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ЗБОРНИК НА АПСТРАКТИ

ABSTRACT BOOK

ШЕСТИ КОНГРЕС НА МАКЕДОНСКОТО ЗДРУЖЕНИЕ ПО КАРДИОЛОГИЈА СО МЕЃУНАРОДНО УЧЕСТВО

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P41. Bilateral DVT

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Introduction. Bilateral deep venous thrombosis (DVT) indicates a condition wherein a blood clot forms within the deep vein of both legs. This condition can lead to serious complications including pulmonary embolism (PE). 80% of PE`s originate from DVT in lower extremities. Here we reported a case in which the patient with bbilateral DVT developed PE. **Case presentation.** A 66 year-old woman was admitted to ICU with bilateral leg swelling, leg pain, shortness of breath and fatigue developed over the previous ten days. For the risk factors evaluated, quadriparesis, overweight, and older than age 40 presented an increased risk for bilateral thrombosis. **Laboratory tests include** D dimer testing that showed extremely elevated results, and general laboratory tests revealed anemia and moderate renal impairment. **Non-Laboratory** imaging test Transthoracic Echocardiography (TTE) findings suggestted high-risk PE, and Computed tomography pulmonary angiography (CTPA) showed massive PE. An initial lower extremity venous duplex scan demonstrated dilated, non-compressible popliteal vein in both lower extremities, with hypoechogenic occlusive thrombus and absence of flow in the thrombosed segment. A repeat scan 1 week later identified improved findings compared to prior scans, with started process of recanalization.Unfractionated heparin was given as an initial intravenous bolus followed by continuous intravenous infusionfor 5 days, and overlapped with acenocumarol. After16 days of hospitalisation the patient was discharged from the hospital. **Conclusion**. Deep vein thrombosis of both legs followed by pulmonary embolism is common in certain high risk patients. Vascular sonography for evaluation of DVT is an excellent first line investigation. It has a greater than 90% sensitivity and specificity for the diagnosis of DVT.Both early diagnosis and appropriate treatment of DVT and its complications can improve the prognosis.

P42. Thromboembolism after partus praetemporarius spontaneus

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Introduction. J.P.female, 33 years old,non smoker with history of partus spontaneous after in vitro fertilization,before two weeks, with chest pain and dyspnea was hospitalized in unit of intensive coronary care. **Aim.**

Thromboembolism after partus pretemporarius spontaneous is not unusual but need multidisciplinary treatment. **Methods and materials.** Echocardiography-EF=68%, small pericardial effusion of 2mm,behind posterior wall, ECG, Laboratory findings d-dime r = 1480 ... 1883... 2080... 3710; LDH=276... CK=64... CRP = 194 ... 54,2...21,6...Chol=5,35...Trig=2,3; RTG pulmo et cor-decreased pulmonary transparency of right, CT pulmoangiography-was technically bad. Right on the subsegment branch of truncus pulmonalis there was small defect, also there were triagonal zones of mosaic attenuation suspected for pulmonary thromboembolism.Echo of abdominal and urogenital tract, and consulted gynecologist for several times. **Results and conclusion**. This patient was treated at department of intensive coronary care with anticoagulant therapy, bronchodilatators, oxygen and antibiotics. With agreement of gynecologist that was involved in this case the patient was transferred to department of gynecology for treatment of residual bleeding after partus. Gynecology findings:Stenosis cervicis.Small and residual blood in cavum uteri. Because of blood in cavum and increased d-dimers and in consultation with transfuziologist the patient is recommended for intervention.

P43. Pulmonary embolism in patient with Factor V Leiden mutation (FVL) – case presentation

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Introduction: Factor V Leiden is an autosomal genetic condition, which causes an increase in blood clotting. **Objective**: We present the case with acute pulmonary embolism and heterozygous FVL thrombophilia. **Case report**: A 51 years old male patient was treated on the Institute for transfussion medicine because of swelling, feeling of warmth and pain in the right calf. He was treated 15 days with LMWH (60 mg/s.c./twice daily for 10 days, and 80mg/s.c./twice daily for 5 days) and the last 3 days of treatment acenocoumarol was added. On the day of Intensive Care Unit admission, sudden pain with swelling in the whole right leg appeared, followed by dyspnea and hypotension. Blood pressure was 90/60mmHG, heart rate 100/min and SaO2 96%. ECG on admission: sinus tachycardia, normal axis deviation. D-dimmer test was positive 6080 (>500ng/ml). A right lower extremity Doppler ultrasound was significant for non-compressible femoral and popliteal vein, with presence of non-obstructive thrombi. Echocardiography was