

hematological, biochemical blood tests.

**Results.** Paraclinical: ECG sinus rhythm with FCC 60 b/min. Signs of left ventricular hypertrophy. EcoCG: severe concentric left ventricular hypertrophy; EF 67%. Duplex of brachiocephalic vessels: obliterating atherosclerosis with bilateral artery damage. On the right: stenosis ACC 20%, carotid bulb – 35%, ACI – 65%, ACE – 25% on the left: stenosis ACC – 20%, carotid bulb – 80%, ACI – 50% general analysis of urine and blood within normal limits, dyslipidemia. Combined treatment with ARB, CCB, diuretic, antiaggregants, statins. Surgical intervention: percutaneous transluminal angioplasty of the left carotid artery with its stenting.

**Conclusion(s).** Ineffective antihypertensive treatment, complicated by hypertensive emergencies, may be caused by carotid stenosis. Smoking patients with hypertension and dyslipidemia require Doppler of extracranial vessels to detect carotid artery stenosis and its interventional treatment.

**Keywords:** hypertension, stenosis of the carotid artery, dyslipidemia

## **DISTINCTIVE FEATURES OF ANCA-ASSOCIATED INTERSTITIAL LUNG DISEASE**

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**Background.** ANCA-associated vasculitis (AAV) usually presents with pulmonary nodules, cavities, or alveolar hemorrhage. However, interstitial lung disease linked to ANCA has emerged as a distinct entity. Many ILD patients show ANCA positivity without vasculitis, raising questions about disease progression and management.

**Objective(s).** To comprehensively compare AAV and isolated ANCA-positive ILD across clinical presentation, serological markers, pulmonary function, imaging features, and treatment responses.

**Materials and methods.** A systematic review was performed by analyzing 60 peer-reviewed studies obtained from medical databases, including PubMed, Google Scholar, Elsevier, ScienceDirect and ResearchGate. These studies were selected based on relevance and quality to provide a comprehensive overview and reliable synthesis of the current knowledge on the subject.

**Results.** 7-15% of ILD patients were ANCA positive at diagnosis, with 25% converting to microscopic polyangiitis. ANCA-ILD was associated with 40% vasculitis risk. Symptoms like cough and dyspnea overlapped, but AAV had more systemic involvement and fever. Laboratory findings showed higher ESR (69 vs. 17,  $p < 0.001$ ) and C reactive protein (23.4 vs. 2.4,  $p < 0.001$ ) in AAV when compared to ANCA-ILD. AAV had mixed restrictive/obstructive lung function; ANCA-ILD mostly restrictive (76.9% vs. 40%). Fibrotic patterns dominated ANCA-ILD (73.9%), AAV had more non-fibrotic (60% vs. 30.7%). Immunosuppressants stabilized AAV; nintedanib showed promise in ANCA-ILD.

**Conclusion(s).** ANCA-ILD and AAV exhibit similar clinical features but vary in systemic involvement, inflammation, and imaging patterns. ANCA positivity in ILD signifies a distinct subgroup that may require more specific, tailored therapeutic approaches for optimal management and improved prognosis.

**Keywords:** ANCA-ILD, vasculitis, AAV, interstitial lung disease, ILD