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# Italian Journal of Medicine

Organo Ufficiale della Federazione delle Associazioni dei Dirigenti Ospedalieri Internisti - FADOI

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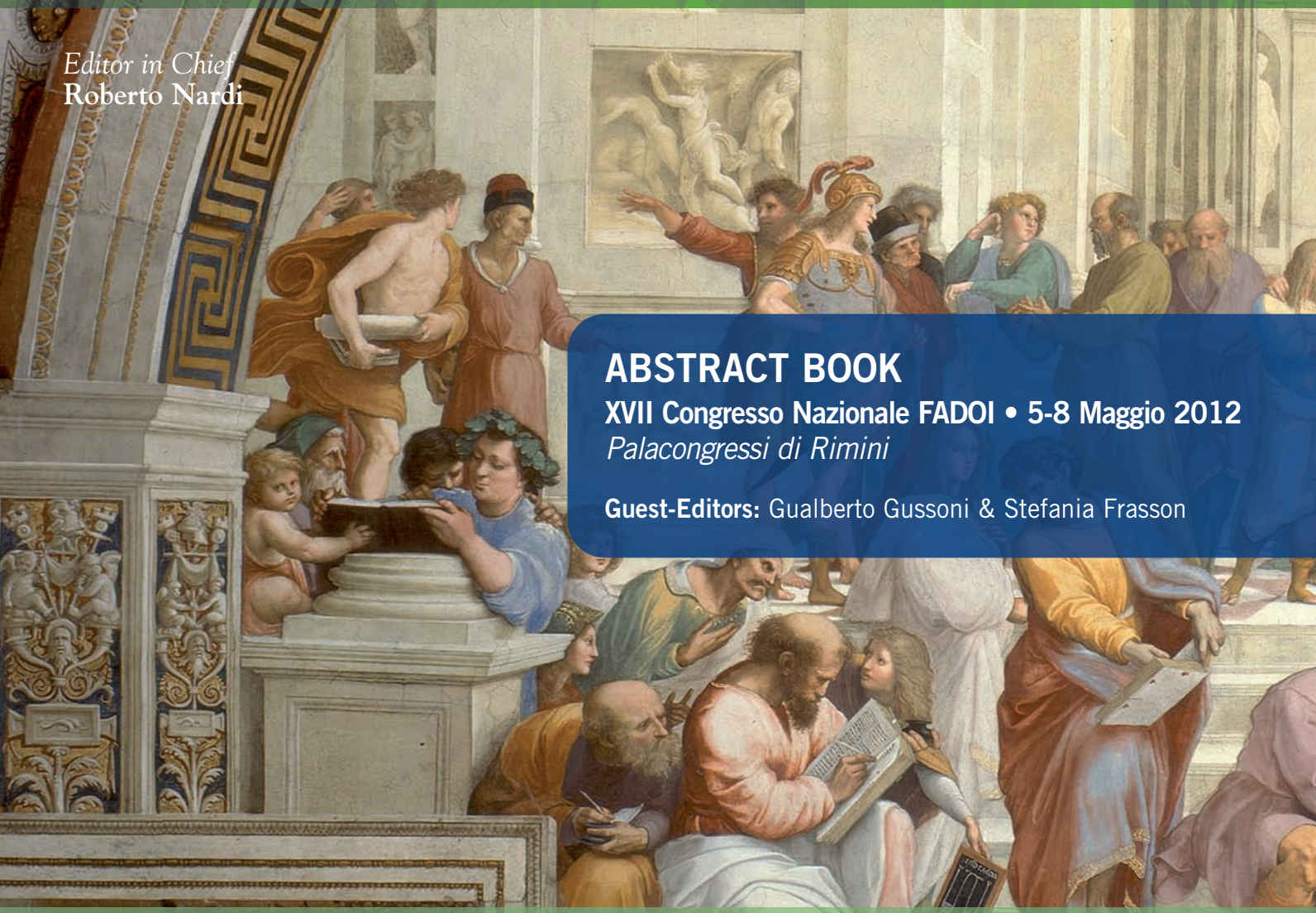

## ABSTRACT BOOK

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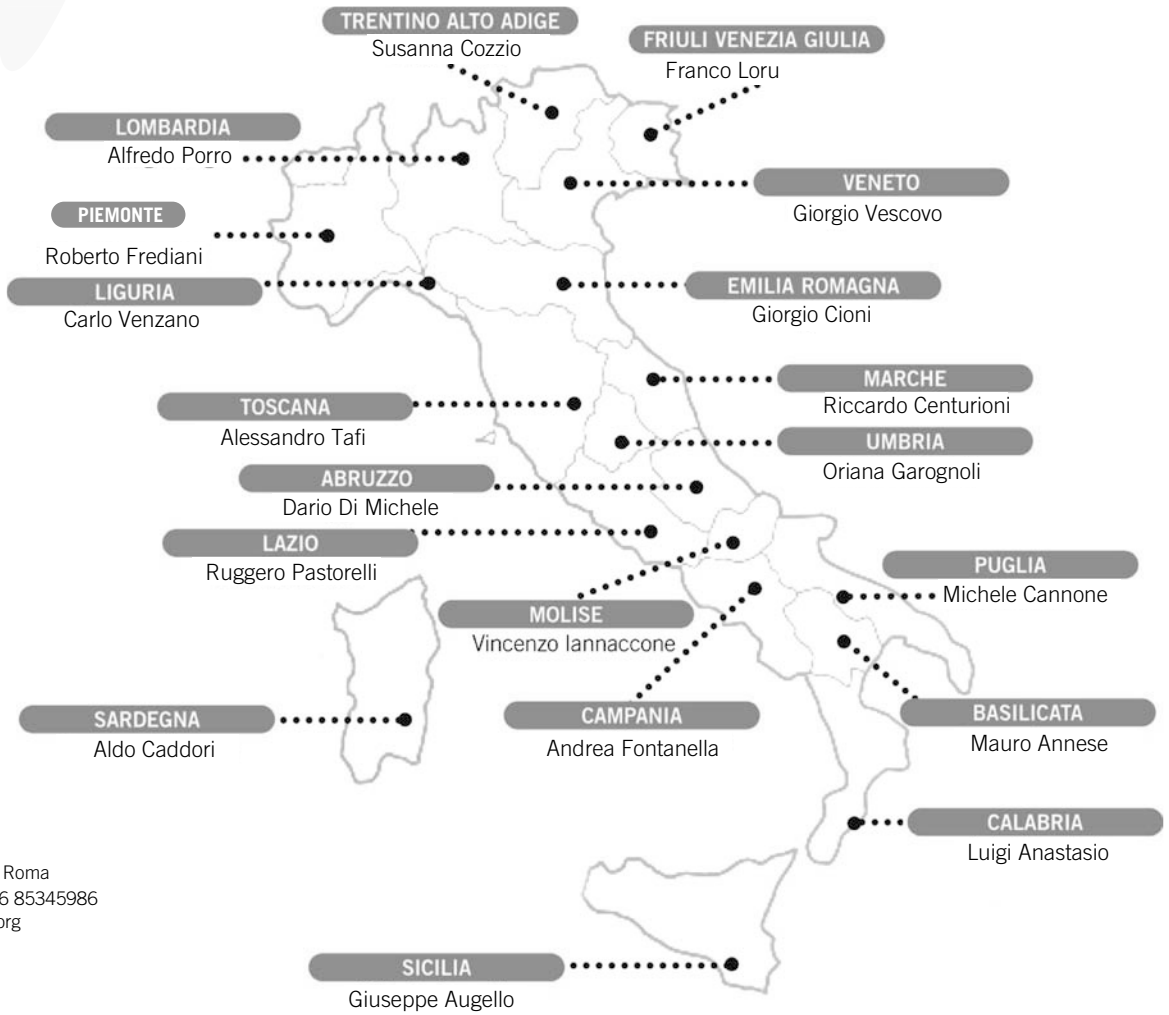


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# Indice

# ABSTRACT

## Polmonite chimica con cavitazioni per avvelenamento da Permetrina

L. Abate[1], D. Fabbrini[1], P. Nardi[2], M. Todini[1], P. Corsi[1], S. Salvadori[1], S. Bocchini[1], G. Notario[1], A. Marcocci[1], S. Zacchei[1]

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**Introduzione** Anche la casa, erroneamente considerata un posto sicuro per eccellenza, può rivelarsi un luogo pericoloso, fonte di incidenti domestici. Le cause vanno ricercate nell'incuria, nella disattenzione, ma anche nell'imprudenza. Proprio in quest'ultima evenienza rientra il caso clinico da noi osservato.
**Caso clinico** Donna di 76 anni. Giunge in PS riferendo che, circa 1 ora prima, accidentalmente aveva bevuto, credendola acqua, da una bottiglia di plastica trasparente in cui era stata travasata, una soluzione incolore antitarlo (Permetrina). A domicilio e in PS episodi di vomito. Il Centro antiveleni consigliava trattamento con Carbone attivo e monitoraggio delle funzioni vitali, in particolare respiratorie, ritenendo la polmonite un'evenienza possibile a causa della potenziale inalazione per via aerosolica con effetto antisurfactante. Ricoverata nei letti di osservazione breve del PS, veniva 24 ore dopo trasferita in Medicina per l'evidenza all'Rx torace di addensamento flogistico del lobo inferiore dx e del medio, con consensuale versamento pleurico. Nei primi giorni di degenza le condizioni respiratorie apparivano compromesse con marcata ipossiemia normocapnica, iperpiressia e stato di prostrazione. Il trattamento infusivo con ambroxol e la copertura con antibiotici ad ampio spettro e antimicotici, conduceva a un graduale recupero della cenestesi, impedendo la temuta ascessualizzazione del focolaio. Tuttavia il decorso della polmonite chimica ha mostrato segni di cavitazione polmonare ma, il consulente chirurgo toracico ha escluso indicazione chirurgica.

## Vanishing lung syndrome: a proposito di un caso

L. Abate [1], D. Fabbrini [1], P. Nardi [2], S. Salvadori [1], M. Artusa [1], S. Zacchei [1], A. Marcocci [1], G. Notario [1], L. Lusini [1], S. Bocchini [1]

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**Introduzione** La *vanishing lung sindrome* o enfisema bolloso gigante idiopatico, è una patologia cronica progressiva, caratterizzata da bolle enfisematose giganti che si sviluppano, comunemente, nei lobi polmonari superiori, occupando almeno un terzo di un emitorace. I fattori di rischio comprendono il fumo, il deficit di alfa-1 antitripsina e l'abuso di marijuana. Si complicare con uno pneumotorace, ma è anche comune l'infezione della bolla. Resta una condizione rara che, purtroppo, diventa clinicamente evidente quando ormai ha raggiunto uno stadio molto avanzato. La bullectomia chirurgica ha dimostrato di produrre immediati e significativi miglioramenti funzionali; sebbene questi vantaggi diminuiscano con il passare del tempo, persistono per almeno 3 anni.
**Caso clinico** Donna di 78 anni, con BPCO per abitudine tabagica inveterata. Giunge a ricovero per modesto focolaio polmonitico basale destro, complicato da severa insufficienza respiratoria acuta tipo 1 su cronica. La radiografia del torace mostra, oltre all'addensamento polmonare flogistico a destra, un quadro di vanishing lung sindrome a carico di tutto il lobo polmonare superiore sinistro. Tale reperto viene ulteriormente precisato con indagine TAC polmonare ad alta risoluzione. La paziente viene stabilizzata e gradualmente recupera il suo precedente stato clinico (NYHA III). Il consulente chirurgo toracico propone trattamento di bullectomia, ma ne sottolinea anche l'alto rischio chirurgico. La paziente informata dettagliatamente sul decorso della malattia e sulle possibilità correttive chirurgiche rifiuta l'intervento.

## Un caso clinico di aortite non infettiva

L. Abate [1], A. Marcocci [1], D. Fabbrini [1], P. Corsi [1], M. Todini [1], S. Salvadori [1], S. Zacchei [1], G. Notario [1], S. Bocchini [1], L. Lusini [1]

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**Introduzione** Le aortiti sono frequentemente caratterizzate da flogosi della tonaca media. Si manifestano con sintomi vaghi e aspecifici quali febbre, elevati indici di flogosi e manifestazioni sistemiche.
L'eziologia infettiva o non infettiva costituisce criterio classificativo. Tra le forme non infettive si distinguono:
- le aortiti gigantocellulari;
- le aortiti associate a malattie autoimmuni sistemiche;
- le aortiti linfo-plasmacellulari aspecifiche.

Il caso clinico da noi osservato fa parte delle aortiti a cellule giganti.
**Caso clinico** Donna di 72 anni. Lamenta febbre-febbricola ed astenia comparse da 1 mese. Presenta notevole incremento degli indici di flogosi, elevazione del complemento e positività degli ANA: nuclear dots 1:5120/mitocondriale 1:320. Vengono attuati plurimi accertamenti laboratoristici, ecocardiografici e radiologici, che portano a concludere per aortite a cellule giganti. In particolare lo studio angio TC dell'aorta mostra un diffuso ispessimento della parete in tutto il decorso del vaso. La proposta di indagine bioptica non trova il consenso da parte della paziente. Si prescrive Prednisone alla dose di 1 mg/Kg, che conduce ad una drammatica regressione di sintomi/segni e recupero di una normale cenestesi. Ai controlli seriati, nel corso della graduale riduzione posologica dello steroide, non si osservano segni di ripresa della malattia. A circa 6 mesi dalla diagnosi, la paziente gode di buona salute.
**Conclusioni** Pur trattandosi di una diagnosi inusuale occorre sempre tenerne conto di fronte a pazienti con sintomi costituzionali e disturbi sistemici.

## Policondrite cronica ricorrente: un caso di nostra osservazione

L. Abate [1], D. Fabbrini [1], P. Corsi [1], M. Todini [1], S. Salvadori [1], A. Marcocci [1], G. Notario [1], S. Zacchei [1], S. Bocchini [1], M. Artusa [1]

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**Introduzione** La policondrite è una rara malattia multisistemica ad eziologia sconosciuta, caratterizzata da ricorrenti episodi di infiammazione delle strutture cartilaginee (orecchio, naso, laringotracheale, articolazioni periferiche, occhi, cuore e vasi sanguigni) con tendenza alla distruzione. Poco si sa dell'epidemiologia: non sono disponibili dati sull'incidenza, prevalenza e tassi di mortalità.

Vari criteri diagnostici sono stati proposti. Per porre diagnosi é richiesto che sia soddisfatto un solo criterio:
1. episodi infiammatori con interessamento di due o tre siti tra cartilagine auricolare, nasale, laringotracheale;
2. interessamento in uno di tali siti, associato a due altre manifestazioni:
3. flogosi oculare (congiuntivite, cheratite, episclerite, uveite),
interessamento cocleo/vestibolare (ipoacusia, disfunzioni vestibolari) o artriti infiammatorie sieronegative.
**Caso clinico** Donna di 56 anni. Si ricovera per la comparsa, da circa 4 giorni, di raucedine, iperpiressia e flogosi violacea del padiglione auricolare sx e, successivamente, dolore alle articolazioni tibio-tarsiche con impossibilità a deambulare associato a vasculite. L'obiettività ORL mostra anche intenso stato flogistico del cappuccio aritenoideo destro ed ipoacusia sx. I dati clinici depongono per una policondrite ricorrente associata a vasculite leucocitoclasica. La paziente trattata con boli di Metilprednisolone, e poi terapia steroidea per os, ha recuperato un soddisfacente stato di benessere.

## Sviluppo di procedure per la diagnosi e la cura del dolore nell'anziano e nel disabile ricoverato in RSA. Studio conoscitivo e propedeutico

E. Acerbis [1]

[1]Clinica Luganese- Lugano

Aim of this study was to investigate the prevalence of pain in a nursing home, and if a relationship could be established between cognitive performance in aged people and ability to refer about pain; particularly, if MMSE could be utilized as an indicator of adequate, or not, ability to communicate a condition of pain.
68 people living in a nursing home have been exposed to MMSE,CDT, NRS, FACES, PAINAD, GDS and ADRS.
Mean MMSE score was 15; 57.35% scored less than 20; mean CDT (0-7)1.32; mean NRS 2.92;mean FACES 3.58 ; mean PAINAD (0-19) 0.9; mean GDS (0-5) 2.36; mean ADRS 8 0-32) 4.48.
Pearson correlation index and the p-value have been calculated, by SSPS calculator.
The relation was an inverse one between cognitive tests ( MMSE and CDT), and PAINAD-GDS-ADRS; a positive low relation was found of MMSE and NRS; relation is low ( but near to moderate level) and statistically significant (p 0.05) between ST orientation in MMSE and NRS.
The result of a very low relation between NRS and PAINAD is worrying and astonishing, as if the test made to depict pain in uncommunicative people were inable to do so.
Further study is needed.

## Medicina interna per intensità e complessità di cura

F. Agnelli [1], F. Colombo [1], G. Bollini [2], S. Magni [3], P. Marino [4], D. Mari [5], G. Ippoliti [6], M. Poli [7], A. Porro [8], M. Vanoli [9], M. Nichelatti [10]

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[2]Ospedale Niguarda Milano;
[3]Ospedale S. Gerardo Monza;
[4]Ospedale Fatebenefratelli Milano;
[5]Istituto Auxologico Milano;
[6]Ospedale Voghera;
[7]Ospedale S. Carlo Milano;
[8]Ospedale Rho;
[9]Ospedale Merate;
[10]Biostatistica Niguarda

**Introduzione** L'intensità di cura, in particolare in Medicina Interna, riconosce 2 componenti: la complessità clinica (instabilità, criticità, gravità, comorbilità) e l'intensità assistenziale infermieristica.
**Materiali e metodi** A questo progetto hanno partecipato le SSCC di Medicina Interna di 10 ospedali lombardi. Lo studio è stato effettuato utilizzando 3 griglie di valutazione: MEWS per criticità/instabilità e IIA per l'intensità assistenziale (valutati all'inizio della degenza e in III giornata), CIRS per gravità e comorbilità (valutato solo all'inizio).
**Risultati** Sono stati osservati 1482 pazienti (età mediana: 78 anni). La patologia più frequente era la patologia cardio-polmonare. Ponendo per la criticità di MEWS un cut-off ≥ 3 risulta critico il 17% dei pazienti. MEWS migliora significativamente ($p<0.00005$) dal 1° al 3° giorno nel 43% dei casi. I parametri di MEWS che cambiano più velocemente sono quelli cardiovascolari e respiratori, verosimilmente da attribuire ad un tempestivo intervento clinico farmacologico.
**Conclusioni** MEWS e CIRS rappresentano strumenti semplici, efficaci e validati per valutare la complessità clinica. Non sempre i 2 score correlano, in quanto un paziente può essere stabile ma pur sempre grave e/o a rischio di riacutizzazione. Instabilità e criticità sono tempo-dipendenti. MEWS e IIA sono significativamente associati, ma MEWS migliora più velocemente di IIA.

## Ultrasounds in non resolving pneumonia

P. Agostinis [1]

[1]Ospedale Sant'Antonio Abate Tolmezzo

**Background** Ultrasonography of the lung is a simple method to learn and can be considered an effective extension of semiotics. It can be performed quickly at the patient's bedside to investigate or aid in the diagnosis for respiratory disease such as dyspnea, pleural effusion, empyema, pneumothorax, mesothelioma, pulmonary edema, pneumonia and neoplastic disease.
**Aims** The lung U.S. enables fine needle aspirations and biopsies of pleural thickening and sub-pleural lung foci for cytological, histological and microbiological analysis.
**Materials And Methods** I describe three patients in whom ultrasound-guided lung biopsy allows etiologic diagnosis of non resolving pneumonia.
**Results** Two patients with hematological disease, unresponsive to broad spectrum antibiotics, showed respectively a Gram-positive pneumonia and Pneumocystis carinii pneumonia. A young female patient had a ischemic infarction from pulmonary embolism.
**Conclusions** The lung U.S. should be part of the Internis's culture because it is of great help in the diagnostic process by allowing, in selected cases, performing the sampling to obtain a precise etiologic diagnosis and the possibility to optimize patient care.

## Blood pressure control and pharmacological treatment in patients evaluated with ambulatory blood pressure monitoring

A.M. Agrati [1], G. Palmieri [1], M.M.R. Negri [1], F. Colombo [1], G. Ferraro [1]

[1]Internal Medicine Dept. and Hypertension Unit; Niguarda Ca' Granda Hospital

**Objective** BP increases with age;a more aggressive treatment should be used in elderly to face their increasing global cardiovascular risk. Relations among BP control, age and treatments were analyzed in all subjects undergoing ABPM at our Institution from 2000 to 2011.
**Methods** 7928 ABPMs performed were analyzed. Usual data were recorded: sistolic, diastolic, pulse pressure, blood pressure variability, dipping status and heart rate, clinical BP measurements, age, sex, body mass index, smoking habits, diabetes, anti-hypertensive therapies. Subjects were divided in two groups according to their mean

systolic and diastolic 24 hour BP values (< or >125/80): normotensives (4632) and hypertensives (3296). Every group was furtherly divided according to age and number of anti-hypertensive drugs used.
**Results** Hypertensive subjects were more frequently receiving no treatment in the extreme age groups (< 40 years or > 70 years); hypertensives received a lesser number of drugs when their age was > 70 years and especially > 75, where therapies with 4 or more drugs were virtually absent. Normotensives showed a direct relation between increasing therapies and age, even if a reduction in 4 or more drugs was noted above 70 year of age. Calcium channel blockers and diuretics were the most used drugs in normotensives independently from their age, while no differences were noted among hypertensives.
**Conclusions** Our data show that a more aggressive therapy is seldom used in elderly subjects, even if it always associates with better BP control, independently from age.

## Risk factors predictive of carotid atherosclerosis in HIV+ patients

G. Aiosa [1], E. Mantia [2], M. Pastorino [1], P. Davio [1]

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**Background** Several studies demonstrated a higher incidence of cardiovascular events in HIV+ patients than HIV- subjects with the same risk factors.
**Materials and methods** We enrolled 70 consecutive HIV+ patients treated with Highly Active Antiretroviral Therapy, subjected to echocardiography, Doppler TSA, AMBP 24h and blood samples for assessment metabolic profile and virological data.
**Study end point** Research of risk factors predictive of carotid atherosclerosis development by analysis of 2 subgroups (carotid plaque presence, 37 subjects, versus plaque absence, 33 subjects) for the following parameters: familiarity, smoke, glycemia, HOMA index, lipid profile, clinical and ambulatory BP, the Framingham risk score, presence of sub-clinical organ damage, creatinine, duration of disease and treatment, nadir CD4 count, the average CD4 for the previous 12 months, HIV and HCV viremia.
**Results** The univariate and multivariate analysis showed an association statistically significant with Framingham score and the nadir CD4 (p 0.0095 and 0.0166 respectively) while the individual risk factors, duration of infection and therapy correlated without reach significance. In the subgroups study, 4/37 subjects with carotid plaque underwent to coronary revascularization conversely none of 33 subjects without plaque.
**Conclusions** An elevated Framingham risk score and a lower nadir CD4 are predictors of carotid atherosclerosis. These factors, if present, should address to a more aggressive control of risk factors and the use of resource for the early diagnosis of coronary artery disease.

## Polmonite interstiziale usuale (UIP) e versamento pericardico, un'associazione inusuale

G. Aiosa [1], S. Prina Cerai [1], C. Donati [1], M. Pastorino [1], A. Pagetto [1], S. Gandolfi [1], P. Davio [1]

[1]Internal Medicine - A.S.O. "S.S. Antonio e Biagio e C. Arrigo" - Alessandria

**Premesse** Descriviamo un caso clinico dove è presente l'associazione, inusuale, di due patologie idiopatiche.
**Materiali e metodi** Donna di 69 anni con anamnesi di TBC polmonare a 29 anni e di osteoporosi con frattura D12, ricoverata per dispnea da sforzo, edemi declivi, mialgie e deficit di forza ai cingoli. L'ecocardiogramma documentava la presenza di un versamento pericardico moderato con iniziali segni di discinesia a carico della parete dell'atrio dx mentre l'ecografia del torace èra caratterizzata dalla presenza di linee B diffuse come da interstiziopatia diffusa bilaterale. La presenza di quest'ultima veniva confermata dalle immagini fornite dalla HRCT che mostravano un aspetto reticolare e micronodulare. Negativi risultavano tutti gli accertamenti bioumorali, colturali, sierologici ed il lavaggio bronchiolo-alveolare (BAL) escludendo in particolare la presenza di malattie del connettivo, sarcoidosi o di patologia infettiva.
**Risultati** Nel sospetto di fibrosi polmonare idiopatica si procedeva a biopsia polmonare toracoscopica ottenendo un quadro istologico di UIP che confermava il sospetto clinico. Il versamento pericardico si autolimitava come dimostrato dal controllo ecocardiografico successivo.
**Conclusioni** La diagnosi era quindi di fibrosi polmonare idiopatica e di concomitante versamento pericardico subacuto postpericarditico. La presenza contemporanea delle due patologie ha determinato un iter diagnostico che, pur ricercando inizialmente una patologia unificante, non ha escluso la presenza di patologie concomitanti permettendo un corretto inquadramento diagnostico.

## Un caso di emorragia digestiva trattato con anticoagulanti

V. Almerigogna [1], S. Donnini [1], F. Bucciero [1], M. Marsico [1], M. Giannotta [1], T. Gabbani [1], R. Puntili [1], M.R. Biagini [1], G. Macrì [1], S. Milani [1], F. Corradi [2], A. Morettini [2]

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**Caso clinico** Maschio, 73 anni. Nel 1999 etp del colon sottoposta a resezione chirurgica e chemioterapia. Nel 2002 TVP arti inferiori. A maggio 2011 giunge alla nostra attenzione per rettorragia e melena con valori di Hb 6,4 g/dL. EGDS nella norma. Alla colonscopia in urgenza abbondante sanguinamento ileale in atto. All'Angio-TC in urgenza trombosi non recente a carico delle vena splenica e mesenterica superiore con formazione di circoli collaterali porto-portali e porto-sistemici (spleno-renale, gastroesofageo, emorroidario, digiuno-ileale e a carico del ventaglio mesenterico); varici venose a carico della parete del tenue nel tratto di passaggio digiuno-ileale con presenza di mdc stravasato nel lume dell'organo. Eseguita trasfusione in emergenza e terapia con terlipressina, plasma expander e profilassi antibiotica. Il paziente è stato sottoposto a confezionamento di shunt tra vena cava e mesenterica superiore. L'intervento si è complicato con trombosi dello shunt per cui sono state eseguite ripetute disostruzioni chirurgiche. È stato inoltre eseguito screening coagulativo con riscontro di mutazione in eterozigosi del fattore II, JAK2 e BOM negativi. È stata intrapresa terapia con warfarin nonostante l'alto rischio di sanguinamento.
**Conclusioni** Questo caso è un esempio della multifattorialità eziologica della trombosi (eterozigosi del fattore II, carcinoma rettale, interventi chirurgici e chemioterapia). Sanguinamenti variceali possono essere conseguenza di trombosi, necessitando in tal caso di un'adeguata terapia anticoagulante nonostante il forte rischio emorragico.

## An unusual ascites clinical case

C. Ambrosca [1], M. Varriale [1], T. D'errico [1], S. Lucà [1], S. Tassinario [1], S. Costa [1], G. De Siena [1], N. Armogida [1], M. Visconti [2]

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Migratory flows and shortage of vaccines have been caused an increasing of TB in west countries, where it was considered eradicated. The ratio of men to women for Tuberculous peritonitis (1-3 % of extrapulmonary manifestations) is one to three; at the beginnings, because of nonspecific symptoms, the diagnoses can be difficult. In 2011 an Asiatic 53 years old lady was hospitalized in our ward for suspected

liver disease; for a month the patient had been had abdominal pain and fever. The physical examination showed ascites; the laboratory analysis showed anemia, VES 100, PCR 33 mg, transaminases increase, negative major and minor hepatitis viruses markers and autoimmunity; the chest-ray was negative. The abdominal eco displayed a 3 cm hypoechoic subglissonian nodule and medium effusion; the results were confirmed by tc images. Ascitic fluid analysis showed a non neoplastic exudate. Anamnestic, clinical, instrumental and laboratory data helped us to hypothesize abdominal TB. An abdominal miliary injury was shown by laparotomy. The histology result of the hepatic injury proved a tuberculous granuloma. A tuberculous and hepatic peritonitis was diagnosed and treated with Rifampicin, Isoniazid, Ethambutol and Pyrazinamide,. After two months the remission was total. This clinical case highlights the importance of considering abdominal TB as a possible cause of ascites, especially in patients coming from high endemic countries. If this pathology is late diagnosed the mortality is high, but if it is early recognized the remission, thanks to the current therapy, is total.

## ✪ Day-night dip and early-morning surge in blood pressure in essential hypertension: prognostic implications

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We investigated the relationship between the day-night blood pressure (BP) dip and the early morning BP surge in 3012 initially untreated subjects with essential hypertension recruited in the "Progetto Ipertensione Umbria Monitoraggio Ambulatoriale" (PIUMA).
The day-night reduction in systolic BP showed a direct association with the sleep-trough and the pre-awakening systolic BP surge (all $p < 0.05$).
Over a mean follow-up period of 8.44 years, 268 subjects developed a major cardiovascular (CV) event (composite of CV death, non fatal myocardial infarction, non fatal stroke and heart failure requiring hospitalization) and 220 subjects died.
In a survival multivariable model, after adjustment for several covariates including age, sex, diabetes, cigarette smoking, total cholesterol, left ventricular hypertrophy, estimated glomerular filtration rate, average 24-hour systolic BP and dipping pattern category (reverse dippers, dippers, nondippers, extreme dippers) a blunted sleep-trough (≤ 19.5 mmHg; quartile 1) and pre-awakening (≤ 9.5 mmHg; quartile 1) BP surge were associated with an excess risk of events (hazard ratios: 1.66; 95% confidence interval (CI) 1.14-2.42; p=0.009 and 1.71; 95% CI 1.12-2.71; p=0.013). After adjustment for the same covariates, neither the dipping pattern nor the measures of early morning BP surge were independent predictors of mortality.
In conclusion, in initially untreated subjects with hypertension a blunted day-night BP dip was associated with a blunted morning BP surge. In addition, a blunted morning BP surge was an independent predictor of CV events, whereas an excessive BP surge did not portend an increased risk of events.

## Ambulatory pulse pressure and neutrophil count for the cardiovascular risk stratification of hypertensive postmenopausal women

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Experimental and clinical studies show that oestrogen deficiency may trigger an inflammatory response associated with endothelial and vascular dysfunction, leading in turn to reduced compliance of large arteries and consequent increase in pulse pressure (PP). To investigate the possible link between menopause, hypertension, and an over-expression of inflammatory state, we assessed the association between elevated neutrophil count and increased arterial stiffness (high PP). We also tested the independent prognostic value of neutrophil count for cardiovascular (CV) events in hypertensive postmenopausal women.
We analyzed 886 hypertensive post-menopausal women. Follow-up of patients was in charge of family doctors in close collaboration with our hospital staff. Median duration of follow-up was 7.4 years (range: 1-21). There was a direct relationship between neutrophil count and 24-h ambulatory PP ($p<0.0001$) and such association remained significant after adjustment for several confounders. During follow-up there were 121 first major CV events. In a multivariate analysis, 24-h ambulatory PP and neutrophil count were independent predictors of total CV events after adjustment for the influence of other risk markers.
No interaction was observed between ambulatory PP and neutrophil count ($p=0.887$).
In conclusion, an increased arterial stiffness, reflected by high values of 24-hour ambulatory PP, is an adverse prognostic marker, and also an additional correlate of systemic inflammation. In addition, we confirmed the additive prognostic value of neutrophil count over traditional risk factors in post-menopausal hypertension.

## Assessment of pain associated to common invasive procedures and nurse's opinion

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**Introduction and aim of the study** Invasive diagnostic and therapeutic procedures (IDTP) may be painful and cause physical and emotional discomfort.
An observational study was conducted in three medical wards of S. Giovanni Battista Hospital, to a) assess pain and discomfort experienced by patients during IDTPs and nurses' opinion; b) describe frequency and outcomes of the administration of analgesics and anxiolitics.
**Methods** Pain was assessed with a Numeric Rating Scale (NRS) before and after IDTPs and patients were asked to describe the main causes of pain/discomfort experienced. An anonymous questionnaire was completed by nurses to express their opinion on painfulness and discomfort caused by a list of IDTPs. Mean an DS were calculated for each IDTP and results compared with nurses' opinion ($P<0.05$) using Wilcoxon Test.
**Results** Data on 186 patients and 200 IDTPs were collected. The most performed IDTPs were EGDS (18%), blood gas analysis (14%) and colonoscopy (12.5%). The most painful were Bone Marrow Biopsy (BOM) (NRS 7.05) and colonoscopy (NRS 6.44); those more anxiety provoking the BOM (NRS 7.26) and bronchoscopy (NRS 5.09). No analgesic or insufficient dosages were administered before some IDTPs and, for 56% of these, patients would have liked it. Nurses rate patients pain and fear/anxiety significantly higher than what experienced by patients.
**Conclusion** Acute pain, fear and anxiety are poorly controlled during

IDTPs; the lack of protocols for pain control may be responsible for the different levels of discomfort experienced.

## Ataxic form of Guillain-Barré Syndrome associated with anti-GD1b IgG

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**Introduction** Guillain Barré Syndrome is a heterogeneous condition with several variants. We report a case of subacute ataxic GBS variant.
Clinical Course A 65 year old man presented to ED with progressive ataxia and sensorial deficit of lower limbs. History was relevant for asbestos exposure;tabagism;monoclonal gammopathy IgM e IgG kappa. Neurological examination revealed severe ataxia with gait disorder, dysmetria and adiadococinesia. Distal paresthesia with propioceptive sensorial deficis and areflexia were present without motor deficit. Cranial nerves were normal. A cranial CT scan showed a chronic vascular encephalopathy, a cranial MRI was not done for the presence of a PM device. An electromyography showed a sensorial distal assonopatic polyradiculoneuropaty.A cerebrospinal fluid examination showed increase in protein concentration with albumin/citologic dissociation. A total body CT scan was negative for neoplastic lesions. High titer antiganglioside autoantibodies(GD1b-IgG) were detected. Anti GQ, anti-GM and anti-MAG were negative. Plasmapheresis followed by intravenous immunoglobulin (0,4g/kg/day) treatment was undertaken with progressive improvement of clinical picture.
**Conclusion** Screening for autoantibodies against glycolipides GD1b have to be considered in ataxic and dysmetric patients with sensorial polyneuropathy. The ataxic variant of GBS is a rare but well-described condition associated with anti GD1b-IgG well responding to plasmapheresis and intravenous Ig therapy.

## Una grave complicanza in un caso di Catheter-Related Blood Stream Infection in paziente dializzata

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Riportiamo il caso di una donna di 63 anni giunta alla nostra osservazione per episodi febbrili recidivanti e decadimento clinico generale.
**Anamnesi** DM tipo II insulino-dipendente determinante IRC in trattamento dialitico eseguito attraverso CVC Tesio giugulare.
**Decorso** All'ingresso paziente piretica ,ipotesa. All'esame obbiettivo soffio sistolico ad alta frequenza udibile all'apice. Agli esami ematochimici leucocitosi neutrofila,incremento degli indici di flogosi. Documentazione ecografica di formazione endocarditica tricuspidalica in continguità con apice del CVC ,determinante insufficienza valvolare severa. Alla TC torace focolai ascessuali multipli. Emocolture da CVC e vena periferica positive per MRSA e VRE.Rimosso CVC e instaurata politerapia antibiotica mirata. Deterioramento emodinamico progressivo nonostante gli opportuni interventi di carattere farmacologico. All'ETE ascesso anulare mitralico. Paziente trasferita presso il Reparto di CardioChirurgia per essere sottoposta a sostituzione valvolare tricuspidalica e mitralica.
**Discussione** Sempre piu' importante la diffusione nei reparti ospedalieri ,specialmente nei centri di emodialisi, di infezioni da MRSA e VRE. Nei pazienti uremici, per lo stato di immunodeficienza spesso presente, l'accesso vascolare rappresenta un'importante porta di ingresso per i microorganismi. Le complicanze secondarie alle Catheter Related Blood Streem Infection(CR-BSI),prima tra tutte l'endocardite, devono essere considerate precocemente in quanto possono rappresentare un 'importante causa di mortalità.

## Arthralgia, palpable purpura, abdominal pain and hematuria: a pathognomonic clinical tetrad

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**Introduction** Systemic vasculitis are multi system diseases requiring detailed multidisciplinary assessment.
**Case report** We report the case of a 56-year-old man who presented to our ward with a two-day history of abdominal pain. Two weeks previously he had first noticed arthralgia treated with Ketoprofene. He was subsequently evaluated for generalized palpable purpuric rash at Dermatology Clinic where hypersensitivity vasculitis was suspected. Two days later he developed abdominal pain and was hospitalized.
At admission, lab tests showed just mildly elevated inflammatory markers. Skin biopsy was performed and "wait and see" strategy chosen. In few days the patient developed rectal bleeding and computed tomography (CT) and pan colonoscopy (PC) were performed: the CT showed a diffusely edematous and thickened gut while the PC detected severe petechiae throughout the intestinal wall. Intestinal and Skin biopsy showed leukocytoclastic vasculitis while the control lab tests revealed new onset microscopic hematuria.
A diagnosis of Henoch-Schönlein Purpura (HSP) was set. Intravenous Methylprednisolone was started and transitioned to Prednisone tapering orally to complete six months therapy. There was marked improvement of abdominal pain and gastrointestinal bleeding while skin lesions gradually faded.
**Conclusion** HSP, the most common systemic vasculitis in children, is an uncommon syndrome in older patients. Anyway, even in adults, HSP can present with arthralgia, abdominal pain and rectal bleeding, palpable purpura and hematuria which represent a pathognomonic clinical tetrad.

## Major digestive bleeding secondary to chronic portal venous thrombosis as clinical onset of previously unknown hepatic cirrhosis complicated by hepatic carcinoma

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**Introduction** Hepatocarcinoma (HCC) is a complication of hepatic cirrhosis (HC) generally detected in early stage due to Ultrasonographic (US) surveillance in hepatopathic patients. It can be treated effectively with well tolerated loco-regional treatment.
In advanced stages of the disease, HCC may be complicated by portal vein thrombosis (PVT) that represents the limiting element of the treatment and, therefore, the more devastating prognostic element.
**Case reports** We present two cases of major digestive bleeding that led us to diagnose chronic PVT due to silent HC complicated by multifocal HCC.
In both cases the diagnostic role of Doppler US study is emphasized such as the importance of alpha fetoprotein requested in the correct scenario.
In both cases patients underwent endoscopic variceal ligation (VL) regardless to the chance of etiologic treatment of HCC and anticoagulant therapy was attempted.

Just in the first case it was possible to begin Sorafenib due to the better Child Class present at the diagnosis (A5 versus B8).
**Conclusion** Nowadays despite US surveillance in hepathopathic patients lets generally the early diagnosis of HCC in pre-clinical phase, it is still possible that digestive bleeding secondary to chronic PVT represents the clinical onset of previously unknown HC complicated by HCC. In this scenario anticoagulant therapy can be considered just in case of preserved liver function and should be individualized.
Unlike the anticoagulation, VL is codified therapy and shouldn't be denied to patients since it appears to significatively prolong surveillance.

### Osteoclastoma of the heel as a first sign of primary hyperparathyroidism

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**Clinical case** A 43-year-old man was brought to the ER because of persistent pain in his right hip and left heel. The patient had recently undergone surgical removal of a bone tumor in the left heel (about 10 months before). X-rays performed in the ER revealed an area of bone resorption in the right hip, therefore the patient was admitted in the Internal Medicine ward.
The patient provided the histological report of the previously removed tumor, that revealed a diagnosis of osteoclastoma. At admission, the patient was found to have hypercalcemia (14.7 mg/dl) and elevated serum PTH (831 pg/mL). Furher X-rays showed multiple bone cysts localized in the right hip (iliopubic branch and iliac crest) and in both the scapulas.
Neck ultrasonography revealed a hypoechoic nodule of 3 cm in diameter adjacent to the lower pole of the left thyroid lobe, compatible with a parathyroid adenoma. Abdomen ultrasound showed a 6 mm stone in the right kidney.
The patient underwent surgical removal of the abnormal gland, and the histological findings confirmed the diagnosis of parathyroid adenoma.
Post operative period was marked by persistent hypocalcemia, and the patient was managed consequently.
**Conclusion** According to signs and symptoms, to laboratory and imaging findings, a diagnosis of primary hyperthyroidism complicated by osteitis fibrosa cystica was made. The previously removed osteoclastoma was probably a first sign of the skeletal involvement in primary hyperparathyroidism. Therefore, when a diagnosis of osteoclastoma is made, it would be worth investigating mineral metabolism in order to exclude the presence of primary hyperparathyroidism.

### ✪ A complicated diagnostic and therapeutic course between science and clinical practice

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**Background and aim of the study** A diagnostic and therapeutic challenge.
**Materials and methods** We studied a 50 years old woman for persistent cough and fever with a history of prolonged juvenile pulmonary infection.
**Results** Normal physical examination with oxygen saturation of 99% while breathing ambient air; normal blood tests except for ESR 82mm/h, CRP 6 mg/dl, mild anemia; negative QuantiFERON and weakly positive Tubercolin skin test (4mm). At chest radiograph pleuric and pulmonary fibrotic outcomes at the right apex and a pulmonary infiltrate at the right upper lobe. The chest CT revealed a cavity with internal vegetation at the right apex and multiple right infiltrates. A bronchoscopy was performed with diffuse bronchial inflammation. Not sure, but still suspecting TB, treatment with Isoniazid, Pyrazinamide, Rifampin and Ethambutol was started with slow improvement of symptoms, inflammation and radiographs. After 2 months treatment was tapered to Isoniazid and Rifampin, but the patient clinically relapsed despite a improvement on chest CT . Assuming drug resistance we restarted a 4 drugs regimen plus levofloxacin for 2 months with new slow improvement. The clinical course was complicated by polyneuropathy, attributed to levofloxacin; the drug was replaced with linezolid for 1 month and then the 4 drugs regimen was continued for 2 months. Complete clinical and laboratoristic resolution was obtained with disappearance of all radiologic lesions.
**Conclusions** In our opinion this clinical report shows the frequent diagnostic and therapeutic challenges of tuberculosis.

### From fever to retroperitoneal abscess: a case report

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A 21 year old male patient arrives to emergency room because of fever for 7 days.
Objective examination shows treatable abdomen, reduced MV, hyperpyrexia and he reports sacrococcygeal pain, because of which he fails to maintain the sitting position.
In case history he presents a previous history of bladder infection with hematuria.
On examination, there aren't clinical signs of relief, except for sacrococcygeal pain patient-reported and hyperpyrexia.
The patient began treatment with ciprofloxacin 500 mg x 2 + ceftazidime 1 g x 2 for 8 days, but no improvements are observed.
Routine investigations shows positivity for an inflammatory process, proved by the high values of WC, ESR, CRP and neutrophils.
The microbiological investigations, such as the Widal Wright serodiagnosis, throat swab and urine culture, result negative.
Abdominal ultrasound shows a gross swelling of 8x6 cm, multilobed and multi-divided, in front inseparable from the rear wall of the rectum and in the back to the coccyx; this finding is confirmed by NMR.
For this reason, the patient undergoes surgery of drainage of the retroperitoneal abscess by laparotomy, and bacteriological examination concludes for Staphylococcus Aureus etiology.

### On a case of Pott's disease

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Senegalese patient, 34 years old, arrived to emergency room because of generalized asthenia for a few days, therefore he fails to maintain the upright position.
He also complains severe pain in the sacral region.
Routine investigations shows a severe lymphocytopenia and the signs of a possible degenerative process in action, as evidenced by high values of LDH and CPK.
The chest X-ray is negative; microbiological analyzes show previous HSV and mononucleosis infections, negativity for the serodiagnosis of Widal-Wright and anti-HIV Ab.
The patient underwent lumbosacral CT scan, which shows lysis of D11-12 with heterogeneous paravertebral tissue (cold abscess) seat left anterolateral.

The findings of tuberculous spondylodiscitis is then confirmed by MRI and laboratory tests.
Therefore the patient begins therapy with Isoniazid 10 mg/kg and rifampicin 10 mg/kg: according to protocol such therapy should be continued for a year.
As a result of a CT lumbar scan, practiced after 6 months of therapy, the cold abscess is almost absorbed.

## Stupor state of unknown origin

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Male patient, 78 years old, arrives to emergency room in stupor state. In case history the patient was taking sertraline hydrochloride for depressive syndrome. He carries out ECG, routine laboratory tests, cranial CT and neurological consultation, which excludes acute neurological diseases, and he is hospitalized in the Department of Medicine. In objective examination he appears stupor, responsive to painful stimuli. The biochemical investigations show alterations of electrolyte balance, with reduction in the concentrations of sodium and potassium, plasma osmolarity below normal, abnormal nitrogen balance, with reduced concentrations of uric acid; thyroid hormones normal. The clinical presentation seems consistent with impaired secretion of ADH, evidenced by high plasma concentrations of cortisol. Chest CT scan shows an outbreak of pneumonic thickening in the basal right, which is treated with ciprofloxacin 400 mg x 2 ev for 10 days. For electrolyte abnormalities he takes therapy with physiological saline + NaCL hypertonic and tolvaptan 15 mg a day for 8 days. The patient is discharged after thirteen days with a diagnosis of iatrogenic Syndrome of inappropriate secretion of ADH and right basal bronchopneumonia.

## The iperkalemic risk in diabetic and elderly patients

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**Background** Iperkalemia is potentially a lethal metabolic disorder, whose prevalence in the hospitalized patient can reach 10%. The diabetic subjects are considered to great risk in relationship to the concomitant diabetic nephropathy with secondary hyporeninemic hypoaldosteronism .
**Materials and Methods** In the first semester of 2011 we have observed an iperkalemia (K+ >6 mMol/L; 7,06 ± 0,66) in 162 patients (agerange= 44-91 ys), not in hemodiayitic treatment and in prevalence of female sex. In 8 patients diagnosis of "pseudoiperkalemia" has been set (the plasma potassium was normal unlike the serum potassium). In around 1/5 of the cases of "true iperkalemia", a basal kalemia to the upper limit of the normal range was documentable and it was referable at least partly to the action of drugs as ACE-I and ARBs.
**Results** In 10 patients the iperkalemia was induced from the assumption of azole antifungals; but the most interesting element is that the 42,6% of our patients was affected from Diabetes Mellitus. In the diabetic subgroup, the incidence of iperkalemia slightly results superior in comparison to that found in not-diabetic patients (RR= 1,46); Nevertheless, stratifying the analysis for the age (<75/[3]75 years), the incidence, in the range [3] 75 years is substantially equivalent in the two subgroups.
**Conclusions** The lethal effects of the iperkalemia suggest a careful monitoring of the plasma potassium concentrations both in the elderly and in the patients in treatment with medications that alter potassium handling, independently from the presence of Diabetes.

## An unusual presentation of pulmonary embolism

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**Case Report** A 29 year old woman, suffering from sickle cell disease and deaf-mute, is admitted to the ER because of a widespread intense pain, especially to the lower limbs, occurred suddenly a few of hours. To the clinical examination she is in good hemodynamic compensation with ascending right lung base, confirmed by chest x-ray. The skin has a yellowish tinge and she denies fever. The ECG is normal; the BGA in room air shows an hypoxemic respiratory failure and laboratory tests underline a light increase of leucocytes, bilirubin and LDH. The hemoglobin electrophoresis indicates high levels of HbS and of HbF. In the following hours the patient is confused: brain CT is negative. The hematologist decides to transfuse two filtered and washed packed red blood cells bags, suspecting a vaso-occlusive complication. After the transfusion, an intense chest and abdominal pain appears with vomit, hypotension, polypnea and abdominal tenderness. The laboratory tests highlight a further increase of leucocytes and bilirubin with increase of D-dimer and Troponin I. Assuming an acute abdominal disease, an ultrasonography is performed: a nasogastric tube is placed and thick bile is drained. To the echocardiogram EF is preserved, with right ventricular dilatation, PAPs= 60mmHg and paradox motion of the I.V. septum. The possible diagnosis of Pulmonary Embolism is supported by a Wells Score of 4,5. The chest CT-Angiography displays multiple defects of thromboembolic opacification. The specific treatment is started (LMWH) with graduated elastic compression of the lower limbs.

## A dry and persistent cough

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**Case Report** A 45 year old woman, smoker of about 20 cigarettes a day, is admitted to the ER for dry cough arised 2 weeks ago. The patient denies notable pathologies. To the clinical examination the vital signs are normal, reduced the vesicular murmur to the bases with some adventitious expiratory sounds to the apexes. Chest radiography underlines reticulonodular changes in the upper-lung zones and the costophrenic angles are spared; normal the laboratory tests. After chest CT, a HRCT is performed and it shows ill-defined nodules (maximum diameter 5 cm), especially to superior lobes, some of which are excavated. The patient performs a bronchoscopy too. The cytological examination of BAL underlines a inflammatory pattern with bronchial cells, macrophages and neutrophils, while the immunological analysis highligths inversion of the CD4/CD8 ratio and increase percentage of CD1a+ Langherhans cells. The diagnostic suspect directs toward a granulomatosis disease (Langherhans Cells Histiocytosis)
**Conclusions** Pulmonary Langerhans Cell Histiocytosis (PLCH) is an uncommon disorder of young adult. The relatively selective lung involve-

ment could represent a response to cigarette smoke; nevertheless it is unclear why only a small percentage of smokers have this problem. The development of PLCH following Hodgkin disease or its treatment raises the question of common etiologic factors or aberrant immune responses by dendritic cells following iatrogenic immunosuppression. However smoking cessation is recommended although the resolution of disease has rarely been documented.

## Bacterial myositis: a challenging disease with poor prognosis - personal series of 9 cases

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**Background** Bacterial myositis (BM) is a relatively rare disease, difficult to manage. Muscle involvement may come from contiguous infectious foci, penetrating trauma, vascular ischemia or haematogenous spreading. Staph. aureus, Gr.A and B-Strept., Clostridium and other gangrenous agents represent the more frequently causative agents. Gram-neg. bacteria are rarely involved (in presence of severe immunedeficiency).
**Patients & Methods** We observed 9 cases of BM in 4 years (4 F and 5 M; mean age 56.8 years-range 27-78). Ileopsoas muscle was involved in 7 cases; thigh muscles in 5; gluteus in 2, abdominal rectus and lions in 1. Isolated bacteria were: Staph. a., 5 cases; E. coli, 2 cases; Gr.A-Strept., Acinetobacter and Fusobacter, 1 case; 2 patients presented co-infection of 2 germs. Relevant comorbidity was present in 7 patients. For diagnosis we utilised: MRI in all cases, CT-scan in 8, ultrasound in 5; 7 patients underwent FNAB for culture; bacterium were isolated from blood in the remaining 2 cases. Associated arthritis (sacroileitis, spondilodiscitis, coxitis) was found in 7 patients. Antibiotics were administered for long periods; 4 patients needed surgical debridement and drainage. No mortality was registered; functional recovery was observed in 2 cases only.
**Conclusions** BM should be suspected also in patients without predisposing factors. MRI is important both in early diagnosis and follow-up; antibiotics should be utilised at high dose and long periods; *quoad valetudinem*-prognosis is almost always poor.

## Poorly-differentiated hepatocellular carcinoma without underlying liver disease presenting with recurrent fever: case-report

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**Background** Hepatocellular carcinoma (HCC) is almost always associated with chronic viral diseases (B or C) or with other-etiologies liver cirrhosis. Patients without underlying liver diseases are very rare and generally they are incidentally discovered or show symptoms such as weight loss, nausea, anemia, juandice, abdominal pain and less frequently low-grade fever.
**Case Report** A 62 years-old male was admitted because of recurrent fever (various episodes in 3 months; constant values -38°C- for 2-3 days, without other symptoms). Antibiotic treatment was uneventful; routine lab-data normal; chest x-ray negative. Partial resolution with steroids. One month before admission: increasing asthenia and anorexia. At admission: smooth hepatomegaly; ESR 54/Ih, alfafetoprotein 537.2 ng/ml; viral markers (B &C) negative. Ultrasound: hyperechogenous liver nodules, regular portal vein, no ascites. CT-scan with contrast-enhancement: 3 hypodense lesions (31, 18 and 14 mm) at I, V and VI liver segment; multiple lymph-nodes at hilum, coeliac and para-aortic sites. EGDS, colonoscopy and chest CT negatives. Echo-guided FNAB of two right hepatic lobe nodules: lobular structure preserved; neoplasm with positivity for hepatocellular antigen (poorly-differentiated hepatocellular carcinoma, grades II-IV Edmondson). The patient underwent termoablative procedures of the three nodules followed by sorafenib treatment. Seven months later, admission in ER for acute dyspnoea: occurrence of massive, fatal pulmonary embolism.

## Pulmonary tumor thrombotic microangiopathy associated with heart neoplasm: report of a fatal case

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**Background** Pulmonary Tumor Thrombotic Microangiopathy (PTTM) is a rare type of pulmonary tumor embolism with tumor-related microangiopathic lesions in small pulmonary arteries and arterioles. Its incidence at autopsy among patients with metastatic carcinoma ranges from 0.9 to 3.3%. The most frequent primary tumors are breast, stomach and lung. Tumor cells spread occurs by means of direct hematogenous metastasis or through the lymphatics, with entrance into the venous system through the thoracic duct. Typically, there is evidence of metastatic disease at the time of presentation, but cases of occult cancer manifested as PTTM have been reported.
**Case Report** A 49 years-old female was admitted because of dyspnea and thoracic pain. No relevant anamnestic data were recorded. Examination revealed ortho-tachypnea, tachycardia, hypoxemia, peripheral edema. Contrast-enhanced CT-scan showed bilateral lung multiple nodules (max 3 cm) with multiple adenopathies at hilum with partial occlusion of the pulmonary artery; presence of an intraventricular large mass starting from the muscular wall and occupying more than 50% of the lumen; metastatic nodule into the liver and multiple paraaortic lymph-nodes. During the hospital stay (8th day) the patient died because of irreversible cardiogenic shock.
**Conclusions** The present case highlights the challenges that physicians face in managing PTTM. Treatment targeting the primary tumor remains the only therapeutic option. Unfortunately, the poor performance status of most patients at the time of presentation usually precludes this treatment.

## A case of difficult management: multiple paraneoplastic syndromes with predominant severe thrombophilia in ovarian cancer

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**Background** 30-50% of patients with cancer have paraneoplastic syndromes (PNS) of varying severity and can affect various organ systems (nervous, skin and muscle, hematological, renal, endocrine).We report a unique case of multiple syndromes retrospectively correlated to later diagnosis of ovarian cancer.
**Case report** A woman of 59 aa.,obese and hypertensive,comes to our observation for 1 ° episode of deep massive vein thrombosis of the left lower limb.Subjected to heparin therapy and then to warfarin with initial clinical improvement.Anamnesis reports erythema migrans skin (erythema nodosum) by 4-5 months,and joint pain.Routine biochemical and rheumatologic examinations are normal.After 2 weeks of therapeutic warfarin dose(INR = 3) right iliofemoral DVT is detected.We

prescribe a total body CT (chest X-ray and abdomen scan are neg.) documenting expansive right ovarian lesion with related lymphonodes. It is also present right pulmonary massive embolism.Then we proceed with a full dose of enoxaparin; you can not place a vena cava filter via trans-jugular.The very severe thrombophilic syndrome leads to postpone the surgical time for the ovarian mass,continuing enoxaparin and starting chemotherapy.
**Conclusions** The diagnosis in this case was multiple SNP (erythema nodosum, polyarthritis, severe thrombophilia) in ovarian cancer misunderstood.Erythema nodosum and polyarthritis (without palmar fasciitis) appeared 5 months before the cancer diagnosis.This leads us to emphasize the importance of conducting a clinical screening for cancer in patients with symptoms correlated with PNS.

## Effects of 2 years of receptor blockade or anti-TNF antibodies therapy in patients with psoriatic arthritis

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Vascular involvement in psoriatic arthritis (PsA) has been attributed to endothelial dysfunction. TNFa exerts its function via TNF type1 and type2 receptors which depending on crosstalk each other can show pro-apoptotic or pro-survival function. We evaluated the impact of receptor blockade or anti-TNF antibodies therapy on vascular structure/function, inflammation, and disease activity of PsA.
**Methods** We studied 32 PsA who were intolerant or had inadequate response to DMAR in a open-label study of anti-TNF therapy. Mean carotid intima-media thickness (mean-IMT) and maximum IMT (MMAX) were evaluated by ultrasound. Endothelial function was evaluated by flow mediated dilation (FMD) of the brachial artery.
**Results** At enrolment 14 PsA were on steroid therapy (≤5 mg of prednisone equivalent). After starting an anti-TNF agent, only two of them continued on steroids. PsA received a receptor blockade (etanercept n=21) or an anti-TNF antibodies (adalimumab n=6, infliximab n=5) for 2 years. In both groups mean-IMT and MMAX increased similarly whereas FMD remained impaired. Throughout the study period, the DAS28, that evaluates tender and swollen joint and patient global assessment of well-being, decreased similarly in the two groups (-2.0 vs -1.5). Among blood pressure, serum lipids and circulating inflammatory markers (hs-CRP, TNFα, IL6, OPG, VEGF) no difference was observed between the two groups.
**Conclusions** The atherogenic remodelling occurring in PsA was not affected by a 2-year anti-TNFα therapy despite improvement in clinical status. No difference was observed among therapies with receptor blockade or anti-TNF antibodies.

## ✪ Chronic obstructive pulmonary disease, comorbidities and complexity of the patients: the FADOI-COMPLEXICO observational study

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**Introduction** Comorbidities affect disease management and clinical outcome in patients with Chronic Obstructive Pulmonary disease (COPD). Patients hospitalized in Internal Medicine (IM) are frequently elderly, with a great burden of comorbidity and frail. The setting of IM seems particularly adequate to evaluate the real-life burden of comorbidities in COPD, as well as the complexity of these patients.
**Methods** This is an observational, prospective study involving 44 IM Units in Italy. At least 1000 consecutive patients hospitalized for any cause with known or de novo diagnosis of COPD documented by spirometry will be included. Only patients with severe impairment of clinical or cognitive status will be excluded. The study will evaluate the percentage of COPD patients with at least three concomitant chronic diseases, and the prevalence of COPD among patients hospitalized in IM. Complexity of COPD patients will be described by means of the Multidimensional Prognostic Index (MPI). The prognostic value of MPI is considered higher than those provided by the individual parameters included in the MPI score: Activities/Instrumental Activities of Daily Living (ADL/IADL), Short-Portable Mental Status Questionnaire (SPMSQ), Mini-Nutritional Assessment (MNA), Exton-Smith Score (ESS), Comorbidity Index Rating Scale (CIRS), medications, and cohabitation status. The study is ongoing and the estimated conclusion is in September 2012. This study will offer good opportunities to learn more about the complexity of patients with COPD, and to raise the awareness of physicians on this issue.

## Efficacia del trattamento con mofetil micofenolato in due casi di pancitopenia secondaria a mielopatia autoimmune cellulo-mediata

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**Premesse e scopo dello studio** Casistica clinica di sindromi mielodisplastiche in cui viene evidenziato l'approccio fisiopatogenetico al quadro clinico biologico e la risposta clinica ottimale.
**Materiali e metodi** Studio di due pazienti con pancitopenia/anemia trasfusione-dipendente primitiva, senza rilevanti comorbidità. La biopsia osteomidollare con studio citogenetico ed immunofenotipico rivelava una sindrome mielodisplastica (rispettivamente anemia refrattaria con displasia multilineare con fibrosi midollare ed anemia refrattaria) con significativa infiltrazione di linfociti T, non clonali. Dopo terapia con eritropoietina senza risposta soddisfacente, una terapia "di seconda linea" con mofetil micofenolato (1000 mg/die) ha indotto una risposta clinica ottimale. Il paziente è stato seguito con periodici controlli emocromocitometrici, valutazione delle tossicità secondo le indicazioni "CTCAEv3.0", analisi dell'aspirato midollare e dell'IPPS score ogni 3-6 mesi, valutazione della "qualità di vita" ogni mese.
**Risultati** Il trattamento è stato efficace e ben tollerato in entrambi i pazienti. I due casi, nonostante un quadro di sindrome mielodisplastica con cariotipo normale e con fattori prognostici favorevoli, sono stati interpretati come casi di "mielopatia autoimmune a patogenesi cellulo-mediata".
**Conclusioni** L'ottima risposta clinica alla terapia con micofenolato conferma la validità di questa interpretazione diagnostica, per cui possiamo affermare la validità dell'uso di tale farmaco anche a queste seppur rare condizioni, meritevoli di ulteriore definizione diagnostica.

## Cognitive autopsy: a new tool for the analysis of diagnostic errors

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**Background** Diagnostic reasoning is a critical aspect of clinical performance and cognitive errors underlie most diagnostic errors that are made in the course of clinical decisionmaking. In order to understand the nature of error process we apply a new tool: the cognitive autopsy to the study of diagnostic errors.
**Methods** We retrospectively selected cases of diagnostic errors occurred in our emergency department in the last two years. For each case we revised all the clinical documentation and we interviewed the physicians involved. We apply the cognitive autopsy to the study of four diagnostic errors: a) pulmonary embolism diagnosed as pneumonia; b) missed fracture of C2; c) chest pain with a delayed diagnosis of mediastinal neoplasia; d) rupture of an abdominal aortic aneurysm diagnosed as cobp exacerbation. The cognitive autopsy is a reflective approach to problem solving that involves stepping back from the immediate problem to examine and reflect on the thinking process that lead to the fallacy. With this methodology the heuristic shortcuts of the clinical reasoning are investigated and cognitive errors are disclosed.
**Results** We found 12 heuristic-cognitive errors (3 error/case), the most commons were: availability error, framing effect, premature closure, confirmation, anchoring, search satisfaction and representativeness. Premature closure was the single most common cause.
**Conclusion** An alternative approach to diagnostic error analysis is to perform a cognitive autopsy trying to understand what was wrong with our reasoning. Becoming aware of common cognitive errors might lead to sustained improvement in patients care.

## Low molecular heparin and early discharge in the treatment of pulmonary embolism

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**Background** Low molecular weight heparin (LMWH) is a relatively new treatment for pulmonary embolism (PE).
**Methods** We retrospectively evaluated the records of 57 patients with acute PE. Analysis involved demographic characteristics, severity of symptoms, diagnostic methods, echocardiography data, ECG signs, presence of deep vein thrombosis (DVT), outcome, 30 days follow-up.
**Results** From 1-1-2008 to 31-12-2010 57 patients were admitted to our department for PE. 43 female 75% and 14 man 25%, the average age was 75 years; the most frequent presentation symptom was dyspnea (82%), whereas syncope was present in 12%. On admission 7% had hypotension; 19% had severe tachycardia; 23% had hypoxia; 21% had dilatation of the right ventricle, 23 pts. had DVT 40,3%. In 11 pts. 19,3% the PE was idiopathic, in 46 was secondary 80,7%. In 45 cases 79% the diagnosis was made with spiral chest computed tomography pulmonary angiography (CTPA), in 12, 21% ventilation perfusion lung scan was performed. All pts. received LMWH, in 3 cases inotropes were used to reach hemodynamic stability. Two (4%) patients died, and we had 3 (5%) major hemorragic complications. 79% of the pts. were discarged with oral anticoagulation. The mean length of hospital stay was 6,4 days (1 to 14), 70% of pts were dismissed after 6 days. At 30-days follow-up we observed 2 (4%) re-admission for respiratory problems.
**Conclusions** In our experience, according to the most recent international literature, treatment of PE with LMWH was safe and effective. Early discarge was possible in the 70% of cases with a low rate (4%) of re-admission.

## The CVC Team: the answer to the problem of venous access

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**Background** The procedure of isolating a CV line, that once was restricted to the anesthesists, has now become, especially thanks to the Ultrasounds, a procedure well known and handled by the internist as well.We present the results of a year of practice of our CVC team created by the department of Medicine of our hospital.
**Methods** In 2010 we established a team that could be called upon when a cv line was needed. This team initially was formed by doctors who already had a great expertise in the procedure: they decided to set up a common protocol and organize training courses necessary to teach the US-guided cv line start technique so that it could be of common use for other doctors. Computerized request form was introduced so that the entire hospital could ask for consultancy for the placement of a cv line. Our medicine department has now reached his own autonomy for the placement and management of a cv line.
**Results** From the 1st of January 2011 to the 31st of Dicember 2011 78 cvc were placed; 60 of them in internal jugular vein, 18 in the common femoral vein. In 54% of the cases the request was made for lack of peripheral vein, 43.5% for a condition of septic or ipovolemic shock, 2.5% for patients in need of emodynamic monitoring. The time elapsed from the request to the cv line placement was on average not more than 3.5 hours. No complication occurred, except one cv line displacement that required substitution.
**Conclusions** We can say that the CVC team, in our reality , is an effective end efficient choice, and the us- guided cv line start is easy and safe.

## Nephrotic syndrome, prolonged bleeding time and factor XIII deficiency associated with parvovirus B19 infection in an adult woman

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Acute post-infectious glomerulopaties due to parvovirus B19 (PB19) are described in anecdotal reports. Laboratory studies indicate coagulation factor XIII (FXIII) as a mediator of glomerular immune diseases. This is the first description in the literature of reduction of FXIII level and prolonged bleeding time associated with nephrotic syndrome due to PB19.
Our patient had no significant clinical history and recent normal lab exams. In May 2011 she had aspecific viral infection symptoms. In June she developed edema, vomiting, headache and oliguria. At hospital admission she had an anasarcatic state (weight gain of 16 kg) and hypertension (160/90 mmHg). Lab tests showed hyporegenerative anemia (Hb 8.9 g/dL), acute renal failure (CrCl<50 mL/min), signs of immune complex disease (low C3 and C4) and glomerular damage (proteinuria 3.2 g/day, hypoalbuminemia 2.8 g/dL, microhematuria). Diagnosis of aplastic anemia and nephrotic syndrome was made: the suspect of acute PB19 infection was confirmed by specific IgM and

PCR+. A renal biopsy was programmed, but a prolonged bleeding time (14') and FXIII deficiency (61% activity) contraindicated it. The bleeding time remained high during hospitalization and the biopsy was avoided. All other haemostatic tests were normal.
The patient was treated with furosemide, albumin, steroids, pantoprazol and dopamine. A therapy with steroids, diuretics and antihypertensive agent was prescribed at the discharge. All the abnormalities, including blood pressure, Hb, proteinuria, renal function, bleeding time (7') and FXIII (104%) normalized within weeks.

### A case of pernicious anemia with rare encephalic RMN findings

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Subacute combined degeneration, a diffuse demyelinization of spinal cord involving posterior and lateral columns, presenting with distal symmetric paresthesias, ataxia, progressive spastic paresis, loss of pallesthesia and sense of position, is typical of vitamin B12 deficiency together with peripheral neuropathy and neuropsychiatric alteration. Simmetric hyperintense signal in posterior and later columns in cervico-thoracic segments on T2-weighted RMN are common, while cranial RMN findings are rarely reported.
**Case**: male, 35, Chinese, is admitted to our department complaining of subrecent distal lower limb paresthesiae and gait impairment rapidly proceeding to bedridden status, sudden urinary dysfunction. On admittance he showed severe ataxia, lower and upper limb symmetric hyperreflexia, bilateral lower limb hypostenia and clonus, bilateral reduced sense of vibration and position. Blood samples showed macrocytic anemia with B12 deficiency. Hystologic examination of gastric biopsy and positive search for antimucosal antibodies were diagnostic for pernicious anemia. EMG suggested a spinal origin for neurologic deficiencies. We found no hyperintense signal alteration on spinal cord in RMN, while cranial RMN showed bilateral and simmetic sovratentorial and cerebellar white matter-limited hyperintensity. Exhaustive search for other possible causes were negative. Signs and symptoms rapidly and progressively improved with parenteral cobalamin supplementation. By 1 month follow up he could walk steadily. Cranial RMN showed reduction of hyperintense signal.

### ✪ Real life single center experience with "FCR lite" in the treatment of chronic lymphocytic leukemia (CLL): role of Comprehensive Geriatric Assessment (CGA)

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Combination of decreased fludarabine and cyclophosphamide with rituximab (FCR "lite") is highly effective and safe in elderly CLL-patients (pts). Comprehensive geriatric assessment (CGA) is a scoring system for the treatment choice in geriatric pts. We treated seven male CLL patients (median age 74y; range 69-78) with FCR-lite between 2010 and 2011. CGA group was 1 in 5 cases and 2 in 2 pts. Treatment was initiated following NCI-ICLLWG guidelines. Only two patients had undergone a previous course (R-CVP), both obtaining a partial remission (PR). Number of FCR-lite cycles were 4 in four pts, 5 in one pt, 6 in one pt; one pt discontinued therapy after one cycle due to prolonged asymptomatic neutropenia. All pts obtained a PR according to the NCI-ICLLWG criteria. Non-hematological complications comprised: acute COPD exacerbation in one pt, mucositis in one pt, FUO in 2 pts, lack of glycemic control in DM and prostatitis in one pt. Principal hematological toxicity was neutropenia (6/7 pts, grade≥3 in 5 cases) with one case of febrile neutropenia, while thrombocytopenia was milder and mild anemia occurred in 3 cases. Both hematological and non-hematological complications resolved without sequelae. All patients are still in follow up (median 6 months, range 1-13) and off-therapy. Our experience confirms FCR-lite as a safe and successful option for CLL treatment in elderly pts, and CGA as a useful tool for a patient-centered therapy.

### Idiopathic thrombocytopenic purpura (ITP) in pregnancy: a wide range of clinical presentations in a single-center cohort

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Management of ITP in pregnancy is still complex and requires collaboration among different professionals. According to the most recent guidelines intervention is needed in 31% of pregnant women with diagnosis of ITP.
Six ITPs in pregnancy were followed at our center: in 3 patients (pts) diagnosis was made in pregnancy, while three forms were preexisting (two of which on therapy with corticosteroids). Average time for diagnosis was 19th week of pregnancy (range 6-35); three pts were at their second pregnancy (one exited in early abortion). Mean platelet count was 103 x 10^9/L. Cutaneous bleeding was present in one case.
Two pts (who were at second trimester of pregnancy) were treated with methylprednisolone at standard dose (1mg/kg/dd): one pt showed no response, and after a high dose dexamethasone course still without response, was treated with rituximab; platelet count increased, but pregnancy exited in abortion after five weeks from diagnosis.
The other pt showed initial response, and her pregnancy is currently in follow up.
The two patients already on treatment continued corticosteroids but both had an early abortion (7th and 10th week). Two pts didn't require therapy: one delivered without complication, one is still monitored at week 35, with a regular pregnancy so far.
Our experience comfirms the severity of ITP in pregnancy and the need of a early and careful management to decrease risks for patients and infants.

### Gastrite autoimmune ed anemia sideropenica

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**Introduzione** La gastrite cronica autoimmune (GAI) è caratterizzata da atrofia della mucosa del corpo e fondo gastrico e dalla presenza di anticorpi anticellule parietali e anti fattore intrinseco. La GAI non solo è responsabile della nota anemia perniciosa più evidente nelle fasi tardive, ma anche del 20-30% delle anemie sideropeniche resistenti alla terapia orale e non dovute a perdita. L' acloridria infatti ostacola il rilascio del ferro dalle proteine, la sua riduzione a ione ferroso e il suo assorbimento . Noi proponiamo un caso di GAI con anemia sideropenica.
**Caso clinico** Donna, 36 anni; dispepsia e astenia; da 10 anni anemia resistente a terapia marziale per os . GR 3.830.000/mm3; Hb 9,1 g/dl; MCV 65,4; sideremia 15mcg/dl; ferritina 4,3 ng/ml; Vit B12 112 pg/ml; gastrinemia >1000pg/ml; sierologia per celiachia negativa; anticorpi anticellule parietali 1/160; SOF=0. Gastroscopia: atrofia corpo e fondo gastrico. Istol: gastrite atrofica e metaplasia intestinale; iperplasia lineare e nodulare cellule neuroendocrine; Helicobacter pilori (HP)

positivo. Terapia: eradicazione di HP e periodiche infusioni di ferro gluconato.
**Conclusioni** La GAI deve essere tenuta presente fra le cause di anemia sideropenica resistente alla terapia orale; nelle giovani donne, a causa delle perdite mestruali, l'anemia sideropenica può rendersi manifesta precocemente e precedere di molti anni l'anemia perniciosa; a differenza di quanto riportato da altri autori, nel nostro caso l'eradicazione dell'HP non ha ridotto la refrattarietà dell'anemia alla somministrazione orale di ferro.

## Il morbo di Basedow è una nuova, importante causa di recidiva della infezione da Helicobacter pylori

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**Introduzione** La infezione da Helicobacter pylori (Hp) è diffusa globalmente coinvolgendo circa il 50% della popolazione mondiale. In molti studi il tasso di recidiva della infezione è intorno al 3% annuo nei paesi industrializzati. Lo scopo del nostro lavoro è stato di studiare se il M. di Basedow influiva sulla quota di recidive da Hp dopo un adeguato trattamento farmacologico di eradicazione.
**Materiali e Metodi** La positività dell'Hp venive studiata su campione di feci fresche con immunotest (IDEIA Hp StAR, DakoCytomation). In un gruppo di pazienti ipertiroidei con M. di Basedow alla prima diagnosi veniva eseguita la classica terapia di eradicazione con amoxicillina 1 gr, claritromicina 0,5 gr e esomeprazolo 20 mg per due somministrazioni quotidiane per sette giorni. Dopo cinque settimane si controllava la effettiva eradicazione ripetendo il test sulle feci. Quindi sono stati selezionati 30 basedowiani Hp eradicati (eta' 39±4.0 anni) e 30 corrispettivi soggetti sani Hp eradicati (41±3.2 anni). Dopo dodici mesi venivano ritestati per la presenza di Hp nelle feci i pazienti basedowiani, ora eutiroidei, durante trattamento a dosi variabili con metimazolo ed i rispettivi controlli sani. I risultati ottenuti venivano messi a confronto con metodi statistici (Test di Fisher).
**Risultati** Tra i pazienti basedowiani ben 16 su 30 risultavano nuovamente infetti, al contrario tra i controli sani solo 6 su 30 (P=<0,01, odds ratio 5,23).
**Conclusioni** Il MB è una nuova ed importante causa di recidiva della infezione da Hp e le indagini endoscopiche come la gastroscopia dovrebbero essere inserite nello screening routinario di questi pazienti.

## Anemia emolitica in corso di polmonite da Mycoplasma pn.

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**Caso clinico** Paziente di 48 anni,non patologie internistiche di rilievo,giunge alla nostra osservazione per febbre,dispnea,astenia.In terapia antibiotica,amoxicillina/clavulanato prima e Ciprofloxacina poi con scarso beneficio,da 8 giorni per addensamento polmonare dx. Inizia in reparto trattamento con Macrolide e Cefalosporina.In III giornata comparsa di anemia emolitica grave associata a leucocitosi importante e lieve piastrinosi.Lo striscio periferico è risultato negativo per forme immature ma ha evidenziato crioprecipitati. E' stata riscontrata positività per Ab IgM antiMycoplasma Pneumonie e sono risultati positive le crioagglutinine.
Alla terapia antibiotica è stata quindi associata terapia steroidea con progressivo miglioramento clinico , rapido incremento dei valori di emoglobina, riduzione della leucocitosi e regressione degli indici di emolisi. La radiografia di controllo ha dimostrato completa risoluzione dell'addensamento polmonare dx.
**Conclusioni** In corso di infezione da Mycoplasma la formazione di agglutinine fredde, anticorpi IgM diretti contro l'antigene I dei globuli rossi, è presente nel 50-75% dei casi pediatrici ma l'incidenza decresce con l"età ed è quindi molto meno frequente il suo riscontro nel paziente adulto.

## La mielodisplasia: una diagnosi spesso fatta in ritardo

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**Introduzione** Le sindromi mielodisplastiche sono definite un gruppo eterogeneo di disordini clonali del midollo osseo caratterizzati da emopoiesi inefficace di tipo displastico e da un rischio variabile di trasformazione leucemica. L'incidenza varia fra 3 e 12 casi/100000 annui.
**Caso clinico** Donna di 81 aa, anemia da circa 10 aa; ripetuti ricoveri in Medicina, trattata con folati e vit.B. Negli ultimi mesi non responsività alla terapia. Presenta Psoriasi e poliartralgie. All'atto del ricovero: Hb 8.3%, Hct 24.7%, GR 2.810.000; MCV 113.0, MCH 38.1, RDW 29.7, VES 75, Sideremia 151, Ferritina 822, Panel reumatologico negativo. Eco addome: steatosi epatica , milza nella norma. Il quadro ematologico non migliora pur aggiungendo eritropoietina 4.000 UI la settimana. Viene sottoposta ad aspirato midollare che evidenzia quadro istologico compatibile con sindrome mielodisplastica del tipo anemia refrattaria; Citogenetica: non alterazioni numeriche e strutturali dei cromosomi. Dimessa con terapia a base di Eritropoietina 40.000 UI la settimana.
**Discussione** Tale patologia è determinata da emopoiesi inefficace dell'eritrone fino al blocco maturativo completo delle cellule ematopoietiche staminali e di quelle più differenziate, con conseguente proliferazione leucemica.
**Conclusioni** Nell'anziano con anemia, sopratutto macrocitica, la mielodisplasia va sempre sospettata. Un dato epidemiologico sicuro è l'aumento di incidenza correlato all'età, il che fa delle mielodisplasie un problema essenzialmente geriatrico.

## Ipertensione arteriosa resistente ed edemi generalizzati: un caso di carcinoma surrenalico secernente

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Riportiamo il caso di un uomo di 46 anni ricoveratosi per comparsa da 3 mesi di dispnea da sforzo ed edema del tronco, del volto e degli arti inferiori.
**Anamnesi** Familiarità per ipertensione arteriosa; da 2 anni ipertensione arteriosa prevalentemente diastolica in terapia con sartanico con scarso controllo dei valori.
**Decorso** All'ingresso PA 150/95 mmHg, facies lunaris, gibbo di bufalo, edemi improntabili fino al ginocchio bilateralmente. All'ECG RS, PR e QRS nei limiti, onda U. Agli esami ipokaliemia (2,3 mEq/L), alterata glicemia a digiuno; funzionalita' epatica e renale, NT-proBNP e TSH nei limiti.Aumento del cortisolo libero urinario(9.248 nmol/24h) con ACTH ridotto. Alla TC torace-addome con MDC massa surrenalica destra disomogenea a margini irregolari (12x10x10cm) e nodularita' polmonari verosimilmente ripetitive. E' stato corretto lo squilibrio elettro-

litico, potenziata la terapia antipertensiva, intrapresa terapia diuretica con risparmiatori di potassio. Il paziente è stato sottoposto ad intervento di surrenectomia e nefrectomia destra.In seguito regressione degli edemi e miglior controllo pressorio.
**Discussione** Nonostante le ipertensioni secondarie endocrine siano rare (<5% dei casi di ipertensione arteriosa) è opportuno ricercarle specie nei soggetti giovani ipertesi anche in presenza di familiarità perché questo può incidere sull'iter terapeutico e sulla prognosi. Il carcinoma surrenalico è per una malattia rara (0.5-2 casi/milione/anno) nel 30-60% dei casi non secernente; nel 75% dei casi viene diagnosticato allo stadio III-IV di malattia.

## Un esame citologico negativo ci fa stare tranquilli di fronte ad un versamento pleurico monolaterale?

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Un uomo di 74 anni si ricovera per dispnea ingravescente e versamento pleurico monolaterale.
**Anamnesi** Ex-fumatore.Ipertensione arteriosa. 2 anni prima polipectomia endoscopica con follow-up negativo. 2 settimane prima tosse non produttiva risolta con ciprofloxacina; poi dispnea da sforzo ingravescente, non altri sintomi; ecocardiogramma nei limiti, ma versamento pleurico sinistro.
**Decorso** All'ingresso paziente eupnoico(SpO2 95%) apiretico.All'RX torace versamento pleurico con addensamento adiacente. Alla toracentesi: essudato, ricco di linfociti; esame citologico,microscopico e colturale per germi comuni e BK negativi. Alla TC torace conMDC addensamenti parenchimali alveolari nel lobo superiore ed inferiore sinistro con scarsa impregnazione, non linfoadenopatie. Esame colturale e citologico su BAL negativi. Agli esami lieve rialzo degli indici di flogosi,non leucocitosi, sierologia ed Ag urinari negativi, BNP nei limiti;quantiferon positivo; PCR per BK positiva nelle urine. Mediante terapia antibiotica ad ampio spettro e terapia antitubercolare parziale risoluzione degli addensamenti ma recidiva del versamento pleurico omosede. Eseguita pleuroscopia con citologico negativo; alle biopsie pleuriche diagnosi di mesotelioma epiteliomorfo.
**Discussione** L'esame citologico su liquido pleurico è diagnostico solo nel 60% dei versamenti neoplastici, rilevare più campioni non aumenta l'accuratezza diagnostica. Il mesotelioma pleurico rappresenta l'80% dei casi di mesotelioma, solo in alcuni sottotipi si associa a versamento pleurico e nel 38% dei casi l'esame citologico è negativo.

## Una donna di poco polso

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Riportiamo il caso di una donna rumena di 42 aa ricoveratasi per vertigine soggettiva ed elevati valori pressori.
**Anamnesi** Ipertensione arteriosa non in terapia.Fenomeno di Raynaud.
**Decorso** All'ingresso asimmetria pressoria(230/120-130/80mmHg)e dei polsi periferici degli arti superiori;soffi carotidei,femorali e renali bilaterali;soffio proto-mesosistolico2/6 aortico.
Non claudicatio.E.O.neurologico nella norma. All'ecocardiogramma FE conservata, lieve steno-insufficienza mitro-aortica. All'angioTC ispessimento iperecogeno miointimale con apposizioni trombotiche a carico dei vasi di grosso e medio calibro(aorta,tronchi epiaortici,vasi viscerali,arterie renali), stenosi critica II tratto di IVA e CX. Rialzo degli indici aspecifici di flogosi,quantiferon e FR negativo, non rialzo dei markers di miocitolisi.Erano presenti i criteri necessari per la diagnosi di Arterite di Takayasu. Eseguita terapia con metilprednisolone ev con normalizzazione degli indici di flogosi e dimostrazione ecografica di iniziale regressione di malattia.
**Discussione** L'Arterite di Takayasu è una rara vasculite stenosante coinvolgente l'arco aortico e le sue diramazioni;predilige il sesso femminile in giovane età. La diagnosi si basa su criteri clinici(American College of Reumatology 1990) e studio imaging(angiografia,angio-TC,RMN). L'angio-TC consente di valutare spessore,alterazioni della parete arteriosa e presenza di trombi endoluminali. Il trattamento di rivascolarizzazione è da riservare alla fase di inattività di malattia e a pazienti con sintomatologia disabilitante o pericolosa *quod vitam*.

## Doppler nella diagnosi di una ipertensione severa

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**Premessa** Le ipertensioni severe in soggetti giovani richiedono sempre la valutazione per lo screening delle forme secondarie.
**Caso clinico** Un uomo di 28 anni veniva ricoverato presso il nostro reparto di Medicina Interna per una severa ipertensione e cefalea. Il primo riscontro di ipertensione risaliva all'età di 21 anni quando fu prescritta una terapia con ACEi, poi modificata con Calcio antagonisti. L'esame clinico mostrava un soffio rude in mesogastrio; polsi radiali normosfigmici e iposfigmici i polsi femorali. La PA era di 180/100 mmHg in entrambi gli arti superiori e 105/60 mmHg agli arti inferiori. L'ecocardio evidenziava una ipertrofia di tipo concentrico con una buona funzione contrattile. L'istmo aortico non era ben visualizzabile. Il doppler dell'aorta addominale e dei vasi renali mostrava un flusso demodulato con una elevata pressione diastolica negli stessi vasi. Veniva posto il sospetto di una coartazione aortica, confermato con esame angio/TC che evidenziava una stenosi distalmente all'orgine della succlavia di sinistra. Il paziente venne quindi trasferito in un reparto di cardiochirurgia dove la coronarografia confermò la presenza di una stenosi aortica serrata trattata con perforazione con radiofrequenze e impianto di stent.
**Conclusioni** La coartazione aortica è uno rara cardiopatia congenita. Nei soggetti adulti la diagnosi deve essere sospettata in presenza di ipertensione severa e ridotto polso agli arti inferiori. La dilatazione del tratto stenotico è necessaria perché la prognosi è fortemente condizionata dalle conseguenza dell'ipertensione.

## Schmidt's syndrome and hyposplenism: a clinic case

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A 45 year-old patient suffering from recurrent bronchitis, *type 1 diabetes, vitiligo, autoimmune thyroiditis*. At least from ten years the patient shows leukocytosis with neutrophilia, eosinophilia, monocytosis and basophilia, iron deficiency anemia in the absence of hypermenorrhea and gastrointestinal bleeding, and thrombocytosis. No evidence of macroscopic changes of the stomach by endoscopy but by histological examination framework of autoimmune gastritis and in duodenum increasing intraepithelial lymphocytes as lesion of type 1 or infiltrative in according to Marsh. In peripheral blood smears is observed the presence of anisopoichilocitosi, target cell and Howell-Jolly bodies, rare schistocytes, no immature cells of granulocytic series and mild thrombocytosis. At abdominal ultrasound presence of spleen at the lo-

wer limits in the absence of adenomegalie. Were carried out in order to investigate the alterations of blood cell count, haematological exams of second level that let we rule out the presence of chronic myeloproliferative disease. Were carried out investigations for the research of autoimmunity with the finding of positivity of APCA, Ab anti-adrenal glande while negative were finded all other autoantibody.
In conclusion our patient is afflicted by autoimmune polyglandular syndrome, type Schmidt's syndrome, for presence of autoimmune thyroiditis, diabetes mellitus, vitiligo, autoimmune enteropathy, positivity of antibodis against adrenal glande with associated red and white bloods cells alterations related to hyposplenic states.

## A strange case of vasculitis or a trivial allergic reaction?

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A 75 year-old patient affected by diabetes mellitus type 2, hypertension, seasonal allergic rhinitis, nasal polyposis, previous atypical pulmonary resection five years ago with istological framework of granulomatous inflammation with tissue eosinophilia has come to our attention for the appearance of significant eosinophilia, persistent fever, increase in inflammatory markers and bone pain. Were performed radiological, serological and culture tests of blood, feces and urine that revealed no evidence of infective, parasitic and/or neoplastic diesease. At a subsequent anamnestic investigation emerged an increasing of eosinophils that was persisting for two months from taking bactrim that had caused a minor skin reaction. For the persistence of systemic symptoms and laboratory abnormalities was performed BOM, bone marrow aspirate, cytogenetic and molecular biology of bone marrow without evidence of hematologic disease. In examinations of autoimmune emerged a positive p-ANCA and in pulmonary function tests a mild obstructive ventilatory defect. At home, the patient, has taken steroid therapy on the advice of the doctor for new reaction to bactrim with rapid disappearance of systemic symptoms and reduction of peripheral eosinophilia. Based on the data collected we hypothesized that the patient may be suffering from Churg-Strauss syndrome or allergic granulomatous angioitis, a rare disease (incidence of 1 per million year) with variable course characterized by asthma, peripheral eosinophilia, formation of extravascular granulomas, neuropathy and vasculitis of multiple organs.

## L'Internista nei reparti chirurgici: in cammino verso la medicina perioperatoria

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**Premesse** Dal Gennaio 2011 un consulente Internista è stato dedicato ai reparti chirurgici (ortopedia, chirurgia generale e vascolare) dell'Ospedale di La Spezia.
L'Internista effettua consulenze programmate 2 giorni/settimana. Negli altri giorni è disponibile su chiamata per urgenze.
La valutazione internistica prevede la possibile presa in carico di pazienti particolarmente complessi da trasferire in letti dedicati alla Medicina perioperatoria.
Si propone un'analisi dei risultati dopo un anno di attività.
**Risultati** Sono state effettuate 151 consulenze di cui 40(=26.5%) in Chirurgia generale/vascolare e 111 (=73.5%) in ortopedia.
L'età media dei pazienti è di 79,7 anni.
Il 16.5% dei pazienti valutati è stato trasferito nei letti di Medicina perioperatoria. Di questi, il 68% proveniva dalla chirurgia ed il restante 32% dall'ortopedia.
Le principali cause di trasferimento sono state: dispnea (45.8%), emorragie (16.6%), insufficienza renale acuta (8.3%).
La richiesta di consulenze è progressivamente cresciuta nell'arco dell'anno, nel 3° quadrimestre infatti è stato effettuato il 49% delle consulenze ed il 64% dei trasferimenti dell'anno.
**Conclusioni** Nei reparti ortopedici prevale la necessità di interventi per complicanze acute pre/post-chirurgiche, nelle chirurgie prevale la necessità di trasferimento per approfondimenti diagnostici o prosecuzione dell'iter terapeutico.
La presenza dell'internista nei reparti chirurgici è richiesta con sempre maggior frequenza per risolvere acuzie, ridurre durata della degenza, affrontare comorbidità mediche con visione olistica.

## Epatite B acuta e panarterite nodosa: una rara ma pericolosa associazione

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**Premesse** PAN è una vasculite necrotizzante delle arterie di medio e piccolo calibro legata ad HBV. In questa eziologia la sola terapia immunosoppressiva aumenta le morti per insufficienza epatica.
**Caso clinico** Uomo di 47 anni, con stile di vita a rischio, febbre, edemi, petecchie e dolore all'arto inferiore dx
**Profilo di laboratorio** Ipertransaminasemia, leucocitosi neutrofila, aumento PCR e sierologia virus B compatibile con epatite B acuta.
Il decorso ospedaliero si complicava per il peggioramento del dolore e del quadro neurologico con impotenza funzionale a carico dell'arto inferiore destro, andatura steppante ed ipoestesie.
L'elettromiografia evidenziava danno assonale acuto. La biopsia del nervo surale orientava per vasculite.
La diagnosi di PAN da HBV si fondava sulla compatibilità di tutti i dati clinico-laboratoristici virologici, strumentali ed istologici.
Alla terapia con prednisone ev, entecavir e cicli di aferesi è seguito un progressivo miglioramento della funzione motoria con recupero della deambulazione autonoma.
**Conclusioni** E' possibile che il nostro approccio terapeutico, inibendo la replicazione virale, abbia ridotto il rischio d'insufficienza epatica e favorito il rapido recupero della funzione motoria/deambulatoria.

## Abdominal aneurysm: an uncommon presentation

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**Premesse e scopo dello studio** Abdominal aortic aneurysm is a serious disease burdened with heavy mortality (50%) when submitted to surgical repair in emergency.Unfortunately, aneurysms are often asymptomatic unless rapid expansion or complications and are mainly detected on routine abdominal U.S.scan.
**Materiali e Metodi** The patient observed was a 77 y.o.male suffering from obesity , arterial hypertension and bilateral policystic kidney.He was admitted for worsened kidney function and huge bilateral oedema of the legs started a few days before. Neither signs or symptom of shock nor abdominal or back pain were present. The blood specimens were normal beside BUN and Creatinine elevation. ECG, lower limb venous doppler sound scan and chest xRay were normal.
**Risultati** The abdominal U,S, Scan revealed a large ( 10 x 10 x 16 cm lenght) aortic aneurysm with thick mural trombus; renal arteries were

involved. The lateral surface of the lesion showed signs of rupture which required emergency operation.
**Conclusioni** The surgeon confirmed the diagnosis with a CTscan and the operation revealed e spontaneus rupture of the aneurysm forming an arteriovenous fistula to inferior cava vein which gave rise to obstruction of blood stream in lower limb veins. The clinical outcome after the surgery was excellent.

## La biopsia osteomidollare in Medicina Interna

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La biopsia osteomidollare è un'indagine fondamentale per la diagnosi , per la stadiazione e per il controllo della risposta al trattamento nelle patologie ematologiche.
Nell'ambito dei pazienti ricoverati in un reparto di Medicina Interna è una metodica di semplice utilizzo in mani esperte, priva fondamentalmente di rischi per il paziente e molto importante per approfondire cause di anemie e/o di altre citopenie.
Riportiamo la nostra esperienza ed i dati in merito: nel 2011 abbiamo sottoposto ad indagine bioptica 42 pazienti , di cui 22 in regime di valutazione ambulatoriale e 20 in regime di ricovero in reparto, con un'età variabile da 90 a 46( età media 68.7 ).
L'indicazione più frequente nei pazienti ricoverati è stata di citopenia con diagnosi di MDS in 7 pazienti,mieloma in 3, malattia mieloproliferativa in 2 , linfoma in 4, leucemia acuta in 1, plasmocitosi reattiva in 4 ( connettivite e eosinofilia di Churg Strauss ) e amiloidosi in 1 paziente.
Nei pazienti ambulatoriali invece l'indicazione più frequente è stata di patologia linfoproliferativa o mieloproliferativa.
L'anemia e le citopenie in genere sono dati abbastanza comuni nei pazienti internistici, rappresentando una causa di morbidità, con impatto sulla qualità della vita.; la biopsia ossea rappresenta la metodica ideale per spiegarne l'eziologia e per escludere patologie ematologiche con necessità di approcci terapeutici diversificati.

## Uno strano caso di sanguinamento intestinale: metastasi da carcinoma renale

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**Caso** Donna 65 anni, monorene per nefrectomia sinistra 17 anni fa per eteroplasia renale, viene ammessa nel nostro reparto per comparsa da alcuni mesi di anemia e astenia. Gli esami di laboratorio depongono per un'anemia da perdita, con successivo rilievo di neoformazione polipoide duodenale inducente substenosi del lume duodenale, compatibile con neoplasia tipo GIST.
Per persistenza di sanguinamento e dolore addominale, la paziente è stata sottoposta a resezione gastroduodenale. L'istologia del pezzo operatorio è risultata positiva per metastasi da carcinoma a cellule renali. Segnalato un nodulo pancreatico, non presente alla TC perioperatoria, di dubbia natura.
**Conclusioni** In letteratura si riconoscono solo 2% di casi autoptici di metastasi duodenali da carcinoma a cellule renali, a sede bulbare o periampollare. Si manifestano nella loro rarità con sanguinamenti gastrointestinali.
La maggior parte avvengono per contiguità con neoplasie a carico del rene destro, circa un anno dopo la diagnosi; insorgono in concomitanza di metastasi pancreatiche e appaiono spesso con caratteristiche e clinica assimilabile a tumori tipo GIST.

## Melanoma maligno: un'atipica localizzazione

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Il tratto intestinale è sede primitiva atipica di melanoma maligno. Origina da melanociti della mucosa intestinale o da cellule provenienti dalla cresta neurale del sistema APUD. Solo rari casi si conoscono in letteratura, raramente diagnosticati prima del decesso, dovuto ad emorragia massiva. La prognosi è pessima.
**Caso** Uomo, 61, si ricovera per infarto miocardico acuto, trattato con angioplastica e stenting. Durante il ricovero episodio di melena, in corso di duplice terapia antiaggregante, con rilievo endoscopico di ulcera duodenale attiva a sede bulbare, trattata con PPI. In anamnesi abuso di FANS per cefalea cronica, tutt'ora presente. Per la persistenza di cefalea e di un episodio di disfasia transitoria, è stata effettuata RMN cranio, con evidenza di lesione espansiva in fossa cranica posteriore a sede vermiana, determinante effetto massa, sottoposta a escissione chirurgica. L'esame istologico ha posto diagnosi di metastasi da melanoma. La valutazione dermatologica ha escluso la presenza di lesioni primitive cutanee o mucose; negativa anche la valutazione oftalmologica. Per recidiva di sanguinamento massivo da ulcera duodenale attiva, indicata embolizzazione di arteria gastroepiploica. Alla Tc addome, preliminare alla procedura, presenza di tumefazione polilobata delle pareti duodenali associata a voluminosa e disomogenea massa inglobante e ostruente le anse ileali. Eseguita asportazione chirurgica della massa: l'esame istologico è risultato positivo per melanoma maligno intestinale. Il paziente è deceduto pochi giorni dopo l'intervento.

## Sentinel events: a much-needed renewed interest

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A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response. The occurrence of a single case is enough to temporarily close a ward and start an investigation to determine whether avoidable and reducing factors have contributed and activate appropriate measures. Surveillance of these events, already consolidated in other countries, represents an important health action and a required tool to prevent risks and to promote patient's wellness. In the present study an year of activity of our Department (Dipartimento del cuore e dei vasi – Azienda Ospedaliero Univeristaria Careggi – Firenze) was reviewed and an analysis of the improvement derived from the actions taken was performed demonstrating the efficacy of this model.

## Clinical risk: to err is human?

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Medical error and his prevention problems began to be dealt with much later than other high-risk environments like transport or energy. A first step was the publication of "To err is human" report by the American

Institute of Medicine back in 2000, where a 53% of preventable mortal medical errors were consequences of the so-called "malpractice". Medical errors are often the final results of a multi-step process where many different factors, working together to diagnose and to treat, lead to an adverse event, i.e. damage to patient's health, preventing or delaying his health recover. Every 8 million people admitted in hospital wards, 320 thousand of them are discharged with damages or sicknesses due to a medical error. For the same reason, 30-35 thousand patients die, corresponding to a 5.5% of total deaths in 2000. Administration errors (wrong drug, dose or route of administration) are easily prevented (28-56% of possible prevented errors).
Prescription errors may be reduced by a careful and properly written prescription, too. To prevent as many errors as possible, we have to seek a balance between attention paid to patients and to hospital resources. It's also important to understand, both doctors and patients, medicine isn't an exact science, neither in diagnosis nor in therapy, and uses statistical and case studies to improve. That means there always will be a minimal risk in every medical procedure.

## Low doses of modified-release prednisone as first line treatment in five patients affected by polymyalgia rheumatica

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**Background** Polymyalgia rheumatica (PR) is a systemic inflammatory syndrome characterized by pain and sometimes stiffness, usually interesting neck, shoulders, and hips. The pain can have a sudden onset, or can occur gradually over a longer period.
**Objective** Side effects due to high doses of prednisone are frequent, especially on the long course, and for such reason the lower efficacious dose is the best to administer. We evaluated the efficacy of a therapy based on the use of 10mg daily of modified release prednisone (MRP) (Lodotra®, Mundipharma) in patients affected by PR.
**Materials and methods** Five patients, affected by PR (table 1), naïve to steroids, were administered with MRP, 10mg daily, for a period of 6 months and received a visit and a laboratory testing every 2 months.
**Results** All patients demonstrated a complete clinical and laboratory response to the therapy with MRP (Table 2). Followup reached 6 months now. None of patients developed any side effects due to therapy, none of them reported increase of blood glucose, hypertension, glaucoma, fractures.
**Conclusions** The use of MRP seems to be efficacious and safe in patients affected by PR.

**Table 1. Demographic and clinical characteristics**

| | age | Sex | neck | Shoulder | Hip |
|---|---|---|---|---|---|
| 1 | 60 | F | - | + | + |
| 2 | 73 | F | + | + | + |
| 3 | 67 | F | + | + | + |
| 4 | 61 | F | - | + | + |
| 5 | 72 | F | + | + | + |

**Table 2. Followup of patients**

| | | pain VAS | | | | ESR | | | | CRP | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 2 | 4 | 6 | 0 | 2 | 4 | 6 | 0 | 2 | 4 | 6 |
| 1 | 9 | 3 | 2 | 2 | 68 | 22 | 18 | 12 | 8,3 | 0,7 | 0,3 | 0,9 |
| 2 | 8 | 2 | 2 | 2 | 58 | 30 | 26 | 20 | 10,1 | 1,1 | 0,5 | 1 |
| 3 | 9 | 2 | 2 | 2 | 65 | 14 | 16 | 6 | 8,9 | 0,8 | 0,5 | 0,6 |
| 4 | 10 | 4 | 3 | 2 | 72 | 21 | 22 | 14 | 7,6 | 3 | 0,8 | 1,1 |
| 5 | 9 | 4 | 4 | 2 | 74 | 17 | 16 | 19 | 9,4 | 3,2 | 0,8 | 1,4 |

## PICC (Peripherally Inserted Central Catheter). Failure of accurate tip position. Analysis of our cases

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**Introduction** Venous access is a significant problem in the departments of internal medicine both for patients who suffer pain and discomfort and for health personnel.
The use of PICCs (Peripherally Inserted Central Catheters), that can also be inserted by nurses, does not mean that the doctors shouldn't have expertise and knowledge in managing these devices. One of the problems for the correct placement of a PICC is the optimal location of the distal tip.
The veno-atrial junction (lower third of the upper vena cava) has been identified as the ideal location of the catheter tip. None of the methods described in the literature ("landmark technique", ECG, electromagnetic tracking technology, X-ray or fluoroscopy) has the ideal characteristics for handiness, reliability and safety. Currently chest x-ray is considered the gold standard to confirm and demonstrate the position of the terminal tip of a PICC.
**Results** From our series of about 180 cases in the past three years, we present seven images of PICC malposition sometimes in unusual positions. These events can be due to alterations of the vascular anatomy clinically not previously suspected or to errors in the technique of catheter insertion. In some cases it was possible to replace correctly the catheter at the bedside in others angiographic techniques have been used.
**Conclusions** The physician should be able to decide when, how and which device is better to use for a venous access in every clinical situation and must also be able to recognize and manage problems and complications resulting from the use of PICCs.

## Dysphagia and dizziness: a case report

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A 82-year old woman presented to the internal medicine department with a progressive dysphagia associated with dizziness.
The physical examination showed rigidity of the neck muscles with pain and difficulty of the neck rotation. Neck magnetic resonance imaging showed a solid and expansive mass that invaded the anterior pharynx and posterior invaded the vertebrae from C1 to C3 and causing osteolytic lesions as evidenced by computed tomography scan.
The histopathological diagnosis was a chordoma as evidenced by the classic lobular architecture: fibrous bands divide it into lobules containing cords of cohesive epithelioid cells.
Chordomas are rare, slowly growing, locally aggressive neoplasms of bone that arise from embryonic remnants of the notochord.
These tumors typically occur in the axial skeleton and have a proclivity for the spheno-occipital region of the skull base and sacral regions.
Craniocervical chordomas most often involve the dorsum sella, clivus, and nasopharynx.
Clinical presentation is usually with pain and neurologic deficits as the cardinal symptoms based on the location of the lesion. However, the main clinical presentation of our patient was represented by a progressive dysphagia initially for solid foods only and subsequently also for liquids.
In particular, the ingestion of the food also was accompanied from intense dizziness and pain to the scapular cingulum.

## "IDENTIKIT": a fast comprehensive assessment instrument for frail hospital patient could properly impact on future hospitalization

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**Background and purpose** Patients hospitalised in departments of Internal Medicine are often affected by chronic comorbidities, sometimes with difficult family situations, so "fragile". These patients are those most exposed to the risks associated with the "transition", ie those moments in the diagnostic-therapeutic course, during which different professional care settings are involved in the care process. Therefore we developed a tool, "Identikit" of the patient, for medical and nursing staff, which collects data about clinical and cognitive-psycho-social aspects of patient, even by the assessment of encoded scales, which is quick to build, immediate to see, useful for identification of main critical issues, when a new patient arrives in setting and at the moment of a subsequent hospitalization.
**Materials and Methods** 68 patients hospitalized in the Medicine Continuity of Castelfiorentino were included, divided randomly into the "Identikit" Group and the Control Group, assessed with the usual methods.
**Results** The population studied with the Identikit was found to be high average age (76 aa), functionally dependent (59%), bedridden (33%), with mild-moderate cognitive impairment (44%) Our tool has proved to be simple to use and suitable to characterise the population hospitalised.
**Conclusion** The continuation of the prospective study (300 patients) aims to assess the number of rehospitalisations, length of stay and clinical outcomes in the two groups. The "Identikit" could quickly identify patient's critical issues, streamline costs, improve quality of life and long-term prognosis.

## First italian case of spinning-induced rhabdomyolisis. A new role for MRI

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**Background** Rhabdomyolisis (RML) is an acute necrosis of skeletal muscle, with release of intracellular contents into the bloodstream. Crush injuries, exertions and drugs as statins or opiates are the main causes. Spinning, or indoor cycling, is an expanding fitness activity which uses a stationary bike. MRI demonstrated in RML a sensibility higher than CT and US do. Complications of RML are rare, but life threatening.
**Case report** Healthy girl, 19 years old, untrained. Twelve hours after her first spinning class she presented severe pain and swelling in both thighs accompanied by reddish urine. First day: serum creatine kinase (CK) 124.688 UI/ml, serum myoglobin (MG) 18.488 ng/ml, MRI of both thighs showed in T2WI and STIR sequences increased signal consistent with severe myositis. Absolute rest and hydrating treatment was prescribed. Twentieth day: vanishing of pain and swelling, normalization of CK and MG, whereas MRI picture was unexpectedly unchanged.
Discussion Expanding gym attendance and increasing use of statins and dope make RML a very actual problem.
This is to our knowledge the first Italian and the fourth European described case of spinning-induced RML, a probably underestimated illness that may also result from light exertions.
Through MRI we detected in our RML a clear-cut temporal dissociation between clinical healing and anatomical recovery: this observation could be very useful in athletes for timing exercise resumption at no risk. Taking account of future social impact of spinning we advise right training, correct hydration and air-conditioned gyms.

## Factor XI deficiency with thrombotic tendency. A case report

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**Background** Factor XI (FXI) deficiency or haemophilia C is a rare (prevalence 1:100.000) inherited autosomal disorder of the intrinsic coagulation pathway; nowadays over two hundred genic mutations are known, specially in Ashkenazi Jews. Unlike the more frequent A and B haemophilias, spontaneous bleeding is exceptional, but it may follow injuries or surgery; it is not related to the FXI blood level and therefore unpredictable. In some studies FXI deficiency seems able to protect from stroke and venous thrombosis. Treatment, reserved to emergencies, consists essentially of frozen fresh plasma or FXI concentrates.
Case report Caucasian female 56 years old, nothing noteworthy in the family, no previous bleeding, treated with aspirin for myocardial infarction and occasionally with heparin for recurrent thrombophlebites of the legs, admitted for erysipelas promptly responder to antibiotics. Lab.: PTT ratio 2.82 (0.7-1.3), FXI 1% (50-150), the remaining coagulation and thrombophilia tests, LAC, autoantibodies, FVIII, FIX and FXII into the range.
**Discussion** Reports of FXI deficiency in Italy are very few, nevertheless it must be recognized to avoid potentially bleeder drugs, as in our patient, and to carry out prevention in surgery. Lack of bleeding in a severe deficiency (likely a "null allele"), even during treatment with aspirin and heparin, confirms the unpredictability of the bleeding tendency in this disease. On the other hand thrombotic diathesis of our patient seemingly clashes with recent searches about FXI as antithrombotic target using antisense oligonucleotides.

## Hepatic abscess as unusual manifestation of chronic brucellosis: a case report

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A 59-year-old man was admitted to our hospital for 4-months standing pain in the right hypochondrium and recurrent fever. The medical history included brucellosis 35 years before.
Previous US and Ct abdominal scanning detected a hypodense hepatic lesion containing a cystic area and a single calcification in its central portion. Laboratory findings included increased alkaline phosphatase, γGT, ESR and C-reactive protein; serological tests were negative except for Brucella IgG antibody titres; blood cultures were sterile. Hepatic biopsy and FNA were performed: histological evaluation revelead fibrosclerosis and inflammatory infiltration. Despite treatment with metronidazole and ceftriaxone symptoms did not disappear and the patient was referred to our hospital for further evaluation.
On admission he was febrile, his vital signs were normal and physical examination revealed pain on deep palpation in right upper quadrant. Empirical treatment with meropenem was started. The new CT scanning of the abdomen showed a hepatic lesion increased in size. A new liver biopsy was performed but any germ was isolated from the hepatic fragment. A repeated agglutination test in serum confirmed high Brucella IgG antibody titres.

In view of the aforementioned anamnestic, clinical, and radiographic findings, the diagnosis of brucelloma was considered. A targeted antibiotic therapy was started (rifampicin and minocycline) and outcome was rapidly favorable: fever subsided, with clinical improvement in the following days. At abdominal US and CTscan follow-up reduced liver lesion was detected.

## Difficult hospital discharges and overcrowding in Internal Medicine wards of Piemonte

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**Background** Internal medicine patients are mostly elderly, with multiple, progressive and chronic comorbidities. Those "complex" patients represent a large number of admissions to hospital, in contrast to disproportionate number of hospital beds. In addiction the discharging of patients is often delayed due to social and organizational problems, as well as clinical factors. The phenomenon of difficult hospital discharges (DHDs) is nowadays a very topical problem. Prolonged hospitalisation not only increases cost, it is also associated with overcrowding and related complications: hospital overcrowding is associated with increased morbility and mortality. The aim of this survey was to investigate the prevalence of DHDs as a reason for overcrowding in Internal Medicine wards of Piemonte.
**Methods** We sent a questionnaire to each Internal Medicine Unit of Piemonte to collect data. Information about the whole year 2010 ward activity and about the index day (22/09/2011) ward activity were required. Data were archived in a Microsoft Excel database and NCSS program was used for statistical processing.
**Results** We analyzed data from 47/60 (78%) Internal Medicine wards. In 2010 the average length of stay was 11,87 days and the bed occupation average rate was 98%. In index day DHDs accounts for 13% of overall ward admissions.
**Conclusion** Our results confirm high prevalence of DHDs and overcrowding trend in Internal Medicine wards of Piemonte. New models of care in organization of health services with specific tailored programmes are required to reduce DHDs and to prevent overcrowding.

## A rare case of autoimmune hepatitis (AIH) induced by interferon therapy

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**Introduction** Interferon (IFN) is a cytokine produced by different cell types of the immune system and plays a crucial role in immune response. The use of IFN-á therapy in chronic HCV infection can induce autoimmune reactions.
**Case report** 30-year-old woman with chronic hepatitis C. In November 2008 she started therapy with subcutaneous pegylated IFN 1.5 mg/kg per week and oral ribavirin 800 mg/day. Treatment was stopped in April 2009, serum HCV RNA remained undetectable indicating that the patient had achieved sustained viral response.
Hypothyroidism with positive anti-thyroid antibodies was diagnosed after treatment completion. No further problems occurred during the follow up in the first year post-treatment. In June 2010 she presented a skin rash. Between July and August she had acute icteric hepatitis with AST >2000 U/l, bilirubin up to 29 mg/dl, hypoalbuminemia and hypergammaglobulinemia. Viral studies were negative for active infection. She was positive for ANA (1:1280) and anti SS-A (Ro) and anti sp 100. The liver biopsy revealed severe interface hepatitis. The revised score for the diagnosis of AIH was consistent with (probable) AIH. On October 2010 treatment with oral prednisone 60 mg/day was started and four days later oral azathioprine was added at a dose of 50 mg/day. At February 2012 she is asymptomatic with normal liver function tests.
**Conclusions** This is a rare case of AIH reported 1.5 years after successful IFN treatment for HCV hepatitis and confirms the importance of long term follow-up after sustained virological response.

## Un caso di preeclampsia in una paziente affetta da feocromocitoma

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Il feocromocitoma rappresenta lo 0,1-0,3% dei casi di ipertensione arteriosa. Ancora più raro è il presentarsi di questo tumore delle cellule cromaffini durante la gravidanza, si riportano infatti 232 casi in letteratura e l'incidenza è considerata inferiore a 0,2 casi per 10.000 gravidanze. La mortalita' materno-infantile può essere elevata in assenza di diagnosi precoce.
Riportiamo il caso di una donna di 34 anni ricoverata alla 27° settimana di gravidanza con diagnosi di preeclampsia sovrapposta a ipertensione preesistente. I valori pressori erano scarsamente controllati a domicilio da una terapia con Metildopa , Nifedipina , Clonidina . Lo scarso controllo dei valori pressori, il carattere parossistico degli stessi, la cefalea e la tachicardia, fecero porre il sospetto di feocromocitoma che fu confermato dai livelli decisamente elevati delle catecolamine urinarie. Una TC addominale evidenziò una formazione espansiva del surrene dx di 4 x 3 cm. L'aumento della proteinuria fino a 22.000 mg/24 ore, la alterazione degli enzimi epatici, resero necessario il taglio cesareo in urgenza. Le condizioni pressorie e emodinamiche furono ben controllate nel perioperatorio dal Labetalolo ev che è farmaco di elezione una volta posta la diagnosi di feocromocitoma. Dopo tre mesi con PA e FC ben controllati da 6mg di Doxazosina e 100 mg di Atenololo, e scomparsa della proteinuria, fu eseguita surrenalectomia dx per via laparoscopica. Dopo l'intervento la Pz. potè sospendere ogni terapia. Anche la figlia, dopo un periodo in terapia intensiva neonatale fu dimessa in buone condizioni.

## Prospective observational study of chronic non-cancer-related pain treatment in elderly: safety and efficacy of oxycodone and of oxycodone/naloxone prolonged-release

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**Aim** Evaluate efficacy and safety of oxycodone in pain control in elderly affected by chronic pain.
Study design: Patients aged > 75 and with moderate-severe pain (NRS > 6) were enrolled and subdivided in three groups: subset "G" for the general survey of pain treatment received at home (100 people), subset "O" for treatment with naloxone (40 people), subset "O/N" to receive oxycodone/naloxone CR (40 people). Analyzed variables included pain severity (NRS), quality of life (QoL, SF 36)) and side effects.
**Results** In subset "G" at the time of the survey 14.9% of patients received no pain therapy, 18.4 % FANS, 52.6 % opiates, 14.1 % other

treatments e.g. acetaminophen, pregabalin, gabapentin. In subset "O" (age 80.9 ± 3.7; CIRS (IC) 4.1 ± 1.5; CIRS (IS) 1.6 ± 0.7; MMSE 28.8 ± 1.6) perceived pain significantly reduced, from NRS (t0) 7.2 ± 1.7 to NRS (t7) 1.1 ± 1.7 after 1 week of treatment, and was maintained over time NRS (t21) 1.4 ± 2.4. Fifteen patients (subset "O/N", enrolment still open at the present time; age 79.4 ± 4.1) received oxycodone/naloxone CR. Also in this subset a satisfactory pain control was achieved, from NRS (t0) 8.5 ± 1.6 to NRS (t7) 1.2 ± 1.3 and maintained NRS (t21) 1.3 ± 1.1. Analysis of side effects and of QoL recorded in the three subsets of the studied population will be presented.
**Conclusions** Currently elderly affected by chronic non-oncologic pain are still undertreated. Our results show that it is possible to use major opiates to treat moderate-severe pain: side effects are known, preventable and easy to manage by means of a close follow up.

