factors detected prevalence of tobacco – 8 (57.14 %), sedentary – 12 (85.71%), obesity – 9 (64.28%) and dyslipidemia - 8 (57.14%) cases for the high risk and diabetes prevalent in those with intermediate risk - 13 (86.67%) cases. The distribution of functional class (FC) revealed that patients with FC III and IV prevails in high risk group with 5 (35.71%) patients in each. The radiation of the angina pain was more significant in high risk group – 10 (71.43%) cases comparing with 8 (53,33%) - in intermediate and 3 (18,75%) in low risk group. Improving pain at rest predominated in those with low risk - 12 (75 %) cases, while 10 (71.43%) with high risk cases needed administration of sublingual nitroglycerin. The ST segment deviation on ECG at rest was present in group II and III - in 13 (86.67%) and 11 (78.57%), respectively. Old myocardial infarction was identified also only in group II and III - 4 (26.67%) and 8 (57.14 %) cases. Left ventricular dysfunction was observed in 9 (64.28%) cases, only in those with high risk stratification.

Conclusions. High risk stratification in stable angina is characterized by presents of traditional cardiovascular risk factors: tobacco - 8 (57.14%), sedentary - 12 (85.71%), obesity - 9 (64.28%) and with variety of clinical tools: radiation of the angina pain - 10 (71.43%), administration of sublingual nitroglycerin -10 (71.43%), ST segment deviation on ECG -11 (78.57%) and left ventricular dysfunction in 9 (64.28 %) cases.

Key words. Stable angina pectoris, risk stratification, risk factors.

60. CLINICAL AND PARACLINICAL PECULIARITIES OF SENSORY CIDP AND DADS POLYNEUROPATHIES

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Introduction. Chronic inflammatory demyelinating polyneuropathy (CIDP) is an acquired disorder of peripheral nerves and nerve roots. The classic form of CIDP is fairly symmetric and motor involvement is greater than sensory. Recent series and epidemiologic data have shown that 35% of CIDP patients may have only sensory symptoms. The term distal acquired demyelinating symmetric (DADS) neuropathy was introduced by Katz et al. (2000) to describe a group of patients with predominantly distal sensory and ataxic demyelinating neuropathy. In our study we want to determine what are the most sensitive tests to perform in sensory CIDP and DADS, and what are the most frequent clinical findings in these patients.

Materials and methods. We selected 14 patients with definite or probable sensory CIDP and 6 patients with DADS neuropathy according to the EFN/PNS guideline at the Center of Peripheral Disimunitary Polyneuropahy, Hospital Pitie-Sapletriere, Paris in the period 2010-2015. Clinical examination included the following scales: Overall Neuropathy Limitation Scale – (ONLS), 9 hole peg test, MRC (Medical Research Council). Nerve conduction studies (NCS) were performed in all the patients. A full routine biochemistry, immunofixation of proteins, all spectrum of anti-myeline and anti-ganglioside antibodies, cerebral spinal fluid (CSF) microscopic examination were performed.

Results. There were 14 male and 6 female patients, ranging in age from 55 to 79 years. Evolution of disease is more sparing in sensory CIDP patients: 10 patients had stationary symptoms, while 5 DADS patiens had a proggresive course of the disease. All sensory CIDP patients had clinically pure sensory peripheral neuropathy and normal muscle strength according to MRC scale. In DADS group 3 patients had normal strength, and another 3 only distal weakness (MRC 95/100 points). Romberg sign was negative in 11 cases (78%) in sensory PDIC and positive in all DADS patients. Tremor was present in 50% cases of DADS, and only in 22% sensory PDIC patients. Average ONLS is 1,85± 0,286 in sensory CIDP and 3,6± 0,240 in DADS ($p<0.001$). In 90% cases with sensory CIDP or DADS deep tendon reflexes were diminished. Average level of proteins in CSF: 0,63g/l in sensory PDIC compared to 1,25 g/l in DADS ($p<0.001$). Average distal motor latencies (DML) in DADS patients: median nerv– 8,32±0,63 ms ($p<0,001$); ulnar nerv– 5,45±0,35 ms ($p<0,05$); peroneal nerv– 7,36±0,45 ms ($p<0,05$). Only 30% patients with sensory CIDP had demyelinating findings on NCS.

Conclusions. DADS patients have a clinically sensory neuropathy with distal weakness, with ataxia as a predominant feature, frequent generalized areflexia and postural tremor. Gait ataxia is not common in sensory CIDP. NCS is not a sensitive test to diagnose sensory CIDP, in 70% cases motor conduction velocities were not affected. Uniform extensions of DML in all motor nerves on NCS is the key feature of DADS.

Key-words: sensory CIDP, DADS, polyneuropathy.

61. RENAL RESISTIVE INDEX AND CAROTID RESISTIVE INDEX MARKERS OF EARLY CARDIOVASCULAR DAMAGE IN HYPERTENSIVE PATIENTS

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Introduction. Resistive index (RI) is an useful tool for the evaluation of circulatory resistance and the presence of atherosclerosis with the use the Doppler ultrasound exam, but differences of the RI among various vascular beds have not been fully elucidated. So we decided to evaluate the relationship between renal and carotid artery RI and to compare the clinical implication and the potential use of these two parameters for an early detection of cardiovascular damage in the hypertensive patients.

Materials and methods. The article is based on international publication data and on-line materials.

Discussion results. Various studies showed a positive correlation between, pulse pressure (PP), and serum glucose level were positively correlated in the same time diastolic blood pressure (DBP) and creatinine clearance were negatively correlated with the RI of the interlobar arteries. It was found a positive correlation of sex (male) and PP, whereas DBP correlated negatively with the RI of the common carotid artery (CCA). The renal RI of was positively Associated with the carotid RI, even after adjustment for major cardiovascular risk factors. An particularly interesting fact was correlation between CCA RI and age, systolic blood pressure, heart rate, carotid intima-media thickness (IMT), left ventricle