206. PARTICULARITIES OF ISCHEMIC HEART DISEASE IN DIALYSIS PATIENTS

Author: Dumitrița Barcaru **; Co-author:** Anastasia Spatari

Scientific adviser: Georgeta Mihalache , PhD in Medical Sciences, Associate Professor, Department of Internal Medicine, Cardiology, *Nicolae Testemitanu* State University of Medicine and Pharmacy of the Republic of Moldova

Introduction. Ischemic heart disease is frequently associated with chronic kidney disease, a major cardiovascular risk factor. Among dialysis patients, its prevalence ranges from 40–60%, while non-ST-elevation myocardial infarction (NSTEMI) accounts for up to 80% of acute coronary syndromes in this population.

Case presentation. A 68-year-old patient with ischemic heart disease, lower limb atherosclerosis, and chronic diffuse secondary glomerulonephritis (post-endocarditis), complicated by stage V chronic kidney disease (KDOQI), presented with exertional dyspnea, fatigue, and uncontrolled hypertension. Laboratory tests showed dyslipidemia, anemia and elevated troponin (0.86 ng/mL; reference 0–0.10 ng/mL). Echocardiography revealed left ventricular hypertrophy, ejection fraction 45%, grade III aortic, mitral and tricuspid regurgitation and hypokinesia of the inferior left ventricular wall. The Agatston calcium score was 559. Coronary angiography demonstrated triple-vessel disease, with severe stenosis of the LAD and RCA and moderate stenosis of the circumflex artery. PCI was performed with implantation of two drug-eluting stents in the LAD (June 18, 2025) and two in the RCA (July 30, 2025), followed by dialysis. Medical therapy included beta-blockers, angiotensin receptor blockers, calcium channel blockers, centrally acting antihypertensives, nitrates, dual antiplatelet therapy, and statins.

Discussions. Accelerated atherosclerosis in dialysis patients results from chronic inflammation associated with calcification of the intima and media of blood vessels. Silent or atypical symptoms create diagnostic challenges, requiring an individualized, multidisciplinary approach. Angina is rare and may be difficult to differentiate from chest pain caused by hypotension, hypovolemia, uremic pericarditis or cardiomyopathy, valvular disease, anemia, or hypertensive crises. Troponin is often chronically elevated; acute coronary syndrome is suspected with a ≥20% rise from baseline or a dynamic increase in hs-cTnI. ECG may show left ventricular hypertrophy and hyperkalemia- related changes. Echocardiography should be performed post-dialysis in a euvolemic state, focusing on regional wall motion abnormalities. Coronary angiography should be decided within a Heart Team, considering the increased risks of bleeding and intrastent restenosis.

Conclusions. Ischemic heart disease in dialysis patients progresses aggressively and poses significant diagnostic and therapeutic challenges. A multidisciplinary, individualized Heart Team approach—integrating clinical evaluation, biomarkers, imaging, and angiographic data is essential for optimal management and improved prognosis in these patients.

Keywords. ischemic heart disease, hemodialysis, atherosclerosis.

https://doi.org/10.66603/medespera2026.737