

in urine. The treatment with intravenous infusions of Vancomycin 2g/day (6 weeks) and i/v administration of Gentamicin 240 mg/day, antifungal medications, vitamins and aspirin improved the patient's condition by eradicating the infection and resolving the pneumonia. After being treated conservatively, the patient was consulted by the cardiac surgeon. At the moment he does not require surgical correction of the tricuspid valve.

**Conclusions.** Patient Y, 29 years old, an intravenous drug user, develops an Infective Endocarditis of the right side in intact valves, the source of bacteremia being the intravenous administration of the drug and also the skin infection. The febrile syndrome and the recurrent pulmonary complications, together with the auscultative changes of the tricuspid valve, anemia, leukocytosis, increased ESR led to an early diagnosis. Following the combined antibacterial treatment, according to the standard schemes, the infectious process has been definitively resolved, but the patient requires long-term monitoring and schooling regarding intravenous drug cessation and lifestyle change.

**Key words:** Infective endocarditis, pulmonary complications, septic pneumonia.

## 232. CHRONIC INFLAMMATION AS A NEW CARDIOVASCULAR DISEASE FACTOR

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**Introduction.** Cardiovascular disease (CVD) is a major public health problem, in most areas of the world. While traditional risk factors for the development of CVD have been researched, the science community has recently identified chronic Inflammation as an additional risk factor. Inflammation is the result of the body's immune system activity recognizing and removing harmful stimuli to start the healing process. Chronic inflammation is referred to as a long-term disorder. Chronic inflammatory disorders include diseases such as rheumatoid arthritis (RA), systemic sclerosis (SSc), systemic lupus erythematosus (SLE), ankylosing spondylitis (AS) and psoriatic arthritis (PsA) etc., which play a crucial role in the process of atherogenesis.

**Aim of the study.** This research was on studying cardiovascular patients, that previously have been diagnosed with a form of chronic inflammation, to show that patients with chronic inflammatory diseases are likely at high risk of developing CVD.

**Materials and methods.** The aim of the research consisted in studying cardiovascular patients, that have been previously diagnosed with a form of chronic inflammation, to show that patients with chronic inflammatory diseases are likely to be at a high risk of developing CVD.

**Results.** By studying the significant inflammatory indicators like C-reactive protein, fibrinogen, Cytokines interleukin, the helper T cells, LDL cholesterol, triglycerides, etc. and their effects on atherosclerosis we can underline the pathophysiology of atherogenesis. When the pro-inflammatory activity starts, it also commences the alteration of lipoprotein concentrations, oxidative stress, and macrophage accumulation, the injury of the endothelial and the activation of the immune system. All these factors and many others are increasing the risk of the atherosclerosis/arteriosclerosis and supported by the traditional factors they create the best conditions for the development of CVD. Patients with rheumatoid arthritis are in the

group of an increased risk of CVD; the EULAR recommendations in 2017, updated in 2019, announced that the estimated risks are multiplied by 1.5- 2 for all patients with RA. The same data was found on systemic lupus erythematosus, in which the risks increase by 2-3 times. A similarity was suggested also on psoriatic arthritis and systemic sclerosis.

**Conclusions.** Chronic inflammatory disorders, influenced by their pro-inflammatory effects are relevant as the new risk factors of Cardiovascular disease such as atherosclerosis, arteriosclerosis, acute coronary syndrome, etc.

**Key words:** Chronic inflammation; Cardiovascular disease; risk factor; atherosclerosis.

### 233. ANGINA PECTORIS „DE NOVO”

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**Background.** Angina Pectoris (AP) „de novo” represents 31% of the total patients with unstable AP. The annual incidence of AP „de novo” is 3 cases per 1000 persons, affecting mainly patients between 42-71 years old. The rate of men/women being of 66.6-80.6% compared with 19.4-33.3%. Patients present concomitant pathologies: Arterial Hypertension - 54.8%, dyslipidemia - 51.6%, Diabetes Mellitus - 29.0 % and smoking - 51.6% [3, 4, 5]. This pathology is characterized by constricting retrosternal pain at rest or at exertion, with the onset up to 30 days. Symptoms can evolve, depending on the structure of the atherosclerotic plaque, as either stable AP - 76%, or Acute Myocardial Infarction - 34 %. Both groups have been admitted to inpatient treatment in specialized Cardiology Departments [1, 2].

**Case report.** We report a case of a 54 year old patient, teacher, admitted in the Cardiology Department nr.3 of SMH „Holly Trinity” with the diagnosis: Unstable Angina Pectoris „de novo”. HF II NYHA. Patient presented with: constricting retrosternal pain at moderate effort and at rest, dyspnea at low physical effort, palpitations, occipital headache, dizziness, fatigue. History: the symptoms started about 3 weeks ago, when for the first time, after psychological stress, palpitations and retrosternal pain appeared. Symptoms have diminished after the rest. The pain reappeared after low physical effort (walking 10-15 m), after smoking, after cold exposure and excessive coffee consumption. The patient went to the family doctor and he was urgently admitted to the cardiology department to establish the diagnosis and to choose the appropriate treatment. Risk factors: aggravated family history, smoking, dyslipidemia, hyperuricemia. Objective data: moderate severity. The skin is pink, clean. Pulmonary auscultation: there is vesicular murmur, murmurs are absent, RR - 22 b / min. The apex beat is determined in the V intercostal space, on the left of the medioclavicular line. Rhythmic cardiac noises with HR 100 beats/min, BP - 130/90 mm/Hg. The abdomen is soft, painless at palpation. The liver and spleen are not palpable. Intestinal transit present. Giordano sign – negative bilaterally. Osteo-articular system – no pathologies. Paraclinical examination: ECG – Sinusal tachycardia with HR 106 beats/min. Left axis deviation. Signs of hypertrophy of the LV myocardium. Echocardiographic conclusion: Induration of the ascending aorta walls. Moderate dilatation of LA, RA. Moderate hypertrophy of LV. Insufficiency of the VTr., VM gr.II, VAP gr. I. Moderate HTP. Laboratory analysis: Hemoleucogram: Hb. - 146 g/l, RBC - 4.6x10<sup>12</sup>/l, WBC - 5.8 x10<sup>9</sup>, SR - 25 mm/h. CK-MB - 20, Troponines - negative, glucose - 4.9 mmol/l,