## IMPRESS (Italian Multicentric study on PREgnancy in Systemic Sclerosis): final data

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**Objective** To assess fetal and maternal outcomes in women with systemic sclerosis (SSc).
**Methods** Prospectively collected data were retrospectively analyzed. In 25 Italian centers 99 SSc women were observed during 109 pregnancies (in 2000-2011) and compared to the general obstetrical population (GOP, 3939 deliveries). Maternal mean age at conception was 31.8 years (SD 5.3) and median disease duration was 60 months (range 2-193).
**Results** In SSc patients preterm deliveries (25% vs. 12%) and severe preterm deliveries (<34 weeks) (10% vs. 5%), intrauterine growth restriction (6% vs. 1%) and very-low-birth-weight babies (5% vs. 1%) were significantly more frequent than in the GOP. Multivariable analysis found that corticosteroid use was associated with preterm deliveries (OR 3.63, 95% CI 1.12-11.78), while the use of folic acid was protective (OR 0.30, 95% CI 0.10-0.91), as were antitopoisomerase antibodies (OR 0.26, 95% CI 0.08-0.85). The disease remained stable in most SSc patients, but there were four cases of progression within one year from delivery, all in antitopoisomerase-positive women, three of them with less than three years' disease duration.
**Conclusions** SSc patients can have successful pregnancies, but they have a higher than normal risk of preterm delivery, intrauterine growth restriction and very-low-birth-weight babies. High-risk multidisciplinary management should be standard for these patients and pregnancy should be avoided in cases with severe organ damage and postponed in women with SSc of recent onset, particularly if antitopoisomerase positive.

## La polmonite è sempre di origine infettiva?

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G.A., donna di 70 anni giunge ricoverata nella nostra UO per febbre, tosse secca, astenia da 1 mese e calo ponderale di circa 10 Kg in 2 mesi. All' ingresso in reparto la paziente è vigile, con parametri vitali nella norma; all' auscultazione del torace apprezzabili crepitazioni bilaterali. L' EGA mostra una insufficienza respiratoria ipossiemico normocapnica. L' Rx torace rileva multipli addensamenti bilaterali. Si intraprende terapia antibiotica ad ampio spettro
Per il persistere di febbricola e tosse viene eseguita TC torace con mdc con riscontro di multipli consolidamenti diffusi con alone di ground glass periferico e broncogramma aereo; linfonodi mediastinici aumentati di volume. La paziente viene quindi sottoposta a broncoscopia con BAL (negativo) e biopsie che evidenziano un reperto flogistico con granulociti neutrofili . Negativi il Quantiferon TB e la sierologia per micoplasma, legionella ed aspergillo.
Nel sospetto di BOOP /COP si imposta terapia cortisonica a scalare con beneficio clinico e riduzione alla TC torace di controllo eseguita a distanza di 1 mese degli addensamenti precedentemente segnalati
La BOOP ( bronchiolitis obliterans organizing pneumonia) è una rara patologia infiammatoria dei bronchioli e del tessuto circostante. La patogenesi è sconosciuta. E' anche conosciuta come COP
( cryptogenetic organizing pneumoniae). Le caratteristiche cliniche e radiologiche ricordano una polmonite infettiva; va comunque sospettata nel caso non ci sia risposta ai trattamenti antibiotici e data la negatività delle indagini microbiologiche.

## Un caso di sindrome vertiginosa soggettiva..davvero maligna

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MM, uomo di 52 anni privo di precedenti anamnestici di rilievo ed in pieno benessere, giunge alla nostra attenzione per il persistere da 1 mese di lievi ed transitori episodi di instabilità posturale e riferita disosmia. La TC encefalo mostra a livello di entrambi i lobi cerebrali multiple lesioni di tipo sostitutivo. Alla TC torace voluminosa massa solida tondeggiante di 5x7 cm di natura disproliferativa a carico del polmone sinistro. Conglomerati linfonodali ilari omolaterali. Alla TC addome alcune lesioni sostitutive epatiche. Aree osteolitiche a carico della branca ischio pubica sinistra, dell' ala iliaca omolaterale e di alcuni corpi vertebrali. La broncoscopia mostra a livello del bronco lingulare superiore una formazione endocanalicolare di colorito brunastro e consistenza poltacea che viene biopsiata. Il referto anatomopatologico depone per metastasi di melanoma maligno epitelioide positivo per HMB45. La ricerca di melanomi a livello cutaneo effettuata dal dermatologo risulta negativa così come a livello delle mucose: in particolare negativa la ricerca di melanomi in sede retinica Il paziente viene sottoposto a cicli di CT anche con farmaci biologici di ultima generazione senza successo. Il decesso si verifica a distanza di 6 mesi dalla diagnosi.
Il caso clinico descritto riguarda un melanoma regredito totalmente dalla sua sede di origine cutanea o mucosa. Questo accade spesso quando la neoplasia è già metastatizzata. E' tipica la sede delle ripetizioni a livello epatico, polmonare, cerebrale ed osseo così come la rapida evoluzione e la prognosi infausta.

## Un caso di contaminazione alimentare davvero insolito

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O.L., uomo di 70 anni viene ricoverato per iperpiressia fino a 40 C con astenia, diarrea e disidratazione. Gli esami bioumorali mostrano ipereosinofilia (40%), rialzo degli indici di citolisi e colestasi epatica e della PCR. Alla TC addome con mdc aree compatibili con ascessi epatici e splenomegalia. Il paziente riferisce di avere mangiato recentemente pesce crudo marinato sul lago di Bolsena. Insospettiti dalla peculiarità

del caso clinico, con la collaborazione dell' infettivologo, apprendiamo che è presente in tale zona un' epidemia da Opistorchis Felineus. Viene quindi inviato un campione ematico e delle feci all' ISS che conferma la presenza del parassita. S'inizia trattamento con Praziquantel con rapida remissione dei sintomi e dei segni
Opistorchis Felineus è un parassita trematode la cui infezione è comune in cani e gatti. La trasmissione all' uomo è occasionale ed avviene tramite l' ingestione di pesci d'acqua dolce crudi o poco cotti contenenti le metacercarie del parassita. Queste si liberano nel duodeno rilasciando larve che poi migrano e maturano a vermi nell' albero biliare. I vermi rilasciano delle piccole uova che passano nell' intestino e si liberano con le feci. Se il paziente alberga una bassa carica parassitaria può anche essere asintomatico; in caso contrario può sviluppare sintomi eclatanti.
Nel periodo estivo le enteriti possono avere un' eziologia rara ( parassitaria). La diagnosi precoce e la terapia mirata sono indispensabili per una risoluzione di quadri clinici che se non diagnosticati possono divenire minacciosi per la vita del paziente

## Dosaggio del BNP: un valore aggiunto per i pazienti ricoverati per scompenso cardiaco?

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**Premessa e scopo dello studio** Il BNP è il biomarker dello Scompenso Cardiaco (SC).Valutarne l'uso che se ne fa nella nostra realtà ospedaliera.
**Materiali e metodi** Analizzare un gruppo di 160 pz ricoverati (2010-2011) per SC. Confrontare l'uso del BNP nella nostra realtà e negli studi SEOSI, TEMISTOCLE, OSCURE, Registro Italiano AHF. Il test statistico: t test per il confronto tra le medie (significatività statistica se p≤0,05).
**Risultati** Dei 160 pz solo per 80 (58M e 22F) è stato dosato il BNP:valore medio rispettivamente di 825,5±830,8 pg/ml nei M e di 634,5±837,6,pg/ml nelle F ;p: NS),mentre non compare negli studi SEOSI, TEMISTOCLE, OSCURE, Registro Italiano AHF. Gli 80 pz sono stati divisi in 2 gruppi a seconda della EF%: 58 (46 M e 12F) avevano una EF% depressa: 29,3±7,8% e 22 (10F e 12M) una EF% conservata:59,1±7,8%. Anche per questi 2 gruppi è stato valutato il valore medio del BNP: 909,9±906,5pg/ml nei "sistolici" e di 379,3±365,9pg/ml nei "diastolici" (p:0,0009). Per 15 (10M e 5F) è stata eseguita la coronarografia: nelle F per 2 sono emerse stenosi emodinamicamente significative (> al 50%) e con altrettanti valori significativi di BNP: 787,0±657,6pg/ml .Per i M in 7 sono state riscontrate stenosi significative con valori di BNP di 766,0±319,5pg/ml (p:NS dal confronto tra i due gruppi).
**Conclusioni** Il BNP risulta sottoutilizzato e il suo impiego deve essere incentivato. Se p:NS nei due sessi (M e F), la significatività è emersa in "pz sistolici vs diastolici" e come indicatore di coronaropatia.

## ✪ Terapia farmacologica dello scompenso cardiaco: confronto tra un ambulatorio generale ed uno dedicato

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**Premessa e scopo dello studio** La terapia dello scompenso cardiaco ha come obbiettivi:ridurre i sintomi, aumentare la capacità funzionale del paziente, rallentare la progressione della malattia. Scopo:vedere l'uso che se ne fa in ambulatorio.
**Materiali e metodi** Abbiamo selezionato 103 pz in classe NYHA I/II (15F, 88M, età media di 67,0±11,0 anni) seguiti presso l' ambulatorio dedicato negli anni 2010-2011, confrontati con 103 pz (53 F, 50 M, età media di 63,2±12,9 anni) seguiti presso l'ambulatorio generale per valutare la terapia farmacologia anti-scompenso (beta-bloccanti, ACE-I, Diuretici, Digitale, Risparmiatori di K+).Test statistico: t test per il confronto tra le medie (significatività statistica se p≤0,05).
**Risultati** Dosaggi medi statisticamente significativi per i beta-bloccanti per i pz dell'ambulatorio dedicato rispetto a quelli del generale :carvedilolo con 34,6±17,1mg (p.0,0005) vs 17,8±13,5mg; bisoprololo: 5,03±1,95mg/dl (p:0,0004) vs 3,18±2,57mg/; furosemide:92,5 ±84,9 vs 49,6±35,2mg (p: 0,001). Dosaggi medi con p: NS sono emersi dal confronto degli ACE-I: ramipril con 6,48±2,63 mg vs 5,96±2,90 mg, perindopril: 6,51±2,38mg vs 5,71±1,5mg, enalapril:25,2 ±14,0mg vs 17,3±2,5mg. Al contrario,significatività statistica per i risparmiatori di K+ (p: 0,0007) nell'ambu non dedicato:57,4±30,5mg vs 25±0,0mg del "dedicato",idem per la digitale con 0,162±1,62mg vs 0,142±0,04mg.
**Conclusioni** L'ambulatorio dedicato per lo SC è utile per la titolazione della terapia farmacologia, così come raccomandato dalle linee-guida.

## Gastrointestinal stromal tumors (GISTs): a case report

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Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal tumors of the gastrointestinal tract and represent 0.1-1% of gastrointestinal malignancies with an estimated incidence of 1.5/100.000/year. They are commonly asyntomatic and found incidentally during laparoscopy, surgical procedures or radiological studies.
We describe a case of GIST in which abdominal ultrasonography (US) plaied an important role in diagnosis of this tumor.
A 71 years old male refferred to our institution because of syncope. Hematologic test showed anemia. Upper gastrointestinal endoscopy and colonscopy were negative. US showed, between kidney and gallbladder, an oval markedly hypoechoic mass with anechoic internal areas, of 46x28 mm, with peripheral vascular signs at color Doppler study. Abdominal CT confirmed this lesion while positron emission tomography (PET) was negative. The patient underwent surgical removal of the described mass. The diagnosis of GIST, with high grade of malignancy, was confirmed histologically and immunohistochemically. The patient had an uncomplicated postoperative course and was referred to the oncologist for suitable treatment.
The standard approach to patients with GIST is endoscopic ultrasound (EUS) with EUS-guided fineneedle aspiration biopsy (EUS-FNAB). Therefore, CT scan but also transaddominal US play an important role in the detection of GIST in contrast to PET, wich has proved most useful in the follow-up.
This neoplasia can be suggested by imaging studies, in all cases histological diagnosis is essential.

## A case of diverticulitis mimicking Crohn's disease in a young lady

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Diverticular disease of the colon is uncommon before age 40 and its complications affect 5% of the patients.
A 35-year-old lady was seen because of abdominal pain localised in right lower quadrant. The pain has been presented for a week and it was associated with dysuria and oliguria. Past medical history showed chronic diarrhoea and epilepsy. Laboratory tests revealed severe macrocytic anaemia with folic acid and vit. B12 deficiencies, increased

white cell count, ESR and CRP, and acute renal insufficiency; coeliac antibodies were negative. Stool tests excluded infections. On the basis of the young age of the patient, Crohn's disease was suspected. Abdominal ultrasonography showed thickened small bowel in left and right lower quadrant and colonoscopy showed acute diverticulitis in the sigma and descending colon. CT scan and MR not only confirmed the diagnosis but also showed multiple abscesses. One single diverticulum presented a covered perforation. Gynecologic, urologic and surgical consultation excluded other conditions. The patient was treated conservatively with fluids, antibiotics, mesalazine and blood transfusion; she rapidly improved. The causes of the macrocitic anaemia are currently under investgation.
Diverticular disease should always be considered, not only in elderly patients. Severe diverticulitis can mimic inflammatory bowel disease.

## Prevalenza dell'arteriopatia periferica e carotidea e loro relazione con i fattori di rischio in un Paese in via di sviluppo: una sottopopolazione di pazienti ipertesi nella città di Beira-Mozambico

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In Africa lo sviluppo ha contribuito all'aumento delle malattie croniche non trasmissibili incluse le MCV i cui FdR stanno divenendo gravi problemi di salute pubblica.Ci sono pochi dati sulla ricerca CV in tale area e lo studio di popolazioni campione offre dati utili. Abbiamo studiato la prevalenza di aterosclerosi carotidea e periferica e la sua relazione con FdR CV in una popolazione di 86 pz ipertesi in un'area urbana del Mozambico. Per ogni pz eseguiti questionario,visita con PAO e BMI,prelievo di sangue,ecografia carotidea e misurazione di indice caviglia/braccio. Risulta: elevata prevalenza di ictus, non individuati pazienti con sospetta coronaropatia ma in assenza di conferme strumentali; controllo glicemico nei diabetici inadeguato; livelli medi di tot-colesterolo superiori a quelli nazionali; l'obesità interessa maggiormente il sesso femminile con BMI medi superiori a quelli nazionali; buono il consumo di pesce e di carboidrati;quello di frutta/verdura e di carne limitato a un gruppo ristretto di pz che ha valori maggiori di BMI,livello socio-economico più elevato e maggiore abitudine al consumo di tabacco; medio basso è il livello di attività fisica. Il danno vascolare studiato mostra prevalenze simili a quelle degli studi dei paesi occidentali. Questionari,PAO e BMI sono utili nella stratificazione del rischio CV in aree con risorse limitate. Esami ematochimici sono auspicabili ma possibili in poche situazioni. L'ecografia carotidea è limitata a pochi ospedali. La misurazione dell'ABI potrebbe essere diffusa per individuare pazienti con un rischio CV elevato.

## Common Variable Immunodeficiency: clinical presentation in our experience

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Common variable immunodeficiency (CVID) is a primary immunodeficiency disease that is characterized by the following: low levels of serum immunoglobulin classes (Ig), B-lymphocytes or plasma cells deficiency, and an increased susceptibility to infections and/or an autoimmune disease. The diagnosis is most commonly made in adults aged 20-40 years or older. As many as 20% of patients develop autoimmune complications: hemolytic anemia, Systemic Lupus Erythematosus, vitiligo, thrombocytopenia, and neutropenia have all been associated with CVID. Gastrointestinal diseases include sprue like disorders, autoimmune hepatitis, pernicious anemia, intestinal nodular lymphoid hyperplasia, and inflammatory bowel disease. The risk of malignancies is high, in particular lymphomas and gastric cancer.
The authors describe four cases of CVID: the first one was characterized by idiopathic thrombocytopenia, autoimmune neutropenia, bone marrow granulomas and recurrent pneumonia.
The second one was characterized by autoimmune haemolytic anemia (AIHA), recurrent bronchitis and spleen granulomatosis. The third one was characterized by recurrent fungal pneumonia (Aspergillus fumigatus) and the last one was characterized by recurrent bacterial pneumonia (Streptococcus pneumoniae) and Sjogren Syndrome. All patients had severe ipogammaglobulinemia. All patients were successful treated with the replacement of antibodies, at dosage of 400 mg/Kg every 21-28 days.

## Ruolo della TIPS in terapia dei sanguinamenti recidivanti da ipertensione portale

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**Caso clinico** Donna di 74 aa. Nel 2008 diagnosi di cirrosi HCVcorrelata complicata da ipertensione portale in assenza di varici esofagee. A Febbraio 2010 ricovero per ematemesi e grave anemizzazione con rilievo all'EGDS di varici F2, sottoposte a legatura endoscopica con eradicazione completa. Non sono stati somministrati b-bloccanti per intolleranza al farmaco. Nuovo ricovero a Febbraio 2011 per grave anemizzazione(Hb 6,7 g/dl). È stata nuovamente effettuata EGDS con rilievo di cordoni varicosi F2 con segni rossi, di mucosa nel corpo-fondo gastrico edematosa ed erosa e di erosioni multiformi come da GAVE. Una colonscopia ha inoltre mostrato severa congestione del plesso emorroidario interno che presentava 2 stigmate di recente sanguinamento. Considerato che l'origine dei sanguinamenti fosse imputabile alla gastropatia congestizia e alle grosse varici emorroidarie secondari a importante ipertensione portale, è stato posizionato TIPS. Dopo la procedura il gradiente portosistemico è sceso da 20 mmHg a 6,6 mmHg. Al controllo eco-doppler post-procedura buona omogeneità del flusso sanguigno lungo tutto il decorso del TIPS con flusso epatofugo nei rami portali intraepatici. Attualmente la paziente è in buone condizioni generali, emodinamicamente stabile e asintomatica per encefalopatia ed emorragia, all'ultimo controllo presso il nostro D.H. Hb nella norma (10 g/dl).
**Conclusioni** Questo caso clinico dimostra la validità del TIPS nella riduzione della frequenza di sanguinamento da varici conseguente a ipertensione portale non suscettibile di terapia endoscopica.

## Paraneoplastic thrombophilia with rapid evolution

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A 41 years old man with no relevant clinical history particularly for cardiovascular and neoplastic deseases, was admitted in our hospital for recurrent angor and cardiac symptoms with diagnosys of STEMI with uninjured coronary. Cardiologists started with calcium antagonist therapy interpreting these episodes as vasospastic coronary occlusion, in association with double antiplatelet therapy and statin. The patient

was admitted in our division because of diffuse arms and legs pain resistant to analgesic therapy with no signs of rhabdomyolysis (escluding an adverse reaction to statin). There was then signs of superficial phlebitis on right arm and the patient underwent a Doppler study of both arms and legs with evidence of bilateral leg DVT without of clinical features. An abdominal ultrasound study was then performed with evidence of expansive lesion of pancreatic head and multiple small hepatic lesions suggestive for metastasis. The PET-CT scan confirmed the pancreatic lesion, the hepatic multiple metastasis and showed a splenic infarction, right kidney infarction, diffuse intra-abdominal linfadenopathy. The biopsy of one of the hepatic lesions was not diriment. Despite of the anticoagulant therapy with Fondaparinux the patient developed expressive aphasia and right hemiparesis as consequence of multiple ischemic brain lesions and then another episodes of coronary occlusion. There was then a rapid clinical worsening until death in about 10 days.

## Un raro caso di epatite acuta colestatica da farmaci, in corso di trattamento con Para-aminobenzoato per malattia di Peyronie

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La malattia di Peyronie (Induratio Penis Plastica – I.PP) è una fibrosi del pene , con predisposizione genetica, spesso associata a traumi legati all'attività sessuale. L'evoluzione delle placche di fibrosi nei seni cavernosi, porta a calcificazione, deformità del pene con progressiva curvatura, dolore in corso di erezione e progressiva impotenza .Vari trattamenti sono stati proposti, con scarso successo, per limitare l'evoluzione della malattia, sia locali (iniezione intracavernosa di Verapamil o con ionoforesi), che sistemici, con Para-aminobenzoato di Potassio per os (ora non consigliato), interferone alfa-2a-2b. In letteratura sono descritti rari casi di epatite da Para-aminobenzoato di Potassio in pazienti affetti da IPP. Un uomo di 60 anni fu ricoverato per ittero (bilirubina totale 20.2 mg\dl diretta 14.1mg\dl) insorto da 7 gg a seguito di trattamento da 45 gg con cp di Para-aminobenzoato di Potassio, prescritto per IPP. La storia di discreto abuso alcolico, nonché la ritrosia riguardo alla malattia inerente la sfera sessuale,avevano inizialmente orientato verso un'epatopatia alcolica con severi indici di citonecrosi epatica (AST 2745 UI\ml ALT 4300 UI\ml). I marker per epatite virale (HAV-HBV-HCV) risultarono negativi. Fu esclusa genesi autoimmune per la negatività degli autoanticorpi ANA; ENA; AntiDna; LKM. Fu effettuata biopsia epatica che evidenziò un quadro di epatite cronica attiva in fase di moderata attività. I segni di danno epatico regredirono progressivamente 2 mesi dalla sospensione del trattamento con Para-aminobenzoato e astensione alcolica.

## ✪ Usefulness of point-of-care lung ultrasonography in an Internal Medicine Unit

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**Introduction and aim of the study** Lung ultrasonography (LU) has been shown to be more accurate than auscultation or chest X rays (RX) in the critical care setting, but very few studies has been conducted in Internal Medicine (IM) cohort of patients.
**Materials and methods** This prospective observational study started in November 2011 in our IM Unit. It involved 41 consecutive patients with admission diagnosis including one or more of these signs and symptoms: dyspnea, chest pain, fever, cough, findings suggestive for pulmonary disease. ECG, RX, laboratory tests were routinely obtained; computed tomography (CT) when indicated. LU was performed by an IM trainee under supervision by an expert physician, through a validated protocol (BLUE-Protocol). An Esaote MyLab25 portable unit was used. A compression ultrasound of lower limb veins was added when indicated.
**Results** M:F 20:21, mean age 72±13. Ongoing data analysis showed no significant difference between LU and RX in diagnosing heart failure, pneumonia, pleural effusions, atelectasis, and cancer. LU results more accurate than physical examination ($p<0,01$) in diagnosing pneumonia, and as accurate as CT in diagnosing pneumonia, pleural effusions, atelectasis and cancer.
**Conclusions** LU is a potential diagnostic tool for internal medicine physician, and it could be particularly useful and accurate for inpatient with suspected pulmonary disease. However CT (Gold standard) was performed only in a few patients, thus limiting comparison and statistical analysis. We need to continue collecting further patients.

## ✪ Cum FADOI docet: an audit about the management of patients with acute pancreatitis

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**Background** Aim of this study was to audit the management of patients with acute pancreatitis (AP) in 12 centres of different Italian Regions against the standards of practice in the guidelines. The Master course on Clinical Governance in Internal Medicine becomes a diffusion network, while maintaining the link between the nodes: master participants faced with the guidelines in an extended audit experiment.
**Methods** The study retrospectively analysed 188 patients with AP in 2011. Audit targets: mortality for AP and for severe acute pancreatitis (SAP); severity assessment by APACHE II score; adequate fluid replacement and analgesia; in SAP, availability of CT after 48 h from illness onset, enteral feeding and prophylactic use of a carbapenemic antibiotic. Results were graded through a quintile classification range: very poor, poor, average, good and excellent.
**Results** Out of 188 AP patients, 64 (34%) had SAP. Patient mortality was 2.1% in AP and 6.25% in SAP. We have also evidenced excellent fluid replacement (97%) and good pain control (75%) but poor APACHE II score evaluation (35%). In the 64 patients with SAP the inappropriateness of the CT timing was high (78.1% within 48 hours of illness onset), enteral feeding was very poor (5%) and the use of a carbapenemic antibiotic on average (42%).
**Conclusion** The study, despite of the excellent outcomes, highlights a wide spectrum of opportune improvement actions in terms of implementation APACHE II score, enteral feeding, appropriateness of CT timing and carbapenemic use. The re-audit is going to be performed within 1 year.

## Rare hemorrhagic disease: a case report

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We observed a female patient , MC 65 yeras old, affected by ulcerative colitis treated with mesalazin,because of a serious anaemia with large hemorrhages of both lower limbs.

The patiente suffered of similar events four times in the last four yeras always during summertime. Blood transfusions were necessary to correct the deep anaemia we found at admission time. No hemorrhagic source was found with upper and lower endoscopy, body CT scan was normal. A first level blood exams panel and Ivy test were performed with normal results,so a second level blood exam panel was performed ( AT III Plasminogenmia S and C Protein von Willebrand Factor activity and antigen ) with normal results too, only an important increase of D-dimer , due to an increased fibrinolitic activity, was found.We decided to initiate a therapy with small dose ( 0.5 mg\Kg a day ) of prednison obtaining a quick and permanent correction of anaemia.
A determination of XIII Factor blood activity was performed demonstrating a meaningful reduction of it; we tried to demonstrate circulating antibodies against XIII Factor but , with 1:64 diluition, we couldn't find them, probably because of steroid therapy .We believe that our patient is affected by an acquired defect of coagulation XIII Factor due to ulcerative colitis for clinical presentation ,anamnestic relief and good effect of steroid therapy.
The patient was discharged with prednison and no more anaemia either hemorrhages and with a 22% blood activity of XIII Factor that's an activity degree able to prevent new spontaneous hemorrhages.

## Ischemia critica degli arti inferiori: dalla diagnosi al trattamento in un DEA

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L'ischemia critica degli arti inferiori (critical limb ischaemia, CLI) è una fase evolutiva dell'arteriopatia periferica, durante la quale il paziente presenta un elevato rischio di amputazione e di mortalità.
Importante è riconoscere la CLI soprattutto per le conseguenze del suo tardivo riconoscimento per la vitalità dell'arto e la vita del paziente.
Nello studio sono stati arruolati dal 01/01/2010 al 30/11/2011 35 pazienti che in Pronto Soccorso presentavano:
• dolore ischemico a riposo da più di due settimane e/o lesioni trofiche distali degli arti inferiori;
• iposfigmia dei polsi tibiali, peronieri e pedidi;
• eventuali patologie associate quali eventi ischemici cardiovascolari o encefalici, diabete mellito, tabagismo.
Nel ricovero tutti pazienti sono stati sottoposti a ad angio-RM o angio-TC degli arti inferiori e ossimetria transcutanea.
Tutti i pazienti sono stati trattati con procedura di rivascolarizzazione endovascolare, seguita da amputazione minore in quelli con gangrena distale. Nei pazienti con maggiore compromissione della circolazione periferica sono stati utilizzati prostanoidi per via endovenosa, il cui ciclo, iniziato durante il ricovero, è stato completato in regime di Day Hospital. I successivi controlli (visita medica, ossimetria transcutanea) sono stati effettuati al 10°, 30°, 60° e a 90° giorno dall'accesso in Pronto Soccorso. I risultati hanno evidenziato il successo del trattamento con l'immediata regressione della sintomatologia dolorosa con degenza media di 6,7 giorni e persistenza dell'efficacia terapeutica al 90° giorno.

## Metabolic, vascular and cardiorespiratory modifications in patients undergoing to a 3-month in-hospital controlled physical activity

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**Background** Primary prevention with non-pharmacologic approaches represents an intriguing option for cardiovascular(CV) diseases treatment. In 2008 we started a project to evaluate if a 3-months in-hospital course of physical activity can improve metabolic and vascular parameters among otherwise healthy obese subjects.
**Methods** We enrolled 70 obese patients (age 56.8±8.91 years,M:F 2:1,7,BMI 34.2±5.69 kg/m2) without previous vascular events. CV familiarity was present in 45%, hypertension in 64.3%, smoke in 16.7%. Each patient underwent to a complete CV and metabolic evaluation before physical activity. After a 3-months training subjects were reassessed.T-test for repeated measures was used to analyze differences.
**Results** At baseline sample showed insulin resistance, hypertriglyceridemia, endothelial dysfunction, increased IMT, and increase in left ventricle(LV) mass; double product at treadmill resulted within lower limits. Framingham risk was 14.8%, with a 13.8% comparative increase.At 3 months we observed a significant reduction of weight (96.5±18.9-87.8±13.2kg),BMI(34.2±5.69-28.9±9.03kg/m2),IMT(0.95±0.14-0.76±0.08mm),
left ventricle(LV) mass(108.2±34.0-76.36±28.73g/m2),
HOMA index(7.21±6.44-2.76±2.14); FMD(7.43±10.4-23.7±13.6%) and double product increased (254.6±60.7-286.5±49.8).
**Conclusion** In-hospital controlled physical activity reduced body weight and BMI, the extent of preclinical atherosclerosis and dysmetabolic markers, suggesting that lifestyle changes are as important as drugs in primary prevention.

## Una questione di pelle in Medicina Interna

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**Introduzione** La S. di Lyell e la S. di Stevens-Johnson sono due stadi diversi della stessa patologia in cui a cambiare è l'entità dell'interessamento cutaneo. In entrambe la pelle è l'organo più severamente colpito ma anche le mucose degli occhi, del cavo orale e dei genitali sono spesso gravemente interessate. Si parla di Stevens-Johnson quando le lesioni interessano meno del 10% della superficie corporea, oltre il 30% si configura la Lyell che è in tutto assimilabile al grande ustionato richiedendo un trattamento in un reparto di terapia intensiva ma che, almeno nella fasi iniziali, possiamo trovarci a seguire in Medicina Interna.
**Caso clinico** Presentiamo il caso di un uomo di 62 anni, diabetico, iperteso, trasferitoci da una riabilitazione cardiorespiratoria per la comparsa di gravi lesioni cutanee legata all'assunzione di sulfametoxazolo/trimetoprim per deiscenza della ferita chirurgica dopo bypass Ao-Co. Il paziente si presentava febbrile con estesa epidermolisi al tronco e grave coinvolgimento delle mucose interessanti circa il 30% della superficie corporea; erano inoltre presenti anemia, leucopenia, ipoalbuminemia ed elevazione degli indici infiammatori. Nel sospetto di stato settico il paziente veniva trattato con prednisone 1 mg/kg/die, teicoplanina, piperacillina e caspofungina. Il circolo è stato sostenuto dal quotidiano bilancio idrosalino e infusione di albumina. Dopo risoluzione dell'acuzie il paziente è stato trasferito in Malattie Infettive, per la gestione in camera asettica delle medicazioni, da dove è stato poi dimesso.

## Un caso di mancato consenso: etica giuridica e coscienza professionale

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"La libertà personale è inviolabile..." ( art.13 CI) " La Repubblica tutela la salute come fondamentale diritto dell'individuo.." ( art. 32 CI).

Questi art. della CI tutelano dei diritti fondamentali di ogni cittadino. Nel caso clinico che presentiamo abbiamo affrontato la conflittualità tra tutelare il diritto alla salute di una paziente affetta da psicosi cronica paranoide con delirio persecutorio, ritenuta incapace di esprimere un valido consenso, priva di un legale rappresentante non essendo mai stata interdetta dal tribunale, affetta da polipatologie e con necessità di impianto di pace-maker e di altre procedure interventiste ( polipectomia endoscopica) e rispettare la chiara volontà della paz. che rifiutava qualsiasi procedura. Nessuna delle procedure proposte, pur in presenza di patologie gravi e con concreto rischio di pericolo di vita anche se non attuale, presentava i caratteri della necessità Come internisti abbiamo mediato qualsiasi decisione avvalendoci delle consulenze " tecniche" del cardiologo, psichiatra, geriatra, medico-legale e direttore sanitario. In questi anni c'è stata una evoluzione normativa che riguarda le persone delle "fasce deboli" a cui viene riconosciuto sempre di più il bene inalienabile in quanto persone dell'autodeterminazione. In questo caso la paz. non era in grado di esprimere un valido consenso tecnico, ma le è stato riconosciuto in pieno il diritto di esprimere liberamente la sua volontà e quindi il diniego a sottoporsi ad una procedura interventista.

## A back pain very internistic

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A 63 years man, with mental retardation due post-partum meningitis, presents for 1 month fever, fatigue, weight loss and low back pain, treated by ceftriaxone for 10 days without benefit. Performs diagnostic study: negative immunological tests, autoantibody panel, tumor markers, serological infective tests and blood and urine cultures. Abnormal tests are: WBC 11320, N 80%, ALT 55, GGT 185, CRP 4, ESR 80, a2 globuline 16%.
Abdominal and neck ultrasound shows mild hepatic steatosis, a cyst of the left kidney and a thyroid nodule.
TC of lumbosacral spine shows confluent areas of osteolysis with irregular margins at L1-L2.
MR confirms the diagnosis of subacute spondylodiscitis with soft inflammatory component and impression on the median-paramedian left dural sac.
Echocardiography excludes endocarditis; a total body CT scan excludes other sources of infection.
He performs empirical therapy with iv levofloxacin 500mg x2/die + cefotaxime 2gx3/die. The fever disappears after 5 day with marked physical improvement.
After 3 weeks of therapy the low back pain disappeares, inflammation indices are halved and the patient is discharged with oral therapy: levofloxacin 500mg/die + rifampicin 600mg/die for 6 weeks.
After 6 weeks MR shows discrete alteration of impregnation L1-L2 and the disk interposed, disappeares the paravertebral endocanal component. Another 4 weeks of oral ciprofloxacin 500 mg twice are prescribed and then stopped. The last MR of the lumbar spine performed 2 months after shows reduction in height of degenerated disc and low residual alteration of vertebral bone.

## Studio SOLVET: efficacia, sicurezza ed effetto ponderale della terapia con insulina detemir in pazienti con DM2 - coorte italiana

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**Premesse dello studio** L'analogo detemir è un'insulina basale che nei Trials Clinici ha mostrato un minor rischio di ipoglicemie versus 'insulina NPH e un profilo migliore in termini di peso rispetto a glargine e NPH. Materiali e Metodi: SOLVE™è uno studio internazionale della durata di 24 settimane sull'uso d'insulina detemir in monosomministrazione in pazienti con DM2. Scopo dello studio è quello di valutare la sicurezza associata alla sua monosomministrazione in pazienti con DM2 in trattamento con OADs nella reale pratica clinica.Endpoint principale:incidenza di SADR fra cui ipoglicemie maggiori. Alla visita iniziale sono stati registrati: HbA1c,FBG,eventi ipoglicemici, ADR,SADR e peso.
**Risultati** Sono stati arruolati 4624 pazienti in 223 centri diabetologici con età media di 66,5 anni, durata media del diabete 13,3 anni, peso di 79,0 kg,BMI di 29,5 kg/m2, FBG media di 205 mg/dl e un'HbA1c media di 9,2%. La dose media di detemir era 0,16 U/kg.A fine osservazione, il controllo glicemico migliorava con una riduzione di 1,4% di HbA1c e di 70 mg/dl di FBG. Il dosaggio era pari a 0,23 U/kg e la percentuale di pazienti in target ADA era pari al 21,9%. Sono state riportate solo 3 SADR in 2 pazienti. La % di pazienti con eventi ipoglicemici minori alla visita iniziale era 2,8% e saliva a 4,7% alla fine. È stata osservata una riduzione di 0,5 kg di peso più marcato nei pazienti con BMI più elevato.
**Conclusioni** I risultati dalla coorte italiana mostrano che l'insulina detemir once daily migliora il controllo glicemico senza aumento delle ipoglicemie e con riduzione del peso.

## ✪ Study of Once-daily Levemir (SOLVE): glycaemic control & impact of insulin detemir in real-life clinical practice, global results

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**Aims** The aim of this analysis is to provide insights on the impact of initiating insulin detemir in real-life clinical practice in different countries around the world. Methods: SOLVE is a 24-week observational study in 10 countries evaluating the safety & effectiveness of once-daily insulin detemir in insulin naïve people with T2D treated with 1 or more OADs. Hypoglycaemia episodes were defined as follows: major hypoglycaemia requiring third party assistance,and minor hypoglycaemia, a daytime or nocturnal glucose measurement <3.1 mmol/L ± symptoms.Major hypoglycaemia was recorded as events recalled within the preceding 12 weeks, and minor hypoglycaemia as events recalled within the preceding 4 weeks.
**Results** A total of 14,785 participants have been enrolled in the study. Of these, 10,786 have completed the 24-week study (53% male, age 62±11 years, BMI 29.6±5.3, duration of diabetes of 10±7 years,of which 9±7 years was on OAD therapy).Pre-insulin HbA1c and FPG were 9.0±1.6% and 10.4±3.2 mmol/L, respectively.After 24 weeks of treatment, HbA1c and FPG decreased by 1.4±1.6% to a mean 7.7±1.2% and by 3.3±3.1 mmol/L to 7.1±1.9 mmol/L, respectively. Insulin dose at the end of the study was 22±16 U. The incidence of major hypoglycaemia fell from 3 episodes per 100 person years pre-insulin to 0.8 episodes per 100 person years at the end of study, whereas the incidence of minor hypoglycaemia increased from 1.4 to 1.8 episodes per person year.
**Conclusion** Insulin initiation is delayed until late in the course of the

disease. Using modest doses of insulin detemir, there were substantial improvements in HbA1c,FPG without increased risk of major hypoglycaemia.

### Una insolita intolleranza alla ciprofloxacina!

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**Premesse e scopo dello studio** Una paziente di sesso femminile, di 78 anni, è giunta in ospedale per l'insorgenza da due giorni di dolore toracico, accentuato dagli atti respiratori, e di dispnea ingravescente nelle ultime 24 ore, con scarsa tosse, in assenza di febbre. La paziente presentava desaturazione arteriosa (85% in aria ambiente) scarsamente influenzata dalla ossigenoterapia.
**Materiali e Metodi** La paziente veniva sottoposta ad esame radiologico del torace che poneva in evidenza Velatura di tutto l'ambito polmonare sinistro con modica attrazione omolaterale dell'ombra cardio-mediastinica. Seno costofrenico destro libero. Nel sospetto di una condizione atelettasica da ostruzione bronchiale si è proceduto all'esecuzione di un esame TC del torace che poneva in evidenza "Atelettasia del lobo superiore e della lingula per la presenza di corpo estraneo endobronchiale di circa 15 mm. Pervio il bronco del lobo inferiore. Non linfoadenopatie mediastiniche".
**Risultati** La paziente, risultata affetta da ostruzione a carico del bronco lobare superiore sinistro per la presenza di un corpo estraneo di circa 15 mm, veniva trasferita in chirurgia toracica presso la quale veniva eseguito esame broncoscopico che confermava la presenza del corpo estraneo, consistente in una compressa di Ciproxin da 500 mg, che veniva estratta per via endoscopica.
**Conclusioni** La presenza di una atelettasia da ostruzione bronchiale, specialmente in pazienti molto giovani o anziani, o con severe difficoltà di tipo prassico-cognitivo deve indurre sempre il sospetto di un possibile corpo estraneo inalato.

### Spondilodiscite: rara complicanza di biopsia prostatica

F. Cardoni [1], R. Cesareo [1], C. Cianfrocca [1], V. D'alfonso [1], P. Del Duca [1], A. Maietta [1], G. Straface [1], G. Tommasi [1], B. Virgilio [1], G. Campagna [1]

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A67, biopsia prostatica ecoguidata transrettale (BPTR) per rialzo PSA. Profilassi con chinolonico.24 ore dopo, febbre, brivido, sensibile a paracetamolo. 10 giorni dopo, dolore dorsale violento, febbre con brivido, mal controllati da ceftriaxone, diclofenac.20 giorni dopo,ricovero per febbre intermittente, dorso-toracoalgia, scadimento condizioni. Ingresso: T°37.2, GR3480000, GB10200, N76 ,PCR29.8, Fibrinog 684,D-dim1.17.VES104,alfa2-glob17.3. Negativi Rx torace,es colturale urine,autoimmunità.Obiettività non significativa.PSA4.7.PCT0, 64, picco monoclonale ambito gamma-globuline,beta2-glob2.2, proteinuria Bence-Jones negativa.4 giornata:febbre serale con brivido(38.5) e intensa dorso-toracoalgia:emocolture. Ecocardio: negativo. Obiettività: spiccata spinalgia pressoria dorsale, necessaria terapia antalgica. TAC body:tessuto disomogeneo interessante disco-corpi vertebrali D8-D9. Prostata disomogenea. RMN: spondilodiscite D8-D9, raccolta paravertebrale, iniziale compressione midollare. Terapia empirica con carbapenemico. EMOCOLTURE: Positive per E. Coli multiresistente, sensibile al meropenem. Dopo 48 ore drammatico miglioramento: regressione febbre, riduzione dolore. Valutazione NCH,applicazione busto. In15 giornata trasferimento neuroriabilitazione. Dimesso dopo 8 settimane di antibioticoterapia venosa,buone condizioni generali.Referto biopsia: Ca.prostata Gleason 3+3.
**Conclusioni** Caso presentato evidenzia spondilo-discite rara grave complicanza di BPTR che occorre considerare sempre,specialmente quando sospetto clinico indirizza in tal senso,malgrado contraddittorietà esami laboratoristici.

### Monossido di Carbonio (CO): silenzioso veleno per cuore e cervello ma...non per tutti!

F. Cardoni [1], R. Cesareo [1], C. Cianfrocca [1], V. D'alfonso [1], P. Del Duca [1], G. Straface [1], G. Tommasi [1], B. Virgilio [1], E. Pucci [2], G. Campagna [1]

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A 47,maschio,vicino braciere spento,shock,stato confusionale, incontinenza sfinterica.In PS:CPK 550-1718,Troponina I 0,51,PH7,4, O2 90mm/Hg, CO 4,8g%sostanze d'abuso:neg.TC encefalo:ipodensità nuclei base,cerebellare,tronco-encefalo.Dopo 3 trattamenti con O2iperbarico, RMN: miglioramento cerebellare,tronco-encefalo; iperintensità simmetrica nuclei base.Rx torace:impegno interstizio-alveolare bilaterale.ECG:Tneg.V1-3. Ecocardio: normale cinesi,EF 60%.Tests psicometrici: deficit memoria breve termine, attenzione, concentrazione, capac.linguistica. Stabilizzato, trasferito Neuroriabilitazione.
A 90, donna, vicino camino spento, stato confusionale, disidratazione. In PS:90/50,glicemia 532mg%, CPK35,Troponinal 0,008,PH7,41,O2 66mm/Hg, CO 10,4g%.Lattati1,2.TC encefalo:neg.Hb glicata:11mg%. Rapida normalizzazione neurologica e di CO con O2 normobarico, ripristino normoglicemia con infusione insulinica.
A 44,donna,stato soporoso,vicino stufa "a pellet".In PS:90/70,Fc110/min,CPK690,MB-massa31.3, Troponinal 0,6,creatinina1,6, CO 39g%,Lattati14.TC encefalo:neg.Dopo 2 trattamenti con O2 iperbarico,normalizzazione CO.ECG:Tneg V1-V4.Ecocardio:inizialmente ipocinesia diffusa(EF43%); successivo sensibile miglioramento (EF58%).
**Conclusioni** I casi descritti, in accordo con i dati della letteratura, esemplificano la diversa tossicità del CO, evidenziabile soprattutto a livello neurologico e cardiovascolare.L'entità del danno,tuttavia,è indipendente dall'età del soggetto esposto,dalla concentrazione del CO rilevata e da possibili morbilità pre-esistenti.

### ✪ Invasive pulmonary aspergillosis in non-neutropenic patients: an emerging fungal disease

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Invasive aspergillosis (IA) has been traditionally considered one of the major causes of morbidity and mortality in patients with well-established risk factors, such as neutropenia, hematologic malignancies, organ transplantation, or HIV. However there is increasing evidence that apparently immunocompetent patients, such as those with severe liver disease, diabetes mellitus and chronic obstructive pulmonary disease patients, most of whom, but not all, were receiving steroid treatment, are also at high risk for Aspergillus infections, with a very high mortality rate. The detection of galactomannan (GM) performed in respiratory specimens is a new valuable test for the diagnosis of probable IPA, even in non-neutropenic high risk patients. Since the frequency and clinical impact of IPA in non-hematologic patients is not well known, it seemed rational to us to evaluate patients hospitalized for whom an Infectious Diseases consultation was required. Patients were evaluated

according to recently recommended diagnostic criteria. Our experience seems to suggest an emerging role of IA in patients with specific risk factors, who may have a higher mortality rate than their neutropenic peers, and provides preliminary evidence that early diagnosis and prompt initiation of antifungal therapy may improve the ultimate outcome of their IA. Furthermore, our data seem to confirm the diagnostic usefulness of GM detection in bronchoalveolar lavage fluid in non-neutropenic patients with risk factors for IA and evidence of pneumonia not responding to initial broad-spectrum antibiotic therapy.

## Erythema multiforme associated with Haemophilus parainfluenzae pneumonia

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Erythema multiforme (EM) is an acute, self-limited skin condition characterized by itchy red papular skin lesions, associated with certain infections, medications, and other various triggers. Involvement of oral mucosa identifies patients with the major form of EM, similar to that described by Steven and Johnson in 1922, from which, however, differs for precipitating factors and clinical patterns. The pathophysiology of EM is still not completely understood, but it is probably immunologically mediated as a hypersensitivity reaction that can be triggered by a variety of stimuli, particularly bacterial, viral, or chemical products. Among bacterial respiratory infections, Mycoplasma species appears to be a common cause of EM. However, approximately 50% of cases of EM are idiopathic. Haemophilus species other than H. influenzae and H. ducreyi are unusual causes of disease, presumably because of their low pathogenic potential. Haemophilus species, particularly H. parainfluenzae, are recognized increasingly as a cause of infective endocarditis, up to 5% of cases. They have been also documented as rare causes of a variety of respiratory and systemic infections. We report a case of 45 year old man with community acquired pneumonia due to Haemophilus parainfluenzae and associated cutaneous findings within the spectrum of erythema multiforme. To the best of our knowledge this is the first case reported; furthermore, we extensively review the literature and discuss the association between bacterial infections and EM.

## Gastrointestinal stromal tumors (GISTs): case report

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**Background and Aims** Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal tumors of the gastrointestinal tract with an incidence of 1.5/100.000/year, commonly asymptomatic and incidentally found during laparoscopy, surgical procedures or radiological studies.
We describe a case of GIST in which abdominal ultrasonography (US) played an important role in the diagnosis of this tumor.
**Patients and Methods** A 50-years-old man with no past medical history but with familiarity for colon cancer, came to our attention because of iron deficiency anemia. Colonoscopy revealed a tubular adenoma of the transverse colon endoscopically removed. Anti-endomisio IgA antibodies were positive with an upper gastrointestinal endoscopy negative for villi alterations, histologically confirmed. US showed a rounded hypoechoic mass of the small bowel, of 45x35 mm, with echographic aspect suggestive of GIST, confirmed at abdominal computed tomography (CT).
**Results** The patient underwent surgical removal of the mass because of acute anemia (Hb 4 g/dl). Diagnosis of GIST was histologically and immunohistochemically confirmed, with evidence of low-grade GIST. After surgery the patient was referred to the oncologist for suitable treatment.
**Conclusions** The standard approach to patients with GIST is endoscopic ultrasound (EUS) with EUS-guided fine-needle aspiration biopsy (EUS-FNAB). Therefore, CT scan but also transabdominal US play an important role in the detection of this tumor in contrast to PET, which is most useful in the follow-up. In all cases histological diagnosis is essential.

## ✪ Non-celiac wheat sensitivity diagnosed by double-blind placebo-controlled challenge: exploring a new clinical entity

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**Background** Non-celiac wheat sensitivity (WS) is considered a new clinical entity. We aimed to demonstrate the existence of WS and define its clinical, serologic and histological markers.
**Methods** We reviewed the clinical charts of all subjects who had been diagnosed with wheat sensitivity (WS) using a double-blind placebo-controlled challenge (DBPCC) from 2001-2010. One hundred CD patients served as controls.
**Results** Four hundred and seven patients with WS were included, as diagnosed by DBPCC.
Two groups showing distinct clinical characteristics were identified: wheat sensitivity alone (Group 1) and wheat sensitivity associated with multiple food hypersensitivity (Group 2).
Group 1 WS was characterized by clinical features very similar to those found in CD patients: all subjects showed the HLA DQ2 and/or DQ8 haplotypes, EmA assay in the culture medium of the intestinal biopsies was positive in 27% and duodenal lymphocytosis was seen in 94% of cases. Group 2 WS was characterized by a high frequency of IBS, the presence of HLA DQ2 or DQ8 haplotype in 50% of cases, a high frequency of positive serum anti-gliadin IgG (60%) and basophil in vitro activation with wheat antigen stimulation (80%), as well as eosinophil infiltration of the duodenal (47%) and colon (67%) mucosa.
**Conclusions** Our data confirm the existence of not-celiac WS as a distinct clinical condition. We also suggest the existence of two distinct populations of subjects with WS: one with characteristics more similar to CD and the other with characteristics pointing to food allergy.

## Internal carotid artery plaque characteristics and percent of stenosis: which indicators for follow-up controls?

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**Aim of the study** The goal of our study is to analyze the ultrasound characteristics of carotid plaques among a population of outpatients and to propose the criteria for the planning of ultrasound follow- ups.
**Methods** We studied 747 consecutive outpatients. A Color-Doppler sonography of the carotid arteries was performed on all of them. 397

(53%) of the patients were females and 350 (47%) were males. Most of them presented multiple cardiovascular risk factors or were patients in follow-up for carotid artery stenosis.
**Results** The most significant data concerning the Internal Carotid Arteries (ICA) showed for the right ICA that 419 out of 747 (56.1%) presented a stenosis between 1% to 69% and for the left ICA 408 of 747 (54.5%) presented a stenosis between 1% to 69%. The carotid plaques have been sorted using the modified Gray-Weale classification: in the right ICA the plaques Type 1 and Type 2 were 124 out of 419 (29.5%), in the left ICA 77 out of 408 (18.8%).
**Conclusion** Plaques Type 1 and Type 2 are the so called "vulnerable plaques". In the group of patients that we studied, 160 out of the total of 747 (21.4%) presented such types of plaque. These are the patients, even if they have only moderate stenosis, that should be put in a preferred position in planning of ultrasound follow-ups.

## Eosinophilic colitis, first manifestation of undifferentiated connectivitis

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**Clinical case** A 30 years old man with sub-contnuous abdominal pain and diarrhea (3-4 daily) was admitted to our department. Anamnestic arterial hypertension treated with perindopril. In 2009 he underwent colonscopy, with a negative macroscopic picture but histological appearance of eosinophilic colitis, not investigated further.
**Clinical course** In our department the diagnostic work-up was focused on the abdominal pain and the eosinophilic related diseases, so he underwent blood and urine culture and fecal parasitological examination, all negative, such as abdominal ultrasound scan, inflammatory markers and thyroid functional tests.
A pancolonscopy with biopsies was repeated and histological results showed non-specific inflammation of the lamina propria with the presence of eosinophils.
Patient re-evaluation was significant with former Raynaud's phenomenon; ANA test resulted positive 1/360 with a nucleolar spectrum, ENA research with anti-PM-Scl75 immunoblot and capillaroscopy were positive as well. The case has been therefore interpreted as undifferentiated connectivitis, with a likely low expression scleroderma pattern.
**Conclusion** Eosinophilic colitis is a rare form of intestinal disease that recognizes several causes (parasitic infection, allergic reaction to medication, inflammatory bowel disease) and may be seldom associated with autoimmune connective diseases, such as slerodermia, dermatomyositis and polymyositis. In our case it was the first symptom of a low expression pattern autoimmune disease.

## Indagini invasive e doppia antiaggregazione

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Maschio 60 anni, ex fumatore, giunge al nostro reparto a seguito di un IMA trattato con PTCA e stenting (stent medicato). All'RX del torace si rileva un versamento pleurico basale sn confermato alla TC di controllo e trattato con antibiotici. Il paziente nega dispnea e febbre, riferisce solo dolore a livello della spalla e della base polmonare sn. L'esame obiettivo durante il decorso però mostra un aumento progressivo del versamento. Si effettuano quindi: BAL (negativo per malignità), emocolture (negative), markers neoplastici (diffusamente mossi: Cyfra21-1, Ca-125, NSE, Ca19-9, CEA, PSA e Tpa) ed esame del liquido pleurico (ematico) che esclude la presenza di cellule maligne. L'aumento del versamento si complica con un'insufficienza respiratoria che richiede il posizionamento di un drenaggio pleurico in urgenza. Non potendo eseguire esami invasivi per la doppia antiaggregazione,si riesamina il liquido pleurico(ancora negativo)e si effettua una nuova TC che mostra un ispessimento irregolare della pleura basale con enhancement. Per poter eseguire una pleuroscopia con biopsia, malgrado la presenza dello stent da meno di 90 giorni, viene sospeso il prasugrel e l'asa per poche e iniziata terapia ev continua con Aggrastat. L'istologia pleurica dà come esito"etp epiteliale".Il paziente comincia quindi la chemioterapia, ma a causa delle condizioni cliniche non più stabili,muore dopo il 1°ciclo.
**Conclusioni** La doppia antiaggregazione rappresenta un grosso problema nei soggetti in cui una diagnosi precisa e tempestiva apporta benefici in termini di sopravvivenza e/o guarigione.

## Un caso particolare: dall'infarto al melanoma IV stadio

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Z.T, 60 anni, iperteso e pregresso ictus emorragico cerebellare, giunge alla nostra SOD dopo un IMA trattato con PTCA e stenting in trattamento con doppia antiaggregazione per melena con grave anemizzazione durante la degenza in cardiologia, una EGDS mostra una lesione ulcerativa duodenale attiva. Per una cefalea persistente viene eseguita TC cranio, da cui emerge una lesione espansiva necrotico-cistica cerebellare. I neurochirurghi pongono indicazione all'intervento terminata la doppia antiaggregazione. Nonostante il trattamento con PPI ev in perfusione, il paziente continua ad anemizzarsi e la seconda EGDS non mostra miglioramenti. Si effettua una TC addominale, con rilievo di un ispessimento di parete duodenale ed una massa disomogenea paraduodenale di possibile natura linfomatosa, suscettibile quindi di un'exeresi risolutiva. Al momento dell'intervento NCH alla istologia risulta: metastasi da melanoma. Né il dermatologo, né l'otorino, né l'oculista hanno trovato l'origine. Gli esami ematici, pur rilevando una neoplasia, risultavano del tutto aspecifici (LDH 318U/L, Tpa 120U/L, NSE 26,1ng/mL, Ca-125 37,6 U/ml), la clinica risultava praticamente muta.
**Conclusioni** Tutte le patologie del paziente (ictus emorragico, IMA, ulcera, cefalea) erano verosimilmente ascrivibili al tumore, peraltro raro (melanoma cistico), che ha reso difficile la gestione del paziente e la diagnosi. Consigliamo un'attenta valutazione nei soggetti con ulcere non responsive al trattamento e di includere il melanoma nella DD di casi simili.

## ✪ Diagnosis of stroke in the acute vertiginous patient: a bedside three-step tool

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**Aim of the study** To investigate a bedside structured examination (CODIT: COntinous Direction Impulse Test) to differentiate central from peripheral vestibulopathy.
**Methods** Patients presenting to our ED(May 2011-January 2012)with isolated vertigo were prospectively evaluated with CODIT by 5 trained emergency physicians or ordinarily by the rest of the medical staff (controls). The CODIT consists of three steps:1)type of nystagmus: Continous or positional. When continuous nystagmus was present the direction was examined 2)Pluridirectional and vertical nystagmus indicated central vestibulopathy. When monodirectional nystagmus was present

head impulse test (HIT) was performed. 3)negative HIT indicated central vestibulopathy.Complete neuro-otological examination was the gold standard. If central origin was suspected, patients underwent CT and/or RM. Test characteristics, neuroimaging tests and hospitalization rates were the main outcome measures.
**Results** 292 patients with isolated vertigo were evaluated: fifty-two (17.8%) had central and 240 (82.2%) had peripheral vestibulopathy. Ninety-seven out of 292 patients were evaluated with the CODIT. The CODIT showed a 100% sensitivity(CI 95%:80.3-100%)and 97.6% specificity(CI 95%: 94-97.6%) for central vestibulopathy. Hospitalization and neuroimaging rates were significantly lower in patients evaluated by the CODIT (27.6% and 28.6%) than in controls (50.3% and 70.5% respectively, P<0.01 for both).Conclusions: The CODIT identified central vestibulopaty with a very high sensitivity, reducing neuroimaging tests and hospitalization rate.

## ✪ Large monofocal hepatocellular carcinoma (HCC) mimicking cavernous hemangioma

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**Case report** A 77 years old male was admitted because of sudden abdominal pain and mild jaundice. He was on warfarin for atrial fibrillation Neither liver disease nor alcohol intake were reported.
Blood tests showed anemia (Hb 4.9 g/dl), mild hyperbilirubinemia and hypertransaminasemia, negative HBV and HCV serology.
A large (15 cm) liver lesion not better characterizable was demonstrated by CEUS. A possible HCC with intralesional hemorrhage was suspected by CT. MR did not confirm HCC, and proposed cavernous hemangioma. Alpha1fetoprotein (AFP) and FDG-PET were negative. Percutaneous biopsy couldn't be performed because of a large hemorrhage in the mass and due to the good general conditions and the absence of HCC risk factors (pre-existing liver disease, alcohol abuse, HBV and/or HCV infection, AFP increase), we decided for surveillance. A CT scan three months later showed smaller mass size and unchanged contrast features. Fifteen months later liver US revealed two smaller nodules and RM demonstrated multifocal HCC. Again, AFP was normal. The liver biopsy showed well differentiated HCC.
**Conclusions** HCC usually develops in patients with chronic liver disease, mainly after viral hepatitis, and it is very rarely reported in non cirrhotic liver and in the absence of alcohol abuse. Although the pretest probability for HCC in these case is low, if only one out of the three imaging techniques (CEUS, TC and MR) is suggestive for HCC, liver biopsy in mandatory. Because AFP and FDG-PET have a very low sensitivity for HCC, their negative results are clinically useless.

## A Kappa light chain deposition disease (LCDD)

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LCDD is the deposition of monoclonal, amorphous, noncongophilic LC in multiple organs that do not exhibit a fibrillar structure. Renal involvement is a constant feature. 50-60%of patients with LCDD have associated lymphoproliferative disorder (MM), 40-50% of patients develop LCDD in the setting of progression of MGUS. 85% of cases are associated with K LC deposition. LC is usually demonstrate in serum/urine;25% of patients have no demonstrable in serum/urine by immunoelectophoresis or immunofixation. Frequency of LCDD is unknown.
A 76 years old man admitted with diagnosis of "suspected pancreatic cancer". Symptoms: fatigue, decreasing bw 5kg, hypothyroidism. Past story no alcohol, smoke, cardiovascular disease. Clinical features: most increasing liver area, icterus. Blood chemistry: increased AST(109 U/l), ALT(65U/l), yGT(1448 U/l) bilirubin tot (7mg/dl),dir (5.92 mg/dl) functional renal index (creatinine 2.91 mg/dl, BUN 149 mg/dl), proteinuria 24h (3523mg/24h), configurated like nefrosic syndrome. ECG: sinousal bradycardia. Ultrasound abdomen and TC total body: most increasing liver area. Echocardiography: asymmetric parietal hypertrophy with conserved EF(65%). Absence of monoclonal LC in Immunoelectoforesis and immunofixation serum/urine. In suspicion of amyloidosis(A) was performed a liver biopsy. In hematoxylin-eosin were highlighted widespread amorphous deposits like A, but in the electronic microscopy were not present microfibrils typical A. Immunohistochemical evaluation showed diffuse positivity for LC K, negative for LC L and AA.

## A 10-year study on epidemiology and clinical characteristics in 256 HCC patients in North Italy

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**Background and aims** Hepatocellular carcinoma (HCC) is a common cancer worldwide; a rising incidence has been reported in Europe and United States. We performed this study in order to assess epidemiology and clinical characteristics in HCC patients.
**Methods** We carried out 273 consecutive HCC from June 2000 to July 2010 at S.Croce Hospital, Cuneo (North Italy). We analyzed clinical and pathological data; data were grouped into two five-years periods, based on the diagnosis date (2000-2005 and 2005-2010).
**Results** 256 HCC were included (M/F 182/74; mean age 70 years), 133 in the first period and 123 in the second one. Hepatitis C virus infection was the most common HCC risk factor (54.1% in the first period, 50.4% in the second one; p>0.05); a non-viral/non-alcoholic etiology rate was 3.7% in the first period and 20.3% in the second one (p=0.02). Child class A patients increased significantly in the second period (p<0.001). Adjusting for age, gender and etiology, we observed an increased HCC surveillance during the second period (p=0.01). Differences were seen in tumor parameters: 53 unifocal HCC in the first period and 69 in the second one (p=0.02) and, respectively, 22 and 37 HCC ≤3 cm (p=0.01). Stage BCLC 0 (very-early) and A (early) were 34.6% and 50.4% in the two groups respectively (p=0.007).
**Conclusions** This study shows a decreased number of HCC-HCV related in the last years, with an increase of non-viral/non-alcoholic aetiology. In the second period we observed an increased application of surveillance programs, leading to an increased number of early-diagnosed HCC.

## ✪ 256 HCC patients in North Italy: a 10-year study on treatment patterns and outcome

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**Background and aims** Hepatocellular carcinoma (HCC) is the fifth most common cancer and the third leading cause of cancer mortality worldwide. Surveillance of HCC-risk patients is known to improve survival. We performed this study in order to assess treatment patterns and outcome in HCC patients.
**Methods** We carried out 273 consecutive HCC from June 2000 to July 2010 at S.Croce Hospital, Cuneo (North Italy). We analyzed clinical and therapeutic data; data were grouped into two 5-years periods, based on the diagnosis date (2000-2005 and 2005-2010). Patients underwent a 6 months follow up.
**Results** 256 HCC were included (M/F 182/74; mean age 70 years), 133 in the first period and 123 in the second one. Patients underwent treatment (curative or palliative) were 62.4% in the first group and 89.4% in the second one (p=0.007). In the first period 47% of patients underwent a curative treatment; 42.3% in the second one (p>0.05). Over the entire study period, 79.6% of patients susceptible to curative treatment according to BCLC stage underwent it. Diagnosis period (p<0.001), BCLC stage (p<0.001) and treatment per se (p<0.005) were predictors of better prognosis; surveillance was not related to survival (p=0.15).
**Conclusions** In the second period we observed an increased application of surveillance programs, leading to an increased number of early-diagnosed HCC, but without a parallel increase in curative therapies. Otherwise, in our study surveillance per se does not significantly improve outcome in HCC. Surveillance program must be accompanied with appropriate treatment options.

## Beware of back pain..when the pain doesn't go back

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**Introduction** A 42 year-old man from Sri Lanka repeatedly presented to the Emergency Department because of unremitting back pain. All plain X-ray exams were normal and he was discharged home without a clear diagnosis. In the following month the pain worsened, together with low grade fever and weight loss.
A CT and MRI scan revealed a T9-T10 spondylodiskitis with neoformed tissue surrounding vertebral bodies with initial involvement of the spinal canal. CT-guided biopsy showed inflammatory tissue with cultures positive for Staphylococcus aureus. There was no evidence of mycobacterial infection and no clear sources of infection were found. Antibiogram-guided antibiotic therapy was started and clinical improvement ensued.
**Discussion** Infectious spondylodiskiitis should always be considered in the differential diagnosis of long-standing and worsening back-pain. The presence of risk factors should be investigated (i.e., immunodepression, i.v. drug abuse). In the acute phase, plain films can be completely negative and CT/MRI should be early considered because a delayed diagnosis could lead to invalidating sequelae (abscesses, vertebral fractures, medullary compression).
The treatment of spondylodiskitiis should include a consult with a spine surgeon, the identification of the infectious agent through microbiological cultures (with a particular attention to M.tubercolosis), and the exclusion of a possible occult source of infection (i.e., endocarditis).

## A case of myxedematous coma and pneumonia: a dangerous mixture

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**Introduction** A 89 year-old woman affected by type 2 diabetes mellitus and Parkinson's disease with progressive loss of autonomy presented to the Emergency Department because of rapidly worsening dispnea at rest. Her relatives referred a progressive deterioration of the mental status in the last weeks together with anorexia and dysphagia. At admission to the hospital the patient was lethargic; there was no evidence of focal neurological signs; non-pitting edema of the legs was present. BP was 90/60, HR 60, temperature 36.7°. The blood gas analysis revealed a severe respiratory and metabolic acidosis; blood test showed leukocytosis, hypoglicemia, blood urea nitrogen and creatinine elevation. The chest X-ray showed bilateral pneumonia; a head CT scan was negative.Thyroid function tests were obtained, showing a TSH elevation (67 mIU/L) with low free T4 and T3 levels. Despite thyroid ormone replacement and supportive therapy (non invasive ventilation, vasoactive agents and antibiotics) the patient died.
**Discussion** Severe hypothyroidism and mixedema crisis are endocrinological emergencies. A precipitating stressor (i.e., pneumonia) can decompensate a preesisting uncorrected hypothyroidism and lead to potentially lethal complications. Early clinical suspicion is fundamental, especially in the elderly, who can present subtle signs and symptoms of the disease. Ormone replacement is the cornerstone of the therapy; however, mortality remains high.

## Acute psychosis in systemic lupus erythematosus (SLE): lupus cerebritis or steroid (CST) - induced psychosis?

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Lupus cerebritis identifies neuropsychiatric SLE disorders, in absence of other causes. It should be distinguished from psychiatric CST side effects.
**Description** A 35 years old woman 10 years ago was treated for idiopathic thrombocytopenia with high-dose CST: after a month acute psychosis occurred. Drugs were stopped and she could suspend psychiatric therapy. 3 years ago SLE was diagnosed without signs of lupus cerebritis. She started hydroxychloroquine but, as worsening, prednisolone 25 mg/day was added and she showed new psycosis. Shifted to azathioprine she returned to normality. 3 months ago, in another hospital, she started prednisolone 50 mg/day, again due to thrompocytopenia. Relapsed a psychotic syndrome, treated with delorazepam, haloperidol, biperiden. There weren't signs of active SLE and MRI was negative. Only visual field was abnormal. After CST discontinuation her mental status improved but she needs continuous antipsychotic therapy.
**Conclusions** Lupus cerebritis is often associated to active disease and antibodies positivity; MRI abnormalities aren't mandatory. CST psychosis is related to drug assumption, in high doses, and hypoalbuminemia; it occurs after few days(21 days on average)of therapy, resolving with suspension. Our patient always showed development of psychosis after CST introduction although the resolution of neuropsychiatric symptoms was slow and incomplete;moreover there aren't signs of neurological disease except of visual field abnormality. We need to closely monitor psychological state of patient without confounding CST treatment.

## Acute heart failure, BNP levels, deaths and days of hospitalization in patients admitted in a Internal Medicine department: a retrospective study

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**Background** Acute heart failure(AHF) is frequently associated to poor prognosis among elderly patients admitted to Internal ad Emergency Medicine departments. Increased brain natriuretic peptide(BNP) levels have been related to increased mortality in this subset. Aim of this study is to evaluate if among patients who die for AHF, BNP at admission can be associated to the length of hospitalization.
**Methods** We enrolled 400 consecutive patients admitted to our Internal Medicine Department with a clinical diagnosis of AHF. BNP was evaluated at admission in all the patients, stratified in four categories: patients with BNP less than 100 pg/ml (group 1), BNP 101-500 pg/ml (group 2), BNP 501-1500 pg/ml (group 3) and BNP higher than 1501 pg/ml (group 4). Each patient underwent to a complete diagnostic workup. Patients with BNP levels less than 100 pg/ml or a final diagnosis other than AHF were excluded. Kaplan-Meier model with log-rank test was used to assess the differences.
**Results** 293 patients were suitable for final analysis. Mean age was 80±9.85 years, males representing 58% of the sample. Patients in group 2 had a significantly longer hospitalization (mean: 46.0 days, SE 3.71) than patients in group 3 (mean: 36.7 days, SE 2.51) and group 4 (mean: 22.9 days, SE 1.88) ($p<0.05$, all ties).
**Conclusion** Among elderly patients admitted in an Internal Medicine department who die of AHF, higher BNP levels are associated to a shorter hospitalization due to a faster progression of the pathology and in-hospital death.

## Nuove linee guida ITP: cosa cambia nell'approccio al paziente? Esperienza della S.C. Medicina 1 ed Ematologia di Savona

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Immune thrombocytopenia ( ITP ) is a disorder characterized by isolated thrombocytopenia due to platelet destruction and/or inadequate production often occurring in the absence of identifiable and specific precipitants commonly encountered in clinical practice.Recently the guidelines published in 1996, which have become the reeference standard for the diagnosis and treatment of the disease, have been updated also for the intoduction of new drugs for the therapy of ITP. Initial therapy consists of corticosteroids or intravenous immunoglobulin (IVIg). Patients with chronic refractory disease might undergo splenectomy. Although there is no treatment of choice in those who do not respond to splenectomy, immunosuppressive agents are typically prescribed. Now two new drugs are available, Romiplostim and Eltrombopag, that work through stimulation of the thrombopoietin (TPO) receptor (c-Mpl) to increase platelet production.The authors describe their little experience with romiplostim, review the clinical efficacy and tolerability of this drug in adults with immune thrombocytopenia (ITP), as well as summarizing its pharmacological properties.

## Intensive rehabilitation in patients with acute physical disability: a multi-disciplinary approach in a model of care intensity

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**Background** Intensive rehabilitation of acutely disabled patients has been proved to be effective. In this context, the care intensity model is based on a multidisciplinary approach. Since March 2011, ten beds for intensive rehabilitation of patients acutely disabled for neurological disorders, mainly stroke, or post surgery, have been opened in the location of two Internal Medicine wards of Siena district. Multidisciplinary approach is guaranteed by Internal Medicine Physicians present 24 hours for day, one Physical Medicine Physician present 18 hours for week in each hospital, Physiotherapists, Speech Language Therapists and Nurses. Internists take care of medical problems and the other Figures of rehabilitative problems and nursing needing. The aim of our study was to describe first results of the ongoing project.
**Methods** Data records of patients admitted in the rehabilitation beds of medical area (March-December) were analyzed.
**Results** In this period 80 patients were recovered in the intensive rehabilitation beds, 75% for neurovascular disorders, whereas 25% for post-surgical disabilities. 70% of patients has been admitted from the same ward or hospital, while 30% of patients has been recovered from other Hospitals. Mean stay was around 20 days. 2,5% of patients died. 95% of patients has been discharged with a program of outpatient care shared by all Figures. Median of Functional Independence Measure Scale improved from 37 to 59.
**Conclusion** Despite advantages of our model must be closely evaluated, first results seem encourage able. This model could be cost-effective.

## Splenomegalia iperreattiva post malarica con severa ipertensione portale presinusoidale

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**Giugno 2005** Keniota, maschio, nero, 53 anni, presenta emorragia digestiva da varici esofagee trattata in urgenza con sonda di Blakemore. Alla TC addome evidenza di splenomegalia, ascite e ipertensione portale. Funzionalità epatica conservata: CTP A6.
**Luglio 2006** Esegue biopsia epatica con evidenza di fibrosi portale, minima duttopenia, non evidenza di cirrosi. HVPG 9 mmHg. HCV, HBV, AMA, ANA, anticorpi anti Schistosoma negativi. Anticorpi per Plasmodium Falciparum positivi. Ricerca diretta del Plasmodium nel sangue negativa.
**Ottobre 2006** Esegue EGDS: varici esofagee e varici gastriche GOV1; l'ecografia addominale conferma splenomegalia con ipertensione portale, piastrine 40.000, HVPG 16 mmHg. E' stata pertanto posizionata TIPS.
**Dal 2006 al 2011** Gli indici di funzionalità epatica sono rimasti permanentemente normali, TIPS funzionante senza segni di encefalopatia epatica; persiste importante splenomegalia con marcata ectasia dell'asse splenoportale; progressiva ulteriore riduzione delle piastrine (15.000-25.000).
**Gennaio 2012** Negli ultimi 12 mesi quadro clinico sostanzialmente invariato con riduzione delle piastrine fino a 8.000. Attualmente in corso di valutazione per splenectomia.
**Conclusione** Nei paesi con malaria endemica la presenza di ipertensione portale idiopatica non cirrotica è spesso secondaria ad una residua iper-reattività immunologica nei confronti del Plasmodium, in assenza di segni o sintomi di malaria attiva.
In questa condizione la conseguente sindrome da ipersplenismo può

essere così grave da portare a considerare la splenectomia come scelta terapeutica.

### Treatment with pegylated interferon and ribavirin in chronic hepatitis C patients with Crohn's disease

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**Background** Treatment with interferon and ribavirin in patients with chronic hepatitis C (CHC) and Crohn's disease (CD) is not currently very used because it has not yet been established security.
**Casa report** A man of 64 years suffering from chronic hepatitis C and Crohn's disease with frequent exacerbations and fistulas. Following detection of high levels of transaminases GOT: 182, GPT 317 and HCV-RNA 6.740.000 UI/ml, it was decided to undertake treatment with IFN and ribavirin. E 'was submitted prior to colonoscopy that showed no signs of active inflammation.
He was treated with peginterferon-alpha-2a at a dose of 180 mic / week in combination with ribavirin 800 mg / day. In the fourth week PCR detected HCV and normalization of ALT values. The third month decrease in hemoglobin of more than 2 g were introduced hematopoietic growth factors and has been repeated colonoscopy riultata negative. The patient has completed treatment for 6 months with persistent negativity of HCV RNA.
**Conclusion** With our experience we found that treatment of patients with chronic hepatitis cem Crohn's and is similar to that of patients without Crohn's disease, the treatment is safe and that any side effects can be corrected by growth factors hematopoietic.

### TH 1-84: analisi dei parametri biochimici in pazienti con osteoporosi severa

R. Cesareo [1], G. Tommasi [1], F. Cardoni [1], G. Straface [1], V. D'alfonso [1], B. Virgilio [1], P. Del Duca [1], C. Cianfrocca [1], A. Maietta [1], G. Zeppieri [1], D.M. Giovanni [2], F. Marrocco [1], M. Lombardi [1], G. Campagna [1]

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Tra gli effetti collaterali rilevati nel trial clinico T.O.P. (Treatment of Osteoporosis with Parathyroid hormone) che ha validato l'utilizzo del paratormone 1-84 per la prevenzione delle fratture vertebrali si segnala un' aumentata incidenza di ipercalcemia (27%) e di ipercalciuria (47%). Noi abbiamo valutato i valori della calcemia e della calciuria nel corso di 1 anno di trattamento con PTH 1-84 e li abbiamo confrontati con un gruppo di controllo in terapia con alendronato e vitamina D3.
Le variazioni dei livelli di calcemia e calciuria nel corso di un anno sono state valutate in 10 donne osteoporotiche, in terapia con paratormone 1-84, e in 10 donne affette da osteoporosi, in terapia con acido alendronico con aggiunta di colecalciferolo. Tutti i pazienti sono stati sottoposti a terapia con colecalciferolo in monosomministrazione settimanale (2800 UI) in combinazione con l'alendronato o separatamente nel gruppo PTH 1-84 in associazione a regime alimentare che prevedeva l'assunzione di circa 1.5 gr di calcio elementare al giorno. Il dosaggio della calcemia e della calciuria nei due gruppi di pazienti è stato effettuato prima della terapia, a 24 ore e dopo 3, 6, 9, e 12 mesi. L'analisi statistica dei dati non ha evidenziato differenze significative nelle variazioni dei livelli di calcemia, di calciuria e di 1,25 (OH)2 Vitamina D tra i due gruppi. In nessuno dei soggetti del gruppo trattato con PTH 1-84 sono stati riscontrati alterati valori di calcemia o di calciuria tali da indurre la sospensione del trattamento.

### Carpineto study: prevalence of thyroid disorders

R. Cesareo [1], M. Iozzino [2], G. Tommasi [3], F. Cardoni [3], G. Straface [3], V. D'alfosno [3], B. Virgilio [3], P. Del Duca [3], C. Cianfrocca [3], A. Maietta [3], G. Zeppieri [3], F. Marrocco [3], G. Di Meo [4], G. Campagna [3]

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**Aim** To determine the consumption of iodized salt and the prevalence of thyroiditis, thyroid nodules and goiter in an adult population of Carpineto Romano, a previously iodine deficient area in the southern part of Lazio region.
We designed a cross-sectional descriptive study, performed during 2009 in an adult population of Carpineto Romano. A total of 255 consecutive subjects were recruited. All participants underwent thyroid ultrasonography (US) and blood and urine samplings for the measurement of serum FreeT3, FreeT4, TSH, TPO-Ab, and urinary iodide were obtained. The gland has been described as hypoechoic in 12,5% of subjects. In the whole group, 81 subjects had US evidence of thyroid nodules (31.8%); 37.7% among women and 27,5% among males (P=0.115). 58 subjects (27%) had uninodular thyreopathy and 27 (13%) had US evidence of more than one nodule. Auto-antibodies antithyroperoxidase (Ab-TPO) were presents in the 13% of the whole population (16,5% in women vs 7,9% in males; P = 0,103). 31,7% declared to assume iodized salt; in this group the mean urinary iodine level was 118,4±75,5microg/L (vs 104,5±76,8ug/L among those not taking iodized salt; 109.8±79.9microg/L in the whole population). In 19% of subjects urinary iodine levels were <50microg/L; among these the 73% were not taking iodized salt. Neither urinary iodine nor autoantibody concentrations correlated with the prevalence of thyroid nodules in sonography. The negative correlation between urinary iodine and thyroid volume was not significant (R=-0.05;P=0.482).

### Osteoporosi maschile: caso clinico

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Uomo.70a. Ipertensione,TVP,frattura di femore,osteoporosi femorolombare.
Terapia: stronzio ranelato.
2010:"TVP arto inferiore sin e TEP" MDTC: "surreni iperplasici incidentaloma sx".
RMN-LS:"fratture vertebrali".
Esami per osteoporosi: nella norma.
Test di Liddle:"ipercortisolismo ACTH indipendente".
Gammapatia monoclonale con Bence Jones positiva.K/λ:normale.
RX.scheletro:"assenza di osteolisi; sella turcica molto allargata".

RMN cranio:"sindrome della sella vuota". TSH soppresso. Scintigrafia tiroidea:"Gozzo nodulare tossico". Terapia radiometabolica (RM) e tionamidi. Inizia terapia off-label con teriparatide.
**Discussione** Nell'osteoporosi maschile va esclusa la secondarietà presente nei 2/3.Il RS non ha indicazione nell'osteoporosi maschile ed è controindicato in caso di trombofilia perché associato a TEV. Il paziente ha 2 cause note di osteoporosi: ipercortisolismo ed ipertiroidismo.
La gammopatia si associa ad osteoporosi.
La rarità del caso è correlata alla concomitanza di più sindromi causa di osteoporosi e dell'ipercortisolismo. Il trattamento con teriparatide è indicato in pazienti maschi solo in corso di terapia cortisonica. Il suo utilizzo in caso di ipercortisolismo endogeno, benché non EBM e off label, dovrebbe apportare vantaggi simili in quanto teriparatide è un induttore degli osteoblasti che vengono cronicamente repressi ed inibiti funzionalmente negli ipercortisolismi.

## Low TSH is not always hyperthyroidism: a case of central hypothyroidism

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**Introduction** Central hypothyroidism (hypo) is due to insufficient stimulation by TSH of an otherwise normal thyroid gland. It has a prevalence of 1 in 80,000 to 1 in 120,000.It is usually due to pituitary adenomas, pituitary surgeries or post-irradiation. Fatigue and peripheral edema are the most specific clinical features.
**Case report** We present a 69-year-old man with tiredness. He had a suppressed TSH (0.006 mU/L) with normal serum FT4 (0.94 ng/dL; 0.56-1.21). All autoantibodies were negative. Thyroglobulin was normal (8.8 ng/mL). On echography the thyroid gland appeared normal with normal echogenecity and vascularization. Technetium scintigraphy was normal. Urinary iodide was normal. Further investigations showed a reduced TSH with slightly low FT4, and central hypo was suspected. A TRH stimulation test confirmed the diagnosis (peak of TSH: 0.26 mU/L). No lesion was found by MRI. No other pituitary hormone insufficiency was detected. Finally, after excluding, the intake of any drug affecting the hypothalamo-pituitary-thyroid axis and the presence of critical systemic illness, the unusual diagnosis of idiopathic isolated central hypo was made.Since FT4 levels was normal we not performed thyroxine therapy.
**Conclusion** To diagnose central hypo, look for lower FT4 levels together with low or inappropriately normal TSH levels in a clinical situation suggestive of the disease. By the use of the TSH assay as an initial screening test for thyroid disease, the diagnosis of central hypo can be missed or delayed.

## Valori di vitamina D 3 in pazienti diabetici tipo 2

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**Premesse** Numerosi studi suggeriscono che bassi livelli di vit D si associano al rischio di sviluppare DM2.La vitD interferirebbe con alcuni meccanismi patogenetici del DM2.Elevati livelli di vitD potrebbero migliorare la funzionalità delle beta cellule favorendo l'escrezione e la sensibilità insulinica.
**Materiali e metodi** Abbiamo dosato i livelli di vitD3 e calcemia in un gruppo di 10 pazienti affetti da DM2,8 maschi e 2 femmine,età media 61.2 aa,confrontandoli con un gruppo di controllo di 10 pazienti non diabetici, 8 maschi e 2 femmine,età media 57.9 aa.Criteri di esclusione:nefropatie, epatopatie, osteoporosi,terapia corticosteroidea.
**Risultati e conclusioni** I valori di vitD3 nei pazienti diabetici sono risultati mediamente più bassi rispetto ai non diabetici.In tutti i diabetici il valore di vitD3 dosato risultava inferiore al limite inferiore di norma proposto dal nostro laboratorio di analisi
Quanto riscontrato conferma i dati in letteratura secondo cui il DM2 si assocerebbe a bassi valori di vit D.

| PAZIENTI DIABETICI | | | | | CONTROLLI | | | |
|---|---|---|---|---|---|---|---|---|
| Età | Sesso | VIT D 3 | Calcemia | Emogl. Glic. | Età | Sesso | VIT D3 | Calcemia |
| 58 | M | < 5ng/ml | 10.3mg/dl | 6 % | 64 | M | 12ng/ml | 9.3mg/dl |
| 80 | M | 9ng/ml | 9.1mg/dl | 6.4 % | 69 | M | 89ng/ml | 9.5mg/dl |
| 70 | M | 11ng/ml | 10 mg/dl | 6.2 % | 54 | F | 90ng/ml | 9.9mg/dl |
| 61 | M | 18ng/ml | 8.6 mg/dl | 7 % | 69 | M | 18ng/ml | 9.7mg/dl |
| 57 | M | 6ng/ml | 9.1mg/dl | 11 % | 41 | F | 20ng/ml | 10mg/dl |
| 74 | F | 8ng/ml | 9mg/dl | 14 % | 62 | M | 19ng/ml | 9.2mg/dl |
| 52 | M | 10ng/ml | 9.3mg/dl | 7.4 % | 21 | M | 12ng/ml | 9.7mg/dl |
| 60 | F | 12ng/ml | 9.3mg/dl | 6.2% | 55 | M | 73ng/ml | 9.6mg/dl |
| 49 | M | 16ng/ml | 10.1mg/dl | 7.3 % | 74 | M | 61ng/ml | 10.2mg/dl |
| 51 | M | 17ng/ml | 9.5mg/dl | 7.6 % | 70 | M | 52ng/ml | 9.6mg/dl |

VIT D3 v.n 20-120ng/ml

## Management del paziente con ictus cerebrale in Medicina Interna

I. Chiti [1], N. Napoli [1], N. Pugliese [1], R. Pierotello [1], M. Straniti [1], G. Panigada [1]

[1]Medicina Interna Pescia

**Premesse e scopo dello studio** L'ictus cerebrale è il 2°DRG nella nostra U.O. Più del 90% viene ricoverato in stroke unit dove viene garantito un approccio multidisciplinare e multiprofessionale, attraverso una clinical patway definita secondo linee guida. Da 2 anni viene effettuata anche trombolisi sistemica. Il percorso è stato certificato a cura di ente esterno nel 2011.
**Materiali e Metodi** Analisi della casistica del 2011.
**Risultati** Nel corso del 2011 ricoverati 334 stroke 267 (ischemici), 67 (emorragici); 165 F, Età media 76,0 ( M72,6, F79,0) Mortalità intraospedaliera 5.3%, Degenza media 9.9 gg, Valore medio NIHSS 8. Fattori di rischio: fumo 18%, ex 15%, IA 65%, Diabete 31%, FA 23%, Pregresso Stroke31%, dislipidemia 23%. Comorbilità: CIC 27%, Scompenso cardiaco 14%, PAD 9%, Demenza 14%. BPCO 10%. Complicanze:polmoniti 4.2%, infezioni vie urinarie 6%, convulsioni 7%, insuff respiratoria 6.8%, ricorso a NIV 1.4%, IMA 1%, cadute 1%, emorragie digestive 1.4%, occlusione intestinale 1.4%, TEV 0.4%. Trombolisi sistemica 11 pazienti, Destinazione Domicilio senza tutela 13%. Domicilio con tutela 36%, RSA 4%, cure intermedie 1.4%. Degenza riabilitativa Cod 56 34%, riabilitazione territoriale 6%, Riabilitazione DS 0.9%.
**Conclusioni** La gestione internistica del paziente con stroke può essere ottimizzata attraverso la strutturazione di un percorso intraospedaliero che preveda il ricovero in stroke unit, l'applicazione di clinical patways, la riabilitazione precoce. La trombolisi è parte integrante di tale percorso di cui l'internista può essere tutor .

## Un'infezione urinaria da Klebsiella pneumoniae KPC

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**Premesse e scopo dello studio** Le infezioni da patogeni MDR (Multi-Drug Resistent), tra cui quelle sostenute da Enterobacteriaceae resistenti ai carbapenemici, costituiscono una sfida emergente per i reparti di Medicina Interna.
**Materiali e Metodi** Descriviamo il caso di una donna di 76 anni ricove-

rata nel nostro reparto per FUO persistente da oltre 3 mesi.
**Risultati** La paziente non ha patologie di rilievo tranne l'obesità né sintomi di localizzazione d'organo. E' presente marcata elevazione degli indici di flogosi.L'urinocoltura mostra positività per Klebsiella pneumoniae panresistente. I test di sinergismo danno indicazione a terapia di associazione con Tigeciclina e Gentamicina con cui si ottiene rapida defervescenza. Tuttavia per la persistenza di indici di flogosi molto elevati viene eseguita TAC Total Body nel sospetto di patologia neoplastica.
La TAC rivela una grossolana raccolta ascessuale addominale. La coltura del materiale ottenuto dal drenaggio percutaneo ecoguidato è positiva per E.Coli per cui si prosegue terapia antibiotica con Tigeciclina e Meropenem. Per la persistente positività del tampone rettale per Klebsiella- KPC si è reso necessario attuare misure di isolamento da contatto e attivare un programma di sorveglianza all'interno del reparto.
**Conclusioni** Questo caso sottolinea la difficoltà di gestire una corretta terapia antibiotica nel caso di patogeni MDR, l'importanza delle azioni di prevenzione e la necessità di una collaborazione tra internista, infettivologo e microbiologo. Ribadisce inoltre l'importanza della TAC Total Body nei casi di FUO.

## Cochran's test and "ANGIOTC SCORE" Study: correlative analysis of nominal variables in 20 radiologists. Biennial experience

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**Purpose of the experiment** "AngioTC SCORE" study reports 20 radiologists who were given Miller, Mastora and Qanadli scores, in order to assess the severity of the angiotomographic clinical picture in those patients with venous thromboembolism hospitalized in the period 2010 – 2011. This study has the following aims: to verify the differences in the choice of given scores, as well as to determine the meaning of statistical significance by using the Cochran's Q test in the comparative analysis.
**Procedures used** To calculate $x^2$ we apply the following formula: $\chi 2$ = (k-1)[(k x)-y2]/(k y)-z=28,9. "K" refers to 3 variables, "x" refers to the total sum of squares of the 3 variables. "Y" stands for the total of the chosen scores. "$Y^2$" is the square of the total chosen scores. . "Z" means the sum of the squares of the chosen scores. The $x^2$ relative value (VR) we obtained is 28,9 with Degree of Freedom (GL) = 2. $X^2$ critical value (VC) for p=0,001 is 13,816.
**Observation/Data/Results** The Cochran's Q test shows how the Qanadli choice is so significant because the $x^2$ relative value (VR) we obtained is 28,9 with Degree of Freedom (GL) = 2 and $x^2$ critical value (VC) for p=0,001 is 13,816. The differences in the choice are really important with p<0,001.
**Conclusions** "AngioTC Score" study reveals how the choice of Qanadli score, assessed with the Cochran's Q test, is based on statistical criteria of high importance.

## RV/LV report and ECG score: Pearson's test and "PRISCO" Study. Biennial experience

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**Purpose of the experiment** "PRISCO" study reports 20 patients with venous thromboembolism hospitalized in the period 2010 – 2011. In all the patients we determined the ecocardiographic report RV/LV and ECG score at the entrance. This study has the following goals: to verify any relationship between the values of RV/LV report and those of ECG score in 20 patients tested, as well as to determine the meaning of statistical significance by using Pearson's parametric test.
**Procedures used** To determine the test the Pearson correlation "r" coefficient formula is applied: $\Sigma(A\text{-}\bar{A})\ (E\text{-}\bar{E}) / \sqrt{\Sigma(A\text{-}\bar{A})2\ \Sigma\ (E\text{-}\bar{E})2}$. The r value obtained with degrees of freedom (GL) = 19 is 0,04. Since the critical value (CV) of "r" is equal to 0.693 with GL = 19 p = 0.001, the "r" relative value (RV) of the Pearson test is 0,04, it shows a positive correlation between the absolute values of covariation of the two variables found to be highly significant with p <0.001.
**Observation/Data/Results** Pearson's test carried out in 20 patients has shown that there is a significant correlation (p<0,001) between the two variables considered (RV/LV scores at the entrance and ECG scores at the entrance). The "r" value obtained is 0,04 and "r" VC (critical value) for p=0,001 is equal to <0,693 con GL=19.
**Conclusions** "PRISCO" study reveals how there is a strong correlation between RV/LV scores and ECG scores in 20 patients affected with venous thromboembolism, with a positive correlation according to the Pearson's test.

## ✪ Large vessel vasculitis presenting as septic fever of unknown origin. The diagnostic role of 18-FDG positron emission tomography

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Even after extensive workup, 51 % of cases of fever of unknown origin (FUO) remain undiagnosed. When a diagnosis is reached, 22% show an autoimmune etiology, giant cell arteritis (GCA) being the most common and reaching the 15% in old people. Clinical eterogenity makes diagnosis of GCA often challenging, expecially in the absence of cranial symptoms or supportive results at temporal artery biopsy. To underdiagnose vasculitis can expose patients to the risk of inadequate treatment and serious complications.
18-fluorodeoxyglucose positron emission tomography (FDG-PET) cannot visualize temporal arteries, but it has been recently shown a relevant role in assessing extracranial involvement in large vessel vasculitis, with a positive predictive value of 93% for thoracic vascular uptake in GCA.
We report of an old patient presenting with high fever, clinical and laboratory data of aspecific inflammation, and negative results for infective, autoimmune or neoplastic diseases at invasive and non-invasive workup. Due to worsening clinical condition, medium-high dose steroid therapy was started with a prompt clinical and laboratory recovery.
FDG-PET performed a week after showed enhanced subclavian bilateral symmetric uptake consistent with vasculitis. As expected the patient was asymptomatic for upper limb ischemia.
Since both FUO and vasculitis are frequent clinical challenges in Internal Medicine wards, the utility of FDG-PET should be underlined although, in cases of suspected GCA, positive findings at temporal artery biopsy still constitutes diagnostic gold standard.

## Healthy/unhealthy: an early possibility to catch the right sliding door

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Since the Eighties the great improvement of the diagnosis of infectious disease and better selection criteria for blood donors, resulted in a large reduction of transfusion related diseases. Mostly for above mentioned reasons, blood donors were considered de facto healthy subject. However, the concept of health is a more comprehensive definition that looks beyond the infection-free condition. We studied 993 consecutive healthy blood donors (722 male and 271 female) enrolled at Centro di Immunoematologia e Trasfusionale of Azienda Ospedaliero-Universitaria Careggi (Florence). For each donor we analyzed the most important hematochemical parametres and we discovered an interesting "trend" of lipidic profile: 148 blood donors presented high levels of tryglicerides (> 150 mg/dL) and 248 blood donors presented high levels of total cholesterol (> 220 mg/dL). Most of them were young (<30 years) and performing a so-called a healthy lifestyle. This data suggest confirms the need for early identification of subject with cardiovascular risk factors and for a prompt starting of preventive therapy even in young "healty" and well-being subjects.

## Febbre e splenomegalia: una insolita presentazione di Morbo di Crohn

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Un uomo di 31 anni è stato ricoverato per iperpiressia associata a faringodinia e brivido scuotente. Negli ultimi mesi aftosi orale recidivante. Agli esami ematici: assenza di leucocitosi, modesto aumento di VES e PCR, lieve anemia normocitica con iperferritinemia e bassi valori di transferrina e sideremia, sangue occulto feci presente su 3 campioni, ipofolatemia e modesto incremento del PT. Lieve incremento delle transaminasi epatiche in assenza di potus. Urinocoltura ed emocolture negative (6 campioni). Autoimmunità negativa (ANA, ENA, Ab antiDNA, ANCA, FR, complementemia, ACA, HLA-B51). Sierologia per HIV, CMV, EBV, HBV, HCV, Borrelia, Widal-Wright e Weil-Felix negative. Quantiferon negativo. Rx torace ed ecocardiogramma nella norma. Le indagini radiologiche addominali hanno mostrato modesto ispessimento di anse intestinali in sede pelvica e splenomegalia (16 cm). EnteroRMN compatibile con malattia infiammatoria intestinale per ispessimento delle anse ileali. Colonscopia e biopsie compatibili con M. di Crohn. In considerazione dell'insolita presentazione clinica e della splenomegalia, sono state proseguite le indagini con esecuzione di PET e BOM risultate negative per neoplasie e infezioni. La splenomegalia è un reperto insolito della malattia di Crohn e può essere persistente o transitoria. E' probabilmente una risposta non specifica alla malattia infiammatoria di base o talora una risposta all'epatopatia cronica che può associarsi alla malattia infiammatoria intestinale.

## Uno stato di coma di difficile interpretazione

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Un uomo di 58 anni, ricoverato per frattura femorale da caduta accidentale e sottoposto ad intervento chirurgico, è giunto alla nostra osservazione in stato di coma. In anamnesi psicosi in terapia cronica con carbolitio. Il paziente aveva sviluppato, dopo l'intervento di osteosintesi, iporessia ed iperemesi con alterazione progressiva dello stato di vigilanza. Al momento del trasferimento presso il nostro reparto, il paziente si presentava cachettico, comatoso, disidratato. Agli esami ematici grave ipernatriemia (160 mmol/l, v.n. 135-145), leucocitosi neutrofila (26.840/µl), lieve aumento della PCR (3 mg/dl, v.n. < 0.9). Rachicentesi, TC e RMN encefalo hanno escluso una patologia del SNC. Gli esami colturali di liquor, urine e sangue hanno escluso uno stato settico. Si è assistito ad un miglioramento dello stato di vigilanza dopo abbondante idratazione e trattamento con tiamina (nel sospetto di encefalopatia di Wernicke legata a malnutrizione). La grave ipernatriemia associata a poliuria, in presenza di iperosmolarità plasmatica (307 mOsm/kg, v.n.270-295) ed osmolarità urinaria ai limiti inferiori (191 mOsm/kg), ha permesso di ipotizzare un diabete insipido nefrogenico da sali di litio, slatentizzato dalla ridotta assunzione di liquidi dopo l'intervento chirurgico. E' stato sospeso il carbolitio ed è stato inserito un diuretico tiazidico. Nel diabete insipido la reintegrazione idrica è l'obiettivo principale del trattamento. Nelle forme più lievi la diagnosi può essere sottovalutata; se trascurato può però diventare pericoloso a causa della disidratazione che comporta.

## Integrazione ospedale-territorio

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**Premesse e scopo** Rappresentare un esempio di assenza di integrazione tra servizi sociale, sanitario e istituzioni.
**Materiali e Metodi** Un paziente, privo d'identità, è giunto in Ospedale da un Campo Nomadi, per stato di agitazione. Non necessita di ricovero, ma posta la diagnosi di grave oligofrenia, si provvede alla ricerca di una struttura che possa accoglierlo. Sono stati coinvolti: familiari, Sos, Suore di Madre Teresa di Calcutta al Celio, NAE, Ufficio Nomadi del Dipartimento delle Politiche Sociali, Ufficio Tutele Tribunale Civile, Procura della Repubblica presso il Tribunale Civile, CSM, delegato CRI per rom, Commissariato di Polizia, Servizio Handicap Adulti, Opera Nomadi, Caritas, Ufficio Immigrazione della Questura e Polizia scientifica.
**Risultati** I servizi a carattere sociale non hanno centri di accoglienza idonei e non possono accogliere un paziente senza tessera sanitaria. Non è possibile rilasciare la tessera sanitaria se non in possesso di una residenza e quindi, di un permesso di soggiorno, che prevede una identificazione. Il percorso intrapreso ha permesso l'identificazione del paziente, ma non di ottenere il permesso di soggiorno poiché esiste un ordine di espulsione da altra Questura, mai eseguito perché non noto il Paese di origine.
**Conclusioni** Il paziente è sprovvisto di documento d'identità, di residenza anagrafica, di tutore legale che si possa fare carico della sua situazione, di una pensione di invalidità e pertanto non è ancora stato inserito in una struttura idonea alla sua disabilità, permanendo così in ospedale.

## Still's disease: a complex clinical diagnosis

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A 37-years-old Caucasian man presented with a 3 weeks history of high fever (up to 40°C), myalgia, arthralgia and abdominal pain; broad-spectrum antibiotic treatment was administered without resolution. ESR was 90 mm/h, CRP was 153 mg/l, WBC was 14,100/mm3, AST was 89 U/l and ALT was 147 U/l. Ferritin was normal. A work-up for infective diseases was negative (HIV, HBV, HCV, CMV, EBV, Salmonella, Brucella and blood, urine and stool cultures, Mantoux test). Neoplastic and connective tissue diseases were excluded too. A chest radiography

and a echocardiography were normal; a CT scanning of abdomen showed mesenteric lymphadenopathy suggesting mesenteric inflammation. According to the Yamaguchi criteria the Adult-onset Still's disease (AOSD) was suspected and indomethacin treatment was started with resolution of symptoms. The patient is in follow up to clarify the course of the disease (monocyclic, polycyclic or chronic form).
**Discussion** The absence of diagnostic tests and the wide range of clinical manifestation do difficult the AOSD diagnosis. Different reviews showed that Still's rash, splenomegaly and serum ferritin level were not essential elements for diagnosis; rash is present in 50-85% of patients, splenomegaly in 17-65% of patients, hyper-ferritinemia in 20-90%. In our case the mesenteric inflammation was an additional element useful for diagnoses. The variability between the different studies could be explained by different clinical expression (CE) of OASD in people of different ethnicities (CE: in Western countries is slightly different from Eastern countries).

## A case of "indoor hypothermia"

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**Background** "Indoor hypothermia" is more likely to occur in patients with significant medical comorbidities (alcoholism, sepsis, hypothyroidism/hypopituitarism) and bears a worse outcome than exposure hypothermia. Hypothermia is associated with benzodiazepine overdose and antipsychotic drug use.
**Clinical course** A 54-year-old woman presented to the emergency department with psychomotor agitation and aggressiveness. She was resident in a nursing home. The patient had a history of poliomyelitis, generalized *epilepsy,* alcoholism and *cognitive* impairment. During 2 months before admission, the patient begun to present psychomotor agitation and quetiapine and diazepam were started.. On admission she presented with severe psychomotor agitation treated with midazolam, diazepam, clorpromazine, haloperidol. Blood tests revealed hypernatremia (164 mEq/L)., creatinine was normal. A chest x-ray and a brain CT scan didn't detect acute lesions. Twenty-four hours later psychomotor agitation persisted along with the appearance of hypotension and hypothermia. Electrocardiography revealed sinus bradicardia, long *QT* and a Osborn wave. The patient has been treated successfully with low doses of atypical antipsychotic drugs, hydratation and rewarming.
**Conclusion** Hypothermia is a frequently misdiagnosed condition in agitated hospitalized patients treated with benzodiazepine and antipsychotics drugs. Hypothermia bears a significant risk of death if undetected, thus should be recognized and corrected early.

## A case of acute disseminated encephalomyelitis mimicking acute ischemic stroke in a young post-partum lady

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**Background** Acute disseminated encephalomyelitis (ADEM) occurs usually in the post-infectious setting, it is associated with multiple white matter lesions and multiple clinical syndromes are described.
**Clinical course** A 35-year-old healthy smoker woman, 2 months postpartum, presented to the emergency department 4 hours after the acute onset of dysarthria and right hyposthenia. She reported 2 weeks before admission fever, headache and widespread joint pain. On examination right seventh cranial nerve palsy and right hyposthenia. A brain CT scan demonstrated a subcortical shaded hypodensity in the left rolandic area that was confirmed at MRI. Brain angiography was negative. Cerebrospinal fluid examination showed elevated white cell count and high protein level. Spinal fluid cultures and immunologic testing were negative. There were no oligoclonal bands. In the following days neurological worsening with motor aphasia and complete right hemiplegia. A brain CT scan revealed increasing of the lesion. The patient was treated with antibiotics, antivirals, a cycle of pulse bolus methylprednisolone and immunoglobulin. In the following days progressive neurological improvement. After 1 month she recovered completely and control MRI detected an almost complete clearance of the radiological findings.
**Discussion** ADEM is a rare cause of acute onset neurological deficits and this case suggests the importance of considering acute demyelinating lesions in the differential diagnosis of ischemic stroke in young subjects.

## Performance of transient elastography (Fibroscan) in chronic hepatitis

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**Introduction** The extracellular Matrix (ECM) store during chronic liver disease is not a static and one-way phenomenon, but may be counterbalanced by fibrolysis. The fibrolysis phase is the most important predictor of disease progression. The phase may influence therapeutic choises and is useful to value the treatment response. Fibroscan assess, by pulse elastography technique, the liver fibrosis by measuring its stiffness.
**Patients & methods** We studied 36 outpatients (28 male and 8 female), mean age 65.4 (range 28-32 ys) with chronic hepatitis of various causes: 7 HCV+, 2 HBV/HBeAg+, 2 biliary cirrhosis, 25 with steatosis/NAFLD/NASH. All patients had increased transaminases 1-2 times the normal values. We excluded decompensed cirrhosis, patients with HCC, obese patients with BMI >28. All patients have been subjected to two fibroscan at a distance of 6-8 months. We considered normal values of liver stiffness index (LSI) <5.1 and IQR less than 30% of LSI. Values between 5.1 and 7.6 are considered equivalent to F1-F2 fibrosis of Metavir.Results. Patients with chronic viral hepatitis HBV and HCV have presented LSI <5.1 in those subjects with SVR after IFN/antiviral therapy. Among steatosis/NAFLD/NASH there were no significant variations.Discussion & conclusions. Fibroscan is considered an useful examination, non-invasive, not operator dependent and repeatable in time; can be used to estimate the evolution of liver fibrosis and the effectiveness of therapy.

## Critical analysis of packed mixtures and supplements use for parenteral nutrition in Regional Hospital (RH) of Busto A. (Varese)

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**Background and aim** Appropriate Total Parenteral Nutrition (TPN) requires supplementation of multi-vitamins and trace elements in high nutritional risk patients, long staying in hospital, according to SINPE guideli-

nes. In the three hospitals of Busto Arsizio RH, where there is a Nutritional Unit (NU) in only one of them, each doctor can prescribe TPN freely. Pharmacy Department supply separately industrially packed mixtures, supplements of multi-vitamins and trace elements. We examined demand of nutritional mixtures of TPN in the 16 medical and 20 surgical non-intensive unit for adults, in order to estimate their use adequacy.
**Materials and methods** We analyze demand and costs of standard mixtures and TPN supplements in 2010 and 2011 in medical and surgical departments, were the mean hospital stay was 10.45 and 6.65 days respectively. Results: requests of standard mixtures with electrolytes were 6956 (51.22%) from medical units and 6623 (48.77%) from surgical units, supplementation of multi-vitamin compounds and multiple trace elements instead were used only respectively in 31.29% and 19.50% of the pockets. The imbalance of prescriptions was less evident in Medical Units, especially where a NU is present.
**Conclusions** Omission of multi-vitamins supplementation and trace elements is notable when prescription is made by non-qualified staff. This makes nutritional intervention useless, potentially dangerous and economically disadvantageous. Drawing up of local guidelines is advisable in order to manage of the right application procedures and right prescription of TNP.

## The regional census 2011 Hospitalist FADOI Tuscany

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**Introduction** In most developed countries general pratictioners are not expected to come to the hospital: rather, according to the patient's main clinical problem, a hospital-based specialist or subspecialist assumes the responsibility for the hospital care.
The increase of identifiable diseases per subiect in aging population and the clinical relevance of polypathology have forced many changes in the health field.
The "hospitalist model of care", in which a generalist physician cares for (and coordinates the care of) hospitalized patients, has been defined as "the fastest growing medical specialty in history". Most hospitalists are trained in internal medicine (80%), cause internal medicine training adequately prepares hospitalists for the clinical issues they will face in hospital care.
**The aim of the study** In order to know if general (internal) consultants are really ready to these important changes, the Tuscan board of FADOI, in 2011, took a census about competencies and skills in the Internal Medicine Units in Tuscany.
**Methods and materials** The census involved 24 Internal Medicine Units in Tuscany acquiring and recording informations about skills and organization: i.e. medical and surgical paths, multidisciplinary clinical training, clinical risk management, bed co-management, "Hospitalist model of care" implementation.
**Results** In 8 Internal Medicine Units in Tuscany experimented with bed co-management, 8 with multidisciplinary pathways of disease, 8 with multidisciplinary clinical research and 4 with "Hospitalist model of care".
Conclusions There is a correlation between wide hospital size and the experimentation of "Hospitalist model of care", while bed co-management is common in small size hospitals.
Co-management of multidisciplinary pathways of disease is common in medium size hospitals.

## Unusual polyendocrine failure syndrome: a case report

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**Introduction** Adrenal and thyroid failure is usually associated to autoimmunity (Type 2 autoimmune polyglandular or Schmidt's syndrome). Sunitinib is a tyrosine kinase inhibitor with antiangiogenic and antineoplastic activities approved for treatment of metastatic renal cell carcinoma (RCC). Hypothyroidism is a possible side-effect, but adrenal involvement is unknown. To the best of our knowledge, this is the first case of sunitinib-related Schmidt's syndrome.
**Case-presentation** A 55-year-old man was admitted for fatigue, drowsiness, and low-normal blood pressure. In 2007 his left kidney was removed for RCC. In 2008 he was treated with interferon for lung metastasis. In 2009 he underwent spleen and pancreas-tail removal for local relapse of RCC. In 2010 his right adrenal was removed for metastasis of RCC. Before operation adrenal scintigraphy showed bilateral cholesterol uptake. Then he started sunitinib therapy. On admission blood tests revealed hyponatremia (111 mmol/L) with normal kaliemia (4.3 mmol/L). Plasma cortisol (4.9 mcg/dL) and aldosterone (<20 ng/L) were low, while ACTH (1250 ng/L) and renin (186 ng/L) were high. Adrenal autoantibodies were negative. CT imaging showed an atrophic left adrenal. A severe hypothyroidism was also found (TSH>100 mIU/L, fT4 2.5 ng/L) without anti-thyroid autoantibdies. Ultrasound showed a thyroid reduced in volume with low vascular signal.
**Conclusions** Sunitinib may induce impairment and atrophy of both thyroid and adrenals (non-autoimmune Schmidt's syndrome). We recommend thyroid and adrenocortical function tests on sunitinib therapy in order to recognize and promptly treat polyendocrine failure.

## Determinanti della mortalità intraospedaliera nei ricoverati per scompenso cardiaco nei reparti di Medicina - ospedale di Trento

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**Premesse e scopo dello studio** Nei reparti medici lo scompenso cardiaco è la 1a causa di ricovero sopra i 65 anni; le copatologie e l'età influenzano la prognosi. L'obiettivo è individuare i fattori clinici e biologici dei pazienti con scompenso cardiaco acuto che siano associati alla probabilità di decesso.
**Materiali e metodi** Sono riportati i dati di 210 dimessi per scompenso cardiaco acuto dei quali si conoscono età, sesso, copatologie, recidiva, pressione sistolica, eziologia, frazione di eiezione. È stata condotta un'analisi descrittiva, seguita da una regressione logistica multivariata per confrontare le caratteristiche dei deceduti e non.
**Risultati** L'età media dei pazienti è di 79,1 ± 10,8 anni; i maschi rappresentano il 42,4% della casistica. La mortalità intraospedaliera è stata del 10%. I fattori associati con la mortalità sono età, primo episodio e fenotipo. Nel dettaglio, pazienti con età >80 anni hanno una probabilità di decesso di quasi 5 volte superiore; quelli che avevano avuto uno o più precedenti episodi hanno una probabilità di decesso di 15 volte più alta rispetto ai pazienti che sono di nuovo riscontro. Quei pazienti che si presentano con un quadro d'ipoperfusione d'organo hanno una probabilità di decesso 18,8 superiore rispetto a quelli che non sono ipoperfusi.
**Conclusione** Nella nostra casistica la probabilità di decesso durante il ricovero è influenzata dall'età, dalla durata della malattia e dall'ipoperfusione d'organo. Le patologie associate, la frazione di eiezione, i fattori scatenanti e l'eziologia dello scompenso non modificano l'outcome.

## Follow-up a medio termine in dimessi per scompenso cardiaco dai reparti di Medicina dell'Ospedale di Trento nel 2010

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**Premesse e scopo dello studio** I ricoveri per scompenso cardiaco assorbono il 2% della spesa sanitaria nel mondo occidentale. Ci si propone di indagare quali fattori clinici e biologici influenzino la recidiva a medio termine.
**Materiali e metodi** Abbiamo seguito il follow-up a dieci mesi di 142 dimessi per scompenso cardiaco acuto dalla medicina di Trento. È stata condotta un'analisi descrittiva, seguita da una regressione logistica multivariata per confrontare le caratteristiche dei pazienti che si sono ripresentati per un ricovero.
**Risultati** L'età media dei pazienti è di 80,0 ± 9,3 anni; i maschi rappresentano il 43,6% della casistica. Il 47,2% è stato riammesso per un ricovero nel follow-up. I fattori associati alla riammissione sono la durata della malattia e le riacutizzazioni di bronchite cronica ostruttiva. Nel dettaglio, pazienti che avevano avuto uno o più precedenti episodi hanno una probabilità di riammissione quasi 3 volte superiore rispetto ai nuovi riscontri e quelli portatori di bronchite cronica ostruttiva hanno una probabilità di riammissione 2 volte maggiore.
**Conclusione** La probabilità di riammissione durante il follow-up è influenzata dalla durata della malattia e dalla bronchite cronica ostruttiva. Età, sesso, eziologia, frazione d'eiezione, motivo del ricovero, indice cardiaco e le altre copatologie non modificano l'outcome.

## Confronto fra caratteristiche cliniche di soggetti ricoverati in medicina e cardiologia nell'ospedale di Trento nel 2010

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**Premesse e scopo dello studio** Lo scompenso cardiaco è la prima causa di ricovero ospedaliero negli over 65 anni. Ci proponiamo di descrivere le caratteristiche cliniche di questi pazienti ricoverati nello ospedale di Trento nei reparti di medicina e cardiologia nel 2010.
**Materiali e Metodi** 210 ricoveri in medicina e 161 in cardiologia. Confronto ed analisi bivariata con test del T di Student per le variabili continue e Chi quadro per le categoriche.
**Risultati** I casi ricoverati in medicina hanno rispetto a quelli ricoverati in cardiologia una età media di 79.10 anni → 69.6 anni (p <0,001), sono maschi il 42,38% → 71.42 % (p 0.001), si presentano per recidive nel 63,81% → 45,96 % (p 0,006), l'insufficienza renale grave è rappresentata per il 22,85 % → 7,45 % (p 0,005), la demenza 25,71% → 0,6% (p< 0,001), le neoplasie 13,33% → 4,34%, la fibrillazione atriale 67,14% → 37,26 % (p 0,001), la frazione di eiezione è conservata nel 62,83% → 32,49 % (p 0,001); l'eziologia ipertensiva è presente nel 28,57% → 6,21% (p <0,001), quella ischemica nel 39,04% → 54,14% (p 0,05) , l'infezione delle vie aeree determina il ricovero nel 59,17% → 2,48% ( < 0,001), La SCA nel 4,73 → 52,1 % (< 0,001).
**Conclusioni** I pazienti delle medicine sono più anziani, in prevalenza femmine, con copatologie limitanti gli interventi terapeutici, spesso hanno frazione di eiezione conservata ed eziologia ipertensiva. In cardiologia predomina l'eziologia ischemica. I ricoveri in medicina sono determinati prevalentemente da infezioni delle vie aeree, quelli in cardiologia da sindromi coronariche acute.

## The Provincial Protocol for Multiple Myeloma Treatment Vicenza (PPTM): model for integrated management of patients (pt) with MM between the Department of Hematology and the internal medicine/oncology departments in the province of Vicenza (VI), Italy

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**Background** Novel agent for MM,Thalidomide (T),Lenalidomide (L),Bortezomib (B), increases overall survival, especially in pt < 65 years old. Oral drugs (as T and L), facilitates the outpatient management of MM by internists/oncologists in secondary hospitals (SH).
**Objectives** The aim of PPTM is to improve and standardize the management throughout the province of VI of MM treated in different hospitals during the course of the disease.
**Materials and Methods** PT with newly diagnosed MM are recruited in the protocol.Pt <65 years, if eligible for high-dose chemotherapy plus autologous stem cell transplantation (ASCT), receive 3 cycles of T-dexamethasone at the SH, then they are sent to the Hematology department of VI for ASCT; consolidation therapy post-ASCT and follow up are carried on at the SH were pt are first seen. Elderly pt/not eligible for ASCT are treated at the SH with 12 cycle of Melphalan, Prednisone and T (MPT). PPTM contains treatment guidelines for relapsed/refractory pt. SH provided with the required expertise manage elderly pt through the entire course of the disease, as well during the induction and followup for transplant-eligible pt.
The pt are registered in an electronic database and clinical data are gathered by a data manager.
**Results** 54 pt affected by MM have been registered so far: 34 pt are on treatment,4 have been excluded from the PPTM and 16 pt are receiving follow-up care (asymptomatic). PPTM is the first example of integrated management of a haematological malignancy between a referral center and all SH of an Italian province.

