

examination, biological explorations and imaging scans. Our study group was analyzed from demographical point of view and also etiological and compensation type. The severity was evaluated with Child-Pugh-Turcotte score, being dosed serum albumin and protrombine time. On the basis of these criteria was elaborated the prognosis.

Results and discussions: The HRS is a frequent complication in cirrhosis evolution. The most common progression of cirrhosis, no matter the etiology or Child score, is to HRS type 2. Death in 6 months usually occurs in patients with ethanolic cirrhosis. It generally emerges in male patients from urban environment. HRS type 2 develops in male with Child C class cirrhosis and is usually followed by death.

Conclusions: HRS is present in the evolution of any patient with cirrhosis, independent of the etiological factors and environment. Child score is not influenced by cirrhosis etiology, but it might complicate the disease during its evolution. With nowadays therapeutical methods, cirrhosis complication succeeded by HRS has a low chance of survival improvement. Death is the most common form of evolution of HRS.

Keywords: Hepatorenal syndrome, ethanolic cirrhosis, death

85. COMMUNITY ACQUIRED PNEUMONIA AND CARDIOVASCULAR COMPLICATIONS

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Introduction: Community- acquired pneumonia (CAP) is one of the leading causes of mortality and morbidity, both inside the country and around the world, affecting children, youngsters, adults and the elderly alike. CAP incidence varies throughout the world, 5 to 12 cases being reported per 1000 patients. This number increases significantly in older patients and those debilitated, reaching up to 25-40 in 1000. Cardiovascular complications increase the risk of short-term mortality, reduce the quality of life of these patients and prolong the hospitalization period, hence have as well an economic impact.

Purpose and Objectives: To evaluate the particularities of the clinical course and course for treatment in patients with CAP who developed cardiovascular complications.

Materials and methods: This is a retrospective study that included 68 patients with confirmed CAP admitted to the Municipal Hospital N3 „Sfinta Treime” during the period of 1.01.2013-1.01.2014. The patients were divided into two groups: group I included patients admitted with CAP that developed cardiovascular complications; group II included patients with CAP alone. All the data was statistically processed in Excel, applying Student T Test and *Fisher's exact test* for contingency tables.

Results: During our study we've looked for cardiovascular complications in patients with CAP: new or worsening arrhythmias, new or worsening heart failure, or both. Our study revealed that 17,7% (12/34) of patients we've examined presented with new or worsening arrhythmias, 20,6% (14/34) presented with new or worsening heart failure, and 11,8 % (8/68) presented with both. Following a careful analysis of the acquired data we've established there is a statistically significant difference between the two groups considering the average age of the patients (64.74 ± 12.21 – I group, 49.46 ± 20.58 – II group). Patients from the I group presented more frequently with COPB (50%, 17/34), hypertension (67,7%, 23/34), chest pain (53%, 18/34), heart failure (53%, 18/34). There was a difference in the clinical manifestations of the patients from the two groups. The first group presented with dyspnea in 97% of cases (33/34) vs the second group where dyspnea was reported in 85,3% (29/34). Also patients from the first group presented more frequently with sweating 50% (17/34) vs 35,3% (12/34). It takes longer for the clinical parameters to normalize in patients from the first group. Also the average period of hospitalizations was longer for the patients from the first group ($10,1 \pm 2,3$ days) vs patients from the second group ($8,9 \pm 2,1$ days).

Conclusion: Patients with CAP that developed cardiovascular complications present more frequently with comorbidities that are risk factors for the onset of their cardiovascular

complications. The clinical course of CAP reveals a jumble of symptoms that vary in intensity and severity. The treatment course of this kind of patients is longer and requires special attention, especially in terms of sodium intake. These patients require longer hospitalization and the frequency of short-term death is higher among them.

Keywords: CAP, cardiovascular complications

86. COMMUNITY-ACQUIRED PNEUMONIA IN PATIENTS WITH LOW BODY MASS INDEX

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Introduction: Community-acquired pneumonia (CAP) represents a serious medical and social problem. The criteria that place it among the main respiratory syndromes are high incidence, risk of severe evolution and complications. Some studies about severe CAP suggest that a body mass index (BMI) <18,5 is an important risk factor that influences negatively clinical and paraclinical manifestations of pneumonia. There is lack of data about mild-to-moderate CAP in patients with low BMI.

Purpose and Objectives: Elucidation of etiological, clinical and paraclinical peculiarities of mild-to-moderate CAP in patients with low BMI.

Materials and methods: The study included 60 patients with mild-to-moderate CAP, divided into two groups, the first group included 30 patients with a BMI<18,5 and mean age 46,3±20,4 years and the second one included 30 patients with a BMI=20,0-24,9 and mean age 50,7±17,4 years (p>0,05). The patients were examined clinically, biologically, microbiologically and performed chest X-ray.

Results: The etiological agent was determined in 53,4% of patients with a low BMI and in 73,4% of those with a normal BMI, Streptococcus pneumoniae prevailed in both groups. We noticed a number of statistically significant differences between the two groups. The patients with a low BMI had a higher incidence of chest pain (23 (76,6%) vs 20 (66,6%) patients), a longer period of hospitalization due to a slower disappearance of symptoms and signs (10,9±3,6 vs 9,2±2,5 days), a lower percentage of lymphocytes (20,3±7,2 vs 25,5±11,8%), monocytes (6,1±3,4 vs 8,5±3,9 %), a lower number of erythrocytes (3,9±0,8 vs 4,3±0,4, ×10¹²/l), a lower quantity of hemoglobin (116,1±25,2 vs 127,1±14,9 g/l), fibrinogen (3,6±0,7 vs 4,1±1,0 g/l), total cholesterol (3,9±1,0 vs 4,5±1,0 mmol/l) and blood glucose (4,4±0,93 vs 4,9±0,7 mmol/l). There were not significant differences between the groups in localization, extension and resolution of pneumonia.

Conclusion: In our study no etiological and radiological peculiarities of mild-to-moderate CAP in patients with low BMI were found. The patients with a low BMI had a longer clinical course of CAP and a decreased systemic inflammatory response comparing to patients with a normal BMI.

Keywords: Community-acquired pneumonia, low body mass index

87. CLINICAL PROFILE, COMMON THROMBOPHILIA MARKERS AND RISK FACTORS IN 47 YOUNG PATIENTS WITH ISCHEMIC STROKE

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Introduction: Stroke is one of the most common causes of death worldwide, along with cardiovascular pathology and oncology. Hereditary or acquired thrombophilia is often associated with arterial-venous thrombosis. Ischemic stroke caused by thrombophilia has an incidence of approximately 1-4% of total cerebral vascular accidents, with a higher incidence in the period from 45 years old, representing a deficiency of antithrombin, protein C, protein S, factor mutations V Laiding, and associated risk factors.