the General Medicine Service.

DISCUSSION
Being Still's Disease a diagnosis of exclusion, it is vital that the etiological study of the fever syndrome of unknown origin is complete and that the patient presents with a clinical improvement with corticoids.
A look at our population

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Objectives: The fragility of the population hospitalized on the care of Internal Medicine is well known, due to the cumulative effect of their comorbidities. Thus, the high number of hospitalizations that this population can have during the year, some of them with a negative outcome, is not surprising. This study aims to analyze the number of hospitalizations before and after the admission in a functional team of Internal Medicine and to correlate that with the mortality.

Methods: This study was based on a population of 209 patients admitted to the care of a functional team of Internal Medicine, in 2017. The number of hospitalizations and the number of deaths were collected from the institutional database.

Results: In the studied population 54% were female and 46% were male, with a mean age of 79 years. Before admission, 21% had some hospitalization in the last 12 months, 11% in the last 6 months and 21% in the last month. As for the subsequent analysis, 19% were hospitalized 3 months after the discharge and 23% in the next 6 months. Of the patients evaluated, 27% had an unfavorable outcome, of which 63% died in the months after the hospitalization. In respect to the patients who died half of these had more than one hospitalization after our discharge.

Conclusion: A large part of the population admitted to the care of Internal Medicine presents comorbidities that influence hospitalizations. In respect of the deaths, the majority of them did not occur during the hospitalization, but after an accumulation of subsequent admissions. It is suggested, therefore, that the number of hospitalizations can influence the negative outcomes. We intend to highlight the idea that the number of comorbidities influences the state of fragility which ends up with several exacerbations in a short period of time.
A Quality Improvement Project: Empowering The Medical Registrar in everyday practice.

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Introduction.
The Medical Registrar is recognised as a busy and challenging role, negative perceptions of it creates an impact on doctors pursuing careers that encompass this role.1 We undertook a multifaceted Quality Improvement Project aiming to improve the experience of Medical Registrars locally by giving them a forum to channel concerns, a structured handover to improve the efficiency of the on call team and simulation sessions for essential practical skills.

Methods
Monthly Registrar forum meetings were introduced which were minuted and surveyed. A formal handover proforma was introduced, which was audited and improved following a PDSA cycle. Simulation training of procedural skills for General Internal Medicine Registrars was initiated and feedback obtained.

Results
Monthly meetings were held between October and April 2018. Out of 18 Registrars invited, 71% attended—an average of eight Registrars. 85.7 % found the forum useful. There was a marked improvement in uptake of using a handover proforma from 0 to 73% with 50% rating the handover process as satisfactory. Several areas were identified as needing further improvement. A simulation session for procedural skills was attended by 10 Registrars. 100% reported that it had helped them achieve their General Internal Medicine curriculum objectives.

Discussion:
Simple interventions guided by a trainee led forum helped address challenges encountered by Medical Registrars. A collaborative approach to present day problems using a PDSA cycle has established a forum which boosts morale and confidence and helps deliver a safe and effective patient care with a formal handover process.

A revealing diplopia

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Introduction: The request for complementary studies is very common in all specialties, being a fundamental part of the study of a patient. However, it's important to consider the clinic and recognize the results that are not congruent with it.

Case Description: A 87 years old independent man was admitted for the study of a hyponatremia. He had a history of arterial hypertension and long-term sinusitis. During the hospitalization, he began complaints of diplopia with no other objectified symptoms or deficits. A head CT was performed, acute ischemic injury or other abnormal changes, weren’t evident except for signs of chronic sinusitis. It was request observation by Ophthalmology, which ruled out ophthalmologic pathology and Otorhinolaryngology, which sent the patient to the outpatient clinic for follow-up of sinusitis. The patient was discharged, with a slight improvement of the complaints and follow-up in consultation. Later, in Otorhinolaryngology appointment, due to the aggravation of the complaints, a new head CT was requested, and the result was overlapping. For better characterization, cranial nuclear magnetic resonance was performed, that describe a probable infectious or, less probably, tumor process involving the right cavernous sinus, sphenoid sinus, pterygomaxillary fossa and right nasal fossa. Therefore, he was hospitalized for further study. He had a biopsy of the right nostril wich confirmed a neoplastic process with characteristics of a not differentiated adenocarcinoma with intestinal type phenotype. In a multidisciplinary meeting, it was decided to start radiotherapy and referred for pain consultation, however, patient died before starting treatments.

Discussion: With this case, we intend to demonstrate the need to always question the complementary studies, looking at them with critical spirit, supported by the patient’s clinics, to avoid delays of diagnosis and to prolong the time of beginning of treatment.
A therapeutic dilemma

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Hypersensitivity pneumonitis (HP) is a syndrome caused by an immunologic reaction to an inhaled antigen in the lung. Treatment requires antigen avoidance. Immunosuppressants may be needed for remission of refractory cases, leading to a state of immunodepression which predisposes to higher risk of infections and neoplasms.

We describe a case of a 66-year-old man admitted with worsening dyspnoea and vespertine fever for three weeks. He had been diagnosed with hypersensitivity pneumonitis one year ago and treated initially with corticoids and then switched to corticoid-sparing drugs. The patient had a one-week course of amoxicillin-clavulanate before admission and was submitted for 7 days to piperacillin-tazobactam as respiratory infection could not be excluded. Microbial cultures were negative. Due to the lack of clinical improvement, thoracic CT scan was performed which revealed ground glass areas in both lungs suggesting exacerbation of HP. It also showed a nodule in the right chest wall and several adenomegalias in the right axilla and mediastinum. Mass biopsy revealed hypercellularity with lymphoproliferative character. The case was discussed altogether with Pneumology and Hematology specialists and it was decided to discontinue MMF and restart prednisolone in order to achieve lung disease remission in a way that could prevent progression of the lymphoma.

As is known there is a higher propensity to neoplasms (particularly hematologic malignancies) in patients treated with chronic immunosuppressants and it can have an important role predisposing indolent lymphomas transformation. When malignancy is superimposed, considerations should be made on therapeutics. We brought this case to highlight the importance of teamwork among different specialities in order to provide the best care to patients with this level of complexity.
About a Complex Internal Medicine Clinical Case

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We describe the case of a 79 year old woman with arterial hypertension, dyslipidemia and peripheral venous insufficiency who resorted to the emergency department for dyspnea, cough and pink sputum. She was diagnosed with heart failure (HF) decompensated by acute tracheobronchitis. Electrocardiogram showed atrial fibrillation with rapid ventricular rhythm, and therefore she initiated frequency control and anticoagulation with enoxaparin. Paralysis of the right diaphragmatic cupule was evident on chest radiography. Since the admission, levofloxacin was given with a good response, however it was suspended on the 7th day due to psychomotor agitation, with no acute lesions on brain computed tomography (CT). On day 10, a spontaneous hematoma appeared in the left thigh, requiring transfusional support. Anticoagulation was discontinued. After 3 days the patient had aggravation of her respiratory insufficiency associated with asymmetric edema of the lower limbs. Echography confirmed recent bilateral popliteal venous thrombosis and pulmonary thromboembolism was excluded. After balancing risks/benefits with Vascular Surgery, three weeks later, it was decided to start prophylactic enoxaparin and mechanical measures. The patient also received antibiotic treatment for nosocomial pneumonia. Due to HF, respiratory infection and diaphragmatic hemiparesis, she maintained type 2 respiratory insufficiency, requiring noninvasive ventilation. She was discharged after 41 days, maintaining vigilance in ambulatory and physical rehabilitation due to disuse myopathy. Although admitted with frequent diagnoses, hospitalization had multiple complications that required collaboration between medical and surgical specialties. We consider that the case illustrates the complexity of the medical ward and the importance of articulation between specialties.
About a Palliative Care Team, a retrospective analysis

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Palliative care (PC) has as its philosophy the improvement of the quality of life of patients and their families, through the prevention and relief of suffering due to an incurable and severe illness with a limited prognosis, in several settings – hospital wards, nursing homes and outpatient clinics (OC).

Retrospective and descriptive study, evaluating the patients followed by the PC team during 2017. During that period, 1256 medical consultations (MC) were made, 897 in the OC and 359 in the patients’ residences. Since the evaluation is multidisciplinary, 828 nurse, 45 nutritionist and 243 psychology consultations were also made. In the last group, 19 for the patients and 224 for their caregivers, being the main purpose complicated grief. Regarding the wards, 334 patients were evaluated. Most of them were male (N=204; 56%), with the mean age of 71 years old. The most requiring specialties were Internal Medicine (N=142; 39,0%), General Surgery (N=91; 25,0%) and Pneumology (N=50; 13,7%). In this group, 79% had oncological disease (lung [N=53], colon and rectum [N=42], stomach [N=39] and central nervous system [N=26] cancer) and 21% non-oncological (heart failure [N=23], dementia [N=22] and chronic obstructive pulmonary disease [N=8]). The main purpose of activation was symptomatic control (44%), care organization (43%), planning of the hospital discharge (9%) and decision-making (4%). Of the inpatients; 47.8% died at the hospital; 37.9% were discharged (DP) to their houses and 3.9% were transferred to a Palliative Care Unit (PCU). In the DP group, 20.5% died in the hospital (in the Emergency Department or in a subsequent hospitalization) and 66.7% died at home (46.2% in their houses and 20.5% in nursing homes).

Although most patients in follow-up were oncologic, it is non-oncologic patients who, due to their complexity and erratic evolution, deserve an earlier referral. Most of them died at their houses like they wanted, thus fulfilling the team's mission.
About pigeons, lungs and heart

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Interstitial lung disease is caused by progressive scarring of lung tissue, generally irreversible, with different etiologies, specifically long-term exposure to hazardous materials such as asbestos; inhalation of dust, mold, bird proteins or other irritants; autoimmune diseases such as rheumatoid arthritis; and in other cases the causes remain unknown.

Woman, 80 years old, history of heart failure (HF) and long-term exposure to pigeons, went to the emergency department due to progressive worsening of dyspnea and nonspecific thoracalgia. Thoracic radiography was performed showing evidence of diffuse thickening of pulmonary interstitium; later thoracic angiotomography with evidence of cardiomegaly, bilateral pleural effusion, extensive interstitial thickening of the reticular lung pattern, apparent honeycomb changes, possible interstitial lung disease with a fibrosis component and depolarized glass densification dispersed by both lungs. Diagnostic thoracentesis was performed, transudate in patient with decompensated HF, adjusted medication and oriented to Pneumology consultation.

Interstitial lung disease should always be considered as a diagnose due to its irreversibility and importance of early treatment as medication may slow damage and progression of the disease.
Acculturation stress and the process of acclimatization, as the main predisposing factors in the development of diseases among students of a foreign department.

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Objectives: 1. To differentiate the diseases directly caused by climate change and the acculturation process, from general disorders, compare to average Kazakh student, as a result of a change in the quality of life. 2. Identify the main group of diseases, determine the nature of their development and the risk group for each specific system.

Methods: 100 students of SMU 1, 3 courses were examined. The main group consisted of 50 people, in which 25 people are first-year students, 25 are third-year students of the foreign department, with an average age of 22 years. The control group consisted of 50 people living in these climatic conditions for more than 10 years, with an average age of 19 years.

A survey was conducted, it borrowed from the Giessen inquirer adapted by psychoneurological institute of V. Bekhterev. The questionnaire was processed using Epi Info. An also anamnesis collected for determination of diseases caused by acculturation and generated by stress illnesses. The third method was objective methods of investigation (palpation, percussion, auscultation by organs and systems included).

Results: As a result of the questionnaire, the respiratory system (68%), GIT (52%), musculoskeletal (49.1%), MPS (22%), CNS (12%) were detected in the main group.

In the control group, gastrointestinal tract diseases (85%), musculoskeletal system (72%) were noted. The results of questioning in the main group were detected by differential respiratory system (68%), gastrointestinal tract (52%), musculoskeletal (49.1%), MPS (22%), CNS (12%).

Conclusion: The data obtained make it possible to draw up a schedule of medical preventive and health improvement measures for students of a foreign department, to identify the dependence of the development of diseases with a change in the climatic zone and lifestyle.
Acute Generalized Pustular Psoriasis of von Zumbusch - A medical emergency

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Introduction: Von Zumbusch is the most severe form of generalized pustular psoriasis (GPP) and it usually starts as multiple erythematous, tender plaques later becoming studded with satellite sterile pustules that coalesce to form lakes of pus. It can precede the onset of psoriasis or can be a continuum of the psoriatic disease, like the case presented. In most cases the trigger is unknown. It's one of the few dermatological emergencies.

Case description: We present the case of a 50-year-old woman with a history of inverse psoriasis diagnosed 20 years early. The patient was admitted to our hospital with widespread patches of erythema with overlying pustules affecting more than 90% of body surface showing numerous pinpoint pustules with a progressive development over the 3 weeks prior to admission. She also presented with fever (maximum temperature: 38.3°C), intense pruritus, dehydration and generalized pain. Physical examination showed erythematous, painful skin and widespread sterile pustules, with lakes of pus that ruptured, resulting in extensive areas of desquamation. Systemic abnormalities included fever, malaise, leukocytosis and elevated protein-c reactive. Treatment with betamethasone mixed in equal parts with emollient and acitretin was initiated. After 6 days and only a very slight response, Methotrexate was initiated- with a positive response after 2 administrations (1 per week). A skin biopsy confirmed on histology the diagnose of GPP. No trigger was identified. During the follow up the patient developed oligoarticular psoriatic arthritis.

Discussion: GPP is one of the most severe forms of psoriasis because of life-threatening complications like capillary leak syndrome, heart failure, acute respiratory distress syndrome and sepsis. Our goal is to increase awareness to the importance of recognizing this condition in an early state and to the new treatment options, such as biological response modifying drugs.
Amyotrophic Lateral Sclerosis: a case report. Diagnostic difficulties and treatment limitations.

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Introduction: Amyotrophic Lateral Sclerosis (ALS) is a rare, devastating neuromuscular disorder affecting motor cell function. Occurs in middle age adults, slightly more common in men. Dominant clinical features are progressive muscular weakness, spasticity and fasciculations. ALS is incurable, the clinical course is unpredictable with median survival of 3 years. Case description: 67-year-old woman with hypertension, dyslipidemia, obesity and stroke on 2009 without neurological sequels presented at emergency department with right hemiparesis grade 3+/5 and walk difficulty, over the last month without other neurological symptoms. No familial history of neuromuscular disease associated, she was admitted with the initial suspicious of stroke. Brain computer tomography was normal. Blood tests: hemogram, serum electrolytes, liver, thyroid and renal functions were normal. Tumour, viral and vasculitis screening tests were negative. Brain and cervical magnetic resonance image were unremarkable. One month later, she had an upper and lower right electromyography that revealed fasciculations in all members, it was assumed the diagnosis of ALS, ALSFRS score 35; she started treatment with Riluzole and multidisciplinary follow up. One year’s later, she lost her autonomy, the right hemiparesis progressed to tetraparesis with right dominance, right facial paralysis, tongue and shoulders fasciculations, muscular spasticity, dysphagia, dyspnea that needed supplementary oxygen therapy and non invasive ventilation, depression; ALSFRS score 14. Discussion: This case illustrates the usually delay of months from onset of symptoms to the diagnosis, related to the subtleness of the initial clinical manifestations. It's important a meticulous initial approach to establish an early diagnosis due to ALS dark prognosis. This was an ALS aggressive form with rapidly progress to autonomy loss and life-threatening events; unfortunately, we can’t control that progress we can only offer supportive care.
Introduction: Paget's disease is a bone disease that begins by its reabsorption, followed by excessive bone formation, causing deformation. It is usually asymptomatic and multifocal, being its accidental diagnosis.

Case Description: Female, 70 years old, independent, with a history of hypertension, type 2 diabetes mellitus, hyperthyroidism and meningitis in childhood. Calls to the emergency department for sudden deafness of the right ear, with no other associated complaints and without alterations on the physical examination. Therefore she was admitted to the care of Otorhinolaryngology for study. During the hospitalization was performed a nuclear magnetic resonance of the skull that identified a luxuriant left lesion extending in the frontoparietal, petrous areas of the mastoid and occipital, suggestive of Paget's disease, associated with a left parietal meningioma. The collaboration was requested from Internal Medicine, to guidance of the disease. Laboratory exams were unremarkable. At discharge, she maintained the hearing loss, without other complaints and was oriented to follow-up in internal medicine consultation.

Discussion: As in the vast majority of cases, Paget's disease is an accidental finding. This case excels by its exuberance in imagiologic terms, however, without visible bone deformation or equivalent analytical changes.
An atypical presentation of Guillain-Barré syndrome

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Introduction:
Guillain-Barré syndrome (GBS) is a clinical spectrum of an acute inflammatory demyelinating polyneuropathy. A possible common autoimmune mechanism has been described; the presence of the same antibody in different variants of GBS could explain the overlap syndrome.

Case description:
A 45-years-old woman, with flu-like symptoms, presented at the urgency with complains of difficult to swallow, perioral and peripheral paraesthesias with 24 hours evolution. At examination were noticed bilateral ptosis, diplopia, dysarthria and dysphagia. She progressed with flaccid tetraparesis, abolition of trunk reflexes, requiring mechanical ventilation and admission in the intensive care unit. A cranial computed tomography and an angiography were performed to exclude stroke. The lumbar puncture was inconclusive and the electromyogram was compatible with GBS. The treatment with intravenous immunoglobulin was started and repeated two weeks later. To rule out encephalitis an electroencephalogram and a head magnetic resonance imaging, were performed, both normal. The results of antiganglioside antibodies where positive for: GD1a, GT1a, GT1b, GD3 and GQ1b. Four weeks after the admission she started to improve gradually.

Discussion:
We report a case of a GBS with an “atypical” presentation. We admitted the overlap with Miller Fisher and the acute motor and sensory axonal neuropathy variant. The evolution with “locked-in syndrome like” let us to suspect of an overlap with Bickerstaff encephalitis. These three forms have been described together in literature and could explain this clinical presentation. A decisive factor in outcome of SGB cases is the early suspicion and rapid referral to a differentiated care unit.
An unexpected diagnosis

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Introduction: Multiple Myeloma corresponds to 10% of all hematologic cancers. It’s more common in middle age and the most frequent symptom is bone pain. The average life expectancy is between 1 and 10 years after the diagnosis.

Case Description: Woman, 70 years old, with a history of hypertension was referred to the emergency department for dyspnea and lower limb edema. On physical examination presented decreased pulmonary sounds in the lower third of the right pulmonary parenchyma and crepitations on the left. Laboratory tests showed acute renal injury, increased inflammatory parameters, NT-ProBNP and leukoproteinuria. Radiography and chest CT revealed right moderate pleural effusion and fracture, in consolidation, from the fourth to seventh right costal arches. Thoracocentesis was performed, with study of pleural fluid suggestive of exudate. Therefore, it was proposed hospitalization for acute renal injury correction and pleural effusion study. The workup carried out highlight a serum immunoelectrophoresis showing an IgG / Kappa monoclonal peak with increased free serum and urine Kappa light chains, moderate albuminuria, normal serum calcium and elevated B2microglobulin. The cranioencephalic CT exhibit extensive lytic lesions dispersed by cranial decay. Therefore, myelogram and spinal biopsy were performed, and confirmed the diagnosis of multiple myeloma.

Discussion: With this case we want to show that, multiple myeloma is a complex disease, that can present with several unspecific signs and symptoms.
An unexpected finding

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Introduction:
Aspergillus is a fungus that exists in the environment and is commonly isolated from both the outside and inside environments, including hospitals. It may be manifested by a variety of infectious and allergic diseases depending on the host's immune status and structural lung changes. The most frequently identified agent is Aspergillus fumigatus. This disease is part of a spectrum of clinical conditions caused by the inhalation of Aspergillus spores.

Case description:
A 75-year-old woman, caucasian, non-smoker, with a personal history arterial hypertension. No previous history of pulmonary tuberculosis or recurrent respiratory infections and no respiratory symptoms. Admitted to our hospital by proximal fracture of the right humerus after a road accident. During the hospitalization she underwent chest radiography, which showed nodular changes in the right upper lobe. CT of the thorax showed the presence of bronchiectasis in the apical segment of the right upper lobe, partially occupied by nodular hyperdensity. From the study performed, analytically without relevant changes, without peripheral eosinophilia and immunological and autoimmune study were negative. Microbiology and sputum smear microscopy were negative. Bronchoscopy without topographic or morphological alterations. However, with Aspergillus fumigatus isolation in the bronchoalveolar lavage and bronchial aspirate. Thus, we assumed the diagnosis of pauci-symptomatic pulmonary aspergilloma, and clinical surveillance and treatment was delayed.

Discussion:
Based on this clinical case, we highlight the most common and best-recognized form of pulmonary involvement due to Aspergillus. The authors intend to alert for its consideration in the differential diagnosis with other entities, thus requiring a high level of suspicion, especially when the patients are asymptomatic.
Introduction: Polycythemia vera (PV) is an acquired myeloproliferative disease characterized by an increase in the absolute number of erythrocytes. The annual incidence is estimated at about 1/36,000 - 1/100,000. PV occurs at all ages, but is more common in people between 50-70 years. It increases the risk of vaso-occlusive events, like stroke, which although unusual, may be the initial manifestation of this disease. These events are due to increased blood viscosity, platelet activation in the cerebral arterial vessels, and, although less frequently described, extrabrain embolic events.

Case report: The authors describe a case of a 53 year old man with a relevant personal history of atrial fibrillation (controlled ventricular response). He went to the emergency department with stroke suggestive clinic and was therefore hospitalized for an etiological study. He showed clinical and analytical alterations compatible with PV: Hb of 19g/dL, HTC of 58%, EPO 2.5 mU/mL, as well as aquagenic pruritus. The diagnosis was confirmed with the existence of the JAK2V617F mutation. He was treated with phlebotomy and hydration, having a symptomatic improvement.

Conclusion: Although cerebrovascular disease has several possibilities, only 15% of patients with PV have stroke as the initial manifestation, however, it is a hypothesis that, at the time of diagnosis, should be considered through laboratory alterations.
Analysis of mortality of Internal Medicine Department

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Background: Statistics on the causes of death form a significant part of information for public health. This analysis reflects the hospitalization mortality in our department during 2016.

Methods: It is a retrospective cross-sectional study of patients deceased between 1.1 - 31.12.2016. The primary objective was to evaluate main causes of death and associations of the non-communicable diseases with mortality.

Results: 288 patients died in 2016, 51% were males (n:148) and 48% females (n:140). The mean age of death was 73 years, the average length of a hospital stay was 12 days. The higher age, more increasing mortality. The most common leading cause of death were cardiovascular diseases (31%), from which the most dominant was cardiac failure (n:43). Gastrointestinal diseases were the second most frequent cause of death (20%), from which major one was liver cirrhosis (n:39). 3rd group were made by neoplasms(19%). Causes of death differentiate among age groups. In the lower age groups, gastrointestinal diseases prevailed in both sexes. Tumors began to appear among men after the 60th year, in women it was sooner after the 50th year. Cardiovascular diseases in patients over 80 years of age prevailed in both sexes. The average BMI of deceased patients was 33 kg/m2, diabetes mellitus was detected in 30%, alcohol abuse 21% and frailty 48% (PRISMA-7 criteria).

Conclusion: The results of analysis were similar to studies reported in our country, but there are some differences in other countries. Frailty is yet an unseen substantial co-morbidity.
Analyzing the mortality of an internal medicine unit

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Background: Nowadays the internal medicine wards have a lot of old and dependent people. It is essential that doctors analyze their patient’s deaths in order to improve clinical practice. It is also important, given the age and dependence of the patients, to analyze and decide which of them have a “do not resuscitate” (DNR) order.

Methods: We studied the deaths of the patients that were admitted during 2017 in a unit of an internal medicine service in a tertiary hospital.

Results: During 2017 our unit received 902 patient; 140 of them passed away (15,5%). The dead patients were 80,1 years old on average and were mostly men (53,6%). The most common causes of dead were pneumonia (72), metastatic cancer (12) and heart failure (8); 77% died from the disease that motivated hospitalization. Our patients had an average Charlson of 4,79; the most common comorbidities were hypertension (94), heart failure (58) and cancer (41). We also calculated mRankin scale: 73% were 4 or 5; only 4% were 1 ou 2. About readmissions, 22,9% had a hospital admission in the 30 days before and 40,7% had a hospital admission in the 6 months before. Another important data is that 11,4% were observed during hospitalization by the palliative care team and 27,1% were admitted for end of life care. If we look for the “do not resuscitate” label, we get this information: in 65% patients the medical team decided they were DNR at the admission; 27% didn't have any information about advanced life support (ALS) written by the medical team; 8% had indication for ALS at the admission. Besides that, during hospitalization the previous decision changed and at the time of death no patient had indication for ALS and this intervention wasn’t performed in any patient.

Conclusion: We conclude that our death patient are very dependent and normally don’t have indications for ALS; besides that it is important that the medical team is aware for the importance of deciding at the admission if the patient is DNR or not.
Attitude to the limitation of therapeutic effort in a tertiary hospital

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OBJETIVES
To determine the frequency, type and source of limited therapeutic effort (LTE). To determine the frequency of sedation and analgesia and do not resuscitate order (DNRO); survival after DNRO application and existence of differences in patients with and without LTE, and DNRO.

METHODS
Retrospective observational study with patients died of stroke from 1st January 2015 to 31th August 2016 at the Rafael Mendez Hospital. The clinical data of the patients, their evolution and the medical orders of the electronic medical records were collected.

RESULTS
Of the 485 patients admitted to neurology, 38 (7,23%) died. Women 21 (55,3%), mean age 82.21(+8). 27(71%) died for an ischemic event, 11 (29%) for bleeding. 35 patients (95%) had cardiovascular risk factors. The median NIHSS Score was 21 (15-24), hospital survival was 7 (3-10) days and the median Rankin Score 2.5 (0-4). Of the 38 patients who died, 23 (60.5%) presented some determinant of poor prognosis. LTE was indicated in 37 patients (97.36%); Type 1 in 27 (71.1%), type 2 LTE in 10 (26.3%). Of the LTE 1 highlighted the DNRO indicated in 18 patients, (47.4%). In 11 patients (30%) palliative sedation was indicated. The LTE motif in 92.1% was a poor prognosis. We saw differences in enolic habit (0%, 12.5%, p=0.05) and in the presence of sepsis (12.5%, 0%, p=0.05) between LTE and non-LTE patients. And in the presence of advanced heart failure (33.3%, 5%, p=0.024), and in the use of palliative sedation (50%, 15%, p=0.02) between patients with and without DNRO.

CONCLUSION
The LTE is a common practice in deaths from stroke in our service. The main LTE used is type 1 (do not apply active measures). There are important differences regarding the medical attitude in patients with LTE reflected in their clinical history and those who do not.
Austrian syndrome: report of a rare clinical entity with high mortality and morbidity

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Introduction
The triad of pneumococcal pneumonia, endocarditis and meningitis, known as Austrian Syndrome, is a rare entity nowadays. It is commonly seen in middle-aged alcoholic men and associated with a high mortality of 50-65%, even with appropriate antibiotic treatment.

Clinical report
We report a 67-year-old caucasian woman with no significant medical history, admitted in this unit for coma, leading to oro-tracheal intubation for persisting decrease in the Glasgow Coma Score (GCS) and respiratory distress. Clinical evaluation had no further findings, apart a GCS of 7, respiratory distress with a PaO2/FiO2 ratio of 108 and inspiratory crackles at the base of the lung on auscultation. White blood cell count was 17.9x10^9/L (94.7% of neutrophils cells) and C-reactive protein 39.1 mg/dL. Chest X-ray demonstrated opacification of the lower and superior right lobe and the analysis of the cerebrospinal fluid revealed 46 cells/mm3 (polymorphonuclear leukocytes), protein 1109 mg/dL and glucose 20 mg/dL (serum glucose 93 mg/dL). A transoesophageal echocardiogram demonstrated a vegetation of the anterior flap of the mitral valve. Blood and cerebrospinal fluid cultures were positive for Streptococcus pneumoniae. Under antibiotic with ceftriaxone, the patient remained in deep coma (GCS between 3 and 6) after 3 weeks, resolved the pneumonia and was under medical treatment for endocarditis. After the resolution of septic shock the patient was transferred to the infectious diseases unit on day 16 where she died of cardiac arrest 2 days after.