## Sensorimotory polyneuropathy, dysautonomia and neuropsychiatric symptoms as the first clinical manifestation in a patient with small cell lung cancer

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**Background** Paraneoplastic neurologic syndrome (PNS) can affect any part of the nervous system. PNS usually occur as the first sign of a tumor or lead to its detection We report on a patient who developed symptoms and signs of intestinal obstruction and sensorimotory polyneuropathy six months before a diagnosis of lung cancer was made.
**Case report** A 74-year-old man presented first in December 2010 with bowel obstruction and negative laparotomic inspection. In February 2011 he was diagnosed with legs sensorimotory polyneuropathy. At he same time he was diagnosed with neuropsychiatric symptoms and put on antidepressants. In June 2011 he was admitted to our department with intestinal pseudoobstruction. Extensive work-up (CT scan, PET-CT, thorascopy with biopsy) lead to a small cell lung cancer diagnosis. Among onconeural autoantibodies only anti-Hu were strongly positive. Extensive search for autoimmune, infectious and endocrine diseases was negative. Serum level of chromogranin was increased, urinary porphyrins were normal. The patient was inoperable. Corticosteroids

and high-dose immunoglobulins were ineffective. The patient began chemotherapy that was poorly tolerated and was discontinued after the first cycle due to progression of the disease.
**Comment** In the case we present, a PNS with sensorimotory polyneuropathy,dysautonomia and neuropsychiatric symptoms appeared as the first clinical manifestation of a small cell lung cancer.

## Time for abandoning B12 intramuscolar injections?

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**Background** Vitamin B12 deficiency (Bd) is common and rises with age. Most people with Bd are treated by General Practioners (GP) with i.m. B12, wich is a source of work for health care professionals. Evidence suggest equal efficacy of B12 oral therapy (OT) . We report on two cases of quick and effective responses to high oral doses of B12 in women with Bd.
**Case #1** A 69-year-old woman presented first with pancitopenia in December 2011. WBC 3.2/mcl; RBC 2.15/mcl; Hb 8.8 g/dL; MCV 117,6 fL; PLts 46.000/mcl; B12 102 pg/mL, folates 11 ng/mL; LDH 291 U/L; Endoscopy showed biliary reflux and antral gastritis. Biopsies were not performed due to thrombocytopenia. After 4 days of OT with 5.000 mcg of cyanocaonalmin and folates, reticolocytes increased respect to basal. After 4 weeks: WBC 4.25/mcl; RBC 2.98/mcl; Hb 10.9 g/dL; Ht 34.3%; MCV 115 fL; plts 94.000/mcl; sB12 1883 pg/ml; folates 35,8 ng/mL. After 8 weeks of OT a near complete clinical normalization occurred.
**Case #2** A 81-year-old woman was admitted in January 2012 with with megaloblastic anemia found on routine CBC by his GP. She complained of shortness of breath, vertigo, pain and symmetrical tinglings in the legs, impaired balance when standing or walking . Three months before she was diagnosed with a peripheral sensorimotor polyneuropathy and depression and started antidepressant drugs. Bd was diagnosed and OT started as in case #1 with progressive normalization of clinical and laboratory signs.
**Comment** 5.000 mcg/day of oral cyanocobalamin for two months normalize most clinical and laboratory signs of Bd.

## Pancreatiti acute recidivanti in giovane uomo

F. Corradi [1], S. Milani [2], M.R. Biagini [2], R. Puntili [2], F. Bucciero [2], N. Manetti [2], C. Faini [2], G. Razzolini [2], M. Marsico [2], T. Gabbani [2]

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**Motivo del ricovero** Maschio di 30 anni giunto alla nostra attenzione per dolore addominale diffuso ai quadranti superiori,irradiato al dorso associato a vomito biliare.
**Anamnesi** Cinque pregressi episodi di pancreatite acuta alitiasica. Le precedenti indagini di approfondimento quali TC addome, colangio-RM, Angio-RM, EGDS e dosaggio delle sottoclassi di IgG non hanno permesso una diagnosi eziologica di certezza.
**Decorso** All'EO: addome trattabile, diffusamente dolente e dolorabile in particolar modo ai quadranti superiori, Murphy e Blumberg negativi. Agli esami ematici: leucocitosi ed aumento dei livelli sierici di amilasi e di lipasi. Tali reperti e l'ecografia dell'addome sono risultati compatibili con un nuovo episodio di pancreatite acuta edematosa alitiasica per la quale è stata intrapresa terapia reidratante per via endovenosa e antibiotico terapia ad ampio spettro a scopo profilattico con risoluzione del quadro clinico e bio-umorale. Il paziente ha eseguito inoltre ERCP e colangio-RM con stimolazione con secretina con rilievo di sbocco separato del dotto di Wirsung e del coledoco e presenza di dotti pancreatici accessori a decorso irregolare. La ricerca delle mutazioni del gene CFTR ha esitato in: mutazione in eterozigosi L997F sull'esone 17A del gene CFTR.
Conclusioni Nelle pancreatiti acute recidivanti a causa non identificabile è sempre consigliabile una ricerca di anomalie morfostrutturali dell'organo e/o ricerca di mutazione del gene della fibrosi cistica.

## Un tipico caso clinico di neoplasia cistica mucinosa del pancreas

F. Corradi [1], S. Milani [2], M.R. Biagini [2], A. Morettini [1], F. Bucciero [2], R. Puntili [2], C. Faini [2], N. Manetti [2], M. Marsico [2], G. Razzolini [2]

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**Motivo del ricovero** Donna di 69 anni giungeva alla nostra attenzione per comparsa da 5 mesi di dolore addominale a sbarra associato a calo ponderale di 10Kg e alla recente comparsa di diabete mellito di tipo II.
**Decorso clinico** L'addome era trattabile, dolente e dolorabile nei quadranti superiori, Blumberg e Murphy negativi, fegato e milza non palpabili. Agli esami ematici: incremento del Ca 19.9 senza ulteriori alterazioni degne di nota. La TC addome evidenziava a livello della testa pancreatica la presenza di due neoformazioni ipodense di aspetto cistico: una di 3,8cm che improntava il dotto di Wirsung, ectasico nel tratto corpo-coda, e un'altra di 2,5cm in prossimità del processo uncinato. Sulla base di tali reperti la paziente ha eseguito colangio-RM che ha confermato la presenza delle suddette lesioni. La paziente è stata sottoposta a ERCP con aspirazione del succo pancreatico nel quale sono stati dimostrati elevati livelli di Ca 19.9. L'esame istologico del campione bioptico prelevato nella papilla mostrava la presenza di atipie cellulari.
**Conclusioni** Sulla base del quadro clinico e radiologico è stato posto il sospetto di IPMN del dotto pancreatico principale. In considerazione del numero e delle dimensioni delle lesioni, della presenza di atipie citologiche a livello della papilla del Vater e dell'aumento del Ca 19.9 nel succo pancreatico, la paziente è stata sottoposta ad intervento di pancreasectomia totale. L'esame istologico su pezzo operatorio ha confermato la presenza di una IPMN con associata una componente di adenocarcinoma invasivo.

## Polmonite atipica in cirrosi epatica HCV correlata

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**Motivo del ricovero** Donna di 68 anni giunge alla nostra attenzione per confusione mentale e iperpiressia.
**Anamnesi** Cirrosi epatica HCV correlata complicata da HCC. Crioglobulinemia.
**Decorso** All'EO: assenza di versamento ascitico e riduzione del murmure vescicolare alle basi polmonari. Agli esami ematici reperti compatibili con l'epatopatia, valori di ammoniemia nella norma e iponatriemia. L'Rx torace, la TC cranio e le emocolture sono risultati negativi. Il dosaggio dell'ADH è risultato nella norma. Nell'ipotesi che l'iponatriemia fosse indotta dallo stato ipervolemico del cirrotico è stata interrotta terapia diuretica e introdotta terapia con albumina e soluzione fisiologica. Il decorso si è complicato con l'insorgenza di acidosi metabolica, aumento dei livelli di creatinina e iperkaliemia. E'stata intrapresa terapia con soluzione glucosata, insulina e soluzione ipertonica con ripristi-

no dei normali valori di creatininemia e kaliemia e con parziale correzione della natriemia. Nell'ipotesi di una mancata correlazione temporale tra quadro clinico e radiologico di un eventuale processo flogistico polmonare e del rilievo di pancitopenia, è stato eseguito un nuovo Rx torace che ha mostrato addensamento polmonare basale destro. La ricerca dell'antigene urinario della Legionella e delle IgM specifiche, sono risultati entrambe positivi.
**Conclusioni** Polmonite basale destra da Legionella Pneumophyla in paziente con iponatriemia inducente confusione mentale. La terapia antibiotica mirata ha determinato la risoluzione dell'iponatriemia, dell'iperpiressia e della confusione mentale.

## Bioimpedenziometer and hyponatremias differential diagnosis

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**Background** Among 2583 patients admitted to our ward in 2010, 398 had hyponatremia. We applied the diagnostic algorithm by Schrier RW et al. and distinguished between hypotonic (95%) and hypertonic hyponatremias (5%), then among hypotonic hyponatremias, we separeted hypo-(54%) from hyper- (30.7%) and normo-volemic (15.3%). The distinction between hypovolemic and normovolemic hypotonic patients with hyponatremia is not always easy on clinical basis, even if it is fundamental as it determines different treatments.
CardioEFG is a rapid, bedside tool that enables highly sensible and specific classification of hydration state of an individual, already used in the assessment of congestive heart failure patients.
**Objectives and methods** We investigated the usefulness of CardioEFG to objectively confirm the hydration state in a small sample of normovolemic patients with hypotonic hyponatremias.
**Results** We found that 54% of them patients were not normovolemic as in appearance, but they were from slightly to highly hyperidrated (hydragram score from 72.1 to 87.3%).
**Conclusions** CardioEFG could be a promising tool to assess hydration state in hyponatriemic patients. Larger studies are needed to confirm this role.

## L'ecografia toracica: una realtà nella pratica clinica

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L'ecografia rappresenta oggi una metodica diagnostica indispensabile nella pratica clinica. La sua utilizzazione interessa le diverse branche della medicina, anche quelle superspecialistiche.
L'approccio toracico è sicuramente quello meno utilizzato.
Il caso riportato riguarda una Signora di anni 60, giunta alla nostra osservazione per un dolore all'emitorace sinistro. La paziente era stata trattata con terapia antivirale, nel sospetto di Herpes Zoster, ed antiinfiammatoria, senza alcun risultato. Aveva effettuato un RX torace, RX emitorace sinistro per coste, ecg, ecocardiogramma, prova da sforzo, visita senologica e mammografia, esami ematochimici, risultati tutti negativi, ad eccezione di un lieve incremento della PCR. L'obiettività risultava negativa.
Abbiamo effettuato una valutazione ecografica nella zona sede di dolore con sonda ecografica convex e lineare ed abbiamo riscontrato la presenza di ispessimenti pleurici multipli, in assenza di pattern vascolare evidente. Abbiamo effettuato una TAC Torace con mdc, e poi una PET-TAC, che hanno confermato la presenza di ispessimenti pleurici nodulari, bilateralmente, da riferire a verosimili secondarietà. L'approccio videotoracoscopico ha riconfermato il tutto e sono stati effettuati prelievi bioptici. L'esame istologico concludeva per foci flogistici. La paziente è in follow up clinico-strumentale.
Sicuramente l'utilizzazione dell'ecografia avrebbe permesso un più rapido iter diagnostico, evitando terapie non congrue, indagini strumentali talora inappropriate e stress psico-fisico per la paziente.

## ✪ Home telemonitoring: due anni di attività

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L'invecchiamento della popolazione e l'aumento della cronicità di molte patologie richiedono modifiche dell'assetto organizzativo del SSN nel tentativo di ridurre i costi sia diretti che indiretti.Scopo del nostro studio è valutare se il telemonitoraggio domiciliare possa rappresentare un modello assistenziale in grado di ridurre la spesa sanitaria senza pregiudicare la qualità del servizio.
**Materiali e Metodi** Sono stati arruolati pazienti afferenti a diverse strutture sanitarie dell'ospedale che,altrimenti,avrebbero necessitato ricovero ospedaliero.Sono stati esclusi pazienti non in grado di utilizzare i device e/o con care giver inaffidabili. Ogni paziente ha utilizzato i device per la registrazione di dati biometrici e sintomi secondo un protocollo individualizzato. Ai messaggi di alert è seguita un'appropriata risposta (variazione terapeutica, visita ambulatoriale, accesso in DEA).
**Risultati** In 2 anni di attività sono stati arruolati 542 pazienti (M 55%, F 45%),di 64±14 anni, per 28±12 giorni di degenza. Il 71% dei pazienti proveniva dal DEA cardiologico (fibrillazione atriale,scompenso cardiaco),il 29% ( BPCO,diabete,ulcere vascolari,neoplasie) dai reparti ed ambulatori.Sono stati controllati a distanza oltre 86367 parametri: (ECG,glicemia,peso,SPO2,PA,FC,etc.).Con l'attività svolta sono diminuiti il numero di ricoveri (-347), le giornate di degenza (-76gg),accessi in DEA (-84),visite ambulatoriali (-430).
**Conclusioni** Home telemonitoring ha consentito un risparmio di 1.068.000€ con un grado di soddisfazione alto sulla qualità del servizio prestato nel 79% dei pazienti arruolati.

## La telemedicina negli istituti penitenziari

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L'aumento della popolazione carceraria determina un sovraffollamento degli istituti penitenziari con conseguente deterioramento della qualità della vita dei detenuti ed un'assistenza sanitaria non adeguata. Il progetto di introdurre la telemedicina nelle carceri si prefigge di migliorare l'assistenza ai detenuti e di fornire ai sanitari uno strumento utile per una diagnosi differenziale tra simulazione e patologia reale e per un indirizzo terapeutico e di follow-up.
Per i teleconsulti i dispositivi medici sono posizionati in una valigetta facilmente trasportabile. I dati misurati vengono trasferiti al Pc dell'infermeria che confezionerà il teleconsulto e lo invierà ai medici dell'ospedale. Per tale trasferimento dati viene utilizzata obbligatoriamente

la connettività del Ministero di Giustizia sulla quale sono stati aggiunti dei sistemi di sicurezza dedicati quali impostazioni di Firewall, sistemi di crittografia, IPSec, VPN. Il progetto prevede 3 fasi con incremento progressivo delle prestazioni erogate anche in urgenza. In atto siamo nella fase T1 che prevede un teleconsulto specialistico cardiologico non in urgenza con risposta entro 48 ore di giorni lavorativi.
In due mesi di attività sono stati effettuati 21 teleconsulti con tempo di risposta di 4±0,20 ore (14% in meno di 30',62% in oltre 160').Il 95% delle risposte suggerivano diagnosi, il 5% prescrivevano variazioni terapeutiche.
La telemedicina potrebbe diventare un metodologia accreditata per migliorare l'assistenza sanitaria carceraria con soddisfazione sia dei detenuti che dei sanitari.

## Telemonitoraggio domiciliare (TD) nel follow-up della fibrillazione atriale (FA) post cardioversione

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**Scopo dello studio** Scopi del nostro studio sono:
1) valutare se il TD sia in grado di ridurre gli accessi in DE in pazienti con FA cardiovertiti;
2) riscontrare se la maggior parte dei pazienti affetti da FA possa essere trattata in DE senza ricovero ospedaliero ma ricovero in TD;
3) verificare se tale strategia operativa consenta di gestire l'incidenza di recidiva di FA post cardioversione.
**La ricerca** Sono stati arruolati 194 pazienti, età 65±13 anni., 104 uomini (54%) e 90 donne (46%) con FA persistente (<48h) cardiovertiti farmacologicamnte o DC shock. Sono stati esclusi pazienti con tireopatia nota e valvulopatia reumatica e non in grado di utilizzare i device. Sono state eseguite registrazioni domiciliari giornaliere di ECG e di ogni emergenza sintomatologica.
164 pazienti (84.5%) con FA isolata o rara (<1 al mese)non eseguivano profilassi antiaritmica mentre 30 pazienti (15.5%) con FA ricorrente iniziavano o continuavano terapia antiaritmica. Di questi ultimi solo 10 sono stati trattati in DE per 15 recidive, mentre gli altri 20 hanno gestito a domicilio 50 episodi di FA, seguendo le indicazioni terapeutiche dello staff dell'unità di telemedicina.
**Conclusioni** TD consente:
a) di rilevare precocemente esordi di FA,
b) di ridurre gli accessi in DE, di rassicurare pazienti e familiari,
c) un risparmio di € 15.450,00 (50 accessi in DE per un DRG rate quantificato in almeno € 309,00 ciascuno).

## Case report: subclinical bone marrow metastasis in colorectal cancer patient

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**Case report** A 72 years-old man, was admitted to the medicine Unit, reporting fever until 39°C, and generalized weakness. Patients underwent two months before left emicolectomy for colorectal adenocarcinoma confirmed to histology and TC total body (staging T3, N1, M0; G3) with dissemination in lymphatic e venous loco-regional vessels. Patient attend a future chemotherapy to complete the cure of neoplastic disease. At admission, routine biochemistry including alteration of liver function tests (GOT; 49 UI/L) and a more remarkable increase of LDH (1147 UI/L) and alkaline phosphatase (246 UI/L), PCR and VES, hemoglobin (10.1 g/dl), RBC (3.550.000 cells/mm3), WBC (7.700 cells/mm3) and 374.000 platelets/mm3. Clinical condition worsen rapidly with a generalized abruption of petechiae excluded the hands and the feet. Urgent Biochemistry evaluation revealed a progressive anemia (Hb:6.9g/dl) and a severe piastrinopenia 23.000 cells/mm3. Patients were transfused with platelets and treated with vitamin K , steroids and submitted to bone-marrow biopsy. Histology revealed a sub-total infiltration of epithelial cells with neoplastic typical alterations. Immunohistochemistry revealed the positivity to CEA and CK 20 suggestive of bone marrow infiltration of CRC cells. Despite the obtaining diagnosis and the appropriate treatment used patients died after one months of hospitalization
**Conclusion** Bone marrow examination should be useful in all CRC patients with predictive signs of invasion. This will help better define the need for adjuvant systemic therapy.

## Cerebral ischemia as initial neurological manifestation of atrial myxoma: a case report

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**Case report** 57-year-old man showed right hemiparesis with brachial predomination (degree IV+) and dysarthria for 8 hours, with a partial improvement in the subsequent hours. Laboratorial exams showed normal values. The electrocardiogram was normal. Computerized tomography was negative for cerebral infarction or hemorrhagic suffusion. Transthoracic echocardiogram showed a mass in the left atrium, apparently dissociated to mitral valvular lembus in first hypothesis attributed to embolic origins. Transesophageal echocardiogram revealed the presence of expansive atrial myxoma (AM). At diagnosis, the patient start a treatment with warfarin to maintain INR between 2 and 3. The patient had surgery and the diagnosis of AM was confirmed. In the postoperative, the patient did not show other neurological events.
**Discussion** Cerebrovascular diseases (CVD) are the main cause of death and permanent handicap in Italy. Around 14% to 20% of ischemic CVD are of cardio-embolic etiology. AM is responsible for 0.4% of cases and neurological manifestations are reported in 25% to 45% of cases. Therefore, surgery has to be performed as soon as possible, even on asymptomatic patients, as secondary prevention of cerebral infarction. Neurological events after surgery are rare. We conclude that ischemic cerebral vascular accident may indicate the presence of an AM, since its diagnosis is important to establish a quick surgical conduct, in order to avoid the occurrence of new cerebral events.

## ✪ Fatty acid synthase (FAS) expression in duodenal mucosa of celiac patients

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**Introduction** Celiac disease (CD) is characterized by intolerance to the gluten protein in genetically predisposed subjects causes the immune-

mediated damage of the small bowel mucosa. Fatty Acid Synthase (FAS) is the only protein able to synthesize de novo long-chain fatty acids. Considering that the intestinal mucosa in CD patient have an higher rhythm proliferation in comparison to normal epithelium, the aim of study was to assess the degree of FAS expression before and after gluten-free diet in CD patients.
**Methods** The histological assessment and FAS immunoreactivity were performed on specimens of the duodenal epithelium. CD was classified according to the Marsh-Oberhuber criteria and FAS expression determined on the ratio of positive cells: absent (grade 0: 0% of positive cells); moderate (grade 1: <50% of positive cells); high (grade 2: >50% of positive cells).
**Results** On 29 CD patients in gluten-free diet, at diagnosis, 7 patients (24%) were classified grade IIIC Marsh-Oberhuber classification, 10 (35%) under grade IIIB, 6 (21%) under grade IIIA, 4 (13%) under grade II and 9 (7%) under grade I. Out of 29 CD patients in 16 (55%) were found high FAS expression and in 14 (45%) a moderate expression. At evaluation after 6 months of gluten-free diet, FAS enzyme was highly expressed in 13 (45%), moderate in 11 (38%) and absent in 5 patients (17%).
**Conclusions** Persistence of FAS expression could be reflected a metabolic normal reaction to chronic mucosal damage.

## Risk of constrictive pericarditis after acute pericarditis

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**Background** Constrictive pericarditis (CP) is a rare, dreaded complication of pericarditis. There is a lack of prospective studies evaluating the specific risk according to different etiologies. Aim of this study is to evaluate the risk of CP after a first episode of acute pericarditis (AP).
**Methods and Results** Prospective cohort study. 500 consecutive cases with a first episode of AP (age 51±16 years; 270 men) were prospectively studied. Etiologies were viral/idiopathic in 416 cases (83.2%), connective tissue disease/pericardial injury syndromes in 36 cases (7.2%), neoplastic pericarditis in 25 cases (5.0%), tuberculosis in 20 cases (4.0%) and purulent in 3 cases (0.6%). During a median follow-up of 72 months, CP developed in 9 patients (1.8%): 2/416 patients with idiopathic/viral pericarditis (0.48%) versus 7/84 patients with a non viral/non idiopathic etiology (8.3%). The incidence of CP was 0.76% cases per 1000 person-years for idiopathic/viral pericarditis, 4.4 for connective tissue disease/pericardial injury syndrome, 6.33 for neoplastic pericarditis, 31.65 for tuberculous pericarditis and 52.74 for purulent pericarditis.
Over the same years we observed other 11 patients with CP; they presented directly with typical signs of congestion (2 for tuberculosis, 1 for radiotherapy).
**Conclusions** CP is a very rare complication of a first episode of viral/idiopathic AP (<0.5%) but in contrast is relatively frequent after AP of specific etiologies, especially bacterial. In all, the more common presentation of CP is congestion, without previous history of pericarditis.

## Colchicine halves but does not eliminate recurrences in pericarditis: COlchicine for Recurrent Pericarditis (CORP)

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**Background** Recurrences are the most common complication of acute pericarditis (20 to 50% of cases). Aim of this study is to evaluate the efficacy and safety of colchicine for the secondary prevention of recurrent pericarditis (RP).
**Method** This is a prospective randomized double-blind placebo-controlled multicentric trial; 120 patients with a first episode of RP were randomized to receive placebo or colchicine on top of a conventional treatment (aspirin, NSAIDs, corticosteroids). Colchicine was given at the maintenance dose of 0.5 to 1.0 mg daily for 6 months. The primary study end point was the recurrence rate at 18 months.
The secondary end points were symptom persistence at 72 hours, remission rate at 1 week, number of recurrences, time to first recurrence, disease-related hospitalization, cardiac tamponade and constrictive pericarditis rates.
**Results** Colchicine significantly reduced the incidence of recurrences at 18 months compared to placebo (23.9% vs. 55.3%; p<0.001; number needed to treat-NNT 3). It also significantly reduced the symptoms persistence at 72 hours (23.3% vs. 53.3%; p=0.001) and the mean number of recurrences; it increased the remission rate at 1 week (81.7% vs. 48.3%; p<0.001) and prolonged the time to a subsequent recurrence. The rate of side effects and drug withdrawal were similar in the colchicine and placebo groups (respectively 6.7% vs. 6.7% for side effects, 8.3% vs. 5.0% for drug withdrawal).
**Conclusions** Colchicine is safe and efficacious for the secondary prevention of RP. It halves recurrences but does not eliminate them.

## Clues to detect TRAPS syndrome among patients with idiopathic recurrent acute pericarditis: results of a multicentre study

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**Background** The clinical expression of tumor necrosis factor receptor-associated periodic syndrome (TRAPS) in the form of idiopathic recurrent acute pericarditis (IRAP) has not been explored in the medical literature.
**Objective** To evaluate the incidence of TRAPS mutations in patients with IRAP and identify possible clues to TRAPS diagnosis.
**Results** 131 consecutive Caucasian patients with IRAP were investigated for mutations of the TRAPS gene and prospectively evaluated. 8 of the 131 patients (6.1%) carried a TRAPS mutation.
These patients had more frequently a positive family history for pericarditis (75% vs. 8%), a higher mean number of recurrences after the first year (4 vs 0.75), on colchicine treatment (4 vs 0.16), and a higher need of immunosuppressive therapies (88% vs 21%). 6 of these patients (75%) was successfully treated with anakinra (n.1) or etanercept (n.5). In the other 2 cases a chronic administration of high doses prednisone was required in order to prevent recurrences.
**Conclusion** TRAPS is a cause of recurrent pericarditis in 6% of unselected cases with IRAP. A positive family history for pericarditis, a poor response to colchicine, recurrences after the first year from the index attack or on colchicine treatment and the need of immunosuppressive agents are clues of the possible presence of TNFRSF1A gene mutations in patients with IRAP.
The identification of genetically-positive IRAP patients would also allow – in the case of poor response to conventional therapies – to prescribe more specific treatments such as anti-IL 1 or anti-TNF agents.

## Come organizzare un Servizio di Angiologia a "Isorisorse"

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**Introduzione** L'attività di Angiologia nell'Ospedale di Rovigo è stata , sino all'anno 2009, svolta dalla Medicina Interna, dalla Chirurgia Vascolare e da altri professionisti coinvolti singolarmente. Nell'anno 2009 la Medicina Interna è stata investita del compito di coordinare tutta la attività , prendendo spunto dalla ristrutturazione logistico-tecnologica del Presidio Ospedaliero. Il raggiungimento di tale obiettivo è rientrato nella contrattazione annuale del budget.
**Materiali e Metodi** Il processo è risultato articolato su una serie di passaggi obbligati :1) Riunione di tutte le risorse tecnologiche e umane in un unico polo 2) Creazione di un calendario di presenza settimanale feriale 3) Creazione di un' agenda appuntamenti unica per interni, post-ricovero e post-intervento 4) Creazione di un data base unico , grazie all' utilizzo della nuova cartella clinica informatizzata 5 ) Organizzazione di un evento formativo angiologico semestrale 6) Percorso diagnostico-terapeutico angiologico condiviso con il Pronto Soccorso 7) Definizione di incontri semestrali con i MMGG.
**Risultati** A distanza di due anni il progetto è diventato una realtà ben evidente all'interno del Presidio Ospedaliero , realizzando tutti i passaggi ricordati sopra. Tuttavia alcune problematiche , stante la trasversalità delle equipe coinvolte, appaiono più complesse e difficilmente realizzabili in tempi brevi. **Conclusioni** L'organizzazione di un Servizio di Angiologia a "isorisorse" è una strada percorribile che necessita del massimo impegno clinico-organizzativo quotidiano e della più grande disponibilità da parte della Direzione Sanitaria.

## Percorso diagnostico- terapeutico integrato del paziente con arteriopatia degli arti inferiori (PAD)

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**Introduzione** L'arteriopatia degli arti inferiori ( PAD) è una patologia il cui approccio multidisciplinare ben si presta a verificare il reale funzionamento di un percorso diagnostico-terapeutico.
**Materiali e Metodi** Dall'anno 2005 all'interno del Dipartimento di Medicina Interna le SOC di Medicina Interna e di Diabetologia hanno messo a punto una strategia sistematica di approccio al paziente con sospetta PAD .Tutti i pazienti con sospetta PAD venivano sottoposti ad Indice di Winsor (IW); il successivo percorso seguiva la flow-chart suggerita dalla TASC 2007. L'ecocolordoppler veniva eseguito in Angiologia Medica o in ChirurgiaVascolare . I pazienti con ischemia critica venivano sottoposti ad arteriografia oppure alla sola terapia medica. Tutti i pazienti con ischemia non critica eseguivano una valutazione clinico-strumentale semestrale. Per i pazienti che si sottoponevano ad intervento veniva organizzato un follow-up a 1-3 - 6 mesi.
**Risultati** Questo tipo di organizzazione ha portato alla valutazione di circa 500 pazienti all'anno ; i positivi alle indagini di primo livello sono risultati circa il 50% ( 15% con IW < 0.5, 30% tra 0.7 e 0.5, 40% tra 0.9 e 0.7). I pazienti inviati a valutazione chirurgica sono risultati il 10% e di questi l'80% ha eseguito esame angiografico; la procedura endovascolare è risultata la più utilizzata. L'1.5% dei pazienti sottoposti ad angiografia è stato giudicato inoperabile ed avviato alla sola terapia medica.
**Conclusioni** L'organizzazione di questo percorso diagnostico-terapeutico ha permesso di ottimizzare le risorse umane e tecnologiche già esistenti, coordinando e razionalizzando la loro attività.

## Aumento del BNP dopo scarica elettrica di ICD

V. D'alfonso [1], G. Straface [1], F. Cardoni [1], G. Tommasi [1], B. Virgilio [1], R. Cesareo [1], P. Del Duca [1], A. Maietta [1], C. Cianfrocca [1], G. Campagna [1]

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Paziente di 80 anni inviato dal PS per "scompenso cardiaco". Dal punto di vista anamnestico presentava numerosi ricoveri per insufficienza cardiaca in cardiopatia dilatativa post-ischemica con bassa FE (circa 25%), per cui circa un anno prima era stato impiantato un ICD. Il paziente era inoltre affetto da BPCO e FAC. Al fine di ottimizzare la terapia medica fin dall'ingresso è stato monitorato il valore di BNP (circa 500 rgr/ml). Il peptide natriuretico tipo B (BNP) è un neurormone, secreto principalmente dai ventricoli cardiaci, in risposta al carico di volume intracardiaco, contro-regolando gli effetti dell'angiotensina II, della norepinefrina e dell'endotelina, con effetti vasodilatatori e diuretici. Durante il 3° giorno di ricovero assistiamo ad una scarica appropriata dell'ICD dovuta ad un episodio di tachicardia ventricolare sostenuta. Eseguito il prelievo del BNP ematico riscontriamo un valore triplicato dello stesso (1581 pgr/ml). Tale incremento non si è associato ad un aumento degli indici di miocardiocitolisi risultando pertanto difficilmente imputabile ad una sofferenza ischemica del cuore legata alla scarica elettrica dell'ICD. Sembra altresì verosimile che la tachiaritmia ventricolare causando un abbassamento ulteriore della FE abbia portato ad un aumento della tensione parietale dell'atrio e ventricolo sinistro con conseguente rilascio di BNP. Questa osservazione evidenzia l'estrema sensibilità del BNP alle variazioni di tensione dell'atrio e del ventricolo sinistro, ed il repentino aumento dello stesso anche dopo eventi di brevissima durata.

## ✪ Tubular injury in type 2 diabetic patients: a pathogenetic role in diabetic nephropathy?

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Nephropathy in type 1 diabetes is a glomerular disease, in contrast several type 2 diabetic patients (T2DM) have severe tubulo-interstitial lesions with mild or absent glomerular injury. The role of tubulo-interstitial lesions in the pathogenesis of diabetic nephropathy in T2DM is unknown.
**Aims** 1) To quantify in T2DM tubular basement membrane width (TBM width), cortical interstitial fractional volume [Vv(Int/cortex)] and the proportion of atrophic tubules [Vv(Ta/Tt)]. 2) To evaluate the relationships between these parameters, glomerular structural parameters [glomerular basement membrane-GBM width and mesangial fractional volume-Vv(Mes/glom)] and functional parameters (AER and GFR).
**Methods** In 42 T2DM with different levels of albuminuria a kidney biopsy was performed to estimate by electron and light microscopic morphometric analysis the structural parameters.

**Results** TBM width, Vv(Int/cortex) and Vv(Ta/Tt) increased with increasing AER ($p < 0.001$); TBM width and Vv(Ta/Tt) were correlated with GBM width and Vv(Mes/glom) ($p<0.01$). Vv(Int/cortex) was related only to Vv (mes/glom) ($p<0.05$). Multiple regression analysis between all morphometric parameters and AER showed that the only structural parameter correlated with AER was TBM width ($p<0.05$). TBM width was also related with HbA1c ($p<0.01$).
**Conclusions** TBM thickening is present in T2DM and probably plays a role in the pathogenesis of abnormal AER. The relationship between HbA1c and TBM width suggests a direct role of hyperglycaemia in the pathogenesis of this structural lesion in T2DM.

## Microalbuminuria, renal artery resistence index and Aliskiren in resistant artery hypertension

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**Objectives** Evaluate the effects of Aliskiren (A),a strong direct renin inhibitor, in ambulatory population with Resistant Arterial Hypertension (RAH) and significant Microalbuminuria MA. RAH is defined that condition in which the BP is above 140/90 despite the concurrent use of three or more medications, including a diuretic at the highest dose. It's a very high cardiovascular risk.
**Materials and Methods** We enrolled 56 pts (36 f), mean age 64±7, among those who occurred in six months at the Center of Hypertension of Cardarelli Hospital during 2010, who were affected by RAH and MA for at least 12 months. All underwent ABPM, renal artery resistence index measurement and the routine provided by ESH; only the ACE inhibitors and the anti ARBs were suspended. All were prescribed A150 mg/day or 300 mg/day, if the BP was not controlled after 30 days. Monthly BP cecks were carried out and after a year of the ABPM and MA.
**Results** S.B.P. was 156± 5 and DBP 89± 6; at 12 months respectively 133± 5 and 83 ± 4. The MA at time zero was on average 80± 12 and after 12 months 20± 5. It should be noted that after a month with A, the reduction of SBP and DBP was significantly reduced. The RI of cortical arteries decreased from 0,71 ± 2 of time zero to 0,66 ±3 after 12 months.
**Conclusions** A.has shown not only to act quickly in Pts with RAH, but also to eliminate almost completely Microalbuminuria (effect not achieved by previous treatment with ACE or ARBs) and to reduce and control the renal arteries resistance, improving and lowering the cardiovascular risk of these pts.

## Reliability of ABPM for blood pressure measurement

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**Objective** ABPM is nowdays considered a very important procedure for the"White Coat Hypertension" recognition, to verify the arterial pressure circadian rhythm and the patients respond to therapy. But beside these certain advantages, we must consider that this procedure may cause some discomfort, until sleep disturbances, that can alter whether the BP levels or the Diurnal Index (DI=daytime BP nighttime BP/ daytime BP per 100%).
**Materials and Methods** We have studied 122 pts affected by grade 2 AH , aged 51± 6,1 and 52± 7,1 who were recruited for the first time by our center in the last three years and had never assumed any hypotensives. They underwent an ABPM twice in 48 consecutive hours.
**Results** SBP diurnal values in the first day were 162±7,3 and those at night (from 11 p.m.to 5 a.m.) 146±5,9, while DBP was 109±7,2 during the day and 93±3,7 at night. In the second day SBP was 150±3,9 daytime and 139±4,8 nights, while the DPB was 94± and 88±6,1 nights.
**Conclusions** These data don't reduce neither the importance of ABPM in the White Coat Hypertension diagnosis nor in the evaluation of the therapy efficacy, but we suggest that they have to be taken with caution, because the device can cause problems to the patients during the day but mostly for the discomfort during night registration and so give us information not surely true, leading us to diagnoses not correct.

## Trend of blood pressure and revascularization with stents (Stent-R)

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**Objective** The aim of work is monitor the performance of the BP in hypertensives for resistant renal artery stenosis underwent Stent-R (SR), through outpatient monitoring at home (HBPM) and ambulatory ABPM.
**Materials and methods** Of 947 pts arrived in 2008-2009 at the Hypertension Center of Cardarelli Hospital, we selected 51 pts ( 21 F), mean age 53.8, with renovascular hypertension and were subjected to Stent-R. They were treated with three or more drugs including a diuretic.The mean value of BP before SR were evaluated with HBPM: SBP 158±9.7 mmHg and DBP 99.1±7.1 in the morning; SBP 150.5±8, DBP 92.8±6.3mmHg in the evening. BP assessed by ABPM showed the mean daytime 161.3/99.5 mmHg; nocturnal 149.2/89.1 mmHg and 24 hours 155.2/94.3 mmHg.
**Results** In the first week after SR, the mean values of the BP with HBPM, in the morning were SBP 133.2 ±5.4( $p<0,0005$) and DBP 82.4 ±7.1( $p<0,0005$); SBP 125 ±4.( $p<0,0001$) and DBP 74.6±7.7( $p<0,0005$) in the evening. After 3 months, BP was assessed by ABPM. The mean value daytime were 135/83.5($p<0,0001$), nocturnal 125.6/75.5($p<0,0005$) and 24 hours 130.6/79.($p<0,0005$). After 12 months , the BP values were optimal with average daytime 132.7/80 ($p<0,0005$), nocturnal 117.7/72($p<0,0005$) and 24 hours 126.3/76.3($p<0,0005$). In 20 (8 F) we devolved therapy.
**Conclusions** Stent-R improves the performance of the values of BP and early detection of stenotic disease can reduce access to emergency department and the general practitioner, pharmaceutical expenditure and especially the severe complications of organ.

## New arterial hypertension in liver transplantation

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**Objective** Hypertension is an important comorbidity related to immunosuppression schedule (ISS) after solid organ transplantation.Calcineurin inhibitor (CNI) are the common IS drugs.
Aim of this study,is to evaluate the incidence of new hypertension in liver transplantation.
**Materials and Methods** 249 transplanted are under follow-up. In our ISS steroids are used with tacrolimus or cyclosporine.98 hypertensives

(64 m, 53 ± 6 yrs) out 249 with no more than 10 year of transplantation were enrolled.We measured renal function, metabolic parameters every month in a year, and Renal Arterial Resistant Index (RI).
**Results** All patients received a dietetic treatment and they evaluated BP by using approved electronic device. 85 out 98 has AH grade 1or2.29 were treated with Ca-antagonist (Group A), 28 with ACE inhibitor and Ca-antagonist ( Group B),28 with ARBs (Group C).Group A and C did not show any statistical increase of their parameters.9\28 in B showed differences in renal function.RI didn't show alteration, without significant statistical differences.
**Conclusions** AH is an important issue after liver transplant.This morbidity is relevant and not related to one of the CNI drugs. Moreover the IS does not seem to affect renal function in patients under Ca-antagonist or ACEI-inhibitor plus Ca-antagonist but not in those with ARBs treatment.The only common variable in PTS is steroid induction.Further studies are required to better evaluate possible involved variables and to confirm our findings to avoid possible graft and systemic organ damaged due to hypertension.

## Ipotiroidismo subclinico come causa di scompenso cardiaco acuto nel paziente anziano

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**Caso clinico** Donna di 72 anni accede in Reparto per scompenso cardiaco congestizio.In anamnesi ipotiroidismo iatrogeno in terapia sostitutiva da circa 10 anni.Malattia di Alzheimer,con recente peggioramento cognitivo. Anamnesi negativa per malattia cardiovascolare.
**Decorso** All'esame obiettivo edemi declivi,turgore giugulare con segni di sovraccarico polmonare e versamento pleurico bilaterale.All'ecocardiogramma diffusa ipocinesia del ventricolo sinistro,con FE 30%,lieve versamento pericardico circonferenziale. Non alterazioni ischemiche all'ECG.Agli esami ematici grave ipotiroidismo (TSH 32.45 mU/l), proBNP 32700 pmol/l.Ad un'attenta anamnesi riferita scarsa compliance alla terapia medica,in particolare all'assunzione della Levotiroxina.E' stata impostata terapia dello scompenso cardiaco e dell'ipotiroidismo. A 3 mesi di distanza,netto miglioramento clinico con scomparsa degli edemi declivi e del versamento pleuropericardico,con recupero della funzionalità cardiaca (FE 40%).
**Conclusioni** Nell'inquadramento diagnostico dello scompenso cardiaco acuto di nuova insorgenza, è importante considerare la possibile presenza di un distiroidismo. Nella popolazione anziana l'ipotiroidismo, specialmente di natura iatrogena, ha un'alta incidenza ed una presentazione clinica subdola,pertanto è spesso misdiagnosticato e sottotrattato. Nei pazienti anziani inoltre la compliance alla terapia può essere spesso difficile,comportando uno squilibrio ormonale,con conseguente progressivo peggioramento dello stato cognitivo fino alla demenza ed alterazioni sistemiche come lo scompenso cardiaco.

## Un raro esordio di un linfoma meningeale: la sindrome di Vernet

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**Caso clinico** Donna di 69 anni accede in pronto soccorso (PS) per episodi sincopali recidivanti. Nell'ultimo mese comparsa di lieve dislalia. In PS eseguito il massaggio del seno carotideo sinistro risultato positivo, trattato con impianto di pace maker (PM). Successivamente recidiva di episodio sincopale, accompagnato da crisi comiziale, per cui è stata trasferita presso il nostro Reparto.
**Decorso** Ad un attento esame obiettivo rilievo di massa solida laterocervicale sinistra, disfagia, disfonia per paralisi della corda vocale sinistra e deficit motorio della spalla omolaterale. TC encefalo e EEG negativi. All'ecografia del collo dimostrazione di lesione non vascolarizzata a livello della biforcazione carotidea sinistra. Durante il ricovero progressivo peggioramento clinico con paralisi progressiva dell'VIII e XII nervo cranico, associata a crisi epilettiche recidivanti. Eseguita rachicentesi con esame citologico compatibile con linfoma meningeale, confermato successivamente dall'agobiopsia della massa laterocervicale. RMN encefalo per studio della base cranica non eseguibile per presenza di PM. Alla PET-TC del cranio evidente lesione laterocervicale con effetto compressivo a livello del foro giugulare.
**Conclusioni** La Sindrome di Vernet è una rara patologia neurologica caratterizzata dalla progressiva paralisi dei nervi cranici (glossofaringeo, vago ed accessorio) che attraversano il foro lacero posteriore. Nel nostro paziente la lesione neurologica era dovuta alla presenza di una lesione espansiva,di natura linfomatosa,con effetto massa a livello del foro lacero.

## Lombalgia nel paziente neoplastico: oltre alle metastasi c'è di più

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**Caso clinico** Uomo di 69 anni con dolore al rachide lombare resistente a FANS da circa 1 mese. Pregresso carcinoma renale sottoposto a nefrectomia sinistra con residua IRC di grado moderato. Diabete mellito di tipo 2. Cirrosi HCV-correlata. Da circa un anno gammopatia monoclonale e crioglobulinemia
**Decorso** All'esame obiettivo disestesie dell'arto inferiore destro in neuropatia diabetica. Alla RMN del rachide rilievo di grossolana lesione sostitutiva a carico di L1 con elevato rischio di crollo vertebrale.TC con mdc non eseguibile per IRC in monorene destro.Dato il rilievo anamnestico di carcinoma renale la lesione era stata inizialmente interpretata come ripetizione metastatica.Esisteva pertanto l'indicazione al trattamento radioterapico,non urgente vista l'assenza di una sintomatologia neurologica chiaramente riconducibile alla lesione.Previa immobilizzazione con busto ortopedico è stata pertanto eseguita agobiopsia della lesione, risultata positiva per un linfoma a grandi cellule-B. E' stata quindi intrapresa una chemioterapia mirata, con ottima risposta clinica e radiologica
**Discussione** La localizzazione metastatica vertebrale è comune in molti carcinomi ed il trattamento di scelta per il controllo delle complicanze è la radioterapia. Il trattamento radioterapico deve però possibilmente essere sempre preceduto dall'identificazione cito/istologica della lesione. In particolare il linfoma vertebrale (2% dei linfomi) deve essere sempre sospettato in presenza di HCV positività. Inoltre la concomitante presenza di crioglobulinemia ne aumenta l'incidenza di circa 35 volte

## ✪ Il tolvaptan come "bridge-treatment" nella SIADH paraneoplastica in corso di microcitoma polmonare: caso clinico e revisione della letteratura

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**Caso clinico** Uomo di 69 anni giunge nel nostro Reparto per stato confusionale ed instabilità posturale. Da circa un mese astenia per sforzi prima ben tollerati e calo ponderale (circa 10 Kg in 3 mesi). Forte esposizione tabagica.
**Decorso** All'ingresso paziente confuso,con instabilità posturale senza segni di lato. TC cranio e RMN encefalo nella norma. Agli esami ematici severa iposodiemia (110 mEq/l). Nel sospetto di SIADH paraneoplastica le indagini strumentali eseguite hanno portato alla diagnosi di microcitoma polmonare con metastasi mediastiniche.
Per il persistere di grave iposodiemia sintomatica, non responsiva al reintegro endovenoso, è stata intrapresa terapia con tolvaptan con normalizzazione della sodiemia e con possibilità di eseguire il completo trattamento chemioterapico (CT). Sono state eseguite 2 linee di chemioterapia, solo la seconda risultata efficace.
**Conclusioni** La SIADH paraneoplastica è spesso l'esordio del microcitoma polmonare, si manifesta con severa iposodiemia sintomatica e l'unica terapia è il trattamento della neoplasia sottostante . Il tolvaptan, antagonista non peptidico dell'arginina vasopressina, è il farmaco di scelta per l'iposodiemia in corso di SIADH.
Nel nostro caso il Tolvaptan è stato utilizzato come "bridge" per il controllo della sintomatologia clinica dell'iponatriemia, permettendo l'esecuzione della seconda linea di CT risultata efficace nella riduzione del microcitoma e della iponatremia.

## Two years of experience in the computerized drugs prescription: clinical risk

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**Background and purpose of the study** The computerized prescription drug system (BUSTER SPID), is operative in our ward since December 2009 (experimental program) and:
• involves the computed prescription of therapy by doctors
• has made obsolete the written prescription
• involves the administration of the therapy by the nursing staff (identified by personal key) with discharge of the drug in real time at bed patient identified by the wristband
• prevents transcription errors and reduces prescription and delivery errors
• is not operative for patients so called in support
**Materials and methods** Emerged problems are:
• Buster is not operative for patients in support. Therapy are sometimes pencil written with a heavy risk error
• difficulty in providing drugs to other departments for our patients in support
• patients are not registered on the system until they return in Medicine
• Server blackouts with impossibility of prescribing and administering drugs to hospitalized patients
• areas of the department in which wireless connectivity is not guaranteed.
**Results and conclusions** Immediate restoring written therapy has prevented service interruption. Department Managers and DS resolved electrical and connectivity problems. Operativity for in support patient is unresolved.

## Case report: "Una strana vertigine"

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Il Case Report in questione, riguarda un paziente di 55 anni giunto di recente al nostro Pronto Soccorso. Questi, lamentava da alcuni giorni una sintomatologia caratterizzata da poussee'vertiginose. Tale disturbo, si associo', nei giorni successivi, ad un'andatura "strana" e difficoltosa. Il Paziente, forte fumatore, fu sottoposto – all'ingresso in P.S.– ad esami di laboratorio (assenti alterazioni patologiche); ecg, risultato nella norma; TC cranio, che non evidenzio' lesioni cerebrali acute. Eseguì', quindi, una ecografia dei tronchi sovra-aortici che rilevo' un modesto ispessimento intimale carotideo. Effettuo', infine, una ecografia transcranica per escludere compromissioni vascolari intracerebrali. Lo studio del circolo anteriore cerebrale consentìi di osservare normale morfologia e flussimetria delle arterie cerebrali intracraniche. Il circolo cerebrale posteriore, evidenzio' arterie vertebrali con flussi regolari. Cio' che richiamo' la nostra attenzione, fu il rilievo di "aliasing", all'esame color, nel tratto di origine dell'arteria cerebellare postero-inferiore sinistra (PICA). Lo studio flussi- metrico Doppler pulsato, permise di osservare un significativo incremento velocimetrico (PSV: 200 cm/sec.) in corrispondenza dell'aliasing seguito, da repentina riduzione velocimetrica, ed assenza di flusso nei segmenti a valle. Il giorno dopo, la TC cerebrale di controllo, diagnostico' la presenza di un'area ischemica cerebellare sinistra.
**Conclusioni** Ictus ischemico cerebellare da occlusione dell'arteria cerebellare infero-posteriore sinistra.

## Endoscopic ultrasonography (EUS)-guided celiac plexus neurolysis in pancreatic cancer pain

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**Background** Celiac Plexus Neurolysis (CPN) is a safe and effective technique for reducing pain in pancreatic cancer.
**Objectives** To determine efficacy and safety of CPN in reducing pancreatic cancer pain, to identify adverse events and differences in efficacy between the different techniques.
**Methods** We searched in Medline, Cochrane Central, Embase and in Health Technology Assessment Engine from 1990 to June 2011. We selected randomised controlled trials (RCTs) or metanalysis of neurolysis by percutaneous, surgical or EUS-guided approach.
**Results** The search identified 118 potentially eligible studies (six RCTs, one metanalysis and two prospective studies). About pain, assessed by VAS (Visual Analogue Scale) the results were in favor of CPN. Opioids consumption was lower in the neurolysis group than in the control group. The main adverse effects were diarrhea or constipation (this last symptom was more likely in the control group, where opioids consumption was higher). We identified one RCT comparing EUS-guided or computed tomography (CT)-guided CPN but its aim was to assess efficacy of CPN in pain associated with chronic pancreatitis.
**Conclusions** Evidence of neurolysis superiority on pain relief compared to opioids therapy is minimal. Nevertheless, fewer adverse effects are observed in the CPN group. Further studies are recommended to demonstrate the potential efficacy of a less invasive technique under EUS guidance. Moreover the ability to perform the procedure in conjunction with tumor staging and fine needle aspiration (FNA) may streamline the care of these patients.

## Embolia paradossa multiorgano? Un caso clinico

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**Introduzione** L'embolia paradossa è condizione di embolia arteriosa che non origina dal cuore sinistro o dal sistema arterioso,in presenza di trombosi venosa profonda e/o embolia polmonare. Necessita di presenza di anomala e documentata comunicazione tra sistema arterioso e venoso con aumento pressorio destro che contribuisca allo shunt destro–sinistro.
**Caso clinico** Paziente, anziano,iperteso e precedenti TIA, ricoverato per ictus ischemico, manifesta improvvisa dispnea,tachicardia e parestesie arti inferiori. Diagnosi:embolia polmonare ed occlusione embolica asse iliaco femorale destro e ostruzione iliaca sinistra. Ecocardiogramma documenta forame ovale pervio. Trattamento praticato: Embolectomia trans femorale bilaterale e terapia anticoagulante. Remissione clinica e dimissione paziente con diagnosi di embolia paradossa multiorgano in forame ovale pervio.
**Discussione** Condizione cardiaca di frequente associata a embolia paradossa è forame ovale pervio (PFO), spesso di riscontro occasionale. Diagnostici sono: ETE e doppler transcranico. L'embolia paradossa è infrequente, multiorgano è rara, prognosi severa. Spunti di discussione del caso: L'ictus è espressione di embolia paradossa o,considerate età e anamnesi,è aterotrombotico? L'ictus può essere dovuto a embolia paradossa anche nei soggetti di età > 55 anni? La letteratura non è concorde. Quale terapia adottare? Indirizzare il paziente alla chiusura del PFO? La scelta di esclusiva terapia medica è sostenuta da un recente studio ma anche da attuali condizioni cliniche del paziente che,a distanza, è del tutto asintomatico

## Is "time of event" reported in the epidemiological studies on in-hospital falls? A systematic minireview of recent literature

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**Background and Aims** Falls represent common and serious problems among older people and represent social and economic burden. We do know much on where, how, and why a patient falls. We aimed to evaluate how frequently the epidemiological studies collected data on time of events.
**Methods** Relevant papers published from 2009 to 2011 were searched across PubMed. The MeSHM terms used were: "Aged", "Aged, 80 and over", and "Accidental Falls". Systematic reviews, meta-analyses, controlled trials, cohort studies, and case-control studies were considered.
Results Out of 320 references, we considered 15 studies (Australia, China, Japan, Taiwan, Sweden, Denmark, Ireland, Italy, Switzeland, Turkey) collecting 3314 cases. The lowest number of cases per study was 17 and highest 657. Eight studies (53%, 1749 cases) contained report on time of falls, although methods of data analysis were different.
**Conclusions** Only 50% of studies reported time of events. Potential causes of in-hospital falls are numerous: confusion, cognitive impairment, sleep disturbance, medications, older age. Daytime or nighttime main peaks of events may underly different causes: diurnal falls mostly occur in patients' room and bathroom, secondary to daily common activities (moving/transferring/toileting), whereas nocturnal falls are often due to medications (sedatives, diuretics). Again, in a same setting different risk windows may be present. Adding precise indication of time of falls to the minimum data set collected for each setting, could provide useful additional information and help prevention efforts.

## Modifications of lipid profile in patients with rheumatoid arthritis during biological therapy

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**Background** Patients with severe rheumatoid arthritis (RA) present an increase cardiovascular risk, frequently linked with an atherogenic lipid profile. The pathogenic mechanism has not been already completely explained, but some pro-inflammatory cytokines are probably involved (i.e. TNF-alpha). We have evaluated the effects of biologic therapy on lipid profile in comparison with conventional therapy.
**Methods** 94 patients with RA treated with anti TNF-alpha drugs (Etanercept, Adalimumab, infliximab) have been compared with 57 patients treated with traditional antirheumatic drugs (DMARDS). We evaluated lipid profiles and clinical evolution of illness (using the "DAS 28" index).
**Results** In patients treated with biological drugs, we observed a reduction of total cholesterol concentration by 5%, of LDL-cholesterol by 11,7% and an increase of HDL cholesterol by 8,8% with a reduction of the atherogenic ratio from 3,63 to 3,17 (-12,6%). In the control group we observed similar variations.
**Conclusions** The effects on lipid profile and DAS 28 index were comparable between the group with RA treated with biological agents and DMARDS, even if the severity of illness was higher in the former.

## Sicurezza nella gestione della terapia farmacologia in un reparto di Medicina: ruolo della FMECA e sinergie con altri strumenti

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**Introduzione** In reparto di Medicina la gestione della terapia risulta rischiosa a più livelli, coinvolgendo sia aspetti tecnici sia non tecnical skills.
Scopo dello studio Verificare se l'utilizzo integrato di diversi strumenti (metodi reattivi e proattivi) sia utile per esplorare il rischio esistente e rendere più coerenti ed efficaci le azioni di miglioramento per il contenimento del rischio.
**Metodi** Nel Gennaio e Marzo 2010 è stata effettuata la prima FMECA coinvolgendo tutto lo staff del reparto, poi ripetuta nel 2012. Il processo di gestione dei farmaci si è scomposto in 8 fasi, con 41 failure mode e un punteggio complessivo di rischio di 7838. Sono emerse 40 azioni di miglioramento, tradotte in un programma costantemente monitorato nel tempo. Per valutare l'adesione dei professionisti agli standard interni si è fatto un audit con: revisione di cartelle cliniche, intervista, osservazione diretta.
**Risultat**i Concluse 31 azioni di miglioramento. Con un audit è stata mappata la qualità prescrittiva di ogni medico. La ripetizione della FMECA ha documentato la riduzione del punteggio complessivo di rischio (5598 punti, - 28.6%) soprattutto nelle fasi di prescrizione iniziale, monitoraggio e modifica prescrittiva della terapia. Si sono azzerati tre failure mode ed è emerso un nuovo rischio in fase di somministrazione del farmaco.
**Conclusioni** L'utilizzo contemporaneo di più metodi di analisi e gestione del rischio clinico è risultato molto efficace per ridurlo ed avviare un processo continuo di miglioramento che coinvolge tutti gli operatori dedicati alla cura del paziente.

## Decisive mediastinoscopy in the differential diagnosis of a clinical case of sarcoidosis associated with mediastinal adenopathy

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**Background and purpose of the study** The mediastinoscopy has been

able to come to definitive diagnosis and initiate proper medical treatment in the Sarcoidosis clinical case.
**Materials and Methods** Male patient, thirty-two years ago, from Bangladesh, textile worker was admitted to medicine internal ward of the hospital for persistence of anterior chest pain and fever.Objectivity did not show clinical significant symptoms or signs.Electrocardiogram and Echocardiogram documented the alterations of the ST-T tract and pericardial effusion, chest x-ray showed the presence of left pleural effusion.CT Chest described: enlarged lymph nodes (up to two cm) mediastinal and hilar bilateral confluent and the pleurisy and pericarditis. The lymphocyte typing of bronchoalveolar lavage showed an increase in the ratio TCD4 + / + TCD8 equal to 5.5. Histological examination of a paratracheal lymph node in the Mediastinoscopy showed "non-necrotizing granulomatous inflammation giant evolving sclerotic sarcoidosis type".
**Results** The origin of the patient from Bangladesh,well known the high prevalence epidemiology of tuberculosis, has strongly influenced both the diagnostic procedure that initial choice of specific therapy but no the next and final steroid treatment that in the clinical and radiological (CT scan) control tests showed progressive regression of the disease.
**Conclusions** The clinical observation, diagnostic steps and treatment options were shared with referring physicians (infectious disease specialist, pulmonologist, oncologist).

## Paraneoplastic persistent hyperbilirubinemia treated with clinical success by selective plasmapheresis for bilirubin

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**Background and purpose of the study** A patient with obstructive jaundice to secondary liver cancer was treated with biliary stent placement with mild clinical improvement.Then the persistent hyperbilirubinemia was treated with the selective plasmapheresis for bilirubin.
**Materials and Methods** A male patient, caucasian, fifty-four years old, is admitted in the department of internal medicine for diarrhea, nausea, jaundice and intense, intolerable skin itchy.Two years earlier he had undergone surgery before bowel resection for junction recto-sigmoid cancer followed by chemotherapy and then surgical resection of liver metastases. Laboratory tests showed: ESR 39, CRP 2.85 mg/dL, total bilirubin 33 mg/dL, direct bilirubin 23 mg /L,487, cholalemia mcmol/L, CA19.9 825U/ml. Abdominal echography documented: gallbladder distension for bilious dense material,marked dilatation of the choledochus 15 mm. Abdominal CT scan indicated the presence of secondary liver lesions.PET showed liver and lung hypermetabolic areas.ERCP described severe stenosis of choledocus by extrinsic infiltration; the abdominal control echography showed good patency of the biliary stent but total bilirubin was always elevated.
**Results** Four sessions of selective plasmapheresis for bilirubin decreased quickly the total bilirubin from 33 mg / dl to 5.5 mg /dL.
**Conclusions** Selective plasmapheresis has allowed to obtain clinical improvement in the absence of side effects and resume chemotherapy.

## Cavernous Sinus Thrombosis (CSC): a rare case of chordoma

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**Background and purpose of the study** TSC represents 1-3% of all cerebral venous thrombosis;it often complicates infectious processes of the face (sinuses).In elderly or debilitated patients more often it is caused by non septic causes (systemic and vascular disorders favouring thrombotic phenomena and /or expansive processes or compression secondary to obstructive tumors of the skull base or nasopharynx).
**Materials and methods** Good health 72 year-old men.In May 2011 onset of headache,photophobia,eyelid ptosis and diplopia.After 15 days he was referred to our clinic by his family doctor.INSTRUMENTAL EXAMINATION: Brain TC with intracranial vessels mdc-Brain MRI+Angio intracranial MRI+OPHTHALMOLOGY Consult.NO infection foci, coagulation abnormalities,emboligene sources nor autoimmunity wewrw detected.
DIAGNOSIS was: cavernous sinus venous thrombosis sx.We started therapy with steroid+quinolone+LMWH and TAO to INR in the range,with complete remission of symptoms in 20 days.In late August symptoms represented,we repeated a new cycle of steroids+quinolone resulting in a new remission.We submitted diagnostic imaging performed to a neuroradiologist for a second opinion:was identificated a hypodense area with lumpy medial spur gains the sellar region/under saddle.
**Results** In September,complete excision of the mass.Istology: Chordoma, a rare tumor of the CNS (0.2%).The patient at 8 months is asymptomatic.
**Conclusions** In the case of TSC,neoplastic hypothesis of adjacent structures should always be assumed and always excluded,using all: consultants and technology.

## Un caso misconosciuto di miastenia gravis

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La miastenia gravis può comparire in tutte le fasce di età: diagnosticarla tempestivamente è importante per la prevenzione di gravi complicanze respiratorie legate ad uso di anestetici o di alcuni farmaci.
Sig.ra L. di 28 aa, da 3 aa con diagnosi di Artrite reumatoide in terapia con idrossiclorochina e steroide assunto in modo discontinuo. Nel 2009 salpingectomia per gravidanza extrauterina con post operatorio complicato da insufficienza respiratoria. Ricovero in Rianimazione insufficienza respiratoria con acidosi grave insorta dopo bronchite acuta trattata con amoxicillina/ac.clavulanico; ad estubazione avvenuta (dopo un tentativo fallito per desaturazione grave) trasferita in Medicina. La valutazione neurologica e neurofisiologica poneva diagnosi di sindrome miastenica generalizzata: avviate piridostigmina e terapia immunosoppressiva steroidea. Alla TC total body disomogeneità compatibile con residuo timico, confermata alla RM. Ab anti recettore dell'acetilcolina positivi (8 nmol/L – v.n.< 0.25). Sottoposta ad intervento di timectomia, istologico negativo per iperplasia timica.
Al follow up autoanticorpi in riduzione e quadro neurologico in ottimo compenso.

## Efficacia analgesica del fentanile transdermico nella fase oncologica palliativa

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**Premesse e scopo dello studio** Scopo è valutare l'efficacia del fentanile transdermico su 822 degenti in Hospice con malattia oncologica terminale di cui l'85.35% deceduti.
**Materiali e Metodi** 42 pazienti, 5.11%, non hanno utilizzato oppioidi transdermici. Dei rimanenti 780, 439, 56.28%, hanno così utilizzato fentanile transdermico: 74 (16.85%) dispositivo da 25 µgr/h, 181

(41.23%) da 50 µgr/h, 109 (24.83%) da 75 µgr/h, e 75 (17.08%) da 100 µgr/h a 200 µgr/h. Il cut-off della scala V.A.S. è 2. Il dosaggio era tale da mantenere una V.A.S. inferiore a 2 nei 4 monitoraggi prefissati alle ore 8, 12, 16 e 20. Le giornate di degenza valutate sono state complessivamente 5593, con una degenza media pari a 12.74 giorni ed una mediana pari a 7 giorni.
**Risultati** Le osservazioni di V.A.S. superiori al cut-off sono 97, ed il dolore è stato trattato con fiale da 10 mg di morfina in via sottocutanea. Sono state usate 308 fiale, con una mediana di 3 per paziente, in un range da 1 a 9. In 29 casi, 0,66% del campione analizzato, si rendeva necessaria l'integrazione con morfina nelle prime 24 ore di applicazione del dispositivo, mentre le rimanenti integrazioni venivano richieste nelle 48 e, soprattutto, 72 ore successive.
**Conclusioni** Nel campione si è riscontrata un buon controllo del dolore, definito come V.A.S. inferiore a 2, in 342 (pari al 77.90%). I rimanenti 97 pazienti hanno avuto necessità di integrare con complessive 308 fiale di morfina cloridrato da 10 mg, incidendo per un incremento pari al 5.14% della spesa farmaceutica relativa al fentanile, assunta pari a 100.

## ✪ Ruolo dell'ecografia/eco-color-Doppler nella diagnosi di paraganglioma carotideo in una zona di endemia per sindrome paraganglioma tipo 1 (PGL1)

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**Premesse e obiettivi dello studio** La sindrome paraganglioma è una malattia ereditaria rara causata da una mutazione in uno dei geni che codificano per il complesso mitocondriale II (SDHA, SDHB, SDHC, SDHD, SDHAF2). In Trentino abbiamo osservato un numero insolitamente elevato di paragangliomi del collo. Abbiamo potuto dimostrare un effetto fondatore per una mutazione del gene SDHD. Abbiamo identificato 100 famiglie con sindrome paraganglioma di tipo 1 (PGL 1) per un totale di 306 carriers della mutazione e 150 soggetti affetti. Il fenotipo largamente prevalente è il tumore del glomo carotideo bilaterale.
Obiettivo del nostro lavoro è stato quello di valutare il ruolo dell' ecografia / eco color Doppler ( ECD) nella diagnosi dei paragangliomi carotidei.
**Materiali e metodi** In 50 individui residenti nell'area di endemia per sindrome PGL1, caratterizzati come portatori della mutazione SDHD, l' ECD del collo è stata eseguita come indagine di primo livello.
Risultati In tutti i 50 individui la diagnosi ecografica di paraganglioma del collo è stata confermata dal successivo studio con RMN/TC. Lo studio ECD ha evidenziato come quadro caratteristico la presenza, a livello della biforcazione carotidea, di una massa solida ben definita, ipoecogena, finemente disomogenea, riccamente vascolarizzata.
**Conclusioni** In questa popolazione ad alto rischio genetico, l'ECD è una metodica ad alta sensibilità per la diagnosi del PGL carotideo e per le sue caratteristiche di non invasività e basso costo potrebbe essere utile anche per il follow-up.

## Familial Mediterranean Fever: description of a clinical case

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The FMF is a rare genetic sudden onset disease, characterized by abdominal, thoracic and articular pain, affection of serosas and spontaneous remissions. FMF can also occur as incomplete kinds of the disease causing a difficult diagnoses. Renal amyloidosis is the worse complication of FMF; familiarity is rarely found for the autosomal recessive feature. The responsible gene (marenostrina/pirica MEFV; 16p13 3) is expressed in granulocytes, monocytes and eosinophils. Clinical features can be caused by stress, fatigue and infections. In February 2009 a 23 old man, for which 9 months before a surgical diagnosis had been given and an operation had been planed because of recurrent abdominal pain and fever, came to our observation. No familiarity for periodic fever was found. Clinical examination and laboratory results were negative. The case history and the clinical picture directed us towards diagnoses of FMF, which was treated with colchicine. The further evaluations showed a normal clinical picture. This clinical case shows that FMF must always be considered during the evaluation of differential diagnosis of fever, even when no familiarity exists, because of the possible occurrence of clinical manifestions miming peritonitis and so to avoid useless operations. The therapy with colchicine inhibits the attacks or extend the free symptoms periods in the 90% of patients, avoiding the development of amyloidosis. Alfainterferone, being an efficacious therapeutic choice, can be given to colchicine-proof patients.

## Meningite da Haemophilus Influenzae in adulto immunocompetente

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**Introduzione** La meningite da Haemophilus Influenziae (Hi), relativamente comune nell'infanzia, è estremamente rara nell'adulto immunocompetente. Presentiamo un caso di meningite da Hi in un soggetto adulto di 64 anni, senza deficit immunitari, ricoverato per iperpiressia e cefalea da 4 giorni.
**Caso clinico** All'ingresso paziente orientato, collaborante senza deficit focali; lieve rigor nucalis, segni di Kerning, Brudzinski e Binda negativi, Lasegue positivo. ECG, RX torace, ecoaddome, TC encefalo negativi. Eseguiti routine, urinocoltura, emocolture e rachicentesi. Riscontrati leucocitosi neutrofila, PCR elevata, liquor limpido con proteine lievemente aumentate e 315 cell/ul (85% neutrofili e 15% linfociti). Ricerca antigeni solubili liquorali ed esami batterioscopico e colturale del liquor negativi. Emocolture (preliminari) positive per germi aerobi, (definitive) positive per Hi. Tests immunodeficit negativi. Paziente trattato con Desametazone 4 mg ogni 6 h, Ceftriaxone 2 gr ogni 12 h e Ampicillina 2 gr ogni 6 h. Riscontrata rinorrea. Visita ORL negativa. TC massiccio facciale documentante soluzione di continuo dell'osso sfenoidale sn a ridosso del canale ottico.
β Trace Protein elevata (20,20 mg/L) indicativa di rino-liquorrea. Diagnosi di fistola rino-liquorale sottoposta a trattamento chirurgico risolutivo.
**Conclusioni** La meningite da Hi può, seppur raramente, colpire soggetti adulti immunocompetenti. In questi pazienti vanno attentamente ricercate possibili condizioni predisponenti l'infezione, quali ad esempio, come nel nostro caso, una fistola rino-liquorale.

## ✪ Multiresistant bacteria as a hospital epidemic problem: study on a Continuity Care Hospital

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**Background and purpose** Since the introduction of antibiotics into clinical use bacteria have protected themselves by developing antibiotic resistance mechanisms. Worldwide problems are increasing with the emergence of organisms defined multi drugs resistant (MDROs). These problems are especially evident within hospitals, where they frequently present as nosocomial epidemics. Currently the most important nosocomial resistance problems are caused by methicillin-resistant Staphylococcus aureus, vancomycin-resistant enterococci and Enterobacteriaceae with plasmid-encoded extended-spectrum beta-lactamases. We assessed the incidence of multiresistant bacteria in a Continuity Care Hospital from 1st January 2011 to 31 December 2011.
**Subjects and Methods** 756 patients, mean age 79+SD 11.4 were consecutively enrolled; total coltural samples were 2498. Results: positive coltures were 601 (24%). 310 of them (51%) are due to MDROs. The relative percentage was 15%, 13.5%, 13.8%, 10% and 7% for E. Coli, Pseudomonas Aeruginosa, Acinetobacter baumannii, Klebsiella spp pneumoniae, Staphilococcus aureus respectively. 87,3% had urinary catheter, 73.3% had CVC, 83.9% was hospitalized in the previous 6 months, 68,5% were malnourished and underwent to artificial nutrition. Provenience: 26%, 66,7% and 7,3% from home, hospital or nursing homes respectively.
**Conclusion** MDROs are highly prevalent in a Continuity Care Hospital representing an emerging problem for clinicians. Our data strongly suggest that preventive measures should be adopted as soon as possible during the admission to the hospital.

## You have a hole in a lumbar vertebra

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In patients with venous thromboembolism and contraindication to anticoagulation, vena cava filters can be a safety and important option. However, filters, particularly permanent ones, can be associated with severe complications. Therefore, some clinicians prefer using a new generation of retrievable filters. However, although retrievable filters are clearly effective in preventing potentially fatal pulmonary embolism, their safety can became uncertain, expecially left in place for a long time. Herein we present the case of a 25 years old woman with severe and misdiagnosed complication from a so-called retrievable filter left in place for a long time. This filter was positioned two years before for a femoral venous thrombosis without a reasonable cause. One limb of this filter caused a deep hole in her second lumbar vertebra, while two stainless steel of this filter were kept hold of duodenum and uretere. After an unsuccesfull endovascular procedure, a long vascular surgical intervention was necessary for removing this filter. The vena cava was repaired and her symptomps disapperead after two weeks.
Clinician should must carefully consider the indications to caval filters and the optimal timing for their retrieval. In fact, also the new generation retrievable filters can became dangerous and lifethreatening if not correctly used.

## Hydroxyurea as NO donor in myeloproliferative disorders

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Several studies have reported an indirect anti-thrombotic effect of hydroxyurea (HU), a cytoreductive agent in myeloproliferative disorders (MPNs). Among pharmacological mechanisms of HU the release of nitric oxide (NO) can be considerd. In this pilot study we verified in vivo effects of HU on NO release in MPNs patients and its consequence on leukocyte-platelet activation.
**Design and methods** A total of 11 consecutive MPNs subjects candidates to only HU therapy were included. A standard dose of 1000 mg was administered at day 1 (T0) uid while a maintenance dose of 500 mg was prescribed bid for 7 consecutive days. Blood analysis was performed before administration of HU (T0), and successively, 4 hrs (T1), 24 hrs (T2) and 1 week (T3) after the standard dose.A statistical analysisperformed with P value ≤ 0.05 as significant.
**Results** In these patients NO plasma level was significantly increased at T1 (P=0.008) and an inverse correlation between NO and granulocyte-platelet (GP) and monocyte-platelet (MP) aggregates was confirmed. NO plasma level resulted also inversely correlated with TF expressed on monocyte. An inverse correlation was also shown between NO levels.
**Discussion** Organic nitrates, also known as NO donors, have been used for over a century in cardiovascular therapy. Also HU, the most widely used cytoreductive agent in MPNs, can be also considered a NO donor. Our data seem to support hypothesis that the reduction of platelet and leukocyte activation, and specifically of percentage of aggregates and CD11b and TF expression, could be due to potential NO effects on platelet and leukocyte modifying specified surface molecules.

## Novel diagnostic and therapeutic strategies in polycythemia vera

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The clinical and diagnostic approach to a patient with polycythemia vera (PV) has been recently greatly simplified by the introduction of new genetic testing in addition to traditional tests, such as measurement of red cell mass and serum erythropoietin level. Clonal erythrocytosis, which is the diagnostic feature of PV, is almost always associated with a JAK2 mutation (JAK2V617F or exon 12). Therefore, in a patient with acquired erythrocytosis, it is reasonable to begin the diagnostic work-up with JAK2 mutation analysis to distinguish PV from secondary erythrocytosis.
Moreover, the clinical course of PV is marked by a high incidence of thrombotic complications which represent the main cause of morbidity and mortality in MPNs patients. Blood hyperviscosity as well as platelet and leukocyte quantitative and qualitative abnormalities play a major role in the pathogenesis of thrombophilia. So, prevention of vascular events and minimizing the risk of disease transition into acute leukaemia are the main targets of the whole PV treatment strategy. In this paper we report the main diagnostic and therapeutic options and strategies in PV patients, from low dose aspirin to pegylated interferon, imatinib and novel JAK2 inhibitors.

## Splanchnic vein thrombosis in polycythemia vera

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**Background** Myeloproliferative disorders (MPNs) are reported in 25 to 65% of patients with splanchnic vein thrombosis (SVT) which also re-

presents an early complication of polycythemic patients. However, the natural history of SVT in MPNs subjects remains controversial being from small studies. This study exploited the large database collected within the cohort study of European Collaboration on Low-dose Aspirin in Polycythemia Vera (ECLAP) to investigate the history of SVT in PV.
Patients and methods We used prospectively information among 1,638 PV patients recruited in the ECLAP study and followed for 2.7+1.3 years. All clinical data regarding all the patients affected by SVT (extra-hepatic portal vein obstruction and Budd-Chiari syndrome) were analysed.
**Results** We gathered information on 926 vascular thrombosis in 668 PV patients. Of these, 42 involved abdominal district (33 and 9 extra-hepatic and hepatic vein, respectively). All these events SVT resulted the presenting thrombosis. The database analysis confirmed young age and female gender as the most important risk factors for SVT.
**Conclusion** SVT was confirmed a common early complication of youngest polycythemic patients, frequently associated with a bad prognosis. Particularly, female gender was significantly associated with Budd-Chiari syndrome. However, an early diagnosis and effective treatment of these vascular events may be safe for young PV patients.

## ✪ Polycythemia vera and gender-related differences

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In Polycythemia Vera (PV) gender effect on the disease phenotype is unknown. This issue was investigated by using the database of the European Collaboration on Low-dose Aspirin in Polycythemia Vera (ECLAP) study. The ECLAP study recruited and followed for $^{2}.^{7} \pm {}^{1}.^{3}$ years $^{1},^{638}$ polycythemic subjects. At study entry males, compared to females, had a higher prevalence of myocardial infarction ($P<0.000^{1}$) and peripheral arterial disease ($P<0.0^{5}$) while a history of venous thrombosis was more common in females ($P=0.0^{16}$). Women, compared to men, had higher platelet count ($P < 0.000^{1}$) and lower hematocrit ($P < 0.000^{1}$). Among other laboratory parameters, cholesterol plasma level was lower in male patients ($P<0.000^{1}$). During follow-up there were $^{2}0^{5}$ major thromboses confirming an high incidence of myocardial infarction in males although not statistically significant. The ECLAP study analysis reports interesting gender related differences both in the thrombotic history but also in the prevalence of vascular risk factors among PV patients.

## From bench to clinical practice: waiting for SNOOPY study results we should start setting the stage with Woodstock

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**Aim of the study** To evaluate the diagnostic and organizational impact of the availability of procalcitonin dosage (PCT) in patients presenting sing/symptoms suggestive of sepsis or infection on admission to our Emergency Room/Emergency Medicine Dept (ER/EMD) from Jan to Dec 2011.
**Methods** In 2011 all pts admitted to ER/EMD could be tested stat for PCT (24h/d available in our lab). Inflammatory markers such as C-reactive protein (CRP) or white blood cells (WBC) and blood culture were also determined.
**Results** 129 pts: 72 females (mean age: 71.46) and 57 males (m.a.65) presented or referred on admission sing/symptoms suggestive of sepsis or infection.
For 13.17% (17/129) with PCT levels >10 ng/ml diagnosis of sepsis/shock was made. 22.48% (29/129) were classified at high risk infection (2.01-10.0 ng/ml), 9.30% (12/129) at medium risk (0.51-2.00 ng/ml) and 23.26% (30/129) at low risk according to PCT (0.06-0.50 ng/ml).
PCT (0.00-0.05 ng/ml) ruled out infection risk for 32% of all pts population (m.a.56).
**Conclusions** PCT has so far been a powerful tool in identifying septic and infectious pts among our population.The availability of the test increased the speed of the diagnostic process in our high-paced environment; reasonably confirming or excluding one of the crucial diagnostic dilemma for ER/EMD physicians. Referrals supported by PCT set the stage for a more rational use of Hospital settings (high intensity of care units vs low intensity of care). Implementing a PDTA for sepsis/infection in ER/EMD will further improve system output and ultimately provide better clinical outcomes.

## Are Harriet and Woodstock so different if they get infection/sepsis? Just wondering meanwhile we wait for SNOOPY study results

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**Aim of the study** To evaluate if any gender difference to infection prevalence can be postulated from 2011 available lab data (blood cultures/CVC cultures, PCT) to better determine whether the Hospital organizations needs to set up different setting of care for female and males.
**Methods** The PCT data from ER/EM for the same year had shown a slight prevalence of females over males classified as septic (53% vs. 47% mean age 76 yo). Among females and males of same age but classified as at high risk infection the prevalence has been 48% vs. 34%. On the opposite PCT values of medium and low risk did not show any difference in prevalence among males and females.Therefore we decided to review all the 2011 overall microbiologic data (blood cultures/CVC cultures) of pts admitted to IM (Internal Medicine)/Geriatric Medicine (GM) wards:136 positive blood/CVC cultures among males and 118 positive blood/CVC cultures among females of same age group and comorbidities. In female population we had a higher incidence of high risk microorganisms (E coli ESBL, Acinetobacter baumanii compl, S aureus MRSA, P aeruginosa MDR).
**Conclusions** The impact of gender on severe infection is in highly controversial discussion. Some author postulate female gender needs to be considered an independent predictor of increased mortality in ICU pts. From our very preliminary data we understand that differences are present also in not ICU and, the actual lacking of data for pts admitted to IM/GM wards deserves more gender oriented multivariate, high number wards research to fill knowledge and potential therapy gaps.

## Un caso di microangiopatia trombotica trombocitopenica in corso di terapia con prasugrel

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B.M.,donna,81 anni.DM2.Ipertensione.Nel 1995 IMA trattato con terapia medica. Nel 2011 TEA carotidea destra. Nello stesso anno episodio di NSTEMI per CAD trivasale con interessamento del tronco comu-

ne, trattato con PTCA e impianto di stents medicati. La paziente è stata dimessa dalla cardiologia in terapia con prasugrel.
Dopo un mese la paziente accede al DEA per edema polmonare acuto e insufficienza renale acuta per cui è stata trattata con diuretici ad alte dosi e CVVH, ottenendo un miglioramento clinico che però regrediva alla sospensione della CVVH,per cui è stata avviata alla terapia dialitica.
Nel novembre ricovero per broncopolmonite a focolai multipli con riscontro di lieve piastrinopenia.
Nel dicembre si reca nuovamente in DEA per la comparsa di petecchie agli arti superiori e inferiori da 15gg circa e confusione mentale;agli esami ematici riscontro di Plt 88.000/ml,Fibrinogeno 169 mg/dL,D-dimero 3.177 microg/ml. Durante la degenza in reparto sono state somministrate due unità di plasma fresco congelato e sostituito il prasugrel con il clopidogrel, con netto miglioramento delle condizioni cliniche della paziente. Nei giorni successivi non si sono più presentate nuove gittate purpuriche ed i controlli ematici hanno mostrato un incremento delle piastrine e riduzione dei valori di D-dimero.
In letteratura non sono riportati casi di porpora trombocitopenica indotta da prasugrel,tuttavia sono stati segnalati casi in pazienti in trattamento con clopidogrel,come descritto in un recente articolo del New England Journal of Medicine.

## Manifestazione atipica articolare in paziente con diagnosi di polimialgia reumatica

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**Caso** Donna,58 anni. In anamnesi asma bronchiale,rene a ferro di cavallo e tiroidite in terapia sostitutiva. La paziente viene ricoverata per dolore e tumefazione delle articolazioni tibiotarsiche e metacarpofalangee. Nei 12 giorni precedenti riferisce febbre (TC 38 C°).
All'ingresso dolore al cingolo superiore invalidante associato a claudicatio dei masseteri. Agli esami ematochimici anemia normocitica, aumento degli indici di flogosi (VES 60 mm/ora,PCR 92, alfa2 globuline 15,4%).Fattore reumatoide,ANA,ANCA e peptide anti-citrullinato negativo. Alla palpazione dell'arteria temporale dolorabilità, per cui viene sottoposta ad ecocolorDoppler con riscontro di reperti suggestivi di flogosi arteritica plurisegmentaria. Iniziato prednisone (50 mg/die), la paziente riferisce netto miglioramento della sintomatologia dolorosa mioarticolare e della claudicatio. In corso di terapia corticosteroidea sono state eseguite biopsia dell'arteria temporale e PET risultate negative.
**Diagnosi** Manifestazione atipica articolare in polimialgia reumatica associata ad arterite di Horton.
**Conclusioni** Le manifestazioni artritiche periferiche, maggiormente se ad entrambe le mani,presenti nel 21-40% dei pazienti con polimialgia reumatica,possono creare dei problemi di diagnosi differenziale con l'artrite reumatoide ad inizio ritardato. Il peptide anti-citrullinato ci aiuta il tal senso. In alcuni studi è stato dimostrato che tali patologie sono la stessa entità e che pazienti con una prima diagnosi di polimialgia reumatica, ad un successivo follow up, sviluppavano un' artrite reumatoide.

## Insufficienza renale acuta in paziente con successiva diagnosi di granulomatosi di Wegener

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**Caso** Donna, 77 anni. Sindrome ansioso depressiva. Glaucoma bilaterale. Da circa un mese dolori articolari diffusi trattati con FANS e paracetamolo con comparsa di mucosite ed edema del volto periorbitale, migliorati con terapia cortisonica. La paziente viene ricoverata per tremori diffusi, difficoltà della deambulazione, della coordinazione dei movimenti fini ed edemi delle caviglie. In DEA riscontro di creatinemia 6,59 mg/dl ,azotemia 2,87g/l, VES 69 mm/h. All' EGA acidosi metabolica. All' Rx torace: addensamenti polmonari multipli; All'ecografia addome: iperecogenicità della corticale renale compatibile con nefropatia acuta. All'esame urine presenza di sedimento attivo con proteinuria, emoglobinuria, cilindri, eritrociti e leucociti. In reparto prelevati autoanticorpi e immunocomplessi circolanti leganti C1q e C3q risultati aumentati. La paziente è stata trattata con cortisonici con miglioramento del quadro renale e polmonare. Dimessa in attesa della risposta degli autoanticorpi, dopo 2 settimane si ripresenta in DEA con una porpora palpabile,epistassi da ulcerazioni nasali e riscontro TC di addensamenti polmonari a vetro smerigliato. Gli autoanticorpi risultano positivi per cANCA e per anti PR3.
**Diagnosi** Granulomatosi di Wegener con iniziale interessamento renale, articolare,neurologico e successivo interessamento polmonare, delle prime vie aeree e porpora palpabile.
Conclusione Dalla letteratura in tali pazienti una presentazione iniziale renale si ha nel 18%, i sintomi muscolo scheletrici nel 25% e neurologici nel 7%.

## Un difficile caso di FUO

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**Caso** Uomo, 33 anni affetto da talassemia minor. Il paziente viene ricoverato per febbre remittente elevata (TC 39 C°) da circa 15 giorni con sudorazione, brividi e cefalea. All'esame obiettivo epato-splenomegalia Agli esami ematochimici pancitopenia , valori indicativi di CID like con D-dimero elevato , fibrinogeno ai limiti inferiori; marcato incremento delle transaminasi come per epatopatia acuta (AST 1623,ALT 1758), LDH 882, ipertrigliceridemia, ferritina 8.218, procalcitonina 0,41. Emocolture negative. Negatività di tutti i virus e batteri epatotropi eccetto la presenza di IgG per EBV 760 U/ml con PCR qualitativa e quantitativa (1741 genomi virali/ml) per EBV. ANCA, Atc anti-ds DNA, atc anticardiolipina negativi. Due componenti monoclonali (IgG KAPPA e IgM LAMBDA in quadro oligoclonale). BOM e ago aspirato midollare nella norma; alla biopsia epatica rilievo di epatite granulomatosa non necrotizzante compatibile con danno da EBV. Ecocuore negativo; alla Tc torace e addome splenomegalia e ipertrofia del lobo epatico sn. Non linfoadenomegalia. La febbre non rispondeva inizialmente a terapia antibiotica ad ampio spettro con meropenem e vancomicina.Un miglioramento clinico è stato ottenuto con terapia antivirale e con corticosteroidi.
**Conclusioni** In considerazione dei dati clinici (febbre, epato-splenomegalia, risposta clinica al cortisone)e degli esami di laboratorio abbiamo posto diagnosi di sindrome da attivazione macrofagica secondaria a infezione da EBV.

## Un caso insidioso di patologia tubercolare

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**Premessa** Una linfoadenite sistemica non deve farci sospettare solo un linfoma, ma essere clinicamente ben differenziata anche con patologie spesso dimenticate perché poco frequenti.

**Caso clinico** Z. M. A. maschio, aa 23, somalo. A. P. remota negativa; A.P. prossima: dispnea, toracoalgia, cervicalgia, tumefazione scrotale. Primo ricovero presso altro ospedale, dove viene sottoposto a Tc torace +addome, da cui ci viene trasferito col sospetto di "malattia linfomatosa". Nella ns U.O. si evidenzia tumefazione linfonodale in vari distretti superficiali e al testicolo sx. Gli esami ematochimici mostrano modesta leucosi con linfopenia relativa, PCR e fibrinogeno elevati; markers virali negativi; intradermo di Mantoux positiva; ricerca diretta e colturale di BK nelle urine ed nell'espettorato negativa. Alla Tc torace+addome: nodulia miliariforme polmonare apicale dx, linfoadenite necrotico-colliquativa mediastinica ed addominale, aree di osteolisi costali e vertebrali. L'Ecografia genitale mostra una tumefazione testicolare sx aspecifica, che esclude una neoplasia. La biopsia linfonodale mostra una linfoadenite dermatopatica. Sulla base del tine-test, della diagnostica per imaging e del consulto infettivologico si pone diagnosi di "Tbc polmonare post-primaria, linfoadenite tubercolare sistemica, Tbc ossea, orchite acuta". Iniziata terapia con levofloxacina, streptomicina e cortisone, si trasferisce in infettivologia per competenza.
**Conclusioni** Una attenta diagnostica differenziale ci hanno permesso di scoprire un caso insidioso di patologia tubercolare, altrimenti misconosciuto.

## La ventilazione non invasiva. L'esperienza di un reparto di Medicina Interna

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**Premessa** La Ventilazione Meccanica non Invasiva (NIV) offre l'opportunità di trattare pazienti critici con insufficienza respiratoria acuta/riacutizzata, spesso BPCO, anche in area medica dedicata, altrimenti destinati alle esigue UTIR presenti sul territorio. Riportiamo l'esperienza nella ns UOS in Area Critica.
**Risultati** La ns UOD in area critica è dotata di 4 posti (semintensiva) attrezzati con monitoraggio cardio-repiratorio e la possibilità di assistenza respiratoria, avendo in dotazione due ventilatori Bilevel multifunzione (CPAP, PSV) dedicati a pazienti critici con insufficienza respiratoria acuta/riacutizzata, con BPCO e/o insufficienza cardiaca. Nel periodo compreso tra febbraio 2011 - gennaio 2012 (12 mesi) sono stati ricoverati e trattati nella ns UO 20 pazienti, 11 F e 9 M, età compresa tra 32 – 92 aa.: 17 erano affetti da Insufficienza Respiratoria Acuta su Insufficienza Respiratoria Cronica in BPCO e sono stati trattati con Bilevel in modalità PSV, 3 presentavano Insufficienza Respiratoria Acuta in Edema Polmonare Acuto e trattati in modalità C-PAP. In totale, 18 pazienti (90%) hanno avuto remissione clinica e dei parametri emogasanalitici (acidosi respiratoria, ipossiemia, ipercapnia); di questi, 9 (45%) sono stati dimessi con NIV domiciliare; in 2 casi vi è stato exitus.
**Conclusioni** I risultati ottenuti ci fanno riflettere sull'utilità che ogni medicina interna possa munirsi di un ventilatore per NIV da impiegare in area dedicata al fine di trattare i pazienti critici, come sopra esposto, per migliorarne l'outcome e ridurre la richiesta di posti in UTIR.

## A rare case of chronic lymphocytic leukemia complicated with the occurence of systemic lupus erithematosus

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Authors describe a rare case of Systemic Lupus Erythematosus (SLE) developed in a patient with Chronic Lymphocytic Leukemia (CLL) after 3 year course. The patient was a 48-year-old white male who had a particular clinical outcome. He was diagnosed as stage IVB Chronic Lymphocytic Leukemia with bone marrow involvement and serious cutaneous infiltrations in December 94'. From January '95 to July '97 he was treated with different chemiotherapies with a good partial response and reduction of lymphocytosis, anaemia and thrombocytopenia. In June '98 the occurrence of arthralgia localized at his hands, wrists, knees and ankles led to the diagnosis of SLE antiDNA +ve and he was treated with prednisone. One year later the patient experienced a deterioration of his clinical conditions with asthenia, abdominal pain and weight loss, considered a Richter Syndrome, unresponsive to any treatment.
He died few months later. The association between SLE and CLL is a rare condition that has been poorly reported in literature, even though the coexistence of lymphoproliferative disorders and autoimmunity is well established. It remains still unknown if the chemiotherapy may have had a role in autoimmune disease pathogenesis.
Authors consider this case worth to be reported for the singularity of the clinical course.

## ✪ The clinical characteristics, treatment strategies and outcome of Italian patients enrolled in the RIETE Registry

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**Background** The clinical characteristics, treatment strategies and outcome of patients enrolled in RIETE for VTE in Italy are reported. Usually clinical characteristics of patients with VTE may vary from country to country.
**Patients and methods** The RIETE registry is a multicentre, international, prospective registry of consecutive patients with active and symptomatic VTE confirmed by objective methods.
The aim is to assess the influence of surgery, immobility for non-surgical reason on 3 months outcome of patients with VTE enrolled in Italy.
**Results** Through July 2008, 21397 patients with acute VTE were registered in RIETE. Of these 896 (4.2%) were enrolled from Italy. 360 of them showed a PE.
Overall 137 developed VTE after surgery, 156 after immobility 4 days and 603 in absence of surgery or immobility. 83% received LMWH as staring drug while 15% UH. For long term therapy, 63% received VKA. The incidence of fatal PE during the first 3 months of therapy was 1.5% for patients with post-operative VTE, 7.7% for who developed VTE after immobility, and 1.2% for the remaining patients. The incidence of fatal bleeding was 1.5%, 1.9% and 0.3%, respectively. Of the 137 patients with post-operative VTE, 61% had received pharmacological thromboprophylaxis. Of the 156 patients with immobility for non-surgical reasons, 24% received pharmacological prophylaxis.
**Conclusions** VTE arising after a period of immobility was associated with highest rate of fatal PE and fatal bleeding during the first 3 months of treatment. The use of thromboprophylaxis in this clinical setting should be improved.

## Valore predittivo della cistatina C nei pazienti ospedalizzati per insufficienza cardiaca cronica instabilizzata

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**Premesse e scopo dello studio** L'ospedalizzazione per insufficienza cardiaca cronica (ICC) instabilizzata è di per sé un fattore prognostico negativo. Anche la malattia renale cronica correla con la mortalità di questi pazienti. La cistatina C ha migliore sensibilità nella stima del filtrato glomerulare (FG) rispetto alla creatininemia nei pazienti con funzione renale compromessa e ha valore predittivo sfavorevole nei pazienti con ICC. Scopo dello studio: verificare il valore predittivo della cistatina C per mortalità e per riospedalizzazione ad un anno dal ricovero nei pazienti con ICC instabilizzata.
**Materiale e metodi** Determinazione della cistatina C entro 48 ore dal ricovero (T0) e ad un mese dalla dimissione ( T1) nei pazienti ricoverati per ICC instabilizzata: registrazione di durata della degenza, mortalità per tutte le cause e riospedalizzazione nell'anno successivo al ricovero. Analisi statistica: modello di rischio proporzionale di Cox.
**Risultati** 432 pazienti arruolati consecutivamente (51% M, età media 75.58 ± 10.29 anni).La cistatina T0 correla significativamente con durata della degenza (p<0.001) e con mortalità ( p=0.001). La cistatina T1 correla significativamente con mortalità (p=0.03) e con numero di riospedalizzazioni (p<0.001). Cistatina T0 e T1conservano identico valore predittivo nei pazienti con FG ridotto (<90 mL/min.) e in quelli con FG conservato quando considerati separatamente.
**Conclusioni** La determinazione della cistatina C può essere un utile marcatore prognostico a breve e a lungo termine nei pazienti con ICC instabilizzata.

## HASBLED score in elderly (E) with disability and permanent atrial fibrillation (PAF) in oral anticoagulant therapy (OAC)

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**Background** E with PAF and CHA2DS2VASc≥1 have Thromboembolic Risk (TR) reduced by OAC. TR is related to Hemorrhagic Risk (HR) assessed by HASBLED Score. We tested useful of HASBLED in E with PAF in OAC discharged by a Medicine Unit.
**Methods** 112 E (69female,43male;79±4aa) with PAF in OAC followed by OAC Surveillance Ambulatory between Jan 2006/Dec 2008 (not tested by HASBLED score) were compared with 105 E with PAF in OAC (51female,54male 81±5aa) and HASBLED≤3 (excluded patients with score>3) followed between Jan 2010/Dec 2011. Almost all E in 2 groups had disability (88vs86%, mean Barthel 70±11vs74±8) and caregiver. 2 groups had the same comorbidity (hypertension 74vs76%; diabetes 32vs33.5%; previous cerebrovascular events 34vs36%, abnormal renal/liver function 13vs11%), alcohol consumption, TR (CHA2DS2-VASc ≥1). We calculated the bleeding events in first group and in subgroups of second.
**Results** In first group there were 3 cardiovascular deaths(3,36%),1 fatal stroke(1%),6 non-fatal stroke(6,7%),8TIA(9%),17 hospital admissions(HA) for cardiovascular events(CE19%), 21 minor bleeding(23%),4 major bleeding (4,4%). In second group: 2 cardiovascular deaths (2%),no fatal stroke,3 non-fatal stroke(3%),12 TIA (12,6%),14 HA for CE(14,7%),14 minor bleeding (14,7%),no major bleeding. In this group, 40(A),53(B),12(C) E had HASBLED score, respectively, 1-2-3. All bleedings occurred in B and C.
**Conclusions** HASBLED is considered useful for assessing HR in E with PAF in OAC. Our study confirm HR reduction when HASBLED is tested (14vs25). If HR is low, presence of caregiver helps to reduce this risk.

## ✪ Hypercapnic COPD exacerbations: mixed acid-base, hydroelectrolyte and lactate disorders as aggravating the respiratory failure

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Hypercapnic COPD exacerbation in patients with comorbidities is complicated by mixed acid-base, hydro-electrolyte and lactate disorders. Aim of this study was to determine the relationships of these disorders with the requirement for and duration of noninvasive ventilation (NIV) when treating hypercapnic respiratory failure.
**Methods** 67 consecutive patients who were hospitalized for hypercapnic COPD exacerbation had their clinical condition, respiratory function, blood chemistry, arterial blood gases, blood lactate and volemic state assessed. Heart and respiratory rates, pH, PaO2 and PaCO2 and blood lactate were checked at the 1st, 2nd, 6th and 24th hours after starting NIV.
**Results** NIV was performed in 11/17 (64.7%) mixed respiratory acidosis–metabolic alkalosis, 10/36 (27.8%) respiratory acidosis and 3/5 (60%) mixed respiratory-metabolic acidosis patients (p=0.026), with durations of 45.1±9.8, 36.2±8.9 and 53.3±4.1 hours, respectively (p=0.016). The duration of ventilation was associated with higher blood lactate (p<0.001), lower pH (p=0.016), lower serum sodium (p=0.014) and lower chloride (p=0.038). Hyponatremia without hypervolemic hypochloremia occurred in 11 respiratory acidosis patients. Hypovolemic hyponatremia with hypochloremia and hypokalemia occurred in 10 mixed respiratory acidosis–metabolic alkalosis patients, and euvolemic hypochloremia occurred in the other 7 patients with this mixed acid-base disorder.
**Conclusions** Mixed acid-base and lactate disorders during hypercapnic COPD exacerbations predict the need for and longer duration of NIV.

## ✪ Rare presentation of extrapulmonary tubercolosis: gastric tubercolosis

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Gastric tuberculosis, usually secondary to pulmonary tuberculosis is rarely found, even in endemic areas. This rarity is due to the antibacterial properties of hydrochloric acid, to gastric motility and to the scarcity of lymphatic follicles in the gastric wall, unfavorable environment for the development of tuberculous lesions.
S.Z. 84, Albanian, was admitted to the Medical Ward (Castel San Giovanni Hospital) from E R with diagnosis of anemia, recurrent syncope and dyspnea with pulmonary opacities.
RPA: Surgery for unspecified abdominal disease 16 y ago. A hypotensive treatment is followed. Has suffered from fatigue, fever and dyspnea for 15 days. ABG:hypoxemia, hypocapnia.
Chest X-ray: emphasis on texture, pseudonodular peri-hilar thickening. Treated with empirical antibiotic therapy, LMWH for DVT.
Chest CT: round thickenings in both lungs, enlarged mediastinal lymph nodes. Filling defect of the pulmonary artery. abdomen CT: negative.
EGDS: extensive ulcer process in the gastric fundus. Biopsies:scattered interstitial not confluent and non-necrotizing granulomas with epithelioid and multinucleated giant cells. The Ziehl Neelsen: acid-alcohol resistant bacilli in the granulomas site.
Moved to Infectious desease Ward, treated and discharged with tuberculosis treatment.
The case underlines the need for an open mind attitude as lately the coming back of tuberculosis is to be faced.
The complete treatment is carried out with oral anti-tuberculosis drugs for an appropriate period. Surgery is reserved for complex and refractory lesions.

## A continuum of mistakes. What was wrong?

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A 77-year-old man was admitted to the hospital for upper gastrointestinal bleeding due to duodenal ulcer, elevated PT-INR, severe anemia and mild thrombocytopenia. His past medical history was relevant for multiple admissions in various hospitals due to: atrial fibrillation and a remote ischemic stroke, treated with warfarin; cronic obstructive pulmonary disease with secondary pulmonary hypertension and severe right heart failure; a recent macroematuria not otherwise investigated, with need of multiple blood transfusions; a recent diagnosis of multiple myeloma, treated about 15 days earlier with a first cycle of melphalan/prednisone. An analysis of his therapy revealed that the patient had mixed the treatments prescribed by different specialists; oral anticoagulant therapy had been substituted with aspirin by a cardiologist, but had been resumed at high doses to reach rapidly the target of INR by another specialist without removal of aspirin; two identical beta-blockers were ongoing due to different commercial names. The patient lived with his elderly wife and both had a low cultural level.
The case is very interesting because it shows that a complex comorbid elderly patient should receive a strict follow-up about the compliance to potentially life-threatening drugs. The role of Internal Medicine in this context is crucial, since it views a patient in his whole without focusing on a specif aspect of his medical problems.

## A case of cardiac liposarcoma

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A 41-year-old man with a partly cistic cardiac mass was referred to our institutions. He reported a remote excision of a "lipoma" of the left popliteal region, about 17 years earlier. The patient had been well until 3-4 months earlier, when dyspnea on exertion developed.
The two-dimensional (2D) echocardiography, computed tomography (CT) and magnetic resonance imaging (MRI) displayed a patchy lobulated epicardial mass (transversal diameter 7 cm, thickness 4 cm) near the left cardio-frenic angle, partially occupying the left ventricle chamber.
An analysis of his past medical history revealed that the tumor resected in the popliteal region was actually a myxoid liposarcoma. After a positron emission tomography (PET) of the whole body revealing only a mild myocardial uptake, and a single-photon emission computed tomography (SPECT) study of the myocardium , showing the technical feasibility of a surgical resection, which is still the mainstay of treatment in these cases, the patient underwent surgery. The histopathological analysis of the completely resected tumour, which macroscopically resembled a jellyfish, revealed a low grade myxoid liposarcoma. The postoperative course was uneventful, with discharge after 12 days.
The patient presented eight months later with a progression of disease (heart, mediastinum, pleura), so chemotherapy was began and is still ongoing one year after surgical treatment.

## Un caso di pseudotumor infiammatorio polmonare

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**Caso clinico** Uomo di 47aa, non fumatore, con anamnesi muta, giunge alla nostra osservazione per tosse, febbricola, astenia, dispnea e riscontro Rx torace di addensamento parailare dx; la TAC torace conferma un processo espansivo parailare dx che infiltra le strutture bronco-vascolari, negativi i linfonodi, la TAC cerebrale e addominale. La PET è positiva in sede di lesione, negativo il mediastino. Vengono eseguite due broncoscopie che hanno mostrato a dx stenosi infiltrativo-compressiva del tratto distale dell'intermedio, in particolare a carico dell'ostio del medio che risulta ostruito. L'istologico è negativo per cellule neoplastiche e descrive infiltrato flogistico polimorfo di linfociti a fenotipo misto B e T, neutrofili ed eosinofili. Il paziente viene infine sottoposto a toracotomia esplorativa con riscontro di massa di 4cm bianco-gialla di consistenza duro-lignea e l'istologico descrive un processo fibroinfiammatorio costituito da linfociti e plasmacellule mature con granulociti per lo più eosinofili e blandi elementi miofibroblastici, che infiltra il connettivo bronco-vascolare del polmone, la pleura e i tessuti molli del mediastino. E' stata quindi iniziata terapia con prednisone 1mg/Kg con beneficio clinico e radiologico (TAC a 1 mese processo ridotto del 80%, PET a tre mesi negativa), completato dopo cinque mesi.
**Conclusioni** Un caso di pseudotumor infiammatorio, processo espansivo caratterizzato da infiltrato linfoplasmacellulare che, pur nella negatività della ricerca di IgG4 tissutale, presenta interessanti analogie con la sindrome IgG4 correlata.

## Incident Reporting: a new tool to reduce risk of errors and to improve the quality of services in Internal Medicine.

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**Introduction** Clinical Risk is defined as a possibility that a patient suffers damage or distress unintentionally, due to health care.
The incident reporting (IR) is a useful tool to reduce the risk of potential errors and to improve the quality of services for citizens: the "adverse events" are unexpected, unintended and preventable; sometimes there are "almost events", that do not occur because promptly corrected, or that do not generate damage in the patient. This phenomenon is called the "Swiss-cheese" of J. Reason.
Rivoli'Hospital introduced this tool, which consists in the voluntary and anonymous reporting by operators. The project has the following objectives:
- sensibilize all parties on preventable adverse event;
- build a culture of awareness and responsibility among the operators;
- Improve the quality of services for citizens.
- Helping decision makers in order reduce "adverse events".

**Methods** In internal medicine Department of Rivoli'Hospital, we used a new IR system, with the introduction of three tabs:
1. reporting of accidental falls
2. reporting of errors in treatment
3. other potential adverse events.

**Results** A preliminary analysis showed that this tool help operators to:
- Analyze the event and the causes;
- Assessing the aggravating factors;
- Estimating the risk of event;
- Plan strategies for not repeating the error.

In addition there is a growing sensibility of operators about these issues.
**Conclusions** IR is a useful tool for operators to improve best practice in Internal Medicine care processes and patient care.

## Polmonite da bortezomib

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**Introduzione** Il danno polmonare da vecchi chemioterapici antineoplastici è noto in letteratura. Tuttavia stanno emergendo pneumopatie correlate a nuovi farmaci quali gli inibitori proteasomici. Presentiamo un caso di polmonite da Bortezomib.
**Caso clinico** Uomo di anni 60, affetto da mieloma multiplo, ricoverato per dispnea, tosse ed iperpiressia. Leucocitosi neutrofila, incremento della PCR. EGA (ipossiemia), RX Torace (addensamenti polmonari bilaterali). Antibioticoterapia a dosaggio congruo in primis con Levofloxacina ed in seguito con Piperacillina/Tazobactam, senza miglioramento clinico-laboratoristico. Riscontro HRCT di aree consolidative parenchimali bilaterali con broncogramma aereo e coinvolgimento interstiziale. Sierologia per Clamidia, Legionella e Mycoplasma negativa.
Esami batterioscopico e colturale su escreato negativi. Broncoscopia + BAL. Esami batterioscopico e colturale su BAL negativi.
Esame istologico compatibile con BOOP. In anamnesi recente trattamento di seconda linea con Velcade (Bortezomib). Nel sospetto di polmonite da Bortezomib (descritti in letteratura casi di pneumopatie di gravità variabile fino all'acute lung injury secondo per gravità solo all'ARDS) è stata impostata terapia steroidea (metilprednisolone 80 mg/die per 14 giorni) con risoluzione del quadro clinico-laboratoristico e miglioramento radiologico (HRCT).
Ulteriore controllo a 1 mese.
**Conclusioni** Nel paziente oncologico occorre prestare particolare attenzione all'anamnesi farmacologica per individuare precocemente e trattare appropriatamente eventuali pneumopatie iatrogene.

## ✪ Prevalence and management of hyponatremia in an Internal Medicine Unit

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**Introduction** Hyponatremia (HNa+), defined as serum Na+ <135 mmol/L, is common in hospitalized patients (pt). Pt with HNa+ have an increased risk of death in hospital and after discharge. Even mild, HNa+ has been shown to be associated with higher frequency of falls and risk of fracture. To our knowledge, no definitive data are available about the prevalence of HNa+ in hospital in Italy.
**Methods** All pt admitted to our Unit between January and December 2011 have been included in the study. We evaluated plasma Na+ at admission, during the stay and at discharge.
**Results** 2034 pt (1045 ♀, 989 ♂, median age 76 yrs) have been admitted at our Centre from January 1st to December 31st 2011. 284 (148 ♀, 136 ♂, median age 79 yrs) had HNa+ (prevalence 13,9%): 79,2% mild (130-134 mmol/L), 13,7% moderate (125-129 mmol/L), 7% severe (<125 mmol/L). 89 pt (31,3%) developed hospital-acquired HNa+ (HAH). 37 pt with HNa+ at admission had gait and attention disorders (13), falls with trauma/fractures (15), falls (9). 24 pt died in hospital (8,5%), one with severe HNa+.
Metastatic cancer, heart failure, cirrhosis, and sepsis were the most frequent diseases associated with HNa+. 62 pt (21,8%) have been discharged with mild HNa+.
**Conclusion** In our study prevalence was similar to that obtained by other authors. HNa+ was a marker of poor prognosis. Pt with mild/moderate HNa+ had a high risk of developing severe HNa+ and falls. A lot of pt developed HNa+ during the stay or were discharged with HNa+. Physicians shouldn't overlook this condition and constant vigilance is essential to prevent morbidity.

## Angioedema: un'imprevedibile diagnosi

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**Caso clinico** Uomo di 52 ricoverato per gastroenterite acuta. APP: recente episodio di vasculite necrotizzante cutanea agli arti inferiori regredita con prednisone. APR: ipertensione arteriosa, BPCO, rinite stagionale. Durante il ricovero rapida regressione dei sintomi gastroenterici ma comparsa di angioedema del volto, raucedine e asma bronchiale regrediti con steroidi/broncodilatatori e antiistaminici. La valutazione allergologica mostrava positività del prick test e delle Ig E specifiche per Anisakis simplex. Emergeva dall'anamnesi una frequente abitudine ad assumere pesce crudo (ristoranti giapponesi) con ricorrenti episodi di angioedema dopo l'assunzione di tale cibo.
**Diagnosi** Angioedema/vasculite da allergia ad Anisakis simplex
Decorso clinico Il paziente, seguendo le norme alimentari consigliate (evitare pesce crudo, crostacei e per tre mesi pesce cotto compresi i frutti di mare), non più ha lamentato episodi di angioedema/vasculite ed ha ridotto il numero di riacutizzazioni bronchiali.
**Commento** L'Anisakis simplex è un nematode i cui ospiti definitivi sono aringhe, merluzzi, sgombri, sardine, salmonidi e molluschi. L'anisakidosi nell'uomo si verifica per ingestione di tali cibi crudi o poco cotti. Gli antigeni di Anisakis simplex sono molto resistenti al congelamento/cottura e possono determinare reazioni di ipersensibilità Ig E mediate poche ore dopo l'ingestione del cibo contaminato.
Le forme allergiche di anisakidosi si manifestano soprattutto nei paesi dove il parassita non è ubiquitario e nei turisti che visitano il Giappone. Il trattamento si basa su steroidi ed antiistaminici e nell'evitare l'esposizione.

## Una insolita forma di ascite neoplastica

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Donna di 49 anni, ricoverata in High Care medica per dispnea, edemi declivi ed ascite. Grave obesità. All'ECG tachicardia sinusale, parametri ecocardiografici nei limiti. Ecograficamente copiosa ascite con mammellonature peritoneali come per carcinosi, linfoadenopatie lombo-aortiche e mesenteriche multiple. Alla paracentesi liquido lattescente denso, puruloide. Assenti i segni obiettivi ed umorali della peritonite acuta. Marcatori neoplastici alterati: Ca 125 e la B2 microglobulina. Emocromo: lieve anemia normocitica, formula leucocitaria normale. TC addome: conferma il quadro ecografico e pone qualche dubbio morfo-patologico sull'ovaio dx, ma l'ecografia transvaginale esclude patologia utero-annessiale significativa.
Sul liquido ascitico tappeto di linfociti senza alterazioni cellulari visibili al microscopio, non altre cellule con caretteri di malignità. L'EGDS evidenzia una zona ulcerata del corpo gastrico dove la peristalsi si arresta su cui vengono effettuate biopsie, sospetta per cancro gastrico. In attesa dell'esame istologico, viene effettuata la citofluorometria dei linfociti ematici con esito negativo. Di concerto con il Medico di Laboratorio, si ripete l'esame citofluorometrico sul liquido ascitico con esito fortemente positivo per linfoma.
Dopo alcuni giorni l'indagine istologica conferma l'origine linfomatosa della lesione gastrica con caratteristiche intermedie fra linfoma a grandi cellule B aggressivo/linfoma di Burkitt.
La paziente è attualmente in chemioterapia e presenta una regressione della sintomatologia generale, dell'ascite e della lesione gastrica dimostrata endoscopicamente.

## La strana epatite dell'affezionata all'erboristeria

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Segnaliamo il caso di una donna di 46 anni giunta alla ns. osservazione per un quadro di grave epatite acuta, nella quale si poneva un problema di diagnosi differenziale tra epatite autoimmune ed epatite tossica. A seguito della comparsa da qualche gg.di ittero franco, nausea, anoressia e dolore in ipocondrio dx, si era rivolta al PS del ns. ospedale. Gli esami ematochimici all'ingresso evidenziavano: AST 1950- ALT 2537- GGT 180 – ALP 55 – bilirubina 9 → salita a 20 mg/dl nei gg. successivi. PLT 99.000, INR 1,5, lieve ipoalbuminemia (3 g/dl). Tutti i marcatori virali dell'epatite risultavano negativi. Positività degli Ac ASMA e LKM . Negativa la sierologia per Leptospira, nella norma le Immuno-Globuline, la ceruloplasmina . La sig.ra negava assunzione di alcolici e di farmaci, a parte la levotiroxina di uso abituale da anni, ma ammetteva di aver recentemente assunto delle tisane a base di erbe a scopo "depurativo". L'ecografia addominale evidenziava solo un fegato piuttosto ingrandito e milza ai limiti alti di norma. Colangio RMN escludeva stenosi delle vie biliari. Si eseguiva pertanto una biopsia epatica, che mostrava un quadro di" epatite acuta con necrosi confluente intralobulare. Estesi fenomeni di colestasi." Il quadro non risultava diagnostico per una specifica etiologia ma il patologo poneva diagnosi differenziale tra epatite autoimmune ed epatite da farmaci. Trattata con prednisone a 1 mg/kg/die, si osservava nei gg. successivi un graduale miglioramento degli indici di citolisi e colestasi nonché della sintomatologia dell'ingresso.

## ✪ The utility of F-FDG PET/CT in diagnosis and follow up of large vessel vasculitis

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**Background** The diagnosis of large vessel vasculitis is often very difficult and expensive for a multiplicity of clinical manifestations and lack of diagnostic tests.18F-FDG PET/CT appears to a useful diagnostic tool.

