

group of an increased risk of CVD; the EULAR recommendations in 2017, updated in 2019, announced that the estimated risks are multiplied by 1.5- 2 for all patients with RA. The same data was found on systemic lupus erythematosus, in which the risks increase by 2-3 times. A similarity was suggested also on psoriatic arthritis and systemic sclerosis.

**Conclusions.** Chronic inflammatory disorders, influenced by their pro-inflammatory effects are relevant as the new risk factors of Cardiovascular disease such as atherosclerosis, arteriosclerosis, acute coronary syndrome, etc.

**Key words:** Chronic inflammation; Cardiovascular disease; risk factor; atherosclerosis.

### 233. ANGINA PECTORIS „DE NOVO”

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**Background.** Angina Pectoris (AP) „de novo” represents 31% of the total patients with unstable AP. The annual incidence of AP „de novo” is 3 cases per 1000 persons, affecting mainly patients between 42-71 years old. The rate of men/women being of 66.6-80.6% compared with 19.4-33.3%. Patients present concomitant pathologies: Arterial Hypertension - 54.8%, dyslipidemia - 51.6%, Diabetes Mellitus - 29.0 % and smoking - 51.6% [3, 4, 5]. This pathology is characterized by constricting retrosternal pain at rest or at exertion, with the onset up to 30 days. Symptoms can evolve, depending on the structure of the atherosclerotic plaque, as either stable AP - 76%, or Acute Myocardial Infarction - 34 %. Both groups have been admitted to inpatient treatment in specialized Cardiology Departments [1, 2].

**Case report.** We report a case of a 54 year old patient, teacher, admitted in the Cardiology Department nr.3 of SMH „Holly Trinity” with the diagnosis: Unstable Angina Pectoris „de novo”. HF II NYHA. Patient presented with: constricting retrosternal pain at moderate effort and at rest, dyspnea at low physical effort, palpitations, occipital headache, dizziness, fatigue. History: the symptoms started about 3 weeks ago, when for the first time, after psychological stress, palpitations and retrosternal pain appeared. Symptoms have diminished after the rest. The pain reappeared after low physical effort (walking 10-15 m), after smoking, after cold exposure and excessive coffee consumption. The patient went to the family doctor and he was urgently admitted to the cardiology department to establish the diagnosis and to choose the appropriate treatment. Risk factors: aggravated family history, smoking, dyslipidemia, hyperuricemia. Objective data: moderate severity. The skin is pink, clean. Pulmonary auscultation: there is vesicular murmur, murmurs are absent, RR - 22 b / min. The apex beat is determined in the V intercostal space, on the left of the medioclavicular line. Rhythmic cardiac noises with HR 100 beats/min, BP - 130/90 mm/Hg. The abdomen is soft, painless at palpation. The liver and spleen are not palpable. Intestinal transit present. Giordano sign – negative bilaterally. Osteo-articular system – no pathologies. Paraclinical examination: ECG – Sinusal tachycardia with HR 106 beats/min. Left axis deviation. Signs of hypertrophy of the LV myocardium. Echocardiographic conclusion: Induration of the ascending aorta walls. Moderate dilatation of LA, RA. Moderate hypertrophy of LV. Insufficiency of the VTr., VM gr.II, VAP gr. I. Moderate HTP. Laboratory analysis: Hemoleucogram: Hb. - 146 g/l, RBC - 4.6x10<sup>12</sup>/l, WBC - 5.8 x10<sup>9</sup>, SR - 25 mm/h. CK-MB - 20, Troponines - negative, glucose - 4.9 mmol/l,

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