Conclusion
Besides increasing awareness of this relatively rare but life-threatening disease, this report also aims to highlight the potential for development of Austrian Syndrome in patients that do not have predisposing conditions. In our case the change in the mental status of our patient was atributed to severe sepsis due to pneumonia, so the diagnosis of pneumococcal meningitis and endocarditis was not immediately considered.
A 59-year-old male with medical history of hypertension, dyslipidemia, obesity, ischemic heart disease. The patient was admitted in January 2017 referring in the last two months constipation with loss of 8 kg, unspecific abdominal pain and one positive fecal occult blood test. A colonoscopy was performed without signs of neoplastic malignancies and resected two sessile polyps compatible with tubular adenomas with low grade epithelial dysplasia, a full body CT scan was also made in which a perivascular soft tissue mass that surrounds the infrarenal abdominal aorta as well as the inferior vena cava compatible with retroperitoneal fibrosis is found. A CT-guided needle aspiration biopsy of the mass was performed resulting in a non-specific chronic IgG-dependent inflammatory process without significant participation of IgG4 cells. There were no significant alterations in standard blood and autoimmunity tests, at this time steroid treatment was started with prednisone (1 mg/kg). Initially, the evolution was favorable allowing to reduce the dose of prednisone up to 7.5 mg daily, evidencing radiological improvement in control CT. After 6 months of treatment, in June 2017 he presents an episode of right obstructive uropathy secondary to retroperitoneal fibrosis that requires the placement of a double J ureteral catheter due to worsening of his renal function. A renogram was performed showing a normal left kidney function but moderate functional insufficiency of the right kidney, after that a PET-CT scan shows increased metabolic activity of periaortic soft tissue with extension till both iliac arteries suggestive of an active inflammatory process and also hypermetabolism of the aortic segment at the crural level without evidence of soft tissue activity. After the previous findings it is decided to start treatment with mycophenolate and progressive withdrawal of steroids with a stabilization of the patient's disease. This is a patient with non-IgG4-related retroperitoneal fibrosis.
Beyond the evidence: the role of the internist in complex cases

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We present the case of a 22-year-old woman with a history of intermittent abdominal pain. At the age of 21, she was diagnosed with facioscapulohumeral dystrophy. During follow-up by the neurologist, the patient reported recurrent episodes of abdominal pain since childhood that associated low-grade fever, nausea, vomiting, edema in forearms and hands and occasionally, in ankles and feet. She was referred to the gastroenterologist who performed routine tests which were normal. The patient then suffered a more severe episode which also associated an increased abdominal perimeter and was admitted into the hospital’s Internal Medicine department. The initial suspicion was acute intermittent porphyria as the rapid qualitative test for elevated porphobilinogen in urine was positive, but the patient did not improve with intravenous hemin and the 24h urine levels of porphyrins were normal, so it was excluded. No pathogenic mutations of the MEFV gene were found, so familial Mediterranean fever was also excluded. Finally, the presence of ascites together with the recurrence of the symptoms raised the possibility of hereditary angioedema. Levels of complement and C1 inhibitor were low, confirming the diagnosis. She was treated with recombinant human C1 inhibitor during the outbreak and started prophylactic treatment with tranexamic acid but suffered a relapse, so the treatment was changed to danazol with a positive outcome. The internist participates actively in most healthcare challenges, especially complex cases, but cannot always cover in depth all the knowledge available, so he must work as a team with other specialists. This case is an example of the role of the internist as a guarantor of comprehensive care in the hospital environment, offering a global vision and an integrated, patient-centered approach to reach the final diagnosis.
Body composition and brain atrophy among alcoholics

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Objectives: In neurodegenerative disorders or in normal aging humans relationships between fat mass, muscle mass and/or performance and brain volume have been reported, that are not dependent on age or other confounding factors. These kind of studies have not been performed in alcoholics, who frequently show altered fat deposition, muscle atrophy, and brain atrophy. Methods: We included 101 male patients aged 58.35 ± 11.59 years, and 44 controls, all of them workers of our hospital of similar age. Patients and controls underwent dominant handgrip assessment with a Collins’ dynamometer, whole body composition analysis by densitometry, and brain computed tomography (CT) examination, with further calculation of several indices indicative of brain atrophy. Results: Brain atrophy is not related to total fat amount. Total fat is not different among alcoholics and controls, but shows indeed marked differences in fat distribution. Alcoholics show increased trunk fat but less fat in arms, so the peripheral fat/trunk fat index was significantly different among alcoholics and controls. In contrast with fat there is a relationship between reduced lean mass and brain atrophy, and a close correlation between handgrip strength and brain atrophy, that is independent of age and liver function. Conclusion: Brain atrophy is common among alcoholics. As in other neurodegenerative conditions, there is a relationship between reduced lean mass and brain atrophy, and a close correlation between handgrip strength and brain atrophy, that is independent of age, duration of ethanol consumption and liver function, but no relation with total fat or fat distribution.
Introduction
Takotsubo cardiomyopathy (TC) is a rare cardiac syndrome most often occurring in post-menopausal women after an acute episode of severe emotional or physical stress. It has been described an association to psychiatric conditions that may not only predispose an individual to develop TC, but also exacerbate the psychiatric illnesses that have, in themselves, acutely triggered TC.

Case description
A 74-year-old Caucasian woman with hypertension, dyslipidemia and atrial fibrillation was admitted for increased agitation, aggressiveness, and persecutory delusions. Three months earlier, she had been hospitalized with the diagnosis of Takotsubo cardiomyopathy. At admission: analysis, electrocardiography and cranial computed tomography scan had no alterations. It was assumed to have acute confusion syndrome and was excluded causes of rapidly progressive dementia. It was performed lombar puncture and was excluded infection of the central nervous system. The electroencephalogram did not present paroxistic activity. Normal brain magnetic resonance imaging. Echocardiogram showed good systolic function, without segmental abnormalities. After about five days under risperidone, there was improvement of the complaints that led the patient to the hospital with self-criticism for delusions.

Discussion
This case shows an intimate relationship between the brain and the heart and wishes to emphasize the influence of psychiatric illness in the pathogenesis of TC, that may be an under-recognized association.
Bullous pemphigoid in a patient with pruritic skin lesions of long evolution

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Introduction
Pemphigoid diseases is an autoimmune disease characterized by subepidermal blisters at the level of the basement membrane. These include bullous pemphigoid, pemphigoid gestationis, linear IgA disease, cicatricial pemphigoid, lichen planus pemphigoides, anti-p200, anti-p105 and anti-p450 pemphigoid, epidermolysis bullosa acquisita, and bullous systemic lupus erythematosus.

Case description
A 77-year-old woman presented with generalized pruritus for more than four months that does not yield with oral antihistamine treatment. Small vesicular lesions, in small quantities and broken with crust on the extremities, back and scalp, are observed by Dermatology. BP230 antibodies with epidermal basal membrane pattern is observed in the autoimmunity study. This specificity is compatible with pemphigoid diseases. A skin biopsy of the skin is performed, which is reported by pathological anatomy as subepidermal bullous dermatitis and deposits of IgG and C3 in the basement membrane compatible with bullous pemphigoid.

Discussion
Bullous pemphigoid is the most common autoimmune dermatosis with subepidermal blistering in Central Europe and North America. It has an incidence of 1.3 to 4.2 new cases per year per 100000 inhabitants. The disease mainly affects older people and manifests clinically through swollen blisters. However, it can evolve for weeks and months without blistering. For this reason, bullous pemphigoid can be included in the differential diagnosis in older patients with pruritic skin changes of long duration. The autoantibodies in bullous pemphigoid are directed against the hemidesmosomal proteins BP180 and BP230. BP230 is a transmembrane glycoprotein that contributes its c-terminal domains to the anchoring of keratin filament systems and the N-terminal in hemidesmosomes.
Caso em branco

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Causes of an Elevated Vitamin B12 in Outpatient Settings: a Retrospective Study

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Background: Causes of vitamin B12 elevation (VB12E) have been previously reported in inpatients - however, evidence is scarce in ambulatory care. Our aim is to describe the distribution of known aetiologies of VB12E in an outpatient cohort and their one-year prognosis.

Methods: Retrospective cohort study. Adult outpatients with VB12E measured in our laboratory in September 2016 were included. We recorded demographic variables, comorbidities, known causes of VB12E at the moment of diagnosis and one-year prognostic outcomes (all-cause death or development of cancer).

Results: Of the 255 eligible patients, 200 were included - excluding 49 patients receiving treatment with cobalamin and 6 younger than 16 years-old. Sixty-eight patients (34%) had at least one identifiable cause in their medical history or after a basic workup: 13 neoplasms, 3 haematologic diseases, 14 hepatopathies, 24 nephropathies, 10 inflammatory diseases and 20 acute infections. One hundred and thirty-two patients (66%) did not have a known cause despite an initial evaluation. After one year follow-up, only two patients without a former diagnosis (1.5%) developed haematological malignancies (follicular lymphoma and acute myeloid leukemia) and none of them were diagnosed with solid tumors. There were no deaths in this group during the first year after the detection of VB12E, whereas seven patients (10.3%) died in the group with a known aetiology.

Conclusion: Most outpatients with VB12E do not suffer from malignant diseases at the moment of diagnosis. Patients without a known cause after a basic evaluation have a good one-year prognosis, with a low incidence of cancer. Further studies are needed in order to rationalize the approach to these patients.
Cerebral Amyloid Angiopathy – Differential diagnosis in a case of expression aphasia

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INTRODUCTION: Cerebral amyloid angiopathy (CAA) is characterized by the deposition of amyloid beta peptide within cerebral vessels, not associated with systemic amyloidosis. This disease is mostly asymptomatic and most common amongst the elderly. It can present as dementia, intracerebral hemorrhage and/or self-limited neurological symptoms. Lobar hemorrhage is the most common presentation.

CLINICAL CASE: 71 years old male, history of prolactinoma, medicated with bromocriptine, presents to the emergency department with a sudden onset expression aphasia. Cranioencephalic computed tomography (CE-CT) revealed a voluminous left frontal lobar hemorrhage with pronounced mass effect and deviation of medium line structures. Magnetic resonance also identified superficial hemosiderosis (typical finding of multiple microhemorrhages), making the CAA diagnosis probable. On the third day after hospital admission there was worsening of the expression aphasia and right hemiparesis. A new CE-CT revealed signs of re-hemorrhage. Two weeks later there was clinical and imagiological improvement. After 34 days of inpatient treatment, the patient recovered from the aphasia, regained muscular strength and walking ability and was discharged.

DISCUSSION: Although the CAA definite diagnosis can only be established post-mortem, the identification of signs of multiple cerebral hemorrhages on MRI, in patients over 60 years old, makes this diagnosis probable. Being a chronic disease, without specific treatment, the recommendations are to control blood pressure and use anticonvulsants. In this case report, the patient presented with lobar hemorrhage, which is associated with 11-32% mortality and mostly a favorable functional outcome. However, microhemorrhages and re-hemorrhage worsen the prognosis, leading to a greater mortality (up to 40%). CAA is a diagnosis to be considered in the elderly with lobar hemorrhage, in the absence of other risk factors.
Cervical dystonia: an uncommon disease on emergency department

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Introduction:
Cervical dystonia is a specific movement disorder that affects the head and neck producing a repetitive pattern of involuntary movements and posture which can be classified as torticollis, anterocollis, retrocollis and laterocollis. Its origin can be primary or secondary, to trauma, drugs reactions or neurodegenerative disorders. The treatment includes anticholinergics, dopaminergic drugs, benzodiazepines and muscle relaxants. In selected cases, botulinum neurotoxin injections and deep cerebral stimulation can be used to relieve symptoms.

Case description:
A forty-one years old man was admitted in the emergency department complaining of involuntary rotation movements of the head to the right. No history of trauma or new medication. Had personal history of kidney transplant sixteen years before, without other remarkable medical antecedents. He was prescribed with sirolimus 1mg, mycophenolate mofetil 1000mg, prednisolone 5mg, enapril 5mg, sinvastatin 10mg and clonidine 0.15mg. His physical examination was unremarkable except for an involuntary, spasmodic, rotational movement of the head to the right with small oscillation. Blood analysis, brain CT scan and MRI were normal. The diagnosis of cervical dystonia type torsicollis was admitted and treatment initiated.

Discussion:
Dystonia is an uncommon disorder that includes several symptoms from pain to postural abnormalities. The diagnosis is clinical but often delayed, which can have poor impact on patient’s health quality and daily activity. In this patient, it was important to recognize the clinical entity in order to exclude secondary causes of dystonia and begin adequate treatment.
Characteristics of hospital readmissions in an Internal Medicine Service of a general hospital.

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Objectives: To know and describe the readmissions rate of an Internal Medicine Service of a general hospital.

Material and methods: A retrospective study was carried out. Patients discharged in April and May 2016 and January and February 2017 in the Internal Medicine service of the Virgen de Valme University Hospital of Seville were included. A follow-up period of 30 days after discharge was established. Data were obtained from the digitized clinical history of each patient, complying with the confidentiality law of data. Patients who were transferred to another service, hospital or died during the first hospital episode were excluded. Hospital readmission is defined as hospital admission for any cause in the follow-up period.

Results: 830 patients were included, 16% were readmitted to 30 days of hospital discharge. 57% were males, 78 year, 71 - 85 years. 60% patients had a partner; 62% have economic incomes; 88% enjoyed good social support; 60% had no previous studies. 58% presented 3 or more comorbidities, 53% were independent for the daily activities. 41% were readmitted by cardiac diseases. 40% were readmitted for the same pathology as in the index episode and 26% for different reasons. 65.7% were readmitted in the first two weeks of the follow-up period. Urgent readmissions were the most prevalent, 86.8% patients. 68.4% patients were reevaluated during the follow-up period

Discussion: Our results are similar to the previously reported in the literature (estimate rate of hospital readmissions between 15 and 25%). We proposed as a strategy to improve the quality of care: to study modifiable factors to reduce the rate of avoidable readmissions.

Conclusions: the majority of the readmissions correspond to the elderly male patients and with an important comorbidity. Cardiovascular diseases were the most frequent pathology. Most of them have a partner and are retired; They have adequate social support, autonomy for daily activities and good therapeutic compliance.
Choosing wisely in case of multimorbidity

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Introduction:
The therapy in case of multimorbidity is uncalculable, in spite of a successful start in therapy, the complexity of different organic diseases can change all therapy completely.

Case description:
Anamnesis:
Inpatient clinical stay of a 70 year old female patient with severe community acquired pneumonia, (headache, fever, exsiccosis).
Anamnestic:chronic heart failure NYHA II-III by ischämic and hypertensive heart disease,actually compensated, chronic renal insufficience, multifactorial anaemia, hypertension.
Physical status:
Poor state of general condition, nutritional state poor, (BMI 19kg/m2),Cor und Pulmo:pronounced dyspnoea, arrhytmia, heart sounds normal,heart rate 112/min, RR: 150/85mmHg, normal abdominal state, extremities: slight leg edema, normal pulses. Normal neurological state.
Laboratory examinations:
Striking laboratory values: CRP> 120g/dl, Hb: 8,2 g/dl, Crea 4,8 GFR 46ml,
Diagnostic: X-Ray pulmo: pneumonia lower lobe left
Therapy and progress:
At first i.v. antibiotic therapy, (Ampicillin and Sulbactam) and infusions. After three days stabilisation. Small improvement of general state, starting mobilisation. Day 5 fall with femoral neck fracture left.
Hip surgery, postoperative, cardial decompensation, decrease in hemoglobine, transfusions, renal decompensation, acute kidney failure.Very poor general state.
Patient and relatives refuse dialysis and intesive care.
Palliative care and pain therapy. On day 12 the patient died.
Discussion:
The case report shows impressively the changing in therapy in case of multimorbidity. Choosing wisely with respect to the complications and general state is a great challenge and needs a balance between medical decision and medical ethical decision.
Clinical reasoning as a way to solve a complex case

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Introduction
Soft tissue sarcomas have an annual incidence between 1.4 to 5 cases per 100000. Within the leiomyosarcoma variety, cutaneous localization as a primary tumor is infrequent, especially important if it is the subcutaneous subtype, as our case, with a higher rate of recurrences and metastasis, hence its prognostic importance.

Case descriptions
A 60-years-old Ghana nature previously healthy man consulted for cough, dyspnea, abdominal pain and fever of 39°C since two days. On physical examination, we found disseminated crackles and hypophonosis in both lungs and a scar in the right costal area. The imaging studies showed us several solid hypoechogenic masses in both lung parenchymas that explained the exploratory findings. He did not have other studies to compare and radiology thought in neoplasia as a first option. The only antecedent is a surgery of chest wall mass six month ago, which anatomopathological results (FNAP) concluded cells with non-atypical features. So, we looked for information about the surgery: the piece was described as a cerebriform mass, which gave us the clue to continue investigating. We reevaluated it, this time with biopsy. The tumor cells had nuclear atypia and were immunoreactive for AML, vimentina, caldesmon y desmina, and negative for S100. With these results, it was diagnosed with leiomyosarcoma and, the lung lesions, were metastasis.

Discussion
According to our oncological knowledge and the patient's history and anamnesis, we decided to doubt about the veracity of previous anatomopathological results (FNAP). Therefore, we expanded the study of previous surgical piece with a more adequate test: the biopsy, reaching the diagnosis of leiomyosarcoma. Since, we want to emphasize the importance of assessing the patient global way and the need to pursue a reasoned diagnosis.
Comorbidities influence, of patients admitted to Internal Medicine, on the echocardiography window in VSCARDIO study cohort

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OBJECTIVE: To analyze the clinical-pathological characteristics of patients who were asked for an echocardiography according to the criteria of an internist. In this poster we focused our attention on the different comorbidities that patients presented and we tried to determine which of them predispose to a worse echographic window.

MATERIAL AND METHODS: Observational study of prospective cohorts in which a randomized sample of 200 patients who had been assessed by internal M was selected and an echocardiography was requested during their hospitalization between Feb’17 to Feb’18.

RESULTS: 51% women. The average age was 73.4 years, with 94.5% of patients older than 50 years. 81.2% were sick people who led independent lives. 62.5% of the patients had not been hospitalized in the last year of the rest, 31.3% had only required an income compared.
Cardiovascular Risk Factors: 71.1% arterial hypertension (ATH), 41.2% diabetic and 46.2% dyslipidemic patients; 42.5% had CHF. Only 7.1% was recognized as a smoker, and 19.4% ex-smokers. Of the total sample, had resulted in a coronary event throughout his life 12.7%.

Of the total number of patients, 41.6% had acute respiratory failure (ARF), with more than half of the patients (54.4%) requiring oxygen therapy during admission. With an acute renal failure (RF), 26.1% of the patients studied.

If we analyze the predisposition to a worse window according to the different variables studied, we obtain significance in those patients who have suffered ATH (p=0.36), RF (p=0.34), ARF (p=0.11), Oxygen therapy (p=0.008). Likewise, we found a p close to the significance in the variables: obesity (p=0.105), active smoker (p=0.064), COPD (p=0.108).

CONCLUSIONS: In this sample, almost half had CHF and several CVRFs such as HTA or DM were in a large percentage. Suffering more than 40% ARF. Among the comorbidities studied we found a clear predisposition in patients who have suffered ATH, RF, ARF and Oxygen therapy to have a worse echographic window.
Constitutional Syndrome and progressive neurological clinic due to occupational poisoning by mercury

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INTRODUCTION:
Occupational poisoning by mercury is an infrequent entity described in literature, showed in that people who works manipulating and inhaling steam of acetaldehyde.

CASE DESCRIPTION:
A 46 year-old male with this personal background: smoker 2 packs per day and and psicotic attack ten years ago. He worked in a recycling company.

Four months before admission, he had started with a inespecific neurological clinic consisting on dysesthesias in inferior members, parasit visual hallucinations, anorexia and constitutional syndrome with 25 Kilogram weight lost in two months. In the last days, this case were associated with an altered level of consciousness progressing unfavorabled in a short time and in the end he had been in a coma.

He was hospitalized at intensive care unit(ICU). Orotracheal intubation, mechanical ventilation as well as vasoactive drugs were required. Tremor, fluctuating level of consciousness, mutism and perioral myoclonias were observed in a physical examination.

After leave ICU, he was admited in Internal Medicine service and many tests were realized: craneus CT and MRI scaners, electroencephalogram, electromyography, complete blood test, including vitamin profile and viral serology, and cerebrospinal fluid (CSF) analysis. Mild sensory polyneuropathy in electromyography and 70 cells (neutrophils all of them) high proteins and low glucose levels in CSF were showed.

Because of the patient was smoking while he was manipulating alkaline and car batteries, which are made of heavy metals, the internist started to suspect a case of occupational poisoning by mercury. For this reason, he applied for the heavy metals levels in blood and urine, which were triple of the normal value.

DISCUSSION:
Poisoning by heavy metals should be taken into account in the case of young people who had undergone a rapidly progressive cognitive decline, being very important to ask for their work environment and its connexion to toxic occupational exposure.
Data Safety Monitoring Committee (DSMC) in clinical trials with mentally disabled subjects: a critical gap-analysis of the current regulatory guidance documents

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Objectives: Due to considerable progress in the research of disabling mental disorders the number of clinical trials with mentally disabled subjects increases. However, a clinical trial in subjects not able to give informed consent is one of the most sensitive situations in clinical research. In order to protect the study participants, to balance the interests of sponsor and the general public against the individual risk a DSMC is mandatory for such studies. The DSMC is a group of experts monitoring safety and efficacy of an ongoing study using unblinded interims data.

Methods: DSMC guidelines and other literature sources were reviewed. Recommendations specifically targeted to mentally disabled subjects (or vulnerable subjects) were summarized and critically analyzed for adequateness, practicability and reliability.

Results: In opposite to the great sensitivity of the matter, the guidance documents provide very little to none specific recommendations for DSMC work in clinical trials with mentally disabled subjects. Guidance for important aspects such as how to create greatest possible independence to the sponsor and to the involved clinical investigators, sponsor independent source data review, additional non-clinical ethical support to protect the individual patient’s rights etc., are widely lacking. Further examples for relevant deficiencies, but also for mitigation strategies are given in the poster.

Conclusion: The demands for the DSMC in a clinical trial with mentally disabled subjects are greater and broader than usual. To fulfil its ethical responsibilities unquestionable and unanimously various specific, additional measures must be implemented which are not or not adequately covered in the current guidance documents.
**Descriptive study of patients admitted in Intensive Care Unit (ICU) from Internal Medicine in a tertiary hospital in Alcalá de Henares (Madrid).**

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**OBJECTIVE:**
To analyze the characteristics and needs of patients moved from Internal Medicine to ICU.

**METHODS:**
It’s a descriptive, observational and retrospective study from patients who were moved from Internal Medicine hospitalisation to ICU, between 2012 to 2017, in the Principe de Asturias Hospital.
clinical and epidemiological features has been studied, causes of derivation, days of admission and APACHE scale. It has been used SPSS V.18.

**RESULTS:**
There were 185 cases, related to 178 patients (5 patients were admitted several times in the ICU). It made up 4.6% of all the hospitalized patients in ICU in the years that were analyzed.
The average age was 69 years old, with a similar distribution between gender (male, 53.5%). The causes of derivation were acute respiratory insufficiency (42.7%), followed by hemodynamic instability (26.4%), mainly for septic shock (12.4% of all), cardiogenic shock (5.4%), or hypovolemic shock (4.9%). Other important causes were coma (9%), cardiac arrest (4.9%) or cardiological disorders such as acute coronary syndrome (7%) or bradicardia (5.4%).
Most of the admissions were during winter, especially in January (15%). Active support has been required in 47.7%, invasive mechanical ventilation in 34%. However, up to the 33.5% of patients only needed NIMV.
The average hospital stay was 10.87 days. The mortality was 30.3%. In relation to APACHE scale, the scoring was: 0-9 points, 19 patients (10.5% deaths); 10-19 points, 93 patients (13.97% deaths); 20-29 points, 56 patients (54.5% deaths); > 30 points, 17 patients (64.7% deaths).

**CONCLUSION:**
The complexity of the patients from Internal Medicine is very high. The most frequent causes of derivation were respiratory, infectious and cardiovascular disorders. One third of patients could be treated with intermediate measures, and could avoid admission to ICU. These patients usually had a poor prognosis before admission, that means a very high mortality (one third of patients in our cohort).
Do early handoffs in internal medicine wards affect the quality and cost of care?

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Objectives
Continuity of care is a key feature for high quality of care. To maintain the continuity of care of patients in the hospital, physicians conduct handoffs to transfer both patient information and accountability from one provider to another. Prior studies show that handoffs are associated with an increased risk of complications and an increased length of stay. We were interested in studying the association between early handoffs (handoffs occurring between residents within the first 72 hours of a patient's admission) and length of stay (LOS), use of resources (number of blood tests and procedures) and incidence of major complication (transfers to ICU/ intermediate care unit or death).

Methods:
This is a retrospective cohort study of adult patients admitted to the General Internal Medicine Ward of Geneva University Hospital between 2012 and 2014, with a LOS > 72 hours. We compared patients admitted by physicians other than the usual day team with patients who were admitted by the usual day team in univariate and multivariate linear and logistic regression models. Our outcomes were LOS, use of resources, and incidence of major complications. We adjusted the models for potential cofounders.

Results
We included 11'869 patients, 38% of whom were in the early handoff group. Early handoff was independently associated with an increase of LOS (+6.4%, 95% CI of 3.5-9.5, p<0.001). Although early handoffs were not significantly associated with a higher use of resources, they were associated with an increased rate of major complications (OR=1.3, 95% CI of 1.1-1.7, p=0.012). In our subgroup analysis, the association between early handoff and increased LOS were not statistically significant when the admission occurred on a public holiday.

Conclusion
Among patients admitted in our internal general medicine division, early handoffs were associated with significantly longer length of stay and major complication rate, but not in patients admitted on public holidays.
Epileptic status in non-infectious meningoencephalitis.

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INTRODUCTION: Convulsive status epilepticus is defined as a general or focal epileptic seizure that lasts more than 5 min or recurrent seizures without regaining consciousness between seizures. Status epilepticus is a life-threatening condition caused by underlying pathologies.

DESCRIPTION: 67-year-old patient with a personal history of antiphospholipid syndrome in follow-up due to neurology and mesangial glomerulonephritis, which activates Ictus code due to acute aphasia and weakness in MMII, with progressive worsening, repetitive generalized clonic seizures with need for antiepileptic drugs, Glasgow 5 / 15 in need of Orotracheal Intubation and invasive mechanical ventilation. Pathological clear cerebrospinal fluid (CSF) obtaining 35 cells, 95% mononuclear with glucose consumption and hyperproteinorrachia. Negative culture for bacteria, viruses and fungi. Polymerase chain reaction for virus in negative CSF. Computed tomography and normal cranial magnetic resonance. Electromyogram corresponds to polyneuropathy of the critical patient. Electromyogram: status in regression. Negative autoimmunity. Given the possibility of demyelinating aseptic encephalitis, corticoid treatment is started with progressive clinical improvement.

DISCUSSION: The diagnosis of a patient with aseptic meningitis can be difficult due to the great variety of potential etiological agents and the superposition between self-limiting viral diseases and potentially fatal bacterial infections, excluding other autoimmune, drug and neoplastic.
Erythema annulare centrifugum and malignant carcinoid tumour: A paraneoplastic manifestation?