Patients and methods35 patients (23 females,12 males;median age 62 y, range 23-80) were examined with 18F-FDG PET/CT; 26 with suspected large vessel vasculitis, 5 with large vessel vasculitis during steroid therapy, and 4 with fever of unknown origin (FUO). Follow-up scans were performed in nine patients. The severity of large-vessel 18F-FDG uptake was visually graded using a four-point scale. FDG PET scan was compared with diagnosis.
**Results** 18F-FDG PET/CT was considered pathologic in13/35 (37,14%) patients,and negative in 25/35 (71,4%) pts.In 26 pts with suspected large vessel vasculitis:7 (27%) were positive, and 19 (73%) negative;in 5 pts with large vessel vasculitis during steroid therapy:3 (60%) were positive, and 2 (40%) negative;in 4 pts with fever of unknown origin (FUO):3 (75%) were positive and 1 (25%) negative. 18F-FDG PET/CT had an overall sensitivity of 80% [95% confidence interval (CI) 55-92%], a specificity of 95% (95% CI 76-99%), a positive predictive value of 92% (95% CI 66-99%) and a negative predictive value of 86% (95% CI 66-95%). The diagnostic accuracy of 18F-FDG PET/CT was of 77% (95% CI 63-91%).
**Conclusions** 18F-FDG PET/CT should be considered a gold standard method in diagnosis and in monitoring therapy in large vessel vasculitis.In FUO F-FDG PET/CT appears very usefull to arrive to diagnosis when the convectional test have been negative.

## Use of procalcitonin in detection inflammatory flares or latent infection in biological DMARDs therapy

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**Background** Biological DMARDs used in the treatment of RA,such tocilizumab (TCZ) are very effective in inducing remission (RAr),but potentially burdened by side effects of immunosuppressive action.
**Case report** We report a case of a 60 y M treated with TCZ in RAr. Diagnosis of RA since 2004. Diabetes mellitus. None benefit of therapy with various DMARD (Mtx,cloroquine,leflunomide,cortison).For 2005 treatment with etanercept.In 2008 for detection at QTB of latent TB, hi performed therapy with isoniazide and a treatment with abatacept was performed for 3 mth unsuccessfully,then rituximab treatment for 18 months without response. From May 2010 a treatment with TCZ started with RAr, and suspension of the steroid framework. In august 2011 cystitis, and reactive arthritis ankle and knee which underwent steroid infiltration.The pt developed a septic shock. At the admission hypotension, pancytopenia and fasciitis in the right knee with bursitis, and right foot were present. The values of VES and PCR were moderately high. S-procalcitonin were 19.Were performed emocolture positive for E Coli in urinary departure. The pt was treated with meropenem and levofoxacin with CR of clinical symptoms.The monitoring of the infection, was also performed using serial assays of S-procalcitonin not appeared reliable inflammation index.After recovery the pt was subjected to therapy with abatacept reaching after 4 infusions das 28 3.8
**Conclusions** During treatment with biological DMARDs the dosage of S-procalcitonin may be useful in discriminating inflammatory flares or latent infections.

## Metabolic and vascular alterations in "healthy" overweight subjects

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**Background** Primary prevention represents the best treatment for cardiovascular(CV) diseases.Especially among younger patients non-pharmacologic approaches are frequently underused.We started a project of in-hospital physical activity program for primary prevention among high-risk patients.
Aims To evaluate metabolic and vascular derangement among considered-healthy overweight subjects before a 3 months-course of in-hospital physical activity.
**Methods** 70 consecutive obese patients with no history of acute vascular events(IMA,stroke/TIA or peripheral artery disease)or other diagnosed comorbidities were enrolled.Each patient underwent to complete metabolic/cardiovascular evaluation before physical activity.
**Results** Baseline characteristics were a mean age of 56.8±8.91 years(M:F 2:1,7),BMI of 34.2±5.69g/m2.CV familiarity was present in 45%,hypertension in 64.3%,smoke in 16.7%.We observed high preva-

lence of insulin resistance(HOMA Index 7.21±6.44) and hypertriglyceridemia;preclinical markers showed endothelial dysfunction (FMD 7.43±10.4%) and high prevalence of increased IMT(30% of the sample);echocardiography showed an increased left ventricle mass(MVSI 108.2±34.0g/m2);double product at stress test resulted within lower limits (25.857±6.023).Framingham risk was 14.8%,with a 13.8% comparative increase.
**Conclusions** In this sample of italian obese patients we observed a high prevalence of endothelial dysfunction,insulin-resistance,hypertension with end-organ damage with an increased risk for CAD.Paradoxically,we should apply an aggressive therapy for these "healthy",high-risk,subjects.

## Brain natriuretic peptide levels and days of hospitalization in elderly patients admitted for acute heart failure

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**Background** Acute heart failure(AHF)is a frequent condition associated to high mortality and morbility among elderly patients admitted to Internal ad Emergency Medicine departments. Length of hospitalization is associated to higher mortality among medical patients. Increased brain natriuretic peptide(BNP) levels have been associated,in AHF patients,to increased mortality and morbidity. Our aim is to evaluate if BNP levels can be associated to longer hospitalizations in this subset.
**Methods** We enrolled 400 consecutive patients admitted to our Internal Medicine Department with a clinical diagnosis of AHF. BNP was evaluated in all the patients,who were stratified in four categories: patients with BNP less than 100pg/ml (group 1),101-500pg/ml (group 2),501-1500pg/ml (group 3) and BNP higher than 1501pg/ml (group 4). Each patient underwent to a complete diagnostic workup. Patients with BNP levels less than 100 pg/ml or a final diagnosis other than AHF were excluded. Kaplan-Meier model with log-rank test was used to assess the differences.
**Results** 293 patients were suitable for final analysis.Mean age was 80±9.85 years,males represented 58% of the sample. Among patients who were successfully dismissed,group 4 had a significantly longer hospitalization (16.6 days,95%CI:13.7-19.5)than patients in group 3(13.1 days,95%CI:11.7-14.6) and group 2(12.3 days,95%CI: 10.6-13.9)($p<0.05$,all ties).
**Conclusion** BNP is useful for diagnosis and prognostic stratification in patients with AHF.If confirmed in larger cohorts,it could also predict longer hospitalizations in this specific subset of patients.

## A case of an aggressive epithelioid hemangioendothelioma

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**Introduction** Epithelioid hemangioendothelioma is a rare tumor of the vascular origin. Some reports of occurrences of the tumor have been made for number of locations, but most often tumor can be found in soft tissues, liver, lungs, bone and skin.
**Case report** A 56-year old male was admitted to hospital with abdominal pain and sciatalgia. There were no fever, no vomit, no diarrhea; only a claudicatio intermittens was observed on the right leg.
**Results** The ultrasounds-Doppler examination revealed an arterial demodulation of blood fluxum till the peripheric vessels in both legs. The patient was submitted to an angio-Tc examination that revealed a critical obstruction of both iliac arteries due to the proliferation of an undetermined tissue; so he was surgically treated by stenting. After treatment, a strong lumbar pain was presented, associated with epigastralgia; a skeletal TC and EGDS were made and revealed some lytic bone areas in lumbal vertebrae L1-L5, ischiatic zone and proximal right femur; some ulcers were found into the gastric fundus. Many bioptic samples were checked. The histo-and cytological exams were diagnostic for " Epithelioid hemangioendotelioma" with gastric metastasis. After 6 months occurred a digestive hemmoragy that led the patient to death.
**Conclusions** Hemangiendothelioma epitheliod is considered to be a low or borderline malignant tumor with, usually, slow progression, but aggressive forms have been described. It is very uncommon to discover gastric metastasis: they have to be considered a malignancy prognostic factor.

## Could Mycoplasma pneumoniae induce JIA?

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**Introduction** Juvenile idiopathic arthritis is a disease due to an increased inflammation response and appeared mostly with peripheral arthritis; it is improved by two main reasons: the immunological predisposition and the environmental factors that include infections. The relation between JIA and infections is not clearly defined. The main infective agents detected are: Mycoplasma pneumoniae, Chlamydophila pneumonia, Campylobacter jejuni, Salmonella enteritidis, Borrelia burgdorferi.
**Case report** A 19-year old female was admitted to hospital with strong pain in her right wrist and functional impairment, fever and cough. The blood check revealed leucopenia with relative neutrophilia, elevated PCR. The ultrasound examination revealed intra-articular inflammation and lungs X-rays revealed an acute interstitial pneumonia. The research of Mycoplasma spp antibodies was made.
**Results** Antibodies vs Mycoplasma pneumoniae were found in a high title and therapy with macrolides was started. Fever disappeared in 5 days and X-rays control after therapy was negative. Wrist arthritis got better but not disappeared. After 6 months the patient had to start an immunomodulating therapy.
**Conclusion** Etiopathogenesis of JIA is not clearly understood and suggested that various factors can trigger the disease. The pre-diagnosis of microorganisms, which can play a role as primarily or by intervening in the etiopathogenesis of JIA and adding specific antimicrobial therapy to the standard JIA therapy, could perform new, extended, especially molecular based serial case studies.

## Assistenza personalizzata al paziente anziano in un reparto di Medicina Interna

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**Premesse e scopo dello studio** L'ospedale per acuti oganizzato per intensità di cura richiede sia la contrazione dei posti letto che delle giornate di degenza nonostante il progressivo aumento dell'età dei pazienti,le loro comorbilità, la fragilità, i ricoveri ricorrenti.Il progetto scaturisce dalla collaborazione tra UOC Medicina e Riabilitazione, prevede l'assistenza personalizzata al paziente anziano nel reparto di Medicina attraverso la valutazione multidimensionale ed il trattamento riabilitativo intensivo.
**Materiale e metodi** Adeguamento strutturale della degenza riservata alla sezione di geriatria; internisti dedicati all'assistenza all'anziano, un riabilitatore geriatrico e fisioterapisti di cui uno assegnato al reparto di medicina; valutazione M.D. dei pazienti (test di Barthel e Rankin in-

gresso ed uscita, valutazione della disfagia e stato nutrizionale, valutazione stato cognitivo) ed attivazione del trattamento riabilitativo in reparto con l'ausilio di una piccola palestra annessa; educazione del care giver per la mobilizzazione a domicilio
**Risultati** La rapida mobilizzazione ha contribuito a ridurre l'insorgenza delle complicanze dovute all'immobilità, migliorando sensibilmente la soddisfazione dell'utenza e facilitando il processo di dimissione; migliorata la definizione della complessità assistenziale del paziente e l' identificazione del paziente eleggibile per le cure intermedie; migliorata l' appropriatezza prescrittiva degli ausili a domicilio.
**Conclusioni** Miglioramento della continuità assistenziale nel percorso ospedale territorio.

## ✪ Combined oral prolonged-release oxycodone and naloxone in cancer-related chronic pain treatment: a single institution observational experience about efficacy and tolerability

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**Introduction and study end-points** Opioids represent the mainstay of pain management for patients with cancer pain. However there are several problems in patients treated with those drugs, mostly because of adverse reactions, in particular opioid-induced bowel dysfunction. Our observational experience, had the objectives to better understand efficacy and tolerability of prolonged-release oxycodone/naloxone combination in daily practice.
**Patients and methods** 35 cancer afflicted patients with moderate to severe chronic pain, both opioid-pretreated and untreated, were observed in year 2011. These patients started pain treatment with PR oxycodone/naloxone twice-daily. Efficacy of pain therapy was detected by using Verbal Numeric Scale and tolerability was evaluated by reporting side effects at each visit.
**Results** In 22 opioid-pretreated patients a good pain-control was obtained with oxycodone/naloxone administration (average reduction of strongest pain of 2.9 points according to VNS) and a decrease of adverse reactions was noticed, in particular we observed a marked decrease of constipation from 71% to 34%. In 13 opioid-naïve patients oxycodone/naloxone administration showed an average pain reduction of 4.5 points with only low grade of adverse reactions.
**Conclusions** Our experience, even if evaluates a small number of patients, shows how a combination of a highly effective opioid and an antagonist offers the chance to control pain, reducing opioids-related side effects improving both the patients' compliance to treatment and quality of life.

## Bevacizumab induced arterial hypertension as a marker of efficacy of anti-angiogenic treatment: a retrospective analysis

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**Introduction and study end-points** Bevacizumab is an anti-VEGF monoclonal antibody showing efficacy in metastatic breast, colorectal, lung and kidney cancer prolonging survival and improving response rates in combination with standard chemotherapy. Side effects are arterial hypertension (HTN), bleeding, proteinuria, wound healing complications and thromboembolism. Actually there are no factors to predict response to this molecule. In our institution we retrospectively analyzed a small group of patients affected by metastatic cancer to study correlations between Bevacizumab-induced HTN and molecule's efficacy.
**Patients and methods** 20 metastatic cancer patients (13colorectal cancer, 5lung cancer and 2breast cancer patients), treated with Bevacizumab in association with chemotherapy regimens, were retrospectively analyzed to evaluate a possible correlation between HTN and efficacy of treatment in terms of Progression free Survival (PFS) and response rates (RR).
**Results** 8 patients developed Bevacizumab related HTN, 5 patients had a pre-existing HTN worsening and 7 patients had no HTN. PFS in patients with HTN was 8.5 months, while it was 5 months in patients without HTN. Also RR were higher in patients who developed this side effect (48% vs 30%).
**Conclusions** Our data show a possible correlation between Bevacizumab-induced arterial hypertension and its efficacy, both in terms of survival and responses. These results, if confirmed perspectively and in a larger series of patients, could attribute to this kind of toxicity the role of marker of Bevcizumab efficacy.

## Situations of stress and coping strategies of the personal health

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**Introduction** The Internal Medicine requires new skills and relationship counseling to be able to better manage stress and work-related training needs and communication requires that the new health.
The aim of the study Studying the level of stress and analyze the various coping strategies utlizzate by the medical staff, nursing and OOS U.O. Internal Medicine and Geriatrics.
**Materials and methods** To measure perceived stress and coping strategies was used Healt Professional Stress and Coping Scale (HPSCS), while acquiring new skills and relational counseling was built a training course of 84 hours for half of the staff, making in this way a control group and one experimental.
**Results** In the experimental group was observed a significant reduction in the level of stress and a greater uniformity of coping strategies used, keeping in this way more adherent to the requests in difficult situations.
**Conclusions** The quality and patient safety also involves stress management operators and a more careful control of the relationship dynamics and organization. Better management of emotional conflict has improved the communication between colleagues both horizontally and vertically that is, to direct patients/relatives.
This result leads to a better management of clinical risk in a complex system such as healthcare.

## Cadasil: un caso clinico

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**Premesse e scopo dello studio** Il Cadasil è una malattia genetica autosomica dominante, caratterizzata da patologia cerebro-vascolare con ischemie multiple sottocorticali riguardanti la sostanza bianca, decadimento cognitivo a scalini, attacchi emicranici, sintomi psichiatrici e polineuropatia. Il decorso è progressivo con esito fatale.

**Materiali e Metodi** Donna di 69 aa. Gentilizio positivo per diabete mellito, un fratello † a 63 aa. per malattia di Alzheimer. La sintomatologia è insorta 20 aa prima, con turbe dell'umore, etichettata più volte come sindrome depressiva. Da 8 aa, insorgenza di turbe del movimento e della deambulazione, con difficoltà a mantenere la stazione eretta. Il mese precedente ricovero in Neurologia per turbe comportamentali severe, con agitazione psico-motoria, marcati deficit cognitivi. Alla dimissione emiparesi fbc dx. Ecodoppler TSA: ispessimento intimale diffuso, piccole placche a livello delle biforcazioni. RMN dell'encefalo: esiti vascolari ischemici multipli sottocorticali; atrofia diffusa della corteccia. MMSE:08/30, CDR:3, scala di Barthel:0/100. Al ricovero presenta atteggiamento assente, postura rigida, volto spento e inespressivo, comportamento motorio rallentato, significativa difficoltà di espressione. Viene trattata con infusioni di Reidratante, Nimodipina, ASA, EBPM, Glargine bb+I.R. bp.
**Risultati** Alla dimissione: stabilizzata clinicamente, con recupero parziale delle performances funzionali globali.
**Conclusioni** Allo stato attuale il CADASIL trattato come una DV può avere risultati clinici accettabili per le funzioni della vita quotidiana.

## ✪ Resistant hypertension and pharmacological treatment over the years

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**Objective** Resistant hypertension identifies the absence of clinical results on blood pressure (BP) in subjects treated with at least 3 antihypertensive drugs. We evaluated clinical and therapeutic characteristics of patients undergoing ambulatory blood pressure monitoring at our Institution in the years 2000, 2006 and 2011.
**Materials and methods** We analyzed data from our patients undergoing ambulatory blood pressure monitoring at our Institution from the year 2000 to 2011. Mean monitored BP, clinical BP, sex, age and drug therapy were recorded in every subject. Most of them had also informations about smoking habits, diabetes mellitus, BMI and lipidic profile.
**Results** We analyzed 864, 1102 and 756 ambulatory blood pressure monitorings in the related years: 173 (20,02%), 264 (23,95%) and 219 (28,83%) presented a picture of resistant hypertension, even if the number of drugs used significantly increased. There were no significant differences in age, sex and BMI; diabetics resulted significantly increased while smokers decreased. Over the years AT II blockers use was significantly increased along with a reduction in alfa blockers prescription. Use of fixed drug association significantly increased even if we still still see a great number of self made drug association.
**Conclusions** Our data show how resistant hypertension is still a great problem over the years, even if we act more aggressively in drug therapy and new, well tolerated drugs and fixed associations, became available.

## Grasso viscerale e colesterolemia totale

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**Introduzione** L'adiposità viscerale rappresenta un importante fattore di rischio per la salute associandosi ad alterazioni del metabolismo glucidico e lipidico,ipertensione arteriosa,malattie cardiovascolari, sindrome dell'apnea notturna.
**Scopo** Valutare la possibile correlazione tra grasso viscerale e concentrazione di colesterolemia totale(CT) in una popolazione di soggetti normotesi e non diabetici.
**Materiali e metodi** Sono stati valutati 107 consecutivi pazienti afferiti presso l'ambulatorio di medicina interna nel corso del 2011. Di questi sono stati selezionati 53 soggetti, di entrambi i sessi, non diabetici , non fumatori e non ipertesi. Tutti sono stati sottoposti a misurazione ecografica del grasso viscerale e sottocutaneo ed al dosaggio CT.
**Risultati** Dei 107 soggetti sono risultati eleggibili 53 , dei quali il 62% apparteneva al sesso maschile(età media 42 anni) ed il 38% al sesso femminile (età media di 49 anni), La popolazione è stata divisa in due gruppi A;maschi con grasso viscerale medio di 71,5 mm e CT media di 187,8 mg/dl e gruppo B femmine:con grasso viscerale medio di 67 mm e CT media di 199,5 mg/dl. I due gruppi sono stati suddivisi ripsettivamente in due sottogruppi A1/B1 con valori di CT ≤200 mg/dl e A2/B2 con valori di CT >200mg/dl.

| A1 maschi ≤ 200mg/dl | A2maschi >200mg/dl | B1femmine ≤ 200mg/dl | B2femmine >200mg/dl |
|---|---|---|---|
| 74,7 mm | 64,2 mm | 69,5 mm | 63,8 mm |

**Conclusione** Dai dati ottenuti lo spessore del grasso viscerale valutato con metodo ultrasonografico sembra non essere correlato con la concentrazione della colesterolemia totale in entrambi i sessi.

## Sjogren's syndrome and pulmonary arterial hypertension - Clinical case

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**Clinic case** The author describes a case of Sjogren's syndrome (SS) with Pulmonary arterial hypertension(PAH).
The clinical presentation involves a woman 50 years old with oral and ocular sicca syndrome, arthralgia in the small joints of hands with stiffness' functional morning and Raynaud's phenomenon.
The clinical and laboratory suspicion of SS was confirmed with a biopsy of minor salivary glands. In the follow-up the patient presented with recurrent parotid swelling and progressive effort's dyspnea.
Laboratory and instrumental tests have excluded a possible evolution towards a chronic lymphoproliferative disease and disease of the lung parenchyma.
An echocardiogram detected PAH (NYHA class III) confirmed by right heart catheterization. Ambrisentan improved dyspnea and obtained passage NYHA class II.
**Discussion** The development of PAH, although rarely, may be associated in course of SS( described in the literature less than 50 cases). Suspicion of PAH must be confirmed with echocardiogram as the diagnostic definition is achieved by the execution of right heart catheterization.
Therapy should be established in accordance with a reference center with proven experience.
The indications of the main drugs to be used ( bosentan,ambrisentan, sidenafil,epoprostenol) follow NYHA classes but the low number of reported cases and the lack of data also allows users to take conclusions on optimal treatment of PAH associated with SS.
**Conclusions** We need standardized guidelines for optimal treatment of PAH in patients with SS.

## Idiophatic PAH - Clinical cases analysis

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**Background and purpose of the study** Idiopathic Pulmonary Arterial Hypertension (PAH) in elderly patients- Clinic cases analysis.
**Materials and methods** We have had recent observation of 3 clinic cases of idiopathic PAH quite similar to the late diagnosis in elderly patients with misleading symptoms for years The precapillary hypertension was diagnosed when the framework of HF was already advanced with a left ventricular involvement. In these patients, it may be difficult to distinguish PAH from PH associated with LV disfunction especially patients with borderline values of PWP ( 15-18 mmHg) and an elevated transpulmonary gradient ( mean PAP minus mean PWP) > 12 mmHg is suggestive of intrinsic changes in the pulmonary circulation over-riding the passive increase in PWP.
**Conclusions** PAH is not 'more' prerogative of the female sex-age 'youth. It is difficult to confirm diagnosis and very insidious disease. In these patients PAH was diagnosed when the framework of HF was already advanced with LV disfunction and sequential combination therapy resulted effective but the diagnosis should be as 'early as possible to improve more effective the quality' of life and the evolution of disease with the drugs that we have available today.

## Abdominal angina: an unusual case of "refractoriness" to gluten free diet in coeliac disease

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Mrs M.B., 70-year-old long-time smoker, referred to us for a recurrent postprandial abdominal pain and a 9 kg weight loss in the last year without bowel habit alterations. In 1987, she received a diagnosis of coeliac disease (CD), ever since she followed a strict gluten free diet obtaining a good clinical response. In 1997, Graves' Disease occurred and she was treated with radioactive iodine. At present M.B. is under L-thyroxine treatment together with two antihypertensive drugs. Physical examination showed only a low body weight. Laboratory tests were not significantly altered without evidence of malabsorption, oncomarkers were negative, TSH was slightly increased. Serology for CD was negative, demonstrating good adherence to gluten free diet. She underwent esophagogastroduodenoscopy and colonoscopy without remarkable findings, duodenal biopsy showed normal villous architecture thus excluding a refractory CD. Abdominal ultrasonography showed hemodynamic stenosis of celiac trunk and both mesenteric arteries. A contrast enhanced CT scan confirmed sonographic findings and M.B. underwent surgical aorto-mesenteric bypass with good clinical response. Abdominal angina is a rare syndrome, smoke is the main risk factor, female/male ratio is 3:1. Recent data show a possible atherogenic role of CD. A coeliac patient with abdominal symptoms and weight loss should be evaluated not only for disease specific complications but also for other intestinal diseases.

## ✪ Noninvasive mechanical ventilation (NMV) in elderly patients (e-pts) with acute exacerbations (AE) of chronic obstrutive pulmonary disease (COPD)

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**Objective** To assess the efficacy of NMV in improving arterial blood parameters (ABP) of E-pts (³65 yrs old), with severe (pH <7.25 Group A[GA]) and mild (pH³7.25, Group B [GB]) respiratory acidosis (RA) due to AE of COPD and in decreasing length of in-hospital stay (HS) and mortality.
**Design** Prospective cohort study (December 1th 2009-December 1th 2011).
Setting Budrio Hospital Medicine Ward.
Patients 278 COPD pts with AE, admitted to our Unit, 90 met predefined inclusion criteria (pH£7.34, PC02>45 mmHg).
**Results** 42 pts (20 men, mean age: 80.5±8.9 yrs) had severe and 48 (25 men, mean age: 79.7±9.9 yrs) mild RA, improvement of ABP (table) was obtained in 77/90 (85%) surviving (s-) pts; 13 (15%) pts (7 in GA, 6 in GB, p=NS) died during HS. HS was similar in s- vs not s-pts (16.9±9.9 vs 10.7±10.9 days).

| | Group | admission | 2-6h | 24h | 48h | discharge |
|---|---|---|---|---|---|---|
| pH | A | 7.18±0.54 | 7.27±0.77* | 7.36±0.75*§ | 7.40±0.04*§# | 7.42±0.05*§#´ |
| | B | 7.29±0.02 | 7.36±0.04* | 7.39±0.05*§ | 7.41±0.04*§# | 7.43±0.04*§#´ |
| PC02 | A | 86.2±18.9 | 70.616.8* | 58.5±13.3*§ | 54.5±11.6*§# | 47.8±9.5*§#´ |
| | B | 66.7±12.4 | 58.8±12.9* | 58.110.3*§ | 53.8±9.0*§# | 49.2±8.1*§#´ |
| P02/ Fi02 | A | 235.595.7 | 248.1±85.5 | 279.4±92.3* | 287.1±88.5*§ | 312.2±74.2*§# |
| | B | 222.9±63.3 | 253.7±85.7 | 257.5±68.2* | 290.2±71.0*§ | 310.8±72.6*§# |

*<0.05 vs admission, § vs 2 h of treatment, # vs 24 h,´ vs 48 h

**Conclusion** NMV is a very effective treatment for E-pts with AE of COPD irrespective of pH, even in non-ICU environment; a well-trained medical and nursing staff, supervision of a Pneumologist with problem-solving ability, a continuous monitoring of pts, a rapid access to invasive ventilation when appropriate are factors affecting NMV success

## ✪ Real-world economic burden of venous thromboembolism and antithrombotic prophylaxis in medical inpatients. The FADOI-LIUC CGM-I study

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In medical patients venous thromboembolism (VTE) is a significant cause of morbidity and mortality. The economic burden of this disease is plausibly relevant, but few real-world data are available on this topic. Aim of our study was to assess the costs of VTE management and thromboprophylaxis in patients hospitalized in Internal Medicine (IM).
**Methods** The in-hospital paths of 160 patients with VTE (VTE group) and 160 patients without VTE and receiving prophylaxis (NO-VTE group) were retrospectively evaluated within 26 IM units. The economic analysis was undertaken by applying a process analysis, the initial phase of the more comprehensive Activity Based Costing technique. Accordingly to this approach, only information closely linked to VTE or its prevention was registered.
**Results** The total median costs for VTE management were around four-times higher than those for prophylaxis (€ 1,348.68 vs € 373.03). The most important cost-driver were human resources (55.5% and 65.7% in VTE and NO-VTE groups), followed by instrumental (24.6% in VTE and 15.5% in NO-VTE) and haematologic tests (12.6% in VTE patients and 13.3% in controls). The direct costs for prophylaxis accounted for 4.5% of total (NO-VTE group).
**Conclusions** Data from this study confirm the economic burden of in-hospital treatment of VTE, and the relatively low costs of thromboprophylaxis. An extended follow-up would have probably added consi-

stency to these results. A greater adherence to evidence-based protocols for VTE prevention could probably reduce the current financial burden of VTE on healthcare systems.

### Analysis of appropriate clinical management of therapy and diagnosis in hospitalized elderly population with TEV

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**Background and goal of study** Tev has multifactorial etiopathogenesis; incidence is between 0.001-0.003 cases/year with mortality of 1% in young to 10% in elderly.
**Materials and methods** This retrospective study included 60 patients(41-94yrs)with TEV,divided into three groups:affected of TVP (n=26)mean age 78y,affected of EP(n=26)mean age 80y,affected both TVP and EP(n=8)mean age 79y.Epidemiological,clinical and therapeutical features were compared and therapeutical and diagnostic behaviour referred to ACCP 2008 and ESC 2009,were analized.At admission diagnosis of TVP was made with ultrasound and EP was dimonstrated with angioTC or ventilatory perfusion scintigraphy.
**Results** Mean age of our population was 79y,72% were women and 28% men.In 86.6%, hospitalization was first cause of TEV;admission mean time was 9 days without any significatively differences in three groups.A second episode of TEV occurred in 20% of patients and of these,50% were affected of neoplastic disease.Mortality was 13.3%. 57% of neoplastic patients was administred with EBPM;angioTC was performed in 96% of cases studied with suspected EP,only 3.84% of patients with EP underwent to pulmonary scintigraphy,being angioTC the gold standard.67% of patients were treated with bridge therapy and heparin was administred only in 30% of cases.
**Conclusions** Our data demonstrate good adherence to guidelines. Evaluation of patients must be globally using all informations and guidelines finded in literature as an helpful support to clinical activity expecially in elderly patients with a complexity of pathologies.

### ✪ Sometimes heart failure is due to a rare disease such as cardiac amyloidosis

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**Background** Cardiac amyloidosis is a rare disorder caused by deposits of an abnormal protein (amyloid) in the heart tissue leading to restrictive cardiomiopathy.Is more common in men than in women but rare in people under age 40.It can be difficult to diagnose,because the signs can be related to a number of different diseases and become a long-term condition that slowly gets worse.On average,patients live less than 1year.
**Case report** A 68 year old woman was admitted for severe heart failure, with a history of carpal tunnel syndrome,dysgeusia,dyspnea,peripheral neuropathy,periorbital purpura.During admittance patient's conditions worsened with orthostatic hypotension,atrial fibrillation,lower limbs paresthesia,pulmonary infiltrate and pleural effusion not responsive to diuretic therapy.Abdominal subcutaneous fat pad biopsy was negative but rectal biopsy and cardiac MRI were suggestive.Bone marrow aspirate confirmed monoclonal lambda free light chains making diagnosis of unusual amyloidosis AL without renal involvement.Only after administration of steroides and melphalan we observed a rapid decrease of lambda chains in serum and patient get better.
**Conclusions** http://circ.ahajournals.org/content/112/13/2047.full - ref-2#ref-2 Patients who developed restrictive cardiomyopathy and prominent signs and symptoms of right-sided heart failure should raise the suspicion of cardiac amyloidosis.Even if endomyocardial biopsy is the best diagnostic tool,a combination of characteristic ECG and echocardiographic findings,positive extracardiac tissue biopsy and primarily cardiac MRI may provide an alternative approach less invasive to diagnosis.

### ✪ Clinical, biochemical and ecocardiographic effects in patients with systolic preserved function heart failure, due to ischemic chronic cardiopathy, who received ivabradine in combination with conventional therapy: a pilot study.

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**Introduction** Numerous reports suggest that about one-third of patients with congestive heart failure have a normal left ventricular ejection fraction. The guidelines emphasize control of diastolic dysfunction biological effects, but there is insufficient data from randomized trials to support a preference for one agent or class of agents over another. This pilot study seeks to investigate if ivabradina could become part of traditional therapy for diastolic heart failure.
**Materials and methods** We studied 45 patients who were discharged from the internal medicine department with the diagnosis of diastolic heart failure. All patients had two visits in the span of six months that included: history, physical examination, echocardiography examination of systolic and diastolic function, six-minute walk corridor test and test of quality of life (SF-36). 9 patients received conventional therapy, and 18 patients received ivabradina in combination with conventional therapy.
**Results** 9 out of 18 patients that had taken ivabradina alongside conventional therapy had experienced improvements in their diastolic class of dysfunction. Only 3 patients in the control group had increased his diastolic class of dysfunction; 6 had decreased, and 18 experienced no change. All diastolic values experienced an improvement in the ivabradina group, whereas the control group had worsened for the same values. Additionally, resting heart rate and heart rate during exercise decreased in the ivabraina group. In the same group NT-proBNP values were lowered after six months.

### Unexplained syncope: one more cause to consider

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**Case presentation** A 73-year-old woman had hypertension and CAD, due to infarct, that she had had revascularized four years earlier, no diabetes. The patient had a transient loss of consciousness after a episode of diarrhea, she reported no palpitations, no chest pain and no dyspnea before the episode. Her husband, that saw her on the floor, reported that she rapidly and spontaneously recovered consciousness, and showed no signs of confusion. The ECG obtained in the emergency department showed sinus rhythm of 70 bpm and the skull TC showed an aneurysm of a. basilar, for which urgent treatment was deemed unnecessary after the evaluation of a specialist. During patient's stay in hospital the TTT and the MSC tests were negative. The echocardiography found conserved systolic function and moderate diastolic

dysfunction. The patient was discharged with the diagnosis of syncope neuromediated.
**Discussion** The study of Ungar A. et al. reported that, in >65 year old population, unexplained syncope represents the 14,1%. The case described before seems to have the same characteristics. The study of Jerry M. et al., despite the discharge diagnosis, gives reason to reconsider a cardiac cause of syncope. This work, that enrolled 48 elderly (> 69 yr) patients with diastolic dysfunction and 25 healthy age-matched controls, demonstrates that the first group have decreased LV end-diastolic volume, stroke volume, and cardiac output in response to postural change. Therefore could we reconsider a cardiac cause of unexplained syncope?

## Long-term effectiveness, safety and tolerability of a red yeast rice extract. A retrospective observational study

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**Aim** Red yeast rice (RYR) is a dietary supplement containing monacolins, pigments and phytosterols able to reduce the cholesterol plasma levels. Some authors reported on its use in clinical practice or in statin-intolerant patients but long term studies are still lacking. This study evaluated the effectiveness, safety and tolerability of RYR after two years of treatment in moderately hypercholesterolemic subjects.
**Methods** Observational data were collected retrospectively from 152 moderately hypercholesterolemic subjects (LDL-C > 4,1 < 5,2 mmol/l) treated with a supplement containing of RYR dried extract (Redactive®, Frama), one pill per day (3 mg of monacholins). Total cholesterol (TC), low density lipoprotein cholesterol (LDL-C) high density lipoprotein cholesterol (HDL-C), triglycerides (TG), CPK, AST and ALT plasma levels were detected at the start and after 24 months.
**Results** After 24 months 118 subjects was still treated. 34 patients discontinued treatment due to personal reasons (19 subjects) or lacking effectiveness (14 subjects) or increased CPK (one subject). In the subjects evaluated after 24 month the TC decreased from 7,1 ± 1,2 to 6,2 ± 1,2 mmol/l (-15,4%; p<0,001) and LDL-C decreased from 4,8 ± 1,0 to 3,8 mmol/l (-20,8%; p<0,001). HDL-C,TG, AST, ALT and CPK do not change significantly.
**Conclusions** In this study the RYR extract was well tolerated and showed a good effectiveness and safety in the long term treatment of moderate hypercholesterolemia.

## Usefulness of CHA2DS2-VASc in elderly (E) with permanent atrial fibrillation (PAF) and thromboembolic risk (TR)

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**Background** E with PAF have TR which is reduced by OAC or antiaggregation therapy (AT). In our OAC Surveillance Ambulatory TR is tested by CHA2DS2VASc(Euro Heart Survey on Atrial Fibrillation). Aim of the study is to confirm utility of CHA2DS2VASc in E with TR discharged by a Medicine Unit (PO Colleferro).
**Methods** 160 E(78female,82male;81±6aa) with PAF in OAC were compared with 89 E(54female,35male;79±5aa) with PAF in AT. They didn't differ from comorbidity (hypertension 73.5%vs74%;diabetes 38%vs39.5%; previous thromboembolic events–TE- 36%vs38%, abnormal renal/liver function 14vs12%), alcohol consumption. All E in OAC had CHA2DS2VASc≥1 while 33,41, 15 E in TA had, respectively, CHA2DS2VASc =0,1,>1.
**Results** After 4yrs observation in OAC group were checked 4 cardiovascular deaths(6,4%),1 fatal stroke(1,6%),4 non-fatal strokes(6,4%),8 TIA(12,8%), 21 hospital admissions(HA) for cardiovascular events (CE-33,6%),13 minor bleeding(20,8%),1 major bleeding. In AT group were checked 7 cardiovascular deaths(6,2%),5 fatal strokes(4,4%),8 non-fatal stroke(7%),19 TIA(17%),31 HA for CE (27,5%), 5 minor bleeding(4,4%), no major bleeding. Considering E in AT, we recorded no TE in subgroup with CHA2DS2VASc=0(A),7 TE in CHA2DS2VASc =1(B), 25 TE in CHA2DS2VASc>1(C).
**Conclusions** CHA2DS2VASc discriminate E with PAF who really need OAC since in this group TR remain low during OAC(13 OACvs32 AT). Considering AT group, in (A) there are no TE: they probably don't need antithrombotic therapy while in (B) we could chose between AT and OAC although the latter would be better when hemorrhagic risk is low.

## Cognitive Impairment (CI) in elderly (E) with permanent atrial fibrillation (PAF) in oral anticoagulant therapy (OAC)

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**Background** E with PAF have Thromboembolic Risk (TR) and a major risk of CI/D which is reduced by antithrombotic therapy. The aim of this study is evaluate CI/D in E previously discharged by a Medicine Unit (PO Colleferro).
**Methods** 102 E (58 female, 44 male; 81 ± 6 aa) with PAF in OAC (warfarin) and CHA2DS2-VASc ≥ 1 were compared with 89 E (54 female, 35 male 79 ± 5 aa) with PAF in antiaggregation therapy (AT). They didn't differ from comorbidity (hypertension 68%vs66%; diabetes 31%vs36%; previous thromboembolic events –TE- 24%vs27%, abnormal renal or liver function 8vs11%) and alcohol consumption. We tested into two groups cognitive status by Mini Mental State Examination (MMSE) and autonomy level with Barthel Index (BI).
**Results** After 4 years observation in OAC group were checked 4 cardiovascular deaths (4,1%) and 1 fatal strokes (1%), 6 non-fatal stroke (6,1%), 11 TIA (11,2%), 26 hospital admissions for cardiovascular events (26,5%), 17 cases of minor bleeding (17,3%), 1 major bleeding. In AT group were checked 8 cardiovascular deaths (7,1%) and 5 fatal strokes (4,4%), 11 non-fatal stroke (9,7%), 25 TIA (22,2%), 36 hospital admissions for cardiovascular events (32%) 12 episodes of minor bleeding (10,6%), 1 major bleeding. At the start of observation mean MMSE/BI were in OAC/AT groups, respectively, 28±2/97±15 and 25±3/90±15 while, after 4 years, MMSE/BI were, respectively, 26±2/91±10 and 22±1/65±10.
**Conclusions** With limitations due to small cases we can assume that OAC has a role in maintaining cognitive status and autonomy in E with PAF.

## The usual suspects

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A 74 aged heavy drinker man was hospitalized for high fever, diarrhea, mental confusion, spreaded maculopapular rash, scratching lesions and lower limbs edema. One month before he had presented a withdrawal alcohol syndrome with generalized seizure and was therefore assuming phenobarbital.
A chest x-ray showed pneumonitis. Despite antimicrobial therapy he went on presenting symptoms. A chest CT scan performed with steroidal premedication showed pneumonitis resolution. New antibiotic therapy was set with significant improvement in the clinical picture. The

patient showed new high fever episode with diarrhea. Test for C. Difficile resulted positive so vancomycin therapy was began. Recovery of diarrhea was obtained but fever and maculopapular erythema got worse. Eosinophilia and rise of serum creatinine appeared. After 7 days for the suspect of drug reaction, vancomycin therapy was discontinued. A global severe erythroderma, lower limbs edema and inguinal lymphadenopathy was appeared.
At this point for the suspect of drug reaction, Phenobarbital therapy was replaced and corticosteroids treatment was began. So we observed fever disappearance with improvement of erythroderma and lower limbs edema. The DRESS syndrome is characterized by at least three of followings: fever, exanthema, eosinophilia, atypical lymphocytes, lymphadenopathy and hepatitis. The Naranjo adverse drug reaction scale indicated a probable correlation (score 7 of 10) between the development of DRESS syndrome and Phenobarbital.

## Gastric incidentaloma

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A 65 aged man was admitted for abdominal pain. A CT scan showed a slightly bulbous appearance of the pancreas with a thickening of the perivisceral tissue. The presence of a hypodense mass with calcification at the lesser curvature of the stomach is worthy of note. This finding was compatible with a gastric diverticulum. Ematochemistry tests showed an increase of pancreatic amylase.
The tumor markers were negative. We started therapy with PPI, antibiotics, besides of keeping the patient fasting. The patient showed an improvement of clinical picture with normalization of amylase. A cholangio-MRI confirmed thickening of peripancreatic adipose tissue. Along the outer wall of the lesser curvature of the stomach it was confirmed the presence of a solid round mass with irregular borders and heterogeneous signal intensity, increased in size compared to the previous scan.
Total body-PET showed no areas of radio metabolic uptake.
An endoscopy showed edematous aspect of the stomach, without any presence of infiltrative lesions. The endoscopic ultrasonography showed the presence of a nodule with internal calcifications, adjacent to the gastric wall by which a clear cleavage plane could be detected.
The gastric wall appeared to be preserved in terms of thickness and layering. Biopsies showed a discrepancy between the cytological and histological sampling. The first sample identified the lesion as a scleroialin nodule, while the second identified lesion as a mesenchymal neoplasm. The patient underwent surgical resection of the lesion and histologic exam confirmed the diagnosis of GIST.

## The use of antibiotics in a ward of Internal Medicine

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**Introduction** Due to the high rate of resistance, aggressive antibiotic therapies are widely used in hospital, mostly on empiric base. We evaluated the modalities of use of antibiotics in our ward of Internal Medicine.
**Material and methods** The medical records of all the pts admitted since Oct and Dec 2011 were retrospectively evaluated for modality of antibiotic administration, clinical and microbiological diagnosis.
Results 56.9% of 130 pts received antibiotics as follows: empiric 63.5%, specific 29.7%, prophylactic 6.7%. The more frequent infections were: respiratory tract infections - RTI (28), sepsis (10), urinary tract infection - UTI (9), skin and soft tissues infections - SSTI (7). All sepsis and UTI, 42.8% of SSTI and 3.5% of RTI were microbiologically documented. The empiric therapy was performed according to guidelines in 78.5% of RTI. Among microbiologically documented infections, the empiric therapy was upgraded in 20% and descaled in 15% of cases.The mean length of therapy was 14.5 dys for sepsis, 11.1 dys for SSTI, 10.1 days for UTI, 8.4 dys for RTI. Among pts with RTI, 39.3% switched to oral home therapy.
**Conclusions** More than half of pts received antibiotics, mostly empirically and 1/3 modified the initial therapy according to microbiologic results. Many pts with RTI were early discharged with oral home therapy.

## Behind the Curtains of an Unusual FUO

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**Introduction** Felty's Syndrome (FS) is an unusual cause of FUO, its treatment a difficult task in the presence of active HCV infection.
**Case report** A woman of 62 was admitted on 28.1.2012 for fever, fatigue, anorexia, weight loss, sweating and arthralgias of six weeks duration. She had chronic HCV infection (active hepatitis, hepatic function in range) in no treatment, and hypertension. Physical examination showed enlarged spleen without palpable lymphnodes, no hands or feet deformities.
Blood findings consisted of mild anemia, leuco and neutropenia, increased ESR, alfa2, RF, WR and cryoglobulins; decreased C3 and C4, normal CIC and ferritin levels; negative other autoimmune tests, coltural samples, virus, atipycal bacteria, BK and parasites serology.
Echocardiography excluded endocarditis and pericardial effusion. TC scan showed left basal pneumonia, splenomegaly, abdominal adenopaties, no ascites, no portal vein enlargement. Bronchoscopy and BAL demonstrated no neoplastic cells nor infective microorganisms.
On the basis of RA, neutropenia and splenomegaly we hypothysed FS; large granular lymphocites syndrome (LGLs) + RA, or Pseudo-FS, was excluded by bone marrow examination not showing T cell proliferation or clonal TCR gene rearrangement. MTX, the drug of choice in FS, was contrandicated by the persistence of HCV RNA. Alternative drugs: other DMARDs and rituximab. No clear indications to GCFs and splenectomy.
**Conclusions** FS and LGLs+RA are rare causes of FUO. In both MTX is the drug of choice, but when contraindicated alternative therapeutic options are empyrical.

## ✪ Solitary cystic pancreatic metastasis from recurrent adenocarcinoma of the lung: case report

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**Background** Pancreatic gland is an uncommon site of metastases (about 2% of all pancreatic malignancies). Metastatic lesions are often asymptomatic and detected incidentally or during follow-up investigations. Renal cell cancer represents the most common primary tumor by far, followed by colorectal cancer, melanoma, sarcoma and lung cancer. Almost all lesions are solid whereas cystic shape is extremely rare.
**Case Report** A 64 years-old man was admitted because of dyspnea at rest. Anamnesis revealed diabetes and a 3-months previous diagnosis of stage-IV lung cancer (SCLC) treated with chemotherapy (two cycles). At admission, no abdominal complaints were present. Total body CT-scan showed an apical right lobe nodular lesion with bilateral pleural effusion, mediastinal and abdominal lymph-nodes and a solitary cystic lesion of the pancreas at the tail level. The cyst (absent in previous CT-scan investigations) was irregular in shape with well-defined wall. Ultrasound-guided

FNAB (cytology) of the cyst revealed a yellowish fluid material and the presence of atypical cells positive for adenocarcinoma hysto-markers. Considering the advanced stage of the primary lung cancer, its poor prognosis and the absence of pancreatic complication/symptoms, no therapeutic option was suggested for this solitary pancreatic metastasis.
**Conclusions** Physicians should be aware of the possibility of pancreatic metastasis. A more detailed definition for criteria for the selection of patients for pancreatic metastasectomy is needed, representing the main goal of investigations in the near future.

## Un caso di tamponamento cardiaco alla diagnosi di neoplasia polmonare

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**Caso clinico** Paziente di 77 anni ricoverato per dispnea ingravescente. La TC del torace mostra numerosi linfonodi a livello del mediastino anteriore e medio, un tessuto neoformato che si sviluppa a manicotto intorno alle vie aeree e un interessamento diffuso del lobo superiore sinistro.
È inoltre presente un modesto versamento pericardico (spessore max 1.1 cm).
Il paziente viene sottoposto ad una broncoscopia che non mostra stenosi bronchiali e ad una PET che evidenzia numerosi linfonodi patologici anche a livello laterocervicale. Uno di questi viene escisso e l'esame istologico concluderà per metastasi da adenocarcinoma scarsamente differenziato. Prima ancora che il referto sia disponibile insorge un ulteriore peggioramento della dispnea, associato alla comparsa di tachicardia, ipotensione e riscontro di polso paradosso. Un controllo ecocardiografico mostra i segni del tamponamento cardiaco, per cui il paziente viene sottoposto a pericardiocentesi con drenaggio di 1000 ml di liquido siero-ematico, che all'esame citologico mostra le caratteristiche immunoistochimiche di una pericardite neoplastica.
**Discussione** Le neoplasie rappresentano la causa di pericardite acuta nel 7% dei casi, ma in caso di tamponamento cardiaco questa percentuale sale al 32-58%. Le neoplasie più frequentemente responsabili di pericardite maligna sono quelle della mammella, i linfomi e le neoplasie polmonari.

## Triple whammy: an obscure threat for elderly patients

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Triple whammy is drug-induced renal failure which usually occurs following the combination of an ACE-inhibitor or an ARB with diuretics and a non steroidal anti-inflammatory drug. We present a case report of triple whammy in a 79-year-old woman who was hospitalized in a geriatric ward for asthenia and swelling of the face.She had undergone surgery for aortic biological prosthesis 7 years prior and was affected with hypertension, depression and arthritis.A month before she had been hospitalized for abdominal pain but was later discharged with normal renal function. A few days after she was visited at home for depressive symptoms, pain in the right shoulder and cystitis. She had been on oral ketoprofen (50 mg/day) for six days and she had been using it together with ciprofloxacin, furosemide, aspirin, carvedilol, omeprazole, ramipril.One week after this she began experiencing loss of appetite, asthenia and swelling of the face.Blood analyses showed acute renal failure, whereas clinical examination showed heart failure and pleural effusion. She was hospitalized again and her clinical conditions soon appeared severe.Blood gases showed metabolic acidosis. All treatments and even hemodialysis were vain and the patient died thirteen days following her hospitalization. History suggested a drug-related acute renal failure, defined as triple whammy. The different mechanisms probably involved include: inhibition of both prostaglandin-mediated control of glomerular afferent arteriolar tone and angiotensin control of efferent arteriolar tone; decrease of the plasma volume by diuretics.

## Hepatosteatosis and myocardial infarction in diabetic patients: peaceful coexistence or cause and effect?

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Recently some authors have shown the presence of a possible correlation between NAFLD and CVD diseases regardless of the concomitant presence of DM2T.With this retrospective study. The Author wanted to test a possible correlation between NAFLD and CVD.
**Materials & Methods** We had investigated retrospectively on 1617 DM2T; all were hospitalized in the last 6 years at our Department of Diabetology. All were subjected to ultrasound examination and the diagnosis of hepatosteatosis has been placed through the relief of the ultrasound features. The presence of previous cardiovascular events was validated by the finding of folders of previous hospitalizations or clinical reports instrumental.
**Results** Between examined patients we had found 186 diabetics (11.5%) with a previous cardiac event documented. Both groups of patients have abnormal values of HbA1c, the changes are more pronounced in patients with MI and the simultaneous presence of NAFLD. We have not found a significant correlation in the total population, so we had divided the population on the basis of the treatment administered and we have verified that the presence of NAFLD represents a risk factor for CVD only in the group receiving insulin therapy (OR=1.57-CI:1.046-2.289-p<0.05).
**Conclusions** Our results indicate that the simultaneous presence of NAFLD and CVD may not occur as a result of the hyperlipidemia, we hypothesize there may be a cause/effect relationship even if only in patients treated with insulin therapy. Unfortunately, the limited series has not allowed us to further subdivide the population on the basis of the different classes of oral hypoglycemic practiced.

## Which markers in cardiovascular risk in a population of diabetic patients?

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We all know the usefulness of having of safe and early markers of cardiovascular risk (CV). The recent literature is full of praise for a markers or another one. In this observation we verified the relationship between some markers and CVD in a population of hospitalized DM2T.
**Materials and methods** We examined the population of DM2T hospita-

lized in the last four years in our department, 2238 patients. The entire population was divided into 2 subgroups on the possible presence of a documented previous MI.
**Conclusion** In the individual patient, the presence of multiple risk factors contemporary determines a multiplicative effect with significant increase in the global CV risk. In daily clinical practice of the physician a frustration arises also from the impossibility to modify some risk factors and from poor adherence by the patient to prescribed therapies, so also modifiable factors are not in the target. Numerous studies have praised the factors "editable", and they have emphasized the importance of one or another marker. In our study we have prepared a table examining various risk markers; all calculated on the same people, then surely some problem related to the reason for hospitalization. The patients were evaluated while they were undergoing therapy, so did not represent the ideal patient selected in the international trial, but the patient in the "real life", what the physician meet daily while is working, with its prescribed therapy, taken probably only in part. Wwe have compiled this list not for a classification, but we believe that every marker of CV risk is important to activate a change in lifestyle and appropriate therapy.

## A "rare" bone marrow

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A 71 years old woman suffering from multiple vertebral collapse, hydatid cysts, jaw neoplasia surgically treated, recurrent DVT in oral anticoagulant therapy. Multiple admissions in hospital because of abdominal pain, epigastric pain, bilious vomiting, weight loss and reduced food intake. She underwent esophagogastroduodenal endoscopy with evidence of hiatal hernia and HP+ duodenitis (treated and eradicated) and abdominal CT scan with evidences of the known hydatid cysts, aspecific para-aortic and celiac linfadenopathy and little fluid in Douglas pouch. She was admitted in our department because of fever, diarrhea, abdominal pain and evidence of leukocytosis and elevation of inflammatory indexes. She underwent another abdominal CT scan that showed increased retroperitoneal and mesenteric linfadenopathy, splenomegaly, increased intra-abdominal fluid, and a PET-CT scan that showed diffuse bone and splenic capitation. In relation with persistent leukocytosis with linfo-monocytic predominance we analyzed a peripheral blood film that showed mastocytosis and then the patient underwent a bone marrow biopsy with evidence of fused mast cells CD117+, CD2+, CD25+, CD68+, CD20-, CD34-, reduced erythroid series, severe enhancement of granulopoietic series with correct maturation, normal amount of megakaryocytes (systemic mastocytosis evocative finding). The patient was transferred in our Haematology Clinic, starting Interferon therapy waiting for molecular genetic analysis in order to decide if a therapy with new II generation tyrosine-chinase inhibitors is feasible.

## ✪ A project of continuity of care: SE.RE.NA (faSE avanzata di malattia, cuRE palliative, mediciNA interna)

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**Background** Early care of patients in advanced stage of disease, in the transition between the "specific"care and "palliative" care.
**Methods** Geriatrician funded by voluntary association, multidimensional geriatric assessment (VGM) (Barthel, BADL, IADL, MMSE, PS, Charlson). Recruited patients are discussed in a twice-weekly briefing between referring physician, palliative care physician, a doctor and a nurse of medical division. Very important is the meeting with the family to explore the theme of incurability with them and sharing the most appropriate care settings in relation to the new needs that have been submitted on return home with ADI activation (Assistenza Domiciliare Integrata)/ ODCP (Ospedalizzazione Domiciliare managed by the Department of Palliative Care) or indication to stay in hospital Palliative Care (Hospice).
**Results** In the first year of activity 89 patients recruited in the network of palliative care: 34 return home with ADI activation, 8 in ODCP, 25 admitted in Hospice and 6 directed in ambulatory service, 16 died before the final setting of care. Other geriatric activities were: 55 multidimensional geriatric assessment, 80 VGM for certificate of disability, 6 home visits; production of pain management protocol.
**Conclusions** The model tested has shown efficacy in improving quality and earliness of care by the palliative care of frail patients in an advanced stage of disease, strengthening the network of Medicine, Palliative Care and the Voluntary Associations.

## Splenic abscess and cough

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**Introduction** The differential diagnosis of fever and related symptoms is one of the most complex chapters of medicine. Even when recognized macroscopically lesions, which may result in fever, is not always easy to establish the relationship between there cause and effect.
**Clinical case** Is a woman of 65 years, type II diabetes, suffering from hypothyroidism, ocular myasthenia and previous episode of hemolytic anemia and in immunosuppressive treatment with Azathioprine 50 mg x 2 die and Prednisone 5 mg day. 2 months before the patient was treated with Ciprofloxacin for salmonellosis. For the persistence of asthenia, malaise, low-grade fever and weight loss of10 Kg, patient went in PS; a chest radiograph showed the presence of a shaded left basal lung densification. Discontinued treatment with azathioprine, continued steroid and began Ceftriaxone ev .. After 2 days began to complain chills, cough with fever and splenomegaly. Was associated tratement with Levofloxacin ev. and executed an eco abdomen which showed a homogeneous mass confirmed by TC as cercinata, liquid 15x25x10 cm of diameters . There were not collections inside the chest. At the same time vomiche of purulent material appeared. She was transferred in thoracic surgery where was inserted a small drainage in the spleen and 1 litre of pus were evacuated. Vomiche and fever disappeared and the patient recovered without other surgical measures.
**Conclusions** The correct assumption of the presence of a trans diaphragmatic fistula allowed to choose the easiest way to solve the patient's problem.

## Project for a medical area organized according to treatment intensity

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**Background** The medical care centered on care intensity is based upon the diversity of patients according to the complexity of the clinical picture and the care intensity they need. Differently from what presently occurs at the Santo Spirito Hospital, a precise evaluation of comple-

xity of the clinical picture of each patient at admission would allow to exactly evaluate the necessary medical and nursing attendance burden. It would be thus possible to assign patients to the proper medical facilities, independently of the specialty of reference.
**Methods** In order to carry out this project, we applied an evaluation score on the medical (mEWS) and nursing attendance (ACI, assistance complexity index) requirements on 347 consecutive patients admitted to Santo Spirito Hospital Internal Medicine ward during four month period (June-September 2011).
**Results** Basing on results indicated in tables, we have elaborated, working with a technical team, an architectural project, adjusted on the present hospital structure, with a rearrangement of the existing wards in order to adjusted the care intensity for proper patient needs. Moreover, a personnel riorganization chart, adequate to the work load, was proposed for a relevant fund saving in front of a better quality medical assistance given.
**Conclusion** In S.Spirito Hospital of Rome, the medical assistance can and should be riorganized, logistically and assistentially, according to modulated care intensity in order to give to every patient his proper requested care.

## Sanguinamento gastrointestinale occulto

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**Premesse e scopo dello studio** Gli autori descrivono un caso di grave anemia sideropenia riscontrato in una signora di 79 anni. Scopo del presente lavoro è quello di evidenziare un caso di sanguinamento gastrointestinale da angiodisplasia, e di ridefinire l'iter ospedaliero in caso di sanguinamento gastrointestinale occulto.
**Materiali e Metodi** Viene descritto il caso di una signora di 79 anni, già in precedenza sottoposta ad EGDscopia e colonscopia (risultate negative), per melena ed anemia. Veniva ricoverata con grave anemizzazione (Hgb 6 gr/dL) e sottoposta ad emotrasfusioni in urgenza. Concomitavano cardiopatia ipertensiva ed obesità. Ottenuta la stabilità emodinamica, e raggiunti valori di HGb >10 gr/dL, veniva intrapreso l'iter diagnostico che permetteva, dopo EGDscopia, colonscopia (entrambe negative) e Video Capsula Endoscopica (VCE), di giungere alla diagnosi di angiodisplasia del tenue.
**Risultati** Veniva proposto trattamento chirurgico, rifiutato dalla signora,e si propendeva per trattamento conservativo per l'anemia sideropenia a base di ferro e.v. La suignora veniova quindi seguita ambulatorialmente per il follow-up.
**Conclusioni** Le angiodisplasie intestinali rappresentano la più frequente causa di sanguinamento dal tenue (33% circa),causano fino all'8% dei sanguinamenti dal tratto digestivo superiore, e fino al 6% dal colon. La descrizione del caso permette di rivedere gli attuali protocolli diagnostici in caso di sanguinamento intestinale occulto, di rivedere le attuali indicazioni all'uso della VCE, e le recenti evidenze sulle angiodisplasie intestinali.

## Un caso di scompenso cardiaco con overlap syndrome

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**Background and purpose of the study** Patients with chronic heart failure (CHF) may present sleep disordered breathing (SDB). Moreover COPD is a frequent co-morbidity. SDB and COPD are among the most common pulmonary diseases. We describe the case of a man hospitalized for dyspnea.
**Materials and methods** A 74 years old man went to the emergency room for dyspnea was hospitalized with diagnosis of heart failure. He performed ECG, chest x-ray, echocardiogram, spirometry, arterial blood gas analysis, CT brain scan and was properly treated.
**Results** We acknowledged the presence of COPD, difficult to control hypertension, a history of episodes of TIA and chronic urological troubles. Arterial blood gas analysis during clinical stability showed daytime mild hypercapnia. His wife reported habitual snoring and daytime sleepiness. A severe SDB was detected with a portable monitoring device. SDB was quantified by the apnea-hypopnea index, the average number of apneas and hypopneas per hour of sleep.
**Conclusions** This case points the importance to perform a screening for SDB in cardiac patients with suspected SDB and probably in all patients with CHF in which the correction of the respiratory disorders could modify the prognosis. Moderate to severe SDB treatment currently consist of continuous positive airway pressure and oxygen as needed.

## Incidence of contrast induced nephropathy (CIN) in patients with monoclonal gammopathies (MG)

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**Background** Iodine Contrast Medium (ICM) is necessary for most contrastographic evaluations, but it is usually avoided in patients with MG because it is considered a potential cause for CIN (1-6% on general population). This behaviour is based on clinical observations between 1954 and 1992, when a few episodes of acute kidney injury or death after infusion of ICM were reported in patients affected by multiple myeloma (MM) or Waldenström macroglobulinemia. Radiologists therefore test as a rule for presence of MG before infusion of ICM. New iso- and ipo-osmolar ICM, much safer, are available since '70ies; moreover, preventive measures as hydration or antioxidant agents and preprocedural blood test for serum creatinine are recommended.
**Materials and Methods** We retrospectively examined incidence of CIN in patients with MG of unknown significance (MGUS), excluding MM, in a large patients population from 5 Latium Institutions: S.Spirito H., N. Regina Margherita H., Pol. Umberto I H., S.Eugenio H., S.Giovanni H., to define the problem's dimension, with contributions of radiologists, nephrologists, neurologists and interventionist cardiologists.
**Results** Our observations show, as far as MGUS is concerned, that the risk of CIN during ICM infusion is not significantly higher than for general population, and the problem therefore is overestimated.
**Conclusion** Due to the relevance in clinical practice, a better definition of the relationship between MGUS and CIN, by a perspective study (in progress) in the same 5 Institutions, is worthwhile.

## ✪ Association between the presence of teleangiectases and deterioration of the lung function in systemic sclerosis

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Teleangiectases are vascular lesions composed of vasodilated post-capillary venules without evidence of neovascularization or inflammation
**The Aim** To investigate the association between the presence of teleangiectases and lung involvement in a cohort of SSc Patients.
**Methods** During 2011 a total of 88 SSc patients with teleangiectases were assessed. .All clinical parameters were evaluated and the presen-

ce of teleangiectases was assessed in 11 different body areas. The teleangiectasia's score for each body areas was calculated: zero if teleangiectases were absent, 1 point if were 1-9, 2 point if ≥ 10 teleangiectases were present. Lung function were assessed by evaluating the forced vital capacity (FVC) and the ratio between DLCO/FVC.
**Results** We found: stellate teleangiectases in 4%, matted teleangiectases in 34%, both type in 62%. Body median teleangiectasia's score: face 1,6- arms 0,7- hands 0,4- thorax 0,6-abdomen 1,4-back 1,2- legs 0,8- feet 0,7. Female gender (79,9%), Age 54,7±12,9 years, disease duration 14,3±12,2 years; Diffuse subset in 16(18,2%), Limited subset in 62( 70,4%), intermediate subset in 22,4%);
Total teleangiectasia score: 7,07±0,72; FVC: 99,2±25,7; DLCO/FVC: 92,6±22,3; Total teleangiectasia score vs. DLCO/FVC: rho 0,42 p<0,005.
**Conclusion** In the SSc cohort, the presence of higher total teleangiectasia's score was associated with a more important deterioration of the lung function and teleangiectases in SSc are clinical marker of pulmonary involvement

## Capillaroscopic findings in patients with clinical and laboratory antiphospholipid syndrome (aps)

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We investigated the relationship between abnormal capillaroscopic findings with positive antiphospholipid antibody profile.
**Methods** 36 patients were consecutively screened with capillaroscopy ( DS Medica-200x magnification) for clinical signs for vasculopathy. All thrombotic events were recorded. All patients were tested for γCL antibodies ( > 20 U/ml) and γ2GP1 Abs (>8,0 U/ml).The Chi-square test and Fisher's exact test were used to compare the frequencies.
**Results** 36 patients (30 F, 6 M-mean age 48,92±12,40 years) exhibited capillary microhaemorrages. 15 patients were γCL antibodies and β2GP1 Abs negative but these patients with a clinical history of thrombosis exhibited a capillaroscopic patterns suggestive for antiphospholipid syndrome. 9 patients / 36 were αCL positive: 5 with arterial thrombotic events, 4 with venous thrombotic events (p 0,642); 12 patients/36 was β2GP1 Abs positive: 9 patients with arterial thrombotic events, 3 patients with venous thrombotic events (p 0,356). Thrombotic events included: premature abortions (5 pts),cerebrovascular events (3pts),pulmonary embolism (2 pts), deep vein thrombosis (5 pts), epileptic crisis (2 pts),digital ulcers (2 pts), arterial limb ischemia ( 1 pts), coronary event ( 1 pts). αCL antibodies and β2GP1 Abs were both found to correlate significantly and independently with thrombotic events ( p<0,001).
**Conclusion** Nailfold capillaroscopy has proved to be one of the best diagnostic non-invasive imaging techniques to evaluate microcirculation in vivo.

## MRI brain in patients with rheumatoid arthritis

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**Background** CNS involvement is frequent in many autoimmune diseases, in RA is rare and often limited to aseptic meningitis, inflammation or infections. Recent reports show atrophy of subcortical gray matter and often cognitive impairment compared to the age of patients.Rarely there are at the MRI brain signs of demyelination or vasculitis, while the PML (JC) has been described only in 2% of the series.
**Case report** We report two cases of RA with abnormal MRI brain.
Pt 1: F. 37y suffering from RA for 20 years. Previous treatment with methotrexate, infliximab and actually with tocilizumab with low activity disease (28 DAS 3.1).Onset of isolated generalized seizure following hypocalcaemia from anorexia nervosa. At RMI in T2 there were multiple hyperintensities in the white matter without enhancement by contrast medium. IEF, sierological and microbiological tests (also JC) were negative.Neurological examination and cognitive tests were normal.
Pt 2: F 55y suffering from RA for 10 years,treated with abatacept with remission of RA (DAS 28 2.1).Onset of panic attacks with tremors. The brain MRI showed multiple T2 hyperintense lesions not modified by contrast medium. All serological tests and IEF were negative. Neurological examination and cognitive tests revealed an anxiety disease.
**Conclusions** In RA the presence of lesions at T2MRI brain suggest the presence of past vasculitic or ischemic injury rather than demyelinising diseases. MRI brain appears mandatory even in pts with controlled RA that develop cognitive or behavioral problems.

## Accuracy of multi-organ ultrasound for the diagnosis of pulmonary embolism. Multicenter prospective study

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**Purpose** Multi-detector Computed Tomography Pulmonary Angiography (MCTPA) is considered the standard of care for the detection of Pulmonary Embolism (PE) but it involves radiation exposure and has contraindications. Multi-organ (venous, cardiac, thoracic) ultrasound (US) could be an alternative but his diagnostic accuracy is unknown.
**Methods** Consecutive patients presenting to four emergency departments with clinical suspicion of PE were enrolled. MCTPA was considered the gold standard for PE diagnosis. Multi-organ US was performed before MCTPA. PE was considered echographically present if venous US was positive for limb deep vein thrombosis or cardiac US was positive for right ventricular dysfunction or at least one pulmonary subpleural infarct was detected with thoracic US. The accuracy of the single and multi-organ US was calculated.
**Results** Among 123 patients MTCPA was positive for acute PE in 46(37%). Table 1 shows the diagnostic performance of single and multi-organ US.
**Conclusions** Multi-organ US has a higher sensitivity compared with all single organ US, has a high negative predictive value and could be a good tool to rule-out PE.

**Table 1. Accuracy of single and multi-organ ultrasound in patients with suspected PE.**

| Ultrasound | Sen% (95%CI) | Spec% (95%CI) | PPV% (95%CI) | NPV% (95%CI) |
|---|---|---|---|---|
| Venous | 67(53-79) | 95(87-98) | 89(74-95) | 83(74-89) |
| Cardiac | 24(13-39) | 89(79-94) | 55(33-75) | 67(57-76) |
| Thoracic | 65(49-78) | 90(81-95) | 78(61-89) | 83(73-90) |
| Multiorgan | 93(80-98) | 72(60-82) | 66(52-78) | 94(84-99) |

Sens= Sensitivity; Spec=Specificity; PPV=Positive Predictive Value; NPV= Negative Predictive Value; CI= 95% Confident Interval.

## A case of acquired Fanconi syndrome secondary to conventional adefovir therapy in chronic hepatitis B

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**Background** Adefovir (ADV) is used in chronic hepatitis B (CHB) at 10 mg/daily dosage, which is considered safe from nephrotoxicity observed at higher doses. Fanconi syndrome is a proximal tubular dysfunction leading to electrolyte imbalance, causing fatigue, bone pain, osteomalacia and fractures. We report a case of Fanconi syndrome after prolonged ADV therapy for CHB. Few other cases have been reported.
**Case report** A 52 years-old woman with CHB was first treated with peginterferon, then with Lamivudine (LAM) after treatment failure. LAM was then withdrawn because of LAM-resistance with hepatitis flare. ADV was initiated, achieving complete and sustained viral response. Five years later, the patient developed impaired renal function. Proximal tubular dysfunction with hypophosphatemia and metabolic acidosis was identified: Fanconi syndrome was diagnosed. The patient was not treated with possibly nephrotoxic drugs other than ADV. ADV was discontinued, the patient was shifted to Entecavir, maintaining complete and sustained viral response. Glomerular and tubular renal function recovered within few months.
**Conclusions** Acquired Fanconi syndrome can develop in CHB patients taking ADV at 10 mg/daily dose: our case reinforces the need to monitor serum phosphate, glycosuria and proteinuria besides serum creatinine and glomerular filtration rate in patients under conventional doses of ADV. Early diagnosis of proximal tubular toxicity can lead to prompt drug withdrawal, allowing clinical recovery, preventing the development of complications as osteomalacia and bone fractures.

## Argatroban for treatment of DVT complicating heparin-induced thrombocytopenia in multiple myeloma undergoing hemodialysis: a case report

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**Background** Heparin-induced thrombocytopenia (HIT) is a severe adverse effect of heparin therapy associated with an increased thrombotic risk. Severe renal failure (RF) complicates the clinical picture and affects the choice of treatment.
**Case report** A 82 year old woman was admitted to Nephrology Dept. because of worsening of RF and underwent daily haemodialysis (HD), dalteparin was administered in the extracorporeal circuit. Ten days after admission she started chemotherapy for a new diagnosed multiple myeloma (MM). The 14th day platelet's count dropped from 104.000 to 37.000/µl. After further 6 days the patient presented a swollen and painful leg. A venous sonography showed a femoral DVT, and PF4/heparin antibodies were positive at ELISA test. Dalteparin was stopped and alternative anticoagulant lepirudin started immediately to maintain aPTT ratio 1.5-2.5. Because of severe RF aPTT resulted unacceptably unsteady, thus, 24 hours after, lepirudin was replaced with argatroban in order to maintain aPTT ratio 1.5-3.0. The therapeutic target was reached after the first laboratory assessment, and went on unchanged until its stop 10 days later. HD did not interfere with the anticoagulant treatment. Five days after starting argatroban, warfarin was added, and 5 days later, after reaching a therapeutic INR, argatroban was stopped, and anticoagulation continued with warfarin only. The patient was discharged 7 days after.
**Conclusions** Argatroban was effective and safe for anticoagulation in MM with HIT and thrombosis maintaining a stable aPTT during HD treatment.

## Tetanos Quick Stick in practice: application in an Emergency Department in Italy

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**Background** Correct prophylaxis is the cornerstone for tetanus prevention and is a daily issue faced in internal and emergency medicine departments worldwide. Vaccination history and wounds characteristics are lacking to guide vaccine booster and tetanus immunoglobulin administration in patients with acute injuries. Tetanos Quick Stick (TQS), a rapid bedside semi-quantitative immunochromatography-based test, provides an excellent help in this field, showing in ten minutes the actual tetanus antitoxin antibodies level of the patient.
Study Objectives To check the agreement between vaccination history reported by patients and TQS results and to assess if TQS can lead to a more accurate tetanus immunoglobulin administration.
**Methods** Ninety-eight patients presenting with acute tetanus prone wounds unable to ensure to have undergone a previous complete vaccination program were enrolled. Medical immunization interview and TQS were blinded carried out, the last being used as the gold standard to established the seroprotection rate of patients.
Results Forty-five percent of patients had a protective title. In 49% of cases we found a discrepancy between the history and test's result and so we were able to better manage tetanus prevention measures. In particular, 46.5% of the tetanus immunoglobulin were unnecessary and have been avoided, whereas 70% were needed and have been recruited.
**Conclusion** This is the first experience in which TQS is applied in real clinical practice. This study reinforce the value of the test, proposing it as part of standard tetanus prophylaxis protocols.

## La colchicina nel mantenimento di remissione della fibrosa retroperitoneale idiopatica

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**Premesse e scopo dello studio** La Fibrosi Retroperitoneale (FRP) è una patologia cronica, caratterizzata dalla presenza di tessuto fibroso che coinvolge gli organi in sede retroperitoneale. In considerazione degli effetti collaterali di un trattamento a lungo termine con farmaci come il cortisone, il tamoxifene e immunosoppressori, che attualmente costituiscono i farmaci di scelta, sono stati valutati gli effetti terapeutici della colchicina nella terapia di mantenimento della FRP.
**Materiali e metodi** Sono stati inclusi pazienti con FRP senza IRC. La colchicina è stata somministrata in associazione a minime dose di steroidi (2 mg/die). I pazienti sono stati monitorati attraverso esami laboratoristici (VES, PCR, emocromo, CPK) e strumentali (TC o RMN).
**Risultati** Sono stati arruolati 5 pazienti di sesso maschile di età compresa tra i 41 ai 70 anni. In 4 casi, la FRP era associata ad altra malattia (Febbre Mediterranea Familiare, pericardite ricorrente, spondilite anchilosante e morbo di Behçet). I 5 pazienti erano stati sottoposti ad una terapia di attacco con steroidi o con steroidi più immunosoppressori. Dopo l'induzione della remissione, è stata introdotta la colchicina, sono stati sospesi gli immunosopressori e ridotta la dose di steroidi.

Dopo 3 anni non si è avuta ripresa di malattia in alcun paziente.
**Conclusioni** La colchicina, farmaco antinfiammatorio con attività antifibrotica, potrebbe essere considerata un'alterativa terapeutica valida nella terapia di mantenimento dei pazienti con FRP.

## L'addominalgia non sempre è sintomo di patologia chirurgica

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La Sindrome Polighiandolare Autoimmune di tipo II (APS) è una condizione rara, la mancata diagnosi può determinare gravi conseguenze e mettere in pericolo la vita del paziente.
Si determina dall'associazione di un'insufficienza surrenalica cronica autoimmune, da una patologia tiroidea autoimmune, e/o da diabete mellito autoimmune tipo 1.
Uomo di 40 aa. APR: diabete mellito tipo 1.
Terapia domiciliare: insulina ed EBPM per una trombosi all'avambraccio.
APP: Melanodermia. Bassi valori pressori. Crisi ipoglicemiche, ridotto fabbisogno insulinico
In PS: PA 90/70, vomito, glicemia 280 ed addominalgia. Ematochimici: PCR 4.9, Ac. urico 11.22. Es. urine: glucosio 100, chetoni >80. EGA: PH 7.33, Lattati 25, Bicarbonati 21.8, Eccesso basi -2.6. No leucocitosi neutrofila, PCT nella norma.
Ricovero in Chirurgia.
RX addome: gastrectasia e coprostasi, posizionato SNG.
TC addome: formazioni linfonodali mesenteriche, all'ilo epatico ed alla piccola curvatura dello stomaco.
EGDS: gastrite cronica.
TC Torace: elementi nodulari-linfonodali al lobo inferiore, area a vetro smerigliato. Laparoscopia esplorativa: negativa.
Trasferito in Medicina.
Esegue: TSH 0.009, ACTH 896.0, Cortisolo-antimeridiano 0.02, Cortisolo-pomeridiano 44.44, FT3 4.97, FT4 1.86, anti-TPO >600.
Trattamento: Tapazole, Cortone Acetato, terapia insulinica.
Il paziente presentava i sintomi suggestivi per addominalgia, quadro clinico forviante, interpretato come sintomo di patologia chirurgica.
Il colorito della cute, le frequenti ipoglicemie nonostante il basso fabbisogno insulinico, suggerivano la presenza di altri deficit endocrini.

## Una malattia infiammatoria polmonare alquanto rara: bronchiolite obliterante-polmonite in organizzazione (BOOP) o polmonite organizzata criptogenetica (COP)

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La Bronchiolite Obliterante-Polmonite in Organizzazione (BOOP) o Polmonite Organizzata Criptogenetica (COP), è una malattia polmonare infiammatoria con quadro clinico, radiologico e patologico caratteristico. La comparsa dei sintomi è subacuta, con febbre, tosse, malessere, anoressia e perdita di peso. La biopsia polmonare chiarisce la diagnosi. Il trattamento d'elezione si basa sui corticosteroidi.
Donna di 55 anni. APR: Litiasi renale. Soffre di cefalea occipitale pulsante per cui assume betabloccante. Riferisce brivido febbrile settimanale da mesi, trattato con sintomatici. APP: sottoposta a colecistectomia laparoscopica a fine aprile, dopo tre giorni inviata in PS per iperpiressia ed addominalgia.
RX torace e TC: lesioni consolidative parenchimali. Il trattamento antibiotico con Cefalosporina e Fluorochinolonico non hanno sfebbrato la paziente. Le indagini microbiologiche, l'autoimmunità risultano negative. PCR 9, IgE 259.6, no leucocitosi neutrofila, PCT nella norma. Mantoux: negativa.
Esegue broncoscopia con BAL e biopsia transbronchiale. L'esame istologico: danno acuto polmonare sotto forma di polmonite in organizzazione.
Inizia terapia steroidea, la paziente si è sfebbra con miglioramento della soggettività.
Dimessa con terapia steroidea da proseguire e scalare in sei mesi. La polmonite in organizzazione può essere sostenuta da varie cause, tutte da valutare dal punto di vista clinico per escludere un'infezione. In questo caso la presenza di capillarite focale e l'occasionale eosinofilia fa prendere in considerazione la possibilità di una patologia immuno-mediata.

## Purpura fulminans (PF) e shock settico da S. pneumoniae in splenectomizzata. Quando la vaccinazione fa poco

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Purpura Fulminans (PF) è un raro evento acuto, caratterizzato da trombosi dei vasi cutanei con necrosi tissutale emorragica., che si associa generalmente a sepsi da N. meningitidis, e talvolta da S. pneumoniae. Caso clinico Donna di 64 anni., splenectomizzata, come debulking di LNH stadio IV A, ed immunizzata con vaccino pneumococcico polisaccaridico 23 valente (pneumo23) nel 2010 , affetta da gammopatia monoclonale IgM-K. ed anemia emolitica refrattaria alla terapia, viene ricoverata nel febbraio 2011 per shock settico da S. agalactiae ed un mese dopo per shock settico da S. pneumoniae. Nonostante richiamo con pneumo23, nel dicembre 2011, viene nuovamente ricoverata per shock settico con Multiple Organ Failure (MOF) e PF (cute marezzata al tronco, cianosi periferica alle mani ed ai piedi con necrosi digitale acrale cutanea) da S. pneumonie (emocolture ed antigene urinario positivi). Viene trattata con successo con espansione volemica, vasopressori, ceftriaxone ed enoxiparina, vaccinata con vaccino pneumococcico coniugato 13 valente (PVC13v) sottoposta a profilassi con amoxicillina. Ad un mese, buone condizioni generali, migliorata la necrosi cutanea alle dita.
**Conclusioni** La PF può costituire un segno precoce di sespi pneumococcica e, se trattata per tempo può guarire senza esiti permanenti. Il ripetersi di infezioni invasive pneumococciche dopo vaccinazione deve indurre a valutare la copertura del vaccino per il ceppo responsabile ed a valutare l'opportunità di un richiamo con il PVC 13 valente e/o o la profilassi antibiotica per anni.

## Granulomatosi di Wegener ad esordio come prostatite acuta

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La granulomatosi di Wegener (WG) è una vasculite che interessa tratto respiratorio superiore, polmone e reni ed occasionalmente basse vie uro-genitali. L'interessamento prostatico è raro e solo pochi casi sono riportati con esordio come prostatite acuta.
**Caso clinico** Uomo di 57 aa. ex fumatore con storia di rinite cronica, nel febbraio 2011 inizia a lamentare disuria; esegue mapping prostatico: prostatite cronica e sospetta neoplasia intraepiteliale. A maggio ricovero in urologia per ritenzione urinaria; ripete mapping prostatico: flogosi granulocitaria neutrofila ed eosinofila, necrotizzante, senza rilie-

vo di Bacilli Alcol-Acido Resitenti. Dopo circa 10 giorni versamento endotimpanico, otite cronica, inizia steroide. In seguito, tracce ematiche nell'escreato con febbre, inizia terapia con fluorochinoloni (FQ). Sottoposto a TC Torace: focolai di aspetto flogistico-infettivo. Sospende FQ per inefficacia ed inizia associazione C3G e aminoglicoside fino al trasferimento in M. Infettive, dove esegue emocolture e urino colture: negative, cANCA: positivo, pANCA: negativo ANA ed ENA: negativi. Trasferito in Reumatologia ripete TC Torace e biopsia transbronciale: granulomatosi di Wegener con alveolite emmorragica. Inizia ciclofosfamide e rituximab, ma per insufficienza respiratoria viene traferito in UTI dove decede dopo qualche mese.
**Conclusioni** L'esordio della WG come prostatite acuta è un evento raro. La biopsia prostatica con rilievo dei granulomi necrotizzanti tipici di vasculite, se ben interpretata, può essere la sola possibilità per una diagnosi tempestiva.

## Serum carbohydrate antigen 125 levels in heart failure: a case report

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**Background** Over the last years a growing interest for the biochemical abnormalities detectable in heart failure has become evident. Quite recently the attention of clinicians and researchers has also been directed towards high serum levels of tumour markers in this syndrome. Carboidrate antigen 125 levels has been observed to increase in patients with congestive heart failue, to correlate with haemodynamic and clinical parameters of severity, and to show significant changes after adequate treatment.
**Methods** We report a case report about a 86-year-old female admitted to the emergency room with acute dyspnea. Chest-X ray showed right pleural effusion and echocardiogram showed signs of pericardial tamponade. Biochemical assay revealed increased pro-BNP 3979 ng/ml (normal value < 450 ng/ml) and Ca-125 115.62 U/l (normal value < 35 U/l). After intravenous diuretic therapy the patient showed clinical improvement and reduction of the values of pro-BNP and Ca-125.
Results Selective literature review and consideration of the author's own clinical experience.
**Conclusion** Ca 125 and BNP are markedly elevated in heart failure and closely reflect heart function. Detecting BNP combined with CA 125 for diagnosing HF and evaluating the efficiency treatment.

## Splenoportal vein thrombosis in sepsis by severe diverticulitis

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**Introduction** Many medical conditions can lead to portal vein thrombosis (PVT); extra hepatic PVT has high clinical significance and prevalence. In a swedish study about 10% of PVT is caused by major abdominal infection or inflammatory disease.
**Clinical case** A 32 year old male came to our ED for fever, vomiting, diarrhoea and abdominal pain. He was hospitalized with the suspicious of acute gastroenteritis. Empirical antibiotic therapy (ciprofloxacin and amoxicillin/clavulanate) was started and then improved with metronidazole after blood culture results, positive for anaerobic bacteria. Laboratory findings showed high activated Protein C, moderate leukocytosis, mild hepatic function impairment. Abdominal ultrasonography showed unattended probable splenoportal vein thrombosis, initial hepatosplenomegaly, colic inflammation signs, with oedema at the sigma tract. CT scan confirmed wide splenoportal thrombosis and severe sigma diverticulitis. EPBM was started and after 1 month US showed partial splenoportal thrombosis resolution and hepatosplenomegaly normalization.
**Discussion** PVT has a wide spectrum of clinical manifestation including liver function impairment, splenomegaly and abdominal pain, but the most common is variceal bleeding in portal hypertension. PVT has to be detected by efficient imaging techniques such Doppler US. Anticoagulation is recommended in acute PVT, because spontaneous repermeation is uncommon. With our case we would stress to suspect PVT in severe abdominal infection and to detect it by accurate Doppler US.

## Abdominal pain and sepsis

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It's not always easy to understand the origin of a right abdominal pain, especially when we are forced by the urgency of sepsis. There are many clinical conditions that cause a gallbladder wall thickening without it means to be a real acute cholecystitis. Medical literature describes a few cases of acute cholecystitis and pyelonephritis.
We describe a case of two young women that came to our Hospital in different years for similar symptoms, right upper quadrant abdominal pain with peritonism, neutrophilic leukocytosis, fever and eleveted RCP. In both cases there was a gallbladder without gallstones but with wall thickening, more than 1 cm, and edema. In the first case the patient underwent to laparoscopic surgery that evidentiated only cholecystic edema, more on right Gerota fascia, no kidney or other gallbladder abnormalities. The second case, a young mother with left kidney gallstone history and left contracted kidney, had a bipolar right kidney diameter more than 14 cm, abnormal urinalysis and minimal fluid in the Morrison's pouch. It was helpful the absence of US Murphy sign, and a past US examination with right kidney diameters of 12,5 cm. The patient improve with only medical therapy.
In conclusion, internist should be familiar with extrarenal manifestations of severe acute pyelonefritis that may be seen on US as well, and should look for renal abnormalities to diagnose a clinically unsuspected pyelonephritis. Alternatively, pyelonephritis should be included in the differential diagnosis of systemic diseases that cause gallbladder wall thickening to avoid misdiagnosing, as acute cholecystitis.

## Antimicrobial Stewardship: a clinical, microbiological and pharmacoeconomical policentric study on Infections in Internal Medicine

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**Background** The antibiotics and resistant infections management is one of the most important problems for Public Health Service for clinic and economic impact, due to increased morbidity, mortality, length of illness and risk of developing complications and epidemics, with consequent increasing health costs.

**Design and methods** In the wake of similar European and American strategies, the multidisciplinary project named "Antimicrobial Stewardship" has been planned and managed in San Giovanni Battista Hospital, in Turin, with the aim of testing antibiotics from the Clinician, the Microbiologist, the Infectivologist and the Chemist point of view, upon a cohort of 188 patients admitted to three Internal Medicine wards.
**Results** The study, even if based on a restricted number of patients, has localized initial crucialities, giving a starting point to promoting interventions for an appropriate use of antibiotics in Hospital in terms of right choice, doses, length and route of subministration.
Conclusions Preliminary data suggest to extend the multidisciplinary project to the whole Hospital then, if confirmed clinical and economical efficacy with a bigger cohort of patients, to point it out as a regional or national standard.

## Implementazione della cartella clinica informatizzata (CCI) in una UO di Medicina Interna: luci ed ombre

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**Introduzione** Nell'Ottobre 2010 la Medicina 2 dell'Ospedale Infermi è stata scelta come UO pilota per l'implementazione della CCI nella ASL di Rimini.
**Metodi** Al fine di indagare l'efficacia/efficienza del nuovo strumento nell'attività quotidiana, dopo 15 mesi dall'implementazione, è stato proposto un questionario di valutazione a 49 operatori: 11 medici (M) e 23 infermieri (I) afferenti all'UO, e 15 medici che afferiscono all'UO per attività di guardia (G). Il questionario prevedeva 16 "items" riguardo ai quali gli operatori dovevano esprimere un giudizio in una scala da 1 (molto disaccordo) a 5 ( molto d'accordo).
**Risultati** La giudizio sulla CCI è risultato positivo per gli operatori afferenti all'UO (M+I) (3,9) ma non per G (2,2), p<0,001.
La CCI consente una più accurata compilazione e consultazione dei dati clinici secondo M+I (3,9) ma non per G (1,5), p<0.001.
Si è riscontrato un risparmio di tempo nella procedura di dimissione (3,59), ma non nella procedura di gestione quotidiana (3,0), tanto meno nella procedura di gestione dell'ingresso in reparto (2,51).
L'impossibilità di potere utilizzare esclusivamente la CCI (3,87) e la necessità di mantenere la cartella cartacea (3,92) sono percepiti come i principali limiti della CCI.
**Conclusione** La CCI consente una maggiore efficacia nella gestione dei dati clinici talvolta a prezzo di una diminuita efficienza, in termini di spesa temporale.
L' estensione dell'utilizzo alle altre UO, l'integrazione con gli altri supporti informatici e l'eliminazione della copia cartacea rappresentano i fattori critici per ottimizzarne l'utilizzo.

## Relapsing catastrophic antiphospholipid syndrome: when everything is not enough

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**Introduction** Catastrophic antiphospholipid syndrome (CAPS) is a very rare (<1%) variant of antiphospholipid syndrome (APS) characterized by the presence of widespread thrombotic microangiopathy, multiorgan failure and a high mortality rate. This is the report of a case of relapsing CAPS.
**Clinical course** A 29 year old man with APS diagnosed at the age of 18 was admitted to the hospital for dyspnea and hemoptysis. Blood tests revealed hemolytic anemia and thrombocytopenia compatible with a mycroangiopathic hemolytic process; a thorax/abdomen CT scan showed initial diffuse alveolar hemorrhage. Early treatment with intravenous immunoglobulin (IG) and high-dose corticosteroids (CS) was started with rapid and progressive improvement . After 6 weeks of complete remission the patient presented a recurrence of hemoptysis. Afterward a lung biopsy was performed showing typical signs of CAPS. Along with a new cycle of IG and high-dose CS, treatment with pulsed cyclophosphamide was started. The patient was discharged in good clinical condition; however, after 7 weeks massive hemoptysis with severe respiratory failure requiring endo-tracheal intubation ensued leading to death within 24 hours after admission.
**Conclusion** CAPS is an extremely rare disease burdened by a high mortality rate. While the occurrence of thrombotic phenomena is typical of APS, patients with the relapsing CAPS represents an exceptional phenomenon.

## ✪ Idiopathic hypereosinophilic syndrome presenting with cholestatic hepatitis

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**Introduction** We present an unusual case of idiopathic hypereosinophilic syndrome (IHS) associated with clinical and histological features of cholestatic hepatitis.
**Clinical course** A 64 year old woman presented to our department for fever and acute abdominal pain; past medical history was unrelevant and she was not taking medications. Blood tests showed leukocytosis with severe eosinophilia (14,7x109/l) and signs of cholestasis. The peripheral blood smear didn't show blast cells. An abdominal CT scan showed a thickened gallbladder and enlarged liver with perihepatic fluid collections. A laparotomy was performed revealing absence of acute cholecystitis. Liver biopsy demonstrated necrotic areas surrounded by inflammatory eosinophil rich infiltrates. Secondary causes of hypereosinophilia were excluded. A bone marrow aspiration and biopsy, immunophenotype cytogenetic analysis and mast cell tryptase levels were negative. A diagnosis of IHS was then performed and treatment with high dose corticosteroids and imatinib was started obtaining improvement and progressive eosinophil cell count normalization.
**Conclusion** Criteria for the diagnosis of hypereosinophilic syndromes include blood eosinophilia (≥1.5x 109/L), absence of conditions associated with secondary eosinophilia, and eosinophil-mediated organ damage. IHS is a diagnosis of exclusion. In literature there are few reports of IHS with histologically documented eosinophilic cholestatic hepatitis.

## Clinical characteristics and in-hospital outcome of patients infected with multi-drug resistant A. baumannii in an internal medicine department

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**Background and aim of the study** The role of multi-drug resistant Acinetobacter baumannii (MDR Ab) as a pathogen causing serious infections in critically ill patients (Pt) has become increasingly evident, but whether Ab is just a marker of the critically ill or is an independent predictor of death still remains unclear. Moreover, we are now facing a spread of Ab infections outside the ICU from which

most of the available data derive. Aim of this study was to describe the clinical characteristics and in-hospital outcome of Pt infected with MDR Ab admitted to high dependency unit of an internal medicine department.
**Patients and methods** Case-control study, Jan 2010- Jan 2012 with objectively confirmed MDR Ab infection.Results 86 Pt (43 MDR Ab infected and 43 uninfected) were included in the study. In Pt with MDR Ab tracheostomy (37%vs14%,p=0,02), previous admission to ICU (58%vs32%,p=0,03), invasive ventilation (56%vs16%,p<0,001) and previous treatment with fluoroquinolones (63%vs33%,p=0,009) or carbapenems (65%vs 35%,p=0,009) were significantly higher. MDR Ab infection was an independent predictor of in-hospital death and/or clinical deterioration (O.R.6,4; p=0,002).
**Conclusion** MDR Ab infection is spreading outside the ICU and it is becoming a relevant problem in internal medicine wards. In this case-control study MDR Ab infection resulted to be an independent risk factor for death and clinical deterioration requiring transfer to ICU.

## Aspirin and primary prevention of cardiovascular disease: update on

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**Background and aim** Thrombosis is the main cause of cardiovascular disease (CVD) and aspirin is often prescribed for primary prevention (PP). The aim of this study was to compare the results of studies on aspirin use in PP to determine if there is disparity between current evidence and current practice.
**Method** A literature search of the studies reporting on aspirin and PP of CVD was conducted on key resources (Medline/PubMed, Cross Reference, Cochrane Library) and limited to 26 English language documents selected for quality published between Dec 2002 to Jul 2011.
**Results** Many studies don't support the use of aspirin for PP of CVD, while new evidence demonstrates that aspirin use reduces the number of CVD events in these patients but it does not seem to affect CVD mortality or all-cause mortality in either men or women. In addition to the uncertainty of efficacy research has shown that aspirin use increases the risk for serious major bleeding events as gastrointestinal bleeding and hemorrhagic stroke. FDA has denied requests to approve aspirin for PP of CVD twice, once in 1998 and again in 2003, due to lack of evidence supporting its efficacy.
**Conclusion** Part of the literature examined confirmed that in PP aspirin decreased the risk for total CV events and nonfatal MI with no significant differences for decreased incidences for stroke, CV mortality, all-cause mortality and total coronary heart disease, while all the literature reviewed confirmed that aspirin use increases the risk of severe bleeding as gastrointestinal bleeding in men and women and hemorrhagic stroke in men.

## Novel approaches to resistant hypertension: focus on

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**Objective** The treatment of resistant hypertension (RH) requires alternative strategies including interventional approaches.
This review will focus on novel approaches to RH.
**Design-method** A literature search of the studies reporting on novel approaches to RH was conducted on key resources (Medline/PubMed Embase, Cross Reference and The Cochrane Library). The search was also limited to English language documents published between Nov 2004 to May 2011. Internet links were provided, where available.
The summary of findings was prepared by analysis of articles, reviews, main trials, selected for their scientific relevance.
**Results** The studies reviewed showed the importance of renal sympathetic hyperactivity in maintenance and progression of hypertension and renal sympathetic denervation (RSD) of both efferent and afferent renal nerves should result in long-term attenuation of hypertension.
Data from recent studies showed that RSD has effectively lowered blood pressure and prolonged life expectancy of hypertensive patients.
An implantable device to electrically stimulate the carotid baroreceptors is another new approach used to decrease sympathetic outflow. Early results showed adequate blood pressure and heart rate reduction, and feasibility studies showed promising long-term results.
**Conclusions** Catheter-based RSD and the implantation of a permanent bilateral perivascular carotid sinus pulse generator for carotid baroreceptor stimulation are innovative therapeutic strategies minimally invasive to reduce blood pressure in patients with RH with short procedural and recovery times.

## Cardiac geometry in hypertensive patients in a dedicated outpatient clinic

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**Background and purpose of the study** Mass and morphology of left ventricle represents an index to evaluate the status of hypertensive disease and to determine the drug treatment. Echocardiography is the best tool to evaluate morphology and mass of the heart.
**Materials and Methods** We evaluated the mass and the morphology of heart, by echocardiography, in 303 consecutive patients with hypertension referred to a dedicated outpatient clinic for hypertension. Mass was evaluated according to Devereux (Am J Cardiol, 1986) and De Simone (Am J Cardiol, 1992), morphology by tickness/radius ratio (h/r) [(IVST + PWT)/LVTDD] (normal value <0.42). It was also rated the achievement of target BP with ABPM (Spacelabs 90207).
**Results** 53% of patients were male. The mean age was 57.2±13.6 years. Only 23% of hypertensive patients had a normal pattern of geometric and mass at echocardiography. The 39% had concentric remodeling. The eight % had eccentric hypertrophy and 31% concentric hypertrophy. Regarding the degree of control of blood pressure (measured by ABPM), only 58% of patients reached the therapeutic goals, 40% in patients with concentric hypertrophy.
**Conclusions** Despite the limitations of the study, related to the selection of patients (specialist clinic for hypertension), the results show a high prevalence of alterations in cardiac mass and geometry associated with hypertension and poor BP control. Echocardiography is an essential method for the detection of subclinical abnormalities that have a high prognostic impact and result on therapeutic choice.

## A classic "abnormal" FUO

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T.A., male of 61 years visited for tibiotarsal arthritis associated with evening fever and asthenia from a few weeks. Performs a DH diagnostic study which highlights: VES 27, PCR 7.3, Hb 10.3, PLT 77000, GB

7400, N 69%, negative autoantibody panel and tumor markers. Chest Rx: no pneumonic consolidations. Normal right ankle Rx. Performs 2 hemocultures. After rheumatologic consultation is initiated steroid + ciprofloxacin therapy at home, which improves arthritis but does not solve the fever. After a week, due to the persistent fever, the patient is hospitalized. On the 2nd day comes the hemoculture result: positive for Streptococcus Bovis. Echocardiography is performed: coarse vegetation (1.8x2cm) adherent to the posterior leaflet of the tricuspid with moderate-severe valvular insufficiency. Diagnosis Right heart endocarditis. On the basis of antibiogram, therapy is started with Teicoplanin+ampicillin-sulbactam. However, for the presence of mobile vegetation >10mm of the endocardium, as required by the European and American LG on endocarditis, the patient was hospedalized to the intervention of tricuspid valve replacement with a biological valve, successfully performed with the recovery of the patient. Teaching of the case In the presence of FUO, the possibility of a right heart endocarditis must be considered even in the absence (as in our case) of general risk factors for endocarditis (dental procedures, cardiac abnormalities, etc..) and for right heart endocarditis (drug abuse, multiple pulmonary infiltrates, intravenous procedures, intracardiac device).

## A too much anemic patient

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**Case report** A 50-yr old male patient presented with severe anemia (Hb 6,8g/dl). During adolescence, he suffered rheumatic fever with valve involvement and, when he was 33-yrs old, he had a double valve replacement with two (mitral and aortic) mechanical prostheses; from then he was on anticoagulant. One month before his Hb was 14g/dl. He referred a 7- day history of evident hematuria. He needed blood transfusion.
The INR was in therapeutic range and ultrasound kidneys and bladder examination was normal. Upper endoscopy didn't show anything abnormal, nor did a complete body CT scan examination. There was no blood in his stool. Laboratory values were normal except for bilirubin (Total 3,1mg/dl, Indirect 2,7mg/dl) and lactate dehydrogenase (5600 UI/l). Coombs tests were negative. Morphologic peripheral blood cells examination showed anisocytosis with some fragmented red blood cells.
A transesophageal echocardiography was performed, which showed dysfunction of both prostheses. He was then re-operated and his hemoglobin remained normal after operation.
**Conclusions** Mechanical hemolysis with mild anemia in patients with mechanical valve prostheses is a well known phenomenon. In our case, the patient developed sudden severe mechanical hemolysis with hemoglobinuria and severe anemia, two uncommon problems probably due to the sudden, otherwise asymptomatic, dysfunction of both the prosthetic valves.

## The management of the cerebral ictus in Naples and Campania

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**Background** The incidence of Cerebral Ictus is increasing: in Italy the number of new cases/year, for all the classes of age, is esteemed around 186.000 with a 20-25% mortality to brief term.
**Materials and Methods** Taking in examination the ISTAT data (year 2010) and those emanated by the regional organisms, it notices that, in Campania, the mortality for Ictus is more raised in comparison to the rest of the country. In comparison to the other provinces of the regional territory, the Neapolitan population introduces further differentiations. In fact, considering the index of old age (= 83), it is deduced that a great number of young people is present in comparison to the over 65.
**Results** The data testify an inadequacy of the System of Primary Care around the individualization and the management of the risk factors, that it excessively penalizes the under 65. At the same time the elevated rate of mortality for Ictus implies a diagnostic delay and an inadequate answer to the relief needs, also in presence of a remarkable consumption of resources, both in the acute phase and in that of rehabilitation.
**Conclusions** To the light of the recent PNP (2010 -2012), in the management of Ictus in Campania, an insufficient integration of the relief service and the missed application of Diagnostic-Therapeutic Runs scientifically corroborated and shared are individualized. It appears more and more besides urgent an active involvement of the population recipient (customer involvement) and an explicit informative system and of evaluation (data management).

## Milkman syndrome

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**Background** Osteomalacia (O) is a disorder of decreased bone mineralization of newly formed osteoid at sites of bone turnover in adults. Osteopenia is the most common finding but is not specific. More specific abnormalities are changes in vertebral bodies and Looser zones (pseudofractures). In the past O was commonly caused by nutritional deficiency, malabsorption now is more common. Recent literature suggests that nutritional vitamin D deficiency follows various bariatric surgeries for morbid obesity.
**Case report** A 59-year-old woman suffered from progressive diffuse bone pain. She underwent jejunoileal bypass for morbid obesity 25 years earlier. Bone radiography showed bone thinning, multiple symmetrical "hot spots" were detected on bone scintigraphy. It suspected multiple metatastatic bone cancer. We found hypocalcemia, elevated ALP, No urinary calcium loss, higher PTH serum values, but lower vitamin D. Whole body CT, PET, mammography and bone marrow biopsy ruled out solid and hematological neoplasms. A diagnosis of O due to Vitamin D depletion and hyperparathyroidism secondary was made. We started calcium and vitamin D supplements. A few weeks later, the patient's bone pain has resolved. Two years later patient was still asymptomatic.
**Conclusion** O is an misdiagnosed late complication of bariatric surgery. Pseudofractures can also be seen with bone scans where they appear as hot spots. The term "Milkman syndrome" refers to the combination of multiple, bilateral and symmetric pseudofractures in O. Early recognition can avoid circuitous diagnosis and inappropriate management.

## Real setting management of osteoporosis after liver transplantation

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Osteoporosis and fragility vertebral fractures are complications after orthotopic liver transplantation. Aim was to evaluate the management of osteoporosis in transplanted patients is approached in the real set-

ting.113 patients were admitted after OLT in the period 2005-10. 69 of them had either an anamnesis of bone loss or risk factors for osteoporosis. In these patients DEXA (N=8) or QUS (N=61) was performed, while spine x-rays were obtained to diagnose prevalent fractures. Patients with osteopenia were treated with calcium/vitamin D. Fragility fractures were treated with bisphosphonates.The median follow up of patients after OLT was 38 months (range 14-232). Osteoporosis (T score < -2,5) was found in 37 patients (54%), osteopenia (T score between -1 and -2.5) in 19 (27%), a normal T score (> -1) in 13 patients (19%). Twenty-nine patients (42%) had vertebral fractures: 2 of them (7%) had normal bone densitometry and 6 (21%) had evidence of osteopenia. An improvement of bone density after 12 months treatment (mean T score +0,98) was recorded in 90% of patients, while only one had a worsened T score (-0,1). In our on-field experience, evaluation of osteoporosis was prompted mainly by symptoms, even if impaired bone density and vertebral fractures are still frequent after transplant, in some cases with no close relationship between altered bone density and severity of osteoporosis. Treatment with bisphosphonate is effective in most patients. Our study confirms the importance of the systematic evaluation of osteoporosis in the follow-up of transplanted patients.

### Osteoporosi severa e trapianto epatico: qualita' della vita e teriparatide

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The incidence of vertebral fractures after liver transplantation is variable and high.The vertebral fracture generates chronic pain with marked reduction in physical performance and function resulting inan overall reduction of Quality of Life (QoL). We evaluated the improvement of pain and physical function in five patients with osteoporosis complicated by vertebral fractures using teriparatide. From a population of 69 patients undergoing liver transplantation, we sampled 5 patients with severe osteoporosis. Were enrolled for treatment with teriparatide.Have been assessed, the VAS pain patient and the Back Pain Score Function(BPFS) at time 0, 12.18 months. During therapy, there were no adverse reactions or intolerances. Four patients no longer have 'pain after 18 months of therapy. In one fell significantly. Back PainFunctional Score (BPFS) showed a downward trend in all patients with a goodfunctional recovery. The use of teriparatide in liver transplant patients with vertebral fractures from osteoporosis seems to be well tolerated. Is accompanied by an improvement in pain significantly and to an improvement of the function vertebral parameters that allow a greater functional autonomy and therefore an improvement in QOL. This our observation needs further confirmation in controlled trials.

### ✪ History and therapy of 49 patients with mixed cryoglobulinemia. A single center experience

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**Introduction and objectives** Mixed cryoglobulinemia (MC) refers to the presence of circulating cryoprecipitable immune complexes in the serum responsible for a small vessel vasculitis. We describe characteristics and outcome of patients with MC evaluated at our department.
**Patients and methods** 49 patients with MC, were identified between January 1995 and June 2011. Ten patients were treated with apheretic therapy and 5 patients with Rituximab (RTX) because of a relapsing or not responsive disease. Three plasmapheresis every other day followed by methilprednisolone o cyclophosphamide infusion for ≥ 6 cycles monthly were performed. RTX was administered at dosage of 375mg/m2. Instrumental and serological (M component, cryoprecipitate and C4 levels, B lymphocytes levels) response to therapy was analyzed.
**Results** Sex 17/32 M/F, mean age 59±11.2 years and follow up 79±55.3 months. Main ethiology was HCV (85%), followed by Sjogren Syndrome (8%). Most common symptoms: purpura (67%) and neuropathy (59%); in 3 cases NHL were associated. In apheresis group we found in 5 cases EMG improvement of neuropathy and in all cases stabilization of cutaneous and vascular manifestations. In RTX groups, all patients presented purpura resolution in 1-3 months and clinical/instrumental improvement of neuropathy and nephropathy at 6 months.
**Conclusions** Long term syncronized apheretic therapy seems to improve remission time, but not to modify the outcome; RTX appears a safe, well tolerated and effective treatment. These regimens merits further exploration in prospective trials.

### Morbo di Whipple associato a ipertensione polmonare e reazione di Herxheimer dopo terapia antibiotica: case report

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**Caso clinico** Una donna di 72 anni, affetta da sindrome ansioso-depressiva, è stata ricoverata per approfondire una sintomatologia presente da 2 mesi caratterizzata da astenia, inappetenza, epigastralgia, diarrea, febbricola e calo ponderale. Fra gli esami: Hb 8,6 g/dl e segni di malassorbimento, NT-proBNP 4018 ng/l. All'esofagogastroduodenoscopia era presente quadro macroscopico e istologico patognomonico di morbo di Whipple (MW). All'ecocardiogramma si evidenziava modesta dilatazione delle camere cardiache destre con severa ipertensione polmonare (PAPs 95 mmHg). La TAC torace escludeva presenza di embolia polmonare. E' stata iniziata terapia con ceftriaxone; alla prima somministrazione episodio di malessere generale e severo rialzo febbrile (tipo reazione di Herxheimer). E' stato completato trattamento con ceftriaxone (14 giorni) e proseguito trattamento con sulfometossazolo/trimetoprim, con rapido miglioramento della sintomatologia. Al controllo ecocardio dopo 40 giorni di terapia si è osservata normalizzazione dell'impegno delle camere dx (PAPs 29 mmHg).
**Commento** Il MW è una malattia multisistemica ad eziologia infettiva. L'ipertensione polmonare è una rara associazione probabilmente dovuta a infiltrazione vascolare da Tropheryma whippelii. A nostra conoscenza sono descritti in letteratura 5 casi di tale complicanza, di cui tre responsivi alla terapia antibiotica. Pur non essendo contemplata fra le cause di ipertensione polmonare, l'associazione con MW va tenuta in considerazione poiché potenzialmente reversibile con la terapia antibiotica

### Troponin levels in patients with acute ischemic stroke. Correlation with clinical presentation in according to NIHSS score

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**Introduction** Recent studies showed that levels of troponin T are frequently elevated in patients with acute ischemic stroke (AIS), but, the-

re is uncertainty about the meaning. We sought to determinate if Troponin Ths levels are related to worst clinical condition in patients with acute ischemic stroke, in presence, or absence of EKG signs or clinical history of cardiac ischemic disease (CID).
**Methods** We enrolled 64 patients with AIS consecutively admitted to Internal Medicine and Geriatric Departments of Villa Sofia Hospital. We divided the sample in two groups: group 1 by patients with no-EKG signs of CID at admission and without clinical story, group 2 by patients with EKG signs or clinical history of CID. Patients with worse clinical condition were identified in presence of higher NIHSS-score (>8).
**Results** From the original sample (16 men, and 48 women; mean age: 77.8 ± 10.4), in the group 1 the mean Troponin Value was significantly higher in patients with NIHSS score > 8 (29 against 18; p=0.08), while there were no differences in patients that showed EKG signs of myocardial ischemia (40/37; p=NS).
**Conclusion** Our findings indicate that, in our sample of patients with acute ischemic stroke, in absence of conclamate signs or clinical history of CID, higher value of troponin are in patients with higher NIHSS, suggesting that these patients could have a concomitant very early involvement of myocardial ischemia. These findings should be confirmed by new echocardiographic methods (Strain rate, longitudinal function) able to identify pre-clinical condition of CID.

## ✪ Follow-up of patients treated with non invasive mechanical ventilation (NIMV) in Internal Medicine

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**Background** NIMV has been shown to be effective in chronic and acute respiratory failure (RF). In the past, all the forms of mechanical ventilation were managed in intensive care unit (ICU). Anyway, the decrease and expensiveness of ICU beds and the population ageing and comorbidities spread it outside ICUs.
**Objectives and Methods** From 1/1/2009 to 11/15/2011 we delivered 148 NIMV treatments. Inhospital mortality, survival at 3-6-12-24 months from discharge and readmissions to hospital within one month were collected.
Study population: 104 pts (mean age: 84.3 ys) treated by BPAP for hypercapnic RF due to exacerbation of COPD and 44 pts (mean age: 74.5 ys) treated by CPAP for hypoxemic RF due to pneumonia (30%) and pulmonary edema (70%). All of them have at least 2 comorbidities.
**Results** In BPAP group, 33.6% died in hospital, 75.3% pts (52/ 69) survived at 3 mo., 79.5% (39/49) at 6 mo., 24/33 (70%) at 12 mo.; 5/17 patients are still alive after 24 mo.; readmission within 1 mo. occurred in 20% (14/69) of cases. In CPAP group, 29.5% died in hospital, 80.6% (25/31) survived at 3 mo., 81% (22/27) at 6 mo., 15/21 (71.4%) at 12 mo. and 3/6 at 24 mo.; readmission within 1 mo. occurred in 19% (6/31) of cases.
**Conclusions** Nowadays, NIMV is widely used in Internal Medicine. Considered that a large proportion of do-not-intubate pts are treated in this setting, survival resulted quite prolonged and readmission rate is not very high in both the groups.

## A rare complication of acute pancreatitis

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**Case report** Female, 38 yo, previous lysteriosis and occupational asthma, chronic back pain treated by steroids and NSAIDS, surgery for carpal tunnel 10 days before, was admitted for left thoracic pain, fever and dyspnoea, refractory to antibiotics, pleural effusion at X-rays. Thoracic CT escluded pulmonary embolism, but showed bilateral pleural, mediastinic and multiple abdominal effusions. Blood tests revealed increased neutrophils, acute phase reactants (APR), LDH, slightly increased amylase, lipase with no morphologic pancreatic lesions. On meropenem and teicoplanine, fever disappeared, but no effect on APR and effusions was observed. Gastric perforation was excluded. Thoracentesis revealed exudate with increased levels of amilase and LDH; microbiologic and cytologic tests on pleural fluid were negative, as well as polyserositis, neoplastic and pancreatitis screening. Treatment with gabexate mesilate and octreotide was ineffective. Explorative laparoscopy was not contributive showing only neutrophilic peritoneal inflammation and no macroscopic pancreatic lesions. Finally, the forth CT suspected a Wirsung's fistula, confirmed by MRI and treated by sphynterectomy, ineffective stenting and distal pancreasectomy. In conclusion, pancreatic fistulae and subsequent pancreatic ascites are a rare, but possible complications of acute pancreatitis, even focal.

## Ischemic hepatitis: a case report

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**Background and aim** Ischemic hepatitis is due to an acute circulatory failure of the liver which is underdiagnosed and may be lethal. The diagnosis is usually made by the laboratory finding of high aminotransferase and lactate dehydrogenase values.
**Case report** RS, male, 80 years old, underwent transvesical prostatectomy and, on the following day, second surgery to stop the bleeding. After two days, because of the onset of jaundice the patient was admitted to our division. On admittance, laboratory tests showed the following: WBC 26200, Hb 7.0, Ht 21%, creatinine 3.6, CRP 92, fibrinogen 459, AST 40, ALT 7, total bilirubin 4.4, ALP 264 UI/L, LDH 422 UI/L, aptoglobin 2.0. During hospitalization, total bilirubin and AST/ALT rose to a peak of 18.4 mg/dl (direct fraction 14.9 mg/dl) and 491/373, respectively. Hepatotropic infections (HAV, HBV, HCV, CMV, EBV, Leptospira) were excluded by serological testing. Autoantibodies against mytochondria, smooth muscle, LKM, nuclei, DNA and ENA were not detectable. A chest X-ray and ECG were normal. Hepatobiliary imaging by ultrasonography, CT-scan and RMN-scan showed resolution of the haematoma in hypogastric region and no sign of hepatobiliary, pancreatic, renal, and splenic lesion; in particular the biliary tract was never enlarged. Bilirubin and aminotransferases levels, remained elevated for 4 months.
**Conclusions** In our opinion this case is of interest because: 1) it is characterized by rare severe hyperbilirubinemia and 2) it allows us to focus on the pathogenesis of the hypoxic hepatopathy.

## Morbo di Still dell'adulto

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Viene ricoverato nel nostro reparto un uomo di 26 anni per iperpiressia e poliartralgie diffuse.Nessuna patologia pregressa, nessuna terapia in atto.In anamnesi: comparsa, da circa 20 giorni, di iperpiressia (fino a 39°C) associata a mialgie e artralgie migranti (ginocchio destro, polso sinistro, spalla destra).Riferita anche faringodinia regredita spontaneamente dopo alcuni giorni.Durante il ricovero comparsa di rush cutaneo evanescente color salmone a livello di entrambi gli avambracci regredi-

to alla scomparsa della febbre.Agli esami ematici: leucocitosi neutrofila spiccata, VES, PCR, fibrinogeno, alfa2-globuline elevate, procalcitonina negativa. Rialzo delle transaminasi e della ferritina.Emocolture seriate, urocoltura, tampone faringeo sono risultati negativi. Radiografia del torace ed ecografia addominale negative (non ascessi, non adenomegalie sospette). Ecocardio negativo per presenza di vegetazioni. Ecografia articolare negativa. Sierologia per CMV, EBV, Parvovirus B19, HCV, HBV e HIV negativa. ANA, anti-citrullina, fattore reumatoide, frazioni del complemento nella norma.Il Morbo di Still dell'adulto è una patologia infiammatoria caratterizzata da febbre, artrite e rush cutaneo evanescente. Il quadro clinico, la negatività delle ricerche sierologiche e il quadro laboratoristico consentiva la diagnosi di Morbo di Still dell'adulto secondo i criteri di Yamaguchi.Dopo iniziale trattamento con FANS abbiamo iniziato trattamento steroideo (0.5 mg/Kg/die) con scomparsa della febbre, risoluzione delle artralgie e progressiva riduzione degli indici di flogosi.

