gender, age over 70 years, arterial hypertension, smoking, atrio-ventricular block and bundle branch block are predictive factors for the RV implication in patients with inferior AMI. The patient R., 72 years old, was admitted to the Cardiology Department nr. 1 of the PMSI Institute of Cardiology with the diagnosis: Ischaemic cardiopathy. Inferior acute myocardial infarction. Cardiac asthma accesses. Acute cardiac failure II Killip.

Complaints: Constrictive pain in the right parasternal and in the epigastric areas, inspiratory dyspnea at light physical effort, cardiac asthma accesses, calf swelling, fatigue.

History of the disease: The general state has been worsening for 2 weeks with epigastric pain, dyspnea progression, and apparition of cardiac asthma accesses. Ambulatory Echo-CG determined RV cardiomegaly, ejection fraction decrease (35%) and presence of akinetic areas. He was immediately hospitalized in the Cardiology Department of PMSI Institute of Cardiology.

Clinical examination: General state severe, pale skin, acrocyanosis. Hoarse vesicular murmur in the lungs. Rhythmic, diminished heart sounds, with HR=74 beats/minute, BP=140/90 mm Hg. Liver +4 cm.

Paraclinical investigations: ECG at admission: Sinus rhythm, HR=95/minute, LV myocardium hypertrophy, repolarization changes on the inferior wall of the LV. Repeated ECG: comparatively, with no visible changes. Echo-CG: Moderate aortic stenosis. Regurgitation of the AoV of the IInd degree. Moderate dilation of the LA, RA, RV. Akinesia of the inferior wall of the LV, of the basal and medium segments in the lateral and posterior walls of the LV. Akinesia of the RV wall. Regurgitation of the TV of the IIIrd degree, MV of the IInd degree. Severe pulmonary hypertension. Markers of myocardial necrosis: negative.

Treatment: Beta-blockers, nitrates, diuretics, ACE inhibitors, anticoagulants, antiplatelets.

Conclusion: The patient R., 72 years old, presenting with an extended AMI, involving the LV and RV, which determined intensive therapy. According to literature data, patients with an inferior AMI of the LV, involving the RV, have a worst prognosis.

Keywords: RV, infarction, extended, morbidity

48. PARTICULARITIES OF SEXUAL FUNCTION IN MEN WITH OBESITY

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Introduction: Obesity has become a worldwide public health problem of epidemic proportions. In 1980, about 5 % of men worldwide were obese, by 2008 the rate was nearly 10%. It's no secret that obesity is hazardous to health. Men pay an extra price for excess weight, since obesity takes a special toll on male hormones and sexuality.

Purpose and Objectives: The objective of the study was to show the peculiarities of sexual function and sex hormones profile in men with obesity.

Materials and Methods: 42 male patients were included in the study. Young age (20-30 years) and BMI $\geq$ 30 kg/m^2 were including criteria. Patients were divided into three groups according to degree of obesity: group 1 – 11 patients (BMI from 30 to 34.9 kg/m^2); group 2 – 13 patients (BMI from 35 to 39.9 kg/m^2) and 18 patients displayed to morbid obesity (BMI > 40 kg/m^2) – group 3. The following analyses were done: anthropometric study (waist circumference, body weight, BMI), common blood test, serum lipid, hormonal profile (total and free testosterone, LH, estradiol), SHBG.

Results and Discussion: The prevalence of androgen deficiency (circulating total testosterone <12 nmol/L) is different for the three groups and increases with BMI. Thus, in men from group 1 the prevalence of androgen deficiency was 45.5%, in men from group 2 and 3 was 69.2% and 86%, respectively. The total testosterone levels decrease linearly with the increasing of BMI, from the average value of 11.8±1.6 nmol/l in group 1 to 9.5±1.9 and 7.3±0.4 nmol/l in men from group 2 and 3, respectively ($p<0.05$, $r=-0.91$). The LH levels don't change significantly for the 3 groups, ranging from 3.38±0.77 to 2.6±0.46 U/l. The estradiol levels increased linearly with the decreasing of testosterone

levels, from the average value of 45.1±1.8 pg/ml in group 1 to 46.6±1.6 and 52.5±2.6 pg/ml in men from group 2 and 3, respectively. The prevalence of clinical manifestations of sexual dysfunction in men from group 1 was 36.4%, in men from group 2 and 3 was 61.5% and 88.8%, respectively.The most common clinical manifestations are decreased libido (9.1-27.8%) and erectile dysfunction (18.2-44.4%).

Conclusions: The prevalence of androgen deficiency increases with the obesity's degree from 45.5% to 100%. In the same time, there is not a compensatory secretion of LH. The androgen deficiency is associated with the linearly increasing of estradiol levels, from the average value of 45.1±1.8 pg/ml in first degree of obesity to 52.5±2.6 pg/ml in third degree of obesity ($p<0.05$, $r=-0.92$). Sexual dysfunctions are more frequent in men with severe obesity 88.8%. The most common clinical manifestations are decreased libido (9-22%) and erectile dysfunction (18-44%).

Keywords: Obesity, androgen deficiency, testosterone, decreased libido, erectile dysfunction

49. QUALITY OF LIFE OF PATIENTS WITH RHEUMATOID ARTHRITIS AND METABOLIC SYNDROME

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Introduction: Metabolic syndrome (MS) – syndrome, which is based on insulin resistance – impaired insulin-mediated glucose utilization by peripheral tissues. Rheumatoid arthritis (RA) – an autoimmune rheumatic disease of unknown etiology, which belongs to the group of the most common chronic inflammatory diseases. RA is one of the most often causes of disability, not just temporary - more than half of patients consistently incapacitated in 5-10 years from onset. Metabolic syndrome was the focus not only rheumatologists, but also cardiologists, endocrinologists, gynecologists, forcing allied professionals actively cooperate.

Aims and Objectives: Study was to examine the clinical status based on the study of quality of life (QL) in patients with rheumatoid arthritis (RA), depending on the presence of metabolic syndrome (MS).

Methods and Results: The study involved 20 patients who were hospitalized in the department of Rheumatology of Chernivtsi Regional Hospital. I group consisted of 10 patients with rheumatoid arthritis. The II group included 10 patients with RA combined with MS. The control group consisted of 10 healthy individuals. QL assessment was carried out by questionnaire HAQ (Health Assessment Questionnaire). Articular status was assessed according to pain, joint, inflammatory indices, as well as the status of local joints Ritchie. Statistical analysis of the data was carried out using the program Statistica 6.0. It was established, that patients with RA had lower ($p < 0.05$) articular indices and local status than in patients of main group where RA was combined with MS, which is possible due to persistent inflammation and decreased immune status. Index HAQ (survey to assess the health status) in the group of patients with combined lesions was 20.2% higher ($p < 0.05$).

Conclusion: In patients with rheumatoid arthritis, the presence of concomitant metabolic syndrome leads to worsening of clinical picture and quality of life.

Key words: Metabolic syndrome, rheumatoid arthritis

50. THE SOCIAL SUPPORT FOR PATIENTS WITH KNEE OSTEOARTHRITIS

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Introduction: The knee osteoarthritis (OA), the most common chronic illness, has the potential to compromise the health and quality of life of not only in the patient but also affect family members. The burden of disease determines the need to provide socio-emotional support and task assistance to the patient.