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A 76-year-old man consulted for pruritic erythematous-desquamative skin lesions with circinate reinforcement of cyclic course in several body areas. Patient reported hyporexia without weight loss with good functional status. Physical examination showed pruritic erythematous desquamative plaques of 1x1cm. Laboratory tests showed ESR 68mm, CRP 6.5 mg/l and positive autoantibodies (ANA 1/80 and Anti-DNA 28IU/ml), complement C3 and C4 within normal values. Cutaneous lupus erythematosus was suspected and hydroxychloroquine and prednisone was initiated with improvement of the lesions.

After 5 months of treatment skin lesions persisted. Skin biopsy was performed showing centrifugal annular erythema (CAE). Etiological study was undertaken including screening for infections and neoplasms. The biochemical study revealed a pathological elevation of chromogranin A and enolase. A CT scan revealed a mesenteric mass and a lesion in distal ileum suggestive of metastatic carcinoid tumor. Octreoscan showed intense expression of somatostatin receptors. Excision of the lesion was performed resulting in a low-grade neuroendocrine neoplasia (carcinoid tumor).

Discussion

CAE consists of palpable migratory erythema with annular erythematous lesions that migrate centrifugally. It usually occurs in adults with a peak incidence around 50 years. It is idiopathic but can be associated with infections, neoplasms and autoimmune diseases. In published series, it is described that patients presented resolution of the CAE after optimal treatment of the underlying pathology. From there, the possibility of the existence of a paraneoplastic centrifugal annular erythema, consequence of the release of cytokines and growth factors associated with the tumor. In our case, after surgery the patient reported complete disappearance of the cutaneous clinic, which suggests the close relationship between carcinoid tumor and CAE.

Evaluation of the Degree of Inpatient Dependence in the Internal Medicine Service - Retrospective Study

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Introduction
Given the current aging of the world population, the growing number of older people is reflected in the hospital reality. These patients are complex, with high comorbidities and dependence.

Objectives
It is intended to determine the degree of functional dependence of patients admitted to the Internal Medicine Service and its impact on length of hospital stay and mortality.

Methods
Retrospective study included 547 patients hospitalized for medical care from January 2016 to December 2017. Patients were assessed according to the Barthel scale and graded (autonomous, mild, moderate, severe or total dependence).

Results
There were 547 patients, mean age of 76.4 years, of which 53% were men. Women were older (79.5 years), although with less co-morbidities (9.13 secondary diagnoses versus 9.72, respectively). More than 25% of patients had degree of autonomy from severe to totally dependent. The mean age of these patients was 82 years. In patients > 65 years of age (82% of patients), it was found that > 70% of the patients had some degree of dependence. There were no significant differences in mean length of hospital stay in the different groups. The mortality rate was 11.9%, with > 50% of deaths belonging to patients with degree of autonomy from severe to totally dependent. This subgroup of patients presented mortality rates of 20% and 26%, respectively. The main diagnosis in these patients was pneumonia.

Conclusions
About 65% of patients admitted to the Internal Medicine Service have some degree of dependence and > 25% have severe to total dependence. There were no differences between the mean length of hospital stay in these patients. Relative mortality rates were higher in patients with high levels of dependence. This study demonstrates the need for adaptation of the Internal Medicine Services to patients with high dependence, with the objective of adapting the care provided, improving the outcome of these patients.
Everything is not always what it seems

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Introduction
Patients who have received an organ transplant are becoming more frequent every year in Europe. It’s a priority, therefore, to take into account its complications. On the other hand, Primary central nervous system lymphoma (PCNSL) is increasing its frequency, being immunodeficiency its main predisposing factor.

Case description
A 77 years old male with a history of heart transplant in 1999 (treated with everolimus, mycophenolate mofetil and prednisone), lung epidermoid carcinoma operated in 2011 and cutaneous epidermoid carcinomas, develops irritability and weakness in lower and upper members. A contrast enhanced CT is performed which shows multiple intracranial mass with ring enhancement pattern, being identified by the radiologist as metastasis. Patient is hospitalized and a body-CT, oral endoscopy and a colonoscopy are performed, showing no primary lesion and negative serological studies. A contrast enhanced MRI is made compatible with metastasis or infectious abscess, treatment with dexamethasone was started and a cerebral biopsy was performed, showing infiltration with diffuse large B cell lymphomas, with CIHQ positive to EBV and CD20.

Discussion
PCNSL is an extranodal non-Hodgkin lymphoma that involves the brain, leptomeninges, eyes, or spinal cord without evidence of systemic disease. The main predisposing factor is immunosuppression, (HIV infection, iatrogenic or congenital immune suppression). The diagnosis is usually reached through cerebral stereotactic biopsy, which could be negativized by treatment with corticoestroidos. In our case PCNSL was not the first diagnostic option because transplant was 20 years ago and masses were multiple, so we started dexamethasone, having a positive biopsy even though.
Febrile iatrogenia

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INTRODUCTION: Pharmacological fever is characterized by a febrile response that coincides with the administration of a drug and that disappears after its discontinuation, in the absence of another plausible cause.

CASE DESCRIPTION: 56 year old male patient, with history of hypertension and alcoholism. Brought to the ED by convulsive crisis in the context of alcohol withdrawal. Admitted in the intensive care unit (ICU) for status epilepticus with need of sedation and orotracheal intubation. Excluded infection of the central nervous system and vascular or neoplastic brain lesions. He was diagnosed with aspiration pneumonia, successfully treated with antibiotic therapy. Resolution of the neurological status after introduction of levetiracetam and benzodiazepines. Recurrence of fever in 8th day of hospitalization, without clinical signs or symptoms of infection. No relevant epidemiological context. Blood analyses with de novo normocytic / normochromic hypoproliferative anemia and thrombocytosis, without leukocytosis. Erythrocyte sedimentation rate of 89 mm/1 h and ferritin level of 731.7 ng/ml. Several sets of blood and urine cultures were negative. Serologies of Coxiella and Brucella were negative. Chest CT without pulmonary parenchymal lesions. Abdominal ultrasound without alterations and echocardiogram showed no evidence of vegetations, abscesses or valvular dysfunctions. Ecodoppler of the temporal arteries was normal. After therapeutic review, ranitidine was withdrawn, with subsequent apirexia and normalization of the analytical alterations.

DISCUSSION: Pharmacological fever is a cause of fever of unknown origin, being a diagnosis of exclusion - its confirmation comes from the resolution of fever after suspension of the drug. There are few cases reported in the literature and the drugs most frequently described are beta-lactamics, sulfonamides and antihistamines. The exact mechanism of pharmacological fever is unknown.
Fever of (Un)known Origin – 30 years/30 days/30pack-year later?

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INTRODUCTION:
The three main causes for fever of unknown origin (FUO) are infectious, autoimmune and neoplastic disorders.
The following report considers a patient who has risk factors for all of the previous, presenting a challenge to the differential diagnosis.

CASE DESCRIPTION:
A 65 year old male, with a known history of Systemic Lupus Erythematosus (SLE) (diagnosed 30 years ago), active smoker (30 pack-year), and a recent Myocardial Infarction (30 days). Under antiplatelet and immunosuppressive therapy.
He was readmitted in the Cardiology Unit a month after being hospitalized with a heart stroke, with an acute coronary syndrome type 2, consequence of an acute gastrointestinal hemorrhage.
His medication was suspended and he received 4 blood transfusions.
Clinically stable and three days later he starts having fever pikes, without a distinctive pattern and with no accompanying physical signs or symptoms.
Blood work revealed a small rise of inflammatory parameters and an elevated erythrocyte sedimentation rate. No other relevant test results.
He started empirical antibiotherapy for 7 days and no clinical change was obtained.
When reviewing the in-hospital medication, we realize that he is not taking his usual SLE drugs.
Four days later he is apyretic and is discharged with his usual medication.

DISCUSSION:
The presence of FUO, can seem to be a real challenge, specially when we have a patient without accompanying symptoms and in whom we can consider such a broad spectrum of pathologies, from nosocomial infections, endocarditis, to bloodborne, autoimmune and neoplastic diseases.
In this case, we took a holt in our work up, before progressing to other exams, with their inherent costs and risks, and reviewed the clinical history and bumped on the answer, which was there all along, proving once again that it's crucial to have a good clinical history taken.
Fever is one of the most frequent clinical signs but it is also one of the most non-specific. Male patient, 68 years old, Caucasian, with no relevant personal history. He used the Emergency Department (SU) for a 4-day course of fever on the order of 38-39 °C, with no time for antipyretics, without another accompanying complaint. At entry without changes of relief to the objective exam but laboratory leukocytosis with neutrophilia, PCR 54.4 mg/L and urine II with leukocyturia and positive nitrites. He collected blood cultures and uroculture and was admitted to the Medicine Service for febrile syndrome. At the time of hospitalization he started empirical antibiotic therapy with Ceftriaxone and at day 2, Klebsiella pneumoniae multisensitivity was isolated in blood cultures. In order to investigate the clinical picture, he underwent abdominal and pelvic computed tomography (APC), which showed a massive hepatic lesion in the right lobe suggestive of abscess / secundarism, with 11 x 9 x 6 cm. The case was discussed with hepatobiliary surgery that indicated the maintenance of antibiotic therapy and imaging reevaluation. He fulfilled 14 days of intravenous antibiotic therapy and was discharged to the consultation of hepatobiliary surgery, with maintenance of therapy. He repeated CT scans that documented maintenance of hepatic lesion of similar dimensions, and he was submitted to hepatectomy of segment VI, whose piece was compatible with hepatic abscess with organization areas. This case has several aspects that make it peculiar: until the 1980s E. coli was the main microorganism responsible for this infectious pathology, since then the paradigm has changed and K. pneumoniae infections have been described more frequently; the development of hepatic abscess is more frequent in individuals with previous pathology that confers some degree of immunosuppression, unlike the clinical case presented and lastly the need for hepatectomy to resolve the infectious condition is rare.
Fracture of the tibial malleolus, a complicated history.

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INTRODUCTION
Description of a case of pyomyositis after a tibial malleolus fracture.

CASE DESCRIPTION
We present a 70 year old woman with a history of hypertension, dyslipidemia. After suffering a fracture of the left tibial malleolus, it presents flictenas in the dorsum of the left foot with necrosis of the subcutaneous cellular tissue in the back, side face and plant of the same. And painful swelling on the anteromedial aspect of the right thigh. Not having a fever. In the emergency room, surgical debridement of left foot lesions is performed, samples are sent for culture, empiric antibiotic treatment is initiated with Piperazilina/Tazobactam and Vancomycin. A lower limb CT scan revealed a loss of definition of the superficial fascias of the muscles and aponeurotic planes of the right thigh and small collections in the rectus inner muscle with peripheral enhancement. A Clindamycin-sensitive Streptococcus pyogenes was isolated from the surgical specimens, and empiric antibiotic therapy was discontinued and Clindamycin 600 mg c / 8 h was started for 4 weeks. Diagnosing the patient of pyomyositis by S. pyogenes. After 4 days, a control CT was performed showing new collections organized in the Gracilis and Sartorio right muscles, requiring drainage by suction puncture guided by ultrasound. Being the subsequent favorable evolution.

DISCUSSION
- Within the differential diagnosis of pyomyositis we must consider necrotizing fasciitis, gas gangrene and viral or parasitic myositis.
- Your treatment requires antibiotic coverage for Staphylococcus aureus, gam negative bacilli and anaerobes. And in many cases surgical drainage of abscesses.
INTRODUCTION:
Language disorders are often associated with stroke, while memory disturbances are usually related to dementia. However, both conditions can be associated with seizures or migraines, or may even involve the diagnosis of a neoplasm.

CASE DESCRIPTION:
The authors describe the cases of 2 patients hospitalized for study of brain lesions.
1st case: 77-year-old autonomous woman, with previous history of hypertension, atrial fibrillation and dyslipidemia, who presented with memory and speech disorders with 3 weeks of evolution. The cranial tomography (CT) revealed a left frontal corticossubcortical cystic lesion, with associated edema, exerting mass effect on the lateral ventricle. She performed thoracoabdominopelvic tomography, endoscopic studies, endovaginal ultrasound and mammography, which revealed no alterations. She underwent for surgical removal of the brain lesion, whose histology was compatible with an anaplastic oligodendroglioma.
2nd case: 42-year-old healthy autonomous woman (besides a depressive syndrome with 1 year of evolution, related to her divorce). She presented with asthenia, confusion, difficulty in performing daily tasks, memory and speech disorders ongoing for 2 months. The onset of a left frontoparietal headache led to a CT, which revealed 2 expansive left lesions, temporal and occipital, with associated edema, conditioning ventricular molding and midline deviation. The study performed to detect a possible primary lesion was negative. Surgical biopsy of the temporal lesion was done, with the histology demonstrating a diffuse large B-cell lymphoma.

DISCUSSION:
Although less frequent than metastasis, primary brain tumours are a differential diagnosis to consider. Histologic examination is essential since similar clinical presentations and imaging features may result from distinct neoplasms.
From Galaxy to Bedside diagnosis: improving the patient safety

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OBJECTIVES
In our hospital, the medical information is digitalized since 2012 and included in a program called Mambrino XXI with a specific box for drug allergy. This information is automatically discharged in the program for drug prescription called “FarmaTools”, and it allows the pharmacologist to know the alert information before the electronic treatment validation for inpatients.

The objective was to review the information registered in Mambrino XXI and its correlation with FarmaTools.

METHODS
A descriptive study was made in Hospital La Mancha Centro (Alcázar de San Juan, Spain) from October 2017 to March 2018. The recruitment criteria were to be admitted in charge of a specific internist and to have a drug allergy. The information was collected from the inpatients and their family, the medical history, Mambrino XXI and FarmaTools.

RESULTS
A total of 39 patients were included. They were 17 men and 22 women, with median age of 78.3 and average stay of 9.1 days. The most frequent allergy was penicillin (36%) followed by pyrazolone (15%) and iodinated contrast (10%).

We had information about the allergic reaction in 26 cases. The most frequent was the anaphylactic reaction (6 inpatients, 15%) followed by dyspnea (13%) and adverse reaction after muscular injection (13%). The drugs responsible for anaphylactic reactions were quinolones (2 cases), pyrazolones (2) and iodinated contrast (2).

As recommended in the Spanish guide for anaphylaxis (called GALAXIA), it is essential to realize a correct diagnosis and treatment in order to avoid the drug involved. FarmaTools provide us two mechanisms. First, the pharmacologist can see the alert and give us advice in case we prescribe the drug. Second, the physician can fill by hand the box in FarmaTools and choose the therapeutic group so an automatic alert is created if we select a drug of that group.

CONCLUSION
A correct update of the electronic allergy alert can help us to prevent drug mistakes and improve the patient safety.
Future Challenges and Uncertainty When Restructuring the Primary Health Care system in Greece to be serviced mainly by General Practitioners than Internists

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The health sector in Greece is based on a public/private mix. It is comprised of three distinctive sub-systems, namely: (a) the National Health System (NHS) providing hospital care throughout the country and primary care coverage in rural areas and (b) the Social Insurance Organization covering different professional groups and (c) the private sector, reflecting a totally competitive market. Funding of services, as well as the criteria for remuneration of providers, vary among these three subsystems. The NHS is funded by general taxation and insurance premiums. The insurance organizations are funded through contributions from employers and employees, while the private sector is funded either by social insurance contributions or by private payments and private insurance.

Recently the Government announced the inauguration of a large-scale transformation of the primary health system that is revising the service packages and the contractual arrangements and conditions for every health unit. This plan requires the development of a short-term re-training program for general practitioners and revision of the curriculum for post-graduate training of general practitioners because it is designed at most to be serviced by this medical specialty. Internists will participate in the transition time until the required number of general practitioners will reach the target set. We believe that this decision by the Greek authorities will be potentially harmful for the national healthcare provision, as they chose unwisely to prefer the less equipped knowledge and experience of general practitioners than internists.

Therefore, quick action has to be taken by the European Union since it remains the financial source to fund the new primary care plan for Greece as a part of the Strengthening Capacity for Universal Coverage, Phase 2 action, which contributes to improving health and health equity in Greece, especially among the most vulnerable in the crisis-stricken population.
Introduction
The vascular ectasia of the gastric antrum (GAVE) is a rare cause of gastrointestinal bleeding counting for about 4% of the causes of upper gastrointestinal bleeding (UGB) not attributable to varicose veins. Typical presentations of this condition range from asymptomatic to severe iron deficiency anemia.

Case description
The authors present the case of a 68-year-old man with a history of hypertension, chronic kidney disease (CKD) in stage 5, anemia and prostate adenocarcinoma. The patient was hospitalized in the Internal Medicine department for worsening of his anemia associated with gastrointestinal bleeding losses. The patient featured a 6.0 g/dL hemoglobin, iron 36 µg/dL, ferritin 113 ng/mL, iron binding capacity of 307 µg/dL and transferrin saturation of 11.7%, vitamin B12 of 776 pg/mL, folate > 20 ng/mL and reticulocytes of 5.5%. The patient carried out upper gastrointestinal endoscopy (UGE) and low (LGE). The UGE showed mosaic pattern on the body and gastric antrum and the gastric biopsy revealed signs of atrophic gastropathy. The LGE showed no major injury. The study was complemented with endoscopic videocapsule which revealed a GAVE, abundant bleeding in the pylorus-duodenum transition and non-bleeding hemorrhagic angioectasias in various parts of the small intestine. The patient repeated again the UGE and this time it showed a GAVE pattern for which the patient carried out treatment with argon plasma, returning to its usual level of hemoglobin at the time of the discharge.

Discussion
We highlight the importance of this case in the perseverant search for a rare and misdiagnosed cause of anemia, especially in a patient with CK. We also discussed the diagnosis role of the endoscopic videocapsule. This case also demonstrates the limited value of the biopsy in GAVE since the disease has space limitation. Thus, the diagnosis essentially relies on the ecstatic endoscopic vessel aspect limited to the antrum which distinguishes it from other conditions.
Global transient amnesia: a case report

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Introduction: Global Transient Amnesia (GTA) is a Clinical Syndrome characterized by the sudden onset of anterograde and retrograde amnesia, without permanent neurologic impairment. The clinical recover completely within 2-24 hours. It seems to be implicated vascular or epileptic factors, with transitory dysfunction of mediobasal temporal region, hippocampal or parahippocampal gyri. Despite being considered a benign condition, with good clinical and cognitive recovery, there is still few studies regarding the pathophysiology of this syndrome. Case description: A 65-year-old Caucasian woman, without known cardiovascular risk factors or epilepsy, presented on emergency department with a complaint of confusion and forgetfulness. She was awake this morning enjoying her baseline state of generally good health when, suddenly her husband found her confused, disoriented, and asking ‘repetitive questions’. There wasn’t associated to other neurological symptoms, despite her past history of migraines with visual and sensitive aura. The study, including laboratory investigations, Electrocardiogram, CT and MRI of Brain, study ruled out vascular, toxicologic and epileptic etiology. The patient returned to her baseline normal neurologic state over the course of a 12-hour and has not had any further recurrences. Discussion: GTA is a syndrome of reversible disruption of short-term memory (anterograde and retrograde), accompanied by repetitive questioning, without other signs of impaired cognitive functioning or focal deficits. It occurs with an unclear etiology in middle-aged individuals. The typical cardiovascular risk factors such as hypertension, diabetes, and hypercholesterolemia has a weak role in the pathophysiology of GTA, while migraines have been found to be strongly associated. Due clinical diligence is required in the investigation of these patients. Treatment is generally not required, and the condition usually does not recur. Clinicians need awareness of this condition.
Guillain Barre Syndrome: A Study of Ten Years

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Background: Guillain-Barre Syndrome (GBS) is an heterogeneous condition with several features, best characterized as a severe demyelinating neuropathy of immune nature. Generally GBS presents as an acute monophasic paralytic disease of unknown etiology, although strongly related with a previous infection. As a condition with a rapid onset and variable magnitude, a prompt diagnosis is mandatory. The diagnosis is initially based on clinical features but it is confirmed by the albuminocytologic dissociation and neurophysiologic studies. Treatment is supportive and immunomodulation.

Objective: Epidemiologic, clinical and therapeutic characterization in patients with the diagnosis of GBS.

Methods: Observational, retrospective study of the clinical records in patients aged 18 or more with GBS diagnosis between 1 July 2007 and 30 June 2017 period.

Results: We observed 23 cases, 13 (56,5%) males, average age of 55 years old. In 12 cases (52.2%) the respiratory infection was the first manifestation. Most of the cases presented with motor disturbances, 3 (13,0%) with cranial nerve involvement, 12 (52,2%) with sensitive disturbances and one (4,3%) autonomic disturbances. Fourteen patients (60,87%) had the albuminocytologic dissociation and electromyographic pattern of demyelinating processes were found in 12 (52,2%) cases. (73,9%) of the patients were treated with endovenous immunoglobulin (IgEV). Infections occurred in 6 cases (26,1%), 1 of which (16,7%) demanded mechanic ventilation (MV). Eight patients required rehospitalization and three (13%) died.

Conclusions: Our data is consonant with the ones described in the literature for the epidemiology, clinical evolution, severity and treatment. Age, severity at presentation, MV necessity, axonal lesions were associated with worst prognosis.
Healthy Living Support Program

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Objectives: Health is a state of complete physical, mental, social wellbeing (WHO). In 1991 European Council, “Health for all” policy was pointed out. We aim to increase healthy living behaviors by generating the Healthy Living Support Programs (HLSP) via integrative techniques.

Methods: 12-weeks programs are aimed to support patients in fields of oncology, smoking cessation, weight control and cardiology. 39 programs were run since October, 2016. The sample was consisted of 10 weight control, two smoking cessation, and one oncology patients. The multidisciplinary council is consisted of specialists from related divisions, dietitian, clinical psychologist, family counselor and healthy living coach, physiotherapist, yoga-breath trainers.

Results: For before-after analysis, paired-samples t-tests were run. Fat mass, BMI (p=0.001); Beck Depression Inventory, Beck Anxiety Inventory (p=0.005); Healthy Life Style Behavior Scale (p=0.022) were significant.

Conclusion: It was revealed that application of HLSP is beneficial for the scope of complementary medicine. It is suggested that this kind of programs could be developed and spread.
Heat stroke - The risk of extreme temperatures

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INTRODUCTION: Hyperthermia consists in the elevation of body temperature above 37.5°C due to failure of thermoregulation mechanisms. It includes heat stroke, malignant hyperthermia and neuroleptic malignant syndrome. Classic heat stroke is defined as temperature above 40°C associated to neurological dysfunction, in the absence of intense physical exertion.

CASE DESCRIPTION: A 57 year-old man, with a history of mixed personality disorder under antipsychotic medication, was admitted in the Emergency Room (ER) with altered mental state after being found unresponsive inside his car on a summer day with extreme temperatures. He had a GCS of 3, tympanic temperature > 42.2°C, tachypneic and tachycardic. The blood tests revealed leukocytosis, acute kidney injury and rhabdomyolysis. Arterial blood gases showed metabolic acidosis and hyperlactatemia. Heat stroke was suspected and the patient started on cooling methods, including intravenous hydration, with slow improvement. During the stay in the ER he started with seizures, including intravenous hydration, with slow improvement. During the stay in the ER he started with seizures and progressed to status epilepticus, so he was sedated, intubated and admitted in the Intensive Care Unit (ICU), where he evolved with distributive shock needing vasoactive drug support. In the ICU he had a favorable outcome, without further seizures, and steady improvement of rhabdomyolysis and shock. He was then discharged to an Internal Medicine Ward.

DISCUSSION: The authors intend to highlight the importance of a timely diagnosis, since the mortality is directed related with an early start of the cooling measures. In this specific case we underline the multi-organic complications and their particular approach.
How general practitioners decide to refer or not to specialists: a qualitative study in an ambulatory university setting

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Background: Variations in referral rates to specialists among general internal medicine practitioners (GPs) remain largely unexplained. Qualitative studies can contribute to the understanding of factors involved in the referral process and decision. Our study aims at describing how GPs working in a university environment experience the referral process and how they decide to refer to a specialist.

Methods: A questionnaire survey, based on the existing literature, was distributed to the GPs of the Department of Ambulatory Care and Community Medicine (DACCM, University of Lausanne). We then conducted two focus groups (FGs), the first one with residents and the second one with chief residents.

Results: 32 GPs (80%) responded to our questionnaire; 10 residents and 8 chief residents participated in the FGs. Two distinct cases emerged through the material analysis: a) the “clear-cut situations”, where the decision to refer or not seems obvious to GPs and b) the “complex cases”, in which GPs hesitate to refer or not. Regarding the latter, the decision-making process involves three different sets of expectations with regard to the consequences of the referral: i) for the treatment, ii) for the doctor-patient relationship and iii) for the GP himself. Various factors are associated with the decision: contextual (i.e. patients’, supervisors’/colleagues’ expectations), and ‘personal’ elements (i.e. issues of responsibility, or pressure by feelings of uncertainty and anxiety). Prior validation by colleagues through informal exchanges seems to relieve some of the decision-related distress.

Conclusion: Our study demonstrates that referral cannot be understood in biomedical terms only. Multiple factors are involved in the referral decision: the GPs can and do take into account the potential effects of the referral on patients, on their relationship with them and on themselves. Anxiety regarding institutional responsibility and wish to avoid appearing incompetent are highlighted.
Idiopathic Basal Ganglia Calcification and Spasmodic Dysphonia: an exceptional association

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Introduction: Idiopathic basal ganglia calcification (Fahr’s disease) is an uncommon neurological disorder which is characterized by massive calcifications in basal ganglia and cerebral cortex. Laryngeal dystonia is an exceptional finding in this entity. We present a rare case of laryngeal dystonia as the first manifestation of Fahr’s disease.

Case Report: A 50 year-old man without medical history was attended because changes in his voice pitch and a subjective feeling of not being able to articulate the words. The clinical picture started four months before, improved when the patient drank. No cranial trauma was related. The clinical and neurological examination was normal. No cognitive impairment was observed. Hemogram, coagulation study, biochemistry (ions, kidney function, calcitonin, parathormone, alkaline phosphatase, ANA, ANCA, ACE, complement) were normal. Laryngoscopy was normal too. Brain computed tomography (CT) showed infra and supratentorial calcifications in both hemispheres. Brain IRM confirmed symmetric calcified lineal lesions in subcortical regions in both hemispheres and in both basal nucleus, compatible with Fahr’s disease. A genetic study was made: no mutation in the sequencing of SLC20A2 was identified. To date, the patient is followed up in consulting room and no treatment has been initiated.

Discussion: The diagnosis of Fahr’s disease is based in radiological, clinical and analytic criteria: the presence of bilateral calcification of the basal ganglia; progressive neurologic dysfunction; absence of an alternative metabolic, infectious, toxic or traumatic cause. The classical clinical profile includes dementia, vision impairment and movement disorders. No treatment exits for this entity.
Idiopathic transverse myelitis. About a case

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INTRODUCTION: Transverse myelitis is a neurological disorder caused by an inflammation of the spinal cord that causes sensory, motor and autonomic disorders in variable degree and duration. The causes are not clear and it has been considered idiopathic, however, it has been related to multiple sclerosis, neuromyelitis optica, infections, autoimmune disorders, vasculitis, some drugs, vaccinations, neoplasms. DESCRIPTION: A 40-year-old woman with a history of subclinical hypothyroidism and an abortion 3 months ago that begins with an episode of acute low back pain followed by paresthesias and heaviness of the right lower limb, subsequently begins with sensation of paresthesias in the left laterocervical region. Examination revealed diastolic dysesthesia in the left laterocervical region and lower limbs with gait instability. Basic analytical and cranial magnetic tomography without lesions. Cranial MR without lesions. Medullary MR with multifocal hyperintense lesions in T2 that capture contrast in C2, C3-C4, D3-D4 and D10, not meeting criteria neither in time nor space of multiple sclerosis. Normal CSF analysis. It was treated with bolus of iv corticosteroids and was cited in consultation to collect results. The patient continues sometimes with tingling sensation and cold / warm sensation in the legs. In the new MRI the previous lesions are observed very badly. Defined, residual aspect and no contrast enhancers and a single lesion right subcortical frontal inespecifica. Antibodies ANA, antiDNA, ECA 52, folic, B12 and homocysteine normales. Ac anticardiolipin IgM and Betaglicoproteina IgM positive.

