and fatigue. The patient's medical history is remarkable by osteoporosis due to treatment with corticosteroids, bilateral hip artroplasty for avascular necrosis. The physical examination was remarkable by proximal muscular atrophy, calcinosis of gluteus muscles. The remainder of examination was normal.

In this patient, our goal was to apply clinical tools in order to assess disease's outcomes.

Clinical case: Changes Associated with damage in MII are post-inflammatory, cumulative and irreversible, present at least 6 months despite prior immunosuppressive treatment or rehabilitation. In order to assess diseases outcomes in this patient we applied the next tools: patient's questionnaire, Myositis Damage Index(MDI), Manual Muscle Test 8(MMT8), LifeSatisfaction 11, PATIENT GLOBAL ACTIVITY ASSESSMENT(PGA), PHYSICIAN GLOBAL ACTIVITY ASSESSMENT(MDGA). After analyzing the results we determined that MMT8 score was rather high 55 out of 80, due to the rehabilitation programs that the patient attended. There was an insignificant discrepancy between PGA and MDGA, with the trend from patient to diminish the role of the disease. We tried to measure life satisfaction by LiSat 11, in this patient, it was dissatisfied due to psychological health and leisure situations. The MDI score got 14 points out of 38, the most damage was found in muscular and skeletal systems.

Conclusion: In order to determine how myositis patients' illnesses change over time we have to assess them using special established and validated tools and to have patient-reported outcome measures for myositis.

Competing interests None.

Key words: idiopathic inflammatory myositis, outcomes.

8. INFECTIVE ENDOCARDITIS AT THE PATIENTS A T HEMODIALISIS

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Introduction: Infective endocarditis (IE) at patients on hemodialysis (HD) is 10-18 times higher than in the general population, caused by arterio-venous fistula or central catheter, increased susceptibility to infections and renal failure. HD patients with valvular calcification often presents (28% - 36% calcification Vao and VM), fistulae and synthetic venous catheters 7.6% being the gateway to infection. Severe complications frequently occur in staphylococcal IE at patients on HD: pulmonary edema (82-100%) embolic syndrome, cerebral often (9-17%) lung abscess. High mortality in the first year of evolution of the disease 45-75% compared with 25-52% in-hospital death.

Clinical case: Patient X. 64 years old. Diagnosis: chronic renal disease. Chronic diffuse glomerulonephritis. End-stage chronic renal failure. Hypertension gr. III very high additional risk. CF II NYHA at dialysis 1.5. months.

Results: subfebrility, palpitations, inspiratory shortness of breath, sore legs, pain in lombar, asthenia. Objective: skin petechiae, limited verbal contact, right hemiparesis, rhythmic heart sounds, TA-105/70 mmHg. FCC-109 c / min. Anemia (Hb 62 g / l), thrombocytopenia, lymphopenia, leucocytozis and increased ESR. Blood biochemistry: hyperuricaemia, hipercreatininemie. Staphylococcus aureus blood culture positive. ECG: Sinus tachycardia 100 c / min, ventricular premature beats, atrioventricular block gr.I. AEC left deviation. LV hypertrophy EcoCG: Expansion AS, moderate AD, LV and RV. LV hypertrophy EF - 49%. VAO failure gr.I. VM failure gr.II. VTS failure gr.II. Impaired VAP gr.I. Moderate pulmonary hypertension.

Treatment: HD, antimicrobial, antifungal, vascular rheology.

Conclusions: patients with HD who develop IE onset of congestive heart failure, peripheral stigma, developing hypotension, staphylococcal etiology, embolic complications at onset in disease presents a reserved prognosis.

Key words: Infective endocarditis, Hemodialysis, High mortality.

9. DIAGNOSTIC DIFFICULTIES IN A CHILD WITH PROLONGED FEVER

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Introduction: Fever of unknown origin is defined as a rectal temperature higher than 38.3°C more than 3 weeks, the diagnosis of which remains uncertain after initial investigations. Identification of the causes and management of prolonged fever in children is important and is guided by thorough history-taking and repeated physical examinations combined with standard laboratory tests and simple imaging procedures.

Clinical case: We report the case of a two-years-old male who had been managed 1 week for rinofaringitis at home and for 6 days in a tertiary clinic were had been placed on various intravenous antibiotics with no clinical improvementand and was finally referred for further management to our hospital. Physical examination revealed pyrexia (temperature of 38.2°C), faringeal congestion and injected tympanic membranes.The signs of meningeal irritation were absent. Other aspects of physical examination were normal. Results of laboratory tests showed nothing of significance apart from anaemia. He received antibiotic treatment. The fever persisted and in 3-rd day of hospitalisation the child becomes drowsy and father describes cutaneous hyperesthesia. The cerebrospinal fluid analysis showed features in keeping with meningeal inflammation and he had a raised erythrocyte sedimentation rate. The brain computed tomography scan revealed a **tetraventricular hydrocephalus**. He had ventricular shunt and was placed on antituberculous drugs and intravenous steroids but despite this his clinical condition slowly ameliorated and he developed right spastic hemiparesis.

Conclusion: The diagnosis of TB meningitis in this patient highlights that when a patient is not obviously exposed to the causative factors of a disease and clinical signs are absent, possible occurrences may present a diagnostic problem.

Key words: fever of unknown origin, meningitis, child.