manifestations. One hallmark feature of the disease is acromegalic cardiomyopathy; a syndrome of progressive cardiac dysfunction characterized by left ventricular (LV) hypertrophy, diastolic dysfunction, and combined systolic and diastolic dysfunction in advanced stages. Dilated cardiomyopathy (DCM) is relatively rare in this setting but is associated with increased mortality.

Case report. We report the case of a 44 y.o man who was admitted to the cardiology department because of progressive dyspnea on exertion and paroxysmal nocturnal dyspnea with recent onset. Physical examination revealed systolic murmurs in mitral and tricuspid areas and jugular vein distension. Laboratory findings showed moderate hepatic cytolysis. Electrocardiogram showed sinus rhythm (SR) and LV hypertrophy. Echocardiography revealed DCM with severe LV dysfunction (LV ejection fraction (LVEF) = 20%), LV hypertrophy, restrictive diastolic dysfunction, biatrial enlargement, moderate mitral regurgitation and pulmonary hypertension (systolic pulmonary artery pressure (PAPs) = 60 mmHg). A coronary angiography was performed to rule out coronary disease. It revealed normal coronary arteries. Optimal heart failure (HF) treatment was started. The patient did not attend follow-up visits. Ten years later, he presented with NYHA class III HF symptoms. Mandibular enlargement with widened space between the lower incisor teeth, macroglossia, enlargement of his hands and feet over the last 10 years was noted on physical examination. Laboratory findings revealed hepatic cytolysis and elevated NT-proBNP (9668 pg/ml). Electrocardiogram identified atrial fibrillation. Echocardiography showed dilated cardiomyopathy with further deterioration of LV function (LVEF=15%) and pulmonary hypertension. Magnetic resonance imaging showed non-specific LV myocardial fibrosis. Genetic tests, carried out to exclude a genetic DCM (170 genes evaluated), did not identify any pathogenic variants. At this point an endocrinology evaluation was requested. It revealed active acromegaly (IGF-I = 416 ng/ml) due to pituitary microadenoma. Considering a high surgical risk, conservative treatment with somatostatin analogue was initiated. Follow up at 5, 10 and 18 months revealed improved clinical status, spontaneous restauration of SR, progressive improvement in LVEF (30%, 33% and 40%), normalization of PAPs and of NT-proBNP = 186 pg/ml.

Conclusions. Here we report the case of a patient with acromegaly and severe non-ischemic DCM. Treatment with somatostatin analogue resulted in early improvement of clinical status and LV systolic function sustaining a probable causal relation between endocrinological dysfunction and DCM. This is a one of the few reported cases of acromegalic DCM with significant improvement under somatostatin analogue therapy as an initial option.

Key words: acromegaly , dilated cardiomyopathy , acromegalic cardiomyopathy

223. LEFT ATRIAL ENCAPSULATED THROMBUS IN A NON-COAGULATED PATIENT WITH SEVERE MITRAL STENOSIS

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Background. Rheumatic mitral stenosis (MS) is associated with left atrium (LA) thrombus in patients in sinus rhythm (3 % – 13 %) and markedly increases in atrial fibrillation (~33 %).The presence of LA thrombus carries a risk of systemic embolization and neurologic morbidity.

The discovery of a massive thrombus through echocardiography obliges the clinicians to strategies for secondary prevention of trombembolic events. The main line of actions of stroke prevention in cardioembolism is mostly connected with antithrombotic drugs, but also other, more invasive. Certainly, surgery is the best solution for a successful prognostic.

Case report. We present a case of a non-anticoagulated 56-year-old woman with severe MS. She was admitte to cardiology department with dyspnea, palpitations and fatigue. Anamnesis: 10 years of atrial fibrillation (AF) and 7 years with arterial hypertension. Physical examination revealed an irregular pulse, at a rate of 76 beats/min. The ECG revealed an atrial fibrillation with a rate 75-100 b/min. ECHOCG - revealed a severe MS (V max 2.9 m/s, GP max – 33.8 mm/hg, area – 0.5 cm2) with third degree mitral regurgitation and LA thrombus (90*80 mm), fixed to the upper and rear wall of the LA, third-degree tricuspid regurgitation. Left atrium was enlarged (59 mm), severe pulmonary arterial hypertension. The preoperative coronarography showed the absence of any sign of atherosclerosis. The patient was referre to cardiac surgery for correction of valvular pathology. Cardio-surgical intervention was performe: mechanical MV prosthesis ST – JUDE MED 27, DEVEGA-CABROL tricuspid annuloplasty, removing the massive encapsulated thrombus (90*80 mm) from the LA with the origin into the left appendage, obliterating the pulmonary veins, then - surgical closure of the left atrial appendage. After surgery, the patient had recovered well without any neurologic dysfunction in the postoperative period.

Conclusions. The risk of cardioembolic complication to the patient with severe mitral valve stenosis is very high and depends on age and the presence of other comorbidities. Anticoagulant treatment in patients with severe MS and AF is paramount, cessation of anticoagulant treatment leads to serious complications such as stroke. In our case, the size and organized nature of the thrombus, prevented embolization into the systemic circulation, but in other cases the risk is very high. In the era of open-heart surgery and of mitral valve replacement, the prognosis for most patients with valvulopathies, especially those with rheumatic etiology is excellent.

Key words: mitral stenosis, thrombus, anticoagulation, surgery

224. CLINICAL AND INTERVENTIONAL KEY POINTS IN PATIENTS WITH MYOCARDIAL BRIDGES

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Introduction. Myocardial bridges, parts of cardiac tissue that cover some parts of underepycardial coronary artery. It is important to study their morphological and clinical aspects, because of their possible implication in the genesis of the coronary hemodynamic changes.

Aim of the study. To determine the incidence of myocardial bridges detected by coronary angiography, their clinical features and management peculiarities.

Materials and methods. We have retrospectively analyzed 6168 cases of diagnostic angiography and coronary angioplasty between 2013-2019. Myocardial bridges were detected in 357 cases (4,9%). For the study of the clinical aspects of patients with myocardial bridges, only cases of angiography with myocardial bridges and coronary arteries with mild or without