DISCUSSION: In the antiphospholipid syndrome there may be neurological manifestations that resemble multiple sclerosis and a high percentage of patients with a first outbreak of myelitis will be diagnosed with MS. Therefore, in the study of patients with atypical multiple sclerosis, the determination of antiphospholipid antibodies is recommended.
Illness, dependency, family and hospital discharge - A study of hospital delayed discharges for non-clinical reasons

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Objectives: In an aging patient population, the prevalence of comorbidities is high, generating high dependence. The elevated number of affected systems (mean Cumulative Illness Rating Scale for Geriatrics = 7.5/patient) leads to recurrent hospitalizations as well as to prolonged length of stay (LOS). There are, however, situations of constraints (family / social / institutional) at the moment of hospital discharge with LOS prolongation for non-clinical reasons. We intended to look for its main causes and consequences.

Methodology: A convenience sample of 50 elderly patients consecutively admitted to an internal medicine ward, for a period of 3 months was selected, to evaluate the reasons for the non-coincidence between clinical discharge and hospital leave, increasing LOS.

Results: In 28% of patients, there was an average increase in LOS of 16 days. It’s main reason (14% of cases) was associated with a community’s protracted institutional response. In 11%, families were unavailable to receive their relatives, who scored 4 on the ECOG dependence scale, with multicomorbidities and/or special needs.

Conclusions: A high degree of dependence is associated with an increase in LOS. The work of the multidisciplinary team has a fundamental role in the early detection of these very dependent patients, in order to ponder their needs, to manage family expectations and to achieve a hospital leave as soon as the patient is clinically stable. However clinical discharges are often compromised by the scarcity of integrated responses, in the context of the legal health framework and of the social policies in Portugal.
Increasing demand of consultations from Surgical areas

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OBJECTIVES
Analyze the number of consultations sent from Orthopaedic Surgery (OST) and Vascular Surgery (VS) to a team (E) of Internal Medicine and Cardiology assigned to control decompensated medical pathologies in surgical areas, in relation to the number of total admissions in those areas.

MATERIAL AND METHODS
Descriptive analysis on total number of consultations sent quarterly from OST and VS to E compared to the total number of admissions.

RESULTS
From 06/2008 to 11/2014, 1486 consultation were sent from OST to E (table 1) and 173 from VS (table 2). The number of inquiries made an upward progression until it began to stabilize in the first quarter of 2012. In VS a very significant decrease appears in the third quarter of 2013, due to a new professional who was not informed of the existence of E. These were compared to the total number of admissions during the same period (tables 3 and 4).

The number of admissions remains approximately constant throughout the period. At the beginning of the activity of E, the% of patients for whom OST consulted did not reach 5% and VS was slightly higher than 6%. In OST the overall percentage of admitted patients to be evaluated is 11.84. VS stabilizes around 10% (excluding the aforementioned 3rd quarter of 2013) of admitted patients and in 2014 the percentage decreases to 7.36%.

CONCLUSIONS
There is an increase in the demand for assessment of patients admitted by OST to E since was created.
- In OST it continued in ascending progression at the end of activity E, reaching in some quarters to request evaluation of 1/6 admitted patients. This did not correspond to a higher number of OST admissions. The data seem to suggest that the OST professionals delegate more and more any type of medical pathology to E.
- In VS, this demand tends to stabilize around 10%, and in the last year it decreases. This did not correspond to a greater or lesser number of admissions in VS. The data suggest good control of medical decompensation by VS professionals.
Internal Medicine at Orthopaedic Service: experience Of a Medical Team

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Introduction: As a consequence of the increasing complexity of hospitalized patients in Orthopedy, there has been a growing number of requests for observation of Internal Medicine (IM). To overcome the difficulties observed, a consulting team was established in 2014.

Objective: To describe casuistic and personal experience of a resident during the time she stayed with IM consulting team.

Methods: Retrospective study, which included all patients observed by the IM consulting team from January 2nd to 31st, 2018.

Results: A total of 57 patients were observed, mostly female (N = 42), with a mean age of 81 years. The reasons for hospitalization resulted in the majority of traumatic pathology, with the main highlight being, fracture of femoral neck and trochanteric fracture. Regarding the reasons for observation, 34 were requested according to our proximal femur fracture protocol, followed by requests for decompensation of chronic disease, infectious, acute renal injury, therapeutic orientation and etiological study. It was necessary to delay surgery timing in 3 patients. Regarding the characterization of the sample, it was verified that the majority presented a high risk of falling, 23 patients had dementia syndrome, 3 Parkinson's disease and 9 osteoarticular disease. In addition to other comorbidities, cerebrovascular and / or coronary disease (n = 13), heart failure (n = 7), atrial fibrillation (n = 7), chronic kidney disease (n = 7) and chronic lung disease (n=5). Most patients required daily follow-up during hospitalization. During this period, one died from refractory shock in the context of mesenteric ischemia.

Conclusion: This stage allowed us to verify that inpatient paradigm is changing. Increasingly, Internal Medicine stands out for its versatility and ability to manage the patient with pluripathology. This experience was enriching in that it allowed us to know other realities, as well as to create ties between colleagues.
Internal medicine palliative care support team in patients with ALS in a third level hospital

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OBJECTIVES: describe service provided in the treatment of this patients.

METHODS: a retrospective descriptive study based on the histories of the patients diagnosed with amyotrophic lateral was realized. Sclerosis who have been treated from October 2014 to October 2016.

RESULTS: 15 patients diagnosed have been treated, 8 needed home care, 23 home care visits have been made. The care plan was approached in a progressive way, and the team also organized the record of two Advanced Directive Documents. Five of the patients died in this period, with the unit intervention in patients last few days.

CONCLUSIONS: The participation in the multidisciplinary outpatient service allows the team to follow the progression of the illness in each patient, with true relationship between doctors, patients and families, considering the patient’s wishes concerning the care planning and checking them throughout the process. It is thus easier to provide a high quality service when the patients require home care.
Internal Medicine under the eyes of the External Consult - a retrospective analysis

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The consult is the oldest and most noble of medical art. The Internal Medicine Department of our Hospital is responsible for conducting external consultations, supporting a significant number of outpatient patients.

Objectives: A retrospective case series study was realized for better characterization of a sample of patients observed at the outpatient Internal Medicine consult.

Methods: It was realized a collection of data from the clinical process of each patient. The selection of the sample obeyed the following inclusion criteria: all patients observed during the second semester of 2017 in the Internal Medicine consult.

Results: A total of 128 consults were investigated during the second semester of 2017. The ages ranged from 32 to 94 years, with a mean age of 67 years. According to the ICD 10 classification, diseases of the circulatory system (n = 82; 37%), endocrine-metabolic diseases (n = 57; 26%) and respiratory diseases (n = 21; 10%) were the main diagnoses of the patients observed (n = 128). The main comorbidities of the patients observed were Atrial Fibrillation, 26 (62%), Congestive Heart Failure (CHF), (n = 32; 25%) and COPD (n = 15, 11.7%).

Conclusion: The vast majority of these patients present several reasons for consultation, and in fact, this complexity intrinsic to Internal Medicine requires careful management of the time for each consult. On the other hand, the multiple co-morbidities of patients combined with the dynamism and unpredictability of their decompensations are the most challenging factors that the Internists have to deal every day. Reviewing the patient at a stage of improvement and clinical stability after the critical period is also one of the factors and they make us realize that the consultation is really a central act in the practice of Medicine.
Is Portuguese Internal Medicine Turning Barren?

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Objectives: The authors proposed to study clinically and demographically a population of in-patients on an Internal Medicine Enfermary, underlining the prevalence of the geriatric group and its principal characteristics.

Methods: Retrospective analysis of records of in-patients during the year 2017, comparing two distinct age groups.

Results: In a sample of 239 patients, with mean age of 72, 58.6% were women. The majority of the sample (74.9%) were over 65 years old (Group A). The minority, 25.1% were under 65 years old (Group B). The main motives for hospitalization in Group A were, by descending order of frequency, cardiovascular diseases (21%), infectious diseases (19.6%), and neoplasms (7.3%). Of the main co-morbidities present, 30.7% of patients had more than 5, meaning that 18.4% had dementia and 8.9% were bedridden. Nosocomial infectious complications occurred in 11.2% of cases. In Group B the main motives for hospitalization were, by descending order, infectious diseases (38%), cardiovascular diseases (20%) and neoplasms (20%). Of the main co-morbidities present, 11.7% of patients had more than 5, meaning that none had dementia and 1% bedridden. The mortality rate was 10.6% in group A and 26.3% in group B.

Conclusion: As mother of all medical specialties, it’s from Internal Medicine that all the others are born. With the great population ageing, the approach to patients and disorders have to suffer changes, as there are so many differences between older and younger groups. The competence in Geriatry and the creation of a new area of expertise is becoming inevitable and Portuguese Internal Medicine has to become more proactive in bearing the necessary fruits to the population it serves.
Is there a relationship between hospital readmissions and health care?

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Objectives: To evaluate the relationship between parameters related to health care with readmissions.

Material and methods: A retrospective study was carried out. Patients discharged in April and May 2016 and January and February 2017 in the Internal Medicine service of the Virgen de Valme University Hospital of Seville were included. A follow-up period of 30 days after discharge was established. Data were obtained from the digitized clinical history of each patient, complying with the confidentiality. Patients who were transferred or died. Hospital readmission is defined as hospital admission for any cause in the follow-up period.

Results: 16\% patients were readmitted. Cardiorespiratory diseases were the most prevalent (54\%) cause of hospital admission. We analyzed the relationship between pathology of index episode and readmission, oncology (46\%) had the strongest association (p<0.005); it confers 4 times more risk of readmission (OR 3.84, IC95\% 1.47-10.01, p<0.005) with respect to the remainder. 94\% patients were readmitted trough emergency department. 98\% were discharged in a situation of clinical stability. The previous discharge was programmed in 70\% patients. 28\% of patients with hospital stay greater than 20 days readmitted and we estimated a relative risk for readmission 2 times higher than who with hospital stay less or equal to 20 days (IC 95\% 1.19-3.91 p <0.05). Multivariate analysis showed that patients who were not reevaluated at follow-up period had twice the risk of readmission (IC95\% 1.17-2.87, p <0.005).

Discussion: There are modifiable factors related to health care that influence readmissions: hospital stay, reevaluation in 30 days after discharge, clinical stability and programmed discharge.

Conclusions: There is a clear relationship between the pathology causing the admission index and readmissions, being due this relation of neoplasm, with higher rate of readmission. Patients with hospital stay greater than 20 days were more likely to readmitted.
Is there a relationship between hospital readmissions and the sociodemographic characteristics of patients?

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Objectives: Evaluate the relationship between the sociodemographic factors with readmissions.

Material and methods: A retrospective study was carried out. Patients discharged in April and May 2016 and January and February 2017 in the Internal Medicine service of the Virgen de Valme University Hospital of Seville were included (n=840). A follow-up period of 30 days after discharge was established. Data were obtained from the digitized clinical history of each patient, complying with the confidentiality. Patients who were transferred or died. Hospital readmission is defined as hospital admission for any cause in the follow-up period.

Results: We include 840 patients of whom 16% were readmitted. 57% were males (median age 78 years). 62% of the patients who readmitted were active or retired. 60% patients had no studies, without finding significant relationship with readmissions. 60% of the patients were partnered, it implies up to 1.5 times more risk to readmission (OR 1.53, IC95% 1-2.3, p < 0.005). 65% of the patients lived in metropolitan area compared to 34% in rural areas, without significant relationship with the readmission. 34% lived further than 30 km from the hospital. 51% patients lived more close than 1 km to the primary care center. 53% of the patients were independent for the daily activities and 28% patients had severe or total dependence. 58% of the patients had 3 or more comorbidities according to the Charlson index.

Discussion: In our sample we only confirm that marital status influence risk of readmission, interpreting as being alone or accompanied. These types of factors are not modifiable.

Conclusions: Marital status is associated statistically significantly with the readmission. We have not obtained a relationship with sex, age, employment situation, distance from home to health centers, social support, associated comorbidity or dependency for the daily activities with the risk of hospital readmission.
Spontaneous dissection of the internal carotid artery occurs in every 3 of 100,000 individuals / year, being responsible for 2% of ischemic vascular cerebral accidents. Most individuals affected are in the fifth decade of life and there is no predilection for gender. There is an association with risk factors such as: systemic arterial hypertension, diabetes mellitus, dyslipidemia, antiphospholipid antibody syndromes, thrombophilia, cervical traumas and genetic alterations (fibromuscular dysplasia, Marfan syndrome and Ehlers-Danlos syndrome).

Regarding the theme, we present the case of a 54-year-old man, previously healthy, who went to the emergency department because sudden right hemiparesis. A brain CT was performed and detected left fronto-opercular ischemic focus so the patient was admitted for further study. Echocardiogram was requested, without alterations, and echocardiography of the neck vessels showed a high resistance pattern in the left internal carotid artery. So the patient underwent angio-CT for better characterization of the lesion, demonstrating progressive reduction of the artery caliber and tapered morphology, suggesting carotid stenosis. After excluding the main etiological factors and hypocoagulation and rehabilitation plan were started, the patient was discharged with great improvement of neurological deficits.

In conclusion, the pathogenesis of arterial dissections is based on the fragility of the vascular endothelium, allowing the blood to spread between the layers of the vessel. The clinical manifestations depend on which portion of the arterial wall is most affected. When more internal layers(intima and average) are involved, luminal stenosis occurs, promoting hypoperfusion and distal ischemia. Thus, despite being a less common cause, this entity should not be forgotten due to good outcome when treated correctly.
KLINFELETER SYNDROME: Looking beyond appearances

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Introduction
Venous thromboembolism (VTE), including deep venous thrombosis (DVT) and pulmonary embolism (PE), is an important cardiovascular cause of death and disability. Even after the acute phase, consequences such as chronic thromboembolic pulmonary hypertension (CTEPH) may remain.

Case report
41-year-old male, followed at obese Internal Medicine consult, with venous leg ulcers and a history of VTE: DVT in the right lower limb and bilateral high-risk PE submitted to fibrinolysis, both in 2011. Maintained hypocoagulation with vitamin K antagonist for 1 year (non-conclusive initial study). Presented with moderate-risk PE in 2016 with PSAP ~ 62 mmHg (51 + 10), good bi-ventricular systolic function on transthoracic echocardiography (ETT) discharged with vitamin K antagonist. During the consult reassessments, he maintained dyspnea on moderate exertion. To the examination: gynecomastia, truncated hairy rarefaction, extensive abdominal adipose panicle and lower limbs ulcers. Complementary study: thoracic CT angiography showed persistent central thromboembolism signs, right pressure overload and parenchymal opacities suggestive of pulmonary infarction; normal BNP; standard S1Q3T3 on the ECG; functional respiratory tests showed mixed ventilatory disorder and moderate diffusion deficit, normalized when corrected; ETT: persistent signs of right pressure overload with > 3 months of oral hypocoagulation. The investigation allowed us to exclude autoimmune disease and thrombophilia. He was referred to Pulmonary Hypertension consult, where ventilation / perfusion scintigraphy was performed with findings compatible with chronic EP / CTEPH. Given the patient's biotype, Klinefelter syndrome (KS) was suspected, and confirmed after karyotype (XXY).

Conclusion:
SK is one of the most common chromosomal disorders, although only 25% of patients are diagnosed due to frequently subtle findings. Venous ulcers after deep venous thrombosis are associated with a 5-fold higher thromboembolic risk.
Life threatener complicatio of combined oral contraceptives.

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INTRODUCTION: Pulmonary embolism (PE) is an important clinical entity with variable and nonspecific clinical presentation, of multifactorial cause, with considerable mortality. The combined oral contraceptives (COCs) can increase the risk of thrombosis determined by hypercoagulable state induced by hormonal replacement. The clinical suspicion should be lifted in women at any age with suggestive clinic. Appropriate therapy it is based using stratification of the markers and the risk scale.

Case description: It is a 19-year-old woman, with no personal and family history of relief. She started taking COCs (Ciproterona + Etnilestradiol) during the last two months. She was admitted to the Emergency Department for episode of syncope with spontaneous recovery, left chest pain and tiredness. Physical examination to admission revealed polypnea, normotensive blood pressure profile, tachycardia (120 bpm). ECG with right axis deviation, inversion of the T wave in DII-DIII, aVF. In the biochemical study with Lactacidemia of 4.6 (arterial blood), positivity of the markers of myocardial necrosis. We suspected pulmonary thromboembolism (Wells' score + 1.5), where was confirmed endoluminal repletion defect of the level of the main arteries. The transthoracic echocardiography revealed signs of overload with dilatation of the right cardiac cavity. The patient underwent thrombolytic therapy with 1 mg/kg tenecteplase, with favourable hemodynamic and clinical response. Prothrombotic study was negative and in the absence of additional risk factors it was assumed a thrombotic event in context of the use of COCs. It was started hypocoagulation with low-molecular-weight heparin and kept new oral anticoagulants.

Discussion: The authors try to remember the presence of prothrombotic status induced by COCs, with increased incidence of the first months from the onset of hormone replacement in women without risk factors or genetic predisposition in thrombotic events.
Long-term follow up in chronic inflammatory demyelinating polyradiculoneuropathy: efficacy of corticotherapy in an African HIV patient

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INTRODUCCION
Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP) is a progressive paralytic illness characterized by weakness and sensory deficits due to an acquired immune-mediated disorder. CIDP is described in HIV-infected patient.

CASE DESCRIPTION
An HIV-infected 31 years female from Equatorial-Guinea reported six months of progressive ascending weakness, paresthesia in legs and arms and impaired gait with falls. Neurologic exam showed tetraparesis, incapacity to stand up and walk, glove & sock hypoesthesia and deep tendon reflexes absent. The rest of physical exam was normal.
She was taking antiretrovirals and blood tests revealed CD4 count 706/µl, undetectable viral-HIV load and polyclonal hypergammaglobulinemia. Blood antiganglioside IgM were positive. The rest of blood analyses were normal. Cerebrospinal fluid only showed hyperproteinorrachy. Body CT and cerebral CT/NMR were normal. Multiple serologies, cultures and PCR tests in blood and CSF were negative. Electromyogram showed a moderate-severe sensitive-motor demyelinating polyradiculoneuropathy in all four limbs.
Intravenous immunoglobulins were started without results. After beginning oral prednisone 1 mg/kg a fast improvement was seen and she could get up and walk alone with a walking stick at hospital discharge. After one year of tapering corticosteroids, she was asymptomatic, neurologic exam was normal, deep tendon reflexes reappeared and antiganglioside antibodies were negative.

DISCUSSION
CIDP can appear at any time in HIV infection even with good viral control. An African study reported that corticotherapy in CIDP seems more long-term effective in HIV-infected than in HIV-negative. Other neuropathies such as Guillain-Barré syndrome also have different responses to immunosuppressive therapy so, a correct diagnosis is important.
Looking for primary lesion

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An osteolytic lesion is a softened section of a patient's bone formed as a symptom of specific diseases, including metastatic lung, breast cancer and multiple myeloma. Osteolytic lesions may cause bone pain, pathologic bone fractures and spinal chord compression.

A 56-year-old female patient was admitted to the Internal Medicine Service for the study of osteolytic lesions in the sacrum, right iliac and spine on a computerized tomography, suggesting that these lesions were secondary. An etiological study was carried out during hospitalization to identify primary neoplasm, with no alterations in the thoracic, abdominopelvic, thyroid, mammary, endoscopic, and gynecological evaluations. Biopsy of an osteolytic lesion compatible with metastasis of breast carcinoma. Patient-oriented Oncology consultation.

Osteolytic lesions should always be investigated in order to establish a definite diagnosis and start early treatment.

The authors present iconography.
Introduction: Follicular lymphoma is the second most common type of non-Hodgkin's lymphoma B cell (NHL-B). It is an indolent lymphoma, but it can progress to aggressive histologic types.

Case description: A 77-year-old woman recurred to the Emergency Department with fever, prostration, anorexia, dysuria and oliguria over the previous 4 days. She had type 2 diabetes, dyslipidaemia, hypertension and atrial fibrillation. She was taking metformin 700 mg twice daily; warfarin 5 mg qb, simvastatin 20 mg daily and carvedilol 6.25 mg twice daily. She presented normocytic normochromic anaemia, elevated inflammatory parameters, acute kidney injury and urinalysis with leukocyturia. Renovesical ultrasound showed right renal excretory system ectasia, with no clear obstructive cause. It was assumed an uncomplicated acute pyelonephritis, and she was started endovenous ceftriaxone, with clinical and analytical improvement. As she maintained a pelvicalyceal dilatation, Uro-CT was performed, which showed ectasia conditioned by a retroperitoneal expansive formation, with extension to the pelvic excavation and also inguinal lymphadenopathies, to the right. Thoracoabdominopelvic CT revealed submandibular adenopathy and right intra-abdominal masses with extension to the pelvic cavity and peritoneal effusion. From the study: pancytopenia, elevated HDL and B2-microglobulin. She underwent biopsy of one of the inguinal lymphadenopathies and pathology was compatible with follicular-type NHL-B (grade II), with concordant flow cytometry, with bone marrow aspirate and bone biopsy showing no bone marrow attainment. She was referred to the consultation of Hematoncology by follicular NHL-B (Grade II), Stage III. Discussion: The maintenance of pelvicalyceal dilatation after pyelonephritis treatment lead to the suspicion of another aetiology, with subsequent diagnosis of Follicular Lymphoma, staging and therapeutic orientation, avoiding the progression to more advanced stages, with worse prognosis.
Megestrol acetate. Is its use so harmless as it might seem?

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INTRODUCTION
Megestrol acetate (MA) is a synthetic progestogen, used for its orexigenic properties, that can cause different adverse effects. One of these is its inhibitory action on the pituitary axis.

CASE DESCRIPTION
An 83-year-old woman with hypertension and hypothyroidism was admitted for a 4-month history of asthenia and weight loss. She took megestrol acetate as orexigenic drug. Examination showed a generalized intense weakness and arterial hypotension. Chest X-ray and thoraco-abdominal CT were all inane. Laboratory results showed hypoglicemia and hyponatremia. Adrenal insufficiency was suspected and basal cortisol and ACTH were performed, showing results compatible with secondary adrenal insufficiency. A complete hormonal study showed central hypogonadism and hypothyroidism. Pituitary MRI was normal. In the absence of other causes of pituitary axis inhibition, a probable pharmacological etiology was considered. MA administration was discontinued and treatment with hydrocortisone was initiated, improving signs and symptoms and bringing ions, blood glucose and bloodpressure to normal values.
At 2 months of follow-up, the patient remained asymptomatic with normal hormonal and laboratory results, and hydrocortisone treatment was withdrawn.
Hypopituitarism secondary to inhibition of the hypothalamic-pituitary axis induced by megestrol acetate was diagnosed.

DISCUSSION
Only few cases of hypogonadism and none of hypothyroidism related to treatment with MA have been described in medical literature. It may be due to the fact that, in hypopituitarism, the sequence in the hormonal loss is, first, ACTH deficiency, followed by LH/FSH and finally TSH. It turned out to be not so infrequent but it is usually under-diagnosed as symptoms are mostly unspecific. Therefore in patients receiving MA the possibility of inhibition of hypothalamic-pituitary axis should be suspected.
Meningoencephalomyelitis disseminates subacute. About a case.

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INTRODUCTION: Acute disseminated encephalomyelitis (ADEM), also known as postinfectious encephalomyelitis, is an autoimmune demyelinating disease of the central nervous system caused by an inflammatory reaction in the brain and spinal cord triggered by viral infections. It is an uncommon disease whose precise incidence it is unknown.

DESCRIPTION: 53-year-old patient who began two years ago with weight loss, anorexia and nausea without vomiting, and later cognitive symptoms were added: forgetfulness of recent events, spatial confusion while driving and fever. Complementary tests are performed (seven lumbar punctures, cranial MRI and cervical, electroencephalogram, chest CT, abdominal ultrasonography, determination of onconeuronal antibodies in CSF, anti-NMDA, Mantoux, study of prionopathies) with meningoencephalitis with signs of cervical transverse myelitis in MRI (initially 180 cells with 95% mononuclear and hyperproteinorrachia; 590 cells in the second and 100 cells in the last) with positive Epstein-Barr virus PCR and protein 14-3-3 in positive cerebrospinal fluid on two occasions, with negative prion gene polymorphisms and slow EEG tracing with some acute potentials. The hospitalization presents two episodes of restlessness / agitation, visual and auditory hallucinations and possible myoclonus. He successfully responded to megadoses of methylprednisolone.

DISCUSSION: Most patients with ADEM improve with corticosteroid treatment, but complete recovery occurs only in 10 to 46 percent of adult patients and the rest have motor impairments or cognitive impairment. In sudden cases, death can occur, there is a risk of of relapses although they are unusual and in other cases ADEM progresses towards multiple sclerosis.
Morbidity and Mortality in the Internal Medicine Infirmay Vs Other Infirmaries - Retrospective Study

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Introduction
Patients admitted to the care of Internal Medicine are complex, with multiple co-morbidities and high dependence. The infirmary and care provided are adequate to the type of patient usually hospitalized, being specific to each infirmary. The increasing attendance to the Emergency Department obliges patients in the care of Internal Medicine to be hospitalized outside the Internal Medicine infirmaries.

Objectives
The purpose of this study was to evaluate the existence of differences in hospitalization time between hospitalized patients in the care of Internal Medicine, physically hospitalized outside (OH) and inside Internal Medicine (IH) infirmaries.

Methods
Retrospective and observational study that included patients hospitalized for medical care from January 2016 to December 2017.

Results
The study included 547 patients, 67 OH patients. The subgroups studied did not present differences in terms of mean age, gender or degree of complexity. The OH patients had a higher mortality rate than the IH patients (16.4% vs. 11.3%). The mean age of the OH deaths was higher than the IH deaths. However, OH patients were more dependent (severe/total dependence of 38.8% vs 26%) than IH patients. Regarding length of hospital stay, OH patients had a mean time of 9.6 days, which was lower than IH, with an average hospitalization time of 12.1 days.

Conclusions
Although a higher mortality rate was observed in OH patients, these patients were also more dependent and, therefore, if on one hand they are more dependent on specific care, on the other hand, they are also more fragile. This study shows the fact that more dependent patients are likely to benefit from admission to specific Internal Medicine infirmary. It should be noted that the analysis is very reductive both in the number of patients observed and in the non-distinction between patients admitted to medical and surgical infirmary, which seems to have some relevance.
More or Less a pill?

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Thyroid dysfunction has a direct and indirect relation on cardiovascular system. Any minor change on thyroid hormones may cause decompensation of chronic cardiac disease previously stable.

