Results. Cardiac biomarkers: TnI – 0.01 ng/ml, CK-MB – 14 U/L. ECG: Sinus rhythm, HR – 56 bpm, QRS axis deviated to the left, complete LAFB, sequelae in the anteroseptal wall of the LV. ECHO: Mild LA dilation, normal LV dimensions, IVS and LVPW – 8-9 mm, preserved EF – 50%, LV apex akinesia (thickness in the given region ~ 4.0-4.5 mm), impaired relaxation of the LV. Coronary angiography: Tricoronary atherosclerotic lesions: severe stenoses on RCA and aCX (OM II), moderate on LAD (DIA I). Coronary angioplasty with pharmacologically active stent implantation on the RCA III was performed, with restoration of the arterial lumen – «blush» grade 3.
Conclusion(s). Thorough screening of people at risk for ischemic cardiopathy by evaluating the ECG, cardiac biomarkers, and ECHOCG, will contribute to the prompt detection of patients with silent coronary ischemia, indication of the correct treatment and prevention of acute cardiovascular events.
Keywords: chronic coronary syndrome, silent ischemia, prevention.

ASCENDING AORTIC ANEURYSM WITH SEVERE VALVULAR INSUFFICIENCY AND ATYPICAL ONSET WITH EPIGASTRIC PAIN, CASE REPORT

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Background. Ascending aortic aneurysm remains a severe condition with high risk of dissection or rupture. Atypical clinical presentation may delay diagnosis.
Objective(s) of the study. To present a case of ascending aortic aneurysm with atypical onset, complicated by dissection and severe valvular insufficiency.
Materials and methods. A 50-year-old hypertensive male was admitted on May 6 to the district hospital with severe abdominal pain, chills, nausea, and vomiting. After 10 days of unfavorable evolution, he was transferred to a tertiary center with dyspnea, fatigue, and edema. Transthoracic echocardiography, thoracic angio-CT, coronary angiography, and interdisciplinary consultation were performed.
Results. Aneurysm of the ascending aorta and Valsalva sinus (61 mm) was identified, with severe aortic regurgitation (grade IV), mitral regurgitation (grade III), tricuspid regurgitation (grade II), and preserved ejection fraction. Angio-CT confirmed the aneurysm without dissection. Coronary angiography showed no lesions. Intraoperatively, a Stanford A, DeBakey II dissection was found in the proximal ascending aorta, involving the aortic valve, which was not visible on imaging. A Bentall procedure with valve prosthesis, coronary artery reimplantation, and dissection repair was performed. Postoperative evolution was favorable.
Conclusion(s). An atypical onset with epigastric pain and signs of heart failure may delay the diagnosis of ascending aortic aneurysms. Limited dissections may be missed by imaging, making intraoperative assessment crucial for accurate diagnosis and treatment.
Keywords: ascending aortic aneurysm, dissection, valvular insufficiency

FREDERICK SYNDROME ASSOCIATED WITH BETA-BLOCKER OVERDOSAGE, CLINICAL CASE

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Background. Frederick syndrome is a rare entity characterized by atrial fibrillation (AF) associated with complete atrioventricular (AV) block. Incidence consisting of 1-2 cases per 100,000 people/year, predominantly in patients over 65 years of age with cardiovascular comorbidities and degenerative changes in the conduction system.
Objective(s) of the study: We present the clinical case of a patient known with chronic coronary syndrome, permanent atrial fibrillation, hypertension and type 2 diabetes mellitus, hospitalized with an overdosage of b-blockers.
Materials and methods. Woman, 82 years old, admitted to the MCH "Holy Trinity", Cardiology Department with altered general condition, palpitations, marked fatigue, severe bradycardia (32 bpm) and hypotension (80/60 mmHg), in the context of an accidental overdosage of beta-blockers (metoprolol), associated with chronic treatment with digoxin.
Results. ECG revealed AF with a slow, regular ventricular rhythm, suggestive for complete AV block, characteristic for Frederick syndrome. In the context of severe hemodynamic instability and the impossibility of rapid drug correction, emergency implantation of a permanent pacemaker, a VVIR mono chamber pacemaker, set at the stimulation parameter 70 bpm, implanted through the right sub clavicular vein approach. The post-procedural evolution was favorable with a rapid clinical improvement by normalization of heart rate, stabilization of blood pressure and hemodynamics.
Conclusion(s). This case highlights the importance of recognizing Frederick's syndrome in patients with atrial fibrillation with beta-blocker and cardiac glycoside overdose. Pacemaker implantation remains the treatment of choice to restore ventricular rhythm and prevent major complications.
Keywords: Frederick's syndrome, single-chamber pacemaker, beta-blocker.

THE ROLE OF FERINJECT IN THE MANAGEMENT OF ANEMIA IN CARDIORENAL SYNDROME

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Introduction. Cardiorenal syndrome (CRS) includes a spectrum of renal and cardiac disabilities, where loss of function of one organ contributes to diminished function of the other. Cardiorenal syndrome is frequently complicated by comorbid anemia leading to reciprocal and progressive cardiac and renal damage.
Objective(s). Presentation of the clinical case of a man inpatient in Cardiorecovery Ward of the "Holy Trinity" Hospital with Anemia in cardiorenal syndrome (CRAS) brought under control by i/v iron administration.
Materials and methods. A 69-year-old man presents with palpitations, general weakness, dyspnea, and retrosternal pain on light physical exertion. Anamnestic, clinical, and laboratory data were obtained from the medical record. The patient was monitored by ECG and laboratory tests; he was diagnosed with HTN, DM type 2, chronic HF NYHA III st. C ACC/AHA, CKD st. III KDIGO.
Results. After analyzing the history, it was determined that he was a patient with chronic CRS type II. Upon admission, an ECG was performed with atrial fibrillation rhythm, and blood tests were taken: Hb - 76 g/l, urea - 20.97 mmol/l, creatinine - 198.1 mmol/l, eGFR - 31 ml/min/1.73m2, NT-proBNP - 3290.37 pg/ml, elevated Cystatin C. During hospitalization, Ferinject 500 mg was administered with a gradual increase in Hb: 82 g/l – day 1, day 2 – 85 g/l and at discharge 95 g/l; reticulocyte storm: reticulocytes 24.8, RET-He