

heart failure associated with rhythm disorders. Standard EKG showed: supraventricular extrasystoles in 5 (20,83%) cases, ventricular extrasystoles in 3 (12,5%) cases, extra-junctional extrasystoles in 2 (8,33%) cases, atrio-ventricular dissociation in 2 (8,33%) cases, sinus tachycardia in 2 (8,33%) cases, repolarization process disorders in 2 (8,33%) cases, idioventricular rhythm in 1 (4,16%) case. Holter monitoring has allowed the tracking of the following transitory and concealed arrhythmias: sinus rhythm with shift to atrial rhythm in 2 (25%) patients, sinus tachycardia in 4 (50%) patients, supraventricular extrasystoles in 6 (75%) patients, ventricular extrasystoles in 5 (62,5%) and a case of ventricular tachycardia (12,5%).

Conclusions: Of the total number of 54 children with MA, 25 (46,3%) had various isolated and combined arrhythmias and 17 (68%) children had a history of a viral prodrome. The most common arrhythmias revealed with standard EKG were associated with a I-II degree heart failure in 8 (40%) children, of whom 3 with sinus tachycardia, 2 with supraventricular extrasystoles, and 1 child with ventricular extrasystole. Holter monitoring allowed to determine arrhythmias undetected by EKG at rest, including 6 (11,1%) cases of arrhythmias with an increased sudden death risk.

Key-words: myocarditis, arrhythmias, Holter-monitoring.

FEATURES OF INFECTIVE ENDOCARDITIS WITH EMBOLIC COMPLICATIONS

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Introduction: Infective Endocarditis (IE) is a severe disease with in-hospital mortality up to 20%, mostly due to embolic complications that increase the risk of death about 3 times. The incidence of cerebral embolism is 17-20% of all patients with IE, while non-cerebral embolism incidence is about 23-27%, both being probably underestimated because of the silent clinical evolution.

Methods: Retrospective survey of 94 adults with definite IE admitted in 3 hospitals from November 2008 through January 2012.

Results: The average age of the patients was $51,8 \pm 0,6$ years, including 62% men and 38% women.

In our survey 16 (17%) of patients developed embolic episodes, of which cerebral embolism 6.4%, pulmonary embolism 4.3%, kidney embolism 3.2%, splenic embolism 3.2%, retinal embolism 2.1%, extremities embolism 2.1% and cardiac embolism 1.1%. There is a relatively small percentage of cerebral embolism (6,4%) compared with data reported in literature.

Embolism detected in one organ had a higher rate of 81.3% (n=16) compared to embolization of two organs 18.8%. *Staphylococcus aureus* was more commonly detected 12,5% in patients with embolic episodes (n=16) vs. those without embolic complications – 3,8% (n=78).

In patients with IE and embolic complications transthoracic echocardiography revealed vegetations in 13 (81,3%) versus 49 (62,8%) in those without embolism. In both groups aortic and mitral valve were more commonly affected, but in patients with IE and embolic conditions mobile vegetations were 1,8 times more frequently (50%) than in patients without embolism (28,2%). Also large vegetations (>20 mm) were observed by 2,5 times more frequently in patients with embolism than in those without embolic complications (12,5% vs. 5.1%).

Conclusions:

1. Patients with IE complicated by embolism had more frequently proven mobile valvular vegetations and *Staphylococcus aureus* infection.

2. In IE, the embolic complications are widely undiagnosed and require imaging investigations (CT, MRI, Doppler investigation) for early diagnosis, initiation of appropriate treatment and prognosis improvement in these patients.

Key words: Infective Endocarditis, embolic complications, vegetations.

ASSOCIATION BETWEEN STATIN THERAPY AND INSTENT RESTENOSIS

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Introduction: Restenosis after percutaneous coronary interventions (PCI) remains an unsolved clinical problem. Increasing evidence indicates the importance of inflammatory responses to vascular injury in the pathogenesis of restenosis. Several agents with anti-inflammatory action have been studied for the prevention of restenosis post-PCI, including statins. Their pleiotropic effects act favorably on disease progression. The aim of our retrospective study was to examine the association between statin therapy and occurrence of instent restenosis.

Methods: A total of 67 patients (mean age of 56 years, range 39-72 years, 82% men, 24% with diabetes mellitus) with coronary stents who underwent a repeated coronary angiography due to worsening of their clinical symptoms, were enrolled in the study. According to angiographic findings these patients were divided into three groups: 1st group - without instent restenosis and progression of other coronary lesions (15 patients); 2nd group - patients with instent restenosis ± progression of other coronary lesions (28 patients) and 3rd group - without instent restenosis, but with progression of other coronary lesions (24 patients).

Results: 47 (70%) patients were on treatment with statins and 20 (30%) patients did not receive any statins after initial PCI. The number of patients that did not receive statins in each of these three groups were the following: in 1st group - 2 (13,3%) patients; 2nd group - 10 (35,7%) patients and 3rd group - 8 (33,3%) patients. The high percentage of patients that were not receiving statins is explained by low medication compliance. In addition, there were no differences in total cholesterol (CT), LDL-cholesterol (LDL-C) and HDL-cholesterol (HDL-C) levels between these three groups, irrespective of statins treatment: 1st group - CT - 5,02 mmol/l, HDL-C - 1,23 mmol/l, LDL-C - 2,93 mmol/l; 2nd group - CT - 4,97 mmol/l, HDL-C - 1,2 mmol/l, LDL-C - 2,88 mmol/l and 3rd group - CT - 4,9 mmol/l, HDL-C - 1,21 mmol/l, LDL-C - 2,83 mmol/l.

Conclusion: This study suggests that statins may have a favorable effect in reducing the angiographic restenosis independent of their cholesterol-lowering effect. Statin therapy improve clinical outcome of patients after percutaneous coronary interventions and represents an independent predictor factor for restenosis.

Key words: percutaneous coronary intervention, instent restenosis, statins.