CASE DESCRIPTION: Woman, 70 years old, heart failure with preserved ejection fraction by dilated myocardiopathy, multinodular goitre, arterial hypertension, dyslipidaemia and hyperuricemia. One month before visiting the ER she had antithyroid drug adjustment, under this treatment her routine lab showed hypothyroidism. Because of misunderstanding, instead of decrease in dose, she started higher dosage. She developed complaints of breathlessness, paroxysmal nocturnal dyspnoea, fatigue, reduced exercise tolerance and increased time to recover after exercise. Developed ankle swelling. She also had facial oedema. She had diastolic hypertension, bradycardia, systolic heart murmur grade III/VI and fine lung crackles, venous jugular ingurgitation until the mandible angle. Also had hypoxemic respiratory distress, hyponatremia and hypokalaemia. Thorax X-ray showed a bilateral pleural effusion. She was admitted in ward with the diagnosis of heart failure decompensated by severe iatrogenic hypothyroidism (myxedema). Initial lab results showed TSH 22.5 µIU/mL, so we suspended antithyroid drugs. Adjusted diuretic therapy and ions correction was made.

She had a fast and great clinical and laboratorial response. 15 days after discharge she was observed again at internal medicine appointment and normalized thyroid function.

Hypothyroidism is an independent factor on heart failure progression, as it is a direct factor that enhances prognostic of these patients. When under chronic therapeutic, more importantly on elderly or with various comorbidities, it should be taken in attention and care these therapeutic changes, confirming posology each appointment. On these kind of patients strict lab control should be done each 3-4 weeks after adjustment on therapeutic.
Multidimensional assessment of long-term population in tertiary level health care

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Background: Increasingly clinical instability of patients affected by chronic diseases might cause a reduction in their quality of life and lead to significantly increased costs for the healthcare system. Our approach is based on the multidimensional evaluation of complex inpatients through a multiprofessional team to identify frailty conditions and give the best quality of care.

Methods: A cross-sectional study was conducted at the Long-term Care of ARNAS Civico-DiCristina-Benfratelli, Palermo, Italy. One hundred consecutive inpatients (53 female and 47 male, mean age 69.6 years) underwent multidimensional assessment. Nutritional state was assessed with the Malnutrition Universal Screening Tool (MUST) and Geriatric Nutritional Risk Index (GNRI), sarcopenia was estimated with Skeletal Muscle Index (SMI). The following nutritional, biochemical variables were also evaluated: serum albumin, cholesterol, iron, and hemoglobin. Cognitive impairment was evaluated by the Short Blessed Test (SBT). Depression was analyzed using the Geriatric Depression Scale 5-items (GDS). Barthel Index (BI) was used to assess the functional state.

Results: The prevalence of cognitive impairment and depression was 63% and 73.7% respectively. MUST showed 81.8% of patients at high risk of malnutrition. Sarcopenia was present in 77% of patients. BI showed that 57.6% of patients were not autonomous. The statistical analysis pointed out a significant correlation between male gender and severe sarcopenia (P<0.001). GNRI correlated with depression (P<0.001) and serum albumin (P<0.001).

Conclusion: Multidimensional assessment is a potent instrument to evaluate the clinical complexity of long-term care units and potentially may improve the quality of care allowing the early identification of frail patients.
Needs on teaching/learning sexuality in a medical curriculum

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Objectives: Human sexuality is only addressed in university core curricula when it comes to sexually transmitted diseases, or in psychiatry. But the component of the patient's sexual history must be well integrated into his medical history. We intended to assess the needs of medical students in these issues.

Material and Methods: A initially validated survey on the topics in human sexuality that students would like most to be treated during their medical years, was built and sent via internet to 2200 medical students of all school years through the students’ association of the Faculty of Medicine of Lisbon.

Results: Only 11.3% of the reporting population responded (n=250), with a predominance of females - 68%. The most needed issues to be considered in medical teaching were: Brain and sex (79.2%), Disorder of arousal and female sexual desire (69.6%), Hypo/hi/peractive libido disorder (68%), Gender identity disorder (65%), Sexual clinical history taking (63.2%) and Physical examination in clinical sexology (56%). 50.4% considered also important the “aspects of eroticization in physician-patient relationship”. In the item “others”, 2.4% enunciated the following: “LGBTQ community sexual education; Transsexuality - sex change surgery; Contraception; STDs: myths and what we should know”.

Conclusions: The majority of students did agree that education about human sexuality is missing at the medical school they attend, and that it should be an important part of medical curriculum being relevant to their future practice as some of them feel uncomfortable to address sexuality issues with their patients.
Neurosarcoidosis relapse on Azathioprine: what now?

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Introduction: Neurosarcoidosis occurs in approximately 5-10% of patients with Sarcoidosis. Corticosteroids are the mainstay of treatment. When corticotherapy is not an option patients may benefit from alternative therapies such as Mycophenolate mofetil, Azathioprine, Methotrexate, Cyclophosphamide or Tumor necrosis factor-alpha (TNF-alfa) inhibitors.

Case description: 30-year-old white female with Neurosarcoidosis. Due to an avascular necrosis secondary to corticotherapy, she was medicated with Azathioprine 2 mg/kg body weight (maximum of 150 mg/day) and 5mg of Prednisolone. Total regression of the multiple foci of uptake of cortical contrast originally present was observed after the beginning of the treatment. The patient initially presented positive clinical and imagiological responses to the tapering of the immunosuppressant therapy. At 50mg of Azathioprine, however, multiple adenopathies started to re-emerged. A year and a half after, reappearance of small areas of cortical juxtacortical/pial contrast enhancement suggesting reactivation of the central nervous system by Sarcoidosis was observed in the control MRI.

Discussion: The patient described in this clinical case had a contraindication to high-dose corticosteroid treatment and was treated with Azathioprine, showing relapse of the disease when the drug was tapered. Because a patient’s response to any drug cannot be predicted, more than an agent should be tried before concluding that the patient’s disease is refractory. Azathioprine and Methotrexate have significant steroid-sparing potency and comparable side effects, so Methotrexate could be a good treatment option for our patient now. Infliximab and Adalimumab are also reported as useful after other agents have failed.
New drugs in multimorbidity patients

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Objectives
In recent years, multiple drugs have been marketed such as sodium-glucose co-transporter-2 (SGTL2) and glucagon-like peptide-1 (GLP1) for the treatment of diabetes mellitus (DM) and Angiotensin II Blocker Receptor Neprilysin Inhibitor (ARNI) for the treatment of heart failure with reduced ejection fraction (HFrEF). The aim of our study was to analyze the multimorbidity patients with HFrEF and DM who received either 2 or 3 of these new drugs.

Methods
Observational study. Multimorbidity patients in follow-up by the Chronic-Multimorbidity Unit of the Complejo Hospitalario de Navarra. October 2016 to May 2018.
For data analysis student t-test for paired samples we were performed. All analyzes were performed using SPSS version 20.

Results
We included 13 multimorbidity patients with HFrEF who presented DM between their comorbidity. The average age was 73 years, with 62% men. The Charlson index was 7 points. The Barthel index was 80 points.
The most frequent etiology of HFrEF was ischemic (69%). 54% of patients received the dose of 24/26 mg every 12 hours of Sacubitril-Valsartan. 62% of the patients received either Empaglifozin 12.5 mg every 12 hours or Dulaglutide 1.5 mg/weekly; only 23% received both drugs (Empaglifozina and Dulaglutida). The medication was well tolerated.
We found a non-significant reduction in HbA1c levels (7.94% vs 7.68%). The patients presented a reduction in the hospital admission rate due to decompensation of the HFrEF (32 versus 24). 85% of the patients had an improvement in the NYHA scale, with a significant reduction in the Maggic score (28.54 vs 23.77, P <0.001, 95%CI 3.48-6.06). The six minute walking test (6MWT) had a significant improvement of 90 meters (224 vs 314, 95% CI 13.9-166.08, P = 0.028).

Conclusion
It seems that the optimization of the HFrEF and comorbidities can help to reduce the prognostic risk of our patients and reduce hospital admissions and improve functionality in 6MWT.
Nivolumab: The unknown

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Introduction: Lung cancer is the main neoplastic cause of death in the world. In Portugal there are approximately 4000 new cases each year. Because of its high incidence and morbimortality, new therapies have emerged: Immunotherapy. Targeting "oncogenic drivers" have transformed the cancer treatment. Nivolumab, approved in 2015, is an IgG4 monoclonal antibody that blocks the PD-1 (negative receptor for T cells), and is approved as 2nd line treatment of non-small cells lung cancer. The main side effects (5-10%) are fatigue, nausea, anorexia and pruritus. The immune-related adverse effects are rare.

Case description: Man, 59 years, stage IV lung adenocarcinoma, cerebral and bone metastization (cT4N2M1b), without EGFR mutation, ALK or ROS1 rearrange. Documented disease progression under 1st line chemotherapy, nivolumab was initiated. 10 days later, he was admitted in the ER with fever and bilateral gonalgia. On physical examination: several papular lesions, desquamative, non-painful and non pruriginous; inflammatory signs on both knees (excluded skepticism arthritis). Blood tests: elevated C-reactive protein (155 mg/L), no leukocytosis; an elevated creatinine of 3,8 mg/dL. X-ray, urine analysis and renal echography were normal. After exhaustive exclusion of other causes: cutaneous, renal and articular toxicity caused by nivolumab were assumed (Photo documentation). Systemic corticotherapy was initiated with immediate and sustained response, also nivolumab was stopped.

Discussion: The authors present a case of multiple toxicities after initiating nivolumab: Kidney and skin which are very rare. With innovation comes great responsibility, but with a global approach and multidisciplinary team, it is possible to treat our patients the best.
Not everything is what it seems

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Introduction:
Hepatic abscesses are the most frequent form of visceral abscesses. They are often due to peritonitis, with propagation via portal vein, or by direct route, after bile ducts infection.

Case description:
Man, 83 years-old, diabetic. He was referred to the emergency department with fever, chills and concentrated urine. He had underwent dental treatment 6 months earlier. On presentation, with chills, aperetic, systolic murmur and painful abdominal palpation. Laboratory findings revealed elevated inflammatory markers (leukocytosis 17.100x109/L; C-reactive protein 40.1mg/dL), and elevated liver enzymes (ALT 116U/L, AST 101U/L). Urinalysis with leukocyturia and nitrituria. He was hospitalized with the diagnosis of urosepsis and initiated antibiotic therapy with ceftriaxone. After 72 hours, he maintained fever, hypotension, and no laboratorial improvement, so antibiotic therapy was switched to piperacillin/tazobactam and abdominal ultrasound was performed, which revealed a 7 cm liver abscess, that was percutaneously drained. Streptococcus intermedius was isolated in blood cultures. Given the good response to antibiotic therapy and the frequent polymicrobial etiology in liver abscesses, it was decided to maintain the ongoing therapy. Given the isolated organism, commonly associated with abscess formation and gastro-intestinal neoplasms, thoraco-abdomino-pelvic and cranio-encephalic computed tomography scans were performed, and excluded those possibilities. An echocardiogram was also performed, which excluded the hypothesis of endocarditis. The patient completed 6 weeks of antibiotic therapy with evident clinical and laboratory improvement.

Discussion:
Liver abscesses are manifested as pain and fever. When it is identified, drainage is recommended and the duration of antibiotic therapy should be between 4 and 6 weeks.
Introduction: Melanoma is the most serious form of skin cancer, whose incidence has increased over the past few decades. Most cases of malignant melanoma are diagnosed at an early stage. However, a few patients have metastatic disease at presentation, and some develop metastases after the definitive treatment, which makes it so important to follow-up these patients.

Case Description: Male, 85 years old, independent. He had a history of prostate adenocarcinoma under hormonal blockade and pigmented lesions, some excised in 2014, one of them corresponding to nodular melanoma. He is referred to the emergency department with pain in the right hip and edema of the right lower limb with 2 months of evolution and exacerbation in the last ten days. The complementary tests performed emphasized a lesion / mass in the right iliac bone and a deep venous thrombosis of the right lower limb, interpreted as a paraneoplastic syndrome in the context of the probable progression of the prostate adenocarcinoma, a reason why was admitted to the care of Urology. During hospitalization, there was no evidence of prostatic cancer progression, and as such, a bone lesion biopsy was performed, and the anatomopathological exams revealed melanoma metastases. PET-CT was requested where and showed a lytic lesion of the right iliac, pelvic adenopathies, abdominals, adrenal and pulmonary nodules, therefore, suggesting a malignant neoplastic infiltration. This case was presented at a multidisciplinary group and palliative radiotherapy of the iliac bone lesion was decided, which patient did not perform by the unfavorable outcome.

Discussion: With this case, we aim to highlight the importance of the long-term follow-up of melanoma since it is a neoplasm that usually has a good prognosis if complete excision is performed. However, it can sometimes relapse and metastasize, and in these situations, the prognosis varies greatly which makes a timely diagnosis fundamental.
Obstetric Internal Medicine in Spain

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Background
Obstetric Internal Medicine is an unrecognised and little known subspecialty in Europe, which focuses on the care of pregnant women with underlying medical disorders. That specific area is not included in the specialty training program of Internal Medicine in Spain. We aimed to gather reliable data about current clinical and academic implication of internists on the care of pregnant women with medical disorders in Spain.

Methods
A web-based survey was sent to all members (8000) of the Spanish Society of Internal Medicine in March 2017. Responses were collected for the following 2 months.

Results
We received 260 responses from 167 hospitals in 43 of 50 Spanish provinces, and 6 abroad. Overall, 62.93% respondents belonged to a university hospital. For 74.81% of them internists were the doctors most frequently involved in medical disorders in pregnancy in their centre, followed by obstetricians (45.74%) and other medical specialists (43.02%). Around 18.82% have a specific unit/clinic of medical diseases in pregnancy in their hospital. Of those, 8 centres deal with various general disorders, another 8 focus on cardiovascular and hypertensive disorders, and 12 on systemic autoimmune diseases. Nearly 20.39% of respondents receive more than one referral per week from the Obstetrics department; whereas 18.29% are seen by an internist specialised in that field. Similarly, 12.55% of participants have a member in their unit involved in training and/or research in the domain. Only 14.84% identify opportunities for specific training around them. Most of respondents (92.55%) do not know any society that focuses on medical complications of pregnancy.

Conclusions
Internists may be the specialist most frequently involved in medical disorders in pregnancy in Spain, although their implication in research, teaching and training in that field may still be improved. Formal collaboration between internists and obstetricians, and structured training activities may be pertinent.
Oral methotrexate-induced leukoencephalopathy

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INTRODUCTION: Neurotoxicity is a rare but well-known side effect of high-dose, intravenous or intrathecal methotrexate (MTX) treatment, but it has only rarely been described in the context of prolonged low-dose oral treatment.

CASE DESCRIPTION: A 72 year old woman with long-term mechanical polyarthralgias, treated for 8 years with low-dose (10 mg/day) oral MTX, recently suspended, for presumed rheumatoid arthritis, was admitted with rapidly progressive impairment of memory, cognition and gait. There was a history of peripheral blood large granular lymphocytosis without known progression to leukemia, and a single episode of posterior idiopathic uveitis, treated with oral corticosteroids. Cerebral imaging showed extensive leukoencephalopathy and electroencephalogram unspecific slow activity. The study was negative for infectious, systemic autoimmune or neoplastic diseases. Autoimmune encephalitis or central nervous system (CNS) lymphoma where admitted as the most probable diagnoses. The patient was treated with corticosteroid pulses and cyclophosphamide, without improvement, and acquired multiple nosocomial infections, which eventually lead to her death. Neuropathological examination revealed extensive myelinolysis of subcortical white matter, with discrete perivascular, predominantly macrophageal infiltrates, and neuron loss, astrogliosis and small perivascular inflammatory infiltrates in the basal ganglia and cerebellum. These findings, in the absence of histological findings suggestive of alternative causes, are compatible with MTX-induced leukoencephalopathy.

DISCUSSION: MTX-induced leukoencephalopathy is rare. Its pathophysiological mechanism is not well defined, but may be related to the CNS accumulation of toxic substances; in oral treatment, cumulative dose may be relevant. Early drug discontinuation is the only possible treatment, but outcome is variable, ranging from mild, completely reversible symptoms to death.
Dercum disease or Adiposis Dolorosa is a rare disease which mainly affects obese women among 35 to 50 years. It is characterized by multiple painful lipomas of the trunk and limbs and it is associated to asthenia and mood disorders.

We present a case of a 53 years obese woman, who was sent to Internal Medicine consultation. She mentioned the arise of multiple painful lumps with regular edges, mainly in abdomen, limbs and scalp, four years since. The associated pain was described as very intense, similar to a burn.

There were no significant changes in the laboratory results, with normal sedimentation rate and negative autoimmunity study.

The abdominal-pelvic CT documented: “Some areas of subcutaneous tissue focal thickening are found in anterior abdominal wall, which don’t consist in definitive lumps.” The soft tissue ultrasound showed “echogenic lumps, with 18 and 15 mm, which were compatible with lipomas.”

The patient has been submitted to a lump biopsy and the anatomopathological exam suggested “fatty tissue, with a few lines of fibrous tissue, which characterizes a lipoma.”

According to these findings, we assumed the diagnosis of Dercum Disease and symptomatic treatment was initiated, with an unsatisfactory response though.

In fact, the treatment of the associated chronic pain is an important challenge in Dercum disease, since there is no significative response to nonsteroidal anti-inflammatory drugs or corticosteroids in most cases.

Apparently, there is some benefit with a local anaesthetic injection but, ultimately, the effective treatment would be the liposuction.
Palliative Care support team work in a third level hospital

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OBJECTIVES: Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual- World Health Organization.

The Palliative Care Support Team at the Puerto Real University Hospital was founded in January 2007 to provide home care to terminally ill oncology patients.

We provide service in a geographically dispersed area with more than 300000 habitants. Was formed initially by a part time Internal Medicine Doctor and a full-time nurse but due to its increasing demand since 2014 it comprises of two full-time internal medicine doctors and two full-time nurses.

We want to compare the activity of the team in 2007 with 2015.

METHODS: Retrospective descriptive study is made based on the documents of the patients included in the Palliative Care Program in 2007 and in 2015. All patients have been reviewed.

RESULTS: 132 patients were treated in 2007, comparing with 418 of 2015.

639 home visits were made in 2015, far from the 74 visits made in 2007. 56% of the patients died in their homes in 2015, compared with 47% of in 2007. The average stay was 33.8 days in 2007 and went up to 87.7 days in 2015.

CONCLUSION:

The activity of the team has increased since it started in 2007, this rise of the average stay in Palliative Care programs stands out due to an earlier referral which allows better care planning.

The higher home care visits, can explain the fact that in the first years the patients died mostly at the hospital, a tendency that has been recently inverted.
Patient with exclusive oral affection by pemphigus vulgaris

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Introduction
Pemphigus diseases are bullous autoimmune dermatoses characterized by the formation of blisters by intraepidermal acantholysis. Among them are pemphigus foliaceus, pemphigus vulgaris and IgA-pemphigus. They are characterized by forming anti-desmoglein-1 and anti-desmoglein-3 antibodies of the desmosomes which are structural proteins of the skin that allow cell-to-cell contact of the keratinocytes within the epidermis.

Case description
A 68-year-old woman diagnosed with Behçet's Disease since 1999 without meeting criteria (no visual alterations, no genital ulcers or skin lesions).
The patient presented severe and recurrent oral aphthae for a year. He did not respond to treatment with high doses of systemic and topical corticosteroids, colchicine and aloclair.
Multiple oral aphthae with a whitish pseudomembrane in the entire oral cavity and serohematic scab in the lower lip is observed in the dermatology examination.
Anti-Desmoglein-3 antibodies with Epidermal Intercellular pattern is observed in the autoimmunity study. This specificity is compatible with pemphigus diseases, being Desmoglein-3 predominant in pemphigus vulgaris. Suprabasal acantholysis is observed in the cutaneous biopsy of the labial mucosa. Deposits of IgG at the intercellular level in the epithelium and C3 in the deeper layers is detected in the direct immunofluorescence study. Finally, it is reported by pathological anatomy as suprabasal bullous lesion suggestive of pemphigus vulgaris.

Discussion
The presence of anti-Desmoglein-3 antibodies predominates in pemphigus vulgaris, and if this antibody is found exclusively, mucous membranes will be affected mainly. Acontolysis develops in the deep epidermal layers, with the blisters firmer.
Patient with periorbital headache and diplopia: a case report

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INTRODUCTION
Description of a clinical case of a 44-year-old man who went to the emergency department of our hospital for a clinical picture of 2-3 hours of evolution, characterized by diplopia and right periorbital headache.

CASE DESCRIPTION
The neurological examination shows right mydriasis and complete ophthalmoplegia of the right eye. Suspecting a vascular etiology activates the stroke code and moves to the reference hospital. A brain CT scan shows a sellar mass with suprasellar extension of 2,3 x 3,3 x 3,3 cm. The lesion causes expansion and erosion of the turkish chair, as well as mass effect on the overlying structures, sphenoid sinus and wide contact with right cavernous sinus. The following differential diagnoses were raised: Carotid-cavernous fistula, cavernous sinus thrombosis, intracavernous aneurysm of the internal carotid artery, Tolosa-Hunt syndrome, vasculitis, pituitary adenoma, cranioopharyngioma, meningioma, trauma and infectious diseases. Cerebral nuclear magnetic resonance was performed where a macroadenoma was observed that partially invades the right cavernous sinus and compresses the optic chiasm. The patient was diagnosed with a hypophyseal prolactinoma. Finally, medical treatment with Carbegoline with good posterior evolution was started.

DISCUSSION
Painful ophthalmoplegia is a diagnostic challenge due to the numerous pathologies that can cause this clinical picture. Taking into account the young age of the patient, the first suspicion was a Tolosa-Hunt syndrome or a vasculitis but finally a prolactinoma was diagnosed. The pituitary macroadenoma is a pathology that can cause neurological symptoms, usually of visual type due to the involvement of the optic chiasm. The cavernous sinus is located laterally to the turkish chair and contains internal carotid artery and cranial nerves III, IV, VI and part of V, so it is necessary to keep in mind that the pituitary macroadenoma can cause few symptoms endocrine and severe neurological symptoms.
INTRODUCTION
We present an 80-year-old male followed by endocrinology for a cold thyroid nodule for more than 30 years with a medular compression syndrome, and testing for diagnosis and treatment.

CASE DESCRIPTION
One year after the last revision by endocrinology, the patient comes to his doctor for low back pain, hypoesthesias with level in abdominal region and disorder of the gait of 20 days of evolution that has been progressively getting worse, needing a cane, and successively crutches. It derives from neurology consultation. The patient presented tactoalgesic hypoaesthesia and palestesic with level T9-T10. Knee heel test and ataxic gait test. Dorsal Magnetic Resonance shows metastasis in dorsal vertebrae T9 and T10, stenosis of the spinal canal and compressive myelopathy in cord posterior to D9. The clinic evolves into a paraplegia, whereby Dexamethasone is given and the patient is entered to complete the study. Hours later, a nocturnal dysphagia and desaturation begins, CT angiography of pulmonary arteries is performed, showing nodular lung metastases and lymphangitis. Finally, with the help of the pathological anatomy of de metastases, the diagnosis of the metastatic thyroid follicular carcinoma with metastases in dorsal column and lung was made.

DISCUSSION
Differential diagnosis: Demyelinogenic myelopathy, infectious, neoplastic, paraneoplastic. Compressive myelopathy, infectious, neoplastic or spondylotic.
To discard the importance of control by the physician in patients with thyroid pathology, which can lead to uncommon complications such as spinal cord compression syndrome when neither neoplastic disease is diagnosed nor treated.
Program for integrated care management of complex chronic patients - 1 year experience

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Introduction The hospital demography is changing due to the increase of life expectancy leading to the growth of complex chronic patients, physically and socioeconomically dependent, with multiple chronic diseases (CD) who are the major consumers of health resources.

Goals Implement a program for integrated care management of complex chronic patients (Pro-GiC) with an holistic approach to patient and their families in order to reduce hospital admissions and improve quality of life.

Methods Population: 912 patients with 4 or more emergency department (ED) visits in 2016 and 65 or more years old. Subpopulation: patients with 1 or more CD and belonging to 3 health units of primary care.

Results 146 patients were included and 81 were effectively evaluated. About 70% had 75 years or more, 53% were female, had 5.3 episodes in ED a year, 25% were illiterate. Lawton and Barthel scales showed respectively 65% and 50% patients with moderate to severe dependence. Up to 41% had signs of depression, 34% were at risk of malnutrition and 60% at social risk. Geriatric and Charlson index showed a high number of CD (medium 6), low life expectancy and drugs used were 7.6 units per patient. Our interventions were: social involvement in community (60%), health knowledge and empowerment in patients self-management (23%), therapeutic adjustments (22%) and prophylactic actions (8%). Overall mortality rate was 7% (n=6). We find a statistical correlation between age, presence of caregiver and education level and clinical variables, such as the number of CD, self-management capacity, admissions in ED, days of hospitalization and social status. The impact in ED admissions and hospitalizations is under evaluation but provisory data shows a reduction in these parameters.

Conclusion Our patients were elderly, with physical, social and mental dependences, had multiple comorbidities which require multiple interventions. In our opinion, Pro-GiC program represents a good clinical practice by focusing the action on patient.
Pyomyositis due to a soccer game: A Case Report

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Introduction
Pyomyositis is a purulent infection of skeletal muscle that arises from hematogenous spread, usually with abscess formation.

Case description
We present a 15-year-old soccer-player, with no other background, that consults about one week of fever up to 38°C and left inguinal pain. At admission, he presented 115/70 mmHg; 91 bpm; and 38.9 ºC. He presented painful inguinal exploration, at the internal face of the left thigh and laboratory showed an increased C reactive protein. He was started on Cloxacilin at high doses, adding Gentamicine when blood cultures were positive to Cloxacilin sensible S. aureus. Abdomino-pelvic CT scan was compatible with myositis and osteosytis. Magnetic resonance confirmed the findings and a small collection near pubis. After 2 weeks of intravenous Cloxacilin and Gentamicin, he was discharged with oral Cloxacilin for 2 weeks more.

Discussion
Predisposing factors for pyomyositis include immunodeficiency, trauma, injection drug use, concurrent infection, and malnutrition. About 25 to 50 percent of patients with pyomyositis report a history of trauma. It has also been described among athletes performing vigorous exercise, suggesting the potential role of minor muscle damage in the pathogenesis. S. aureus causes up to 90 percent of tropical cases and up to 75 percent of temperate cases. Although it can be treated with antibiotics alone in the early stages, most patients require both antibiotics and drainage for definitive management. Pyomiositis is an strange infectious condition, that should be taken into account when facing fever along with muscular pain.
Rare cause of ascites

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Objectives
The main causes of infectious ascites are spontaneous bacterial peritonitis and rupture of viscus. Ascites secondary to cirrhosis and neoplasia are common causes of inpatient hospital admission. Authors made a retrospective analyses of a rare cause of ascites, the tuberculous peritonitis, which is normally very difficult to diagnose and identify. We characterize clinical signs and symptoms, laboratory findings and diagnostic tools.

Methods
Consult of clinical data from every admission in one Internal Medicine ward from 2010 to 2018.

Results
There were four cases with ages between twenty seven to sixty four years old. Every patient had insidious clinical condition characterized by fever, abdominal pain and ascites with exudate characteristics. Two patients underwent exploratory laparotomy/laparoscopy. There was significant delay in diagnosis, which was confirmed in all cases by culture of lymph node biopsy (one patient), ascitic fluid (two patients) and peritoneal biopsy (two patients). Nucleic acid amplification testing was positive in only two patients and Mycobacterium tuberculosis complex was resistant to streptomycin and isoniazid in one patient.

Conclusion
Authors have considered an interesting retrospective study due to rarity of this pathology in occidental countries and the difficulty in identifying etiology, usually being necessary invasive methods.
Recurrent transient ischaemic attack - causes behind the clinical picture

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Introduction: Erythrocytosis is a cause of blood hyperviscosity and hypercoagulability, which are risk factors for thrombosis. Cerebral ischemia, in turn, even if transient, can lead to irreversible neurological damage, with possible development of epileptogenic foci.

