Симпозиум со меѓународно учество „НОВИНИ ВО КАРДИОЛОГИЈАТА“

КНИГА НА АПСТРАКТИ

ABSTRACT BOOK

Symposium with international participation "HIGHLIGHTS IN CARDIOVASCULAR DISEASES"

Society of Cardiology of N.Macedonia

01-03.10.2021
Online

Симпозиум со меѓународно учество „НОВИНИ ВО КАРДИОЛОГИЈАТА“

Symposium with international participation "HIGHLIGHTS IN CARDIOVASCULAR DISEASES"

Издавач:
Македонско здружение по кардиологија

Publisher:
Macedonian Society of Cardiolog

Уредник:
Проф. д-р Елизабета Србиновска Костовска

Editor:
Prof. Dr. Elizabeta Srbinovska Kostov

Техничко уредување:
Пруф Принт - Скопје

Technical editing:
Pruf Print - Skopje

Печати:
Датапонс - Скопје

Printing:
Datapons - Skopje

Тираж:
250

Copies:
250

CONTENT

COMMITTEES

President of the Symposium
Srbinovska Kostovska Elizabeta

General Secretary
Marjan Bosevski

Scientific Committee
Andova Valentina
Antova Emilija
Anguseva Tanja
Bosev Marijan
Bushljetikj Oliver
Georgievska Ismail Ljubica
Gerakaroska Radoncic Marija
Fatmir Ferati
Kostov Jorgo
Kostova Nela
Lazarova Emilija
Mitevska Irena
Taleski Jane
Trajkov Ivan
Pejkov Hristo
Poposka Lidija
Zafirovska Planinka
Zimbakov Zan

International Scientific Committee
Boyle Noel (USA)
Bucciarelli Ducci Chiara (England
Burazor Ivana (Serbia)
Brida Margarita (Croatia)
Cameli Matteo (Italy)
Grapsa Julia (Greece)
Giga Voislav(Serbia)
Ivanusa Mario (Croatia)
Hristova Krassimira (Bulgaria)
Lalic Katerina (Serbia)
Nachoski Dejan (Germany)
Podlesnikar Tomaz (Slovenia)
Price Susanna (England)
Raskovic Vlatka (Croatia)
Sade Elif (Turkey)
Sheparovic Handzevacki Jadrank
(Croatia)
Solliman Hatem (England)
Stankoviv Ivan (Serbia)
Stojanov Vesna (Serbia)
Tsonev Svetliv (Bulgaria)
Traykov Vasil (Bulgaria)

A12 INTRACARDIAC THROMBI IN A PATIENTS WITH ACUTE ABDOMEN

G. Kamcheva Mihailova[1], S. Dokuzova[1], G. Dimova[2], S. Jordanova[3], A. Serafimov[3], M. Jovev[3]

Department of Internal medicine[1], Department of radiology[2], Departman of cardiology[3], Clinical hospital, Stip, North Macedonia

Introduction. Predisposing factors for left atrial thrombosis (LA) are mitral valve pathology, prosthetic mitral valve, impaired left ventricular function, and abnormal left atrial contractile function, such as atrial fibrillation (AFF). Thrombus formation is less common in the right atrium (DA) than in the left atrium, is often dangerous, and is rarely diagnosed. They usually result from embolization from a peripheral venous source. Damage to the right atrial wall by intracardiac devices may be responsible for the presence of thrombosis. DA thrombi are associated with venous thromboembolic disease, such as DA transit zone (thrombi in transit) on the path between the lower extremities and pulmonary arteries, and in 7-18% of patients with pulmonary embolism. (3-4) When a systemic thromboembolic event occurs, paradoxical embolism should be suspected. Another condition more commonly associated with systemic thromboembolism is thrombosis in a patient with an open foramen ovale (PFO). (5) One study described a rare case of vascular complication of hepatic veins and inferior vena cava thrombosis (IVC) extending into the right atrium in a young man with a large amoebic liver abscess where the optimal result was achieved with early diagnosis by CT scan, percutaneous abscess drainage, intravenous metronidazole, perioperative anticoagulation, sternotomy, and thrombectomy.

