

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 Myocardial Infarction Department with the Diagnosis: Ischemic heart disease. Myocardial 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 sinus rhythm, HR=85/minute, LV myocardium hypertrophy, repolarization changes on the anterior wall of the LV. Repeated ECG with no visible 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 (Stanford 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 PATIENTS, A CLINICAL CASE

**Victoria Gnaciuc, Alina Toma, Elena Samohvalov**

Scientific advisers: Livi Grib, Professor, MD, PhD; Grejdieru Alexandra, MD, PD, Associate Professor, Cardiology, Medical Clinic No. 3, Department of Internal Medicine, *Nicolae Testemitanu* State University of Medicine and Pharmacy, Chisinau, Republic of Moldova

**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).

**Materials and Methods:** Patient X., 64 years Diagnosis: Ischemic heart disease. Angina de novo ( from 2/5/2016 ). Hypertension gr. II, very high additional risk. IC II NYHA st. B ACC / AHA. Subcompensated type 2 diabetes. Dyslipidemia.

**Results.** Accusations: constrictive chest pain triggered by minimal physical exertion, lasting 5 minutes ceding 1 nitroglycerin pill, inspiratory dyspnea, palpitations, congestion. The CBC: Hb-144g / l, Er.- 4.9x10<sup>12</sup> / l, L.- 9,2x10<sup>9</sup> / l, ESR - 31mm / hour. Biochemistry: Urea - 10.7 mmol / l; creatinine - 120 mmol / l; uric acid - 470 mmol / l; glucose - 8.7 mmol / l; Cholesterol - 7.9 mmol / l, triglycerides - 3.60 mmol / L, K - 4.9mmol / l; N & It; 146 mmol / l; Prothrombin - 90%, fibrinogen -3.5 g / l. The glycemic profile: 7<sup>00</sup>- 9 mmol/l, 13<sup>00</sup>-10.8 mmol/l, 17<sup>00</sup>- 10,7 mmol/l; 20<sup>00</sup>- 9,4 mmol/l. ECG: sinus rhythm with 75 b / min. Heart Axis - horizontal deviation. Repolarization disorders in region of LV; EcoCG: Ao gracious walls ascend., V.Ao VM. LA moderate dilatation. Moderate concentric hypertrophy LV. Pump function of LV is preserved. LVEF-53%. Echo-Doppler CS: Vmax-N. Etc Not. VM gr.II. Etc Not. VT gr. II. Doppler intima media - 0.9 mm. Coronary angiography: LAD stenosis at the bifurcation of DIAI 40-50%. IMA: non-dominant. IMA stenosis in the segment average of 70%. Stenosis of the proximal RCA 70-90%. Conclusion: trivascular atherosclerotic lesions, stenosis important IMA, RCA, LAD stenosis moderate.

**Treatment:** Percutaneous Coronary Intervention on RCA, IMA, Atorvastatin 80 mg / day, Plavix 75 mg / day, Bisoprolol 5 mg / day Ramipril 5 mg / day, Diaprel 60 mg / day

**Conclusions:** Patients with AP de novo in 76 % evolve s AP stable and 24 % in AMI. AP de novo early detection, diagnosis by coronary angiography significant coronary lesions and facilitate prompt treatment prevent AMI development.

**Key words:** ischemic heart, angina de novo, dyslipidemia.