Case description: A 81-year-old man, with several cardiovascular risk factors, including atrial fibrillation, presented in the ER with a 2-week history of self-limited speech disturbance episodes. He had normal neurological exam and CT scan, haemoglobin (Hb) 19.2g/dL, haematocrit (Hct) 63.6%, activated partial thromboplastin time (aPTT) 50 seconds and no other remarkable changes. After he was admitted, Polycythemia Vera (PV) was diagnosed and specific treatment was started, with phlebotomy and hydroxyurea. Nevertheless, he kept having episodes of self-limited motor aphasia. Etiological study of stroke was repeated and electroencephalography performed, once again with no evident changes. He was started on Levetiracetam. Even though cardiovascular risk factors, PV and possible vascular epilepsy treatment was optimized, symptoms persisted occasionally until discharge.

Discussion: Managing cerebrovascular disease of undetermined aetiology in patients with different comorbidities competing for the development of neurological events is a complex activity in which it is important to consider therapeutic options directed to the various diagnostic hypotheses.
Referral to national ambulatory care facilities: benefit or curse? Experience of a Portuguese center.

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Objectives: To study the effect of referring patients to the National Network of Integrated Continuing Care (NNICC) on the average length of hospital stay and secondary medical complications in a Portuguese center. In 2006, NNICC was created in Portugal to provide integrated response to the increasing demands of the elderly population.

Methods: Retrospective observational study of all referred patients in a medical department between the 1st of April and 30th of June of years 2010, 2012 and 2016. A p<0.05 was considered statistically significant.

Results: During the study period, 130 patients were referred to the NNICC (15 patients in 2010, 59 in 2012 and 56 in 2016), 56.2% were men. Mean age at referral was 74 ± 12.8 years with an increase of older patient’s referral from 2012 (median of 74 years with an interquartile range [IQR] of 12.1 years) to 2016 (median of 79 years [IQR 6.4]), p=0.016. Most of referred patients were admitted due to infection (43.1%) or neurological disease (42.3%). The major reason for referral was physiotherapy. There was an increase in hospital stay over the years (from a mean of 22.7 ± 12.5 days in 2010, to a median of 19 days [IQR 13.4] in 2012 and 37 days [IQR 18] in 2016; p=0.0001-0.0029), mainly related to the extra days referred patients remained hospitalized while waiting for integration in the NNICC (2 days [IQR 3.9] in 2010, 5 days [IQR 9.1] in 2012 and 13 days [IQR 14.3] in 2016; p=0.002-0.008). During this period, 36.2% of patients developed clinical complications.

After hospital discharge, 40.4% of patients developed a clinical complication severe enough to require evaluation at the emergency department or re-hospitalization within 3 months.

Conclusion: This study reveals a current Portuguese reality of saturation of the NNICC. Where it is increasingly difficult to have an appropriate time response to the care needed, consequently leading to an increase in hospitalization time and the development of medical complications.
Relationship between hospital readmissions and adherence to treatment and prescription to discharge in the internal medicine service of general hospital.

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Objectives: To know how readmissions are influenced by therapeutic compliance, diet and non-pharmacological recommendations.

Material and methods: A retrospective study was carried out. Patients discharged in April and May 2016 and January and February 2017 in the Internal Medicine service of the Virgen de Valme University Hospital of Seville were included. A follow-up period of 30 days after discharge was established. Data were obtained from the digitized clinical history of each patient, complying with the confidentiality. Patients who were transferred or died. Hospital readmission is defined as hospital admission for any cause in the follow-up period.

Results: We include 840 patients of whom 16% were readmitted. 1.5% patients had bad therapeutic compliance, 33% were readmitted. In the other hand 98% patients had good therapeutic compliance, 16% were readmitted (OR 0.38; p = 0.118). In readmitted patients, the median number of drugs was 10 (Q1-Q3, 7 – 13). 1.5% readmitted patients performed a different diet than prescribed. 47% of readmitted patients had only one non-pharmacological recommendation at hospital discharge.

Discussion: 99% of the patients had good therapeutic compliance. Although the relationship between this variable and hospital readmissions is not statistically significant, we could afirm that it is a protective factor. The modification of it may lead to a significant reduction in readmissions. The evaluation of therapeutic compliance is complex with the tools that we currently have. Dietary compliance, pharmacological recommendations, higher number of drugs, can influence on the risk of readmissions, so it would be important to design actions to facilitate compliance.

Conclusions: 99% of the patients had a good therapeutic compliance, they presented lower readmissions, without having found statistically significant relationship. No relationship was found between readmissions and the number of non-pharmacological recommendations or dietary compliance.
Objective: To analyse ischemic strokes in a stroke unit of an hospital of the Northern region of Portugal, according to its clinical classification and site, comparing them with dysphagia, degree of dependency, aspiration pneumonia and mortality.

Methods: We identified all patients admitted during 2017, selecting and characterizing the ischemic strokes, according to the Bamford Stroke Classification and National Institutes of Health Stroke Scale (NIHSS), and gathered information about degree of dependency, dysphagia, and rates of pneumonia, duration of admission and mortality. The dependence degree was quantified using modified-Rankin and Barthel scales, and dysphagia using Gugging Swallowing Screen (GUSS). The data were submitted to single and multivariate analysis.

Results: Among all the patients (n=376), 301 had an ischemic stroke. Our population had 55.8% women and median age of 76.4 years-old. Clinically, 47.5% were total anterior circulation infarction (TACI), 20.3% had pneumonia, and 16.6% deceased. TACI’s had the lowest GUSS scores (11.8 at admission), highest rates of aspiration pneumonia (35%), mortality (33%), and longest duration of hospital admission (16.22 days), followed by posterior circulation infarctions (POCI). Infarction of the right side had lowest GUSS, with highest rates of pneumonia.

Conclusion: Dysphagia is a major risk-factor for stroke-associated pneumonia, being a frequent complication during the first days post-event, with increased mortality and dependency rates. This study shows that more severe strokes embracing larger territories have lowest GUSS, representing greater degrees of dysphagia, higher incidence of aspiration pneumonia and mortality, and longest admissions with greater health costs.
Relying On Intuition

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Introduction

Visceral leishmaniasis is a non-contagious zoonosis caused by the protozoan Leishmania and transmitted by mosquitos. Although not very frequent in Europe, one should be aware of this disease because of its systemic repercussion and high mortality when untreated. Our aim is to show a case of illness diagnosed in a less common way.

Case Description

We present a case report of a girl admitted with fever, pancytopenia and splenomegaly, who had been to a summer camp, close to a river, two years earlier. The diagnostic tests used were blood analysis with several serologies, blood and urine cultures, full-body ct scan and myelogram. The patient maintained sustained fever and pancytopenia worsening, requiring blood transfusion. We first instituted antibiotic therapy with clarithromycin and posteriorly piperacillin-tazobactam and metronidazole, without improvement. Given the past history of stay in a holiday camp close to a river, there was a high suspicion of leishmaniasis. The blood analysis revealed iron metabolism in favor of an inflammatory/chronic disease, the serologies were all negative except IgG anti-Leishmania, and the myelogram did not show Leishmania amastigotes. We initiated therapy with liposomal amphotericin B, with resultant sustained apyrexia and favourable evolution of pancytopenia and splenomegaly.

Discussion

This case report shows an indirect way of diagnosing visceral leishmaniasis, through late immunity and therapeutic response. The most common is to find the parasite in the spinal examination, which was not possible in this patient. Despite negative or inconclusive analytic results, one should always rely on intuition and act accordingly.
Shorthand Training and Cognition – Results of a 5 Year Pilot Study

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Objectives:
Cognitive decline and dementia are associated with ageing. In 2010 we started a pilot study on shorthand training and cognitive outcome within 5 years.

Methods:
Study participants were trained in shorthand in weekly sessions by an experienced trainer and examined for history, physical performance, technical and laboratory examinations as well as extended neuropsychological testing every year for 5 years. The study started with 17 female community dwelling participants with a mean age 71.8±4.9 years, independed in ADL and IADL and without severe somatic, cognitive, psychiatric or neurologic diseases. They were all right handed.

Results:
12 participants (76.9±4.8 years at examination in 2016) completed the full 5 year training program. A total of 5 women were lost to various reasons (depression, malignancy and personal reasons). In all neuropsychological test instruments we found no age-associated cognitive decline within 5 years, instead in a subset of instruments (Rey-Osterrieth Complex Figure, Mini Mental Status Examination (MMSE)) we find a significant improvement (Rey CFM p=0.015, Rey CQM p=0.002, MMSE subtest orientation p=0.035).

Conclusion:
Comparing to baseline results we found no decline over 60 month in global cognition or in sub-tests in a group of older healthy woman who were trained in shorthand with further speed training over the whole time period. In some tests we found a significant improvement. Overall we can state that in this study cognitive abilities are preserved over five years.
Spontaneous cerebrospinal leak and bacterial meningitis – a case report

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Introduction
Bacterial meningitis is a severe inflammatory disease of the leptomeninges, caused by a bacterial agent. Cerebrospinal fluid (CSF) rhinorrhoea results from a direct communication between the subarachnoid space and the paranasal sinuses, and may serve as a path for the spread of microorganisms and development of meningitis and intracranial infections.

Case description
A 73 year-old female was admitted to the Internal Medicine Intermediate Care Unit with the diagnosis of bacterial meningitis, for neurological supervision, given the marked lethargy on admission. The typical clinical syndrome (headache, photophobia, fever and vomiting) developed after a three weeks complaint of watery rhinorrhoea. Ceftriaxone and ampicillin were started, with prompt clinical improvement. After neurological recovery, the patient referred postural headaches and important watery rhinorrhoea that occurred mostly when seated or standing, with immediate improvement when laying down in bed. The hypothesis of CSF leak was raised and, indeed, the rhinorrhoea fluid tested positive for glucose in the urine dipstick test. The culture of the CSF revealed Streptococcus viridans, which is part of the normal microbiota of the upper respiratory tract. There was no history of head trauma or persistent sneezing. The brain MRI confirmed the existence of a small continuity solution located in the cribriform plate. The leak resolved spontaneously with conservative measures. The patient was discharged home, asymptomatic, after 21 days of antibiotics.

Discussion
CSF leak is a rare cause of meningitis. It may also be complicated with the development of pneumocephalus and secondary brain compression. Bacterial meningitis is the major cause of mortality and morbidity in patients with CSF fistulae. The authors emphasize the significance of proper symptom characterization in the identification of uncommon aetiologies of pathological states that carry significant morbidity and mortality.
Spontaneous pneumomediastinum after cocaine inhalation

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Introduction: Chest pain is a common complaint of cocaine users in the emergency department. Pneumomediastinum is an uncommon complication of cocaine abuse that occurs more commonly when cocaine is smoked, but can also occur when cocaine is nasally insufflated.

Case description: A previously healthy 27 year-old male presented to the emergency department with chest pain and dyspnoea. He was a chronic and habitual user of cocaine, heroin and tobacco. He admitted to have consumed about 5 grams of intranasal cocaine and several shots of vodka in the previous night. During the night we was awaken by a constant pressure-like pain, with substernal localization and 10/10 in severity, exacerbated by movement and deep inspiration and alleviated with rest. There was no history of penetrating trauma or severe respiratory infection. Oh physical examination, his vital signs were stable and a subcutaneous emphysema on the neck and upper chest was palpable; pulmonary auscultation was clear, cardiac sounds were rhythmic, without murmurs, but with mediastinal crunch (Hamman’s sign), and the abdomen was soft and non-tender. Blood analysis had no relevant alterations. Urine toxicology screening for cocaine proved positive. Electrocardiogram showed a sinus rhythm without QRS or ST segment changes. The chest x-ray revealed pneumomediastinum and subcutaneous emphysema, which was confirmed by a thorax computed tomography. Esophageal rupture or bronchial tree laceration were excluded. During hospitalization, the patient recovered rapidly without intervention other than oxygen and his chest radiograph returned to normal after 3 days.

Discussion: When evaluating a patient with chest pain it is essential to consider the possibility of spontaneous pneumothorax and pneumomediastinum in the differential diagnosis. In the case of the last, it is important it is exclude or confirm the use of abusing substances, namely cocaine for its frequent association with pneumomediastinum.
Sporadic hemiplegic migraine with prolonged aura: A case report

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INTRODUCTION: Hemiplegic migraine is a rare form of migraine with aura, being the sporadic hemiplegic migraine with prolonged aura an anecdotal condition.

CLINICAL CASE: A 24 years old woman with no relevant medical history. She was admitted to the emergency department for a 6-day clinical evolution characterized by sudden episodes of right hemicranial headache, associated with nausea, photophobia, paresthesias in the right facial region, diplopia, ataxia, vertigo, and left hemiparesis. The physical examination revealed central right facial palsy, partial paralysis of the left oculomotor nerve, right hearing loss, left hemiparesis, left-sided allodynia, and truncal ataxia. The fundoscopy was normal. Axial computed tomography scan of the brain and contrasted nuclear magnetic resonance of the brain with cerebral angioresonance were both reported normal. Given the above, a diagnosis of hemiplegic migraine was made. Treatment was initiated with flunarizine, noticing progressive improvement of symptoms and complete resolution of the motor deficit after 4 days of treatment.

DISCUSSION: With a reported prevalence of 0.002-0.005%, hemiplegic migraine is a very infrequent form of migraine with aura, whose main characteristic is reversible motor deficit, being the sporadic hemiplegic migraine with prolonged aura a less documented disease in the literature. It can be associated with basilar migraine manifestations in up to 72% of cases. Its clinical presentation is very heterogeneous, so it can often be confused with multiple sclerosis or an attack of cerebrovascular disease, representing a diagnostic challenge to the attending physician.
Stop orders in the prevention of CAUTI. Salamanca, Spain.

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Background: to evaluate whether a multimodal intervention (MI) that included stop orders for bladder catheter (BC) removal was effective in reducing the time of BC and the frequency of catheter-associated urinary tract infection (CAUTI).

Methods: all patients with BC admitted between October and December 2017 (P2) were included. This cohort was compared with a historical cohort of the year 2013 (P1). The MI of P2 consisted of: 1) training sessions for all staff on management of BC and prevention of CAUTI, 2) use of BC stop orders (Houdini protocol), 4) surveillance of CAUTI (CDC criteria), and 5) feedback of results. The average time of BC, mean catheterization rate, and CAUTI rate between cohorts were compared.

Results: In P1 129 patients with BC were included. They were monitored during 1189 days of BC and 3783 days of stay, and they developed 28 CAUTI. In the P2 252 patients with BC were included. They were monitored for 1298 days of BC and 5005 days of stay, and they developed 11 CAUTI. In P2 it was found: a significant reduction of BC days (12.7 vs 6.7), of mean catheterization rate (31.4% vs 25.9%; RR 0.8; 95%CI 0.77-0.88); of CAUTI risk (21.7% vs. 4.4%, RR 0.20, 95%CI 0.10-0.39); of CAUTI per 1000 stay days rate (23.5 vs 8.5, HR 0.36, 95%CI 0.18-0.72); and of CAUTI per 1000 catheter days rate (7.4 vs 2.2, HR 0.29, 95%CI 0.15-0.60).

Conclusion: our protocol specifically designed for BC withdrawal is effective in reducing BC and the frequency of CAUTI.
Subacute onset bilateral diaphragmatic paresis

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Introduction: Ventilation depends on several factors like respiratory muscles strength, the main one being the diaphragm. Diaphragmatic paresis has multiple causes and its presentation is usually insidious and in the context of a systemic disease.

Case description: The authors present the case of a 54 years old man with metabolic syndrome with a 3 day history of orthopnea and progressive bilateral cervico-omalgia. He had an influenza infection in the previous weeks. He presented to the emergency department with tachypnea on orthostatism, severe orthopnea, paradoxical breathing, mild hypoxemic respiratory insufficiency worsened by dorsal decubitus and reduced vesicular murmur in the lower half of both lung fields. No neurological deficits were found. Suspected bilateral diaphragmatic paresis was confirmed by ultrasound and fluoroscopy, conferring a restrictive ventilatory syndrome with frank worsening in decubitus. He was admitted to an intermediate care unit and started on non-invasive ventilation. Isolated pleocytosis was found in the CSF and a cervical CT showed bilateral C3-C5 compressive radiculopathies without space conflicts. The remaining etiological study was normal.

There was progressive improvement during the first week of hospitalization. However, the intolerance to decubitus below 30° with dyspnea class mMRC 2 persisted. The absence of other neurological symptoms, the exclusion of other causes and the partial clinical improvement without specific treatment supports an idiopathic aetiology.

Discussion: Several diseases may be associated with diaphragmatic paresis, such as neuromuscular diseases, infectious polyneuropathies and lupus erythematosus. In this case the initial clinical presentation is very suggestive of an idiopathic subacute diaphragmatic paresis, an uncommon entity.
Sudden deafness ... clinical presentation of cerebrovascular events of the posterior circulation

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Introduction: POCI-type strokes are often confused, at an early stage, with otorhinolaryngological pathology. They represent the minority of events according to the Oxfordshire classification, but are also associated with the worse prognosis.

Case description: 53-years-old male, with hypertension, type 2 diabetes, dyslipidemia, and peripheral vertigo syndrome with discontinuation of the medication in the late month. He presented in our ER with left facial paralysis, left sensorineural hypoacusis and dizziness with about 3 weeks of evolution. The cranial CT had no acute changes. After symptomatic therapy with corticoid - with improvement of complaints of deafness – patient performed a cranial MRI with "recent infarction of perforating branches of the basilar artery". At that time were ordered several complementary diagnostic tests to stage the cardiovascular risk. The Holter of 24-hours documented periods of rapid ventricular response in an atrial fibrillation. He was discharged with hypocoagulant therapy.

Discussion: The present case report intends to expose the diagnostic complexity of a cerebrovascular event of the posterior circulation in a patient with history of vertiginous syndrome.
Systematic handoffs to improve patient outcomes and resident satisfaction

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Objectives

Recent studies have shown that an increase in patient handoffs is directly contributing to increased adverse medical events. Medical residents are at the forefront of patient care in many healthcare institutions and thus become an integral part of ensuring safe and efficient handoffs. Implementation of an innovative standardized handoff procedure has been shown to minimize medical errors without significantly disrupting workflow. The purpose of this study was to prospectively assess the effect of a standardized handoff procedure at our institution on patient outcomes, adverse events, and resident satisfaction.

Methods

Baseline data was collected on resident satisfaction with the quality of handoffs received using the current handoff procedure at our institution. Resident satisfaction was collected using a 3-question survey of satisfaction as rated on a 5-point Likert scale. Residents were also asked to track non-lethal adverse events, that could have been prevented with a more efficient handoff, i.e. an inappropriate altered mental status workup on a patient with known dementia that was not documented and not conferred in the handoff. A standardized handoff procedure was then created that best served the unique needs of our residency program. Following this baseline data collection, all residents were trained in the new handoff procedure and we again collected data on resident satisfaction and adverse events.

Results

After initiation of a standardized handoff method, residents are more satisfied with the quality of patient handoffs while covering teams feel more confident managing patients. Non-lethal adverse events were reduced pertaining to more efficient communication regarding patients’ baseline status, illness severity, or action list.

Conclusion

Our work underscores the importance of a thoughtful and deliberate effort to standardize the handoff procedure. Doing so improves not only resident satisfaction, but also reduces non-lethal adverse events.
Tansforming growth factor beta 1 (TGFβ-1) and brain atrophy in alcoholism

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Objectives: There is uncertainty regarding the role of TGFβ-1 on adult brain. Serum levels of TGFβ-1 were decreased in Alzheimer disease (AD), but not in healthy seniors. Others described increased TGFβ-1 in cerebrospinal fluid in patients with AD and Parkinson disease, but normal ones in amyotrophic lateral sclerosis. The relation between TGF beta and brain atrophy in alcoholics has not been described. Methods: 75 alcoholic patients aged 59.09 ± 11.56 years, drinkers of 180 g etanol daily for > 10 years and 34 age and sex-matched controls, underwent a brain CT scan, on which several indices were calculated, and routine laboratory evaluation and determination of TGFβ-1, IL-6, TNF-α, IL-4, interferon-γ and C-reactive protein (CRP) Results: Serum TGFβ-1 levels were higher in alcoholics, and directly related (i.e., the higher the TGFβ-1 levels the greater brain atrophy) with bicaudate index (r=0.27, p=0.023), cella index (r=0.23, p=0.047), and ventricular index (r=0.24, p=0.040), and, in a nearly significant way, with bifrontal index (r=0.22, p=0.067); By multivariate analysis, besides Evans and bifrontal index, both age (in the first place) and TGFβ-1 (in the second place) were independently related with the CT indices. TGFβ-1 was inversely correlated with IL-6 (p=-0.39; p=0.001), IL-4 (p=-0.30; p=0.017), and interferon gamma (p=-0.27; p=0.031), but not with TNF-α (p=-0.02) or CRP (p=-0.22, 0.06>p>0.05). Conclusions: TGFβ-1 is increased in alcoholics, and, similarly to what is described AD and other neurodegenerative conditions, it is related to CT-assessed intensity of brain atrophy.
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The azygos lobe: an unusual anatomical variation

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Case description: A 47-year-old male was admitted in the emergency department with a history of breathlessness, cough, pleuritic chest pain and fever for the past week. Based upon the history, clinical examination, laboratory results and imaging studies a diagnosis of viral upper respiratory infection was made.

His chest radiograph showed an azygous lobe of the lung with a thin fissure separating it from the rest of the right upper lobe and a tear-shaped shadow due to azygos vein.

Conclusion: The azygos lobe is a rare but normal anatomic variant of right upper lung seen in only 0.4% of population radiologically. It may be confused with a cavitation, an abscess or lung mass if consolidated but is generally an incidental finding of clinical unimportance. However some pulmonary disorders such as infections, tumors or pneumothorax may develop within this lobe and the recognition of this anomaly is therefore important, specially during thoracic surgical procedures.
The clinical sense - when the patients don´t tell you all

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Introduction:
Infection by the human immunodeficiency virus (HIV) in its initial phase may not present symptoms and, when symptoms are non-specific, may be confused with other diseases. Early diagnosis before AIDS is important, after HIV infection has progressed to AIDS, there is an increased risk of death that varies dramatically from person to person.

Case description:
The authors present the case of a man, 42 years of age, with no relevant past history, with multiple visits to the emergency department in the last 8 months due to diarrhea and abdominal pain. Colonoscopy, upper endoscopy, abdominal / pelvic CT scan were normal. Admitted to the medicine ward by diarrhea, pain on bowel movement, fever and weight loss of etiology to be clarified. To objective examination only emaciated and anal fissure. From the complementary study performed during hospitalization: analytically increased inflammatory parameters, microcytic / hypochromic anemia, adenovirus, rotavirus, clostridium toxin, parasitological and microbiological tests of stools were negative. Group TORCH negative. Abdominal ultrasound without changes. HIV serotypes 1 and 2 were requested with HIV 1 positivity, viral load 132 600.00UI / mL, CD4 + 79. The patient denied risk behaviors, namely sexual, injecting drug use or blood transfusion.

Discussion:
In the presence of the clinical history provided by the patient, the suspicion of HIV infection was remote since there were no risk factors, however, in the case of chronic diarrhea, we must always exclude all etiologies, even when patients deny us some key factors the diagnosis. We can not exclude the diagnostic hypothesis of HIV infection in a patient with chronic diarrhea.
The danger of complementary therapies: acupuncture-induced pneumothorax

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Introduction
Pneumothorax is defined as free “air in the pleural cavity” 1 and is a well-recognised complication of medical procedures involving the pleural space. There is an increase in frequency of iatrogenic pneumothorax following complementary therapies like acupuncture. 2 We present a case of a lady who developed an iatrogenic pneumothorax following an acupuncture session.

Case
A 69-year-old lady was admitted with dyspnoea and chest pain radiating to the right shoulder. Four hours previously she had attended a physiotherapy session, which also involved acupuncture for chronic back pain. Admission chest radiography demonstrated a large, approximately 50% right sided pneumothorax with almost complete collapse of the lower lobe. Good resolution of the pneumothorax was achieved following tube thoracostomy, which was removed after 24 hours.

Discussion
Acupuncture is a complementary therapy that uses needles to stimulate sensory nerves in the skin and muscle. In view of its popularity, clinicians should be familiar with its complications. In addition, acupuncture practitioners should be trained to recognise and refer patients who experience complications that require medical treatment. A well-documented adverse event profile 3, 4 suggests that the practice of acupuncture should include an informed consent process.

References
The deleterious impact of nonsteroidal antiinflammatory drugs in our health: A case-by-case study

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Objectives:
To estimate and characterize the number of patients under anti-inflammatory therapy at home;
To assess the impact of this therapy on the development of acute renal injury;
To evaluate the recognition of the deleterious impact of non-steroidal anti-inflammatory drugs on medical pathology.

Methods:
The data correspond to a retrospective analysis based on letters of discharge from the internal medicine service of Centro Hospitalar da Universidade de Coimbra, dos Hospitais da Universidade de Coimbra (CHUC-HUC) between March 1, 2017 and March 31, 2018. The terms used for chart search were: non-steroidal anti inflammatory (NSAID’s).

Results:
The study included a sample of 104 patients who were medicated with non-steroidal anti inflammatory drugs on a daily basis. The overall mean age was 70 years and 54.4% were female. The most used NSAID was naproxeno (32.2%) and the less used celecoxib (0.9%), drugs association were used in 7.8% of the cases. 35% of the patients developed acute renal failure, and of these 67% were also medicated with angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs). Only 38.9% had written recommendations on their discharge letter to stop taking these drugs.

Conclusion:
Despite their analgesic and anti-inflammatory properties, NSAIDs have detrimental systemic effects, which may exacerbate or cause disease in different organs, putting their users at risk. Although several studies have already been carried out on this negative impact, the Portuguese population continues to be a major consumer of these drugs, mostly women, even being carriers of diseases that contraindicates their use. On the other hand, there seems to be an undervaluation by medical teams of these effects.
The diagnostic challenge of fever

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Introduction
Fever of unknown origin (FUO) is associated with many clinical syndromes and there is no standard diagnostic algorithm to evaluate it. Q fever is a zoonosis caused by Coxiella burnetii and is one of the most common infectious etiologies of FUO, with a wide spectrum of clinical manifestations.

Case description
The authors present a case of a 58 years old woman admitted to the emergency department (ED) with fever greater than 38° C with 3 days of evolution and myalgias. Past history of hypertension, diabetes mellitus, obesity and history of venous thromboembolism in the left leg 1 month ago, under hypocoagulation. Recent travel in the previous 10 days to South of France and Andorra. Physical examination in the ED showed no signs of hemodynamic instability and blood tests revealed elevation of inflammatory markers, with no evident focus of infection. Admitted for further investigation. Ceftriaxone was started after blood and urine cultures. Thoracic angio-CT scan was performed and excluded pulmonary thromboembolism or other parenchymal changes. Abdominal and pelvic CT scans revealed inguinal adenopathy with 2 cm, histology biopsy revealed granulomatous lymphadenitis (GLA). Blood and urine cultures were negative. Cultures for Mycobacterium tuberculosis were also negative. Doxycycline was associated to Ceftriaxone at day 3, with no more registration of fever since day 11 of admission. The immunological study was negative. After 17 days she was asymptomatic and discharged with follow-up in medical consultation. Serology for Coxiella was available after discharge, with anti-IgM and and-IgG phase II titers strongly positive.

Discussion
The majority of fever syndromes stay without a final diagnosis, despite intensive evaluation. The diagnosis of Q fever is retrospective. The authors emphasize the importance of knowing the epidemiology and clinical characteristics of Q fever in order to enable an early therapeutic approach.
The effect of cardiac complications on outcomes of extensive surgical interventions

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Background: cardiac mortality after noncardial operations according to the literature is between 0.5% and 1.5%, and the incidence rate is from 2% to 3.5%. Objective: to assess the frequency of cardiac complications occurring in patients during the first month after major surgical interventions.

