

Renovascular Hypertension: Mechanisms of Development, Clinical Manifestation, Management of Treatment. Review of Literature

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This presentation is a review of international literature that elucidates the clinical manifestation, management of treatment, and mechanisms of renovascular hypertension. Another object of our work is to report some real clinical cases relating to this study and make a difference between international and Moldavian practice in the management of patients with renovascular hypertension. Hypertension in the presence of renal artery stenosis may not necessarily be renovascular hypertension. The two conditions may simply co-exist. Renovascular hypertension is usually symptomless, while hypertension that is difficult to control with antihypertensive therapy is probably the best indication as to whether further diagnostic evaluation is indicated. Some features of renovascular hypertension include: a worse prognosis than essential hypertension, less amenable to drug treatment, a greater risk of dose-dependent side effects, a higher risk of progression to accelerated hypertension and it may result in irreversible ischaemic failure of the affected kidney. Renal artery stenosis may be present in up to 30% of drug resistant hypertensive patients. Arteriosclerotic renovascular disease is an increasingly important cause of renal failure. Functional diagnostic tests for renovascular hypertension such as rapid sequence intravenous urography have now been superseded by the captopril challenge test and in particular scintigraphy following captopril provocation. Tests of prediction as to whether correction of a demonstrated renal artery stenosis will lead to an improvement in the blood pressure include renal vein renin estimations and scintigraphy. The key diagnostic procedure is renal angiography. The approaches to management primarily include appropriate antihypertensive therapy, while there is an increasing place for percutaneous transluminal angioplasty, with or without stenting of an occluding lesion. There is still a small place for corrective surgery. Renal ischaemia due to atherosclerotic renovascular disease is becoming an increasing problem in nephrology. Treatment should be directed at preserving or even restoring renal function.

Right-Sided Infective Endocarditis-Review, Clinical Study

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The aim of this paper is to review the clinical and laboratory features, treatment and prophylaxis of right-sided infective endocarditis, and in particular to compare the clinical manifestations and the outcome of right-sided endocarditis to left-sided endocarditis. Between November, 2008, and March, 2010, 50 patients were examined and investigated with the diagnosis of definite infective endocarditis. All the patients included in the study follow the diagnostic criteria for infective endocarditis developed by Duke Endocarditis Service (Durham, North Carolina). The patients were divided in two study groups, the first group- 8 (16%) patients with right-sided infective endocarditis and the second group- 42 (84%) patients with left-sided infective endocarditis. In the study, predominately male (68%), the ratio male / female was 2:1; median age was 43.1 years. While the tricuspid valve is the usual site of infection (5 patients, 62.5%), pulmonary (2 patients, 25, %) and Eustachian valve (1 patient, 12,5%) infection was also observed. Right-sided infective endocarditis occurs in intravenous drug users (3 patients), the patients with a permanent pacemaker (1 patient), implantable cardioverter defibrillator (1 patient), prosthetic valve (1 patient), central venous catheter