between individuals: some patients accumulate minimal disability over their lives, whereas others experience a rapidly disabling disease course. A part of patients with multiple sclerosis presents also seizures that lead to epilepsy. Several clinical series reported an association between multiple sclerosis and epilepsy. The most studies show an increased comorbidity between multiple sclerosis and epilepsy. The cumulative incidence of epilepsy by 10 years after diagnosis of MS was 1.9%. The probable anatomic basis for the seizures is areas of inflammation, edema, and/or demyelination in the cerebral cortex and the juxtacortical white matter generated by a mechanism that is not completely understood; the fact that these plaques are very common suggests that other factors must operate in view of the rarity of seizures in MS. In most cases, however, the prognosis of epilepsy was good and there seemed not to be any clear correlation between the severity of MS and epilepsy.

Case report. A patient V. male, 41 years , came at a neurologist in April 2019 with the following complaints: facial hyperemia, heat sensations, alterations of consciousness with convulsive components in the anamnesis. At the same time: walking instability, recurrent diplopia, frequent urination, sleeping disorders, memory loss and decrease in body mass. Anamnesis: In 2005 patient has an acute respiratory infection, possible a flu. After a half a year had appeared diplopia, diplopia and frequent urination. In 2007 the diagnosis of multiple sclerosis was established. The diagnosis was confirmed in Moscow and the patient started the treatment with Galatimer acetate (Copaxone) that he administered for 5 years with the improvement of the evolution of the disease. Subsequently administered Acsoglatiran till present but without any obvious effect. In 2015 the patient has a seizure for the first time with unconsciousness but without warning signs. Other signs and symptoms associated with unconsciousness the patient doesn't remember. A similar episode was in 2017. In 2019 the patient received symptomatic treatment in the neurology department for diagnosis: Multiple sclerosis clinically and imagistic defined, recurrent remissive form, in exacerbation, with pronounced atactic syndrome. Structural epilepsy-mesial temporal sclerosis on the right associated to multiple sclerosis plague with focal seizures with bilateral passage treated with Carbamazepine retard 300 mg/day. Now the antiepileptic treatment is Timonil 750 mg/day with a very good outcome.

Conclusions. MS is a risk factor for developing epilepsy. Patients with MS have a threefold increase in risk for developing epilepsy when compared with that expected in the general population. The reason for this increased risk is unclear and needs further investigation.

Key words: Multiple sclerosis, epilepsy, seizures, disability.

DEPARTMENT OF ONCOLOGY

34. COLLECTING DUCT CARCINOMA APPEARING AS A HEPATIC HYDATID CYST. A RARE CASE REPORT

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Background. Collecting duct carcinoma is located in the renal medulla and it originates from the collecting duct epithelium. It involves about 1% from all renal epithelial malignancies.

Male patients are more exposed and the tumor localization shows a right sided predominance. It is characterized by aggressiveness and poor prognosis.

Case report. We present a case of a middle age male patient who complained of right hypochondriac pain. The physical examination evidenced a large abdominal tumor formation in the right hypochondria and ultrasonography highlighted a mass, localized in the 8th segment of the right liver lobe. The primary diagnosis defined a hepatic hydatid cyst. A subsequent CT scan revealed a cystic structure of the right kidney, which presented Bosniak III type and measured 126x121x146 mm. Surgical treatment was initiated and intraoperatively a right kidney tumor was detected, due to which right nephrectomy was performed. The histopathological examination and the immunohistochemical profile established the final diagnosis of collecting duct carcinoma, with the tumor stage of pT3Nx. Regarding the patient's evolution, he was mobilized on the first postoperative day and was discharged after seven days. The patient did not receive any oncological treatment. 18 months following surgery the laboratory investigation values were within normal limits and any sign of relapse was excluded with ultrasonography. After 20 months the patient affirms that he is in good overall condition.

Conclusions. As conclusion early diagnosis and surgical treatment can improve patient's prognosis and disease-free survival. This work was supported by the Collegium Talentum 2019 Program of Hungary.

Key words: collecting duct carcinoma; hepatic hydatid cyst; case report

DEPARTMENT OF PNEUMOLOGY AND ALLERGOLOGY

35. TUBERCULOSIS - "MASK" OF PULMONARY EDEMA

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Background. Cardiogenic pulmonary edema is a medical emergency, which requires prompt management.

Case report. A 28 years old female with pregnancy 22 weeks, without anamnestic of cardiovascular pathology, but with periodic syncopal conditions caused by stress and chronic tonsillitis. Without any tuberculosis contact. The patient has been consulted by the family doctor with moderate pain in the bilateral lumbar region, fever 39, pollakiuria, dysuria and macrohematuria and she was admitted to the district hospital. In the blood test highlighted changes for inflammatory syndrome, at the urinalysis - insignificant proteinuria and leukocyturia. Was initiated antibacterial treatment with cephalosporins generation III. Over 24 hours the condition of the patient with the sudden exacerbation manifested by dyspnoea and hemoptysis (sputum with fresh blood sprays). X-Ray changes - bilateral pneumonia. The patient was transferred to the pneumology clinic, ATI section with the clinical diagnosis: Bilateral community pneumonia, severe evolution. Suspected of pulmonary TB? Chronic bilateral pyelonephritis, exacerbation. Pregnancy 22 weeks. From the objective data we can emphasize SaO2 at 87% TA 100/50 mmHg, FCC - 115 b / min, auscultation in lungs - crackles bilaterally. At auscultation of the heart - systolo-diastolic murmur at the apex and systolic at the tricuspid valve. Sputum and urine testing at BAAR, GeneXpert – negative.