Methods: analysis of the results of treatment of patients (n = 61) with kidney cancer and tumor thrombosis of the inferior vena cava and musculo-invasive bladder cancer. Radical nephrectomy was performed in 18 patients, radical cystectomy - in 43 patients. 35 patients (57%) had the 3-d degree of anesthesia risk (ASA), the 2-d degree - in 26 patients (43%). Among the concomitant pathologies prevailed: arterial hypertension - 65%, coronary heart disease – 14.7%, diabetes mellitus – 14.7%, acute cerebrovascular accidents – 9.8%. The combination of two or more diseases in one patient occurred in 29.4% of cases.

Results: within a month after the operation, cardiac complications in 8.2% of cases were observed in patients, including those with a fatal outcome: 3 cases of acute myocardial infarction development, 1 case of acute cerebrovascular accident, 1 episode of pulmonary embolism. Nonfatal complications included: transient myocardial ischemia (19.6% of cases), paroxysm of atrial fibrillation (4.9% of cases).

Conclusion: considering the large number of cardiac complications in patients who underwent extensive surgical interventions, careful pre-operative correction of risk factors, including correction of drug therapy in patients with comorbid pathology, observation of patients by a therapist in the early postoperative period is necessary.
The first results of "Choosing Wisely" campaign of Russian Scientific Medical Society of Internal Medicine

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Objective: to identify a list of top-5 recommendations of the Russian Choosing Wisely campaign.

Methodology and results. The Russian Scientific Medical Society of Internal Medicine (RSMSIM) has join the global campaign "Choosing Wisely". The concept of the campaign implies promoting the rational distribution and increasing the efficiency of the use of health care resources. Each participating professional community created a list of clinical situations (recommendations) that should be considered in terms of rationalizing therapeutic and diagnostic approaches. The resulting lists stimulate discussion about the appropriateness of many frequently applied interventions.

At the first stage, all the recommendations published in other campaigns of internal medicine societies, have been screened by the working group and 90 recommendations the most relevant to clinical practice in the field of internal medicine in Russian, were retrieved. As a second step, a group of experts evaluated the rating of the selected items. Then 26 items that received the highest score, as well as 4 items, additionally proposed by the experts, were submitted as online voting to the RSMSIM full members for the rating evaluation. As for the attribution of priority, the voters could express their opinion intuitively, without request for justifications. After a four-month voting period, experts evaluated the evidence base for 10 situations with the maximum score and developed a coordinated position.

Conclusion. Thus, the top-5 list of Russian Choosing Wisely Campaign, supposed to be discussed by professional therapeutic community, was finally identified. The future studies will show whether the recommendations will lead to a reduction in morbidity and mortality, as well as a reduction of financial waste in the healthcare. The campaign can be a useful tool for inducing therapists and subspecialists to a different way of thinking about professionalism and appropriateness of interventions.
The ghost man: hard to believe!

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Introduction: Parvovirus B19 infection may have a broad spectrum of clinical presentation, ranging from benign to potentially life-threatening, depending on the patient's age and hematological and immunological status.

Case description: We present a 55 years old male, sportsman. Background of peripheral arterial disease, submitted to bilateral femoro-popliteal tip and medicated with clopidogrel and rosuvastatin. He attended the emergency department for easy fatigue and dizziness, with 5 days of evolution, diarrhea, fever and sweating. Analytically: Hb 3.8 g / dl, Htc 15.6%, Hb 3.8 g / dl, Hb 3.8 g / dl, VGM 102.7fl, normal leukocytes and platelets, normal vitamin B12. High digestive endoscopy without alterations. He had a red blood cell transfusion and was hospitalized for study. During hospitalization with excellent general condition and hemoglobin rise to 5.8g / dl. Analytically: low iron and ferritin, reticulocytes 3.4% (decreased), normal haptoglobin, normal complement, normal IgA, IgG and IgM, HIV negative, ANCA and negative ANAs, normal B2 microglobulin. Virus positive for Parvovirus B19. CT scan showing only stasis liver. Echocardiogram with moderate mitral insufficiency. Unchanged colonoscopy. Bone marrow biopsy "reactive erythroid hyperplasia, abnormalities in myxacariocytic lineage usually observable in myelodysplastic syndromes (SMD). OncoFISH for SMD 7% positive for del7q31. The patient was discharged with iron supplementation and was re-evaluated the following week, with Hb 9.2g / dl already present.

Conclusion: Such a low hemoglobin in a patient entering the foot itself is unbelievable. In this case, it was due to an erythroid aplastic crisis, which is fortunately self-limited, but which, given the patient's previous hematological susceptibility, was sufficient for an infection by Parvovirus B19 had such a marked rebound in erythropoiesis.
The Hidden Truth

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INTRODUCTION:
Human immunodeficiency virus (HIV) infection compromises the host immune response, facilitating opportunistic infections. HIV infection is often associated with other sexual transmitted or hematogenous infections, such as hepatitis C virus (HCV). The diagnosis of this immunodeficiency should be considered in all patients with atypical clinical presentation or in those severely ill due to common diseases.

CASE DESCRIPTION:
The authors describe the case of a 45 years old woman with previous history of hypertension and obesity. She presented in the emergency department with 2 weeks ongoing of dry cough, fever and dyspnea. She was hospitalized with the diagnosis of community acquired pneumonia and empirical antibiotic was initiated. In the first days of hospitalization she had a clinical worsening with sustained fever and increased need of supplemental oxygen delivery. An exuberant oral candidiasis developed in the meantime. Laboratorial finding showed elevated infectious parameters (C-reactive protein and neutrophilia), anemia, hypoalbuminemia and increased sedimentation rate. After the resolution of the pneumonic syndrome, a sustained bicytopenia (anemia and leucopenia) was revealed. In the following study, HIV and HCV serologies were positive.

DISCUSSION:
There were several factors that suggested a compromised immune response in this case: it was a young woman with no apparent risk factors who presented with a severe pneumonia with poor response to the initial treatment. The emergence of bicytopenia also favors this hypothesis. In addition, the development of oral candidiasis can be framed as an opportunistic infection in an immunocompromised host. The co-existence of HIV and HCV infections suggests hematogenous transmission.
The importance of differential diagnosis

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Introduction: Liver abscesses are a rare and challenging clinical entity with respect to their diagnosis and treatment. It occurs in about 2,3 cases per 1000,000/year and corresponds to 48% of visceral abscesses, affecting 13% of intra-abdominal abscesses. Microbiology is often polymicrobial.

Case description: A 53-year-old male, smoker. Presentend with fever, asthenia and right pleuritic thoracalgia, and was discharged with antibiotics for community acquired pneumonia. Two days later, he returned to the emergency department for maintenance of fever (39ºC), asthenia, pleuritic thoracalgia and myalgias. He also reported an episode of food vomiting and pain in the right hypochondrium. No other symptoms were presented, travel and contact with animals were excluded. The patient has no previous surgery. On physical examination was caught the attention the temperature, decreased vesicular murmur at right base and slight abdominal distension. On blood panel, there was elevation of inflammatory markers and liver and colesthatic enzimes. The thoracic RX revealed pleural effusion of small volume on the right, with atelectasis and elevation of the diaphragm. On thoraco-abdomino-pelvic CT scan, hepatic abscess was observed in segment VIII, without biliopancreatic or splenic alterations.

Infection screening and broad spectrum antibiotic therapy were initiated. The patient underwent percutaneous eco-guided drainage with product collection for microbiology. Toxic, iatrogenic, hepatotropic viruses and patient immunocompetence were tested.

Under guided therapy, there were symptom resolution and normalization of hepatocellular function.

Discussion: Liver abcesses are often misdiagnosed due to unspecific symptoms. Untretead, have a very poor prognosis with high mortality.

The symptoms, physical findings and laboratory markers can be variable as illustrated by our patient. Our case underlines the importance in keeping hepatic abscesses on the differential diagnosis.
INTRODUCTION: Breast cancer is the most common cancer in women in Portugal. Mortality has declined about a third in the last three decades, partly because of increasing screening programs, but also because of improved and early treatment institution. Screening detects disease in early stages, when chances of successful treatment are also higher.

CASE DESCRIPTION: We present a 76-year-old woman, with history of hypertension, dyslipidemia and obesity, medicated with furosemide, perindopril/amlodipine, indapamide and pitavastatin. She developed cervical and dorsal pain 3 months prior to admission with subsequent weight loss (around 5kg within a month). Three months later she also developed dyspnea for medium efforts. A thoracic CT was performed showing "numerous pulmonary nodules, most of them <5 mm (...) Ganglia in the left axilla, the largest with maximum axis of 2.7 cm. Lithic images in multiple vertebral bodies and costal arches suggestive of bone and pulmonary metastasis". She was then admitted for study of metastasis of unknown primary. On physical examination presented inversion of the left nipple, hardened area in the upper quadrant of the left breast and left axillary adenopathy, changes that the patient reported to be present for about 6 months. A mammography was performed showing a suspicious lesion in this region, and a biopsy of the lesion and axillary ganglion was performed. Histologically, breast adenocarcinoma was confirmed. She was then proposed for palliative chemotherapy that was readily suspended due to intolerance. She died three months later.

DISCUSSION: In spite of the advances observed in recent years, both in terms of complementary diagnostic exams and therapeutics, clinical history and physical examination continue to play a fundamental role. It is through these that clinical suspicion arises, guiding all the etiological investigation, allowing an early diagnosis and therapeutic institution, which may have a great impact on prognosis.
The Internal obstetric medicine: A frequent situation in consultation

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Introduction:
Internal obstetric medicine is a common, transversal and multidisciplinary medical exercise. This retrospective study of 41 patients' files taken in Oran's internal medicine unit for maternal pathologies and pregnancy aims to study the epidemiological, evolutionary aspects of her pregnancies and associated diseases.

Materials and methods:
This retrospective study was conducted over a three-year period. The inclusion criteria are clinical, biological and radiological known pregnant patients carriers of medical conditions or who presented the disease during pregnancy.

Results:

The mean age of our parturients is 32 years. The most common association found in our study was Diabetes, and dysthyroidism marked by good Pregnancy changes.

5 patients with dysthyroidism and other conditions such as hypertension, celiac disease, anemia and alpha thalassemia and psoriasis.

Two patients presented with progressive onset of Behçet's disease, one during pregnancy and the second postpartum. Complications noted posterior uveitis with decreased visual acuity and a case of postpartum cerebral thrombophlebitis.

Two patients followed for multiple sclerosis were stable on corticosteroids before pregnancy and during pregnancy but with postpartum complications and outbreak of the disease.

Two patients with type 1 diabetes, hypothyroidism associated with celiac disease for the first and a Crohn's disease for the second marked by a good evolution.

A case of maternal thyroid cancer during the first trimester of pregnancy of a 46-year-old patient, with a favorable evolution of the cancer but unfavorable for the fetus.

Conclusion:
Obstetrical internal medicine is a very distinct and frequent way of exercising medicine in our current practice, taking care of maternal pathologies associated with pregnancy, improving maternal-fetal prognosis, strict follow-up, adapted treatments and, above all, the programming of pregnancy.
The internist teacher: An experience of the use of the social media in teaching during the undergraduate rotating internship in Internal Medicine

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OBJECTIVES
The aim of our work was to develop, to implement and to evaluate an educational method based in the use of the social networks in the practical education (hospital practice) of the Internal Medicine during the undergraduate rotating internship of the Degree of Medicine.

METHODS
Initially, a bibliographical review was made, and groups of discussion were created to select the social network that better adapted to the educational aims of the study and to identify the areas in which its utilization could be more useful. Based on this information, an educational strategy was designed and implemented and, finally, its usefulness was assessed in semi structured interviews.

RESULTS
The social network selected (for its broad diffusion and usability) was WhatsApp. Thirty 4th and 5th year students (in WhatsApp groups of 4-5 members) voluntarily participated in the experience. The tutors distributed in the groups selected complementary tests images of patients (always strictly preserving the right of intimacy). Likewise, links to educational material to guide and illustrate later discussions (individually or in group) were included. Sometimes, a gamification strategy was employed (see our other submitted paper). The easy availability of the clinical material was specially estimated by teachers and students, who could also prolong their discussions and comments out of the hospital schedule. Instead, the low quality, in occasions, of the clinical images could complicate its appropriate analysis. Measures to keep absolute intimacy of patients were well accepted.

CONCLUSION
Globally, WahsApp's use in the context of our study showed its usefulness in terms of satisfaction among teachers and students.
The internist teacher: Implementation of a strategy of gamification in the undergraduate rotating internship in the Degree of Medicine.

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Objetives:
To elaborate an educational method based on the strategy of gamification (to use dynamics of game in not playful environments and applications, to promote motivation, effort, loyalty and other positive common values to all the games) applied to the undergraduate rotating internship (hospital practice) of students of the Degree of Medicine.

Methods
Based on our previous experiences (see our other submission) the work was carried out using WhatsApp, by means of the creation of groups of 4 students and two teachers. The teachers proposed queries related to patients who had been seen in the unit of hospitalization, including: direct questions, interpretation of diagnostic tests, images and differential diagnoses, among others. Qualities of the gamification were applied as: immediate feed-back, collaborative work, level of competence recognition, recognition of partial achievements, presence of not predictable events for the students and open solutions to the challenges.

Results
The strategy was applied in four groups of 4th and 5th year students. The students participated actively, even during out of term periods. It was required, on the part of the teachers, major dedication and commitment to response, comment and correct the answers in a rapid / almost immediate way. The students valued very positively to be rewarded (with a virtual medal) for their correct answers and for the reasoned corrections of the mistakes, with the possibility of returning to solutions in a trial and error dynamic.

Conclusion
The partial gamification of the subject of rotating internship is possible, but it needs an infrastructure, which still we have not elaborated completely. The method is useful in learning and it is well-regarded by students and teachers.
The knowledge of health professionals about Palliative Care in a Portuguese tertiary center

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INTRODUCTION: The knowledge of health professionals about palliative care (PC) may be a barrier to their availability.

OBJECTIVES: Evaluate the knowledge of health professionals about Palliative Care

METHODS: Cross-sectional study with the application of a questionnaire on PC, authored by Professor Olivério Ribeiro and Master Susana Lopes, to all physicians and nurses in a Portuguese tertiary center, with a collection of socio-demographic variables, including years of professional experience, pre-graduated and postgraduate formation in PC. The response rate was 4.96%, corresponding to 90 professionals, of whom 30 were doctors and 60 nurses, aged between 24 and 65 years.

RESULTS: Sixty-three percent of the nurses and 26.7% of the physicians stated that they received pre-graduate training in PC, while 41.7% and 36.7%, respectively, postgraduate training. Overall PC scores ranged from 76.1% to 98.5% with an average of 88.6%, and these values were considered satisfactory by the authors of the instrument used. Physicians have a PC score higher than nurses (p=0.037) and “symptoms-control” is the dimension which more contributes to PC score (p<0.0001). There was no statistically significant relationship between PC knowledge and the number of years of professional experience (p=0.193) or between this same knowledge and the completion of pre-graduate PC training (p=0.438). However, professionals who attended post-graduate training in PC present higher PC knowledge (p=0.065).

CONCLUSIONS: The continuous training of professionals in PC seems to translate into better knowledge, and it is therefore essential to promote it.
The most likely diagnosis is not always the etiological diagnosis

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An 80-years-old patient with GoodPasteur's syndrome, with a unique functioning kidney, hemodialysis dependent since a month and half. She went to the Emergency Room due to respiratory distress, asthenia and pink expectoration. Blood analysis showed PCR 201 mg/lU; Hb 7.6 g/dL (1 g/dL drop). Gasometry with severe acute respiratory failure. X-ray thorax: bilateral pneumonia with greater exuberance on the right. For a better characterization, a thoracic computed tomography was performed: "(...) multiple bilateral parenchymal infiltrates of peribroncovascular predominance involving the middle and lower right lobes of the right hemitorax. Depolarized glass pattern (...) peribronchovascular nodular opacities." In agreement with Nephrology, Internal Medicine and Pulmonology, he made pulses of methylprednisolone, hemodialysis, plasmapheresis and started Meropenem. For better characterization, the patient underwent bronchofibroscopy, which revealed the presence of fungal structures compatible with Aspergillus in the cytologic examination of bronchoalveolar lavage. He immediately started voriconazole, suspended plasmapheresis and gradually improved respiratory failure, hemoptotic sputum disappeared. The pulmonary atrophy of Goodpasteur's disease was not the reason for the patient's symptoms, but instead a pulmonary Aspergillosis. The authors wish to point out that the most obvious diagnoses, at the onset compatible with the overall picture and antecedents of patients may not be the cause of their complaints, especially if the symptomatology is similar between the different entities.
The Night Stain

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INTRODUCTION:
Erythema Nodosum (EN) is a nodular erythematous eruption, with septal panniculitis and no vasculitis, associated with infections, inflammatory diseases, reactive arthritis (RA), Sill disease, drugs, sarcoidosis and tumors.

CLINICAL CASE:
A 57-year-old man was admitted with fever in the last 24 hours, EN diagnosed by skin biopsy (septal and lobular lymphocitary panniculitis and necrosis with Miescher granulomas, with no vasculitis), polyarthritis and morning stiffness since 2 months before. He had EN in 2015, pre-diabetes, dyslipidemia and hypertension medicated with loratadine, polyvitamins, acarbose, enalapril, lercanidipine, fenofibrate, simvastatin, calcium, ibuprofen and prednisolone that suspended 7 days before.
He presented with EN in the four limbs.
Laboratory study revealed 4.4x10^9/L neutrophil counts, haemoglobin of 8.0 g/dL microcytic, normal kidney function, C-reactive protein 9.15 mg/dL, ferritin 938.0 ng/mL, normal adenosine deaminase and angiotensin conversion enzyme. Autoimmune and infectious diseases screening was negative for vasculitis, cryoglobulinemias, antiphospholipidic syndrome, rheumatoid arthritis, Treponema pallidum, Coxiella burnetii, Cytomegalovirus, Epstein-Barr virus, hepatitis B, C, human immunodeficiency virus and tuberculosis.
Chlamydiae trachomatis (Ct) IgM was reactive with a title of 1:90.
Endoscopy, colonoscopy, echocardiography and thoracic, abdominal and pelvic tomography showed no changes.
He started azithromycin 1g and prednisolone 1mg/Kg/d and was discharged with prednisolone 40mg/d.
In the follow-up he presented progressive clinical improvement and started a slow corticosteroid withdrawal.

DISCUSSION:
We present a case of RA to Ct infection with EN and polyarthralgias. EN as manifestation of C. trachomatis infection is rare and a few cases have been described. Therefore, a strict follow-up is important in order to search for possible alternative causes.
The Quick Memory Check correlates with the Quick Mild Cognitive Impairment Instrument Screen

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Objectives:
To compare validity and reliability of the QMC with the Qmci in a community-based Memory clinic.

The prevalence of cognitive impairment (CI) is increasing worldwide as populations age.

The Quick Mild Cognitive Impairment Instrument (Qmci) has demonstrated superiority in distinguishing MCI from both NC and dementia, compared to the standardized Mini Mental State Examination and the Montreal Cognitive Assessment (MOCA).

The Quick Memory Check (QMC) is a short cognitive screening test specifically for the general public. We examined and compared the sensitivity and specificity of the QMC with the SMMSE and Qmci.

Methods:
 Patients with caregivers presenting to the Memory Clinic at St. Finbarr’s Hospital, Cork, were routinely administered the Qmci.

The QMC was administered by caregivers to patients, at home, before coming to clinic.

Caregivers brought the QMC with them to clinic and the QMCI was administered blind to the results of the caregiver’s QMC.

Results:
A sample of 410 patients with combined 912 visits were collected in the period of July 2011 – March 2018.

Based on 529 visits with both Qmci and QMC scores, we found statistically significant strong correlation between them, r = .67, p < .001; ICC = .80, p < .001.

This indicates high degree of consistency between QMC and Qmci instruments.

Significant correlation was also found between Caregiver report and QMC scores further confirming validity of QMC tool, r = -.41, p < .001.

Receiver operator curve analysis suggests a cut-off point 44 to be more appropriate than 62 to categorize cognitive impairment, AUC = .79 (95% CI .71 to .85), p < .001.

Conclusion:
The QMC is a short, valid and reliable cognitive screening tool, correlating well with other validated memory tests for caregivers. It can be used at home with brief instructions.

A short training video has been developed for caregivers, to study if it will increase the correlation with the Qmci and sensitivity and specificity of the QMC.
The risks of being a lifeguard, a case report

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INTRODUCTION

A 24-year-old man with no history of interest who presented 3 episodes of self-limited dizziness and diplopia of about 30 seconds. The patient had performed the physical tests for the aquatic lifeguard test 24 hours before.

CASE DESCRIPTION

On neurological examination he experienced drowsiness and lateropulsion of gait to the right. Being normal the rest of physical examination. A blood test is performed highlighting an elevation of creatine quinase and myoglobin enzymes. A brain CT and lumbar puncture are performed that are normal. At 24 hours after admission the patient no longer has drowsiness, he reports cervical pain several days before admission. On neurological examination difficulty in walking in tandem stands out. An echodoppler of supra-aortic trunks shows findings compatible with the dissection of the left vertebral artery (segments V2-V3). A brain angio-CT was performed showing a dissection of the V2 segment of the left vertebral artery with areas of significant luminal stenosis (60%-70%). In a cerebral magnetic resonance, hypodensity was observed in the right thalamus compatible with infarction. The patient reported having performed life-saving tests with a lifesalver fixed to the chest by the left shoulder with traction of the neck. Therefore, the diagnosis of lacunar right thalamic infarction secondary to posttraumatic dissection of left vertebral artery was established. Conservative treatment was started with acetylsalicylic acid 100 mg and relative resistance, with good evolution.

DISCUSSION

Spontaneous dissection of the vertebral artery is a frequent cause of cerebrovascular accident in a young population. But cervical manipulation can also present vascular complications late. Therefore, in patients with symptoms of cervical pain, headache or vascular involvement after cervical physical stress, the differential diagnosis of vertebral artery dissection must be taken into account among the possible causes.
The Sword of Damocles - Two Potentially Fatal Diseases Diagnosed Simultaneously

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Introduction
Pulmonary embolism (PE) and aortic dissection (AD) are severe pathologies which demand emergent diagnosis and therapy.

Case description
A 68 y/o hypertensive patient, was admitted in our department for sudden shortness of breath and excessive sweating. His left calf had been swelling for three days. On examination, he was hemodynamically stable, presented tachycardia, polypnea, tricuspid, aortic and mitral systolic murmurs, left calf edema and Homans sign. The ECG revealed sinus tachycardia, Q3T3 pattern, negative T waves V1-V4. The lab tests showed metabolic acidosis, positive troponin, elevated NT-proBNP and D-dimers. The transthoracic echocardiographic exam revealed RV dysfunction, McConnell sign, and mild to moderate tricuspid regurgitation. The venous ultrasound examination showed left femoral deep venous thrombosis. The chest CT angiography revealed acute central PE (thrombus in the trunk and in both pulmonary arteries) and a Stanford B AD with thrombosis of the false lumen which contraindicated the thrombolytic therapy. Given the high risk of the PE (PESI score 118), and in the absence of cardiac surgery, anticoagulant therapy with unfractionated heparin was started with adjusted doses for aPTT of approximately 70 s, followed by treatment with acenocumarol. Ten months later the CT angiography showed chronic PE without a thrombus in the pulmonary trunk, and the echocardiographic transesophageal exam exposed a reduction of thrombus size in the false lumen of the AD and an intimal flap.

Discussion
A surgical solution in a center with experience in pulmonary endarterectomy and aortic reconstruction should still be the first-line treatment. Otherwise thoracic endovascular aortic repair might considered.
The vision of health professionals about euthanasia and assisted suicide

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OBJECTIVES:
The debate on a possible regulation of euthanasia and assisted suicide is currently the subject of considerable controversy at the political and legal level, generating a social debate that requires adequate information and knowledge of the subject. The purpose of this study is to assess the knowledge of health professionals about terms and concepts related to this debate.

METHODS:
It is a descriptive study whose unit of analysis were the answers issued by 50 health professionals (doctors, nurses, and nursing assistants) of our hospital to a self-made questionnaire relating these terms (euthanasia, assisted suicide, rejection of treatment, and limitation of therapeutic effort).

RESULTS:
Of the 50 people who answered the survey, 18% were in the age group between 20 and 35 years old, 28% between 36-50 years and 54% between 51-65 years. 32% were men and 68% women. 68% answered they had clear the concept of assisted suicide, 94% the term of euthanasia, 88% the term limitation of therapeutic effort, and 94% rejection of treatment. When we asked if they knew the differences between the four terms, 34% answered they knew it. When we asked if they knew specifically the differences between euthanasia and palliative sedation, only 10% answered correctly.

CONCLUSION:
Although initially the respondents express having the concepts referred to clearly, only a small percentage (10%) actually knows the differences. We consider it very necessary to disseminate information on this subject to maintain a responsible social debate.
The white cerebellar sign – an uncommon aetiology

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Introduction
Hepatic encephalopathy is a common complication of advanced cirrhosis. In decompensated cirrhosis with encephalopathy, cerebral edema is not as usually found as in cases of acute liver failure. The white cerebellar sign is a radiological finding characterized by decreased density of cerebral gray matter and decrease of the gray-white matter interface, with preservation of the central structures and cerebellum, and mostly occurs along with irreversible brain damage, as in cases of severe cerebral hypoxia and edema.

Case description
Male, 57 year-old. History of cirrhosis due to alcohol abuse and hepatitis C (treated with direct-acting antivirals), on liver transplant waiting list. Admitted with upper gastrointestinal bleeding and hepatic encephalopathy. Cerebral CT scan on admission revealed no abnormalities. In less than 24 hours the patient deteriorated with generalized seizure without ensuing neurological recovery (Glasgow Coma Scale score of 6 - E4M1V1), and was intubated for airway protection. The electroencephalogram excluded paroxistic activity or status epilepticus. There was diffuse cerebral edema on the cerebral CT scan at this time, without herniation. The patient was admitted to the Intensive Care Unit and was initiated on anti-edematous measures. Few hours later the patient develops bradycardia and nonreactive mydriasis. The cerebral CT scan then showed diffuse cerebral edema with the white cerebellar sign and transtentorial herniation.

Discussion
In decompensated cirrhosis, neurotoxins play a more important role comparing to the cerebral edema in the development of encephalopathy, and the treatment in these cases is mostly directed to the removal of the former. When cerebral edema coexists, anti-edematous measures must be instituted promptly. Despite of these measures, the outcome is often fateful. This case also presents us with an uncommon aetiology to an unusual radiological finding.
Variant AMAN of the Guillain-Barre Syndrome

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INTRODUCTION: Acute inflammatory polyradiculoneuropathy, or Guillain-Barre syndrome, is a progressive autoimmune disease manifested secondary to a viral infectious process in almost 60% to 70% of cases, with spontaneous recovery, that is characterized by muscle weakness, motor and symmetric paralysis, with or without lost of sensitivity that may be accompanied by autonomic disorders. In the acute motor axonal neuropathy variant (AMAN), lesion affects nerve terminals, there is axonal neuropathy mediated by macrophages, blockage of ion channels in the axolema and the lymphocitary infiltration may be limited or null.

DESCRIPTION: A 77-year-old male patient who went to the emergency department lost strength in the lower right limb with lumbar pain irradiated to MID for 5-6 days. He was diagnosed with lumbar pain and returned two weeks later with paresthesias in feet that had been ascending with progressive weakness and paresthesias in the hands in the last few days. Cranial magnetic resonance (MR) with chronic ischemic changes, cervical and lumbosacral MR with degenerative changes is requested. In the face of clinical persistence, consult again. On exploration, motor deficit was observed in all four limbs, hypoarreflexia and gait disturbance, and diarrhea was observed the week before the start. Lumbar puncture was performed with CSF with protein increase without leukocytes and normal glucose. EMG: Findings compatible with polyradiculopathy predominantly axonal and motor, subacute (probable type AMAN). IgG1 anti-ganglioside antibodies positive. Treatment is started with iv immunoglobulins.

