Introduction*:* Inferior Vena Cava(IVC) hypoplasia is a rare anomaly that may be Associated with Deep Venous Thrombosis(DVT), particularly in pediatric patients. However, this case is speci al due to association of multiple venous malformations, renal agenesis, deep vein thrombosis and pulmonary embolism (PE) with late diagnosis at a child with inherited thrombophilia.

Clinical case*:* This paper reports the case of a 10 year-old-female patient, who was hospitalised for dispneea, loss of weight and asthenia. No risk factors for deep venous thrombosis were evident, in particular, no immobilization, surgery, known coagulopathy, or family history.

Phisical examination revealed dulness to percution and diminished breath sounds of the right hemithorax, abdominal distension with presence of shifting dullness.

Labs results showed, microcytic anemia(Hb=10.2 g/dl), inflammatory syndrome(ESR=30 mm/h) and normal-range coagulation parameters.

Imaging was performed (chest x ray, followed by abdominal ultrasound, CT, echocardiography), revealing: pleural effusion, free intraperitoneal fluid, hepatomegaly, left pulmonary artery thrombus, interruption of the IVC with azygos-like continuation containing thrombus, right renal vein plexiform malformation with thrombi, cavernoma of the portal vein, right renal infarction, left renal agenesis.

Thrombophilia profile: mutations of MTHFR C677T, PAI1 4g/5g, EPCR -G4678C and factor XIII V34L.

Treatment: anticoagulation indefinitely at target INR 2-3

Discussions: The exact role of coexisting thrombophilic gene mutations is far from being completely understood. There have been reported in english literature 62 patients with IVC agenesis and DVT with typical caracteristics. Also, we found that IVC malformation in association with thrombophilia it's an infrequent condition.

Conclusion: DVT and PE should be included in differential diagnoses even at pediatric ages. We should keep in mind these associations, coagulopathies beeing possible causes of various malformations. With the new imaging techniques, these anomalies can be diagnosed non-invasively. The absence of IVC segments can be discovered incidentaly or as a result of a thrombotic event. In this case, because of the additive risk of coagulopathy and venous malformations, careful prophylaxis for recurrent DVT after treatment of complications is recommended lifelong.

Keywords: thrombophilia, inferior vena cava hypogenesia, multiple venous malformation, pulmonary embolism, pediatrics, DVT, imaging, cavernoma, renal agenesis

26. CLINICAL CASE: ACUTE AORTIC DISSECTION

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Introduction: Acute aortic dissection is the most common life-threatening disorder affecting the aorta. The immediate mortality rate in aortic dissection is as high as 1% per hour over the first several hours, making early diagnosis and treatment critical for survival. The most important predisposing factor for acute aortic dissection is systemic hypertension. The prevalence and incidence of thoracic aortic

disease is increasing, as are the number of operations for thoracic aortic disease. However, a timely diagnosis can be elusive in the event of an atypical presentation.

Clinical case: We report a case of a 51 years old male who presented with signs and symptoms of myocardial infarction and was later found to have aortic dissection. He was successfully managed with surgery. Patient V. admitted in PMSI MCH ,,HOLY TRINITY'', Acute Miocardial Infarction Department with the Diagnosis: Ischemic heart disease. Miocardial infarction anterior extended of LV. AHT II degree, High CV risk. IC II (Killip). His examination was remarkable for a blood pressure of 120/80 mm Hg, heart rate of 85 bpm, respiratory rate 18 bpm. The cardiovascular examination was notable for a soft systolic ejection murmur. The pulmonary and general examinations were unremarkable. ECG demonstrated sinusal rhythm, HR=85/minute, LV myocardium hypertrophy, repolarization changes on the anterior wall of the LV. Repeated ECG with no vis ible changes. Chest x-ray was normal. His troponin levels were negative. EcoCG: it showed MCC. Bicuspid Ao Valve, dilated aortic root and the aortic arch, with aortic dissection signs, normal wall motion with normal systolic function, an ejection fraction of 57%. Patient was planned for cardiac catheterization and angiography. Angiography: Three-vessel atherosclerotic lesions. Moderate to severe stenosis on aCX II, (thrombus spree). Moderate stenosis in LAD II, LAD III, DIA I, OM I, RCA II.

He underwent a spiral computed tomography scan, which instead demonstrated an acute aortic dissection type I de Bakey (Standford A) ectasia of the ascending thoracic aortic segment. The patient was planned for aortic root replacement with aortic valve conduit and reimplantation of coronary arteries, electively.

Conclusion: We report an unusual mode of presentation of a rare and often fatal condition. This case illustrates the importance of considering aortic dissection as one of the differentials in mind when a patient with signs and symptoms of myocardial infarction. It also emphasizes that non-invasive diagnostic methods such as CT and echocardiography should be performed promptly to rule out aortic dissection, which is a very severe life threatening condition.

Keywords: acute aortic dissection, computer Tomography

27. ANGINA DE NOVO IN DYSLIPIDEMIC PATI ENTS, A CLINICAL CAS E

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Introduction: Angina is the most frequent pathology of coronary heart disease (CHD) with a prevalence of between 0.76 to 15.1 % for men and 0.73 to 14.4 % for women. Angina de novo represents 31% of total patients with unstable Angine, predominantly affecting patients 52-71 years old with concomitant pathologies: hypertension (HA) in 54.8 %, dyslipidemia (51.6 %), diabetes (DM) in 29.0 % and smoking (51.6 %). If we can reduce cholesterol levels by 25 % achieve a 50% reduction in the risk of acute myocardial infarction (AMI).