cardiolipin and anti-B2 glycoprotein I antibodies were positive in 47.1% and 52.8% of cases respectively. Anticoagulant therapy was prescribed in thrombotic cases. Pericarditis were treated with corticosteroids and patient with myocarditis had both corticosteroid and immunosuppressant agent.

Conclusions DVP were the most frequent vascular manifestation in patients with APLS. Cardiac involvements are rare but serious. They can affect all parts of the heart but cardiac valvulopathy and coronary artery thrombosis are the most frequent.

The author hereby declares no conflict of interest

0383

Clinical and echocardiographic profile of HIV-infected patients in cardiology department at the University Hospital of Brazzaville (Congo)


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Aim To describe the clinical and echocardiographic aspects of HIV-infected patients.

Method This descriptive and analytical study was conducted from 2008 to 2012 in the cardiology department at the University Hospital of Brazzaville.

Results One hundred and thirteen patients were included, 75 women (66.4%). There were 46 (40%) known HIV patients, and 40 (35.4%) were on antiretroviral treatment. Heart failure was noted in 59 cases (52.2%) which 15 cases (13.3%) of pulmonary acute oedema. The mean ejection fraction was 54.8±16.2% (range: 17-80), and the ejection fraction was lowered in 39 cases (34.5%). Pulmonary hypertension was present in 8 cases (7.1%). The main pathologies were myocarditis (n=33; 29.2%), dilated cardiomyopathy (n=27; 23.9%), myopericarditis (n=20; 17.7%) and tuberculous pericarditis (n=30; 26.5%). The death was recorded in 16 cases. Average CD4 count, ejection fraction, left ventricle diameter and right ventricle diameter were lower in deceased patients, no statistical difference.

Conclusion Untreated HIV exhibit more cardiovascular complications. Mortality is due to several comorbidities. For limiting these complications, prevention and antiretroviral treatment actually poorly used, are required.

The author hereby declares no conflict of interest

0224

Cardiac involvement in glycogen storage disease type III

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Glycogen storage disease type III (GSD III) is an autosomal recessive disease, due to deficiency of glycogen debranching enzyme (GDE), a key enzyme involved in glycogen degradation. Clinical presentation includes hepato-megaly, myopathy, hypoglycemia and cardiomyopathy.

The cardiac natural history of patients with GSD III and its relationship with genetic abnormalities is not well known. We performed a longitudinal study in order to describe the natural history of heart involvement in patients with glycogen GSD III.

47 patients were included our study (16 male/31 female). Mean age was 25.7 years ±1.54.

All patients were in sinus rhythm except one patient (atrial fibrillation), 9 patients/47 disclosed abnormal repolarization. Electrical left ventricular hypertrophy was found in 22 patients/47.

Heart failure was found in 10 patients/47 and 2 patients/47 disclosed a left ventricular dysfunction. Hypertrophic cardiomyopathy was found in 23 patients/47; and 4 patients/47 disclosed obstructive hypertrophic cardiomyopathy.

In conclusion, hypertrophic cardiomyopathy is frequent in patients with GSD III.

The author hereby declares no conflict of interest

0201

Cardiac involvement in patients with sarcoidosis

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Introduction Sarcoidosis is a systemic granulomatous disease of unknown etiology. Cardiac involvements in patients with sarcoidosis are rare with an estimated prevalence of 7%. These serious involvements are hard to diagnose at early stage of disease.

Patients and Methods We performed a retrospective study of patients’ files diagnosed with sarcoidosis in the Internal Medicine Department of Rabta University Hospital in Tunis. The diagnosis of sarcoidosis was based on clinical, paraclinical and histological criteria. Cardiac involvements were confirmed by the electrocardiogram and echocardiography.

Results Cardiac involvement (CI) was found in seven patients among 138 with sarcoidosis (5%). They were 6 females and one male with a mean age at diagnosis of 49 years. Electrical disorders such as bundel branch block were seen in two cases. First degree atrioventricular block was noted in two cases. Ventricular hypertrophy was check out in two cases by electrocardiography and ultrasound. Mitral regurgitation with a flutter was noted in one patient and pericardial effusion with a normal ventricular function in another case. Only one patient was clinically symptomatic, he complained of palpitations. Thallium 201 scintigraphy was performed in one case and objectived reversible ischemia of the inferior and latero-inferior walls of myocardium. Other manifestations of sarcoidosis were dominantly associated to CI such as lung disease, which was found in all patients. Skin and neurological involvement were observed, each in three cases. Hepatosplenic involvements were noted in two patients and otorhinolaryngology involvements in one case. All patients received initially high dose of corticosteroids. Four of the patients had a good response to treatment and three were lost to follow up.

Conclusion Cardiac involvements in sarcoidosis are rare but serious, an early diagnosis and treatment with corticosteroid may rapidly improve patients.

The author hereby declares no conflict of interest

0413

Cardiac involvements in patients with amyloidosis

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Introduction Amyloidosis is a rare disease. Some types of amyloidosis may significantly affect the heart; abnormal monoclonal light-chain s (AL), transthyretin-related hereditary (TTR) and senile amyloidosis.

Patients and Methods Patients’ files with amyloidosis were studied (hospitalized in an internal medicine department, from 2000 to 2013), only patients with cardiac involvement were enrolled.

Results Forty patients with cardiac amyloidosis were included; sex ratio M/F was 1. Mean age at diagnosis was 60.6 years (range 36-76 years). Cardiac manifestations revealed amyloidosis in 42.8% of cases. Patient complained of fatigue (50%), dyspnea (35.7%), chest pain (28.5%) and palpitation (14.2%). One patient presented with recurrent syncope attack due to paroxysmal atrioventricular block. Four patients had cardiac failure at amyloidosis diagnosis.

Amyloidosis was systemic in all cases; kidney localization (9 cases), hepato-megaly (6 cases), and macroglossia (4 cases). N-terminal pro-brain natri-