## Emorragia maggiore da rottura di aneurisma dell'arteria splenica

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Un uomo di 73 anni viene ricoverato per la comparsa di dolore in fossa iliaca sx e stipsi. In anamnesi: FA permanente in TAO, IRC. Tra gli esami: leucocitosi (15000/mm3),anemia normocitica (Hb 11.5),elevati valori di INR (4.64). Una ecografia addominale urgente evidenzia: diverticolosi del sigma con peridiverticolite e versamento nello scavo pelvico in sede paramediana sin.Agli esami di controllo (eseguiti dopo 12 ore):anemizzazione significativa (Hb 7 g/dl) e peggioramento degli indici di ritenzione azotata.Nel sospetto di emorragia addominale abbiamo ricoagulato il paziente (vitamina K ev e PCC 30 U/Kg) ed eseguito una TAC addominale che ha evidenziato un esteso ematoma retroperitoneale con effetto compressivo sull'uretere sx e presenza di aneurisma dell'arteria splenica (55x50 mm). Sottoposto ad angiografia addominale: aneurisma dell'arteria splenica trombizzato in assenza di segni di sanguinamento attivo.Il paziente,veniva sottoposto ad intervento di splenectomia e pancreasectomia parziale con legatura dell'arteria splenica.Gli aneurismi dell'arteria splenica sono i più comuni aneurismi delle arterie viscerali.La maggior parte decorrono in maniera asintomatica.Possono essere legati a fattori congeniti o acquisiti (aterosclerosi). Sono più frequenti nelle donne, specialmente nel III trimestre di gravidanza.Il caso clinico descritto ribadisce che il dolore addominale, in special modo in un paziente anticoagulato, deve sempre implicare da parte del clinico, una maggiore attenzione nell'escludere una genesi emorragica perché la tempestività d'intervento è spesso determinante.

## Trombocitopenia immune farmaco-indotta

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Paziente di 86 anni ricoverata per ictus ischemico acuto con emiplegia destra ed afasia in fibrillazione atriale cronica in ASA Veniva contestualmente riscontrato addensamento polmonare (probabile polmonite ab ingestis) ed iniziata, per tale motivo, antibioticoterapia ad ampio spettro con ampicillina/sulbactam e metronidazolo. Iniziava inoltre profilassi antitrombotica con enoxaparina a dosaggio profilattico. Dopo 5 giorni, emergeva piastrinopenia significativa all'emocromo (PLT: 72000/mm3, valori basali: 162000/mm3) in assenza di segni clinici e laboratoristici di emorragia, di sepsi e di coagulopatia da consumo. Nel sospetto di HIT (heparin induced thrombocytopenia) veniva sospesa la terapia con enoxaparina e sostituita con fondaparinux a dosaggio profilattico. Il dosaggio degli anticorpi antiPF4 è risultato negativo. Nel sospetto di DIT (drug induced thrombocytopenia) veniva sospesa anche ampicillina e veniva monitorato l'esame emocromocitometrico. Si assisteva ad un progressivo recupero dei valori piastrinici con rientro ai valori basali dopo 6 giorni dalla sospensione. La trombocitopenia immune farmaco-indotta è molto spesso associata a FANS, anticonvulsivanti ed antibiotici (cotrimossazolo, penicilline). La sospensione del farmaco potenzialmente responsabile comporta la risoluzione della piastrinopenia entro una settimana. La terapia con corticosteroidi non si è dimostrata efficace per il trattamento.

## Microvascular involvement in chronic inflammatory bowel diseases: in-vivo study by means of nailfold videocapillaroscopy

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**Background & Aim of the study** Nailfold videocapillaroscopy (VCP) is nowadays worldwide considered as one of the best non-invasive diagnostic imaging technique for microcirculation. Use of VCP is more and more increasing in rheumatic diseases but it has been showed valuable in many extra-rheumatic disorders. Dysfunctional microcirculatory mechanisms have been postulated in chronic inflammatory bowel disease (IBD). Aim of the present study was to evaluate the presence of microvascular involvement in such patients by means of nailfold VCP.
**Materials & Methods** 33 patients (F: 18, M : 31; mean age: 48 ± 14.5 years; ulcerative cholitis 21 cases, Crohn's disease 8 cases, undifferentiated cholitis 4 cases) and 24 pair-matched controls were enrolled. VCP was performed with a digital PAL-color probe (200x) and dedicated software (Videocap, DS Medica, Milan). Two main data expressing neoangionesis phenomena: increase of the vascular loop diameter (capillary ansae > 25 µ) and tortuosity of capillary vessels in relationship to the ansae total number.
**Results** A significant increase of the vascular loop diameter ($p < 0.01$) and tortuosity ($p < 0.01$) was found in patients with chronic IBD in comparison with control subjects. Considering the same parameters, no difference was observed into the comparison of Chron's disease vs ulcerative cholitis patients.
**Conclusions** Our results suggest a relevant pathologic microvascular involvement in chronic IBD and confirm the usefulness of nailfold VCP into the study of microcirculation in other extra-rheumatic fields of Internal Medicine.

## ✪ Type-3 autoimmune polyendocrine syndrome: two case reports

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**Background** Autoimmune Polyendocrine Syndrome (APS) are rare diseases, classified in four types: APS-1 (hypoparathyroidism + Addison's disease + chronic candidiasis), APS-2 (Addison's disease + autoimmune thyroid diseases and/or type-1 diabetes mellitus), APS-3 (autoimmune thyroid diseases + other autoimmune diseases excluding Addison's disease and/or hypoparathyroidism), APS-4 (combination not included in the previous groups).
**Case Report** Patient 1: a 30 years-old female was admitted because of ketoacidotic coma. 3 years before, insulin-dependent diabetes was discovered; more recently, autoimmune thyroiditis was diagnosed and treated with tapazole. During hospitalization, laboratory data showed a low level of platelet count with high positivity of antiplatelet antibodies.

Association of autoimmune thyroiditis + type-1 diabetes + autoimmune piastrinopenia allows to APS-3 diagnosis. Patient 2: a 72 years-old female was admitted because of fever. Diagnosis of miastenia gravis was made 7 months before; fever and neck pain were observed 2 months before. Post-thyroiditic hypothyroidism and atrophic fundic gastritis with macrocitic anemia were diagnosed during the hospital stay. The association of all these autoimmune pathologies allows to a definite diagnosis of APS-3.
**Conclusions** APS should be considered in presence of any autoimmune endocrinopathy as a timely identification of these different combinations of autoimmune diseases in the potential or subclinical phase allows to a more efficacious treatment.

### Unusual distant metastasis of hepatocellular carcinoma: case report

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**Background** Metastases from hepatocellular carcinoma (HCC) are primarily intrahepatic; extrahepatic metastases are more rare (prevalence: nearly 15%) and poorly understood with many reports from autopsy cases. Main sites of extrahepatic spreading are lung (45%), lymph nodes (45%), bone (35%). Adrenal gland metastases are more rare, accounting for the 10-12% of all extrahepatic localization.
**Case Report** A 60 years-old male was admitted because of vomitus, anorexia and abdominal pain. Anamnesis revealed alcohol abuse and previous diagnosis of liver chronic disease. Clinical features and lab-data were consistent with a not-compensated liver cirrhosis; alfafetoprotein was 390 U/l and EGDS showed F2-esophageal varices. Contrast-enhanced CT-scan demonstrated: ascites; multiple hyper-vascularised nodules within the liver; portal vein and side-branches thrombosis with arterio-portal fistulas; multiple celiac and lumbo-aortic lymph-nodes; bilateral adrenal gland solid nodules with contrastographic behaviour equivalent to that of the intrahepatic lesions. Liver FNAB showed the presence of HCC. Due to the diffusion of the disease and poor general condition no specific therapy was carried out. Four months later, the patient experienced an episode of massive gastrointestinal bleeding and died.
**Conclusions** Adrenal glands may be site of HCC metastases. The prognosis of these patients is dismal. Specific treatment should be considered only for selected patient who have good hepatic reserve and are free of portal venous invasion.

### ✪ Applicability and effectiveness of non invasive ventilation in a medical ward without critical care area: an observational study

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**Background** NonInvasive Ventilation (NIV) reached an important role in treatment of Acute Respiratory Failure (ARF): it improves clinical and gasanalytic features, reduces intubation (ETI) and mortality. First data on NIV come from Intensive Care Units and Emergency Departments. However, use of NIV in medical wards is largely incomplete.
AIM Observational study to verify applicability - effectiveness of NIV in a medical ward without critical care area.
**Methods** 73 consecutive Pts with Hypoxemic or Hypercapnic ARF in 6 month: 22Pts (30%) Acute Cardiogenic Pulmonary Edema (ACPE), 36Pts (49%) acute exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD), 10Pts (14%) Pneumonia, 5Pts (7%) Acute Respiratory Distress Syndrome (ARDS). Baseline (mean): respiratory rate 36min, Kelly score 2.77, arterial blood pH 7.22, PaCO2 70mmHg, PaO2 49 mmHg. ACPEPts received CPAP (Continuous Positive Airway Pressure). COPDPts Pressure Support Ventilation (PSV+PEEP), Pneumonia and ARDSPts CPAP or PSV+PEEP.
**Results** 15Pts (20.5%) met the primary endpoint: failure of NIV. 1 Pts needed ETI (6 BPCO, 3Pneumonia, 5ARDS, 0ACPE), 1Pt (Pneumonia) died. Median duration of treatment: 16:06 hrs. Mean hospitalisation: 8.66 days.
**Discussion** Global failure rate of NIV in ARF is similar to those reported in literature. Aetiology remains the most important factor determining prognosis: ARF due to AECOPD and ACPE shows a better outcome. Hypoxemic ARF related to ARDS and pneumonia a worst one. NIV is feasible, safe and effective in a general medical ward. This should encourage the diffusion of NIV in this setting.

### Sepsis and meningoencephalitis due to listeria monocytogenes in patients with liver cirrhosis: case of non-hepatic encephalopathy?

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**Introduction** The appearance of neurological disorders in a patient with liver cirrhosis suggests first hepatic encephalopathy, but other causes should be considered, including bacterial infections.
**Methods** A 80 year old woman suffering from HCV-related cirrhosis was admitted for fever, confusion, stupor. Treatment with cephalosporins, lactulose and fluids did not lead to improvements.
**Results** Listeria monocytogenes was isolated from blood cultures. A lumbar puncture confirmed the infection. Antibiotic therapy was changed with the introduction of ampicillin. Bacterial infections are more common and more aggressive in patients with liver cirrhosis probably for immune dysfunction.
**Discussion** The presence of neurological disorders in a patient with liver cirrhosis may be caused not only by hepatic encephalopathy but also by other causes, including bacterial infections. In this case it is possible that the localization of listeria to central nervous system, a more aggressive infection in these patients, was responsible for the syntoms.

### Boussignac CPAP for acute hypoxemic respiratory failure

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**Background** Acute hypoxemic respiratory failure (hypoxemic ARF) may be treated with the early application of a continuous positive airway pressure (CPAP) with a facial mask: thanks to its hemodynamic and ventilatory effects CPAP improves clinical and gasanalytic parameters and may decrease intubation and mortality. Boussignac CPAP is a simple lightweight disposable device useful for a "first line" treatment of ARF even in medical wards.
**Aim** To verify the effectiveness of Bousignac CPAP in hypoxemic ARF

due to Acute Cardiogenic Pulmonary Edema (ACPE) and severe Pneumonia in a general medical ward
**Methods** We enrolled 40 Pts with hypoxemic ARF: 20 Pts with ACPE and 20 Pts with Pneumonia. We excluded Pts with potential Acute Respiratory Distress Syndrome (ARDS) because of their worst outcome with non invasive ventilation. Pts received conventional medical treatment and Buossignac CPAP with a mean positive pressure of 9 cm H2O and a mean FiO2 of 68%.
**Results** All 20 Pts with ACPE improve in clinical and gasanalytic parameters since the first minutes of treatment ($p<0.05$ vs baseline), resolved ARF and then stopped CPAP. 6 Pts with pneumonia (33%) did not improve in respiratory failure so they required intubation and mechanical ventilation (intensive care unit).
**Discussion** Failure rate of Buossignac CPAP treatment in acute hypoxemic ARF due to ACPE and Pneumonia is similar to those reported in literature with other CPAP devices (Venturi-like flow generator, ventilators). This simple disposable device is effectiveness and safe even in a general medical ward

## Il paziente anziano, fragile, pluripatologico: teoria o realtà?

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L'incremento dell'età media aumenta le malattie croniche e coesistenza nello stesso paziente di più patologie. Si descrive il caso di una donna di 74 anni affetta da Diabete M., Coxartrosi, Polineuropatia, Stenosi del canale midollare. Ricoverata per Shock in Urosepsi, migliorava con antibiotico, emotrasfusione, enoxaparina. In seguito secrezioni uretrali e vaginali purulente, sopore, ipotensione, DIC trattata con meropenem, dopamina, idratazione, plasma in CVC. Visita Ginecologica senza anomalie; si evidenziava TVP arto inferiore dx. Per persistenza di secrezioni vaginali Tac Addome con ascesso paravaginale sinistro: 2 infruttuosi tentativi di drenaggio chirurgico; la lesione si individuava all'ecografia nel sottocute e regione sottopubica sin. e veniva drenata. Esclusa fistola vescicovaginale; successiva stabilizzazione clinica. Nuovo episodio di ipotensione, anemizzazione, occlusione intestinale trattati con supporto emodinamico, trasfusionale, nutrizione parenterale totale con miglioramento. Colonscopia con detensione del colon disteso e riscontro di pseudomembrane coliche (Infezione da Clostridium o da ischemia). All'Angiotac addome colite ischemica da ateromasia diffusa dell'albero vascolare addominale, stenosi dell'arteria mesenterica inferiore e distensione retto-sigma, colon discendente, trasverso e livelli idroaerei. Al controllo endoscopico peggioramento delle pseudomembrane ed ulcerazione della mucosa in 30 cm di intestino esplorato. Per le condizioni e l'elevato rischio anestesiologico, si soprassedeva ad emicolectomia: dimissione dopo 92 giorni di ricovero.

## ✪ TORS for OSAS in hypertensive patients

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**Introduction** It has been long confirmed the association between OSAS (Obstructive Sleep Apnea Syndrome) and the increased cardiovascular risk in hypertensive patients.
**The aim of the study** To reduce blood pressure and sleep apnea in hypertensive patients undergoing robotic surgery using TORS (Trans Oral Robotic Surgery) with Da Vinci robots, compared to a control group treated with C-PAP (Continuous Positive Airway Pressure).
**Materials and methods** We enrolled 26 hypertensive patients (14 M, 12 F, mean age 55 years) with Mean Arterial Pressure (MAP) 133 mmHg. In these patients we performed 24-hour monitoring of arterial pressure (ABPM), and OSAS was evaluated by means of polysomnography, with defined episodes of apnea > 25 . Patients underwent a TORS resection of the lingual tonsil, septoplasty and tonsillectomy. A comparison was made by considering 24 patients with similar demographic and clinical characteristics, but who were treated with C-PAP.
**Results** After 6 months, in the TORS group we achieved a reduction of MAP to 106 mmHg, and a reduction in sleep apnea < 10 recorded polysomnography episodes. In the group with C-PAP the final MAP was 118 mmHg and apneas were reduced to a number of episodes between 15 and 20.
**Conclusions** The TORS, although an invasive surgical technique, is however highly specific and aesthetically better, and it showed a more relevant reduction in apnea episodes and blood pressure compared to the use of the helmet of C-PAP. TORS was also more accepted from the point of view of the psychological discomfort.

## Changing the clinical practice, a new challenge for prophylaxis of venous thromboembolism (VTE) for hospitalized nonsurgical patients : reality or science fiction?

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**Background** Most hospitalized medical patients have at least 1 risk factor for VTE. 5% to 10% of all in-hospital deaths are direct result of VTE. Evidence does not support routine VTE prophylaxis in all medical patients, but assessment of VTE and bleeding risk should always be done, according to individual factors.
**Methods** In July 2011, after a literature revision, we predisposed a order set ad hoc to evaluate the patient at time of charge for TEV risk (4 risk group) and bleeding risk. In a plenary meeting the program was presented at the medical team.
In this observational study, started on 3 August, we evaluated the routinely use of a order set in the 3 sections of our Internal Medicine Unit. In the order set, we also suggested the possible therapy for TEV prophylaxis (heparin, fondaparinux, mechanical device) with the specific controindications.
**Results** From august to dicember 2011, we identified 674 acutely-ill medical inpatients in the 3 sections. 328 (49%) order set were completed, F: M 160/168, mean age 68 ±17; 48 patients (14%) took correctly INR targeted warfarin at admission.
We observed 6% with a low TEV risk, 21% intermediate risk, 36% high and 37% very high risk (according to choosen risk stratification)
Heparin therapy was not prescribed in 17 % because of absolute o relative contraindication.
**Conclusions** These data highlight the low rates of appropriate use of thromboprophylaxis order set. More effort is required to improve the use of appropriate thromboprophylaxis in agreement with the on-going literature recommendations.

## Caveats on essential hypertension

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Secondary hypertension is often an easy-to perform diagnosis but in some case sit entails some pitfalls that may result in a missed or delayed diagnosis. We present the case of a 60 years old male outpatient

that presented to our service with hypertension. No relevant illness was present in his past history. The features of the hypertension resembled those of an essential one but after a two months follow up he appeared to be resistant to a three line drug therapy and the patient developed hypokaliemia. The patient underwent an abdomen CT scan that was negative except a very slight enlargement of right surrenal gland. Laboratory findings were able to identify a secondary hyperaldosetronism. This case suggests the need to a careful follow-up even in those patients in which hypertension seems to be typically essential.

## An unusual diagnostic challenge

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**Background and aim of the study** A 80 years old Sicilian man was admitted to our department suffering evening-fever since one month, weight loss (8 kg in three months),abdominal pain and asthenia.
**Materials and methods** Our diagnostic work-up for fever of unknown origin was carried out: blood and urinary culture, parasitological stool examination, autoimmunity serology, Widal-Wright reaction and Rickettsia serology gave negative results; QuantiFERON assay was positive while purified protein derivative(PPD), urinary, faecal, sputum BK search and lung CT scan were negative; fecal occult blood was positive in three samples and abdominal CT scan showed scattered parietal thickening of terminal ileal loops. Suspecting Chron's disease the patient underwent colonscopy which showed cobbled stone areas and ulcerations in the terminal ileum; histology revealed marked inflammation with erosive and non-necrotizing giant cells granulomas, suppurating locally, some cryptic abscess with negative Ziehl-Neelsen stain.
He was therefore prescribed steroids with clinical benefit, was then discharged and came back to Sicily.
**Results** Two months later he was hospitalized again in Palermo for abdominal pain and subsequently died because of bowel perforation in intestinal tuberculosis disease.
**Conclusions** Differentiating intestinal tuberculosis from Crohn's disease can be a diagnostic challenge and the morbidity or mortality resulting from a delayed diagnosis or misdiagnosis is considerably high.

## DIC: the unexpected fatal enemy

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**Background and aim of the study** Intravascular disseminated coagulation (DIC) is a gloomy and dreadful complication of severe diseases: albeit rare, it is always almost fatal,especially if cancer related.
**Materials and methods** A 54 years old woman was admitted to our department for confusion and distal weakness of the superior right limb without meningeal signs.She had a history of hypertension and breast cancer with bone and liver metastases.A brain CT scan was negative for hemorrage:she started ASA and LMWH to prevent thromboembolic disease.On the next day the weakness worsened and bilateral reduced visual acuity occurred:a new brain CT scan revealed focal hemorrages in the frontoparietal lobes:LMWH and ASA were discontinued.Myoclonus, aphasia, dysphagia and stupor appeared next: echocardiogram ruled out endocarditis emboli and lumbar puncture was negative. A brain NMR showed a mixture of widespread sbacute ischemic lesions and microhemorrages in the microcirculation. Differential diagnosis among hepatic insufficiency, thrombotic microangiopathy, antiphospholipid antibody syndrome and DIC was made.
**Results** Blood tests showed thrombocytopenia,decrease fibrinogen and antithrombin III;PT and aPTT elongation,D-dimer,transaminase,alcaline phosphatase,gGT,LDH increase with normal cholinesterase.LAC positivity,Coombs test negative.Peripheral blood smear revealed immature elements and schizocytes.The International Society of Thrombosis and Haemostasis scoring system for DIC was very high.
**Conclusions** The peculiarity of our case is in the atypical DIC manifestation,in the brain only.

## A peculiar case of acute onset interstitial pneumonitis in patient with spondyloarthropathy

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**Case** A 56 years old women with spondyloarthritis HLA-B27 positive, was referred to our Unit for cough, dyspnoea, sweating, fever. Despite antibiotics, she deteriorated and became increasingly breathless. One month before she had been started Methotrexate (MTX) and metilprednisolone for exacerbation of spondyloarthropathy.
Patient was initially treated with antibiotic without clinical improvement; MTX was stopped. A high resolution computed tomography (HRCT) showed bilateral ground-glass opacity lung, thickening of interlobular septa, mediastinal lymphadenopathies. Blood cultures were negative, all serological tests were negative. A bronchoscopy showed hyperemic mucosa without any other macroscopic alteration. Bronchoalveolar lavage (BAL) was performed: the BAL examinations showed: 55% macrophages, 25% lymphocytes; BAL cultural and cytological examination were negative. Based on negativity of microbiological tests, Methyl-prednisolone was prescribed. With significant and rapid clinical improvement and fever remission. Steroid therapy was progressively tapered with continuous and persistent improvement of clinical conditions. After 15 days a HRCT confirmed a complete resolution of ground-glass areas.
**Conclusion** Respiratory complications can occur in the connective tissue diseases. MTX is a drug used in rheumatic diseases; severe side-effects of MTX (hematologic, hepatic, pulmonary) are described. In this patient a definite diagnosis of hypersensitivity pneumonitis related to low dose of MTX could be made according previous published criteria (Searles-McKendry Criteria).

## Arterial hypertension control in elderly men

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**Aim** Aim of this study was to evaluate the efficacy of anti-hypertensive therapy in elderly men.
**Methods** Data of 165 patients with arterial hypertension (males, mean age 60.5 years) were retrospectively reviewed. Age, systolic/diastolic pressure at last control, number of anti-hypertensive medications were analyzed. Patients were divided in group A and B according to age: group A (n=90) with age£65 years (mean: 50 years), group B (n=75) with age>65 years (mean: 73.2 years). According to guidelines, diagnosis of hypertension was defined the arterial pressure >140/90mmHg. Arterial hypertension was considered controlled in case of arterial pressure £140/90mmHg during anti-hypertensive therapy.
**Results** In group A 22 patients have a good pressure control (22/90;24.4%) compare to 16 patients in group B (16/75;21.3%). Mean pressure value in good controlled patients was respectively

126/82mmHg and 127/74mmHg in group A and B. Mean pressure value in not controlled patients was respectively 149/92mmHg and 153/87mmHg in group A and B. In group A 18/68 (26.4%) patients not controlled have high systolic pressure compare to 26/59 (44%) in group B. The number of anti-hypertensive drugs ranges from 1 to 3 in group A (mean 1.54) and from 1 to 4 in group B (mean 2.37).
**Conclusion** In our experience, the control of hypertension was similarly obtained in the 2 groups; the number of drugs necessary to obtain a good control of hypertension resulted higher in elderly than in younger men. In elderly men the systolic isolated hypertension is more frequent and difficult to control compare to younger men.

### ✪ Treatment of hepatocellular carcinoma in elderly patients with liver cirrhosis

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**Aim** Aim of this study was the analysis of therapeutic approach and efficacy of treatment in elderly patients (>70years) with diagnosis of hepatocellular carcinoma (HCC) in cirrhosis.
**Methods** Data of 166 cirrhotics with HCC were analyzed: the population was divided in 2 groups: group A (n=88) including patients with age <70years, group B (n=78) including patients with age >70years. All HCCs were treated: the characteristics of treatment, survival, disease-free survival (DFS) were analyzed. The Charlson Index (a comorbility index) was calculated for all patients.
**Results** Patients of Group A were treated with curative treatment (transplantation, resection, percutaneous treatments) (n=41), trans-arterial chemoembolization (TACE) (n=29), non-curative treatments (n=9), symptomatic support (n=9); patients of group B were treated with curative treatment (n=32), TACE (n=24), non-curative treatments (n=6), symptomatic support (n=16). The mean DFS for curative treatments was 24.5 months and 12 months respectively in group A and B (p 0.08); the mean DFS for TACE was 9 months and 12 months respectively in group A and B (p 0.913). The Charlson index influences the DFS at monovariate analysis (p 0.004). The survival was similar in the 2 groups; Charlson index and HCC stage influence the survival considering curative treatment/TACE and overall survival.
**Conclusion** Data show not significant differences in DFS and overall survival of elderly with treated HCC. The presence of comorbility influences the prognosis, in particular in elderly, as confirmed by results about Charlson index.

### Unusual decrease of DLCO in diffuse alveolar haemorrhage (DAH)

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**Clinical case** A 25 year-old male smoking patient complains of haemoptysis after exertion. His chest X-ray shows multiple lung opacities with interstitial pattern, the CT scan bilateral ground glass areas. Spirometry is unremarkable with a mild decrease of DLCO. He has mild normocitic anemia, microscopic hematuria and a negative ANCA test. Bronchoscopy shows no alterations of the airways, while BAL retrieves a total increased number of cells with an increased ratio of neutrocytes. No blood or hemosiderin containing macrophages are retrieved. A diagnosis of DAH in an ANCA-negative nephro-pulmonary syndrome is suspected and the patient is referred to the nearest centre for vasculitis. A renal biopsy is suggestive for Goodpasture Syndrome, as are the high title positive anti glomerular basal membrane antibodies.
Despite the therapy with high doses of 6-MPS, CFX, ev Ig and plasmapheresis, the patient conditions deteriorate, developing rapidly progressive renal failure and severe respiratory failure; three months after the first evaluation exitus occurs.
**Conclusions** In this case of DAH, DLCO was reduced instead than increased as usually described. The available data could be impaired by the rarity of the disease and the challenge of executing a DLCO test in an acutely ill patient; For this reason they may not describe all the clinical phases of DAH, or the different functional state of Hb molecules in the lung tissue at different time since the occurrence of alveolar haemorrhage.

### An atypical presentation and diagnosis of giant cell arteritis (GCA)

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**Case-report** A 71 year-old patient is admitted for a month-lasting fever associated with no other symptoms than nocturnal diaphoresis, unmodified by antibiotic therapy. He has a history of hypertension, aortic valve insufficiency, diverticuli of sigma, renal cysts, bowel resection for a GIST in 2008 and endoscopic resection of adenomatous colonic polyps. The physical examination on admission is unremarkable.
Suspecting an infectious or neoplastic disease, a cardiac US scan, a chest and abdomen CT scan as well as an abdominal US and NMR scans are performed; no significant anomalies are found. The blood analysis is negative for infective disease, while ESR, CRP, AP and ferritin are elevated with inflammatory anemia and hypergammaglobulinemia.
A PET/CT scan is suggestive of vasculitis involving the aorta and the carotid, subclavian, iliac and femoral arteries.
The patient is then referred to the nearest centre for vasculitidis where a GCA is diagnosed and therapy with steroids and MTX is started. Aspirin is also added for chest pain and a cardiac NMR shows inflammation of the thoracic aorta and the left subclavian artery; ten minutes after the exam an AMI occurs, and coronaric PCI is required in addition to high dose steroids. To date the patient is in good conditions and his therapy is based on MTX and steroids.
**Conclusion** In this case report an early diagnosis of vasculitis was established before the occurrence of vascular symptoms, with the aid of a not established imaging system, the PET/CT scan. However a major complication occurred regardless of the therapy.

### Effetti clinici di un campo elettrostatico pulsato sul piede diabetico con lesione ischemica critica

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**Premesse e scopo dello studio** Nel diabete mellito tipo II (DM2) la microangiopatia, in aggiunta alla macroangiopatia, riduce l' ossigenazione, la nutrizione, la protezione, l'effetto di farmaci (es. antibiotici) ed influisce sulla comparsa e l'evoluzione di lesioni vascolari. Col fine di migliorare la perfusione tissutale periferica abbiamo sperimentato

una nuova tecnica, non farmacologica, in grado di agire sul microcircolo (vasomotion) e sulla attrazione fra globuli rossi.
**Materiali e Metodi** I gruppi trattati sono soggetti sani (A), nefropatici (IRC) emodializzati (B), IRC con DM2 emodializzati (C) e tre IRC diabetici (D) di cui due in emodialisi ed uno in terapia conservativa. Il gruppo D presentava ulcere ischemiche refrattarie. Tutti sono stati trattati con 13 sedute di campo elettrostatico pulsato (PESF).
**Risultati** Gli effetti sulla performance del microcircolo sono stati valutati mediante miglioramento della %SpO2, valutazione della riduzione del dolore e della eventuale variazione del peso corporeo. Nel gruppo D gli effetti sulle ulcere sono stati documentati con immagini fotografiche.
**Conclusioni** Nel DM2 le ulcere al piede o pretibiali, ancorché refrattarie, esprimono grave compromissione del macro e del microcircolo. Il controllo nutrizionale, ancorché benefico, pone dubbi sull'aumento della mortalità totale correlata alla malattia cardiovascolare e all'elevato rischio di grave ipoglicemia. La PESF è una tecnica semplice, non invasiva, non pericolosa, in grado di produrre in tempi brevi risultati positivi clinicamente e funzionalmente documentabili.

## Effetti di un campo elettrostatico pulsato sull'emostasi in pazienti intolleranti al glucosio: valutazione dei recettori piastrinici

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**Premesse e scopo dello studio** Il diabete mellito tipo II (DM2) è una patologia che più di altre si associa a differenti implicazioni micro e macrovascolari. Nel DM2 vi è una alterata caratteristica che è quella per cui gli eritrociti tendono ad unirsi formando pili o rouleaux. All'origine del fenomeno di attrazione fra cellule non sono presumibilmente estranee cariche elettriche presenti sulla superficie delle membrane. Modificate cariche elettriche superficiali potrebbero essere all'origine della sensibilità della funzione piastrinica, già predisposta nei malati con DM, in senso pro-trombotico mediante espressione patologica dei recettori di superficie. Pertanto abbiamo valutato gli effetti di un campo elettrostatico pulsato (PESF) sulla funzione delle piastrine in un gruppo di individui con intolleranza al glucosio.
**Materiali e Metodi** Abbiamo selezionato 7 individui obesi intolleranti al glucosio ed ognuno di loro è stato sottoposto, prima e dopo esposizione ad un ciclo di 13 sedute di PESF, ad esame di aggregazione piastrinica (ADP ed Epinefrina), tipizzazione dei recettori piastrinici di superficie CD41a e CD42b, adesività piastrinica e piastrine reticolate.
**Risultati** Dopo PESF l'aggregazione piastrinica, la espressione dei recettori piastrinici di superficie CD41a e CD42b e l'adesività piastrinica risultano favorevolmente modificate in modo statistico.
**Conclusioni** Il sistema PESF è una tecnica non farmacologica, non invasiva, ripetibile in grado di influire su alcune alterazioni dell'emostasi tipiche del DM2.

## Una diagnosi complicata di iperpiressia

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Pz AL ricoverato per iperpiressia in assenza di altra sintomatologia. In APR: diabete mellito tipo 2, ipertensione arteriosa, pz vasculopatico, in attesa di eseguire intervento di protesi anca dx. Dagli esami ematochimici: aumento PCR. Ecografia addome, rx torace, TAC torace-addome, colturali:negativi.
Iniziava terapia antibiotica a largo spettro,con persistenza dell'iperpiressia. Nel sospetto di coxartrite l'ortopedico consigliava ecografia cutanea che evidenziava versamento, e programmata artrocentesi evacuativa.In sede di intervento non evidenziava alcun versamento e decideva di eseguire intervento di protesi d'anca dx. Nei giorni successivi per persistenza dell'iperpiressia eseguiva TAC anca dx con raccolta ascessuale in sede periprotesica. Dagli esami colturali eseguiti in sede di intervento presenza di Corybacterium striatum. Iniziava terapia antibiotica mirata su antibiogramma, con completa apiressia.
**Riflessioni** 1) escluse le più frequenti cause di iperpiressia pensare ad un'artrite settica in presenza di sintomatologia dolorosa localizzata 2) nel sospetto clinico di artrite settica e/o osteomielite posticipare l'intervento protesico.

## Fascite necrotizzante: un approccio multidisciplinare ad un caso difficile

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Paziente ricoverata per iperpiressia con tumefazione ed iperemia in sede inguinale sx insorta dopo trauma contusivo dell'anca sx. Rx bacino:neg. ecografia muscolare:in regione inguino-crurale sx edema del tessuto adiposo sottocutaneo con presenza di bolle gassose. Persistenza di febbre con grave scadimento delle condizioni generali ed aumento degli indici infiammatori.
All'E.O. edema duro dolente localizzato della radice della coscia sx, con iperemia e crepitii alla palpazione. Nel sospetto di fascite necrotizzante iniziava terapia antibiotica senza beneficio. La TAC della coscia sx confermava la presenza di aria libera sottocutanea e sottofasciale.
L'ortopedico poneva indicazioni alla fasciotomia evacuativa che veniva però eseguita dal chirurgo.
Nei giorni successivi il chirurgo notava fuoriuscita di materiale fecale dalla ferita per cui richiedeva la TAC addome cmdc che evidenziava raccolta fluida con coefficienti gassosi in stretta adiacenza ad un'ernia, il chirurgo concludeva per ernia crurale sx strozzata e perforata per cui veniva sottoposta ad intervento di resezione parziale dell'intestino tenue.
Nei giorni successivi miglioramento clinico.La paziente veniva dimessa dopo circa 30 giorni con guarigione totale.
**Conclusioni** La particolarità di questo caso clinico è che la fascite non era post-traumatica ma era provocata da un'ernia crurale asintomatica strozzata perforata e successivamente fistolizzata.

## ✪ A case of autoimmune hypoglycemia

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**Background** Insulin autoimmune syndrome (IAS) is a rare condition characterized by hyperinsulinemic hypoglycemia associated with high titer of antibodies to endogenous insulin, in the absence of pathologic abnormalities of the pancreatic islets. IAS is extremely uncommon in Western countries: only three cases were reported in Italy. In 40% of patients IAS is triggered by exposure to medications and it is often associated with rheumatologic diseases.

**Aim** We reported a case of IAS in a woman with persistent hypoglycemia.
**Case Report** A 63-year old woman was admitted to the Emergency Room with a pre-coma: blood tests showed extremely low glucose with high insulin levels. Continuous intravenous glucose infusion was started, which failed to stably normalized blood glucose. While her pituitary and adrenal functions were normal, she was diagnosed with vitiligo and senile-Rheumatoid-Arthritis. Factitious hypoglycemia was excluded because of unsuppressed c-peptide levels and negative blood screening for sulphonilureas. Abdominal-Thoracic CT, Endoscopic ultrasound and PET 68Ga-DOTATOC were negative for pancreatic lesions. Search for anti-insulin antibodies, performed both by Immunoenzimatic assay and RIA, disclosed circulating anti-insulin antibodies. A carbohydrate-controlled hypercaloric diet with six fractionated meal was started together with acarbose, resulting in a good control of blood glucose levels.
**Conclusion** IAS, although rare, must be considered in the differential diagnosis of hypoglycemia.

## Sleep disordered breathing and heart failure. Heart failure and Sleep disordered breathing

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Vi presentiamo il caso di un paziente di 70 anni, giunto alla nostra osservazione per l' insorgenza di dispnea progressivamente ingravescente, che aveva goduto sino a quel momento di buona salute.
E' stato sottoposto ad esami di routine, BNP, Procalcitonina, enzimi miocardio specifici seriati , ECG, ECG secondo Holter, Ecocardiogramma Transtoracico, Rx torace, Saturimetria notturna, Polisonnografia, Eco-stress con test ergometrico, Spirometria e Coronarografia.
E' stato riscontrato uno Scompenso Cardiaco da severa disfunzione sistolica del ventricolo sinistro (FE=32%) in cardiomiopatia dilatativa, versamento pleurico bilaterale maggiore a destra, ipertensione polmonare secondaria PAPs 55mmHg, severo "Sleep disordered breathing" con AHI=65.
Eco stress e Coronarografia risultarono negativi.
In regime di ricovero il paziente è stato sottoposto a ossigenoterapia mediante NIV con miglioramento della sintomatologia e della saturazione.
Esiste in letteratura una documentata relazione tra i disturbi del sonno e lo scompenso cardiaco e per tale motivo c'è indicazione a ricercare in tali pazienti una "Sleep disordered breathing".
Sono principalmente due i meccanismi che spiegherebbero la comparsa di uno scompenso cardiaco da cardiomiopatia dilatativa in pazienti affetti da desaturazioni notturne:
1) l 'alternanza tra tono simpatico e recupero del tono vagale caratteristiche delle OSAS potrebbero indurre nel tempo una disautonomia con perdita dell'effetto trofico dell'innervazione neurovegetativa;
2) le desaturazioni prolungate indurrebbero sofferenza metabolica cronica.

## The activity of the Local Health Unit TO3 in the eyes of the citizen

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**Introduction** The Civic Audit is an empowerment tool offered to citizens and civic organizations to promote quality assessment in health services; it is also a useful planning tool in health.
**Methods** The Civic Audit combines three methodological approaches:
1. civic analysis;
2. participation of citizens in the evaluation of services;
3. procedures of quality.
To evaluate the performance of local health unit (LHU), the following indicators have been identified:
a. importance given by LHU to citizens;
b. how LHU promote social and health policies;
c. the citizens involvement in the policies of LHU.
For each of these indicators, a Standard Adequacy Index (SAI) has been calculated to value the difference between the observed and expected values.
**Results** The LHU TO3 has obtained an overall excellent result. Dividing the indicator (a) by single items, the best results (SAI=87) were on "customizing of care, privacy and patients assistance".
In the (b) indicator, the component with the best result was "Chronic Disease and Oncology" (SAI=100), followed by "Patient Safety" (SAI=96).
Both (c) indicator components "Operation of the Participating Institutes" and "other forms of citizen/health agency participation and interaction" reported the highest score (SAI=100).
**Conclusion** By the information gathered, it was possible in LHU TO3:
to enhance the capacity of civic organizations to liaise with policy decisors;
to bring a real change and, often, at low cost;
to inform citizens on the management of health services provided.

## Pancreatite acuta e malnutrizione: un caso di encefalopatia di Wernicke

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**Premesse e scopo dello studio** La Pancreatite acuta può comportare digiuno prolungato e malnutrizione. Le alterazioni metaboliche (deficit di tiamina) possono causare l'Encefalopatia pancreatica,spesso misconosciuta.
**Materiali e Metodi** Donna di 66 anni in seguito a Pancreatite acuta ha sviluppato malnutrizione per digiuno prolungato, manifestando sopore, afasia, deficit di motilità degli arti ed altre complicanze (pancitopenia, embolia polmonare). RM encefalo:iperintensità dei tubercoli quadrigemini superiori, del grigio periacqueduttale e delle porzioni mediali di ipotalami e talami (Encefalopatia di Wernicke).
TC addome e torace: raccolte fluide peripancreatiche - tromboembolia della arteria polmonare dx, della arteria lobare inferiore omolaterale, della arteria lobare inferiore controlaterale.
Trattata con vit.B1 I.M. 100 mg. al di, acido folico per os, emotrasfusione di GR concentrati. Per l'embolia polmonare:fondaparinux 2,5 mg. 1 fl. s.c.
**Risultati** Il trattamento con tiamina ha comportato la ripresa graduale della motilità, dello stato di coscienza e della parola. Acido folico ed emotrasfusione, la ripresa dell'alimentazione per os hanno migliorato le condizioni generali della paziente. Trattamento con fondaparinux regressione della embolia polmonare.
**Conclusioni** Pancreatite acuta e digiuno prolungato sono associati al rischio, anche in ospedale, di malnutrizione, deficit di tiamina con Encefalopatia di Wernicke e di complicanze (embolia polmonare, anemia). Va effettuata precocemente, nei pazienti a rischio, la profilassi con tiamina e la prevenzione delle complicanze.

## Fattori di rischio per complicanze intraospedaliere e mortalità ad 1 anno nei pazienti anziani con frattura di femore prossimale

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**Introduzione** La gestione del paziente anziano con frattura del femore prossimale (FFP) rappresenta un problema rilevante, la prevalenza è in costante incremento, la popolazione anziana è sempre più fragile per polipatologia sistemica. Inoltre, l'anziano con FFP ha un'elevata mortalità e morbilità post-operatorie, conseguenti alle condizioni cliniche del paziente, all'intervento e al prolungato allettamento.
Lo scopo di questo studio è di valutare l'impatto delle comorbilità e del timing chirurgico sull'occorrenza di complicanze intraospedaliere e della mortalità ad 1 anno dell'anziano con FFP.
**Campione e risultati** Sono stati inclusi nello studio 132 pazienti ultrasessantenni operati di FFP. La presenza di >2 comorbilità era presente nel 45,5%. L'insorgenza di complicanze post-operatorie precoci era del 21% e la mortalità ad 1 anno di follow-up del 22%. La tempistica dell'intervento non incideva sulla mortalità (p=0,826) e sullo sviluppo di complicanze intraospedaliere (p=0,237); mentre le comorbilità preesistenti sono risultate significativamente correlate con l'aumento delle complicanze post-operatorie (p=0,031), le quali determinavano un elevato rischio di mortalità (p=0,0001).
**Conclusioni** L'anziano fragile con FFP ha un impatto sanitario e sociale rilevante con una mortalità del 22% a 1 anno dall'evento. La presenza di multiple comorbilità rappresenta il principale fattore di rischio per lo sviluppo di complicanze intraospedaliere, e quindi per la mortalità post-operatoria. Il timing chirurgico non ha dimostrato effetti sulla morbilità e mortalità intraospedaliere.

## Acute coronary syndrome in Internal Medicine Department

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**Introduction** The BLITZ Study 2 showed that about 30% of patients with acute coronary syndrome (ACS) are not admitted to cardiology and internal medicine division . In the literature there are no studies that have examined what is the impact and outcomes of ACS in internal medicine. We have collected and analyzed the cases of ACS patients in our internal division from 2005 to 2011.
**Case Study** 83 cases of ACS NSTEMI 2% of total admissions with a mean age of 84 ± 12 years. During hospitalization 26 patients died and the 30-day mortality was 14.2% and 25.4% a year. The causes of death were: cardiogenic shock 4 patients , 8 septicemia, 5 respiratory failure, 3 stroke, 6 cancer cachexia. Patients had frequent comorbidity: 53 diabetes, 83 hypertension, 59 renal failure, COPD 42, 21 neoplasms. During the hospitalization therapy was performed as follows: aspirin 68.4%, thienopyridine 12%, LMWH or fondaparinux 67.1%, Beta-blockers 17.8%, calcium antagonists 21.3%, nitrates 93%. A coronarography was performed in 6 cases, and angioplasty (PTCA) in 4. At the time of discharge, the recommended therapy included aspirin 56.8%, tienopirimidine 8%, beta blockers 22.2%, nitrates 91%, calcium antagonists 32%, ACE-inhibitors 53%.
**Conclusions** We believe that the increase of the average age will carried in a progressive increase in cases of ACS NSTEMI in patients with multiple comorbidities, and particularly in so called "frail old people" in terms of clinical and therapeutic management and the internist will be involved more and more in management of this desease.

## A case of thyphoid fever complicated by acute acalculous cholecystitis

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**Premise** Thyphoid fever is a potentially fatal multisystemic illness characterized by sustained fever and abdominal symptoms. Acute acalculous cholecystitis is a rare, however severe complication of typhoid fever which has been reported mainly in children.
In this paper we present a case of typhoid fever complicated by acute acalculous cholecystitis occurring in a middle age woman.
**Clinical case** A 44 year old Indian woman, in good health, who has been living in Italy for about 12 years, was admitted to our ward, after having spent a brief period of time in her native Country a month earlier. At the time of admission she was complaining of fever, abdominal pain, diarrhoea and vomiting; she definitely looked ill, febrile, but conscious; the abdominal examination revealed pain to deep palpation in all quadrants.
Blood tests revealed leukopenia and thrombocytopenia, high values of CRP, procalcitonin and transaminases; total bilirubin resulted normal.
Acute acalculous cholecystitis was detected at the abdominal sonography. Blood cultures resulted positive for Salmonella typhi.
A 15 days course of ciprofloxacin prompted the complete resolution of fever and of any other clinical sign; futhermore the sonographic follow up showed a full recovery of the cholecystitis.
**Conclusion** Acute acalculous cholecystitis has been identified as a complication occurring with many kinds of systemic infections. Acute acalculous cholecystitis is a well known complication of thyphoid fever in children, but, as shown in this paper, even adults may experience it.

## Assessing body changes with both anthropometry and bioelectrical impedence during moderate weight loss

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**Background/objectives** Monitoring changes in total fat mass and abdominal adiposity is with a a simple, inexpensive, noninvasive, and universally applicable technique is important. Our objective was to assess the usefulness of bioelectrical impedance analysis (BIA) in predicting fat mass changes during moderate weight loss compared to anthropometric measurements.
**Subjects/methods** 44 subjects were enrolled, 20 male and 24 female, mean age 55 ± 5years and BMI 32.0 ± 3.0 kg/m2. Fat mass changes were assessed before and after a 12-week weight loss induced by caloric restriction (-30% of requirement) using BIA and anthropometric measures such as waist and hip circumference (cm) and BMI (cm/m2).
**Results** Diet intervention resulted in a significant decrease in body weight (- 8.0 ± 3.0 kg), body mass index (BMI – 3.0 ± 1.0 kg/m2), total body fat (- 5.0 ± 3.0 kg), truncal fat (- 2. 0 ± 1.5 kg) and waist circumference (- 6.0 ± 4.0 cm). Compared to anthropometric measurements, BIA measured a less accurate estimation of total body fat changes in males (- 1.0 kg, p<0.001).
**Conclusions** BIA, Body mass index, body weight, and waist circumfe-

rence provide simple and accurate estimates of relative changes in total and truncal fat during moderate weight loss in adults. BIA estimates of fat mass were lower in men before and after moderate weight loss. The gender discrepancy by BIA may be reflective of difference in the regional distribution of fat in men and women.

## Clinical Governance: a useful tool for the 3rd millennium Internist

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**Scopo** 1year ago we started using a nutrition clinical patient record (CPR). It contains anthropometric measurements, food-religion preferences and malnutrition evaluation through the MUST (Malnutrition Universal Screening Tool), long implemented in England. The MUST focuses patients' malnutrition and monitors it during hospitalization.
**Materiali e Metodi** After 10 months we began an AUDIT process. We used the GIMBE framework (setting priorities, GLAM, FAIAU, DIE). Our process indicator was filling in all parts nutrition CPR from May to September 2011. A multidisciplinary team (1 doctor, 1 nurse, 1 dietician and 1 administrative officer) in our medical and surgical wards (2 Pneumology, 1 ICU, 2 Surgery) was created.
**Risultati** We collected 140 nutrition CPR's: 55% (77 cards) contained weight, height, BMI, only 40% (56) showed waist/ hip, only 30% (42 cards) had MUST compilation, 100% showed patients' dietary/religious preferences. We decided to conduct monthly meetings with single wards; we distributed nutritional CPR's and measuring devices and conducted a Root Cause Analysis (RCA) (5 whys), in order to obtain appropriateness through changing professional behaviors. In next 5 months we will implement this procedure again using the audit cycle. We started a benchmark with 5 Medicine wards of our Region (Campania) which recently started collecting nutritional CPR.
**Conclusioni** Using Clinical Governance (RCA and clinical audit tools), is important in achieving effectiveness and clinical appropriateness, necessary tools for the third millennium internist.

## A therapeutic dilemma with no clinical guidelines: before heart or lung?

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Caucasian man of 66 years is admitted in our Medicine ward for worsening dyspnea and lower limbs oedema. Clinical record: smoking 15 cigarettes/day for 40 years, COPD, mild tricuspid regurgitation and mild aortic stenosis. Physical examination shows murmurs of mitral and aortic foci (3/6), mild hepatomegaly and lower limbs oedema, chest wheezing. Laboratory tests are normal. Routine chest X-ray examination shows lower left lobe retrocardiac nodule, US heart scan shows moderate to severe aortic stenosis with mild regurgitation (V1/V2 0.23), mild tricuspid regurgitation, PAP 35 mmHg, LVEF 42.4%. Chest CT confirms parenchymal nodule with irregular margins in the left lower lobe, total body PET-CT-scan shows area of high metabolic activity at the left posterior basal segment (SUV max 9.83). Additional hypermetabolic lymph nodes in the hilar region (SUV max 3.14) and left peribronchial region (SUV max 6.43). Left lung FNAB examination is positive for malignant cells from non-small cell carcinoma. At this point, how to choose between two alternatives? Before tumor surgical excision and then valve replacement, or vice versa? The Thoracic surgeon recommends surgery after aortic valve replacement. Heart Surgeon decides to perform aortic valve replacement with extracorporeal circulation with a "beating heart technique" using a biological valve. The patient performs a coronary angiography study before aortic valve replacement, later the lung carcinoma excision will be performed.

## Un caso insolito di polmonite da S. Epidermidis in un paziente immunocompetente

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M.M.C., donna di 67 anni, fumatrice, ricoverata per tosse produttiva, dispnea per sforzi lievi, astenia intensa e calo ponderale negli ultimi 2 mesi. Anamnesi positiva per ipertensione arteriosa, non assume alcun farmaco. All'ingresso leucocitosi neutrofila, PCR 19 mg/dl, VES 103, FBG 730 mg/dl. All'Rx torace "multiple lesione escavate dell'emitorace destro prevalenti a carico del LSD, con livelli idroaerei all'interno". La TC torace conferma il reperto, l'ecografia descrive dettagliatamente "un area disomogenea con livelli idroaerei e margini iperecogeni". Dopo esclusione di infezione da BK mediante PCR viene iniziata antibioticoterapia con ampicilllina/tazobactam, metronidazolo, levofloxacina e fluconazolo con scarso giovamento. Viene pertanto effettuata FBS con broncolavaggio che identifica lo Stafilococco Epidermidis come agente eziologico e sulla scorta dell'antibiogramma si instaura antibioticoterapia mirata (teicoplanina, clindamicina,levofloxacina, fluconazolo) con progressivo miglioramento clinico e dei parametri di laboratorio. Vengono inoltre escluse cause di immunocompromissione tra cui malattie ematologiche e infezione da HIV. Un'ecografia di controllo a distanza ha documentato la scomparsa della lesione polmonare.Lo Stafilococco Epidermidis, commensale non patogeno della cute, può rendersi responsabile di infezioni anche gravi legate ad un corpo estraneo (ad esempio catetere venoso centrale) o, in assenza di questo, in pazienti immunocompromessi. La nostra esperienza suggerisce di considerarlo anche nel paziente immunocompetente e soprattutto di raggiungere sempre una diagnosi di natura, in particolare nei quadri clinici più impegnati.

## Evaluation and control of patient care results: Isernia Internal Medicine Project

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**Background and purpose of the study** Medical patients are complex, with chronic diseases at high risk of relapse, with multiple concurrent diseases and at high risk of re-hospitalizations. The key issue is assure to a patient a continuity of care that means : discharge him in stable conditions, and/or set up a course of alternative treatments.
**Materials and methods** The options for continuity of care are:
• scheduled home visits of family physician to bedridden patient (RANKIN = 4-5)
• scheduled visits to our Internal Medicine or Specialist Clinic
• **ADI** (Assistenza Domiciliare Integrata) discharge. Treatment plan is prepared by our staff with nursing instructions (infusions, medications

....) and scheduled general practitioners and internal medicine specialist visits.
• Home rehabilitation. A weekly physiatric access is operative in our ward to provide a rehabilitation home program.
• Day Hospital re-admission of patients in need of further invasive procedures or instrumental monitoring (biopsies, paracentesis, thoracentesis ...).
Alternative choice is to transfer the patient to a:
• Long-term care. The nearest long-term care is 50 km. This requires coordination between family, nurses, and doctors of both departments.
• Rehabilitation department (nearest is 20 Km) for a course of intensive rehabilitative care.
The transfer is by ambulance with our staff.
**Results and conclusions** Indicators are: number of repeated hospital admissions in 2012 compared to 2011, with subanalysis of the observed pathologies.

## ✪ Meningoencephalitis: LES vs Herpes

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**Background and purpose of the study** Meningoencephalitis can be a serious complication in patients with comorbidity and severe immunodepression. Differential diagnosis and therapeutic choises are a challenge for internist who assist this patient.
**Materials and methods** A 40 years-old female was admitted to our department with pneumonia, respiratory failure and diabetic ketoacidosis. Her history was: sickle cell disease, lupus nephritis treated until June 2011 with cyclosporine (1500 mcg/monthly) and steroid (dexamethasone 50mg/day) therapy, DM1 treated with microinfusion device. Clinical course We successfully treated the patient with broad-spectrum antibiotics, antifungal, and steroid therapy with clinical improvement. We reported marked lymphocytopenia, TH CD3/CD4 = 120 cell. At day 12 th: she was symptomatic for vescicular lesions on spine and lumbar region with rapidly evolution on abdomnen and recurrent seizures (morsus no nuchal rigor), apyrexia. EGA: pH=7.25, PCO2=53 mmHg, PO2= 51 mmHg, HCO3=20 mmol, Brain MRI: diffuse meningoencephalitis, Liquor: 110 cell/µl, glucose = 124 mg/dl, protein = 361 g/l, LDH = 310 UI. We started therapy with acyclovir 10 mg/kg and the patient was transferred in Infectious Diseases department.
**Discussion and conclusions** CNS lupus, post herpetic encephalitis (EPS) or other meningoencephalitis (Criptococcal...) should be considered in the differential diagnosis of the present case. In the immunocompromised patients Systemic Lupus Erythematosus can be risk factor for EPS. We, likely, administered the adequate therapy in this patient.

## An unusual case of neurological disorder with ataxia and cognitive impairment

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**Background** Patients with CJD initially can show rapidly progressive cognitive decline, ataxia, visual and functional impairment, behavioral disturbance; myoclonus is a rare initial feature. Brain magnetic resonance imaging (MRI) shows bilateral high signal in the striatum only two thirds of patients and can be normal even in a very symptomatic patient; electroencephalography (EEG) can be nonspecifically. Cerebrospinal fluid (CSF) usually shows an elevated protein level and the recognition of a CSF protein marker makes diagnosis with high accuracy in an reasonable clinical likelihood of CJD.
**Case report** We observed a case of a 74 years old woman with a history of fatigue, weight loss, recent onset memory impairment, some confusion episodes and loss of functional independence. Neurological examination showed symmetric ataxic signs, dysarthria, extrapyramidal rigidity, postural instability and cerebellar gait without involuntary movements. We also observed coordination deficits, language disturbance and neuropsychological alterations with behavioral abnormality. We performed a brain MRI that didn't give any explanation of the disease, meanwhile the EEG showed nonspecific slowing abnormality. In presence of a high clinical suspicion, CSF examination was requested to obtain protein marker to diagnose CJD.
**Conclusions** Although CJD is a rare form of degenerative of central nervous system, an elevated clinical suspicion is essential issue in the evaluation of a patient with rapid deterioration of cognitive function, ataxic signs and appearance of functional dependency.

## New onset cutaneous nodulosis in a patient affected by longstanding rheumatoid arthritis treated with tocilizumab: case report and systematic review of the literature

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**Background** Tocilizumab(TCZ) is a novel anti-IL6 drug licensed for moderate to severe Rheumatoid Arthritis(RA). Few data about effectiveness and safety coming from real-life practice are still available. We report the case of a woman developing subcutaneous nodules while on TCZ therapy from 1y.
**Case description** In Feb 2010 we started TCZ 8mg/Kg/4week in a 45y woman, affected by active, severe(DAS28 6.8), seropositive RA from 1998, who had previously failed corticosteroid, DMARDs, Rituximab and anti-TNFα (etanercept, adalimumab and infliximab) therapies. She reported a noticeable rapid clinical improvement (DAS28 <2.6 as from the fourth infusion). After one year, she began noting parenchymatous, not painful nodules, without inflammatory signs, on the right index finger. In the following months similar lesions appeared around both the olecranons, despite persistent remission of the disease. A clinical diagnosis of rheumatoid nodules was formulated. The histological characterization of one nodule is under way. Literature Review Accelerated rheumatoid nodulosis has been described in RA patients treated with etanercept or infliximab, but not with TCZ, despite the improvement of articular symptoms, suggesting that different pathogenetic mechanisms mediate the two disease manifestations in RA. Literature reports one single case of disappearance of rheumatoid nodules in a RA patient treated with TCZ after the third infusion.
**Conclusion** We report the first description of a new onset cutaneous nodulosis during TCZ treatment in a patient with severe longstanding RA.

## "TIASCOLTO":"I take care of you" A project to assess unmet clinical and social needs in a sample of frail oncological elderly

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**Objective** To assess unmet clinical and social needs in frail elderly patients with advanced neoplastic disease.
**Patients and Methods** 165 patients >65 yrs discharged from Medical/Surgical units or followed in the onco-geriatric internal medicine outpa-

tient clinic were evaluated at baseline with a Multidimensional Comprehensive Geriatric Assessment (CGA) (Charlson's Index, Karnofsky, ECOG Performance Status, ALD, IADL, BMI, MMSE). Patients completed questionnaires about their socio-economic, functional and physical status, and were re-assessed at 1 and 3 months.
**Results** 80% were very frail at enrolment. 43% of patients died. Lung (25%), gastrointestinal (16%) and breast (9%) were the more prevalent neoplasms. Charlson's index was >6 in 88% of patients (particularly cardiovascular and pulmonary disease), and geriatric syndromes were recorded in 43%. MMSE >23 was observed in 98% of patients.
**Conclusions** Frail oncological elderly have a high burden of unmet needs and cognitive impairment is not present. To meet their needs we propose: a multidisciplinary team to obtain a continuity of care extended to the territory; use of CGA to recognize frailty; cultural focus on frailty and its management. Dedicated Internal Medicine units are crucial to take care of these patients and their comorbidities, conjugating typical internal medicine competences with a good palliation.

## La gestione del paziente diabetico all'interno del dipartimento medico

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Il diabete è presente nel 25% di pazienti ricoverati e oltre il 90% di questi presenta iperglicemia, la cui correzione comporta riduzione della mortalità e della degenza media. Abbiamo costituito un gruppo di lavoro comprensivo di personale medico, infermieristico e di un farmacista, per rendere omogeneo il percorso del paziente diabetico in ospedale. Il piano di miglioramento riguarda: numero di pazienti con riscontro di glicemia>180 mg/dl, attualmente pari al 10% degli ingressi ed inferiore ai dati di letteratura; percentuale di tali pazienti che iniziano entro 24 ore terapia insulinica, ora il 90%; percentuale di tali pazienti che vengono sottoposti a 4 controlli glicemici al dì, ora il 60% e percentuale di pazienti che raggiungono il target glicemico entro le 24 ore, ora pari al 30% circa. La glicemia è un parametro vitale, da rilevare in tutti i pazienti che entrano in dipartimento. Nei pazienti iperglicemici vengono rilevati HbA1C, peso ed attivata la consulenza infermieristica, per l'educazione del paziente all'automonitoraggio. Viene attivato un algoritmo per l'impostazione della terapia insulinica in funzione del peso corporeo e composta da 4 iniezioni, stabilisce uno schema per la correzione dell'iperglicemia , richiesti i controlli glicemici, stabilito un range terapeutico. Ogni giorno l'apporto insulinico viene adeguato alle condizioni cliniche del paziente e viene attivata la consulenza per i pazienti che non hanno raggiunto il target glicemico. Al momento della dimissione l'HbA1c viene utilizzata per valutare la terapia domiciliare.

## La solita insufficienza venosa?

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Donna 72 anni, fortemente obesa, ipertesa, severa insufficienza venosa degli arti inferiori che afferisce in DEA per peggioramento degli edemi declivi e comparsa di flittene agli arti inferiori. La paziente riferisce che il periodico peggioramento degli edemi declivi è trattato al domicilio con furosemide ed elastocompressione. All'ecodoppler venoso degli arti inferiori,non TVP in atto,ma rilievo di demodulazione del flusso a livello delle femorali comuni. Alla palpazione addominale si riscontra voluminosa tumefazione epigastrica non mobile sui piani circostanti. Gli esami ematici mostrano una creatinina di 1,5 mg/dl e un Ca125 di 12.000.Alla Tc addome con mdc presente massa ovalare a densità sovraidrica con pareti sottili che ingloba l'ovaio di destra, con compressione degli ureteri con conseguente idroureteronefrosi di III grado, dislocazione laterale delle anse intestinali, di utero e vescica. Si evidenziano inoltre numerose formazioni ovalari di significato secondario e linfoadenopatia lungo il decorso dei vasi digiunali.
Si trasferisce quindi la malata in ginecologia dove viene praticata isterectomia totale, annessectomia bilaterale e omentectomia; viene rimossa una massa di circa 40 cm e l'ovaio controlaterale di circa 20 cm.
L'esame istologico definitivo risulterà positivo per adenocarcinoma endometriale. Si presenta il caso in quanto esemplificativo di come una patologia benigna quale l'insufficienza venosa possa mascherare l'importanza di un segno clinico quale l'insorgenza di edemi agli arti inferiori e portare a una diagnosi tardiva di malattia neoplastica avanzata.

## Liraglutide Effect and Action in Diabetes: Evaluation of cardiovascular outcome Results (LEADERT) Trial: rationale and study design

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**Background** Liraglutide is a once-daily human glucagon-like peptide-1 analog approved for use in patients with T2D. Although liraglutide is associated with significant reductions in fasting glucose, hemoglobin A1C, weight, and systolic blood pressure, its effect on cardiovascular (CV) outcomes is unknown.
**Methods** LEADER™ is an international, multicenter, randomized, doubleblind, placebo-controlled trial designed to investigate the hypothesis that liraglutide is non-inferior to placebo, both in combination with standard of care, for a composite of major adverse CV events in patients with T2D. Approximately 9000 patients with T2D and at high CV risk will be enrolled in >30 countries. Patients are randomized 1:1 to once daily liraglutide 1.8 mg or placebo plus standard of care for 3.5–5 years. The primary endpoint is time from randomization to an adjudicated composite outcome of CV death, non fatal MI, or non-fatal stroke. The study is event- and time-driven and will not end until 611 events have accrued and a minimum duration of drug exposure has reached 42 months. Non-inferiority of liraglutide will be established if the upper bound of the 95% CI is <1.3. If non-inferiority is demonstrated, a test for superiority will be performed.
**Current results** The first patient was enrolled in September 2010; results are expected in 2016.
**Conclusions** LEADER™ is the first trial to test the long term effects of liraglutide on CV outcomes in patients with T2D.

## Flexible once-daily dosing of insulin Degludec does not compromise glycemic control or safety compared to insulin Glargine given once daily at the same time each day in people with type 2 diabetes

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**Introduction and aim of the study** Insulin degludec (IDeg), an ultra-long-acting basal insulin may enable more flexible dosing intervals as an alternative to the recommended strict dose timing of current insulins. The primary objective was to evaluate non-inferiority of IDeg dosed once daily in a flexible regimen (IDegFlex) compared to insulin glargine (IGlar) given at the same time each day.
**Materials and Methods** Randomized, open-label, 26-weeks trial in subjects with DMT2. Insulin was added to any existing OAD therapy.
Results: 229 subjects with IDeg and 230 with IGlar were enrolled (mean: A1C 8.4%; FPG 161 mg/dL; duration of diabetes 10.6 yr). For both groups, 88% of participants completed the trial. At 26 weeks, IDegFlex and IGlar reduced A1C by 1.28 and 1.26% respectively ([ETD] IDegFlex-IGlar: 0.04% [–0.12; 0.20]; non-inferiority was confirmed as the upper 95% CI limit was <0.4). Mean FPG at Week 26 was significantly lower for IDegFlex than IGlar (104 vs 112 mg/dL; ETD: –7.6 mg/dL [–14.8; –0.4] p=0.04). Rates of confirmed hypoglycemia (PG<56 mg/dL or severe) were similar for IDegFlex and IGlar (3.6 vs 3.5 episodes/patient-yr; (ERR) IDegFlex/IGlar: 1.03 [0.75; 1.40], p=NS), as were rates of nocturnal confirmed hypoglycemia (0.6 vs 0.8 episodes/patient-yr; ERR: 0.77 [0.44; 1.35], p=NS). Severe hypoglycemia was rare (two episodes/group).
**Conclusion** Even using dosing intervals of 8–40 h, IDeg does not compromise glycemic control or safety compared to IGlar dosed at the same time each day according to label.

## Multiple sclerosis-like neurological manifestation of vitamin B12 deficiency in a vegetarian celiac patient: a case report

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**Abstract** A severe cobalamin (vitamin B12) deficiency can occur with several disorders, involving different organs and systems, including blood, bowel, nervous system and eyes. Although most important features characterizeing this deficiency are usually haematological ones, presence of neurological involvement, in absence of blood count alterations, was just described in literature. Here we reported the case of a forty-eight years old male, suffering from celiac disease for, approximately, 5 years, vegetarian, which was admitted to our Department, referring dysesthesia of left lower limb, decreased libido and erectile dysfunction. Vitamin B12 deficiency was proved, even in absence of blood count alteration, and treated with vitamin supplement, resulting in complete remission of symptoms.

## Overt hypothyroidism with rhabdomyolysis and myopathy: a case report

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**Introduction** Hypothyroidism has been reported rarely as the cause of rhabdomyolysis in adults and children. We present here a man with a diagnosis of hypothyroidism who developed rhabdomyolysis with no additional predisposing factor.
**Case report** A 47-year-old man without a previous history of hypothyroidism presented with generalized myalgia lasting for two months. Neurological examination revealed bilateral marked weakness and tenderness of muscles of both lower and upper extremities. Serum creatine phosphokinase levels were elevated (4598U/l).Thyroid stimulating hormone (TSH) levels were high (60.82 mU/L), and free thyroxine (FT4) and triiodothyronine (FT3) levels were low (<0.25 ng/dL; normal value 0.56-1.21 and 1.52 ng/dL, normal value 2.20-3.80, respectively), compatible with uncontrolled hypothyroidism. All thyroid autoantibodies were positive. On echography the thyroid gland appeared normal with hypoechoid aspect and increased vascularization. Other causes of rhabdomyolysis such as muscular trauma, drugs, toxins, infections, vigorous exercise, and electrolyte abnormalities were excluded. After L-thyroxine therapy, thyroid function tests normalized, muscle strength improved, serum muscle enzyme levels returned to normal levels.
**Conclusion** One must be aware that rhabdomyolysis may develop in a non-compliant patient with hypothyroidism.

## A modified Yale protocol in the management of hyperglycemic medical patients

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**Background** Hyperglycaemia is a negative prognostic factor in critically ill pts, with and without known diabetes. Different insulin-infusion protocols (IIPs) have been developed for the management of hospitalized hyperglycaemic pts (HHPs). Some are completely managed by nurses. One of the most used is the Yale protocol, developed for medical ICU pts with a goal blood glucose range (BGR) of 100-139 mg/dl. Anyway, we registered a significant number of hypoglycaemic episodes in our previous experience with Yale protocol, outside ICU. So, as the NICE-SUGAR study showed that a good glycemic control (140-180 mg/dl) is better than a thight control (80-110 mg/dl), we modified the Yale protocol by moving the goal BGR from 100-139 to 140-180 mg/dl. Here we present a small case-series of pts, treated with our modified Yale protocol.
**Patients and methods** HHPs (>250 mg/dl) with an acute illness and unable to eat have been enrolled from 15/2/2011 to 15/2/2012. Glycemic control charts have been reviewed and total time on protocol (TTP), median time to glucose target range (MTGTR), number of hypoglycaemic episodes were collected.
**Results** We studied 10 patients (5M; 5F; mean age 85 yo), 7 with and 3 without known diabetes.

Bedside blood glucose was measured 719 times. The mean TTP was 47h. The MTGTR was 8.5 hours (range 3-16h), consistent with other data from literature. We registered only 1 episode of severe hypoglycaemia.
**Conclusions** Modified Yale protocol is a valuable tool in the management of HHPs. The increased target range improves the safety in elderly, complex and frail pts.

## Ipocalcemia sintomatica in giovane donna

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Giunge alla nostra attenzione da Pronto Soccorso giovane donna di 33 anni, di origine marocchina, per ipocalcemia (5.73 mg/dL, valori normali 8.4-11 mg/dL) sintomatica da alcuni giorni (dolori muscolari, segno di Trousseau e Chvostek, agitazione psicomotoria). In anamnesi segnalate 2 gravidanze a termine con parti eutocici (ultimo nel marzo 2011, valori di calcemia allora nella norma). Attualmente in corso allattamento al seno. Gli accertamenti del caso hanno evidenziato ipovitaminosi D (25OH-Vitamina-D 3 ng/dL, valori normali >30), valori di PTH "inappropriatamente" entro i limiti di norma con valori di calcemia e calcio-ione ridotti, calciuria delle 24 h lievemente ridotta, creatinina clearance nei limiti di norma. Nella norma i valori di cortisolemia basale e ACTH, funzionalità tiroidea, glicemia. Assenza di vitiligine all'esame obiettivo. Positività di anticorpi anti-cellule parietali gastriche (nella norma i valori di vitamina B12). Negativi gli ulteriori esami di screening autoimmunitario (complemento, ANA, ENA, ANCA). Negativi i marcatori neoplastici. Ecografia di tiroide e paratiroidi e radiografia del torace nella norma. In letteratura vi sono isolate segnalazioni d'ipocalcemia correlata a deficit di vitamina D e a ipoparatiroidismo primitivo idiopatico a insorgenza nel post-partum e durante l'allattamento: s'ipotizza il ruolo di proteine PTH-simili secrete in corso di gravidanza dal tessuto placentare e in corso di allattamento dalla ghiandola mammaria, finalizzate a garantire un adeguato apporto di calcio al neonato.

## ✪ Use of non-invasive mechanical ventilation in very old inpatients: a prospective cohort study

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**Introduction** Non-invasive mechanical ventilation (NIV) improves the outcomes of acute hypercapnic respiratory failure (AHRF). Data on its efficacy in elderly population are scanty.
**Aim of the study** To assess the outcomes of NIV in very old inpatients with AHRF who do not meet the criteria for Intensive Care Unit admission at the Emergency Room evaluation because of their age and complex comorbidity.
**Results** During 2009, 68 patients (72% males) received NIV for AHRF. The mean age was 83,7 + 4,3 years (range 75-94 years). The mean APACHE II score was16,3 + 5,2 and the mean pH was 7,30 (range 7,19-7,35). Mortality during hospitalization was 43% (29 patients). Age, comorbidity index, functional status and pH at initiation of NIV and after 60 minutes were not statistically different between survivors and deceased. APACHE II score and prevalent delirium were higher in deceased patients (respectively 18,4 + 5,5 VS 13,3 + 3,3; $p < 0,01$ and 48% VS 20%; $p < 0,001$). Mortality after 12 months was 31% (12 patients). Multivariate analysis identified impaired functional status and prior delirium as independent predictors of mortality ($p < 0,01$). At 12 months, patients without delirium (n = 31) had 19% long term care placement and 13% mortality, compared to 62% and 50% in the delirious group ($p < 0,01$).
**Conclusions** Severity of acute illness, rather than age or comorbidity, is the main predictor of mortality during hospital stay in very old patients with AHRF. Delirium is an important predictor of adverse outcomes at 12 months: its detection should be implemeted during hospitalization.

## Tossicità epatica da diclofenac gel

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**Premesse** Come descritto in letteratura la somministrazione orale e endovenosa di Diclofenac può essere epatotossica.
Il Diclofenac è spesso usato anche in gel e in alcuni casi si può riscontrarne un abuso, in quanto è commercializzato come farmaco da banco e pertanto facilmente reperibile. La cute ha grande capacità di assorbimento dei farmaci e pertanto anche in questa forma, se usato in dosi eccessive o in soggetti predisposti, potrebbe portare epatotossicità.
**Caso clinico** Donna di 50 anni si ricovera per ittero a esordio improvviso e vomito. Non presentava storia di malattia epatica cronica, né di abuso alcolico. Da un mese applicava Diclofenac gel su spalle e ginocchia per dolori articolari su base artrosica.
Gli esami erano indicativi di epatite colestatica acuta con rialzo di transaminasi e indici di colestasi (MELD 29, Child 11C), tanto da far ipotizzare l'urgenza di trapianto epatico. Livelli di ferritina >3000 mg/dl ponevano il sospetto di emocromatosi. La paziente veniva trattata per 4 mesi con antiossidanti e multiple sedute di plasmaferesi. Alla dimissione l'ittero era quasi scomparso e gli esami pressoché ai limiti della norma.
**Conclusioni** La tossicità da Diclofenac gel dovrebbe essere considerata nella diagnosi differenziale dell'epatite colestatica acuta. Nel caso descritto l'emocromatosi può essere stata l'elemento predisponente alla reazione avversa e potrebbe anche essere responsabile della patologia articolare. Bisognerebbe considerare epatotossica anche la forma gel del Diclofenac, soprattutto in soggetti predisposti o se usata per lunghi trattamenti.

## A case of fondaparinux induced thrombocytopenia with thrombosis (HITT) in a previous heparin-induced thrombocytopenia

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**Introduction** Heparin-induced thrombocytopenia (HIT) is an immune-mediated disorder caused by the development of antibodies against platelet factor 4 (PF4)/heparin complexes and it is characterized by an increased risk of thromboembolic complications. Generally the risk of HIT is greater with the exposition to Unfractioned Heparin (UH), being the Low Molecular Weight Heparin (LMWH) safer. Fondaparinux, a factor Xa inhibitor appears to be safer, despite the lack of evidence about its use. In literature a causal association between use of fondaparinux and HIT has not been established and only few case reports are described.
**Case report** A 82-year-old woman with a previous HIT associated to LMWH use complicated by both deep venous thrombosis (DVT), monolateral pulmonary embolism (PE) (HITT) and treated with fondaparinux

reported left hip fracture and required prosthesis replacement. Any incidental exposure to UFH or LMWH was carefully avoided and she was given fondaparinux. The platelets count begun to fall reaching the nadir on day 3, while a left DVT and a bilateral PE were detected. Anti-heparin/PF4 antibody immunoessay (EIA) were positive.
**Conclusions** In this case the diagnosis of "fondaparinux-related HITT" is very likely because of the entity of the platelet count's drop togheter with the thrombotic manifestation, the absence of alternative diagnosis and the timing (in this case the rapid onset is justified by the recent exposure to fondaparinux). Unfortunely the Anti-heparin/PF4 antibody immunoessay lacks in specificity. Further functional tests are required.

### ✪ Approach in glucocorticoid induced osteoporosis (GIO) prevention: results from the Italian multicenter observational EGEO study

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Glucocorticoid-induced osteoporosis (GIO) is the most frequent cause of secondary osteoporosis. GIO is linked to GC daily assumption with maximum effect within first months of treatment and decreasing to basal levels as the therapy is discontinued. Lazio GISMO (Italian Group for Study and Diagnosis of Bone Metabolism Diseases) group organized the GC and Osteoporosis Epidemiology study (EGEO) to evaluate physician's approach in preventing GIO.
The study involved 19 osteoporosis centres. Patients taking long-term GC therapy were recruited and information collected: medical history and anthropometric data, GC therapy, primary disease, physician's specialty, osteopororosis screening and pharmacological intervention. 1334 patients were included in the study. Mean age was 63±13 years; 243 (18%) patients had a history of falls from standing position in the previous 12 months, 78 (35%) vertebral fractures, 91 (41%) fractures other than vertebral, 27 (12%) femoral fractures and 27 (12%) multiple sites fractures. GC therapy was prescribed more frequently by rheumatologists (62%). Anti-osteoporotic drugs for GIO prevention were prescribed in 431 patients (32%). Only 27% of patients (360) received Calcium and Vitamin D supplements and 39% of patients (319) treated by rheumatologists received antiresorptive drugs.
In conclusion our data show that in Italy, as already described elsewhere, only a small subpopulation of GC treated patients was supported by an anti-osteoporotic therapy, indicating the need to further stimulate awareness of both patients and specialists, prescribing GC therapy, to an appropriate and prompt GIO prevention.

### A dramatic case of transplant associated microangiopathy

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Among the clinical categories of acquired thrombotic thrombocitopenic purpura (TTP) the post hematopoietic stem cells transplantation (HSCT) TTP has been well recognized with the recommended nomenclatura: transplant associated microangiopathy (TAM). Sepsis is a main risk factor for development of this syndrome. We have observed a mieloma patient submitted to allogeneic HSCT hospitalized for severe sepsis who developed a TAM with low ADAMTS-13 activity and antigen and low title of anti ADAMTS-13 antibody.The characteristic and dramatic complication of this case has been not a multivisceral ischemia but a complete ischemia of hand-foot distal vessels with evident necrosis even if a prompt steroid and plasma-exchange therapy was started. This case confirms the clinical data of literature.In post-transplants microangiopathy there is an unclear role of ADAMTS-13 deficiency, the disease process is inherently different from that seen in "classic" TTP, prognosis is generally poor and finally probably the therapy of TMA must be different from that of "classic" TTP. In immunosuppressed patients there is an unpredictable response to plasma exchange and steroid; management is largely supportive and primarily consists of withdrawal of offending agent.

### Healt promotion for prevention of hypertension: the patient educator?

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**Objective** To evaluate information needs of hypertensive patients with reference to the relationship with the general practitioner (GP).
**Materials and Methods** The Italian Medicines Agency education program for better adherence to hypertension treatment consists of focus group and role playing. Through the direct observation of patients' behavior and knowledge and the social interaction, the interviews first recorded, then written, and the analysis of the questionnaires (hypertension questionnaire and SF-36), the hypertension's awareness, especially related to the risk patients run without taking BP values under control, is interpreted and understood.
**Results** 140 patients were answered to the questionnaires, 120 participated into focus group and role playing. We found a lack of an appropriate information system in the dissemination of information to patients.
**Conclusions** The lack of preventive information to patients is due to the lack of an organized information system involving both GPs (core information-receptive) and patients (core receptive-information). Based on these results the working group of hypertension plans a training of the trainers, informational/educational meetings scheduled on a regular basis managed by trained GPs on prevention, awareness, treatment of hypertension, directed to patients. Trained patients will train other patients offering an information based on patients' needs, realized by patients for patients and for this reason certainly well accepted by patients as coming from people who share the same condition.

## Intussuscezione intestinale da adenocarcinoma del cieco

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**Premesse e scopo dello studio** L'intussuscezione intestinale è rara nell'adulto e rappresenta la causa dell'1-5% delle occlusioni intestinali. Nel 80-90% dei casi l'eziologia è di natura neoplastica, sia benigna (polipi infiammatori, lipomi, adenomi) che maligna (adenocarcinomi, linfomi, metastasi).
**Materiali e metodi** Donna di 59 anni, con storia di diverticolosi colica, ricoverata per calo ponderale, addominalgie intermittenti, alvo alterno e dispepsia, presenta anemia sideropenica (Hb 10.8 g/dl), VES 86 mm/h, FOBT positivo, screening anticorpale per celiachia negativo, markers neoplastici nella norma. Alla palpazione addominale lieve dolenzia in fossa iliaca sin. La radiografia dell'addome esclude segni di occlusione. La colonscopia dimostra la presenza di diverticolosi del sigma e una massa mobile invalicabile rivestita da mucosa edematosa a livello del trasverso. Segue TC Addome con mdc da cui emerge dilatazione di colon trasverso e cieco-ascendente, a pareti ispessite, determinanti immagine a 'bersaglio', caratteristica per invaginazione ileo-ciecale.
**Risultati** La paziente viene sottoposta ad emicolectomia dx + resezione dell'ultima ansa ileale. All'atto operatorio si riscontra voluminoso polipo peduncolato del cieco. L'analisi istologica dimostra un adenocarcinoma mucinoso altamente differenziato.
**Conclusioni** In base al comportamento dell'intussuscezione che può essere spontaneamente riducibile, i sintomi possono essere acuti o cronici. La TC addome è l'indagine più accurata. Per il rischio teorico di perforazione è prevista la resezione in blocco senza riduzione.

## Riattivazione di HBV e linfomi

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**Premesse e scopo dello studio** La riattivazione dell'epatite da HBV può verificarsi in corso di trattamenti immunosoppressori. Scopo del presente lavoro è quello di porre l'attenzione su questo fenomeno, e sulle sue possibilità terapeutiche.
**Materiali e Metodi** Uomo di 64 anni. Dopo ripetuti cicli di chemioterapia, manifestava marcata astenia, iporessia, dispepsia associate ad ipertransaminasemia (ALT x 10 N.). Ricoverato e sottoposto ad ecografia, che evidenziava epatomegalia e splenomegalia con linfadenopatia ilare epatica, senza ipertensione portale. Anamnesi negativa per consumo alcolico, e precedenti episodi itterici. Era nota la positività per HBsAg, negativi A-HAV, A-HCV, HBsAg. Venivano eseguite le ricerche virologiche anche per virus epatotropi minori e per autoimmunità.
**Risultati** Veniva rilevata positività per HBsAg, A-HBe (e-minus), IgM-Anti HBc ad alto titolo, HBVDNA ad alto titolo. I valori di ALT sono stati monitorizzati ogni 3 giorni, ed è stata intrapresa subito la terapia con analogo nucleosidico. La durata e l'entità dell'episodio epatitico acuto sono state certamente mitigate dalla tempestiva utilizzazione della terapia anti-HBV.
**Conclusioni** Gli autori sottolineano l'importanza del precoce trattamento con antivirali specifici nei pazienti in trattamento con immunosoppressori e chemioterapici, per evitare temibili riattivazioni che possono assumere andamento progressivamente ingravescente e pericoloso quoad vitam.

## Pancreatite complicata asintomatica

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**Premesse e scopo dello studio** La pseudocisti pancreatica (PP) è una raccolta di natura infiammatoria, che generalmente insorge come complicanza di una pancreatite acuta (PA). Scopo del lavoro è sottolineare l'importanza del corretto approccio diagnostico-terapeutico in casi di PA, che nell'anziano, può decorrere in modo atipico.
**Materiali e Metodi** Uomo di 79 anni, in Ospedale per dolore addominale e crisi ipertensiva. Rilevato incremento severo di citolisi pancreatica. No: iperglicemia, ipocalcemia, dolore dorsale, compromissione sistemica. Il paziente è stato sottoposto ad accertamenti (ecografia in Reparto, TC) e monitoraggio di indici bio-umorali.
**Risultati** Miglioramento clinico rapido e normalizzazione degli indici di citolisi in 4°giornata. Compenso emodinamico. In contrasto col dato clinico e bio-umorale, l'ecografia evidenziava complicanze locali (raccolte, edema persistente, aree necrotiche), confermate dalla TC. Al controllo u.s. in 6° giornata, veniva rilevata la presenza di una PP. Il paziente veniva sottoposto ad ecoendoscopia. Condizioni generali buone. Prosegue follow-up.
**Conclusioni** La PP è una complicanza della PA. Il caso evidenzia il forte contrasto fra esiguità clinica/laboratoristica, e quadro strumentale. Proposto un percorso diagnostico-terapeutico nella PA.

## Caso clinico: storia di un'"ecatombe" coagulativa

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CFM, donna di 70 anni, non significativi precedenti clinici. Veniva trasferita al nostro Reparto dall'Ortopedia, dove era stata sottoposta a posizionamento di chiodo gamma per frattura del collo femorale sn, in seguito a sviluppo, pur in presenza di corretta profilassi con eparina a basso peso molecolare, di trombosi venosa profonda femoro- poplitea dell'arto inferiore sn e riscontro alla TC polmonare di segni di embolia polmonare non sintomatica.
Dopo alcuni giorni dall'ingresso la paziente presentava un quadro improvviso di dispnea con ipotensione e desaturazione arteriosa di ossigeno:veniva eseguito un elettrocardiogramma che evidenziava tachicardia sinusale e segni di lesione transmurale in sede inferiore.
La paziente veniva quindi trasferita alla Cardiologia dove il percorso clinico si complicò ulteriormente.e le condizioni peggiorarono in modo irreversibile.. Solo il riscontro diagnostico e alcuni esami pervenuti dopo il decesso ne spiegarono la causa.

## Early neurological deterioration (END) in patients with spontaneous non surgical intracerebral hemorrhage (sICH)

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**Background** END within 24 hours from symptoms onset is a feared occurrence in patients with sICH. The aim of our study was to identify factors associated with END in this context.
**Materials and Methods** 133 patients with ICH admitted in our ward from Emergency Department were included. Clinical, biochemical and neuroimaging variables were registered on admission. Age, systolic, diastolic and mean arterial blood pressure, history of antithrombotic drug use, site, volume, intraventricular bleeding, mass effect, midline shift at first brain CT scan, glycemia, markers of inflammation and

modified Rankin Scale were the analyzed variables. Patients with END at our ward arrival were compared with patients without END.
**Results** END was present in 34.6% of patients. Patients with END showed a significant higher and earlier mortality (76.7% vs 8.6%; P<0.0001) and a worse functional outcome (P<0.0001). Patients with GCS≤4 increased from 4.1% in ED to 25.8% at IM ward arrival. Intra-hospital mortality was 87.5%,50%,15.3%,7.2% in patients with GCS at ward arrival equal to ≤4,5-8,9-13, and ≥14 respectively. Patients with END had significantly older age, greater ICH volume, greater frequency of intraventricular bleeding, midline shift, mass effect at first CT scan and hematoma enlargement at second CT and higher original ICH score. Median values of glycemia and markers of inflammation, and antithrombotic drug use but not blood hypertension were significantly predictors of END.
**Conclusion** END in the first hours is predictable. Efforts to avoid or reduce it are warranted.

## Bilateral thalamic stroke in very old patients: report of two cases

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**Background** Bilateral thalamic infarct (BTI) is a rare stroke presentation, mainly due to anatomic variations of vertebrobasilar system known as Percheron syndrome. Presentation could be non specific and coma or stupor could be the main manifestation. Literature evidence lacks in very old patients. We describe two cases of BTI occurred in octogenarian females.
**Case Reports** A female 84 years old presented to Emergency Departement because she was found comatose to wake up. Her history revealed only blood hypertension treated with ACE inhibitor. First examination showed no motor defects. Since than mild fever was present, lumbar puncture was performed with negative results. Basal CT scan was negative, whereas brain MR showed bilateral thalamic infarcts.
Clinical course was favorable with substantial recovery of vigilance. Another female 86 years old came to our attention for stupor associated to right hemiplegia. Her history revealed blood hypertension and diabetes. 12-leads ECG showed sinus rhythm. Basal CT scan was negative. Carotid ultrasonography revealed mild atherosclerotic plaques. We started therapy with acetyl salicil acid, saline solution and low molecular weight heparin for venous thomboembolism prophylaxis.
After four days control CT scan revealed bilateral thalamic hemorrhagic transformation of stroke. After one week the patient presented sudden paroxysmal tachycardic atrial fibrillation. After ten days the patient was discharged with modified Rankin Scale 5.
**Conclusion** BTI in older patients presenting comatose should be thought as diagnostic possibility.

## Early mortality risk stratification, treatment and outcome of acute pulmonary embolism (PE) in very old patients over the years

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**Background** Early mortality risk is now considered the key point for the treatment choices in acute phase of PE. However literature lacks in very old patients. The aim of our study was to evaluate the adherence to guidelines in very old patients with PE regard the risk based treatment.
**Materials and Methods** Data records of 116 consecutive patients 70 years older were analyzed. Patients were classified in high, moderate and low risk according to ESC guidelines. Patients admitted before and after 2009 were compared.
**Results** 14,7% of patients were classified as high risk (6,5% before 2009,20% after) whereas 57,8% (58,6% vs 54,2%) and 27,5% (34,8% vs 25,8%) were classified as moderate and low risk respectively. 12,9% of patients died (8,6% before 2009, 100% PE-related; 17,1% after 2009, 12,8% PE-related). Mortality was 29,4% (33% before 2009 vs 28,5% after), 12,3%(7,4% vs 15,7%), 8,8%(6,25% vs 11,1%) in high, moderate and low risk respectively.
Thrombolysis was performed in 23,5% of patients with high risk PE. 43.1% of moderate risk PE and 58.8% of patients with low risk PE received LMWH or fondaparinux, whereas the other received iv unfractioned heparin (UFH). Before 2009, 73,9% of patients received iv UFH, whereas after 2009 62,8% received LMWH or fondaparinux. After 2009, 74% receiving UFH had renal failure, while before 2009 renal failure was present in 26,4% of patients.
**Conclusion** Nevertheless more high risk PE patients were admitted over the years, thrombolytic choice in this subset remain under-practiced. Despite pharmacological treatment seems to be more appropriate, mortality is increased, especially in low-moderate risk PE.

## HAS-BLED and ATRIA scores in patients with atrial fibrillation (AF) and spontaneous oral anticoagulant therapy (OAT) related spontaneous intracerebral hemorrhage (ICH)

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**Background and aim** The balance between risk of embolism and bleeding should drive the choice on best antithrombotic drug in AF. Much recently, HAS-BLED and ATRIA have been proposed as two practical scores aimed to stratify the annual risk of spontaneous bleeding in patients taking OAT as cardioembolic prohylaxis of AF. HAS-BLED ≥ 3 identifies annual bleeding risk ≥ 3.5%, whereas ATRIA categorizes patients at low risk (0-3, annual risk 0,8%), moderate (4, annual risk 2,6%) and high risk (5-10, annual risk 5,8%). However literature lacks in reporting evidence on these scores in patients with OAT related ICH. Therefore the aim of this study was to provide information about it.
**Materials and Methods** We retrospectively analyzed data records of patients on AF with OAT related spontaneous ICH. We calculated HAS-BLED and ATRIA scores in these patients.
**Results** On 26 consecutive patients admitted in our ward for OAT related spontaneous ICH in the last six years, 18 were taking OAT for AF. 100% of patients resulted at low risk according to ATRIA score (median 3), whereas 44% of patients were at low risk according to HAS-BLED score (median 3). Old age and hypertension were the most represented variables.
**Conclusion** The risk of OAT related spontaneous ICH could be underestimated with HAS-BLED and ATRIA scores. New oral anticoagulants, overall demonstrating a relative risk reduction of around 50%, could be a safer alternative.

## Esperienza su 165 pazienti trattati con farmaci antiTNF: persistenza in terapia

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**Obiettivo** Riportare l'esperienza di una coorte di pazienti (pz) trattati con antiTNfα affetti da Artrite reumatoide (AR), spondiloartrite (Spa), Spondilite anchilosante (SA) artrite psoriasica (aps).
**Materiali e metodi** Si sono inclusi pz con AR, Spa, SA aps, trattati da almeno 12 mesi (m) con antiTNFα di 1ª generazione (etanercept infliximab adalimumab); si sono valutati: distribuzione per patologia; distribuzione per linea di terapia biologica; durata media di terapia; percentuale e cause di drop out.
**Risultati** Nei 119 pz trattati da almeno 12 m, 53% AR,17% Spa, 16% aps 14% SA, etanercept era 1ª linea(83%) 2ª(16%) o 3ª(1%); i pz in 2ª linea venivano da infliximab(87%) e adalimumab(13%); la durata media di terapia era 41 m; il 16 % dei pz era in drop out, 47% AR, 21% Spa 16% SA e aps, per perdita di efficacia (PE) (40%) o eventi avversi (AE)(47%). I 25 pz in infliximab, 48% Spa, 36% SA, 12% aps 5% AR erano 1ª linea(72%), 2ª(24%), o 3ª(4%); i pz in 2ª linea venivano da etanercept (33%) e adalimumab (67%); la durata media di terapia era 44 m; il 32% dei pz era in drop out, 62,5% SA, 37;5% Spa, per PE(50%) o AE(45%). I 21 pz in adalimumab, 76% AR, 14% Spa, 10% SA; erano 1ª linea(90%) o 2ª(10%); i pz in 2ª linea venivano da infliximab (100%); la durata media di terapia era 36 m; il 5% dei pz era in drop out (100% aps) per PE.
**Conclusioni** Etanercept è il prodotto più prescritto in prima linea; i pz in infliximab persistono più a lungo in trattamento ma con più drop out; i pz in adalimumab hanno meno drop out ma perdurano di meno in trattamento.

## ✪ Esperienza su 19 pazienti trattati con abatacept: persistenza in trattamento

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**Introduzione** Abatacept è un inibitore del CTLA4, indicato per il trattamento di prima e seconda linea dei pazienti (pz) affetti da Artrite reumatoide (AR), non responsivi a DMARDs o biologici anti TNFα.
Obiettivo Riportare l'esperienza di una coorte di pz trattati con abatacept (antiCTLA4) per almeno 12 mesi affetti da AR.
**Materiali e metodi** Si sono inclusi pz affetti da AR, trattati da almeno 12 mesi (mm) con abatacept in prima, seconda o altra linea di trattamento; sono stati valutati: distribuzione per patologia, distribuzione della linea di trattamento biologico; distribuzione dei farmaci biologici precedentemente assunti prima di abatacept; persistenza media in terapia; percentuale e cause dei drop out registrati.
**Risultati** Nei 19 pz trattati da almeno 12 mm con abatacept; il farmaco era utilizzato in 1ª linea nel 5%, in 2ª nel 74% in 3ªnel 16% ed in 4ª nel 5% dei casi; i pz in 2ª linea avevano effettuato switch da etanercept (50%), adalimumab(45%) ed infliximab(5%); la durata media di terapia era 24 mm; il 10 % dei pz era in drop out; il drop out era avvenuto per perdita di efficacia.
**Conclusioni** Abatacept risulta un prodotto affidabile con una buona pesistenza media in trattamento e un basso tasso di drop out, indicativo di un soddisfacente profilo di efficacia e tollerabilità.

## Esperienza su 12 pazienti trattati con tocilizumab: persistenza in trattamento e profilo di safety

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**Introduzione** Tocilizumab è un inibitore dell'IL-6, indicato per il trattamento di prima e seconda linea dei pazienti (pz) affetti da Artrite reumatoide (AR), non responsivi a DMARDs o biologici anti TNFα.
Obiettivo Riportare l'esperienza di una coorte di pz trattati con tocilizumab affetti da AR .
**Materiali e metodi** Si sono inclusi pz affetti da AR, trattati con tocilizumab in prima, seconda o altra linea di terapia; sono stati valutati: distribuzione per patologia, distribuzione della linea di trattamento biologico; distribuzione dei farmaci biologici assunti prima di tocilizumab; persistenza media in terapia; percentuale e cause dei drop out; effetti collaterali.
**Risultati** Nei 12 pz trattati con tocilizumab, il farmaco è stato utilizzato in 1ª linea nell' 8% dei casi, in 2ª nel 33%, in 3ª nel 42% ed in 4ª nel 17%; i pz in 2ª linea avevano effettuato switch da etanercept (75%) e adalimumab(25%); i pz in 3ª linea avevano prima effettuato terapia con 2 antiTNFα (60%) o antiTNFα + antiCTLA4 (40%); i pz in 4ª linea avevano prima effettuato terapia con 2 antiTNFα+AntiCTLA4 (50%) o 1 antiTNFα+AntiCTLA4+antiCD20 (50%); la durata media di terapia è stata di 11 m; il 15% dei pz ha interrotto il trattamento; il drop out è avvenuto per perdita di efficacia.
**Conclusioni** Tocilizumab, sia pur in un periodo breve di follow-up, appare prodotto efficace e sicuro, anche quando utilizzato in linee avanzate di terapia.

## Ophthalmoplegia, headache, anemia: Tolosa-Hunt syndrome?

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The Tolosa-Hunt syndrome ("painful ophthalmoplegia" or "ophthalmoplegic migraine syndrome") is caused by idiopathic inflammation of the superior orbital fissure and/or cavernous sinus. It presents as complete or partial paralysis of one or more of the muscles eye movement and is painful. The syndrome usually begins with unilateral headache, often of severe intensity that precedes the ophthalmoplegia. The pain is hard, throbbing and affects the ophthalmic branch of trigeminal nerve; ophthalmoplegia total or partial, with or without pupillary involvement with reduction of visual acuity, is of varying size.
Imaging (CT, MRI, etc..) may show a focal mass or a little limited, as evidenced by contrast, sometimes associated with signs of bone erosion in the sellar and parasellar areas. For the diagnosis must exclude vasculitis, sarcoidosis and tuberculosis. It is thought that the cause of the syndrome is to be found in an abnormal immune response that causes inflammation of the cavernous sinus and superior orbital fissure.
The syndrome affects males and females (1:1) and the average age of onset is 41 years, although it can occur at any age.
We present a clinical case of a subject of 77 years, hospitalized for anemia and headache. The images show a gradient of RMM impregnation right at the orbital apex region of the nose cavernous sinus. A bronchoscopy of the right posterior nasal showed hypertrophic tissue (biopsies). The steroid therapy significantly reduced the pain.

## The Ortogeriatria as a paradigm of health care integration

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**Introduction** Around 35.000 a year older is hospitalized for hip fracture. Mortality, morbidity and entrapment syndrome are the major issues. 50% of these patients does not recover the same level of self-sufficiency it had before the fracture.

The aim of the study The department of Geriatrics, Medicine and Orthopedics Hospital "F. Miulli" Acquaviva delle Fonti have defined a plan for establishing the Unit of Ortogeriatria.
**Objectives** To ensure the best possible care to the elderly frail, reduce local and general complications (immobilization syndrome, delirium, malnutrition, pressure ulcers), promote early recovery of the functional autonomy. Expect, also, economic and operational advantages for the rationalization of hospital stay in acute care and early identification of post-acute venues, and the rationalization of pharmaceutical expenditure.
**Organization** The Ortogeriatria will be located into Geriatrics ward and initially will have 2 beds. The frail elderly with hip fracture will follow a route from the emergency room, where a team will evaluate the ortho geriatric comorbidity and decide on admission to geriatric ward if the patient is unstable or in the orthopedic ward.
In Unit of Ortogeriatria, ortho geriatric team, after having stabilized the patients, decide: the date and type of surgery and the seat of hospital stay after surgery.
**Conclusions** The ortogeriatria could be a model for integrating multidisciplinary health care effectively and efficiently.

### ✪ The first FADOI course on methodology of clinical research: effective and high level of education

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**Introduction** The FADOI and Foundation Fadoi have, among their institutional objectives (Charter Article 3 and Article 2) to "promote the scientific activities through the implementation of clinical trials and research ... to promote education and training update ..., to achieve annual and multi-annual activity CME ", to promote the development of scientific and medical knowledge to contribute to the development of clinical research ...".
**Aim** Therefore, Fadoi Foundation with University Campus Bio-Medico of Rome, has designed and conducted the first edition of the Postgraduate Course on Methodology of Clinical Research. The goal was to create, within the Unit of Internal Medicine, the mini-research teams consist of Doctors and Nurses trained in the methodology of designing and conducting clinical trials, also complex.
**Materials** Duration 60 hours spread over 9 days, 33 participants (physicians and nurses), 32 teachers, 11 experimental project works.
Results The satisfaction index, checked with a questionnaire showed that 96.6% was assigned to the highest degree of quality updated, 100% defined good teaching staff, the participant-faculty interaction has been defined as good-excellent, 82,6% and 94% of respondents would recommend this course to a colleague. The popularity of the course was high and very high for 82,8 % of participants.
**Conclusions** The course highlighted the great need for training of doctors and nurses and the full achievement of educational goals.

### Sincopi recidivanti in iperteso con pacemaker

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Maschio, 84 aa, con cardiopatia ipertensiva ed FE moderatamente depressa (38%), con pacemaker (PM) bicamerale per BAV di 3°grado, BPCO, IRC, FA persistente, ricoverato per sincopi recidivanti giornaliere associate a scosse tonico-cloniche nucali. La PA era normale, non ipotensione ortostatica. La rotazione a destra del capo a circa 90° determinava pallore, sudorazione, aura, scosse tonico-cloniche del collo e degli arti superiori e perdita di coscienza di alcuni sec., clinica che si risolveva riportando in asse il capo. Controllo PM, EEG, ECG-Holter, TC-cerebrale normali. L'eco-TSA: art. vertebrali esili con un flusso appena registrabile a dx. L'angio-TC vasi extracranici: stenosi del 50% dell'art. vertebrale sx alla confluenza con la basilare e stenosi del 60% dell'art. vertebrale dx con compressione ab-estrinseco da ipertrofia del massiccio articolare di C6. Non indicata per le comorbidità rivascolarizzazione con stent dell'art.vertebrale dx e l'intervento NCH di riduzione dell'l'ipertrofia di C6. Diagnosi: drop-attacks da insufficienza vertebro-basilare da compressione ossea ab-estrinseco e da extrarotazione del capo a dx. Nei 4 giorni seguenti altri 10 episodi sincopali. Durante telemetria, la rotazione del capo dava sincope con asistolia all'ECG da perdita di cattura del PM, che si risolveva riportando in asse del capo; l'impianto di un nuovo elettrocatetere (EC) nel VDx risolse la clinica.
L'RX-torace non rilevava lesioni degli EC; è suggestiva l'ipotesi di una dislocazione meccanica (stiramento) dell'EC con la rotazione del capo, probabilmente secondaria a fenomeni di reazione flogistico-fibrotica all'interfaccia EC-miocardio.

### ✪ Influenza genetica del polimorfismo I/D dell'enzima di conversione dell'angiotensina (ACE) sul profilo pressorio delle 24 ore

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L'associazione tra polimorfismo I/D nell'introne 16 del gene dell'ACE, pressione arteriosa (PA) clinica e monitorata nelle 24h e danno d'organo (TOD) è controversa. In 285 ipertesi (139 uomini e 146 donne) d'età ³65 anni facenti parte del ROVIGO study, il TOD cardiaco è stato definito come presenza d'ipertrofia ventricolare sinistra (IVS) all'ECG secondo i criteri di Sokolov-Lyon; il TOD renale è stato definito come stima della riduzione filtrato glomerulare ≤ a 60 ml/min con la formula MDRD o per albuminuria ≥30 mg/24h. Le frequenze alleliche all'equilibrio di Hardy-Weinberg sono state valutate con il test del c2; i dati sono stati analizzati come genotipo DD vs. genotipo non-DD (DI+II) e le variabili continue confrontate con l'analisi della varianza attraverso i genotipi. Le frequenze degli alleli D e I erano 64.9% e 35.1%, rispettivamente. I valori di PA sistolica e diastolica clinica erano significativamente più alti nei solo maschi con genotipo non-DD che nei DD (141.7±18.4 vs. 136.05±15.6, $p<0.05$ e 79.2±10.7 vs. 75.5±10.2, $p<0.04$). Solo i valori medi di PA sistolica-24h (PASm-24h) e PA diurna sistolica-24h (PASd-24h) erano più alti nei maschi non-DD che nei DD (139.36±14.2 vs. 134.9±12.4, $p<0.05$ e 143.27±14.2 vs. 138.3±13.1, $p<0.03$). La prevalenza d'IVS era maggiore nei non-DD che nei DD (58.3% vs. 32.7%, $p<0.003$). Non vi era relazione tra il suddetto polimorfismo ed il TOD renale nei due sessi. Nei maschi ipertesi, elevati valori di PASm-24h e PASd-24h sono significativamente associati al polimorfismo D/I dell'ACE ed in parte spiegano il più alto TOD cardiaco.

### Pegylated interferon and ribavirin for treatment in patients with indolent non Hodgkin lymphomas (NHL) hepatitis virus C related: a long term study

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**Background** Here we evaluate efficacy and safety of therapy with pegylated IFN plus ribavirin in patients with hepatitis C related and indolent NHL.
**Methods** 12 patients, were recruited in the study (7 F and 5 M; median age 55 years, 10 patients with lymphoplasmocitoid lymphomas and 2 patients with splenic lymphoma with villous lymphocytes). All cases were HCV-RNA positive: genotype 1b (60%), genotype 2a/2c in the others. 8 patients (75%) presented abnormal levels of aminotransferases. A chronic liver disease was found in all 8 cases. 8 patients (75%) had detectable levels of cryoglobulins (from 2 to 20%) and clinical manifestations (purpura, arthralgias, peripheral neuropathy). All patients were treated with peg-interferon alfa-2b 1.5 mcg/kg. once weekly plus ribavirin 1,000-1,200 mg/day for 48 weeks. All patients were followed for at least 48 weeks after therapy. Results 7 patients (58%) achieved a sustained virological response (SVR) with complete haematological remission (CR) and partial remission (PR) of lymphoma in 5 and in 2 cases respectively. No response was observed in 5 cases (42%). One patient relapsed was treated later with Rituximab. At end of follow-up, 4 patients, who originally obtained SVR, were still in CR.
**Conclusions** As well as in previous studies, these data confirm the efficacy of antiviral treatment in the indolent NHL HCV-related. The haematological response of lymphoma was related to the clearance HCV. Antiviral therapy should be the first line of treatment in NHL hepatitis C virus related.

## ✪ Prevalence of extrahepatic manifestations in infection with hepatitis C virus: study of 440 cases

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**Aim** To assess prevalence of clinical and biological extrahepatic manifestations of hepatitis C virus (HCV) and to correlate with age, sex, degree of fibrosis and genotipe of HCV.
**Material and Methods** The natural history of extrahepatic manifestations (EHM) has been investigated in 440 patients with HCV chronic infection for 6 years. Patients positive for HbsAg or HIV have been excluded. The prevalence of dermatologic, neurologic, and nephrologic manifestations, including the presence of autoantibodies and cryoglobulins has been assessed. Results Mean age was 56 year (range 21-79), 60% women. All cases were HCV-RNA positive: genotype 1b 60%, genotype 2a/2c 40%. EHM were found in 33% of patients: mixed cryoglobulinemia (MC) in 29%, type II IgM k (87.6%) and type III (12.4%), purpura of the lower extremities (9%), weakness (9%) and arthralgias (8%). Peripheral neuropathy was found in 11 %, sicca syndrome in 3%, elevated levels of rheumatoid factor in 27% of cases, autoimmune thyroiditis in 1.4% of cases, nephropaty cryoglobulinemic 1.4% and non Hodgkin's lymphoma (NHL) in 4.3% of cases. During the follow-up, we found 1 case of large cells NHL, 1 case of MALT and 2 cases hepatocellular carcinoma. A positive correlation was found between the prevalence of EHM and the female sex. EHM were significantly associated with cirrhoris.
**Conclusion** EHM should be screened systematically in patients with HCV infection. The most frequent immunologic abnormalities include mixed cryoglobulinemia. Pathogenic mechanism in B-cell proliferation should be further investigated.

## ✪ Progetto Lifestyle Gym (LsG): un intervento multidisciplinare integrato per facilitare il cambiamento dello stile di vita, alimentare e motorio, come strumento preventivo/terapeutico delle malattie dismetaboliche: dalla prescrizione alla somministrazione

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**Premesse e scopo dello studio** L'esercizio fisico previene e cura le malattie croniche dismetaboliche ed un comportamento alimentare inadeguato accelera la loro incidenza e prevalenza. Lo studio ha cercato di verificare l'efficacia di un intervento multidisciplinare integrato - che prevede le figure professionali di medico, laureato scienze motorie, nutrizionista - sui parametri delle malattie dismetaboliche. Lo studio è basato su un modello di prescrizione e somministrazione per 6 mesi (2 volte/settimana) di una dose di esercizio fisico e di un programma di educazione alimentare.
**Materiali e Metodi** Sono stati analizzati i dati antropometrici e sierologici di 112 pazienti (72 maschi/40 femmine) arruolati ambulatoriali, dismetabolici (59 diabete mellito tipo 2, 111 sovrappeso/obesi, 71 ipertesi, 65 dislipidemici, 86 con sindrome metabolica) del Riminese, con età compresa fra 18 e 75 anni, sottoposti ad una dose di esercizio fisico somministrato e ad un programma di educazione alimentare assistito tramite colloquio motivazionale.
**Risultati** Sono risultati modificati in modo significativo a 3/6 mesi: peso (-4/-5 kg), BMI (-2/-2 Kg/m2), circonferenza vita (-3/-3 cm), PA sistolica (-5/-5 mmHg), PA diastolica (-4/-4 mmHg); a 3 mesi HbA1c (-0.5%); a 6 mesi,HDL-C (+4 mg/dl). Non hanno avuto variazioni significative il colesterolo totale, LDL-C , trigliceridi.
**Conclusioni** Questo modello d'intervento è risultato efficace nel modificare positivamente alcuni parametri delle malattie dismetaboliche.

## Recurrent common bile duct gallstones after cholecystectomy: a complicated cholangitis secondary to unusual foreign bodies

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**Background** Retained stones often cause choledocholithiasis after cholecystectomy. They are secondary to biliary stasis due to malignancy, benign stricture, infection and foreign bodies. Surgical sutures or clips, especially those composed of non-absorbable materials, play the role of a nidus for crystallization.
**Methods** A 77 years old woman was admitted to our division with fever and jaundice in absence of pain. She had undergone a routine cholecystectomy with coledocotomy ten years earlier. Biochemical markers showed an obstructive pattern. We performed imaging studies: an abdominal ultrasound detected dilated intra and extrahepatic channels and some hepatic abscesses, an ERCP showed a dilated common bile duct and a filling defect, suggestive of gallstones encompassing metal clips, associated to a bilio-duodenal fistula, an abdominal CT detected also a bilateral intrahepatic portal trombosis.
**Results** After endoscopic sphincterotomy, three ESWLs and another operative ERCP, all the material, including a catgut, was removed. The

patient was successful managed with nasobiliary drain, intravenous antibiotics and LMWH at low dose.
**Conclusion** The formation of gallstones around surgical clips after cholecystectomy is a rare complication and the use of absorbable materials has not been free of recurrent stone formation. Migration is likely to be influenced by inaccurate surgical clip placement which results in bile duct injury, suppurative inflammation, and erosion of the clip through the bile duct into the lumen. ERCP with sphincterotomy is the treatment of choice.

## Early diagnosis and treatment of infective endocarditis is the key for a successful outcome, especially when "time is brain"

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**Background** Although risk factors for infective endocarditis are well known, patients with atypical signs and symptoms continue to challenge us. Embolization of endocardial vegetations into cerebral vessels affects the clinical course of about the 40% of patients with infective endocarditis and can lead to a large spectrum of neurological symptoms.
**Methods** A 70 years old man with a history of chronic ischemic heart disease previously revascularized, a severe mitralic insufficiency and a mild-severe aortic insufficiency with a mild aortic stenosis, was found to have a mild anemia at routine exams. He was admitted with Hb 8.8 gr/dl and for dysarthria, confusion and disequilibrium persistent in the last 10 days; a CT scan of the brain showed a hypodense area in the left frontal region. Because of slight fever a set of peripheral blood cultures was taken, which were positive for Staphylococcus epidermidis. Transthoracic and transesophageal echocardiogram showed a vegetation on the mitral valve and a suspect aortic valve endocarditis.
**Results** The patient was treated with antibiotics and combined aortic and mitral valve replacement with bioprostheses. A postprocedural echocardiogram showed a good function of the prosthetic valves with no evidence of endocarditis, a CT scan showed a regular malacic evolution of the ischemic area.
**Conclusion** When infective endocarditis is complicated by neurologic injury early surgical treatment is favoured because of the high risk of recurrent embolic events. The incidence of postoperative cerebral hemorrage is much lower than thought.

## Acute psychosis associated with rapidly progressive dementia in an elderly male: not always an easy diagnosis

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**Background** The differential diagnosis of psychosis in elderly patients includes delirium, dementia and primary psychiatric disorders. Creutzfeldt-Jakob Disease (CJD) is the most common cause of rapid progressive neurodegenerative dementia; psychosis is reported in about the 42% of cases but rarely at presentation.
**Methods** A 80 year-old male, recently discharged from the psychiatric department for a suicide attempt with a diagnosis of major depression with psychotic feature, was admitted to our division due to anemia and thrombocytopenia. These hematological disorders, initially attributed to quietiapine, improved after drug withdrawal but subsequent worsening of mental condition required diazepam treatment. The patient's history included retinitis pigmentosa, neurosensory hypoacusis and an episode of severe iporigenerative anemia treated with blood transfusion. He showed confusion, restlessness, dysarthria, myokymia of the legs and irregular breathing, with an episode of respiratory arrest requiring endotracheal intubation and mechanical ventilation.
**Results** Brain CT, oncomarkers, autoimmunitary screening and EEG excluded acute lesions and specific encephalopathies. Lumbar puncture was performed and molecular examination showed a high positivity for "tau" and "14.3.3" proteins. The patient was tracheostomized for recurrent episodes of respiratory arrest after estubation and sedated with *morphine*.
**Conclusion** CJD must always be considered when a patient presents with acute psychosis. Nowadays it is still debated if blood transfusion is a risk factor for the sporadic form.

## Presentazione atipica di grave recidiva di carcinoma vescicale

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**Caso clinico** Uomo di 69 anni da due mesi edema dell'arto inferiore sx con incapacità alla deambulazione autonoma. Era iperteso con cardiopatia ischemica postinfartuale; due anni prima cistectomia radicale per carcinoma (a cellule transizionali) infiltrante la parete muscolare. Obiettivamente appariva orientato, non in grado di deambulare. TC 37.2. Edema coscia e gamba sx, normale l'arto dx, la cute dei due arti era isotermica, senza segni d'infiammazione. Gli esami evidenziavano anemia normocitica, marcata iposideremia, lieve alterazione della funzione renale, disprotidemia, incremento della VES. L'ecodoppler venoso documentava la pervietà del circolo venoso profondo e l'ecografia mostrava bilateralmente in sede inguinale multipli linfonodi ad ecostruttura regolare. La TC TB evidenziava la presenza di una voluminosa massa a carattere ripetitivo, che si estendeva dalla pelvi alla regione paravertebrale sx, determinante erosione e cancellazione ossea somato-apofisiaria a carico del corpo dell'ala iliaca omolaterale. Si praticava trattamento di supporto con ac. Zoledronico, le patologie concomitanti sconsigliavano altri tipi di approccio. Il grosso deficit funzionale e la difficile situazione socioeconomica del paziente rendevano necessaria la dimissione protetta in RSA, che avveniva in 18° giornata.
**Conclusione** Il carcinoma della vescica costituisce il 70% delle neoplasie dell'apparato urinario e il 3% di tutti i tumori. In Italia è la terza neoplasia del sesso maschile. Il trattamento è multidisciplinare ed in rapporto all'istotipo ed allo stadio clinico patologico.

