atherosclerotic lesions were selected – 226 cases. The complications and difficulties of the interventional procedures in the presence of myocardial bridges and severe coronary atherosclerotic lesions have been studied in a group of 131 patients.

Results. Preferential localization of the myocardial bridges (97% of cases) was on the anterior interventricular artery, 1,81% - on the diagonal branch, in 0,9% of cases – on posterolateral and marginal branches, 0,6% - on the right coronary artery, and 0.3% along the circumflex artery. In the detected cases, the degree of arterial systolic stenosis exceeded 75% were described in 16% of cases, 50-75% in 36% and in 46% of cases the stenosis was below 50%. In 48% of cases the stress test was considered as typical positive in patients with myocardial bridges with documented myocardial ischemic change on ECG and without severe coronary atherosclerotic stenosis. There was no interdependence between the degree of stenosis caused by the bridge and the degree of ST-segment depression in the effort test. In the conducted study, only in 3 cases, the reason for hospitalization for diagnostic coronary angiography was acute coronary syndrome in the arterial territory covered by a myocardial bridge. In 9 cases, due to myocardial ischemia caused by the myocardial bridge, revascularization by aortocoronary bypass was recommended. In 6 cases the arterial portions under the bridge were stented with mechanical compression and deformation of the installed stent after 3 months in 3 cases. Within the group of patients with severe atherosclerotic coronary lesions and myocardial bridges who need PCI, in 6 cases, due to coronary deformation at the entrance under the bridge, the stent crossing was difficult in the respective segment. In 14 cases, the presence of the bridge and the entrance of the distal end of the stent under the myocardial bridge when stenting the proximal to bridge atherosclerotic lesions, induced prolonged coronary spasm or coronary dissection.

Conclusions. Although no correlation between the degree of compression caused by the bridge and the degree of myocardial ischemia has been established, myocardial bridges could cause myocardial ischemia by possibly an addition to the mechanical action on the artery under the bridge of the coronary spasm, determining thereby acute coronary syndromes. The treatment of patients with significant myocardial bridges with recurrent ischemia on optimal drug therapy would preferably be by coronary bypass due to the mechanical action of the myocardial bridge on the coronary stents. Coronary stenting with penetration of the stent distal end under the myocardial bridge may be associated with coronary dissection, coronary spam and/or mechanical deformation of the stent.

225. AN UNUSUAL CASE OF CONGENITAL TRICUSPID VALVE ANOMALY

Author: **Inessa Cojuhari**
Scientific adviser: Irina Cabac-Pogorevici, PhD, University Assistant, Department of Internal Medicine, Cardiology, *Nicolae Testemitanu* State University of Medicine and Pharmacy, Chisinau, Republic of Moldova

Background. A 38 years old man is presented with acute onset with dyspnoea for 2 months. From anamnesis is known that he suffered 10 years ago a car accident complicated with multiple fracture. Patients is unknown with cardiac pathology and he does not use any medication.

Case report. Upon arrival at the emergency department, his vital signs were: blood pressure 120/80 mmHg, heart beat 70 beats/min, body temperature 36.7 C and O2 saturation 98 %. Electrocardiography (ECG) registered right bundle branch block. Initial laboratory data didn't

revealed any abnormalities. Transthoracic ECHO CG, which was performed when the patient arrived at the hospital, showed normal ejection fraction (EF- 57 %), severe dilated right heart chambers and severe tricuspid regurgitation with suspicion of rupture of septal leaflet. As well, heart MRI was made to establish cardiac diagnosis. Heart MRI registered: Dysplasia of the septal cusp of the tricuspid valve. Severe tricuspid valve regurgitation (regurgitation volume – 110 ml, regurgitation fraction – 55%). Right ventricle is severely dilated, global systolic function normally. Right atrium severe dilated. Was made differential diagnosis between posttraumatic rupture of tricuspid valve and congenital tricuspid valve anomaly. The patient was consulted by cardio-surgeons and was disseated heart intervention for the Tricuspid Valve repair. During the intervention was noticed severe dilated ring of Tricuspid Valve (65 mm). Posterior leaflet with rupture of chordae, septal leaflet pasted by sept with abnormal attached of chordae. The anterior leaflet with abnormal big dimension and total prolapse in the right atrium. Foramen ovale patent. A tricuspid valve anomaly was confirmed. There was made Tricuspid Valves repair with implantation of the ring. Due to severe dilatation of the ring of Tricuspid Valve it wasn't possible to apply a classic method of Tricuspid Valve repair. Two techniques were combined to solve our patient's problem. The annuloplasty was made by Kay technique, the posterior leaflet was completely excluded, and a functional bicuspid valve is finally obtained. After that was stitched together the middle point of the free edges of the tricuspid leaflets by Alfieri technique. In cases of severe annular dilatation, annuloplasty alone is unlikely to be durable so an additional procedure, such as "clover technique," was used to obtain a more durable repair. On ECHO made in dynamics was revealed Tricuspid Regurgitation of second degree with persisting severe dilatation of right chambers. The dyspnoea after surgery improved and the patient was discharged after 5 days post - surgery.

Conclusions. Tricuspid valve disease affects millions of patients worldwide. It has always been considered less relevant than the left-side valves of the heart, but still represents a great challenge for the cardiac surgeons, especially in the most difficult symptomatic scenarios. When possible, valve repair still remains the most useful procedure, while replacement is generally preferred in the most demanding cases. Only the accurate choice of the most appropriate procedure will provide optimal and long-term results.

Key words: Tricuspid Valve Anomaly, Valve Repair, Congenital Anomaly

226. ACUTE PULMONARY THROMBEMBOLISM ON THE BACKGROUND OF PULMONARY ASPERGILLOSIS

Author: **Alina Sirbu**

Scientific adviser: Irina Cabac-Pogorevici, PhD, University Assistant, Department of Internal Medicine, Cardiology, *Nicolae Testemitanu* State University of Medicine and Pharmacy, Chisinau, Republic of Moldova

Background. Invasive pulmonary aspergillosis is a severe fungal infection with a high mortality rate. Diagnosis is challenging due to the non-specific nature of symptoms. Allergic bronchopulmonary aspergillosis (ABPA) complicated with pulmonary thromboembolism (PTE) is rare. This report describes a patient who was diagnosed with ABPA and soon developed PTE, for which he was admitted to our department. In the recent years, ABPA has become more and more common clinically, especially in patients with cystic fibrosis or asthma, which can lead to irreversible bronchiectasis, pulmonary fibrosis, and even death. The common complications of ABPA include recurrent exacerbations, bronchiectasis, and acute respiratory