DISCUSSION: The atypical clinical presentation and the initial approach of the patient together with the lack of data in the anamnesis produce a significant delay in the diagnostic suspicion and treatment. Although in the AMAN variant the sequels are smaller and the prognosis better.
Visual hallucinations in the elderly. About a case

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INTRODUCTION: In the presence of visual hallucinations in later ages, professionals usually consider diagnoses related to deterioration of cognitive functions or psychiatric disorders. However, in a few cases the possibility arises that the cause corresponds to a disorder associated with the visual sphere itself. Charles Bonnet syndrome (SCB) It is characterized by the appearance of complex, elaborate and persistent visual hallucinations in healthy elderly patients, without cognitive impairment, presenting a significant visual deficit of any origin.

DESCRIPTION: This is an 80-year-old woman with a history of congenital cataracts, cardiovascular risk factors, without cognitive impairment who goes to the emergency room for acute visual hallucinations complex isolated without other accompanying symptoms. No change or incorporation of new medication, without toxic habits or known psychiatric pathology. Physical examination including normal neurological. Basic normal analysis. Cranial magnetic tomography with chronic ischemic-hypertensive periventricular leukoencephalopathy. Lacanary infarctions in basal ganglia and ischemic lesions in radiated crowns and semioval centers. Mixed mild atrophy. Admission is made and after being assessed by neurology is discharged for follow-up in consultation with suspected diagnosis of Charles-Bonnet syndrome.

DISCUSSION: This is a relatively frequent syndrome, affecting 10-15% of patients with low vision, 1 despite which it is not well known. This can have important implications considering the diagnostic alternatives with which the differential diagnosis should be established: dementia, delirium, psychosis and / or pharmacological cause / drugs mainly.
Wernicke Encephalopathy

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INTRODUCTION: Wernicke encephalopathy is an acute neurological condition characterized by a clinical triad of ophthalmoplegia with nystagmus, ataxia, and confusion. This is a life-threatening illness caused by thiamine deficiency, this is characteristically associated with severe alcohol use disorder.

CASE DESCRIPTION: A 63-year-old woman brought to the hospital after being found lying on the floor in the middle of her house among bottles of rum and little reactive. She is admitted to our service as a social problem.
His personal history includes severe tobacco and alcoholic habits and a recently diagnosed depressive syndrome.
On physical examination the patient is hemodynamically stable, disoriented in time, space and person and obnubilated. It emphasizes an ophthalmoplegia of the horizontal gaze, with vertical nystagmus and gait ataxia (Image 1). Being the rest of the normal exploration.
Given the clinical suspicion of Wernicke encephalopathy, and after ruling out other causes such as hepatic encephalopathy, hypercapnic or intracranial involvement, treatment with thiamine was started at high doses, followed by oral supplementation.
The clinical evolution was favorable, ophthalmoplegia and nystagmus disappearing at 24 hours (Image 2), and progressive recovery of encephalopathy and gait.

DISCUSSION: Wernicke encephalopathy should be suspected in any patient with chronic alcohol abuse. The classic triad is altered mental status, ataxic gait, and ophthalmoplegia. The treatment consists of replenishing thiamine, with high doses parenterally. Wernicke encephalopathy is a medical emergency and considered a reversible condition, however, in some cases, there are persistent neurological deficits, and the acute condition can progress to chronic Korsakoff syndrome.
What Can A Pelvic Mass Hide?

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Behind a palpable mass are concealed multiple diagnostic hypotheses, often being the study of it a dynamic and challenging process.

We present the case of a 81 year old male, Caucasian, autonomous, with a history of hyperuricemia without usual therapy. She visited the Emergency Department for intermittent pain complaints for 1 month in the left sacroiliac region with irradiation to the leg and ipsilateral inguinal area, without aggravating or relieving factors, accompanied by progressive edema of the left lower limb(MIE). He also reported weight loss of 14kg the last 2 months. On observation, MIE lymphedema and a bulging and painful inguinal mass on palpation were prominent. Analytically with normocytic and normochromic anemia, increased PCR and dimer, protein electrophoresis and immunofixation with monoclonal component of lambda IgG type. He performed abdominal and pelvic computed tomography (CT), which documented a massive osteolytic lesion of the left iliac artery with a massive soft tissue component, involving the muscular structures, which were associated with adenopathies in the left inguinal, external and primitive iliac chains. Doppler echocardiography excluded thrombophlebitis and deep venous thrombosis. An echogenic biopsy was performed, reporting a large mass suggestive of sarcoma, with aspects of local aggressiveness. The anatomopathological results revealed a diffuse large B-cell lymphoma, germinalcenter, CD20 +, CD10 +, BCL6 +, MUM1 +, CD5- and Cyclin D1. LDGCB is the most common type of lymphoma non-Hodgkin's disease (30%), and may occur at any age with a predominance of the elderly. It is a lymphoma with an aggressive presentation, characterized by a fast and symptomatic growth, with the possible involvement of multiple organs. Usually have a good response to therapy, when instituted in a timely manner.
What to expect when Orthopaedic Surgeon ask us to evaluate a patient

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OBJECTIVES
To analyze the most frequent consultations on patients admitted to Orthopedic Surgery and Traumatology (OST) unit asked to medical physicians.

MATERIAL AND METHODS
Descriptive analysis of consultations on patients admitted to OST who suffered any medical decompensation that needed to be notified.

RESULTS
From June 2008 to November 2014, 1486 consultations were sent from OST to a team (Internal Medicine+Cardiology) assigned to control of medical pathologies in surgical areas. The most common consultations were: dyspnea 371 (25%), pluripathology control 163 (11%), diabetes control 124 (8.3%) and high blood pressure 123 (8.3%). Digestive pathology was 10.5% (specified according to the disease: diarrhea, nausea-vomiting or abdominal pain). Analytic alterations 4%. Dyspnea was analized as it was considered too nonspecific. 48.7% were of respiratory origin: pneumonia (32%, of which 56% nosocomial), noncondensing respiratory infection (26%), exacerbation of COPD (18%), bronchospasm (16%) and pulmonary thromboembolism (2%). 41% of dyspnea had a cardiological origin; 66% the main factor inducing heart failure was not clearly identified; 13.6% presented excessive intravenous fluid therapy, 11.3% anemia secondary to the intervention, 11.3% uncontrolled atrial fibrillation. Then anxiety (4.7%). In 3.7% no dyspnea was observed.

CONCLUSIONS
25% of consultations for medical decompensation in OST patients correspond to dyspnea, almost half from respiratory origin and somewhat less from cardiological. An important percentage are due to intrahospital processes (nosocomial pneumonia and excessive intravenous therapy). An early examination of patients with personal history of heart failure and pneumological problems, performed before the surgery, could be beneficial in terms of morbidity.
What to expect when the Vascular Surgeon ask us to evaluate a patient

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OBJECTIVES
To analyze the most frequent consultations on patients admitted to Vascular Surgery (VS) sent to a medical team.

MATERIAL AND METHODS
Descriptive analysis of consultations on patients admitted to the VS Service who suffered any medical decompensation that needed to be notified to Internal Medicine or Cardiology.

RESULTS
From February 2011 to November 2014, 173 consultations were sent from the VS Service to a team assigned to the control of medical pathologies in surgical areas. The most common consultation was dyspnea in 62 cases (35.8%), followed by pluripathology control in 18 (10.4%), decreased level of consciousness in 13 (7.5%), fever in 13 (7.5%), renal failure in 7 (4%) and blood pressure control in 7 (4%) patients. We analyzed the meaning of dyspnea: 43.5% of the dyspneas were from respiratory origin, being the most frequent pneumonia (37%, 50% of which were nosocomial), exacerbation of COPD (14.5%), non-condensing respiratory infection (6.5%), and bronchospasm (3.2%). 33.8% of dyspneas were diagnosed as heart failure. In 11.3% of the cases, no specific diagnosis of dyspnea was established.

CONCLUSIONS
More than one third of the consultations for medical decompensations in the patients admitted to the VS unit correspond to dyspnea. Almost half of them correspond to pneumological origin, in a high percentage by potentially preventable situations such as nosocomial pneumonia, and almost 1/3 correspond to heart failure. An early examination of patients with personal history of heart and pneumological problems, performed before the surgery, could be beneficial in terms of morbidity.
When a rarity isn't alone: two complications in an unusual disease

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Introduction: DRESS syndrome - Drug Reaction with Eosinophilia and Systemic Symptoms - is rare and possibly life threatening. It’s characterized as a late manifestation after treatment initiation, with non-specific symptoms and multiorgan failure.

Case description: A 60 years old male, with past medical history of Bentall’s surgery 8 months before, presents with acute heart failure symptoms, dynamic changes of the ST segment and elevation of myocardial necrosis biomarkers. He’s diagnosed with non-ST segment elevation myocardial infarction. Coronarography suggests extrinsic compression of the common trunk coronary arteries, by a pseudoaneurysm formed between the aortic prosthesis valve and the conduit. This rare surgical complication was confirmed by CT angiography. The aortic prosthesis replacement was performed, unexpectedly revealing signs of endocarditis. With low clinical suspicion of endocarditis, nevertheless, the patient was started on empiric therapy with vancomycin, rifampicin and ceftriaxone. After 21 days of antibiotic therapy, the patient develops fever, non-confluent and dispersed maculopapular rash, lymphocytosis with eosinophilia, acute hepatitis, acute renal injury and altered mental status. Evolution to shock follows, with invasive ventilation and vasopressor support needed. After exclusion of further diagnosis through an exhaustive workup, the hypothesis of DRESS syndrome secondary to vancomycin is admitted. The suspension of vancomycin along with intensive care support and high-dose corticotherapy, led to improvement of organ dysfunction.

Discussion: Multiorgan manifestations, multisystemic dysfunction, lymphocytosis and eosinophilia, associated with long lasting vancomycin therapy, alerted us to the diagnosis of DRESS Syndrome. Early discontinuation of vancomycin led to a favorable outcome. Patients with multiorgan failure without an identified cause, should have this syndrome included in their diagnostic differentials.
When a slight symptom leads to a catastrophic diagnosis

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A 68-year-old female, autonomous, with no relevant clinical history. Admitted to the emergency service (ES) by a 2-month history of cough, initially dry and progressively productive of mucous sputum; asthenia and dyspnea for small efforts with 1 month of evolution. Febrile peak of 38°C prior to the use of ES. She also presented with cold chills and weight loss of 3kg from the beginning of the complains. No nocturnal hypersudoresis nor relevant epidemiological context. Pulmonary auscultation with ruddy murmur with abundant snores dispersed. Blood analysis showed protein C reactive 38.3mg/dL; 11500 leukocytes with 95% neutrophils. Ambient air gases with respiratory insufficiency type 1, requiring supplemental O2 at 8L/min; chest X-ray: bilateral nodular infiltrate; chest tomography: “Extensive areas of bilateral parenchymal consolidation evidencing pneumonic process(...)”. She was transferred to the Intermediate Care Unit under antibiotic therapy with Levofloxacin. On the 3rd day, requiring only 2l/min of supplementary O2, the patient was admitted to inferrmary. On the last day of antibiotic therapy and had a fever peak of 38.9°C, without any agent isolation, episodes of severe bronchospasm and maintenance of productive cough. Smear microscopy (negative), and collected sputum for mycobacteriological examination. Bronchofibroscopy showed no disease. Bacilloscopy in the bronchoalveolar lavage wash was negative. Gama interferon was also negative. Cytology of bronchoalveolar lavage: suspected malignancy. High resolution tomography: “extensive areas of pulmonary consolidation, more luxurian and confluent in the post basal segments of the lower lobes(...) areas of depolarized glass(...) associated atelectasis and bronchiectasis(...) the hypothesis of an invasive pulmonary adenocarcinoma (ex-bronchioloalveolar carcinoma) should be considered.” Histology: mucinous adenocarcinoma with immunophenotype compatible with pulmonary primary. Valuing the clinic is crucial for timely diagnosis.
When a stroke strikes back

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Introduction:
Stroke represents the most common medical emergency affecting the central nervous system (CNS). To act promptly on its suspicion is of the most importance, as it is mandatory to perform imaging complementary study, since some other CNS conditions may mimic the classic presentation of stroke.

Case description:
The authors present a case of a 54 years old male, smoker, without other relevant past medical history. He was admitted to emergency department after one hour onset of aphasia and right facial paralysis, scoring 3 on NIHSS. Brain CT showed a left cortical-subcortical peri-Rolandic expansive lesion with 23mm, suggestive of a secondary lesion/brain primitive lesion. Dexamethasone was initiated, with regression of neurological deficits. Brain MRI was performed and confirmed a secondary brain lesion from unknown source. Body CT then revealed an apical nodular lesion of the right lung with 12mm and multiple mediastinal enlarged lymph nodes. Bronchofibroscopy and endobronchial ultrasound (EBUS), with lymph node biopsy were performed, which confirmed a non-small cell lung cancer (NSCLC). The patient was then referred to Cardiothoracic and Neurosurgery consults for evaluation and treatment.

Discussion:
Cerebrovascular diseases represent a worldwide major cause of death, though it is also important to make differential diagnosis with many other CNS conditions that mimic stroke.
INTRODUCTION: The use of corticosteroids is a therapeutic approach transversal to several pathologies with the most diverse etiologies.

CLINICAL CASE: A female patient of 59 years old, followed up by polyarthralgia, attributed at that time to degenerative pathology of the cervical and lumbar spine, and the initial hypothesis of polymyalgia rheumatica was not confirmed. In that same year the patient was referred to the emergency department for a septic shock in the context of a sore-nodular fever requiring hospitalization at the Intensive Care Unit. As a result, the patient develops adrenal insufficiency and she initiates hydrocortisone. Already in an ambulatory, clinically stable, and after 3 months of treatment with corticoid (hydrocortisone 20mg id at breakfast and 10mg id at dinner). During the follow up she started a progressive reduction of the same without any intercurrence. After 3 months of suspension of hydrocortisone, she developed inflammatory lumbar pain, with a morning stiffness greater than one hour, which implied some periods of sweetening. It also appears with hand edema and arthritis of the 2nd, 3rd and 4th metacarpophalangeal (MCF) of the left hand and 2nd MCF of the right hand. The objective examination also included ulnar dislocation of the wrist. Analytically positive ANAs (1: 320, fine dense granular pattern), strong anti-CCP positive (greater than 600 U / ml), positive rheumatoid factor. Once the diagnosis of rheumatoid arthritis is made, the patient is medicated with prednisolone 5mg, methotrexate 7.5mg weekly and folic acid 5mg.

DISCUSSION: Rheumatoid arthritis is not always an immediate diagnosis, especially in the presence of some confounding variables, as evidenced in this case, due to prolonged systemic corticosteroid therapy. In diseases such as rheumatoid arthritis, early therapy has a significant impact on the evolution of the disease and consequently on the quality of life of patients.
When iatrogenia turns hallucinations reality

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Any medical act represents an ethical dimension, which should be object of reflection, to avoid its inherent iatrogenic consequences. The transition from the biomedical to biopsychosocial model allowed the mitigation of these consequences, but it's insufficient.

A 63-year-old woman with a history of bipolar disorder presents with a one-week regular vomiting, 8 days after sertralin and oxacarbazepin dose increase. Refers adynamia and exhibits a nihilistic speech and apathy. Analytically: Na+ 119 mmol/L. Interned in the Internal Medicine Service, in a 6-bed room, for hyponatremia correction secondary to psychiatric medication. During hospitalization presented hallucinations with dead, and Psychiatry was requested to readjust the therapy. After hyponatremia correction, the hallucinations ceased, despite remaining depression. The night before Psychiatry transference, the death of a patient with whom she shared room, with consequent psychomotor agitation, led to Risperidone 1mg + Haloperidol 10mg intake (previously taken by the patient). Progressive alteration of consciousness until comatose state, constant hyperthermia, tachycardia, fluctuation of the tension profile, diaphoresis, rhabdomyolysis and severe type 1 respiratory insufficiency were verified, requiring invasive mechanical ventilation. A malignant neuroleptic syndrome was diagnosed, which led to dantrolen, biperidene and bromocriptine initiation and Intensive Care Medicine transference. Two weeks later, the patient returns to complete a ventilator-associated pneumonia treatment, but with the neuroleptic malignant syndrome resolved. Once the infectious intercurrence was treated, the patient was transferred to Psychiatry to stabilize her bipolar disorder.

An hospitalization that was foreseen simple and short, promptly complicates when ignored the psychological context. It's interesting to see how this carelessness allows a patient, who hallucinated with the dead, to mimic her own death after another patient died.
When the diagnosis is a headache...

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INTRODUCTION

Temporal arthritis is a chronic vasculitis of the medium and large-calibre blood vessels, which usually occurs in individuals over 50 years old, involving mainly extra-cranial branches of the arteries originating from the aortic arch. Its etiology is unknown, although hypothesis such as genetic predisposition and infectious agents are being considered.

CASE REPORT

The present case is of an 83-year-old woman who resorts to the Emergency Room due to an intense holocranial headache, hyperalgesia in the oral cavity, as well as claudication of the mandible followed by visual acuity loss on the left. She had already had similar symptoms the month before, accompanied by the appearance of vesicles on the trigeminal nerve dermatome, having been prescribed with Aciclovir for suspicion of Herpes Zoster Ophthalmicus.

During objective examination, she presented with fever and pain with palpation of the temporal regions and the temporal mandibular joints. The sedimentation rate was high (>50mm/1st hour), having done a biopsy of the temporal artery during the diagnostical investigation which confirmed the temporal arthritis diagnosis.

DISCUSSION

The suspicion of this diagnosis should be considered when a patient over 50 years old presents with a recent headache. Data from the objective examination, such as the palpation of the temporal arteries may guide the suspicion even though the symptoms are often interpreted as an infectious disease. Timely treatment with corticosteroids improves the prognosis and reduces the symptoms.
When the investigation of a symptom reveals unexpected findings

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Male, 64-years-old, with no relevant clinical history or medication. He was referred to the Hospital of Braga from another health institution for the study of acute liver cytolysis. The patient reported a 5-day course of sudden onset of fever (axillary temperature: 38°C), with poor response to the antipyretic and anti-inflammatory therapy. No other associated symptomatology.

At his first consultation on Braga's Hospital, he presented with slight hepatomegaly with palpable liver about 1cm below the rib cage at the intersection of the mid-clavicular line, with no other changes. Blood analysis showed normal bilirubin, AST 440 U/L; ALT 450 U/L; FA 119 U/L; LDH 594 U/L; PCR 60.20 mg/L. Thoraco-abdomino-pelvic tomography: "(...) In right and apparently extra-pulmonary paravertebral topography, a massive solid rounded lesion measuring 84x65x39 mm is identified, without evident bone erosion (...)". He was hospitalized due to a febrile syndrome with hepatic cytolysis and paravertebral mass de novo, treated only with pantoprazole 20mg and enoxaparin 40mg. He performed magnetic resonance imaging (MRI) of the spine which "(...) by imaging characteristics the most probable hypothesis is to be a Schwannoma (...)". He was evaluated by neurosurgeons that prescribe only vigilance.

During hospitalization he never again had fever and cytolysis showed a decreasing profile, corroborating the hypothesis of fever originating in a virus syndrome and cytolysis in iatrogenesis of self-administered drugs. This case alerts to the need for the clinic's attitude should be supervised by experts and that when it is least expected a serious injury can develop, sustaining the need for routine consultations.
INTRO: A stroke occurs when the blood supply to part of brain is interrupted or reduced. It is defined as focal neurological deficit and it is an important health problem in the world. There are several aetiologies, among them atherosclerosis of main arteries, cardio embolism and small vessel occlusion.

CLINICAL CASE: Man, 69 years old with a prior history of hypertension, dyslipidaemia, asthma and an ex-smoker. Presented to the ER with dizziness, numbness feeling of left arm, lasting 30 minutes and with spontaneously resolution. Denied any other symptoms. At admission he was hypertensive and with barré sign positive at left. Head CT Scan showed neither hemorrhage nor established infarctions. He was admitted in ward for aetiology complementary study of transient ischemic attack. After admission he referred imbalance when trying to talk. Doppler of neck vessels revealed fibrocalcified plaque in the proximal portion of the right internal carotid conditioned stenosis of 70%. He performed CT angiography of the vessels of the neck that confirmed the findings of the ecodoppler.

He was observed by vascular surgery whom preformed endovascular surgery. We made the follow-up controlling cardiovascular risk factors as arterial hypertension, dyslipidaemia and prescribed exercise.

Therapeutic strategies should include lifestyle and pharmacological interventions targeting hyperglycemia, hypertension, dyslipidemia, obesity, cigarette smoking, physical inactivity, and prothrombotic factors.

Stroke has a very significant incidence worldwide. Most of them result from an obstruction of a blood vessel by a thrombus. However, its aetiology can be very diverse, so that it becomes fundamental to identify the pathophysiological mechanism underlying ischemia for adequate guidance.
When the unfavorable evolution suggests the diagnosis!

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Introduction: Diffuse alveolar hemorrhage (DAH) syndrome is caused by injury or inflammation of the arterioles, venules or alveolar septal capillaries. DAH is associated with a variety of diseases that can be divided into three different histopathologic patterns: pulmonary capillaritis, bland alveolar hemorrhage and diffuse alveolar damage. Flexible bronchoscopy with sequential bronchoalveolar lavage (BAL) is the preferred method for diagnosis.

Case description: A 81-year-old woman with metabolic syndrome, was admitted in the emergency department complaining of dyspnea and chest pain. Tachypnea was observed and crepitations were present in the lower 2/3 of both hemithoraxes. Blood investigation revealed discrete leukocytosis, global respiratory failure with acidemia and elevated erythrocyte sedimentation rate. Blood cultures were negative. Chest radiography showed bilateral diffuse opacities. Unfavorable evolution occurred with total dependence of noninvasive mechanical ventilation, fever, hemoptysis and hemoglobin fall. Computerized thoracic angiotomography was suggestive of diffuse alveolar hemorrhage: multiple diffuse and bilateral consolidations and ground glass opacities. Antinuclear antibodies were positive. The patient was unable to perform bronchofibroscopy due to hemodynamic instability. Intravenous pulse of methylprednisolone was initiated, however her clinical status deteriorated and the patient died without a definite etiology.

Discussion: Despite BAL is a key step in the diagnosis of DAH, the authors consider that the diagnosis of DAH can be admitted taking into account the clinical presentation and imaging exams. Although rare, we highlight the importance of early diagnostic suspicion. Once the diagnosis of DAH is made, the underlying cause is sought through careful review of the history, physical examination and laboratory tests.
When what the mirror shows is not just vanity

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INTRODUCTION: Alopecia areata is a genetic disease, complex and immuno-mediated, with no preponderance of age or gender, which, despite affecting the hair follicle, does not cause permanent damage with potential for recovery. The presence of this disease increases the risk of autoimmune pathologies, especially the thyroid, which can affect up to 28% of patients.

CLINICAL CASE: The authors report the case of a 22-year-old woman referred to Internal Medicine for alopecia with 3 months of evolution, with progressive onset but later formation of oval regions without hairs on the scalp. The patient was depressed and distressed with self-image, having to resort to several strategies to hide the extent of the lesions. It would have been previously medicated with topic medication without improvement. It is a patient followed in multiple consultations by metabolic syndrome, obesity and polycystic ovarian syndrome. In the requested analytical control, an autoimmune thyroiditis was observed with asymptomatic hypothyroidism. She was referred to dermatology clinic that confirmed histologically the presence of alopecia areata. Treatment with levothyroxine 25mcg/day, prednisolone at low dose (5mg / day) and hydroxychloroquine (400mg/day) was initiated, with partial recovery of the condition after 3 months of treatment, maintaining treatment and clinical response slow but favorable.

DISCUSSION: Although the association between alopecia areata and other autoimmune diseases is well documented in the literature, it is necessary to evaluate thyroid function and immunity even in the presence of alopecia, even if the clinic is not suggestive. The relationship between alopecia and the metabolic syndrome is not yet fully understood but it is known to be more significant in females. In conclusion, the overlap between metabolic and autoimmune syndromes is a diagnostic and therapeutic challenge for which the clinician should be alert.
Woman with recurrent orofacial edema, a case report


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INTRODUCTION
A 44-year-old woman with a history of type II diabetes mellitus, hypertension and fibromyalgia. Go to Neurology Consultation for recurrent episodes of peripheral left facial paralysis. Symptoms resolve spontaneously in a few days after taking Prednisone. It also reports episodes of inflammation in the left side of the brain that resolves spontaneously in a few days.

CASE DESCRIPTION
At the time of the assessment in consultation the patient is asymptomatic and the neurological examination is negative but provides a photograph showing edema of the labial, zygomatic and left infraocular region with deviation of the buccal commissure. The following differential diagnoses were considered: allergic hereditary angioedema, recurrent erysipelas, sarcoidosis and Crohn’s disease. A brain magnetic resonance with gadolinium was performed, which was normal, an analytical with serologies for neurotrope viruses that were negative and a chest CT scan that was also normal. Due to the normality of the complementary tests requested, the patient was diagnosed with a Melkersson-Rosenthal Syndrome. Finally, treatment with Prednisone 0.5 mg/Kg was started with good later evolution.

DISCUSSION
The prevalence of Melkersson-Rosenthal syndrome is low, around 0.08% of the general population. It is characterized by a triad composed of idiopathic facial paralysis, fissured tongue and orofacial edema. Facial paralysis is usually unilateral. Orofacial edema is one of the most frequent signs and occurs in approximately 50% of cases. One third of patients have a fissured tongue. The etiology is unknown, an infectious origin has been assumed without identifying the causal agent. Laboratory tests and neuroimaging studies are usually normal. The characteristic finding is the presence of noncaseating epithelial granulomas. It can be treated with corticosteroids or clofazimine although the response is variable.
“Type 2” Ischemic Stroke

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INTRODUCTION:
Iron Deficiency Anemia (IDA) has been suggested to be associated with stroke. Involved mechanisms include cerebral hypoxia induced by anemia, thrombocytosis secondary to iron deficiency or a hypercoagulable state secondary to iron deficiency. The association between IDA and stroke has been better defined in children, with very few cases reported in adults.

CASE DESCRIPTION:
We describe a case of a thirty-nine-years-old female with past medical history of hypertension and a suspicion of pro-thrombotic syndrome. She was diagnosed with an ischemic stroke of the right middle cerebral artery (MCA) secondary to an atheromatous occlusion of the right internal carotid. Three months later, she presented a new stroke of the same territory assumed in the context of collateral flow insufficiency. At that time she had an inaugural diagnosis of IDA (hemoglobin 9.6 g/dL) without bleeding evidence. Three months after the last event, she was admitted at the emergency room with complaints of syncope and generalized involuntary movements followed by hematemesis. She was normotensive and presented new findings of left central facial paralysis and worsened left hemiparesis. Blood analysis showed hemoglobin 6.4 g/dL and 290000 platelets/µL. Upper gastrointestinal endoscopy revealed a bulbar ulcer Forrest Ib. Head computerized tomography showed no recent lesions. Magnetic resonance (MR) revealed an acute infarction in right MCA distribution and MR angiography revealed no evidence of thrombus or carotid dissection. As all other known causes were ruled out, hypoperfusion secondary to IDA was considered the cause for the stroke.

DISCUSSION:
IDA should be considered at the differential diagnosis of stroke’s etiology. Since there are more prevalent risk factors for stroke, some cases may be underdiagnosed. At the present case, cerebral hypoxia may have been potentiated by the concomitant atherosclerotic disease.