## Ferite difficili: medicazioni avanzate nelle ulcere da pressione

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**Ipotesi** Per ferita difficile si intende una "perdita di sostanza dermoipodermica che non dimostra alcuna tendenza alla riparazione spontanea a causa dell'alterazione dell' omeostasi vascolare sostenuta da processi endogeni o esogeni"; queste lesioni hanno conseguentemente un impatto negativo sulla salute fisica e psichica e più in generale sulla qualità della vita dei pazienti, con rilevanti ripercussioni sul sistema sanitario in termini organizzativi ed economici.
**Materiali e Metodi** Nella nostra U.O. è stata elaborata una procedura di medicazioni avanzate basata sulle ultime EBN.
**Risultati** Dall'anno 2009 non sono insorte lesioni da pressione durante la degenza e i pazienti che presentavano lesioni dal momento del ricovero sono nella maggior parte dei casi migliorati. Risultati sempre mag-

giori si potranno ottenere con VAC Terapy, recentemente attivata dalla nostra Azienda
**Conclusioni** Poiché i costi in termini di dolore e sofferenza per una persona con ulcere non possono essere quantificati, dovrebbero essere messi in atto tutti gli sforzi possibili per prevenire le lesioni cutanee. Dove purtroppo tali ferite sono già presenti si deve affiancare alla prevenzione un'attenta procedura di medicazione, aggiornata secondo le ultime evidenze scientifiche che aiuti ad uniformare anche la scelta terapeutica da parte degli operatori.

## A rare mutation of MEFV gene in FMF

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Familal mediterranean fever (FMF) is an autosomal recessive disease affecting mainly mediterranean population. In its classical form it is characterised by recurrent crises of fever, serosal inflammation, erithema and myalgia. The symptoms are often unrecognized and patients histories often include multiple laparatomies, laparascopies and psychiatric evaluations. The major complication is the devolopment of renal amyloidosis. Standard laboratory tests are non-informative. The gene responsable of the disease has been identified on chromosome 16p13.3: MEFV. More than 35 mutations have been identified so far. We have observed a 30 years old italian woman with recurrent hospitalization for severe articular pain, myalgia, erysipela-like erythema without serositis or fever. Systematic diseases were ruled out. A DNA analysis of the chromosome region 16p13.3 showed a mutation of the MEFV gene: the rare mutation K695R in heterozygosys state. Treatment with colchicine has been highly efficcacious. The combination of clinical manifestation among FMF patients are quite heterogeneous but no connections between individual mutation and specific clinical pictures have been established so far. We have described this case because we must be careful not to rule out a diagnosis of FMF just because of atypical clinical features as our data indicate that MEFV mutation are sometimes demonstrable in such patients.

## Rottura spontanea di milza: una presentazione non usuale di trombocitemia essenziale

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Spontaneous rupture of the spleen without a history of trauma is a rare clinical entity and represents a dramatic abdominal emergency. It is also an uncommon but life-threatening complication of hematologic malignancies, despite the frequent involvement of the spleen in these diseases. It has been reported in patients with acute and chronic leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, and histiocytic lymphoma. We present a case of spontaneus rupture of the spleen as initial manifestation of an Essential Thrombocitemia. A 69-year-old man , with CODP , hypertension, and vascular diseasas underwent a prostatic adenectomy and two days after presented with acute symptoms of spontaneous splenic rupture . Emergency splenectomy was performer and some days after our consultation was required for an increased platelet number. Antitrombotic therapy and platelet aferesis was started and with further examinations ( Jak2 , myelobiopsy etc. ) the diagnosis of Essential Thrombocitemia was performed . He began a therapy with oncocarbide but after some days because the non optimal response and the progressive increase of the platelet he began a therapy with anagrelide . The patient was vaccinated to decrease the risk of overwhelming postsplenectomy sepsis (OPSS) due to organisms such as Streptococcus pneumoniae, Haemophilus influenzae type B, and Neisseria meningitidis.Splenic rupture as a consequence of malignant disease is discussed, together with a brief review of the literature.

## Remission of SLE induced by the use of modified release steroids (Lodotra®, Mundipharma) associated to hydroxychloroquine

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**Background** The use of steroids in SLE is widely diffused and the side-effects of steroids are also very common in patients undergoing for long periods to such kind of therapy.
**Objective** We report data on the use of modified-release prednisone therapy (MRP), associated to hydroxychloroquine (HCQ), in a patient affected by SLE naïve to all immunosuppressant drugs.
**Materials and methods** We report the case of a 36 years old male with a newly diagnosed SLE characterized by high titers of DNA Ab, proteinuria, fever, photosensitivity, non-erosive arthritis and recurrent pericardial serositis who underwent to a MRP based therapy associated with HCQ for disease control. Both clinical and laboratory parameters were observed for 6 months. A therapy with 15mgs of MRP associated with 400mg/daily of HCQ was started in march 2010, as patient presented pericardial serositis, fever (38.3°C), low levels of C3 and C4, ESR of 59mm/h, and proteinuria (2,86g/24h) (SLEDAI score 11).
**Results** After one month of therapy, proteinuria was completely reverted, C3 and C4 levels returned within normal ranges, no signs of pericardial serositis were detectable by ultrasound performed every month and ESR was 31mm/h. AntiDNA Ab persisted during whole followup at low titers.
**Conclusions** MRP (Lodotra®, Mundipharma), may represent a suitable option for treating patients affected by SLE; the lower doses respect to the ones of oral prendisone may also grant a reduction of steroids-related side-effects, granting more secure and compliant profiles of therapy.

## ✪ Public domiciliary radiography program for frail elderly in Internal Medicine

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**Introduction and purpose** The Piedmont Regional Agency for Health Services (AReSS) has funded a public domiciliary radiography (r@dhome) program for frail elderly and immobile patients in order to evaluate the benefits and the cost-effectiveness of this service.
**Methods** Eligible patients are acutely ill patients treated at home by the r@dhome between June 2008 and December 2010. At home the radiological examinations are carried out using a portable high frequency X-ray tube and a mobile radiological station. These images are immediately sent, via web, at x-ray hospital department that provides radiology reporting. All patients are examinated using a standardized protocol which includes multidimensional assessment reasons for needing

the domiciliary radiography service, customer satisfaction, cost analysis and radiological quality of imaging.
**Results** Of the 463 patients admitted to the r@dhome between June 2008 and June 2010, one hundred twenty three patients were eligible for X-ray examination. Sixty nine (55%) were enrolled and randomly assigned to Intervention group (n=34) and Control group (n=35). Fifty four (45%) were excluded because in need of a X-Ray examinations not suitable at home (n=36) or an urgent examination (n=16); 2 persons did not sign the informed consent. Enrolled and refusals did not show significant differences in age and gender.
**Conclusion** This project is very innovative in the outline of international literature. Domiciliary radiography may be of great value to the patients, family, consultants and general pratictioners in clinical medicine.

## GST gene polymorphisms in the pathogenesis of hypothyroidism in Italian patients

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**Background and Aim** Hypothyroidism is a multifactorial endocrinal disease characterized by abnormally low thyroid hormone production. Thyroiditis is one of the primary cause of hypothyroidism. It refers to an increasing level of inflammation in the thyroid gland that could be due to a failure of anti-inflammatory response. Glutathione S-transferases are biomarkers of inflammation and oxidative stress. These phase II enzymes play a relevant role in detoxifying xenobiotic compounds. Particular attention has been focused on GSTA1, GSTM1, GSTO2, GSTP1, and GSTT1 gene to evaluate if GST gene polymorphisms are associated with hypothyroidism .
**Materials and Methods** We screened a case-control population (n = 232) to analyze GST gene polymorphisms
**Results** In this study, we found differences in genotype distribution between hypothyroid individuals and controls only for the GSTO2*N142D polymorphism. Logistic regression analysis, after adjustment for age and gender, confirmed these positive association (OR = 4,46; 95% CI = 1,19-16,72).
**Conclusions** GSTO2 enzyme can catalyze several reactions important for countering redox stress: subjects with D142 allele may have a deficiency in the anti-oxidant enzymatic system. A decrease in antioxidant capacity may trigger increased oxidative stress. Previous studies have highlighted the role of GST enzymes in inflammation disorders, but no data are available on their role in hypothyroidism disease. Our results suggest that GSTO2 could increase disease risk susceptibility and could act as a risk factor for hypothyroidism in Italian patients.

## L'iposurrenalismo : diagnosi difficile o quadro multiforme?

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L'iposurrenalismo è una patologia con un quadro clinico vario e multiforme; per tale motivo la diagnosi può essere difficile e procrastinata. A novembre dello scorso anno veniva ricoverata nel nostro reparto una paziente di 65 anni ipertesa, broncopatica cronica, diabetica, perché affetta da calo ponderale e inappetenza da diversi mesi. Sottoposta a diversi controlli specialistici era stata inquadrata come una paziente affetta da patologia depressiva. Inoltre ricoverata precedentemente presso altro nosocomio era stata dimessa con diagnosi di scompenso cardiaco destro in paziente con cardiopatia ipertensiva. All'ingresso nel nostro reparto la paziente presentava astenia, iporessia, calo ponderale, iperpigmentazione cutanea, disturbi comportamentali con agitazione psicomotoria tale da rendere necessario l'intervento dello psichiatra e una terapia sedativa. Gli esami di laboratorio mostravano anemia, lieve iponatremia e aumento della potassemia. Lo studio del surrene confermava la presenza di bassi livelli di cortisoluria (15 microg/24 H) e di cortisolemia oraria (quasi indosabile), mentre l'ACTH era elevato (1189 pg/ml). Lo studio della paziente veniva completato con Tac torace ed addome che non evidenziava patologia degna di nota. Posta diagnosi di iposurrenalismo primitivo la paziente veniva avviata a terapia con fludrocortisone e cortisone acetato con progressiva risoluzione del quadro clinico, ripresa della corretta alimentazione, scomparsa dei disturbi psichiatrici e dell'astenia. La paziente è ancora seguita presso il nostro centro e gode di buona salute.

## Osteoporosis treatment in diabetic patients: what's different?

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**Introduction** Diabetes mellitus (DM) and osteoporotic fractures are two of the most important causes of mortality and morbidity in older subjects. Recent data report a close association between fragility fracture risk and DM, justified by negative influence by DM on bone metabolism. Antifracturative drugs, tested in general population, should be also effective in diabetics, however to date data on antifracturative therapy in diabetic patients are lacking. Aim of the present study was to describe antifracturative drugs effect on bone mineral density and bone formation in osteoporotic patients with DM.
**Subjects and methods** In a retrospective review of 320 clinical records outpatient of Metabolic Bone Diseases at Grosseto Hospital, 140 subjects resulted osteoporotic (age: 73±8 yrs) [OpnDM], whose 32 were also diabetic [OPDM]. All subjects were treated with antifracturative drugs and in all bone alkaline phosphatase (BALP) serum levels and bone mineral density (BMD) were measured at basal and after 2 years.
**Results** At basal both BALP activity and BMD did not differ between OpnDM and OPDM. After 2-years treatment BMD increases in both groups with a minor effect on OPDM treated with thiazolidinediones. Instead, BALP did not change except for diabetic patients treated with strontium ranelate (+30% and +15% vs basal at 1st and 2nd year, respectively).
**Conclusions** Although the small sample size, the study may suggest that: strontium ranelate induces BALP increase in OPDM more than in OpnDM. Antifracturatuve drugs have similar effects on BMD in diabetic and general osteoporotic patients.

## La sfida delle dimissioni difficili in Medicina Interna. Calcolo dell'indice di Flugelman per individuare precocemente i pazienti a rischio

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**Background** Il prolungamento delle degenze nei reparti di Medicina Interna è considerato fattore critico di qualità nell'assistenza sanitaria e determinante sui costi. Fra i diversi strumenti utilizzati la valutazione dell'indice di Flugelman (Italian J Med 2011;5:103-108) è stata proposta come uno dei parametri più attendibili per la valutazione del rischio di prolungamento della degenza e di mortalità intraospedaliera.
**Pazienti e metodi** L'indice di Flugelman (IF) è stato valutato in tutti i pazienti ricoverati presso la UOC di Medicina 5 dell'Ospedale San Giovanni di Roma dal 1 gennaio al 15 febbraio 2012. La valutazione sta-

tistica è stata condotta con metodi di statistica non parametrica (Wilcoxon Two-sample test).
**Risultati** Dal 1 gennaio al 15 febbraio 2012 sono stati dimessi dall'UOC Medicina 5 dell'Ospedale San Giovanni di Roma 146 pazienti. La degenza media trimmata è risultata pari a 12,56 giorni. La media dell'IF nei pazienti arruolati è stata pari a 13,19. Nei pazienti con IF inferiore a 16 la degenza media è risultata essere pari a 10,05 giorni. Nei pazienti con IF uguale o superiore a 17 la degenza media è risultata pari a 19 giorni. La differenza risulta statisticamente significativa ($p < 0,0001$).
Del pari significativa risulta la differenza dell'IF nei pazienti deceduti durante il ricovero nei confronti dei pazienti dimessi vivi (12,43 vs 20,00 $p < 0,00001$).
**Commento** Nelle nostre mani la determinazione dell'IF risulta uno strumento attendibile e riproducibile per valutare il rischio di prolungamento abnorme della degenza e di mortalità a breve termine.

## Drug reaction with eosinophilia and systemic symptoms (DRESS): a potentially life-threatening syndrome

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**Case 1** Patient of female sex, 63 ys, in ER for fever from about 5 days, resistant to the antipyretics drugs. Domiciliary therapy includes ramipril, atenolol, ASA and recently allopurinol (300 mg/die). The Body Temperature is 38°C; a labial edema and a skin eruption are appreciated; the liver volume is increased; the neurological examination is negative. SBP = 90; HR = 110/m', RR = 20 c/m.'
**Case 2** A 75 year old man, hospitalized for cerebral hemorrhage: during the observation period, a convulsive episode rises up. The prescribed therapy includes fluids, fhenobarbital (100 mg/die) and clonidine. In 4 ^ day, the appearance of fever, hypotension, tachycardia is verified; in 5 ^ day is noticed a severe maculopapular rash and, in 6 ^ day, a drastic worsening of lung exchange.
**Results** In both cases, the laboratory examinations underline an increase of leucocytes with eosinophilia, an increase of aminotransferase, LDH, CPK, a varying bilirubin increase. Performing a search on Medline (key words: Drug rash-Eosinophilia-Systemic symptoms), we have found 130 studies related to the so-called DRESS (Drug Reaction with Eosinophilia and Systemic Symptoms)
**Conclusions** The DRESS is a severe drug-related adverse reaction. The involved drugs are manifold, but mainly the anticonvulsants and the allopurinol, Different mechanisms have been proposed for explaining its development: detoxification defects with subsequent formation of immune-reactive compounds and more recently the reactivation of the human herpesvirus 6.

## Association of anti-citrullinated peptide antibodies with erosive arthritis in SSc patients

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**Objective** To determine the frequency of anti-citrullinated peptides antibody( ACPA) in SSc patients and to evaluate the association with clinical arthritis and inflammatory findings.
**Methods** A total of 142 (122 F-20 M) unselected, consecutive pts with SSc were included in our study, with an average age of 58 years, 16 pts (11.3%) with Early Sclerosis, 12 pts (8.4%) with intermediate SSc, 72 pts (50.7%) with Limited SSc, 42 pts (29.6%) with Diffuse SSc, and 40 healthy control group subjects. ACPA and rheumatoid factor were determined in all SSc patients and control group; and clinical data were carefully analyzed in 142 consecutive SSc patients fulfilling Leroy and Medsger criteria.
**Results** ACPA were found in 30/142 (21,1%)patients with SSc: 1/16 with early sclerosis,2/12 with intermediate SSc,11/72 with limited SSc,16/42 with diffuse SSc; They were not found in control group.Significantly higher percentage of diffuse SSc had positive ACPA compared with others pts with SSc ( 26,2%vs 7,1% p= 0,009.Positive RF was found in 36/142 (25%) SSc pts, RF not found in control group.Statistically significant association was found between positive ACPA and erosion (p=0,0002)
**Conclusion** ACPA are associated with erosion by radiography and inflammatory findings in SSc. There has not been any standardized therapy of arthritis in SSc, our study may contribute to decide an aggressive treatment of arthritis in SSc patients.

## Malnutrition in elderly patients accepted in geriatric departements

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**Introduction and aim of the study** Malnutrition is frequently undetected and untreated causing a wide range of adverse consequences. Elderly patients at risk of malnutrition stay in hospital significantly longer and have a worse clinical outcome. It is essential an early and effective approach in order to identify patients at risk.
**Materials and methods** MUST (Malnutrition Universal Screening Tool) is a rapid, simple and general procedure used by nursing, medical or other staff on first contact with the patient. We evaluated 30 elderly patients (age > 70, 14 men and 16 women) admitted to our department long-term care for multiple chronic diseases.
**Results and conclusions** In relation to MUST score, 18 patients were at high risk of malnutrition (score > 1), 6 patients at medium risk (score 1), 6 at low risk risk (score 0). Our data confirm that malnutrition is an important problem in hospitalized elderly patients in long term care and indicate the need for an early approach to this problem.

## Crowned dens syndrome mimicking acute meningitis

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The crowned dens syndrome (CDS) is a clinic-radiological entity defined as acute neck pain due to deposition of crystals around the odontoid process. Crystal deposition may occur without symptoms or exhibit myelopathy by compressing the spinal cord.
Here we present a case report of a 72 year old female admitted to the medical departement with a clinical presentation mimicking acute meningitis, characterized by acute onset fever, neck pain, diplopia, drowsiness. On physical examination, Kernig's and Brudzinski's sign were present. Blood tests showed elevation of aspecific inflammatory markers. Brain CT scan and cerebral liquid fluid analysis was performed, ruling out the diagnosis of meningitis. Subseguent CT and MRI of the cervical spine confirmed the diagnosis of CDS. Chondrocalcinosis of a wrist and knee was also found. Treatment with non-steroidal antiinflammatory drugs resulted in dramatic improvement. Differential diagnosis should be made with rheumatoid and other seronegative arthritis, connective tissue diseases, polymyalgia rheumatica, giant cell arteritis, discitis, meningitis, neoplasm, osteoarthritis.

This entity should be better known, since it can mimic numerous diseases leading to unnecessary and prolonged treatment, apart from being a possible aetiology for fevers of unknown origin.

## The relationship between serum aldosterone and left ventricular hypertrophy in a population with resistant hypertension

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**Background** Cardiac remodelling might be an important mechanism for aldosterone-mediated cardiovascular (CV) morbidity and mortality. In previous our studies (XV Congresso nazionale FADOI 2010) we have find 30% Primary Hyperaldosteronism (idiopathic IHA and adrenal adenoma APA) in patients with resistant hypertension. We aimed to evaluate the relationship of serum aldosterone concentration (SAC) and aldosterone-to-renin ratio (ARR) with echocardiographic parameters of LV in our population with hypertension resistant (IRA) inflows in our center.
**Methods** 126 patients with IRA underwent measurement of SAC and ARR, Average age was 53,6 years. BMI 33 ± 4. All patients were under treatment at least three drugs with PAS average 158 ± 10mmHg and diastolic 96 ± 6mmhg. The patients were subjected to echocardiogram Patients were divided into two groups. Group A 78 patients with ARR <40 and Group B 48 patients with ARR> 40.
Results The results are shown in the table:

| | Gruppo A | Gruppo B | |
|---|---|---|---|
| BMI | 33,1 | 33,6 | P<0,7 |
| IVSD mm | 10,8 | 12,6 | P<0,01 |
| LVID mm | 48,6 | 52,7 | P<0,01 |
| PWTD mm | 10,6 | 12,3 | P<0,01 |
| LA mm | 38,2 | 41,5 | P<0,01 |
| LV Mass/h2,7 | 55,3 | 70,3 | P<0,01 |
| RWT | 0,43 | 0,46 | P<0,01 |
| FE % | 52,4% | 51,8 | P<0,9 |

**Conclusion** Our data are suggestive that there are aldosterone-mediated pro-hypertrophic effects. And that the left ventricular hypertrophy does not only depend on the pressure load.

## Integrazione ospedale-territorio: l'introduzione dell'ABI in un programma di ottimizzazione delle richieste di Doppler vascolare

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**Premesse scopo dello studio** L'ABI (Ankle Brachial Index) è un indicatore semplice e a basso costo di arteriopatia periferica e mortalità/morbidità cardiovascolare. Dal 2011 è attivo un ambulatorio dedicato per la determinazione di ABI in funzione della ottimizzazione delle richieste di doppler arterioso arti inferiori.
**Materiali e Metodi** Abbiamo analizzato 200 determinazioni ABI effettuate mediante uno sfigmomanometro manuale e sonda doppler Huntleigh Dopplex SD2.
**Risultati** Sono stati individuati 17 ABI patologici 8,5%, di questi il 60% era iperteso, il 36% diabetico di cui il 50% diabetico + iperteso. L'89% dei pazienti con ABI patologico era asintomatico per claudicatio. In parallelo si è notata una riduzione del 5% delle richieste di doppler arterioso rispetto all'anno precedente.
**Conclusioni** La determinazione di ABI individua una popolazione affetta da arteriopatia obliterante asintomatica con costi inferiori a quelli del doppler. La comorbidità di più frequente riscontro è l'ipertensione e in seconda battuta il diabete (associato peraltro a ipertensione). I nostri dati sono in linea con la casistica internazionale L'introduzione di questa metodica nell'ambito del PDTA aziendale finalizzato alla ottimizzazione delle richieste di doppler vascolare permette di ridurre le indagini doppler arteriosi arti inferiori a favore di altre indagini ultrasonografiche con un contenimento dei tempi di attesa.
**Programma futuro** Assoggettare l'esecuzione del doppler arterioso all'esecuzione dell'ABI; effettuare un ecodoppler dei vasi epiaortici nei soggetti con ABI< 0,5.

## BMI 85,6: un caso di gravissima obesità

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Paziente di 56 aa affetta da grave obesità BMI 85.6 in NIMV per OSAS con BiPAP e supplementazione di ossigeno, inviata (aprile 2011) per valutazione ambulatoriale dietologica e eventuale trattamento dietetico; trasferita in PS per grave scompenso cardiaco NYHA IV e severa insufficienza respiratoria ipercapnica (pH 7.30, pO2 27.6 mmHg, pCO2 69.6 mmHg), OSAS, incontinenza urinaria: ricovero in Medicina Interna. All'arrivo le condizioni respiratorie hanno richiesto trattamento ventilatorio con NIMV (PSV: PS 14 cmH2O PEEP 4 cm H2O in O2 3 L/min) e trattamento con diuretici ev ad alte dosi; per comparsa di FA inizia TAO. Durante la degenza si è assistito un calo ponderale di circa 60 kg, rendendo possibile il passaggio letto sedia a rotelle. Alla dimissione Kg 151 BMI 53,5. La durata della degenza è stata di circa 7 mesi per l'impossibilità di trovare una sistemazione compatibile con il peso della paziente. Le condizioni respiratorie sono progressivamente migliorate tanto da interrompere la LTOT, prosegue ventilazione notturna con ventilatore Carat II. Ottobre 2011: Kg 105 BMI 37,2 polisonnografia: dimezzate le apnee notturne; risolta l'insufficienza respiratoria ipercapnica, controllato lo scompenso cardiaco (NYHA II), risolta l'incontinenza urinaria. Persiste impossibilità alla deambulazione per "scomparsa delle rime articolari bilaterali, sublussazione laterale delle tibie rispetto ai femori". Programmata per marzo 2012 protesi bilaterale di ginocchio. La eccezionalità del caso clinico è dovuta alla eccellente risposta alle terapia in una forma di gravissima obesità.

## Grave ipercalcemia postoperatoria in iperparatiroidismo primitivo

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**Premesse e scopo dello studio** L'iperparatiroidismo primitivo, caratterizzato da ipercalcemia con paratormone (PTH) inappropriatamente elevato, con prevalenza di 3/1000 nella popolazione generale, ma raro prima dei 50 anni, è frequentemente asintomatico. Nel 5-10% dei casi è presente in forma familiare (MEN1/MEN2/iperparatiroidismo familiare isolato).
Descriviamo un caso di iperparatiroidismo primitivo diagnosticato con presentazione inusuale.

**Materiali e Metodi** Un uomo di 37 anni, affetto da insufficienza renale in stenosi del giunto pielo ureterale bilaterale con rene destro escluso e calcolosi pielica bilaterale, sottoposto a pieloplastica, presenta, nell'immediato postoperatorio, stato di shock con insufficienza multiorgano, miopatia e CID. Gli esami mostrano grave ipercalcemia (Ca 20 mg/dl) con PTH elevato (360 pg/ml-v.n. 6-36). Un voluminoso nodulo (37 mm) compatibile ecograficamente con paratiroide, è captante alla scintigrafia con Tc99-m. Il controllo dell'ipercalcemia è stato ottenuto con cinacalcet e, dopo miglioramento della funzione renale, con zoledronato. Gli esami ormonali per escludere una MEN sono risultati negativi. Nella norma la MOC vertebrale e femorale. Dopo paratiroidectomia la calcemia risulta di 8,9 mg/dl in trattamento con calcio e calcitriolo.
**Conclusioni** L'iperparatiroidismo del paziente, espresso clinicamente solo dalla litiasi renale, è stato complicato nel post operatorio da gravissima ipercalcemia, sottolineando la necessità di un attento studio eziologico della litiasi renale e l'esclusione dell'iperparatiroidismo anche nei soggetti giovani.

## Microrganismi patogeni multiresistenti: una minaccia crescente

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**Introduzione** La diffusione di patogeni multiresistenti rappresenta una crescente minaccia per la salute con elevata mortalità e morbilità. Klebsiella Pneumoniae (KP) è un batterio gram negativo produttore di betalattamasi a spettro esteso (ESBL), derivate da mutazioni di enzimi TEM-1 e SHV-1 e varianti. Recente descrizione di resistenza a carbapenemasi tipo KPC e di una metallo-beta-lattamasi chiamata NDM-1.
**Materiali** Paziente di 63 anni con perforazione esofagea spontanea complicata da fistola, veniva trattato con protesi autoespansibile; rapido peggioramento del quadro clinico con stato settico e isolamento alle emocolture di KP. Dopo lunga degenza in Rianimazione e negativizzazione delle emocolture, veniva trasferito in Medicina.
**Risultati** Portatore di esofagostomia cervicale, tracheotomia, esclusione dell'esofago e digiunostomia. Recidiva di febbricola con negatività delle emocolture e isolamento nel liquido drenaggio esofageo di KP; effettuata segnalazione per microrganismi "alert" e attuate le procedure per la prevenzione della trasmissione delle malattie infettive.
**Conclusioni** I fattori associati alla colonizzazione o all'infezione da germi produttori di ESBL sono: presenza di CV, CVC, chirurgia addominale d'urgenza, ospedalizzazione prolungata, assunzione di antibiotici ed età avanzata. E' indispensabile evitare la diffusione del germe il più precocemente possibile con l'adozione di misure precauzionali, rendere omogeneo il comportamento degli operatori coinvolti nell'assistenza e implementare il corretto uso degli antibiotici sia in ospedale che nel territorio.

## Una curiosa e casuale associazione

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**Premessa** L' acronimo LADA (latent autoimmune diabetes in adults) identifica una forma di diabete autoimmune a insorgenza in età adulta, a lenta progressione, che condivide aspetti genetici e immunologici con il DM1, ma anche tratti metabolici e antropometrici con il DM2. Spesso la diagnosi di LADA rimane misconosciuta. Oltre il basso BMI e l'età di insorgenza, devono far sospettare il LADA la familiarità o la presenza di altre malattie autoimmuni.
**Materiali e metodi** Donna di 54 anni, recente diagnosi di DM2 in terapia con metformina. Da due anni vitiligine e negli ultimi mesi calo ponderale con BMI di 21Kg/m2. HbA1c 10,1 %. C-Peptide 2,1 g/L (v.n.1,1-4,4). Nella norma i restanti esami ematochimici. Positivi gli anticorpi anti GAD e anti IA2. Anticorpi anti tTg, anti TPO, antirecettore del TSH, antisurrene, ANA, ENA negativi. Sopra la norma fT3 e fT4 con TSH inappropriatamente normo- alto (4,95 mUI/L v.n. 0,30-5,00) e con eutiroidismo clinico. Normale la risposta del TSH al TRH- test e la RMN ipofisi. I dati escludevano l'ipertiroidismo secondario, consentendo la diagnosi di resistenza periferica agli ormoni tiroidei, condizione causata da mutazioni a carico del recettore-beta per gli ormoni tiroidei e che non richiede terapia. Per il LADA veniva associato alla metformina il sitagliptin con netto miglioramento del compenso glicemico.
**Conclusioni** Il LADA come il DM1 può associarsi ad altri disordini autoimmuni, come, nel nostro caso, la vitiligine. Invece non è ad oggi riportata in letteratura l'associazione tra autoimmunità e resistenza periferica agli ormoni tiroidei.

## A chronic inflammatory bowel disease

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In February 2011 came in Emergency Medicine a young woman 19 year old with fever, vomiting, abdominal pain, profuse diarrhea. The patient was transferred to Infectious Diseases Unit, where were negative Blood cultures and culture and parasitological stool tests, serology for Salmonella, enterovirus, HIV; also were normal thyroid function, ANA, ANCA, ASCA and the study of Rx digestive tract. The endoscopic investigations have shown signs of duodenitis with histological features of lymphocytic inflammation and villous atrophy, and edema of the mucosa of the colon and cryptic microabscesses. The patient came to our attention after having been treated with antibiotics in combination, antifungals, steroids and gluten-free diet, with partial benefit. The laboratory tests revealed hypokalemia, microcytic anemia, thrombocytosis, whereas calprotectin was positive. Even in the presence of a histological picture compatible, the negativity of anti transglutaminase and antiendomysial there appeared to support the hypothesis of diagnostic Celiac disease; the pattern was present HLADQ8, but not DQ2. We have suspended all therapy and allowed a free diet, observing remittent fever, anorexia, abdominal discomfort, bloating, diarrhea with six stools per day decreased stool consistency and normal appearance. The diagnosis of inflammatory bowel disease has been formulated on the basis of the clinical-instrumental, the initial response to intermediate doses of steroids and exclusion of other diseases.

## Ipertensione arteriosa secondaria

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Nel mese di luglio 2011 è giunta alla nostra osservazione una donna di 72 anni a motivo di ipertensione arteriosa severa, ipopotassiemia (K+ 2,2

mEq/l), astenia; a domicilio la paziente seguiva trattamento con Sartani, Doxazosina, e supplementi orali di Potassio. Le indagini di laboratorio hanno messo in evidenza alcalosi metabolica (pH 7,47 - pCO2 40 mmHg - pO2 87 mmHg - HCO3- 29,1 mmol/L) ed aumento significativo dell'Aldosterone plasmatico (in ortostatismo 815,5 pg/ml, per v.n. 35-300), con mancata soppressione della Renina verosimilmente da attribuire alla somministrazione di farmaci inibenti il sistema RAA; il rapporto Aldosterone/Renina era pari a 28, e quindi superiore a 20, che è considerato il limite significativo sul piano diagnostico. La TC ha rivelato una lesione rotondeggiante di 1,5 cm di diametro a carico del surrene sinistro, compatibile con adenoma. Abbiamo intrapreso terapia con Spironolattone, ottenendo normalizzazione della pressione arteriosa e della potassiemia. Nel successivo mese di agosto la paziente è stata sottoposta a surrenectomia sinistra per via laparoscopica. L'esame istologico ha confermato l'ipotesi diagnostica di adenoma surrenalico. La pressione arteriosa si è normalizzata nell'arco di pochi giorni, senza dover fare ricorso a farmaci anti-ipertensivi. La potassiemia, dopo un mese di valori superiori alla norma si è gradualmente riportata verso la normalità.

## Ipertensione polmonare idiopatica

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Nel mese di agosto 2011 è giunta alla nostra osservazione una donna di 41 anni, in vacanza da qualche giorno nella nostra Regione. Il motivo del ricovero era costituito da dispnea a riposo, facile faticabilità, distensione addominale, edemi malleolari, incremento di peso. Sei mesi prima la paziente si era sottoposta ad interruzione volontaria di gravidanza; di seguito, inserimento di un anello vaginale contenente estroprogestinici, e comparsa di dispnea ingravescente. L'ecocardiogramma all'ingresso metteva in evidenza ipertensione polmonare di grado severo (PAPS 120 mmHg) e dilatazione delle sezioni destre; concomitavano ipossiemia moderata, alcalosi respiratoria (pH 7,46 - pCO2 25mmHg - pO2 56mmHg - HCO3- 24,7 mmol/L) segni clinici e strumentali di Scompenso cardiaco destro (fegato da stasi accompagnato da riscontro ecografico di ectasia delle vene sovra epatiche, proBNP 4730 pg/ml), versamento pericardico lieve, ipotiroidismo subclinico. Il cateterismo cardiaco destro ha rilevato una ipertensione polmonare precapillare di grado severo (pressione arteriosa polmonare 110/75/55 mmHg), e dimostrato assenza di vasoreattività. L'ipotesi di eziopatogenesi tromboembolica non ha trovato conferma con angioTC polmonare e Scintigrafia polmonare perfusionale; sono state anche escluse altre possibili cause. Abbiamo somministrato Ossigenoterapia, diuretici dell'ansa, Spironolattone ed istituito terapia anticoagulante orale con Warfarin, osservando graduale miglioramento della dispnea e del peso corporeo, sceso da 57 a 51 Kg.

## MICI ed eritema nodoso

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Nel mese di novembre 2011 è giunta alla nostra osservazione una studentessa di 18 anni, per una sintomatologia esordita nelle due settimane precedenti e caratterizzata da febbre e diarrea con sette-otto scariche al giorno di feci muco ematiche, e successivamente da comparsa di eritema nodoso. A domicilio era stata somministrata terapia antibiotica con Ciprofloxacina. Gli esami di laboratorio hanno messo in evidenza segni di flogosi (Fb 806 mg/dl, PCR 181 mg/l, PLT 918.000) positività di ASCA e Calprotectina fecale e negatività di Coprocolture, Emocolture, esame parassitologico delle feci, Sierodiagnosi Vidal Wright, ANA, ENA, ANCA, Anticorpi anti-endomisio, anti transglutaminasi, anti-HIV. La colonscopia si è dovuta arrestare a livello del sigma distale per acuzie del quadro infiammatorio; l'esame istologico ha rilevato una mucosa del grosso intestino con distorsione e riduzione della muciparità ghiandolare, intensa flogosi cronica attiva, ulcero erosiva della lamina propria con criptite. In sintesi, l'aspetto endoscopico del tratto di colon esaminato e l'esame istologico facevano propendere per la diagnosi di Colite ulcerosa, mentre la positività di ASCA era a favore della Malattia di Crohn del colon. Abbiamo istituito terapia immunosoppressiva con Steroidi ed anti-infiammatoria con 5-ASA, osservando sfebbramento, miglioramento della sintomatologia e remissione dell'eritema nodoso. I dati a disposizione consentono allo stato attuale di esprimere la diagnosi di Malattia infiammatoria cronica del colon, in remissione parziale.

## Ictus da embolia paradossa

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Nel dicembre 2011 è giunta alla nostra osservazione una paziente di 51 anni, a motivo di deficit motorio parziale all'emisoma destro, con evidenza TC di ischemia in sede periventricolare laterale sinistra. La paziente era affetta da Diabete mellito di tipo 1, esordito nell'adolescenza e complicato con retinopatia proliferativa che aveva determinato amaurosi bilaterale. L'eco-colorDoppler non metteva in evidenza alterazioni significative a livello carotideo. L'ecocardiogramma trans-toracico ha rivelato un aneurisma del setto interatriale, mentre l'ecocardiogramma trans-esofageo ha consentito di individuare un forame ovale pervio. Abbiamo dimesso la paziente prescrivendo terapia con ASA per la prevenzione secondaria dello stroke, e successivamente, d'intesa con i colleghi della Cardiologia Emodinamica si è deciso di riparare il difetto per via transcatetere. Il caso ci sembra degno di menzione in quanto dovrebbe indurre a ricercare una possibile causa di embolia paradossa anche in pazienti adulti di età inferiore a 55 anni con fattori di rischio cardiovascolare come il diabete mellito.

## Ipercalcemia grave

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**Introduzione** IPTP si realizza quando vi è una iperproduzione autonoma di PTH.Massima incidenza dopo la sesta decade.Rapporto F:M di 3:1.E'causato da adenoma di paratiroide(85%),iperplasia di tutte le ghiandole(10-15%)e carcinoma paratiroideo(1%).Uomo di 74 anni si rivolge al PS per intensa astenia e poliuria e viene ricoverato in rep. di medicina con diagnosi di insufficienza renale acuta su cronica ipercalcemia ed iperkaliemia.
A.F negativa. A.P.R:ipertrofia prostatica.Nel 2009 emicolectomia dx per polipi adenomatosi. Cheratoacantosi cutanea su cheratosi attinica. Calcoli renali. A.P.P:astenia malessere generale inappetenza incontinenza urinaria e confusione mentale.E.O:,cute e mucose asciutte addo-

me trattabile non dolente.Vigile ma rallentato nell'ideazione e nell'eloquio.
Es.strumentali e lab: TC:36,5°C; pH:7.34;HCO3:18.1;BE:-6.6; Ca2+: 2.320mmol/L()K:5,5.
ECG:ritmo sinusale.EASX.OndeTda ipercalcemia.QT corto.
Prot.Tot:5,2g/dl; Alb:2,8g/dl; PTH:2.490,0() pg/ml; 25-OHVitamina D: 8,9(¯).
Ca+Urin:17mg/24h; Ph urin:36 gr/24h;iniziava terapia reidratante e diuretica.
Rx torace nei limiti; eco addome:calcoli renali;eco tiroide:nodulo ipoecogeno di 32x23mm;scintigrafia con tecn.-sestamibi:paratiroidi iperfunzionanti iperplasico-adenomatose loggia di dx.Alla dimissione: crea t:1,99;K:3.60;Ca:10.2;Ph:2.4.Risoluzione della sintomatologia.Il paziente rifiutava intervento chirurgico di paratiroidectomia.

## Polisierosite con tamponamento cardiaco

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**Presentazione** S.M. uomo di 37 anni, in buona salute, accusa comparsa di febbre, tosse stizzosa e toracoalgia. All' Rx torace addensamento parenchimale sn; viene prescritta terapia antibiotica con regressione della febbre ma comparsa di dispnea da sforzo. In data 05/8/2011, al risveglio, grave dispnea a riposo; si reca in PS dove viene riscontrato quadro di tamponamento cardiaco.
**Decorso** Trasferito in UTI, viene sottoposto a pericardiocentesi (1400 ml sieroematico) e a drenaggio toracico bilaterale (1000 ml di trasudato per lato); la TC evidenzia anche presenza di ascite. Negativi gli esami microbiologici, la sierologia per HIV, EBV, CMV, HBV, HCV, tampone per H1N1, autoimmunità. Negativi per neoplasia i citologici su liquido pericardico, pleurico, BAL e istologico su broncoaspirato. Alla TC dopo 6 gg pressochè totale detersione alveolare e scomparsa dei versamenti pleurico e peritoneale. In reparto proseguita la terapia antibiotica e steroidea con progressivo scalare. Elevati valori di CA 125 e CA 19-9 all'ingresso, normalizzati alla dimissione; persiste minuta falda liquida pleurica sn e pericardica (< 10 mm). A pochi gg dalla dimissione monoartrite tibiotarsica dx, risolta con FANS, e riscontro di TVP gemellare dx, con reperto US toracico e cardiaco invariato; viene iniziata TAO. Dopo pochi giorni ricomparsa della dispnea: all'ecocardio tamponamento cardiaco, con PEA durante l'esame, risolta con RCP e pericardio centesi. La citologia su liquido pericardico è positiva per AdenoCa.
**Conclusioni** AdenoCa polmonare in giovane esordito con polisierosite e tamponamento cardiaco.

## Le sindromi ipereosinofile: descrizione di un caso clinico

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**Premesse e scopo dello studio** Le s. ipereosinofile costituiscono una patologia rara, caratterizzata da ipereosinofilia (> 1500/mm3 ) per almeno 6 mesi, in assenza di cause allergiche o parassitarie, con danno d'organo indotto dagli eosinofili. Descriviamo un caso di s. ipereosinofila e puntualizziamo gli aspetti classificativi e diagnostico-terapeutici.
**Caso clinico** Donna di anni 50, si presenta in PS per dispnea e dolore epigastrico. Non diatesi allergica in anamnesi. Si evidenzia: ipereosinofilia (all'ingresso: 6650, dopo 4 giorni: 10700/mm3), Hb 13.1, Plt 34000, PCR < 5, IgE >2000, vit.B12 1066, LDH 809, ANCA assenti; Prick test negativi, Ricerca parassiti nelle feci e sierologia Toxoplasma, Strongyloides, Echinococco, Schistosoma, Toxocara canis, Trichinella spiralis: negative. Spirometria nella norma. HRTC polmonare: non segni di lesioni parenchimali; strutture cardiovascolari regolari. Ecocardiogramma regolare; Eco e TC addome: epatomegalia, non splenomegalia. Gastro-e colonscopia: reperto regolare. BOM: moderata eosinofilia. La ricerca di BCR/ABL, di traslocazione della regione PDGFRB, del riarrangiamento FIP1L1-PDGFRA ha dato esito negativo. Analisi immunofenotipica: assenza di cloni cellulari T. Biopsia gastrica: gastrite cronica atrofica di grado moderato. Biopsia epatica: Flogosi portale a spiccata impronta eosinofila, focali aspetti granulomatosi"a palizzata"con necrosi. Buona risposta ai corticosteroidi (Eo 870/mm3, Plt 208000, dopo 3 settimane).
**Conclusioni** Secondo la nuova classificazione, il nostro è un caso di s. ipereosinofila idiopatica complessa.

## ✪ Analysis of 25-OH vitamin D in patients with type 2 diabetes mellitus

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Deficiency in 25-hydroxyvitamin D (25OHD) has been associated with insulin resistance, pancreatic beta-cell dysfunction and metabolic syndrome. More recent evidence supports an association also between 25OHD deficiency and coronary artery disease. In the present study was evaluated the prevalence of vitamin D deficiency and was investigated the association between vitamin D deficiency and ischemic heart disease in type 2 diabetes mellitus patients. We assessed vitamin D status in a large cohort of outpatient type 2 diabetic patients consecutively enrolled in the period from December to March in the Units of Diabetes and Internal Medicine of San Gennaro Hospital, Naples, Italy (n=698). Serum vitamin D levels were analyzed as a continuous variable and were defined as normal (≥20 ng/ml) or deficient (<20 ng/ml). In our cohort, 75% of patients were women, the mean age was 66.1 ± 9.36 years, the mean body mass index (BMI) was 31.14 ± 6.14. The mean serum levels of vitamin D were 18.23 ± 10.06 ng / ml; 234 subjects (33%) showed normal vitamin D levels while 464 (77%) were found to be in the deficient range. Moreover, we found that vitamin D deficiency was associated with coronary heart disease with an odds ratio of 1.6. In conclusion, this study shows that low vitamin D levels has high prevalence in Southern Italian diabetic patients (67% of subjects) and is associated with an increased risk of cardiovascular disease. Unfortunately, food fortified with Vitamin D is not commonly available in Italy and supplementation should be recommended in this patient population.

## ✪ Clinical Governance and Internal Medicine: from theory to practice

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**Background** Increased health expectations, new technologies and decreased economic resources have led to the development of Clinical

Governance (CG), a multidimensional tool to improve appropriateness and promote excellence.
**Objectives and methods** To evaluate the actual use of CG in Internal Medicine Wards (IMW) of Italian hospitals, we administered a 67-item questionnaire to 39 physicians from 33 IMW. We examined the perceived usefulness (graded from 0 to 4), the utilization rate of 46 CG tools and correlations between CG use and wards' characteristics/location. We also investigated the level (organization, department, ward) of CG use.
Results The 33 IMW cared for about 44.700 in- and 197.000 outpatients in 2010 (mean length of stay: 8.83 days; mean occupancy rate: 94.6±13.6%; mean DRG weight: 1.2).
The mean age of medical staff was 48.7±5.4 ys. On average 54% (9-84%) of the studied tools are used by the investigated hospitals and 21 hospitals use more than 50% of them. Clinical guidelines resulted the most used (100%) and the most useful (3.57/4) tool, whereas observational studies the least one (22%; 1.5/4). The utilization rate showed a geographical trend from northern (70±13.7%) to central (62.6±16.4%) and southern regions (40±18.6%). Only 10% of the investigated tools is used at organization level.
The number of CG tools used appeared related to IMW characteristics/performance and previous knowledge of CG.
**Conclusions** The present study showed that CG is quite used in Italian hospitals, mainly at ward level. All the interviewed physicians considered CG tools useful.

## Pancreatite acuta e dissezione focale dell'aorta addominale

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Non sempre due eventi acuti concomitanti hanno un'unica genesi. Un paziente iperteso di 80 aa giungeva in DEA per dolore addominale e lombare, con iperlipasemia e lieve ipertransaminasemia. Il controllo TC seriato mostrava una tumefazione pancreatica con raccolta liquida peripancreatica e modesto versamento pleurico sx, ma anche un flap intimale a livello dell'aorta addominale, tra mesenterica inferiore e arterie renali, di circa 2cm, senza impegno delle arterie viscerali e degli assi iliaci e senza complicanze ischemiche o emorragiche. La dissezione focale veniva attribuita a pousseè ipertensiva. Esclusa l'opzione chirurgica, veniva monitorato in UTIC. A 72 ore si osservava un lieve aumento della raccolta peripancreatica, con anemizzazione. Trasferito in Medicina, accusava allucinazioni visive non criticate, senza altri segni neurologici, ma migliorava con cure mediche e trasfusioni. I controlli post-dimissione hanno confermato la risoluzione della pancreatite (organizzazione della raccolta, regressione del versamento pleurico) e la stabilità del flap aortico. A posteriori non si può stimare con precisione il contributo della dissezione focale alla sintomatologia algica indicata. Gli esami US e TC non hanno messo in luce anomalie o altre lesioni a carico dei vasi tributari del pancreas. La pancreatite, eclatante (con spiccata iperlipasemia, progressione della raccolta peripancreatica, verosimile encefalopatia pancreatica), è stata etichettata come idiopatica.

## Un complicato caso di ematoma epatico con deficit di Fattore XII

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La coesistenza di più malattie e le politerapie propongono a volte quesiti la cui soluzione rimane speculativa. Un paziente di 76 aa con DMT2, ipertensione arteriosa, cardiopatia ischemica, MGUS IgG-λ, venne ricoverato in Medicina dopo 2 interventi di appendicectomia (gen.2010) e bypass aorto-coronarico (mar.2010), per una sepsi da Staphylococcus haemoliticus meticillinoresistente e Bacteroides capillosus. Accanto ai segni di flogosi e allo squilibrio glicometabolico, si registrava una doppia componente monoclonale IgG-λ con proteinuria di Bence Jones e un deficit del fattore XII della coagulazione, da possibile presenza di inibitore plasmatico. Una terapia antibiotica mirata consentiva la risoluzione della febbre con stabilizzazione metabolica, ma nel frattempo si documentava un voluminoso ematoma al IV-V segmento epatico, con modesta anemia normocitica. Si disponeva monitoraggio strumentale dell'ematoma, che subiva pian piano una progressiva riduzione, seppure parziale, senza ulteriori complicanze settiche. A distanza di alcuni mesi si constatava la normalizzazione del FXII. In questo caso la genesi dell'ematoma è stata attribuita alla terapia antiaggregante. Sono invece controverse l'origine del deficit di FXII (consumo selettivo per flogosi acuta; induzione di inibitori specifici; interferenza farmacologica; disordine dell'immuno-competenza da gammopatia, descritto nel m. di Waldenstrom) e il suo ruolo nella genesi dell'ematoma: le attuali conoscenze riconoscono infatti a questo deficit un'azione protrombotica, peraltro non ben definita in ambito clinico.

## Danno polmonare acuto (ALI) da verosimile embolia grassa in paziente con frattura maggiore

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**Premesse** Il danno polmonare acuto (ALI) è una sindrome clinica caratterizzata da insufficienza respiratoria acuta ipossiemica ed infiltrati polmonari bilaterali, non secondari ad ipertensione atriale sn. ma a danno polmonare diretto o indiretto e tra le cui cause ci può essere l'embolia grassa successiva a frattura ossea maggiore.
**Presentazione del caso** Uomo di 28 anni con comparsa di dispnea a riposo, tosse stizzosa e febbre con brividi 48 ore dopo la frattura scomposta tibio-peroneale sn. causata da incidente stradale. All'esame obiettivo: tachipnea (28-30 atti/min), tachicardia (100 b/min), senza deficit neurologici né ulteriori dati patologici rilevanti. All'emogasanalisi arteriosa in aria ambiente: insufficienza respiratoria acuta con riduzione del rapporto pressione parziale arteriosa/frazione inspiratoria di ossigeno (PaO2/FiO2 <300 mmHg); indici di funzionalità renale, epatica, emocromo, ecocardiogramma e eco-color-Doppler venoso degli arti inferiori nella norma. Emocolture e urinocoltura negative. Alla Tac del torace con m.d.c., diffusa interstiziopatia a "vetro smerigliato" e aree di consolidamento ai lobi inferiori; escluso il tromboembolismo. E' stata intrapresa la terapia corticosteroidea e.v. e la ventilazione meccanica non-invasiva in modalità pressione di supporto (PSV) + pressione positiva di fine espirazione (Peep) con rapido miglioramento clinico, radiologico ed emogasanalitico.
**Conclusioni** In base alla sequenzialità degli eventi, al quadro clinico ed al suo decorso, è stata posta la diagnosi di ALI secondario a possibile microembolia grassa.

## ✪ Evaluation of renal dysfunction in type 2 diabetes mellitus patients

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**Background** The National Kidney Foundation recommends the use of equations to estimate glomerular filtration rate (GFR). The aim of our study was to compare the different equations for GFR estimation in a cohort of outpatients with type 2 diabetes mellitus (T2DM).

**Patients and methods** This cross sectional study included 1686 T2DM patients (age 68±10 years; 57.1% males) of whom 7% were on glitazones, 39.5% on metformin, 6.8% on repaglinide, 10.5% on sulphonylureas, 35.5% on sulphonylureas and metformin and 0.7% on dipeptidyl peptidase 4 (dpp4) inhibitors. Results obtained with the different formulae were compared with Bland-Altman analysis.
**Results** Serum creatinine was equal or lower than 1.22 mg/dl in 81% subjects. By calculating the two four variables MDRD equations (MDRD186, MDRD175), 27% patients and 31.5% respectively, were classified in stages 3 to 5 of CKD, by the new CKD-EPI formula 30%, by Cockcroft-Gault formula 26%, and by the Mayo Clinic Quadratic formula 15%.
The lowest GFR was found in the group of patients treated with repaglinide while the highest GFR was detected in subjects treated with dpp4 inhibitors. The mean differences in measuring GFR with the different formulae ranged from1.03±6.20 to -14.5±11.9 ml/min/1.73m2 .
**Conclusion** Evaluation of GFR with different formulae could classify T2DM patients differently into the 5 stages of CKD, especially in the early stages of renal dysfunction. Consequently in T2DM patients the evaluation of the risk of adverse outcome could be affected by the formula chosen by physicians.

## Una ragazza con una rara malattia

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Ragazza di 31 anni, con anamnesi patologica remota positiva per porpora trombocitopenica immune per la quale 20 anni fa fu sottoposta a splenectomia con ripristino della normale conta piastrinica, giungeva al ricovero a seguito della persistenza da 2 settimane di astenia, dispnea per modesti sforzi, cefalea. Il medico curante prescriveva emocromo che attestava anemia macrocitica (8.1 Hb, 102 MCV) e piastrinopenia (40000/mmc). Veniva disposto ricovero urgente.
All'ingresso la ragazza riferiva cicli mestruali regolari per frequenza e quantità. Il giorno precedente il ricovero segnalava febbre continua (38°C), dolori addominali diffusi con 1 episodio di vomito alimentare. Un emocromo di 1 anno fa segnalava 14 g/dl di Hb e 416000 piastrine. L'esame obiettivo neurologico ed addominale erano negativi (così come il cardiaco ed il toracico), non linfoadenopatie.
Un profilo ematobiochimico confermava sostanzialmente i valori suddetti all'emocromo mentre i parametri emocoagulativi erano nella norma cosi' come la funzionalità renale, transaminasi, amilasi, Coombs diretto ed indiretto, crioglobuline e CPK; elevata era invece la LDH (3230 U/l), la bilirubina tot (2.1, diretta 0.3 mg/dl) e ridotta la aptoglobina (7 mg/dl) a suggerire la sede intravascolare dell'emolisi. Uno striscio di sangue periferico evidenziava la presenza di schistociti (6%). La paziente veniva trasferita con urgenza in Ematologia per effettuazione di plasmaferesi nel forte sospetto di s. di Moschowitz.

## An unusual presentation of a pheocromocytoma-paraganglioma syndrome type 4

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A 34-year-old man was referred to our outpatient hypertension (H) clinic for the diagnosis of severe H. He had a familiar history of H; he did not complain of any symptom and referred of normal blood pressure (BP) a year before. BP was 270/150 mmHg; target organ damage (TOD) was evident in the retina, heart, kidney. He was admitted to the Internal Medicine Unit for treatment of malignant H and to screen for a secondary origin. The patient was treated with i.v. labetalol and oral amlodipine, ramipril, hydroclorothiazide and potassium canreonate. After 24 hours BP was 180/110; labetalol was then given by mouth. Two 24 hour urinary normetanephrine determinations were elevated; a CT scan of the abdomen was negative; a 18 fluorodopamine PET revealed a mass in the right side of the neck which was 21 x 6.5 cm (long axis) at TC scan. The patient was referred to a tertiary hypertension clinic in Padua where a clonidine suppression test showed no substantial reduction in plasma noradrenaline. A MIBG scintigraphy confermed the PET functional imaging. The patient underwent a surgical procedure to remove the neck mass. Histology: paraganglioma(P). Genetic testing: mutation in the succinate dehydrogenase complex, subunit B gene, exon 8: patognomonic for pheocromocytoma-P syndrome type 4. Six months after surgery the patient's BP is well controlled with five drugs, urinary normetanephrines are normal and we observed regression of renal and cardiac TOD. Genetic testing of first degree relatives is ongoing.

## Il governo clinico attraverso la certificazione

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**Premesse e scopo dello studio** Nel 2011 l'UO di Medicina Interna dell' Ospedale di Pescia ha contribuito alla certificazione dell'Area Medica organizzata per intensità di cure, per i processi di ricovero a ciclo continuo, Day,hospital, day service e per i percorsi diagnostico terapeutici assistenziali I nei pazienti con ictus cerebrale e insufficienza respiratoria.
**Materiali e Metodi** Il progetto ha richiesto un approccio integrato alla qualità e sicurezza con l'applicazione di analisi del rischio tramite la Fmea (failure modes and effect analysis) su ogni processo con coinvolgimento di tutti gli operatori. I percorsi diagnostico-terapeutici sono stati definiti alla luce delle linee guida , identificate clinical patways, , validati e condivisi singoli indicatori per il monitoraggio continuo. Eseguiti ripetuti audit esterni ed interni di verifica.
**Risultati** Nel processo di ricovero a ciclo continuo (3570 ricoveri per la sola Medicina Interna nel 2011) definiti i criteri di assegnazione alle singole UUOO e ai diversi setting in base a instabilità clinica e complessità assistenziale. Definita la modalità gestionale in day service con l'identificazione di pacchetti diagnostico terapeutici ( 650 nuovi pazienti di Medicina Iinterna con patologie ematologiche, infettivo logiche, angiologiche, pneumologiche endocrine, reumatologiche, nutrizionali).
**Conclusioni** Il modello adottato garantisce il miglioramento continuo della qualità dell'assistenza in termini di sicurezza, tempestività, equità, ma richiede una verifica continua del sistema che coinvolge attivamente l'internista.

## Klebsiella Pneumoniae liver abscesses, an emerging disease - a case with uncommon endocardial involvement

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**Introduction** Until the end of the last century, E. coli was the predominant bacterial cause of pyogenic liver abscesses; beginning from 1990s Klebsiella pneumonia liver abscesses (KLA) have been described as an emerging pathology, first in Asia then in some Western countries.
**Case report** A 42-yr old Filipino man, living in Naples for many years, presented with a 7-day history of high fever without other symptoms. We demonstrated he was diabetic, although he wasn't aware of this disease. He hadn't travel abroad for the last 5 years. An ultrasound examination revealed multiple liver abscesses. A CT examination revealed other abscesses in the lungs and in the brain. Blood cultures and

cultures of the pus drained from the bigger liver abscess grew Klebsiella pneumonia. During the first antibiotic course (piperacillin plus ciprofloxacin plus metronidazole), ophthalmitis of the left eye developed, and endocardial aortic vegetation was seen with TE echocardiography. We then used meropemen at high doses until follow-up imaging showed complete resolution of all the abscesses.
**Conclusions** KLA with metastatic involvement of other organs is an emerging disease all over the world, although we didn't find until now any Italian case, nor cases with endocarditic involvement. More than one half of the patients have diabetes mellitus, as in our case. Many KLA patients are of Asian origin, but the reasons for this predominance aren't known until now.

## Knowledge evaluation of Clinical Governance tools: a pre-post training survey among healthcare employees in Department of Internal Medicine of Rivoli Hospitals

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**Background** The awareness of Clinical Governance (CG) among healthcare professionals is the main vehicle for continuously improving the quality of patient care.
**Methods** A pilot survey by a questionnaire (score 1-10) investigating CG items has been performed to physicians, nurses and healthcare assistants of Department of Internal Medicine of Rivoli Hospitals in 2011. Then, a training program about CG has been provided for employees from October 2011 to January 2012. Finally, the same questionnaire has been administered to professionals have attended training program.
**Results** The overall self-assessment was < 5 in 48% of all employees. A good degree of knowledge (>5) of guidelines who had a younger age (OR=0.5; 95% CI=0:22-1:11) has been showed, while for the older ones it was related to advanced knowledge about the following items: RM (OR=1:44, 95% CI=0.78-2.65), error (OR=1.68; 95% CI=0.87-3.21) and CG overall (OR=1:58; 95% CI=0.81-3.09).
In a pre-post training evaluation, a significant improving of good knowledge were found on CG overall (61.7%), RM (57.8%) and Sentinel Events (48.3%) items among physicians and on CG overall (52.8%), RM (56.7%) and Malpractice (42.6%) items among nurses/healthcare assistants. By professions, significant differences on CG overall ($p<0.07$), RM ($p<0.005$) and Malpractice ($p<0.001$) items were shown.
**Conclusions** Although the research shows an increasing knowledge among healthcare professionals of the CG tools, there is the need to raise awareness among frontline clinical staff to ensure that CG becomes recognized as an integral part of their clinical workload.

## Reversible central pontine myelinolysis manifested as cerebellar ataxia: case report and literature review

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**Clinical Case** 43 year old man presented with acute onset of come and spastic quadriplegia. After endotracheal intubation he was transferred to Intensive Care Unit. There was no prior history of any neurological disorder, alcoholism or chronic debilitating illness. He was in venlafaxina treatment.
**Course** During the hospital stay he showed rapid neurological improvement with complete cognitive recovery. On third day neurological examination showed truncal ataxia and dizziness. Magnetic resonance imaging (MRI) of the brain revealed central pontine myelinolysis (CPM). Bloods tests did not show electrolyte abnormalities and showed acid folic deficiency.
**Discussion** There are several reports of CPM in a setting of electrolyte abnormalities, malnutrition or alcoholism; however, in some cases the etiology remains unknown. We report a case of CPM without a clear cut etiology during venlafaxina treatment. This case of CPM was caracterized by a rare neurological presentation with cerebellar ataxia and dizzness, followed by complete spontaneous recovery without treatment. A brain MRI at two months showed complete resolution of radiological findings.

## Transient Lupic Anticoagulant (LAC) due to phenytoin use after traumatic brain injury: a case report and literature rewiew

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**Clinical case** A 72 year old man was admitted to our hospital after traumatic brain injury with subdural hematoma. He developed seizures, successfully treated with phenytoin (PH). The clinical history was remarkable for a previous ischemic stroke and mechanic aortic valve replacement on chronic anticoagulation, stopped soon after brain injury. Laboratory exams were normal. In hospital course After one week since starting phenytoin therapy, he developed recurrent transient ischemic attacks (TIA): neither seizure activity on EEG, nor extracranial and intracranial vascular disease were documented, he remained persistently in sinus rhythm. Laboratory exams showed prolongation of aPTT with normal INR, not present on hospital admission and in previous tests. Lupus anticoagulant (LAC) with high titer IgM anticardiolipin antibodies (ACA) was detected. After extensive investigation of the causes of recurrent TIAs, only LAC was identified as the etiologic agent and its presence was presumed to be associated with PH therapy which was readily stopped. Fondaparinux therapy was prudently increased. Eight weeks after PH discontinuation abnormal laboratory tests (i.e. aPTT, LAC, ACA) returned to normal values.
**Discussion** Transient LAC is a well known epiphenomenon of several infections, with uncertain pathgenetic significance; conversely it is rarely associated with drugs. We report a case of transient LAC after phenytoin treatment and presumably associated with recurring TIAs.

## Management of oral anticoagulation at discharge in elderly patients with atrial fibrillation hospitalized in an Internal Medicine ward: an observational study

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**Background** Atrial fibrillation(AF) is a leading cause of stroke. Vitamin K antagonists(VKA) are currently the drugs of choice; however, there's evidence that they are often unprescribed. The aim of the study is to review the determinants of oral anticoagulation(OA) management at hospital discharge in elderly with AF admitted to an Internal Medicine ward.

**Methods** Prospective,observational study on patients > 65 years with AF.Clinical characteristics and risk profile(CHADVASC,HASBLED) were recorded.Causes for not prescribing OA were identified in 4 main reasons:1)high hemorrhagic risk (HHR)HASBLED >2;2)high risk of fall (HRF);3)difficult management at home (DMH)(i.e. lack of supervision and/or compliance);4)difficult accessibility to INR measurement or aware refusal (DAR).
**Results** 144 patients were enrolled (mean age 80 ± 8.6 years) 42% being female.The most common comorbidities were hypertension,HF and COPD.Overall,OA was indicated by a CHADVASC>2 in 135 patients (94%),however only 54 patients (40%) received VKA prescription at hospital discharge.Main reasons for not prescribing OA were:1) HHR in 62%;2)HRF in 12%;3)DMH 11%;4)DAR 15%.
**Conclusions** OA is currently the choice for most elderly with AF,however it's still underprescribed.In our experience a high hemorrhagic risk was the main contraindication to OA.Nevertheless,there's a substantial proportion of patients (26%) in which aware refusal of VKA or difficult accessibility to INR measurement were objective reasons for unprescription of OA.These patients could be successfully treated by more versatile new oral anticoagulants.

## Remitting seronegative symmetrical synovitis with pitting edema (RS3PE) syndrome associated with carotid glomus tumor

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**Background** RS3PE syndrome is a rare form of arthritis characterized by sudden appearance of bilateral swelling of the dorsal part of hands with pitting edema and local synovitis. In the past, RS3PE was considered a disorder with favourable prognosis; more recently, association of the disease with solid tumors and heamatologic malignancy have been reported. Some authors suggest that some tumor-released factors, such as Vascular-Endothelial-Growth-Factor, may be responsible of RS3PE onset.
**Case Report** A 55 years-old female was admitted because of asthenia, neck tension and painful bilateral swelling of the hands. Examination revealed clinical features typical of RS3PE syndrome and an elastic mass in sub-mandibular left region. Lab-data showed increase of ESR and CRP values and mild microcytic anemia; normal values of tumor markers, rheumatic tests and auto-immunity. Articular ultrasound showed bilateral symmetrical synovitis of MCP, PIP and DIP (good response to steroids and NSAIDs treatment). Neck ultrasound showed a solid -4 x 3 cm- mass with loco-regional lymph-nodes. CT multislice-scan: dys-homogeneous, hypo-dense and well-vascularised expansive lesion within the origin of the left internal carotid artery; association of parietal thrombosis and occlusion of external carotid artery and internal jugular vein. Tumor of the carotid glomus was diagnosed; the patient refused surgical treatment and then circumvented the follow-up controls.
**Conclusions** Our report underlines that even a rare rheumatic disease as RS3PE may be expression of a paraneoplastic syndrome.

## ✪ Intensive monitoring of adverse drug reactions in hematologic patients: our experience

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**Background** The aim of the study is the systematic and timely detection of adverse drug reactions (ADRs) in hematologic patients, trough the analysis of the reduction of risks and adverse effects. It increases the culture of safety and security of processing through the collection of data, helping to provide statistical and epidemiological value to otherwise casual observations.
**Materials and Methods** Following the training sessions at regional level according to the project FARMAREL, meetings were held inside, repeated every 3 months in order to show the progress of the work and analyze any problems found. All patients treated in our hematology unit from April 2009 to December 2011 were monitored and if ADRs occured, physician and pharmacist team analysed the event according to the WHO definition.
**Results** We reported a total of 64 cases, categorized by the severity of adverse events (36 no severity, 3 deaths, 3 endangered life, 22 hospitalizations). The most significant clinical cases in terms of severity are: Gram-negative septic shock (suspect drug: thalidomide), intestinal ischemia (bortezomib), acute renal failure (amphotericin B); dilated cardiomyopathy (doxorubicin); atrioventricular block (lenalidomid). We also observed a significant increase of reports (from 2 to 25/year).
**Conclusions** The study has increased the culture of pharmacovigilance and the attention of the clinical data for adverse drugs reactions. The present evaluation has revealed opportunities for intervention especially for the preventable ADRs which will help in promoting safer drug use.

## ✪ Gender medicine and adverse drug reactions

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**Background** There is an increasing and specific interest for Gender Medicine that it involves study of etiology, and performance of new therapies. National data indicate that women are major consumers of drugs, but also more vulnerable to Serious Adverse Events (SAE).
**Objective** To evaluate the incidence of SAE in both genders and any quantitative and qualitative differences between them. Method: observational study conducted by SAE population that referring to Day Hospital (DH) of Internal Medicine Department.
**Results** 950 patients in three years were evaluated in DH for SAE, of these 645 were females (F = 67.9% vs. M = 32.1%; P <0.001). Females was 39.3 and males 38.9 years average aged. 286 SAE were triggered by beta-lactam antibiotics (30,2%), 210 by Beta lactam antibiotics did not (22,1%), 192 NSAID (20,2%), 142 general and local anesthetics (14,9%) and 115 by other drug classes (Cardiovascular, gastro-protective, contrast agents, etc..) (12,2%). SAE by NSAIDs were 124 women (64.6%) vs. 68 (35.4%) males (p <0.01). SAE of contrast media (15 total) were 12 (80.0%) in female compared to only three (20.00%) in the male gender (p <0.001). No significant difference was recorded for SAE from other drugs.
**Conclusions** This study has confirmed the hypothesis about the higher incidence of SAEs in the female gender, particularly in SAE by NSAIDs and contrast media agents. There are no apparent reasons for such a difference and further studies are needed on larger populations, to pursue a higher knowledge and safe level by use of drugs in female gender.

## Fibrinolisi di trombo mobile dell'atrio destro

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Una donna di 89 anni affetta da malattia di Alzheimer arriva al Pronto Soccorso del nostro Ospedale in seguito alla comparsa di dispnea ed edemi degli arti inferiori (PA=90/60 mmHg, FC=110 bpm, frequenza respira-

toria=30). Pur avendo inizialmente posto ipotesi diagnostica di embolia polmonare non è stato possibile eseguire una TC spirale per la presenza di insufficienza renale. L'esame ecocardiografico ha evidenziato un trombo mobile nell'atrio destro con segni indiretti di ipertensione arteriosa polmonare (video 1). L'ecocolordoppler venoso degli arti inferiori ha inoltre evidenziato una trombosi venosa profonda bilaterale delle vene poplitee. Malgrado l'età avanzata la paziente è stato sottoposta ad infusione di rt-PA e dopo un'ora il trombo dell'atrio destro era ridotto di volume (video 2). Dopo 24 ore il trombo era completamente dissolto (video 3) ed il sovraccarico delle camere cardiache di destra era ridotto. Il quadro clinico è stato complicato dalla comparsa di un ematoma del muscolo ileopsoas sinistro ed è stato necessario effettuare la trasfusione di due sacche di emazie concentrate. Nei successivi 20 giorni è stato apprezzato miglioramento della funzione respiratoria e di quella renale e la paziente è stata dimessa con la prescrizione di eparina a basso peso molecolare.

## ✪ An audit of oxygen therapy on an internal medicine ward

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**Background** Oxygen(O2) is a life-saving drug for patients(p) with severe hypoxaemia but excessive amounts can be harmful for p vulnerable to hypercapnic respiratory failure(HRF), e.g p with exacerbated chronic obstructive pulmonary disease. Audits of O2 use and prescription have shown consistently poor performance in many countries. As about 30-35% of p on our ward receive O2, our study aimed to assess current practice against evidence-based guidelines for emergency O2 use, to improve implementing key recommendations.
**Methods** We reviewed 111 p in the first audit (Nov-Dec 2010) and 181 in the second (Mar-May 2011) after educational input for clinical staff on O2 prescribing and therapy. Performance measures were:1) proportion(prop) of p whose O2 saturation (SaO2) was checked by pulse oximetry at admission;2)prop of SaO2 recorded with the inspired O2 concentration;3)prop of p in which the prescription of O2 is written with a specified target range ;4)prop of SaO2 between 94-98% recorded in p not at risk of HRF;5)prop of SaO2 between 88-92% recorded in p at risk of HRF.
**Results** In the second audit the first measure decreased from 73% to 71,2%, the second rose from 54,6% to 77,1%, and the third from 84,6% to 87,5%. The prop of SaO2 in target range in p not at risk of HRF changed from 68,5% to 82,6% and the prop of SaO2 in range in p at risk of HRF rose from 34,4% to 43,5%, with the majority of SaO2 above target range.
**Conclusions** There is an improvement in O2 prescribing and administration, but additional strategies are required especially in monitoring p at risk of HRF.

## Sclerosing encapsulating peritonitis: a case report

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Sclerosing encapsulating peritonitis (SEP) is a well recognised but rare complication of peritoneal dialisys (PD). It usually developes after 4-6 years from the beginning of PD. The prognosis is poor when the small bowel becames obstructed. The diagnosis is supported by echography or TC scan.
**Case** We present a case of a male 75 y. old affected by end stage renal desease treated for 13 y. with PD. Haemodialysis was started three months before admission. The patient had been in his usual health until admitted to our ward due the developing of malaise and hypotension appeared after a short episode of fever, treated with antibiotics.
Complete blood count, electrolytes and liver functional tests were normal, albumin was near normal. The examination of the abdomen showed the presence of several hard masses. An abdominal echo scan revealed the presence of ascites. A TC scan of the abdomen revealed the presence of diffused calcifications of visceral and parietal peritoneum. A diagnosis of SEP was made. During the stay complete parenteral feeding was begun. Treatment with tamoxifen and steroids was started with initial benefits of clinical status. After 8 weeks of therapy bowel obstruction developed and the patient died.
**Conclusion** Medical treatment is not defined and is aimed to reduce the peritoneal inflammation and sclerosis. Death comes due bowel obstruction or his inability to absorb nutrients. Awareness of SEP and its early recognition may allow to start treatment before bowel's structural changes develop.

## Valutazione del profilo pressorio e lipidico in prevenzione secondaria post ictus cerebrale

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**Premesse e scopo dello studio** Obiettivo della prevenzione secondaria nei pazienti con stroke è di ridurre le recidive e la mortalità per cause cardio-cerebro-vascolari mediante il controllo dei fattori di rischio modificabili. Obiettivo di questo studio pilota è stato quello di verificare il raggiungimento dei target pressori e di colesterolo LDL in soggetti con ictus ischemico recente non cardioembolico.
**Materiali e Metodi** Soggetti di età inferiore a 75 anni dimessi consecutivamente dalla Stroke Unit e dalla Medicina Interna con diagnosi di stroke ischemico sono stati sottoposti, dopo un periodo medio di 4-6 mesi, a ABPM e profilo lipidico.
**Risultati** 25 pazienti (22 maschi e 3 femmine) con età media di 61,8 anni, sono stati inclusi nello studio.
Di questi 23 erano ipertesi e 6 diabetici noti. In dimissione 20 erano in trattamento anti-ipertensivo e 14 in terapia con statina. Il 56% dei soggetti presentava un profilo pressorio non a target con PAS24h >130 mmHg e il 44% dei casi con PAD24h >80 mmHg. I non dipper erano il 44% mentre il 76% presentava una elevata variabilità pressoria. Nel 52% dei casi il colesterolo LDL era maggiore di 100 mg /dl.
**Conclusioni** Nella popolazione studiata la percentuale dei pazienti con adeguato target pressorio e di colesterolo LDL, come suggerito dalle linee guida in ambito di prevenzione secondaria, è risultata bassa. E' pertanto indicato rafforzare il follow-up di pazienti con profilo di rischio cardio-vascolare molto elevato per ottimizzare gli interventi di prevenzione secondaria.

## ✪ GSTM1 copy number variant in the pathogenesis of late-onset Alzheimer's disease in Italian patients

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**Background and Aim** Alzheimer's disease (AD) is a progressive neurodegenerative disease. More than 90% of Alzheimer's cases are of the

late-onset form (LOAD), which manifests in the elderly. Several factors participate in LOAD pathogenesis, including free radicals that contribute to oxidative stress and neuronal death. Glutathione S-transferases are multifunctional enzymes involved in cellular detoxification. Particular attention has been focused on GST genes because polymorphisms are associated with differential detoxification capacity and can help with the identification of subjects that present susceptibility to the AD development. Aim of the study is to evaluate if GSTA1, GSTM1, GSTP1, and GSTT1 genes are associated with LOAD.
**Materials and Methods** We analyzed 168 AD and 143 elderly controls for the GSTA1, GSTM1, GSTP1, and GSTT1 gene polymorphisms.
Results Differences in genotype distributions between AD patients and controls were found only for the GSTM1 null genotype ($P < 0.001$). Logistic regression analysis, after adjustment for age and gender, confirmed a positive association between GSTM1 null genotype and LOAD (OR = 2.09; 95%CI = 1.31 – 3.35).
**Conclusions** GSTM1 enzyme detoxifies xenobiotics and endogenous metabolites and plays a regulatory role in cellular signaling. Previous studies have highlighted that GSTM1 plays a role in neurodegenerative disorders, but no data have associated the GSTM1 gene with AD risk. Our results suggest that GSTM1 null genotype could increase disease risk susceptibility and could act as a risk factor for LOAD in Italian patients.

## Insulin Degludec improves long-term glycemic control with less nocturnal hypoglycemia compared with insulin Glargine: 1-year results from a randomized basal-bolus trial in people with type 2 diabetes

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**Introduction and aim of the study** Degludec (IDeg) is a new ultra long acting basal insulin. This study compared efficacy and safety of IDeg with insulin glargine (IGlar) in DMT2.
**Materials and Methods** Randomised (3:1), open-label, treat-to-target, 1yr trial. IDeg and IGlar administered once daily in basal–bolus with mealtime insulin aspart (IAsp)±metformin±pioglitazone.
**Results** 992 subjects (mean: 58.9 yrs, diabetes duration 13.5 yrs, A1C 8.3%, FPG 166 mg/dL) were enrolled. A similar % of subjects completed the trial with IDeg (83%) and IGlar (85%). At 1 yr, IDeg and IGlar improved overall glycemic control (A1C) by 1.2% and 1.3% points respectively ([ETD] IDeg–IGlar: 0.08% [95% CI: –0.05, 0.21]). In both groups, 50% of subjects achieved A1C<7% (p=NS). FPG was reduced by 43 mg/dL with IDeg and 38 mg/dL with IGlar (ETD: –5.2 mg/dL [95% CI: –11.7, 1.1], p=NS). Rates of nocturnal confirmed hypoglycemia (occurring between 00:00–05:59, with PG<56 mg/dL or considered severe per ADA definition) were 25% lower with IDeg compared with IGlar (1.4 vs 1.8 episodes/patient-yr; [ERR]: 0.75 [95% CI: 0.58; 0.99] p=0.0399). Rates of overall confirmed hypoglycemia were lower with IDeg than IGlar (11.1 vs 13.6 episodes/patient-yr; ERR IDeg/IGlar: 0.82 [95% CI: 0.69; 0.99], p=0.0359). At 1 yr, total mean daily insulin doses were 1.46 and 1.42 U/kg in the IDeg and IGlar groups.
**Conclusion** Degludec, given as basal–bolus treatment with insulin aspart in DMT2, improves long-term glycemic control with significantly lower risk of overall and nocturnal hypoglycemia compared with insulin glargine.

## ✪ Randomised open label trial comparing two different dosages of oral mesalazine in the maintainence treatment of ulcerative colitis

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**Background and Aim** The optimal dosage of oral mesalazine, as maintenance therapy in ulcerative colitis (UC), remains to be defined. To establish whether a daily treatment with 4.8 g of oral mesalazine is more effective than 2.4 g in preventing disease relapse.
**Material and Methods** A total of 112 pts with UC in remission were randomly treated for 1 year with 4.8 (n = 56) or 2.4 (n = 56) g/day of mesalazine. Activity of disease was assessed by periodical clinical, endoscopic and histological examinations.
**Results** After 12 months, at ITT analysis, 40 out of 56 pts (71.4%) on 4.8 g and 36 out of 56 pts (64.2%) on 2.4 g were still in remission (NS). At PP-analysis, 36 out of 52 pts (69.2%) in the 2.4 g group remained in remission for a shorter time than the 42 out of 48 pts included in the 4.8 g group (87.5%) (NS). In group B, the relapse of disease has been observed more frequently in pts with an younger age 32 ± 6 years vs 51 ± 15 years (p=0,03). Data regarding group B showed that 8 out of 41 left-sided UC pts (19%) had had a relapse in comparison to 8 out of 15 extended UC patients (53%) achieving a difference statistically significant (OR: 4.71; p=0.023 at Fisher exact test). At PP-analysis 8 out of 15 pts with extended colitis (53%) relapsed in comparison to 4 out of 33 pts with left-sided colitis (12%) (OR:9.42; p=0.0023 at Fisher exact test).
**Conclusions** A daily dosage of 4.8 g of oral mesalazine seems to be more efficacious to prevent and delay relapses of UC than 2.4 g. A dosage of 4.8g should be preferred in young patients and extended form of the disease.

## Quality of life in ulcerative colitis: patients treated medically versus patients undergoing surgery

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**Background and Aim** Total colectomy with ileorectal anastomosis (IRA) was usually performed for UC. Nowadays, the ileal pouch-anal anastomosis (IPAA) has become the procedure of choice. Aim of this study was to assess the quality of life of inflammatory bowel disease (IBD) pts who have undergone colectomy with IRA or proctocolectomy with IPAA compared to a group of pts with UC.
**Materials and Methods** 131 IBD pts (41 IRA, 48 IPAA, 42 UC) observed between 2008-2010 were studied. To all pts was administered a self completed questionnaire with four different scores for intestinal symptoms (IS), systemic symptoms (SS), emotional function (EF), social function (SF) and an overall quality-of-life (QoL) score. Higher scores were related to a worse QoL. Kruskal-Wallis test was used for statistical analysis.
**Results** Only the median SI values resulted statistically significant (KW= 35,8) in the IRA-group vs the Pouch-group (p<0,001) and in the IRA –group vs the CU-group (p<0,001). The other different dimensions (SS, EF, SF) and overall quality-of-life scores (Qol) were similar between the three group of patient (not significant).

**Conclusion** Our study do not demonstrate a substantial gain of the QOL in patients operated-on for UC in comparison to patients with active disease and no difference QOL has been observed between the two kind of surgical procedures (IRA versus IPPA) except for Intestinal symptoms (IS). In conclusion, these observations result to favour of a more oppressive and continuous medical treatment before sending those patients to surgery.

### Pregnancy and successful delivery in a patient with chronic thromboembolic pulmonary hypertension (CTEPH) previously submitted to pulmonary endarterectomy (PEA)

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Chronic thromboembolic pulmonary hypertension (CTPH) results from a partial resolved obstruction of the major pulmonary arteries or organized pulmonary emboli incorporated into artery wall, eventually increasing pulmonary vascular resistance (PVR). In a subgroup of patients pulmonary endarterectomy (PEA) is the only curative option. Pregnancy in CTPH women is related to a maternal mortality rate of 30-56%. No report is available on the management of pregnancy and delivery in these patients. We report our experience about a pregnant woman submitted to PEA.
EFS, 29 yrs, suffered recurrent hemoptysis and effort dispnea. She came to our attention in 2005 with severe pulmonary artery pressures (PAP) and PVR. We found dilation of the common pulmonary artery, right side visible only at proximal level, typical CTPH lesions of the left side, no signs of deep vein thrombosis. In April 2005 PEA was performed on the left side. PAP decreased but remained higher than normal due to partial intervention as the right side resulted fibrotic probably after a previous occlusion. In September 2005 she was pregnant. Anticoagulant treatment was switched from warfarin to low molecular weight heparin, reduced to prophylactic dosage two days before elective delivery. In March 2006 she had a healthy baby. In 2007 she was pregnant again and she opted for a therapeutic abortion. Patient is today in good health, under warfarin treatment. Functional parameters normalized. Maternal mortality in CTPH women remains high. Pregnant CTPH women warrant a multidisciplinary approach to appropriate therapies.

### ✪ Sequential peginterferon-alpha and telbivudine for 48 weeks in HBeAg-negative chronic hepatitis B: the Tel-B-PEG randomized trial

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**Background** Short-term treatment for HBeAg-negative chronic hepatitis B remains unsatisfactory. Aim of our study was to compare efficacy and safety of two sequential regimens of peginterferon $\alpha$ (PEG-IFN) and telbivudine (LdT) in a multicenter, randomized trial.
**Methods** Inclusion criteria were biopsy-proven HBeAg-negative chronic hepatitis B, elevated ALT, serum HBV DNA$^3$2000 IU/ml; HCV, HDV or HIV coinfections and lamivudine-resistance were excluded. Patients were randomized at baseline to receive PEG-IFN 180 mcg/week for 24 weeks followed by LdT 600 mg/die for 24 weeks (PEG-IFN first), or vice versa (LdT first), plus 24 week follow-up. Primary endpoints were serum HBV DNA <2000 IU/ml and normal ALT at week 72.
**Results** Thirty patients (86% male; median age, 48 years) were enrolled. Baseline serum HBV DNA, 5.56±1.4 Log IU/ml: mean ALT 2.9±2.5 x normal. After 48 weeks of treatment and 24 weeks of follow up, HBV DNA<2000 IU/ml was achieved in 6% (PEG-IFN first) vs. 40% (LdT first); $p<0.05$. Mean ALT levels were also significantly lower in the LdT first group (1.3±1.1 vs. 3.4±2.7 x normal, $p<0.05$).
PEG-IFN dose was reduced in 2 patients (7%). One patient (7%) dropped out due to peripheral neuropathy.
**Conclusion** Sequential treatment with 24 weeks PEG-IFN followed or preceded by 24 weeks of LdT is safe. Suppression of HBV DNA to<2000 IU/ml at week 72 was achieved in significantly more patients treated with LdT followed by PEG-IFN than vice versa. A sequential antiviral regimen, if confirmed in larger series, could improve response rates compared to standard PEG-IFN monotherapy.

### Sarcoidosi meningea

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**Premesse e scopo dello studio** La sarcoidosi è una malattia sistemica granulomatosa ad eziologia indeterminata. Le localizzazioni principali sono a livello polmonare cutaneo e linfonodale ma può colpire anche occhio muscoli e sistema nervoso centrale e periferico. La localizzazione meningea si ha nel 2-5% dei pz con sarcoidosi e rappresenta il 1.2% delle lesioni espansive cerebrali.
**Materiali e Metodi** Descriviamo il caso clinico di una donna di 70 aa ricoverata nel nostro reparto per astenia e atassia da circa 20 gg
**Risultati** La pz viene ricoverata per sospetta ischemia cerebrale. Non presenta patologie in anamnesi né fattori di rischio cardiovascolari. La TAC cranio eseguita in PS mostra vistoso edema in regione frontale destra con shift della linea mediana, l'esame obiettivo non evidenzia deficit di lato. Una seconda TAC eseguita con m.d.c. rivela una massa di 3x2.5x0.8 cm circondata da vasto alone di edema da riferire a neoplasia primitiva cerebrale. La paziente viene sottoposta ad exeresi del tumore che macroscopicamente orienta per meningioma. L'istologia rivela in realtà flogosi granulomatosa gigantocellulare non necrotizzante compatibile con sarcoidosi. Lo screening a carico dei vari organi non ha rivelato altre localizzazioni di malattia.
**Conclusioni** La sarcoidosi meningea rappresenta un quadro raro di presentazione della malattia, ma deve essere presa in considerazione nella diagnostica differenziale delle lesioni espansive cerebrali.

### ✪ Risk management and quality: an innovative survey at Internal Medicine level. Preliminary results

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**Background and purpose of the study** The interest in Risk Management (RM), set of actions to improve the quality of care ensuring increased patients safety is growing, touching levels of quality management and certification bodies are back to their international activities in the field

of RM. The FADOI Lazio RM Commission has made a survey to address the lack of data on RM in the Internal Medicine Departments (IMD).
**Materials and Methods** The qualitative method used was a semi-structured interviews (SSI) of doctors and checklists to verify the IMD logistic characteristics. The time schedule was as follows: acquisition of Lazio IMD list; pilot phase completing the checklist and administration of SSI, identifying activities where an increased risk is perceived, presence of error analysis initiatives; therapy prescription pathways; verification tools; improving proposals.
**Results** From 06.06.11 to 30.09.11 were collected 59 interviews out of 62 doctors in charge in 4 IMD in Rome and province. High risk constantly perceived in routine daily activities (on-call, handover, discharge). Presence of Single Treatment Card (STU) in 3 of 4 IMD. Specific procedures to control the effective treatment administration were described in 75% of the STU. Absence of a control system to verify whether the drugs have been effectively administered.
**Conclusions** Sporadic presence of "systems" to analyze errors. Episodic activation of RM Unit only for sentinel events. Widespread absence of risk culture. Proposed an innovative ECM Theoretical and Practical Course focused on Internal Medicine RM.

## New clinical skills for Liberian medical doctors, training needs identification to create a new professional role in a post war context: an innovative project of Italian Institute of Health (ISS) financed by Ministry of Foreign Affairs (MAE)

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**Background and purpose of the study** The civil war ended in 2003 have severely compromised the health sector in Liberia with destruction of infrastructure, loss of manpower, reduced access to services, lack of organization. The Istituto Superiore di Sanita (ISS) through the project "Strengthening the training capacity of the Medical University of Monrovia (Liberia)", financed by Ministry of Freign Affaires, have conducted a situation analysis and a training needs assessment for new educational curricula development of the Liberian Medical Doctors.
**Materials and Methods** The survey was conducted from May to August 2010 using: 1. semi-structured interviews with professors, medical students, doctors, 2. focus groups with healthcare professionals, students and teachers, community representatives, 3. secondary health data collection. Results 60 students and 20 doctors were interviewed; 80 people participated in Focus Groups. Currently there are only 389 doctors (in a population of 3.2 million inhabitants) whose diagnostic skills are deemed valid for 61% of respondents, 25% of diagnoses are made by nurses. There is lack of laboratory diagnostic and the quality of diagnosis depends on the patient's ability to pay for the service. Inadequate is the access to drugs.
**Conclusions** Modify the curriculum of medical training is considered crucial to improve the health of the country. Identified areas for improvement are: diagnostic and therapeutic, surgical skills, laboratory medicine, prevention, training on the job.

## ✪ Impact of nutritional status on hospital length of stay in Internal Medicine Departments: validated key factors and related costs. A literature review

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**Background and purpose of the study** We performed a literature review of data from clinical studies on obesity, nutrition, hospital length of stay (LOS) and hospitalization costs, in order to identify specific areas of study on the impact of nutritional status in Internal Medicine (IM) patients.
**Materials and Methods** Data Sources: MEDLINE, citation review of relevant primary and review articles, personal files, contact with expert informants. Study Selection: first we examined studies with keywords "socioeconomic status" and "obesity", thus selecting 416 articles including 21 reviews. Subsequently, we focused attention on diet, LOS and costs. We assumed that the diet was evidenced by nutritional status at the admission and examined standardized tools. Six reviews (4861 subjects) were selected with the keywords "nutritional status" and "LOS", highlighting if LOS is influenced by nutritional status (both malnutrition and overweight).
**Results** Studies conducted over the past 20 years demonstrated inverse relationship between socioeconomic status and obesity in industrialized countries, and direct relationship in developing countries. Many evidences showed an increase LOS in malnourished patients, while few studies documented the effect of overweight on LOS.
**Conclusions** The review highlighted lack of data on relationship among overweight, IM patients, LOS and related costs, indicating need for further studies. At the same time, comparative analyses of useful tools for defining nutritional status and dietary history, and their correlation with chronic diseases, are needed.

## Rapid diagnostic test (RDT) in malaria case management: a retrospective study to evaluate the impact and the potential cost-effectiveness in Gambia and Senegal

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**Background and purpose of the study** Malaria is a major cause of morbidity and mortality in Gambia and Senegal. Progress were made in the last years with the objective of the pre-elimination (less than 5% slides positivity) by 2015. We investigated the impact of Rapid Diagnostic Test (RDT) use in the Malaria Case Management (MCM) and its potential cost effectiveness.
**Materials and Methods** From January to December, 2011 we undertook a retrospective analysis of original records to establish numbers and proportions of RDT performed, cases confirmed and treatment administered at Kombo South District (Gambia) and Diolololoulou District (Senegal). We obtained additional data from single sites for treatment cost analysis.
**Results** In Kombo South District (total population 74,247) 3,309 RDT were performed in children <5 years and 9,986 in >5 years with a positivity of 54%. In Diolololoulou District (total population 85,798) 308 RDT were performed in <5 years and 1,385 in >5 years with a positivity of 30%. Standard cost of malaria treatment according to the National Guidelines, Artemether 20 mg+Lumefantrine 120 12 tablets, is 2,4 $ and the RDT cost is 0,65 $.
**Conclusions** The use of RDT rapid tests has improved MCM by reducing significantly the number of patients subjected to inappropriate tre-

atment. The preliminary cost analysis highlights yearly potential savings of 118,402 $ in Diololoulou District and of 89.839 $ in Kombo South District. Health personnel training to improve MCM can further increase efficiency and contribute to reduce the onset of resistance.

### Una rara causa di linfoadenopatia: Malattia di Kikuchi- Fujimoto

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Una donna di 23 anni si presenta per febbre da 15 gg prevalentemente serotina, astenia, artralgie diffuse, faringodinia e voluminosa linfoadenopatia laterocervicale destra. In anamnesi storia di asma bronchiale non in trattamento farmacologico. Non epatosplenomegalia ma voluminosa tumefazione laterocevicale destra dolente e dura. Agli ematochimici: leucopenia con formula leucocitaria conservata, aumento di LDH, aumento della VES, PCR nella norma, transaminasi aumentate. Negativi Rx torace, ecografia addome emocolture, ricerca EBV, anticorpi anticitomegalovirus, antirosolia, markers epatite B e C, HIV, anticorpi virus Herpetici, Mantoux. All'ecografia del collo linfoadenopatie multiple laterocevicali destra di tipo reattivo. All TAC collo-torace-addome linfoadenopatie latero-cevicali bilaterali, sottoclaveare sinistra, ascellare bilaterale, ilo-mediastinica e addominale sospette per patologia linfoproliferativa sistemica. Alla tipizzazione linfocitaria riduzione dei linfociti T e aumento policlonale dei linfociti B. L'esame istologico del linfonodo laterocervicale dx ha posto la diagnosi di linfadenite istiocitica necrotizzante non ascessuale o sindrome di Kikuchi, forma benigna self-limited a eziologia sconosciuta, che si risolve nel giro di 2 o 3 mesi. Abbiamo pertanto completato le indagini con lo studio dell'autoimmunità (ANA anticorpi antinucleo positivi 1:80, ab anti DNA neg, ENA lievemente aumentati). Abbiamo impostato terapia sintomatica con cortisone e antibiotica con chinolonici di copertura con risoluzione completa del quadro clinico in pochi giorni.

### Reletionship between capillaroscopy and bone mineral densitometry by ultrasonography in SSc patients

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Patients with SSc can suffer from comorbidities or related problems. Osteoporosis is one of them.
**Objective** To perform bone ultrasonography assessment in SSc Patients and to correlate with capillaroscopy findings.
Methods BMD by bone ultrasonography of every patients, all digits capillaroscopy and clinical data were carefully analysed in 44 consecutive SSc patients fulfilling Leroy and Medsger criteria.
**Results** we include 44 post-menopausal consecutive women ( average age 58,6 years) with an average duration of disease 8 years; 22 pts(50%) were diffuse SSc, 40% with digital ulcers, 18% smokers, 58% were treated with glucocorticoids and 9% suffered from fractures earlier.75% presented T-score <-1,00 (osteopenic) and 25% were osteoporotic. Nailfold capillaroscopic pattern was found Late in all osteoporotic patients ( 100%). In 33 osteopenic patients nailfold capillaroscopic pattern was found active in 20 pts (60,6%), Early in 10 pts (30,3%), Late in 3 pts (9,1%).Another association was found between both BMD, Late capillaroscopic pattern and modified Rodnan Skin Score >18.
**Conclusion** BMD was lower in diffuse SSc pts, this may be due to reduced physical activity in relation to pulmonary, cardiac and muscle skeletal involvement and by persistence of a chronic inflammatory state with consequent development of local oxidative stress.

### Ultra-sensitive troponin and its clinical associations in SSc patients

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Cardiac troponin ( cTn) is a biomarker of myocardial injury.
**Objectives** Our aim was to assess the role of ultra sensitive troponin (hs-cTn) in SSc related cardiac involvement and to examine associated factors with elevated hs-cTn.
**Methods** Thirty pts ( 21 Limited, 9 Diffuse SSc) with Cardiac Involvement ( C I ) were enrolled.27 F- 3M with a mean age 56 years and mean disease duration of 6 years. C I was defined as haemodynamically significant arrhythmias, pericardial effusion or congestive heart failure requiring specific treatment.
All pts had normal pulmonary artery systolic pressure and none had serum creatinine > 1,2 mg. This group was compared with 42 SSc pts without evidence of C I ( N C I ).
**Results** Reduced LV/RV contractility as assessed by echocardiography was detected in 18 pts ( 60%),eight pts (28%) had more 1000 extrasystoles in 24/h, one pts (3%) had atrial fibrillation, one pts (3%) had sinus rhytm with frequent ventricular extrasistoles, two pts (6%) had pace-makers. In the group with C I 17 pts ( 56%) had elevated hs-cTn concentration more 14 ng/l vs 3 ng/l in the group without C I . Hs-cTn correlated with pro-BNP ( r = 0,52, p<0,001). Increased hs-cTn were associated with modified Rodnan Skin Score ( p<0,050),Age ( p<0,04), ACA ( p< 0,03), PCR (p< 0,032).
**Conclusion** Hs-cTn might be a marker of global myocardial involvement and may reflect the severity of the disease.

### ✪ Thyroid autoimmune disorders in systemic sclerosis

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Autoimmune phenomena are a constant feature of patients with systemic sclerosis (SSc).
**Objective** To evaluate the prevalence of clinical and subclinical thyroid diseases in a group of patients with SSc.
**Methods** A total of 142 (122 F-20 M) unselected, consecutive pts with SSc were included in our study, with an average age of 58 years, 16 pts (11.3%) with Early Sclerosis, 12 pts (8.4%) with intermediate SSc, 72 pts (50.7%) with Limited SSc, 42 pts (29.6%) with Diffuse SSc, and 70 healthy control group subjects. TSH,FT3, FT4,antithyroid peroxidase autoantibodies (AbTPO)and thyroid ultrasonography were performed in all SSc patients and control group; and clinical data were carefully analyzed in all142 consecutive SSc patients.
**Results** AbTPO 107± 286 IU/ml in SSc pts vs 24 ± 47 in control group (p<0,004); FT3 4,4 ± 1,5 pmol/l vs 4,6 ± 0,8 (pNS);clinical hypothyroidism in 6 SSc pts (4,2%) vs 1contro group (1,4%) p<0,003; subclinical hypothyroidism in 28 SSc pts (19,7%) vs 4 control group (5,7%) p<0,001; Graves'disease in 2 SSc pts (1,40%) vs 0 in control group; Thyroid volume < 6ml in48 SSc pts (33,8%) vs in 16 control group (22,8%); hypoechoic pattern in 76 SSc pts (53,5%) vs 15 control group (21,4%) p<0,001.
**Conclusion** Hypothyroidism in SSc pts is significantly associated with a thyroid hypochoic pattern by ultrasonography and a lower thyroid volume,AbTPO positivity was found in about half of SSc pts with Hypothyroidism.Thyroid function anf ultrasonography should be tested in clinical profile of SSc pts.

## Pattern of skin thickness progression and its clinical associations in SSc patients

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Sclerosis Systemic is characterized by abnormal fibrosis of the skin and other organs.
**Objectives** To investigate the pattern of skin thickness and its clinical associations, the correlations with capillaroscopic pattern and risk factor for digital ulcers.
**Methods** Data were collected retrospectively from 28 patients with DU (mean age 56±9 years and mean disease duration 3±2 years), with and without pulmonary arterial hypertension, who were initiating bosentan+prostanoids therapy in 2004 ( 8 pts), in 2005 (6), in 2006 (4), in 2007 (10) and followed until December 2011. The skin thickness progression rate (STPR) was calculated by the difference in mRSS at enrollment and at the end of follow-up divided by the time of follow-up. Rapid Skin Progression (RSP) was defined as STPR > 6/52 point/years, intermediate skin progression 6/52, slow progression < 6/52.In all pts the capillaroscopic pattern ( early, active, late) was recorded.
**Results** The most common skin pattern was slow skin progression ( 18 pts 64,2%) (Group A), intermediate skin progression (6 pts 21,4%) (Group B), rapid skin progression (4 pts 14,4%) (Group C).Anti- centromere was associated with a lower skin progression rate,SCL-70 with rapid and intermediate skin progression rate. In group C we found >3 recurrent DU /year, in group B >1 recurrent DU /year, in group A<1 recurrent DU /year. 3 deaths in group C vs 0 in A,B.In the pts of group C we found lung fibrosis and late capillaroscopic pattern.
**Conclusion** A higher STPR,SCL-70 positivity, higher activity disease, joint contractures and more recurrent digital ulcers were statistically linked to a further increase in mRSS and death.

## Anemia emolitica autoimmune associata a lenalidomide

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Da qualche anno talidomide e lenalidomide sono divenuti preziosi strumenti di cura in oncoematologia. In un crescente impiego di tali farmaci segnaliamo un effetto indesiderato di lenalidomide inatteso e pressoché sconosciuto. Donna di 76 aa., seguita dal 2007 per mielodisplasia ( 5q -). Per inefficacia di eritropoietina ed elevato fabbisogno trasfusionale, inizia nel dicembre 2008 lenalidomide (dose iniziale 10 mg/die x 21 gg. per 7 cicli complessivi). Ottima risposta ematologica (Hb 13 g/dl), ma necessarie frequenti interruzioni e riduzioni posologiche per rash cutaneo, recidivante nonostante uso continuativo di prednisone (10 mg/die per os). Qualche gg. dopo l'inizio dell' VIII ciclo (marzo 2010) grave anemizzazione (Hb 5,1 g/dl; MCV 112 fL), LDH e bilirubina indiretta aumentati, Coombs positivo (anti C3d++) ed aptoglobina indosabile. Sospendendo definitivamente lenalidomide ed aumentando il prednisone (1mg/Kg/ die), recupero parziale di Hb (8 g/dl) e regressione degli indici di emolisi.
**Conclusioni** Generalmente è attribuito a talidomide e derivati un effetto immunomodulatore, per cui talidomide è utilizzata anche in malattie autoimmuni (LES, m. di Werlhof, etc.). In questo contesto sorprende che lenalidomide possa causare anemia immunoemolitica.Tale effetto indesiderato non è citato nel foglietto illustrativo, ma in altro documento è riportato dalla casa produttrice come non comune. A nostro avviso solo un uso più estensivo ed una vigilanza critica da parte dei Centri utilizzatori potranno meglio chiarire la reale incidenza di questa reazione avversa.

## Un'inusuale e severa ipoglicemia di origine splenica

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Uomo di 79 aa, ricoverato nell'agosto 2009 per coma ipoglicemico (in PS glicemia 18 mg/dl) ed alvo diarroico da qualche gg. In anamnesi cardiopatia ischemica, parkinsonismo ed episodi ipoglicemici recidivanti da 2 aa. EO: condizioni generali scadute; fegato a 3 cm dall'arco; milza all'ombelicale trasversa. Laboratorio: Hb 9,5 g/dl; plts 126.000/mm3; GB 4700/mm3 (linfociti 670); glicemia 67 mg/dl; protidemia 53 g/l (elettroforesi n.d.p.). Creatinina 0,7 mg/dl; tracce di BJ proteinuria di tipo I. Successive glicemie: 38 ~ 90 mg/dl. Proinsulina, peptide C ed insulina elevati anche durante ipoglicemia spontanea o digiuno. IGF-1, GH, ACTH e cortisolemia in range. Tipizzazione linfocitaria su periferico: popolazione clonale B, suggestiva per linfoma della zona marginale. TAC di torace e addome: pancreas regolare; non masse; splenomegalia (18 cm) e linfoadenopatie mesenteriche. Instaurata terapia con diazossido con miglioramento glicemico. Successivo nuovo ricovero per decadimento psico-fisico: sazietà precoce da compressione gastrica con ipoglicemie frequenti e protratte. Splenectomia seguita da normalizzazione glicemica e miglioramento di emocromo; istologia "Linfoma B splenico diffuso della polpa rossa a piccole cellule".
**Conclusioni** In letteratura è eccezionale l'associazione linfoma-ipoglicemia. In casi isolati ne è stata dimostrata la patogenesi autoimmune: anticorpi di origine linfomatosa verso recettore insulinico o insulina. Nel ns. caso possibili anticorpi leganti proinsulina con rallentata clearance della stessa e quadro clinico-laboratoristico mimante insulinoma.

## Liraglutide: an effective therapeutic choice in a psychiatric patient

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**Background** The metabolic syndrome is highly prevalent in schizophrenia patients and represents an enormous source of cardiovascular risk. Patients with schizophrenia are at risk for developing obesity due to many factors including inactive lifestyle, poor dietary choices, and side effects of psychotropic medications.
Female patients with schizophrenia appear to be particularly vulnerable both to central obesity and metabolic syndrome.
**Aim** To describe the improvement of glycemic control in a schizophrenic woman in whom insulin treatment was substituted with liraglutide therapy.
**Case report** A schizophrenic woman refer to our out-patient care center in January 2010 because of newly diagnosed diabetes. The Patient was naïf from anti-psycotic drug. The Patient also suffered from morbid obesity being treated with metformin. The glycemic control was extremely difficult because of her psychiatric pathology. The biguanide was subsequently interrupted because of respiratory insufficiency due to sleep apnea syndrome. Treatment with gliclazide and pioglitazone in association with a long acting insulin analogue failed to achieve an adeguate control during the subsequent year (HbA1c 8.1%, weight 137 Kg in January 2011).
In February 2011 a therapy with liraglutide was started in association

with gliclazide. A rapid improvement of the glycemic control with a progressive weight loss were observed. On February 2012, after one year of tyherapy HbA1c was 6.5% and weight 123 Kg.
**Conclusions** Liraglutide seems to be an effective therapeutic choice in a diabetic, obese psychiatric patient.

## Sternal wound infection after cardiac surgery: results of a national study

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**Introduction** Sternal wound infection (SWI) is a serious complication of cardiac surgery. Early diagnosis is pivotal for prognosis. Diagnosis often occurs after discharge. We report the clinical and microbiological features of a large series of SWI.
**Material and methods** 22 divisions of Cardiac Surgery participated to our observational study from Oct. 2005 to Sept. 2008. SWI was defined according to the CDC criteria. Clinical and microbiologic characteristics, treatment and outcome were analyzed.
**Results** Out of 4711 pts, 126 (2,6%) developed SWI; 73% were incisional (I-SWI), and 27% organ space involving (OS-SWI). 99% of I-SWI and 35% of OS-SWI were detected after discharge. Wound discharge was the commonest signs of I-SWI (93.5%) and OS-SWI (85.3%); in OS-SWI sternal instability and fever were present in 76,5% and 70,6%. Staph. coag. neg and S.aureus were the leading pathogens (MR: 65% and 46% respectively). Surgical reoperation was performed in 94,1% of OS-SWI. The mean length of antibiotic course was 26,9 days for I-SWI and 50,3 days for OS-SWI. Mediastinal irrigation was performed in 1/3 of SWI. Continuous Vacuum Aspiration (VAC) was used in 30,4% of I-SWI and 52,9% of OS-SWI, with a increasing trend. Mortality was and 2,9% for OS-SWI. The mean LOS was >50 days.
**Conclusions** SWIs are often detected after discharge. Diagnosis lays on clinical criteria. OS-SWIs require an aggressive surgical management, a long course of antibiotic and adjunctive treatment (mediastinal irrigation or VAC). Do to high rate of resistance, microbiologic diagnosis should always be attempted.

## A "stroke" right in the eye!

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**Introduction** Carotid disease is the most common cause of ischemic visual loss. Approximately 60% of patients with monolateral blindness is affected by carotid stenosis, atherosclerotic or not: fibromuscolar dysplasia, carotid artery dissection (CAD), Takayasu's arteritis, carotid trauma or radiations damage.
**Case report** A 57-year-old man developed bilateral blurred vision. Few days before he had reported frontal headache with eye strain and "bright spots" on the right field, mimicking a migraine attack. His medical history was unremarkable except for smoke.
Ophthalmologic evaluation showed right homonymous hemianopsia (HH) without other neurologic deficits. Cervical and transcranial doppler sonography showed right internal carotid artery (ICA) stenosis, distal to bifurcation, and right middle cerebral artery (MCA) hypoperfusion. Brain magnetic resonance revealed temporal ischemia in the right anterior choroidal artery territory; computed tomography angiography confirmed a flame-like occlusion of the right carotid, suggestive of acute dissection.
**Conclusions** 62% of patients with CAD shows ophthalmologic symptoms, ipsilateral to carotid disease: painful Horner syndrome has been reported in up to 58% of cases, monolateral visual loss in 6-30%, oculomotor nerve palsies in 2.6%. On the other hand HH usually occurs as a result of a MCA or posterior cerebral artery stroke involving optic radiation or occipital lobe visual cortex. Ophthalmologic symptoms are often the presenting features of CAD, which should always be suspected in young people without cardiovascular risk factors.

## "Mannequin's legs"

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**Introduction** Thyroid dermopathy (TD) is a rare autoimmune manifestation of Graves' disease, due to accumulation of glycosaminoglycans (GAG) in the reticular dermis. It's commonly localized in the pretibial area (Pretibial Myxedema, PM) and is classified in four forms: nonpitting edema (most frequent, 43%), plaque, nodular or elephantiasic. TD is often associated with ophthalmopathy and generally they appear much later than hyperthyroidism. A diagnosis of PM in the absence of ophthalmopathy is rare (3%).
**Case report** A 39-year-old woman was admitted for bilateral pretibial edema and multiple lower legs brownish-red nodules of several months duration. The lesions were focally indurated with prominent hair follicles, orange-peel like. Her past medical history was unremarkable and clinical examination was negative except for mild thyroid enlargement and distal tremor. Laboratory tests showed a patent autoimmune hypertyroidism: TSH < 0.01 mUI/ml, fT3 16 pg/ml, fT4 42 pg/ml, Anti-TPO 340 U/ml Anti-TSH Receptor 95 U/L. Radioactive Iodine uptake and neck ultrasonography confirmed Graves' disease. A punch biopsy showed an infiltration of lymphocytes in the perivascular space and only little amounts of GAG in the reticular dermis, as in PM.
**Conclusions** In this patient PM was the earliest manifestation of Graves' disease, even without associated ophthalmopathy. TD is rare and usually asymptomatic; sometimes it's only of cosmetic relevance but it should always be investigated in every autoimmune thyroid disease.

## Hemorrhagic thrombocytosis (HT): an apparent paradox?

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**Introduction** HT is a clinical syndrome characterized by recurrent spontaneous bleedings (particularly from mucosal sites and brain) associated with extremely high platelet count and usually leukocytosis. HT can be primary (myeloproliferative disorders) or secondary to infections, malignancies, trauma or post-surgical. The rate of hemorrhage in primary thrombocytosis is 24%, while it's 1 to 3% in the reactive forms.
**Case report** A 64-year-old man was admitted with spontaneous intraparenchymal brain hemorrhage. Except for previous HCV-related liver disease, interferon treated, his medical hystory was unremarkable: normotensive, no bleeding disorders, no treatment (unless NSAIDs sporadically). Laboratory data showed leucocytosis (17830/mmc, neutrophils 72%) and thrombocytosis (715000/mmc). During rehabilitation he developed a muscle hematoma in right thigh that required blood transfusion; he also suffered from recurrent epistaxis and melena from gastric stress ulcer. Coagulations tests were normal, instead, a measurement of platelet aggregation and of adenosine triphospathe-dense granule release showed a platelet hypoactivity, probably responsible for the important hemorrhagic diathesis. The bone marrow biopsy confirmed a picture of myelofibrosis.
**Conclusions** Low platelet count increases bleeding risk but sometimes

even too many platelets may lead to bleeding. The mechanism of excessive bleeding in chronic myeloproliferative disorders may be due to extreme thrombocytosis that leads to platelet wth abnormal morphologic features, reduced aggregation and procoagulant activity.

## Venous ischemia

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**Introduction** Mesenteric venous thrombosis (MVT) is a rare but potentially catastrophic complication that may lead to bowel ischemia and/or infarction, requiring laparotomy and resection of the involved segment. An association between inflammatory bowel disease (IBD) and MVT is rare, but has already been described since IBD is a recognized condition of thrombophilia. Otherwyse diagnosis of MVT in IBD is difficult because the symptoms of thrombosis can be confused with an IBD reactivation and can delay diagnosis and early treatment.
**Case report** A 55-year-old man developed lower abdominal pain, diarrhea and fever (40°C). A month earlier had been diagnosed Crohn's disease, treated with steroids (Methylprednisolone 45 mg/die). A physical examination showed an acute abdominal pain. A subsequent computed tomography (CT) revealed a suspected perforation of ileocolic tract associated with dilated and tortuos superior mesenteric vein, suggestive of thrombosis. A resection of necrotic small bowel tract was performed and, after surgery, was started low molecular weight heparin therapy with resolution of abdominal disconfort. The histologic examination confirmed a framework of ischemic hemorrhagic enteritis, secondary to a MVT.
**Conclusions** The persistence of the abdominal pain in IBD, despite adequate steroid treatment, is suggestive of MVT. In these cases a study with CT scan can facilitate the diagnosis and prevent ischemia.

## A cryptogenic stroke

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**Introduction** About a 25% of ischemic strokes has a cryptogenic source and subclinical atrial fibrillation (AF) should always be suspected, even if the prevalence and prognostic value of subclinical AF is difficult to assess. Moreover, as showed by ASSERT trial, also subclinical atrial tachyarrhythmias (TA), without clinical AF, are associated with a significantly increased risk of ischemic stroke or systemic embolism and occur frequently in patients with pacemakers (PM).
**Case report** A 79-year-old man developed fluctuating aphasia and right leg weakness. He had had an history of cerebral ischemia and a PM had been implanted five years before for a total atrioventricular blockade, symptomatic for syncopes. Brain computed tomography revealed a left parietal ischemia; cervical and transcranial doppler sonography showed bilateral atheromas without hemodynamic effects. Blood pressure and serum cholesterol were normal and he had a good compliance to antiplatelet treatment. The EKG showed normal sinus rhythm, but the PM report revealed recurrent episodes of TA-AF. Given the patient's high thromboembolic risk (CHADS> 2) aspirin was replaced by oral anticoagulant therapy (OAT).
**Conclusions** PM can detect subclinical episodes of rapid atrial rate that may be associated with an increased risk of ischemic stroke. The OAT should be taken into consideration especially if the ischemic recurrences occur with an optimal control of all other cardiovascular risk factors. So the PM report should always be investigated in order to reveal silent, but potentially embolic, TA.

## Una scala di valutazione del patrimonio venoso associata a un algoritmo di scelta per l'individuazione del catetere intravascolare

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**Premesse** Nella nostra azienda non vi sono attualmente istruzioni per la tutela del patrimonio venoso del paziente.
Vi è spesso un inadeguato approccio alla scelta del catetere endovenoso. Abbiamo quindi ritenuto necessario da un lato formare una nostra infermiera (master universitario U. Cattolica S.Cuore Roma) e successivamente attuare un programma (ECM n.9595/2012) di sensibilizzazione del personale finalizzato alla conservazione del patrimonio venoso e all'utilizzo ragionato di PICC/Midline.
**Scopo dello studio** Valutazione dei comportamenti e stato dell'arte. Stesura e condivisione di un albero decisionale per l'individuazione del miglior dispositivo per cateterismo intravascolare contenente una scala di valutazione del patrimonio venoso non disponibile in letteratura.
**Materiali e Metodi** Accreditamento di corso ECM; somministrazione di un questionario ai discenti; stesura albero decisionale e scala di valutazione del patrimonio venoso.
**Risultati** I dati del questionario evidenziano una non conformità di comportamenti e una scarsa conoscenza del problema. E' stato condiviso un algoritmo di scelta che verrà applicato in via sperimentale in reparto dal mese di giugno 2012.
**Conclusioni** I dati in nostro possesso confermano la non consapevolezza tra medici e infermieri della possibilità di ottimizzare le risorse per salvaguardare il patrimonio venoso del paziente in funzione delle necessità diagnostico terapeutiche. Il progetto prevede un miglioramento a livello di sicurezza del paziente, rapporto costo beneficio della metodica e efficienza aziendale.

## ✪ Functional polymorphisms of GST genes and recurrent miscarriage risk

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**Background and Aim** Recurrent miscarriage (RM) is a common and distressing disorder with unclear etiology. Epidemiological studies have suggested that this condition might be multifactorial with a possible genetic predisposition and involvement of environmental factors. Glutathione S-transferase (GST) enzymes play an important role in cellular protection against endogenous and exogenous compounds, and GST genetic variants are considered to be indicators of disease risk. Aim of this study is to investigate the role of functional GST gene polymorphisms in the pathogenesis of RM.
**Materials and Methods** 121 women with RM and 113 women without a history of miscarriages were recruited. All study population was genotyped for functional variants of GST genes: GSTA1*-69C/T, GSTM1 positive/null, GSTP1*I105V, GSTO2*N142D, GSTT1 positive/null.
**Results** The GSTA1*-69C/T genotype distribution was significantly different between women with RM and controls. In particular, significant outcomes were obtained considering different genetic models: codominant (P = 0.008), dominant (P = 0.003) and Log-additive (P = 0.002). In addition, the interaction analysis suggest that GSTA1 and GSTM1 variants have a significant interaction (P = 0.008).
**Conclusions** Our study highlighted a significant association between GSTA1 gene and RM pathogenesis. This outcome is particularly interesting because very few studies investigated the role of GSTs in RM and none of these analyzed GSTA1.

