

124. CYTOMEGALOVIRUS INFECTION AND INFLAMMATORY BOWEL DISEASE

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Introduction: Inflammatory bowel disease (IBD) is a general name of two entities: Crohn's disease (CD) and ulcerative colitis (UC) which represent chronic non-specific inflammation of gastrointestinal tract. The etiology of IBD is not clear and Cytomegalovirus infection is often associated with IBD. The pathogenetic link between IBD and CMV infection was supposed and began to be studied in the last decades.

Purpose and objectives: The aim of the study was to evaluate critically literature data on the relationship between CMV and IBD.

Materials and methods: Internet search was conducted in Medline (from 1966 to 2013) and PubMed (from 1980 to 2013) database using words “cytomegalovirus”, “inflammatory bowel disease”, “ulcerative colitis”, “Crohn's disease”.

Results: 419 articles were found. Early studies indicated that CMV infection can lead to subsequent development of IBD. But in the more recent studies was demonstrated that CMV colitis occurred primarily in patients with pre-existing IBD. There have also been reports of colitis patients with evidence of active CMV infection who improved with steroids and did not require antiviral treatment, as well as patients with active colonic CMV infection without active colitis. In these cases CMV seems to behave like an innocent bystander.

CMV has the propensity to infect rapidly growing tissue, especially endothelial cells in granulation tissue. Some studies suggested that CMV represents an opportunistic infection in severely inflamed mucosa rather than a primary pathogen.

The most widely held theory is that CMV infects areas of active IBD and causes further tissue injury aggravating the severity of the underlying IBD. In the majority of case-reports patients with severe attacks of IBD and CMV infection had significant morbidity (toxic megacolon 15%, colectomy up to 62%) and mortality (up to 44%). Antiviral treatment prevented colectomy in some but not all of the patients. In more recent series the morbidity of CMV colitis in UC were 30% and the rate of surgery 40%. CMV disease seems to be less frequent in patients with CD compared to patients with UC. The prevalence of CMV infection in steroid-refractory IBD patients, in 2 studies, was 36% and 33%, respectively.

Conclusion: The role of CMV infection in patients with IBD has not yet been clearly defined. In the majority of published studies CMV is considered as pathogenetic factor, which complicates the IBD course causing the resistance, while in others CMV does not seem to alter the natural course of the underlying IBD.

Keywords: Cytomegalovirus, inflammatory bowel disease, ulcerative colitis, Crohn's disease

125. NON-SCARRING ALOPECIA - CLINICO-DIAGNOSTIC AND TREATMENT SYNTHESIS

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Introduction: Hair loss (alopecia) is a very common patient problem and often a significant source of patient distress. An accurate diagnosis can frequently be difficult. A rational, organized approach is crucial, as therapy is dictated by the appropriate diagnosis. The first task of the physician is to address the patients' concerns fully, exploring the impact of alopecia on psychosocial well-being.

Androgenetic alopecia (AGA) is by far the most common cause of hair loss. It affects approximately 50% of men by the age of 50 and 20% to 53% of women by the age of 50. Although it is a medically benign condition, it can have a significant psycho-social impact for patients.

Alopecia areata is a chronic inflammatory disease that affects the hair follicle and sometimes the nail. About 20% of people with alopecia areata have a family history of the disease indicating a genetic predisposition. The prognosis is less favorable when onset occurs during childhood and in ophiasis. The risk of developing alopecia areata in life is 2%.

Telogen effluvium (ET) is probably the second most common form of hair loss. The number of secondary causes that can cause ET is growing.

The aim of the study: Evaluation of the anamnesis, clinical course and treatment of non-scarring alopecia and confrontation data reviewed in literature with my study.

Materials and methods: For observations were subjected 44 patients, 10 with alopecia areata, 14 with androgenetic alopecia and 20 with telogen effluvium.

Prospective analysis: Clinical examination was performed selectively in outpatient. Patients were subjected to the following tests:

Hair loss history questionnaire

What is the duration and pattern of the hair loss?

Is the hair coming out by the roots, or is it breaking?

Increased shedding or increasing thinning?

Age of onset

Drugs

Menses, pregnancy, menopause

Present and past health

Thyroid function screening questions

Family history

Hair care, hair cosmetics

Diet

1. **A contrast paper test**

2. **Pull test:** To determine the ongoing activity of hair loss.

3. **Trichogram/pluck test:** The trichogram/ pluck test is another method of assessing hair loss

4. **Light microscopic examination of hairs**

Results: At the end of the observation period was noticed the characteristic differential features of each disorder.

	<i>Androgenetic alopecia</i>	<i>Telogen effluvium</i>	<i>Alopecia areata</i>
Hair loss distribution	Focal balding pattern: Norwood-Hamilton (men) Ludwig (women)	Generalized	Usually patchy, but can be generalized
Course	Gradual onset with progression	Onset abrupt/trigger factor	Onset abrupt; often waxes and wanes with relapses
Appearance	Thinning with or without bare Patches. Bare patches are gradual, not abrupt	Thinning with no bare patches	Thinning with abrupt bare patches; exclamation mark hairs
Shedding	Minimal	Prominent	Prominent
Age onset	Onset at puberty or older	Onset at any age, but usually not childhood	Onset at any age; majority have their first patch before the age of 20
Pull test	Usually negative	Positive; telogen hairs	Positive; dystrophic anagen and telogen hairs

Conclusions: The majority of common hair disorders can be readily diagnosed in the physician's office through the recognition of the characteristic differential features of each disorder. The first task of the physician is to acknowledge the patient's concerns and have an empathetic approach to the problem of hair loss. The diagnosis depends upon a combination of findings obtained from meticulous history, physical examination and any necessary investigations. An organized diagnostic and management strategy will help both to identify the cause of alopecia and to direct therapy.