revealed any abnormalities. Transthoracic ECHO CG, which was performed when the patient arrived at the hospital, showed normal ejection fraction (EF- 57 %), severe dilated right heart chambers and severe tricuspid regurgitation with suspicion of rupture of septal leaflet. As well, heart MRI was made to establish cardiac diagnosis. Heart MRI registered: Dysplasia of the septal cusp of the tricuspid valve. Severe tricuspid valve regurgitation (regurgitation volume – 110 ml, regurgitation fraction – 55%). Right ventricle is severely dilated, global systolic function normally. Right atrium severe dilated. Was made differential diagnosis between posttraumatic rupture of tricuspid valve and congenital tricuspid valve anomaly. The patient was consulted by cardio-surgeons and was disseated heart intervention for the Tricuspid Valve repair. During the intervention was noticed severe dilated ring of Tricuspid Valve (65 mm). Posterior leaflet with rupture of chordae, septal leaflet pasted by sept with abnormal attached of chordae. The anterior leaflet with abnormal big dimension and total prolapse in the right atrium. Foramen ovale patent. A tricuspid valve anomaly was confirmed. There was made Tricuspid Valves repair with implantation of the ring. Due to severe dilatation of the ring of Tricuspid Valve it wasn't possible to apply a classic method of Tricuspid Valve repair. Two techniques were combined to solve our patient's problem. The annuloplasty was made by Kay technique, the posterior leaflet was completely excluded, and a functional bicuspid valve is finally obtained. After that was stitched together the middle point of the free edges of the tricuspid leaflets by Alfieri technique. In cases of severe annular dilatation, annuloplasty alone is unlikely to be durable so an additional procedure, such as "clover technique," was used to obtain a more durable repair. On ECHO made in dynamics was revealed Tricuspid Regurgitation of second degree with persisting severe dilatation of right chambers. The dyspnoea after surgery improved and the patient was discharged after 5 days post - surgery.

Conclusions. Tricuspid valve disease affects millions of patients worldwide. It has always been considered less relevant than the left-side valves of the heart, but still represents a great challenge for the cardiac surgeons, especially in the most difficult symptomatic scenarios. When possible, valve repair still remains the most useful procedure, while replacement is generally preferred in the most demanding cases. Only the accurate choice of the most appropriate procedure will provide optimal and long-term results.

Key words: Tricuspid Valve Anomaly, Valve Repair, Congenital Anomaly

226. ACUTE PULMONARY THROMBEMBOLISM ON THE BACKGROUND OF PULMONARY ASPERGILLOSIS

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Background. Invasive pulmonary aspergillosis is a severe fungal infection with a high mortality rate. Diagnosis is challenging due to the non-specific nature of symptoms. Allergic bronchopulmonary aspergillosis (ABPA) complicated with pulmonary thromboembolism (PTE) is rare. This report describes a patient who was diagnosed with ABPA and soon developed PTE, for which he was admitted to our department. In the recent years, ABPA has become more and more common clinically, especially in patients with cystic fibrosis or asthma, which can lead to irreversible bronchiectasis, pulmonary fibrosis, and even death. The common complications of ABPA include recurrent exacerbations, bronchiectasis, and acute respiratory

failure. It is generally believed that, however, pulmonary thromboembolism (PTE) is a rare complication of ABPA. We describe here the case of a young man with ABPA who was admitted to hospital because of PTE after reccurent treatments for aspergillosis.

Case report. A 40-years old man was hospitalized in our department for "Acute pulmonary thrombembolism at the level of big pulmonary vessels (pulmonary artery trunk) involving acute pulmonary heart disease". The patient was earlier diagnosed with Pulmonary aspergilosis, for which he received a specific treatment 4-5 months ago with anti-fungic drugs-Itroconazol, in Phthisiopulmonology Institute "Chiril Draganiuc". At the time of admission, the patient presented the following accusations: moderate permanent dyspnea that does not depend on physical effort, rare hemoptysis, weakness. No tuberculosis or asthma was reported, neither other pathologies with immunosuppression. The patient had a 20-year smoking history with 20-30 cigarettes per day. Vital signs in the emergency department were temperature 36,7oC, blood pressure 110/70 mm Hg, heart rate 82 bpm, respiratory rate 19/min, and oxygen saturation 94% on room air. Auscultation showed a widespread audible expiratory wheeze on both upper lungs and moist rales on both lower lungs. Breathing sound was low and the patient had the symptom of expiratory dyspnea. Previous laboratory findings showed serum Apergillus IgE levels of 1277 UI/mL (ULN<100.0) and positive A. fumigatus IgG =154mg/L (ULN<39). Sputum culture was performed and A. fumigatus grew. The result of the D-dimer test was 435μg/L (ULN 500μg/L). However, chest angiography revealed filling defects in the main pulmonary artery and both branches of the pulmonary artery, indicating the occurrence of PTE. 1 day later, the D-dimer tests had higher values and eosinophilia in addition. At EchoCG examination: Pronounced dilatation of the right atrium and right ventricle. Severe pulmonary hypertension (pulmonary artery = 28mm; pulmonary artery pressure = 81mmHg). Ejection fraction = 56%. Congenital heart defect - ostium secundum=6mm.The patient was diagnosed with PTE and received treatment of low molecular heparin (0.8mL every 12hours for 7 days) and Warfarine (5mg once per day). Symptoms gradually improved and the patient was discharged with continued anticoagulant treatment.

Conclusions. 1. ABPA is a chronic disease with a relapsing remitting course, and the prognosis can be improved by early diagnosis and treatment. 2. ABPA complicated with PTE is extremely rare. 3. Consequently, much more attention should be paid to the ABPA patients with the associated risk factors and/or those who are not responsive to antifungal treatment in consideration of the life-threatening severity of PTE. 4. Since PTE is a life-threatening disorder, clinicians should consider PTE in patients with ABPA, especially in patients who suddenly had symptoms such as dyspnea or ineffective use of antifungal and hormonal drugs. It is important to assess the additional risk of PTE in ABPA patients, and patients at high-risk of PTE should receive prophylactic treatment, unless they have contraindications.

Key words: allergic bronchopulmonary aspergillosis, aspergillus, pulmonary thromboembolism, anticoagulant therapy.