34. DRESSLER'S SYNDROME AFTER MYOCARDIAL INFARCTION

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Introduction: Dressler's syndrome is a secondary form of pericarditis following myocardial infarction (MI) or postsurgical injury of the pericardium. It presents with fever, pleuritic pain and pericardial effusion between 2 weeks to several months after MI, and is affecting 1-5% of patients.

Case Report: A 37-year-old male presented to the emergency room (ER) with acute chest pain, accompanied by general weakness after 18 hours from onset of symptoms. Cardiac risk factors included hypertension, smoking, dyslipidemia and a family history of coronary artery disease. The ECG was consistent with an acute inferior ST-segment elevation MI. Despite the late presentation, he was taken to the catheterization lab because of his ongoing pain and persistent ST elevation. Coronary angiography revealed proximal circumflex artery occlusion. Target lesion angioplasty was performed and a bare metal stent (INTEGRITY 3.5×15 mm) was implanted, obtaining a successful opening of the artery with a TIMI 3 flow. Following loading doses of aspirin and Clopidogrel in the ER, the treatment continued with Metoprolol, Zofenopril, Atorvastatin and Heparin. Level of troponin I was elevated to 166.23 μg/l. Transthoracic echocardiogram (EcoCG) showed akinesis of the inferior, posterior and lateral walls of the left ventricle (LV) from the base to the apex with a reduced systolic function (EF 35%) and no pericardial effusion. His impatient stay was complicated by pyrexia, raised inflammatory markers (CRP 239.72 mg/l) and a negative chest X-ray dynamic with worsening venous stasis to grade 2, focal infiltration in the right 7^{th} and 8^{th} segments and minimal amount of pleural fluid. A right lung lower and middle lobes pneumonia was diagnosed and antibacterial therapy (Ampicillin/Sulbactam 1.5 g × 4 times/day) was added. Further laboratory findings revealed mild anemia, leukocytosis, raised inflammatory and liver markers. Sputum culture was negative. Two weeks after admission, despite antibiotic therapy, the patient continued to have fever, dyspnea, dry cough and pleuritic pain. EcoCG examination showed progressive pericardial effusion with no visible mechanical defects. Subsequent cardiac magnetic resonance revealed pericardial effusion of heterogeneous fluid: LV lateral wall 28 mm, inferior wall 22 mm, anterior wall 27 mm, right ventricle lateral wall 20 mm, left atrium 30 mm, right atrium 24 mm, with its systolic collapse. Pericardiocentesis for decompression was not performed because of no clinical signs of hemodynamic compromise. In the absence of sufficient data for a "hidden" cardiac rupture and the presence of rich pericardial fluid accumulation, a diagnosis of Dressler's syndrome was considered, and a glucocorticoid therapy with Prednisolone 1 mg/kg/day was initiated. Because of persistent inflammatory indicators, antibacterial treatment was changed to Piperacillin/Tazobactam 4.5 g × 4 times/day. During the next few days on treatment patients' fever subsided, cough and dyspnea were reduced. Heart rate normalized to 74 beats/min and blood pressure was 120/70 mmHg. Auscultation revealed vesicular breathing in the lungs, without rales. A prednisolone dose reduction to 5 mg/week was recommended to be continued after discharge. One month later the patient presented to the hospital for reevaluation and he had no recurrence of pericardial symptoms and a repeated EcoCG showed no pericardial effusion.

Keywords: Dressler syndrome, myocardial infarction

35. SCORAD INDEX EVOLUTION IN CHILDREN WITH ATOPIC DERMATITIS

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Introduction: Atopic dermatitis (AD) is a chronic inflammatory disease of the skin conditioned mostly by IgE allergic reactions genetic associated with atopy. It was proven that AD clinic evolution has some particularities related to the age, the severity of process and disease's duration. The severity of the disease is appreciated by SCORAD index assessment (scoring atopic dermatitis).

Objective: SCORAD index assessment in AD clinical evolution in children.

Materials and methods: The study group consisted of 30 patients with AD (10 males, 20 females) with the age range between 2 months and 14 years. The diagnosis was based on patients' history, clinical and laboratory investigations. The dynamic of SCORAD index, total Ig E, CIC were assessed. SCORAD index was calculated in points, includes the evaluation of the process progression (affected area), the intensity of skin manifestations (erythema, oedema/papules, moist/crusted areas, excoriations, lichenification, xerosis) and the accuracy of subjective signs (itching, sleep disturbances), thus reflects the gravity of the process. The patients were divided into 3 groups by SCORAD index: I group- 8 patients with the index points below 20 (mild form), II group- 12 patients with SCORAD index ranged between 20 and 30 (moderate form), III group- 10 patients with the index>30 pts. (severe form). AD therapy included: diet therapy, local treatment with specific remedies of daily skin care, local anti-inflammatory and antihistamines remedies. Therapeutic efficacy was based on SCORAD index further determination.

Results and discussions: The average SCORAD index for all the groups of study was 35,0 pts., in I group of study- 19,8 pts., II group-28,0 pts., III group-59,0 pts.. At the first reexamination in 7 days, average SCORAD index was 22,0 pts. (the index decreased with cca. 33%), after 12 days it consisted 10,4pts. (77% decreased from initial values). Xerosis extinction and clinical remission induction was noticed in 20 patients. In 10 patients (4 from II group and 6 from III group), a slow decreasing, till 30%, of the clinical signs was noticed. The individual analysis of these patients showed the presence of comorbidities (chronic amigdalitis, adenoiditis, gastroduodenitis), that needed prolonged further treatment.

Conclusion: This study sustains the efficiency of the SCORAD index's prediction value in AD evolution assessment. SCORAD index decreasing in the study group reflects the treatment's efficacy. The presence of digestive system's disturbances and of infections with focal chronic inflammation leads to a prolonged inflammatory dermic process and a prolonged therapy.

Keywords: SCORAD index, predictive value, atopic dermatitis

36. QUALITY OF LIFE IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS AND PULMONARY INVOLVEMENT

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Introduction: The influence of systemic lupus erythematosus (SLE) on the quality of life (QoL) is an important principle in the management of patients with SLE.

Purpose and objectives: Evaluation of QoL in patients with SLE and pulmonary involvement.

Material and Methods: The study included a group of consecutive patients who meet the SLICC, 2012 criteria of SLE classification. The disease activity was assessed by SLEDAI and SLAM, organ damage – by SLICC Damage Index. Evaluation of lung involvement was performed by St. George Respiratory Questionaire, imaging (Rx, ECHO, HRCT) and functional respiratory tests (spirometry, DLCO). QoL was assessed by the SF-36 questionaire, which includes eight areas summed to Physical Component Summary (PCS) and Mental Component Summary (MCS). The correlation between variables was calculated by Pearson coefficient.

Results: The study enrolled 30 patients with mean age 42.3 ± 11.64 yrs, the disease duration 7.29 ± 7.1 yrs, mean age at onset – 34.43 ± 11.4 yrs, female:male ratio 9:1. The average of SLICC classification criteria was 6.2 ± 1.64. The activity, assessed by SLEDAI was 12.33 ± 8.07 and by SLAM – 13.63 ± 6.41 points, respectively, SLICC DI was 2.13 ± 2.45 points. Thirteen (43.3%) patients had pulmonary implications: 6 with pleurisy, 3 – pulmonary hypertension, 1 – shrinking lung syndrome, 1 – interstitial pneumopathy, 1 – pulmonary embolism and 1 – lupus pneumonitis. The comparative analysis of patients with and without lung disease showed a decrease in the quality of life in both groups. In the group of patients with pulmonary involvement was obtained a lower summary score of physical