Results: subfebrility, palpitations, inspiratory shortness of breath, sore legs, pain in lombar, asthenia. Objective: skin petechiae, limited verbal contact, right hemiparesis, rhythmic heart sounds, TA-105/70 mmHg. FCC-109 c / min. Anemia (Hb 62 g / l), thrombocytopenia, lymphopenia, leucocytozis and increased ESR. Blood biochemistry: hyperuricaemia, hipercreatininemie. Staphylococcus aureus blood culture positive. ECG: Sinus tachycardia 100 c / min, ventricular premature beats, atrioventricular block gr.I. AEC left deviation. LV hypertrophy EcoCG: Expansion AS, moderate AD, LV and RV. LV hypertrophy EF - 49%. VAO failure gr.I. VM failure gr.II. VTS failure gr.II. Impaired VAP gr.I. Moderate pulmonary hypertension.

Treatment: HD, antimicrobial, antifungal, vascular rheology.

Conclusions: patients with HD who develop IE onset of congestive heart failure, peripheral stigma, developing hypotension, staphylococcal etiology, embolic complications at onset in disease presents a reserved prognosis.

Key words: Infective endocarditis, Hemodialysis, High mortality.

9. DIAGNOSTIC DIFFICULTIES IN A CHILD WITH PROLONGED FEVER

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Introduction: Fever of unknown origin is defined as a rectal temperature higher than 38.3°C more than 3 weeks, the diagnosis of which remains uncertain after initial investigations. Identification of the causes and management of prolonged fever in children is important and is guided by thorough history-taking and repeated physical examinations combined with standard laboratory tests and simple imaging procedures.

Clinical case: We report the case of a two-years-old male who had been managed 1 week for rinofaringitis at home and for 6 days in a tertiary clinic were had been placed on various intravenous antibiotics with no clinical improvementand and was finally referred for further management to our hospital. Physical examination revealed pyrexia (temperature of 38.2°C), faringeal congestion and injected tympanic membranes.The signs of meningeal irritation were absent. Other aspects of physical examination were normal. Results of laboratory tests showed nothing of significance apart from anaemia. He received antibiotic treatment. The fever persisted and in 3-rd day of hospitalisation the child becomes drowsy and father describes cutaneous hyperesthesia. The cerebrospinal fluid analysis showed features in keeping with meningeal inflammation and he had a raised erythrocyte sedimentation rate. The brain computed tomography scan revealed a **tetraventricular hydrocephalus**. He had ventricular shunt and was placed on antituberculous drugs and intravenous steroids but despite this his clinical condition slowly ameliorated and he developed right spastic hemiparesis.

Conclusion: The diagnosis of TB meningitis in this patient highlights that when a patient is not obviously exposed to the causative factors of a disease and clinical signs are absent, possible occurrences may present a diagnostic problem.

Key words: fever of unknown origin, meningitis, child.