Objective: In this study we tried to evaluate the trend of the risk factors and their effects in causing stroke.

Materials and Method: The study involved 50 hypertensive patients, including 11 diagnosed with stroke. Data were collected from records of clinical observation and discussions with patients.

Risk factors based on which the study was conducted are: hypertension, sex, age, hypercholesterolemia, smoking, diabetes, atrial fibrillation.

Cardiovascular risk factors	Hypertension and stroke 11p. (22%)	Hypertension without stroke 39p. (88%)
Sex		
Male	45,5% (5)	46,15% (18)
Female	54,5% (6)	53,84% (21)
Age		
<40 years old	9% (1)	5,12% (2)
>40 years old	91% (10)	94,8% (37)
Dyslipidemia	63,63% (7)	35,89% (14)
Smoking	63,63% (7)	41,02% (16)
Diabetes	18,18% (2)	38,46% (15)
Stress	27,27% (3)	69,23 (27)
Atrial Fibrillation	54,54% (6)	33,3% (13)

Our data show that smoking, diabetes, dyslipidemia, and atrial fibrillation are the risk factors for stroke.

The risk factor's number	Hypertension and stroke 11p. (22%)	Hypertension without stroke 39p. (88%)
0 cardiovascular risk factors	0	0
1 cardiovascular risk factors	0	33,33% (13pts.)
2 cardiovascular risk factors	36,36% (4pts.)	27,77% (10pts)
>3 cardiovascular risk factors	63,63% (7pts.)	41,02% (16pts)

Data obtained elucidates that the number of cardiovascular risk factors increased risk for developing of stroke.

Discussion: We found that hypertension, smoking, diabetes and hypercholesterolemia as the most important factors in the occurrence of stroke.

Conclusion: Stroke is serious problem worldwide, including the multitude of risk factors that can cause it. So a large number of strokes can be prevented if the risk factors are known, if they are effectively monitored patients at risk and whether the treatment administered fighting appropriate risk factors.

Keywords: Stroke, hypertension, risk factors

47. CLINICAL CASE: INFERIOR MYOCARDIAL INFARCTION OF THE LEFT VENTRICLE, EXTENDED TO THE RIGHT VENTRICLE

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Introduction: Acute myocardial infarction of the right ventricle (AMI RV) is rarely met, it being associated with an inferior AMI of the left ventricle (AMI LV) in 33-50% of the cases, determining the increase of early morbidity and mortality. The symptoms of hypotension, clear pulmonary areas and turgid jugular veins are considered a marker of the RV lesion in patients with inferior AMI. Approximately 25-50% of AMI RV present with hemodynamic disturbances. Female

gender, age over 70 years, arterial hypertension, smoking, atrio-ventricular block and bundle branch block are predictive factors for the RV implication in patients with inferior AMI. The patient R., 72 years old, was admitted to the Cardiology Department nr. 1 of the PMSI Institute of Cardiology with the diagnosis: Ischaemic cardiopathy. Inferior acute myocardial infarction. Cardiac asthma accesses. Acute cardiac failure II Killip.

Complaints: Constrictive pain in the right parasternal and in the epigastric areas, inspiratory dyspnea at light physical effort, cardiac asthma accesses, calf swelling, fatigue.

History of the disease: The general state has been worsening for 2 weeks with epigastric pain, dyspnea progression, and apparition of cardiac asthma accesses. Ambulatory Echo-CG determined RV cardiomegaly, ejection fraction decrease (35%) and presence of akinetic areas. He was immediately hospitalized in the Cardiology Department of PMSI Institute of Cardiology.

Clinical examination: General state severe, pale skin, acrocyanosis. Hoarse vesicular murmur in the lungs. Rhythmic, diminished heart sounds, with HR=74 beats/minute, BP=140/90 mm Hg. Liver +4 cm.

Paraclinical investigations: ECG at admission: Sinus rhythm, HR=95/minute, LV myocardium hypertrophy, repolarization changes on the inferior wall of the LV. Repeated ECG: comparatively, with no visible changes. Echo-CG: Moderate aortic stenosis. Regurgitation of the AoV of the IInd degree. Moderate dilation of the LA, RA, RV. Akinesia of the inferior wall of the LV, of the basal and medium segments in the lateral and posterior walls of the LV. Akinesia of the RV wall. Regurgitation of the TV of the IIIrd degree, MV of the IInd degree. Severe pulmonary hypertension. Markers of myocardial necrosis: negative.

Treatment: Beta-blockers, nitrates, diuretics, ACE inhibitors, anticoagulants, antiplatelets.

Conclusion: The patient R., 72 years old, presenting with an extended AMI, involving the LV and RV, which determined intensive therapy. According to literature data, patients with an inferior AMI of the LV, involving the RV, have a worst prognosis.

Keywords: RV, infarction, extended, morbidity

48. PARTICULARITIES OF SEXUAL FUNCTION IN MEN WITH OBESITY
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Introduction: Obesity has become a worldwide public health problem of epidemic proportions. In 1980, about 5 % of men worldwide were obese, by 2008 the rate was nearly 10%. It's no secret that obesity is hazardous to health. Men pay an extra price for excess weight, since obesity takes a special toll on male hormones and sexuality.

Purpose and Objectives: The objective of the study was to show the peculiarities of sexual function and sex hormones profile in men with obesity.

Materials and Methods: 42 male patients were included in the study. Young age (20-30 years) and BMI $\geq$ 30 kg/m^2 were including criteria. Patients were divided into three groups according to degree of obesity: group 1 – 11 patients (BMI from 30 to 34.9 kg/m^2); group 2 – 13 patients (BMI from 35 to 39.9 kg/m^2) and 18 patients displayed to morbid obesity (BMI > 40 kg/m^2) – group 3. The following analyses were done: anthropometric study (waist circumference, body weight, BMI), common blood test, serum lipid, hormonal profile (total and free testosterone, LH, estradiol), SHBG.

Results and Discussion: The prevalence of androgen deficiency (circulating total testosterone <12 nmol/L) is different for the three groups and increases with BMI. Thus, in men from group 1 the prevalence of androgen deficiency was 45.5%, in men from group 2 and 3 was 69.2% and 86%, respectively. The total testosterone levels decrease linearly with the increasing of BMI, from the average value of 11.8±1.6 nmol/l in group 1 to 9.5±1.9 and 7.3±0.4 nmol/l in men from group 2 and 3, respectively (p<0.05, r=-0.91). The LH levels don't change significantly for the 3 groups, ranging from 3.38±0.77 to 2.6±0.46 U/l. The estradiol levels increased linearly with the decreasing of testosterone