## Accuracy of emergency physician-performed ultrasonography in the diagnosis of deep vein thrombosis: a systematic review and a meta-analysis of the literature

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**Background** Duplex ultrasonography is the first-line method to detect deep vein thrombosis (DVT) in the lower extremity but it is time consuming, requires patient transport and the availability of Vascular Physician on a 24-h basis. Some studies have evaluate the accuracy of the emergency physician–performed ultrasound (EPPU) in the diagnosis of DVT. However, data on the accuracy of EPPU in this setting are not compelling. Thus, we decided to perform a systematic review and meta-analysis of the literature with the aim of providing reliable data on the accuracy of EPPU in the diagnosis of DVT in this setting.
**Methods** Studies evaluating the accuracy of EPPU compared to either colour-flow duplex ultrasound performed by a radiology department or vascular laboratory, or to angiography, in the diagnosis of DVT were systematically searched for in the MEDLINE and EMBASE databases (up to November 2011). Weighted mean sensitivity and specificity with 95% confidence intervals (CIs) were calculated using a bivariate random-effects regression approach.
**Results** Twelve studies for a total of 1857 patients were included. The pooled prevalence of DVT was 22.1% (411 DVT in 1857 patients). Using the bivariate approach, the weighted mean sensitivity of EPPU compared to the reference imaging test was 97.1% (95% CI 91.4, 99.1%), and the weighted mean specificity was 96.9% (95% CI 94.6, 98.2%).
**Conclusions** Our findings suggest that EPPU may be useful in the management of patients with suspected DVT. Future prospective studies are warranted to confirm our preliminary findings.

## Percorso strutturato utente candidato a esami diagnostico-operativi in analgo-sedazione

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**Obiettivo generale e specifico** L'assistenza anestesiologica rende tollerabile l'endoscopia digestiva; è necessaria nei pazienti poco collaboranti. Facilitare l'esecuzione di prestazioni non urgenti nei pazienti per i quali l'accesso ai servizi sarebbe difficoltoso. Tutelare i pazienti sottoposti a procedure endoscopiche/radiologiche in analgo-sedazione, garantendo l'esecuzione degli accertamenti preprocedura, la preparazione all'esame e il monitoraggio postprocedura.
**Metodologia e azioni** Utenti esterni candidati ad endoscopia digestiva/indagini radiologiche. Percorso: 1)prenotazione ricovero 15 gg prima; 2)valutazione paziente, programmazione accertamenti preprocedura; 3)valutazione anestesiologica, se indicato; 4)ricovero del paziente il giorno precedente, verifica accertamenti, preparazione all'esame; 5) osservazione in reparto; 6) dimissione il giorno successivo se non complicanze.
**Risultati** Da febbraio 2011 20 pazienti (13 F; 7 M; età media 66,8 aa): RMN/TAC in anestesia: 2; RCS in anestesia: 3; ERCP in anestesia 4; EGDS in anestesia: 3; RCS operativa: 5; endoscopia con video capsula: 1; EGDS: 2. paz. non collaboranti: 5 (25%).
**Conclusioni** L'integrazione tra Endoscopia, Radiologia, CeVaP e Medicina permette agli utenti esterni l'esecuzione di esami diagnostico-terapeutici complessi per invasività o non collaborazione del paziente. La presa in carico permette di valutare il rischio del paziente, di effettuare la preparazione e l'esame in sicurezza. Garantisce la sicurezza degli operatori che "ospitano" un paziente "noto".

## An intriguing case of serum CA 19-9 elevation

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Serum CA 19-9 is the mainstay marker for the diagnosis of biliopancreatic malignancies, even though its diagnostic specificity is limited by elevated serum levels also found in other digestive carcinomas and benign diseases. Autoimmune pancreatitis (AIP) is a rare disorder of presumed autoimmune aetiology which is associated with characteristic clinical, histologic, and morphologic findings. Among patients with AIP, serum IgG4 levels are elevated to more than two times the upper normal limit in most patients.
We report the case of a 75-year-old man with a moderate and fluctuating elevation of CA 19-9, having a slight elevation of serum IgG4 levels (184 mg/dL) and the presence of a type 2 IPMN at MRCP. IPMN was detected by a routine abdominal US performed in 2009 for the follow up of hepatitis and confirmed by RMCP. The determinations of serum CA 19-9 and IgG4 were carried out due to the presence of IPMN and parenchymal pancreatic heterogeneity of the pancreas at US. Other imaging investigations such as PET/CT, abdomen and thoracic CT scan, upper GI and colon endoscopy confirmed the findings in the pancreas, thorax and GI tract.
Elevation of serum CA 19-9 in this patient can only be accounted for using weak explanations: 1) AIP, whose clinical presentation, however, does not fit with that of the present case (Ig4 levels were moderately increased), 2) IPMN which is type 2 and with no other signs of suspected malignant degeneration, 3) previous HCV related hepatitis which does not show current cholestatic involvement.

## ✪ Stratification of malnutrition risk in patients admitted in internal medicine ward

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**Background** At the admission in hospital malnutrition is present in a lot of subjects and more than half of these worsens their nutritional state during hospitalization.
Malnutrition is associated with increased complications and comorbidities, a greater number of days of hospitalization and increased mortality.
**Materials and methods** We used the MUST (Malnutrition Universal Screening Tool), a simple method used by both doctor and a dietitian / nurse. Parameters used in the MUST: 1-Body Mass Index, 2-Decrease involuntary weight, 3-Effects of acute illness in the short term. It was applied to 50 patients consecutively admitted at the Internal Medicine ward with a prediction of hospitalization > 5 days. The procedure was performed within 48 h from the patient admission and repeated 7 days after.
**Results** The 84% of patients evaluated were over seventy. The main diseases that had conditioned the admission of all the patients evalua-

ted were cardiological (32%), abdominal (28%) and pulmonary (14%). Malnourished patients were admitted for abdominal pathology in 39% of cases conversely in 17% of cases for cardiac disease or pulmonary disease. The 32% of the patient evaluated were malnourished, the14% were at risk of malnutrition and finally the 54% were not at risk.
**Conclusions** Our risults are quite similar to those reported in the literature with incidence of malnutrition between 20% and 40%. These data encourage us to schedule a patient stratification of the risk of malnutrition at the hospital admission in order to improve the effectiveness of treatment and reduce the time of stay.

## Impact of 2 years of anti-TNF-alfa therapy on clinical, inflammation and vascular remodelling in patients with psoriatic arthritis

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**Objective** Increased cardiovascular morbidity/mortality along with subclinical atherosclerosis have been described in psoriatic arthritis patients (PsA). We evaluated the impact of anti-TNF-a therapy on vascular remodelling, inflammation, and disease activity of PsA.
**Methods** We studied 32 PsA who were intolerant of/or had inadequate response to disease-modifying antirheumatic drugs. In a open-label study of anti-TNF-a therapy, patients received either etanercept (n=21), or adalimumab (n=6), or infliximab (n=5) for 2 years. Mean carotid intima-media thickness (mean-IMT) and maximum IMT (M-MAX) were evaluated by ultrasound of carotid artery (common, bulb, internal) bilaterally. Endothelial function was evaluated by flow mediated dilation (FMD) of the brachial artery. Inflammatory markers and disease activity were assessed.
**Results** Throughout the study period, the Disease Activity Score 28, that evaluates tender and swollen joint and patient global assessment of well-being, decreased significantly after treatment (from 4.2 to 2.3). Among the inflammatory markers, serum levels of TNF-a increased whereas osteoprotegerin decreased significantly. Blood pressure, serum lipids and hs-CRP levels were unaffected. IMT values increased significantly irrespective of hypertensive status (mean-IMT from 0.72 to 0.95 mm, M-MAX from 0.88 to 1.08 mm) whereas FMD remained impaired (5.9% vs 5.3%). No difference was observed among receptor blockade and anti-TNF antibodies.
**Conclusions** Our novel observation implies that the pro-atherogenic remodelling occurring in PsA was not affected by a 2-year anti-TNF-a therapy despite significant improvement in clinical status.

## Retrospective evaluation of the need of a semi-intensive care unit for patients admitted in Internal Medicine Department

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**Background** An increasing number of patients with comorbidities needing of semi-intensive care are admitted to hospitals of Italian National Health System. To meet to this request we dedicated 4 beds in a MICU (medical intermediate care unit) room in the context of a 28-bed acute care internal medicine unit. The MICU room is equipped by multiparameter monitors and other devices for an higher level of care where patients meeting clinical criteria (based on comorbidities and critical scores) are followed.
**Aim of the study** To evaluate the needing of semi-intensive care in patients admitted in Internal Medicine Department.
**Methods and results** We observed retrospectively clinical and administrative data from all 3117 consecutive patients admitted to Internal Medicine Department from 2009 to 2011. The overall mean length of stay was 11.45 ± 8 days. 361 patients (11.58%) were followed in MICU room for overall 1960 days (mean length of stay 5.4 ± 2 days; $p<0.001$) having 100% of occupancy rate. Preliminary data suggest that an higher rate of the overall sample met criteria for needing of semi-intensive care.
**Conclusion** Our data show that in Internal Medicine Department the presence of semi-intensive care unit is necessary. Taking account of our data and of previous epidemiological studies that indicate an increasing number of elderly patients with comorbidities, the need of semi-intensive care is underestimated. Follow-up data of our sample are ongoing.

## "Don't say cat if you don't have it in the sac"

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A 57 years old woman was admitted in our department because of persistent legs pain with progressive loss of function and complete immobilization in bed; there was Rx and TC evidences of diffuse bone lithic reassessment mainly involving femurs and iliac bones on both sides. These evidences were first interpreted as signs of bone metastasis from an occult cancer. The haematic exams showed normochromic normocytic anemia (Hb 11.3), hypercalcemia (12.1 mg/dL), hyperphosphatemia (5.6 mg/dL), low D vitamin levels (6.4 ng/mL), elevated alkaline phosphatase values (3120 U/L) and very high PTH values (1450 pg/mL). During the hospitalization the patient underwent a scintigraphy study with evidence of multiple pathologic bone areas of hypercaptation and, in a second phase of the diagnostic path, the patient has been studied with total body tomoscintigraphy and thoracoabdominal TC scan with no signs of a primary localization but with a new possible interpretation for the multiple bone lesions: multiple pagetoid lesions. A biopsy on the jaw was performed and the hypothesis of brown tumour secondary to hyperparathyroidism was confirmed.
At this point a new scintigraphy was performed to study parathyroids with evidence of an image suggestive for parathyroid adenoma.
No other invasive procedures were allowed because of the patients comorbidities and the high anestesiological risk but a medical therapy has been started up with Cinecalcet; during the follow-up the haematic exams showed a good reduction of calcium and PTH serum levels (respectively 9.1 mg/dL and 830 pg/mL).

## The diagnostic labyrinth has only one exit: the right decision in an apparently simple case

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The diagnostic process is a very difficult task especially in those conditions in which the symptoms may widen several scenarios and the decision may direct the therapy in opposite directions. We report the case of a 79-years old male patient with a chronic myelodisplastic disease that was admitted for fever (lasting for three months before the admittance) and a cardiac US suspect for endocarditis on his prosthetic aortic valve. Moreover, a blood culture, that was performed few days after the beginning of the fever, was turned out to be positive for E. fecium in only one

sample out of three. Therefore, antibiotic drug was started at patient's home but the fever was always still present. Firstly, we performed culture on several blood samples, after antibiotic drug withdrawal, that resulted always negative. The fever was still present despite the absence of any evidence of infectious disease. A chest CT scan showed the presence of several enlarged lymphnodes that were absent in the previous ones. A biopsy was performed on one of the nodes on the latero-cervical region and the histopatologic examination showed surprisingly the presence of a giant cell B lymphoma. Eventually, the patient was treated for the lymphoma and improved just after the first cycle of chemotherapy. This case highlights the concept that the diagnosis is both a deductive as well an inductive process that entails some risk of error even in those conditions in which apparently everything fits perfectly. Only a perpetual self-criticism even on the most sound diagnostic hypothesis may save from the most ominous errors.

## Increased of osteoprotegerin levels in patients with unprovoked venous thromboembolism

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**Background and aim** Population studies demonstrated a significant association between osteoprotegerin (OPG) serum levels and the risk of future atherosclerotic events. No information is available about a relationship between OPG and the risk of venous thromboembolism (VTE). Aim of the study was to investigate the association between OPG serum levels and VTE.
**Materials and methods** We performed a case-control study including 110 patients with previous unprovoked VTE and an identical number of sex-matched control individuals. In all the subjects we assessed lipid profile, blood glucose, renal function, hs-CRP and OPG levels. Presence of diabetes, hypertension, use of medications and VTE characteristics were documented.
**Results** Mean body mass index was significantly greater in patients with VTE compared to controls (26,8 ± 4,6 and 25,4 ± 3,8 respectively, p= 0.018) whereas lipid profile, hs-CRP levels, blood pressure, renal function and glycemia were similar between the two groups. On the contrary, a significant increase in OPG serum levels was observed in VTE compared to controls [median: 1100,4 (IQR 888,5 -1342,9) pg/ml and 800,5 (IQR 646,1 – 1026,8) pg/ml respectively, p<0.0001]. A significant trend of increasing OR for VTE was observed among OPG tertiles. In particular, a multivariate analysis showed that the OR for VTE in the third tertile of OPG levels as compared with the first tertile was 10,09 (95% CI 4,06 – 25,05, p<0,0001).
**Conclusions** OPG levels are increased in patients with previous VTE compared to healthy controls subjects.

## Pulmonary embolism: clinical assessment, before anything else!

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**Introduction** An accurate clinical-anamnestic valuation is always very important for a proper rapid diagnosis.
**Clinical Case** A.E. female, 86, previous myocardial infarction, recent "arteriopathy" (actually deep venous thrombosis), turns to Emergency Room because of swoon and severe dyspnea.
A/B balance (supplemental O2 12 l/m): pH 7.25, pCO2 35, pO2 68, HCO3- 15.3, Lact 7.6; ECG: Previous necrosis; WBC 17000; CXR within the limits; TC cranium: ischemic outcomes. Admitted into Medicine Division, diagnosis: Cerebral stroke. Dyspnea.
Required D-dimers dosage (9000), established treatment with enoxaparine 6000 U twice/day in addition to steroids and antibiotics, required an echocardiogram: "Septo-apical acinesia; left atrium and right sections in the limits", and pulmonary scintigraphy: "Large perfusive deficit, compatible with pulmonary embolism (PE)".
Later, additional diagnosis: monoclonal gammopathy. Discharged on the 10th day, diagnosis: PE, chronic cerebral vasculopathy, monoclonal gammopathy.
**Discussion** Leukocytosis and CXR would suggest pneumonia. The mixed acidosis (due to shock), and the normality of the right sections of the heart wouldn't lead to think of PE. However a careful clinic evaluation immediately leads to the suspect of PE, then upheld by scintigraphy.
**Conclusions** The case shows how a cautious clinical-anamnestic valuation has allowed, despite of different admission diagnosis and apparent contradiction of some exams, to have an immediate, surely not simple, diagnostic suspect and to practise an adequate treatment for a very dangerous disease

## When pancreatitis suggests a genetic disease

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**Background** Depending on levels of triglycerides, the risk of pancreatitis and/or cardiovascular (CV) disease can increase.
**Clinical Case** MM, male, 38, smoker, not drinker, BMI 34, is hospedalized because of abdominal pain. WBC 14000; glucose 170, amylase 460, lipase 2948; chylous serum. ECG, CXR and X-ray abdomen within the limits; abdominal echography not practicable because of abdominal pain; abdomen CT: Enlarged pancreas, with soft edges. Cholesterol 325 (HDLc 25), triglycerides 1140, ApoB 134. Family history: father myocardial infarction at age 50, dyslipidemic brothers. Discharged on the sixth day, diagnosis: Acute pancreatitis in familial combined hyperlipidemia (FCH). Diabetes mellitus (DM) due to pancreatitis.
**Discussion** Cholelithiasis and alcohol are the main causes of pancreatitis, hypertriglyceridemia is responsible for 2-3%. It may be primary (hyperchylomicronemia, family hypertriglyceridemia, dysbetalipoproteinemia and FCH), or secondary (alcohol, type II DM, obesity, medications). Criteria for FCH: LDLc >160 and/or triglycerides >200 in the patient, associated with different phenotypes and/or early CV events in his first degree relatives. Further criterion: ApoB >125 in a patient with early CV familiarity. High risk of acute pancreatitis for levels >1000, while moderate hypertriglyceridemia is a marker of atherogenic dyslipidemia.
**Conclusions** The case shows as hypertriglyceridemia, frequent bio-humoral alteration, should ask the doctor to identify the implications of systemic diseases, such as FCH, which shouldn't be runned in a hasty manner

## Prevalent delirium in the hospitalized elderly: a neglected sign of bad prognosis

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**Introduction** Delirium is a serious event associated with adverse outcomes in hospitalized elderly. It is frequently unrecognized or confused with dementia.
**Aim of the study** To assess some characteristics of very old patients with diagnosis of prevalent delirium (presence of symptoms at hospital admission), diagnosed with the Confusion Assessment Method (CAM).
Results We evaluate 100 consecutively admitted patients to our Acute Geritric Unit at the Infermi Hospital, Rimini. Patients with severe dementia (4 or 5 at the Clinical Dementia Rating Scale) were excluded (33 subjects) because in these patients CAM could not be properly administrated. The mean age was 83,5 ± 6,9 years (range 66-99 years). Prevalent delirium was diagnosed in 15 subjects (22%). Patients with delirium had higher APACHE II score (21,1 ± 7,1 VS 14,6 ± 5,2; p= 0,000) and lower functional status (BADL scale) (2,0 ± 2,4 VS 3,6 ± 2,1 p = 0,016). Mortality during the hospitalization was 40% in delirious patients and 10% in patients without delirium (p = 0,005). Six-month mortality rate was 60% in delirious patients and 38% in patients without delirium (p = 0,138).
**Conclusions** Prevalent delirium is an important predictor of early bad prognosis in elderly inpatients. Its detection should be essential to identify patients with high risk for adverse outcomes.

## Mucinosal adenocarcinoma conditionating jejunal stenosis: a case report

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**Background** Although the small bowel is one of the longest organs of the human body, less than 2% of all the gastro-enteric tract-malignant tumors takes origin from it.
About 50% of all small bowel malignancy involves the first or the second duodenal portion and it is rappresented by ADK.
**Material and methods** A 60 years old man was admitted to our Unit because of dyspepsia, vomiting and abdominal pains. The personal anamnesis was positive for smoking, HBV-realted epatopathy.
Laboratory tests showed increased values of CEA (37.9 ng/ml) and CA 19.9 (80 U/ml).
We decided to perform first EGDS and colonoscopy (both negative), and then PET total body with F-1-8FDG, that showed enhanced metabolic activity in the small bowel with distension of intestinal loops.
**Results** In a second time the patient was submitted to Rx clisma of small-bowel and to entero-TC with contrast medium wich revealed a jejunal severe stricture without c.e. but with ectasia of the proximal loops. Considering the entity of the stricture, the patient was referred to a Surgery Unit for jejunal resection.
**Conclusions** The hystologic examination was positive for mucinose ADK with lymphonodal metastasis (T4N1Mx). Finally the patient was referred to oncological department for chemotherapy.

## ✪ Using a tool of Clinical Governance (clinical AUDIT) for treating hyperglycemia in hospitalized patients

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**Scopo** In hospitalized patients prevalence of diabetes is high (5-25%). While hospitalized, it is strictly recommended a good metabolic control, but often there is little or no uniformity in managing hyperglycemia. Our Hospital has developed and implemented a specific protocol for the management of hyperglycemia.
**Materiali e Metodi** We developed a protocol (insulin infusion) based on clinical guidelines and literature meta-analysis adapted to local context. We chose an examplification of the Yale protocol that, after being initiated by a medical doctor has a total nursing management. This protocol has been discussed with the medical and nursing staff of our Medicine, ICU and Surgery Units through the GLAM Tool (AUDIT). It has been discussed, printed and reviewed by the medical and nursing staff of the different wards. The final work has been published in digital and paper format in a Conference held in our hospital (DIE method). We have implemented it by a clinical audit process through: "reminders" in different wards, meetings in small groups with medical and nursing staff, individual patient clinical records (CPR) .
**Risultati** The process indicator was the number of CPR's treated with the protocol, the outcome indicator was the reduction of diabetological counselling requests. 2 months after protocol implementation we observed a 26% reduction of diabetological counselling requests; at the moment we collected 34 CPR of patients treated by new protocol.
**Conclusioni** Using clinical audit, tool of Clinical Governance, is useful and effective.

## An iceberg in the lung

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Un uomo di 44 anni,non fumatore ,anamnesi patologica remota muta, si ricovera per tosse stizzosa e rilievo TC di tumefazione solido-omogenea con margini irregolari ilo-parailare superiore destra,estesa al mediastino.
Incremento di CEA, NSE, TPA agli esami ematici. Alla fibrobroncoscopia compressione ab estrinseco del bronco principale destro;aspetto infiltrato del bronco superiore destro . All' esame istologico reperti morfologici ed immunoistochimici indicativi di neoplasia neuroendocrina a basso-intermedio grado di malignità.Possibile carcinoide polmonare. Attività proliferativa <2%. TC cranio, addome con mdc e scintigrafia ossea per staging: non ripetizioni a distanza. Il carcinoide polmonare rappresenta l'1-2% di tutte le neoplasie polmonari,origina dalle cellule del Sistema Neuroendocrino Diffuso. Vi è un ampio spettro di differenziazione dei tumori neuroendocrini polmonari: carcinoide tipico, carcinoide atipico,carcinoma a grandi cellule atipico,microcitoma. Markers specifici: cromogranina, sinaptofisina,NSE, leu-7,bombesina.
I carcinoidi tipici sono il 90% dei carcinoidi,hanno localizzazione centrale,raramente presenti metastasi alla diagnosi; sopravvivenza a 5aa:98%;frequente aspetto ad iceberg; bassa attività proliferativa e assenza di necrosi all'es. istologico.I carcinoidi atipici sono il 10% dei

carcinoidi, più spesso localizzazione periferica; dimensioni più grandi alla diagnosi rispetto al tipico(>3 cm);più frequenti le metastasi alla diagnosi; sopravvivenza a 5aa:69%. Il paziente è stato inviato ad intervento chirurgico per carcinoide polmonare tipico.

## Inflammatory pseudotumor of the spleen: a rare entity that may mimic a malignant lymphoproliferative disorder

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**Introduction** Splenic inflammatory pseudotumor is a rare mass-forming lesion characterized by fibroblastic or myofibroblastic spindle cell proliferations with varying degrees of inflammatory cell infiltration.
**Clinical case** A 47-years-old woman visited our hospital complaining of fever, asthenia, sweating. Laboratory investigation showed anemia, higher levels of inflammatory markers and hypergammaglobulinemia. Chest-x-ray, endoscopic evaluation, screening for autoimmune and infective diseases were negative. Abdominal ultrasound showed a solid mass on spleen measuring 74x50 mm, confirmed by CT-scan. The combined PET/CT scans provided images that pinpointed the location of abnormal metabolic activity within the spleen. Bone marrow biopsy was negative. Splenectomy was performed with the differential diagnosis including lymphoma of the spleen. Histological examination of the splenic mass consisted of myofibroblasts and admixture of inflammatory cells. Immunohistochemistry was positive for CD68K and CD68-PGM1 and negative for S100, ALK-1, desmin and CD30. IPT of the spleen was diagnosed.
**Discussion** and conclusions IPT of the spleen is an extremely rare benign condition and frequently may mimic a malignant lymphoproliferative disorder clinically and radiologically. It is important to consider it in order to distinguish benign tumors of the spleen from malignant tumors, such as lymphoma. It is very difficult to diagnose this disease by image study preoperatively. A final diagnosis can only be obtained through postoperative histopathological and immunohistochemical examination.

## Trans-abdominal focused ultrasonography versus recto-colonoscopy for diagnosis of recto-colonic cancer in elderly patients

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**Aim** To evalue diagnostic accuracy of trans-abdominal focused ultrasonography (US) for recto-colonic cancer (RCC) in elderly patients, who have frequent limitations to the recto-colonoscopy (RCS).
**Materials and methods** We reviewed the cases afferent to geriatric division in biennium 2010-11, submitted to US of colon-rectum and subsequent RCS for clinically suspected RCC (anemia and abnormal alvus such as constipation and/or diarrhea and/or rectal bleeding, abdominal pain, abdominal mass and/or weight loss): 83 patients (men 37, women 46; mean age 79, range 69-91). US diagnosis of RCC was for segmental thickening >4 mm of the rectal or colonic wall, with eccentric lumen, abrupt demarcation, irregular profile, intralesional high resistivity index (> 0.7) at color-Doppler.
**Results** 33 of 83 patients (39.7%) had histologically verified RCC to RCS. The table shows the results.

| | CRC | Colon | Rectum | Total |
|---|---|---|---|---|
| RCS | POSITIVE | 22 | 11 | 33 |
| | NEGATIVE | 61 | 72 | 50 |
| | Prevalence (%) | 26,5 | 13,25 | 39,75 |
| US | POSITIVE | 22 | 4 | 26 |
| | NEGATIVE | 61 | 79 | 57 |
| | Veri positivi | 19 | 2 | 21 |
| | Falsi positivi | 3 | 2 | 5 |
| | Veri negativi | 58 | 70 | 45 |
| | Falsi negativi | 3 | 9 | 12 |
| | Sensitivity (%) | 86,3 | 18,1 | 63,6 |
| | Specificity (%) | 95 | 97,2 | 90 |
| | Positive predictive value (%) | 86,3 | 50 | 80,7 |
| | Negative predictive value (%) | 95 | 88,6 | 78,9 |
| | Accuracy (%) | 92,7 | 86,7 | 79,5 |
| | Positive Likelihood Ratio | 17,56 | 6,54 | 6,36 |
| | Negative Likelihood Ratio | 0,14 | 0,84 | 0,4 |
| | Post-test probability (%) | 86,3 | 50 | 80 |

**Conclusions** US shows good diagnostic performance for RCC in colonic tract, low for rectum. The less invasive association of US with proctoscopy would be a good diagnostic tool in elderly patients clinically selected, but larger samples studies are required.

## Intracranial moyamoya type vasculitis associated with post-pneumococcal meningitis and previous pulmonary tuberculosis. A case report

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**Background** CNS vasculitis is a known complication of bacterial meningitis most frequently due to S.Pneumoniae, M.Tuberculosis, N.Meningitidis or H.Influenziae. Signs typically occur within the first two weeks of the disease, while delayed postinfectious vascular events are less common. Few cases of persistent post-infective vasculitis are reported and most of them refer to pneumococcal meningitis. Her, we describe an unusual association of moyamoya syndrome with pneumococcal meningitis and previous pulmonary tuberculosis.
**Case description** A 56 year old man from Pakistan with a history of right frontal and occipital stroke diagnosed as "post-pneumococcal moyamoya syndrome", treated with occasional prednisone, was referred to our unit with fever, left hemiparesis, amnesia, visual illusion and microzoopsias. Considering past medical history and geographical origin, we performed tubercolin skin test and Quantiferon TB Gold in-tube assay, which were both positive, whereas BAL was negative for acid fast bacilli [cultural test ongoing]; HRCT showed specific features for past TBC. In addition to Prednisone 17.25 mg p.o. daily, antitbc prophylactic treatment was started (Isoniazide 300 mg p.o. daily for 6 months).
**Conclusion** Clinical and laboratory findings led to revise the past diagnosis suggesting at least two other possible hypotheses: 1) a tubercolar vs. pneumococcal chronic recurrent meningitis (in this case PET could be a useful tool to detect possible granulomas), 2) the presence of a vasculopathy recurrence during uncomformed steroid treatment

### Sarcopenia and bone mineral density in frail elderly persons: results of the evaluation by dual-energy X-ray absorptiometry (DXA) in elderly subjects

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**Introduction** Sarcopenia is a syndrome characterized by the progressive and generalized mass loss and muscular strength.
The aim of this study is to assess sarcopenia by relative skeletal muscle mass (RSMM) and bone mineral density among elderly inpatients.
**Materials and Methods** A prospectic longitudinal study. Currently, after 8 months of study, the sample is composed by 135 subject (female/males: 98/37; age 81.4±7) inpatients in "Santa Margherita" Geriatric Hospital (Pavia).
Participants were assessed using DXA.
**Results** 87 of patients (64.4%, 35 men equal to the 94.6% of the male population and 52 women equal to 53% of the female population) has been diagnosed with sarcopenia according to the RMMI, 34 subjects (25%, 1 man equal to the 2.7% and 33 women equal to 34%) are in risk of sarcopenia and the remainders 14 subjects (11%, 1 man equal to the 2.7% and 13 women equal to 13%) has been classified as non-sarcopenic. Regarding the BMD, 70 subjects (52%, 5 men equal to the 13.5% and 65 women equal to the 66.5%) had osteoporosis, 40 subjects osteopenia (30%, 15 men equal to the 40.5% and 25 women equal to the 25.5%) and the remainders 25 subjects (18%, 17 men equal to 46% and 8 women equal to 8%) don't show any alterations of the bone mineral density.
**Conclusions** Both sarcopenia and osteoporosis, that are not just elderly diseases despite the age correlation, are prevalent among the population studied and in particular sarcopenia are more prevalent in men and osteopenia and osteoporosis are more prevalent in women.

### Anaemia and fat-free mass in the elderly: two parameters going on the same track?

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The research derives from a study on malnutrition among elderly people in a nursing home. The 56 patients, depending on the level of autonomy for a proper nutrition, were assigned to two different groups: self-sufficient and not (assistance from a health worker during meal). The levels of haemoglobin (Hb) and fat-free mass (FFM) were examined with regard to age, gender and level of eating autonomy. The data show that the correlation between age and anaemia is highly significant ($p<0.001$), as well as the correlation between age and FFM reduction, examined with BIA ($p<0.001$). The comparison between males and females for Hb levels (g/dl 12.8 +/- 1.4 vs. 12.1 +/- 1.2) doesn't show any statistically significant difference, whereas the comparison between the two genders for FFM percentage (61.1 +/- 12.7 vs. 43.9 +/- 9.5), was significant ($p<0.01$). The most interesting element to our purposes is the FFM levels between self-sufficient and not. The difference between the two groups (FFM% = 49.3 +/- 10.8 of the first group vs. FFM% = 44.3 +/- 14.2 of the second one) wasn't significant. The comparison of Hb levels between self-sufficient (g/dl 12.6 +/- 1.1) and non-self-sufficient (g/dl 11.6 +/- 1.3) doesn't show a significant difference. From these data we can assume that in the examined patients the Hb levels and FFM % decrease at the same rate with aging, whereas the FFM and the Hb levels are not related to the eating autonomy.

### Idrocefalo normoteso: una causa reversibile di demenza, caso clinico

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**Descrizione del caso clinico** 76enne, più volte valutata e ospedalizzata nell'ultimo anno per instabilità posturale, vertigini e iniziale decadimento cognitivo.
**Decorso Clinico** All'esame obiettivo rilievo di andatura atassica con marcia allargata e difficoltà a mantenere la postura eretta senza appoggio (numerose cadute a domicilio), decadimento cognitivo di grado lieve-moderato con MMSE (Mini Mental Stata Examination) 21/30 (vn ≥24), riferita incontinenza urinaria residua anche un anno dopo intervento per prolasso vescicale, con incontinenza da urgenza e da sforzo. La paziente è stata sottoposta ad approfondimento del quadro neurologico, anche alla luce di una TC eseguita 8 mesi prima che segnalava dilatazione significativa del sistema ventricolare. La TC e la RMN di controllo hanno confermato la presenza di idrocefalo ostruttivo sovratentoriale dovuto a stenosi congenita dell'acquedotto del Silvio.
**Risultati** La paziente è stata inviata al Neurochirurgo che ha effettuato intervento di terzo ventricolo cisterno-stomia per via endoscopica, con rapida regressione, nel post-intervento della sindrome vertiginosa e netto miglioramento della deambulazione. Alla TC encefalo di controllo riduzione del volume del sistema ventricolare sovratentoriale. Ad una valutazione post-dimissione: MMSE 26/30.
**Conclusioni** L'idrocefalo normoteso rappresenta una causa reversibile di demenza importante da valutare, in particolare se è presente la triade sintomatologica classica, poiché la sua correzione porta ad un rapido miglioramento clinico.

### Dysautonomia-symptoms could be systemic disease?

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**Background** AL amyloidosis is one of the most common forms of systemic amyloidosis and is often associated with plasmacellular dyscrasia. The diagnosis may be difficult due to the heterogeneity as well as to the vagueness of symptoms. It is considered a rare disease, but necroscopy studies suggest a higher incidence.The present case report is intended to emphasize the diagnostic complexity of AL amyloidosis.
**Study subject and Results** In February 2008 a 62-years- old man started to complain of persistent diarrhea, without any apparent cause (biochemical and cultural tests as well as digestive endoscopy were negative) up to January 2009. At that time a proteinuria appeared, whereas renal function was still normal.The subsequent test addresses to a diagnosis of AL amyloidosis, with prominent renal and autonomic nervous system involvement. The patient underwent various types of treatment, which resulted in a reduction of proteinuria, but not of diarrhea (which was also resistant to Octreotide). The patient died in 2011 because of cardiac failure.
**Conclusions** This clinical report suggest in the first place that even a nonspecific symptom, such as diarrhea, should be evaluated in its complexity, including a neurological evaluation, so as not to exclude in the differential diagnosis AL amyloidosis, which can typically present as a damage of the autonomous nervous system.

### Estesa polmonite bilaterale, ma il paziente sta quasi bene...!?

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Maschio, 75 aa, ex fumatore, lieve insufficienza valvolare aortica, mitralica, tricuspidalica in terapia anticoagulante orale per fibrillazione atriale cronica. 1 mese dopo l'insorgenza di incostante febbricola e astenia, riscontro di polmonite a focolai multipli, taluni con aspetto nodulare. Apiretico, in discrete condizioni generali,indici di flogosi solo lievemente mossi, lieve sindrome restrittiva con ipossiemia; BAL sterile, con linfocitosi (76%). In considerazione dell'età e dei problemi cardio-respiratori, si è convenuto, pur in assenza di diagnosi di certezza, di iniziare un trattamento steroideo, con stretto monitoraggio. Dopo 60 gg: negativizzazione del quadro clinico, radiologica e funzionale. 1 mese dopo la sospensione del cortisone: ripresentazione del problema. Veniva allora effettuata biopsia polmonare toracoscopica, che diagnosticava "OP" (Organizing pneumonia). Con la ripresa della terapia steroidea, si assisteva a pronta risoluzione della malattia. Abbiamo previsto un più prolungato trattamento steroideo. Nel follow up permane in benessere

## Tocilizumab treatment in rheumatoid arthritis: results from a real-life retrospective cohort study

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**Background** Tocilizumab(TCZ) is a novel anti-IL6 drug licensed for moderate to severe Rheumatoid Arthritis(RA). No data about its effectiveness and safety coming from real-life practice are still available in Italy. Population In this retrospective study we describe 39pz, F/M 35/4, aged 61y(median), duration of disease 8y(median), who received TCZ 8 mg/kg every 4 weeks. Median follow-up is 12.5 months. 23/39 were treated in monotherapy. The most frequent combination therapy was Methotrexate(31%). Only 20% of the enrolled pz were naïve for previous biological treatments.
**Results** We observed an high survival to the treatment (80% at 12 month). All the drop-out (6 cases: lack of efficacy (2), adverse events (3) and other reasons (1)) were observed within the 8° month. Mean DAS-28 significantly decreased from 5.07 to 2.57 after 6 months (31 evaluable pz), with a further fall to 1.9 after 12 months (21 evaluable). Remission or low-disease activity was achieved in all pz after one year, either in monotherapy or combination. We observed 10 infectious events: 9 mild upper respiratory or mucocutaneous infections and 1 pneumonia requiring parenteral therapy. Furthermore we report mild neutropenia in 9 cases, transient increase of liver enzymes (5) and two minor infusional reactions (0,44% of 451 infusions) leading to TCZ discontinuation.
**Conclusions** Our experience is the first evaluation of TCZ efficacy and safety in a italian population followed in a real practice setting. Our data confirm the favorable safety and efficacy profile for this drug, even when used as monotherapy.

## A team-work on atypical abdominal pain

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A 38 years old woman, no delivery before, was admitted to our Medical Department for abdominal pain and cramping appeared since 48 hours, together with vomiting and nausea. Her medical history included monthly abdominal pain episodes, depressive mood, regular menstrual cycles associated with dysmenorrhea; recent endoscopic exams (gastroscopy, colonoscopy) were negative.
At the admittance, clinical and x-ray findings showed an incomplete intestinal obstruction, CT scan revealed an ileal substenosis. The patient was treated with nasogastric tube, fasting , antibiotics therefore in few days the obstruction was solved. Blood tests (RSE, RPC, autoantibodies in the average) were not suggestive of Chron's disease. Gynecological exam evidenced an enlargement in the left ovary. Discharged with follow-up indication, she came back 60 days later reporting 2 similar abdominal pain episodes occurred close to the menstrual cycle; a futher gynaecological visit hypothesized the existence of an endometriosic nodule with indication for laparoscopy (she refused). Four months later, she was operated for ileal resection and discharged with diagnosis of "intestinal obstruction for ileal intussusception by ileal endometriosis" (confirmed with histology).
Ileal localization is rare and atypical for extragenital endometriosis, with a low index of suspicion in comparison with Chron's disease or irrital bowel syndrome for abdominal recurring pain cause in a young woman. Here, a complete medical history, the outpatient follow-up and a cooperation of encountering specialities elucidated the diagnosis.

## Clinical case: chronic diarrhoea in patient affected by corticoadrenal insufficiency

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We describe the clinical case of a 76 old man suffering from chronic diarrhoea. The diagnosis of corticoadrenal insufficiency was done only two years after the beginning of the symptoms. This disease is very difficult to be diagnosed early because symptoms are of gastroenterological type. This case is worthy to be considered to avoid belated diagnosis and the dead of patient.
The patient suffered from chronic diarrhoea the first time in 2008 with the diagnosis of ulcerous proctitis. In October 2010, the patient was affected by dyspeptic syndrome and anaemia and EGDS revealed the occurrence of gastric ulcer (deltacortene with no gastric covering). Celiac disease was excluded. The colonoscopy excluded an inflammatory intestinal disease and therefore the cortisone therapy was suspended. Gastroenterologists supposed a diarrhoea derived by protonic pomp's inhibitor. The diarrhoea was go on and the patient was increasingly debilitated. Low values of cortisolemia and ACTH permitted to make the diagnosis of (secondary due using corticosteroids?) corticoadrenal insufficiency. Only after giving Cortone acetato we obtained an improving of clinical picture.
Concluding, we believe that the patient since the beginning was affected by corticoadrenal insufficiency (primitive?) and not by an inflammatory, intestinal process.

## A "faint" young woman. Role of estro-progestinic therapy

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**Case report** We describe a young woman, referred to our Unit for recurrent orthostatic syncope. Past medical history was unremarkable but recent lab tests showed hyperaldosteronism and low ACTH levels. She

was on http://www.ncbi.nlm.nih.gov/pubmed/22336820 oral estro-progestinic therapy. On clinical examination she complained of mild fatigue and low blood pressure values (90/50); orthostatic hypotension was confirmed while cardiologic examination was unremarkable. Laboratory tests showed high serum aldosterone (744, n.v. 30-100 pg/ml in orthostatic position) and plasma renin activity (4.74, n.v. <3.9 ng/ml/h), with normal serum and urinary electrolytics. Such findings, along with hypotension were in contrast with the hypothesis of secretive adrenal mass or renal artery stenosis, anyway abdominal CTscan and renal Doppler ultrasound were negative. The role of oral contraceptive (ethinylestradiol/drospirenone) was evaluated. Drospirenone, a synthetic progestinic drug, has known strong antimineralcorticoid activity, thus determining hypotension and hyperaldosteronism secondary to its natriuretic activity. After withdrawal of contraceptive therapy, laboratory values quickly normalized and symptoms disappeared.
**Conclusions** The diagnostic work up of hyperaldosteronism should take into account the possible role of estro-progestinic therapy, given its widespread use. Contraceptive prescription should be supervised and patients informed about possible side effects.

## An unusual and insidious cause of lower back pain

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**Introduction** Retroperitoneal fibrosis can cause obstructive uropathy, rarely associated with compression of retroperitoneal vessels. It is idiopathic or secondary to drugs (methysergide et al.), malignancy, tuberculosis, radiations.
**Case report** A 45 years old woman came at our observation for untreatable lower back pain and weight loss on October 2011. Symptoms started on March 2011; afterwards she was admitted three times to her local hospital for suspected recurrent urinary infection and lumbar spine disease, and treated with antinflammatory drugs/antibiotics. At that time abdominal ultrasound and CTscan, CT and MRIscan of lumbar spine and colonoscopy were negative. On her arrival physical exam showed slight hypotrophy of right quadriceps, limping, pain at palpation of right lower abdominal quadrant. On lab tests: hemoglobin 10.4 g/dl, PCR 8 mg/dl, VES 34 mm. Tumoral markers, autoantibodies, Quantiferon were negative. Contrast enhanced CTscan showed enhancing tissue encasing abdominal aorta and cava (36x28x24 mm). PET confirmed hypermetabolic tissue (SUVmax 32.4). Urgent surgical intervention showed solid tissue infiltrating aortic wall, not removable. Histological exam revealed retroperitoneal fibrosis. According to the literature, she started prednisone induction therapy (1 mg/kg/day for one month), with sudden release from the pain at one month of follow-up. Now on tapering.
**Conclusions** Retroperitoneal fibrosis presents insidiously with vague symptoms delaying diagnosis as, like our case, symptoms for a long time were ascribed to spine disease, even if never proven.

## Paraplegia in una paziente in trattamento con warfarin

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L'emorragia intraspinale spontanea è una complicanza rara ma ben conosciuta della terapia con anticoagulanti orali (TAO). La Risonanza magnetica (RM) è l'esame di immagine più sensibile e specifico per la diagnosi ed una evacuazione chirurgica precoce può ridurre il deficit neurologico. Descriviamo il caso di una donna di 71 anni portatrice di PMK , in terapia con Warfarin, giunta al Pronto Soccorso per paraparesi da circa 24 ore e ritenzione urinaria.Una settimana prima comparsa di dolore in sede dorsale con un controllo dell' INR di 5,6sec.La TC urgente senza e con mdc dell'encefalo e del rachide cervico – dorsale evidenziava iperdensità estesa da D4 a D11 compatibile con componente ematica; a livello cervicale alterazione strutturale dell'emisoma destro, del peduncolo e parzialmente dell'emilamina del corpo vertebrale di C7, caratteristiche deponenti per un angioma.L'INR era 3,16sec. La presenza del PMK precludeva l'esecuzione di una RM, dirimente nel sospetto di ematomielia o ematoma spinale D4-D11. Il quadro clinico nelle otto ore successive evolveva in una paraplegia completa. In considerazione dei rischi e della prognosi e in assenza di integrazione diagnostica con RM, dopo colloquio con i Neurochirurghi la paziente rifiutava l'intervento esplorativo di decompressione. Molte sono le cause che possono determinare ematomielia: traumi, malformazioni vascolari, diatesi emorragica, terapia con anticoagulanti, neoplasie. Nel nostro caso possono aver contribuito all'evento emorragico sia la terapia con Warfarin sia la presenza di un angioma.

## Manifestazione extragastrica dell'infezione da Hp

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**Introduzione** L'infezione da Helicobacter pylori (Hp) può determinare un ampio spettro di malattie a livello gastroduodenale, dalla gastrite semplice all'ulcera peptica, fino al MALToma e cancro gastrico. Più rare, ma oramai accertate, sono le manifestazioni extragastriche quali anemia sideropenica e trombocitopenia immune. Si segnala un caso di trombocitopenia immune.
**Caso clinico** Donna di 47 anni ricoverata per cefalea e crisi ipertensiva. Esami routinari: piastrinopenia (37000/ml), valore confermato in citrato ed eparina, in assenza di aggregati. Negativi HIV, HCV, HBV, ANA, anti-DNA, LAC e antifosfolipidi, antitiroide, Parvovirus, EBV, CMV, cause midollari, iatrogene, ipersplenismo, nella norma immunoglobuline e striscio di sangue periferico. Positività dell'antigene fecale Hp, in assenza di sintomi dispeptici. Ipotizzando l'origine autoimmune della piastrinopenia, indotta dalla infezione da Hp eradicavamo l'infezione con una triplice terapia. Dopo 20 giorni, in assenza di altre terapie, le piastrine erano 100000/ml; antigene fecale Hp negativo. In corso breath-test e monitoraggio emocromocitometrico.
**Conclusioni** L'infezione da Hp dovrebbe essere ricercata in corso di piastrinopenia immune, che, con l'anemia sideropenica, ne sono le uniche manifestazioni extragastriche validate.
Come fattore patogenetico si pensa che componenti batteriche dell'Hp e la risposta immunologica dell'ospite abbiano un ruolo determinante.

## Una rara complicanza della paracentesi evacuativa

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**Introduzione** Il danno epatico cronico, indipendentemente dalla causa, evolve sino alla cirrosi epatica, che, se scompensata, produce versamento ascitico. L'ascite viene trattata farmacologicamente, se refrattaria, mediante paracentesi evacuative. Tali monovre tuttavia, anche se eseguite correttamente, non sono esenti da rischi e complicanze. Presentiamo un caso di rara complicanza della paracentesi evacuativa.
**Caso clinico** Paziente di anni 71 affetto da cirrosi epatica HBV-relata ed ascite refrattaria, sottoposto periodicamente a paracentesi evacuative in regime di DH. In occasione dell'ultima procedura eseguita, il paziente, dimesso dopo 2 ore di osservazione, presentava a domicilio, a

distanza di circa 4 ore dalla paracentesi, dolore addominale e sincope per cui veniva trasportato in in PS ove veniva posta diagnosi di shock emorragico (valori di Hb 6,8 g/dl, precedenti 12 g/dl). Nel sospetto di emoperitoneo veniva eseguita una laparotomia che mostrava, in corrispondenza della sede della paracentesi, la presenza di una varice peritoneale sanguinante trattata chirurgicamente. Il paziente, trasfuso con GRC, manteneva la stabilità dell'emocromo ai controlli.
**Conclusioni** La paracentesi evacuativa è una manovra invasiva indicata nel trattamento dell'ascite refrattaria, non scevra da rischi e complicanze, tra cui, sebbene raro, va annoverato l'emoperitoneo da sanguinamento di varici peritoneali, favorito peraltro dalla concomitante coagulopatia da cirrosi. E' consigliabile pertanto, dopo ogni procedura, tenere il paziente in osservazione per almeno 6 ore.

## The role of transient elastography (FibroScan) in the study of liver fibrosis in systemic sclerosis

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**Objective** Systemic Sclerosis (SSc) is an autoimmune disorder of unknown etiology. The aim of this study was to determine the role of Transient Elastography (FibroScan)in the study of liver fibrosis in SSc.
**Methods** Thirty-three SSc patients (32 female and 1 male, mean age 54 year) without liver diseases and thirty-three controls (all female, mean age 54 years) were consecutively studied. All patients underwent FibroScan and 9 (4 with suspected liver disease) underwent double-enhanced magnetic resonance (MR) imaging with superparamagnetic iron oxide (SPIO)-enhanced and double-enhanced spoiled gradient-echo (SPGR) sequences.
**Results** Sixteen SSc patients had a FibroScan Stiffness value of less than 5.3 kPa, while in seventeen patients Stiffness was more than 5.3 kPa (suspicion of liver disease). The Spearman test showed the presence of a linear regression between the values of Stiffness and that of creatinine clearance (Spearman = -0531, p = 0.034) and between Stiffness and creatininemia (Spearman = 0,396, p = 0.022). The Pearson's correlation index (FibroScan versus diffusion-MR) showed a linear regression between the values of Stiffness and the diffusion-coefficient (ADC AVG )(r = -0.83, p = 0.0056) and in agreement with this McNemar's test (FibroScan versus diffusion-MR and SPIO-MR) did not show the presence of significant differences between the methods compared.
**Conclusion** FibroScan suggested liver fibrosis in 50% of patients with SSc; this finding was confirmed by diffusion-MR and SPIO-MR. Stiffness correlated with creatinine clearance and creatininemia values.

## Reactivation of hepatitis B virus infection after anti-Tumor Necrosis Factor alfa (anti-TNF alfa) therapy in patients with rheumatic diseases

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**Objective** Reactivation of hepatitis B is defined as the recurrence or an abrupt rise in hepatitis B virus (HBV) replication. This reactivation can occur in situations in which the ratio of HBV replication and immune response is altered, for example chemotherapy or immunosuppressive therapy.
**Methods** 86 consecutive Caucasian patients (42M/44F, mean age 50,2 years) with rheumatic diseases (Rheumatoid Arthritis, Ankylosis Spondylitis and Psoriatic Arthritis) were investigated for reactivation of hepatitis B virus infection during a year of therapy with anti-Tumor Necrosis Factor $\alpha$ (anti-TNF$\alpha$). 13 patients were excluded for incomplete data. Each patients underwent detailed examinations in order to rule out occult infection.
**Results** None patients were HBsAg or HBV-DNA positive instead 14 were HBsAb positive (9 HBcAb positive and 5 HBcAb negative) and 4 HBcAb positive-HBsAb negative (occult infection); three of them were treated with antiviral drugs (Lamivudine) during the therapy. The prevalence of occult infection was not significantly different between rheumatoid arthritis and seronegative arthritis pts.
**Conclusion** We didn't find reactivation of hepatitis B virus infection in our group, but 4 patients had an occult infection. These patients, according to the last Guidelines, should be treated with antiviral therapy before, during and after immunosuppressive therapy.

## High prevalence of vitamin D insufficiency\deficiency in patients with lymphoproliferative neoplasias and multiple myeloma

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**Background** Vitamin D (D) insufficiency (DI) is common. From 25% to 50% of patients seen in clinical practice have vitamin D levels below the optimal range (D-BOR). Vitamin D has a central role in bone metabolism, but also has pleiotropic effects on cellular differentiation, proliferation, apoptosis, and angiogenesis, Several reports suggest low serum D levels ( may be associated with increased cancer incidence and/or poor prognosis in some solid tumors, in lymphoproliferative neoplasias (LN) and multiple myeloma (MM). We report on our experience on DI in pt with LN and MM.
**Material and Methods** In June 2011 a prospectic study was started on DI in patients (pt) with haematological neoplasms. All pt newly diagnosed with LN seen at our department are recruited in this study. DI was defined as serum level of D (sD) <10 ng/mL; D deficiency (DD) as sD between 10-30 ng/ml. sD were measured at initial presentation. Pt treated with calcium/D were excluded. Therapy with D/calcium was started in DI-pt.
**Results** D-BOR ( 3DD, 5DI) were observed in 8/9 (7F, 2M; mean age 74,7;¸range 65-82) low-grade LN. In these pt mean sD were 16,2 ng/mL; range 7,3-41,4). D-BOR ( 3DD, 4DI) were present in 7/8 (4F, 4M; mean age 68,7; range 52-81) pt with Chronic Lymphocytic Leukemia (CLL). In CLL mean sD were 13,8 30 ng/ml (range 7,4-33,3). D-BOR were observed in 9/9 (5M,4F; mean age 58,5; range 51-73) pt with MGUS/myeloma. In these pt (1DD,7DI) mean sD were 19,5 ng/mL (range 7,1-28).
**Comment** In our population of pt with LN/MGUS/MM DI prevalence is higher than in the general population.

## Group therapy for better treatment adherence in hypertensive patients

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**Objectives** The aim of this study was to evaluate if a group-therapy program run by hospital pharmacist/counselor could improve antihypertensive treatment adherence and blood pressure (BP) control.
**Materials and Methods** Hypertensive patients attending the Centre for Diagnosis and Therapy of Arterial Hypertension of Cardarelli Hospital, Naples, Italy were randomly allocated either to a control group (routine care) or to an intervention group (8 biweekly sessions lasting two hours each and one six-month follow-up run by a hospital pharmacist). BP and medication adherence (Belief Medicine Questionnaire) were evaluated at baseline and after one year. Analysis was performed using SPSS version 19.0.
**Results** 44 intervention and 40 control patients were recruited.
There were no significant differences (P > 0.05) in both groups concerning mean age, gender, body mass index, and antihypertensive pharmacotherapy. After one-year there was a significant reduction of BP for intervention group (P<0.001) and a significant reduction only for systolic BP in control group (P =0.002). Medication adherence was higher in the intervention group at the end of the study (74.5% vs. 57.6%).
**Conclusions** Our preliminary results suggest that group-therapy intervention improve BP control, offering individuals the opportunity to learn behavioral techniques for better adherence to lifestyle modifications and drug therapy.
These findings show that a multidisciplinary approach is needed to take care of chronic conditions such as hypertension , and counseling abilities should be implemented for all team members.

## Telephone counseling for hypertensive patients: does it work?

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**Objectives** The purpose of this study was to evaluate the effect of telephone counseling intervention conducted to improve blood pressure (BP) control.
**Materials and Methods** Hypertensive patients attending the Centre for Diagnosis and Therapy of Arterial Hypertension of Cardarelli Hospital, Naples, Italy were randomly allocated to receive a pharmacist/counselor-administered counseling intervention (group I, 84 patients) or usual care (group C, 80 patients). Group I patients received the counseling intervention bi-monthly for two years via telephone; the goal of the intervention was to promote medication adherence and improve hypertension-related health behaviors. BP values were registered at baseline, after one year and at the end for both groups. Medication adherence (Belief Medicine Questionnaire) was assessed. Analysis was performed using SPSS version 19.0.
**Results** The average phone call lasted 18 minutes (range 7 to 45 minutes). After two years there was a significant reduction of BP values for group I (t=0: Systolic = 146.8±2.3 Diastolic= 90.2±4.2, t= 24 months Systolic = 138.4±4.6 Diastolic =86.9±3.8) (P<0.001). From baseline to two years, medication adherence increased by 24% in group I (from 63% to 87%) vs. 3% in group C (from 66% to 69%) .
**Conclusions** These findings suggest that, for patients with chronic conditions, telephone counseling can significantly improve BP control. Our data show also that interventions run by allied health professionals (i.e. other than the prescriber/doctor), improve adherence to medicines and promote hypertension-related health behaviors.

## Data manager: facilitator and coordinator in clinical trials. The integrated experience of the Treviso Hospital

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**Introduction** Accrual to clinical trials (CT) is essential to determine effectiveness of treatments and establish whether beneficial effects are of clinical and statistical significance. However, only 2%-5% of eligible patients are entered into clinical trials both for patients' and clinicians' barriers to enrolment. Improved efficiency in clinical trials may also positively impact on the hospital pharmaceutical expenses as innovative drugs are made available to patients. Among physicians' barriers to include patients in CT is the burden of additional workload and lack of specific staff to manage non-clinical aspects of the trial (EC submission, maintaining regulatory documents, completing case report forms, ensuring compliance with protocols, regulations and Good Clinical Practice). In providing organizational support and quality assurance, Data Managers' contribution to research may prove crucial to the success of the entire process.
**Materials and methods** An innovative approach to Data Management is being carried out at our Regional Hospital.
**Results and Conclusions** An experienced Data Manager has been integrated to cooperate with clinical staff, Ethic Committee, Sponsors and so forth. Cost for the hospital Data Manager is practically nonexistent as the whole project is self-founded with no additional costs on the Institution. A specific fund has been set up in which a percentage of grants for patients enrolled to For-Profit clinical trials (at P.I.'s discretion), contributions of the requiring units/departments and donations from Charities and Pharma converge.

## Progetto OSCAR - Ospedale Senza CARta

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**Premesse** Con Il progetto ESCAPE l'Azienda ULSS9 Treviso ha realizzato un modello per la gestione dei referti firmati digitalmente. Tale esperienza di dematerializzazione si sta estendendo all'intero ospedale (OSCAR - Ospedale Senza CARta). Si punta cioè a digitalizzare non più un singolo referto ma tutta la documentazione clinica prodotta durante un ricovero.
**Metodo** Lo slogan "senza carta" si traduce nell'obiettivo di integrare tutte le informazioni e gli strumenti di gestione del paziente. Il metodo seguito è il seguente:
- diversi sottoprogetti, uno per ogni area di intervento
- attività di project management, con modelli implementativi comuni;
- formazione sul campo, riconosciuta con crediti ECM;
- clincal data set standardizzato;
- SW modulare e integrato, con moduli trasversali (ADT, referti ambulatoriali, lettere di dimissione), altri verticali (cartella cardiologica, di patologia neonatale);
- infrastruttura tecnologica con elevati standard di sicurezza.

**Risultati** In ospedale sono firmati digitalmente tutti i referti di laboratorio, di radiologia, i verbali di Pronto Soccorso ed oltre il 50% delle lettere di dimissione. Il 70% dei referti ambulatoriali è informatizzato. In 5 reparti la cartella è gestita interamente senza carta: viene stampata al termine del ricovero solamente per necessità di archiviazione e conservazione.
**Conclusioni** La sfida ora sta nel definire le regole per poter definitivamente abbandonare la carta. È in fase di avvio un tavolo regionale che

definisca le regole ed i requisiti minimi standard per una cartella clinica paperless.

## Le competenze informatiche del personale come chiave del successo dei progetti ICT

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**Introduzione** L'Azienda ULSS 9 di Treviso è da anni impegnata in un importante percorso di innovazione tecnologica, attuato tramite progettualità ICT di rilevanza strategica e di grande impatto organizzativo, finalizzato al miglioramento del processo clinico-assistenziale. L'esperienza maturata ha evidenziato come fattore chiave il livello di alfabetizzazione informatica del personale sanitario.
**Materiali e Metodi** E' stata effettuata una rilevazione delle competenze informatiche di base, mediante portale web, utilizzando il questionario della certificazione "ECDL start", standard di riferimento europeo in tema di competenze informatiche; ai quattro moduli base (Sistema Operativo, Internet, Elaborazione dei testi, Foglio elettronico) ne sono stati aggiunti due ulteriori: hardware e "informatica in ospedale".
**Risultati** L'iniziativa ha coinvolto 500 dipendenti. Non sono state rilevate sostanziali differenze nelle varie unità operative, nè tra personale medico e sanitario non medico; si nota una performance migliore per il personale medico nel modulo di videoscrittura. Le unità operative già impegnate nei progetti ICT presentano percentuali di insufficienza inferiori alla media complessiva.
**Conclusioni** L'analisi dei risultati ha fornito dati preziosi per definire il piano di intervento: sono stati attivati percorsi di formazione informatica di base ECM per il personale sanitario, ed è in fase di studio l'ipotesi di organizzare sessioni ad hoc per la presentazione degli applicativi informatici aziendali, nonché per la corretta fruizione del servizio di assistenza tecnica.

## Salt and bread: content in a Calabrian city

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**Background** Increasing evidences show a direct relationship between salt (NaCl) intake, arterial hypertension, cardiovascular disease and other diseases. The reduction of salt intake (<5 g/day) results in reduction of blood pressure levels both in individuals with hypertension than in normotensive subjects and a reduction of other diseases salt related. Unfortunatly, the most recent Italian data (Progetto Minisal Gircsi) show a high salt intake in the regions of the south of Italy (> 10 g / day).
Bread is the most responsible for salt intake in most countries. The average content of salt in bread, in Italy, is about 15 g/kg of bread. So, the reduction of salt content in bread may therefore represent an effective strategy for diseases prevention. Moreover, its reduction does not cause significant increased of salt intake from other dietary sources.
**Methods and results** We wanted to evaluate the average composition in salt in bread in fifteen bakeries in Cosenza (Calabria). The average grams of salt was 22.6 g/kg of bread (± 7.36). Only four of the fifteen bakeries adds less than 20 g/kg of salt. Three bakeries add more than 30 g/kg.
**Conclusions** The European Union, the Italian Ministry of Health and the Italian Federation of Bakers promote (Progetto Pane MezzoSale) the reduction of salt in bread. For example, the bakers of the Italian capital, proposed to reduce the amount of salt from 20 to 10 g/kg of bread. So, similar strategies should be applied in the bakeries of our city as part of programs for prevention of cardiovascular and other disease salt related.

## Enteric lymphoangectasia and protein dispersion in patient with Proteus syndrome

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Male, 27 years, with Proteus syndrome, diagnosed at the age of 12 years.
He presented to our observation for the appearance and the gradual deterioration of a anasarcatic state, ascites and pleural effusion maked at the left.
The hemodynamic parameters were normal at the entrance.
Echocardiography showed a normal EF (60%) and nothingh signs of congestive right-sided. Laboratory tests excluded chronic liver disease. Anti-endomysium and anti-transglutaminase antibodies were normal, and parasitological and bacteriological examination of stool was negative. The indices of renal function, and the indices of inflammation were normal. He presented significant leukopenia (2900u /L) markeable of lymphocytic series. Paracentesis showed chylous ascites. EGDS and colonoscopy showed widespread mucosal congestion with numerous telangiectasias; and duodenal mucosa showed short villous with rare broad-based and presence of microvillous and the evidence of lymphocytic infiltration of the corium with widespread lymphatic ectasia.
The Proteus syndrome is very rare, the etiology is unknown, and all reported cases are sporadic events in normal families. The lymphatic and vascular ectasia, that causes enteric protein dispersion, is always present in various districts and can affect vessels of any dimention.

## Renal artery thrombosis in a patient with homozygous mutation of MTHFR gene

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Male, 47years old, worker, married, two sons witch one died for breathing desease unknowed while child. Smoker, without significated deseases in his anamnesis; and normal major risks of aterogenesis.
Comes to our attention for pain in right lumbar region. The patient was very ill in antalgic posture, with a modest fever increase (38 ° CT), and with spontaneous pain exacerbated on palpation in the lumbar region and right side. The hemodynamic parameters were normal. Laboratory data showed: slight increase in creatinine (1.3 mg / dl), indirect bilirubin (1.7 mg / dl), CPK (600UI / L), AST (55 U / L), ALT (56 U / L), a significant increase in LDH (1515 U / L) and proteinuria (116 mg / dl). Abdominal ultrasound did not describe organic pathology. CT scan showed, however, thrombosis with stenosis throughout the course of right renal artery with extensive infarction of the kidney, with inflammation around the kidney and mild baseline ipsilateral pleural effusion. Homocysteine serum showed a significant increase (35, 6 micromol / L) and folate were of value lower than normal (1.2 ng / ml). The following genetic study showed a homozygous mutation in MTHFR-C677T. A subsequent functional renal scintigraphy documented permanent and functional complete exclusion of the right kidney. The homozygous C677T mutation of the gene encoding MTHFR is the most common cause of moderate hyperhomocysteinemia and has a prevalence of 5% in Caucasians and 10% in patients with thromboembolic episodes occurring usually around 40-45 years.

## COPD: an important disease. Are we sufficiently aware of?

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**Introduction** COPD is the fourth leading cause of mortality/morbidity in the world. It's associated with serious co-morbidity, primarily cardiovascular. The primary cause is smoking. So every smoker should be investigated using pulmonary function tests (PFT), "gold standard" for COPD diagnosis.
**Clinical Case** P.A., 65, male, 10 years before: NSTEMI ACS, undergoing PTCA, and since then stop smoking (before: over 20 p/y). Never any more detailed respiratory diagnostic investigation . October 2010: fever, coughing and asthenia. CXR: parenchymal thickening on the left side. So the patient is hospitalized in Day Hospital for more detailed diagnosis. Chest CT: diffuse emphysema; PFT: moderately severe obstructive alteration and absence of significant broncho-dynamic. Diagnosis: COPD, GOLD stage 2 (moderate), previously unrecognized.
**Discussion** We must always seek the symptoms of COPD (cough, phlegm, and wheezing) in a smoker. COPD is not currently diagnosed and treated adequately. As a proper hygienic-dietary (lifestyle) and pharmacology therapy (according to GOLD and AGENAS guidelines) is delayed, COPD worsens the more quickly.
**Conclusions** The case shows that hospital and territorial doctors don't even consider that COPD is a serious disease, but early treatable. So we need to reduce the diagnostic deficit, and therefore the therapeutic deficit. In fact, among the chronic diseases, COPD is the only one with a trend of increasing incidence, so that, according to the WHO, by 2020 will be the third leading cause of mortality/disability in the world.

## When doctors examine personally the radiograms

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**Introduction** Doctors must get used to examine personally the radiograms and to work directly with radiologists; if not, can make errors, as in the case described below.
**Clinical Case** EE, male, 63, smoker (over 60 p/y), reaches our observation with a diagnosis of "pneumonia". The report of a recent CXR describes generic parenchymal thickening, that must be re-evaluated after therapy. Looking at the radiogram we see right lung field reduced in size, and denser. Clinical history and direct "vision" of radiogram determine "alarm"; therefore further investigations are practiced. CT chest extended to Total Body, reveals the presence, on the right, of solid mass in soft edges, starting from the main bronchus; there are also multiple metastatic liver lesions; FBS: macroscopic confirmation of the cancer. LDH> 2000 and NSE> 200 are sign of small cell lung cancer, subsequently confirmed by cytology on FNAB.
**Discussion** Smoking is the leading cause of lung Ca. Very often, especially in the absence of hemoptysis, we arrive late at diagnosis. The symptoms (cough, phlegm, and wheezing) and their possible changes, should be well-evaluated every time a smoker reaches our observation.
**Conclusions** The case shows that CXR, frequently practiced in smokers, should never be underestimated. The simple reading of the reporting can mislead; detailed request, with a description of symptoms and diagnostic doubt, it's useful for the collaboration of radiologist. The "holistic" approach, with direct evaluation of the radiograms, is an important "added value" to clinical activity.

## Una strana crisi epilettica

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**Introduzione** La sindrome delle apnee notturne si caratterizza per un indice di apnea (AI) >5 ed indice di apnea-ipopnea (AHI) >15, è una patologia complessa che influenza molteplici aspetti clinici che vannodalla cardiologia, alla pneumologia, all'endocrinologia fino alla gastroenterologia.
**Caso Clinico** Paziente di 67 anni, BMI 29, giunge presso il PS con una riferita crisi epilettica. In anamnesi: ipertensione arteriosa. All'e.o. vistose escoriazioni sulla lingua dovute a morsicatura. In Medicina d'Urgenza veniva sottoposto esami a TC cranio, EEG, RM cranio che risultavano nella norma. L'approfondimento anamnestico portava riposo notturno disturbato per cui un esame polisonnografico metteva in evidenza respiro di tipo Cheyne-Stokes con presenza di apnee centrali/miste con desaturazione
**Discussione** La relazione tra sindrome delle apnee notturne e crisi epilettiche è un'evidenza ormai nota: la privazione del sonno e l'ipossia cerebrale con meccanismi diversi e ancora non del tutto chiariti, sono in grado di tramutarsi in trigger per l'epilessia. L'opzione di una terapia farmacologica con amitriptillina, per scarsa compliance alla VMNI e ad un follow up di 6-12 mesi assenza sintomatologia epilettica..
**Conclusioni** Sfortunatamente ancora oggi la Sindrome delle Apnee Notturne, nonostante sia una sindrome che sottenda a numerose patologie, è comunemente sotto-diagnosticata in tutte le fasce d'età dei pazienti ed in ogni caso la diagnosi è spesso ritardata. la combinazione di russamento e stanchezza diurna, specialmente, in pazienti obesi sono fortemente predittivi e devono far immediatamente eseguire un esame polisonnografico.

## Postpoliomyelitis syndrome: a rare manifestation of a more complex disease

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**Background** The post poliomyelitis syndrome (PPS) is a rare complicance of primary poliovirus infection.
**Case report** We describe the case of a woman 57 years old, who contracted poliomyelitis in childhood with neurologic sequel (amiothophy of legs). Subsequently, the patient developed a progressive erosive rheumatoid arthritis with FR positive and was treated with all the DMARDs and than, for ineffectiveness, with anti tnf-$\alpha$ (etarnecept). After five years, the patient discontinued the use of etanercept, for ineffectiveness after initial benefict. The patients had worsening of neurogical symptoms with the appearance of post poliomyelitis syndrome which is characterized by new or progressive muscle weakness and disability occurring after the onset of acute poliomyelitis. The patient was treated with IVIG with an improvement of neurological symptoms and subsequently with abatacept for rheumatoid arthritis in the active phase (DAS 28 =5.4). After abatacept treatment, DAS 28 was reduced to 3.2. and we obtain a improvement in the quality of life.
**Discussion** The cause of progressive neurologic deterioration in PPS in unknown. The main theory of pathogenesis involve progressive degeneration of reinnervated motor units; persistence of poliovirus in neural tissue, and induction of autoimmunity with consequent destruction of neural structures. There is no evidence of gold standard therapy, however some studies have showed the potential therapeutic role of IVIG that induce improvement of pain and muscle weakness.

## Area di accoglimento e degenza breve: parte integrante di un reparto di medicina interna organizzato per intensità di cure

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**Background** Analysis of the production related to health-care activities in the medicine ward of the Hospital dell'Angelo of Mestre-Venezia revealed that in 2010 short-term hospitalization, defined as less than 3 days, was 18% of all admitted patients.
**Aim of the study** We organized a functional section named Admission and Short Stay Area formed by 8 beds, from a total of 84 inward beds, performing diagnostic and therapeutic disease-related pathways. The aim of this new-model section was to reduce the average length of stay of patients without increasing readmission rates and share clinical pathways in health-care professionals.
**Methods** We arranged clinical pathways employing bedside diagnostic procedures like ultrasounds. Data of admission rate in 2011 were compared to those in 2010. Readmission was evaluated considering the most frequent diseases of admitted patients.
**Results** In 2011 there was an increased rate in short term hospitalization compared to 2010 (from 18% to 22%). The overall mean ward length of stay was decreased (from 10.6 to 10.3 days), but the number of readmissions within 90 days remained unchanged. More than 90% of health care professionals followed the established clinical pathways.
**Conclusions** Organization of functional beds assigned to a second-line triage in the internal medicine ward allowed to identify and categorize the needs of care in admitted patients. Diagnostic and therapeutic needs were satisfied in 22% of patients within 3 days from admission. It is necessary that health care providers share disease-oriented clinical pathways and that bedside ultrasound is easily available to achieve this goal.

## Piastrinopenia transitoria da consumo periferico (ITP) da infezione acuta primaria da Parvovirus B19

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**Premessa e scopo dello studio** La diffusione del Parvovirus B19 è ubiquitaria. I periodi epidemici sono la fine dell'inverno e l'inizio della primavera e colpisce il 50% dei bambini in età scolare. È trasmessa per via aerea. Tra gli adulti la prevalenza è del 40%. Non vi sono differenze significative tra maschi e femmine.
**Materiali e metodi** Paziente femmina di 30 anni ricoverata per febbricola persistente e riscontro occasionale di severa piastrinopenia (2.000 mm3). Anamnesi ed obiettività negativi tranne petecchie cutanee diffuse. Nella norma gli esami di routine. Iniziata terapia con Ig 0.4gr/Kg/ev per 5 gg associata a metilprednisolone 1 mg/kg/die/os. A completamento fu eseguito aspirato midollare con quadro di piastrinopenia da consumo periferico e positività per IgM antiparvovirus B19.
**Risultati** A 48 ore dall'inizio della terapia la paziente si é sfebbrata con graduale incremento delle piastrine. In dimissione le piastrine erano 140.000 mm3. Dopo 2 settimane la paziente non evidenziava petecchie e valore delle piastrine in ascesa (200.000 mm3). La terapia steroidea é stata proseguita a dosi scalare per 1 mese.
**Conclusioni** L'infezione da parvovirus B19 decorre generalmente in maniera asintomatica (20-50 % dei casi), pertanto una diagnosi di certezza può essere eseguita solo con test sierologici. Le IgM sono rilevabili nel 90% dei casi, già dal terzo giorno successivo alla comparsa dei sintomi. Il Parvovirus B19 umano ha uno spiccato tropismo per i tessuti eritroidi. La piastrinopenia é un evento raro in pazienti con infezione acuta primaria da parvovirus B19.

## Un insolito versamento pleurico

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**Premessa e scopo dello studio** Femmina di 50 anni ricoverata nel marzo 2011 per dispnea da sforzo e riscontro occasionale di versamento pleurico sinistro. In anamnesi si segnalava nefrectomia sinistra nel 2004 per neoplasia (ca. a cellule chiare) in follow-up oncologico negativo. Esame obiettivo nei limiti della norma.
**Materiali e metodi** Gli esami ematici di routine risultarono nei limiti della norma,a parte modesta leucocitosi neutrofila e lieve aumento della PCR 1,2 (v.n. fino a 0,7). Praticata terapia antibiotica empirica con normalizzazione della PCR e della leucocitosi. A completamento furono eseguiti: ricerca autoimmunità, markers neoplastici ed esami microbiologici, che risultarono tutti negativi, ad eccezione di un sensibile aumento del CA 125 (353,v.n. 0-35); TAC toraco-addominale negativa ed infine toracentesi ecoguidata con esami citologico e colturale negativi. Risultati La paziente fu dimessa con prescrizione di radiografia del torace a trenta giorni, che evidenziò una recidiva del versamento pleurico noto. La paziente fu sottoposta a toracoscopia diagnostica con riscontro di istologia positiva per neoplasia a cellule chiare compatibile con carcinomatosi metastatica a primitività renale. La paziente attualmente è in chemioterapia adiuvante.
**Conclusioni** Tra le neoplasie renali la variante a cellule chiare rappresenta circa il 25%, con picco d'incidenza intorno ai 60 anni d'età. La sopravvivenza a 5 anni allo stadio iniziale del di circa 80%. La particolarità del caso sta nella comparsa di metastasi a distanza di 8 anni e con follow-up oncologico negativo.

## The pain of a young woman

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**Introduction** Parvovirus B19 human infection can give more clinical manifestations,due virus ability to target different cells type:benign erythema,transient aplastic crisis, congenital hydrops fetali,idiopathic arthritis,vasculitis,meningoencephalitis,hepatitis,myocarditis.
**Case report** A 21-year-old woman come to our observation with three month fatigue, slight fever, polyarthralgia, transaminase increase.Clinical examination for chest, heart, abdomen was normal, right arm showed oedema.Doppler Ultrasound showed brachial vein thrombosis. Normal ECG,chest radiographs, ultrasound abdominal imaging.Complete laboratory investigations panel gave normal result,except for protein S (34%) reduction, transaminase (GOT 257, GPT 123)and D- dimer (1027 ng/ml) increase.No recurrence of neoplastic diseases. Infectious disease tests showed Parvovirus B19 infection ( IgM 88.0 Index).The patient showed severe muscolar asthenia and increased muscolar enzymes:creatine kinasi (1075 IU/l),myoglobin (224.7 ng/ml). No anti acetylcholine antibody. EMG showed polymyositis. Rachiocentesis showed normal liquor,excluding Guillain-Barré.The adopted therapy was anticoagulation with Acenocumarol 4mg (target INR 2.5 ; range 2.0-3.0),Prednisone 25mg daily. At discharge the patient was referred to physiotherapy.At follow up recovery of vein thrombosis, moderate amelioramento of neuro-muscular symptoms.
**Discussion** Many viral infection can be associated to autoimmunity diseases.In our case, thombosis, polymyositis, hepatis can be early symptoms of autoimmune disease , triggered by Parvovirus B19 infection.

## Effect of Liraglutide, Exenatide, and Sitagliptin on the composite outcome of glycemic control and weight loss

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**Introduction** Achieving durable glycemic control in type 2 diabetes with existing antidiabetic agents is commonly accompanied by weight gain, which frustrates patients and potentially increases the risk of cardiovascular disease. Incretin-based therapies, however, offer enhanced glycemic control with weight neutrality (dipeptidyl peptidase-4 inhibitors) or weight loss (glucagon-like peptide-1 receptor agonists).
**Design and methods** We compared the number of patients reaching the composite endpoint of glycated hemoglobin (A1C) levels <7% and weight loss after 26 weeks' treatment with liraglutide 1.8 mg or 1.2 mg once daily, exenatide 10 µg twice daily, and sitagliptin 100 mg once daily (with metformin ± sulfonylurea background therapy) using patient-level data from 2 large randomized trials. A logistic regression analysis was performed on intent-to-treat populations (last observation carried forward) with treatment and country as fixed effects and baseline A1C and baseline body weight as covariates. A1C and weight changes for each treatment group are shown in the table.
**Results** Significantly more patients reached the composite endpoint with liraglutide 1.8 mg than with liraglutide 1.2 mg (odds ratio [95% CI]: 1.66 [1.14, 2.41]; p<0.01), exenatide (2.10 [1.41, 3.14]; p<0.001), or sitagliptin (5.70 [3.63, 8.94]; p<0.001; Figure).
**Conclusion** Patients are more likely to achieve glycemic control with weight loss on liraglutide 1.8 mg than exenatide or sitagliptin.

## An unusual solution for a case of myalgia

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We report the case of a 51 year old woman: she came to our attention because of swelling of the legs, myalgia and muscle weakness. She referred a single episode of fever during the last month, associated with two days of diarrhoea. No other symptoms were referred. She had two hospitalizations due to unspecific symptoms. During the second admission, the blood chemistry revealed eosinophilia, increased inflammatory indexes and worsening myopathy indexes. A complex path of differential diagnosis was carried on, and finally a muscle biopsy showed the infection with Trichinella spiralis. The patient was a housewife with a vegetarian diet and she probably got the infection preparing boar meat. The case was characterized by a positive outcome free of complications, with rapid clinical and laboratory response to therapy.
Trichinellosis is a parasitic infection caused by the ingestion of raw or inadequately cooked meat infected with larvae of nematodes of the genus Trichinella. The clinical course of the disease is characterized by two phases: an enteral phase in which the larvae of the nematode parasite arrive in the duodenum mucosa and a parenteral phase in which they reach the striated muscle where they actively penetrate into the muscle cells. In the world, the yearly incidence of trichinellosis is of about 10,000 clinical cases. There are no pathognomonic signs or symptoms of the disease making this infection unfamiliar and often unrecognised. Therapy consists of anthelmintics, glucocorticosteroids, and preparations that compensate for protein and electrolyte deficits.

## A kidney dyspnea

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A 27 years male, with no previous medical history, was admitted to the Orthopedic clinic after a road trauma which caused fracture of the right leg. The patient underwent therapy with traction of the limb, in preparation for surgery, and thrombotic prophylaxis with low molecular weight heparin. After a day from the admittance, appeared, progressively respiratory distress associated with tenderness in the left chest region. Laboratory tests showed increased D-dimer, neutrophilic leukocytosis, and increased LDH. Standard radiographs of the chest showed rib fractures and small pleural effusion on the left.
For suspected pulmonary embolism perfusion lung scan was required and it showed, bilaterally, in the distal portions of the parenchyma, perfusor deficits. Was titrated therapy with low molecular weight heparin to anticoagulation levels.
After three days of admission, due to onset of fever, anemia, and worsening of dyspnea, were performed consulting internist. Physical examination showed dullness area of the left basal lung and severe pain on palpation on the ipsilateral lumbar region. The CT examination, performed urgently, showed a fracture of the upper pole of left kidney and lifts hemidiaphragm.
The patient underwent urgent surgery with resolution of the event.
The urologic trauma are present in 10% of road accidents and the kidney is the organ most involved. It is possible that kidney damage may be, initially, asymptomatic. The systematic search of the involvement of kidney, though without hematuria, must be searched in each poly traumatized.

## A rare case of rapid evolution of PAN

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**Background** Polyarteritis nodosa is a vasculitis of medium and small sized arteries,which become swollen and damaged by immunitary cell system.Most cases occur between 30 and 49 years old.Symptoms are due to ischemic damage of affected organs,such as skin, heart,kidneys and nervous system.Diagnosis is based on physical examination and a few laboratory tests;treatment includes prednisone and cyclophoshamide.
**Case report** A 64 year old woman affected by COPD,arterial hypertension, liver steatosis was admitted for fever,strep throat and pain,weakness and tenderness to right side of the body.EMG showed a peripheral neuropathy with axonal damage.Patient's conditions got worse during admittance,with increase of right hand tenderness,sweating and tachycardia.Laboratory tests demonstrated high levels of PCR and creatinine unresponsive to antibiotic therapy.
US demonstrated biliary ducts dilatation without gallstones, others radiological investigations were negative. Supposing collagen disease, patient was treated with steroides but a rapid worsening of clinical conditions lead to death our patient. Post mortem examinations made diagnosis of polyarteritis nodosa involving medium and small size arteries of ileopsoas and renal parenchyma.
**Conclusions** Our first hypotesis of peripheral neuropathy and cholecystitis alitiasica mislead us to real diagnosis;in this case rapid evolution of

disease doesn't allowed us to confirm PAN with clinical and laboratoristics criteria.Fortunately this fatal progression is rare and early diagnosis and treatment may improve the chance of a good outcome.

### Acute coronary syndrome in Churg-Strauss syndrome: a case report

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**Background** The Churg-Strauss syndrome (CSS) is a systemic vasculitis characterized by asthma, sinusophaty, eosinophilia, pulmonary infiltrates, neuropathy. Cardiac involvement includes eosinophilic endomyocarditis, coronary vasculitis, congestive heart failure, pericarditis and it is known to be the major cause of death. Although acute coronary syndrome is unusual clinical manifestation of CSS, it should be suspected because requires early and aggressive treatment with glucocorticoids in combination with cyclophosphamide.
**Clinical case** We report a case of a 57-year old man with history of chronic rhinosinusitis and pulmonary infiltrates, who presented with fever, palpable purpura, muscle weakness, polyneuropathy and dyspnea. Two days later he presented chest pain, elevated troponins and ST-segment elevations. Echocardiography confirmed significant diminution of left ventricular contractility. Hypereosinophilia and IgE elevation were present, p-ANCA were positive and CSS was diagnosed. Coronary angiography revealed dilated coronary arteries. A rapid improvement was observed after steroid therapy. Echocardiography after one week showed normal left ventricular function. Symptoms, eosinophilia, IgE count, Troponin T decreased to normal ranges. Cyclophosphamide was initiated to maintain remission.
**Conclusions** This case report highlights the importance of considering primary vasculitis as a differential diagnosis in patient presenting with multiple organ involvement and acute coronary syndrome because early specific therapy in such cases has shown to change the outcome.

### Two cases of secondary cutaneous vasculitis: when the medical history outlines the diagnosis

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**Case 1** A 63 years old woman was admitted to our department for a sudden cutaneous vasculitis onset with palpable purpura of the lower extremities, ulcers and hemorrhagic blisters. Her medical history included essential hypertension and a depressive disorder; the patient was on AT-2 receptor antagonist and antidepressants treatment. In addition, she took penicillin for a dental infection two weeks before the lesions appearence. Autoab, ANCA, neoplastic markers, complement tests were negative. Cutaneous biopsy showed: "leucocytoclastic vasculitis". During the stay she received corticosteroids i.v. and started oral cyclosporine; in two months there was a clinical complete remission.
**Case 2** A 77 years old man was admitted to our medical section for relapsed purpura over the buttocks and on the lower extremities, already occurred and spontaneously disappeared a month before, following a high-respiratory tract infection and unknown drug intake (first diagnostic hypothesis). Features and presence of melena (severe hemorrhagic gastropathy) let us suppose a Henoch-Schonlein purpura, but further exams revealed the possibility of a biliary tract cancer; the patient, worsened, did not survive.
**Conclusions** The cases above presented, despite the different outcome, show that an important diagnostic tenet in patients with cutaneous vasculitis is to search for an etiology, be it an exogenous agent, such as a drug or an infection, or an endogenous condition, such as an underlying disease (malignancy, rheumatic disease). However, the possibility of a systemic vasculitis should be ruled out.

### Sindrome linfoproliferativa autoimmune: un caso clinico

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**Premessa** La Sindrome Linfoproliferativa Autoimmune (ALPS) è una rara patologia correlata ad un difetto primitivo dell'apoptosi linfocitaria dovuta ad una mutazione del gene FAS o di un altro gene implicato nella via apoptotica. ALPS è caratterizzata dalla triade clinica: sindrome linfoproliferativa, patologia autoimmune ed aumentata incidenza di neoplasie.
**Materiali e Metodi** Il paziente affetto da ALPS è un uomo di 23 anni che ha presentato neutropenia associata ad infezioni ricorrenti invasive. In anamnesi presenta porpora trombocitopenica idiopatica refrattaria trattata con splenectomia e rettocolite ulcerosa complicata con pioderma gangrenoso.
Gli esami clinici e strumentali hanno evidenzato linfoadenopatie multiple diffuse reattive, neutropenia ed ipogammaglobulinemia. Inoltre hanno mostrato riduzione dei linfociti B, T CD4+ e T CD8+ ed aumento dei linfociti T CD4-/CD8-. Lo studio midollare ha mostrato un quadro di displasia trilineare con cariotipo maschile normale. Gli episodi infettivi hanno presentato risoluzione completa con terapia antibiotica, fattore di crescita granulocitario ed immunoglobuline endovena.
**Risultati** Il quadro laboratoristico, la presenza di patologie autoimmuni e di una linfoproliferazione aspecifica hanno permesso la diagnosi clinica di ALPS; a supporto di ciò risulta utile l'identificazione molecolare di una mutazione di FAS e del deficit dell'apoptosi linfocitaria.
**Conclusioni** Il paziente con ALPS necessita di una terapia di supporto adeguata e di uno stretto monitoraggio per l'insorgenza di patologie autoimmuni o neoplastiche.

### La malattia di Kikuchi-Fujimoto: caso clinico

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**Premessa** La Malattia di Kikuchi-Fujimoto (MKF) o Linfoadenite Necrotizzante è una patologia rara benigna ad eziologia sconosciuta caratterizzata da febbre e linfoadenopatia prevalentemente laterocervicale. Può presentare anche sudorazione notturna, calo ponderale, vomito o diarrea, artralgie, mialgie, manifestazioni cutanee ed epato-splenomegalia. Colpisce prevalentemente le giovani donne asiatiche intorno a 30 anni. Recede spontaneamente in 1-4 mesi ma può recidivare anche a distanza di anni. La MKF entra in diagnosi differenziale con altre patologie tra cui i linfomi.
**Materiali e Metodi** Una donna caucasica di 37 anni é giunta alla nostra osservazione per sospetta patologia linfoproliferativa. Lamentava comparsa di febbre da circa 1 mese associata a sudorazione notturna ed astenia. Clinicamente presentava linfoadenopatie dure non dolenti (2 cm circa) laterocervicali e sovraclaveari e splenomegalia. Gli esami ematochimici e microbiologici erano tutti nei limiti della norma.

In anamnesi riferiva sindrome ansiosa, tonsilliti ricorrenti e un episodio pregresso di linfoadenite cervicale risolto spontaneamente.
All'ecografia le linfoadenopatie risultavano non reattive per cui abbiamo eseguito escissione chirurgica.
**Risultati** L'istologia del linfonodo ha diagnosticato Linfoadenite Necrotizzante di Kikuchi-Fujimoto.
**Conclusioni** Il trattamento è stato sintomatico con analgesici ed antipiretici e risoluzione del quadro in 40 giorni. La paziente è stata avviata ad un follow up periodico per l'aumentata incidenza di patologia autoimmuni associate alla MKF come il LES.

## Caso clinico di porpora trombotica trombocitopenica trattata con plasma-exchange, plasma-safe e rituximab

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**Premessa** La Porpora Trombotica Trombocitopenica (PTT o Sindrome di Moschowitz) è una patologia rara ematologica caratterizzata da anemia emolitica microangiopatica, piastrinopenia da consumo e sintomi neurologici. Può essere idiopatica o secondaria ad infezioni, neoplasie, collagenopatie, gravidanza o farmaci.
**Materiali e Metodi** Un uomo di 54 anni con storia di pregressa angina instabile trattata con PTCA e stent coronarico viene ricoverato in urgenza in Cardiologia per dispnea ingravescente; si riscontra anemia macrocitica di grado severo per cui il paziente viene trasferito presso l'Ematologia. Gli esami ematochimici mostravano indici di emolisi alterati con test di Coombs diretto ed indiretto negativi, reticolocitosi e grave piastrinopenia. La coagulazione risultatava nei limiti. Riferiva episodio di enterocolite recente. È stata eseguita terapia steroidea ad alte dosi ed immunoglobuline endovena senza miglioramento del quadro ematologico.
**Risultati** Nel sospetto clinico di PTT è stata eseguita terapia con Plasma-Exchange ed infusione di Plasma-Safe con risposta parziale dell'anemia e della piastrinopenia. Dopo 7 procedure di Plasma-Exchange giornaliere abbiamo eseguito terapia di mantenimento a cadenza bi-settimanale associata ad infusione di 4 Rituximab (anti-CD20) settimanali.
**Conclusioni** Dopo 2 settimane dall'inizio della terapia specifica per la PTT, il paziente ha presentato normalizzazione del valore emoglobinico e della conta piastrinica e risoluzione completa del quadro sintomatologico.

## Case report: an atypical chest pain on the edge of the knife in a young patient

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We report the case of a 28 year old boy referring to the Emergency Department for a sudden dizziness, which rose while he was driving; 30 minutes later he was at the office, there he felt a mild retrosternal pain associated with disesthesia at his fingers and his feet and legs.
At the ED admission the patient was completely asymptomatic. The first-line check-up and the physical examination were normal, except for obesity (BMI 34 kg/m2); EKG and blood tests were not significant, in particular ultra-sensitive Troponin assay and D-dimer were negative; chest X-ray showed a mediastinal widening. His history was silent except for smoking.
Then the patient was admitted to our Acute Medical Unit, where patients with chest pain at low-intermediate risk for Acute Coronary Syndrome undergo a complete diagnostic iter in a priority lane.
Since Troponin curve and EKG confirmed negative, and the patient maintained hemodinamically stable, he underwent an echocardiogram, with evidence of aortic insufficiency and aortic root aneurysm.
A CT scan showed then a spiraliform aortic dissection which originated from the aortic valvular plan to the aortic convexity of the arch, involving the origin of the great arteries.
This is a case of an unusual chest pain in a young boy which helps us to refresh the differential diagnosis and the correct management of chest pain. It can also help us to keep in mind all the tricks that can hide behind this simple well-known shorthand that we use to describe a wide variety of experiences: "chest pain".

## Assessment of chest pain in the emergency department

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Chest pain is one of the most common complaints in ER. This symptom can be expression of a life-threatening disease (acute coronary syndrome, pulmonary embolism or aortic dissection), even though most of the times chest pain has a benign cause, a differential diagnosis is a crucial diagnostic challenge.
2068 patients (pts) complaining chest pain were evaluated in a year in our ER (~ 3% of the overall ER visits per year).
In this retrospective study we evaluated in detail 692 pts, seen in a 4 month period in our ER (March-June 2011).
According to the international literature, our data show that our ER clinicians focus mainly on recognition and exclusion of acute coronary syndrome. Although a cardiac aetiology was found in only 12% of patients, the assessment of chest pain involves an extensive and time-consuming diagnostic pathway (serial EKGs and blood tests). Moreover, since 50% of pts were dismissed with a generic diagnosis of "chest pain" and 38% of pts with "no cardiac chest pain", resource use remains a concern. We would like to stress the concept that targeted testing can lead to more cost-effective care, such as Thoracic CT-scan, that could be useful to diagnose several life-threatening pathologies of "no cardiac" aetiology. Chest pain requires the attention and sensitivity typical of the internal medicine too.

## Non-compacted cardiomyopathy presenting as repeated syncope

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Non-compaction of the ventricular myocardium (NCVM) is a rare congenital cardiomyopathy. In the WHO classification of cardiomyopathies, the NCVM is included in the group of unclassified cardiomyopathies. The NCVM is an idiopathic cardiomyopathy characterized by impaired ventricular structure resulting in intrauterine arrest of normal ventricular compaction. The clinical manifestations of the NCVM can include malignant arrhythmias. We report the case of a male, aged 27, with a negative personal history, who presented three syncopal episodes in three months. The last episode of syncope, which occurred while he was sitting at lunch, led to hospitalization in our unit. At the admittance, clinical examination was negative as well as the electrocardiogram, chest radiography and routine laboratory tests. At our unit, patient un-

derwent echocardiographic examination that has shown isolated non-compaction of left and right ventricles. The patient undergone to MRI of the heart. This exam confirmed myocardial alteration. Holter ECG, performed during 72-hour, was negative. Patient was treated with amiodaron, 200 mg daily. Patient is in follow-up at the laboratory of arrhythmology.

### Transthoracic ultrasound in patients with systemic sclerosis

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**Background** Transthoracic ultrasound (TUS) is an imaging technique, that is being increasingly used for the study of diseases affecting the pleura and the subpleural regions of the lungs.
**Materials and methods** We investigated the clinical applicability of TUS in 106 (11 males and 95 female, aged 22 to 61 years) consecutive patients with Systemic Sclerosis. All 106 patients underwent TUS examinations . An Esaote Technos MPX scanner, with set up for lung ultrasound, and with convex (3,5-5 MHz) an linear (8-12.5 MHz) transducers was used. At the same time all patients underwent standard chest radiography in AP and LL and HRCT of chest. In each patient we measured the thickness of "pleural line", that in normal conditions is about 2 mm, and detected the presence / absence of subpleural nodules. We have considered a cut-off value of > 3 mm. Images were recorded and interpreted by a second examiner too.
**Results** In 43 out of 106 patients , we detected a pleural line < 3 mm (with convex probe) and < 2.3 mm (with linear probe). These patients at HRTC scan didn't show any sign of fibrosis. Of the remaining 63 patients (all with a pleural line > 3 mm with convex probe and > 2.3 mm with linear probe) some (32) showed subpleural nodules too. All the 63 patients showed signs of pulmonary fibrosis at HRTC scan (honey-combing, diffuse nodules and reticular-nodules).
**Conclusion** Our preliminary data give a clear input to the forthcoming role of TUS as a complementary diagnostic test of pulmonary fibrosis in SS, both at early stage and in the course of follow-up.

### ✪ Transthoracic ultrasonography in patients with community acquired pneumonia: a complementary diagnostic tool

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**Background and aim** To investigate the findings and to test the potential clinical utility of transthoracic ultrasound (TUS) in diagnosis and follow-up of community acquired pneumonia.
**Patients and Methods** We investigated 502 patients (296 men and 206 women, aged 4 to 87 years) consecutively admitted to our Hospital between September 2007 and December 2011 because of community acquired pneumonia. At admission, all patients underwent chest radiography, and then TUS. The latter was performed by utilizing an echography, provided with a multi-frequency 3.5-5 MHz convex scanner and with a linear scanner (8-12.5 MHz). All patients were separately examined in a seated or half-seated position by two operators. Video-clips were utilized to test inter-observer agreement. Additional investigation by CT and fibro-broncoscopy was carried out whenever needed. Follow-up TUS exams during treatment were performed at 4th and 8-10th day.
**Results** In all patients chest radiography identified at least a pulmonary consolidation, which was also detected by TUS in 455 of them (90%), whose thoracic ultrasonographic signs were analyzed. Pleural effusion was detected in 141/455 (31 %) patients by TUS and in 118/455 (26%) patients by chest radiography.
**Conclusions** TUS examination proved to be an useful and safe complementary diagnostic tool in most patients affected by acute inflammatory pulmonary diseases. Being cheap, easy to perform, and reproducible, TUS may be proposed as a useful complementary tool for the diagnosis and, namely, the follow-up of pneumonia, at least in selected patients.

### ✪ Il Registro Stroke FADOI Toscana

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Il Registro Stroke FADOI Toscana è un database on-line disegnato per raccogliere informazioni cliniche e gestionali dei pazienti ricoverati per stroke negli Ospedali della Regione sia nei dipartimenti di Medicina Interna che di Neurologia e Geriatria. Il Registro è ospitato su un server connesso ad internet e l'accesso al registro avviene attraverso una username e una password per ogni centro, passando attraverso il sito ufficiale FADOI Toscana (www.fadoitoscana.com). Le informazioni sui pazienti sono registrate in maniera anonima secondo le leggi vigenti sulla privacy e dopo il consenso informato del paziente o dei parenti. Lo scopo del registro è quello di valutare lo stato corrente di gestione dello stroke acuto in Toscana raccogliendo informazioni sul timing di ammissione, diagnosi e trattamento nella fase di emergenza in DEA e nei reparti di degenza, destinazione alla dimissione,terapie prescritte e outcome a 3 mesi. Esso permette inoltre di monitorare gli aspetti epidemiologici e assistenziali, identificare le possibili criticità del processo assistenziale, verificare il livello organizzativo degli interventi, valutare la compliance dei percorsi diagnostico-terapeutici alle linee guida. In quest'ottica il registro può fornire informazioni anche dal punto di vista economico da sottoporre alle autorità regionali. il registro inoltre è dotato di una applicazione statistica in tempo reale che permette di confrontare il dato del singolo centro con quello regionale. Presentiamo i dati raccolti dal 1 luglio 2010 al 31 dicembre 2011.

### The hidden diagnosis

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**Background** Two women were hospitalized for Hb 5 g/dL. Either have rheumatic disease. They received diagnosis of hemolytic anemia a year ago.
**Case report** The former is a 63-year-old woman with hemolytic anemia for mild paravalvular leak of mechanical valve with double intraprothesic regurgitant jets. LDH 2381 U/L, bilirubin 3,38 mg/dL, schistocytes, Aptoglobin <0,08 g/L, C4 0.6 g/L, Direct and indirect Coombs test results were negative.
The latter is a 84-year-old woman with microangiopathic hemolytic anemia for mild periprosthetic biological mitral valve regurgitation and mild aortic calcified stenosis. LDH 1780 U/L, bilirubin 9 mg/dL, absence of schistocytes, Aptoglobin <0,08 g/L, Direct and indirect Coombs test results were negative, fecal occult blood on a single stool sample 345 ng/mL.
This one was hospitalized again, after a week from dismission, for presyncope with hypotension, Hb 4.9 g/dL, LDH 560 U/L, total bilirubin 1.27 mg/dL.
In this case we got a sedimentation of the sample-tube of serum of both patient (the former and the latter -2° admission-). Only the serum of the first patient changed in brown-red color. We treated with Argon plasma coagulation gastric telangiectasia in this patient with aortic calcified stenosis (Heyde syndrome).
**Conclusions** The Intravascular Hemolysis increases the free hemoglobin to> 5 mg/dL. If this one have a sedimentation >1 hour Hemoglobin (Hb) oxidation to methemoglobin (MetHb) with a change in brown-red color of the serum.

## Differential diagnosis of pulmonary embolism in outpatients with non-specific cardiopulmonary symptoms

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**Background** Most cardiopulmonary diseases share at least one symptom with pulmonary embolism (PE). Aim of this study was to identify the most common acute causes of dyspnea, chest pain, fainting and/or palpitations, which diagnostic procedures have been performed, and whether clinicians investigated them appropriately.
**Methods** 17,497 Emergency Department sheets of patients admitted from January 2007 to June 2007 were gathered from six Italian hospitals, 800 of those being hospitalized were selected through a block random sampling procedure. Case-mix of enrolled patients was assessed in terms of cardiopulmonary symptoms and prevalence of acute disorders. Actual performance of procedures was compared with a measure of their accuracy as expected in the most common clinical presentations.
**Results** PE occurred in less than 4% of patients with cardiopulmonary symptoms. Acute heart failure, pneumonia and chronic obstructive pulmonary disease exacerbation were the most likely diagnosis in patients with dyspnea. Echocardiography, computed tomographic pulmonary angiography, perfusion lung scan, D-dimer test and B-type natriuretic peptide were performed less than expected from their accuracy.
**Conclusion** Diagnostic strategies, starting from non specific symptoms and coping with the eventuality of PE, are likely to benefit from an increased awareness of the exam's accuracy in discriminating among several competing hypotheses, rather than in testing the single PE suspicion.

## ✪ Thyroid disease, antithyroid or thyreomimetic agents, and the risk of pulmonary embolism

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**Background** Thyroid hormone is known to affect the coagulation and fibrinolytic systems, but the effect of both hyperthyroidism and hypothyroidism on the occurrence of venous thromboembolism remains to be elucidated. We therefore aimed to evaluate the risk of pulmonary embolism (PE) associated with thyroid disease and treatment.
**Methods** A nested case-control study was conducted using the PHARMO Record Linkage System, a Dutch population-based registry that links medication histories to hospital admission records. Cases were patients hospitalized for PE and the date of hospitalization was set as index date. Controls were sex- and age-matched subjects without a history of PE prior to this index date. New use of antithyroid or thyreomimetic agents were used as indicators for diagnosis of thyroid disease.
**Results** The study population consisted of 3479 cases and 11830 controls. Diagnosis of hypothyroidism prior to the index date, i.e. treated hypothyroidism, was significantly associated with PE (OR 2.1, 95% CI 1.1-3.8), especially within the first three months after diagnosis (OR 4.9; 95% CI 1.4-17.8). No association was found for diagnosis of hypothyroidism after the index date, i.e. untreated hypothyroidism. Also, no clear association was found for hyperthyroidism, but odds ratios were highest for diagnosis within three months after the index date (OR 3.5; 95% CI 0.6-21.1).
**Conclusions** Our findings suggest that patients with hypothyroidism are at increased risk of pulmonary embolism. This most likely relates to treatment with thyreomimetic agents rather than hypothyroidism itself.

## Prognostic clinical prediction rules to identify low-risk pulmonary embolism: a systematic review and meta-analysis

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**Background** Prognostic assessment is important for the management of patients with pulmonary embolism (PE). A number of prognostic clinical prediction rules (CPRs) have been proposed for stratifying PE mortality risk. Aim of this systematic review is to assess the performance CPRs in identifying low-risk PE.
**Methods** MEDLINE and EMBASE databases were systematically searched until August 2011. Derivation and validation studies that assessed the performance of prognostic CPRs in predicting adverse events-risk in PE patients were included. Weighted mean proportion and 95% confidence intervals (CIs) of adverse events were then calculated and pooled using a fixed and a random-effects model. Statistical heterogeneity was evaluated through the use of I2 statistics.
**Results** Of 1125 references in the original search, 33 relevant articles were included. Nine CPRs were assessed in 37 cohorts, for a total of 35,518 patients. Pulmonary Embolism Severity Index and prognostic Geneva CPR were investigated in 22 and 6 cohorts, respectively. Ele-

ven (29.7%) cohorts were of high quality. Median follow-up was 30 days. In low-risk PE patients, pooled short-term mortality (within 14 days or less) was 0.7% (95% CI 0.3-1.1%, random-effects model; $I^2$ = 49.6%), 30-day mortality was 1.7% (95% CI 1.1-2.3%, random-effects model; $I^2$ = 82.4%), and 90-day mortality was 2.2% (95% CI 1.2-3.4%, random-effects model; $I^2$ = 59.8%).
**Conclusions** Prognostic CPRs efficiently identify PE patients at low risk of mortality. CPRs should be implemented in the routine care of PE patients to drive appropriate management.

### Insulinoma and amnesia: when neurologic symptoms mask a metabolic problem

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Hypoglycaemia is a diagnostic challenge in internal medicine and may be due to an adenoma of the islet of Langerhans called insulinoma. Insulinoma is a very rare neuroendocrine tumor, with an incidence of 1-4 per million persons yearly. It can occur sporadically or can be associated (16%) with MEN-1 syndrome. Clinical manifestations can mimic central nervous system or psychiatric disorders.
We describe the case of a 66-yr-old male patient with fatigue, stress, disorientation, and lack of concentration that previously lead to a diagnosis of depression and transient amnesia. He referred to our department for a hypoglycaemia (28 mg/dL, nv 65-110) demonstrated by routine blood glucose determination. Inappropriate insulin secretion was elicited during fasting test [glucose 41 mg/dL, with insulin (24,3 mU/mL) and C-peptide (1,39 mmol/L) inadequately in the "normal range"] and by calculating the blood insulin/glucose ratio (0,59, nv <0,50). Basal pituitary hormonal function and PTH were found normal and a correct counter-regulatory hormone response occurred during hypoglycaemia. Abdominal CT scans an MRI revealed a single lesion in the pancreatic head. An 18F-FDOPA PET study was also performed, with normal results. Histological examination after surgery showed a neuroendocrine adenoma without evidence of malignancy. No further hypoglycaemic episodes occurred. Key neuroglycopenic symptoms, together with biochemical proof, establish the diagnosis of insulinoma.

### The "inappropriate hormone secretion" concept: a paradigmatic tool to avoid "inappropriate diagnosis"

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Resistance to thyroid hormone (RTH) is a rare cause of hyperthyroxinemia with inappropriate TSH secretion, a syndrome characterized by reduced tissue responsiveness to circulating free thyroid hormones. There are mainly two forms of the syndrome, overlapping clinically and biochemically, a generalised resistance (GRTH) and a more selective pituitary resistance (PRTH). In the presence of thyrotoxic symptoms it may be difficult to differentiate the syndrome from a TSH-secreting pituitary tumour.
A 46-yr-old female patient with inappropriate TSH secretion is described. In 1986 she was diagnosed as affected by hyperthyroidism, treated with methimazole. At that stage was noted a "normal" TSH level in the presence of elevated fT4 and fT3. She referred to our department for persistently elevated fT3 levels (6 pg/ml, nv 2,1-4,4) with inappropriate "normal" TSH concentration (3,57 mU/mL, nv 0,15-5) in absence of thyrotoxic symptoms. Tests for antithyroid antibodies were negative. SHBG and bone turnover's markers were in normal range. She had a markedly exaggerated TSH response to TRH (46 mU/ml at zenith). TSH rose during methimazole administration. The remaining anterior pituitary function was intact.
As confounding aspect a small image compatible with cystic lesion was revealed by MRI of the pituitary region.
Most of the laboratory findings argue against the presence of a TSH producing pituitary tumour and the most likely cause for inappropriate TSH secretion in this patient is resistance to thyroid hormones, with absence of thyrotoxic symptoms suggesting GRTH.

### ✪ Innovative models for Hospital/Territory integrated care

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International studies observed a substantial association between regional rates of rehospitalization and overall admission rates, despite coordination of care interventions to reduce readmissions.
In our experience we design organizational models to ensure Hospital/Territory integration, protect resignations and reduce readmission, working in both directions. In 2008 started a project for territorial medicine and hospital activity coordination, through General Practitioners (GPs) Primary Care Groups (PCG), with territorial activities provided by integrated hospital specialists (internist, diabetologist, cardiologist, pneumologist, and rheumatologist). Milan District and Legnano Hospital activated 5 PCGs (43,500 clients). Among GCP groups, from 2008 to September 2011, we observed a 14‰ reduction in global hospital admissions rate compared to GPs routinely territorial assistance (158,040 clients). To support protected resignation we activated a Call Centre Clinic for Internal Medicine, through clinic/phone management, personalized care plan, PCG involvement. Between September 2010 and September 2011 there were 2750 health services provided, 463 evaluated patients (77 taken in care). Efficacy results relating to heart or respiratory failure, OCBP, showed readmissions within 30 days equal to 8,6% (10,3% within 90 days). Our experience confirms the importance of a comprehensive vision to achieve reduction in readmissions rate through integration in primary care, particularly for chronic illness and appropriate use of the beds.

### Pneumonia ab ingestis with mycotic superinfection in patient with Zenker's diverticulum

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F.78 y.o.came to our attention because of persistent vomiting, that had caused no food intake.Was already treated with antibiotic therapy for pneumonia.O.E. poor general conditions, pale skin and mucous membranes.Dullness to percussion the right lung base.Prominent thoracic scoliosis.Previous mastectomy. Laboratory exams normal values except for Ca 125 = 68.30 U/ml (<35.00) erythrocyte sedimentation rate = 80, s.iron = 26 mg/dl; neutrophil leucocytosis. Normal ECG.Chest X-ray (first day): prominent and extended interstitial thickening.Obliteration of the right costophrenic sinus suggesting pleural reaction.Enlarged heart shadow.Ectasy of the aortic arch.Prominent thoracic scoliosis.Chest X-r.after 10 days: obliteration of the right costophrenic sinus suggesting pleural effusion.Clinical picture moderately worse than previous one. Chest CT with contrast agent: parenchymal consolidation with air bronchogram interesting the minor fis-

sure, in the right upper lobe. Shaded areas of parenchymal consolidation due to alveolar filling, in the right lower lobe.Pleural effusion with compression atelectasis of the right lower lobe.No mediastinal lymphoadenomegaly. Enlargement of the proximal esophagus food-filled. An endoscopic examination could be useful.EGDS: large pharyngoesophageal diverticulum (Zenker's).Several mucosal erosion of the gastric antrum.Diagnosis: Multiple foci of bronchopneumonia ab ingestis with likely mycotic superinfection (sputum culture positive for fungi). Large Zenker's diverticulum.Erosive gastritis.Right pleural effusion.Kyphoscoliosis.Previous mastectomy

## Sospetta sindrome di Heyde

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**Introduzione** La sindrome di Heyde descrive l'associazione tra la stenosi aortica severa e l'emorragia del tratto gastrointestinale, spesso da angiodisplasia. Sembra che la stenosi valvolare induca una ischemia cronica a livello della mucosa intestinale e successiva formazione di malformazioni artero-venose facilmente sanguinanti.
**Caso clinico** Uomo, 64 anni, affetto alcaptonuria, stenosi aortica severa già in lista per intervento chirurgico, pregresse polipectomie coliche. Giungeva in PS per dispnea e melena. Hb 4.6 g/dl. ECG tachicardia sinusale con sovraccarico ventricolare sinistro. Dopo trasfusione, l'esofagogastroduodenoscopia mostrava eritema della mucosa bulbare. All'ingresso presso il nostro reparto Hb 8.6 g/dl. Durante la degenza persisteva melena e successiva anemizzazione da richiedere numerose trasfusioni. La colonscopia risultava negativa. Angio Tc negativa. Nonostante l'impossibilità di dimostrare la sede del sanguinamento si iniziava terapia con somatostatina con un buon controllo della sintomatologia. Dopo stabilizzazione del quadro clinico-laboratoristico veniva trasferito presso il reparto di cardiochirurghia per eseguire intervento di sostituzione valvolare con protesi biologica. Follow-up negativo per sanguinamento.
**Conclusioni** Molti autori sostengono la completa remissione dell'emorragia intestinale in seguito a sostituzione valvolare. Noi non abbiamo evidenziato la sede del sanguinamento ma l'assenza di ulteriori episodi di perdite ematiche gastrointestinali successivamente all'intervento ci ha avvalorato il sospetto diagnostico di sindrome di Heyde.

## From kidney disease to vascular calcification: Ca-P metabolism

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Vascular calcification (VC) is very common in patients with chronic kidney disease (CKD) and this is one of the causes of the increased mortality of these patients. The pathogenesis of VC in CKD is due to passive precipitation of Ca and P but also to the increase of promoters and reduction of inhibitors of calcification. In CKD there is an active process in which vascular smooth muscle cells (VSMC) undergo apoptosis and vescicle formation and are transformed into osteoblast-like cells that induce matrix formation and attract local factor that are involved in the mineralization process. Patients with CKD have low sierum fetuin-A that is an extracellular calcium-regolatory protein that inhibits Ca-P precipitation, calcification by binding hydroxyapatite, and protects VSCM transformation. In kidneys there are also some bone morphogenetic proteins (BMP) that inhibit calcification. In CKD there is a reduction of BMP with increase of Ca and P and calcification of VMSC. In CKD there are also higher serum osteoprotegerin (OPG) levels that, interacting with RANKL, determine VC. Pyrophosphate is a inhibitor of calcification that is reduced in CKD and promote VC especially among patients on dialysis. Increased leptin levels partecipate in the process of VC because serum leptin concentrations are increased in renal failure as a result of reduced leptin excretion. Finally, in CKD, there are hyperphosphatemia, hyperpatathiroidism and alteration of vitamin D concentrations that facilitate VC.
In conclusion, alteration of Ca-P metabolism in CKD causes VC and increase cardiovascular disease.

## Embolia polmonare: la conferma che la clinica è sempre superiore ai test di laboratorio

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Riportiamo i casi clinici di 12 soggetti giunti presso la nostra unità con un quadro compatibile con EP per i quali il dosaggio del d-dimero è risultato negativo, mentre la successiva esecuzione dell'indagine Angio-tc del polmone ci ha permesso di giungere alla diagnosi di EP. L'EP presenta segni e sintomi molto aspecifici, per tale motivo sono stati codificati alcuni criteri per favorire l'esecuzione di un pre-test clinico utile al fine di stabilire il grado di probabilità del sospetto diagnostico di EP e di decidere quindi di proseguire con esami strumentali specifici. Negli ultimi dieci anni, il test del d-dimero ha guadagnato popolarità nella diagnosi di EP, soprattutto a causa della sua non invasività e dell'elevato valore predittivo negativo. Spesso viene dimenticato che il test del d-dimero deve essere usato in combinazione con la valutazione di probabilità clinica pre-test, dal momento che l'EP può essere tranquillamente esclusa in caso di una bassa probabilità clinica associata ad un normale risultato del test del d-dimero, mentre non è vero il contrario ed il test di imaging aggiuntivo è obbligatorio. Anche se questa strategia è ormai scientificamente consolidata, nella pratica quotidiana spesso con valori di d-dimero nella norma si esclude erroneamente a priori la possibilità di EP. Nel sospetto di EP è necessario esaminare il paziente e valutare la probabilità clinica di EP, quindi, nei pazienti con una elevata probabilità pre-test, il test del d-dimero dovrebbe non essere eseguito e si dovrebbe procedere direttamente con esami strumentali specifici.

