

cholesterol - 6.0 mmol/l, triglycerides - 1.44 mmol/l, LDL - 4.0, HDL - 1.31, urea - 6.0 mmol/l, creatinine - 79 mmol/l, total bilirubin - 10.2 mmol/l, bound bilirubin - 2.0 mmol/l, free bilirubin - 8.2 mmol/l, ALAT - 40 U/l, ASAT - 30 U/l. Treatment: Fraxiparin 0.6 s/c, Sol Isosorbide dinitrate 10 mg i/v lineomat infusion, Sol Meldonium 500 mg i/v, Ramipril 5 mg/day, Bisoprolol 5 mg/day, Rozuvastatin 10 mg/day, Adenuric 40 mg/day.

**Conclusions.** "De novo" Angina Pectoris is a form of unstable AP, characterized by retrosternal pain and progressive dyspnea, with transient changes of the ST segment on EKG in 15-30% of cases. The prognosis of "de novo" AP is favorable in the early diagnosis of this pathology with the administration of the appropriate treatment and the cessation of risk factors.

**Key words:** Angina Pectoris „de novo", constricting retrosternal pain.

### **234. CARDIAC RECURRENT HYDATID CYST OF THE RIGHT VENTRICLE: CASE REPORT**

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**Background.** Hydatid disease is a parasitic infection caused by larvae of *Echinococcus granulosus*. Hydatid cysts can be located in various tissues, although they are most common in the liver and the lungs. Cardiac involvement is scarcely encountered with a frequency of 0.01% to 2. Areas of cardiac involvement in hydatid disease including the left ventricle (60% of cases), right ventricle (10%), pericardium (7%), pulmonary artery (6%), and left atrial appendage (6%); involvement of the interventricular septum is rare (4% of cases). Right ventricular cysts have characteristics different from those of left-sided cysts. Right-sided cysts have a tendency to expand intracavitarily and subendocardially, and rupture more frequently, and can cause fatal complications such as anaphylactic shock, dissemination, and pulmonary embolisms.

**Case report.** We present the case of 58 years asymptomatic old man with cardiac cyst. His past history revealed surgery for a cardiac hydatid cyst 22 years previously, embedded in the right ventricular myocardium. The cyst was resected, during the operation, rupture of the cyst was noted. He completed lasting courses of albendazole therapy. During a 22 years follow-up, the patient was asymptomatic, with no cystic appearance on transthoracic echocardiography, but was observed pulmonary dissemination over a period. This time, at the routine examination, through transthoracic echocardiography was performed and revealed in the apical region of right ventricle, in the free wall, a multicameral cystic formation with d- 31 x 23 mm suggestive for hydatid cyst. Further investigation was performed with cardiac magnetic resonance imaging (MRI), which showed a conglomerate of hydatid cysts of the lateral apical myocardium of the right ventricle (measured 27 x 23 mm), with protrusion into the cavity of the right ventricle and into the cavity of the pericardium and nodular lesions of pulmonary areas suspected for hydatid lesions. Chest X-ray revealed bilateral nodular opacities of different dimensions. A coronary angiogram showed severe stenosis on LAD II-III, DP, insignificant on RCA II, III. The patient was recommended to repeat cardiac surgery with by-pass, and pulmonary CT for provide an accurate diagnosis.

**Conclusions.** According to the literature, cardiac cystic echinococcosis remains a very infrequent zoonotic infection. Surgical treatment is associated with a low morbidity and

mortality, and the selection of proper technique is very important to completely remove the hydatid cyst and prevent recurrence. A superadded infection is the most common complication of a ruptured hydatid cyst. The risk of recurrence is present; the recurrence may appear much later hence the importance of echocardiographic and radiological monitoring.

**Key words:** cardiac cystic echinococcosis, recurrence, right ventricle

### **235. ANALYSIS OF RISK FACTORS OF NON ST SEGMENT ELEVATION MYOCARDIAL INFARCTION IN LOW AND INTERMEDIATE RISK PATIENTS**

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**Introduction.** Non ST segment Elevation Myocardial Infarction (Non-STEMI) is a problem at the global level, which annually takes a large number of lives. The evolution and algorithms of patients treating differs significantly depending on whether the risk according to the GRACE scale is high or whether it is intermediate or low. What factors increase the risk in this patients group remains to be determined.

**Aim of the study.** To evaluate incidence frequency and to analyze the risk factors in non ST segment elevation myocardial infarction with low an intermediate risk.

**Materials and methods.** The study included 252 patients with non ST segment elevation myocardial infarction and score GRACE below 140 who was admitted in the hospital. The risk factors for these patients were analyzed.

**Results.** The average age of the patients was  $59.94 \pm 0.639$  years. 208 (82.5%) of them are men and 44 (17.5%) are women. High blood pressure was noted in 176 patients (69.8%). Stage 1 - 3 cases (1,2%), stage 2 - 87 cases (34,5%), stage 3 - 86 (34,1%). 146 patients (57.9%) were obese. The average body mass index was  $26.537 \pm 0.173$ . Diabetes mellitus was detected in 59 patients (23.4%). High cholesterol was found in 116 (46.0%) patients and averaged  $5.308 + 0.085$  mmol /l. 77 (30.6%) patients were smokers. 208 (82.5%) patients had a family history of heart disease or other cardiovascular disease.

**Conclusions.** Non ST segment elevation myocardial infarction is more susceptible in men over the age of 50 years. Obesity, arterial hypertension of stages 2 and 3 and family history of heart disease or other cardiovascular disease increase the risks of developing Non-STEMI with low and intermediate risk. The presence of diabetes mellitus, high cholesterol and smoking are not so common among this type of patients, these risk factors are most likely to lead to the development of Non-STEMI with a high risk.

**Key words:** Non-STEMI, myocardial infarction, risk factors.