

unit of Kyiv Regional Hospital over a period from 1 January 2009 to 1 January 2010. The average age of patients is $58,6 \pm 3,1$. We assessed dynamics of ST segment reduction, depending on the time of thrombolytic medicine injection with the intervals of 2 hours, 2-4 hours and 4-6 hours from the beginning of clinical manifestation of acute coronary syndrome. 34 patients (20 %) underwent thrombolysis with 2 hour interval, 89 patients (51 %) – with 2-4 hour interval, 51 patients (29 %) – with 4-6 hour interval. Thrombolysis was considered to be more efficient in patients with more than 50% reduced ST segment with damaged front parts of aortic ventricle, more than 70% with damaged back parts of aortic ventricle, 90 minutes after medical injection according to ECG data in leads with maximum ST segment elevation. The results showed that thrombolysis, with 2 hour interval was effective in 30 patients (88 %), with 2-4 hour interval – in 74 patients (83 %), with 4-6 hour interval – in 28 patients (55%). Proved ST segment reduction was more frequently observed in those groups of patients who underwent thrombolysis with interval up to 4 hours comparing to the group of patients where thrombolytic therapy was carried out with 4-6 hour interval.

Insulin resistance and adiponectin

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The aim of the paper was to demonstrate the relationship between plasma adiponectin levels and insulin resistance of peripheral tissues as well as the mechanism of action of adiponectin. There is positive correlation between plasma adiponectin levels and insulin sensitivity of peripheral tissues independently of age, gender and BMI. However, there is negative correlation between adiponectin and insulin plasma levels and HOMA index (Homeostasis Model Assessment). Adiponectin levels predict potential alterations of insulin sensitivity of tissues. High levels are associated with decreased risk of developing diabetes. Adiponectin can also constitute an index for predicting an underlying disorder of carbohydrates metabolism in people with normal glucose tolerance test. Finally, variations in its gene expression can predispose to hyperglycemia. Mechanism of adiponectin influencing insulin resistance of tissues is not well known. Potential mechanism is decrease of fatty acid levels in plasma as well as triglycerides in liver and skeletal muscles resulting in increased insulin activity and muscle glucose up taking. In addition, it limits fatty acids hepatic flow. Other mechanisms appear to be: inhibition of gluconeogenesis, TNF- α action in adipose tissue and increase of AMP-activated kinase. Adiponectin is an adipose tissue hormone that increases the sensitivity of tissues to insulin action. Further studies are needed to determine precisely action mechanisms.

Hodgkin's Disease - Case Presentation

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Hodgkin's lymphoma is a type of cancer of the lymph tissue found in the lymph nodes, spleen, liver, and bone marrow. The diagnosis can be set strictly morphological and it is based on the presence of Sternberg-Reed cells in the structure of an enlarged lymph node. The disease occurrence shows two peaks: the first in young adulthood (age 15–35) and the second in those over 55 years old. The cause is not known but risk factors include male gender, history of Epstein-Barr virus infection and a genetic predisposition. At onset the disease affects one lymph node and it slowly disseminates

either through the lymph, or through the blood, affecting all the lymphatic system and other organs. Female patient, aged 22, without significant pathological history, is admitted in 2005 to the Hematological Clinic from Iasi for special diagnosis and therapy after the appearance of a left developing latero-cervical adenopathy. The clinical and paraclinical exams (lymph node biopsy, sternal puncture, thoracic and abdominal CT) have set the Hodgkin's lymphoma diagnosis with mixed cellularity, stage IV B and the cytostatic treatment was begun. Despite all treatment, the disease progressed rapidly – generalized adenopathies, osteolytic lesions in the lower ½ of the sternum and finally hepatorenal failure with exitus. Although the global cure rate of Hodgkin's lymphoma is about 85%, in this case diagnosing the disease in an advanced stage (because of the absence of symptoms) has determined the unfavorable evolution of the disease, with lack of response to treatment administered according to international standards and exitus in 4 years.

Late Complications Following Permanent Pacemaker Implantation

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The objective of the work was to determine prospectively the rate of late complications (6, 12 months) following first implantation of a permanent pacemaker or generator replacement. To illustrate our pathology using 3 case reports with particular problems concerning the diagnosis and treatment options. We studied 126 consecutive patients with definite indications for permanent pacemaker implantation, included between 2006 and 2009. Generator replacement was required in 12 patients because of pulse generator electrical failure. In all cases a VVI pacemaker was used. Implantation of the lead-catheter used right/left subclavian vein (108 cases vs. 18 cases) access. We realized a clinical follow-up (local pocket integrity, signs/symptoms for ipsilateral superior limb deep venous thrombosis or pulmonary thromboembolism-TEP) combined with biologic (D-dimers, fibrinogen, platelets), microbiologic (wound secretion, hemocultures) and imaging methods. Imaging follow-up protocol used venous ultrasound, ipsilateral superior limb phlebography, perfusion lung scintigram, transthoracic and transesophageal echocardiography. The overall rate of late complications was 23.8% in our study. There were infectious, thromboembolic complications and pacemaker syndrome signs/symptoms. Local pocket-related infection (pocket erosion/necrosis) with *Staphylococcus aureus/epidermidis* was found in 7.14% of cases; in two cases *Enterobacter/ Staphylococcus aureus* septicemia complicated local infection. Infective endocarditis complicated evolution in one case (vegetation on the stimulation catheter). Late infectious complications rate was significantly lower after first implantation of the permanent pacemaker comparing generator replacement (1.4% vs. 6.5%) and also in the subgroup with prophylactic antibiotherapy (0.6% vs. 3.1%). Pacing electrode thrombosis was defined by ultrasound in 10 patients (12.6%) and by phlebography in 19.04%; echocardiography detected one case of thrombosis in right atrium and manifest TEP complicated evolution. In 2 cases there were clinical signs for superior limb deep venous thrombosis. Perfusion lung scintigram revealed high /intermediate probability for TEP in 5 patients, respectively 2 patients. In 3.17% of cases both types of complications were present. Pacemaker syndrome was manifest through mild symptoms/signs in 2 cases. Our data are comparable with literature concerning the rate of late infectious and thromboembolic complications. Pacing electrode thrombosis is frequently asymptomatic and underestimated in clinical terms. For this reason, the decision for anticoagulation is better individualized. Even conducted in rigorous asepsis conditions invasive technique is better followed by antibiotherapy. The low incidence of pacemaker syndrome is in relation with follow-up period.