## L'importanza di una corretta e tempestiva diagnosi di endocardite infettiva. La nostra esperienza e la nostra proposta per linee guida gestionali specifiche

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L'Endocardite Infettiva (EI) è un infezione microbica endovascolare delle strutture miocardiche native (per es. valvole, endocardio atriale o ventricolare) o impiantate chirurgicamente (ad esempio valvole protesiche, pacemaker o elettrodi di un ICD). Presentiamo i dati clinici e la strategia adottata ed adeguatamente individualizzata su 9 pazienti. Inoltre, traendo spunto dalle osservazioni clinico-laboratoristico-strumentali abbiamo tentato di stabilire alcune linee-guida "interne" utili per non trascurare l'importanza di una corretta e tempestiva diagnosi di EI al fine di ridurne la mortalità. Secondo le nostre osservazioni, infatti, qualsiasi paziente in cui si sospetta esserci un EI sulla base di criteri clinici dovrebbe essere sottoposto ad un screening attraverso una ecocardiografia transtoracica (ETT). Se le immagini sono di buona qualità, l'ETT risulta negativa e c'è solamente un basso dubbio clinico di EI, bisognerebbe prendere in considerazione una diagnosi differenziale. Se le immagini sono di scarsa qualità o l'ETT risulta negativa in presenza di un fondato dubbio dovreb-

be essere sempre presa in considerazione l'ecocardiografia tranesofagea multiplana. Purtroppo la natura seminvasiva dell'ecocardiografia transesofagea (ETE) e la necessità di un operatore esperto in questa metodica ne impediscono l'utilizzo come prima scelta in tutti i pazienti sospettati di avere un EI. Infine se l'ETE risulta negativo ma rimane il sospetto, l'ETE dovrebbe essere ripetuto dopo 48 ore e dopo una settimana per consentire ad eventuali vegetazioni di diventare più evidenti.

## Una fatale combinazione

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Donna di 48 anni, insegnante di educazione fisica, giunta per comparsa di senso di morte imminente, sincope con stridore respiratorio seguito da epigastralgia irradiata ai cingoli scapolari. Anamnesi negativa per malattie cardiovascolari ed abitudini voluttuarie, portatrice di spirale medicata anticoncezionale. Presso il P.S. parametri vitali, e.o., ECG, Rx torace, TC encefalo ed EEG erano negativi a fronte di incremento dei marker di miocardiocitonecrosi in 2 prelievi seriati; ecocardiogramma: minimo rigurgito aortico, lieve insufficienza mitralica, polmonare e tricuspidalica. Durante la degenza, paziente asintomatica, si eseguivano: studio ecografico dell'aorta, ECG Holter e screening trombofilico, risultati negativi con progressiva normalizzazione degli indici di miocardiocitonecrosi ma comparsa di onda T invertita in V4 e in V5. Si procedeva, quindi, a coronarografia: IVA a "cavaturacciolo", dissezione spontanea fino all'apice, discreto flusso a valle. Dopo 2 gg, comparsa di precordialgia seguita da sincope, rilievo di FV ed exitus. La dissecazione coronaria spontanea, sebbene rara causa di SCA, deve essere sospettata in giovani donne senza fattori rischio, ancor più in epoca perigravidica o post-partum o in trattamento estroprogestinico. La terapia rappresenta il vero ostacolo nel management poichè le opzioni raccomandate (mediche o chirurgiche) non sono unanimi. Nel nostro caso, la perfusione a valle ci ha indotto ad un atteggiamento conservativo; l'imprevedibilità della malattia, considerato l'alto rischio di recidiva, ha reso vana ogni nostra inziativa.

## Assessment of nutritional status in patients hospitalized for heart failure and for respiratory failure

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Primary aim of the study was to detect malnutrition ( M ) or risk of nutritional depletion ( MR ) in patients with HF and in patients with RF using for the assessment of nutritional status first step items : BMI , mini nutritional assessment test (MNA), values of serum prealbumin, transferrin , blood lymphocytes count and second step item : bioimpedentiometry to calculate FFM. Secondary aim was to compare the power of items to detect malnutrition or risk of nutritional depletion. We enrolled (April –September 2011) 40 patients ( 26 males and 14 females 51 to 93 years of age) referred for heart failure ( 27 ) and for respiratory failure ( 13 ).The of nutritional status was assessed 1)calculating BMI 2)filling MNA 3) evaluating values of serum prealbumin and transferrin , blood lymphocytes count 4) performing bioimpedentiometry which evaluates the percentage of fat mass of the patient related to that of a anthropometric matched normal subject ( FFM )The patients with M or MR : 12 ( 30 %) calculating BMI, 15 ( 37.5% ), 19 (47.5% ) and 33 ( 82% ) using threshold values of prealbumin, transferring and lymphocytes counts, respectively. The score of MNA discriminated 10 ( 25% ) malnourisched subjects and 19 ( 47.5% ) at risk of malnutrition: in the two groups are 72.5% of enrolled patients. Bioimpedentiometry showed 28 ( 70% ) subjects with abnormally low FFM. BMI is less sensitive than MNA and FFM for detecting patients with M or MR.The MNA is as sensitive as FFM for diagnosis of protein-energy malnutrition but is more easy to do and less expensive . Lynphocytes counts is the more sensitive laboratory finding.

## Trombosi venosa profonda dell'arto superiore ed embolia polmonare in giovane calciatore con compressione dinamica sugli assi venosi

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Un calciatore di 19 anni viene ricoverato per edema dell'arto superiore destro (ASD) in assenza di altri sintomi. Riferisce pregresse ernioplastica inguinale, appendicetomia e un recente episodio di confusione mentale con TC e RMN encefalo negative. L'ECG, l'ecocardiogramma, l'ecoaddome e l'EGA risultano nella norma. L'ECD venoso ASD mostra TV occludente della succlavia dx con testa del trombo in vena anomina omolaterale e la angioTC mostra embolia polmonare bilaterale; reperto confermato da successiva scintigrafia polmonare. Gli esami generali e per trombofilia risultano nella norma eccetto D dimero e PCR elevati e mutazione MTHFR (C677T) in eterozigosi. Un ECD venoso mirato della succlavia dx a un mese documenta riperfusione del vaso; dopo manovra di abduzione attiva (90°) apprezzabile occlusione funzionale completa a dx; normale la succlavia sn. Il soggetto viene dimesso in TAO ed esami eseguiti in altri presidi rilevano normalità di: omocisteinemia dopo carico, LAC, ACL, antibeta2GPI, folati, B12, fattori VIII e XII; l'ECD degli arti superiori con studio dinamico dei diametri prossimale e distale alla clavicola della vena ascellare a 0°, 90°, 180° di abduzione dell'arto sul torace conclude per compressione dinamica su entrambi gli assi venosi axillo-succlavi da parte della pinza sottoclaveare, più marcata a destra. Dopo otto mesi, data la normalità di ecocardiogramma e scintigrafia polmonare di controllo, il soggetto sospende la TAO, inizia di fisioterapia specifica e riprende l'attività calcistica evitando attività fisica eccessiva e duratura degli arti superiori.

## ✪ Defining the role of ultrasound in the prognostic stratification of patients with suspected acute pulmonary embolism: our experience

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Purpose of our study was to evaluate the role of echocardiogram (EC) in the risk stratification of patients with acute pulmonary embolism (PE). Ultrasounds (US) were associated with a clinical index (CI), ECG, chest X-ray, blood gases (BG), D-dimer (Dd), troponin T (trT), natriuretic peptide (pro-BNP), in order to compare sensitivity, specificity, positive and negative predictive value.

**Methods** The 175 consecutive patients with suspected PE were subjected to EC with criteria of right ventricular (RV) dysfunction, such as RV dilatation and hypokinesis, reduction of respiratory variations of the inferior vena cava, visualization of thrombi. In addition, they underwent clinical evaluation using a multiparametric CI, supplemented by: ECG; chest X-ray; BG; Dd; trT; pro-BNP. Predictive value of mortality and clinical deterioration of the examinated parameters was calculated by multivariate analysis. We evaluated sensitivity, specificity, positive and negative predictive value, and $\chi 2$ for differences between proportions. Diagnosis of PE was confirmed by CT angiography.

**Results** Patients with positive US showed a statistically greater number of PE. The index of severity of PE we adopted, in its entirety, showed a

sensitivity of 98%, specificity of 96%, positive predictive value of mortality rate of 99% and predictive value of clinical deterioration 96%.
**Conclusions** Statistical analysis showed high sensitivity and specificity of EC and all parameters we adopted, taken together. Risk stratification in acute phase allowed us to identify patients requiring more aggressive treatment.

## Role of lung ultrasound in the diagnosis of dyspnoeic patients

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Purpose of our study was to evaluate lung ultrasound (US) in the diagnosis of dyspnea. Chest X-ray, proBNP and echocardiogram were associated in order to compare sensitivity, specificity, positive and negative predictive value.
**Methods** We enrolled 101 patients admitted with a diagnosis of dyspnea, excluding lung cancer, fibrothorax, congenital lung disease, severe chest deformity or recent major surgery of the chest. The patients underwent chest X-ray, proBNP, ECG, clinical evaluation and lung US, that was considered positive when the number of B lines was higher than 8. It was regarded as gold standard the final clinical diagnosis given by medical experts according to the guidelines of the AHA. It was also performed echocardiogram. All data were analyzed using SPSS and Excel for Windows. Were evaluated sensitivity, specificity, positive and negative predictive value, and the $\chi 2$ for differences between proportions.
**Results** Patients with positive US showed a statistically greater number of diagnosed heart failure (45 patients with heart failure compared to 11 without in the group with positive ultrasound; 1 to 44 in the other group, $\chi 2$ 92.5 $p < 0.005$), and showed values of proBNP significantly higher than others. Furthermore, patients with higher values of proBNP showed significantly higher values of lines B. ($\chi 2$ 17.2 $p < 0.005$). Our echocardiographic data showed mean levels of sensitivity and specificity, thus allowing the use of echocardiogram for confirmation of diagnosis.
**Conclusions** Lung US, associated with echocardiogram, may be a predictor of cardiogenic pulmonary edema.

## Evaluation of the diagnostic accuracy of bedside lung ultrasound and chest radiography in patients with suspected pneumonia: our experience

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Purpose of this study was to evaluate the diagnostic accuracy of bedside lung ultrasound and chest radiography (CXR) in patients with suspected pneumonia compared with CT scan and final diagnosis at discharge.
**Methods** It was a prospective clinical study, conducted from January 2007 to January 2012. Lung ultrasound and CXR were performed in sequence in adult patients admitted to our emergency department (ED) for suspected pneumonia. A chest CT scan was performed during the hospital stay when clinically indicated.
**Results** 201 patients entered the study. A discharge diagnosis of pneumonia was confirmed in 162 (81%). The first CXR was positive in 108/162 patients (sensitivity 67%; CI 57.2% to 76.1%) and negative in 33/39 (specificity 85%; CI 73.7% to 96.3%), whereas lung ultrasound was positive in 160/162 (sensitivity 98%; CI 93.3% to 99.9%) and negative in 37/39 (specificity 95%; CI 82.9% to 99.6%). A CT scan was performed in 60 patients (52 of which were positive for pneumonia); in this subgroup the first CXR was diagnostic for pneumonia in 37/52 cases (sensitivity 71%), whereas ultrasound was positive in 50/52 (sensitivity 96%). The feasibility of ultrasound was 100% and the examination was always performed in less than 5 min.
**Conclusions** Bedside chest ultrasound is a reliable tool for the diagnosis of pneumonia in the ED, and its accuracy is likely superior to CXR's in this setting. Its wider use will probably allow a faster diagnosis, in favor of a more appropriate and timely therapy.

## Role of ultrasound assessment in patients with suspected sepsis: our experience

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Purpose of our study was the evaluation of a more rapid recognition of the causes of sepsis with the help of ultrasound (US), whereas the early detection of this disease can improve prognosis.
**Methods** The study was conducted from January to December 2011. We diagnosed and treated 42 cases of sepsis patients, confirmed by clinical laboratory instrumental data, including US. The patients were immediately investigated in search of a focus of infection by US evaluation (including echocardiography). We then performed a comparative assessment of mortality with the cases of sepsis diagnosed and treated from January to December 2011 without the immediate help of US.
**Results** Ultrasound allowed us the immediate individuation of the outbreak of infection in 80% of patients with systemic septic response. Furthermore, echocardiography played a key role in 7 cases to demonstrate the typical irregularities and vegetations of endocarditis. US also allowed percutaneous and surgical treatment of the infectious outbreak in 16 septic patients. In 33 cases we could also obtain the central venous pressure by considering the measurement of the diameter of the inferior vena cava with US. The protocol for diagnosis and therapy that we achieved allowed us to significantly increase the number of cases treated early, with statistically significant effects on survival of patients.
**Conclusions** Early US enables the preparation of a diagnostic-therapeutic protocol for early identification and proper treatment of patients, improving clinical risk management.

## Abdominal pain and fever: case report

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A woman aged 48 came to our observation for clinical condition initially characterized by symptoms such as headache, myalgias, arthralgias, nausea and malaise, with subsequent onset of chills and fever with large daily fluctuations, associated with vomiting and persistent dry cough. No rash. In the last few hours the patient became worse for the appearance of diffuse abdominal pain, mainly in the epigastric area, with sensation of palpitations and dyspnea on mild exertion. Previously the patient had enjoyed perfect health and she didn't take any medication at home. At chest X-ray, mild pleural effusion and accentuation of the pulmonary texture, especially in the basal regions. ECG, sinus tachycardia with diffuse repolarization abnormalities, ST elevation on inferior leads. Frequent supraventricular and ventricular extrasystoles. Positive cardiac enzymes, with a growing trend. Laboratory tests: moderate leukopenia with relative monocytosis and moderate microcytic hypochromic anemia, hyponatremia and hypochloremia. Blood cultures were also performed and initiated therapy with levofloxacin, aspirin, carvedilol, furosemide. The echocardiogram showed vegetations on major non-coronary aortic cusp and left coronary artery, mild pericardial effusion, with no gross abnormalities of segmental kinetic; global kinetic was mildly depressed. Microbiological negative blood cultures. Ne-

gative serodiagnosis. An endo-peri-myocarditis with aortic valve endocarditis caused by ricketsia was diagnosed and appropriate antibiotic therapy was practiced, with slow resolution of the clinical state.

## Unusual case of epigastric pain and syncope

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49 years old man was admitted for epigastric pain, unrelated to physical exertion or meals. In addition, the patient complained of an episode of syncope with moderate head injury with dry cough and dyspnea after minor efforts. In the days before he had a fever and vomiting. Repeatedly hospitalized for previous similar episodes, with a final diagnosis of neurally mediated syncope. On examination, marked hypotension and tachycardia with gallop rhythm, sour breathing on the whole lung field. Ultrasound abdomen negative. On chest radiographs, reinforced bronchoalveolar plot without obvious pleural or parenchimal lesions. Nonspecific increase in cardiac enzymes, ECG within normal limits. Echocardiography: minimal pericardial effusion. Laboratory tests: moderate hyponatremia, mild renal impairment, mild macrocytic anemia, moderate leukopenia with relative monocytosis, mild hypergammaglobulinemia with hypoalbuminemia. Prothrombin time shortened. ACTH and cortisol levels within normal limits. Blood gases: respiratory alkalosis. First negative blood coltures with negative serodiagnosis. After 3 days, severe respiratory failure requiring intubation and triple antibiotic therapy. Then there was the detection of antibodies against richettsia (Immunoglobulins G and M), with positive blood cultures. An echocardiogram showed marked hypokinesia cardiac apex. Coronary angiography was performed, which had a negative result. HRCT of the chest did not clarify the case. The final diagnosis was sepsis caused by riccketsia.

## A strange liver lesion in a patient with abdominal pain and fever

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**Clinical Case** A 37 years old woman, with a history of cholecystectomy and therapy with oral contraceptives,was admitted in hospital for right upper quadrant pain, vomiting, chills and high fever. She reported a history of travel to tropical country where she ate raw fish. On examination the patient had right upper quadrant tenderness with sluggish peristalsis.Laboratory tests documented the presence of marked neutrophilic leukocytosis and an increase of GOT, GPT, LDH and Gamma-GT. Viral markers were negative. An ultrasonography showed the presence of dilatation of the intrahepatic bile ducts with multiple hyperechoic spots with "comet tail" reverberation artifactas, suspected for cholangitis.The common bile duct was normal. The sixth hepatic segment documented a rounded and heterogeneously hypoechoic lesion, measuring 21 X 13 mm, with poor vascular signal on echocolorDoppler. The lesion was first interpreted as a liver abscess and treated with antibiotics, moreover with clinical benefit. An ultrasound check documented persistence of the lesion, so we did contrast-enhanced ultrasound that showed rapid enhancement of the lesion with "cartwheel" appearance in the arterial phase and slow washout in the portal phase.
**Conclusion** Even in the presence of typical symptoms and suggestive laboratory tests, uncertain sonographic findings require further exams. In our case, CEUS documented the typical appearance of a benign lesion, focal nodular hyperplasia. An ultrasound performed three months after suspension of contraceptives showed a clear reduction of the lesion.

## L'importanza del ruolo semeiologico dell'ecografia in Medicina Interna: un caso clinico

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**Introduzione** L'ecografia in ambito internistico costituisce un sussidio utile, fornendo molteplici informazioni a volte non evidenti all'esame clinico. E' una metodica con un limite: l'operatore-dipendenza; tuttavia, utilizzando criteri ben riconosciuti,può suggerire ipotesi diagnostiche in situazioni particolari.
**Caso clinico** Pz di 47 anni, con anamnesi per carcinoma mammario sottoposto a quadrantectomia, follow-up oncologico nella norma, esegue presso la nostra UO ecografia dell'addome per dispepsia. L'esame ha documentato la presenza di epatomegalia con aspetto iperecogeno ed attenuazione posteriore del fascio US, come da steatosi moderata, con riscontro, al IV segmento, anteriormente alla biforcazione portale, di due aree ipoecogene a contorni sfumati, grossolanamente ovalari, non assumenti segnale ecocolordoppler, del diametro massimo di mm 32. In relazione all'anamnesi, tali reperti potrebbero essere suggestivi di lesioni focali di natura metastatica. Tuttavia, l'aspetto frastagliato, la sede tipica (anteriormente alla biforcazione portale) e la stabilità dimensionale (la paziente ha eseguito controllo US a 3 mesi, risultato sovrapponibile) orientano per una diagnosi di aree di steatosi focale nel contesto di una steatosi generalizzata. Tale dato viene confermato da una TC addome con mdc.
**Conclusioni** Anche in presenza di una forte componente anamnestica per neoplasia, il riscontro di segni ecografici tipici in un contesto caratteristico (nel nostro caso steatosi focale in parenchima epatico steatosico) può indirizzare verso ipotesi diagnostiche piuttosto che altre.

## A correlation study between BNP levels and length of hospitalization

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**Background** Increased brain natriuretic peptide(BNP) levels have been related to several conditions, such as acute heart failure(AHF), pulmonary embolism(PE) and acute coronary syndromes(ACS). Particularly among elderly patients, a longer hospitalization is related to higher morbidity and mortality. Aim of this study is to evaluate the relationship between BNP levels and length of in-hospital stay.
**Methods** We retrospectively evaluated 500 consecutive patients admitted to our Internal Medicine Department. BNP was evaluated at admission in all the patients. Each patient underwent a complete diagnostic workup. We evaluated the curve-fit correlation between BNP levels and days of hospitalization using SPSS 13.0 for windows systems.
**Results** Mean age was 80±9.85 years, males representing 58% of the sample.AHF represented 74.9%, ACS 13.5%, PE 11.6% of the sample. We found that BNP levels and days of hospitalization were better described by a logarithmic regression model (R2: 0.674, $p < 0.0001$)
**Conclusion** Among elderly patients admitted in an Internal Medicine department, higher BNP levels are associated to longer hospitalizations independently to the pathology. This relationship is better described by a logarithmic regression model. Larger cohorts are required to validate this observation.

### Usefulness of echocardiography and tissue Doppler imaging (TDI) in the management of the acute patient: a clinical case report

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**Case Presentation** Male, 64 years old,overweight,hypertensive,current smoker. Arrived to our emergency department(ED)for epigastric pain, sweating, nausea, bradicardia (45 bpm) and hypotension. At physical examination, pain at palpation in epigastric region. At admission ECG,sinus bradicardia, negative T-waves in inferior leads without ST-segment alterations. Blood chemistry showed troponin I 2.18 ng/ml, d-Dimers 1290 ng/ml. Echocardiography showed hypokinesis of left ventricle inferior wall associated to diffuse hypokinesis and systodiastolic dysfunction of right ventricle RV), as diagnosed with TDI (TAPSE not evaluated for suboptimal window). Right chambers didn't result dilated,with normal PAPs.Inferior vena cava was dilated (25 mm) and non-collapsing.Our first diagnosis was RV NSTEMI-ACS, and the patients was treated and then admitted in our Internal Medicine Department (critical care area). At arrival, a new ECG showed 1 mm ST-elevation in DII,DIII and aVF leads,associated with epigastric pain. Patient was then taken to our Hub hospital for urgent coronarographic examination, which showed an occlusion of 100% in proximal right coronary artery with a large endoluminal thrombotic occlusion. After PTCA and stenting,the patient was admitted again in our department in good clinical conditions.
**Conclusion** Echocardiography and ultrasound examination,integrated with TDI examination can be useful to the Internist working in ED and in critical care area for a correct and fast diagnosis. In this case,it is important to enlighten how echocardiography allowed a correct bedside differential diagnosis.

### La cartella clinica informatizzata. Esperienza della S.C. Medicina Interna 1° Ospedale San Paolo Savona

R. Tassara [1], M. Brignone [1], M. Cavaliere [1], O. Consiglio [1], A. Saccone [1], E. Sacchi [2], S. Lanza [2]

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La cartella clinica elettronica o informatizzata è uno strumento sempre più utilizzato nelle realtà ospedaliere. La struttura di base di una cartella clinica elettronica, in generale, consente a tutto il personale clinico di redigere e rivedere la documentazione, stilare ordini sia di farmaci sia di terapie ed esami e di gestire il prontuario farmaceutico. L'introduzione dell'uso di un prodotto di cartella clinica elettronica in ospedale comporta notevoli vantaggi sia amministrativi sia clinici, ottenendo un impatto positivo sulla cura del paziente. Fondamentale nei progetti di questo genere è il coinvolgimento del personale medico e la credibilità del leader clinico del progetto. Il prodotto deve permettere un miglioramento delle procedure senza che le stesse siano stravolte e senza modificare le pratica clinica. L'ASL 2 del Savonese ha voluto iniziare questo percorso chiamato " UNY.SYS " , che è un sistema gestionale sanitario unificato che costituisce una unica interfaccia per il caricamento, l'interrogazione, l'estrazione e la gestione dei dati amministrativi e sanitari inerenti i pazienti che accedono ai servizi ASL2, relativamente a prestazioni erogate sia in regime di ricovero, sia in regime ambulatoriale e consultoriale ed uno strumento comune di interscambio delle informazioni fra le differenti strutture all'interno di ASL2, favorendo la consultazione informatizzata delle informazioni .

### La Medicina Interna per intensità di cura. Esperienza "work in progress" a Savona

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Accanto alle Divisioni di Medicina Interna si sono progressivamente create Aree Critiche per il trattamento del paziente grave ma anche aree a minor intensità di cura ( Cure Intermedie ) con il compito di accogliere pazienti stabilizzati clinicamente ma che necessitano ancora di assistenza sanitaria. La necessità di razionalizzare le risorse obbliga ad istituire posti letti divisi per intensità di cure. Da alcuni anni all'Ospedale di Savona è presente un'Area Critica in Medicina Interna , Degenze Ordinarie e letti di Cure Intermedie nate per cercare di garantire una continuità di cure all'interno dell'ospedale e nel passaggio ospedale – territorio. Gli autori intendono analizzare i risultati della loro attività come momento di passaggio alla organizzazione della Medicina Interna per intensità di cure, che nell'ambito della rete rappresenta la chiave del problema. Non più reparti, divisioni, servizi ma strutture che si modellano intorno alle esigenze del paziente avvicinandosi alle sue necessità terapeutiche. Viene infatti ribaltata la tradizionale organizzazione per discipline specialistiche, in cui l'assistenza è prestata in base alla specialità del reparto, passando dal vecchio modello con posti letto prefissati ai cosiddetti "letti funzionali". Il nuovo ospedale è centrato sui bisogni assistenziali del paziente-utente: cura efficace, tempestiva, sicura; presa in carico da un riferimento certo (tutor); informazioni chiare sul proprio percorso di cura; essere ascoltato, accolto, rassicurato; avere confort con rispetto della privacy e tutela della propria dignità.

### ✪ Correlation between high homocysteine and NT-pro BNP serum levels and asymptomatic left ventricular dysfunction in type 2 diabetic patients

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Diabetic cardiomyopathy is characterized by an often-asymptomatic LV diastolic dysfunction that can, however, progress to systolic dysfunction. Among diabetic patients the incidence is about 10%, reaching 21% in patients older than 65 years, and it is higher in females than males.
**Objective** To critically investigate, in diabetic patients, the correlation between the serum levels of homocysteine and NT-proBNP and the asymptomatic LV diastolic dysfunction.
**Methods** 96 patients (55 females and 41 males) with type 2 diabetes mellitus were recruited (mean ± SD age= 62 ± 11 years; mean ± SD disease duration= 6.84 ± 5.69 years). The patients with full-blown cardiovascular disease were excluded. The patients were anthropometrically evaluated; moreover, the homocysteine and the NT-pro BNP serum levels were determined. The enrolled patients were divided in two groups: 40 with normal echocardiographic parameters of LV function and 56 showing only diastolic dysfunction. The abnormal LV relaxation and the psuedonormal/restrictive filling *patterns* were considered predictive of diastolic dysfunction.
**Results** The serum levels of NT-proBNP (868 ±65 pg/ml vs. 188±93 pg/ml, p=0.001) and homocysteine (18.9 ± 5.27 µmol/l vs. 10.15 ± 3.49 µmol/l, $p < 0.001$) were higher in diabetic patients with diastolic dysfunction than in patients with normal LV function, independently of age, disease duration and anthropometric features.
**Conclusions** This study provides direct evidence that *LV* diastolic dysfunction correlates with increased serum levels of homocysteine and NT-pro BNP, being the correlation higher, albeit not significant, among females.

## Lesione vertebrale litica in paziente recentemente sottoposto ad epatico-digiunostomia per colangiocarcinoma, l'importanza della diagnosi differenziale

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A.M., sottoposto ad epatico-digiunostomia per colangiocarcinoma, si reca in DEA a 8 mesi dall'intervento per comparsa di forte dolore al rachide lombare ed episodi febbrili. Alla TC si rilevano lesioni litiche di L2-L3 e L4-L5, compatibili in prima istanza con ripresa di malattia neoplastica. Tuttavia, in considerazione dell'anamnesi positiva per intervento chirurgico nei mesi precedenti, per i recenti episodi febbrili e per il riscontro di livelli ematici di Ca 19.9 nei limiti, veniva richiesta una RMN del rachide che evidenziava segni di spondilodiscite L2-L3 con flogosi paravertebrale e venivano eseguite emocolture "a freddo" risultate positive per Staphylococcus haemolyticus. La diagnosi di spondilodiscite su base infettiva è stata completata dalla biopsia della lesione ossea che ha permesso di escludere la presenza di tessuto neoplastico metastatico o di origine specifica, in un soggetto già affetto da TBC. Un'indagine PET mostrava fissazione patologica nella sola sede vertebrale descritta. Da segnalare anche l'esecuzione di un ecocardiogramma trans-esofageo (ETE) per lo studio degli apparati valvolari dopo il riscontro clinico di un soffio sistolico 3/6 L sul focolaio mitralico, con ecocardiogramma trans-toracico positivo per prolasso mitralico severo. L'indagine ETE ha,infatti, consentito di studiare la lesione valvolare, da non correlare apparentemente alla patologia infettiva, che dovrà essere rivalutata dai cardiochirurghi al termine della terapia antibiotica. Il paziente è stato trattato con vancomicina ev ed analgesici con progressivo buon recupero funzionale.

## Status of malis epilepticus secondary to Hashimoto encephalopathy: description of a clinical case

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Hashimoto encephalopathy (HE) is a rare neurological disorder, of unknown origin, characterized by encephalopathy associated to autoimmune thyroid disease. Clinical case: a 50-year old man was admitted to our ITU in coma following a convulsive episode. A CT of brain did not show abnormalities. His medical history included diabetes, hypertension and obesity. 7 months before current admission he had been admitted to another hospital with a similar presentation, and a diagnosis of HE had been made. We administered prednisone (25 mg OD) and levetiracetam increased gradually to 1000 and 500 mg per day. In the following hours, the patient regained consciousness. After 72 hours, and a second normal CT, the patient was transferred to the medical ward. His TFT were normal but antibodies antiperoxidase were positive. Since his symptoms had resolved and he was receiving full dose of antiepileptics, we decided, in light of his coexistent diabetes, to discontinue steroids. 4 days later the patient was discharged home without neurological reliquates. We confirmed the diagnosis of HE on the basis of the following : positivity of antibodies anti-peroxidase, absence of alternative neurological disorder, rapid regression of the symptoms after starting steroid treatment. It cannot be ruled out that the clinical improvement which followed the beginning of steroid treatment may bear no relation with this therapy; the number of patients thus treated for this condition remains too small for a defined conclusion. Our patient remained asymptomatic 4 months after discharge on antiepileptics alone.

## Pulmonary cystic lesions and CFTR gene mutation: description of a case and literature review

D. Tirotta [1], V. Durante [1]

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**Introduction** Diagnosis of cystic fibrosis in adulthood is often difficult, however studies show that heterozygous CFTR mutations is associated with some forms of idiopathic bronchiectasis.
**Case report** A Moroccan woman is admitted for respiratory global failure. She had recurrent infections of upper/lower respiratory tract. Particularly thoracic TAC detected interstitial lung disease with cavitary lesions. Haemophilus and Mycobacteria other than tuberculosis were isolated from BAL. Transbronchial biopsy showed honeycomb pattern, fibrosis, lymphohistiocytic infiltrate, bronchiectasis, emphysema.
Currently she present leukocytosis, anemia, inflammatory syndrome, elevation of liver tests.
Hypothesis are cystic fibrosis, idiopathic bronchiectasis, alpha1-antitrypsin deficiency, sarcoidosis, TBC.
Alfa1antitripsine, autoimmunity, fecal elastase are normal.
Chest CT confirme cystic bronchiectasis, reticular pattern, enlargement of mediastinal lymphnodes; PFR restrictive pattern and DLCO deflection; echo abdomen intrahepatic cholestasis.
Hypothesis of mild cystic fibrosis is formulated; sweat test is inconclusive; analysis of CFTR gene (Reverse Dot Blot techniques: 92% sensibility, 99.9% accuracy) detect single mutation D1445N CFTR gene. Patient improve after antibiotics, steroids, bronchodilators, physiotherapy. Genetic test are performed also in first degree relatives.
**Discussion** This case shed some light on association of single heterozygous mutation in CFTR gene and pulmonary cystic lesions: expression of idiopathic bronchiectasis or, perhaps, of atypical mild cystic fibrosis.

## A case of hypogammaglobulinemia discovered in adulthood

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**Background** Immunodeficiency must be suspected for unusual organism or unusual frequency, duration, severity of infection. Also the idea of B cells deficiency should occur for susceptibility to encapsulated bacteria.
**Case report** A 70 years man was admitted for diarrhea, cachexia, increased waist circumference. In history: from 20 years diagnosis of COPD with recurrent exacerbations, treated with several antibiotics, bronchiectasis, necrotizing Pseudomonas pneumonia, severe restrictive respiratory failure, atrial fibrillation, hepatosplenomegaly with ascites.
Tests revealed: anemia, cholestasis, inflammatory syndrome, hypokalemia, stool tests positive for Giardia, major and minor hepatotropic viruses negatives, as well as autoimmmunity.
Recurrent infections induces search of immunodeficiency.
Tests showed reduction of immunoglobulins (Ig) and of CD4/CD8 ratio; HIV was negative. Lymphnodenomegaly were absent and BOM negative for lymphoma. Finally EGDS shows atrophic gastritis and duodenal positivity for Giardia Lamblia. Diagnosis of variable common immunodeficiency (ICV) was made, after excluding secondary deficit. The patient receives intravenous Ig and metronidazole, followed by albendazole, with clinical benefit.
**Discussion** Extensive search in Pubmed shows 2 case report with Giardia and ICV; there are also some associations in cohort studies of ICV. Studies reveal that diagnosis of ICV is often misunderstood, as in our case. However early detection is associated with better prognosis, as Ig therapy results in reduction of infection recurrence and its complications.

## A case of temporal arteritis with major vessels extension

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**Introduction** Temporal arteritis is a granulomatous vasculitis with predilection for extracranial branches of the carotid.
Case report A woman 72 years old comes to our attention for episodes of illness and hypertensive crisis in patient with previous diagnosis of Horton's arteritis (in 2005) asociated with fever and headache, confirmed by histological examen and in remission after steroid therapy.
Tests showed negative biological inflammatory syndrome and systemic immune serology. (during steroid therapy).
Investigations showed also aneurysmal dilatation of the ascending aorta (5 cm) and descending aorta (5.2 cm) without aortic valve insufficiency, this is also an additional aneurysm (4 cm) of suprarenal abdominal aorta.
To confirm the hypothesis of an extension in major vessels of vasculitis, PET and MRI of abdominal aorta.were planned.
**Discussion** This case is characterized by the association between temporal arteritis and aneurysmal dilation of thoracic and abdominal aorta. A correct definition of extension is a prerequisite for correct management of vasculitis.

## Efficacia di daptomicina nella riduzione di estesa vegetazione endocardica in soggetto portatore di pacemaker bicamerale

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**Premesse e scopo dello studio** La descrizione del caso clinico prende spunto dall'acquisizione nell'ambito ospedaliero del Molise del farmaco daptomicina nel trattamento dell'endocardite infettiva da Staphylococcus. Obiettivo era verificare l'efficacia del trattamento intensivo con daptomicina in un soggetto portatore di pacemaker bicamerale con estesa vegetazione endocardica in termini di riduzione delle dimensioni della lesione al fine di permettere l'espianto del catetere infetto per via cutanea, in considerazione del rischio embolico dell'intervento chirurgico.
**Materiali e Metodi** Caso clinico: paziente di 76 anni; nel 2004 impianto di PM bicamerale definitivo tipo VVD per BAV totale; dopo persistente stato febbrile riscontro ecocardiografico di vegetazione calcifica nel lembo posteriore della valvola aortica di 7 cm di diametro; emocoltura positiva per stafilococco epidermidis. Dato l'elevato rischio embolico legato ad intervento tradizionale viene contattata l'equipe di cardiologia interventista dell'Ospedale S. Chiara di Pisa, nota per l'introduzione della metodica di rimozione di dispositivi intracardiaci infetti per via transvenosa.
**Risultati** Viene instaurato trattamento antibiotico con Daptomicina al dosaggio di 6 mg/kg ev per 40 giorni.
Al termine del ciclo viene constatata una riduzione del diametro della vegetazione a 2 cm che permette l'espianto per via transcutanea del catetere senza alcuna complicazione e necessità di reimpianto di PM.
**Conclusioni** Il caso esposto evidenzia come la scelta terapeutica con daptomicina abbia influito in maniera decisiva nell'eradicazione di una grave infezione endocardica.

## Progetto pneumococco

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**Premesse e scopo dello studio** Mentre è consolidata la proposta del vaccino antipneumococcico in età pediatrica e ai soggetti >65 anni, più difficile è raggiungere i soggetti di ogni età a rischio di infezioni invasive da S. pneumoniae (IPD) per patologia. L'implementazione nella UO Medicina PO Rovereto di un percorso vaccinazioni antipneumococco ha lo scopo di favorire l'adesione da parte di soggetti con patologie a rischio per IPD.
**Materiali e Metodi** Nel febbraio 2011 il Servizio Igiene Pubblica Vallagarina ha condotto un incontro formativo nella UO Medicina sull'immunoprofilassi delle IPD. E'stata attivata una procedura per la vaccinazione di alcune categorie di pazienti ricoverati: scompenso cardiaco (SC) e polmonite comunitaria (CAP).
**Risultati** Candidati alla vaccinazione (febbraio-dicembre 2011): 113 soggetti, di cui 24 esclusi perché già vaccinati e 11 non hanno dato il consenso. Dei 78 soggetti vaccinati, 49% erano ricoverati per SC e 51% per CAP. Dei pazienti vaccinati <65 anni (23%) il 66% era affetto da CAP, il 34% da SC. Dei pazienti con età >65 anni (77%), il 43% era affetto da CAP e il 67% da SC.
**Conclusioni** L'integrazione tra Ospedale e Territorio è possibile anche nell'ambito vaccinale. L'offerta della vaccinazione durante il ricovero ai pazienti a rischio di IPD sembra essere più efficace e più accessibile rispetto all'invito a presentarsi ai servizi vaccinali dopo la dimissione. L'esperienza fa ritenere che si possa ampliare l'offerta della vaccinazione ad altri gruppi a rischio ed è riproducibile in altre strutture e servizi che accolgono soggetti a rischio.

## ✪ Dosaggio della procalcitonina quale indice di fase acuta

G. Tommasi [1], F. Cardoni [1], G. Straface [1], V. D'alfonso [1], B. Virgilio [1], R. Cesareo [1], P. Del Duca [1], C. Cianfrocca [1], G. Zeppieri [1], A. Lentini [1], M. Lombardi [2], C. Alessandri [2], A. Maietta [1], G. Campagna [1]

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La procalcitonina, un peptide di 116 aminoacidi, precursore della calcitonina è diventato un nuovo indice di fase acuta che, per le sue caratteristiche, può essere usato come importante strumento diagnostico e prognostico in alcune condizioni come le sepsi e le infezioni batteriche in generale. Riteniamo che praticare regolarmente in tutti i casi di infezioni batteriche il dosaggio di tale indice, in un reparto di medicina interna come il nostro possa fornire ulteriori chiarimenti sul suo significato e possa consentire di perfezionarne l'uso.
A tale scopo abbiamo raccolto i valori di procalcitonina provenienti da 21 casi di soggetti affetti da sepsi derivanti da focolai sepsigeni localizzati in sedi diverse come endocarditi, infezioni urinarie e colecistiti calcolose acute.
I dati, confrontati anche con quelli della proteina c reattiva, sono ancora in fase di studio ma le prime risultanze sembrano confermare la sua tendenza ad essere particolarmente elevata nella sepsi, inoltre esso diminuisce in maniera più sensibile e più rapida, rispetto alla PCR, in caso di risposta ad una terapia antibiotica efficace. Questa ultima caratteristica può essere particolarmente utile nei casi di terapia antibiotica stabilita in maniera empirica quando non sia stato possibile ottenere una diagnosi supportata con certezza da un emocoltura o da un altro esame batteriologico.
In questa tabella abbiamo raggruppato i dati di tutti i pazienti esaminati e, nella seconda colonna, li abbiamo confrontati con quelli provenienti da campioni prelevati dopo l'inizio della terapia.

## Uno strano caso di splenomegalia, lesioni osteoaddensanti e shock anafilattico

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[1]UO Medicina Interna Ospedale di Pavullo nel Frignano Modena

Donna di 45 anni giunta al nostra osservazione per splenomegalia ad un esame ecografico, milza di 15x7x6 cm omogenea, eseguito per trauma toraco-addominale da schiacciamento. Unico dato anamnestico di rilievo: shock anafilattico da farmaci. Dagli esami bioumorali emergeva un quadro di anemia normocromica normocitica, VES, PCR e acido folico alterati. HCV, HBsAg, HbcAb, HIV, CMV, EBV, HSVI-II, Widal-Wright, ANA, ACE, Markers neoplastici negativi. Una TAC total body con mdc confermava la splenomegalia, segnalava adenomegalie sovrasottodiaframmatiche di 1 cm e in sede ascellare bilaterale di circa 2 cm, un utero aumentato di volume disomogeneo, un piccolo nodulo di 5 mm nel segmento laterale del lobo medio ma il dato di rilevo era la presenza di molteplici minute aree osteoaddensanti e prevalentemente steorarefacenti a carico dei metameri dorso-lombari e del bacino. Si proponevano ulteriori accertamenti tra i quali la BOM che permetteva di porre diagnosi di mastocitosi atipica, infiltrazione di mastcellule del 50%, con mutazione del c-KIT D816V presente e FIP1L1-PDGFRalfa assente. La PET captava in sede ascellare bilaterale, nella loggia tiroidea dx e nella parete gastrica. Completava la diagnostica con EGDS e biopsie, con ecografia e dosaggi ormonali e anticorpali della tiroide che risultavano negativi mentre l'rx scheletro in toto confermava le lesioni osteoaddensanti in tutti i segmenti ossei ed una piccola lesione osteolitica della tibia di dx; il dosaggio delle triptasi risultava marcatamente elevato. Per la rarità dell'emopatia si affidava all'Ematologia del COM.

## Flogosi dell'omento di non univoca interpretazione in paziente con LNH diffuso a grandi cellule B in corso di trattamento chemio-immunoterapico

S. Tonelli [1], G. Carrieri [1], G. Cioni [1]

[1]UO Medicina Interna Ospedale di Pavullo nel Frignano Modena

Uomo di 58 anni ricoverato per dolore all'arto superiore sx con irradiazione alla spalla. All'esame obiettivo si riscontrava una neoformazione laterocervicale dx, confermato alla TAC e alla RM che evidenziavano inoltre tessuto neoformato paravertebrale da C3 a D3 con interessamento dei forami di coniugazione ed estensione all'interno del canale midollare. LDH di 1272 U/L; HCV, HBsAg e HIV negativi. La linfoadenectomia laterocervicale poneva diagnosi di LNH B diffuso a grandi cellule. La BOM e le indagini correlate risultavano negative per linfoma così l'ecografia del testicolo e la TAC cerebrale con mdc. La TAC TAP con mdc segnalava adenomegalie sovra e sottodiaframmatiche, noduli del muscolo quadrato dei lombi sx, della sede sottocutanea del gluteo sx e una formazione solida di 5 cm adiacente al muscolo iliaco di sx; sedi PET positive. Conclusione: Linfoma diffuso a grandi cellule B a localizzazione extranodali stadio IV A IPI alto. Si proponeva: R-CHOP 6 cicli+2 cicli di R, profilassi del SNC con MTX IT 4 somministrazioni e RT palliativa sul rachide. Dopo il 3°ciclo R-CHOP e il 3° MTX IT, compariva febbre e addominalgia. Eseguiva una TAC TAP con mdc che mostrava un quadro di RP dll'emopatia mentre segnalava alcune anse ileali distese e un ispessimento ed aumento della densità del grande omento che veniva biopsiato la cui istologia risultava negativa per linfoma; le LDH erano normali e i colturali negativi. Iniziava prednisone e levofloxacina. Una TAC addome con mdc successiva mostrava una completa risoluzione del quadro associato a risoluzione della sintomatologia.

## Banale episodio amnesico in ambito geriatrico

A. Toschi [1], G. Paxia [1], A. Di Taranto [1], G. Bergamini [1], G. Carrieri [2], S. Tonelli [2], C. Graziosi [2], C. Cappi [2], C. Rontauroli [2], R. Bortolotti [2], G. Cioni [2]

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90enne inviata dal Curante per comparsa da 7 giorni di stato confusionale e amnesia.

**Anamnesi** Nefrectomia 30 aa fa per patologia non neoplastica. Pregressa isterectomia. Esame obiettivo in PS senza particolari elementi a parte lo stato di confusione/amnesia. PA100/60. Esami bioumorali: creatinina 2.8 mg/dl, PCR 2.2 mg/dl, Na142 mEq/L, K: 3,4 mEq/L, Cl 99 mEq/L, Ca 14.5 mg/dl; protidogramma con probabile componente Monoclonale. Esame urine: lieve proteinuria 50 mg/dl. TAC: presenza di lesioni puntiformi ischemiche pregresse ai nuclei della base in prevalenza a sn. Sfumata ipodensità della s. bianca perivetricolare.

Si inizia tp.con steroidi, idratazione, difosfonato, diuretici e correzione della kaliemia. Dopo alcuni giorni in cui la paziente presenta atteggiamento simil parkinsoniano, facies amimica, atteggiamento a volte distaccato, apatico, la paziente si risveglia, scompare lo stato di astenia e ricompare l' appetito, solo dopo TAC rachide si ha conferma di microlesioni osteolitiche diffuse allo scheletro (rx precedente negativo). Esegue BOM che conferma Mieloma Multiplo (stadio III). Si raccolgono: beta2-microglobulina > 27 mg/dl, Bence Jones positiva per la presenza di catene Kappa monoclonali. Aumento catene kappa libere plasmatiche. A causa di una ins.renale acuta dopo alcuni giorni la paziente decede.

**Conclusioni** Un quadro apparentemente banale di confusione in anziano etichettato come TIA risulta un complesso quadro di delirio da severa ipercalcemia paraneoplastica.

## ✪ Iatrogenic mesenteric vein thrombosis: a case report

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**Introduction** In looking for a thrombophylic condition we shouldn't underestimate drugs as possible causal agents.

**Case report** A 42 years old man was admitted for severe abdominal pain and massive rectal bleeding.

He had a clinical history of chronic acquired demyelinating polyneuropathy in treatment with intravenous immunoglobulins (IVIG), the last infusion of which had taken place 20 days before entry. On clinical examination the abdomen was tender, metheoric, peristalsis absent.

A CT scan evidenced complete superior mesentheric and splenic vein thrombosis (VT), partial inferior cava and portal VT with secondary venous intestinal infarction.

The patient personal and family histories were negative for VT, he had no concomitant illnesses held as thrombophylic. On the contrary the time relationship between the IVIG infusion and the intestinal infarction was relevant. In Literature we found more than one reports relating IVIG to venous and arterial thrombosis.

We also found that the patient had factor II gene mutation heterozygosis and increased serum omocysteine levels.

In conclusion we held this unusual site VT as provoked (adverse reaction to IVIG), in a patient with two minor congenital thrombophylic factors. Anticoagulant treatment was started with follow-up at six months.

**Conclusions** The distinction between provoked and unprovoked VT is essential in establishing the duration of an anticoagulant treatment. A careful pharmacologic investigation is of basic importance in patients with apparent unprovoked VT in order to avoid a useless and dangerous long-term treatment.

## A case of septic portal vein thrombosis: the role of bacteroides fragilis

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**Introduction** Portal vein thrombosis (PVT) without hepatic chyrrosis may be related to infective causes.

**Case report** We report the case of an 85 years old man admitted to the Emergency Unit for hyperpirexia associated with right upper quadrant and epigastric pain.
He had a clinical history of COPD (GOLD III) and hypertension; past gastric resection for early gastric cancer and right emycolectomy for cancer, pT2 N0.
On physical examination the abdomen was tender in the upper quadrant and hepigastric regions. Clinical signs (polypnea, increased heart rate, temperature >38°C) of SIRS were present as well as laboratory findings (CRP 19 mg/dl, procalcytonin 27 ng/ml) of sepsis. US examination showed partial PVT, the pathogenesis of which had to be defined.
There were no laboratory nor instrumental (CT scan, gastric and colonscopy) signs of an underlying hepatic chyrrosis nor of a neoplastic disease relapse. No congenital or acquired thrombophylia was present on screening except for blood coltures positive for Bacteroides Fragilis infection. This made us formulate a diagnosis of partial PVT in course of Bacteroides sepsis. Anthibiotic treatment as well as anticoagulation was started with a favourable clinical outcome on follow-up.
**Conclusions** In Literature a significant association between PVT and Bacteroides Fragilis bacteriemia is reported: the pathogenetic mechanism might be a transient hypercoagulability state. Such an association is so strong that some Authors recommend a systematic screening for PVT in case of proven Bacteroides Fragilis bacteriemia.

## Graves' thyreotoxicosis following Hashimoto's disease (HD)

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Rare cases of Graves' disease occurring years after chronic thyroiditis have been reported. We describe a rare case of simultaneous Graves' thyreotoxicosis and chronic hypothyroidism due to HD in a 55 years old woman treated with 75mg levothyroxin for 10 years. She presented neck pain, tremors, sweating, anxiety, heat intolerance, weakness and weight loss. We found 120 bpm heart rate, tender thyroid gland and tibial oedema. Laboratory showed: TSH<0.01 mcIU/mL (nL 0.30-4.00), FT4> 6.0 ng/dL (nL 0.8-1.70), FT3 19.6pg/mL (nL 1.8-5.0), TGab 165U/mL (nL 0-55), TPOab 470U/mL (nL 0-35), TSHRab 21.9U/L (nL 0-1), normal inflammatory markers. US showed enlarged homogeneous gland with mild hypervascularity. Scan showed an enlarged gland and spread trapping despite of LT4 replacement therapy. After LT4 stop we used high doses of thyreostatic treatment (thiamazole 30mg) added with prednisone 10 mg. After 2 month she was still in thyreotoxicosis although treatment.
**Discussion** We observed a rapid unexpected onset of thyreotoxicosis with high spread scan trapping in patient with HD, replaced with LT4. Literature mainly reports Graves' disease developing years before HD, in susceptible patient, after autoimmune changes. Autoimmune thyroid disorders can be related to genetic mediated mechanisms (HLA typing, clusters of gastric and adrenal autoimmunity, strong family history). In this case we can suppose that balance between activity of stimulating vs blocking antibodies could be impared by environmental factors, i.e. thyroid "disruptors" (patient born in polluted old dioxin area).

## Un insolito caso di melena

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Uomo di 47 anni affetto da epatopatia cronica HBV-relata, in follow-up presso UO di Malattie Infettive ed in terapia con entecavir. Da due anni febbricola, artralgie, polmoniti ricorrenti, calo ponderale di 20 kg, edemi declivi. Negli ultimi mesi comparsa di diarrea. Esegue TC addome con riscontro di linfoadenopatie mesenteriche, sospette per malattia linfoproliferativa per cui viene sottoposto a laparoscopia con prelievo di linfonodo addominale. Agli ematochimici anemia sideropenica, ipoalbuminemia marcata, verosimilmente non correlabile alla sola epatopatia, elevazione degli indici di flogosi. Viene sottoposto a EGDS, negativa per varici esofagee o altre fonti di sanguinamento attivo, segnalato aspetto biancastro della mucosa duodenale per cui vengono effettuati prelievi bioptici. Gli esami istologici effettuati sul linfonodo e sulle biopsie duodenali mostreranno marcata PAS-positività compatibile con morbo di Whipple. Dopo cinque giorni il paziente viene ricoverato presso la nostra UO per melena condizionante grave anemizzazione. La EGDS mostra sanguinamento a nappo nelle sedi dei pregressi prelievi bioptici. Agli ematochimici si esclude coagulopatia congenita e acquisita. Il paziente viene trattato con supporto trasfusionale, inibitori di pompa e terapia antibiotica con cotrimoxazolo. Dopo otto mesi presenta buone condizioni generali con miglioramento clinico, incremento ponderale, normalizzazione dei parametri bioumorali. Riteniamo opportuno segnalare questo caso in quanto rappresentativo di una complicanza rara in pazienti affetti da morbo di Whipple.

## Accessi venosi centrali sotto guida ecografica: un aiuto anche per gli Internisti

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Negli ultimi anni si è assistito all'invecchiamento della popolazione dei pazienti ricoverati presso i reparti di Medicina Interna con maggiore incidenza di polipatologie. Sono aumentate anche le possibilità terapeutiche con un incremento del livello di cura grazie all'utilizzo di farmaci un tempo appannaggio solo delle Terapie Intensive. La nostra Struttura consta di un reparto di Medicina ed uno di Lungodegenza con circa 600 ricoveri all'anno; la Terapia Intensiva di riferimento dista circa 20 Km. Fino alla metà del 2010 quando era necessario reperire un accesso venoso centrale dovevamo prendere accordi con gli Anestesisti dell'ospedale di riferimento spesso critici sulle indicazioni terapeutiche su pazienti talvolta molto compromessi; organizzare il trasporto con ambulanza e spesso con accompagnamento di un infermiere professionale. Durante il 2011 su 604 pazienti è stato necessario posizionare 16 CVC che sono stati inseriti mediante l'uso di guida ecografica da un medico del reparto appositamente formato. Non si sono verificate complicanze durante il posizionamento e non è stato necessario controllare RX torace eseguendo controllo ecografico. Si è evitato di spostare i pazienti con riduzione delle spese e si è iniziata la terapia al momento adeguato in tempi più rapidi. Per la nostra esperienza riteniamo utile per gli Internisti imparare a posizionare CVC soprattutto con l'uso di sonda ecografica che permette di ridurre le complicanze, "vedere" quello che si sta facendo ottenendo un miglioramento del livello terapeutico e talvolta degli outcome dei pazienti.

## Prevalenza di sintomi colici in una coorte di pazienti con intolleranza al lattosio

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**Introduzione** Vista l'elevata affinità dell'intolleranza al lattosio nei pazienti affetti da colon irritabile è stata valutata la prevalenza di sintomi colici in pazienti con intolleranza al lattosio.
Scopo dello studio Valutare la prevalenza dei seguenti sintomi intestinali: dolore addominale, meteorismo, stipsi e diarrea in pazienti affetti da intolleranza al lattosio dopo l'assunzione di latte e derivati.

**Metodi** Nell'anno 2011 circa 400 pazienti sono venuti nell'ambulatorio di gastroenterologia con sospetta intolleranza al lattosio. Tale intolleranza è stata valutata tramite H2 Breath test dopo somministrazione di 50 g di lattosio e prelievi di aria ogni 30 minuti per 4 ore. 250 pazienti che hanno eseguito il test (circa il 62% del totale) sono risultati positivi al test. Sono state valutate le schede di questi pazienti positivi per valutare la presenza dei seguenti sintomi colici: dolore addominale, diarrea, stipsi e meteorismo.
**Risultati** Il 90% dei pazienti positivi al test dopo l'assunzione di latte e derivati presentava meteorismo, il 70% presentava dolore addominale, il 50% presentava diarrea e il 30% stipsi. Inoltre solo il 12% dei pazienti presentava tutti e quattro i sintomi contemporaneamente, il 33% presentava dolore addominale + meteorismo + diarrea, mentre il 26% presentava dolore addominale + meteorismo + stipsi.
**Conclusioni** In pazienti che presentano sintomi intestinali soprattutto dopo l'assunzione di latte e derivati è utile eseguire un H2 Breath test al lattosio per escludere una eventuale intolleranza al lattosio.

## Prevalenza di pattern ecografico steatosico in pazienti con ipertransaminasemia in una coorte di 800 pazienti

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**Introduzione** La valutazione epatica tramite esame ecografico rappresenta attualmente una costante clinica nella valutazione diagnostica dei pazienti con ipertransaminasemia.
Scopo dello studio Valutare il riscontro di steatosi epatica in pazienti con presenza di ipertransaminasemia.
**Metodi** Sono stati esaminati circa 812 pazienti provenienti dal reparto di Medicina Interna ed Ambulatorio di Epatologia con aumento delle transaminasi. A tali pazienti è stata eseguita una ecografia epatica a scopo diagnostico. L'eventuale presenza di steatosi è stata categorizzata in lieve, moderata e severa. I pazienti erano poi suddivisi in base alla eziologia riscontrata. Veniva inoltre valutato il B.M.I, i valori di colesterolo e trigliceridi.
**Risultati** Il riscontro ecografico di steatosi era presente nel 62% dei pazienti con ipertransaminasemia indipendentemente dall'eziologia. Raggiungeva il 95% in pazienti con elevato B.M.I e presenza di dislipidemia. Nelle epatiti virali era presente nel 50% in pazienti con epatite B, il 56% nella epatite C (nel genotipo 3 l'80%). Nelle epatiti alcoliche la steatosi era presente nell'84%, mentre nelle epatiti autoimmuni nel 26%. Nelle altre ipetransaminasemie la steatosi era presente in circa un 32%. I dati presentati sono conformi alla letteratura. La tabella successiva riepiloga i risultati ottenuti.
**Conclusioni** La nostra esperienza clinica documenta come il reperto ecografico di steatosi sia un riscontro ad ampia prevalenza nelle patologie epatiche e causa di ipertransaminasemia indipendentemente dalla etiologia del disturbo epatico.

## ✪ Effect of Iloprost on pain-free walking distance and clinical outcomes in patients with IIb-stage peripheral artery disease non-eligible for surgery. The FADOI - 2bPILOT study

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**Introduction** Patients with peripheral arterial disease (PAD) at stage IIb, with pain-free walking distance (PFWD) less than 100 metres and unable to undergo revascularization have both impaired quality of life, and severe clinical outcome. Aim of the study was to evaluate the efficacy of the prostacyclin analogue iloprost, added to standard therapy, in these patients.
**Methods** In a multicenter study, patients were randomized to receive standard medical therapy (Group A) or standard therapy plus iloprost (Group B), for 12 months. Iloprost was administered for ten days every three months (0.5-2.0 ng/kg/min for 6 hours/day). Treadmill test was performed every three months, before starting the ten-day iloprost cycle (Group B).
**Results** Fifty patients in Group A and fifty-one in Group B were enrolled. At baseline, the two study groups were very similar as for mean age, concomitant diabetes and ankle-brachial index. By considering the last observation carried forward, PFWD was significantly higher in patients treated with iloprost (87.465.5 vs 127.3±70.3, $p< 0.01$). Major cardiovascular events occurred in 30% and 5.8% of patients in Group A and Group B ($p<0.001$). Five patients in Group A died, vs none in Group B. No serious unexpected adverse reactions occurred in patients receiving iloprost.
**Conclusions** Iloprost, in addition to standard therapy, significantly increases exercise capacity in patients with PAD at stage IIb. Of particular interest, the percentage of patients who died or experienced major cardiovascular events was significantly lower in patients receiving iloprost.

## ✪ Clinical predictors of in-hospital outcome in elderly patients with community acquired pneumonia

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**Background** Community acquired pneumonia (CAP) is a common reason for hospitalization in elderly patients. Many predictors of in-hospital outcome have been studied in general population with CAP; however definite data are lacking in the elderly population. This study sought to evaluate in-hospital prognostic predictors in patients older 65 years admitted with CAP.
**Methods and patients** A prospective study on patients over ≥ 65 years with CAP enrolled from January to December 2011 was conducted. Primary outcome was the composite of in-hospital mortality and/or clinical deterioration requiring ICU transfer.
**Results** We enrolled 108 patients (mean age 82.9±7.6, range 65-99 years). Main comorbidities were: CHF(37.5%), COPD(21.4%) , chronic renal failure(23.4%). Upper of ≥ 3 comorbidities was present in 41.6%. Mean CURB 65 score was 2.1±0.9 points. In hospital mortality was 10.1% and combined outcome occurred in 13.8%. At univariate analysis predictors of combined in-hospital outcome were: previous stroke (OR 1.3; 0.4-4.6 95% CI; p=0.01), delirium (OR 3.9; 1.3-12.1 95% CI; p=0.02), CURB 65 (OR 8.1; 2.4-26.9 95% CI; p=0.001).
**Conclusions** According to literature, predictors of in-hospital outcome in elderly patients with CAP were similar to those in the general CAP population. However, delirium was an independent risk factor for death in this elderly patients sample. Pending confirmatory results in larger cohorts, every effort should be oriented to in-hospital delirium prevention and treatment in view of its detrimental effect.

## Ectopic ACTH production and Cushing's disease: when the diagnosis is not straightforward

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Introduction Ectopic ACTH syndrome (EAS) is a rare but described paraneoplastic syndrome at times difficult to differentiate from Cushing's disease (CD). We report a case of EAS in a patient with conflicting results of endocrinological and imaging diagnostic tests challenging the diagnosis of EAS and CD.
Clinical course A 66-year-old man was admitted to our hospital for progressive resistant hypertension, weakness and severe back pain. He had typical cushingoid features with muscle wasting. Blood tests showed microcytic anemia, hypokalemia and uncompensated diabetes. A complete diagnostic evaluation for CD and search for neoplastic lesion was carried out. A peptic ulcer was detected by EGD; a spine X-ray showed osteoporosis with multiple vertebral collapses. Dynamic endocrine tests showed elevated plasma ACTH and cortisol levels, lack of their circadian rhythm, not suppressed by high-dose dexamethasone, but positive response to CRH. Pituitary MRI showed an equivocal small lesion. Inferior petrosal sinus sampling did not detect a gradient of plasma ACTH after CRH stimulation. Chest-CT scan showed two basal opacities in both lungs of possible infectious origin, uptaking contrast at PET scan. After days of progressive clinical deterioration, the patient died from infectious complications. Post-mortem a cytological examination from BAL was positive for carcinoid.
Conclusion This was a diagnostic challenging case with EAS indistinguishable from CD by various endocrine and imaging tests. Many tests lack of sensitivity and specificity and the diagnosis is difficult.

## Liver abscesses with portal thombosis

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Fever may be a challenging diagnosis in internal medicine. We present the case of a 62 years old man complaining of several weeks fever associated to night sweats, no signs on physical examination, laboratory tests showed elevated inflammatory markers, at US only mild iperechogenicity of liver. After two cycles of antibiotics with transient response, he was referred to us. Metabolically active multiple nodules in the liver with lymphonodes in abdomen at PET scan. At CT scan multiple subcentimetric ipodense hepatic nodules with no or minimal contrast enhancement and thrombosis of liver portal branches. We believed it was the case of liver abscesses with thrombophlebitis of portal vein, therefore we prescribed parenteral broad-spectrum antibiotics active on anaerobic organisms too and LMWH. The patient quickly improved , on the third day fever disappeared. After 4 weeks of therapy a CT scan reported a slight reduction of liver nodules and persistence of portal thrombosis. Laboratory test resulted within normal range. Patient was discharged home transitioned to oral antibiotic therapy up to 6 weeks , going on with LMWH. Liver abscesses with pylephlebitis are established complications of appendicitis in the young and diverticulitis in the adults. Our patient in the past suffered of a single episode of diverticulitis. PET scan must be viewed in the clinical context, if critically read it remains a diagnostic tool of value in the study of fever. Fever is an intriguing challenge for the internist. Only by the interaction between his clinical skills and modern imaging techniques is possible to get to correct diagnosis.

## Hospitalist: nuova centralità dell'Internista in Ospedale

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**Background and purpose of the study** We want to evaluate how the regular presence of a Hospitalist in an Orthopaedic Department changes the assistance to the population of ancient and complicated patients.
**Material and Methods** We examined the common parameters of Department function (number of admissions, days of hospitalization, in-hospital mortality). We also studied the consumption of drugs ( antibiotic ,opioids , alendronate ),the number of specialized consultations ( cardiologic and neurologic), the number of surgical infections, and the number of major haemorrhagic or thrombotic complications.
**Results** During the period of the Hospitalist work we observed a progressive reduction in the days of hospitalization, a reduction in in-hospital mortality, a reduce spending on antibiotics, an increased consumption of opioid, an increased consumption of drugs for osteoporosis, a reduction of all specialized consultations ,the absence of thrombotic or haemorrhagic complications, a reduced number of infective surgery complications.
**Conclusions** The regular activity of a Hospitalist in an Orthopaedic Department improves the global medical assistance offering better support to high risk and complicated patients. The Hospitalist guarantees a correct utilization of antalgic therapies, antibiotics, antithrombotic and osteoporosis drugs. Reduction in post –surgical complications results in higher survivals and lower healthcare costs.

## OEIGE S.Carlo 2011: overview of Candida infections

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Object of the study Candidiasis is an increasingly important nosocomial infection and despite the offer of new drugs mortality remains high. We studied the Candida species present in 2011 in our Hospital and the systemic Candida infections.
Materials and Method We examined all Candida isolations ,all Candida systemic infections, the drug sensibility, the characteristic of systemic infected patient (age , sex, comorbidities, department of delivery), the mortality rate . We studied also the anti mycotic drugs employed in each Department.
Conclusions We observed 5 BSI ( Blood Stream Infections) cases on 1000 Hospital admission, 52% of Candida spp were non albicans,the higher percentual ( 5% ) fluconazolo resistant Candida spp was in ICU and in Internal Medicine Department , the higher percentual of crude mortality rate was in Surgery Department (55%) and Internal medicine ( 48%). All the patients had High Candida score. Catheter was the most significant extrinsic risk factor. The most used drugs were fluconazole and Anfotericina B despite the introductions of echinocandine and the suggestions of new ISDA guidelines.

## Spontaneous tumor lysis syndrome in accelerate myelofibrosis

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Tumor lysis syndrome (TLS) is an oncologic emergency that is caused by massive tumor cell lysis with the release of large amounts of potassium, phosphate, and nucleic acids into the systemic circulation. Catabolism of the nucleic acids to uric acid leads to hyperuricemia, and a marked increase in uric acid excretion can result in the precipitation of uric acid in the renal tubules and acute renal failure. Hyperphosphatemia with calcium phosphate deposition in the renal tubules can also cause renal failure.

TLS most often occurs after the initiation of cytotoxic therapy in patients with high-grade lymphomas (particularly the Burkitt subtype) and acute lymphoblastic leukemia. However, TLS can occur spontaneously and with other tumor types that have a high proliferative rate, large tumor burden, or high sensitivity to cytotoxic therapy.
We report a case of TLS occurred spontaneously in a women affected by myelofibrosis post polycithaemic
Treated with hydrosiurea in accelerated phase with fast increase of leucocytosis.

## Listeria meningoencephalitis in a women with myelo- and lymphoproliferative disease

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The coexistence of chronic lymphocytic leukemia (CLL) and myeloproliferative neoplasms (MPN) has been sporadically reported in the literature and recently a review of this association is reported with demonstration that the risk of developing LPN is significantly increased in MPN patients compared with the general population.
We report a case of association af myelofibrosia with chronic lymphatic leukemia complicated by Fatal Listeria meningoencephalitis.

## Efficacia dell'Anakinra nella terapia della febbre mediterranea familiare con insufficienza renale

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**Premesse e scopo dello studio** La Febbre Mediterranea Familiare (FMF) è caratterizzata da attacchi ricorrenti di febbre e flogosi sistemica, con possibile comparsa a lungo termine di insufficienza renale (IRC). La terapia di scelta è rappresentata dalla colchicina, che previene gli attacchi flogistici nel 90% dei casi. La colchicina è inefficace nel 10% dei casi e tossica nella IRC. L'interleuchina 1β (IL-1β) è centrale nella patogenesi della FMF, per cui Anakinra, un biologico anti IL-1β, risulta efficace nel controllare la FMF, anche a dosi ridotte per l'IRC.
**Materiali e metodi** Descriviamo il caso di un maschio, 63 anni, affetto da FMF (omozigote per M694V), e nefropatia diabetica, in trattamento da lunga data con colchicina 2 mg/die. Dal 2008 comparsa di diarrea cronica, effetto collaterale della colchicina, e successiva comparsa di rabdomiolisi e pancitopenia. Ridotto il dosaggio della colchicina a 1 mg/die, per la funzionalità renale, risoluzione dei sintomi da tossicità del farmaco e normalizzazione dei valori degli enzimi muscolari, ma ripresa degli attacchi di FMF. Il paziente iniziava quindi terapia con anti-IL1 β alla dose di 100 mg s.c. ogni 2 giorni.
**Risultati** Controllo ottimale degli attacchi flogistici con riduzione degli indici di flogosi. Il follow up di 12 mesi mostra persistente remissione degli attacchi di FMF.
**Conclusioni** Abbiamo documentato sicurezza ed efficacia dei biologici anti IL-1β per ottenere un controllo ottimale della FMF e per prevenire la tossicità da colchicina, anche in presenza di insufficienza renale.

## Il corretto uso del Ca 19-9: una paziente alla ricerca della sua diagnosi

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**Premesse e scopo dello studio** Nella medicina moderna si accrescono informazioni e strumenti per una rapida identificazione e cura della malattia. Tuttavia, la ricerca frenetica di una diagnosi, associata alla situazione economica attuale, sta portando a perdere di vista la nostra missione principale: il paziente.
**Materiali e metodi** Descriviamo il caso di una donna, 65 anni con astenia da circa 6 mesi. Agli esami ematochimici anemia, modico aumento di ALT e di CA 19-9 e CEA, nella norma creatinina, ferritina e folati, sangue occulto negativo in 3 campioni. Due colonscopie in regime di ricovero, di cui una in narcosi per intollaranza all'esame, risultate negative, in dimissione diagnosi di dolicocolon, senza ulteriori indicazioni. Per la persistenza dell'astenia, veniva consultato un internista che rivalutata l'anamnesi, con esordio caratterizzato da mialgia, astenia, stipsi; e valutati esami ematochimici che documentavano ipercolesterolemia con elevati valori di CPK, assenza di indici di flogosi e di autoimmunità, formulava l'ipotesi di ipotiroidismo, confermato dagli esami richiesti. Anti TG e anti TPO elevati portavano a diagnosi di tiroidite di Hashimoto pertanto iniziava terapia con l-tiroxina con beneficio, e normalizzazione dei valori di CA 19-9.
**Risultati** Un'anamnesi incentrata sul sintomo astenia del paziente invece che sul Ca19-9, avrebbe evitato un ricovero inappropriato ed esami inutili e costosi.
**Conclusioni** Il CA 19-9 non andrebbe utilizzato per ricercare neoplasie, poiché può essere aumentato in numerose altre condizioni tra cui l'ipotiroidismo.

## Anemia macrocitica e gastrite atrofica: un caso clinico

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**Premesse e scopo dello studio** Le sindromi mielodisplastiche sono definite un gruppo eterogeneo di disordini clonali del midollo osseo caratterizzati da emopoiesi inefficace di tipo displastico e da un rischio variabile di trasformazione leucemica. L'incidenza varia fra 3 e 12 casi/100000 annui.
**Materiali e Metodi** Donna di 81 aa, anemia da circa 10 aa; ripetuti ricoveri in Medicina, trattata con folati e vit.B. Negli ultimi mesi non responsività alla terapia. Presenta Psoriasi e poliartralgie. All'atto del ricovero: Hb 8.3%, Hct 24.7%, GR 2.810.000; MCV 113.0, MCH 38.1, RDW 29.7, VES 75, Sideremia 151, Ferritina 822, Panel reumatologico negativo. Eco addome: steatosi epatica , milza nella norma. Il quadro ematologico non migliora pur aggiungendo eritropoietina 4.000 UI la settimana. Viene sottoposta ad aspirato midollare che evidenzia quadro istologico compatibile con sindrome mielodisplastica del tipo anemia refrattaria; Citogenetica: non alterazioni numeriche e strutturali dei cromosomi. Dimessa con terapia a base di Eritropoietina 40.000 UI la settimana.
**Risultati** Tale patologia è determinata da emopoiesi inefficace dell'eritrone fino al blocco maturativo completo delle cellule ematopoietiche staminali e di quelle più differenziate, con conseguente proliferazione leucemica.
**Conclusioni** Nell'anziano con anemia, sopratutto macrocitica, la mielodisplasia va sempre sospettata. Un dato epidemiologico sicuro è l'aumento di incidenza correlato all'età, il che fa delle mielodisplasie un problema essenzialmente geriatrico.

## Iperosmolarità in corso di intossicazione acuta da alcool

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**Introduzione** I sintomi neurologici dell'intossicazione acuta da alcool sono variabili e solo parzialmente correlati con l'alcoolemia (ALC). L'intossicazione da alcool porta ad un aumento dell'osmolarità (OSM) plasmatica. Riportiamo una casistica di pazienti (pz) giunti in PS per intossicazione acuta da alcool, per valutarne dati di laboratorio (ALC e OSM) e la loro correlazione con la presentazione clinica.
**Materiale e metodi** Sono stati analizzati:stato di coscienza [AVPU (Alert, Voice, Pain, Unresponsive)],ALC,calcolo della OSM mediante la formula:2[Na]+[glucosio]/18+[urea]/2.8+ [alcool]/4.6.ALC>300 mg/dl significativa per intossicazione severa; OSM normale ≤295 mOsm/l.
Risultati Sono stati studiati 182 pz;AVPU:A 64%,V 24%,P+U 12%. L'ALC era aumentata con la severità neurologica; l'OSM era significativamente più alta nei pz con alterazioni dello stato di coscienza. In 43/64 pz con alterazione dello stato di coscienza l'ALC era <300 mg/dl,in questi pz l'OSM era >295 mOsm/l nel 65% dei casi.
**Conclusioni** I valori di ALC solo in parte correlano con le alterazioni dello stato di coscienza. L'OSM mostra un'alterazione nella quasi totalità dei casi. E' stata riscontrata una OSM elevata in pz con ALC <300 mg/dl ma con alterazioni dello stato di coscienza. L'iperosmolarità potrebbe quindi essere un cofattore determinante lo stato di coscienza. Tale aspetto deve essere tenuto in considerazione, soprattutto per interpretare in modo più completo le alterazioni dello stato di coscienza che probabilmente non sono solo legate a livelli di ALC ma a più complesse modifiche dell'omeostasi.

## La glicemia non può attendere. Analisi di un errore preanalitico

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**Obiettivo** Verificare se gli esami ematochimici subiscono variazioni rilevanti stazionando in reparto dopo il prelievo (PR).
**Materiali e metodi** In 50 pz sono stati eseguiti PR in doppia quantità per l'analisi di 3 tipi di provette: emocromo,biochimica (glucosio, Na, K, CPK) e coagulazione (PT).Un primo set di provette (PR1) è stato inviato subito in laboratorio e quindi processato. Un secondo set (PR2) è stato inviato dopo un'attesa per un periodo variabile di tempo.Sono stati calcolati:la differenza di valore fra i due PR (Δ), le medie±DS dei valori, lo scostamento >5% del Δ rispetto al PR1.
**Risultati** Non vi erano differenze significative fra i valori medi dei due PR. Vi erano scostamenti > 5% significativi per K, piastrine e glicemia. Per K e piastrine lo scostamento era distribuito in modo variabile fra Δ + e -; per la glicemia lo scostamento era solo per Δ -:cioè il PR2 mostrava sempre glicemie più basse rispetto al PR1. Il Δ delle glicemie era correlato con l'aumentare del tempo fra i due PR; era significativa un'attesa >60 min. In 20 pz il Δ glicemico era >10 mg/dl. In 4 pz la glicemia del PR2 era <70 mg/dl:portando a una diagnosi erronea di ipoglicemia non reale (nel PR1 sempre >70 mg/dl). In altri 2 pz la cui glicemia al PR1 era >126 mg/dl, nel PR2 il valore era inferiore e quindi verrebbe tralasciata la necessità di iniziare l'iter diagnostico per la presenza di diabete.
**Conclusioni** Ritardare l'esame della glicemia oltre 60 min porta a significativi valori più bassi. Una conoscenza del problema può evitare una non corretta interpretazione del dato di laboratorio.

## Un caso di polmonite a eziologia inaspettata

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**Caso clinico** Un uomo di 76 anni giungeva alla nostra osservazione per iperpiressia, astenia, iporessia e tosse secca con obiettività polmonare di fini rantoli medio-basali a sx. Veniva avviata terapia antibiotica empirica con Levofloxacina e Piperacillina/Tazobactam, mentre pervenivano gli esiti delle indagini sierologiche che escludevano tra i possibili agenti eziologici legionella, mycoplasma pneumoniae, clamidie, VRS, virus influenzali e parainfluenzali, adenovirus, EBV, HBV e salmonella. La TC evidenziava la presenza a sx di uno sfumato addensamento a vetro smerigliato. Dagli esami ematochimici emergeva un deficit di CD 4 con sierologia HIV negativa. Il Paziente veniva sottoposto a broncoscopia con esecuzione di BAL, nel quale si rilevava la presenza di ovocisti di Pneumocystis carinij. Veniva pertanto somministrata terapia con Trimetoprim/Cotrimossazolo con defervescenza e risoluzione dell'obiettivita' polmonare. La TC a 2 mesi dall'episodio acuto mostrava risoluzione dell'addensamento, mentre persisteva linfopenia, con conta CD4 comunque superiore a 200/mmc.
**Conclusioni** La linfopenia potrebbe giustificare la comparsa di una infezione opportunistica nel nostro Pz in assenza di altri fattori di rischio noti. Il caso clinico presentato è suggestivo per una linfocitopenia CD4 + T idiopatica che si caratterizza appunto per un riscontro di CD4 inferiori a 300/mmc in almeno due occasioni nel corso di sei settimane di osservazione, in assenza di infezione HIV, terapie immunosoppressive o altre forme di immunodeficienza.

## Un insolito caso di emoftoe

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Una paziente rumena di 46 anni ,é stata ricoverata nel nostro reparto (10/2011) per peggioramento di emoftoe, sintomo presente da 3 anni. In anamnesi TBC polmonare nel 1996 pluri-trattata con fibrotorace residuo, insufficienza repiratoria cronica,bronchiectasie, Ricovero in Romania per emoftoe ,positività dell'escreato per Staph.Aureus non meticillino-resistente ,trattato con chinolonici e gentamicina.
All'esame obiettivo all'entrata in reparto reperto polmonare normale a destra, a sinistra netta ipofonesi con murmure ridotto,sfregamenti pleurici anteriori.
**Esami strumentali** Alla scintigrafia polmonare polmone sinistro non perfuso, di volume ridotto,alla TC retrazione emitorace sinistro, bronchiectasie, area ascessualizzata di aspetto colliquato,alla spirometria diffusa compromissione delle piccole vie aeree.
Broncoscopia: stenosi cicatriziale del segmentario anteriore sinistro,al bronco-aspirato BAAR negativo, positiva la ricerca di ife micotiche, positivo galattomannano su BAL. Paziente apiretica, unico episodio di emoftoe dopo l'esame broncoscopico, iniziato trattamento con voriconazolo prima e.v., poi per os. In relazione al non significativo miglioramento della Tc, praticata (1/2012) pneumonectomia sinistra, all'esame istologico bronchiolite cronica, area cavitaria fibrosa con accumuli di ife fungine settate, pachipleurite cronica con fibrosi.Questo caso ci mostra una complicanza fortunatamente rara (infezione ascessualizzata da aspergillo), di fibrotorace da infezione tubercolare ,complicanza potenzialmente letale e che ha reso necessaria la pneumonectomia.

## Pressure-relieving mattresses at the Clinical Medicine Department

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**Background** Anti-bedsores surfaces are made up of various types of media or devices designed to prevent bed-sores. In our clinical medicine department we introduced anti-bedsore mattresses as fixed leases based on the rental cost of the previous year. The aim of this study is to evaluate if an HTA approach could influence the process of introduction of this technologies.
**Methods** We choice an approach mini-HTA. We performed a revision of literature on the efficacy and on risk assessment of anti-ulcer tools, and an analysis of the costs of the devices and dressings, used for the prevention and treatment of pressure ulcers. A prevalence study on number of ulcers and patient at risk for pressure ulcer was also conduct.
**Results** Literature on effectiveness and comparison of various devices is poor. In addition, there are no validated instruments for making appropriate choices for individual patients. The fixed lease vs leasing on demand helped reduce single unit costs, but the choice of type and quantity of aids was not supported by an effectiveness evaluation, resulting in an overall expenditure increase.
**Conclusion** Finally, in prevision of upcoming bids, it was decided to keep the same number of mattresses but to use two risk types only. An HTA approach was able to support and modify the process of introduction of the technology but it is difficult to apply at the department level, in the absence of a dedicated structure. It is important to sensitize decision makers and stakeholders to the need to introduce tools to evaluate effectiveness, and appropriateness before the introduction of health technologies.

## Ascessi cerebrali multipli dopo embolizzazione di aneurisma del sifone carotideo

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**Premesse e scopo dello studio** Il trattamento delle patologie vascolari intracraniche è in incremento e le complicanze più frequenti sono emorragiche e tromboemboliche. La formazione di ascessi cerebrali dopo procedure di embolizzazione è molto rara.
**Materiali e Metodi** Donna di 47 aa con aneurisma del sifone carotideo bilaterale. Nel 2009 viene trattata con embolizzazione e stent a dx. Nel 2011 posiziona stent a sx senza procedura di embolizzazione per conformazione anatomica dei vasi. L'RM encefalo un mese dopo la procedura mostra la presenza di noduli cerebrali con impregnazione a cercine sospetti per secondarismi o ascessi. La Paziente (pt) è apiretica, asintomatica. Emocolture, urinocoltura, oncomarkers, quantiferon e test per connettiviti risultano negativi. Alla TC torace nodulo apicale con centro cavitato. PET negativa. BAL negativo per BK. Eco cuore TE negativo.
**Risultati** Nel sospetto di ascessi la pt è stata trattata per 6 settimane con levofloxacina e meropenem ev, successivamente con linezolid e levofloxacina per os per 2 mesi. Ai controlli RM successivi progressiva riduzione delle lesioni.
**Conclusioni** Le complicanze infettive dopo procedure endovascolari sono rare, favorite da gestione impropria del device e durata della procedura. L'encefalomalacia periembolizzazione può comportare un danno della barriera ematoencefalica e favorire la batteriemia. Gli ascessi cerebrali possono comparire da 4 mesi a 10 anni dalla procedura. Stafilococco aureo e pseudomonas aeruginosa sono i patogeni più implicati. L'uso profilattico di antibiotici ev può prevenire la batteriemia.

## Anemia reveals bone fracture that caused it

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**Background** Patients hospitalized in departments of internal medicine sometimes have anemia that often has a multifactorial etiology that, in some cases, is misunderstood.
**Case report** 84 years old man with left hip trauma caused by accidental falls. Left hip + pelvis x-ray: thin compound fracture of left ischium-pubic branch. Hospitalized in orthopedics and after three days at our department. History: atrial fibrillation, previous TIA, treated with warfarin. Blood chemistry: progressive anemia: Hb from 13.4 to 9.2 g/dl, increased reticulocytes, normal: WBC, PLT, Fe, ferritin, folate, vitamin B12. Fecal occult blood test: negative. Physical examination, chest x-ray, abdomen echo: no significant alterations. During hospitalization: beginning rehabilitation cycle; not highlighted external blood loss; suspended warfarin; due to the absence of causes which could support the anemia and to exclude hematomas in the region of trauma, we thought to perform CT pelvis: in addition to the first thin fracture, detection of a more important compound left ilium fracture with multiple rhymes and acetabular involvement; orthopedic consultation: stop rehabilitation and still in bed; at discharge: no left hip pain, Hb 11.4 g/dl, resumed warfarin.
**Conclusions** 1) progressive anemia, after left hip trauma, due to blood loss secondary to fractures, since other causes haven't been documented, nor macroscopic bleeding, 2) importance of performing CT pelvis to discover a second fracture, to stop the load and to prevent other complications which probably would have required surgery.

## Transient bisalbuminemia related to cholestatic jaundice

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**Background** Bisalbuminemia is a rare hereditary or acquired condition characterized by the presence of two albumin bands in serum electrophoresis. The acquired form are due to exogenous alteration of the albumin structure that changes its electrophoretic mobility .
**Case report** A 79-year-old man was admitted for jaundice and pruritus associated with elevation of bilirubin (19.80 mg/dL), GT (1308 U/L), alkaline phosphatase (950 U/L) , AST(242 u/L) and ALT (233 U/L). Amylase and lipase in the normal range. Hepatitis A, B , C serologies and ANA, SMA, ANCA were negative. ECHO and MRI were normal. Six weeks before he had started ticlopidine for CHD. A diagnosis of ticlopidine-induced hepatitis was formulated and prednisone was started. The serum protein electrophoresis showed two distinct albumin bands, the first band with the mobility of the normal albumin, the second band with a slow variable. In the course of the disease the second band, parallelly with the highest grade of cholestasis, became more prominent and disjoined from the first band.Three weeks later, when the clinical and laboratoristic parameters were normalized, the second band disappeared and the serum electrophoresis returned to normal.
**Conclusion** The transient bisalbuminemia observed in our patient may

be due to the binding of high bilirubin levels, or to the action of liver enzymes altering the properties of serum albumin. The clinical relevance of bisalbuminemia has not been established and it has not been defined yet how albumin variant may affect the binding affinities of several molecules, hormones and drugs.

## A twice-daily antihypertensive drug assumption promotes circadian blood pressure pattern in elderly hypertensive patients

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**Aim** Many trials have documented that ingesting at least one antihypertensive drug at bedtime, compared with treatment with all medication upon awakening, is associated with increased blood pressure (BP) control. We evaluated if morning and evening antihypertensive medication assumption allows the same result in a population of ambulatory hypertensive elderly patients without overt heart diseases.
**Methods and results** All patients consecutively referred to our cardiologic clinic in the period from January 2005 to August 2009, were enrolled in the study and underwent a 24-hour ambulatory arterial pressure monitoring (ABPM). Four hundred and one patients were enrolled of which 187 (46.6%) were men and 214 (53.4%) were women (mean age 77.7±11 years). Hypertension was not adequately controlled in 290 (72.3%) patients and 281 out of 401 (70%) were non dippers; patients who were taking a single antihypertensive medication during the morning presented a higher night:day ratio of BP in comparison to a twice-daily, morning and evening, assumption (0.98±0.11 and 0.94±0.11 respectively, p=0.006). During the 50±14 months year follow-up, there were 34 death for cardiovascular (CV) diseases; thirty (88%) of them were non dipper (p=0.016).
**Conclusion** In our elderly study, non dipping pattern of BP is common and associated with CV death and with a once daily morning antihypertensive therapy. A twice daily assumption of antihypertensive drugs (morning and evening) promote a bedtime decline in BP toward a dipping pattern and a better BP control.

## Thrombotic microangiopathy: onset of advanced gastric cancer

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A 39 years old woman has had fever and worsening dyspnea. The blood tests documented severe normocytic anemia and thrombocytopenia, elevated levels of LDH, transaminases, reticulocytes and indirect bilirubin. Peripheral blood smear revealed numerous schistocytes. It was diagnosed a thrombotic microangiopathy (TM) and was started plasma-exchange. Meanwhile, she was subjected to further investigations (CT scan, bone marrow biopsy, endoscopy) with evidence of diffuse gastric cancer with bone-marrow infiltration and peritoneal carcinomatosis. Plasma-exchange was stopped and, despite the poor conditions and cytopenia, chemotherapy with 5-fluorouracil continuous infusion was started. We assisted to a rapid improvement in blood counts and general condition, and she could be discharged with the program to start chemotherapy with ECF (epirubicin, cisplatin and infusional 5-fluorouracil) as outpatient. When TM is found, promptly investigations are necessary to differentiate the idiopathic forms (TTP, thrombotic thrombocytopenic purpura or Moschowitz syndrome) from the secondary ones. TTP is usually associated with severe deficiency of ADAMTS-13 (usually due to the presence of acquired autoantibodies against the enzyme) causing excessive accumulation of ultra-large vWF multimers and platelet aggregation with organ failure. In this case is mandatory to start plasma-exchange as soon as possible. TM secondary to cancer are frequently associated with gastric adenocarcinoma and bone marrow infiltration, while plasma-exchange is generally ineffective.

## Impact of inflammatory parameters and lipids on subclinical atherosclerosis in well controlled hypertensives

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**Objective** To evaluate structural and functional characteristics of the arterial wall in a cohort of hypertensives with well controlled blood pressure (BP) levels.
**Methods** We studied 30 grade I / grade II hypertensives by assessing the B-mode ultrasound of mean carotid intima-media thickness (mean-IMT) and maximum IMT (M-MAX) in carotid artery (common, bulb, internal), bilaterally. Endothelial function was evaluated by flow mediated dilation (FMD) of the brachial artery. Along with traditional risk factors, we focused on the impact of serum hs-CRP, TNF-a, IL-6, VEGF, and osteoprotegerin (OPG). Office BP was taken three times at the time of the study.
**Results** Demographic data: age 48±10 years, BP 132±12/83±8 mmHg, LDL-cholesterol 142±37 mg/dl, triglycerides 108±56 mg/dl, HDL-cholesterol 50±12 mg/dl. The average IMT was within the normal range (mean-IMT 0.68 mm, M-MAX 0.79 mm) whereas FMD was impaired (6.4%). In multivariate analyses it turned out that IMT values were related to age, hs-CRP, and OPG in particular. LDL-cholesterol was the only factor related to FMD. There was no relationship of IMT and FMD with BP levels.
**Conclusions** In our hypertensives with well controlled BP, the pro-atherogenic remodelling (IMT) is mainly dependent upon age and inflammatory cytokines, OPG in particular. The functional impairment of the arterial wall (FMD) are related to levels LDL-cholesterol. Under these conditions, when the impact of BP is minimized, the role of inflammatory cytokines and lipids on structural/functional remodelling becomes predominant.

## Introduzione dell'ABI nella stratificazione del rischio cardiovascolare nel paziente iperteso

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**Premessa dello studio** l'indice caviglia braccio è il rapporto ottenuto tra la pressione sistolica rilevata alla caviglia e quella rilevata al braccio ed è alterato precocemente nell'arteriopatia obliterante periferica (AOP) prima della comparsa dei segni e sintomi tipici della malattia. Dal 2007 è inserito fra gli esami utili nella stratificazione del rischio CV del paziente iperteso. L'ABI è normale se compreso tra 0,9 e 1,29 mentre è patologico se <0,9.
**Materiali e Metodi** Da agosto 2010 a gennaio 2012 abbiamo sottoposto ad ABI 274 pazienti ipertesi afferenti al nostro centro con almeno una delle seguenti caratteristiche: età >70 anni, cardiopatia ischemica nota, diabete mellito, insufficienza renale, ateromasia carotidea, pregresso ictus o TIA, aneurisma dell'aorta addominale, fumo di sigaretta, dislipidemia. La valutazione è stata eseguita con un sistema automatico validato (ABI SYSTEM 100) che ne permette il calcolo attraverso metodica oscillometrica misurando contemporaneamente

la pressione arteriosa alle caviglie e alle braccia determinandone il rapporto.
**Risultati** Dei 274 pazienti selezionati 48 avevano un ABI mono o bilateralmente <0,9 (17,5%).
**Conclusioni** L'introduzione di questa metodica in pazienti selezionati permette di ottenere, a completamento della valutazione ambulatoriale, una migliore stratificazione del rischio CV aumentando il numero di diagnosi di AOP fino ad oggi sottostimate.
Ha consentito, inoltre, di porre indicazione corretta all'esecuzione di ecocolordoppler arterioso oltre che ottimizzare la terapia medica e il follow-up dei nostri pazienti.

## Sindrome di Tako-Tsubo e Morbo di Still dell'adulto: descrizione di un caso

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**Descrizione del caso** Donna di 68 anni ricoverata per astenia, febbre e sospetta pancreatite. In anamnesi colecistectomia per litiasi e ricoveri per pancreatite acuta sine causa; 10 mesi prima del ricovero comparsa di artralgie diffuse per cui nel sospetto diagnostico di artrite reumatoide sieronegativa ad esordio senile si iniziava terapia con metilprednisone sospesa 1 mese prima del ricovero. Gli esami eseguiti durante il ricovero hanno mostrato rapida normalizzazione delle amilasi sieriche, persistente leucopenia, elevati livelli di ferritina (>2000 ng/mL) e LDH (1582 U/L). Durante il ricovero comparsa di febbre intermittente fino a 40°C, accompagnata da rash fugace eritematoso al tronco; gli accertamenti escludevano patologia infettiva, autoimmune e linfoproliferativa. In occasione di un rialzo febbrile comparsa di insufficienza cardio-respiratoria acuta con dolore toracico associata ad aumento di troponina ed alterazioni elettrocardiografiche ischemiche a sede anteriore con ipo-acinesia apicale all'ecocardiogramma. La coronarografia documentava coronarie indenni mentre la risonanza magnetica cardiaca era compatibile con Sindrome di Tako-Tsubo. E' stata elaborata diagnosi di Morbo di Still dell'adulto ed intrapresa terapia steroidea con rapida risoluzione del quadro clinico e normalizzazione nel follow-up a tre mesi dell'emocromo, della ferritina e dell'LDH.
**Commenti** Descriviamo per la prima volta l'associazione di Sindrome di Tako-Tsubo con il Morbo di Still dell'adulto.

## Un fulminante caso di morbo di Graves

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**Premessa** Il morbo di Graves è caratterizzato da un anticorpo diretto contro il recettore tiroideo per il TSH con stimolazione continua della ghiandola e sintesi di quantità eccessive di T4 e T3. I pazienti con morbo di Graves possono andare incontro alla crisi tireotossica, evento a volte mortale, caratterizzata da alterazione dello stato di coscienza sino al coma, ittero, aritmie, febbre.
**Caso clinico** Donna di 42 anni ricoverata per perdita di peso da 2 mesi, in anamnesi ipertirodismo da tempo non più in trattamento: all'ingresso febbrile, soporosa, esoftalmo, tachicardia, edemi pretibiali, al laboratorio aumento di bilirubina, azotemia, sodio, CPK, FT4,FT3, elevati valori di antiperossidasi, TSH soppresso.
**Considerazioni** La presentazione clinica e i dati di laboratorio orientano per una evidente situazione di grave ipertiroidismo non controllato con crisi tireotossica in corso, nonostante il tempestivo ripristino della terapia antitiroidea, dei beta bloccanti e della reidratazione il decorso in Ospedale si è risolto con l'exitus della paziente dopo appena 48 ore. Questo caso è di insegnamento circa l'elevato rischio a cui sono esposti i pazienti con ipertiroidismo, la sottovalutazione del problema è a volte fatale.

## Un insolito caso di encefalite

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Si definisce encefalite un processo infiammatorio che colpisce l'encefalo, le cause possono essere diverse, infettive, tossiche, ipersensibilità e altre. La presentazione prevede disturbi dello stato di coscienza con obnubilamento, confusione mentale, o stati di eccitamento, segni di focolaio come aprassie, afasie, agnosie, epilessia, disturbi della motilità, della sensibilità, e segni di irritazione meningea come dolore e rigidità nucale.
**Caso clinico** Paziente di 60 anni ricoverata per sospetto ictus, in anamnesi diabete e ipertensione, all'ingresso agitata, afasia completa, non deficit motori di lato, TAC positiva per ischemia frontale, a casa febbrile da diversi giorni. Da un attenta rivalutazione della paziente si evince rigidità nucale e il secondo giorno compaiono crisi tonico-cloniche, viene effettuata una RMN encefalo che mostra lesioni da encefalite in assenza di fatti vascolari, quindi trasferita in Rianimazione dove effettua la rachicentesi.
**Considerazioni** Il dato anamnestico va sempre saputo indagare, spesso la clinica è mascherata da evidenze fuorvianti, come accade con la punta di un iceberg.

## Un caso clinico di leptospira ittero-emorragica

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**Premessa** La rabdomiolisi è una condizione in cui le fibre muscolari scheletriche demoliscono le proprie proteine riilasciando nel sangue CPK e mioglobina, le cause sono tre, eccessiva richiesta energetica (iper-ipotermia, ischemia, disturbi metabolici, convulsioni) danno muscolare diretto, interazioni tra farmaci (CYP 450).
**Caso clinico** Uomo di 46 anni ricoverato per improvvisa comparsa di dolori agli arti inferiori, in anamnesi diabete mellito non insulino dipendente. All'ingresso lievemente febbrile, itterico, epatosplenoegalia, marezzature agli arti, diuresi contratta, al laboratorio CPK aumentato, iponatriemia, piastrinopenia, indici renali alterati; il paziente per l'instaurarsi di una instabilità del quadro emodinamico con grave insufficienza respiratoria venne trasferito in Rianimazione, la ricerca degli anticorpi antileptospira successivamente effettuata risultò positiva.
**Considerazioni** L'infezione da leptospire decorre nella maggior parte dei casi in modo del tutto inapparente tanto che è difficile stimare l'entità della quota di queste infezioni , la variante ittero-emorragica, morbo di Weil, è la più grave di tutte e l'insufficienze renale da massiva rabdomiolisi può essere a volte fatale se non tempestivamente individuata.

## Efficacia del trattamento con l'analogo del GLP-1 liraglutide in una coorte di pazienti con diabete tipo 2

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**Introduzione** L'analogo del GLP-1 Liraglutide agisce sul compenso glicemico ed è efficace nel calo ponderale. Si riportano i dati di efficacia a lungo termine su una coorte di pazienti T2DM seguiti presso tre Centri in Regione Veneto.
**Metodi** I dati sono stati analizzati al baseline e a 8 e 12 mesi di trattamento. Le variazioni sono state valutate statisticamente mediante Wilcoxon T-test.
**Risultati** Caratteristiche al baseline: N=94, M=56%, età 56.1(8.5)y, durata diabete 9.1(6.1)y, terapie associate Met (94%, di cui 35%+SU e 14%+TZD), SU 5%, TZD 1%; HbA1c 8.7(1.7)%, FBG 184.4(51.0) mg/dl, peso 104.3(21.1)kg, BMI 36.7(5.7)kg/m2. Il 53% era trattato con 1.8 mg/die. Risultati a 8 mesi: HbA1c -1.4%, FBG -41.6 mg/dl, peso -4.5 kg. Risultati a 12 mesi: HbA1c -1.4%, FBG -44.7 mg/dl, peso -5.7 kg. (Tutti p<0.0001). Sono state condotte analisi per classi di HbA1c e BMI al baseline. Risultati a 12 mesi per classi HbA1c <=7.5%, 7.6-8.5%, >8.5%: HbA1c -0.2%, -0.8%, -2.3%; FBG -27.6, -33.5, -62.1 mg/dl; peso -14.9, -0.9 (p=ns), -7.6 kg. Risultati a 12 mesi per classi di BMI <35, 35-39, >39: HbA1c -1.4%, -0.9%, -2.0%; FBG -58.1, -22.6 (p=ns), -49.7 mg/dl; peso -3.1, -2.9, -15.3 kg. Salvo ove indicato, tutti i p erano significativi.
**Discussione** A 12 mesi l'efficacia di Liraglutide osservata a 8 mesi viene mantenuta ed accentuata rispetto al calo di peso. L'efficacia si mantiene anche per le classi di glicata più basse, con un calo di peso rilevante per la classe inferiore. Rispetto al BMI, si nota un'efficacia trasversale alle varie classi, con calo ponderale importante per BMI>39.

## Una "strana" broncopolmonite con eosinofilia severa

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L'ipereosinofilia (eosinofili > 500/ mm3) può essere farmaco-indotta o comparire in corso di malattie allergiche, infestazioni parassitarie, malattie autoimmuni, neoplastiche ed ematologiche. Il riscontro di valori > 1500/mm3 si associa spesso ad infiltrazione dei tessuti con danno d'organo anche letale.
Riportiamo il caso di una donna di 62 anni, ex fumatrice, affetta da grave obesità, ipertensione arteriosa, BPCO, OSAS, DM tipo 2, senza storia di atopia. La paziente giunge nel nostro reparto per recente insorgenza di dispnea, febbre e tosse non produttiva con rilievo all'ingresso di insufficienza respiratoria globale ed addensamento polmonare in campo medio destro. Agli esami ematici leucocitosi con neutrofilia ed eosinofilia severa (5290/mm3). La paziente è stata trattata inizialmente con antibiotici per CAP, senza miglioramento. Una TC torace ha mostrato un quadro radiologico suggestivo per polmonite eosinofila cronica, ma la terapia steroidea è risultata inefficace. Per la severa eosinofilia (riscontro ai controlli successivi di eosinofilia 9000/mm3) ed il quadro di insufficienza respiratoria refrattaria è stata iniziata terapia con imatinib mesilato e successivamente con idrossiurea senza alcun beneficio. L'esame citologico su BAL è risultato positivo per adenocarcinoma. Il quadro radiologico rivisto alla luce della citologia era fortemente suggestivo per carcinoma bronchioloalveolare di tipo simil-polmonitico. La paziente è deceduta una settimana dopo la diagnosi per l'aggravamento dell'insufficienza respiratoria.

## Caso clinico di NET non secernente

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I tumori neuroendocrini (NET) sono un gruppo di neoplasie rare con manifestazioni cliniche eterogenee.
Donna di 67 anni, con storia di diverticolosi del colon e di ernia iatale, accede nel nostro reparto per comparsa da circa 1 anno di dispepsia, di alvo tendenzialmente diarroico e di episodi di dolore addominale ai quadranti inferiori. Una EGDS è risultata nei limiti. La colonscopia documentava la presenza di diverticolosi del sigma. Non presenti altri reperti patologici. Agli esami ematici anemia normocitica, nei limiti gli indici di flogosi, cromogranina A 648ng/mL (VN 10-185), Ca125 70.5 U/ml (VN>35U). Una TC addome con mdc ha documentato nel contesto del mesentere una massa di dimensione cm 4.6x3.5x6 con calcificazione interna. La massa era a stretto contatto con le anse intestinali con marcato ispessimento di queste ultime e trazione del mesentere associato a linfoadenopatia retroperitoneale, impianti peritoneali multipli e alterazioni di significato eteroplasico a carico dell'ovaio destro. La paziente è stata sottoposta ad intervento chirurgico esplorativo con conferma del quadro macroscopico di una malattia metastatica descritto alla TC. Ai fini diagnostici è stata eseguita asportazione dell'ovaio dx, un frammento di peritoneo del mesentere e di alcuni linfonodi patologici del tripode celiaco. La diagnosi istopatologica è risultata compatibile con neoplasia neuroendocrina G2 coinvolgente l'ovaio e tutti gli altri frammenti esaminati. La clinica, le caratteristiche radiologiche e l'esame istologico depongono per un NET non secernente del piccolo intestino.

## Treatment of bleeding peptic ulcer: our experience

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**Background** Bleeding peptic ulcer (PU) is a common gastroenterologic emergency. Aim of this study was to present our data regard the management of acute bleeding from PU during urgent endoscopy (examination performed in 2-6 h by the call).
**Material and Methods** We retrospectively analyzed 518 consecutive patients with PU (184 F, 334 M; median age 71.5 years; range: 19-100 years), who underwent urgent endoscopy for bleeding peptic ulcer in the years 2004-2010.
**Results** Out of 518 patients with PU, 240 (65.6%) were treated with endoscopic hemostasis followed by medical therapy (inhibitor proton pump –PPI-), while 178 (34.4%) patients received only medical therapy (PPI). All ulcerative lesions with endoscopic stigmata of acute bleeding, visible vessels or adherent clot (Forrest Ia-IIb) were treated during the gastroscopy. The endoscopic procedures used were: injection of adrenaline in 186 cases (55%); injection therapy and thermal method (argon plasma coagulation) in 106 cases (31%); injection therapy and mechanical method (metallic clips) in 40 cases (12%); only metallic clips in 8 cases (2%). Endoscopic hemostasis was achieved in 502 pts (97%), while 34 pts (6.5%) required a second endoscopy for rebleeding. Six patients (1.16%) underwent surgery for failure of primary endoscopic hemostasis. The mortality within 30 days from the bleeding episode was 3.9% (20 pts).
**Conclusions** Our data are in keeping with previous studies of the literature, that show how emergency endoscopy with specific techniques for hemostasis, significantly decreases rebleeding and the need for surgery.

## Bleeding peptic ulcers are related to seasons?

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**Background and aim** Previous studies have reported seasonal fluctuation in the incidence of peptic ulcer (UP) activity. Our aim was to assess the seasonality in the prevalence of acute beeding of UP during urgent endoscopy.
**Material and methods** We retrospectively analyzed 248 consecutive patients with PU (70 F, 178 M; median age 71.5 years; range: 19-100 years), who underwent urgent endoscopy for bleeding peptic ulcer in the years 2004-2010.
**Results** We found 248 cases of UP, 70 gastric ulcer (UG), 166 duodenal (UD) and 12 both (UG/UD). Out of these, 24 of 82 (29,27%) showed active bleeding from UG and 82 of 178 (46,07%) from UD. Consumption of anty-inflammatory drugs (FANS) were revealed in 97 patients (39,1%). Acute bleeding in the several season was the sequent: winter (6 UG and 30 UD), spring (8 UG and 316 UD), summer (4 UG and 16 UD), autumn (6 UG and 20 UD).
**Conclusions** Our study seems to indicate only a tendency of UD exacerbation during cold season (autumn and winter). Maybe, this could be explained also by the concomitant use of FANS especially during these seasons. If confirmed in a large series of patients, these data could help in the correct programming of the endoscopy's service.

## Endoscopic management of bile duct stones. Comparison of therapeutic ERCP between elderly and younger patients

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**Background and aim** Choledocholithiasis is increasing in elderly pts. The aim was to evaluate the rates of successful clearance of CBD stones and the endoscopic techniques (ET) used in a population aged 75 years-old or older compared with a younger group.
**Materials and methods** Data relating pts who underwent ERCP for CBD stones in the years 2010-2011 were analyzed. For each patient, gender, age at diagnosis, ET (stone extraction using baskets/baloon, mechanical lithotripsy (ML), baloon dilatation (ESD), placement of stent or naso-biliary tube) and need of surgery were analysed. Two groups of pts were identified: pts aged <75 years-old (group A) and pts aged ≥ 75 years-old (group B). For the statistical analysis were used Mann-Whitney and Fischer's Exact test.
**Results** 117 pts (56 F, 61 M; mean age of 78 years; range: 25-96) were enrolled in the study with 128 ERCP performed. Group A consisted of 47 pts (22 F, 25 M; mean age of 60.5±12.35 years; range: 25-74) and group B consisted of 70 pts (35 F, 35 M; mean age of 83.4±5.3 years; range: 75-96) (p<0,0001). No statistically significances were observed for gender, previous cholecystectomy, CBD dilatation, gallbladder stones and periampullary diverticula. Complete clearance of CBD stones was achieved in 115 pts (97.5%). For difficult stones, ML was performed in 10 (4 group A, 6 group B), ESD in 9 (4 group A, 5 group B), stent placement in 2 of group B, naso-biliary tube placement in 8 (3 group A, 5 group B) (NS). The need of surgery was 2.5%.
**Conclusion** ERCP is a safe and effective procedure also in older patients.

## Endoscopic balloon dilatation for benign colonic post-anastomotic strictures. Personal experience

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**Background and Aim** Colorectal post-anastomotic benign strictures are not uncommon. The purpose of this study was to investigate the results of endoscopic balloon dilatation of this kind of anastomotic strictures.
**Material and Methods** This study is based on an observational retrospective protocol. Records of 15 consecutive patients with benign post-anastomotic colorectal strictures (5 F, 10 M; median age 64 years; range: 50-87 years), attending our GI Unit from February 1st 2008 to December 31st 2010, were analyzed. All patients had been operated for colon carcinoma. The anastomosis was performed mechanically (Stapler) in 12 cases and manually in 3 cases. Intravenous antibiotic prophylaxis was administered 2 h before the procedure (ceftriaxone 2gr). All the dilatation were perfomed with the assistance of the anaesthetist, using propofol e.v. for sedation. All of them were treated with pneumatic dilatation using balloon TTS (through the scope) (ECL colonic dilatation baloon, Cook e CRE, Microvasive, Boston Scientific), under endoscopic and fluoroscopic guidance.
**Results** All the patients presented symptoms of obstruction. The total number of dilatation sessions was 39 and the median number of sessions by patient was 1,5 (range: 1-7). After the procedures, all patients had an improvement of symptoms. No complications were observed.
**Conclusions** Our experience underlines that endoscopic ballon dilatation, in patients with post anastomotic benign strictures, is a safe technique with a low rate of complications.

## Correlation between magnetic resonance imaging (MRI) and faecal calprotectin in Crohn's disease

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**Background and Aim** Calprotectin may be considered a marker of intestinal inflammation. To investigate the role of MRI in CD for assessment disease activity in comparison with faecal calprotectin (FC) levels.
**Material and methods** 24 consecutive CD pts (12 F,12 M, median age:56; range: 22-77) were studied. At the time of the MRI examination, pts provided a single stool sample for calprotectin measurement (ELISA, Calprest). Pathological values were considered >50 mg/g. All pts underwent MRI, performed at 1.5 T, with HASTE T2w with and without fat-saturation, FLASH T1w fat-saturated sequences pre and post iv injection of 10 ml of Gadolinium. The MRI degree of wall inflammation was graded with a 0-3 scoring system (0=absent 1=light 2=moderate 3=severe) by considering findings observed on T1 post Gd and T2 fat-suppressed images, as the degree of wall thickness. The length of extension was in divided into < 15 cm, between 15-30 cm and > 30 cm. Kruskal-Wallis test was used for statistical analysis.
**Results** Grade 0 was found in 1 pt (FC 206,25 mg/g); Grade 1 in 4 pts (median FC of 100 mg/g: 5-325); Grade 2 in 10 pts (median FC of 243,75 mg/g: 7,5-606,25); Grade 3 in 9 pts (median FC of 1012,5 mg/g: 30-1268,8). A trend of correlation was found between MRI scores and calprotectin levels (p<0,0074). No apparent correlation was observed between FC concentration and lenght and thickening of intestinal involvement.
**Conclusions** Our data show an appearent relationship between calprotectin levels, which correlate with the degree of mucosal inflammation, and MRI findings.

## A 43-year-old man, with ulcerative cutaneous masses on the abdomen

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A 43-year-old man, Romania's ethnic group was admitted to the emergency room with a one year history of small asymptomatic, brown macules on the abdomen. Two of these Macules, in the last three months has developed rapidly, and become solid masses mobile with ulceration (Figure A).His medical history Without disease, he denies any prior surgeries, he is heavy smoker,drink alcohol at weekends. On physical examination, temperature is 36,5°C. Pulse is regular, with a rate of 70 beats/min.Blood pressure is 120/80 mm Hg, and Respiratory rate is 14 breaths/min. auscultation of the heartreveals a normal S1 and S2, the lungs are clear, palpation of the abdomen reveals two superficial solid masses mobile, no tenderness, or enlargement of the liver or spleen. The biochemical parameters examined are within normal physiologic limits. Hematologic examination shows a Hemoglobin level of 14.7 g/dL, total leukocyte count of 9,580 x 103/µL and a platelet count of 192 x 103/ml. A biopsy of the solid mass was performed, and dermal infiltration of large B cell lymphoma. (Figure B,C). Both immunohistochemical staining and flow cytometric analysis reveal neoplastic cells positive for CD20+,and negative for CD30+.Total Body CT was performed showed only two masses 7x2,5x5cm in soft tissue on the abdomen, without lymphadenopathy. A bone marrow biopsy does not show any lymphomatous infiltration. He had undergone medical treatment with combined use of rituximab and CHOP.

## Neurofibromatosis type 1 associated with pheochromocytoma

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A 47-years-old Romanian man was admitted to our department for palpitation, sweating and headache due to hypertensive crisis (BP 190/115). He lives in Italy for about two years. His medical history is neurofibromatosis type1 See (Panel A and B). Last year he was admitted to another hospital for weakness of the left side, there was found low-grade glial tumors in the brainstem. He refused to perform the radiotherapy. NF-1 is an autosomal dominant multisystem disorder. The most prominent clinical hallmarks of the disorder are café-au-lait macules, neurofibromas (dermal plexiform), and axillary/inguenal freckling (Crowe's sign). Other clinical manifestations are abnormalities of the cardiovascolar, skeletal, Gastrointestinal, ophthalmologic,Endocrine systems, facial and body disfigurement ,cognitive deficits. About 25% of people with neurofibromatosis type 1 develop one or more of these clinical complications, which together cause significant morbidity and mortality. The tumors that occur in NF-1 are dermal and plexiform neurofibromas,optic gliomas malignant peripheral nerve sheath tumors, rhabdomyosarcomas and adrenal, extraadrenal abdominal,and extraadrenal-thoracic PHEO. In our patient A CT scan of the abdomen, chest showed diffuse pulmonary nodules. Urinary catecholamines were makedly increased. Extraadrenal-thoracic PHEO was diagnosed. PHEO occurs in 0,15-5,7% of patients with NF-1. After diagnosis of NF-1, patients who have episodes of hypertension, sweating, headache and palpitation should be evaluated for Pheochromocytoma.

## Swollen shoulder in young woman

S. Ziyada [1], R. Schirripa [1], V. Valeriano [1], M.C. Zaccaria [2], R. Satira [1], F.R. Pugliese [1]

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23 year old woman presents to the emergency department with a days history of pain,swollen of left shoulder and cold hand after physical work. Her medical history Without disease, She denies any prior surgeries, and her only medications are oral contraceptives agents in the past for a long time. She does not smoke tobacco, drink alcohol, or use illicit drugs.On physical examination, temperature is 36.8°C. Pulse is regular,with a rate of 80 beats/min. Blood pressure is 135/80 mm Hg, and Respiratory rate is 14 breaths/min. Swollen of left shoulder, auscultation of the heart reveals a normal S1 and S2, with no murmurs or rub. Palpation of the abdomen reveals no tenderness,masses, or enlargement of the liver or spleen, the lungs are clear. The biochemical parameters examined are within normal physiologic limits. C-reactive protein levels are 8.3mg/dl, D-dimer 403ng/ml, Fibrinogen 536mg/dl.the hematologic examination shows a Hemoglobin level of 11.5 g/dL, total leukocyte count of 10,800 x103/µL and a platelet count of 434 x 103/ml. Ananteroposterior chest x-ray does not show any localized lesions in the lungs.A contrast chest and abdomen computed tomography (figure 1) demonstrates in the anterior mediastinum is detected the presence of mass 9.1 x 6.1 x 9.8 cm.Thrombosi the left jugular vein (figure 2),left para-aortic lymphadenopathy (figure 3).
The biopsy is performed and the results showed non-Hodgkin.

## Quando l'edema colpisce l'intestino

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**Caso clinico** Ragazzo di 26 anni, che presenta fin dall'età di 8 episodi di addominalgia tipo colica associata a nausea e vomito in assenza di febbre. Tali episodi regredivano nell'arco di 48 ore per ripresentarsi a distanza di un mese . Il pz veniva ricoverato in osservazione breve, eseguiva rx addome: neg ed esami bioumorali che evidenziavano leucocitosi ( GB 19.000), non anemia, né alterazione PCT o PCR.
**Metodo clinico** Vista la recidiva degli eventi acuti, il pz viene sottoposto ad ulteriori accertamenti diagnostici: eco addome e tac addome. Entrambi evidenziavano la presenza di ascite in sede periepatica e perisplenica con presenza di modica distensione nell'ultima ansa intestinale.
**Diagnosi** Differenziale Il pz veniva posto in DD con M Crohn ( addominalgia e distensione ultima ansa intestinale), mal neoplastica ( retro peritoneale, neuroendocrina?). Mal rara: PAI? o Angioedema ereditario ( per le ricorrenti addominalgie).
**Conclusioni** Venivano escluse la mal, infiammatorie intestinali o neoplastiche,per negatività EGDS, Colonscopia, PET e dosaggio CgA. In seconda battuta veniva eseguito il dosaggio delta-aminolevulinico e porfobilinogeno nelle urine e il C1 esterasi inibitore nel sangue. Quest'ultimo aveva un attività funzionale < al 60% ponendo diagnosi di Angioedema ereditario. E' una malattia dovuta alla carenza, nel siero, dell'inibitore della prima frazione del complemento per difetto genetico ( 25% dei casi è de novo) e clinicamente si manifesta con ricorrenti episodi di edema a livello cutaneo, laringeo o intestinale. Alta mortalità se vi è edema laringeo.