Case report. 68-year-old male patient admitted to the internal medicine ward due to abdominal pain localized under the right costal arch with nausea, afebrile. A few days ago he was treated by a cardiologist due to hypertensive crises. On physical examination, his body temperature was 36.7 °C, pulse 90/min and saturation SpO2=95%. On palpation of the abdomen: soft, with mild painful tenderness especially under the right costal arch. The ultrasound of the abdomen showed a liver with a homogeneous structure, in segment 6 a larger heteroechogenic septal change with several cystic changes in it and with a diameter of 9 cm. Gallbladder distended with dense contents and a few calculi in the lumen. The wall is thick, layered. Intrahepatic bile ducts un dilated. Pancreas and spleen echo neat. Kidneys with moderately reduced parenchyma without congestion and calculus in the duct system. Bladder empty, no free fluid in the abdomen and small pelvis. The finding of a native X-ray of the abdomen seen two aeroliquid levels in the right hemiabdomen. Due to the

deterioration of the condition a few days after the application of infusion, antibiotic, analgesic and vitamin therapy, with a rise in body temperature and elevated inflammatory markers, CT of the abdomen was performed with contrast where a clearly limited encapsulated change with thickness in segment 8 of the liver was shown. followed by a clearly limited encapsulated change with a capsule thickness of 4 mm and dimensions 118x119 mm where daughter cysts are seen in it - hydatid cysts. Gallbladder distended with very dense contents and present air and free fluid around it. The finding goes into a pirogy for necrotizing gangrenous cholecystitis with suspected perforation. Ascending colon and segment of transverse colon with a painted wall affected by inflammatory process. Enlarged lymph nodes are seen in the ileocecal region and around the ileocolic artery. Sections involving the heart show a suspected defect in the left atrium - a thrombus? The echocardiographic finding showed a present TU formation in the left atrium, mobile, which gives the impression that it is attached to the IAS loop, the same with dimensions 2.41x1.19 cm, as well as the present TU formation in the right atrium, attached to a thick loop in area of the mouth of this v.cava superior, with dimensions 1.35x1.05 cm. From laboratory analyzes, there were elevated values of D-dimers: 5540, CRP> 320, Le = 16.32, other lab findings in reference values. On the recommendation of a cardiologist, a CT pulmonary angiography was performed, where there are no signs of pulmonary thromboembolism. The patient is referred for digestive surgery for further treatment.

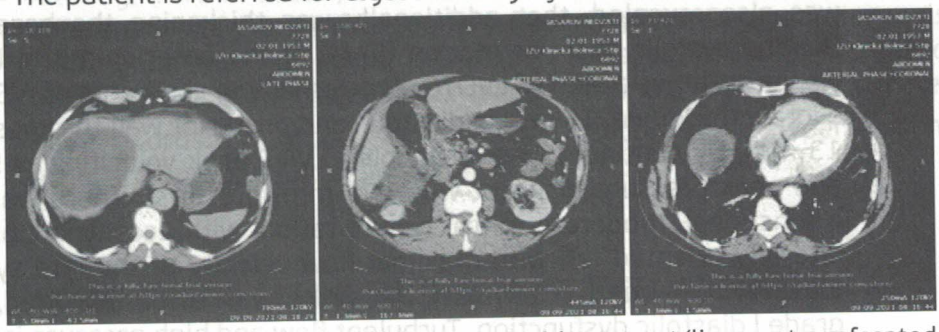

Figure 1 and 2 (09.09.2021). Abdominal CT with contrast (liver cyst, perforated gallbladder, and free fluid). Figure 3 (09.09.2021). Abdominal CT with contrast (Random finding of left atrial thrombus)

Conclusion. Diagnosis and management of intracardiac thrombi combined with acute abdomen is best done with an interprofessional team that includes an internist, cardiologist, radiologist, vascular, abdominal surgeon, and a team of specialized nurses. It is vital to treat intracardiac thrombi, as this may reduce the risk of stroke, myocardial infarction, and pulmonary embolism.

Keywords: intracardiac thrombi, left atrial thrombus, right atrial thrombus, acute abdomen

AUTHOR INDEX